Keeping Warfighters Ready. For Life.

Evaluation of the TRICARE Program

FY 2007 Report to Congress

TRICARE

Evaluation of the TRICARE Program

To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

FEBRUARY 27 2007

THE FY 2007 EVALUATION OF THE TRICARE PROGRAM IS PROVIDED BY:

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A MESSAGE FROM WILLIAM WINKENWERDER, JR., MD, MBA ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS, ASD(HA)

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A MESSAGE FROM WILLIAM WINKENWERDER, JR., MD, MBA ASSISTANT SECRETARY OF DEFENSE, HEALTH AFFAIRS, ASD(HA)

I am pleased to provide to the Congress this year's annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. I have now served military medicine for over five years, and continue to be impressed with the amazing effort and accomplishments of the Military Health System (MHS), especially given the demanding operational tempo during these years since September 11, 2001.

In addition to responding to the National Defense Authorization Act (NDAA) for FY 1996 (Section 717), this report offers a tremendous opportunity to report on our disciplined focus on performance results based on targeted metrics. It supports the President's Management Agenda and is used to measure near- and mid-term performance in those areas critical to our longer-term TRICARE goals. This report presents three-year trended information (FYs 2004–2006) where programs are mature, and compares TRICARE performance to relevant civilian-sector benchmarks where possible.

It presents the baseline data that are used to manage and sustain our benefit, assess our transformation efforts (including preparing for the Base Realignment and Closure initiatives), and monitor the effectiveness of our business information systems.

Safeguarding the health and well-being of our service members is my top priority. The mission of the MHS in supporting the security of our nation is reflected in our commitment to individual and unit medical readiness to ensure the health and well-being of our Active Component and mobilized Reserve and Guard personnel. The Surgeons General of the Army, Navy, and Air Force and I are fully committed to the philosophy that the health and well-being of our fighting forces extends to the care and wellness of their family members, and retirees and their family members. These beneficiaries are integral to the readiness mission and to the recruitment and retention of soldiers, sailors, airmen, and marines.

The successful performance of our TRICARE health benefits program is crucial to accomplishing this mission.

MISSION

To enhance DoD's and our nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.

VISION

A world class health system that supports the military mission by fostering, protecting, sustaining, and restoring health. There are three pillars in our strategic plan which are synergistic in creating value for our stakeholders and customers:

- Provide a medically ready and protected force and medical protection for communities.
- Create a deployable medical capability that can go anywhere, anytime, with flexibility, interoperability and agility.
- Manage and deliver a superb health benefit.

STRATEGIC GOALS FOR FY 2007 AND THE NEXT THREE YEARS

Our MHS Strategic Plan supports our vision and guides the ongoing effort to provide high quality health care to those we serve, and to improve performance and capabilities in the near future. This strategy has six overarching goals:

- Enhance deployable medical capability, force medical readiness and homeland defense by reducing time from "bench to battlefield" for more effective mission-focused products, processes, and services.
- Sustain the military health benefit through cost-effective, patient-centered care and effective long-term patient partnerships.
- Provide globally accessible health and business information to enhance mission effectiveness.
- Transform to performance-based management for both force health protection and delivery of the health care benefit.
- Develop our most valuable assets—our people.
- Align, manage, and transform the MHS infrastructure.

MHS STRATEGY ARCHITECTURE

The framework for our MHS strategy through FY 2006 is presented below. This framework is used to drive performance improvement in our system, and is supported by key Balanced Scorecard metrics to monitor the success in meeting strategic and operational objectives. This Balanced Scorecard is predicated on five perspectives or "themes" underlying our MHS strategy as shown below: Stakeholders, Financial, External Customers, Internal (which includes Readiness, Quality, and Efficiency), and Learning and Growth (for our internal customers). These themes provide the framework for this year's report, and their supporting metrics are reflected throughout. While we track these metrics every month, many of them are presented in this report on an annual basis to provide clearer understanding of critical long-term trends in our performance. Consistent with our strategic plan and emphasis on transformation, we will revise some of these metrics in FY 2007.

MHS STRATEGY ARCHITECTURE

STAKEHOLDER PERSPECTIVE

Our stakeholders are the American people, expressed through the will of the President, Congress, and the Department of Defense (DoD).

Goal:

- To enhance DoD's 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.

FINANCIAL PERSPECTIVE

Accomplish our mission in a cost-effective manner that is visible and fully accountable.

Goals:

- Determine and account for costs
- Obtain appropriate resources
- Optimize stewardship of resources

EXTERNAL CUSTOMER PERSPECTIVE

Our customers are the armed forces and all those entrusted to our care.

Goals:

- Deliver a fit, healthy, and medically protected force
- Deliver high quality care anywhere
- Improve customer service
- Build healthy communities

INTERNAL PERSPECTIVE

READINESS THEME

Focus on activities to enhance readiness of military forces and the medical assets that support them.

Goals:

- Provide a medically ready total force
- Provide a ready medical capability

QUALITY THEME

Ensure benchmark standards for health and health care are met.

Goals:

- Improve patient safety
- Increase patient-centered focus
- Improve health outcomes
- Provide quality claims processing

EFFICIENCY THEME

Obtain maximum effectiveness from the resources we are given.

Goals:

- Enhance system productivity
- Manage demand
- Gain efficiency through Information Management/ Information Technology
- Improve interoperability with partners

LEARNING AND GROWTH PERSPECTIVE (INTERNAL CUSTOMERS)

Our people and our support systems are critical to giving us the capabilities to execute all we set out to achieve.

Goals:

- Leverage science and technology
- Recruit, retain, and develop personnel
- Complete, accurate, and timely data collection
- Patient/provider focused information systems that enhance capability
- Enhance jointness

EXECUTIVE SUMMARY: KEY FINDINGS FY 2006

Stakeholder Perspective

Beneficiary and Plan Enrollment Trends

- The number of beneficiaries eligible for DoD medical care increased slightly from 9.22 million at the end of FY 2004 to 9.24 million at the end of FY 2005 and then dropped to 9.17 million by the end of FY 2006. An increase in retirees in FY 2006 was slightly offset by a decrease in active duty, Guard/Reserve, and their family members (Ref. page 12).
- Because of base closures and changes in the beneficiary mix over time (especially given the addition of Reservists and their family members), there has been a downward trend in the number of beneficiaries living in MTF catchment areas (i.e., within about 40 miles of a military hospital) and PRISM areas (i.e., within about 20 miles of a military clinic). This trend has implications for the proportion of workload performed in direct and purchased care facilities (Ref. page 15).
- Over 5 million beneficiaries, or about two thirds of the MHS population eligible for TRICARE Prime, were enrolled by the end of FY 2006 (Ref. page 16).
- The percentage of the beneficiary population that uses MHS services has steadily increased since FY 2004. The utilization rate of active duty personnel and their family members increased from 81 to 84 percent and the utilization rate of retirees and their family members increased from 71 to 75 percent (Ref. page 17).

Financial Perspective

Unified Medical Program Funding Trends

- The Unified Medical Program (UMP) projected FY 2007 (estimated) budget of almost $39.4 billion represents an increase of almost 21 percent since FY 2004, without adjusting for inflation. This funding includes the normal cost contribution to the DoD Medicare-Eligible Retiree Health Care Fund (MERHCF, or the "Accrual Fund"), as well as funding in support of the Global War on Terrorism (GWOT). In constant FY 2007 dollars, programmed FY 2006 funding valued at $41.6 billion is almost 9 percent more than the FY 2004 purchase value of $38.3 billion. UMP expenditures were 7.2 percent of the FY 2004 DoD Total Obligational Authority (TOA), and expected to increase to 9.0 percent in FY 2007. The rate of growth in UMP expenditures from FY 2005 to FY 2006 is expected to be 10 percent (including GWOT and Accrual funding) and currently programmed to be less (negative growth) in FY 2007 (Ref. pages 18 and 19).

MHS Workload Trends and Impact of New Benefits From FY 2004 to FY 2006

- MHS workload totals increased for all major components of care between FY 2004 and FY 2006. Total inpatient dispositions (direct and purchased care combined) increased by 3 percent between FY 2004 and FY 2006 and an intensity-weighted measure of dispositions increased by 4 percent (both excluding TFL workload). Outpatient encounters increased by 11 percent and an intensity-weighted measure of encounters increased by 13 percent. Finally, total MHS prescription workload (direct, retail, and mail-order combined) increased by 7 percent, excluding TRICARE Senior Pharmacy (TSRx) benefit workload, discussed below (Ref. pages 20 and 21).
  - For all major components of care, workload increases were driven entirely by increased purchased care utilization. Direct care inpatient, outpatient, and prescription workloads all declined between FY 2004 and FY 2006.
- For inpatient, outpatient, and prescription drug services, the proportion of total health care costs provided in DoD facilities declined between FY 2004 and FY 2006. Overall, the proportion of direct care costs to total costs (direct and purchased care) declined from 60 percent to 52 percent during this time, with the greatest percentage shift occurring for prescription drugs (Ref. page 22).
- Most DoD Medicare-eligible beneficiaries have already taken advantage of the TFL benefit, with about 80 percent filing health care claims in each year from FY 2004 to FY 2006 (Ref. page 23).
- The percentage of TFL-eligible beneficiaries filing at least one claim for prescriptions under the TSRx benefit peaked at 78 percent in FY 2005 and then dropped to 74 percent in FY 2006 (Ref. page 23).
- Prescription drugs (direct and purchased care) accounted for more than half (54 percent) of the $6.4 billion in TFL/TSRx expenditures in FY 2006 (Ref. page 23).

External Customer Perspective

Overall Customer Satisfaction With TRICARE

- MHS beneficiaries' satisfaction with the overall TRICARE plan, health care and one's specialty physician improved between FY 2004 and FY 2006. MHS rates continue to lag civilian benchmarks. Overall satisfaction with the TRICARE Plan improved for Prime enrollees with a military primary care provider between FY 2004 and FY 2006, but lagged civilian counterparts. However, MHS beneficiaries enrolled with civilian network providers reported the same or higher level of satisfaction than their civilian counterparts. Active duty satisfaction with TRICARE improved each year from FY 2004 to FY 2006 (Ref. pages 25 and 26).

Building Healthy Communities

- **Meeting Preventive Care Standards:** Over the past three years, the MHS has met or exceeded targeted Healthy People 2010 goals in providing mammograms and

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2006 *(CONT'D)*

testing for cholesterol. Efforts continue toward achieving Healthy People 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings.

- **Tobacco Use:** The overall FY 2006 self-reported rates for nonsmoking (76 percent) and nonobese (80 percent) people have remained stable over the past three years, and continue to lag the HP 2010 adjusted goals of 88 percent nonsmoking and 85 percent nonobese (Ref. page 28).

Internal Customer Perspective: Readiness

- While the overall MHS dental readiness in Classes 1 and 2 remains high, the 95 percent target rate continues to be elusive, at 89.3 percent in FY 2006, about 1 percent lower than in FY 2005 (Ref. page 30).
- By the end of the program's first full year, enrollment in TRICARE Reserve Select (Tier 1 in 2006) reached almost 34,000 covered lives through almost 12,000 individual or family plans (Ref. page 32).

Internal Customer Perspective: Quality

Access to Care

- **Overall Outpatient Access.** Access to and use of outpatient services remains high, with over 83 percent of Prime enrollees reporting having at least one outpatient visit in FY 2006.
- **Availability and Ease of Obtaining Care.** MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2004 and FY 2006, with retired beneficiaries reporting higher levels of satisfaction than active duty personnel or their family members (Ref. page 33).
- **TRICARE Provider Participation.** The number of TRICARE participating providers increased by 41 percent from FY 2002 to FY 2006. The Prime network increased by 80 percent over that same period. Furthermore, the numbers of primary care providers and specialists have increased at about the same rate (Ref. page 37).
- **Claims Processing.** Satisfaction with the timeliness and accuracy of claims being processed in a reasonable period of time increased between FY 2004 and FY 2006. The number of claims processed continues to increase, reaching almost 148 million in FY 2006, due to increases in purchased care workload as well as how pharmacy claims are reported. The processing of retained claims within 30 days exceeded the TRICARE performance standard of 95 percent over the past four years, reaching 100 percent for the first time in FY 2005 (Ref. pages 39, 40 and 41).

Special Study: Assessment of Civilian Physician Acceptance of New TRICARE Standard Patients

- The Department has completed the second year of a three-year study of civilian physician acceptance of TRICARE Standard patients. The FY 2006 Survey of 20 states and 38 Hospital Service Areas (HSAs) corroborates the FY 2005 findings: 9 of 10 doctors are aware of the TRICARE Program and over 8 in 10 accept new TRICARE Standard patients if they accept any new patients at all, with variation among HSAs (Ref. page 42).

MTF Results on Core Quality of Care Measures from Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

- MHS MTFs are currently involved in many of the JCAHO National Implementation of Hospital Care Measures as part of its Oryx® initiative. MHS MTFs have maintained the expected high rate of aspirin therapy for Acute Myocardial Infarction (AMI) patients, relative to the Joint Commission's comparative national average. However, while MHS documentation of smoking cessation counseling for those adults admitted for AMI appears to be generally improving, it remains below the Commission's national rate (Ref. page 43).

Direct Care Access

- The level of satisfaction with care received in the MTF reported by MHS beneficiaries has increased over the past three years (to 91 percent in FY 2006), exceeding the 89 percent target (Ref. page 44).

TRICARE Dental Programs Satisfaction

The overall TRICARE dental benefit consists of several delivery programs serving the MHS beneficiary population. Across the three dental venues, overall DoD dental patient satisfaction remains high: almost 95 percent for care received in military dental treatment facilities (DTFs), about 94 percent for the TRICARE Dental Program, and almost 92 percent for the TRICARE Retiree Dental Program (Ref. page 45).

Internal Customer Perspective: Efficiencies

MTF Market Share Trends

- The percentage of inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas has declined slightly over the past three years, from FY 2004 to FY 2006: by 2 percent for inpatient market share and almost 4 percent for outpatient market share (Ref. page 46).

Health Care Services Utilization

- Utilization of inpatient, outpatient, and prescription services by Prime enrollees was 57 percent,

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2006 *(CONT'D)*

41 percent, and 24 percent higher, respectively, than that of civilian HMO enrollees in FY 2006 (Ref. pages 47, 53, 57).

- Utilization of acute inpatient hospital services by non-enrolled beneficiaries was more than double that of civilian PPO participants in FY 2006 (due largely to a much higher volume of newborn deliveries in the MHS). On the other hand, utilization of outpatient and prescription services by non-enrolled beneficiaries was 21 percent and 8 percent lower, respectively, than that of civilian PPO participants (Ref. pages 48, 54, 58).

Beneficiary Family Out-of-Pocket Costs

- TRICARE beneficiary families have much lower out-of-pocket costs than their civilian counterparts.
  - For enrolled active duty families, costs were about $3,400 less than their civilian HMO counterparts in FY 2006. For non-enrolled active duty families, costs were about $3,500 less than their civilian PPO counterparts (Ref. pages 63–64).
  - For enrolled retiree families under age 65, costs were about $3,300 less than their civilian HMO counterparts in FY 2006. For non-enrolled retiree families, costs were about $3,900 less than their civilian PPO counterparts (Ref. pages 63–64).
  - For Medicare-eligible MHS beneficiary families in FY 2006, costs were $3,200 less than their civilian counterparts. The lower costs were due to the TFL and TSRx benefits programs, which enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments (Ref. page 66).

Learning and Growth Perspective

- **Information Technology:** As of September 2006, AHLTA Block 1, DoD's electronic health records system, has been deployed at 137 of 138 planned DoD MTFs spanning 11 time zones worldwide, with almost all (99.4 percent) of the targeted 55,230 total users fully trained, including almost 18,000 health care providers. AHLTA Block 1 functionality includes encounter documentation, order entry/results retrieval, encounter encoding support, alerts and reminders, role-based security, health data dictionary, master patient index, and ad hoc query capability. The AHLTA Clinical Data Repository currently contains electronic clinical records for over 8.6 million beneficiaries. As of September 2006, AHLTA processed over 30 million outpatient encounters, an average of almost 94,000 patient encounters per workday. Worldwide deployment of Block 1 is expected to be completed by the end of calendar year 2006, at which point AHLTA will be available to over 9.2 million beneficiaries (Ref. page 69).

WHAT IS TRICARE?

TRICARE is the health plan of the MHS. TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health services for all eligible beneficiaries. TRICARE brings together the worldwide health resources of the Army, Navy, Air Force, Coast Guard and commissioned corps of the Public Health Service (often referred to as "direct care") and supplements this capability with network and non-network civilian health professionals, hospitals, pharmacies, and suppliers (referred to as "purchased care") to provide better access and high quality service while maintaining the capability to support military operations. In addition to receiving care from MTFs, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the non-network benefit, formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except active duty service members. Once eligibility is recorded in the Defense Eligibility Enrollment Reporting System (DEERS), no further application is required from our beneficiaries to obtain care from TRICARE-authorized civilian providers. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard but TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a Primary Care Manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations) and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment, and waiting times in doctors' offices. A point-of-service 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.

NEW BENEFITS AND PROGRAMS IN FY 2006

TRICARE continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation even while providing high quality care for 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 service members, retirees, and their families. Even as we aggressively work to sustain the TRICARE program through good fiscal stewardship, we also refine and enhance the benefit and programs consistent with industry standard of care practices and statute to meet the changing health care needs of our beneficiaries. In addition to the DoD initiatives to improve the TRICARE benefit in FY 2006, Congress has legislated other program changes, to include the following:

Benefit Enhancements and Changes

- **Colorectal cancer screening for beneficiaries age 50 and older who are at normal risk, beginning March 2006.** Prior to this enhancement of the benefit, colonoscopies were not reimbursable for normal-risk, non-Medicare beneficiaries, between the ages of 50 and 64, if symptoms had not been identified or if testing was done for screening purposes only. Only beneficiaries identified as having high risk factors, determined by direct family history (to include age and specific type of cancer discovered in the family member), received the option of a screening colonoscopy. Otherwise, fecal occult blood stool tests and proctosigmoidoscopy or sigmoidoscopy, every 3 to 5 years, were available to normal risk individuals over the age of 49 and did not include a screening colonoscopy. By providing colonoscopies to a larger population, TRICARE will not only save a greater number of lives, but will also eventually realize a significant savings due to the noticeable cost differential between treating patients with early-stage colorectal cancer and treating those with later-stage colorectal cancer. Preventive screening allows for diagnosis and treatment for early-stage colorectal cancer at two-thirds the cost of a later-stage diagnosis.
- **Improving access to maternity ultrasounds.** The DoD maternity ultrasound policy was modified to make ultrasounds easier to obtain when medically necessary. Ultrasounds for medical necessity have always been part of TRICARE's maternity benefit; however, they were formerly covered as a service within the global fee for prenatal care and delivery services. TRICARE will cost share medically necessary obstetrical ultrasounds separately from the delivery fee. Doctors often perform medically necessary maternity ultrasounds at different

NEW BENEFITS AND PROGRAMS IN FY 2006 *(CONT'D)*

times during pregnancy. The enhanced ultrasound benefit also helps TRICARE beneficiaries and providers develop stronger partnerships as they discuss when it is appropriate to perform an ultrasound to ensure the best outcome. This benefit enhancement gives uniformed services families greater peace of mind during what can be an emotional time. If an obstetric provider has reason for concern, TRICARE will cover the ultrasound.

- Enhanced mental health services such as additional coverage for Post Traumatic Stress Disorder (PTSD) and mental health conditions and development of plans addressing regional PTSD and mental health challenges.
- **Extended coverage under TRICARE Prime for surviving children.** The NDAA for FY 2006 provides continuation of the TRICARE Prime benefit at the active duty family member (ADFM) payment rate for the children of service members who died while serving on active duty for more than 30 days. Under the new legislation, surviving children continue TRICARE Prime, Extra and Standard benefits at the ADFM payment rate for the duration of their TRICARE eligibility. They may also be able to receive benefits under the Extended Care Health Option and TRICARE Prime Remote for ADFM programs.
  - Surviving spouses maintain TRICARE Prime, Extra, and Standard benefits at the ADFM rate for a three-year period. At the end of the three-year period, eligible surviving spouses continue TRICARE Prime, Extra, and Standard benefits at the retiree pay rate.
- **TRICARE Launches Healthy Choices for Life Programs:** Established two demonstration projects and one pilot program to test multiple education and prevention initiatives to help service members and their families battle the dangerous effects of obesity, tobacco use, and excessive drinking. These projects were launched in mid-2006. The demonstration projects and pilot program will span three years and the sole pilot program will cover two years from start-up. The demonstration projects are scientifically based studies that will help DoD determine the effectiveness of behavior-modification programs that may be used throughout the MHS.

Dental Benefits

- **Beginning February 1, 2006.** Dental implants and related prosthetics were covered at a 50 percent cost share under the new TRICARE Dental Program (TDP) Contract. The TDP Survivor Benefit was expanded to include the surviving active duty spouse if both spouses are on active duty when one of the spouses dies, and the surviving spouse enrolls in the TDP after retirement or separation within three years of death.

Pharmacy Benefits

- A process for coordinating pharmacy benefits was established in FY 2006 to make access easier for beneficiaries. A beneficiary with other health insurance can walk into a TRICARE Network retail pharmacy and have their prescription claims from both the other health insurance and TRICARE adjudicated before departing with the filled prescription.

Guard & Reserve Benefits

TRICARE Reserve Select (TRS).

- TRS is the premium-based health plan with three premium tiers offered by the DoD to members of the Selected Reserve. TRS offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra including deductibles and cost shares. Separate qualification requirements and premium rates apply to each tier. TRS offers member-only coverage as well as member and family coverage, with worldwide availability. TRS members and covered family members can access care by making an appointment with any TRICARE authorized provider, hospital, or pharmacy—TRICARE network or non-network. TRS members may access care at a MTF on a space-available basis only. Pharmacy coverage is available from an MTF pharmacy, TMOP, and TRICARE network and non-network retail pharmacies.
- In 2005, Tier 1 coverage was the only option available, and then only to members of the National Guard and Reserve who served on active duty for more than 30 days in support of a contingency operation or after September 11, 2001, and who executed a service agreement with their Service/Reserve Component (RC) to continue serving in the Selected Reserve. TRS Tier 1 requires the member to pay 28 percent of the total cost of the premium.
  - The NDAA for FY 2006 added two more premium tiers, which expanded TRS coverage to all qualified members of the Selected Reserve. Tier 2 requires the member to pay 50 percent of the total cost of the premium, while Tier 3 requires payment of 85 percent.
  - The TRS "open season" for Tier 2 and Tier 3 Selected Reserve members began on August 1 and ended November 25, 2006, with benefits available as early as October 1, 2006, the beginning of FY 2007.
- **Extended the TRICARE Reserve Family Demonstration.** The TRICARE Reserve Family Demonstration Benefit due to end October 31, 2005, was extended through October 31, 2007. The DoD extended the benefit for an additional two years to ensure continuity of care for family members of approximately 170,000 National Guard and Reserve members called to active duty for more than 30 days in support of Operation Noble Eagle/Enduring Freedom and Operation Iraqi Freedom. This demonstration offers continuity of care and reduced out of pocket expenses for their family members by waiving the TRICARE annual

NEW BENEFITS AND PROGRAMS IN FY 2006 *(CONT'D)*

deductible for family members who use TRICARE Extra or Standard; waives the preauthorization requirement for non-emergency inpatient civilian care at civilian hospitals; and authorizes TRICARE to pay nonparticipating providers up to 115 percent of the TRICARE maximum allowable charge.

Program Cost Shares

Effective October 1, 2005, the cost of inpatient care in civilian hospitals for ADFMs under TRICARE Standard and TRICARE Extra increased from $13.90 to $14.35 per day, or $25, whichever is greater. For example, if a family member of an active duty service member is an inpatient for one day, he or she will pay $25. For inpatient stays that are two days or more, the cost would be $14.35 per day.

- The TRICARE Standard diagnosis-related group (DRG) daily rate for most civilian nonmental health hospital admissions increased from $512 in FY 2005 to $535 for FY 2006. This rate increase applies only to retirees, their families and survivors who use TRICARE Standard. They must pay either $535 per day or a cost share of 25 percent of the hospital's billed charges, whichever is less. A 25 percent allowable charge for separately billed professional services could also apply. There was no DRG rate increase for beneficiaries who use a civilian TRICARE network facility under TRICARE Extra.
- Rates for inpatient mental health care or a substance-use disorder increased from $169 to $175 per day for retirees, their families, and survivors who use TRICARE Standard. They also pay 25 percent of the allowable charge for separately billed professional services. The inpatient mental health rate is unchanged under TRICARE Prime and Extra for family members of active duty service members, military retirees, their families and survivors.

Program Management

Beneficiaries Help Keep Health Care Costs Low. In support of the health care initiatives in the President's management agenda, TMA posted its allowable charges on an easy-to-use Web site in August 2006.

- The cost of medical care varies widely across the country, and neither hospitals nor doctors' offices usually post their charges for various procedures. That makes it hard for patients to judge if they're being charged a reasonable amount for operations or examinations. By making its maximum allowable charges easily available to the public, TRICARE's intent is to promote quality and efficient delivery of health care through transparency regarding health care quality and price.
- The new Web site shows the TRICARE Maximum Allowable Charge tables, listing the most frequently used procedures, more than 300 of them, and the amount TRICARE is legally allowed to pay for them. These charges are tied to Medicare allowable charges, effectively making them a federal standard for health care costs.
- On July 12, 2006, TMA announced that TRICARE policy requires active duty service members with overseas orders to verify command sponsorship for accompanying family members for enrollment in TRICARE Overseas Program (TOP) Prime, including TRICARE Global Remote Overseas (TGRO). The policy also requires family members to reside with their sponsor to be eligible for enrollment into TOP Prime. Beneficiaries may seek command sponsorship through Service personnel channels. If service families without command sponsorship move overseas, they may pay costly out-of-pocket health care expenses, as they are only eligible for TRICARE Standard, TRICARE Plus, and space-available care at MTFs. When TRICARE Standard beneficiaries seek care overseas, they may have to pay the entire bill at the time of service and then file a claim for reimbursement with TRICARE. Under TRICARE Standard, family members must pay an annual deductible and cost shares each time they get care outside of the MTF. If command-sponsored families enrolled in TOP Prime or TGRO have a newborn or adopt a child while overseas, they may enroll the child in TRICARE Prime.

Technology Initiatives

Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) Medical Surveillance: DoD has developed an improved version of ESSENCE, a Web-based syndromic surveillance application, to examine DoD health care data for rapid or unusual increases in the frequency of certain syndromes. An increase in frequency may be a sign of diseases occurring during possible outbreaks of communicable illnesses or from the possible use of biological warfare agents.

- Local, regional, and national military officials use ESSENCE to screen for possible disease outbreaks among service members, dependents, and retirees. In the event of a possible outbreak, DoD officials are alerted and are kept informed about the results of investigations. As needed, DoD public health officials then notify their counterparts at the Departments of Health and Human Services (HHS), Homeland Security (DHS), and the Centers for Disease Control and Prevention (CDC).
- ESSENCE receives and analyzes data for approximately 90,000 daily outpatient and emergency room visits in DoD health care facilities worldwide. ESSENCE sifts through the data for infectious disease syndromes occurring in patterns and trends that might need further investigation. Military public health specialists monitor the information in ESSENCE at several levels, including local installations, regional authorities, the individual armed services, and the DoD level.

NEW BENEFITS AND PROGRAMS IN FY 2006 *(CONT'D)*

- ESSENCE uses sophisticated computer methods to calculate expected rates of infectious disease syndromes in the DoD population. ESSENCE also uses standardized disease codes, or International Classification of Diseases (ICD-9) to organize patients' diagnoses into the syndromes of most interest. ESSENCE provides the MHS with the information needed to facilitate informed decision-making and enable timely response, including the allocation of any needed medical assistance, resources, and supplies to control disease outbreaks and render timely medical care to those already affected.
  - The March 2, 2006 edition of *Nature* magazine features an article about the DoD overseas laboratories supporting disease epidemic preparedness around the world. The article, "Laboratories for Global Epidemic Preparedness," discusses the work of the five laboratories comprising the DoD Global Emerging Infections Surveillance and Response System (DoD-GEIS), created by a Presidential Decision Directive in 1996. Army and Navy science and medical professionals assigned to the labs work with host nations and the World Health Organization (WHO) to improve detection and response for avian influenza and other emerging infections.
- DoD-GEIS surveillance networks play an important role in identifying and helping to contain avian influenza outbreaks in birds and people wherever they occur. Patient enrollment sites have been established in more than 20 countries in South America, the Middle East, Sub-Saharan Africa, and Central and Southeast Asia.
- In some nations, these networks provide WHO with the only information available on disease strains essential for vaccine development and pandemic preparedness. In fact, they often identify diseases where they were not previously known to occur. For example, this past year, military laboratories identified new outbreaks of dengue, an acute infectious disease transmitted by mosquitoes, in areas of Peru, Sudan, and Yemen.
- **TRICARE Encounter Data (TED):** The congressionally mandated TRICARE Encounter Data record system collects, verifies, and tracks billions of dollars annually in purchased care claims and encounter data for the MHS. TEDs are submitted by TRICARE claims processing contractors in batches for processing, and volumes frequently exceed more than 1 million records a day. TED's automated prompt processing of purchased care claims data records is a measurable incentive for more health providers to accept and treat TRICARE's 9.2 million beneficiaries. TED helps ensure that purchased care claims reimbursement is faster and more efficient by tracking claims immediately after submission, posting payments and denials, and systematically following up on unpaid claims. The result is shorter billing cycles and reimbursements paid within 30 days, one of the fastest claims processing cycles in the health care industry. In FY 2006, nearly 177 million TED records were processed for an estimated government expenditure of more than $13 billion dollars.
- **AHLTA Clinical Data Repository and the VA Health Data Repository.** DoD and VA have established interoperability between the Clinical Data Repository (CDR) of AHLTA, DoD's electronic health record, and VA's Health Data Repository (HDR) of VA's electronic health record. The initial release of this interface, known as the Clinical/Health Data Repository (CHDR), supports the exchange of interoperable and computable health data between the Departments. During the fourth quarter FY 2006, VA and DoD successfully completed production testing and received government acceptance of CHDR in a live patient care environment using standardized pharmacy and medication allergy data. Clinicians from the William Beaumont Army Medical Center and the El Paso VA Healthcare System exchange pharmacy and medication allergy data on patients who receive health care from both health care systems. The DoD's outpatient pharmacy data exchange includes MTF pharmacy, retail pharmacy, and mail order pharmacy. The exchange of interoperable, computable, and standardized data through the CHDR interface enables decision support which provides the ability to conduct drug-drug and drug-allergy order checking and alerting using the consolidated pharmacy and allergy data from both agencies. DoD will begin deployment and VA will continue field testing at two additional sites in first quarter of FY 2007 and then begin enterprise-wide implementation of this capability.
- **Pre- and Post-Deployment Health Assessments and Post Deployment Health Reassessment**

  The Federal Health Information Exchange (FHIE) Program is a Federal IT health care initiative that facilitates the secure electronic one-way exchange of patient medical information between government health organizations. The project participants are the DoD and the VA. DoD has extended the FHIE capabilities to incorporate pre- and post-deployment health assessment (PPDHA) information for separated service members and demobilized Reserve and National Guard members. PPDHAs are provided to active duty service members and demobilized Reserve and National Guard members as they leave and return from deployment outside the U.S. In addition, a post deployment health reassessment (PDHRA) is conducted to identify deployment-related health concerns that may arise in the three to six months after returning from deployment. This information is used to monitor the overall health condition of deployed troops, inform them of potential health risks, as well as maintain and improve the health of service members and veterans. As of September 2006,

NEW BENEFITS AND PROGRAMS IN FY 2006 *(CONT'D)*

over 1.4 million PPHDA forms on over 604,000 individuals have been sent electronically from DoD to the VA. Additionally, DoD has completed the historical data extraction and transfer of over 29,000 PDHRA forms and plans to begin including these data in the monthly electronic transfer to VA beginning in the first quarter FY 2007. DoD will also begin a weekly transfer of PDHRA data for individuals referred to VA for care or evaluation as part of the PDHRA process.

