Keeping Warfighters Ready. For Life.

Evaluation of the TRICARE Program:
Access, Cost, and Quality

Fiscal Year 2012
Report to Congress

TRICARE®

Evaluation of the TRICARE Program
Access, Cost, and Quality

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, 2012

The **Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2012 Report to Congress** is provided by the TRICARE Management Activity (TMA)/Office of the Chief Financial Officer (OCFO)—Defense Health Cost Assessment and Program Evaluation (DHCAPE), in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). Once the Report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx*.

Front cover photo descriptions, from left to right:

A – A Marine Corporal injured during deployment to Iraq becomes the first Marine with an above-the-knee amputation to deploy to Afghanistan.

B – A Coast Guard helicopter crew performs a search and rescue exercise at the Panama City Marina.

C – Airmen load pallets of technical search and rescue gear that will provide assistance after the 2011 earthquake and tsunami hit Japan.

D – The Arleigh Burke-class guided missile destroyer USS Barry launches a Tomahawk cruise missile as part of Odyssey Dawn, the U.S. military support for the international response to the unrest in Libya and enforcement of United Nations Security Council Resolution 1973.

E – Marines assigned to the 2nd Assault Amphibian Battalion, Ground Combat Element, check their gear during a break in a Southern Partnership Station training exercise.

F – A retired U.S. Air Force Master Sergeant becomes the first female to undergo a hand transplant at a Defense Department facility.

G – A U.S. Air Force Sergeant looks over a toddler during a medical civil action program at a village school in Goubetto, Djibouti.

H – The B-1B Lancer flies as one of the aircraft joint terminal attack controllers often requested for close-air support.

I – U.S. Army Soldiers and Afghan Border Police walk along a mountain trail during a patrol near Combat Outpost Herrera in the Paktiya province of Afghanistan.

J – U.S. Navy Sailors treat patients as part of continuing relief efforts in Haiti.

K – Navajo Code Talkers participate in a ceremony at Kirtland Air Force Base, N.M., to pay tribute to veterans and to celebrate Native American Heritage Month.

Photos used throughout this report are courtesy of U.S. Army, www.navy.mil, www.usmc.mil, and www.af.mil/photos.

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

MILITARY HEALTH SYSTEM MISSION

EXECUTIVE SUMMARY

INTRODUCTION

NEW BENEFITS AND PROGRAMS IN FY 2011 SUPPORTING THE MHS QUADRUPLE AIM

MHS WORLDWIDE SUMMARY: POPULATION, WORKLOAD, AND COSTS

EXPERIENCE OF CARE

EXPERIENCE OF CARE (CONT'D)

POPULATION HEALTH

PER CAPITA COST

READINESS

APPENDIX

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

It is an honor and a privilege to provide to the Congress our annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. In addition to responding to Section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106) requiring an assessment of TRICARE program effectiveness, this report extends our analysis of clinical quality furnished by the Military Health System (MHS) and related measures.

Our funded $54 billion FY 2012 Unified Medical Program (UMP) supports the physical and mental health of 9.7 million beneficiaries worldwide. The MHS extends from theater medical care for our deployed forces to the daily "peacetime" health services provided. The FY 2012 UMP is 16 percent larger than in FY 2009, commensurate with increases in population served, workload, and medical inflation. Health care costs for Overseas Contingency Operations (OCO) and caring for our wounded, ill, or injured (almost $3 billion) were 6 percent of the FY 2011 UMP. Purchased care cost increases have been partially mitigated by implementing the Outpatient Prospective Payment System for reimbursing outpatient services, utilizing rebates from drug manufacturers, and encouraging the use of the less costly pharmacy home delivery program. Enrollment is growing in new premium-based benefit programs such as TRICARE Young Adult and TRICARE Retired Reserves, and, in FY 2011, surpassed 200,000 covered lives in TRICARE Reserve Select. We continuously strive to improve the quality of health care and safety of our patients, engaging our population to encourage healthy behaviors and assessing beneficiary satisfaction.

This report describes the mission, vision, and core values of MHS leadership, and presents 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. The unprecedented length of two wars has taxed our resilience in providing operational medical support and managing returning wounded warriors with complex, long-term health care needs. The slow recovery from a severe global recession coupled with a growing number of senior beneficiaries beginning to receive promised entitlements have created a daunting federal fiscal challenge that will impact both the Department of Defense (DoD) and the military health care system. Military medicine will likely undergo major changes in the years to come in response to fiscal challenges to reduce and consolidate infrastructure, improve efficiencies, and provide comprehensive, consistent, and high-quality health care benefits. There will be more emphasis on healthy living to reduce the chronic disease burden of our eligible population, and changes in the delivery of health care involving greater collaboration, continuity, and accountability. Our guide for mastering the required transformation is the Quadruple Aim, the four key elements that define military medicine: readiness, better health, better health care, and responsibly managed costs.

This evaluation report presents results trended over at least the most recent three fiscal years, where programs are mature and data permit. MHS cost, quality, and access data are compared with corresponding comparable civilian benchmarks, such as comparing beneficiary-reported access and experience to results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sponsored by the Agency for Healthcare Research and Quality (AHRQ), comparing our quality measures to the national expectations and results of the Joint Commission, and comparing health-risky behavior to Healthy People 2020 objectives. I am proud of the accomplishments of the MHS and the TRICARE program, and inspired by the focus of leadership toward critical appraisal and efforts to improve continuously the TRICARE benefit and our processes. Once this report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx. — Jonathan Woodson, M.D.*

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The purpose, mission, vision, and overall strategy of senior DoD and MHS leadership are focused on the core business of 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. 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.*

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. Key MHS mission elements of research and innovation, medical education and training, and a uniformed sustaining base and platform are interdependent and cannot exist alone. A responsive capacity for research, innovation, and development is essential to achieve

MHS PURPOSE, MISSION, VISION, AND STRATEGY *(CONT'D)*

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 these quality medical professionals without a uniformed sustaining base and platform that can produce healthy individuals, families, and communities.

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. Since the fall of 2009, MHS leaders agreed to align the MHS strategic plan with the unifying construct of the Triple Aim proposed by the Institute for Healthcare Improvement (IHI; *http://www.ihi.org/IHI/Programs/StrategicInitiativesTripleAim.htm*), consistent with the primacy of our readiness mission. Centered on Readiness to reflect our core mission and reason for being, the MHS Quadruple Aim embodies the goals of the Triple Aim construct designed to achieve the kind of results expected when all of the elements of a true health care system work together to serve the needs of a population.

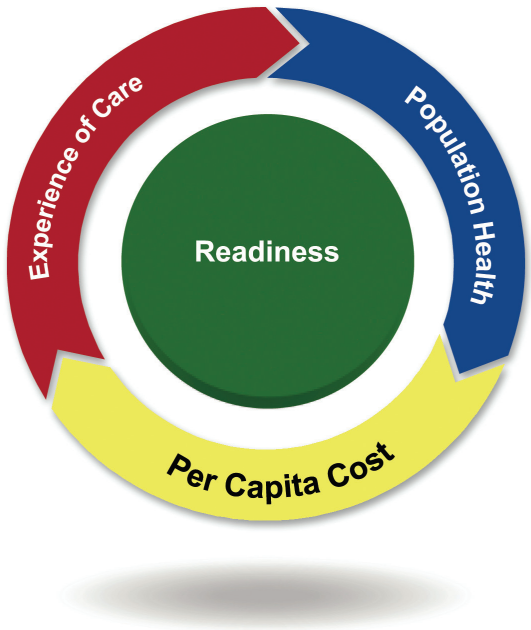
MHS QUADRUPLE AIM AND STRATEGIC DIRECTION AND PRIORITIES IN FY 2012 AND BEYOND

The MHS Quadruple Aim:

- **Readiness**
  Readiness means 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. The Readiness Aim includes strategic imperatives of Individual and Family Medical Readiness and Psychological Health and Resiliency.

- **Population Health**
  The Population Health Aim entails 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. The protection of the health of deployed Service members and the DoD civilian employees is paramount to the sustainment of readiness and an inherent component of population health. The Population Health Aim includes strategic imperatives such as Engaging Patients in Healthy Behaviors, the results of which are monitored by various measures, including the use of tobacco, the prevalence of obesity, and the use of preventive services among the MHS population.

- **Experience of Care**
  The focus of the Experience of Care Aim is to provide a care experience that is patient- and family-centered, compassionate, convenient, equitable, safe, and always of the highest quality. The Experience of Care Aim includes strategic imperatives of Evidence-Based Care (supported by hospital quality indexes), Wounded Warrior Care (supported by turnaround 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).



- **Per Capita Cost**
  The goal of the Per Capita Cost Aim is to responsibly manage total health care costs by focusing on quality, eliminating waste, and reducing unwarranted variation, and by considering the total cost of care over time, not just the cost of an individual health care episode. The Per Capita Cost 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.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2011

Stakeholder Perspective

- The $54 billion slated for the Unified Medical Program (UMP) for FY 2012 is 16 percent greater than the almost $47 billion spent in FY 2009. The UMP was 5.4 percent of the FY 2011 total Defense expenditures (including the normal cost contribution to the Accrual Fund for retirees), and is expected to be almost 7 percent of the FY 2012 Defense budget as currently programmed (Ref. pages 17–18).
- The number of beneficiaries eligible for DoD medical care increased from 9.6 million in FY 2009 to 9.7 million at the end of FY 2011 (Ref. page 10).
- The number of enrolled beneficiaries remained at about 5.5 million from FY 2009 to FY 2011 (Ref. page 15).
- The percentage of beneficiaries using MHS services increased from 82.4 percent in FY 2009 to 83.5 percent in FY 2011 (Ref. page 16).

MHS Workload and Cost Trends[1]

- Excluding TRICARE for Life (TFL), total MHS workload grew from FY 2009 to FY 2011 for all major components—inpatient (+5 percent), outpatient (+20 percent), and prescription drugs (+7 percent) (Ref. pages 20–22).
- Direct care inpatient workload grew by 3 percent, outpatient workload by 14 percent, and prescription workload by 3 percent from FY 2009 to FY 2011. Overall, direct care costs increased by 11 percent. Purchased care workload rose for all service types, especially for prescription drug services, which grew by 14 percent. Overall, purchased care costs rose by 10 percent, but the increases were mitigated somewhat by the Outpatient Prospective Payment System, rebates from drug manufacturers for TRICARE retail pharmacy brand-name drugs, and a campaign to educate beneficiaries on the benefits of home delivery pharmacy services (Ref. pages 20–23).
- The purchased care portion of total MHS health care expenditures held steady from FY 2009 to FY 2011 at about 50 percent. As a proportion of total MHS health care expenditures (excluding TFL), FY 2011 purchased care expenditures were 58 percent for inpatient care, 56 percent for prescription drugs, and 45 percent for outpatient care (Ref. page 23).
- Out-of-pocket costs for MHS beneficiary families under age 65 are between $4,100 and $4,400 lower than those for their civilian counterparts. Out-of-pocket costs for MHS senior families are $2,700 lower than those for their civilian counterparts (Ref. pages 78, 80, 83).

Access to Care

- **TRICARE Young Adult (TYA):** Less than five months after the TYA program began, enrollment has reached 9,400, most of whom are family members of non-Active Duty (82 percent; Ref. page 24).
- **Overall Outpatient Access:** Access to and use of outpatient services remained high, with 85 percent of Prime enrollees reporting at least one outpatient visit in FY 2011 (Ref. page 29).
- **Availability and Ease of Obtaining Care:** MHS beneficiary ratings for getting needed care and getting care quickly improved between FY 2009 and FY 2011 but continued to lag the civilian benchmark (Ref. page 30).
- **Doctors' Communication:** Satisfaction levels of non-enrollees with their providers exceeded that of their civilian counterparts between FY 2009 and FY 2011. Prime enrollees' satisfaction with military primary care managers lagged the civilian benchmark (Ref. page 31).
- **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 grown at a slightly greater rate than the number of specialists (Ref. page 33).
  - Results from the third of a four-year survey indicate 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. Psychiatrists and nonphysician behavioral health providers report lower awareness and acceptance than physicians in general (Ref. page 34).

Experience of Care

- **Overall Customer Satisfaction with TRICARE:** MHS beneficiary global ratings of satisfaction with the TRICARE health plan and health care improved from FY 2009 to FY 2011 (exceeding the civilian benchmark for health plan). Global satisfaction ratings of personal provider and specialty physician remained stable, but still lagged the civilian benchmark (Ref. pages 38–42).
- Satisfaction with the TRICARE health plan increased for Prime enrollees and non-enrollees (Ref. page 39).

Population Health

- **Meeting Preventive Care Standards:** For the past three years, MHS has exceeded targeted Healthy People (HP) 2020 goals for mammograms and prenatal exams. Efforts continued toward trying to achieve HP 2020 standards for Pap smears, flu shots (for age 65 and older), and blood pressure screenings. The overall FY 2011 self-reported rate for smoking among beneficiaries (13 percent) remained above the HP 2020 adjusted goals (12 percent smoking; Ref. pages 53–59).

Readiness

- **Reserve Component Enrollment in TRICARE Plans:** National Guard and Reserve enrollment in the TRICARE Reserve Select (TRS) benefit program topped 201,000 covered lives by the end of FY 2011 in over 76,000 individual-only and family plans. Enrollment in TRICARE Retired Reserve (TRR) reached almost 2,000 covered lives in nearly 900 individual and family plans (Ref. page 85).
- **Force Health Protection:** Overall MHS dental readiness remained high and stable between FY 2009 and FY 2011 (Ref. page 88).

[1] 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.

WHAT IS TRICARE?

TRICARE is the Department of Defense health care program serving 9.7 million Active Duty Service members, National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide (*http://www.tricare.mil/mybenefit/home/overview/WhatIsTRICARE?*). As a major component of the Military Health System (MHS; *www.health.mil*), TRICARE brings together the worldwide health care resources of the Uniformed Services (often referred to as "direct care," usually in military treatment facilities, or MTFs) and supplements this capability with network and non-network participating civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care") to provide access to high-quality health care services while maintaining the capability to support military operations.

In addition to providing care from MTFs, where available, TRICARE offers beneficiaries a family of health plans, based on three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as the 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 Enrollment Eligibility 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 Transitional Assistance Management Program (TAMP) to continue accessing any of TRICARE's three major options following deactivation, or the premium-based TRICARE Reserve Select (TRS) or TRICARE Retired Reserves (TRR) for those who are retired from Reserve status but not yet eligible for the TRICARE benefits as a military retiree;
  - 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 Benefit Program; and
  - Clinical and educational services demonstration programs (such as chiropractic care, autism services, and TRICARE Assistance Program [TRIAP]).

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; and
- Communicate and distribute educational information to beneficiaries and providers.

NEW BENEFITS AND PROGRAMS IN FY 2011 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

T-3 Contracts

Health care delivery in the TRICARE North Region began April 1, 2011, under the new third generation (T-3) contract with Health Net Federal Services after resolving bid protests since initial selection in July 2009. Health care delivery under the new T-3 contract is scheduled to begin in the TRICARE South Region in April 2012 with Humana Military Healthcare Services. The T-3 contract review will continue into FY 2012 for the TRICARE West Region.

Dental Care

TRICARE Management Activity (TMA) awarded the TRICARE Dental Program (TDP) contract to Metropolitan Life Insurance Company of Bridgewater, N.J., with a base year award of over $7 million for care coverage to begin February 1, 2012, and five one-year options valued at $1.9 billion. Under the new contract, all enrollees will have lower premiums in the first year. The TDP rates will change in FY 2012. The TDP is a voluntary, premium-sharing dental insurance program that is available to eligible Active Duty family members, Selected Reserve and Individual Ready Reserve members, and their families. The monthly TDP premiums for Active Duty family members will decrease on May 1, 2012, from $12.69 in single plans and $31.72 in family plans in 2011 to $10.30 and $30.89, respectively, while the rates for Guard/Reserves and their families will decrease from $31.72 (single enrollment) and $79.29 (family enrollment) to $25.74 and $77.22, respectively (*www.tricare.mil/mybenefit/home/Dental/DentalProgram* and *www.tricare.mil/TDPcontract*).

QUADRUPLE AIM: EXPERIENCE OF CARE

Wounded Warrior Care

Landstuhl Regional Medical Center Opened a European-Based Mild Traumatic Brain Injury Center

The first center offering comprehensive care for European-based mild Traumatic Brain Injury (TBI) patients opened February 25, 2011, at Landstuhl Regional Medical Center. The center is staffed with 32 military and civilian employees covering medical disciplines that include neurology, optometry, audiology, physical therapy, speech language pathology, occupational therapy, psychology, and nurse case managers.

Patients needing care beyond the scope of their local health clinic can travel to Landstuhl Regional Medical Center for more intensive treatment, which includes the Synapse Program, a four-week in-resident program.

Access to Care

TRICARE Young Adult Program

The premium-based TRICARE Young Adult (TYA) program implements the NDAA of FY 2011. The Patient Protection and Affordable Care Act of 2010 required civilian health plans to offer coverage to adult children until age 26. Dependent eligibility for TRICARE previously ended at age 21, or age 23 for full-time college students. The TYA program offers TRICARE Standard coverage for a monthly premium of $186 (dropped to $176 on January 1, 2012). TRICARE Prime coverage was available for purchase December 1, 2011, and coverage began January 1, 2012. The monthly premium for TYA TRICARE Prime is $201. The TYA TRICARE Prime enrollment follows the 20th of the month rule. Beneficiaries whose applications are received by the 20th of the month will begin coverage on the first of the following month (*www.tricare.mil/tya/*).

Improving Access through Technology

TRICARE Online, the MHS patient portal, enables users who get care at an MTF to schedule appointments, track their medications, order prescription refills, and view and even download their personal health records. Patients can now also get their laboratory and x-ray results through the portal, along with secure messaging from their health care providers.

TRICARE plans to increase the number of clinics that offer online appointment scheduling. In addition, health care providers will begin using the portal to get patients to fill out forms and questionnaires at their convenience before they arrive for their appointments.

Beneficiaries increasingly are taking advantage of the new capability. During one week in January 2011, they scheduled almost 3,000 appointments and refilled more than 1,000 prescriptions.

TriWest, the TRICARE health care support contractor for the West Region, developed a smartphone application ("app") for TRICARE beneficiaries. TriWest's app can be downloaded free through the iTunes Store and Android Market. The app organizes health care provider contact information and provides other information, such as TRICARE plan comparisons and guidelines on what to do in the case of a major life change. For security reasons, confidential health data is not available on the app,

although customers can connect to the secure mobile TriWest Web site through the app and enter their user ID and password.

Health Net Federal Services, LLC, the TRICARE health care support contractor for the North Region, launched a mobile app in October 2011. The app allows users to locate providers, urgent care, and convenient clinics anywhere in the North Region (*https://www.hnfs.com/content/hnfs/home/tn/common/mobile.html/pp/content/hnfs/home/tn/bene*).

Humana Military Healthcare Services, the health care support contractor for the South Region, has launched a Web site for mobile phones and tablets. Some of the traditional Web site's features such as the provider locator and TRICARE eligibility check are now available through iPhone, Android, Blackberry devices, and tablet operating systems, as well as other phones with Internet capabilities. The Interactive Voice Response (IVR) telephone system allows text messaging to an Internet-enabled phone on topics such as TRICARE Prime enrollment payments and a link to the TRICARE provider locator. Find more information at *www.humana-military.com*.

Pharmacy Benefits

Generic Pharmacy Prescription Home Delivery Copayments Reduced

As of October 1, 2011, beneficiaries using TRICARE Pharmacy Home Delivery services for generic formulary drugs will see their copayments reduced to zero. Brand-name formulary drugs purchased through Home Delivery will continue to have a $9 copayment. Copayments for prescriptions filled through Home Delivery cover a 90-day supply, but only cover a 30-day supply when purchased at a retail pharmacy.

TRICARE Expands Retail Pharmacy Vaccine Program

Effective August 12, 2011, TRICARE has expanded the number of preventive vaccines covered at retail network pharmacies. Since late 2009, TRICARE has covered seasonal flu, H1N1 flu, and pneumococcal vaccines at retail pharmacies, while other vaccines were covered only when obtained through a physician's office. The expanded program covers immunizations for measles, mumps, shingles, and many other preventable diseases, and waives all copays for TRICARE beneficiaries who obtain vaccination services from network pharmacies. Beneficiaries who obtain vaccines through their regular physician do not pay copayments for preventive care such as immunizations and recommended screenings, but usual cost shares and copayments for office visits may apply (*www.tricare.mil/vaccines/*).

TRICARE Pharmacy Mobile App

TRICARE and Express Scripts, Inc. now offer the TRICARE Express Rx mobile app and mobile-optimized Web site. Beneficiaries can register for TRICARE Pharmacy Home Delivery, switch current prescriptions to home delivery, order refills, and check order status. On GPS-enabled smartphones, the app can direct beneficiaries to the closest retail pharmacy in their network. Beneficiaries must register through the member portal at *www.express-scripts.com/TRICARE* before logging in to the Express Rx app or mobile-optimized site. For more information about TRICARE pharmacy, visit *www.tricare.mil/pharmacy*.

Customer Service

Transferring Prime Enrollment for Active Duty Families Moving to New Locations

The "Moving Made Easy" option allows Active Duty Service members and their families to transfer their Prime enrollment option to a new region before they move. Once the Service member knows of the pending move, he or she should call the current contractor and give them information about the upcoming move. The current contractor begins the enrollment transfer, and the new contractor will contact the Service member within five days of the arrival date to complete the process. The Service member should not disenroll from any plan before the move. Active Duty Service members must enroll in a TRICARE Prime option (TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Overseas, or TRICARE Prime Remote Overseas). Family members must be command-sponsored to enroll in a TRICARE Prime option overseas.

TRICARE Retired Reserve-DoD Self-Service Logons for Gray-Area Retirees

Since September 1, 2010, members of the Retired Reserve who are not 60, the so-called "gray-area" retirees, have been able to purchase TRICARE Retired Reserve (TRR) to provide health coverage for themselves and their eligible family members. To make purchasing TRR easier, gray-area retirees can now get a DoD Self-Service Logon (DS Logon) by contacting the Defense Enrollment Eligibility Reporting System/Defense Manpower Data Center Support Office (DSO, 1-800-538-9552) and remotely verify their identity. The DS Logon can be used to access the Web-based Reserve Component Purchased TRICARE Application (RCPTA) to qualify for and purchase TRR.

Gray-area retirees who do not have a retired ID card and a DS Logon can get both at a Real-Time Automated Personnel Identification System (RAPIDS) ID card issuing site (RAPIDS sites are locatable at *www.dmdc.osd.mil/rsl*) or via a nearby Department of Veterans Affairs (VA) regional office (*www.vba.va.gov/vba/benefits/offices.asp*).

Data Breach

On September 14, 2011, TMA learned that Science Applications International Corporation (SAIC) had a data breach involving personally identifiable and

protected health information (PII/PHI) affecting an estimated 4.9 million military clinic and hospital patients. The measures taken by TMA to respond to and mitigate the breach exceeded industry standards, including measures to offer patients peace of mind that their credit and quality of life would be unaffected by this breach.

- Considering the totality of the circumstances, TMA determined that potentially impacted persons or households would be notified of the incident via letter from SAIC. The company mailed a final total of 4,714,184 notification letters.
- TMA also directed SAIC to set up an Incident Response Call Center to address questions and concerns from impacted patients.
- TMA mandated that SAIC provide one year of credit monitoring for those patients who request it and restoration services to patients who qualify. Additionally, SAIC will be conducting analysis of all available data to help TMA determine if identity theft occurs because of the data breach.

QUADRUPLE AIM: POPULATION HEALTH

TRICARE's Patient-Centered Medical Home

Under the medical home concept, patients are assigned to a medical team that typically consists of a doctor, a physician's assistant, a nurse, and medical technicians. Every member of the provider team has access to the beneficiary's medical records, and works with the rest of the team to provide the best care possible. When patients visit a hospital or clinic or call in with a question or concern, they see or talk to a member of that team—not another health care provider who steps in because the patient's provider is unavailable. This improves the patient experience by improving continuity of care. If the patient needs to be referred to a specialist, the team makes the referral and tracks the results.

In 2011, over 750 TRICARE network providers were certified as medical homes, and 655,000 MTF beneficiaries were enrolled in the medical home concept, with a continuing goal of reaching 2 million.

HPV DNA Testing for Women 30 and Older

TRICARE has added coverage for an enhanced cervical cancer screening test that helps detect the human papillomavirus (HPV). HPV infections can cause cervical cancer. The HPV DNA test is covered under TRICARE's clinical preventive services when performed in conjunction with a Pap smear for women aged 30 and older. Coverage is based on national guidelines for the use of HPV DNA testing and is retroactive to September 7, 2010.

The TRICARE Assistance Program Has Been Extended through March 20, 2012

The Web-based TRICARE Assistance Program (TRIAP) Demonstration, which began on August 1, 2009, and is available from any location in the United States, was extended through March 20, 2012, to continue evaluating the effectiveness of Web-based technologies to deliver information and counseling services to our beneficiaries. The demonstration program allows Active Duty Service members and their families to use the Internet and a Web cam to speak "face-to-face" with mental health counselors. All TRIAP services are provided on a one-to-one basis, in the context of a confidential relationship, with a licensed professional. TRIAP services are available in the United States to Active Duty Service members, Active Duty family members (children must be age 18 or older), beneficiaries using TRICARE Reserve Select (TRS), and beneficiaries covered under the Transitional Assistance Management Program (TAMP). A referral or prior authorization is not needed (*www.tricare.mil/TRIAP*).

QUADRUPLE AIM: PER CAPITA COST

Increase in TRICARE Fees

Participant fees under TRICARE were set in 1995 and have remained unchanged at $230 per year for individual plans and $460 per year for family plans. Costs for new enrollees will increase in the next fiscal year, beginning October 1, 2011. Beneficiaries who join TRICARE Prime in FY 2012 will pay an additional $2.50 per month for individual members and $5 per month for family enrollment, bringing the total annual fee to $260 and $520, respectively. Costs for retirees already in the program, as well as survivors of Active Duty Service members and medically retired participants, remain at $230 and $460 per year until October 1, 2012. Additionally, premiums for the TRS and TRR will increase in FY 2012 (see page 85).

QUADRUPLE AIM: READINESS

New Adenovirus Vaccine

The Food and Drug Administration (FDA) approved the vaccine on March 16, 2011. Adenovirus can cause severe flu-like illness and is commonly transmitted person-to-person in basic training sites where recruits live in close quarters.

The vaccine is indicated for active immunization to prevent febrile acute respiratory disease caused by Adenovirus Types 4 and 7, and is approved solely for use in military populations 17 through 50 years of age. The current DoD policy is to administer the vaccine only to new military recruits during in-processing at basic training locations. The vaccine was developed specifically for the U.S. Military by Teva Pharmaceuticals USA, Inc./Barr Laboratories, Inc. DoD will be the only user of the vaccine.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2012[1]

Total Beneficiaries	9.7 million[2]
Military Facilities—Direct Care System	**Total[3] U.S.**
Inpatient Hospitals and Medical Centers	56 (41 in U.S.)
Ambulatory Care Clinics	365 (293 in U.S.)
Dental Clinics	281 (213 in U.S.)
Veterinary Facilities	255 (199 in U.S.)
Military Health System (MHS) Personnel	144,376
Military	86,007 31,843 Officers 54,164 Enlisted
Civilian	58,369
Civilian Resources—Purchased Care System[4]	
Network Individual Providers (primary care, behavioral health, and specialty care providers)	438,424 (from 379,233 in FY 2011)
Network Behavioral Health Providers (included in above)	59,587
TRICARE Network Acute Care Hospitals	3,224 (from 3,146 in FY 2011)
Contracted (Network) Retail Pharmacies	64,712 (from 63,775 in FY 2011)
Contracted Worldwide Pharmacy Home Delivery Vendor	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	Over 2 million covered lives, in over 800,000 contracts
Network Dentists	72,459 59,196 general dentists 13,263 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and families)	Over 1.3 million covered lives, in almost 640,000 contracts
Total Unified Medical Program (UMP)	$54.1 billion[5]
(Includes FY 2012 receipts for Accrual Fund)	$10.85 billion

[1] Note: Unless specified otherwise, this report presents budgetary, utilization, facility, 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 beginning of FY 2012 is 9,667,000, rounded to 9.7 million, is based on the Projection of Eligible Population (PEP), OASD(HA) Deputy Assistant Secretary of Defense, Health Budgets and Financial Policy Memo dated November 23, 2011.

[3] MTF data from real property reports, Office of the Chief Financial Officer, December 15, 2011.

[4] As reported by TRICARE Regional Offices for contracted network providers and hospitals, and TRICARE Program Operations Division Dental managers for dental provider data.

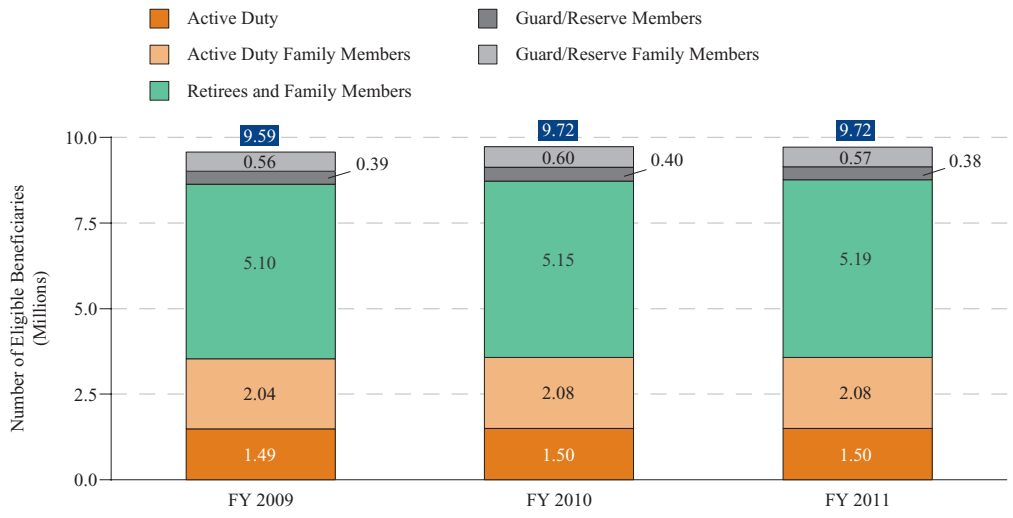
[5] Includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund") DoD Normal Cost Contribution paid by the U.S. Treasury.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Number of Eligible and Enrolled Beneficiaries Between FY 2009 and FY 2011

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) grew from 9.59 million at the end of FY 2009 to 9.72 million[1] at the end of FY 2011. After increasing for most of the past decade, the number of Guard/Reservists and their families took a turn downward in FY 2011. The largest increase was in the number of retirees and family members, especially those age 65 and older (numbers included but not shown separately on the chart below).

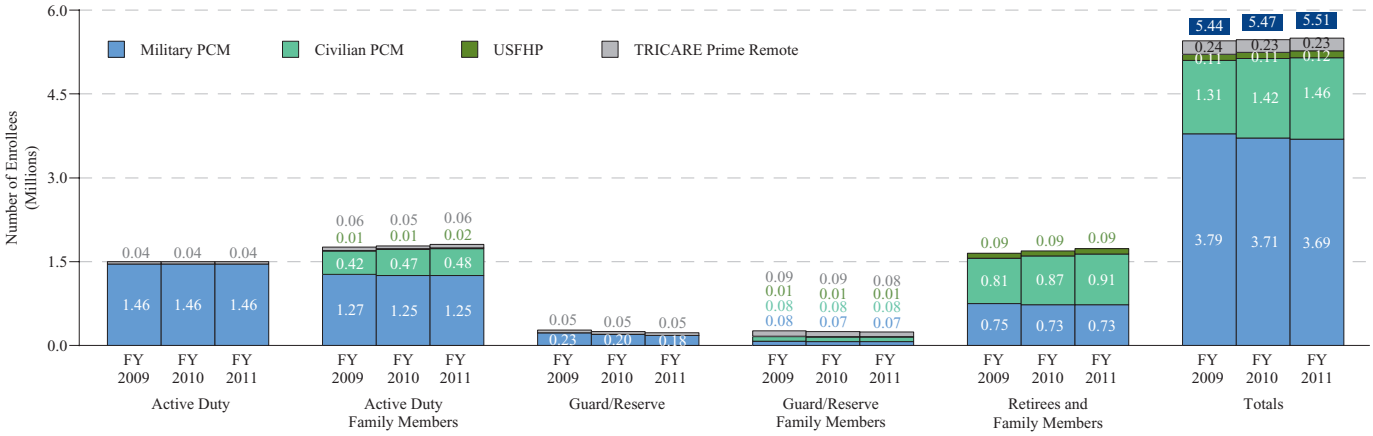
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: DEERS, 1/5/2012

- As MTF capacity remained tight, more enrollees (especially retirees) were assigned to civilian PCMs.
- TRICARE Prime Remote (TPR) and Uniformed Services Family Health Plan (USFHP) enrollment remained flat between FY 2009 and FY 2011 for all beneficiary groups.

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



Source: DEERS, 1/5/2012

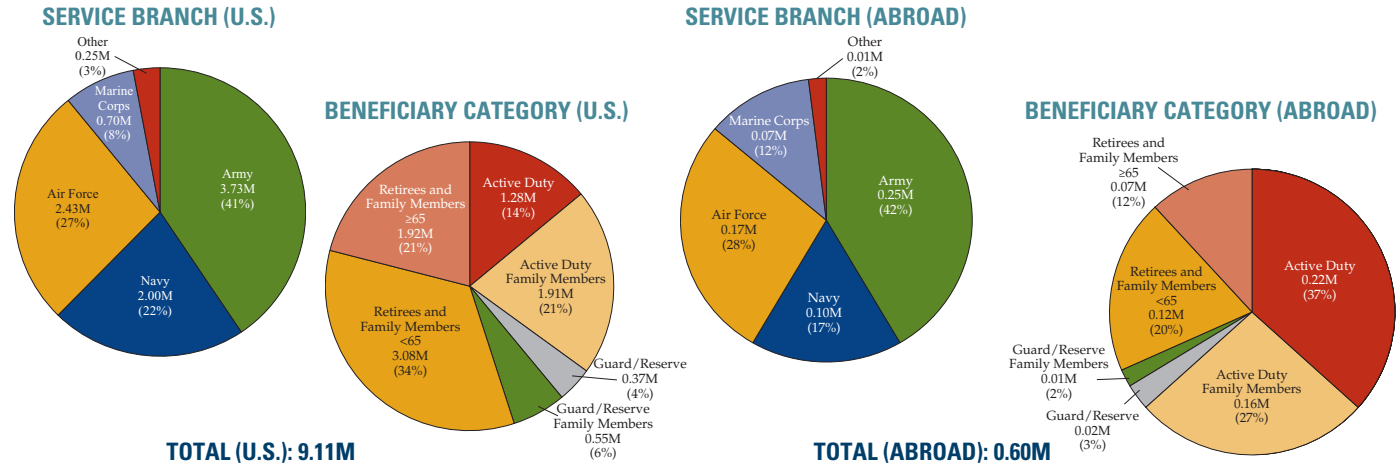
[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 9. The population figure on page 9 is a projected FY 2012 total, whereas the population reported on this page is the actual for the end of FY 2011.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2011

- Of the 9.72 million eligible beneficiaries at the end of FY 2011, 9.11 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 (68 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 92, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, the MHS is confronted with an aging beneficiary population.

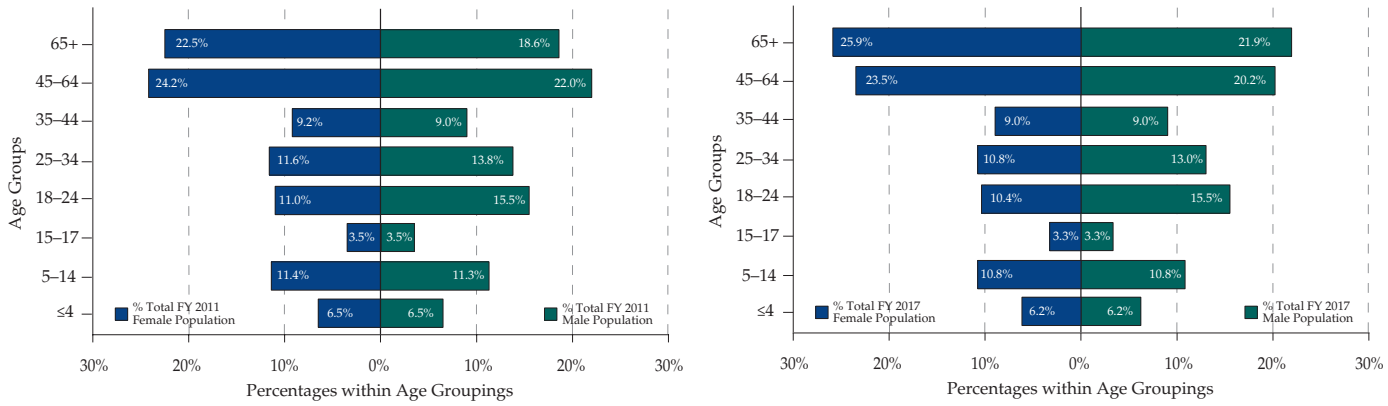
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2011



Source: DEERS, 1/5/2012

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

MHS END-YEAR POPULATION BY AGE AND GENDER: FY 2011 AND FY 2017



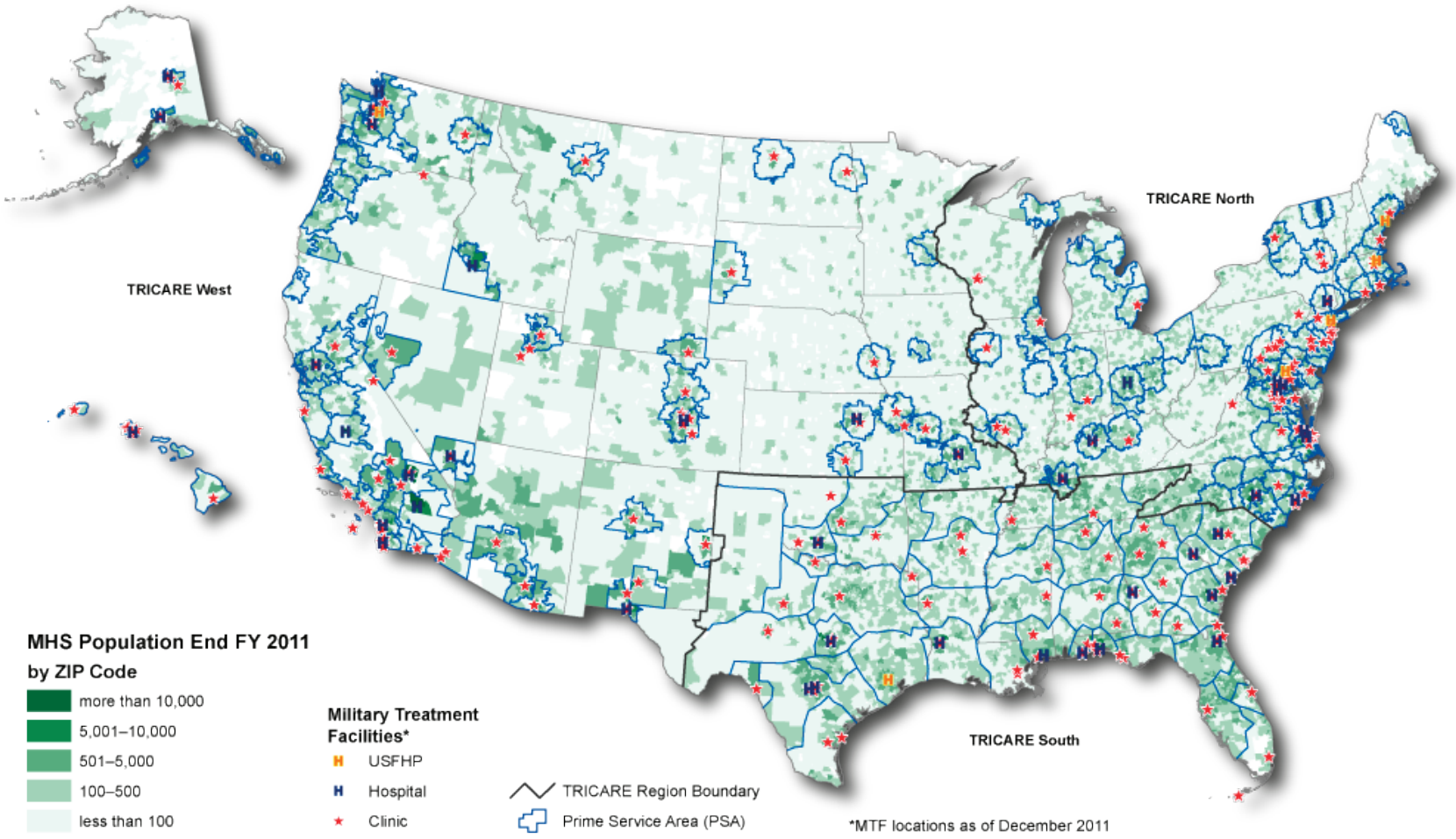
TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: CURRENT FY 2011 AND PROJECTED FY 2017

	Age Group								Total by Gender	Total MHS Population
	≤4	5–14	15–17	18–24	25–34	35–44	45–64	≥65		
FY 2011 Female MHS Beneficiaries	0.31	0.54	0.17	0.52	0.55	0.44	1.15	1.06	4.74	9.72
FY 2011 Male MHS Beneficiaries	0.32	0.56	0.17	0.77	0.68	0.45	1.09	0.93	4.98	9.72
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: FY 2011 from DEERS as of 12/30/2011, and FY 2017 estimates from Managed Care Forecasting and Analysis System (MCFAS) as of 12/28/2010

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs IN FY 2011



Source: MTF information from TMA Portfolio Planning Management Division, 12/30/2011; residential population and Geographic Information Systems (GIS) information from TMA/OCFO-DHCAPE and DEERS, 12/30/2011

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

[1] Eligible MHS beneficiary data are from the MHS Data Repository (MDR) DEERS, effective September 1, 2011. For Active Duty and Guard/Reserve members, unit ZIP code was used for location; for all other beneficiaries, residential ZIP code was used.

