THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

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

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law I04-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost effectively improving access to and the quality of our health care services.

Our $41 billion program supports the physical and mental health of over 9 million beneficiaries worldwide, extending from theater medical care for our deployed Active and Reserve Component forces, to the daily "peacetime" health services provided in our military treatment facilities or purchased in the private sector. The Military Health System workload continues to increase even as deployments extend the medical force, while beneficiary satisfaction has improved for some of our key metrics, including wounded warrior ratings of their military health care experience. Other measures remained stable for access and satisfaction in the face of medical deployments and attention to the global war on terror. With your help, we continue to enhance the TRICARE benefit, such as for our reserves forces and their families, and look for ways to improve our efficiency and effectiveness.

Thank you for your continued support of the Military Health System.

Sincerely,

;-

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable John M. McHugh
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Joe Wilson
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

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

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable John P. Murtha
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, *NID*

Enclosure:
As stated

cc:
The Honorable C.W. Bill Young
Ranking Member

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

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

Dear Mr. President:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

THE ASSISTANT SECRETARY OF DEFENSE
1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

APR 06 2009

The Honorable Nancy Pelosi
Speaker of the House of Representatives
U.S. House of Representatives
Washington, DC 20515

Dear Madam Speaker:

I am pleased to provide you with the Department of Defense Evaluation of the TRICARE Program Fiscal Year (FY) 2009 Report to Congress. The enclosed report responds to the annual requirement outlined in Section 717 of the National Defense Authorization Act for Fiscal Year 1996, Public Law 104-106. This report reflects metrics routinely used to assess the effectiveness of TRICARE in meeting our strategic goals for cost-effectively improving access to, and the quality of, our health care services.

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Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

Keeping Warfighters Ready. For Life.

Evaluation of the **TRICARE** Program

Fiscal Year 2009 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 25, 2009

The Fiscal Year (FY) 2009 Evaluation of the TRICARE Program is provided by:
The TRICARE Management Activity, Health Program Analysis and Evaluation Directorate (TMA/HPA&E) in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD/HA). Key agency and individual contributors to this analysis are:

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Front cover photos courtesy of U.S. Army, www.navy.mil, www.usmc.mil and www.af.mil/photos.

A MESSAGE FROM S. WARD CASSCELLS, MD ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS), ASD (HA)

It is with profound pride and great pleasure that I am reporting to the Congress this year's annual assessment of the effectiveness of TRICARE, the Department's premier health care benefits program. This is my second report responding to Section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996.

America has given us a humbling responsibility: The care of our country's fighting forces, their families, and those who have served before us—more than 9 million people in all. The Military Health System (MHS) is a $41 billion-plus annual program employing almost 132,000 people. We want to be the nation's workplace of choice. Our health care team has performed exceptionally, in supporting the war fighters—with 95,000 MHS and integral-line, military medical forces deployed to combat theaters—and in providing peace through medicine in humanitarian and disaster relief. During this conflict, military medicine has achieved unprecedented outcomes that are truly remarkable. These results were founded on a vibrant military medical culture—one based on innovation, service to others, and an unrelenting persistence to achieve excellence.

Although those within and outside of our system know well and acknowledge our clinical excellence and achievements, we continue to have opportunities for improving areas of service to our warriors. We have been offered the opportunity to reinvent the disability rating process, to coordinate medical and personal services, and to look deeply inside our operations to rebuild our model and deliver exceptional service to those we care about most—our military family.

In addition to responding to the NDAA for FY 1996, this report also allows me to report on many of the measures we use to assess the performance of the entire MHS in meeting our strategic goals for 2008, covering our operational and humanitarian mission as well as the TRICARE health benefits program. As explained in greater detail in the pages that follow, this report presents data for each of our four mission elements or strategic objectives: (1) maintaining casualty care and humanitarian assistance, (2) creating and sustaining a healthy, fit and protected force, (3) promoting health and resilient individuals, families and communities, and (4) sustaining education, research and performance improvement. As in prior annual reports, where feasible and appropriate, data are trended over the most recent three fiscal years (usually FYs 2006–2008 in this year's report), where programs are sufficiently mature. We also continue the approach used in past years of comparing TRICARE with civilian-sector benchmarks where available and appropriate.

A FUTURE WORTH CREATING

Purpose, Vision, and Strategy

The senior medical leadership, the Surgeons General, and our staffs over the past year have reexamined our fundamental purpose, our vision for the future, and strategies to achieve that vision. We are refocusing our efforts on the core business in which we are engaged: creating an integrated medical team that provides optimal health services in support of our nation's military mission—anytime, anywhere. We are ready to go into harm's way to meet our nation's challenges at home or abroad, and to be a national leader in health education, training, research, and technology. We build bridges to peace through humanitarian support whenever and wherever needed—across our nation and the globe—and we provide premier care for our warriors and the military family.

Our ability to provide the continuum of health services across the range of military operations is contingent upon the ability to create and sustain a healthy, fit, and protected force. Each of the MHS mission elements is interdependent and cannot exist alone. A responsive research, innovation, and development capacity is essential to achieving improvements in operational care and evacuation. A medical education and training system that produces the quality clinicians demanded for an anytime, anywhere mission is critical, and we cannot produce the quality of medical professionals without a uniformed sustaining base and platform that can produce healthy individuals, families, and communities.

We have a singular opportunity to build bridges to peace in hostile countries. In many circumstances, the MHS will serve as the tip of the spear and a formidable national strategy tool for the nation. And, we can take advantage of a one-time opportunity to design and build health facilities that promote a healing environment during the clinical encounter, empower our patients and families, relieve suffering, and promote long-term health and wellness. We will employ evidence-based design principles that link to improved clinical outcomes, patient and staff safety, and long-term operational efficiencies.

Secretary Gates calls our work sacred. Caring for America's heroes is not a motto. It is what we do. Our

commitment is to provide the strategy, policy, and resources to achieve excellence. We are indebted to the sacrifice of our forces, and are honored to serve them.

Much has changed since we last published the MHS Strategic Plan in 2006. Leadership has responded to enormous challenges, and we have renewed our focus on quality. We have received suggestions and guidance from Secretary Gates's Independent Review Group, the President's Commission, the Task Force on the Future of Military Health Care, the Mental Health Task Force, and other thoughtful organizations. We have taken bold steps to redefine how we work collaboratively with the Department of Veterans Affairs (VA) and our civilian partners to address the issues identified at Walter Reed, and to improve coordinated care for wounded warriors and all whom we have the honor to serve.

This report reflects our new mission and vision statements, updates and refines descriptions of our core values, and presents key results of the metrics supporting our strategic plan. This plan focuses on how we define and measure mission success, and how we plan to continuously improve performance. The MHS purpose, mission, vision, and strategy are open, transparent, and available at *http://www.health.mil/StrategicPlan/Default.aspx.*

MILITARY HEALTH SYSTEM (MHS) MISSION ELEMENTS

Our team provides optimal Health Services in support of our nation's military mission—anytime, anywhere. The key mission elements are: (1) maintaining Casualty Care and Humanitarian Assistance, (2) creating and sustaining a Healthy, Fit and Protected Force, (3) promoting Healthy and Resilient Individuals, Families and Communities, and (4) sustaining Education, Research and Performance Improvement.

- **Casualty Care and Humanitarian Assistance:** We maintain an agile, fully deployable medical force and health care delivery system, so that we can provide state-of-the-art health services—anytime, anywhere. We use this medical capability to treat casualties, restore function, support humanitarian assistance and disaster relief: building bridges to peace around the world.
- **Healthy, Fit, and Protected Force:** We help the Services' commanders create and sustain the most healthy and medically prepared fighting force—anywhere.
- **Healthy and Resilient Individuals, Families, and Communities:** The MHS provides long-term health coaching and health care for over 9 million DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury or disease.
- **Education, Research and Performance Improvement:** Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment. To accomplish this, we must be an actively learning organization that values personal and professional growth and supports innovation.

MHS VISION STATEMENT

The provider of premier care for our warriors and their families

- We maintain an agile, fully deployable medical force and health care delivery system so that we can provide state-of-the-art health services—anytime, anywhere. The MHS provides long-term health coaching and health care for over 9 million DoD beneficiaries. Our goal is a sustained partnership that promotes health and creates the resilience to recover quickly from illness, injury or disease.

An integrated team ready to go in harm's way to meet our nation's challenges at home or abroad

- We help the Services' commanders create and sustain the most healthy and medically prepared fighting force anywhere.

A leader in health education, training, research and technology

- Sustaining our mission success relies on our ability to adapt and grow in the face of a rapidly changing health and national security environment.

A bridge to peace through humanitarian support

- We use our medical capability to support humanitarian assistance and disaster relief: building bridges to peace around the world.

A nationally recognized leader in prevention and health promotion

- We must be a learning organization that values both personal and professional growth and supports innovation.

KEY MHS MISSION ELEMENTS

Casualty care and humanitarian assistance

- Reduce combat losses
- Effective medical transition to VA and civilian care
- Improve rehabilitation and reintegration into the Force
- Increase interoperability
- Reconstitution of Host Nation medical capability

Healthy, fit, and protected force

- Reduce medical noncombat loss
- Improve mission readiness
- Optimize human performance

Healthy, resilient individuals, families, and communities

- Healthy communities/healthy behaviors (public health)
- Health care quality
- Access to care
- Beneficiary satisfaction and perceptions of MHS quality

Education, training, and research

- Capable MHS work force and medical force
- Contribution to the advancement of medical science
- Contribution to advances in global public health
- Create and sustain a healing environment (facilities)
- Performance-based management and efficient operations
- Deliver information to people so they can make better decisions

CORE VALUES

We are a values-based organization. Our core value system is the never-changing bedrock that reflects who we are and drives our behavior every day.

Selfless and Courageous Service

We are honored to serve those who serve, the warfighters and beneficiaries who trust us to always meet their needs—anytime, anywhere. Our high calling demands the courage to take risks, do what is right, and go into harm's way.

Caring, Healing, and Creating Health

We are healers who have an obligation to the life-long health and well-being of all those entrusted to our care. We are compassionate and committed to doing the right thing for our patients to eliminate disease, ease suffering, and achieve health. We build trusting relationships with our patients to permit them to take control of their health.

Helping our People Achieve Greatness

We work in teams, with passion, respect, and loyalty, constantly demanding mission success. It is this fusion of principles that brings out the potential of our people and creates a constant flow of leaders.

GUIDING PRINCIPLES

The MHS is a global system delivering health services—anytime, anywhere. In everything we do, we adhere to common principles that are essential for accomplishing our mission and achieving our vision. We must embed these principles into our processes and culture.

Health care is the ultimate team sport

We work as an integrated team, using Service capabilities, in partnership with the VA, our contract partners, and other governmental agencies to find the best way to accomplish our mission. We accept the inherent risk of being interdependent, because it is the only way to get the job done.

You have to know the score to win the game

We know that the best information leads to the best decisions, so we are committed to creating a true electronic, personal health record fully accessible to the patient. We also know that sharing our results freely builds knowledge and creates wisdom to better serve the people who trust us with their lives.

Breakthrough performance through innovation

We encourage our people to be curious and take risks in creating new solutions to the challenges of a constantly changing world. We hold leaders accountable for providing the environment and resources that foster innovation.

Reward outcomes, not outputs

We employ incentives to reward mission success, because we know that focusing on quality is the best way to improve efficiency.

Health-creating partnerships

We are committed to a caring, long-term relationship that allows patients to control their health and fitness. We will educate and coach our patients to be experts on their own health and achieve their trust by employing the highest quality healing methods.

MHS STRATEGIC PRIORITIES FYs 2008–2010

To close the gap between our current and desired performance, the MHS has 10 high-level strategic priorities. The annual plans for organizational elements within the MHS will specify focused tactical initiatives in support of these priorities. For reference, see the HA/TMA 2008 annual plan at *www.health.mil/.*

1. Enhance warrior care: Strengthen the continuum of care, from point of accession, through active service (including deployment and casualty care), to rehabilitation and transition.
2. Build a bridge to peace: Expand humanitarian missions and disaster relief to support U.S. strategic objectives and champion aspirations for human dignity through better health.
3. Promote patient choice and accountability, promote healthy communities, and demonstrate MHS commitment to safety and quality outcomes.
4. Communicate MHS value, and build an interactive community to improve clinical quality, performance, and integration.
5. Deliver information to people so they can make better decisions.
6. Continuously improve quality and value.
7. Support and develop our people.
8. Strengthen medical education and research.
9. Improve governance by aligning authority and accountability.
10. Create healing environments.

EXECUTIVE SUMMARY: KEY FINDINGS FY 2008

Stakeholder Perspective

- The nearly $45 billion ($44.7) FY 2008 Unified Medical Program (UMP) is more than 13 percent larger than the FY 2006 expenditures of over $39 billion. As currently programmed, the FY 2009 budget is nearly unchanged from the FY 2008 amount. For FY 2009, the UMP is programmed to be almost 9 percent of the total Defense budget, up from 7.4 percent in FY 2006 (Ref. pages 27–28).
- The number of beneficiaries eligible for DoD medical care increased from 9.2 million in FY 2006 to almost 9.4 million at the end of FY 2008 (Ref. page 20).
- The number of enrolled beneficiaries increased from 5.12 million in FY 2006 to 5.28 million in FY 2008 (Ref. page 25).
- The percentage of beneficiaries using MHS services increased from 79.3 percent in FY 2006 to 80.6 percent in FY 2008 (Ref. page 26).

MHS Workload and Cost Trends

- Total MHS workload increased from FY 2006 to FY 2008 for all major components—inpatient (+ 1 percent), outpatient (+13 percent), and retail prescription drugs (+5 percent); these increases were predominantly due to increases in purchased care workload excluding TRICARE for Life (TFL) (Ref. pages 30–31).
- Direct care inpatient, outpatient, and prescription workload all remained about the same from FY 2006 to FY 2008. Purchased care workload increased for all service types and total purchased care costs increased by 12 percent in both FY 2007 and FY 2008 (Ref. pages 30–31, 33).
- By the end of FY 2008, the direct care portion of total MHS health care expenditures had declined to 49 percent from about 53 percent in FY 2006. As a proportion of total MHS health care expenditures (excluding TFL), FY 2008 purchased care expenditures were 60 percent for prescription drugs, 56 percent for inpatient care, and 46 percent for outpatient care (Ref. page 33).
- Out-of-pocket costs for MHS beneficiary families under age 65 are between $3,700 and $4,000 lower than those for their civilian counterparts. Out-of-pocket costs for MHS senior families are $2,700 lower than those for their civilian counterparts (Ref. pages 86, 88).

Providing Quality Care

- **Overall Customer Satisfaction With TRICARE:** Satisfaction for all MHS beneficiaries with the overall TRICARE plan, health care, and one's specialty physician has improved from FY 2006 to FY 2008, yet continues to lag civilian benchmark rates. TRICARE Prime enrollee satisfaction with the health plan increased between FY 2006 and FY 2008, for those with military as well as civilian primary care managers. Satisfaction of members enrolled with civilian network providers reported the same or higher level of satisfaction as their civilian counterparts (Ref. pages 46–47).
- **Meeting Preventive Care Standards:** For the past three years, the MHS has exceeded targeted Healthy People 2010 goals in providing mammograms. Efforts continue toward trying to achieve Healthy People (HP) 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings. The overall FY 2008 self-reported rates for nonsmoking (82 percent) and non-obese (76 percent) beneficiaries have remained stable over the past three years, below the desired HP 2010 adjusted goals (88 percent nonsmoking; 85 percent non-obese) (Ref. page 64).
- **Force Protection:** Overall MHS dental readiness remained stable between FY 2006 and FY 2008. Force immunization rates for Active and Reserve Components increased between FY 2006 and FY 2008 (Ref. pages 42–43).

Access to Care

- **MHS Provider Trends:** The number of TRICARE participating providers continues to increase but at a much slower rate than during the earlier part of this decade. The number of Prime network providers has also been increasing, both in total numbers and as a percentage of total participating providers (Ref. page 55).
- **Overall Outpatient Access:** Access to and use of outpatient services remains high, with over 85 percent of Prime enrollees reporting having at least one outpatient visit in FY 2008 (Ref. page 51).
- **Availability and Ease of Obtaining Care:** MHS beneficiary ratings for getting necessary care and waiting for a routine appointment remained stable between FY 2006 and FY 2008, with retired beneficiaries reporting higher levels of satisfaction than Active Duty personnel or their family members (Ref. page 52).
- **Enrollment in TRICARE Reserve Select (TRS):** The TRS program was restructured in the FY 2007 NDAA to expand eligibility and simplify the plan structure. Since the revised benefit became available, enrollment more than doubled. TRS enrollees' average ratings of access and quality are statistically comparable to their non-enrolled Selected Reserve peers and MHS Standard/Extra users, and statistically higher than MHS Prime users on almost all measures. (Ref. pages 44–45).

WHAT IS TRICARE?

TRICARE is a family of health plans for the MHS. TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health services for all eligible beneficiaries. The TRICARE plans integrate and supplement the MHS capability in providing health benefits in peacetime for all eligible beneficiaries. TRICARE brings together the worldwide health resources of the Army, Navy, Air Force, Coast Guard and commissioned corps of the Public Health Service (often referred to as "direct care"), and supplements this capability with network and non-network civilian health professionals, hospitals, pharmacies, and suppliers (referred to as "purchased care") to provide better access and high-quality service, while maintaining the capability to support military operations. In addition to receiving care from 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 and most Medicare-eligible beneficiaries. Once eligibility is recorded in the Defense Eligibility Enrollment Reporting System (DEERS), no further application is required from our beneficiaries to obtain care from TRICARE-authorized civilian providers. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment, and waiting times in doctors' offices. A point-of-service (POS) option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. These plans and programs provide additional benefits or offer benefits that are a blend of the Prime and Standard/Extra options with some limitations. Some examples are:
  - Dental Benefits (military dental treatment facilities, claims management for active duty using civilian dental services, as well as the premium-based TRICARE Dental Program and the TRICARE Retiree Dental Program)
  - Pharmacy Benefits (in military treatment facilities, or via the national retail pharmacy contract, the national mail order program, and the TRICARE senior pharmacy benefits)
  - Overseas purchased care and claims processing services
  - Programs supporting reserves including the premium based TRICARE Reserve Select program and the Transitional Assistance Management Program
  - Supplemental programs including TRICARE Prime Remote in the U.S. and overseas, VA-DoD sharing arrangements, joint services, and claims payment.
  - US Family Health Plan (USFHP)
  - Continued Health Care Benefits Program
  - Clinical and educational services demonstration programs (such as chiropractic care and autism services demonstrations)

HOW TRICARE IS ADMINISTERED

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

- Establish TRICARE provider networks.
- Operate TRICARE service centers and provide customer service to beneficiaries.
- Provide administrative support, such as enrollment, disenrollment, and claims processing.
- Communicate and distribute educational information to beneficiaries and providers.

NEW BENEFITS AND PROGRAMS IN FY 2008 SUPPORTING MHS MISSION ELEMENTS

MHS continues to meet the challenge of providing the world's finest combat medicine and aeromedical evacuation, while supporting the TRICARE benefit to DoD beneficiaries at home and abroad. Since its inception more than a decade ago, TRICARE continues to offer an increasingly comprehensive health care plan to Uniformed Services members, retirees, and their families. Even as we aggressively work to sustain the TRICARE program through good fiscal stewardship, we also refine and enhance the benefit and programs in a manner consistent with the industry standard of care, best practices, and statutes to meet the changing health care needs of our beneficiaries.

Key MHS Mission Element: Casualty Care and Humanitarian Assistance

Caring for Wounded Warriors

Enhanced Health Information Sharing Supports Care of Wounded Warriors: The Department of Defense (DoD) released organization-wide enhancements that allow DoD to share electronic health information with the Department of Veterans Affairs (VA) through the Bidirectional Health Information Exchange (BHIE) and the Clinical Data Repository/Health Data Repository (CHDR) interfaces. Providers in both agencies have more information available to support patient care decisions, and the continuity of care is greatly enhanced for the nation's wounded warriors, from the combat zone to medical facilities here at home.

With the new enhancements in place, each agency is now able to view the other agency's clinical encounters, medical procedures, and lists of medical problems on shared patients using BHIE. This adds to the pharmacy, allergy, microbiology, and chemistry/hematology data, as well as radiology reports that were made available earlier this year. Additionally, DoD providers are also able to view combat zone data (including inpatient data) from the Theater Medical Data Store.

The CHDR software actively synchronizes data between DoD and VA repositories for patients who receive health services from both agencies. That synchronization significantly increases patient safety by enabling drug-drug and drug-allergy interaction checks with data from DoD, VA, and retail pharmacies. CHDR has been operating on a limited basis since late 2007, but new configuration enhancements have enabled all sites to view data on shared patients.

New Advocacy Program for Wounded Warriors: Each TRICARE region has a program to designed to provide guidance and assistance to Active Duty and Guard and Reserve Service Members as they transition through the MHS.

For example, Humana Military Healthcare Services (HMHS), the managed care support contractor for TRICARE's Southern Region, offers the Warrior Navigation and Assistance Program (WNAP). WNAP offers one-on-one assistance with many unique health care challenges service members may face. Issues may include access to care, or simply the need for information on all available resources, be it the MHS, VA, or other community assets. Calling 888-4GO-WNAP provides direct access to a multidisciplinary team with the mission to assist Service Members and their family members.

The WNAP incorporates four elements: tools and information for the Service Members, program management, clinical programs, and provider education and resources.

Care management initiatives include behavioral health support and assistance with seamless transition for Service Members and their families for the care they need, when they need it. There is also expanded outreach to Guard and Reserve members with transition coordinators delivering detailed TRICARE benefit education.

WNAP services via the toll-free line are available to those who live in the TRICARE Southern Region, which includes South Carolina, Georgia, Florida, Alabama, Mississippi, Tennessee, Oklahoma, Arkansas, Louisiana, but not the southwestern corner of Texas. Web site tools and information are available to anyone worldwide with computer access.

Respite Care for Caregivers of Severely Injured Service Members: TRICARE now offers primary caregivers of Active Duty Service Members (ADSMs) much needed rest, relief, and reprieve, thanks to section 1633 of the Fiscal Year (FY) 2008 National Defense Authorization Act (NDAA). The respite benefit specifically helps homebound ADSMs who need frequent help from their primary caregiver.

To provide the best possible help and respite for caregivers, this benefit provides a maximum of eight hours of respite per day, five days per week. The benefit is retroactive to January 1, 2008, and has no cost shares or copays.

ADSMs, or their legal representatives, can submit receipts for reimbursement of respite care services provided after January 1, 2008, by a TRICARE-authorized Home Health Agency.

Newest Army Warrior Transition Unit: The U.S. Army Garrison Wiesbaden Warrior Transition Unit (WTU) officially opened during a ceremony February 5 at Wiesbaden Army Airfield. The facility, open since last fall, is a healing hospice for wounded service members.

The facility can lodge up to 40 troops. Wheelchair ramps and wheelchair lifts are installed in the front and at both ends of

NEW BENEFITS AND PROGRAMS IN FY 2008 SUPPORTING MHS MISSION ELEMENTS *(CONT'D)*

the building. Four rooms are modified to be accessible to all, including disabled, emergency call buttons and modified showers.

The offices of platoon cadre personnel and the Soldier and Family Assistance Center are co-located in the facility to provide life support, social, administrative, and counseling services to the healing soldiers.

SHARE Initiative: On March 10, 2008, HMHS and the Shepherd Center, an Atlanta-based hospital specializing in the medical care and rehabilitation of people with spinal cord and brain injuries, announced a partnership with Home Depot. This partnership assists military Service Members wounded during their service in Operation Iraqi Freedom and Operation Enduring Freedom, as well as their families, in obtaining additional care that will aid in their recovery from combat-related injuries.

The SHARE Initiative, started in January 2008, primarily focuses on wounded Service Members in the Southeast and will subsequently expand to encompass a larger population. SHARE's vision is to enrich the hope and recovery for wounded men and women of the military. The partnership with Shepherd Center complements health care that may not be covered by TRICARE or other health insurance. Services may include specialized rehabilitation and community reintegration for spinal cord or traumatic brain injuries (TBI) survivors who sustained injuries while serving in Iraq and Afghanistan.

Humanitarian Missions

Pacific Partnership: The USNS Mercy returned to San Diego September 25, 2008, after completing Pacific Partnership, a four-month humanitarian/civic assistance (HCA) and theater security cooperation mission, conducted with countries from the Western Pacific and Southeast Asia.

Throughout the 2008 Pacific Partnership mission, USNS Mercy served as an enabling platform for military and non-governmental organizations (NGOs) to coordinate and carry out HCA efforts in the Republic of the Philippines, Vietnam, the Federated States of Micronesia, Timor-Leste, and Papua New Guinea. The relationships built and sustained with multinational partners in the Asia Pacific region through exercises and professional and military exchanges are designed to help in humanitarian efforts and preserve peace and stability in the region.

Over the course of the mission, more than 90,000 patients were treated by the medical teams in various locations throughout the Western Pacific, including more than 1,300 surgery patients and more than 14,000 dental patients.

Medical and engineering professionals from the partner and host nations of Australia, Canada, Chile, India, Indonesia, Japan, New Zealand, Republic of Korea, Portugal, Singapore, Republic of the Philippines, Vietnam, Timor-Leste, Papua New Guinea, and the Federated States of Micronesia served on the Pacific Partnership team.

Baghdad: The American Forces Information Services reported that 300 Iraqi school children and 150 adults received medical care January 16, 2008, when soldiers from the 101st Airborne Division's 1st Battalion, 320th Field Artillery Regiment, 2nd Brigade Combat Team, held a medical operation at central Baghdad's Swaib school.

Soldiers from 3rd Brigade, 6th Iraqi Army Division, handled security and crowd control, while Iraqi doctors, physicians, nurses, pharmacists, and a dentist worked side-by-side with their American counterparts to meet the needs of Iraqi citizens. During the medical operation, the physicians saw everything from upper respiratory infections to toothaches.

The medical operation provided a chance for Iraqi and U.S. physicians to reach out to the people in Swaib. The long-term goal of the effort is to help Iraqis to be able to sustain themselves. (*http://www.defenselink.mil/news/newsarticle.aspx?id=48747*)

Key MHS Mission Elements: Healthy, Fit and Protected Force and Healthy, Resilient Individuals, Families and Communities

Chemical-Biological Warfare Exposures Web site The DoD's Force Health Protection and Readiness Directorate (FHP&R) launched the Chemical-Biological Warfare Exposures Web site to provide Service Members, veterans, their families, and the public with information on the testing of chemical and biological warfare agents from 1942 to 1975. The Web site presents sections on World War II, Project 112/SHAD (Shipboard Hazard and Defense) and the Cold War. (*http://fhp.osd.mil/CBexposures/*)

To evaluate the ability of U.S. forces to fight on a chemical and biological battlefield, DoD conducted testing programs. In some programs, Service Members were present but not test subjects, and in other programs they were volunteer human subjects. This testing ended in 1975. DoD has been actively engaged in an extensive search of official records to find the names of veterans who may have been exposed to chemical or biological agents. DoD plans to complete the search in 2011, but will pursue any leads from veterans or others who may have information.

The Service Member names identified by DoD, along with specific exposure information, are provided to the VA. The VA then notifies the individuals of their potential exposure; provides treatment if necessary; and adjudicates any claim for compensation. For privacy reasons, the Web site does not contain the names of the veterans exposed.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

Dental Benefits

Establishing a Network of Dental Providers: The DoD awarded the TRICARE Active Duty Dental Program (ADDP) contract to United Concordia Companies, Inc. of Harrisburg, Pa., on September 26, 2008. Contract implementation is projected to begin on August 1, 2009.

The contract provides for private sector dental care services to ADSMs referred from military Dental Treatment Facilities (DTFs), as well as dental coverage for those ADSMs in remote areas. The remote program provides dental care to ADSMs who have a duty location and residence farther than 50 miles from a DTF.

The new ADDP contract establishes a network of providers that was previously unavailable to ADSMs. United Concordia will establish an extensive dental provider network covering the U.S., U.S. Virgin Islands, Guam, Puerto Rico, American Samoa, and the Northern Mariana Islands. Network dentists will provide the same dental benefits received at military DTFs, to include comprehensive preventive services such as oral cancer screenings.

Enhanced Maternity Dental Benefit: The American Dental Association (ADA) stresses the importance of maintaining good oral health as an integral part of overall health, especially during pregnancy. Research suggests there may be a correlation between periodontal (gum) disease, and pre-term and low birth weight babies. Pregnant women with gum disease may be more likely to develop gestational diabetes.

In response to this research, TRICARE Management Activity (TMA) approved an enhanced Maternity Dental Benefit through United Concordia, the TRICARE Dental Program (TDP) contractor. The enhanced benefit authorizes an additional cleaning at no cost for all pregnant TDP enrollees.

The TDP benefit includes two dental cleanings in a consecutive 12-month period. The modification allows for a third cleaning for mothers-to-be in the 12-month period.

Dental Care Overseas

TRICARE Overseas Preferred Dentists (TOPDs): Reduced dental staffing in DTFs overseas has forced more military families to seek dental care from host nation dentists. Many host nation dentists require military families to make full payment up front, and then wait for reimbursement from United Concordia, the administrator of the TDP. That can mean hundreds of dollars out of a Service Member's pocket while waiting for reimbursement. Paying up front creates a hardship for TRICARE beneficiaries and limits access to dental care. In some cases, beneficiaries postpone needed care, even procedures that are completely covered by the TDP.

To help beneficiaries avoid this financial difficulty, TRICARE has partnered with United Concordia to find host nation dentists who will agree to be listed as TOPDs. These dentists will require only the beneficiary's cost share at the time of care. In general, this means that beneficiaries can receive dental services like examinations, cleanings, and simple restorative care with little or no out of pocket expense.

Beneficiaries can see the list of TOPDs on the United Concordia Web site, at *www.tricaredentalprogram.com.*

Enhanced-Overseas TRICARE Retiree Dental Program: On October 1, 2008, TMA announced that the Enhanced-Overseas TRICARE Retiree Dental Program (TRDP) was available for eligible Uniformed Services retirees and their families living overseas.

Prior to the enhancement, the TRDP was only available to retirees and their families in the U.S., the District of Columbia, Guam, Puerto Rico, the U.S. Virgin Islands, American Samoa, the Commonwealth of the Northern Mariana Islands, and Canada. The Enhanced-Overseas TRDP now allows retirees worldwide to purchase dental coverage.

There is no TRDP dentist network overseas. However, an online host nation provider list is located on the TRDP Web site. To find out more about this program enhancement, please visit *www.trdp.org.*

Pharmacy Benefits

Encouraging Beneficiaries to Switch to the TRICARE Mail Order Pharmacy (TMOP): Prescriptions filled through the mail-order service are 30–40 percent less compared with retail pharmacies. The DoD estimates saving as much as $22 million a year with just a one percent shift of prescriptions from retail to mail order.

Letters explaining TMOP and its convenient, safe, and cost-saving features were sent to beneficiaries who receive regular maintenance prescriptions at network retail pharmacies. The letters tell beneficiaries how they can switch from retail pharmacies to TMOP and save up to 66 percent on their prescription drug costs. TMOP offers up to a 90-day supply of medication for the same copayment as a 30-day supply from a retail pharmacy. In all, a beneficiary's savings with TMOP could range from $24 a year for each regular formulary generic drug to as much as $176 a year for each nonformulary brand-name drug. The savings increase with each additional prescription.

For many beneficiaries, the key factor is the convenience of making the switch through the Member Choice Center (MCC) and the appeal of "home delivery." TMOP pharmacists are available 24 hours a day, any day of the week.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

The MCC can also refill a beneficiary's prescription by mail, phone, fax, or online, and take payment by check or credit card.

There are other convenient features. An electronic alert is e-mailed to beneficiaries when their prescription is about to expire, giving them time to arrange for a renewal from their physician. Beneficiaries also get an e-mail when prescriptions are shipped and an additional reminder is sent when they are eligible to refill the prescriptions.

Beneficiaries can register for TMOP at *http://www.express-scripts.com/TRICARE*, or by calling the MCC at 877-363-1433. Once the registration process is complete, beneficiaries may use the MCC service online and request that TMOP obtain prescriptions from their provider.

Since launch of the MCC in August 2007, more than 90,000 retail prescriptions have been switched to TMOP, well exceeding the goal of converting 60,000 retail prescriptions to TMOP in one year.

Expanding Benefits

MRI Screenings for Breast Cancer: Recognizing the importance of early detection, TMA recently changed its policy, adding coverage for Magnetic Resonance Imaging (MRI) screening for women at high risk of developing breast cancer. The American Cancer Society has clear guidelines defining high risk, which doctors can use to determine who qualifies for the coverage. If any qualified beneficiary receives this care in the near future and it is denied, they can resubmit their claim for reimbursement.

Breast cancer is the third most common cancer among TRICARE beneficiaries and the second most common cause of cancer death for women in the U.S. An individual's level of risk can be impacted by a number of factors, including age, family history, and race.

Anyone who meets the criteria for a breast MRI will be covered by TRICARE, retroactive to March 1, 2007. If any qualified beneficiaries received this care on or after March 1, 2007 and it was denied, they can resubmit their claim for reimbursement.

Shingles Vaccine: Following a Centers for Disease Control and Prevention (CDC) recommendation on October 19, 2007, TRICARE now covers Zostavax, the vaccine designed to prevent shingles for beneficiaries 60 and older.

Shingles is a painful viral disease that affects more than one million Americans every year. More than half of those cases happen in people age 60 or older. The CDC recommends a single dose of shingles vaccine for everyone age 60 and older.

Beneficiaries who receive the shingles vaccine after October 19, 2007, must have vaccinations administered in a provider's office. Zostavax is covered under the TRICARE medical benefit and is not reimbursable under the pharmacy benefit.

Minimally invasive back surgeries authorized: TMA announced that percutaneous vertebroplasty and kyphoplasty, two minimally invasive back surgeries, are now covered under TRICARE. Either may replace spinal fusion, an invasive surgical procedure, for treatment of fractured vertebrae. The policy change is retroactive to February 6, 2006.

Usually occurring in patients with osteoporosis, many vertebral fractures heal on their own with bed rest and anti-inflammatory medication in approximately three months. It is only when pain persists beyond three months that surgery is recommended. The traditional treatment was spinal fusion surgery, which requires up to 12 hours in the operating room with days of hospitalization afterward. Percutaneous vertebroplasty and kyphoplasty are outpatient surgeries, which have patients back to relative normality in 24 hours. Approval must be obtained from a provider for either surgery.

Laparoscopic adjustable gastric banding: On January 16, 2008, TMA announced that TRICARE covers laparoscopic adjustable gastric banding, also commonly called Lap-Band surgery, for qualified beneficiaries. Although the TRICARE policy change has only recently been made, coverage is retroactive to February 1, 2007.

Lap-Band surgery, like gastric bypass, gastric stapling, or gastroplasty, is only for those suffering morbid obesity, defined as body weight 100 pounds over ideal weight for the individual's height and bone structure and weight associated with severe medical conditions known to have higher mortality rates. A person whose body weight is 200 percent or more of the ideal weight for height and bone structure may also indicate morbid obesity.

In addition, TRICARE will cover the surgery if a patient has had an intestinal bypass or other surgery for obesity and, because of complications, requires a second surgery.

Forensic Examinations following Sexual Assault: The DoD published a proposed rule in the *Federal Register* on July 7, 2008. This proposed rule implements section 701 of the John Warner National Defense Authorization Act for Fiscal Year 2007, Public Law 109-364. Section 701 amends Chapter 55 of title 10 section 1079(a) of the U.S.C. by authorizing coverage in civilian health care facilities (e.g., civilian rape crisis facilities) for forensic examinations following a sexual assault or domestic violence for eligible beneficiaries. The final rule is in review with payment designed to be retroactive to October 17, 2006. The new

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

provision is consistent with services that are authorized in MTFs for all beneficiaries who were victims of a sexual assault or domestic violence .

Expanding & Maintaining Access:

TRICARE Benefits Management for Natural Disasters: August and September were active months for the Atlantic hurricane season, but TRICARE beneficiary health care needs were being met. In the aftermath of Tropical Storm Fay and Hurricane Gustav, TRICARE assisted over 500,000 beneficiaries in affected areas.

TRICARE partnered with HMHS and MTFs in the South region to prepare in advance of the storms and to be responsive after the storms.

In the first wide-reaching request since Hurricane Katrina, requirements for referrals from primary care managers (PCMs) were waived for TRICARE beneficiaries in designated areas impacted by Gustav. Waivers of PCM referrals allowed beneficiaries to seek medical care from any TRICARE-authorized provider without a referral from a PCM during the waiver period. The waiver was scheduled to be in effect through September 12, 2008.

Early prescription refills for beneficiaries impacted by the hurricane were also authorized for a six-week period. This proactive measure enabled TRICARE beneficiaries to obtain critical medication refills before evacuation, after the storm, or in cases of extended relocation.

TRICARE beneficiaries impacted by storms or flooding could also use their one-time-per-year override. TRICARE pays for the beneficiary's additional refill when this override is used, but beneficiaries are responsible for applicable copayments. Additional provisions may be authorized if this benefit has already been used.

Urgent Health Care Options Expanded for Active Duty Overseas: TMA has directed the TRICARE Global Remote Overseas (TGRO) contractor, International SOS, to assist ADSMs with emergency and urgent care needs—even if they are in the vicinity of MTFs overseas.

Previously, if an ADSM needed urgent care, and they were within 40 miles or an hour's drive of an MTF, that was the only option. Urgent care is medical attention for a condition that, while not life or limb threatening, could become more serious if not treated.

The MTF still has the first right of acceptance for urgent care cases and the TGRO contractor will contact the MTF before arranging urgent care to determine if the Service Member can be seen there instead. The TRICARE access standard for urgent care is 24 hours.

If the ADSM is admitted to the facility, the TGRO contractor will coordinate with the ADSM's enrolled MTF or with the nearest available MTF, whichever is appropriate, to determine whether the patient should be transferred to another facility. The TGRO contractor will also coordinate emergency transport.

Increasing the Civilian Provider Network: For two years, TriWest Healthcare Alliance, the managed care support contractor for the western region, and TRICARE program leaders, have spearheaded an innovative program to collaborate with governors in the TRICARE western region to increase the network of providers delivering care to beneficiaries. The net result is an increase from approximately 80,000 providers to over 125,000.

The Minnesota Medical Association House of Delegates recently adopted a resolution to increase its membership's awareness of TRICARE. The Minnesota initiative is just one of many from governors in TRICARE's western region to ensure beneficiaries have unprecedented access to care. It's all due to a continuing partnership between governors in the west, TMA, and the TriWest Healthcare Alliance, the managed care support contractor for the western region.

Governors in the 21-state western region contacted the medical associations in their states to applaud those providers already participating in TRICARE, and to encourage others to consider contracting with TriWest to deliver care to military personnel and families in their states.

The outreach focused on ensuring a quality network of providers at a time when Congress continues to enhance TRICARE benefits for Guard and Reserve members and their families. TRICARE needs a robust network to care for beneficiaries who may not live near military facilities, and for those who live in communities where limited military presence means that TRICARE may not be commonly accepted.

The regional effort followed an outreach program in Idaho, launched earlier in 2006 by Secretary of the U.S. Department of the Interior Dirk Kempthorne, who was at that time the Governor of Idaho.

TRICARE Reimbursement Rates Change: TMA announced on September 26, 2008, that TRICARE reimbursement rates increased 0.5 percent from 2007 levels as a result of a new law. This rate increase was included in the initial 2008 rates.

The new law retroactively replaces the midyear 2008 Medicare Physician Fee Schedule (MPFS) rate reduction of 10.6 percent with fee schedule rates (0.5 percent increase) in effect from January to June 2008. In addition, MPFS payment rates are being revised to increase the fee schedule amounts for certain mental health services. The new rates went into effect on September 1, 2008.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

The exact terms of the incentive plans for health care providers were outlined in Medicare's final rule on the 2009 MPFS.