➤ **Data Safeguards and Protections**

The TMA Privacy Office is committed to the protection of personally identifiable information. The increase in data breaches experienced throughout the government and private sector has generated increased diligence toward ensuring adequate safeguards are placed on data entrusted to the MHS. TMA accomplished the following in FY 2006:

- **MHS Notice of Privacy Practices Available On TRICARE Web Site.** In March 2006, TMA provided information on its Web site to ensure beneficiaries were made aware of the Health Information Privacy Regulation rights. Beneficiaries are made aware once every three years both of the availability of the MHS Notice of Privacy Practices and how to obtain it. TRICARE beneficiaries may review this notice at *www.tricare.osd.mil/tmaprivacy*. This notification process complies with the Health Insurance Portability and Accountability Act (HIPAA) of 1996.
- All HA/TMA personnel have received refresher training on their responsibilities for safeguarding personally identifiable information. This is in addition to previously mandated annual training on the use and disclosure of health information. The Privacy Office also continues to sponsor annual conferences to train HIPAA Privacy and Security Officers appointed to each MTF.
- An inventory of personally identifiable information within TMA was conducted with a special emphasis on internal sources that are accessed remotely or transported/stored offsite.
- Existing policies related to the access, use or removal of data is under review. Analyses resulted in the amendment of existing policy or the creation of new documentation.
- An integrated approach to privacy and security data protection is being woven into operational and monitoring activities: establishment of an interdisciplinary, cross-enterprise Health Information Privacy and Security Compliance Committee, incorporation of privacy and security requirements into the systems investment process of the DoD and in the Department of Veterans Affairs (VA) sharing agreements.
- Data Use Agreements (DUAs) and Privacy Impact Assessments (PIAs) were analyzed to ensure data sharing outside of the organization and between information systems met appropriate standards.

REPORT APPROACH AND SCOPE

In addition to presenting trend data over the most recent three fiscal years, this report continues the approach used previously of comparing TRICARE with civilian-sector benchmarks, where available and appropriate.

This report summarizes nationwide trends under TRICARE and, unless otherwise noted, compares the U.S. (all 50 states) regions of TRICARE with comparable U.S. civilian-sector benchmarks.

TRICARE WORLDWIDE PROGRAM OPERATIONS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2007

Total Beneficiaries	9.1 million*
Military Facilities—Direct Care System	
Inpatient Hospitals and Medical Centers	65
Ambulatory Medical Clinics	412
Ambulatory Dental Clinics	414
Veterinary Facilities	259
Military Health System Personnel	132,725
Military	86,398
Civilian	46,327
Total Unified Medical Program (UMP):	$39.4 billion**
(Includes estimated FY 2007 receipts for Accrual Fund)	$11.2 billion***

* DoD health care beneficiary population projected for the end of FY 2007 is approximately 9,132,000 based on the Managed Care Forecasting and Analysis System (MCFAS) as of September 2006.

** Includes direct and private sector care funding, military personnel, military construction, and the MERHCF ("Accrual Fund") DoD Normal Cost Contribution paid by the U.S. Treasury.

*** The DoD Medicare-Eligible Retiree Health Care Fund (MERHCF), implemented in FY 2003, is an Accrual Fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The Fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three forms of contribution to Defense health care: (1) the Accrual fund ($11.2B) discussed above is paid by the Treasury for future health care provided to current active duty, Guard and Reserve beneficiaries when they become retired and Medicare eligible; (2) $15.6B to fund future health care provided to today's retirees and family members; and (3) $7.68B to pay for health care benefits provided today to current Medicare eligible retirees, dependents and survivors.

TRICARE is administered on a regional basis, with three regional contractors in the U.S. working with their TRICARE regional offices (TROs) to manage purchased care operations and coordinate medical services available through civilian providers with the MTFs. The TROs and regional support contracts help:

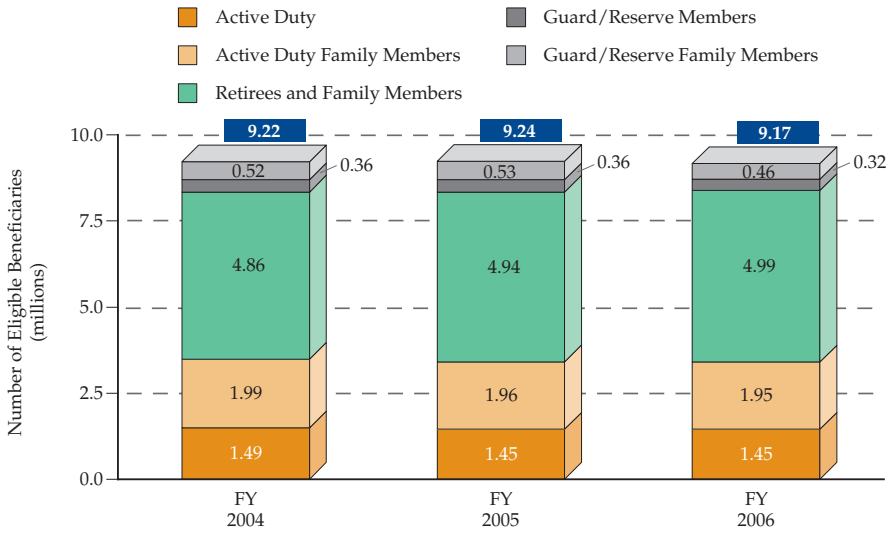
- establish TRICARE provider networks.
- operate TRICARE service centers and provide customer service to beneficiaries.
- provide administrative support, such as enrollment, disenrollment, and claims processing.
- communicate and distribute educational information to beneficiaries and providers.

BENEFICIARY TRENDS AND DEMOGRAPHICS

Number of Eligible and Enrolled Beneficiaries Between FY 2004 and FY 2006

The number of beneficiaries eligible for DoD medical care increased slightly from 9.22 million at the end of FY 2004 to 9.24 million at the end of FY 2005 and then dropped to 9.17* million by the end of FY 2006. The increase in retirees in FY 2006 was slightly offset by a decrease in active duty, Guard/Reserve, and their family members.

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

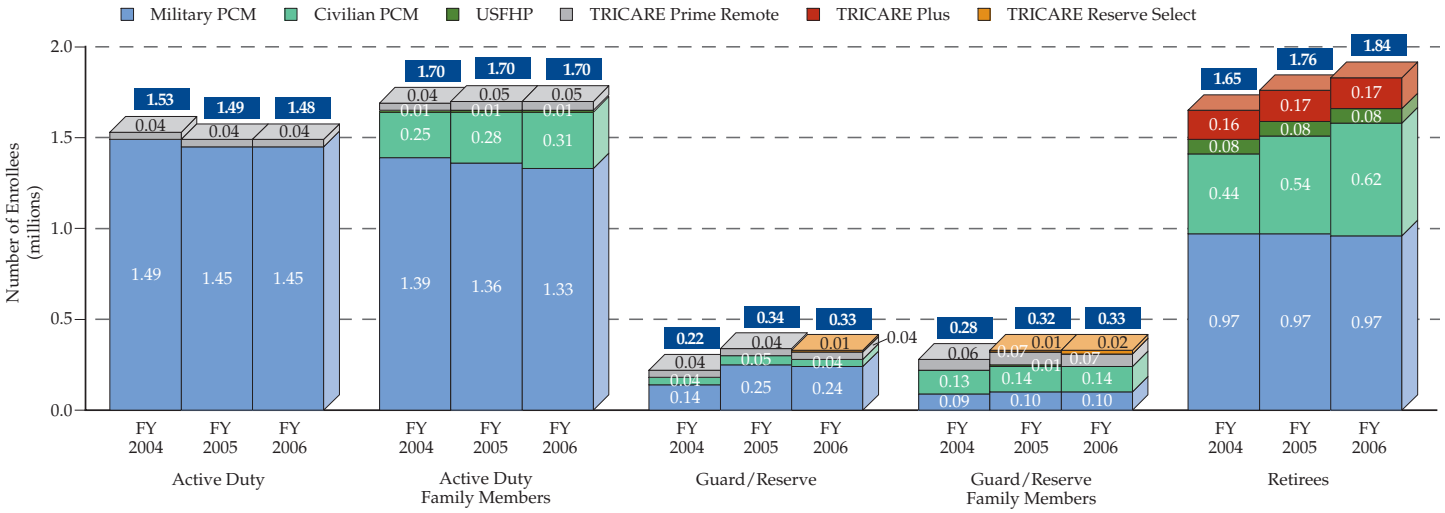


Source: Defense Enrollment Eligibility Reporting System (DEERS), 11/21/2006

* This number should not be confused with the one displayed under TRICARE FACTS AND FIGURES on page 11. The former is an actual FY 2006 total whereas the latter is a *projection* for FY 2007.

- As MTFs reached capacity as a result of the mobilization of Guard/Reserve members, more enrollees were given civilian PCMs.
- TRICARE Reserve Select (TRS) enrollment more than tripled from about 9,000 in FY 2005 to over 30,000 in FY 2006. TRS first became available on April 26, 2005.

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



Source: Defense Enrollment Eligibility Reporting System (DEERS), 11/21/2006

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

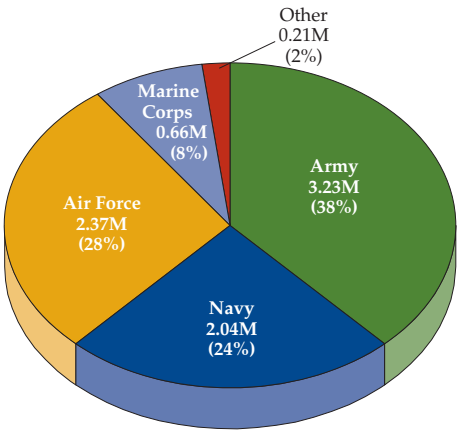
Eligible Beneficiaries in FY 2006

Of the 9.17 million eligible beneficiaries at the end of FY 2006, 8.51 million (almost 93 percent) are stationed or reside in the United States and 0.66 million are stationed or reside abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.

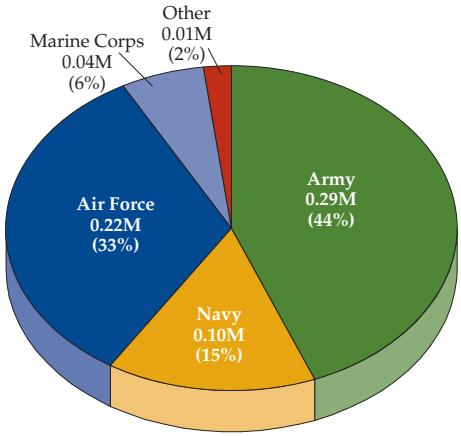
Whereas retirees and their family members comprise the largest percentage of the eligible population (57 percent) in the U.S., active duty personnel (including Guard/Reserve Component members on active duty for at least 30 days) and their family members comprise the largest percentage (70 percent) of the eligible population abroad.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2006

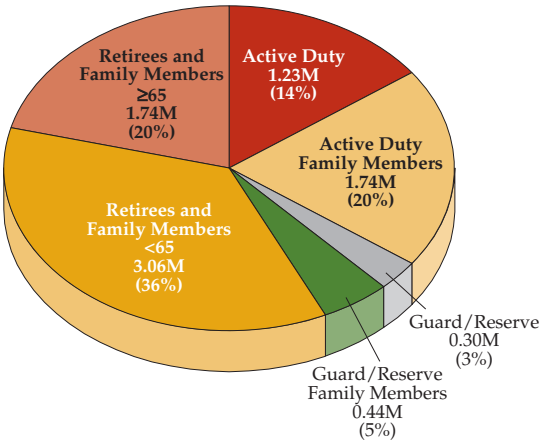
SERVICE BRANCH (U.S.)



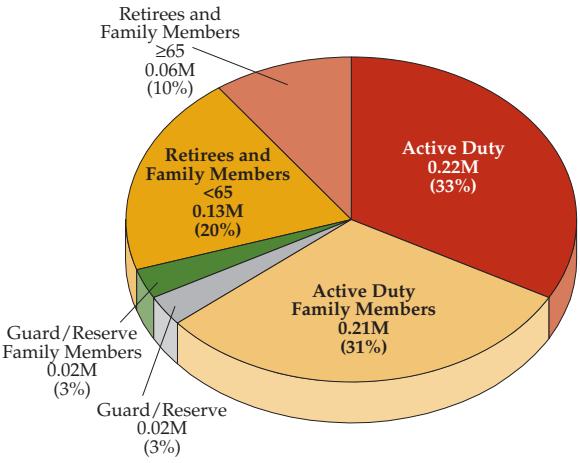
SERVICE BRANCH (ABROAD)



BENEFICIARY CATEGORY (U.S.)



BENEFICIARY CATEGORY (ABROAD)



TOTAL (U.S.): 8.51M

TOTAL (ABROAD): 0.66M

Source: DEERS, 11/21/2006

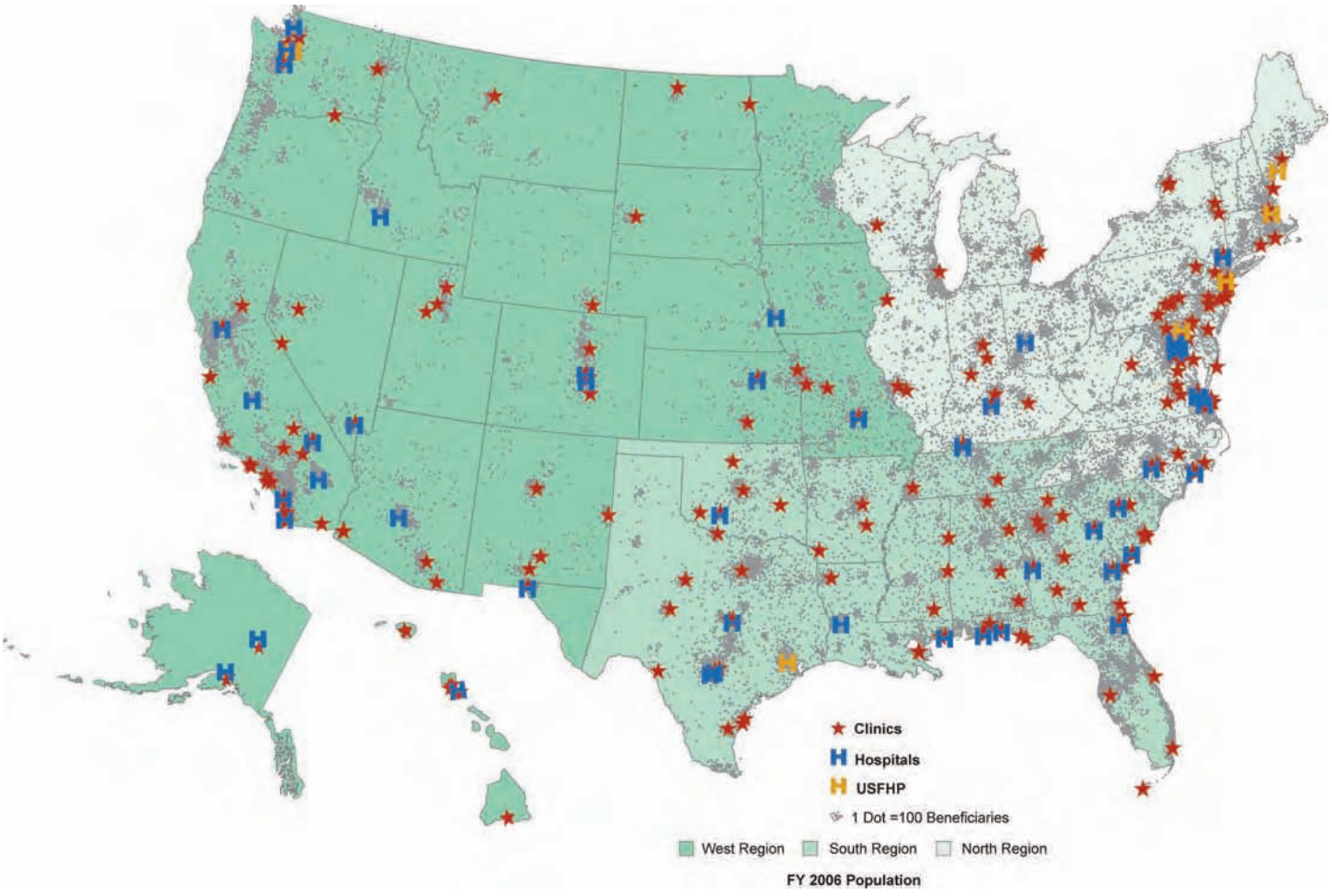
Note: Percentages may not add to 100 percent due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. Military Medical Treatment Facilities (Hospitals and Ambulatory Care Clinics) in FY 2006

The map below presents the geographic diversity of that proportion of the MHS beneficiary population residing within the United States (93 percent of the total 9.2 million beneficiaries). 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 does and does not reside near the direct care system.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MILITARY MEDICAL TREATMENT FACILITIES (HOSPITALS AND AMBULATORY CARE CLINICS) IN FY 2006



Source: MTF information from TMA Portfolio Planning Management Division; residential population and GIS information from TMA/HPA&E, 1/12/2006

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

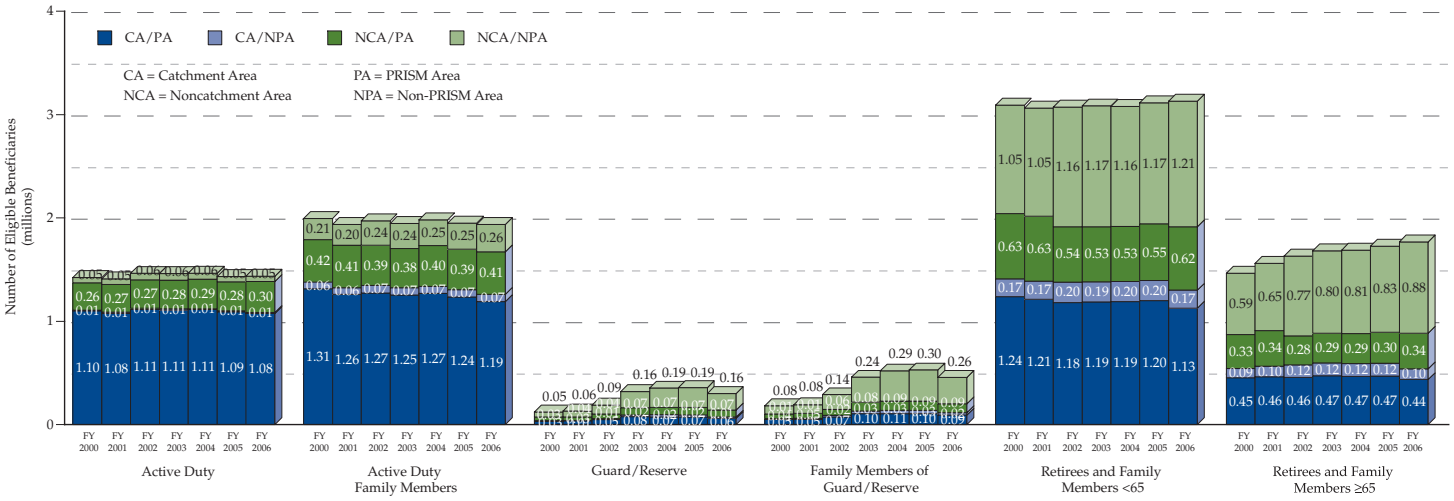
Eligible Beneficiaries Living in Catchment and PRISM Areas

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

Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 55 percent in FY 2000 to 48 percent in FY 2006) and PRISM areas (from 71 percent in FY 2000 to 64 percent in FY 2006). This trend has implications for the proportion of workload performed in direct care and purchased care facilities.

- More beneficiaries live in PRISM areas because, though smaller than catchment areas, they are far more numerous (about 300 PRISM areas vs. 50 catchment areas).
- There has been a decreasing trend in the number of active duty and retiree family members living in catchment areas.
- Within noncatchment areas, there has been a decreasing trend in the number of beneficiaries living in PRISM areas.
- The recent call-ups 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.

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



Source: DEERS, 10/13/2006

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

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

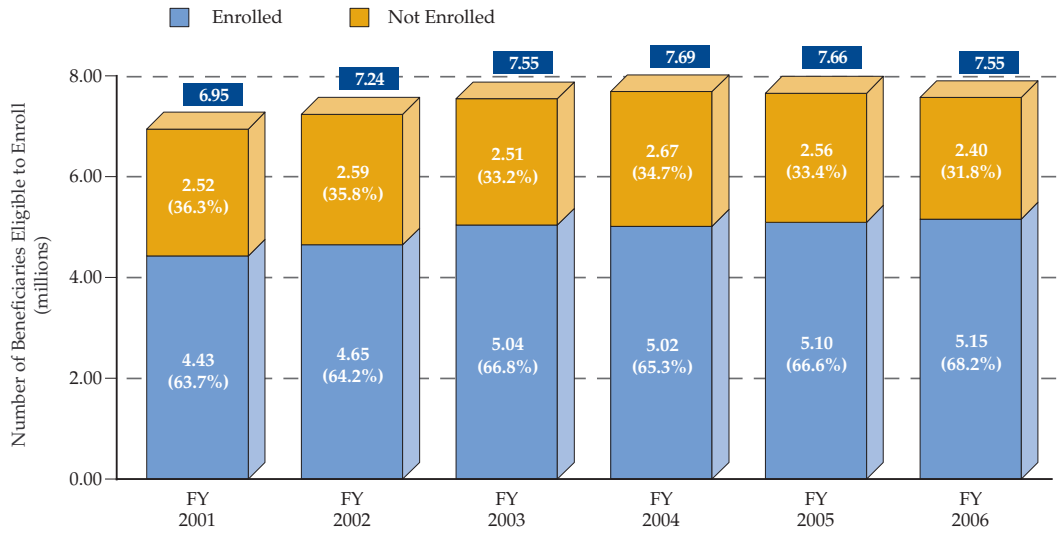
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from the Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this presentation, all active duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and over (some were eligible for TRICARE Senior Prime in FY 2001 and early FY 2002) 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 TRICARE Plus (a primary care enrollment program that is offered at selected MTFs) and TRICARE Reserve Select are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- In terms of total numbers, TRICARE Prime enrollment has steadily increased since FY 2001. As a percentage of those eligible to enroll, TRICARE Prime enrollment increased between FY 2000 and FY 2003 and then leveled off.
- The number of beneficiaries enrolled in TRICARE Plus decreased slightly from 167,654 at the end of FY 2005 to 166,558 at the end of FY 2006. This marks the first decline in enrollment since the program's inception in FY 2002 and is likely due to reduced capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2006, 68 percent of all eligible beneficiaries were enrolled in Prime (5.15 million enrolled of the 7.55 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 10/13/2006

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

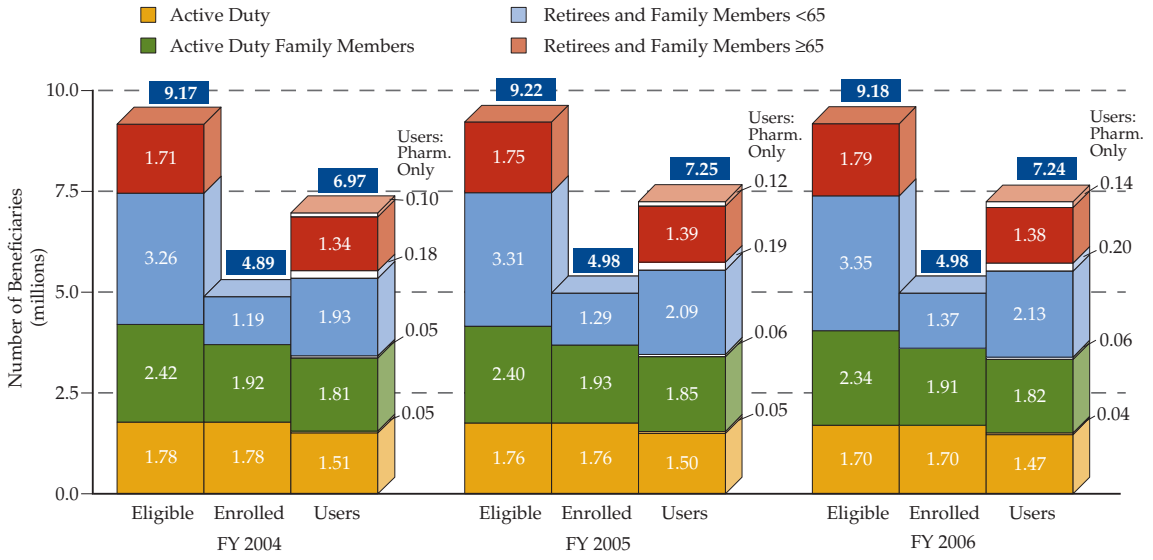
Average Eligibles, Enrollees, and Users Between FY 2004 and FY 2006

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 2004 to FY 2006 were determined from DEERS. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and therefore include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts.

Two types of users are defined in this section: (1) users of inpatient or outpatient care, regardless of pharmacy utilization; and (2) users of pharmacy only. No distinction is made here between users of direct and purchased care. The sum of the two types of users is equal to the number of beneficiaries who had any MHS utilization.

- Active duty personnel experienced a decrease of 4.4 percent in the number of eligible beneficiaries between FY 2004 and FY 2006 whereas retirees and family members age 65 and older experienced an increase of 4.4 percent.
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased from 37 percent in FY 2004 to 41 percent in FY 2006. The increase is due primarily to formerly non-MHS-reliant retirees dropping their private health insurance because of rising premiums.
- The overall user rate increased from 76 percent in FY 2004 to 79 percent in FY 2006. The user rate increased for all beneficiary groups.
- Retirees and family members under age 65 have the greatest number of users of the MHS but the lowest user rate.

AVERAGE NUMBER OF FY 2004 TO FY 2006 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



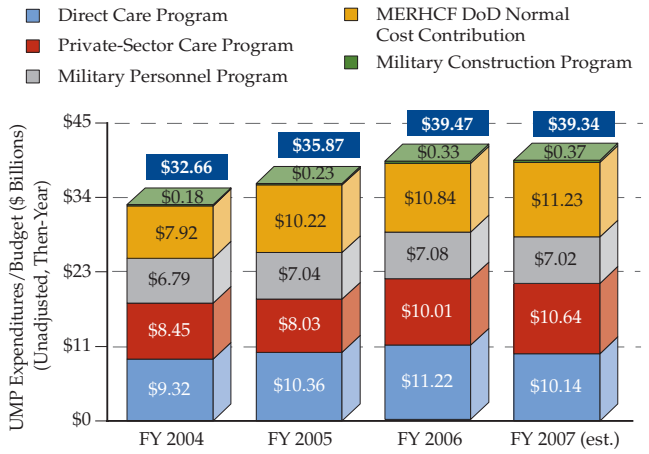
Sources: DEERS and MHS administrative data, 11/21/2006

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

UNIFIED MEDICAL PROGRAM FUNDING

As shown in the first chart below, in terms of unadjusted expenditures (i.e., "then year" dollars, unadjusted for inflation), the Unified Medical Program (UMP) increased from almost $33 billion in FY 2004 to slightly over $39 billion estimated for FY 2007 (as of the Program Objective Memorandum, August 13, 2006). The FY 2004 to FY 2007 funding and programmed budget shown includes the normal DoD cost contribution to the Medicare-Eligible Retiree Health Care Fund (the "Accrual Fund"). This fund (effective October 1, 2002) pays the cost of DoD health care programs for Medicare-eligible retirees, retiree family members, and survivors. Two of the major cost drivers for the Accrual Fund are the TRICARE Senior Pharmacy benefit, which began in April 2001, and the TRICARE for Life (TFL) benefit, which began in October 2001.

FY 2004 TO FY 2007 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (UNADJUSTED, THEN-YEAR DOLLARS)

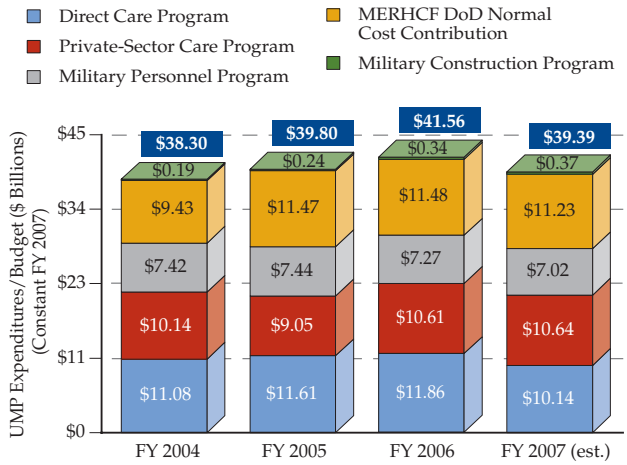


Cost and Budget Estimates good as of 1/12/2007

Notes: Numbers may not sum to totals due to rounding.

1. FYs 2004–2006 reflect Comptroller Information System actual execution; and FY 2007 is reflected in the FYs 2008–2013 Program Objective Memorandum estimates as of September 2006. The President's Budget position estimates were not available at time of this writing.
2. FY 2004 budget includes $658.4 million (M) for GWOT; FY 2004/FY 2005 Title IX Funding of $683M (executed in FY 2005); $400M for NDAA Reserve Health Care Benefit; FY 2005 budget includes the FY 2004/FY 2005 Title IX funding of $683M (executed in FY 2005), $210.6M in GWOT supplemental, $20.5M for Hurricane/Tsunami Supplement; FY 2006 actuals include supplemental funding supporting GWOT ($1,110.8M), Hurricane Relief ($208.1M), Avian Flu ($120M), and Army Modularity ($42.8M).

FY 2004 TO FY 2007 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (CONSTANT FY 2006 DOLLARS)



In constant-year funding, when actual expenditures or projected funding are adjusted for inflation (using constant FY 2007 dollars), the FY 2006 purchasing value ($41.6 billion) is almost 9 percent greater than the FY 2004 purchasing value ($38.3 billion). The FY 2007 Budgeted purchasing value of $39.4 billion is programmed to be only about a 3 percent increase over the FY 2004 purchase value of about $38.3 billion.

Cost and Budget Estimates good as of 1/12/2007

Notes: Numbers may not sum to totals due to rounding.

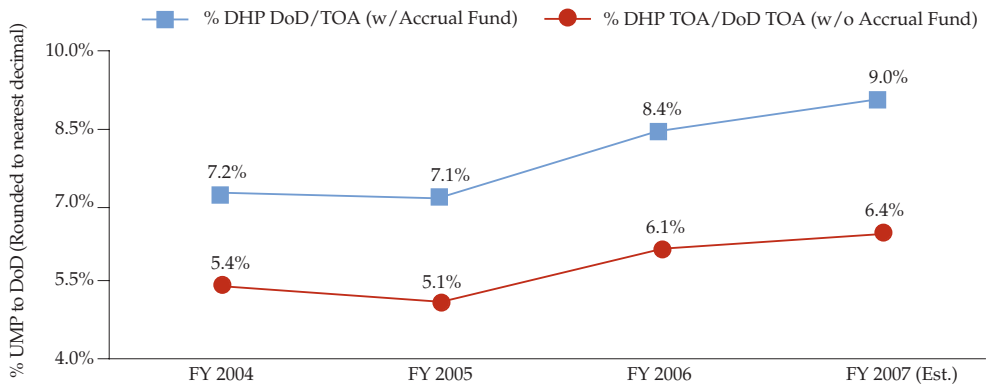
1. FYs 2004–2006 reflect Comptroller Information System actual execution; and FY 2007 is reflected in the FYs 2008–2013 President's Program Objective Memorandum estimates as of September 2006. The President's Budget position estimates were not available at time of this writing.
2. Source of data for deflators: (1) FY 2007 OSD Comptroller table for MilPers, DHP, Procurement, RDT&E and MILCON is Tables 5-4/5-5, Department of Defense Deflators—TOA, National Defense Budget Estimates for FY 2007 (Green Book).
3. TRICARE for Life (TFL) and other NDAA enhancements commenced in FY 2002 resulting in an approximate $4 billion (B) increase.
4. FY 2004 budget includes $658.4M for GWOT; FY 2004/FY 2005 Title IX Funding of $683M (executed in FY 2005); $400M for NDAA Reserve Health Care Benefit; FY 2005 budget includes the FY 2004/FY 2005 Title IX funding of $683M (executed in FY 2005), $210.6M in GWOT supplemental, $20.5M for Hurricane/Tsunami Supplement.

UNIFIED MEDICAL PROGRAM FUNDING

UMP Share of Defense Budget

UMP expenditures are expected to increase from 7.2 percent of DoD Total Obligational Authority (TOA) in FY 2004 to 9 percent estimated for FY 2007, including the Accrual Fund (as currently reflected in the FYs 2008–2013 Program Objective memorandum position estimates, September 2006). When the Accrual Fund is excluded, the UMP's share is expected to increase from 5.4 percent in FY 2004 to 6.4 percent in FY 2007.

