UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 26 2015

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense's Fiscal Year (FY) 2015 Evaluation of the TRICARE Program Report to Congress. The enclosed report responds to the requirement in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104-106), as amended by section 714 of the NDAA for FY 2013 (Public Law 112-239), by addressing access and quality for members of the Armed Forces (whether in the regular or reserve components) and their dependents, military retirees and their dependents, as well as dependents of members on Active Duty with severe disabilities and chronic health care needs.

Our funded $48.5 billion FY 2015 Unified Medical Program (UMP) supports the physical and mental health of 9.5 million beneficiaries worldwide. Representing about 8 percent of the total Department of Defense outlays, the UMP includes $7 billion normal cost contribution to pay for the future cost of care for our dual-Military Medicare-eligible beneficiaries, and almost $3 billion for overseas contingency operations. As appropriated, the FY 2015 UMP is almost 2 percent lower than FY 2014 expenditures, and is over 8 percent lower than our peak funding of $53 billion in FY 2012.

The FY 2015 eligible population is projected to be slightly less than in FY 2014 as Active Duty Service members and their families depart the military, and Reservists return to non-active status in their civilian lives, but buoyed by an increase in the number of retirees and family members retaining their TRICARE eligibility and continued increased enrollment by non-active Reservists into the premium-based TRICARE Reserve Select instead of private health insurance, and Reservists enrolling in TRICARE Retired Reserve pending reaching retirement age for full TRICARE benefits. Consistent with national health care trends, total Military Health System (MHS) workload decreased from FY 2012 to FY 2014 for inpatient care (-8 percent), outpatient care (-4 percent), and prescription drugs (-5 percent). Costs were moderated in FY 2014 by over $1.3 billion collected due to pharmacy refunds, $195 million in program integrity (anti-fraud/abuse) and claims recoveries, and encouraging the use of the less costly pharmacy home delivery program and generic drugs.

As the Defense Health Agency approached the end of its first year since standing up on October 1, 2013, on May 28, 2014, the Secretary of Defense ordered a comprehensive review of the MHS with respect to access to care, the quality of care, and the safety of our patients. Overall, the MHS Review team found that the MHS provides safe, timely, and quality care. External experts validated that the review was conducted appropriately and that the MHS is using measures consistent with other health organizations. However, the MHS does demonstrate performance variability compared to civilian counterparts and national benchmarks, outperforming in some areas and under-performing in others. The external experts confirmed that greater focus and improvement is required for the MHS to become a top-tier health system in all facets of our delivery system. We continuously strive to improve the quality of health care and safety of our patients, engaging our population to improve in healthy behaviors, and assessing beneficiary satisfaction.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the President of the Senate, the Speaker of the House, and the Chairpersons of the other congressional defense committees.

Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

MAR 26 2015

Dear Mr. Chairman:

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 26 2015

The Honorable Thad Cochran
Chairman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

I am pleased to provide you with the Department of Defense's Fiscal Year (FY) 2015 Evaluation of the TRICARE Program Report to Congress. The enclosed report responds to the requirement in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104-106), as amended by section 714 of the NDAA for FY 2013 (Public Law 112-239), by addressing access and quality for members of the Armed Forces (whether in the regular or reserve components) and their dependents, military retirees and their dependents, as well as dependents of members on Active Duty with severe disabilities and chronic health care needs.

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Barbara A. Mikulski
Vice Chairwoman

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 26 2015

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 26 2015

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

Dear Mr. President:

I am pleased to provide you with the Department of Defense's Fiscal Year (FY) 2015 Evaluation of the TRICARE Program Report to Congress. The enclosed report responds to the requirement in section 717 of the National Defense Authorization Act (NDAA) for FY 1996 (Public Law 104-106), as amended by section 714 of the NDAA for FY 2013 (Public Law 112-239), by addressing access and quality for members of the Armed Forces (whether in the regular or reserve components) and their dependents, military retirees and their dependents, as well as dependents of members on Active Duty with severe disabilities and chronic health care needs.

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
H-209, The Capitol
Washington, DC 20515

MAR 26 2015

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Sincerely,

Jessica L. Wright

Enclosure:
As stated

Evaluation of the TRICARE Program:

Access, Cost, and Quality

Fiscal Year 2015 Report to Congress

Evaluation of the TRICARE Program:

Access, Cost, and Quality

Fiscal Year 2015 Report to Congress

February 28, 2015

The Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2015 Report to Congress is provided by the Defense Health Agency (DHA), Decision Support Division, 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.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program*.

Front cover photo descriptions, from left to right:

A – A C-130H Hercules aircraft assigned to the 142nd Airlift Squadron, Delaware Air National Guard on the flight line at Lielvarde Air Base, Latvia. (September 2014)

B – A Staff Sergeant inspects an MQ-9 Reaper with the 62nd Expeditionary Reconnaissance Squadron at Kandahar Airfield, Afghanistan. (August 2014)

C – A Marine Lieutenant Colonel pins a Meritorious Service Medal onto a Marine involved in the defense of Camp Bastion, Afghanistan. (May 2013)

D – An aircrew aboard an MH-65C Dolphin helicopter raises the basket from a Customs and Border Patrol Office of Air and Marine boat crew aboard a 38-foot Coast Guard vessel. (July 2013)

E – An Army Sergeant First Class with the Army Special Operations Command team passes the Olympic torch to a retired Marine Corporal and gold medal Paralympian during the opening ceremonies of the 2014 Warrior Games. (September 2014)

F – Pacific Partnership personnel help deliver boxes of donated medical supplies to the Gizo Branch of the Solomon Islands Red Cross during Pacific Partnership 2013. (August 2013)

G – A paratrooper assigned to 4th Battalion, 319th Airborne Field Artillery Regiment, 173rd Infantry Brigade Combat Team (Airborne) conducts a training jump. (February 2014)

H – An airman from the Senegalese air force explains to a Staff Sergeant how they use the Mi-17 helicopter to sling-load cargo. (June 2014)

I – Sailors direct an F/A-18E Super Hornet on the flight deck of the aircraft carrier USS George H.W. Bush (CVN 77). (October 2014)

J – A member of the Wounded Warrior Amputee Softball Team gets instruction from the first base coach during a game. (January 2013)

K – A Chief Master Sergeant demonstrates how to hook up a winch in Dakar, Senegal. (June 2014)

L – A Corporal and Lieutenant Corporal provide security as a CH-53E Super Sea Stallion helicopter lands during a mission in Helmand Province, Afghanistan. (October 2012)

M – Three 100th Battalion World War II Veterans give honors during a French Legion of Honor ceremony aboard the French Floreal-class frigate FS Prairial (F731). (July 2014)

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

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BETTER HEALTH

LOWER COST

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

It is an honor and privilege to provide to the 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) and to section 714 of the NDAA for FY 2013 (Public Law 112–239), which expanded 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, military retirees and their dependents, and dependents of members on Active Duty with severe disabilities and chronic health care needs.

Our $48.5 billion FY 2015 Unified Medical Program (UMP) supports the physical and mental health of our 9.5 million beneficiaries worldwide, and is almost 2 percent lower than actual FY 2014 expenditures, and $4.5 billion less than our peak expenditures in FY 2012 (nearly $53 billion). The UMP continues to represent about 8 percent of the total Department of Defense (DoD) outlays, including $7 billion to fund the future cost of care for our dual-Military Medicare-eligible beneficiaries, and almost $3 billion for overseas contingency operations, even as Active Duty Service members and their families depart the military, and Reservists return to non-active status in their civilian lives. The TRICARE-eligible population has not declined as fast as the Active forces or Active Reserves returning to civilian life because of the increase in the number of retirees and family members and continued increased enrollment by non-active Reservists into the premium-based TRICARE Reserve Select instead of private health insurance; Reservists enrolling in TRICARE Retired Reserve, pending reaching retirement age for full TRICARE benefits; and young adults up to the age of 26 eligible for TRICARE Young Adult, similar to coverage required by the Affordable Care Act.

I reported last year that military medicine is undergoing major changes, which will continue in the near future in response to fiscal challenges to reduce and consolidate infrastructure, and specifically, to section 731 of NDAA 2013 (Public Law 112-239) requiring a detailed plan for the reform of the administration of the Military Health System (MHS). The Defense Health Agency (DHA) became operational at the beginning of FY 2014, on October 1, 2013. Operating under my authority and as a designated combat support agency, the DHA has oversight from the Chairman of the Joint Chiefs. Within MHS, the Military Departments will retain their own medical commands, with each led by their respective surgeon general.

The DHA is responsible for shared health care support services, initially consisting of 10 shared services, half of which reached initial operational capability (IOC) with the stand-up of the Agency on October 1, 2013, and the remaining reaching IOC in FY 2014. All shared services are programmed to reach full operational capability by October 1, 2015.

Additionally, under DHA, six enhanced Multi-Service Market Areas, or eMSMs, have been established, each led by a flag or general officer responsible for integrating resources and adhering to jointly developed five-year marketing plans. These enhanced markets are the Washington, D.C., area; San Antonio, Texas; Colorado Springs, Colorado; the Puget Sound region of Washington state; the Tidewater area of Virginia; and Oahu Island in Hawaii.

As the DHA was standing up, on May 28, 2014, the Secretary of Defense ordered a comprehensive review of MHS. The review was to assess whether: (1) Access to medical care in MHS meets defined standards; (2) The quality of health care in MHS meets or exceeds defined benchmarks; and (3) MHS has created a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. The MHS Review included industry-standard measure sets with hundreds of sub-measures across safety, quality, and access for the direct care system, as well as measures used for assessing the care provided by our private sector network. Metrics included externally established and reported measures, along with internal MHS metrics and benchmarks. In addition to DoD and Service subject matter experts, the review team included six independent and esteemed external experts in patient safety and quality, who reviewed both the methodology for assessing access, safety and quality and the actual performance of MHS. All external reviewers acknowledged the challenge of comparing performance across health systems and noted that many of the challenges facing MHS are similar to challenges inherent throughout U.S. health care. Overall, the MHS Review team found that MHS provides safe, timely, and quality care. However, MHS does demonstrate performance variability compared to civilian counterparts and national benchmarks, outperforming in some areas and under-performing in others. The external experts validated that the review was conducted appropriately and that MHS is using measures consistent with other health organizations. They confirmed that greater focus and improvement is required for MHS to become a top-tier health system in all facets of our delivery system.

This annual 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 some of the strategic imperatives we continually monitor. We assess MHS cost, quality, and access against corresponding civilian benchmarks where available and appropriate. 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 benefits and our processes. Once this report has been sent to the Congress, an interactive digital version with enhanced functionality and searchability will be available at: *http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.*

—Jonathan Woodson, M.D.

MHS PURPOSE, MISSION, VISION, AND STRATEGY

The purpose, mission, vision, and overall strategy of senior Department of Defense (DoD) and Military Health System (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.

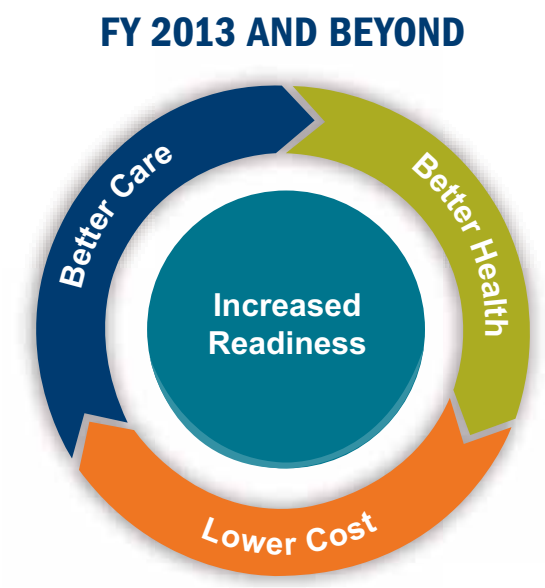
MHS is a global system delivering health services—anytime, anywhere. In everything we do, we adhere to common principles that are essential for accomplishing our mission and achieving our vision.

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

The MHS Quadruple Aim has served as the MHS strategic framework since the fall of 2009, and continues to remain relevant in describing our priorities and strategies for the coming years. This framework was 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*). Senior MHS leaders modified the Quadruple Aim in FY 2013 by explicitly emphasizing the desired direction of improvement: toward increased readiness, better care, better health in our population, and at lower costs to the Department and MHS.

The MHS Quadruple Aim

- **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.
- **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.



- **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.
- **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.)*

Defense Secretary Chuck Hagel has given six "priorities" to Service Secretaries and Chiefs as well as combatant commanders as the Pentagon prepares to move ahead with living under sequestration.

1. **Institutional reform:** Cut the Defense Department's 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 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:** 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 enterprise-wide 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 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 enterprise-wide 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 MHS, and executes responsibility for shared services, functions, and activities of 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 2014

MHS Worldwide Summary

- The nearly $48.5 billion Unified Medical Program (UMP) authorized in fiscal year (FY) 2015 is almost 2 percent lower than actual expenditures of over $49.3 billion in FY 2014, and remains at about 8 percent of the overall Defense budget (ref. pages 22–23).
- The number of beneficiaries eligible for Department of Defense (DoD) medical care fell slightly, from 9.66 million in FY 2012 to 9.53 million in FY 2014 (ref. page 14). The number of Prime-enrolled beneficiaries remained between 5.4 million and 5.5 million from FY 2009 to FY 2012 but began to fall in FY 2013 and reached 5.1 million in FY 2014, corresponding to a drop in the eligible population (ref. page 19).
- **TRICARE Young Adult (TYA):** Almost 42,000 young adults under age 26 enrolled in TYA in FY 2014, with 60 percent selecting the Prime option (ref. page 61).
- **Reserve Component (RC) Enrollment in TRICARE Plans:** Enrollment for Selected Reserve members and their families in TRICARE Reserve Select (TRS) increased to almost 122,000 plans/324,000 covered lives, and to almost 2,000 plans/4,700 covered lives for retired Reservists and their families in TRICARE Retired Reserve (TRR).

MHS Workload and Cost Trends[1]

- The percentage of beneficiaries using MHS services remained about the same between FY 2012 and FY 2014, at just under 85 percent (ref. page 20).
- Excluding TRICARE for Life (TFL), total MHS workload (direct and purchased care combined) fell from FY 2012 to FY 2014 for inpatient care (–8 percent), outpatient care (–4 percent), and prescription drugs (–3 percent) (ref. pages 25, 26, 28).
- Direct care workload decreased for inpatient care (–1 percent), outpatient care (–2 percent), and prescription drugs (–3 percent) from FY 2012 to FY 2014. Overall, direct care costs rose by only 0.1 percent. Excluding TFL, purchased care workload fell for inpatient care (–12 percent), outpatient care (–5 percent), and prescription drugs (–5 percent). Overall, purchased care costs rose by less than 1 percent (ref. pages 25, 26, 28).
- The purchased care portion of total MHS health care expenditures remained at about 50 percent from FY 2012 to FY 2014 (ref. page 31).
- In FY 2014, out-of-pocket costs for MHS beneficiary families under age 65 were between $4,800 and $5,200 lower than those for their civilian counterparts, while out-of-pocket costs for MHS senior families were $2,700 lower (ref. pages 94, 96, 99).

Lower Cost

- MHS estimated savings include $1.3 billion in retail pharmacy refunds in FY 2014, $182 million in Program Integrity (PI) activities in calendar year (CY) 2013, and an additional $13.4 million in claim recoveries in FY 2014 (ref. page 77).

Increased Readiness

- **Force Health Protection:** In FY 2014, the Active Component (87 percent) and Reserve Component (84 percent) each exceeded the strategic goals of 82 percent Total Force medically ready to deploy, for an overall readiness status of 86 percent. Dental readiness remained high in FY 2014, at 93 percent (ref. pages 33–34).

Better Care

- **Access to Care:** In FY 2014, nearly 88 percent of Prime enrollees reported at least one outpatient visit, compared with 85 percent for the national benchmark. Patient-Centered Medical Home (PCMH) primary care administrative measures showed improvement in provider and team continuity, reduced third-available wait time, and reduced inpatient bed days per 1,000 enrollees. DHA and Service surveys of beneficiary self-reported outpatient experience generally show strong and stable ratings of access to care. Population-based surveys indicate that ratings for getting needed care, getting care quickly, and getting referrals to specialists improved between FY 2012 and FY 2014, but lagged the civilian benchmarks (ref. pages 35–36, 39).
  - **MHS Provider Trends:** The number of TRICARE network providers increased by 20 percent from FY 2010 to FY 2014. The total number of participating providers increased by 8 percent over that same time period (ref. page 62).
  - **Access for TRICARE Standard/Extra Users:** Eight of 10 physicians accept new TRICARE Standard patients, higher acceptance than behavioral health providers (ref. page 63).
- **Quality of Care—National Hospital Quality Measures:** Military treatment facility (MTF)- and MHS-supporting civilian hospitals report many Joint Commission quality measures that are comparable to the national standards (ref. pages 43–45).
- **Beneficiary Ratings of Inpatient and Outpatient Care:** MHS beneficiaries generally rate the TRICARE health plan higher than the average civilian benchmark CAHPS rating, while lagging average civilian ratings of providers of overall care (ref. page 47).
- **Patient Safety:** Since 2010, DoD's Patient Safety Report continues to reflect trends in harm stratification across MHS that are consistent with industry standards of reporting (ref. pages 54–56).

Better Health

- MHS continues to exceed some population health measures such as Healthy People (HP) 2020 goals for mammograms, prenatal exams, non-smoking, and HEDIS cervical cancer screening (ref. pages 65–67).

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

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

- **TRICARE Standard** is the non-network benefit, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), open to all eligible DoD beneficiaries, except ADSMs. Beneficiaries who are eligible for Medicare Part B are also covered by TRICARE Standard for any services covered by TRICARE but not covered by Medicare. 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 up to 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 [TDP] and the TRICARE Retiree Dental Program [TRDP]);
  - Pharmacy benefits in MTFs, via TRICARE retail network pharmacies, and through the TRICARE Pharmacy Home Delivery program (formerly called TRICARE Mail Order Pharmacy);
  - Overseas purchased care and claims processing services;
  - Programs supporting the Reserve Components (RCs), including the premium-based TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR) for those who are retired from Reserve status but not yet eligible for the TRICARE benefits as a military retiree;
  - Supplemental programs including TRICARE Prime Remote (TPR) in the United States and overseas, DoD-Veterans Affairs (VA) sharing arrangements, and joint services;
  - Designated Provider/Uniformed Services Family Health Plan (USFHP), which provides the full TRICARE Prime benefit, including pharmacy, under capitated payment to non-Active Duty MHS enrollees at six statutorily 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 Reserve Component members who have served more than 30 consecutive days in support of a Contingency Operation, or certain Active Component members separating from Active Duty, continued access to the TRICARE benefit for 180 days after release from Active Duty.

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 2014 SUPPORTING THE MHS QUADRUPLE AIM

The Military Health System (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

Government Shutdown

On October 1, 2013, for those DoD employees not considered as working in an excepted function, work stopped due to a government shutdown. The shutdown remained in effect for Defense Health Agency (DHA) employees until October 7, when they were recalled to normal operations. During the shutdown, certain aspects of medical and dental care were excepted and continued on, including inpatient care in DoD military treatment facilities (MTF) and attendant maintenance of patient medical records, surgery to continue recovery of function/appearance of Wounded Warriors, acute and emergency outpatient care in DoD medical and dental facilities, private sector care under TRICARE, and certification of eligibility for health care benefits. Elective surgery and other elective procedures in DoD medical and dental facilities were not excepted activities. Patients seeking new routine appointments during this time may have experienced delays.

DoD Closes U.S. Walk-In Service Centers

Walk-in, face-to-face customer service at the TRICARE Service Centers (TSCs) located within the 50 United States was closed on April 1, 2014. Due to the unique needs at our overseas installations, walk-in customer service continues to be available at the TSCs located overseas. When TRICARE was first implemented to replace CHAMPUS almost 20 years ago, walk-in customer service at the TSCs was viewed as critical to the success of the program, education of our beneficiaries, and prompt resolution of beneficiary issues. For the first time, TRICARE provided our beneficiaries with three plan options (TRICARE Prime, TRICARE Extra, and TRICARE Standard), as well as enrollment requirements, network providers, and enrollment fees, and introduced new managed care concepts. With TRICARE now a very mature program, and more and more beneficiaries using electronic communications when needing assistance (Internet Web sites, mobile applications, and toll-free telephone service), walk-in customer service is no longer needed. Recent surveys indicate that 88 percent of all customer service visits to the TSCs concerned benefits, available plans, billing, enrollment, changing primary care managers, or referrals—all of which can easily be researched and resolved using one of the Web sites or by calling the customer service center. The remaining 12 percent of inquiries primarily concerned claims, which can also be resolved using the dedicated claims Web site or call center. Few, if any, commercial health plans offer walk-in customer service centers, as it is by far the most expensive option available to provide customer service. Closure of the TSCs in the United States reduces the cost of administering TRICARE.

A detailed communication plan was implemented to advise all beneficiaries of the pending TSC closures and educate them on the numerous other customer service options available. Emphasis was placed on the "I want to..." section of the *www.tricare.mil* Web site, which provides quick, one-stop access to TRICARE information and links to secure Web sites to assist beneficiaries with questions about benefits, plan options, enrollment, claims, referrals, changing primary care managers, finding a physician, etc. The implementation team also monitored several customer service standards required of our managed care support contractors (MCSCs), who contractually must meet specific targets for answering calls, providing information, and responding to inquiries. Those contractual standards remain in place. This change supports the Department's efforts to manage the rising cost of providing health care for our 9.5 million beneficiaries without making any changes to the benefits, fees, or beneficiary cost-shares. Data and feedback received since the closures indicates that the electronic communication options and our contractors' customer service centers continue to serve our beneficiaries efficiently and effectively.

DoD Awards Express Scripts a Seven-Year Contract to Administer TPharm4

Express Scripts was awarded the next generation TRICARE Pharmacy support contract administered by the DHA. Pharmacy services under this contract are scheduled to begin May 1, 2015. The company has been providing DoD's home delivery, retail pharmacy network services, and specialty pharmacy services since 2003, 2004, and 2009, respectively. The company's services will expand under the new TRICARE Pharmacy Program, Fourth Generation (TPharm4) contract.

DoD Renews WPS Health Insurance Contract

Wisconsin Physicians Service (WPS), the current administrator of TRICARE for Life (TFL) was awarded a six-year $515 million contract renewal. TFL currently provides Medicare wraparound coverage to about 2 million military retirees. WPS has held the contract since 2004. The new contract went into effect on January 1, 2015.

NEW BENEFITS AND PROGRAMS IN FY 2014 SUPPORTING THE MHS QUADRUPLE AIM *(CONT.)*

Mailed Benefit Update Notification Letters Discontinued

The DoD will no longer send paper letters through the mail to notify beneficiaries about changes to their coverage and eligibility status. TRICARE beneficiaries should watch their e-mail for notifications directing them to go to milConnect and read new letters. Postcards will be sent to those who do not have an e-mail address in the Defense Enrollment Eligibility Reporting System (DEERS).

Defense Health Agency Addresses Research Oversight Compliance

The DHA has established a Research Regulatory Oversight Office to ensure compliance with the DoD's ethical and regulatory requirements for research activities involving humans and animals. The new office, along with the DHA Privacy and Civil Liberties Office, launched a new Web tool to standardize the way researchers obtain the compliance information and documents needed to ensure the publication of their work. The new tool is available and can be accessed on the MHS Web site.

Prime Eligibility Reinstated for Some Beneficiaries

The FY 2014 National Defense Authorization Act (NDAA) required DoD to give beneficiaries affected by the October 2013 Prime Service Area (PSA) reduction a one-time option to continue in TRICARE Prime. In accordance with the law, TRICARE sent letters in April 2013 to notify those eligible for Prime eligibility reinstatement. Approximately 76,000 of the 177,000 who lost eligibility in 2013 were eligible for reinstatement. The remaining beneficiaries either moved and were no longer affected or did not live both in a ZIP code designated as a PSA prior to the 2013 change and within 100 miles of an MTF.

Affordable Care Act (ACA) Has Little Impact on TRICARE Beneficiaries

The majority of TRICARE beneficiaries met the minimum essential coverage (MEC) required as of January 1, 2014, under the ACA. This included all beneficiaries enrolled in:

- 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
- Uniformed Services Family Health Plan
- TRICARE Reserve Select
- TRICARE Retired Reserve
- TRICARE Young Adult
- Continued Health Care Benefit Program

The following premium-based TRICARE plans also met the ACA MEC requirements (but only if purchased):

Beneficiaries who do not have MEC from DoD include those eligible only for care in MTFs (not eligible for TRICARE coverage by civilian providers) and former members eligible for MTF care only for Line of Duty conditions; those who choose not to purchase premium-based TRICARE coverage; and those losing TRICARE coverage due to loss of military benefits. All have several options to comply with the ACA mandate.

QUADRUPLE AIM: INCREASED READINESS

DoD Reviews Traumatic Brain Injury (TBI) Policy Guidance

The Department has a specific set of policies pertaining to the management of concussions and mild TBI that occur in the deployed setting. In response to section 723 of the FY 2014 NDAA, the Department has reported on how it identifies, refers, and treats TBI for Service members who served in Operation Iraqi Freedom or Operation Enduring Freedom before the June 2010 Directive-Type Memorandum 09-033 entitled "Policy Guidance for Management of Concussion/Mild Traumatic Brain Injury in the Deployed Setting." Current MHS policies were found to be robust, to exceed civilian standards, and to offer an unprecedented safety net of care.

Integrated Disability Evaluation System (IDES)

DoD has conducted a review of the IDES backlog of pending cases with respect to members of the Reserve Components of the Armed Forces. The report addressed several issues, including the current number of pending IDES cases, average case processing time, measures to resolve the backlog, resolution date for case backlog, progress to transition IDES to a readily accessible electronic format for Service members, a cost estimate for the integrated and readily accessible electronic format, and assessment of the feasibility of improving in-transit visibility of pending cases.

Policies Regarding Members of the Armed Forces Infected with HIV or HBV Reviewed

The DoD and the Military Services have policies in place to address the management of individuals with Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV). The Department responded to section 572 of the FY 2014 NDAA by reporting on these policies. The report reviewed the policies for accession, retention, deployment, and discharge. It found that the policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed

regularly and updated as practices, guidelines, and standard of care have evolved.

DCoE Hosts "Living Blog" as Mental Health Resource

To mark the importance of reaching out for help, a "living blog" question-and-answer forum was hosted in May by Defense Centers of Excellence (DCoE) social media (DCoE Blog, Facebook, and Twitter) as part of Mental Health Awareness Month. Service members, Veterans, and families posted questions about mental health, and psychology experts provided answers within 24 hours, with questions on Post-Traumatic Stress Disorder (PTSD) dominating the forum. The experts addressed concerns related to angst associated with denied re-enlistment due to PTSD diagnosis, confusion about military medical terms and diagnostic inconsistencies, family difficulties stemming from a PTSD diagnosis, and escalating PTSD symptoms.

QUADRUPLE AIM: BETTER CARE

Comprehensive Review of the Military Health System

Secretary Hagel ordered a 90-day comprehensive review of the Department's MHS in May. The review focused on the core areas of access to health care, safety of care, and quality of care. The final report was delivered at the end of August. The MHS Review team found that, overall, MHS provides safe, timely, and quality care. However, MHS does demonstrate performance variability compared to civilian counterparts and national benchmarks, outperforming in some areas and under-performing in others.

TRICARE Simplifies ABA Benefits

On July 25, 2014, TRICARE introduced a new Applied Behavior Analysis (ABA) policy that covers all beneficiaries with autism spectrum disorder (ASD) under a single benefit. Prior to the change, beneficiaries with ASD received ABA coverage through one of three programs, depending on their sponsor's duty status. The new Autism Care Demonstration program combines these three programs into a single benefit and offers several enhancements to previous ABA TRICARE programs. All beneficiaries who received ABA under the prior benefits will transition to the new benefit by December 31, 2014, with no gap in coverage (source: *http://www.tricare.mil/CoveredServices/BenefitUpdates/Archives/06_16_14_AutismCareDemo.aspx*).

TRICARE Increases Access to Mental Health Counselors

The TRICARE benefit now offers beneficiaries a choice between two qualified mental health counselor types: independent practicing TRICARE Certified Mental Health Counselors (TCMHC) and Supervised Mental Health Counselors (SMHC). TCMHCs can independently treat TRICARE beneficiaries, while SMHCs will continue to practice under the referral and supervision of TRICARE-authorized physicians. Beneficiaries currently receiving treatment can continue with their existing provider regardless of their counselor's provider type (source: *http://www.tricare.mil/CoveredServices/BenefitUpdates/Archives/07_18_14_TCMHCS.aspx*).

TRICARE Plans to Change Counselor Accreditation Requirements

Starting January 1, 2015, all counselors serving clients under TRICARE must have graduated from a university accredited by the Council for Accreditation of Counseling and Related Educational Programs. The purpose of these changes is to improve mental health care for the military.

TRICARE Launches New Laboratory-Developed Test Demonstration

By law, TRICARE has only covered medications and medical devices (such as laboratory developed tests [LDTs]) that have been reviewed and approved by the Food and Drug Administration (FDA). The demonstration announced on June 18, 2014, will permit the DoD to review tests not examined by the FDA to determine if they are safe and effective for use, and establish a list of those tests. The regional contractor must preapprove use of the test for it to be covered. Beneficiaries who have paid for covered LDTs included in the demonstration since January 1, 2013, will be eligible for retroactive reimbursement (source: *http://armymedicine.mil/Pages/TRICARE_launches_new_laboratory_developed_test_demonstration.aspx*).

TRICARE to Cover Single-Level Cervical Total Disc Replacement

The decision to cover the surgery was made in January 2014 following a re-evaluation of a prior decision to not cover the artificial disc-replacement procedure. The procedure can help troops suffering from certain spinal injuries enjoy a quicker recovery. The decision will affect military personnel going forward as well as those who have sought treatment since December 2012.

TRICARE South Region United States Coast Guard (USCG) Access to Care Demonstration for TRICARE Prime/TRICARE Prime Remote (TPR) Beneficiaries

The purpose of the demonstration project is to determine if the elimination of the requirement to obtain a referral influences beneficiaries to seek care at less intensive health care resources such as a TRICARE authorized Urgent Care Center (UCC), rather than the Emergency Room (ER).

The goal of this demonstration is to decrease emergency room costs, increase access to care, and improve patient satisfaction. If USCG Service members or their families are unable to get an appointment

with their primary care manager (PCM) for acute/urgent care, they may visit a TRICARE South network urgent care center up to four times for each family member per fiscal year without prior authorization. The demonstration began January 1, 2012 and has been extended until May 4, 2015.

Access to primary health care for acute episodic primary care continues to be in high demand by TRICARE Prime beneficiaries. The current law and regulations require that Prime beneficiaries obtain a referral for primary or urgent care if they seek that care from someone other than their PCM. As a result, when an enrollee needs urgent care after hours or when the PCM in the MTF does not have available appointments, they have been seeking care from civilian sources such as the ER or with a UCC, including Convenience Clinics. MHS continues to promote secure messaging and the Nurse Advice Line (NAL) to enhance beneficiary access to advice and care outside the routine patient-provider encounter (see page 37).

In an effort to avoid overuse of ER care and meet the demand for acute primary care, many facilities have expanded acute care hours within the MTFs or worked with the managed care support contractors (MCSCs) to use provider groups or UCCs in their network. However, these visits require an authorization. Seeking emergency care in an ER does not require authorization. Additionally, the cost of care in a civilian ER for non-emergent reasons is much higher than any other source of care.

QUADRUPLE AIM: BETTER HEALTH

Navy and Marine Corps Public Health Center (NMCPHC) Launches New App

NMCPHC partnered with the DoD's National Center for Telehealth and Technology (T2) to develop a mobile app edition of the Navy Leader's Guide. The guide is primarily designed for sailors in supervisory roles to help them identify other sailors who may be in distress. It provides information on operational stress control, suicide prevention, mental health, medical issues, and common problems that junior sailors face. In addition, it provides supportive interventions, resources, and strategies, as well as guidance for leaders when they are assisting a distressed sailor. The app contains the same resources available in the online version in a format optimized for mobile devices, and can be downloaded from iTunes and Google Play. It can also be accessed from both the NMCPHC and T2 Web sites.

DoD Expands Available Treatments for Substance Abuse

Restrictions prohibiting TRICARE from covering certain drug therapies used in substance abuse treatment were lifted on November 21, 2013. Previous rules allowed TRICARE to cover these medications—but only for short-term, intense detoxification or pain management. This policy differed from the general medical community, which has found such treatments to be effective as part of an overall treatment plan to wean patients from opiate painkillers. The proposal for change gained steam in September 2012, after an Institute of Medicine panel urged the Pentagon to change the restrictions "to reflect the practice of contemporary health plans and be consistent with the range of treatments available." Pain medication abuse remains a concern in the military, where prescriptions for such drugs have skyrocketed in the past decade.

DoD and Military Service Branches Release a Series of Free Programs to Support Healthy Living

Some examples of the newly released tools and mobile apps include:

- **My Pregnancy A to Z Journal**: This pregnancy app from the Air Force's Center of Excellence for Medical Multimedia allows users to track health statistics, manage appointments, maintain a pregnancy journal, note vaccinations and immunizations, upload ultrasounds, record doctor's notes, and more.
- **The Big Moving Adventure**: Created through a partnership between the National Center for Telehealth and Technology (T2) and the Sesame Workshop, this app helps children ages three to five cope with the mental stresses associated with moving to a new area.
- **Pier Pressure**: Developed by the Navy, the Pier Pressure app promotes responsible drinking by integrating real-life choices into a fun game. It also provides resources to help individuals drink responsibly using a blood alcohol content calculator.
- **High Intensity Tactical Training**: This new Web site and mobile app from Marine Corps Semper Fit introduces High Intensity Tactical Training to Marines. It offers advanced, functionally based strength and conditioning exercise programs aimed at optimizing physical performance in combat for all Active Duty and Reserve Marines.

For a full list of mobile apps and tools that support healthy living, visit Operation Live Well (*http://www.health.mil/Military-Health-Topics/Operation-Live-Well*).

DoD Offers Programs to Promote the Mental Health of Military Children

The military lifestyle can be hard on children, who face parental deployments, multiple relocations, and other difficult transitions. The DoD offers several programs to help ensure the needs of all military children are met. The programs include:

- **Exceptional Family Member Program (EFMP):** This program assesses each child's all-around needs and facilitates the availability of services to meet those needs.
- **Educational and Development Intervention Services:** A multidisciplinary program designed to identify unique needs in young children and ensure the military provides federally mandated services in schools outside of the U.S.

Youth Centers at installations also offer many options for children. Military chaplains are another helpful resource for children.

TRICARE Launches New Online Pharmacy Calculator Tool

The new Pharmacy Calculator lets beneficiaries enter the number of brand name and generic medications they are currently filling at a retail pharmacy and see immediately how much money they can save by moving those medications to Home Delivery. Visit *www.tricare.mil/pharmacy* to use the calculator and view the potential savings.

Beneficiaries can also ask their doctor to write a prescription for a generic version of their medication, which has no copay through the Pharmacy Home Delivery program.

TRICARE Web Site Launches New Navigation Feature

The *tricare.mil* home page has a new "I want to…" feature to help beneficiaries navigate the site and manage their health care. The new feature offers quick links for more than a dozen customer service login portals including:

- Book Appointments
- Find a Doctor
- Compare Plans
- See What's Covered
- Manage My Prescriptions
- Pay My Bill
- File or Check a Claim
- Get Proof of TRICARE Coverage
- Enroll or Purchase a Plan

Visit *tricare.mil* for the complete set of options.

QUADRUPLE AIM: LOWER COST

TRICARE Dental Program (TDP) Fees Increase

The annual increases for the TDP went into effect on February 1, 2014. Under the TDP, there is a $1,300 annual maximum benefit per beneficiary, per plan year for non-orthodontic services. The new TDP monthly premium rates for Active Duty are:

	ENROLLED BETWEEN MAY 1, 2014, AND APRIL 30, 2015
Individual	$10.96
Family	$32.86

Pharmacy Benefits

Prescription costs are based on the type of prescription and where it is filled. The table below shows the copays for FY 2014, unchanged from FY 2013.

	FY 2012 (EFFECTIVE OCTOBER 1, 2011)	FY 2013 AND FY 2014
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*, 11/17/2014

Notes:

- 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, TSO, 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.
- Beneficiaries using TRR pay 25 percent of the total cost, after the annual deductible is met.

Per the FY 2013 NDAA, future pharmacy copays are reviewed annually and adjusted to align with cost-of-living adjustments not to exceed the cost-of-living allowance for retirees.

TRICARE for Life (TFL) Pharmacy Pilot

In 2013, Congress authorized a five-year pilot program requiring TFL beneficiaries living in the United States and the U.S. territories who use select maintenance medications to fill those prescriptions using TRICARE Pharmacy Home Delivery or a military pharmacy. Maintenance medications are defined as those used for chronic, long-term conditions that need to be filled on a regular basis, and do not include medications taken for a sudden illness or infection, such as antibiotics or short-term pain relief. The pilot went into effect February 14, 2014, and is scheduled to end December 31, 2017, unless extended.

Beneficiaries can opt out of the pilot after being covered by the program for one full year. If beneficiaries decide to continue to get their prescriptions filled at a retail

NEW BENEFITS AND PROGRAMS IN FY 2014 SUPPORTING THE MHS QUADRUPLE AIM *(CONT.)*

pharmacy, they will be required to pay 100 percent of the cost, starting at the third fill after March 14, 2014.

Home delivery also includes no cost for shipping, 24/7 access to a pharmacist, access to specialty medications and free use of the Specialty Medication Care Management Program, and automatic refills and shipment options designed to ensure that a beneficiary's medication is available on time without lapse.

TRICARE Over-the-Counter Demonstration Extended

The Over-the-Counter Medication Demonstration Project (OTC Demo) began in 2009 and was scheduled to end November 2014. DoD has extended the OTC Demo to allow more time to determine the effectiveness of the initiative, allowing TRICARE beneficiaries to obtain certain OTC medications from retail network pharmacies and TRICARE Pharmacy Home Delivery at no cost. Beneficiaries must get a prescription from their doctor for most of the medications covered under the OTC Demo. Covered drugs include certain allergy medications, heartburn medications, and now the Plan-B One-Step Emergency Contraceptive. Plan-B will be available at no cost and without a prescription to all Active Duty Service women and female beneficiaries, without any age restriction. Plan-B is not available through TRICARE Pharmacy Home Delivery, because it must be taken within three days.

The OTC Demo permits beneficiaries to fill prescriptions for certain OTC drugs, from network pharmacies and through home delivery (in most cases), and for free.

Prime Enrollment Fees Increase

TRICARE Prime annual enrollment fees are subject to change at the beginning of each fiscal year (October 1). All TRICARE Prime enrollees are required to pay annual enrollment fees, except ADSMs, Active Duty family members (ADFMs), 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.

PRIME ENROLLMENT FEES

	BETWEEN FY 1995–FY 2011	FY 2012 STARTING OCTOBER 1, 2011	FY 2013 STARTING OCTOBER 1, 2012	FY 2014 STARTING OCTOBER 1, 2013	FY 2015 STARTING OCTOBER 1, 2014
Individual	$230/yr	$260/yr	$269.28/yr	$273.84/yr	$277.92/yr
Family	$460/yr	$520/yr	$538.56/yr	$547.68/yr	$555.84/yr

BENEFICIARY TRENDS AND DEMOGRAPHICS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2015[a]

	PROJECTED FOR FY 2015	FY 2014 (AS PROJECTED LAST YEAR)
Total Beneficiaries	**9.5 million[b]**	9.6 million
MILITARY FACILITIES—DIRECT CARE SYSTEM	**TOTAL[c] U.S.**	**TOTAL U.S.**
Inpatient Hospitals and Medical Centers	**55 (41 in U.S.)**	56 (41 in U.S.)
Ambulatory Care and Occupational Health Clinics	**373 (315 in U.S.)**	360 (290 in U.S.)
Dental Clinics	**264 (210 in U.S.)[d]**	262 (210 in U.S.)
Veterinary Facilities	**253 (198 in U.S.)**	254 (199 in U.S.)
Military Health System (MHS) Personnel	**151,785[e]**	153,616
Military	**84,564**	86,039
	31,500 Officers	31,852 Officers
	53,064 Enlisted	54,187 Enlisted
Civilian	**67,221**	67,577
CIVILIAN RESOURCES—PURCHASED CARE SYSTEM[f]		
Network Primary Care, Behavioral Health, and Specialty Care Providers (i.e., individual, not institutional, providers)	**550,194**	523,297
Network Behavioral Health Providers (shown separately, but included in above)	**68,465**	60,272
TRICARE Network Acute Care Hospitals	**3,812**	3,524
Behavioral Health Facilities	**1,757**	948
Contracted (Network) Retail Pharmacies	**59,670**	58,535
Contracted Worldwide Pharmacy Home Delivery Vendor	**1**	1
TRICARE Dental Program (TDP) (for Active Duty families, Reservists and families)	**About 2.0 million covered lives, in over 790,000 contracts**	About 1.97 million covered lives, in over 800,000 contracts
TDP Network Dentists	**90,901 total dentists**	85,598 total dentists
	72,484 general dentists	68,431 general dentists
	18,437 specialists	17,167 specialists
TRICARE Retiree Dental Program (for retired Uniformed Services members and families)	**Over 1.4 million covered lives, in over 721,000 contracts**	Over 1.4 million covered lives, in over 660,000 contracts
Total Unified Medical Program (UMP)	**$48.5 billion[g]**	**$49.84 billion**
(Includes FY 2015 Normal Cost Contribution)	**$7 billion**	**$7.4 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) 2015 is 9,471,000, rounded to 9.5 million, and is based on Deputy Director, Defense Health Agency (DHA) memo dated October 29, 2014, "Estimate of Beneficiaries Eligible for Health Care in Fiscal Year 2015."

