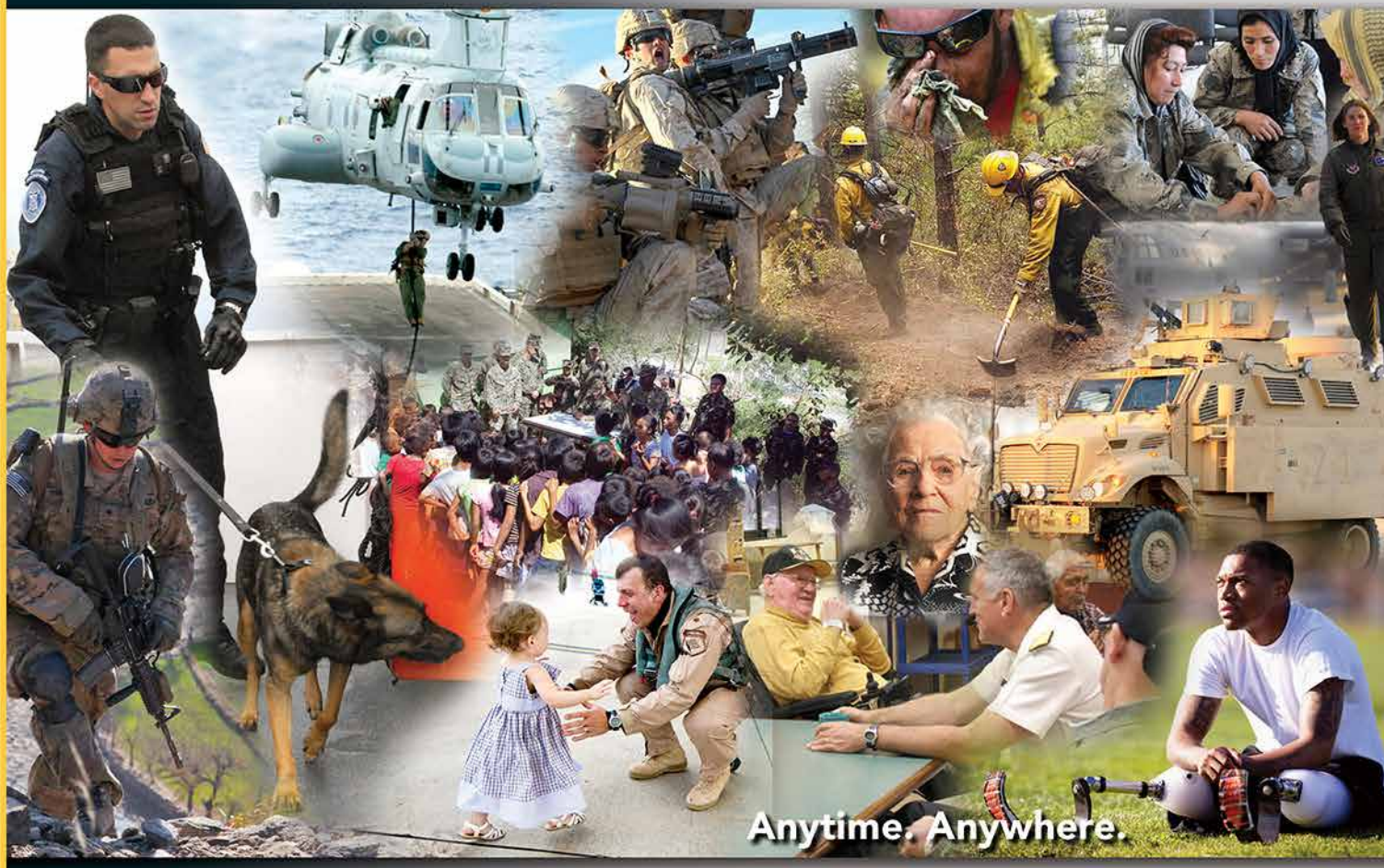

Keeping Warfighters Ready. For Life.

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

Fiscal Year 2013
Report to Congress

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, 2013

The **Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2013 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 Coast Guard Petty Officer, a K-9 handler at Maritime Safety and Security Team San Francisco, and his dog, Evy, conduct a sweep of an Alcatraz Island ferry while at Alcatraz Island. (October 2012)

B – A U.S. Army Specialist climbs a mountain in Watapur district, Kunar province, Afghanistan, as part of the Army's Comprehensive Soldier Fitness program. (January 2012)

C – Marines fast-rope from a CH-46E Sea Knight helicopter to the flight deck of the amphibious assault ship USS Peleliu (LHA 5). (October 2012)

D – Marines prepare to shoot a shoulder-launched multipurpose assault weapon on top of Machine Gun Hill at the Marine Corps Air Ground Combat Center in Twentynine Palms, CA. (September 2012)

E – U.S. Air Force officials, Marines, Sailors, and hundreds of Santa Juliana residents gathered for the dedication ceremony of the recently renovated Patal Bato Literacy and Day Care Center. (April 2012)

F – A U.S. Air Force pilot is greeted by his daughter after returning home from a six-month deployment to Kandahar Airfield, Afghanistan. (October 2011)

G – A U.S. Air Force firefighter wipes sweat from his face while cutting a fire line in the Mount St. Francis area of Colorado Springs, CO. (June 2012)

H – Firefighters from Vandenberg Air Force Base, CA—Hot Shots—cut a fire line while helping battle several fires in Waldo Canyon, Colorado Springs, CO. (June 2012)

I – One of the Air Force's oldest female veterans recently passed away at age 104. (November 2012)

J – A Rear Admiral visits with veterans at the Veteran's Medical Center during Navy Week. (March 2012)

K – An Army Sergeant looks on as two Afghan Patrol Police Soldiers practice splint techniques during training near Mazar-e-Sharif, Balkh province, Afghanistan. (April 2012)

L – A U.S. Air Force C-130 Hercules pilot walks off the flight line. (March 2009)

M – A Mine Resistant Ambush Protected vehicle crosses the border, ending the transition of troops and equipment from Iraq as Operation New Dawn comes to a close. (December 2011)

N – A U.S. Marine, a bilateral leg amputee and below-elbow amputee, stretches before practice for the 2012 Marine Corps Trials. (February 2012)

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

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

It is with profound pride and honor that I report to the Congress our annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. This is my third report since my appointment in December 2010, responding to Section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106).

Our $50 billion FY 2013 Unified Medical Program (UMP) in the 2013 President's Budget supports the physical and mental health of 9.6 million beneficiaries worldwide. The Military Health System (MHS), composed of direct care provided in our over 400 military treatment facilities and care purchased through civilian providers and institutions, extends from theater medical care for our deployed forces to the daily "peacetime" health services.

Consistent with the efforts of the Department of Defense (DoD) to sustain the force while containing costs, the FY 2013 UMP as currently programmed is almost 7.2 percent less than expended in FY 2012, is similar to expenditures of three years ago (unadjusted for inflation), and when adjusted for inflation using DoD deflators, is similar in purchasing value to FY 2006 expenditures. The UMP has remained between 7.1 and 7.5 percent of the DoD budget during the past six fiscal years.

As I travel to visit our medical forces, I am witness to the profound effect military medicine has in creating and sustaining dialogue with foreign countries and governments. DoD's depth of mobile medical assets, research abilities, personnel, equipment, and aeromedical evacuation capabilities are unique in the world and an essential instrument of national security. Medicine and health often offer a nonthreatening environment for the start of discussions with former adversaries and offer an opportunity to expand engagements with our allies for contingencies and health engagements. As one of the senior commanders in the Pacific related to me, medicine is the beginning of goodwill that will then expand to other areas. It helps build a sense of trust between nations. Global health engagement is a force multiplier.

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. This report presents results of quadruple aim strategic imperatives we continually monitor, trended over at least the most recent three fiscal years, where programs are mature and data permit. We assess MHS cost, quality, and access against corresponding civilian benchmarks by comparing values such as beneficiary-reported access and experience vs. results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sponsored by the Agency for Healthcare Research and Quality (AHRQ), our quality measures vs. national expectations and results of the Joint Commission, and health-risky behavior vs. Healthy People 2020 objectives.

Military medicine will 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. The Military Department Surgeons General and I are dedicated to the MHS Governance decisions made by the Deputy Secretary of Defense in March 2012. All of us in the MHS are committed to a fully collaborative and transparent process, with our intent to make our already high-performing system even stronger.

Consistent with the Deputy Secretary of Defense's decision, we are addressing three significant areas for improvement: (1) establish a Defense Health Agency that will have the structure and authority to drive common clinical and business processes across the enterprise; (2) develop and mature Multi-Service markets, and provide additional authority in areas such as budget, workforce, and workload to a single market manager in designated markets; and (3) transition to a more permanent organizational structure for the National Capital Region (NCR), given the conclusion of the Base Realignment and Closure (BRAC) activities. This will be achieved by establishing an NCR Medical Directorate within the Defense Health Agency, into which we will transition Joint Task Force CapMed. Our decisions will be rooted in sound leadership principles and business practices with a keen eye on our responsibility to better manage increasingly precious resources for the future.

Our goal remains the same—to ensure the medical readiness of our Service members and to provide a ready force able to deliver the best medical services anywhere in the world, under any conditions, to all our beneficiaries.

I am proud of the accomplishments of MHS and the TRICARE program, and inspired by the focus of leadership on critical appraisal and efforts to continuously improve 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.*

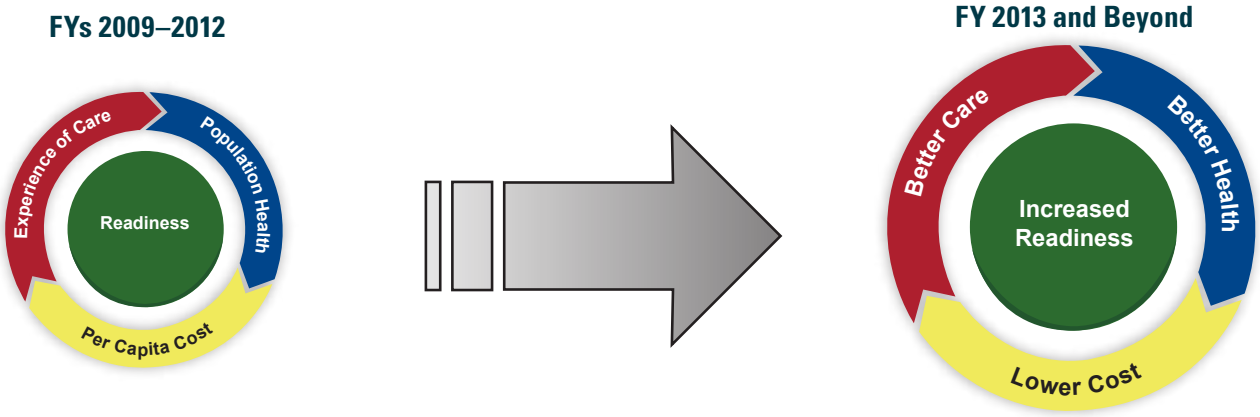
MHS PURPOSE, MISSION, VISION, AND STRATEGY

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 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.

MHS QUADRUPLE AIM AND STRATEGIC DIRECTION AND PRIORITIES IN FY 2013 AND BEYOND

Since the fall of 2009, the Quadruple Aim, adopted from the unifying construct of the Triple Aim from the Institute for Healthcare Improvement (IHI; *http://www.ihi.org/offerings/Initiatives/TripleAim/Pages/default.aspx*), has served as the MHS strategic framework, and remains relevant in describing our priorities and strategies for the coming years. During FY 2012, senior MHS leaders agreed to begin FY 2013 by explicitly emphasizing in the Quadruple Aim the desired direction of improvement: toward increased readiness, better care, better health in our population and at lower costs to the Department and the MHS.



The MHS Quadruple Aim:

- **Readiness → Increased 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.
- **Population Health → Better Health**
  Our goal is to reduce the frequency of visits to our military hospitals and clinics by keeping the people we serve healthy. We are moving "from health care to health" by reducing the generators of ill health by encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.
- **Experience of Care → Better Care**
  We are proud of our track record—but there is more to accomplish. We will provide a care experience that is safe, timely, effective, efficient, equitable, and patient- and family-centered.
- **Per Capita Cost → Lower Cost**
  To lower costs, we will create value by focusing on quality, eliminating waste, and reducing unwarranted variation; we will consider the total cost of care over time, not just the cost of an individual health care activity. There are both near-term opportunities to become more agile in our decision making and longer-term opportunities to change the trajectory of cost growth through a healthier population.

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2012

MHS Worldwide Summary

- The $50 billion Unified Medical Program (UMP) in the FY 2013 President's Budget is 7.2 percent less than actual expenditures in FY 2012 and similar to FY 2010 expenditures. The UMP is projected to be 6.2 percent of FY 2013 total Defense expenditures (including the normal cost contribution to the Accrual Fund for retirees; Ref. pages 17–18).
- The number of beneficiaries eligible for DoD medical care fell slightly from 9.72 million at the end of FY 2010 to 9.66 million at the end of FY 2012 (Ref. page 10).
- The number of enrolled beneficiaries remained between 5.4 and 5.5 million from FY 2009 to FY 2012 (Ref. page 15).
- The percentage of beneficiaries using MHS services increased from 83.3 percent in FY 2010 to 84.1 percent in FY 2012 (Ref. page 16).
- **TRICARE Young Adult (TYA):** After more than a year in operation, TYA enrollment is over 21,000 young adults under age 26, with almost half enrolled in the Prime option; most are family members of non-Active Duty (Ref. page 46).
- **Reserve Component Enrollment in TRICARE Plans:** National Guard and Reserve enrollment in the TRICARE Reserve Select (TRS) benefit program topped 240,000 covered lives by the end of FY 2012, while enrollment in TRICARE Retired Reserve (TRR) reached almost 2,700 covered lives in nearly 1,100 individual and family plans (Ref. page 44).

MHS Workload and Cost Trends[1]

- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) grew from FY 2010 to FY 2012 for outpatient services (+16 percent) and prescription drugs (+3 percent), but fell for inpatient services (–3 percent) (Ref. pages 20–22).
- Direct care outpatient workload grew by 13 percent and prescription workload by 1 percent, while inpatient workload fell by 4 percent from FY 2010 to FY 2012. Overall, direct care costs increased by 5 percent. Purchased care workload rose for outpatient services (18 percent) and prescription drugs (5 percent), but fell by 3 percent for inpatient services. Overall, purchased care costs rose by 10 percent, but the increases were eased somewhat by the Outpatient Prospective Payment System (OPPS), refunds 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 20–22, 24).
- The purchased care portion of total MHS health care expenditures held steady from FY 2010 to FY 2012 at about 50 percent. As a proportion of total MHS health care expenditures (excluding TFL), FY 2012 purchased care expenditures were 58 percent for inpatient care, 58 percent for prescription drugs, and 45 percent for outpatient care (Ref. page 24).
- In FY 2012, out-of-pocket costs for MHS beneficiary families under age 65 were between $4,500 and $5,400 lower than those for their civilian counterparts. Out-of-pocket costs for MHS senior families were $2,600 lower than those for their civilian counterparts (Ref. pages 83, 85, 88).

Per Capita Cost

- MHS estimated savings in FY 2012 include $1.4 billion in pharmacy refunds, $840 million resulting from the OPPS, and up to $127 million in identified possible excessive/improper payments from FY 2009 to FY 2012 (Ref. pages 23, 24, and 66).

Experience of Care

- **Overall Outpatient Access:** Access to and use of outpatient services remained high, with 87 percent of Prime enrollees reporting at least one outpatient visit in FY 2012 (Ref. page 31).
- **Availability and Ease of Obtaining Care:** MHS beneficiary ratings for getting needed care and getting care quickly remained stable between FY 2010 and FY 2012 but continued to lag the civilian benchmark (Ref. page 32).
- **Doctors' Communication:** Satisfaction levels of Active Duty and Active Duty family members lagged the civilian benchmark between FY 2010 and FY 2012. Satisfaction levels of retirees and families equaled the civilian benchmark over this period (Ref. page 33).
- **MHS Provider Trends:**
  - The number of TRICARE network providers continues to increase, but at a slower rate than in previous years. After years of increases, the total number of participating providers began to level off in FY 2012 (Ref. page 49).
  - Results from a completed four-year survey of civilian providers indicate that seven of 10 physicians accept new TRICARE Standard patients if they accept any new patients. Behavioral health providers report lower awareness and acceptance of TRICARE Standard and Medicare than nonpsychiatrist physicians (Ref. page 50).
- **Overall Customer Satisfaction with TRICARE:** MHS beneficiary global ratings of satisfaction with the TRICARE health plan exceed the civilian benchmark between FY 2010 and FY 2012. Global satisfaction ratings of health care, personal provider, and specialty physician continue to lag the civilian benchmark (Ref. pages 36–39).

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 2012 self-reported rate for smoking (11.7 percent) dropped below the HP 2020 goal of 12 percent or less (Ref. pages 57–61).

Readiness

- **Force Health Protection:** Overall, total force individual medical readiness continued to improve, from 78 percent in quarter three (Q3) calendar year (CY) 2011 to 84 percent in Q3 CY 2012 of those Service members fully or partially medically ready to deploy. In addition, the Services reduced the rate of not medically ready from 11 percent to 6 percent during that period. Dental readiness remained high in the same period, at 92.5 percent, but short of the goal of 95 percent (Ref. pages 91–92).

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

WHAT IS TRICARE?

TRICARE is the DoD health care program serving 9.6 million Active Duty Service members (ADSMs), National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide (*http://www.tricare.mil/Welcome.aspx?sc_database=web*). 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 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 health maintenance organization (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:

- The premium-based TRICARE Young Adult (TYA) Program available to qualified dependents under the age of 26;
- 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 the Reserve Components, including 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, and joint services;
- Uniformed Services Family Health Plan (USFHP);
- Clinical and educational services demonstration programs (such as chiropractic care, autism services, and TRICARE Assistance Program); and
- Other programs, including the premium-based Continued Health Care Benefit Program, providing a Consolidated Omnibus Budget Reconciliation Act (COBRA)-like benefit, and the Transitional Assistance Management Program (TAMP), which allows Reservists activated for at least 30 days in support of Contingency Operations continued access to the TRICARE benefit for up to 180 days after deactivation.

HOW TRICARE IS ADMINISTERED

TRICARE is administered on a regional basis, with three regional contractors in the United States and an overseas contractor 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 2012 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 benefits 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 Contract Changes

As noted in last year's report, the three U.S. Managed Care Support contracts were re-competed in 2009, and after resolving bid protests, the new TRICARE Third Generation (T-3) Support Contracts became operational between 2011 and 2012. Health care delivery under the new T-3 Contracts began April 1, 2011 for the North region with Health Net Federal Services. Humana Military Healthcare Services began health care delivery for TRICARE South region April 1, 2012. UnitedHealthcare will begin delivery of services to the TRICARE West region April 1, 2013.

As a result of the revised contracts, all beneficiaries within a 40-mile radius of Fort Campbell, Ken., are now in TRICARE South and will fall under Humana's care. Half of this market has always been in TRICARE South, but the other half was in TRICARE North, often leading to complicated transactions and referrals. Every effort was made to ensure that beneficiaries' new coverage was as similar as possible to their previous coverage, and most were able to keep their current doctor.

Dental Care

Over 2 million Selected Reserve and Individual Ready Reserve members, Active Duty family members, and survivors changed coverage from United Concordia to MetLife. MetLife began accepting applications on March 21 for coverage beginning May 1, 2012, allowing access to their network of more than 164,000 dentist locations. Beneficiaries will see enhanced dental coverage at a lower premium share under this new contract. Highlights of benefits and enhancements include an increase in the annual and lifetime maximum benefits, coverage of certain resin fillings, additional cleanings for pregnant women, and expansion of the survivor benefits. Most enrollees did not have to do any paperwork or take any action during the transition; only those using automatic payments to pay premiums needed to take action to reauthorize the payment to MetLife. The Active Duty Dental Program will continue to be administered by United Concordia. For more information see: *www.TRICARE.mil/TDP* or *https://mybenefits.metlife.com/tricare.*

QUADRUPLE AIM: EXPERIENCE OF CARE

Access to Care

TRICARE Young Adult Program

Eligible young adult beneficiaries meeting TYA requirements were offered TRICARE Prime coverage beginning January 1, 2012, with monthly premiums of $201. TYA Standard has been offered as an option since May 2011, with monthly premiums reduced for 2012 to $176. TYA Prime coverage follows the "20th of the month rule," whereby applications received by the 20th of the month will be processed for coverage beginning the first of the following month. Premiums can be paid in advance through monthly automated electronic payment. Complete information and application forms are available at *www.tricare.mil/tya.*

Autism Services Demonstration (ASD)

As part of the Extended Care Health Option (ECHO), the Enhanced Access to Autism Services Demonstration has been extended through March 2014, allowing eligible beneficiaries to receive applied behavioral analysis (ABA) intervention services. A 2010 survey showed that parents with children participating in the demonstration were satisfied overall with the quality of ABA services received. Learn more about ECHO at *www.tricare.mil/ECHO* and the TRICARE Autism Services Demonstration at *www.tricare.mil/autismdemo*.

Improving Access through Technology

DSTRESS: The DSTRESS Line is a 24/7/365 contact center providing anonymous phone, chat, and online counseling services to the entire Marine Corps. The contract was awarded to TriWest Healthcare Alliance, which has administered DoD's TRICARE Program since 1996 in the TRICARE West Region. The DSTRESS Line began providing global Corps-wide support beginning March 23, 2012, and is accessible at *DSTRESSLine.com* and 1-877-476-7734.

NEW BENEFITS AND PROGRAMS IN FY 2012 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

Dental Care

Changes for National Guard and Reserve Members Separating from Active Duty

Effective January 27, 2012, those separating from Active Duty after an activation of greater than 30 days in support of a contingency operation began receiving the same dental care benefits as Active Duty Service members. The TRICARE Active Duty Dental Program (ADDP) will provide coverage to these members in the Transition Assistance Management Program (TAMP), which provides 180 days of transition health care benefits to help certain Uniformed Service members and their families transition to civilian life. Family members and dependents are not eligible for ADDP benefits under TAMP but remain eligible to purchase coverage through the TRICARE Dental Program (TDP). Service members receiving benefits under TAMP are ineligible for the TDP until the end of the 180-day transitional benefit period. For more information about Active Duty dental benefits, visit *www.addp-ucci.com.* For more information about the TRICARE Dental Program, visit *www.tricaredentalprogram.com.*

QUADRUPLE AIM: POPULATION HEALTH

Mental Health

DoD Web site Launched for Children

In January 2012, DoD launched a new highly interactive Web site for children experiencing the challenges of military deployments, to help them better cope with the stress. The site contains videos, educational tools, games, and activities for three age groups of children. The Web site has features that will help children, parents, and educators navigate the wide range of practical and emotional challenges military families must live with throughout the deployment cycle (*www.MilitaryKidsConnect.org*).

The TRICARE Assistance Program Canceled

The Web-based TRICARE Assistance Program demonstration, which began on August 1, 2009, was shut down in 2012 for lack of use. The $3 million demonstration program was designed to test the use of Web-based video conferencing for mental health counseling. The program logged 5,109 calls during a two-year period, with only 1,188 being initial calls (the rest were follow-up calls).

QUADRUPLE AIM: PER CAPITA COST

TRICARE Fees and Copays

TRICARE Prime Fee Increase for FY 2013

The TRICARE Prime enrollment fee increase took effect on October 1, 2012. Fees increased last year for new enrollees for the first time since the program began. For FY 2013, most existing enrollees saw a slight increase, which was calculated based on the CY 2012 cost-of-living adjustment of 3.6 percent. This increase will not affect Active Duty Service members or their families. Additionally, survivors of Active Duty deceased sponsors or medically retired Uniformed Service members and their dependents are exempt from enrollment fee increases.

FY 2011 (October 1, 2010–September 30, 2011)	FY 2012 (October 1, 2011–September 30, 2012)	FY 2013 (October 1, 2012–September 30, 2013)
$230/individual	$260/individual	$269.28/individual
$460/family	$520/family	$538.56/family

Pharmacy Benefits

Effective October 1, 2011, pharmacy copays for generic drugs were reduced from $3 to $0 for home delivery and were increased from $3 to $5 for retail. Copays for non-formulary drugs at both retail and home delivery pharmacies rose to $25, up from $22.

	FY 2002–FY 2011	FY 2012 (Effective October 1, 2011)
Military Treatment Facility	Generic, Brand—$0 Non-Formulary—n/a	No Change
Home Delivery/ Mail Order (90-day supply)	Generic—$3 Brand—$9 Non-Formulary— $22	Generic—$0 Brand—$9 Non-Formulary—$25
Network Retail Pharmacy (30-day supply) (non-Network retail benefit at Note)	Generic—$3 Brand—$9 Non-Formulary—$22	Generic—$5 Brand—$12 Non-Formulary—$25

Source: *http://tricare.mil/CoveredServices/BenefitUpdates/Archives/PharmacyCopayChanges.aspx*, 1/11/2013

Note: **Non-network pharmacy (up to a 90-day supply)**

For formulary drugs: TRICARE Prime options: 50 percent copayment applies after point of service (POS) deductible is met; all other beneficiaries: $12 or 20 percent of the total cost, whichever is greater (was $9 prior to FY 2012) after annual deductible is met.

For non-formulary drugs: TRICARE Prime options: 50 percent copayment applies after POS deductible is met; All other beneficiaries: $25 or 20 percent of the total cost, whichever is greater, after annual deductible is met (was $22 prior to FY 2012).

NEW BENEFITS AND PROGRAMS IN FY 2012 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

Costs to DoD

The Congressional Budget Office report published in February 2012 analyzed the budgetary savings resulting from the limitation on employer incentives to TRICARE-eligible beneficiaries. They estimate there is a high probability that the enactment of section 707 resulted in savings to DoD, and the expected value of those savings is about $55 million per year (net savings is about $30 million per year because of certain effects on federal revenues). Between 45,000 and 70,000 working-age military retirees are estimated to have accepted incentives prior to implementation of section 707. To read the full report, please visit: *http://www.cbo.gov/sites/default/files/cbofiles/attachments/GrahamLetter021712.pdf.*

QUADRUPLE AIM: READINESS

Wounded Warrior Care

Prosthetics for Wounded Soldiers

For the first time, a new prosthetic arm operated by a wounded Soldier at Walter Reed National Military Medical Center enabled the Soldier to control the device's metallic fingers and wrist with his thoughts. The limb was developed as part of a four-year research program by Johns Hopkins University and the Uniformed Services University. Researchers are exploring other mechanisms to rewire nerves and learn even more about how the body and brain can interface with computers.

TRICARE PROGRAM AND BENEFITS TIMELINE: FY 1995–FY 2012

1995

- TRICARE benefit begins in the Northwest Region.
- Catastrophic cap for non-Active Duty enrollees is reduced from $7,500 to $3,000.
- Expanded Active Duty Dental Benefit Plan begins.

1996

- Cancer Treatment Clinic Trial demonstration begins.
- Requirement for Outpatient Nonavailability Statement dropped.
- TRICARE Web site is launched.

1997

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

1998

- TRICARE implementation is complete.
- TRICARE Senior Prime demonstration begins.

1999

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

2000

- Expansion of TRICARE Retiree Dental Program to dependents begins.
- Catastrophic cap for unenrolled retirees, their family members, and survivors is reduced from $7,500 to $3,000.
- DoD waives charges for Active Duty Prime Remote family members through August 31, 2000.
- TRICARE benefits are expanded to cover school physicals.

2001

- TRICARE eliminates Prime copays for Active Duty family members.
- TRICARE Senior Pharmacy benefit begins.
- TRICARE simplifies and reduces copay structure for prescription drugs.
- Active Duty Service members get permanent chiropractic care benefit in MTFs.

2002

- TRICARE for Life benefit begins and TRICARE Senior Prime Demonstration ends.
- TRICARE Prime Remote benefit begins for Active Duty family members.

2003

- TRICARE Prime Remote is modified to allow family members residing in Prime Remote locations to remain enrolled when sponsors undergo Permanent Change of Station on unaccompanied tour.
- Requirement for Guard/Reserve sponsor's activation orders TRICARE Global Remote Overseas benefit begins.
- Requirements for TRICARE Standard beneficiaries to obtain a Nonavailability Statement eliminated except for mental health.

2004

- Transitional Assistance Management Program (TAMP) coverage is permanently extended to 180 days following Active Duty, making "early benefit" permanent for National Guard and Reserve Members called to Active Duty.

2005

- TRICARE Reserve Select (TRS) benefit begins.

2006

- Opportunity to purchase TRS is extended to all qualifying members of the National Guard and Reserve.
- Gastric bypass, gastric stapling, or gastroplasty become covered benefits under TRICARE.
- Family members are given a 30-day period to submit a TRICARE Prime enrollment form.

2007

- Anesthesia and other costs for dental care for certain children and other beneficiaries are authorized.
- Eligibility expanded for Selected Reserve members.
- Claims processing under TRICARE program and Medicare program is standardized.
- Mental health screening and services for members of the Armed Forces are enhanced.
- TRS is simplified and opened to all Reservists other than those with Federal Employees Health Benefits Plan (FEHBP).

2008

- Mental health care program is included in definition of health care.

2009

- Active Duty Dental Program is implemented.
- Extended Care Health Option (ECHO) government liability is increased to $36,000 per year for certain services.
- TRICARE Pharmacy manufacturer refunds are established (retroactive to January 2008).
- OPPS is implemented.

2010

- TRICARE Overseas Program begins health care delivery.
- TRICARE Retired Reserve (TRR) program is launched, allowing gray-area retirees to purchase TRICARE health coverage for themselves and eligible family members.

2011

- TRICARE Young Adult (TYA) begins offering TRICARE Standard coverage to certain beneficiaries through age 25.
- TRICARE Pharmacy announces copay decreases for the home delivery option, coinciding with increases to copays for retail pharmacy purchases.
- TRICARE Prime enrollment fee is adjusted and can now be changed annually (frozen for survivors and certain significantly injured or ill retirees).

2012

- Copays for authorized preventive services eliminated.
- TYA extended to offer TRICARE Prime coverage.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2013[a]

	Projected for FY 2013	FY 2012 (as Projected Last Year)
Total Beneficiaries	**9.6 million[b]**	**9.7 million**
Military Facilities—Direct Care System	**Total[c] U.S.**	**Total U.S.**
Inpatient Hospitals and Medical Centers	56 (41 in U.S.)	56
Ambulatory Care Clinics	361 (292 in U.S.)[d]	365
Dental Clinics	249 (194 in U.S.)	281
Veterinary Facilities	254 (199 in U.S.)	255
Military Health System (MHS) Personnel	146,440	144,376
Military	86,051 31,804 Officers 54,247 Enlisted	86,007 31,843 Officers 54,164 Enlisted
Civilian	60,389	60,162
Civilian Resources—Purchased Care System[e]		
Network Individual Providers (primary care, behavioral health, and specialty care providers)	477,891	438,424
Network Behavioral Health Providers (included in above)	62,064	59,587
TRICARE Network Acute Care Hospitals	3,310	3,224
Behavioral Health Facilities	914	—
Contracted (Network) Retail Pharmacies	57,763	64,712
Contracted Worldwide Pharmacy Home Delivery Vendor	1	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	About 1.97 million covered lives, in over 800,000 contracts	Over 2 million covered lives, in over 800,000 contracts
TDP Network Dentists	85,598 total dentists 68,431 general dentists 17,167 specialists	72,459 total dentists 59,196 general dentists 13,263 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and families)	Almost 1.4 million covered lives, in over 660,000 contracts	Over 1.3 million covered lives, in almost 640,000 contracts
Total Unified Medical Program (UMP)	**$52.5 billion[f]**	**$54.1 billion**
(Includes FY 2013 receipts for Accrual Fund)	**$8.3 billion**	**$10.85 billion**

[a] Unless specified otherwise, this report presents budgetary, utilization, and cost data for the Defense Health Program (DHP)/Unified Medical Program (UMP) only, not those related to deployment.

[b] Department of Defense (DoD) health care beneficiary population projected for the beginning of FY 2013 is 9,634,085, rounded to 9,634,000 or 9.6 million, and is based on the Projection of Eligible Population (PEP), Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Deputy Assistant Secretary of Defense, Health Budgets and Financial Policy Memo dated November 15, 2012.

[c] Military treatment facility (MTF) data from real property reports, Office of the Chief Financial Officer (OCFO), November 20, 2012.

[d] Excludes leased/contracted facilities and Aid Stations, but does include Active Duty troop clinics and Occupational Health Clinics.

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

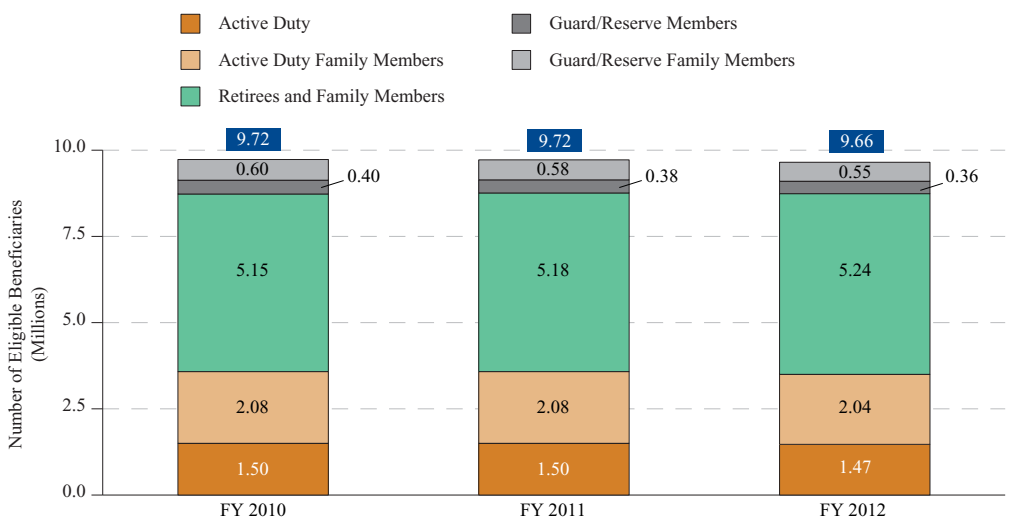
[f] Includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund") DoD Normal Cost Contribution paid by the U.S. Treasury.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Number of Eligible and Enrolled Beneficiaries Between FY 2010 and FY 2012

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) fell from 9.72 million at the end of FY 2010 to 9.66 million[1] at the end of FY 2012. After increasing for most of the past decade, the number of Guard/Reservists and their families took a turn downward in FYs 2011 and 2012. 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).

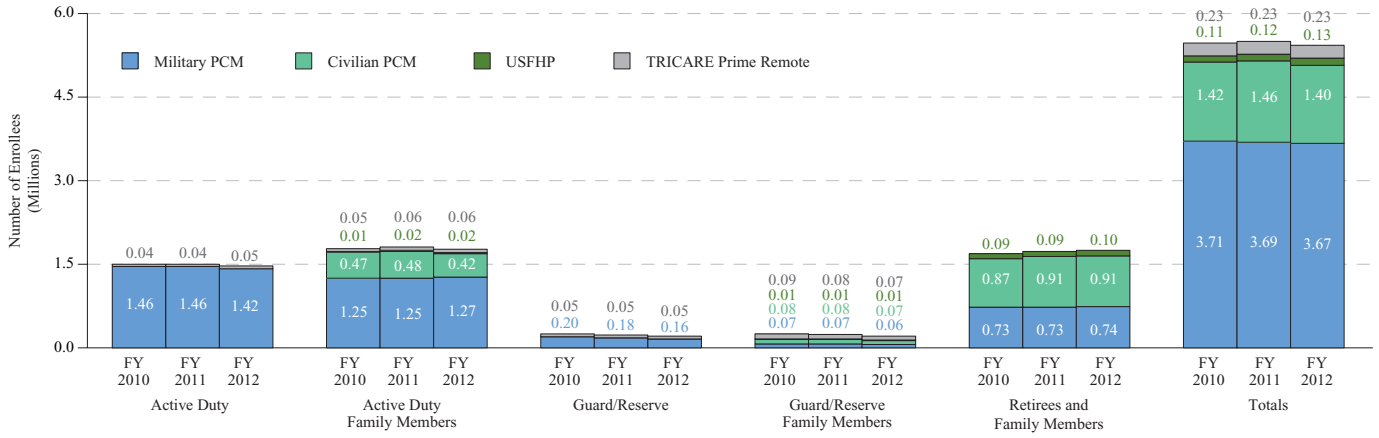
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 1/8/2013

- Slight declines in Prime enrollment are primarily due to corresponding declines in the Active Duty and Guard/Reserve populations and their family members.
- TRICARE Prime Remote (TPR) enrollment remained flat, whereas Uniformed Services Family Health Plan (USFHP) enrollment increased slightly from FY 2010 to FY 2012.

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



Source: DEERS, 1/8/2013

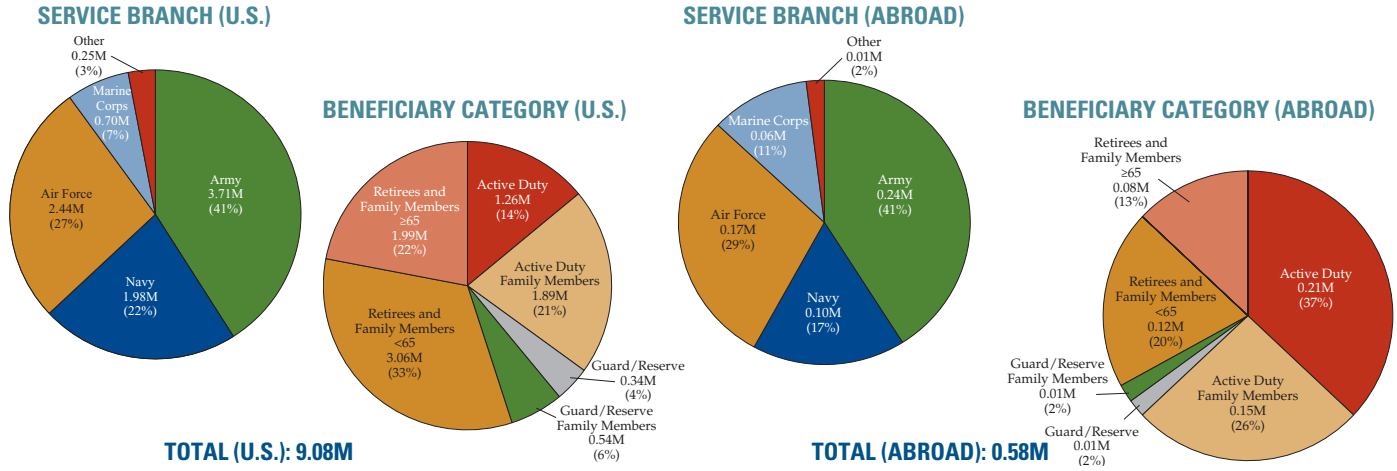
[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 9. The population figure on page 9 is a projected FY 2013 total, whereas the population reported on this page is the actual for the end of FY 2012.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2012

- Of the 9.66 million eligible beneficiaries at the end of FY 2012, 9.08 million (94 percent) were stationed or resided in the United States (U.S.) and 0.58 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 (56 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 (67 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 96, 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.