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2007 (EST.)

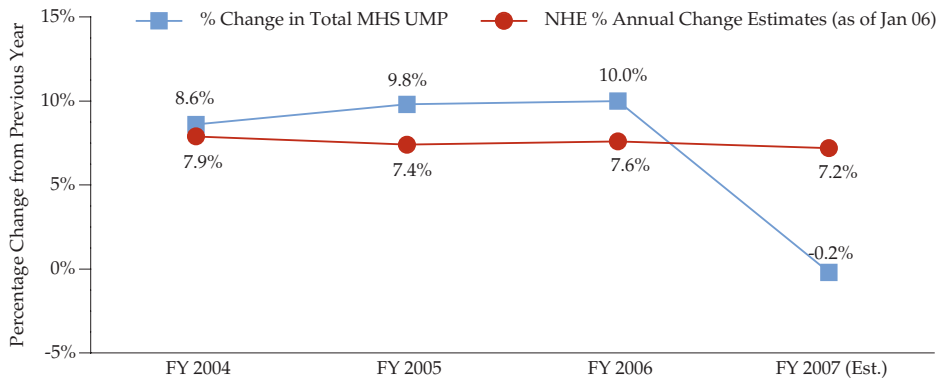


Cost and Budget Estimates good as of 1/25/2007
Source: FYs 2004–2006 reflect Comptroller Information System actual execution; and FY 2007 is reflected in the FYs 2008–2013 Program Objective Memorandum as of September 2006. Budget Authority, Outlays, and Direct Obligations for the total Department TOA were identified by using the 07PB Green Book and Financial Summary Tables. The ratios in the above chart include in the numerator all costs shown in the top chart of the previous page ("FY 2004 to FY 2007 (Est.) Unified Medical Program, Unadjusted, Then-year dollars") including the MERHCF DoD Normal Cost Contribution; but exclude from the denominator the MERCHF funds because they are in Department of Treasury budget.

Comparison of Unified Medical Program and National Health Expenditures Over Time

The estimated rate of growth in the Department of Health and Human Services estimates of National Health Expenditures (NHE) between FY 2004 and FY 2006 has been stable at between 7.4 and 7.9 percent. The annual rate of growth in the UMP has exceeded the rate of growth in NHE for the past three years by 0.7 percent in FY 2004 and 2.4 percent in FY 2005 and FY 2006. As currently programmed, the FY 2007 budget will be substantially below the estimated growth of national health expenditures. As noted in previous annual reports, the UMP grew significantly with the establishment of the MERHCF in October 2002. Since that time, this growth may be attributed to additional funding for the Global War on Terror and the influx of Guard and Reservists and their family members eligible for and using TRICARE and disaster relief.

COMPARISON OF CHANGE IN ANNUAL UNIFIED MEDICAL PROGRAM AND NATIONAL HEALTH EXPENDITURES OVER TIME: FY 2004 TO FY 2007 (EST.)



Cost and Budget Estimates good as of 1/12/2007
Sources: Unified Medical Program and DHP Expenditures: Comptroller Information System final reports for President's Budget Submissions (percentages from data reflected in the chart on the previous page entitled "FY 2004 to FY 2007 (Est.) Unified Medical Program"). The MHS UMP and associated annual percentage changes used above include the MERHCF DoD normal cost contribution reflected beginning in FY 2003.

National Health Expenditures based on Dept. of Health and Human Services estimates, "National Health Care Expenditures projections: 2005–2015, January 2006 *http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp*
Prior report estimates based on: Heffler, S. Smith, Keehan, S., et al. U.S. Health Spending Projections for 2004–2014: Health Affairs. 23 February 2005 W5–75.
Actual expenditures (in $ billions): 2002 ($1,559.00), 2003 ($1,678.9), 2004 ($1,804.7 projected), 2005 ($1,936.5 projected) and 2006 ($2,077.5) projected.

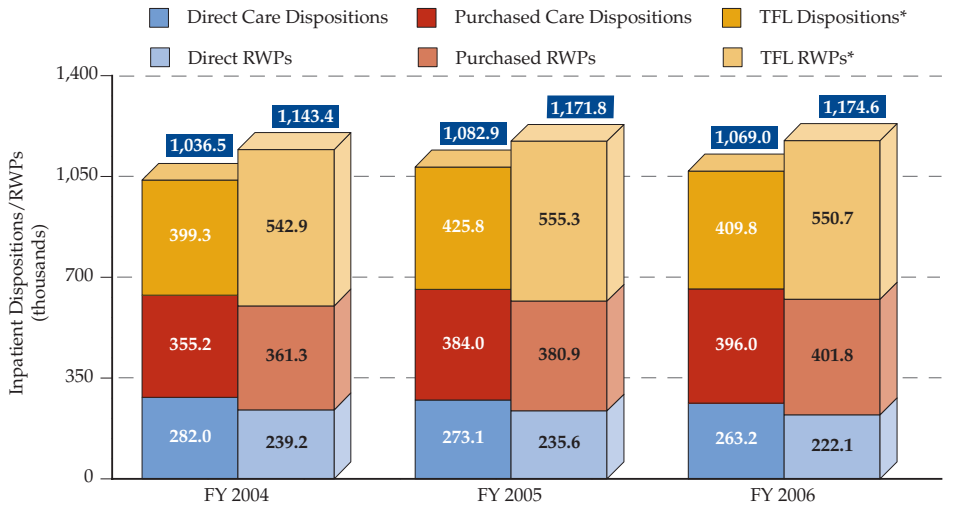
MHS WORKLOAD TRENDS

MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: as the number of inpatient dispositions and as the number of Relative Weighted Products (RWPs). The latter measure, relevant only for acute care hospitals, reflects the relative resources consumed by a hospitalization as compared with the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. Total inpatient workload (direct and purchased care combined) increased between FY 2004 and FY 2006 (dispositions increased by 3 percent and RWPs by 4 percent), excluding the effect of TFL.

- Direct care inpatient dispositions and RWPs declined by 7 percent over the past three years.This can be largely attributed to an 8 percent decline in the number of MTFs performing inpatient workload over this period.
- Excluding TFL workload, purchased care inpatient dispositions and RWPs increased by 11 percent from FY 2004 to FY 2006. Although most of the increase in dispositions occurred in FY 2005, RWPs increased by an equal amount in both FY 2005 and FY 2006.
- Including TFL workload, purchased care dispositions increased by 7 percent and RWPs by 5 percent between FY 2004 and FY 2006.
- While not shown, about 12 percent of direct care inpatient dispositions and 11 percent of RWPs were performed abroad during FYs 2004–2006. Purchased care and TFL inpatient workload performed abroad accounted for less than 3 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



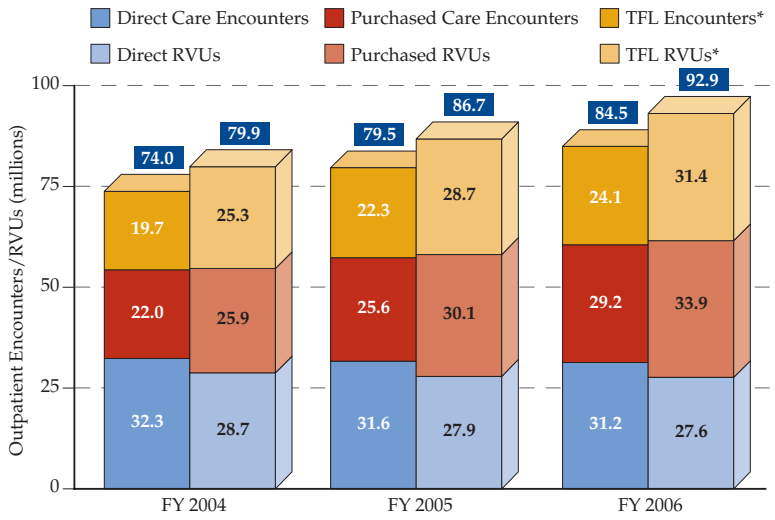
Source: MHS administrative data, 1/5/2007
* Purchased care only.

MHS WORKLOAD TRENDS *(CONT'D)*

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of Relative Value Units (RVUs). The latter measure reflects the relative resources consumed by an encounter as compared to the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2004 and FY 2006 (encounters increased by 11 percent and RVUs by 13 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/5/2007

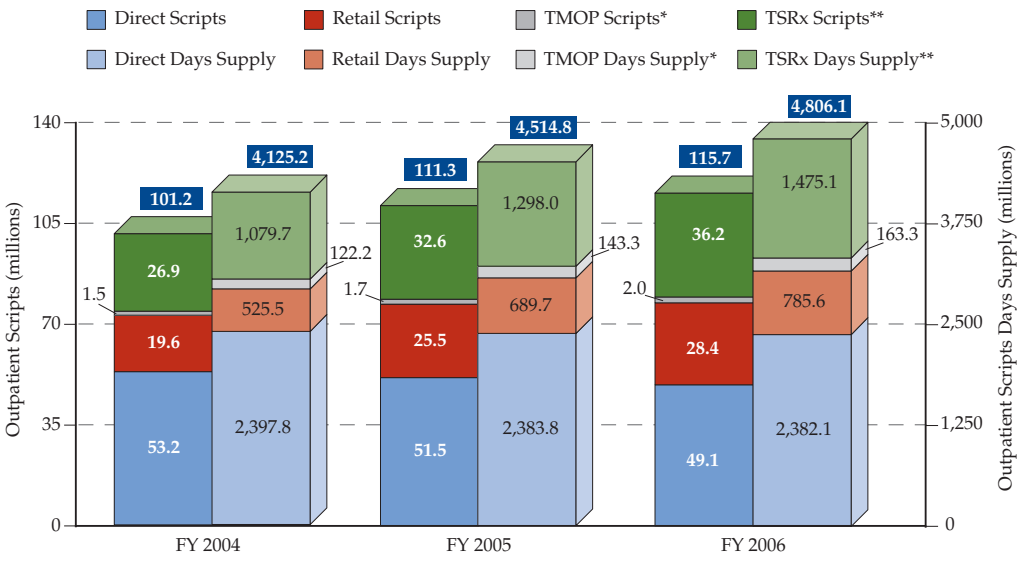
* Purchased care only.

- Direct care outpatient encounters and RVUs each declined by 3 percent over the past three years, indicating a constant level of workload intensity being performed in MTFs.
- Excluding TFL workload, purchased care outpatient encounters increased by 33 percent and RVUs by 31 percent. Including TFL workload, encounters and RVUs each increased by 28 percent.
- While not shown, about 13 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for only about 1 percent of the worldwide total.

MHS Prescription Drug Workload

Total MHS outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply. Total prescription drug workload (direct and purchased care combined) increased between FY 2004 and FY 2006 (scripts increased by 7 percent and days supply by 9 percent), excluding the effect of TSRx.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/5/2007

* TMOP workload for TFL-eligible beneficiaries is included in the TSRx total.

** Purchased care only.

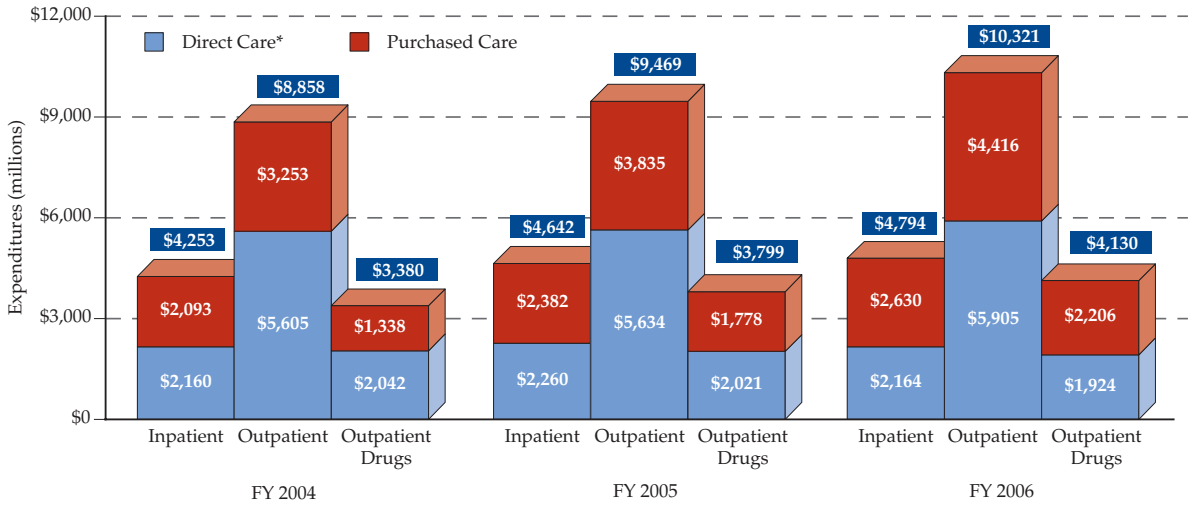
- Direct care scripts fell by 8 percent but days supply fell by only 1 percent between FY 2004 and FY 2006.
- Purchased care scripts increased by 44 percent and days supply by 47 percent from FY 2004 to FY 2006 (about 2/3 of the increase occurred in FY 2005), excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased scripts increased by 39 percent and days supply by 40 percent.
- While not shown, just under 8 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for less than 1 percent of the worldwide total.

MHS COST TRENDS

Total MHS costs (net of TFL) increased between FY 2004 and FY 2006 for all three major components of health care services: inpatient, outpatient, and prescription drugs. Inpatient services accounted for a decreasing proportion of total MHS costs whereas prescription drugs accounted for an increasing proportion. The relative proportion of outpatient services remained about the same.

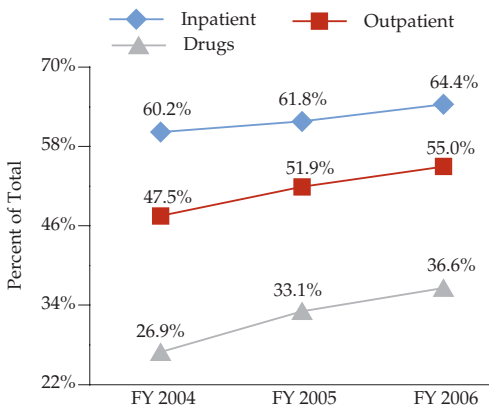
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 67–68 percent from FY 2004 to FY 2006. For example, in FY 2006, DoD expenses for inpatient and outpatient care totaled $15,116 million, of which $10,322 million was for outpatient care for a ratio of $10,322/$15,116 = 68 percent.
- In the interval from FY 2004 to FY 2006, DoD spent an average of about $2.10 for outpatient care for every $1 spent on inpatient care.
- The proportion of total expenses for care provided in DoD facilities fell from 60 percent in FY 2004 to 52 percent in FY 2006.

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

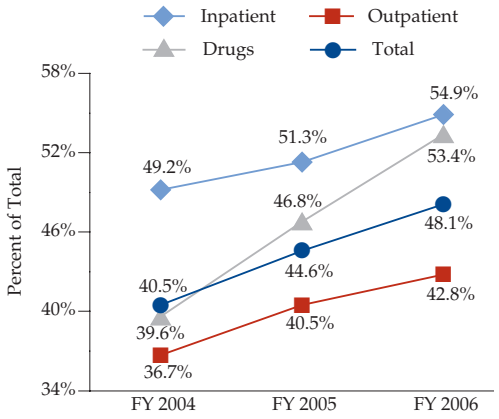


Source: MHS administrative data, 1/5/2007
* Direct care prescription costs include an MHS-derived dispensing fee.

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



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



Source: MHS administrative data, 1/5/2007
Note: TFL purchased care costs are excluded from the above calculations.

- The purchased care share of total inpatient utilization increased from 60 percent in FY 2004 to 64 percent in FY 2006. The purchased care share of total outpatient utilization increased from 48 to 55 percent. The purchased care share of total drug utilization showed the largest increase, from 27 to 37 percent.
- The purchased care share of total MHS outpatient costs increased in FY 2005 and then leveled off in FY 2006. For inpatient costs, the purchased care share increased in both FY 2005 and FY 2006. Of all the medical services, prescription drugs exhibited the steepest increase in the purchased care share.

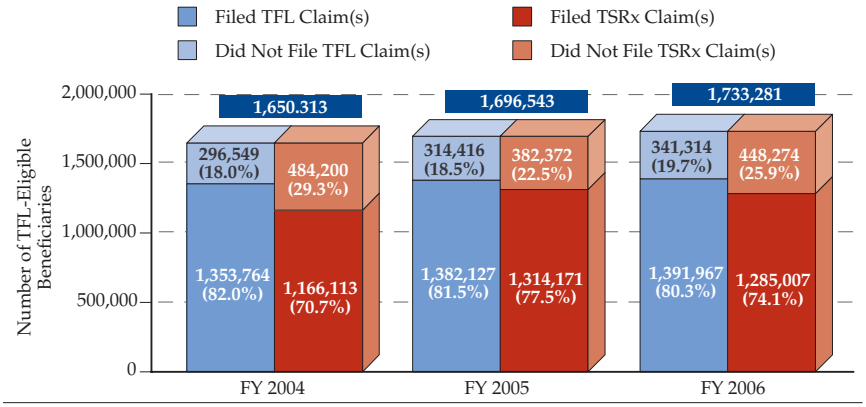
IMPACT OF TRICARE FOR LIFE (TFL) IN FYs 2004–2006

The TFL program began October 1, 2001, in accordance with the Floyd D. Spence National Defense Authorization Act for FY 2001. Under TFL, military retirees age 65 years and older, and those family members enrolled in Medicare Part B, are entitled to TRICARE coverage.

TRICARE for Life and TRICARE Senior Pharmacy Beneficiaries Filing Claims

- The number of Medicare-eligible beneficiaries grew slightly from 1.68 million at the end of FY 2004 to 1.77 million at the end of FY 2006.
  - The percentage eligible for TFL remained about the same from FY 2004 to FY 2006. At the end of FY 2006, about 98 percent (1.73 million) were eligible for the TFL and TRICARE Senior Pharmacy (TSRx) benefits, whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage.

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2004 TO FY 2006



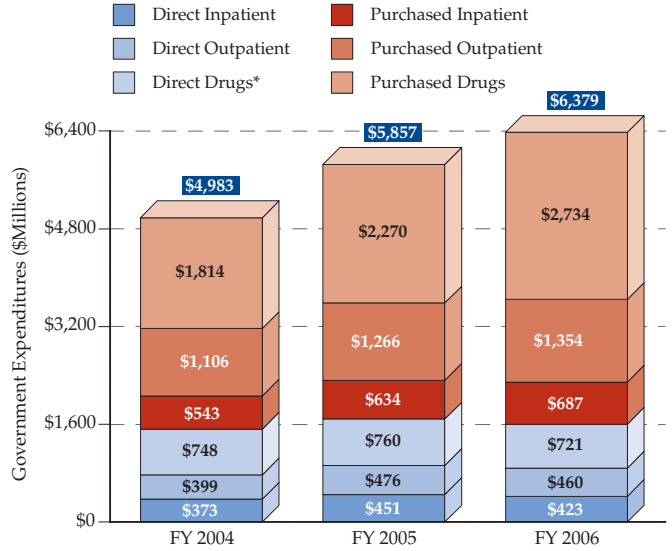
Source: MHS administrative data, 1/5/2007

- The percentage of TFL-eligible beneficiaries who filed at least one claim remained about the same between FY 2004 and FY 2006.
  - The reasons some beneficiaries do not file claims are varied, including retaining an employer-sponsored insurance policy (some senior beneficiaries with a spouse under age 65 will retain employer-sponsored coverage to keep their spouse insured) and not receiving any care at all.
- The percentage of TFL-eligible beneficiaries who filed at least one TSRx claim increased in FY 2005 but then declined in FY 2006. One possible reason for the decline may be the availability of the new Medicare prescription drug benefit (Medicare Part D).

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The Medicare-Eligible Retiree Health Care Fund (MERHCF) covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. Note that the MERHCF is not identical to TFL/TSRx, 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 and TSRx do not. Total MERHCF expenditures increased from $4,985 million in FY 2004 to $6,380 million in FY 2006 (28 percent).

MERHCF EXPENDITURES IN FY 2004 TO FY 2006 BY TYPE OF SERVICE



- MERHCF-eligible beneficiaries had very little impact on total DoD direct care expenses from FY 2004 to FY 2006.
  - In FY 2004, TRICARE Plus enrollees accounted for 68 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. That share increased slightly to 69 percent in FY 2006.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 48 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2004. That percentage increased slightly to 50 percent in FY 2005 and remained at that level in FY 2006.
- Purchased care TFL expenditures increased from FY 2004 to FY 2006 for inpatient, outpatient, and prescription drugs. The most dramatic increase was for prescription drugs, where DoD costs increased by 51 percent in only two years.

Source: MHS administrative data, 1/5/2007 * Direct care prescription costs include an MHS-derived dispensing fee.

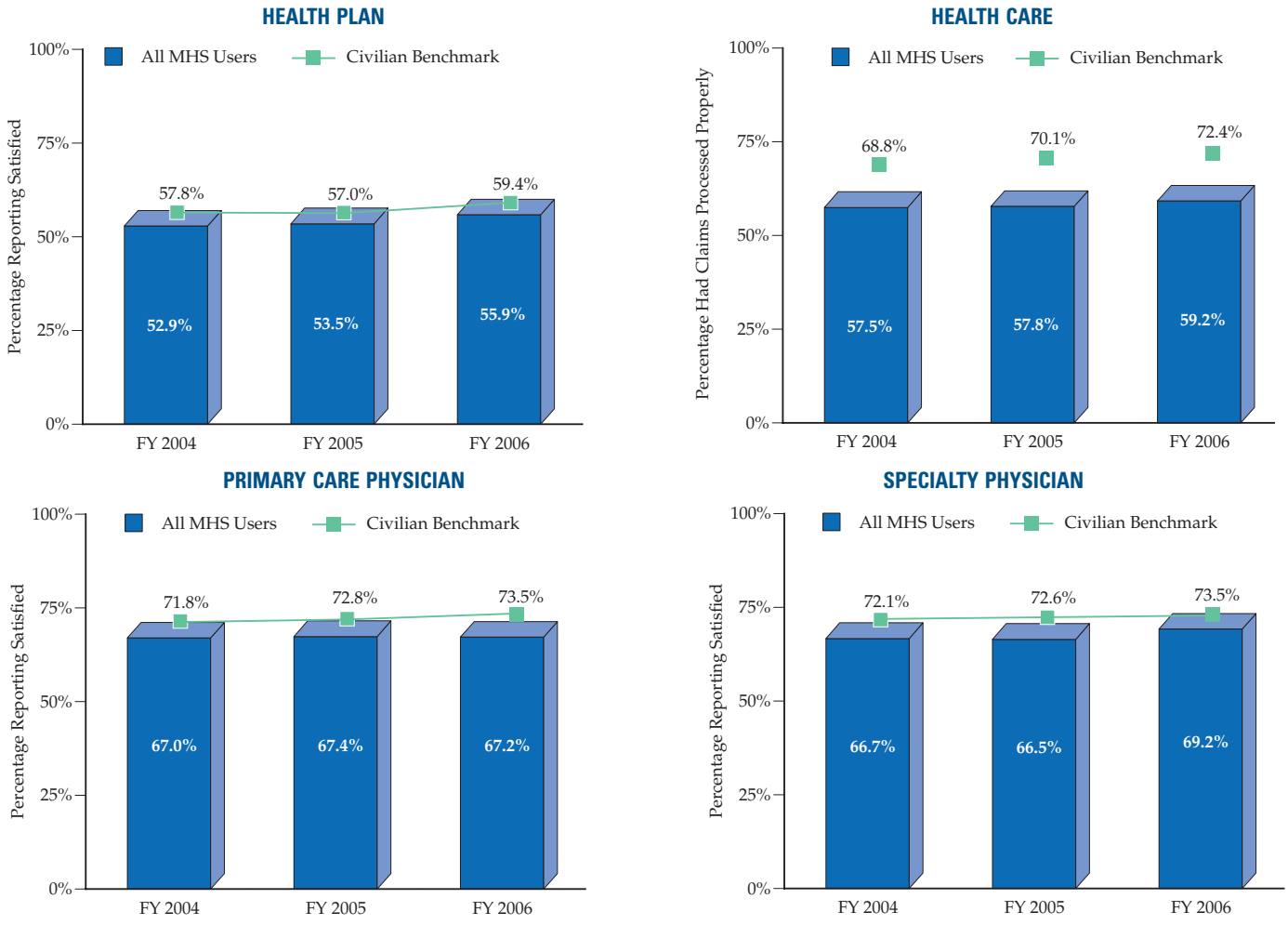
The External Customer theme focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on customer satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER SATISFACTION WITH KEY ASPECTS OF TRICARE

The health care consumer satisfaction surveys used by the MHS and many commercial plans ask beneficiaries to rate various aspects of their health care. MHS beneficiaries in the United States who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. The civilian benchmark is based on health care system performance metrics from the national Consumer Assessment of Health Care Providers and Systems (CAHPS). Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals and customer complaints.

- Satisfaction with the overall TRICARE plan, health care, and one's specialty physician improved between FY 2004 and FY 2006. There was no statistically significant difference in satisfaction with one's personal physician during this three-year period.
- MHS satisfaction rates continue to lag civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

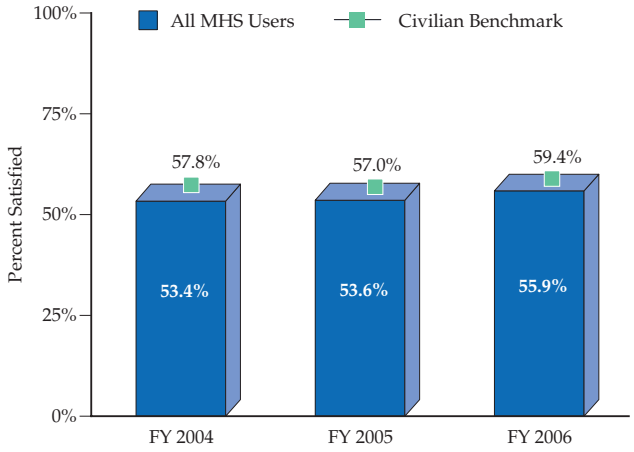
SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

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.

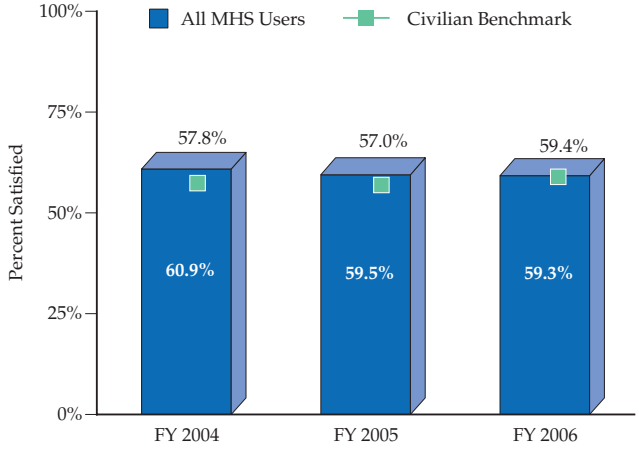
- Overall satisfaction with the TRICARE plan improved between FY 2004 and FY 2006 for Prime enrollees with a military Primary Care Manager (PCM). There has been no statistically significant change across the three-year period for enrollees with civilian PCMs and non-enrollees.
- During each of the past three years (FY 2004 to FY 2006) MHS beneficiaries enrolled with civilian network providers reported the same or higher level of satisfaction than their civilian counterparts (i.e., no statistically significant difference in the proportions).
- MHS beneficiaries enrolled with military PCMs and those not enrolled at all generally reported lower levels of satisfaction than their civilian plan counterparts (i.e., there is a statistically significant difference).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

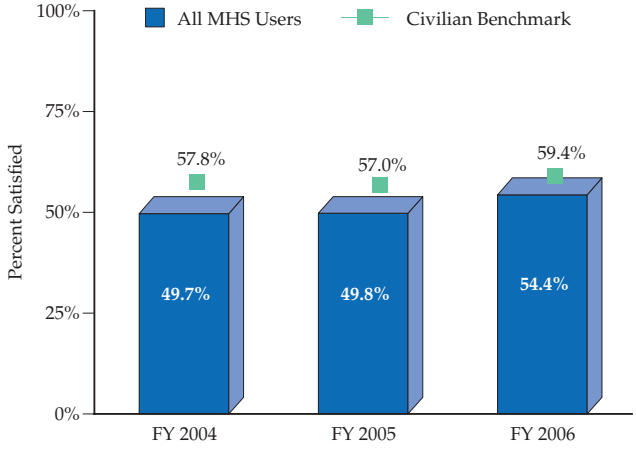
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

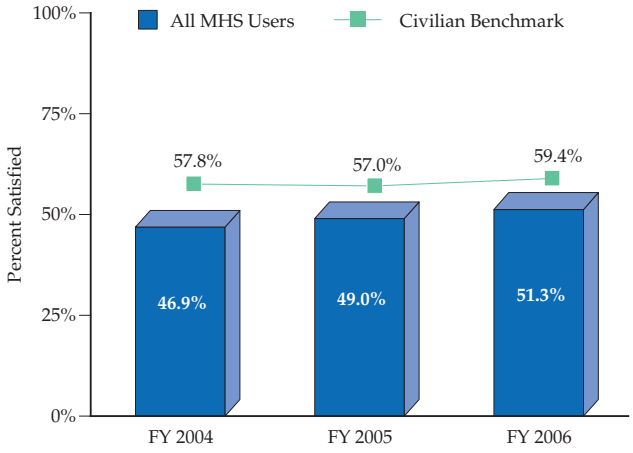
SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

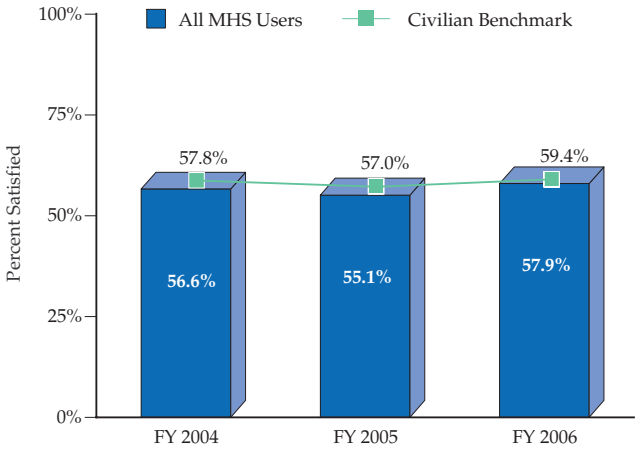
- Active duty satisfaction with TRICARE improved each year from FY 2004 to FY 2006.
- Both active duty and their family member ratings continued to lag the civilian benchmarks for the past three years (significantly different for active duty).
- Satisfaction of retired DoD beneficiaries each year over the past three years is comparable to the general population using a commercial plan (no statistically significant difference in the proportions).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

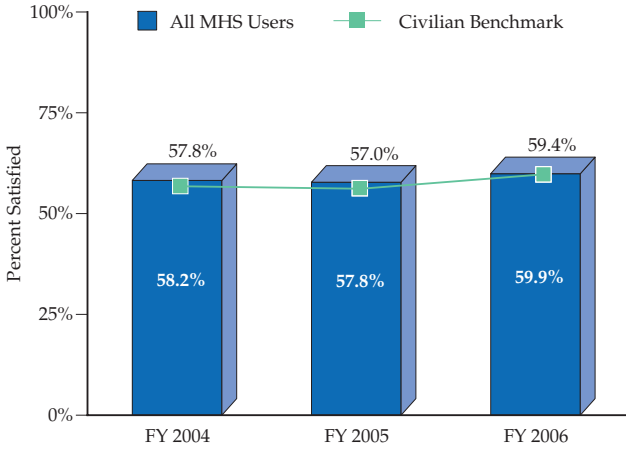
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



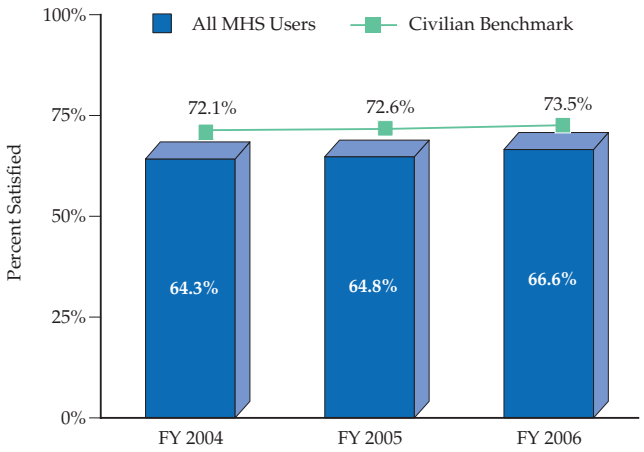
Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION WITH ONE'S SPECIALIST BASED ON ENROLLMENT STATUS

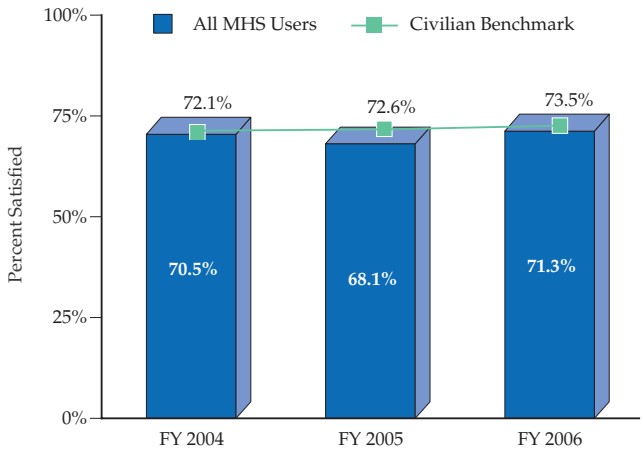
MHS enrollees, with either military or civilian PCMs, have remained stable in their level of satisfaction with their specialist from FY 2004 to FY 2006, and continue to lag a similarly stable civilian benchmark. Non-enrollees, however, report satisfaction levels comparable to their civilian counterparts (i.e., no statistically significant difference).