[c] Military treatment facility (MTF) data from DHA Business Support Directorate, Facility Planning, 11/4/2014.

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

[e] MHS personnel from FY 2015 president's budget as of 11/20/2014.

[f] As reported by TRICARE Regional Offices (TROs) for contracted network providers and hospitals data (10/22/2014), and by TRICARE Dental Office, Health Plan Execution and Operations for dental provider data (11/18/2014).

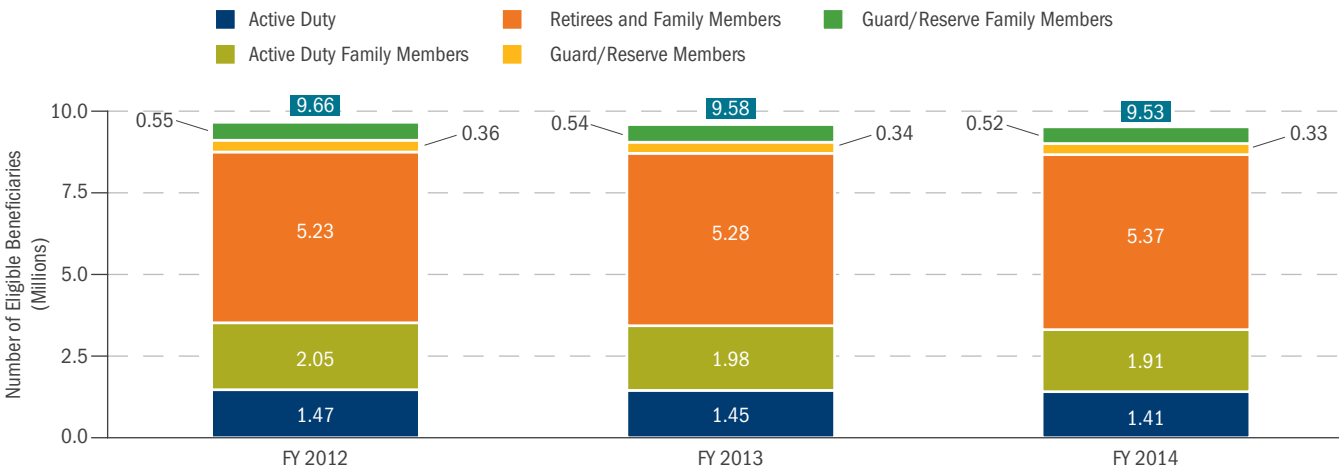
[g] Includes direct and private-sector care funding, military personnel, military construction, and the Medicare-Eligible Retiree Health Care Fund (MERHCF) ("Accrual Fund") DoD Normal Cost Contribution paid by the U.S. Treasury as of 11/25/2014.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Number of Eligible and Enrolled Beneficiaries Between FY 2012 and FY 2014

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 9.66 million at the end of FY 2012 to 9.53 million[1] at the end of FY 2014. 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).

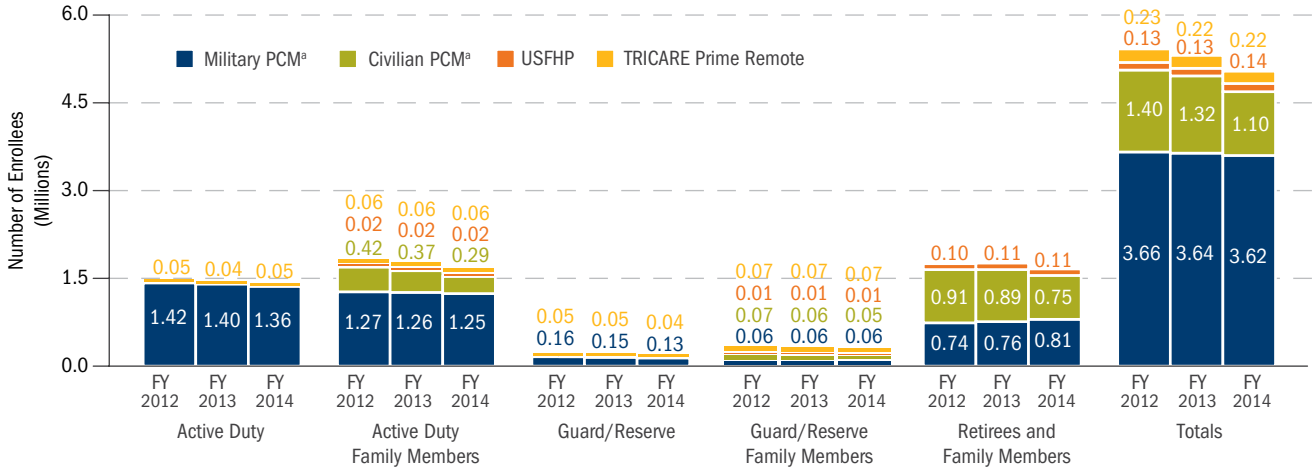
TRENDS IN THE END-YEAR NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 12/22/2014

- 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) enrollment declined slightly and Uniformed Services Family Health Plan (USFHP) enrollment increased slightly, overall and across beneficiary groups, from FY 2012 to FY 2014.

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



Source: DEERS, 12/22/2014

[a] Primary care manager

[1] This number should not be confused with the one displayed under TRICARE Facts and Figures on page 13. The population figure on page 13 is a projected FY 2015 total, whereas the population reported on this page is the actual for the end of FY 2014.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

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 9.5 million eligible beneficiaries, approximately 7.5 million (or 79 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 2014)

PLAN TYPE	0–17	18–24	25–44	45–64	≥65	TOTAL[a]
Prime	1,371,066	919,131	1,585,174	1,053,885	2,288	4,931,544
USFHP	27,030	7,294	14,054	45,162	44,993	138,533
TRS	122,529	32,123	143,093	28,849	116	326,710
TRR	1,192	670	408	2,824	6	5,100
TFL	0	0	0	0	2,086,353	2,086,353
Plus	5,507	1,872	3,088	16,703	166,900	194,070
TYA Prime	0	22,652	4,006	0	0	26,658
TYA Standard	0	14,248	3,071	0	0	17,319
Multiple Plans	0	–778	–122	0	–204,170	–205,070
Total Enrolled	1,527,324	997,212	1,752,772	1,147,423	2,096,486	7,521,217
Non-Enrolled	463,371	194,331	311,291	961,805	82,464	2,013,262
Total	**1,990,695**	**1,191,543**	**2,064,063**	**2,109,228**	**2,178,950**	**9,534,479**

Source: DEERS, 12/22/2014

- 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).
- Beneficiaries aged 45 to 64 had the lowest TRICARE enrollment rate at 54 percent. Enrollment rates for the other age groups were 77 percent for 0–17, 84 percent for 18–24, 85 percent for 25–44, and 96 percent for 65+.

PLAN CHOICE BY BENEFICIARY CATEGORY (END OF FY 2014)

PLAN TYPE	AD/GRD	ADFM/GRDFM	RET/RETFM <65	RET/RETFM ≥65[b]	TOTAL[a]
Prime	1,587,987	1,779,295	1,562,658	1,604	4,931,544
USFHP	316	28,228	65,009	44,980	138,533
TRS	121,912	203,860	938	0	326,710
TRR	2	0	5,092	6	5,100
TFL	0	0	0	2,086,353	2,086,353
Plus	28	3,401	24,539	166,102	194,070
TYA Prime	0	3,826	22,832	0	26,658
TYA Standard	0	2,392	14,927	0	17,319
Multiple Plans	0	–745	–155	–204,170	–205,070
Total Enrolled	1,710,245	2,020,257	1,695,840	2,094,875	7,521,217
Non-Enrolled	30,494	406,049	1,497,280	79,439	2,013,262
Total	**1,740,739**	**2,426,306**	**3,193,120**	**2,174,314**	**9,534,479**

Source: DEERS, 12/22/2014

[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.
- Ten 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 (GRDFMs) 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 80 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.

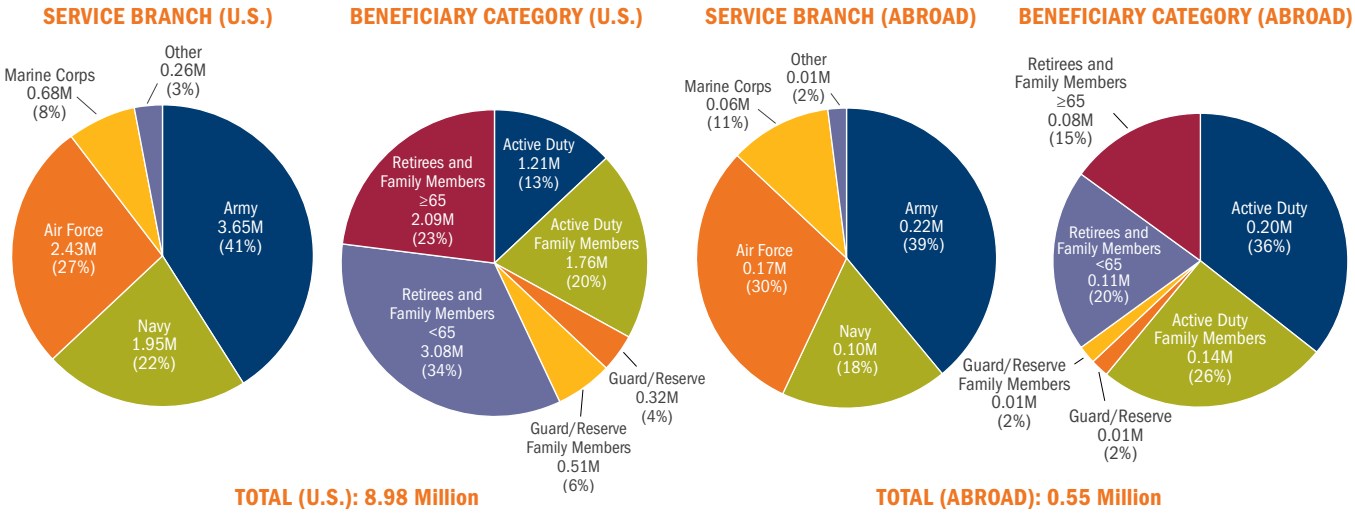
[1] Some beneficiaries use more than one plan, e.g., some TFL-eligible beneficiaries are also enrolled in TRICARE Plus. To avoid double-counting when summing beneficiary counts over plan types, the numbers with multiple plans are displayed as negatives so that the totals equal the number of unique beneficiaries.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Eligible Beneficiaries in FY 2014

- Of the 9.53 million eligible beneficiaries at the end of FY 2014, 8.98 million (94 percent) were stationed or resided in the United States (U.S.) and 0.55 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 (58 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 (65 percent) of the eligible population abroad. The U.S. MHS population is presented at the state level on page 21, reflecting those enrolled in the Prime benefit and the total population, enrolled and non-enrolled.
- Mirroring trends in the civilian population, MHS is confronted with an aging beneficiary population.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2014



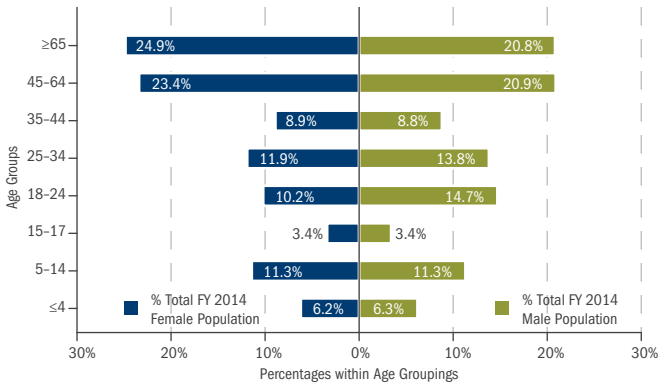
TOTAL (U.S.): 8.98 Million

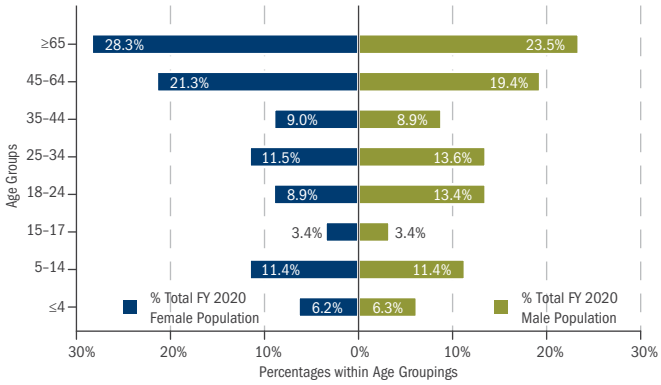
TOTAL (ABROAD): 0.55 Million

Source: DEERS, 12/22/2014

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

MHS END-YEAR POPULATION BY AGE AND GENDER: ACTUAL FY 2014 AND PROJECTED FY 2020





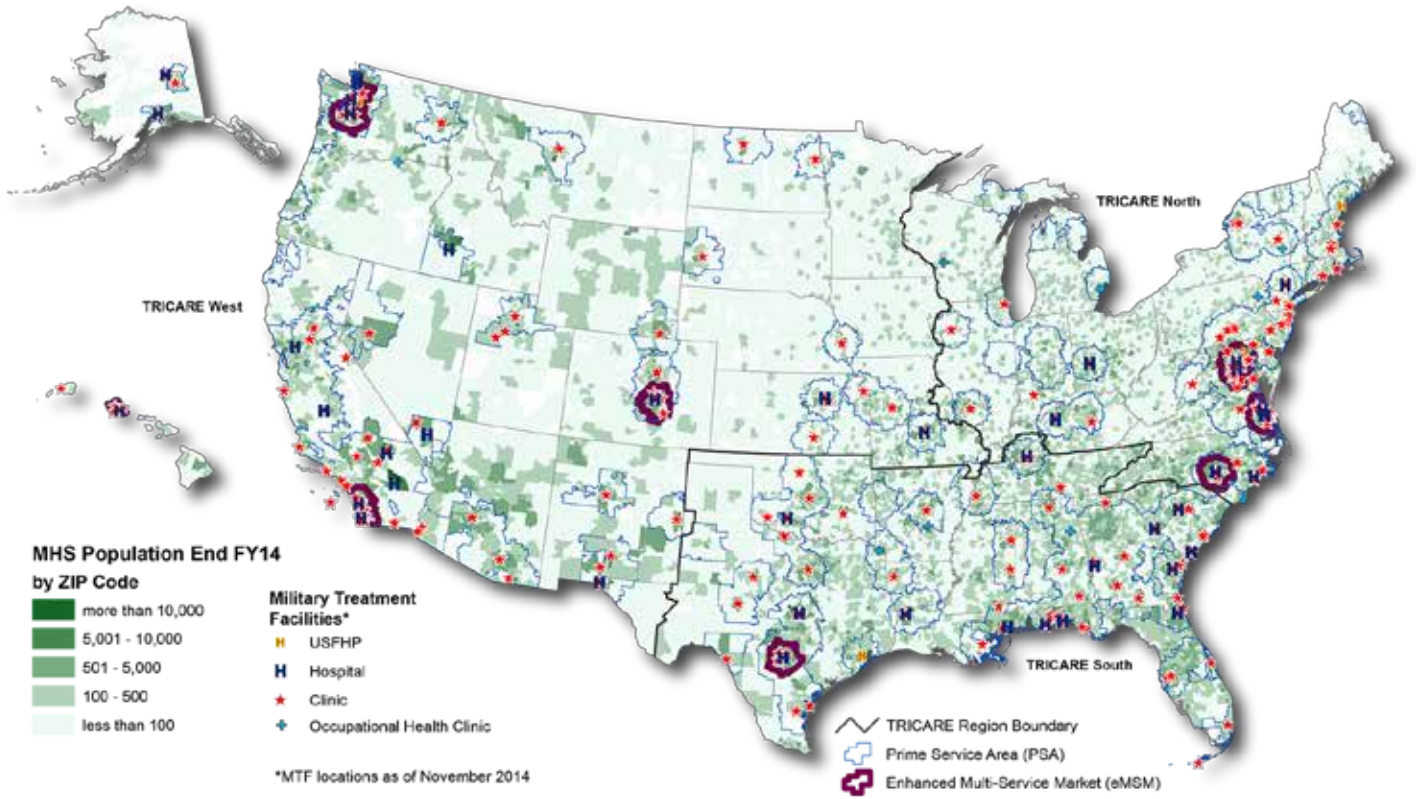
TOTAL MHS POPULATION (IN MILLIONS) BY AGE AND GENDER: ACTUAL FY 2014 AND PROJECTED FY 2020

	AGE GROUP								TOTAL BY GENDER	TOTAL MHS POPULATION
	≤4	5–14	15–17	18–24	25–34	35–44	45–64	≥65		
FY 2014 Female MHS Beneficiaries	0.29	0.53	0.16	0.48	0.56	0.42	1.10	1.17	4.69	9.53
FY 2014 Male MHS Beneficiaries	0.30	0.55	0.16	0.71	0.67	0.42	1.01	1.01	4.84	9.53
FY 2020 Female MHS Beneficiaries, Projected	0.28	0.52	0.16	0.40	0.52	0.41	0.97	1.29	4.55	9.27
FY 2020 Male MHS Beneficiaries, Projected	0.30	0.54	0.16	0.63	0.64	0.42	0.92	1.11	4.72	9.27

Sources: FY 2014 actuals from DEERS and FY 2020 estimates from Defense Health Agency (DHA) Projections of Eligible Population (PEP) model as of 12/22/2014

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MTFs AT THE END OF FY 2014



MILITARY HEALTH SYSTEM ELIGIBLE BENEFICIARY PROXIMITY TO MILITARY TREATMENT FACILITIES IN 2014[a]

BENEFICIARY GROUP[b]	POPULATION TOTAL (FY 2014)	POPULATION IN PSAs	% IN PSAs	% IN CATCHMENTS	% IN PRISMs	% IN MTF SERVICE AREAS	% IN eMSMs
Active Duty and Their Families	2,984,838	2,821,483	94.5%	69.5%	87.5%	92.1%	37.7%
Guard/Reserves and Their Families	838,756	570,402	68.0%	24.0%	38.7%	53.3%	12.8%
Retirees, Their Families, Survivors, and Other Eligibles[c]	5,175,237	3,962,069	76.6%	36.1%	50.2%	64.4%	20.5%
Total MHS Eligibles, U.S.	8,998,831	7,353,954	81.7%	46.0%	61.5%	72.5%	25.5%
MHS Eligibles, Overseas	537,452						
Total MHS Eligibles, Worldwide	9,536,283						
VETERANS HEALTH ADMINISTRATION PRIORITY BENEFICIARIES							
Eligible Veterans without TRICARE Eligibility	7,973,072	4,636,909	58.2%	15.7%	23.0%	41.7%	6.4%
Dual Eligible TRICARE and VHA Eligible Veterans	1,452,877	1,075,065	74.0%	34.0%	48.2%	61.6%	17.6%
Total VHA Priority Veterans	9,425,949	5,711,974	60.6%	18.5%	26.9%	44.8%	8.1%
Overseas	99,005						
Total Worldwide	9,524,954						

Sources: DHA/Decision Support Division, 12/16/2014; MHS population as of 9/30/2013 pulled 11/21/2014; and VHA population (as of the end of FY 2013, provided February 2014)

Notes:

[a] Eligible MHS beneficiary data from the MHS Data Repository (MDR) DEERS, effective September 1, 2014. 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 DHA Catchment Area Directory (CAD) database, September 2014.

[c] TRICARE medically eligible Guard/Reserve beneficiaries, not all Select Reserve, including those who have opted into TRS.

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: Includes ZIP codes in the 20-mile circle around an active MTF (inpatient or outpatient), subject to overlap rules, barriers, and other policy overrides
- MTF Service Area: Includes ZIP codes in the 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 2014 (since the October 1, 2013 reductions).
- PSAs include the ZIP codes in 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.
- Enhanced multi-Service market (eMSM) area used here is defined as the six eMSMs used in the MHS strategy and market management (National Capital Region, Hawaii, Puget Sound, Colorado Springs, San Antonio, and Tidewater), as well as two densely populated multiple-market areas in San Diego and Fort Bragg.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

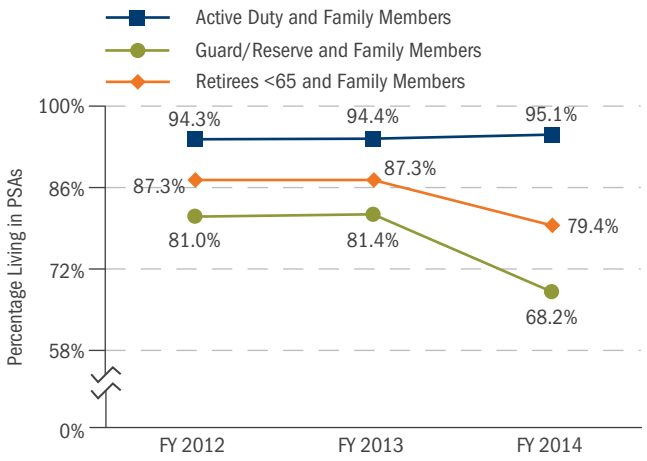
Locations of MTFs (Hospitals and Ambulatory Care Clinics) at the End of FY 2014

The map on the previous page shows the geographic dispersion of the almost 9 million beneficiaries eligible for the TRICARE benefit residing within the United States (94 percent of the 9.5 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 in which 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 Base Realignment and Closure (BRAC) process ("BRAC PSAs"), and by designated providers through the USFHP as of October 1, 2013. The overlay of MTF and BRAC PSAs on the previous map shows the eligible beneficiary population.

Beneficiary Access to Prime

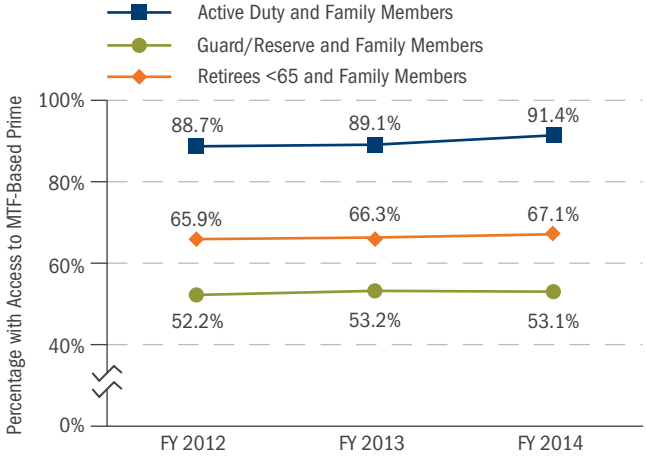
Effective October 1, 2013, DoD reduced the number of locations designated as PSAs to those within a 40-mile radius of existing MTFs or designated BRAC locations (closed MTFs). The left chart below shows the effect of the reduction on the percentage of beneficiaries living in PSAs (defined only in the U.S.). The right chart below shows the percentage of the eligible population in the U.S. with access to MTF-based Prime. The latter is defined as the percentage living in both a PSA and an MTF Service Area (see the notes to the right of the map on the previous page for the definition of an MTF Service Area).

TREND IN ELIGIBLE POPULATION LIVING IN PSAs



Source: DEERS, 12/22/2014

TREND IN ELIGIBLE POPULATION WITH ACCESS TO MTF-BASED PRIME



- The reduction in the number of PSAs in FY 2014 had no effect on the access to Prime by Active Duty members and their families. However, the percentage of Guard/Reserve and family members (including those in a pre- and post-mobilization status) and retirees and family members living in PSAs each declined substantially in FY 2014.
- As determined by residence in an MTF PSA, access to MTF-based Prime increased slightly from FY 2012 to FY 2014 for all beneficiary groups. In that time, the number of military hospitals and clinics remained about the same.
- As expected, Active Duty 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.)*

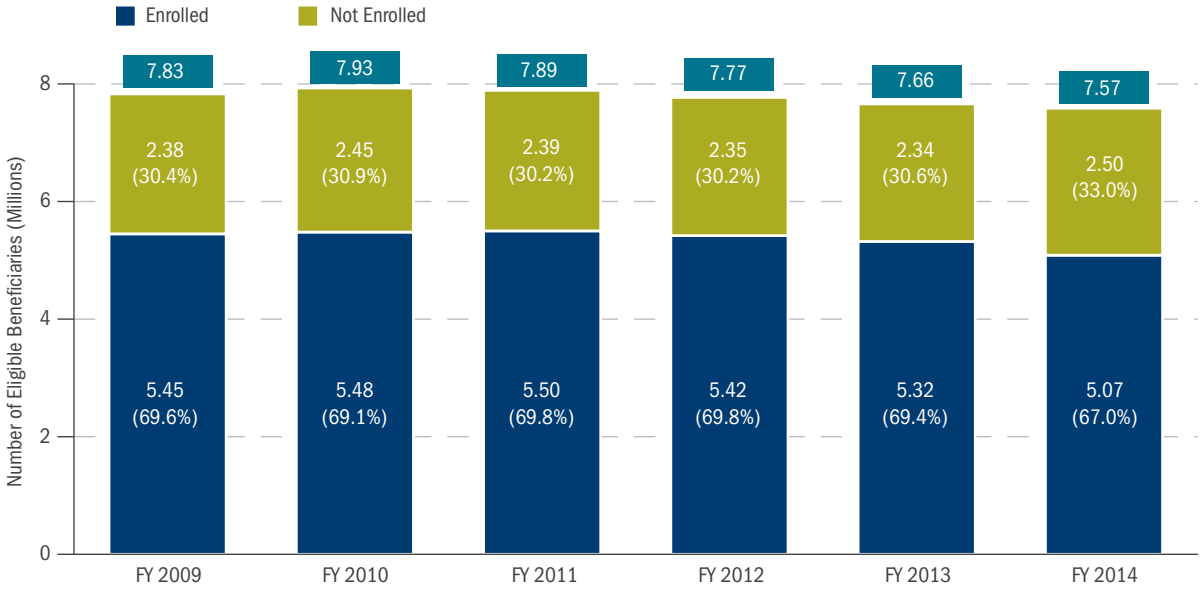
Eligibility and Enrollment in TRICARE Prime

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 has continued to drop. As a percentage of the beneficiary population, TRICARE Prime enrollment remained level from FY 2011 to FY 2013 but dropped significantly in FY 2014, largely due to a reduction in Active Duty end-strength.
- By the end of FY 2014, 67 percent of all eligible beneficiaries were enrolled (5.07 million enrolled of the 7.57 million eligible to enroll).

HISTORICAL END-YEAR ENROLLMENT NUMBERS



Source: DEERS, 12/22/2014

Note: Numbers may not sum to bar totals due to rounding. Detailed MHS enrollment data by state can be found on page 21.

BENEFICIARY TRENDS AND DEMOGRAPHICS *(CONT.)*

Recent Three-Year Trend in Eligibles, Enrollees, Users

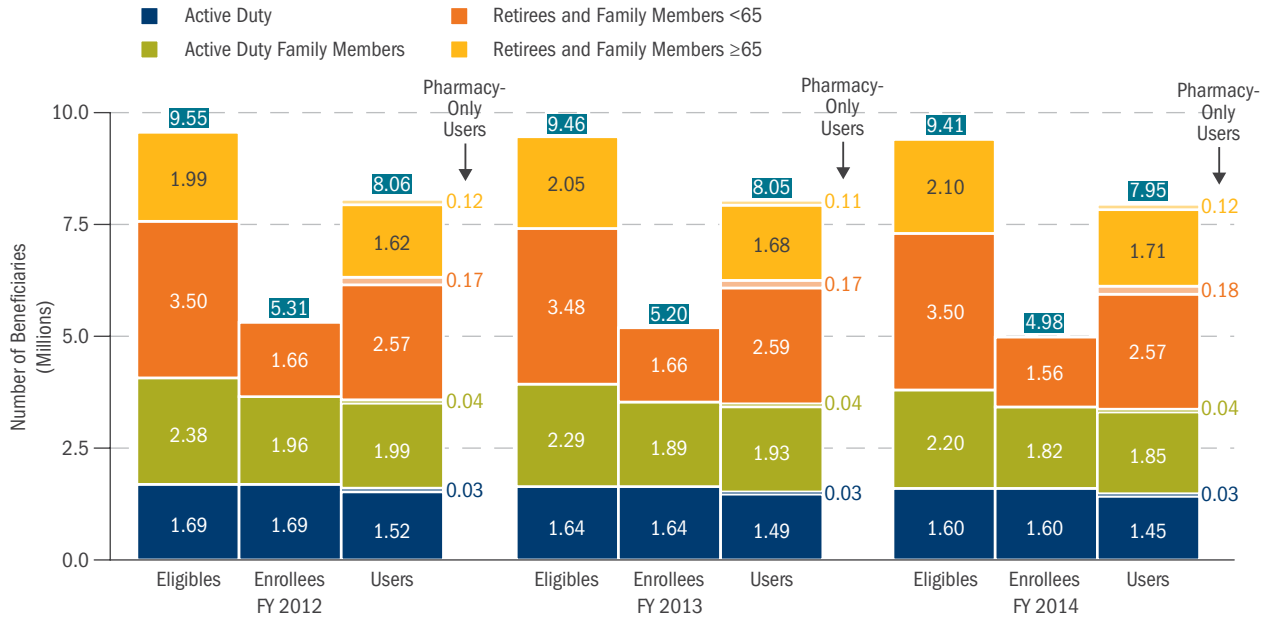
This section compares the number of users of MHS services with the numbers of eligibles and enrollees. Because beneficiaries eligible for any part of the year can be users, average (rather than end-year) beneficiary counts were used for all calculations.

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2012 to FY 2014 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 union 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 7 percent between FY 2012 and FY 2014. 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 remained at about 83 percent from FY 2012 to FY 2014. The percentage of RETFMs under age 65 enrolled in Prime decreased from 48 percent in FY 2013 to 45 percent in FY 2014 because of the reduction in PSAs in the latter year.
- The overall user rate remained about the same between FY 2012 and FY 2014 at just under 85 percent. 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 some of them have other health insurance (OHI).

AVERAGE NUMBERS OF FY 2012 TO FY 2014 ELIGIBLES, ENROLLEES, AND USERS BY BENEFICIARY CATEGORY



Sources: DEERS and MHS administrative data, 12/22/2014

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.

MHS POPULATION: ENROLLEES AND TOTAL POPULATION BY STATE

STATE	TOTAL POPULATION	PRIME ENROLLED	TRS ENROLLED
AK	85,986	66,470	1,355
AL	207,976	90,218	7,082
AR	90,367	34,015	4,541
AZ	203,109	98,877	6,803
CA	836,849	484,118	21,341
CO	253,659	158,690	7,679
CT	48,891	22,149	1,936
DC	22,648	16,825	389
DE	33,813	16,649	1,274
FL	692,861	330,374	19,489
GA	441,789	272,449	11,161
HI	166,557	125,625	2,000
IA	43,884	8,817	4,681
ID	50,750	19,548	3,759
IL	148,362	70,475	7,311
IN	89,400	23,963	7,983
KS	130,023	80,330	5,351
KY	152,757	90,396	5,942
LA	130,721	67,679	6,850
MA	70,788	30,233	4,888
MD	246,932	162,636	5,373
ME	40,036	23,620	1,974
MI	96,394	22,501	5,808
MN	65,831	10,579	9,306
MO	154,545	66,114	10,205
MS	111,869	49,673	6,809
MT	34,939	12,222	2,268
NC	511,753	311,192	11,385
ND	32,778	20,215	1,945
NE	61,426	29,690	3,814
NH	30,147	15,541	1,648
NJ	84,884	39,999	3,959
NM	86,933	48,327	1,462
NV	103,644	52,668	3,043
NY	182,603	92,936	6,267
OH	164,205	51,747	10,251
OK	157,131	84,861	5,981
OR	68,297	13,333	3,106
PA	160,590	41,659	8,649
RI	25,038	12,631	1,044
SC	243,202	125,059	8,556
SD	33,108	13,660	4,356
TN	195,488	71,592	9,836
TX	880,571	516,427	27,265
UT	72,307	31,575	7,612
VA	757,116	455,420	11,529
VT	12,712	5,149	1,084
WA	353,045	220,517	7,981
WI	69,799	13,294	5,923
WV	35,750	7,086	2,227
WY	22,481	11,287	1,246
Subtotal	**8,996,744**	**4,741,110**	**323,727**
Overseas	**537,735**	**329,941**	**2,983**
Total	**9,534,479**	**5,071,051**	**326,710**

Source: MHS administrative data systems, as of 12/17/2014 for end of FY 2014

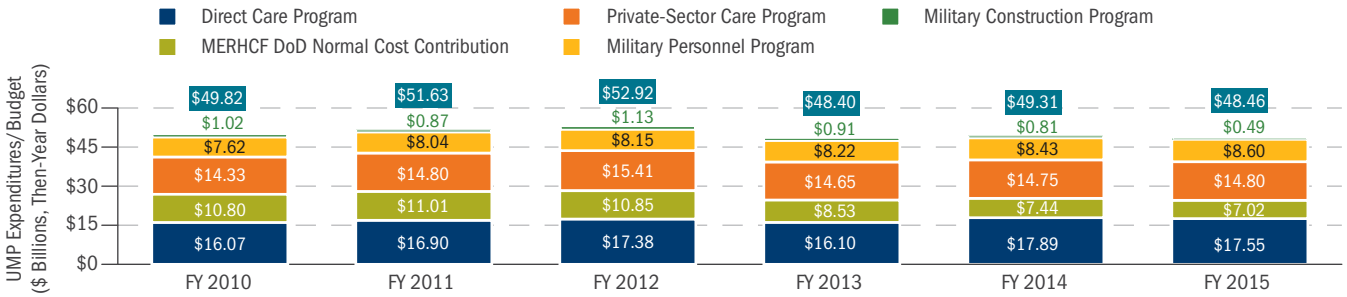
Note: "Prime Enrolled" includes Prime (military and civilian primary care managers), TRICARE Prime Remote (and Overseas equivalent), TRICARE Young Adult (TYA) Prime, and Uniformed Services Family Health Plan; and excludes members in TRICARE for Life, TRICARE Plus, TYA Standard, and TRICARE Reserve Select (TRS).

UMP FUNDING

The Unified Medical Program (UMP), authorized at almost $48.5 billion for FY 2015, is almost 2 percent lower than the $49.3 billion in actual expenditures in FY 2014 and over 8 percent lower than the peak of almost $53 billion in FY 2012 (unadjusted, then-year dollars). 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.

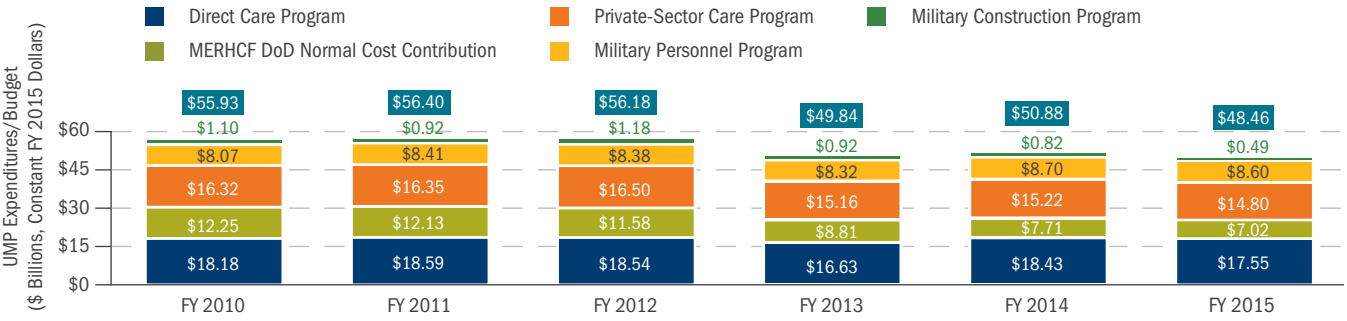
Accrual Fund expenditures continue to decline from a high of $11 billion in FY 2011 to about $7 billion estimated for FY 2015. Military construction, while small relative to other UMP sectors, continues to decline, and is currently programmed at under $0.5 billion in FY 2015—almost 40 percent less than the previous year (FY 2014, $0.8 billion) and less than half the peak of $1 billion in FY 2012.

FY 2010 TO FY 2015 UMP FUNDING ($ BILLIONS) IN UNADJUSTED, THEN-YEAR DOLLARS



In constant FY 2015 dollar funding, when actual expenditures or projected funding are adjusted for inflation as estimated by the Department, the FY 2015 $48.5 billion estimated budget in purchasing value is currently programmed to be over 2 billion (4.7 percent) less in purchasing value than actual expenditures in FY 2014 and almost $8 billion (14 percent) less than the peak in FY 2011 of $56.4 billion in constant FY 2015 dollars.

FY 2010 TO FY 2015 UMP FUNDING ($ BILLIONS) IN CONSTANT FY 2015 DOLLARS



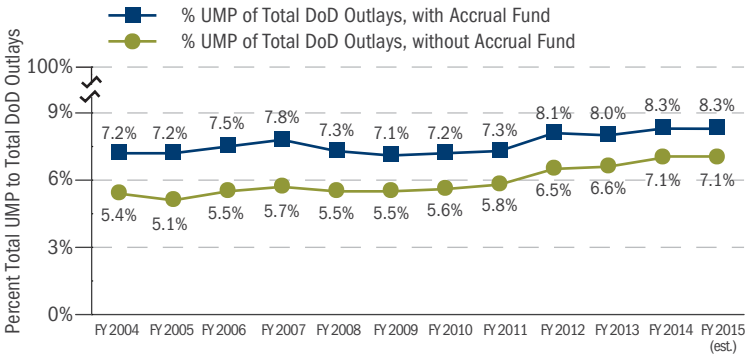
Source: Cost and budget estimates, Defense Health Agency/Business Support Directorate/Program, Budget, and Execution (PB&E), 12/30/2014

Notes: 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 sources of revenue for Defense health care, and reflect the following for FY 2015: (1) The Accrual Fund ($7.02 billion), reflected in the charts and discussion above, is the normal cost contribution funded by the UMP at the beginning of each fiscal year. This fund 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) $4.0 billion is paid by the Treasury to fund future health care liability accrued prior to October 1, 2002 for retired, Active Duty, Guard, and Reserves and their family members when they become retired and Medicare-eligible; and (3) $9.7 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, of which $7.8 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 [$0.5 billion] costs).
- FYs 2010–2014 reflect Comptroller Information System actual execution.
- FY 2010 current estimate includes O&M funding of $1.2567 billion in support of Overseas Contingency Operations (OCO) requirements and $140.0 million ($132.0 million for O&M and $8.0 million for Research, Development, Test, and Evaluation [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 includes $715.484 million in OCO supplemental funding for O&M, plus congressional additions and statutory reductions as reflected in Public Law 113-76.
- FY 2015 includes $300.531 million in OCO supplemental funding for O&M, plus congressional additions and statutory reductions as reflected in FY 2014 Defense Appropriations (H.R. 83, PL 113-235).

UMP FUNDING *(CONT.)*

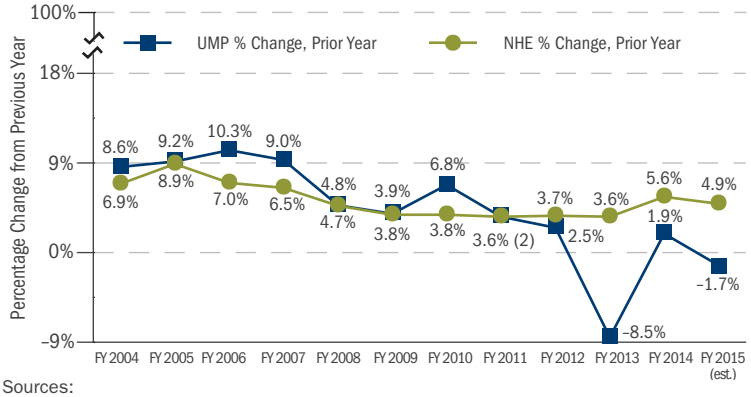
UMP EXPENDITURES AS A PERCENTAGE OF TOTAL DoD OUTLAYS: FY 2004 TO FY 2015



Source: Defense Health Agency/Operations Support Directorate/Program, Budget, and Execution (PB&E), 12/30/2014

Note: FY 2014 and FY 2015 percentages are estimates based on total DoD outlays reflected as of the writing of this report.