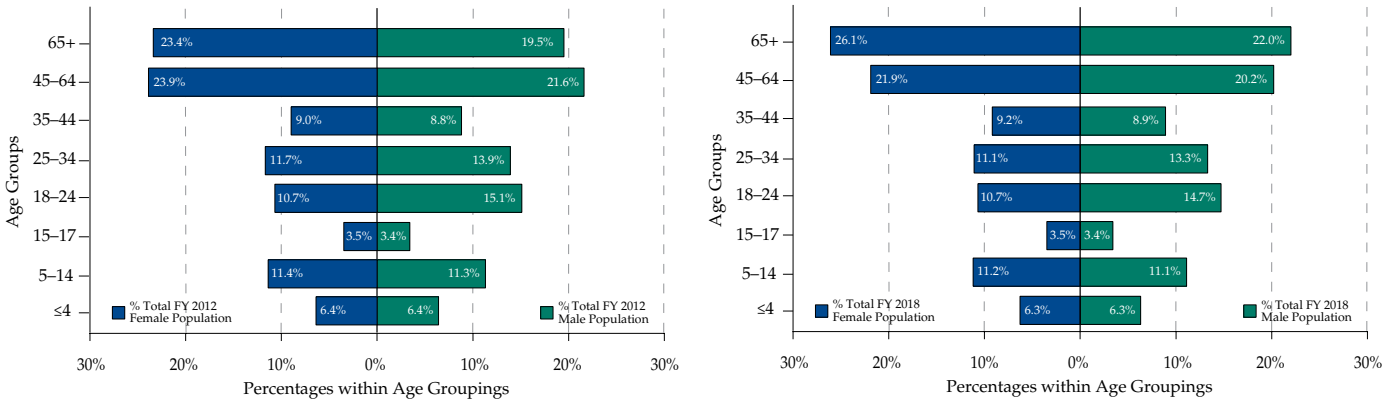
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2012



Source: DEERS, 1/8/2013

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

MHS END-YEAR POPULATION BY AGE AND GENDER: FY 2012 AND FY 2018



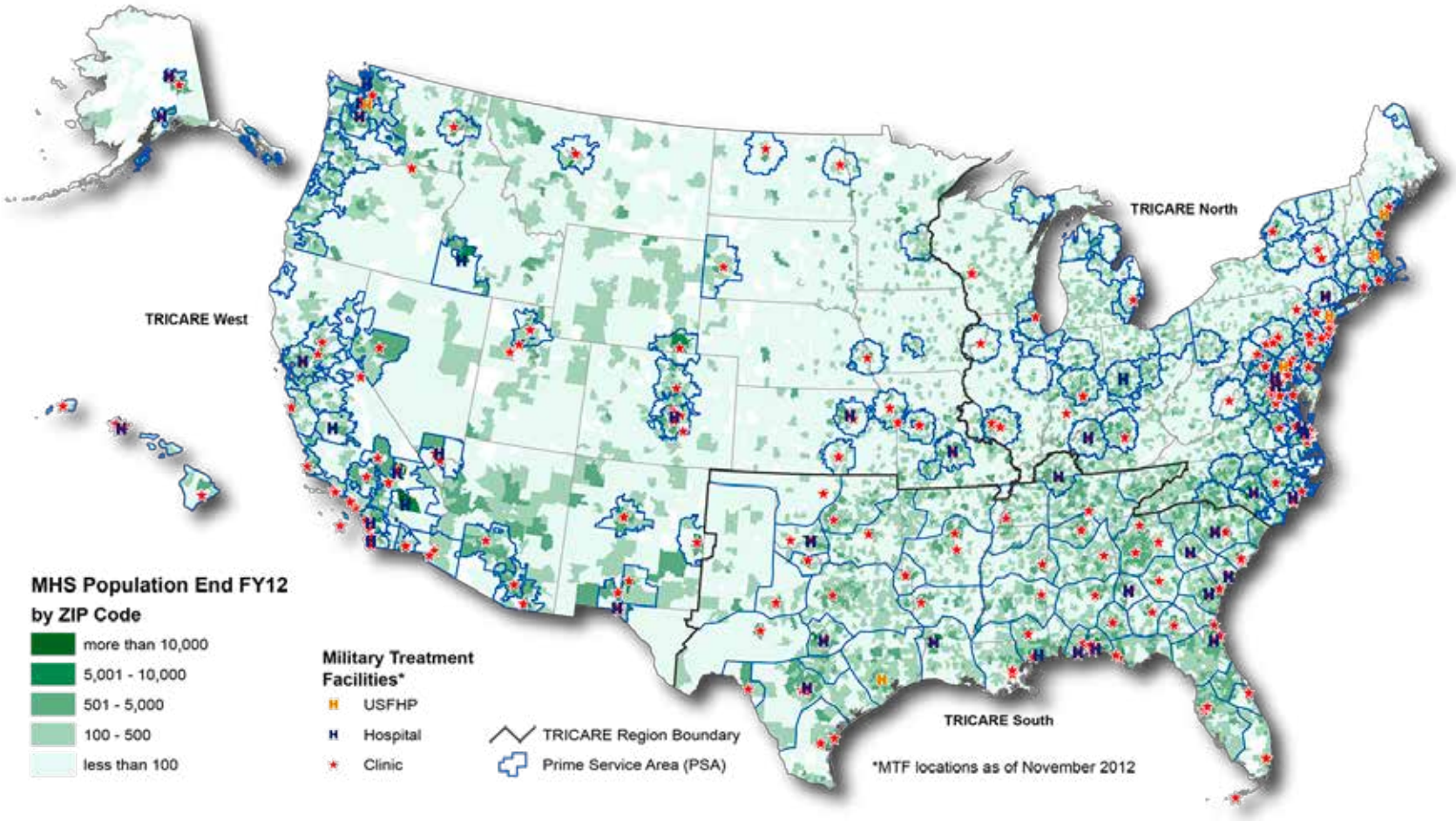
TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: CURRENT FY 2012 AND PROJECTED FY 2018

	Age Group								Total by Gender	Total MHS Population
	≤4	5–14	15–17	18–24	25–34	35–44	45–64	≥65		
FY 2012 Female MHS Beneficiaries	0.30	0.54	0.16	0.51	0.55	0.43	1.13	1.10	4.73	9.66
FY 2012 Male MHS Beneficiaries	0.32	0.56	0.17	0.74	0.68	0.44	1.06	0.96	4.93	9.66
FY 2018 Female MHS Beneficiaries, Projected	0.29	0.52	0.16	0.50	0.52	0.43	1.02	1.21	4.65	9.49
FY 2018 Male MHS Beneficiaries, Projected	0.30	0.54	0.17	0.71	0.64	0.43	0.98	1.07	4.84	9.49

Source: FY 2012 actuals from DEERS as of 1/8/2013, and FY 2018 estimates from TRICARE Management Activity (TMA) Projections of Eligible Population (PEP) model as of 11/7/2012

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs AT THE END OF FY 2012



Source: TMA/OCFO-Defense Health Cost Assessment and Program Evaluation (DHCAPE), 11/29/2012

Note:

[a] Location information determined by TMA Catchment Area Directory (CAD) database, September 2012.

[b] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective September 1, 2012. For Active Duty and Guard/Reserve members, unit ZIP code was used for location; for all other beneficiaries, residential ZIP code was used.

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

[d] This includes 145 eligible beneficiaries who are in the U.S. (per DEERS) but not located by TMA CAD data.

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

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

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

[h] Prime Service Areas: Both MTF Service Areas as well as similar geographies around closed MTFs (BRAC Prime Service Areas) and other locations with high concentrations of MHS beneficiaries

MILITARY HEALTH SYSTEM ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES IN 2012[a]

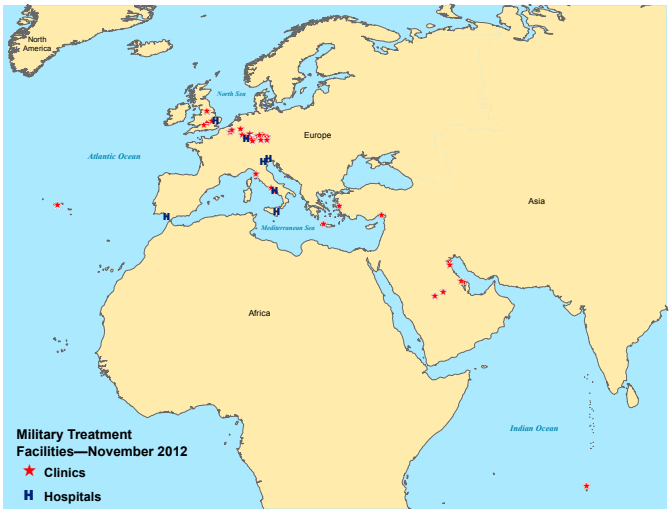
BENEFICIARY GROUP[b]	Population Total (FY 2012)	Population in PSAs[h]	% in PSAs[h]	% in Catchments[e]	% in PRISMs[f]	% in MTF Service Areas[g]
Active Duty and Their Families	3,144,658	3,050,327	97%	70%	88%	92%
Guard/Reserves and Their Families	882,512	718,733	81%	25%	39%	54%
Retirees, Their Families, Survivors, and Other Eligibles[c]	5,054,225	4,421,996	87%	36%	50%	64%
Total MHS Eligibles, U.S.	9,081,395	8,191,056	90%	47%	62%	73%
MHS Eligibles, Overseas	580,762					
Total MHS Eligibles, Worldwide[d]	9,662,157					

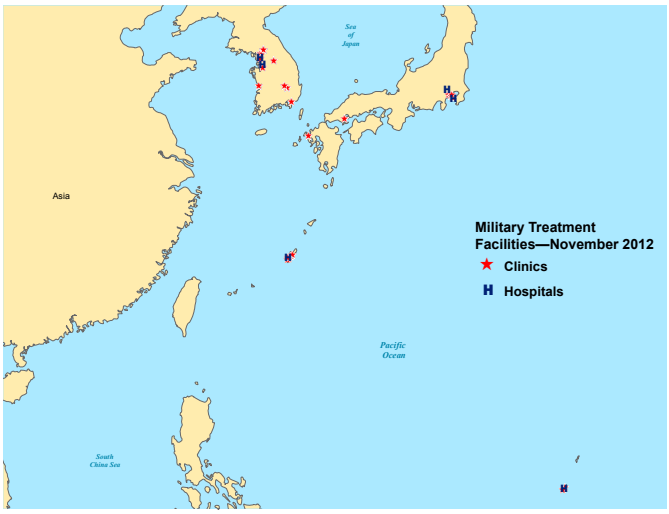
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2012

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 TRICARE Prime reflected in Prime Service Areas, including in direct care MTFs, provider networks and by Designated Providers through the Uniform Services Family Health Plan (USFHP). As provided by law, DoD has contracted with certain former U.S. Public Health Service hospitals to be TRICARE Prime-designated providers. The USFHP offers the TRICARE Prime benefits plan to approximately 125,000 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. are depicted in the two maps below.

MTFs OUTSIDE THE U.S.





Source: MTF information from TMA, Portfolio Planning Management Division, and geospatial representation by TMA/OCFO-DHCAPE, 11/20/2012

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.

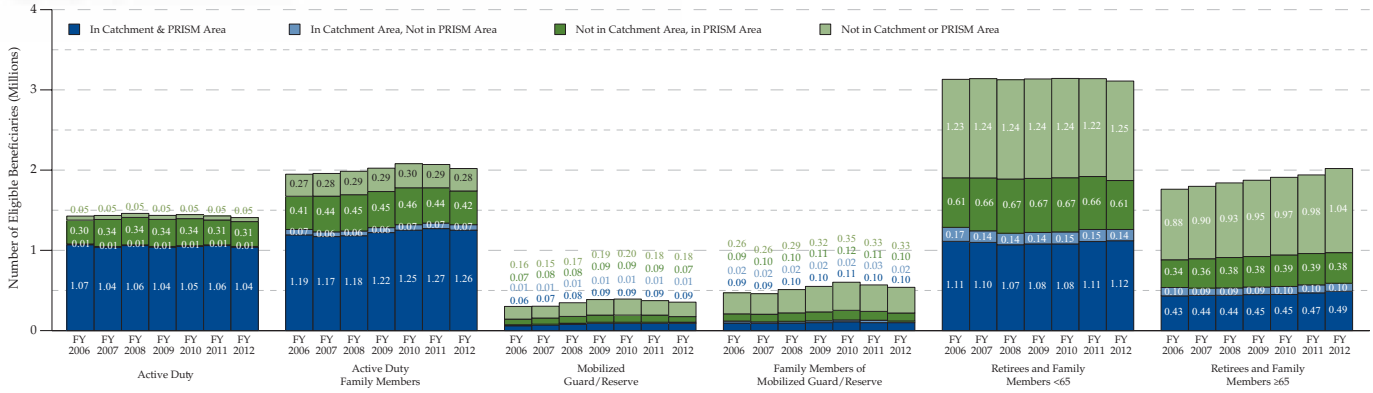
Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there had been a downward trend in the proportion of beneficiaries living in catchment areas. However, that trend has slowed such that the percentage living in catchment areas declined by only one percentage point (from 48 percent to 47 percent) from FY 2006 to FY 2012. The percentage living in PRISM areas declined slightly as well, from 64 percent to 63 percent.

- More beneficiaries live in PRISM areas because, though smaller than catchment areas, they are far more numerous (365 PRISM areas vs. 56 catchment areas worldwide).
- After declining for several years, the number of ADFMs living in catchment areas is back on an upward trajectory.
- 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 in FYs 2011 and 2012 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, MTF Enrollment Areas have not yet been implemented within DEERS or in MHS administrative data and are 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, 1/24/2013

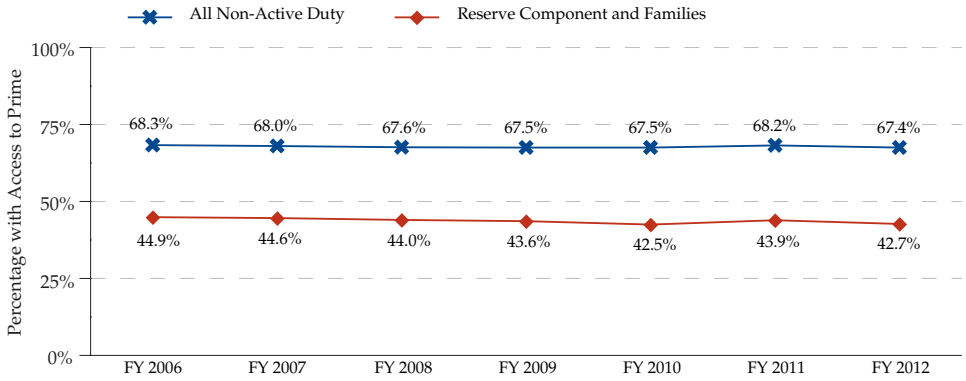
Note: "In Catchment & PRISM Area" refers to the area within 20 miles of a military hospital; it indicates proximity to both inpatient and outpatient care. "In Catchment Area, Not in PRISM Area" refers to the area beyond 20 but within 40 miles of a military hospital; it indicates proximity to inpatient 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 the eligible non-Active Duty beneficiary population with access to MTF-based Prime (i.e., those living in a catchment or PRISM area) remained roughly constant at 68 percent from FY 2006 to FY 2012.
- The percentage of the eligible Reserve Component population with access to MTF-based Prime declined from 45 percent in FY 2006 to 43 percent in FY 2012.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 1/8/2013

- 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)*

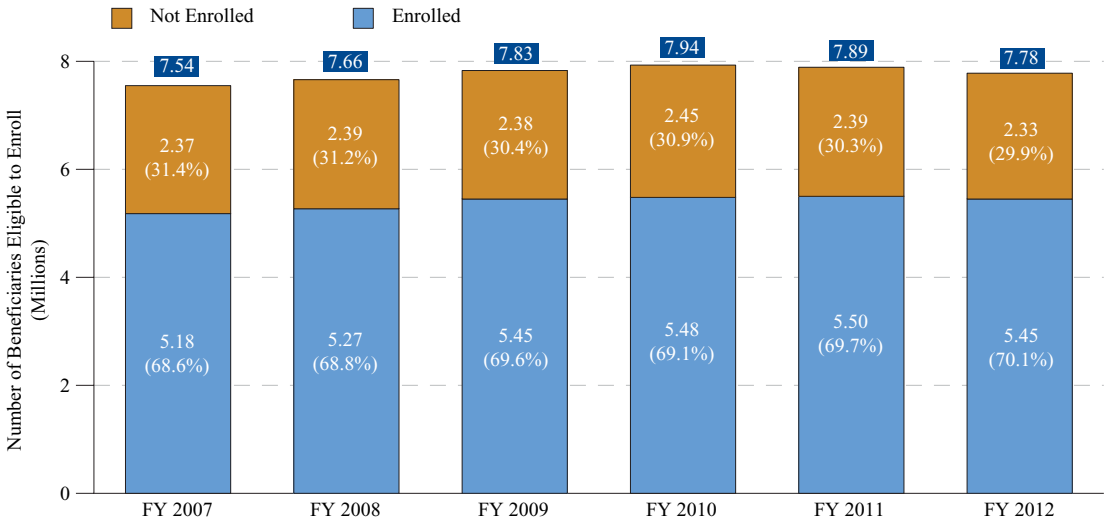
Eligibility and Enrollment in TRICARE Prime

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), TYA Prime, 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 Standard, and TRR are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- After peaking in FY 2011, the number of beneficiaries enrolled in TRICARE Prime dropped slightly in FY 2012. However, as a percentage of the beneficiary population, TRICARE Prime enrollment continues to increase.
- By the end of FY 2012, 70 percent of all eligible beneficiaries were enrolled (5.45 million enrolled of the 7.78 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS



Source: DEERS, 1/8/2013

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found in the Appendix, page 96.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

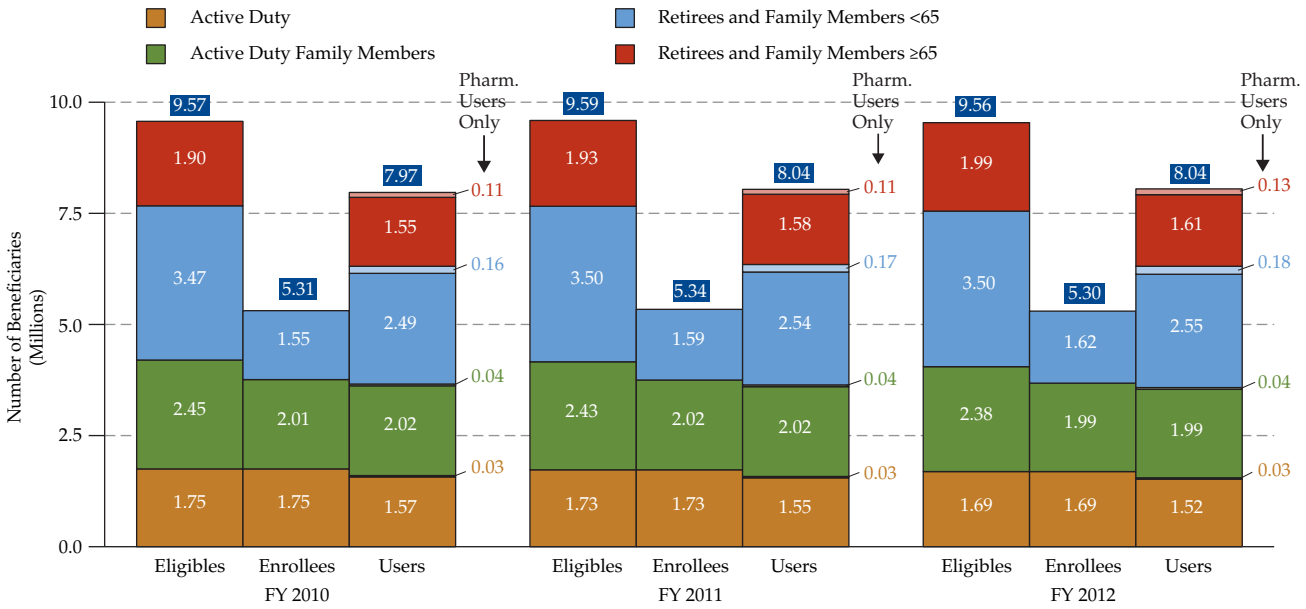
Recent Three-Year Trend in Eligibles, Enrollees, Users

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 2010 to FY 2012 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 declined by 3 percent between FY 2010 and FY 2012. The number of retirees and family members under age 65 increased by 1 percent, while the number of retirees and family members age 65 and older increased by 5 percent.
- The percentage of ADFMs enrolled in TRICARE Prime increased slightly, from 82 percent in FY 2010 to 84 percent in FY 2012. The percentage of retirees and family members under age 65 enrolled in Prime increased slightly from 45 to 46 percent.
- The overall user rate grew from 83.3 percent in FY 2010 to 84.1 percent in FY 2012. 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 constitute the greatest number of MHS users but have the lowest user rate. Their MHS user rate is lower because many of them have other health insurance (OHI).

AVERAGE NUMBERS OF FY 2010 TO FY 2012 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 1/8/2013

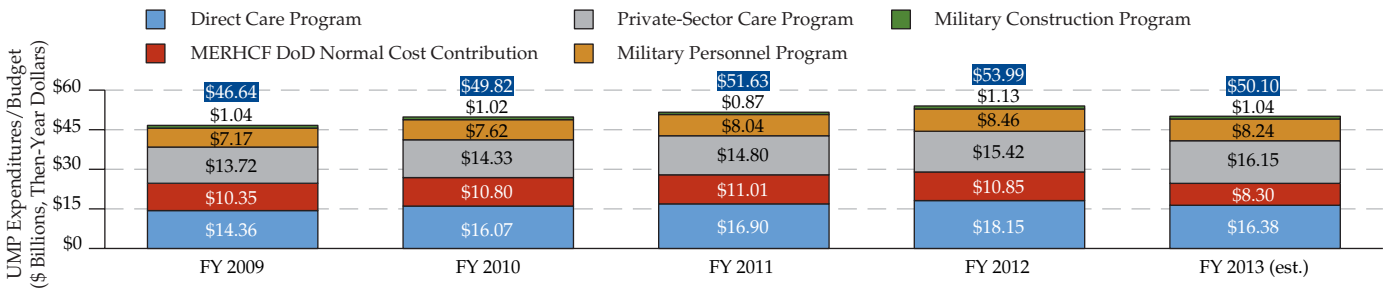
Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts, to account for beneficiaries who were eligible or enrolled for only part of a year.

UMP FUNDING

The UMP reached almost $54 billion in actual expenditures in FY 2012 (unadjusted, then-year dollars), for an 8.4 percent increase over the $49.82 billion FY 2010 UMP (first chart below). The UMP is currently programmed at about $50 billion (estimated) in the FY 2013 President's Budget, or 7.2 percent less than spent in FY 2012 and 0.6 percent higher than in FY 2010.

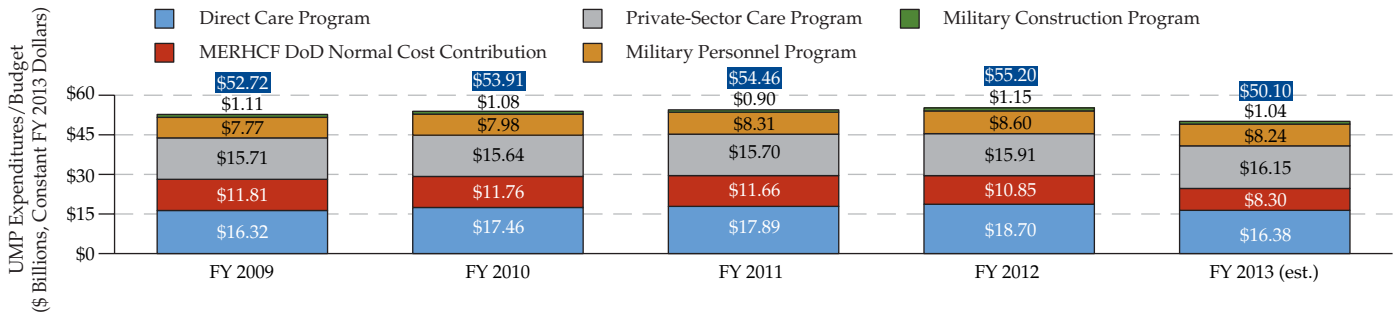
Although most of the $4.7 billion growth in total expenditures from FY 2010 to FY 2012 was due to the increase in MTF-based direct care and military personnel costs, the essentially flat level from FY 2010 to FY 2013 is due to a reduced Accrual Fund in FY 2012, and relatively flat overall outlay for direct care. The UMP shown includes the normal DoD cost contribution to the 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 2009 TO FY 2013 (EST.) UMP FUNDING ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



In constant FY 2013 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2013 $50 billion estimated budget in purchasing value is currently programmed to be about 7 percent less than in FY 2010, and over 9 percent less than in FY 2012.

FY 2009 TO FY 2013 (EST.) UMP FUNDING ($ BILLIONS) IN CONSTANT FY 2013 DOLLARS



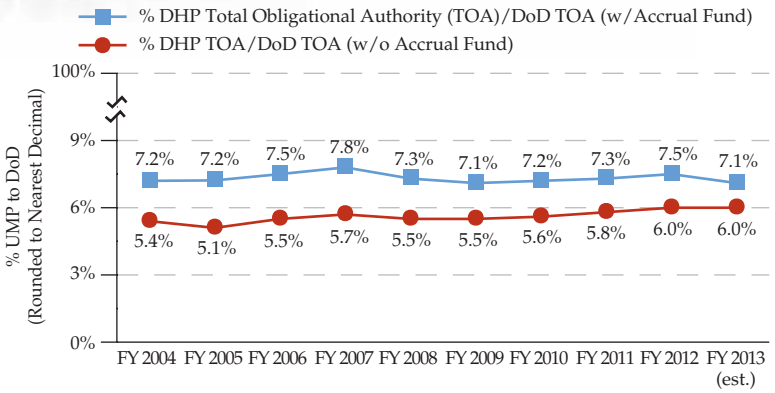
Source: Cost and budget estimates OASD(HA)/OCFO, 1/7/2013

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

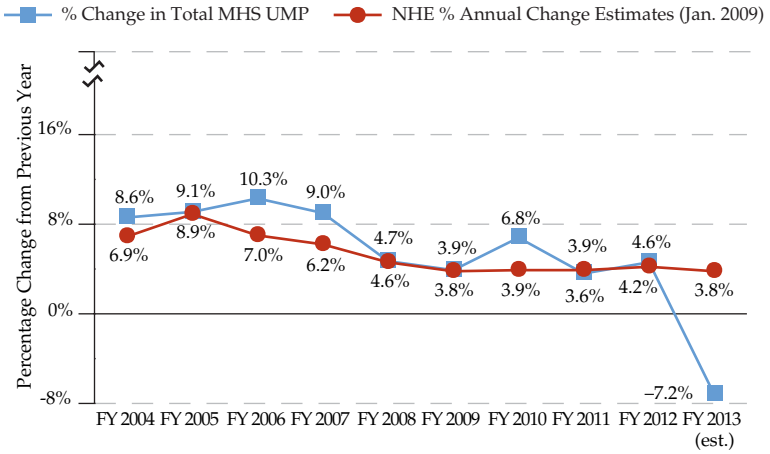
- The DoD MERHCF, also referred to herein as the "Accrual Fund," implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retirees, dependents of retirees, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased 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 2013: (1) The Accrual Fund ($8.3 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) $6.1 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) $9.5 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—$7.6 billion for purchased care, $1.9 billion for direct [MTF] care, both Operations and Maintenance [O&M; $1.4 billion] and Military Personnel costs [$0.5 billion]).
- FYs 2008–2012 reflect Comptroller Information System actual execution.
- Not shown directly, but FY 2007 actuals include supplemental funding ($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.
- FY 2008 actuals include $1.454 billion O&M supplemental funding in support of GWOT.
- FY 2009 actuals include Overseas Contingency Operations (OCO) and additional supplemental funding for O&M; Procurement; and Research, Development, Test, and Evaluation (RDT&E).
- FY 2010 current estimate includes O&M funding of $1.2567 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 (DHHS) for Pandemic Influenza Preparedness and Response.
- FY 2011 includes $1.4 billion OCO supplemental funding for O&M and $23.4 million in OCO funding for RDT&E.
- FY 2012 includes $1.2 billion OCO supplemental funding for O&M and reductions for DoD efficiency initiatives (FY 2012 OCO includes $452 million in Private Sector; $765 million in Direct Care).

UMP FUNDING *(CONT'D)*

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2013 (EST.)



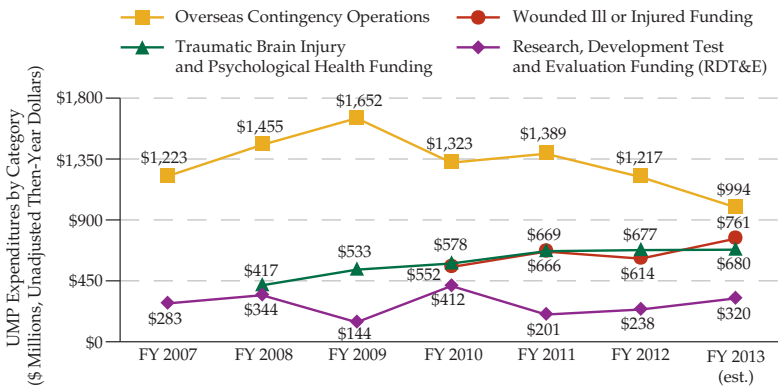
COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2004 TO FY 2013 (EST.)



Sources, as of 1/7/2013:

- CMS, Office of the Actuary, Table 1, National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2006–2021.
- *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2011PDF.pdf*, accessed 12/12/2012. The health spending projections were based on the NHE released in January 2012, updated to take into account the impacts of ACA and regulatory changes. Also reported in the *Washington Post*, January 8, 2013, p. A3.

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



Source: Cost and budget estimates OASD(HA)/OCFO, 12/12/2012

Notes:

- TBI and PH expenditures shown for FY 2008 include FY 2007 and FY 2006.
- 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, including the Accrual Fund, increased from 7.2 percent of total DoD outlays in FY 2010 to 7.5 percent in FY 2012, and are estimated to be 7.1 percent in FY 2013. As currently programmed, the UMP as a proportion of overall DoD expenditures appears consistent over time at between 7 and 8 percent. When the Accrual Fund is excluded, the DHP's share is expected to increase from 5.6 percent in FY 2010 to 6.0 percent estimated for FY 2013. This proportion may increase in the future to the extent that medical costs (i.e., the numerator) remain to care for returning forces or increase due to inflationary pressures and the Department's overall budget (i.e., the denominator) is constrained or reduced due to fiscal pressures and the return of operationally deployed forces.

Comparison of UMP and National Health Expenditures over Time

The Centers for Medicare and Medicaid Services (CMS) estimates that National Health Expenditures (NHE) reached $2.7 trillion in 2011, for an increase of 3.9 percent over 2011, the same rate as between 2009 and 2010, and near the historic low growth rate of 3.8 percent in 2009. DHHS estimates NHE expenditures will increase modestly in 2012 and 2013 (reaching $2.9 trillion), at 4.2 percent and 3.8 percent respectively, and then rise to 7.4 percent in 2014 (not shown) due to the major coverage expansion legislated by the Affordable Care Act (ACA; ref. source notes at left). 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 declined almost every year since, except for a spike in FY 2010. As noted in the middle chart at left, the estimated FY 2013 is currently programmed to be 7.22 percent less than FY 2012.

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

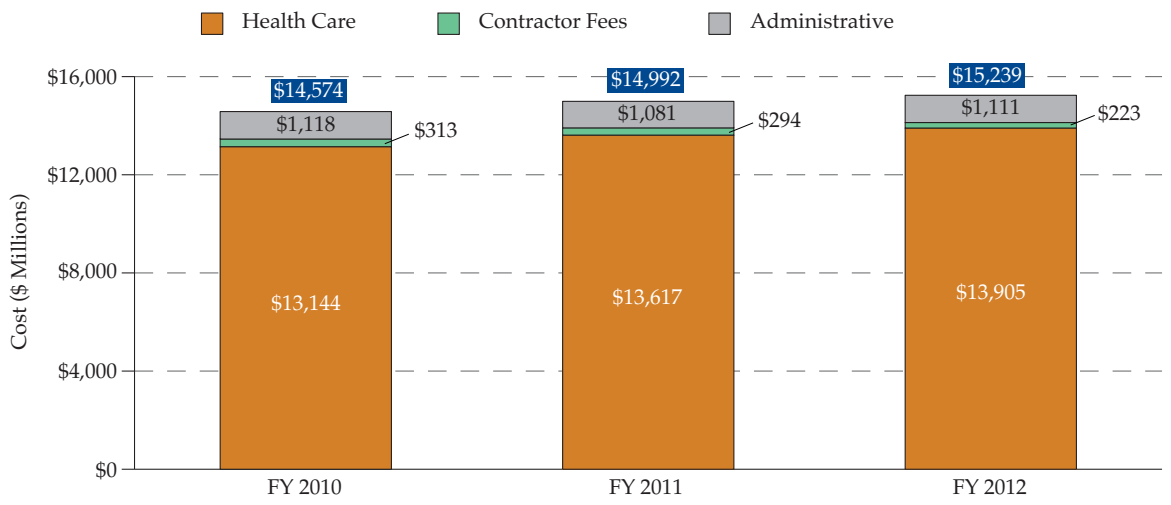
The graph at left reflects the total actual DHP funding for OCO and resultant care since FY 2007. Actual DHP expenditures declined from about $2.9 billion in FY 2011 to under $2.8 billion in FY 2011 and FY 2012. These overall expenses are the sum of OCO operations; care for traumatic brain injury; wounded, ill, or injured; and psychological health, as well as research and development shown as separate expense lines in the chart. These funds are within the DHP(O&M) funding line and are reflected in the earlier budget charts.

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 $14,574 million in FY 2010 to $15,239 million in FY 2012, an increase of less than 5 percent. Private-sector health care costs grew by 6 percent, whereas administrative costs remained about the same and contractor fees fell by 29 percent.
- Excluding contractor fees, administrative expenses decreased from 7.8 percent of total private-sector care costs in FY 2010 ($1,118 million of $14,261 million) to 7.4 percent in FY 2012 ($1,111 million of $15,016 million). Including contractor fees (in both administrative and total costs), administrative expenses decreased from 9.8 percent of total private-sector care costs in FY 2010 ($1,431 million of $14,574 million) to 8.8 percent in FY 2012 ($1,334 million of $15,239 million).
- Contractor fees decreased by 29 percent between FY 2010 and FY 2012. The decrease is a result of the shift to the new T3 contracts (North: April 1, 2011; South: April 1, 2012; West: April 1, 2013), which transitioned from incentive-based underwriting fees to lower fixed fees.

TREND IN PRIVATE-SECTOR CARE COSTS



Source: TMA, OCFO Private-Sector Care Requirements Office budget data execution and methodology, 11/5/2012

Note: The FY 2010, FY 2011, and FY 2012 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 2010, FY 2011, and FY 2012 amounts carried forward from the prior-year appropriation were $246 million, $276 million, and $297 million, respectively.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

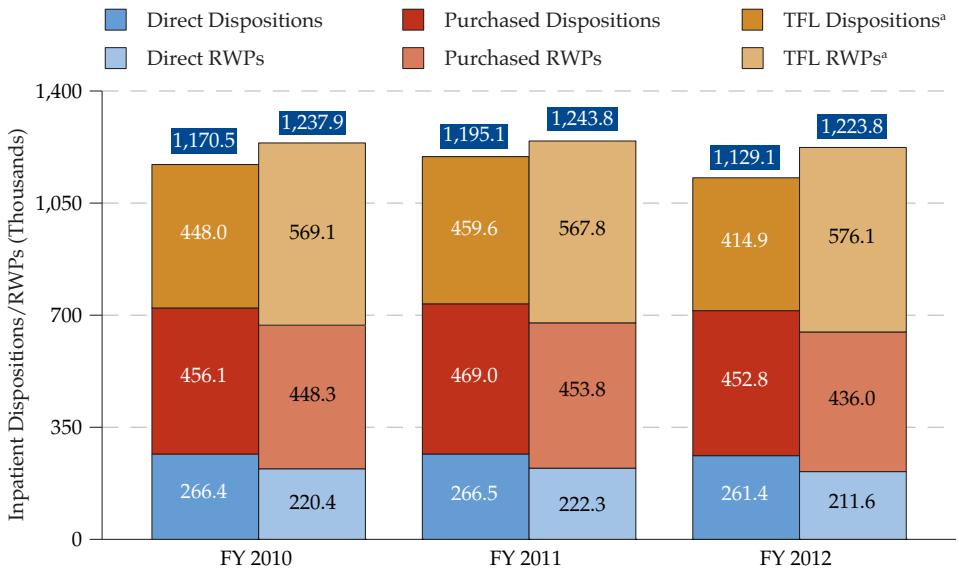
MHS Inpatient Workload

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 2010 to FY 2012.

Total inpatient dispositions (direct and purchased care combined) remained unchanged while RWPs declined by 3 percent between FY 2010 and FY 2012, excluding the effect of TFL.

- Direct care inpatient dispositions decreased by 2 percent and RWPs by 4 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions decreased by 1 percent and RWPs by 3 percent between FY 2010 and FY 2012.
- Including TFL workload, purchased care dispositions decreased by 4 percent and RWPs by 1 percent between FY 2010 and FY 2012.
- While not shown, about 8 percent of direct care inpatient dispositions and RWPs were performed abroad in FY 2012. 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, 1/24/2013

[a] Purchased care only

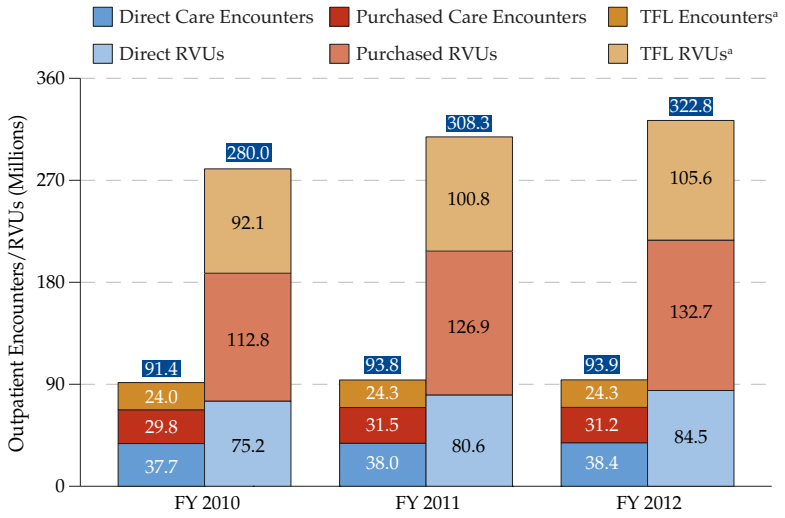
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT'D)*

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 2010 to FY 2012. 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.

Purchased care encounters were measured using a different methodology than in previous years' reports. Because encounters do not appear on purchased-care claims, they are calculated using a TMA-developed algorithm. The previous measure tended to overstate the number of "face-to face" encounters with physicians, so the number of encounters shown in this report are lower than those in previous years. RVU totals are unaffected by the change in methodology for calculating encounters.

TRENDS IN MHS OUTPATIENT WORKLOAD



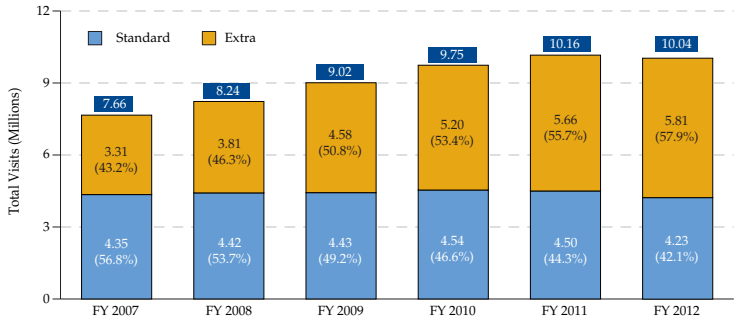
Source: MHS administrative data, 1/24/2013
[a] Purchased care only

- Total outpatient workload (direct and purchased care combined) increased between FY 2010 and FY 2012 (encounters increased by 3 percent and RVUs by 16 percent), excluding the effect of TFL.
- Direct care outpatient encounters increased by 2 percent and RVUs by 13 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters increased by 5 percent and RVUs by 18 percent. Including TFL workload, encounters increased by 3 percent and RVUs by 16 percent.
- Although 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 2007, Extra visits (calculated using the new methodology mentioned above) accounted for only 43 percent of all non-Prime visits. By FY 2009, the number of Extra visits exceeded the number of Standard visits for the first time (51 percent). In FY 2012, 58 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 49).

TRENDS IN EXTRA VS. STANDARD VISITS



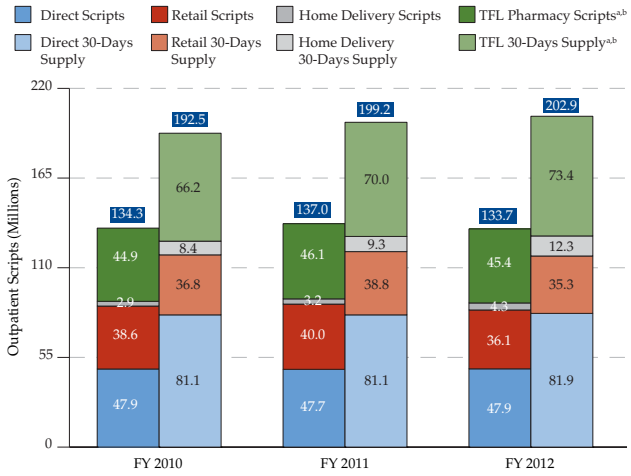
Source: MHS administrative data, 1/24/2013

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 2010 and FY 2012 (prescriptions decreased by 1 percent and days supply increased by 3 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/24/201

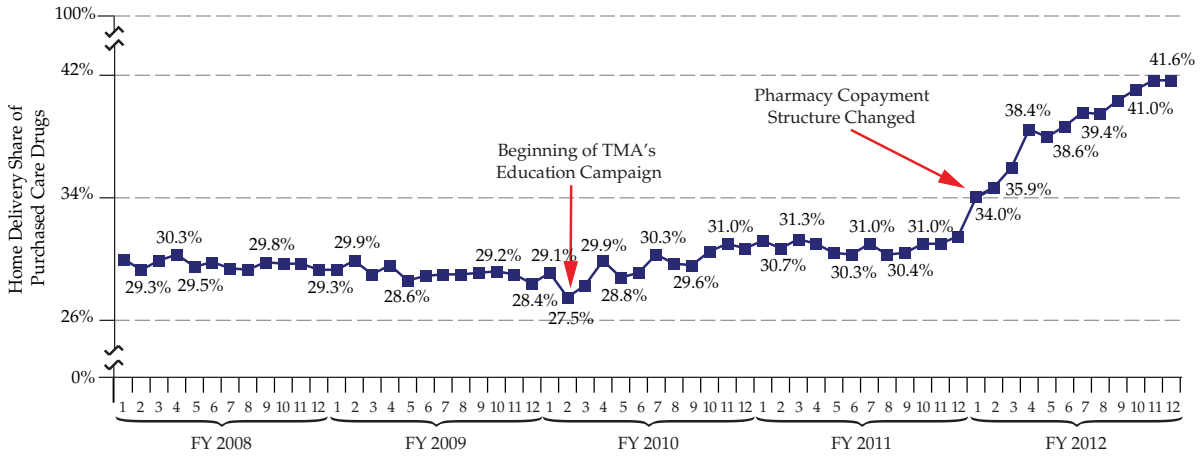
[a] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.
[b] Purchased care only Source: MHS administrative data, 1/24/2013

- Direct care prescriptions remained unchanged and days supply increased by 1 percent between FY 2010 and FY 2012.
- Purchased care prescriptions decreased by 3 percent and days supply increased by 5 percent from FY 2010 to FY 2012, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 1 percent and days supply increased by 9 percent. The discrepancy in trends between purchased care prescription counts and days supply is due to increased beneficiary utilization of home delivery services.
- While not shown, about 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for little more than 2 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, effective October 1, 2011, TRICARE eliminated home delivery beneficiary copayments for generic drugs while at the same time increasing retail pharmacy copayments.