[2] Location information was determined by TMA Catchment Area Directory (CAD) database, September 2011.

[3] These are medically eligible Guard/Reserve beneficiaries, and not all Select Reserve. These include those who have opted into TRS.

Definitions:

a. Catchment Area: 40-mile circle around an inpatient MTF, subject to overlap rules, barriers, and other policy overrides

b. PRISM Area: 20-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides

c. MTF Service Area: 40-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides

d. Prime Service Areas: Both MTF service areas and similar geographies around closed MTFs (BRAC Prime Service Areas) and other locations with high concentrations of MHS beneficiaries

PROXIMITY TO TRICARE PRIME MTFs OR THE NETWORK

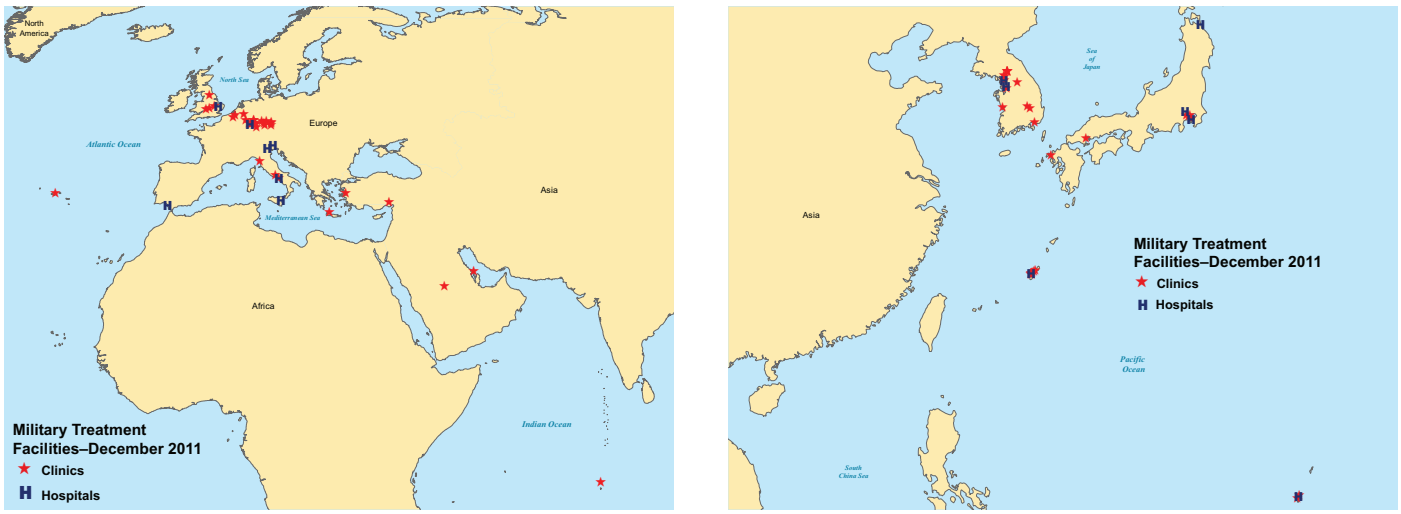
BENEFICIARY GROUP[1]	Population Totals (FY 2011)[2]	Population in PSAs	% in PSAs	% in Catchments	% in PRISMs	% in MTF Service Areas
Active Duty and Their Families	3,192,044	3,092,983	97%	69%	88%	93%
Guard/Reserves and Their Families	924,187	746,005	81%	25%	41%	56%
Retirees, Their Families, Survivors, and Other Eligibles[3]	5,003,900	4,379,142	88%	36%	51%	67%
Total MHS Eligibles, U.S.	9,120,131	8,218,130	90%	47%	63%	75%
MHS Eligibles, Overseas	596,548					
Total MHS Eligibles, Worldwide	9,716,723					

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. MTFs (Hospitals and Ambulatory Care Clinics) in FY 2011

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 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 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 115,000 Active Duty family members (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/OCFO-DHCAPE and DEERS, 12/30/2011

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] Noncatchment and non-PRISM areas lie outside catchment area and PRISM area boundaries, respectively.

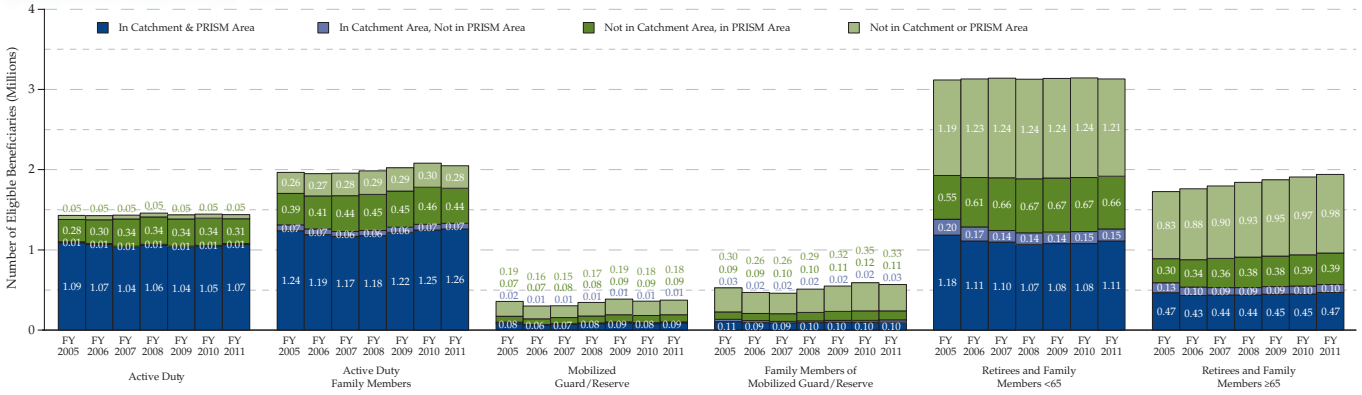
Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 51 percent in FY 2005 to 47 percent in FY 2011). The percentage 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 2005–2011 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 ADFMs living in catchment areas in FY 2011 is roughly back to its level in FY 2005.
- The number of retirees and family members living in catchment areas has started to increase after several years of declines.
- The number of beneficiaries living in noncatchment PRISM areas declined slightly in FY 2011 after several years of steady increases.
- 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, 1/5/2012

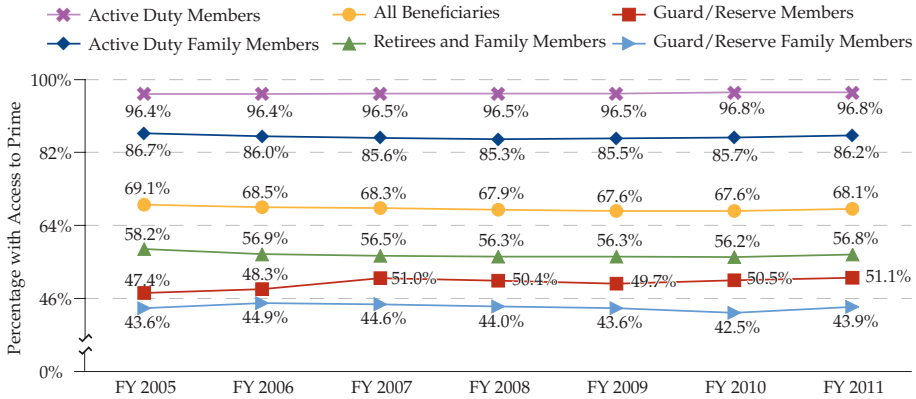
Note: "In Catchment & PRISM Area" refers to the area within 20 miles of a military hospital; it indicates proximity to both inpatient and outpatient care. "In Catchment Area, Not in PRISM Area" refers to the area beyond 20 but within 40 miles of a military hospital; it indicates proximity to inpatient 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 MTF-Based 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 slightly from 69 percent of the eligible population in FY 2005 to 68 percent in FY 2011.
- The decline is largely due to the closings of military hospitals and clinics over that time period. Guard/Reserve members (including pre- and post-mobilized) and their families have the lowest level of access to MTF-based Prime.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 1/5/2012

- 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 12 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)*

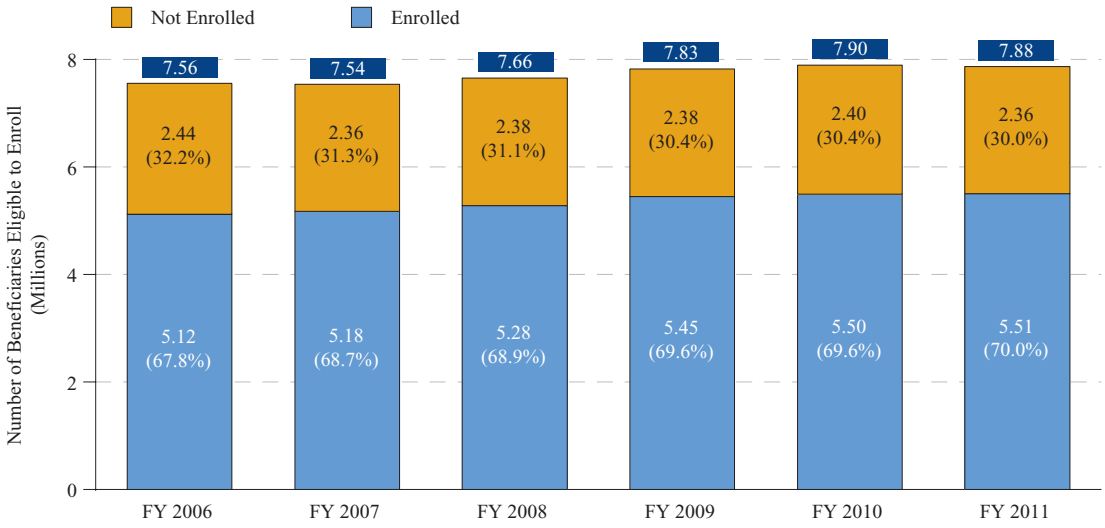
Eligibility and Enrollment in TRICARE Prime

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), TRS, TYA, and TRR 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 2006.
- Enrollment in TRICARE Plus (not shown) has remained flat since FY 2006. This is likely due to limited capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2011, 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, 1/5/2012

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

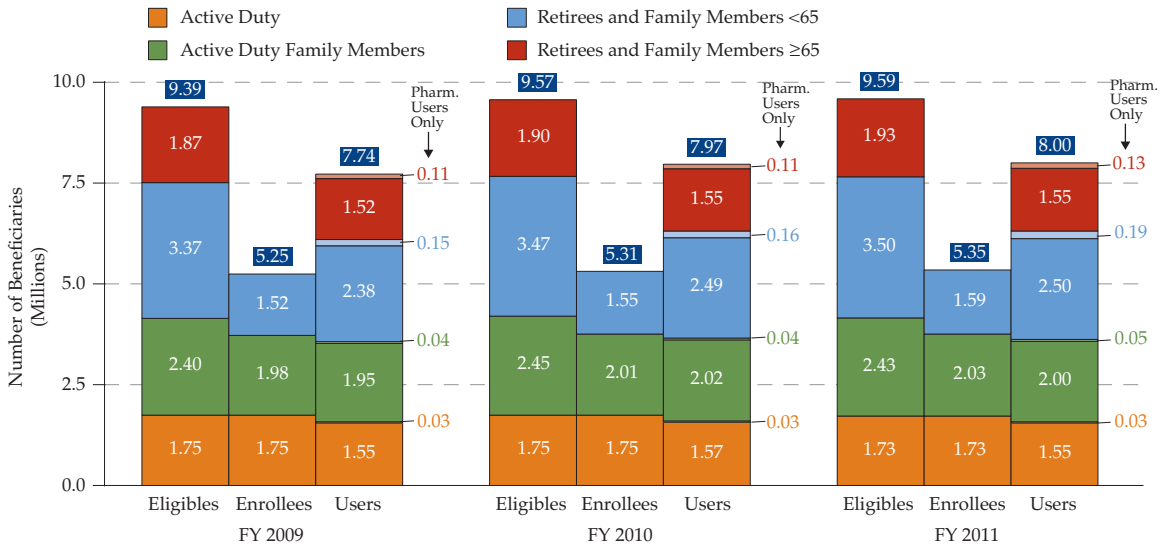
Recent Three-Year Trend in Eligibles, Enrollees, Users

When calculating the number of beneficiaries eligible to use MHS services, average beneficiary counts are more relevant than end-year counts because total utilization is generated by beneficiaries eligible for any part of the year. The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2009 to FY 2011 were determined from DEERS data. 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 Active Duty and eligible family members remained about the same between FY 2009 and FY 2011. The number of retirees and family members under age 65 increased by 3.9 percent, while the number of retirees and family members age 65 and older increased by 3.2 percent.
- The percentage of ADFMs enrolled in TRICARE Prime increased slightly, from 83 percent in FY 2009 to 84 percent in FY 2011. The percentage of retirees and family members under age 65 enrolled in Prime remained constant at about 45 percent.
- The overall user rate grew from 82.4 percent in FY 2009 to 83.5 percent in FY 2011. 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 2009 TO FY 2011 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 1/5/2012

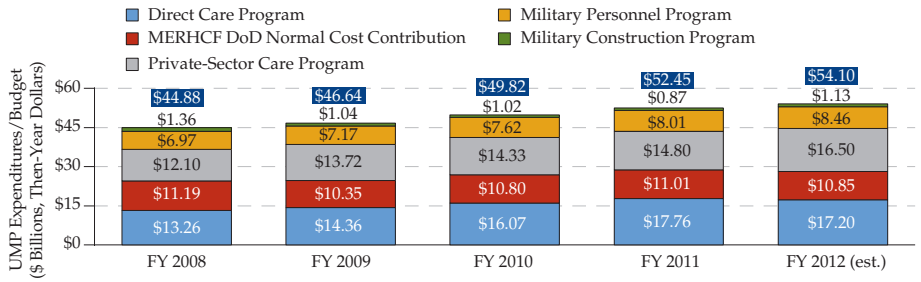
Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts, to account for beneficiaries who were eligible or enrolled for only part of a year.

UNIFIED MEDICAL PROGRAM (UMP) FUNDING

As shown in the first chart below, in terms of unadjusted expenditures (i.e., "then-year" dollars, unadjusted for inflation), the UMP increased nearly 13 percent from almost $47 billion in FY 2009 to nearly $53 billion in FY 2011, and is programmed in FY 2012 to be $54 billion (estimated), or 16 percent greater than FY 2009.

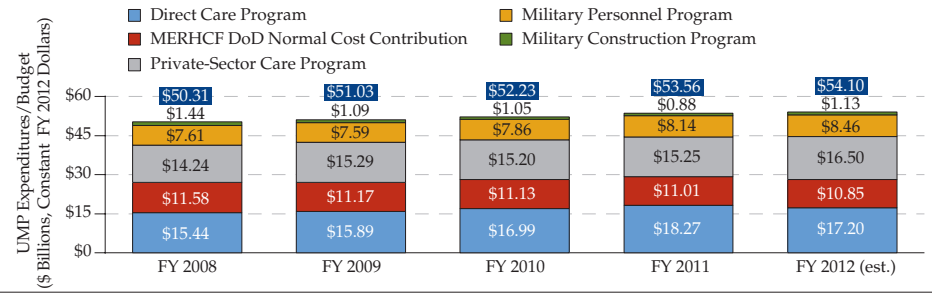
- Over one-third (38 percent) of the $7.5 billion growth in total expenditures from FY 2009 to the projected FY 2012 budget is due to the increase in MTF-based direct care, and another third (37 percent) is in the private-sector, purchased care component of the UMP. The FY 2008 to FY 2012 funding and 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 (both direct and purchased care) for Medicare-eligible retirees, retiree family members, and survivors. The majority of Accrual Fund payments for health care provided to Medicare-eligible beneficiaries are for purchased care pharmacy and outpatient care.

FY 2008 TO FY 2012 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



In constant-year FY 2012 dollar funding, when actual expenditures or projected funding are adjusted for inflation, the FY 2012 purchasing value ($54 billion) is currently programmed to be about the same as the purchasing value of FY 2011 expenditures ($53.6 billion), and slightly over 6 percent greater than the FY 2009 purchasing value of $51 billion (chart below).

FY 2008 TO FY 2012 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN CONSTANT FY 2012 DOLLARS



Source: Cost and budget estimates OASD(HA)/OCFO, 1/27/2012

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

a. 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 retirees, dependents of retirees, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TRICARE for Life (TFL) benefit first implemented in FY 2002. There are three forms of contribution to Defense health care, and reflect for FY 2012: (1) The Accrual Fund ($10.8 billion), 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) $6.7 billion 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) $9.8 billion 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—$8.0 billion for purchased care, $1.8 billion for direct [MTF] care, both Operations and Maintenance [O&M] and Military Personnel costs).

b. FYs 2008–2011 reflect Comptroller Information System actual execution.

c. Not shown directly, but FY 2007 actuals include supplementals ($1.2 million) supporting the Global War on Terrorism (GWOT) and other programs such as Traumatic Brain Injury/Psychological Health (TBI/PH), Wounded Warrior, and Pandemic Influenza.

d. FY 2008 actuals include $1.454 billion O&M supplemental funding in support of GWOT.

e. FY 2009 actuals include Overseas Contingency Operations (OCO) and additional supplemental funding for O&M; Procurement; and Research, Development, Test, and Evaluation (RDT&E).

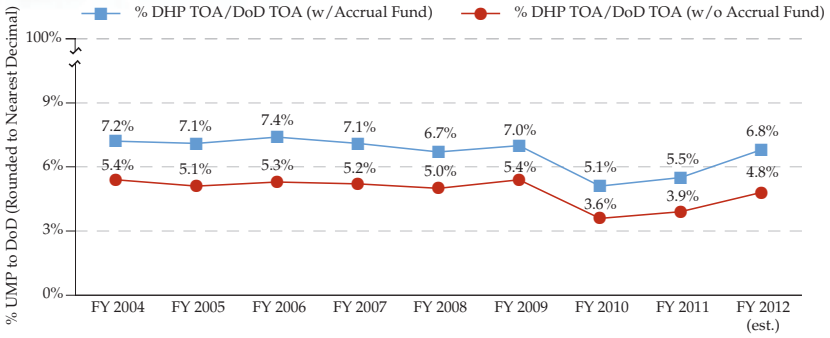
f. FY 2010 current estimate includes O&M funding of $1.323 billion in support of OCO requirements and $140.0 million ($132.0 million for O&M and $8.0 million for RDT&E) transferred from the Department of Health and Human Services for Pandemic Influenza Preparedness and Response.

g. FY 2011 includes $1.4 billion OCO supplemental funding for O&M and $23.4 million in OCO funding for RDT&E.

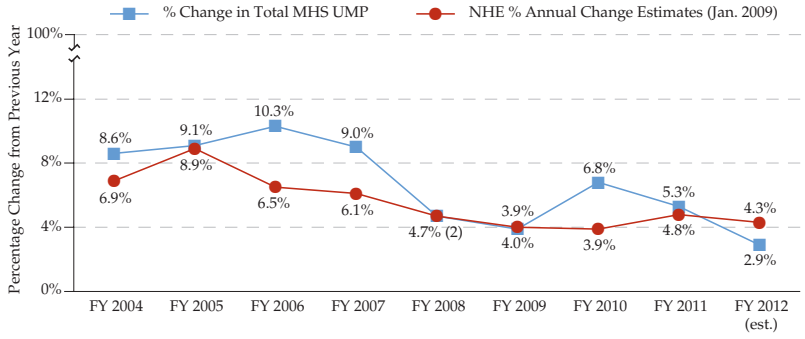
h. FY 2012 includes $1.2 billion OCO supplemental funding for O&M and reductions for DoD efficiency initiatives.

UNIFIED MEDICAL PROGRAM FUNDING *(CONT'D)*

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2012 (EST.)



COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2004 TO FY 2012 (EST.)

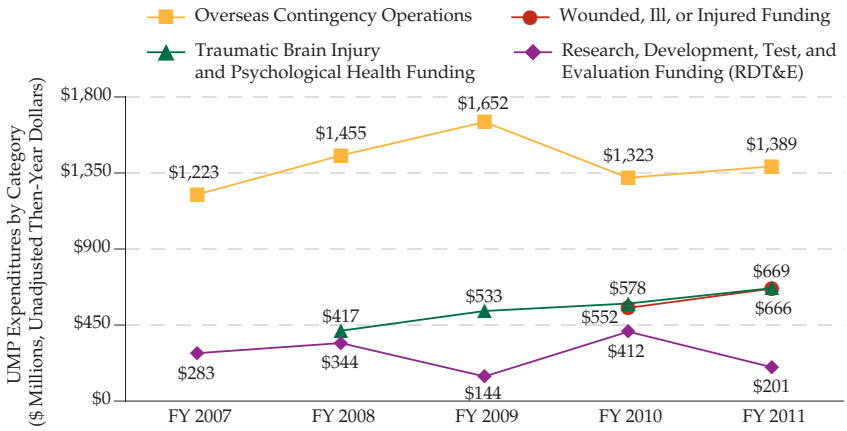


Sources, as of 1/27/2012:

a. CMS, Office of the Actuary, Table 1, National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2005–2020.

b. *Https://www.cms.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp*. The health spending projections were based on the NHE released in January 2011 and include impacts of the Patient Protection and Affordable Care Act. The latest projections begin after the latest historical year (2009) and go through 2020. The projections are based on the 2009 version of the NHE released in January 2011.

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



Source: Cost and budget estimates OASD(HA)/OCFO, 1/27/2012

Notes:

a. Traumatic Brain Injury and Psychological Health expenditures shown for FY 2008 include FY 2007 and FY 2006.

b. 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.

UMP Share of Defense Budget

UMP expenditures are expected to increase from 5.1 percent of DoD Total Obligational Authority (TOA) in FY 2010 to 6.8 percent estimated for FY 2012, including the Accrual Fund. As currently programmed, the increase in the ratio of the UMP to overall DoD budget appears to presage a return to the 7 percent reflected in the six years from FY 2004 to FY 2009. When the Accrual Fund is excluded, the UMP's share is expected to increase from 3.6 percent in FY 2010 to 4.8 percent estimated for FY 2012.

Comparison of Unified Medical Program and National Health Expenditures Over Time

The U.S. Department of Health and Human Services (DHHS) estimates that, although National Health Expenditures (NHE) will continue to rise over time, the projected rate of growth will hover between 4 and 5 percent through FY 2012. While not shown, Centers for Medicare and Medicaid Services (CMS) projects NHE growth to reach over 8 percent in 2014, in part due to the estimated impact of FY 2010 health care reform legislation. The actual 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 7 percent growth in the past three years. The estimated FY 2012 increase over FY 2011 is projected to be almost 3 percent.

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

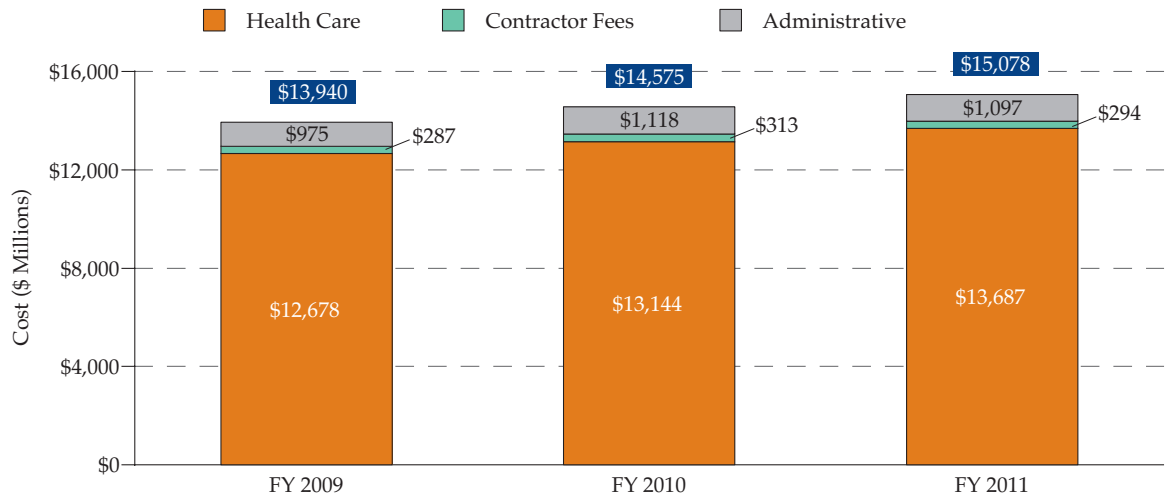
The graph at left reflects the total actual Defense Health Program (DHP) funding for overseas contingency operations (OCO) since FY 2007 (top line). This chart depicts this unique funding source, and these costs are also included in the previous expenditure/budget data. FY 2011 actual DHP expenditures of over $2.9 billion included care for traumatic brain injury; wounded, ill, or injured; and psychological health, as well as research and development. These expenditures are reflected in the lower lines (these funds are within the DHP operations and maintenance [O&M] 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 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 $13,940 million in FY 2009 to $15,078 million in FY 2011, an increase of 8 percent. Private-sector health care costs grew by 8 percent whereas administrative costs grew by 13 percent and contractor fees by 3 percent.
- Excluding contractor fees, administrative expenses increased from 7.1 percent of total private-sector care costs in FY 2009 ($975 million of $13,653 million) to 7.4 percent in FY 2011 ($1,097 million of $14,784 million). Including contractor fees (in both administrative and total costs), administrative expenses increased from 9.1 percent of total private-sector care costs in FY 2009 ($1,262 million of $13,940 million) to 9.2 percent in FY 2011 ($1,391 million of $15,078 million).
- Administrative costs were lower in FY 2011 than they were in FY 2010. In FY 2010, TMA paid one-time costs of $63 million for the North Region's transition to the third generation of TRICARE contracts and an additional $15 million in TRICARE Overseas Program transition costs. Also in FY 2010, the North Region contract transitioned from incentive fees to lower fixed fees.

TREND IN PRIVATE-SECTOR CARE COSTS



Source: TMA, OCFO Private-Sector Care Requirements Office budget data execution and methodology, 11/21/2011

Note: The FY 2009, FY 2010, and FY 2011 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 1 percent of its O&M funding into the following year. The FY 2009, FY 2010, and FY 2011 amounts carried forward from the prior-year appropriation were $226 million, $246 million, and $276 million, respectively.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

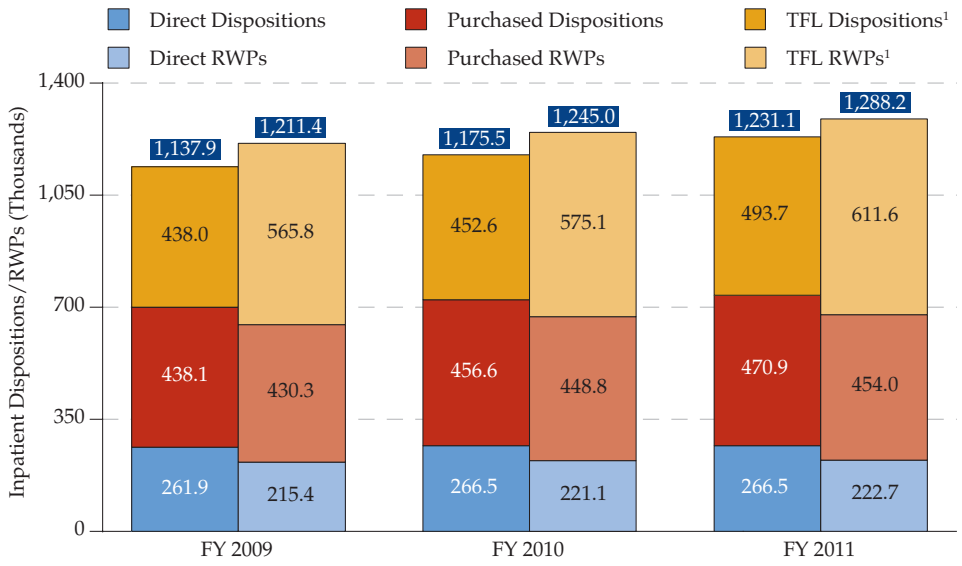
MHS Inpatient Workload

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 single 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 2009, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform to 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 2009 to FY 2011.

Total inpatient dispositions and RWPs (direct and purchased care combined) each increased by 5 percent between FY 2009 and FY 2011, excluding the effect of TFL.

- Direct care inpatient dispositions increased by 2 percent and RWPs by 3 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions increased by 8 percent and RWPs by 6 percent between FY 2009 and FY 2011.
- Including TFL workload, purchased care dispositions increased by 8 percent and RWPs by 6 percent between FY 2009 and FY 2011.
- While not shown, about 8 percent of direct care inpatient dispositions and RWPs were performed abroad in FY 2011. 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, 1/30/2012

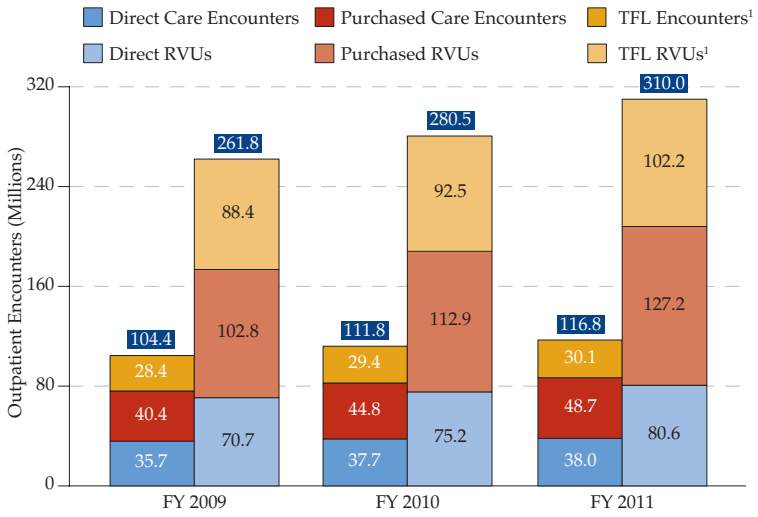
[1] Purchased care only

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 a single 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 2009 to FY 2011. The RVU measure used in this year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the latter RVU measures. Note that previous years' reports used only the Physician Work RVU, and the workload levels are not comparable with those exhibited in this year's report.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/30/2012

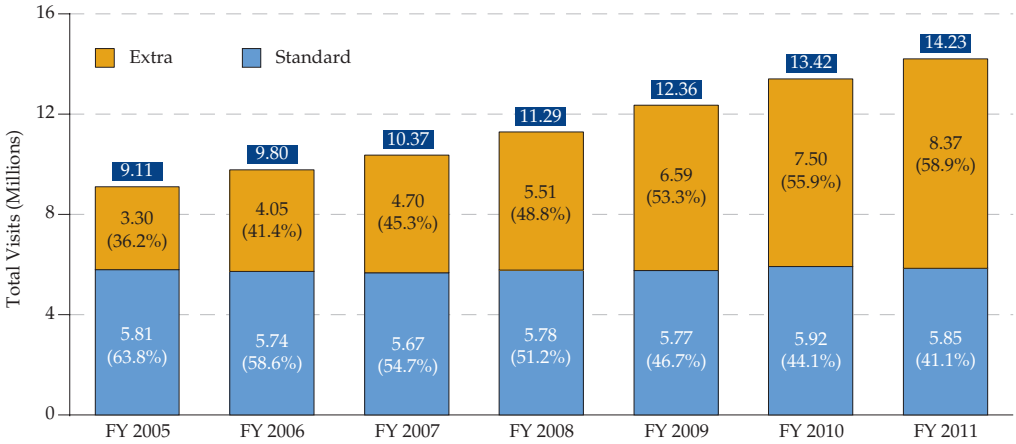
Total outpatient workload (direct and purchased care combined) increased between FY 2009 and FY 2011 (encounters increased by 14 percent and RVUs by 20 percent), excluding the effect of TFL.

- Direct care outpatient encounters increased by 6 percent and RVUs by 14 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 21 percent and RVUs by 24 percent. Including TFL workload, encounters increased by 15 percent and RVUs by 20 percent.
- While not shown, about 8 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 2005, Extra visits accounted for only 36 percent of all non-Prime visits. By FY 2009, the number of Extra visits exceeded the number of Standard visits for the first time (53 percent). In FY 2011, 59 percent of all non-Prime visits were to Extra providers. One reason for the increasing usage of Extra providers is the expansion of the TRICARE provider network (see page 33).

TRENDS IN EXTRA VS. STANDARD VISITS



Source: MHS administrative data, 1/30/2012

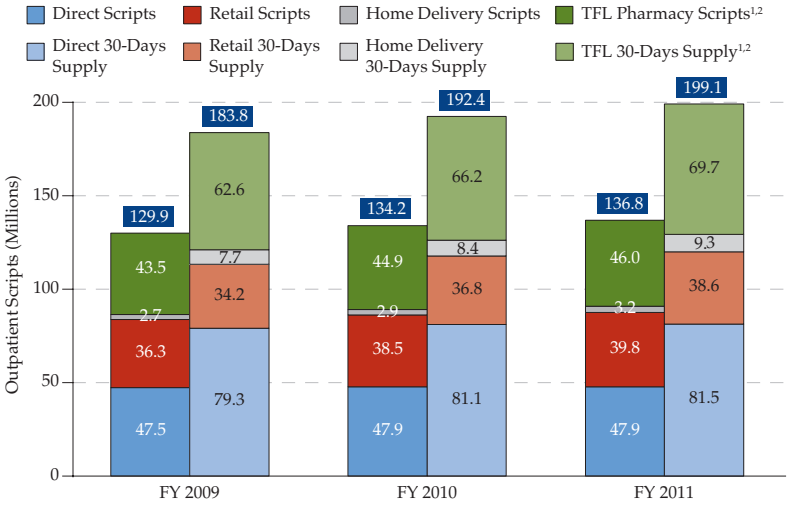
[1] Purchased care only

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 2009 and FY 2011 (prescriptions increased by 5 percent and days supply by 7 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD



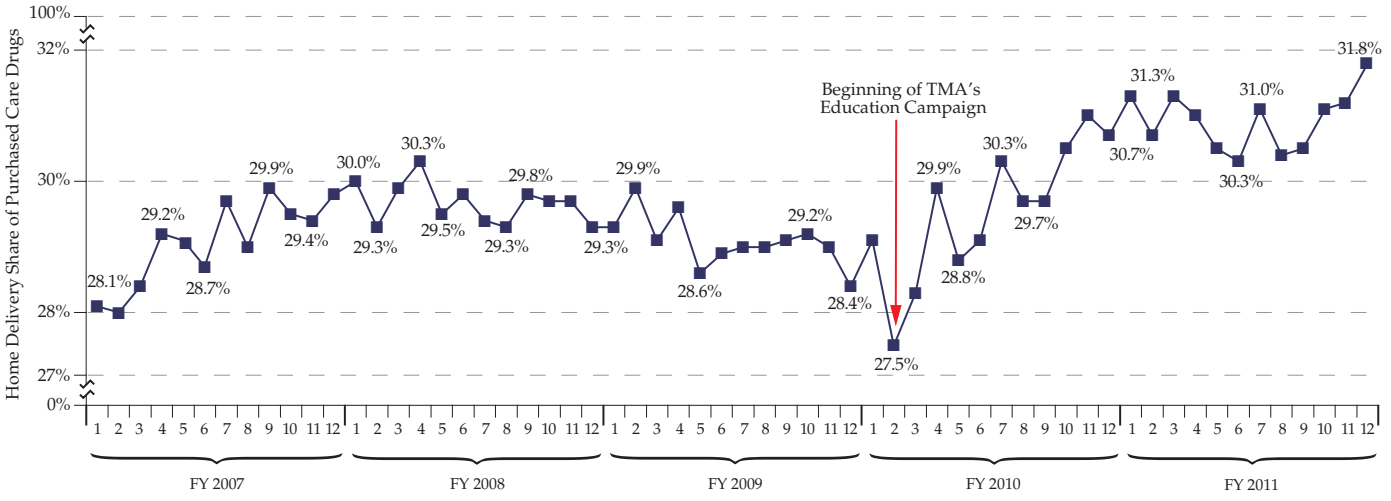
Source: MHS administrative data, 1/30/2012

- Direct care prescriptions increased by 1 percent and days supply by 3 percent between FY 2009 and FY 2011.
- Purchased care prescriptions increased by 10 percent and days supply by 14 percent from FY 2009 to FY 2011, excluding TFL utilization. Including TFL utilization, purchased care prescriptions increased by 8 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. In November 2009, DoD consolidated its pharmacy services under a single contract (called TPharm) and launched an intensive campaign to educate beneficiaries on the benefits of home delivery services. As an additional incentive for beneficiaries to use home delivery services, TRICARE eliminated home delivery beneficiary copayments for generic drugs effective October 1, 2011 (effect not yet known).

The home delivery share of total purchased care utilization had been steadily increasing until January 2008, when it reached a peak. The home delivery share then gradually declined through November 2009, after which it began a climb upward and reached a new peak in September 2011, presumably due to TMA's education campaign.

