Evaluation of the TRICARE Program:
Access, Cost, and Quality
Fiscal Year 2014 Report to Congress

Evaluation of the TRICARE Program
Access, Cost, and Quality

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

February 25, 2014

The **Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2014 Report to Congress** is provided by the Defense Health Agency (DHA), Defense Health Cost Assessment and Program Evaluation (DHCAPE), in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx*.

Front cover photo descriptions, from left to right:

A – A C130J Super Hercules from the 146th Airlift Wing in Port Hueneme, CA, drops fire retardant over trees in the mountains above Palm Springs. (July 2013)

B – A soldier from the 327th Infantry Regiment assists Afghan forces in securing the customs checkpoint at Torkham Gate, Afghanistan. (April 2013)

C – The crew of the Coast Guard Cutter Forward escorts one ton of cocaine seized north of the Galapagos Islands to Naval Station Mayport, FL. (September 2013)

D – A Staff Sergeant and aerial porters load a shipping container into a C-130 at Forward Operating Base Salerno, Khost province, Afghanistan. (September 2013)

E – The experimental X-47B Unmanned Combat Air System lands on the USS Theodore Roosevelt. (November 2013)

F – The Medical Operations Officer in Charge cleans the wound of an Afghan boy during a visit to Shar-E-Sa-Fa, Tarnek Wa Jaldek district. (August 2013)

G – A Vietnam Veteran speaks with a Marine from the 7th Engineer Support Battalion during a reunion ceremony at Camp Pendleton, CA. (September 2013)

H – A Technical Sergeant coordinates traffic with a local parking attendant at Forward Operating Base Salerno, Khost province, Afghanistan. (September 2013)

I – A Master Sergeant at Camp Fallujah displays his prosthetic leg while saluting the American flag. (June 2009)

J – Four U.S. Air Force F-15C Eagles participate in the Arctic Challenge exercise in Norway. (September 2013)

K – Marine Veterans compete in the men's 100-meter dash at the 2013 Marine Corps Trials in Camp Pendleton, CA. (March 2013)

L – An Army Specialist helps a woman displaced by Hurricane Sandy at an emergency shelter in Piscataway Township, NJ. (October 2012)

M – Aircraft carrier USS Nimitz conducts maritime security operations in the U.S. 5th Fleet area of responsibility. (October 2013)

N – A Lance Corporal mans his machine gun during a combat logistics patrol in Helmand province, Afghanistan. (October 2013)

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

MESSAGE

MILITARY HEALTH SYSTEM MISSION

EXECUTIVE SUMMARY

INTRODUCTION

MHS WORLDWIDE SUMMARY: POPULATION, WORKLOAD, AND COSTS

INCREASED READINESS

BETTER CARE

CONTENTS

BETTER CARE (CONT'D)

BETTER HEALTH

LOWER COST

APPENDIX

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

I am honored to report to Congress our annual assessment of the effectiveness of TRICARE, the Department's premier health benefits program. This report responds to section 717 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 1996 (Public Law 104–106). This year's report also responds to section 714 of the NDAA for FY 2013 (Public Law 112–239) amending the FY 1996 legislation by expanding the evaluation of the effectiveness of the TRICARE program to include members of the Armed Forces (whether in the Active or Reserve components) and their dependents and military retirees and their dependents. Further, beginning in last year's report, in response to the NDAA 2013 legislation, this report specifically has been extended to address dependents of members on Active Duty with severe disabilities and chronic health care needs.

Our $49 billion FY 2014 Unified Medical Program (UMP) includes nearly $7.5 billion funding to pay for the cost of care for our dual-Military-Medicare eligible beneficiaries and supports the physical and mental health of our 9.6 million beneficiaries worldwide. The Military Health System (MHS), composed of direct care provided in our over 400 military treatment facilities and care purchased through civilian providers and institutions, extends from theater medical care for our deployed forces to the daily "peacetime" health services. The FY 2014 UMP is less than 2 percent higher than FY 2013 expenditures and over 7 percent lower than our peak funding of almost $53 billion in FY 2012. When adjusted for inflation, the FY 2014 UMP is almost 13 percent less in purchasing value than FY 2011 or FY 2012.

This report describes the mission, vision, and core values of MHS leadership, and presents the Quadruple Aim strategy we have followed since the fall of 2009 and the results of the strategic imperatives we continually monitor. We assess MHS cost, quality, and access against corresponding civilian benchmarks where available and appropriate: we compare the ratings of our beneficiaries' experiences against the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey sponsored by the Agency for Healthcare Research and Quality (AHRQ), our quality measures against national expectations and results of the Joint Commission, and health-risky behavior against Healthy People 2020 objectives.

I reported last year that military medicine will undergo major changes in the years to come in response to fiscal challenges to reduce and consolidate infrastructure, improve efficiencies, and provide comprehensive, consistent, and high-quality health care benefits.

The Department responded March 15, 2013, to section 731 of NDAA 2013 (Public Law 112-239) requiring a detailed plan for the reform of the Administration of the MHS as well as the delivery of periodic reports on the progress toward the plan. The first report to the congressional defense committees, dated March 15, 2013, identified our reform efforts and provided detailed goals, milestones, and schedules for implementing the Defense Health Agency (DHA), the enhanced Multi-Service Markets (eMSMs), and the National Capital Region (NCR) Directorate. The second report, dated June 27, 2013, provided our strategic objectives, success measures, and business case analyses for four of the initial 10 identified shared services. In the third report we provided the results of our assessments for the remaining six shared services to be implemented in FY 2014: Pharmacy, Medical Education and Training, Medical Research and Development, Budget and Resource Management, Acquisition, and Public Health.

We are rapidly progressing in implementing the restructuring of the MHS. Effective October 1, 2013, the DHA formally became operational, operating under my authority and as a designated combat support agency, with oversight from the chairman of the Joint Chiefs. Within the DHA, the services will retain their own medical commands, each led by their respective surgeon general. The DHA is responsible for shared health care support services and is initially contemplated to consist of 10 shared services, half of which began with the stand-up of the Agency under initial operational capability on October 1, and the remainder of which will be assumed by October 1, 2015. Additionally, under DHA there will be six eMSMs led by a flag or general officer responsible for integrating resources and adhering to five-year marketing plans developed jointly. These enhanced markets are the Washington, D.C., area; San Antonio, Texas; Colorado Springs, Colo.; the Puget Sound region of Washington state; the Tidewater area of Virginia; and Oahu Island in Hawaii.

Our goal remains the same—to ensure the medical readiness of our Service members and to provide a ready force able to deliver the best medical services anywhere in the world, under any conditions, to all our beneficiaries. I am proud of the accomplishments of MHS and the TRICARE program, and inspired by the focus of leadership on critical appraisal and efforts to continuously improve the TRICARE benefit and our processes. Once this report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://tricare.mil/tma/aboutDHA.aspx.*

—Jonathan Woodson, M.D.

MHS PURPOSE, MISSION, VISION, AND STRATEGY

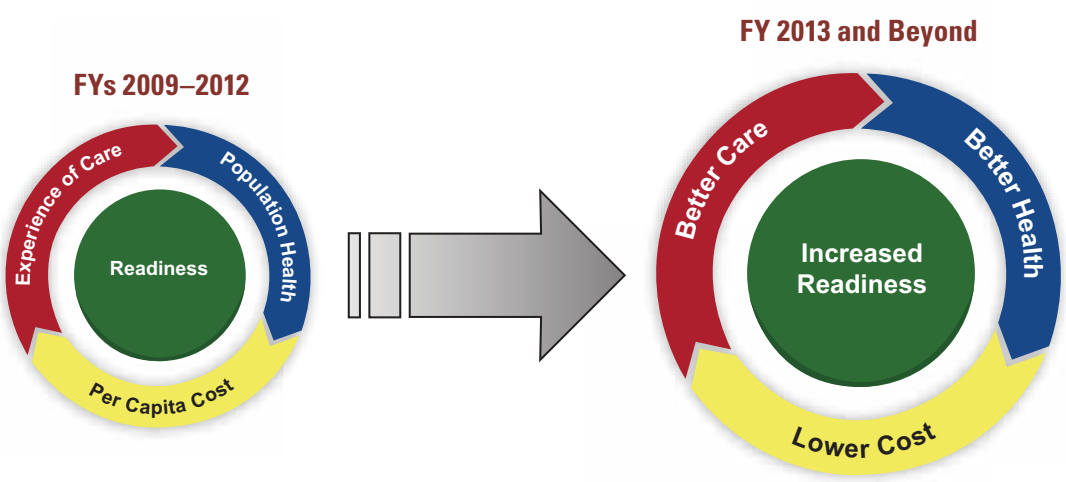
The purpose, mission, vision, and overall strategy of senior DoD and MHS leadership are focused on the core business of creating an integrated medical team that provides optimal health services in support of our nation's military mission—anytime, anywhere. We are ready to go into harm's way to meet our nation's challenges at home or abroad, and to be a national leader in health education, training, research, and technology.

Our ability to provide the continuum of health services across the range of military operations is contingent upon the ability to create and sustain a healthy, fit, and protected force. Key MHS mission elements of research and innovation, medical education and training, and a uniformed sustaining base and platform are interdependent and cannot exist alone. A responsive capacity for research, innovation, and development is essential to achieve improvements in operational care and evacuation.

MHS is a global system delivering health services—anytime, anywhere. In everything we do, we adhere to common principles that are essential for accomplishing our mission and achieving our vision.

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

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



The MHS Quadruple Aim

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

MHS QUADRUPLE AIM AND STRATEGIC DIRECTION AND PRIORITIES IN FY 2013 AND BEYOND *(CONT'D)*

Defense Secretary Chuck Hagel has given six "priorities" to service secretaries and chiefs as well as combatant commanders as the Pentagon prepares to try to move ahead with living under sequestration.

1. **Institutional reform:** Cut the Defense Department's infamous administrative "back office" and apply as much of the savings as possible to "real military capabilities."
2. **Force sizing and planning:** Service leaders should change the calculus by which they organize, train, and equip their forces to "better reflect our goals in the shifting strategic environment."
3. **Preparing for a prolonged military readiness challenge:** Services should assume that shrinking budgets mean they will have to prioritize some units—likely an unpopular goal within the military.
4. **Protecting investments in emerging military capabilities:** Fencing off space, cyber, special operations forces, and "intelligence, surveillance and reconnaissance" from cuts could preserve the U.S. edge.
5. **Balancing capacity and capability across the Services:** Cuts should not come too much at the expense of any one service or capability—perhaps keep heavy Army tank units, for example, but move more of them to the Guard and Reserve.
6. **Balancing personnel responsibilities with a sustainable compensation policy:** Personnel and compensation policy: Congress should help the Pentagon reform pay, benefits, health care, and other costly areas of the personnel side of the budget, but lawmakers in the past have not been keen to go along.

MHS OBJECTIVES

1. Promote more effective and efficient health operations through enhanced enterprisewide shared services.
2. Deliver more comprehensive primary care and integrated health services using advanced patient-centered medical homes.
3. Coordinate care over time and across treatment settings to improve outcomes in the management of chronic illness, particularly for patients with complex medical and social problems.
4. Match personnel, infrastructure, and funding to current missions, future missions, and population demand.
5. Establish more inter-Service standards/metrics, and standardize processes to promote learning and continuous improvement.
6. Create enhanced value in military medical markets using an integrated approach in five-year business plans.
7. Align incentives with health and readiness outcomes to reward value creation.

DHA VISION AND MISSION

A joint, integrated, premier system of health, supporting those who serve in the defense of our country.

"A premier workplace delivering world-class customer service."

"Provide the foundation for the mission success of the Defense Health Agency by delivering enterprisewide customer focused support services."

The DHA Mission and objectives align with the MHS objectives that support the Secretary of Defense's priorities

The DHA is a Combat Support Agency supporting the Military Services. The DHA supports the delivery of integrated, affordable, and high-quality health services to beneficiaries of the MHS, and executes responsibility for shared services, functions, and activities of the MHS and other common clinical and business processes in support of the Military Services. The DHA serves as the program manager for the TRICARE health plan and medical resources, and as market manager for the National Capital Region (NCR) enhanced Multi-Service Market. The DHA manages the execution of policy as issued by the Assistant Secretary of Defense for Health Affairs and exercises authority, direction, and control over the inpatient facilities and their subordinate clinics assigned to the DHA in the NCR Directorate.

Goal 1: Improve customer service and satisfaction by identifying and managing needs and expectations.

Goal 2: Acquire, shape, and retain a diverse workforce.

Goal 3: Make processes more lean, efficient, and standardized.

Goal 4: Improve internal and external communications.

Goal 5: More effectively generate, capture, and transfer knowledge.

Goal 6: Incorporate resource stewardship in all decision-making.

http://www.tricare.mil/Welcome/About.aspx

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2013

MHS Worldwide Summary

- The $49 billion Unified Medical Program (UMP) in the fiscal year (FY) 2014 President's Budget is less than 2 percent higher than actual expenditures in FY 2013 and over 7 percent lower than FY 2012's expenditures (Ref. pages 20–21).
- The number of beneficiaries eligible for DoD medical care fell slightly from 9.72 million at the end of FY 2011 to 9.59 million at the end of FY 2013 (Ref. page 12).
- The number of Prime enrolled beneficiaries remained between 5.4 and 5.5 million from FY 2009 to FY 2012 but fell to 5.3 million in FY 2013, corresponding to a drop in the eligible population (Ref. page 18).
- **TRICARE Young Adult (TYA):** In FY 2013 TYA enrollment exceeded 31,000 young adults under age 26, with almost 60 percent enrolled in Prime (Ref. page 52).
- **Reserve Component Enrollment in TRICARE Plans:** National Guard and Reserve enrollment increased to almost 270,000 covered lives in TRICARE Reserve Select (TRS) and 3,600 covered lives in TRICARE Retired Reserve (TRR) (Ref. page 50).

MHS Workload and Cost Trends[1]

- The percentage of beneficiaries using MHS services increased from 83.3 percent in FY 2011 to 84.9 percent in FY 2013 (Ref. page 19). Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) grew from FY 2011 to FY 2013 for outpatient services (+4 percent) but fell for inpatient services (–7 percent) and prescription drugs (–1 percent) (Ref. pages 23–26).
- Direct care workload increased for outpatient care (9 percent) and prescription drugs (1 percent), and decreased for inpatient care (2 percent) from FY 2011 to FY 2013. Overall, direct care costs increased by 7 percent. Purchased care workload rose for outpatient services (+2 percent) but fell for inpatient services (–9 percent) and prescription drugs (–3 percent). Overall, purchased care costs rose by 1 percent (Ref. pages 23–28).
- The purchased care portion of total MHS health care expenditures declined slightly from 51 percent in FY 2011 to 49 percent in FY 2013. In FY 2013, the share was 55 percent for inpatient care, 44 percent for outpatient care, and 58 percent for prescription drugs (Ref. page 28).
- In FY 2012, out-of-pocket costs for MHS beneficiary families under age 65 were between $4,500 and $5,400 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $2,600 lower (Ref. pages 90, 92, 95).

Lower Cost

- MHS estimated savings include $1.4 billion in retail pharmacy refunds in FY 2013, $141 million in Program Integrity activity in calendar year (CY) 2013, and an additional $27.8 million in claim recoveries in FY 2013 (Ref. page 73).

Increased Readiness

- **Force Health Protection:** In FY 2013, 85 percent of the combined Active Component (AC) and Reserve Component (RC) Total Force was medically ready to deploy, exceeding DoD goals. Dental readiness remained high in the same period, at 94 percent, short of the goal of 95 percent (Ref. pages 31–32).

Better Care

- **Overall Outpatient Access:** In FY 2013, 87 percent of Prime enrollees reported at least one outpatient visit, compared with 85 percent for the national benchmark. MHS beneficiary ratings for getting needed care and getting care quickly remained stable between FY 2011 and FY 2013, lagging civilian benchmarks (Ref. pages 37–38).
- **MHS Provider Trends:**
  - The past few years have seen a slowing rate of increase in the number of TRICARE network providers to the point where it increased by only 1 percent from FY 2012 to FY 2013. A similar pattern was observed for total participating providers (Ref. page 56).
  - A survey of civilian providers shows eight of 10 physicians accept new TRICARE Standard patients, higher acceptance than behavioral health providers (Ref. page 57).
- **National Hospital Quality Measures:** MHS performance is comparable to many Joint Commission quality measures (Ref. pages 60–62).
- **Overall Ratings of Inpatient and Outpatient Care:** MHS beneficiaries generally rated the overall TRICARE health plan higher than the civilian CAHPS-Plan ratings, while lagging civilian ratings for overall care and their primary care or specialty providers between FY 2010 and FY 2012 (Ref. pages 37–40).

Better Health

- **Healthy People and HEDIS Preventive Care Standards:** In FY 2013, MHS exceeded Healthy People (HP) 2020 goals for mammograms and prenatal exams, and exceeded National Committee for Quality Assurance (NCQA) 90th percentile Healthcare Effectiveness Data and Information Set (HEDIS) rates for cervical cancer screening and asthma appropriate medications. The overall smoking rate (11.4 percent) remained below the HP 2020 goal (12 percent) (Ref. pages 63–68).

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

WHAT IS TRICARE?

TRICARE is the DoD health care program serving 9.6 million Active Duty Service members (ADSMs), National Guard and Reserve members, retirees, their families, survivors, and certain former spouses worldwide (*http://www.tricare.mil/Welcome.aspx?sc_database=web*). As a major component of the Military Health System (MHS; *www.health.mil*), TRICARE brings together the worldwide health care resources of the Uniformed Services (often referred to as "direct care," usually in military treatment facilities, or MTFs) and supplements this capability with network and non-network participating civilian health care professionals, institutions, pharmacies, and suppliers (often referred to as "purchased care") to provide access to high-quality health care services while maintaining the capability to support military operations.

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

- **TRICARE Standard** is the non-network benefit, formerly known as the Civilian Health and Medical Program of the Uniformed Services, open to all eligible DoD beneficiaries, except ADSMs. Beneficiaries who are eligible for Medicare Part B are also covered by TRICARE Standard for any services covered by TRICARE but not covered by Medicare. An annual deductible (individual or family) and cost shares are required.
- **TRICARE Extra** is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard; however, TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- **TRICARE Prime** is the health maintenance organization-like benefit offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment and waiting times in doctors' offices. A point-of-service (POS) option permits enrollees to seek care from providers other than the assigned PCM without a referral, but with significantly higher deductibles and cost shares than those under TRICARE Standard.
- **Other plans and programs:** Some beneficiaries may qualify for other benefit options depending on their location, Active/Reserve status, and/or other factors. These plans and programs provide additional benefits or offer benefits that are a blend of the Prime and Standard/Extra) options with some limitations. Some examples are:
  - The premium-based TRICARE Young Adult (TYA) Program available to qualified dependents under the age of 26;
  - Dental benefits (military dental treatment facilities, claims management for Active Duty using civilian dental services, as well as the premium-based TRICARE Dental Program and the TRICARE Retiree Dental Program [TRDP]);
  - Pharmacy benefits in MTFs, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy);
  - Overseas purchased care and claims processing services;
  - Programs supporting the Reserve Components, including the premium-based TRICARE Reserve Select (TRS) or TRICARE Retired Reserves (TRR) for those who are retired from Reserve status but not yet eligible for the TRICARE benefits as a military retiree;
  - Supplemental programs including TRICARE Prime Remote in the United States and overseas, DoD-Veterans Affairs (VA) sharing arrangements, and joint services;
  - Designated Provider/Uniformed Services Family Health Plan, which provides the full TRICARE Prime benefit, including pharmacy, under capitated payment to non-Active Duty MHS enrollees at six legally specified locations: Washington, Texas, Maine, Massachusetts, Maryland, and New York;
  - Clinical and educational services demonstration programs (such as chiropractic care, autism services, and TRICARE Assistance Program); and
  - Other programs, including the premium-based Continued Health Care Benefit Program, providing a Consolidated Omnibus Budget Reconciliation Act-like benefit, and the Transitional Assistance Management Program, which allows Reservists activated for at least 30 days in support of Contingency Operations continued access to the TRICARE benefit for up to 180 days after deactivation.

HOW TRICARE IS ADMINISTERED

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

- Provide oversight of regional operations and health plan administration;
- Manage the contracts with regional contractors;
- Support MTF Commanders; and
- Develop business plans for areas not served by MTFs (e.g., remote areas).

NEW BENEFITS AND PROGRAMS IN FY 2013 SUPPORTING THE MHS QUADRUPLE AIM

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

Contract and Organizational Changes

Transition to T-3 Contracts

On April 1, 2013, the West Region transitioned from the T-Nex to the T-3 generation of managed care support contracts. The contractor supporting the West Region (serving 2.9 million beneficiaries) changed from TriWest to UnitedHealthcare. Due to significant processing difficulties in the UnitedHealthcare Military & Veteran's system, TRICARE Management Activity (TMA) extended temporary waivers allowing West Region Prime enrollees to obtain recommended specialty care without obtaining authorization or paying a penalty. The waivers were in place for referrals received through July 2, for care with dates of April 1 through September 15, 2013.

Transition of Some Prime Service Areas

As of October 1, 2013, DoD reduced its TRICARE Prime managed care program to locations within 40 miles of an active or former military base. The change affected approximately 181,600 beneficiaries (roughly 3 percent) previously eligible for Prime, and switched these retirees and family members (more than half in the TRICARE South Region) to TRICARE Standard, a traditional fee-for-service health care program. Although this will cost each family more in out-of-pocket costs, it is estimated to save the government $45–$56 million annually. Active Duty members and their families are not affected by the changes. Notifications were sent to all affected and tools were made available on the TRICARE Web site to assist beneficiaries in determining their options. There is a provision, however, that will allow Prime beneficiaries who see providers outside the 40-mile service area to remain in Prime if they reside within 100 miles of an available PCM and sign an access waiver (see *http://www.tricare.mil/PSA* for details).

Defense Health Agency

The newly created Defense Health Agency (DHA) became operational on October 1, 2013. The DHA replaces the former TMA and takes responsibility for shared services, functions, and activities of the MHS and other common clinical and business processes in support of the Military Services.

DoD Furloughs for Medical Personnel

For six weeks, beginning July 8, 2013, most DoD civilians were furloughed per the Secretary of Defense. Other avenues for reducing costs were first explored—reduced training, maintenance, and other short-term savings. Following these reductions, initial estimated furlough days were reduced from 22 to 11. In August, due to a combination of congressional approvals on flexibility in moving funds across accounts and Departmental budget management efforts, this number was further reduced to a final of six days. The furloughs included civilian medical personnel, requiring some TRICARE beneficiaries to see private doctors, at increased cost.

Government Shutdown

On October 1, 2013, the DHA issued a statement regarding the government shutdown. The statement noted that: "Inpatient, acute and emergency outpatient care in our medical and dental facilities [would] continue, as [would] private sector care under TRICARE….Patients needing to schedule new routine appointments might [have] experience[d] delays. For TRICARE beneficiaries using providers in the private sector, little or no effect [was] anticipated at [that] time." For more information see *http://www.tricare.mil/Welcome/MediaCenter/News/Archives/10_1_13_Shutdown.aspx*.

Affordable Care Act, Minimum Essential Coverage, and TRICARE

The 2010 Affordable Care Act (ACA) requires most Americans to maintain basic health care coverage, or minimum essential coverage (MEC). Those who do not meet the mandate are required to pay a penalty for each month of noncompliance after January 2014.

The following TRICARE plans meet the ACA MEC requirements:

- TRICARE Prime
- TRICARE Prime Remote
- TRICARE Prime Overseas
- TRICARE Prime Remote Overseas
- TRICARE Standard and Extra
- TRICARE Standard Overseas
- TRICARE for Life (Medicare Parts A & B required)
- Transitional Assistance Management Program

NEW BENEFITS AND PROGRAMS IN FY 2013 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

The following premium-based TRICARE plans meet the ACA MEC requirements only if purchased:

- TRICARE Reserve Select
- TRICARE Retired Reserve
- TRICARE Young Adult
- Continued Health Care Benefit Program

Beneficiaries who are eligible only for care in MTFs (not eligible for TRICARE coverage by civilian providers) or non-Active Duty members being treated for Line of Duty conditions do not have MEC provided by DoD. Those who choose not to purchase premium-based TRICARE coverage, are not provided MEC by DoD, or are losing TRICARE coverage due to separation from military service or age have several options to comply with the ACA mandate. They can purchase commercial health coverage through their employer, from the state Marketplaces, or on the commercial open market. They can also have coverage through a family member or use another qualified federal plan. The Department has advised MHS beneficiaries of the applicability of the ACA MEC requirements to TRICARE in print and through Internet notices tailored to the various health plans. These Web site notices include:

Prime: *http://www.tricare.mil/Welcome/Plans/Prime.aspx*

Standard: *http://www.tricare.mil/Welcome/Plans/TSE.aspx*

TYA: *http://www.tricare.mil/Welcome/Plans/TYA.aspx*

TRS: *http://www.tricare.mil/Welcome/Plans/TRS.aspx*

ACA Info Page: *http://www.tricare.mil/Welcome/About/MEC.aspx?sc_database=web* (2nd tab on Welcome Page)

ACA/MEC FAQs: *http://www.tricare.mil/FAQs.aspx?search=affordable%20care%20act*

QUADRUPLE AIM: INCREASED READINESS

Understanding and Treating PTSD and TBI

Joint DoD and VA Research Consortia for PTSD and mTBI

DoD and VA have established two joint research consortia, at a combined investment of $107 million to research the diagnosis and treatment of post-traumatic stress disorder (PTSD) and mild traumatic brain injury (mTBI) over a five-year period. The Consortium to Alleviate PTSD (CAP) will attempt to develop the most effective diagnostic, prognostic, novel treatment, and rehabilitative strategies to treat acute PTSD and prevent chronic PTSD. The Chronic Effects of Neurotrauma Consortium (CENC) will examine the factors that influence the chronic effects of mTBI and common co-morbidities in order to improve diagnostic and treatment options.

DoD Brain Tissue Repository

DoD has established the world's first brain tissue repository. The Center for Neuroscience and Regenerative Medicine Brain Tissue Repository for Traumatic Brain Injury was established at the Uniformed Services University of the Health Sciences (USU) to advance the understanding and treatment of TBI in Service members. DoD is hoping the research will help it better understand Chronic Traumatic Encephalopathy (CTE), a neurodegenerative disorder involving the progressive accumulation of the protein tau in nerve cells within certain regions of the brain. This accumulation disturbs function and appears to lead to symptoms seen in affected patients, such as boxers and, more recently, football players, with multiple head trauma. This research is aimed at addressing the issues facing Service members coming home with these problems and developing approaches to detecting accumulated tau in the living individual as a means of diagnosing CTE.

Research and Education

U.S. News & World Report Rates USU in Bethesda, Md. One of Top-Ranked U.S. Graduate Schools

The USU has earned distinction as one of the top-ranked U.S. graduate schools. *U.S. News & World Report* identified the university's F. Edward Hebert School of Medicine as a top-tier medical school in its "Best Graduate Schools 2014" rankings released in March. In addition, the university's nurse anesthesia master's degree program ranked fifth in the nation. Its partner program, run by the Army in San Antonio, maintained the No. 1 ranking it has held for the past several years. The American Academy of Family Physicians has recognized the university's family medicine department has one of the nation's top 10 for the past three years.

Winners of the First Military Health System Innovation Challenge

DoD's first MHS Innovation Challenge was open to all Defense personnel and drew more than 120 proposals. Ideas were judged based on innovativeness, cost-effectiveness, ease of implementation, adherence to the quadruple aim, and scalability across the entire DoD enterprise. Three winning ideas were selected and are undergoing development: StorkTracker: A Mobile Application of the Goal-Oriented Guide to Prenatal Care; The Military Acuity Model; and TRICARE Rewards: A Customer Loyalty Incentive Program.

NEW BENEFITS AND PROGRAMS IN FY 2013 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

Navy Medical Research Center Shows Effectiveness of Malaria Vaccine in Human Clinical Trials

Despite the significant need, there currently is no approved vaccine against malaria. The malaria parasite is incredibly complex, making it particularly difficult to develop a vaccine. However, a human clinical trial of a malaria vaccine developed by the Navy Medical Research Center and federal and industry collaborators has shown 100 percent protection against the disease. The DoD has focused on developing a vaccine since World War II because of its significant impact on U.S. military operations. Not just a military issue, malaria is a global health concern in tropical and subtropical regions of the world. The World Health Organization reported 216 million cases and an estimated 655,000 deaths in 2010 alone.

QUADRUPLE AIM: BETTER CARE

TRICARE Young Adult Program

A final rule issued in the *Federal Register* on May 29, 2013, made the TYA program a permanent health care option for adult children of Active Duty and military retirees. The program applies to unmarried children under age 26 who do not qualify for their own health insurance or meet the age requirements to remain on regular TRICARE (age 21, or 23 if the beneficiary is a full-time college student). The monthly TYA premiums in 2013 are $176 for Prime and $152 for Standard, and will rise slightly for 2014 to $180 and $156, respectively (see *http://www.tricare.mil/Costs/HealthPlanCosts/TYA.aspx*).

MHS Children with Autism

Beginning July 25, 2013, TRICARE launched a one-year pilot to provide for the treatment of autism spectrum disorders, including applied behavior analysis (ABA), expanding coverage to military retirees and their dependent family members. Prior to this pilot, the ABA reinforcement had not been available for non-Active Duty family members. TRICARE additionally changed a part of the qualifications for military families with autistic children (see *http://www.tricare.mil/abapilot* for more details).

Same Sex Spousal Benefits

DoD now makes spousal and family benefits available, regardless of sexual orientation, as long as Service member sponsors provide a valid marriage certificate. TRICARE coverage can begin as of June 26, 2013, or the spouse's eligibility in the Defense Enrollment Eligibility Reporting System (DEERS), whichever is later. Entitlements such as TRICARE enrollment, basic allowance for housing, and family separation allowance are retroactive to the date of the Supreme Court's decision. DoD recognizes that same-sex military couples who are not stationed in a jurisdiction that permits same-sex marriage would have to travel to another jurisdiction to marry, so will implement policies to allow military personnel in such a relationship nonchargeable leave for the purpose of traveling to a jurisdiction where such a marriage may occur. (See *http://www.defense.gov/releases/release.aspx?releaseid=16203 or http://www.tricare.mil/LifeEvents/Marriage/SameSexRetro.aspx?p=1* for more information.)

Pharmacy

On July 25, 2013, TRICARE delayed the implementation of any change in practice on compounded prescriptions. Compounded medications are created for individuals by pharmacists, combining an active medication with other ingredients to modify a dosage, change delivery (from a pill to a liquid or liquid to a patch, for example) or eliminate an allergen. As many compounded prescriptions use inert ingredients not subject to Food and Drug Administration approval, TRICARE had planned to stop covering these types of prescriptions containing these ingredients. The agency decided to step back and evaluate its policies regarding these prescriptions, to ensure the safe care of its beneficiaries.

New Philippine Demonstration Pilot

The pilot is intended to test a closed-network model on about 11,000 retired military beneficiaries in the Philippines, one of the agency's most troubled areas, with complaints of poor service, ballooning costs, and fraud. Since January 1, all retirees living in Manila, Angeles City, and Subic Bay are required to use doctors and hospitals approved by the TRICARE network, or pay their own medical bills. Other areas of the country are scheduled to be added into the network in 2014. After three years, TRICARE will assess whether the system will be adopted permanently—and perhaps become a model for other retirees living overseas.

QUADRUPLE AIM: BETTER HEALTH

Operation Live Well

The Healthy Base Initiative, a part of the Operation Live Well program, is designed to increase the health and wellness of the total force, including civilians and family members, and emphasizes the importance of moving from health care to health by focusing on making healthy lifestyle choices and developing prevention-based habits. Core areas include healthy eating, physical activity, mental wellness, and tobacco avoidance. MHS has developed a site featuring links to tools, programs, and organizations that promote healthy living and offering outreach materials and links to Operation Live Well's social media channels. In March 2013, DoD announced the selection of 13 sites to participate in its Healthy Base Initiative, 11 of which are military installations. An additional two are the Defense Logistics Agency

NEW BENEFITS AND PROGRAMS IN FY 2013 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

and the Defense Health Headquarters. For more information about Operation Live Well and the Healthy Base Initiative, please visit: *http://www.militaryonesource.mil/olw*.

Safe Helpline Launched for Sexual Assault

The DoD has launched a new service allowing victims of sexual assault to participate in group chat sessions to connect with and support one another in a moderated secure online environment at *www.SafeHelpline.org*. The Safe HelpRoom is administered by DoD and operated by the non-profit group Rape, Abuse and Incest National Network. Staff with the Safe Helpline provide one-on-one assistance and offer service referrals for resources on and off military bases and installations.

TRICARE Online

TRICARE beneficiaries who regularly get their care at military clinics and hospitals now can download a summary of their personal health data at TRICARE Online (*www.tricareonline.com*). A continuity of care document, or CCD, is now available to include such information as lab results, medications, allergies, and lists of medical problems. Easy to share with other health care systems, including non-DoD, this document is an industry standard. Patients can download their data into a CCD and share it with any system capable of accepting the file.

Expansion of Tobacco Cessation Program

In April 2013, DoD expanded its tobacco cessation program. Related medications are now available to TRICARE patients through MTFs, pharmacies, and TRICARE Mail Order Pharmacy (TMOP). TRICARE offers Zyban and Chantix, as well as a number of nicotine replacement therapies, such as patches, gums, and inhalers, which are free to beneficiaries through prescription. Tobacco cessation medications are available to all beneficiaries age 18 and older in the continental United States. TRICARE's tobacco cessation aids also include a 24/7 chat service via instant messaging, toll-free telephone coaching assistance available around the clock, and face-to-face counseling with a certified tobacco cessation counselor that can be arranged through a primary care provider.

Military Health Care Provider Resilience Mobile Application

DoD has released a mobile application for military health care providers to help keep them productive and emotionally healthy as they cope with burnout and compassion fatigue. The app includes a "rest and relaxation" clock, a resilience rating, and update buttons that provide easy access to the four main areas affecting the resilience rating. A burnout scale lets users rate themselves on their feelings of being happy, trapped, satisfied, preoccupied, connected, worn out, caring, on edge, valuable, and traumatized. The app's toolbox encourages users to reduce stress through restful breaks with educational videos, inspirational cards, patient testimonials, and stretching exercises, and was created by the National Center for Telehealth and Technology, DoD's primary office for cutting-edge approaches in applying technology to psychological health.

QUADRUPLE AIM: LOWER COST

Prime Enrollment Fees Increase

TRICARE Prime annual enrollment fees are subject to change each fiscal year (October 1–September 30 each year). All TRICARE Prime enrollees are required to pay annual enrollment fees, except ADSMs, Active Duty family members, transitional survivors, and beneficiaries under age 65 that have both Medicare Parts A and B. Fees can be paid annually, quarterly, or monthly. As fees are nonrefundable, monthly or quarterly payments are recommended.

The only beneficiaries who are exempt from the enrollment fee increases each year are those classified as either survivors of Active Duty deceased sponsors or medically retired Uniformed Service members and their dependents.

The fee remains frozen at the rate when the survivor or medically retired member is classified in DEERS in either category and enrolls, as long as there is a continuous Prime enrollment.

	Enrolled Between Oct. 1, 2012, and Oct. 1, 2013	Enrolled On or After Oct .1, 2013
Individual	$269.28/yr	$273.84/yr
Family	$538.56/yr	$547.68/yr

NEW BENEFITS AND PROGRAMS IN FY 2013 SUPPORTING THE MHS QUADRUPLE AIM *(CONT'D)*

Pharmacy Benefits

Prescription costs are based on the type of prescription and where it is filled. The table below shows the changes for FY 2013.

	FY 2012 (Effective Oct. 1, 2011)	FY 2013 (Effective Feb. 1, 2013)
Military Treatment Facility	Generic, Brand—$0 Non-Formulary—n/a	No Change
Home Delivery/ Mail Order (90-day supply)	Generic—$0 Brand—$9 Non-Formulary—$25	Generic—$0 Brand—$13 Non-Formulary—$43
Network Retail Pharmacy (30-day supply) (non-Network Retail Benefit at Note)	Generic—$5 Brand—$12 Non-Formulary—$25	Generic—$5 Brand—$17 Non-Formulary—$44

Source: *http://www.tricare.mil/Pharmacy/Costs.aspx*, 11/26/2013

Note: Non-Network Pharmacies: ADSMs will receive a full reimbursement after they file a claim.
All others enrolled in a Prime option pay 50 percent cost share after the POS deductible is met.
Beneficiaries using Standard/Extra, TRS, TRR, or TYA pay:
Formulary-Generic or Brand Name: $17 or 20 percent of the total cost, whichever is greater, after the annual deductible is met.
Non-Formulary: $44 or 20 percent of the total cost, whichever is greater, after the annual deductible is met.

Per the FY 2013 National Defense Authorization Act, future pharmacy copays will be reviewed annually and adjusted to align with cost-of-living adjustments not to exceed the cost-of-living allowance for retirees.

Changes for TRICARE Retiree Dental Program (TRDP)

Delta Dental of California will continue managing the TRDP through 2018. Delta will prorate benefits this year from October 1 to December 31 (will not increase the member's premium or deductible). TRDP enhanced program and overseas participants will see several changes effective January 1, 2014, including an An increase in the annual maximum amount for each person enrolled, to $1,300 (excluding accident services and orthodontics).

- The coverage year will run from January 1 through December 31.
- An increase in the annual maximum amount for dental accident coverage for each person enrolled, to $1,200 with a lifetime orthodontic maximum amount of $1,750.
- A third cleaning allowed for children and adults with documented Type 1 or Type 2 diabetes.
- Starting October 1, TRICARE Dental will only take payments for premiums in one of three forms: (1) government allotment, (2) electronic funds transfer (EFT), or (3) recurrent credit card charges.

Dental enrollment cards will now be managed by DEERS. Current dental enrollment cards will remain valid under the new contract. For more information, visit *www.tricare.mil/trdp*.

TRICARE Reserve Select/Retired Reserve Changes in Payment Acceptance

Starting January 1, 2013, TRICARE began accepting only electronic funds transfers or credit and debit cards for monthly premium payments, aligning MHS's payment procedures and saving processing costs by eliminating mail-in payments. Monthly premiums are due by the last day of the month for the following month's coverage. Failure to pay by that day results in termination of coverage, and could result in a 12-month lockout. With this change, the only premium payments permitted by mail are for TriWest Healthcare Alliance (West Region) TRICARE Prime premiums.

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2014[a]

	Projected for FY 2014	FY 2013 (as Projected Last Year)
Total Beneficiaries	**9.6 million[b]**	**9.6 million**
Military Facilities—Direct Care System	**Total[c] U.S.**	**Total U.S.**
Inpatient Hospitals and Medical Centers	56 (41 in U.S.)	56
Ambulatory Care Clinics	360 (290 in U.S.)[d]	361
Dental Clinics	262 (210 in U.S.)	249
Veterinary Facilities	254 (199 in U.S.)	254
Military Health System (MHS) Personnel	153,616	146,440
Military	86,039	86,051
	31,852 Officers	31,804 Officers
	54,187 Enlisted	54,247 Enlisted
Civilian	67,577	60,389
Civilian Resources—Purchased Care System[e]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., indvidual, not institutional, providers)	523,297	477,891
Network Behavioral Health Providers (shown separately, but included in above)	60,272	62,064
TRICARE Network Acute Care Hospitals	3,524	3,310
Behavioral Health Facilities	948	914
Contracted (Network) Retail Pharmacies	58,535	57,763
Contracted Worldwide Pharmacy Home Delivery Vendor	1	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	About 1.8 million covered lives, in over 800,000 contracts	Over 1.97 million covered lives, in over 800,000 contracts
TDP Network Dentists	88,157 total dentists	85,598 total dentists
	70,372 general dentists	68,431 general dentists
	17,785 specialists	17,167 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and families)	Over 1.4 million covered lives, in over 690,000 contracts	Almost 1.4 million covered lives, in almost 660,000 contracts
Total Unified Medical Program (UMP)	**$49.84 billion[f]**	**$52.5 billion**
(Includes FY 2014 receipts for Accrual Fund)	**$7.4 billion**	**$8.3 billion**

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

[b] Department of Defense (DoD) health care beneficiary population projected for mid–fiscal year (FY) 2014 is 9,550,000, rounded to 9.6 million, and is based on the Projection of Eligible Population (PEP), Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Acting Deputy Assistant Secretary of Defense, Health Budgets and Financial Policy Memo dated 12/6/2013.

[c] Military treatment facility (MTF) data from DHA Business Support Directorate, Facility Planning, 11/21/2013.

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

[e] As reported by TRICARE Regional Offices (TROs) for contracted network providers and hospitals data, and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data.

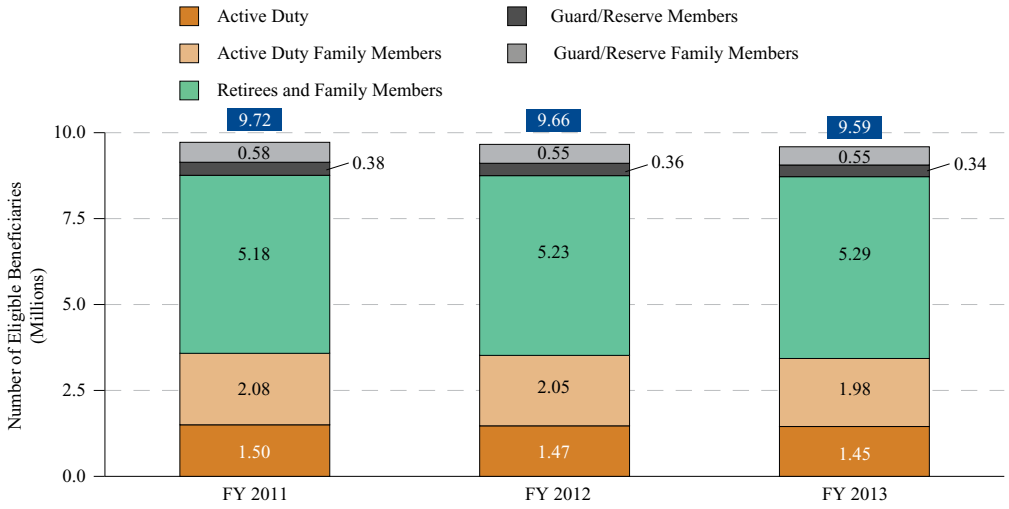
[f] Includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund"). DoD Normal Cost Contribution paid by the U.S. Treasury.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Number of Eligible and Enrolled Beneficiaries Between FY 2011 and FY 2013

The number of beneficiaries eligible for DoD medical care (including TRICARE Reserve Select [TRS], TRICARE Young Adult [TYA], and TRICARE Retired Reserve [TRR]) fell from 9.72 million at the end of FY 2011 to 9.59 million[1] at the end of FY 2013. The decline was due primarily to a drawdown in the number of Active Duty (AD) personnel and associated family members. After increasing for most of the previous decade, the number of Guard/Reservists and their family members also took a turn downward. Compensating somewhat for the downturn in the latter beneficiary groups was an increase in the number of retirees and family members (RETFMs), especially those age 65 and above (numbers included but not shown separately in the chart below).

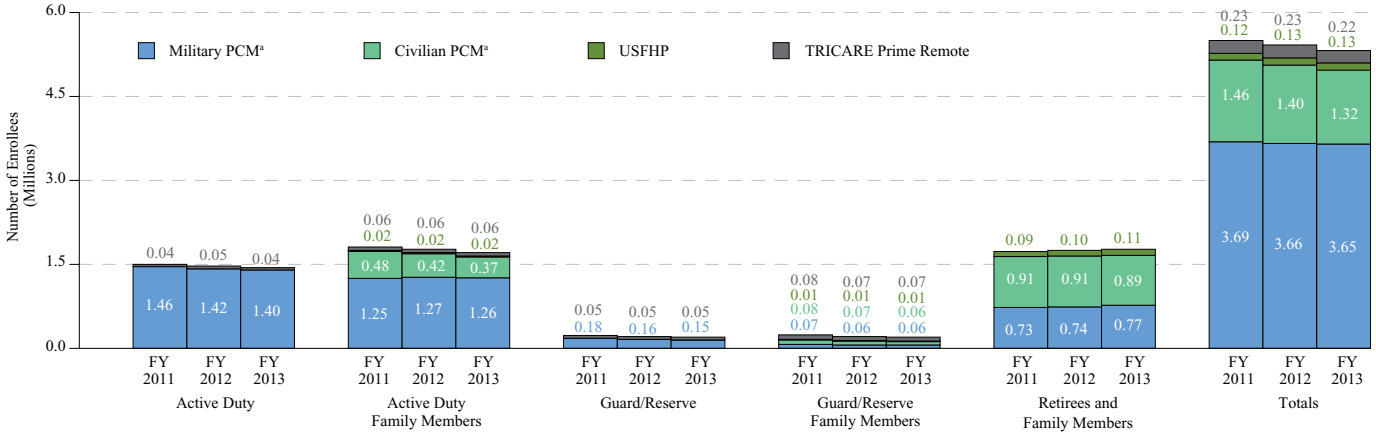
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 12/20/2013

- Declines in Prime enrollment are due primarily to corresponding declines in the Active Duty and Guard/Reserve populations and their family members.
- TRICARE Prime Remote (TPR) and Uniformed Services Family Health Plan (USFHP) enrollment remained flat, overall and across beneficiary groups, from FY 2011 to FY 2013.

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



Source: DEERS, 12/20/2013

[a] Primary care manager

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 9. The population figure on page 9 is a projected FY 2014 total, whereas the population reported on this page is the actual for the end of FY 2013.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Beneficiary Plan Choice by Age Group and Beneficiary Category

Although Prime and Standard/Extra are the primary choices for most TRICARE beneficiaries, several other options are available to those who do not qualify for the latter. Of the 9.6 million eligible beneficiaries, approximately 7.6 million (or 80 percent) were enrolled in one or more of the plans below.[1] Plan choice varied by age group and beneficiary category.

PLAN CHOICE BY AGE GROUP (END OF FY 2013)

Plan Type	0–17	18–24	25–44	45–64	65+	Total[a]
Prime	1,446,323	965,594	1,650,042	1,127,135	2,315	5,191,409
USFHP	24,244	6,981	12,483	44,985	43,578	132,271
TRS	104,349	27,611	119,654	25,056	103	276,773
TRR	900	480	320	2,172	9	3,881
TFL	0	0	0	0	2,018,854	2,018,854
Plus	5,634	1,928	3,135	16,773	158,404	185,874
TYA Prime	0	17,634	1,858	0	0	19,492
TYA Standard	0	10,791	2,563	0	0	13,354
Multiple Plans	0	–570	–74	0	–194,240	–194,884
Total Enrolled	1,581,450	1,030,449	1,789,981	1,216,121	2,029,023	7,647,024
Non-Enrolled	435,050	193,811	288,025	930,958	92,859	1,940,703
Total	**2,016,500**	**1,224,260**	**2,078,006**	**2,147,079**	**2,121,882**	**9,587,727**

Source: DEERS, 12/20/2013

- About one-third of USFHP enrollees are seniors (≥65) and one-fifth are children (0–17).
- The vast majority of those age 65 and above are enrolled in Medicare Part B and are covered by TRICARE for Life (TFL) as their supplemental plan. About 8 percent of seniors covered by TFL are also enrolled in TRICARE Plus, the primary-care-only plan available at selected military treatment facilities (MTFs).
- The largest eligible age group, those aged 45 to 64, had the lowest TRICARE enrollment rate at 57 percent. Enrollment rates for the other age groups were 79 percent for 0–17, 84 percent for 18–24, 86 percent for 25–44, and 96 percent for 65+.

PLAN CHOICE BY BENEFICIARY CATEGORY (END OF FY 2013)

Plan Type	AD/GRD	ADFM/GRDFM	RET/RETFM <65	RET/RETFM ≥65[b]	Total[a]
Prime	1,650,652	1,883,019	1,656,034	1,704	5,191,409
USFHP	322	25,028	63,351	43,570	132,271
TRS	101,049	175,002	722	0	276,773
TRR	3	1	3,868	9	3,881
TFL	0	0	0	2,018,854	2,018,854
Plus	31	3,715	24,579	157,549	185,874
TYA Prime	0	2,986	16,506	0	19,492
TYA Standard	0	1,975	11,379	0	13,354
Multiple Plans	0	–558	–86	–194,240	–194,884
Total Enrolled	1,752,057	2,091,168	1,776,353	2,027,446	7,647,024
Non-Enrolled	37,141	417,523	1,396,306	89,733	1,940,703
Total	**1,789,198**	**2,508,691**	**3,172,659**	**2,117,179**	**9,587,727**

Source: DEERS, 12/20/2013

[a] The totals in the right-hand columns of the above tables may differ slightly from ones shown in other sections of this report. Reasons for differences may include different data pull dates, end-year vs. average populations, and different data sources.

[b] The column total does not match the "≥65" total in the top table because the latter includes a small number of Active Duty family members age 65 and over.

- Four percent of RETFMs under the age of 65 are enrolled in plans other than Prime or Standard/Extra.
- Eight percent of Active Duty family members (ADFMs) are enrolled in plans other than Prime or Standard/Extra. The vast majority are Guard/Reserves and family members enrolled in TRS.
- The large majority of beneficiaries enrolled in TYA are children of retirees under the age of 65 (most Active Duty members are not old enough to have children in the requisite age group). TYA Prime is the favored plan for those enrolled in TYA.
- About 81 percent of beneficiaries enrolled in the USFHP are RETFMs, most of whom are under age 65. The USFHP is available at only six sites nationwide, so enrollment is low relative to Prime.

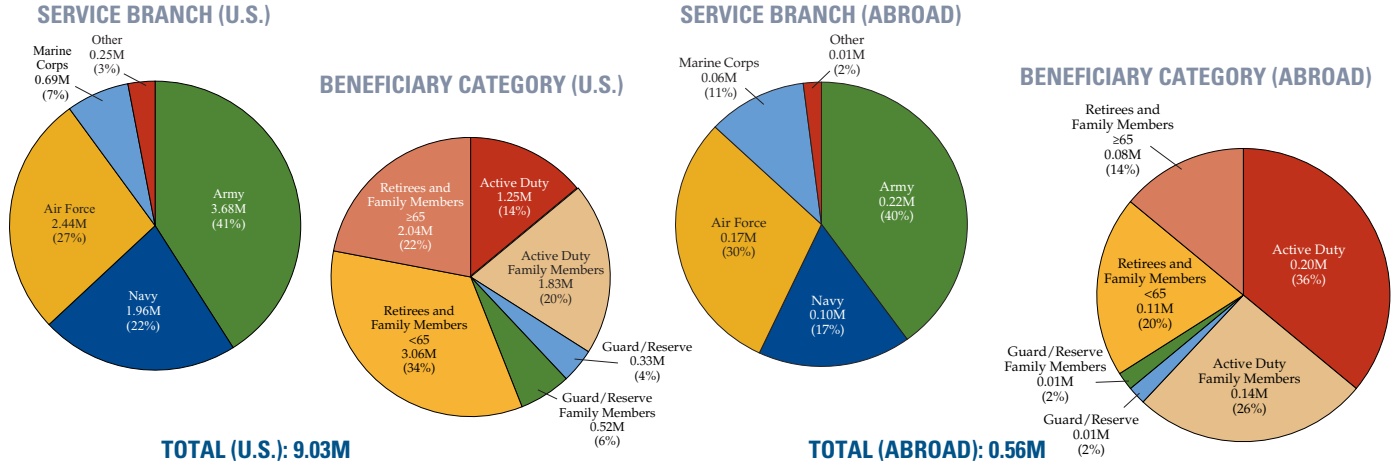
[1] Some beneficiaries use more than one plan, e.g., some TFL-eligible beneficiaries are also enrolled in TRICARE Plus. To avoid double-counting when summing beneficiary counts over plan types, the numbers with multiple plans are displayed as negatives so that the totals equal the number of unique beneficiaries.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Eligible Beneficiaries in FY 2013

- Of the 9.59 million eligible beneficiaries at the end of FY 2013, 9.03 million (94 percent) were stationed or resided in the United States (U.S.) and 0.56 million were stationed or resided abroad. The Army has the most beneficiaries eligible for Uniformed Services health care benefits, followed (in order) by the Air Force, Navy, Marine Corps, and other Uniformed Services (Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration). Although the proportions are different, the Service rankings (in terms of eligible beneficiaries) are the same abroad as they are in the U.S.
- Whereas retirees and their family members constitute the largest percentage of the eligible population (56 percent) in the U.S., Active Duty personnel (including Guard/Reserve Component [RC] members on Active Duty for at least 30 days) and their family members make up the largest percentage (66 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 96, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, the MHS is confronted with an aging beneficiary population.