Reserve Benefits: The DoD published a final rule in the *Federal Register*, which implements sections 704 and 705 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005.

These provisions apply to eligible family members who become eligible for TRICARE as a result of their Reserve Component (RC) sponsor (including those with delayed effective date orders up to 90 days) being called or ordered to active duty for more than 30 days in support of a federal/contingency operation and choose to participate in TRICARE Standard or Extra, rather than enroll in TRICARE Prime.

The first provision gives the Secretary the authority to waive the annual TRICARE Standard (or Extra) deductible, which is set by law (10 U.S.C. 1079(b)) at $150 per individual and $300 per family ($50/$100 for families of members in pay grades E-4 and below).

The second provision gives the Secretary the authority to increase TRICARE payments up to 115 percent of the TRICARE maximum allowable charge, less the applicable patient cost share if not previously waived under the first provision, for covered inpatient and outpatient health services received from a provider that does not participate (accept assignment) with TRICARE.

These provisions help ensure timely access to health care and maintain clinically appropriate continuity of health care to family members of Reservists and Guardsmen activated in support of a federal/contingency operation; limit the out-of-pocket health care expenses for those family members; and remove potential barriers to health care access by Guard and Reserve families. This rule was effective August 12, 2008.

Enhanced Access to Autism Services Demonstration: The DoD and TRICARE announced a demonstration project to care for military family members diagnosed with Autism Spectrum Disorders (ASD).

The Enhanced Access to Autism Services Demonstration, which went into effect March 15, 2008, allows reimbursement for educational intervention services, such as Applied Behavior Analysis (ABA), delivered by paraprofessional providers. ABA is a systematized process of collecting data on a child's behaviors and using a variety of behavioral conditioning techniques to teach and reinforce desired behaviors while extinguishing harmful or undesired behaviors. Time-limited, focused ABA methods have been shown to improve communication abilities, reduce or eliminate specific problem behaviors and teach new skills to some individuals with autism.

The DoD has been a leader in providing coverage for health and special education services for children with autism. TRICARE is one of the very few health plans providing coverage for special education services. In recent years, the per month limit on the expanded benefits program for qualifying family members, TRICARE's Extended Care Health Option (ECHO), was increased from $1,000 to $2,500. And, with the passage of the National Defense Authorization Act for Fiscal Year 2009, the limit has been further increased to $36,000 per year. The Department is working hard to put this new amount into effect as quickly as possible.

Except as provided by the Autism Demonstration, TRICARE-authorized providers of ABA are currently limited to those recognized by the Behavior Analyst Certification Board (BACB). However, the professionalization of the field remains in its infancy and the number of BACB-certified behavior analysts, while continuing to increase, is still less than optimal to provide services to all individuals with ASD. These certified professionals are for the most part providing behavior analysis evaluation and intervention planning services rather than the one-on-one technical intervention that is the actual tool effecting behavior change in autistic children. This new field has yet to define the provider class that delivers the one-on-one technical services to children. ABA tutors will increasingly be asked to provide services to the many children being diagnosed with ASD.

TRICARE's three Managed Care Support Contractors are building a referral network of ABA providers who will agree to be reimbursed for TRICARE-eligible beneficiaries referred for care.

TRICARE Behavioral Health Support: TMA has launched the Behavioral Health Provider Locator and Appointment Assistance Service to make behavioral health care access simpler for Prime beneficiaries. All ADSMs and their enrolled family members living in the U.S. who need help locating and making appointments with behavioral health care providers can now contact their Managed Care Support Contractor (MCSC) for assistance.

All ADSMs must have a referral from their primary care manager for behavioral health care before calling the MCSC appointment assistance line. TRICARE Prime active duty family members (ADFMs) can receive the first eight outpatient behavioral health care visits per fiscal year (October 1 to September 30) without a referral, but they must receive the care from TRICARE network providers to avoid point-of-service cost sharing charges.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

TRICARE also provides resources and information regarding behavioral health benefits on the Mental Health and Behavior Web page, where beneficiaries can access information on conditions, providers, treatments and learn how to get care. A new section on the site can help with suicide prevention.

In addition to TMA's efforts, the managed care support contractors for the three TRICARE regions have developed programs and services to help beneficiaries with behavioral health concerns.

TriWest Healthcare Alliance, TRICARE's MCSC for the West region, provides 24/7 telephone access and crisis intervention services. Service Members and their families can request assistance with a mental health crisis or with simple requests for behavioral health information by calling (866) 284–3743.

Health Net Federal Services, TRICARE's MCSC for the North region, provides an online "Behavioral Health Resource Center," available in English and Spanish. The resource center is designed to help beneficiaries balance work, family and life by providing comprehensive articles, information sheets, quick tips, and additional resources on dozens of emotional health issues and more.

HMHS, TRICARE's MCSC for the South region, offers "AchieveSolutions," an online resource offering TRICARE beneficiaries a secure, safe environment to seek information, educational materials and self-assessment tools in the South region. It can be accessed through the behavioral health link on Humana's Web site at *www.humana-military.com.*

Promoting Healthy Behaviors

Healthy People: The DoD and TMA highlighted a few programs and initiatives designed to help TRICARE beneficiaries with weight management and fitness, tobacco cessation, and responsible alcohol use.

"That Guy," the social marketing initiative for alcohol abuse awareness among active duty personnel, has expanded to include radio public service announcements (PSAs) in multiple major markets such as Philadelphia, Atlanta, and Seattle.

"Quit Tobacco. Make Everyone Proud," the *ucanquit2.org* Web site, has been redesigned and expanded to include articles and materials that highlight content specific to each of the uniformed services, with service-specific statistics. The expanded features include the availability of both general usage and service-focused materials that can be used in newsletters, e-blasts, and other promotional vehicles produced by Surgeons General, cessation class program managers, commanders, and installations.

Military OneSource has added new programs and offers a more robust menu of services. Military OneSource now provides weight management (iCanChange), stress management (iCanRelax), and cardiovascular health (iCanThrive) coaching services with the new Healthy Habits Health Coaching Program. The program is available to all military Service Members and their families, and offers them the right tools to take charge of their health—including a personal health coach by phone or e-mail. The personal, dedicated health coach provides expertise in nutrition, exercise physiology, and behavioral health. (*http://www.militaryonesource.com*) or, to get to these pages: (*http://www.militaryonesource.com/skins/MOS/display.aspx?ModuleID=ae74eaa3-d1b6-4dbd-b23e-354880172094&Mode=User&action=category&ObjectID=96c6633c-9f2d-4f4f-ba26-96b42d2a6a99*)

Childhood Obesity: TRICARE launched a new Web page, at *http://www.tricare.mil/getfit,* to promote a healthy lifestyle partnership aimed at military families.

TRICARE is partnering with the Defense Commissary Agency (DeCA), Military OneSource, and the Army and Air Force Exchange Service (AAFES), to raise awareness of childhood overweight and obesity issues. The "Healthy Youth for a Healthy Future" initiative was launched by the United States Department of Health and Human Services (HHS).

According to the U.S. Surgeon General, obese children are more likely than children of normal weight to become overweight or obese adults. Overweight or obese adults are more at risk for several health problems, including heart disease, Type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

Partner initiatives include a special childhood obesity "Dietitian's Voice" column at *http://www.commissaries.com.* Military families can also get additional information on losing weight, getting in shape, and maintaining good health at the DeCA Web site, including advice-packed columns, recipes, and an open question and answer forum.

Providing Quality Care

High marks for DoD health care on the annual federal government report from the 2007 American Customer Satisfaction Index (ACSI): On December 21, 2007, TMA announced that it received high marks on the annual federal government report from the 2007 American Customer Satisfaction Index (ACSI). TRICARE scored 89 for inpatient care and 84 for outpatient care, well above the federal government average score of 67.8 on ACSI's 100-point scale.

The ACSI is the only uniform, national, cross-industry measure of satisfaction with the quality of goods and serv-

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

ices available in the U.S. Since 1999, more than 100 federal government agencies have used ACSI to measure citizen satisfaction of more than 200 services and programs.

The ACSI measures beneficiary satisfaction by asking questions about expectations, the perceived quality of care received, and the outcomes of beneficiary complaints in two main areas: inpatient and outpatient care. Inpatient care is hospitalization for one or more days, and outpatient care is the care received at a doctor's office.

TRICARE partners with civilian companies, Health Net Federal Services, Inc., Humana Military Healthcare Services, Inc., and TriWest Healthcare Alliance, Corp., as well as military hospitals and clinics, to provide health care services and support in the three TRICARE regions where beneficiaries were surveyed. Those regional managed care support contractors have established the TRICARE provider networks that beneficiaries use each and every day.

TriWest Healthcare Alliance Achieves URAC Accreditation for Health Care Services UM: TriWest Healthcare Alliance, TRICARE's Managed Care Support Contractor (MCSC) for the West Region, has earned URAC accreditation for its Health Care Services Utilization Management and Case Management operations at the company's five hub offices in Colorado Springs, Honolulu, Mountain, San Diego, and Tacoma, which expands the company's excellence standards beyond its corporate headquarters.

URAC, a Washington, D.C.-based health care accrediting organization, establishes quality standards reflective of best practices for the health care industry. Accreditation serves as a symbol of excellence. The accreditation standards establish key quality benchmarks for core business practices and managed care programs including network management, provider credentialing, utilization management, quality management and improvement, disease management, consumer protection, and confidentiality.

TriWest received URAC Health Network Accreditation for Case Management, Disease Management, and Utilization Management in April 2007, and for URAC Provider Network Accreditation in 2005.

TriWest's Suicide Prevention Hot Line Earns National Certification: Concluding an extensive review of policy, procedures, and personnel, the American Association of Suicidology in Washington, D.C. certified TriWest Healthcare Alliance's Suicide Prevention Hot Line, available to TRICARE beneficiaries throughout 21 western states.

The Hot Line exceeded the association's seven challenging criteria: administration and organizational structure, training program, general service delivery, services in life-threatening crises, ethical standards and practice, community integration, and program evaluation. Association evaluators also conducted a day-long site visit and studied the personnel files of the hot line's clinicians. Eighty percent of the hot line staff already has individual certifications from the association.

TriWest launched its suicide prevention hot line 11 years ago when the company first earned a DoD contract to administer the military's health care program, TRICARE. The hot line is staffed around the clock every day by a team of clinicians, nurses, and social workers, and today serves 2.9 million people.

J.D. Power and Associates Call Center Certification for excellence in serving customers awarded to TriWest Healthcare Alliance: TriWest Healthcare Alliance received the J.D. Power and Associates Call Center Certification for excellence in serving customers. J.D. Power and Associates measures call center effectiveness judged by recruiting, training, employee incentives, management roles and responsibilities, performance standards and quality assurance.

TriWest is TRICARE's MCSC for the West Region. Each of TriWest's six call centers, and the call center of TriWest's subcontractor, Wisconsin Physicians Services (WPS), received the certification after audits and surveys of 1,800 TriWest customers conducted by a third party over 15 days.

TriWest's call centers are staffed by highly trained and equipped call center specialists. TriWest's J.D. Power and Associates certified call centers are in Anchorage, Colorado Springs, Honolulu, Phoenix, San Diego and Tacoma and the WPS call center is in Wausau, Wisconsin.

Key MHS Mission Element: Education, Training and Research

Keeping Beneficiaries Informed

Monthly summaries of Explanation of Benefits (EOB) for TFL Members: TMA announced that, starting in January 2008, TRICARE for Life (TFL) beneficiaries living in the U.S. and U.S. territories received monthly summaries of their EOB instead of individual EOBs. The exception to this is if a claim includes services that are rejected, and those services have appeal rights, or if the EOB is mailed with a payment to the beneficiary. TRICARE overseas beneficiaries will continue to get their EOBs as usual.

In February, 2008, TFL beneficiaries received the option to receive an electronic notification every time a claim is processed. Beneficiaries can log onto the secure Web site, at *www.TRICARE4U.com*, to view and print their EOB.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

The EOB will be available online and beneficiaries will have the ability to access EOB's for any claim processed during the past 27 months. Once a beneficiary signs up for this option, he or she will not receive a monthly paper summary.

En Espanol: TMA recently launched the TRICARE Beneficiary Website "en Español" (*http://www.tricare.mil/mybenefit/espanol/*) as part of its ongoing effort to educate TRICARE beneficiaries in both English and Spanish.

The new Spanish Website features the beneficiary profile, which has been well received on the English Website. By selecting beneficiary status, country, zip code, and TRICARE plan, beneficiaries are able to receive more customized information about health care benefits. In addition to the Website, TMA has released informational materials in Spanish to further increase access to its diverse community.

Using the Web to Inform Beneficiaries

The MHS is constantly looking for new avenues to communicate and interact with the military community about health, education, research, and much more. Over the past year, the MHS has expanded its use of Web 2.0 to reach beneficiaries.

- **Dot-Mil-Docs:** On May 1, 2008, the MHS debuted its weekly Internet radio show on BlogTalkRadio. Hosted by the DoD, "Dot-Mil-Docs" broadcasts on BlogTalkRadio every Thursday at *www.blogtalkradio.com/Dot-Mil-Docs*. MHS topics Dot-Mil-Docs range from advances in medical research to traumatic brain injury, suicide, and adjustment from deployment.

  Programs also offer an opportunity for listeners to call and ask questions. Previous programs are available 24/7.

- **Online Town Halls:** Assistant Secretary of Defense for Health Affairs, S. Ward Casscells, MD, hosted the first Web-based live "Webhall" for the MHS on February 14, 2008. During the session, leaders from the MHS joined Dr. Casscells in answering more than 25 questions from service members and their families.

  Additional live "Webhall" discussions have already taken place at *www.health.mil* with beneficiaries asking questions of senior MHS leadership. Webhall questions and answers are archived on health.mil for viewing at any time.

- **Blogs:** The deputy director of TMA is using a weekly blog to communicate with beneficiaries and other readers. Army Maj. Gen. Elder Granger's blog can be found on the TRICARE Website at *http://www.tricare.mil*. He welcomes feedback from readers, and a recent autism blog garnered nearly 100 comments. To offer feedback, readers can go to the recent posts section on the blog page and scroll to the bottom.

- **E-mail Newsletters:** TMA is offering its beneficiaries an option to subscribe to receive beneficiary newsletters, news releases, and benefit updates by e-mail. Subscribers can choose alerts by topics or beneficiary category. Subscribers also have a unique page they can manage 24/7 and can choose to be notified as soon as news or benefit changes are posted or select daily, weekly or monthly updates.

  The new subscription service links users up to similar alerts available on other MHS Websites including *http://www.health.mil*, which features MHS news, debates, videos, and blogs; as well as Force Health Protection and Readiness and the Uniformed Services University of the Health Sciences.

Advancing Medical Science

In-Utero Fetal Surgical Repair of Myelomeningocele demonstration project: The DoD collaborated with the National Institute of Child Health and Human Development to offer the In-Utero Fetal Surgical Repair of Myelomeningocele demonstration project to TRICARE beneficiaries.

TRICARE beneficiaries whose fetuses have been diagnosed with myelomeningocele (spina bifida) may be eligible to receive prenatal and postnatal surgical intervention through this clinical trial. The trial tests the safety of intrauterine repair of fetal myelomeningocele and whether, if repaired early in gestation, neurological functioning of spina bifida patients improves.

Eligibility: To be eligible for the trial, beneficiaries must be:

- registered in the Defense Enrollment Eligibility Reporting System (DEERS);
- 18 or older; and
- diagnosed with myelomeningocele at 16 to 25 weeks of gestation.

Beneficiaries enrolled in the Continued Health Care Benefit Program or the Federal Employees Health Benefits Program are not eligible for the trial.

Providing Quality Facilities

DoD Establishes Center of Excellence to Address Traumatic Brain Injury and Psychological Health

The Defense Center of Excellence (DCoE) for Psychological Health (PH) and Traumatic Brain Injury (TBI) began initial operations and will be fully functional by October 2009. It is currently operating in temporary office spaces in Rosslyn, Va., as part of its initial phase.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

The DoD, with support from the VA, is leading a national collaborative network to advance and disseminate PH/TBI knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the urgent and enduring needs of warrior families with PH and/or TBI.

The Defense and Veterans Brain Injury Center (DVBIC) is now integrated into the center. DVBIC has DoD's primary subject matter expertise on TBI and many of its functions are transitioning to the DCoE. The DoD Center for Deployment Psychology, currently at the Uniformed Services University of the Health Sciences, is also integrated into the training and education functions of the DCoE.

Center of Excellence for Battlefield Health and Trauma Research: On January 11, 2008, a groundbreaking ceremony occurred at Fort Sam Houston, Texas, for a $92 million center for all DoD combat casualty care and trauma research missions.

The 150,000-square-foot Joint Center of Excellence for Battlefield Health and Trauma Research marks the first construction project at Fort Sam Houston under the 2005 Base Realignment and Closure (BRAC) legislation.

Military leaders from the Army, Navy, and Air Force joined community leaders at the ceremony. The new facility is slated for completion in September 2009.

The center will be co-located with the Institute of Surgical Research, and adjacent to Brooke Army Medical Center. The Institute will also benefit from the BRAC law with a 5,000-square-foot renovation. In addition, the research center adds 230 people to the 440 already working there.

The focus of the Institute of Surgical Research and the future focus of the new joint center will be on the delivery of immediate care for warfighters who suffer life-threatening injuries on the battlefield. (*http://www.dcmilitary.com/stories/011708/journal_27976.shtml*)

DoD-VA Facilities: The first completely integrated DoD and VA federal health care center officially entered its final phase of construction near Naval Station Great Lakes.

Officials from DoD, VA, federal, and local government joined in a ceremonial ribbon-cutting and groundbreaking to complete a $16-million parking and infrastructure project and to mark the beginning of construction of a $71-million, four-story addition to the existing North Chicago VA Medical Center.

Naval Health Clinic Great Lakes is gradually merging operations with the existing VA staff and facilities. This will provide a full range of modernized medical and support resources for patients while at the same time eliminating costly duplications that exist between the two nearby medical facilities.

NAVFAC Midwest is in charge of constructing the facility, which will be the first to use a completely integrated VA/Navy staff to treat recruits, ADSMs, retirees, family members, and veterans.

Integration will be complete in 2010, and the new care center, named in honor of Navy retiree and commander of Apollo 13 Capt. James A. Lovell, is expected to save approximately $160 million over the projected 40-year life span of the facility.

Joint Tri-Service Training Facility: On July 10, 2008, a ceremonial ground-breaking for the Medical Education and Training Campus (METC) was held, marking another step toward the largest consolidation of training in the history of the DoD.

Upon completion in 2011, the joint campus, led by tri-service leadership, will centralize all Army, Navy, and Air Force basic and specialty enlisted medical training at Fort Sam Houston, Texas.

Fort Sam Houston will gain five instructional facilities, six dormitories, an Air Force and Navy headquarters building, dining facility, gym, and lighted troop walks. The six existing Army Medical Department Center and School (AMEDDC&S) buildings will become part of the training campus.

Several units will then join the AMEDDC&S here to include the 882nd Training Group, Sheppard Air Force Base, Wichita Falls, Texas; the Naval Schools of Health Sciences in San Diego and Portsmouth, Va.; the Naval Hospital Corps School in Great Lakes, Ill.; and the enlisted medical training mission at Walter Reed Army Medical Center, Washington, D.C.

METC's average daily student load is projected to be more than 9,000 and the support staff nearly 4,000.

The nearly $1 billion project, directed by BRAC 2005 legislation, is the largest economic development project that has occurred in San Antonio to date. (*http://www.health.mil/Press/Release.aspx?ID=279*)

Walter Reed National Military Medical Center: The Walter Reed National Military Medical Center ground- breaking ceremony was held July 3, 2008, at the National Naval Medical Center in Bethesda, Md. The future 345-bed facility represents a new direction of collaborative efforts to enhance the quality of care available to military personnel and their families.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

Recommended by the 2005 Base Realignment and Closure Commission (BRAC), the $970 million project will add or renovate 2.5 million square feet of facility space, and is set to provide tertiary, subspecialty, and complex medical services. The BRAC commission's plan was to relocate certain Walter Reed Army Medical Center activities from Washington, D.C., to Bethesda. The facility is scheduled for completion by September 2011.

The Walter Reed National Military Medical Center will be complemented by a 120-bed community hospital, scheduled to be located at Fort Belvoir, Va. The smaller center will be used for nontertiary care services to the Northern Virginia area, and is also scheduled to be completed by September 2011. (*http://www.health.mil/Press/Release.aspx?ID=262*)

Uniformed Services University of the Health Sciences (USUHS) Academic Program Center: The Uniformed Services University of the Health Sciences (USUHS) held a ribbon-cutting ceremony for its newly constructed 50,000 square foot Academic Program Center on May 15, 2008. The event marked a historic day, as the university celebrated its first major construction project on the USUHS campus since the completion of the original four buildings almost 30 years ago.

The new Academic Program Center addresses urgently required classroom space and provides facilities for university-wide, mission-related, and ever-expanding educational programs and support activities for the MHS.

USUHS is the nation's federal school of medicine and graduate school of nursing. Students are Active Duty uniformed officers in the Army, Navy, Air Force, and Public Health Service. USUHS educates health care professionals dedicated to career service in the DoD and the United States Public Health Service. The university provides military and public health-relevant education, research, service, and consultation to the nation and the world, pursuing excellence and innovation during times of peace and war.

Managing Health Care Costs

TRICARE Program Integrity-Insurance Fraud: According to the Associated Press, the U.S. military's health insurance program, TRICARE, has been swindled out of more than $100 million over the past decade in the Philippines, where doctors, hospitals, and clinics have conspired with American veterans to submit bogus claims.

Seventeen people have been convicted so far—including at least a dozen U.S. military retirees—in a little-noticed investigation that has been handled by federal prosecutors out of Wisconsin because a Madison company holds the contract to process many of the claims. It has not been accused of any wrongdoing.

Health care providers in the Philippines filed claims for medical services never delivered, inflated claims by as much as 2,000 percent, and shared kickbacks with retirees who played along, court records show.

TRICARE paid $210.9 million in overseas claims in 2006, the latest year for which figures were available. At the height of the fraud in 2003, Pentagon officials say, two-thirds of the $61.8 million paid to Philippine providers—about $40 million—was fraudulent.

The fraud was so extensive that the number of claims filed in the Philippines skyrocketed nearly 2,000 percent between 1998 and 2003 even as the number of beneficiaries there—about 9,000 mostly retired military members and their families—remained constant.

A Pentagon audit in February 2008 warned that the TRICARE program is still vulnerable to rip-offs because of lax controls and that similar fraud schemes are starting to emerge in Latin America. A spokesman for TMA said the agency added numerous controls and is making every effort to stop fraud.

Data Safeguards and Protections

The TMA Privacy Office is committed to the protection of personally identifiable information (PII). Data breaches throughout the government and the private sector continue to require that increased diligence be applied to ensure that adequate safeguards are placed on the data entrusted to the MHS. TMA Privacy Office accomplished the following goals in FY 2008:

- The TMA Privacy Office was recognized as Health Information Industry Leaders and participated in the American Health Information Community (AHIC) Confidentiality, Security and Privacy (CPS) Workgroup meetings. This federal advisory commission panel advised the Department of Health and Human Services (HHS) Secretary on key considerations required to protect health information and promote the adoption of Health Information Technology (HIT) and Health Information Exchange (HIE).
- The MHS Defense Business Transformation (MHS DBT) worked closely with the TMA Privacy Office to ensure Privacy and Security integration using MHS DBT Investment Reviews. These reviews address protection of data privacy by ensuring MHS systems meet Privacy Standards before funding is granted.
- An active role was played by the TMA Privacy Office as part of the Federal Security Strategy Health Information Exchange (FSSHIE) in assessing privacy standards that could be used as a national standard for HIE.

NEW BENEFITS AND PROGRAMS LAUNCHED IN FY 2008 *(CONT'D)*

- The parameters of Data Use Agreements have been realigned more closely with Federal privacy standards, including the Health Insurance Portability and Accountability Act (HIPAA). This enhanced process addressed all forms of Data Sharing Agreements between agencies and business associates as well as provided additional guidelines for the proper protection of health data.
- The Incident Response Team and Breach Notification process was updated. Two Data Protection Seminars were hosted for TMA employees; these seminars included lectures, activities, and a breach response table top exercise based on the Incident Response and Breach Notification Standard Operating Procedure (SOP).
- The Privacy Act of 1974 and Health Insurance Portability and Accountability Act (HIPAA) of 1996 refresher training was updated to maintain the accuracy and applicability of the data while reducing duplicate information and preserving resources.
- Privacy Impact Assessments (PIAs) were analyzed to improve the processes surrounding data sharing outside of the organization and between information systems met appropriate standards. Other initiatives included contributing to the DoD Workgroup focused on the reduction of the use of Social Security numbers throughout the Department.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2009*

Total Beneficiaries	9.3 million**
Military Facilities—Direct Care System	
Inpatient Hospitals and Medical Centers	59 (45 in U.S.)
Ambulatory Medical Clinics	376 (297 in U.S.)
Dental Clinics	285 (218 in U.S.)
Veterinary Facilities	258 (238 in U.S.)
Military Health System Personnel	131,716
Military	80,364 30,272 Officers 50,092 Enlisted
Civilian	51,352
Civilian Resources:	
Participating Primary Care and Specialty Providers (filing claims, estimated)	Over 350,000
TRICARE-authorized Acute Care Hospitals	Approximately 3,800
TRICARE Network Acute Care Hospitals	Approximately 1,700
Contracted Retail Pharmacies	55,000
Contracted Worldwide Pharmacy Mail Order Vendor	1
TRICARE Dental Program	Over 760,000 contracts
TRICARE Retiree Dental Program	Over 519,000 contracts
Total Unified Medical Program (UMP)	$44.8 billion***
(Includes estimated FY 2009 receipts for Accrual Fund)	$10.4 billion****

* Note: Unless specified otherwise, this report presents budgetary, utilization and cost data for the DHP UMP only, not those related to deployment.

** DoD health care beneficiary population projected for the end of FY 2009 is 9,252,719 (rounded to 9.3 million) based on the Managed Care Forecasting and Analysis System (MCFAS) as of January 5, 2009.

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

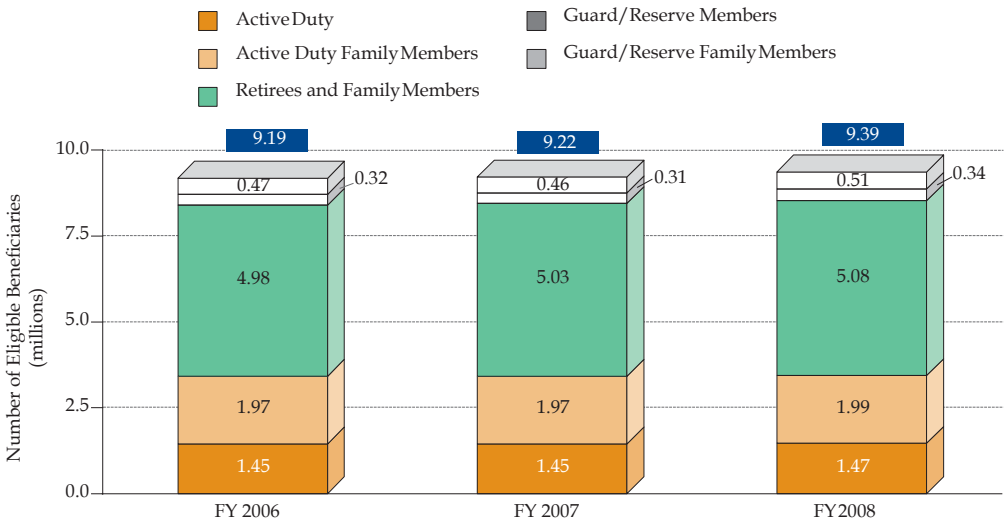
**** The DoD (MERHCF), implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retired, dependent of retired, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TFL benefit first implemented in FY 2002. There are three forms of contribution to Defense health care: (1) The accrual fund ($10.4B, normal costs contribution) discussed above is paid by the military Services for future health care liability accrued since October 1, 2002, for Active Duty, Guard, and Reserve beneficiaries and their family members when they become retired and Medicare-eligible; (2) $10.7B is paid by the Treasury to fund future health care liability accrued prior to October 1, 2001, for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) $8.7B to pay for health care benefits provided today to current Medicare-eligible retirees, family members, and survivors (i.e., actual projected outlays from the trust fund—$7B for purchased care, $1.7B for direct (MTF) care, (both Operations and Maintenance as well as Military Personnel costs).

BENEFICIARY TRENDS AND DEMOGRAPHICS

Number of Eligible and Enrolled Beneficiaries Between FY 2006 and FY 2008

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select) increased from 9.19 million at the end of FY 2006 to 9.39 million* at the end of FY 2008. There were increases for all beneficiary groups, but the largest increase was for retirees, particularly those age 65 and older.

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

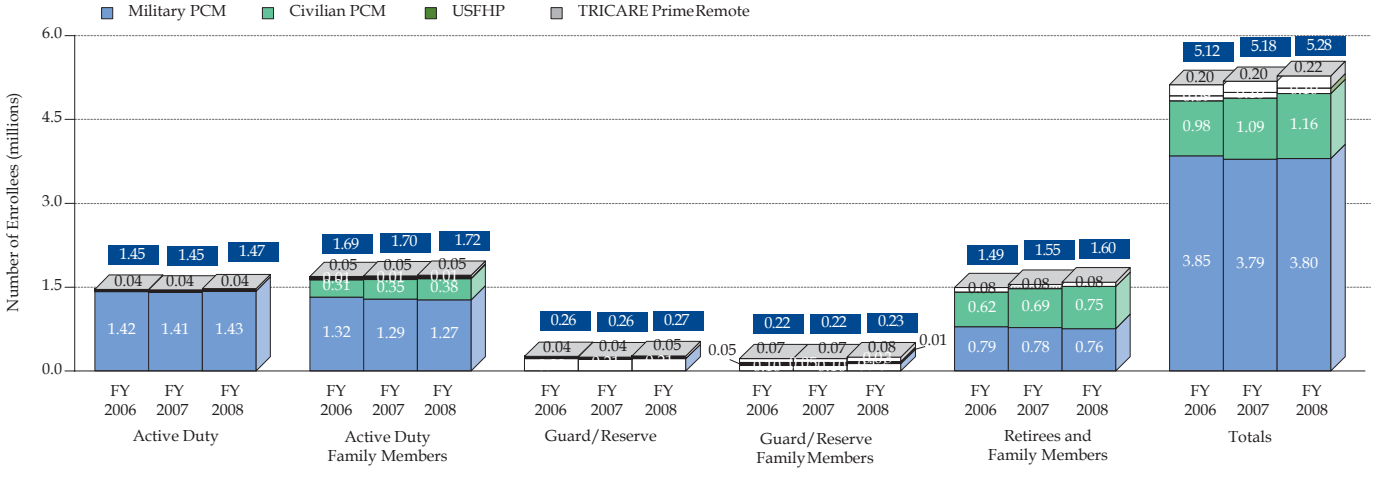


Source: DEERS 12/11/2008

* This number should not be confused with the one displayed under TRICARE FACTS AND FIGURES on page 19. The population figure on page 19 is a projected FY 2009 total, whereas the population reported on this page is the actual for the end of FY 2008.

- As MTF capacity remained tight as a result of the mobilization of Guard/Reserve members, more enrollees (especially retirees) were assigned to civilian PCMs.
- Both TRICARE Prime Remote (including TGRO) and USFHP enrollment remained essentially constant from FY 2006 to FY 2008.

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



Source: DEERS 12/11/2008

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

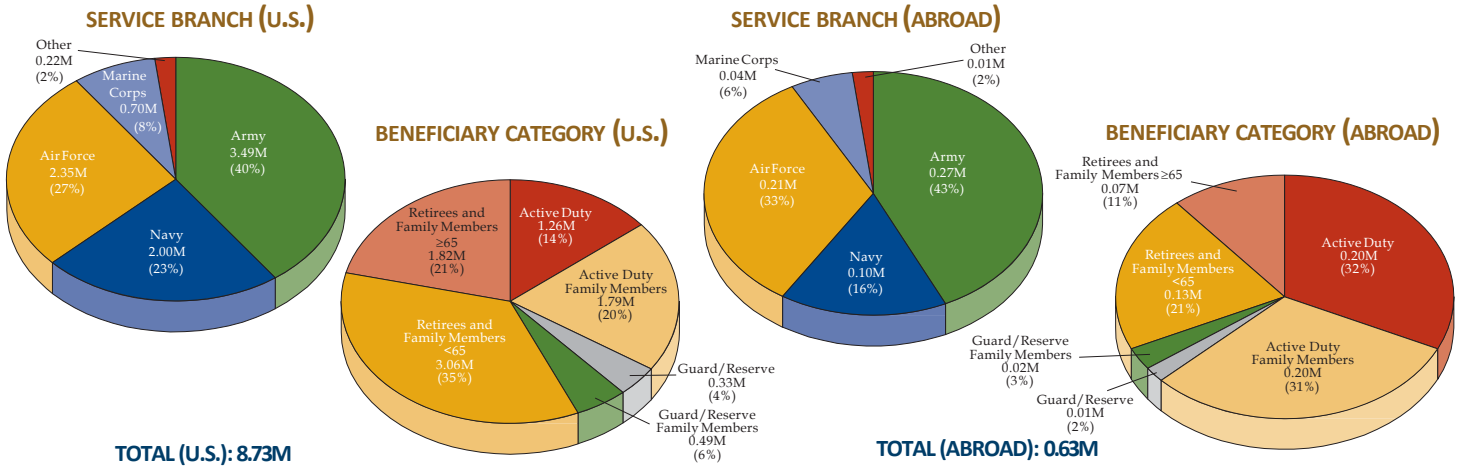
Eligible Beneficiaries in FY 2008

Of the 9.39 million eligible beneficiaries at the end of FY 2008, 8.76 million (93 percent) are stationed or reside in the U.S. and 0.64 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 (56 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component members on Active Duty for at least 30 days) and their family members comprise the largest percentage (68 percent) of the eligible population abroad.

Mirroring trends in the civilian population, the MHS will be confronted with an aging beneficiary population.

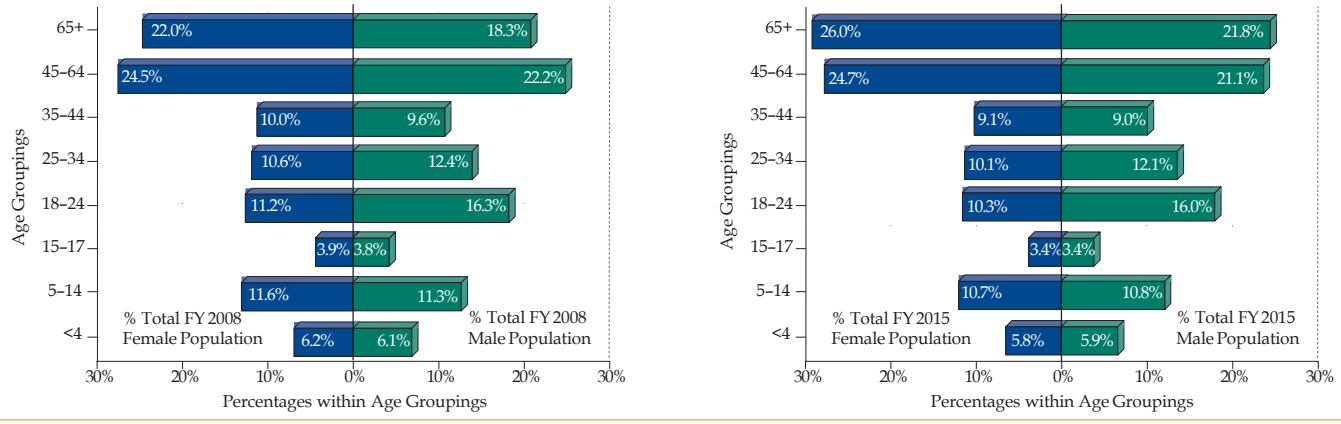
BENEFICIARIES ELIGIBLE FOR DOD HEALTH CARE BENEFITS AT THE END OF FY 2008



Source: DEERS, 12/11/2008

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

MHS END-YEAR POPULATION BY AGE AND GENDER, FY 2008 AND FY 2015



TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: CURRENT FY 2008 AND PROJECTED FY 2015

	Age Group								Total by Gender	Total MHS Population
	<4	5–14	15–17	18–24	25–34	35–44	45–64	65+		
FY 2008 Female MHS Beneficiaries	0.28	0.53	0.18	0.51	0.48	0.46	1.12	1.00	4.55	9.39
FY 2008 Male MHS Beneficiaries	0.29	0.55	0.18	0.79	0.60	0.47	1.07	0.89	4.83	9.39
FY 2015 Female MHS Beneficiaries, Projected	0.26	0.48	0.15	0.46	0.45	0.40	1.10	1.16	4.46	9.05
FY 2015 Male MHS Beneficiaries, Projected	0.27	0.49	0.16	0.73	0.56	0.41	0.97	1.00	4.59	9.05

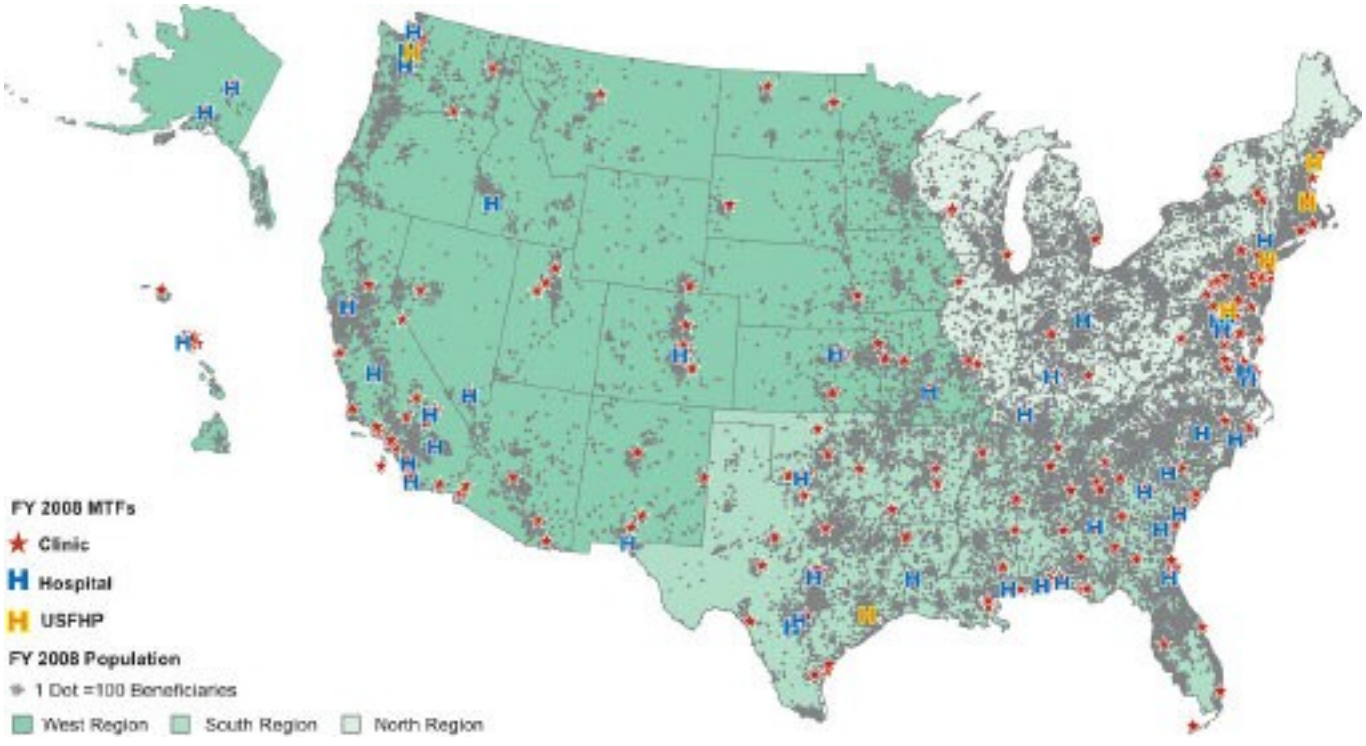
Source: MCFAS, as of 10/28/2008

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Locations of U.S. MTFs (Hospitals and Ambulatory Care Clinics) in FY 2008

The map to the right presents the geographic diversity of that proportion of the MHS beneficiary population residing within the United States (93 percent of more than 9 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 has access to direct care.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs IN FY 2008



Source: MTF information from TMA Portfolio Planning Management Division; residential population and Geographic Information Systems information from TMA/Health Program Analysis and Evaluation 11/26/2008

MTFs OUTSIDE THE U.S.