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



Source: MHS administrative data, 1/9/2012

[1] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.

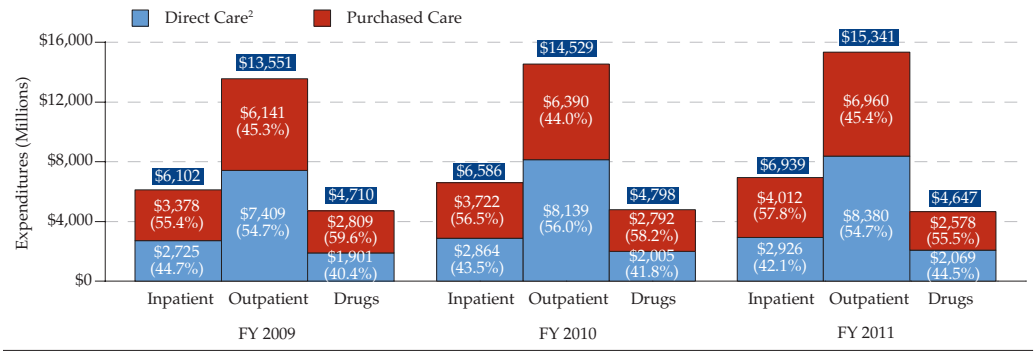
[2] Purchased care only

MHS COST TRENDS

Total MHS costs (excluding TFL) increased between FY 2009 and FY 2011 for inpatient and outpatient services but declined for prescription drugs. The NDAA 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 purchased care prescription drug costs in FYs 2010 and 2011. 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 11 percent and purchased care costs increased by 10 percent.

- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at 69 percent from FY 2009 to FY 2011. For example, in FY 2011, DoD expenses for inpatient and outpatient care totaled $22,279 million, of which $15,341 million was for outpatient care, for a ratio of $15,341/$22,279 = 69 percent.
- Increases in purchased care outpatient costs were mitigated 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.[1] TMA/OCFO-DHCAPE estimates that OPPS saved TRICARE $715 million in health care costs in FY 2010 and $809 million in FY 2011.

TREND IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING TFL)



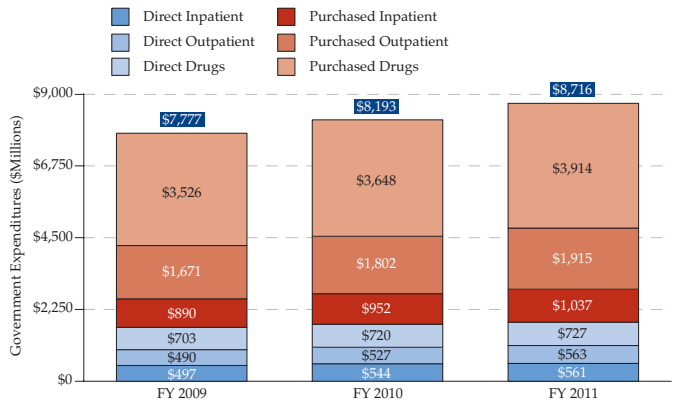
Source: MHS administrative data, 1/30/2012

- In FY 2011, DoD spent $2.21 on outpatient care for every $1 spent on inpatient care.
- See Addendum on page 89 for additional charts showing recent trends in the purchased care share of total utilization and costs.

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 $7,777 million in FY 2009 to $8,716 million in FY 2011 (12 percent), while the percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

MERHCF EXPENDITURES FROM FY 2009 TO FY 2011 BY TYPE OF SERVICE



Source: MHS administrative data, 1/30/2012

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 10 percent from FY 2009 to FY 2011. The most notable increase was in direct outpatient expenses (15 percent).
  - From FY 2009 to FY 2011, TRICARE Plus enrollees accounted for 68–70 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 51 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2009. That figure rose to 54 percent in FY 2011.
- Total purchased care MERHCF expenditures increased by 13 percent from FY 2009 to FY 2011. Inpatient expenditures rose by 17 percent, outpatient expenditures by 15 percent, and prescription drug expenditures by 11 percent.

[1] TMA News Release 09–35, May 19, 2009, accessed from *http://www.tricare.mil/pressroom/news.aspx?fid=527*

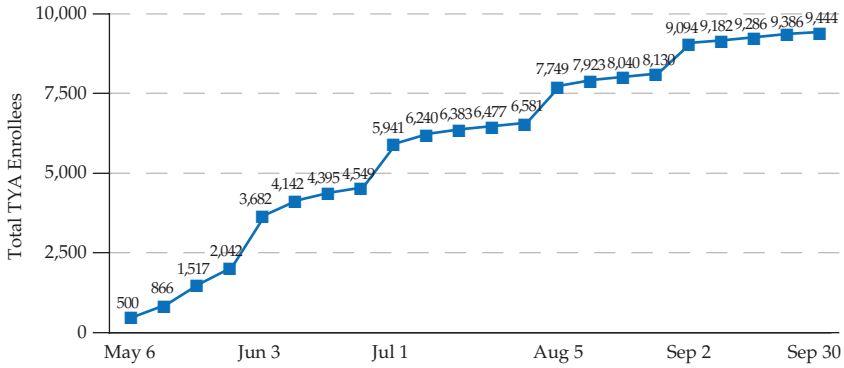
[2] Direct care prescription costs include an MHS-derived dispensing fee.

TRICARE YOUNG ADULT

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 provided new or expanded options and consumer protections for those with private health insurance coverage. Most provisions under the 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 9.7 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.

One of the very few provisions under the PPACA that was not already addressed in the FY 2010 TRICARE entitlement was coverage for dependents up to the age of 26. The PPACA legislation 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 NDAA for FY 2011 included a provision that extends dependent medical coverage up to age 26. Beginning in the spring of FY 2011, qualified dependents up to age 26 were able to purchase TRICARE Standard coverage on a month-to-month basis under the new TYA benefits program. The TYA program will be further expanded beginning in FY 2012 with a TRICARE Prime option as well.

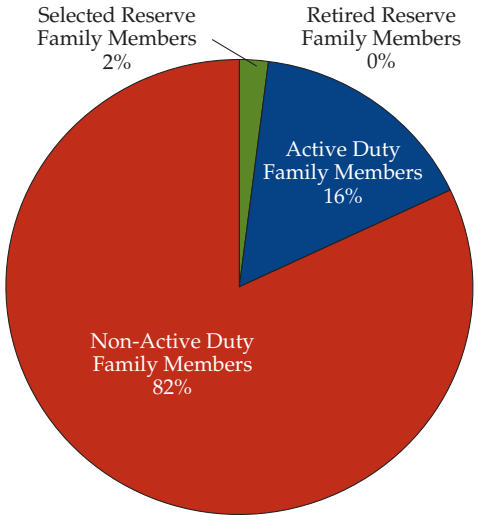
TREND IN TRICARE YOUNG ADULT ENROLLMENT SINCE INCEPTION (MAY 2011 TO SEPTEMBER 30, 2011)



Source: HA/TMA–TRICARE Operations, 11/9/2011

➤ As shown at left, enrollment reached over 9,400 less than five months after the program began.

TYA ENROLLMENT BY FAMILY MEMBER CAREER STATUS



Source: HA/TMA–TRICARE Operations, 11/9/2011

➤ As shown in the accompanying pie chart, 82% of TYA enrollees are family members of those who are not Active Duty (e.g., dependents of retirees and others).

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

The ability to sustain the benefit is anchored in 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 Military Health System (MHS) leadership addressing patient access, satisfaction, and clinical quality processes and outcomes, including (1) efforts to monitor and improve patient safety in the MHS; (2) beneficiary self-reported access to, and experience with, MHS care, such as satisfaction with various aspects of care like the availability and ease of obtaining care, timeliness of care, communication with health care providers, and experience receiving care in our military facilities or contracted hospitals or doctor's offices; (3) civilian provider participation in TRICARE; (4) responsiveness of customer service, quality and timely claims processing (both reported by patients and tracked through administrative systems); and (5) hospital-focused metrics sponsored by the National Quality Forum (NQF) in military treatment facilities (MTFs) compared with Joint Commission findings nationwide.

Patient-Centered Medical Home

In FY 2011, the MHS continued implementing the Patient-Centered Medical Home (PCMH) model of care at all Army, Navy, and Air Force family medicine, primary care, internal medicine, pediatrics, undersea medicine, and flight medicine clinics in order to improve health care quality, medical readiness, access to care, and patient satisfaction, and to lower per capita cost growth. 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 a primary care manager (PCM); the PCM, supported by a team, is accountable for integrating all primary, specialty, and ancillary care for the patient. The PCMH model is expected to provide greater care continuity, better outcomes, higher satisfaction, and lower per capita costs, achieved in part by lower emergency room utilization, better coordinated specialty care, and fewer hospitalizations.

Each Service formalized detailed guidance in Service instructions and began sending out implementation and training teams to each installation to ensure practices received consistent and comprehensive support.[1] In addition to the Services agreeing upon seven MHS-specific PCMH criteria, the MHS began its first formal PCMH recognition process by the National Center for Quality Assurance (NCQA). In order to evaluate the readiness of all MHS primary care practices to seek recognition, a PCMH baseline analysis was conducted February–May 2011, during which over 386 practices were evaluated against NCQA PCMH standards. Starting in September 2011, 48 MHS primary care practices sought formal recognition; as of December 29, 2011, 97 percent of the practices achieved formal recognition with 93 percent recognized by NCQA's highest possible rating. The recognition process was supported by TRICARE Management Activity (TMA) with a detailed recognition guidebook as well as six training events held over 40 days in late FY 2011, during which over 300 MTF personnel were trained. In FY 2012, approximately 100 MHS primary care practices are expected to seek formal recognition from NCQA.

The MHS PCMH program is enhanced by frequent and strong TMA-Service collaboration. Governance of the PCMH program is accomplished through the Tri-Service PCMH Advisory Board (AB) with representatives from each Service, the Coast Guard, and TMA experts in key functional areas. Several working groups report to the Tri-Service PCMH AB, including Information Management/Information Technology (IM/IT), Strategic Communication, Staff Satisfaction, Private-Sector Care (PSC), and Performance Metrics.

- The PCMH IM/IT working group focuses on implementing new technologies such as secure messaging, as well as on modifying and enhancing existing MHS business intelligence tools such as the electronic health record (EHR), TRICARE On-Line, and the Carepoint Population Health Portal to increase the usefulness of these tools in the PCMH model of care.
- The Strategic Communication working group developed and implemented consistent guidance and communication to all stakeholders including MTF staff and patients using Web sites, newsletters, and social media.
- The Staff Satisfaction working group implemented the MHS's first primary care staff satisfaction survey in September 2011. The survey queried all team members about their satisfaction with various aspects of the PCMH model of care and implementation. Overall, 59 percent of MHS primary care staff members were satisfied. In December 2011, the MHS approved funding for fielding the survey twice annually in the future.
- In addition, PCMH care components are also monitored through the PSC working group for those enrollees seeking care in the network. The PSC working group, consisting of TRICARE Regional Office and TMA representatives, monitors PCMH recognition of providers with whom

[1] Army OPORD 11-20, Patient-Centered Medical Home, January 2011; BUMED Instruction 6300.19, Primary Care Services in Navy Medicine, May 26, 2010; Air Force Instruction 44-171, Patient-Centered Medical Home and Family Health Operations, January 18, 2011.

TRICARE beneficiaries are enrolled and evaluates demonstration opportunities and required care components, especially for high-utilizer and chronically ill beneficiaries.

- Finally, the Performance Metrics working group tracks performance in key areas including, but not limited to, access to care for acute and routine appointments, PCM continuity, recapturable primary care for MTF enrollees, patient satisfaction, staff satisfaction, emergency/urgent care utilization, per member per month cost growth, many Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures, and percent Active Duty medical readiness. Preliminary analysis and evaluation of mature MHS PCMH practices have indicated improvements in PCM continuity and access to acute and routine appointments. Performance tracking continues with assistance from key areas in TMA including the Office of Strategy Management, the Defense Health Cost Assessment and Program Evaluation (DHCAPE) Office and the TRICARE Operations Center. Performance is reported to the Office of the Chief Financial Officer (OCFO), where it is tied to PCMH Program Objective Memoranda funding for FYs 2012–2016. In addition, the PCMH, and its associated performance monitoring, is one of the 11 MHS Personnel and Readiness Portfolios of Initiatives.

For the second year in a row, the PCMH program is working with and guiding the project efforts of graduate students at the Columbia University School of International and Public Administration. In FY 2011, the graduate students evaluated the program, interviewed patients and MTF staff, and provided TMA with recommendations on how to empower and motivate patients to be active members of their own care teams. In FY 2012, graduate students will study and provide recommendations on PCMH care components that best reduce health care costs and utilization of the MHS by the most chronically ill and costliest patients.

PATIENT SAFETY IN THE MHS

The Department of Defense's (DoD) primary goal of patient safety is to promote the overall health and readiness of our military force by eliminating preventable harm through the identification and reporting of actual and potential problems in medical systems and processes, and the implementation of effective actions to improve patient safety throughout the MHS. In the MHS direct care system, patient safety is largely measured through event reporting.

PATIENT SAFETY REPORTING

In FY 2011, DoD launched its first standardized Web-based reporting system, known as the Patient Safety Reporting System (PSR), across 171 MTFs around the world, including medical and dental facilities. The PSR allows for anonymous, voluntary reporting of patient safety events in the direct care system. PSR enables a shift from unstructured, paper-based reporting to the standardized capture and review of event-related information. Event reporting facilitates analysis of trends, identifies process issues, and tracks factors contributing to events to share lessons from preventable patient safety events across facilities.

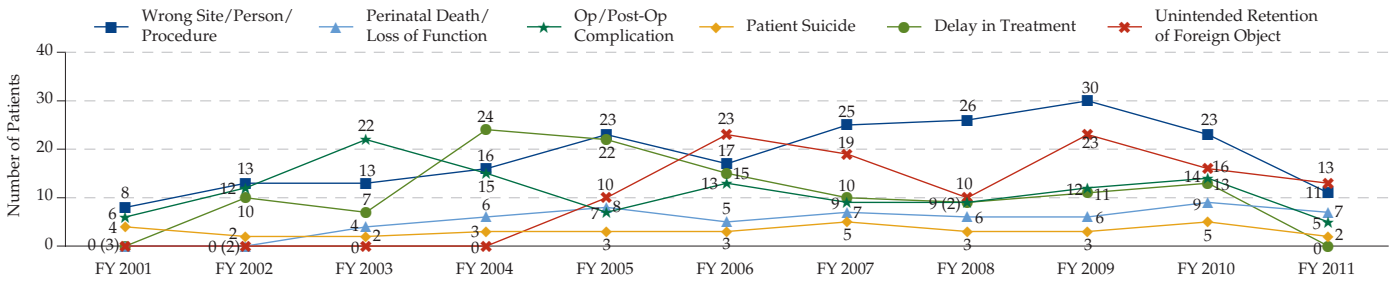
HARM STRATIFICATION OF REPORTED PATIENT SAFETY EVENTS, FYs 2004–2011

HARM STRATIFICATION	2004		2005		2006		2007		2008		2009		2010		2011	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Events Did Not Reach Patient, Near Miss	110,523	71.6%	114,370	71.9%	119,615	75.7%	124,868	78.0%	127,429	74.4%	140,257	80.0%	125,771	74.2%	90,733	68.4%
Events Reached Patient, No Harm	39,123	25.4%	40,215	25.3%	34,934	22.1%	31,519	19.7%	38,265	22.3%	32,746	18.7%	40,512	23.9%	37,547	28.3%
Events Reached Patient, Harm	4,683	3.0%	4,482	2.8%	3,478	2.2%	3,698	2.3%	5,672	3.3%	2,255	1.3%	3,177	1.9%	4,437	3.3%
Total	154,329	100.0%	159,067	100.0%	158,027	100.0%	160,085	100.0%	171,366	100.0%	175,258	100.0%	169,460	100.0%	132,717	100.0%

Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2011

- DoD experienced an overall upward trend in reporting of patient safety events in the direct care system from 2004 to 2010. In FY 2011, DoD anticipated reporting pattern changes during the transition to the Web-based system, PSR. As of July 2011, all MTFs worldwide completed implementation of PSR.
- In FY 2011, near-miss reporting accounted for 68.4 percent of total reported events, while harm events constituted 3.3 percent of all reported events. Near-miss reporting decreased 28 percent between 2010 and 2011, while reported harm events increased 40 percent.[1] In FY 2012, further analysis will be conducted to assess whether reporting patterns are changing.
- MTFs submitted 52 Root Cause Analyses (RCAs) to DoD in FY 2011,[2] down from 96 in FY 2010 and from 102 in FY 2009. Across the top six event categories for RCAs submitted, each category decreased in reported RCA events from FY 2010 to FY 2011 (see chart below). The event categories of Unintended Retained Foreign Object and Wrong Site Surgery[3] persisted as leading event types associated with RCAs.

ANNUAL COUNT OF LEADING ROOT CAUSE ANALYSIS (RCA) CATEGORIES: LEADING RCA EVENT TYPES, FYs 2001–2011



Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2011

Note: n<4 are not visible to conform to 10 USC 1102 statutes for aggregate data.

[1] The AHRQ Harm Scale was grouped into categories to facilitate comparisons between harm: Near Miss—Unsafe Condition and Near Miss; No Harm—No Harm and Emotional Distress or Inconvenience; Harm—Additional Treatment, Temporary Harm, Permanent Harm, Severe Permanent Harm, and Death.

[2] RCAs submitted as of December 14, 2011, for RCAs completed through September 30, 2011.

[3] Wrong Site Surgery encompasses a surgery or procedure performed on the wrong side/site of the body, an incorrect surgery or procedure performed, or a surgery or procedure performed on the wrong patient.

PATIENT SAFETY IN THE MHS *(CONT'D)*

From RCAs submitted, DoD develops publications or hosts webinars to share lessons and recommended actions for MTFs with the aim to prevent similar events from recurrence. During FY 2010, four out of the five leading event types indicated staff-to-staff communication as a contributing factor for the event's occurrence. This data continued to drive an overall focus in FY 2011 on implementing resources and solutions that improve communication techniques among health care teams.

TRAINING AND EDUCATION TO IMPROVE PERFORMANCE AND PATIENT SAFETY

TeamSTEPPS® is an evidence-based teamwork development system designed to produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. TeamSTEPPS is widely implemented within the MHS direct care system, and, as of FY 2011, two of the three Services mandated TeamSTEPPS training as an initiative to improve patient safety.

Patient Safety Managers (PSMs) serve as local champions at the front lines of care. The award-winning Basic Patient Safety Manager (BPSM) course develops these champions by equipping new PSMs with the knowledge, skills, and tools to lead patient safety initiatives at MTFs. Following the course, DoD conducts coaching sessions at three, six, and 12 months post-course, during which PSMs report 100 percent confidence in their understanding of patient safety roles and responsibilities and the expected impact of their activities on patient safety at their organization. To build on the success of the BPSM course, DoD created a standardized PSM competency model to guide a strategy for building patient safety workforce capacity throughout the MHS.

After TeamSTEPPS training, 85 percent of trainees report confidence in their abilities to clearly and accurately communicate with team members compared to 50 percent prior to training.

82 percent are confident in their ability to use the knowledge and skills learned during TeamSTEPPS training on their unit.

ENGAGEMENT IN NATIONWIDE EFFORTS TO IMPROVE PATIENT SAFETY

In June 2011, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and Director, TMA, signed a pledge on behalf of the MHS to support the Partnership for Patients initiative, a nationwide effort to make health care safer, more reliable, and less costly. Meeting the goals of the Partnership for Patients will be a major focus of FY 2012 patient safety initiatives:

- Decrease preventable hospital-acquired conditions by 40 percent by 2013; and
- Reduce all hospital readmissions by 20 percent by 2013.

The MHS pledged to work to attain the goals of the Partnership for Patients initiative by building on work already underway and supporting local initiatives to improve the quality of care. As a system, the MHS committed to lead, learn from, and partner with other federal agencies and private-sector organizations to drive the improvements necessary to reduce hospital-acquired conditions and facilitate better care transitions to reduce preventable patient harm.

All three Services contributed to, and accepted, a concept of operations defining an MHS approach to meeting the aims of the Partnership for Patients in terms of organizational roles and responsibilities. In a collaborative effort, DoD leads the work underway to define metrics of success and develop an operational plan to optimize patient safety and quality in the MHS in support of the aims of the Partnership.

The managed care support contractors and designated providers remain in compliance with the TRICARE Operations Manual requirements to report NQF Serious Reportable Events to their respective program offices and TMA. Additionally, each contractor audits the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators in their respective regions as a means to identify potential patient safety and quality issues. All of the contractors have approved mechanisms in place to monitor potential issues and to request corrective action plans from network providers if needed.

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:

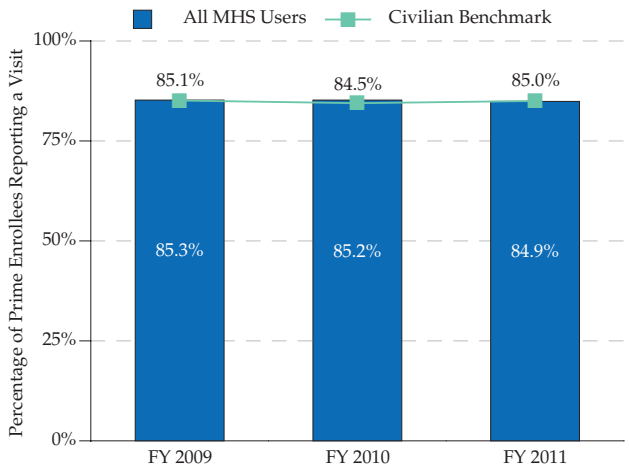
- Access based on reported use of the health care system in general
- Availability and ease of obtaining care and communicating with providers
- Responsive customer service
- Quality and timeliness of claims processing

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 2011.
- The MHS Prime enrollee rate equaled the civilian benchmark in FYs 2009 and FY 2011 and exceeded it in FY 2010.

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



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

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

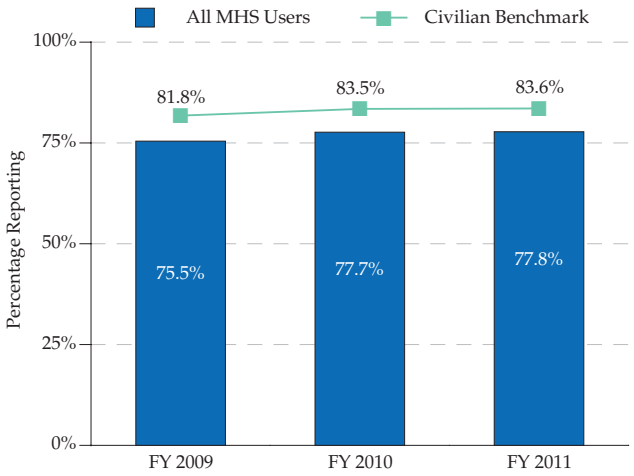
AVAILABILITY AND EASE OF OBTAINING CARE

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 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey—getting needed care and getting care quickly—address these issues. Getting needed care has a submeasure: problems getting an appointment with specialists. Getting care quickly also has a submeasure: waiting for a routine visit.

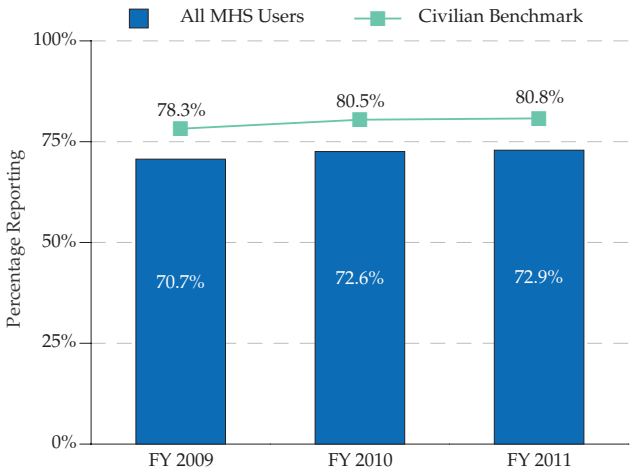
- MHS beneficiary ratings for getting needed care (composite) and problems getting an appointment with specialists improved between FY 2009 and FY 2011, but continued to lag the civilian benchmark, which also improved during this period.
- MHS beneficiary ratings for getting care quickly (composite) and waiting for a routine visit also improved between FY 2009 and FY 2011, but continued to lag the civilian benchmark.

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

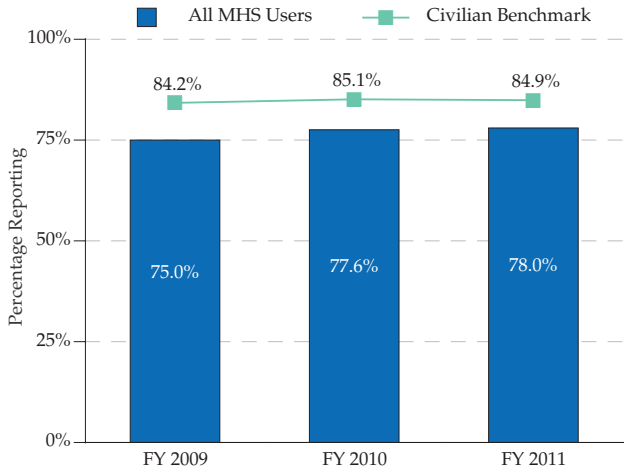
GETTING NEEDED CARE



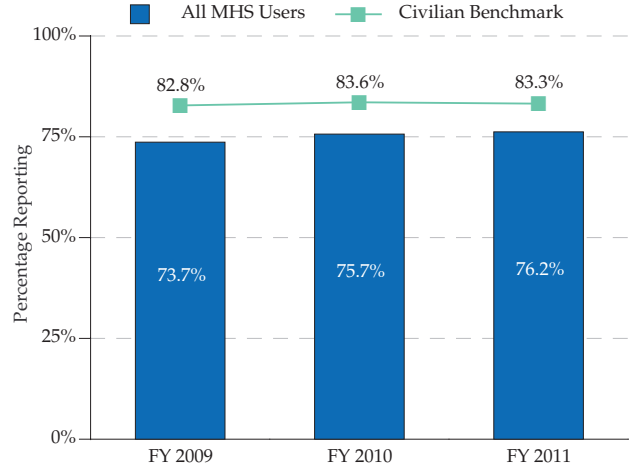
GETTING A REFERRAL TO A SPECIALIST



GETTING CARE QUICKLY



GETTING TIMELY ROUTINE APPOINTMENTS



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

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

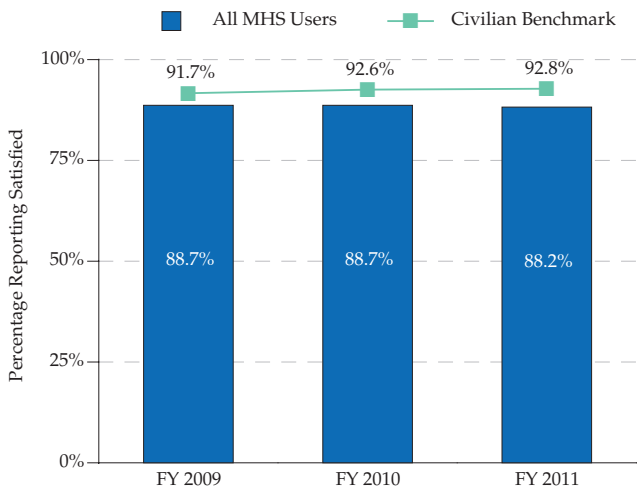
SATISFACTION WITH DOCTORS' COMMUNICATION

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.

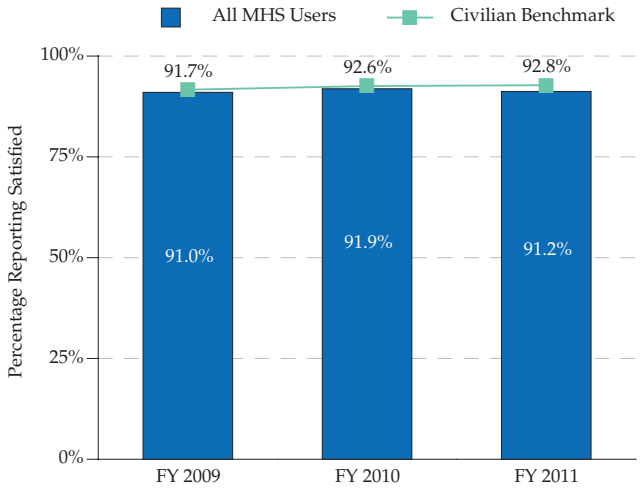
- Satisfaction levels with doctors' communication for Prime enrollees with military PCMs remained stable between FY 2009 and FY 2011, but lagged the civilian benchmark, which increased during this period.
- Satisfaction levels of Prime enrollees with civilian PCMs equaled the civilian benchmarks (no statistically significant difference) in FYs 2009 and 2010, but fell behind in FY 2011 when the benchmark increased. Satisfaction levels of non-enrollees exceeded the benchmark in FYs 2010 and 2011.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION

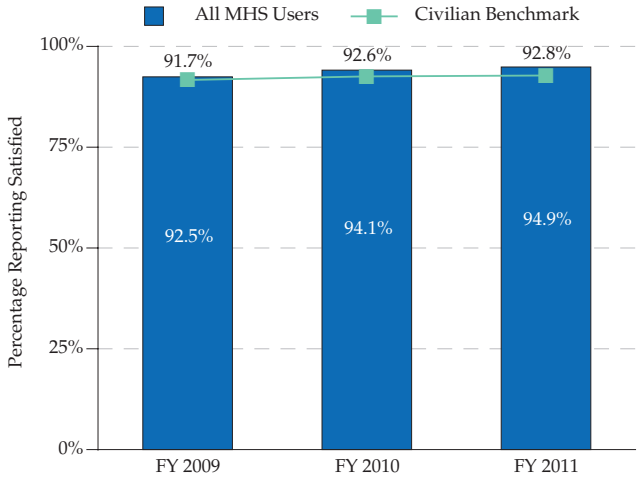
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

TRICARE PRIME REMOTE—SPECIAL STUDY

TRICARE Prime Remote (TPR) is TRICARE's HMO plan for Active Duty (AD) beneficiaries and their family members (ADFMs) who live and work more than 50 miles or an hour's drive from an MTF. TPR was initiated in 1999 with the goal of providing benefits similar to those offered by TRICARE Prime to AD beneficiaries on assignments far from an MTF, and was expanded in 2002 to include ADFMs. TPR enrollees are required to use PCMs from TRICARE's civilian network when those are available in their area, but may use any TRICARE-authorized provider for primary care if no network provider is available. The design is similar to a point-of-service plan with a primary care gatekeeper.[1] Beneficiaries must enroll with a PCM and are subject to higher costs for bypassing the PCM to receive care, but can see any provider without penalty after obtaining the appropriate referral. Thus, TPR is intended to provide managed care even when TRICARE's network of providers is unavailable in the area.

In recent years, TPR enrollment has grown substantially, but not much research has been done comparing the health care experiences of TPR enrollees with those of beneficiaries in other TRICARE plans. Mueller et al. (2006) compared the health care ratings of TPR AD enrollees to those of AD Prime enrollees, but did not analyze the health care experiences of TPR ADFM enrollees.[2] In this report, we compare the health care experiences of TPR ADFM enrollees who responded to a special survey in Spring 2010 to those of other ADFM beneficiaries who responded to the 2010 Health Care Survey of DoD Beneficiaries (HCSDB). The study population includes TRICARE Prime enrollees, TRICARE beneficiaries using TRICARE Standard/Extra (S/E), and TRICARE beneficiaries using civilian health insurance.

Comparisons of the characteristics and survey responses of TPR ADFM beneficiaries to those of ADFMs in four other TRICARE beneficiary comparison groups yield the following findings:

- **Characteristics of TPR enrollees:** TPR enrollees are more similar to beneficiaries with civilian health insurance than to Prime enrollees and beneficiaries using Standard/Extra. Like TRICARE beneficiaries with civilian health insurance, most TPR enrollees are family members of active National Guard and Reserve members; a larger proportion of TPR enrollees than Prime enrollees and beneficiaries using Standard/Extra have a sponsor in the Army; and a larger (but still small) proportion are male.
- **Health Care Experiences of TPR Enrollees:** As shown in the table below, the health care ratings and reported access of TPR enrollees are comparable to Prime enrollees with civilian PCMs (first column, mostly "no difference" between the two), better than those with military PCMs in most aspects of health care (second column, mostly "+"), and similar to those of beneficiaries using Standard/Extra (third column), which offers the most choice, no enrollment or PCM, and at greater cost given required copays and deductibles. TPR enrollees rate their health care higher than do Prime enrollees with either a military or civilian PCM, and rate their access to specialists lower than do Standard/Extra users.
- **Access of TPR Enrollees to TRICARE's Network of Civilian Providers (not shown):** A greater percentage of TPR enrollees than beneficiaries using Standard/Extra receive their health care from TRICARE's civilian network, and have a personal doctor who is a network member. TPR enrollees are also more likely than Prime enrollees to receive most of their care from TRICARE's civilian network, but are still more likely than Prime enrollees to have problems with access to personal doctors and specialists who are network members or who accept TRICARE.

COMPARING ADFM TPR ENROLLEES TO OTHER TRICARE ADFM BENEFICIARIES

HEALTH CARE EXPERIENCES	TPR vs. Prime (Civ)	TPR vs. Prime (Mil)	TPR vs. S/E
Global Ratings (rating of 8 or above)			
Health Care	+	+	No diff
Health Plan	No diff	+	No diff
Personal Doctor	+	+	No diff
Specialist	No diff	No diff	–
Mental Health Provider	–	No diff	No diff
Access			
Getting Needed Care	No diff	+	No diff
Personal Doctor	No diff	+	No diff
Specialist	No diff	+	–
Mental Health Provider	No diff	No diff	No diff

Source: OASD(HA) TMA/OCFO-DHCAPE survey results of 12/21/2011

(–) = TPR enrollees have lower score than comparison beneficiary group.
(+) = TPR enrollees have higher score than comparison beneficiary group.
No diff = TPR enrollees and comparison beneficiary group have statistically similar score.

[1] Wagner, E. 2001. "Types of Managed Care Organizations." In *The Managed Health Care Handbook*, ed. P. Kongstvedt. Gaithersburg, MD: Aspen.
[2] Mueller, K., J. Meza, L. Chen, T. Williams, and F. Ulrich. 2006. "Differences in Beneficiary Assessments of Health Care Between TRICARE Prime and TRICARE Prime Remote." *Military Medicine* 171 (10): 950–54.

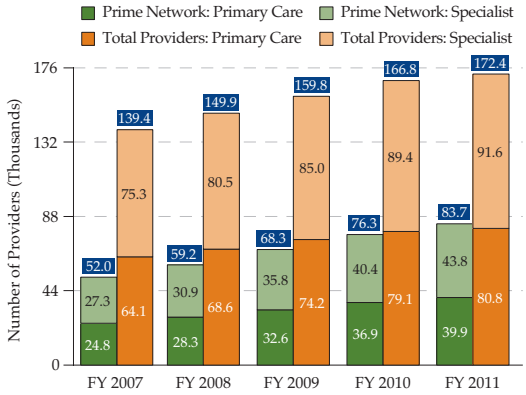
TRICARE PROVIDER PARTICIPATION

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] Providers were counted in terms of full-time equivalent (FTE) units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily since FY 2007. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually declined. Furthermore, as evidenced from the claims data, the number of primary care providers has increased at a slightly higher rate than that of specialists.[2]

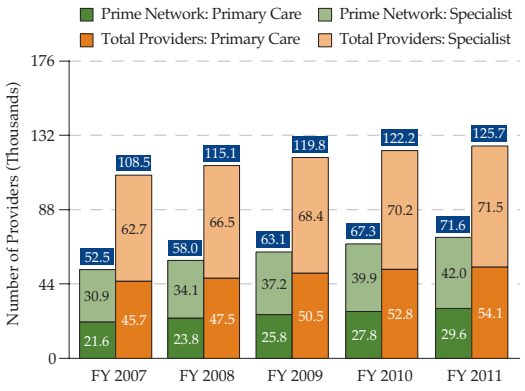
- Between FY 2007 and FY 2011, the North Region saw the largest increase in the total number of TRICARE providers (24 percent), followed by the West Region (20 percent) and the South Region (16 percent).
- The West Region saw the largest increase in the number of network providers (79 percent), followed by the North Region (61 percent) and the South Region (36 percent).
- The total number of TRICARE providers increased by 26 percent in catchment areas and by 19 percent in noncatchment areas (not shown).[3]
- The number of network providers increased by 61 percent in catchment areas and by 57 percent in noncatchment areas (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs[4]

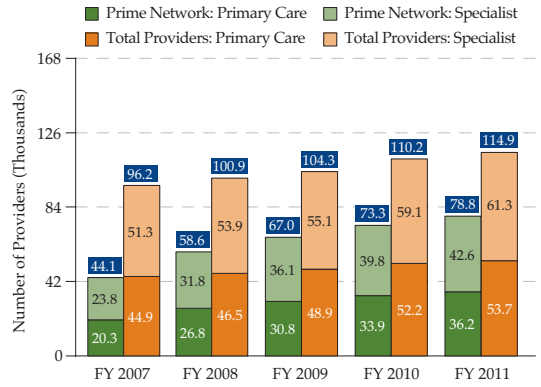
NORTH



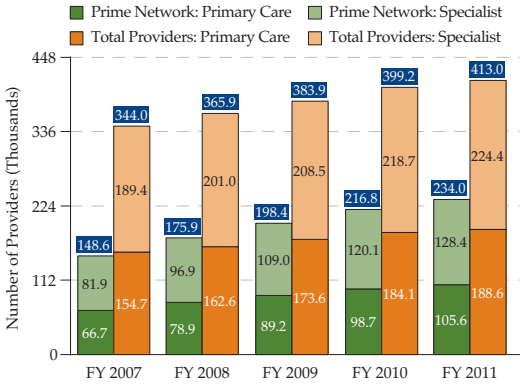
SOUTH



WEST[5]



NORTH, SOUTH, WEST COMBINED[6]



Source: MHS administrative data, 1/30/2012

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.

[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, based on data from TMA, 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.

SURVEYS OF CIVILIAN PROVIDER ACCEPTANCE OF, AND MHS BENEFICIARY ACCESS TO, TRICARE STANDARD AND EXTRA

Purpose of Study

The Department has completed the third of four planned annual surveys to determine beneficiary access to civilian physicians willing to accept 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.