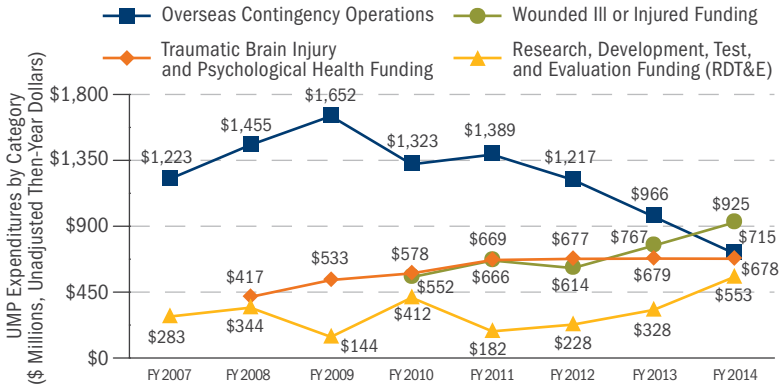
COMPARISON OF CHANGE IN ANNUAL UMP AND NHE EXPENDITURES OVER TIME: FY 2004 TO FY 2015



Sources:

- UMP data from Defense Health Agency/Business Support Directorate/Program, Budget, and Execution (PB&E), 12/30/2014
- NHE data from CMS, Office of the Actuary, Table 2, National Health Expenditure Amounts with the Impacts of the Affordable Care Act, and Annual Percent Change by Type of Expenditure: Calendar Years 2007–2023; table modified 8/28/14, accessed 11/25/2014
- *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-reports/NationalHealthExpendData/NationalHealthAccountsProjected.html/Proj2013tables.zip*

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



Source: Defense Health Agency/Business Support Directorate/Program, Budget, and Execution (PB&E), 12/30/2014

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) as a percentage of total DoD expenditures (outlays), has fluctuated around 8 percent since FY 2012, peaked at 8.3 percent in FY 2014, and is estimated to remain at 8.3 percent in FY 2015—or at 7.1 percent if the Accrual Fund is excluded. 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 (in then-year dollars) 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 and a deep drop in FY 2013 (–8.5 percent). After an increase of almost 2 percent in FY 2014, the UMP is currently funded at 1.7 percent less for FY 2015. In comparison, the Centers for Medicare and Medicaid Services (CMS) estimates that National Health Expenditures (NHE) should have exceeded $3 trillion in 2014, for an increase of 5.6 percent over 2013 and estimates NHE expenditures will increase by almost 5 percent in FY 2015, reaching $3.2 trillion. These increases are expected due to the major coverage expansion legislated by the Affordable Care Act (ACA; ref. source notes at left).

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

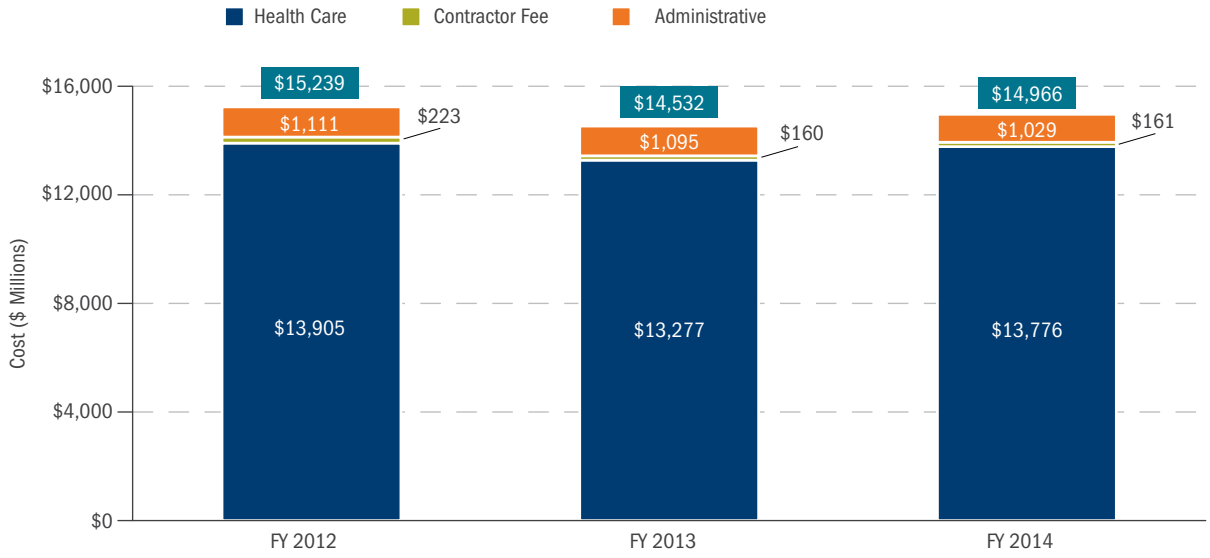
The graph at left reflects the total actual DHP funding for OCO and resultant care since FY 2007. Total annual DHP expenditures have hovered between $2.74 billion and $2.91 billion since FY 2010 in then-year dollars; FY 2014 actual expenditures were $2.87 billion. These overall expenses are the sum of 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 $15,239 million in FY 2012 to $14,966 million in FY 2014, a decrease of 2 percent. Private-sector health care costs declined by 1 percent, whereas administrative costs declined by 7 percent and contractor fees fell by 28 percent.
- Excluding contractor fees, administrative expenses decreased from 7.4 percent of total private-sector care costs in FY 2012 ($1,111 million of $15,016 million) to 7.0 percent in FY 2014 ($1,029 million of $14,805 million). Including contractor fees (in both administrative and total costs), administrative expenses decreased from 8.8 percent of total private-sector care costs in FY 2012 ($1,334 million of $15,239 million) to 8.0 percent in FY 2014 ($1,190 million of $14,966 million).
- Contractor fees decreased between FY 2012 and FY 2014 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, 10/23/2014

Note: The 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 2012 and FY 2014 amounts carried forward from the prior-year appropriation were $297 million and $308 million, respectively. There was no funding carried over from FY 2012 to FY 2013 because of sequestration.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE)

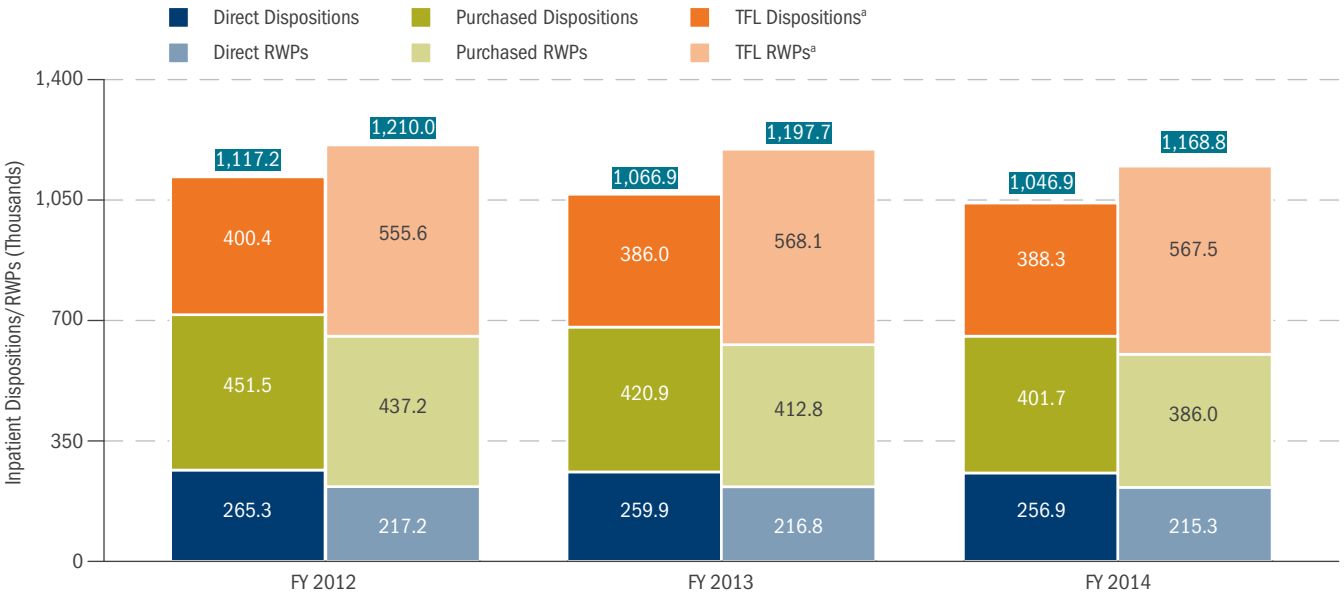
MHS Inpatient Workload

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 2012 to FY 2014.

Total inpatient dispositions and RWPs (direct and purchased care combined) declined by 8 percent between FY 2012 and FY 2014, excluding the effect of TFL.[1]

- Direct care inpatient dispositions decreased by 3 percent and RWPs by 1 percent over the past three years.
- Excluding TFL workload, purchased care inpatient dispositions decreased by 11 percent while RWPs decreased by 12 percent between FY 2012 and FY 2014.
- Including TFL workload, purchased care dispositions decreased by 7 percent and RWPs decreased by 4 percent between FY 2012 and FY 2014.
- Although not shown, about 7 percent of direct care inpatient dispositions and 6 percent of RWPs were performed abroad in FY 2014. Purchased care and TFL inpatient workloads performed abroad accounted for less than 3 percent of the worldwide total.

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/15/2015

[a] Purchased care only

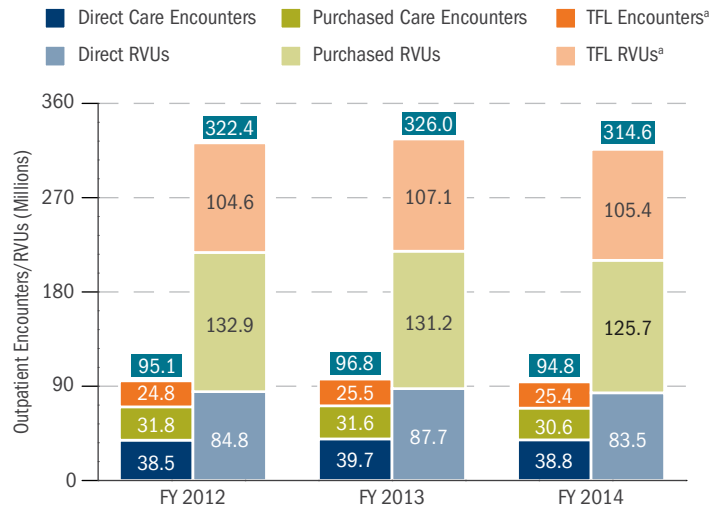
[1] Although TFL claims are not technically MHS workload (i.e., MHS does not deliver the care, it just acts as second payer to Medicare), it would give an incomplete picture of the services provided by MHS if they were excluded.

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

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 2012 to FY 2014. 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, 1/15/2015

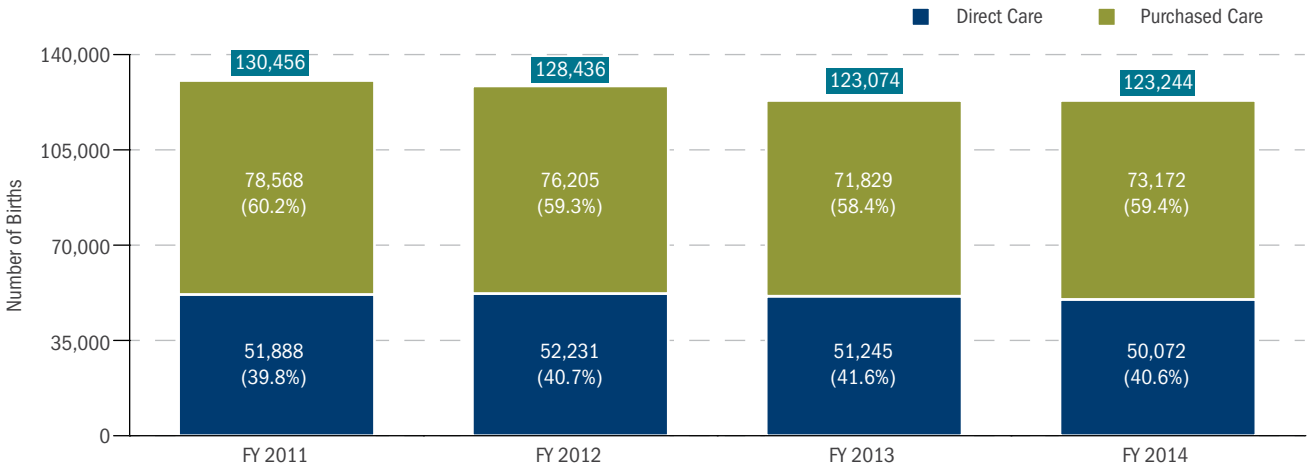
[a] Purchased care only

- Total outpatient workload (direct and purchased care combined) decreased between FY 2012 and FY 2014 (encounters decreased by 1 percent and RVUs by 4 percent), excluding the effect of TFL.[1]
- Direct care outpatient encounters increased by 1 percent, but RVUs declined by 2 percent over the past three years.
- Excluding TFL workload, purchased care outpatient encounters decreased by 4 percent and RVUs by 5 percent. Including TFL workload, encounters decreased by 1 percent and RVUs by 3 percent.
- Although not shown, about 8 percent of direct care outpatient workload (both encounters and RVUs) were performed abroad. Purchased care and TFL outpatient workload performed abroad accounted for less than 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, overall MTF OB market share increased slightly between FY 2011 and FY 2013 but dropped back to the FY 2012 level in FY 2014. This pattern suggests that satisfaction with MTF OB care has remained essentially unchanged.

TREND IN MTF MARKET SHARE FOR CHILDBIRTHS



Source: MHS administrative data, 1/15/2015

[1] Although TFL claims are not technically MHS workload (i.e., MHS does not deliver the care, it just acts as second payer to Medicare), it would give an incomplete picture of the services provided by MHS if they were excluded.

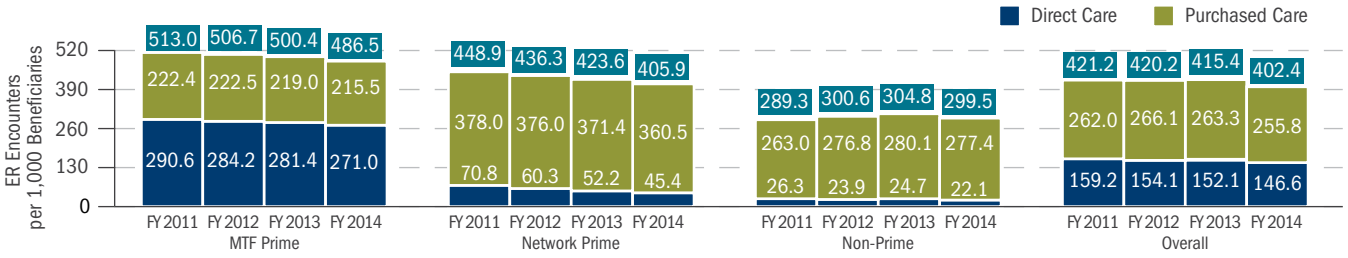
MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

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 per capita declined for Prime enrollees from FY 2011 to FY 2014 (10 percent for network Prime enrollees and 5 percent for MTF Prime enrollees). The rate for non-Prime enrollees was essentially flat over the same time period.
- In FY 2014, MTF Prime enrollees had an ER utilization rate 20 percent higher than that of network Prime enrollees and 62 percent higher than that of non-enrollees. Network Prime enrollees had an ER utilization rate 36 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 most recent available year of data.[2]

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

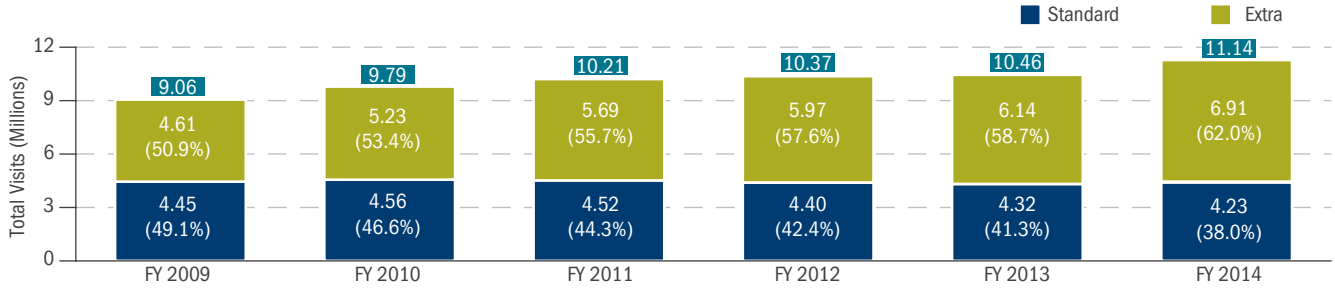


Source: MHS administrative data, 1/15/2015

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 2014, 62 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 62).

TRENDS IN EXTRA VS. STANDARD VISITS



Source: MHS administrative data, 1/15/2015

[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*

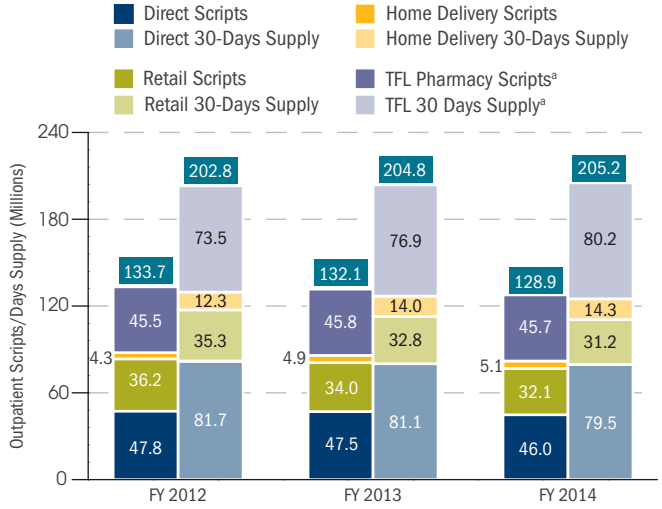
[2] Centers for Disease Control and Prevention, "National Hospital Ambulatory Medical Care Survey: 2010 Emergency Department Summary Tables," Table 1, *http://www.cdc.gov/nchs/data/ahcd/nhamcs_emergency/2010_ed_web_tables.pdf*

MHS WORKLOAD TRENDS (DIRECT AND PURCHASED CARE) *(CONT.)*

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 2012 and FY 2014 (prescriptions decreased by 6 percent and days supply by 3 percent), excluding the effect of TFL purchased care pharmacy usage.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/15/2015

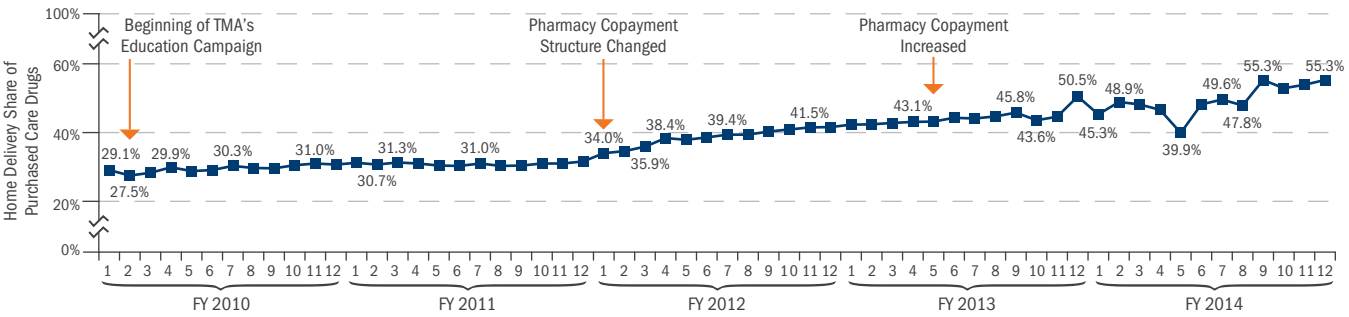
[a] Home delivery workload for TFL-eligible beneficiaries is included in the TFL total.

- Direct care prescriptions decreased by 4 percent and days supply by 3 percent between FY 2012 and FY 2014.
- Purchased care prescriptions (retail and home delivery combined) decreased by 8 percent and days supply by 5 percent from FY 2012 to FY 2014, excluding TFL utilization. Including TFL utilization, purchased care prescriptions decreased by 4 percent and days supply increased by 4 percent. The discrepancy in trends between purchased care prescription counts and days supply is due to increased beneficiary utilization of home delivery services, which are dispensed for up to a 90-day supply.
- Although 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 went into effect on February 14, 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 TRICARE Management Activity's (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 55 percent at the end of FY 2014.

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



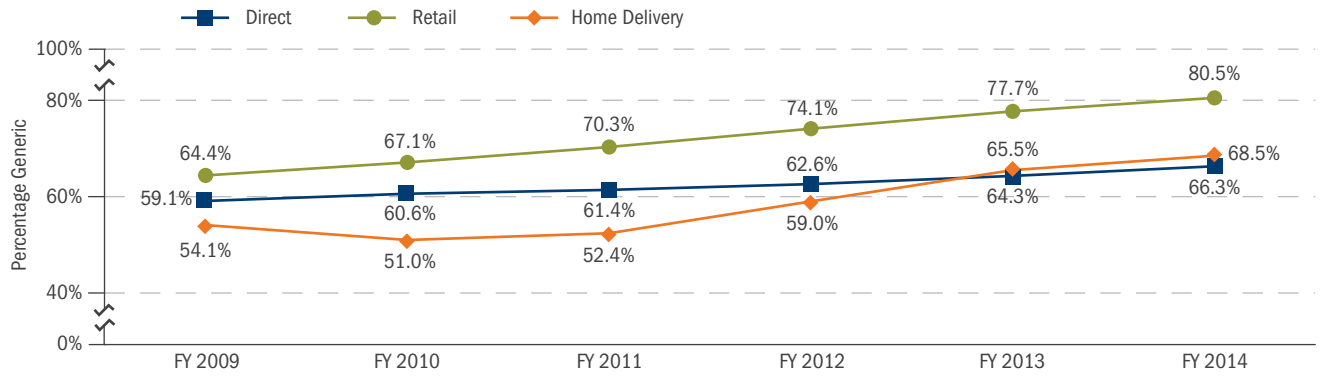
Source: MHS administrative data, 1/15/2015

[b] The large and sudden dip in February 2014 was due to a computer system problem in Express Scripts' auto-refill program, which resulted in a reduced volume of home delivery prescriptions.

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 64 percent in FY 2009 to 81 percent in FY 2014.
- Although the rate of generic drug dispensing is increasing in MHS, it still lags the private sector. In 2013, approximately 81 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 2014 was $48 versus $13 for direct care, $226 (net of manufacturer refunds) versus $22 for retail pharmacies, and $79 versus $8 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

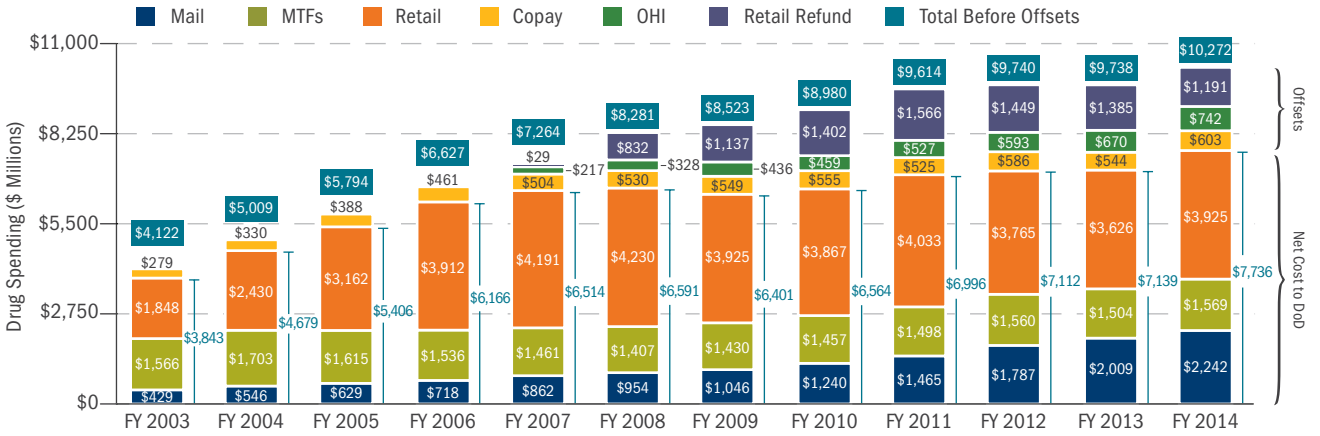


Source: MHS administrative data, 1/15/2015

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 2014, the refunds are estimated to have saved DoD almost $1.2 billion. Net DoD costs in FY 2014 are only 17 percent higher than they were in FY 2008, equating to an average increase of only 2.7 percent per year.

MHS OUTPATIENT DRUG SPENDING (FYs 2003–2014)



Sources: Pharmacy Data Transaction Service (PDTS) Data Warehouse; DHA Pharmacy Operations Directorate (POD) (refunds)

Notes: Net cost to DoD represents total prescription expenditures minus copays, coverage by other health insurance (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] CVS/Caremark, Insights 2014: 7 Sure Things, *http://info.cvscaremark.com/insights2014/INSIGHTS%20Trend%202014-v2.pdf*

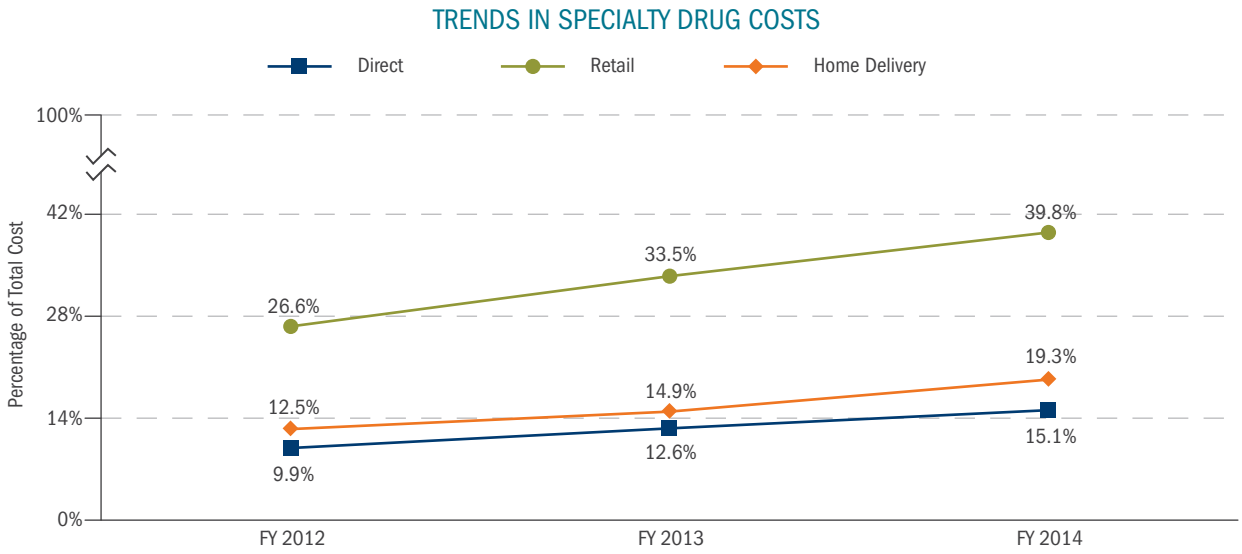
[2] The MHS generic dispensing rate may be lower than in the private sector because MHS can frequently buy a branded drug at a lower cost, either under contract or at federal pricing, than the generic drug (this occurs during the 180-day exclusivity period when there is only one generic drug competing 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.

SPECIALTY DRUG COST TRENDS

Specialty drugs are prescription medications that require special handling, administration, or monitoring. They are used to treat complex, chronic, and often costly conditions, such as cancer, multiple sclerosis, rheumatoid arthritis, and many other conditions and diseases. Although they are needed by only a small percentage of the population, they account for a disproportionate share of total drug costs because they are very expensive, often costing thousands of dollars per month per beneficiary. According to Prime Therapeutics, a pharmacy benefit manager, specialty drugs accounted for 30 percent of private-sector drug costs in 2013.[1] They predict that number will reach 50 percent by 2018.

There is no industry-standard definition or list of specialty drugs; it varies from insurer to insurer. However, CMS has maintained a Medicare Part D specialty tier threshold of $600 per month since 2008.[2] That threshold is often used in studies of specialty drugs as a rough way of standardizing the definition; we will use that definition in our examination of TRICARE specialty drug trends below. However, because MHS purchases drugs directly from manufacturers and pays Federal Supply Schedule prices for drugs dispensed by MTFs and through home delivery, the $600 threshold would exclude many more drugs at those sources than it would at retail pharmacies. We therefore determined the list of specialty drugs by applying the $600 threshold solely to drugs dispensed at retail pharmacies.

TRICARE specialty drug costs were computed as a percentage of total DoD drug costs for each pharmacy source (direct, retail, and home delivery) from FY 2012 to FY 2014.



Data source: MHS administrative data, 1/15/2015

- As a percentage of total drug costs, specialty drug costs increased from FY 2012 to FY 2014 for all pharmacy sources, especially retail. The increase is due largely to the introduction of several new high-cost specialty drugs, such as Solvadi and Olysio, used to treat hepatitis C (over $100 million for those two drugs alone), as well as other drugs for the treatment of muscular sclerosis, idiopathic pulmonary hypertension, and cancer.
- Retail specialty drugs account for twice the percentage of total drug costs as those of home delivery and almost three times those of MTF pharmacies. Many specialty drugs are clinician-administered injectables that cannot be filled via home delivery.
- The FY 2013 retail specialty drug percentage (34 percent) is somewhat higher than the percentage found in the private sector (30 percent). If direct care pharmacy prescriptions are included, the specialty drug percentage is somewhat lower (27 percent) than in the private sector.
- Although retail specialty drugs account for 40 percent of total retail drug costs in FY 2014, they account for only 1.4 percent of total utilization, as measured by days supply (not shown).

[1] *https://www.primetherapeutics.com/PDF/specialtydtr2013/index.html*

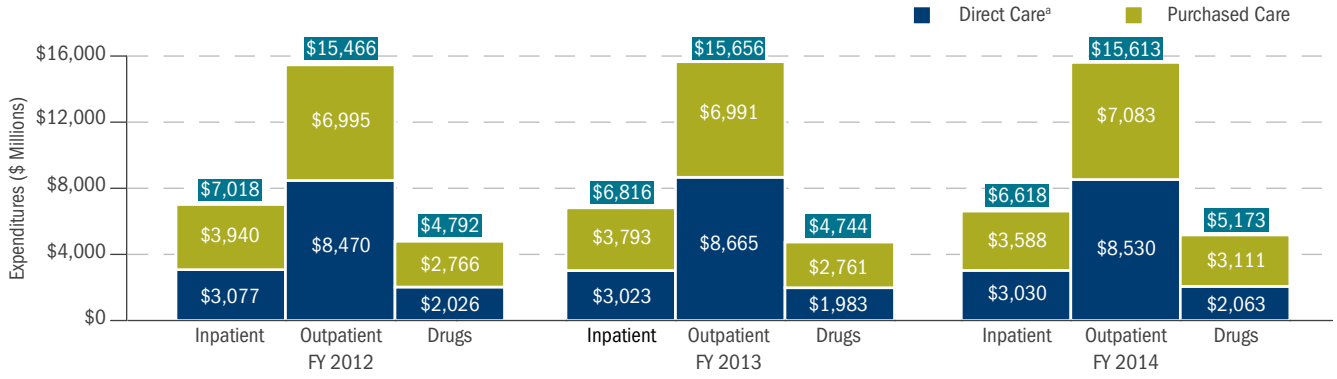
[2] *http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/SpecialtyTierMethodology.pdf*

MHS COST TRENDS

In May 2009, TRICARE implemented the Outpatient Prospective Payment System (OPPS) fee schedule, consistent with Medicare reimbursement. The program included a five-year phase-in period, which concluded in May 2013. OPPS aligns the TRICARE program with Medicare rates for reimbursement of hospital outpatient services. The implementation reduced health care costs by approximately $4.3 billion during the implementation period (May 1, 2009–April 30, 2013).

- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care increased slightly from 69 percent in FY 2012 to 70 percent in FY 2014. For example, in FY 2014, DoD expenses for inpatient and outpatient care totaled $22,231 million, of which $15,613 million was for outpatient care, for a ratio of $15,613/$22,231 = 70 percent.
- Purchased care drug costs shown below have been reduced by manufacturer refunds for retail name brand drugs accrued to the years in which the drugs were dispensed.
- Increases in purchased care outpatient costs were eased by DHA's implementation of the 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 Decision Support Division 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 2014, DoD spent $2.21 on outpatient care for every $1 spent on inpatient care.

TREND IN DoD EXPENDITURES FOR HEALTH CARE (EXCLUDING MERHCF)



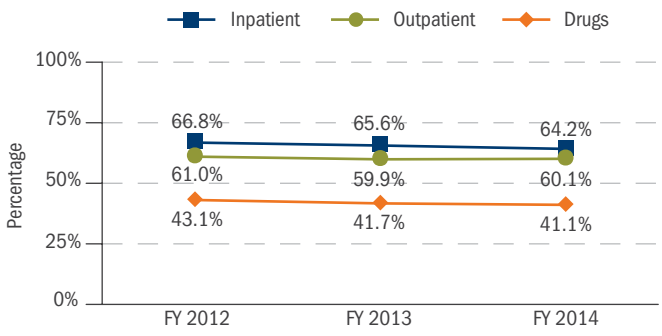
Source: MHS administrative data, 1/15/2015

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

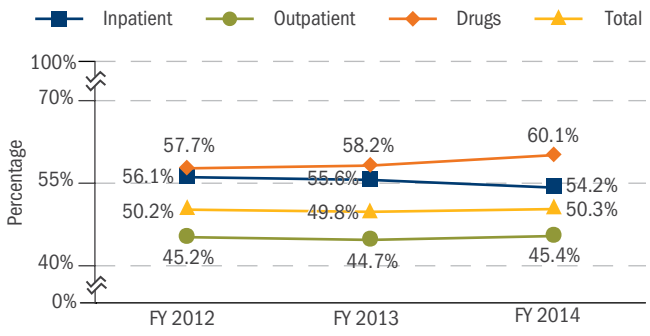
Note: Numbers may not sum to bar totals due to rounding.

- The purchased care shares of all MHS health services utilization decreased from FY 2012 to FY 2014. Purchased care shares decreased by two percentage points for inpatient, one percentage point for outpatient, and two percentage points for prescription drug services.
- The purchased care share of total MHS costs remained about the same between FY 2012 and FY 2014. The purchased care share of inpatient costs declined, but the share increased for prescription drug costs despite a decline in the share of purchased care utilization.

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, 1/15/2015

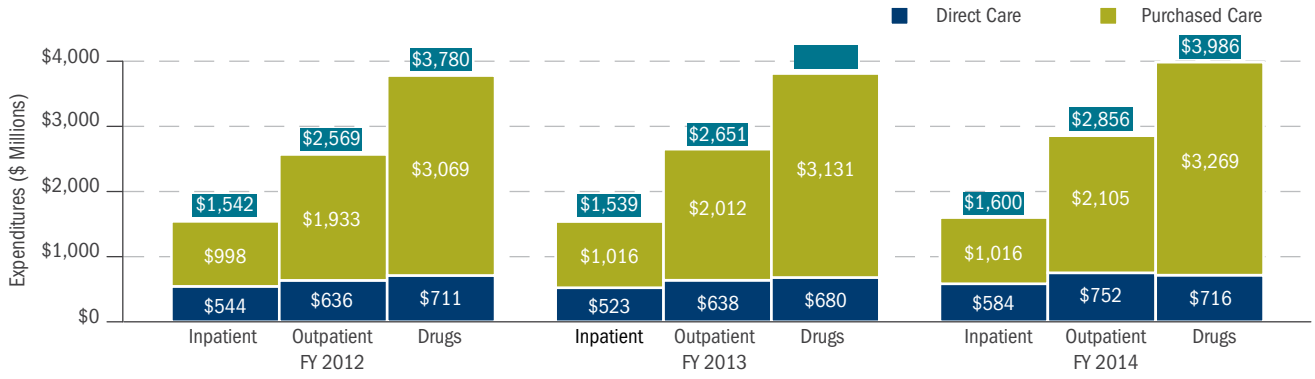
MHS COST TRENDS *(CONT.)*

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 $7,891 million in FY 2012 to $8,442 million in FY 2014 (7 percent), including manufacturer refunds on retail prescription drugs. The percentage of TFL-eligible beneficiaries who filed at least one claim remained at about 83 percent.

- Total DoD direct care expenses for MERHCF-eligible beneficiaries increased by 9 percent from FY 2012 to FY 2014. The increase was due largely to outpatient expenses, which grew by 18 percent. Direct inpatient expenses increased by 7 percent, while prescription drug expenses increased by 1 percent.
  - In FY 2012, TRICARE Plus enrollees accounted for 71 percent of DoD direct care inpatient and outpatient expenditures on behalf of MERHCF-eligible beneficiaries. By FY 2014, the TRICARE Plus share had grown to 73 percent.
  - Including prescription drugs, TRICARE Plus enrollees accounted for 55 percent of total DoD direct care expenditures on behalf of MERHCF-eligible beneficiaries in FY 2012. That figure rose to 58 percent in FY 2014.
- Total purchased care MERHCF expenditures increased by 7 percent from FY 2012 to FY 2014. Inpatient expenditures rose by 2 percent, outpatient expenditures by 9 percent, and prescription drug expenditures by 7 percent.

MERHCF EXPENDITURES FROM FY 2012 TO FY 2014 BY TYPE OF SERVICE



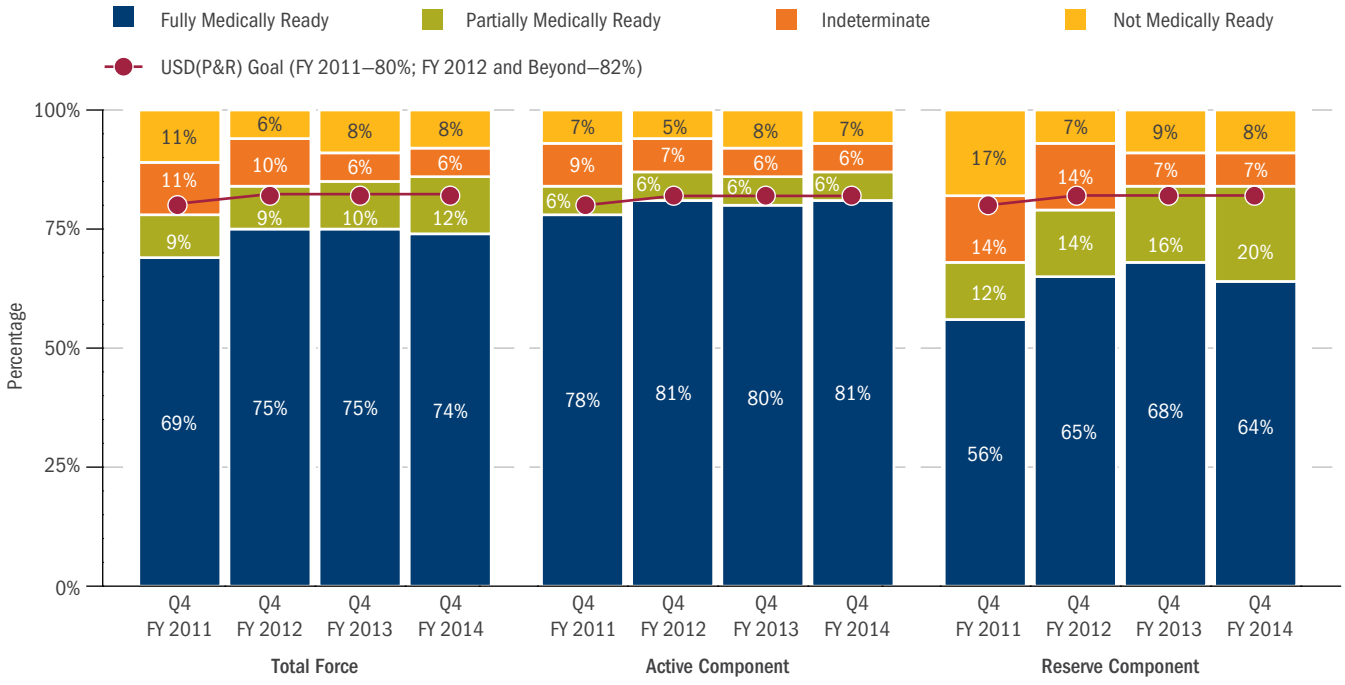
Source: MHS administrative data, 1/15/2015

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 of 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, 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 IMR chart below, by the end of fiscal year (FY) 2014, the total force overall (at 86 percent), the AC (at 87 percent), and the RC (at 84 percent) surpassed the Under Secretary of Defense for Personnel and Readiness (USD[P&R]) strategic goal of 82 percent medically ready (shown as the sum of the percentages in the blue and green sections). Similarly, by the end of FY 2013, the total force overall (at 85 percent), the AC (at 86 percent), and the RC (at 84 percent) exceeded the 82 percent goal. The total force medically ready increased by one percentage point each year from the end of FY 2012 (at 84 percent) to the end of FY 2014 (at 86 percent), reflecting the aggressive efforts of the Department to close the gap between the RC and the AC and improve the overall readiness of the total force. As the total force has improved, the USD(P&R) medical readiness goal has increased as well, from 80 percent in FY 2011, to 82 percent from FY 2012 to FY 2014. This goal will further increase to 85 percent early in FY 2015. The IMR status metric continues to be monitored closely by the Surgeons General, individually and collectively, in the quarterly Office of the Assistant Secretary of Defense, Health Affairs (OASD[HA]) and Tri-Services Surgeons General Quarterly Requirements and Analysis reviews.