Source: MTF information from TMA Portfolio Planning Management Division; residential population and GIS information from TMA/HPA&E, 11/26/2008

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

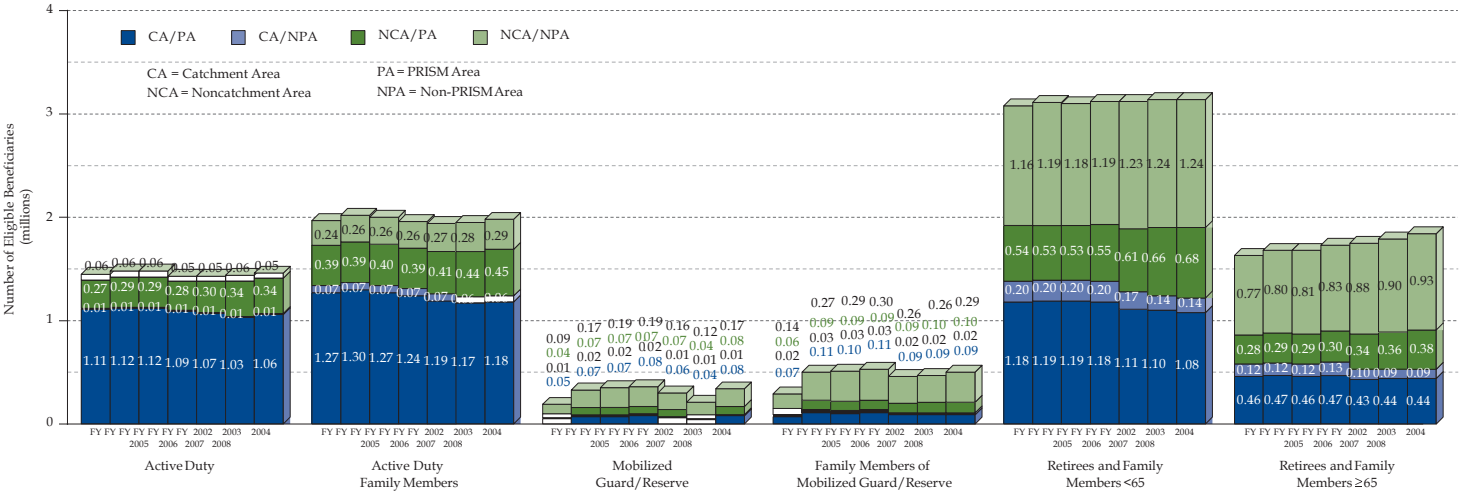
Eligible Beneficiaries Living in Catchment and PRISM Areas

Historically, military hospitals have been defined by two geographic boundaries or market areas: a 40-mile catchment area boundary for inpatient and referral care and a 20-mile 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] Non-catchment and non-PRISM areas lie outside catchment area and PRISM area boundaries, respectively.

Because of Base Realignment and Closure (BRAC) actions, other facility closings and downsizings, and changes in the beneficiary mix over time, there has been a downward trend in the proportion of beneficiaries living in catchment areas (from 53 percent in FY 2002 to 46 percent in FY 2008) and PRISM areas (from 67 percent in FY 2002 to 64 percent in FY 2008). These population trends partially explain the shift in MHS workload from direct care to purchased care facilities in the FYs 2002–2008 time frame.

- 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.
- There has been a steady increase in the number of beneficiaries living in non-catchment PRISM areas.
- The mobilizations of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in non-catchment areas. Most Guard/Reserve members already live in non-catchment 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, 12/11/2008

[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.

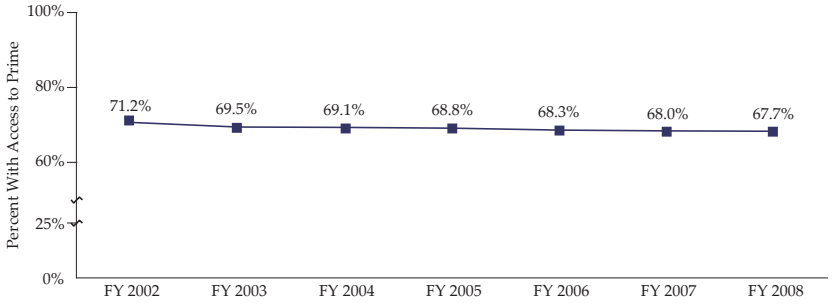
BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Beneficiary Access toPrime

Non-Active Duty beneficiaries living in neither a catchment nor a PRISM area have limited or no access to MTF-based Prime.

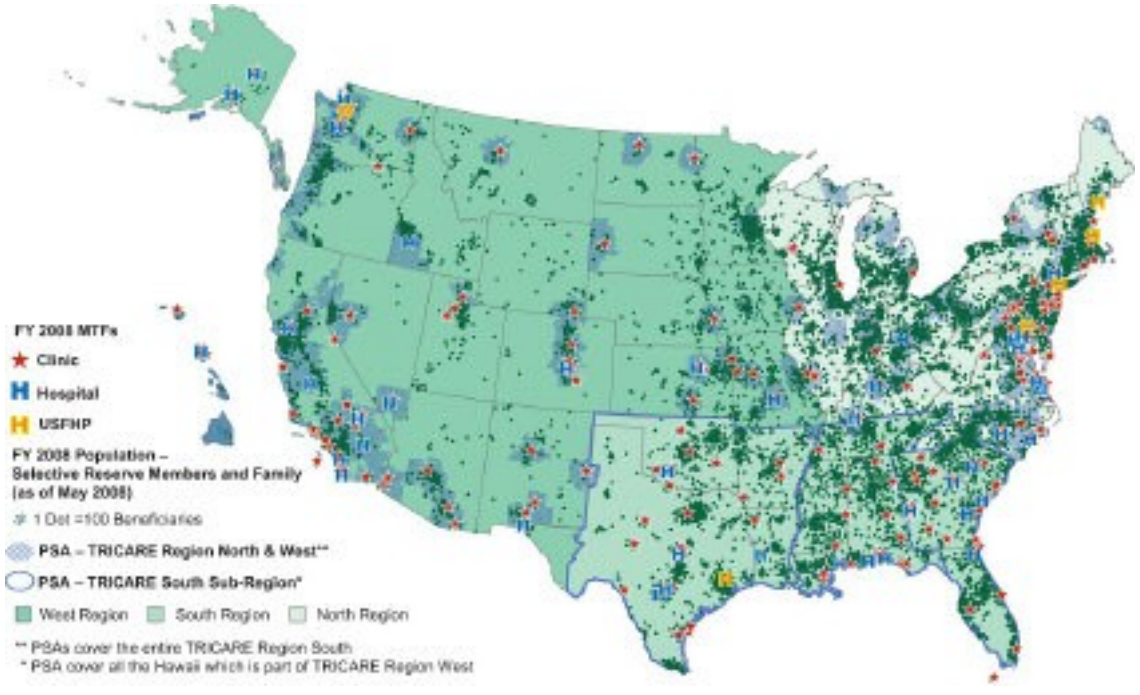
- The number of beneficiaries with access to MTF-based Prime (i.e., those living in a catchment or PRISM area) declined from 71 percent of the eligible non-Active Duty population (ADFMs and retirees and family members under age 65) in FY 2002 to 68 percent in FY 2008. The decline is largely due to the closings of military hospitals and clinics over that time period.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 12/11/2008

- Prime Service Areas (PSAs) are those geographic areas where the TRICARE managed care support contractors (MCSCs) offer the TRICARE Prime benefit through established networks of providers. TRICARE Prime is available at MTFs, in areas around most MTFs ("MTF PSAs"), in a number of areas where an MTF was eliminated in the Base Realignment and Closure (BRAC) process ("BRAC PSAs"), and in some other areas where the MCSCs proposed in their contract bids to offer the benefit ("non-catchment PSAs"). The map below shows the non-catchment PSAs. Note that in the TRICARE South Region the MCSC has identified as a non-catchment PSAall portions of the region that lie outside MTF and BRACPSAs.



Source: TRICARE Regional Office, 2/7/2008

Note: See previous page: 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.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

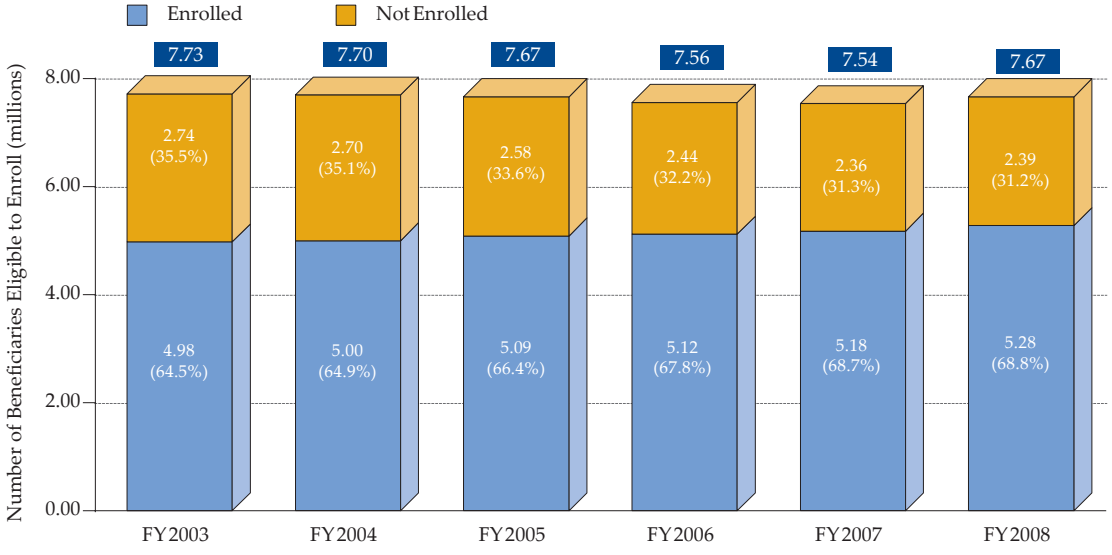
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from 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 older but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

Beneficiaries enrolled in TRICARE Prime Remote (including Global Remote) and the Uniformed Services Family Health Plan are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program 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, and as a percentage of those eligible to enroll, TRICARE Prime enrollment has steadily increased since FY 2003.
- After peaking in FY 2005, the number of TRICARE Plus enrollees declined slightly in FY 2006 and again in FYs 2007 and 2008 (not shown). The drop is likely due to reduced capacity for TRICARE Plus enrollment at many MTFs.
- By the end of FY 2008, 69 percent of all eligible beneficiaries were enrolled in Prime (5.28 million enrolled of the 7.67 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 12/11/2008

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

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

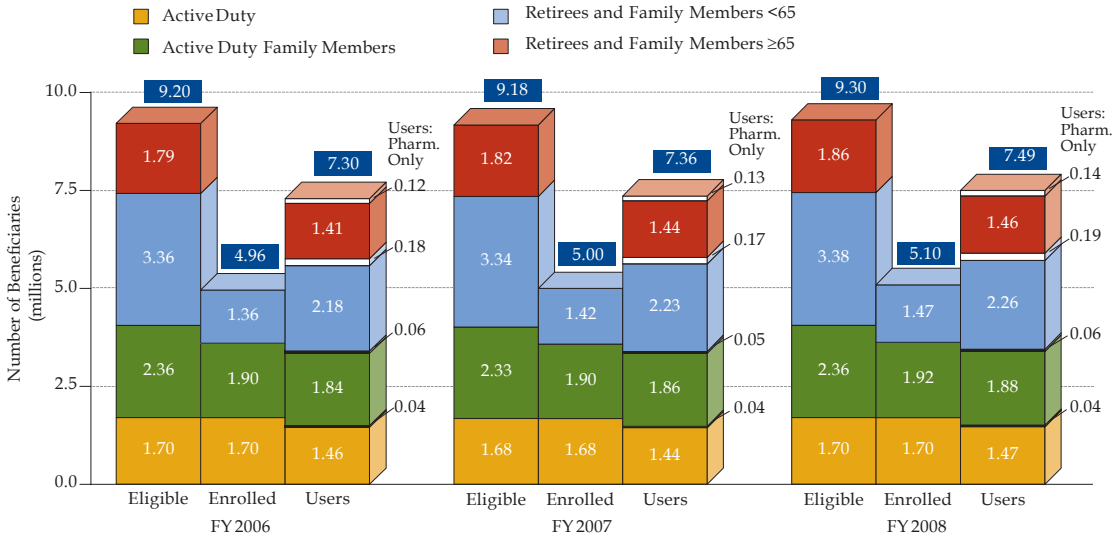
Recent Three-year Trend in Eligibles, Enrollees, Users

When calculating the number of beneficiaries eligible to use MHS services, average beneficiary counts are more relevant than end-year counts because total utilization is generated by beneficiaries eligible for any part of the year. The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2006 to FY 2008 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.

- With the exception of retirees and family members age 65 and older, the number of eligible beneficiaries changed very little between FY 2006 and FY 2008. The number of retirees and family members age 65 and older experienced an increase of 4 percent.
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased from 41 percent in FY 2006 to 44 percent in FY 2008. 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 79.3 percent in FY 2006 to 80.6 percent in FY 2008. The user rate remained about the same for all beneficiaries except retirees and family members under age 65, whose user rate increased from 70.2 to 72.6 percent.
- Retirees and family members under age 65 have the greatest number of users of the MHS but the lowest user rate. Their MHS utilization rate is lower because many of them have other health insurance.

AVERAGE NUMBER OF FY 2006 TO FY 2008 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY

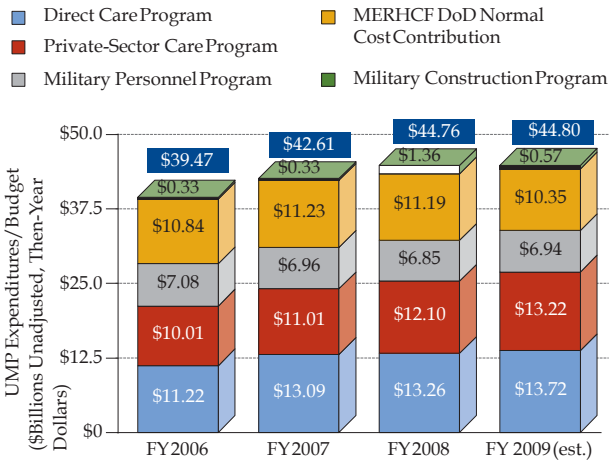


Sources: DEERS and MHS administrative data, 12/11/2008

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

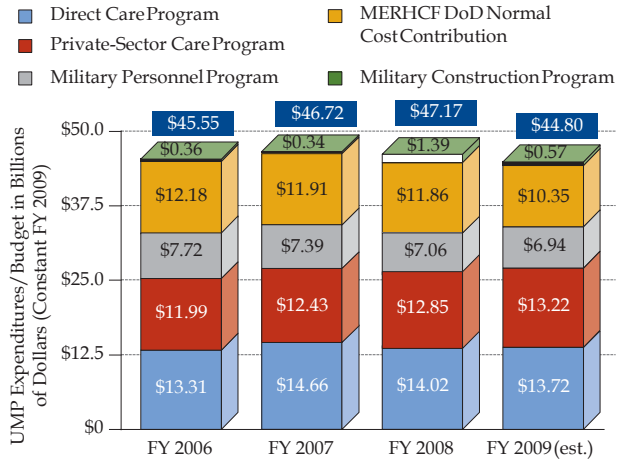
UNIFIED MEDICAL PROGRAM FUNDING

FY 2006 TO FY 2009 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) (UNADJUSTED, THEN-YEAR DOLLARS)



As shown in the first chart to the left, in terms of unadjusted expenditures (i.e., "then-year" dollars, unadjusted for inflation), the UMP increased from over $39 billion in FY 2006 to over $44 billion in FY 2008, and is currently programmed for about $45 billion (estimated) in FY 2009 (as reflected in the President's Budget Estimates). The FY 2006 to FY 2009 funding and programmed budget shown includes the normal DoD cost contribution to the MERHCF (the "Accrual Fund"). This fund (effective October 1, 2002) pays the cost of DoD health care programs 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 TFL benefit, which began in October 2001.

FY 2006 TO FY 2009 (EST.) UNIFIED MEDICAL PROGRAM ($ BILLIONS) IN CONSTANT FY 2009 DOLLARS



In constant-year FY 2009 dollar funding, when actual expenditures or projected funding are adjusted for inflation, the FY 2008 purchasing value ($47.2 billion) is slightly more than the FY 2006 purchasing value ($45.6 billion). In constant FY 2009 dollars, the FY 2009 budgeted value of $44.8 billion is currently programmed to be 4 percent less than the FY 2007 purchasing value of $46.7 billion.

Source: Cost and Budget Estimates OASD(HA)/OCFO as of 1/30/2009. Note:

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

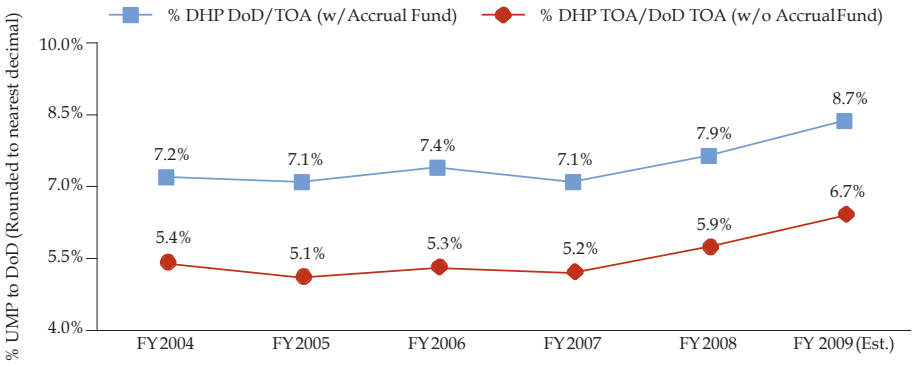
1. FYs 2006–2007 reflect Comptroller Information System Actual execution.
2. FYs 2008–2015 reflect the FY 2009 DHP POM submission.
3. Source of data for deflators (MILPERS, DHP, Procurement, RDT&E and MILCON) is Tables 5-4/5-5, Department of Defense Deflators--TOA, National Defense Budget Estimates for FY 2009 (Green Book).
4. Deflators for FY 2014 and FY 2015 use a factor of 1.000.
5. Medicare Eligible Retiree Healthcare Fund Deflator computed using a combination of MILPERS and DHP factors.
6. TRICARE for Life and other NDAA enhancements commenced in FY 2002, resulting in an approximate $4 billion increase.
7. TRICARE for Life reached maturation in FY 2003.
8. 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.
9. 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.
10. FY 2006 Actuals include supplementals supporting GWOT ($1,110.8M), Hurricane Relief ($208.1M), Avian Flu ($120M), and Army Modularity ($42.8M).
11. FY 2007 Actuals include supplementals ($2,528M) supporting GWOT and other programs such as TBI/PH, Wounded Warrior and Pandemic Influenza.

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 8.7 percent estimated for FY 2009, including the Accrual Fund (as currently reflected in the FYs 2008–2015 President's Budget Request). When the Accrual Fund is excluded, the UMP's share is expected to increase from 5.4 percent in FY 2004 to 6.7 percent in FY 2009.

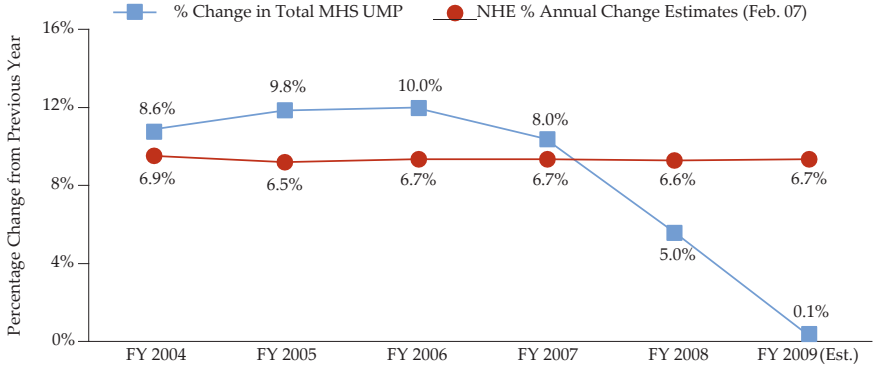
UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2004 TO FY 2009 (EST.)



Comparison of Unified Medical Program and National Health Expenditures Over Time

The estimated rate of growth in the U.S. Department of Health and Human Services (DHHS) estimates of National Health Expenditures (NHE) has been stable at about 7 percent since FY 2004. The annual rate of growth in the UMP has exceeded the rate of growth in NHE for the past four years but appears to be narrowing by FY 2007 (actual for the UMP, estimated for NHE). Growth in actual funding from FY 2007 to 2008 declined to under 2 percent, and, as currently programmed, the FY 2009 budget is 0.1 percent above the actual FY 2007 and 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, disaster relief, and pandemic influenza.

COMPARISON OF CHANGE IN ANNUAL UMP AND NHE OVER TIME: FY 2004 TO FY 2009 (EST.)



National Health Expenditures based on Dept. of Health and Human Services estimates are from Posal, J.A., Truffer, C. et al. (2007), "Health spending projects through 2016: Modest changes obscure Part D's impact, Exhibit 1," "National Health Expenditures (NHE), Selected Calendar years 1993–2016," and associated Web-based table, DOI 10.1377 /hlthaff.262.w242. Full table obtained October 22, 2008 from *http://www.cms.hhs.gov/NationalHealthExpendData/03_NationalHealthAccountsProjected.asp*. Actual expenditures (in $ billions): 2002 ($1,603.4), 2003 ($1,732.4), 2004 ($1,852.3), 2005 ($1,973.3), 2006 ($2,105.5); projected expenditures: 2007 ($2,245.6), 2008 ($2,394.3), 2009 ($2,555.1).

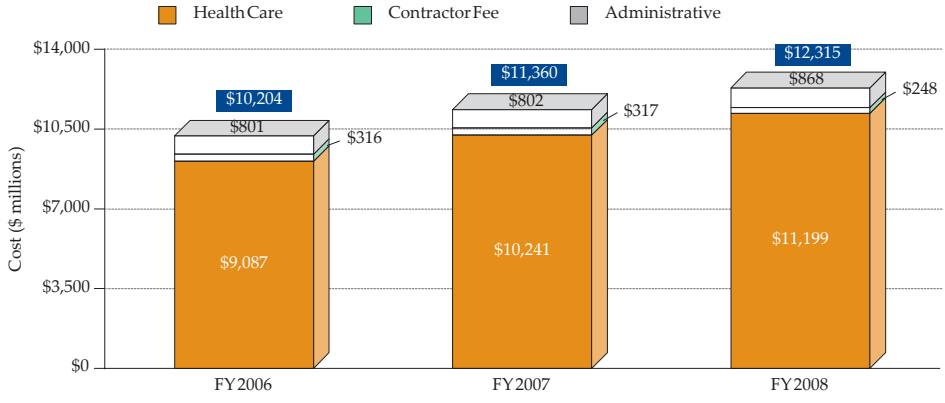
Source: Cost and Budget Estimates OASD(HA)/OCFO as of 01/30/2009.

PRIVATE SECTOR CARE ADMINISTRATIVE COSTS

The private sector care budget activity group includes underwritten health care, pharmacy, active duty supplemental care, dental care, overseas care, the health care portion of USFHP capitation, funds received and executed for the Global War on Terrorism, funds authorized and executed under the DHP carry-over authority, and other miscellaneous expenses. It excludes costs for non-DoD beneficiaries and MERHCF expenses.

- Total private sector care costs increased from $10,204 million in FY 2006 to $12,315 million in FY 2008, an increase of 21 percent.
- Excluding contractor fee, administrative expenses declined from 8.1 percent of total private sector care costs in FY 2006 to 7.2 percent in FY 2008. Including contractor fee, administrative expenses declined from 10.9 percent to 9.1 percent of total private sector care costs.

TREND IN PRIVATE SECTOR CARE COSTS



Source: TRICARE Management Activity, Office of the Chief Financial Officer, Private Sector Care Requirements Office budget data execution and methodology.

Note: The FY 2006 and FY 2007 totals in the chart above are greater than the Private Sector Care Program costs shown in the top chart on page 26 because the former include carryover funding. TMA had authority to carry over 2 percent of its funding into the next year in addition to the appropriated funds for FY 2006 and FY 2007.

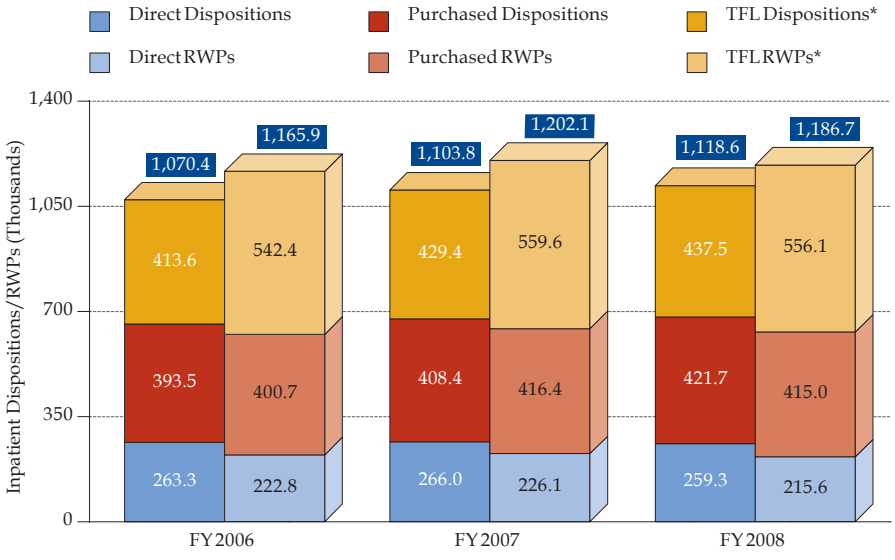
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: As the number of inpatient dispositions and as the number of relative weighted products (RWPs). The latter measure, relevant only for acute care hospitals, reflects the relative resources consumed by a hospitalization as compared with the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. Total inpatient workload (direct and purchased care combined) increased between FY 2006 and FY 2008 (dispositions increased by 4 percent and RWPs by 1 percent), excluding the effect of TFL.

- Direct care inpatient dispositions declined by 1 percent and RWPs declined by 3 percent over the past three years. This can be largely attributed to a 10 percent decline in the number of MTFs performing inpatient workload over this period.
- Excluding TFL workload, purchased care inpatient dispositions increased by 7 percent and RWPs by 3 percent from FY 2006 to FY 2008.
- Including TFL workload, purchased care dispositions increased by 5 percent and RWPs by 1 percent between FY 2006 and FY 2008.
- While not shown, about 12 percent of direct care inpatient dispositions and 11 percent of RWPs were performed abroad during FYs 2006–2008. Purchased care and TFL inpatient workload performed abroad accounted for less than 4 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/6/2009

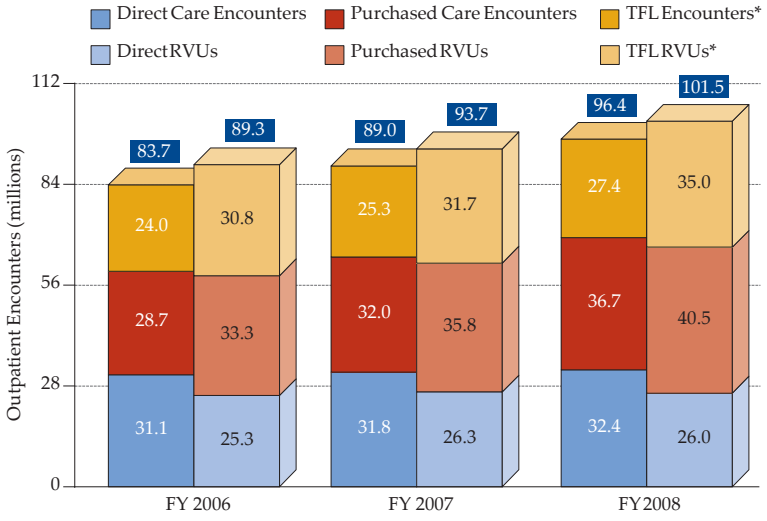
* Purchased care only

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

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: As the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). The latter measure reflects the relative resources consumed by an encounter as compared with the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2006 and FY 2008 (encounters increased by 15 percent and RVUs by 13 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/6/2009

* Purchased care only.

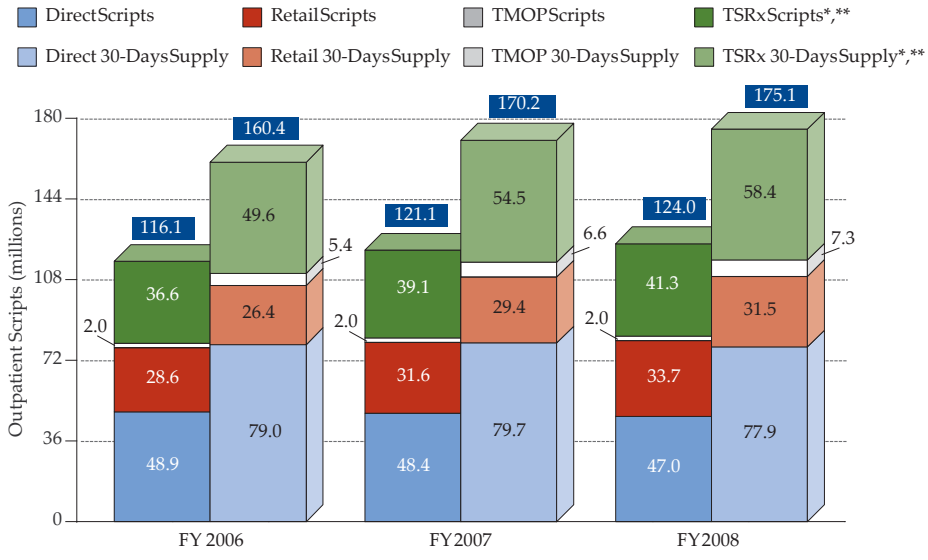
- Direct care outpatient encounters increased by 4 percent and RVUs by 3 percent over the past three years, despite a slight decrease in the number of MTFs performing outpatient workload.
- Excluding TFL workload, purchased care outpatient encounters increased by 26 percent and RVUs by 20 percent. Including TFL workload, encounters increased by 21 percent and RVUs by 16 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.

Note: The Centers for Medicare and Medicaid Services (CMS) recently completed a quintennial study of payment policies for professional services that resulted in a "re-baselining" of RVUs. Consequently, part of any observed changes in FYs 2007 and 2008 RVUs are artificial and can be attributed directly to the change in weights and not necessarily volume or complexity of services. FYs 2007 and 2008 RVUs were therefore adjusted to reflect the FY 2006 RVU weights.

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 (in 30-day increments). Total prescription drug workload (direct and purchased care combined) increased between FY 2006 and FY 2008 (both scripts and days supply increased by 5 percent), excluding the effect of TRICARE Senior Pharmacy.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/6/2009

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

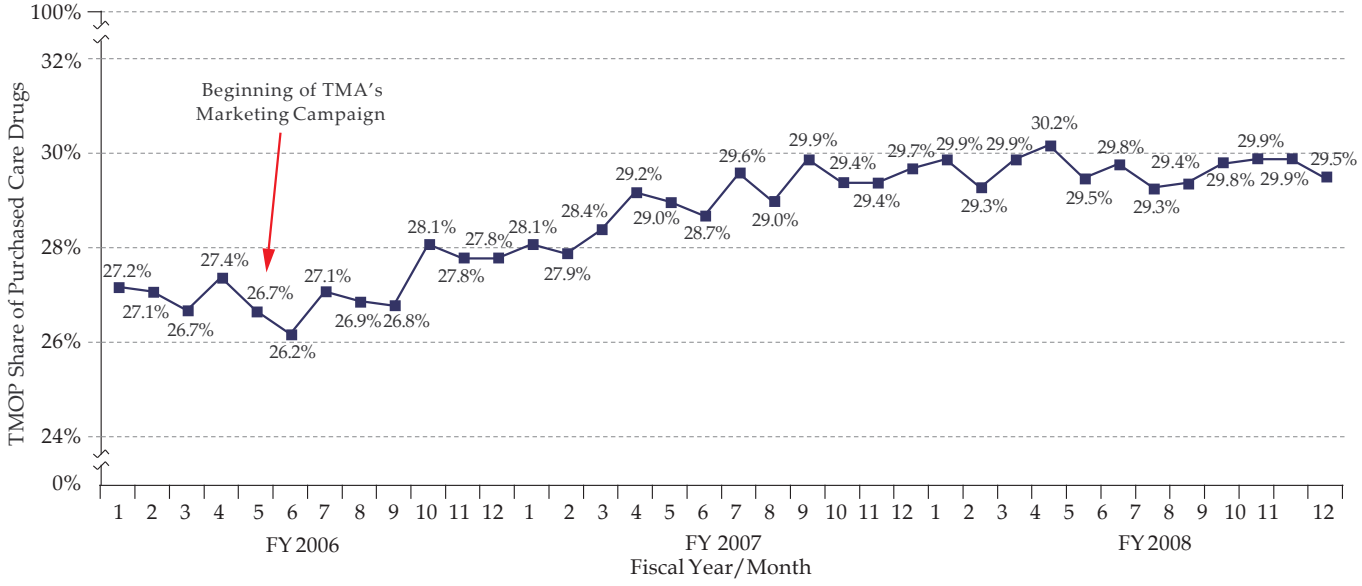
** Purchased care only.

- Direct care scripts fell by 4 percent and days supply fell by 1 percent between FY 2006 and FY 2008.
- Purchased care scripts increased by 20 percent and days supply by 23 percent from FY 2006 to FY 2008, excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased scripts increased by 16 percent and days supply by 20 percent.
- While not shown, more than 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for slightly more than 1 percent of the worldwide total.

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

Although the TRICARE Mail Order Pharmacy (TMOP) and its predecessor, the National Mail Order Pharmacy, have been available to DoD beneficiaries since the late '90s, they have never been heavily used. TMOP offers benefits to both DoD and its beneficiaries since DoD negotiates prices that are considerably lower than those for retail drugs, and the beneficiary receives up to a 90-day supply for the same copay as a 30-day supply at a retail pharmacy. Concerned that beneficiaries were not taking advantage of a good benefit, DoD launched a marketing campaign in February 2006 to increase beneficiary awareness of the benefits offered by the TMOP.

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



Source: MHS administrative data, 1/6/2009

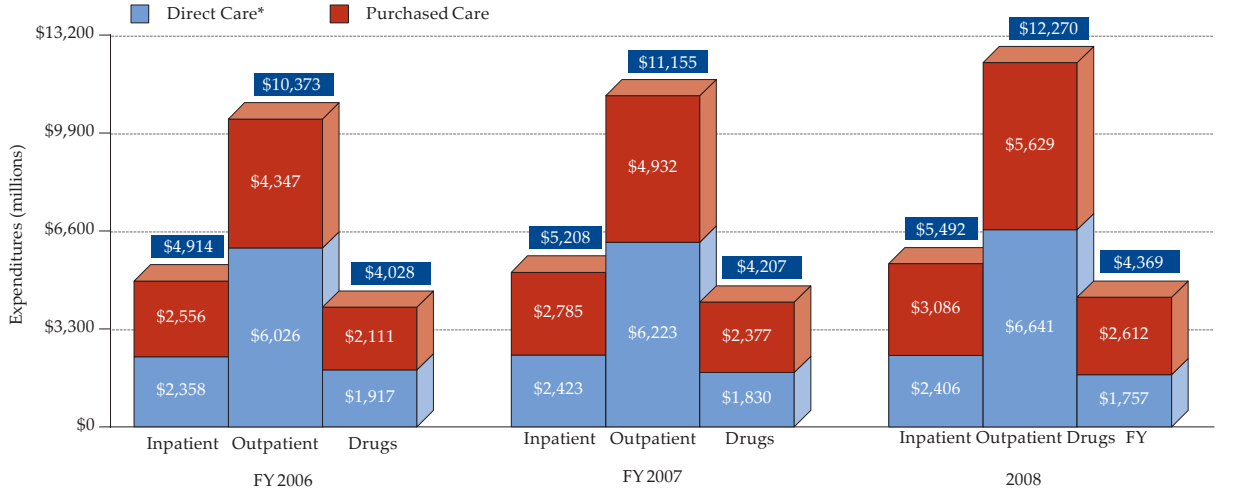
From the inception of the TMA marketing campaign through the end of FY 2007, the TMOP share of total purchased care utilization had been steadily increasing. However, the TMOP share of total purchased care utilization barely increased from an average of 29.0 percent in FY 2007 to an average of 29.7 percent in FY 2008.

MHS COST TRENDS

Total MHS costs (net of TFL) increased between FY 2006 and FY 2008 for all three major components of health care services: Inpatient, outpatient, and prescription drugs. The proportion of total MHS costs accounted for by each health care service type remained about the same.

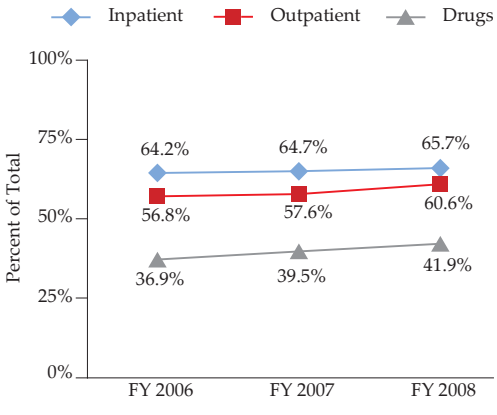
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 68–69 percent from FY 2006 to FY 2008. For example, in FY 2008, DoD expenses for inpatient and outpatient care totaled $17,761 million, of which $12,270 million was for outpatient care for a ratio of $12,270/$17,761 = 69 percent.
- In FY 2008, DoD spent $2.23 on outpatient care for every $1 spent on inpatient care.
- The proportion of total expenses for care provided in DoD facilities fell from 53 percent in FY 2006 to 49 percent in FY 2008.

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

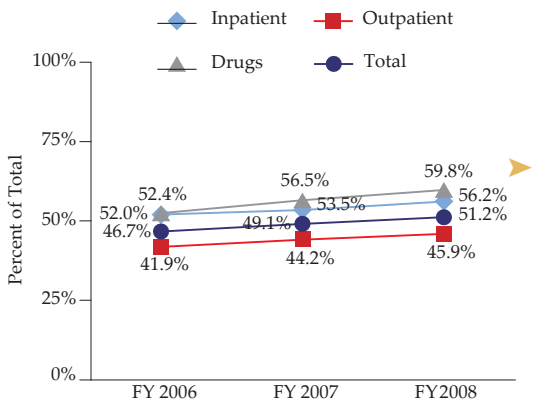


Source: MHS administrative data, 1/6/2009
* Direct care prescription costs include an MHS-derived dispensing fee.