- **Background:** 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.
  - 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 BENEFICIARY AND PROVIDER SURVEYS AFTER THREE YEARS (2008–2010)

Provider survey results after three years:

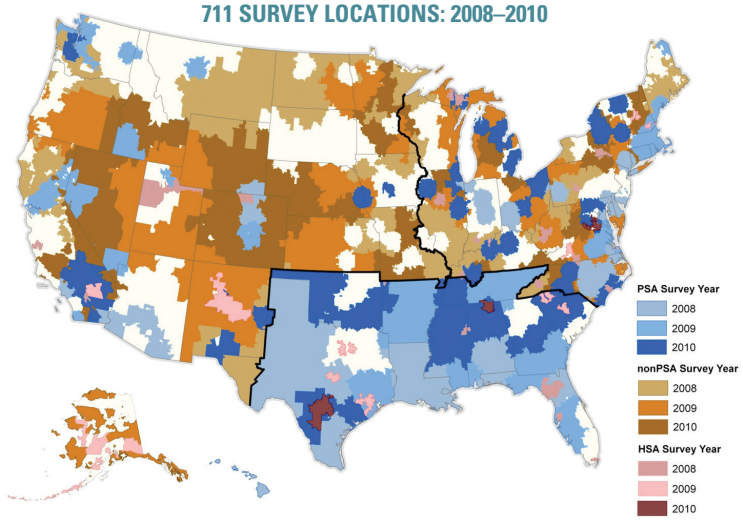
- **Awareness of the TRICARE program:** There is a high level of provider awareness of the TRICARE program in general.
  - All providers: About 8 of 10 (80.3 percent) providers overall (physicians and nonphysician behavioral health providers such as psychologists and social workers) are aware of the TRICARE program in general.
  - Physicians: Almost 9 of 10 physicians (89.4 percent) are aware of TRICARE, similar to the 2005–2007 physician-only benchmark survey (87 percent).
- **Acceptance of new TRICARE patients:**
  - All providers: About 6 of 10 (58.9 percent) physician and nonphysician providers accept new TRICARE Standard patients if they accept new patients of any insurance.
  - Physicians: Just over 7 of 10 physicians (71.3 percent) accept new TRICARE Standard patients if accepting any new patients at all, which remains lower than the benchmark survey (81 percent).
- Behavioral health providers (psychiatrists and nonphysicians) generally report lower awareness and acceptance of new TRICARE Standard and Medicare patients than nonpsychiatrist physicians.
- Prime and non-Prime Service Area differences: Provider acceptance of new TRICARE Standard patients is lower in areas with Prime networks (Prime Service Areas, PSAs) than in non-PSA locations, although provider awareness is comparable.

Beneficiary survey results after three years:

- **In general**, Standard/Extra (S/E) users in non-PSAs, compared to users in PSAs:
  - Report greater access to getting needed care and getting care quickly; they also report greater access than the civilian benchmark.
  - Report fewer problems finding personal doctors and getting to see specialists, and more problems receiving urgent care in a timely manner.
  - Report greater satisfaction in one of four global measures (rate your health care).
  - Report similar satisfaction in three of four global measures (rate your health plan, personal doctors, and specialists), and similar ratings of behavioral health providers or receiving preventive care.
- Results vary among PSAs, non-PSAs, and HSAs.

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/OCFO-DHCAPE and administrative data, 11/22/2011

CUSTOMER SERVICE

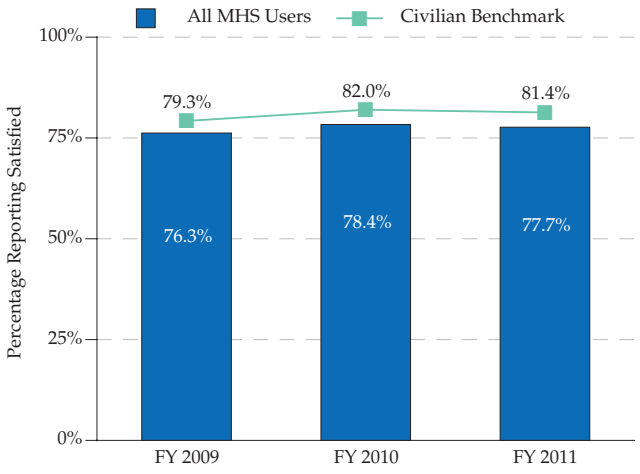
SATISFACTION WITH CUSTOMER SERVICE

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

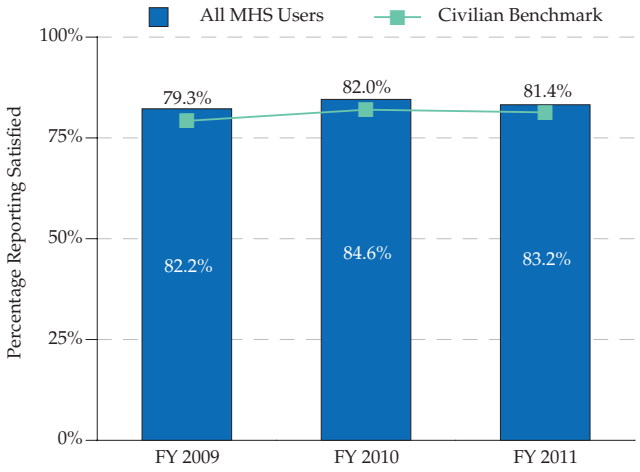
- MHS beneficiaries' reported satisfaction with customer service, in terms of understanding written materials, getting customer assistance, and dealing with paperwork, remained stable between FY 2009 and FY 2011 (no statistically significant change). The civilian benchmark increased over this period.
- MHS enrollees with civilian PCMs reported levels of satisfaction that exceeded the civilian benchmark in FY 2009 and FY 2010. The reported levels of satisfaction are comparable in FY 2011.
- Non-enrollee satisfaction exceeded the civilian benchmark in FY 2009 and FY 2010, and was comparable to the benchmark in FY 2011. MTF enrollee satisfaction continued to lag the civilian benchmark.

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

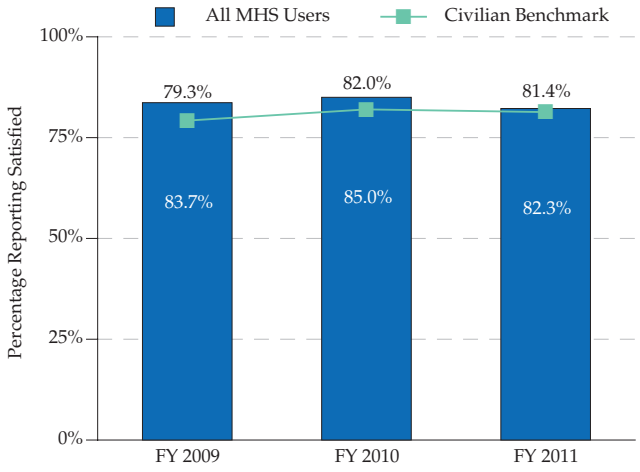
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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 (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

CLAIMS PROCESSING

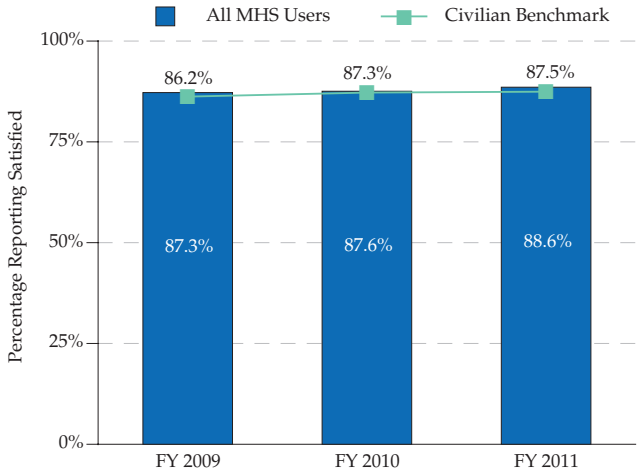
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for the promptness of processing, as well as the accuracy of claims and payment. MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary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

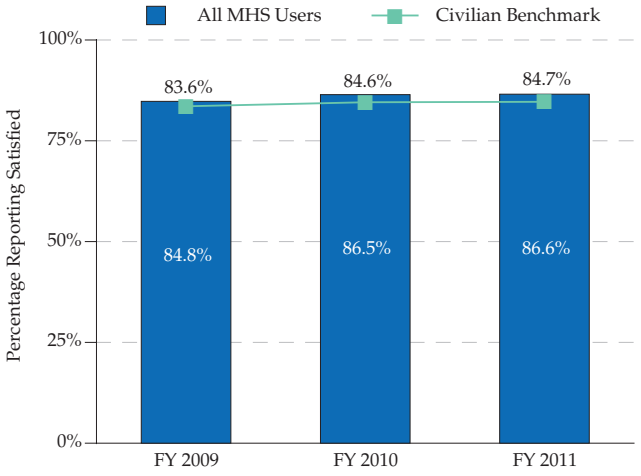
- Satisfaction with claims being processed accurately remained stable from FY 2009 to FY 2011. Satisfaction with processing in a reasonable period of time increased slightly between FY 2009 and FY 2011.
- MHS satisfaction levels for claims processed properly exceeded the civilian benchmark in FY 2009 and FY 2011 and were comparable (i.e., not statistically significantly different) in FY 2010.
- Satisfaction levels for claims processed in a reasonable period of time exceeded the civilian benchmark over all three years (FYs 2009–2011).

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

CLAIMS PROCESSED PROPERLY (IN GENERAL)



CLAIMS PROCESSED IN A REASONABLE TIME



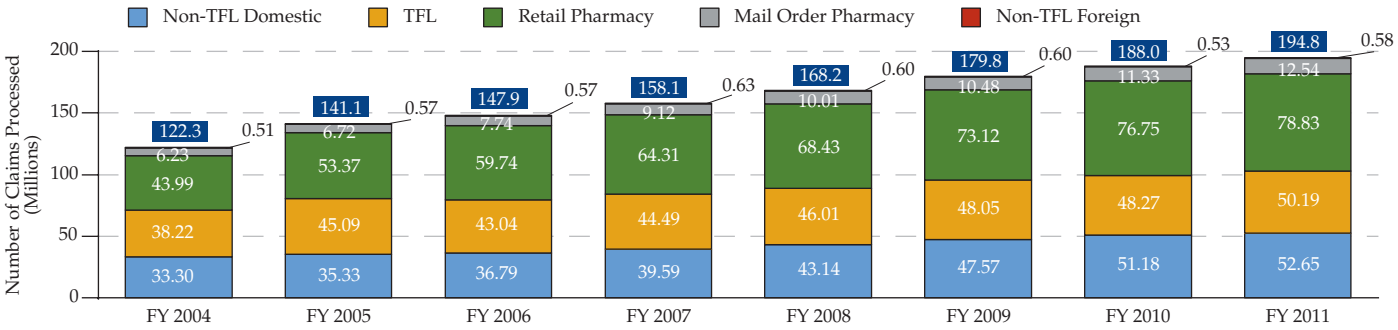
Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "usually" or "always." "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

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, but at a slower rate since FY 2008. The increased claims are due to the combination of an increase in the overall volume of all categories of claims as well as a change in how pharmacy claims have been reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas beginning in FY 2005, individual pharmacy prescriptions were reported separately. Home delivery and retail prescriptions grew the fastest between FY 2004 and FY 2011 (101 percent and 79 percent, respectively), with home delivery (mail) pharmacy increasing from 36 percent of claims processed in FY 2004 to over 41 percent in FY 2011. Clean claims continue to exceed TRICARE standards with over 99 percent completed in 30 days.

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2004 TO FY 2011



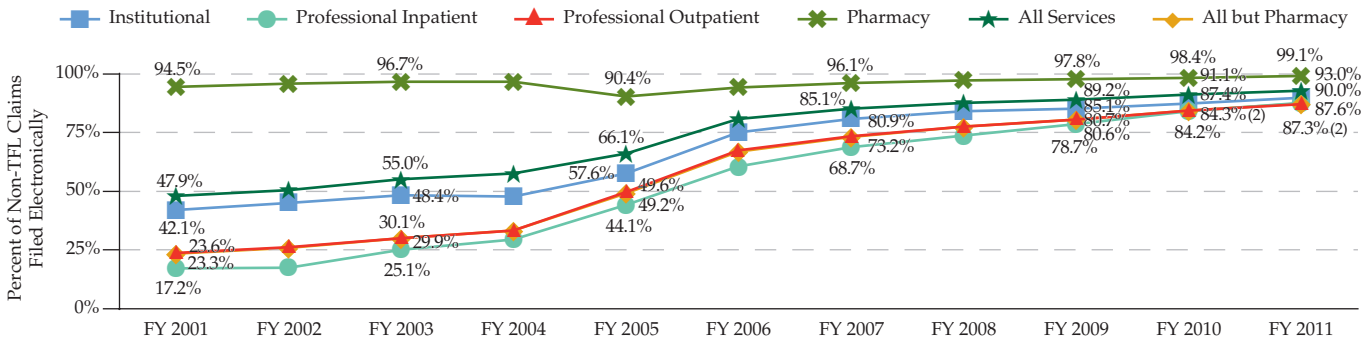
ELECTRONIC CLAIMS PROCESSING

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 TRICARE Regional Offices (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 93 percent in FY 2011, up one percentage point from the previous year. Pharmacy claims are almost entirely electronic, reaching 99 percent in FY 2011. 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 87 percent in 2011 (the individual categories below are institutional and professional inpatient and outpatient services). 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.

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



Source: MHS administrative data, 11/20/2011

Note: Foreign claims are excluded. The "All but Pharmacy" line is hidden behind that of "Professional Outpatient" because their data points are almost equivalent.

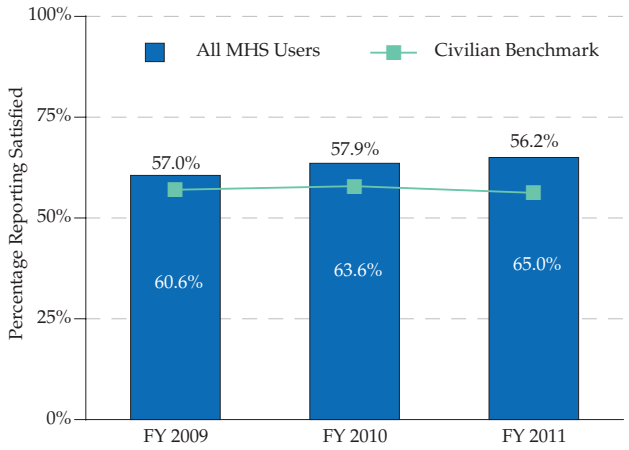
CUSTOMER REPORTED EXPERIENCE AND SATISFACTION WITH KEY ASPECTS OF TRICARE

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.

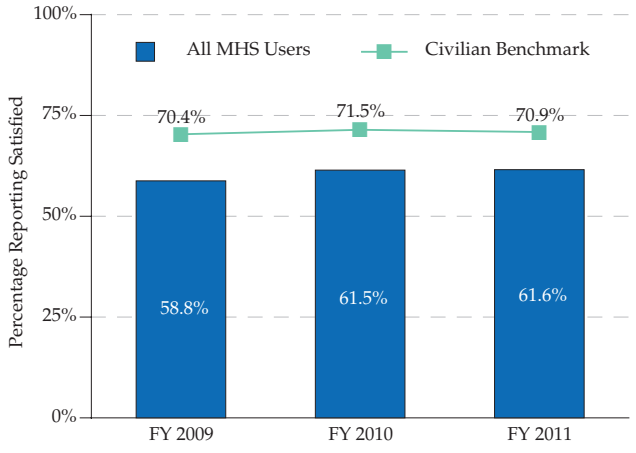
- Satisfaction with the overall TRICARE plan and health care increased between FY 2009 and FY 2011. Satisfaction levels with primary care and specialty care physicians remained stable over this period.
- MHS satisfaction rates continued to lag civilian benchmarks, with the exception of health plan, which exceeded the benchmark over this period.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS

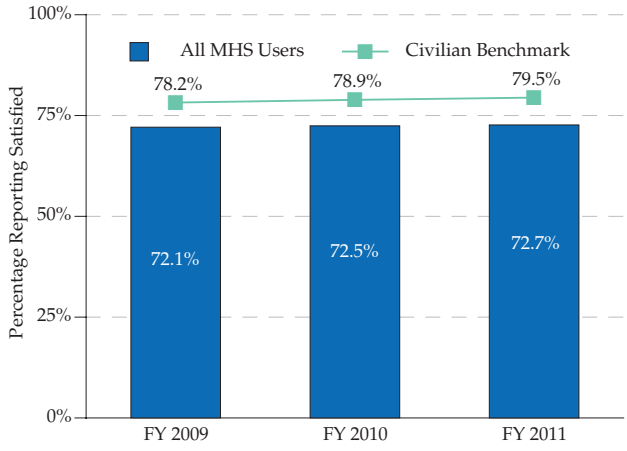
HEALTH PLAN



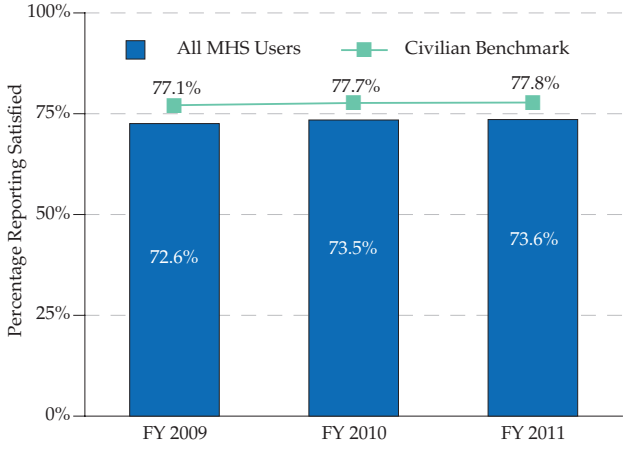
HEALTH CARE



PRIMARY CARE PHYSICIAN



SPECIALTY PHYSICIAN



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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 (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

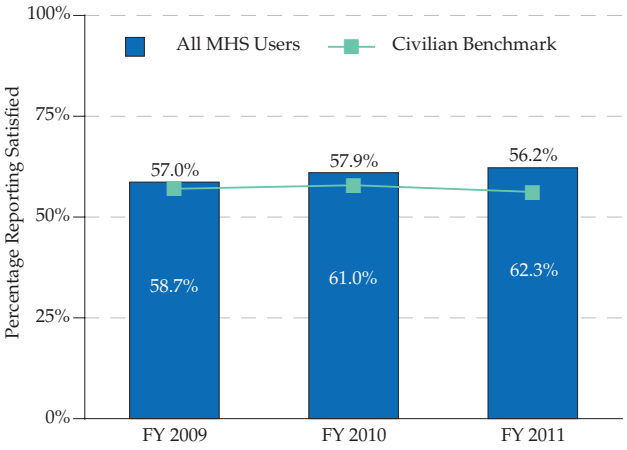
SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

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.

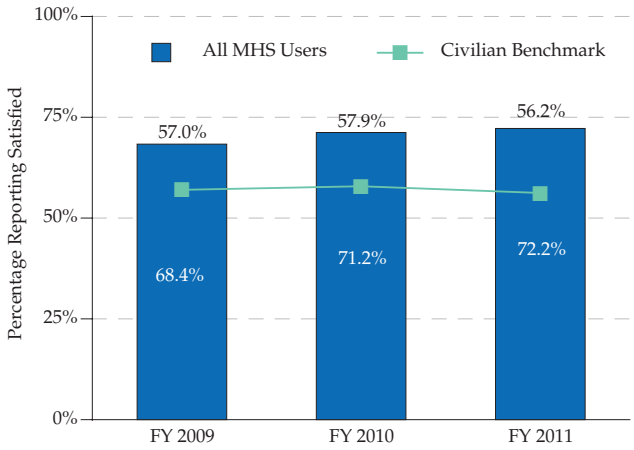
- Satisfaction with the TRICARE health plan increased for Prime enrollees and non-enrollees from FY 2009 to FY 2011 while the civilian benchmark decreased.
- During each of the past three years (FY 2009 to FY 2011), MHS beneficiaries enrolled with civilian and military PCMs reported higher levels of satisfaction than their civilian counterparts.
- Non-enrolled MHS beneficiaries also reported higher levels of satisfaction than their civilian plan counterparts during each of the past three years.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

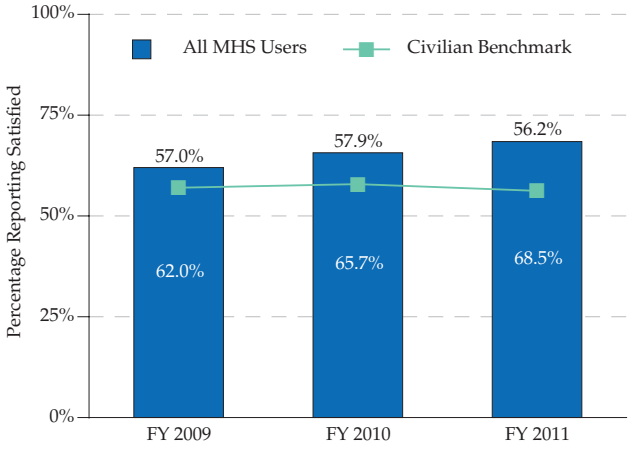
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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 (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

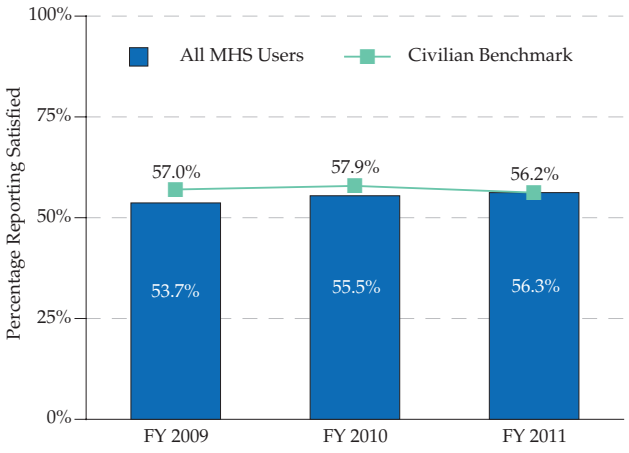
SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

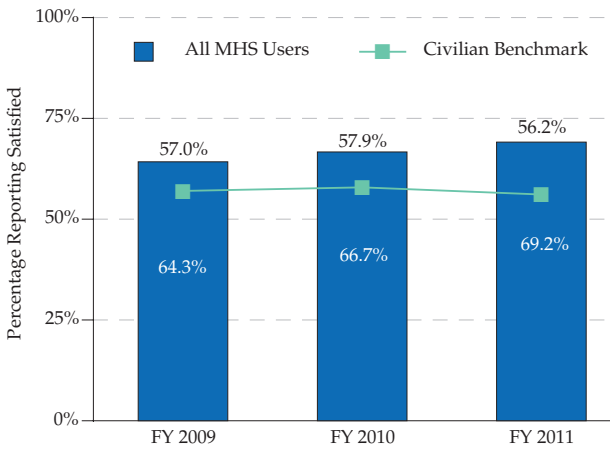
- Satisfaction with the TRICARE health plan improved for all three beneficiary categories between FY 2009 and FY 2011. Satisfaction of Active Duty beneficiaries lagged the civilian benchmark in FYs 2009 and 2010, but equaled it in FY 2011.
- ADFM and retirees and family member satisfaction ratings exceeded the civilian benchmark in all three years (FYs 2009–2011). The civilian benchmark declined slightly from FY 2009 to FY 2011.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY BENEFICIARY CATEGORY

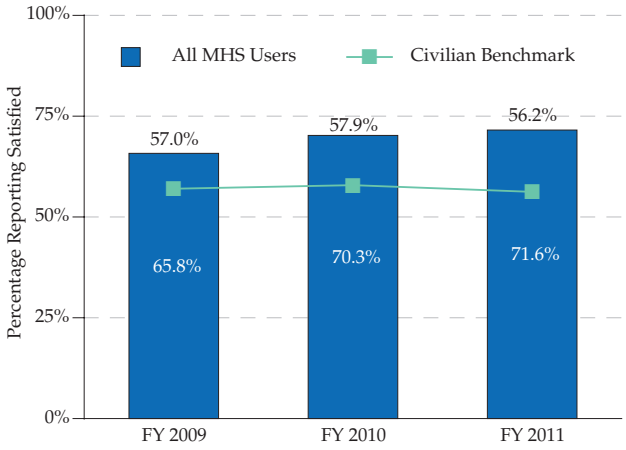
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIREES AND FAMILY MEMBERS



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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 (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

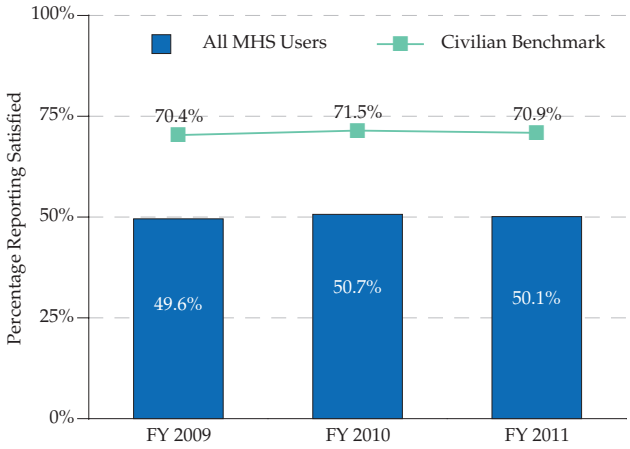
SATISFACTION WITH THE HEALTH CARE BASED ON BENEFICIARY CATEGORY

Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category:

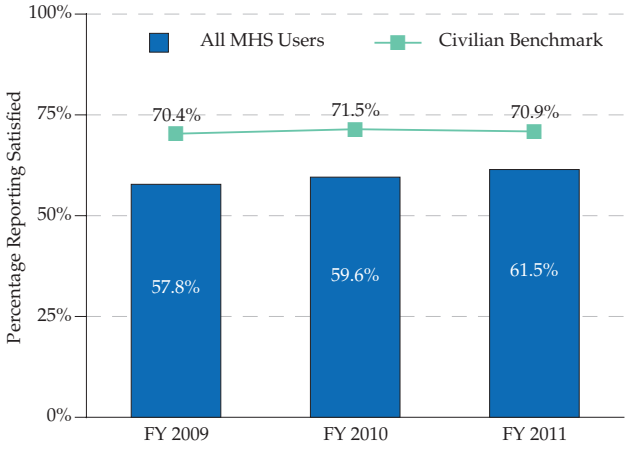
- Satisfaction increased during FYs 2009–2011 for Active Duty families and retirees and families, while satisfaction of Active Duty remained stable.
- The satisfaction levels of Active Duty and their families continued to lag the civilian benchmark, but retirees and families exceeded the benchmark in FY 2010 and FY 2011.
- While not shown, the satisfaction of enrollees with military PCMs remained stable but continued to lag the civilian benchmark over FYs 2009–2011. Satisfaction levels of enrollees with civilian PCMs and satisfaction levels of non-enrollees exceeded the civilian benchmark in FY 2010 and FY 2011.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY

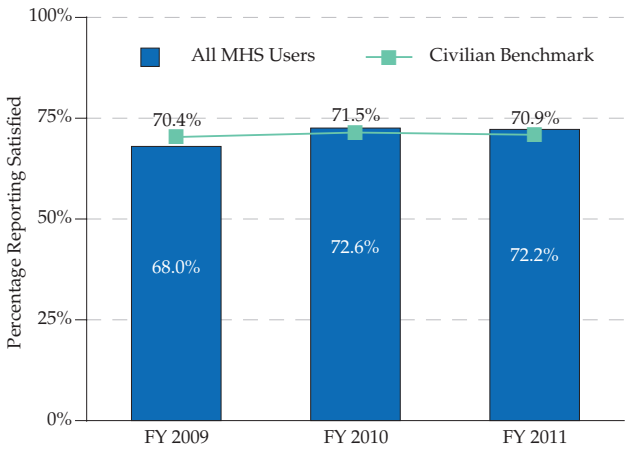
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIREES AND FAMILY MEMBERS



Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, 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 (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

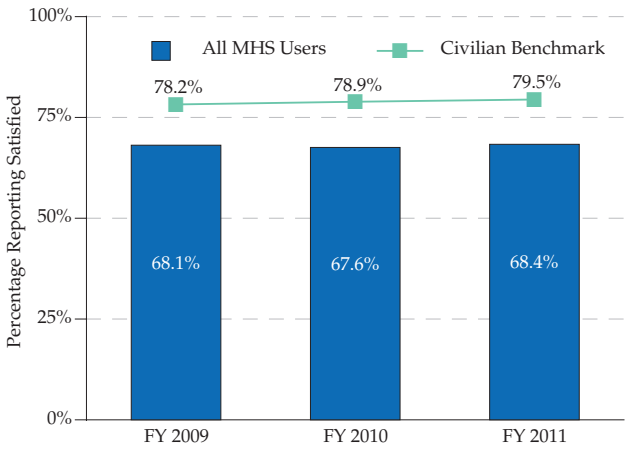
SATISFACTION WITH ONE'S PERSONAL PROVIDER BASED ON ENROLLMENT STATUS

MHS user satisfaction with one's personal provider differs by enrollment status.

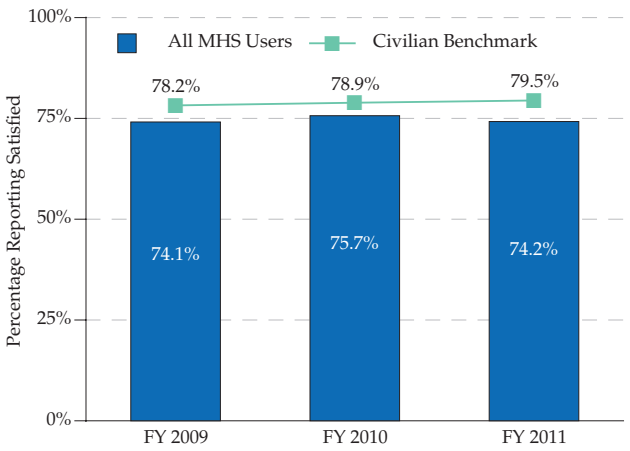
- Satisfaction levels of non-enrollees and Prime enrollees remained stable between FY 2009 and FY 2011.
- Satisfaction levels of Prime enrollees (both military and civilian PCMs) continued to lag the civilian benchmarks. Satisfaction levels of non-enrollees are comparable to the civilian benchmark.
- While not shown, the satisfaction levels of Prime enrollees with military PCMs also lag the civilian benchmark for satisfaction with specialty providers. Satisfaction levels of Prime enrollees with civilian PCMs and those of non-enrollees are comparable to civilian benchmarks for satisfaction with specialty providers.

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

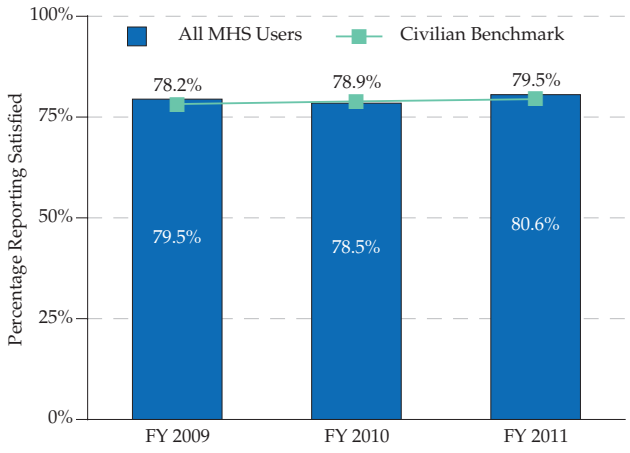
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



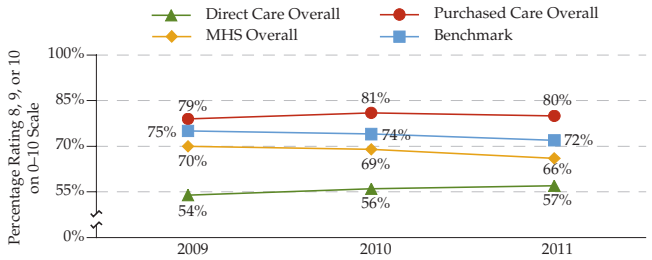
Note: DoD data were derived from the FYs 2009–2011 HCSDB, as of 12/22/2011, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 3, used in 2009, and come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively.

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

TRICARE OUTPATIENT SATISFACTION SURVEY (TROSS)

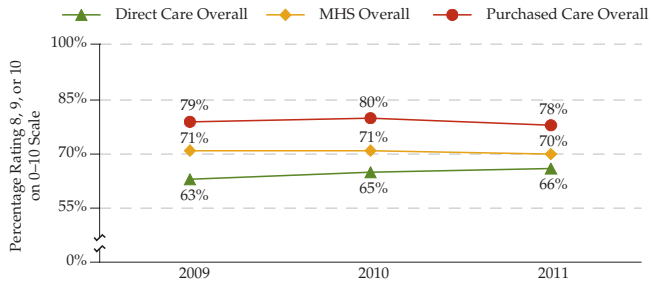
The goal of the OASD(HA)/TMA TRICARE Outpatient Satisfaction Survey (TROSS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian provider office. The TROSS is based on the AHRQ Consumer Assessments of Healthcare Providers and Systems Clinician and Group questionnaire (CAHPS® C&G), which allows for comparison with civilian outpatient services. The TROSS instrument also includes MHS-specific questions that measure satisfaction with various aspects of the MHS. The TROSS was first fielded in January 2007, succeeding the Customer Satisfaction Survey (CSS).

OVERALL RATING OF HEALTH CARE



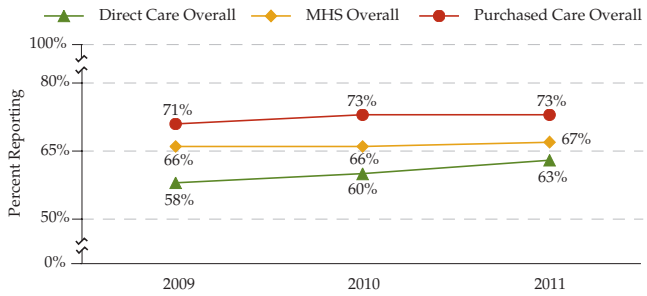
Note: Terms mentioned above: "MHS Overall" refers to the users of both direct and purchased care components, "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process. Benchmark data shown are from the balanced scorecard criteria. The years depicted align with the TROSS schedule (i.e., May 2010–April 2011).

OVERALL RATING OF HEALTH PLAN



Note: Terms mentioned above: "MHS Overall" refers to the users of both direct and purchased care components, "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process. The years depicted align with the TROSS schedule (i.e., May 2010–April 2011).

OVERALL RATING OF MENTAL HEALTH CARE



Note: Terms mentioned above: "MHS Overall" refers to the users of both direct and purchased care components, "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process. The years depicted align with the TROSS schedule (i.e., May 2010–April 2011). Mental Health Care is a composite of ratings measuring "Ease of getting treatment/counseling service" and "Overall rating of treatment/counseling."

Source: OASD(HA) TMA/OCFO-DHCAPE TROSS survey results of 12/19/2011.
Note: The above comparisons of trends over time are based on raw percentage differences and do not reflect statistical tests of significance.

- MHS eligible overall ratings of their **health care** (the percentage rating 8, 9, or 10 on a 0–10 scale) decreased from 70 percent in 2009 to 66 percent in 2011. Among the MHS eligibles, ratings by those using civilian outpatient care slightly increased from 79 percent in 2009 to 80 percent in 2011, while ratings by those using MTF-based care increased from 54 percent in 2009 to 57 percent in 2011.
- Beneficiary overall rating of the **health plan** among MHS eligibles (the percentage rating 8, 9, or 10 on a 0–10 scale) decreased from 71 percent in 2009 and 2010 to 70 percent in 2011. Health plan ratings by those receiving outpatient care at civilian facilities decreased from 79 percent in 2009 to 78 percent in 2011, while plan ratings for MTF-based facilities increased from 63 percent in 2009 to 66 percent in 2011.
- The composite rating of **overall mental health care** (a combination of ratings for "Ease of getting treatment/counseling service" and "Overall rating of treatment/counseling") improved from 2009 to 2011 for users of civilian facilities as well as military facilities. MHS eligible ratings of mental health care improved from 66 percent in 2009 and 2010 to 67 percent in 2011, with ratings by users of civilian mental health care increasing from 71 percent in 2009 to 73 percent in 2010 and 2011. Ratings from users of MTF-based mental health care dramatically improved, from 58 percent in 2009, to 60 percent in 2010 and 63 percent in 2011.

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

TRICARE INPATIENT SATISFACTION SURVEY (TRISS)

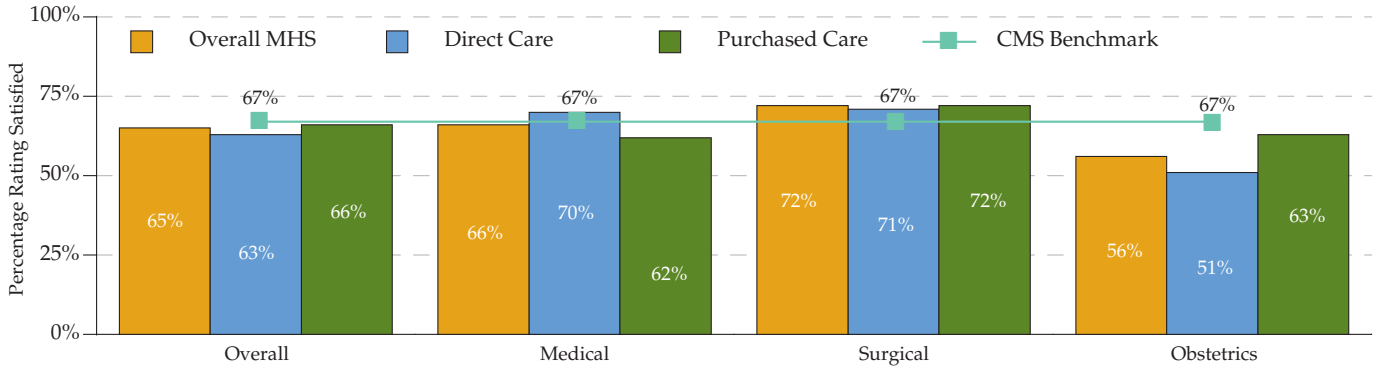
The purpose of the OASD (HA)/TMA TRICARE Inpatient Satisfaction Survey (TRISS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and the Centers for Medicare and Medicaid Services (CMS) for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS®) initiative. The goal of the HCAHPS initiative is to measure uniformly and report publicly patients' experience with their inpatient care through the use of a standardized survey instrument and data collection methodology. The information derived from the survey can be useful for internal quality improvement initiatives, to assess the impact of changes in operating procedures, and to provide feedback to providers and patients.

Comparison of these data with the results from previous surveys as well as comparisons to civilian benchmark data will measure DoD progress in meeting its goals and objectives of high-quality health care. The TRISS compares care across all Services and across venues (i.e., direct MTF-based care and private sector, or purchased care) to include comparisons of inpatient surgical, medical, and obstetrical (OB) care. In 2011, the TRISS was streamlined from 82 to 41 questions, and modified to a mixed-mode, monthly administration (by mail, Web, and telephone), garnering a 44 percent response rate, compared to 34 percent in an annual survey in previous years. This increase in response rate may be attributable to these methodological changes and the new HCAHPS requirement of surveying direct care patients within 42 days of discharge. The survey covers a number of domains, including:

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

Rating of Hospital: Overall, beneficiaries who received their care within the purchased care system rated their hospital higher than those in the direct care system. MHS beneficiaries, whether discharged from MTF or civilian hospitals, rated their hospital stay lower than users that make up the civilian benchmark (CMS). Beneficiaries who received either medical or surgical services in military facilities rated their hospital higher than the civilian benchmark. Beneficiaries who used OB services rated their hospital lower than beneficiaries who received medical and surgical services, and lower than MHS beneficiaries using civilian OB facilities.

TRISS: OVERALL RATING OF HOSPITAL



Source: OASD(HA) TMA/OCFO-DHCAPE TRISS survey results of 12/19/2011

Notes:

a. "Percentage Rating Satisfied" for Rating of Hospital is a score of 9 or 10 on a 0–10 scale where 10 is best.

b. All MHS military facility data are adjusted for selection, non-response, beneficiary category, age, and MTF service branch.

c. All MHS civilian purchased-care data are adjusted for selection, non-response, gender, beneficiary category, age, and TRICARE region.

d. TRISS data have not been case-mix adjusted, limiting comparability to CMS benchmarks.

e. CMS benchmarks for civilian providers represent three product lines combined (medical, surgical, and obstetrics) and are case-mix adjusted. These benchmarks are the latest published from Medicare Hospital Survey of Patients' Hospital Experience (*www.hospitalcompare.hhs.gov*).