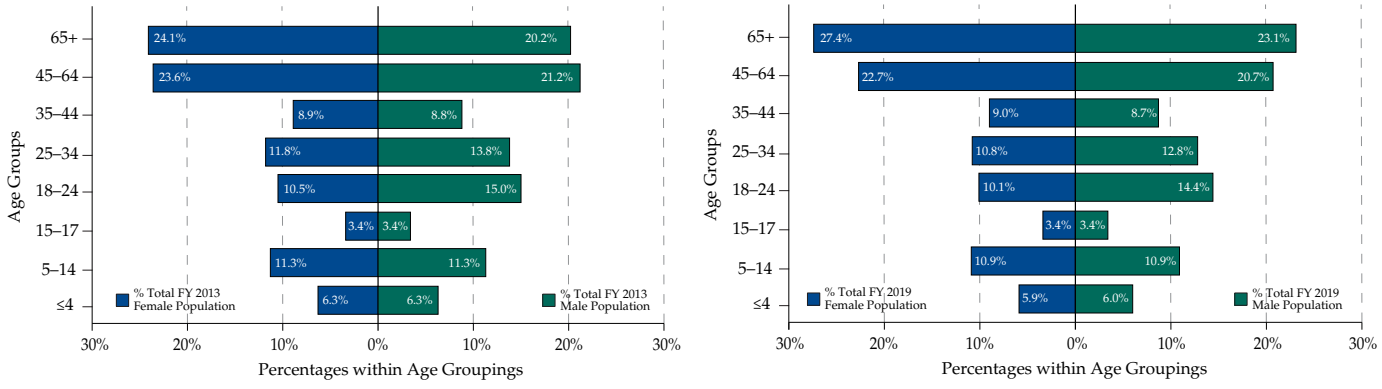
BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2013



Source: DEERS, 12/20/2013

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

MHS END-YEAR POPULATION BY AGE AND GENDER: ACTUAL FY 2013 AND PROJECTED FY 2019



TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: ACTUAL FY 2013 AND PROJECTED FY 2019

	Age Group								Total by Gender	Total MHS Population
	≤4	5–14	15–17	18–24	25–34	35–44	45–64	≥65		
FY 2013 Female MHS Beneficiaries	0.29	0.53	0.16	0.49	0.56	0.42	1.11	1.14	4.70	9.59
FY 2013 Male MHS Beneficiaries	0.31	0.55	0.17	0.73	0.67	0.43	1.04	0.99	4.88	9.59
FY 2019 Female MHS Beneficiaries, Projected	0.26	0.49	0.15	0.45	0.48	0.40	1.02	1.23	4.50	9.13
FY 2019 Male MHS Beneficiaries, Projected	0.28	0.51	0.16	0.67	0.59	0.40	0.96	1.07	4.64	9.13

Source: FY 2013 actuals from DEERS and FY 2019 estimates from Defense Health Agency (DHA) Projections of Eligible Population (PEP) model as of 12/20/2013

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

TRICARE Prime Service Area Reductions Effect on Enrolled Retirees and Family Members

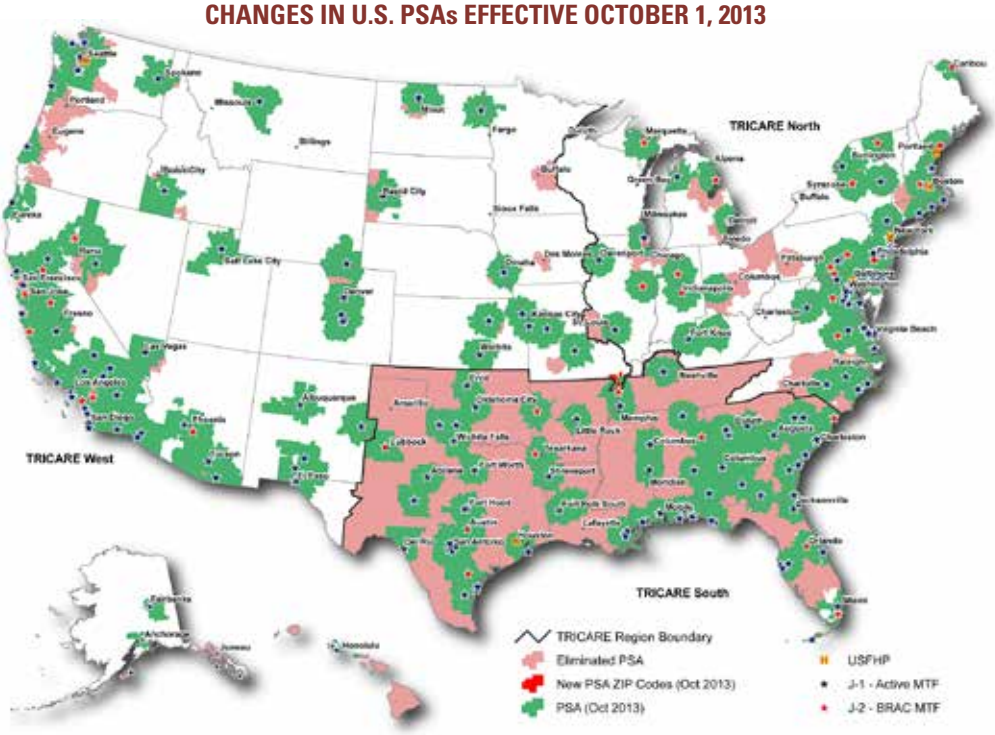
TRICARE reduced the number of designated Prime Service Areas (PSAs) through its latest generation of managed care support contracts, effective October 1, 2013. As a result, some existing PSAs will cease, affecting about 181,600 military retirees and their family members enrolled in TRICARE Prime who would be automatically disenrolled in those locations but still eligible for the TRICARE Standard and Extra options, including coverage for catastrophic limits. Beneficiaries affected by these changes received a letter in February 2013 explaining options available, followed by a second letter between August and September 2013, to ensure that all affected beneficiaries had the time and information to make important decisions about their future health care options before October 1. UnitedHealthcare Military & Veterans (West Region), Health Net Federal Services (North Region), and Humana Military Healthcare Services (South Region) will continue to assist beneficiaries in accessing providers in their regions. TRICARE Prime RETFMs enrolled in a PSA that ceased on October 1, 2013, and living less than 100 miles away from a remaining PSA could re-enroll in TRICARE Prime by waiving their drive-time standards for traveling for primary and specialty care. ADFMs currently enrolled in TRICARE Prime remain enrolled. Approximately 32,600 beneficiaries re-enrolled by the end of October 2013.

TRICARE Prime will remain a health care option for 97 percent of the approximately 5.3 million beneficiaries enrolled in Prime during 2013. TRICARE Prime enrollees not affected by the PSA changes include Active Duty and Guard/Reserve, members on Active Duty for more than 30 days, ADFMs (including those enrolled in TYA Prime), surviving spouses of deceased Active Duty members for the first three years after the sponsor's death, and surviving children of deceased Active Duty Service members (ADSMs; including those enrolled in TYA Prime). These changes did not affect those who were not enrolled in Prime and use other TRICARE options, including TRICARE Standard and Extra, TRR, TRS, TYA Standard, and TFL (other than where access to Extra providers may be affected due to reductions in network providers). The new contracts limit TRICARE Prime networks to regions within a 40-mile radius of existing MTFs and in areas affected by the 2005 Base Realignment and Closure (BRAC) process.

TRICARE Prime enrollees are assigned a primary care provider who manages their health care. TRICARE established the drive-time standard to enable people to access their primary and specialty care within a reasonable period of time. The out-of-pocket, fee-for-service cost of TRICARE Standard will be a bit more, depending on the frequency of health care use and visits. There is no cost-sharing by beneficiaries for preventive care, such as mammograms, vaccines, cancer screening, prostate examinations, and routine checkups. DHA estimates the changes will lower overall government costs by $45 million to $56 million a year, depending on how many military retired beneficiaries remain in TRICARE Prime by re-enrolling in another PSA.

The map at right reflects all of the PSAs in effect prior to the October 1, 2013, change, including all of the TRICARE South Region, and indicates which PSAs will be eliminated October 1, 2013 (shown in pink).

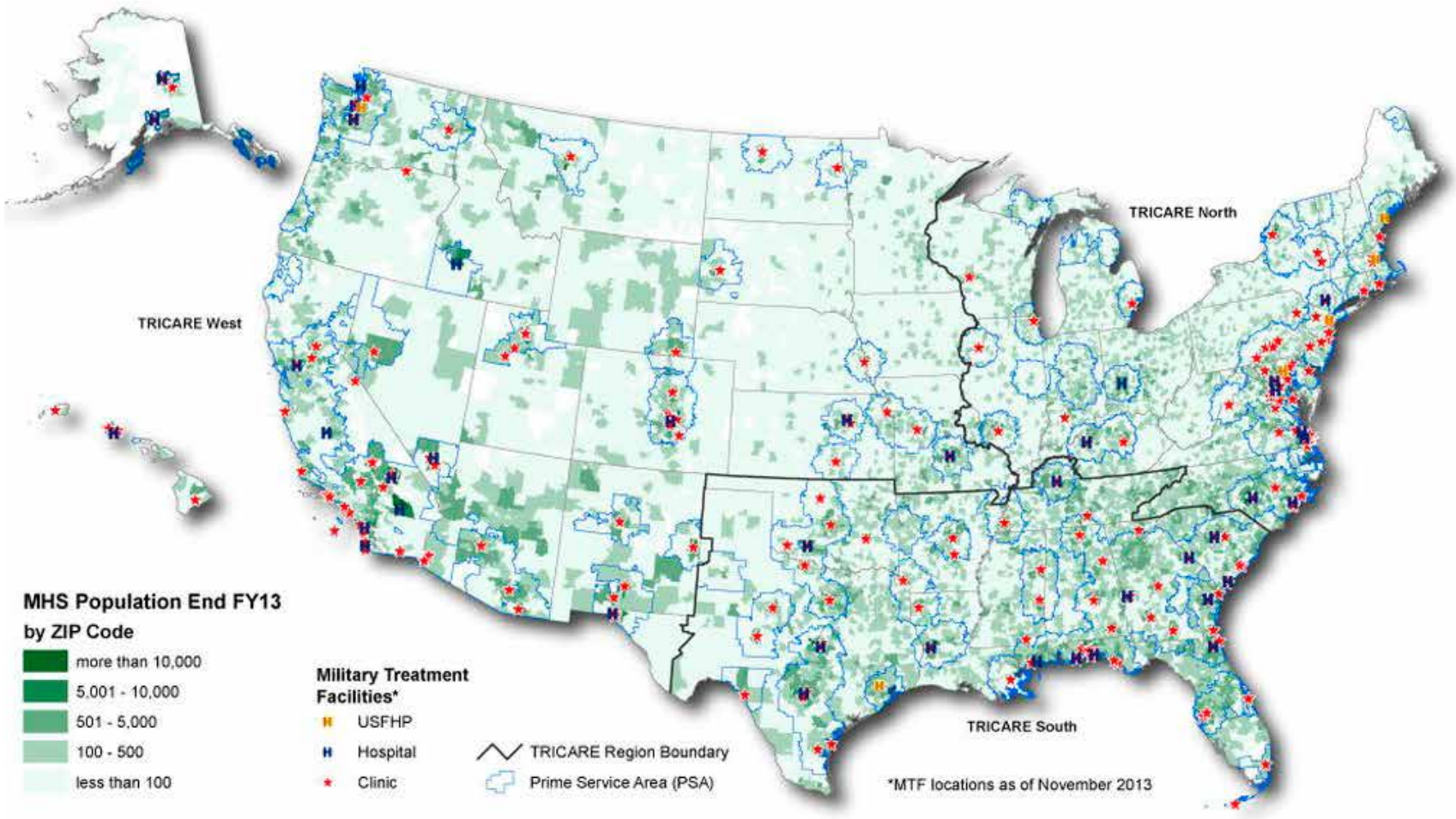
CHANGES IN U.S. PSAs EFFECTIVE OCTOBER 1, 2013



Source: DHA, Health Care Operations Directorate and Benefits Branch, 11/5/2013, and TROs as of 11/30/2013

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs AT THE END OF FY 2013



Source: DHA/Defense Health Cost Assessment and Program Evaluation (DHCAPE), 12/17/2013

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective September 1, 2013. For Active Duty and Guard/Reserve members, unit ZIP Code was used for location; for all other beneficiaries, residential ZIP Code was used.

[b] Location information determined by TRICARE Management Activity (TMA) Catchment Area Directory (CAD) database, September 2013.

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

[d] Includes 38 eligible beneficiaries that are in the U.S. (per DEERS) but not located by TMA CAD data.

Definitions:

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

Provider Requirement Integrated Specialty Model (PRISM) Area: 20-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides

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

PSAs in this map are those in effect during FY 2013 (i.e., prior to changes on October 1, 2013). PSAs include the 40-mile area around existing MTFs as well as previously closed MTFs (BRAC sites) and other locations with high concentrations of MHS beneficiaries; TRICARE South Region in its entirety was a PSA in FY 2013.

MILITARY HEALTH SYSTEM ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES IN 2013[a]

BENEFICIARY GROUP[b]	Population Total (FY 2013)	Population in PSAs	% in PSAs	% in Catchments	% in PRISMs	% in MTF Service Areas
Active Duty and Their Families	3,079,491	2,987,882	97%	70%	88%	93%
Guard/Reserves and Their Families	848,657	695,557	82%	26%	40%	55%
Retirees, Their Families, Survivors, and Other Eligibles[c]	5,098,725	4,458,070	87%	36%	51%	65%
Total MHS Eligibles, U.S.	9,026,873	8,141,509	90%	47%	62%	73%
MHS Eligibles, Overseas	561,042					
Total MHS Eligibles, Worldwide[d]	9,587,915					

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

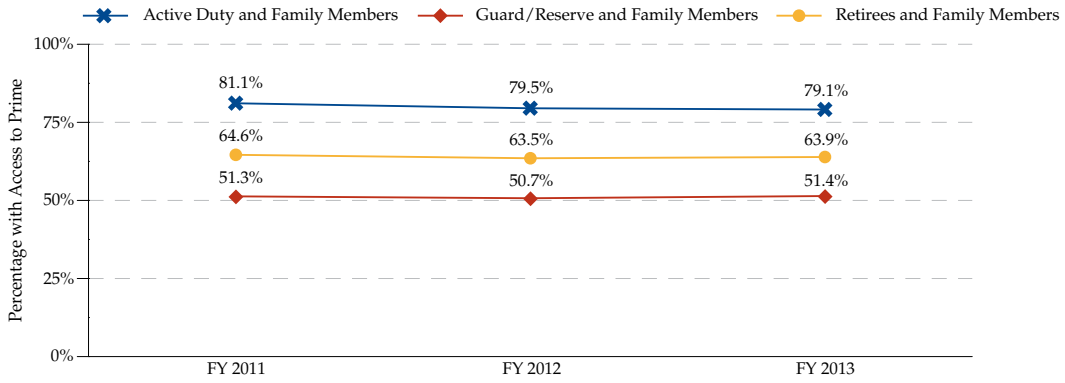
Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2013

The map on the previous page shows the geographic dispersion of the approximately 9.0 million beneficiaries eligible for the TRICARE benefit residing within the United States (94 percent of the 9.6 million eligible beneficiaries described on the previous pages). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population has access to TRICARE Prime. A beneficiary is considered to have access to Prime if he or she resides within a PSA. PSAs are 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 areas where an MTF was eliminated in the BRAC process ("BRAC PSAs"), by Designated Providers through the USFHP prior to October 1, 2013; and in some other areas where the MCSCs proposed in their contract bids to offer the benefit ("noncatchment PSAs"). The overlay of MTF, BRAC, and noncatchment PSAs on the eligible beneficiary population presents an overall picture of the geography of provider networks developed to support TRICARE Prime. Note that in FY 2013, the TRICARE South Region identified as noncatchment PSAs all portions of the region that lay outside MTF and BRAC PSAs. In FY 2014, the South Region eliminated noncatchment PSAs in conformance with the new generation of managed care support contracts.

Beneficiary Access to MTF-Based Prime

Effective October 1, 2013, DoD reduced the number of locations designated as PSAs to those within a 40-mile radius of existing MTFs and in areas affected by the 2005 BRAC process. The chart below shows the trend in beneficiaries living in PSAs under the new definition.

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



Source: DEERS, 12/20/2013

- As determined by residence in an MTF PSA, access to MTF-based Prime declined slightly from FY 2011 to FY 2013 for ADSMs and remained about the same for other beneficiary groups. In that time, the number of military hospitals in the U.S. declined from 44 to 41.
- As expected, ADSMs and their families have the highest level of access to MTF-based Prime, whereas Guard/Reserve members and their families have the lowest. Retirees, some of whom move to locations near an MTF to gain access to care in military facilities, fall in between.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

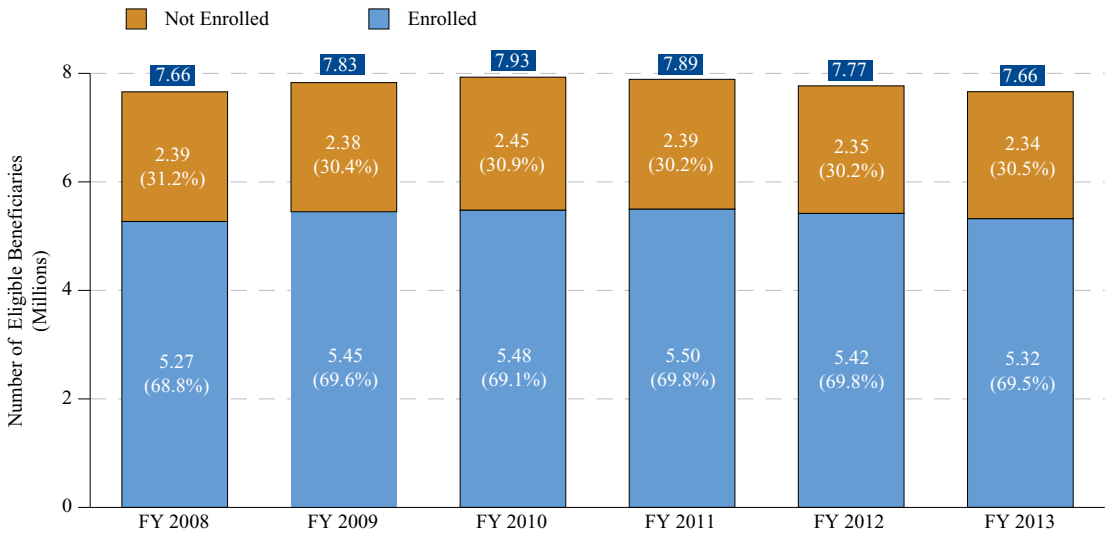
Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from DEERS. For the purpose of this report, all Active Duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and older but include beneficiaries living in remote areas where Prime may not be available. The enrollment rates displayed below may therefore be somewhat understated.

Beneficiaries enrolled in TPR (including Global Remote), TYA Prime, and the USFHP are included in the enrollment counts below. Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program offered at selected MTFs), TRS, TYA Standard, and TRR are excluded from the enrollment counts below; they are included in the non-enrolled counts.

- After peaking in FY 2011, the number of beneficiaries enrolled in TRICARE Prime dropped in FY 2012 and again in FY 2013. However, as a percentage of the beneficiary population, TRICARE Prime enrollment has remained level.
- By the end of FY 2013, 69 percent of all eligible beneficiaries were enrolled (5.32 million enrolled of the 7.66 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS



Source: DEERS, 12/20/2013

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found in the Appendix, page 102.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT'D)*

Recent Three-Year Trend in Eligibles, Enrollees, Users

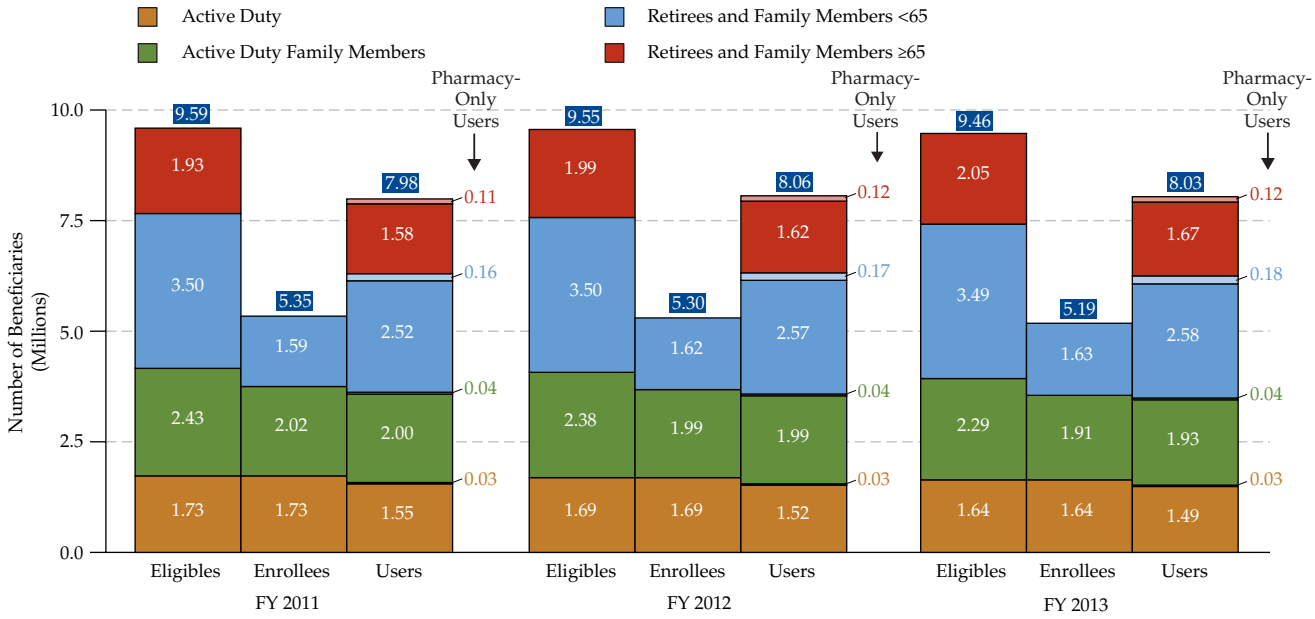
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2011 to FY 2013 were determined from DEERS data. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and, therefore, include those who may not be eligible to enroll in Prime. TRICARE Plus and Reserve Select enrollees are not included in the enrollment counts. USFHP enrollees are excluded from both the eligible and enrollment counts because we did not have information on users of that plan.

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

- The number of Active Duty and eligible family members declined by almost 6 percent between FY 2011 and FY 2013. The number of RETFMs under age 65 remained the same, while the number of RETFMs age 65 and older increased by 6 percent.
- The percentage of ADFMs enrolled in TRICARE Prime increased slightly, from 83 percent in FY 2011 to 84 percent in FY 2013. The percentage of RETFMs under age 65 enrolled in Prime increased slightly from 45 to 47 percent.
- The overall user rate grew from 83.3 percent in FY 2011 to 84.9 percent in FY 2013. The user rate increased slightly for all beneficiary groups except for RETFMs age 65 and older.
- RETFMs under age 65 constitute the greatest number of MHS users but have the lowest user rate. Their MHS user rate is lower because many of them have other health insurance (OHI).

AVERAGE NUMBERS OF FY 2011 TO FY 2013 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 12/20/2013

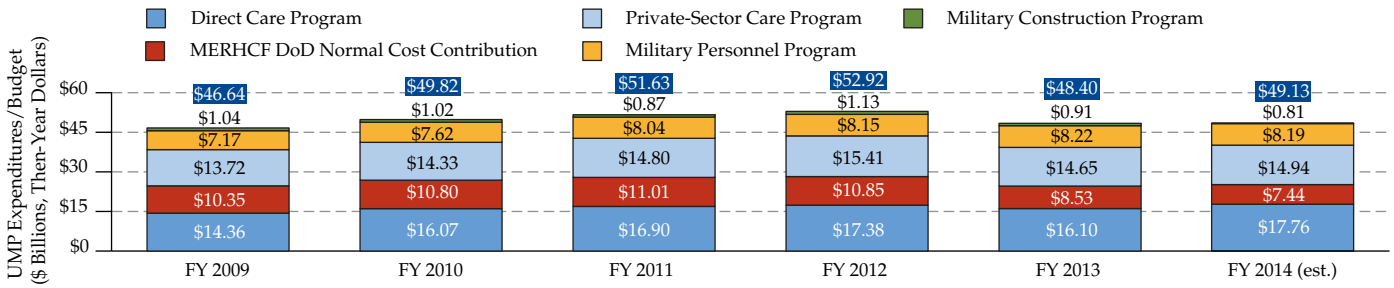
Note: Numbers may not sum to bar totals due to rounding. The bar totals reflect the average number of eligibles and enrollees, not the end-year numbers displayed in previous charts, to account for beneficiaries who were eligible or enrolled for only part of a year.

UMP FUNDING

The UMP actual expenditures were $48.4 billion in FY 2013, over 8.5 percent less than the peak of almost $53 billion in FY 2012 (unadjusted, then-year dollars). The UMP is currently programmed at slightly over $49 billion ($49.13 billion, estimated) in the FY 2014 President's Budget, or almost 1.5 percent higher than expenditures in FY 2013, and 7.2 percent less than spent in FY 2012. The UMP shown includes the normal DoD cost contribution to the MERHCF (the "Accrual Fund"). This fund (effective October 1, 2002) pays the cost of DoD health care programs (both direct and purchased care) for Medicare-eligible retirees, retiree family members, and survivors. The majority of Accrual Fund payments for health care provided to Medicare-eligible beneficiaries are for purchased care pharmacy and outpatient care.

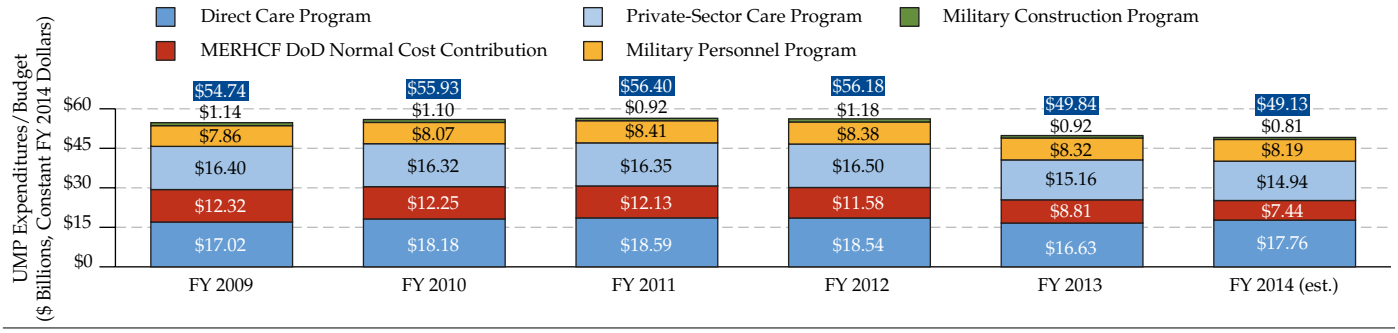
The nearly $3.8 billion decline in UMP from FY 2012 to the budgeted FY 2014 program is due to reduced Accrual Fund expenditures, which are programmed at two-thirds of the FY 2012 expenditures, and a 28 percent ($320 million) decline in military construction; other programs are expected to remain relatively flat (ranging from a 2 percent increase in direct care to a 3 percent decrease in private-sector care).

FY 2009 TO FY 2014 (EST.) UMP FUNDING ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



In constant FY 2014 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2014 $49 billion estimated budget in purchasing value is currently programmed to be almost 13 percent less than in FY 2011, and over 12.5 percent less than in FY 2012.

FY 2009 TO FY 2014 (EST.) UMP FUNDING ($ BILLIONS) IN CONSTANT FY 2014 DOLLARS



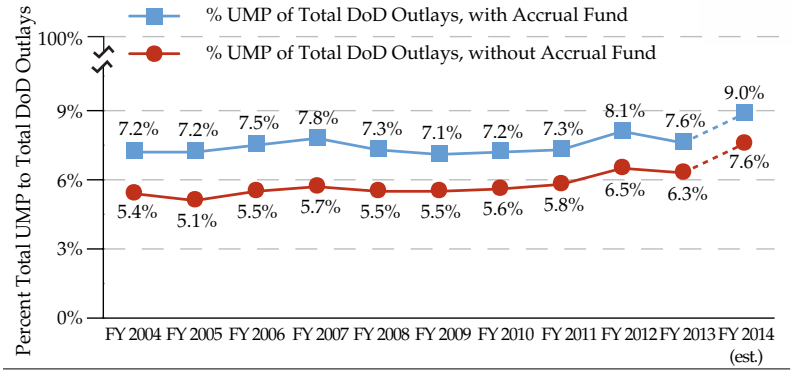
Source: DHA, Program, Budget and Execution (PB&E), 1/27/2014

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

- The DoD MERHCF, also referred to herein as the "Accrual Fund," implemented in FY 2003, is an accrual fund that pays for health care provided in DoD/Coast Guard facilities to DoD retirees, dependents of retirees, and survivors who are Medicare-eligible beneficiaries. The fund also supports purchased care payments through the TRICARE for Life (TFL) benefit first implemented in FY 2002. There are three forms of contribution to Defense health care, and reflect for FY 2013: (1) The Accrual Fund ($7.44 billion), the normal cost contribution funded by the UMP at the beginning of each fiscal year discussed above, is paid by the Military Services for future health care liability accrued since October 1, 2002, for Active Duty, Guard, and Reserve beneficiaries and their family members when they become retired and Medicare eligible; (2) $4.25 billion is paid by the Treasury to fund future health care liability accrued prior to October 1, 2002, for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare eligible; and (3) $11.7 billion to pay for health care benefits provided today to current Medicare-eligible retirees, family members, and survivors (i.e., actual projected outlays from the trust fund—$9.8 billion overall, of which $7.9 billion is for purchased care, and $1.9 billion for direct [MTF] care; direct care includes both Operations and Maintenance [O&M; $1.4 billion] and Military Personnel costs [$0.5 billion]).
- FYs 2008–2012 reflect Comptroller Information System actual execution.
- Not shown directly, but FY 2007 actuals include supplemental funding ($1.2 million) supporting the Global War on Terrorism and other programs such as Traumatic Brain Injury/Psychological Health (TBI/PH), Wounded Warrior, and Pandemic Influenza.
- FY 2009 actuals include Overseas Contingency Operations (OCO) and additional supplemental funding for O&M; Procurement; and Research, Development, Test, and Evaluation (RDT&E).
- FY 2010 current estimate includes O&M funding of $1.2567 billion in support of OCO requirements and $140.0 million ($132.0 million for O&M and $8.0 million for RDT&E) transferred from the Department of Health and Human Services (DHHS) for Pandemic Influenza Preparedness and Response.
- FY 2011 includes $1.4 billion OCO supplemental funding for O&M and $23.4 million in OCO funding for RDT&E.
- FY 2012 includes $1.2 billion OCO supplemental funding for O&M and reductions for DoD efficiency initiatives (FY 2012 OCO includes $452 million in private sector; $765 million in direct care).
- FY 2013 includes $966.022 million in OCO. Reflects reductions for Sequestration, National Defense Authorization Act (NDAA) 2013, sections 3001, 3004, and 8123.
- FY 2014 enacted position for DHP O&M (less OCO), RDT&E, Procurement, and MILCON reflected in Public Law 113-76, Consolidated Appropriations Act, 2014, Jan. 17, 2014.

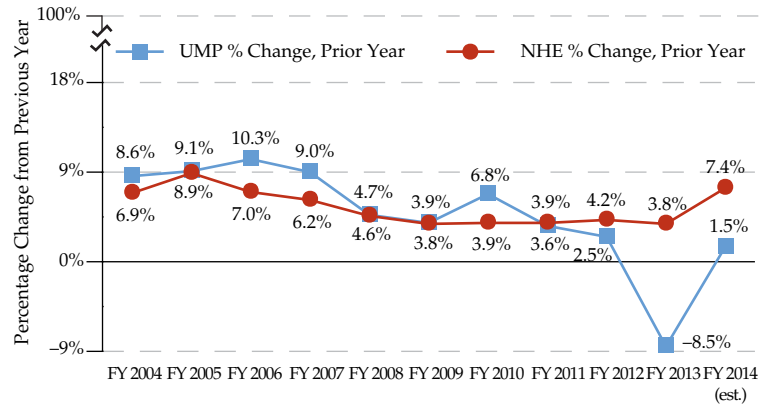
UMP FUNDING *(CONT'D)*

UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DOD OUTLAYS: FY 2004 TO FY 2014 (EST.)



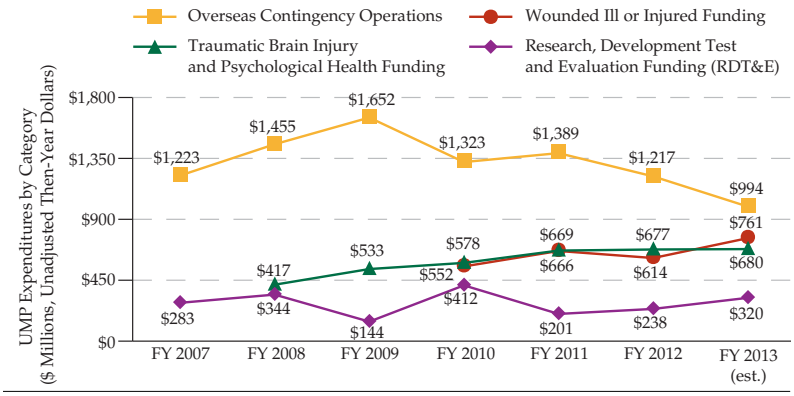
Source: Cost and budget estimates DHA, Program, Budget, and Execution (PB&E), 1/27/2014
Note: FY 2013 and FY 2014 percentages are estimates based on total DoD outlays reflected as of the writing of this report.

COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2004 TO FY 2014 (EST.)



Sources, as of 1/27/2014:
- Cost and budget estimates DHA, Program, Budget, and Execution (PB&E), 1/27/2014
- CMS, Office of the Actuary, Table 1, National Health Expenditures and Selected Economic Indicators, Levels and Annual Percent Change: Calendar Years 2006–2021.
- *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/Proj2012.pdf*, accessed 1/13/2014. The health spending projections were based on the NHE released in January 2012, updated to take into account the impacts of the Affordable Care Act (ACA) and regulatory changes.

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



Source: Cost and budget estimates OASD(HA)/DHA/Program, Budget, and Execution (PB&E), 12/5/2013
Notes:
- TBI and PH expenditures shown for FY 2008 include FY 2007 and FY 2006.
- The Wounded, Ill, or Injured funding line is included in overall OCO funding from FY 2007 to FY 2009 but is identified separately beginning in FY 2010.

UMP Share of Defense Budget

UMP expenditures, including the Accrual Fund, increased from 7.3 percent of total DoD outlays in FY 2011 to 7.6 percent in FY 2013, and are estimated to be 9 percent in FY 2014. As currently programmed, the UMP, including the Accrual Fund, as a proportion of total DoD expenditures (outlays) appears consistent over time at between 7 and 8 percent through FY 2013, and is paralleled by the lower percentage of UMP without Accrual Fund to total DoD outlays. These proportions may increase in the future to the extent that medical costs (i.e., the numerator) remain to care for returning forces or increase due to inflationary pressures, and the Department's overall budget (i.e., the denominator) is constrained or reduced due to fiscal pressures and the return of operationally deployed forces to U.S. bases.

Comparison of UMP and National Health Expenditures over Time

As noted in the middle chart at left, the annual rate of growth in the UMP increased from FY 2004 to FY 2006, reaching a peak of 10 percent growth in FY 2006, and declined almost every year since, except for a spike in 2010. The FY 2013 UMP was 8.5 percent lower than FY 2012, but is expected to increase by 1.5 percent in FY 2014. In comparison, the Centers for Medicare and Medicaid Services (CMS) estimates that National Health Expenditures (NHE) reached $2.9 trillion in 2013, for an increase of 3.8 percent over 2012, equal to the same historic low growth rate of 3.8 percent in 2009. The Department of Health and Human Services estimates NHE expenditures will increase substantially in 2014, reaching $3.1 trillion, 7.4 percent more than in 2013. The increase is expected due, in part, to the major coverage expansion legislated by ACA (refer to source notes at left).

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

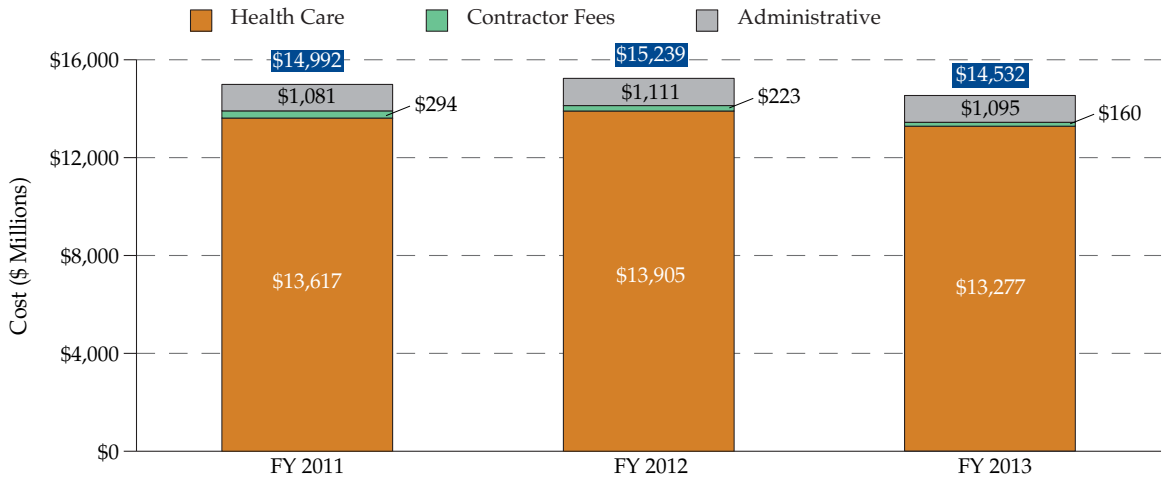
The graph at left reflects the total actual DHP funding for OCO and resultant care since FY 2007. Actual DHP expenditures declined from about $2.9 billion in FY 2011 to under $2.8 billion in FY 2011 and FY 2012. These overall expenses are the sum of OCO operations; care for traumatic brain injury (TBI);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

PRIVATE-SECTOR CARE ADMINISTRATIVE COSTS

The private-sector care budget activity group includes underwritten health care, pharmacy, Active Duty supplemental care, dental care, overseas care, the health care portion of USFHP capitation, funds received and executed for OCO, funds authorized and executed under the DHP carryover authority, and other miscellaneous expenses. It excludes costs for non-DoD beneficiaries and MERHCF expenses.

- Total private-sector care costs dropped from $14,992 million in FY 2011 to $14,532 million in FY 2013, a decrease of 3 percent. Private-sector health care costs declined by 2 percent, whereas administrative costs remained flat and contractor fees fell by 46 percent.
- Excluding contractor fees, administrative expenses increased from 7.4 percent of total private-sector care costs in FY 2011 ($1,081 million of $14,698 million) to 7.6 percent in FY 2013 ($1,095 million of $14,372 million). Including contractor fees (in both administrative and total costs), administrative expenses decreased from 9.2 percent of total private-sector care costs in FY 2011 ($1,375 million of $14,992 million) to 8.6 percent in FY 2013 ($1,255 million of $14,532 million).
- Contractor fees decreased between FY 2011 and FY 2013 as a result of the shift to the new T3 contracts (North: April 1, 2011; South: April 1, 2012; West: April 1, 2013), which transitioned from incentive-based underwriting fees to lower fixed fees.

TREND IN PRIVATE-SECTOR CARE COSTS



Source: DHA, Contract Resource Management, 12/20/2013

Note: The FY 2011 and FY 2012 totals in the chart above are greater than the Private-Sector Care Program costs because the former include carryover funding. DHA has congressional authority to carry over 1 percent of its O&M funding into the following year. The FY 2011 and FY 2012 amounts carried forward from the prior-year appropriation were $276 million and $297 million, respectively. There was no funding carried over from FY 2012 to FY 2013 because of sequestration.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

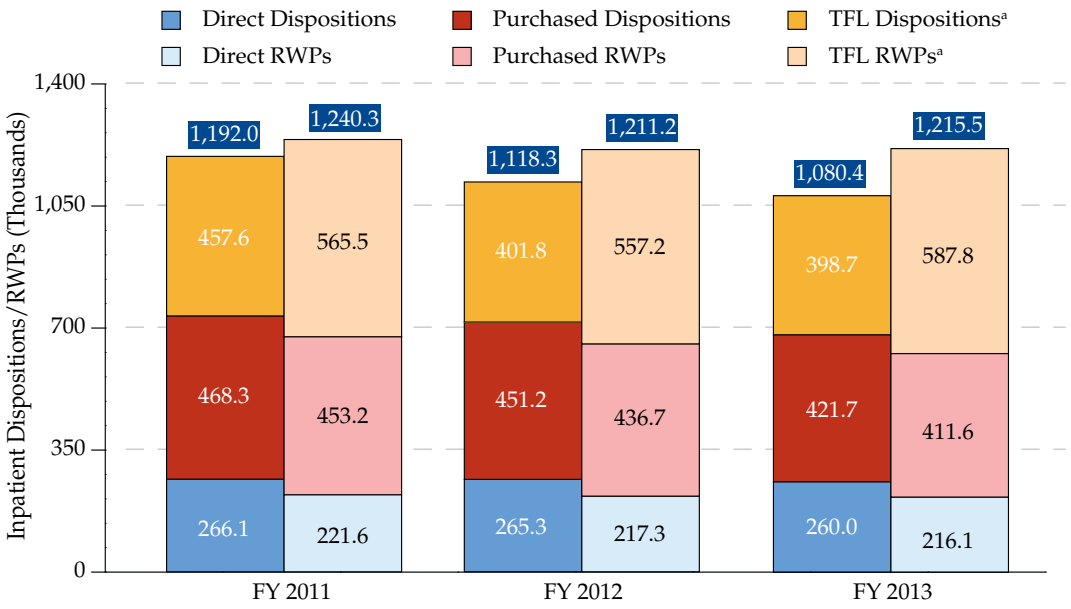
MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: as the number of inpatient dispositions and as the number of relative weighted products (RWPs). The latter measure, relevant only for acute care hospitals, reflects the relative resources consumed by a single hospitalization as compared with the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. In FY 2009, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new DRG classifications resulted in a corresponding change in the calculation of RWPs, which has been applied to the data from FY 2011 to FY 2013.

Total inpatient dispositions and RWPs (direct and purchased care combined) declined by 7 percent between FY 2011 and FY 2013, excluding the effect of TFL.

- Direct care inpatient dispositions and RWPs each decreased by 2 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions decreased by 10 percent while RWPs decreased by 9 percent between FY 2011 and FY 2013.
- Including TFL workload, purchased care dispositions decreased by 11 percent and RWPs decreased by 2 percent between FY 2011 and FY 2013.
- Although not shown, about 8 percent of direct care inpatient dispositions and RWPs were performed abroad in FY 2013. Purchased care and TFL inpatient workload performed abroad accounted for less than 3 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/23/2014

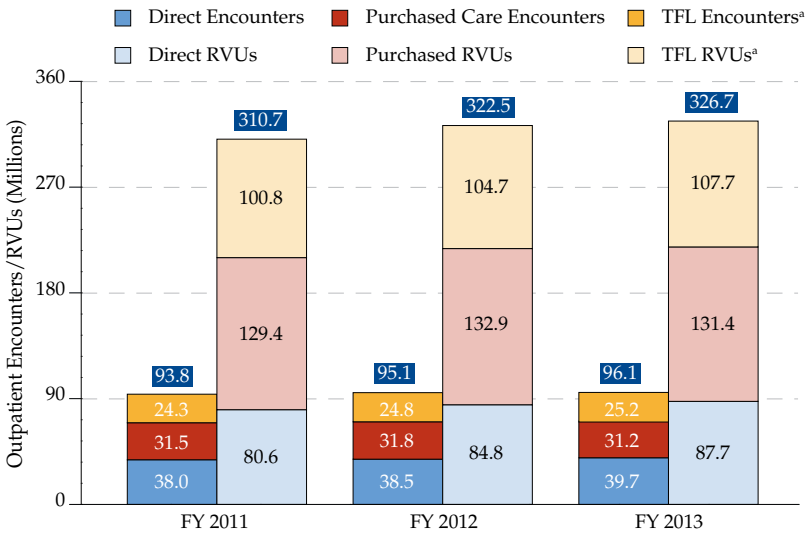
[a] Purchased care only

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

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of relative value units (RVUs). Because encounters do not appear on purchased-care claims, they are calculated using a DHA-developed algorithm. RVUs reflect the relative resources consumed by a single encounter as compared with the average of all encounters. In FY 2010, TRICARE developed an enhanced measure of RVUs that accounts for units of service (e.g., 15-minute intervals of physical therapy) and better reflects the resources expended to produce an encounter. The enhanced RVU measures have been applied to the data from FY 2011 to FY 2013. The RVU measure used in this year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the latter RVU measures.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/23/2014

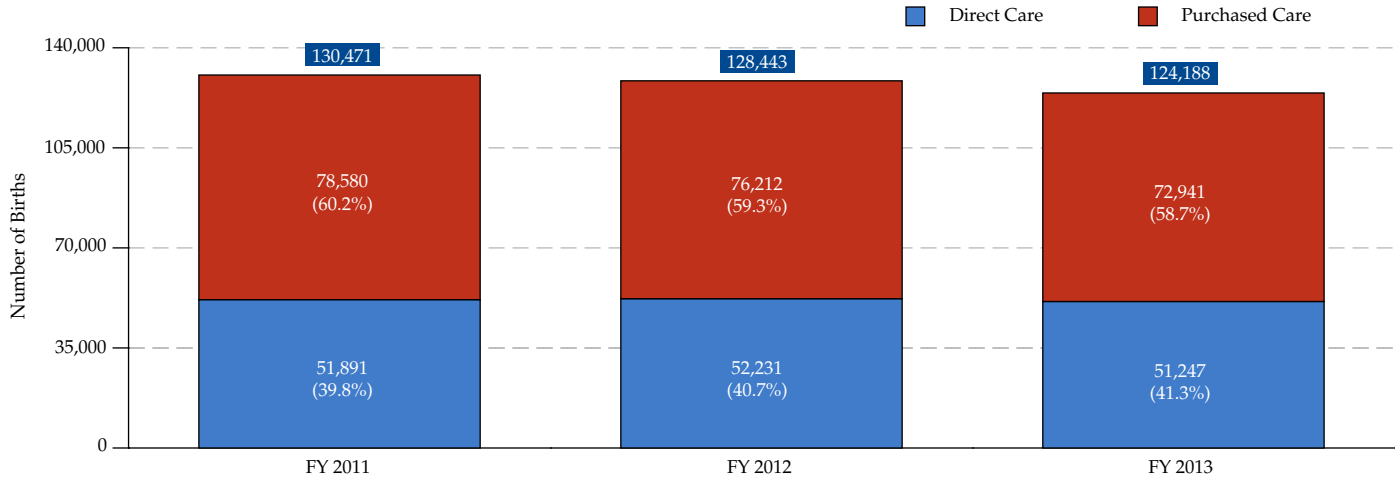
[a] Purchased care only

- Total outpatient workload (direct and purchased care combined) increased between FY 2011 and FY 2013 (encounters increased by 2 percent and RVUs by 4 percent), excluding the effect of TFL.
- Direct care outpatient encounters increased by 5 percent and RVUs by 9 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters decreased by 1 percent and RVUs increased by 2 percent. Including TFL workload, encounters increased by 1 percent and RVUs increased by 4 percent.
- Although not shown, about 8 percent of direct care outpatient workload (both encounters and RVUs) was performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for only about 1 percent of the worldwide total.

MTF Market Share for Childbirths

A 2011–2012 DHA survey of MTF obstetric (OB) patients measured satisfaction with various aspects of their care. Moderate correlations were found between some survey satisfaction levels and MTF market shares for childbirths, i.e., the percentage of total OB workload (direct plus purchased) performed in direct care facilities. MTF OB market shares in the U.S. ranged between 7 percent and 88 percent. From the chart below, it is evident that there has been no erosion in overall MTF OB market share in the past three years.

TREND IN MTF MARKET SHARE FOR CHILDBIRTHS



Source: MHS administrative data, 1/23/2014

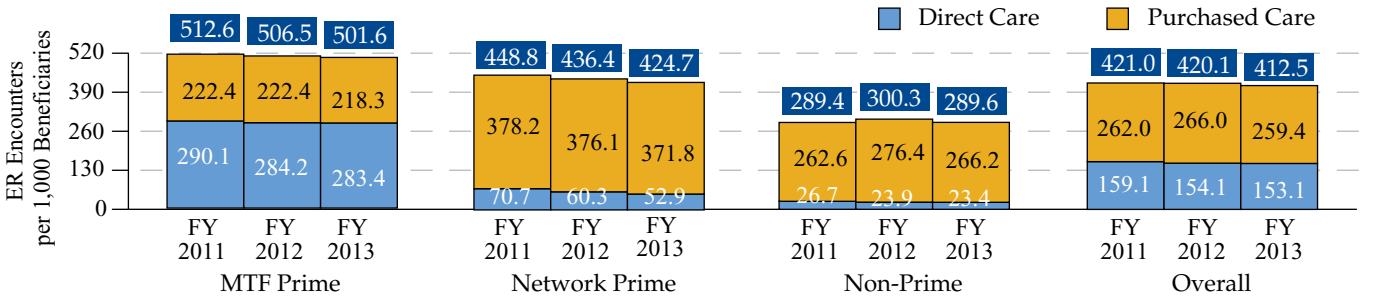
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT'D)*

Emergency Room Utilization

Emergency room (ER) utilization is sometimes used as an indirect measure of access to care, particularly for Prime enrollees. Using data from the National Health Interview Survey, the National Center for Health Statistics reports that almost 80 percent of civilians who use the ER do so because of lack of access to other providers.[1] Although not equivalent, it is reasonable to ask whether a similar situation occurs in MHS, in particular whether Prime enrollees make excessive use of ERs as a source of care because they cannot get timely access to their primary care managers (PCMs) under the normal appointment process. To provide a preliminary evaluation of this issue, direct and purchased care ER utilization rates were compared across three enrollment groups: MTF enrollees, network enrollees, and non-enrollees. The rate for each enrollment group was calculated by dividing ER encounters by the average population in that group. The rates were then adjusted to reflect the age/sex distribution of the overall MHS population. To avoid biasing the comparisons, seniors were excluded from the calculations because they are almost exclusively non-enrollees.

- ER utilization has been declining for all enrollment groups, especially network enrollees (–5 percent from FY 2011 to FY 2013).
- In FY 2013, MTF Prime enrollees had an ER utilization rate 18 percent higher than that of network Prime enrollees and 73 percent higher than that of non-enrollees. Network Prime enrollees had an ER utilization rate 47 percent higher than that of non-enrollees.
- For MTF Prime enrollees, 44 percent of ER encounters were in purchased care facilities (not necessarily in-network).
- Children under five years old had the highest ER utilization rate for all enrollment groups (not shown).
- The FY 2011 overall MHS ER utilization rate of 421 encounters per 1,000 beneficiaries is very close to the civilian rate of 428 per 1,000 reported in calendar year (CY) 2010, the nearest available year of data.[2]

EMERGENCY ROOM UTILIZATION BY ENROLLMENT STATUS AND SOURCE OF CARE (ENCOUNTERS PER 1,000 BENEFICIARIES)

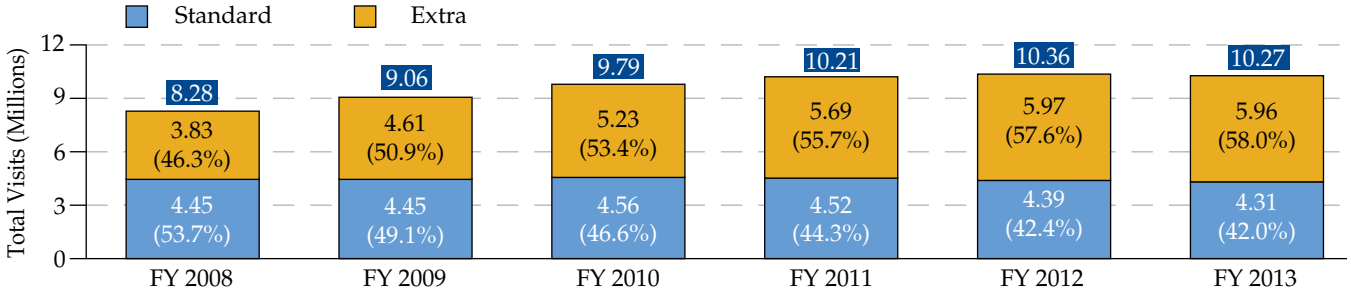


Source: MHS administrative data, 1/23/2014

Extra vs. Standard Non-Prime Visits

For beneficiaries not enrolled in Prime, the ratio of Extra to Standard visits has been steadily increasing with time. In FY 2008, Extra visits (calculated using the new methodology mentioned above) accounted for only 46 percent of all non-Prime visits. By FY 2009, the number of Extra visits exceeded the number of Standard visits for the first time (51 percent). In FY 2013, 58 percent of all non-Prime visits were to Extra providers. One reason for the increasing usage of Extra providers is the expansion of the TRICARE provider network (see page 56).