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, 1/6/2009
Note: TFL purchased care costs are excluded from the above calculations.

- The purchased care share of total inpatient utilization increased from from 64 percent in FY 2006 to 66 percent in FY 2008. The purchased care share of outpatient utilization increased from 57 to 61 percent. The purchased care share of total drug utilization showed the largest increase, from 37 to 42 percent.
- The purchased care share of total MHS inpatient costs increased from 52 percent in FY 2006 to 56 percent in FY 2008. For outpatient costs, the purchased care share increased from 42 to 46 percent. Of all the medical services, prescription drugs exhibited the steepest increase in the purchased care share, from 52 to 60 percent.

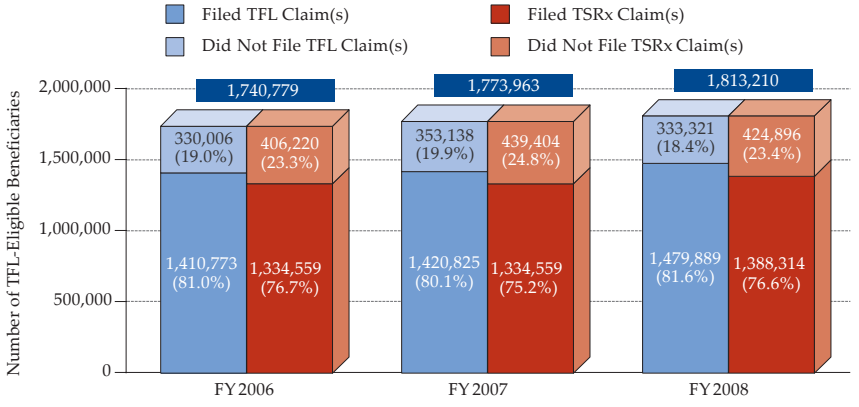
IMPACT OF TRICARE FOR LIFE (TFL) IN FYs 2006–2008

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.

TFL and TSRx Beneficiaries Filing Claims

- The number of Medicare-eligible beneficiaries grew from 1.90 million at the end of FY 2006 to 1.97 million at the end of FY 2008.
  - The percentage eligible for TFL remained about the same from FY 2006 to FY 2008. At the end of FY 2008, about 90 percent (1.77 million) were eligible for the TFL and TSRx benefits, whereas the remainder were ineligible for TFL either because they did not have Medicare Part B coverage or they were under age 65.

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2006 TO FY 2008



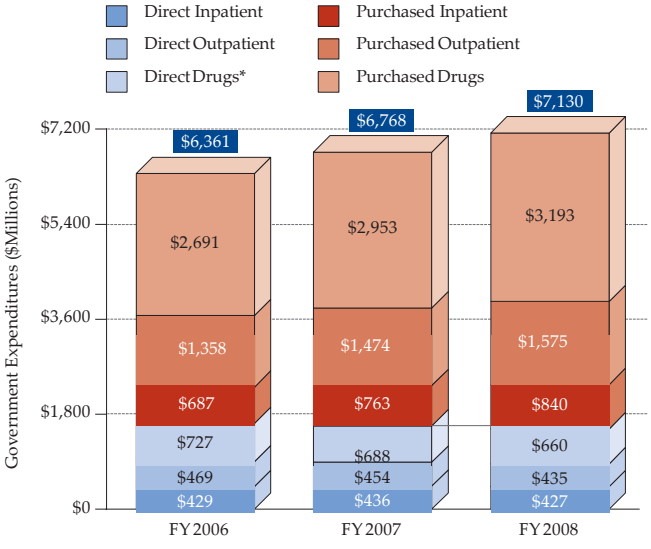
Source: MHS administrative data, 1/6/2009

- The percentage of TFL-eligible beneficiaries who filed at least one claim remained about 81 percent between FY 2006 and FY 2008.
  - 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 remained at about 77 percent between FY 2006 and FY 2008.

MERHCF Expenditures for Medicare-Eligible Beneficiaries

The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL/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 $6,361 million in FY 2006 to $7,130 million in FY 2008 (12 percent).

MERHCF EXPENDITURES IN FY 2006 TO FY 2008 BY TYPE OF SERVICE

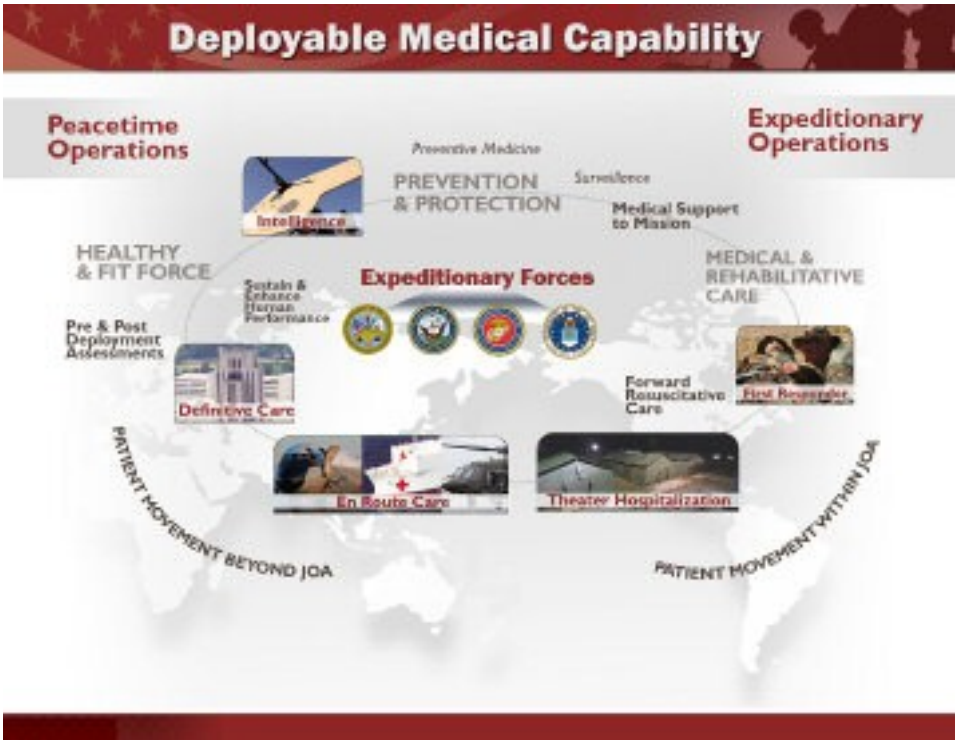


Source: MHS administrative data, 1/6/2009
* Direct care prescription costs include an MHS-derived dispensing fee.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries declined by 6 percent from FY 2006 to FY 2008. The most notable decline was in direct drug expenses (9 percent).
  - From FY 2006 to FY 2008, TRICARE Plus enrollees accounted for 67–68 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 50 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FYs 2006–2008.
- Purchased care TFL expenditures increased from FY 2006 to FY 2008 for inpatient, outpatient, and prescription drugs. The most dramatic increase was for inpatient services, where DoD costs increased by 22 percent in only two years.

DEPLOYABLE MEDICAL CAPABILITY

To meet the needs of operational commanders, we must be able to deploy anytime, anywhere, with flexibility, interoperability, and agility. This capability is dependent on globally accessible health information and rapid development and deployment of innovative medical services and products. Since we support the full range of military operations, we must be ready to assist in civil support and homeland defense operations such as disaster relief and management of pandemic flu.



MHS efforts will ensure future medical support is fully aligned with joint force health protection, and enable rapid response to the needs of a changing national security environment. Current military strategies mandate that the medical force structure be joint, agile, and interoperable to ensure optimal responsiveness in diverse operations.

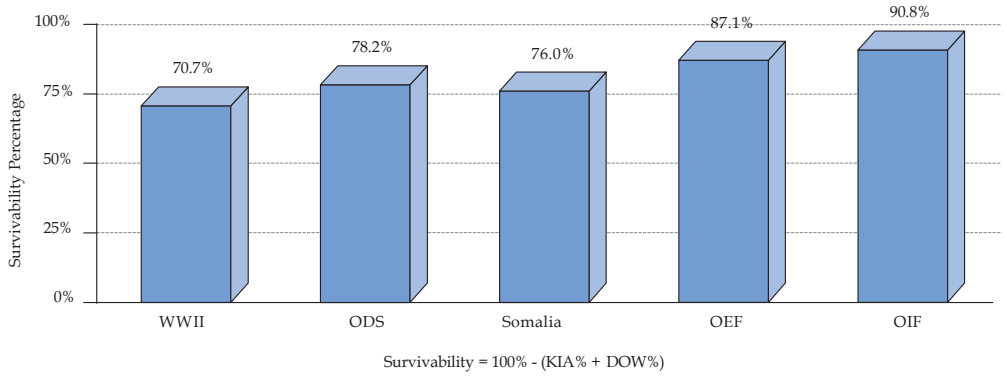
Components of our deployable medical capability include:

- **First Responder Care** is the ability to provide initial medical care at or near the point of injury by the individual, medical, and/or non-medical personnel. This may include preparing the casualty for transportation to the next medical capability as required.
- **Essential Care (Forward Resuscitative Care)** is the ability to provide capabilities required by medical personnel to salvage life, limb, or eyesight and to relieve pain.
- **Definitive Care In-Theater (Theater Hospitalization)** is the ability to provide capabilities required by medical personnel to repair, restore, stabilize, or rehabilitate casualties within the theater. These include preparation for strategic transport, return to duty, or processes for rehabilitation, as appropriate. This includes the utilization of telemedicine in this setting as a force multiplier.
- **En Route Care** is the ability to provide a systematic evacuation capability of critically injured/ill patients accompanied by trained medical providers from one medical capability level to another.
- **Patient Movement Within a Joint Operational Area (JOA) (Intra-Theater)** is the ability to conduct the efficient joint movement of patients to appropriate levels of care. Effective patient regulation and transport ensures that troops receive definitive care quickly and at the appropriate level. Those troops with less severe injuries/conditions are returned to duty in minimal time, while those with injuries or illnesses exceeding local capabilities are safely transported to higher levels of care, thus reducing mortality rates and setting the stage for the best possible long-term outcome, i.e., final level of function.

DEPLOYABLE MEDICAL CAPABILITY *(CONT'D)*

➤ Rapid evacuation by air has been an important factor in increasing survivability. Additional factors include: Body Armor, Far forward Resuscitative Surgical Care, Enhanced Trauma skills of the 91W Combat Medic, Combat Life Savers, Tourniquets, Quick Clot Bandages, Combat Medical Simulation Centers and the Deployable Medical Systems.

TRANSFORMING COMBAT SURVIVABILITY



Source: OASD(HA)/TMA received 12/16/2008

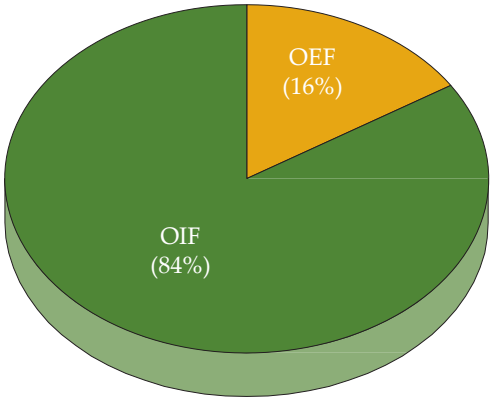
Note: KIA= Killed In Action, DOW = Died of Wounds

➤ **Patient Movement Outside of a JOA (Inter-Theater)** is the ability to conduct effective coordination and movement from a JOA to an appropriate definitive care facility (with en route care provided). Critical patients must be rapidly identified for replacement in the JOA. These processes allow commanders to project forces more accurately and maintain maximum troop strength where needed.

➤ Patients transported via aeromedical evacuation out of operational theaters included the following, and, as shown in the pie chart, those transported out of the Operation Iraqi Freedom represent the majority of patient movement:

- Operation Enduring Freedom (OEF)
  - Afghanistan
  - Philippines
  - Horn of Africa
  - Trans Sahara
  - Pankisi Gorge (Rep. of Georgia)
- Operation Iraqi Freedom (OIF)
  - Includes some areas outside Iraq, such as Kuwait

MEDICAL AIR TRANSPORTS (MAT) BY THEATER OF OPERATION

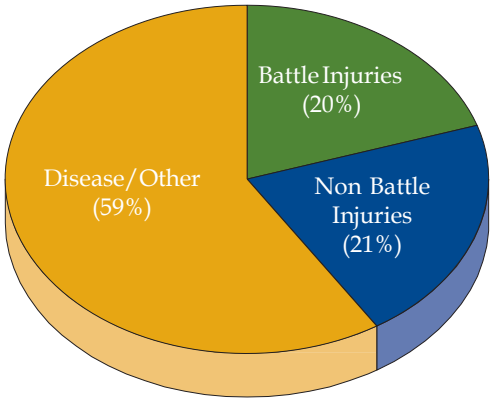


Source: U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of November 18, 2008

DEPLOYABLE MEDICAL CAPABILITY *(CONT'D)*

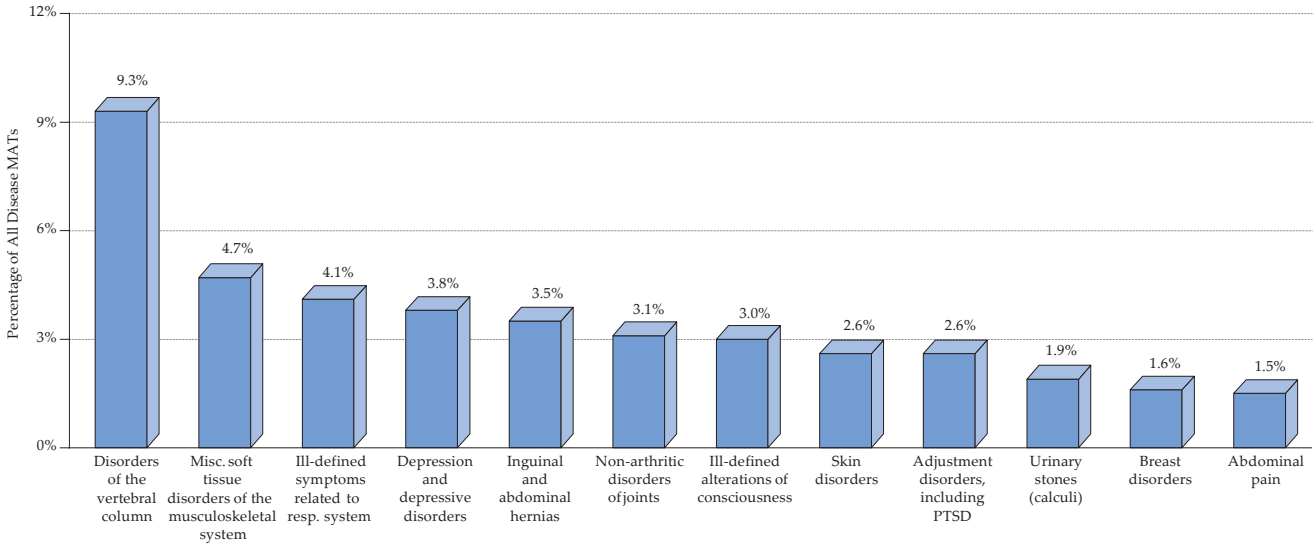
- Since October 1, 2001, a total of 52,388 medical air trans-ports were provided, with disease and other conditions representing almost 60 percent of the movement, and the rest equally split between battle injuries and non-battle injuries (each about one-fifth of total air transport movement).
- These cases cover a wide range of conditions and severity: Back problems, chest symptoms, mental health concerns, kidney stones, hernias, etc. The chart at the bottom of the page shows the 12 most common diseases resulting in medical air transport (MAT).

MEDICAL AIR TRANSPORTS (MAT)



Source : U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of November 18, 2008

12 MOST COMMON TYPES OF DISEASE RESULTING IN MAT MILITARY PERSONNEL ONLY



Source: U.S. Transportation Command Regulating And Command & Control Evacuation System (TRAC2ES) as of November 18, 2008

17-MONTH TREND IN SECRETARY OF DEFENSE-DIRECTED SURVEY OF WOUNDED, ILL OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT

Ensuring that ill, injured, or wounded Service members are receiving high-quality health care is an extremely high priority of the Department. Part of receiving high-quality health care entails an effective and efficient physical environment supporting the Disability Evaluation System. Service designations for these situations vary in name, but less so in function (in which Service members are in transition, as status in the Army's Warrior Transition Units, the Navy's "Medical extension" or the Air Force's "awaiting medical board"). Additionally, the Department is interested in the ill or injured Service member's access to, and perceptions of, health care and support services while involved in receiving outpatient care.

Beginning in May 2007, the Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational Deployment. This survey was fielded as one of several responses to a Secretary of Defense tasking to establish a mechanism to identify and provide actionable information to the Services to resolve shortcomings related to Service members recuperating from illness or injury following return from operational deployment. Developed by the Military Health Services Survey Work Group, chaired by OASD(HA)/TMA Health Program Analysis and Evaluation with membership from staff of the Services Surgeons General, this survey initially focused on Service members returning from operational deployment overseas via aeromedical evacuation.

The sample frame for this monthly survey is designed as a census of all ill or injured Service Members, U.S. and overseas, aeromedically evacuated out of operational theaters since December 1, 2006, and not in an inpatient status at the time of the survey or returned to operational deployment.

The survey was first fielded in May 2007, inquiring about Service member satisfaction with, and access to, health care and personnel support services while in medical hold (or holdover or Warrior Transition Unit) status, in the Disability Evaluation System, and using outpatient health care services. Service members are contacted within 30 to 45 days of departing operational theaters for this part of the survey.

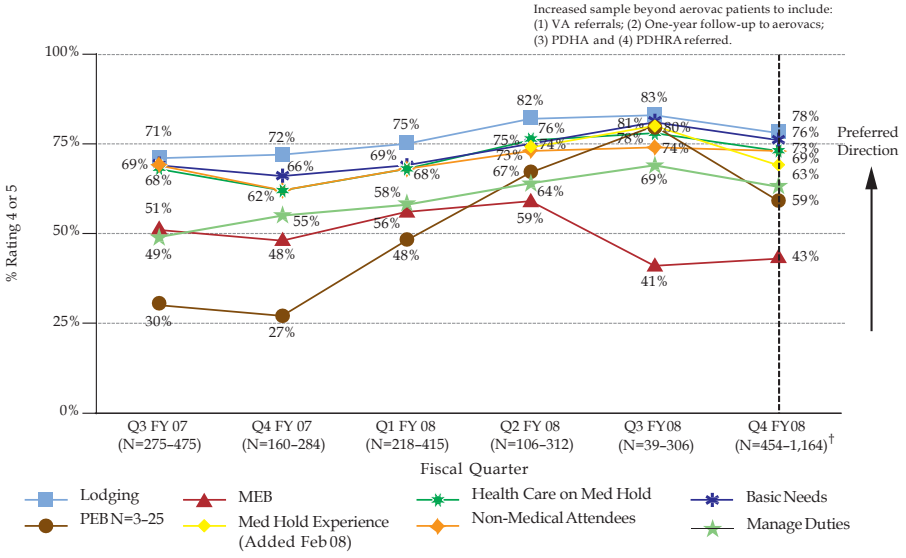
The survey was expanded in the 15th month to include two additional samples of Service members about one year after returning from deployment: (1) a census of those members referred to Veterans Health Administration facilities, and (2) a follow-up sample after one year of those previously aeromedically evacuated. The charts below reflect this latest cohort in the final quarterly data point in the trend lines (Quarter 4 of FY 2008). The survey has been expanded again to include two additional groups (but the results were not available at the time of this writing): a one-year follow-up to those who completed a (1) Post Deployment Health Assessment or (2) Post Deployment Health Reassessment and were subsequently referred by a provider for health care services and also who actually subsequently used the Military Health System.

Over 6,000 monthly telephone surveys were completed between May 2007 and September 2008. More than 14,000 eligible Service members returning from operational theater were surveyed.

Favorable Ratings

The majority of responses rated the medical hold and outpatient health care experience as favorable ("4" or "5" on a 5-point scale with 1=poor: 5=outstanding).

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



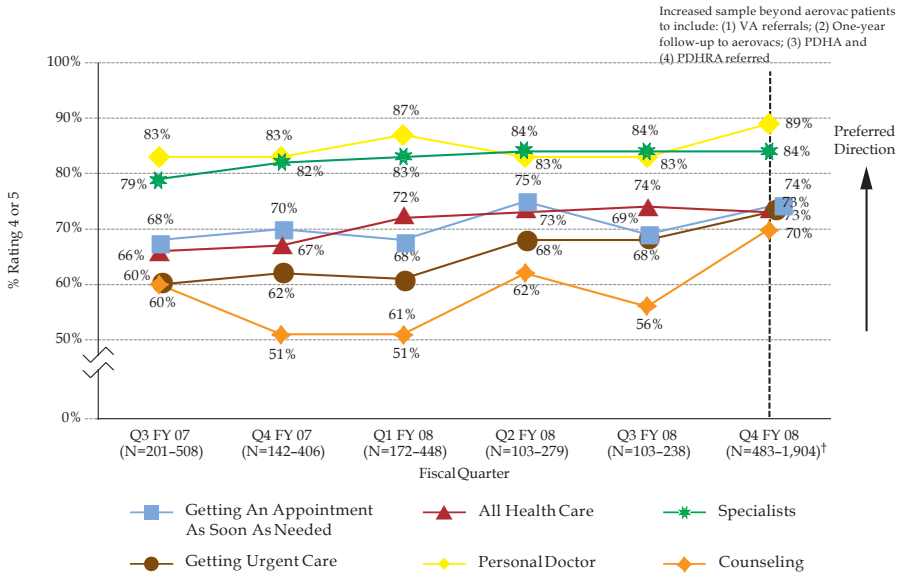
Medical Hold/Holdover: Between the first quarter and the most recent quarter favorable ratings increased for "managing one's duties" and "meeting basic needs" while in medical hold. The increase was statistically significant.

Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured Service Members Post Operational Deployment, 20 November 2008 Note: Very few Service members reported any experience with the PEB process prior to Q4 FY 08 because they were so recently returned from theater.

* Service members completing a PDHA/PDHRA will be included in next reported quarter.

† Q4 FY 2008 includes VA referral and follow-up respondents.

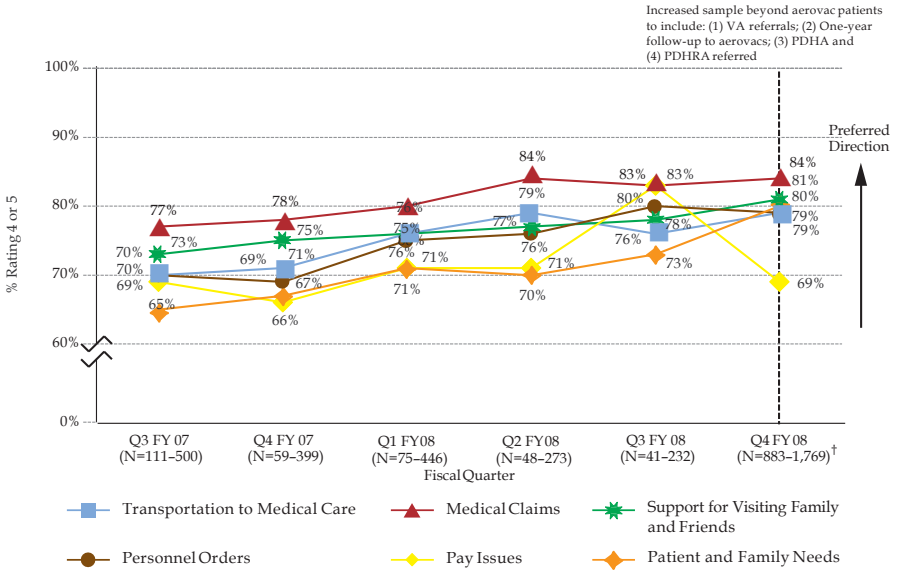
AMBULATORY HEALTH CARE PERCENTAGE OF TOP 2 RATINGS OVER TIME
(PERCENTAGE RATING "4" OR "5" ON 5-POINT SCALE)*



Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured Service Members Post Operational Deployment, 20 November 2008.

* Service members completing a PDHA/PDHRA will be included in next reported quarter.
† Q4 FY 2008 includes VA referral and follow-up respondents.

SUPPORT SERVICES PERCENTAGE OF TOP 2 RATINGS OVER TIME
(PERCENTAGE RATING "4" OR "5" ON 5-POINT SCALE)*



Source: OASD(HA)/TMA-HPA&E Monthly Survey of Ill or Injured Service Members Post Operational Deployment, 11/20/2008.

* Service members completing a PDHA/PDHRA will be included in next reported quarter.
† Q4 FY 2008 includes VA referral and follow-up respondents.

- **Ambulatory Care/Support:** There is an increasing trend in positive ratings of the following ambulatory care/support areas between the first and the most recent quarter: "getting urgent care," "rating of specialists," "rating of all health care," "support to visiting family and friends," "pay issues," "personnel orders," "meeting patient and family needs," and "transportation to medical care."

Unfavorable Ratings

(Not shown on graphs.) Areas of concern are highlighted by unfavorable ratings (ratings of "1" or "2").

- **Medical Hold/Holdover:** Close to one quarter of Service members continue to rate poorly two areas: "ability to manage duties and personal affairs" (19 percent) and "experience with the Medical Evaluation Board (MEB) process" (25 percent).

  Unfavorable ratings for "managing duties and affairs" and "meeting basic needs" show decreasing trends over time, but these trends are not statistically significant.

- **Ambulatory Care/Support:** About 1 in 5 Service members still rate access to health care services poorly, such as: "getting an appointment as soon as needed," "getting urgent care as soon as needed," and "getting treatment or counseling for a personal/family problem."

Health Status

(Not shown on the graphs.) There is a statistically significant increase in favorable ratings between the first and most recent quarter for "overall mental health" and "current overall health." However, about 1 in 5 personnel continue to rate their current overall health and /or overall mental health poorly. Three quarters state their health today is worse/much worse than before they deployed.

SHARING OF DoD INFORMATION WITH OTHER FEDERAL AGENCIES: DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE JOINT STRATEGIC EFFORTS

The Mission of the Department of Veterans Affairs and DoD Joint Strategic Plan is: To improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, Service members, military retirees, and their families through an enhanced VA and DoD partnership.

The Vision Statement for this effort is: A world-class partnership that delivers seamless, cost-effective, quality services to beneficiaries and value to our nation.

The Guiding Principles for this strategic effort are:

- **Collaboration:** To achieve shared goals through mutual support of both our common and unique mission requirements.
- **Stewardship:** To provide the best value for our beneficiaries and the taxpayer.
- **Leadership:** To establish clear policies and guidelines for VA/DoD partnership, promote active decision-making, and ensure accountability for results.

Sharing of Information:

In support of this mission, the Health Executive Council (HEC), was formed in 1997 to establish a high-level program of VA/DoD cooperation and coordination in a joint effort to reduce costs and improve health care for VA and DoD beneficiaries. The emphasis of the strategic plan is on working together to store, manage and share data. The HEC is providing ongoing oversight of the following projects:

- **Federal Health Information Exchange (FHIE):** FHIE supports the transfer of electronic health information from DoD to VA at the time of a Service member's separation. DoD transmits to VA on a monthly basis: inpatient and outpatient laboratory and radiology results, outpatient pharmacy data, allergy information, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records, and demographic data on separated Service members.
- **Deployment Health Assessments:** Deployment Health Assessments are conducted on Service members and demobilized Reserve and National Guard members as they leave and return from duty in a theater of operations. The 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.
- **Bidirectional Health Information Exchange (BHIE):** BHIE leveraged already developed joint VA/DoD infrastructure, IT investments, VA/DoD test facilities, and existing personnel resources to create a real-time, bidirectional interface. BHIE functionality enables the real-time sharing of allergy information; outpatient pharmacy; demographic data; inpatient and outpatient laboratory and radiology results; ambulatory encounters/clinical notes; procedures and problem lists; theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, radiology reports, and vital signs.
- **Laboratory Data Sharing Initiative (LDSI):** LDSI supports the electronic sharing of order entry and results retrieval of chemistry, hematology, anatomic pathology, and microbiology laboratory tests between the DoD, VA, and commercial reference laboratories. LDSI is actively being used on a daily basis between DoD and VA at several sites where one Department uses the other as a reference lab.
- **Clinical Data Repository/Health Data Repository (CHDR):** CHDR establishes interoperability between the Clinical Data Repository (CDR) of AHLTA, DoD's electronic health record, and VA's Health Data Repository (HDR) enabling the exchange of computable outpatient pharmacy and medication allergy data into each agency's electronic health record. Patient safety is now enhanced through medication and allergy data from the other Department being used in drug-drug interaction and drug-allergy checking.
- **AHLTA:** AHLTA is the military's Electronic Health Record (EHR). AHLTA generates, maintains and provides worldwide secure online access to comprehensive patient medical records.
- **VA/DoD Wounded Warrior:** The VA and the DoD are working together to support our most severely wounded and injured Service members transferring to VA Polytrauma Centers for care.
  - **Radiology Image Sharing Initiative:** DoD electronically sends digital radiology images from Walter Reed Army Medical Center (WRAMC), National Naval Medical Center (NNMC), Bethesda, and Brooke Army Medical Center (BAMC) to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis.

- **Scanned/ Electronic Document Sharing Initiative:** WRAMC, NNMC, and BAMC scan the patient's entire paper medical record into portable document format (PDF) for electronic transmission to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis. The PDF document contains records from the entire inpatient stay as well as all available records of treatment provided in Theater medical facilities, care during transport, and care rendered at Landstuhl Regional Medical Center.

The table below reflects the progress made in increasing the sharing of health care data between the DoD and the VA in support of the VA/DoD Joint Strategic Plan.

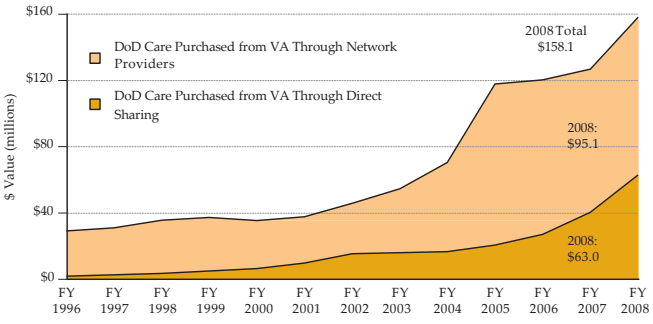
DOD/VA SHARING IT METRICS (CUMULATIVE)

	FY 2005	FY 2006	FY 2007	FY 2008
Millions of unique patients for which DoD has transferred data to the Federal Health Information Exchange (FHIE) repository	3.1	3.6	4.0	4.5
Number of DoD hospitals and medical centers where Bidirectional Health Information Exchange (BHIE) is operational (includes outpatient pharmacy data, allergy, radiology text reports, laboratory results and patient demographics. In FY 08, the following information became available: ambulatory encounters/clinical notes, procedures, problem lists, family history, social history, other history, questionnaires, vital signs and theater clinical data, including inpatient notes, outpatient encounters, and ancillary clinical data, such as pharmacy data, allergies, laboratory results, and radiology reports.	33 Hospitals and 170 Clinics	42 Hospitals and 240 Clinics	All DoD facilities	All DoD facilities
Number of Pre- and Post-Deployment Health Assessments forms sent electronically to VA	452,000	1,400,000	1,900,000	2,400,000
Number of sites operational with CHDR (Clinical Data Respository/Health Data Repository) which allows sharing of computable pharmacy and allergy data	0	3	7	Available to all DoD sites / VA - 7
FHIE transfer includes the following:				
Millions of laboratory results sent to VA	42.3	49.5	55.2	67.1
Millions of radiology reports sent to VA	6.8	8.2	9.1	11.0
Millions of pharmacy records sent to VA	42.6	49.7	55.7	69.1
Millions of standard ambulatory data records sent to VA	40.3	48.9	62.0	68.2
Millions of consultation reports sent to VA	0.972	1.4	1.8	2.8

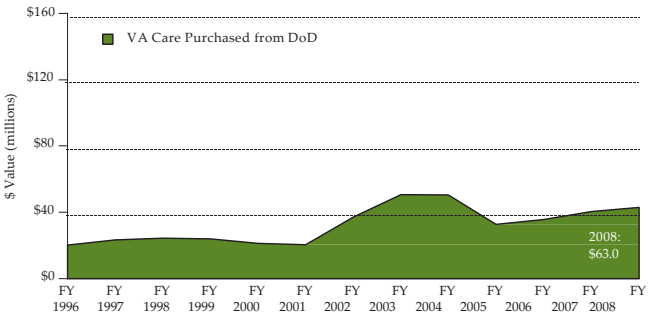
Source: OCIO/ERM Received 12/12/2008

The charts below show the total extent of health care services sharing over the past 12 years, and the dramatic rise over the past four years. The DoD has always purchased more care from the VA than vice-versa (on average, between 1996 and 2003, the DoD purchased $1.44 from the VA for every $1.00 provided to the VA), but over the last four years the DoD has purchased $3.45 for every $1.00 provided to the VA.

DOD/VA SHARING: HEALTH CARE SERVICE PROVIDED BY VA TO DOD($ MILLIONS)



DOD/VA SHARING: HEALTH CARE SERVICES PROVIDED BY DOD TO VA($ MILLIONS)



Source: VA DoD quarterly report prepared by OASD HA/HB & FP. Received 12/3/2008

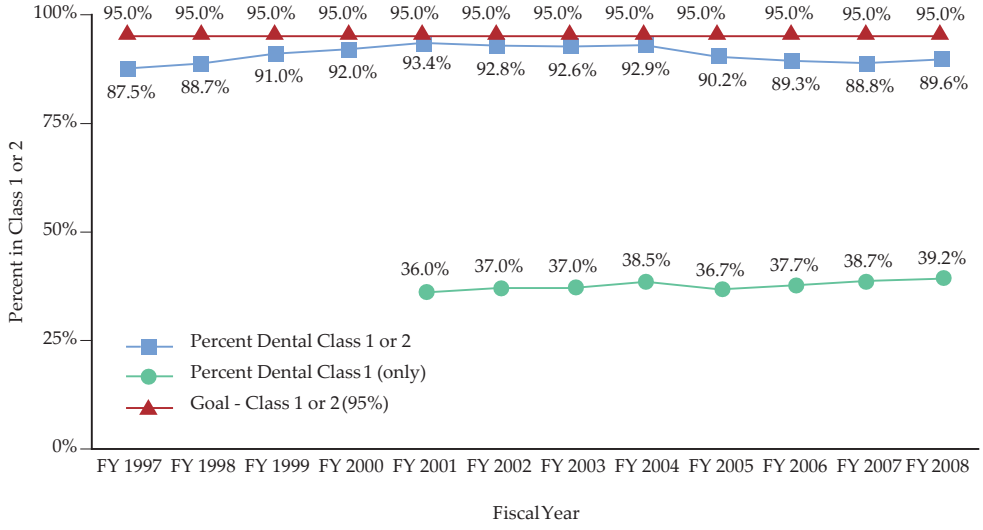
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we: (1) Maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates,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

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require nonurgent dental treatment or 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 11 years, from FY 1997 to FY 2008 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, itremains elusive. The FY 2008 rate of 89.6 percent reflects a slight increase from FY2007.
- The rate for Active Duty personnel in Dental Class 1 increased by one-half percent to 39.2 percent in FY 2008.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 10/30/2008

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

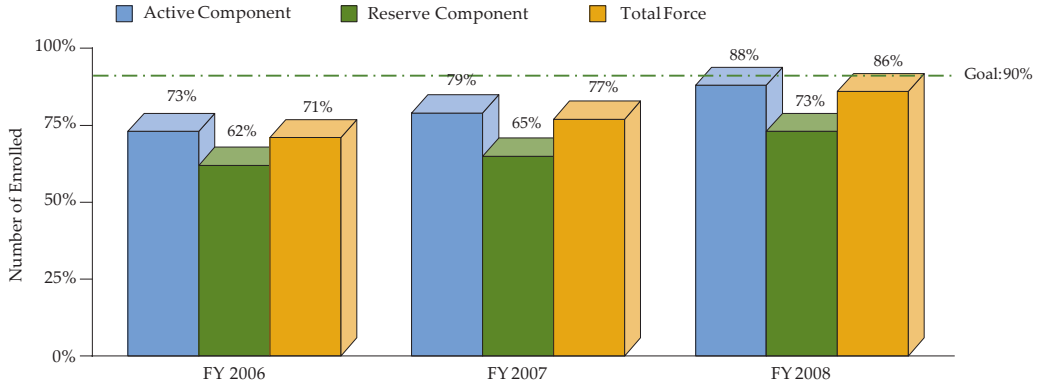
Dental Class 2: Patients with a current dental examination, who require nonurgent dental treatment or re-evaluation for oral conditions, which are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

FORCE IMMUNIZATION RATE

Both Active and Reserve Component members receive vaccinations for globally endemic vaccine-preventable illnesses, including hepatitis A and B, influenza, measles, mumps, rubella, diphtheria, tetanus, and polio. The percentage of the force that is immunized is a measure of both readiness and force protection.

- Immunization rates for both Active and Reserve Component members increased significantly between FY 2006 and FY 2008.
- Immunization rates for Reserve Component members are considerably lower than those for Active Component members.
- In the third quarter of FY 2008 (not shown), the immunization rate for Active Component members reached 92 percent, exceeding the goal of 90 percent for the first time. However, in the fourth quarter, the rate dipped back down slightly under the goal, to 89 percent.

TREND IN FORCE IMMUNIZATION RATE



Source: OASD(HA) Force Health Protection and Readiness Programs administrative data, 11/24/2008

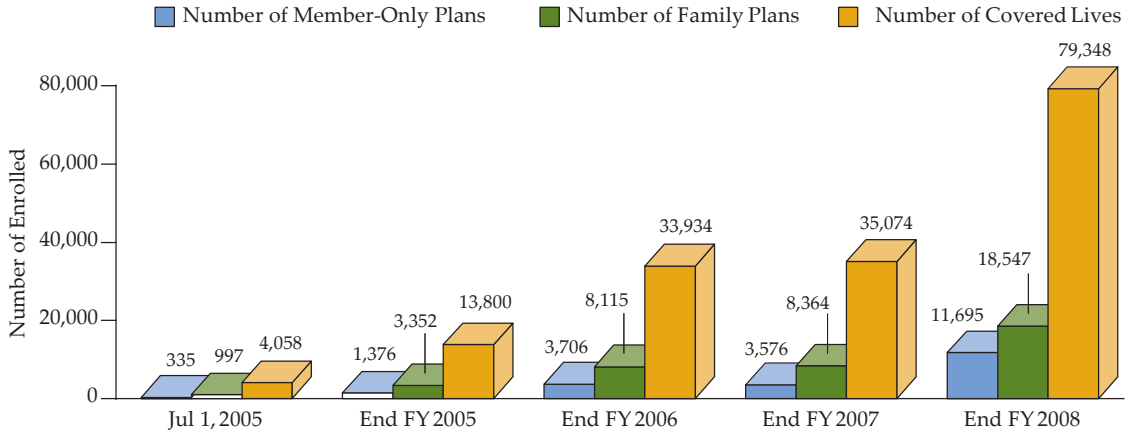
SPECIAL STUDY: TRICARE RESERVE SELECT (TRS) ACCESS AND SATISFACTION

TRS was established by the 2005 NDAA to offer TRICARE Standard and Extra health coverage to qualified members of the Selected Reserve and their immediate family members (*Federal Register*, June 21, 2006). 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. TRS coverage must be purchased, with TRS members paying a monthly premium for health care coverage (for self only or for self and family). Originally, Reserve members were eligible for TRS 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 had to agree for the member to stay in the Select Reserve one or more years to qualify. The NDAA for FY 2006 expanded eligibility and added two more premium tiers. The NDAA for FY 2007 restructured the program to a simpler, single tier plan, expanded eligibility, and eliminated the service agreement requirements. Currently, all Selected Reserves are eligible, unless they are able to obtain health insurance through the Federal Employees Health Benefits Program.