The home delivery share of total purchased care utilization had been on the decline from the beginning of FY 2008 until November 2009, when TMA's education campaign began. The home delivery share then gradually increased through the beginning of FY 2012, when the pharmacy copayment structure was changed. Since that time, the home delivery share of purchased care pharmacy utilization has risen dramatically, increasing from 32 percent at the beginning of FY 2012 to 42 percent at the end.

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

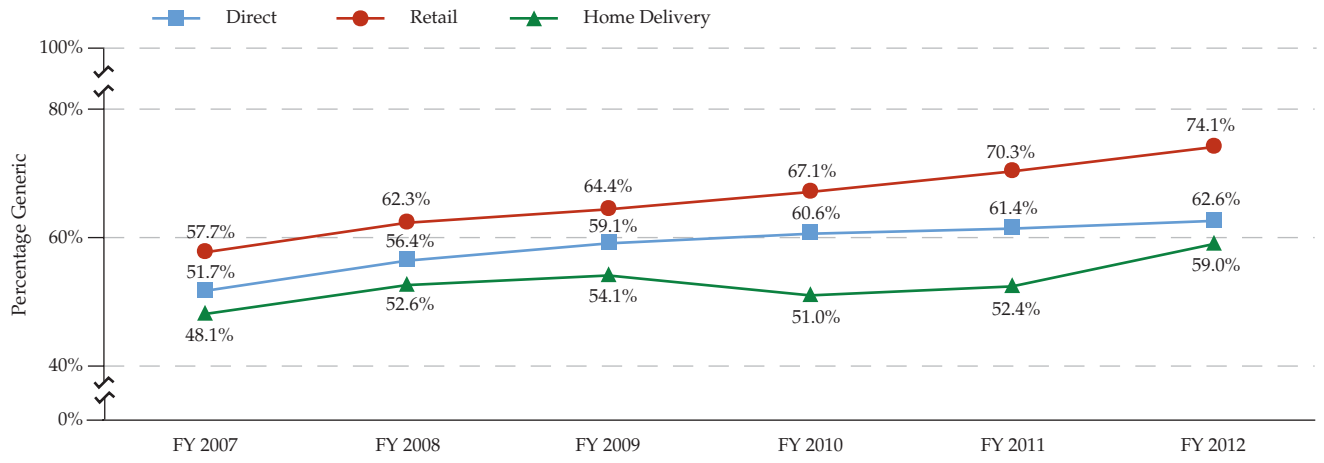


Source: MHS administrative data, 1/24/2013

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Retail pharmacies have seen the greatest increase, from 58 percent in FY 2007 to 74 percent in FY 2012.
- Although the rate of generic drug dispensing is increasing in MHS, it still lags the private sector. In 2011, approximately 78 percent of new and refilled private-sector prescriptions were filled with generics,[1] compared with 67 percent overall (direct plus retail) in MHS. The use of generics in lieu of brand-name drugs is expected to grow, since the patent protection of a sizable number of brand-name drugs will expire by 2015.
- The average cost for a 30-day supply of a brand versus generic drug in FY 2012 was: $44 versus $11 for direct care, $130 (net of manufacturer refunds) versus $20 for retail pharmacies, and $67 versus $9 for home delivery (costs are not adjusted for differences in drug types between brand and generic). Therefore, all other factors being equal, the trend toward greater generic drug dispensing is likely to lower DoD costs for prescription drugs.

TRENDS IN GENERIC DRUG DISPENSING

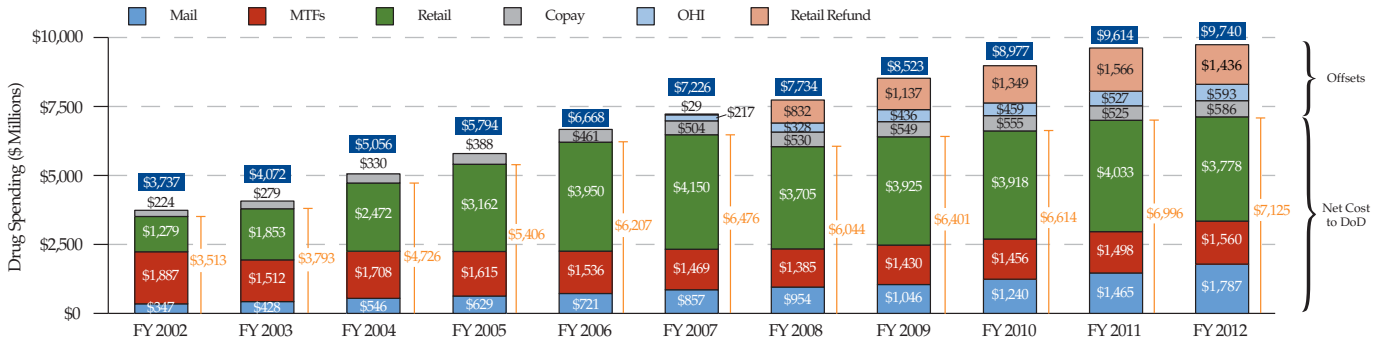


Source: MHS administrative data, 1/24/2013

The National Defense Authorization Act (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 refunds to DoD on most brand-name drugs beginning in FY 2008.

- Although total drug costs have consistently increased over the past decade, retail drug refunds have stemmed the increase in the cost to DoD. In FY 2012, the refunds are estimated to have saved DoD $1.4 billion. Net DoD costs are only 10 percent higher than they were in FY 2007.

MHS DRUG SPENDING



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; TMA Pharmacy Operations Directorate (POD) (refunds), 12/18/2012

Note: Net cost to DoD represents total prescription expenditures minus copays, coverage by OHI, and retail refunds invoiced. OHI and copayment amounts are slightly understated due to using PDTS as source.

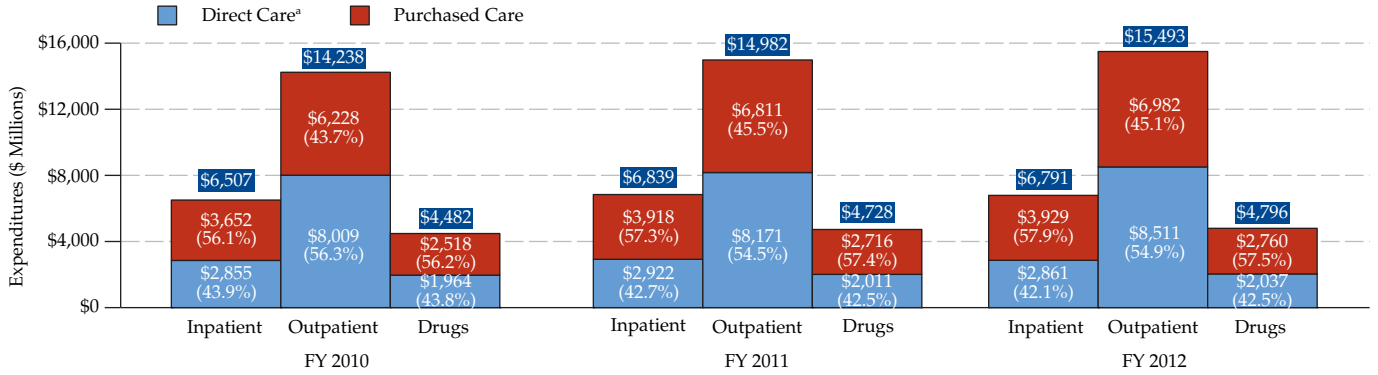
[1] Pal, S. 2012. "Trends in Generic Drugs." *U.S. Pharmacist (Generic Drug Review Supplement)* 37 (6): 8–10.

MHS COST TRENDS

Total MHS costs (excluding MERHCF) increased between FY 2010 and FY 2012 for all medical services (inpatient costs increased from FY 2010 to FY 2011 but then dropped slightly in FY 2012). The proportion of total MHS costs accounted for by each medical service remained about the same over that period of time. Overall, direct care costs increased by 5 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 about 69–70 percent from FY 2010 to FY 2012. For example, in FY 2012, DoD expenses for inpatient and outpatient care totaled $22,283 million, of which $15,493 million was for outpatient care, for a ratio of $15,493/$22,283 = 70 percent.
- Purchased care drug costs shown below include manufacturer refunds for retail name brand drugs.
- Increases in purchased care outpatient costs were eased by TRICARE's implementation of the Outpatient Prospective Payment System (OPPS) in May 2009. OPPS aligns TRICARE with current Medicare rates for reimbursement of hospital outpatient services. TMA/OCFO-DHCAPE estimates that OPPS reduced health care costs for TRICARE by about $2.4 billion between FY 2010 and FY 2012 (FY 2010: $715 million, FY 2011: $800 million, FY 2012: $840 million).
- In FY 2012, DoD spent $2.28 on outpatient care for every $1 spent on inpatient care.

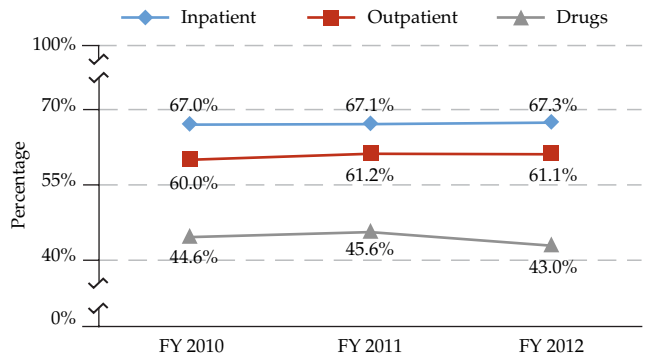
TREND IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF)



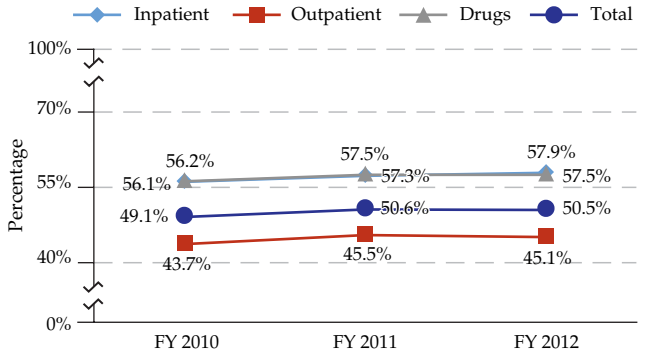
Source: MHS administrative data, 1/24/2013
[a] Direct care prescription costs include an MHS-derived dispensing fee.

- The purchased care shares of MHS inpatient and outpatient utilization increased slightly from FY 2010 to FY 2012. However, after increasing from FY 2010 to FY 2011, the purchased care share of prescription drug utilization declined in FY 2012. This is the first time in many years that the purchased care share for any medical service has shown a decline.
- The purchased care share of total MHS costs increased slightly between FY 2010 and FY 2012 for inpatient, outpatient, and prescription drug services. Even with manufacturer refunds for retail brand-name drugs and a decline in purchased care prescription drug utilization, the purchased care share of total prescription drug costs increased.

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, 1/24/2013

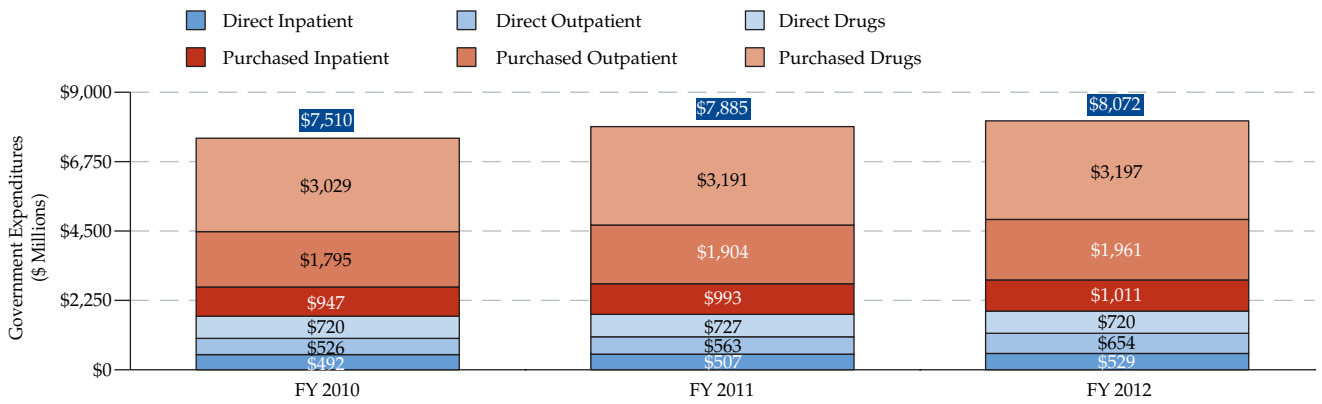
MHS COST TRENDS *(CONT'D)*

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 $7,510 million in FY 2010 to $8,072 million in FY 2012 (7 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

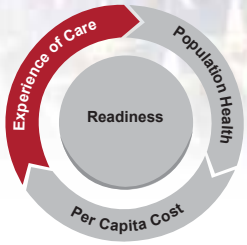
- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 9 percent from FY 2010 to FY 2012. The increase was due largely to outpatient expenses, which grew by 24 percent. Direct inpatient expenses declined by 8 percent while prescription drug expenses remained the same.
  - In FY 2010, TRICARE Plus enrollees accounted for 68 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. By FY 2012, the TRICARE Plus share had grown to 71 percent.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 51 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2010. That figure rose to 55 percent in FY 2012.
- Total purchased care MERHCF expenditures increased by 7 percent from FY 2010 to FY 2012. Inpatient expenditures rose by 7 percent, outpatient expenditures by 9 percent, and prescription drug expenditures by 6 percent.

MERHCF EXPENDITURES FROM FY 2010 TO FY 2012 BY TYPE OF SERVICE



Source: MHS administrative data, 1/24/2013

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: (1) patient safety; (2) beneficiary self-reported access to, and experience with, MHS care in general and following inpatient or outpatient treatment; (3) special programs such as TRICARE Young Adult (TYA), TRICARE for Life (TFL), and children with special needs; (4) civilian provider participation in TRICARE; (5) customer service and claims processing; (6) dental care; (7) experience of wounded, ill, or injured Service members post-deployment; and (8) MHS hospital performance in national quality measures.

Patient-Centered Medical Home

In fiscal year (FY) 2012, 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 team and PCM work with the patient to identify and resolve underlying causes of disease in order to improve the patient's overall health. 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.

In accordance with Service instructions, the Uniformed Services continued implementing and training personnel at their military treatment facilities (MTFs).[1, 2, 3] In addition to primary care practices meeting the eight MHS PCMH criteria, mature PCMH practices were selected by their respective Service to seek formal recognition by the National Center for Quality Assurance (NCQA). MHS selected NCQA to recognize all primary care practices in order to drive consistent application of PCMH principles across the enterprise.

- In calendar year (CY) 2011, 47 practices were formally recognized by NCQA; 46 practices were recognized as Level 3 PCMHs, NCQA's highest rating.
- In CY 2012, the MHS accelerated PCMH implementation and NCQA recognition, with over 125 practices seeking formal recognition. In CY 2012, as of early December 2012, 37 practices have been recognized; the remaining practices are awaiting recognition decisions by NCQA. By December 31, 2012, MHS projects that 40 percent of all primary care practices will be NCQA Recognized Level 2 or 3 PCMHs. Over 1.9 million MTF Prime beneficiaries are enrolled in these practices.
- MHS will continue its accelerated PCMH implementation and NCQA recognition programs in 2013; over 130 primary care practices are expected to seek recognition. In FY 2012, TMA PCMH Division supported the NCQA recognition process by providing seven regional MHS NCQA and PCMH training sessions, where over 900 personnel received guidance. In addition, TMA PCMH developed a new, more detailed MHS Guide to Recognition with validated MHS Level 3 examples for reaching NCQA standards as well as a checklist of required documentation. TMA PCMH also established a staff-focused MHS PCMH Facebook page and added informational threads on milSuite. Finally, TMA PCMH established a suite of secure pages on *max.gov* on best practices, NCQA recognition, strategy, Information Technology (IT) tools, performance measures, and other information to provide assistance and transparency to MHS primary care practices.

The MHS's 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) and Tri-Service PCMH Working Group (WG) with representatives from each Service, the Coast Guard, and TMA experts in key functional areas; both the PCMH AB and PCMH WG are held monthly. In order to maintain momentum and accountability, no PCMH AB or WG has been canceled in 26 months.

[1] Army OPORD 11-20, Patient-Centered Medical Home, January 2011

[2] BUMED Instruction 6300.19, Primary Care Services in Navy Medicine, 5/26/2010

[3] Air Force Instruction 44-171, Patient-Centered Medical Home and Family Health Operations, 1/18/2011

PROVIDING A CARE EXPERIENCE THAT IS PATIENT- AND FAMILY-CENTERED, COMPASSIONATE, CONVENIENT, EQUITABLE, SAFE, AND OF THE HIGHEST QUALITY *(CONT'D)*

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 Measures.

- The PCMH IM/IT working group focuses on identifying and implementing emerging technologies (such as secure messaging) as well as modifying and enhancing existing MHS business intelligence tools (such as electronic health records, TRICARE Online, and the CarePoint Population Health Portal), to increase the usefulness of these tools in the PCMH model of care. Most notably, the PCMH IM/IT working group developed 17 Patient-Centered High Level Functional Requirements (HLFRs) and gained approval from both the PCMH and IM/IT formal governance processes; PCMH HLFRs were the first functional requirements developed and implemented into MHS strategy.
- 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.
- In partnership with Defense Health Cost Assessment and Program Evaluation (DHCAPE), the Staff Satisfaction working group implemented MHS's first primary care staff satisfaction survey in September 2011 and fielded the survey again in March 2012. Based on feedback from the survey, it was shortened dramatically to focus on the most actionable, important questions. In November 2012, the primary care staff satisfaction survey achieved a 45 percent response rate from over 13,000 MHS primary care personnel; this unprecedented response rate in only 21 days was achieved by pushing the survey out to the MTFs through formal chains of command and by the many modes of communication developed by TMA PCMH including Facebook, milSuite, direct e-mails to primary care personnel, and *max.gov*.
- PCMH care components also are monitored for those enrollees seeking care in the network, through the PSC working group. The working group, consisting of the TRICARE Regional Office and TMA representatives, monitors PCMH recognition of providers with whom TRICARE beneficiaries are enrolled, evaluates demonstration opportunities, and analyzes required care components, especially for high utilizer and chronically ill beneficiaries.
- Finally, the Performance Measures 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 (PMPM) cost growth, and many Healthcare Effectiveness Data and Information Set (HEDIS) and other quality measures. The Performance Measure working group identifies best practices and then proliferates these validated processes across the MHS to improve overall performance. Analysis and evaluation of mature MHS PCMH practices have demonstrated improvements in PCM continuity and access to acute and routine appointments, emergency department utilization, primary care leakage, PMPM cost growth, and patient satisfaction. Performance tracking continues with assistance from key areas in TMA, including the Office of Strategy Management, DHCAPE, and the TRICARE Operations Center. Performance is reported to the Office of the Chief Financial Officer, where it is tied to PCMH Program Objective Memoranda funding for FYs 2012–2016. PCMH implementation and sustainment is one of the 11 MHS Personnel and Readiness Portfolio of Initiatives.

In April 2012, the Government Accountability Office reported that PCMH was the only one of 11 MHS initiatives that had completed and approved a detailed implementation plan, including a cost savings estimate.[1] To enhance PCMH implementation and sustainment, the Tri-Service PCMH AB approved seven new Strategic Priorities in October 2012. These include implementation of a clinical and business information dashboard at the provider level, PCMH Optimization and Sustainment training, staff realignment, patient-centered enrollment and call policies, Health Services research capability, and market research and analysis capability. Action plans are under development to drive implementation of these strategic priorities.

[1] GAO12-224, April 2012, "Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System"

PATIENT SAFETY IN THE MHS

Military Health System's patient safety aims to prevent harm to patients through evidence-based system and process improvements. In the MHS Direct Care system, patient safety focuses efforts to guide improvements targeting opportunities identified through reported patient safety events.

Patient Safety Reporting

FY 2012 marked the first complete year after full implementation of the Patient Safety Reporting System (PSR) across the MHS direct care system. From near misses to events resulting in patient harm, PSR automated the previous unstructured paper-based reporting process into a standardized, anonymous, Web-based reporting system. PSR data can be analyzed to identify trends and share lessons throughout the MHS direct care system. The table below shows patient event reporting stratified by harm.

HARM STRATIFICATION OF REPORTED PATIENT SAFETY EVENTS, FYs 2005–2012

HARM STRATIFICATION	2005		2006		2007		2008		2009		2010		2011		2012	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Events Did Not Reach Patient, Near Miss	114,370	71.9%	119,615	75.7%	124,868	78.0%	127,429	74.4%	140,257	80.0%	125,802	73.8%	96,925	65.1%	131,927	68.2%
Events Reached Patient, No Harm	40,215	25.3%	34,934	22.1%	31,519	19.7%	38,265	22.3%	32,746	18.7%	41,426	24.3%	46,913	31.5%	54,267	28.0%
Events Reached Patient, Harm	4,482	2.8%	3,478	2.2%	3,698	2.3%	5,672	3.3%	2,255	1.3%	3,187	1.9%	4,968	3.3%	7,361	3.8%
Total	159,067	100.0%	158,027	100.0%	160,085	100.0%	171,366	100.0%	175,258	100.0%	170,415	100.0%	148,806	100.0%	193,555	100.0%

Source: OASD(HA), Office of the Chief Medical Officer, 12/19/2012

- From FY 2005 to FY 2012, reported patient safety events maintained an upward trend. During the transition to PSR, spanning FYs 2010–2011, reporting-pattern changes were anticipated and observed. FY 2012-reported events increased by 30 percent from FY 2011. Compared with prior years, the total events reported in FY 2012 remained higher.
- In FY 2012, near-miss reporting accounted for 68.2 percent of total reported events, while harm events constituted 3.8 percent. In FY 2012, near-miss reports increased by 36 percent and harm event reports increased by 48 percent over FY 2011 reporting levels. Consistent with previous years, near misses composed the large majority of events reported in FY 2012. Patient safety encourages near-miss reporting in order to proactively address opportunities before patients are involved (events reached patient, no harm) or harmed (events reached patient, harm).

In addition to events reported, patient safety receives root cause analyses (RCAs) submitted by MTFs. Of the RCAs received from FYs 2005–2012,[1] the associated leading event categories included: Wrong Site/Person/Procedure Surgery, Unintended Retention of Foreign Object, Delay in Treatment, Operative/Post-Operative Complication, and Perinatal Death/Loss of Function. Patient safety reviews the RCAs and determines appropriate mechanisms to communicate lessons and trends or recommended actions. The mechanisms include recommending enterprisewide system/process redesign, issuing patient safety notices, recommending new policies, as well as offering focused training or education.

[1] RCAs submitted as of 12/18/2012 for RCAs completed through 9/30/2012.

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

Training and Education to Improve Performance and Patient Safety

Breakdowns in staff-to-staff communication remain frequently cited as a factor contributing to patient safety events. Patient safety offers resources and solutions to improve communication techniques among health care teams: 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 2012, two of the three Services mandated TeamSTEPPS training as an initiative to improve patient safety. The third implements the program based on MTF readiness.

Patient Safety Managers (PSMs) serve as local champions within MTFs. Patient safety conducts a Basic Patient Safety Manager course, to provide new PSMs with standardized knowledge, skills, and tools to implement patient safety initiatives at MTFs. Following the course, patient safety conducts post-course coaching sessions at three, six, and 12 months to assess progress. PSMs report nearly 100 percent confidence in understanding their patient safety roles and responsibilities and the expected impact of their activities on patient safety at their organization.

After TeamSTEPPS training, 87 percent of trainees report confidence in their ability to clearly and accurately communicate with team members compared to 54 percent prior to training.

83 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 of 2011, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs and Director, TRICARE Management Activity, signed a pledge on behalf of MHS to support the Partnership for Patients (PfP) initiative, a nationwide effort to make health care safer, more reliable, and less costly by decreasing preventable patient harm.

MHS pledged to attain the aims of PfP by building on work already underway and supporting local initiatives to improve the quality of care. As a system, MHS committed to lead, learn from, and partner with other organizations to drive the improvements and implementation of evidence-based practices (EBPs). The goal is to reduce by 40 percent preventable hospital-acquired conditions in nine identified areas and to facilitate better care transitions to reduce hospital readmissions by 20 percent by the end of 2013.

To carry out PfP aims, patient safety coordinated with leadership across the MHS direct care system to develop an operational plan. The resulting plan includes a comprehensive educational and improvement strategy, incorporating an internal collaborative where champions in the field share successes and opportunities with others to implement the EBPs. The plan also includes a strategy for tracking the overall progress and success of the initiative at multiple levels.

FY 2013 patient safety efforts will focus on supporting MTFs and Services in EBP implementation, tracking progress achieved, and analyzing the associated data to guide improvement efforts. The PfP initiative and its aims will serve as a springboard to other future comprehensive patient safety initiatives.

PARTNERSHIP FOR PATIENTS: FOCUSED AREAS

Adverse Drug Events	Catheter Associated Urinary Tract Infection
Central Line Blood Stream Infections	Falls
Obstetrical Adverse Events	Pressure Ulcers
Preventable Readmissions	Surgical Site Infections
Ventilator Associated Pneumonia	Venous Thromboembolism Prevention

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

Advancing a Culture of Patient Safety

The Institute of Medicine stated that, "Improvements in patient safety are best achieved when health care delivery organizations adopt a culture of safety."[1] To assess the culture of safety across the MHS direct care system, patient safety collects data from staff surveys on patient safety culture. In FY 2012, the DoD Tri-Service Survey on Patient Safety (Culture Survey), sponsored by TMA, was administered to all staff across MHS direct care. Results of the 2011 Culture Survey are forthcoming in FY 2013 and will convey staff perceptions on areas essential to advancing a culture of safety, including reporting errors, communicating feedback on errors, learning from errors, working in teams, handling care transitions, and engendering management support for patient safety.

Patient Safety in the Purchased Care System

All TRICARE contractors continue to monitor their networks using the National Quality Forum Serious Reportable Events criteria and to analyze administrative data using the Agency for Healthcare Research and Quality (AHRQ) indicators. Occurrences are thoroughly investigated. Findings regarding the standard of care in a facility or by a provider are tracked and used in the recredentialing process. The AHRQ indicators also form the basis for several PfP initiatives to reduce hospital-acquired conditions.

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:

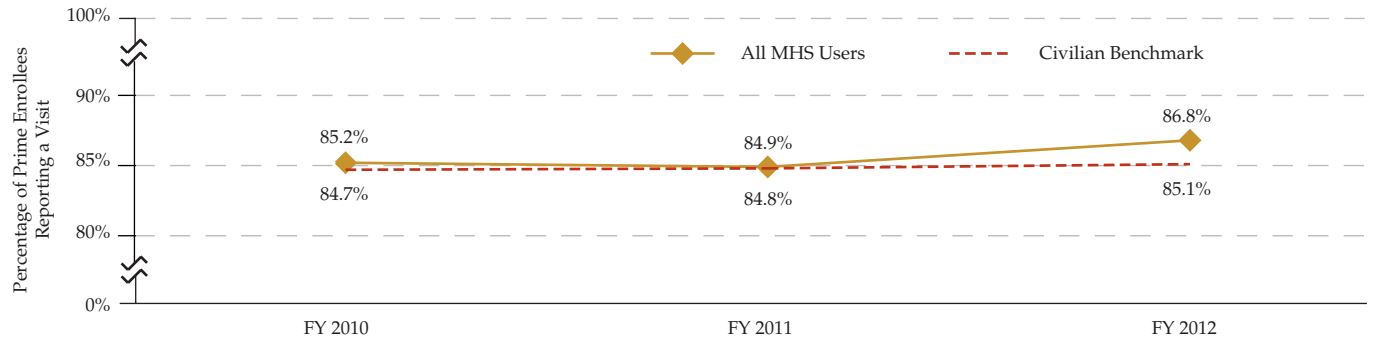
- Access based on reported use of the health care system in general
- Availability and ease of obtaining care and communicating with providers
- Responsive customer service
- Quality and timeliness of claims processing

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 nearly 87 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit in FY 2012.
- The MHS Prime enrollee rate equaled the civilian benchmark in FYs 2010 and 2011 and exceeded it in FY 2012.

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



Note: DoD data were derived from the FYs 2010–2012 Health Care Survey of DoD Beneficiaries (HCSDB), as of 12/14/2012, 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 Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the National CAHPS Benchmarking Database (NCBD). Benchmarks used in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 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.

[1] Institute of Medicine. *Patient Safety: Achieving a New Standard of Care.* Washington, DC: National Academies Press, 2004.

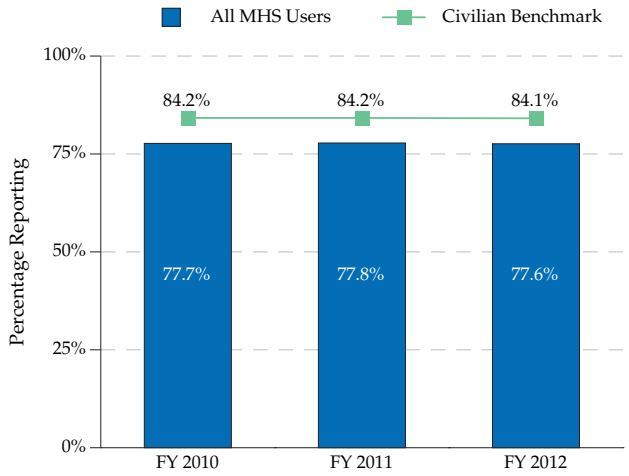
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

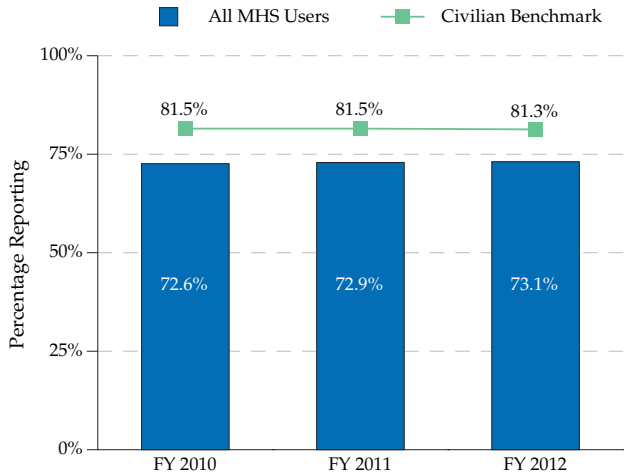
Availability and Ease of Obtaining Care

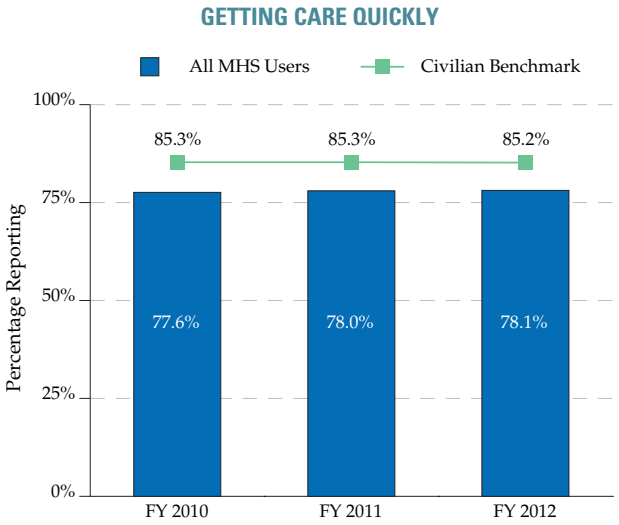
Availability and ease of obtaining care can be characterized by the ability of beneficiaries to obtain the care they need when they need it. Two major measures of access within the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey—getting needed care and getting care quickly—address 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.

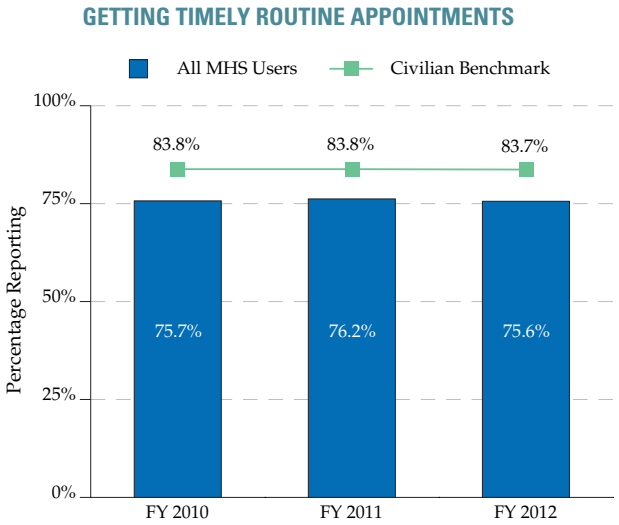
- MHS beneficiary ratings for getting needed care (composite) and problems getting an appointment with specialists remained stable over the three-year period, but continued to lag the civilian benchmark, which also remained stable during this period.
- MHS beneficiary ratings for getting care quickly (composite) and waiting for a routine visit also continued to lag the civilian benchmark between FY 2010 and FY 2012.

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









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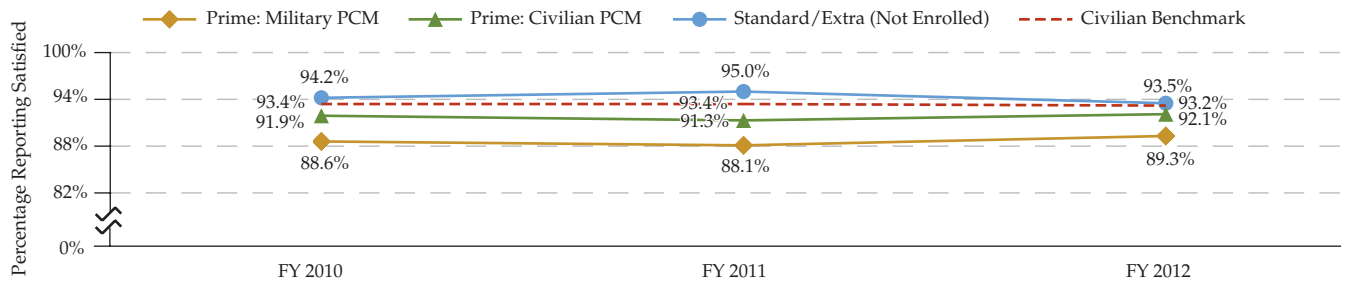
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

Satisfaction with Doctors' Communication

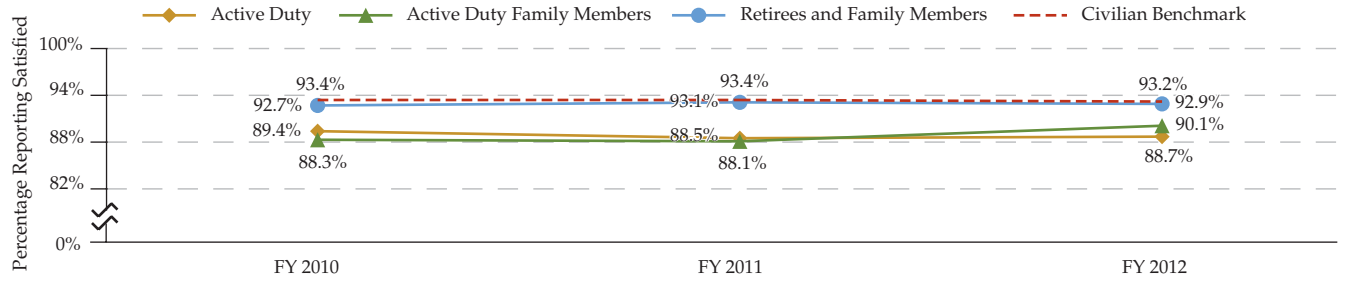
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Satisfaction levels with doctors' communication for Prime enrollees remained stable between FY 2010 and FY 2012. Satisfaction levels of Prime enrollees with military PCMs lagged the civilian benchmark, while Prime enrollees with civilian PCMs equaled the civilian benchmarks (no statistically significant difference).
- Satisfaction levels of Active Duty and Active Duty Family members lagged the civilian benchmarks in FY 2010 through FY 2012.
- Satisfaction levels of retirees and families equaled the civilian benchmarks (no statistically significant difference) in FYs 2011 and 2012.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY



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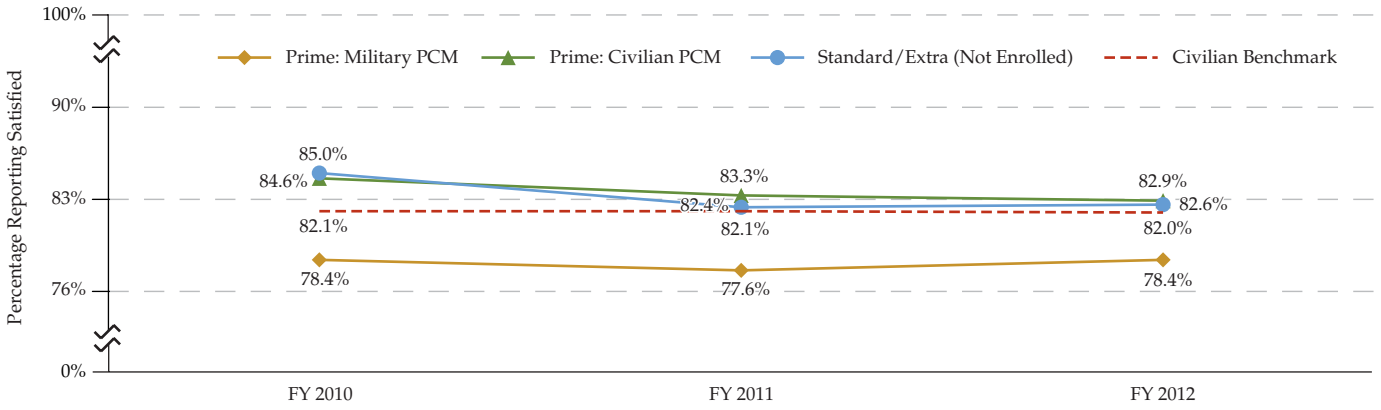
CUSTOMER SERVICE

Satisfaction with Customer Service

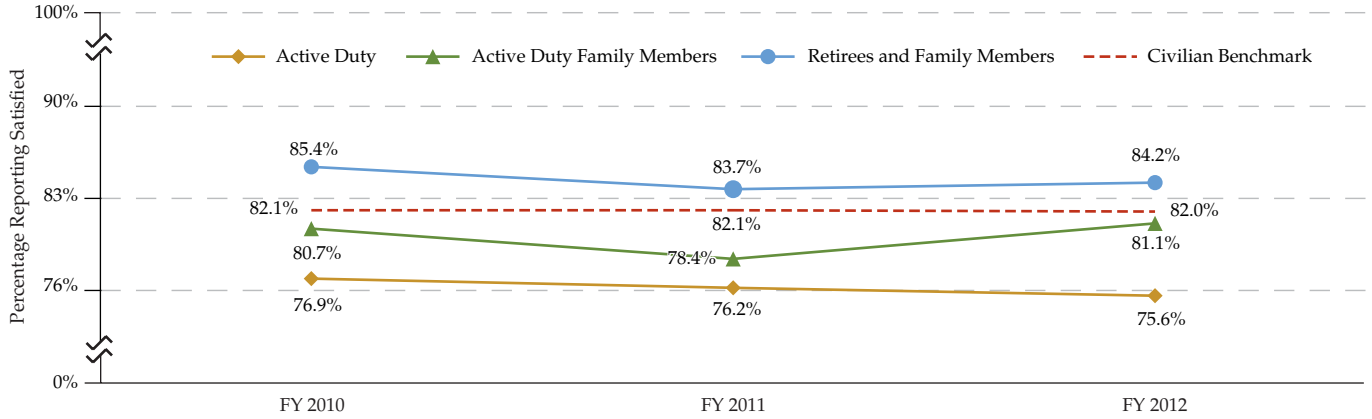
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service in terms of understanding written materials, getting customer assistance, and dealing with paperwork remained stable between FY 2010 and FY 2012 (no statistically significant change). The civilian benchmark also remained stable over this period.
- MHS enrollees with civilian PCMs and non-enrollees reported levels of satisfaction comparable to the civilian benchmark in FY 2011 and FY 2012. Enrollees with military PCMs lagged the civilian benchmark in all three years.
- Satisfaction levels for Active Duty lagged the benchmark for all three years. The satisfaction level of Active Duty Family members was comparable to the civilian benchmark in FY 2012. Retirees' satisfaction levels met or exceeded the benchmark in all three years.