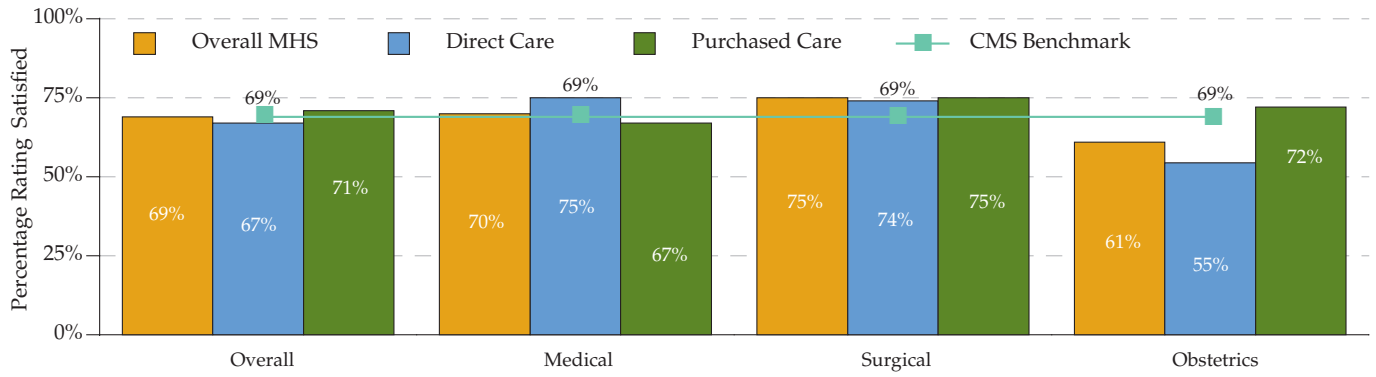
f. Direct care, MTF results are based on discharges from February 17, 2011, through June 30, 2011; purchased-care results are based on discharges from January 1, 2011, through June 30, 2011.

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

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

Recommendation of Hospital: Overall, direct care beneficiaries reported that they "always" recommend their hospital to family and friends slightly less often than purchased care beneficiaries. This is due mostly to lower ratings received by the OB-GYN product line. Direct care (medical and surgical product line) beneficiaries' recommendation of their hospital exceeds the civilian benchmarks. Purchased care beneficiaries' recommendation of their hospital exceeds the civilian benchmarks for the surgical and OB product lines.

TRISS: WILLINGNESS TO RECOMMEND HOSPITAL



Source: OASD(HA) TMA/OCFO-DHCAPE TRISS survey results of 12/19/2011

Notes:

a. "Percentage Rating Satisfied" for Recommendation of Hospital is a score of "always" when asked if one would recommend a hospital to family or friends.

b. All MHS direct care data are adjusted for selection, non-response, beneficiary category, age, and MTF service branch.

c. All MHS purchased care data are adjusted for selection, non-response, gender, beneficiary category, age, and TRICARE region.

d. TRISS data have not been case-mix adjusted, limiting comparability to CMS benchmarks.

e. CMS benchmarks for civilian providers represent three product lines combined (medical, surgical, and obstetrics) and are case-mix adjusted. These benchmarks are the latest published from Medicare Hospital Survey of Patients' Hospital Experience (*www.hospitalcompare.hhs.gov*).

f. Direct care, MTF results are based on discharges from February 17, 2011, through June 30, 2011; purchased-care results are based on discharges from January 1, 2011, through June 30, 2011.

DRIVERS OF PATIENT SATISFACTION

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE

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.

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

  Results from these three surveys for the same period of time during FY 2011 were modeled to identify key drivers of satisfaction. 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, results of modeling three different surveys suggest that improving communication between respondents and health care providers is consistently a common and key factor in improving patient ratings of their health care experience. Additionally, patient ratings are influenced by their perceptions of facility cleanliness and certainly by their ability to access needed health care services.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE ONLY

January 1 through June 30, 2011			
Ranking	**TRISS Direct Care MHS Rating of Hospital**	**TROSS Direct Care MHS Satisfaction with Health Care**	**HCSDB Direct Care CONUS Satisfaction with Health Care**
#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
#2	Communication with Doctors	Office Staff	Getting Care Quickly
#3	Cleanliness of Hospital	Access to Care	Getting Needed Care

Sources: OASD (HA)/TMA TRISS, TROSS, and HCSDB, January 1 through June 30, 2011, data as of 12/28/2011

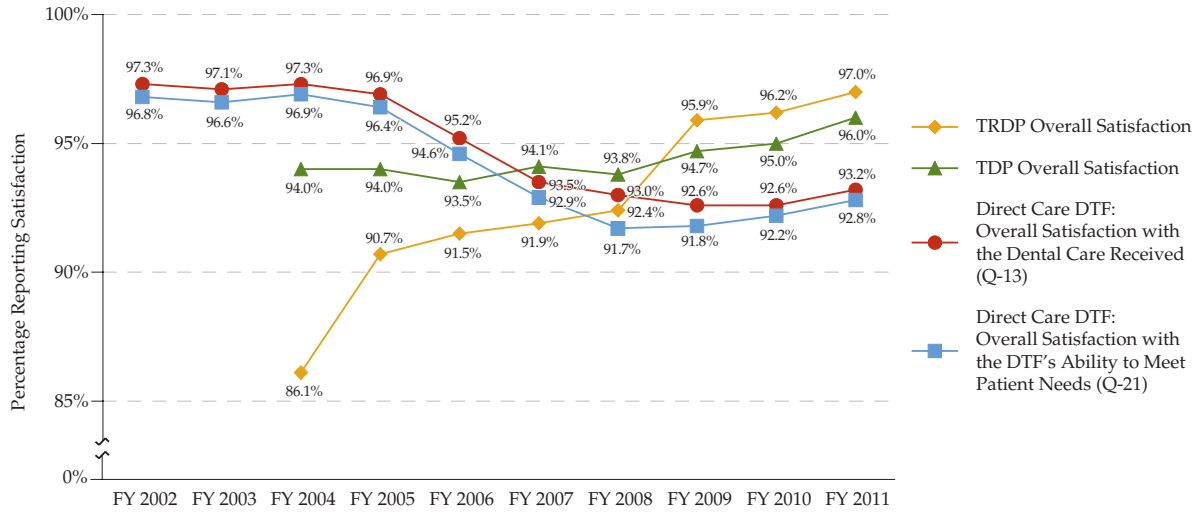
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

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 about the same in FY 2011 (93.2 percent) as in FY 2010 (92.6 percent). DTFs are responsible for the dental care of about 1.8 million Active Duty Service members, as well as eligible OCONUS family members. During FY 2011, the Tri-Service Center for Oral Health Studies collected 181,523 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 improved slightly from 92.2 percent in FY 2010 to 92.8 percent in FY 2011.
- The **TRICARE Dental Program (TDP)** FY 2011 composite overall average enrollee satisfaction increased one percentage point from 95 percent in FY 2010 to 96 percent in FY 2011. 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 families. As of September 30, 2011, the TDP serviced 856,237 contracts (almost 811,000, or 95 percent, in the U.S.), covering over 2 million lives (2,014,242). Although not shown, the TDP survey includes satisfaction ratings for network access (95 percent), provider network size and quality (95 percent), and claims processing (94 percent). The TDP network has over 72,000 dentists, comprising over 59,000 specialists and over 13,000 general dentists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate increased from 96.2 percent in FY 2010 to 97 percent in FY 2011. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. The TRDP ended FY 2011 4.4 percent higher in enrollment with over 1.3 million total covered lives in almost 640,000 contracts, compared to about 1.25 million lives in over 606,000 contracts in FY 2010, the vast majority of whom resided in the U.S.

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, 11/30/2011

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

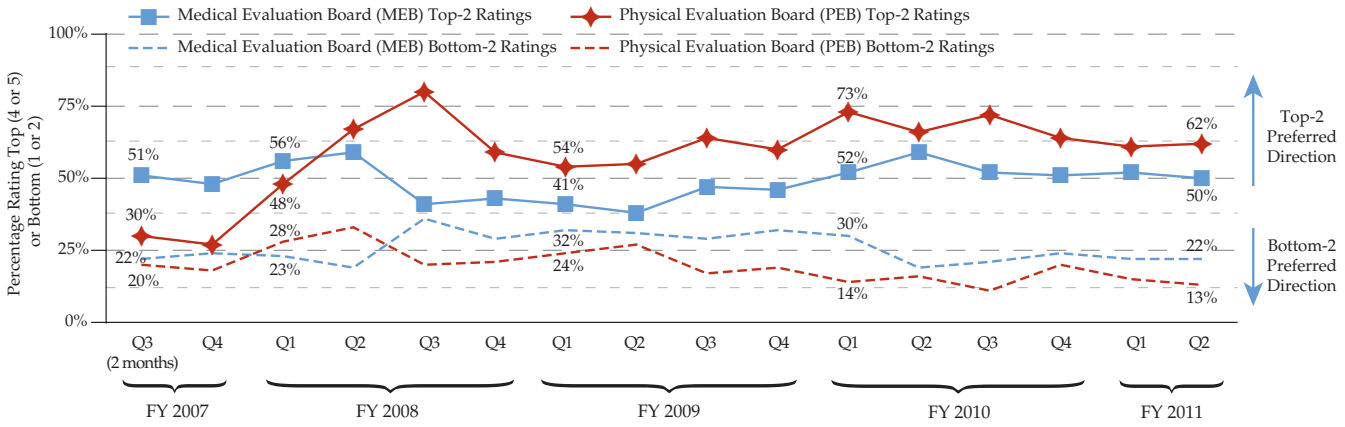
The Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity has telephonically surveyed Service members returning from operational deployment (Afghanistan and Iraq) since May 2007. The Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational 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 more than four years, the survey has been a continuous monthly collection of their experiences. The survey originally focused on the cohort of Service members aeromedically evacuated from operational theaters. It was subsequently expanded in Q4 FY 2008 to include four additional cohorts of Service members who were returned from operational deployment for at least a year, were identified as having a medical condition requiring treatment, and were found to have actually used the MHS in some capacity, hence the term "wounded, ill, or injured." Since Q4 FY 2008, the survey has been fielded to a census (100 percent) of all aeromedically evacuated Service members and a census of all Service members who have been out of operational theater for at least one year and who have used the MHS for care, including (1) a follow-up of those aeromedical evacuees; (2) those referred to VA facilities by the DoD; (3) members completing a Post-Deployment Health Assessment (PDHA); and (4) members completing a Post-Deployment Health Reassessment (PDHRA).

Since May 2007, over 53,000 surveys have been completed of over 205,000 sampled Service members returning from operational theater, for an effective cumulative response rate of 42 percent. In total, the majority of the sample (78 percent) as well as the responses (79 percent) have been Army, followed by Air Force (10 percent sampled and returned), Marines (8 percent sampled and 7 percent returned), Navy (4 percent each), and Coast Guard (under 0.2 percent each). Although Service members returning from operational deployment via aeromedical evacuation have been surveyed since Q3 FY 2007, the survey questions and methodology were changed significantly in Q4 FY 2008. These changes are reflected in the charts on pages 48 and 49.

➤ **Summary of Results:** The focus of the survey is to identify problem areas to resolve. Over the past 47 months, through the current quarter of reporting (Q2 FY 2011), 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.

DISABILITY EVALUATION SYSTEM (DES) RATINGS OVER TIME: TOP AND BOTTOM RATINGS (ON A 5-POINT SCALE)



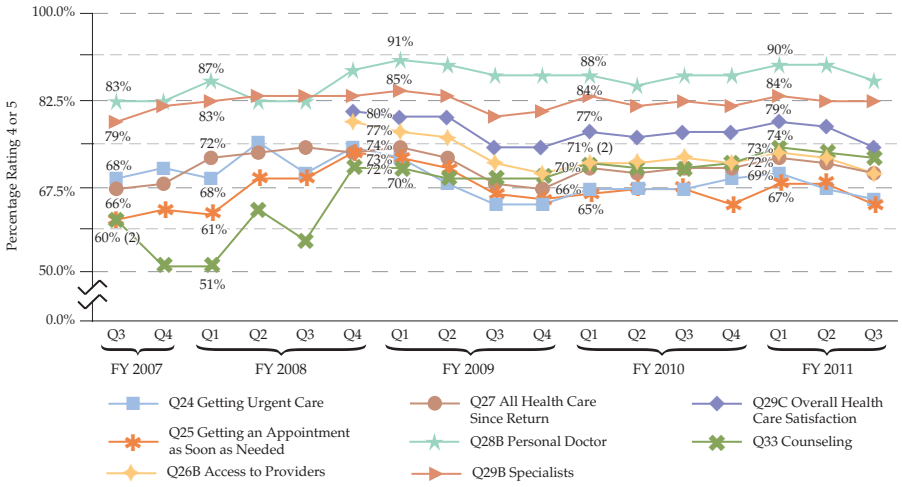
Source: OASD(HA) TMA/OCFO-DHCAPE Monthly Survey of Ill or Injured Service Members Post Operational Deployment, 12/21/2011

➤ **DES:** Service members consistently rate their experience with the Physical Evaluation Board (PEB) more favorably than those rating their experience with the Medical Evaluation Board (MEB). Favorable PEB ratings (4 or 5 on a 1–5 scale; shown in the solid red line) have hovered on or above 60 percent for the past two years, while favorable MEB ratings (blue line) have improved since Q3 FY 2009 and have remained stable at about 50 percent for the past year. Counterpart unfavorable ratings lines (reflecting "Bottom-2" ratings of 1 or 2 on the same 1–5 scale) are shown in dashed lines with MEB unfavorable ratings slightly higher (at about 20 percent) than PEB unfavorable ratings (approaching 10–15 percent).

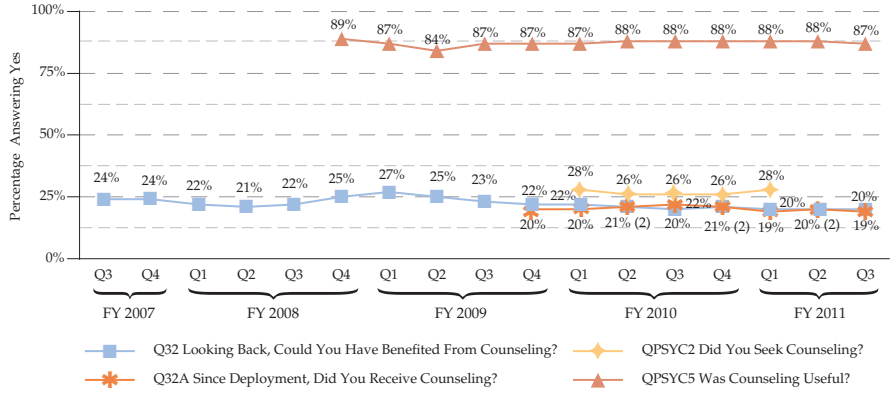
SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT *(CONT'D)*

- **Ambulatory Care:** Most Service members rate favorably their outpatient care (top chart, with ratings of 4 or 5 on a 1–5 scale where 1 = Poor and 5 = Outstanding). Service members are more satisfied with their providers (personal doctors, specialists), but express more concern with access to them (e.g., the lowest lines on the chart over time are for "getting urgent care" or "getting an appointment"). Service members who rate their experience with ambulatory care unfavorably also tend to do so for access rather than for providers or the care itself (not shown).
  - Access to behavioral health care services (middle chart): About one-fourth of Service members reported seeking care for a personal or family problem; one-fifth stated they received care; and, of those receiving care, almost 90 percent have said it was helpful (top trend line). Of those who did not receive care, about one-fifth said that, on looking back, they could have benefited from such care.
  - About two-thirds of Service members report favorable ratings for DoD support for care referred to the VA, while over three-fourths say their medical record was available to the VA at the time they were treated (not shown).
- **Medical Hold:** Most Service members rate favorably various aspects of their experience in Medical Hold/Holdover or Warrior Transition Unit.

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

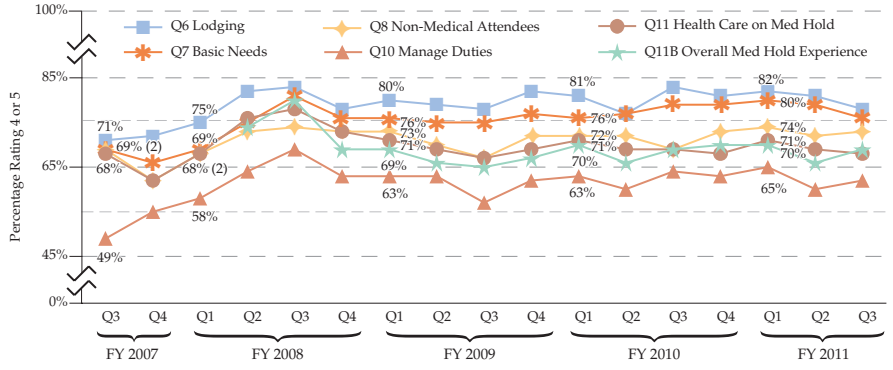


SEEKING COUNSELING FOR PERSONAL OR FAMILY PROBLEM



Note: Skip pattern changed in Q4 FY 2009 so that Q32 ("Looking back, could you have benefited from counseling?") and QPSYC2 ("Did you seek counseling?") are asked only if counseling was not received.

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



Source: OASD(HA) TMA/OCFO-DHCAPE Monthly Survey of Ill or Injured Service Members Post-Operational Deployment, 12/21/2011

NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE

The MHS continually monitors process and outcomes measures to assess the quality of clinical care provided to enrolled beneficiaries. Standardized, nationally recognized, consensus-based metrics are used to ensure consistency in measure methodology and to facilitate comparison with civilian sector care. The measures data provide essential information 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, as well as for beneficiaries in making informed decisions about the quality of health services available to them and their families.

The performance of hospitals in the MHS is in part 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 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*.

To facilitate easy access and support the government mandate for enhanced transparency, the data for the measures are posted for public review. Quarterly, the Hospital Compare data file is downloaded and the participating purchased care network hospitals are identified. Then the MTF data are added to provide a systemwide view. The data file is available on the MHS Clinical Quality Management Web site: *https://www.mhs-cqm.info*. MHS subject matter experts for both direct care and purchased care review the data and work collaboratively to identify and communicate performance excellence and improvement opportunities.

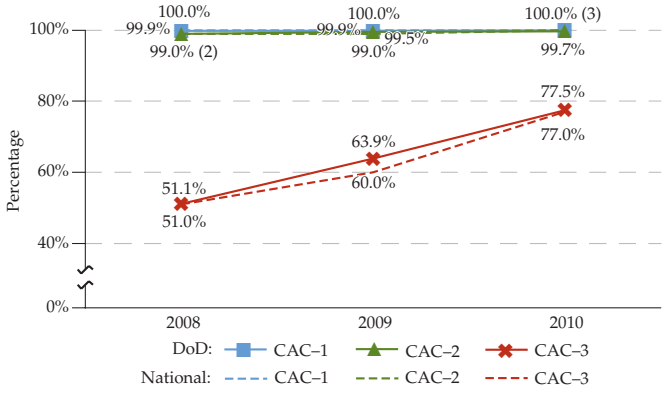
MHS HOSPITAL QUALITY MEASURES—DOD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2008–FY 2010

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.

	2008	2009	2010
CAC–1 Children Who Received Reliever Medication While Hospitalized for Asthma			
DoD	99.9%	99.9%	100.0%
MTF	99.7	100.0	99.7
Purchased Care	99.9	99.9	100.0
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	99.0%	99.5%	99.7%
MTF	98.7	99.2	98.5
Purchased Care	99.0	99.5	99.8
National	99.0	99.0	100.0
CAC–3 Children and Their Caregivers Who Received a Home Management Plan of Care Document While Hospitalized for Asthma			
DoD	51.1%	63.9%	77.5%
MTF	24.0	38.4	51.5
Purchased Care	54.3	65.7	78.7
National	51.0	60.0	77.0

- **Children's Asthma Care:** Although performance for the medication management measures for children's asthma care is almost 100 percent for CAC–1 and CAC–2, the home management plan of care measure results (CAC–3), despite getting better each year, present an opportunity for improvement.

DoD HOSPITAL QUALITY MEASURE: CAC



Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2011

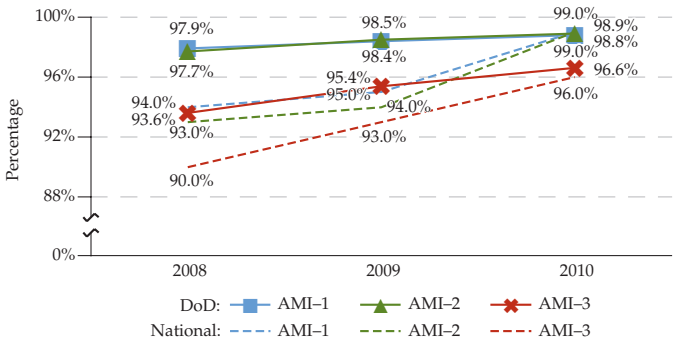
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS HOSPITAL QUALITY MEASURES—DoD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2008–FY 2010

	2008	2009	2010
AMI–1 Heart Attack Patients Given Aspirin at Arrival			
DoD	97.9%	98.4%	98.8%
MTF	98.7	98.8	98.4
Purchased Care	97.9	98.4	98.8
National	94.0	95.0	99.0
AMI–2 Heart Attack Patients Given Aspirin at Discharge			
DoD	97.7%	98.5%	98.9%
MTF	98.6	97.7	97.7
Purchased Care	97.7	98.5	98.9
National	93.0	94.0	99.0
AMI–3 Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)			
DoD	93.6%	95.4%	96.6%
MTF	95.1	97.1	98.3
Purchased Care	93.6	95.4	96.6
National	90.0	93.0	96.0
AMI–4 Heart Attack Patients Given Smoking Cessation Advice/Counseling			
DoD	98.9%	99.3%	99.6%
MTF	91.8	91.6	94.6
Purchased Care	99.0	99.3	99.6
National	95.0	97.0	100.0
AMI–5 Heart Attack Patients Given Beta Blocker at Discharge			
DoD	97.8%	98.4%	98.6%
MTF	97.6	97.0	97.3
Purchased Care	97.8	98.4	98.6
National	93.0	94.0	98.0

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

DoD HOSPITAL QUALITY MEASURE: AMI

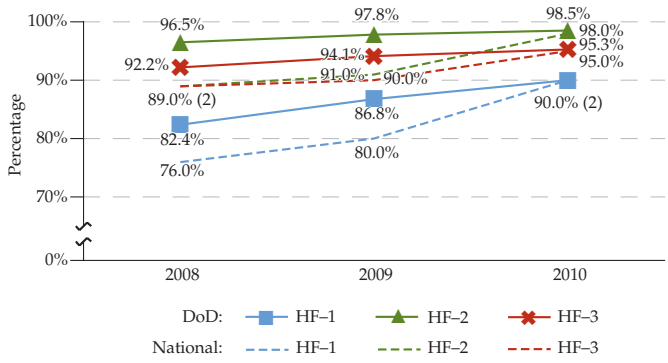


	2008	2009	2010
AMI–8a Heart Attack Patients Given PCI Within 90 Minutes of Arrival			
DoD	81.2%	87.3%	91.2%
MTF	53.4	66.0	59.7
Purchased Care	81.3	87.3	91.3
National	77.0	84.0	91.0

	2008	2009	2010
HF–1 Heart Failure Patients Given Discharge Instructions			
DoD	82.4%	86.8%	90.0%
MTF	68.9	79.8	80.9
Purchased Care	82.4	86.8	90.0
National	76.0	80.0	90.0
HF–2 Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function			
DoD	96.5%	97.8%	98.5%
MTF	95.3	95.6	96.7
Purchased Care	96.5	97.8	98.5
National	89.0	91.0	98.0
HF–3 Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)			
DoD	92.2%	94.1%	95.3%
MTF	93.5	95.0	92.4
Purchased Care	92.2	94.1	95.3
National	89.0	90.0	95.0
HF–4 Heart Failure Patients Given Smoking Cessation Advice/Counseling			
DoD	97.5%	98.4%	99.0%
MTF	86.5	86.0	92.5
Purchased Care	97.5	98.4	99.0
National	91.0	93.0	99.0

➤ **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 measures, current data reveal that the rate is improving.

DoD HOSPITAL QUALITY MEASURE: HEART FAILURE



Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2011

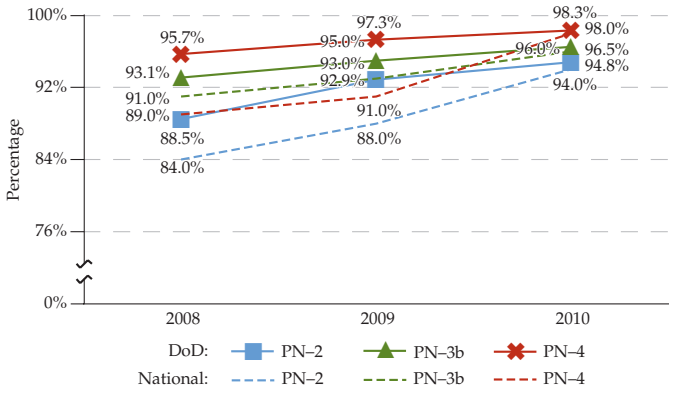
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS HOSPITAL QUALITY MEASURES—DoD COMPARED TO NATIONAL CIVILIAN HOSPITAL COMPARE AND ORYX DATA: FY 2008–FY 2010

	2008	2009	2010
PN–2 Pneumonia Patients Assessed and Given Pneumococcal Vaccination			
DoD	88.5%	92.9%	94.8%
MTF	61.6	73.2	80.5
Purchased Care	88.7	93.0	94.9
National	84.0	88.0	94.0
PN–3b Pneumonia Patients Whose Initial Emergency Room Blood Culture was Performed Prior to the Administration of the First Hospital Dose of Antibiotics			
DoD	93.1%	95.0%	96.5%
MTF	85.9	85.0	90.6
Purchased Care	93.2	95.1	96.5
National	91.0	93.0	96.0
PN–4 Pneumonia Patients Given Smoking Cessation Advice/Counseling			
DoD	95.7%	97.3%	98.3%
MTF	83.0	83.1	86.7
Purchased Care	95.8	97.4	98.3
National	89.0	91.0	98.0
PN–5c Pneumonia Patients Given Initial Antibiotic(s) Within 6 Hours After Arrival			
DoD	93.9%	94.9%	96.0%
MTF	88.3	89.3	91.2
Purchased Care	93.9	95.0	96.0
National	93.0	94.0	96.0
PN–6 Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s) PN6a+6b for ORYX			
DoD	89.7%	91.9%	93.3%
MTF	88.3	91.9	92.4
Purchased Care	89.7	91.9	93.3
National	87.0	89.0	93.0

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

DoD HOSPITAL QUALITY MEASURE: PNEUMONIA

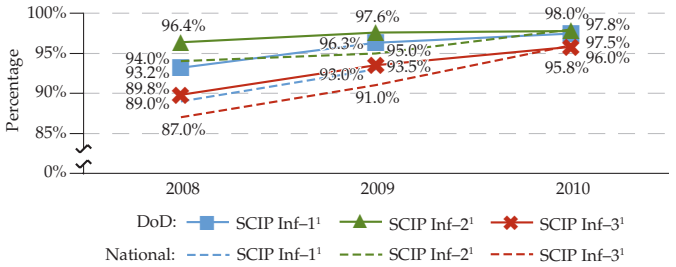


	2008	2009	2010
PN–7 Pneumonia Patients Assessed and Given Influenza Vaccination			
DoD	85.8%	90.2%	92.5%
MTF	53.1	65.4	75.1
Purchased Care	86.1	90.5	92.6
National	82.0	86.0	91.0

	2008	2009	2010
SCIP Inf–1[1] Surgery Patients Who Were Given an Antibiotic at the Right Time (Within One Hour Before Surgery) to Help Prevent Infection			
DoD	93.2%	96.3%	97.5%
MTF	75.9	88.4	92.9
Purchased Care	93.4	96.4	97.6
National	89.0	93.0	97.0
SCIP Inf–2[1] Surgery Patients Who Were Given the Right Kind of Antibiotic to Help Prevent Infection			
DoD	96.4%	97.6%	97.8%
MTF	95.6	97.0	94.6
Purchased Care	96.4	97.6	97.8
National	94.0	95.0	98.0
SCIP Inf–3[1] Surgery Patients Whose Preventive Antibiotics Were Stopped at the Right Time (Within 24 Hours After Surgery)			
DoD	89.8%	93.5%	95.8%
MTF	86.5	91.6	94.2
Purchased Care	89.8	93.5	95.8
National	87.0	91.0	96.0
SCIP VTE–1[2] Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots After Certain Types of Surgeries			
DoD	91.6%	93.5%	94.9%
MTF	92.3	93.8	92.6
Purchased Care	91.6	93.5	94.9
National	87.0	89.0	95.0

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.



	2008	2009	2010
SCIP VTE–2[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	89.0%	91.5%	93.1%
MTF	90.6	92.5	91.9
Purchased Care	89.0	91.5	93.1
National	84.0	88.0	93.0

Source: OASD(HA), Office of the Chief Medical Officer, 12/30/2011

[1] Surgical Care Improvement Project—Infection
[2] Surgical Care Improvement Project—Venous Thromboembolism Prophylaxis

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES

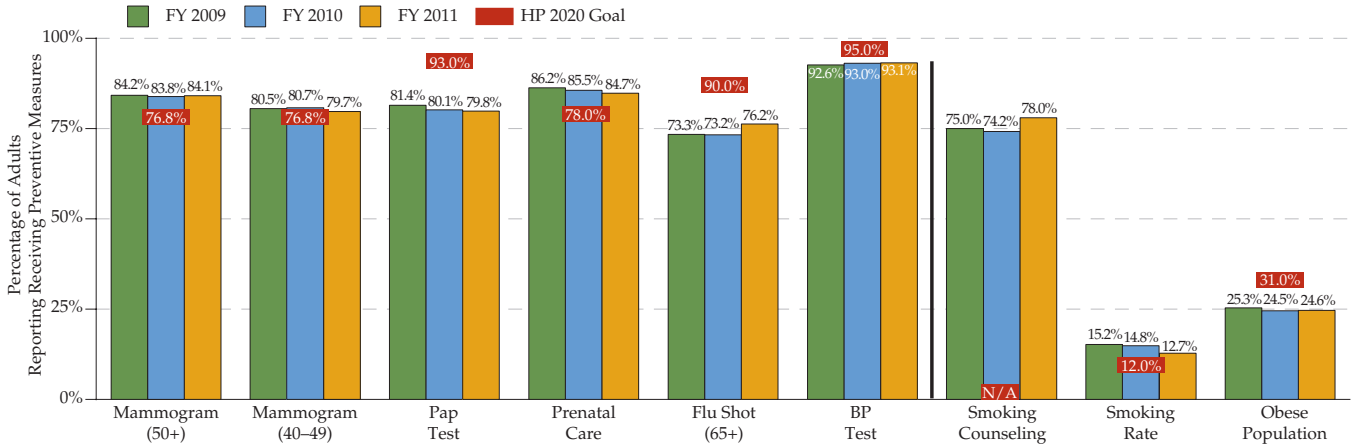
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on health promotion activities through Building Healthy Communities.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS

The Healthy People 2020 (HP 2020) 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 the Military Health System (MHS).

- MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by DHHS in HP 2020. Over the past three years, MHS has met or exceeded targeted HP 2020 goals in providing mammograms (for ages 40–49 years as well as 50+ categories) and prenatal exams (see note below).
- Efforts continue toward achieving HP 2020 standards for Pap smears, 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 2009 through FY 2011 to under 13 percent. While the proportion of smoking MHS beneficiaries appears lower than the overall U.S. population (not shown), it continued to exceed the HP 2020 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 2009 to FY 2011. The MHS rate of 24.6 percent obese in FY 2011, using self-reported data, is below the HP 2020 goal of 31 percent (see note below) and is below the most recently identified U.S. population average of 34 percent (not shown).
- Still other areas continue to be monitored in the absence of specified HP standards, such as smoking-cessation counseling, which increased to 78 percent in FY 2011.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2009 TO FY 2011



Source: Health Care Survey of DoD Beneficiaries and the NCBD as of 12/22/2011

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 2020 goals.
The goal for Prenatal Care was revised down from 90 percent in the HP 2010 goals to 78 percent in the HP 2020 goals.
The goal for Obese Population was revised up from 15 percent in the HP 2010 goals to 31 percent in the HP 2020 goals (see *http://www.healthypeople.gov/2020/topicsobjectives2020/default.aspx* for more information).

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 defined as a Body Mass Index (BMI) of 30 or above, 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.

POPULATION HEALTH

Population Health is devoted to the maintenance and enhancement of the health of the MHS population, using available resources in the most efficient and effective way possible. Population Health Improvement provides a balance of activities promoting awareness, education, prevention, and intervention, all designed to improve the health of a specified population. This model connects medical interventions to individual military treatment facilities (MTFs), worksites, and community-based wellness and prevention activities to improve overall health and reduce morbidity and premature mortality in the MHS population.

TOBACCO CESSATION

Responding to increased tobacco use among junior Active Duty military personnel, Department of Defense (DoD) implemented an education campaign aimed at helping Service members quit tobacco use and lead healthier lives. After extensive research and testing, the TRICARE Management Activity (TMA) launched "Quit Tobacco—Make Everyone Proud" in January 2006. The goals of the campaign are to increase awareness of the negative social and physical effects of tobacco and decrease its use and acceptance in the military work environment. The campaign, designed to motivate tobacco users who want to quit, is aimed at E1–E4 personnel who are 18 to 24 years old—the group with the highest rates of tobacco usage in the military. It includes a multimedia Web site, a turnkey implementation plan and schedule for installation of project officers, centrally funded promotional materials, and central support of special events. The Web site, *www.ucanquit2.org*, hosts a 24/7 instant messaging chat line manned by trained coaches/mentors available to help participants find quitting resources and start a quit plan. The Web site also houses an online customizable quit plan.

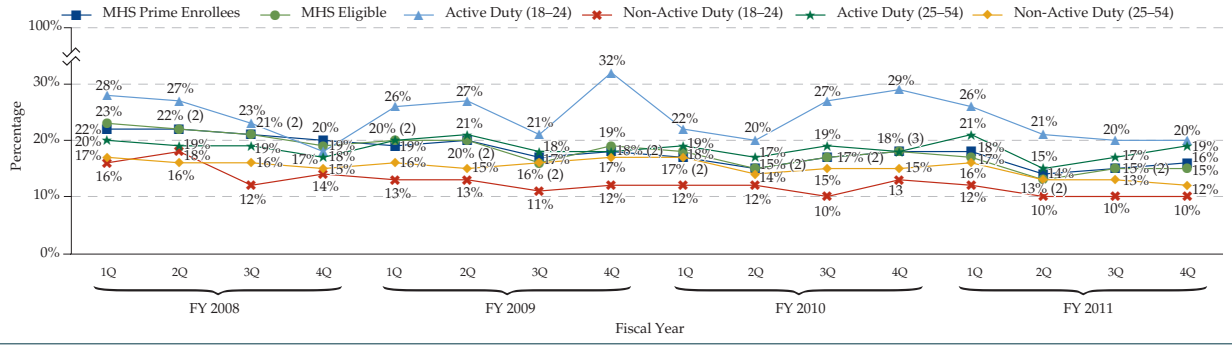
Studies indicate the average tobacco user makes six to eight quit attempts before succeeding, and there are few social barriers to tobacco use in the military. However, results of the recently released 2008 DoD Health-Related Behaviors (HRB) Survey of Active Duty Forces found that 26 percent of respondents on installations with high campaign visibility reported seriously thinking of quitting smoking in the next 30 days, compared to 6 percent from other installations.

While some of the requirements of the 2009 National Defense Authorization Act (NDAA), Section 713 smoking-cessation program have been implemented, including smoking-cessation counseling by TRICARE-authorized providers and access to online and print tobacco-cessation materials, some components require a change to the Code of Federal Regulations. At the end of FY 2011, the proposed rule to implement the pharmaceutical benefit and 24/7 quit line was published in the *Federal Register* for public comment, and once the comment period ends, TMA will continue the process to implement the final rule.

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

- **MHS Cigarette Smoking:**
  The chart below shows that, relative to the other categories, self-reported cigarette use among Active Duty Service members aged 18–24 remains at high levels (ranging from 18 to 32 percent, hovering around 25 percent); and, aside from variation from quarter to quarter, annual levels for all Active Duty have not significantly changed over the past four years (from FY 2008 to FY 2011). Rates of cigarette smoking among older Active Duty, non-Active Duty, and Prime enrollees are lower than those for 18- to 24-year-old Active Duty personnel, and appear to be declining.

MHS CIGARETTE USE RATE: ACTIVE DUTY, FAMILY MEMBERS, AND PRIME ENROLLEES



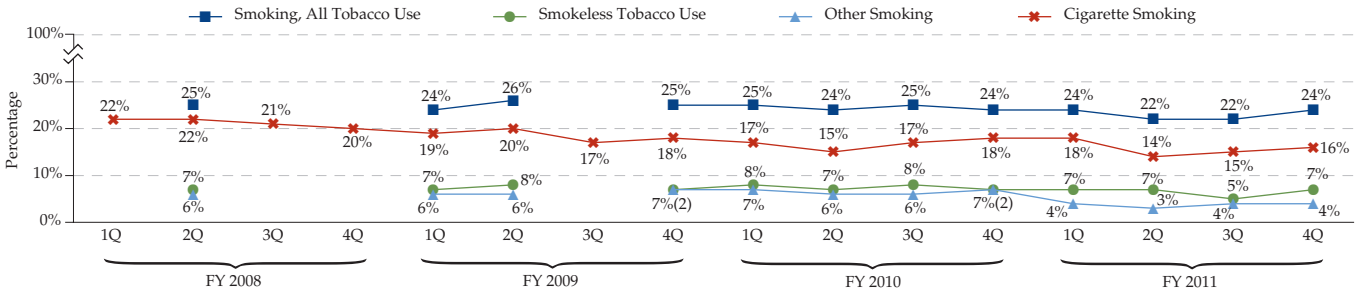
Source: OASD(HA) TMA/OCFO-DHCAPE survey, data provided 12/30/2011

Note: Numbers in parentheses on the graph indicate the number of overlapping data points.