TRENDS IN EXTRA VS. STANDARD VISITS



Source: MHS administrative data, 1/23/2014

[1] Gindi, R. M., et al., "Emergency Room Use Among Adults Aged 18–64: Early Release of Estimates from the National Health Interview Survey, January–June 2011" (National Center for Health Statistics: May 2012), *http://www.cdc.gov/nchs/nhis/releases.htm*.

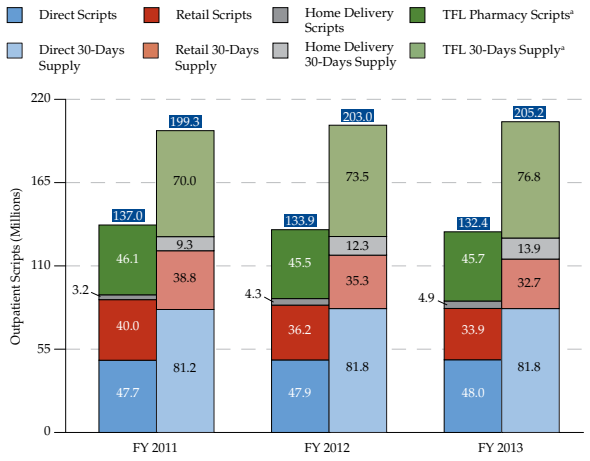
[2] Centers for Disease Control and Prevention, "National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary Tables," Table 1, *http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf*.

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

MHS Prescription Drug Workload

TRICARE beneficiaries can fill prescription medications at MTF pharmacies, through home delivery (mail order), at TRICARE retail network pharmacies, and at non-network pharmacies. Total outpatient prescription workload is measured two ways: as the number of prescriptions and as the number of days supply (in 30-day increments). Total prescription drug workload (all sources combined) decreased between FY 2011 and FY 2013 (prescriptions decreased by 5 percent and days supply by 1 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/23/2014

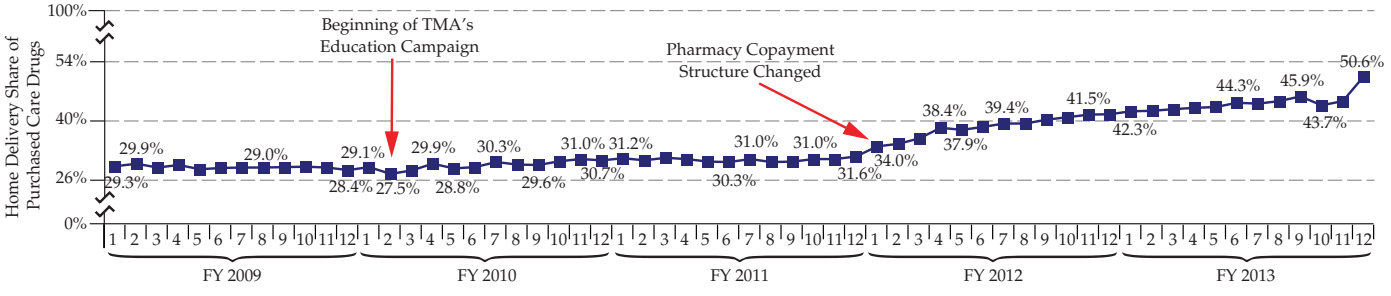
[a] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.

- Direct care prescriptions and days supply each increased by 1 percent between FY 2011 and FY 2013.
- Purchased care prescriptions (retail and home delivery combined) decreased by 10 percent and days supply by 3 percent from FY 2011 to FY 2013, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 6 percent and days supply increased by 5 percent. The discrepancy in trends between purchased care prescription counts and days supply is due to increased beneficiary utilization of home delivery services.
- While not shown, about 7 percent of direct care prescriptions were issued abroad. Purchased care prescriptions issued abroad accounted for little more than 2 percent of the worldwide total.

Although TRICARE pharmacy home delivery services have been available to DoD beneficiaries since the late 1990s, they have never been heavily used until recently. Home delivery of prescription medications offers benefits to both DoD and its beneficiaries since DoD negotiates prices that are considerably lower than those for retail drugs, and the beneficiary receives up to a 90-day supply for the same copay as a 30-day supply at a retail pharmacy. In November 2009, DoD consolidated its pharmacy services under a single contract (called TPharm) and launched an intensive campaign to educate beneficiaries on the benefits of home delivery services. As an additional incentive for beneficiaries to use home delivery services, effective October 1, 2011, TRICARE eliminated home delivery beneficiary copayments for generic drugs while at the same time increasing retail pharmacy copayments. Furthermore, the National Defense Authorization Act (NDAA) for FY 2013 mandated that DoD implement a five-year pilot program requiring TFL beneficiaries to obtain all refill prescriptions for covered maintenance medications from the TRICARE home delivery program or MTF pharmacies. The pilot program is scheduled to begin in mid-February 2014. Beneficiaries may opt out of the pilot program after one year of participation.

The home delivery share of total purchased care utilization had been on the decline from the beginning of FY 2008 until November 2009, when TMA's education campaign began. The home delivery share then gradually increased through the beginning of FY 2012, when the pharmacy copayment structure was changed. Since that time, the home delivery share of purchased care pharmacy utilization (as measured by days supply) has risen dramatically, increasing from 32 percent at the end of FY 2011 to 51 percent at the end of FY 2013.

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

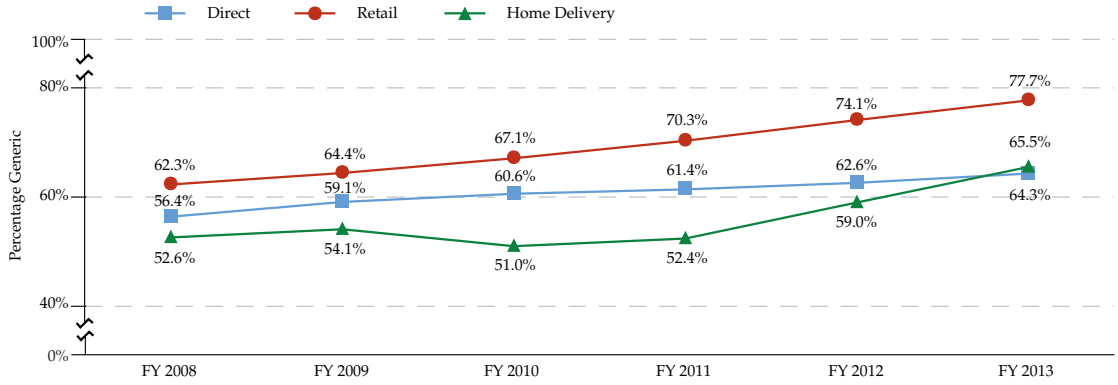


Source: MHS administrative data, 1/23/2014

COST SAVINGS EFFORTS IN DRUG DISPENSING

- The rate of generic drug dispensing has been increasing for all sources: direct, retail, and home delivery. Retail pharmacies have seen the greatest increase, from 62 percent in FY 2008 to 78 percent in FY 2013.
- Although the rate of generic drug dispensing is increasing in MHS, it still lags the private sector. In 2011, approximately 78 percent of new and refilled private-sector prescriptions were filled with generics,[1] compared with 72 percent overall (direct plus retail) in MHS.[2] The use of generics in lieu of brand-name drugs is expected to grow, since the patent protection of a sizable number of brand-name drugs will expire by 2015.
- The average cost for a 30-day supply of a brand versus generic drug in FY 2013 was: $44 versus $12 for direct care, $158 (net of manufacturer refunds) versus $19 for retail pharmacies, and $70 versus $10 for home delivery (costs are not adjusted for differences in drug types between brand and generic). Therefore, all other factors being equal, the trend toward greater generic drug dispensing is likely to lower DoD costs for prescription drugs.

TRENDS IN GENERIC DRUG DISPENSING

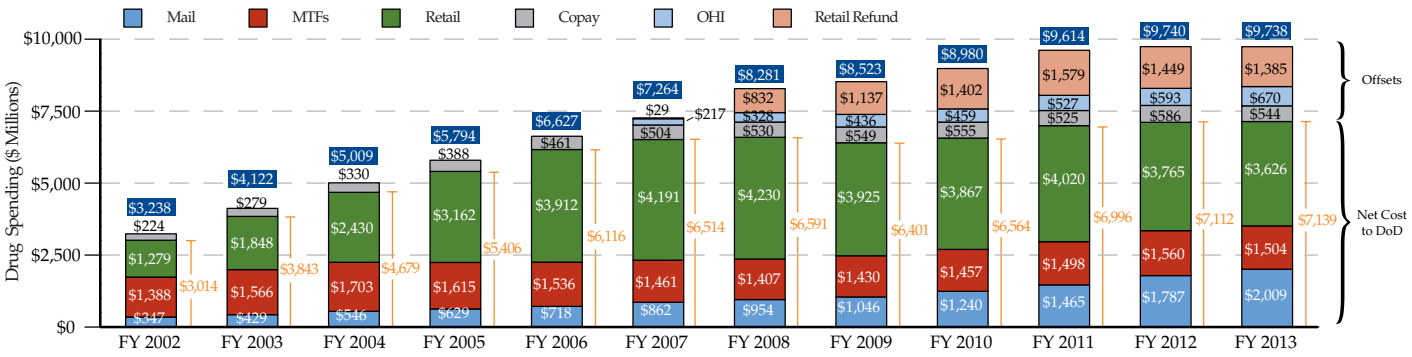


Source: MHS administrative data, 1/23/2014

The NDAA for FY 2008 mandated that the TRICARE retail pharmacy program be treated as an element of DoD and, as such, be subject to the same pricing standards as other federal agencies. As a result, drug manufacturers began providing refunds to DoD on most brand-name retail drugs beginning in FY 2008.

- Although total drug costs have consistently increased over the past decade, retail drug refunds have stemmed the increase in the cost to DoD. In FY 2013, the refunds are estimated to have saved DoD almost $1.4 billion. Net DoD costs are only 10 percent higher than they were in FY 2007.

MHS DRUG SPENDING



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Directorate (POD) (refunds), 1/9/2014

Notes: Net cost to DoD represents total prescription expenditures minus copays, coverage by OHI, and retail refunds invoiced. Mail Order dispensing fees are included; however, other retail/mail contract costs and MTF cost of dispensing are not included. Retail refunds are reported on an accrual rather than a cash basis, corresponding to the original prescription claim data and updated refund adjustments.

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

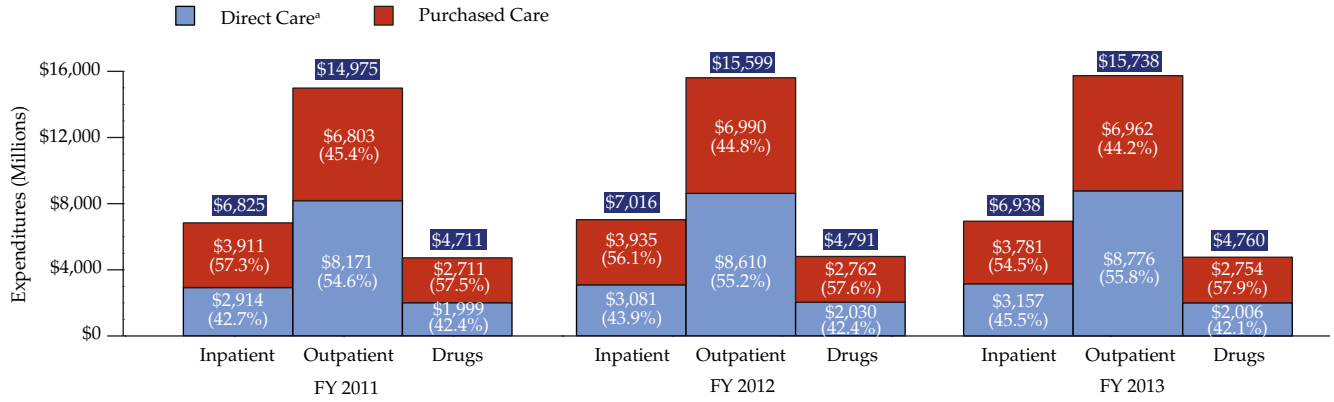
[2] The MHS generic dispensing rate may be lower than in the private sector because MHS can frequently buy a branded drug at a lower cost, either under contract or at federal pricing, than the generic drug (this occurs during the 180-day exclusivity period when there is only one generic drug competing against the branded drug). This is not the case for most commercial plans. MHS is also forbidden by law to purchase generic drugs from countries that do not comply with the requirements established by the Trade Agreements Act.

MHS COST TRENDS

Total MHS costs (excluding MERHCF) increased between FY 2011 and FY 2013 for all medical services (inpatient costs increased by 2 percent, outpatient costs by 5 percent, and prescription drug costs by 1 percent). The proportion of total MHS costs accounted for by each medical service remained about the same over that period of time. Overall, direct care costs increased by 7 percent and purchased care costs increased by 1 percent.

- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 69 percent from FY 2011 to FY 2013. For example, in FY 2013, DoD expenses for inpatient and outpatient care totaled $22,676 million, of which $15,738 million was for outpatient care, for a ratio of $15,738/$22,676 = 69 percent.
- Purchased care drug costs shown below include manufacturer refunds for retail name brand drugs.
- Increases in purchased care outpatient costs were eased by DHA's implementation of the Outpatient Prospective Payment System (OPPS), which began in May 2009 and was completely phased in by May 2013. OPPS aligns TRICARE with current Medicare rates for reimbursement of hospital outpatient services. DHA/Office of the Chief Financial Officer DHCAPE estimates the change from previous billing practices to OPPS reduced healthcare costs for TRICARE by about $2.5 billion between FY 2011 and FY 2013.
- In FY 2013, DoD spent $2.27 on outpatient care for every $1 spent on inpatient care.

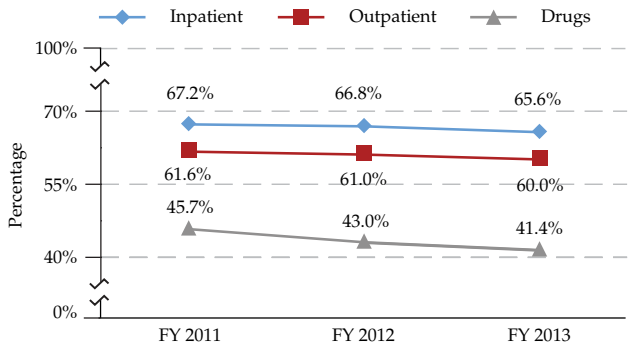
TREND IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF)



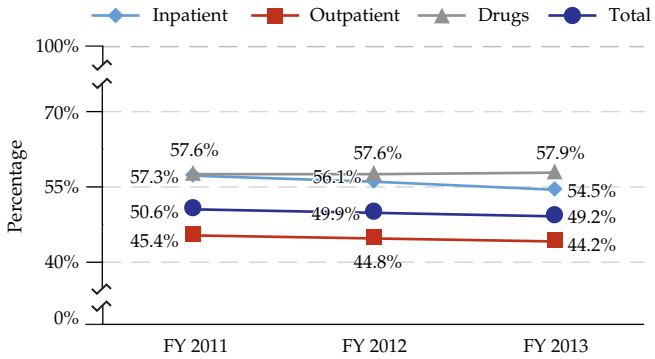
Source: MHS administrative data, 1/23/2014
[a] Direct care prescription costs include an MHS-derived dispensing fee.
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care shares of all MHS health services utilization decreased from FY 2011 to FY 2013, most notably for prescription drugs.
- Breaking a longtime trend, the purchased care share of total MHS costs decreased slightly between FY 2011 and FY 2013. The purchased share of inpatient costs declined but remained flat for outpatient and prescription drug services.

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, 1/23/2014

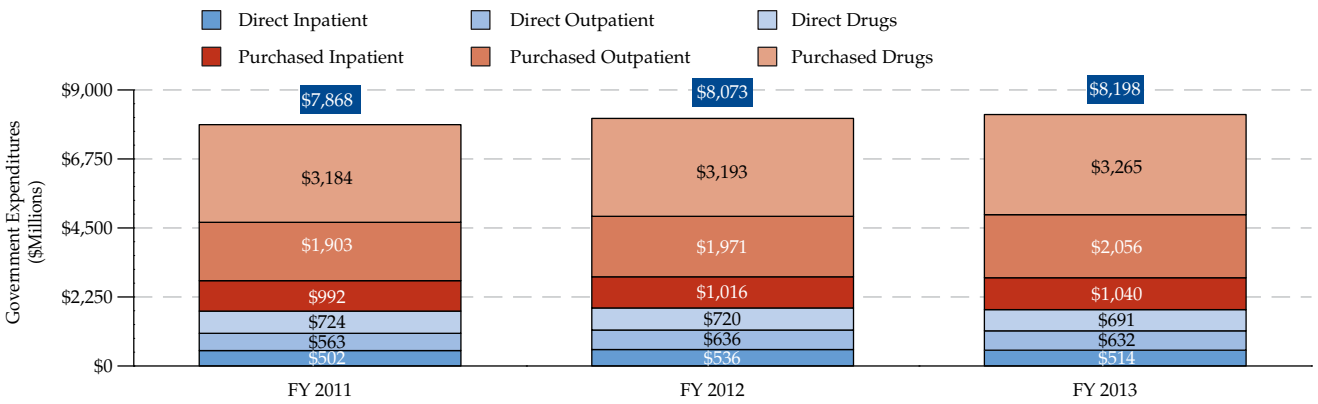
MHS COST TRENDS *(CONT'D)*

MERHCF Expenditures for Medicare-Eligible Beneficiaries

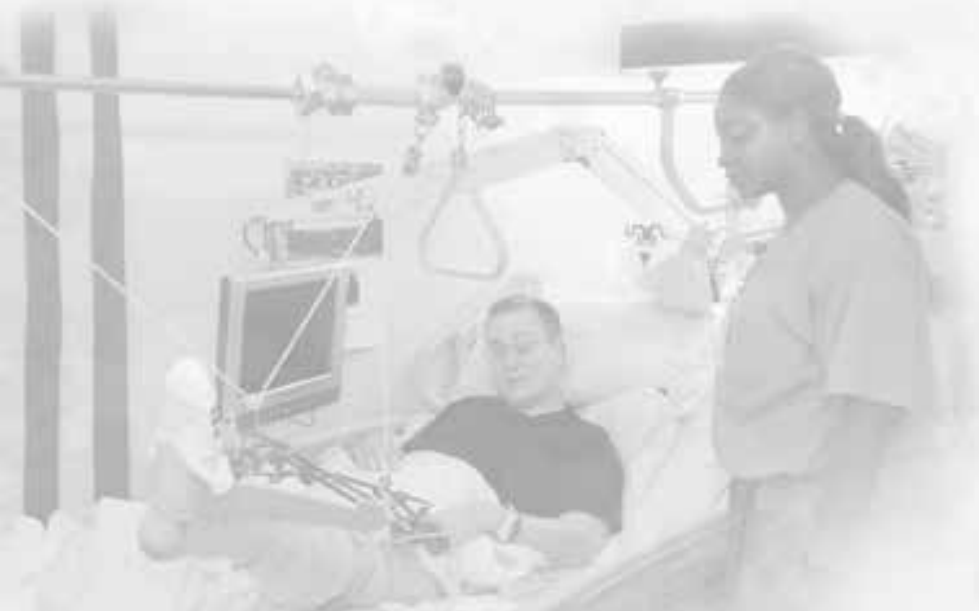
The MERHCF covers Medicare-eligible retirees, retiree family members, and survivors only, regardless of age or Part B enrollment status. The MERHCF is not identical to TFL, which covers Medicare-eligible non-Active Duty beneficiaries age 65 and above enrolled in Part B. For example, the MERHCF covers MTF care and USFHP costs, whereas TFL does not. Total MERHCF expenditures increased from $7,868 million in FY 2011 to $8,198 million in FY 2013 (4 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 3 percent from FY 2011 to FY 2013. The increase was due largely to outpatient expenses, which grew by 12 percent. Direct inpatient expenses increased by 2 percent while prescription drug expenses declined by 5 percent.
  - In FY 2011, TRICARE Plus enrollees accounted for 70 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. By FY 2013, the TRICARE Plus share had grown to 72 percent.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 53 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2011. That figure rose to 56 percent in FY 2013.
- Total purchased care MERHCF expenditures increased by 4 percent from FY 2011 to FY 2013. Inpatient expenditures rose by 5 percent, outpatient expenditures by 8 percent, and prescription drug expenditures by 3 percent.

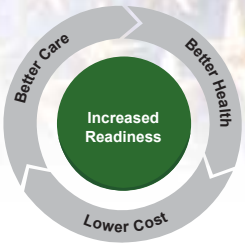
MERHCF EXPENDITURES FROM FY 2011 TO FY 2013 BY TYPE OF SERVICE



Source: MHS administrative data, 1/23/2014



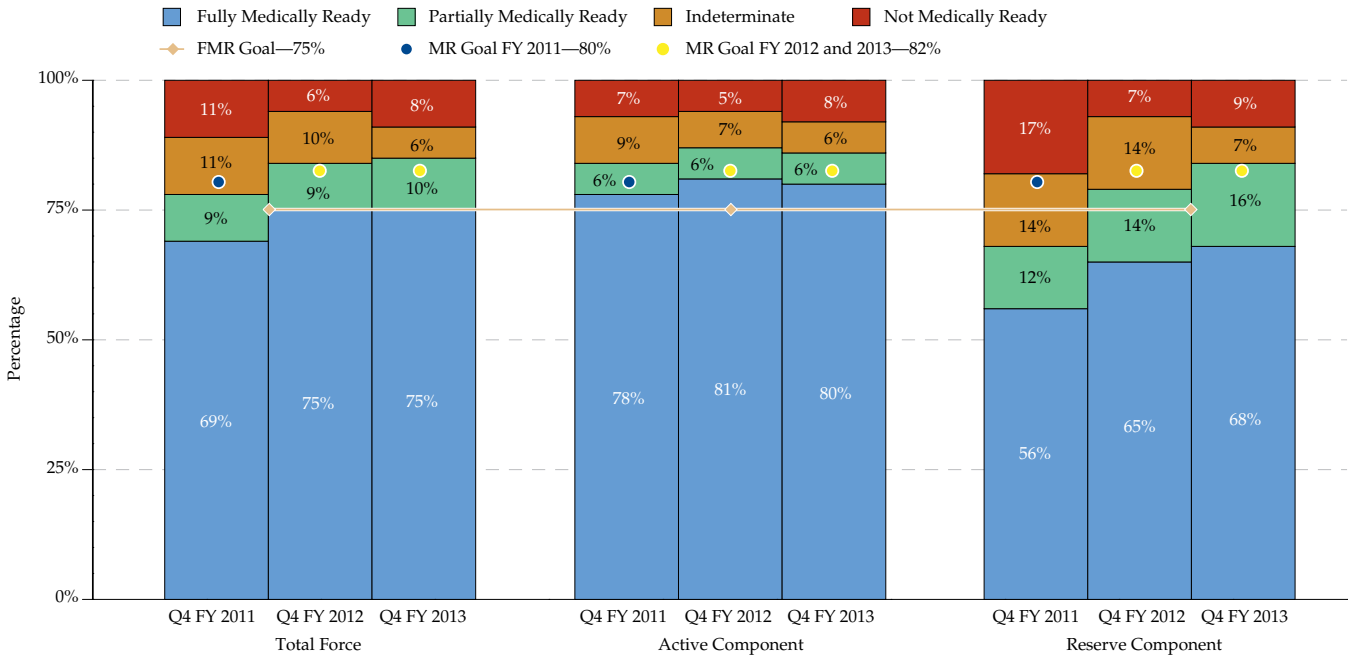
MEDICAL READINESS OF THE FORCE



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

As shown in the chart below, by the end of fiscal year (FY) 2013, the total force, both the AC and RC combined, surpassed the established DoD policy goal of 75 percent fully medically ready and the Under Secretary of Defense for Personnel and Readiness strategic goal of 82 percent medically ready (MR—previously 80 percent). The total force medically ready share increased by one percentage point, from 84 percent by the end of FY 2012 (75 percent fully medically ready plus 9 percent partially medically ready) to 85 percent at the end of FY 2013 (75 percent plus 10 percent). The AC's medically ready status decreased by one percentage point (from 87 percent at the end of FY 2012 to 86 percent at the end of FY 2013), and the RC increased by 5 percentage points (from 79 percent to 84 percent over the same time). It is important to note that in the past two years the RC has increased a total of 16 percentage points. This represents significant progress in the IMR status of the force, surpassing the overall goal in FY 2013. The previous differences in the IMR status between the AC and RC have narrowed significantly. We still have challenges to ensure that all components meet the established goals. DoD is working continuously at making medical and dental services more available to sustain the successes achieved.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS: Q4 FY 2011 TO Q4 FY 2013 (ALL COMPONENTS NOT DEPLOYED)



Source: Defense Health Agency, Healthcare Operations Directorate, Readiness, 12/24/2013

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

HEALTHY, FIT, AND PROTECTED FORCE

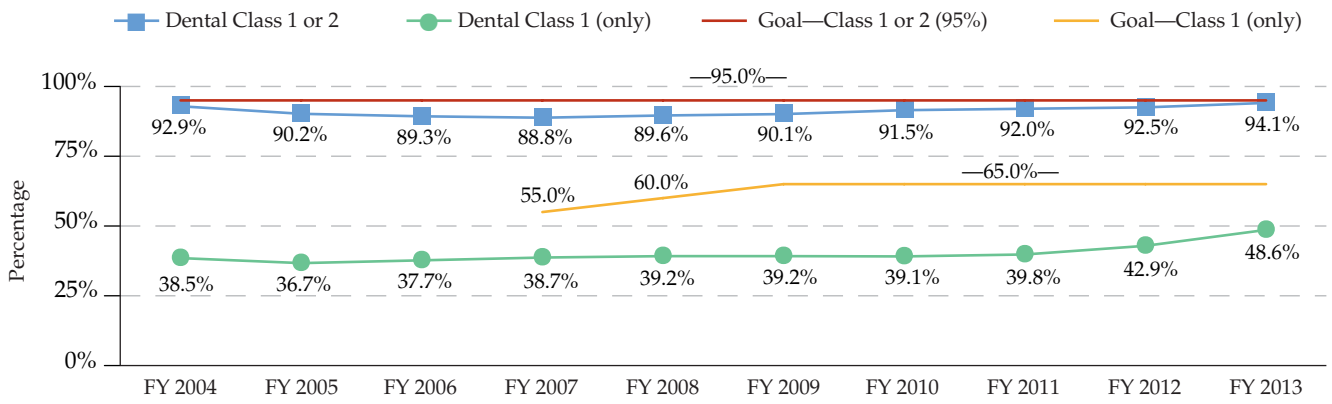
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates;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

DENTAL READINESS

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

- Overall MHS dental readiness in the combined Classes 1 and 2 remains high and reflects a gradual increase each year since FY 2007, reaching 94.1 percent in FY 2013, and within less than 0.9 percentage points of the long-standing MHS goal of 95 percent. Since FY 1997 (not shown), the readiness in combined Classes 1 and 2 hovered between a low of 87.5 percent (FY 1997) and a high of 94.1 percent in FY 2013.
- The rate for Active Duty personnel in Dental Class 1 has increased in the past three years, from about 39 percent (FY 2010) to over 48 percent in FY 2013, remaining well below the MHS goal of 65 percent, which has increased from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



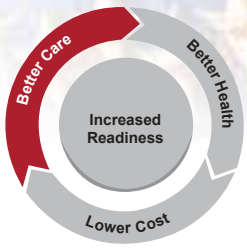
Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/12/2013

Definitions:

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

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

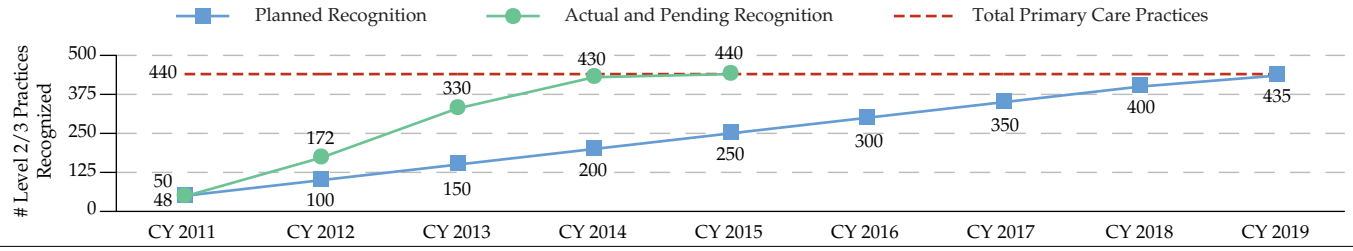
PATIENT-CENTERED MEDICAL HOME IMPLEMENTATION



Begun in early 2011, MHS continued accelerating in fiscal year (FY) 2013 the implementation of the Patient-Centered Medical Home (PCMH) model of care at all Army, Navy, and Air Force family medicine, internal medicine, pediatric, undersea medicine, and other primary care clinics in order to improve health care quality, medical readiness, access to care, and patient satisfaction, and to lower per capita cost growth. In FY 2013, MHS began implementing operationally focused Marine Centered Medical Homes (MCMHs) and Soldier Centered Medical Homes (SCMHs).

The National Center for Quality Assurance (NCQA), which recognizes MHS PCMH practices and allows comparison with the private sector, reported that the MHS primary care practices recognized in FYs 2011–2012 achieved the highest scores in the U.S. MHS is projected to be 119 percent ahead of schedule with initial NCQA PCMH recognition for all 440 primary care clinics. MHS projects that all of its practices will have received initial Level 2 or 3 NCQA Recognition by FY 2015.

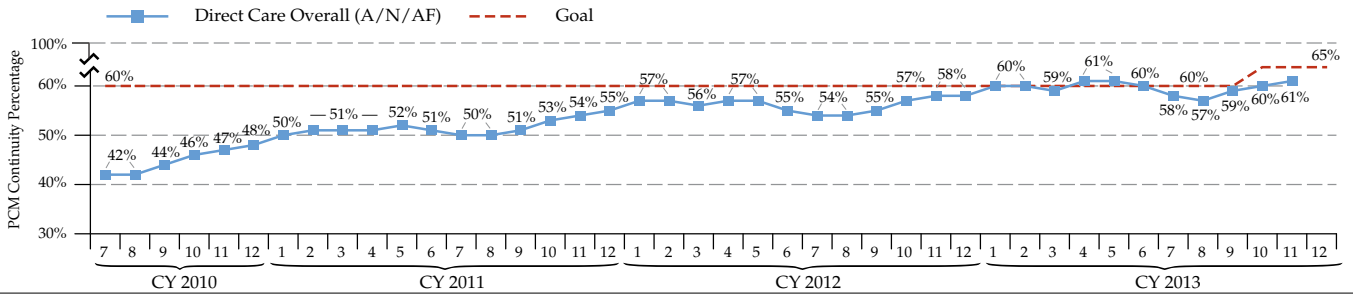
NCQA PCMH RECOGNITION STATUS



Source: Defense Health Agency (DHA)/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

The primary care manager (PCM)/patient relationship continues to be the driving force behind MHS's transformation from a system for health care to one supporting health. The continuous relationship between a patient and his or her provider has improved patient engagement and resulted in a reduction in unnecessary health care utilization and a preventive focus on conditions and behaviors that lead to poorer long-term health. Since PCMH implementation began, PCM continuity has increased 47 percent. MHS recently increased the PCM continuity goal from 60 to 65 percent in order to drive even higher performance.

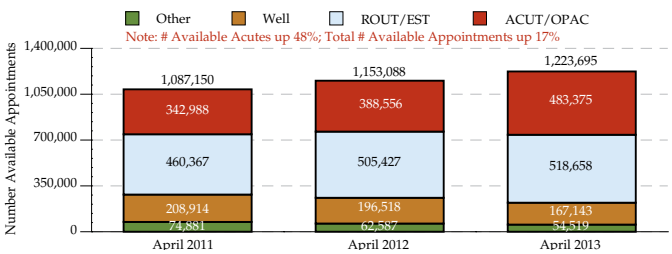
PCM CONTINUITY, JULY 2010–NOVEMBER 2013



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

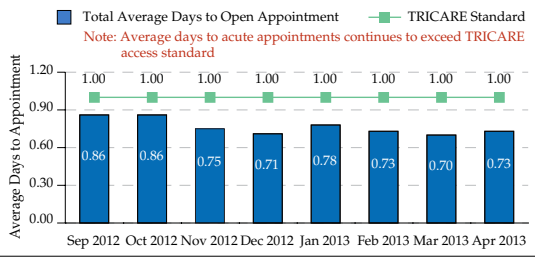
MHS continues to improve access to health care with an increased emphasis on same-day appointments for acute health care problems. Since 2010, MHS has increased the percent of appointments available for same-day health care needs from 23 percent to 40 percent, while also increasing the overall number of available appointments. Although the total number of acute appointments increased 43 percent between 2010 and 2013 in order to match appointment supply to patient demand, the number of days to an acute appointment continues to exceed the TRICARE Access Standard.

AVAILABLE MTF PRIMARY CARE APPOINTMENTS, APRIL 2011–APRIL 2013



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

AVERAGE DAYS TO ACUTE APPOINTMENTS, SEPTEMBER 2012–AUGUST 2013



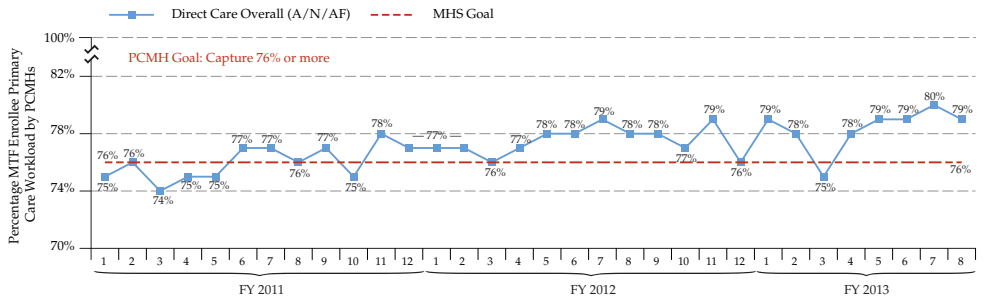
Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

PATIENT-CENTERED MEDICAL HOME IMPLEMENTATION *(CONT'D)*

One of MHS's major goals is to provide more cost-effective, coordinated care in the PCMHs for military treatment facility (MTF) enrollees. To realize this goal, MHS is focusing on reducing unnecessary utilization of urgent care and emergency care, and recapturing more MTF enrollee primary care workload to PCMHs and MTFs. MHS is exceeding the goal of capturing at least 76 percent of MTF enrollees' primary care workload to PCMHs.

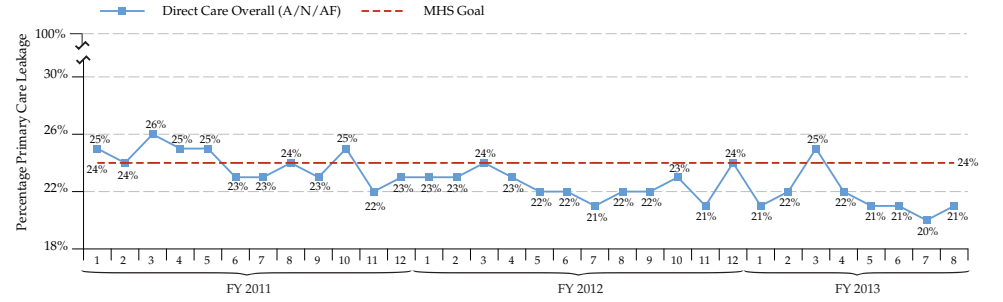
MHS also has expanded the concept of access to health care from the traditional office visit to include options for virtual care. MHS has rapidly adopted secure messaging to allow MTF enrollees to contact PCMs and PCMH teams 24 hours a day to ask questions, schedule appointments, request prescription renewals, and get assistance in coordinating referrals. By the end of FY 2013, over 667,000 MTF enrollees were enrolled in secure messaging. Secure messaging users reported a 97 percent satisfaction rate, and 86 percent of respondents reported secure messaging had helped them avoid unnecessary visits to the MTF or ER. MHS began piloting secure messaging use in specialty clinics in FY 2013 to enhance care coordination and communication.

MTF ENROLLEE PRIMARY CARE WORKLOAD CAPTURE BY PCMH



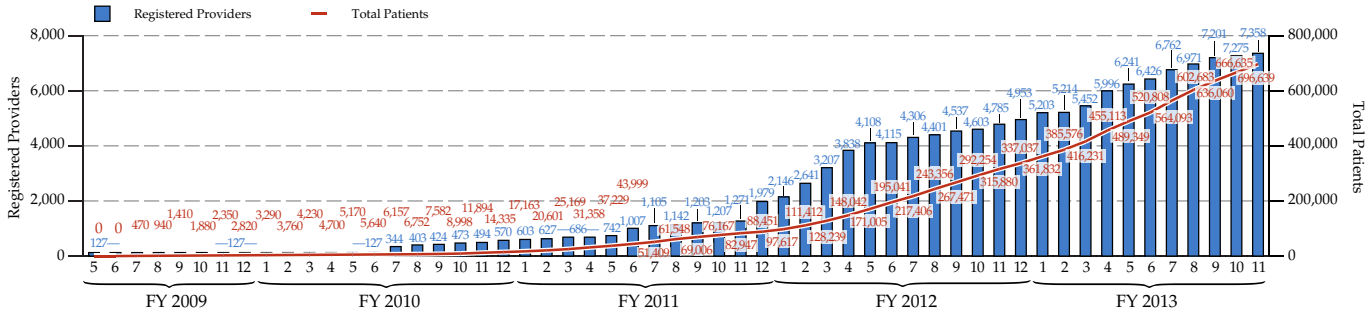
Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

POTENTIALLY RECAPTURABLE PRIMARY CARE LEAKAGE (CONVERSE OF WORKLOAD CAPTURED TO PCMH)



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

SECURE MESSAGING MAY 2009 TO NOVEMBER 2013



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/12/2013

In FY 2014 and beyond, MHS will continue to enhance the PCMH model of care by standardizing business and clinical processes across MTF primary care clinics and to synchronize primary care operations in the extended Multi-Service Markets to maximize recapture of health care to the direct care system. MHS also will optimize the secure messaging system to improve coordination between the primary care team, specialty providers, and the patient, as well as provide additional, convenient virtual opportunities to access health care—this includes implementation of a continental U.S. (CONUS)-wide Nurse Advice Line for all MHS beneficiaries. MHS will continue to leverage a robust extended PCMH team program, including case and disease management, embedded pharmacists, and behavioral health specialists, to improve health outcomes and increase the cost effectiveness of care in MTFs. Finally, MHS is implementing the patient-centered model in specialty care, building an integrated health delivery model to maximize care coordination, resource efficiency and the beneficiary health care experience across time and settings.

PATIENT SAFETY IN THE MHS

MHS's Patient Safety Program (PSP) aims to prevent harm to patients through evidence-based system and process improvements. In the MHS direct care system, the DoD PSP focuses efforts to guide improvements targeting opportunities identified through reported patient safety events.

Patient Safety Reporting

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

HARM STRATIFICATION OF REPORTED PATIENT SAFETY EVENTS, FYs 2006–2013

HARM STRATIFICATION	2006		2007		2008		2009		2010		2011		2012		2013	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Events Did Not Reach Patient, Near Miss	119,615	75.7%	124,868	78.0%	127,429	74.4%	140,257	80.0%	125,807	73.8%	96,881	65.1%	134,405	67.8%	381,711[a]	85.2%
Events Reached Patient, No Harm	34,934	22.1%	31,519	19.7%	38,265	22.3%	32,746	18.7%	41,432	24.3%	46,960	31.6%	56,062	28.3%	57,945	12.9%
Events Reached Patient, Harm	3,478	2.2%	3,698	2.3%	5,672	3.3%	2,255	1.3%	3,189	1.9%	4,987	3.4%	7,654	3.9%	8,512	1.9%
Total	158,027	100.0%	160,085	100.0%	171,366	100.0%	175,258	100.0%	170,428	100.0%	148,828	100.0%	198,121	100.0%	448,168	100.0%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/18/2013. PSR is a dynamic system; events may be re-opened and closed.

[a] One facility comprised 36 percent of reported events and 42 percent of reported near misses. The facility began tracking an issue with healthcare information technology and entering prescriptions.

- From FY 2006 to FY 2013, reporting of patient safety events increased. FY 2013 reported events increased by 126.2 percent from FY 2012. This increase was in part due to one facility's reporting of near-miss events related to prescriptions not transferring among health care information technology systems. This facility represented 36 percent of reported events. Without this facility, the total events reported in FY 2013 still remained higher with a 46 percent increase from FY 2012.
- In FY 2013, near-miss reporting accounted for 85.2 percent of total reported events, while harm events constituted 1.9 percent. In FY 2013, near-miss reports increased by 184 percent (one facility comprised 42 percent of near-miss reporting) and harm event reports increased by 11 percent from FY 2012 reporting levels. Consistent with previous years, near misses constituted the large majority of events reported in FY 2013. The DoD PSP encourages near-miss reporting in order to proactively address opportunities before patients are involved (events reached patient, no harm) or harmed (events reached patient, harm).

In addition to events reported, DoD PSP receives root cause analyses (RCAs) submitted by MTFs. Of the RCAs received from FYs 2006–2013,[1] similar to prior years, the associated leading event categories included: Wrong Site/Person/Procedure Surgery, Unintended Retention of Foreign Object, Operative/Post-Operative Complication, Delay in Treatment, Other Less Frequent Event Types, and Perinatal Death/Loss of Function. DoD PSP reviews the RCAs and determines appropriate mechanisms to communicate lessons and trends or recommended actions. The mechanisms include recommending enterprisewide system/process redesign, issuing patient safety notices, and recommending new policies, as well as offering focused training or education.

[1] RCAs submitted as of 11/19/2013 for RCAs completed through 9/30/2013.

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

Training and Education to Improve Performance and Patient Safety

Breakdowns in staff-to-staff communication remain frequently cited as a primary factor contributing to patient safety events across the nation. The DoD PSP offers resources and solutions to improve communication techniques among health care teams: TeamSTEPPS® is an evidence-based teamwork development system designed to produce highly effective medical teams that optimize the use of information, people, and resources to achieve the best clinical outcomes. TeamSTEPPS is widely implemented within the MHS direct care system. Nearly 95 percent of MTFs have received training and over 100 facilities across the MHS have received TeamSTEPPS coaching to facilitate ongoing sustainment.

Additional targeting training is offered for Patient Safety Managers (PSMs) who serve as local champions within MTFs. DoD PSP conducts a Basic Patient Safety Manager (BPSM) course to provide new PSMs with standardized knowledge, skills, and tools to implement patient safety initiatives at MTFs. It blends traditional industry standard training strategies with creative methodologies founded on the latest research on predictors of workforce training success. BPSM is an award-winning state-of-the-art learning system with a pre-work module, five days of face-to-face training, 12 months of post-training virtual coaching, and opportunities for continuing development through a PSM Ongoing Learning Certificate. Before BPSM, trainees reported an average confidence level of 29 percent across all aspects of their role; after course completion, this increased to 83 percent. After 12 months of coaching, PSM confidence continues to grow, with nearly 100 percent of those surveyed expressing high confidence in their understanding and abilities.

PfP Results for the MHS

MHS has seen a 20.4 percent reduction in patient harm rates and 12.9 percent drop in readmissions, based on Q1 CY 2013 data

Projected cost avoidance of approximately $6M of baseline MHS clinical costs since PfP implementation in Q4 CY 2012

95 percent of MTFs reached full implementation as of September 29, 2013

146 Community of Practice learning sessions held with an average of 444 monthly attendees, as of September 29, 2013

Engagement in Nationwide Efforts to Improve Patient Safety

In June 2011, MHS pledged to attain the aims of the Partnership for Patients (PfP): to reduce preventable hospital-acquired conditions in nine identified areas of harm by 40 percent and to facilitate better care transitions to reduce hospital readmissions by 20 percent by the end of 2013.

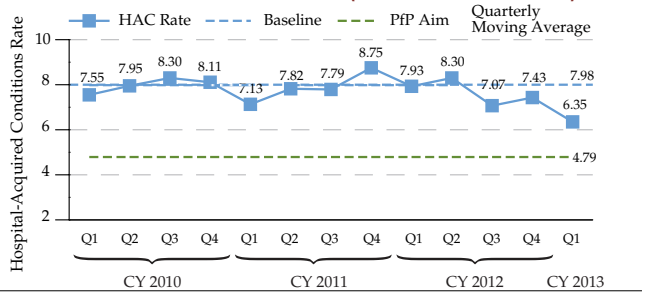
Through the PfP initiative, MHS is introducing an enterprisewide approach to patient safety that will, over time, be an integral part of processes for improving care to patients and affecting the frontline. PfP is the first major patient safety learning-based initiative focused on evidence-based clinical practices (EBPs) implementation to be rolled out in MHS. The transformative, cross-service approach applies standardized, structured tools and processes across the enterprise to effect change for our patients.

Top leadership engagement and cross-Service collaboration have enabled the strategic and transparent application of tools and processes to improve performance and achieve the initiative aims. Data reporting and quantitative analyses are regularly performed to assess implementation progress to inform improvement, as well as ongoing coaching. Implementation guides for each area of harm are used by MTFs to drive successful rollout of EBPs. A Learning Action Network, recognition program, and comprehensive communication strategy are in place to provide improved MTF access to peers, lessons learned, and expertise.

As successes are gained and implementation evolves, opportunities exist to further integrate PfP with MHS strategic priorities. FY 2014 patient safety efforts will focus on continuing to improve and sustain the gains by supporting MTFs and Services in reaching 100 percent implementation of these EBPs, analyzing the associated data to guide improvement efforts, and transitioning PfP practices into daily practices performed throughout MHS. The PfP initiative and its aims will serve as a springboard to other future comprehensive patient safety initiatives and mark significant movement toward MHS becoming a high reliability, learning organization.

- The trend chart below depicts efforts to accelerate the spread of EBPs throughout MHS and reduce preventable hospital-acquired conditions (HACs). The blue line indicates the quarterly variation in the HAC rate ([HACs x 1,000]/dispositions) across MHS relative to the PfP aim of 4.79 in the lower bound and the overall MHS rate of 7.98 in CY 2010. The quarterly moving average reflects the favorably declining trend in the rate at around the time of program implementation in October 2012.

PARTNERSHIP FOR PATIENTS: HOSPITAL-ACQUIRED CONDITIONS RATE PROGRESS (CY 2010–CY 2013 Q1)



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/18/2013

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

Advancing a Culture of Patient Safety

The Institute of Medicine stated that, "Improvements in patient safety are best achieved when health care delivery organizations adopt a culture of safety."[1] To assess the culture of safety across the MHS direct care system, DoD PSP collects data from staff surveys on patient safety culture. In FY 2013, data from the DoD Tri-Service Survey on Patient Safety (Culture Survey), sponsored by DHA, were collected and analyzed. The MHS saw a 43 percent response rate with an average facility overall dimension score of 62.3 percent.

Patient Safety in the Purchased Care System

All TRICARE contractors continue to monitor their networks using the National Quality Forum Serious Reportable Events criteria and to analyze administrative data using the Agency for Healthcare Research and Quality (AHRQ) indicators. Occurrences are thoroughly reviewed with complete follow-up to prevent future harm events.

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

Using beneficiary responses to MHS-wide surveys, five categories of access to care are examined:

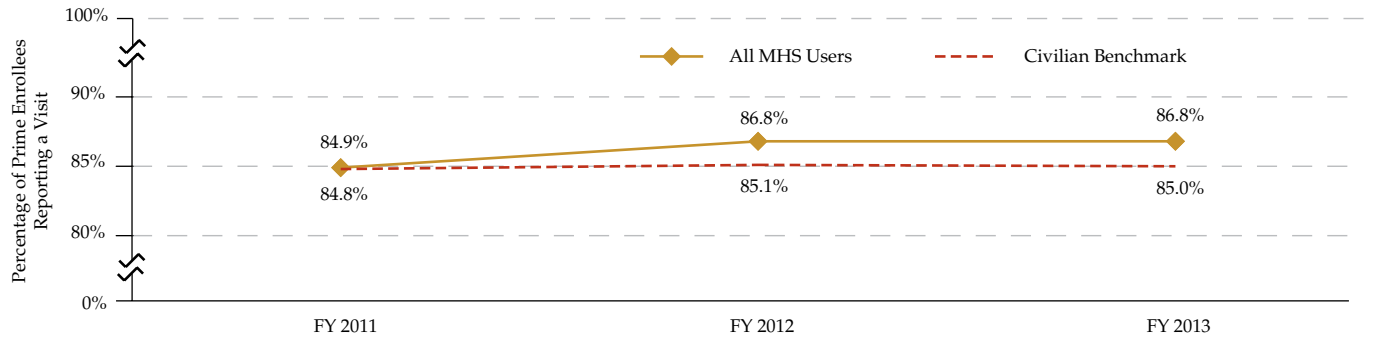
- Access based on reported use of the health care system in general;
- Availability and ease of obtaining care;
- Communications with providers;
- Responsiveness of customer service; and
- Quality and timeliness of claims processing supplemented by administrative claims data.

Overall Outpatient Access

The ability to see a doctor reflects one measure of successful access to the health care system, as depicted below when Prime enrollees were asked whether they had at least one outpatient visit during the past year.

- Access to, and use of, outpatient services remains high, with nearly 87 percent of all Prime enrollees (with military as well as civilian providers) reporting having at least one visit in FY 2013.
- The MHS Prime enrollee rate exceeded the civilian benchmark in FYs 2012 and 2013.

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



Note: DoD data were derived from the FYs 2011–2013 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the National CAHPS Benchmarking Database (NCBD). Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

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

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

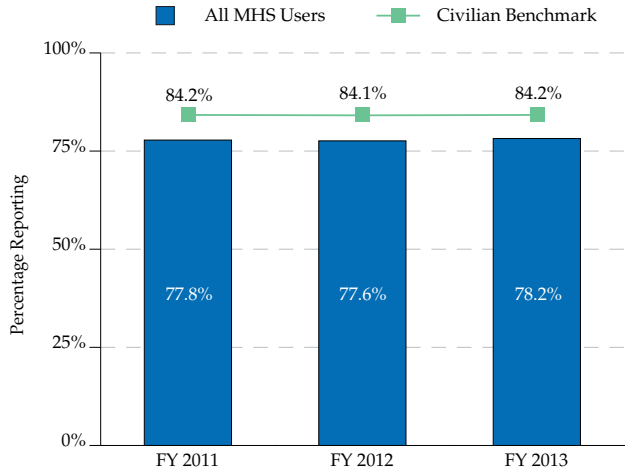
Availability and Ease of Obtaining Care

Availability and ease of obtaining care can be characterized by the ability of beneficiaries to obtain the care they need when they need it. Two major measures of access within the CAHPS survey—getting needed care and getting care quickly—address these issues. Getting needed care has a submeasure: problems getting an appointment with specialists. Getting care quickly also has a submeasure: waiting for a routine visit.