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 an MTF on a space-available basis. Pharmacy coverage is available from an MTF pharmacy, TMOP, and TRICARE network and non-network retail pharmacies.

Since the revised benefit became available on October 1, 2007, TRS enrollment has more than doubled. As of the end of FY 2008, there are more than 79,000 covered lives in over 11,000 member-only plans and over 18,000 family plans.

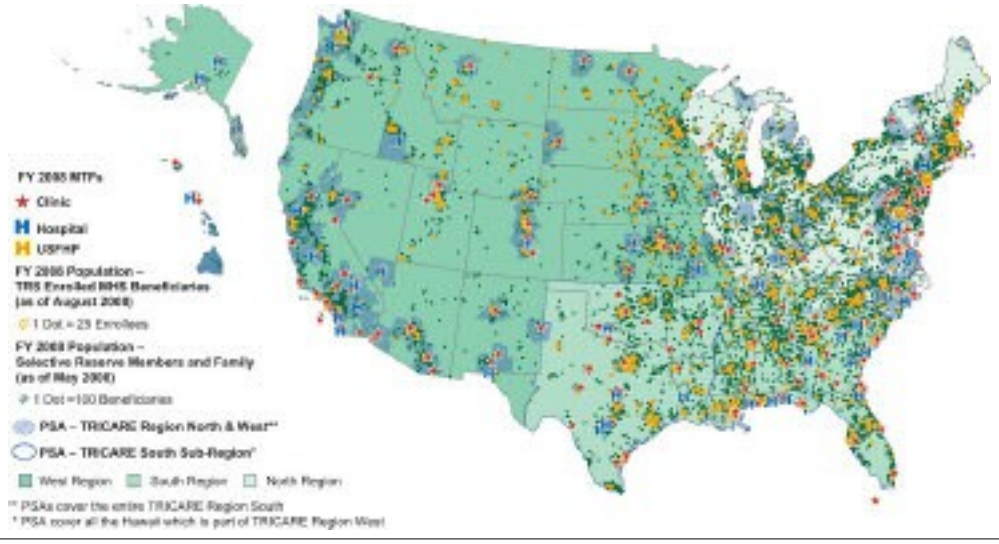
TREND IN ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 – SEPTEMBER 2008)



Source: HA/TMA–TRICARE Operations, 12/01/2008

The 2008 Focused Survey of TRICARE Reserve Select and Select Reserve MHS Access and Satisfaction was designed to better understand motivations for enrolling the TRS benefits as well as to compare satisfaction levels of TRS enrollees with other MHS beneficiaries and non-enrolled Select Reserves.

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTFs IN FY 2008



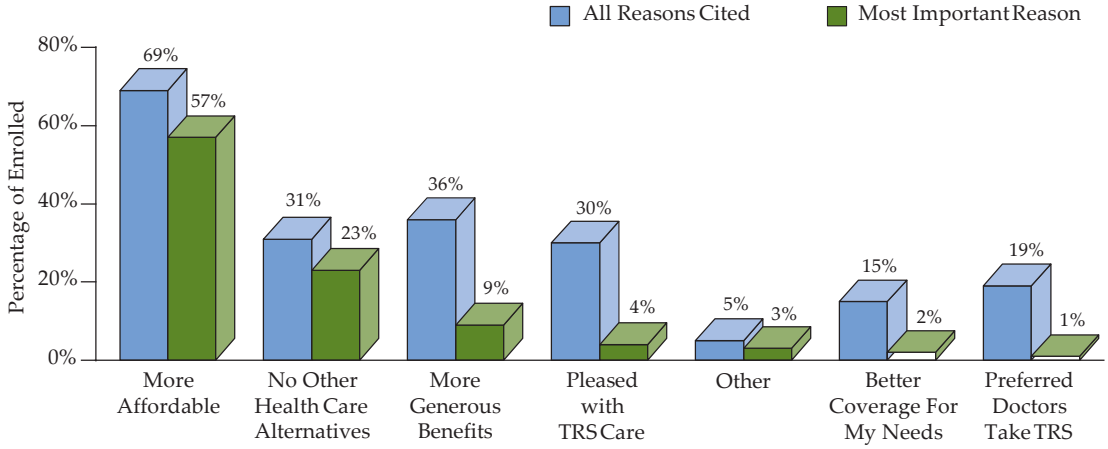
Source: Selected Reserve and Guard residential population data from DEERS, MTF information from TMA, Portfolio Planning Management Division, and geospatial representation by TMA/HPA&E, 11/26/2008

SPECIAL STUDY: TRICARE RESERVE SELECT (TRS) ACCESS AND SATISFACTION

Reasons for Purchasing TRS Coverage

- Those who enrolled in the TRS program cited affordability, lack of other options, and recent changes to the program, including eligibility changes, as the primary reasons they purchased coverage.
- Awareness was an important factor in why eligible Select Reserves did not enroll. Less than half of eligible Select Reserve non-enrollees are aware of TRS. Access to more affordable civilian options and opportunities to obtain civilian health insurance also affected the decision not to enroll.

REASONS FOR PURCHASING TRS COVERAGE



Source: Data were derived from the 2008 HCSDB and adjusted for age and health status. Significant at p<.05.

Satisfaction and Access

- Overall, TRS enrollees are pleased with the access and quality of care their plan provides.
- As shown in the chart, TRS enrollees' satisfaction with access and quality of care was statistically comparable to or higher than that of eligible Select Reserve non-enrollees. TRS enrollees' average satisfaction rating of access and quality of care was statistically higher than Prime users on all measures except the overall rating of health plan. TRS enrollees satisfaction with access and quality of care was comparable to Standard/Extra users on almost all measures.

	TRS Enrollees' Satisfaction Compared to:		
Care Experiences	**Eligible SelRes Non-enrollees**	**Prime**	**Standard/Extra**
Getting needed care	No diff.	Higher	Higher
No problem finding personal doctor	No diff.	Higher	No diff.
No problem seeing specialist	No diff.	Higher	No diff.
Getting urgent care			
Getting care right away when needed	Higher	Higher	No diff.
Routine care	No diff.	Higher	No diff.
<15 minute wait for exam room	No diff.	Higher	No diff.
Doctors and medical care			
Doctors communicate well	Higher	Higher	No diff.
Rating of 8+ for personal doctor	No diff.	Higher	No diff.
Rating of 8+ for health care	Higher	Higher	No diff.
Helpful office staff	No diff.	Higher	No diff.
Health plan (Rating of 8+ for health plan)	Higher	Lower	No diff.

Source: Data were derived from the 2008 HCSDB and adjusted for age and health status. Significant at p<.05.

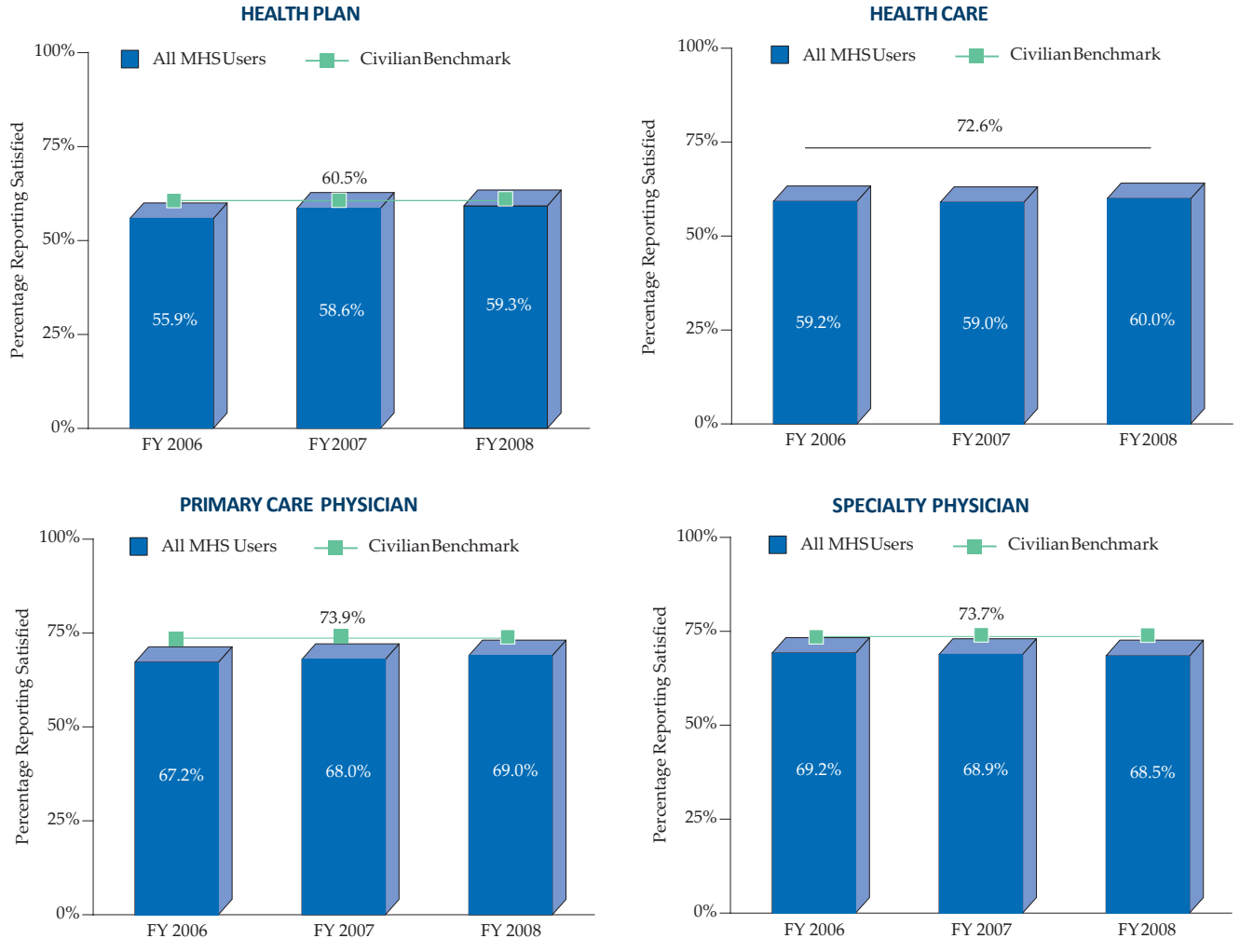
This section focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on customer satisfaction and health promotion activities through Building Healthy Communities.

CUSTOMER REPORTED EXPERIENCE AND 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 U. S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. 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 improved between FY 2006 and FY 2008. Satisfaction with health care and with one's personal or specialty physician remained stable 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 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 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.

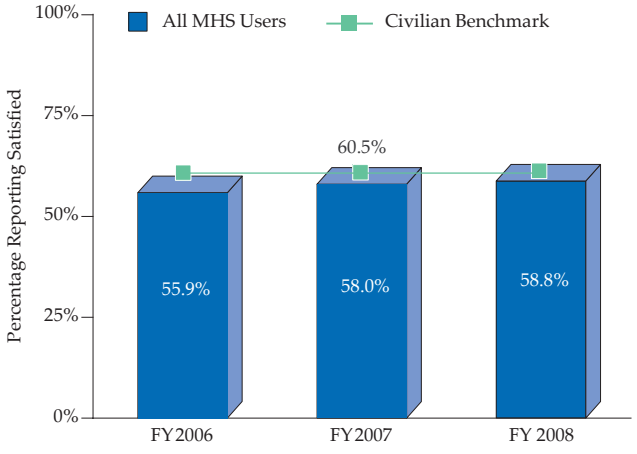
SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

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.

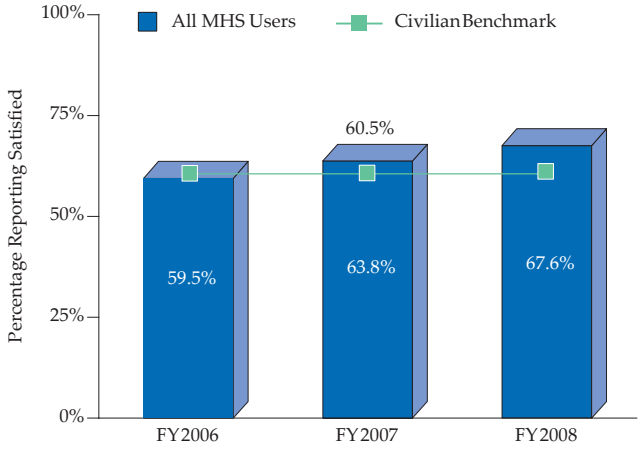
- Satisfaction increased from FY 2006 to FY 2008 for Prime enrollees (with a military PCMs as well as with civilian PCMs). Satisfaction of non-enrollees increased between FY 2006 and FY 2007, but fell between FY 2007 and FY 2008.
- During each of the past three years (FY 2006 to FY 2008), MHS beneficiaries enrolled with civilian network providers reported the same or higher levels of satisfaction than their civilian counterparts (i.e., for FY 2006 there was no statistically significant differences in the proportions; and, for FY 2007 and FY 2008, MHS enrollees reporting satisfied were statistically significantly higher).
- MHS beneficiaries enrolled with military PCMs and non-enrollees reported lower levels of satisfaction than their civilian plan counterparts.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

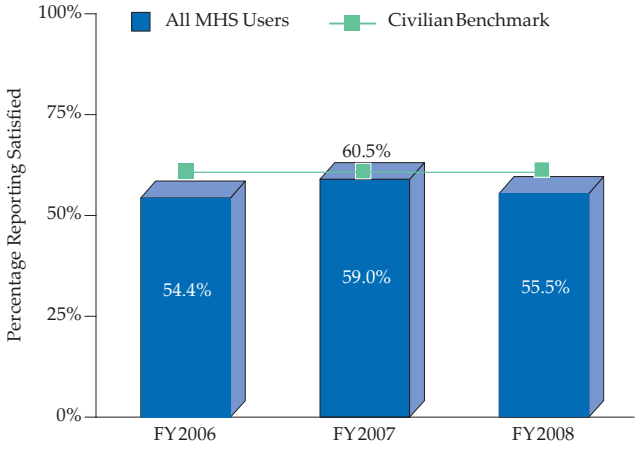
PRIME: MILITARY PCM



PRIME: CIVILIAN PCM



STANDARD/EXTRA (NOT ENROLLED)



Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 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.

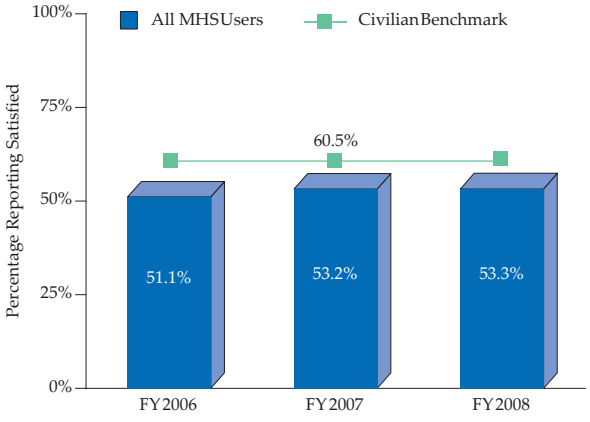
SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

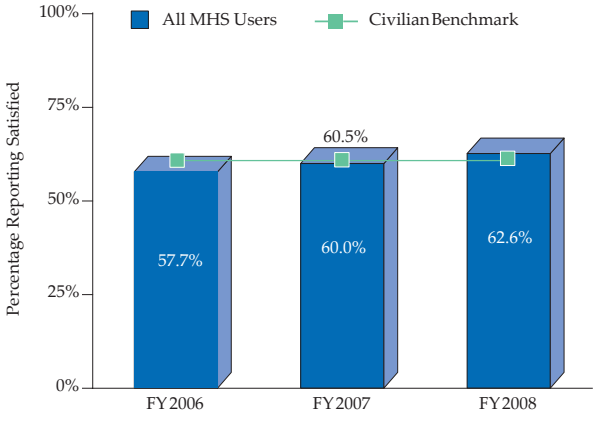
- Satisfaction with the TRICARE health plan improved for all beneficiary categories between FY 2006 and FY 2008. Satisfaction of retired DoD beneficiaries was comparable to their civilian counterparts in FY 2006, and exceeded their rates in FY 2007 and FY 2008.
- Although Active Duty ratings have lagged the civilian benchmarks, family member satisfaction ratings achieved levels statistically comparable to the civilian benchmark by FY 2007 and exceeded the benchmark in FY 2008 .

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

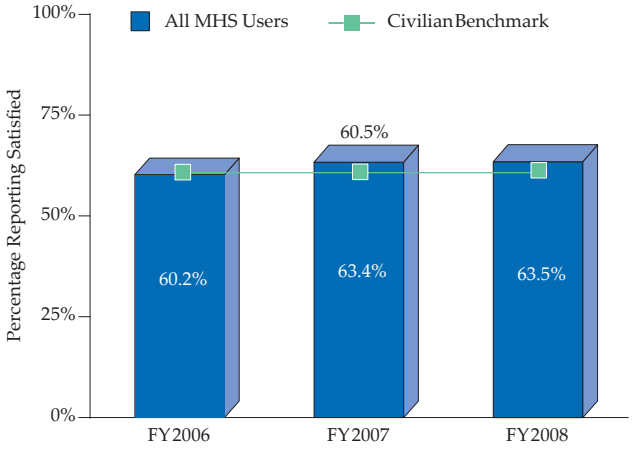
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



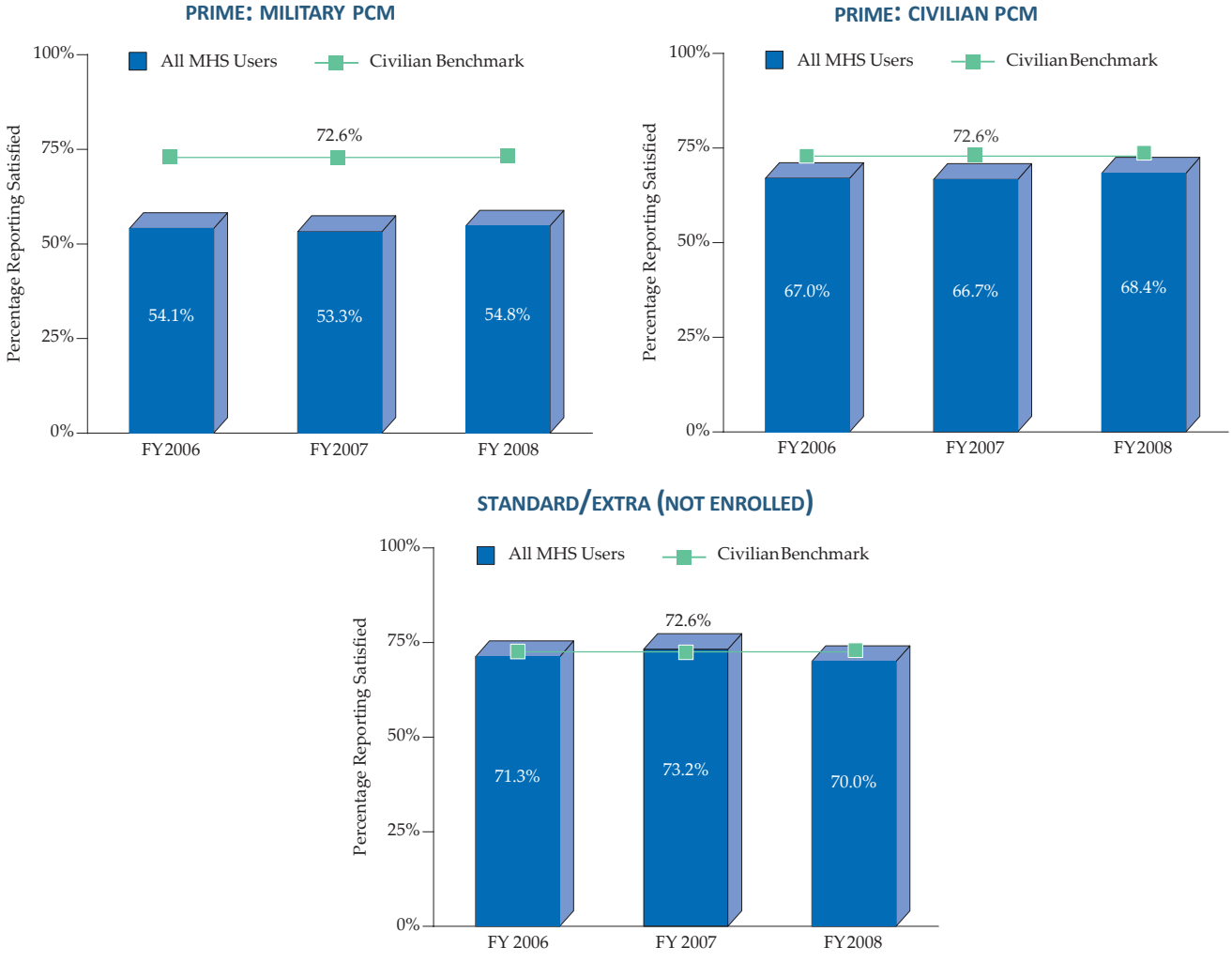
Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking 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 CARE BASED ON ENROLLMENT STATUS

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

- Non-enrollee satisfaction was comparable to the civilian benchmark during FY 2006 and FY 2007 (bottom chart), but declined in FY 2008.
- Between FY 2006 and FY 2008, MHS Prime enrollee satisfaction with their health care remained unchanged (no statistically significant change), and continued to lag the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BASED ON ENROLLMENT STATUS



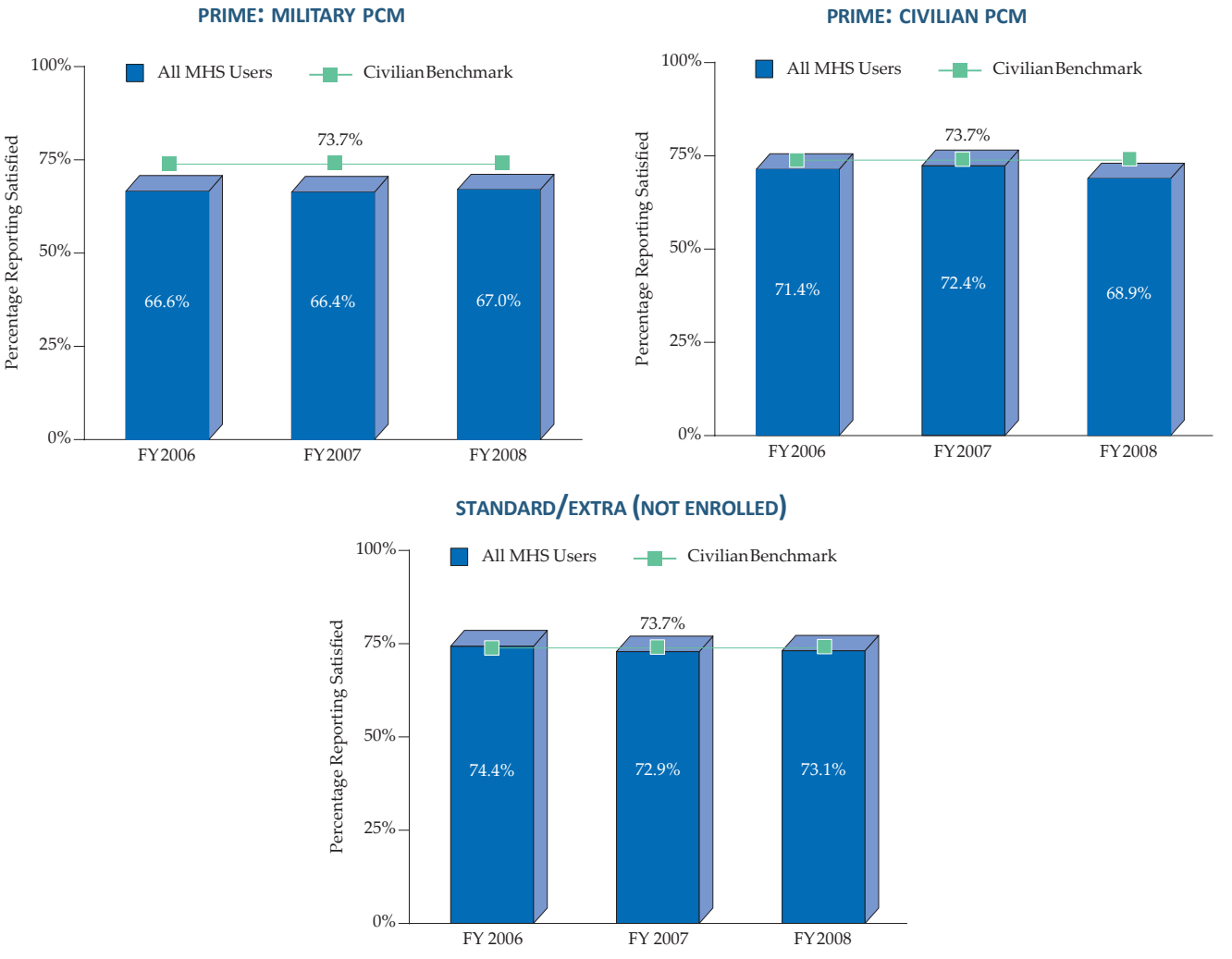
Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking 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 SPECIALTY PROVIDER BASED ON ENROLLMENT STATUS

MHS user satisfaction with their specialty providers differs by enrollment status.

- Satisfaction levels of Prime enrollees with military PCMs remain unchanged and continue to lag the civilian benchmark. Non-enrollees report satisfaction levels comparable to the civilian benchmark and remain unchanged. Prime enrollees with civilian PCMs satisfaction levels were comparable to the civilian benchmark in FY 2006 and FY 2007, but dropped below the benchmark in FY2008.

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



Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 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

Sustaining the benefit is anchored on a number of supporting factors, including access to, and promptness of, health care services, customer services, and the availability of appropriate health care providers. This section enumerates several areas routinely monitored by the MHS leadership addressing patient access and clinical quality processes and outcomes, including: (1) Self-reported access to MHS care overall, (2) satisfaction with various aspects of the MHS (e.g., the availability and ease of obtaining care, getting providers of choice, and access to civilian physicians willing to accept TRICARE Standard), (3) responsiveness of customer service, quality, and timely claims processing (both patient reported as well as tracking through administrative systems), (4) Joint Commission quality metrics in MTFs compared to Commission findings nationwide, and (5) access to and satisfaction with MTF care.

Access to MHS Care

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

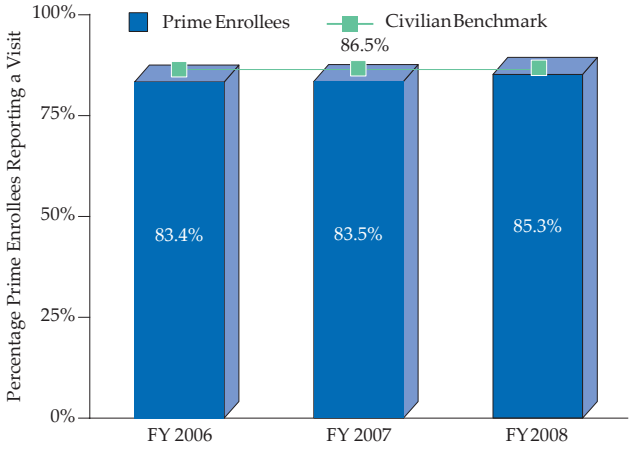
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.
- Quality and timeliness of claims processing.

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

- Access to, and use of, outpatient services remains high with 85 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit in FY 2008.
- The MHS Prime enrollee rate continues to lag the civilian benchmark each year (statistically significantly different each year).

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



Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 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 *(CONT'D)*

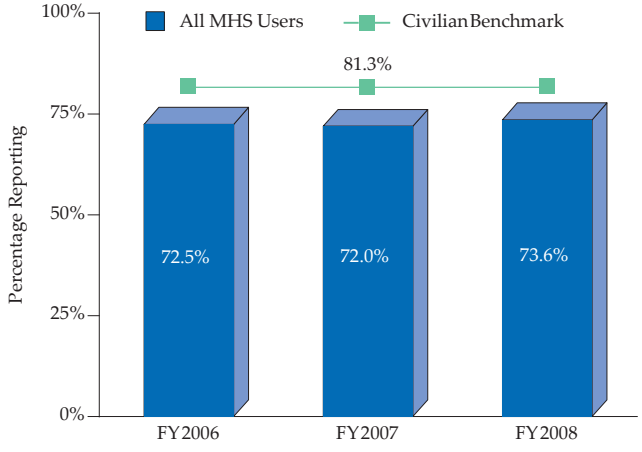
Availability and Ease of Obtaining Care

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) avoid unnecessarily long waits in the doctor's office.

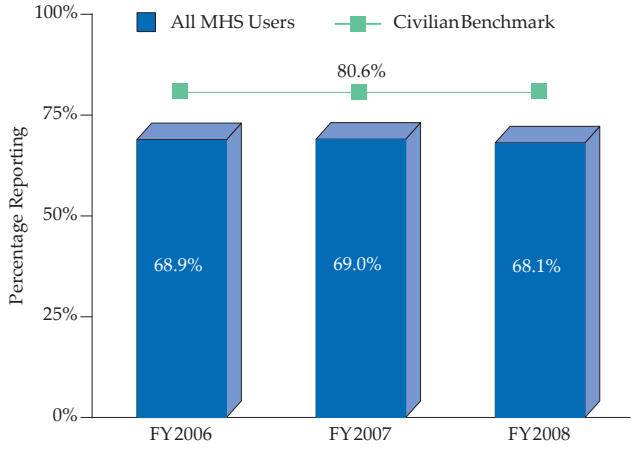
- MHS beneficiary ratings for getting necessary care improved slightly between FY 2006 and FY 2008. The other measures of the availability and ease of accessing care—waiting for a routine appointment and waiting less than 15 minutes in the doctor's office—remained stable between FY 2006 and FY 2008. All three measures lagged the civilian benchmark, which remained stable during the same period.

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

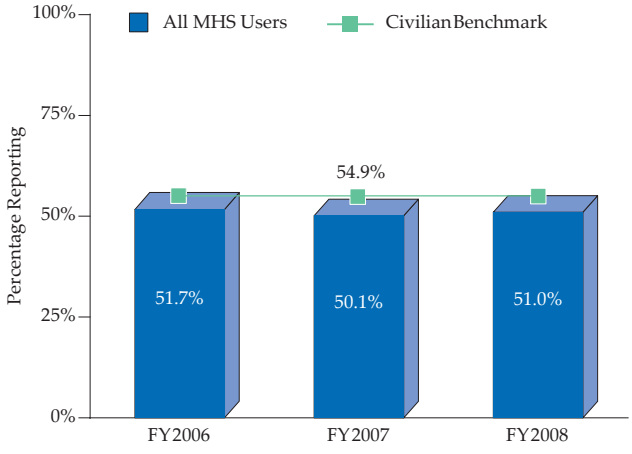
GOT NECESSARY CARE



WAITED FOR ROUTINE APPOINTMENT



WAITED LESS THAN 15 MINUTES TO SEE DOCTOR



Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Reported access ratings for "Got Needed Care" is the percentage rating "not a problem"; "Waited for a Routine Appointment" and "Waited less than 15 Minutes to See a Doctor" are based on the the percentage rating either a "usually" or "always." 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 *(CONT'D)*

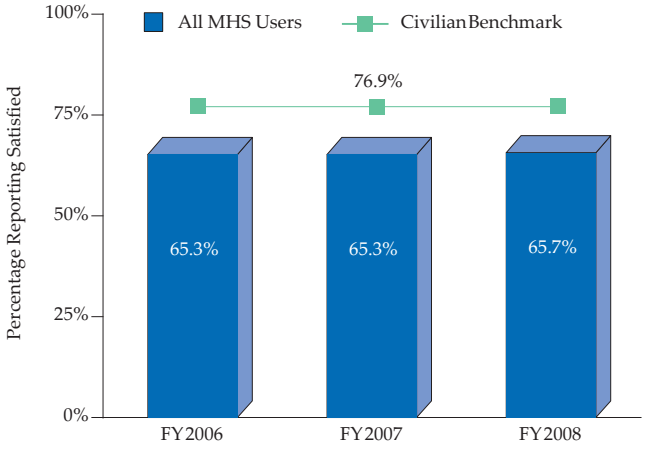
Ability to Obtain Needed Care by Beneficiary Category

The following charts present beneficiary reported perceptions of their ability to obtain care, by examining differences in their beneficiary category.

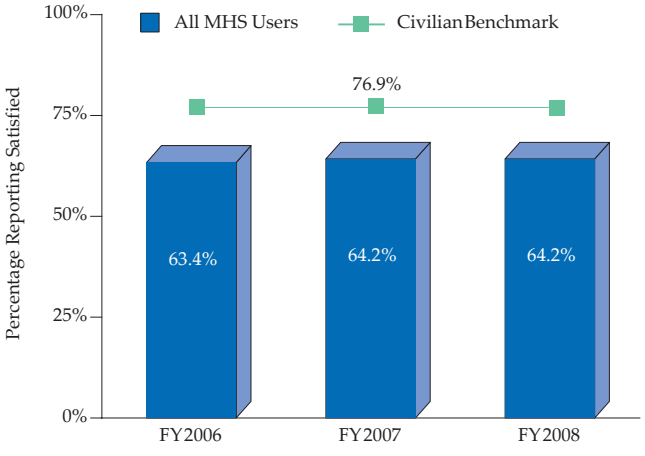
- Retired beneficiaries continue to report higher levels of satisfaction with their ability to get care than Active Duty personnel or their family members.
- The MHS satisfaction levels and civilian benchmarks remained stable across the three-year period from FY 2006 to FY 2008. Therefore, the disparity between the lower MHS satisfaction levels and the higher civilian benchmark remained stable as well.

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

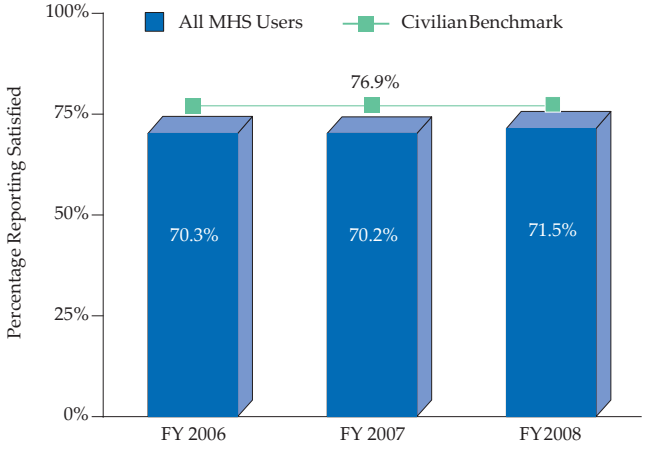
ACTIVE DUTY



ACTIVE DUTY FAMILY MEMBERS



RETIRED AND FAMILY MEMBERS



Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Ratings for "Ability to Obtain Care" is the percentage rating "not a problem." 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 *(CONT'D)*

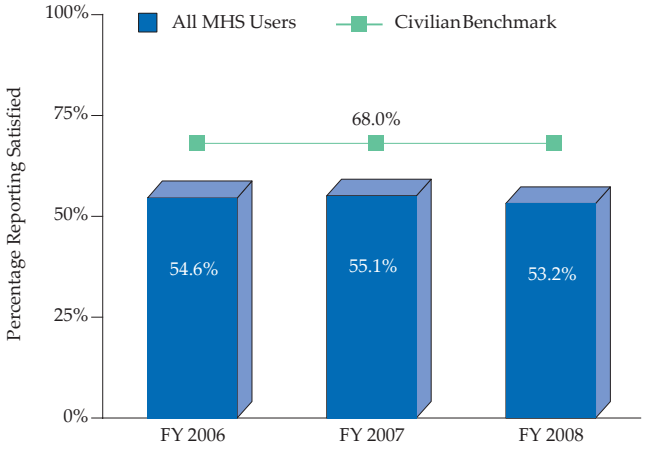
Opportunity to Get a Health Provider of Choice

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.

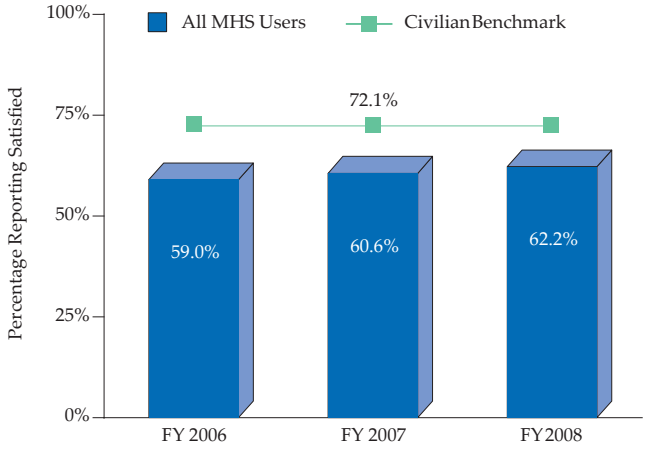
- For MHS users, satisfaction with the measure of access to personal doctors has decreased between FY 2006 and FY 2008.
- MHS user satisfaction with obtaining a referral to a specialty provider has increased between FY 2006 and FY 2008.

TRENDS IN GETTING ACCESS TO PERSONAL OR SPECIALTY PROVIDERS

GETTING A PERSONAL DOCTOR OR NURSE OF CHOICE



GETTING A REFERRAL TO A SPECIALIST



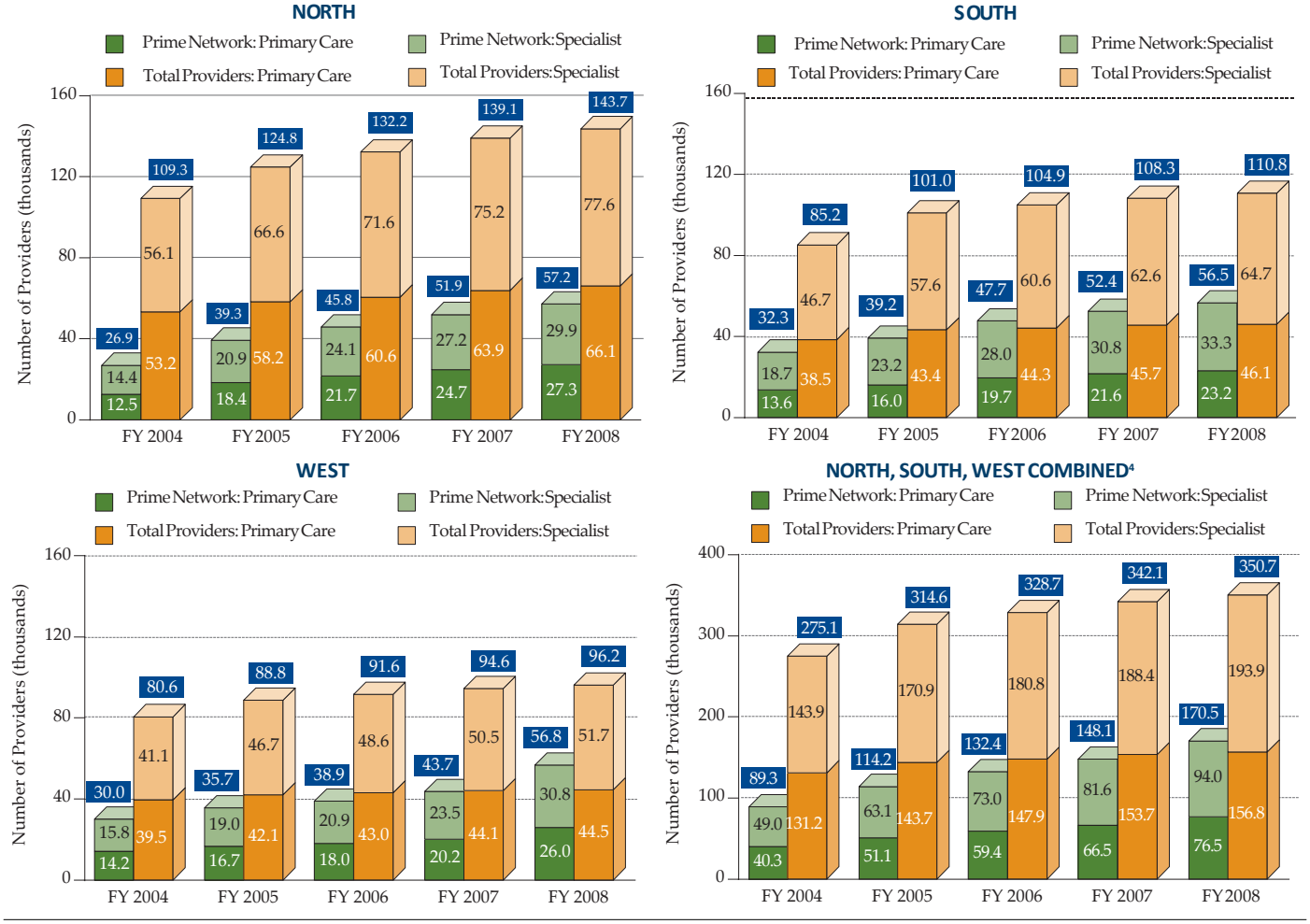
Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "not a problem." Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "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.