OVERALL INDIVIDUAL MEDICAL READINESS STATUS: Q4 FY 2011 TO Q4 FY 2014 (ALL COMPONENTS NOT DEPLOYED)



Source: Defense Health Agency, Healthcare Operations Directorate/Public Health, 11/4/2014
Note: Percentages may not sum to 100 percent due to rounding.

HEALTHY, FIT, AND PROTECTED FORCE

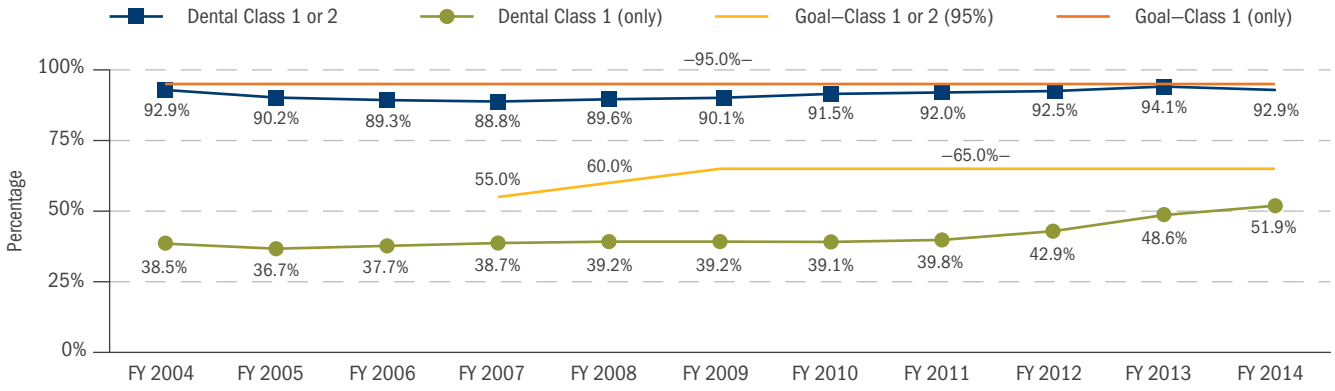
Key among the measures of performance related to providing an efficient and effective deployable medical capability and offering force medical readiness are those related to how well we (1) maintain the worldwide deployment capability of our Service members, as in dental readiness and immunization rates;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

DENTAL READINESS

The MHS Dental Corps Chiefs established in 1996 the goal of maintaining at least 95 percent of all Active Duty personnel in Dental Class 1 or 2. Patients in Dental Class 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require non-urgent 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. Following a steady annual increase since FY 2007, the combined Classes 1 and 2 declined slightly to 92.9 percent for FY 2014 from 94.1 percent in FY 2013, compared to the long-standing MHS goal of 95 percent.
- The rate for Active Duty personnel in Dental Class 1 has increased in the past five years, from about 39 percent (FY 2010) to almost 52 percent in FY 2014—or 13 percentage points short of the MHS goal of 65 percent. The MHS goal of 65 percent was increased from the 55 percent goal established in FY 2007.

ACTIVE DUTY DENTAL READINESS: PERCENT CLASS 1 OR 2



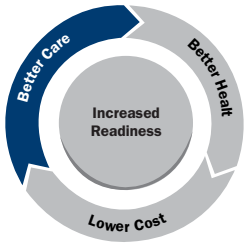
Source: The Services' Dental Corps–DoD Dental Readiness Classifications, 11/18/2014

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 that are unlikely to result in dental emergencies within 12 months. Patients in Dental Class 2 are worldwide deployable.

MEASURES OF ACCESS AND AVAILABILITY



On May 28, 2014, the Secretary of Defense ordered a comprehensive review of the Military Health System (MHS) focused on assessing whether (1) access to medical care in MHS meets defined standards; (2) the quality of health care in MHS meets or exceeds defined benchmarks; and (3) MHS has created a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries. In this review, key staff from all three Services and the Defense Health Agency (DHA) conducted site visits at selected military hospitals in the U.S. and one overseas. The review examined existing measures used to assess access, quality, and patient safety in military treatment facilities (MTFs). Data were also provided by three top-performing civilian health care medical centers to establish a benchmark for what great performance looks like. The report concluded that, although MHS is meeting the standards the Department of Defense (DoD) has set, further work is required to exceed the U.S. average.

This report presents, for the first time, beneficiary self-reported survey data from multiple sources, and, in so doing, offers different perspectives on how MHS assesses the beneficiary experience. Results on various survey-based measures include DHA's Health Care Survey for DoD Beneficiaries (HCSDB), TRICARE Outpatient Satisfaction Survey (TROSS), and TRICARE Inpatient Satisfaction Survey (TRISS); the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA). The Services and DHA measure various aspects of the patient experience with MHS care, and focus on different levels of measurement for different reasons; therefore, their results are often not readily comparable. The Services focus on MHS beneficiaries using their MTFs for outpatient care, and design their surveys with sufficient power to drill down to examine each MTF, as well as individual providers within each MTF, to monitor and improve care at the local level within their Component. The focus of DHA surveys, on the other hand, is at the enterprise level to compare across the Service Departments, across the direct care and purchased care venues, and, where appropriate, to compare to national civilian benchmarks. DHA surveys are not designed to examine the performance of individual providers within MTFs; DHA leaves that to the Services, which have the authority for those installations and providers.

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

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

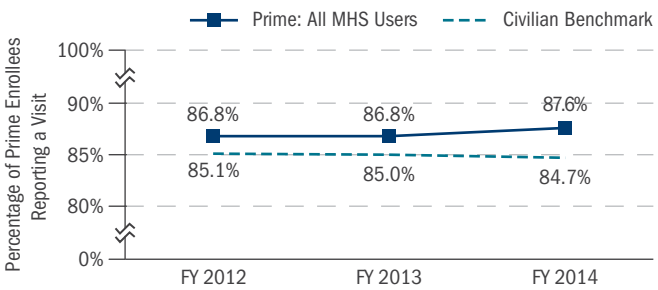
- Access to care based on having at least one outpatient visit during the past year
- MHS-monitored attributes of Patient-Centered Medical Home (PCMH) primary care
- Beneficiary ratings of access to outpatient care
- Population ratings of access to care (getting needed care, getting an appointment)
- Satisfaction with doctor's communication
- Access to care for beneficiaries with severe disabilities, such as autism

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 among Prime enrollees (with either a military or civilian primary care manager [PCM]), with nearly 88 percent reporting at least one visit in fiscal year (FY) 2014.
- The MHS Prime enrollee user rate exceeded the civilian benchmark each year between FY 2012 and FY 2014. In FY 2014, the Prime enrollee user rate was nearly 3 percentage points higher than the comparable civilian rate.

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



Note: DoD data were derived from the FYs 2012–2014 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the National CAHPS Benchmarking Database (NCBD) for commercial health plans and from survey results submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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.

PATIENT-CENTERED MEDICAL HOME (PCMH) PRIMARY CARE

As of September 2014, 3.1 million beneficiaries were enrolled to MTF primary care clinics, which have transformed to a PCMH model of primary care. Over 70 percent of the direct care system's family medicine, internal medicine, pediatrics, and operational medicine clinics have achieved formal PCMH recognition from the NCQA, and MHS expects to complete initial NCQA PCMH recognition of all primary care clinics by the end of calendar year (CY) 2016. In support of medical readiness, the Uniformed Services continue to implement operational medical homes through the Marine Centered, Soldier Centered, Fleet Centered, and Submarine Centered Medical Home programs.[1] In FY 2014, a multivariate model used to examine the impact of the first 48 NCQA-recognized PCMHs was completed. The results indicate that the direct care system's most mature PCMH practices had an average 4 percent lower per member per month cost compared with other direct care primary care practices and a 3 percent higher rating in primary care manager (PCM) continuity. These findings are encouraging, as cost reductions of this magnitude become significant if they can be achieved at all PCMH sites. The improvement in PCM continuity reinforces a central strategy of the PCMH model to support a continuous relationship between a patient and his or her provider.[2]

Access to Care: PCM and PCMH Team Continuity

The PCM-patient relationship continues to be the driving force to improve quality and better health outcomes for MTF-enrolled beneficiaries. Based on MTF administrative appointment tracking (consolidated in the TRICARE Operations Center), in FY 2014 enrollees saw their own PCMs during primary care visits 60 percent of the time, an increase of 9 percent compared with FY 2012. MTF enrollees received health care from their own PCM or a fellow PCMH team provider 91 percent of the time in FY 2014, an increase of 6 percent compared with FY 2012.[3]

	FY 2012	FY 2013	FY 2014
PCM Continuity	55%	58%	60%
PCMH Team Continuity	86%	90%	91%

Access to Care: Average Number of Days to the Third Next Acute and Future Appointments

The direct care system measures access to primary care by evaluating the average number of days to the third next acute appointment and third next routine appointment against the MHS access standards of 1.0 and 7.0 days, respectively. In FY 2014, the average number of days to a third next acute appointment was 1.89 days, a 9 percent improvement over FY 2012. The average number of days to a third next routine appointment was 6.38, an improvement of 4 percent over the same period.[4]

	FY 2012	FY 2013	FY 2014	2-YEAR IMPROVEMENT
Avg # Days to Third Next Acute Appointment	2.09	2.07	1.89	-9%
Avg # Days to Third Next Routine Appointment	6.62	6.51	6.38	-4%

Dispositions and Bed-Days per 1,000 MTF Enrollees

PCMH goals include reducing dispositions (admission) and bed-days per 1,000 MTF enrollees by proactively addressing and managing MTF enrollee comprehensive care in the PCMH setting. PCMH teams are working to reduce the number of times MTF enrollees are admitted to hospitals and medical centers in both the direct and purchased care sectors and the length of time they spend as inpatients if they are admitted, which is measured by bed-days (number of dispositions multiplied by the length of stay). The dispositions per 1,000 MTF enrollees averaged 20.80 in FY 2014, an improvement of 12 percent since FY 2012. The number of bed-days per 1,000 MTF enrollees was 111.51, an improvement of 11 percent over the same period.[5]

	FY 2012	FY 2013	FY 2014	2-YEAR IMPROVEMENT
Dispositions per 1,000 Enrollees	23.65	21.80	20.80	-12%
Bed-Days per 1,000 Enrollees	125.63	117.14	111.51	-11%

[1] Source: Tri-Service Primary Care PCMH Advisory Board
[2] Source: Kennell and Associates
[3] Source: TRICARE Operations Center (TOC)
[4] Source: TOC
[5] Source: M2; Kennell and Associates

PATIENT-CENTERED MEDICAL HOME (PCMH) PRIMARY CARE *(CONT.)*

Access to Primary Care: Reducing Specialty Referrals per 1,000 MTF Enrollees

In order to provide more comprehensive care in the primary care setting, PCMH teams are using team-based workflows to ensure the PCMs can provide more quality health care in the primary care setting rather than referring care outside the PCMH, where clinically indicated. More care in the primary care setting not only reduces health care costs, but also provides more coordinated, integrated care for the MTF enrollee. Consistent with retaining certain care in the PCMH, the table at right shows that the number of referrals initiated by the PCMH PCMs declined by 12 percent from 24.29 per 1,000 MTF enrollees in FY 2012 to 21.35 per 1,000 in FY 2014.[1]

	FY 2012	FY 2013	FY 2014	2-YEAR IMPROVEMENT
Referrals from PCMH per 1,000 Enrollees	24.29	22.70	21.35	–12%

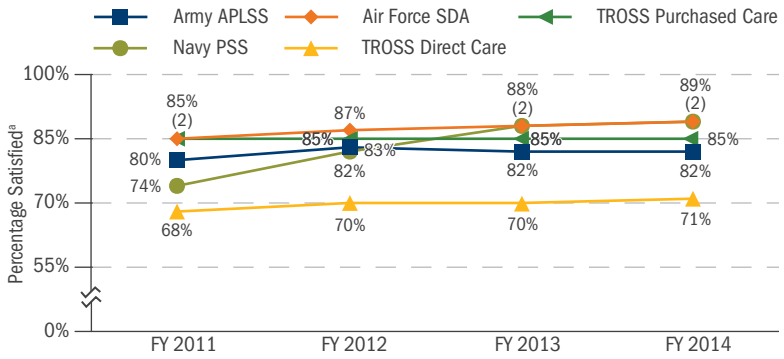
Enhanced Access To Care: Secure Messaging and the Nurse Advice Line (NAL)

The direct care system continues to offer enhanced access to care through the use of a commercially available secure messaging system. Secure messaging allows MTF enrollees to communicate directly with their PCMs and PCMH teams to ask questions about their health or medical tests and to arrange referrals or appointments. Currently, over 1.1 million MTF enrollees are registered in secure messaging. In FY 2014, MHS began implementation of secure messaging in specialty care. In support of quality and safety, MHS also implemented the CONUS Nurse Advice Line (NAL) in FY 2014. The NAL provides MHS beneficiaries with access to a team of registered nurses who offer advice and help beneficiaries decide what type of health care is needed to address their medical condition. The NAL is also able to make PCMH appointments for the beneficiary if he or she is enrolled in the direct care system. The NAL implementation began in late March 2014 and was completed in July 2014. Current call volume is over 1,400 calls per day.

PATIENT-CENTERED SELF-REPORTED ACCESS TO CARE MEASURES

Beneficiary Ratings of Access to Care Following Outpatient Care

RATING OF GETTING CARE WHEN NEEDED, USING MULTIPLE SURVEYS



Source: OASD(HA) DHA Analytics TROSS survey results as of March 2014, Air Force SDA results as of August 2014, and APLSS and Navy PSS results as of September 2014; compiled 11/21/2014

[a] "Percentage Satisfied" for Getting Health Care When Needed is a combination of the responses of Somewhat Agree and Strongly Agree.

Notes:

– "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.

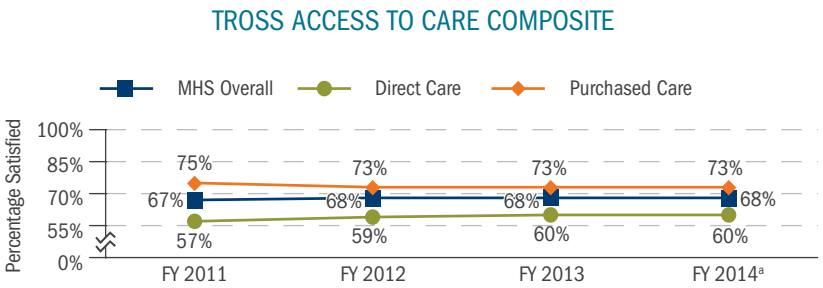
– Please refer to notes accompanying "Overall Rating of Health Care" (page 50) for more detail regarding the TROSS analysis.

Getting Care When Needed: As shown in the chart on the left, using a common question specific to MHS, the beneficiary overall rating of Getting Care When Needed increased for direct care from FY 2011 to FY 2014 across all outpatient surveys (APLSS, PSS, SDA, and TROSS). TROSS scores remained at 85 percent in civilian facilities from FY 2011 to FY 2014. The TROSS survey results indicate that, in FY 2012, there was a statistically significant increase from FY 2011 for beneficiaries receiving care in MTF-based facilities. Statistical significance testing was not performed on Service data.

[1] Source: M2; Kennell and Associates
[2] Source: Service Satisfaction Surveys

PATIENT-CENTERED SELF-REPORTED ACCESS TO CARE MEASURES *(CONT.)*

Beneficiary Ratings of Access to Care Following Outpatient Care *(Cont.)*



Source: OASD(HA) DHA Analytics TROSS survey results as of March 2014; compiled 11/21/2014

[a] The years depicted align with the fiscal year (i.e., FY 2013 represents data from October 2012–September 2013. However, FY 2014 represents data from October 2013–March 2014).

Note: Please refer to notes accompanying "Overall Rating of Health Care" (page 50) for more detail regarding this analysis.

Rating of Access to Care: As shown in the chart at left, MHS beneficiary overall rating of the Access to Care (the percentage rating Always and Almost Always) has remained somewhat stable from FY 2011 to FY 2014 for MHS. Access to Care ratings by beneficiaries receiving outpatient care at civilian facilities had a statistically significant decrease from FY 2011 to FY 2012 but then remained stable at 73 percent through FY 2014. Access to Care ratings for MTF-based facilities increased from 57 percent in FY 2011 to 60 percent in FY 2014. There was a statistically significant increase in FY 2012 and FY 2013 from the prior year for beneficiaries receiving care at MTF-based facilities.

Availability of Mental Health Providers for Active Duty and Families

Given the tremendous growth in DoD mental health staffing since early FY 2002, the current level of behavioral health resourcing appears adequate to serve all Active Duty and eligible Reserve Component members and their families, as well as retirees and their dependents. Since 9/11, with the support of Congress, DoD has increased the outlays for mental health care by a 12 percent compounded annual rate, roughly quadrupling care rendered between the beginning of FY 2002 and the beginning of FY 2014. Approximately 19 percent of the Active Duty force was seen by a mental health professional in 2013, averaging just under 10 visits per Service member seeking care. In addition, care is embedded into both primary care clinics and fighting units. The number of mental health providers in MHS MTFs has risen to 9,257, an increase of 40.5 percent from FY 2009 through FY 2014. Further, TRICARE network assets have been bolstered to better serve Reservists, dependents, and retirees, with a total of 68,465 mental health providers available in the purchased care network. Finally, DoD provides state-of-the-art substance abuse care, including medical therapies for addiction and confidential alcohol abuse treatment, as well as some of the most comprehensive benefits for autism spectrum disorders in the nation, including care to provide early intervention.[1]

Health Care and Related Support for Children of Members of the Armed Forces

MHS provides care for approximately 2.4 million individuals from newborn to 21 years of age through the direct care system as well as through purchased care. In July 2014, DoD submitted a report to Congress responding to section 735 of the National Defense Authorization Act (NDAA) for FY 2013 requiring the Secretary of Defense to conduct a study on the health care provided to dependent children of members of the Armed Forces. The report concluded that MHS is meeting the needs of the children, including those with special needs, as specifically addressed in the nine elements of the report; however, it also noted that there are gaps and issues that DoD must address. The Department is establishing a multidisciplinary working group to address the gaps and findings from the report with input from pediatric stakeholders.[1]

[1] DHA/Healthcare Operations Directorate, Clinical Support Division, 1/23/2015

BENEFICIARY RATINGS OF ACCESS TO CARE BASED ON POPULATION-WIDE SURVEYS

In addition to tracking patient care using administrative and provider-centric data, patient self-reported information provides a more complete assessment of the performance of the health care system, from the non-medical user's perspective. There are a number of methods for evaluating the patient's experience: face-to-face encounters, complaint and suggestion programs, focus groups, and surveys. Within surveys, patients can be asked about their experience following a specific event and time, as in event-based surveys after an outpatient visit or discharge from a hospital. Instead of focusing on a specific health care event, population surveys are designed to sample populations based on the demographics being considered (for example, a survey of all Active Duty Service members about their health behaviors, or a survey of all MHS beneficiaries to assess their use of preventive services and access to primary and specialty care), as in the case of the DHA HCSDB.

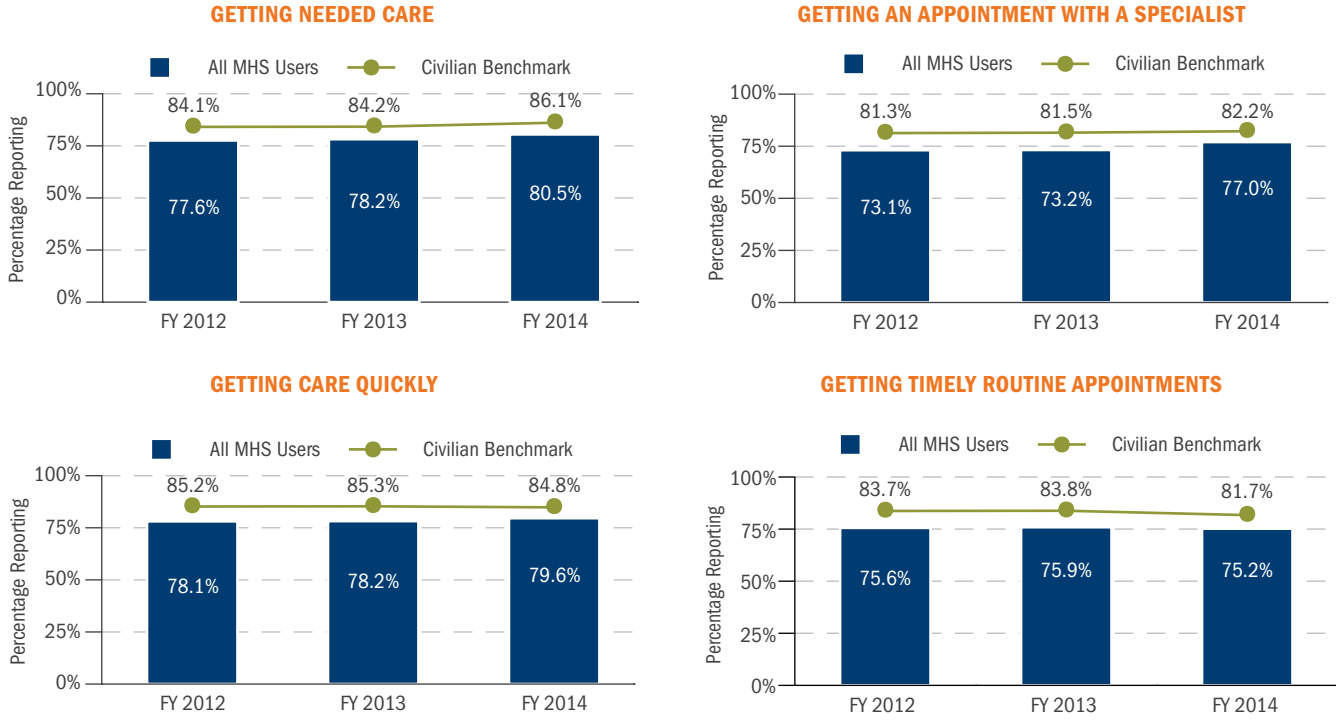
This section begins with an assessment of beneficiary access to care based on a population survey, and compares to national benchmarks; then it presents the results of beneficiary access to care based on several different surveys following their outpatient visit.

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), for getting care quickly, and for getting referrals to specialists improved from FY 2012 to FY 2014. Ratings of wait times for routine appointments remained stable over the three-year period.
- All MHS access measures continued to lag the comparable civilian benchmarks.

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



Note: DoD data were derived from the FYs 2012–2014 HCSDB, as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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.

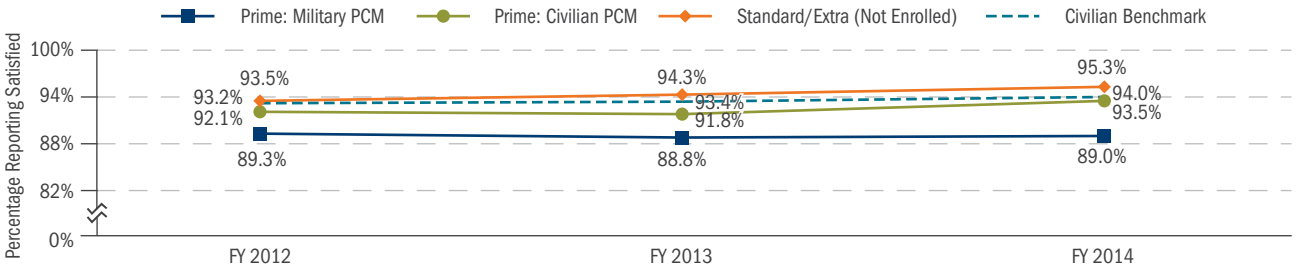
BENEFICIARY RATINGS OF ACCESS TO CARE BASED ON POPULATION-WIDE SURVEYS *(CONT.)*

Satisfaction with Doctors' Communication

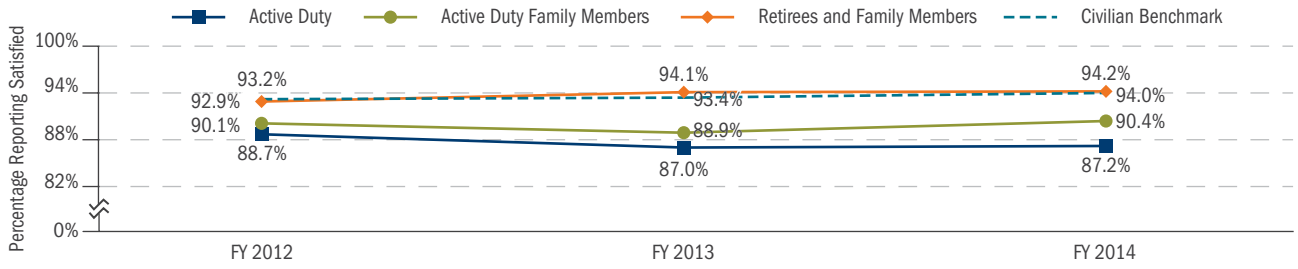
Communication between doctors and patients is an important factor in beneficiaries' satisfaction and their ability to obtain appropriate care. The following charts present beneficiary-reported perceptions of how well their doctor communicates with them.

- Prime enrollee satisfaction levels with their doctors' communication remained stable between FY 2012 and FY 2014. Satisfaction levels for those with a civilian PCM were higher than for those with a military PCM. Non-enrolled beneficiary satisfaction increased over the same time period.
- Satisfaction with doctors' communication lagged the civilian benchmark for Prime enrollees with a military PCM, but was not significantly different from the benchmark for those with a civilian PCM or for non-enrolled beneficiaries.
- Satisfaction levels with their doctors' communication increased for retirees and family members while remaining stable for Active Duty and Active Duty family members (ADFMs).
- Satisfaction with doctors' communication lagged the civilian benchmark for Active Duty and ADFMs, but was not significantly different from the benchmark for retirees and family members.

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 2012–2014 HCSDB, as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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 AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY AND NON-ACTIVE DUTY WITH SPECIAL NEEDS—AUTISM

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

Effective July 25, 2014, the Department created a new comprehensive Autism Care Demonstration, providing all TRICARE-covered applied behavior analysis (ABA) under one new demonstration. This encompasses ABA that recently had been provided under a patchwork of the TRICARE Basic Program, the ECHO Autism Demonstration, and the ABA pilot.

The Extended Care Health Option (ECHO) program supports ADFMs and other eligible beneficiaries with special health care needs by supplementing the TRICARE Basic Program in providing financial assistance for an integrated set of services and supplies. To use ECHO, qualified beneficiaries must be enrolled in the Exceptional Family Member Program (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 $154.2 million in FY 2013: autism spectrum disorders (ASDs), ECHO Home Health Care (EHHC), and all other users. In FY 2013 ASD users had 68.6 percent of the total government payments ($105.8 million), EHHC users had 30.8 percent of TRICARE government payments ($47.4 million), and all other ECHO users had 0.7 percent ($1.1 million) of the total. Of the approximately 8,094 beneficiaries using the ECHO program in FY 2013 to supplement the TRICARE Basic Program, autism beneficiaries accounted for 88 percent, while EHHC users accounted for 6.8 percent (550 users) and all other ECHO users accounted for 5.2 percent (423 users). EHHC users had the highest average annual per capita costs in FY 2013 at $86,252. ASD users cost $14,851 and all other ECHO users cost $2,490 annually per capita in FY 2013.

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 ABA. TRICARE first began covering ABA services for ADFMs with ASD under the Program for Persons with Disabilities in 2001. In 2005, the ECHO program covered ABA services as a nonmedical intervention to those ADFMs enrolled in the EFMP. The Enhanced Access to Autism Services Demonstration (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 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 "Behavior 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).

On June 28, 2013, DoD issued an Interim Coverage Determination for ABA coverage, which indicated that 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

ACCESS TO MHS CARE AND SERVICES FOR FAMILY MEMBERS OF ACTIVE DUTY AND NON-ACTIVE DUTY WITH SPECIAL NEEDS—AUTISM *(CONT.)*

ECHO TUTOR DEMO, ECHO ABA, TRICARE BASIC ABA, AND ABA PILOT PROGRAM USERS BY BENEFICIARY CATEGORY FOR FY 2013 AND THE FIRST HALF OF FY 2014

(INCLUDES ALL CLAIMS PROCESSED THROUGH JULY 15, 2014)

ACTIVE DUTY FAMILY MEMBERS		RETIREE DEPENDENTS < AGE 65		TOTAL ADFMS & RETIREE DEPENDENTS <65	
FY 2013	**Total**	**FY 2013**	**Total**	**FY 2013**	**Total**
ECHO ABA Users	2,508	TRICARE Basic ABA Users	650	**Total Users**	**8,543**
ECHO Tutor Users	6,054	ABA Pilot Users	9		
TRICARE Basic ABA Users	2,768	**Total (Unique Users)**	**653**		
Total (Unique Users)	**7,890**				
FY 2014 First Half	**Total**	**FY 2014 First Half**	**Total**	**FY 2014 First Half**	**Total**
ECHO ABA Users	449	TRICARE Basic ABA Users	831	**Total Users**	**7,994**
ECHO Tutor Users	5,484	ABA Pilot Users	170		
TRICARE Basic ABA Users	2,661	**Total (Unique Users)**	**889**		
Total (Unique Users)	**7,105**				

Note: Although not shown, in FY 2013 expenditures for ADFMs using TRICARE's ASD programs totaled $125.8 million, of which $85.8 million (or 68 percent) was for ADFMs using the ECHO tutor demo program, $22.0 million (or 17 percent) was for the ECHO ABA program, and $18.0 million (or 14 percent) was for ADFMs using the new TRICARE Basic ABA program. The average ADFM user had $15,943 in ASD expenditures during FY 2013, and $8,889 for the first six months of FY 2014.

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.

ASD Benefits for Non-Active Duty Family Members: 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 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.

Faced with various temporary authorities and the resulting complexity of the current interim TRICARE policies concerning coverage of ABA for ASD, the Department created a new comprehensive Autism Care Demonstration providing all TRICARE-covered ABA under one new demonstration that began July 25, 2014. This encompasses ABA that recently had been provided under a patchwork of the TRICARE Basic Program (i.e., the medical benefits authorized under section 199.4 of title 32, Code of Federal Regulations); the ECHO Autism Demonstration (i.e., the supplemental ABA benefits authorized for certain ADFMs under section 199.5 of title 32, Code of Federal Regulations); and the ABA pilot (i.e., the supplemental ABA benefits authorized for certain NADFMs—including retiree dependents and others—under section 705 of the NDAA for FY 2013). It preserves most of the terms and conditions of coverage under that patchwork, incorporating some lessons learned. Coverage of ABA and related services under this new demonstration will apply comprehensively to all TRICARE-eligible dependents with a diagnosis of ASD. The term "eligible dependent" means the dependent of a beneficiary defined under sections 1079 and 1086 of chapter 55 of title 10, U.S. Code, and includes dependents of Active Duty, retired, TRICARE-eligible Reserve Component (RC), and certain other non-Active Duty members. This demonstration will consolidate TRICARE coverage of ABA based on the Department's demonstration authority in section 1092 of title 10, U.S. Code, to improve the quality, efficiency, convenience, and cost-effectiveness of those autism-related services that do not constitute the proven medical care provided under the medical benefit coverage requirements that govern TRICARE Basic.

As noted previously, as of the beginning of FY 2013, NADFM children were able to get ABA therapy benefits under the TRICARE ABA Basic Program for the first time. Additionally, as of July 25, 2013, NADFMs were also able to get services similar to those provided under the ECHO tutor demo through the NADFM ABA pilot program. As shown in the table above reflecting both ADFM and NADFM program users, in FY 2013 there were a total of 7,890 ADFM beneficiaries using TRICARE's ASD programs, of which 2,508 (32 percent) were using the ECHO ABA program, 6,054 (77 percent) were using the ECHO tutor demo, and 2,768 (35 percent) were using the new TRICARE Basic ABA program. Compared to the 7,890 ADFM users, in FY 2013 a total of 653 NADFMs used ASD services in the TRICARE Basic and ABA pilot programs. Only nine of these NADFM beneficiaries actually had claims in the ABA pilot program that started on July 25, 2013. Therefore, it is clear there were few ABA pilot users during FY 2013. By the first half of FY 2014, 889 unique NADFM ASD users had used TRICARE ASD services—up from 653 for the entire year in FY 2013. The number of pilot program users increased from nine users in FY 2013 to 170 users by the first half of FY 2014.

QUALITY OF MHS CARE

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared to National Civilian Hospitals FY 2010–FY 2013

MHS assesses the quality of clinical care through analysis of process and outcome measures for both the inpatient and outpatient settings. Standardized, nationally recognized, consensus-based metrics are used to ensure consistency in measure methodology and to facilitate comparison with civilian-sector care. Although the sources of data vary, the performance in the MTFs and by contracted civilian health care inpatient institutions is reviewed. The measures data provide essential information for leaders and stakeholders who are focused on evaluating and improving the quality of health care delivered to MHS beneficiaries.

The Secretary of Defense mandated a review of the quality of care provided in MHS in May 2014. Extensive data and analysis on the quality of care in MHS is available in the report as well as recommendations to enhance the quality of care (*http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/*). Action plans to address the recommendations are under development.

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 MTFs, the data for the hospital quality measures are abstracted by trained specialists, reported to the Joint Commission to meet hospital accreditation requirements, and presented to facility leadership for analysis and identification of improvement opportunities. Data on the same measure sets for hospitals enrolled in a managed care support contractor (MCSC) network are obtained from the files posted by the Center for Medicare and Medicaid Services (CMS) on the Hospital Compare Web site: *http://www.hospitalcompare.hhs.gov*. Quarterly, the Hospital Compare data file is downloaded, and the participating purchased care network hospitals are identified. These data reflect the overall performance of the network hospitals for the measures and includes both TRICARE-reimbursed patients as well as all others reported by the civilian hospital (the Department does not have access to data based solely on TRICARE patients).

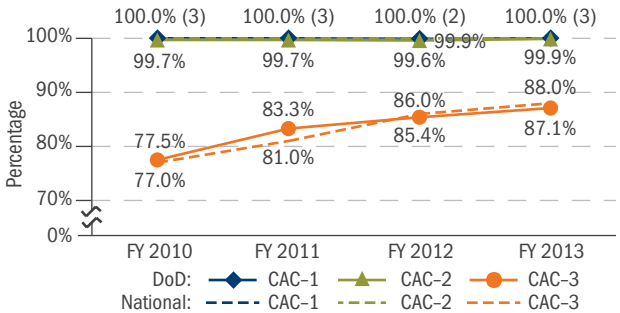
The display of MTF and network facility data provides a systemwide view of the performance of health care facilities available to beneficiaries. MHS subject matter experts for both direct care and purchased care review the data and work collaboratively to identify and communicate performance excellence and improvement opportunities. The data file is available publicly on the MHS Clinical Quality Management Web site: *https://www.mhs-cqm.info*.

DoD data displayed in the following charts include all patients who meet the National Hospital Measures technical specifications for the 55 inpatient MTFs and 2,483 civilian hospitals participating in contracted care networks. As noted in last year's report, a number of measures were retired during 2012. Other measures were continued and, as shown below, new measures were added to some core sets to better focus on areas that require improvement.

	FY 2010	FY 2011	FY 2012	FY 2013
CAC–1 CHILDREN WHO RECEIVED RELIEVER MEDICATION WHILE HOSPITALIZED FOR ASTHMA				
Military/Civilian Hospitals Treating DoD Patients	100.0%	100.0%	99.9%	100.0%
MTFs	99.7%	99.7%	99.3%	100.0%
Civilian Hospitals Treating DoD Pts.	100.0%	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				
Military/Civilian Hospitals Treating DoD Patients	99.7%	99.7%	99.6%	99.9%
MTFs	98.5%	98.5%	98.7%	99.1%
Civilian Hospitals Treating DoD Pts.	99.8%	99.7%	99.7%	99.9%
National	100.0%	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				
Military/Civilian Hospitals Treating DoD Patients	77.5%	83.3%	85.4%	87.1%
MTFs	51.5%	55.7%	70.9%	62.5%
Civilian Hospitals Treating DoD Pts.	78.7%	84.7%	86.1%	88.1%
National	77.0%	81.0%	86.0%	88.0%

- **Children's Asthma Care (CAC):** Health care organizations providing care to DoD beneficiaries are at or near 100 percent for CAC–1 and CAC–2, which focus on medications for asthma patients. CAC–3 focuses on the transition of care from the inpatient to the outpatient setting and is an area for improvement for both DoD and the nation. To support MTF performance for this measure, a standardized note for the electronic medical record has been developed.

DoD HOSPITAL QUALITY MEASURE: CAC



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/19/2014

QUALITY OF MHS CARE *(CONT.)*

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared to National Civilian Hospitals FY 2010–FY 2013 *(Cont.)*

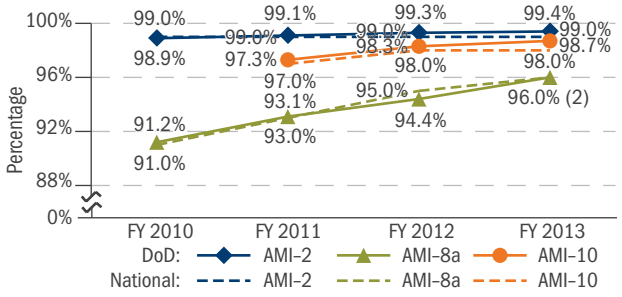
	FY 2010	FY 2011	FY 2012	FY 2013
AMI–2 HEART ATTACK PATIENTS GIVEN ASPIRIN AT DISCHARGE				
Military/Civilian Hospitals Treating DoD Patients	98.9%	99.1%	99.3%	99.4%
MTFs	97.7%	96.8%	98.3%	97.1%
Civilian Hospitals Treating DoD Pts.	98.9%	99.1%	99.3%	99.4%
National	99.0%	99.0%	99.0%	99.0%
AMI–8a HEART ATTACK PATIENTS GIVEN PERCUTANEOUS CORONARY INTERVENTION (PCI) WITHIN 90 MINUTES OF ARRIVAL				
Military/Civilian Hospitals Treating DoD Patients	91.2%	93.1%	94.4%	96.0%
MTFs	59.7%	62.7%	60.3%	59.3%
Civilian Hospitals Treating DoD Pts.	91.3%	93.2%	94.4%	96.0%
National	91.0%	93.0%	95.0%	96.0%
AMI–10 STATINS PRESCRIBED AT DISCHARGE				
Military/Civilian Hospitals Treating DoD Patients	ND	97.3%	98.3%	98.7%
MTFs	ND	87.8%	98.0%	98.2%
Civilian Hospitals Treating DoD Pts.	ND	97.3%	98.3%	98.7%
National	ND	97.0%	98.0%	98.0%

	FY 2010	FY 2011	FY 2012	FY 2013
HF–1 HEART FAILURE PATIENTS GIVEN DISCHARGE INSTRUCTIONS				
Military/Civilian Hospitals Treating DoD Patients	90.0%	91.9%	92.9%	94.7%
MTFs	80.9%	84.9%	87.9%	89.8%
Civilian Hospitals Treating DoD Pts.	90.0%	91.9%	93.0%	94.7%
National	90.0%	91.0%	93.0%	94.0%
HF–2 HEART FAILURE PATIENTS GIVEN AN EVALUATION OF LEFT VENTRICULAR SYSTOLIC (LVS) FUNCTION				
Military/Civilian Hospitals treating DoD patients	99.0%	98.9%	99.2%	99.4%
MTFs	96.7%	97.5%	97.9%	98.9%
Civilian Hospitals treating DoD Pts.	99.0%	98.9%	99.2%	99.4%
National	98.0%	98.0%	99.0%	99.0%
HF–3 HEART FAILURE PATIENTS GIVEN ACE INHIBITOR OR ARB FOR LVSD				
Military/Civilian Hospitals Treating DoD Patients	95.0%	96.1%	96.7%	97.3%
MTFs	92.4%	91.4%	94.3%	96.3%
Civilian Hospitals Treating DoD Pts.	95.0%	96.1%	96.8%	97.3%
National	95.0%	95.0%	97.0%	97.0%

	FY 2010	FY 2011	FY 2012	FY 2013
PN–3b PNEUMONIA PATIENTS WHOSE INITIAL EMERGENCY ROOM BLOOD CULTURE WAS PERFORMED PRIOR TO THE ADMINISTRATION OF THE FIRST HOSPITAL DOSE OF ANTIBIOTICS				
Military/Civilian Hospitals Treating DoD Patients	96.5%	97.0%	97.5%	98.1%
MTFs	90.6%	91.6%	94.0%	94.4%
Civilian Hospitals Treating DoD Pts.	96.5%	97.1%	97.5%	98.1%
National	96.0%	96.0%	97.0%	98.0%
PN–6 PNEUMONIA PATIENTS GIVEN THE MOST APPROPRIATE INITIAL ANTIBIOTIC(S)				
Military/Civilian Hospitals Treating DoD Patients	93.3%	95.2%	95.5%	96.3%
MTFs	92.4%	93.1%	94.9%	94.7%
Civilian Hospitals Treating DoD Pts.	93.3%	95.2%	95.5%	96.3%
National	93.0%	94.0%	95.0%	95.0%

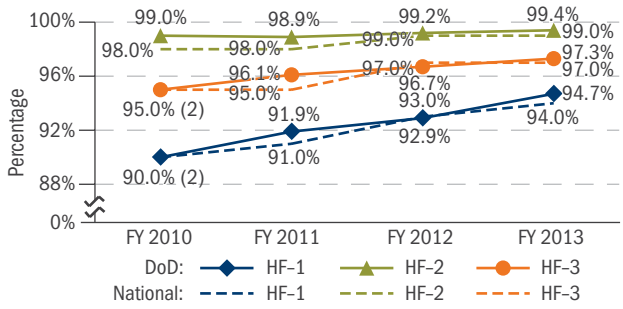
- **Acute Myocardial Infarction (AMI):** DoD performance for the AMI measures is at or near 100 percent. One measure with noted opportunity for improvement is AMI–8a for MTFs. A performance improvement review to analyze the process and timeline for percutaneous coronary intervention (PCI) in the MTFs is underway.