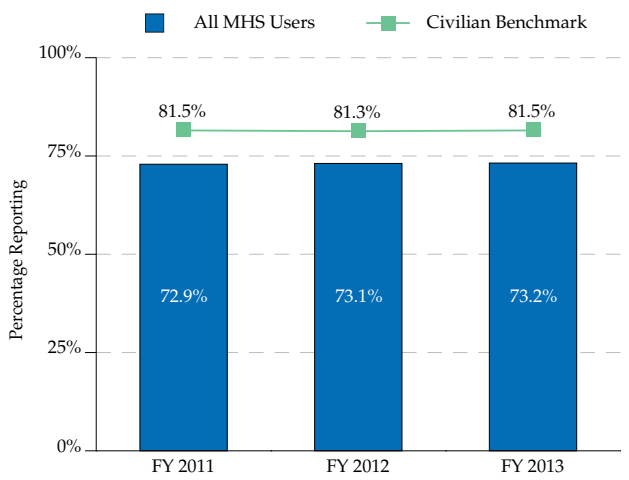
- MHS beneficiary ratings for getting needed care (composite) and problems getting an appointment with specialists remained stable over the three-year period, but continued to lag the civilian benchmark, which also remained stable during this period.
- MHS beneficiary ratings for getting care quickly (composite) and waiting for a routine visit also continued to lag the civilian benchmark between FY 2011 and FY 2013.

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

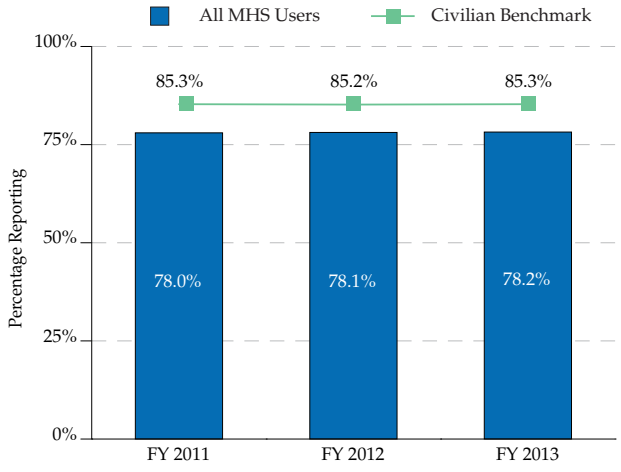
GETTING NEEDED CARE



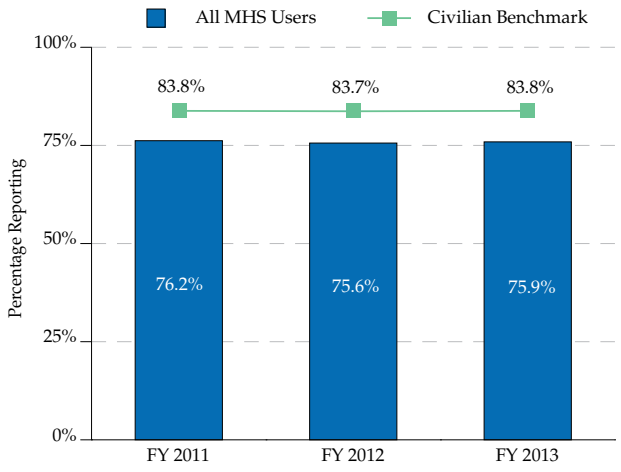
GETTING AN APPOINTMENT WITH A SPECIALIST



GETTING CARE QUICKLY



GETTING TIMELY ROUTINE APPOINTMENTS



Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

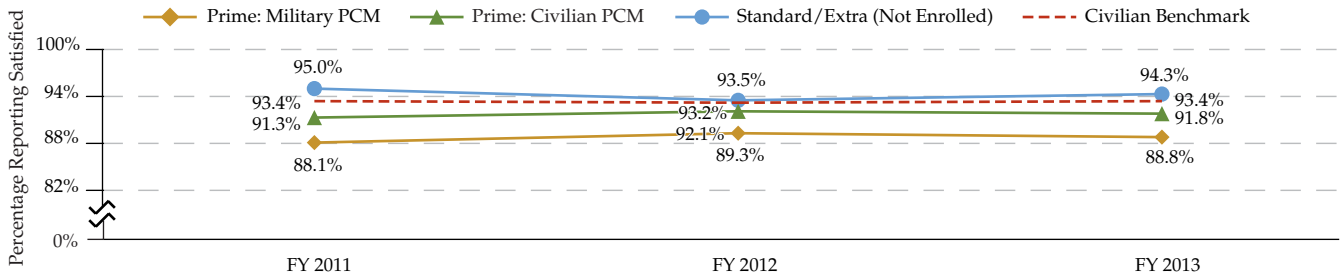
ACCESS TO MHS CARE: SELF-REPORTED MEASURES OF AVAILABILITY AND EASE OF ACCESS *(CONT'D)*

Satisfaction with Doctors' Communication

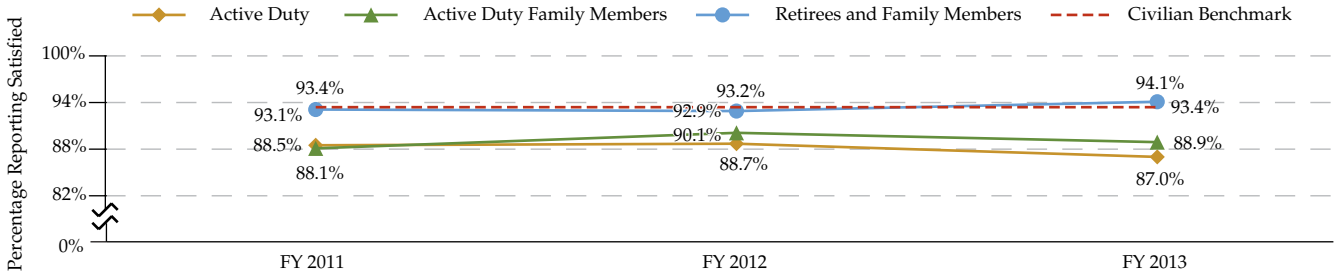
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Satisfaction levels with doctors' communication for Prime enrollees remained stable between FY 2011 and FY 2013. Satisfaction levels of Prime enrollees with military or civilian PCMs lagged the civilian benchmark. The satisfaction levels of non-enrolled beneficiaries equaled the civilian benchmarks (no statistically significant difference).
- Satisfaction levels of Active Duty and Active Duty family members (ADFMs) lagged the civilian benchmarks in FY 2011 through FY 2013.
- Satisfaction levels of retirees and families equaled the civilian benchmarks (no statistically significant difference) in FY 2011 through FY 2013.

TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH DOCTORS' COMMUNICATION BY BENEFICIARY CATEGORY



Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

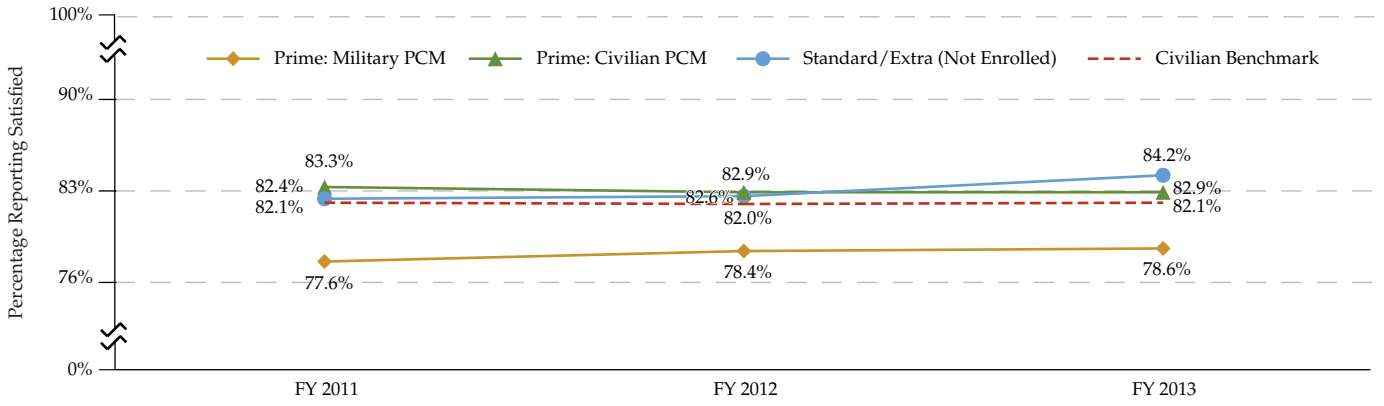
CUSTOMER SERVICE

Satisfaction with Customer Service

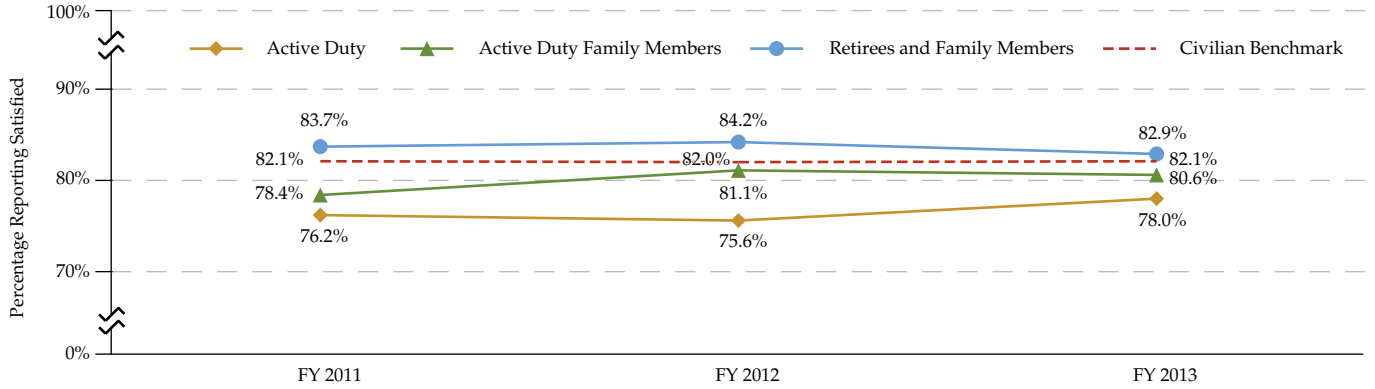
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork remained stable between FY 2011 and FY 2013 (no statistically significant change). The civilian benchmark also remained stable over this period.
- MHS enrollees with civilian PCMs and non-enrollees reported levels of satisfaction comparable to the civilian benchmark in FY 2011 through FY 2013. Enrollees with military PCMs lagged the civilian benchmark in all three years.
- Satisfaction levels for Active Duty lagged the benchmark for all three years. The satisfaction level of ADFMs was comparable to the civilian benchmark in FY 2012 and FY 2013. Retirees' satisfaction levels met or exceeded the benchmark in all three years.

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



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



Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

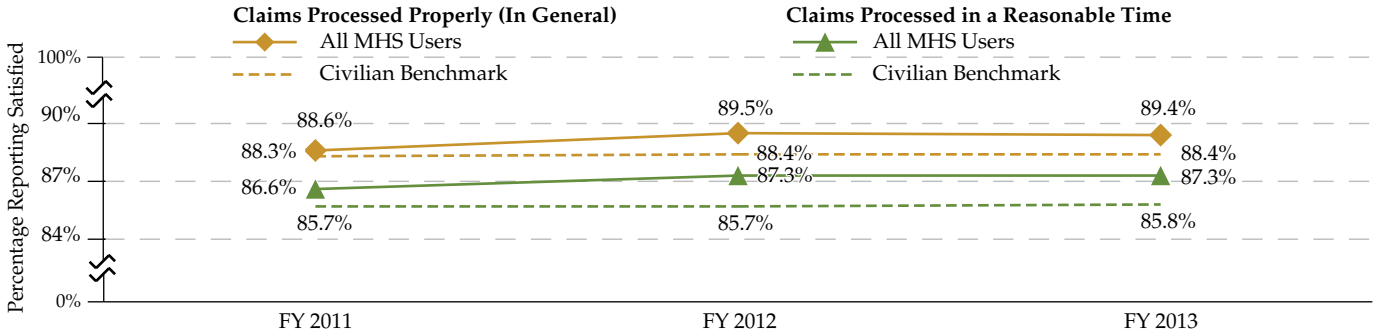
CLAIMS PROCESSING

Both beneficiaries and their providers have an interest in the promptness and accuracy of claims processing and payment. MHS monitors the performance of TRICARE claims processing through surveys of beneficiary perceptions and administrative tracking. Although the overall number of claims processed remained steady at approximately 194 million between FY 2012 and FY 2013, a shift among the types of claims occurred. The move from retail to home delivery continued in FY 2013. An older population in FY 2013 explains the remaining increase in home delivery prescriptions, the 3 percent increase in TRICARE for Life (TFL) claims, and the 3 percent decrease in non-TFL claims.

Beneficiary Perceptions of Claims Filing Process

- Satisfaction with claims being processed accurately remained stable from FY 2011 to FY 2013. Satisfaction with processing in a reasonable period of time also remained stable between FY 2011 and FY 2013.
- MHS satisfaction levels for claims processed properly exceeded the civilian benchmark in FY 2012 and were comparable (i.e., not statistically significantly different) in FYs 2011 and 2013.
- Satisfaction levels for claims processed in a reasonable period of time exceeded the civilian benchmark in FYs 2012 and 2013.

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

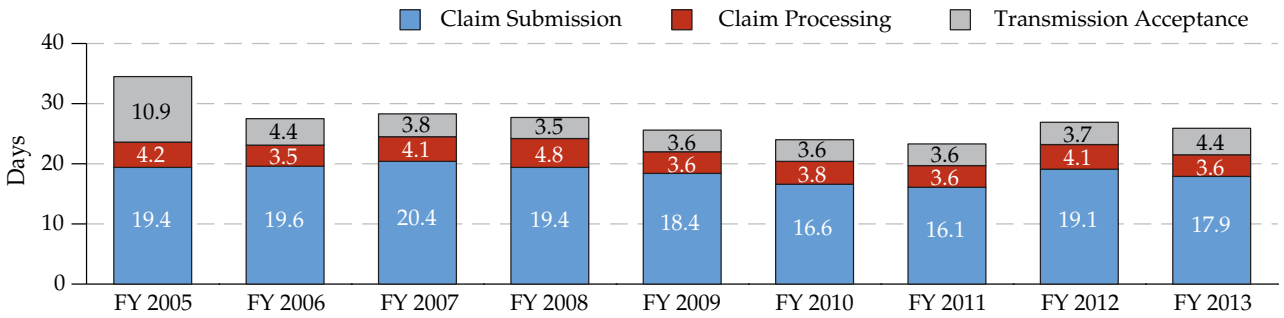


Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

Trends in Claims Filing Process

Claims processing for purchased care can be broken out into three intervals: claim submission, claim processing, and transmission acceptance. Claim submission is the time between the last day of care received and the request for payment of services rendered being received by the contractor for processing. Claim processing is the time between the contractor receiving a request for payment to the time the contractor finishes processing a claim. Transmission acceptance is the time between the TRICARE Encounter Data (TED) good record being created and the time it is initially accepted by DHA as passing all validity edits. The increase in claims processing time in FY 2012 can be traced back mostly to a delay in claim submissions for professional claims.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING



Source: MHS Administrative data, 11/29/2013

Note: Pharmacy, Other Health Insurance (OHI), denied, and paper claims were excluded.

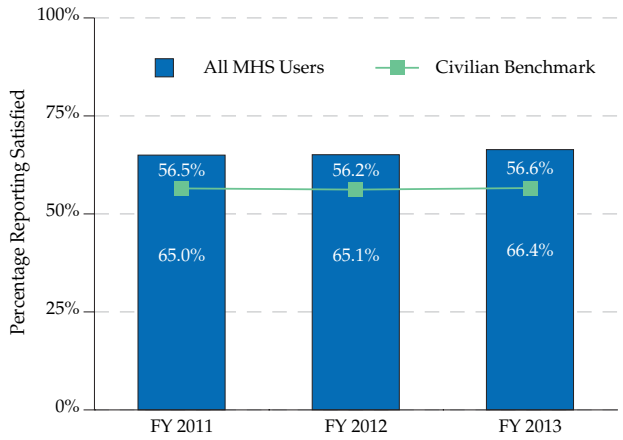
CUSTOMER REPORTED EXPERIENCE AND SATISFACTION WITH KEY ASPECTS OF TRICARE

In this section, MHS beneficiaries in the U.S. who have used TRICARE are compared with the civilian benchmark with respect to ratings of (1) the health plan, in general; (2) health care; (3) personal physician; and (4) specialty care. Health plan ratings depend on access to care and how the plan handles various service aspects such as claims, referrals, and customer complaints.

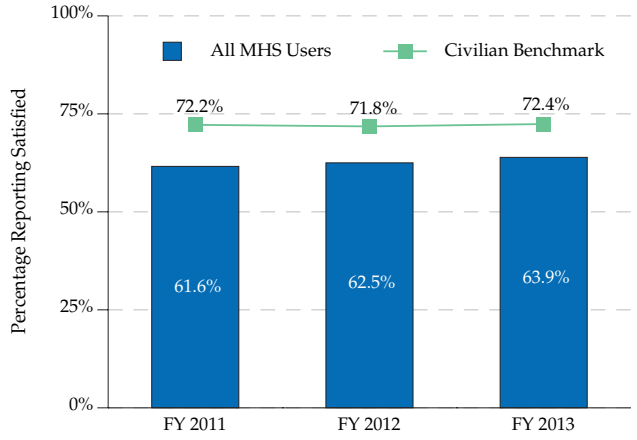
- Satisfaction with primary care and specialty care remained stable between FY 2011 and FY 2013. Satisfaction levels with health care quality and health plan increased slightly over this period.
- MHS satisfaction rates continued to lag civilian benchmarks, with the exception of health plan, which exceeded the benchmark over this period.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS

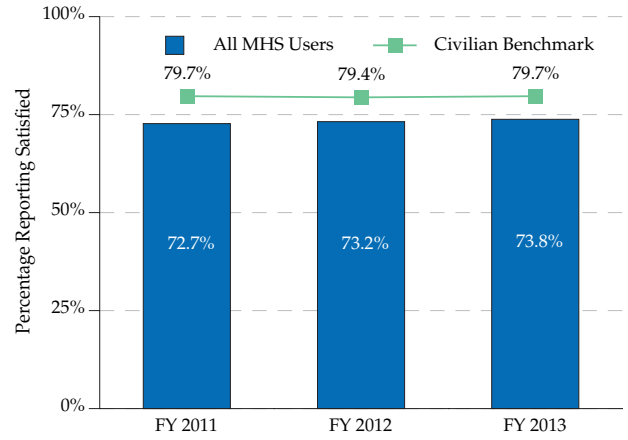
HEALTH PLAN



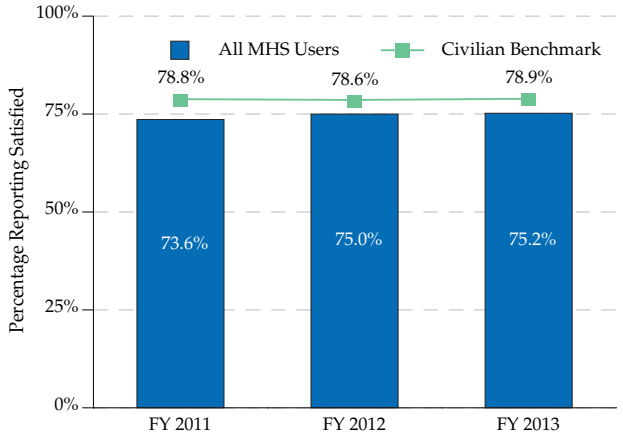
HEALTH CARE



PRIMARY CARE PHYSICIAN



SPECIALTY PHYSICIAN



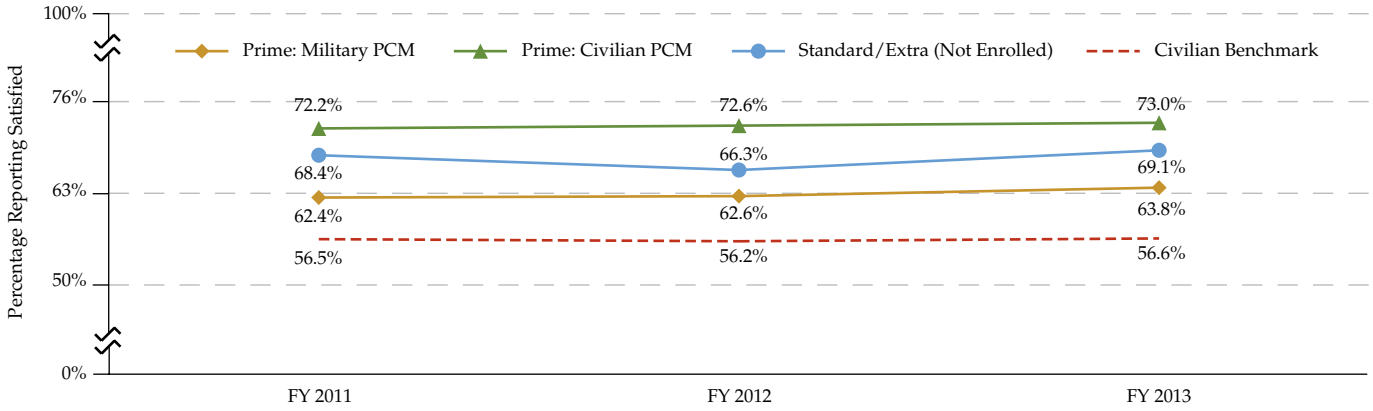
Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

SATISFACTION WITH THE HEALTH PLAN BASED ON ENROLLMENT STATUS

DoD health care beneficiaries can participate in TRICARE in several ways: by enrolling in the Prime option or by not enrolling and using the traditional indemnity option for seeing participating providers (Standard) or network providers (Extra). Satisfaction levels with one's health plan across the TRICARE options are compared with commercial plan counterparts.

- Satisfaction with the TRICARE health plan remained stable for Prime enrollees and non-enrollees from FY 2011 to FY 2013. The civilian benchmark also remained stable.
- During each of the past three years (FY 2011 to FY 2013), enrolled and non-enrolled MHS beneficiaries reported higher levels of satisfaction than their civilian counterparts.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

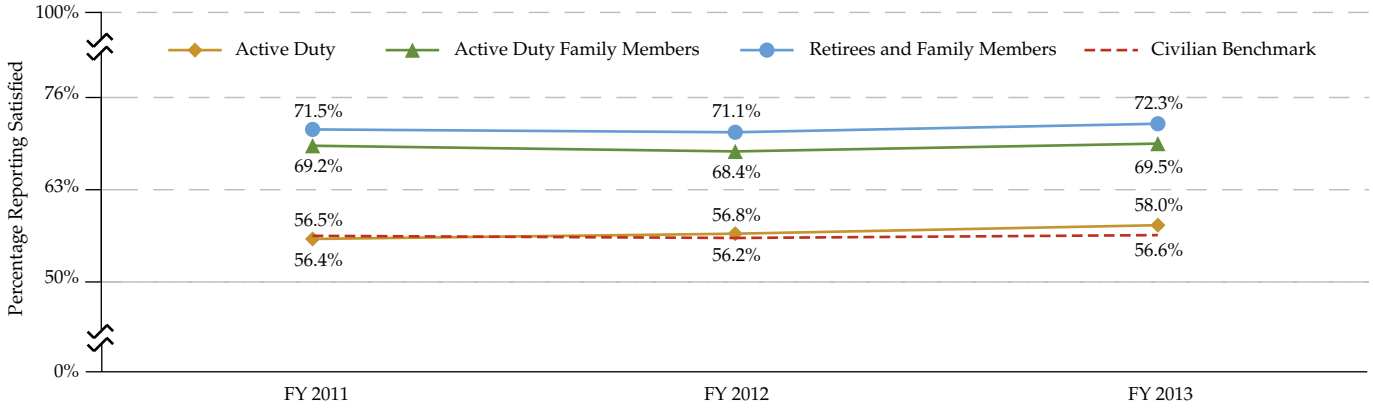


SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY

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

- Satisfaction of Active Duty beneficiaries equaled the civilian benchmark in all three years (FYs 2011–2013).
- ADFM and RETFM satisfaction ratings exceeded the civilian benchmark in all three years (FYs 2011–2013).

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY



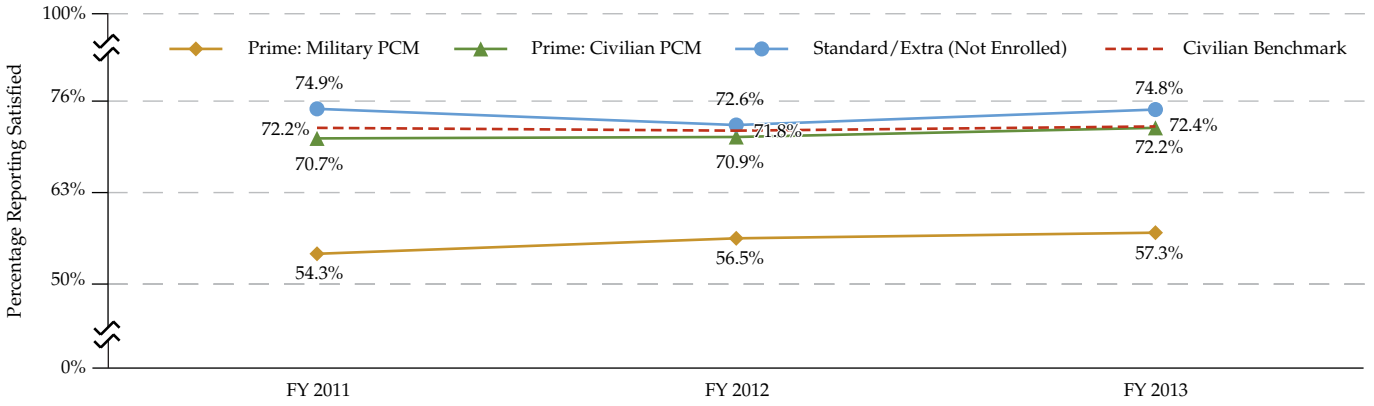
Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

SATISFACTION WITH THE HEALTH CARE BASED ON ENROLLMENT OR BENEFICIARY CATEGORY

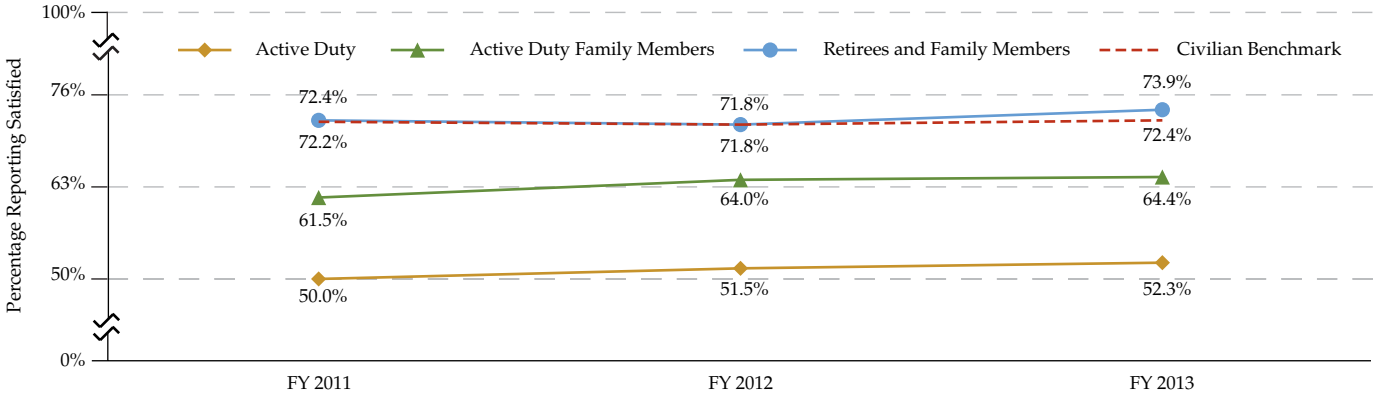
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status:

- Satisfaction remained stable during FYs 2011–2013 for Active Duty, ADFMs, and retirees and families.
- The satisfaction levels of Active Duty and their families continued to lag the civilian benchmark for all three years, but retirees and families equaled (no statistically significant difference) the benchmark over that time.
- The satisfaction of enrollees with military PCMs lagged the civilian benchmark in FYs 2011–2013. Satisfaction levels of enrollees with civilian PCMs and satisfaction levels of non-enrollees equaled or exceeded the civilian benchmark.

TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY ENROLLMENT STATUS



TRENDS IN SATISFACTION WITH TRICARE HEALTH CARE BY BENEFICIARY CATEGORY



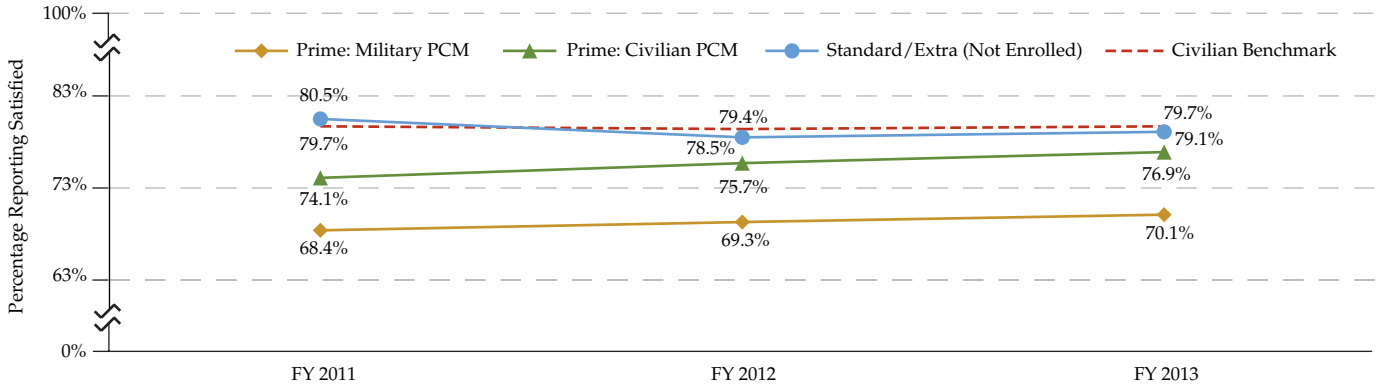
Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

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

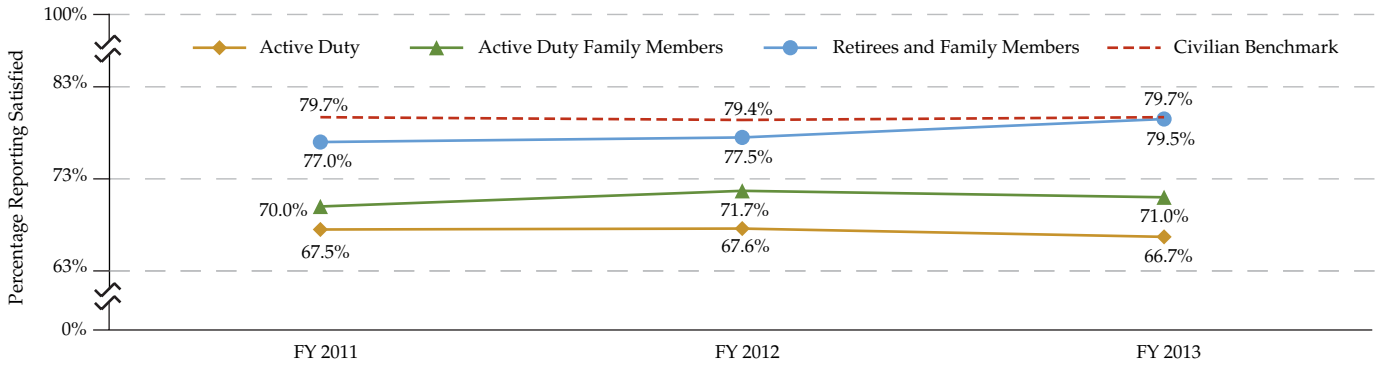
MHS user satisfaction with one's personal provider differs by enrollment status as well as by beneficiary category.

- Satisfaction levels of Prime enrollees (both military and civilian PCMs) continued to lag the civilian benchmarks. Satisfaction levels of non-enrollees are comparable to the civilian benchmark.
- Satisfaction levels by beneficiary category also continue to lag the civilian benchmark. Satisfaction levels for Active Duty, ADFMs, retirees and families remained steady over the three-year period.

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



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



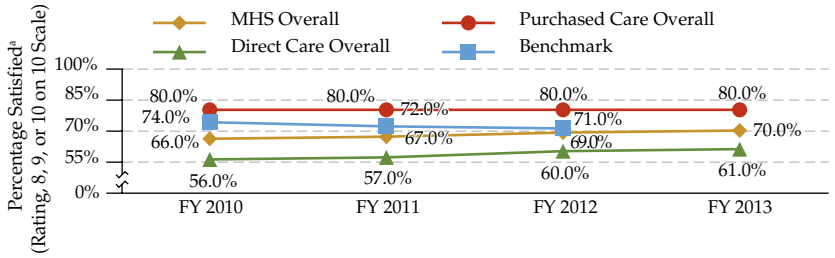
Note: DoD data were derived from the FYs 2011–2013 HCSDB, as of 11/8/2013, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared with the most recent benchmarks of the same CAHPS survey version available at the beginning of the MHS survey year. Civilian benchmarks for the composites and numeric ratings are taken from CAHPS Version 4, used in 2010 and later, and come from the NCBD. Benchmarks used in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 NCBD, respectively. In this, and all discussions of the HCSDB results, the words "increasing," "decreasing," "stable," or "comparable" (or "equaled" or "similar") reflect the results of statistical tests of significance of differences or trends.

BENEFICIARY RATINGS OF CARE FOLLOWING OUTPATIENT AND INPATIENT TREATMENT

TRICARE Outpatient Satisfaction Survey (TROSS)

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

OVERALL RATING OF HEALTH CARE



Source: DHA Business Support Directorate Defense Health Cost Assessment and Program Evaluation (DHCAPE) TROSS survey results of 11/15/2013

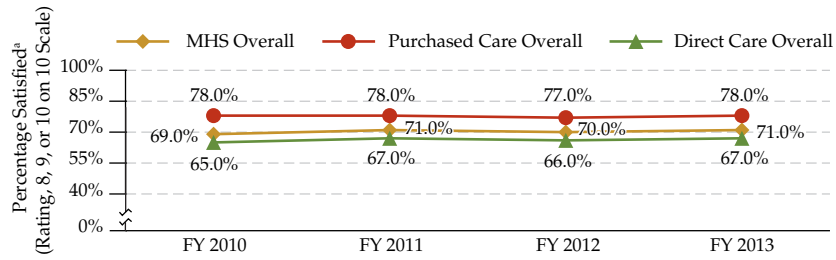
[a] "Percentage Satisfied" for Overall Rating of Health Care is a score of 8, 9, or 10 on a 0–10 scale where 10 is best.

Notes:

- "MHS Overall" refers to the users of both direct and purchased care components, "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- Benchmark data shown are from the balanced scorecard criteria. Benchmark surveys for the TROSS are conducted by the Altarum Institute as an online survey of individuals who have seen a health care provider recently. Respondents to the civilian benchmark survey were screened to determine whether they or their child had a recent (past 12 months) outpatient experience. Civilian benchmarks were created as weighted estimates reflecting the responses of civilian participants.
- Separate sets of benchmark scores were calculated for the Direct Care, Purchased Care, and MHS.
- Overall populations based on their (annual) demographic distributions.
- The years depicted align with the fiscal year (i.e., FY 2012 represents data from October 2011–September 2012. FY 2013 represents data from October 2012–March 2013). Benchmarks for "Overall Rating of Health Care" are not available after 2012. Data will not be directly comparable to results presented in previous TRICARE Evaluation Reports to Congress, due to a change from calendar year to fiscal year reporting.
- All MHS military facility data are adjusted for selection, nonresponse, beneficiary category, age, and MTF service branch.
- All MHS civilian purchased-care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.

Rating of Health Care: As shown in the chart at left, MHS beneficiary overall ratings of their health care (the percentage rating 8, 9, or 10 on a 0–10 scale) increased from 66 percent in FY 2010 to 70 percent in FY 2013. The increased ratings between FY 2011 and FY 2012 were statistically significant when compared to the previous fiscal year. Among MHS beneficiaries, ratings by those using civilian outpatient care remained at 80 percent from FY 2010 to FY 2013, while ratings by those using MTF-based care increased from 56 percent in FY 2010 to 61 percent in FY 2013. Between FY 2010 and FY 2012, the increases were statistically significant when compared to the previous fiscal year.

OVERALL RATING OF HEALTH PLAN



Source: DHA Business Support Directorate DHCAPE TROSS survey results of 11/15/2013

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

Notes:

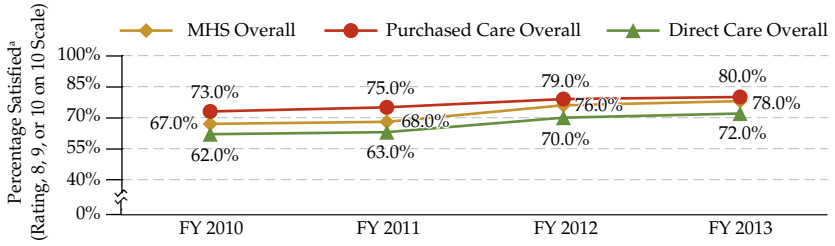
- There is no civilian benchmark for Rating of Health Plan.
- Please refer to notes accompanying "Overall Rating of Health Care" for more detail regarding this analysis.

Rating of Health Plan: As shown in the chart at left, beneficiary overall rating of the health plan among MHS beneficiaries (the percentage rating 8, 9, or 10 on a 0–10 scale) has slightly increased from 69 percent in FY 2010 to 71 percent in FY 2013. The FY 2011 rating (71 percent) was statistically significantly higher compared with FY 2010. Health plan ratings by those receiving outpatient care at civilian facilities has also remained stable around 78 percent, while plan ratings for MTF-based facilities increased from 65 percent in FY 2010 to 67 percent in FY 2013. During FY 2012, there was a statistically significant decrease from FY 2011 for beneficiaries receiving care in civilian facilities.

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

TRICARE Outpatient Satisfaction Survey (TROSS) *(CONT'D)*

OVERALL RATING OF MENTAL HEALTH CARE[a]



Source: DHA Business Support Directorate DHCAPE TROSS survey results of 11/15/2013

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

Notes:

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

– There is no civilian benchmark for Rating of Mental Health Care.

Rating of Mental Health Care: The composite rating of overall mental health care (a combination of ratings for "Ease of getting treatment/counseling service" and "Overall rating of treatment/counseling") improved from FY 2010 to FY 2013 for users of civilian facilities (Purchased Care) as well as military facilities (Direct Care). MHS beneficiary ratings of mental health care improved from 67 percent in FY 2010 and to 78 percent in FY 2013, with ratings by users of civilian mental health care increasing from 73 percent in FY 2010 to 80 percent in FY2013. Ratings from users of MTF-based mental health care also improved, from 62 percent in FY 2010, to 72 percent in FY 2013. In FY 2012, there was a statistically significant increase in ratings among MHS beneficiaries that received care in MTF and civilian facilities, compared to FY 2011.

TRICARE Inpatient Satisfaction Survey (TRISS)

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

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

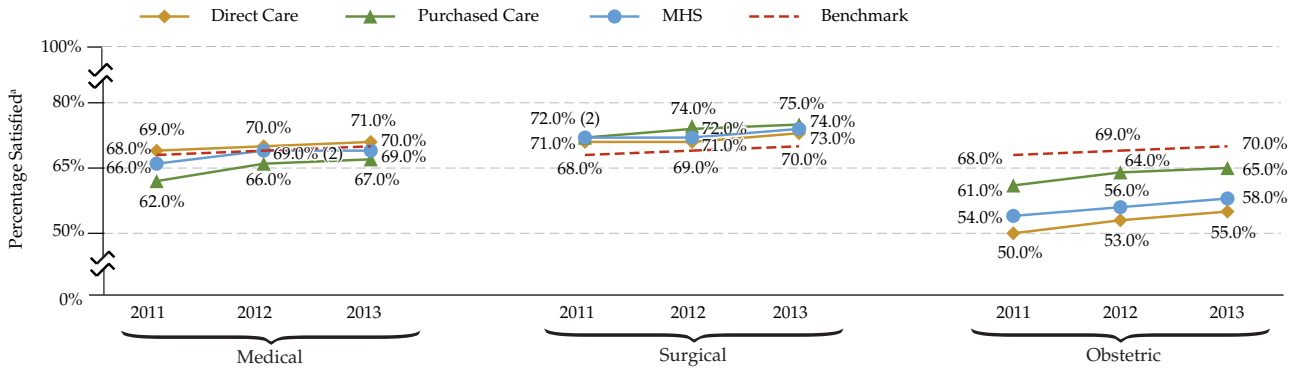
- Overall rating of hospital and recommendation to others;
- Nursing care (care, respect, listening, and explanations);
- Physician care (care, respect, listening, and explanations);
- Communication (with nurses and doctors, and regarding medications);
- Responsiveness of staff;
- Pain control;
- Hospital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

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

TRICARE Inpatient Satisfaction Survey (TRISS) *(CONT'D)*

Rating of Hospital: Overall, beneficiaries who received care within the purchased care system for surgical and OB care rated their hospital higher than did those in the direct care system. MHS beneficiaries needing surgical care, whether discharged from MTF or civilian hospitals, rated their hospital stay higher than users that make up the civilian benchmark. Beneficiaries who received medical services in military facilities rated their hospital higher (71 percent for 2013) than the civilian benchmark (70 percent for 2013; CMS).

OVERALL RATING OF HOSPITAL, 2011–2013



Source: OASD(HA) DHA/Business Support Directorate DHCAPE TRISS survey results of 11/15/2013

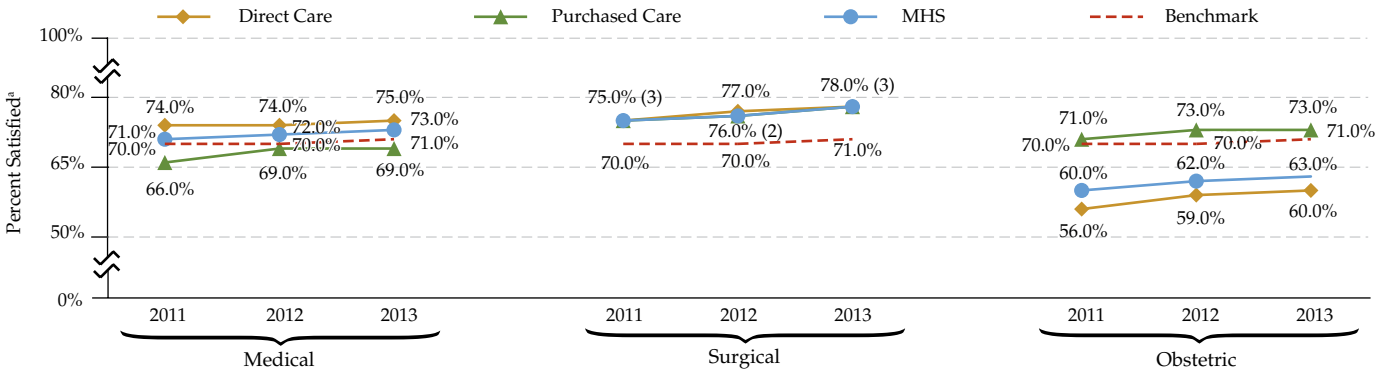
[a] "Percentage Reporting Satisfied" for Rating of Hospital is a score of 9 or 10 on a 0–10 scale where 10 is best.

Notes:

- "MHS Overall" refers to the users of both direct and purchased care components, "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- The years depicted align with the fiscal year. Data for FY 2011 consists of data from Quarter 2 to Quarter 4 of FY 2011. Direct care 2013 MTF results are based on discharges from Q1 2013 through Q3 2013; purchased-care 2013 results are based on discharges from Q1 2013 through Q3 2013. Data reported here will not be directly comparable to previous TRICARE Evaluation Reports to Congress, due to differences in time periods analyzed.
- All MHS military facility data are adjusted for selection, nonresponse, beneficiary category, age, and MTF service branch.
- All MHS civilian purchased-care data are adjusted for selection, nonresponse, gender, beneficiary category, age, and TRICARE region.
- TRISS data have not been case-mix adjusted, limiting comparability to CMS benchmarks.
- CMS benchmarks for civilian providers represent three product lines combined (medical, surgical, and obstetrics) and are case-mix adjusted. These benchmarks are the latest published from Medicare Hospital Survey of Patients' Hospital Experience (*www.hospitalcompare.hhs.gov*).

Recommendation of Hospital: Direct care (medical and surgical product lines) beneficiaries' recommendation of their hospital exceeds the civilian benchmarks. Purchased care beneficiaries' recommendation of their hospital consistently exceeds the civilian benchmarks for surgical and OB product lines.

WILLINGNESS TO RECOMMEND HOSPITAL, 2011–2013



Source: OASD(HA) DHA Business Support Directorate DHCAPE TRISS survey results of 11/15/2013

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

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

DRIVERS OF PATIENT SATISFACTION/EXPERIENCE RATINGS

Results of customer surveys have become increasingly important in measuring health plan performance and in directing action to improve the beneficiary experience and quality of services provided.

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

  Results from these three surveys for FY 2012 and FY 2013 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all surveys, for the direct care system, were determined by examining the effects of composite scores on outcome models. The models controlled for all composites and demographic variables, including beneficiary demographic variables (including beneficiary and category, gender, Service, health status, and region). The statistical significance and effect size of odds ratios were used to rank drivers of satisfaction.
- As shown in the table below, beneficiary ratings of MTF health care are driven by the following factors: communication between patients, doctors, and nurses; access to care; getting needed care and getting care quickly; and cleanliness of hospital. Perceptions of the MHS (a DoD-specific composite) are also important to beneficiary ratings of outpatient care.
- These results suggest that improving communication between respondents and health care providers, access to timely care, and facility cleanliness have the potential to influence a patient's ratings of their health care and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE

FY 2012 and FY 2013				
Fiscal Year	**Ranking**	**TRISS Direct Care MHS Rating of Hospital**	**TROSS Direct Care MHS Satisfaction with Health Care**	**HCSDB Direct Care CONUS Satisfaction with Health Care**
FY 2012	**#1**	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Perception of MHS[a]	Getting Care Quickly
	#3	Pain Control	Access to Care	Getting Needed Care
FY 2013	**#1**	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Perception of MHS[a]	Getting Needed Care
	#3	Cleanliness of Hospital	Access to Care	Getting Care Quickly

Sources: OASD(HA)/DHA TRISS, TROSS, and HCSDB, FY 2012 and FY 2013 (Quarters 1–3 only for TRISS and TROSS), data as of 11/15/2013

[a] DoD Composite

Deep Dive Analysis Investigating Drivers of Patient Satisfaction

The Assistant Secretary of Defense (Health Affairs), working with the Surgeons General, created a (then) TMA-Tri Service initiative in August 2012 tasked with investigating why MHS beneficiaries rated OB care in MTFs lower than MTF medical or surgical care, and why OB ratings, unlike medical and surgical ratings, were lower than national CAHPS ratings. The Tri-Service "Deep Dive Working Group" convened from August 2012 to May 2013, producing a data call to Service MTFs that provide OB care. The Group combined the resulting data with two years of TRISS, TROSS, and Service outpatient survey data to create a multivariate model identifying reasons for the lower OB ratings and possible systemwide strategies for improving the OB experience. The analysis confirmed the lower MTF OB ratings over time, and, consistent with national CAHPS studies, identified key drivers for OB ratings: nurse/provider communications, staff responsiveness, and being treated with courtesy and respect; outpatient ratings were driven principally by being able to see the provider when needed, provider knowledge of the patient's medical history, provider communication, and provider follow-up after tests. In addition to collaborating with the Tri-Service Clinical Quality Forum and Perinatal Advisory Group in recommending strategies for improving provider and staff communications, increased use of spouse rooming-in accommodations, and combined labor-delivery-postpartum rooms, the working group also recommended that the Services adopt systems engineering efforts to standardize and systematize the OB outpatient and inpatient care processes. These efforts would aim to better predict future staffing requirements upon determination of pregnancy, and to fulfill the ongoing MHS effort to universally adopt the PCMH concept, which should improve outpatient access to, and experience of, MTF outpatient as well as inpatient care.

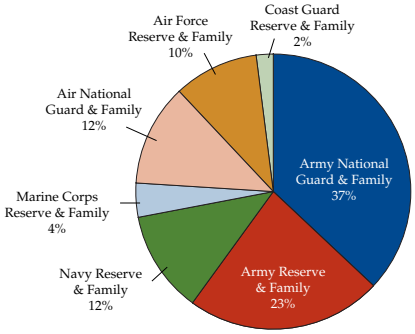
TRICARE BENEFITS FOR THE RESERVE COMPONENT

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

TRICARE Reserve Select (TRS). The premium-based TRS health plan offers comprehensive TRICARE Standard and Extra coverage for purchase by qualified members of the Selected Reserve. The National Defense Authorization Act (NDAA) of 2013, Public Law 112-239, section 701 extended TRS and dental coverage up to 180 days to certain members who are involuntarily separated under other than adverse conditions. Should the RC need to reduce endstrength, this legislation provides extended health care coverage for those Selected Reserve members covered by TRS if they are involuntarily separated under other than adverse conditions with affordable health care coverage during their transition to the civilian market. TRS had grown to over 99,000 plans with almost 270,000 covered lives by the end of FY 2013. The chart below presents TRS enrollment growth since plan inception.

- The pie chart below shows the breakdown of the almost 270,000 TRS-enrolled sponsors and family members by Service, with Army constituting 60 percent of enrollment (combined National Guard and Reserve). Army enrollment in TRS is roughly representative of the 63 percent affiliated with the Army of the total 2.1 million Selected Reserve population shown on page 52.

TRICARE RESERVE SELECT: 270,000 SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2013)



Source: Data are as of the end of September 2013, from Office of the Assistant Secretary of Defense (Reserve Affairs) (OASD[RA]) (M&P), 11/25/2013.

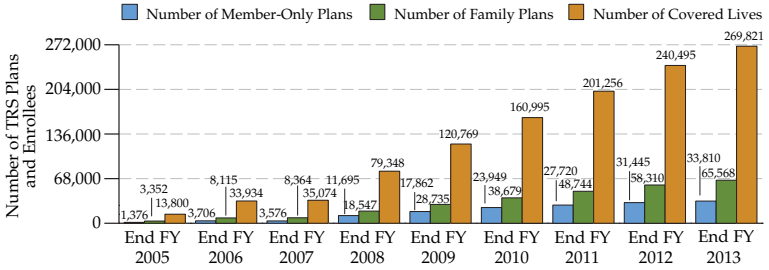
- Decision makers have asked what the TRS "take rate" is—that is, the percentage of eligible sponsors who actually purchased the program. The Government Accountability Office (GAO) has previously evaluated the DoD method for calculating (GAO-11-151, June 2011, pages 11–12) and found the method acceptable, given the complexity of excluding from those eligible all sponsors who are on Active Duty, eligible for TRICARE programs before and after deployment, or eligible for the Federal Employee Health Benefits Program (FEHBP). The methodology estimates that, for June 2013, the TRS "take rate" was nearly 24 percent of the almost 428,000 Selected Reservists eligible to participate, of the total 841,000 in Reserve status.