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



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



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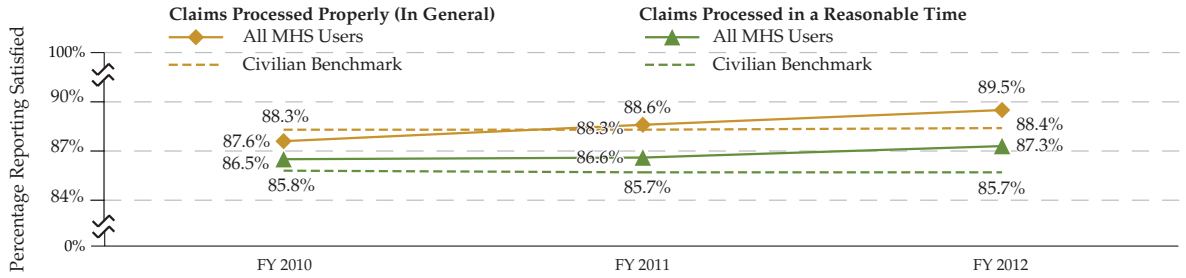
CLAIMS PROCESSING

Claims processing is of interest for beneficiaries as well as their providers, particularly the promptness of processing and accuracy of claims and payment. MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking. The overall number of claims processed decreased by 0.7 percent from 194.8 million claims in FY 2011 to 193.5 million in FY 2012, and can be attributed to the shift from retail to home delivery prescriptions.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed accurately increased from FY 2010 to FY 2012. Satisfaction with processing in a reasonable period of time remained stable between FY 2010 and FY 2012.
- MHS satisfaction levels for claims processed properly exceeded the civilian benchmark in FY 2012 and were comparable (i.e., not statistically significantly different) in FYs 2010 and 2011.
- Satisfaction levels for claims processed in a reasonable period of time exceeded the civilian benchmark in FY 2012.

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



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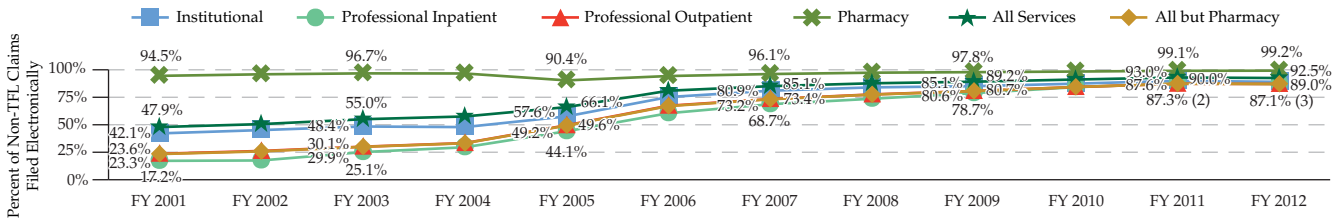
Trends in Electronic Claims Filing

TRICARE continues to work with providers and claims processing contractors to increase the processing of claims electronically, rather than by 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 health care support contractors to improve the use of electronic claims processing.

- The percentage of non-TFL claims processed electronically for all services appears to have hit a plateau at 92.5 percent in FY 2012, down 0.5 percentage points from the previous year. Pharmacy claims are almost entirely electronic, reaching 99.2 percent in FY 2012. The slight decrease in electronic claims remains in the other categories reflected individually below, as well as in the "All but Pharmacy" trend line with 87.1 percent in 2012 (the individual categories below are institutional and professional inpatient and outpatient services). Although not depicted on the chart below, 29.9 percent of the "All but Pharmacy" paper claims were paid at least partially by other health insurance (OHI). Also, 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 the program.

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



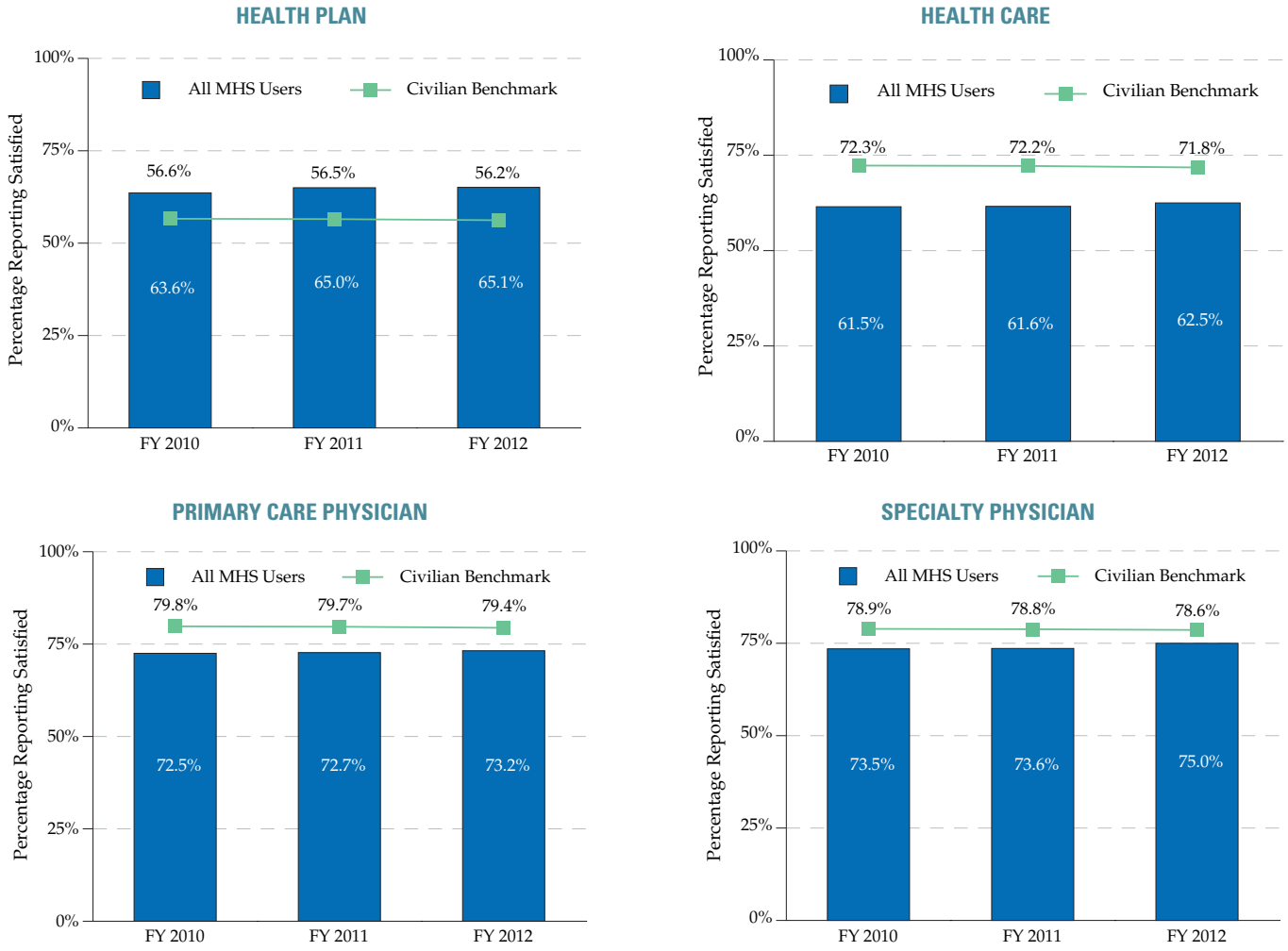
Source: MHS Administrative data, 11/08/2012
Note: Foreign claims are excluded. The "Professional Outpatient" line is hidden behind that of "All but Pharmacy" because their data points are almost equivalent. For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

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 specialty care increased between FY 2010 and FY 2012. Satisfaction levels with primary care and health care quality 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



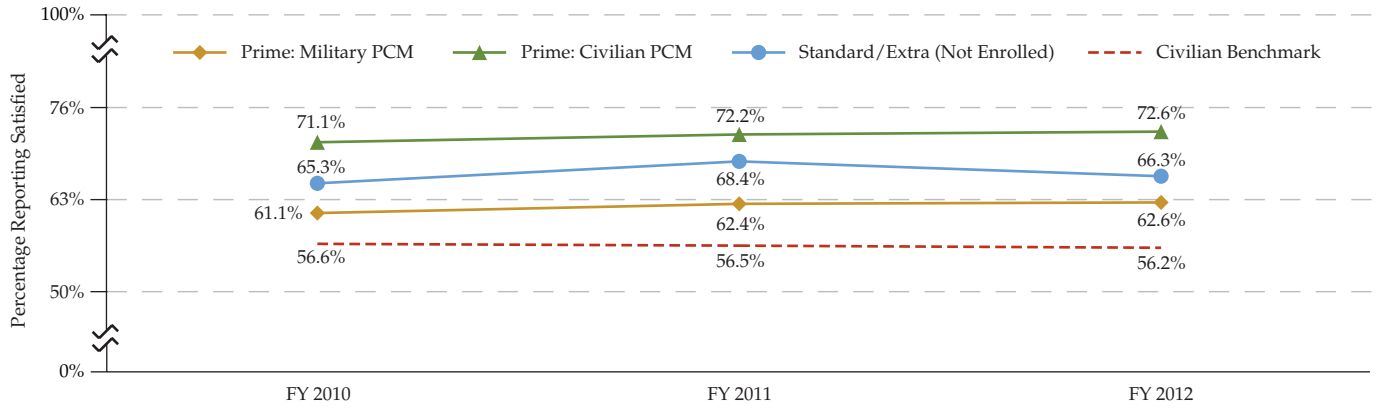
Note: DoD data were derived from the FYs 2010–2012 HCSDB, as of 12/14/2012, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 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.

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 remained stable for Prime enrollees and non-enrollees from FY 2010 to FY 2012. The civilian benchmark also remained stable.
- During each of the past three years (FY 2010 to FY 2012), enrolled and non-enrolled MHS beneficiaries reported higher levels of satisfaction than their civilian counterparts.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

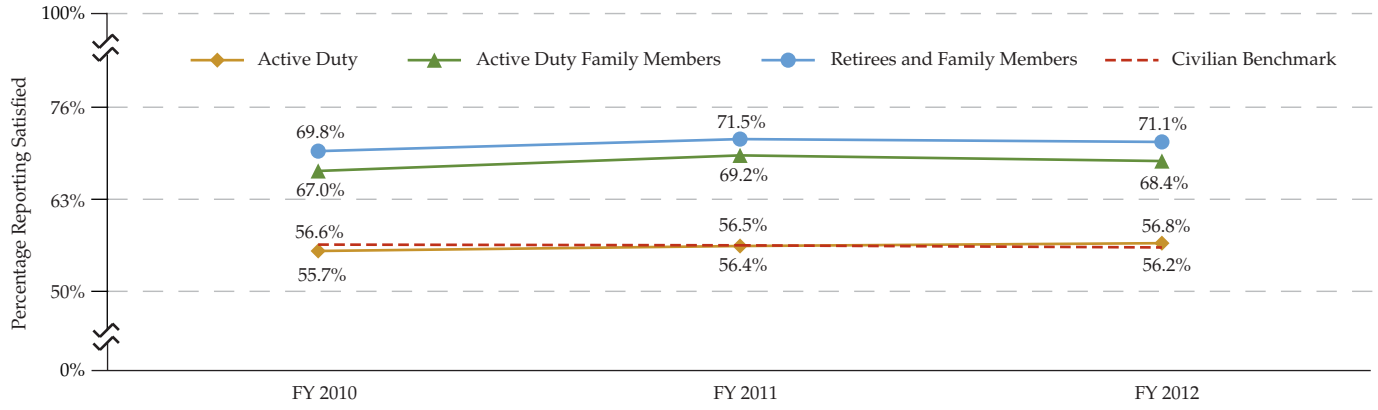


SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

- Satisfaction of Active Duty beneficiaries equaled the civilian benchmark in all three years (FYs 2010–2012).
- ADFM and retirees and family member satisfaction ratings exceeded the civilian benchmark in all three years (FYs 2010–2012).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY



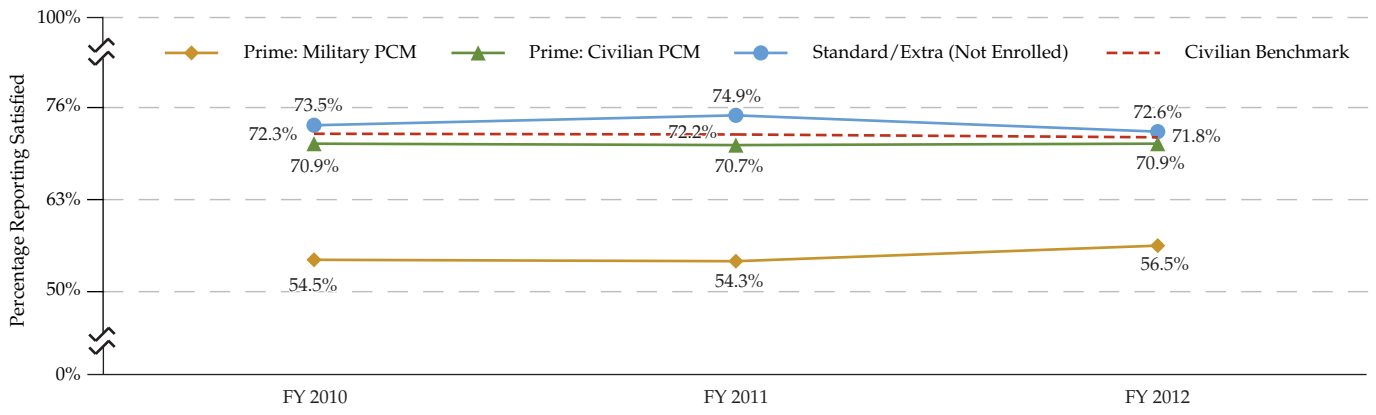
Note: DoD data were derived from the FYs 2010–2012 HCSDB, as of 12/14/2012, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 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.

SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT OR BENEFICIARY CATEGORY

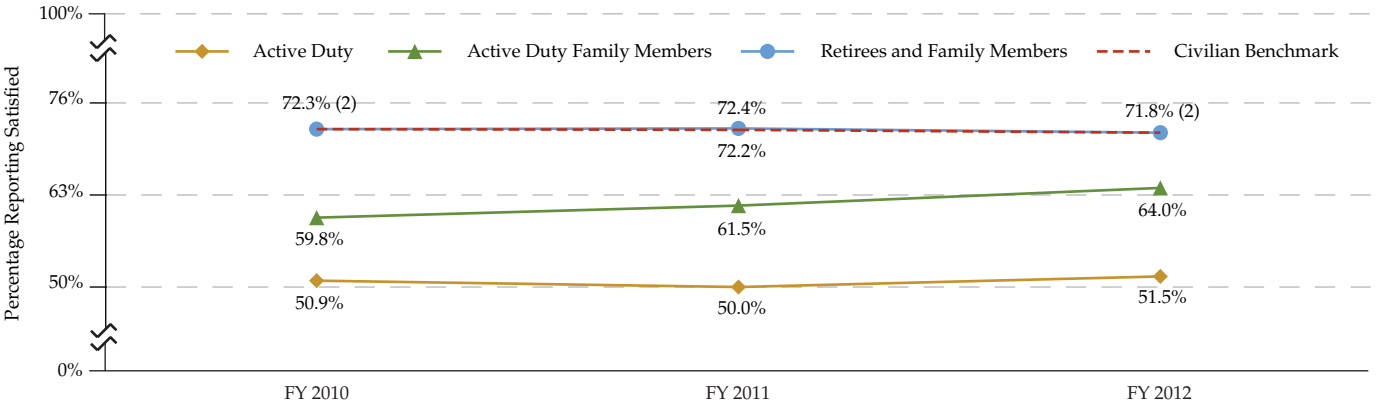
Similar to satisfaction with the TRICARE health *plan*, satisfaction levels with the health *care* received differ by beneficiary category and enrollment status:

- Satisfaction increased during FYs 2010–2012 for Active Duty, while satisfaction of Active Duty families and retirees and families remained stable.
- The satisfaction levels of Active Duty and their families continued to lag the civilian benchmark for all three years, but retirees and families equaled (no statistically significant difference) the benchmark over that time.
- The satisfaction of enrollees with military PCMs lagged the civilian benchmark over FYs 2010–2012. Satisfaction levels of enrollees with civilian PCMs and satisfaction levels of non-enrollees equaled or exceeded the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY



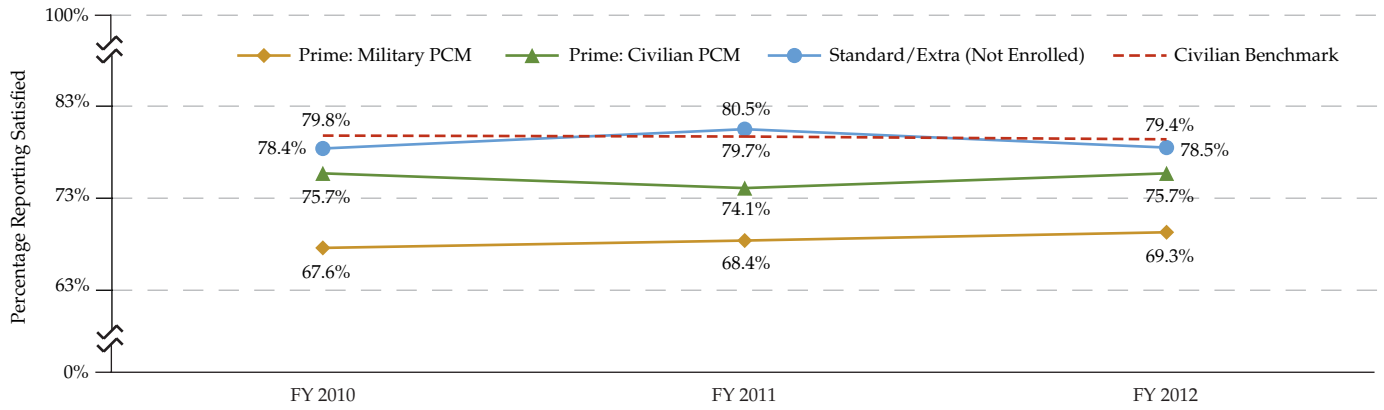
Note: DoD data were derived from the FYs 2010–2012 HCSDB, as of 12/14/2012, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 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.

SATISFACTION WITH ONE'S PERSONAL PROVIDER BASED ON ENROLLMENT OR BENEFICIARY CATEGORY

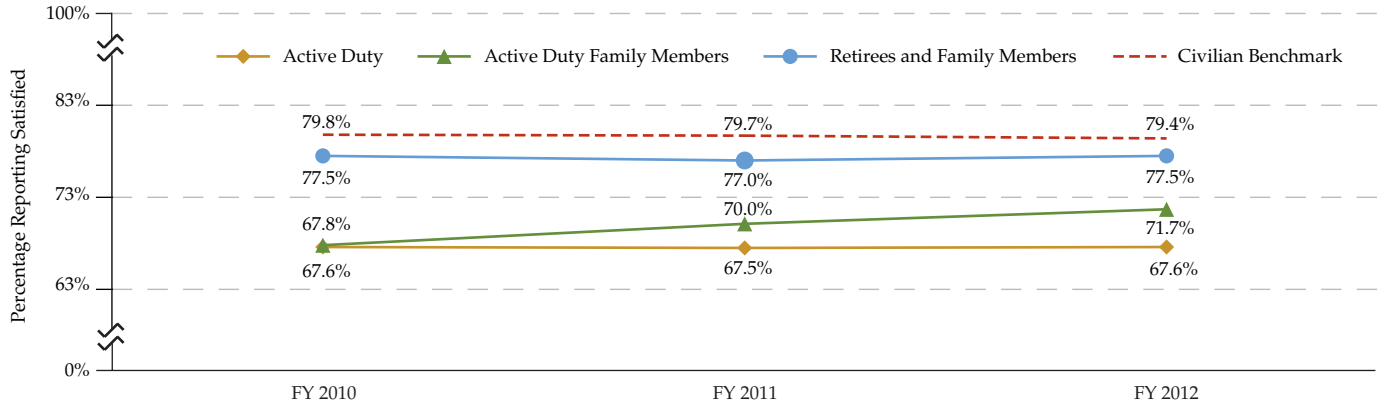
MHS user satisfaction with one's personal provider differs by enrollment status as well as by beneficiary category.

- 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.
- Satisfaction levels by beneficiary category also continue to lag the civilian benchmark. Satisfaction levels for Active Duty family members increased over the three-year period while levels for Active Duty and retirees and families remained steady.

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



TRENDS IN SATISFACTION WITH ONE'S PERSONAL PROVIDER BY BENEFICIARY CATEGORY



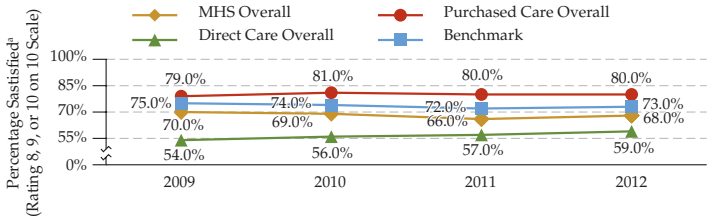
Note: DoD data were derived from the FYs 2010–2012 HCSDB, as of 12/14/2012, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 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.

BENEFICIARY RATINGS OF CARE FOLLOWING OUTPATIENT AND INPATIENT 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 Assessment 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 MHS. The TROSS was first fielded in January 2007, succeeding the Customer Satisfaction Survey (CSS).

OVERALL RATING OF HEALTH CARE

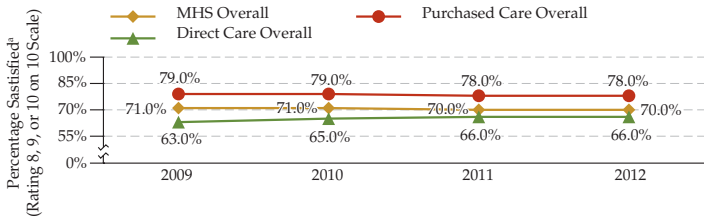


[a] "Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0–10 scale where 10 is best.

Notes:
- "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. Benchmark surveys for the TROSS are conducted by the Altarum Institute as an online survey of individuals who have seen a health care provider recently. Respondents to the civilian benchmark survey were screened to determine whether they or their child had a recent (past 12 months) outpatient experience. Civilian benchmarks were created as weighted estimates reflecting the responses of civilian participants. Separate sets of benchmark scores were calculated for the Direct Care, Purchased Care, and MHS Overall populations based on their (annual) demographic distributions.
- The years depicted align with the TROSS schedule (i.e., 2012 represents data from May 2011–April 2012).
- All MHS military facility data are adjusted for selection, nonresponse, beneficiary category, age, and MTF service branch.
- All MHS civilian purchased-care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

➤ As shown in the chart at left, 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 68 percent in 2012. Among MHS eligibles, ratings by those using civilian outpatient care slightly increased from 79 percent in 2009 to 80 percent in 2012, while ratings by those using MTF-based care increased from 54 percent in 2009 to 59 percent in 2012.

OVERALL RATING OF HEALTH PLAN

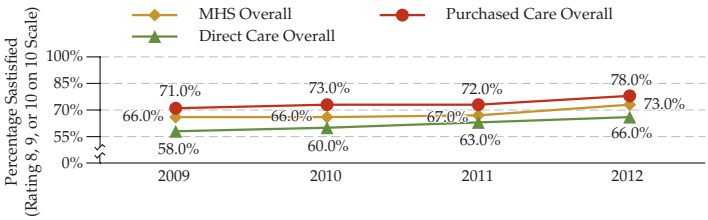


[a] "Percentage Satisfied" for Rating of Health Plan is a score of 8, 9, or 10 on a 0–10 scale where 10 is best.

Notes:
- There is no civilian benchmark for Rating of Health Plan.
- Please refer to notes accompanying "Overall Rating of Health Care" for more detail regarding this analysis.

➤ As shown in the middle chart at left, beneficiary overall rating of the **health plan** among MHS eligibles (the percentage rating 8, 9, or 10 on a 0–10 scale) has remained relatively stable at around 70 percent. Health plan ratings by those receiving outpatient care at civilian facilities has also remained stable around 78 percent, while plan ratings for MTF-based facilities increased from 63 percent in 2009 to 66 percent in 2012.

OVERALL RATING OF MENTAL HEALTH CARE[a]



Source: OASD(HA) TMA/OCFO-DHCAPE TROSS survey results of 12/21/2012

[a] Mental Health Care is a composite of the ratings measuring "Ease of getting treatment/counseling service" and "Overall rating of treatment/counseling." The composite score is an average of the scores of the two questions comprising it.

Note:
- Please refer to notes accompanying "Overall Rating of Health Care" for more detail regarding this analysis.

➤ 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 2012 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 73 percent in 2012, with ratings by users of civilian mental health care increasing from 71 percent in 2009 to 78 percent in 2012. Ratings from users of MTF-based mental health care also improved, from 58 percent in 2009, to 66 percent in 2012.

BENEFICIARY RATINGS OF CARE FOLLOWING OUTPATIENT AND INPATIENT TREATMENT *(CONT'D)*

TRICARE Inpatient Satisfaction Survey (TRISS)

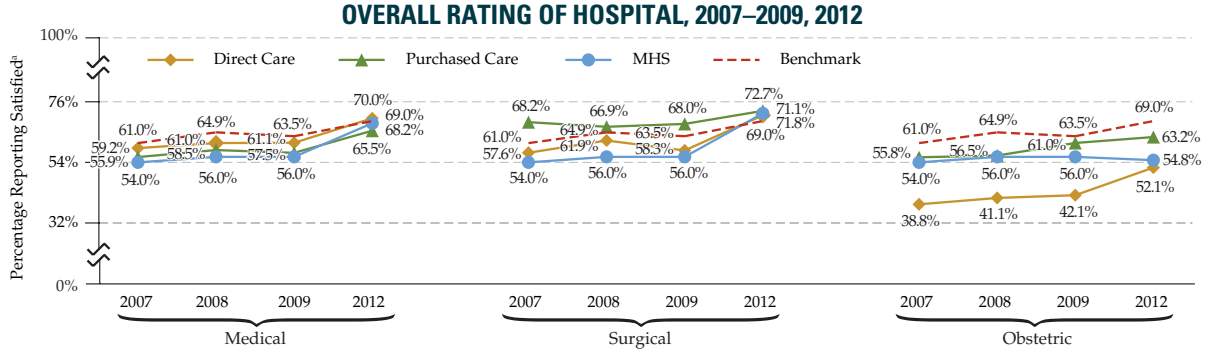
The purpose of the OASD (HA)/TMA TRICARE Inpatient Satisfaction Survey (TRISS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to MTF and civilian hospitals. The survey instrument incorporates the questions developed by the AHRQ and the Centers 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' experiences with 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) including 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 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 care within the purchased care system rated their hospital higher than those in the direct care system (67.4 percent and 64.2 percent, respectively). MHS beneficiaries, whether discharged from MTF or civilian hospitals, rated their hospital stay lower than users that make up the civilian benchmark (65.3 percent and 69 percent, respectively; 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.

OVERALL RATING OF HOSPITAL, 2007–2009, 2012



Source: OASD(HA) TMA/OCFO-DHCAPE TRISS survey results of 12/18/2012

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

Notes:

- All MHS military facility data are adjusted for selection, nonresponse, beneficiary category, age, and MTF service branch.
- All MHS civilian purchased-care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.
- TRISS data have not been case-mix adjusted, limiting comparability to CMS benchmarks.
- 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*).
- Direct care 2012 MTF results are based on discharges from Q4 FY 2011 through Q3 FY 2012; purchased-care 2012 results are based on discharges from Q3 FY 2011 through Q2 FY 2012.
- Difference in results from 2007–2009 and 2012 are likely the result of modifications to the TRISS questionnaire.

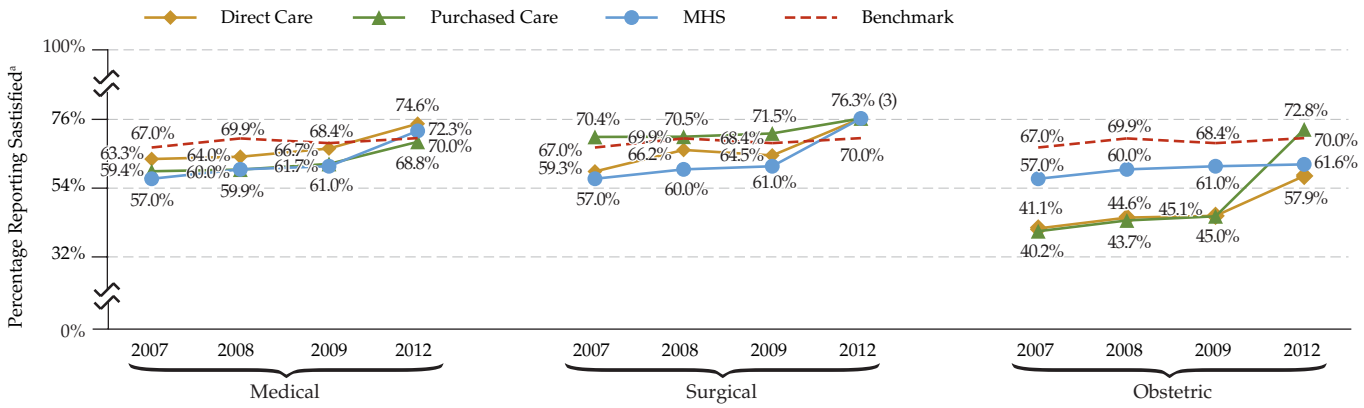
BENEFICIARY RATINGS OF CARE FOLLOWING OUTPATIENT AND INPATIENT TREATMENT *(CONT'D)*

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 (69.4 percent and 72.1 percent, respectively). This is likely due mostly to lower ratings received by the OB product line.

Direct care (medical and surgical product lines) 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 (2012 only) product lines.

WILLINGNESS TO RECOMMEND HOSPITAL, 2007–2009, 2012



Source: OASD(HA) TMA/OCFO-DHCAPE TRISS survey results of 12/18/2012

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

Note:

– Please refer to notes accompanying "Overall Rating of Hospital" for more detail regarding this analysis.

DRIVERS OF PATIENT SATISFACTION/EXPERIENCE RATINGS

Top Three Drivers of Satisfaction by Survey

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 MHS direct and purchased care experiences:
  - TRISS—event-based after a discharge from a hospital;
  - TROSS—event-based following an outpatient visit;
  - HCSDB—population-based quarterly survey sampling MHS eligible beneficiaries who may use MHS or their own health insurance.

  Results from these three surveys for the same period of time during FY 2012 were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys were determined by examining the effects of composite scores on outcome models. The models controlled for all composites and demographic variables, including age, gender, Service, health status, and region. The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.
- As shown in the table below, beneficiary satisfaction with health care provided in MTFs is driven by the following factors: communication between patients, doctors, and nurses; courtesy and respect from office staff; access to care; getting needed care and getting care quickly; and cleanliness of hospital.
- Drivers of satisfaction for purchased care reflect similar beneficiary concerns.
- These results suggest that improving communication between respondents and health care providers, staff courtesy and respect, access to timely care, and facility cleanliness have the potential to influence a patient's satisfaction with their health care and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE

January 1, 2011, through June 30, 2012			
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	Office Staff	Communication with Doctors
#2	Communication with Doctors	Communication with Doctors	Getting Care Quickly
#3	Cleanliness of Hospital	Access to Care	Getting Needed Care

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: PURCHASED CARE

January 1, 2011, through June 30, 2012			
Ranking	**TRISS Purchased Care MHS Rating of Hospital**	**TROSS Purchased Care MHS Satisfaction with Health Care**	**HCSDB Purchased Care CONUS Satisfaction with Health Care**
#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
#2	Communication with Doctors	Office Staff	Getting Needed Care
#3	Cleanliness of Hospital	Access to Care	Getting Care Quickly

Sources: OASD(HA)/TMA-DHCAPE, as of 12/10/2012. Results based on survey data from January 1, 2011, through June 30, 2012, for all three surveys: TRISS, TROSS, and HCSDB.

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 contingency operation (early eligibility), and for 180 days after release from Active Duty through the Transitional Assistance Management Program (TAMP). The Under Secretary of Defense for Personnel and Readiness (USD[P&R]) issued a policy effective September 15, 2011, to ensure that qualified RC members and their families get a full 180 days of TAMP coverage, commencing at the end of a continuous period of Active Duty. For instance, RC members who transition from contingency Active Duty orders immediately to noncontingency orders with no break in service will get 180 days of TAMP coverage, designed to provide sufficient time for them to make arrangements for their ongoing health care coverage. Further, RC sponsors in TAMP now get premium-free Active Duty Dental Program coverage effective January 27, 2012. Qualified Selected Reservists may purchase premium-based TRICARE Reserve Select coverage when not covered by premium free TRICARE, which includes TAMP coverage.

TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and TRICARE Extra coverage for purchase by qualified members of the Selected Reserve. TRS had grown to almost 90,000 plans with over 240,000 covered lives by the end of FY 2012. The chart below presents TRS enrollment growth since plan inception.

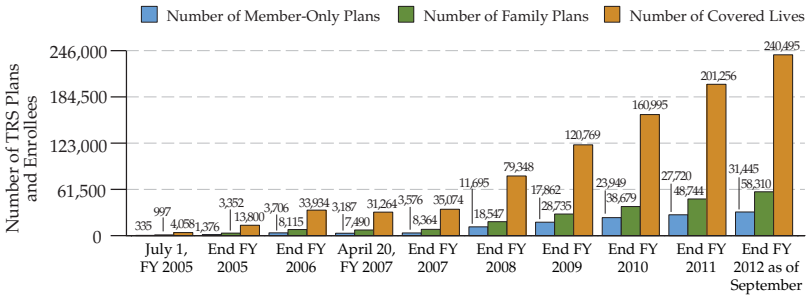
- TRS monthly premiums, based on actual prior year costs, will decrease for member-only plans from $54.35 in FY 2012 to $51.62 in CY 2013 (decrease of 5 percent), while the member-and-family plans will increase from $192.76 in FY 2012 to $195.81 in CY 2013 (increase of 1.5 percent) as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2011	2012	2013
TRS Member-only	$53.16	$54.35	$51.62
TRS Member-and-family	$197.76	$192.89	$195.81

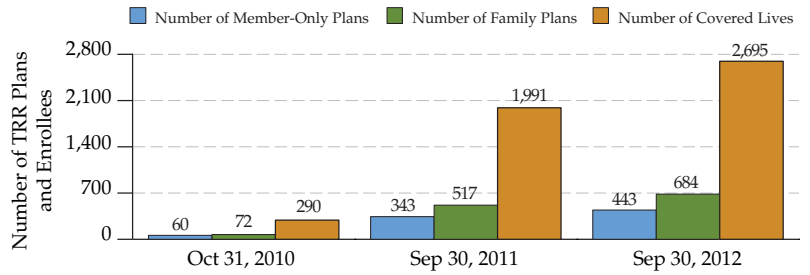
TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010, in response to the National Defense Authorization Act (NDAA) for FY 2010, Section 705, which amended Title 10 United States Code by adding the new Section 1076e. The law allows qualified members 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. Premiums may be adjusted annually.

TREND IN RESERVE COMPONENT ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 TO SEPTEMBER 2012)



ANNUAL TREND IN ENROLLMENT IN TRICARE RETIRED RESERVE SINCE INCEPTION (OCTOBER 2010 TO SEPTEMBER 2012)



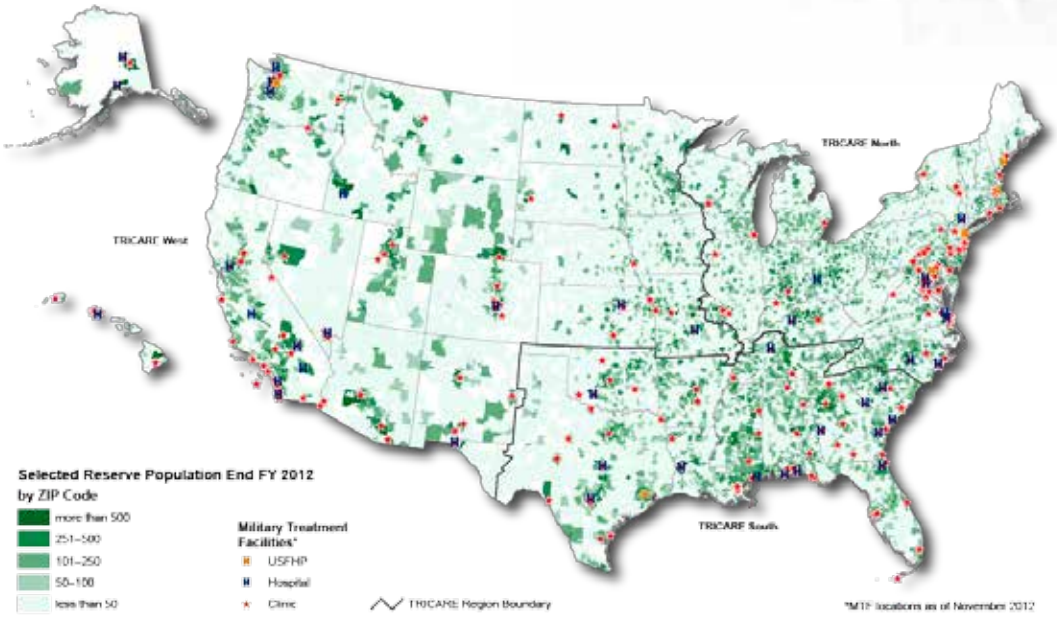
Source: HA/TMA–TRICARE Operations, 11/1/2012

- By the end of FY 2012, almost 2,700 retired reservists and their families were covered by TRR in over 1,100 member-only and member-and-family plans.
- TRR monthly premiums, based on actual prior year costs, will decrease for member-only plans from $419.72 in CY 2012 to $402.11 in CY 2013 (decrease of about 4 percent), and the member-and-family plans will decrease from $1,024.43 in CY 2012 to $969.10 in CY 2013 (decrease of over 5 percent) as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2011	2012	2013
TRS Member-only	$408.01	$419.72	$402.11
TRS Member-and-family	$1,020.05	$1,024.43	$969.10

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 2012



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMIILY MEMBER PROXIMITY TO MILITARY TREATMENT FACILITIES AND NETWORK PROVIDERS IN THE U.S. (SEPTEMBER 30, 2012)

BENEFICIARY GROUP	Population Total (FY 2012)	Population in PSAs	% in PSAs	Population in Catchments	% in Catchments	Population in PRISMs	% in PRISMs	Population in MTF Service Areas	% in MTF Service Areas
Active Duty and Their Families	3,144,658	3,050,327	97%	2,187,519	70%	2,753,457	88%	2,900,970	92%
Selected Reservists and Their Families	2,066,354	1,673,837	81%	496,705	24%	753,933	37%	1,090,229	53%

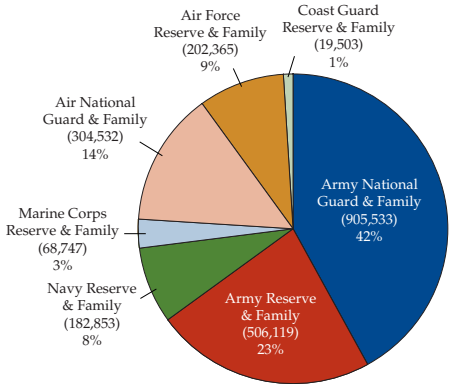
Source: MTF information from TMA, Portfolio Planning Management Division, and geospatial representation by TMA/OCFO-DHCAPE, 11/20/2012; Selected Reservists and their family members, Office of the Assistant Secretary of Defense for Reserve Affairs (OASD[RA]) Reserve Components Common Personnel Data System (RCCPDS) and DEERS Database Extract as of 9/30/2012, provided 11/13/2012; Active Duty and their families from MDR DEERS Extract as of 9/30/2012, provided 11/27/2012.

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.

- As of September 30, 2012, there were more than 2 million Selected Reserve Service members and their families (2,066,354, of which 783,720 were sponsors and 1,282,634 were family members). Approximately 97 percent were identified as residing in the U.S.

SELECTED RESERVE POPULATION: SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2012)



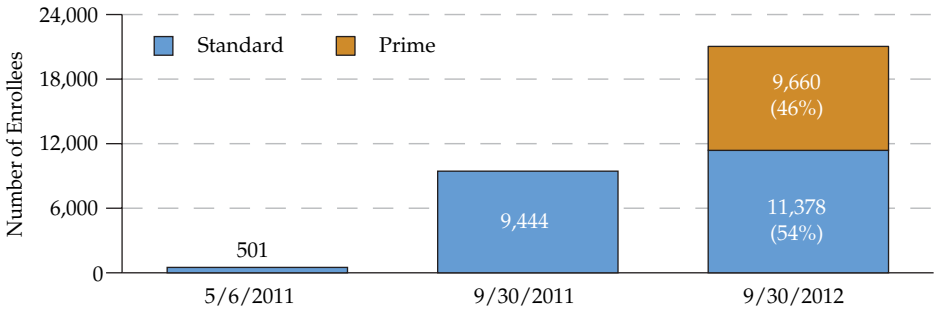
Source: Data are as of the end of September 2012, from OASD/RA (M&P), 11/13/2012.

- The map above depicts where 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 more than half (56 percent) of this population resides near an MTF, compared with 91 percent of Active Duty and their family members.
- As shown at left, almost two-thirds (65 percent) of the worldwide Selected Reserve population of 2.2 million sponsors and their family members are Army National Guard (42 percent) and Army Reserve (23 percent).