TRENDS IN SATISFACTION WITH ONE'S SPECIALIST BASED ON ENROLLMENT STATUS

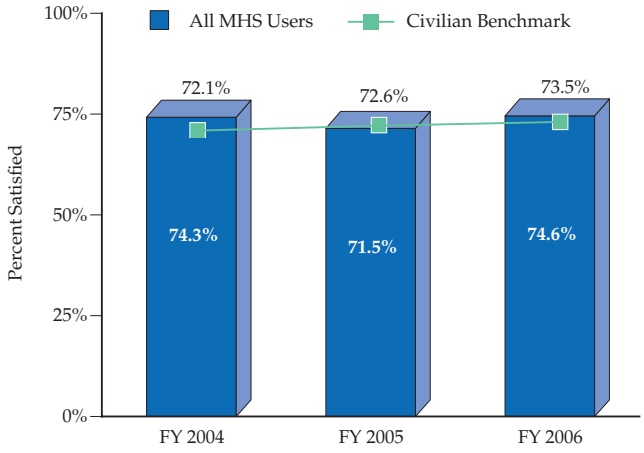
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



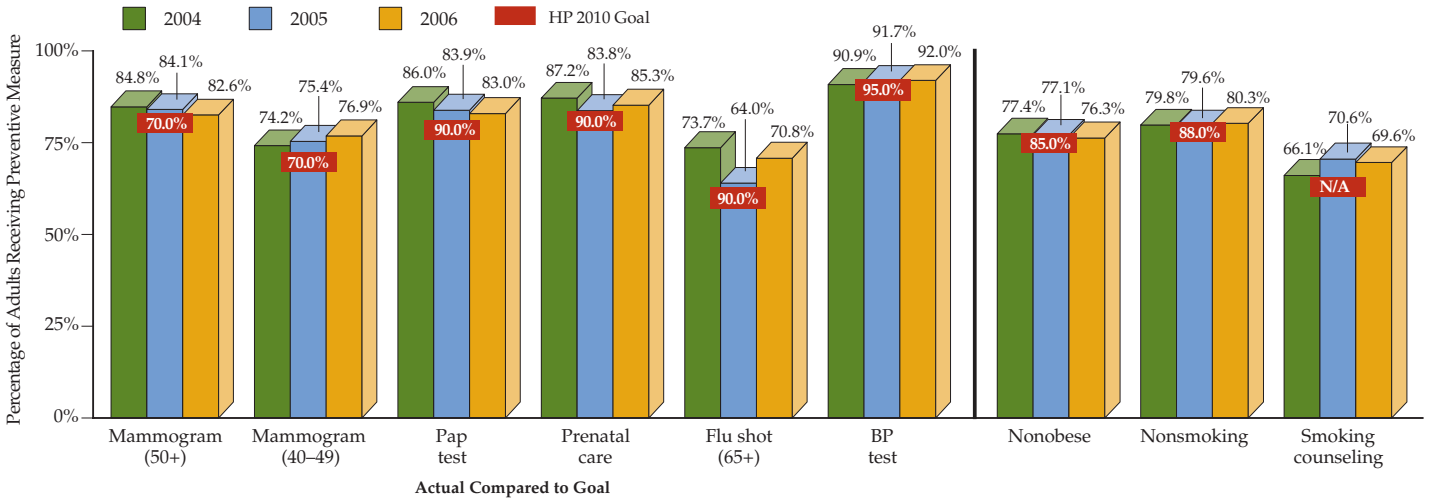
Note: DoD data were derived from the FYs 2004–2006 DoD Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Prime" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

BUILDING HEALTHY COMMUNITIES

Healthy People (HP) goals represent the prevention agenda for the nation over the past two decades *(www.healthypeople.gov/About)*. Beginning with goals established for Healthy People 2000 (HP 2000) and maturing most recently in Healthy People 2010 (HP 2010), this agenda is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats. These strategic goals go beyond restorative care and speak to the challenges of institutionalizing population health within the MHS. There are many indices by which to monitor the MHS relative to HP goals and reported civilian progress. The MHS has improved in several key areas and strives to improve in others.

- The MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by the Department of Health and Human Services in Healthy People 2010. These goals and objectives go beyond restorative care and speak to the need to institutionalize population health within the MHS. Over the past three years, the MHS has met or exceeded targeted Healthy People 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories).
- Efforts continue toward achieving Healthy People 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings.
- **Tobacco Use.** The overall self-reported nonsmoking rate among all MHS beneficiaries remained the same from FY 2004 through FY 2006. While the proportion of nonsmoking MHS beneficiaries appears higher than the overall U.S. population (not shown), it continues to lag the HP 2010 goal of an 88 percent nonsmoking rate (age and sex standardized against the HP goal of 12 percent rate in tobacco use for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month).
- **Obesity.** The metric of "nonobese" has been established to indicate a general sense of the population likely not be excessively overweight and at health risk due to obesity. The overall proportion of all MHS beneficiaries identified as non-obese has remained relatively constant from FY 2004 to FY 2006. The HMS rate of 76 percent non-obese in FY 2006 using self-reported data, has not reached the HP 2010 goal of 85 percent, but does exceed the most recently identified U.S. population average of 69 percent (not shown).
- Still other areas continue to be monitored in the absence of specified Healthy People standards, such as smoking-cessation counseling, which appears to be heading in the right direction, reaching almost 70 percent in FY 2006.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2004 TO FY 2006



Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database as of 12/7/2006

MHS TARGETED PREVENTIVE CARE OBJECTIVES

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

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

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

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

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

Non-Obese: Obesity is measured using the Body Mass Index (BMI), which is calculated from self-reported data from the Health Care Survey of DoD Beneficiaries. An individual's BMI is calculated using height and weight (BMI = 703 times (weight in pounds divided by height in inches squared). While BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn, provides a preliminary indicator of risk associated with excess weight. It should therefore by used in conjunction with other assessments of overall health and body fat.

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

DoD TRIENNIAL SURVEY OF HEALTH RELATED BEHAVIORS AMONG MILITARY PERSONNEL

The results of the 2006 DoD Survey of Health Related Behaviors Among Military Personnel study were released in late FY 2006. This is the ninth in a series of surveys of active duty military personnel, with previous studies conducted in 1980, 1982, 1985, 1988, 1992, 1995, 1998 and 2002. All of these surveys investigated the prevalence of alcohol use, illicit drug use, and tobacco use, as well as negative consequences associated with substance use. The survey has evolved over time, with revisions and additions to accommodate new areas of concern (e.g., mental health of the active force, oral health, and gambling behaviors), as well as including Healthy People, 2010 objectives.[1]

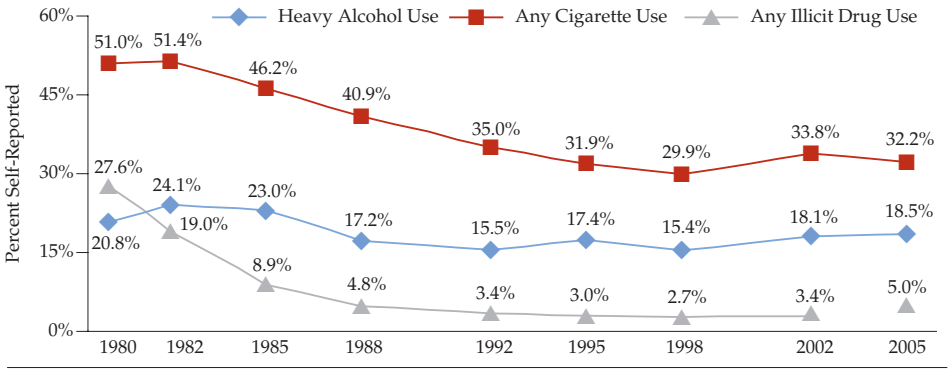
Reported Substance Use by DoD Personnel

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

- Over the past 25 years there has been a statistically significant downward trend among active duty personnel in past-month use of cigarettes and illicit drugs for the total DoD. Cigarette smoking decreased significantly, from 51.0 percent in 1980 to 32.2 percent in 2005, and use of any illicit drugs decreased significantly, from 27.6 percent in 1980 to 3.4 percent in 2002 (note: the rate for 2005 was 5.0 percent but was not comparable to the prior data because of wording changes in the questionnaire). In contrast, the change for heavy alcohol use (five or more drinks per typical drinking occasion at least once a week) from 20.8 percent in 1980 to 18.5 percent in 2005 was not statistically significant.
- Comparisons of findings between the 2002 and 2005 surveys showed a statistically significant decrease in the rate of heavy cigarette use (13.1 percent to 11.0 percent) but no significant change for heavy alcohol use (18.1 percent to 18.5 percent) or any cigarette use (33.8 percent to 32.2 percent). Comparisons were not made for illicit drug use in the past 30 days.

Military–Civilian Comparisons. Standardized comparisons showed substantial differences between substance use patterns of military personnel and civilians (using data from the 2004 National Survey on Drug Use and Health). After adjusting for sociodemographic differences between military and civilian populations, findings showed the following:

TRENDS IN SUBSTANCE USE, PAST 30 DAYS, TOTAL DoD, FY 1980 TO FY 2005



Source: Department of Defense Survey of Health Related Behaviors Among Military Personnel, figure ES–1, p. 2.
Prepared by RTI International, 12/2006

- Military personnel overall were significantly more likely to drink heavily than were their civilian counterparts (16.1 percent vs. 12.9 percent). However, the differences in heavy drinking varied by age group. Military personnel aged 18 to 25 showed significantly higher rates of heavy drinking (24.8 percent) than did civilians (17.4 percent), whereas rates of heavy drinking for personnel aged 26 to 55 (9.7 percent) were not statistically different from those of their civilian counterparts (9.5 percent).
- Military personnel were significantly less likely than civilians to have used any illicit drug in the previous 30 days (4.6 percent vs. 12.8 percent). This pattern held across both age groups (18 to 25; 26 to 55) and for males and females for the total DoD.
- Overall, military personnel were as likely as civilians to smoke cigarettes (30.1 percent vs. 28.9 percent). Cigarette smoking among military men and women aged 18 to 25, however, was significantly higher than among their civilian counterparts (men, 43.9 percent vs. 37.6 percent; women, 29.2 percent vs. 25.8 percent).

Overall findings indicated that the military made steady and notable progress from 1980 to 2005 in combating substance use and its associated problems. However, there is room for considerable improvement in some areas, particularly in reducing heavy alcohol use, binge drinking, cigarette smoking, and smokeless tobacco use.

1. R.M. Bray, et al. Draft reported data as of November 2006. 2005 Department of Defense Survey of Health Related Behaviors Among Military Personnel, ES-1.

Note: In interpreting and understanding the findings, three points should be considered: (a) The data and results are self-reported findings that may differ from information in official records or more objective data sources; (b) some questionnaire items comprise screeners suggestive of possible substance abuse or mental health problems; results from these screeners may suggest the need for further evaluation but do not represent a formal clinical diagnosis; and (c) in reporting the findings, the term "significant" is often used. This term refers to statistical significance resulting from statistical tests of differences that were conducted. Differences between two or more estimates were mentioned if they were significant at the 95 percent confidence level unless otherwise stated.

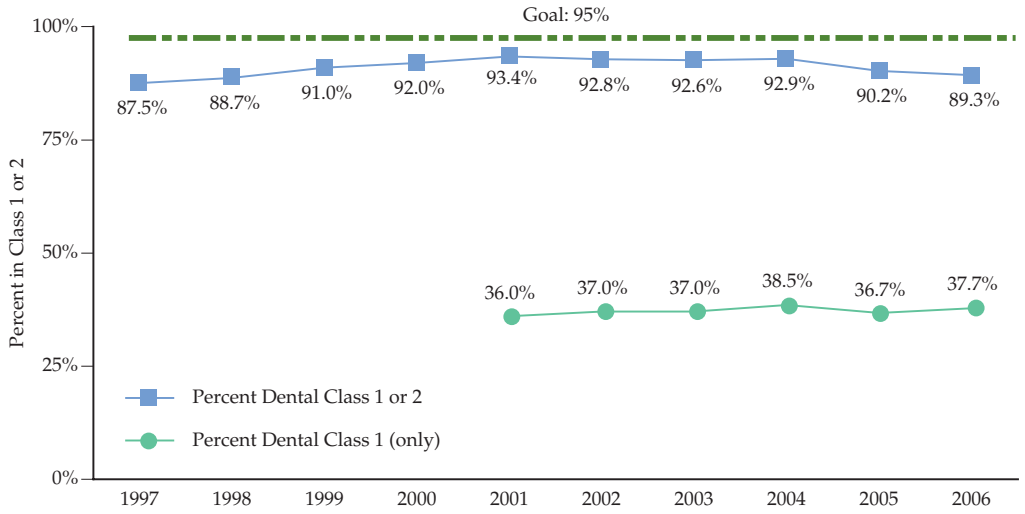
Most health care readiness metrics focus on those unique aspects germane to each of the Services, and are presented by the Surgeons General as appropriate to their combat leadership. Other readiness metrics are classified and presented elsewhere, as appropriate. One nonclassified measure monitored over the past several years has helped define the critical aspect of dental readiness of our active duty personnel.

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 Classes 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require non-urgent dental treatment or reevaluation for oral conditions that are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). This goal also provides a measure of active duty access to necessary dental services. Overall, the percentage of patients in dental Class 1 or 2 has been stable over the past 10 years, from FY 1997 to FY 2006 as shown below:

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high. However, while the gap between MHS performance and the 95 percent target rate for dental readiness in Classes 1 and 2 was almost achieved in FY 2001, it remains elusive. The FY 2006 rate of 89.3 percent reflects almost a one percent decline from FY 2005.
- The rate for active duty personnel in Dental Class 1 increased by one percent to 37.7 percent in FY 2006.

ACTIVE DUTY DENTAL READINESS: PERCENT DENTAL CLASS 1 OR 2



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 12/1/2006

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

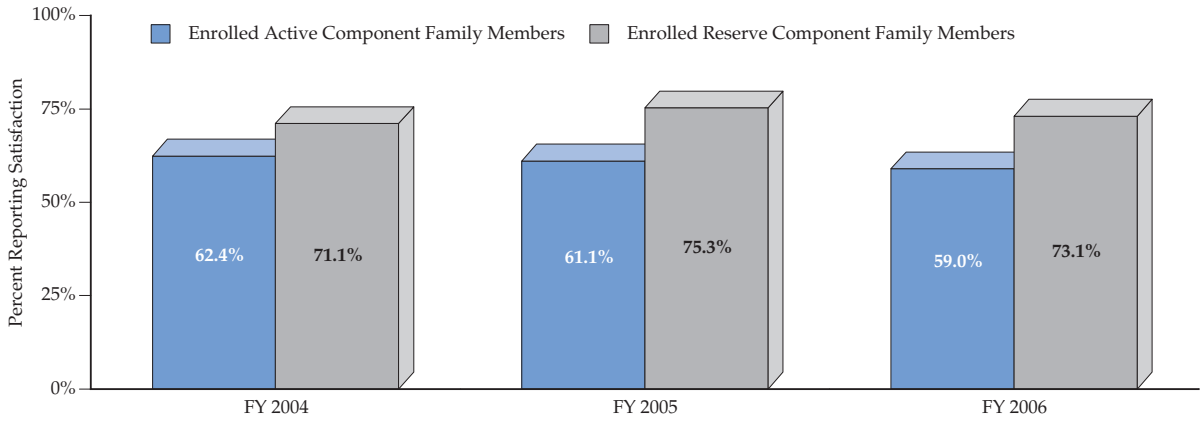
Dental Class 2: Patients with a current dental examination, who require nonurgent dental treatment or reevaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

SPECIAL STUDY: COMPARISON OF RESERVE AND ACTIVE COMPONENT FAMILY MEMBER ACCESS TO ROUTINE CARE INFORMATION

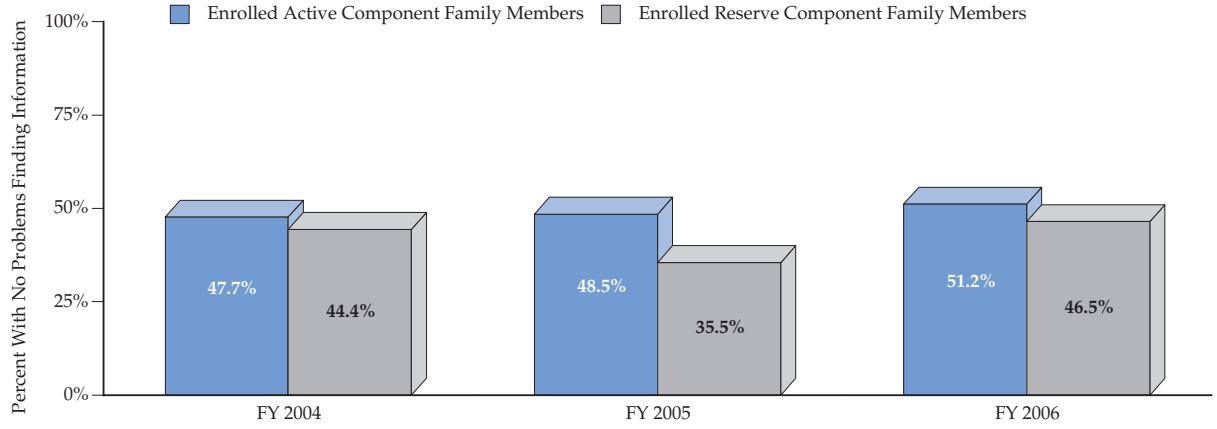
A special study completed in FY 2006 sought to identify if there were differences in access to routine health care and supportive information services between enrolled family members of National Guard and Reserves (reserve component, RC) and enrolled family members of active component personnel. The adult Health Care Survey of DoD Beneficiaries (HCSDB) is designed to measure a number of health care-related factors from samples of eligible MHS beneficiaries. The survey includes core questions from the Consumer Assessment of Health Care Providers and Systems (CAHPS) used by many of the nation's civilian health plans. This special study re-examined survey data previously collected during FY 2006 from eligible beneficiaries through random sampling.

- **Access to Routine Care:** The first chart shows that enrolled RC family members are significantly more likely to report they usually or always get routine care in a timely fashion when they want it than their active component (AC) family member counterparts (i.e., there is a statistically significant difference). Also RC family members reported higher levels of access in FY 2006 than in FY 2004 while AC family member access appears to be stable over the past three years.
- **Access to Information:** Access to and understanding of written materials about one's health plan are important determinants of overall satisfaction with the health plan. In FY 2005, enrolled RC family members were more likely to report they encountered problems in obtaining needed information in writing or over the Internet (statistically significantly different in FY 2005, but not in FY 2004 or FY 2006). This information is relevant because Reservists and their family members are likely to be in greater need of timely program information if they are unfamiliar with their TRICARE benefits or in navigating a system that might be different from their civilian experience.

COMPARISON OF ACTIVE AND RESERVE COMPONENT FAMILY MEMBER ACCESS TO ROUTINE CARE WITH TRICARE



COMPARISON OF ACTIVE AND RESERVE COMPONENT FAMILY MEMBER FINDING INFORMATION ABOUT TRICARE



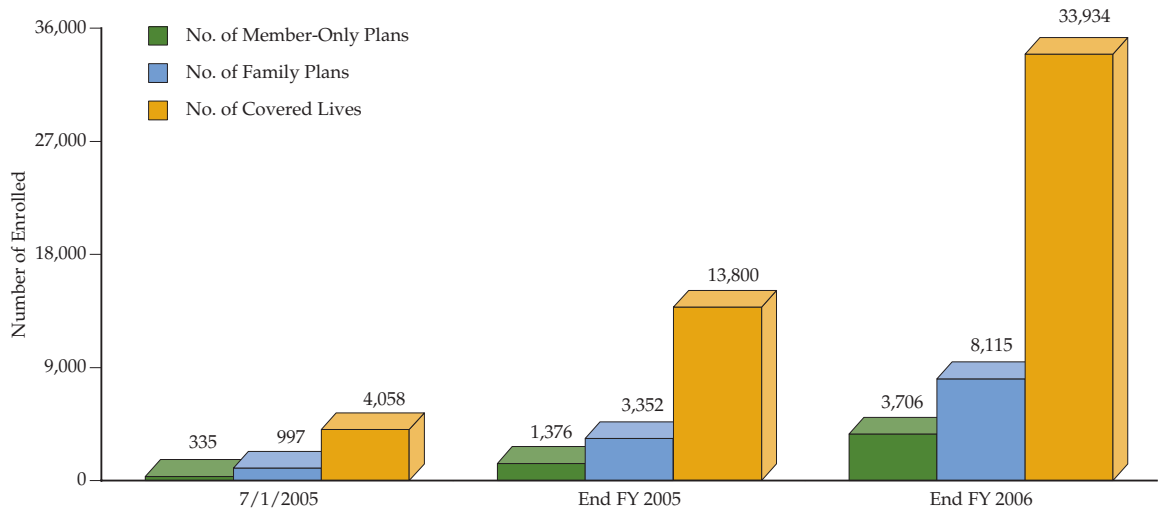
Note: DoD data were derived from the FY 2004, FY 2005 and FY 2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006, and adjusted for age and health status. Rates are based on respondents reporting "usually" or "always" from a five-point scale including "never", "sometimes" and "did not use".

TRICARE RESERVE SELECT

TRICARE Reserve Select (TRS) is the premium-based TRICARE health plan offered for purchase by certain members and former members of the Reserve Component (RC) and their families, if specific eligibility requirements are met. Reserve members are eligible for TRS (Tier 1) coverage if they were called or ordered to active duty, under Title 10, in support of a contingency operation on or after September 11, 2001. RC members and their respective reserve units will need to agree for the member to stay in the Select Reserve for one or more whole years to qualify. TRS coverage must be purchased, with TRS members paying a monthly premium for health care coverage (for self-only or for self and family). The TRS premiums are adjusted January 1 each year. The program offers comprehensive health care coverage similar to TRICARE Standard and TRICARE Extra. Members access care by making appointments with any TRICARE authorized provider, hospital, or pharmacy, network or non-network. TRS members may also access care at a military treatment facility (MTF) on a space-available basis. Pharmacy coverage is available from an MTF pharmacy, TRICARE Mail Order Pharmacy (TMOP), and TRICARE network and non-network retail pharmacies.

- By the end of FY 2006, enrollment in TRS Tier 1 reached almost 34,000 covered lives in 3,700 member-only and over 8,000 family plans.

TREND IN ENROLLMENT IN TRICARE RESERVE SELECT (TIER 1, OPERATIONAL SINCE JULY 2005)



Source: TRS enrollment data

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

Quality metrics in FY 2006 addressed several patient-focused areas: (1) self-reported access to MHS care overall, (2) satisfaction with various aspects of the MHS (e.g., the availability and ease of obtaining care, getting providers of choice, and receiving responsive customer service), (3) quality and timeliness of claims processing (both patient reported as well as tracking through administrative systems), (4) tracking of Joint Commission quality metrics in military treatment facilities, (5) access to and satisfaction with MTF care, and (6) access to TRICARE Standard civilian providers.

Access to MHS Care

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

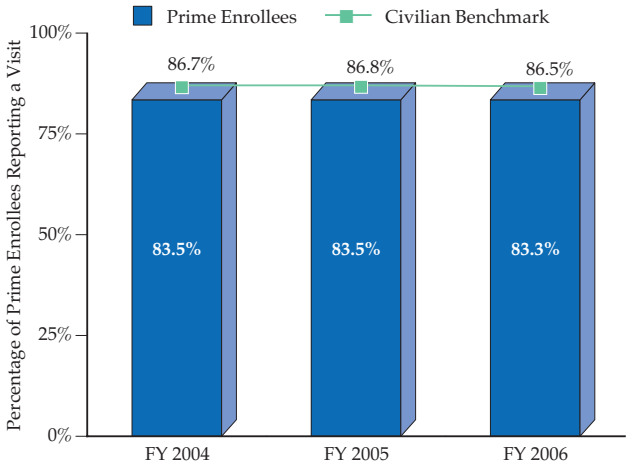
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.
- Quality and timeliness of claims processing.

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 are asked whether they had at least one outpatient visit during the past year.

- Access to and use of outpatient services remains high with 83 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit in the past 12 months in FY 2006.
- The MHS Prime enrollee rate continues to be slightly lower than the civilian benchmark (statistically significantly different each year, from FY 2004 to FY 2006).

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



Note: DoD data were derived from the FYs 2004–2006 DoD Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/7/2006, and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

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

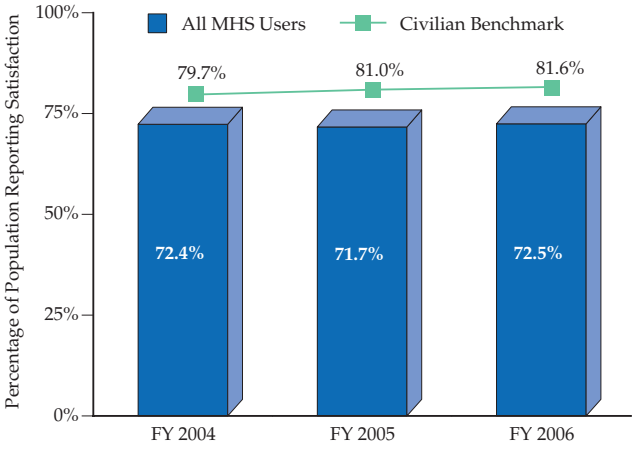
Availability and Ease of Obtaining Care

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

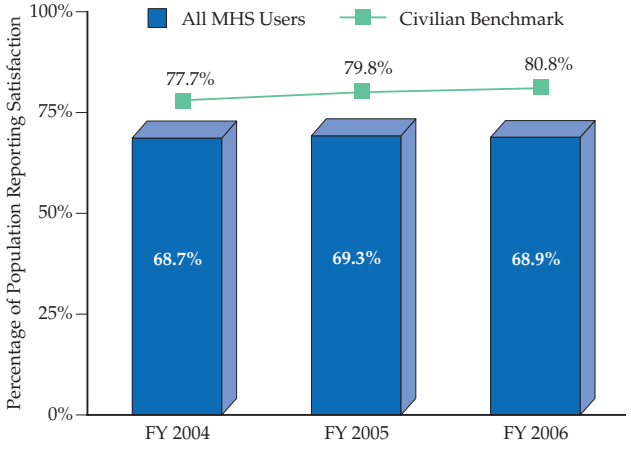
- MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2004 and FY 2006, while lagging the civilian benchmark, which improved over the same period of time.
- Both the MHS and the civilian benchmark ratings for "waiting less than 15 minutes to see the doctor" declined between FY 2004 and FY 2005 and rose in 2006 (statistically different for the MHS and not statistically different for the civilian benchmark between FY 2004 and FY 2006).

TRENDS IN AVAILABILITY AND EASE OF OBTAINING CARE FOR ALL MHS BENEFICIARIES (ALL SOURCES OF CARE)

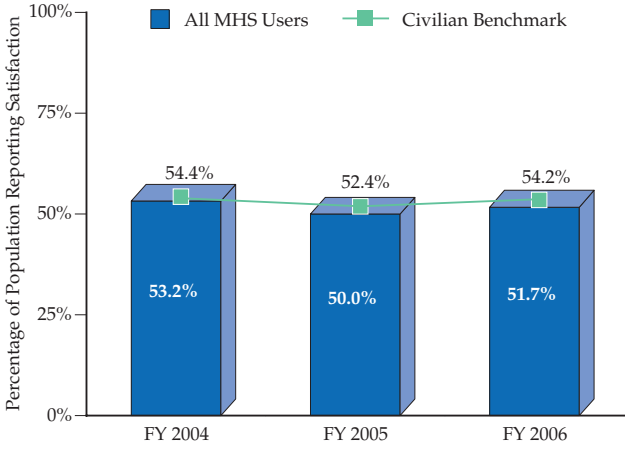
GOT NECESSARY CARE



WAITED FOR ROUTINE APPOINTMENT



WAITED LESS THAN 15 MINUTES TO SEE DOCTOR



Data as of 12/1/2006

Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of December 1, 2006, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "waiting … to see the doctor" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

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

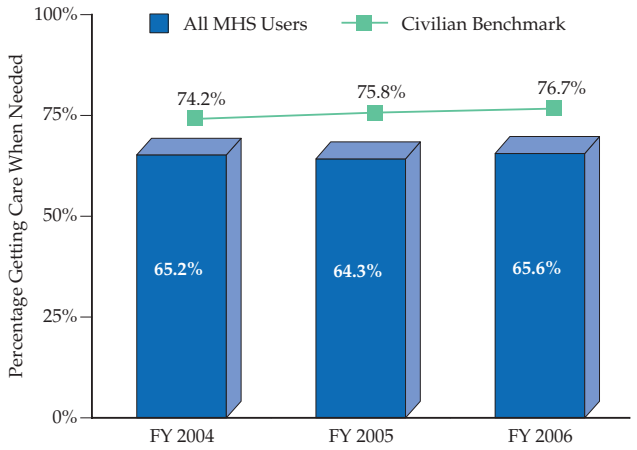
Ability to Obtain Care by Beneficiary Category

In focusing on beneficiary ability to obtain necessary care, differences among beneficiary categories are considered to identify significant disparities of concern.

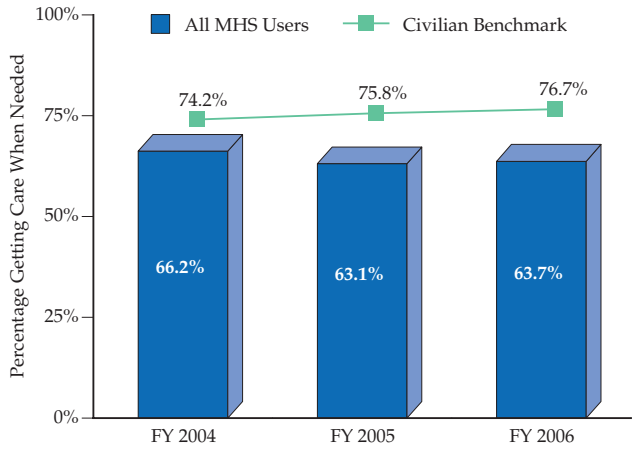
- Retired beneficiaries continue to report higher levels of satisfaction with their ability to get care than active duty personnel or their family members.
- MHS beneficiaries, in all three categories, lag their civilian counterparts in reporting access to care when needed.