	Total
Selected Reserve End Strength	841,742
Active Guard and Reserve	(76,896)
FEHBP	(112,304)
On Active Duty	(122,197)
On Early Identification or Early Eligibility	(14,967)
On Transitional Assistance Management Program (TAMP)	(87,525)
Adjusted TRS Eligible Population	427,853
Enrolled TRS Sponsors	102,566
Take Rate for Eligible Population	23.97%

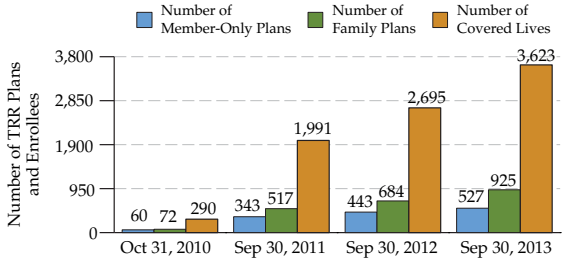
- TRS monthly premiums, based on actual prior year costs, will increase by six cents for member-only plans, from $51.62 in CY 2013 to $51.68 in CY 2014, while the member-and-family plans will increase by 4 percent, from $195.81 in CY 2013 to $204.29 in CY 2014 as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2012	2013	2014
TRS Member-only	$54.35	$51.62	$51.68
TRS Member-and-family	$192.89	$195.81	$204.29

TREND IN RESERVE COMPONENT ENROLLMENT IN TRICARE RESERVE SELECT SINCE INCEPTION (JULY 2005 TO SEPTEMBER 2013)



ANNUAL TREND IN ENROLLMENT IN TRICARE RETIRED RESERVE SINCE INCEPTION (OCTOBER 2010 TO SEPTEMBER 2013)



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

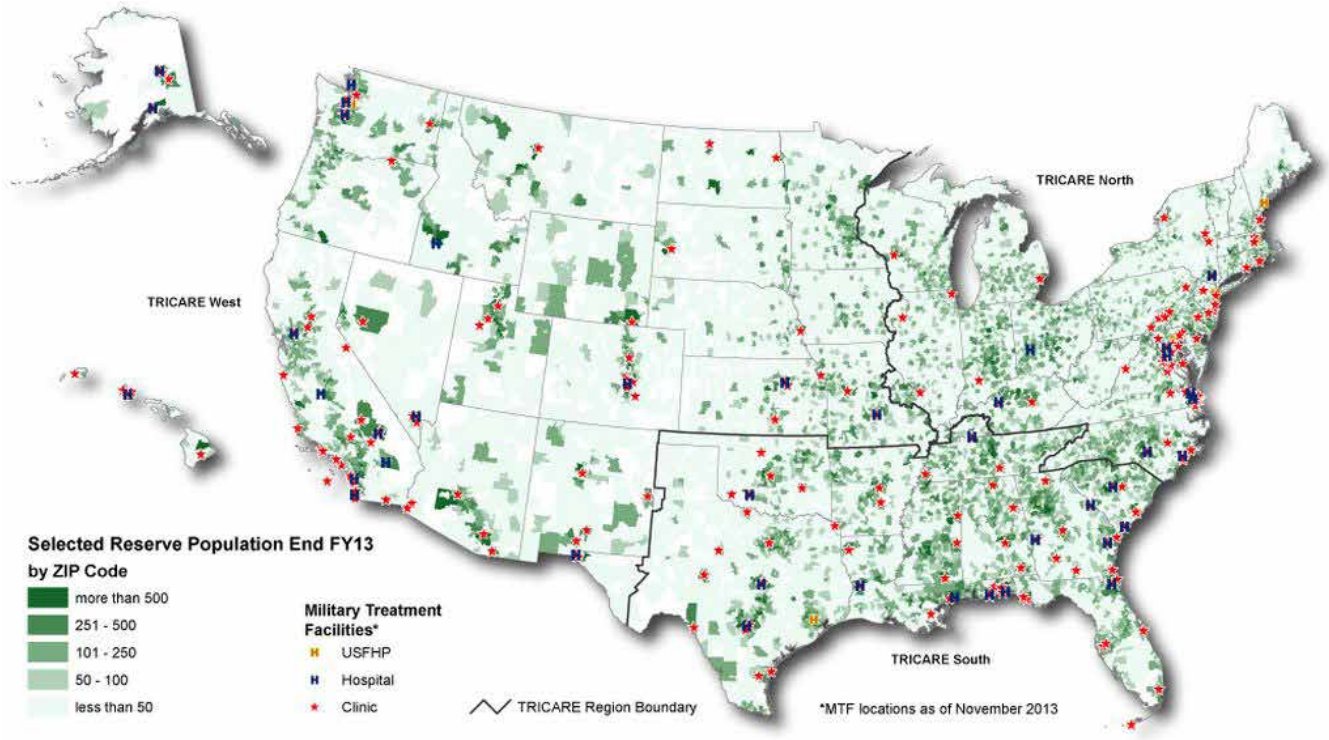
TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010, in response to the NDAA for FY 2010, section 705, which amended Title 10 United States Code by adding the new section 1076e. The law allows qualified members of the Retired Reserve to purchase full-cost,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

Although coverage under TRR is similar to TRS, it differs in the cost contribution. Unlike TRS, where the Department and member share in the cost of the premium, in TRR the member pays the full cost of the premium. Premiums may be adjusted annually.

- By the end of FY 2013, over 3,600 retired Reservists and their families were covered by TRR in over 1,450 member-only and member-and-family plans.
- TRR monthly premiums, based on actual prior year costs, will decrease by about 3 percent in member-only plans, from $402.11 in CY 2013 to $390.99 in CY 2014, and the member-and-family plans will decrease about 1 percent from $969.10 in CY 2013 to $956.65 in CY 2014, as follows (see *www.tricare.mil/trs*):

Monthly Premiums	2012	2013	2014
TRR Member-only	$419.72	$402.11	$390.99
TRR Member-and-family	$1,024.43	$969.10	$956.65

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2013



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMIILY MEMBER PROXIMITY TO MILITARY TREATMENT FACILITIES AND NETWORK PROVIDERS IN THE U.S. (SEPTEMBER 30, 2013)

BENEFICIARY GROUP	Population Totals (FY 2013)	Population in PSAs	% in PSAs	Population in Catchments	% in Catchments	Population in PRISMs	% in PRISMs	Population in MTF Service Areas	% in MTF Service Areas
Active Duty and Their Families	3,079,491	2,934,269	95%	2,151,198	70%	2,714,355	88%	2,851,343	93%
Selected Reservists and Their Families	1,975,851	1,336,021	68%	481,077	24%	729,926	37%	1,055,157	53%

Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 12/12/2013;
Selected Reservists and their family members, OASD(RA) Reserve Components Common Personnel Data System (RCCPDS) and Defense Enrollment Eligibility Reporting System (DEERS) Database Extract as of 9/30/2013, provided 11/25/2013; Active Duty and their families from MHS Data Repository (MDR) DEERS Extract as of 9/30/2013, provided 12/4/2013.

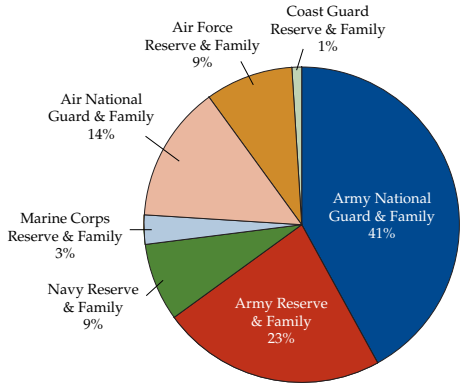
Geographic Definitions:

MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial ZIP codes, subject to overlap rules, barriers, and other policy overrides. Prime Service Areas (PSAs) are both MTF Service Areas and similar geographies around closed MTFs (base realignment and closure [BRAC] PSAs), effective October 1, 2013.

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

- As of September 30, 2013, there were more than 2.1 million Selected Reserve Service members and their families (2,102,908), of which 842,304 were sponsors and 1,260,604 were family members. Approximately 97 percent were identified as residing in the U.S.

SELECTED RESERVE POPULATION: 2.1 MILLION SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2013)



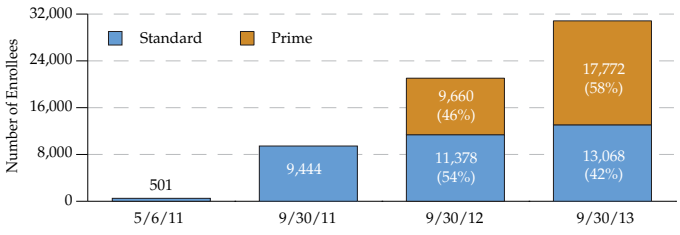
Source: Data are as of the end of September 2013, from OASD(RA) (M&P), 11/25/2013.

- The map on page 51 depicts where Selected Reservists and their family members reside in the U.S., relative to the direct care MTFs, and also to all areas where TRICARE Prime networks are available. As shown in the accompanying table, by October 1, 2013, 68 percent of Selected Reservists and their family members in the U.S. live within the area covered by the TRICARE network (PSAs), ranging from 63 percent in the North, to 67 percent in the West, and 74 percent in the South TRICARE Regions. Slightly more than half (53 percent) of this population resides near a clinic or inpatient MTF, compared with 93 percent of Active Duty and their family members.
- As shown at left, almost two-thirds (64 percent) of the worldwide Selected Reserve population of 2.1 million sponsors and their family members are Army National Guard (41 percent) and Army Reserve (23 percent).

TRICARE YOUNG ADULT

TRICARE already has met or exceeded most of the new health care provisions that took effect on September 23, 2010, under the Affordable Care Act (ACA). However, one of the very few ACA provisions that TRICARE did not fully meet was health care coverage for dependent children up to the age of 26. The NDAA for FY 2011 included a provision that extended dependent medical coverage up to age 26. Beginning in May 2011, qualified dependents up to age 26 were able to purchase TRICARE Standard coverage on a month-to-month basis under the new TRICARE Young Adult (TYA) program. Beginning in January 2012, the TYA program expanded to include a TRICARE Prime option. As noted previously on page 51, reductions in certain PSAs effective October 1, 2013, will limit some locations where TYA enrollees reside.

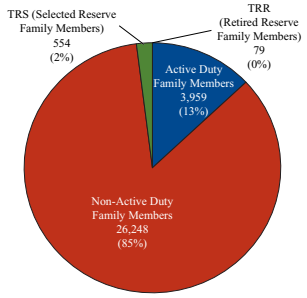
TREND IN TRICARE YOUNG ADULT ENROLLMENT SINCE INCEPTION (MAY 2011 TO SEPTEMBER 2013)



Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 11/8/2013

- As shown in the chart at left, enrollment went from over 21,000 in FY 2012 to almost 31,000 in FY 2013. Also, although TYA began with the Standard option, Prime now accounts for almost 60 percent of total TYA enrollment.
- As shown in the accompanying pie chart, 85 percent of TYA enrollees are family members of those who are not Active Duty (e.g., dependents of retirees and others).

TYA ENROLLMENT BY FAMILY MEMBER CAREER STATUS



Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 11/8/2013

- TYA monthly premiums, based on actual prior year costs, increase for Prime plans from $176 per month in 2013 to $180 per month in 2014, while the Standard plans also increased from $152 per month in 2013 to $156 per month in 2014, as follows (see *http://www.tricare.mil/Costs/ HealthPlanCosts/TYA.aspx*):

Monthly TYA Premiums	2012	2013	2014
Prime	$201	$176	$180
Standard	$176	$152	$156

ACCESS TO MHS CARE AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY WITH SEVERE DISABILITIES AND SPECIAL NEEDS

In response to section 714 of NDAA 2013, this section of the report extends the evaluation of the TRICARE program by addressing dependents of members on Active Duty with severe disabilities and chronic health care needs.

DoD provides a comprehensive medical benefit with a full array of medically necessary services, including access to a full range of medical specialties that address the health care needs of all beneficiaries, including families with special needs. Delivered through the TRICARE program, the Department covers all medically or psychologically necessary and appropriate care for all beneficiaries. For those with special needs, this can include: occupational therapy to promote the development of self-care skills; physical therapy to promote coordination/motor skills; speech and language therapy to promote communication skills; child psychiatry and child psychology to address psychopharmacological needs, psychotherapy, and psychological testing.

The **Exceptional Family Member Program (EFMP)** supports military families with special medical and educational needs. EFMP is a Service-based personnel program supporting the worldwide assignability of military personnel by identifying ADFMs requiring specialized health or educational services. The Services use EFMP information to make appropriate manning assignments consistent with the healthcare and educational needs required by the ADFM. EFMP programs are unique to each Service in the enrollment criteria and eligible medical conditions or educational needs. As of the end of FY 2013, there were a total of 128,582 family members registered in EFMP by the Army, Navy, and Air Force (with Army family members constituting the largest share at almost 54 percent). The program has three components: (1) identification and enrollment of family members with special medical or educational needs; (2) assignment coordination to determine the availability of services at the Service member's projected duty station; and (3) family support to help families identify and access programs and services. Enrollment in the EFMP is mandatory for Active Duty military members; members of the Guard or Reserves may enroll according to Service-specific guidance. Assignment coordination is important because access to appropriate medical and educational services may be limited in some areas, especially in overseas and remote locations. When assignment coordination occurs, family members receive the care and support they require, and the Service member can focus more clearly on mission-related responsibilities.

The **Extended Care Health Option (ECHO)** program supports ADFMs and other eligible beneficiaries with special health care needs by supplementing the basic TRICARE program in providing financial assistance for an integrated set of services and supplies. To use ECHO, qualified beneficiaries must be enrolled in the EFMP as provided by the sponsor's branch of Service and register through ECHO case managers in each TRICARE region. ECHO benefits include training; rehabilitation; special education; assistive technology devices; institutional care in private nonprofit, public, and state institutions/facilities and, if appropriate, transportation to and from such institutions/facilities; home health care; and respite care for the primary caregiver of the ECHO-registered beneficiary. All ECHO benefits must be authorized in advance and received from a TRICARE-authorized provider. ECHO has three distinct program user groups with combined TRICARE government payments of $159.3 million in FY 2012: Autism spectrum disorders (ASDs), ECHO Home Health Care (EHHC), and all other users. In FY 2012 ASD users had 68.4 percent of the total government payments ($108.9 million), EHHC users had 30.3 percent of TRICARE government payments ($48.3 million), and all other ECHO users had 1.3 percent ($2.1 million) of the total. Of the approximately 7,800 beneficiaries using the ECHO program in FY 2012 to supplement the TRICARE basic program, autism beneficiaries accounted for 85 percent, while EHHC users accounted for 7.3 percent (573 users) and all other ECHO users accounted for 7.7 percent (603 users). EHHC users had the highest average annual per capita costs in FY 2012 at $84,371. ASD users cost $16,462 and all other ECHO users cost $3,468 annually per capita in FY 2012.

ECHO Autism Demonstration: In addition to the TRICARE basic program and other services for special needs children provided by the Department, MHS provides one of the most comprehensive sets of specialized services for children with an ASD diagnosis in the U.S., including the provision of applied behavior analysis (ABA). TRICARE first began covering ABA services for ADFMs with ASD under the Program for Persons with Disabilities (PFPWD) in 2001. In 2005, the ECHO program covered ABA services as a nonmedical intervention to those ADFMs enrolled in the EMFP. The Enhanced Access to Autism Services Demonstration (EAASD, or ECHO Autism Demonstration) was implemented on March 15, 2008, in response to section 717 of NDAA FY 2007, with the goal of improving the quality, efficiency, convenience, and cost-effectiveness of providing services to eligible ADFMs with an ASD. In addition, section 732 of the NDAA for FY 2009 increased the limit of government liability for certain benefits, including special education, from $2,500 per month to $36,000 per year. That change was implemented on April 1, 2009.

Central to the ECHO Autism Demonstration was the authority to provide reimbursement for one-on-one ABA services rendered by individuals who are not TRICARE-authorized providers. The key feature of the

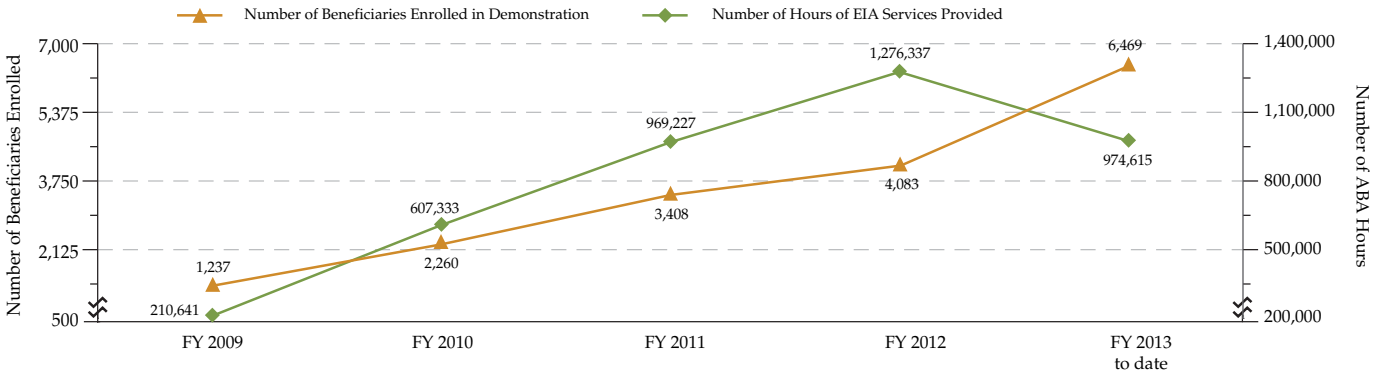
ACCESS TO MHS CARE AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY WITH SEVERE DISABILITIES AND SPECIAL NEEDS *(CONT'D)*

Demonstration is to provide Educational Interventions for Autism Spectrum Disorders (EIA) by a two-tiered delivery model.

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

The purpose of the ECHO Autism Demonstration is to test whether this tiered delivery and reimbursement methodology for ABA services provides increased access to ABA services to those most likely to benefit from them, while at the same time monitoring the quality of ABA services and ensuring that requirements are being met for state licensure or certification of ABA providers (where such exists). Early program evaluation findings indicated high rates of parental satisfaction with the program and support the conclusion that the ABA services provided in the ECHO Autism Demonstration may generally have had a positive impact on the lives of some of the children with autism and their families, and may be positively related to retention and family readiness. Although the ECHO Autism Demonstration has not measured clinical outcomes or treatment progress, the program has increased the number of beneficiaries and their access to the services of authorized ABA providers, as evidenced by the sustained monthly growth in the number of enrollees. As shown in the chart below, participation by beneficiaries and providers continues to increase, with more than a five-fold increase in enrollment from the first complete year of the Demonstration (FY 2009) to FY 2013 (yellow line) and almost a five-fold increase in the number of EIA hours provided.

DoD ENHANCED ACCESS TO AUTISM SERVICES DEMONSTRATION: ENROLLMENT AND HOURS OF SERVICES PROVIDED (FY 2009–FY 2013)



Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 11/25/2013

This represents 90 percent of all children with special needs enrolled in ECHO (only 712 beneficiaries receive non-ABA services under ECHO). The total government cost for these beneficiaries more than tripled as well between FY 2009 and FY 2012 (from $31.0 million to $109.0 million). In FY 2009, only 22 percent of the beneficiaries with an ASD diagnosis were using ECHO ABA services, compared with 40 percent in FY 2012. Demographic information from FY 2012 reflected that 99.8 percent of these beneficiaries were younger than 21 years of age, and 90 percent were younger than age 13. While TRICARE-eligible children with ASD (ages 2 to 17) represent only approximately 2 percent of all children with ASD in the U.S., they utilize 21 percent of the BACB-certified providers in the U.S.

On June 28, 2013, DoD issued an Interim Coverage Determination for ABA coverage that indicated there was not currently enough evidence to demonstrate that ABA was a proven medical treatment under the laws and regulations governing TRICARE. However, a final decision was deferred until there could be a reassessment based on the experience of the ABA pilot and any additional information that comes to light. On December 26, 2013, the Department issued a *Federal Register* notice that the program will be extended through March 14, 2015. During this interim period, TRICARE will continue ABA coverage under the basic program, per existing policy. Neither the ABA pilot nor the Interim Coverage Determination for ABA has any impact on ADFMs or the ABA services they continue to receive under the ECHO Autism Demonstration.

Most recently, the NDAA for FY 2013 authorized TRICARE to provide the type of ABA service delivery model used in the ECHO Autism Demonstration to non-Active Duty family members (NADFMs) under the authority

ACCESS TO MHS CARE AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY WITH SEVERE DISABILITIES AND SPECIAL NEEDS *(CONT'D)*

of a one-year pilot project (these NADFMs include retiree dependents and participants in TRS, TRR, TYA, TFL, and the Continued Health Care Benefit Program). This ABA pilot was implemented on July 25, 2013, as a separate benefit from the coverage of medical benefits currently provided under the TRICARE basic program to NADFMs with ASD, and separate from the ECHO Autism Demonstration services available by law only to ADFMs. It is too early to report data on this program; however, as a point of reference, NADFMs represent only 2 percent of those who use ABA services through the TRICARE basic program. With the growing number of children with an ASD diagnosis in the military and worldwide, TRICARE continues to increase access to ABA services and is a leader in innovative strategies for meeting the needs of military families.

ECHO Home Health Care (EHHC) provides medically necessary skilled services to those ECHO beneficiaries who are homebound and generally require more than 28 to 35 hours per week of home health services or respite care. The EHHC benefit is only available in the U.S., District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. The patient's PCM or attending physician determines patient eligibility for EHHC services and develops a plan that will be reviewed every 90 days or when there is a change in the patient's condition. Beneficiaries are considered homebound if their conditions are such that they cannot leave their homes without considerable and taxing effort. Beneficiaries are not qualified if they leave their homes regularly for therapeutic, psychosocial, or medical treatment or to attend an accredited, certified adult daycare program.

The Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC), also known as the Individual Case Management Program, was a discretionary program for TRICARE beneficiaries with extraordinary medical or psychological conditions. Authorized in NDAA FY 1993, the ICMP-PEC expanded the former Home Health Demonstration Project that was directed by the NDAA for FY 1986. The purpose of the ICMP-PEC was to provide coverage of medical psychological services, supplies, or durable medical equipment that are normally excluded by law or regulation as a TRICARE benefit when the provision of such benefits was cost-effective and clinically appropriate. TRICARE payment of services, which were authorized by the Home Health Demonstration Project, will continue as long as those beneficiaries, who were "grandfathered" when that program was terminated, remain eligible for TRICARE. Today there are 33 beneficiaries in ICMP-PEC. Beneficiaries must continue to meet the TRICARE definition of custodial care in effect prior to December 28, 2001. Custodial care is care rendered to a patient who is disabled mentally or physically, and such disability is expected to continue and be prolonged; who requires a protected, monitored, or controlled environment, whether in an institution or in the home, and requires assistance to support the essentials of daily living; and who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. ICMP-PEC beneficiaries must have a primary caregiver in the home.

Beneficiaries as of December 28, 2001, whose level of services authorized as of December 28, 2001, could be appropriately provided through other TRICARE programs, such as the home health agencies prospective payment system, ECHO, or the skilled nursing facilities prospective payment system, were transitioned into such programs upon identification by the managed care support contractors (MCSCs) in conjunction with the Director, TMA Office of the Chief Medical Officer, or designee.

In FY 2002, Congress changed the definition of custodial care (10 USC 1072 [8]–[9]). Effective December 28, 2001, custodial care is no longer defined by the condition of the patient but by the type of service being rendered. This transitional policy provides TRICARE coverage of medically necessary skilled services to eligible beneficiaries and will remain in effect. Custodial care means treatment or services, regardless of who recommended such treatment or service or where such treatment or services are provided, that can be rendered safely and reasonably by a person who is not medically skilled or is/are designed mainly to help the patient with the activities of daily life (ADL). ADL may also be referred to as "essentials of daily living." ADL may include support for providing food (including special diets), clothing, shelter; personal hygiene; observation and general monitoring; bowel training or management; safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and other necessary services that reasonably can be performed by an untrained adult with minimal instruction or supervision.

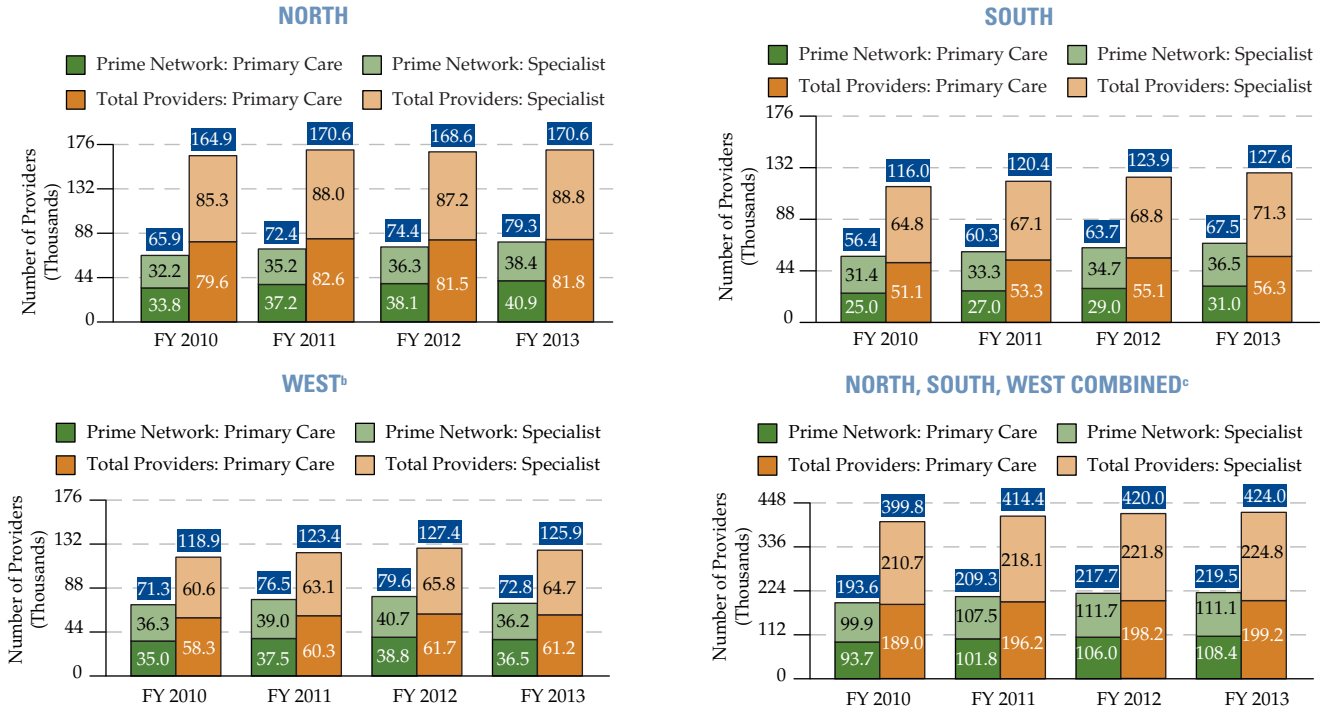
The **Custodial Care Transitional Policy** (CCTP) program came into existence as a stop-gap policy to cover new cases of beneficiaries entitled to expanded benefits under the new definition of custodial care arising on or after the effective date of the law (December 28, 2001), because the new case could no longer be addressed under the repealed law authorizing ICMP. The 43 CCTP beneficiaries are in a category that is separate and distinct from, and does not include, those "grandfathered" ICMP beneficiaries. The CCTP benefits are payable for eligible beneficiaries who meet the custodial care definition and require in-home medically necessary skilled services beyond what is provided by the EHHC benefit.

TRICARE PROVIDER PARTICIPATION

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the United States by CMS. All Health Insurance Portability and Accountability Act (HIPAA)-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. Although CMS has been issuing NPIs since FY 2007, they did not gain widespread use in MHS until FY 2010. In this year's report, providers are counted using the NPI. The number of TRICARE participating providers was determined by the number of unique providers filing TRICARE (excluding TFL) claims.[1] Providers were counted in terms of full-time equivalent (FTE) units (1/12 of a provider for each month the provider saw at least one MHS beneficiary). The total number of participating providers has been rising steadily for more than a decade but began to level off in FY 2013. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually declined. Furthermore, the number of network primary care providers has increased at a higher rate than that of specialists but the total number of participating primary care providers has increased at a slightly lower rate than that of total participating specialists.[2]

- Between FY 2010 and FY 2013, the South Region saw the largest increase in the total number of TRICARE providers (10 percent), while the West Region saw an increase of 6 percent and the North Region an increase of 3 percent.
- The South and North Regions saw the largest increase in the number of network providers (20 percent each), while the West Region saw an increase of only 2 percent.
- The total number of TRICARE providers increased by 8 percent in PSAs but remained about the same in non-PSAs (not shown).
- The number of network providers increased by 13 percent in both PSAs and non-PSAs.
- In FY 2013, 86 percent of all network providers and 82 percent of all participating providers were in PSAs.

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs[a]



Source: MHS administrative data, 1/21/2014

Notes: The source for the provider counts shown above was the TRICARE purchased care claims data for each of the years shown, in which a provider was counted if he or she was listed as a TRICARE participating provider. From FY 2005 forward, the claims explicitly identify network providers. Numbers may not sum to bar totals due to rounding.

[a] Network providers are TRICARE-authorized providers who have a signed agreement with the regional contractors to provide care at a negotiated rate. Participating providers include network providers and those non-network providers who have agreed to file claims for beneficiaries, to accept payment directly from TRICARE and to accept the TRICARE allowable charge, less any applicable cost shares paid by beneficiaries, as payment in full for their services.

[b] The West Region includes Alaska.

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

[1] Providers include physicians, physician assistants, nurse practitioners, and select other health professionals. Providers of support services (e.g., nurses, laboratory technicians) were not counted.

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

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

Purpose of the Study

DoD has completed the first year of a congressionally mandated four-year survey of civilian providers and MHS non-enrolled beneficiaries, designed to determine civilian provider acceptance of, and beneficiary access to, the TRICARE Standard benefit option. This survey complies with the requirements of section 721, NDAA for FY 2012, Public Law (PL) 112-81, amending previous legislation for a four-year survey from 2008–2011 (section 711, NDAA 2008 PL 110-181). It has been approved by the Office of Management and Budget, and has been reviewed by the Government Accountability Office as required by the guiding legislation.

➤ **2012 provider survey results:**

- Acceptance of new TRICARE Standard/Extra patients:
  - About six of 10 providers overall (63 percent of physicians and nonphysician behavioral health providers) and eight of 10 physicians (78 percent) accept new TRICARE Standard patients if they accept new patients of any insurance.
  - Overall provider rates are slightly higher than the all-provider rates in the 2008–2011 benchmark survey (61 percent), while physician acceptance rates are slightly lower (81 percent).
  - Similar to the 2008–2011 benchmark survey, behavioral health providers report lower acceptance rates than physicians (psychiatrists at 56 percent and nonphysician behavioral health providers, 40 percent), which brings down the all-provider acceptance rates.
  - Also similar to the benchmark survey, providers in non-PSAs generally accept TRICARE Standard patients at higher rates than those in PSAs.
- Awareness of the TRICARE program:
  - More than eight of 10 providers overall (85 percent) and nine of 10 physicians (94 percent) are aware of the TRICARE program in general, compared with 82 percent of all providers and 91 percent of physicians in the benchmark survey.
  - Similar to acceptance rates, behavioral health providers (psychiatrists, psychologists, and other nonphysician behavioral health providers) generally report lower awareness of the TRICARE Program.
- Prime and Non-PSA Differences: Responding to guiding legislation to assess differences between areas where Prime is offered (PSAs) and where it is not (non-PSAs), provider acceptance of new TRICARE Standard patients is higher in non-PSAs than in PSAs, although provider awareness is comparable in these locations.

➤ **2012 beneficiary survey results, in the same areas as the provider surveys:**

- MHS non-enrolled Standard/Extra-eligible beneficiaries rate their care and access to care similar to or higher than the civilian benchmark (CAHPS plan).
- As with provider acceptance rates, Standard/Extra beneficiaries rate access and care higher in non-PSAs than in PSAs, but not necessarily in the same PSA/non-PSA locations.
- Users rate their care and access equal to or higher than the civilian benchmark. Our beneficiary survey is based on, and benchmarked to, the standardized CAHPS survey used by Medicare, Medicaid, and commercial health plans and health plan accrediting agencies.

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

721 SURVEY LOCATIONS: 2012

	PSAs	Non-PSAs	HSAs	Total Locations
2012	22	20	7	49
2013				
2014				
2015				
Total	**22**	**20**	**7**	**49**

Source: OASD(HA) DHA Business Support Directorate DHCAPE and administrative data, 11/7/2013

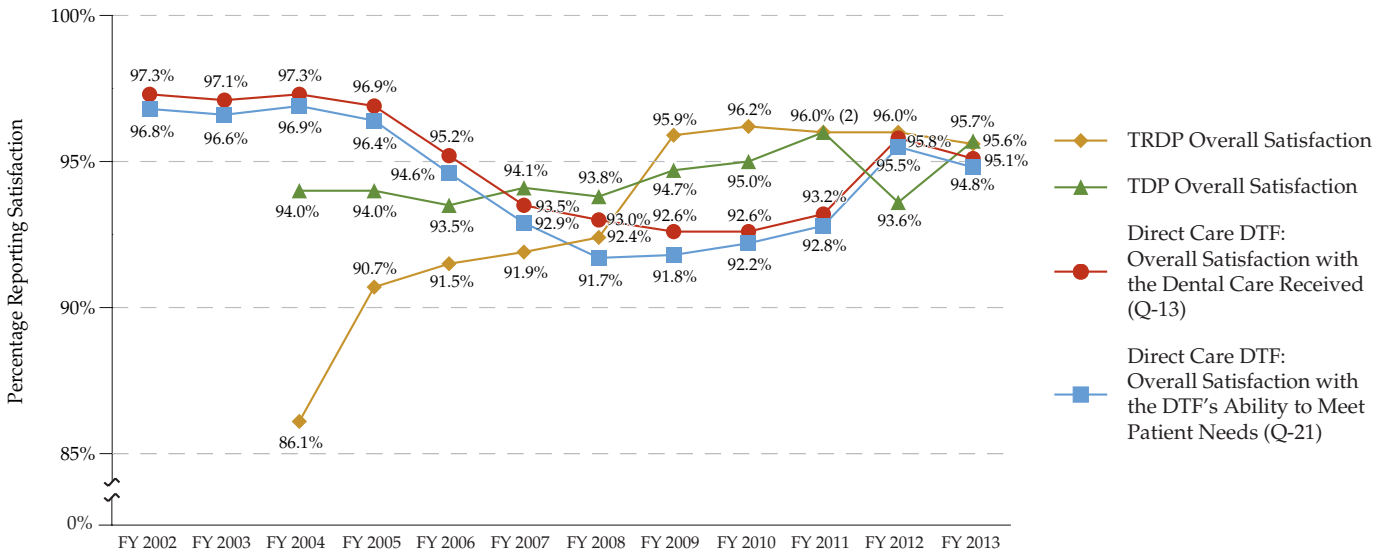
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

Dental Customer Satisfaction

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

- **Military Dental Treatment Facilities (DTFs)** are responsible for the dental care of about 1.8 million Active Duty Service members, as well as eligible family members outside the continental U.S. (OCONUS). The Tri-Service Center for Oral Health Studies completed almost 223,000 surveys in FY 2013. After rising for the two years prior, overall satisfaction with the dental care received and patient ratings of the ability of the DTFs to meet their dental needs dipped in FY 2013.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction increased two percentage points from 93.6 percent in FY 2012 to 95.7 percent in FY 2013. The TDP is a voluntary, premium-sharing dental insurance program available to eligible ADFMs, Selected Reserve and Individual Ready Reserve members, and their families. As of September 30, 2013, the TDP serviced 807,763 contracts, 95 percent of which are in the U.S., covering almost 2 million lives (1,896,075). Although not shown, the TDP survey includes satisfaction ratings for network access (99 percent), provider network size and quality (98 percent), and claims processing (98 percent). The TDP network has almost 220,000 dentist access points (218,105), about 18 percent more than the over 190,000 in FY 2012. The FY 2013 TDP network included 162,483 general dentist access points and 55,667 specialist locations.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate remained stable at about 96 percent over the past five years, from FY 2009 to FY 2013. The TRDP is a full premium insurance program open to retired Uniformed Services members and their families. TRDP enrollment at the end of FY 2013 was higher by 12 percent than in FY 2010, with over 1.4 million total covered lives in over 690,000 contracts, compared with about 1.25 million lives in over 606,000 contracts in FY 2010. Most (i.e., 99 percent), but not all, reside in the U.S.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES



Source: Tri-Service Center for Oral Health Studies, DoD Dental Patient Satisfaction Reporting Web Site (Trending Reports), and TRICARE Dental Office, Health Plan Execution and Operations, 11/5/2013

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

SURVEY OF WOUNDED, ILL, OR INJURED SERVICE MEMBERS POST-OPERATIONAL DEPLOYMENT

The OASD(HA) DHA completed at the end of September 2013 a six-year telephone survey of Service members returning from operational deployment (Afghanistan and Iraq) that began in May 2007. The Department began the monthly Telephone Survey of Ill or Injured Service Members Post-Operational Deployment as one of several responses to a tasking by the Secretary of Defense to establish a mechanism for identifying any problems in Service member care, recuperation, or reintegration and to provide actionable information to the Services to resolve shortcomings or establish mechanisms for improvement.

For over six years, the survey has been a continuous monthly collection of their experiences. The survey originally focused on the cohort of Service members aeromedically evacuated from operational theaters. It was subsequently expanded in Q4 FY 2008 to include four additional cohorts of Service members who were returned from operational deployment for at least a year, were identified as having a medical condition requiring treatment, and were found to have actually used the MHS in some capacity, hence the term "wounded, ill, or injured." Since Q4 FY 2008, the survey has been fielded to a census (100 percent) of all aeromedically evacuated Service members and a census of all Service members who have been out of operational theater for at least one year and who have used the MHS for care, including (1) a follow-up of those aeromedical evacuees; (2) those referred to Department of Veterans Affairs (VA) facilities by DoD; (3) members completing a Post-Deployment Health Assessment (PDHA); and (4) members completing a Post-Deployment Health Reassessment (PDHRA).

After 74 consecutive monthly surveys, over 93,000 Service members of the over 236,000 sampled had completed a survey, for an effective cumulative response rate of 41 percent. In total, the majority of the sample (76 percent) as well as the responses (78 percent) have been Army, followed by Air Force (11 percent sampled and returned), Marines (8 percent sampled and returned), Navy (4 percent sampled and returned), and Coast Guard (under 0.1 percent each). The focus of the survey is to identify problem areas to resolve, but over time, several areas appear favorable and stable.

- **Summary of results:** Through the most current quarter of surveying (Q3 FY 2013), Service members have favorably rated most aspects of medical hold, outpatient health care, and support services, including DoD support for care in VA facilities.
  - One-fifth of Service members state they have received counseling for personal or family problems, most of whom sought care on their own (68 percent); of those receiving care, 87 percent said it was helpful, and 17 percent of those not receiving care thought it would have benefited them had they sought care.
- **Areas needing improvement:** Two areas continue to challenge the MHS: the *Medical Evaluation Board (MEB) (in Integrated/Disability Evaluation System [I/DES])* and access to outpatient care.

Medical Evaluation Board (in I/DES)

- Highest proportion of unfavorable ratings and lowest proportion of favorable ratings compared to other areas of health care measured in the survey.

Unfavorable ratings (a "1" or "2" on 1–5 scale)			
	Average	Q4 FY 2008	Q4 FY 2012
MEB experience	26%	29%	**24%**
Favorable ratings (a "4" or "5" on 1–5 scale)			
	Average	Q4 FY 2008	Q4 FY 2012
MEB experience	49%	43%	**51%**

- Most negative comments about MEBs reflect concerns about the process being slow and time consuming, and insufficient or unclear communication; these comments are common not only in the current quarter, but also in cumulative results.
- Those who have received results tend to rate their MEB satisfaction higher, compared with those still in the process.

Access to Outpatient Care

- Among the eight ambulatory care measures, three consistently have the highest proportion of unfavorable ratings and a low proportion of favorable ratings.

Unfavorable ratings (a "1" or "2" on 1–5 scale)			
	Average	Q4 FY 2008	Q4 FY 2012
Access to Providers	21%	15%	**25%**
Getting Urgent Care	18%	14%	**22%**
Getting an Appt. as Soon as Needed	18%	13%	**20%**
Overall Health Care	15%	12%	**17%**
Counseling	14%	13%	**11%**
All Health Care	10%	8%	**11%**
Specialists	7%	6%	**7%**
Personal Doctor	5%	3%	**6%**

- These items are reflected in Service members' answers to the last survey question, which asks them to describe, in their own words, anything else they wish to add or ideas on how treatment could be improved.

- The ASD(HA) and senior Surgeons General reviewed the results in September 2013 and agreed that: (1) the survey has served its purpose and there is no new effect on policy development; (2) it could be terminated to reduce duplication of other surveys (other survey sources exist to support monitoring of system improvement); and (3) Service initiatives and the Warrior Care Program Office would continue to support the recovery, rehabilitation, and reunification of Service members returning from war.

NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE

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

The performance of hospitals in MHS is in part evaluated through measure sets for the following conditions: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN), children's asthma care (CAC), and surgical care improvement project (SCIP). In direct care facilities, the data for the hospital quality measures are abstracted by trained specialists and reported to The Joint Commission to meet hospital accreditation requirements as well as presented to facility leadership for analysis and identification of improvement opportunities. Data on the same measure sets for hospitals enrolled in an MCSC network are obtained from the files posted by CMS on the Hospital Compare Web site: *http://www.hospitalcompare.hhs.gov*.

There were a number of measures retired during 2012, and new measures were added to some core sets to better focus on areas that require improvement. To facilitate easy access and to support the government mandate for enhanced transparency, the data for the measures are posted for public review. Quarterly, the Hospital Compare data file is downloaded, and the participating purchased care network hospitals are identified. Then the MTF data are added to provide a systemwide view. The data file is available on the MHS Clinical Quality Management Web site: *https://www.mhs-cqm.info*. MHS subject matter experts for both direct care and purchased care review the data and work collaboratively to identify and communicate performance excellence and improvement opportunities.

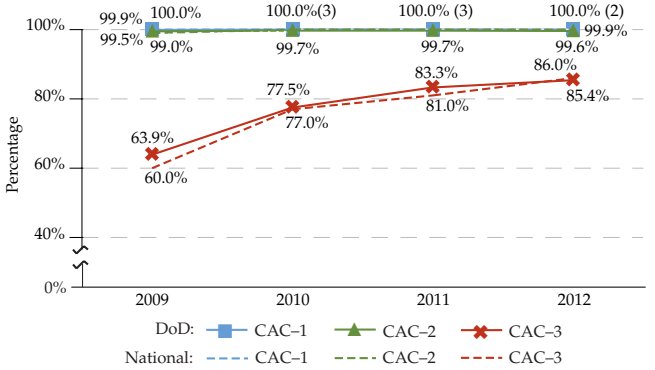
MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2009–FY 2012

DoD data displayed in the following charts include all patients who meet the National Hospital Measures technical specifications for the 55 inpatient MTFs and approximately 3,341 civilian hospitals participating in contracted care networks.

	2009	2010	2011	2012
CAC–1 Children Who Received Reliever Medication While Hospitalized for Asthma				
DoD	99.9%	100.0%	100.0%	99.9%
MTF	100.0	99.7	99.7	99.3
Purchased Care	99.9	100.0	100.0	100.0
National	100.0	100.0	100.0	100.0
CAC–2 Children Who Received Systemic Corticosteroid Medication (Oral and IV Medication That Reduces Inflammation and Controls Symptoms) While Hospitalized for Asthma				
DoD	99.5%	99.7%	99.7%	99.6%
MTF	99.2	98.5	98.5	98.7
Purchased Care	99.5	99.8	99.7	99.7
National	99.0	100.0	100.0	100.0
CAC–3 Children and Their Caregivers Who Received a Home Management Plan of Care Document While Hospitalized for Asthma				
DoD	63.9%	77.5%	83.3%	85.4%
MTF	38.4	51.5	55.7	70.9
Purchased Care	65.7	78.7	84.7	86.1
National	60.0	77.0	81.0	86.0

- **Children's Asthma Care:** Although performance for the medication management measures for children's asthma care is almost 100 percent for CAC–1 and CAC–2, the results for home management plan of care (CAC–3) continue to present an opportunity for improvement across DoD as well as in civilian hospitals, despite significant improvement over the last four years.

DoD HOSPITAL QUALITY MEASURE: CAC



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 11/4/2013

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

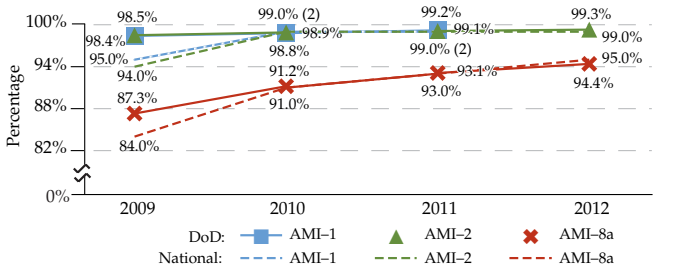
NATIONAL HOSPITAL QUALITY MEASURES—MILITARY HEALTH SYSTEM HOSPITALS PERFORMANCE *(CONT'D)*

MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2009–FY 2012

	2009	2010	2011	2012
AMI–1 Heart Attack Patients Given Aspirin at Arrival				
DoD	98.4%	98.8%	99.2%	Suspended
MTF	98.8	98.4	98.7	Suspended
Purchased Care	98.4	98.8	98.2	Suspended
National	95.0	99.0	99.0	Suspended
AMI–2 Heart Attack Patients Given Aspirin at Discharge				
DoD	98.5%	98.9%	99.1%	99.3%
MTF	97.7	97.7	96.8	98.3
Purchased Care	98.5	98.9	99.1	99.3
National	94.0	99.0	99.0	99.0
AMI–3 Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)				
DoD	95.4%	96.6%	97.3%	Suspended
MTF	97.1	98.3	94.3	Suspended
Purchased Care	95.4	96.6	97.3	Suspended
National	93.0	96.0	97.0	Suspended
AMI–4 Heart Attack Patients Given Smoking-Cessation Advice/Counseling				
DoD	99.3%	99.6%	99.8%	Retired
MTF	91.6	94.6	97.5	Retired
Purchased Care	99.3	99.6	99.7	Retired
National	97.0	100.0	100.0	Retired
AMI–5 Heart Attack Patients Given Beta Blocker at Discharge				
DoD	98.4%	98.6%	99.0%	Suspended
MTF	97.0	97.3	96.1	Suspended
Purchased Care	98.4	98.6	99.0	Suspended
National	94.0	98.0	99.0	Suspended

Acute Myocardial Infarction: DoD overall performance for acute myocardial infarction measures is comparable to, and in some cases slightly above, the national rate. There were a number of significant changes to the AMI measures in FY 2012. CMS and Hospital Compare suspended reporting on AMI–1, AMI–3, and AMI–5 in Q1 2012. Both CMS and The Joint Commission retired AMI–4 in 2012.

DoD HOSPITAL QUALITY MEASURE: AMI[a]

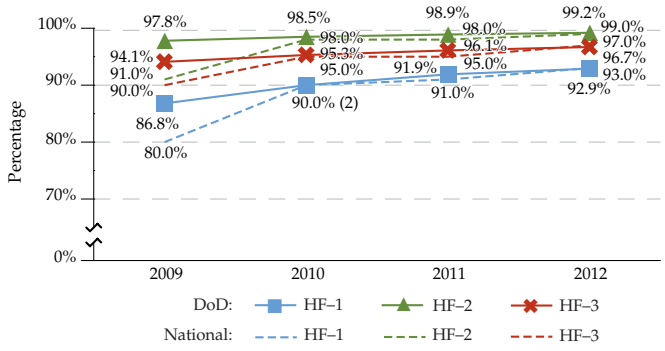


	2009	2010	2011	2012
AMI–8a Heart Attack Patients Given Percutaneous Coronary Intervention (PCI) within 90 Minutes of Arrival				
DoD	87.3%	91.2%	93.1%	94.4%
MTF	66.0	59.7	62.7	60.3
Purchased Care	87.3	91.3	93.2	94.4
National	84.0	91.0	93.0	95.0

	2009	2010	2011	2012
HF–1 Heart Failure Patients Given Discharge Instructions				
DoD	86.8%	90.0%	91.9%	92.9%
MTF	79.8	80.9	84.9	87.9
Purchased Care	86.8	90.0	91.9	93.0
National	80.0	90.0	91.0	93.0
HF–2 Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function				
DoD	97.8%	98.5%	98.9%	99.2%
MTF	95.6	96.7	97.5	97.9
Purchased Care	97.8	98.5	98.9	99.2
National	91.0	98.0	98.0	99.0
HF–3 Heart Failure Patients Given ACE Inhibitor or ARB for LVSD				
DoD	94.1%	95.3%	96.1%	96.7%
MTF	95.0	92.4	91.4	94.3
Purchased Care	94.1	95.3	96.1	96.8
National	90.0	95.0	95.0	97.0
HF–4 Heart Failure Patients Given Smoking-Cessation Advice/Counseling				
DoD	98.4%	99.0%	99.3%	Retired
MTF	86.0	92.5	91.5	Retired
Purchased Care	98.4	99.0	99.3	Retired
National	93.0	99.0	99.0	Retired

Heart Failure: All DoD heart failure measures continue to improve over time. DoD's performance is comparable to or higher than the national rate for HF–2 and slightly below the national rates for HF–1 and HF–3. The HF–4 measure, smoking-cessation counseling, was retired in 2012; however, smoking-cessation advice and counseling were moved to the tobacco treatment (TOB) measure.

DoD HOSPITAL QUALITY MEASURE: HEART FAILURE[b]



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 11/4/2013

[a] CMS Hospital Compare suspended reporting on AMI–1, AMI–3, and AMI–5 in Q1 2012. Both CMS and The Joint Commission retired AMI–4 in 2012.

[b] Both CMS and The Joint Commission retired HF–4 in 2012.

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

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

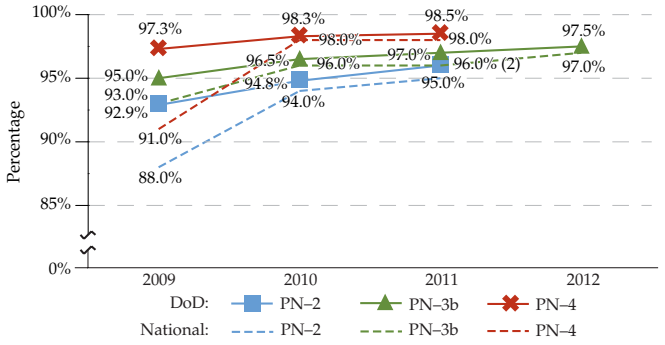
MHS Hospital Quality Measures—DoD Compared to National Civilian Hospital Compare and ORYX Data: FY 2009–FY 2012

	2009	2010	2011	2012
PN–2 Pneumonia Patients Assessed and Given Pneumococcal Vaccination				
DoD	92.9%	94.8%	96.0%	Retired
MTF	73.2	80.5	81.6	Retired
Purchased Care	93.0	94.9	96.1	Retired
National	88.0	94.0	95.0	Retired
PN–3b Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of the First Hospital Dose of Antibiotics				
DoD	95.0%	96.5%	97.0%	97.5%
MTF	85.0	90.6	91.6	94.0
Purchased Care	95.1	96.5	97.1	97.5
National	93.0	96.0	96.0	97.0
PN–4 Pneumonia Patients Given Smoking-Cessation Advice/Counseling				
DoD	97.3%	98.3%	98.5%	Retired
MTF	83.1	86.7	90.2	Retired
Purchased Care	97.4	98.3	98.5	Retired
National	91.0	98.0	98.0	Retired
PN–5c Pneumonia Patients Given Initial Antibiotic(s) within Six Hours after Arrival				
DoD	94.9%	96.0%	96.4%	Retired
MTF	89.3	91.2	93.3	Retired
Purchased Care	95.0	96.0	96.4	Retired
National	94.0	96.0	96.0	Retired
PN–6 Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s) PN6a+6b for ORYX				
DoD	91.9%	93.3%	95.2%	95.5%
MTF	91.9	92.4	93.1	94.9
Purchased Care	91.9	93.3	95.2	95.5
National	89.0	93.0	94.0	95.0

	2009	2010	2011	2012
SCIP Inf–1[b] Surgery Patients Who Were Given an Antibiotic at the Right Time (within One Hour before Surgery) to Help Prevent Infection				
DoD	96.3%	97.5%	98.1%	98.4%
MTF	88.4	92.9	95.5	96.3
Purchased Care	96.4	97.6	98.1	98.4
National	93.0	97.0	98.0	98.0
SCIP Inf–2[b] Surgery Patients Who Were Given the Right Kind of Antibiotic to Help Prevent Infection				
DoD	97.6%	97.8%	98.3%	98.6%
MTF	97.0	94.6	95.8	96.5
Purchased Care	97.6	97.8	98.4	98.6
National	95.0	98.0	98.0	99.0
SCIP Inf–3[b] Surgery Patients Whose Preventive Antibiotics Were Stopped at the Right Time (within 24 Hours after Surgery)				
DoD	93.5%	95.8%	96.8%	97.3%
MTF	91.6	94.2	94.6	96.1
Purchased Care	93.5	95.8	96.8	97.3
National	91.0	96.0	96.0	97.0
SCIP VTE–1[c] Surgery Patients Whose Doctors Ordered Treatments to Prevent Blood Clots after Certain Types of Surgeries				
DoD	93.5%	94.9%	97.3%	98.1%
MTF	93.8	92.6	95.1	96.2
Purchased Care	93.5	94.9	97.3	98.1
National	89.0	95.0	97.0	98.0

➤ **Pneumonia:** DoD performance on the pneumonia measure is consistent with the average performance across the nation. Though trending in a positive direction, the pneumonia measures provide a number of opportunities for MTFs to improve. CMS and The Joint Commission retired PN–2, PN–4, PN–5c, and PN–7 in 2012. Relevant pneumococcal and influenza vaccinations are captured in the immunization measure.