DoD HOSPITAL QUALITY MEASURE: AMI



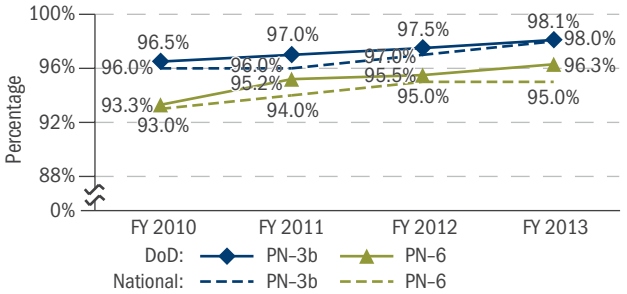
- **Heart Failure (HF):** DoD performance for the heart failure measures continues to improve. The Joint Commission is planning to retire the HF measure set in 2015.

DoD HOSPITAL QUALITY MEASURE: HEART FAILURE



- **Pneumonia (PN):** DoD performance on the pneumonia measures is consistent with the average performance across the nation. The Joint Commission is planning to retire the PN measure set in 2015.

DoD HOSPITAL QUALITY MEASURE: PNEUMONIA



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/19/2014

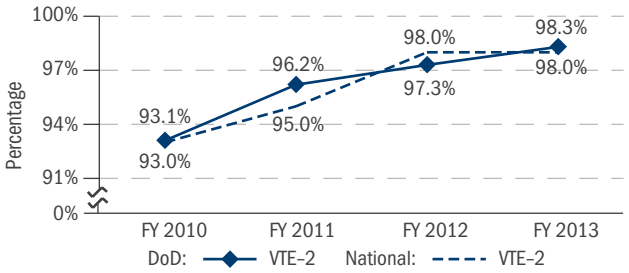
Note: For visual display, numbers in parentheses on the graphs indicate the number of overlapping data points.

MHS Hospital Quality Measures—DoD Military and Contracted Civilian Hospitals Compared to National Civilian Hospitals FY 2010–FY 2013 *(Cont.)*

	FY 2010	FY 2011	FY 2012	FY 2013
SCIP Inf–1[a] SURGERY PATIENTS WHO WERE GIVEN AN ANTIBIOTIC AT THE RIGHT TIME (WITHIN ONE HOUR BEFORE SURGERY) TO HELP PREVENT INFECTION				
Military/Civilian Hospitals Treating DoD Patients	97.5%	98.1%	98.4%	98.9%
MTFs	92.9%	95.5%	96.3%	98.1%
Civilian Hospitals Treating DoD Pts.	97.6%	98.1%	98.4%	98.9%
National	97.0%	98.0%	98.0%	99.0%
SCIP Inf–2[a] SURGERY PATIENTS WHO WERE GIVEN THE RIGHT KIND OF ANTIBIOTIC TO HELP PREVENT INFECTION				
Military/Civilian Hospitals Treating DoD Patients	97.8%	98.3%	98.6%	99.1%
MTFs	94.6%	95.8%	96.5%	97.4%
Civilian Hospitals Treating DoD Pts.	97.8%	98.4%	98.6%	99.1%
National	98.0%	98.0%	99.0%	99.0%
SCIP Inf–3[a] SURGERY PATIENTS WHOSE PREVENTIVE ANTIBIOTICS WERE STOPPED AT THE RIGHT TIME (WITHIN 24 HOURS AFTER SURGERY)				
Military/Civilian Hospitals Treating DoD Patients	95.8%	96.8%	97.3%	98.2%
MTFs	94.2%	94.6%	96.1%	96.5%
Civilian Hospitals Treating DoD Pts.	95.8%	96.8%	97.3%	98.2%
National	96.0%	96.0%	97.0%	98.0%
SCIP Inf–9[a] URINARY CATHETER REMOVED ON POD1 OR POD2 WITH DAY OF SURGERY BEING DAY ZERO				
Military/Civilian Hospitals Treating DoD Patients	ND	93.0%	95.9%	97.6%
MTFs	ND	92.9%	97.4%	98.4%
Civilian Hospitals Treating DoD Pts.	ND	93.0%	95.8%	97.6%
National	ND	93.0%	96.0%	97.0%

- **Surgical Care Improvement Project (SCIP):** DoD performance on SCIP measures is consistent with the average performance across the nation, with all measures above 95 percent—the benchmark used by the Joint Commission to identify top-performing hospitals.

DoD HOSPITAL QUALITY MEASURE: SCIP–VTE[b]



	FY 2010	FY 2011	FY 2012	FY 2013
SCIP VTE–2[b] PATIENTS WHO GOT TREATMENT AT THE RIGHT TIME (WITHIN 24 HOURS BEFORE OR AFTER THEIR SURGERY) TO HELP PREVENT BLOOD CLOTS AFTER CERTAIN TYPES OF SURGERY				
Military/Civilian Hospitals Treating DoD Patients	93.1%	96.2%	97.3%	98.3%
MTFs	91.9%	94.3%	95.1%	96.2%
Civilian Hospitals Treating DoD Pts.	93.1%	96.2%	97.3%	98.3%
National	93.0%	95.0%	98.0%	98.0%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/19/2014

[a] Surgical Care Improvement Project—Infection

[b] Surgical Care Improvement Project—Venous Thromboembolism Prophylaxis

Non-FDA Approved Laboratory Developed Tests Demonstration

Issue

A new demonstration to evaluate whether it is feasible for the DoD to review laboratory developed tests (LDTs) that have not received Food and Drug Administration (FDA) approval was published in the *Federal Register* on July 18, 2014. This three-year demonstration will evaluate the feasibility of establishing a cost-effective and efficient way to review an expanded pool of non-FDA approved LDTs. As a result, TRICARE beneficiaries will have access to those non-FDA approved tests that have been reviewed under the LDT demonstration.

Background

- LDTs are created by individual laboratories and considered medical devices by the FDA. By regulation, TRICARE coverage is limited to only those medical devices approved by the FDA. This regulatory requirement does not extend to the direct care provided in MTFs. Therefore, a number of non-FDA approved LDTs used in MTFs are not covered by TRICARE in the private sector. This has resulted in a disparity in the availability of LDTs between MTFs and TRICARE.
- Under the demonstration, the DHA's Laboratory Joint Working Group (LJWG) has reviewed more than 40 LDTs and their clinical indications. The LDTs and clinical indications recommended by the LJWG were provided to the Director, DHA, for his approval. The approved tests and clinical indications were published in the TRICARE Operations Manual on August 4, 2014. The major categories include 19 tests for cancer diagnosis, cancer risk, and cancer treatment; eight for blood or clotting disorders; seven for genetic diseases or syndromes; and three for neurological conditions. Some LDTs are only for specific or rare conditions.
- The implementation date of the demonstration was September 4, 2014, which allowed the MCSCs time to develop and put in place necessary policies and procedures.
- LDTs identified by Current Procedural Terminology (CPT) codes that were previously denied payment but are now covered by the new demonstration will be reimbursed. Beneficiaries and laboratories can resubmit those claims for adjudication.
- The demonstration provides coverage for prenatal and preconception cystic fibrosis carrier screening when provided in accordance with the most current guidelines from the American Congress of Obstetricians and Gynecologists. Coverage will be extended retroactively to January 1, 2013, and previously denied claims will be reimbursed. MCSCs were given guidance to facilitate the expeditious payment of previously denied claims and reimbursement has already begun.
- Approved LDTs will be integrated into direct care, providing more consistency between MTFs and TRICARE.
- This demonstration will collect data to support potential future regulatory revisions and enhance the flexibility in responding to emerging technologies.

Paid-to-Date

The TRICARE program has paid over $57 million for approved LDTs for care since January 1, 2013.

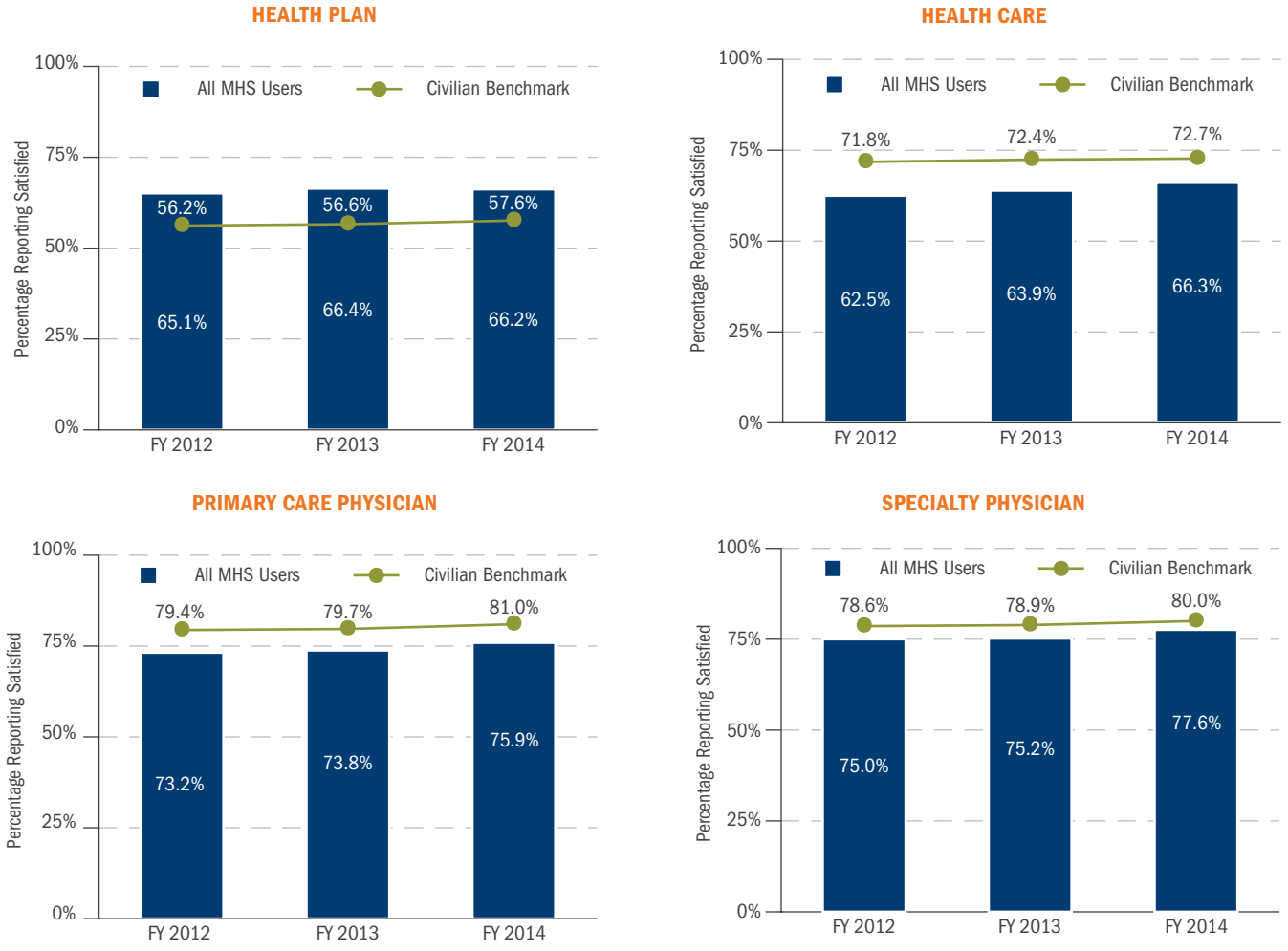
QUALITY OF MHS CARE *(CONT.)*

Beneficiary Ratings of 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.

- Beneficiary satisfaction with health care quality, as well as with primary and specialty care physicians, increased between FY 2012 and FY 2014. Satisfaction with the health plan remained stable over the same period.
- MHS beneficiary satisfaction with the health plan continues to exceed that of the civilian benchmark. However, satisfaction with health care quality and with primary and specialty care physicians lags the civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



Note: DoD data were derived from the FYs 2012–2014 HCSDB, as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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.

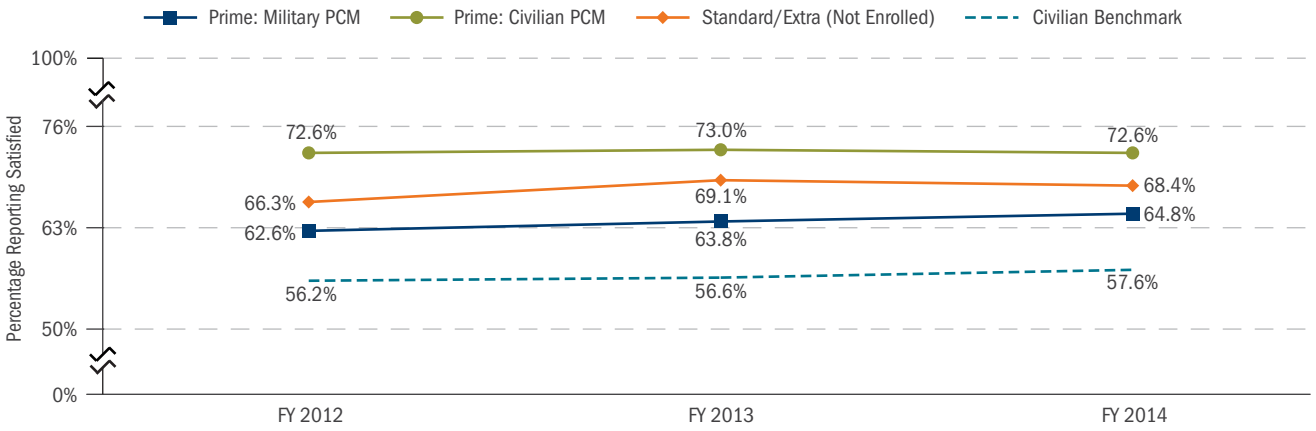
QUALITY OF MHS CARE *(CONT.)*

Beneficiary Ratings of Satisfaction with Health Plan Based on Enrollment Status

DoD health care beneficiaries can participate in TRICARE in two 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 improved from FY 2012 to FY 2014 for Prime enrollees with a military PCM. Satisfaction levels for Prime enrollees with a civilian PCM and for non-enrollees remained stable.
- For each of the past three years (FY 2012 to FY 2014), all beneficiary groups reported higher levels of satisfaction with their health plan than their civilian counterparts.

TRENDS IN SATISFACTION WITH HEALTH PLAN BY ENROLLMENT STATUS

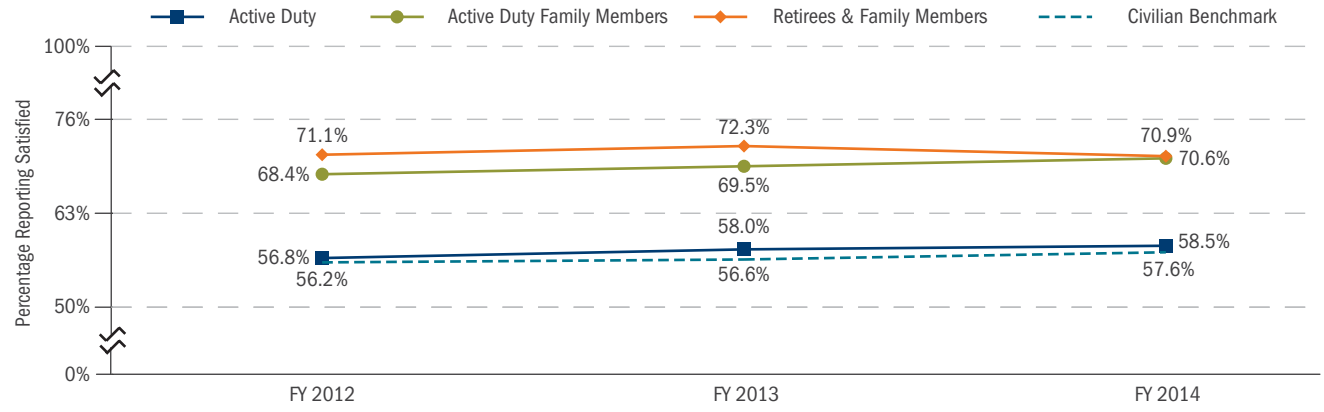


Satisfaction with the Health Plan by Beneficiary Category

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

- Satisfaction with the TRICARE health plan remained stable from FY 2012 to FY 2014 for all beneficiary groups.
- Active Duty satisfaction was not significantly different from the civilian benchmark. However, satisfaction levels for Active Duty family members and non-enrollees were above the civilian benchmarks.

TRENDS IN SATISFACTION WITH THE HEALTH PLAN BY BENEFICIARY CATEGORY



Note: DoD data were derived from the FYs 2012–2014 HCSDB, as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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.

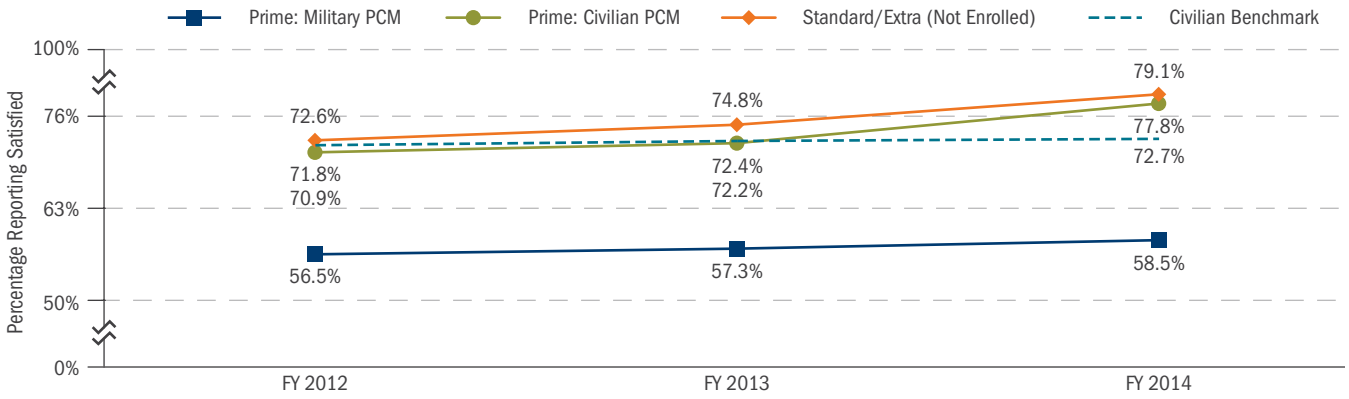
QUALITY OF MHS CARE *(CONT.)*

Beneficiary Ratings of Satisfaction with Health Care Based on Enrollment or Beneficiary Category

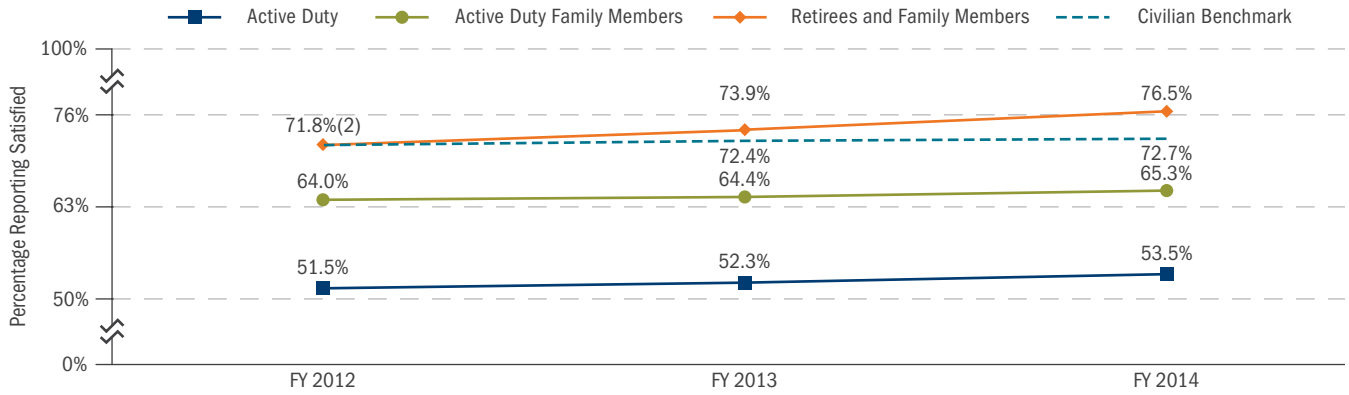
Similar to satisfaction with the TRICARE health plan, satisfaction levels with the health care received differ by beneficiary category and enrollment status:

- Satisfaction with health care remained stable from FY 2012 to FY 2014 for Prime enrollees with a military PCM. Satisfaction levels increased for Prime enrollees with a civilian PCM and for non-enrollees.
- The satisfaction levels of Prime enrollees with a military PCM lag the civilian benchmark. Satisfaction levels for the other enrollment groups exceeded the civilian benchmark in FY 2014.
- Satisfaction with health care remained stable for Active Duty and ADFMs but increased for retirees and family members.
- The satisfaction levels of Active Duty and ADFMs lag the civilian benchmarks. Satisfaction levels for retirees and family members exceeded the civilian benchmark in FY 2014.

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 2012–2014 Health Care Survey of DoD Beneficiaries (HCSDB), as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the National CAHPS Benchmarking Database (NCBD) for commercial health plans and from survey results submitted to the National Committee for Quality Assurance (NCQA) by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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.

QUALITY OF MHS CARE *(CONT.)*

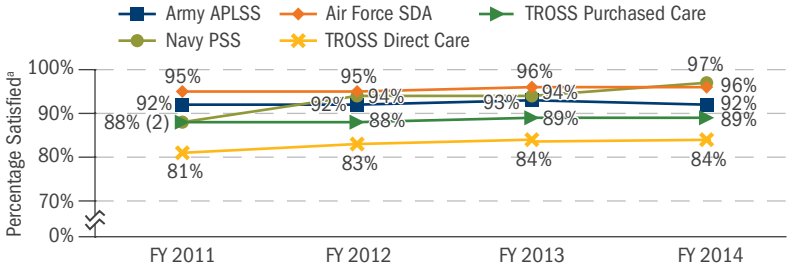
Beneficiary Ratings of Care Following Outpatient Treatment

Ratings of Care Using Multiple DHA and Service Outpatient Surveys

The goal of MHS outpatient surveys 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 TRICARE Outpatient Satisfaction Survey (TROSS) is based on the Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician and Group questionnaire (CAHPS® C&G). The TROSS instrument also includes MHS-specific questions that measure satisfaction with various aspects important to MHS. The Army, Navy, and Air Force also field individual outpatient Service satisfaction surveys: the Army Provider Level Satisfaction Survey (APLSS), the Navy Patient Satisfaction Survey (PSS), and the Air Force Service Delivery Assessment (SDA).

Outpatient Ratings of Care: Tri-Service and DHA Surveys—Overall Satisfaction: The Army, Navy, Air Force, and DHA measure various aspects of the patient experience with MHS care. The Services focus on MHS beneficiaries using their MTFs for outpatient care, and design their surveys with sufficient power to be able to drill down to examine each MTF, as well as individual providers within each MTF. The focus of DHA surveys, on the other hand, is to use a standardized instrument and survey methodology to effectively examine beneficiary experience of care across the Services and between the direct and purchased care venues, as well as to compare to civilian CAHPS benchmarks, but are not designed to examine the performance of individual providers within MTFs.

RATING OF OVERALL SATISFACTION WITH CARE, USING MULTIPLE SURVEYS



Source: OASD(HA) DHA Analytics TROSS survey results as of March 2014, Air Force SDA results as of August 2014, and APLSS and Navy PSS results as of September 2014

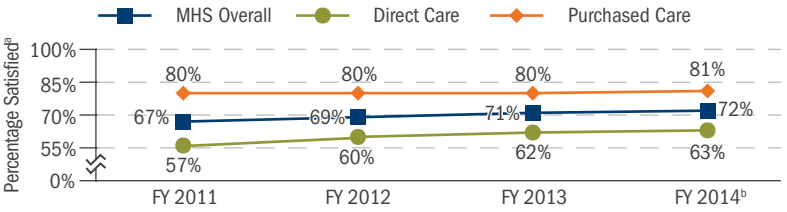
[a] "Percentage Satisfied" for Satisfaction with Care is a response of Somewhat Satisfied and Completely Satisfied.

Notes:

– "Direct Care" refers to MTF-based care, and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.

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

TROSS OVERALL RATING OF HEALTH CARE



Source: OASD(HA) DHA Analytics TROSS survey results as of March 2014; compiled 11/21/2014

[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.

[b] The years depicted align with the fiscal year (i.e., FY 2013 represents data from October 2012 to September 2013. However, FY 2014 represents data from October 2013 to March 2014).

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.

– Overall populations are based on their (annual) demographic distributions.

– 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.

The chart at left shows overall ratings of beneficiary satisfaction with outpatient care from FY 2011 to FY 2014 across all outpatient surveys (APLSS, Navy PSS, Air Force SDA, and DHA TROSS). TROSS results below show beneficiary ratings for direct and purchased care increased during this time. APLSS scores remained somewhat constant from FY 2011 to FY 2014. Navy PSS showed the largest increase (9 percentage points) from FY 2011 to FY 2014. There was a significant increase in TROSS scores among MTF-based facilities from FY 2011 to FY 2012 and from FY 2012 to FY 2013. Among civilian-based facilities, there was a significant increase in TROSS scores from FY 2012 to FY 2013. Statistical significance testing was not performed on Service data.

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 67 percent in FY 2011 to 72 percent in FY 2014. The increased ratings between FY 2011 and FY 2014 were statistically significant when compared with each previous fiscal year. Ratings by beneficiaries using civilian outpatient care remained stable at 80 percent from FY 2011 to FY 2013 and at 81 percent in FY 2014. Meanwhile, ratings by those using MTF-based care increased from 57 percent in FY 2011 to 63 percent in FY 2014, showing a statistically significant increase between FY 2011 and FY 2014 when compared with the previous fiscal year.

Beneficiary Ratings of Care Following Inpatient Treatment

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 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 policy and to provide feedback to providers and patients.

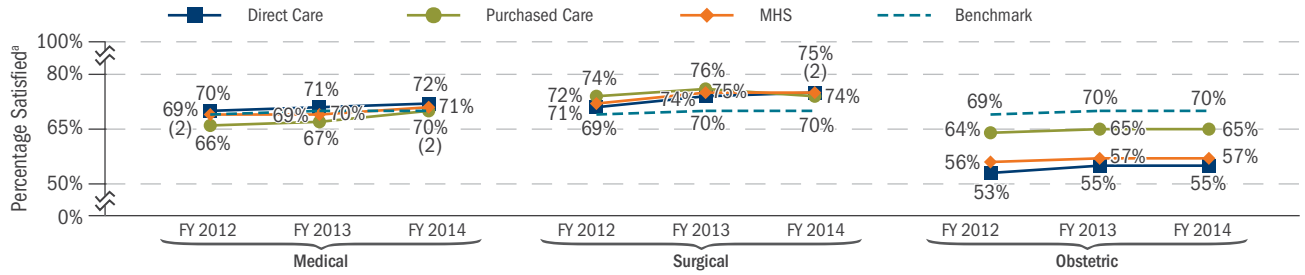
Comparison of these data with the results from previous surveys as well as comparisons to civilian benchmark data measure DoD progress in meeting its goals and objectives of high-quality health care. The TRISS assesses care across all Services and across venues (i.e., direct MTF-based care and private-sector, or purchased, care) including assessment of inpatient surgical, medical, and maternal care. In 2011, the TRISS was streamlined from 82 to 41 questions and modified to a mixed-mode (by mail and telephone), monthly administration, garnering a 40 percent response rate in the 2014 Report of Finding, compared with 34 percent in previous years. This increase in response rate may be attributable to these methodological changes and the new HCAHPS requirement of surveying patients within 42 days of discharge. The survey covers a number of domains, including:

- Overall rating of hospital and recommendation of the hospital 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
- Post-discharge (such as written directions for post-discharge care)

In December 2013, a new TRISS survey was implemented that is based on the new HCAHPS questionnaire and included new DoD questions. The new questionnaire included all of the above measures in addition to a new measure on Care Transition, which comprised three new questions. Not enough data and benchmarks for this new measure, however, were available for this reporting period; hence the data from the new questionnaire are not included in this report.

Rating of Hospital: Overall, beneficiaries who received obstetric care were less satisfied than those who received surgical and medical care. Beneficiaries who received care within the purchased care system for surgical and obstetric care rated their hospital higher than did those in the direct care system. MHS beneficiaries receiving 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 than the civilian benchmark and higher than MHS beneficiaries receiving care from civilian hospitals.

TRISS RATING OF HOSPITAL TREND, FY 2012–FY 2014



Source: OASD(HA) DHA Analytics TRISS survey results as of June 2014, 11/21/2014

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

Notes:

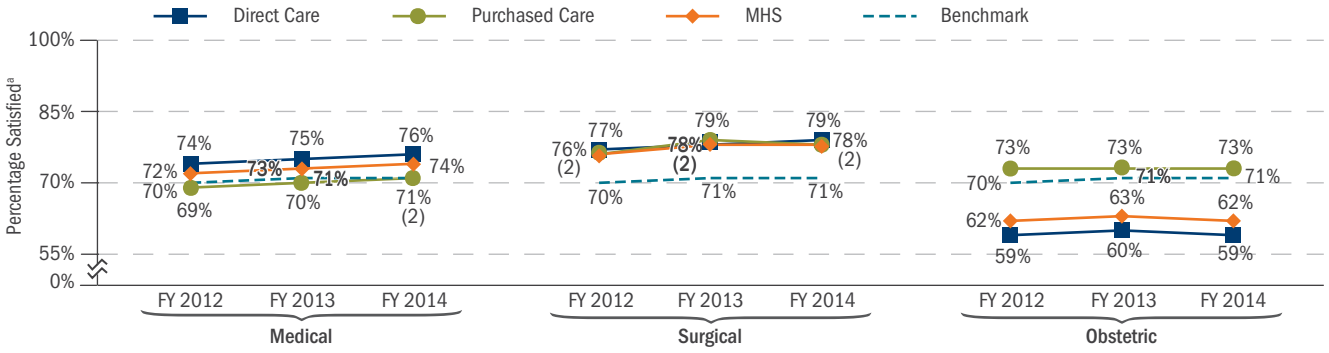
- "MHS Overall" refers to the users of both direct and purchased care components; "Direct Care" refers to MTF-based care and "Purchased Care" refers to care provided in the private sector through the claims-based reimbursement process.
- The years depicted align with the fiscal year. Direct care and purchased care 2014 results are based on discharges from Q1 2014 through Q3.
- 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*).

Beneficiary Ratings of Care Following Inpatient Treatment *(Cont.)*

TRICARE Inpatient Satisfaction Survey (TRISS) *(Cont.)*

Recommendation of Hospital: Beneficiaries who received surgical and obstetric care within the purchased care system had higher ratings of recommending their hospital than the civilian benchmarks, while those who received medical care in MHS facilities had ratings higher than the civilian benchmark. Beneficiaries who received surgical care in civilian and MHS facilities had similarly high ratings for recommendation.

TRISS RECOMMENDATION OF HOSPITAL TREND, FY 2012–FY 2014



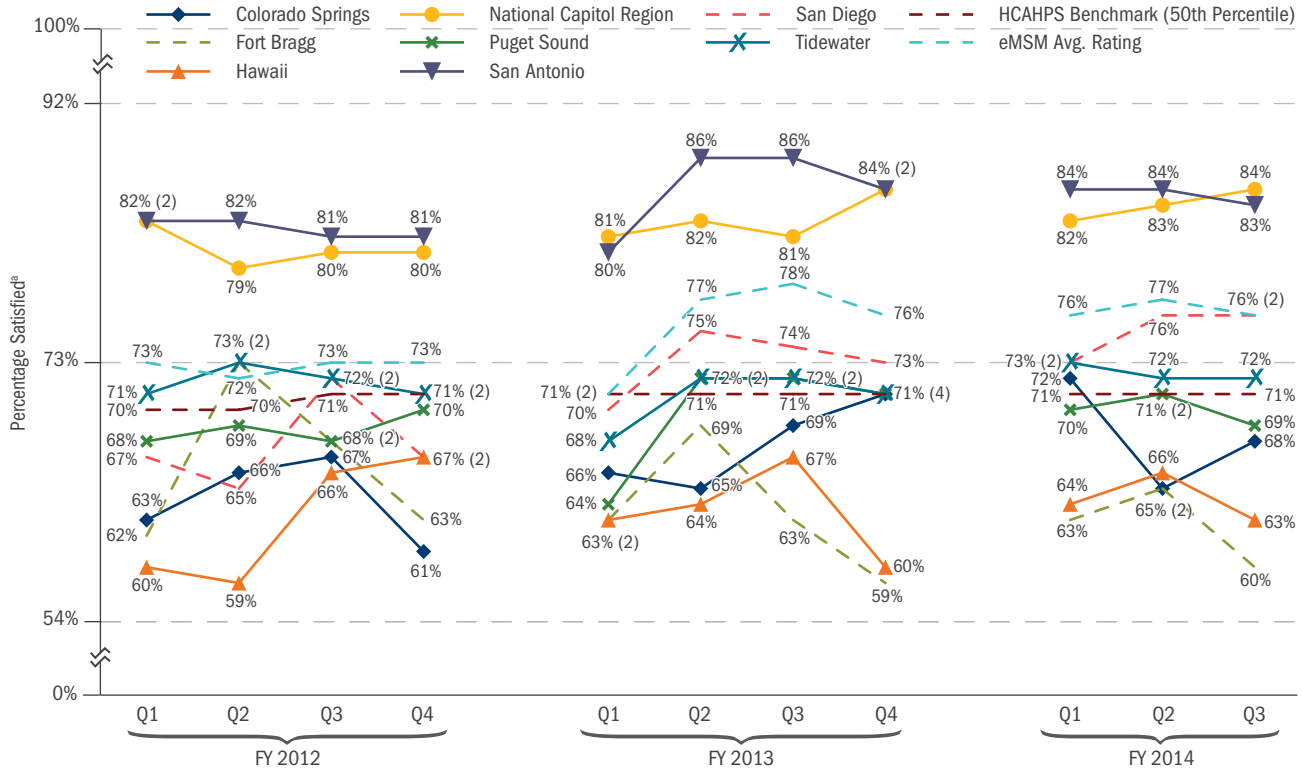
Source: OASD(HA) DHA Analytics TRISS survey results as of June 2014; compiled 11/21/2014

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

Note: Please refer to notes accompanying "Overall Rating of Hospital" (page 51) for more detail regarding this analysis.

Enhanced Multi-Service Market (eMSM) Area: Beginning in 2014, TRISS, TROSS, and Service survey satisfaction ratings were reported for each eMSM. The chart below shows TRISS satisfaction ratings for recommendation of hospital by each eMSM, as well as an eMSM average and a comparison with the HCAHPS benchmark. On average, MHS beneficiaries in hospitals within the eMSMs had higher ratings for recommending their hospital than the civilian benchmark.

eMSM RATINGS FOR RECOMMENDATION OF HOSPITAL



Source: OASD(HA) DHA Analytics TRISS survey results as of June 2014; compiled 11/21/2014

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

Notes:

– The eMSM average is a pooled average and does not include Fort Bragg and San Diego.

– Please refer to notes accompanying "Overall Rating of Hospital" (page 51) for more detail regarding this analysis.

QUALITY OF MHS CARE *(CONT.)*

Drivers of Patient Satisfaction/Experience Ratings

Top Three Drivers of Satisfaction by Survey

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

- Three key beneficiary surveys measure self-reported access to and satisfaction with MHS direct and purchased care experiences:
  - TRISS—event-based after a discharge from a hospital
  - TROSS—event-based following an outpatient visit
  - HCSDB—population-based quarterly survey sampling MHS-eligible beneficiaries who may use MHS or their own health insurance

Results from these three surveys for FY 2013 and FY 2014 (using all data available at the time of analysis) were modeled to identify key drivers of satisfaction. Drivers of satisfaction for all three surveys, for the direct care system, were determined by examining the effects of composite scores on outcome variables. The models controlled for demographic variables, including beneficiary 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 satisfaction with health care provided in MTFs is driven by the following factors: communication between patients, doctors, and nurses; getting needed care and getting care quickly; access to care; satisfaction with mental health care for those patients receiving mental health care; and cleanliness of the hospital. Perceptions of MHS (a DoD-specific composite for TROSS) are also important to beneficiary satisfaction with outpatient care.
- These results suggest that improving communication between respondents and health care providers, access to timely care, facility cleanliness, mental health care services, and overall perceptions of MHS have the potential to influence a patient's satisfaction with their health care and their hospital.

TOP THREE DRIVERS OF SATISFACTION BY SURVEY: DIRECT CARE, FY 2013 AND FY 2014

FISCAL YEAR	RANKING	TRISS DIRECT CARE MHS RATING OF HOSPITAL	TROSS DIRECT CARE MHS SATISFACTION WITH HEALTH CARE	HCSDB DIRECT CARE U.S. SATISFACTION WITH HEALTH CARE
FY 2013	#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Perception of MHS[a] Mental Health Care (tied)	Getting Needed Care
	#3	Cleanliness of Hospital	Access to Care	Getting Care Quickly
FY 2014	#1	Communication with Nurses	Communication with Doctors	Communication with Doctors
	#2	Communication with Doctors	Mental Health Care	Getting Needed Care
	#3	Cleanliness of Hospital	Perception of MHS[a]	Getting Care Quickly

Sources: OASD(HA)/DHA Analytics TRISS, TROSS, and HCSDB, FY 2013 and FY 2014; compiled 11/21/2014

[a] DoD composite

Notes:

– HCSDB data were collected for three fiscal quarters in 2013 (Q1–Q3) and were not available for Q4. TROSS data were available for FY 2013 and Q1 and Q2 in 2014. TRISS data were available for FY 2013 and through Q3 for FY 2014.

– Due to a methodological change in September 2013, FY 2013 TROSS data include only October–August; FY 2014 includes September 2013–March 2014.

PATIENT SAFETY IN 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 (PSR) System was fully implemented across the MHS direct care system in FY 2011, with implementation beginning April 2010. From near misses to events resulting in patient harm, PSR has automated the previously unstructured, paper-based reporting process into a standardized, anonymous, Web-based reporting system. PSR data may be analyzed to identify trends and share lessons throughout the MHS direct care system. The table below shows patient safety reporting stratified by harm classification.

HARM STRATIFICATION OF REPORTED PATIENT SAFETY EVENTS, FYs 2010–2014

HARM STRATIFICATION	FY 2010		FY 2011		FY 2012		FY 2013		FY 2014	
	#	%	#	%	#	%	#	%	#	%
Events Did Not Reach Patient, Near Miss	85,816	67.2%	53,247	58.5%	36,261	50.0%	38,925	48.4%	39,232	50.0%
Events Reached Patient, No Harm	38,609	30.2%	33,255	36.5%	29,590	40.8%	35,026	43.6%	32,771	41.7%
Events Reached Patient, Harm	3,225	2.5%	4,551	5.0%	6,608	9.1%	6,420	8.0%	6,512	8.3%
Total	127,650	100.0%	91,053[a]	100.0%	72,459[b]	100.0%	80,371[b]	100.0%	78,515[b]	100.0%

Source: DHA/Healthcare Operations Directorate, Clinical Support Division

[a] Full transition to the DoD PSR, a dynamic system where events may be re-opened and closed during the investigative process

[b] Data pulled based on reports variable, 10/28/2014

- Data displayed in the chart above are communicated as reports received for each fiscal year, unlike in previous years when data were displayed in event occurrences (number of times occurred [NOTO]). At the start of FY 2014, it was identified that the use of NOTO dramatically increases the denominator, resulting in a skewing of the percentage of harm. One report may contain more than one occurrence and is generally reported as a Near Miss outcome. The use of reports provides better accounting of the reported processes involved and outcomes (i.e., Near Miss, No Harm, Harm) related to those processes. The DoD PSP encourages Near Miss reporting in order to proactively address opportunities before patients are involved or harmed.
- FY 2014 showed a slight decrease of 2.3 percent from patient safety reports during FY 2013. In FY 2014, Near Miss events accounted for 50 percent of the reports, which is consistent with previous years' reporting and an increase of 1.6 percentage points from FY 2013. Harm events accounted for 8.3 percent of the reports for FY 2014, an increase of 0.3 percentage points over FY 2013. For FY 2014, Harm reports consisted of Additional Treatment (84.6 percent), Temporary Harm (13.4 percent), Permanent Harm (0.6 percent), Severe Permanent Harm (0.3 percent), and Death (1.2 percent). FY 2014 No Harm reports decreased 1.9 percentage points from FY 2013.