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

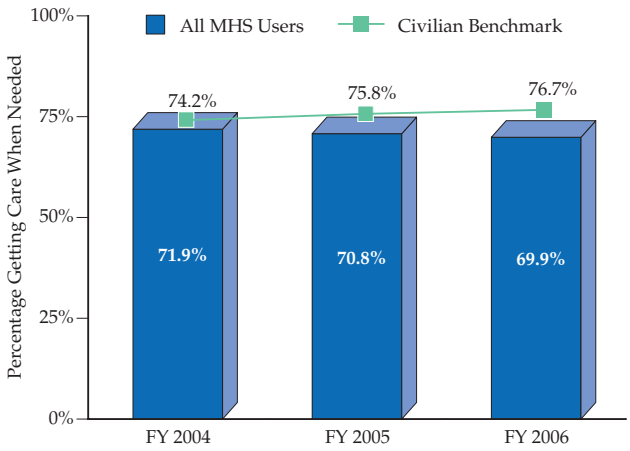
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



Data as of 12/1/2006

Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of December 1, 2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

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

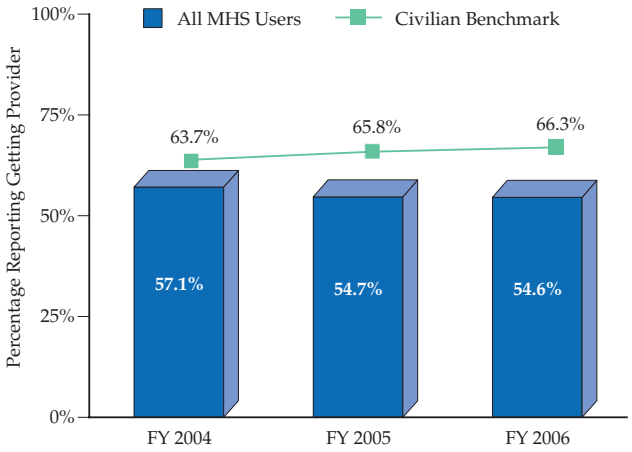
Opportunity to Get a Health Provider of Choice

A major determinant of an individual's satisfaction with a health plan includes being able to access necessary providers. The graphs below depict MHS patient reported satisfaction in (a) getting a personal doctor or nurse of one's choice, and (b) obtaining a referral to a specialty provider.

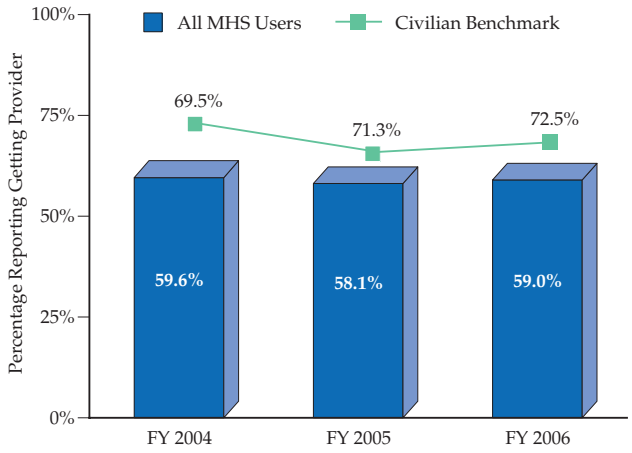
- For MHS users, satisfaction with the measure of access to physicians (getting a personal doctor) has declined between FY 2004 and FY 2006 (not statistically significant difference between years).
- For MHS users, satisfaction with obtaining a referral to a specialty provider has been stable between FY 2004 and FY 2006 (not statistically different).
- MHS rates continue to lag civilian benchmarks.

TRENDS IN GETTING ACCESS TO PERSONAL OR SPECIALTY PROVIDERS

GETTING A PERSONAL DOCTOR OR NURSE OF CHOICE



GETTING A REFERRAL TO A SPECIALIST



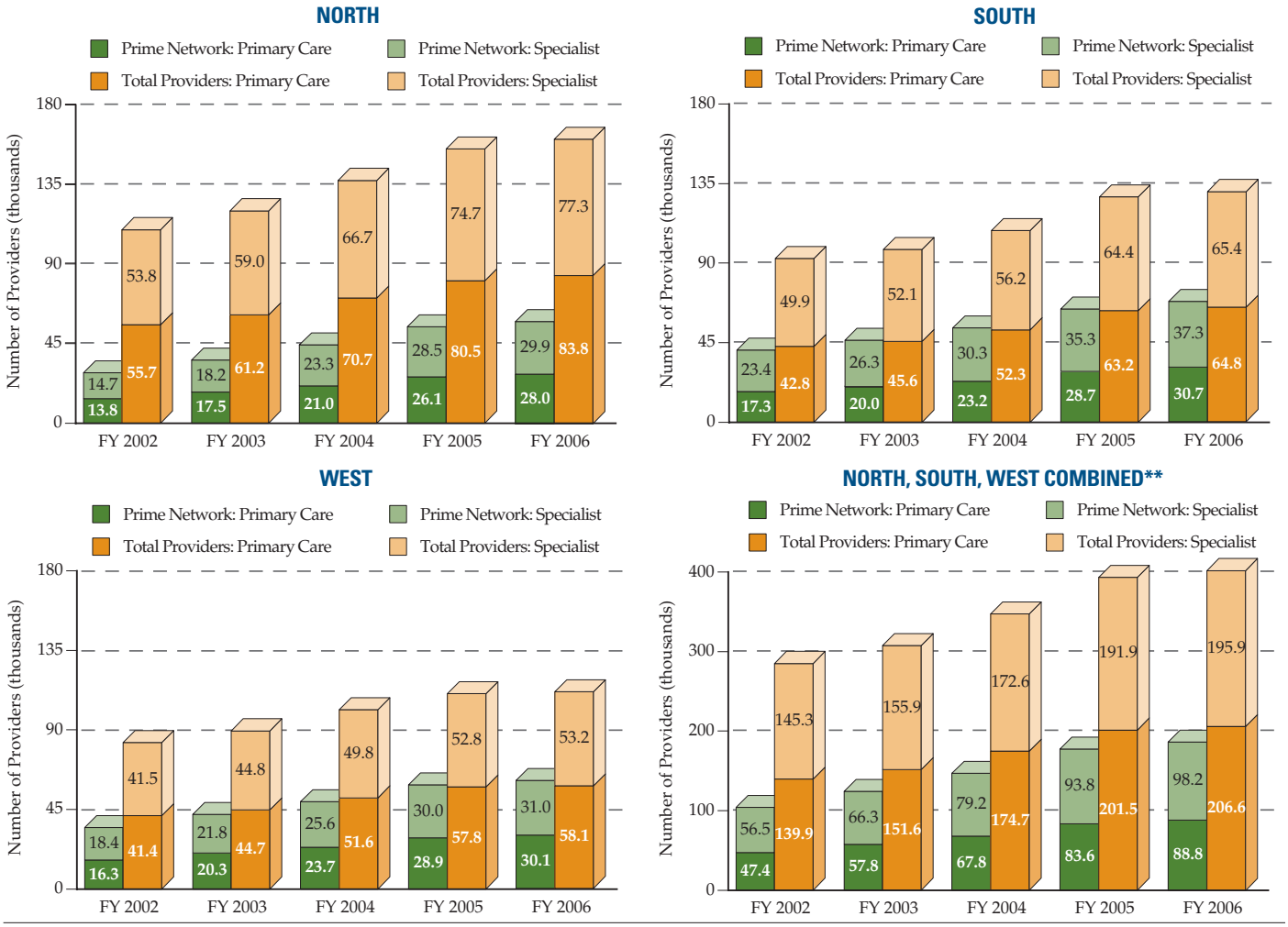
Note: DoD data were derived from the FYs 2004–2006 DoD Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/1/2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "…getting a personal doctor of choice" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

TRICARE PROVIDER PARTICIPATION

Beneficiaries' satisfaction with access to care is influenced in part by the choice of providers available to them. The number of TRICARE participating providers was determined by the number of unique providers filing TRICARE claims. After rising steadily from FY 2002 to FY 2005, the number of providers leveled off in FY 2006. The trend has been evident for both Prime and Standard/Extra providers. Furthermore, as evidenced by the claims data, the numbers of primary care providers* and specialists have increased at about the same rate.

- The North Region saw the largest increase in the total number of TRICARE providers (47 percent), followed by the South Region (40 percent) and the West Region (34 percent).
- The North Region also saw the largest increase in the number of Prime network providers (103 percent), followed by the West Region (76 percent) and the South Region (67 percent).
- The total number of TRICARE providers increased by 39 percent in catchment areas and by 42 percent in noncatchment areas (not shown).[1]
- The number of Prime network providers increased by 68 percent in catchment areas and by 85 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS



Source: MHS administrative data, 1/26/2007

* 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.

** Numbers may not sum to regional totals due to rounding.

Note: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, where a provider was counted if he/she was listed as a TRICARE participating provider. In the case of Prime network providers, the counts were based on claims for Prime enrollees only where the provider produced at least 12 visits per year. The latter condition was added to reduce the possibility of counting out-of-network referrals.

[1] As noted on page 15, the catchment area concept is being replaced within the MHS by MTF Enrollment Areas.

TRICARE PROVIDER PARTICIPATION

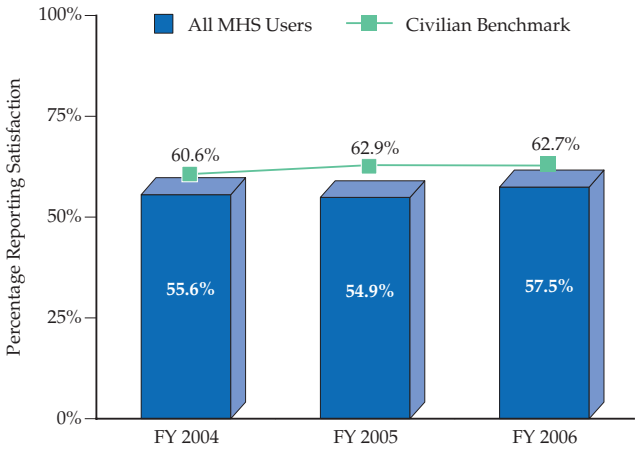
Satisfaction with Customer Service

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

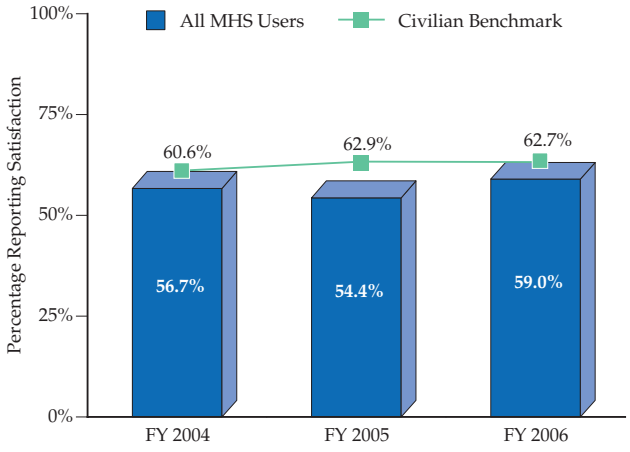
- MHS customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork remained stable over the three-year period from FY 2004 and FY 2006.
- MHS ratings for TRICARE customer service were not as high as those reported by enrollees in commercial plans.

TRENDS IN RESPONSIVE CUSTOMER SERVICE: COMPOSITE MEASURE OF FINDING, UNDERSTANDING WRITTEN MATERIAL; GETTING CUSTOMER ASSISTANCE; & PAPERWORK

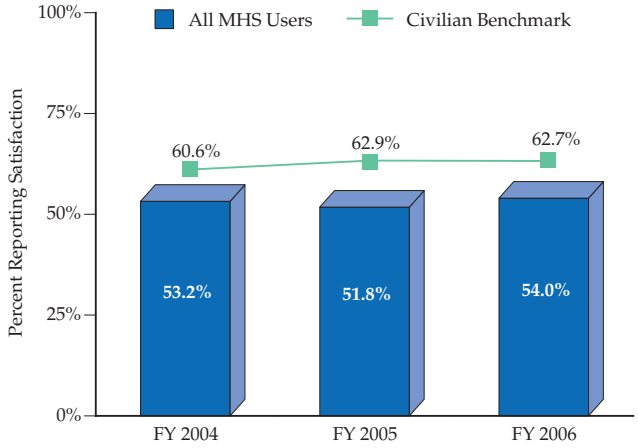
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Data as of 12/1/2006

Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of December 1, 2006, and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to "… paperwork" may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

CLAIMS PROCESSING

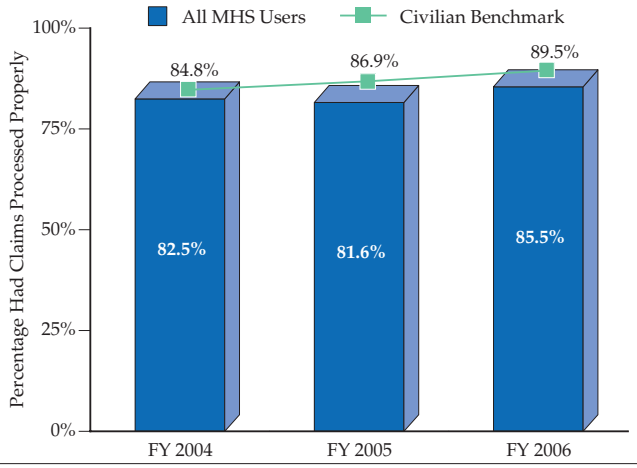
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for both the promptness of processing, as well as the accuracy of claim and payment. The MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary perceptions, and administrative tracking through internal government and support contract reports. This section reflects how MHS beneficiaries report their satisfaction with claims processing, and the next section reflects internal administrative monitoring.

Beneficiary Perceptions of Claims Filing Process

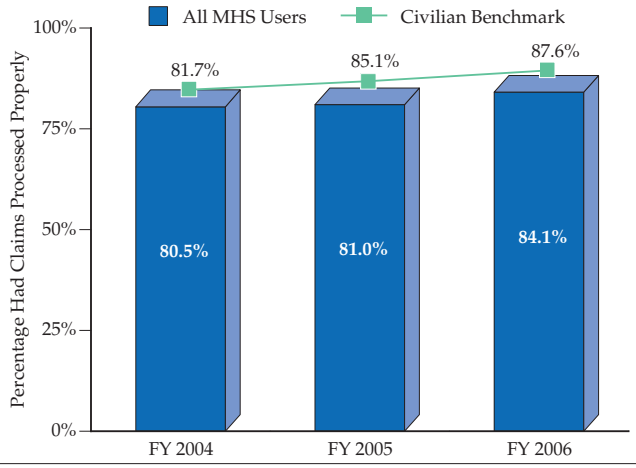
- MHS beneficiary satisfaction with claims being processed in a reasonable period of time increased between FY 2004 and FY 2006 (reaching 84.1 percent in FY 2006), and increased between FY 2005 and FY 2006 for claims being processed properly (about 86 percent).
- MHS satisfaction levels, however, continue to lag the civilian benchmark.
- As shown in the second chart below, the processing of retained claims within 30 days exceeded the TRICARE performance standard of 95 percent over the past four years, reaching 100 percent for the first time in FY 2005. While not shown, as in previous years, 100 percent of claims continue to be processed within 60 days, consistent with the performance standard of 100 percent.

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

CLAIMS PROCESSED PROPERLY (IN GENERAL)



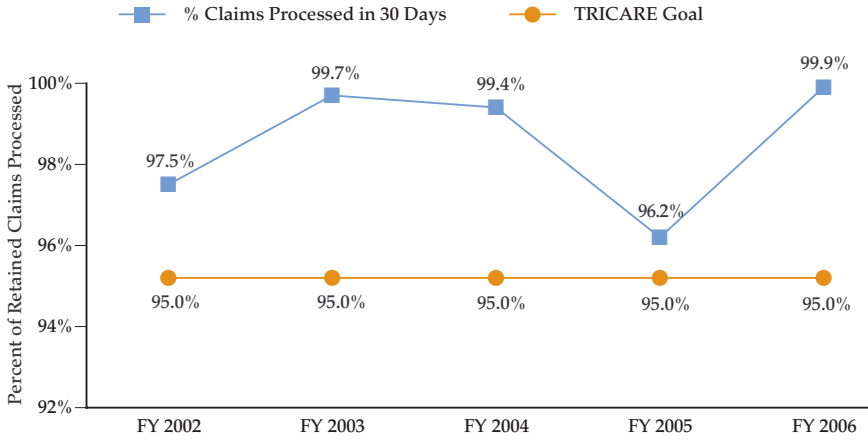
CLAIMS PROCESSED IN A REASONABLE TIME



Data as of 12/1/2006

Note: DoD data were derived from the FYs 2004–2006 Health Care Survey of DoD Beneficiaries (HCSDB) as of December 1, 2006 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

PERCENTAGE OF TRICARE RETAINED CLAIMS PROCESSED WITHIN 30 DAYS



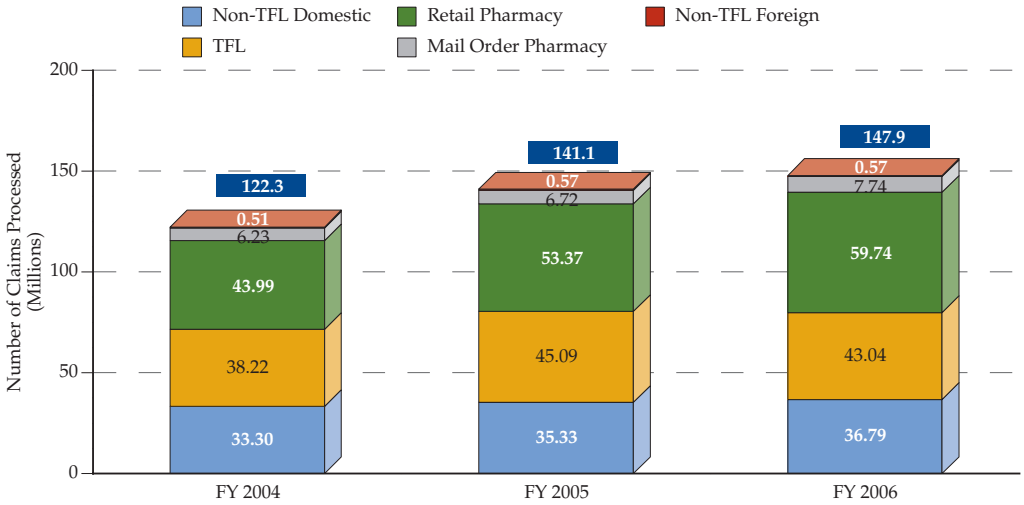
Source: MHS administrative data, 11/15/2005

CLAIMS PROCESSING *(CONT'D)*

Administratively Tracked Claims Filing Process

The number of claims processed continues to increase, due to increases in purchased care workload, including claims from seniors for TRICARE for Life, pharmacy and TRICARE dual eligible beneficiaries. Claims processing volume increased by almost 21 percent between FY 2004 and FY 2006. This increase is due to a combination of an overall volume of claims as well as a change in how pharmacy claims are reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas beginning in FY 2005 individual pharmacy prescriptions were reported separately. Both retail and mail order prescriptions increased the fastest between FY 2004 and FY 2006 (36 percent and 24 percent, respectively).

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2004 TO FY 2006



Source: MHS and Support Contractor administrative data, 1/3/2006

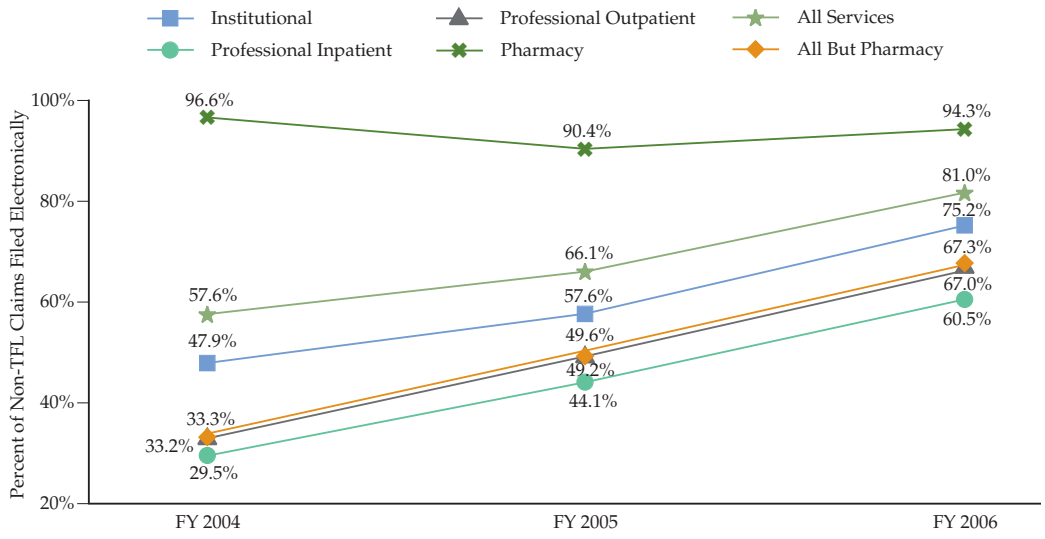
TRENDS IN ELECTRONIC CLAIMS FILING

Trends in Electronic Claims Filing

TRICARE continues to work with providers and claims processing contractors to increase processing of claims electronically, rather than in mailed, paper form. Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in more prompt payment to the provider. The TRICARE Regional Offices have been actively collaborating with the health care support contractors to improve use of electronic claims processing. Additionally, claims processing improvements in FY 2006 included easier-to-use and more standardized software including improvements to Internet/Intranet portals.

- The percentage of the non-TFL claims processed electronically for all services increased to almost 81 percent in FY 2006, up 15 percentage points from the previous year, and over 23 percent over the past three fiscal years. Over 57 million non-TFL claims were processed in FY 2006.
- The percentage of all nonpharmacy claims (institutional, and professional inpatient and outpatient services) processed electronically doubled between FY 2004 and FY 2006, reaching 66 percent in FY 2006.
- TRICARE is second payer to Medicare, and, as such, the TFL claims are predominantly electronic, irrespective of MHS involvement. While not shown, almost 95 percent of all TFL claims and 92 percent of TFL nonpharmacy claims processed in FY 2006 were electronic. As such, the overall rate of electronic claims processed is 88 percent when TFL claims are considered.

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF CLAIMS FILED ELECTRONICALLY



Source: MHS administrative claims data, 11/17/2006

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

CIVILIAN PHYSICIAN ACCEPTANCE OF TRICARE STANDARD PATIENTS

Purpose of Study

The Department has completed the second of three planned annual surveys to determine civilian physician acceptance of new TRICARE Standard patients. The FY 2004 National Defense Authorization Act (Section 723) requires the Department to "conduct surveys in the TRICARE market areas in the US to determine how many health care providers are accepting new patients under TRICARE Standard in each such market area." This legislation required DoD to survey at least 20 market areas each year, giving priority to those areas where representatives of TRICARE beneficiaries/providers identified locations experiencing significant levels of access-to-care problems under TRICARE Standard. Results for the previous two years have been presented in earlier reports (FY 2006 Report, pp. 62–64; FY 2005 Report, pp. 62–65; FY 2004 Report, page 49).

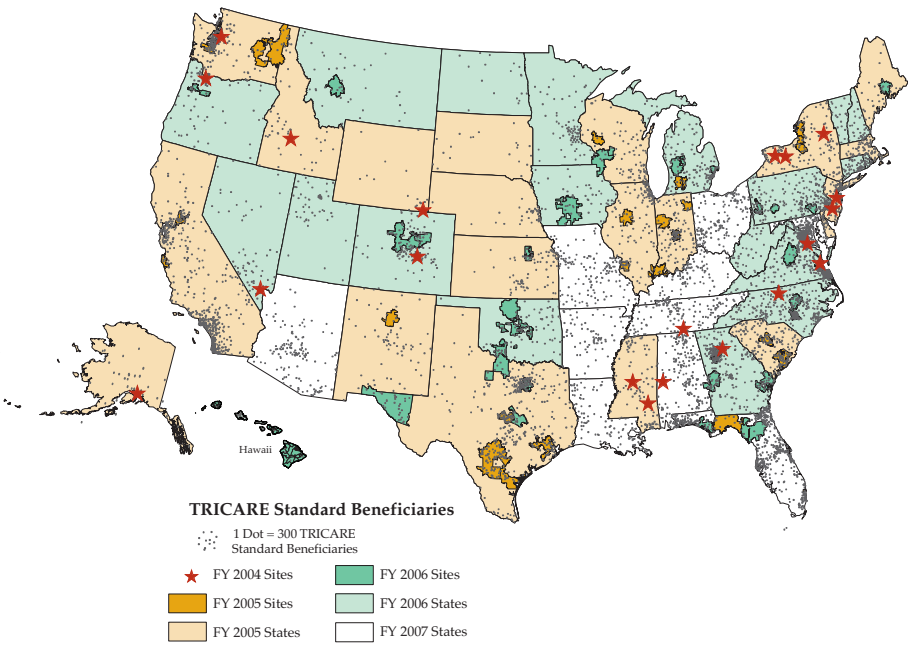
Section 723, NDAA for FY 2004, directed DoD to conduct surveys in U.S. TRICARE market areas to determine how many civilian health care providers are accepting TRICARE Standard beneficiaries as new patients; Section 711, NDAA for FY 2006 provided additional questions to be included in the survey.

FY 2006 SURVEY RESULTS: Over 18,800 eligible physicians replied for overall response rate of over 50 percent. FY 2006 results are consistent with the FY 2005 results: there is a high level of physician awareness of the TRICARE program (nine of ten doctors responding), and relatively high level acceptance of new TRICARE Standard patients (over eight of ten responding doctors), with variability among specific HSAs.

- In FY 2006, almost *93 percent of all responding physicians* in the 38 HSAs *were aware of the TRICARE program*, ranging from 84 percent to 100 percent:
  - Compared to 90 percent aware in FY 2005 Survey (from 55 percent–99 percent)
  - Also in FY 2006, 90 percent aware across the 20 state compared to 84 percent in FY 2005.
- In FY 2006 *82 percent of HSA physicians accepted new TRICARE Standard patients of those accepting any new patients* at all, ranging from 44 percent to 100 percent:
  - Compared to 81 percent in FY 2005 and 82 percent in FY 2004. Also in FY 2006, 85 percent accept new TRICARE Standard patients across the 20 states.
- In FY 2006 *91 percent of HSA physicians* accepting new TRICARE Standard patients *accepted those patients for all claims*, rather than on a claim-by-claim basis.
- In FY 2006 the most frequently cited reason physicians gave for not accepting new TRICARE Standard patients was due to "Reimbursement" (29 percent of all comments received across HSAs and 24 percent across states). "Miscellaneous" reasons were the second most frequently cited across the HSAs (17 percent—e.g., "Doctor's policy" or "not a signed provider"), while "Not accepting patients" was the second reason across the states (all due to "accepting no new patients" or "full patient panel").
  - "Reimbursement" was the second most frequent reason in FY 2005 (24 percent) and the number one reason in FY 2004 (29 percent).
- The FY 2006 survey also indicated that many doctors who accept new Medicare also accept new TRICARE Standard patients, but that there are locations where TRICARE Standard acceptance can be improved: 86 percent of those doctors accepting new Medicare patients accept new TRICARE Standard patients.

The map below reflects where the MHS TRICARE Standard eligible population resides, as well as the states and sub-market Hospital Service Areas surveyed in FY 2006 (green), and FY 2005 (yellow). The baseline FY 2004 sub-market survey sites are also shown (circles). The remaining 10 states to be sampled in FY 2007 are shown in white (HSAs).

LOCATIONS OF DoD SURVEY OF CIVILIAN PHYSICIAN ACCEPTANCE OF NEW TRICARE STANDARD PATIENTS



Source: OASD(HA)/TMA-HPS&E, 1/24/2007

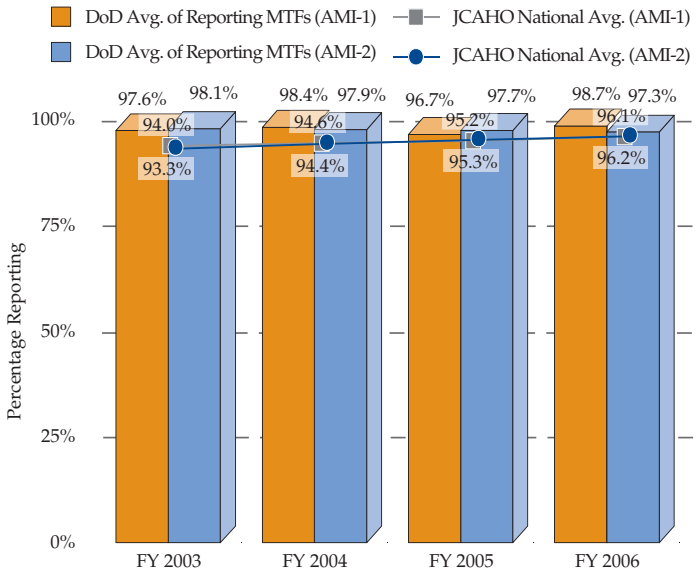
MILITARY TREATMENT FACILITY ASSESSMENT OF SELECTED JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS (JCAHO) CORE QUALITY OF CARE MEASURES

In the United States, the JCAHO is the nationally recognized organization that surveys health care settings using pre-established, published criteria to determine the accreditation status based on a triennial on site survey by health care professionals. Participation in the JCAHO survey process has been an institutionalized aspect of quality in the MHS for two decades. The Joint Commission has established the ORYX® Core Measures initiative to incorporate the use of data for comparative analyses and public reporting as a method to enhance the quality improvement activities in accredited health care organizations.

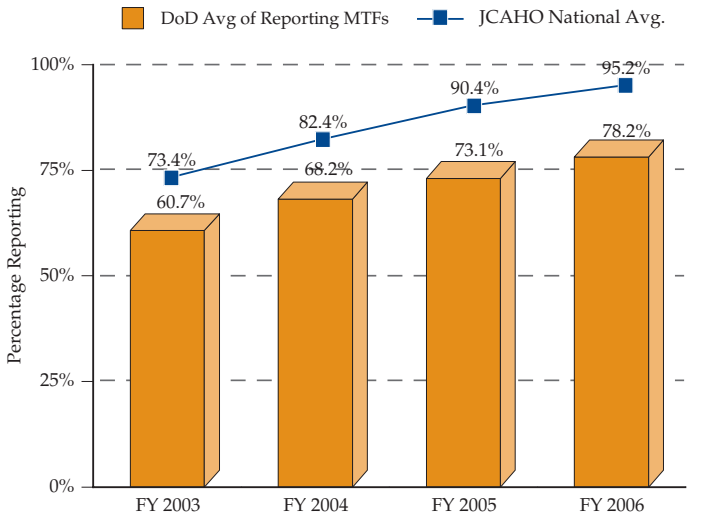
The Joint Commission and the Centers for Medicare and Medicaid Services have collaborated through the Hospital Quality Alliance to align measures across the health care industry. All of the Hospital Quality measures recommended by the Alliance are endorsed by the National Quality Forum. These measures have been designed to permit more rigorous comparisons using standardized, evidence-based measures and data gathering procedures. JCAHO has identified key measures with respect to acute myocardial infarction (AMI), heart failure, pneumonia, pregnancy and surgical care improvement project. MHS military treatment facilities are currently reporting data on several of the JCAHO core measure sets. The charts below provide a sample of a few of the measures focusing on key aspects for managing the effects of AMI, with respect to the provision of aspirin within 24 hours of arrival at the hospital, aspirin prescription upon discharge, and counseling to quit smoking. The annual results of MHS reporting hospitals are compared to the national average of accredited U.S. institutions reported by the Commission for that fiscal year.

- As shown on the left-hand chart below, MHS military treatment facilities have maintained a high rate of aspirin therapy for AMI patients, exceeding the Joint Commission's comparative national average over the last three fiscal years.
- As shown on the right-hand chart below, while MHS documentation of smoking cessation counseling for those adults admitted for AMI has improved over the past three fiscal years, it remains below the national average reported by the Commission which has similarly improved over that time frame.