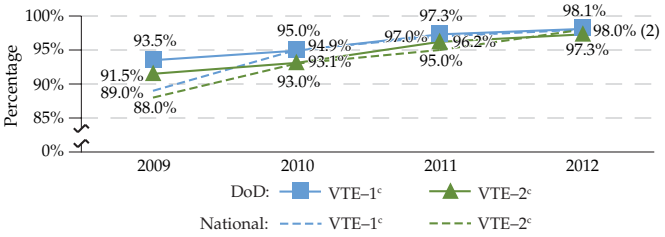
DoD HOSPITAL QUALITY MEASURE: PNEUMONIA[a]



	2009	2010	2011	2012
PN–7 Pneumonia Patients Assessed and Given Influenza Vaccination				
DoD	90.2%	92.5%	94.1%	Retired
MTF	65.4	75.1	75.4	Retired
Purchased Care	90.5	92.6	94.3	Retired
National	86.0	91.0	93.0	Retired

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

DoD HOSPITAL QUALITY MEASURE: SCIP–VTE

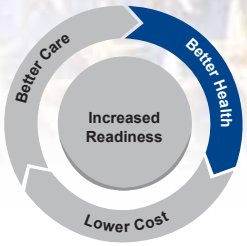


	2009	2010	2011	2012
SCIP VTE–2[c] Patients Who Got Treatment at the Right Time (within 24 Hours before or after Their Surgery) to Help Prevent Blood Clots after Certain Types of Surgery				
DoD	91.5%	93.1%	96.2%	97.3%
MTF	92.5	91.9	94.3	95.1
Purchased Care	91.5	93.1	96.2	97.3
National	88.0	93.0	95.0	98.0

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 11/4/2013

[a] Both CMS and The Joint Commission retired PN–2, PN–4, PN–5c, and PN–7 in 2012.
[b] Surgical Care Improvement Project—Infection
[c] Surgical Care Improvement Project—Venous Thromboembolism Prophylaxis
Note: For visual display, numbers in parentheses on the graphs indicate the number of overlapping data points.

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES



This section presents Military Health System (MHS) efforts to move "from health care to health" by removing generators of ill-health through encouraging healthy behaviors and focused prevention and the development of increased resilience.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS

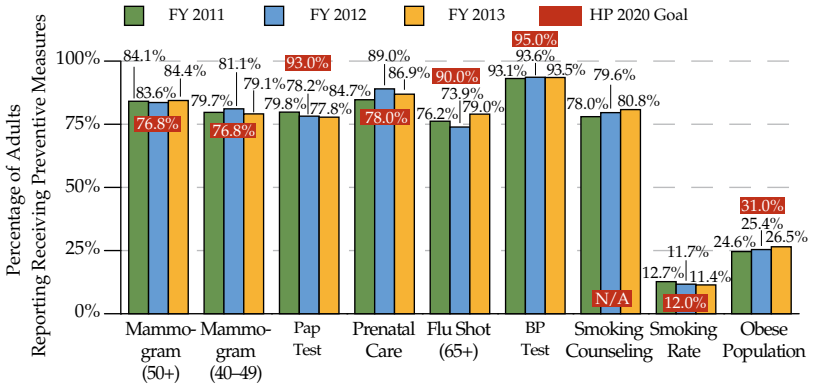
The Healthy People (HP) 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats. The National Prevention Strategy is America's plan for better health and wellness. Both initiatives have shaped the Department of Defense's (DoD's) prevention strategy, which addresses four strategic directions, including coordinating clinical and community prevention services, empowering beneficiaries, creating healthier communities, and eliminating health disparities.

Based on the findings of the annually reported Health Care Survey of DoD Beneficiaries (HCSDB) through 2012 and the Department of Defense Health Related Behaviors Survey of Active Duty Military Personnel (HRB), DoD launched Operation Live Well in 2013. This initiative brings together the resources and capabilities of the entire military community to focus on the best ways to promote health and wellness for all beneficiaries. A major focus will be on increasing MHS's ability to measure the impact of prevention activities, with a specific focus on weight management and tobacco cessation.

These strategic goals go beyond restorative care and speak to the opportunity to influence population health within MHS and across DoD. The chart below reflects self-reported responses from all eligible MHS beneficiaries within the categories below (e.g., all adult women for mammography, all adult pregnant women for prenatal care, etc.).

- MHS has set as goals a subset of the health-promotion and disease-prevention objectives specified by the Department of Health and Human Services (DHHS) in HP 2020. Over the past three years, MHS has exceeded targeted HP 2020 goals in providing mammograms (for women ages 40–49 years as well as those age 50+) and prenatal care (see note below).
- Efforts continue toward achieving HP 2020 standards for Pap smears and blood pressure screenings.
- **Tobacco Use:** This area continues to be monitored in the absence of specified HP standards. The overall self-reported smoking rate among all MHS beneficiaries decreased from 12.7 percent in FY 2011 to 11.4 percent in FY 2013, reaching more than half a percentage point below the HP 2020 goal of 12 percent. Smoking-cessation counseling has increased by nearly 3 percentage points since FY 2011, to almost 81 percent in FY 2013.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese increased by almost two percentage points from 24.6 percent in FY 2011 to 26.5 percent in FY 2013, below the HP 2020 goal of 31 percent (see note below) and below the most recently identified U.S. population average of 36 percent (not shown). See other charts in the following pages, which distinguish obesity rates by beneficiary category.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2011 TO FY 2013



Source: 2013 Annual (Adult Beneficiary) HCSDB, the NCBD *http://www.tricare.mil/survey/hcsurvey/2013/bene/fy2013/html/p9-0-11-0.htm* and the National Health and Nutrition Examination Survey (NHANES); Centers for Disease Control and Prevention, National Center for Health Statistics (CDC/NCHS) *http://www.healthypeople.gov/2020/Data/SearchResult.aspx?topicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141*

Note: Unlike the objective for all other categories, the objective for Smoking Rate and Obese Population is for actual rates to be below the HP 2020 goals.

The goal for Prenatal Care was revised down from 90 percent in the HP 2010 goals to 78 percent in the HP 2020 goals.

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

MHS-TARGETED PREVENTIVE CARE MEASURES

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

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

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

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

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

Obese: Obesity is defined as a Body Mass Index (BMI) of 30 or above, which is calculated from self-reported data from the HCSDB. An individual's BMI is calculated using height and weight (BMI = 703 times weight in pounds, divided by height in inches squared). While BMI is a risk measure, it does not measure actual body fat; as such, it provides a preliminary indicator of possible excess weight, which in turn provides a preliminary indicator of risk associated with excess weight. It should therefore be used in conjunction with other assessments of overall health and body fat.

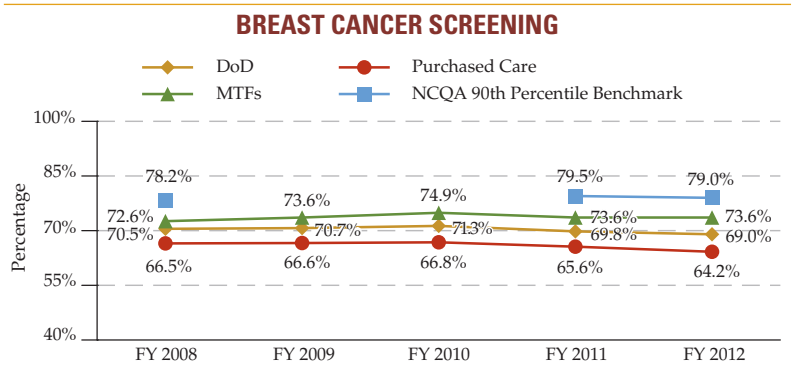
Smoking-Cessation Counseling: People advised to quit smoking in the last 12 months.

HEDIS MEASURES FOR THE MHS 2008–2012

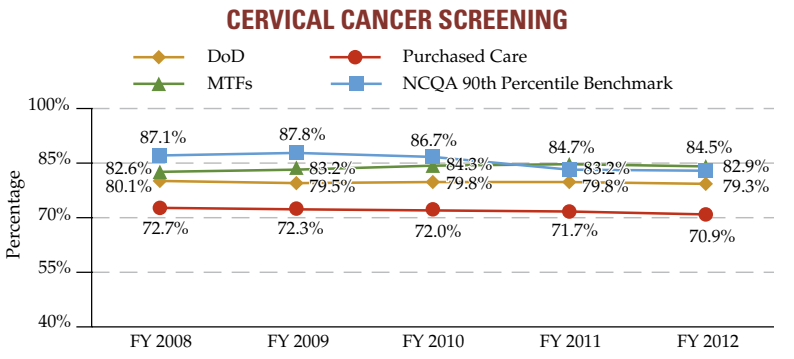
MHS collects health plan measures using the Healthcare Effectiveness Data and Information Set (HEDIS) methodologies. HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Altogether, HEDIS consists of 75 measures across eight domains of care. With so many plans collecting HEDIS data and because the measures are so specifically defined, HEDIS makes it possible to compare the performance of health plans on an "apples-to-apples" basis. The Defense Health Agency (DHA) Tri-Service Clinical Measures Steering Panel (CMSP) selects measures for development on an annual basis. The Population Health Portal, supported by the Air Force Medical Support Agency (AFMSA), maintains data and reports these measures for all of the Services and for the regional managed care support contractors (MCSCs). There are currently 24 measures available for military treatment facilities (MTFs) derived from administrative and Armed Forces Health Longitudinal Technology Application (AHLTA) data and six measures available for purchased care derived from administrative data sources. Other measures are under development to support the Healthy Base Initiative, Disease Management, and Patient-Centered Medical Home (PCMH) programs. The MHS collects and trends metrics for antidepressant medications; asthma care; breast, cervical, and colorectal cancer screening; diabetic management; follow-up after hospitalization for mental illness; well-child care; and use of imaging studies for lower back pain. The available data can be compared to the National Committee for Quality Assurance (NCQA) annual benchmark results. The HEDIS methodologies used by the Portal to calculate HEDIS measures have been reviewed for the past three years by an NCQA HEDIS auditor to validate that the portal methodology is appropriately implemented.

- HEDIS performance is monitored quarterly through the CMSP, with discussion of Service or contractor efforts to improve performance on particular measures. Pay-for-performance programs in the Services encourage MTF compliance with measures. There are also specific clinical incentives in the managed care support contracts that encourage performance improvement on select measures and are evaluated annually.
- There have been concerns raised in the last three years regarding the United States Preventive Services Task Force (USPSTF) recommendations for breast and cervical cancer screening. The recommendations have been reviewed and updated to reflect current evidence-based practice. These changes will make trending of the data difficult for the near future.
- Other methods of engaging patients and families are under consideration to improve compliance with these important clinical service screening and care management recommendations.

- **Breast Cancer Screening:** The MHS (DoD) rate has remained stable over the past five years, and unchanged relative to the NCQA 90th percentile benchmark. For the past two years, there has been some controversy about when mammography is appropriate and the appropriate interval for completing the screening. The NCQA is going to revise the HEDIS specification in the coming year to reflect new guidelines.



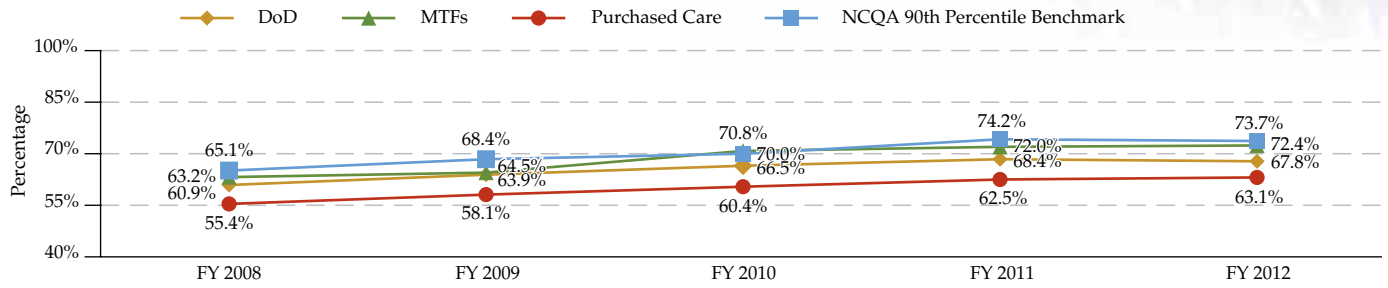
- **Cervical Cancer Screening:** MHS rates have been relatively stable over the past five years, while the NCQA rate appears to have declined. Similar to breast cancer screening guidelines, the cervical cancer screening guidelines are also changing. Discussion of changing the type of testing recommended and the frequency may have already influenced practices. NCQA will be revising the specifications for cervical cancer screening in the coming year.



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 11/4/2013

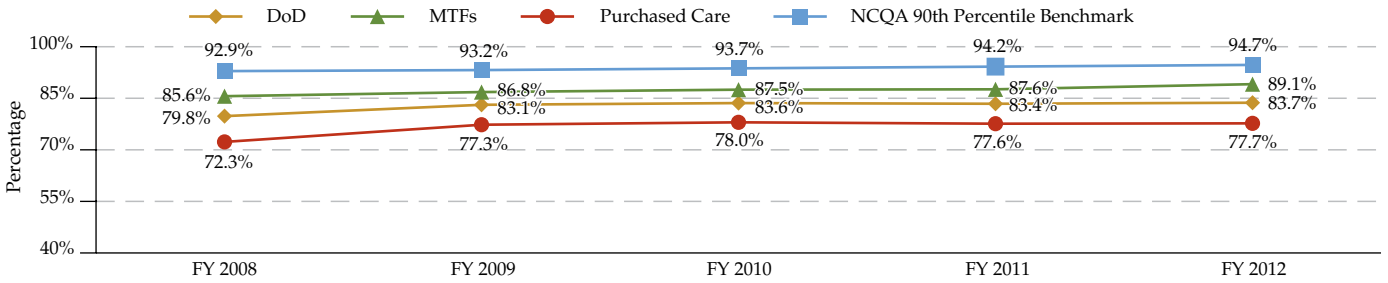
HEDIS MEASURES FOR THE MHS 2008–2012 *(CONT'D)*

COLORECTAL CANCER SCREENING

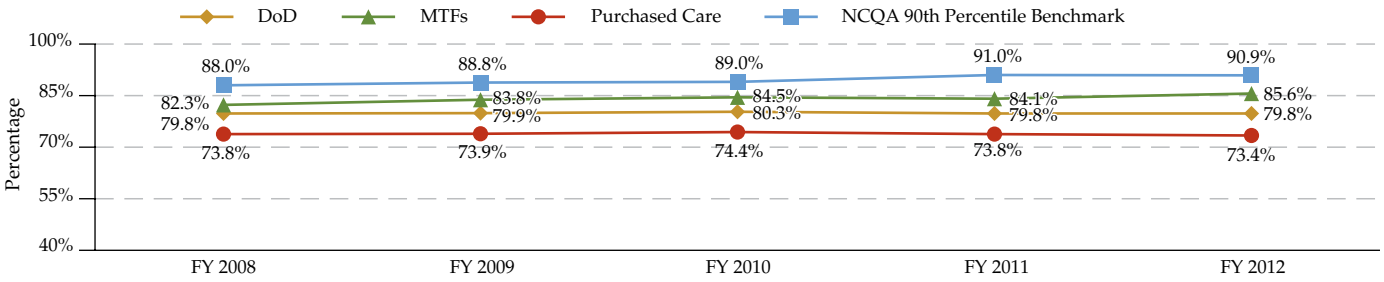


➤ **Colorectal Cancer Screening:** The MHS is making some progress in colorectal cancer screening; although our rates are improving, they still lag the NCQA 90th percentile.

DIABETES HBA1C SCREENING

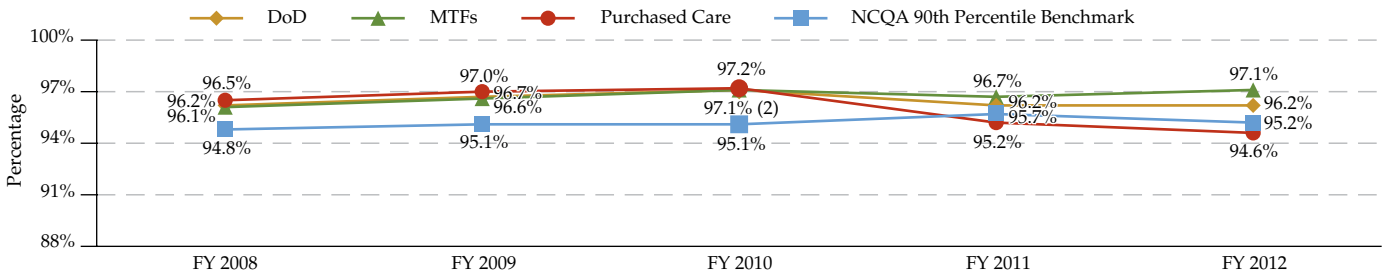


DIABETES LDL SCREENING



➤ **Diabetes HbA1c and LDL Screening:** Only screening for HbA1c and LDL are presented here, because these rates are determined from administrative data only. The MHS continues to work to improve diabetic management.

ASTHMA APPROPRIATE MEDICATIONS



➤ **Asthma Appropriate Medications:** DoD adherence to guidelines for appropriate medications for asthma exceeds the HEDIS 90th percentile.

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 11/4/2013

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

POPULATION HEALTH

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

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

TOBACCO CESSATION

DoD continues to focus on both preventing and mitigating the impact of tobacco use among military personnel. Having observed increased rates of tobacco use among junior Active Duty military personnel, DoD implemented an educational campaign as a key component in helping Service members quit using tobacco and lead healthier lives overall.

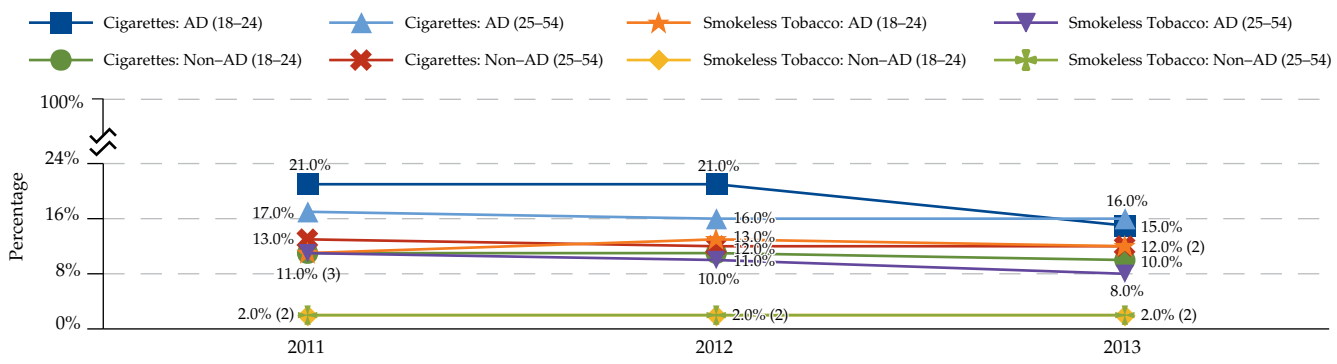
MHS is optimizing tobacco-cessation services through the implementation of the Smoking Cessation Program under TRICARE, which includes the availability of pharmaceutical benefits and smoking-cessation counseling. MHS efforts focus on increasing access to barrier-free nicotine replacement therapy and cessation-support services.

Access to online and print tobacco-cessation material is available through the "Quit Tobacco—Make Everyone Proud" campaign, an initiative informed by extensive research and testing that was launched by TRICARE Management Activity (TMA) in 2006. Campaign goals include increasing awareness of tobacco's negative social and physical effects and decreasing its acceptance and use throughout the military work environment. The campaign is designed to motivate tobacco users who want to quit and is aimed at E1–E4 personnel ages 18 to 24—the age demographic with the highest rates of tobacco usage in the military. The campaign includes a multimedia Web site, a turnkey implementation plan and schedule for installation of project officers, centrally funded promotional materials, and centralized support for special events. On the Web site, *www.ucanquit2.org*, a 24/7 instant messaging chat line was named the best quit-smoking blog of 2013 by Healthline. It is staffed by trained coaches/mentors who can help participants identify quitting resources and design a customizable quit plan online.

MHS continues to support tobacco-free living through working with the Military Services to encourage tobacco-free campus policies for MTFs.

- **Active Duty and Family Member Cigarette Smoking and Smokeless Tobacco Use:** The chart below shows that, relative to the other categories, self-reported cigarette use among the younger Active Duty Service members (ages 18 to 24) has historically been higher than other beneficiary categories, but by 2013 may have declined to levels similar to older Active Duty members (about 15–16 percent in 2013). Smokeless tobacco rates have been stable for each beneficiary group, with family members least likely to use this form of tobacco.

MHS CIGARETTE AND SMOKELESS TOBACCO USE RATES AMONG ACTIVE DUTY AND THEIR FAMILY MEMBERS



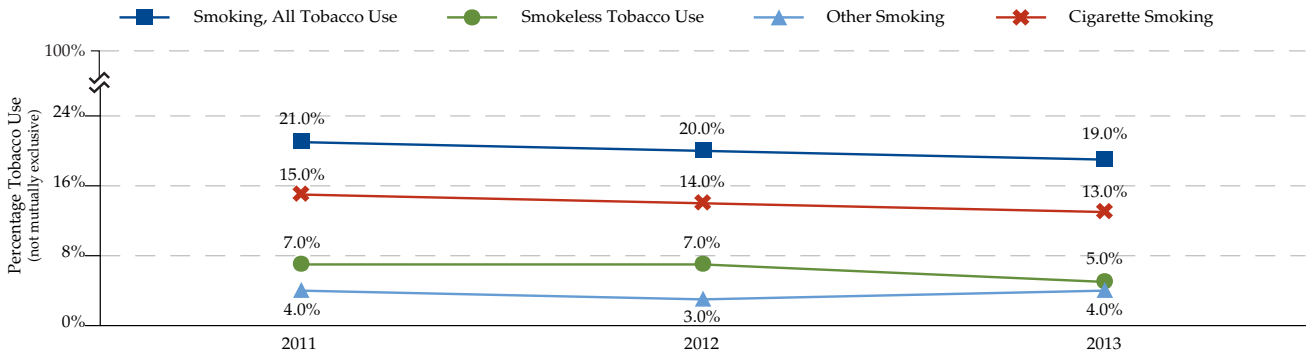
Source: Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]) DHA/Defense Health Cost Assessment and Program Evaluation (DHCAPE) survey, data provided 11/25/2013

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

TOBACCO CESSATION *(CONT'D)*

➤ **MHS Prime Enrollee Use of Any Tobacco Products:** While attention has historically been focused on cigarette smoking, the HCSDB has also been directed to assess the use of various tobacco products across MHS. The chart below presents the self-reported estimates of the prevalence of MHS Prime enrollees using different tobacco products. Prime enrollees include all Active Duty and TRICARE Prime enrolled family members and retirees and their family members under age 65. As the chart indicates, about one-fifth of all Prime enrollees use tobacco in one form or another, but usage of any tobacco product appears to have declined by about 2 percent in the past three years. Cigarette smoking rates dominate among the type of tobacco used. The usages of various tobacco products shown in the chart are not mutually exclusive (e.g., a cigarette smoker can also report being a snuff user [smokeless tobacco] or a pipe smoker [alternate smoking tobacco]) and thus are not additive.

MHS PRIME ENROLLEE USE OF TOBACCO PRODUCTS, BY TYPE OF TOBACCO USE: CIGARETTES, ALTERNATE SMOKING TOBACCO, AND SMOKELESS TOBACCO



Source: OASD(HA) DHA/DHCAPE survey, data provided 11/25/2013

Note: Smokeless tobacco may include dip, snuff, snuss, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks. Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

ALCOHOL-REDUCTION MARKETING AND EDUCATION CAMPAIGN

Current strategies to prevent alcohol problems among military personnel include instituting and enforcing policies that regulate alcohol availability and pricing, deglamorizing alcohol use, and promoting personal responsibility and good health.

After extensive research and testing, TMA launched "That Guy" in December 2006 as an integrated marketing campaign targeting military enlisted personnel ages 18 to 24 across all branches of service. Guided by the results of research, the campaign leverages a multimedia, peer-to-peer social-marketing approach for this age group to increase awareness of the negative, short-term social consequences of excessive drinking, thereby promoting peer disapproval of excessive drinking, and leading to reduced binge drinking. This campaign includes an award-winning Web site (*www.thatguy.com*), online and offline public service announcements, social media channels (e.g., Facebook and YouTube), a mobile site and game app, funded and pro bono billboard and print advertising, a turnkey implementation plan and schedule for installation project officers, centrally funded promotional materials, and centralized support for special events. In its seventh year, the That Guy campaign also has recently released a smartphone-compatible version of its Web site and created additional focus groups to inform the campaign going forward.

Installation leaders consistently support campaign efforts, as they believe alcohol-related incidents have a negative impact on readiness. To date, more than 800 locations (e.g., aircraft carriers, ships, submarines, and installations) are involved in the campaign in 47 states and 23 countries.

Analysis conducted by Fleishman-Hillard of the 2008 HRB shows that rates at installations actively implementing That Guy are lower than the rates of their counterparts: the binge drinking at Army installations that were actively implementing That Guy was 36 percent, versus 56 percent at installations that did not have an active program.

DISEASE MANAGEMENT

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

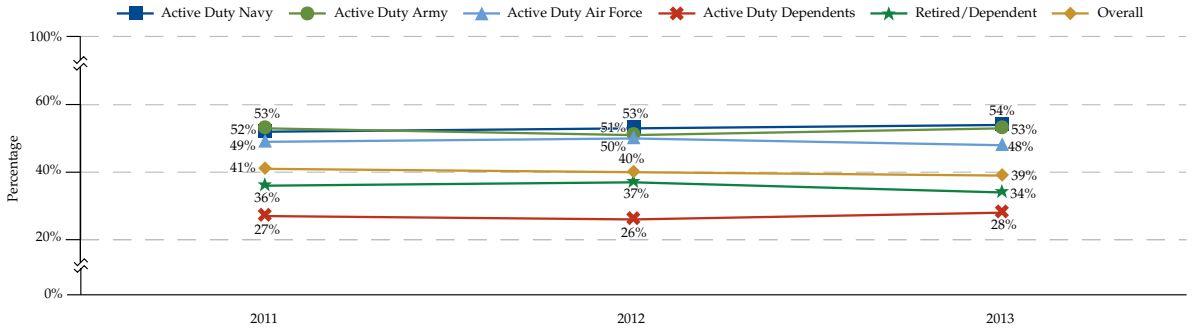
MHS ADULT OBESITY

This measure provides important information about the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. These data also can shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

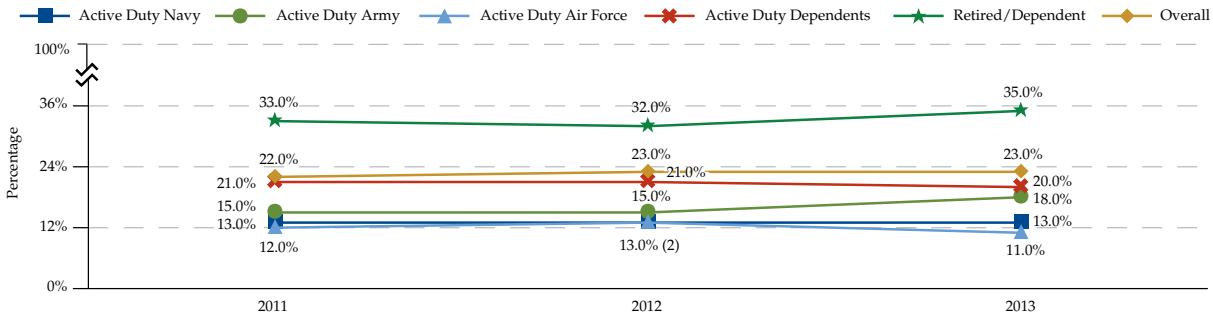
The chart below displays the percentage of the population reporting in the HCSDB a height and weight that, when used in calculating body mass index (BMI), result in a measurement of 30 or higher (30 is the threshold for obesity).

- As shown in the first chart below, 34 percent of retirees and their family members are overweight at a rate comparable to the U.S. overall rate (34 percent). Active Duty family members (ADFMs) appear to have the lowest rate of being overweight, but still represent over one-fourth of that population. Calculated BMI rates reflecting overweightness may not be reflective of Active Duty fitness without consideration of muscle mass, and may explain why Active Duty appears to have high prevalence rates of overweightness, but low obesity rates as shown in the second chart.
- The second chart displays the prevalence of obesity in the MHS population, with Active Duty presenting the lowest rates and well below the National Health and Nutrition Examination Survey (NHANES) rate of 32 percent for 18- to 42-year-olds. Retiree rates appear slightly lower than or similar to the national rate of 38 percent for adults ages 43 to 64 years and 37 percent of adults 65 and over.

MHS OVERWEIGHT RATE (BMI 25–29.9)



MHS OBESITY RATE (BMI 30 OR HIGHER)



Source: HCSDB, data provided 11/12/2013

Note: BMI is defined as the individual's body weight divided by the square of his or her height. The formula universally used in medicine produces a unit of measure of kg/m^2. Because the HCSDB collects height and weight in inches and pounds, BMI is calculated as $lb/in^2 \times 703$. A BMI of 18.5 to 25 may indicate optimal weight; a BMI lower than 18.5 suggests the person is underweight, while a number above 25 may indicate the person is overweight; a number of 30 or above suggests the person is obese (Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion, CDC).
Since the data are self-reported, they are subject to recall bias, while provider measurements are subject to instrument error (lack of calibration of weight scales) and inconsistency in recording (e.g., asking patient's height or weight versus measuring). Self-reported scores are adjusted for user characteristics that allow comparison to civilian benchmarks. No objective validation tool is used to verify accuracy of BMI results.

In an effort to capture objective data on obesity prevalence among the MHS population, an MHS guideline was developed to support the documentation of BMI with all Direct Care patient encounters. This documentation is intended to support the capture of information concerning the overall health of DoD beneficiaries for use by MHS leadership to help promote military initiatives that encourage exercise and healthy nutritional habits. The data also can shape the need for, and development of, medical interventions or modalities that are effective in maintaining healthy weights for all age groups.

PREVALENCE OF MHS BENEFICIARIES WITH CHRONIC MEDICAL CONDITIONS

MHS Chronic Conditions FY 2013

Many TRICARE beneficiaries of all ages suffer with chronic conditions, which may result in poor health outcomes and high health care utilization and costs. This section presents, for the first time in this annual evaluation report, rates of chronic condition diagnoses within the MHS population. This information offers policy makers a better understanding of the burden of chronic conditions among the military population, and provides preliminary insights into possible targets for prevention and management strategies to improve care, its coordination, and the quality of life and health of the MHS population, while potentially reducing costs through effective care management.

Methods: In order to provide some relevance to these statistics, the chronic conditions presented here are consistent with a set of 25 select chronic conditions reported by the Centers for Medicare and Medicaid Services (CMS) Chronic Condition Data Warehouse (CCW). All unique MHS beneficiaries alive, eligible, and in the U.S. during FY 2013 were included. Beneficiaries overseas for the full year were excluded. Beneficiaries were classified as "chronic" under two conditions: first, if they received a flag for a chronic medical condition following application of the Chronic Condition Indicator (CCI) for a given medical condition; and, second, if they had a minimum of: (a) two outpatient visits within the FY with the same "chronic" classified medical condition, and/or (b) one inpatient admission for the given "chronic" classified medical condition. Over 14,000 ICD-9 diagnosis codes were aggregated into 61 medical conditions. Although the CCI is applied at the ICD-9 level, chronic conditions were uniquely assigned within a given medical condition. Where medical conditions contained both chronic and nonchronic elements, we only report rates corresponding to the chronic condition component.

Population Characteristics

The table on the next page presents descriptive statistics of chronic conditions as reported by CMS compared with three different MHS populations of interest: (1) all MHS users, (2) MHS users ages 65 and older, and (3) MHS ADFM users. MHS usage combines care rendered in MTFs as well as in civilian facilities reimbursed by TRICARE, as recorded in health care claims. Comparative statistics are provided for the Medicare population from 2011, which is the most current available data. All numbers represent proportions of the population diagnosed with a given chronic condition. In some cases, there is not a direct match between Medicare-reported conditions and those developed for the MHS population. We provide the best comparison possible when those situations occur. Although hip fractures are not considered a chronic condition by the Agency for Healthcare Research and Quality (AHRQ), we calculated them as such for comparability to Medicare reported conditions.

- Two-thirds (64.9 percent) of MHS users ages 65 and older had one or more chronic conditions in FY 2013, compared with one-third (33.7 percent, or 2,793,727 individuals) of all MHS users and one-fifth (21.6 percent) of the ADFM user population.
- Prevalence rates in the MHS beneficiary population for Medicare CCW chronic conditions are much lower than for Medicare enrollees. The first column of percentages in the table on the next page reflects the prevalence of chronic conditions within the Medicare population in 2011 in descending order. Hypertension is present in more than half (58 percent) of the Medicare user population, far higher than the prevalence of hypertension in MHS user beneficiaries in the same age category (about 12 percent), with all MHS users (including all retirees under and over age 65, as well as Active Duty and family members) far less, at about 4 percent, and ADFMs at less than 1 percent.
- Overall, the MHS beneficiary population age 65 and over appears healthier than comparable Medicare enrollees, with the most prevalent Medicare CCW conditions being hypertension (11.7 percent MHS 65+, 58 percent Medicare enrollees), diabetes (10.4 percent MHS 65+, 28 percent Medicare enrollees), and cataracts (12.1 percent MHS 65+, 19 percent Medicare enrollees). MHS beneficiaries age 65 and over also had relatively high prevalence of eye problems (9.7 percent, no Medicare comparison data available).
- The ADFM population has very low prevalence rates for all Medicare CCW-reported conditions, with the highest prevalence rate (3.1 percent) for mood disorders (which includes depression) and attention deficit disorder (3.2 percent).
- An expanded analysis assessing the prevalence of a broader spectrum of chronic conditions reveals additional chronic conditions with higher prevalence in the TRICARE beneficiary population than Medicare's CCW chronic conditions. The proportional prevalence of the most common chronic conditions is presented at the bottom of the table on the next page. As there are no comparable Medicare data, those conditions are not reported in the Medicare column.

PREVALENCE OF MHS BENEFICIARIES WITH CHRONIC MEDICAL CONDITIONS *(CONT'D)*

Prevalence of Chronic Conditions in the MHS User Population Compared with Medicare Users

Medicare Chronic Condition	Medicare Enrollee Prevalence Rate, 2011	DHA CCS-Based Chronic Condition	MHS FY 2013		
			Age 65+	MHS Users	ADFM
Hypertension	58%	Hypertension	11.7%	3.9%	0.5%
Hyperlipidemia	46%	Hyperlipidemia	2.9%	1.2%	0.2%
Ischemic Heart Disease	31%	Ischemic Heart Disease	4.9%	1.2%	0.0%
Rheumatoid Arthritis/ Osteoarthritis	30%	Rheumatoid Arthritis/ Osteoarthritis	8.4%	3.0%	0.3%
Diabetes	28%	Diabetes	10.4%	3.7%	0.5%
Anemia	25%	Anemia	0.5%	0.1%	0.1%
Cataract	19%	Cataract	12.1%	3.0%	0.0%
Chronic Kidney Disease	16%	Chronic Kidney Disease	2.6%	0.7%	0.0%
Heart Failure	16%	Heart Failure	1.7%	0.4%	0.0%
Depression	15%	Mood Disorders	1.5%	2.7%	3.1%
Benign Prostatic Hyperplasia (BPH)	14%	BPH	3.8%	1.0%	0.0%
COPD and Bronchiectasis	12%	COPD	3.9%	1.0%	0.0%
Glaucoma	10%	Glaucoma	8.7%	2.5%	0.2%
Acquired Hypothyroidism	10%	Thyroid Disorders	1.8%	1.1%	0.9%
Atrial Fibrillation	8%	Cardiac Dysrhythmias	4.7%	1.2%	0.1%
Osteoporosis	7%	Osteoporosis	0.8%	0.2%	0.0%
Prostate Cancer	7%	Prostate Cancer	3.8%	0.9%	0.0%
Alzheimer's Disease and Related Disorders or Senile Dementia	5%	Alzheimer's Disease and Related	1.1%	0.3%	0.0%
Asthma	5%	Asthma	1.2%	1.0%	1.3%
Female/Male Breast Cancer	5%	Breast Cancer	2.2%	0.9%	0.1%
Stroke/Transient Ischemic Attack (TIA)	4%	Stroke/TIA	0.5%	0.1%	0.0%
Colorectal Cancer	1%	Colorectal Cancer	0.4%	0.1%	0.0%
Hip Pelvic Fracture	1%	Hip Fracture	0.5%	0.1%	0.0%
Lung Cancer	1%	Lung Cancer	0.7%	0.2%	0.0%
Endometrial Cancer	0%	Uterine Cancer	0.2%	0.1%	0.0%
		Additional MHS Chronic Conditions			
		Attention Deficit Disorder	0.0%	1.4%	3.2%
		Anxiety Disorders	0.5%	1.9%	2.1%
		Acute Bronchitis and URI	1.1%	1.2%	1.4%
		Adjustment Disorders	0.3%	1.9%	2.4%
		All Other Categories	1.7%	1.4%	0.5%
		Back Problems	3.8%	2.1%	0.5%
		Cancers	3.1%	1.0%	0.2%
		Cardiovascular	2.4%	0.6%	0.1%
		Cerebrovascular Disease	1.9%	0.5%	0.0%
		Developmental Disorders	0.0%	0.5%	1.5%
		Ear, Nose, Throat	1.4%	0.7%	0.6%
		Endocrine	1.9%	1.2%	0.8%
		Eye Problems	9.7%	2.7%	0.5%
		Gastrointestinal	3.0%	1.5%	0.8%
		Heart Conditions	2.5%	0.7%	0.1%
		Musculoskeletal	3.4%	1.7%	0.7%
		Neurologic Disorder	4.5%	2.9%	1.8%
		Reproductive	2.1%	1.8%	2.2%
		Skin	1.2%	0.4%	0.1%

- Reasons contributing to these lower rates of chronic conditions and an overall healthier population include: (1) a generally younger population of MHS users and ADFM than Medicare enrollees; (2) health-related screenings available to beneficiaries, which may identify conditions at earlier ages, resulting in healthier retirees and overall lower prevalence of chronic conditions; (3) health-related exclusions (e.g., fitness for duty criteria) for Active Duty, creating a healthier base population of which a portion would ultimately reach retirement eligibility; and (4) physical activity training for Active Duty, which may reduce rates of chronic conditions, such as obesity and diabetes, in Active Duty and in retirees. Additionally, MHS beneficiaries using other health insurance not involving TRICARE (including TRICARE for Life and dual-eligible TRICARE-Medicare beneficiaries receiving care not involving claims with TRICARE) may result in under-reporting of prevalence rates. Finally, methodological differences in the research contribute to differences in reported prevalence rates.

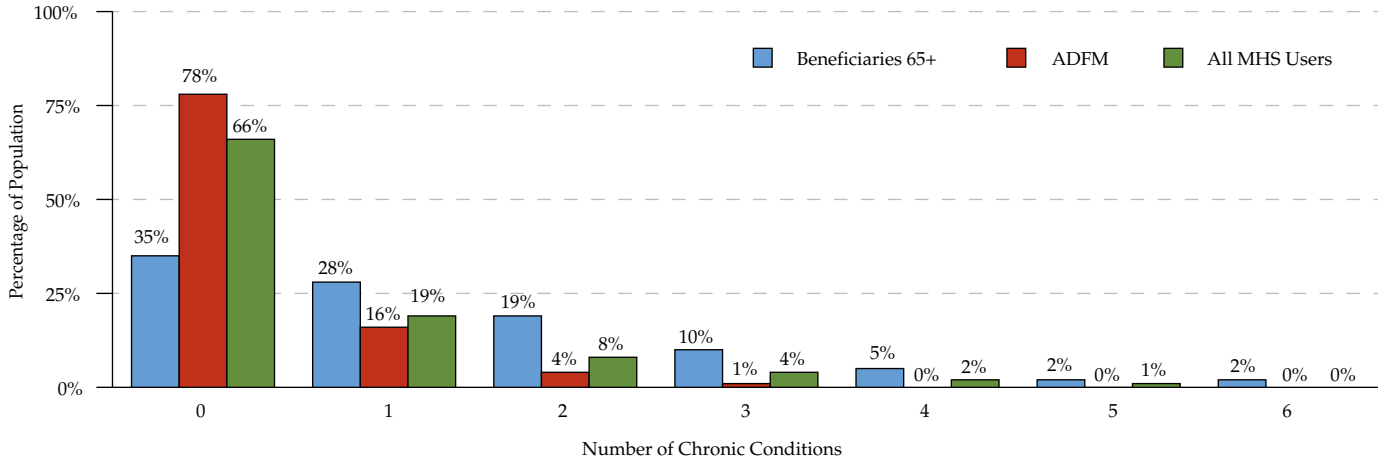
Sources: DHA, DHCAPE, and MHS administrative data sources, 12/10/2013. MHS data were derived from the Standard Ambulatory Data Record (SADR)/ Comprehensive Ambulatory/Professional Encounter Record (CAPER), Standard Inpatient Data Record (SIDR), TRICARE Encounter Data-Institutional (TED-I)/ TED-Noninstitutional (-NI), Pharmacy Data Transaction Service (PDTS), Ancillary (Laboratory/Radiology), and Defense Enrollment Eligibility Reporting System (DEERS) VM6 PITE representing directly provided and purchased inpatient, ambulatory, pharmacy, and ancillary care linked to enrollment and eligibility records. MHS user prevalence rates for breast cancer and uterine cancer are based on the female portion of the population only. MHS user prevalence rates for prostate cancer and benign prostatic hypertrophy are based on the male portion of the population only. Medicare prevalence data from "Medicare—CCW Condition Period Prevalence—2011" report. Source data from CCW. Medicare Beneficiary Summary Files, *http://www.ccwdata.org/business-intelligence/chronic-conditions/index.htm*; Reference period used to calculate Medicare CCW condition prevalence, other than a one-year period are: Alzheimer's disease and related disorders or senile dementia (three years); chronic kidney disease (two years); diabetes (two years); heart failure (two years); ischemic heart disease (two years); and Rheumatoid Arthritis/Osteoarthritis (two years).

PREVALENCE OF MHS BENEFICIARIES WITH CHRONIC MEDICAL CONDITIONS *(CONT'D)*

Prevalence of Co-morbid Chronic Conditions: The prevalence of co-morbid chronic conditions among the three MHS user populations (all, ages 65 and older, and ADFMs) is presented in the chart below.

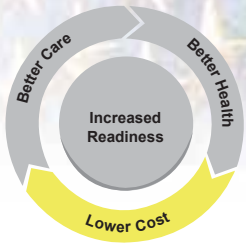
- Clearly over half of ADFMs and all MHS users do not have a chronic condition as classified by AHRQ, while about one-third of beneficiaries ages 65 and over do not. However, approximately one-fifth of the various population groups have at least one condition, while a decreasing proportion has two or more conditions. Beneficiaries ages 65 and over have the highest rates of chronic and co-morbid chronic conditions of the three MHS user populations.

DISTRIBUTION OF NUMBER OF CHRONIC CONDITIONS, BY PROPORTION OF POPULATION AFFECTED, FY 2013



Source: DHA, DHCAPE, and MHS administrative data sources, 12/10/2013
Note: Percentages do not sum to 100 percent due to rounding.

SAVINGS AND RECOVERIES



Pharmacy Retail Refunds

With the District Court's decision that the Department of Defense (DoD) has the authority to require refunds from manufacturers going back to January 29, 2008, affirmed by U.S. Court of Appeals on January 4, 2013, the Defense Health Agency (DHA) produced retroactive refunds for fiscal year (FY) 2008 Q2 through FY 2009 Q3 during FY 2012, along with continuing to routinely bill quarterly refunds. Due to enhancements in the Retail Refund Calculation process and improvements in communication of eligible products among manufacturers, the Department of Veterans Affairs (VA), and DoD, utilization data/refund recalculations are being performed to ensure accuracy of the data reported to manufacturers, as well as refunds due to DoD, since the inception of the Final Rule.

PHARMACY RETAIL REFUNDS ($ MILLIONS)

	FY 2011	FY 2012	FY 2013
Total Receivables	$1,564.80	$3,070.20	$1,446.70
Routine	$1,564.80	$1,436.00	$1,384.90
Retroactive (FY 2008 Q2–FY 2009 Q3)	—	$1,634.20	—
Additional from Recalculations (FY 2009 Q4–FY 2010 Q3)	—	—	$61.80
Total Collections	$1,817.30	$1,517.10	$1,348.10

Source: Defense Health Cost Assessment and Program Evaluation (DHCAPE) and CRM, 1/16/2014

Notes: Refund amounts are netted out of pharmacy costs provided within this report. FY 2010 Q4 through FY 2012 Q1 are being recalculated in FY 2014 and currently have $39.5 million additional refund to be applied to FY 2010 Q4 through FY 2011 Q2.

Program Integrity Activities

The DHA Program Integrity (PI) Office is responsible for all anti-fraud activities worldwide for the Defense Health Program. DHA PI executes policies and procedure regarding prevention, detection, investigation, and control of TRICARE fraud and abuse. In calendar year (CY) 2012, PI recovered $118.5 million in court ordered fraud judgments/settlements and $0.1 million in voluntary disclosures of overpayments from providers. The office monitors contractor PI activities, which identified $6.2 million in administrative recoupments. As an administrative remedy in preventing payment of questionable billing practices or fraudulent services, $16.2 million was saved by prepayment reviews of providers and beneficiaries.

PROGRAM INTEGRITY RECOVERIES/SAVINGS ($ MILLIONS)

	CY 2010	CY 2011	CY 2012
Recoveries	$104.6	$52.9	$124.8
Court-Ordered Fraud Judgments/Settlements	96.6	40.5	118.5
PI Contractors Administrative Recoupment (Identified)	8.0	12.2	6.2
Voluntary Disclosures of Overpayments	0.0	0.2	0.1
PI Contractors Prepayment Savings	$23.1	$22.3	$16.2

Source: TRICARE Program Integrity Operational Reports, CY 2009–CY 2012, 1/16/2014

Note: PI Contractors Administrative Recoupment amounts are based on what was identified. Thus, actual collection may be less than identified.

Claim Recoveries

The DHA is vigilant to ensure the accuracy of healthcare claims payment within the military health benefits program. In addition to post-payment claims payment accuracy reviews, the DHA also uses various internal manual and automated prepayment initiatives to prevent erroneous healthcare payments, which resulted in $19.5 million in FY 2013.

A post-payment duplicate claims system was developed by the DHA Healthcare Operations Directorate's TRICARE Health Plan Division, for use by TRICARE purchased care contractors. The system, designed as a retrospective auditing tool, facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. It has assisted in recovering $8.3 million.

RECOVERIES ($ MILLIONS)

	FY 2011	FY 2012	FY 2013
Improper Payments	$29.9	$18.8	$19.5
Post-Payment Duplicate Claims	$7.4	$8.6	$8.3

Source: Improper Payment Evaluation & Transition Section (IPE&TS), 1/16/2014

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks

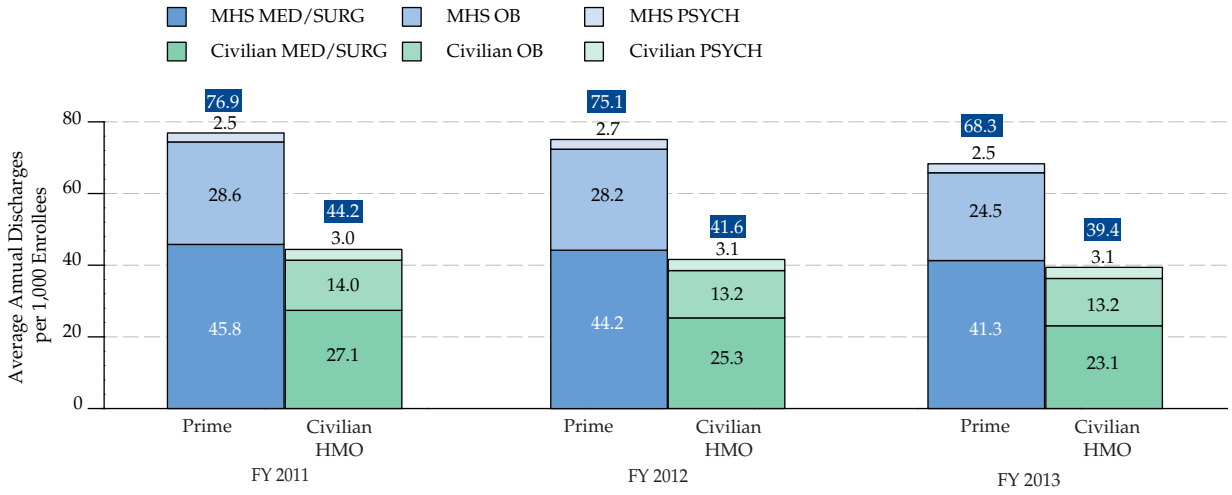
TRICARE Prime Enrollees

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

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

- Both the TRICARE Prime and civilian HMO inpatient utilization rates declined between FY 2011 and FY 2013. In FY 2013, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 73 percent higher than the civilian HMO utilization rate (68.3 discharges per 1,000 Prime enrollees compared with 39.4 per 1,000 civilian HMO enrollees).
- In FY 2013, the TRICARE Prime inpatient utilization rate was 79 percent higher than the civilian HMO rate for MED/SURG procedures, 85 percent higher for OB/GYN procedures, and 19 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) declined by 1 percent between FY 2011 and FY 2013, whereas the average LOS for civilian HMO enrollees declined by 4 percent. In FY 2013, the average LOS for MHS Prime enrollees was 6 percent lower than that of civilian HMO enrollees (not shown).

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

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

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks *(CONT'D)*

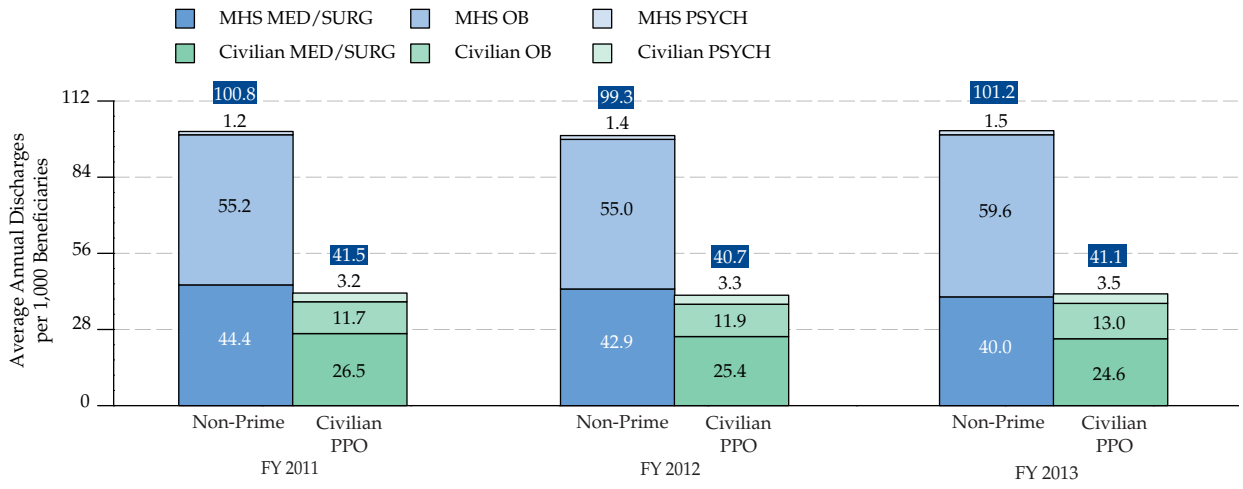
Non-Enrolled Beneficiaries

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

Dispositions are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG procedures—and compared for acute care facilities only. The comparisons exclude beneficiaries age 65 and older because very few are covered by employer-sponsored plans. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that between 15 and 20 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.