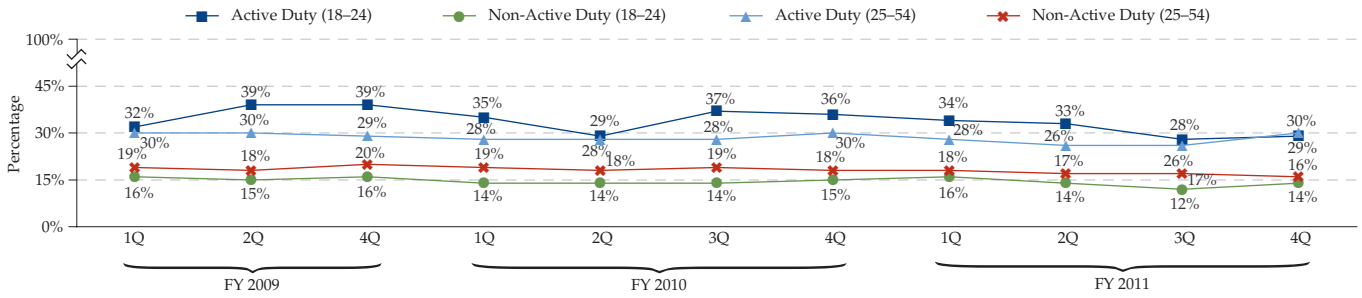
TOBACCO CESSATION *(CONT'D)*

- **MHS Prime Enrollee Use of any Tobacco Products:** While attention has historically been focused on cigarette smoking, the HCSDB has also periodically been directed to assess the use of various tobacco products across the MHS. As the chart below indicates, cigarette smoking among all Prime enrollees (Active Duty, family members, and retirees under age 65) has declined since the first quarter in FY 2008 (red line), and is the major component of any tobacco use (dark blue line; periodically assessed in FY 2008 and FY 2009 and measured each quarter since the beginning of FY 2010). The usages of various tobacco products shown in the chart are not mutually exclusive (e.g., a cigarette smoker can also report being a snuff user [smokeless tobacco] or a pipe smoker [alternate smoking tobacco] and thus are not additive).
- The bottom chart shows that 18- to 24-year-old Active Duty are also the highest users of all tobacco products, ranging from 28 to 39 percent over time, but their non-Active Duty counterparts of the same age are the lowest users of all tobacco products.

MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTE, OTHER SMOKING TOBACCO, AND SMOKELESS TOBACCO



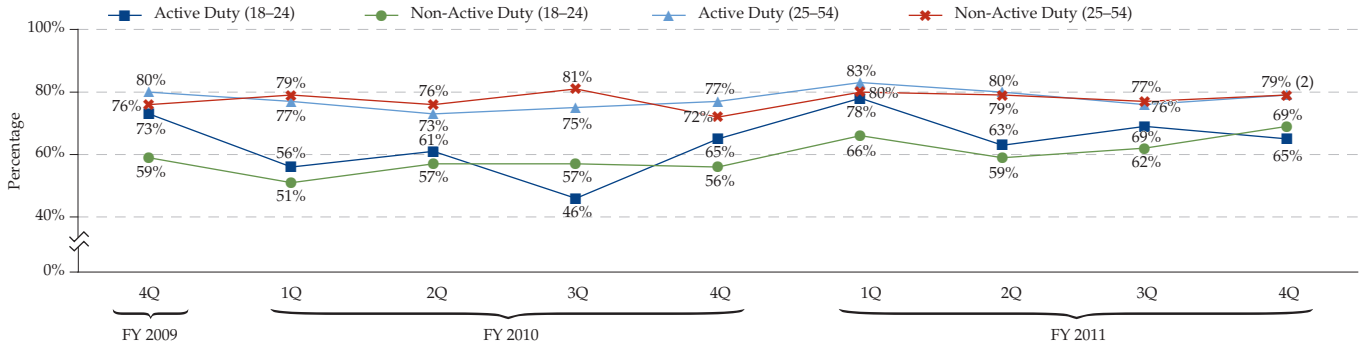
MHS ALL-TOBACCO USE RATE (CIGARETTES, ALTERNATE SMOKE, AND SMOKELESS TOBACCO PRODUCTS)



Source: OASD(HA) TMA/OCFO-DHCAPE survey, data provided 12/30/2011

- **MHS Efforts to Counsel Beneficiaries on Ceasing Tobacco Use:** This measure allows MHS to assess the success rate of tobacco-cessation programs and other healthy lifestyle/health promotion efforts among specific high-risk demographic groups. The chart below shows the success of counseling Active Duty and other beneficiaries who state they use tobacco and indicate how often in the past 12 months they were advised by physicians or other providers to quit smoking or using tobacco. Older Active Duty and family members report they are much more likely to be counseled, while the younger members report lower rates of counseling.

PROVIDER TOBACCO CESSATION COUNSELING RATE (HIGHER PERCENTAGE IS PREFERRED)



Source: OASD(HA) TMA/OCFO-DHCAPE survey, data provided 12/30/2011

ALCOHOL-REDUCTION MARKETING AND EDUCATION CAMPAIGN

After extensive research and testing, TMA launched "That Guy" in December 2006 as an integrated marketing campaign targeting military enlisted personnel of ages 18 to 24 across all branches of service. Solidly based in research, the campaign uses a multimedia, peer-to-peer social marketing approach to raise awareness in this age group of the negative short-term social consequences of excessive drinking, thereby promoting peer disapproval of excessive drinking and leading to reductions in binge drinking. This campaign includes an award-winning Web site, *www.thatguy.com*, as well as online and offline public service announcements, paid and pro bono billboard and print advertising, a turnkey implementation plan and schedule for installation project officers, centrally funded promotional materials, and central support of special events. Installation leadership consistently supports campaign efforts, as they believe that alcohol-related incidents have a negative impact on readiness. Analysis conducted by Fleishman-Hillard of the 2008 Health Related Behaviors Survey shows that, overall, among enlisted aged 18 to 24, binge drinking dropped from 51 percent in 2005 to 46 percent in 2008 (across Army, Air Force, Navy, and Marines). The same analysis shows that binge-drinking rates are lower at installations actively implementing That Guy. For example, the binge-drinking rate at Army installations that were actively implementing That Guy was 36 percent, versus 56 percent at installations that did not have an active program. The That Guy program is now in its seventh year and has recently released a smartphone-compatible version of its Web site and completed additional focus groups to inform the campaign going forward.

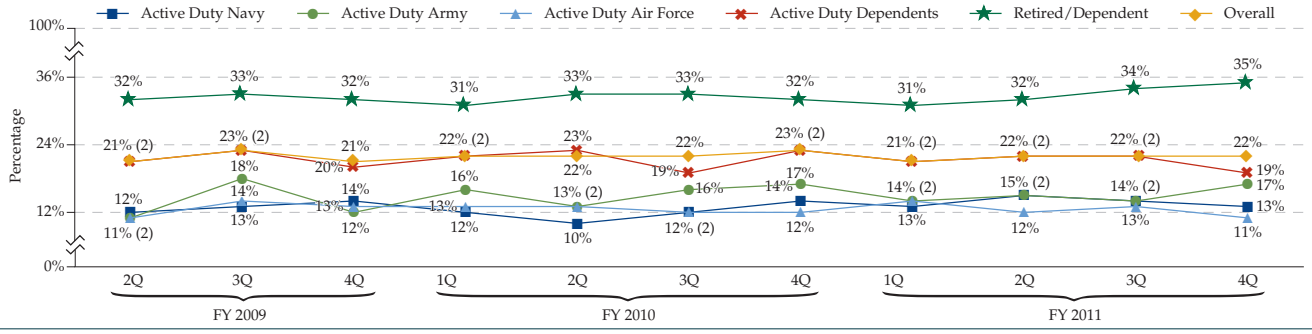
OBESITY

MHS ADULT OBESITY

This chart displays the percentage of the population reporting in the HCSDB a height and weight that is calculated with a body mass index (BMI) of 30 or higher (30 is the threshold value for obesity). This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthful nutritional habits. The data can also shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

- Dependents of Active Duty to some extent, and especially retirees and their dependents, have higher rates of obesity and are therefore at higher risk for the comorbidities associated with being overweight and obese.
- Active Duty BMI rates reflecting potential obesity are very similar across Military Departments within quarterly variation, and hover around 15 percent.
- Generally, for all but retirees, MHS obesity rates are lower than the overall 33.8 percent of U.S. adults reported as obese (data from the National Health and Nutrition Examination Survey [NHANES]).

MHS BODY MASS INDEX RATE



Source: HCSDB, data provided 12/30/2011

Note: BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as $lb/in^2 \times 703$. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).

CHILDHOOD OBESITY INITIATIVES

For over a year, the DoD Childhood Obesity Working Group, co-chaired by Military Community and Family Policy and Health Affairs, has been working toward helping decrease the rate of childhood obesity in the DoD. The group works through the MHS, schools, commissaries, youth centers, and dining facilities to help improve identification of childhood obesity and increase options for physical activity and healthy eating. The MHS subcommittee produced childhood obesity management and prevention guidelines for MHS providers and is evaluating clinical practice guidelines and other provider tools. Concurrently, adult obesity management and prevention guidelines were developed. These guidelines, besides promoting proper diagnosis, documentation, and primary provider advice on physical activity, nutrition, and screen time, also refer providers to the DoD/Department of Veterans Affairs (VA) Clinical Practice Guidelines for adult obesity and overweight. The DoD Childhood Obesity Working Group partners with the First Lady's Let's Move! program that 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 children 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 children.

DISEASE MANAGEMENT

TMA has established and is dedicated to an organized MHS-wide Disease Management (DM) program. This program is targeted at achieving positive outcomes for beneficiaries diagnosed with chronic conditions, which may include asthma, congestive heart failure (CHF), diabetes, chronic obstructive pulmonary disease (COPD), anxiety/depression, and cancer. Through coordinated DM-based programs at regional MTFs and Managed Care Support Contractors (MCSCs), beneficiaries have the ability to take advantage of an integrated care approach that emphasizes self-management skills, and includes dedicated health care professional support, publications, group education classes, telephonic care management, and Web-based information. In addition, DM programs underway within the MHS optimize the use of evidence-based, proactive, patient-centered care and clinical practice guidelines (CPGs). Currently, MTFs and the MCSC partners continue to develop the MHS DM programs that strive to improve the health status of those individuals with chronic illnesses through interventions to address the needs of their specific communities.

SPECIAL STUDY: A SURVEY OF INFLUENZA VACCINATION ATTITUDES AND RELATED RISK FACTORS

Introduction

Protecting all TRICARE beneficiaries against the flu is a policy of the MHS. The DoD requires influenza immunization of all Active Duty and Reserve Component personnel as well as health care personnel with direct patient care in DoD facilities. DoD and the Services also follow Centers for Disease Control and Prevention (CDC) guidelines and attempt to vaccinate all eligible beneficiaries requiring or requesting immunization.

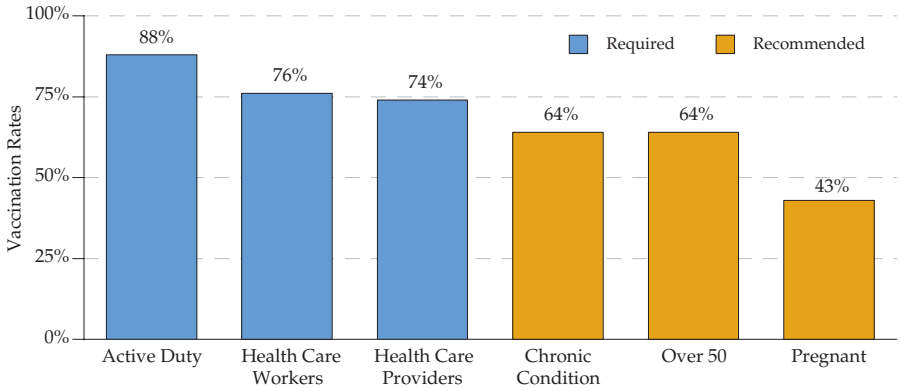
In August 2010, the CDC's Advisory Committee on Immunization Practices (ACIP) published new influenza vaccination recommendations for the 2010–2011 influenza season that now include everyone six months or older among those recommended for vaccination. Previous guidelines recommended vaccination for select groups (persons age 50 or older and those with certain chronic conditions), so this season marked the first in which some groups (specifically, those without chronic conditions between ages 19 and 49) were recommended for vaccination.

TRICARE was interested in better understanding the flu vaccination behaviors, attitudes, and patterns of TRICARE beneficiaries to lead to improved TMA/DoD policy related to flu vaccination, with the ultimate goal of increasing uptake of flu vaccines among the target population and thereby improving beneficiary health systemwide. To do so, the TMA conducted a flu vaccination telephone survey of 10,001 adult TRICARE beneficiaries at two times during the flu season: November 15–30, 2010, and March 18–29, 2011.

Findings

- **Flu vaccination**
  A large proportion of groups required for vaccination and a smaller proportion of groups traditionally recommended for vaccination had been vaccinated by March 2011:
  - Active Duty: 88 percent
  - Health care workers: 76 percent
  - Health care providers: 74 percent
  - Those with chronic conditions: 64 percent
  - Those over age 50: 64 percent
  - Pregnant women: 43 percent
- **Vaccination rates were lower among non-Active Duty beneficiaries:**
  Active Duty dependents: 39 percent
  Retired personnel: 50 percent
  Retired dependents: 48 percent
- **Reasons for not being vaccinated included:**
  - Believing they didn't need the vaccine: 42 percent
  - Concern about vaccine side effects: 11 percent
  - Believing the vaccine is ineffective: 8 percent
  - Other reasons included: getting sick after being vaccinated or seeing others get sick, being too healthy, never having had the flu
- **Role of Provider in Vaccination**
  - 34 percent of respondents cited their health care provider as their main source of flu information, and 99 percent of these respondents said they trust their provider as a flu information source.
  - 43 percent of unvaccinated respondents (and 50 percent of unvaccinated respondents with chronic conditions) reported that their doctor had recommended flu vaccination.
  - Of those whose doctor hadn't recommended vaccination, 59 percent of dependents and retired respondents said they would be vaccinated if their doctor did recommend it.

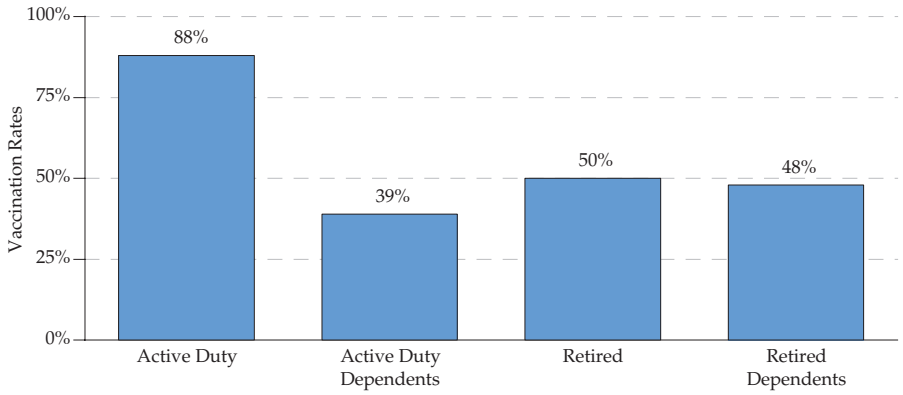
VACCINATION RATES BY REQUIRED AND RECOMMENDED GROUPS



Source: OASD(HA) TMA/OCFO-DHCAPE survey results of 12/29/2011

SPECIAL STUDY: A SURVEY OF INFLUENZA VACCINATION ATTITUDES AND RELATED RISK FACTORS *(CONT'D)*

VACCINATION RATES BY BENEFICIARY CATEGORY

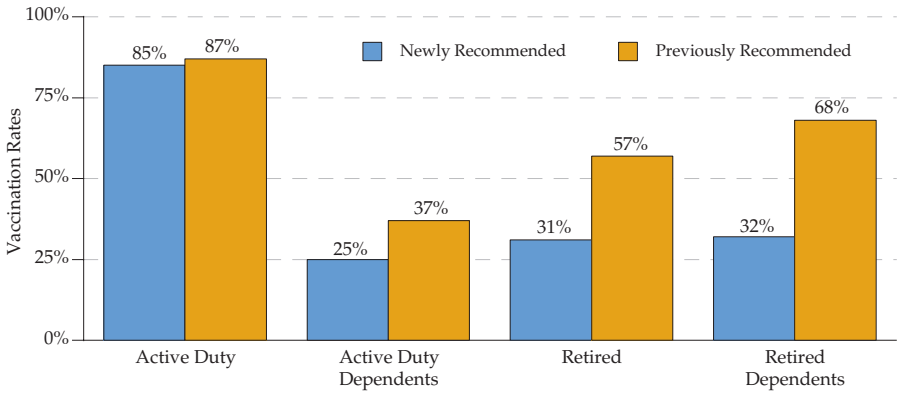


Source: OASD(HA) TMA/OCFO-DHCAPE survey results of 12/29/2011

➤ **Newly recommended for vaccination**

- Respondents who for the first time were part of the population recommended for flu vaccination according to the new ACIP guidelines were less likely to be vaccinated than those previously recommended for vaccination.
- Newly recommended respondent attitudes about vaccination differed from those who had been previously recommended for vaccination. They were:
  - Less likely to be vaccinated than those previously recommended (differences ranging from 2 percent to 36 percent, by beneficiary category; see graph);
  - More likely to believe that they did not need to be vaccinated than were previously recommended respondents (47–55 percent vs. 37–42 percent);
  - Less likely to indicate that their health care provider recommended vaccination than were previously recommended respondents (36 percent vs. 47 percent);
  - Less likely to get their flu information from their health care provider (23 percent vs. 34 percent) than previously recommended respondents and more likely to get it from other sources: Internet (21 percent vs. 18 percent), television (20 percent vs. 15 percent), and family members (9 percent vs. 6 percent).

VACCINATION RATES BY NEWLY AND PREVIOUSLY RECOMMENDED BENEFICIARIES

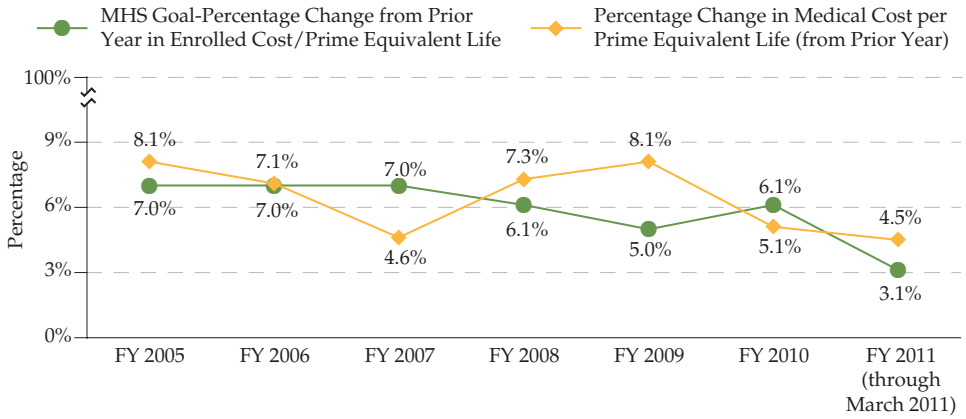


Source: OASD(HA) TMA/OCFO-DHCAPE survey results of 12/29/2011

SYSTEM PRODUCTIVITY: MEDICAL COST PER PRIME ENROLLEE

For FY 2011, the goal of this financial and productivity metric supporting the Quadruple Aim of managing per capita costs was to stay below a 3.1 percent annual rate of increase. The goal in FY 2011 is lower than in FY 2010, reflecting a general downward trend in the projected change in private health insurance premiums. Following an increase in the change in actual per member costs from FY 2007 to FY 2009, the annual rate of increase in average medical costs per TRICARE Prime enrollee has decreased in the past two fiscal years to 4.5 percent in FY 2011 (year-to-date, with incomplete data for the fiscal year).

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



Source: OASD(HA)/Office of the Chief Financial Officer (OCFO), MHS administrative data sources (M2: SIDR/SADR/CAPER/TED-I/TED-NI, PDTS; EASIV) as of 1/3/2012. Enrollees are adjusted for age, gender, and beneficiary category. FY 2011 data are current as of November 2011, with measure reported through March 2011, with preliminary reporting for Q3 FY 2011.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

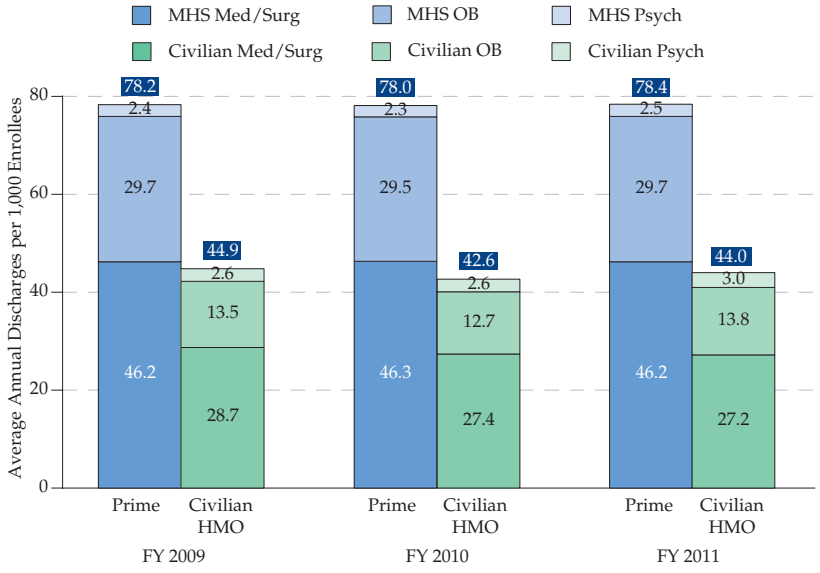
TRICARE Prime Enrollees

This section compares the inpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored health maintenance organization (HMO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because relative weighted products (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 Military Health System (MHS) data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- The TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 78 percent higher than the civilian HMO utilization rate in FY 2011 (78.4 discharges per 1,000 Prime enrollees compared with 44.0 per 1,000 civilian HMO enrollees). That is up from 74 percent higher in FY 2009.
- In FY 2011, the TRICARE Prime inpatient utilization rate was 70 percent higher than the civilian HMO rate for MED/SURG procedures, 115 percent higher for OB/GYN procedures, and 16 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) declined by 2 percent between FY 2009 and FY 2011, whereas the average LOS for civilian HMO enrollees declined by 6 percent. Nevertheless, the average LOS for MHS Prime enrollees was 4 percent lower than that of civilian HMO enrollees in FY 2011 (not shown).

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



Sources: MHS administrative data, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population.
FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

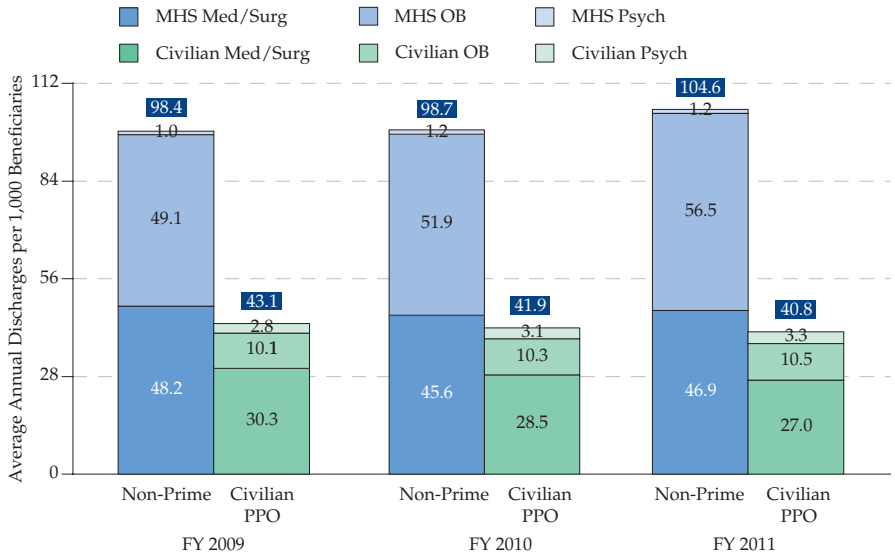
Non-Enrolled Beneficiaries

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 12 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include them.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants. From FY 2009 to FY 2011, the inpatient utilization rate for non-enrolled beneficiaries increased by 6 percent, while it declined by 5 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 2009 to FY 2011, the MHS OB disposition rate increased by 15 percent, whereas it increased by only 4 percent in the civilian sector. In FY 2011, the MHS OB disposition rate was more than five 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.
- The average LOS for MHS non-enrolled beneficiaries (direct and purchased care combined) declined by 2 percent between FY 2009 and FY 2011, whereas the average LOS for civilian PPO participants declined by 9 percent. As a result, the average LOS for MHS non-Prime beneficiaries was 7 percent higher than that of civilian PPO participants in FY 2011, up from 1 percent lower in FY 2009 (not shown).

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



Sources: MHS administrative data, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS non-enrolled beneficiary population.
FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

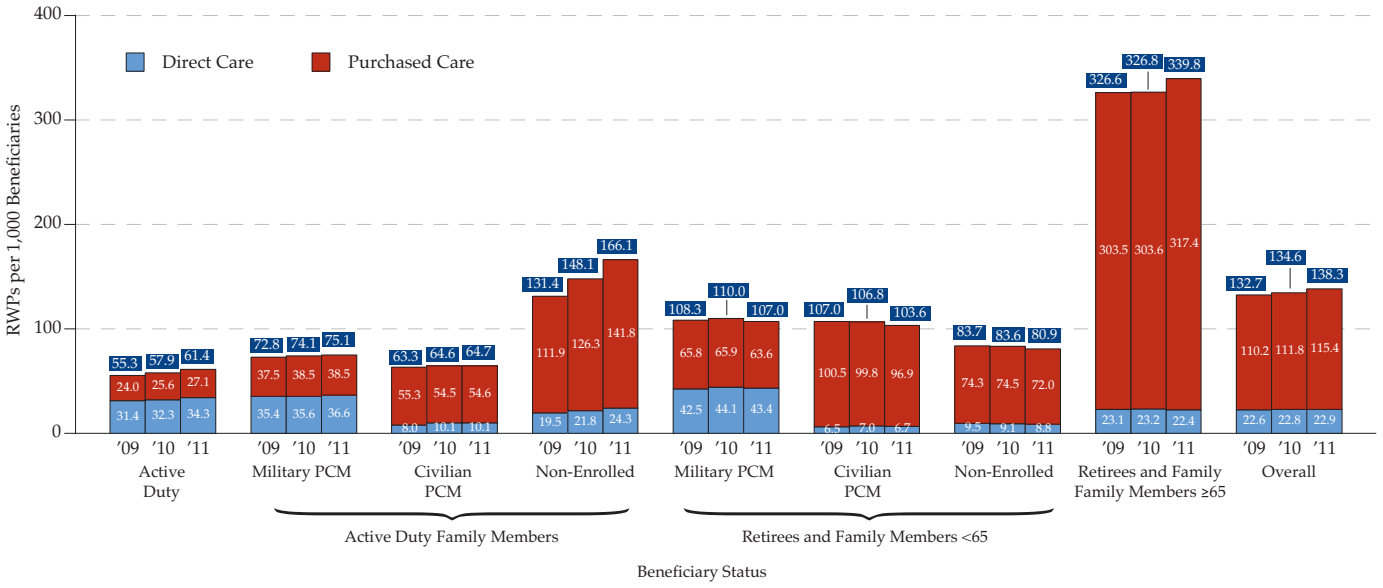
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 2009, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform to 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 2009 to FY 2011.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) increased by 5 percent from FY 2009 to FY 2011.
- The direct care inpatient utilization rate increased substantially for non-enrolled Active Duty family members (ADFMs) and for ADFMs with a civilian primary care manager (PCM) (25 percent for the former and 26 percent for the latter). Non-enrolled retirees and family members under age 65 and retired seniors and family members were the only groups to experience a decline in direct care inpatient utilization (7 percent for the former and 3 percent for the latter).
- Purchased acute care inpatient utilization rates increased the most for non-enrolled ADFMs (27 percent). Active Duty Service members (ADSMs) also saw a large increase in purchased care inpatient utilization (13 percent). All retiree beneficiary groups under age 65 saw declines in purchased care inpatient utilization ranging from 3 to 4 percent.
- 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 73 percent from FY 2009 to FY 2011.
- From FY 2009 to FY 2011, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) remained constant at about 52 percent from FY 2009 to FY 2011.

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



Source: MHS administrative data, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

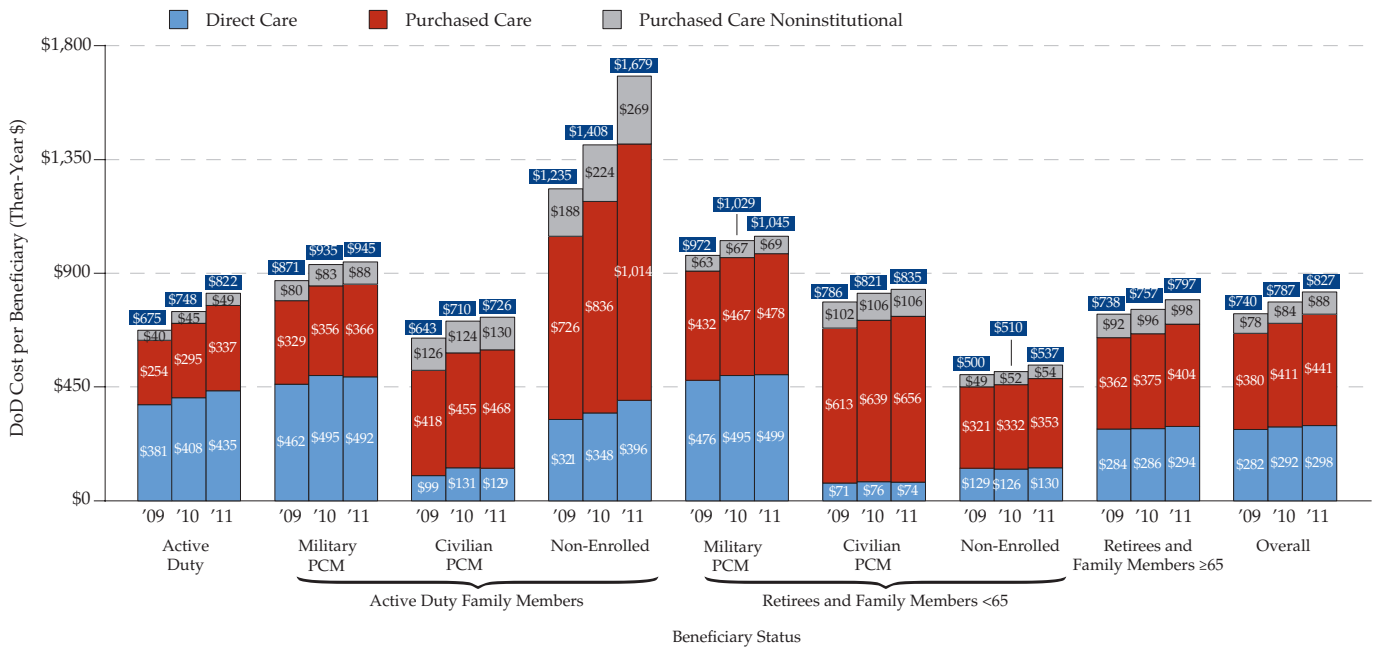
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 12 percent from FY 2009 to FY 2011. The increases were due largely to higher purchased care costs.

- Non-enrolled ADFMs experienced the largest increase in MHS per capita inpatient cost (36 percent) of any beneficiary group. The smallest increase (6 percent) was for retirees and family members under age 65 with a civilian PCM.
- The direct care cost per RWP increased from $12,498 in FY 2009 to $13,020 in FY 2011 (4 percent).
- Exclusive of TRICARE for Life (TFL), the Department of Defense (DoD) purchased care cost (institutional plus noninstitutional) per RWP increased from $7,714 in FY 2009 to $8,717 in FY 2011 (13 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, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

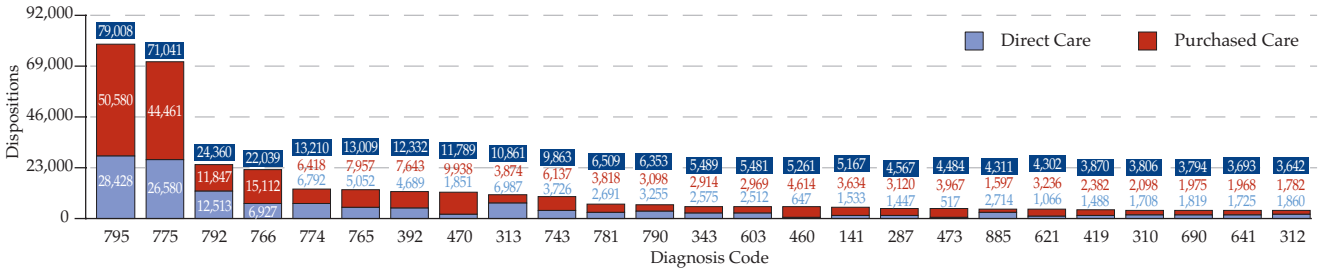
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses

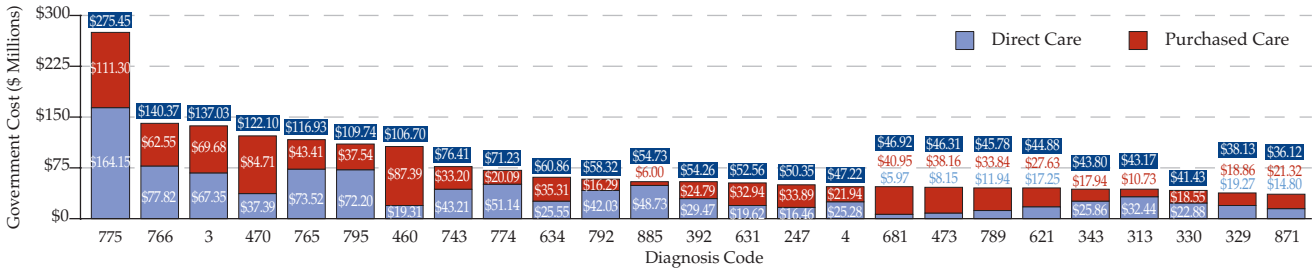
In FY 2009, TRICARE implemented the MS-DRG system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new system is designed to better capture variations in severity of illness and resource usage by reclassifying many diagnosis codes with regard to complication/comorbidity (CC) status.

The top 25 MS-DRGs in terms of volume in FY 2011 accounted for 54 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading diagnoses in terms of cost in FY 2011 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 2011 accounted for 37 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, 1/30/2012

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 six of the 25 top diagnoses. However, expenditures in direct care facilities exceed those in purchased care facilities for 14 of the top 25 diagnoses.
- Surgical procedures for obesity (without CC) are ranked 19th in volume among the top 25 diagnoses (they rank 17th 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

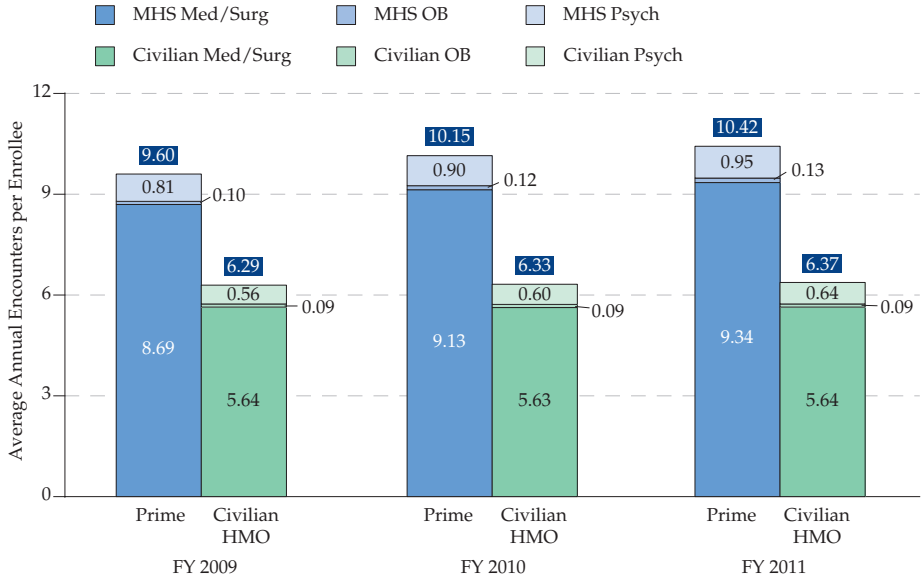
TRICARE Prime Enrollees

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 relative value units (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 8 percent between FY 2009 and FY 2011. The civilian HMO outpatient utilization rate increased by only 1 percent over the same period.
- In FY 2011, the overall Prime outpatient utilization rate was 64 percent higher than the civilian HMO rate.
- In FY 2011, the Prime outpatient utilization rate for MED/SURG procedures was 66 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was 37 percent higher than the corresponding rate for civilian HMOs in FY 2011, but that is due in part to how the direct care system records bundled services.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 49 percent higher than the corresponding rate for civilian HMOs in FY 2011. 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, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] 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 prenatal and postnatal 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)*

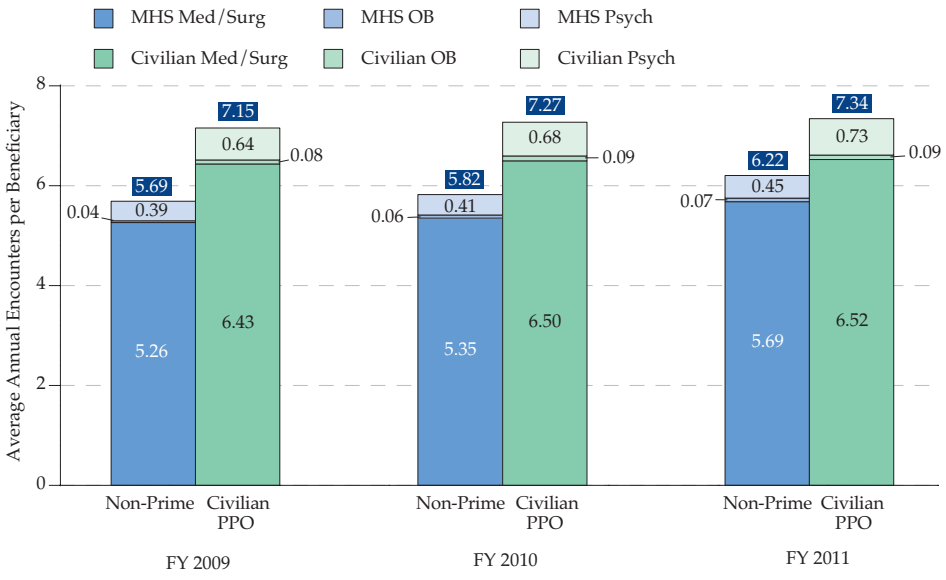
Non-Enrolled Beneficiaries

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 12 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 9 percent from 5.7 encounters per participant in FY 2009 to 6.2 in FY 2011. The civilian PPO outpatient utilization rate increased from 7.2 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 2011, TRICARE non-Prime outpatient utilization was 15 percent lower than in civilian PPOs.
- In FY 2011, the non-Prime outpatient utilization rate for MED/SURG procedures was 13 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 83 percent between FY 2009 and FY 2011, but was still 20 percent lower than the rate for civilian PPO participants.
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 17 percent from FY 2009 to FY 2011, whereas the rate increased by 14 percent for civilian PPO participants. In FY 2011, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 38 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, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

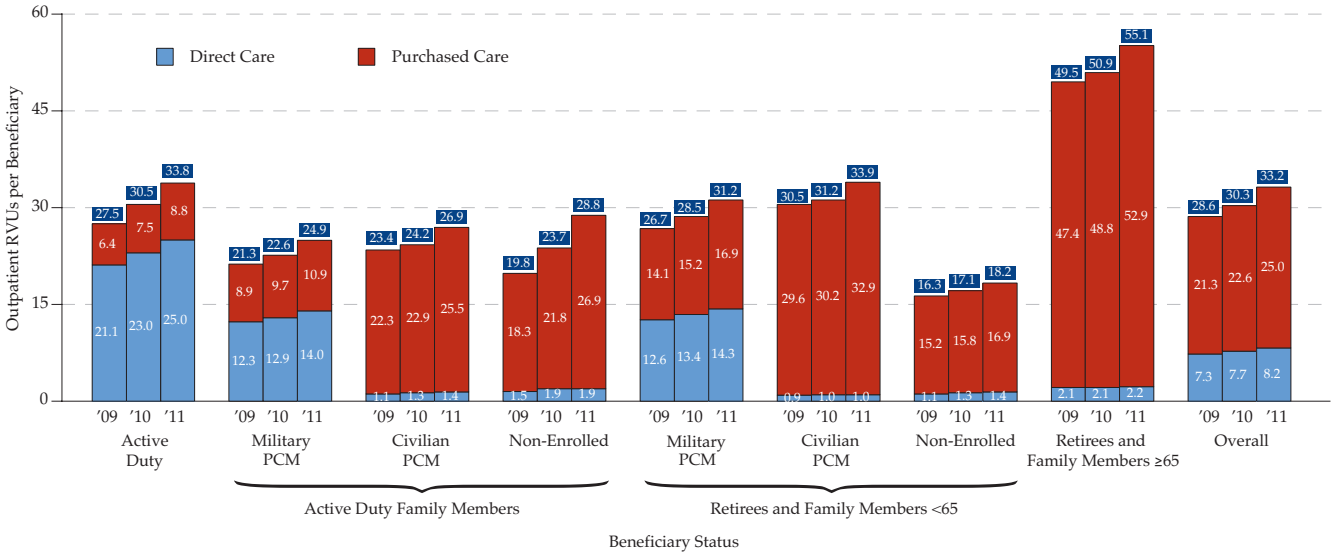
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the latter RVU measures. Note that previous years' reports used only the Physician Work RVU, and the workload levels are not comparable to those exhibited in this year's report.