TRICARE YOUNG ADULT

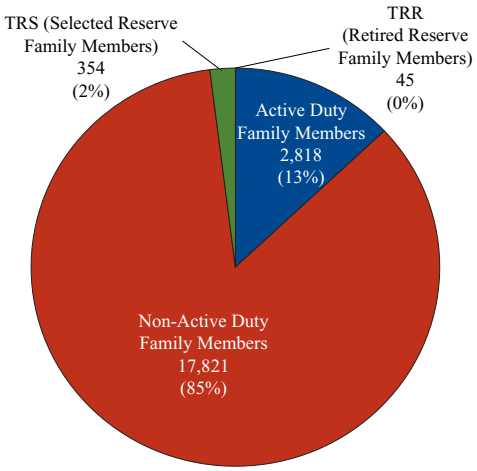
TRICARE already has met or exceeded most of the new health care provisions that took effect on September 23, 2010, under the Patient Protection and Affordable Care Act (PPACA). However, one of the very few PPACA provisions that TRICARE did not fully meet was health care coverage for dependent children up to the age of 26. The NDAA for FY 2011 included a provision that extended dependent medical coverage up to age 26. Beginning in May 2011, qualified dependents up to age 26 were able to purchase TRICARE Standard coverage on a month-to-month basis under the new TYA program. Beginning in January 2012, the TYA program expanded to include a TRICARE Prime option.

TREND IN TRICARE YOUNG ADULT ENROLLMENT SINCE INCEPTION (MAY 2011 TO SEPTEMBER 2012)



Source: Health Affairs (HA)/TRICARE Management Activity (TMA)–TRICARE Operations, 11/5/2012

TYA ENROLLMENT BY FAMILY MEMBER CAREER STATUS



Source: HA/TMA–TRICARE Operations, 11/5/2012

- As shown in the chart at left, enrollment more than doubled, from over 9,400 in FY 2011, to over 21,000 in FY 2012 (123 percent increase). Also, although TYA began with the Standard option, almost half of the enrollees selected Prime by the end of 2012, the first year of its availability.
- As shown in the accompanying pie chart, 85 percent of TYA enrollees are family members of those who are not Active Duty (e.g., dependents of retirees and others).
- TYA monthly premiums, based on actual prior year costs, decreased for Prime plans from $201 per month in 2012 to $176 per month in 2013 (a decrease of over 12 percent), while the Standard plans decreased from $176 per month in 2012 to $152 per month in 2013 (a decrease of almost 14 percent) as follows (see *http://www.tricare.mil/Costs/HealthPlanCosts/TYA.aspx*):

Monthly TYA Premiums	2012	2013
Prime	$201	$176
Standard	$176	$152

ACCESS TO MHS CARE FOR CHILDREN WITH SPECIAL NEEDS

DoD Enhanced Access to Autism Services Demonstration

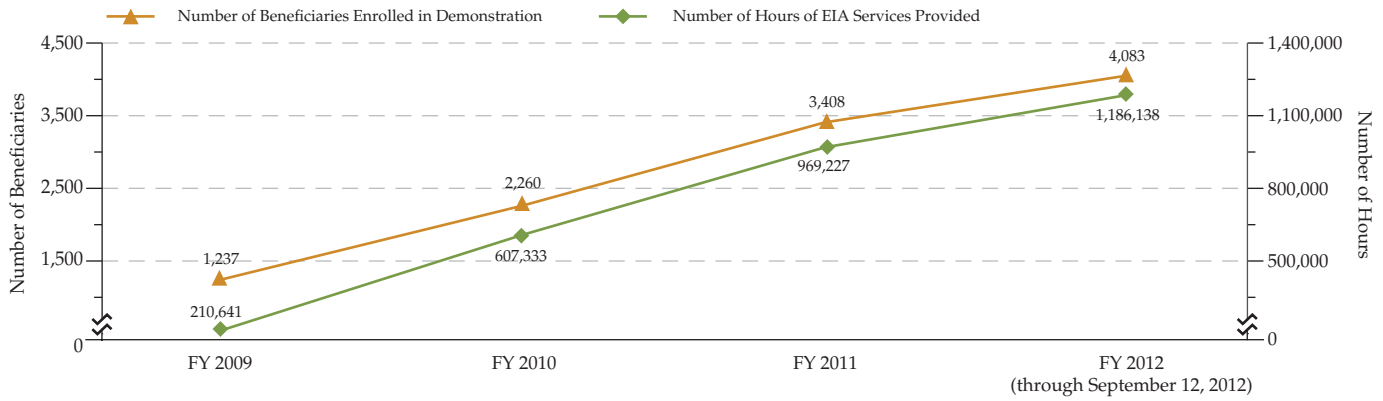
In response to section 717 of the John Warner NDAA for FY 2007, DoD implemented the Enhanced Access to Autism Services Demonstration (the Demonstration) on March 15, 2008. This project tests the advisability and feasibility of authorizing TRICARE reimbursement for Applied Behavior Analysis (ABA) services delivered by nonprofessional providers, thereby expanding the pool of providers of autism treatment services to include those not meeting the strict guidelines of current departmental regulations. The key feature of the Demonstration is to provide Educational Interventions for Autism Spectrum Disorders (EIA) by a two-tiered delivery model:

- Individuals certified as "supervisors" by the Behavior Analyst Certification Board (BACB) at the Board Certified Behavior Analyst (BCBA) or Board Certified Assistant Behavior Analyst (BCaBA) level, who have a contractual relationship with TRICARE, either individually or as an employee of a TRICARE-authorized provider; and
- Noncertified individuals, i.e., "tutors," who provide hands-on ABA services under the supervision of a BCBA or BCaBA.

Administrative requirements of the Demonstration were substantially revised and implemented on September 10, 2008. In addition, section 732 of the NDAA for FY 2009 increased the limit of government liability for certain benefits, including special education, from $2,500 per month to $36,000 per year. That change was implemented on April 1, 2009.

As shown in the chart below, participation by beneficiaries and providers continues to increase, with more than a threefold increase in enrollment from the first complete year of the Demonstration (FY 2009) to FY 2012 and almost a sixfold increase in the number of EIA hours provided.

DoD ENHANCED ACCESS TO AUTISM SERVICES DEMONSTRATION: ENROLLMENT AND HOURS OF SERVICES PROVIDED (FY 2009–FY 2012)



Source: Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA])/TMA POD, 11/21/2012

TRICARE FOR LIFE—SPECIAL STUDY

TFL is a TRICARE program that offers Medicare wraparound coverage to beneficiaries enrolled in Medicare Part B. Initiated in the National Defense Authorization Act (NDAA) of 2001, TFL covers most costs not covered by Medicare, including Medicare's coinsurance and deductible. There is no separate enrollment fee for TFL and beneficiaries may visit any Medicare-approved provider.[1]

The number of TRICARE beneficiaries eligible for TFL has increased substantially since its inception, from about 1.5 million in FY 2002 (TMA 2003) to almost 2 million at the end of FY 2011, a roughly 33 percent increase. The health care ratings and reports of access of TFL beneficiaries are high, compared with those of military retirees under age 65 who are not eligible for Medicare (Andrews et al. 2010). However, the relation between variations in TFL beneficiaries' ratings of and access to health care across different types of Prime Service Areas (PSAs) and the availability of services from military providers has not been explored.[2]

Results of study:

- Overall, the health care ratings and reports of access of TFL beneficiaries are better than those of younger retirees using Standard/Extra (S/E) for most aspects of health care.
- There are no statistically significant differences in health care ratings and reports of access between Prime Service Areas (PSAs) and non-PSAs for TFL beneficiaries and S/E users, apart from problems regarding access to mental health providers. Such access is greater for TFL beneficiaries in PSAs than non-PSAs.
- TFL beneficiaries in PSAs containing an MTF unaffected by Base Realignment and Closure (BRAC), compared with non-PSAs, report lower values for health plan rating, access to and ratings of personal doctors, access to specialists and mental health providers, and getting timely urgent care.
- Comparisons of S/E users by PSA type suggest problems with access to personal doctors and specialists in PSAs other than MTF PSAs and PSAs containing MTFs affected by BRAC (BRAC PSAs).
- Results for users of S/E indicate problems getting timely urgent care in BRAC PSAs (relative to non-PSAs).
- There are differences between TFL and S/E users in how their health care experiences vary according to location, including (1) fewer TFL beneficiaries in MTF PSAs than in non-PSAs rate their personal doctor 8 or above, although this is not the case for S/E users; and (2) fewer S/E users in BRAC PSAs than in non-PSAs report they get urgent care within a day, although this is not the case for TFL beneficiaries.

COMPARING RATINGS AND ACCESS OF TFL BENEFICIARIES

RATINGS AND ACCESS	TFL vs. Standard/Extra	PSAs vs. Non-PSA	MTF PSAs vs. Non-PSAs	BRAC PSAs vs. Non-PSAs	Other PSAs vs. Non-PSAs
Global Ratings (rating of 8 or above)					
Health Care	+	No diff	No diff	No diff	No diff
Health Plan	+	No diff	–	No diff	No diff
Personal Doctor	+	No diff	–	No diff	No diff
Specialist	+	No diff	No diff	No diff	No diff
Mental Health Provider	+	No diff	No diff	No diff	No diff
Access					
Getting Needed Care	+	No diff	No diff	No diff	No diff
Personal Doctor	+	No diff	–	No diff	No diff
Specialist	+	No diff	–	No diff	No diff
Mental Health Provider	+	–	–	No diff	No diff
Timely Care					
Getting Non-Urgent Care within a Week	No diff	No diff	No diff	No diff	+
Getting Urgent Care within a Day	+	No diff	–	No diff	No diff

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

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

[1] TFL beneficiaries can also enroll in TRICARE Plus, a program that allows beneficiaries primary care appointments at an MTF within the same primary care access standards as in TRICARE Prime, TRICARE's HMO option. TRICARE Plus is only available at certain MTFs, however. Other TFL beneficiaries can receive care at MTFs on a space-available basis.

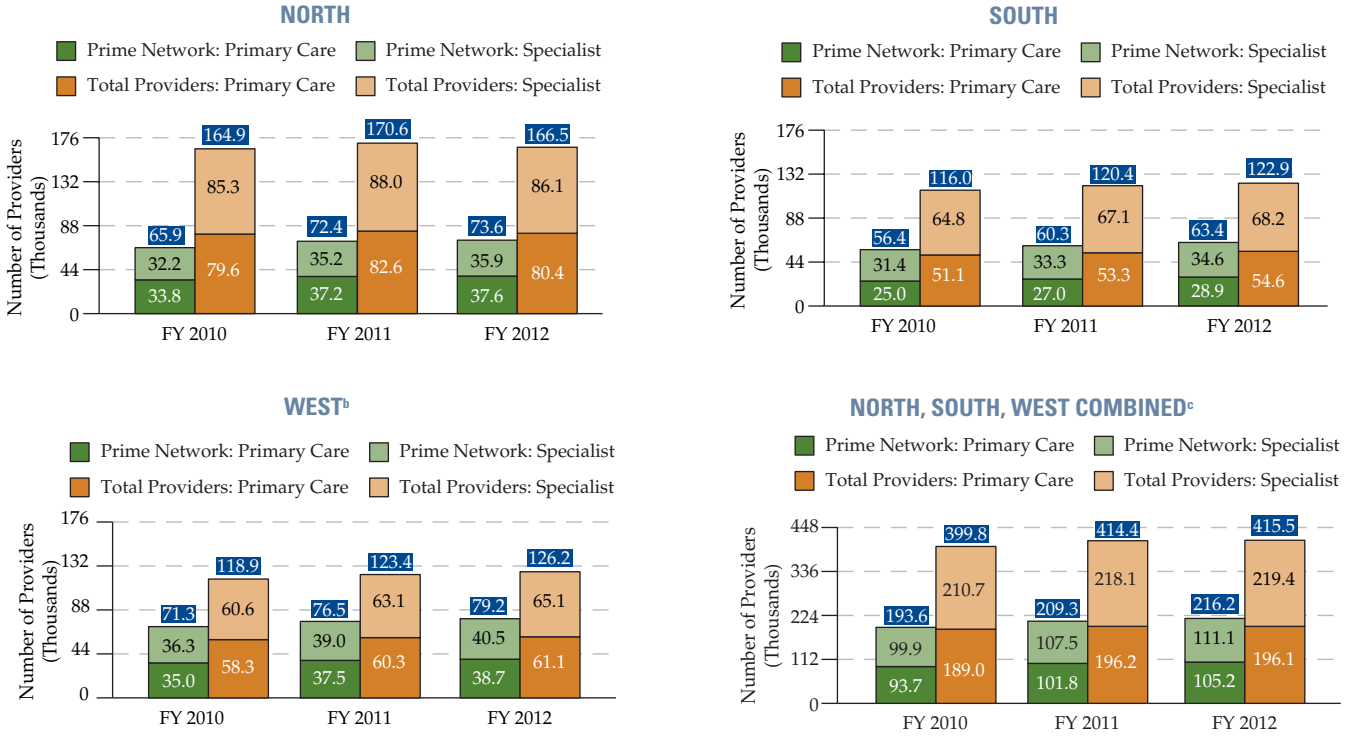
[2] PSAs are areas in which TRICARE Prime is available to active duty and retired service members and their families.

TRICARE PROVIDER PARTICIPATION

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS). All Health Insurance Portability and Accountability Act (HIPAA)-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. Although CMS has been issuing NPIs since FY 2007, they did not gain widespread use in MHS until FY 2010. For the first time, in this year's report, providers are counted using the NPI. 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 for more than a decade but began to level off in FY 2012. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually declined. Furthermore, the number of primary care providers has increased at about the same rate as that of specialists.[2]

- Between FY 2010 and FY 2012, the South and West Regions saw the largest increase in the total number of TRICARE providers (6 percent each), while the North Region saw very little increase (less than 1 percent).
- The South Region saw the largest increase in the number of network providers (13 percent), followed closely by the North (12 percent) and West (11 percent).
- The total number of TRICARE providers increased by 15 percent in catchment areas and by 2 percent in noncatchment areas (not shown).[3]
- The number of network providers increased by 18 percent in catchment areas and by 10 percent in noncatchment areas (not shown).

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs[a]



Source: MHS administrative data, 1/30/2013

Notes: 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.

[a] 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.

[b] The West Region includes Alaska.

[c] Numbers may not sum to regional totals due to rounding.

[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.

[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 13, the catchment area concept is being replaced within MHS by MTF Enrollment Areas.

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

Purpose of Study

The Department has completed the final year of a four-year survey 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 were 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 effort revealed that just under 9 of 10 physicians (87 percent) reported awareness of the TRICARE program in general, and about 8 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 Four Years (2008–2011)

Provider survey results after four years:

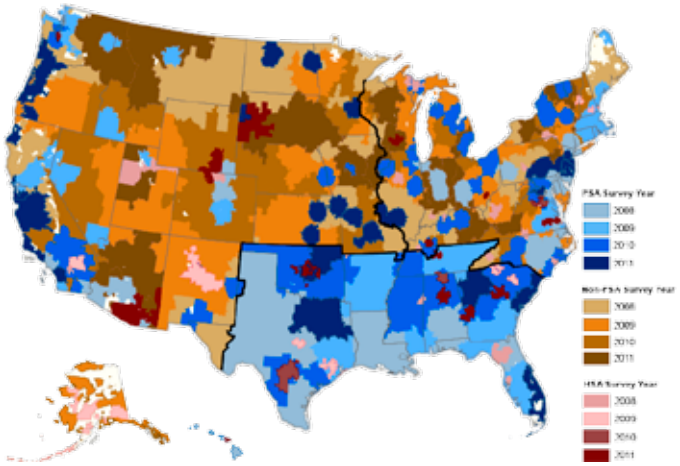
- **Awareness of the TRICARE program:** There is a high level of provider awareness of the TRICARE program in general.
  - Eight of 10 providers overall are aware of the TRICARE program in general (82 percent of physicians and nonphysician behavioral health providers, such as psychologists and social workers). Physician awareness is higher, with 9 of 10 physicians (91 percent) reporting awareness of TRICARE, similar to the 2005–2007 physician-only benchmark survey (87 percent).
- **Acceptance of new TRICARE patients:** More than 7 of 10 physicians and 6 of 10 providers overall (61 percent) accept new TRICARE Standard patients if they accept new patients of any insurance. The physician rate is lower than the 2005–2007 physician-only benchmark survey of 81 percent.
- Behavioral health providers (psychiatrists and nonphysicians) generally report lower awareness and acceptance of new TRICARE Standard and Medicare patients than nonpsychiatrist physicians.
- While results vary among PSAs and non-PSAs, generally, provider acceptance of new TRICARE Standard patients is lower in areas with Prime networks (PSAs) than in non-PSA locations, although provider awareness is comparable.

Beneficiary survey results after four years:

- S/E users generally rate their health care and access higher for most measures than the civilian CAHPS-plan benchmark.
- S/E beneficiaries in non-PSAs report higher ratings than beneficiaries in PSAs for most measures of access to care and overall global rating of health care.
- Compared to non-enrolled beneficiaries using other health insurance:
  - In general, S/E beneficiaries rate their satisfaction with key aspects similarly to MHS beneficiaries using their own health insurance, such as their satisfaction with providers, the overall health plan, and health care, as well as certain aspects of access, such as getting care quickly, urgent care, or appointments.
  - S/E beneficiaries report more problems in other aspects of access to care, such as getting needed care and access to providers including behavioral health.

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

SURVEY LOCATIONS: 2008–2011



Source: OASD(HA) TMA/OCFO-DHCAPE and administrative data, 8/22/2012

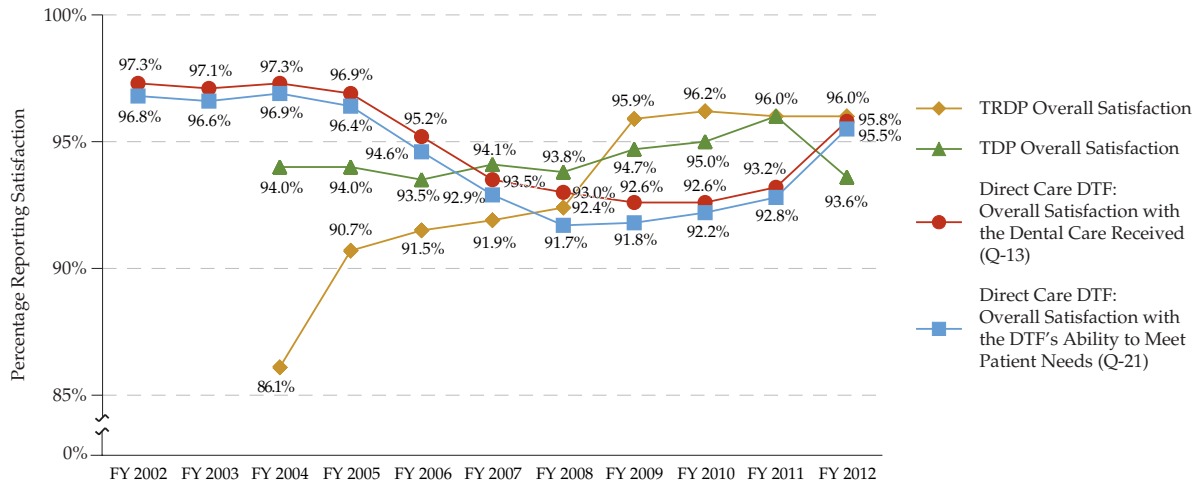
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

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)** are responsible for the dental care of about 1.7 million Active Duty Service members, as well as eligible family members outside the continental U.S. (OCONUS). Satisfaction with dental care reported by patients receiving dental care in military DTFs increased by about two percentage points from FY 2011 to FY 2012 (from 93.2 to 95.8 percent, respectively) based on over 250,000 surveys completed in FY 2012 collected by the Tri-Service Center for Oral Health Studies. Overall patient ratings of the ability of the DTFs to meet their dental needs improved from 92.8 percent in FY 2011 to 95.5 percent in FY 2012.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction decreased two percentage points from 96.0 percent in FY 2011 to 93.6 percent in FY 2012. 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, 2012, the TDP serviced 836,000 contracts (almost 794,000, or 95 percent, in the U.S.), covering almost 2 million lives (1,967,984). Although not shown, the TDP survey includes satisfaction ratings for network access (99 percent), provider network size and quality (98 percent), and claims processing (97 percent). The TDP network has almost 86,000 dentists (85,598), about 18 percent more than the over 72,000 in FY 2011. The FY 2012 TDP network included 68,431 general dentists and 17,167 specialists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate remained stable at about 96 percent over the past three years, from FY 2010 to FY 2012. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2012 was 8 percent higher than in FY 2010, with over 1.5 million total covered lives in over 666,000 contracts, compared to about 1.25 million lives in over 606,000 contracts in FY 2010. Most (i.e., 99 percent), but not all, reside 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, 11/2/2012

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

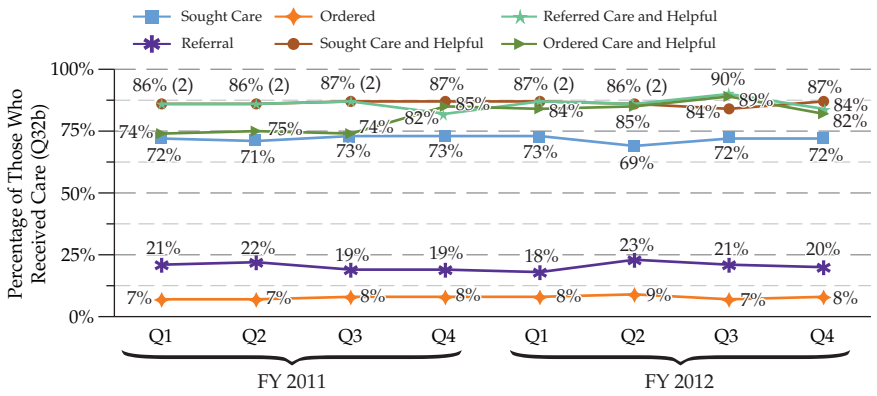
The Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity has telephonically surveyed Service members returning from operational deployment (Afghanistan and Iraq) since May 2007. The Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational 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 six 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 Department of Veterans Affairs (VA) facilities by DoD; (3) members completing a Post-Deployment Health Assessment (PDHA); and (4) members completing a Post-Deployment Health Reassessment (PDHRA).

Since May 2007, over 80,000 surveys have been completed of over 200,000 sampled, eligible Service members returning from operational theater, for an effective cumulative response rate of 41 percent. In total, the majority of the sample (77 percent) as well as the responses (79 percent) have been Army, followed by Air Force (11 percent sampled, 10 percent returned), Marines (8 percent sampled and 6 percent returned), Navy (4 percent sampled and 5 percent returned), and Coast Guard (under 0.1 percent each). The survey questions and methodology were changed significantly in Q4 FY 2008. These changes are reflected in the charts on page 53.

- **Summary of results:** The focus of the survey is to identify problem areas to resolve, but over time, several areas appear favorable and stable. Through the most current quarter of surveying (Q3 FY 2012), Service members have favorably rated most aspects of medical hold, outpatient health care, and support services, including DoD support for care in VA facilities. For example:
  - **Medical hold/holdover and support services:** Ratings continue to appear stable and mostly favorable. Because they are stable, these question domains will be surveyed every six months rather than quarterly.
  - **DoD support for VA care:** Most Service members favorably rate DoD support for their care referred to the VA (62 percent), and state their medical record is available at appointment 77 percent of the time.
  - **Behavioral health care findings:** Ratings for outpatient counseling have improved, with increased favorable ratings and decreased unfavorable ratings. As of Q4 FY 2012:
    - One-fifth of Service members state they have received counseling for personal or family problems and, of those, almost 9 of 10 (87 percent) thought it was helpful. Most receiving counseling state they sought care on their own (72 percent) versus being referred (20 percent) or ordered (8 percent) to get counseling.
    - About 20 percent of those not getting counseling said they could have benefited from counseling had they received it (not shown).
    - About 4 percent of those who did not get counseling indicated they did not seek it due to barriers. The most common barriers were an inability to get an appointment (33 percent) and concern about career impact (30 percent; not shown).

FOR SERVICE MEMBERS WHO RECEIVED COUNSELING OR CARE, HOW DID THEY RECEIVE CARE AND WAS IT HELPFUL?



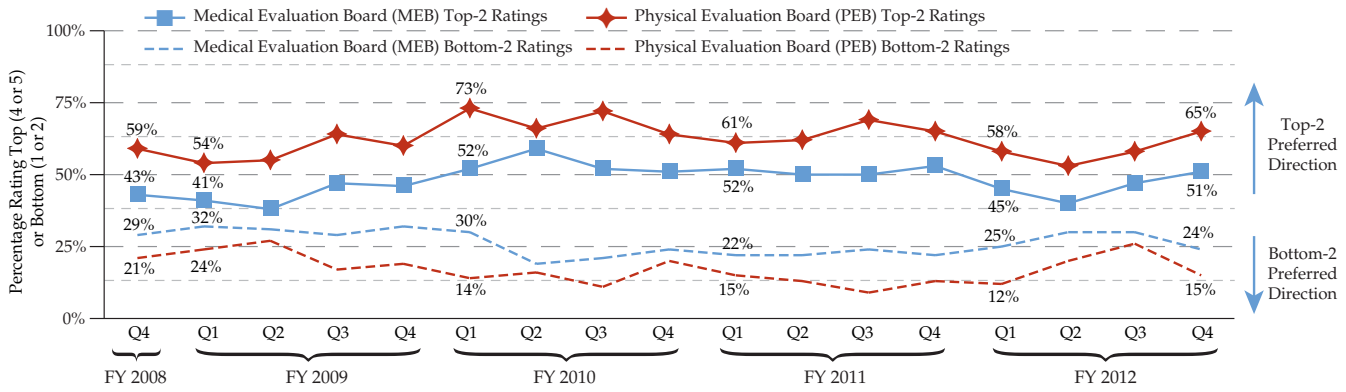
Source: OASD(HA) TMA/OCFO-DHCAPE Monthly Survey of Ill or Injured Service Members Post Operational Deployment, 1/15/2013

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

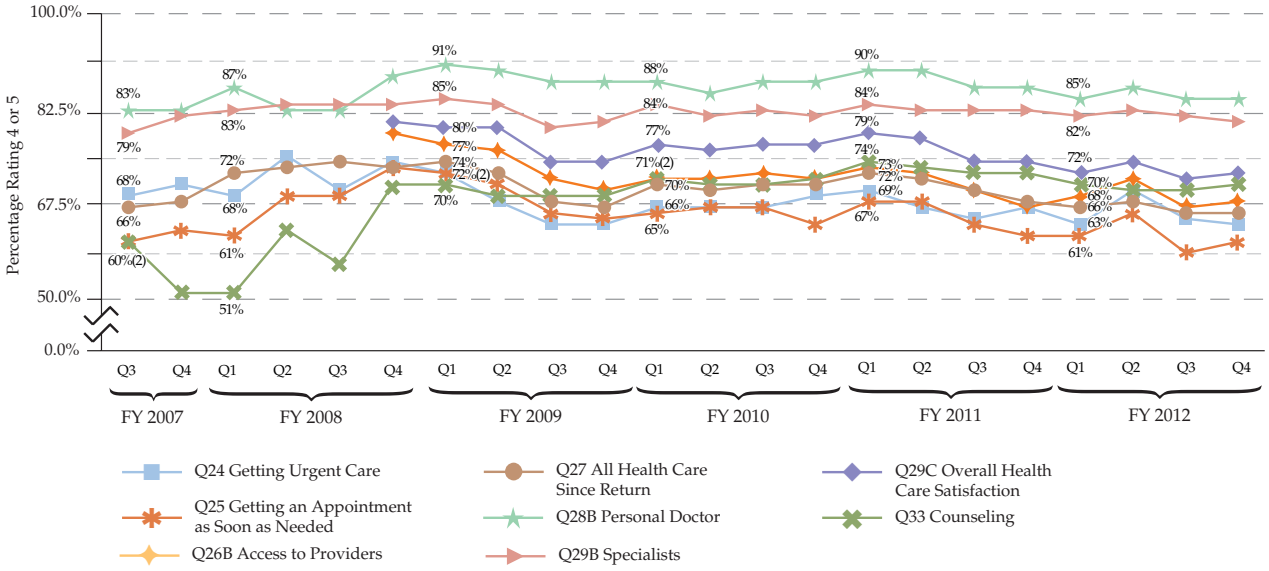
SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT *(CONT'D)*

- **Areas needing improvement:** Some measures continue to challenge the MHS:
  - **Disability Evaluation System:** Ratings of the "Medical Evaluation Board (MEB) Experience," although statistically improved since Q4 FY 2008, when the survey was expanded, continue to have the highest proportion of unfavorable ratings (between 20 and 30 percent, 1 or 2 on 1–5 scale) and lowest proportion of favorable ratings (hovering around 50 percent, 4 or 5 on the same 1–5 scale). When viewed in relation to the past two fiscal years, favorable ratings are decreasing and unfavorable ratings increasing.
    - Most negative comments about MEBs reflect concerns about the process being slow and time-consuming, and having insufficient or unclear communication.
    - Ratings of the Physical Evaluation Board (PEB) experience are better than the MEB ratings.
    - Those who have received results rate their MEB satisfaction higher, compared with those still in the process.
  - **Ambulatory care:** Most favorable and unfavorable ratings remain stable and do not appear to be problematic. Unfavorable access ratings for "access to providers," "all health care," and "getting an appointment as soon as needed" have been increasing since Q4 FY 2008.

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



AMBULATORY CARE: 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, 1/15/2013

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE

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 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 a managed care support contractor (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 to 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.

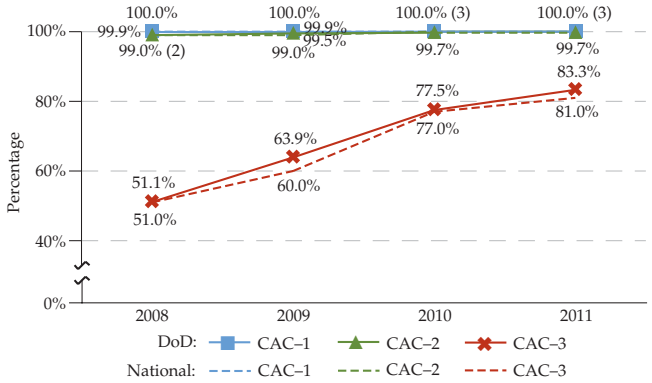
MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2008–FY 2011

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	2011
CAC–1 Children Who Received Reliever Medication While Hospitalized for Asthma				
DoD	99.9%	99.9%	100.0%	100.0%
MTF	99.7	100.0	99.7	99.7
Purchased Care	99.9	99.9	100.0	100.0
National	100.0	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%	99.7%
MTF	98.7	99.2	98.5	98.5
Purchased Care	99.0	99.5	99.8	99.7
National	99.0	99.0	100.0	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%	83.3%
MTF	24.0	38.4	51.5	55.7
Purchased Care	54.3	65.7	78.7	84.7
National	51.0	60.0	77.0	81.0

➤ **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) present an opportunity for improvement across DoD as well as civilian hospitals, despite significant improvement in three years.

DoD HOSPITAL QUALITY MEASURE: CAC



Source: OASD(HA), Office of the Chief Medical Officer, 12/4/2012

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.

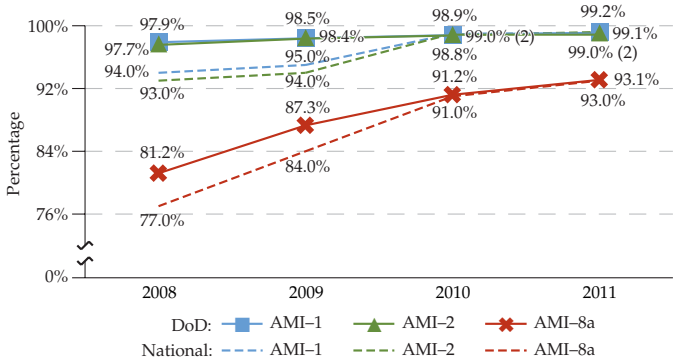
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2008–FY 2011

	2008	2009	2010	2011
AMI–1 Heart Attack Patients Given Aspirin at Arrival				
DoD	97.9%	98.4%	98.8%	99.2%
MTF	98.7	98.8	98.4	98.7
Purchased Care	97.9	98.4	98.8	98.2
National	94.0	95.0	99.0	99.0
AMI–2 Heart Attack Patients Given Aspirin at Discharge				
DoD	97.7%	98.5%	98.9%	99.1%
MTF	98.6	97.7	97.7	96.8
Purchased Care	97.7	98.5	98.9	99.1
National	93.0	94.0	99.0	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%	97.3%
MTF	95.1	97.1	98.3	94.3
Purchased Care	93.6	95.4	96.6	97.3
National	90.0	93.0	96.0	97.0
AMI–4 Heart Attack Patients Given Smoking Cessation Advice/Counseling				
DoD	98.9%	99.3%	99.6%	99.8%
MTF	91.8	91.6	94.6	97.5
Purchased Care	99.0	99.3	99.6	99.7
National	95.0	97.0	100.0	100.0
AMI–5 Heart Attack Patients Given Beta Blocker at Discharge				
DoD	97.8%	98.4%	98.6%	99.0%
MTF	97.6	97.0	97.3	96.1
Purchased Care	97.8	98.4	98.6	99.0
National	93.0	94.0	98.0	99.0

➤ **Acute Myocardial Infarction:** DoD overall performance for acute myocardial infarction measures is comparable to, and in some cases slightly above, the national rate. MTFs continue to improve on the timing of percutaneous coronary intervention (PCI).

DoD HOSPITAL QUALITY MEASURE: AMI

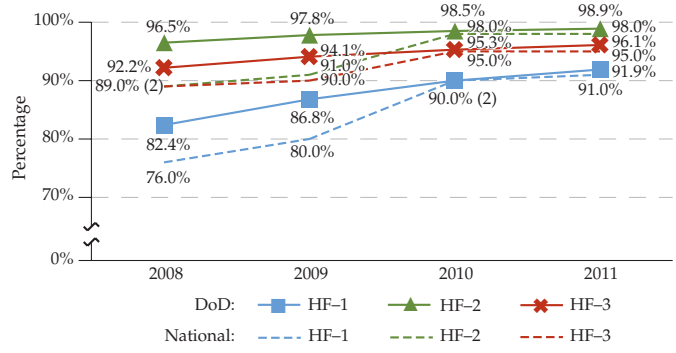


	2008	2009	2010	2011
AMI–8a Heart Attack Patients Given PCI within 90 Minutes of Arrival				
DoD	81.2%	87.3%	91.2%	93.1%
MTF	53.4	66.0	59.7	62.7
Purchased Care	81.3	87.3	91.3	93.2
National	77.0	84.0	91.0	93.0

	2008	2009	2010	2011
HF–1 Heart Failure Patients Given Discharge Instructions				
DoD	82.4%	86.8%	90.0%	91.9%
MTF	68.9	79.8	80.9	84.9
Purchased Care	82.4	86.8	90.0	91.9
National	76.0	80.0	90.0	91.0
HF–2 Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function				
DoD	96.5%	97.8%	98.5%	98.9%
MTF	95.3	95.6	96.7	97.5
Purchased Care	96.5	97.8	98.5	98.9
National	89.0	91.0	98.0	98.0
HF–3 Heart Failure Patients Given ACE Inhibitor or ARB for LVSD				
DoD	92.2%	94.1%	95.3%	96.1%
MTF	93.5	95.0	92.4	91.4
Purchased Care	92.2	94.1	95.3	96.1
National	89.0	90.0	95.0	95.0
HF–4 Heart Failure Patients Given Smoking Cessation Advice/Counseling				
DoD	97.5%	98.4%	99.0%	99.3%
MTF	86.5	86.0	92.5	91.5
Purchased Care	97.5	98.4	99.0	99.3
National	91.0	93.0	99.0	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, 12/4/2012

Note: For visual display, numbers in parentheses on the graphs indicate the number of overlapping data points.

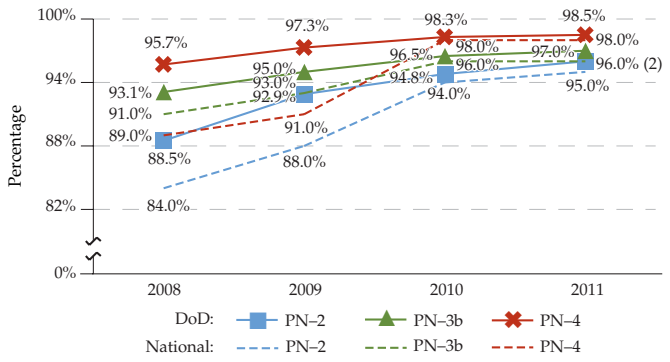
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2008–FY 2011

	2008	2009	2010	2011
PN–2 Pneumonia Patients Assessed and Given Pneumococcal Vaccination				
DoD	88.5%	92.9%	94.8%	96.0%
MTF	61.6	73.2	80.5	81.6
Purchased Care	88.7	93.0	94.9	96.1
National	84.0	88.0	94.0	95.0
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%	97.0%
MTF	85.9	85.0	90.6	91.6
Purchased Care	93.2	95.1	96.5	97.1
National	91.0	93.0	96.0	96.0
PN–4 Pneumonia Patients Given Smoking Cessation Advice/Counseling				
DoD	95.7%	97.3%	98.3%	98.5%
MTF	83.0	83.1	86.7	90.2
Purchased Care	95.8	97.4	98.3	98.5
National	89.0	91.0	98.0	98.0
PN–5c Pneumonia Patients Given Initial Antibiotic(s) within Six Hours after Arrival				
DoD	93.9%	94.9%	96.0%	96.4%
MTF	88.3	89.3	91.2	93.3
Purchased Care	93.9	95.0	96.0	96.4
National	93.0	94.0	96.0	96.0
PN–6 Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s) PN6a+6b for ORYX				
DoD	89.7%	91.9%	93.3%	95.2%
MTF	88.3	91.9	92.4	93.1
Purchased Care	89.7	91.9	93.3	95.2
National	87.0	89.0	93.0	94.0

➤ **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

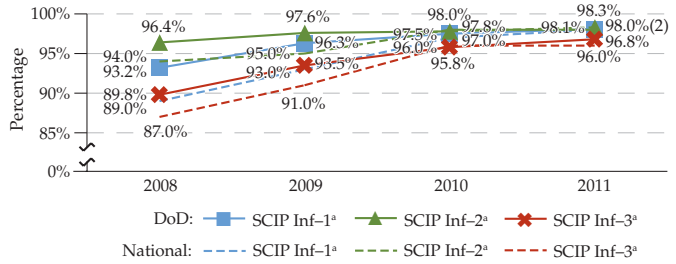


	2008	2009	2010	2011
PN–7 Pneumonia Patients Assessed and Given Influenza Vaccination				
DoD	85.8%	90.2%	92.5%	94.1%
MTF	53.1	65.4	75.1	75.4
Purchased Care	86.1	90.5	92.6	94.3
National	82.0	86.0	91.0	93.0

	2008	2009	2010	2011
SCIP Inf–1[a] 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%	98.1%
MTF	75.9	88.4	92.9	95.5
Purchased Care	93.4	96.4	97.6	98.1
National	89.0	93.0	97.0	98.0
SCIP Inf–2[a] Surgery Patients Who Were Given the Right Kind of Antibiotic to Help Prevent Infection				
DoD	96.4%	97.6%	97.8%	98.3%
MTF	95.6	97.0	94.6	95.8
Purchased Care	96.4	97.6	97.8	98.4
National	94.0	95.0	98.0	98.0
SCIP Inf–3[a] Surgery Patients Whose Preventive Antibiotics Were Stopped at the Right Time (within 24 Hours after Surgery)				
DoD	89.8%	93.5%	95.8%	96.8%
MTF	86.5	91.6	94.2	94.6
Purchased Care	89.8	93.5	95.8	96.8
National	87.0	91.0	96.0	96.0
SCIP VTE–1[b] Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots after Certain Types of Surgeries				
DoD	91.6%	93.5%	94.9%	97.3%
MTF	92.3	93.8	92.6	95.1
Purchased Care	91.6	93.5	94.9	97.3
National	87.0	89.0	95.0	97.0

➤ **Surgical Care:** The overall performance of DoD for the surgical care improvement project measures is consistent with the national rate, having improved since 2008 and reaching near parity for several measures. MTFs are improving the timing of prophylactic antibiotic administration.

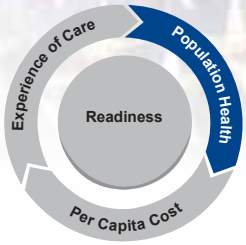
DoD HOSPITAL QUALITY MEASURE: SCIP INF.



	2008	2009	2010	2011
SCIP VTE–2[b] 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%	96.2%
MTF	90.6	92.5	91.9	94.3
Purchased Care	89.0	91.5	93.1	96.2
National	84.0	88.0	93.0	95.0

Source: OASD(HA), Office of the Chief Medical Officer, 12/4/2012
[a] Surgical Care Improvement Project—Infection
[b] Surgical Care Improvement Project—Venous Thromboembolism Prophylaxis
Note: For visual display, numbers in parentheses on the graphs indicate the number of overlapping data points.

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES



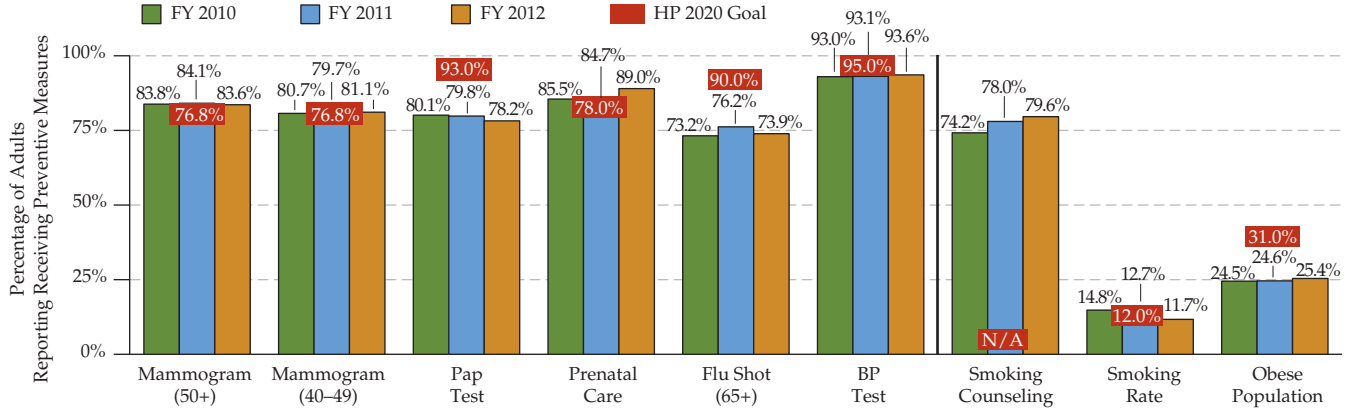
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on health promotion activities through Building Healthy Communities.