- Between FY 2011 and FY 2013, both the TRICARE non-Prime and civilian PPO inpatient utilization rates remained flat. In FY 2013, the inpatient utilization rate (direct and purchased care combined) for non-enrolled beneficiaries was more than double the rate for civilian PPO participants.
- By far the largest discrepancy in utilization rates between MHS and the private sector is for OB procedures. From FY 2011 to FY 2013, the MHS OB disposition rate increased by 8 percent, whereas it increased by 11 percent in the civilian sector. In FY 2013, the MHS OB disposition rate was almost five times as high as the corresponding civilian rate.
- Of the three product lines considered in this report, only PSYCH procedures had lower utilization in MHS than in the civilian sector.
- The average LOS for MHS non-enrolled beneficiaries (direct and purchased care combined) remained constant between FY 2011 and FY 2013, whereas the average LOS for civilian PPO participants declined by 5 percent. As a result, the average LOS for MHS non-Prime beneficiaries was 6 percent higher than that of civilian PPO participants in FY 2013, whereas they were about equal in FY 2011 (not shown).

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

– Numbers may not sum to bar totals due to rounding.

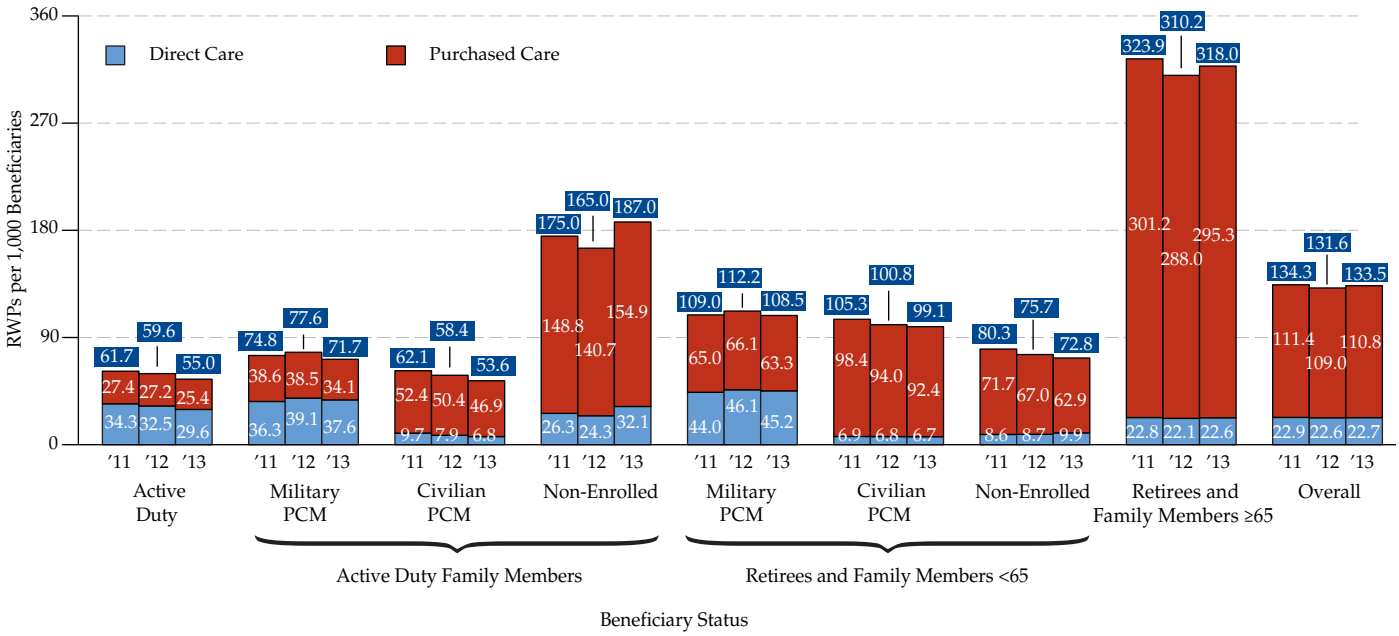
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita more accurately reflect differences across beneficiary groups than discharges per capita. However, RWPs are relevant only for acute care hospitals. In FY 2009, TRICARE implemented the Medicare Severity Diagnosis Related Group (MS-DRG) system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new DRG classifications resulted in a corresponding change in the calculation of RWPs, which has been applied to the data from FY 2011 to FY 2013.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) declined by less than 1 percent from FY 2011 to FY 2013.
- The direct care inpatient utilization rate declined by 1 percent overall, but there was a great deal of variation across beneficiary groups. Active Duty family members (ADFMs) with a civilian primary care manager (PCM) and AD members experienced large declines (30 percent and 14 percent, respectively), but non-enrolled beneficiaries experienced large increases (22 percent for ADFMs and 15 percent for retirees and family members [RETFMs]).
- Purchased acute care inpatient utilization rates decreased for all beneficiary groups except non-enrolled ADFMs (4 percent). ADFMs with a military PCM and non-enrolled RETFMs under age 65 experienced the largest declines (12 percent).
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE is second payer), the percentage of per capita inpatient workload performed in purchased care facilities remained constant at about 73 percent from FY 2011 to FY 2013.
- From FY 2011 to FY 2013, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) remained constant at about 53 percent from FY 2011 to FY 2013.

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



Source: MHS administrative data, 1/23/2014

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

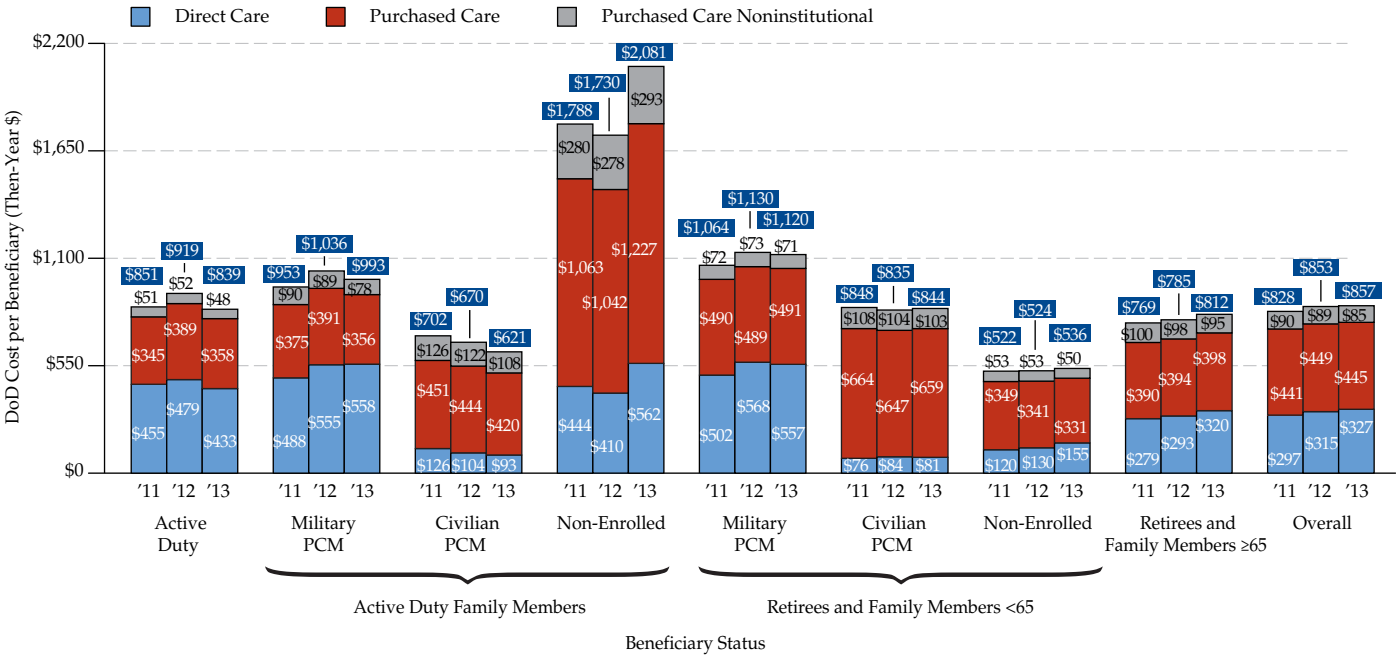
INPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Inpatient Cost by Beneficiary Status

MHS costs for inpatient care include costs incurred in both acute and non-acute care facilities. They also include the cost of inpatient professional services, i.e., noninstitutional charges (e.g., physician, lab, anesthesia) associated with a hospital stay. Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below), including TRICARE for Life (TFL), increased by 4 percent from FY 2011 to FY 2013. The increases were due largely to higher direct care costs.

- Non-enrolled ADFMs experienced the largest increase in MHS per capita inpatient cost of any beneficiary group (16 percent). Next in order were seniors, with a 6 percent increase. ADFMs with a civilian PCM experienced the largest decline (12 percent).
- The direct care cost per RWP increased from $12,968 in FY 2011 to $14,388 in FY 2013 (11 percent).
- Exclusive of TFL, the DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $7,093 in FY 2011 to $7,440 in FY 2013 (5 percent).
- The DoD purchased care cost per RWP is much lower than that for direct care because many beneficiaries using purchased care have other health insurance (OHI). When beneficiaries have OHI, TRICARE becomes second payer and the government pays a smaller share of the cost. If OHI claims are excluded, the DoD cost per RWP in acute care facilities was $8,692 in FY 2011 and $9,004 in FY 2013 (exclusive of TFL).

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/23/2014

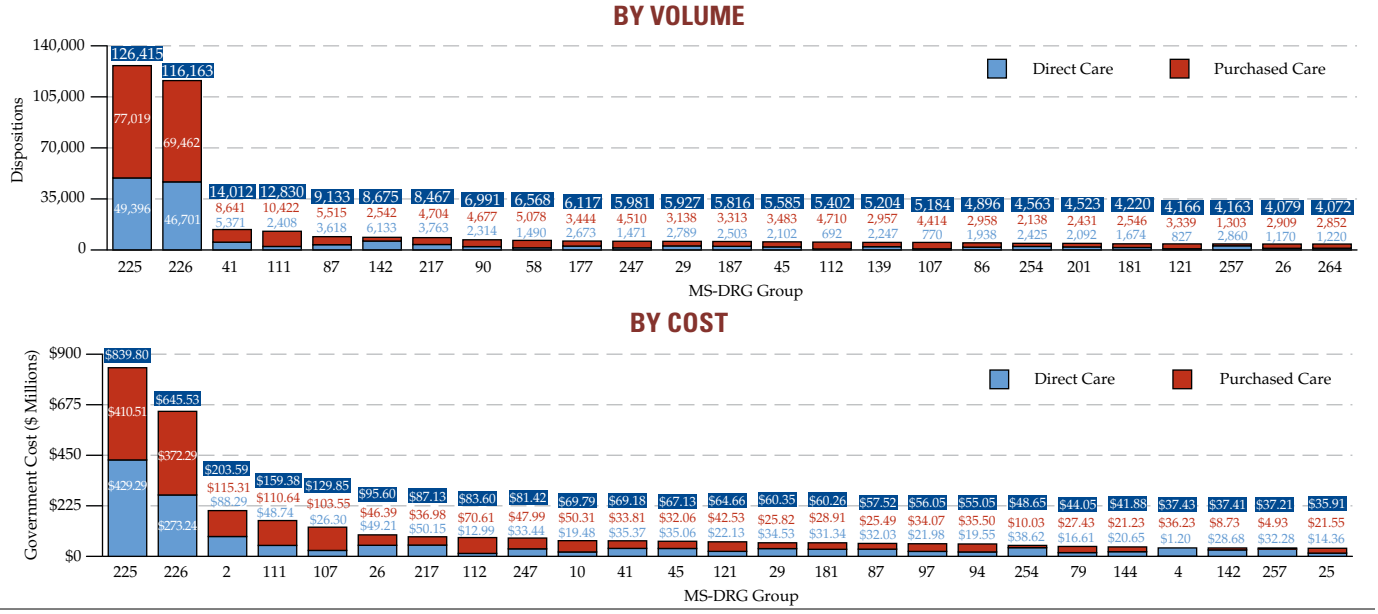
Note: Numbers may not sum to bar totals due to rounding.

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

Leading Inpatient Diagnosis Groups

In FY 2009, TRICARE implemented the MS-DRG system of classifying inpatient hospital cases to conform to changes made to the Medicare Prospective Payment System. The new system better captures variations in severity of illness and resource usage by reclassifying many diagnosis codes with regard to complication/co-morbidity (CC) status. For the purpose of this section, DRGs exhibiting variations in CC status were grouped into like categories[1] and numbered sequentially.

The top 25 MS-DRG groups in terms of volume in FY 2013 accounted for 67 percent of all inpatient admissions (direct care and purchased care combined) in acute care hospitals. The leading DRG groups in terms of cost in FY 2013 include both institutional and noninstitutional claims; i.e., they include hospital, attendant physician, laboratory, drug, and ancillary service charges. The top 25 DRG groups in terms of cost in FY 2013 accounted for 58 percent of total inpatient costs (direct and purchased care combined) in acute care hospitals. TFL admissions are excluded from the calculations for both volume and cost.



Source: MHS administrative data, 1/23/2014

MS-DRG Groups

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

- The top two procedures by volume are related to childbirth, accounting for 42 percent of all hospital admissions and 27 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 61 percent of the total volume of the top 25 DRG groups but only 55 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only three of the top 25 DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 11 of the top 25 DRG groups.
- Surgical procedures for obesity rank 21st in volume and 15th in cost among the top 25 DRG groups. Thus, the obesity epidemic in the civilian sector appears to be mirrored to an extent in the DoD population as well.

[1] DRGs were grouped into like categories using a code set available on *www.FindACode.com*, an online database of medical billing codes and information.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

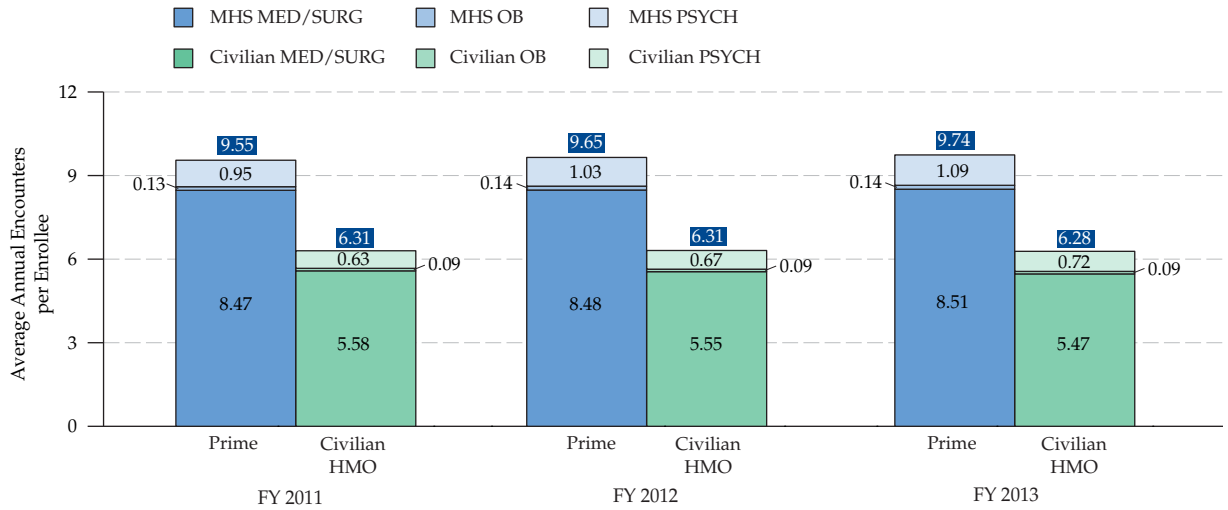
TRICARE Prime Enrollees

This section compares the outpatient utilization of TRICARE Prime enrollees with that of enrollees in civilian employer-sponsored HMO plans. Outpatient utilization is measured in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of relative value units (RVUs). However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

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

- The overall TRICARE Prime outpatient utilization rate (direct and purchased care combined) rose by 2 percent between FY 2011 and FY 2013. The civilian HMO outpatient utilization rate remained essentially unchanged over the same period.
- In FY 2013, the overall Prime outpatient utilization rate was more than 50 percent higher than the civilian HMO rate.
- In FY 2013, the Prime outpatient utilization rate for MED/SURG procedures was 55 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was 50 percent higher than the corresponding rate for civilian HMOs in FY 2013, but that is due in part to how the direct care system records bundled services.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 52 percent higher than the corresponding rate for civilian HMOs in FY 2013. 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 (ADSMs) and their families endure.

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

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

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks *(CONT'D)*

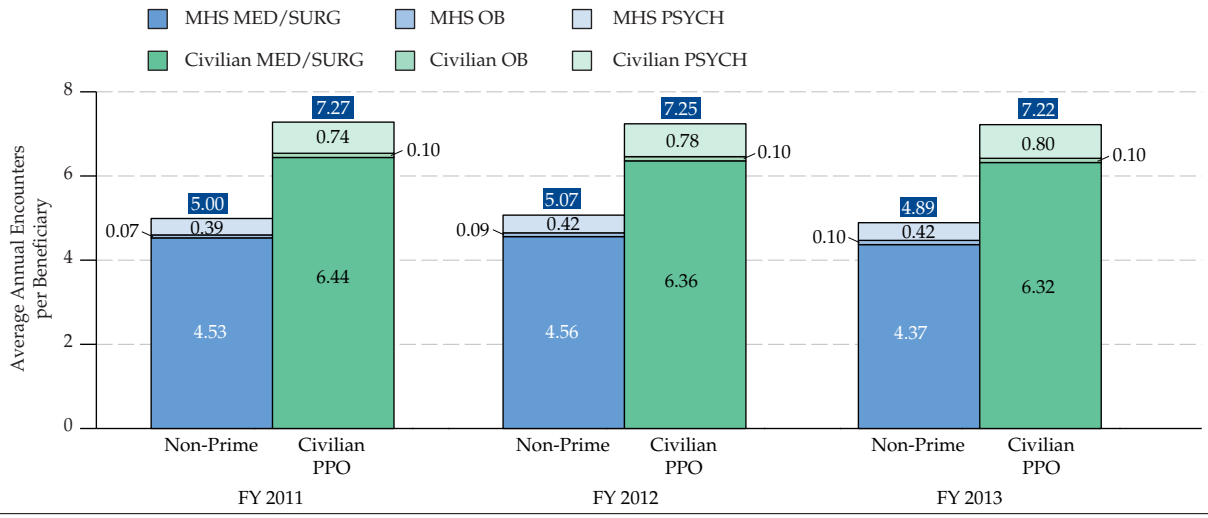
Non-Enrolled Beneficiaries

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 in terms of encounters because the civilian-sector data used in the comparisons do not contain a measure of RVUs. However, there is no fixed definition for what constitutes a "face-to-face" encounter with a physician. TRICARE and the private sector may therefore use varying methodologies to calculate the number of encounters.

Encounters are computed for three broad product lines—OB/GYN, PSYCH, and other MED/SURG. The comparisons are made for beneficiaries under age 65 only. To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Because telephone consults are routinely recorded in direct care data, but appear very infrequently in private-sector claims, they are also excluded from the direct care utilization computations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that between 15 and 20 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 decreased by 2 percent from 5.0 encounters per participant in FY 2010 to 4.9 in FY 2013. The civilian PPO outpatient utilization rate decreased by 1 percent over the same period.
- The overall TRICARE non-Prime (space-available and Standard/Extra [S/E]) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2013, TRICARE non-Prime outpatient utilization was 32 percent lower than in civilian PPOs.
- In FY 2013, the non-Prime outpatient utilization rate for MED/SURG procedures was 31 percent lower than the civilian PPO rate. MED/SURG procedures account for about 90 percent of total outpatient utilization in both the military and private sectors.
- The non-Prime outpatient utilization rate for OB/GYN procedures increased by 36 percent between FY 2011 and FY 2013, but was still 3 percent lower than the rate for civilian PPO participants in FY 2013.[1]
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 8 percent from FY 2011 to FY 2013; the rate increased by 9 percent for civilian PPO participants. In FY 2013, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 48 percent below that of civilian PPO participants. The latter observation, together with the utilization exhibited by Prime enrollees, suggests that MHS beneficiaries in need of extensive PSYCH counseling (primarily Active Duty members and their families) are more likely to enroll in Prime.

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS enrolled beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

[1] The numbers on the chart are the same when rounded to two digits but are slightly different when unrounded.

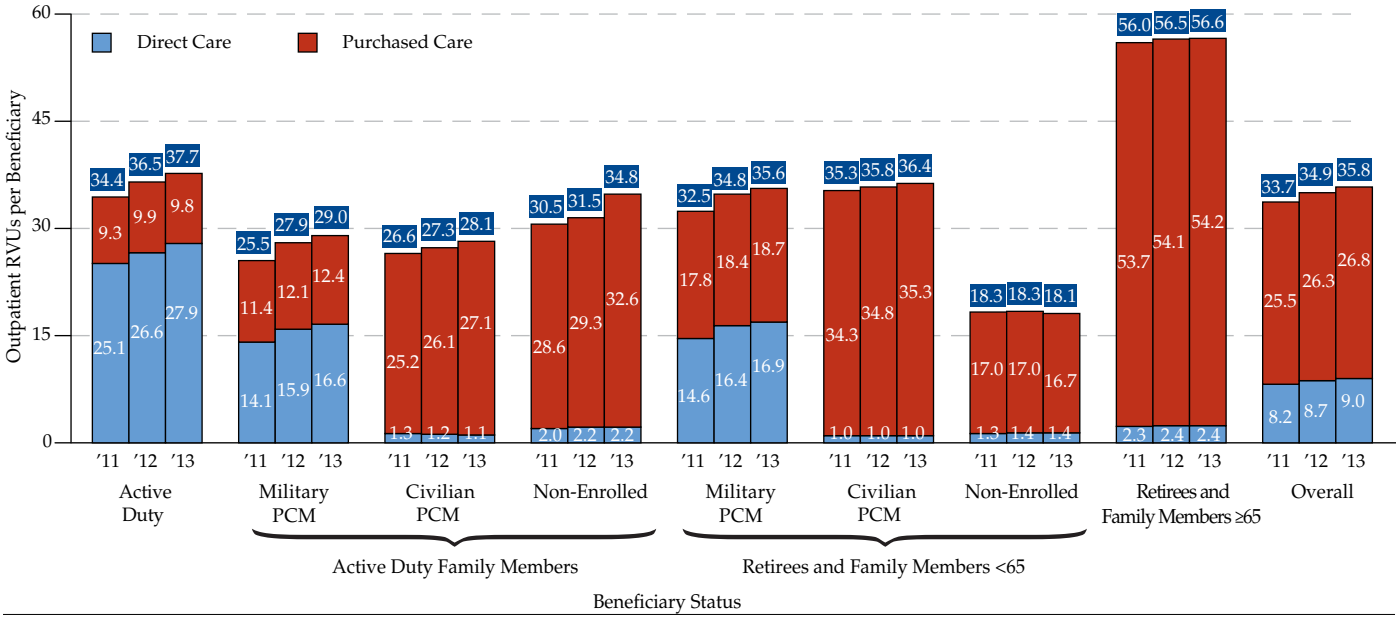
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Utilization Rates by Beneficiary Status

When breaking out outpatient utilization by beneficiary group, RVUs per capita more accurately reflect differences across beneficiary groups than encounters per capita. The RVU measure used in this year's report is the sum of the Physician Work and Practice Expense RVUs (called "Total RVUs"). See the Appendix for a detailed description of the Physician Work and Practice Expense RVU measures.

- Total per capita MHS utilization (direct plus purchased care) increased by 6 percent from FY 2011 to FY 2013.
- All beneficiary groups except those with a civilian PCM experienced an increase in direct outpatient utilization from FY 2011 to FY 2013. Per capita utilization increased the most for beneficiaries with a military PCM (18 percent for ADFMs and 16 percent for RETFMs under age 65).
- From FY 2011 to FY 2013, the purchased care outpatient utilization rate increased for all beneficiary groups except for non-enrolled RETFMs under age 65. The largest increase (14 percent) was experienced by non-enrolled ADFMs, followed by ADFMs with a military PCM (9 percent).
- The TFL outpatient utilization rate increased by 1 percent from FY 2011 to FY 2013.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/23/2014

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

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

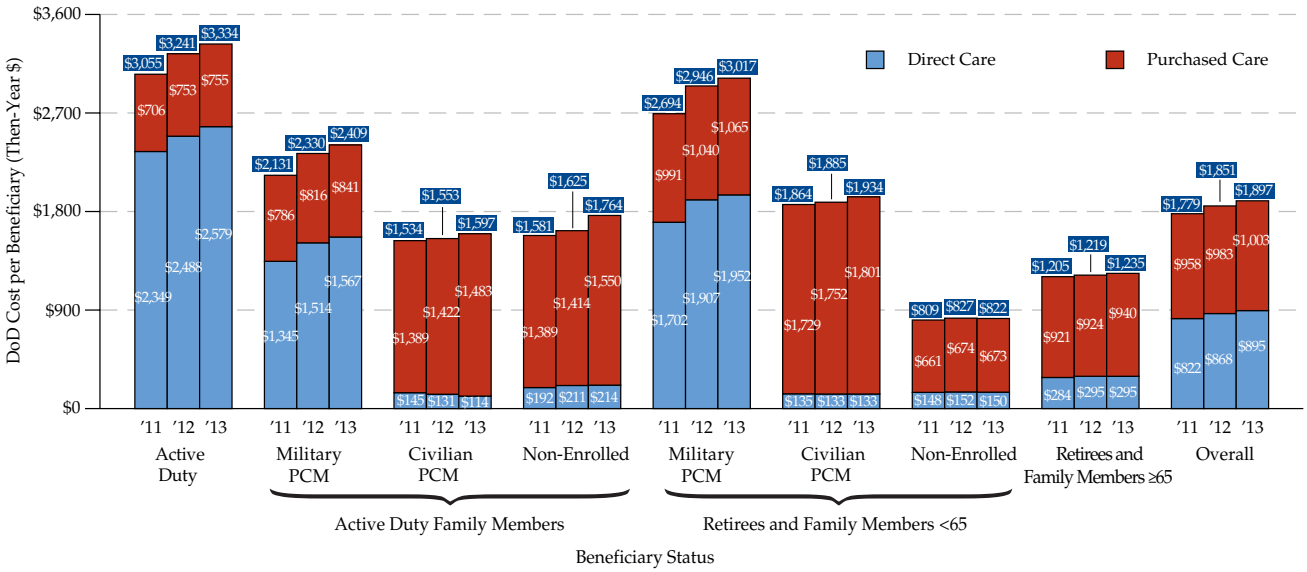
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT'D)*

Outpatient Costs by Beneficiary Status

Corresponding to higher purchased care outpatient utilization rates, DoD medical costs continued to rise but at a slower rate. Overall MHS outpatient costs (in then-year dollars) per beneficiary (far right columns below), including TFL, increased by 7 percent from FY 2011 to FY 2013.

- The direct care cost per beneficiary increased for all beneficiary groups except those with a civilian PCM. The largest increase (17 percent) was for ADFMs with a military PCM, followed by RETFMs under 65 with a military PCM (15 percent). Per capita cost decreases were experienced by ADFMs with a civilian PCM (21 percent) and by RETFMs under 65 with a civilian PCM (1 percent).
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 6 percent from FY 2011 to FY 2013. Per capita costs increased for all beneficiary groups; the largest increase was for non-enrolled ADFMs (12 percent). Increases for other beneficiary groups were in the 2–7 percent range.
- The TFL outpatient cost per beneficiary increased by 2 percent between FY 2011 and FY 2013.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/23/2014

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

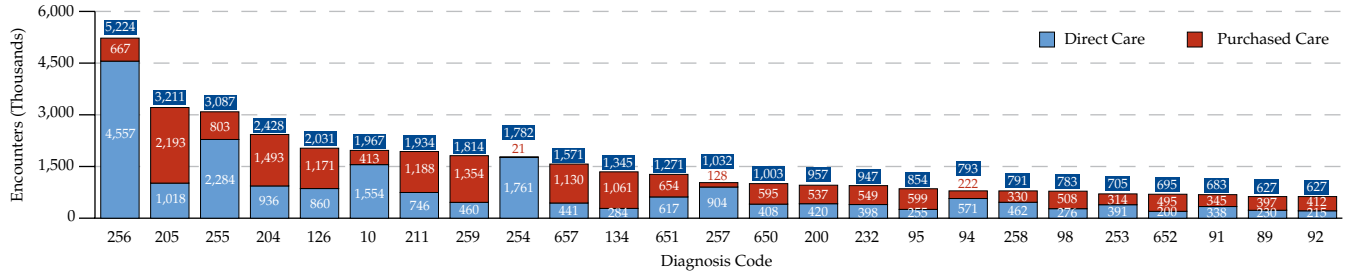
[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

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

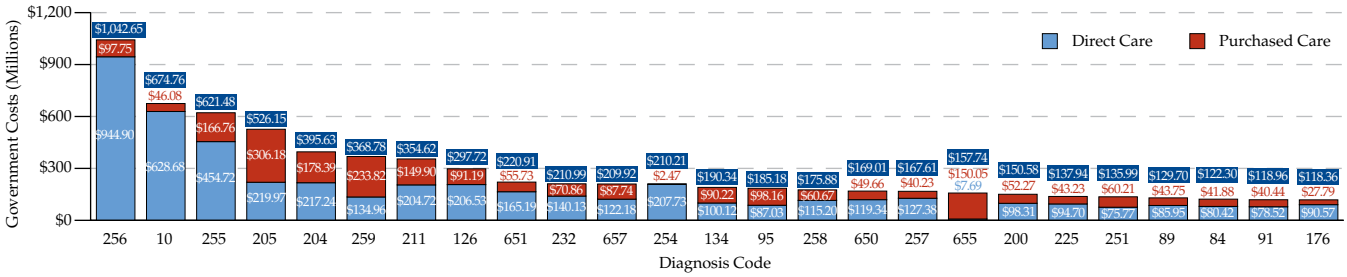
Leading Outpatient Diagnosis Groups

Leading outpatient diagnoses were determined by grouping ICD-9-CM primary diagnosis codes into like categories using the Clinical Classifications Software (CCS) tool developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality. The top 25 outpatient diagnosis groups in FY 2013 accounted for 64 percent of all outpatient encounters (direct care and purchased care combined) and 59 percent of total outpatient costs. Direct care drug expenses, which are included in outpatient costs in the direct care administrative data, are excluded from the cost totals in this section. TFL encounters and telephone consults are excluded from the calculations for both volume and cost.

BY VOLUME



BY COST



Source: MHS administrative data, 1/23/2014

Diagnosis Group

10	Immunization and screening for infectious disease
84	Headache, including migraine
89	Blindness and vision defects
91	Other eye disorders
92	Otitis media and related conditions
94	Other ear and sense organ disorders
95	Other nervous system disorders
98	Essential hypertension
126	Other upper respiratory infections
134	Other upper respiratory disease
176	Contraceptive and procreative management
200	Other skin disorders
204	Other non-traumatic joint disorders
205	Spondylosis, intervertebral disc disorders, other back problems
211	Other connective tissue disease
225	Joint disorders and dislocations, trauma-related
232	Sprains and strains
251	Abdominal pain
253	Allergic reactions
254	Rehabilitation care, fitting of prostheses, and adjustment of devices
255	Administrative/social admission
256	Medical examination/evaluation
257	Other aftercare
258	Other screening for suspected conditions (not mental disorders or infectious disease)
259	Residual codes, unclassified
650	Adjustment disorders
651	Anxiety disorders
652	Attention-deficit, conduct, and disruptive behavior disorders
655	Disorders usually diagnosed in infancy, childhood, or adolescence
657	Mood disorders

- The top two diagnosis groups by volume are general health examinations (adults and children) and intervertebral disc disorders.
- Diagnoses treated in purchased care facilities account for 46 percent of the total volume of the top 25 diagnosis groups but only 32 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only eight of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 21 of the top 25 diagnoses.

PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks

Prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, home delivery and military treatment facility (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.

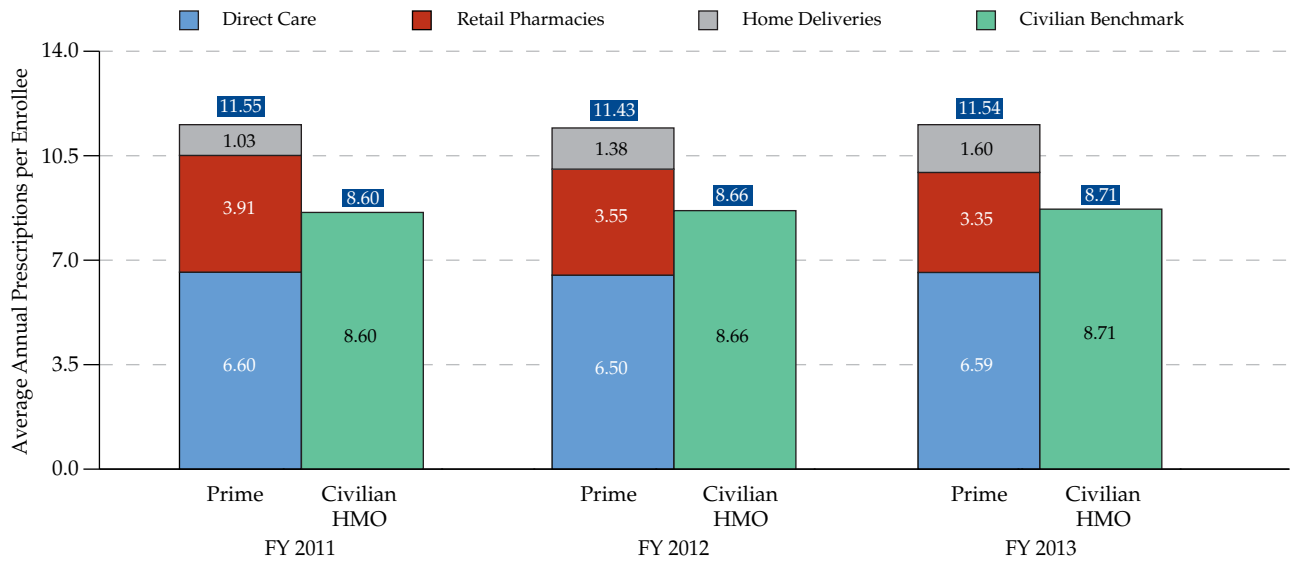
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy Operations Directorate (POD).

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 remained about the same between FY 2011 and FY 2013; the civilian HMO benchmark rate rose by 1 percent. Between FY 2011 and FY 2013, the TRICARE Prime prescription utilization rate was about one-third higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies remained the same between FY 2011 to FY 2013, whereas the utilization rate at retail pharmacies decreased by 14 percent (because of greater reliance on home delivery services).
- Enrollee home delivery prescription utilization increased by 55 percent from FY 2011 to FY 2013. Historically, home delivery utilization has been small compared to other sources of prescription services. However, in FY 2013, home delivery accounted for 32 percent of purchased care prescription utilization by Prime enrollees (as measured by 30 days supply).

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

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

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks *(CONT'D)*

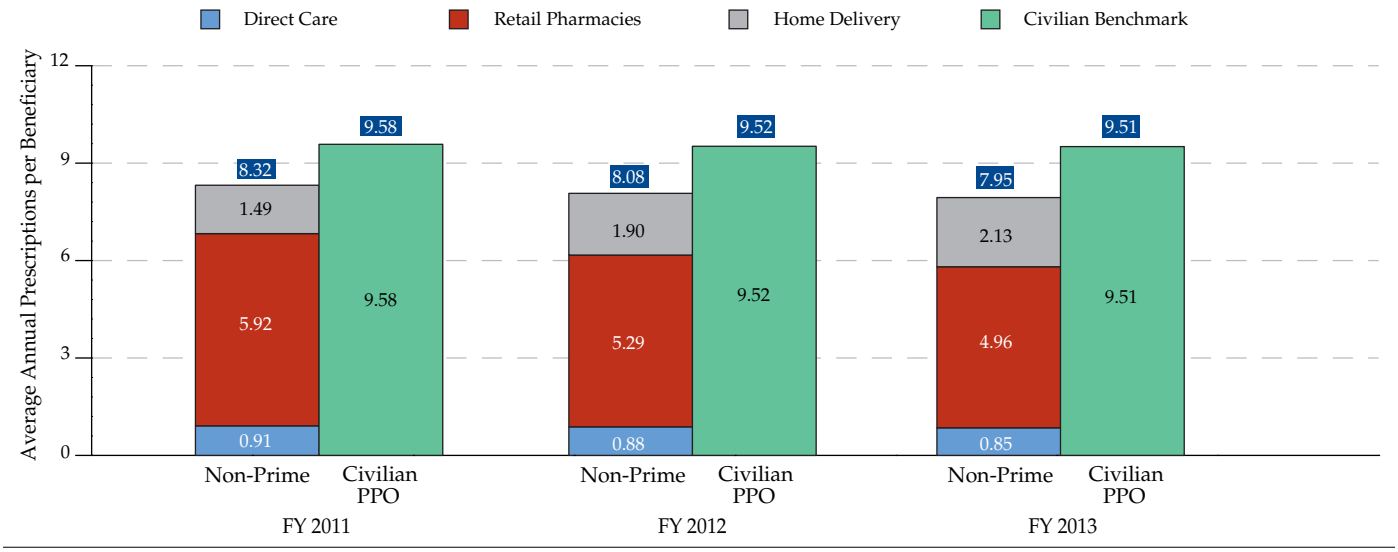
Non-Enrolled Beneficiaries

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

To make the utilization rates of MHS and civilian beneficiaries more comparable, non-enrolled MHS beneficiaries covered by a primary civilian health insurance policy are excluded from the calculations. Although most beneficiaries who fail to file a TRICARE claim have private health insurance, we estimate that between 10 and 12 percent (depending on the year) do not file because they have no utilization. The MHS utilization rates shown below include these non-users to make them more comparable to the civilian rates, which also include them.

- The overall prescription utilization rate (direct and purchased care combined) for non-enrolled beneficiaries decreased by 4 percent between FY 2011 and FY 2013. During the same period, the civilian PPO benchmark rate decreased by 1 percent. In FY 2013, the TRICARE prescription utilization rate for non-enrollees was 16 percent lower than the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries dropped by 6 percent from FY 2011 to FY 2013, whereas the utilization rate at retail pharmacies decreased by 16 percent (because of greater reliance on home delivery services).
- Non-enrollee home delivery prescription utilization increased by 43 percent from FY 2011 to FY 2013. Historically, home delivery utilization has been small compared to other sources of prescription services. However, in FY 2013, home delivery accounted for 30 percent of purchased care prescription utilization by non-enrollees.

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



Sources: MHS administrative data, 1/23/2014, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters database, 1/14/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2013 civilian data are based on two quarters of data, which were seasonally adjusted and annualized.

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

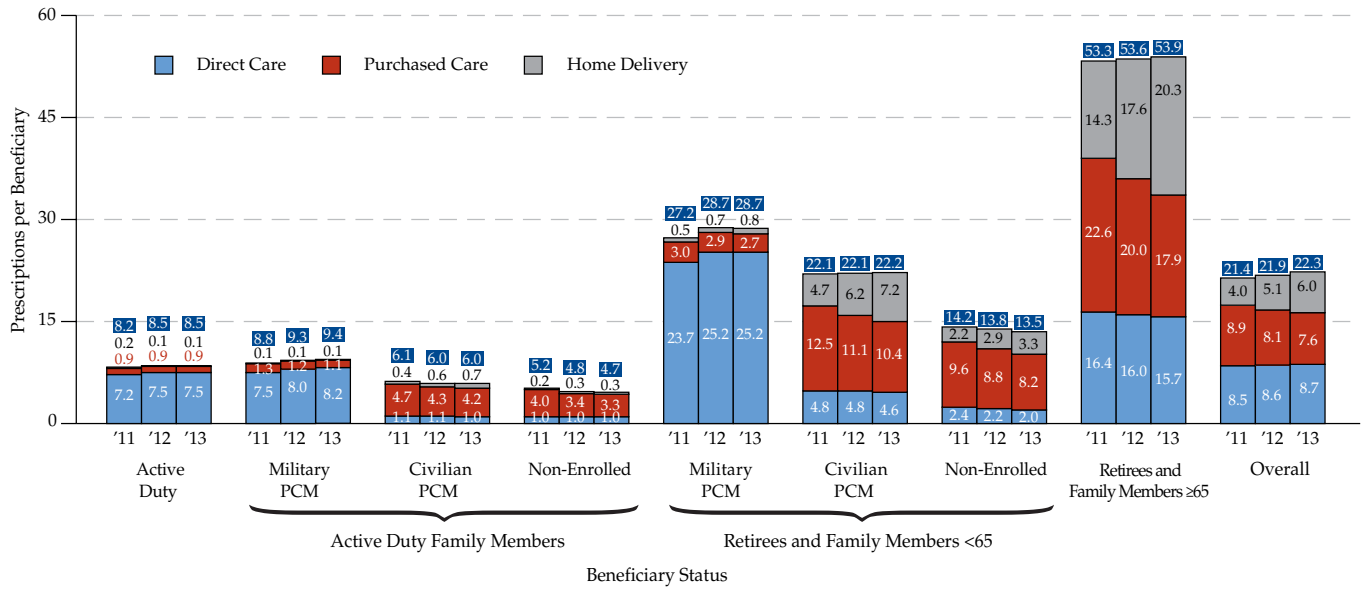
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

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

- The total (direct, retail, and home delivery) number of prescriptions per beneficiary increased by 2 percent from FY 2011 to FY 2013, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 4 percent.
- The average direct care prescription utilization rate increased by 2 percent between FY 2011 and FY 2013. However, the rate increased by 9 percent for ADFMs with a military PCM and by 6 percent for RETFMs under age 65 with a military PCM. Declines were experienced by beneficiaries with a civilian PCM (5–6 percent) and by non-enrolled RETFMs under age 65 (16 percent).
- Average per capita prescription utilization through retail pharmacies decreased by 15 percent overall. Declines occurred for every beneficiary group, most notably for seniors (21 percent). The primary reason for the declines is the change in the copayment structure for retail drugs that caused beneficiaries to migrate to home delivery for their maintenance drugs.
- Home delivery, which once accounted for only a small fraction of purchased care prescription drug utilization, grew by 52 percent between FY 2011 and FY 2013, to the point where it now accounts for 44 percent of total purchased care prescription drug utilization (as measured by 30-day supply) per capita. For beneficiaries under age 65, home delivery accounts for 30 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 53 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/23/2014

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

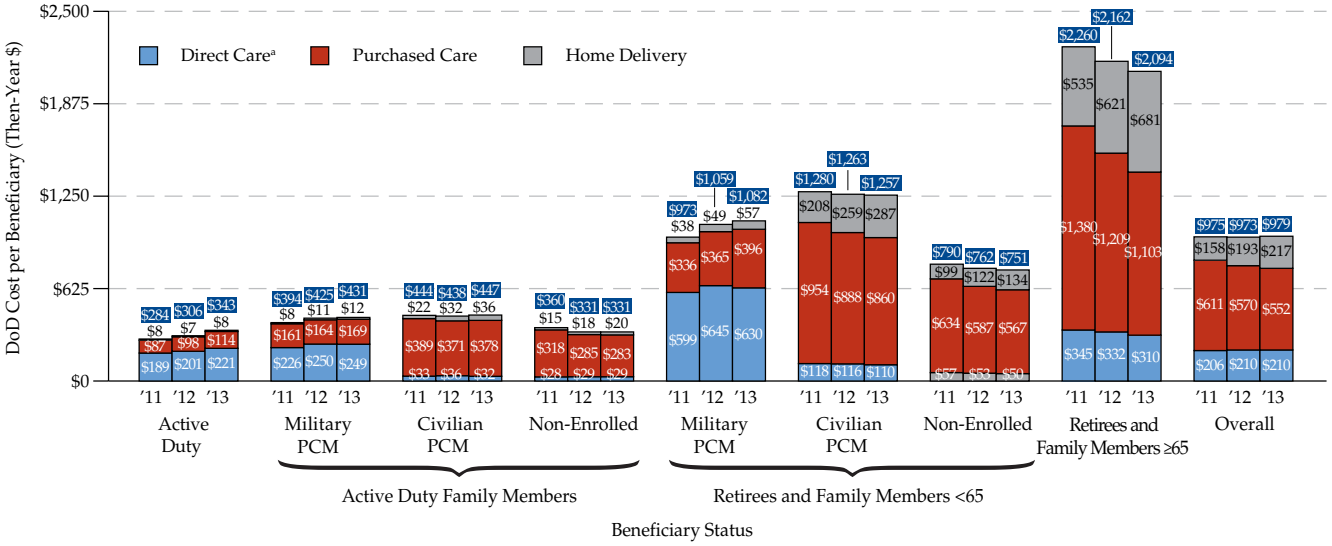
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT'D)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 27 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far right columns below), including TFL, remained about the same from FY 2011 to FY 2013.

- Exclusive of TFL, per capita prescription drug costs rose by 2 percent between FY 2011 and FY 2013. The largest increase (21 percent) occurred for ADSMs.
- Direct care costs per beneficiary decreased by 1 percent, while retail pharmacy costs decreased by 4 percent excluding TFL and by 10 percent including TFL.
- Home delivery costs per beneficiary increased by 41 percent excluding TFL and by 37 percent including TFL.
- Most of the increase in per capita home delivery prescription costs is due to a shift away from retail pharmacy utilization to home delivery.

AVERAGE ANNUAL DoD PRESCRIPTION COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/23/2014

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

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

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

Out-of-pocket costs are computed for Active Duty and retiree families in the U.S. grouped by sponsor age: (1) under 65, and (2) 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. Costs are compared with those of civilian counterparts, i.e., civilian families with the same demographics as the typical MHS family. For beneficiaries under age 65, civilian counterparts are assumed to be covered by other employer-sponsored group health insurance (OHI).

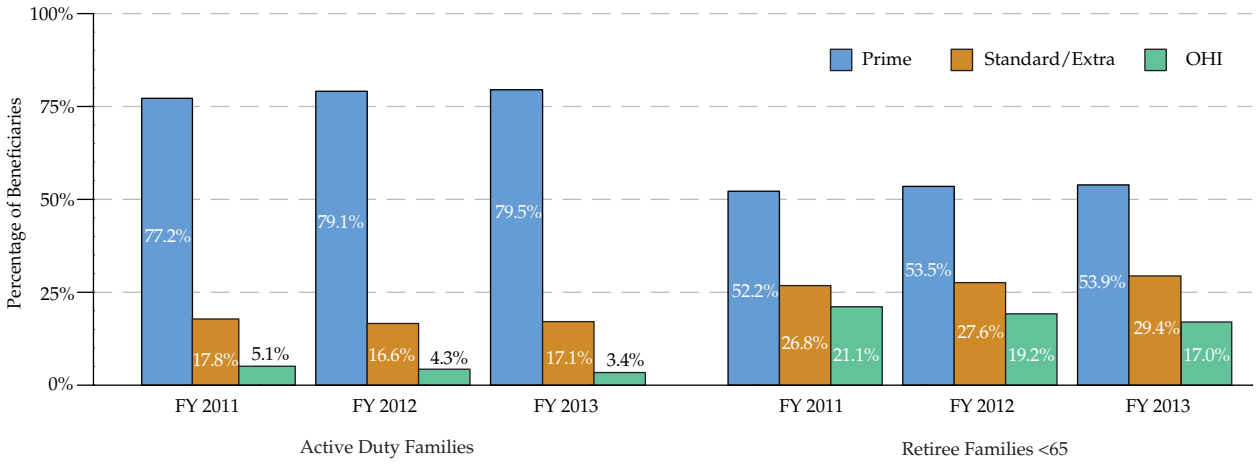
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) OHI. Many beneficiaries with OHI have no TRICARE utilization; however, some use TRICARE as a second payer.

Beneficiaries are grouped by their primary health plan:

- **TRICARE Prime:** Family enrolled in TRICARE Prime (including a small percentage who also have OHI coverage). In FY 2013, 79.5 percent of Active Duty families and 53.9 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and does not have OHI coverage. In FY 2013, 17.1 percent of Active Duty families and 29.4 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2013, 3.4 percent of Active Duty families and 17.0 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: Insurance coverage in FYs 2011–2013 based on Defense Enrollment Eligibility Reporting System (DEERS) and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2013.

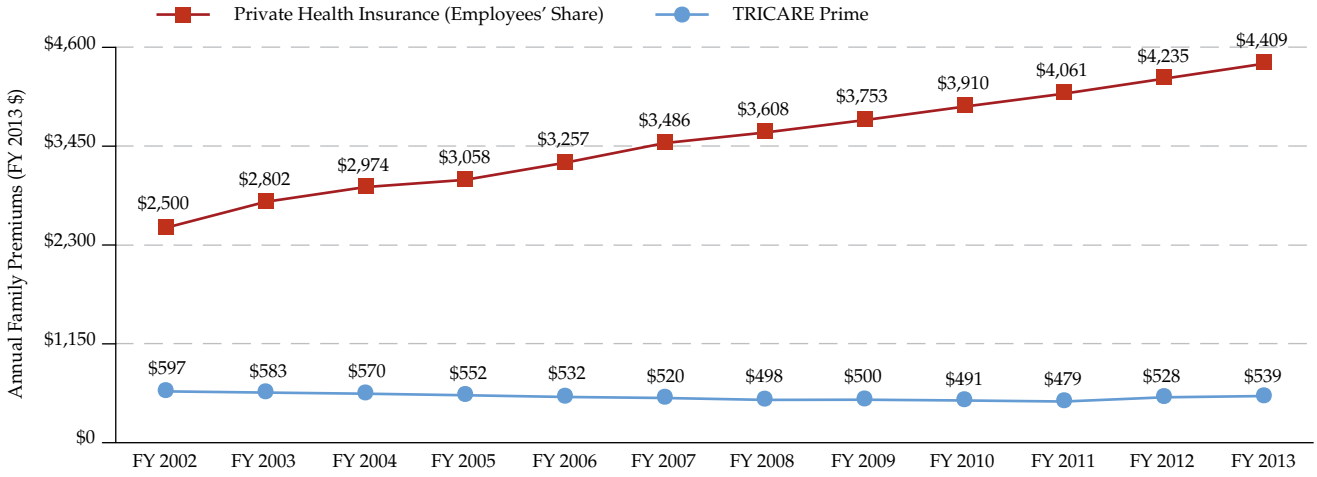
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance, i.e., Federal Employees Health Benefits Plan (FEHBP), a civilian HMO such as Kaiser, or other civilian insurance such as Blue Cross. A small percentage of Prime enrollees are also covered by OHI; these beneficiaries are included in the Prime group. Percentages may not sum to 100 percent due to rounding.

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

Retirees and Family Members Under Age 65 Returning to the MHS

Since FY 2002, private health insurance family premiums have been rising. The annual TRICARE Prime enrollment fee remained fixed at $460 per retiree family through FY 2011; it increased to $520 in FY 2012 and $539 in FY 2013. In constant FY 2013 dollars, the private health insurance premium increased by $1,909 (76 percent) from FY 2002 to FY 2013, whereas the TRICARE premium declined by $58 (–10 percent) during this period.