TRICARE PROVIDER PARTICIPATION

Beneficiaries' satisfaction with access to care is influenced in part by the choice of providers available to them. The number of TRICARE participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] The number of providers has been rising steadily since FY 2004 but leveled off in FY 2008. The trend has been evident for both Prime and Standard/Extra providers. Furthermore, as evidenced by the claims data, the number of specialists has increased at a somewhat greater rate than primary care providers.[2]

- The North Region saw the largest increase in the total number of TRICARE providers (32 percent), followed by the South Region (30 percent) and the West Region (19 percent).
- The North Region also saw the largest increase in the number of Prime network providers (112 percent), followed by the West Region (90 percent) and the South Region (75 percent).
- The total number of TRICARE providers decreased by 4 percent in catchment areas and increased by 37 percent in noncatchment areas (not shown).[3]
- The number of Prime network providers increased by 34 percent in catchment areas and by 115 percent in noncatchment areas (not shown).

TRENDS IN PRIME NETWORK AND TOTAL PARTICIPATING PROVIDERS



Source: MHS administrative data, 12/30/2008

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians, etc.) were not counted. Additionally, providers were counted in terms of full-time equivalent units (1/12 of a provider for each month the provider saw at least one MHS beneficiary) and, based on data from TMA–Aurora, a downward adjustment was made to account for the fact that some providers have multiple identifiers.

[2] Primary care providers were defined as General Practice, Family Practice, Internal Medicine, Obstetrics/Gynecology, Pediatrics, Physician's Assistant, Nurse Practitioner, and clinic or other group practice.

[3] As noted on page 22, the catchment area concept is being replaced within the MHS by MTF Enrollment Areas.

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

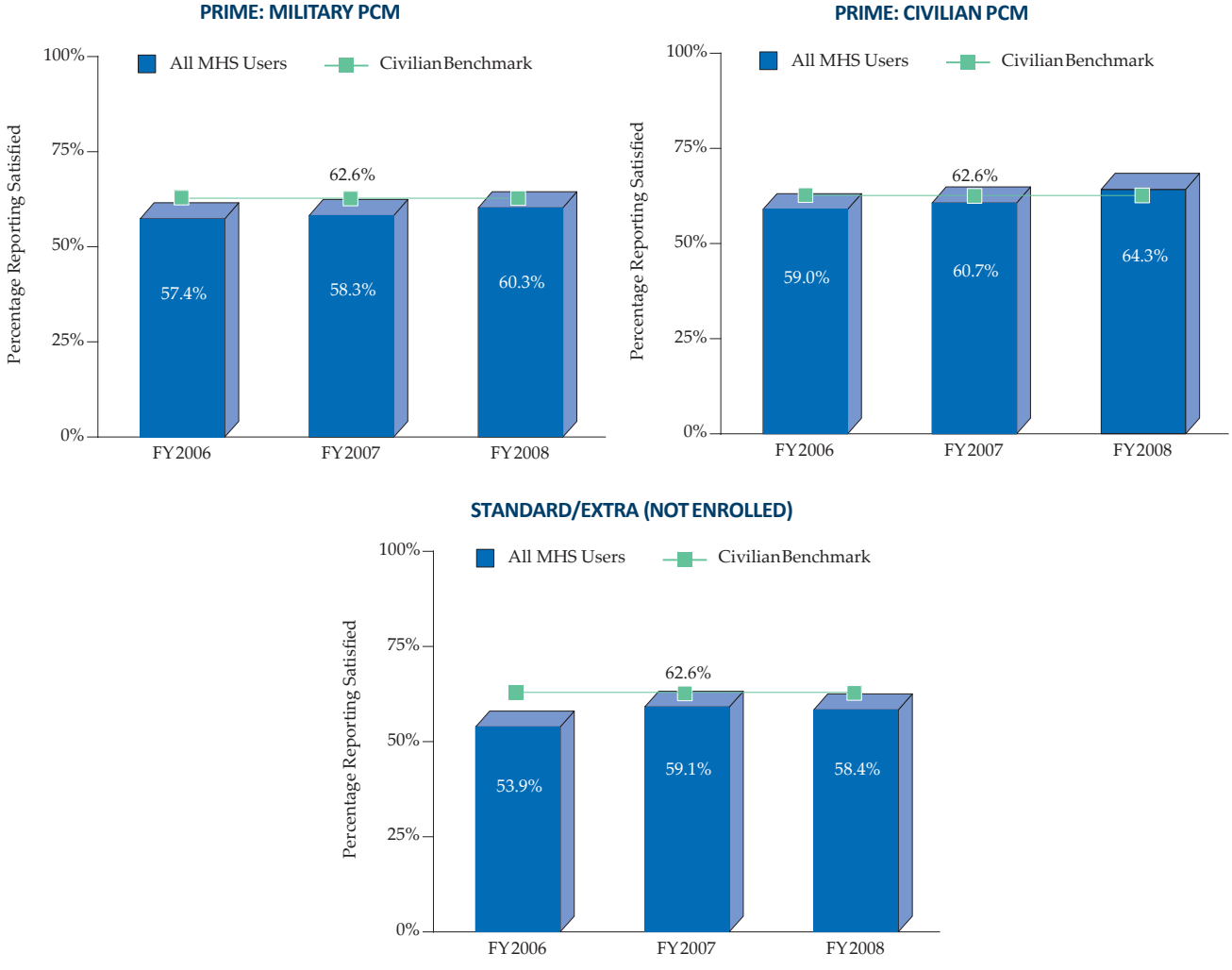
Note: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, where a provider was counted if he/she was listed as a TRICARE participating provider. From FY 2005 forward, the claims explicitly identify network providers. Network provider counts for FY 2004 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.

CUSTOMER SERVICE

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

- MHS beneficiaries' reported satisfaction with customer service increased between FY 2006 and FY 2008; in terms of understanding written materials, getting customer assistance, and dealing with paperwork increased between FY 2006 and FY2008.
- MHS enrollees with civilian PCMs reported levels of satisfaction that exceeded the civilian benchmark in FY 2008 (right chart below).
- MHS MTF enrollee and non-enrollee (users of Standard or Extra) satisfaction improved between FY 2006 and FY 2008, but continues to lag the civilian benchmark.

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

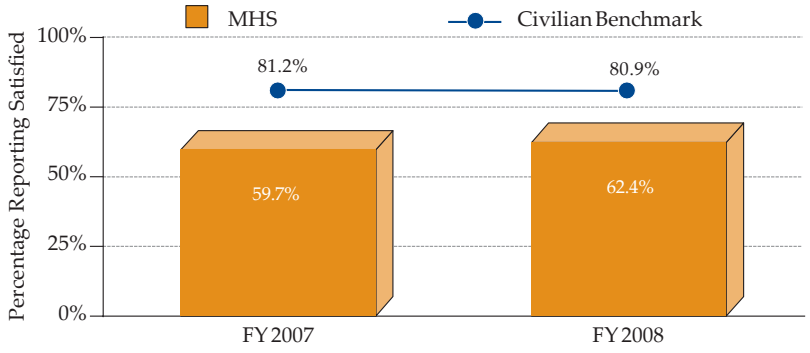


Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "not a problem." Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "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.

SPECIAL STUDY: TRICARE OUTPATIENT SATISFACTION SURVEY

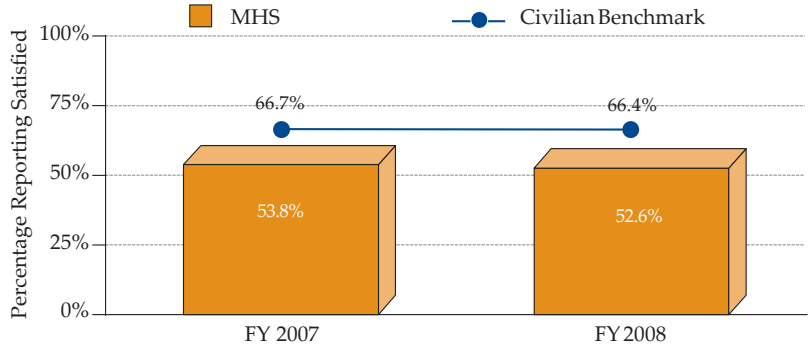
The goal of the OASD(HA)/TMA TRICARE Outpatient Satisfaction Survey (TROSS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have received outpatient care in an MTF or civilian outpatient setting. The TROSS is based on the AHRQ's Consumer Assessment of Health Providers and Systems (CAHPS), which allows for comparison with civilian outpatient services. The TROSS was first fielded in January 2007, succeeding its predecessor, the Customer Satisfaction Survey used in previous Evaluation reports.

EASE OF MAKING APPOINTMENT VIA PHONE



- The MHS is concerned about beneficiary satisfaction with telephone access to the direct care system in addition to the satisfaction metrics previously presented.
- The level of satisfaction reported by MHS beneficiaries remained stable, around 60% in FY 2007 and FY 2008, but lags the civilian benchmark.

RATING OF HEALTH CARE



- The MHS is concerned about beneficiary satisfaction with the actual encounter in the MTF. The percentage of beneficiaries reporting satisfaction with the care received within MTFs has remained stable over FY 2007 and FY 2008, but lags the civilian benchmark.

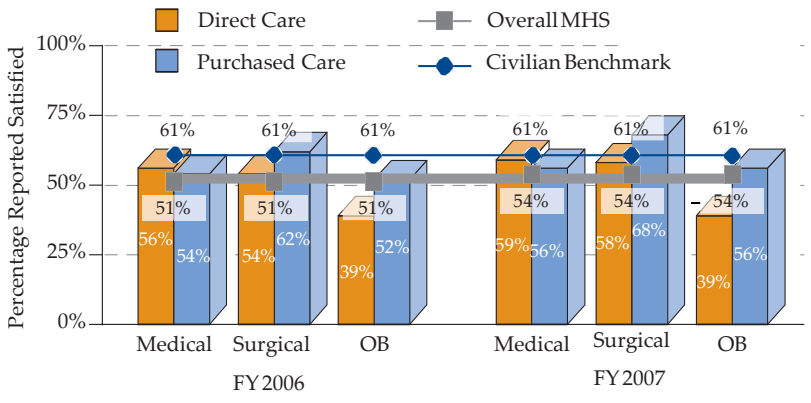
Source: OASD(HA)/TMA-HPA&E TRICARE Outpatient Satisfaction Survey – FY 2007 and FY 2008 (through June 2008). Ratings are on a 5 point scale with "Satisfied" defined as a rating of 4 or 5. Data are as of 12/12/2008.

SPECIAL STUDY: TRICARE INPATIENT SATISFACTION SURVEY

The purpose of the OASD(HA)/TMA TRICARE Inpatient Satisfaction Survey (TRISS) is to monitor and report on the experience and satisfaction of MHS beneficiaries who have been admitted to MTF and civilian hospitals. As with the TROSS, the TRISS is designed to compare across all Services, and across venues (i.e., direct care versus purchased care). Separate but comparable surveys are used for inpatient surgical, medical, and obstetrical care. Like the TROSS and HCSDB, the TRISS is based on the AHRQ's CAHPS surveys. Specifically, the TRISS is based on the Hospital-CAHPS (H-CAHPS) survey instrument, so that results may be benchmarked to civilian hospitals reporting similar measures, and trended over time. Twenty-two TRISS questions come from H-CAHPS, while sixty questions are DoD specific. The survey covers:

- Satisfaction in reference to: overall satisfaction, inpatient care and whether they would recommend to family or friends.
- Nursing care in reference to: care, respect, listening, and explanations.
- Physician care in reference to: care, respect, listening and explanations.
- Communication in reference to: nurses, doctors and medications.
- Responsiveness of staff.
- Pain control.
- Hospital environment in reference to: cleanliness and quietness.
- Post discharge in reference to: written directions for post-discharge care.

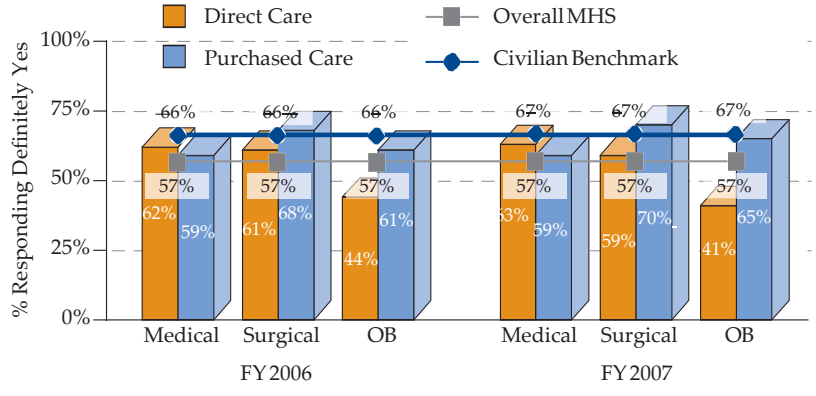
TRISS: RATING OF HOSPITAL



Source: TRICARE Inpatient Satisfaction Survey as of 12/12/08. Data are adjusted to account for the sampling design and nonresponses. (Ratings are on a 0–10 point scale with "Satisfied" defined as a rating of 9 or better.)

➤While the overall MHS rating of hospital lags the civilian benchmark in both years, satisfaction with surgical care received from Purchased Care facilities was comparable to or exceeded the civilian benchmark in both years. Satisfaction levels for Direct Care remained stable (Obstetrics) or increased (Medical; Surgical) between FY 2006 and FY 2007.

TRISS: WILLINGNESS TO RECOMMEND HOSPITAL



Source: TRICARE Inpatient Satisfaction Survey as of 12/12/08. Data are adjusted to account for the sampling design and nonresponses.

➤The overall MHS "willingness to recommend" remained stable between FY 2006 and FY 2007, but lags the civilian benchmark.

DRIVERS OF SATISFACTION

Results of customer surveys have become increasingly important in measuring health plan performance, and in directing action to improve the beneficiary experience and quality of services provided. Customer satisfaction is related to trust in doctors and the intention to switch doctor and health plan. In addition, patients with more positive reports about their care experiences had better health outcomes.

- Three key beneficiary surveys measure self-reported access and satisfaction with the MHS direct and purchased care experience:
  - Health Care Survey of DoD Beneficiaries (HCSDB)—population based,
  - TRICARE Inpatient Satisfaction Survey (TRISS)—event-based after a discharge from a hospital,
  - TRICARE Outpatient Satisfaction Survey (TROSS)—event-based following an outpatient visit.
- OASD(HA)/TMA-HPA&E, supported by the Altarum Institute, analyzed the results of the three key beneficiary surveys to determine the drivers of satisfaction. Drivers of satisfaction for all surveys were determined by examining the effects of composite scores on outcome measures (Health Care, Health Plan, Rating/Recommendation of Hospital) using logistic regression models. The models controlled for all composites and demographic variables, including age, gender, service, health status, and region. The effect size of odds ratios were used to rank-order drivers of satisfaction.
- As shown in the table below, satisfaction with health care is driven by the following factors for direct care services: communication between patients and doctors, nurses and staff, access to needed care and discharge information. Although not shown in the table, communication with doctors, nurses, and staff is also the primary driver of satisfaction with health care for purchased care services.
- These results suggest that improving communication has the potential to influence a patient's satisfaction with their health care, health plan, and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE

DRIVERS OF SATISFACTION	HCSDB January 2005–September 2007 Health Care Direct Care	TRISS FY 2007 Rating of Hospital Direct Care - Medical	TROSS CY 07 Health Care Direct Care
#1	Doctor Communication	Communication with Nurses	How Well Doctors Communicate
#2	Getting Needed Care	Discharge Information	Courteous & Helpful Office Staff
#3	Courteous Staff	Communication with Doctors	Getting Appointments & Health Care when Needed

Sources: OASD(HA)/TMA-HPA&E survey results and Altarum Institute, 12/5/2008

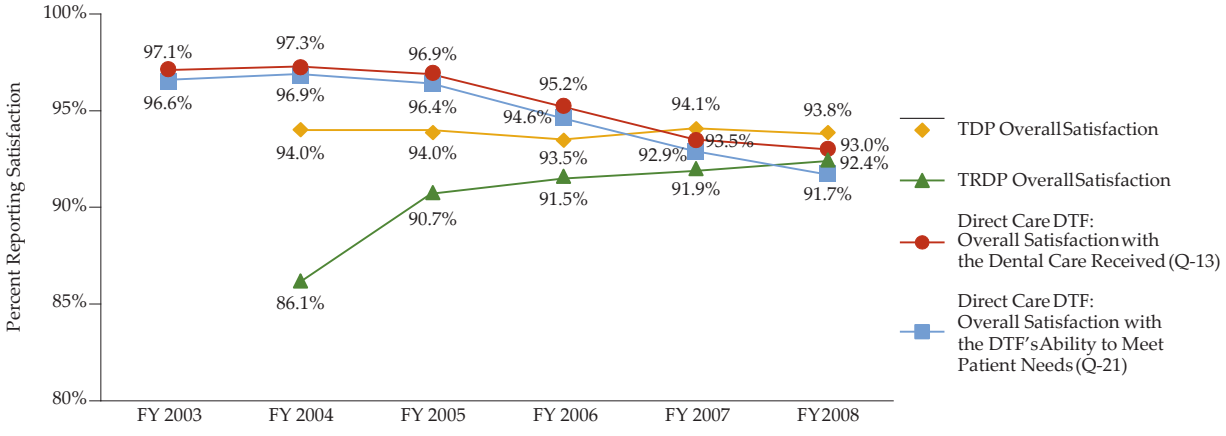
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

Dental Customer Satisfaction

The overall TRICARE dental benefit is composed of several delivery programs serving the MHS beneficiary population. Consistent with other benefit programs, beneficiary satisfaction is routinely measured for each of these important dental programs.

- Satisfaction with dental care reported by patients receiving dental care in military dental treatment facilities (DTFs) was 93 percent in FY 2008, compared with 93.5 percent in FY 2007. DTFs are responsible for the dental care of about 1.8 million ADSMs, as well as eligible Outside Continental U.S. family members. During FY 2008, the Tri-Service Center for Oral Health Studies collected 226,317 DoD Dental Patient Satisfaction Surveys from patients who received dental care at the Services' DTFs, a decrease of over 38,000 from FY 2007's 264,427. The overall DoD dental patient satisfaction with the ability of the DTFs to meet their dental needs also decreased by more than one percent to 91.7 percent in FY 2008.
- The **TRICARE Dental Program** (**TDP**) FY 2008 composite average enrollee satisfaction **decreased to 93.8 percent** in FY 2008. The TDP is a voluntary, premium-sharing dental insurance program that is available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their family members. As of September 30, 2008, the TDP services 766,054 contracts covering 1,838,111 lives. While not shown, this measure includes satisfaction ratings for network access (96.4 percent), provider network size and quality (91.2 percent), claims processing (95.9 percent), enrollment processing (96.2 percent), and written and telephonic inquiries (91.0 percent).
- The **TRICARE Retiree Dental Program (TRDP) overall retired enrollee satisfaction rates increased to 92.4 percent** in FY 2008, from 91.9 percent in FY 2007. The TRDP is a full premium insurance program open to retired Uniformed Service members and their families. It had a 6.3 percent increase in enrollees from FY 2007 to FY 2008, ending the year with 519,198 contracts covering 1,088,424 lives.

SATISFACTION WITH TDPs: 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, 10/31/2008.

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.

CLAIMS PROCESSING

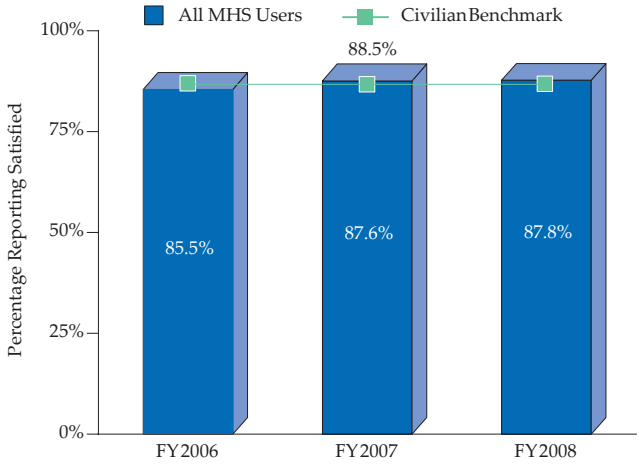
Claims processing is often cited as a "hot button" issue for beneficiaries as well as their providers. This is usually the case for the promptness of processing, as well as the accuracy of claims and payment. The MHS monitors the performance of TRICARE claims processing through two means—surveys of beneficiary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

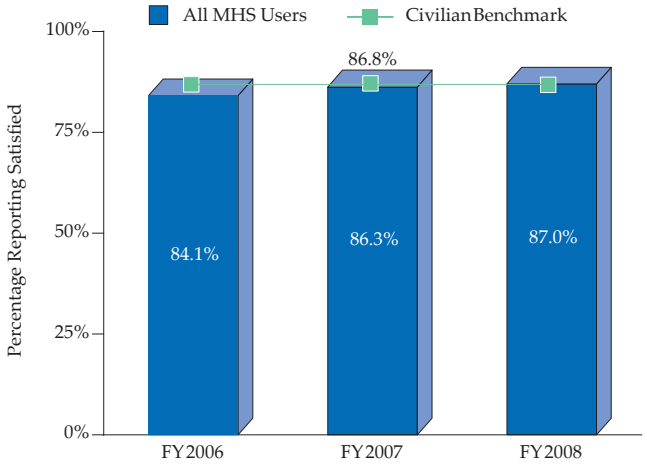
- Two primary measures of MHS beneficiary perceptions of claims processing increased between FY 2006 and FY 2008: Satisfaction with claims being processed accurately and satisfaction with processing in a reasonable period of time.
- While MHS satisfaction levels for both measures lagged the civilian benchmark in FY 2006, they were at parity by FY 2007 (i.e., not statistically significantly different).
- While not shown, the processing of retained claims within 30 days exceeded the TRICARE performance standard of the past seven years of 95 percent.

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

CLAIMS PROCESSED PROPERLY (IN GENERAL)



CLAIMS PROCESSED IN A REASONABLE TIME



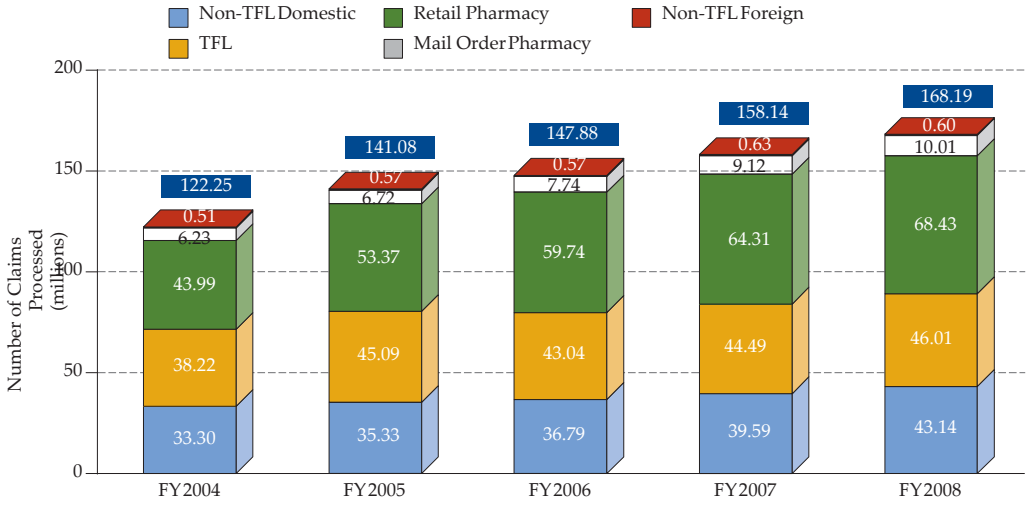
Note: DoD data were derived from the FYs 2006–2008 Health Care Survey of DoD Beneficiaries (HCSDB) as of 12/02/08 and adjusted for age and health status. Satisfaction ratings are based on the percentage rating "usually" or "always." Civilian benchmark is obtained from the National CAHPS Benchmarking 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.

CLAIMS PROCESSING *(CONT'D)*

Administratively Reported Claims Filing by CONUS/TFL/OCONUS

The number of claims processed continues to increase, due to increases in purchased care workload, including claims from seniors for TFL, pharmacy, and TRICARE dual-eligible beneficiaries. Claims processing volume increased by more than one third (more than 37 percent) between FY 2004 and FY 2008 (6 percent from FY 2007 to FY 2008). This increase is due to a combination of an increase in the overall volume of claims as well as a change in how pharmacy claims are reported. Prior to FY 2005, a pharmacy claim could include multiple prescriptions, whereas beginning in FY 2005 individual pharmacy prescriptions were reported separately. Both retail and mail order prescriptions increased the fastest between FY 2004 and FY 2008 (56 percent and 66 percent, respectively).

TREND IN THE NUMBER OF TRICARE CLAIMS PROCESSED, FY 2004 TO FY 2008



Source: MHS Administrative data, 11/12/2008.

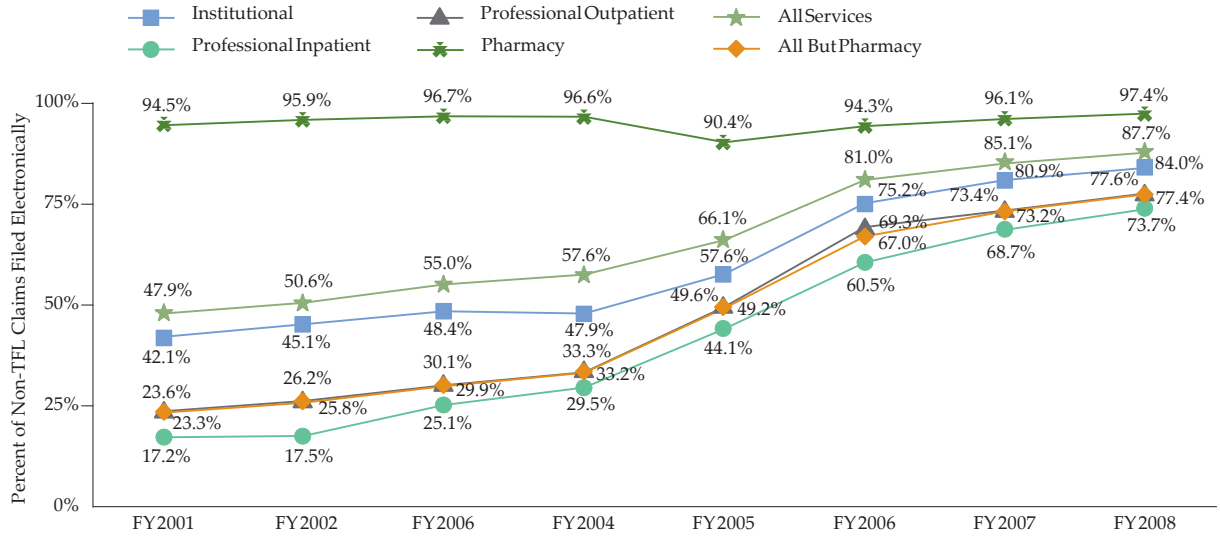
ELECTRONIC CLAIMS PROCESSING

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 prompter payment to the provider. The TROs have been actively collaborating with the health care support contractors to improve the use of electronic claims processing.

- The percentage of non-TFL claims processed electronically for all services increased to more than 87 percent in FY 2008, up two percentage points from the previous year, and more than 30 percentage points since FY 2004. These data focus on non-TRICARE For Life claims because TRICARE is a second payer to Medicare providers, which have, historically, reflected a higher percentage of electronic claims because of their program requirements and the size of their program.
- While pharmacy claims continue to be predominantly electronic, hovering at 95–97 percent, the real growth in electronic claims has been in the other categories reflected individually below, as well as in the "All but Pharmacy" trend line, surpassing 77 percent in 2008 (the individual categories below are Institutional and professional inpatient and outpatient services).

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



Source: MHS administrative claims data, 11/12/2008

Foreign claims are excluded.

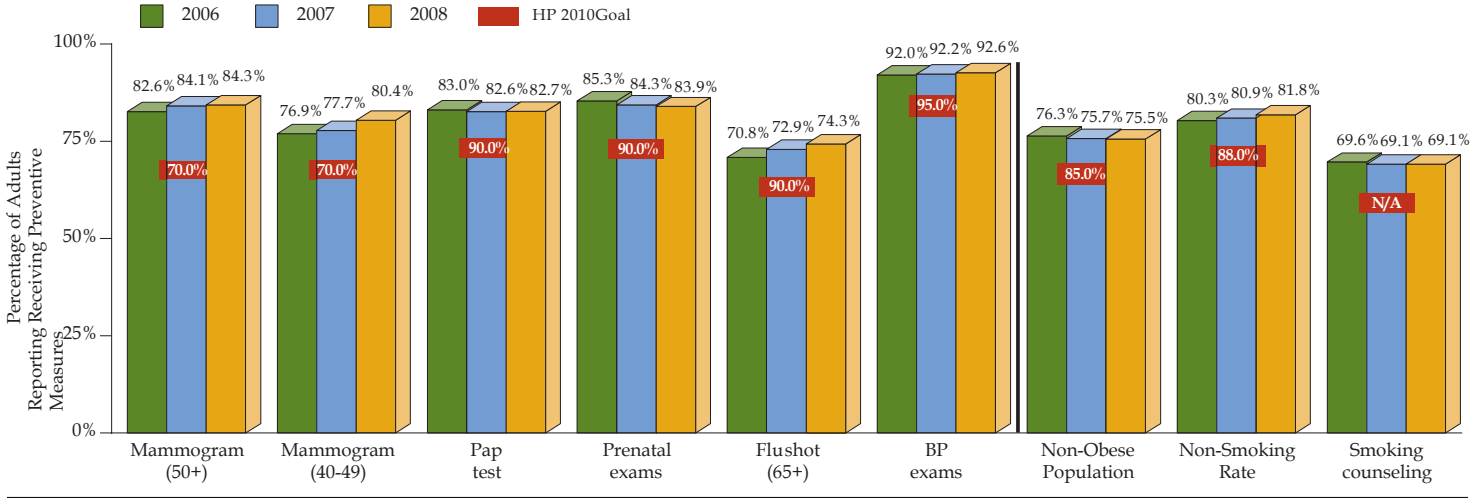
Note: Efforts to increase pharmacy access through the mail order program beginning in mid–FY 2007 may ultimately change the overall percentage of claims processed electronically. This is because mail order scripts cover longer periods of time (90 days for mail order instead of 30 days at retail pharmacies), 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.

BUILDING HEALTHY COMMUNITIES – HP 2010

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 HHS in HP 2010. Over the past three years, the MHS has met or exceeded targeted HP 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories).
- Efforts continue toward achieving HP 2010 standards for Pap smears, prenatal exams and 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 2006 through FY 2008. 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 "non-obese" has been established to indicate a general sense of the population likely not 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 2006 to FY 2008. The MHS rate of 76 percent non- obese in FY 2008, 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 HP standards, such as smoking-cessation counseling, which appears to be heading in the right direction, reaching almost 70 percent in FY 2008.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2006 TO FY 2008



Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database as of 12/02/2008

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 be used in conjunction with other assessments of overall health and body fat.

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

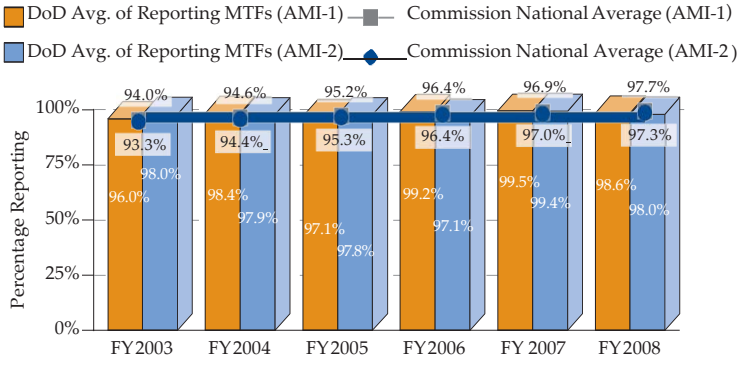
ACUTE MYOCARDIAL INFARCTION MEASURES–PROCESS AND OUTCOMES COMPARISON: MILITARY AND CIVILIAN HOSPITALS REPORTING TO THE JOINT COMMISSION (FY 2003–FY 2008)

In the United States, the Joint Commission is a nationally recognized organization that surveys health care settings using pre-established, published criteria to determine the accreditation status based on a triennial onsite survey by health care professionals. Participation in the Joint Commission survey process has been an institutionalized aspect of quality in the MHS for over 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. Additionally, 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.

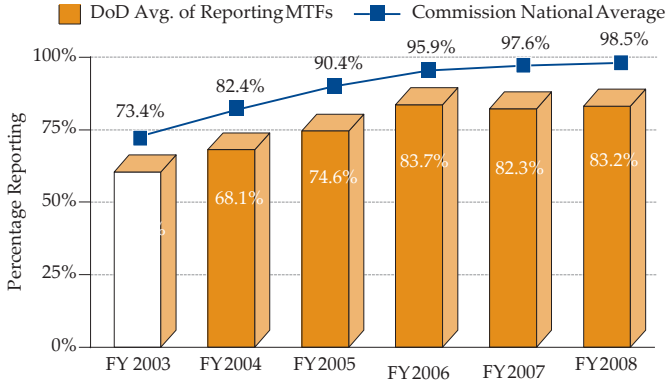
The Joint Commission has identified key measures with respect to acute myocardial infarction (AMI), heart failure, pneumonia, pregnancy, children's asthma care and surgical improvement project. MHS MTFs collect and analyze data on all of the Commission's hospital core measure sets. The charts below provide 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 MTFs have maintained a high rate of aspirin therapy for AMI patients, exceeding the Commission's comparative national average over the last six 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 between FY 2003 and FY 2008, it remains below the national average reported by the Commission which has similarly improved over that time frame.
- As shown in the bottom-most chart, with respect to outcomes of the AMI care process, the MHS-reported inpatient mortality rate has declined between FY 2003 and FY 2008, remaining below the Commission's national average of reporting hospitals.

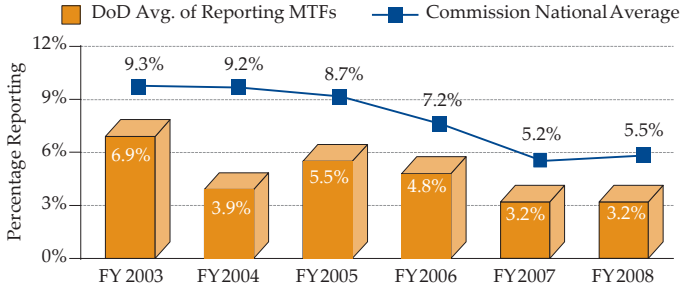
AMI: ASPIRIN AT ARRIVAL AND UPON DISCHARGE



AMI: SMOKING COUNSELING



AMI: RELATED INPATIENT MORTALITY



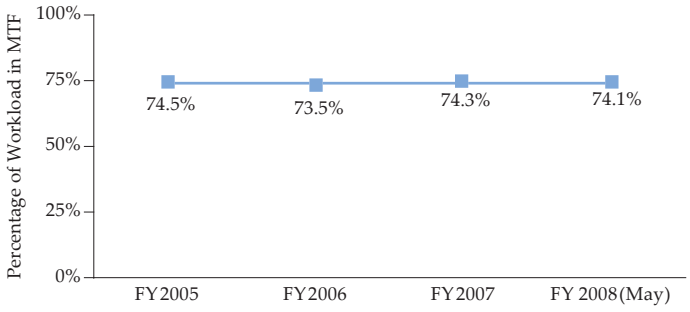
Note: FY 2008 data are through the 2nd quarter 2008.
Source: OASD(HA)/TMA, Office of the Chief Medical Officer, 11/13/2008

MTF ENROLLEE INPATIENT MARKET SHARE

Inpatient market share tracks the relative proportion of Prime enrollee inpatient care for Medical/Surgical that is done in Direct Care MTFs versus purchased in the Private Sector. The measure is based on the weighted workload using RWPs for both direct care and purchased care within catchment areas.[1] Data are adjusted across time to account for Inpatient closures.

The inpatient market share has remained stable from FY 2006 through FY 2008 (May). No adjustments have been made to account for the effects of deploying military providers and support staff, or for the significant influx of National Guard and Reservists and their family members, who have become eligible for the TRICARE benefit.

MTF ENROLLEE INPATIENT MARKET SHARE



Source: OASD(HA)/Office of the Chief Financial Officer, 12/03/2008.

Note: Market share measures exclude TFL workload from purchased care. Inpatient workload is based on RWPs and the 40-mile catchment area. As noted on page 22, the catchment area concept is being replaced within the MHS by MTF enrollment areas

[1] As noted on page 22, the catchment area concept is being replaced within the MHS by MTF enrollment areas.

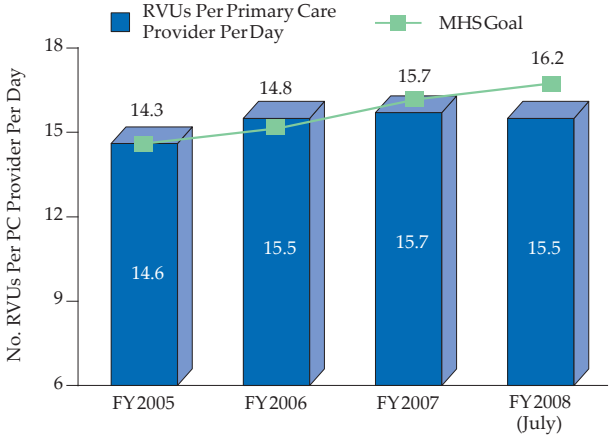
SYSTEM PRODUCTIVITY: RVU PER FULL TIME EQUIVALENT

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 RVU encounters (visits) per full-time equivalent (FTE) primary care provider in U.S. military clinics.

MHS productivity in FY 2008 (through July) is comparable to productivity in FY 2006 and FY 2007 (however, missing data at time of writing may result in overstating performance). Adjustments have been made to allow for proper trending of RVUs to account for CMS weight changes.

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, or for the influx of mobilized National Guard and Reservists and their family members.