- Total per capita MHS utilization (direct plus purchased care) increased by 16 percent from FY 2009 to FY 2011.
- All beneficiary groups experienced an increase in direct outpatient utilization from FY 2009 to FY 2011. Per capita utilization increased the most for non-enrolled ADFMs (26 percent) and the least for seniors (8 percent).
- From FY 2009 to FY 2011, the purchased care outpatient utilization rate increased for all beneficiary groups. The largest increase (47 percent) was experienced by non-enrolled ADFMs. ADSMs also experienced a large increase in purchased care utilization (38 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 military treatment facility (MTF) capacity is the most likely explanation for the increase.
- The TFL outpatient utilization rate increased by 3 percent in FY 2010 and by another 8 percent in FY 2011.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

[1] 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.

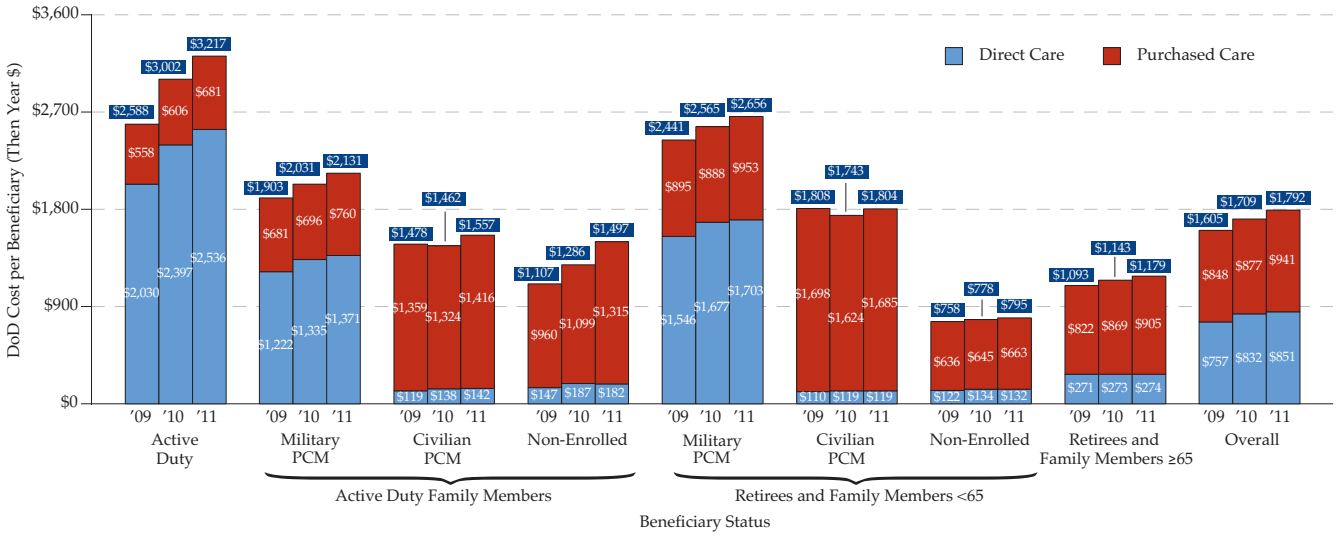
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 2009 to FY 2011.

- The direct care cost per beneficiary increased for all beneficiary groups. Active Duty members experienced the largest increase (25 percent), followed by non-enrolled ADFMs (24 percent). Seniors experienced the smallest increase (1 percent).
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 3 percent in FY 2010 and by another 8 percent in FY 2011.
- The TFL purchased care outpatient cost per beneficiary increased by 6 percent in FY 2010 and by another 4 percent in FY 2011.[1] The direct care outpatient cost per senior remained virtually unchanged from FY 2009 to FY 2011.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

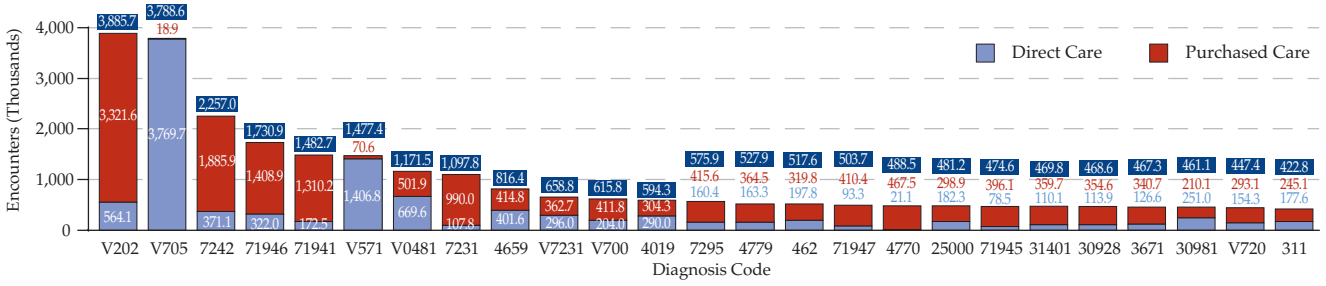
[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number who are not.

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

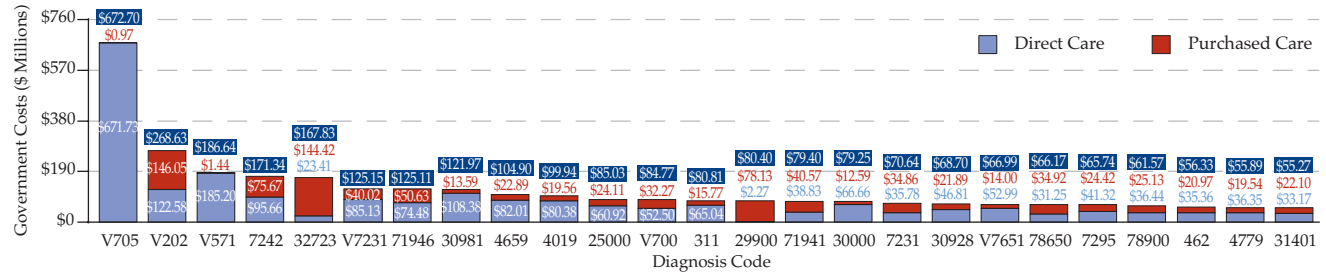
Leading Outpatient Diagnoses

Leading outpatient diagnoses were determined using the primary diagnosis code only. The top 25 outpatient diagnoses in FY 2011 accounted for 34 percent of all outpatient encounters (direct care and purchased care combined) and 26 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 and telephone consults are excluded from the calculations for both volume and cost.

BY VOLUME



BY COST



Source: MHS administrative data, 1/30/2012

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
29900	Autistic disorder, current or active state
30000	Anxiety state, unspecified
30928	Adjustment disorder with mixed anxiety and depressed mood
30981	Post-traumatic stress disorder
31401	Attention deficit disorder, with hyperactivity
71941	Pain in joint involving shoulder region
71945	Pain in joint involving pelvic region and thigh
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	Health examination of defined subpopulations
V7231	Routine gynecological examination
V7651	Special screening for malignant neoplasms, colon

- The top two diagnoses by volume are for routine health examinations (adults and children). The next most common diagnosis is for lower back pain.
- Diagnoses treated in purchased care facilities account for 60 percent of the total volume of the top 25 diagnoses but only 30 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only four of the 25 top diagnoses. However, expenditures in direct care facilities exceed those in purchased care facilities for 20 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.

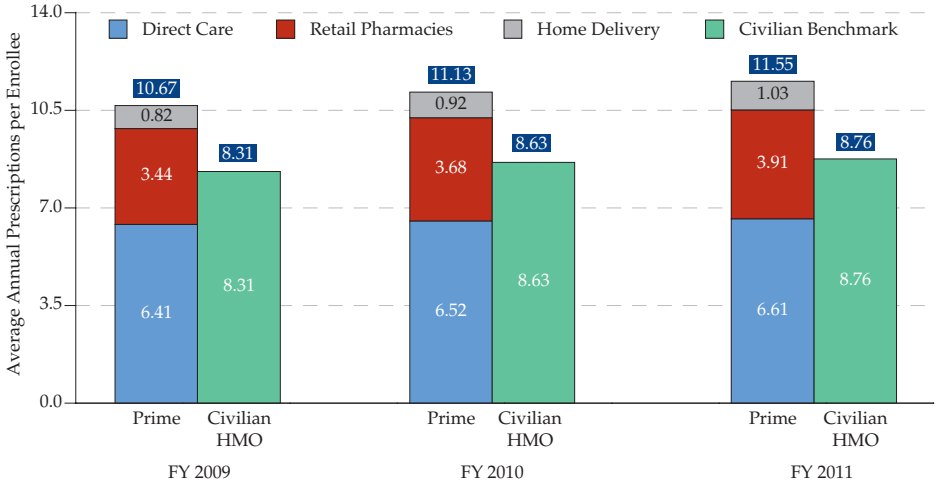
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the TMA Pharmacy 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 8 percent between FY 2009 and FY 2011; the civilian HMO benchmark rate rose by 5 percent. In FY 2009, the TRICARE Prime prescription utilization rate was 28 percent higher than the civilian HMO rate; by FY 2011, the disparity had increased to 32 percent.
- Prescription utilization rates for Prime enrollees at DoD pharmacies increased by 3 percent between FY 2009 to FY 2011, whereas the utilization rate at retail pharmacies increased by 14 percent.
- Enrollee home delivery prescription utilization increased by 26 percent from FY 2009 to FY 2011. Nevertheless, home delivery utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[1]: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] 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)*

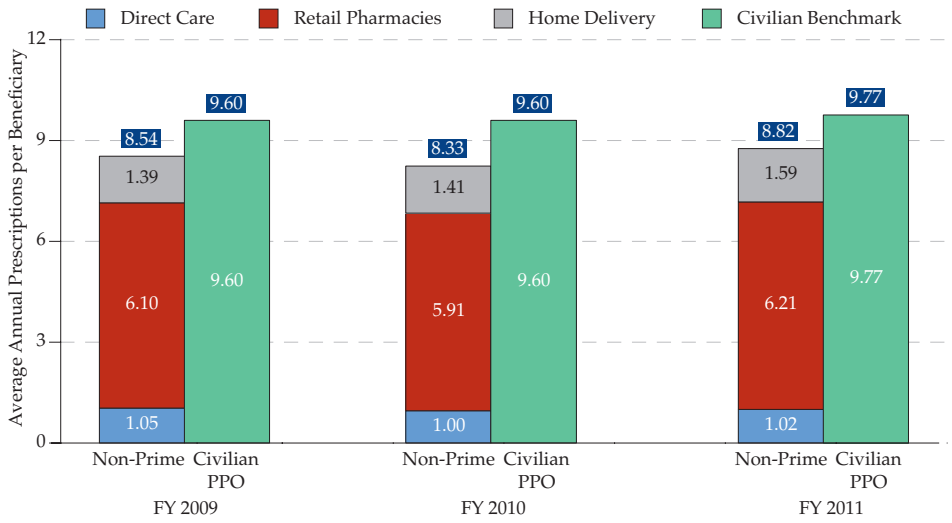
Non-Enrolled Beneficiaries

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 12 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries increased by 3 percent between FY 2009 and FY 2011. During the same period, the civilian PPO benchmark rate increased by 2 percent. In FY 2011, the TRICARE prescription utilization rate for non-enrollees was 10 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries dropped by 3 percent from FY 2009 to FY 2011, but was offset by a corresponding increase in the purchased care rate.
- Non-enrollee home delivery prescription utilization increased by 15 percent from FY 2009 to FY 2011. Nevertheless, home delivery utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES BY SOURCE OF CARE[1]: TRICARE NON-PRIME VS. CIVILIAN PPO BENCHMARK



Sources: MHS administrative data, 1/30/2012, and Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 12/12/2011

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2011 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

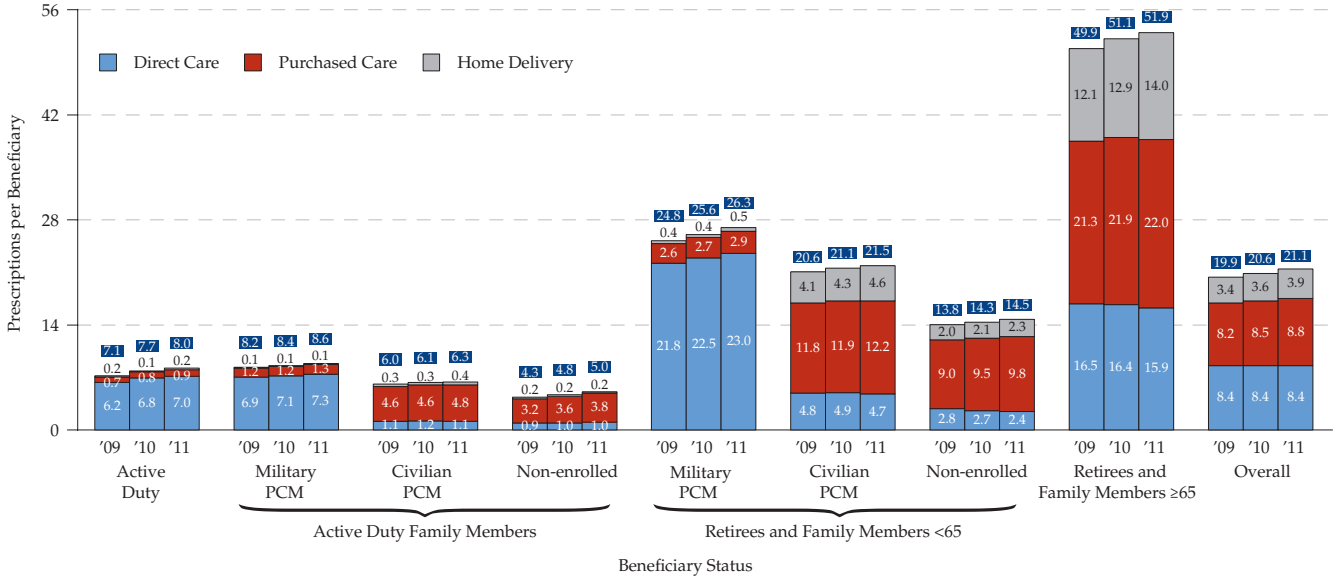
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

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 2009 to FY 2011, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 6 percent.
- The average direct care prescription utilization rate remained unchanged between FY 2009 and FY 2011. However, the rate increased by 13 percent for ADSMs and by 9 percent for non-enrolled ADFMs. Those increases were offset by a decline of 13 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 (19 percent) and ADSMs (15 percent). The remaining beneficiary groups experienced increases in purchased care prescription utilization of between 6 and 10 percent.
- Home delivery remains a relatively infrequent source of purchased care prescription utilization, but its use has been increasing. Home delivery utilization grew by 17 percent between FY 2009 and FY 2011, and, when normalized by 30-day supply, increased as a percentage of total purchased care prescription drug utilization from 29 percent in FY 2009 to 31 percent in FY 2011.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

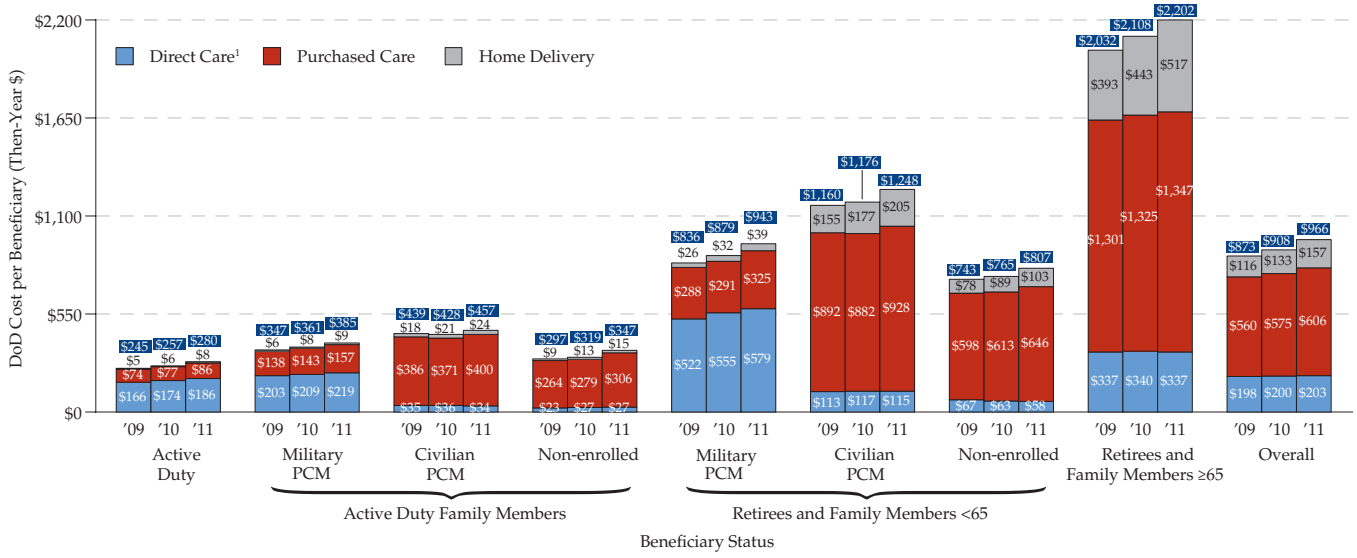
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

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, per capita prescription drug costs rose by 11 percent between FY 2009 and FY 2011. The largest increase (16 percent) occurred for non-enrolled ADFMs. Including TFL, prescription drug costs rose by 9 percent.
- Direct care costs per beneficiary increased by only 3 percent, but retail pharmacy costs rose by 12 percent exclusive of TFL and by 8 percent including TFL.
- Home delivery costs per beneficiary increased by 24 percent exclusive of TFL and by 19 percent including TFL.
- Most of the increase in per capita retail and home delivery prescription costs is due to increased utilization per beneficiary.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/30/2012

Note: Numbers may not sum to bar totals due to rounding.

[1] 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 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.

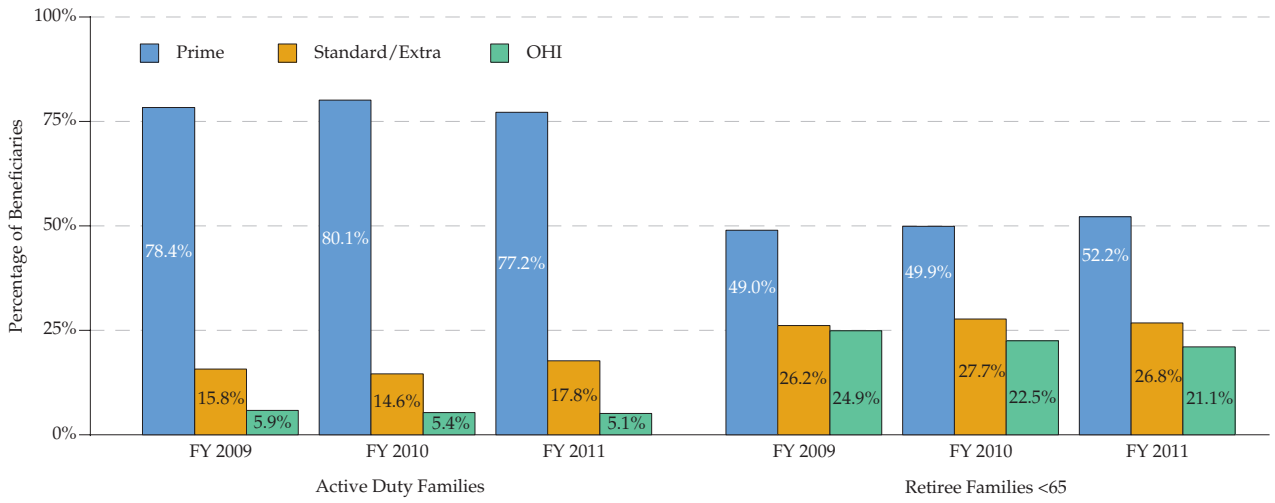
Health Insurance Coverage of MHS Beneficiaries Under Age 65

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 2011, 77.2 percent of Active Duty families and 52.2 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and no OHI coverage. In FY 2011, 17.8 percent of ADFMs and 26.8 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2011, 5.1 percent of Active Duty families and 21.1 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: FYs 2009–2011 Healthcare Surveys of DoD Beneficiaries (HCSDB), as of 1/10/2012

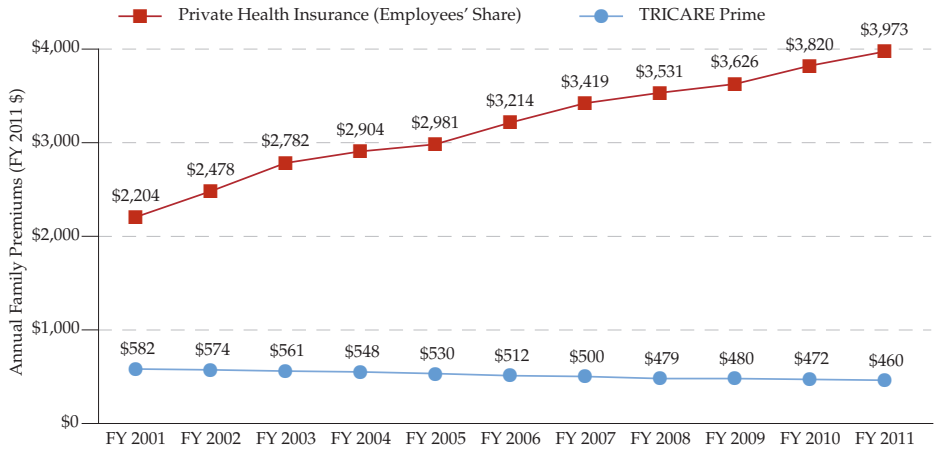
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance, i.e., FEHBP, a civilian 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. The annual TRICARE Prime enrollment fee remained fixed at $460 per retiree family through FY 2011 but was increased in FY 2012 to $520 per family. In constant FY 2011 dollars, the private health insurance premium increased by $1,769 (80 percent) from FY 2001 to FY 2011, whereas the TRICARE premium declined by $122 (–21 percent) during this period.

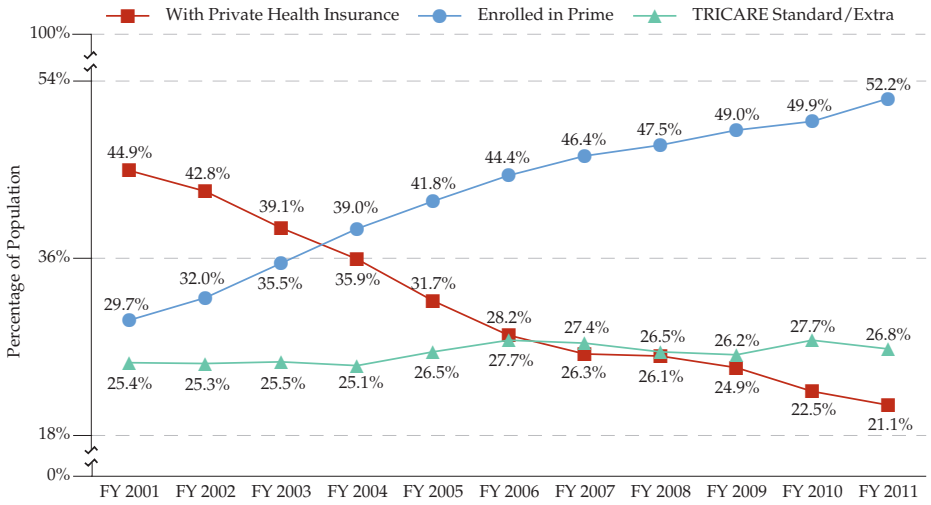
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan: Medical Expenditure Panel Surveys, 2000–2010; forecasted by the Institute for Defense Analyses in FY 2011 based on trends in premiums from Kaiser Family Foundation surveys, as of 1/10/2012

Between FY 2001 and FY 2011, 23.8 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 732,000 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, 2001–2011, as of 1/10/2012

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

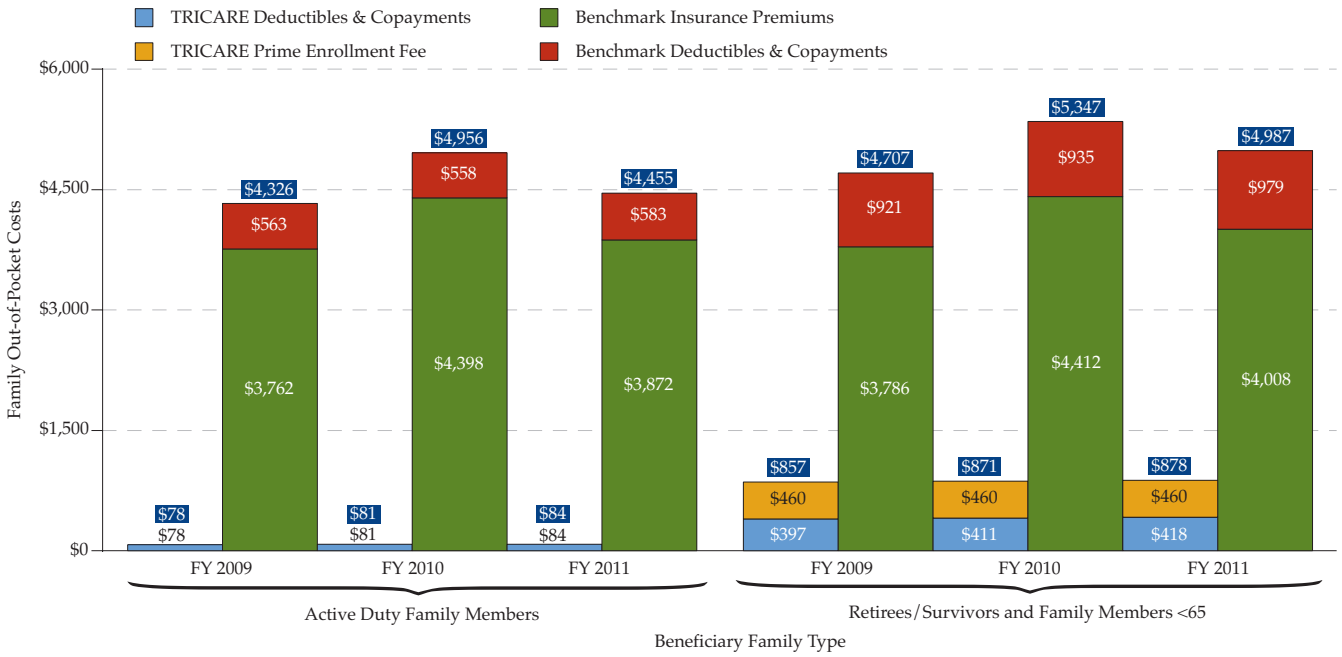
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2009–2011, 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 2011, costs for civilian counterparts were:
  - $4,400 more than those incurred by Active Duty families enrolled in Prime.
  - $4,100 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 2009–2011; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2008–2011; civilian insurance premiums for FYs 2009–2010 from the 2008–2010 Medical Expenditure Panel Surveys; premiums for FY 2011 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys. Private health insurance coverage from Health Care Surveys of DoD Beneficiaries, FYs 2009–2011, as of 1/10/2012

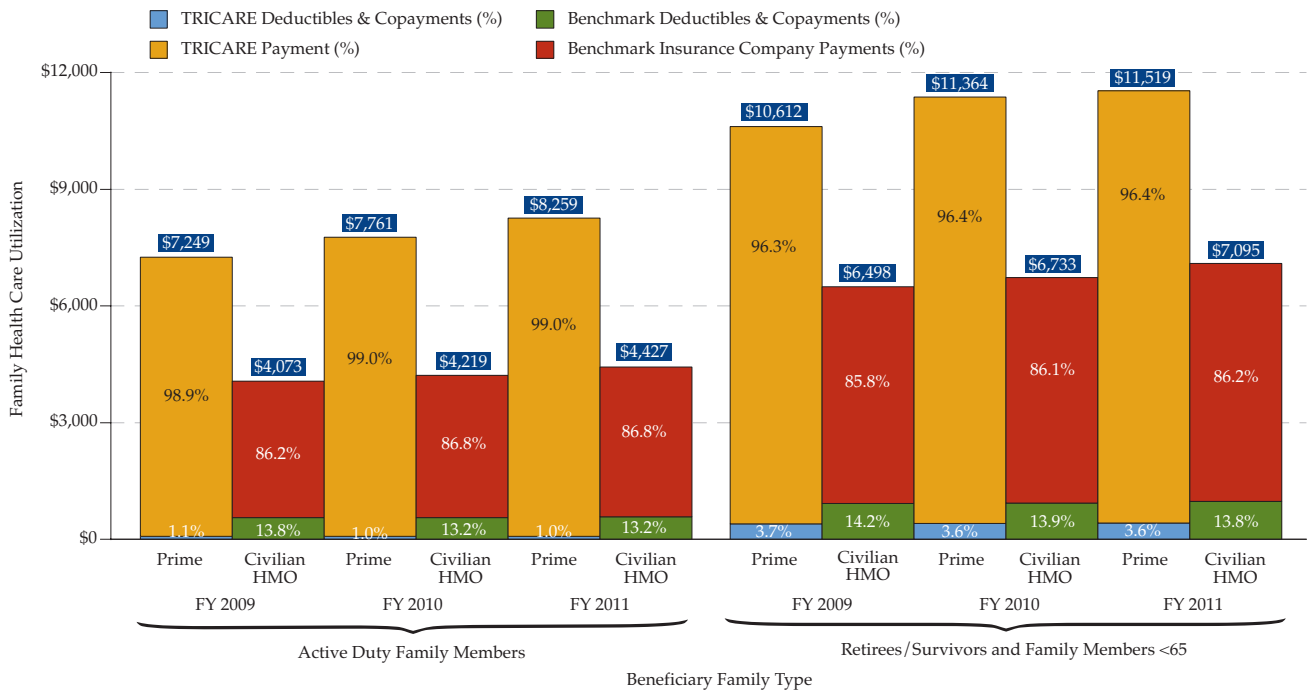
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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).[1] In FYs 2009–2011, 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 2011, the coinsurance rate for Active Duty families was 1.0 percent versus 13.2 percent for civilian counterparts.
  - In FY 2011, the coinsurance rate for retiree families was 3.6 percent versus 13.8 percent for civilian counterparts.
- TRICARE Prime enrollees had 63–87 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2011, Active Duty families consumed $8,300 of medical services versus $4,400 by civilian counterparts (87 percent higher).
  - In FY 2011, retiree families consumed $11,500 of medical services versus $7,100 by civilian counterparts (63 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 2009–2011; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2008–2011, as of 1/10/2012

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

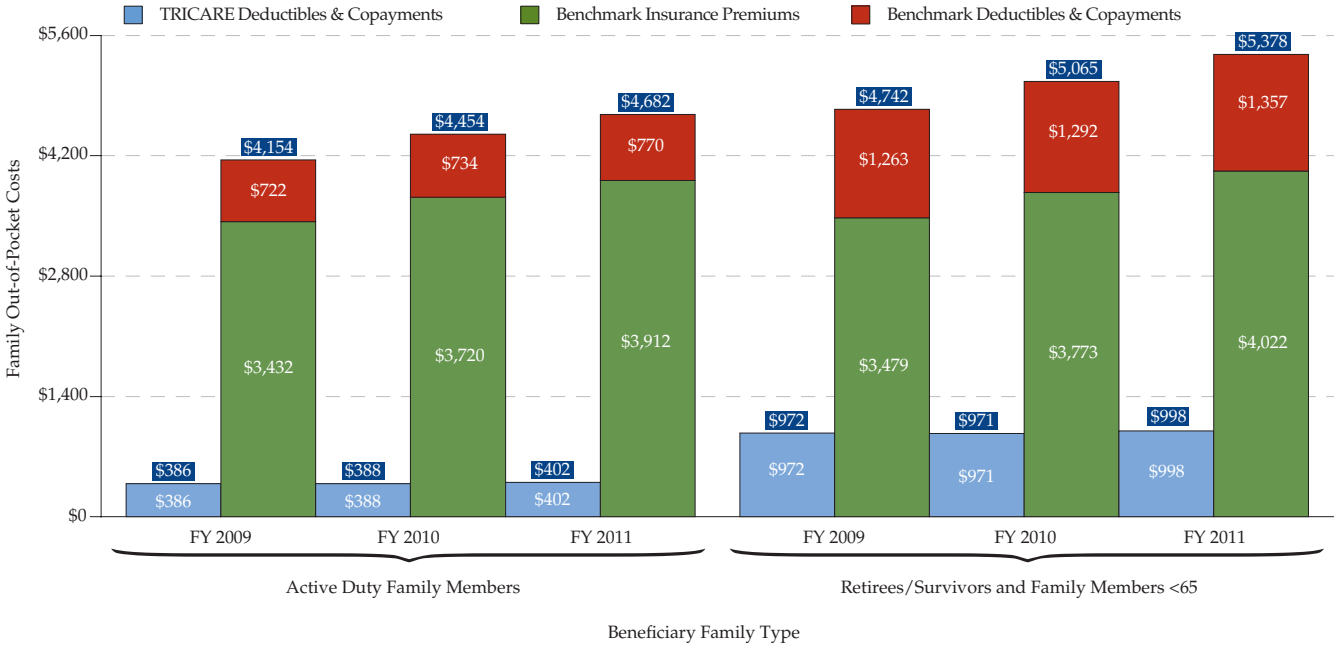
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FY 2009 to FY 2011, 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 2011, costs for civilian counterparts were:
  - $4,300 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $4,400 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 2009–2011; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2008–2011; civilian insurance premiums for FYs 2009–2010 from the 2008–2010 Medical Expenditure Panel Surveys; premiums for FY 2011 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys. OHI coverage from Health Care Surveys of DoD Beneficiaries, FYs 2009–2011, as of 1/10/2012

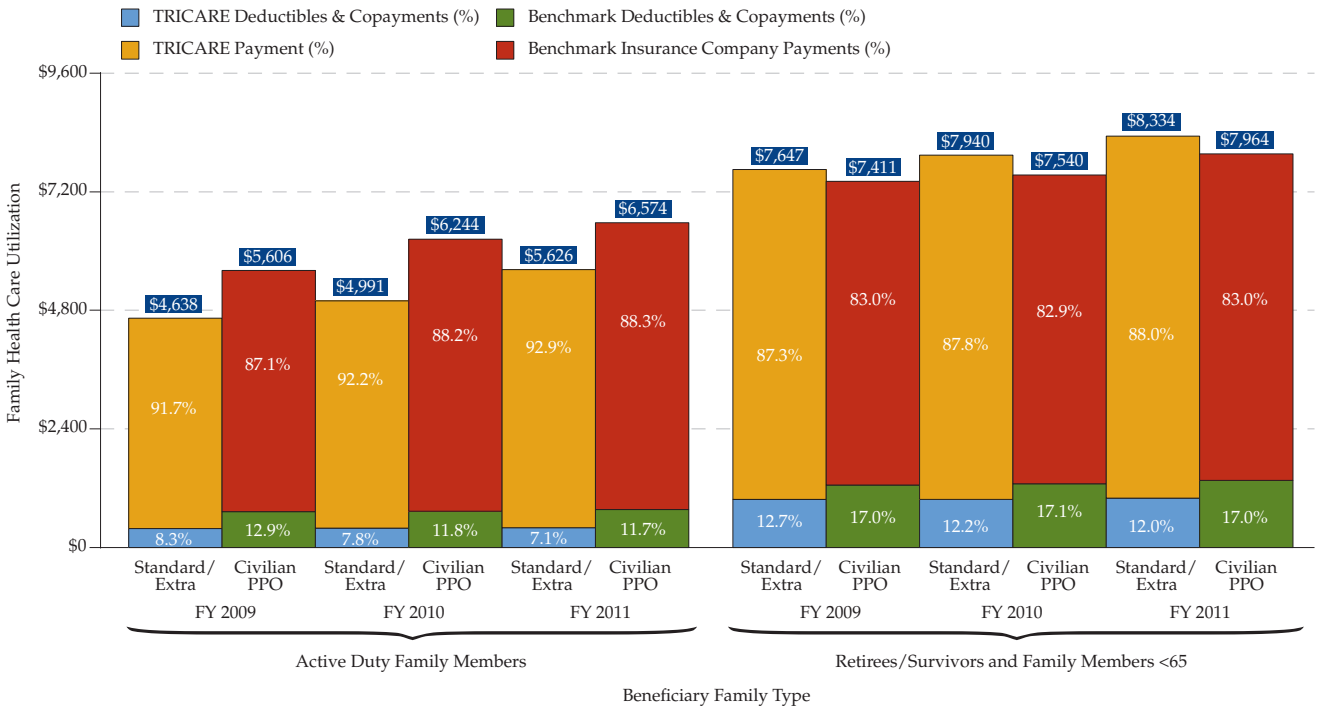
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2009–2011, 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 2009–2011.

- TRICARE Standard/Extra reliant families had somewhat lower average coinsurance rates than civilian PPO counterparts.
  - In FY 2011, the coinsurance rate for Active Duty families was 7.2 percent versus 11.7 percent for civilian counterparts.
  - In FY 2011, the coinsurance rate for retiree families was 12.0 percent versus 17.0 percent for civilian counterparts.
- Despite lower coinsurance rates, health care utilization was similar for TRICARE Standard/Extra families compared with their civilian PPO counterparts.
  - In FY 2011, Active Duty families consumed $5,600 of medical services versus $6,600 by civilian counterparts (15 percent less).
  - In FY 2011, retiree families consumed $8,300 of medical services versus $8,000 by civilian counterparts (4 percent more).