ACUTE MYOCARDIAL INFARCTION—ASPIRIN AT ARRIVAL AND UPON DISCHARGE (AMI-1 AND AMI-2)



ACCREDITATION—CLINICAL QUALITY STANDARDS: SMOKING CESSATION ADVICE AND COUNSELING FOR ADULTS ADMITTED FOR ACUTE MYOCARDIAL INFARCTION

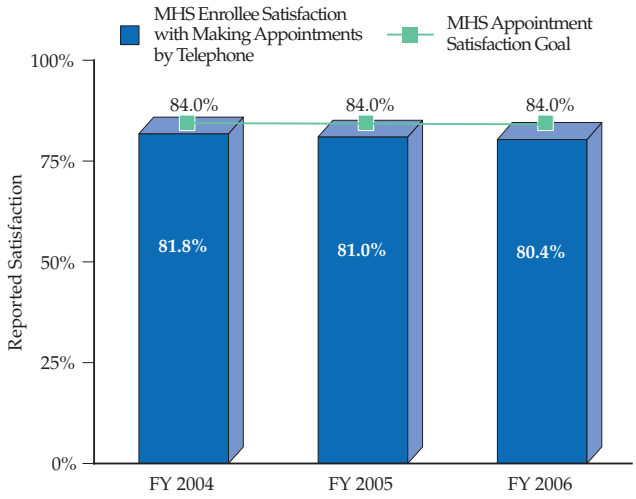


Source: OASD(HA)/TMA, Office of the Chief Medical Officer, 11/12/2006

APPOINTMENT ACCESS IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with telephone access to the direct care system in addition to the satisfaction metrics presented previously (External Customers: satisfaction with the health plan and care overall, as well as the primary care and specialty care physicians). This metric is designed to put MHS patients at the center of attention in the direct care system.

SATISFACTION WITH MAKING APPOINTMENTS BY TELEPHONE IN THE DIRECT CARE SYSTEM



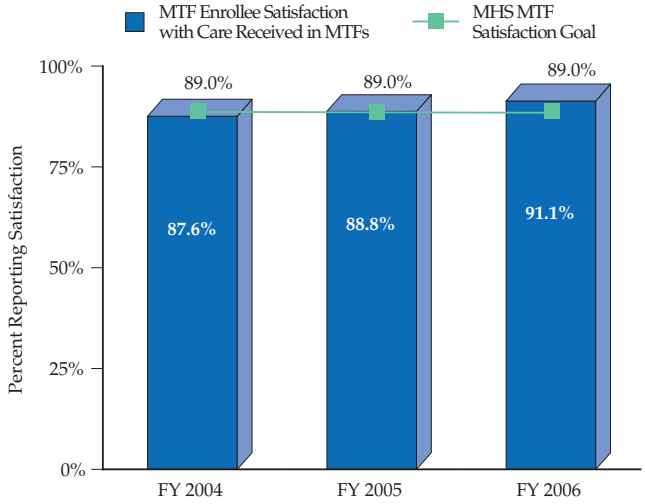
Source: DHP Performance Contract, Satisfaction with Access, 12/1/2006, through 5/2006

The MHS goal was raised in FY 2004 to 84 percent from 82 percent the previous year, when patients reporting satisfaction exceeded the 82 percent goal in FY 2003. The level of satisfaction reported by MHS beneficiaries has not yet met the revised goal of 84 percent this year, and appears to have decreased by about 1 percent since FY 2004.

SATISFACTION WITH CARE RECEIVED IN THE DIRECT CARE SYSTEM

The MHS is concerned about beneficiary satisfaction with the actual encounter in the MTF. Similar to measuring beneficiary access to MTFs via telephone, this metric is designed to put MHS patients at the center of attention in the direct care system. Patient satisfaction here is measured by a survey following a specific clinic visit.

SATISFACTION WITH THE OUTPATIENT VISIT IN THE DIRECT CARE SYSTEM



Source: DHP Performance Contract, Satisfaction with Access, 1/5/2007

The percentage of beneficiaries reporting satisfaction with the care received within military treatment facilities in the past three years has increased by almost 4 percent, and, in FY 2006 (year to date) appears to have exceeded the MHS goal of at least 89 percent satisfaction.

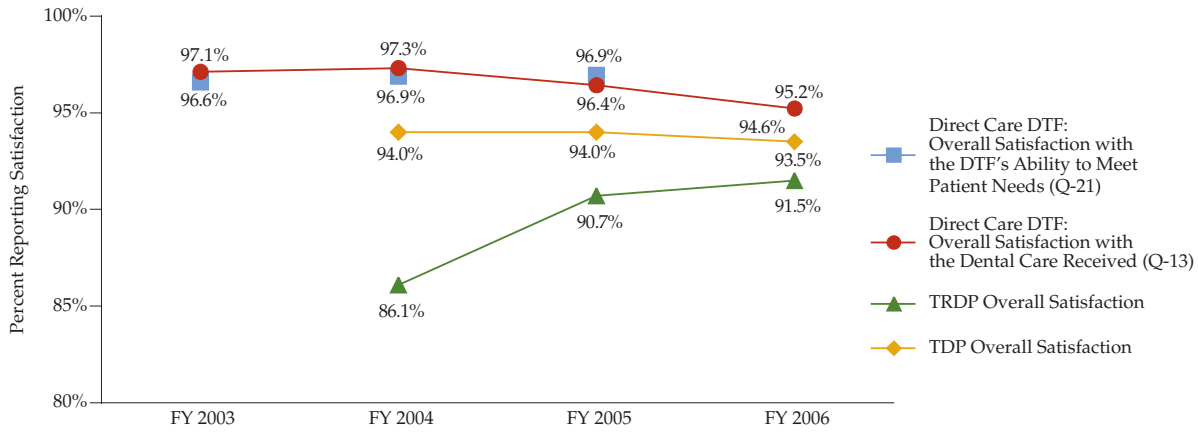
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

Dental Customer Satisfaction

The overall TRICARE dental benefit is comprised of several delivery programs serving the MHS beneficiary population. Beneficiary satisfaction is routinely measured for each of these important dental programs.

- Satisfaction with dental care reported by patients receiving dental care in military dental treatment facilities (DTFs) was almost 95 percent in FY 2006, compared to slightly over 96 percent in FY 2005. DTFs are responsible for the dental care of 1.79 million active duty service members, as well as eligible OCONUS family members. During FY 2006, the Tri-Service Center for Oral Health Studies collected over 146,000 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs. The overall DoD dental patient satisfaction with the ability of the DTFs to take care of their dental needs also decreased to just over 95 percent in FY 2006.
- The **TRICARE Dental Program (TDP)** FY 2006 composite average enrollee satisfaction **remained at about 94 percent**, similar to FY 2005. The TDP is a voluntary, premium-sharing dental insurance program that is available to eligible active duty family members, Selected Reserve and Individual Ready Reserve members, and their family members. As of September 30, 2006, the TDP services 733,383 contracts covering over 1,787,578 lives. While not shown, this measure includes satisfaction ratings for network access (95 percent), provider network size and quality (92 percent), claims processing (95 percent), enrollment process (95 percent), and written and telephonic inquiries (90 percent).
- The **TRICARE Retiree Dental Program (TRDP) overall retired enrollee satisfaction rates increased to 91.5 percent** in FY 2006, from 90.7 percent in FY 2005 The TRDP is a full premium insurance program open to retired uniformed service members and their families. The TRDP demonstrated a 19.6 percent increase in enrollees from FY 2004 to FY 2006, ending the year with 458,385 contracts serving 975,352 lives.

SATISFACTION WITH TRICARE DENTAL PROGRAMS: DTF AND CONTRACT SOURCES



Source: Tri-Service Center for Oral Health Studies, DoD Dental Patient Satisfaction reporting Web site (Trending Reports) and TRICARE Operations Division, 12/1/2006

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.

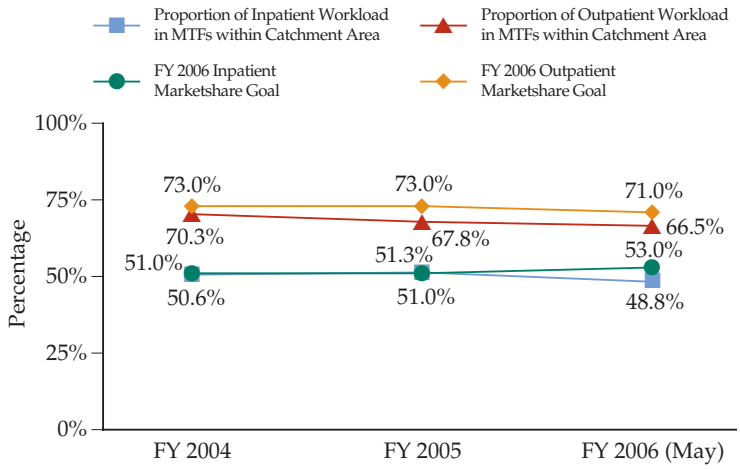
SYSTEM PRODUCTIVITY: MTF MARKET SHARE TRENDS

As a measure of enrollment market share, the percentage of both inpatient and outpatient workload for TRICARE Prime enrollees accomplished in MTFs relative to all Prime workload in catchment areas[1] (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past three years.

From FY 2004 to FY 2006, MTF inpatient workload market share declined by almost 2 percentage points while outpatient workload market share declined by almost 4 percentage points.

No adjustments have been made to account for the effects of deploying military providers and support staff, nor for the significant influx of National Guard and Reservists mobilized since September 11, 2001, and their family members, who have become eligible for the TRICARE benefit.

PERCENTAGE OF ENROLLEE WORKLOAD PERFORMED BY MTFs IN CATCHMENT AREAS



Source: MHS administrative data reported in the Annual Defense Review, 1/16/2007

Note: Market share measures exclude TFL workload from purchased care. Inpatient workload is based on RWPs, and outpatient workload is based on visits. Inpatient workload is based on 40-mile catchment area; outpatient workload is based on catchment areas for stand-alone clinics and 20-mile catchment area surrounding the "Parent" MTF with inpatient services.

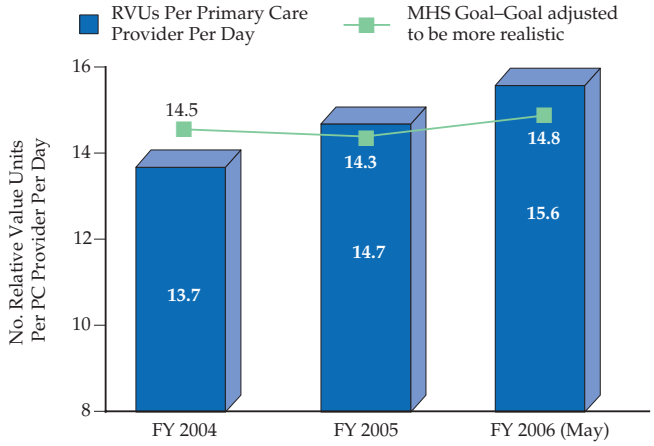
[1] As noted on page 15, the catchment area concept is being replaced within the MHS by MTF Enrollment Areas.

SYSTEM PRODUCTIVITY: MTF PROVIDER PRODUCTIVITY

The purpose of this metric is to focus on the productivity of the direct care system at the provider level. Performance is measured as the number of relative value unit (RVU) encounters (visits) per full-time equivalent (FTE) primary care provider in U.S. military clinics.

MHS productivity increased in FY 2006 to 15.6 RVUs per primary care provider per day (however, missing data at time of writing may result in overstating performance). Similar to the market share analysis above, no adjustments in actual productivity have been made to account for the effects of deploying military providers and support staff, nor for the influx of mobilized National Guard and Reservists and their family members.

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

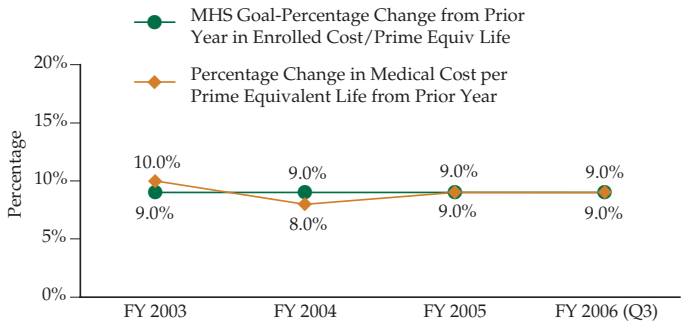


Source: MHS administrative data reported in the Annual Defense Review, 1/16/2007. Measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics.

SYSTEM PRODUCTIVITY: MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric is to stay below a 9 percent annual rate of increase, based on the projected rise in private health insurance premiums. The annual rate of increase in average medical costs per Prime enrollee has declined from a high of 10 percent growth between FY 2002 and FY 2003, to a growth rate of 9 percent annual growth in the past two fiscal years (FY 2005 and FY 2006, through the third fiscal quarter).

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



Source: MHS administrative data reported in the Annual Defense Review, 1/16/2007. Enrollees are not adjusted for age and gender.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

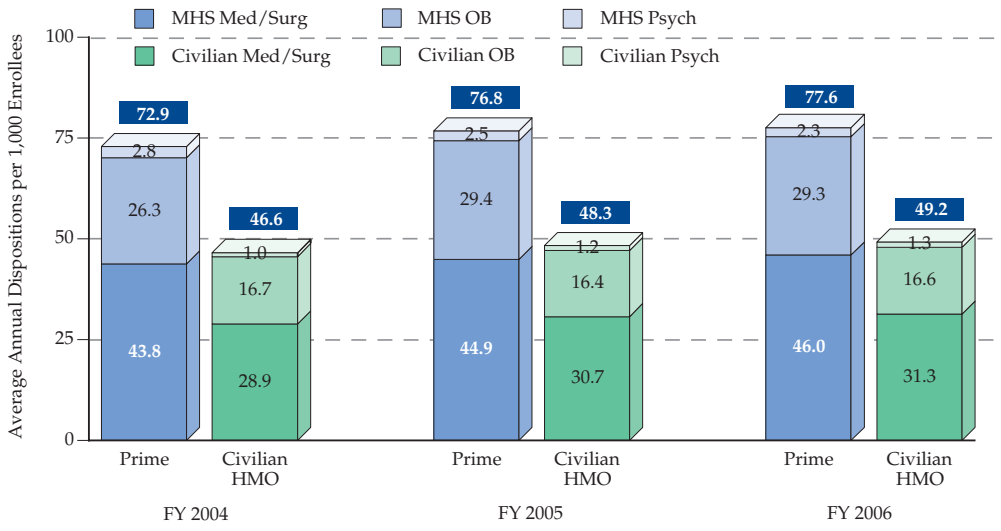
TRICARE Prime Enrollees

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

Dispositions are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical procedures (MED/SURG)—and compared for *acute care facilities only*. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. The MHS data further exclude beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) and TRICARE Plus.

- The TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 57 percent higher than the civilian HMO utilization rate in FY 2006 (77.6 discharges per thousand Prime enrollees compared with 49.2 per 1,000 civilian HMO enrollees). This ratio is essentially unchanged from the previous two years.
- In FY 2006, the overall TRICARE Prime inpatient utilization rate was 57 percent higher than the civilian HMO rate.
- In FY 2006, the TRICARE Prime inpatient utilization rate was 47 percent higher than the civilian HMO rate for medical/surgical procedures, 76 percent higher for obstetrical/gynecological procedures, and 78 percent higher for mental health procedures. The latter ratio, though based on relatively low MHS and civilian disposition rates, reflects the more stressful environment that many active duty service members and their families endure.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

INPATIENT UTILIZATION RATES AND COSTS

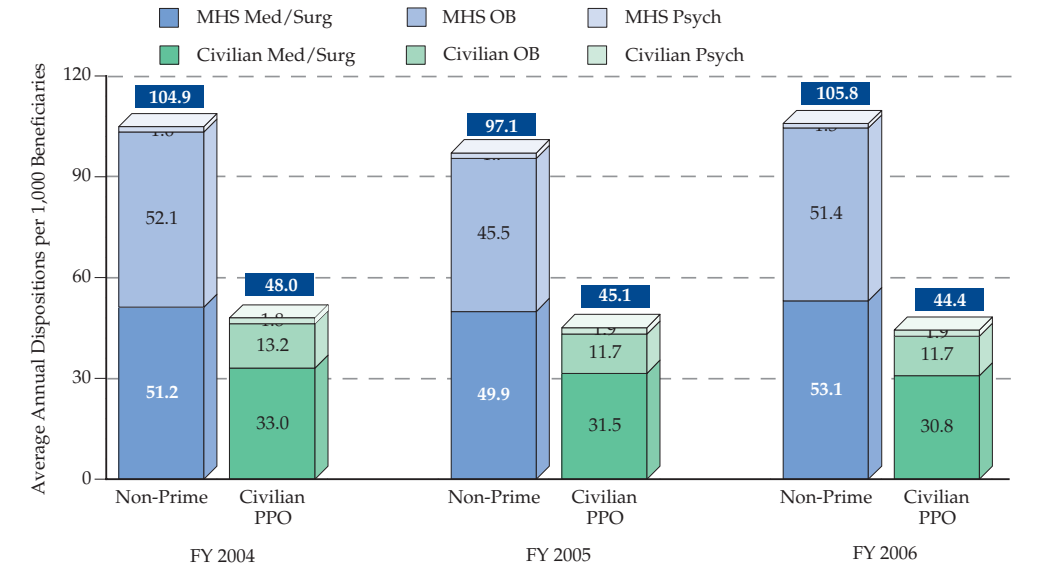
Non-Enrolled Beneficiaries

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—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical procedures (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. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries. 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.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants. The ratio of MHS to civilian dispositions per capita increased from 2.19 to 2.38 from FY 2004 to FY 2006.
- By far the largest discrepancy in utilization rates between the MHS and private sector is for obstetrical/gynecological procedures. In FY 2006, the MHS OB disposition rate was more than four times higher than the corresponding civilian rate.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

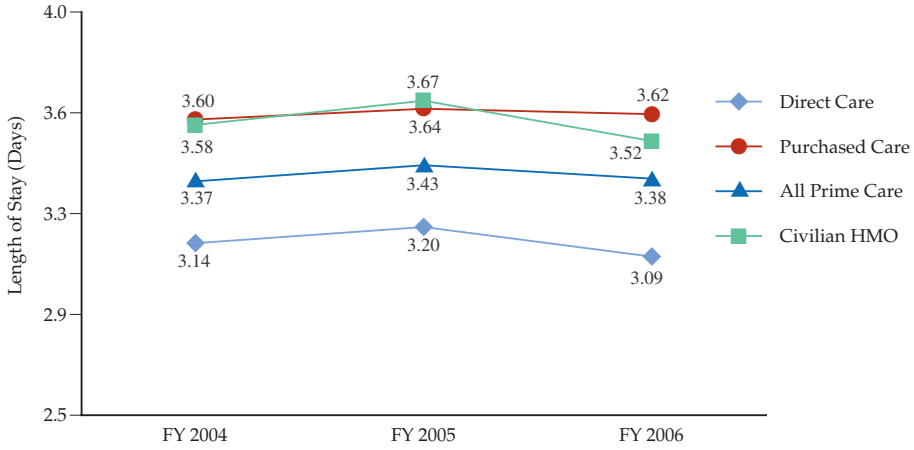
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

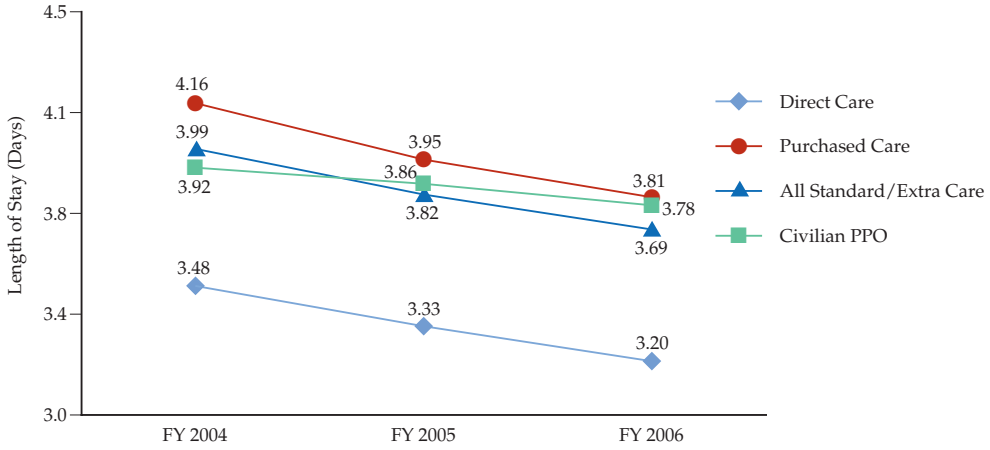
Average Lengths of Stay in Acute Care Hospitals

- Average lengths of stay (LOS) for Prime enrollees in DoD facilities (direct care) were roughly constant between FY 2004 and FY 2006. On the other hand, average LOS for space-available care declined by 8 percent. Identical patterns hold for purchased care Prime and Standard/Extra.
- Average LOS in TRICARE purchased acute care facilities are well above those in DoD facilities. Hospital stays in purchased care facilities are longer on average than in DoD facilities because purchased care facilities perform more complex procedures (as determined by RWPs—a measure of inpatient resource intensity).
- Average LOS for MHS-wide Prime and Standard/Extra care have followed roughly the same trends as their civilian HMO and PPO counterparts, respectively.
- In FY 2006, average LOS for MHS-wide Prime care was 4 percent lower than in civilian HMOs. The average LOS for non-Prime care (space-available and Standard/Extra) was 2 percent lower than in civilian PPOs.

INPATIENT AVERAGE LENGTH OF STAY: TRICARE PRIME vs CIVILIAN HMO



INPATIENT AVERAGE LENGTH OF STAY: TRICARE STANDARD/EXTRA vs CIVILIAN PPO



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: Beneficiaries age 65 and over were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (civilian HMO data were adjusted by Prime dispositions and civilian PPO data were adjusted by Standard/Extra dispositions). FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

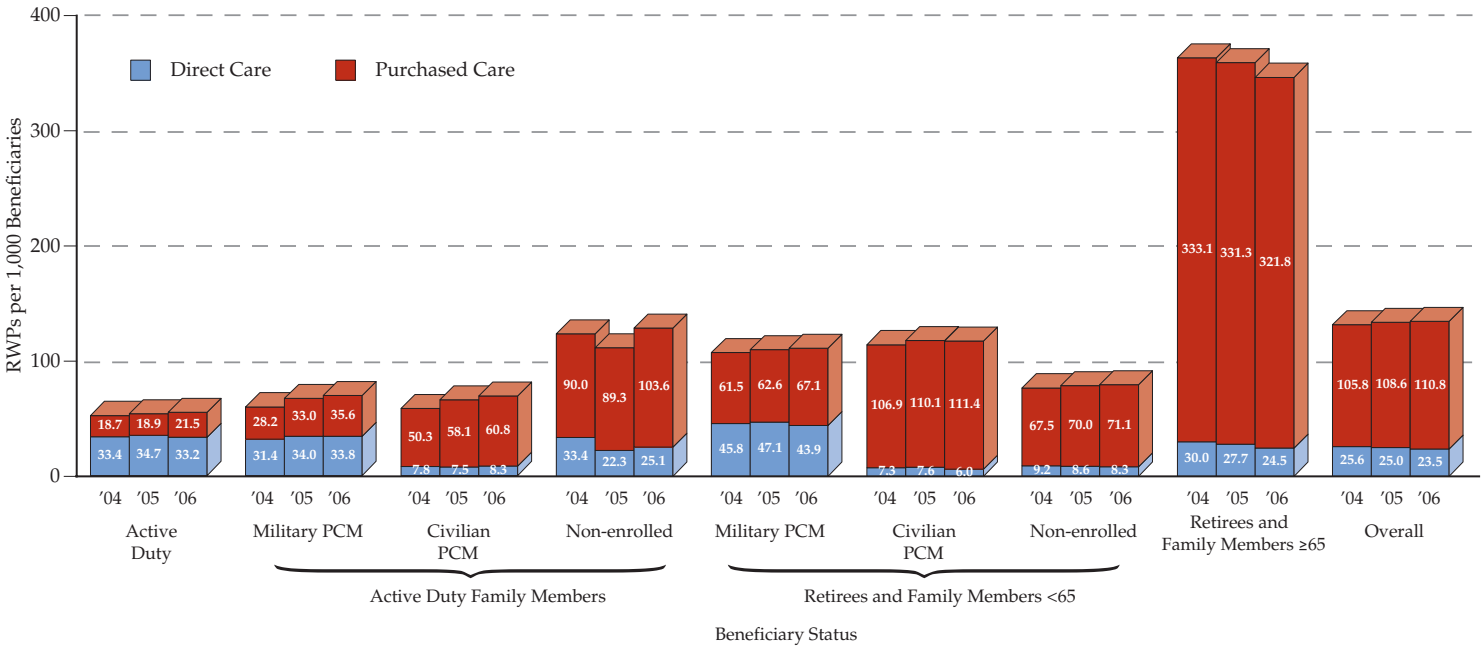
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

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

- The direct care inpatient utilization rate (RWPs per 1,000 beneficiaries) declined or remained the same for all beneficiary groups except enrolled ADFMs.
- Purchased acute care inpatient utilization rates increased for all beneficiaries except retirees and family members over age 65.
- The TFL acute care inpatient utilization rate was about the same in FYs 2004 and 2005 but declined by 3 percent in FY 2006.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer to Medicare), the percentage of total inpatient work- load performed in purchased care facilities increased from 68 percent in FY 2004 to 71 percent in FY 2006.
- From FY 2004 to FY 2006, the percentage of inpatient workload (RWPs) referred to the network on behalf of beneficiaries enrolled with a military PCM (including active duty personnel) increased from 47 percent to 51 percent.

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



Source: MHS administrative data, 1/5/2007

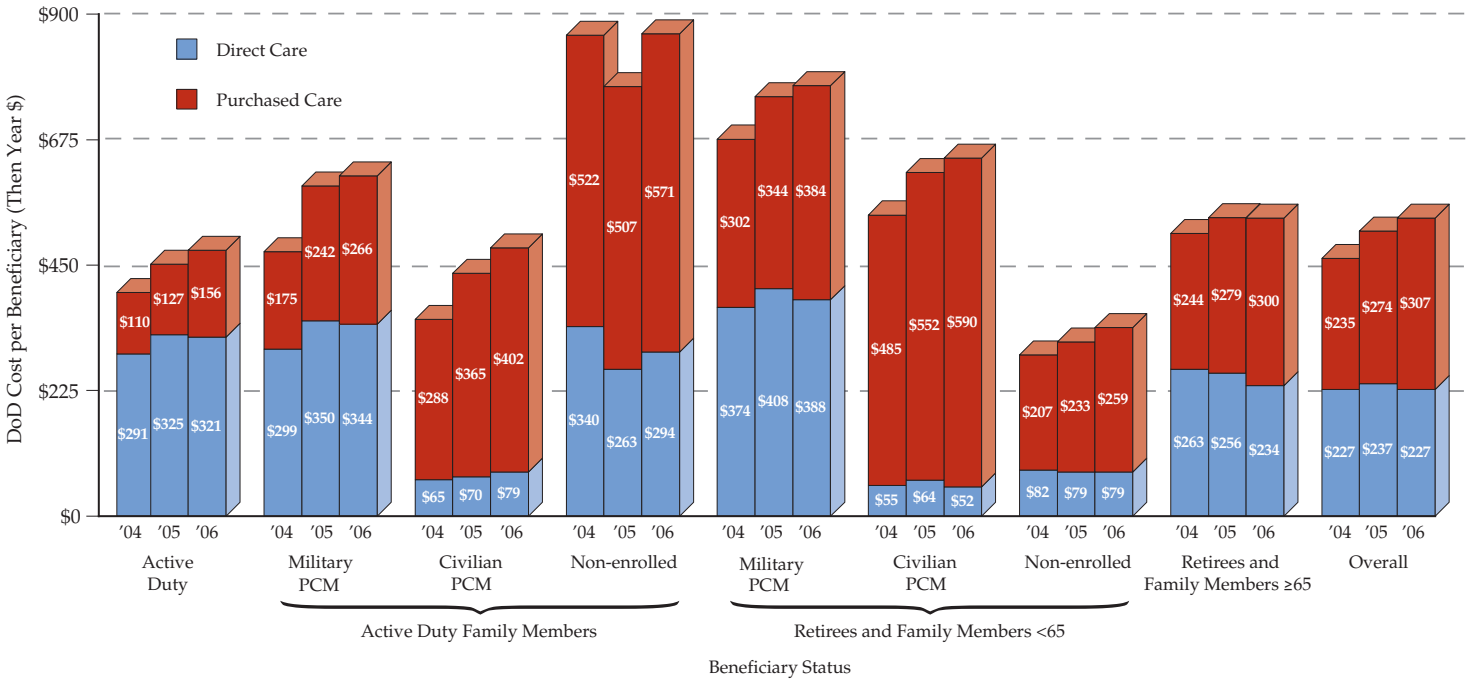
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 11 percent in FY 2005 and by another 2 percent in FY 2006. The increases were due almost exclusively to higher purchased care costs.

- The direct care cost per RWP increased from $8,885 in FY 2004 to $9,675 in FY 2006 (8.9 percent).
- Exclusive of TFL, the purchased care cost per RWP in acute care hospitals increased from $4,545 in FY 2004 to $5,332 in FY 2006 (17.3 percent). The purchased cost per RWP is much lower than that for direct care because many beneficiaries using purchased care have other health insurance. When beneficiaries have other health insurance, TRICARE becomes second payer and the government pays a smaller share of the cost.