In addition to events reported, DoD PSP receives root cause analyses (RCAs) submitted by MTFs. Of the RCAs received for FYs 2010–2014,[1] similar to prior years, the associated leading event categories included Wrong Site/Person/Procedure Surgery, Unintended Retention of Foreign Object, Delay in Treatment, Operative/Post-Operative Complication, 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 enterprise-wide system/process redesign, issuing patient safety notices, and recommending new policies, as well as offering focused training or education. The DoD PSP continues to hone and refine these mechanisms as MHS moves toward becoming a High Reliability Organization.

[1] RCAs submitted as of 10/27/2014 for RCAs completed through 9/30/2014

Training and Education to Improve Performance and Patient Safety

Staff-to-staff communication breakdowns remain frequently cited as a primary factor contributing to patient safety events across the nation. Among the many resources and solutions the PSP offers is TeamSTEPPS®, a system whose purpose is to ultimately improve communication techniques within 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. Throughout the MHS direct care system, TeamSTEPPS has been trained at nearly 95 percent of MTFs and more than 100 facilities since FY 2013, with follow-on coaching to facilitate ongoing sustainment.

Further targeted 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 their facility. Blending traditional industry-standard training strategies with creative methodologies, this course is founded on the latest predictors of workforce training success research. The BPSM course offers 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 continued 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 88 percent. After 12 months of coaching, PSM confidence continued to grow, with nearly 100 percent of those surveyed expressing high confidence in their understanding and abilities.

Engagement in Nationwide Efforts to Improve Patient Safety

In June 2011, the MHS direct care facilities accepted the challenge set by the National Partnership for Patients (PfP) Initiative: to reduce preventable hospital-acquired conditions (HAC) 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.

PfP was the first major enterprise-wide approach to patient safety, and with a learning-based initiative, focused on implementing evidence-based clinical practices (EBPs) across MHS. The transformative, cross-Service approach applies standardized, structured tools and processes across the enterprise to effect change for our patients.

During the DoD PfP Initiative (October 1, 2012, through December 31, 2013), MHS direct care hospitals prevented HACs for 528 patients and avoided $14 million in HAC treatment costs (based on national estimates for direct medical costs for HAC treatment). With an estimated $5.46 million investment in the PfP Initiative, MHS achieved an $8.5 million return on investment.

During that same time, MHS also realized a reduction of 16.8 percent in the harm rate (7.96 harms per 1,000 dispositions—cumulative from CY 2010 Q1 to CY 2012 Q3, to the current rate of 6.62 harms per 1,000 dispositions—cumulative from CY 2012 Q4 to CY 2013 Q4).

The HAC improvements of note were in Central Line-Associated Bloodstream Infections (CLABSIs), Pressure Ulcers, Ventilator-Associated Events (VAEs), and Venous Thromboembolisms (VTEs) as MHS exceeded the 40 percent reduction goal in those HACs. Adverse Drug Events (ADEs) and Falls with Harm increased in their rates; however, since they are self-reported, it is likely that their increase is partially due to improved reporting techniques.

Lastly, all Services have fully implemented PfP EBPs. The Learning Circles and Communities of Practice (CoPs) were instrumental in sharing best practices, preventing harm and improving care for Service members. Ninety percent of the participants who attended the CoPs found them useful. Over 6,000 learning hours were tracked centrally throughout 171 CoP sessions, in which improvement coaches facilitated ongoing learning and leading for and by MTF champions and teams, and external subject matter experts.

PfP Results for MHS

MHS achieved a 16.8 percent (cumulative) reduction in patient harm rates and an 11.1 percent reduction in readmissions by the end of 2013

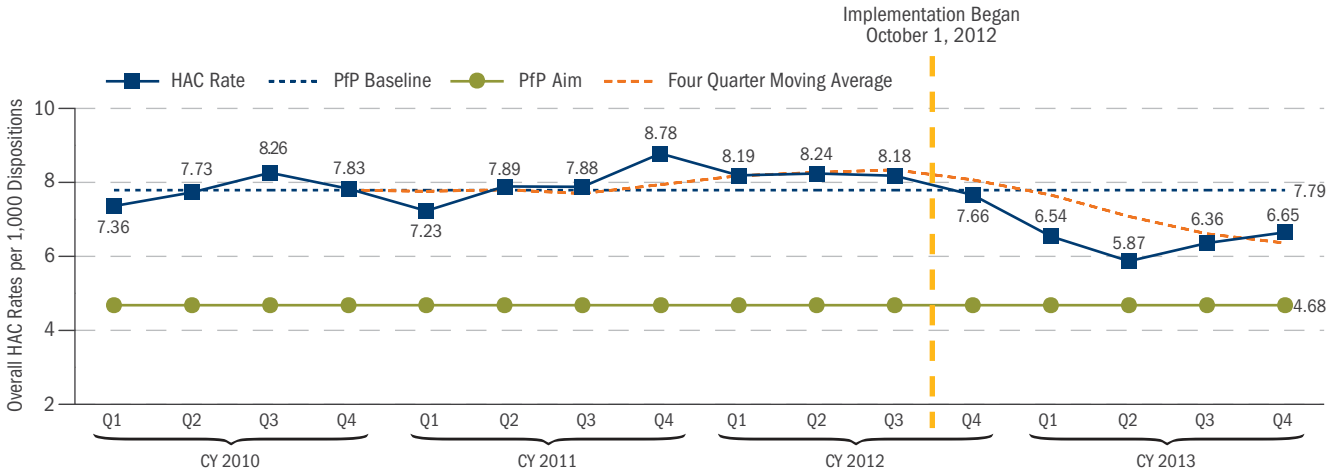
Projected cost avoidance of approximately $14 million of baseline MHS clinical costs since PfP implementation in CY 2012

100 percent implementation across Services

171 CoP learning sessions held, and over 6,000 learning hours completed

- The trend chart on the following page depicts efforts to reduce preventable HACs by accelerating the spread of EBPs throughout MHS. The solid blue line indicates the quarterly variation in the HAC rate ([HACs x 1,000]/dispositions) across MHS relative to the PfP aim of 4.68; this rate is based on a 40 percent reduction from the MHS baseline rate of 7.79 (CY 2010). The quarterly moving average reflects the favorably declining trend in the rate at the time of program implementation in October 2012.

PARTNERSHIP FOR PATIENTS: HOSPITAL-ACQUIRED CONDITIONS RATE PROGRESS (CY 2010–CY 2013 Q4)



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, September 2014

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 AHRQ indicators. Occurrences are thoroughly reviewed with complete follow-up to prevent future harm events.

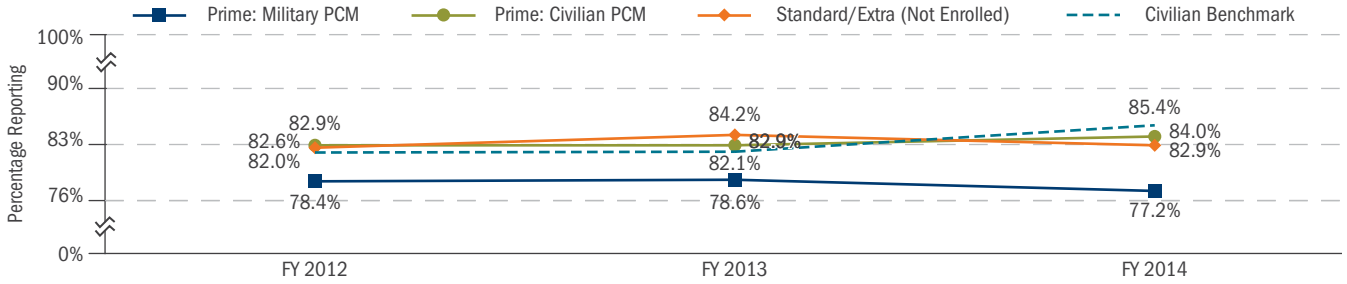
CUSTOMER SERVICE

Satisfaction with Customer Service

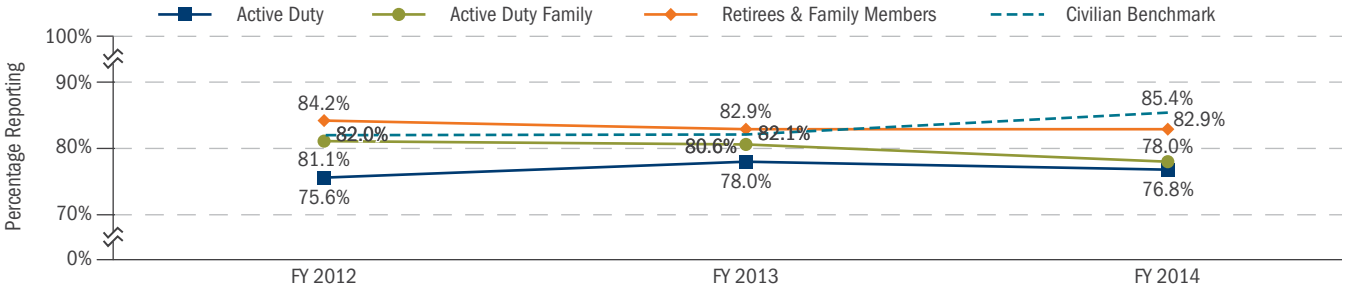
Access to and understanding written materials about one's health plan are important determinants of overall satisfaction with the plan.

- MHS beneficiaries' reported satisfaction with customer service in terms of understanding written material, getting customer assistance, and dealing with paperwork remained stable between FY 2012 and FY 2014 (no statistically significant change). Satisfaction for Prime enrollees with a civilian PCM was significantly higher than for those with a military PCM.
- Satisfaction for Prime enrollees with a military PCM lagged the civilian benchmark. Satisfaction levels for Prime enrollees with a civilian PCM and for non-enrolled beneficiaries were not significantly different from the civilian benchmarks.
- Satisfaction levels for all beneficiary groups remained stable from FY 2012 to FY 2014 (i.e., no statistically significant difference).
- In FY 2014, satisfaction levels for all beneficiary groups lagged the civilian benchmark.

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 2012–2014 HCSDB, as of 11/14/2014, 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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

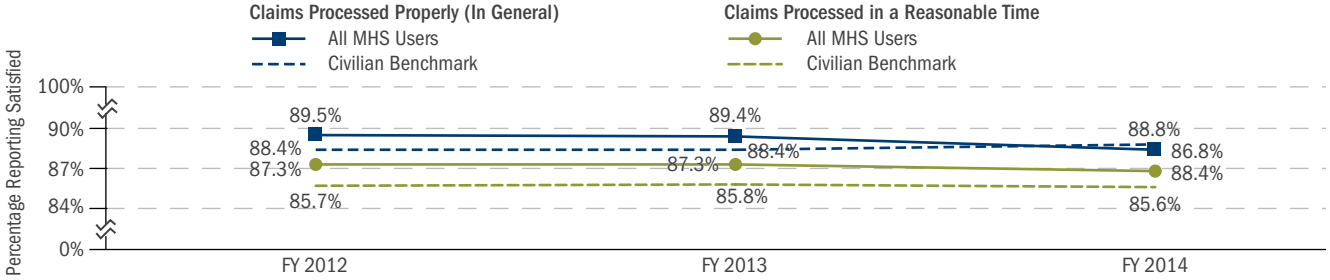
- Satisfaction with claims being processed accurately remained stable from FY 2012 to FY 2014. Satisfaction with processing speed also remained stable during that time period.
- MHS satisfaction levels with both the accuracy and speed of claims processing were not significantly different from the civilian benchmarks in FY 2014.

CLAIMS PROCESSING *(CONT.)*

Trends in Claims Filing Process

TRICARE monitors claims processing to ensure compliance with contractual requirements and to ensure our participating providers are paid on a timely basis. Claims processing for purchased care comprises three intervals: claims submission, claims processing, and transmission acceptance.

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

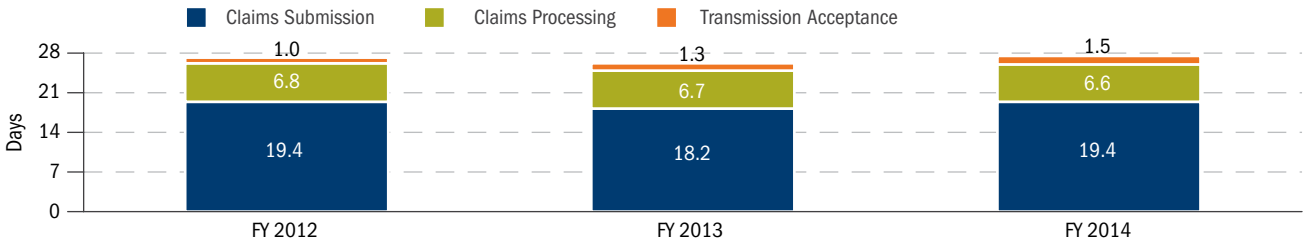


Note: DoD data were derived from the FYs 2012–2014 HCSDB, as of 11/14/2014, and adjusted for age and health status. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (General Method and Data Sources) for more detailed discussion of the HCSDB methodology. Rates are compared 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 4.0, used in the 2012 and 2013 surveys, and CAHPS Version 5.0 for 2014 surveys. CAHPS results come from the NCBD for commercial health plans and from survey results submitted to the NCQA by commercial plans. Benchmarks used in 2012 and 2013 come from the 2011 NCBD, while benchmarks for 2014 come from NCQA's 2013 data. 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 Submission:** The claims submission interval is the time from the patient's last date of care to the date that the treating provider files a claim for payment with the Purchased Care Processing Contractor.
- **Claims Processing:** The Purchased Care Processing Contractor adjudicates the claim and sends a TRICARE Encounter Data (TED) record to DHA requesting payment. Claims processing includes the time needed for the Purchased Care Processing Contractor to ensure the TED records pass all TRICARE validation edits (Services are "Accepted").
- **Transmission Acceptance:** The transmission acceptance interval is the time between when DHA takes an "Accepted" TED record and when it identifies the appropriate program cost fund for payment. The accept date is defined as the "Last Update Date" in the TED by current contracts. Contracts between DHA and MCSC require that TED records be received by 10 AM Eastern time for DHA to accept same day; otherwise, the cutoff moves the TED "Accepted" record to the next day.

DHA pays MCSCs within seven days of the later of "Transmission Receive Date" or "Last Update Date," in compliance with contractual language. The graph below shows that TRICARE payments met time requirements, complying with managed care support contracts.

AVERAGE INTERVAL (DAYS) FOR CLAIMS PROCESSING



Source: MHS Administrative data, 12/22/2014

The above graph excludes paper claims and claims from other health insurance, pharmacy, TRICARE Dual Eligible Fiscal Intermediary Contract, and TRICARE Overseas Program contracts. From FY 2011 to FY 2013, three new contracts were implemented and these changes affected provider networks and their claims submission processes. The North and South Region contracts caused an overall increase in claims processing during FY 2012; the West Region contract caused an overall increase during FY 2014. The lengthiest portion of claims processing is consistently claims submission—the time it takes for the treating provider to submit claims.

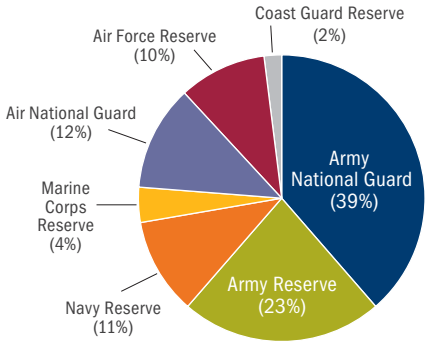
TRICARE BENEFITS FOR THE RESERVE COMPONENT

TRICARE provides 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 Reserve.

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 end strength, this legislation provides extended health care coverage for those eligible Selected Reserve members covered by TRS during their transition to the civilian market. TRS had grown to over 121,000 plans with almost 324,000 covered lives by the end of FY 2014. The chart below presents TRS enrollment growth since plan inception.

- The pie chart below shows the breakdown of the almost 324,000 TRS-enrolled sponsors and family members by Service, with Army constituting 62 percent of enrollment (combined National Guard and Reserve). Army member and family enrollment in TRS is roughly representative of the 64 percent affiliated with the Army of the total 2.1 million Selected Reserve population shown on page 61.

TRICARE RESERVE SELECT: 324,000 SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2014)



Source: Office of the Under Secretary of Defense (Reserve Affairs) (OUSD[RA]) (M&P), as of 9/30/2014, 10/15/2014

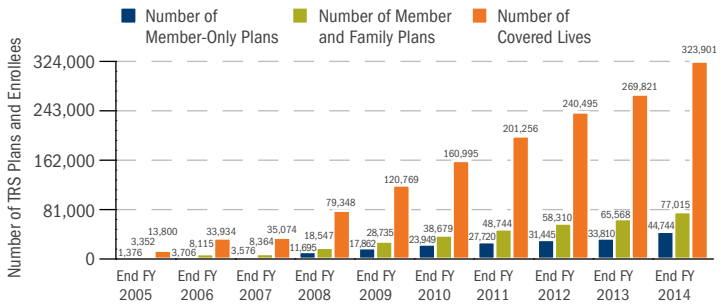
- As shown in the table on the right, the TRS "take rate" for June 2014 was estimated at over 25 percent of the almost 470,000 Selected Reservists eligible to participate, out of the total 833,000 in Reserve status. (The take rate methodology was validated by the Government Accountability Office [GAO], GAO-11-151, June 2011, pages 11–12.)

	TOTAL
Selected Reserve End Strength	832,883
Active Guard and Reserve	(76,896)
Federal Employees Health Benefits Plan (FEHBP)	(112,188)
On Active Duty	(171,622)
On Early Identification or Early Eligibility	(13,007)
On Transitional Assistance Management Program (TAMP)	(67,124)
Adjusted TRS Eligible Population	468,942
Enrolled TRS Sponsors	119,775
Take Rate for Eligible Population	25.55%

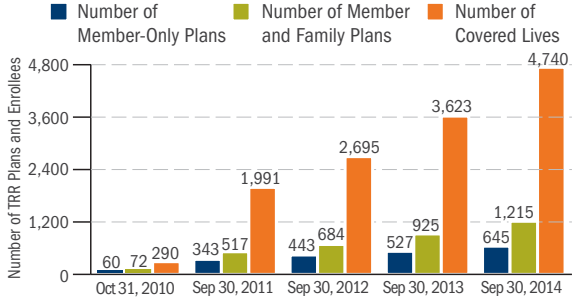
- TRS monthly premiums, based on actual prior year costs, will decrease by $0.93 for member-only plans, from $51.68 in CY 2014 to $50.75 in CY 2015, while the member-and-family plans will increase by $1.33, from $204.29 in CY 2014 to $205.62 in CY 2015 as follows (10/7/2014; see *http://tricare.mil/Costs/HealthPlanCosts/TRS.aspx*):

MONTHLY PREMIUMS	CY 2012	CY 2013	CY 2014
TRS Member Only	$51.62	$51.68	$50.75
TRS Member and Family	$195.81	$204.29	$205.62

TREND IN RESERVE COMPONENT ENROLLMENT IN TRICARE RESERVE SELECT (END OF FY 2005 TO END OF FY 2014)



TREND IN ENROLLMENT IN TRICARE RETIRED RESERVE (OCTOBER 2010 TO SEPTEMBER 2014)



Source: Defense Manpower Data Center (DMDC)/DEERS Medical Policy Report 10/15/2014

TRICARE BENEFITS FOR THE RESERVE COMPONENT *(CONT.)*

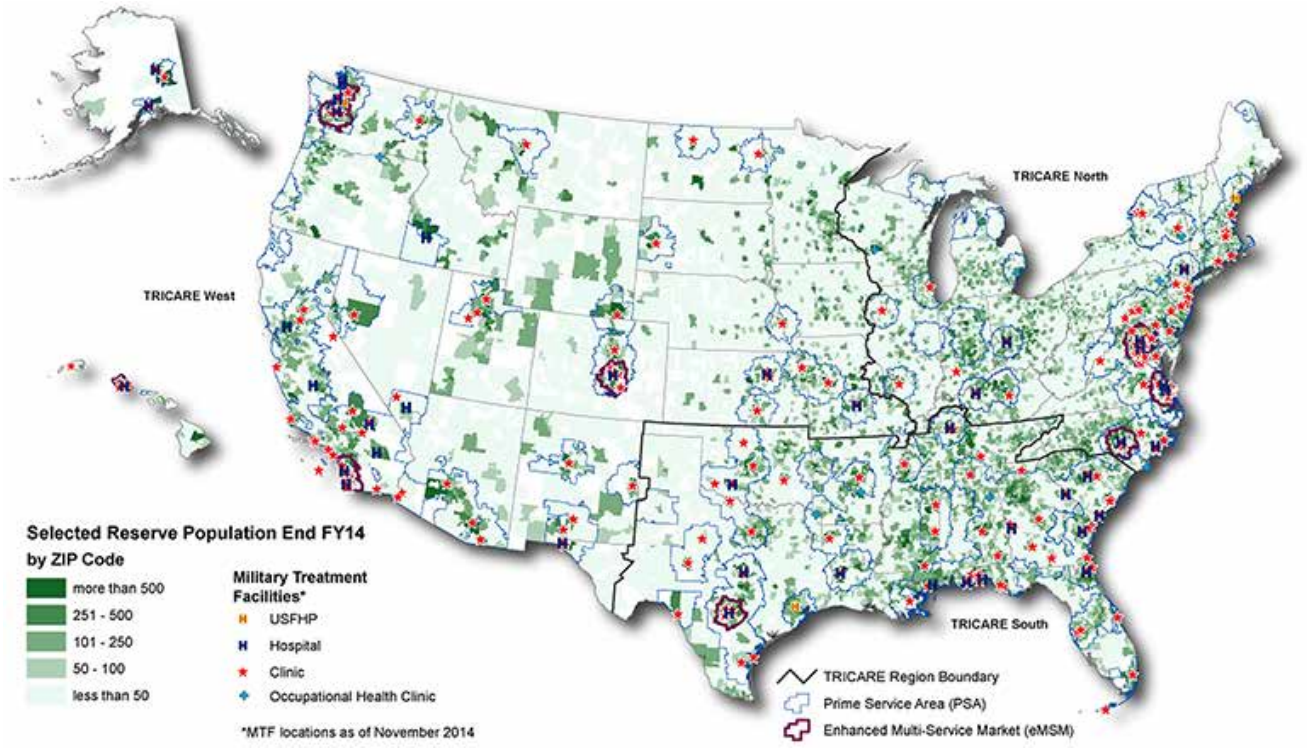
TRICARE Retired Reserve (TRR). Coverage under the TRR premium-based health plan began on October 1, 2010, in response to the NDAA for FY 2010, section 705, which amended Title 10 U.S. Code by adding the new section 1076e. The law allows qualified members of the Retired Reserve to purchase full-cost, 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 2014, over 4,700 retired Reservists and their families were covered by TRR in 1,860 member-only and member-and-family plans.
- TRR monthly premiums, based on actual prior year costs, will decrease by $0.10 in member-only plans, from $390.99 in CY 2014 to $390.89 in CY 2015, and the member-and-family plans will increase by $4.70 from $956.65 in CY 2014 to $961.35 in CY 2015, as follows (10/7/2014; see *http://tricare.mil/Costs/HealthPlanCosts/TRR.aspx*):

MONTHLY PREMIUMS	CY 2012	CY 2013	CY 2014
TRR Member Only	$402.11	$390.99	$390.89
TRR Member and Family	$969.10	$956.65	$961.35

SELECTED RESERVE POPULATION IN THE U.S. RELATIVE TO MTF, PRIME, AND NON-PRIME SERVICE AREAS IN FY 2014



COMPARISON OF SELECTED RESERVE AND ACTIVE DUTY SPONSORS AND FAMILY MEMBER PROXIMITY TO MILITARY TREATMENT FACILITIES AND NETWORK PROVIDERS IN THE U.S. (SEPTEMBER 30, 2014)

BENEFICIARY GROUP	POPULATION TOTALS (END FY 2014)	POPULATION IN PSAs	% IN PSAs	POPULATION IN CATCHMENTS	% IN CATCHMENTS	POPULATION IN PRISMs	% IN PRISMs	POPULATION IN MTF SERVICE AREAS	% IN MTF SERVICE AREAS	POPULATION IN MULTISER-VICE MARKET AREAS	% IN MULTI-SERVICE MARKET AREAS
Active Duty and Their Families	2,984,838	2,821,483	95%	2,072,979	69%	2,612,322	88%	2,748,112	92%	1,124,985	38%
Selected Reservists and Their Families	1,995,020	1,355,113	68%	485,686	24%	737,957	37%	1,068,541	54%	243,392	12%

Sources: MTF information from DHA Business Support Directorate, Facility Planning 10/21/2014, and geospatial representation by DHA/Decision Support Division, 11/25/2014; Populations: Selected Reserve and family member data provided by OASD/RAS Reserve Components Common Personnel Data System (RCCPDS) and Defense Enrollment Eligibility Reporting System (DEERS) database extract as of 9/30/2014, provided 11/25/2014; Active Duty and their families from MHS Data Repository (MDR) DEERS extract as of 9/30/2014, provided 11/25/2014.

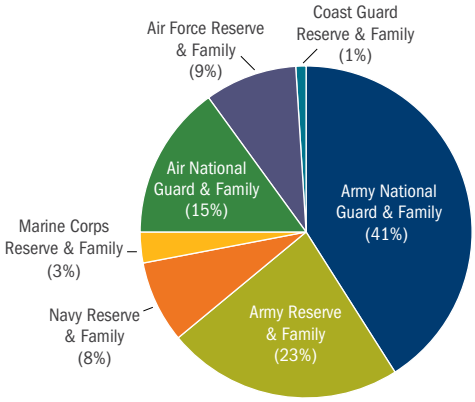
Notes:

- Percentages are rounded to the nearest whole number.
- MTF Service Areas are 40-mile circles around inpatient and outpatient MTFs, rounded to include all complete and partial ZIP codes, subject to overlap rules, barriers, and other policy overrides.
- Prime Service Areas are MTF Service Areas and similar geographies around closed MTFs (Base Realignment and Closure [BRAC] Prime Service Areas), effective October 1, 2013.
- Multi-Service market areas are the six enhanced multi-Service market (eMSM) areas used in the MHS strategy and metrics calculations (i.e., National Capital Region, Puget Sound, Colorado Springs, San Antonio, Tidewater, and Hawaii areas) and two densely populated multiple-market areas in San Diego and Fort Bragg.

TRICARE BENEFITS FOR THE RESERVE COMPONENT *(CONT.)*

- As of September 30, 2014, there were more than 2.1 million Selected Reserve Service members and their families (2,121,427), of which 831,685 were sponsors and 1,289,742 were family members. Approximately 97 percent were identified as residing in the U.S.
- The map on page 60 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 September 30, 2014, 68 percent of Selected Reservists and their family members in the U.S. live within the area covered by the TRICARE network (PSAs). Slightly more than half (54 percent) of this population resides near a clinic or inpatient MTF, compared with 92 percent of Active Duty and their family members.
- As shown below, 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).

SELECTED RESERVE POPULATION: 2.1 MILLION SPONSORS AND FAMILY MEMBERS BY SERVICE (SEPTEMBER 2014)



Source: OUSD(RA) (M&P), as of 9/30/2014, 11/25/2014

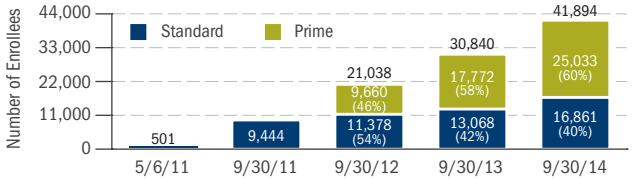
TRICARE YOUNG ADULT

Although TRICARE met or exceeded most of the new health care provisions that took effect on September 23, 2010, under the Affordable Care Act (ACA), 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 under the age of 26 (i.e., a dependent of TRICARE-eligible Uniformed Service sponsor, unmarried, no longer entitled to TRICARE coverage under their sponsor due to age, and not eligible for an employer-sponsored plan) 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 in last year's report (page 51), reductions in certain PSAs effective October 1, 2013, would limit some locations where TYA enrollees reside. To participate, beneficiaries are required to pay monthly premiums that actuarially cover the full cost of the coverage. Coverage options and costs depend on the Uniformed Service sponsor's status and where the former dependent child desires coverage.

- As shown in the chart at right, enrollment went from almost 31,000 in FY 2013 to almost 42,000 in FY 2014. Also, although TYA began with the Standard option, Prime now accounts for about 60 percent of total TYA enrollment.
- As shown in the accompanying pie chart, 86 percent of TYA enrollees are family members of those who are not Active Duty (e.g., dependents of retirees and others).
- Based on actual prior year costs, TYA monthly premiums for Prime plans increased almost 16 percent, from $180 per month in CY 2014 to $208 per month in 2015. Premiums for the Standard plans also increased by 16 percent, from $156 per month in 2014 to $181 per month in 2015, as follows (see *http://tricare.mil/Costs/HealthPlanCosts/TYA.aspx* [last updated 9/22/2014]).

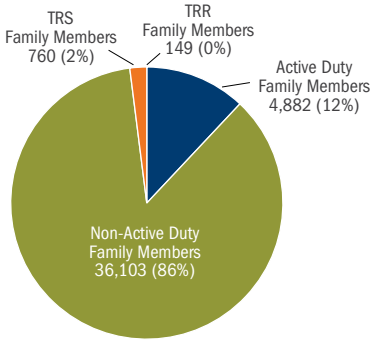
MONTHLY PREMIUMS	CY 2013	CY 2014	CY 2015
Prime	$176	$180	$208
Standard	$152	$156	$181

TREND IN TRICARE YOUNG ADULT ENROLLMENT SINCE INCEPTION (MAY 2011 TO SEPTEMBER 2014)



Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 10/31/2014

TYA ENROLLMENT BY FAMILY MEMBER CAREER STATUS



Source: DHA/Healthcare Operations Directorate, TRICARE Health Plan Division, 11/11/2014

TRICARE PROVIDER PARTICIPATION

The National Provider Identifier (NPI) is a unique identification number issued to health care providers in the U.S. by Centers for Medicare and Medicaid Services (CMS). All Health Insurance Portability and Accountability Act (HIPAA)-covered individual health care providers and organizations must obtain an NPI for use in all HIPAA standard transactions. Although CMS has been issuing NPIs since FY 2007, they did not gain widespread use in MHS until FY 2010. 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 leveled off in FY 2014. The trend is due exclusively to an increase in the number of network providers; the number of Standard providers has actually declined slightly. 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 2014, the South Region saw the largest increase in the total number of TRICARE providers (15 percent), while the North Region saw an increase of 6 percent and the West Region an increase of 8 percent.
- The North Region saw the largest increase in the number of network providers (26 percent), followed by the South at 24 percent and the West at 12 percent.
- The total number of TRICARE providers decreased by 13 percent in PSAs and increased by 100 percent in non-PSAs (not shown). This pattern is not due to any fundamental shift in where providers practice but rather to the reduction in the number of PSAs in FY 2014.
- The number of network providers decreased by 5 percent in PSAs and increased by 171 percent in non-PSAs, also due to the reduction in the number of PSAs in FY 2014.
- In FY 2014, 68 percent of all network providers and 64 percent of all participating providers were in PSAs.

TRENDS IN NETWORK AND TOTAL PARTICIPATING PROVIDER FTEs[a]

Source: MHS administrative data, 2/4/2015

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 second 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 NDAA for FY 2012, Public Law (PL) 112-81, section 721, amending previous legislation for a four-year survey from 2008 to 2011 (NDAA 2008 PL 110-181, section 711). It has been approved by the Office of Management and Budget and has been reviewed by the GAO as required by the guiding legislation.

- **2012–2013 provider survey results:**
  - Acceptance of new TRICARE Standard/ Extra patients:
    - Over six of 10 providers overall (62 percent of physicians and nonphysician behavioral health providers) and nearly eight of 10 physicians (79 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 53 percent and nonphysician behavioral health providers at 39 percent), which brings down the all-provider acceptance rates.
    - Also similar to the benchmark survey, providers in non-PSAs generally accept new TRICARE Standard and new Medicare patients at higher rates than those in PSAs.
  - Awareness of the TRICARE program:
    - Almost nine of 10 providers overall (85 percent) and over 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), providers in non-PSAs report greater awareness and acceptance of new TRICARE Standard than do PSA providers.
- **2012–2013 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), exceeding the benchmark in three of four global measures and two of four access measures, and equal to in all others.
  - As with provider acceptance rates, Standard/ Extra beneficiaries generally rate access and care higher in non-PSAs than in PSAs, but not necessarily in the same PSA/non-PSA locations.
  - The Standard/Extra beneficiary survey is based on, and benchmarked to, the standardized CAHPS-Plan survey used by Medicare, Medicaid, and commercial health plans and health plan accrediting agencies.

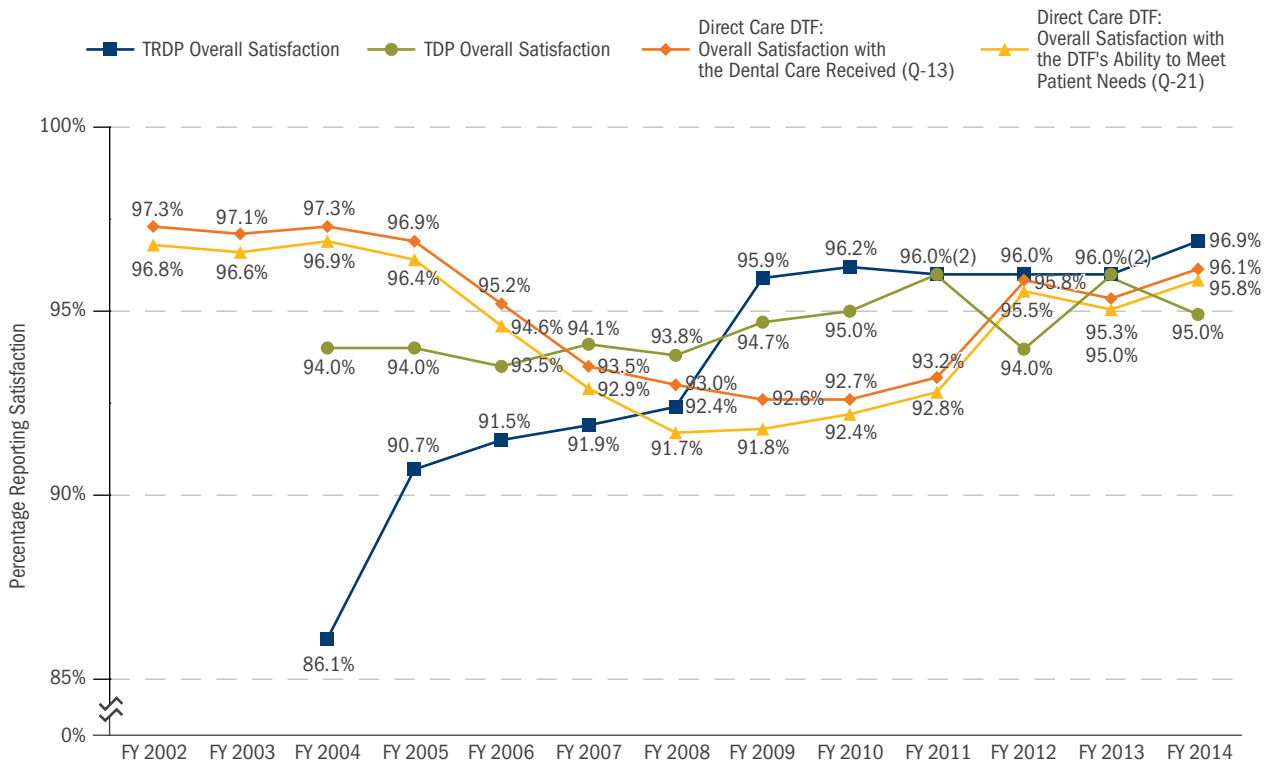
TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

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 1.6 million Active Duty Service members and eligible family members residing outside the continental U.S. (OCONUS). The Tri-Service Center for Oral Health Studies completed almost 206,000 surveys in FY 2014. After dipping last year, overall satisfaction with the dental care received and patient ratings of the ability of the DTFs to meet their dental needs rose in FY 2014.
- The **TRICARE Dental Program (TDP)** composite overall average enrollee satisfaction decreased from 96.0 percent in FY 2013 to 95.0 percent in FY 2014. 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, 2014, the TDP serviced 788,231 contracts, 95 percent of which are in the U.S., covering almost 2 million lives (1,896,075). The TDP network has 90,901 total dentists—or 6 percent more than the 85,598 in FY 2013—of which 72,484 are general dentists and 18,437 are specialists.
- The **TRICARE Retiree Dental Program (TRDP)** overall retired enrollee satisfaction rate increased to 97 percent for the first time in 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 2014 was higher by 13 percent than in FY 2010, with over 1.415 million total covered lives in over 721,000 contracts in FY 2014, compared with about 1.25 million lives in over 606,000 contracts in FY 2010. Most (99 percent), but not all, reside in the U.S.

SATISFACTION WITH TRICARE DENTAL CARE: MILITARY AND CONTRACT SOURCES



Sources: 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, 11/18/2014

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.

HEALTHY AND RESILIENT INDIVIDUALS, FAMILIES, AND COMMUNITIES

This section presents Military Health System (MHS) efforts to move "from health care to health" by making the healthy choice the easy choice. This transition is focused on addressing health determinants across the organization, which includes the military health community and places where beneficiaries live, learn, work, and play.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS

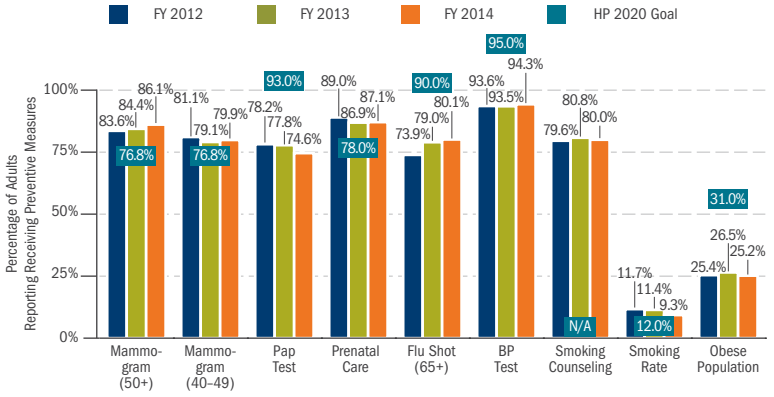
The Healthy People (HP) 2020 goals are national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce those threats; these goals have been embraced by the Department of Defense (DoD) along with the National Prevention Strategy (NPS). The NPS is America's plan for better health and wellness. An additional paradigm guiding our efforts within DoD is Total Force Fitness. This paradigm focuses on several domains that address the NPS, including physical activity; psychological, behavioral, occupational and environmental health; nutrition; and spiritual, social, and family spheres. Adoption of these concepts in support of DoD's prevention strategy supports continuous optimal performance, resilience, and recovery for our Service members and their families through the increased coordination of clinical and community prevention services, and by empowering beneficiaries, creating healthier communities, and eliminating health disparities.

In response to health concerns regarding Service members and their families, DoD launched Operation Live Well (OLW) 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 in 2014 has been on the demonstration projects informing OLW that leverage community programs as force multipliers.

The Health Base Initiative (HBI) is one demonstration project that will inform OLW. The focus of the demonstration is on select initiatives that support improved nutritional choices, increased physical activity, obesity reduction, and decreased tobacco use. An example of these initiatives is UltimateMe, a Web-based self-activation tool that provides beneficiaries with information and feedback on how their health is affected by their behavioral choices (e.g., nutrition, physical activity, tobacco use, alcohol, and sleep). UltimateMe offers Web-based resources and also identifies local community resources for improving health and wellness. Utilization of these resources allows DoD to track behavior change over time.

The MHS strategic goals go beyond those for primary health and wellness. The chart on the right reflects secondary-prevention efforts via 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.).

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2012 TO FY 2014



Sources: Defense Health Agency (DHA)/Decision Support Division 2014 Health Care Survey of DoD Beneficiaries (HCSDB) results, provided 11/25/2014, the NCBD *http://www.tricare.mil/survey/hcsurvey/2014/bene/fy2014/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?ztopicid=29&topic=Nutrition+and+Weight+Status&objective=NWS-9&anchor=141*

Notes:

- 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.