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 2009–2011; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2008–2011, as of 1/10/2012

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

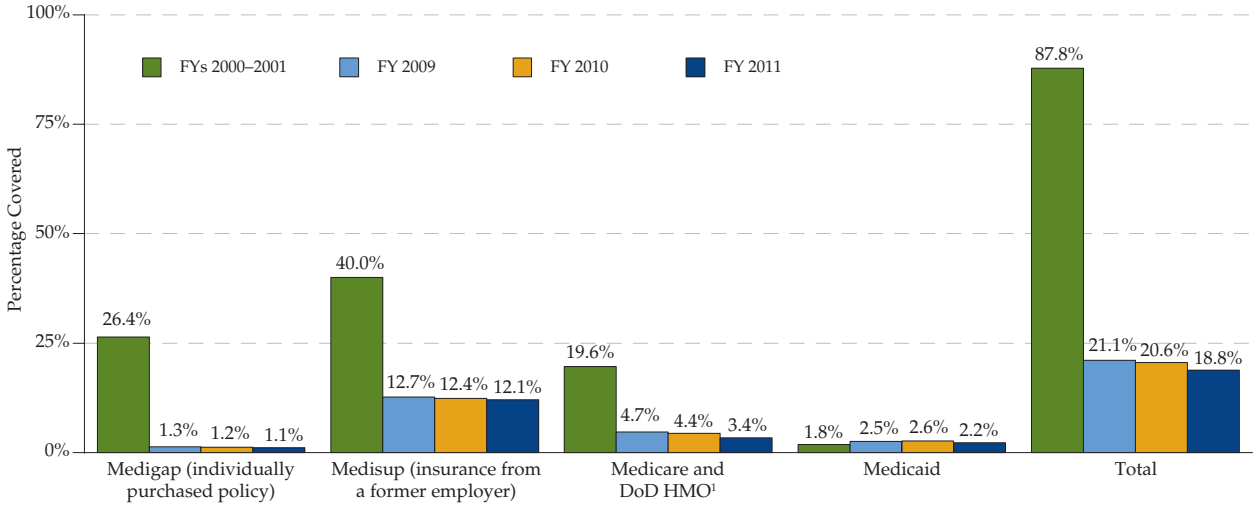
Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL[1]

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 20 percent in FYs 2009–2011.
- 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 2009–2011 Health Care Surveys of DoD Beneficiaries, as of 1/10/2012

[1] 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. These account for less than 1 percent of seniors and are excluded from the above figure.

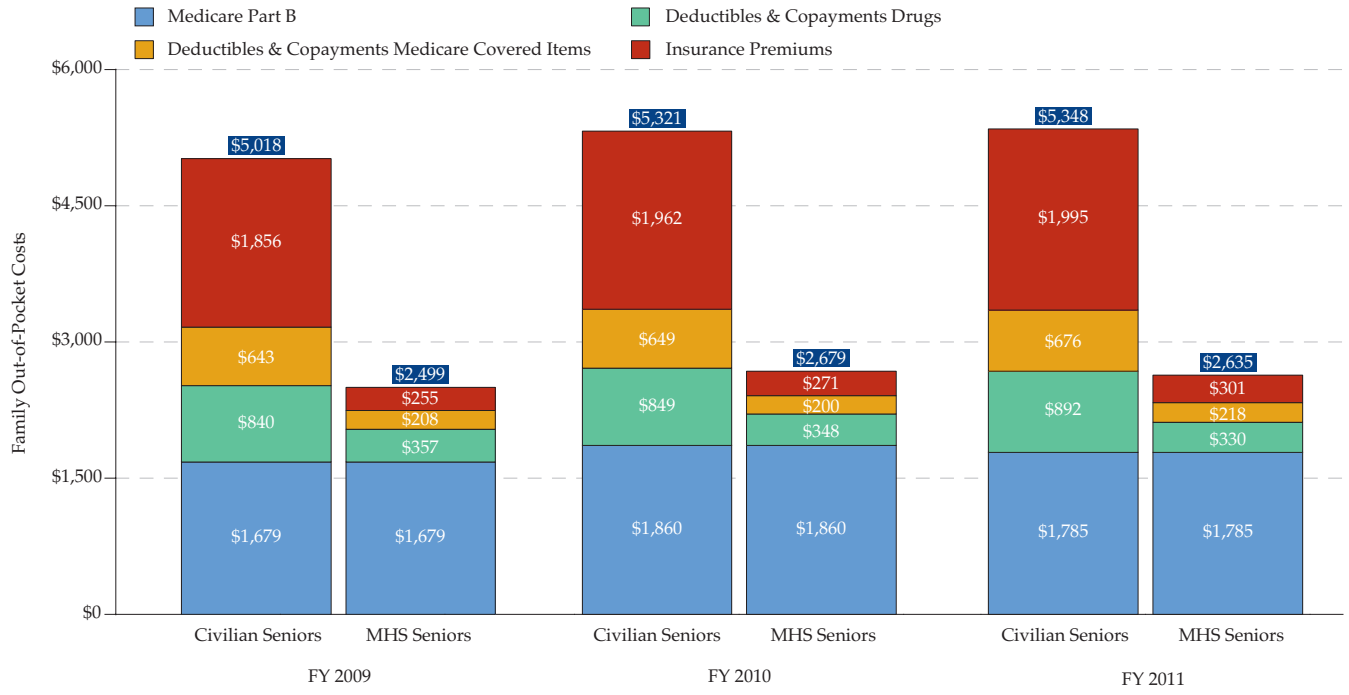
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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 2009–2011, out-of-pocket costs for MHS senior families were about 51 percent less than those of "before TFL" civilian counterparts.
- In FY 2011, MHS senior families saved about $2,700 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 2009–2011; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2008–2011; 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 2008–2011; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and FYs 2009–2011, as of 1/10/2012

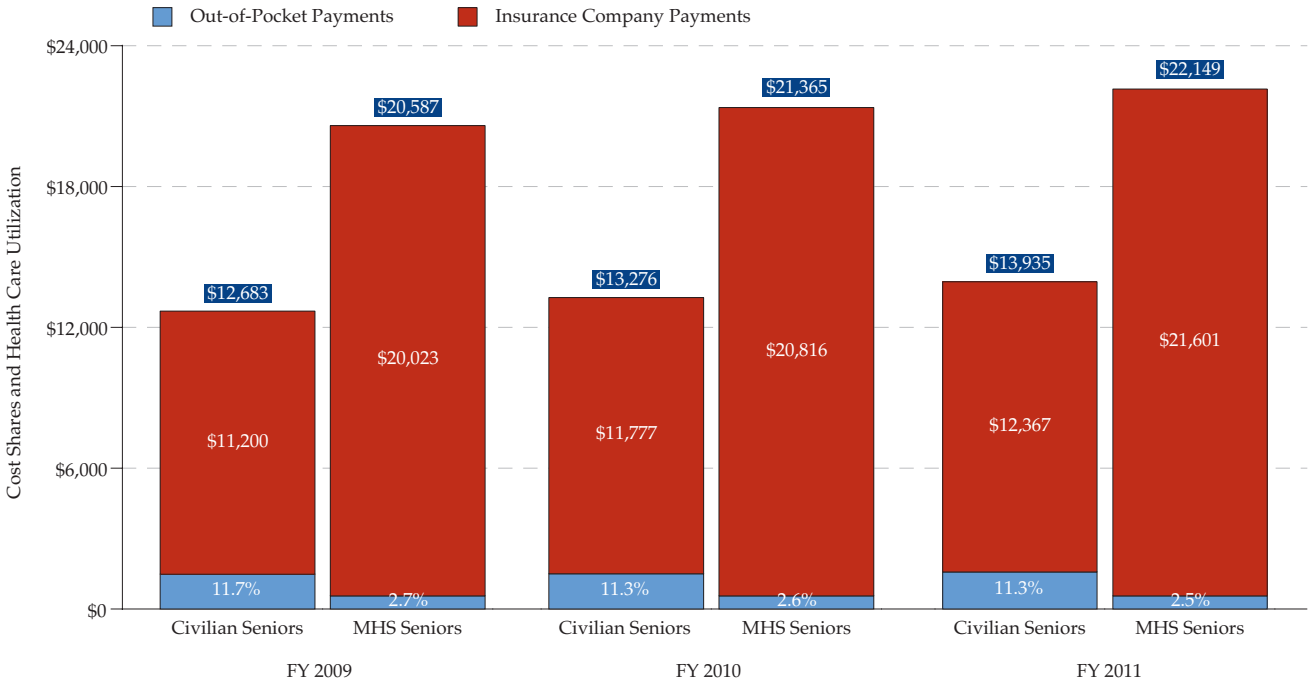
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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).[1] 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 2011, the coinsurance rate for MHS seniors was 2.5 percent; it was 11.3 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2011, MHS families consumed $22,100 of medical services compared with only $13,900 for civilian counterparts (59 percent higher).

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 2009–2011; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2008–2011; Medicare supplemental insurance coverage, before and after TFL, from Health Care Surveys of DoD Beneficiaries, 2000–2001 and FYs 2009–2011, as of 1/10/2012

[1] Physician Payment Review Commission. *Annual Report to Congress: Fiscal Year 1997*. Private Secondary Insurance for Medicare Beneficiaries, pp. 27–28.

TRICARE BENEFITS FOR THE RESERVE COMPONENT

TRICARE continues to provide a broad array of benefits coverage for Reserve Component (RC) members and their families, from pre-deployment and during mobilization, to post-deployment and into retirement from the Selected Reserves.

Pre- and Post-Activation TRICARE coverage. RC members and their families receive premium-free TRICARE coverage for up to 180 days before the sponsor reports for Active Duty in support of a named contingency operation (early eligibility), and for 180 days after deactivation through the Transitional Assistance Management Program (TAMP). Qualified Selected Reservists may purchase premium-based TRICARE Reserve Select coverage when not covered by premium-free TRICARE, which includes TAMP coverage. Prior to September 15, 2011, the clock started on TAMP eligibility the day after the RC Service member's Active Duty segment in support of a named contingency operation had expired, even when the member was continued on Active Duty on a different set of noncontingency orders for medical treatment that carried continued Active Duty TRICARE coverage. In other words, one day clicked off the 180-day TAMP eligibility clock for every day that an RC member served on extended Active Duty; this includes those RC members assigned to Warrior Transition Units (WTUs) or other medical holds. In this situation, no one got a full 180 days of TAMP, and those who served 180 days or more on the Active Duty extension got none of the TAMP coverage designed to ease the transition back to civilian life. However, by USD(P&R) policy effective September 15, 2011, Service members eligible for TAMP but extended on Active Duty with no break in service now receive a full 180 days of TAMP coverage once the continuous period of Active Duty ends (note, this change in policy by Personnel and Readiness was subsequently codified in the NDAA for FY 2012).

TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and TRICARE Extra coverage. TRS was established by the 2005 NDAA for qualified members of the Selected Reserve and their immediate family members (*Federal Register*, March 5, 2005). It was subsequently revised to its present requirements and expanded eligibility effective October 1, 2007 (*Federal Register*, August 20, 2007). The number of plans (member-only and family) and number of covered lives have increased sixfold since the October 2007 changes, from almost 12,000 plans and 35,000 covered lives beginning in FY 2008, to over 76,000 plans and 201,000 covered lives by the end of FY 2011. The chart below presents TRS enrollment growth since plan inception.

- TRS monthly premiums will change from FY 2011 to FY 2012 as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2011	2012
TRS Member-only	$53.16	$54.35
TRS Member-and-family	$197.76	$192.89

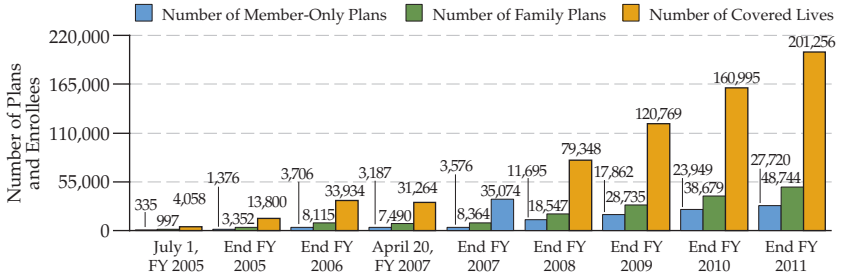
TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010, in response to the NDAA for FY 2010, Section 705 and Title 10 United States Code, Chapter 55, Section 1076e. The law allows qualified members of the Retired Reserve to purchase full cost premium-based coverage under TRR until they reach age 60, when they receive premium-free TRICARE coverage for themselves as retirees and their eligible family members.

While coverage under TRR is similar to TRS, it differs in the cost contribution. Unlike TRS, where the Department and member share in the cost of the premium, in TRR the member pays the full cost of the premium. For calendar year 2010, the TRR member-only monthly premium was $388.31 ($4,659.72 yearly), and the member and family monthly premium was $976.41 ($11,716.92 yearly). Premiums may be adjusted annually. By the end of the first enrollment year, 2,000 RC members were covered by TRR in nearly 900 member-only and member-and-family plans.

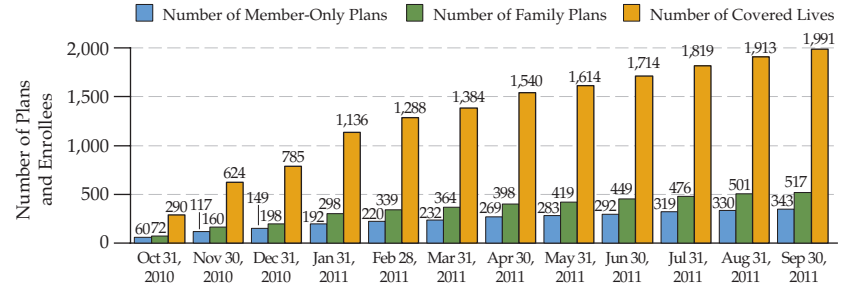
- TRR premiums will change from FY 2011 to FY 2012 as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2011	2012
TRR Member-only	$408.01	$419.72
TRR Member-and-family	$1,020.05	$1,024.43

TREND IN RESERVE COMPONENT ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 TO SEPTEMBER 2011)



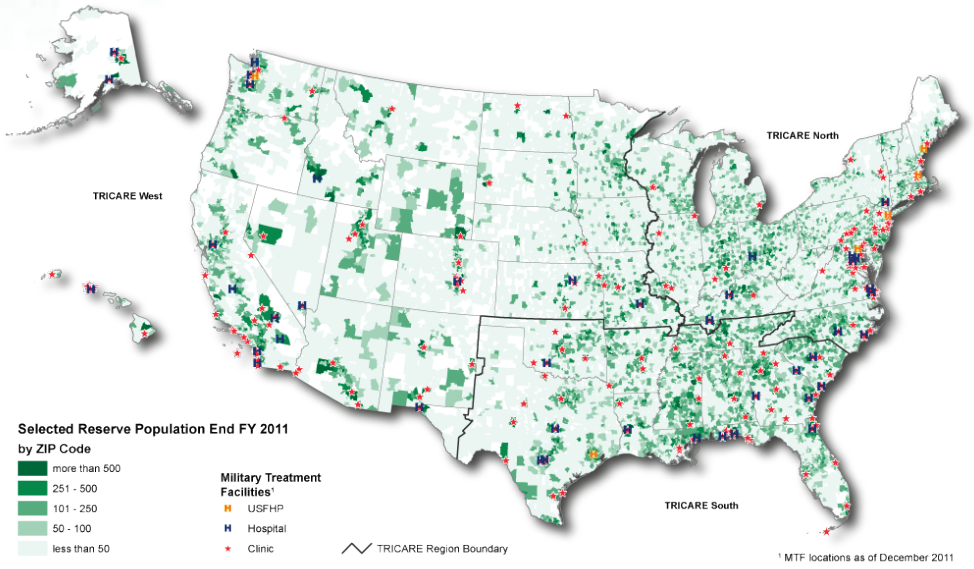
MONTHLY TREND IN ENROLLMENT IN TRICARE RETIRED RESERVE SINCE INCEPTION (OCTOBER 2010 TO SEPTEMBER 2011)



Source: HA/TMA–TRICARE Operations, 12/30/2011

TRICARE BENEFITS FOR THE RESERVE COMPONENT *(CONT'D)*

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2011



Source: Selected Reserve and Guard residential population data from DEERS, MTF information from TMA, Portfolio Planning Management Division, and geospatial representation by TMA/OCFO-DHCAPE, 12/30/2011

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

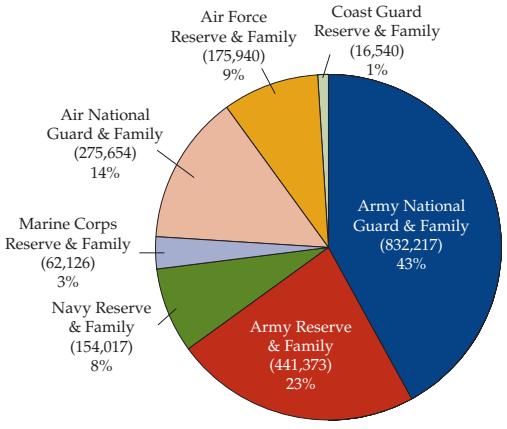
BENEFICIARY GROUP	Population Totals (Ending Sept. 30, 2011)	% in MTF Service Areas	% in PSAs
Active Duty and Their Families	3,192,044	93%	97%
Selected Reservists and Their Families	1,833,679	55%	81%

Note: Population data source: OASD(RA) and DEERS for Selected Reserve (Reserves and National Guard); and MDR DEERS extract for Active Duty and their families provided 11/3/2011. Data are as of 9/30/2011; extracted by DMDC 11/2/2011. 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 and 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 (SEPTEMBER 2011)



Source: Data are as of the end of September 2011, from OASD/RA (M&P), 11/3/2011.

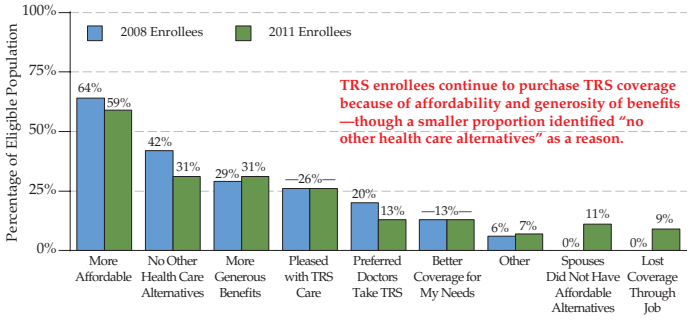
- As of September 30, 2011, there were nearly 2 million Selected Reserve Service members and their families (1,957,867, of which 855,644 were Service members and 1,102,223 family members). Approximately 93.7 percent resided in the U.S.
- The map above depicts where the Selected Reservists and their family members reside in the U.S., relative to the direct care military treatment facilities (MTFs), and also to all areas where TRICARE Prime networks are available. As shown in the accompanying table, 81 percent of Selected Reservists and their family members in the U.S. live within the area covered by the TRICARE network in FY 2011 (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 at left, almost two-thirds (66 percent) of the worldwide Selected Reserve population of 1.96 million sponsors and their family members are Army National Guard (43 percent) and Army Reserve (23 percent).

RESULTS OF 2011 SURVEY COMPARING TRICARE RESERVE SELECT AND SELECTED RESERVE MEMBER ACCESS AND SATISFACTION (FOLLOW-UP TO BASELINE 2008 SURVEY)

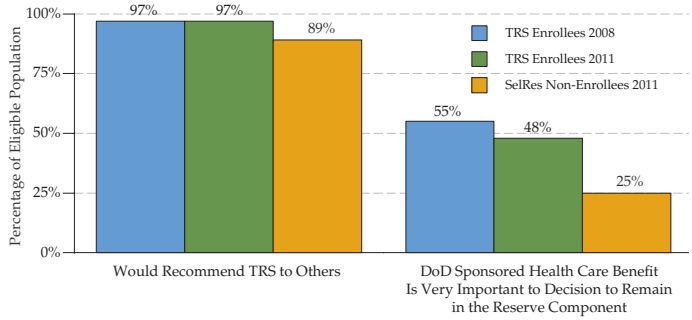
A special survey was fielded in late December 2010 and completed in Spring 2011 to follow up on a baseline survey completed in 2008 designed to better understand RC motivation for enrolling, or not enrolling, in the TRS benefits option, especially after substantial modification to the benefit on October 1, 2007. In addition to identifying the motivation for enrolling or not, a key objective of this survey was to compare satisfaction with, and access to, health care services of TRS adult enrollees to non-enrolled Selected Reserve and to other Military Health System (MHS) adult enrolled and non-enrolled family members.

- **Methodology:** 50,004 Selected Reserve (SelRes) Service and family members, roughly split between TRS and non-enrolled, non-mobilized SelRes, were surveyed randomly.
  - A common instrument was used: an abbreviated version of Health Care Surveys of DoD Beneficiaries (HCSDB) based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) version 4.0 wording with TRS-specific supplemental questions.
- **Results:** TRS enrollees report TRS is more affordable than other alternatives available to them, and more than one-fourth said they had no other alternatives (see first graph).
  - TRS non-enrollees (89 percent) are less likely than enrollees (97 percent) to recommend TRS to others and to factor TRS in their decision to remain in the Reserve Component (see second graph).
- **Compared to non-enrolled Selected Reserves (using their own health insurance; shown in the table below, first column):** There is no difference in TRS enrollee reported satisfaction and access compared to their SelRes non-enrolled counterparts, and TRS enrollees were more likely to assign satisfaction ratings of 8+ to health plans and to overall health care. They were less likely to report satisfaction with health plan customer service.
- **Compared to TRICARE Standard/Extra users:** TRS enrollees did not differ from Standard/Extra users on any aspect of access and satisfaction (see table at right).
  - Use of preventive care was similar to other TRICARE populations, though TRS enrollees had higher nonsmoking and blood pressure screening rates than non-enrolled Selected Reserves.
- **Reserve awareness of TRS and sources of information (no chart shown):**
  - Awareness of the TRS program is much higher now (two-thirds) than in 2008 (one-half), but there are subgroups where awareness, relative to 2008, has declined and could be reinforced.
  - Among sponsors, most TRS enrollees and non-enrollees still appear to learn about TRS from a unit commander, TRICARE information or literature, or a Guard or Reserve colleague.
  - For dependents, most TRS enrollees and non-enrollees still appear to learn about TRS from a Reservist in the family or TRICARE information or literature.

ALL REASONS FOR ENROLLING IN TRS, 2008 VERSUS 2011 (SPONSORS ONLY)



RECOMMENDING TRS AND IMPORTANCE OF TRS FOR RETENTION, 2008 VERSUS 2011 (SPONSORS ONLY)



SUMMARY OF CARE EXPERIENCES OF TRS ENROLLEES VERSUS SELRES NON-ENROLLEES AND FAMILY MEMBERS OF ACTIVE DUTY

	TRS Enrollees' Satisfaction Compared to:	
CARE EXPERIENCES	SelRes Non-Enrollees	ADFM Standard/Extra
Getting Needed Care	No diff	No diff
Ease in Scheduling Specialist Appointments	No diff	No diff
Ease in Obtaining Needed Services	No diff	No diff
Getting Care Quickly	+	No diff
Getting Needed Care Right Away	No diff	No diff
Routine Care	+	No diff
Doctors Communicate Well	No diff	No diff
Personal Doctor Listens Carefully	No diff	No diff
Personal Doctor Explains Things Clearly	No diff	No diff
Personal Doctor Shows Respect	No diff	No diff
Personal Doctor Spends Enough Time	No diff	No diff
Rating of 8+ for Personal Doctor	No diff	No diff
Rating of 8+ for Specialist	No diff	No diff
Rating of 8+ for Health Care	+	No diff
Health Plan Customer Service	–	No diff
Quality of Written Information	–	No diff
Helpfulness of Customer Service	No diff	No diff
Claims Handled Quickly	No diff	No diff
Claims Handled Correctly	No diff	No diff
Rating of 8+ for Health Plan	+	No diff

HEALTHY, FIT, AND PROTECTED FORCE

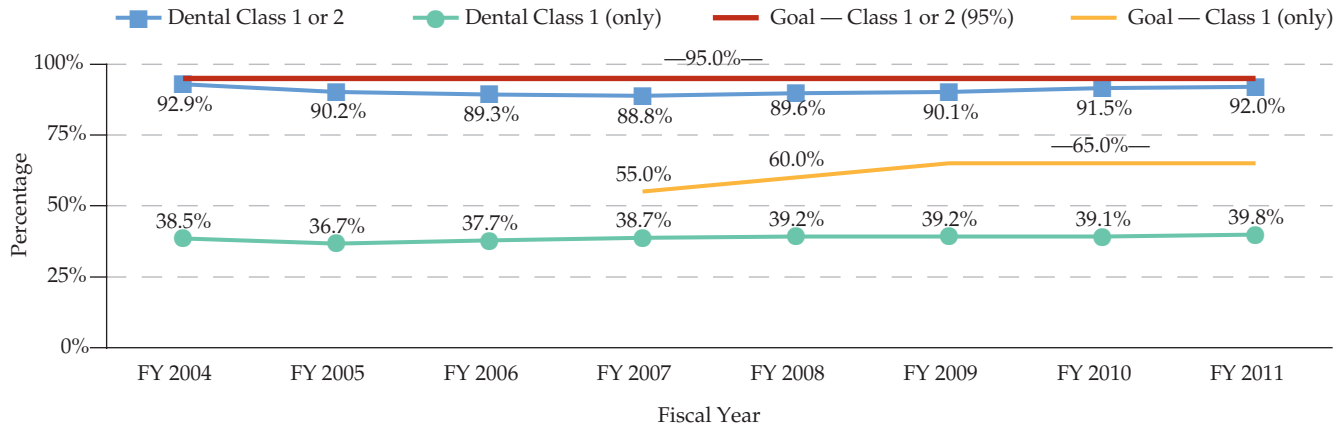
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates; 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. As reflected in the chart below, the percentage of patients in Dental Class 1 or 2 has been stable over the past eight years, from FY 2004 to FY 2011.

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high and stable, reaching 92 percent in FY 2011, similar to FY 2004, and within three percentage points of the long-standing MHS goal of 95 percent. The rate for Active Duty dental readiness in combined Classes 1 and 2 from FY 1997 to FY 2004 (not shown) hovered between 87.5 percent and 93.4 percent.
- The rate for Active Duty personnel in Dental Class 1 has remained steady at around 39 percent over the past five fiscal years, and well below the MHS goal of 65 percent, which has increased from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 12/30/2011

Definitions:

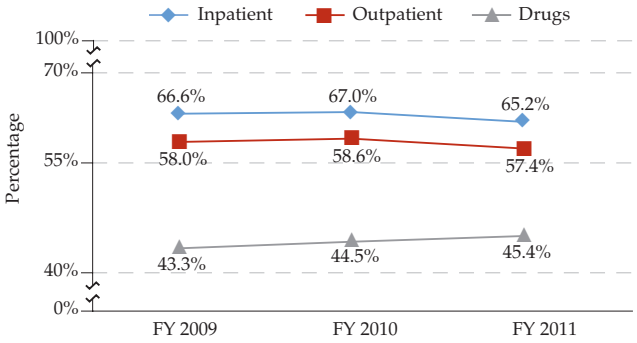
a. Dental Class 1 (Dental Health or Wellness): Patients with a current dental examination, who do not require dental treatment or re-evaluation. Class 1 patients are worldwide deployable.

b. 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.

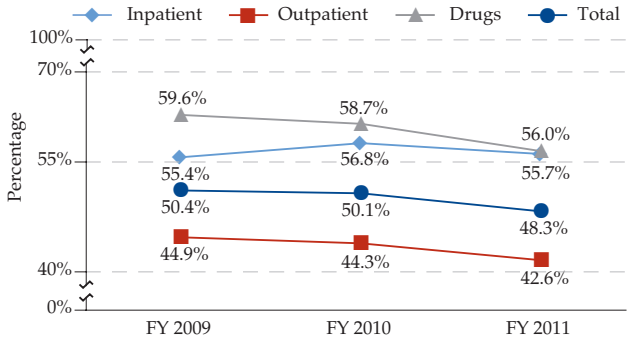
ADDENDUM: TRENDS IN PURCHASED CARE SHARE OF TOTAL UTILIZATION AND COST

- The purchased care share of total MHS inpatient and outpatient utilization declined slightly from FY 2009 to FY 2011. The purchased care share of total inpatient utilization declined from 67 to 65 percent, whereas the purchased care share of total outpatient utilization declined from 58 to 57 percent. The only service for which the purchased care share increased was prescription drugs, which increased from a 43 percent share in FY 2009 to 45 percent in FY 2011.
- The purchased care share of total MHS inpatient costs remained flat at about 55–56 percent between FY 2009 and FY 2011. For outpatient costs, the purchased care share declined slightly from 45 to 43 percent. The purchased care share of total prescription drug costs declined from 60 to 56 percent, largely because of manufacturer rebates for retail brand-name drugs. The overall purchased care share of total MHS health care costs declined from 50 to 48 percent.

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, 1/30/2012

GENERAL METHOD

In this year's report, we compared TRICARE's effects on the access to, and quality of, health care received by the Department of Defense (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 Consumer Assessment of Healthcare Providers and Systems (CAHPS)—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 Military Health System (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 2009–FY 2011) 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—12/22/2011
  - Eligibility/Enrollment data—1/5/2012
  - MHS Workload/Costs—1/30/2012
  - Web sites uniform resource locators (URLs)—1/5/2012
- TRICARE Management Activity (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 TMA to fulfill 1993 NDAA requirements and to provide a routine mechanism to assess TRICARE eligible beneficiary access to and experience with the 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/*).

The worldwide, multiple mode Adult HCSDB is conducted on a quarterly basis (every January, April, July, and October). The survey request is transmitted by email to Active Duty and by postal mail to all other beneficiaries, with responses accepted by postal mail or Web. The worldwide Child HCSDB was completed in 2011 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 adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

About three-fourths of HCSDB questions have been closely modeled on the CAHPS program, in wording, response choices, and sequencing. CAHPS is a standardized survey questionnaire used by civilian health care organizations to monitor various aspects of access to, and satisfaction with, health care. The other one-fourth of HCSDB questions are questions designed to obtain information unique to TRICARE benefits or operations, and to solicit information about healthy lifestyles or health promotion, often based on other recognized national health care survey questions. Supplemental questions are added each quarter to understand specific topics of interest, such as understanding the acceptance and prevalence of preventive services such as colorectal cancer screening, annual influenza immunizations, availability of other non-DoD health insurance, childhood active and sedentary lifestyles, or indications of post traumatic stress in the overall MHS population.

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 Healthcare Research and Quality (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 Questionnaire (for part of 2009) and the CAHPS Version 4 Questionnaire. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Benchmarks for the composites and numeric ratings taken from CAHPS Version 3, used in 2009, come from the National CAHPS Benchmarking Database (NCBD) for 2006. Benchmarks for Version 4 CAHPS used in 2009 come from the 2008 NCBD. Benchmarks for Version 4 CAHPS used in 2010 and 2011 come from the 2009 and 2010 NCBD, respectively. Because of the wholesale changes in the questionnaire, changes in rates are only meaningful when compared to changes in the relevant benchmark.

The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the AHRQ and administered by Westat, Inc. Only HMO, PPO, and HMO/POS plans are used in the calculation of the benchmark scores. 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

DATA SOURCES *(CONT'D)*

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.

Relative value units (RVUs) are used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. 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 Total RVUs to measure both direct and purchased care outpatient workload. Enhanced Total RVUs were introduced by MHS in FY 2010 (and retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for non-physician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see *http://www.tricare.mil/ocfo/_docs/R-6-1000_Using%20the%20M2%20to%20Identify%20and%20Manage%20MTF%20Data%20Quality_Redacted.pptx*.

Access and Quality

Measures of MHS access and quality were derived from the 2009, 2010, and 2011 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the NCBDs for 2006 , 2008, 2009, and 2010 as noted on the previous page.

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

Utilization and Costs

Data on 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); Comprehensive Ambulatory/ Professional Encounter Records (CAPERs—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 CAPER 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	89,871	71,782	1,009
AL	208,926	97,559	4,403
AR	91,725	39,084	3,278
AZ	204,038	105,960	3,943
CA	862,344	518,793	13,461
CO	246,972	161,293	4,898
CT	49,047	22,175	1,130
DC	26,202	20,231	290
DE	33,488	17,408	677
FL	681,900	345,692	12,077
GA	455,087	293,219	7,361
HI	164,645	126,405	1,796
IA	46,962	13,056	2,438
ID	51,881	24,699	1,769
IL	152,326	75,987	4,243
IN	88,549	27,976	4,576
KS	135,723	86,178	3,034
KY	170,179	111,618	3,425
LA	133,296	76,763	4,976
MA	73,445	31,373	2,576
MD	241,704	158,844	2,676
ME	40,613	23,796	1,376
MI	100,063	28,163	2,735
MN	66,927	19,042	5,932
MO	155,589	73,482	6,982
MS	119,927	63,873	4,060
MT	34,855	13,727	1,296
NC	516,648	341,282	7,399
ND	32,229	21,024	1,761
NE	64,256	32,729	2,334
NH	30,994	15,708	740
NJ	85,193	39,683	2,217
NM	91,229	52,487	946
NV	101,628	54,672	1,648
NY	190,086	94,350	3,359
OH	166,255	69,678	5,721
OK	169,288	103,070	3,449
OR	68,296	22,617	2,337
PA	164,001	48,710	4,529
RI	25,644	12,774	542
SC	243,759	134,813	5,574
SD	33,274	15,148	2,966
TN	192,863	91,415	6,508
TX	883,945	554,164	17,524
UT	70,672	33,392	4,926
VA	759,646	469,800	6,730
VT	13,044	5,202	635
WA	362,897	240,262	5,384
WI	69,006	16,981	3,793
WV	36,896	9,169	1,405
WY	22,172	12,033	944
Subtotal	**9,120,204**	**5,139,341**	**199,788**
Overseas	**597,335**	**369,689**	**3,392**
Total	**9,717,539**	**5,509,030**	**203,180**

Notes:

a. Source of data is HA/TMA administrative data systems, as of November 2011 for end of FY 2011.

b. "Prime Enrolled" includes Prime (military and civilian primary care manager [PCM]), TPR (and Overseas equivalent), and Uniformed Services Family Health Plan (USFHP); and excludes members in TRICARE for Life, TRICARE Plus, and TRICARE Reserve Select (TRS).

ABBREVIATIONS

AB	Advisory Board
ACIP	Advisory Committee on Immunization Practices
AD	Active Duty
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction
BMI	Body Mass Index
BPSM	Basic Patient Safety Manager
BRAC	Base Realignment and Closure
CAC	Children's Asthma Care
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAPER	Comprehensive Ambulatory/Professional Encounter Record
CC	Complication/Comorbidity
CCAE	Commercial Claims and Encounters
CDC	Centers for Disease Control and Prevention
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHDR	Clinical Data Repository/Health Data Repository
CHF	Congestive Heart Failure
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
COPD	Chronic Obstructive Pulmonary Disease
CPG	Clinical Practice Guideline
CSS	Customer Satisfaction Survey
DEERS	Defense Enrollment Eligibility Reporting System
DES	Disability Evaluation System
DHCAPE	Defense Health Cost Assessment and Program Evaluation
DHHS	U.S. Department of Health and Human Services
DHP	Defense Health Program
DLAP	DoD Lifestyle Assessment Program
DM	Disease Management
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
EHR	Electronic Health Record
FDA	Food and Drug Administration
FEHB	Federal Employees Health Benefits
FTE	Full-Time Equivalent
FY	Fiscal Year
GWOT	Global War on Terror
HA	Health Affairs
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCSDB	Health Care Survey of DoD Beneficiaries
HEDIS	Healthcare Effectiveness Data and Information Set
HF	Heart Failure
HHS	Health and Human Services
HMO	Health Maintenance Organization
HP	Healthy People
HPV	Human Papillomavirus
HRB	Health-Related Behaviors
IHI	Institute for Healthcare Improvement
IM/IT	Information Management/Information Technology
LDSI	Laboratory Data Sharing Initiatives
LOS	Length of Stay
MCFAS	Managed Care Forecasting and Analysis System
MCSC	Managed Care Support Contractor
MDC	Major Diagnostic Category
MDR	MHS Data Repository
MEB	Medical Evaluation Board
MED/SURG	Medical/Surgical
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MS-DRG	Medicare Severity Diagnosis Related Group
MTF	Military Treatment Facility
NCBD	National CAHPS Benchmarking Database
NCQA	National Center for Quality Assurance

ABBREVIATIONS *(CONT'D)*

NDAA	National Defense Authorization Act
NHANES	National Health and Nutrition Examination Survey
NHE	National Health Expenditures
NQF	National Quality Forum
OASD	Office of the Assistant Secretary of Defense
OB	Obstetrical
OB/GYN	Obstetrician/Gynecologist
OCFO	Office of the Chief Financial Officer
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
PCMH	Patient-Centered Medical Home
PDF	Portable Document Format
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PEB	Physical Evaluation Board
PEP	Projection of Eligible Population
PH	Psychological Health
PHI	Protected Health Information
PII	Personally Identifiable Information
PN	Pneumonia
POS	Point-of-Service
PPACA	Patient Protection and Affordable Care Act
PPO	Preferred Provider Organization
PRISM	Provider Requirement Integrated Specialty Model
PSA	Prime Service Area
PSC	Private-Sector Care
PSM	Patient Safety Manager
PSR	Patient Safety Reporting
PSYCH	Mental Health
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCA	Root Cause Analysis
RCPTA	Reserve Component Purchased TRICARE Application
RDT&E	Research, Development, Test and Evaluation
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SCIP	Surgical Care Improvement Project
S/E	Standard Extra
SelRes	Selected Reserve
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
TMA	TRICARE Management Activity
TOA	Total Obligational Authority
TPharm	TRICARE Pharmacy
TPR	TRICARE Prime Remote
TRDP	TRICARE Retiree Dental Program
TRIAP	TRICARE Assistance Program
TRISS	TRICARE Inpatient Satisfaction Survey
TRO	TRICARE Regional Office
TROSS	TRICARE Outpatient Satisfaction Survey
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TYA	TRICARE Young Adult
UMP	Unified Medical Program
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USFHP	Uniformed Services Family Health Plan
VA	Department of Veterans Affairs
WTU	Warrior Transition Unit

The **Evaluation of the TRICARE Program: Fiscal Year 2012 Report to Congress** is provided by the TRICARE Management Activity (TMA)/Office of the Chief Financial Officer (OCFO)—Defense Health Cost Assessment and Program Evaluation (DHCAPE), in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). Once the Report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx*.

Key agency and individual contributors (and area of expertise) to this analysis are:

Government TMA/DHCAPE Project Director and Lead Researcher:
Richard R. Bannick, Ph.D., FACHE (Surveys, Special Studies, Program Evaluations)

Government Agency Analysts and Reviewers:
OASD(HA) and TMA
Greg Atkinson, M.B.A. (Provider Productivity)
Robert J. Moss, Jr., M.H.A. (Accrual Fund)
Margaret Class, R.N. (Clinical Quality)
Heather A. Ford, M.B.A. (Budget)
Kathleen A. Gates, Lt. Col., USAF, DC (Dental)
Kimberley A. Marshall, Ph.D. (TROSS, TRISS Surveys)
Robert Opsut, Ph.D. (Provider Productivity)
Gregory Woskow, M.S. (Claims Data)

Data Support:
Altarum Institute
Kimberly Bellis, M.S.P.H., Med.
Michelle Klock, Ph.D., R.N.
Koren P. Melfi, M.P.H.
Joe Swedorske, M.S.

Lead Analytic Support:
Institute for Defense Analyses
Philip Lurie, Ph.D.
Lawrence Goldberg, Ph.D.
Susan L. Rose, Ph.D.
David P. Masad

Contributing Analysts:
Mathematica Policy Research, Inc.
Eric Schone, Ph.D.
Nancy A. Clusen, M.S.

Final Report Production:
Forte Information Resources
Richard R. Frye, Ph.D.

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 these entrusted to our care.

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.


TRICARE®


DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA
PUBLIC HEALTH SERVICE
1798
NOAA