AVERAGE ANNUAL DoD INPATIENT COST PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2007

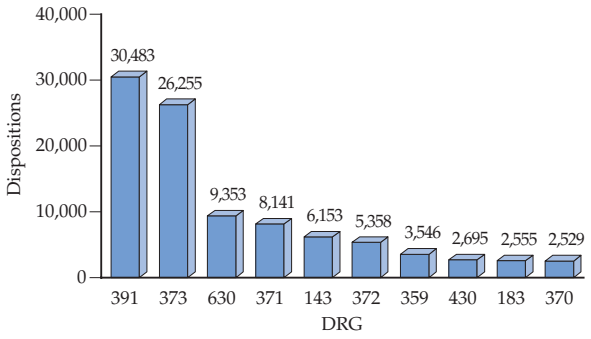
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Volume

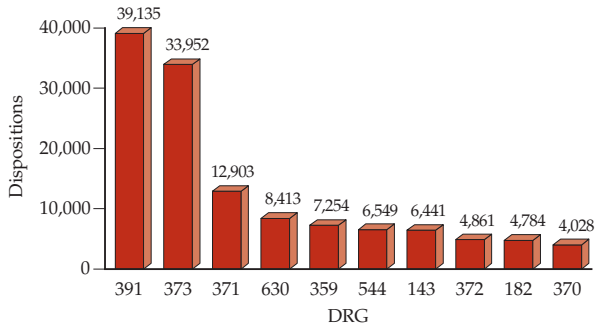
The top 10 diagnosis-related groups (DRGs) in terms of admissions in FY 2006 accounted for 42 percent of all inpatient admissions in military hospitals (direct care) and for 38 percent in civilian acute care hospitals (purchased care). TFL admissions are excluded.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2006 BY VOLUME

DIRECT CARE



PURCHASED CARE



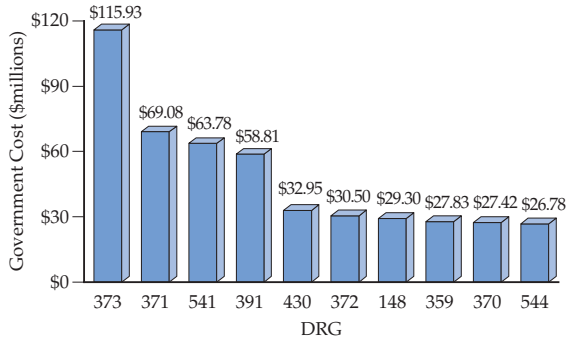
DRG	DESCRIPTION
143	Chest pain
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 with complications and comorbidities (CC)
183	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 without CC
359	Uterine and adnexa procedure for nonmalignancy without CC
370	Cesarean section with CC
371	Cesarean section without CC
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
544	Major joint replacement or reattachment of lower extremity
630	Neonate, birth weight >2499g, without significant operating room procedure, with other problems

Leading Inpatient Diagnoses by Cost

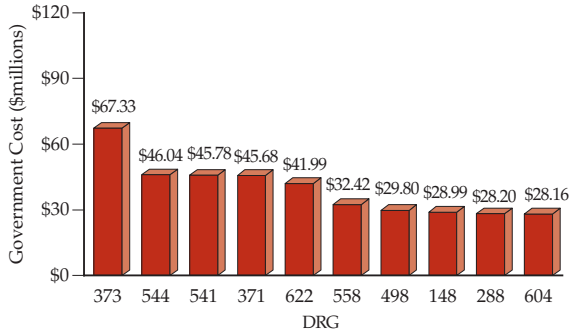
The leading diagnoses in terms of cost in FY 2006 were determined from institutional claims only; i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges. The top 10 DRGs in terms of cost in FY 2006 accounted for 25 percent of total direct care inpatient costs and for 22 percent of total purchased care costs in civilian acute care hospitals. TFL admissions are excluded.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2006 BY COST

DIRECT CARE



PURCHASED CARE



DRG	DESCRIPTION
148	Major small and large bowel procedures with complications and comorbidities (CC)
288	Operating room procedures for obesity
359	Uterine and adnexa procedure for nonmalignancy without CC
370	Cesarean section with CC
371	Cesarean section without CC
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
498	Spinal fusion except cervical without CC
541	Tracheostomy with mechanical ventilation 96+ hours or principal diagnosis except face, mouth, and neck diagnoses with major OR procedure
544	Major joint replacement or reattachment of lower extremity
558	Percutaneous cardiovascular procedure with drug eluting stent without major cardiovascular diagnosis
604	Noeonate, birth weight 750-999g, discharged alive
622	Neonate, birth weight >2499g, with significant operating room procedure, with multiple major problems

Source: MHS administrative data, 1/5/2007

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

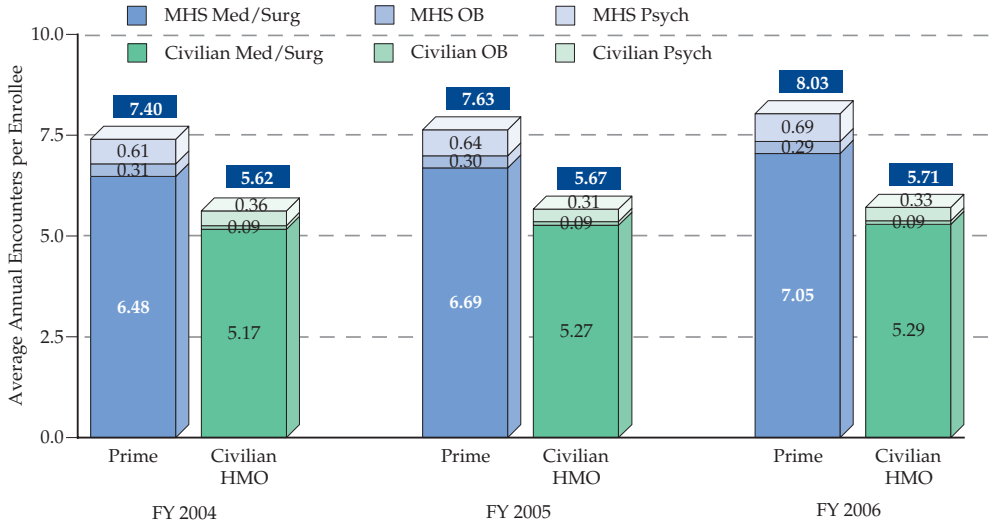
TRICARE Prime Enrollees

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

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

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care utilization combined) increased by 9 percent from 7.4 encounters per enrollee in FY 2004 to 8.0 in FY 2006. The civilian HMO outpatient utilization rate remained about the same over this period.
- In FY 2006, the overall Prime outpatient utilization rate was 41 percent higher than the civilian HMO rate.
- In FY 2006, the Prime outpatient utilization rate for medical/surgical procedures was 33 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for obstetrical/gynecological procedures was more than triple the corresponding rate for civilian HMOs, but that is due largely to how the direct care system records bundled services.[a]
- The Prime outpatient utilization rate for mental health procedures was more than double the corresponding rate for civilian HMOs. This disparity, though based on relatively low MHS and civilian mental health utilization rates, reflects the more stressful environment that many active duty service members and their families endure.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

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

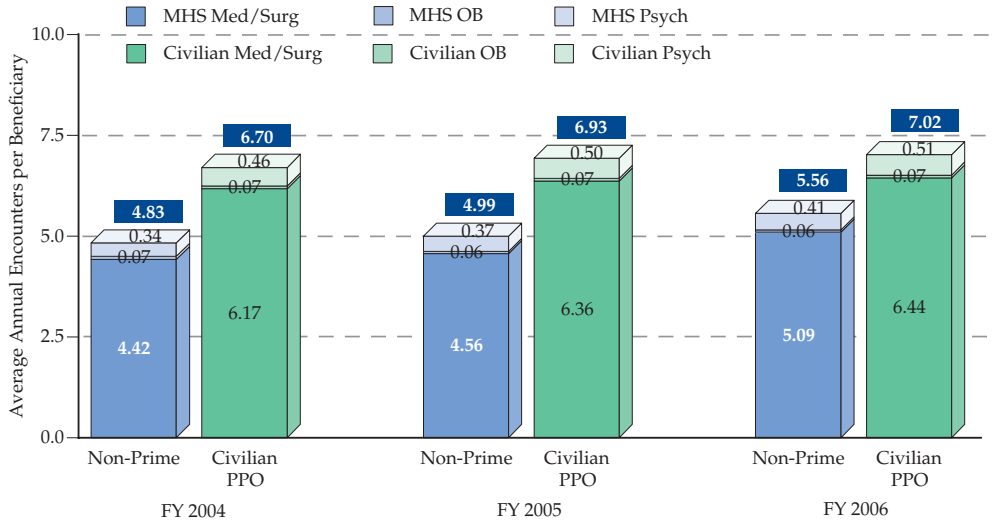
Non-Enrolled Beneficiaries

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

Encounters are computed for three broad product lines—obstetrics/gynecology (OB/GYN), mental health (PSYCH), and other medical/surgical procedures (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.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 15 percent from 4.8 encounters per participant in FY 2004 to 5.6 in FY 2006. The civilian PPO outpatient utilization rate increased by less than 5 percent over this period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2006, TRICARE non-Prime outpatient utilization was 21 percent lower than in civilian PPOs.
- Medical/surgical procedures account for about 92 percent of total outpatient utilization in both the military and private sectors.
- The mental health outpatient utilization rates of PPO participants were constant between FY 2004 and FY 2006. This contrasts with non-enrolled MHS beneficiaries, who had a 19 percent increase in mental health utilization over the same period. Even so, the mental health outpatient utilization rate for non-enrolled beneficiaries was 20 percent below that of civilian PPO participants in FY 2006. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive mental health counseling are more likely to enroll in Prime.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

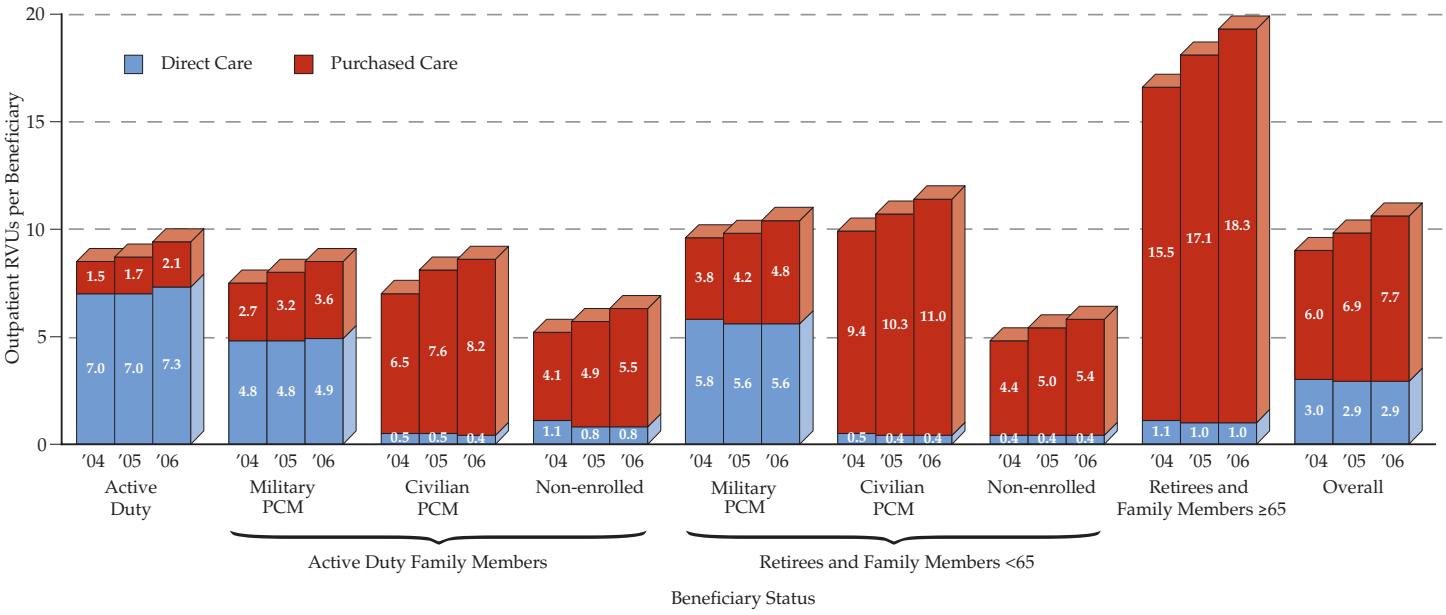
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

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

- The direct care outpatient utilization rate increased by 4 percent from FY 2004 to FY 2006 for active duty personnel. The rate stayed about the same for ADFMs with a military PCM and dropped for all other beneficiary groups, particularly non-enrolled beneficiaries.
- The purchased care outpatient utilization rate increased significantly for all beneficiary groups. The largest increases were for active duty personnel (34 percent), MTF-enrolled ADFMs (32 percent), and non-enrolled ADFMs (36 percent).
- The TFL outpatient utilization rate rose by 11 percent in FY 2005 and by another 7 percent in FY 2006.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2007

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

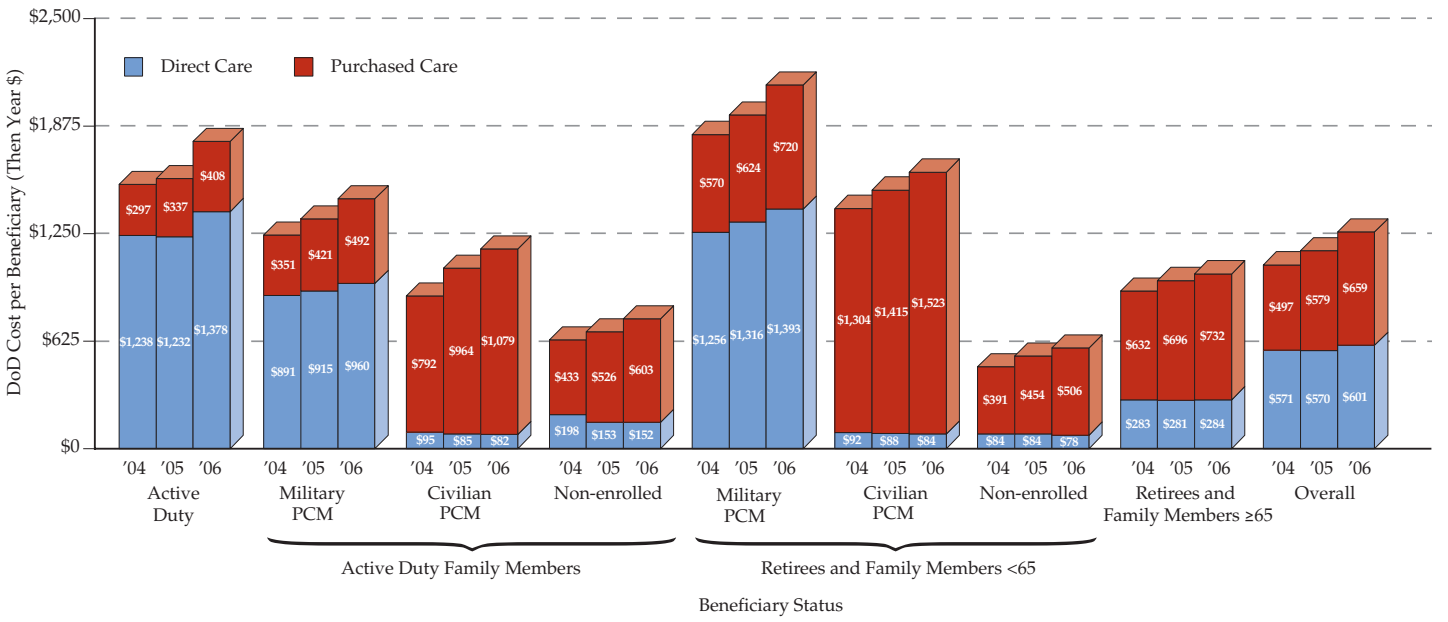
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Cost by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise. Overall, DoD outpatient costs per beneficiary increased by 18 percent from FY 2004 to FY 2006.

- The direct care cost per beneficiary increased for all MTF-enrolled beneficiaries, particularly active duty personnel (11 percent increase).
- The DoD purchased care outpatient cost per beneficiary increased by 16 percent in FY 2005 and by another 14 percent in FY 2006. Thus the recent trend in rapidly rising purchased care costs shows no sign of abatement.
- The TFL purchased care outpatient cost per beneficiary increased by 10 percent in FY 2005 and by another 5 percent in FY 2006.*

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2007

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

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, TMOP and MTF prescriptions can be filled for up to a 90-day supply, whereas retail prescriptions are usually based on 30-day increments for copay purposes. Prescription counts from all sources (including civilian) were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

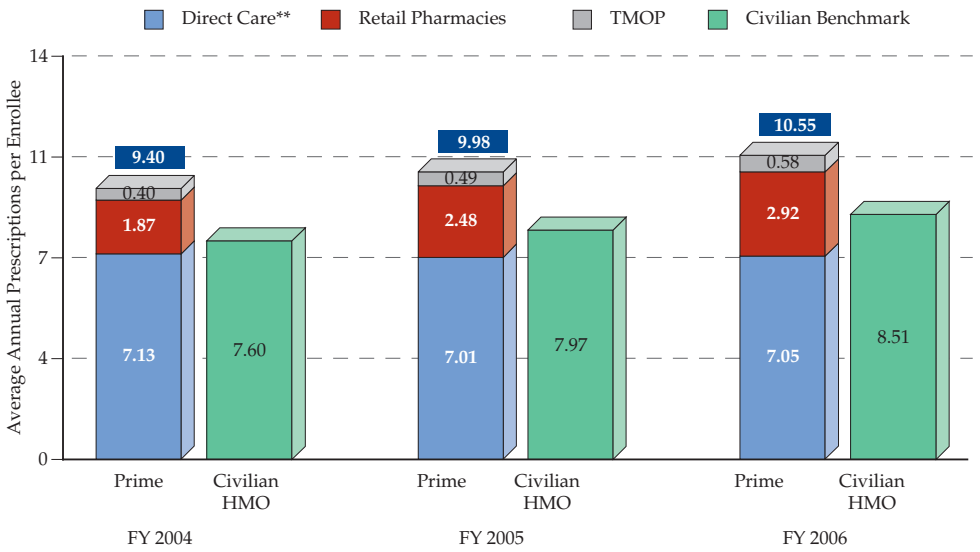
Direct care pharmacy data differ from private sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DoD Pharmacoeconomic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

TRICARE Prime Enrollees

This section compares the prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored Health Maintenance Organization (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 12 percent between FY 2004 and FY 2006. Although the civilian HMO benchmark rate rose by the identical percentage over this period, the TRICARE Prime prescription utilization rate was still 24 percent higher than the civilian HMO rate in FY 2006.
- Prescriptions utilization rates for Prime enrollees at DoD pharmacies decreased slightly whereas the utilization rate at retail pharmacies increased by 56 percent from FY 2004 to FY 2006.
- Enrollee mail order prescription utilization increased by 46 percent from FY 2004 to FY 2006. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

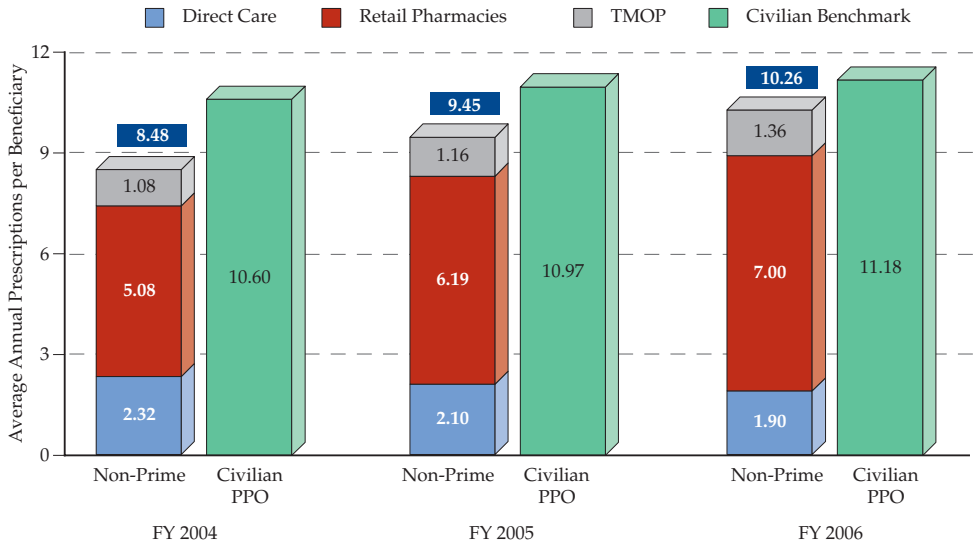
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored Preferred Provider Organization (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.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries rose by 21 percent between FY 2004 and FY 2006. During the same period, the civilian PPO benchmark rate increased by only 5 percent. Although the gap has significantly narrowed, the TRICARE prescription utilization rate is still 8 percent lower than the civilian PPO rate.
- Prescriptions filled for non-enrolled beneficiaries at DoD pharmacies dropped by 18 percent whereas prescriptions filled at retail pharmacies increased by 37 percent from FY 2004 to FY 2006.
- Non-enrollee mail order prescription utilization increased by 26 percent from FY 2004 to FY 2006. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

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



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/5/2007

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2006 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

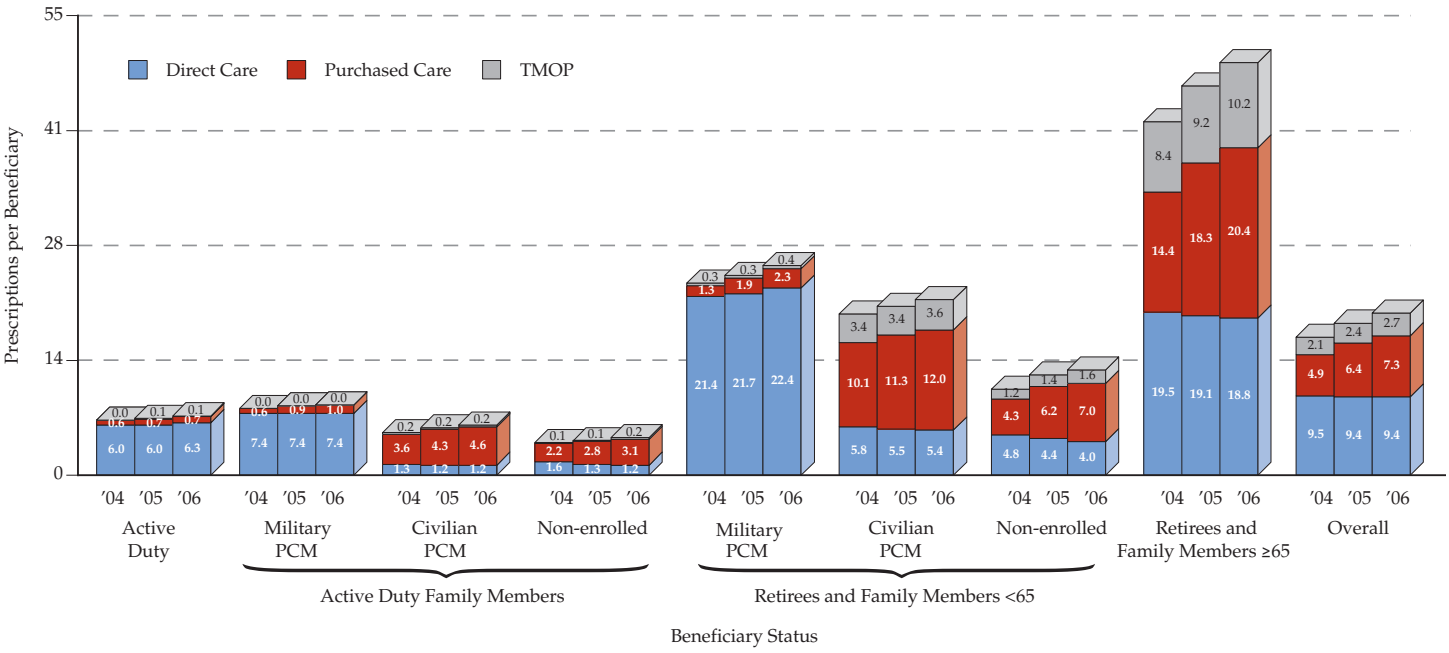
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and the TRICARE Mail Order Pharmacy (TMOP). Prescription counts from these sources were normalized by computing the total days supply for each and dividing by the average days supply for retail prescriptions (28.5 days).

- The total (direct, retail, and TMOP) number of prescriptions per beneficiary increased by 15 percent from FY 2004 to FY 2006, exclusive of the TSRx benefit. Including TSRx, the total number of prescriptions increased by 18 percent.
- The direct care prescription utilization rate increased or remained the same for all MTF-enrolled beneficiaries (including active duty) and fell for all non-enrolled beneficiaries.
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail-order) increased sharply for all beneficiary groups but most notably for beneficiaries enrolled with a military PCM (over 70 percent).
- TMOP remains a relatively infrequent source of purchased care prescription utilization. In fact, when normalized by average days supply, TMOP utilization as a percentage of total purchased care prescription drug utilization dropped from 30 percent in FY 2004 to 27 percent in FY 2006. Even though TMOP utilization increased over this period, retail utilization increased at a faster rate.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



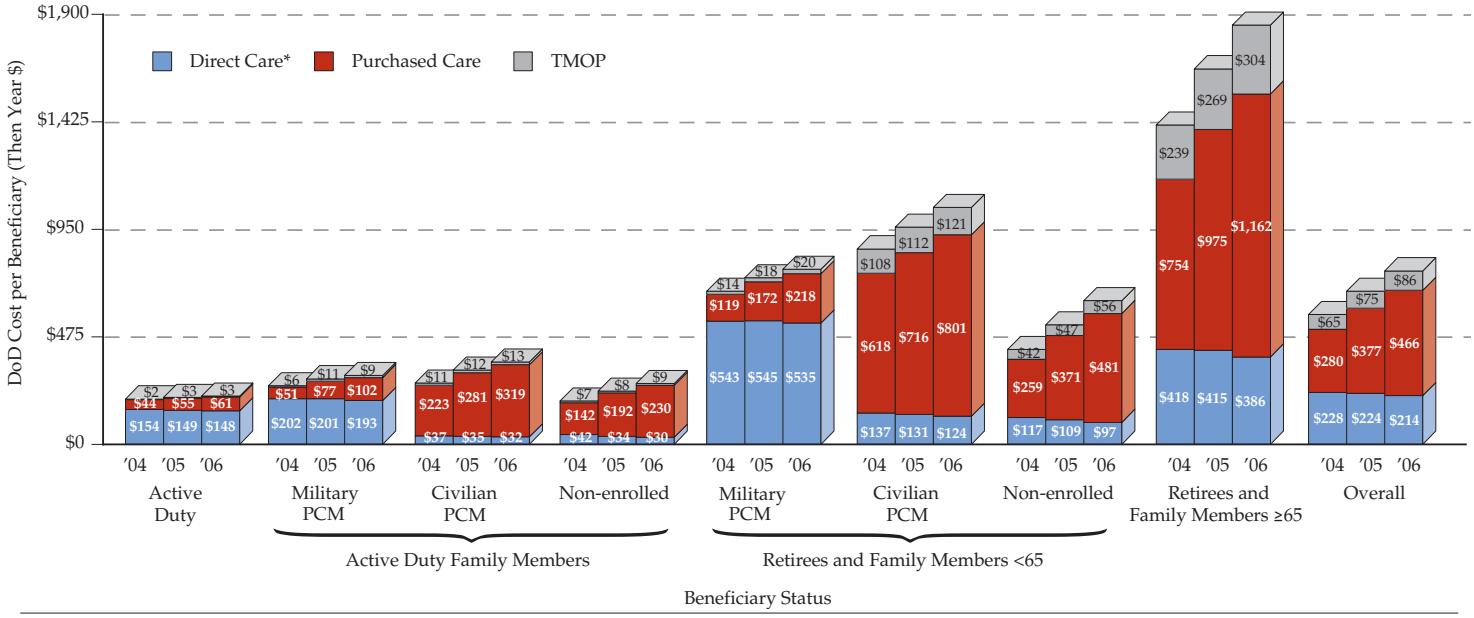
Source: MHS administrative data, 1/5/2007

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

Prescription Drug Cost by Beneficiary Status

- Prescription drug costs continued to rise at the fastest rate of any medical service, increasing by 33 percent irrespective of whether the TSRx benefit is included. About half of the cost increase was due to increased utilization.
- Direct care costs per beneficiary fell slightly but retail pharmacy costs rose by 75 percent exclusive of TSRx and by 66 percent including TSRx.
- TMOP costs increased as well, but at a slower rate than retail pharmacy, increasing by 39 percent exclusive of TSRx and by 33 percent including TSRx.

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/5/2007
*Direct care prescription costs include an MHS-derived dispensing fee.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE

Out-of-pocket costs are computed for active duty and retiree families grouped by sponsor age: (1) under 65, and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. For beneficiaries less than 65, costs are compared with those of civilian counterparts (i.e., civilian families with the same demographics as the typical MHS family). Civilian counterparts are assumed to be covered by employer-sponsored health insurance. Added drug benefits in April 2001 and the TRICARE for Life (TFL) Program in FY 2002 dramatically reduced costs for MHS seniors. For MHS seniors, costs are compared before and after these benefit changes.

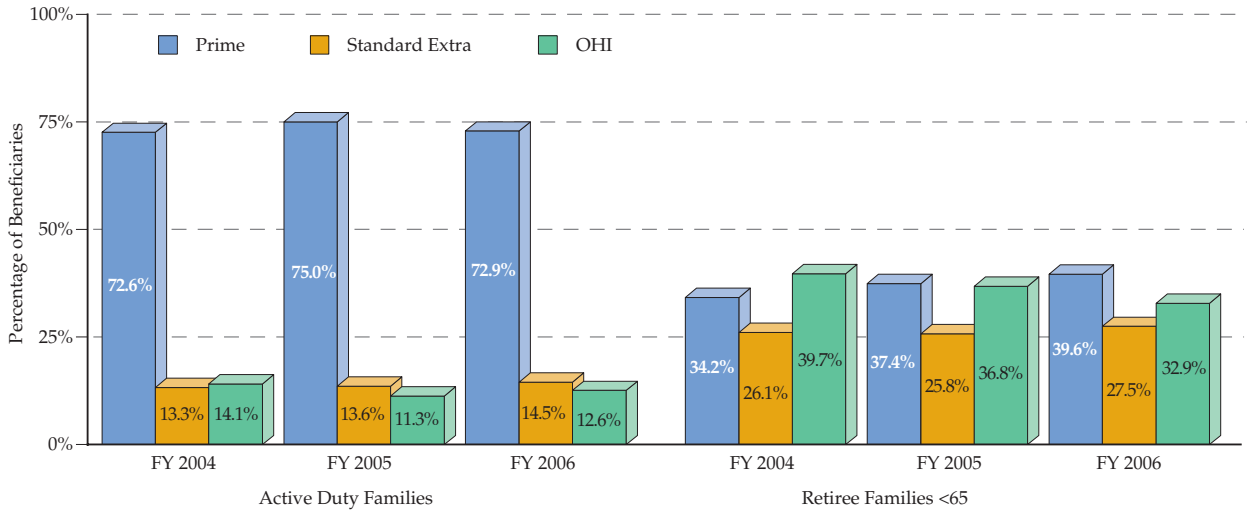
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) other private health insurance (OHI). Many retired beneficiaries choose OHI and opt out of TRICARE entirely; some choose OHI and use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- TRICARE Prime: Family enrolled in TRICARE Prime and no OHI. In FY 2006, 72.9 percent of active duty families and 39.6 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI. In FY 2006, 14.5 percent of ADFMs and 27.5 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2006, 12.6 percent of active duty families and 32.9 percent of retiree families were in this group.

HEALTH INSURANCE PLAN USERS



Source: 2004–2006 administrations of the Health Care Surveys of DoD Beneficiaries (HCSDB)

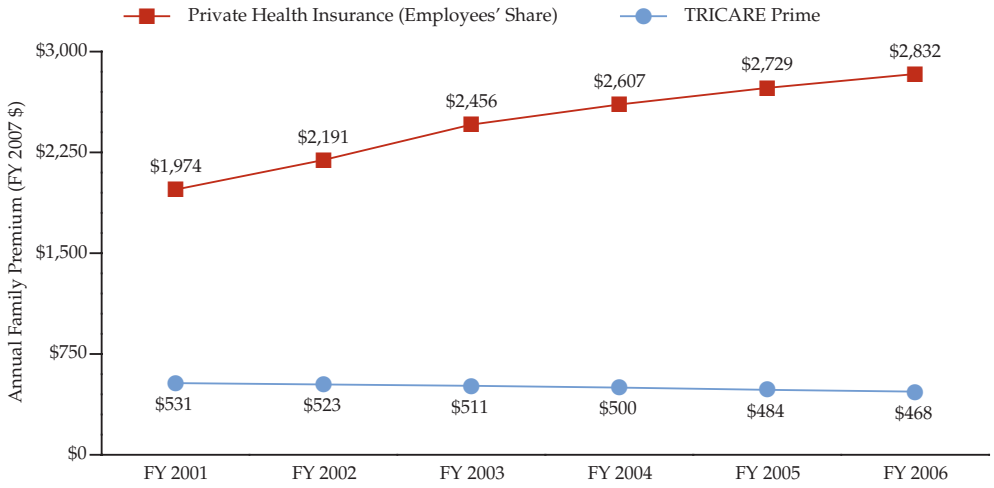
Note: The Prime group includes HCSDB respondents without OHI who are enrolled in Prime based on DEERS. The Standard/Extra beneficiary group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. A small percentage of Prime enrollees are also covered by OHI. These beneficiaries are included in the OHI group.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE *(CONT'D)*

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2001, private health insurance premiums have been rising while the TRICARE enrollment fee has remained fixed at $460 per retiree family. In constant FY 2007 dollars, the private health insurance premium increased by $858 (43 percent) from FY 2001 to FY 2006, whereas the TRICARE premium declined by $63 (–12 percent) during this period.

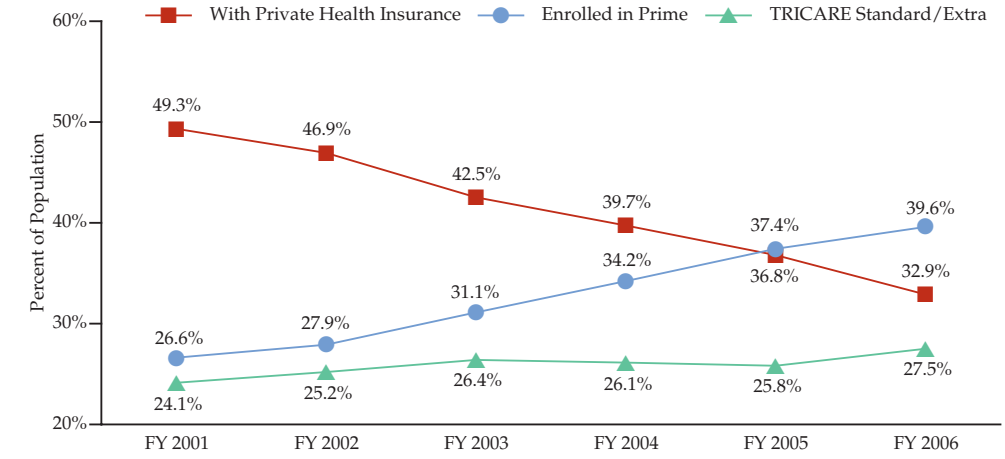
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer sponsored group health plan: Medical Expenditure Panel Surveys, 2000–2004; forecasted by Institute for Defense Analyses in FYs 2005–2006 using regression analysis. Consumer Price Index: Bureau of Labor Statistics

The increasing disparity in premiums induced retirees to drop their private health insurance and enroll in Prime. The trend in insurance coverage translates into an additional 386,000 retirees and family members under age 65 who are using TRICARE instead of private health insurance in FY 2006.