ENGAGING PATIENTS IN HEALTHY BEHAVIORS *(CONT.)*

- 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 on page 65).
- Efforts continue toward achieving HP 2020 standards for Pap smears and blood pressure screenings. The percentage of MHS female beneficiaries receiving Pap tests declined from 78 percent in FY 2012 to 75 percent in FY 2014 and is well below the HP 2020 goal of 93 percent. Conversely, the percentage of MHS beneficiaries having BP screenings has risen to the point where it is just short of the HP 2020 standard.
- **Tobacco Use:** The overall self-reported smoking rate among all MHS beneficiaries decreased from 11.7 percent in FY 2012 to 9.3 percent in FY 2014, almost 3 percentage points below the HP 2020 goal of 12 percent. Smoking-cessation counseling has remained flat at about 80 percent from FY 2012 to FY 2014.
- **Obesity:** The overall proportion of MHS beneficiaries identified as obese remained at about 25 percent between FY 2012 and FY 2014. This is below the HP 2020 goal of 31 percent (see note on page 65) 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.

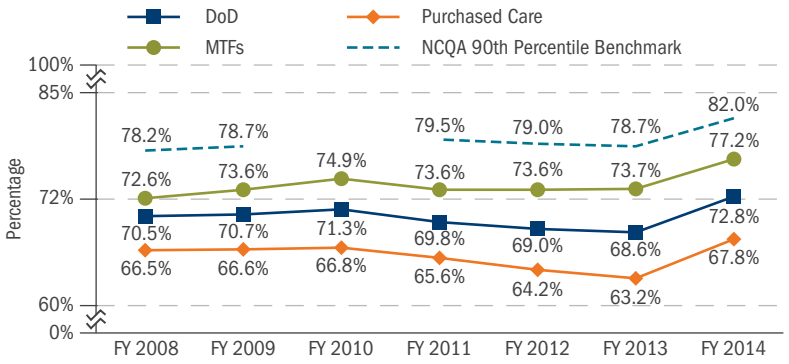
HEDIS MEASURES FOR MHS 2008–2014

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 71 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, 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 data and six measures available for purchased care derived from administrative data sources. Other measures are under development to support the Healthy Base Initiative (HBI), disease management (DM), and Patient-Centered Medical Home (PCMH) programs. 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.

- **Breast and Cervical Cancer Screening:** There have been concerns raised in the last three years regarding the United States Preventive Services Task Force 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.

BREAST CANCER SCREENING

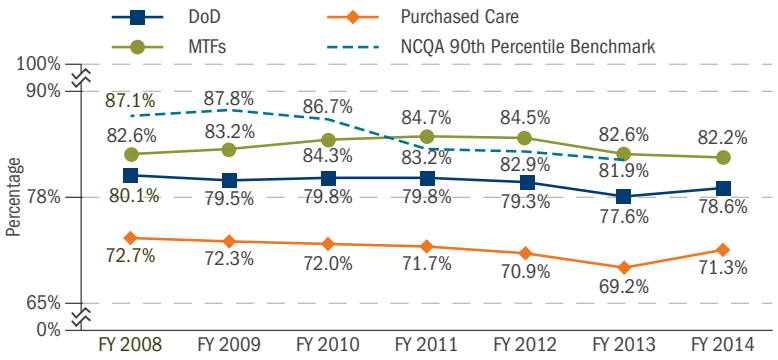


Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/16/2014

HEDIS MEASURES FOR MHS 2008–2014 *(CONT.)*

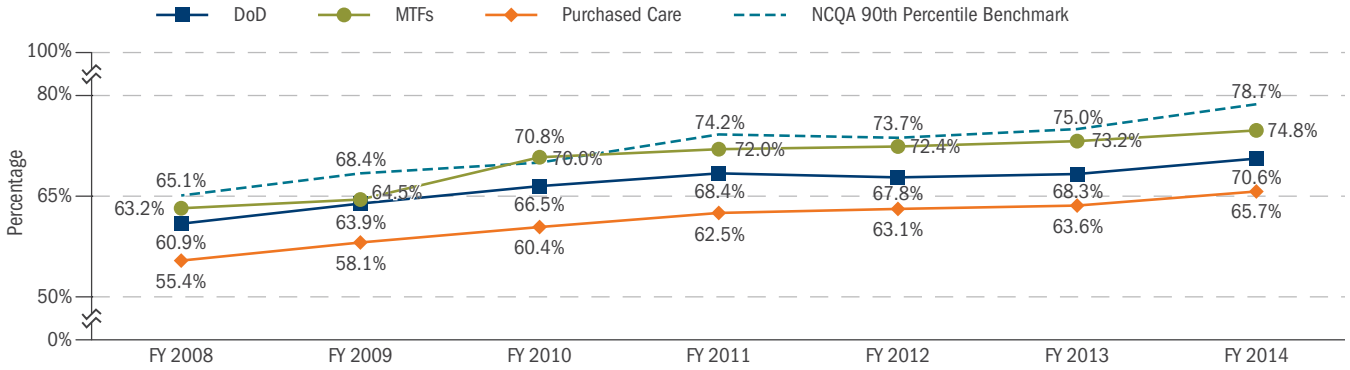
- Other methods of engaging patients and families are under consideration to improve compliance with these important clinical service screening and care management recommendations.

CERVICAL CANCER SCREENING



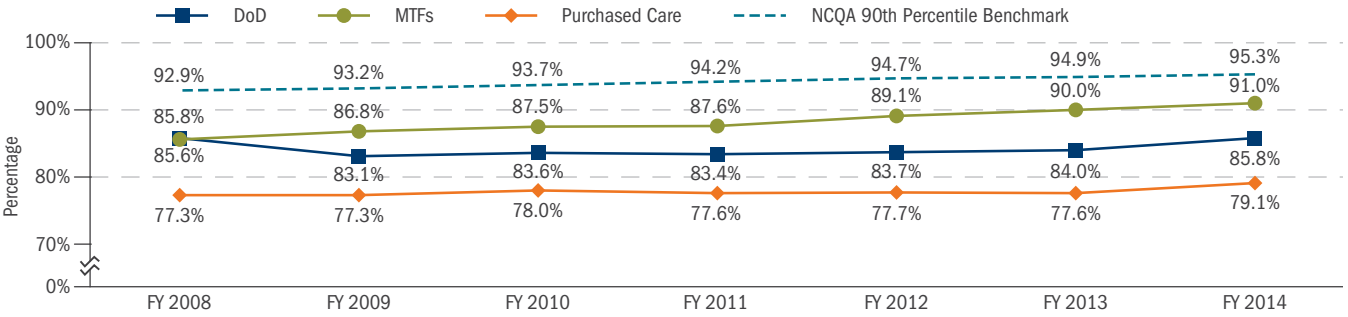
- **Colorectal Cancer Screening:** MHS is making some progress in colorectal cancer screening; although our rates are improving, they still lag the NCQA 90th percentile.

COLORECTAL CANCER SCREENING

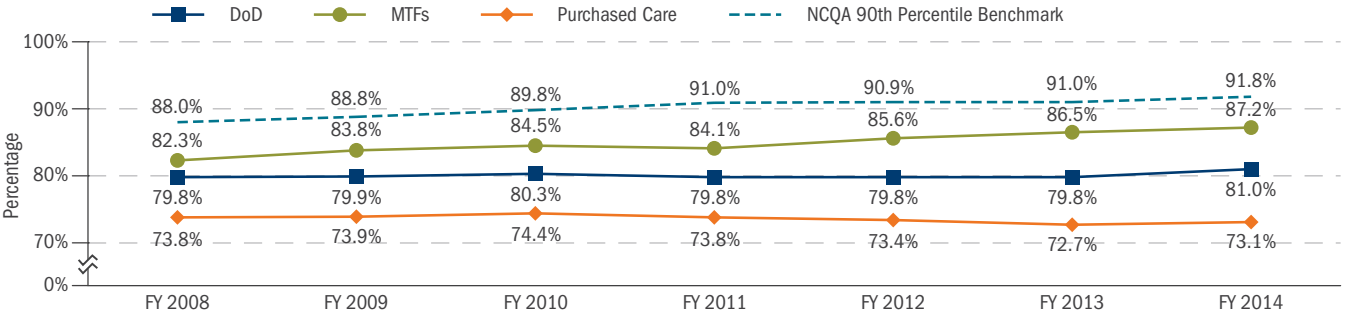


- **Diabetes HbA1c and LDL Screening:** Only screening for HbA1c and LDL are presented here, because these rates are determined from administrative data only. MHS continues to work to improve diabetic management.

DIABETES HBA1C SCREENING



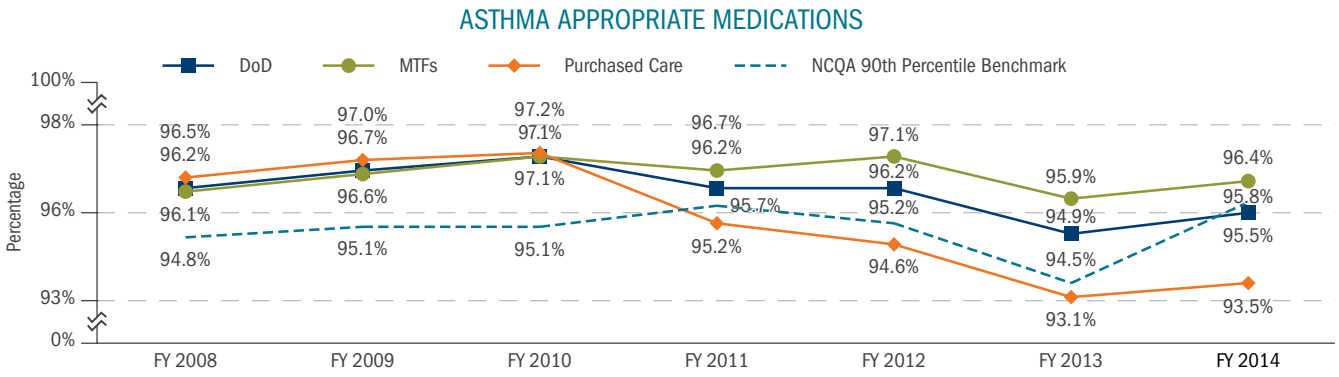
DIABETES LDL SCREENING



Source: DHA/Healthcare Operations Directorate, Clinical Support Division, 12/16/2014

HEDIS MEASURES FOR MHS 2008–2014 *(CONT.)*

- **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, 12/16/2014

ALCOHOL-REDUCTION MARKETING AND EDUCATION CAMPAIGN

The DoD has several educational priorities promoting the reduction of alcohol consumption. These include initiatives that address providers as well as beneficiaries. Efforts targeting providers are focused on facilitating the use of evidence-based screening tools across the Military Services and educating them on new developments in the field of addiction medicine. Most importantly, staffing models in the PCMH enhance access to mental health care in primary care settings.

DoD's integrated marketing campaign, "That Guy," continues to target military enlisted personnel ages 18 through 24. This campaign was launched in December 2006 across all branches of Service. It 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.

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.

Installation leaders consistently support campaign efforts, as they believe alcohol-related incidents have a negative impact on readiness. To that end, in 2014, a focus group was formed to evaluate the "That Guy" campaign and develop a strategic way forward.

DISEASE MANAGEMENT

MHS continues to look for ways to improve the health and quality of life for persons living with chronic conditions. Evaluation of MHS-wide DM activities during the past several years and review of current evidence-based research enabled the Department to determine the most efficient and effective use of resources. This information is being used to establish a framework for DM throughout MHS.

Another major focus for the year has been the refinement and development of DM metrics for monitoring program effectiveness. The MHS DM programs continue to pursue the achievement of positive outcomes for beneficiaries diagnosed with chronic conditions, including asthma; congestive heart failure (CHF); diabetes; chronic obstructive pulmonary disease (COPD); anxiety; depression; and cervical, breast, and colorectal cancer screening, as well as identifying other evidence-based best practices for areas of improvement.

The program's core emphasis is on patient-centered and coordinated care that is proactive and promotes patient engagement and self-management. These elements will drive the ongoing program development and improvements in order to achieve the Quadruple Aim goals of Better Health, Better Care, Lower Cost, and Increased Readiness.

POPULATION HEALTH

Population Health is dedicated to proactively managing the health care of patient populations based on predictable patterns of behavior. Although this concept is generally associated with managing the clinical risks associated with patients, through OLW and the HBI, MHS has extended the notion of helping the population manage their health by creating an environment where the healthy choice is the easy choice. 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., OLW), and collaborating with ongoing initiatives that support patient-centered care through PCMH teams.

Aligning with participation in the National Prevention Council, MHS continues to implement recommendations for the nation's first NPS. 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

Although tobacco use has dropped significantly for Americans during the last two decades, 25 percent of Service members smoke cigarettes, and 13 percent use smokeless tobacco—both well above the civilian averages (18 percent and 2 percent, respectively). Military personnel who smoke experience reduced physical-performance capability, impaired night vision, increased risk of respiratory illnesses and surgical complications, delayed wound healing, and accelerated age-related hearing loss. Further, there are negative impacts on dental readiness, and long-term effects of tobacco use often include cancer, stroke, emphysema, and heart disease. The Web site supporting this campaign, *www.ucanquit2.org*, continues to provide 24/7 instant messaging chat staffed by trained coaches/mentors who can help participants identify smoking-cessation resources and design a customizable quit plan online.

The Secretary of Defense (SecDef) charged his Under Secretary of Defense for Personnel and Readiness (USD[P&R]) to charter a committee to review the DoD's policy on tobacco use and sales. This effort supports sound policy considerations.

In support of this effort, the SecDef requested that the USD(P&R) provide him with a range of options developed by an inclusive committee. The Defense Advisory Committee on Tobacco (DACT), established June 2014, explored options for tobacco policy in DoD that are consistent with national objectives and are based on the CDC's Best Practices for Comprehensive Tobacco Control Programs (2014).

These options, now having been developed, will provide the SecDef with an opportunity to review and select tobacco policies that provide a strategic way forward to address DoD tobacco policy.

MHS continues to support tobacco-free living through working with the Military Services to encourage tobacco-free campus policies for MTFs. In June 2014, DoD launched the Tough Enough social media tobacco campaign directed toward Active Duty Service members. This campaign integrated Facebook, Pandora, Twitter, mobile, and other digital media strategies. The number of impressions released was 19,250,001. Digital media clicks were most popular (51 percent) via the DoD Millennial mobile application. This campaign not only facilitated launching strategic communication regarding tobacco use, but also established insight into the most effective means for communicating with DoD beneficiaries.

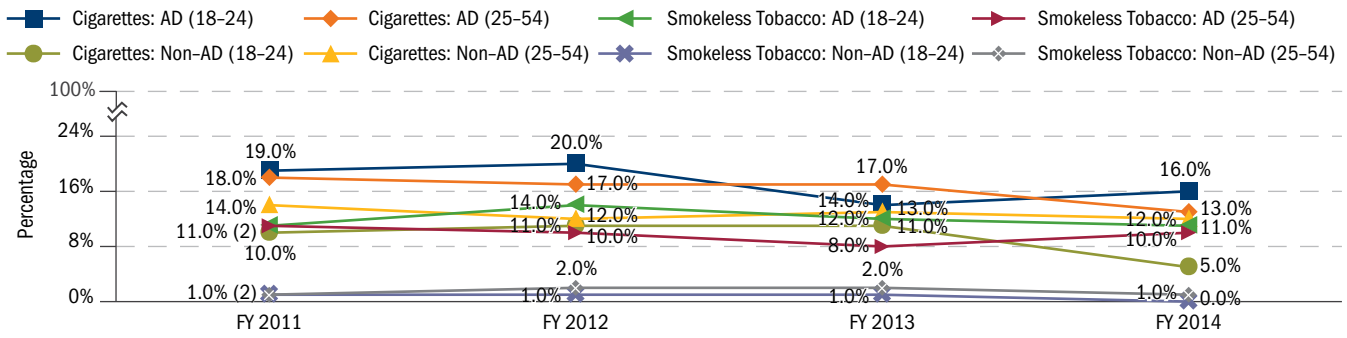
TRICARE covers smoking-cessation products, including prescriptions and over-the-counter (OTC) drugs, for beneficiaries age 18 to 65 in the United States, as well as Active Duty Service members and family members enrolled in Prime overseas. Covered smoking-cessation products may be obtained at no cost at military pharmacies and through TRICARE Pharmacy Home Delivery, where available. Beneficiaries must have a prescription from a TRICARE-authorized provider for any smoking-cessation medication, including OTCs, and the beneficiary does not need to be diagnosed with a related illness.

Access to online and print tobacco-cessation material remains available through the "Quit Tobacco—Make Everyone Proud" campaign, an initiative informed by extensive research and testing that was launched by the TRICARE Management Activity (TMA) in 2006.

TOBACCO CESSATION *(CONT.)*

- Cigarette smoking among older Active Duty (25–54) and younger non-Active Duty (18–24) recorded a statistically significant decline from FY 2011 to FY 2014. Although the population estimated percentages appear lower, they have not changed statistically over the same time period for older Active Duty and younger non-Active Duty. Smokeless tobacco rates have actually declined for the young Active Duty (18–24) but remain stable for other groups, although family members are 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/Decision Support Division survey, 12/5/2014

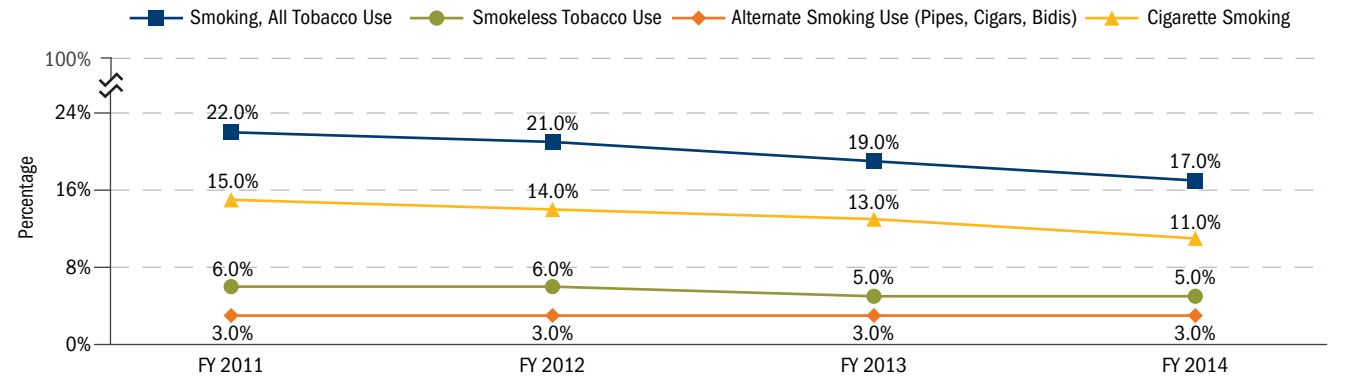
Notes:

– 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.

- **MHS Prime Enrollee Use of Any Tobacco Products:** Although 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.
- Based on the survey, Prime enrollee use of tobacco in one form or another has had a statistically significant decline from 22 percent in FY 2011 to 17 percent in FY 2014. Cigarette smoking, which dominates as the most-used form of tobacco product among Prime enrollees, has declined from 15 percent to 11 percent over the same time period while smokeless tobacco and alternative tobacco usage have remained unchanged.
- Usage of various tobacco products shown in the chart are not mutually exclusive (e.g., a cigarette smoker may 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/Decision Support Division, HCSDB survey, 12/5/2014

Notes:

– Smokeless tobacco may include dip, snuff, snuss, chew, etc., while alternate smoking tobacco may include cigars, pipes, hookahs, bidis, or kreteks.

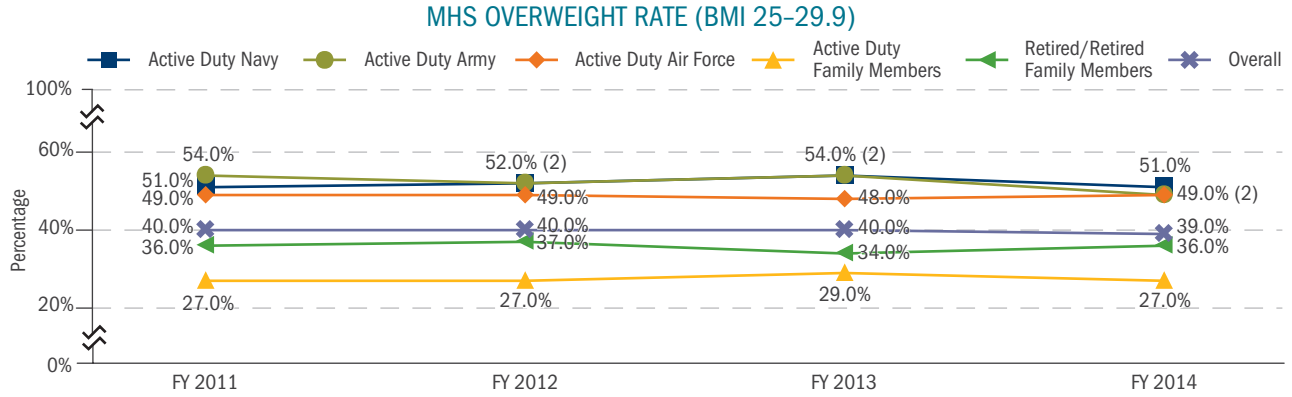
– Percentages are weighted for the probability of selection and nonresponse; variation in quarterly estimates may not be significant and should not be assumed as such without appropriate tests of significance.

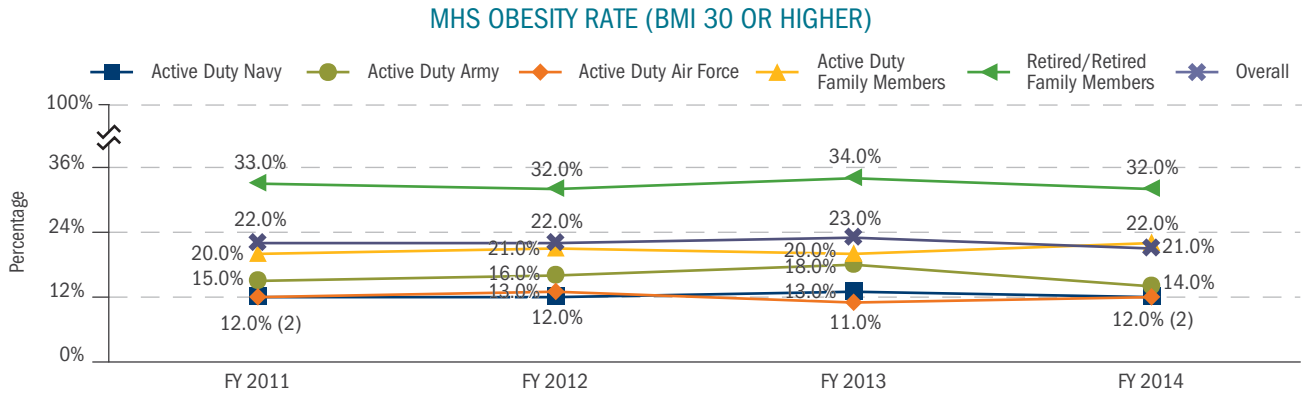
MHS ADULT OBESITY

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, 36 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 (27 percent), 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 (that is, a calculated BMI of 30 or higher based on self-reported height and weight). Active Duty present the lowest rates (between 12–14 percent), which are well below the National Health and Nutrition Examination Survey (NHANES) rate of 32 percent for 18- to 42-year-olds. The overall MHS obesity rate of 21 percent as well as within-group obesity rates are lower than the national rates (NHANES for 18–42 years, 38 percent of adults ages 43 to 64 years, and 37 percent of adults 65 and over). Overweight and obesity rates have not changed from FY 2011 to FY 2014.





Source: HCSDB, Analytics Division survey, 12/5/2014

Notes: 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 (e.g., 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 administration 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 2014

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 rates of inpatient admissions for medical conditions within the MHS population. This information offers policy makers a better understanding of the disease burden among the military population that results in hospitalization, and provides preliminary insights into possible targets for prevention and management strategies to improve care, care coordination, and the quality of life and health of the MHS population, while potentially reducing costs through effective care management.

Methods: All unique MHS beneficiaries alive, eligible, and within the U.S. during FY 2014 were included. Beneficiaries overseas for the full year were excluded. Beneficiaries were identified as having a medical condition if they had at least one inpatient discharge for the given medical condition during FY 2014. Over 14,000 ICD-9 diagnosis codes were aggregated into 63 medical conditions. In order to provide some relevance to these statistics, the medical conditions presented here are compared to similar data from the Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP).

Population Characteristics

The tables on the following pages present descriptive statistics of inpatient discharges for:

a. The top 10 medical conditions for MHS users representing TRICARE compared to three different health care payer groups as reported by HCUP;

b. The top 10 medical conditions for HCUP compared to three different MHS populations of interest in FY 2014: (1) all MHS users, (2) MHS Retiree family member (RETFM) users, and (3) MHS Active Duty family member (ADFM) users; and

c. The top five medical conditions for HCUP and MHS by age group and beneficiary category (i.e., all MHS users, MHS RETFM, MHS ADFM).

MHS usage combines inpatient care rendered in MTFs with that rendered in civilian facilities reimbursed by TRICARE as recorded in health care claims (including TRICARE for Life reimbursement). Comparative statistics are provided from the AHRQ HCUP National Inpatient Sample (NIS) for 2012, which is the most recent year available. All numbers represent the numbers of inpatient discharges for the given medical condition. In some cases, there is not a direct match between MHS age groups and HCUP age groups. We provide the best comparison possible when those situations occur.

- Compared with Medicare, Medicaid, and private insurance health care users, the conditions for which MHS users are hospitalized and their associated rates of hospitalizations are generally comparable to civilian populations. Overall, approximately 13 percent of MHS hospitalizations are related to maternal labor and delivery, with another approximately 10 percent of hospitalizations associated with births.
- More than two-thirds (67 percent) of all ADFM hospitalizations are for maternal labor and delivery and births. Comparatively, the most common reasons for RETFM hospitalizations are gastrointestinal conditions (11 percent) and rheumatoid/osteoarthritis (RA/OA) (6 percent). For MHS overall, maternal labor and delivery and births are responsible for almost 23 percent of hospitalizations, and gastrointestinal conditions are the third most common reason for hospitalization (9 percent).
- Birth is the predominant reason for hospitalization in children in the MHS population under one year of age (85 percent). For RETFM children ages one to 17, over one-third of hospitalizations are related to mood disorders (36 percent), followed by gastrointestinal conditions (9 percent). Comparatively, the most frequent reason for hospitalization for the HCUP population ages one to 17 are gastrointestinal conditions (12 percent); mood disorders account for only 7 percent of inpatient admissions for this age group.
- Hospitalizations for adults ages 18–25 and 18–44 are most frequently related to maternal conditions; in fact, more than 70 percent of ADFM hospitalizations in these age groups occur because of maternal conditions. Gastrointestinal conditions are the most common reason for hospitalization for ages 45–64, 65–84, and 85 and older, and the second most common reason for ages 18–44. Rates of hospitalizations for mood disorders in RETFM ages 18–25 and 18–44 are between 6 percent and 11 percent higher than rates for the HCUP 18–44 age group (15 percent and 11 percent compared with 5 percent in HCUP).

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

Population Characteristics *(Cont.)*

- Reasons contributing to these differences in rates of hospitalization include: (1) a generally younger population of MHS users and ADFMs compared with the civilian sector; (2) health-related screening available to beneficiaries, which may identify conditions at earlier ages; (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.

Top 10 HCUP-Based Medical Conditions: Rate of Discharges for Medical Conditions in the MHS Inpatient User Population Compared with Inpatient Users as Reported by AHRQ HCUP, by Health Plan

MEDICARE		MEDICAID		PRIVATE INSURANCE		TRICARE (MHS)	
TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 MEDICAL CONDITIONS	PERCENT OF ALL MHS INPATIENT DISCHARGES
Gastrointestinal	11.0%	Maternal	24.2%	Maternal	17.9%	Maternal	13.1%
Infectious Diseases	5.7%	Birth	23.1%	Birth	15.7%	Birth	9.6%
Pneumonia	5.2%	Gastrointestinal	6.5%	Gastrointestinal	9.9%	Gastrointestinal	9.0%
Heart Failure	4.7%	Mood Disorders	3.1%	Cancers	4.2%	RA/OA	4.0%
Cerebrovascular Disease	4.2%	Infectious Diseases	2.4%	RA/OA	3.3%	Mood Disorders	3.4%
Complications	4.2%	Mental Disorders	2.1%	Complications	2.8%	Infectious Diseases	3.3%
RA/OA	3.8%	Pneumonia	2.1%	Mood Disorders	2.3%	Pneumonia	2.9%
Cardiac Dysrhythmias	3.5%	Neurologic Disorders	1.9%	Infectious Diseases	2.3%	Rehab	2.8%
Heart Conditions	3.4%	Cancers	1.9%	Heart Conditions	2.1%	Cancer	2.7%
COPD	3.3%	Substance Abuse Disorders	1.9%	Back Problems	2.1%	Complications	2.6%

Top 10 HCUP-Based Medical Conditions: Rate of Discharges for Medical Conditions in the MHS Inpatient User Population Compared with Inpatient Users as Reported by AHRQ HCUP, by MHS Beneficiary Category

HCUP		ALL MHS USERS		MHS ADFM		MHS RETFM	
TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 HCUP MEDICAL CONDITIONS	HCUP PERCENT OF ALL INPATIENT DISCHARGES	TOP 10 MEDICAL CONDITIONS	PERCENT OF ALL MHS RETFM INPATIENT DISCHARGES
Maternal	11.3%	Maternal	13.1%	Maternal	35.1%	Gastrointestinal	11.3%
Birth	10.4%	Birth	9.6%	Birth	31.9%	RA/OA	6.3%
Gastrointestinal	9.8%	Gastrointestinal	9.0%	Gastrointestinal	4.4%	Rehab	4.3%
Infectious Diseases	3.7%	RA/OA	4.0%	Mood Disorders	4.1%	Infectious Diseases	4.3%
Pneumonia	3.2%	Mood Disorders	3.4%	Neonatal	1.6%	Pneumonia	3.7%
Cancers	3.1%	Infectious Diseases	3.3%	Endocrine	1.6%	Mood Disorders	3.6%
Complications	3.1%	Pneumonia	2.9%	Neurologic Disorders	1.5%	Cerebrovascular Disease	3.5%
RA/OA	2.7%	Rehab	2.8%	Acute Bronchitis and URI	1.4%	Complications	3.1%
Cerebrovascular Disease	2.5%	Cancers	2.7%	Cancers	1.3%	Heart Conditions	3.0%
Heart Conditions	2.5%	Complications	2.6%	Reproductive	1.3%	Cancers	3.0%

Source: DHA/Decision Support Division supported by Altarum Institute, 12/18/2014

Notes:

- MHS data was obtained from SIDR, TRICARE Encounter Data-Institutional (TED-I), and DEERS VM6 Point in Time Extract (PITE), representing directly provided and purchased inpatient care linked to enrollment and eligibility records.
- Maternal discharges present the associated percent as a function of all discharges, both male/female for consistency.
- RA/OA is rheumatoid arthritis/osteoarthritis.
- Weighted national estimates from HCUP National Inpatient Sample (NIS), 2012, AHRQ, based on data collected by individual states and provided to AHRQ by the states. Total number of weighted discharges in the U.S. based on HCUP NIS = 36,484,846.

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

Rate of Discharges for Medical Conditions in the MHS Inpatient User Population Compared to Inpatient Users as Reported by AHRQ HCUP, by Select Age Groups and Beneficiary Category

AGE GROUP	TOP 5 HCUP MEDICAL CONDITIONS BY AGE GROUP	HCUP PERCENT OF ALL INPATIENT DISCHARGES	DHA MEDICAL CONDITION	MHS USERS	RETFM	ADFM
				PERCENT OF INPATIENT DISCHARGES	PERCENT OF INPATIENT DISCHARGES	PERCENT OF INPATIENT DISCHARGES
<1 year	Birth	88.7%	Birth	85.4%	85.9%	85.2%
	Neonatal	3.1%	Neonatal	4.2%	4.0%	4.3%
	Acute Bronchitis and Upper Respiratory Infection	2.3%	Acute Bronchitis and Upper Respiratory Infection	2.2%	2.3%	2.2%
	Congenital	1.0%	Congenital	1.4%	1.6%	1.3%
	Gastrointestinal	0.7%	Gastrointestinal	1.0%	1.2%	1.0%
1–17 years	Gastrointestinal	11.7%	Mood Disorders	25.5%	35.7%	21.3%
	Asthma	7.4%	Gastrointestinal	9.7%	9.2%	10.0%
	Mood Disorders	7.0%	Neurologic Disorders	5.1%	4.5%	5.3%
	Maternal	6.7%	Asthma	4.3%	2.6%	5.0%
	Pneumonia	6.6%	Pneumonia	4.2%	2.6%	4.8%
18–25 years	N/A	N/A	Maternal	53.7%	31.5%	78.5%
	N/A	N/A	Mood Disorders	7.6%	15.2%	3.8%
	N/A	N/A	Gastrointestinal	5.8%	7.8%	4.0%
	N/A	N/A	Adjustment Disorders	3.5%	0.9%	0.5%
	N/A	N/A	Substance Abuse Disorders	3.4%	5.5%	1.2%
18–44 years	Maternal	44.7%	Maternal	50.2%	29.4%	71.2%
	Gastrointestinal	9.0%	Gastrointestinal	7.1%	10.0%	5.2%
	Mood Disorders	4.6%	Mood Disorders	5.8%	10.7%	3.2%
	Mental Disorders	2.6%	Substance Abuse Disorders	3.1%	4.1%	1.4%
	Substance Abuse Disorders	2.5%	Back Problems	2.0%	1.9%	0.7%
45–64 years	Gastrointestinal	13.1%	Gastrointestinal	13.5%	14.1%	14.8%
	Cancers	5.0%	RA/OA	7.5%	7.9%	3.9%
	Complications	4.7%	Back Problems	5.3%	4.6%	4.5%
	RA/OA	4.5%	Cancers	5.1%	5.0%	7.1%
	Infectious Diseases	4.2%	Heart Conditions	4.8%	4.4%	6.0%
65–84 years	Gastrointestinal	11.1%	Gastrointestinal	10.6%	11.1%	9.3%
	RA/OA	5.4%	RA/OA	7.7%	8.8%	3.7%
	Infectious Diseases	5.3%	Infectious Diseases	5.3%	4.9%	2.3%
	Pneumonia	4.7%	Cerebrovascular Disease	4.6%	4.2%	4.2%
	Cerebrovascular Disease	4.6%	Pneumonia	4.6%	4.2%	2.3%
85+ years	Gastrointestinal	10.5%	Gastrointestinal	9.6%	9.8%	–
	Pneumonia	7.7%	Rehab	7.7%	8.3%	–
	Heart Failure	7.4%	Pneumonia	7.0%	6.1%	–
	Infectious Diseases	6.8%	Infectious Diseases	6.4%	5.7%	–
	Cerebrovascular Disease	5.4%	Heart Failure	6.3%	5.7%	–

Source: See previous page; the 18–25 year age group was not reported in HCUP.

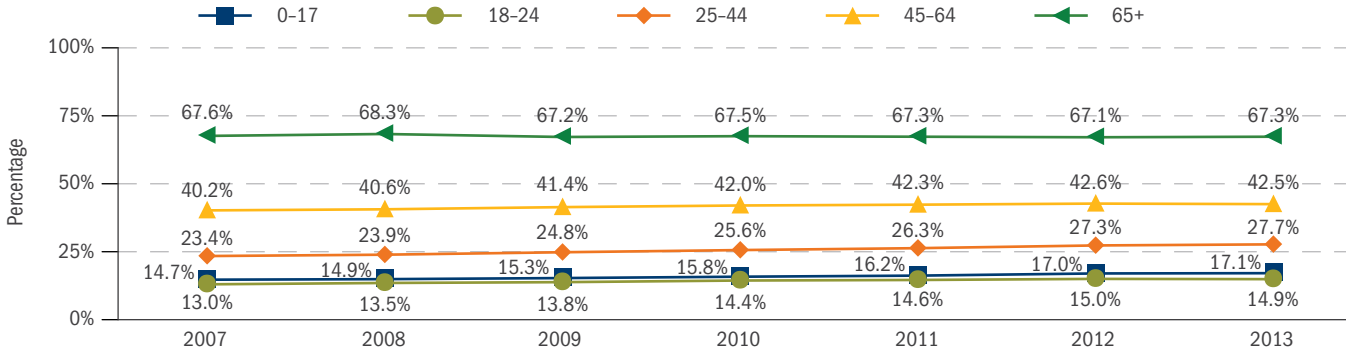
PREVALENCE OF MHS BENEFICIARIES WITH CHRONIC MEDICAL CONDITIONS *(CONT.)*

MHS Chronic Condition Burden

The above data depict the frequency, or rate, at which various medical conditions are responsible for inpatient admissions within MHS. However, these data do not necessarily indicate the prevalence of those conditions within MHS, as conditions that are not highly prevalent may be sufficiently severe and result in high rates of admission. A separate analysis identified the chronic population as a person: (1) with specific ICD-9 tagged as a chronic condition by the HCUP Chronic Condition Indicator algorithm; and (2) having at least two ambulatory visits and/or one inpatient stay with that specific ICD-9 as the primary diagnosis code within a fiscal year.

- As the graph below shows, the percentage of MHS users with chronic conditions increased slightly for most age groups between FY 2007 and FY 2013. The presence of a chronic condition increases with age, beginning with ages 18–24, with 67 percent of those ages 65+ having a chronic condition. Between FY 2007 and FY 2013, the 25–44 age group experienced the greatest increase (4 percentage points) in prevalence of chronic conditions (from 23 percent to 28 percent).

CHRONIC CONDITION POPULATION DISTRIBUTION BY AGE GROUP (MHS USER POPULATION), OVER TIME



Source: HA/DHA/Analytics Data Extraction team analysis of MHS chronic disease data, 12/2/2014

- Over this seven-year time frame, the average increase in per-person costs for the chronic condition population was $1,270. Comparatively, per-person costs of the non-chronic condition population increased by only $306 over the same period. The greatest increase over time (almost $1,900) and also highest per-person costs (approximately $9,340) are for 25–44 year olds with chronic conditions.

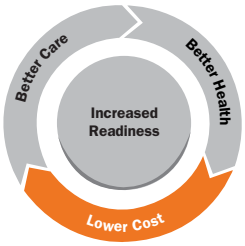
Per-Person Cost Trend for MHS, Chronic and Non-Chronic Populations by Age

AVERAGE DoD COST PER PERSON, BY AGE GROUP, CHRONIC VS. NON-CHRONIC POPULATIONS

	Age Group	2007	2008	2009	2010	2011	2012	2013
Chronic Condition Population	0–17	$5,543	$5,861	$6,059	$6,242	$6,564	$6,473	$6,879
	18–24	$7,572	$8,046	$8,474	$8,694	$9,322	$8,693	$8,811
	25–44	$7,441	$8,078	$8,600	$8,857	$9,434	$9,012	$9,338
	45–64	$7,762	$8,147	$8,507	$8,558	$8,947	$8,803	$8,964
	65+	$4,915	$5,092	$5,398	$5,559	$5,768	$5,629	$5,594
Non-Chronic Condition Population	0–17	$1,161	$1,234	$1,294	$1,318	$1,390	$1,378	$1,532
	18–24	$1,639	$1,693	$1,754	$1,774	$1,892	$1,734	$1,875
	25–44	$1,788	$1,888	$1,985	$2,066	$2,198	$2,135	$2,288
	45–64	$1,876	$1,971	$2,091	$2,132	$2,224	$2,135	$2,159
	65+	$1,869	$1,956	$2,131	$2,210	$2,281	$2,117	$2,008

Source: HA/DHA/Analytics Data Extraction team analysis of MHS chronic disease data, 12/2/2014

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 the U.S. Court of Appeals on January 4, 2013, the Defense Health Agency (DHA) produced retroactive refunds for calendar year (CY) 2008 Q1 through CY 2009 Q3 bill quarters during FY 2012.

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 were performed to ensure accuracy of the data reported to manufacturers, as well as refunds due to DoD, since the inception of the Final Rule. Recalculations were conducted for CY 2009 Q3 through CY 2011 Q4 bill quarters during FY 2013 and FY 2014.

PHARMACY RETAIL REFUNDS ($ MILLIONS)

	FY 2011	FY 2012	FY 2013	FY 2014
Total Receivables	$1,862.81	$3,143.53	$1,491.06	$1,319.28
Routine	$1,862.81	$1,509.28	$1,370.80	$1,280.96
Retroactive (CY 2008 Q1–CY 2009 Q2)	–	$1,634.25	–	–
Additional from Recalculations (CY 2009 Q3–CY 2011 Q4)	–	–	$120.26	$38.32
Total Collections	$1,816.50	$1,516.41	$2,359.77	$1,496.25

Source: Contract Resource Management, 9/30/2014

Notes: Refund amounts are netted out of pharmacy costs provided within this report. The refunds in the chart above are categorized in the fiscal year they were validated and billed to the manufacturers.

Program Integrity Activities

The DHA Program Integrity (PI) Office is responsible for all anti-fraud and abuse activities worldwide for the DHA to protect benefit dollars and safeguard beneficiaries. The PI develops and executes anti-fraud and abuse policies and procedures, provides oversight of contractor program integrity activities, coordinates investigative activities, develops cases for criminal prosecutions and civil litigations, and initiates administrative measures. DHA PI develops areas of focus and analyzes claims data to identify outliers. Through a Memorandum of Understanding, DHA PI refers its fraud cases to the Defense Criminal Investigative Services and coordinates investigative activities with Military Criminal Investigative Offices, as well as other federal, state, and local agencies.