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 the Department of Health and Human Services (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 from FY 2010 through FY 2012 to just under 12 percent, meeting 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 increased slightly in FY 2012 to just over 25 percent. The MHS rate, 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 nearly 80 percent in FY 2012.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2010 TO FY 2012



Source: Health Care Survey of DoD Beneficiaries (HCSDB) and the NCBD as of 12/14/2012

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 dedicated to improving the health of the Military Health System (MHS) population, using available resources in the most efficient and effective ways possible. The MHS model has evolved to better address the determinants of health through strategies such as strengthening the connections between community-based wellness and prevention programs, messaging and strategically communicating through a dedicated MHS campaign (i.e., Operation Live Well), and collaborating with ongoing initiatives that support patient-centered care through Patient-Centered Medical Home teams.

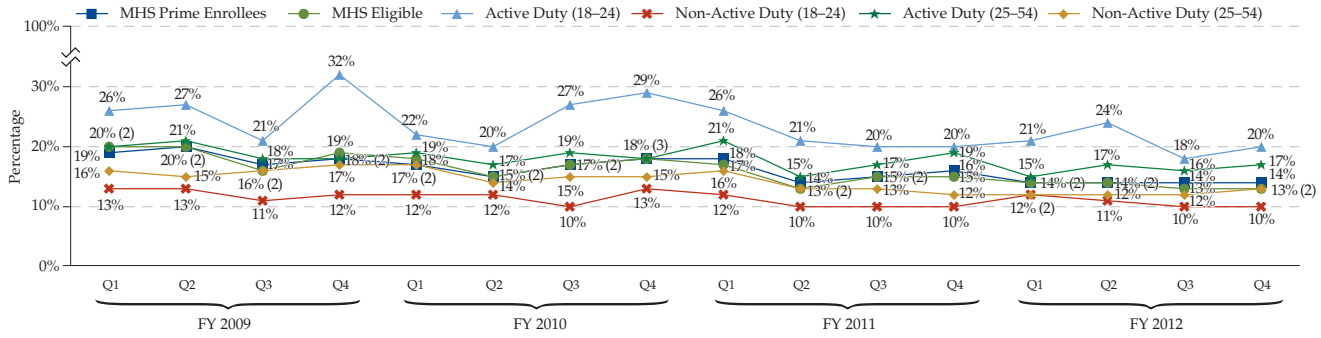
Aligning with MHS participation in the National Prevention Council, MHS is implementing recommendations for the nation's first National Prevention Strategy. These actions are intended to target initiatives that effectively promote health, well-being, and resiliency in support of MHS beneficiaries. Collectively, these efforts will help move our health system from one based on sickness and disease to one based on wellness and prevention.

TOBACCO CESSATION

The Department of Defense (DoD) continues to focus on both preventing and mitigating the impact of tobacco use among military personnel. Having observed increased rates of tobacco use among junior Active Duty military personnel, DoD has implemented an educational campaign as a key component in helping Service members quit using tobacco and lead overall healthier lives. In January 2006, informed by extensive research and testing, the TRICARE Management Activity (TMA) launched the "Quit Tobacco—Make Everyone Proud" campaign, the goals of which include increasing awareness of tobacco's negative social and physical effects, and decreasing its acceptance and use throughout the military work environment. The campaign is designed to motivate tobacco users who want to quit, and is aimed at E1–E4 personnel ages 18 to 24—the age demographic with the highest rates of tobacco usage in the military. The campaign includes a multimedia Web site, a turnkey implementation plan and schedule for installation of project officers, centrally funded promotional materials, and centralized support for special events. On the Web site, *www.ucanquit2.org*, a 24/7 instant messaging chat line is available, staffed by trained coaches/mentors who can help participants identify quitting resources and design a customizable quit plan online. Studies indicate that the average tobacco user makes six to eight quit attempts before succeeding and that few social barriers exist in the military when it comes to tobacco use. However, results from the 2008 DoD Health-Related Behaviors (HRB) Survey of Active Duty Forces report that 26 percent of respondents on installations with high campaign visibility reported seriously thinking of quitting smoking in the next 30 days, compared with 6 percent at 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), TMA continues to support the full implementation of the smoking cessation program.

➤ **MHS Cigarette Smoking:** The chart below shows that, relative to the other categories, self-reported cigarette use among Active Duty Service members ages 18 to 24 remains at high levels (ranging from 18 to 32 percent). While there visually appears to be a downward trend in cigarette smoking, there is no statistical decrease from FY 2009 to FY 2012. 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.

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



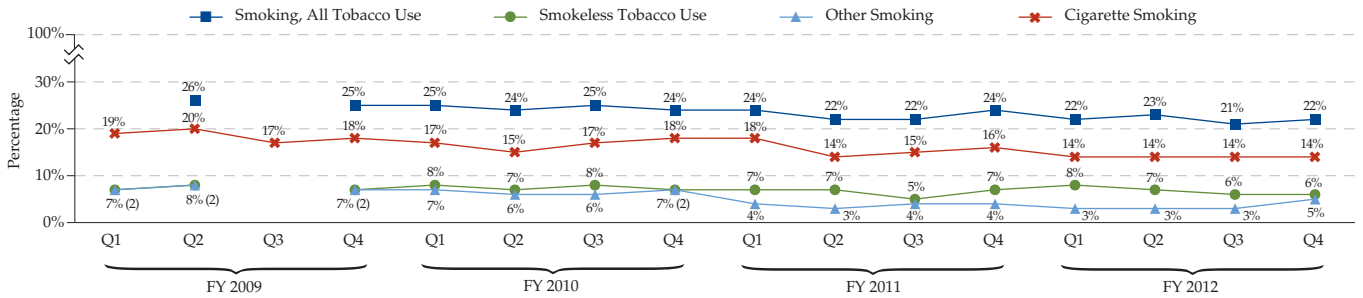
Source: OASD(HA) TMA/OCFO-DHCAPE survey, data provided 11/25/2012

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.
Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

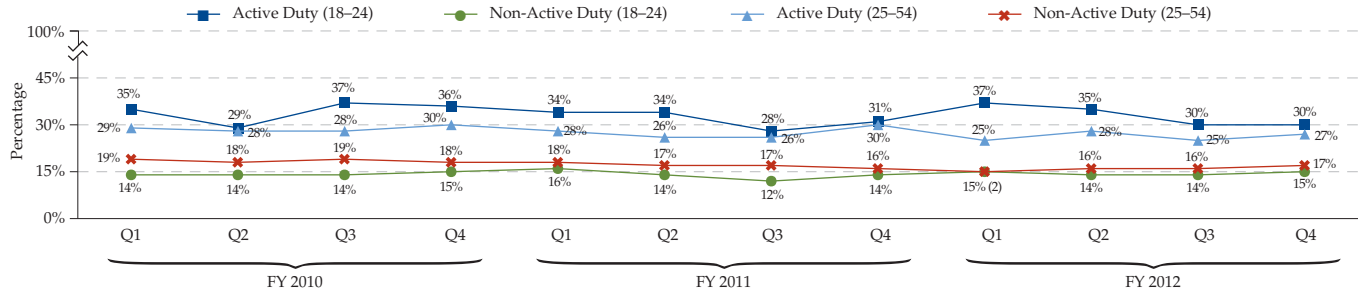
TOBACCO CESSATION *(CONT'D)*

- **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, enrolled family members, and retirees under age 65) has declined since Q1 FY 2008 (red line; shown only since Q1 FY 2009), 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; shown only since Q2 FY 2009). 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 the incidence of self-reported use of cigarettes, smokeless tobacco, cigars, pipes, bidis, or kreteks among four categories of MHS beneficiaries. As with the case of cigarette smoking, 18- to 24-year-old Active Duty are also the highest users of all tobacco products, ranging from 28 to 39 percent over time, and 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, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO



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



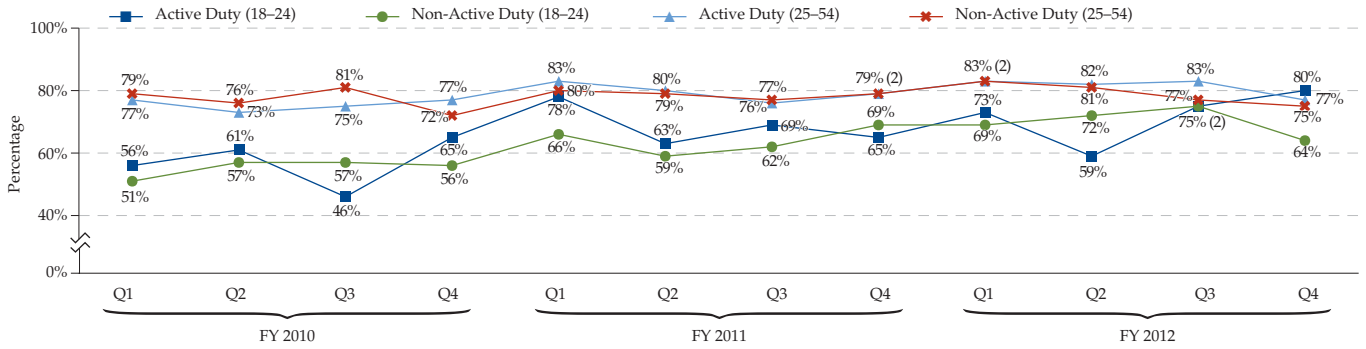
Source: OASD(HA)TMA/OCFO-DHCAPE survey, data provided 11/25/2012

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.
Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

TOBACCO CESSATION *(CONT'D)*

- **MHS Efforts to Counsel Beneficiaries on Ceasing Tobacco Use:** This self-reported 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 that 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 11/25/2012

Note: For visual display, numbers in parentheses on the graph indicate the number of overlapping data points.
Percentages are weighted for the probability of selection and non-response; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

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 ages 18 to 24 across all branches of service. Guided by the results of research, the campaign leverages a multimedia, peer-to-peer social-marketing approach for this age group to increase awareness of the negative, short-term social consequences of excessive drinking, thereby promoting peer disapproval of excessive drinking, and leading to reduced binge-drinking. This campaign includes an award-winning Web site (*www.thatguy.com*), online and offline public service announcements, social media channels (e.g., Facebook and YouTube), a mobile site and game app, funded and pro bono billboard and print advertising, a turnkey implementation plan and schedule for installation project officers, centrally funded promotional materials, and centralized support for special events. In its seventh year, the That Guy campaign also has recently released a smartphone-compatible version of its Web site and created additional focus groups to inform the campaign going forward.

Installation leaders consistently support campaign efforts, as they believe alcohol-related incidents have a negative impact on readiness. To date, more than 800 locations (e.g., aircraft carriers, ships, submarines, and installations) are involved in the campaign in 47 states and 23 countries—the United States, Afghanistan, Australia, Belgium, Portugal, Qatar, Egypt (and other locations in Africa), Bahrain, Greece, Japan, Germany, Italy, Spain, Turkey, Singapore, Cuba, Guam, South Korea, Saudi Arabia, Honduras, United Kingdom, and Iraq.

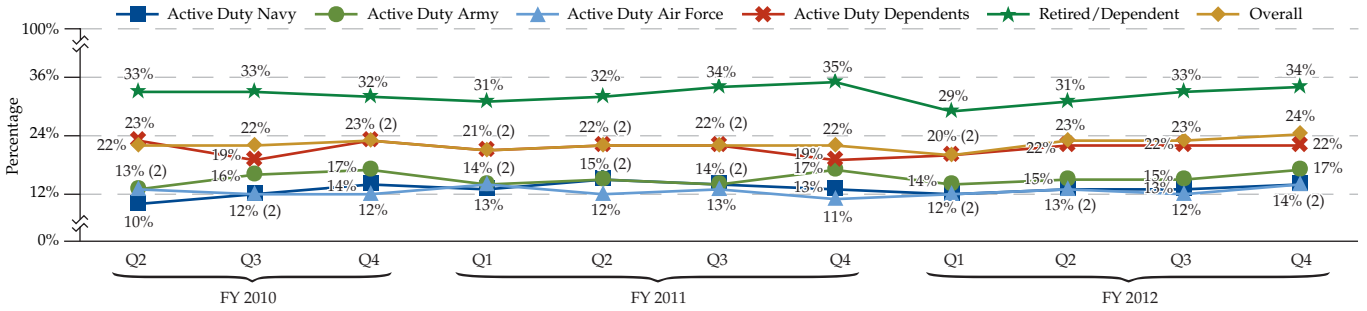
Analysis conducted by Fleishman-Hillard of the 2008 Health Related Behaviors Survey shows that among enlisted Service members across the Army, Air Force, Navy, and Marines ages 18 to 24, overall binge-drinking dropped from 51 percent in 2005 to 46 percent in 2008. The same analysis shows that binge-drinking rates at installations actively implementing That Guy are lower than the rates of their counterparts: 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. According to Fleishman-Hillard's analysis of the annual Status of Forces Survey performed by the Defense Manpower Data Center (DMDC), there has been a steady increase in campaign awareness within the target audience, rising from a "phantom awareness" of 3 percent in 2006, to 14 percent in 2007, 29 percent in 2008, 45 percent in 2009, and 58 percent in 2011. The Status of Forces Survey further shows that binge-drinking is slowly falling, with the target audience's (those 21 and older) participation in binge-drinking (within the past 30 days) decreasing slightly from 55 percent in 2006 to 52 percent in 2009. Preliminary data for 2011 indicate that participation in binge-drinking has decreased to 48 percent, continuing the downward trend.

MHS ADULT OBESITY

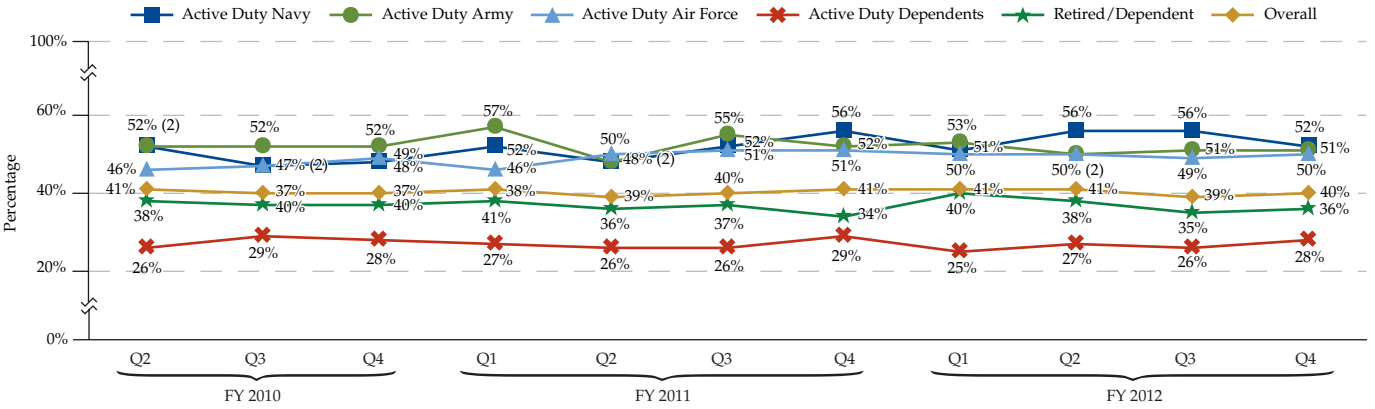
This chart displays the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating body mass index (BMI), result in a measurement of 30 or higher (30 is the threshold for obesity). This measure provides important information about the overall health of DoD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

- As shown in the chart below, retirees and their spouses have rates of obesity comparable to the national average (close to 34 percent) and higher rates than the MHS overall (at about 22 percent) or other beneficiary categories within MHS. They are therefore at higher risk for the comorbidities associated with being overweight and obese. Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison to civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.
- Active Duty BMI rates reflecting potential obesity are very similar across Military Departments within quarterly variation, and hover around 15 percent, well below the National Health and Nutrition Examination Survey (NHANES) rate of 32 percent for 18- to 42-year-olds or 38 percent for adults ages 43 to 64 years.
- Generally, for all but retirees, MHS obesity rates are lower than the overall 33.8 percent of U.S. adults reported as obese.

MHS OBESITY RATE (BMI 30 OR HIGHER)



MHS OVERWEIGHT RATE (BMI 25–29.9)



Source: HCSDB, data provided 12/4/2012

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 x 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, Centers for Disease Control and Prevention [CDC]).

DISEASE MANAGEMENT

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

SURVEY OF HEALTH-RELATED BEHAVIOR AMONG MILITARY PERSONNEL (HRB)

2011 HRB Survey Changes

The results of the 2011 Survey of Health Related Behavior Among Military Personnel (HRB) include self-reported information about the use of alcohol, tobacco, and prescription medications. The 2011 HRB survey underwent considerable changes from the previous 10 reiterations of the HRB with respect to content, questions, and mode of administration. Importantly, the questions related to substance use now closely align with national surveys issued from the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention; reclassify categories of alcohol use; include new forms of smokeless tobacco use such as electronic nicotine products and nicotine dissolvables; clarify the meaning of prescription drug use and misuse; and assess the culture of military substance use. The 2011 HRB, DoD's largest anonymous population-based health survey of Service members, was administered online between August 2011 and January 2012 to a randomized sample of Active Duty personnel from the Army, Navy, Air Force, Marines, and Coast Guard, stratified by Service, gender, pay grade (DoD) or work setting, and pay grade (Coast Guard). Of the 168,366 Active Duty personnel who were sent a letter and four e-mails requesting survey participation, a total of 39,877 usable responses were received, a 23.7 percent response rate. All results are based on stratified weighted samples to match the distribution of the strata in the total military force.

The 2011 HRB was funded by Health Affairs/TRICARE Management Activity with additional support from the U.S. Coast Guard, and the DoD Drug Demand Reduction Program/Under Secretary of Defense for Personnel and Readiness (USD[P&R]) Operational Readiness & Safety.

Because of differences in survey administration and survey questions between the 2011 HRB and earlier HRBs, the results should not be directly compared to past trends of substance use. The results of illicit drug use are not presented, as the responses were statistically unreliable.

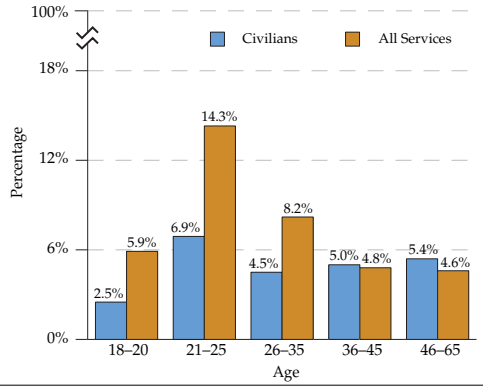
Reported Substance Abuse by DoD and U.S. Coast Guard Active Duty Personnel

Alcohol Use

➤ Overall findings among Active Duty personnel:

- 84.5 percent were current drinkers.
- 58.6 percent were light or infrequent drinkers, having less than four drinks per week, on average.
- 8.4 percent were heavy drinkers, having more than 14 drinks per week for males and more than seven drinks per week for females, on average.
- 33.1 percent reported binge drinking in the past month, consuming more than five drinks for males and more than four drinks for females on one occasion.
- The rate of binge drinking (33.1 percent) was greater than the Healthy People 2020 target of 24.3 percent.

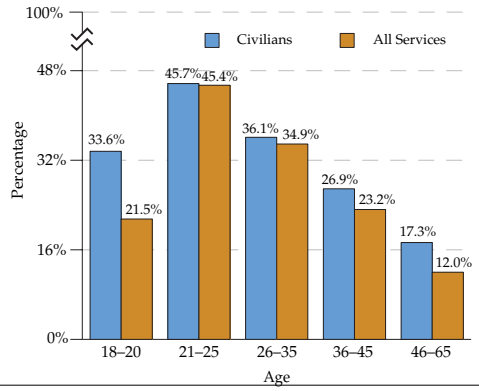
HEAVY DRINKING COMPARISON OF CIVILIANS AND ACTIVE DUTY PERSONNEL BY AGE



Source: TMA/OCFO-DHCAPE, 11/20/2012

Note: The 2011 HRB was aligned with the National Health Interview Survey (2010), which allowed for comparison to national civilian estimates of drinking

BINGE DRINKING COMPARISON OF CIVILIANS AND ACTIVE DUTY PERSONNEL BY AGE



Source: TMA/OCFO-DHCAPE, 11/20/2012

Note: The 2011 HRB was aligned with the National Health Survey on Drug Use and Health (2010), which allowed for comparison to national civilian estimates of binge drinking

Notes:

2011 HRB Questions

- Have you had at least 12 alcoholic drinks over your entire life?
- In the past 12 months, on how many different days would you estimate that you drank any type of alcoholic beverage?
- In the past 12 months, on those days you drank alcoholic beverages, on average how many drinks did you have?

Definitions

Abstainer: Fewer than 12 alcoholic drinks in lifetime
Former drinker: At least 12 drinks in lifetime, but did not drink in the last 12 months
Infrequent/light drinker: Fewer than four drinks per week in the past 12 months
Moderate drinker: Four to 14 drinks for males, and seven or more drinks for females, per week, in the past 12 months
Heavy drinker: More than 14 drinks per week on average for males, and for females, had seven or more drinks per week in the past 12 months

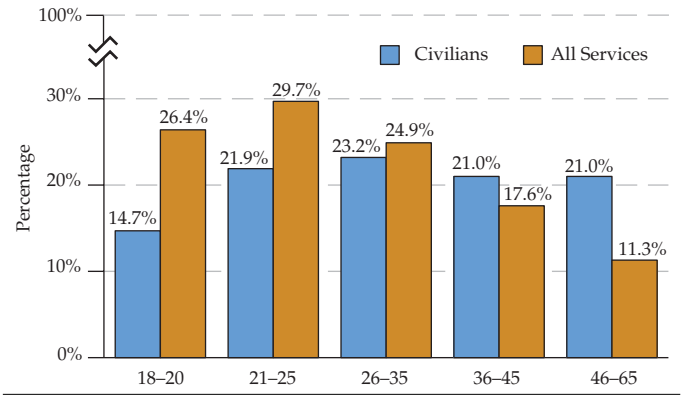
SURVEY OF HEALTH RELATED BEHAVIOR AMONG MILITARY PERSONNEL (HRB) *(CONT'D)*

Tobacco Use

➤ Overall findings among Active Duty personnel:

- 24.1 percent were current cigarette smokers.
- 3.2 percent were classified as heavy smokers—more than one pack of cigarettes per day, on average.
- 19.5 percent used smokeless tobacco, 22.6 percent smoked cigars, and 10.2 percent smoked a pipe in the past year.
- 49 percent used any nicotine-based product in the past year, including cigarettes, smokeless tobacco, cigars, and pipes.
- Rates of cigarette smoking and smokeless tobacco use exceeded Healthy People 2020 targets (12 percent for cigarette smoking, 0.3 percent for smokeless tobacco).

CURRENT CIGARETTE SMOKER COMPARISON OF CIVILIANS AND ACTIVE DUTY PERSONNEL BY AGE



Source: TMA/OCFO-DHCAPE, 11/20/2012

Notes:
2011 HRB Questions (selected questions)
- Have you smoked at least 100 cigarettes in your entire life?
- When did you start smoking cigarettes?
- When was the last time you smoked a cigarette?
- Do you NOW smoke cigarettes every day, some days, or not at all?
- On how many of the PAST 30 DAYS did you smoke a cigarette?
- On the average, how many cigarettes do you now smoke a day?

Definitions
Cigarette use was classified as follows:
Abstainer: Smoked less than 100 cigarettes in lifetime
Former smoker: Smoked at least 100 cigarettes in lifetime, but did not smoke currently
Infrequent smoker: Reported currently smoking cigarettes some days
Light/moderate smoker: Reported smoking cigarettes every day, but less than one pack (20 cigarettes) per day
Heavy smoker: Reported daily smoking and smoked a pack or more (20 cigarettes) per day

Smokeless tobacco use was classified as follows:
Abstainers: No use of chewing tobacco, snuff, or other forms of smokeless tobacco in lifetime
Former users: Use in lifetime, but no use in the past 12 months
Infrequent users: Reported use once per month or less in the past 12 months
Some days users: Use more frequently than once per month but not daily in the past 12 months
Everyday users: Daily use of smokeless tobacco products in the past 12 months

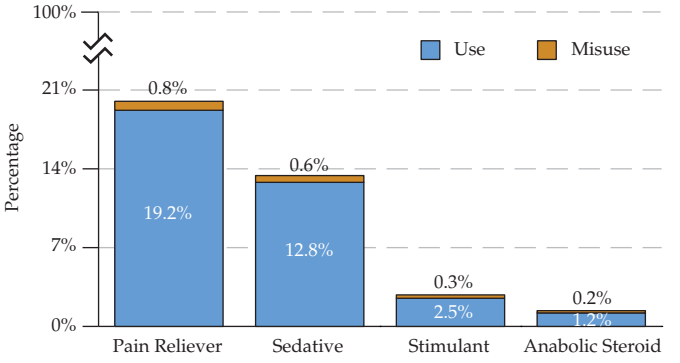
Prescription Drug Use and Misuse

Based on the National Institute on Drug Abuse definition, prescription drug misuse is reported use of stimulants, sedatives, pain relievers, and/or anabolic steroids within the past 12 months AND (1) a positive response to "Prescribed to someone else and I used in the past year" or "Obtained prescription medication another way and I used in the past year"; OR (2) a positive response to "Used a greater amount than prescribed"; OR (3) a positive response to "To feel good (get high or buzzed, etc.)."

➤ Among Active Duty personnel:

- 24.9 percent reported use (including proper use and misuse) of prescription stimulants, sedatives, pain relievers, or anabolic steroids in the past year.
- Pain relievers were used most frequently, with 19.2 percent reporting pain reliever use in the past year. The most common motivation for pain reliever use was "to control pain."
- 1.3 percent misused prescription drugs in the past year, either taking a drug that was not prescribed for them, taking a drug in greater amounts than prescribed, or taking a drug "to feel good" or "get high."

PRESCRIPTION DRUG USE AND MISUSE AMONG ACTIVE DUTY PERSONNEL



Source: TMA/OCFO-DHCAPE, 11/20/2012

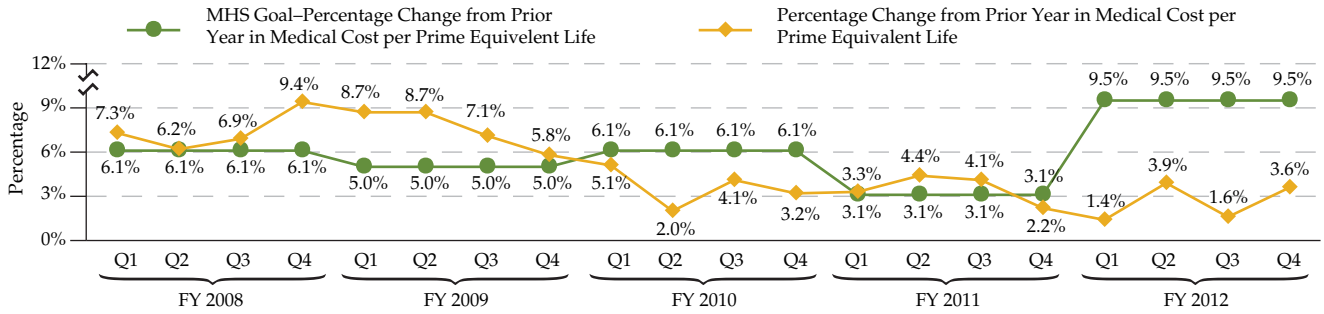
Notes:
2011 HRB Questions
- Have you EVER used the following? (drugs grouped by classification: stimulants, sedatives, pain relievers, anabolic steroids)
- How many days in the PAST 30 DAYS did you use the following?
- IF you have used the following in the PAST 12 MONTHS, how did you obtain it?
- IF you were prescribed the following in the PAST 12 MONTHS, how did you use it?
- How did you obtain the following in the PAST 12 MONTHS?
- What was the reason you took the following in the PAST 12 MONTHS?

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric supporting the Quadruple Aim of managing per capita costs has been to stay below a targeted annual rate of increase based on industry practice. This metric looks at how well the Military Health System (MHS) manages the care for those individuals who have chosen to enroll in a health maintenance organization-type of benefit provided by military facilities. It is designed to capture aspects of three major management issues: (1) how efficiently the military treatment facilities (MTFs) provide care; (2) how efficiently the MTF manages the demand of its enrollees; and (3) how well the MTF determines which care should be produced inside the facility versus that purchased from a managed care support contractor.

- In the area of military health care costs, the Outpatient Prospective Payment System (OPPS) continues to provide pricing reductions for private-sector care as these are phased into full implementation. Pharmacy refunds provide reductions in retail pharmacy, which is the highest cost pharmacy venue. The OPPS and refunds provide short-term pricing decreases, but once fully phased in, pricing will become stable and utilization will again become a cost driver.
- MHS continues to expand the Patient Centered Medical Home (PCMH) strategy. PCMH is a practice model in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. The strategy behind care delivered in a PCMH is to produce better outcomes, reduce mortality and preventable hospital admissions for patients with chronic diseases, lower overall utilization, and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal is based on the Kaiser Family Foundation and the Health Research and Educational Trust (HRET) annual national survey of nonfederal private and public employers with three or more workers. From this survey, the MHS rate is set based on the average annual premiums for employer-sponsored health insurance for family coverage. The FY 2012 goal of a 9.5 percent increase is drastically higher than previous years, based on the higher average premiums forecast in anticipation of the future implementation of the Affordable Care Act (ACA), which limits the growth in premiums according to medical loss ratios. The goal for FY 2013 will be a 3.5 percent increase, in line with prior annual goals, and will place significant pressure on MHS to succeed.

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



Source: Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA])/Office of the Chief Financial Officer (OCFO), MHS administrative data sources (M2: Standard Inpatient Data Record [SIDR]/Standard Ambulatory Data Record [SADR]/CAPER/TRICARE Encounter Data-Institutional [TED-I]/ TED-Noninstitutional [-NI], PDTS; Expense Assignment System IV [EASIV]) as of 2/4/2013. Enrollees are adjusted for age, gender, and beneficiary category. FY 2012 data are reported through September 2012, but Q4 FY 2012 data are preliminary.

SAVINGS AND RECOVERIES

Program Integrity Recoveries/Prepayment Savings

The TRICARE Management Activity (TMA) Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the Defense Health Program. TMA PI executes policies and procedures regarding prevention, detection, investigation, and control of TRICARE fraud and abuse. In calendar year (CY) 2011, PI recovered $40.5 million in court-ordered fraud judgments/settlements and $0.2 million in voluntary disclosures of overpayments from providers. The office monitors contractor PI activities, which in CY 2011 recovered $12.2 million in administrative recoupments and saved $22.3 million in prepayment monitoring of providers.

PROGRAM INTEGRITY RECOUPMENTS/SAVINGS ($ MILLIONS)

	CY 2009	CY 2010	CY 2011
Recoupments	$45.5	$104.6	$52.9
Court-Ordered Fraud Judgments/Settlements	40.9	96.6	40.5
PI Contractor Administrative Recoupment	4.4	8.0	12.2
Voluntary Disclosures of Overpayments	0.2	0.0	0.2
PI Contractor Prepayment Savings	$45.1	$23.1	$22.3

Sources: TRICARE Program Integrity Operational Reports, CY 2009–CY 2011

Excessive/Improper Payments

Between FY 2009 and FY 2012, Defense Health Cost Assessment and Program Evaluation (DHCAPE) identified $127.0 million in possible excessive/improper payments while assessing the effectiveness of internal controls and compliance with current regulation and policy.

Of the possible excessive/improper payments, claims with no other health insurance (OHI) payment for beneficiaries with OHI coverage accounted for $83.7 million and noninstitutional ancillary services billed during inpatient stays contributed to $19.1 million. After claims were processed through TRICARE's Post-Payment Duplicate Claims Software (DCS), identifying $22.7 million (not shown) of improper payments in CY 2012 alone, DHCAPE identified an additional $14.5 million between FY 2009 and FY 2012. Non-network providers and OHI amounts were improperly included in Temporary Military Contingency Payment Adjustment (TMCPA) calculations for OPPS, resulting in $9.7 million of improper payments. The remaining $0.1 million was contributed to a sample of claims paid either over max per procedure code or near billed amount when no max was set.

The possible recoupment not yet collected is mostly due to recoupment processes currently in progress and decisions not to recoup due to financial burden to beneficiaries or providers. DHCAPE is working with Contracting Officer Representatives (CORs) and managed care support contractors (MCSCs) to research, recoup, and identify internal control processes to prevent future errors.

RECOUPMENTS ON EXCESSIVE/IMPROPER PAYMENTS ($ THOUSANDS)

	FY 2009		FY 2010		FY 2011		FY 2012	
	Current	Total Possible	Current	Total Possible	Current	Total Possible	Current	Total Possible
OHI Claims	—	—	$15,792	$22,084	$9,227	$12,713	—	$48,869
Ancillary Claims Paid during Inpatient Stay	$2,532	$3,652	—	—	—	—	—	15,400
Duplicate Institutional Claims	—	—	—	—	3,285	4,378	$2,530	10,134
OPPS–TMCPA	—	—	9,549	9,549	12	128	—	—
Claims Paid Over Max	—	—	—	—	51	104	—	—
Total	**$2,532**	**$3,652**	**$25,340**	**$31,633**	**$12,575**	**$17,323**	**$2,530**	**$74,403**

Sources: DHCAPE, 12/6/2012

Note: Activity was reported by the fiscal year in which issues were identified, not by the year of care.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks

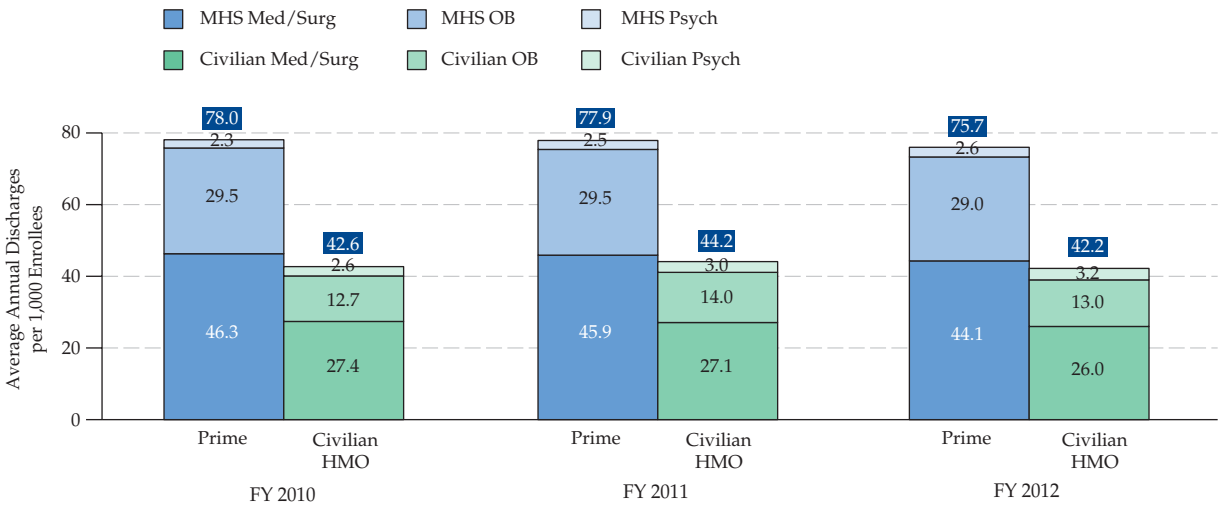
TRICARE Prime Enrollees

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 79 percent higher than the civilian HMO utilization rate in FY 2012 (75.7 discharges per 1,000 Prime enrollees compared with 42.2 per 1,000 civilian HMO enrollees). That is down from 83 percent higher in FY 2010.
- In FY 2012, the TRICARE Prime inpatient utilization rate was 69 percent higher than the civilian HMO rate for MED/SURG procedures, 123 percent higher for OB/GYN procedures, and 17 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) declined by 4 percent between FY 2010 and FY 2012, whereas the average LOS for civilian HMO enrollees declined by 2 percent. In FY 2012, the average LOS for MHS Prime enrollees was 8 percent lower than that of civilian HMO enrollees (not shown).

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



Sources: MHS administrative data, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2012 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

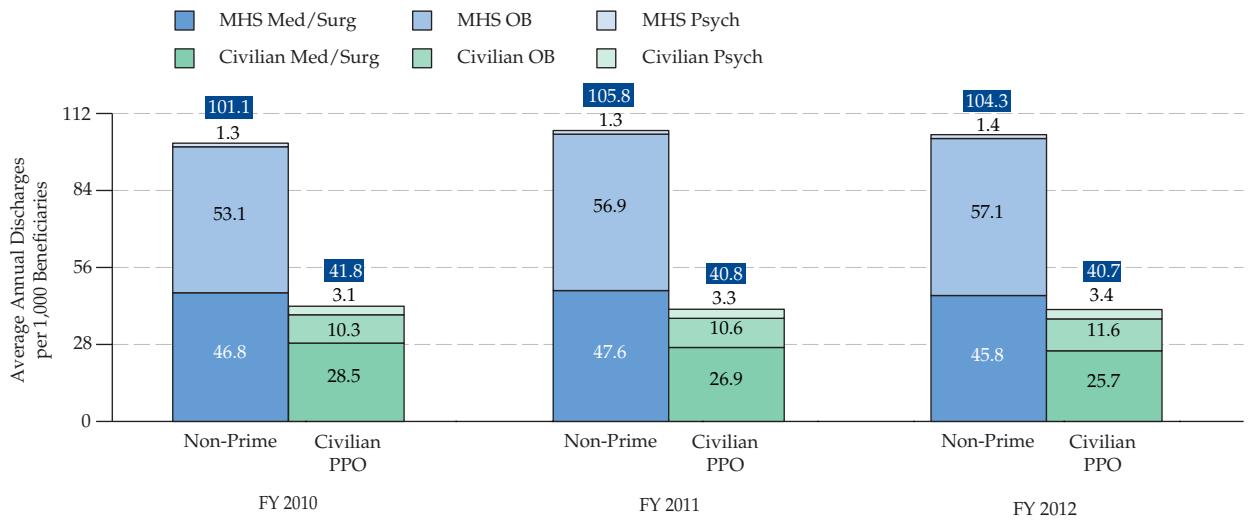
Non-Enrolled Beneficiaries

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 10 and 12 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 2010 to FY 2012, the inpatient utilization rate for non-enrolled beneficiaries increased by 3 percent, while it declined by 3 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 2010 to FY 2012, the MHS OB disposition rate increased by 8 percent, whereas it increased by 12 percent in the civilian sector. In FY 2012, the MHS OB disposition rate was 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 1 percent between FY 2010 and FY 2012, whereas the average LOS for civilian PPO participants declined by 6 percent. As a result, the average LOS for MHS non-Prime beneficiaries was 6 percent higher than that of civilian PPO participants in FY 2012, up from 1 percent higher in FY 2010 (not shown).

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



Sources: MHS administrative data, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS non-enrolled beneficiary population. FY 2012 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

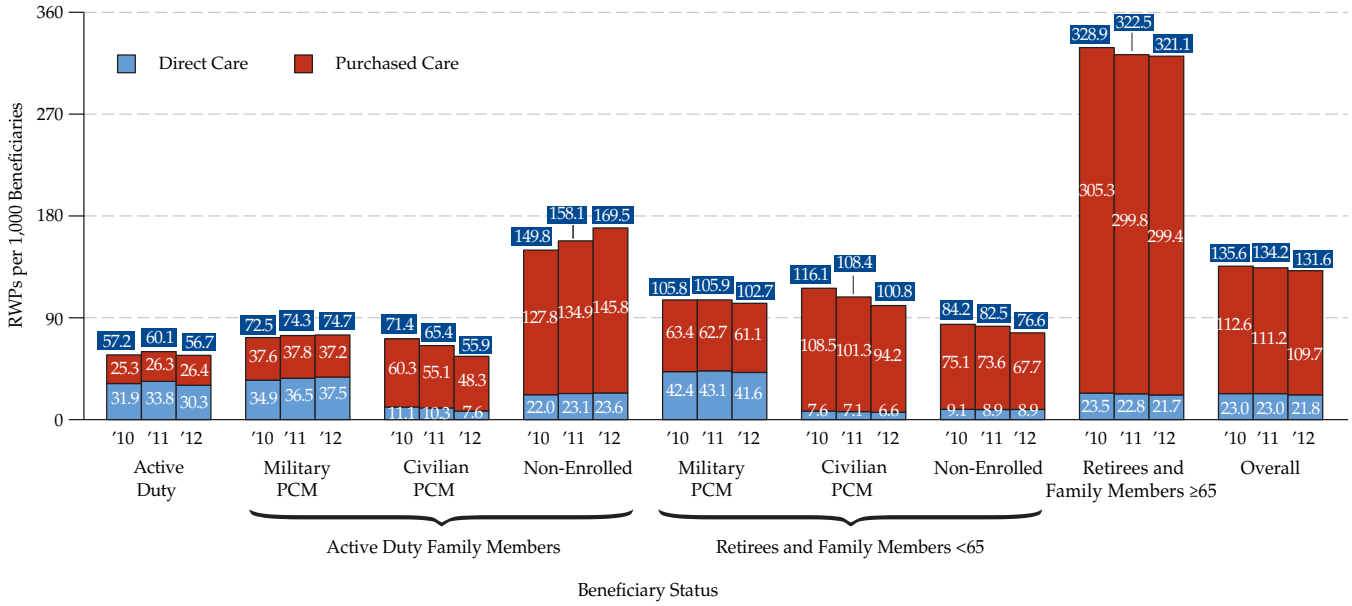
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 2010 to FY 2012.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) decreased by 3 percent from FY 2010 to FY 2012.
- The direct care inpatient utilization rate decreased for all beneficiary groups except non-enrolled Active Duty family members (ADFMs) and for ADFMs with a military primary care manager (PCM; the rate increased by 7 percent for the former and by 8 percent for the latter). ADFMs with a civilian PCM experienced the largest decline (32 percent), followed by retirees and family members with a civilian PCM (13 percent).
- Purchased acute care inpatient utilization rates decreased for all beneficiary groups except Active Duty Service members (ADSMs) and non-enrolled ADFMs (the rate increased by 4 percent for the former and by 14 percent for the latter). ADFMs with a civilian PCM experienced the largest decline (20 percent), followed by retirees and family members with a civilian PCM (13 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 2010 to FY 2012.
- From FY 2010 to FY 2012, 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 2010 to FY 2012.