TRENDS IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: DEERS and Retirees Under Age 65 Health Care Beneficiary Surveys of DoD Beneficiaries, FYs 2001–2006

Note: The Prime enrollment rates above exclude those with other health insurance (about 4.5 percent of retirees).

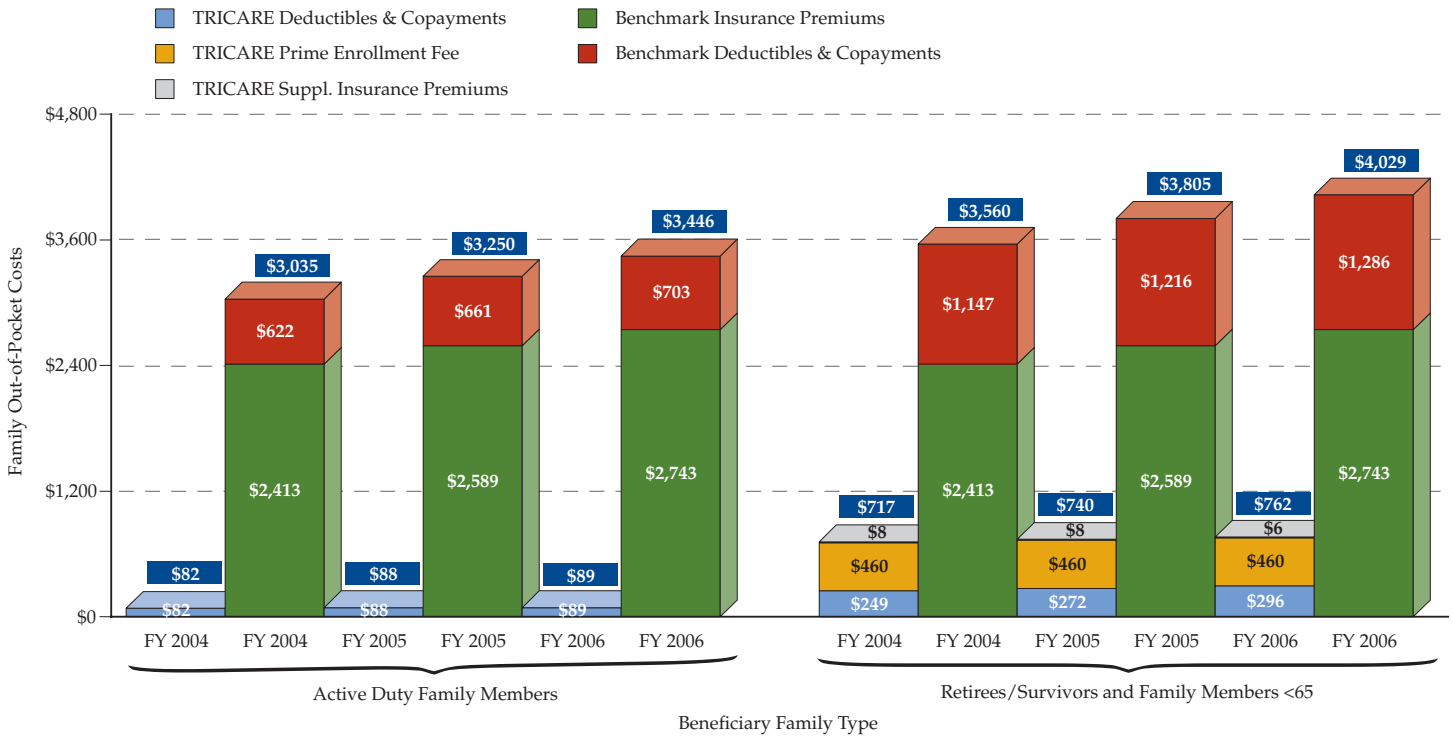
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE *(CONT'D)*

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

In FY 2004 to FY 2006, 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 2006, costs for civilian counterparts were:
  - $3,400 more than those incurred by active duty families enrolled in Prime.
  - $3,300 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, FYs 2004–2006; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2004–2006, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Medical Expenditure Panel Surveys; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, FYs 2004–2006; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), FYs 2004–2006; and TRICARE supplemental insurance coverage from the HCSDB's in July and October 2005.

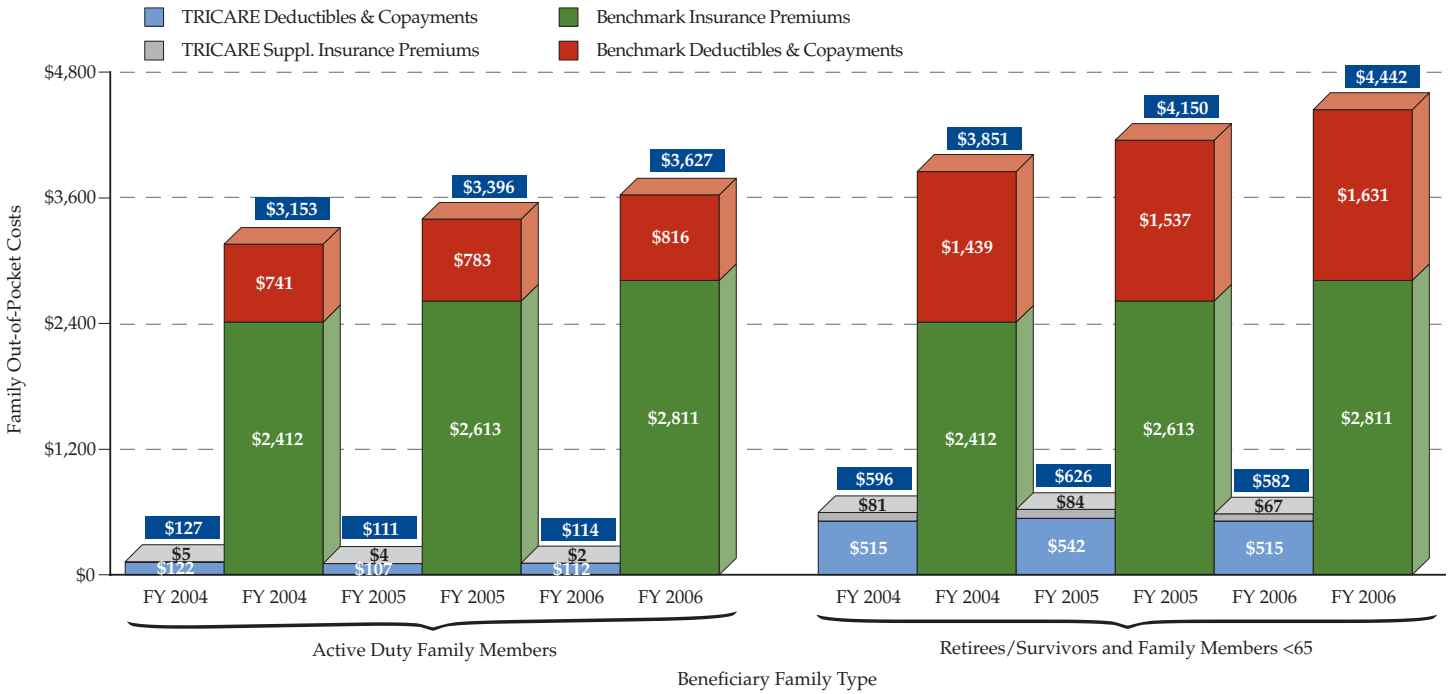
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE *(CONT'D)*

Out-of-Pocket Costs for Families Not Enrolled in TRICARE Prime vs. Civilian PPO Counterparts

In FY 2004 to FY 2006, 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 2006, costs for civilian counterparts were:
  - $3,500 more than those incurred by active duty families who relied on Standard/Extra.
  - $3,900 more than retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, FYs 2004–2006; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2004–2006, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Medical Expenditure Panel Surveys; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, FYs 2004–2006; OHI coverage from Health Care Surveys of DoD Beneficiaries (HCSDB), FYs 2004–2006; and TRICARE supplemental insurance coverage from the HCSDB's in July and October 2005.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE *(CONT'D)*

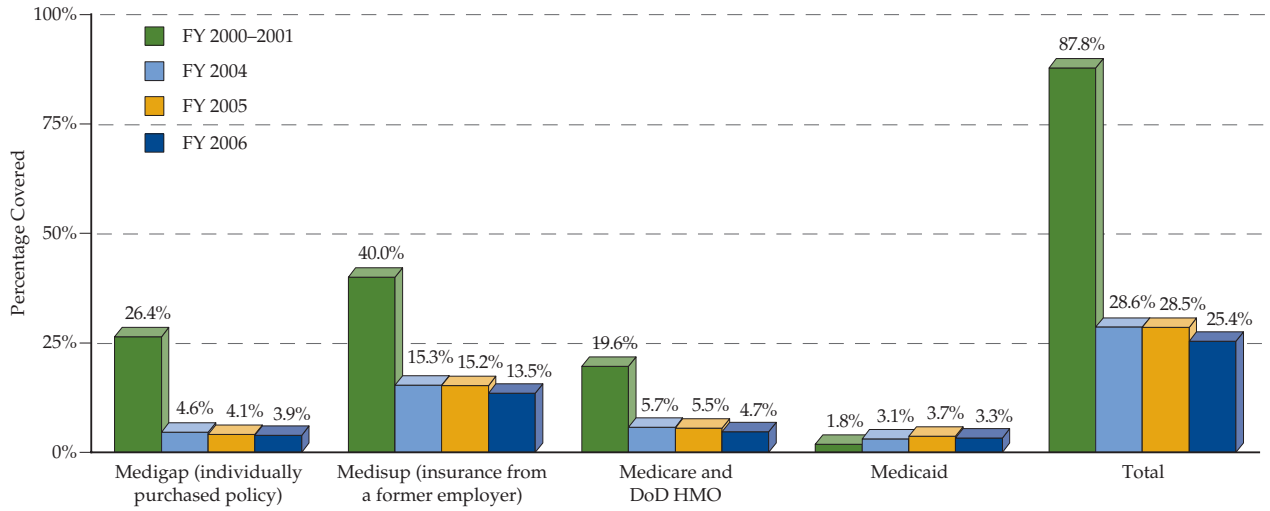
Health Insurance Coverage of MHS Senior Beneficiaries

Medicare provides coverage for medical services and requires substantial deductibles and copayments; it began to cover prescription drugs in January 2006. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance. A small number were active employees with employer-sponsored insurance (OHI) or were covered by Medicaid. Out-of-pocket costs include deductibles/copayments for medical services and premiums for Medicare Part B, supplementary insurance, and OHI.

In April 2001, DoD expanded drug benefits for seniors and on October 1, 2001, implemented the TFL program, which provides free Medicare supplemental insurance. Because of TFL, most MHS seniors dropped their supplemental insurance. According to the Health Care Surveys of DoD Beneficiaries in 2000-2001 and 2004–2006:

- Before TFL (FYs 2000–2001), 87.8 percent of MHS seniors had some type of Medicare supplemental insurance or were covered by Medicaid.
- After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply to about 28.6 percent in FYs 2004–2005. It declined to 25.4 percent in FY 2006.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS (PERCENT)



Source: FYs 2000–2001 and FYs 2004–2006 administrations of the Health Care Surveys of DoD Beneficiaries

* DoD HMOs include TRICARE Senior Prime in FY 2001 and the Uniformed Services Family Health Plan.

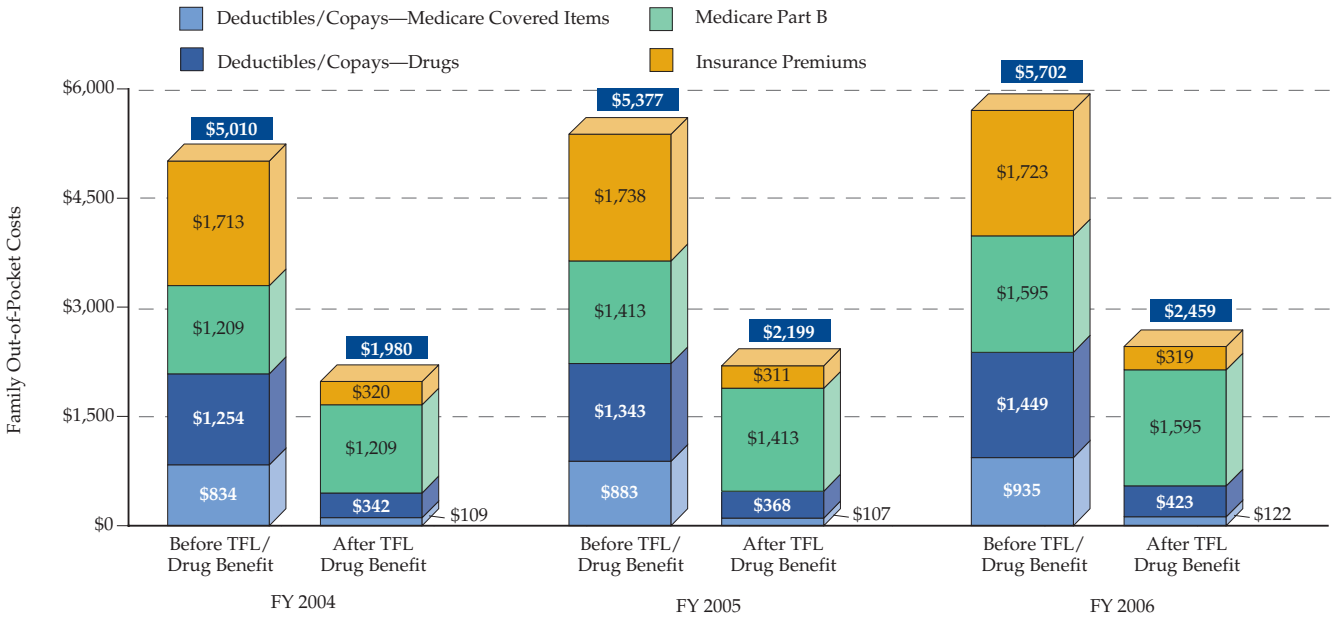
BENEFICIARY FAMILY OUT-OF-POCKET COSTS & OTHER HEALTH INSURANCE COVERAGE *(CONT'D)*

Effects of Benefit Changes on Out-of-Pockets Costs of MHS Senior Families

Added drug benefits and TFL have enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments.

- MHS senior families saw their out-of-pocket expenses reduced by about 60 percent in FYs 2004–2006.
- In FY 2006, MHS senior families saved $3,200 as a result of benefit changes.

OUT-OF-POCKET COSTS OF MHS SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS (BY FISCAL YEAR)



Sources: DoD beneficiary expenditures from MHS administrative data; civilian expenditures from Medical Expenditure Panel Survey projections, FYs 2004–2006, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Medical Expenditure Panel Surveys ; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, FYs 2004–2006; OHI and Medicare supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, FYs 2004–2006.

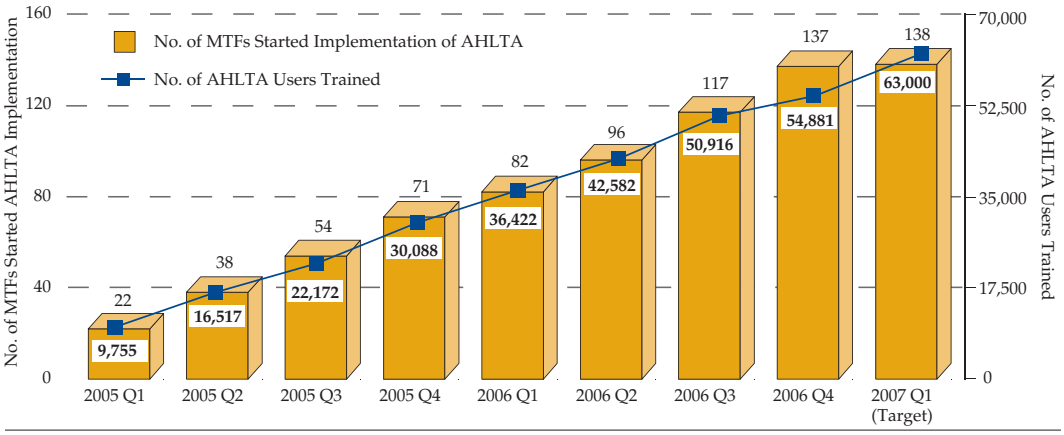
TECHNOLOGY INITIATIVES

On November 21, 2005, the Department of Defense (DoD) launched AHLTA, the largest electronic health record in the nation, serving 9.2 million MHS beneficiaries. When fully deployed to 138 planned medical treatment facilities in 11 time zones around the globe in December 2006, it will provide a centralized repository of beneficiary health information for use by approximately 63,000 care providers throughout the MHS.

AHLTA marks a new era in health care for TRICARE beneficiaries and stands as a significant development in the electronic health record. AHLTA's capabilities will ultimately replace legacy systems, and replace or upgrade the inpatient system solution known as the Clinical Information System (CIS). The robust, standards-based interoperability provided by AHLTA is designed to allow seamless connectivity to deployed forces, sustaining the MHS and the Veterans Administration. As of September 2006, AHLTA Block 1 has been deployed at 137 of the 138 planned MTFs, with almost all (54,881 or 99.4 percent) of the targeted 55,230 total users fully trained, including 17,941 health care providers. AHLTA Block 1 functionality includes encounter documentation, order entry/results retrieval, encounter encoding support, alerts and reminders, role-based security, health data dictionary, master patient index, and ad hoc query capability. The AHLTA Clinical Data Repository currently contains electronic clinical records for over 8.6 million beneficiaries.

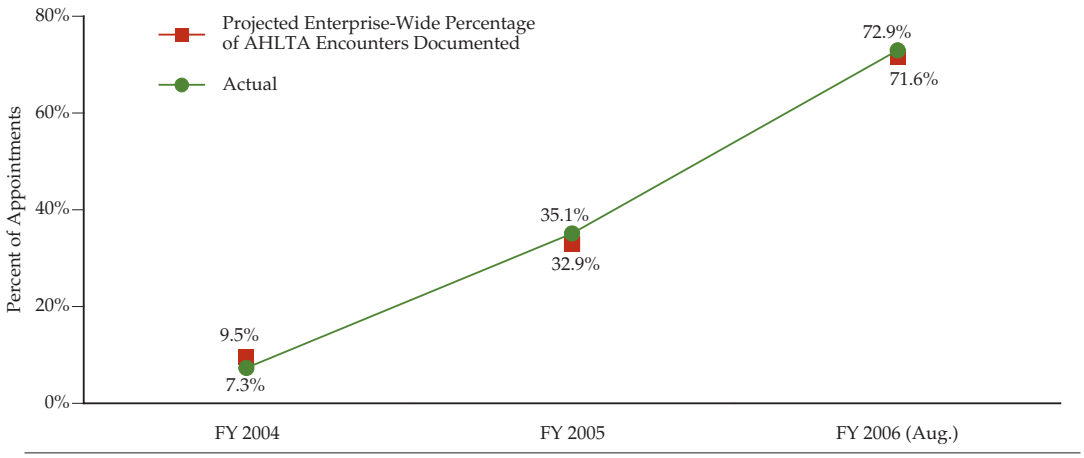
- Key metrics for monitoring the successful deployment of AHLTA focus on both the number of implementing MTFs as well as the training of staff using it. As of September 2006, AHLTA processed over 30 million outpatient encounters, an average of almost 94,000 patient encounters per workday. Worldwide deployment of Block 1 is expected to be completed by the end of calendar year 2006, at which point AHLTA will be available for over 9 million beneficiaries.

MHS ENTERPRISE-WIDE IMPLEMENTATION OF THE AHLTA



Source: Clinical Information Technical Program Office, 10/27/2006

PERCENTAGE OF ENTERPRISE–WIDE PATIENT ENCOUNTERS DOCUMENTED IN AHLTA

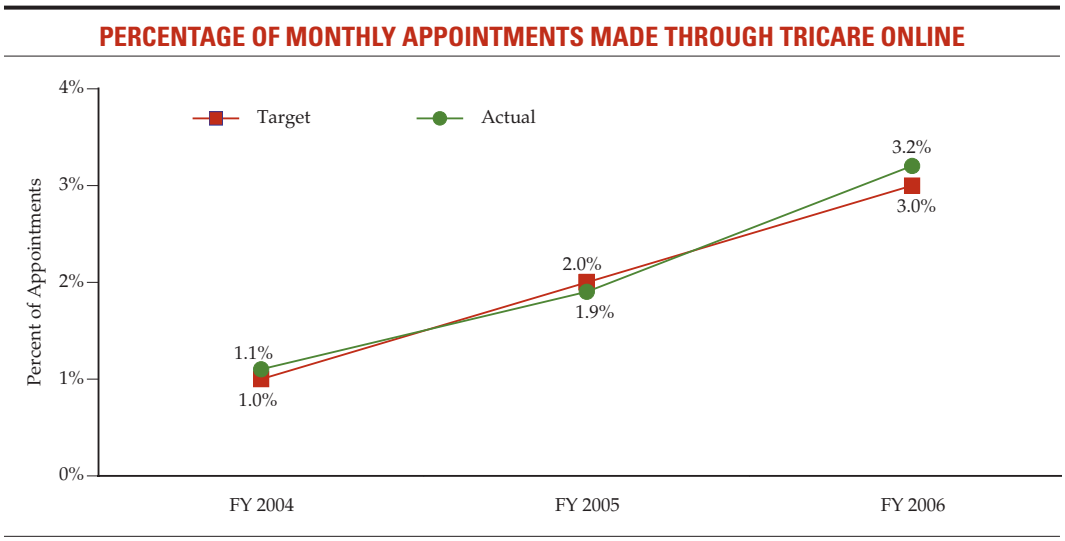


Source: MHS Balanced Scorecard Instrument Panel, 12/13/2006

Another metric used to monitor the maturation of AHLTA focuses on the application of the capability for patient access with respect to recording patient encounters in the new system which feeds into the overall electronic health record. The following chart shows the MHS is on line for recording patient encounters in the enterprise-wide AHLTA electronic health care record.

PERCENTAGE OF MONTHLY APPOINTMENTS MADE THROUGH TRICARE ONLINE

TRICARE Online is the DoD Internet portal designed to provide MHS beneficiaries interactive health care services and information at military treatment facilities. TRICARE Online (TOL) was designed to meet DoD beneficiary needs for greater access and convenience in scheduling appointments, keeping a personal health journal and gathering information on medical and pharmaceutical care. The chart below shows the MHS has kept pace with program targets the past three fiscal years.



Source: MHS Balanced Scorecard Instrument Panel, 12/13/2006

THE CENTER FOR HEALTH CARE MANAGEMENT STUDIES

The Center for Health Care Management Studies (CHCMS) was established to develop, apply, and share knowledge from multiple disciplines to promote and protect the health of MHS beneficiaries. The CHCMS achieves this mission by designing and implementing health services and management studies designed to: (1) improve clinical practice, (2) improve the MHS ability to provide access to and deliver high quality, high-value health care, and (3) provide policymakers in DoD with the information they need to make evidence-based decisions concerning the impact of payment and organizational changes on outcomes, quality, access, cost, and use of health care services. The CHCMS seeks to identify and respond to the challenges of all those responsible for improvement of the MHS with the information they need to make evidence based decisions.

The CHCMS has recently completed three studies that have MHS policy relevance and implications for health services delivery (*http://www.tricare.mil/ocfo/hpae/chmsfacts.cfm*):

Improving Health Care Experiences and Quality of Care among MHS Beneficiaries Living with Chronic Illness

The CHCMS designed a study to investigate chronic illness among Prime enrollees. The study was used to estimate the prevalence and key performance indicators for eight chronic conditions identified as high priority areas for quality improvement by the Institute of Medicine.

Results: Overall, this analysis provides encouraging findings about TRICARE. Across the eight conditions studied, TRICARE performed well on a number of indicators:

- While TRICARE patients had a relatively high prevalence of hypertension, tobacco dependence, and asthma compared to other patient populations studied, TRICARE often achieved superior results in managing care while controlling program costs.
- Across all conditions where readmission rates were assessed, TRICARE readmission rates were consistently among the lowest.

Small Area Variation: Sources of Inappropriate Variation of Medical Procedures and Mediation Strategies

A second study was designed to provide information on unexplained variation of selected medical procedures among enrolled beneficiaries. Administrative data on 1.36 million TRICARE Prime enrollees were collected to create three disease-based subpopulations to identify Prime beneficiaries "at risk" for our study procedures.

Results: The analyses indicate an encouraging lack of unexplained variation in the rate of selected procedures as assessed by standardized differences between observed and expected numbers of procedures. Other results include:

- For CABG and PTCA/stent procedures, less than 10 MTFs have expected numbers of procedures above or below two standard deviations from the average calculated across all study sites.
- The vast majority of enrollees who receive the selected procedures had one or more diagnoses from prior encounters or as a principal diagnosis at the time of the procedure that were appropriate indications for the procedure.
- In terms of quality of care, it was discovered that there were no observed systematic relationships between "over" or "under" use and selected surgical complication rates.

A National Effort to Measure the Inpatient Health Care Experience: The HCAHPS Pilot Project Survey

TMA conducts an annual satisfaction survey of patients discharged from MTF hospitals and purchased care hospitals. The third CHCMS study was a technical investigation of how a national survey of inpatient care could be modified to include supplemental, policy relevant questions of the TMA.

Results: The work was accomplished in coordination with The Agency for Health Care Research and Quality and reflects TMA's capacity to both modify the national survey and benchmark performance for continuous quality improvement. This study also provides information of great interest to other national health systems and promotes cooperation among federal agencies for more transparent measures of inpatient health care quality.

APPENDIX: METHODS AND DATA SOURCES

GENERAL METHOD

In this year's report, we compared TRICARE's effects on the access to and quality of health care received by the DoD population with the general U.S. population covered by commercial health plans (excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the national Consumer Assessment of Health Care Providers and Systems (CAHPS). The CAHPS program is a public-private initiative to develop standardized surveys of patients' experiences with ambulatory and facility-level care.

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

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent three years of data (FY 2004 – FY 2006) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not add to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (1 October – 30 September).
- 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 Internet Web sites accessible by the public. These photos have not been tampered with other than to mask the individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors for direct and purchased care. Because the purchased care completion factors were developed from historical claims experience, the completion factors for FY 2005 may be inaccurate if the claims experience under the new generation of contracts differs from the old.
- Data were current as of:
  - HCSDB/CAHPS—12/14/2006
  - MHS Workload/Costs—1/5/2007
- TMA regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

To fulfill 1993 National Defense Authorization Act requirements, the HCSDB was developed by TMA. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their Department of Defense (DoD) health care benefits. (Source: TMA Web site: *www.tricare.osd.mil/survey/hcsurvey/*).

The HCSDB is composed of two distinct surveys, the Adult and the Child HCSDB, and both are conducted as large-scale mail surveys. The worldwide Adult HCSDB is conducted on a quarterly basis (every January, April, July and October). The Child HCSDB is conducted once per year, from a sample of DoD children age 17 and younger.

Both surveys provide information on a wide range of health care issues such as the beneficiaries' ease of access to health care and preventative care services. In addition, the surveys provide information on beneficiaries' satisfaction with their doctors, health care, health plan and the health care staff's communication and customer service efforts.

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

HCSDB questions on satisfaction with and access to health care have been closely modeled on the CAHPS program. CAHPS is a standardized survey questionnaire used by civilian health care organizations to monitor various aspects of access to and satisfaction with health care.

(CONT'D)

CAHPS is a nationally recognized set of standardized questions and reporting formats that has been used to collect and report meaningful and reliable information about the health care experiences of consumers. It was developed by a consortium of research institutions and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats have been tested to ensure that the answers can be compared across plans and demographic groups. Because the HCSDB uses CAHPS questions, TRICARE can be benchmarked to civilian managed care health plans. More information on CAHPS can be obtained at *www.ahcpr.gov*.

From 1998 to 2003, the HCSDB included questions from CAHPS 2.0. In 2003, civilian plans introduced a revised form of CAHPS, version 3.0. This version of CAHPS included changes to the wording of a number of questions. In order to follow trends in CAHPS questions over the transition period, CAHPS 2.0 questions were retained in the HCSDB for FY 2003, so that they could be compared with the most recent available CAHPS benchmarks, which were based on civilian experience in 2002. Beginning in FY 2004, HCSDB questions were taken from CAHPS 3.0. HCSDB rates for FY 2004 combine three quarters of CAHPS 3.0 results with one quarter of CAHPS 2.0 results. Benchmarks for FY 2004 average together CAHPS 2.0 benchmarks weighted by the proportion of responses coming from FY 2003 and CAHPS 3.0 benchmarks, weighted by the proportion of responses coming from FY 2004. Benchmarks and scores for 2005 and 2006 are based entirely on CAHPS 3.0.

HCSDB results are not adjusted for possible changes in the population's demographics (e.g., gender or age) between years. Tests of significance using the benchmark data assume that the benchmark is measured without error. The normal approximation is used. Differences between the MHS and the civilian benchmark were considered significant at p less than or equal to .05. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

Relative weighted products (RWPs) and relative value units (RVUs) are measures derived from inpatient and outpatient workload, respectively, to standardize differences in resource use as a means to better compare workload among institutions. RWPs, which are based on DRG weights and specific information on each hospital record, are calculated for all inpatient cases in MTFs and purchased care hospitals. They reflect the relative resource intensity of a given stay, with adjustments made for very short or very long lengths of stay and for transfer status. A comparison of total RWPs across institutions therefore reflects not only differences in the number of dispositions but in the case-mix intensity of the inpatient services performed there as well. RVUs are used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. The MHS uses a modified version to reflect the relative costliness of the provider effort for a particular procedure or service.

Access and Quality

Measures of MHS access and quality were derived from the 2004, 2005, and 2006 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the National CAHPS Benchmarking Database (NCBD) for the same time period. The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc.

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

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased care claims information for the previous generation of contracts); TRICARE Encounter Data (TEDs— purchased care claims information for the new generation of contracts) for inpatient, outpatient, and prescription services; and TRICARE Mail Order Pharmacy (TMOP) claims within each beneficiary category. Costs recorded on HCSRs and TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in early January 2007 as referenced above.

DATA SOURCES *(CONT'D)*

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 MEDSTAT 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 2006, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2006 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

ABBREVIATIONS

AC	Active Component
AD	Active Duty
ADFM	Active Duty Family Member
AHLTA	Armed Forces Longitudinal Technology Application
AMI	Acute Myocardial Infarction
ASD	Assistant Secretary of Defense
BMI	Body Mass Index
BRAC	Base Realignment and Closure
CC	Complications and Comorbidities
CAHPS	Consumer Assessment of Health Care Providers and Systems
CCAE	Commercial Claims and Encounters
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCMS	Center for Health Care Management Studies
CHDR	Clinical/Health Data Repository
CIS	Clinical Information System
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DoD	Department of Defense
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
DUA	Data Use Agreements
DVA	Department of Veterans Affairs
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
FFS	Fee for Service
FHIE	Federal Health Information Exchange
FTE	Full Time Equivalent
FY	Fiscal Year
GDP	Gross Domestic Product
GEIS	Global Emerging Infections Surveillance and Response System
GWOT	Global War on Terrorism
HA	Health Affairs
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HP	Healthy People
HPA&E	Health Program Analysis and Evaluation
HSA	Hospital Service Area
IM/IT	Information Management/ Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
LOS	Length of Stay
MDC	Major Diagnostic Category
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MTF	Military Treatment Facility
NAS	Nonavailability Statement
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NHE	National Health Expenditures
OASD	Office of the Assistant Secretary of Defense
OCONUS	Outside Continental United States
OHI	Other Health Insurance
O&M	Operations and Maintenance
PCM	Primary Care Manager
PDHRA	Post Deployment Health Reassessment
PDTS	Pharmacy Data Transaction Service
PIA	Privacy Impact Assessments
PPDHA	Pre- and Post-Deployment Health Assessment
PPO	Preferred Provider Organization
PRISM	Provider Requirement Integrated Specialty Model
RC	Reserve Component
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SAMHSA	Substance Abuse and Mental Health ServicesAdministration
SIDR	Standard Inpatient Data Record
TAO	TRICARE Area Office
TAMP	Transitional Assistance Management Program
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Total Obligational Authority
TOL	TRICARE Online
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRFDP	TRICARE Reserve Family Demonstration Project
TRO	TRICARE Regional Office
TRS	TRICARE Reserve Select
TSRx	TRICARE Senior Pharmacy
TRRx	TRICARE Retail Pharmacy
UCCI	United Concordia Companies Inc.
UMP	Unified Medical Program
USFHP	Uniformed Services Family Health Plan
VA	Department of Veteran Affairs
WHO	World Health Organization

To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care.


TRICARE