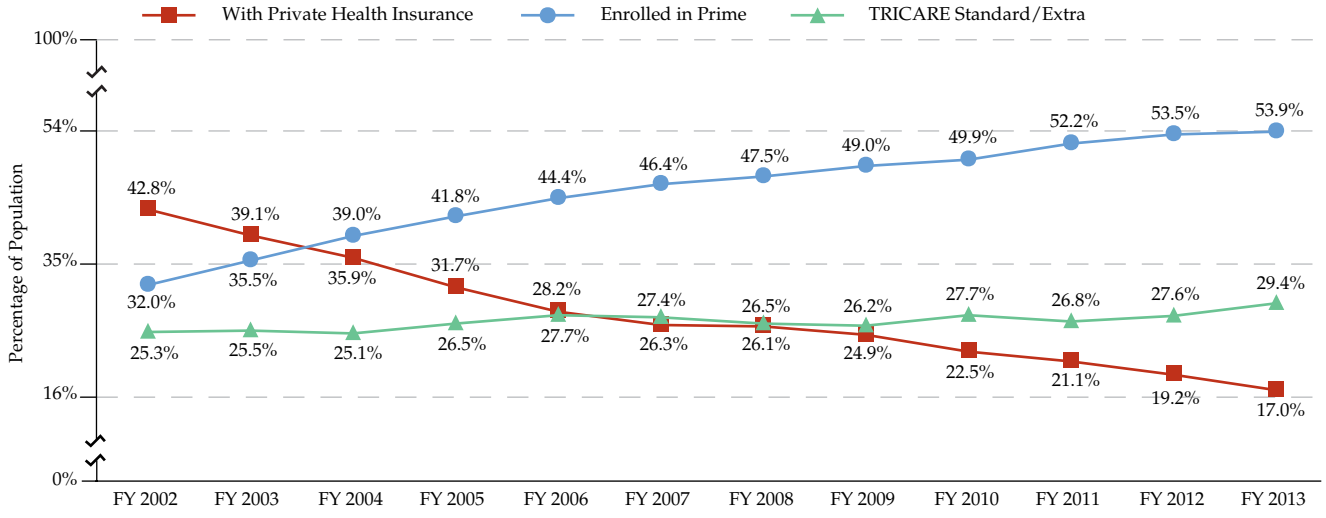
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan in FYs 2002–2012 from the Insurance Component of the Medical Expenditure Panel Surveys 2001–2012; OHI premiums in FY 2013 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2013.

Between FY 2002 and FY 2013, 25.8 percent of retirees switched from private health insurance to TRICARE. Most switched because of an increasing disparity in premiums and out-of-pocket expenses; in the past few years, some lost coverage due to the recession.[1] As a result of declines in private insurance coverage, an additional 777,629 retirees and family members under age 65 are now relying primarily on TRICARE instead of private health insurance.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: Insurance coverage in FYs 2002–2013 based on DEERS and HCSDB responses; as of 12/31/2013.

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

[1] For an analysis of retirees' switching from other health insurance to TRICARE, see Goldberg, et. al., "The Demand for Group Health Insurance by Military Retiree Families," IDA Document NS D-5098 (draft; publication forthcoming).

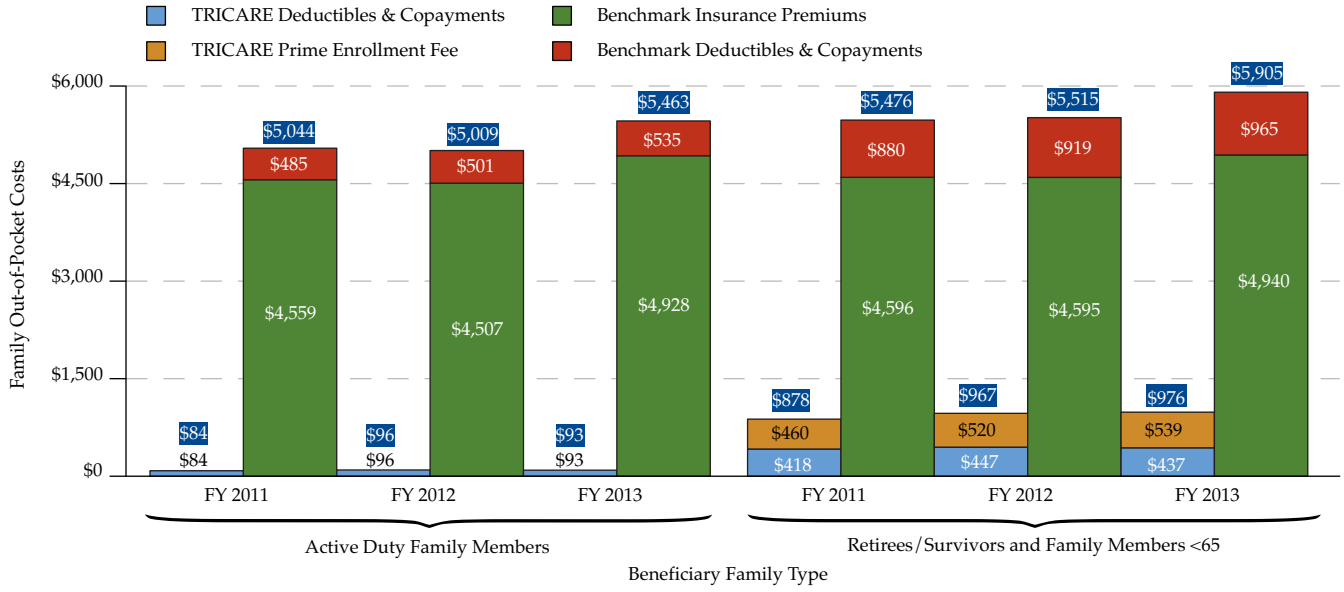
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2011–2013, 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 2013, costs for civilian counterparts were:
  - $5,400 more than those incurred by Active Duty families enrolled in Prime.
  - $4,900 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: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2011–2013 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization; civilian benchmark expenditures for deductibles and copayments from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; civilian benchmark insurance premiums in FYs 2011–2012 from the 2010–2012 Insurance Component of the Medical Expenditure Panel Surveys; OHI premiums in FY 2013 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2013.

Note: Estimates are for a demographically typical family. For Active Duty dependents, the family includes a spouse and 1.54 children on average. For retirees, a family includes a sponsor, spouse, and 0.65 children.

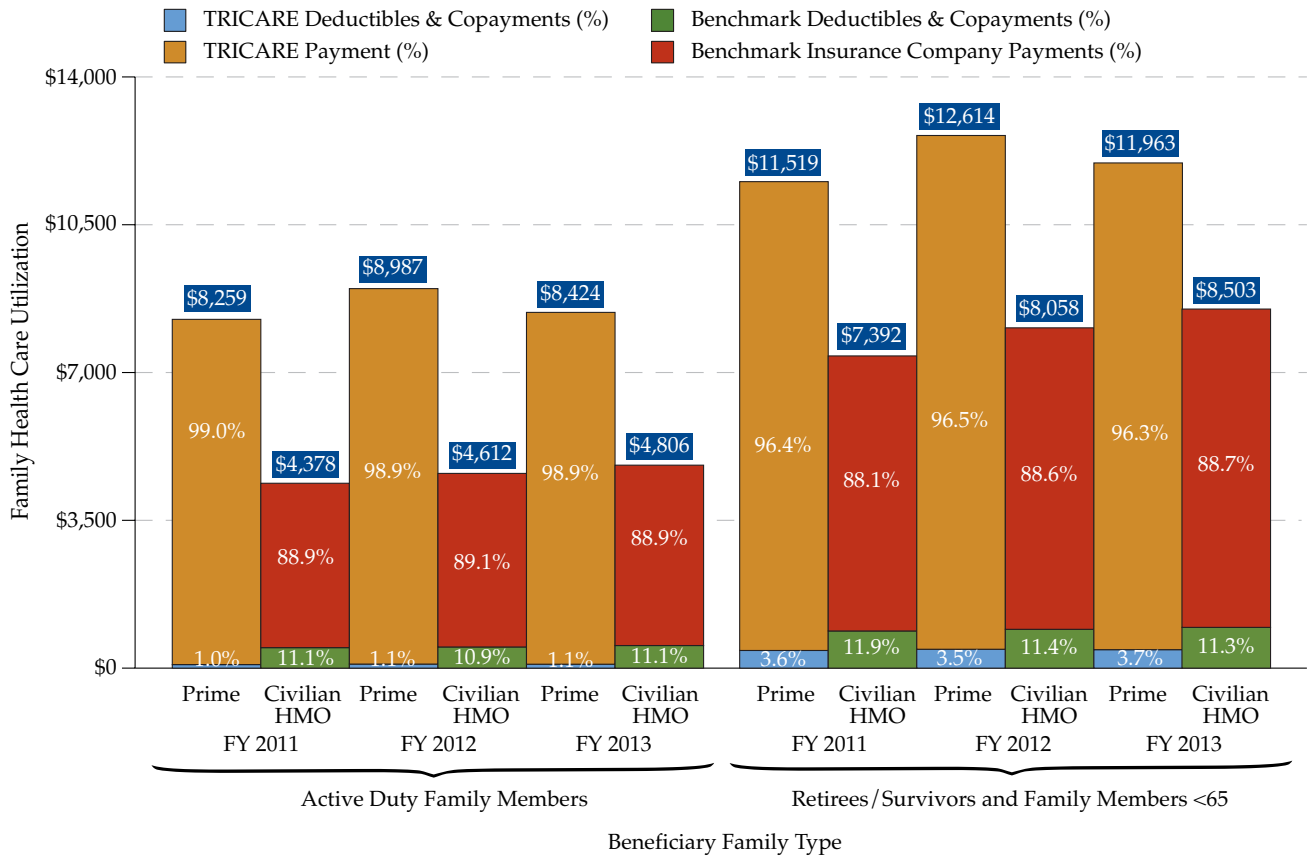
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

Previous private-sector studies found that very low coinsurance rates increase health care utilization (dollar value of health care services).[1] In FYs 2011–2013, TRICARE Prime enrollees had negligible coinsurance rates (deductibles and copayments per dollar of utilization) and, not surprisingly, much higher utilization compared with civilian HMO counterpart families. Differences in coinsurance rates are a major reason for the higher utilization of health care services by Prime enrollees.

- TRICARE Prime enrollees had much lower average coinsurance rates than civilian HMO counterparts.
  - In FY 2013, the coinsurance rate for Active Duty families was 1.1 percent versus 11.1 percent for civilian counterparts.
  - In FY 2013, the coinsurance rate for retiree families was 3.7 percent versus 11.3 percent for civilian counterparts.
- TRICARE Prime enrollees had 41–75 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2013, Active Duty families consumed $8,400 of medical services versus $4,800 by civilian counterparts (75 percent higher).
  - In FY 2013, retiree families consumed $12,000 of medical services versus $8,500 by civilian counterparts (41 percent higher).

COINSURANCE AND HEALTH CARE UTILIZATION FOR FAMILIES ENROLLED IN TRICARE PRIME VS. CIVILIAN HMO COUNTERPARTS



Sources: TRICARE utilization expenditures by MHS and beneficiaries in FYs 2011–2013 from MHS administrative data for all families enrolled in Prime without OHI payments for TRICARE utilization; civilian benchmark utilization payments by insurance companies and families from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; as of 12/31/2013.

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

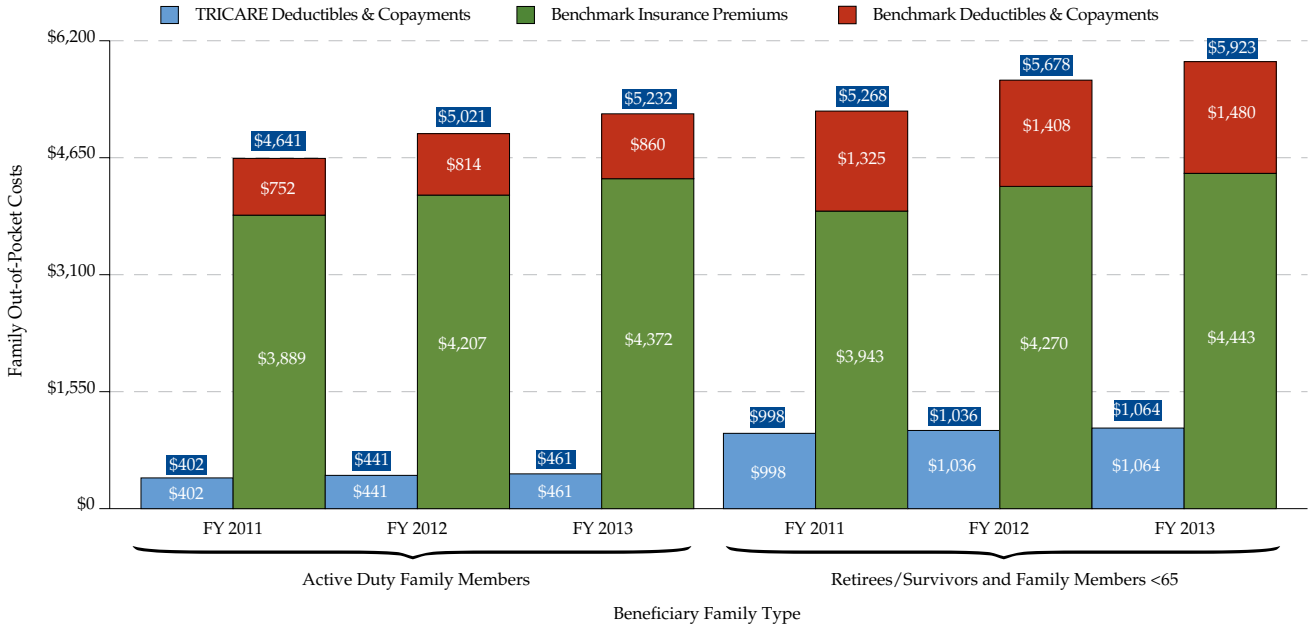
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FY 2011 to FY 2013, 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 2013, costs for civilian counterparts were:
  - $4,800 more than those incurred by Active Duty families who relied on Standard/Extra.
  - $4,900 more than those incurred by retiree families who relied on Standard/Extra.

OUT-OF-POCKET COSTS FOR FAMILIES WHO RELY ON TRICARE STANDARD/EXTRA VS. CIVILIAN PPO COUNTERPARTS



Sources: TRICARE beneficiary expenditures for deductibles and copayments in FYs 2011–2013 from MHS administrative data for all Standard/Extra reliant families without OHI payments for TRICARE utilization; civilian benchmark expenditures for deductibles and copayments from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; civilian benchmark insurance premiums in FYs 2011–2012 from the 2010–2012 Insurance Component of the Medical Expenditure Panel Surveys; OHI premiums in FY 2013 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; insurance coverage from HCSDB, FYs 2011–2013; as of 12/31/2013.

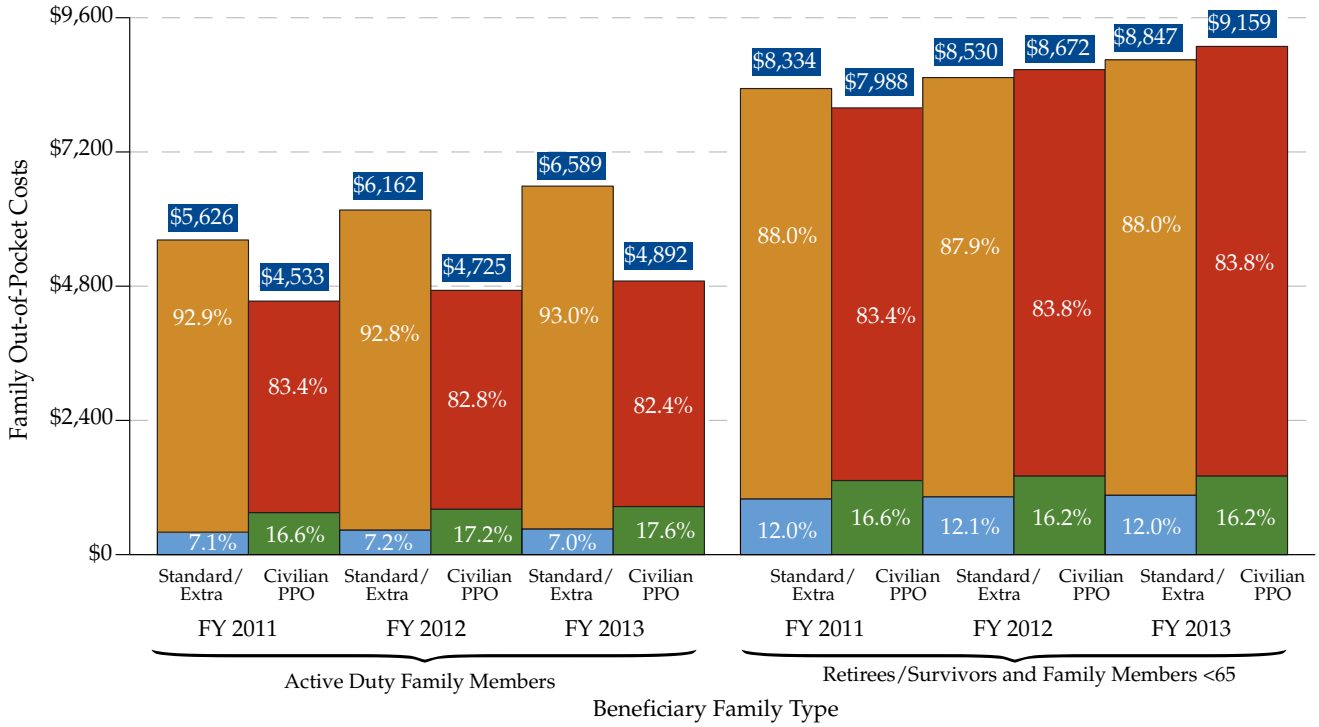
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT'D)*

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

In FYs 2011–2013, Active Duty families who relied on TRICARE Standard/Extra had lower coinsurance rates (deductibles and copayments per dollar of utilization) than civilian counterparts. As a result, utilization (dollar value of health care services consumed) was higher for TRICARE Standard/Extra families compared with civilian counterparts in FYs 2011–2013.

- In FY 2013, TRICARE Standard/Extra reliant families had coinsurance rates that were lower than (Active Duty) or similar to (Retiree) those of civilian PPO counterparts.
  - In FY 2013, Active Duty families had a coinsurance rate of 7.0 percent versus 17.6 percent for civilian counterparts.
  - In FY 2013, the coinsurance rate for retiree families was 12.0 percent versus 16.2 percent for civilian counterparts.
- In FY 2013, health care utilization for TRICARE Standard/Extra families was higher (Active Duty) or similar (Retiree) to that of civilian PPO counterparts.
  - In FY 2013, Active Duty families consumed $6,600 of medical services versus $4,900 by civilian counterparts (35 percent greater).
  - In FY 2013, both retiree families and civilian counterparts consumed about $9,000 of medical services.

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



Sources: TRICARE utilization payments by MHS and beneficiaries in FYs 2011–2013 from MHS administrative data for all Standard/Extra reliant families without OHI payments for TRICARE utilization; civilian benchmark utilization payments by insurance companies and families from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; as of 12/31/2013.

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

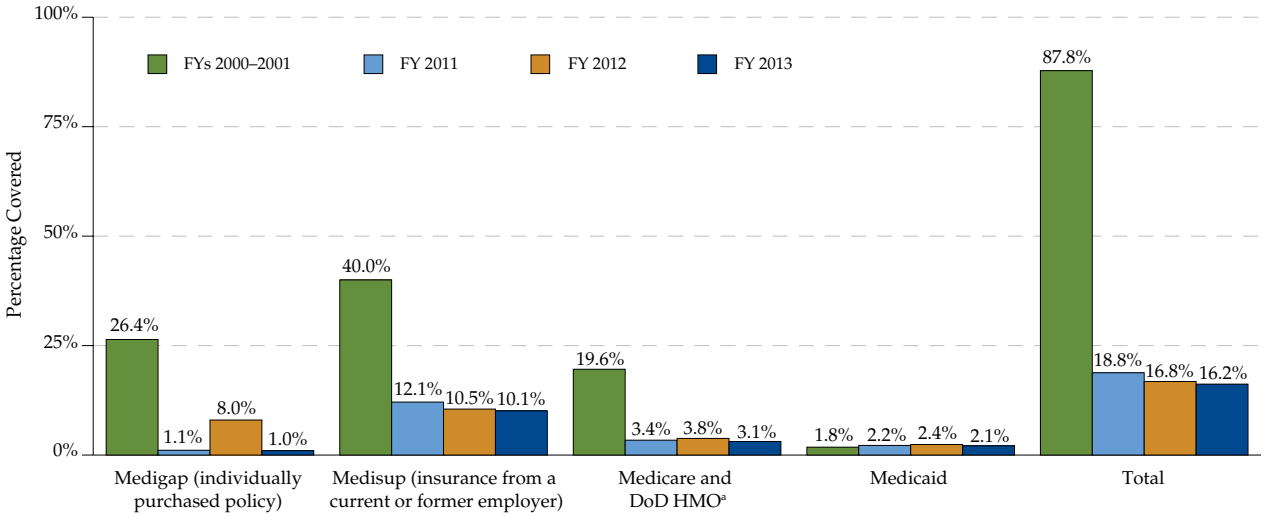
Out-of-pocket costs for retirees 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, DoD expanded drug benefits for seniors; on October 1, 2001, DoD implemented the TRICARE for Life (TFL) program, which provides Medicare wraparound coverage, i.e., TRICARE acts as second payer to Medicare, minimizing beneficiary out-of-pocket expenses. For seniors, costs are compared with those of civilian counterparts having pre-TFL supplemental insurance coverage.

Health Insurance Coverage of MHS Senior Beneficiaries Before and After TFL

Although Medicare provides coverage for medical services, there are substantial deductibles and copayments. Until FY 2001, most MHS seniors purchased some type of Medicare supplemental insurance. A small number were active employees with employer-sponsored insurance or were covered by Medicaid. Because of the improved drug and TFL benefits, most MHS seniors dropped their supplemental insurance.

- Before TFL (FYs 2000–2001), 87.8 percent of MHS seniors had Medicare supplemental insurance or were covered by Medicaid. After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid fell sharply. It was 16.2 percent in FY 2013.
- Why do a sixth of all seniors still retain supplemental insurance, especially a Medisup policy, when they can use TFL for free? Some possible reasons are:
  - A lack of awareness of the TFL benefit.
  - A desire for dual coverage.
  - Higher family insurance 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: FY 2000–2001 and FYs 2011–2013 HCSDB; as of 12/31/2013.

[a] Insurance coverage for DoD HMOs includes TRICARE Senior Prime (until December 2001) and the USFHP. Medisup includes those with Medicare who are covered by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2013.

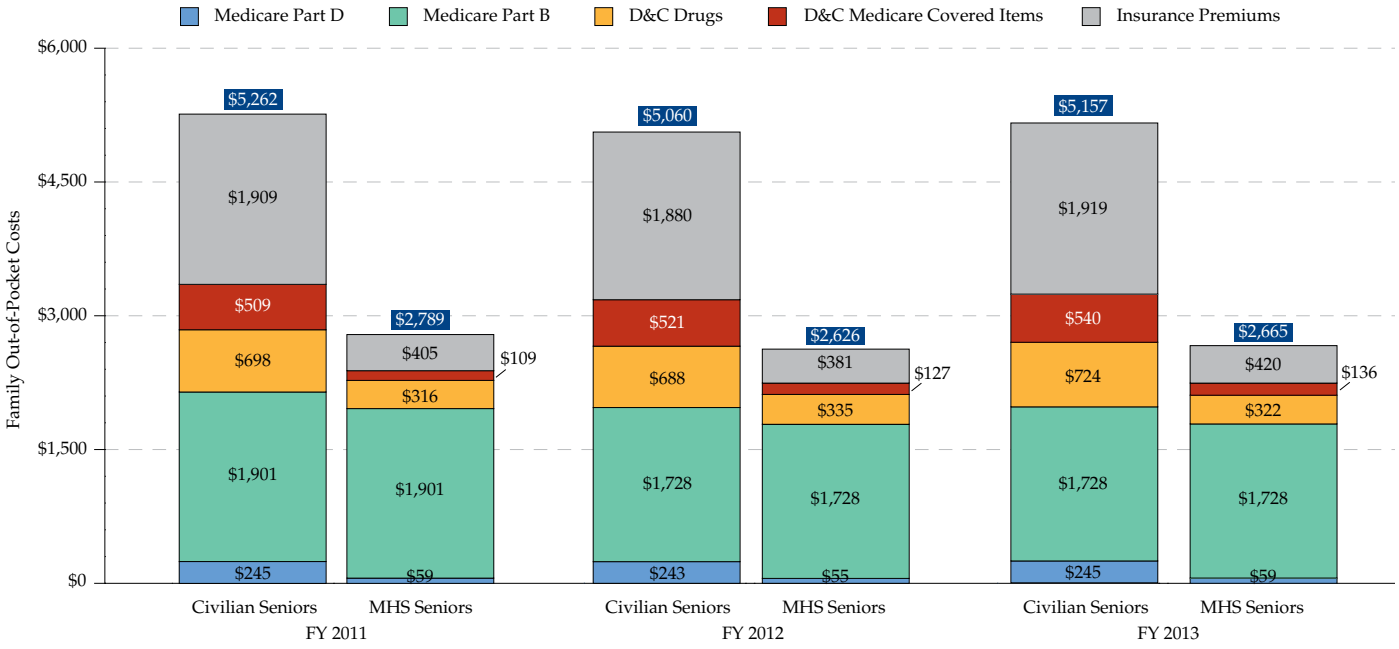
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

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

About 82 percent of TRICARE senior families are TFL users; the other 18 percent use little or no military health care. TFL and added drug benefits have enabled MHS seniors to reduce their out-of-pocket costs for deductibles/co-payments and supplemental insurance. The costs for a typical TRICARE senior family after TFL, including TFL users and non-users, are compared with those of civilian counterparts having the supplemental insurance coverage of TRICARE senior families before TFL in FYs 2000–2001.

- In FY 2013, out-of-pocket costs for MHS senior families were 48 percent less than those of "before TFL" civilian counterparts.
- In FY 2013, MHS senior families saved about $2,500 as a result of TFL and added drug benefits.

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



Sources: TRICARE senior family deductibles and copayments for TFL users in FYs 2011–2013 from MHS administrative data on all TRICARE senior families with TFL utilization. For TFL non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; Medicare Part B and Medicare HMO premiums in FYs 2011–2013 from the Centers for Medicare and Medicaid Services; Medigap premiums in FYs 2011–2013 from Weiss Research, Inc.; Medisup premiums in FYs 2011–2013 from Tower Perrin Health Care Cost Surveys; Medicare Part D premiums in FYs 2011–2013 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL from HCSDB, FYs 2000, 2001, 2011–2013; as of 12/31/2013.

Note: Estimates are for a demographically typical senior family. On average, this consists of 0.7 men and 0.7 women over the age of 65.

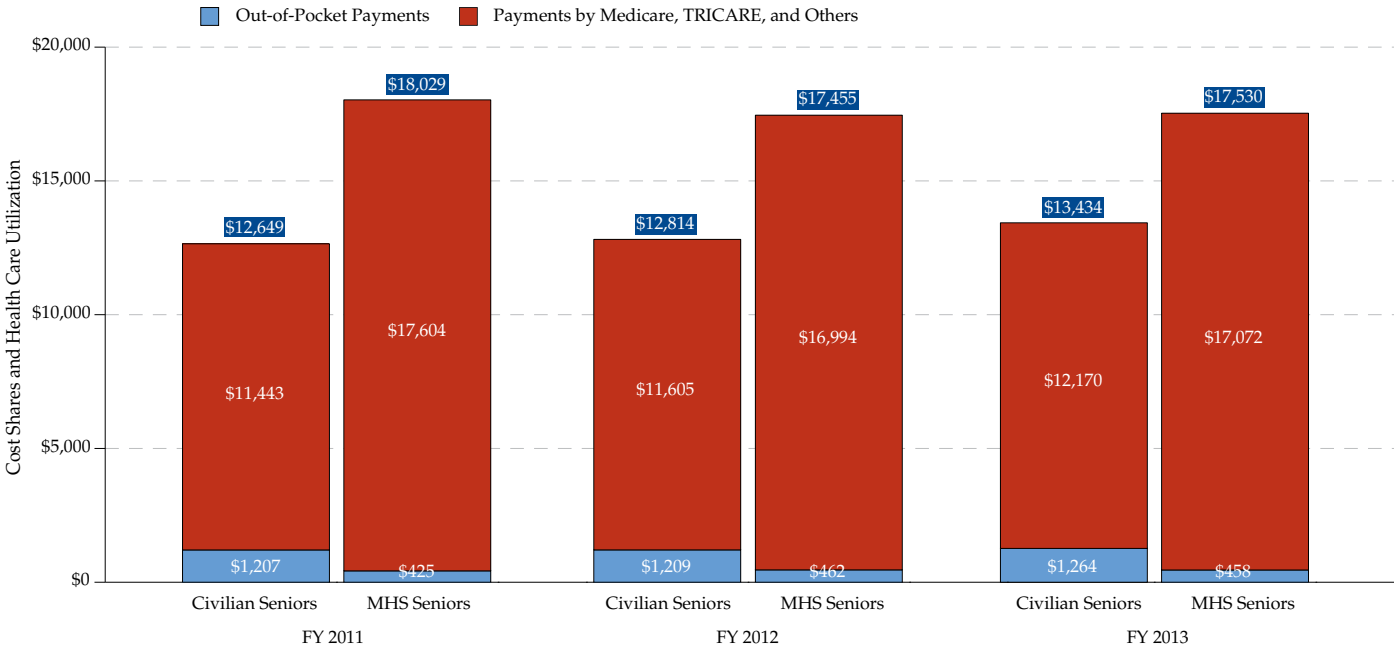
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT'D)*

Coinsurance and Health Care Utilization for MHS Versus Civilian Senior Families

Medicare supplemental insurance lowers the coinsurance rate (deductibles and copayments per dollar of utilization), and previous studies find that this leads to more health care services consumed for seniors.[1] TFL and added drug benefits substantially lowered coinsurance rates, and, not surprisingly, utilization is higher for MHS seniors compared with "before TFL" civilian counterparts.

- TRICARE senior families have relatively low coinsurance rates.
  - In FY 2013, the coinsurance rate for MHS seniors was 2.6 percent; it was 9.4 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2013, MHS families consumed about 30 percent more medical services than their civilian counterparts.

COINSURANCE AND HEALTH CARE UTILIZATION FOR SENIOR FAMILIES VS. CIVILIAN COUNTERPARTS



Sources: TRICARE senior family utilization, deductibles and copayments for TFL users in FYs 2011–2013 from MHS administrative data on all TRICARE senior families with TFL utilization. For TFL non-users and civilian benchmark senior families, utilization, deductibles, and copayments by type of Medicare supplemental coverage from the Household Component of the Medical Expenditure Panel Surveys, actual MEPS in FY 2011 and projected MEPS in FYs 2012–2013; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000, 2001, 2011–2013; as of 12/31/2013.

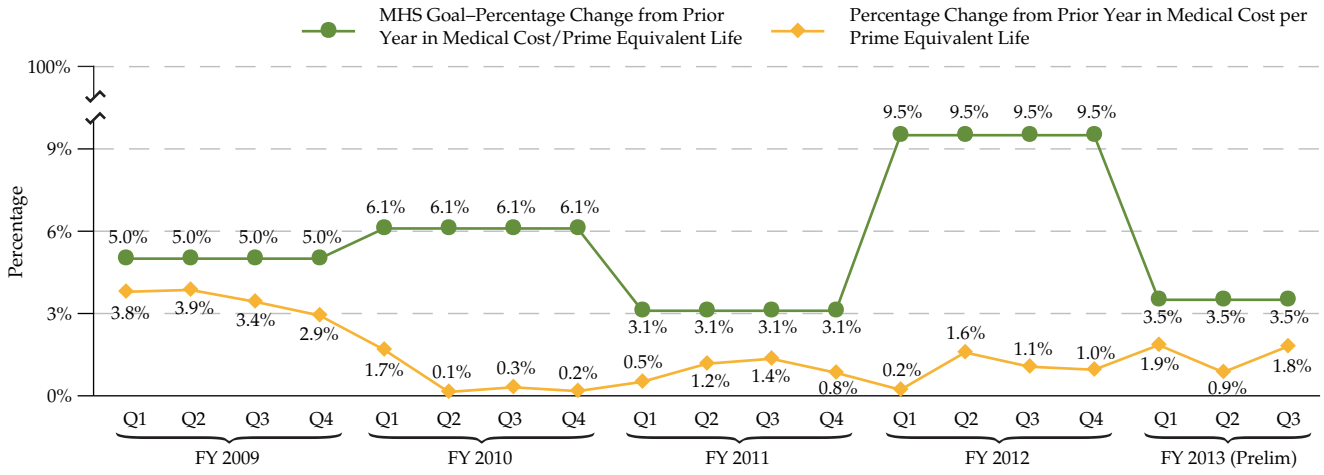
[1] Physician Payment Review Commission. *Annual Report to Congress: Fiscal Year 1997*. Private Secondary Insurance for Medicare Beneficiaries, pp. 27–28.

SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

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

- In the area of military health care costs, increases in purchased care outpatient costs were eased by DHA's implementation of the Outpatient Prospective Payment System (OPPS), which began in May 2009 and was completely phased in by May 2013. OPPS aligns TRICARE with current Medicare rates for reimbursement of hospital outpatient services. Pharmacy refunds provide reductions in retail pharmacy, which is the highest cost pharmacy venue. OPPS and refunds have provided short-term pricing decreases, but, as they are fully phased in, pricing will become stable and utilization will again become a cost driver.
- MHS continues to expand the Patient-Centered Medical Home (PCMH) strategy. PCMH is a practice model in which a team of health professionals, coordinated by a personal physician, works collaboratively to provide high levels of care, access, and communication; care coordination and integration; and care quality and safety. The strategy behind care delivered in a PCMH is to produce better outcomes, reduce mortality and preventable hospital admissions for patients with chronic diseases, lower overall utilization, and improve patient compliance with recommended care, resulting in lower spending for the same population.
- The MHS goal is based on the Kaiser Family Foundation and the Health Research and Educational Trust's (HRET) annual national survey of nonfederal private and public employers with three or more workers. From this survey, the MHS rate is set based on the average annual premiums for employer-sponsored health insurance for family coverage. The FY 2012 goal of a 9.5 percent increase was much higher than previous years, based on forecasted higher average premiums expected under future implementation of the Affordable Care Act (ACA), which would limit the growth in premiums according to medical-loss ratios, while actual changes in MHS medical costs hovered between 1 and 2 percent in FY 2013. The goal for FY 2013 was reduced to an expected annual increase of 3.5 percent, in line with the FY 2011 goal and ACA expectations of contained premium growth. The medical cost per member has remained below the goal for the second consecutive year, due primarily to the overall decrease in health care utilization across the United States associated with national economic uncertainty. Additionally, the lack of any cost of living adjustment for civilian workers and the limited increases for the military providers produced only limited cost increases in the most expensive part of the care delivery process for the Department. As we move forward with an improving economy, utilization will likely increase, but the longer-term implications of the sequestration's impact on funding remains to be determined.

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



Source: Office of the Assistant Secretary of Defense for Health Affairs (OASD[HA]) Health Budgets and Financial Policy and MHS administrative data (M2: Standard Inpatient Data Record [SIDR]/Standard Ambulatory Data Record [SADR]/Comprehensive Ambulatory/Professional Encounter Record [CAPER]/TRICARE Encounter Data-Institutional [TED-I]/TED-Noninstitutional [-NI], Pharmacy Data Transaction Service [PDTS]; Expense Assignment System IV [EASIV]) as of 1/15/2014. Enrollees are adjusted for age, gender, and beneficiary category. FY 2013 data are reported through June 2013 and are preliminary.

GENERAL METHOD

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

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

We made adjustments to both the CAHPS and CCAE benchmark data to account for differences in demographics between the military and civilian beneficiary populations. In most instances, we used the most recent three years of data (FY 2011–FY 2013) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not sum to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are Federal fiscal years (October 1–September 30).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from Web sites accessible by the public. These photos have not been tampered with other than to mask an individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered statistically significant if the significance level was less than or equal to 0.05.
- All workload and costs are estimated to completion based on separate factors derived from MHS administrative data for direct care and recent claims experience for purchased care.
- Data were current as of:
  - HCSDB/CAHPS—11/8/2013
  - Eligibility/Enrollment data—12/20/2013
  - MHS Workload/Costs—1/23/2014
  - Web site uniform resource locators—1/31/2014
- The Defense Health Agency regularly updates its encounters and claims databases as more current data become available. It also periodically "retrofits" its databases as errors are discovered. The updates and retrofits can sometimes have significant impacts on the results reported in this and previous documents if they occur after the data collection cutoff date. The reader should keep this in mind when comparing this year's results with those from previous reports.

DATA SOURCES

Health Care Survey of DoD Beneficiaries (HCSDB)

The HCSDB was developed by TRICARE Management Activity (TMA) to fulfill 1993 National Defense Authorization Act (NDAA) requirements and to provide a routine mechanism to assess TRICARE-eligible beneficiary access to and experience with MHS or with their alternate health plans. Conducted continuously since 1995, the HCSDB was designed to provide a comprehensive look at beneficiary opinions about their DoD health care benefits.

The worldwide, multiple-mode Adult HCSDB is conducted on a quarterly basis (every January, April, July, and October). Due to budget reductions, the HCSDB was not fielded in July 2013, so the annual results are based on three fiscal quarters, compared with FY 2011 and FY 2012, which were based on four fiscal quarters. The survey request is transmitted by e-mail to Active Duty and by postal mail to all other beneficiaries, with responses accepted by postal mail or Web. A worldwide Child HCSDB focusing on preventive services and healthy behaviors was in the field at the time of this writing from a sample of DoD children age 17 and younger.

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

The HCSDB is fielded to a stratified random sample of beneficiaries. In order to calculate representative rates and means from their responses, sampling weights are used to account for different sampling rates and different response rates in different sample strata. Beginning with the FY 2006 report, weights were adjusted for factors such as age and rank that do not define strata but make some beneficiaries more likely to respond than others. Because of the adjustment, rates calculated from the same data differ from past evaluation reports and are more representative of the population of TRICARE users.

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

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

Results provided from HCSDB in 2011 through 2013 were based on questions taken from the CAHPS Version 4.0 Questionnaire. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. Benchmarks for Version 4 CAHPS that used the HCSDB fielded in 2011, 2012, and 2013 come from the 2010, 2011, and 2012 National CAHPS Benchmarking Database (NCBD), respectively. Because of the wholesale changes in the questionnaire, changes in rates are only meaningful when compared to changes in the relevant benchmark.

The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by the AHRQ and administered by a contractor. Only health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (POS) plans are used in the calculation of the benchmark scores. Both benchmarks and TRICARE results are adjusted for age and health status. Differences between the MHS and the civilian benchmark were considered significant at less than or equal to 0.05, using the normal approximation. The significance test for a change between years is based on the change in the MHS estimate minus the change in the benchmark, which is adjusted for age and health status to match MHS. T-tests measure the probability that the difference between the change in the MHS estimate and the change in the benchmark occurred by chance. If p is less than 0.05, the difference is significant. Tests are performed using a z-test and standard errors calculated using SUDAAN to account for the complex stratified sample.

The HCSDB has been reviewed by an Internal Review Board (and found to be exempt) and is licensed by

DATA SOURCES *(CONT'D)*

DoD. Beneficiaries' health plans are identified from a combination of self-report and administrative data. Within the context of the HCSDB, Prime enrollees are defined as those enrolled at least six months.

Access and Quality

Survey-based measures of MHS access and quality were derived from the fiscal year 2010, 2011, 2012, and 2013 administrations of the HCSDB, TRICARE Inpatient Satisfaction Survey (TRISS), and TRICARE Outpatient Satisfaction Survey (TROSS), while military hospital quality measures were abstracted from clinical records by trained specialists and reported to the Joint Commission. The comparable civilian-sector benchmarks came from the NCBDs for 2010, 2011, and 2012 as noted on the previous page.

Preventable admission rates are calculated using both direct (military treatment facility [MTF]) care and purchased (civilian) care workload for adult patients age 18 and older. Each admission was weighted by its relative weighted product (RWP), a prospective measure of the relative costliness of an admission. Rates were computed by dividing the total number of dispositions/admissions (direct care and Civilian Health and Medical Program of the Uniformed Services [CHAMPUS]) by the appropriate population. The results were then multiplied by 1,000 to compute an admission rate per 1,000 beneficiaries.

Utilization and Costs

Data on MHS and beneficiary utilization and costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records), Comprehensive Ambulatory/Professional Encounter Records (CAPERs—MTF outpatient records), TRICARE Encounter Data (TED—purchased care claims information) for institutional and noninstitutional services, and Pharmacy Data Transaction Service (PDTS) claims within each beneficiary category.

Inpatient utilization was measured using dispositions (direct care)/admissions (purchased care) and Medical Severity Diagnosis Related Group (MS-DRG) RWPs, the latter being a measure of the intensity of hospital services provided. Outpatient utilization for both direct and purchased care was measured using encounters and an MHS-derived measure of intensity called Enhanced Total Relative Value Units (RVUs). MHS uses several different RVU measures to reflect the relative costliness of the provider effort for a particular procedure or service. Enhanced Total RVUs were introduced by MHS in FY 2010 (and retroactively applied to earlier years) to account for units of service (e.g., 15-minute intervals of physical therapy) and better reflect the resources expended to produce an encounter. The word "Total" in the name reflects that it is the sum of Work RVUs and Practice Expense RVUs. Work RVUs measure the relative level of resources, skill, training, and intensity of services provided by a physician. Practice Expense RVUs account for nonphysician clinical labor (e.g., a nurse), medical supplies and equipment, administrative labor, and office overhead expenses. In the private sector, Malpractice RVUs are also part of the formula used to determine physician reimbursement rates but since military physicians are not subject to malpractice claims, they are excluded from Total RVUs to make the direct and purchased care workload measures more comparable. For a more complete description of enhanced as well as other RVU measures, see *http://www.tricare.mil/ocfo/_docs/R-6-1000_Using%20the%20M2%20to%20Identify%20and%20Manage%20MTF%20Data%20Quality_Redacted.pptx*.

Costs recorded on TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the SIDR and CAPER data indicate the enrollment status of beneficiaries, the Defense Enrollment Eligibility Reporting System (DEERS) enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed in January 2014 as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans offered by large employers, including PPOs, POS plans, HMOs, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked Truven Health Analytics Inc. to compute quarterly benchmarks for HMOs and PPOs, broken out by product line (MED/SURG, OB, PSYCH) and several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2013, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2013 data to completion. Product lines were determined by aggregating Major Diagnostic Categories (MDCs) as follows: OB = MDC 14 (Pregnancy, Childbirth, and Puerperium) and MDC 15 (Newborns and Other Neonates with Conditions Originating in Perinatal Period), PSYCH = MDC 19 (Mental Diseases and Disorders) and MDC 20 (Alcohol/Drug Use and Alcohol/Drug Induced Organic Mental Disorders), and MED/SURG = all other MDCs. The breakouts by gender and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in DoD and civilian beneficiary populations. We excluded individuals age 65 and older from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

MILITARY HEALTH SYSTEM POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

State	Total Population	Prime Enrolled	TRS Enrolled
AK	89,416	70,100	1,094
AL	207,750	94,611	5,647
AR	91,215	38,012	3,980
AZ	203,395	102,298	5,374
CA	847,053	499,054	18,149
CO	249,870	159,069	6,479
CT	50,204	23,172	1,500
DC	22,886	17,076	453
DE	34,136	17,622	898
FL	687,859	343,725	15,774
GA	445,597	280,906	9,535
HI	165,250	125,214	1,995
IA	43,202	10,498	4,075
ID	50,016	21,191	3,125
IL	150,652	73,925	6,113
IN	88,065	25,528	6,221
KS	130,883	81,529	5,038
KY	163,485	101,906	4,972
LA	133,287	75,274	5,746
MA	70,745	30,323	4,319
MD	245,408	162,785	4,155
ME	39,763	23,589	1,730
MI	96,284	25,155	4,638
MN	63,941	14,102	8,336
MO	156,770	72,892	8,433
MS	115,515	58,452	5,882
MT	34,928	12,900	1,787
NC	519,496	336,993	10,093
ND	33,452	21,507	1,849
NE	61,379	30,226	3,372
NH	29,403	15,147	1,372
NJ	84,101	39,277	3,260
NM	88,662	50,229	1,338
NV	103,140	54,162	2,348
NY	185,042	94,082	5,120
OH	162,970	66,174	8,784
OK	162,730	95,069	5,004
OR	66,050	19,838	3,043
PA	160,891	47,445	6,368
RI	25,427	12,788	865
SC	243,916	133,167	6,813
SD	33,491	14,839	3,528
TN	193,024	88,203	7,855
TX	879,502	536,769	23,017
UT	70,892	32,052	6,380
VA	760,226	463,776	11,085
VT	12,908	5,245	817
WA	360,265	233,514	7,241
WI	68,525	14,797	5,024
WV	35,891	7,830	1,930
WY	22,454	12,011	1,042
Subtotal	**9,041,412**	**4,986,048**	**272,996**
Overseas	**546,529**	**338,658**	**3,777**
Total	**9,587,941**	**5,324,706**	**276,773**

Notes:

- Source of data is MHS administrative data systems, as of 12/4/2013 for end of FY 2013.
- "Prime Enrolled" includes Prime (military and civilian primary care managers), TRICARE Prime Remote (and Overseas equivalent), TRICARE Young Adult (TYA) Prime, and Uniformed Services Family Health Plan; and excludes members in TRICARE for Life, TRICARE Plus, TYA Standard, and TRICARE Reserve Select (TRS).

ABBREVIATIONS

ABA	Applied Behavior Analysis
AC	Active Component
ACA	Affordable Care Act
AD	Active Duty
ADFM	Active Duty Family Member
ADSM	Active Duty Service Member
AHRQ	Agency for Healthcare Research and Quality
AMI	Acute Myocardial Infarction
BACB	Behavior Analyst Certification Board
BCBA	Board Certified Behavior Analyst
BCaBA	Board Certified Assistant Behavior Analyst
BMI	Body Mass Index
BPH	Benign Prostatic Hyperplasia
BPSM	Basic Patient Safety Manager
BRAC	Base Realignment and Closure
C&G	Clinician and Group
CAC	Children's Asthma Care
CAD	Catchment Area Directory
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CAP	Consortium to Alleviate PTSD
CAPER	Comprehensive Ambulatory/Professional Encounter Record
CC	Complication/Co-morbidity
CCI	Chronic Condition Indicator
CCAE	Commercial Claims and Encounters
CDC	Centers for Disease Control and Prevention
CENC	Chronic Effects of Neurotrauma Consortium
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMS	Centers for Medicare and Medicaid Services
CONUS	Continental United States
COPD	Chronic Obstructive Pulmonary Disease
CSS	Customer Satisfaction Survey
CTE	Chronic Traumatic Encephalopathy
CY	Calendar Year
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHCAPE	Defense Health Cost Assessment and Program Evaluation
DHHS	U.S. Department of Health and Human Services
DHP	Defense Health Program
DM	Disease Management
DoD	Department of Defense
DRG	Diagnosis Related Group
DTF	Dental Treatment Facility
EASIV	Expense Assignment System IV
EBP	Evidence-Based Practice
ECHO	Extended Care Health Option
EFMP	Exceptional Family Member Program
EIA	Educational Interventions for Autism Spectrum Disorders
eMSM	Enhanced Multi-Service Market
ER	Emergency Room
FEHBP	Federal Employees Health Benefits Plan
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
HA	Health Affairs
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCSDB	Health Care Survey of DoD Beneficiaries
HEDIS	Healthcare Effectiveness Data and Information Set
HF	Heart Failure
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HP	Healthy People
HRB	Health Related Behaviors Survey of Active Duty Military Personnel
HRET	Health Research and Educational Trust
HTN	Hypertension
I/DES	Integrated/Disability Evaluation System
IHI	Institute for Healthcare Improvement
IMR	Individual Medical Readiness
LOS	Length of Stay
LVS	Left Ventricular Systolic
LVSD	Left Ventricular Systolic Dysfunction
MCMH	Marine Centered Medical Home
MCSC	Managed Care Support Contractor
MDC	Major Diagnostic Category
MDR	MHS Data Repository
MEB	Medical Evaluation Board
MEC	Minimum Essential Coverage
MED/SURG	Medical/Surgical
MERHCF	Medicare-Eligible Retiree Health Care Fund
MHS	Military Health System
MS-DRG	Medicare Severity Diagnosis Related Group

ABBREVIATIONS *(CONT'D)*

mTBI	Mild Traumatic Brain Injury
MTF	Military Treatment Facility
NADFM	Non-Active Duty Family Member
NCBD	National CAHPS Benchmarking Database
NCQA	National Committee for Quality Assurance
NCR	National Capital Region
NDAA	National Defense Authorization Act
NHANES	National Health and Nutrition Examination Survey
NHE	National Health Expenditures
NPI	National Provider Identifier
OASD	Office of the Assistant Secretary of Defense
OB	Obstetric
OB/GYN	Obstetrician/Gynecologist
OCO	Overseas Contingency Operations
OCONUS	Outside Continental United States
OHI	Other Health Insurance
O&M	Operations and Maintenance
OPPS	Outpatient Prospective Payment System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMH	Patient-Centered Medical Home
PDHA	Post-Deployment Health Assessment
PDHRA	Post-Deployment Health Reassessment
PDTS	Pharmacy Data Transaction Service
PEP	Projection of Eligible Population
PfP	Partnership for Patients
PH	Psychological Health
PI	Program Integrity
PN	Pneumonia
POD	Pharmacy Operations Directorate
POS	Point-of-Service
PPO	Preferred Provider Organization
PRISM	Provider Requirement Integrated Specialty Model
PSA	Prime Service Area
PSM	Patient Safety Manager
PSR	Patient Safety Reporting
PSYCH	Mental Health
PTSD	Post-Traumatic Stress Disorder
RA	Reserve Affairs
RC	Reserve Component
RCA	Root Cause Analysis
RCCPDS	Reserve Components Common Personnel Data System
RDT&E	Research, Development, Test and Evaluation
RETFMs	Retirees and Family Members
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SCIP	Surgical Care Improvement Project
SCMH	Soldier Centered Medical Home
SIDR	Standard Inpatient Data Record
TAMP	Transitional Assistance Management Program
TBI	Traumatic Brain Injury
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TED-I	TRICARE Encounter Data-Institutional
TED-NI	TRICARE Encounter Data-Noninstitutional
TFL	TRICARE for Life
TIA	Transient Ischemic Attack
TMA	TRICARE Management Activity
TPR	TRICARE Prime Remote
TRDP	TRICARE Retiree Dental Program
TRISS	TRICARE Inpatient Satisfaction Survey
TRO	TRICARE Regional Office
TROSS	TRICARE Outpatient Satisfaction Survey
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TYA	TRICARE Young Adult
UMP	Unified Medical Program
USFHP	Uniformed Services Family Health Plan
USU	Uniformed Services University of the Health Sciences
VA	Department of Veterans Affairs

The **Evaluation of the TRICARE Program: Fiscal Year 2014 Report to Congress** is provided by the Defense Health Agency, Defense Health Cost Assessment and Program Evaluation (DHCAPE), in the Office of the Assistant Secretary of Defense (Health Affairs) (OASD[HA]). Once the Report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.tricare.mil/tma/StudiesEval.aspx.*

Key agency and individual contributors to this analysis (and their areas of expertise):

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

Government Agency Analysts and Reviewers:
OASD(HA) and DHA
Greg Atkinson, M.B.A. (Provider Productivity)
Tara Blot (Benefits)
Margaret Class, R.N. (Clinical Quality)
William Davies (Pharmacy)
Jody W. Donehoo, Ph.D. (Reserve Benefits)
Heather A. Ford, M.B.A. (Budget)
Judy George, M.H.S.A. (Patient Safety)
Kelly Kuzel, M.S. (Purchased Care Analyst)
Kimberley A. Marshall, Ph.D. (TROSS, TRISS Surveys)
Gary (Chad) Martin, Col., USAF, D.C., M.P.H. (Dental)
Robert J. Moss, Jr., M.H.A. (Accrual Fund)

Data Support:
Altarum Institute
Michelle Kloc, Ph.D., R.N.
Matt Michaelson, G.I.S.P. (Mapping)
Joe Swedorske, M.S.

Lead Analytic Support:
Institute for Defense Analyses
Philip Lurie, Ph.D.
Lawrence Goldberg, Ph.D.
Susan L. Rose, Ph.D.
Maggie X. Li

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

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


DHA
Defense Health Agency


DEPARTMENT OF DEFENSE
UNITED STATES OF AMERICA
UNITED STATES MARINE CORPS
DEFENSE HEALTH AGENCY
PUBLIC HEALTH SERVICE
1798
NOAA