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



Source: MHS administrative data, 1/24/2013

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

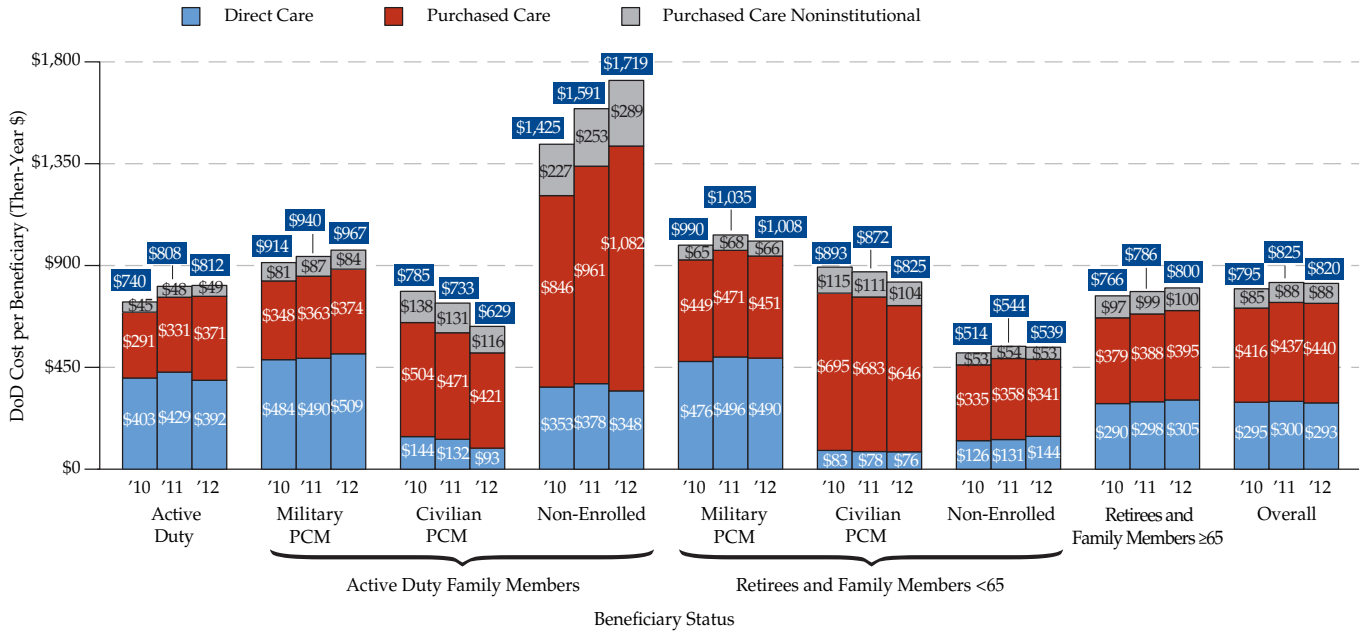
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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), including TRICARE for Life (TFL), increased by 3 percent from FY 2010 to FY 2012. The increases were due largely to higher purchased care costs.

- Non-enrolled ADFMs experienced the largest increase in MHS per capita inpatient cost of any beneficiary group (21 percent) while ADFMs with a civilian PCM experienced the largest decline (20 percent). The only other beneficiary group to experience a decline is retirees and family members with a civilian PCM (8 percent).
- The direct care cost per RWP increased from $12,809 in FY 2010 to $13,420 in FY 2012 (5 percent).
- Exclusive of TFL, the Department of Defense (DoD) purchased care cost (institutional plus noninstitutional) per RWP increased from $8,168 in FY 2010 to $9,059 in FY 2012 (11 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, 1/24/2013

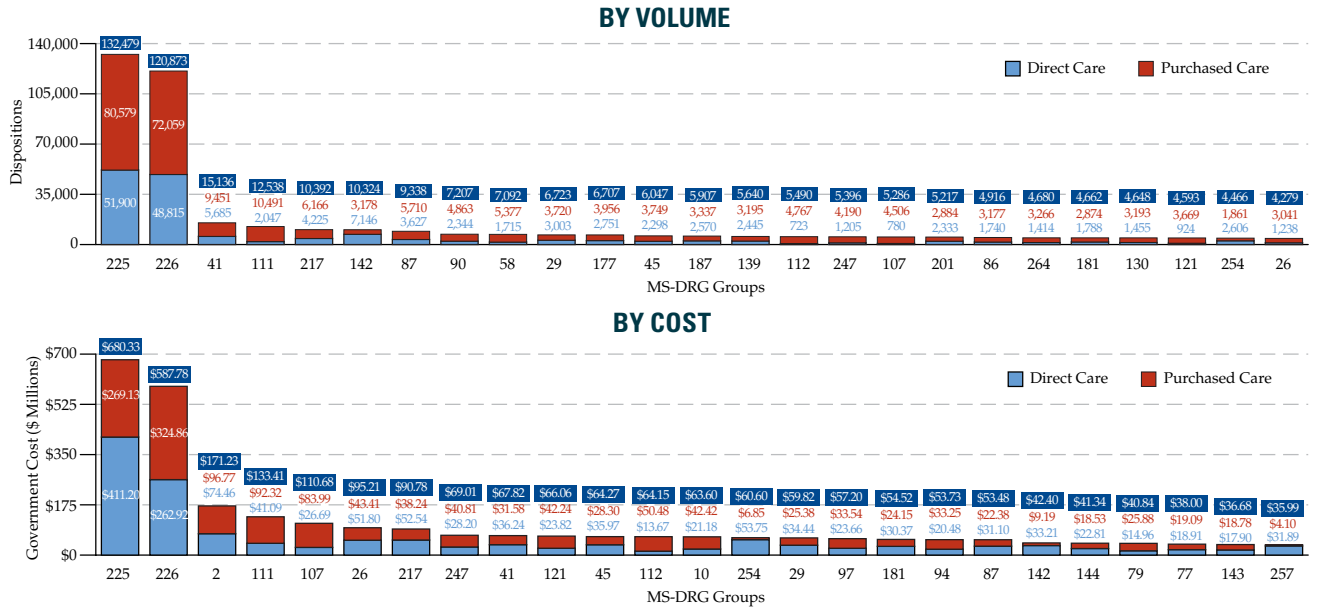
Note: Numbers may not sum to bar totals due to rounding.

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

Leading Inpatient Diagnosis Groups

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 better captures variations in severity of illness and resource usage by reclassifying many diagnosis codes with regard to complication/comorbidity (CC) status. For the purpose of this section, DRGs exhibiting variations in CC status were grouped into like categories and numbered sequentially.

The top 25 MS-DRG groups in terms of volume in FY 2012 accounted for 67 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading DRG groups in terms of cost in FY 2012 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 DRG groups in terms of cost in FY 2012 accounted for 56 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.



Source: MHS administrative data, 1/24/2013

MS-DRG Groups

2	ECMO or tracheostomy
10	Craniotomy
26	Major small and large bowel procedures
29	Appendectomy
41	Esophagitis, gastroenteritis, and miscellaneous digestive disorders
45	Cholecystectomy
58	Seizures and headaches
77	Major chest procedures
79	Respiratory system with ventilator support
86	Chronic obstructive pulmonary disease
87	Simple pneumonia and pleurisy
90	Bronchitis and asthma
94	Cardiac valve and other major cardiothoracic procedures
97	Coronary bypass
107	Spinal fusion except cervical
111	Major joint replacement or reattachment of lower extremity
112	Cervical spinal fusion
121	Percutaneous cardiovascular procedures with coronary artery stent
123	Other vascular procedures
130	Circulatory disorders except AMI, with cardiac catheterization
139	Cardiac arrhythmia and conduction disorders
142	Chest pain
144	Lower extremity and humerus procedures except hip, foot, femur
177	Cellulitis
181	O.R. procedures for obesity
187	Nutritional and miscellaneous metabolic disorders
201	Kidney and urinary tract infections
217	Uterine and adnexal procedures for non-malignancy
225	Pregnancy, childbirth, and the puerperium
226	Newborns and other neonates with conditions originating in perinatal period
247	Septicemia or severe sepsis
254	Psychoses
257	Alcohol/drug abuse or dependence
264	Poisoning and toxic effects of drugs

- The top two procedures by volume are related to childbirth, accounting for 41 percent of all hospital admissions and 25 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 62 percent of the total volume of the top 25 DRG groups but only 50 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only two of the top 25 DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 12 of the top 25 DRG groups.
- Surgical procedures for obesity rank 21st in volume and 17th in cost among the top 25 DRG groups. 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.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

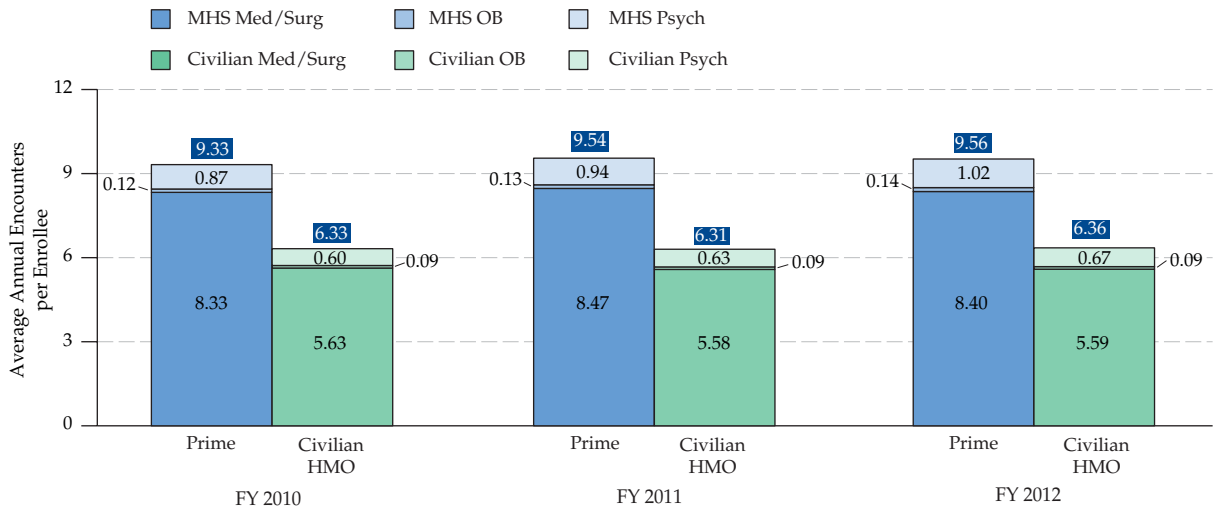
TRICARE Prime Enrollees

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). Purchased care encounters were measured using a different methodology than in previous years' reports. Because encounters do not appear on purchased care claims, they are calculated using a TMA-developed algorithm. The previous measure tended to overstate the number of "face-to-face" encounters with physicians, so the number of encounters shown in this report is lower than those in previous reports.

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 combined) rose by 2 percent between FY 2010 and FY 2012. The civilian HMO outpatient utilization rate remained essentially unchanged over the same period.
- In FY 2012, the overall Prime outpatient utilization rate was 50 percent higher than the civilian HMO rate.
- In FY 2012, the Prime outpatient utilization rate for MED/SURG procedures was 50 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was 44 percent higher than the corresponding rate for civilian HMOs in FY 2012, 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 52 percent higher than the corresponding rate for civilian HMOs in FY 2012. 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, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2012 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 exaggerated.

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

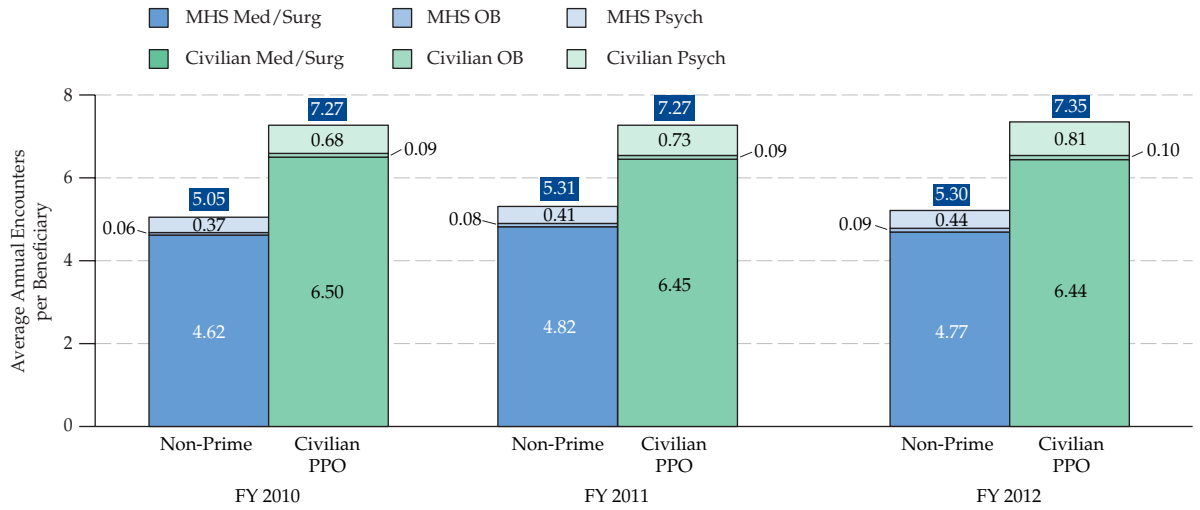
Non-Enrolled Beneficiaries

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. Purchased care encounters were measured using a different methodology than in previous years' reports. Because encounters do not appear on purchased care claims, they are calculated using a TMA-developed algorithm. The previous measure tended to overstate the number of "face-to-face" encounters with physicians, so the number of encounters shown in this report are lower than those in previous reports.

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 10 and 12 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 5 percent from 5.0 encounters per participant in FY 2010 to 5.3 in FY 2012. The civilian PPO outpatient utilization rate increased by 1 percent over the same period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2012, TRICARE non-Prime outpatient utilization was 28 percent lower than in civilian PPOs.
- In FY 2012, the non-Prime outpatient utilization rate for MED/SURG procedures was 26 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 47 percent between FY 2010 and FY 2012, but was still 7 percent lower than the rate for civilian PPO participants.
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 19 percent from FY 2010 to FY 2012; the rate increased by the same amount for civilian PPO participants. In FY 2012, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 46 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, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2012 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

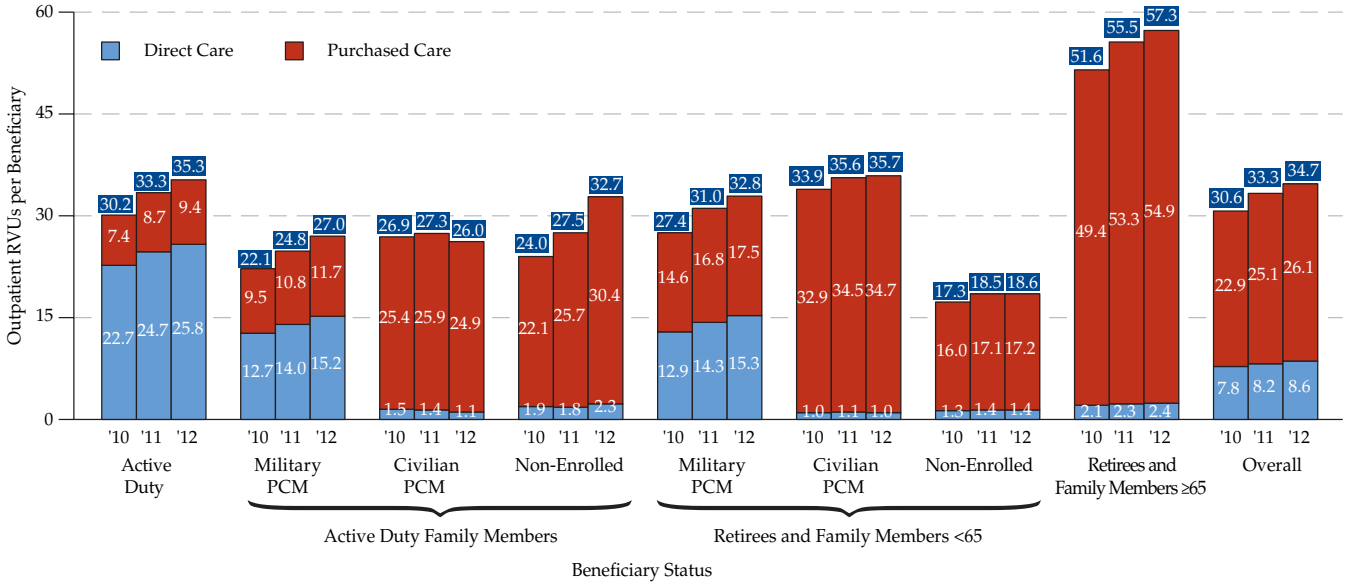
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 Physician Work and Practice Expense RVU measures.

- Total per capita MHS utilization (direct plus purchased care) increased by 13 percent from FY 2010 to FY 2012.
- All beneficiary groups except those with a civilian PCM experienced an increase in direct outpatient utilization from FY 2010 to FY 2012. Per capita utilization increased the most for non-enrolled ADFMs (23 percent), ADFMs with a military PCM (20 percent), and retirees and family members under age 65 with a military PCM (19 percent).
- From FY 2010 to FY 2012, the purchased care outpatient utilization rate increased for all beneficiary groups except for ADFMs with a civilian PCM. The largest increase (38 percent) was experienced by non-enrolled ADFMs. ADSMs also experienced a large increase in purchased care utilization (27 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 8 percent in FY 2011 and by another 3 percent in FY 2012.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/24/2013

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 is a small number who are not.

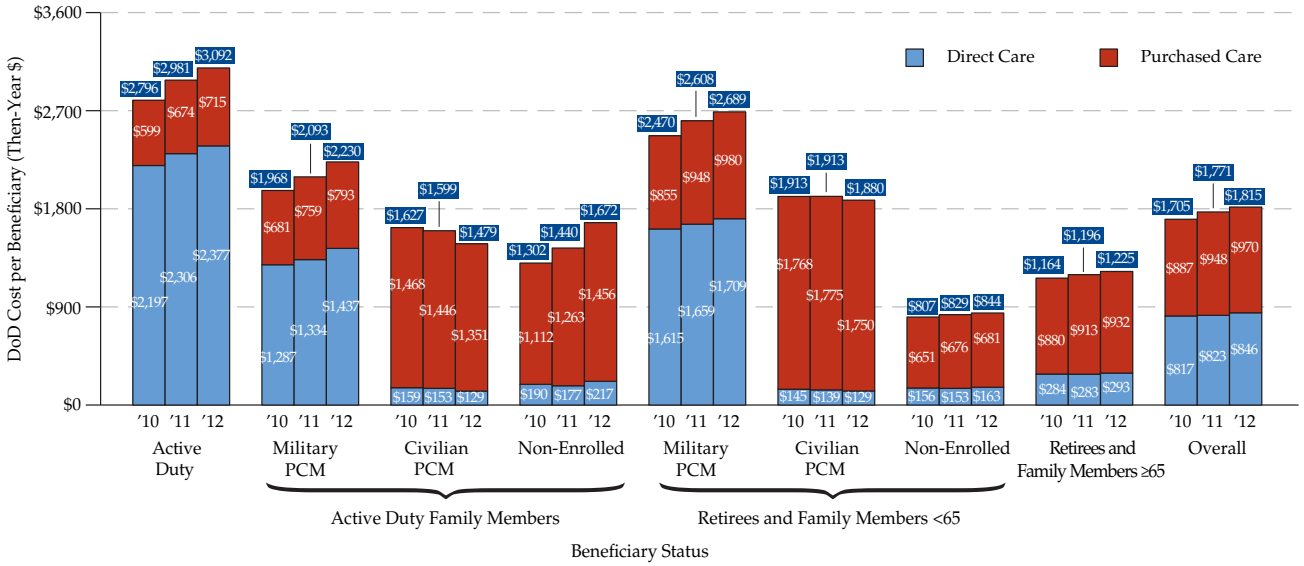
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Costs by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise. Overall MHS outpatient costs (in then-year dollars) per beneficiary (far right columns below), including TFL, increased by 7 percent from FY 2010 to FY 2012.

- The direct care cost per beneficiary increased for all beneficiary groups except those with a civilian PCM (ADFMs and retirees and family members with a civilian PCM experienced declines of 19 percent and 11 percent, respectively). Non-enrolled ADFMs experienced the largest increase (14 percent), followed by ADFMs with a military PCM (12 percent). Seniors experienced the smallest increase (3 percent).
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 8 percent in FY 2011 and by another 2 percent in FY 2012.
- The TFL purchased care outpatient cost per beneficiary increased by 4 percent in FY 2011 and by another 3 percent in FY 2012.[1] The direct care outpatient cost per senior increased by 3 percent in FY 2012 after remaining constant in FYs 2010 and 2011.

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/24/2013

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

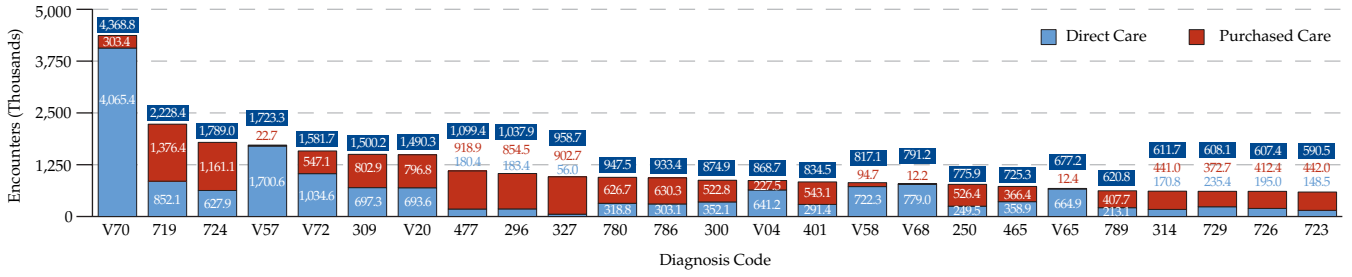
[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

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

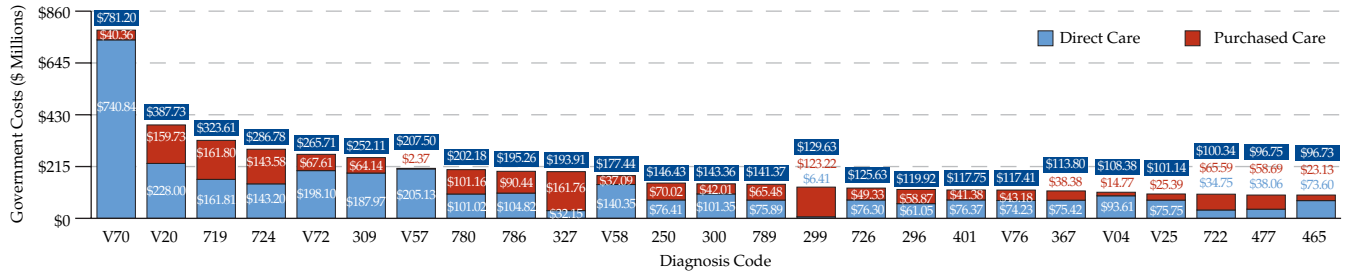
Leading Outpatient Diagnosis Groups

Leading outpatient diagnoses were determined using the primary diagnosis code and then grouping them into like categories based on the first three digits of the ICD-9-CM code. The top 25 outpatient diagnosis groups in FY 2012 accounted for 49 percent of all outpatient encounters (direct care and purchased care combined) and 41 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, 1/24/2013

Diagnosis Group

250	Diabetes mellitus
296	Episodic mood disorders
299	Pervasive developmental disorders
300	Neurotic disorders
309	Adjustment reaction
314	Hyperkinetic syndrome of childhood
327	Organic sleep disorders
367	Disorders of refraction and accommodation
401	Essential hypertension
465	Acute upper respiratory infections of multiple or unspecified site
477	Allergic rhinitis
719	Other and unspecified disorder of joint
722	Intervertebral disc disorders
723	Other disorders of cervical region
724	Other and unspecified disorders of back
726	Peripheral enthesopathies and allied syndromes
729	Other disorders of soft tissues
780	General symptoms
786	Symptoms involving respiratory system and other chest symptoms
789	Other symptoms involving abdomen and pelvis
V04	Need for prophylactic vaccination and inoculation against certain viral diseases
V20	Health supervision of infant or child
V25	Contraceptive management
V57	Care involving use of rehabilitation procedures
V58	Other and unspecified aftercare
V65	Other persons seeking consultation without complaint or sickness
V68	Encounters for administrative purposes
V70	General medical examination
V72	Special investigations and examinations
V76	Special screening for malignant neoplasms

- The top two diagnosis groups by volume are general health examinations (adults and children) and unspecified joint disorders.
- Diagnoses treated in purchased care facilities account for 46 percent of the total volume of the top 25 diagnosis groups but only 36 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only seven of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 19 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.

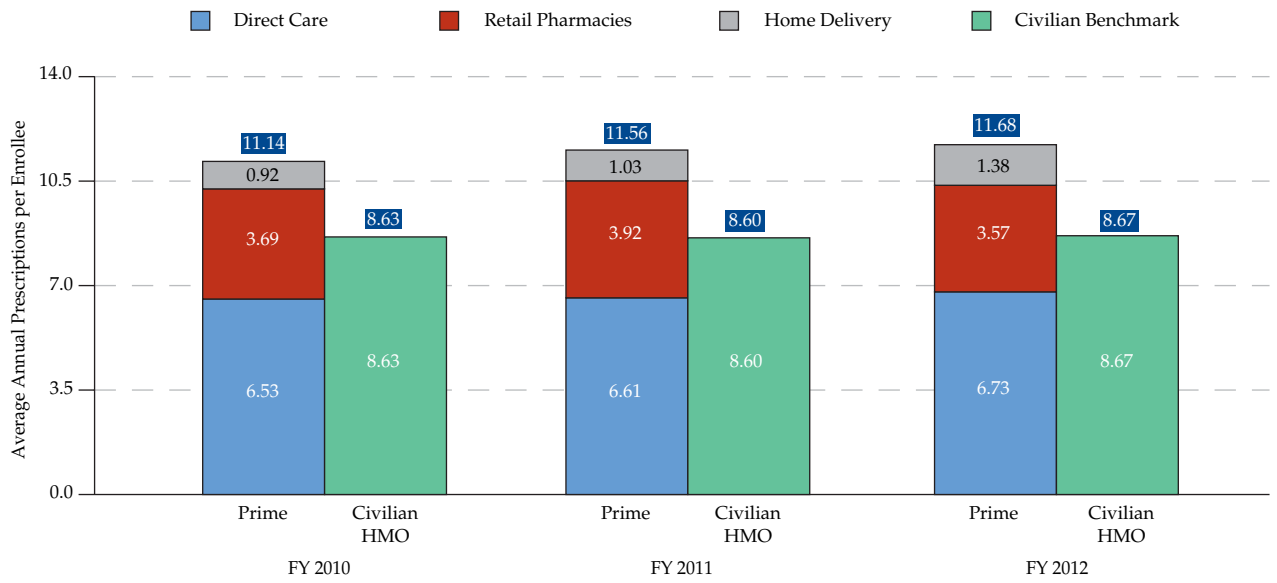
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the TMA Pharmacy 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 5 percent between FY 2010 and FY 2012; the civilian HMO benchmark rate rose by less than 1 percent. In FY 2010, the TRICARE Prime prescription utilization rate was 29 percent higher than the civilian HMO rate; by FY 2012, the disparity had increased to 35 percent.
- Prescription utilization rates for Prime enrollees at DoD pharmacies increased by 3 percent between FY 2010 to FY 2012, whereas the utilization rate at retail pharmacies decreased by 3 percent (because of greater reliance on home delivery services).
- Enrollee home delivery prescription utilization increased by 50 percent from FY 2010 to FY 2012. Historically, home delivery utilization has been small compared to other sources of prescription services. However, in FY 2012, home delivery accounted for 28 percent of purchased care prescription utilization by Prime enrollees.

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



Sources: MHS administrative data, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2012 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)*

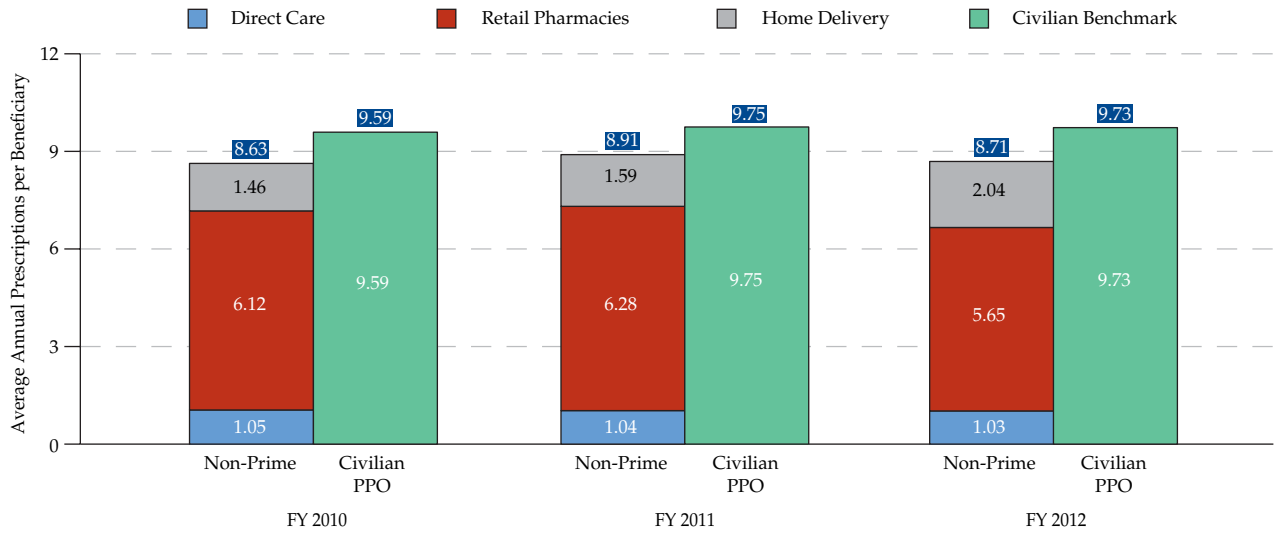
Non-Enrolled Beneficiaries

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 10 and 12 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 1 percent between FY 2010 and FY 2012. During the same period, the civilian PPO benchmark rate increased by less than 2 percent. In FY 2012, 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 2 percent from FY 2010 to FY 2012, whereas the utilization rate at retail pharmacies decreased by 8 percent (because of greater reliance on home delivery services).
- Non-enrollee home delivery prescription utilization increased by 40 percent from FY 2010 to FY 2012. Historically, home delivery utilization has been small compared to other sources of prescription services. However, in FY 2012, home delivery accounted for 26 percent of purchased care prescription utilization by non-enrollees.

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



Sources: MHS administrative data, 1/24/2013, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 12/11/2012

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2012 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

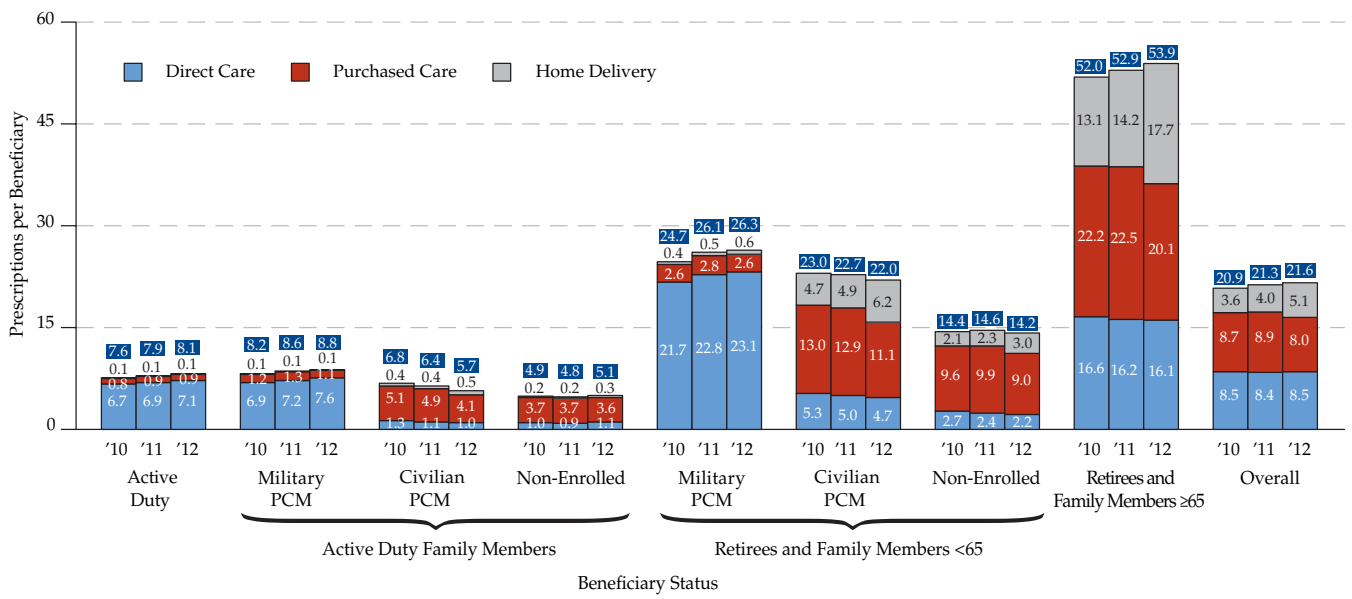
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

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 2 percent from FY 2010 to FY 2012, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 3 percent.
- The average direct care prescription utilization rate remained unchanged between FY 2010 and FY 2012. However, the rate increased by 10 percent for ADFMs, except for those with a civilian PCM (who experienced a decline of 21 percent, similar in magnitude to the decline in inpatient and outpatient utilization for this group). Retirees and family members with a civilian PCM experienced a decline of 11 percent in their direct care prescription utilization.
- Average per capita prescription utilization through nonmilitary pharmacies (civilian retail and home delivery) increased for most beneficiary groups, but most notably for retirees and family members under age 65 with a military PCM and for seniors (7 percent each). Beneficiaries with a civilian PCM experienced declines in their purchased care prescription utilization (14 percent for ADFMs and 2 percent for retirees and family members under age 65).
- Home delivery, which once accounted for only a small fraction of purchased care prescription drug utilization, grew by 39 percent between FY 2010 and FY 2012, to the point where it now accounts for 39 percent of total purchased care prescription drug utilization (as measured by 30-day supply) per capita. For beneficiaries under age 65, home delivery accounts for 27 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 47 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/24/2013

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

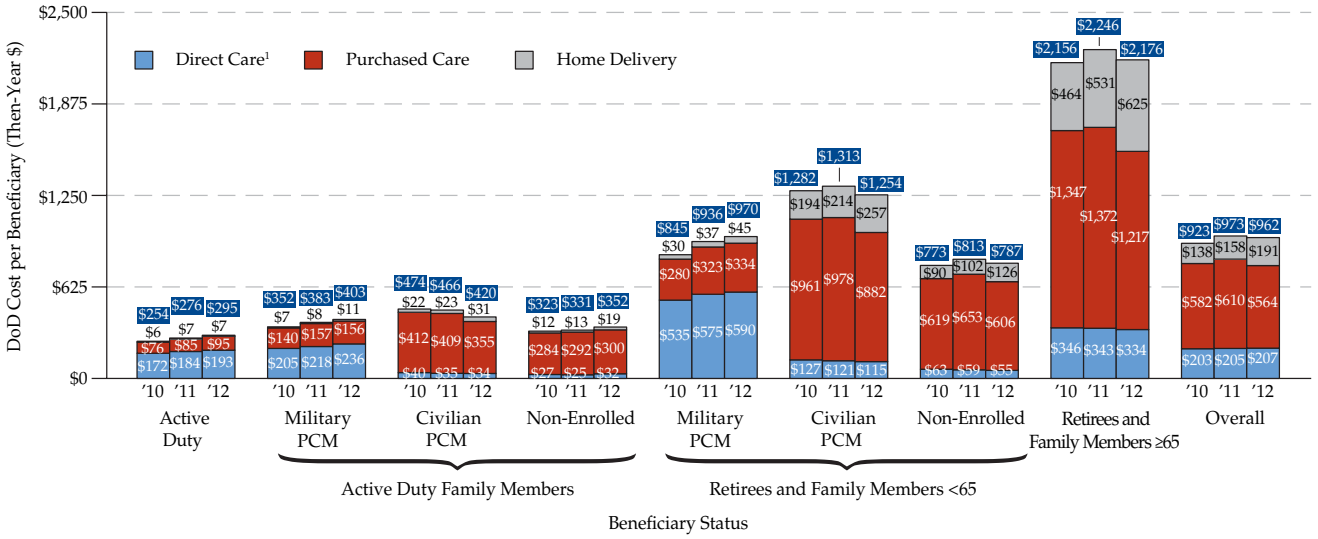
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 23 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far right columns below), including TFL, increased by 4 percent from FY 2010 to FY 2012.

- Exclusive of TFL, per capita prescription drug costs rose by 6 percent between FY 2010 and FY 2012. The largest increase (16 percent) occurred for ADSMs.
- Direct care costs per beneficiary increased by 2 percent, while retail pharmacy costs increased by 2 percent excluding TFL and decreased by 3 percent including TFL.
- Home delivery costs per beneficiary increased by 44 percent excluding TFL and by 39 percent including TFL.
- Most of the increase in per capita home delivery prescription costs is due to increased utilization per beneficiary.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/24/2013

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

[a] 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.

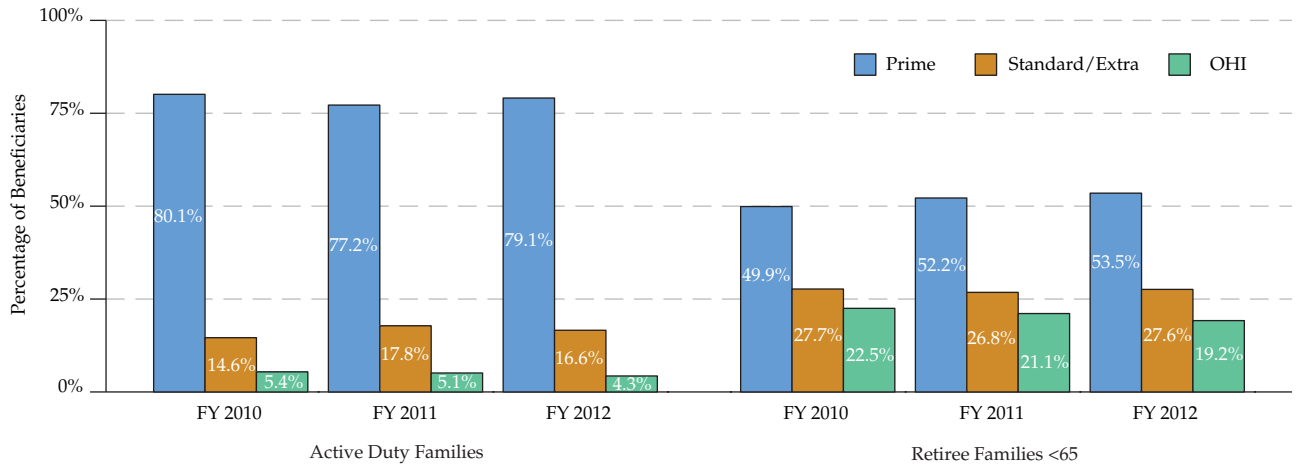
Health Insurance Coverage of MHS Beneficiaries Under Age 65

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 2012, 79.1 percent of Active Duty families and 53.5 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and no OHI coverage. In FY 2012, 16.6 percent of Active Duty families and 27.6 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2012, 4.3 percent of Active Duty families and 19.2 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: HCSDB data for FY 2012 based on total year file released in December 2012, as of 12/31/2012

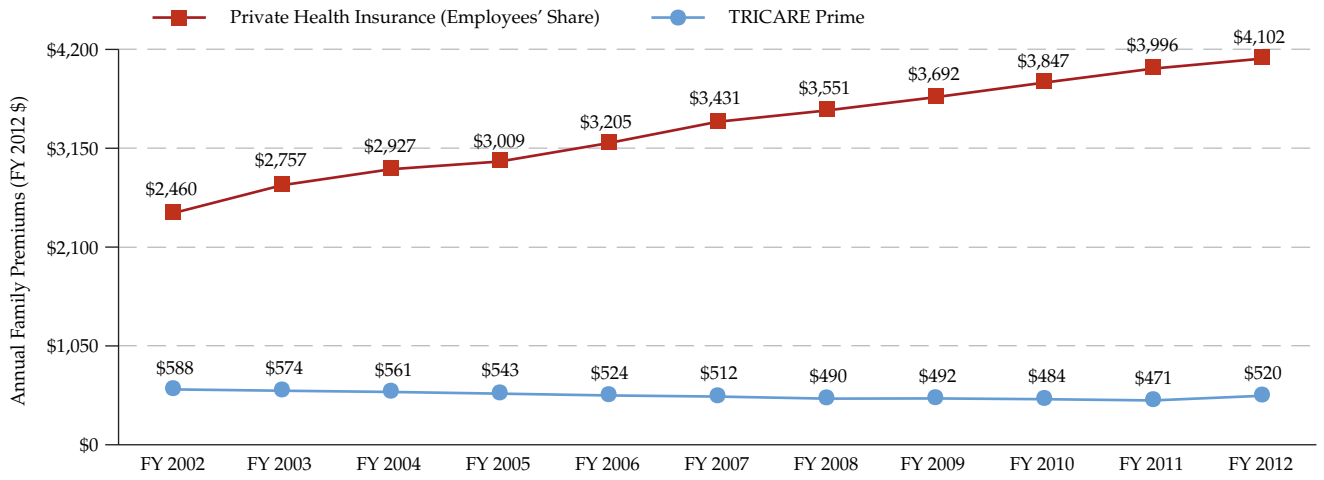
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance, i.e., Federal Employees Health Benefits Plan (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 2002, 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 2012 dollars, the private health insurance premium increased by $1,642 (67 percent) from FY 2002 to FY 2012, whereas the TRICARE premium declined by $68 (–12 percent) during this period.