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

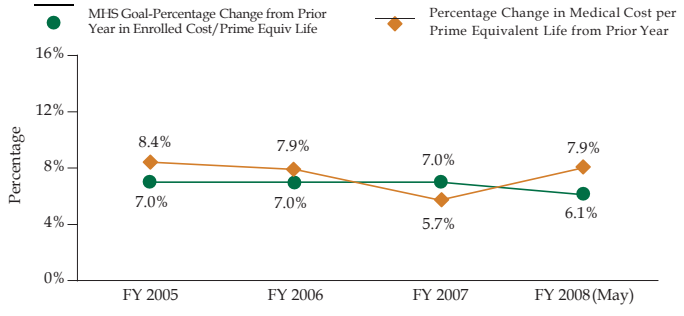


Source: OASD(HA)/Office of the Chief Financial Officer, 12/03/2008. Measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics. Due to missing MEPRS the following MTFs were excluded for FY08: Bliss AHC – Ft. Huachuca, Kimbrough ACC – Ft. Meade, Keller AHC – West Point, Womack AMC – Ft. Bragg, Beaumont AMC Ft. Bliss, Darnall AMC – Ft. Hood, McDonald ANC – Ft. Eustis, Dewitt ACH – Ft. Belvoir, Madigan AMC – Ft. Lewis, and Weed ACH – Ft. Irwin.

MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric in FY 2008 is to stay below a 6.1 percent annual rate of increase (revised downward from 7 percent in prior years), 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 8.4 percent in FY 2005 to 5.7 percent in FY 2007. Through May 2008, the FY 2008 annual rate of increase is 7.9 percent.

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



Source: OASD(HA)/Office of the Chief Financial Officer, 12/03/2008. Enrollee counts are not adjusted for age and gender.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

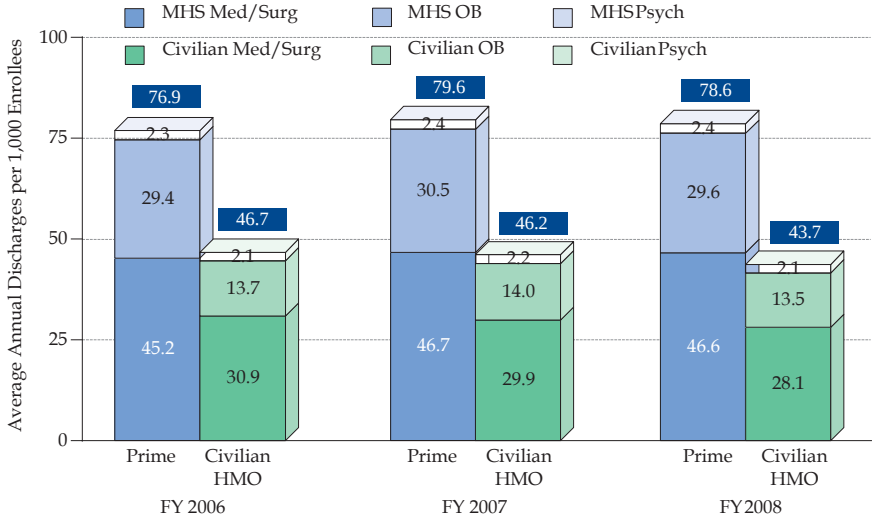
TRICARE Prime Enrollees

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 RWPs are not available in the civilian-sector data.

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

- The TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 80 percent higher than the civilian HMO utilization rate in FY 2008 (78.6 discharges per thousand Prime enrollees compared with 43.7 per 1,000 civilian HMO enrollees).
- In FY 2008, the TRICARE Prime inpatient utilization rate was 66 percent higher than the civilian HMO rate for MED/SURG procedures, 119 percent higher for OB/GYN procedures, and 14 percent higher for PSYCH procedures. The latter ratio, though based on relatively low MHS and civilian disposition rates, likely 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

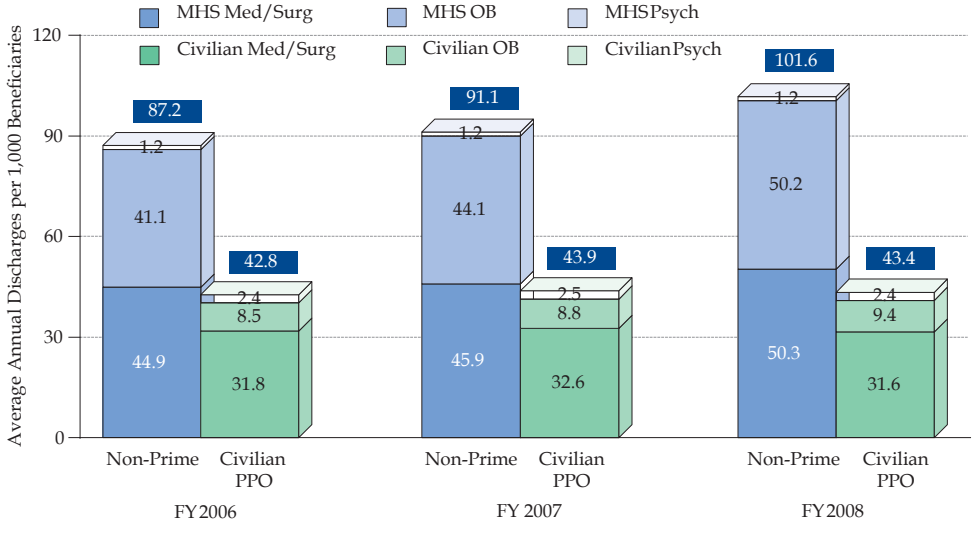
Non-Enrolled Beneficiaries

This section compares the inpatient utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored preferred provider organization (PPO) plans. Inpatient utilization is measured as the total number of dispositions (i.e., the sum of direct and purchased care dispositions) because RWPs are not available in the civilian-sector data.

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 8 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable with the civilian rates, which also include them.

- The inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants. From FY 2006 to FY 2008, the inpatient utilization rate for non-enrolled beneficiaries was increasing while it remained essentially constant in the civilian sector.
- By far the largest discrepancy in utilization rates between the MHS and private sector is for OB/GYN procedures. From FY 2006 to FY 2008, the MHS OB disposition rate increased by 22 percent whereas it increased by only 10 percent in the civilian sector. In FY 2008, the MHS OB disposition rate was more than five 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

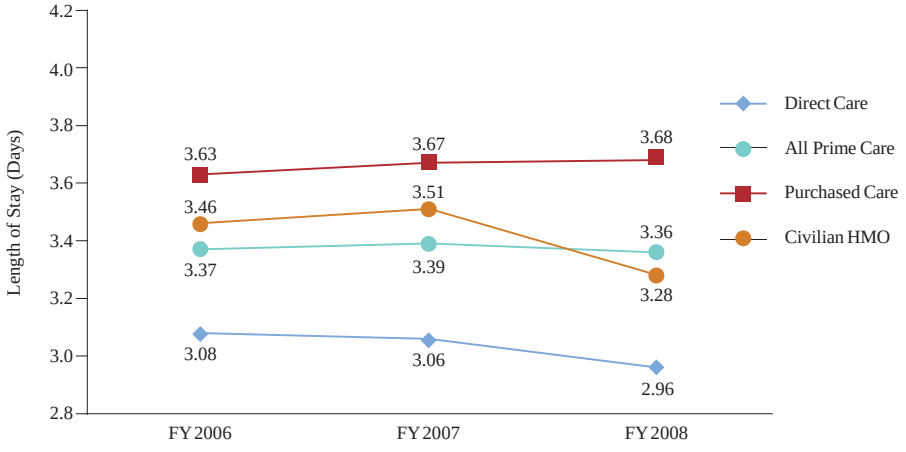
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

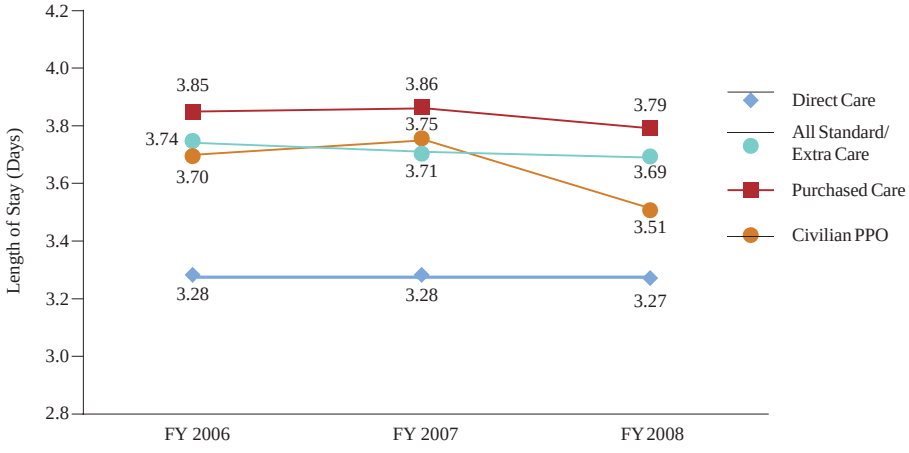
Average Length of Stay in Acute Care Hospitals

- Average length of stay (LOS) for Prime enrollees in DoD facilities (direct care) declined slightly between FY 2006 and FY 2008. Average LOS for space-available care remained flat over that period. Purchased care LOS remained about the same for both enrolled and non-enrolled beneficiaries.
- Average LOS in TRICARE purchased acute care facilities is well above those in DoD facilities. Hospital stays in purchased care facilities are longer on average than in DoD facilities because purchased care facilities perform more complex procedures (as determined by RWPs—a measure of inpatient resource intensity).
- Average LOS for MHS-wide Prime and Standard/Extra care stayed the same between FY 2007 and FY 2008, whereas the average LOS in the civilian sector (both HMOs and PPOs) declined by 5 percent.
- In FY 2008, average LOS for MHS-wide Prime care was 2 percent higher than in civilian HMOs. The average LOS for non-Prime care (space-available and Standard/Extra) was 5 percent higher 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: Beneficiaries age 65 and older were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (civilian HMO data were adjusted by Prime dispositions and civilian PPO data were adjusted by Standard/Extra dispositions). FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

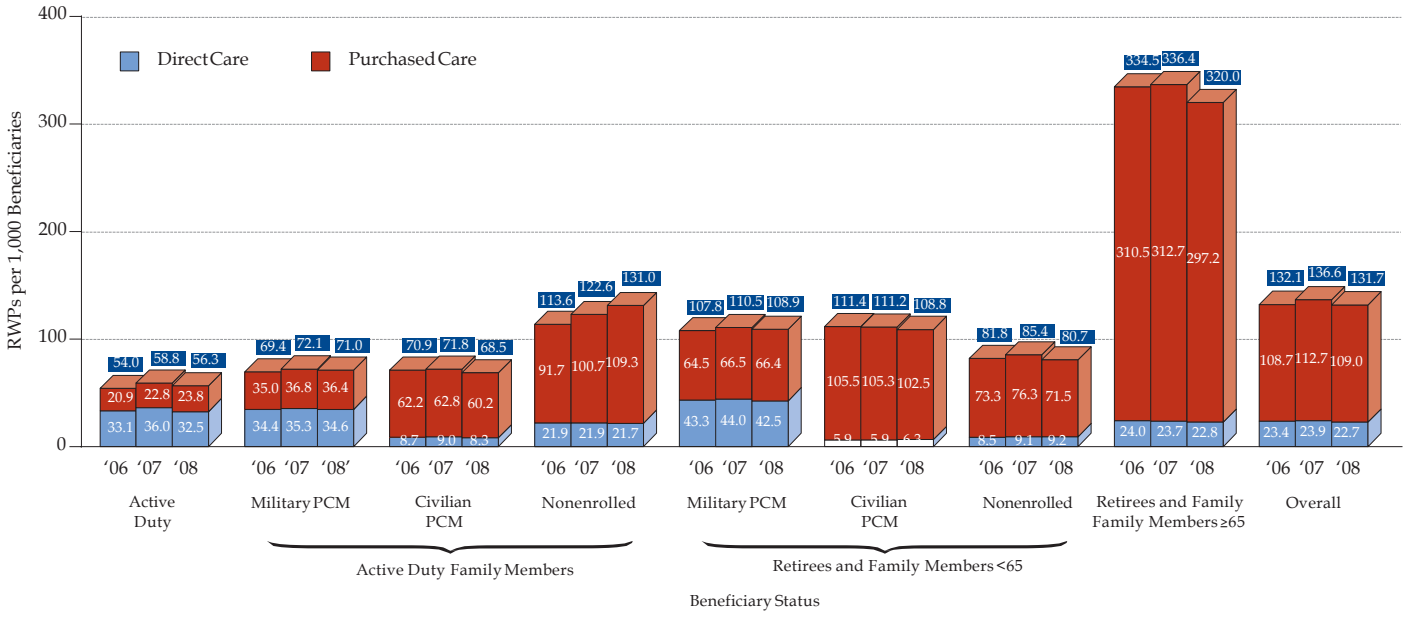
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

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

- The direct care inpatient utilization rate (RWPs per 1,000 beneficiaries) increased the most (8 percent) for nonenrolled retirees and family members under age 65, followed by retirees and family members under age 65 with a civilian PCM (7 percent). The rate either stayed the same or declined for all other beneficiary groups.
- Purchased acute care inpatient utilization rates increased substantially for active duty service members (14 percent) and non-enrolled active duty family members (19 percent). The rate increased slightly for beneficiaries with a military PCM and declined slightly for all other beneficiary groups.
- The TFL acute care inpatient utilization rate declined by 4 percent between FY 2006 and FY 2008.*
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of total inpatient workload performed in purchased care facilities increased slightly from 71 to 72 percent.
- From FY 2006 to FY 2008, the percentage of inpatient workload (RWPs) referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) increased slightly from 50 percent to 51 percent.

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



Source: MHS administrative data, 1/6/2009

* 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.

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

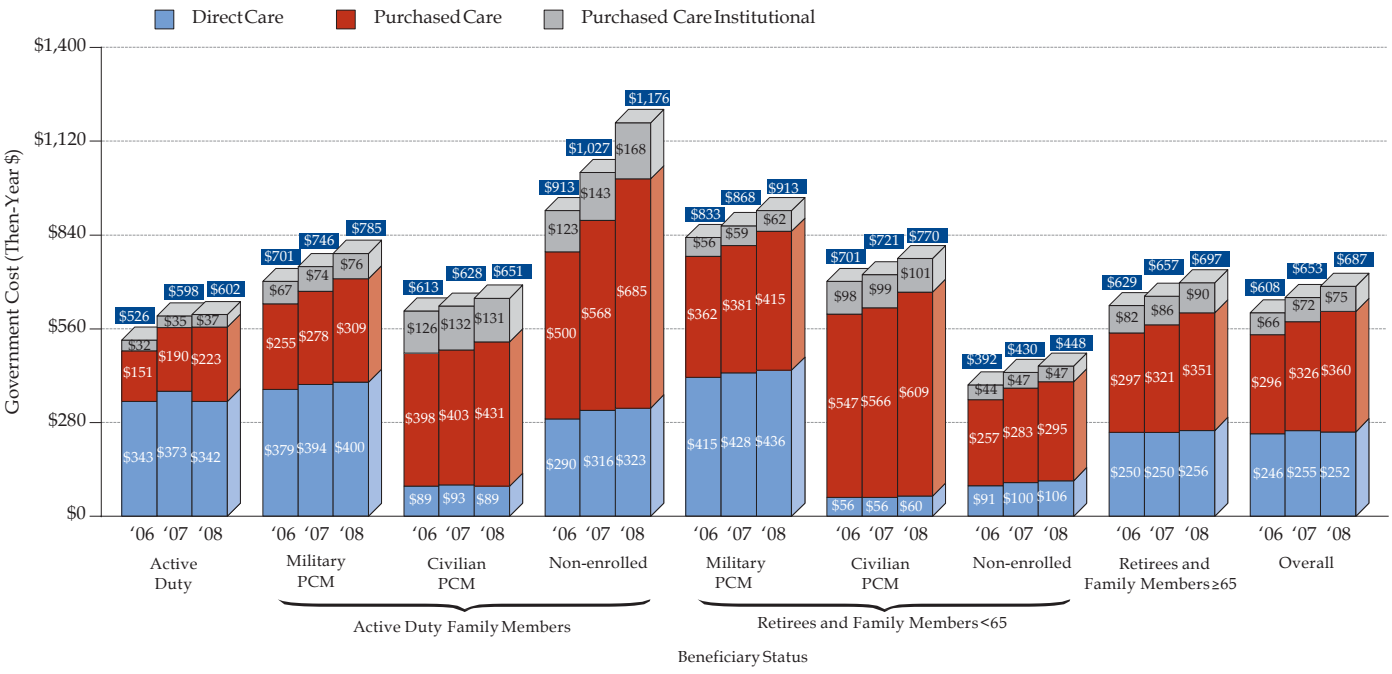
Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services, i.e., noninstitutional charges (e.g., physician, lab, anesthesia) associated with a hospital stay. Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 7 percent in FY 2007 and by another 6 percent in FY 2008. The increases were due largely to higher purchased care costs.

- The direct care cost per RWP increased from $10,530 in FY 2006 to $11,104 in FY 2008 (5 percent).
- Exclusive of TFL, the total purchased care cost (institutional plus noninstitutional) per RWP increased from $6,271 in FY 2006 to $7,341 in FY 2008 (17 percent).

The purchased care cost per RWP is much lower than that for direct care because many beneficiaries using purchased care have other health insurance. When beneficiaries have other health insurance, TRICARE becomes second payer and the Government pays a smaller share of the cost.

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



Source: MHS administrative data, 1/6/2009

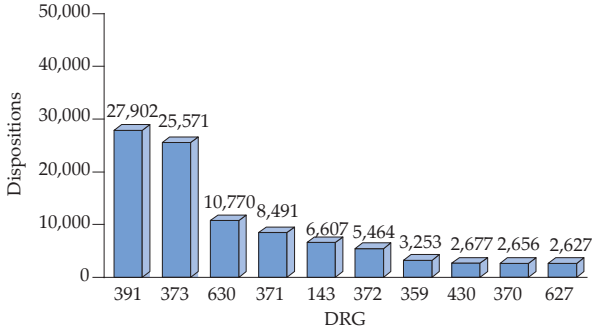
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Leading Inpatient Diagnoses by Volume

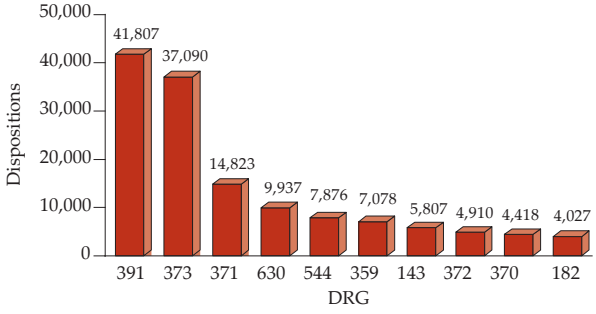
The top 10 diagnosis-related groups (DRGs) in terms of admissions in FY 2008 accounted for 42 percent of all inpatient admissions in military hospitals (direct care) and for 39 percent in civilian acute care hospitals (purchased care). TFL admissions are excluded.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2008 BY VOLUME

DIRECT CARE



PURCHASED CARE



DRGs

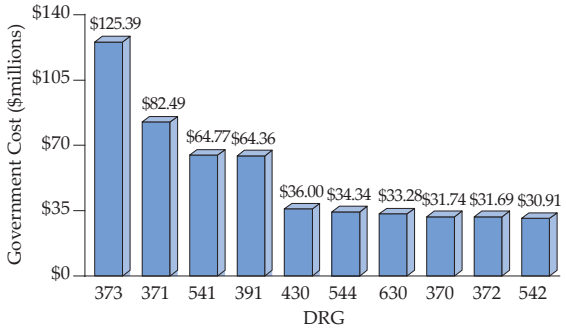
143 Chest pain
288 O.R. procedures for obesity
359 Uterine and adnexa proc for non-malignancy without CC
370 Cesarean section with CC
371 Cesarean section without CC
372 Vaginal delivery with complicating diagnoses
373 Vaginal delivery without complicating diagnoses
391 Normal newborn
430 Psychoses
544 Major joint replacement or reattachment of lower extremity
627 Neonate, birthwt >2499G, without signif or proc, with major prob
630 Neonate, birthwt >2499G, without signif or proc, with other prob

Leading Inpatient Diagnoses by Cost

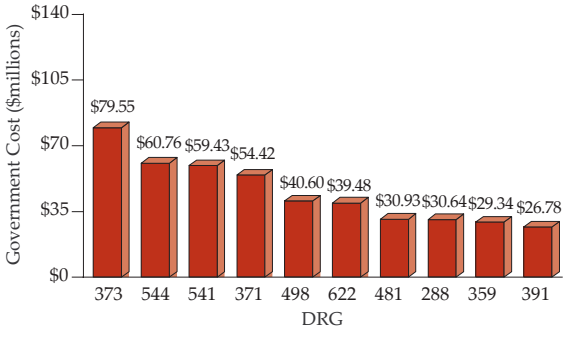
The leading diagnoses in terms of cost in FY 2008 were determined from institutional claims only; i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges. The top 10 DRGs in terms of cost in FY 2008 accounted for 25 percent of total direct care inpatient costs and for 23 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 2008 BY COST

DIRECT CARE



PURCHASED CARE



DRG Description

288 O.R. procedures for obesity
359 Uterine and adnexa proc for non-malignancy 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
481 Bone marrow transplant
498 Spinal fusion except cervical w/o CC
541 Ecmo or trach w mv 96+hrs or pdx exc fce, mouth & nck w maj o.r.
542 Tracheostomy with mv 96+hrs or pdx exc face, mouth & neck w/o maj o.r.
544 Major joint replacement or reattachment of lower extremity
622 Neonate, birthwt >2499g, w signif or proc, w mult major prob
630 Neonate, birthwt >2499g, without signif or proc, with other prob

Source: MHS administrative data, 1/6/2009

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

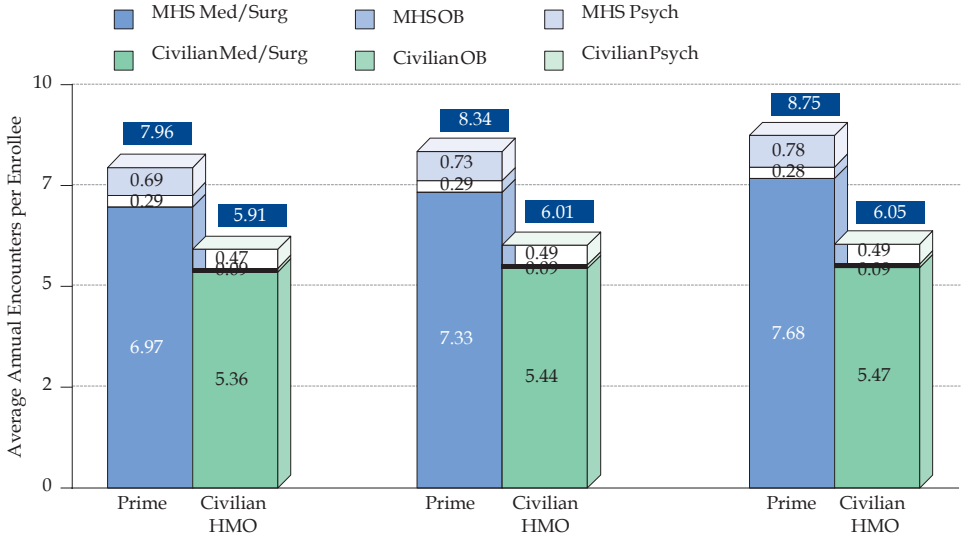
TRICARE Prime Enrollees

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

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

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care utilization) rose by 10 percent between FY 2006 and FY 2008. The civilian HMO outpatient utilization rate rose by 2 percent over the same period.
- In FY 2008, the overall Prime outpatient utilization rate was 45 percent higher than the civilian HMO rate.
- In FY 2008, the Prime outpatient utilization rate for MED/SURG procedures was 40 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was more than triple the corresponding rate for civilian HMOs in FYs 2006 to 2008, but that is due in part to how the direct care system records bundled services.[a]
- The Prime outpatient utilization rate for PSYCH procedures was about 50 percent higher than the corresponding rate for civilian HMOs in FYs 2006 to 2008. This disparity, though based on relatively low MHS and civilian mental health utilization rates, may reflect 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

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

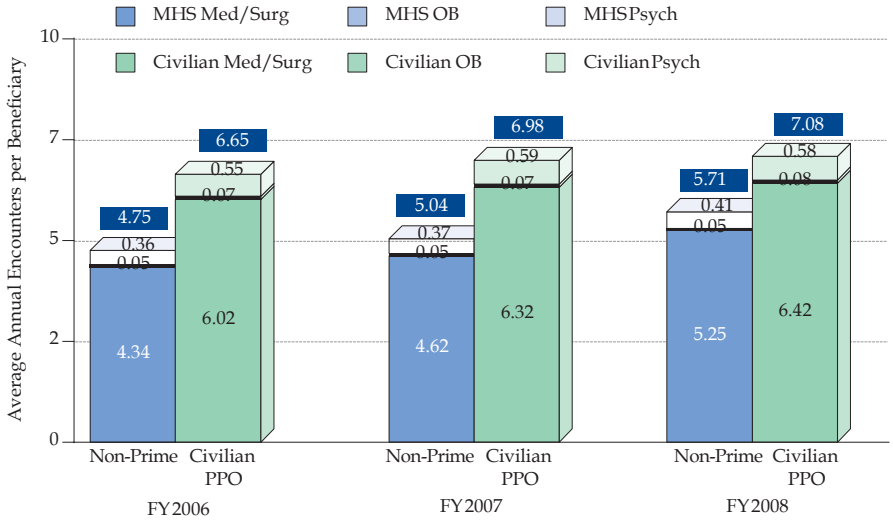
Non-Enrolled Beneficiaries

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

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 8 and 14 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall TRICARE outpatient utilization rate (direct and purchased care utilization combined) for non-enrolled beneficiaries increased by 20 percent from 4.8 encounters per participant in FY 2006 to 5.7 in FY 2008. The civilian PPO outpatient utilization rate increased by only 6 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 2008, TRICARE non-Prime outpatient utilization was 19 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 non-Prime outpatient utilization rate for OB/GYN procedures held steady between FY 2006 and FY 2008 at a level about 30 percent lower than that for civilian PPO participants.
- The PSYCH outpatient utilization rate of non- enrolled MHS beneficiaries increased by 15 percent from FY 2006 to FY 2008 whereas the rate increased by only 5 percent for civilian PPO participants. Even so, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 30 percent below that of civilian PPO participants in FY 2008. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

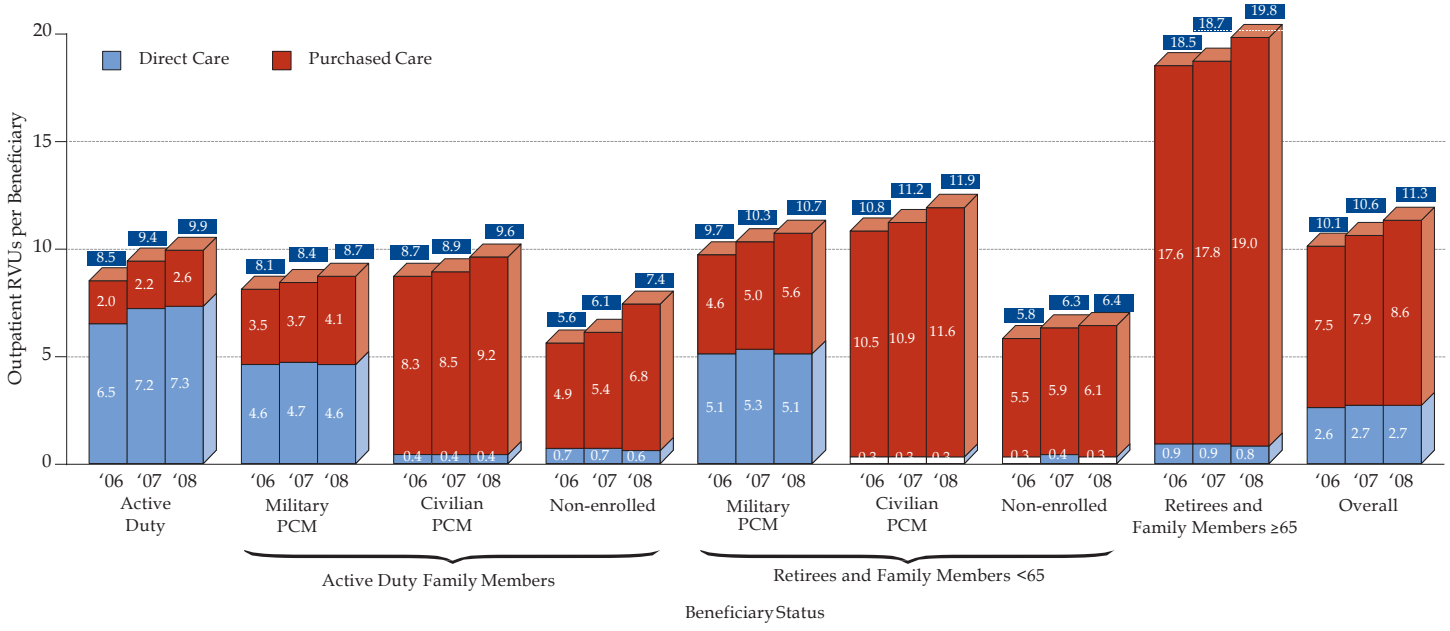
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

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

- The direct care outpatient utilization rate increased by 11 percent from FY 2006 to FY 2008 for Active Duty personnel. The rate increased for enrolled ADFMs and and either declined or stayed about the same for all other beneficiary groups. Non-enrolled active duty family members and seniors experienced the largest declines.
- From FY 2006 to FY 2008, the purchased care outpatient utilization rate increased significantly for all beneficiary groups. The largest increase (37 percent) was experienced by non-enrolled active duty family members. Active duty personnel experienced an increase of 27 percent, continuing a trend of increased purchased care utilization by them.
- After rising by only 1 percent in FY 2007, the TFL outpatient utilization rate increased by 7 percent in FY 2008.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/6/2009

* 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.

Note: The Centers for Medicare and Medicaid Services (CMS) recently completed a quintennial study of payment policies for professional services that resulted in a "re-baselining" of RVUs. Consequently, part of any observed changes in FY 2007 and FY 2008 RVUs are artificial and can be attributed directly to the change in weights and not necessarily to volume or complexity of services. FY 2007 and FY 2008 RVUs were therefore adjusted to reflect the FY 2006 RVU weights.

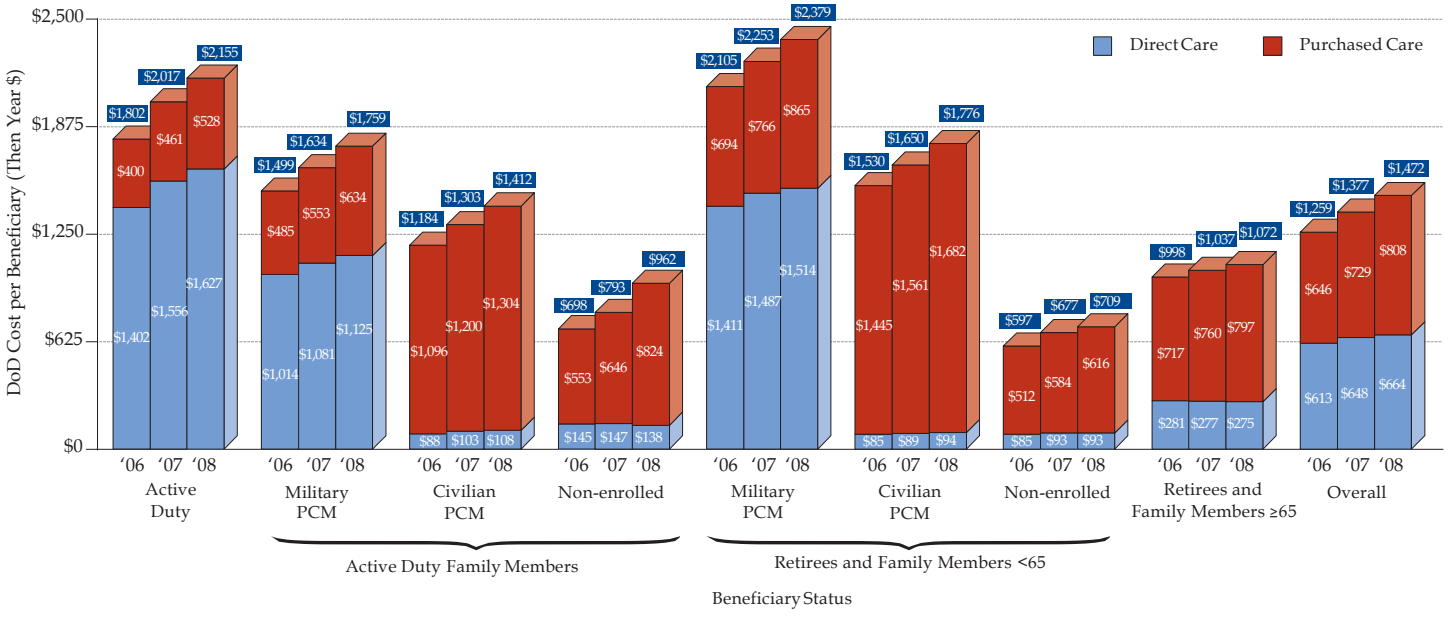
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

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 17 percent from FY 2006 to FY 2008.

- The direct care cost per beneficiary increased for all MTF-enrolled beneficiaries. Active duty family members with a civilian PCM experienced the largest increase (22 percent), followed by Active Duty personnel (16 percent).
- Net of TFL, the DoD purchased care outpatient cost per beneficiary increased by 15 percent in FY 2007 and by 14 percent in FY 2008. Thus, the recent trend in double-digit purchased care cost increases continues unabated.
- The TFL purchased care outpatient cost per beneficiary increased by 6 percent in FY 2007 and by another 5 percent in FY 2008.* The direct care cost per senior declined slightly.

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



Source: MHS administrative data, 1/6/2009

* 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 dividing the total days supply for each by 30 days.

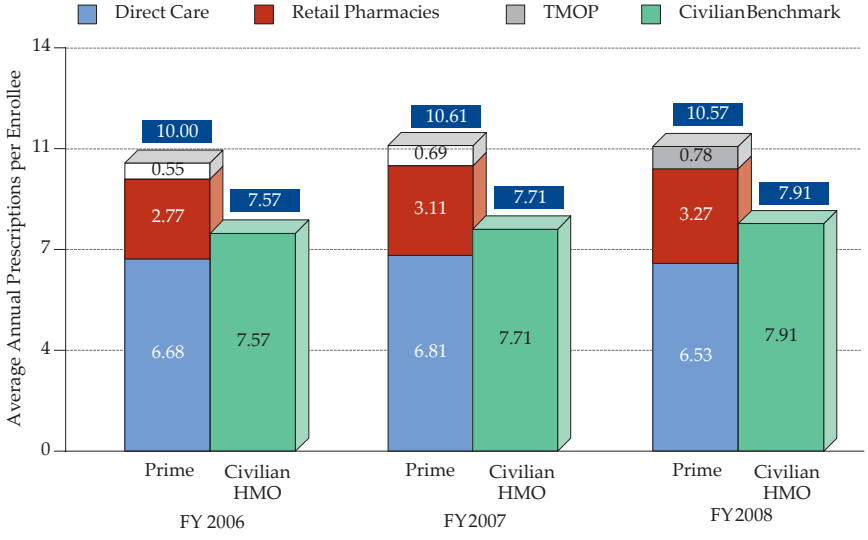
Direct care pharmacy data differ from private sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DoD Pharmacoeconomic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

TRICARE Prime Enrollees

This section compares the prescription drug utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. The comparisons are made for beneficiaries under age 65 only. The MHS data exclude beneficiaries enrolled in the USFHP and TRICARE Plus.

- The overall prescription utilization rate (direct and purchased care combined) for TRICARE Prime enrollees rose by 6 percent between FY 2006 and FY 2008, whereas the civilian HMO benchmark rate rose by 5 percent. The TRICARE Prime prescription utilization rate was 34 percent higher than the civilian HMO rate in FY 2008.
- Prescription utilization rates for Prime enrollees at DoD pharmacies declined by 2 percent, whereas the utilization rate at retail pharmacies increased by 18 percent from FY 2006 to FY 2008.
- Enrollee mail order prescription utilization increased by 41 percent from FY 2006 to FY 2008. 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2008 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

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

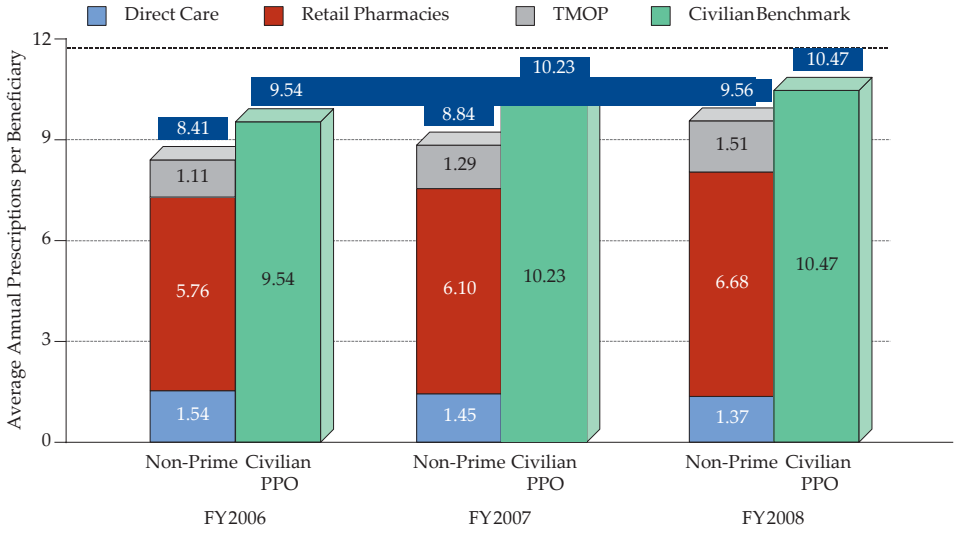
Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. The comparisons are made for beneficiaries under age 65 only.

To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate between 7 and 10 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries rose by 5 percent between FY 2006 and FY 2008. During the same period, the civilian PPO benchmark rate rose by 14 percent. Although the gap has narrowed, the TRICARE prescription utilization rate is still 9 percent lower than the civilian PPO rate.
- Prescriptions filled for non-enrolled beneficiaries at DoD pharmacies dropped by 11 percent, whereas prescriptions filled at retail pharmacies increased by 16 percent from FY 2006 to FY 2008.
- Non-enrollee mail order prescription utilization increased by 36 percent from FY 2006 to FY 2008. 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 Thomson Reuters Inc., MarketScan® Commercial Claims and Encounters database, 1/6/2009

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2008 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.