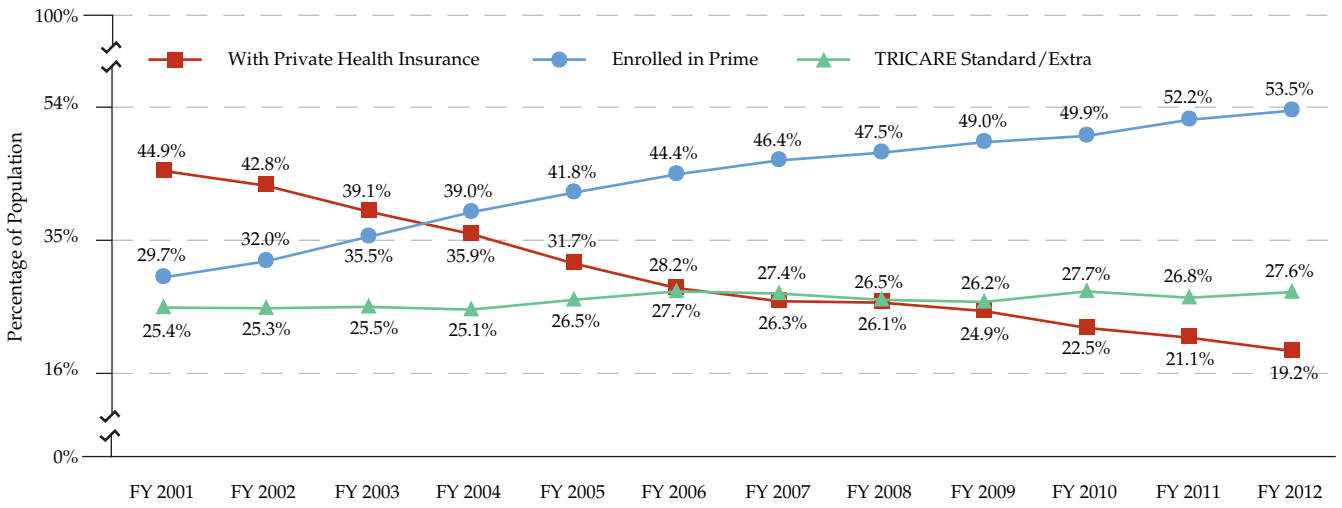
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan: Medical Expenditure Panel Surveys, 2001–2011; forecasted by the Institute for Defense Analyses in FY 2012 based on trends in premiums from Kaiser Family Foundation surveys, as of 12/31/2012

Between FY 2001 and FY 2012, 25.7 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 838,600 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 HCSDB, 2001–2012, as of 12/31/2012

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

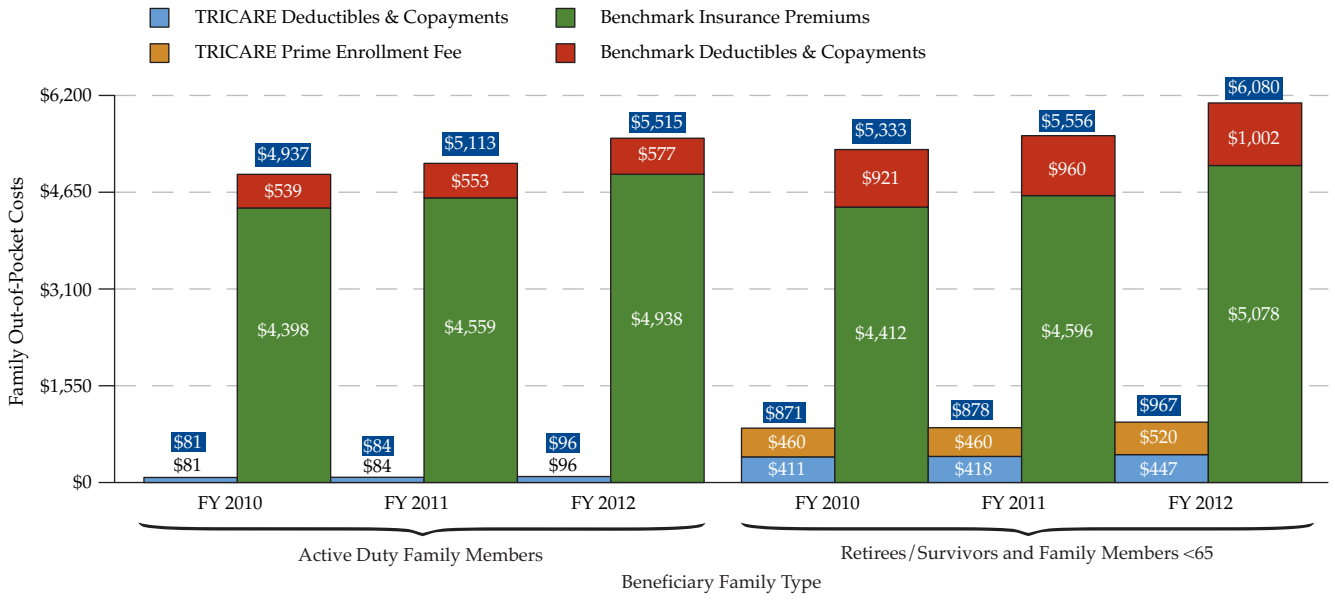
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2010–2012, 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 2012, costs for civilian counterparts were:
  - $5,400 more than those incurred by Active Duty families enrolled in Prime.
  - $5,100 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 2010–2012; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2009–2012; civilian insurance premiums for FYs 2010–2012 from the 2009–2011 Medical Expenditure Panel Surveys; premiums for FY 2012 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys. Private health insurance coverage from HCSDB FYs 2010–2012, as of 12/31/2012. Estimates are for a demographically typical family. For Active Duty dependents, the family includes a spouse and 1.54 children on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

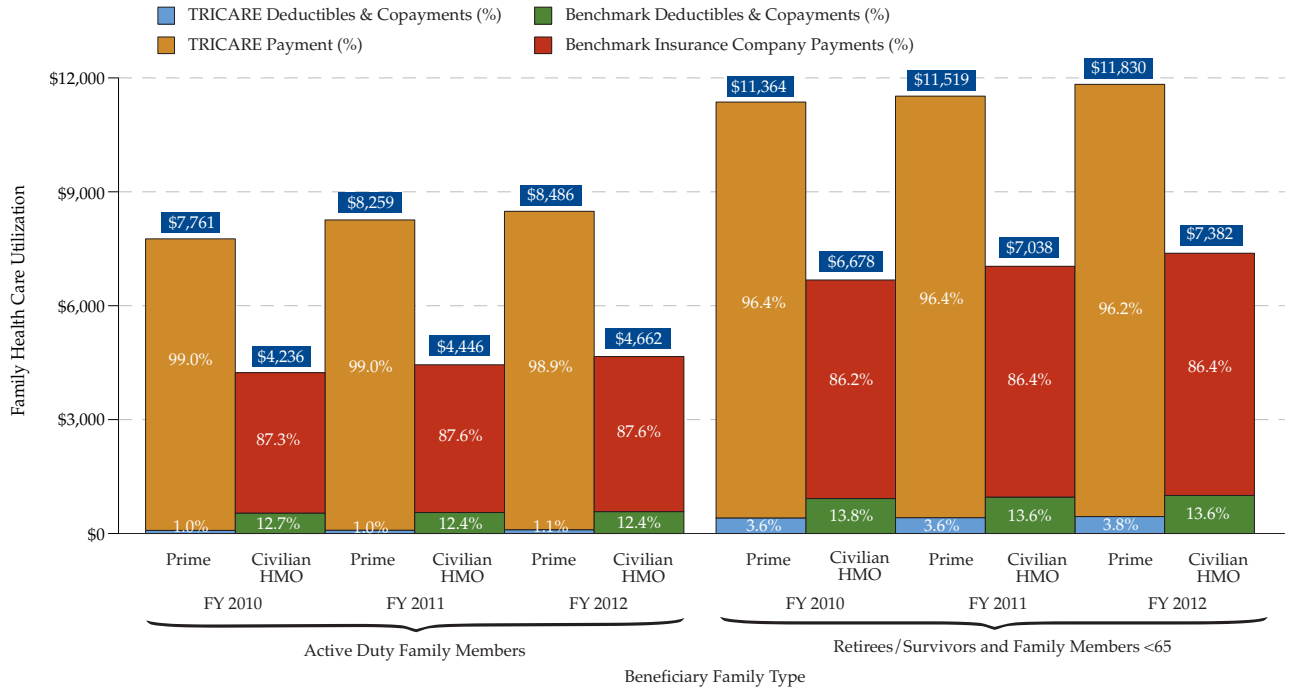
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

Previous private-sector studies found that very low coinsurance rates increase health care utilization (dollar value of health care services).[1] In FYs 2010–2012, 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 2012, the coinsurance rate for Active Duty families was 1.1 percent versus 12.4 percent for civilian counterparts.
  - In FY 2012, the coinsurance rate for retiree families was 3.8 percent versus 13.6 percent for civilian counterparts.
- TRICARE Prime enrollees had 63–82 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2012, Active Duty families consumed $8,500 of medical services versus $4,700 by civilian counterparts (82 percent higher).
  - In FY 2012, retiree families consumed $11,800 of medical services versus $7,400 by civilian counterparts (60 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 2010–2012; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2009–2012, as of 12/31/2012

[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.

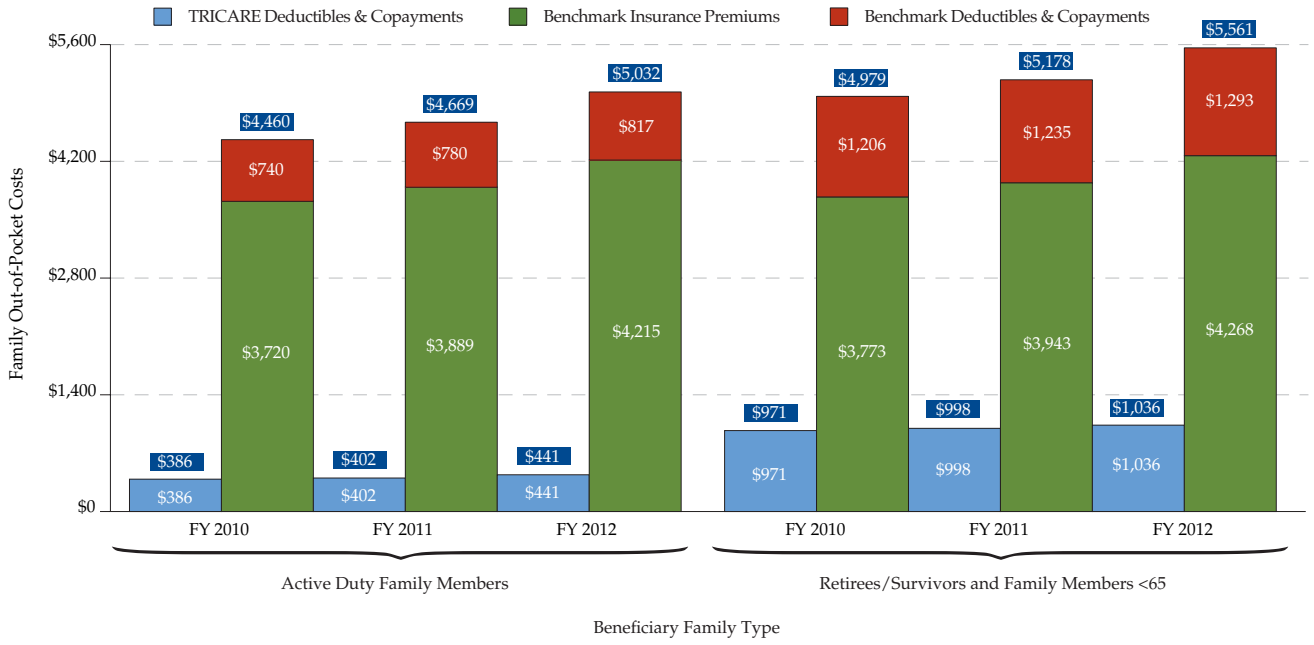
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FY 2010 to FY 2012, 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 2012, costs for civilian counterparts were:
  - $4,600 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $4,500 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 2010–2012; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2009–2012; civilian insurance premiums for FYs 2010–2011 from the 2009–2011 Medical Expenditure Panel Surveys; premiums for FY 2012 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys. OHI coverage from HCSDB, FYs 2010–2012, as of 12/31/2012

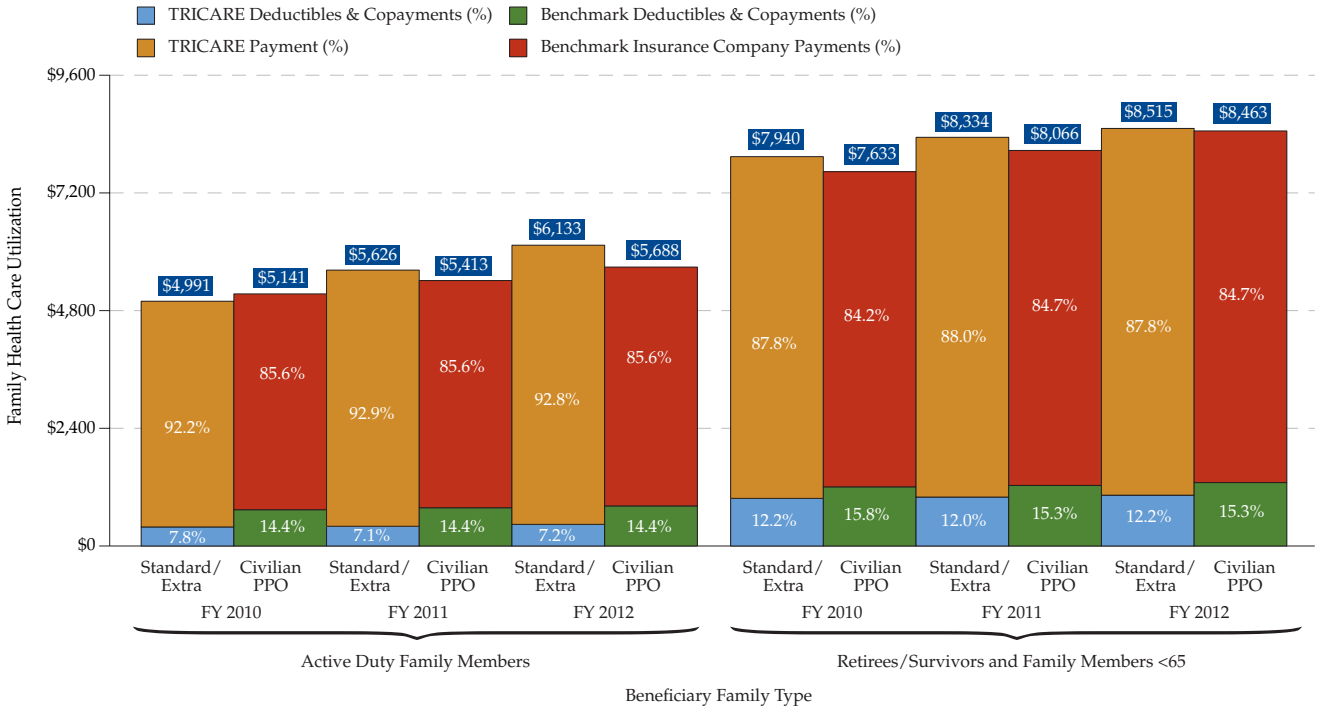
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2010–2012, families who relied on TRICARE Standard/Extra had only slightly lower average coinsurance rates (deductibles and copayments per dollar of utilization) than civilian counterparts. As a result, utilization (dollar value of health care services consumed) was slightly higher for TRICARE Standard/Extra families compared with civilian counterparts in FYs 2010–2012.

- TRICARE Standard/Extra reliant families had somewhat lower average coinsurance rates than civilian PPO counterparts.
  - In FY 2012, Active Duty families had a coinsurance rate of 7.2 percent versus 14.4 percent for civilian counterparts.
  - In FY 2012, the coinsurance rate for retiree families was 12.2 percent versus 15.3 percent for civilian counterparts.
- In FY 2012, health care utilization was slightly higher for TRICARE Standard/Extra families compared with civilian PPO counterparts.
  - In FY 2012, Active Duty families consumed $6,100 of medical services versus $5,700 by civilian counterparts (7.8 percent greater).
  - In FY 2012, both retiree families and civilian counterparts consumed about $8,500 of medical services.

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 2010–2012; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2009–2012, as of 12/31/2012

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

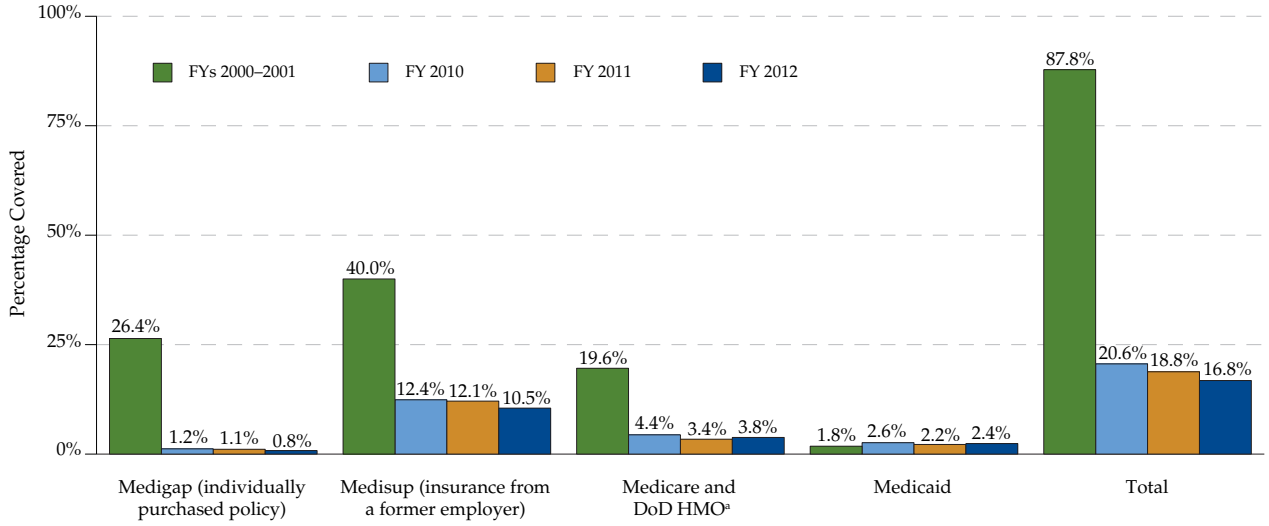
Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL[a]

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 16.8 percent in FY 2012.
- Why do a sixth 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 HCSDB, as of 12/31/2012

[a] Insurance coverage for DoD HMOs includes TRICARE Senior Prime (until December 2001) and the USFHP. Medisup includes those with Medicare who are covered by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. About 1 percent of TRICARE seniors have OHI; these are excluded from the above figure, as of 12/31/2012.

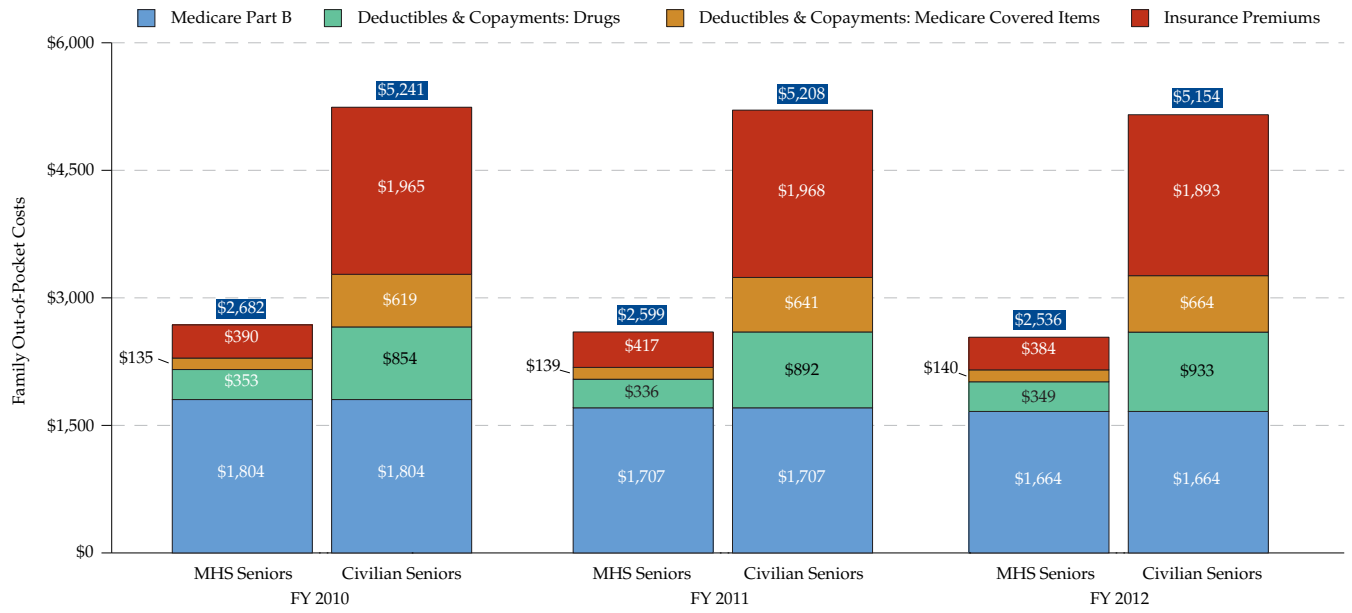
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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

About 83 percent of TRICARE senior families are TFL users; the other 17 percent use little or no military health care. 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 FY 2012, out-of-pocket costs for MHS senior families were about 50 percent less than those of "before TFL" civilian counterparts.
- In FY 2012, MHS senior families saved about $2,600 as a result of TFL and added drug benefits.

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



Sources: Data from Medical Expenditure Panel Surveys and projections, 2009–2012; 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 2009–2012; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, 2000–2001 and FYs 2010–2012, as of 1/30/2013. Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

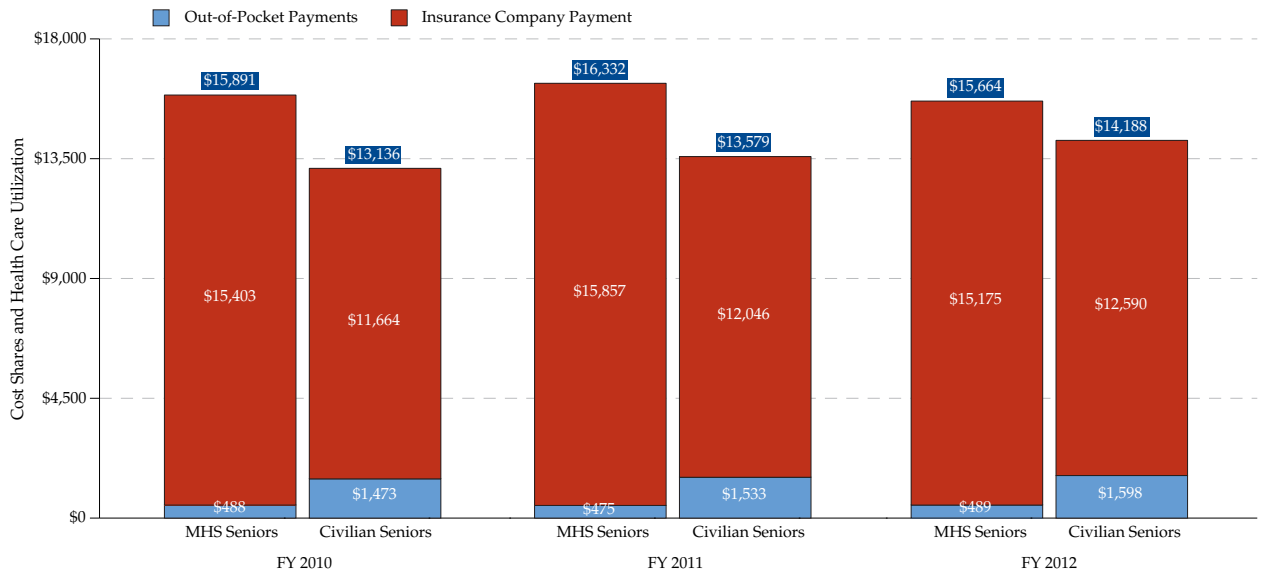
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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 more health care services consumed for seniors.[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 2012, the coinsurance rate for MHS seniors was 3.1 percent; it was 11.3 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FYs 2010 to 2012, MHS families consumed 10 to 20 percent more medical services than their civilian counterparts.[2]

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 2010–2012; expenditures for TFL non-users and civilian counterparts from Medical Expenditure Panel Surveys and projections, 2009–2012; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, 2000–2001 and FYs 2010–2012, as of 1/30/2013

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

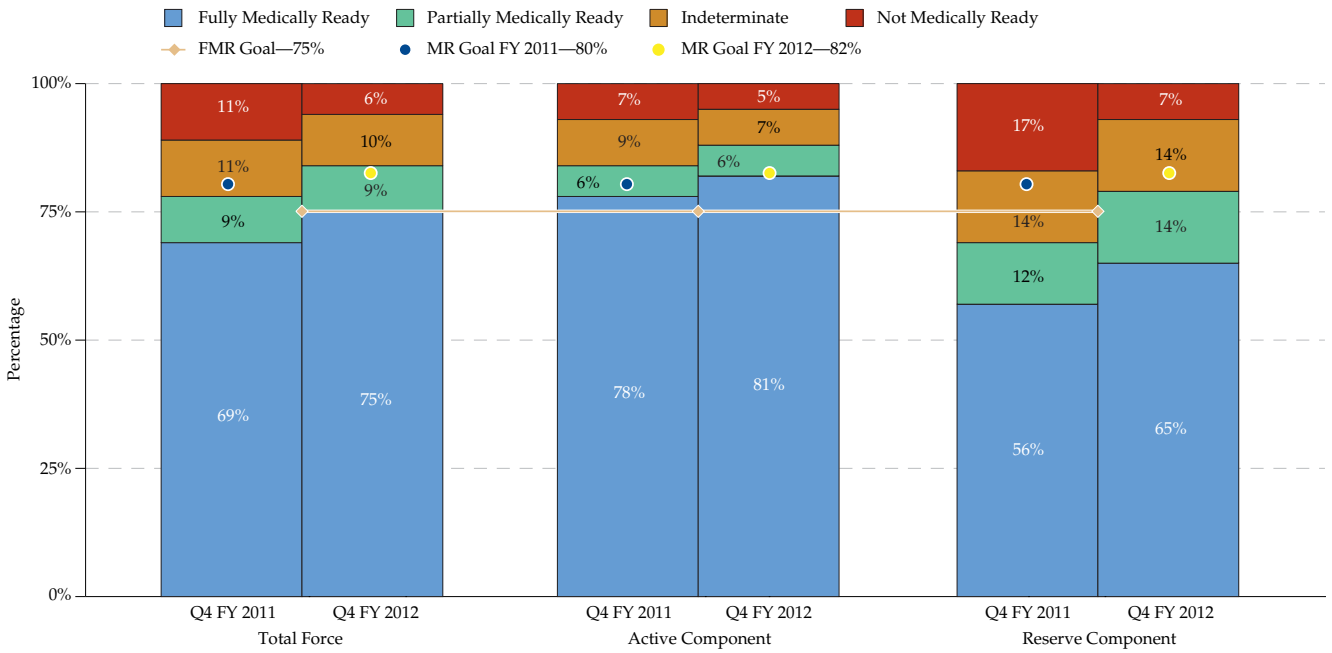
[2] MHS senior families consumed about 20 percent more health care than their civilian counterparts in FYs 2010 and 2011. In FY 2012, the difference was only 10 percent, but the civilian estimate is biased downward (too low). The calculations for civilian counterparts in FY 2012 are based on Medical Expenditure Panel Surveys projections that do not reflect the effects of Medicare policy changes, e.g., greater use of generic drugs. These changes reduced the dollar value of utilization for MHS beneficiaries but are not yet reflected in the civilian estimates. As a result, the difference in utilization is understated in FY 2012.

MEDICAL READINESS OF THE FORCE

The MHS Individual Medical Readiness (IMR) program provides a means to assess an individual Service member's, or larger cohort's (e.g., unit or Service Component), readiness level against established readiness requirements and metrics applied to key elements to determine medical deployability in support of military operations. The Department of Defense (DoD) began tracking IMR status in 2003 to ensure that Service members, both Active Component (AC) and Reserve Component (RC), were medically ready to deploy when required. The six requirements tracked are Satisfactory Dental Health, Completion of Periodic Health Assessments (PHAs), Free of Deployment-Limiting Medical Conditions, Current Immunization Status, Completion of Required Medical Readiness Laboratory Tests, and Possession of Required Individual Medical Equipment.

As shown in the chart below, by the end of fiscal year (FY) 2012, the total force and AC surpassed the established DoD policy goal of 75 percent force medically ready (combined fully medically ready and partially medically ready) and the Under Secretary of Defense for Personnel and Readiness strategic goal of 82 percent medically ready (previously 80 percent), while the RC was close at 79 percent. The total force medically ready share increased by six percentage points, from 78 percent by the end of FY 2011 to 84 percent at the end of FY 2012. The AC's medically ready status increased by three percentage points (from 84 percent at the end of FY 2011 to 87 percent at the end of FY 2012), and the RC increased by 11 percentage points (from 68 percent to 79 percent over the same time). This represents progress in the IMR status of the force, meeting the overall goal in FY 2012. However, there are significant differences in the IMR status between the AC and RC. The biggest challenge is to ensure that all components meet the established goals. DoD is working hard at making medical and dental services more available to close this gap.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS: COMPARING 4TH QUARTER FY 2011 TO 4TH QUARTER FY 2012 (ALL COMPONENTS NOT DEPLOYED)



Source: Military Services data compiled by the Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA])/Force Health Protection & Readiness, 1/22/2013

HEALTHY, FIT, AND PROTECTED FORCE

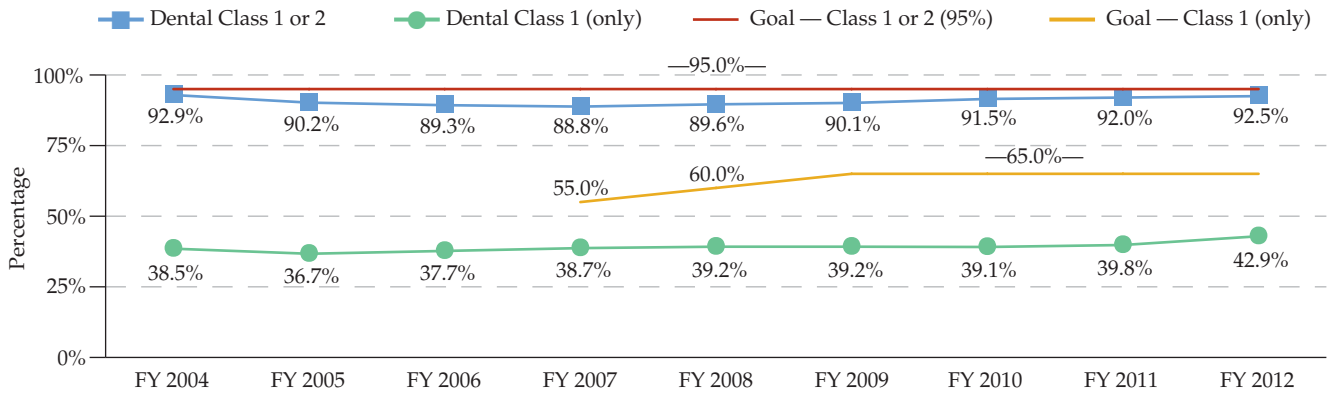
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates;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

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require nonurgent dental treatment or re-evaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). This goal also provides a measure of Active Duty access to necessary dental services.

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high and reflects a gradual increase each year since FY 2007, reaching 92.5 percent in FY 2012, and within less than three percentage points of the long-standing MHS goal of 95 percent. Since FY 1997, the readiness in combined Classes 1 and 2 hovered between a low of 87.5 percent (FY 1997) and a high of 93.4 percent in FY 2001 (not shown).
- The rate for Active Duty personnel in Dental Class 1 has increased in the past two years, from about 39 percent (FY 2010) to almost 43 percent in FY 2012, remaining 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, 11/2/2012

Definitions:

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

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

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 Truven Health Analytics 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 2010–FY 2012) 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 an 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—12/13/2012
  - Eligibility/Enrollment data—1/8/2013
  - MHS Workload/Costs—1/24/2013
  - Web site uniform resource locators—1/31/2013
- 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 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with 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.

The worldwide, multiple-mode Adult HCSDB is conducted on a quarterly basis (every January, April, July, and October). The survey request is transmitted by e-mail to Active Duty and by postal mail to all other beneficiaries, with responses accepted by postal mail or Web. A worldwide Child HCSDB focusing on preventive services and healthy behaviors was in the field at the time of this writing 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 preventive care services. In addition, the Adult survey provides 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 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 explore specific topics of interest, such as the acceptance and prevalence of preventive services including colorectal cancer screening and annual influenza immunizations, availability of other non-DoD health insurance, childhood active and sedentary lifestyles, and 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 HCSDB in 2009 were 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 Version 4 CAHPS used the HCSDB fielded in 2010, 2011, and 2012 come from the 2009, 2010, and 2011 National CAHPS Benchmarking Database (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 health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (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 DoD. Beneficiaries' health plans are identified from a combination of self-report and administrative data. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

DATA SOURCES *(CONT'D)*

Access and Quality

Survey-based measures of MHS access and quality were derived from the 2010, 2011, and 2012 administrations of the HCSDB, TRISS, and TROSS, while military hospital quality measures were abstracted from clinical records by trained specialists and reported to the Joint Commission. The comparable civilian-sector benchmarks came from the NCBDs for 2009, 2010, and 2011 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 institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (purchased care) and MS-DRG RWPs, the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and purchased care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs). MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. 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 nonphysician 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*.

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 Defense Enrollment Eligibility Reporting System (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 January 2013 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 Truven Health Analytics 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 gender 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	90,691	72,099	1,103
AL	208,574	96,731	4,854
AR	91,140	38,487	3,686
AZ	203,177	103,654	5,131
CA	846,735	501,469	16,928
CO	247,689	159,258	5,919
CT	50,624	23,325	1,174
DC	23,937	17,981	381
DE	33,613	17,291	807
FL	686,093	345,154	13,678
GA	448,793	285,580	8,788
HI	165,835	127,159	1,887
IA	43,686	10,581	4,042
ID	49,807	21,392	3,180
IL	151,667	75,022	5,145
IN	88,885	27,547	5,160
KS	134,943	84,734	4,100
KY	166,396	105,960	4,267
LA	133,647	75,216	5,369
MA	72,437	30,925	3,480
MD	245,281	162,067	3,400
ME	40,158	23,746	1,583
MI	98,140	27,545	3,787
MN	67,865	15,572	6,459
MO	155,461	71,822	7,827
MS	117,087	61,089	5,191
MT	34,904	13,182	1,731
NC	526,827	347,466	8,389
ND	32,732	21,153	1,817
NE	62,235	30,889	3,108
NH	29,747	15,154	1,178
NJ	85,244	39,888	2,601
NM	90,230	51,780	1,253
NV	102,067	54,507	2,090
NY	188,630	96,596	4,082
OH	164,964	69,181	7,163
OK	166,997	97,887	3,663
OR	66,739	20,981	2,922
PA	161,717	48,079	5,783
RI	25,168	12,450	665
SC	245,410	135,892	5,692
SD	33,350	14,442	3,488
TN	193,422	90,054	7,408
TX	889,855	554,019	19,967
UT	70,830	32,658	6,116
VA	754,104	460,496	9,076
VT	12,832	5,268	789
WA	369,595	245,303	6,470
WI	68,566	15,940	4,619
WV	36,366	8,525	1,803
WY	22,098	11,831	1,011
Subtotal	**9,096,990**	**5,075,027**	**240,210**
Overseas	**564,772**	**353,348**	**3,381**
Total	**9,661,762**	**5,428,375**	**243,591**

Notes:

- Source of data is HA/TMA administrative data systems, as of 1/17/2013 for end of FY 2012.
- "Prime Enrolled" includes Prime (military and civilian primary care managers), TRICARE Prime Remote (and Overseas equivalent), TRICARE Young Adult (TYA) Prime, and Uniformed Services Family Health Plan; and excludes members in TRICARE for Life, TRICARE Plus, TYA Standard, and TRICARE Reserve Select (TRS).

ABBREVIATIONS

AB	Advisory Board
ABA	Applied Behavior Analysis
AC	Active Component
ACA	Affordable Care Act
AD	Active Duty
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction
BACB	Behavior Analyst Certification Board
BCBA	Board Certified Behavior Analyst
BCaBA	BACB Certified Assistant Behavior Analyst
BMI	Body Mass Index
BRAC	Base Realignment and Closure
C&G	Clinician and Group
CAC	Children's Asthma Care
CAD	Catchment Area Directory
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
CHF	Congestive Heart Failure
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CPG	Clinical Practice Guideline
CSS	Customer Satisfaction Survey
CY	Calendar Year
DCS	Duplicate Claims Software
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
DM	Disease Management
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
EASIV	Expense Assignment System IV
EBP	Evidence-Based Practice
ECHO	Extended Care Health Option
EIA	Educational Interventions for Autism Spectrum Disorders
FEHBP	Federal Employees Health Benefits Plan
FTE	Full-Time Equivalent
FY	Fiscal Year
GWOT	Global War on Terrorism
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
HLFR	High Level Functional Requirement
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HP	Healthy People
HRB	Health-Related Behavior
HRET	Health Research and Educational Trust
IHI	Institute for Healthcare Improvement
IM/IT	Information Management/Information Technology
IMR	Individual Medical Readiness
LOS	Length of Stay
LVS	Left Ventricular Systolic
LVSD	Left Ventricular Systolic Dysfunction
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

ABBREVIATIONS *(CONT'D)*

MS-DRG	Medicare Severity Diagnosis Related Group
MTF	Military Treatment Facility
NCBD	National CAHPS Benchmarking Database
NCQA	National Center for Quality Assurance
NCR	National Capital Region
NDAA	National Defense Authorization Act
NHANES	National Health and Nutrition Examination Survey
NHE	National Health Expenditures
NPI	National Provider Identifier
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
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PDTS	Pharmacy Data Transaction Service
PEB	Physical Evaluation Board
PEP	Projection of Eligible Population
PfP	Partnership for Patients
PH	Psychological Health
PHA	Periodic Health Assessment
PI	Program Integrity
PMPM	Per Member Per Month
PN	Pneumonia
POD	Pharmacy Operations Directorate
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
RA	Reserve Affairs
RC	Reserve Component
RCA	Root Cause Analysis
RCCPDS	Reserve Components Common Personnel Data System
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
SIDR	Standard Inpatient Data Record
TAMP	Transitional Assistance Management Program
TBI	Traumatic Brain Injury
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TED-I	TRICARE Encounter Data-Institutional
TED-NI	TRICARE Encounter Data-Noninstitutional
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMCPA	Temporary Military Contingency Payment Adjustment
TOA	Total Obligational Authority
TPR	TRICARE Prime Remote
TRDP	TRICARE Retiree Dental 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
WG	Working Group

The **Evaluation of the TRICARE Program: Fiscal Year 2013 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*.

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