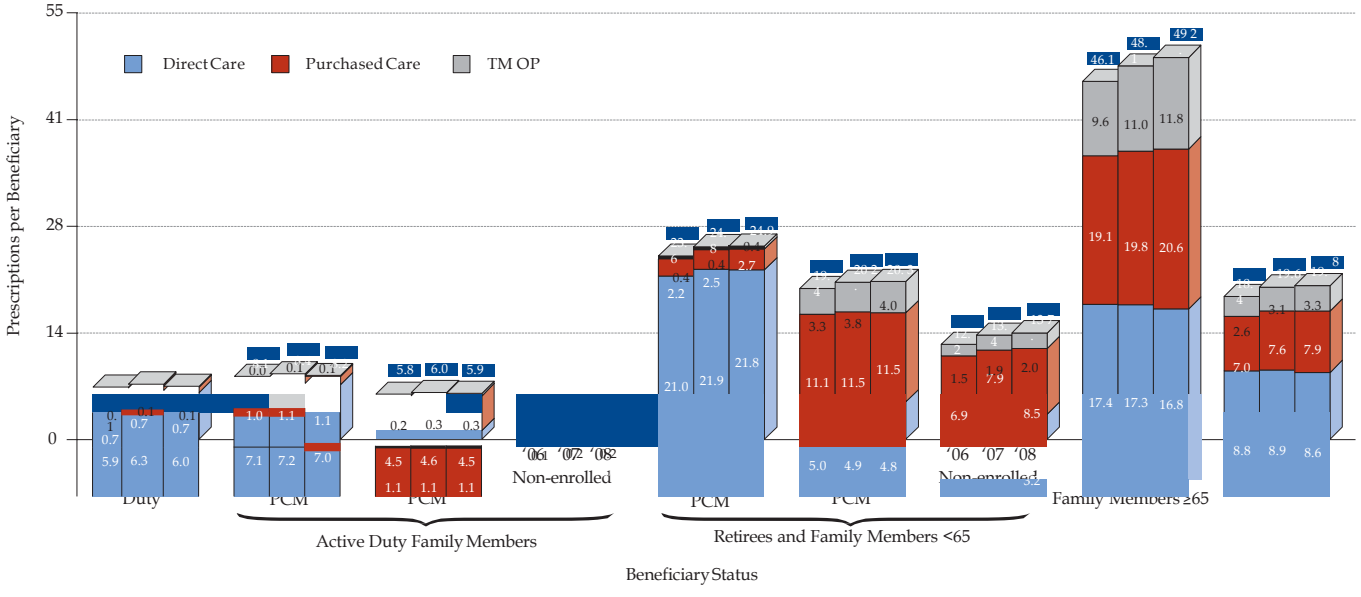
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

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

- The total (direct, retail, and TMOP) number of prescriptions per beneficiary increased by 7 percent from FY 2006 to FY 2008, exclusive of the TSRx benefit. Including TSRx, the total number of prescriptions increased by 8 percent.
- Average direct care prescription utilization declined by 2 percent. The direct care prescription utilization rate increased for active duty service members (2 percent) and for retirees and family members under age 65 enrolled with a military PCM (4 percent). The rate decreased for all other beneficiary groups, with nonenrolled beneficiaries under age 65 experiencing the largest drop (15 percent).
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail order) increased sharply for all beneficiary groups, but most notably for retirees and family members under age 65 with a military PCM and for non-enrolled retirees and family members under age 65 (by 24 and 26 percent, respectively).
- TMOP remains a relatively infrequent source of purchased care prescription utilization but its use has been increasing. When normalized by 30 days supply, TMOP utilization as a percentage of total purchased care prescription drug utilization increased from 27 percent in FY 2006 to 29 percent in FY 2008.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



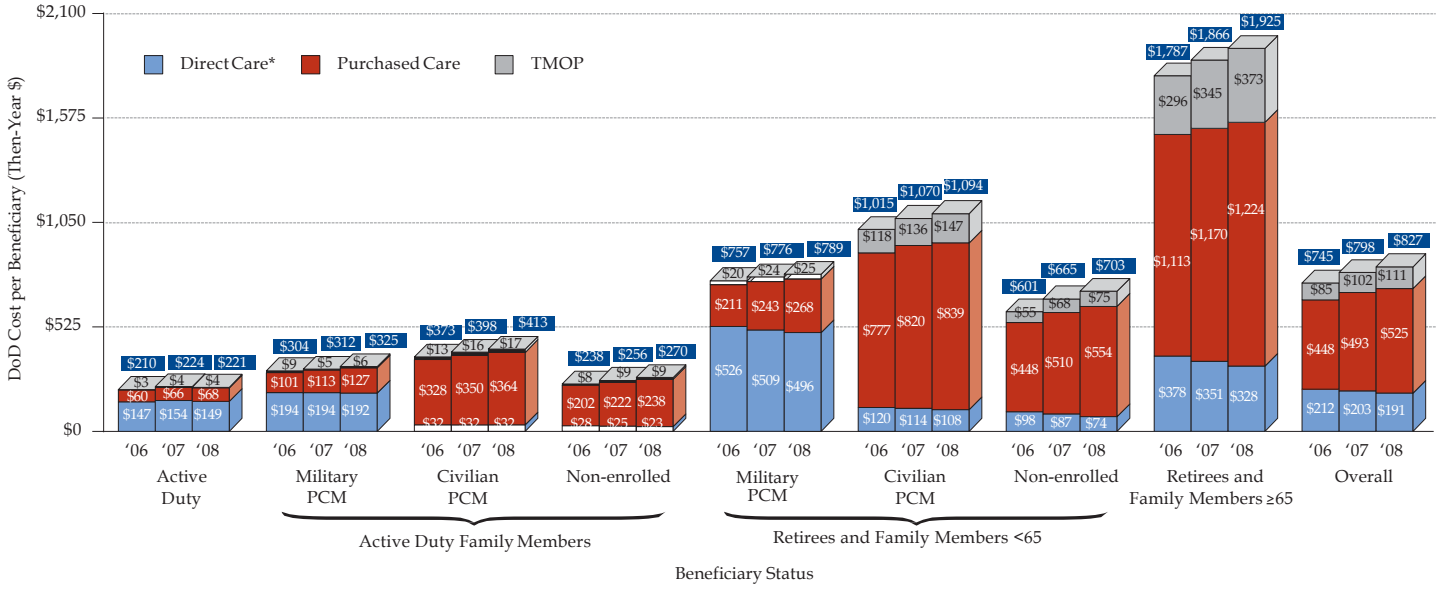
Source: MHS administrative data, 1/6/2009

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

Prescription Drug Cost by Beneficiary Status

- Prescription drug costs rose by 12 percent between FY 2006 and FY 2008, irrespective of whether the TSRx benefit is included. This is lower than the increases in inpatient costs (13 percent) and outpatient costs (17 percent).
- Direct care costs per beneficiary decreased by almost 10 percent but retail pharmacy costs rose by 22 percent exclusive of TSRx and by 17 percent including TSRx.
- TMOP costs increased at a faster rate than retail pharmacy, increasing by 31 percent versus 17 percent for retail.

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/6/2009
* Direct care prescription costs include an MHS-derived dispensing fee.

BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS

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 TFL Program in FY 2002 dramatically reduced costs for MHS seniors. Costs are compared for a typical TRICARE senior family before and after TFL.

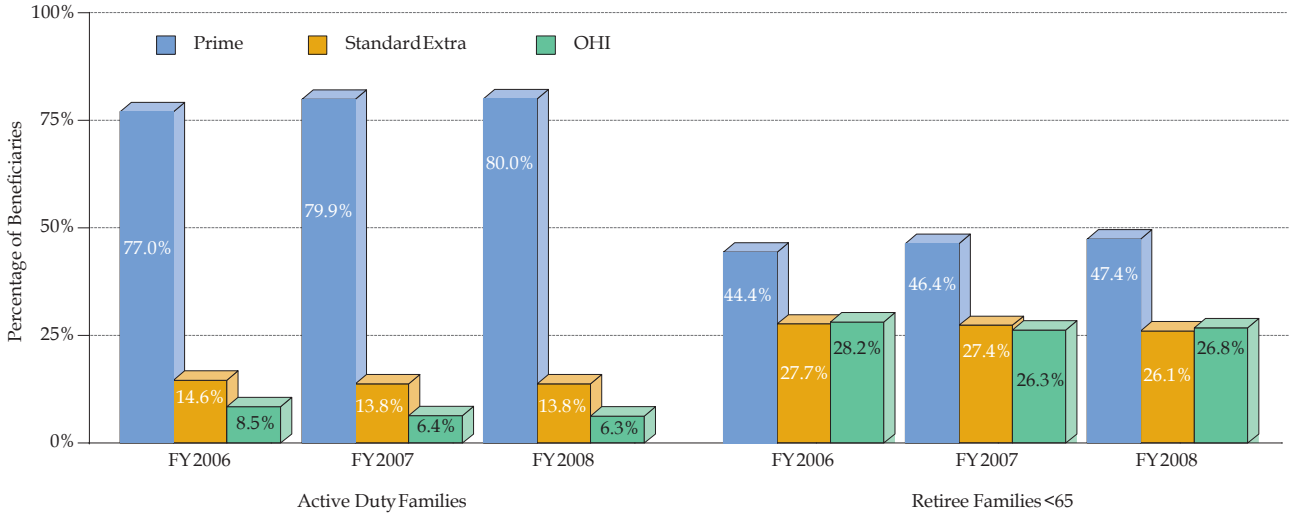
Health Insurance Coverage of MHS Beneficiaries Under Age 65

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

Beneficiaries are grouped by their primary health plan:

- TRICARE Prime: Family enrolled in TRICARE Prime and no OHI. In FY 2008, 80.0 percent of Active Duty families and 47.4 percent of retiree families were in this group.
- TRICARE Standard/Extra: Family not enrolled in TRICARE Prime and no OHI coverage. In FY 2008, 13.8 percent of ADFMs and 26.1 percent of retiree families were in this group.
- OHI: Family covered by OHI. In FY 2008, 6.3 percent of Active Duty families and 26.8 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: FYs 2006–2008 administrations of the Health Care Surveys of DoD Beneficiaries (HCSDB)

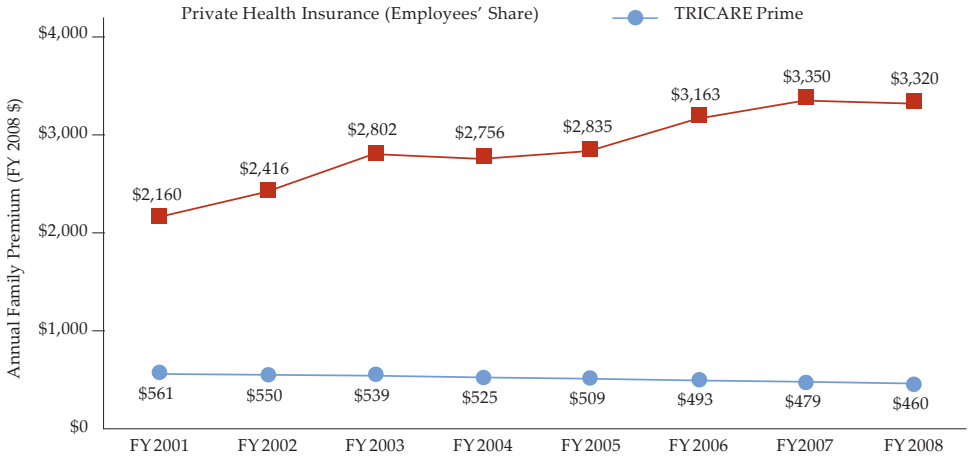
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not add up to 100 percent due to rounding.

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

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2001, private health insurance family premiums have been rising while the TRICARE enrollment fee has remained fixed at $460 per retiree family. In constant FY 2008 dollars, the private health insurance premium increased by $1,160 (54 percent) from FY 2001 to FY 2008, whereas the TRICARE premium declined by $101 (–18 percent) during this period.

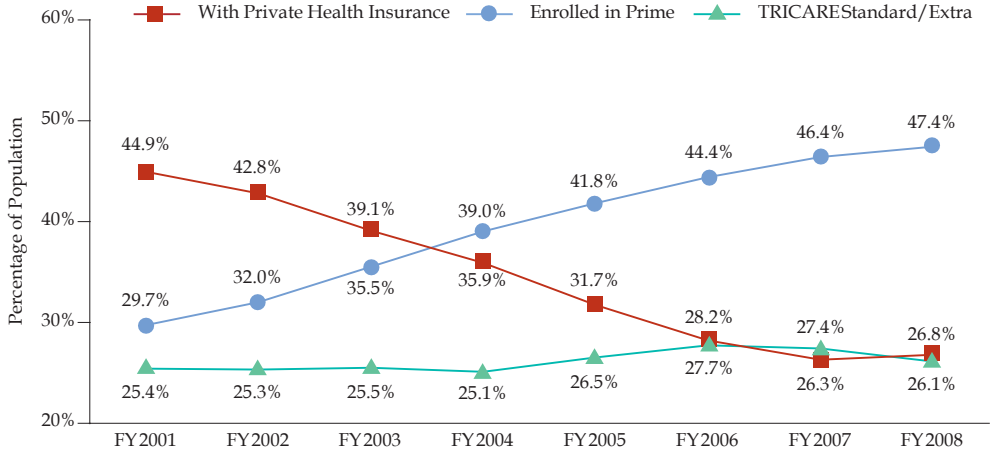
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer sponsored family health plan: Medical Expenditure Panel Surveys, 2000–2006; forecasted by Institute for Defense Analyses in FYs 2007–2008 based on trends in premiums from Kaiser Family Foundation surveys in CYs 2006–2008.

The increasing disparity in premiums induced 18 percent of retirees to drop their private health insurance and switch to TRICARE between FY 2001 and FY 2008. As a result, an additional 550,000 retirees and family members under age 65 are now using TRICARE instead of private health insurance.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: DEERS and Health Care Beneficiary Surveys of DoD Beneficiaries, 2001–2008.

Note: The Prime enrollment rates above include those with OHI (about 4 percent of retirees).

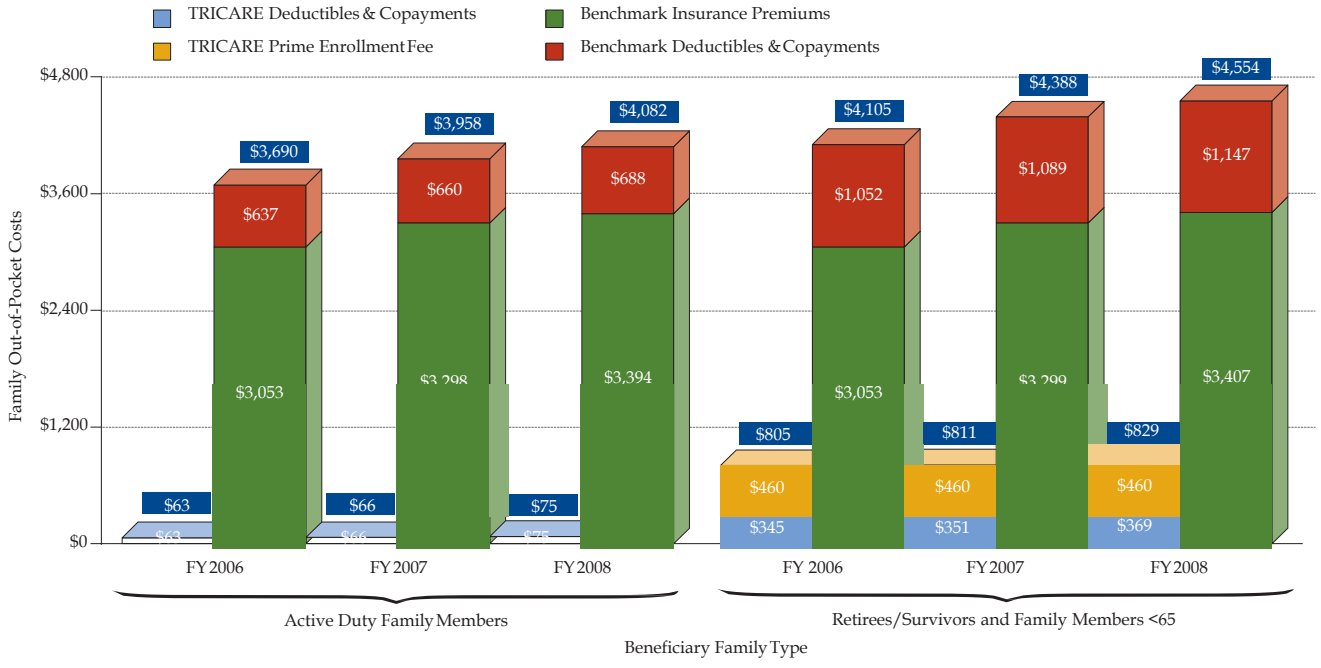
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS *(CONT'D)*

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

In FYs 2006–2008, 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 2008, costs for civilian counterparts were:
  - $4,000 more than those incurred by Active Duty families enrolled in Prime.
  - $3,700 more than those incurred by retiree families enrolled in Prime.

OUT-OF-POCKET COSTS FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2006–08; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–08; civilian insurance premium for FY 2006 from the CY 2005-2006 Medical Expenditure Panel Surveys; premiums for FYs 2007–08 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in CYs 2006-2008. OHI coverage from Health Care Surveys of DoD Beneficiaries, 2006–08.

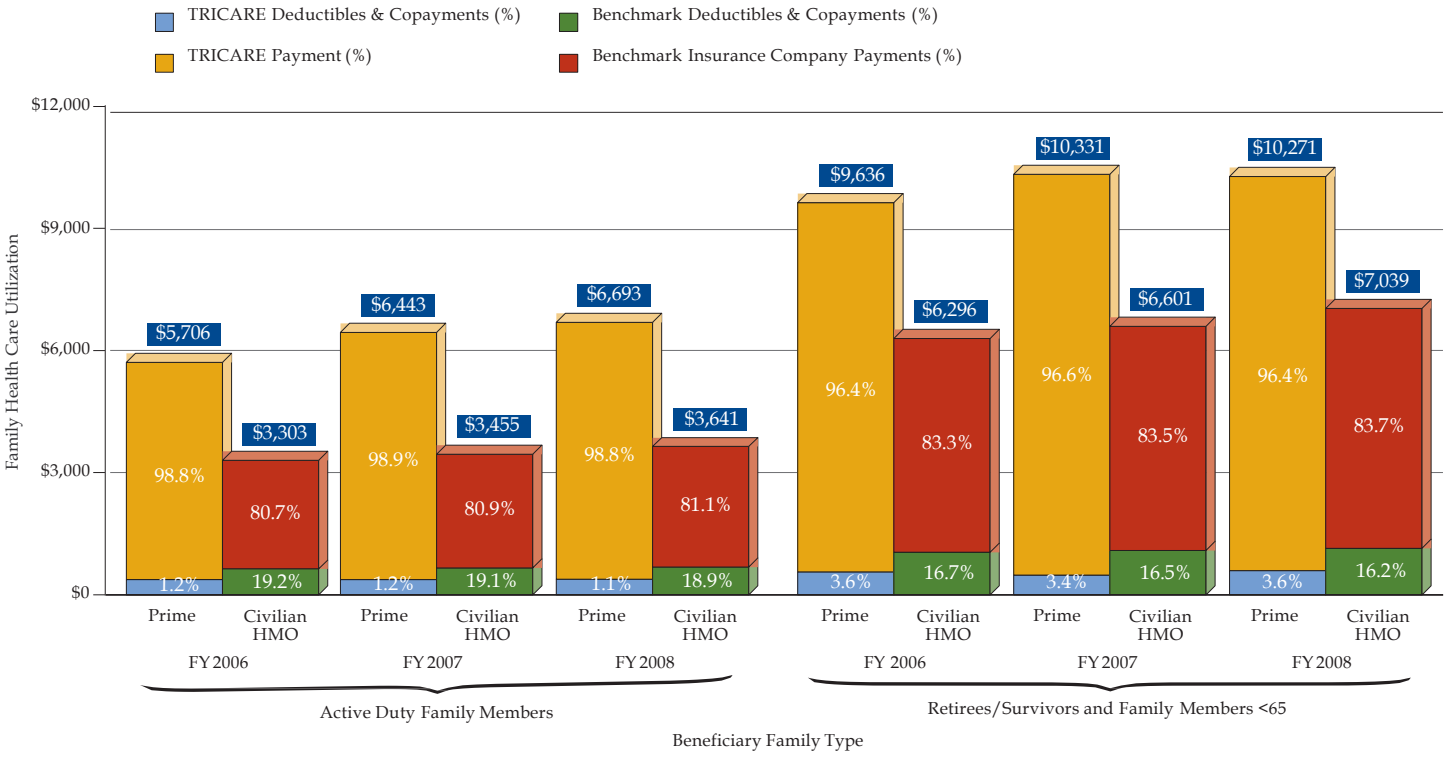
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS *(CONT'D)*

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

Previous private sector studies find that very low coinsurance rates increase health care utilization (dollar value of health care services). In FYs 2006–2008, TRICARE Prime enrollees had negligible co-insurance rates (deductibles and copayments per dollar of utilization) and substantially higher utilization compared to civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- TRICARE Prime enrollees had much lower average co-insurance rates than civilian HMO counterparts.
  - In FY 2008, the co-insurance rate for active duty families was 1.1 percent versus 18.9 percent for civilian counterparts.
  - In FY 2008, the co-insurance rate for retiree families was 3.6 percent versus 16.3 percent for civilian counterparts.
- TRICARE Prime enrollees had higher health care utilization than civilian HMO counterparts.
  - In FY 2008, active duty families consumed $6,700 of medical services versus $3,600 by civilian counterparts.
  - In FY 2008, retiree families consumed $10,300 of medical services versus $7,000 by civilian counterparts.

COST SHARES AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMOCOUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2006–08; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–08.

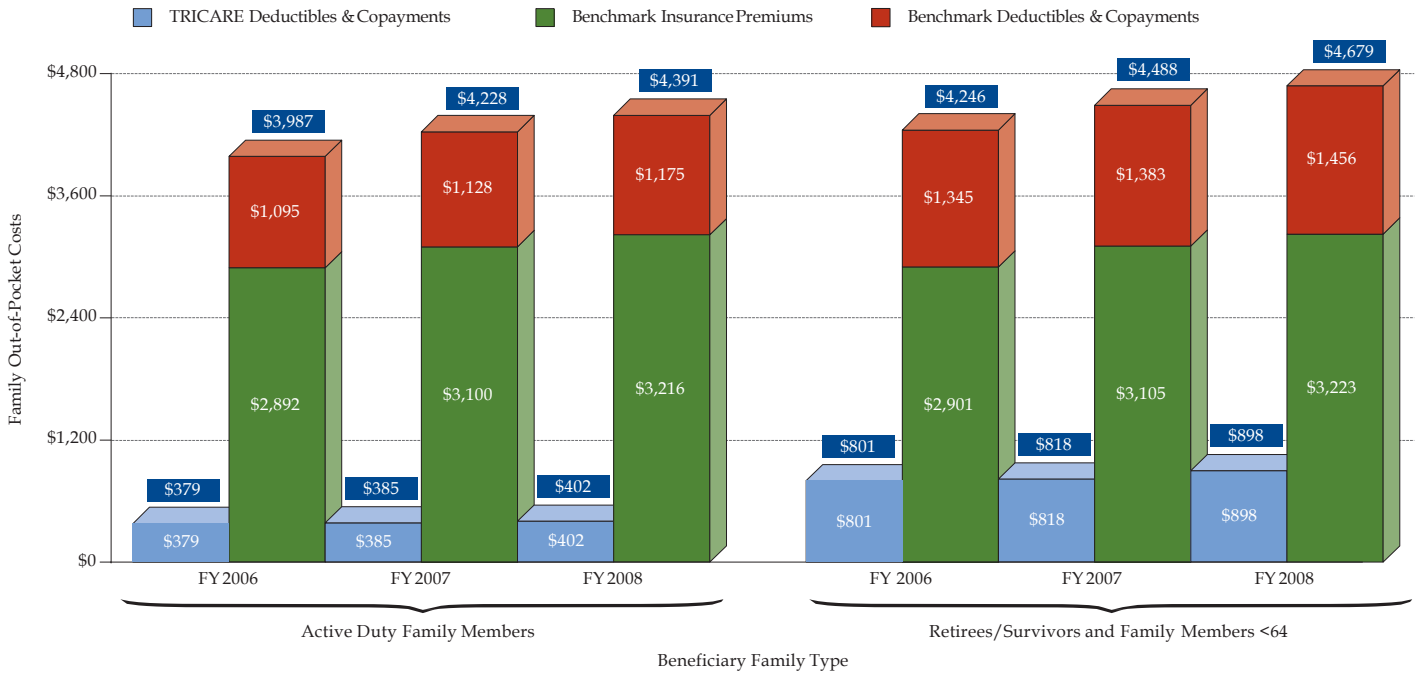
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS *(CONT'D)*

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

In FY 2006 to FY 2008, 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 2008, costs for civilian counterparts were:
  - $4,000 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $3,800 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



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2006–08; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–08; civilian insurance premium for FY 2006 from the CY 2005-2006 Medical Expenditure Panel Surveys; premiums for FY 2007-08 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys in CYs 2006-2008. OHI coverage from Health Care Surveys of DoD Beneficiaries, 2006–08.

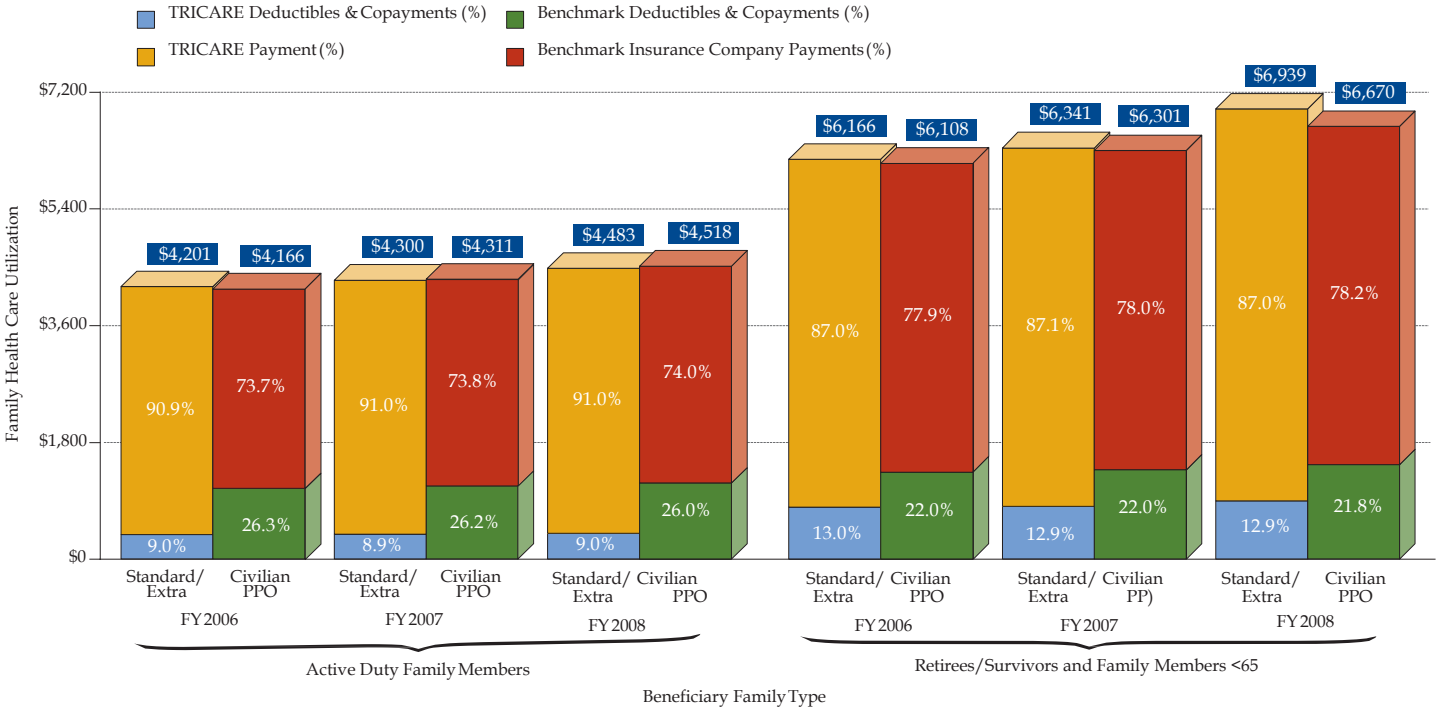
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS *(CONT'D)*

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

In FYs 2006–2008, families who relied on TRICARE Standard/Extra had lower average co-insurance rates (deductibles and copayments per dollar of utilization) than civilian counterpart families. Nevertheless, all families paid a "moderate" share of health care costs, and utilization (dollar value of health care services consumed) was nearly identical for Tricare Standard/Extra and civilian PPO families.

- TRICARE Standard/Extra reliant families had lower average co-insurance rates than civilian PPO counterparts.
  - In FY 2008, the co-insurance rate for active duty families was 9.0 percent versus 26.0 percent for civilian counterparts.
  - In FY 2008, the co-insurance rate for retiree families was 12.9 percent versus 21.8 percent for civilian counterparts.
- Health care utilization was similar for TRICARE Standard/Extra reliant families and their civilian PPO counterparts.
  - In FY 2008, active duty families consumed $4,483 of medical services versus $4,518 by civilian counterparts.
  - In FY 2008, retiree families consumed $6,939 of medical services versus $6,670 by civilian counterparts.

COST SHARES AND HEALTH CARE UTILIZATION FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2006–08; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Surveys and projections, 2006–08.

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

Health Insurance Coverage of MHS Senior Beneficiaries

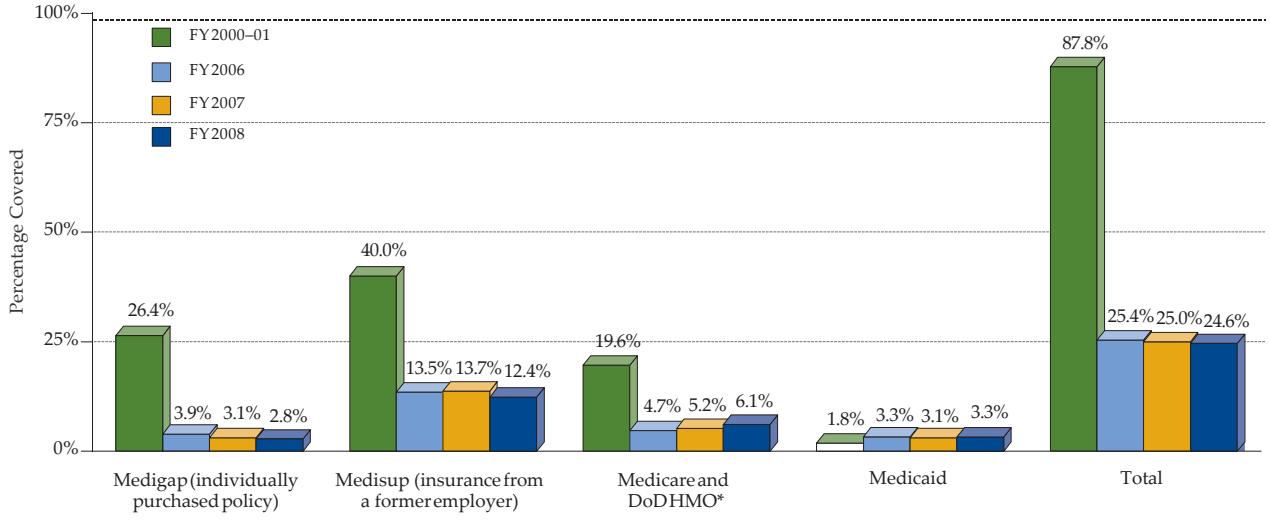
Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare Supplemental Insurance. A small number were active employees with employer-sponsored insurance (OHI) or were covered by Medicaid. Out-of-pocket costs include deductibles/copayments, premiums for Medicare Part B, as well as premiums for supplementary insurance and OHI.

In April 2001, DoD expanded drug benefits for seniors; on October 1, 2001, DoD implemented the TFL program, which provides free Medicare supplemental insurance. Because of these programs, most MHS seniors dropped their supplemental insurance.

- Before TFL (FY 2000–01), 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 25.4 percent in FY 2006. It remained roughly the same in FY 2008.

- Why do a quarter of all seniors still retain some form of other health insurance when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - Higher family costs if a spouse is not yet Medicare-eligible. Dropping a non-Medicare-eligible spouse from an employer-sponsored plan can result in higher family costs if the spouse must purchase a nonsubsidized individual policy.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS



Source: FYs 2000–2001 and FYs 2006–2008 administrations of the Health Care Surveys of DoD Beneficiaries

* Insurance coverage for DoD HMOs includes TRICARE Senior Prime (until December 2001) and the Uniformed Services Family Health Plan.

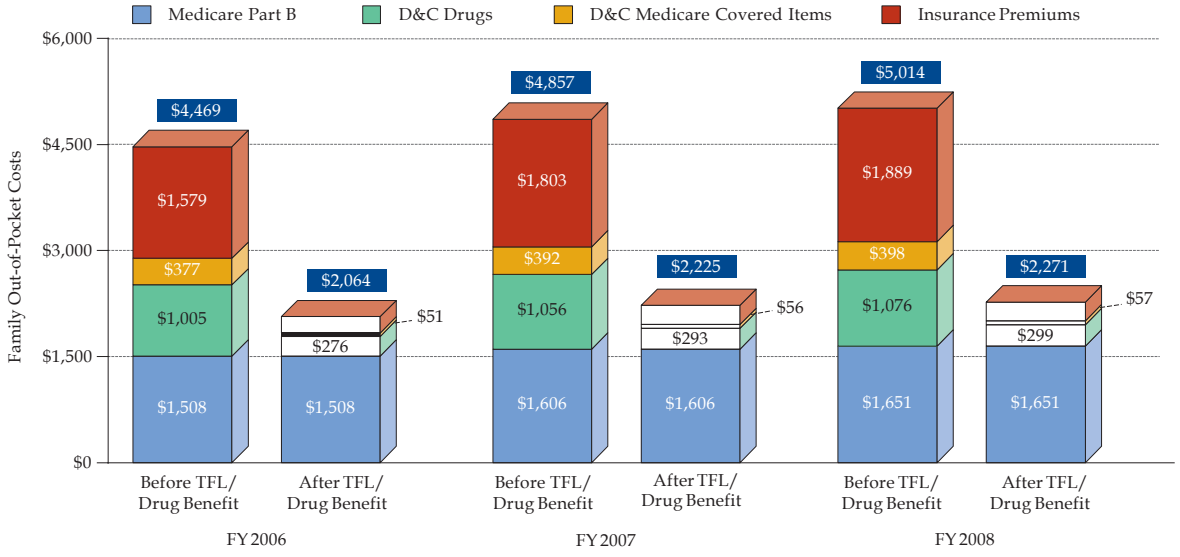
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS *(CONT'D)*

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

TFL and added drug benefits have enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments. Costs are compared for a typical TRICARE senior family before and after TFL.

- MHS senior families saw their out-of-pocket expenses reduced by about 54 percent in FYs 2006–2008 as a result of TFL.
- In FY 2008, MHS senior families saved $2,700 as a result of TFL.

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



Sources: DoD beneficiary expenditures from MHS administrative data; civilian expenditures from Medical Expenditure Panel Surveys and projections, 2006–08; Medicare and Medicare HMO premiums from Centers for Medicare and Medicaid Services; Medigap premiums from TheStreet.com Ratings; Medisup premiums from Tower Perrin Health Care Cost Surveys 2006–2008; Medicare supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, 2006–08.

GENERAL METHOD

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

We also compared the effects of TRICARE on beneficiary utilization of inpatient, outpatient, and prescription services, as well as on MHS and beneficiary costs. Wherever feasible, we contrasted various TRICARE utilization and cost measures with comparable civilian sector benchmarks derived from the MarketScan® Commercial Claims and Encounters (CCAE) database provided by Thomson Healthcare 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 2006–FY 2008) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are Federal Fiscal Years (October 1 – September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the Fiscal Year represented.
- All photographs in this document were obtained from Web sites accessible by the public. These photos have not been tampered with other than to mask the individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - HCSDB/CAHPS—11/26/2008
  - MHS Workload/Costs—1/6/2009
  - Web sites uniform resource locators (urls)—1/21/09
- 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 NDAA 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 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 with the FY 2006 report, weights were 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.

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.*

The HCSDB uses questions from CAHPS version 3.0 health plan survey. The results are compared to commercial health plan results from the National CAHPS Benchmarking Database (NCBD) for 2007. The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc. Both benchmarks and TRICARE results are adjusted for age and health status. Differences between the MHS and the civilian benchmark were considered significant at less than or equal to .05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match the MHS. Beneficiaries' health plans are identified from a combination of self-report and administrative data. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months. The HCSDB will use CAHPS version 4.0 questions beginning in FY 2009 and this report will identify how particular question trends may be affected by the change in next year's report.

RWPs and 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 acute 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 several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. In this report, Organizational Work RVUs are used to measure direct care outpatient workload and Simple RVUs are used to measure purchased care outpatient workload. According to TMA, Organizational Work RVUs are the best direct

DATA SOURCES *(CONT'D)*

care measure to compare the volume of provider work with the purchased care claims' Simple RVUs. See www.tricare.mil/ocfo/bea/downloads/SADR%20-%20MDR%20-%20Current%20-%2031%20July%2007.doc for definitions of these RVU measures.

Access and Quality

Measures of MHS access and quality were derived from the 2006, 2007, and 2008 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the NCBD for 2008.

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 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 2009 as referenced above.

The Commercial Claims and Encounters database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including preferred provider organizations, point-of-service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked Thomson Healthcare Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2007, allowed us to derive annual benchmarks by Fiscal Year and to estimate FY 2007 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 older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

ABBREVIATIONS

AAFES	Army and Air Force Exchange Service
ABA	Applied Behavior Analysis
AC	Active Component
ACS	American Cancer Society
ACSI	American Customer Satisfaction Index
AD	Active Duty
ADA	American Dental Association
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHLTA	Armed Forces Longitudinal Technology Application
AMI	Acute Myocardial Infarction
ASD	Assistant Secretary of Defense
BHIE	Bidirectional Health Information Exchange
BACB	Behavior Analyst Certification Board
BMI	Body Mass Index
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Health Care Providers and Systems
CCAE	Commercial Claims and Encounters
CDC	Centers for Disease Control and Prevention
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
DeCA	Defense Commissary Agency
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DHHS	U.S. Department of Health and Human Services
DoD	Department of Defense
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
ECHO	Extended Care Health Option
EOB	Explanation of Benefits
ESSENCE	Electronic Surveillance System for the Early Notification of Community-based Epidemics
FDA	U.S. Food and Drug Administration
FFS	Fee for Service
FHIE	Federal Health Information Exchange
FHP&R	Force Health Protection and Readiness
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
HCA	Humanitarian/Civic Assistance
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HMHS	Humana Military Healthcare Services
HMO	Health Maintenance Organization
HP	Healthy People
HPA&E	Health Program Analysis and Evaluation
HSA	Hospital Service Area
IM/IT	Information Management/ Information Technology
JMLIS	Joint Medical Logistics and Infrastructure Support
JTMC2	Joint Theater Medical Command and Control
LOS	Length of Stay
MAT	Military Air Transport
MCC	Member Choice Center
MCSC	Managed Care Support Contractor
MDC	Major Diagnostic Category
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MPFS	Medicare Physician Fee Schedule
MRI	Magnetic Resonance Imaging
MTF	Military Treatment Facility
NAS	Nonavailability Statement
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NGO	Nongovernmental Organizations
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
PPO	Preferred Provider Organization
PRISM	Provider Requirement Integrated Specialty Model
PSA	Public Service Announcements
RC	Reserve Component
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SAMHSA	Substance Abuse and Mental Health Services Administration
SHAD	Shipboard Hazard and Defense
SIDR	Standard Inpatient Data Record
TAO	TRICARE Area Office
TAMP	Transitional Assistance Management Program
TBI	Traumatic Brain Injuries
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TFL	TRICARE for Life
TGRO	TRICARE Global Remote Overseas
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TOA	Total Obligational Authority
TOL	TRICARE Online
TOPD	TRICARE Overseas Preferred Dentists
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	US Family Health Plan
VA	Department of Veterans Affairs
WHO	World Health Organization
WNAP	Warrior Navigation and Assistance Program
WPS	Wisconsin Physicians Services
WTU	Warrior Transition Unit
YTD	Year To Date

Toenhance DoDand 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.