PROGRAM INTEGRITY RECOVERIES/COST AVOIDANCE ($ MILLIONS)

	CY 2011	CY 2012	CY 2013
Total Recoveries	$43.3	$121.9	$182.1
Court-Ordered Fraud Judgments/Settlements	$40.5	$118.5	$175.6
PI Contractors Administrative Recoupment/Offsets (Received)	$2.8	$3.4	$6.5
Total PI Contractors Cost Avoidance	$24.2	$17.7	$16.5
Contractor Prepayment Reviews	$22.3	$16.2	$15.4
Excluded Providers	$1.9	$1.5	$1.1

Sources: TRICARE Program Integrity Operational Reports and Quarterly Fraud and Abuse Reports, CY 2011–CY 2013. CY 2013 data are latest reported as of this writing, 1/21/2015.

Program Savings & Claim Recoveries

New reimbursement approaches are continually evaluated for potential savings to TRICARE. As new programs are established, savings are estimated and monitored.

Claim recoveries result from identified overpayments adjusted in TED and the differences are recouped.

RECOVERIES ($ MILLIONS)

	FY 2012	FY 2013	FY 2014
Recovery A—Post-Payment Duplicate Claim Recoveries	$8.6	$8.3	$9.0
Recovery B—Improper Payment Recoveries	$18.8	$19.5	$4.4

Source: Improper payments

Recovery A—Post-Payment Duplicate Claim Recoveries: A post-payment duplicate claims system was developed by DHA Healthcare Operations Directorate's TRICARE Health Plan Division for use by TRICARE purchased care contractors. The system was designed as a retrospective auditing tool and facilitates the identification of actual duplicate claim payments and the initiation and tracking of recoupments. The table above provides the historical recovery of duplicate claims payments.

Recovery B—Improper Payment Recoveries: The DHA is vigilant to ensure the accuracy of health care claims payments within the military health benefits program. The DHA has contracted with an External Independent Contractor (EIC) who is responsible for conducting post-payment accuracy reviews of TRICARE health benefit claims. The EIC is responsible for identifying improper payments made by TRICARE purchased care contractors as a result of contractor non-compliance with TRICARE policy, benefit, and/or reimbursement requirements. The table above provides the historical recovery of improper payments as a result of the EIC compliance reviews.

In addition to EIC post-payment reviews, the DHA requires TRICARE purchased care contractors to use industry best business practices when processing TRICARE claims. Contractors are required to use claims auditing software and develop manual and/or automated pre-payment initiatives to avoid or prevent improper payments.

INPATIENT UTILIZATION RATES AND COSTS

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks

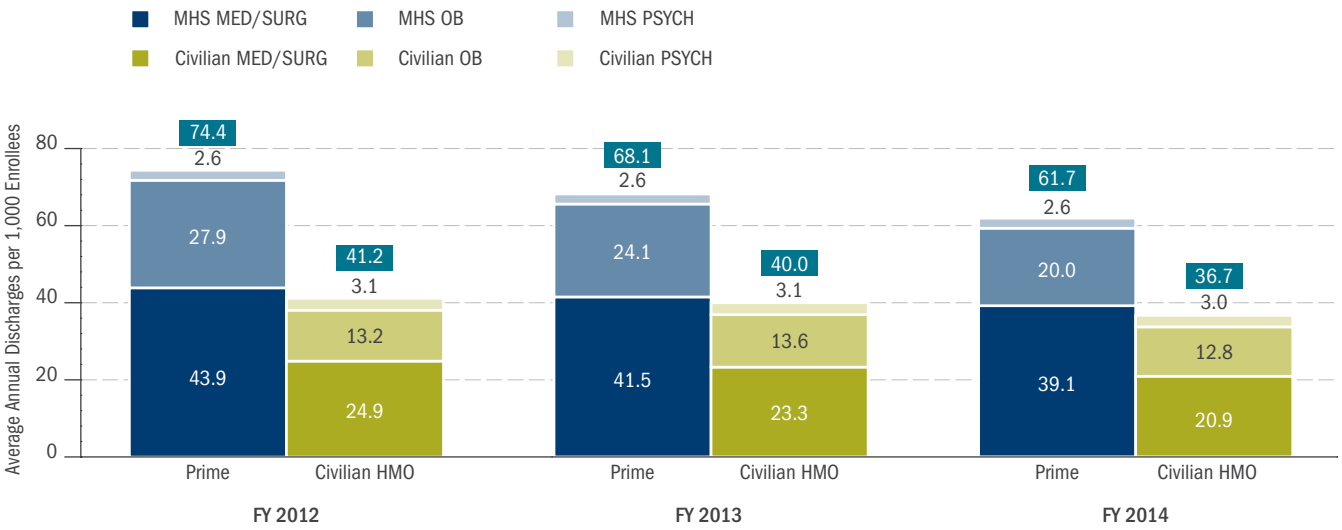
TRICARE Prime Enrollees

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 2012 and FY 2014. In FY 2014, the TRICARE Prime inpatient utilization rate (direct and purchased care combined) was 68 percent higher than the civilian HMO utilization rate (61.7 discharges per 1,000 Prime enrollees compared with 36.7 per 1,000 civilian HMO enrollees).
- In FY 2014, the TRICARE Prime inpatient utilization rate was 88 percent higher than the civilian HMO rate for MED/SURG procedures, 56 percent higher for OB/GYN procedures, and 15 percent lower for PSYCH procedures.
- The average length of stay (LOS) for MHS Prime enrollees (direct and purchased care combined) remained at about 3.2 days between FY 2012 and FY 2014, whereas the average LOS for civilian HMO enrollees declined slightly from 3.6 to 3.5 days. In FY 2014, the average LOS for MHS Prime enrollees was 8 percent lower than that of civilian HMO enrollees (not shown).

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



Sources: MHS administrative data, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2014 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.)*

TRICARE Inpatient Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

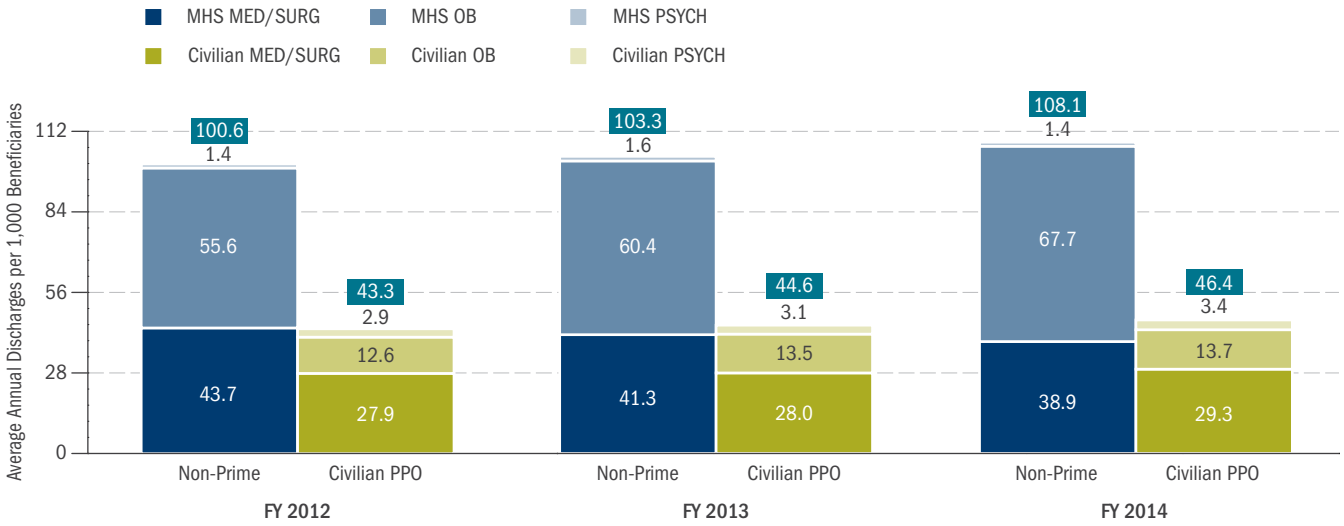
Non-Enrolled Beneficiaries

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 17 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 2012 and FY 2014, both the TRICARE non-Prime and civilian PPO inpatient utilization rates increased. In FY 2014, 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 2012 to FY 2014, the MHS OB disposition rate increased by 22 percent, whereas it increased by 9 percent in the civilian sector. In FY 2014, 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 at about 3.6 days between FY 2012 and FY 2014, whereas the average LOS for civilian PPO participants declined by 2 percent. As a result, the average LOS for MHS non-Prime beneficiaries was 4 percent higher than that of civilian PPO participants in FY 2014 (not shown).

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



Sources: MHS administrative data, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Notes:

– The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2014 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.

LOWER COST

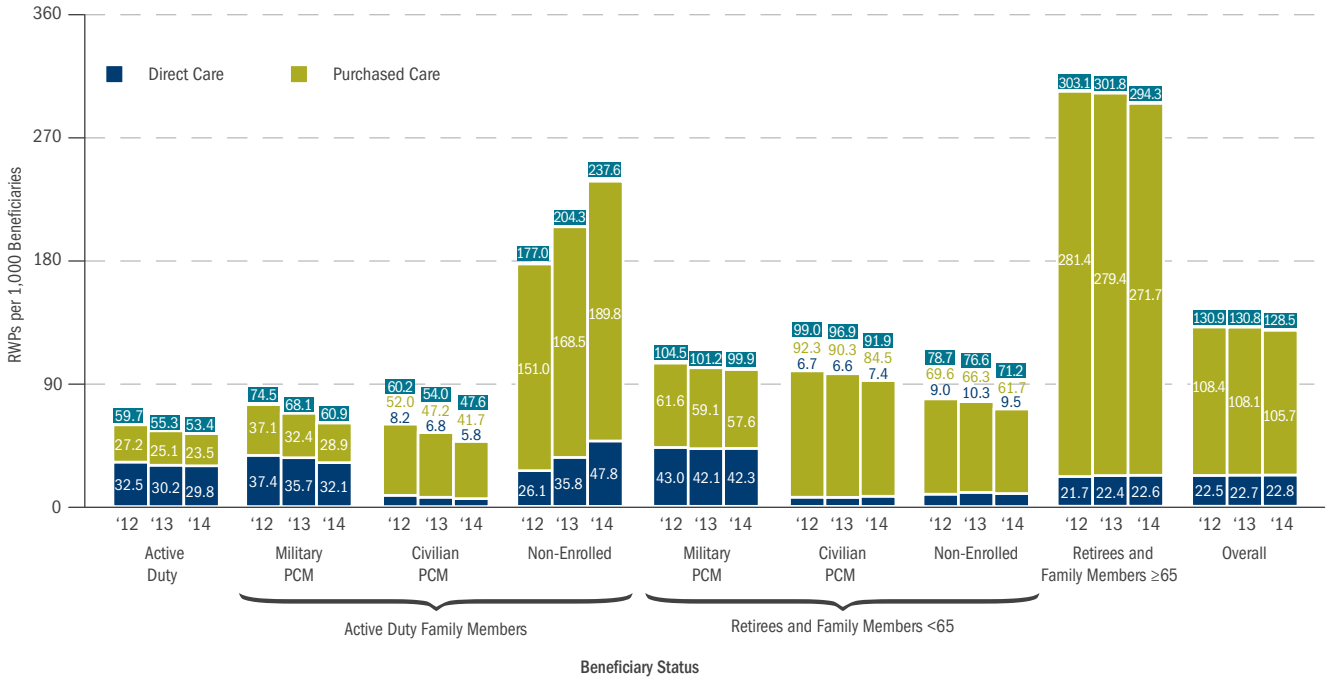
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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 2012 to FY 2014.

- The overall (direct and purchased care combined) inpatient utilization rate (RWPs per 1,000 beneficiaries) declined by 2 percent from FY 2012 to FY 2014.
- The direct care inpatient utilization rate increased by 1 percent overall, but there was a great deal of variation across beneficiary groups. Enrolled Active Duty family members (ADFMs) experienced large declines (29 percent for those with a civilian primary care manager [PCM] and 14 percent for those with a military PCM), but non-enrolled ADFMs experienced a very large increase (83 percent).
- Purchased acute care inpatient utilization rates decreased for all beneficiary groups except non-enrolled ADFMs (26 percent increase). Enrolled ADFMs experienced the largest declines (22 percent for those with a military PCM and 20 percent for those with a civilian PCM).
- 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 fell from 73 percent in FY 2012 to 71 percent in FY 2014.
- From FY 2012 to FY 2014, the percentage of per capita inpatient workload referred to the network on behalf of beneficiaries enrolled with a military PCM (including Active Duty personnel) fell from 53 percent in FY 2012 to 51 percent in FY 2014.

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



Source: MHS administrative data, 1/15/2015

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

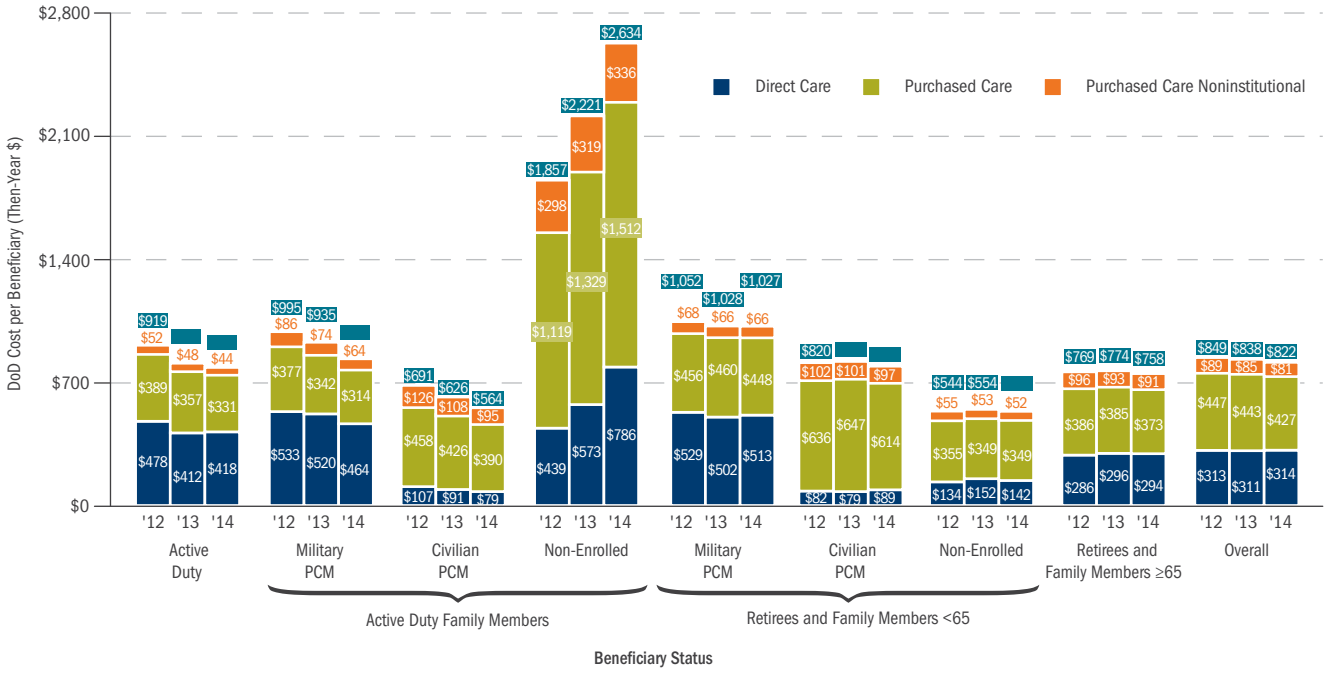
INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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), decreased by 3 percent from FY 2012 to FY 2014. The decreases were due largely to lower purchased care costs.

- Non-enrolled ADFMs experienced a large increase in MHS per capita inpatient cost (42 percent). All other beneficiary groups experienced declines, with enrolled ADFMs having the largest (18 percent for those with a civilian PCM and 15 percent for those with a military PCM).
- The direct care cost per RWP dropped slightly from $13,927 in FY 2012 to $13,792 in FY 2014 (1 percent).
- Exclusive of TFL, DoD purchased care cost (institutional plus noninstitutional) per RWP in acute care facilities increased from $6,968 in FY 2012 to $7,163 in FY 2014 (3 percent).
- The DoD purchased care cost per RWP is much lower than that for direct care partly because some beneficiaries have substantial cost shares (e.g., retirees) and may also 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 increased from $8,514 in FY 2012 and $8,640 in FY 2014 (less than 2 percent, exclusive of TFL).

AVERAGE ANNUAL DoD INPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/15/2015

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

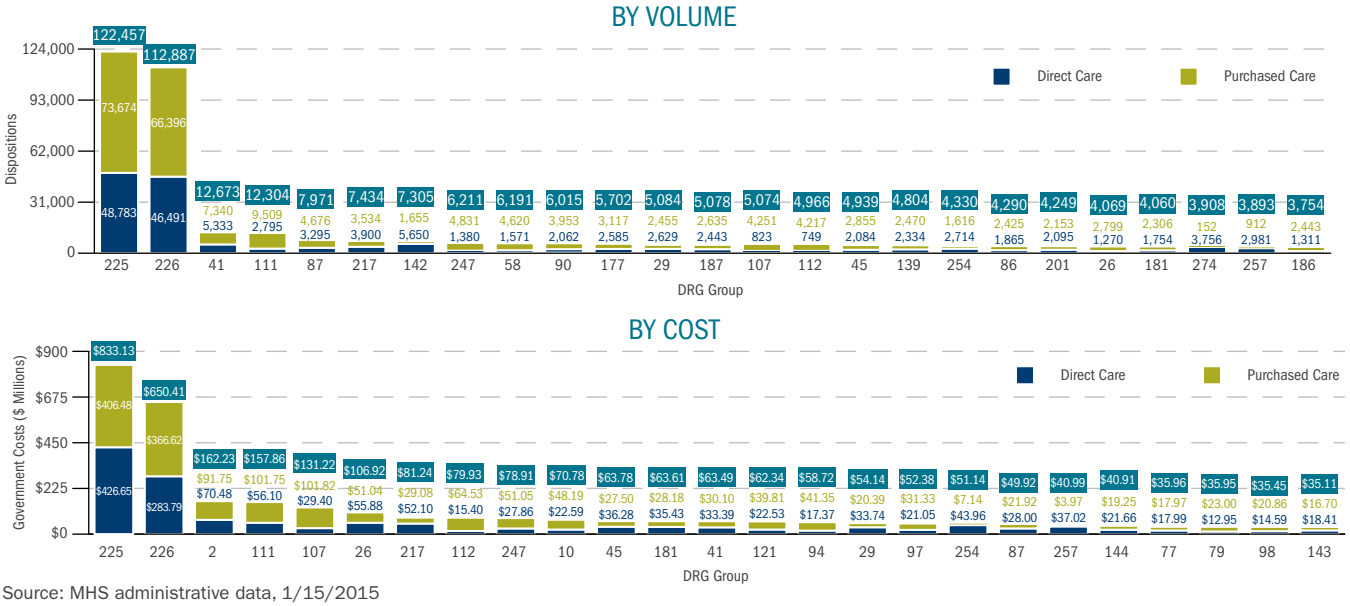
LOWER COST

INPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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 2014 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 2014 include both institutional and noninstitutional claims; i.e., they include hospital, attendant physician, drug, and ancillary service charges. The top 25 DRG groups in terms of cost in FY 2014 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, 1/15/2015

MS-DRG Groups

2 ECMO or tracheostomy
10 Craniotomy
26 Major small and large bowel procedures
29 Appendectomy
41 Esophagitis, gastroenteritis, and miscellaneous digestive disorders
45 Cholecystectomy
58 Seizures and headaches
77 Major chest procedures
79 Respiratory system with ventilator support
86 Chronic obstructive pulmonary disease
87 Simple pneumonia and pleurisy
90 Bronchitis and asthma
94 Cardiac valve and other major cardiothoracic procedures
97 Coronary bypass
98 Major cardiovascular procedures
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
143 Back and neck procedures, except spinal fusion, or disc devices/neurostimulators
144 Lower extremity and humerus procedures except hip, foot, femur
177 Cellulitis
181 O.R. procedures for obesity
186 Diabetes
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
274 Other factors influencing health status

- The top two procedures by volume are related to childbirth, accounting for 43 percent of all hospital admissions and 28 percent of total hospital costs (not just among the top 25).
- Procedures performed in private-sector acute care hospitals account for 59 percent of the total volume of the top 25 DRG groups and 54 percent of the total cost.
- Admissions in direct care facilities exceed those in purchased care facilities for only six of the top 25 DRG groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 13 of the top 25 DRG groups.
- Surgical procedures for obesity rank 22nd in volume and 12th 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/code-set.php?set=DRG*, an online database of medical billing codes and information. The site lists surgical and medical DRGs within each Major Diagnostic Category (MDC) with headings above diagnostically related DRGs. In some cases (e.g., DRGs related to pregnancy and childbirth) the headings were further grouped into larger, descriptively similar categories. The headings were then sequentially numbered, providing the basis for the DRG grouping methodology. The numbers have no significance other than to identify the DRG groups on the horizontal axes in the charts above. See Appendix for additional detail on the DRG grouping methodology.

OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

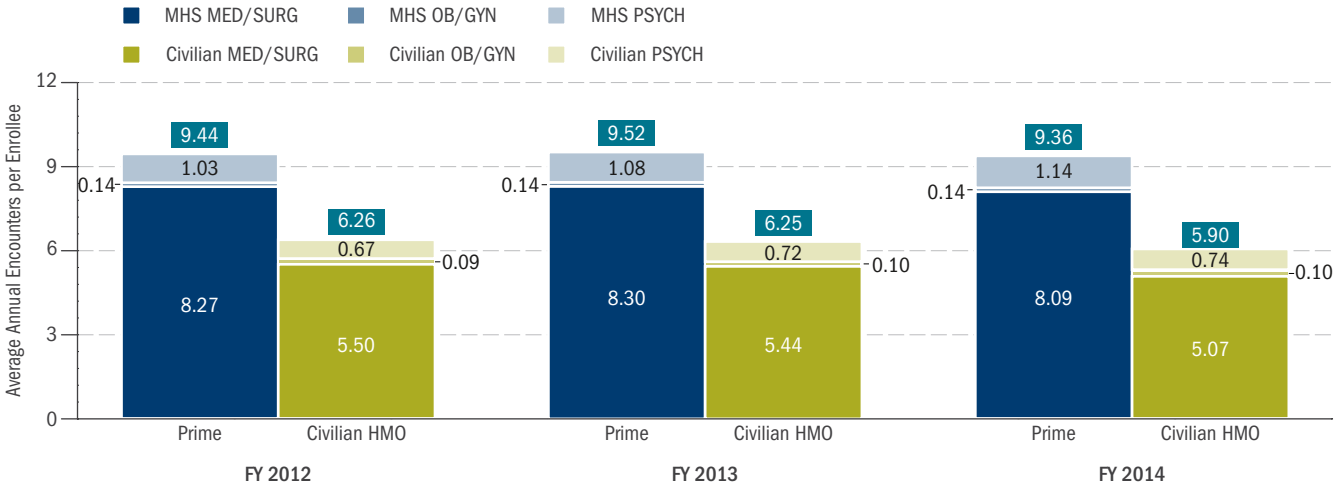
TRICARE Prime Enrollees

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) fell by less than 1 percent between FY 2012 and FY 2014. The civilian HMO outpatient utilization rate dropped by 6 percent over the same period.
- In FY 2014, the overall Prime outpatient utilization rate was more than 50 percent higher than the civilian HMO rate.
- In FY 2014, the Prime outpatient utilization rate for MED/SURG procedures was 60 percent higher than the civilian HMO rate.
- The Prime outpatient utilization rate for OB/GYN procedures was 46 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 global procedures.[1]
- The Prime outpatient utilization rate for PSYCH procedures was 54 percent higher than the corresponding rate for civilian HMOs in FY 2014. 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, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2014 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.

LOWER COST

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

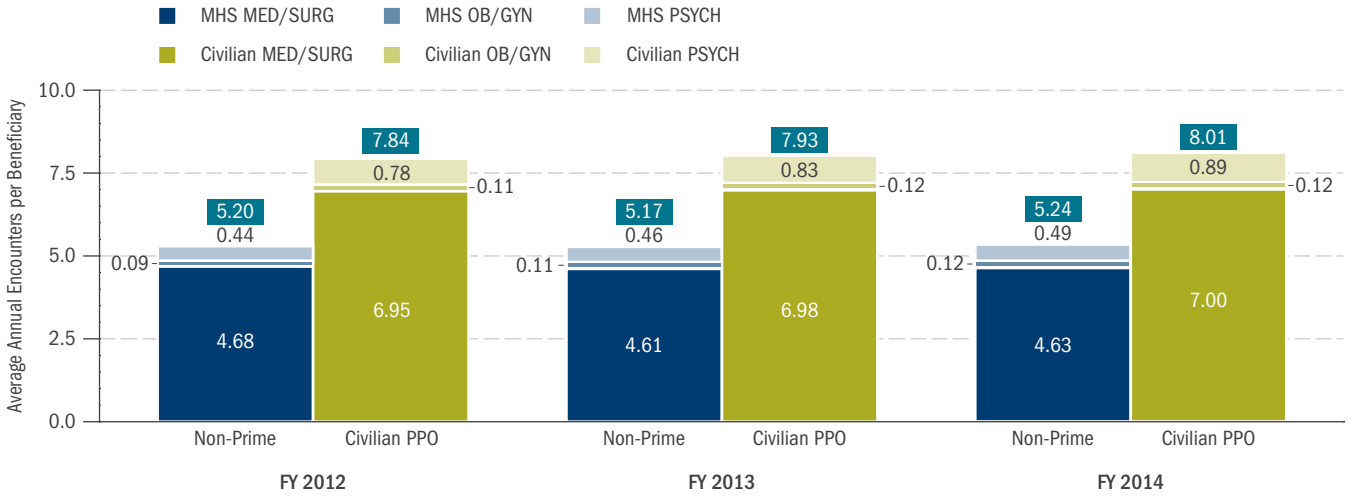
Non-Enrolled Beneficiaries

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 17 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 remained at about 5.2 encounters per participant from FY 2012 to FY 2014. The civilian PPO outpatient utilization rate increased by 2 percent over the same period.
- The overall TRICARE non-Prime (space-available and Standard/Extra) outpatient utilization rate remained well below the level observed for civilian PPOs. In FY 2014, TRICARE non-Prime outpatient utilization was 35 percent lower than in civilian PPOs.
- In FY 2014, the non-Prime outpatient utilization rate for MED/SURG procedures was 34 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 35 percent between FY 2012 and FY 2014. As a result, the MHS OB rate was 3 percent higher than the rate for civilian PPO participants in FY 2014.[1]
- The PSYCH outpatient utilization rate of non-enrolled MHS beneficiaries increased by 12 percent from FY 2012 to FY 2014; the rate increased by 14 percent for civilian PPO participants. In FY 2014, the PSYCH outpatient utilization rate for non-enrolled beneficiaries was 45 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 Service 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, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS-enrolled beneficiary population. FY 2014 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.

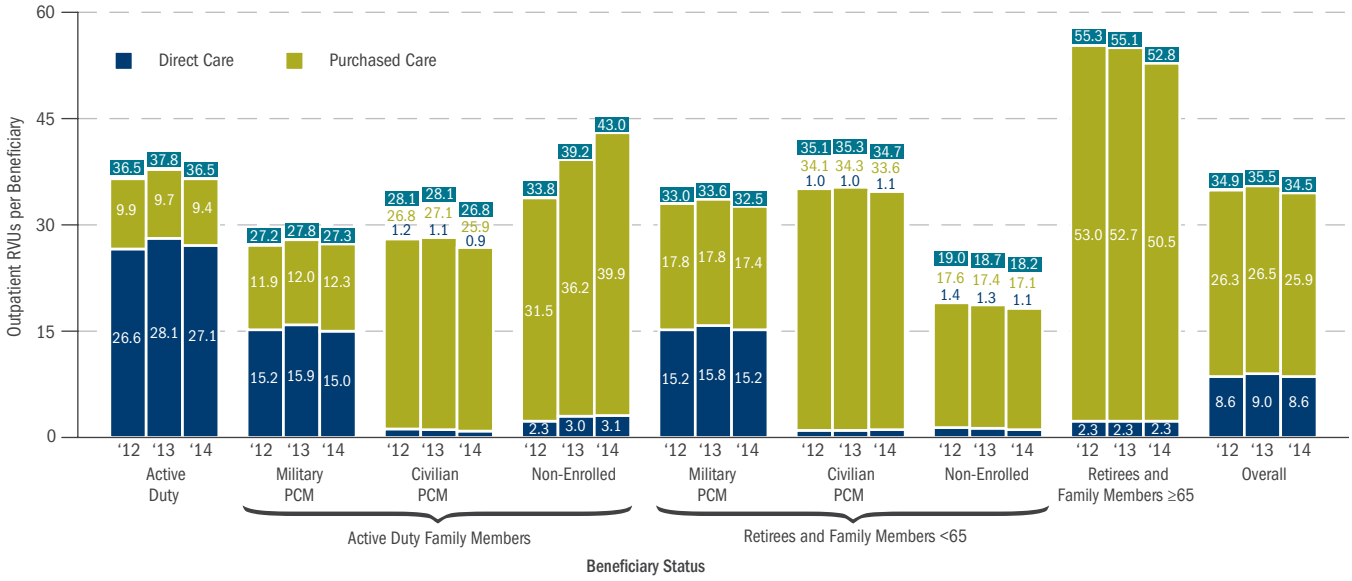
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

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) decreased by 1 percent from FY 2012 to FY 2014.
- Non-enrolled ADFMs experienced a 36 percent increase in direct outpatient utilization from FY 2012 to FY 2014. Retirees and family members under age 65 with a civilian PCM experienced a 9 percent increase. Beneficiary groups experiencing large declines were ADFMs with a civilian PCM (30 percent) and non-enrolled retirees and family members under age 65 (22 percent).
- From FY 2012 to FY 2014, non-enrolled ADFMs experienced a 27 percent increase in per capita purchased care outpatient utilization while ADFMs with a military PCM experienced a 3 percent increase. All other beneficiary groups experienced modest declines.
- The TFL outpatient utilization rate decreased by 5 percent from FY 2012 to FY 2014.[1]

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/1/2015

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.

LOWER COST

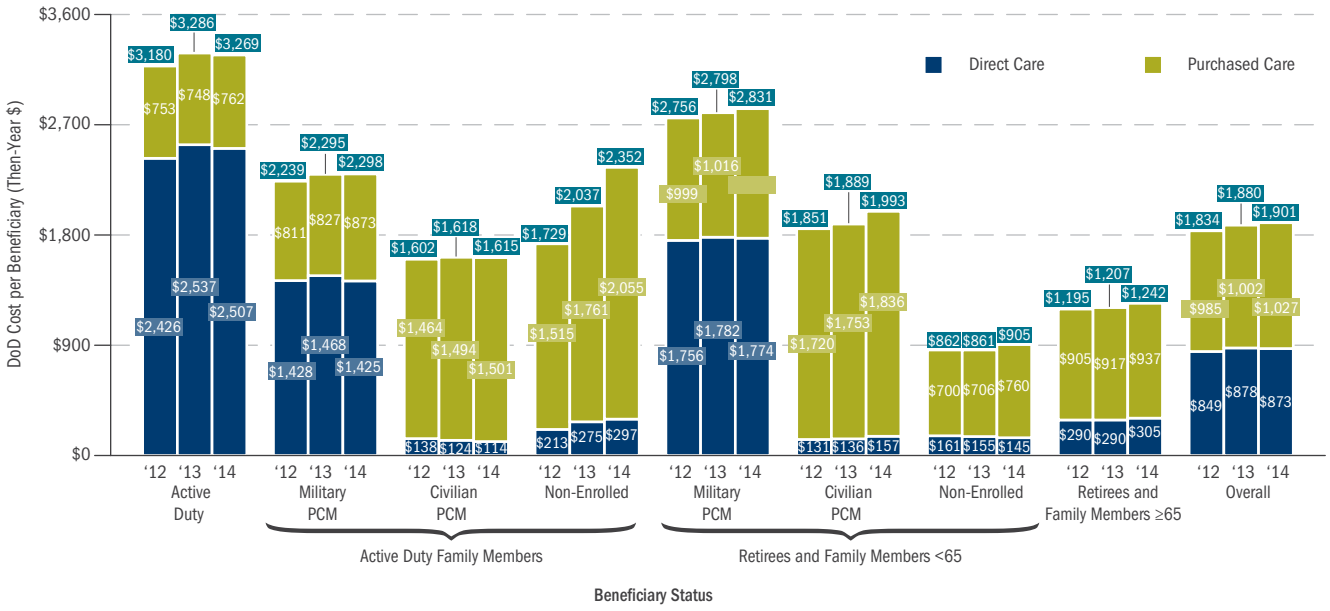
OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

Outpatient Costs by Beneficiary Status

Corresponding to a leveling-off of 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 4 percent from FY 2012 to FY 2014.

- The direct care cost per beneficiary increased sharply for non-enrolled ADFMs (39 percent) and for retirees and family members under age 65 with a civilian PCM (21 percent), corresponding to higher utilization for those groups. Groups experiencing large decreases in costs were ADFMs with a civilian PCM (18 percent) and non-enrolled retirees and family members under age 65 (10 percent).
- Excluding TFL, the DoD purchased care outpatient cost per beneficiary increased by 5 percent from FY 2012 to FY 2014. Per capita costs increased for all beneficiary groups, especially for non-enrolled ADFMs (36 percent). Increases for other beneficiary groups ranged from 1 to 9 percent.
- The TFL outpatient cost per beneficiary increased by 4 percent between FY 2012 and FY 2014.[1]

AVERAGE ANNUAL DoD OUTPATIENT COSTS PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/15/2015

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

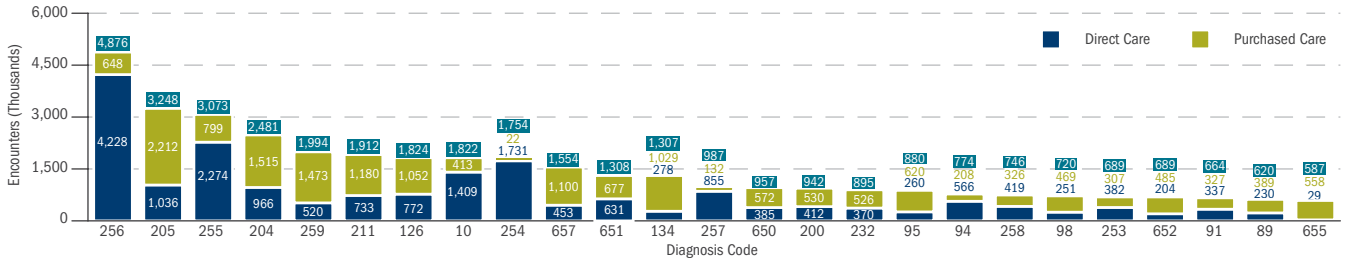
[1] The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there is a small number who are not.

OUTPATIENT UTILIZATION RATES AND COSTS *(CONT.)*

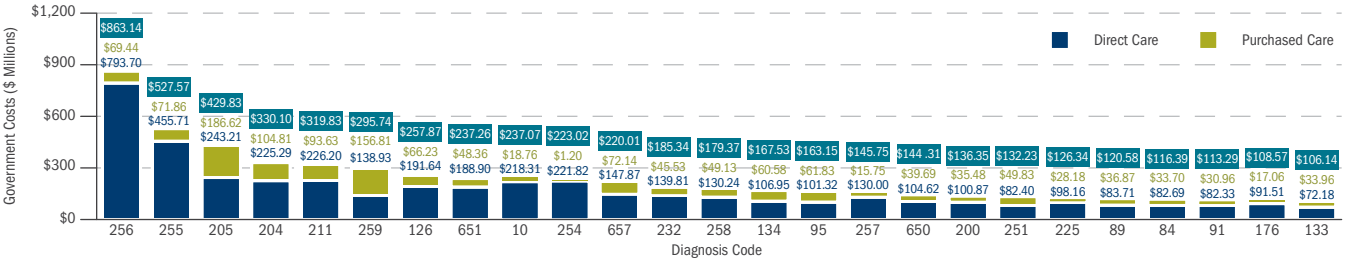
Leading Outpatient Diagnosis Groups

Leading outpatient diagnoses were determined by grouping ICD-9-CM primary diagnosis codes into like categories using the Clinical Classifications Software 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 2014 accounted for 64 percent of all outpatient encounters (direct care and purchased care combined) and 56 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, 1/15/2015

Diagnosis Group

10 Immunization and screening for infectious disease
84 Headache, including migraine
89 Blindness and vision defects
91 Other eye disorders
94 Other ear and sense organ disorders
95 Other nervous system disorders
98 Essential hypertension
126 Other upper respiratory infections
133 Other lower respiratory disease
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 47 percent of the total volume of the top 25 diagnosis groups but only 24 percent of the total cost.
- Encounters in direct care facilities exceed those in purchased care facilities for only nine of the 25 top diagnosis groups. However, expenditures in direct care facilities exceed those in purchased care facilities for 24 of the top 25 diagnosis groups.

LOWER COST

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.

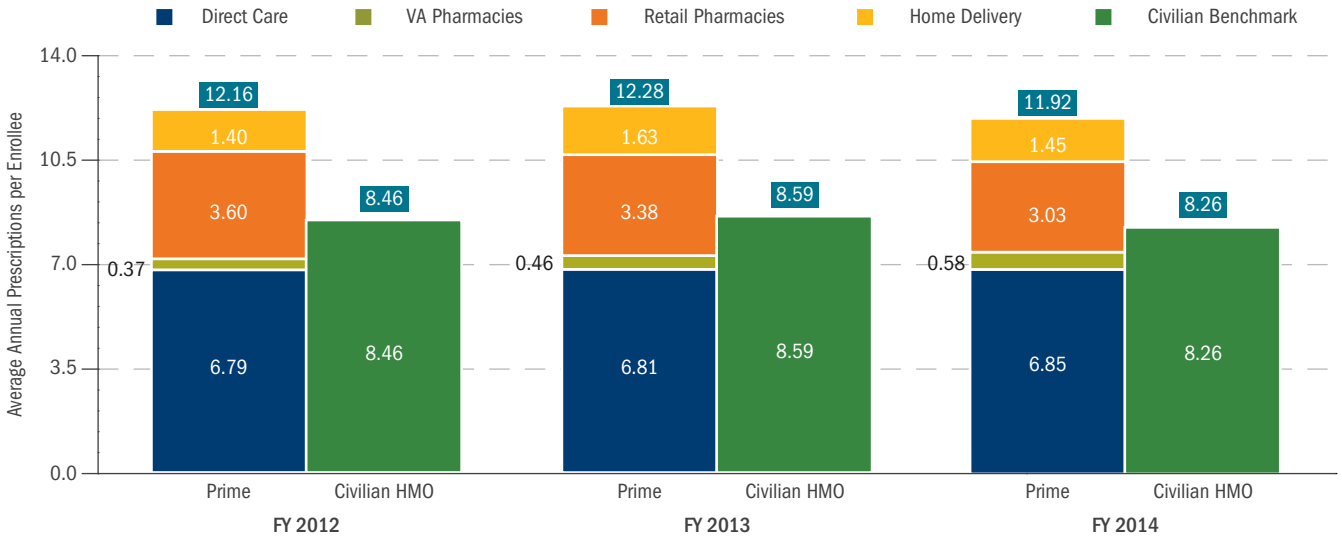
Direct care pharmacy data differ from private-sector claims in that they include over-the-counter medications. To make the utilization rates of MHS and civilian beneficiaries more comparable, over-the-counter medications were backed out of the direct care data using factors provided by the DHA Pharmacy 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. For the first time in this report, prescriptions filled at VA pharmacies are included (i.e., prescriptions filled as part of a beneficiary's VA benefit and paid for by the VA). Prescriptions that were filled at a VA pharmacy under the TRICARE benefit have always been included with retail pharmacy prescriptions. 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 care, VA, and purchased care combined) for TRICARE Prime enrollees fell by 2 percent between FY 2012 and FY 2014; the civilian HMO benchmark rate also fell by 2 percent. In FY 2014, the TRICARE Prime prescription utilization rate was 44 percent higher than the civilian HMO rate.
- Prescription utilization rates for Prime enrollees at DoD pharmacies rose by 1 percent between FY 2012 and FY 2014, whereas the utilization rate at retail pharmacies decreased by 16 percent (due to greater reliance on home delivery services).
- Prescription utilization rates for Prime enrollees at VA pharmacies rose by 57 percent (although the number of prescriptions is small) between FY 2012 and FY 2014. Not all of the increase is a result of higher utilization—a portion is due to improved data sharing between the VA and DoD pharmacy systems.
- Enrollee home delivery prescription utilization increased by 3 percent from FY 2012 to FY 2014. Historically, home delivery utilization has been small compared with other sources of prescription services. However, in FY 2014, home delivery accounted for 32 percent of per capita purchased care prescription utilization by Prime enrollees (as measured by 30-day supply).

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



Sources: MHS administrative data, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2014 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.)*

TRICARE Prescription Drug Utilization Rates Compared with Civilian Benchmarks *(Cont.)*

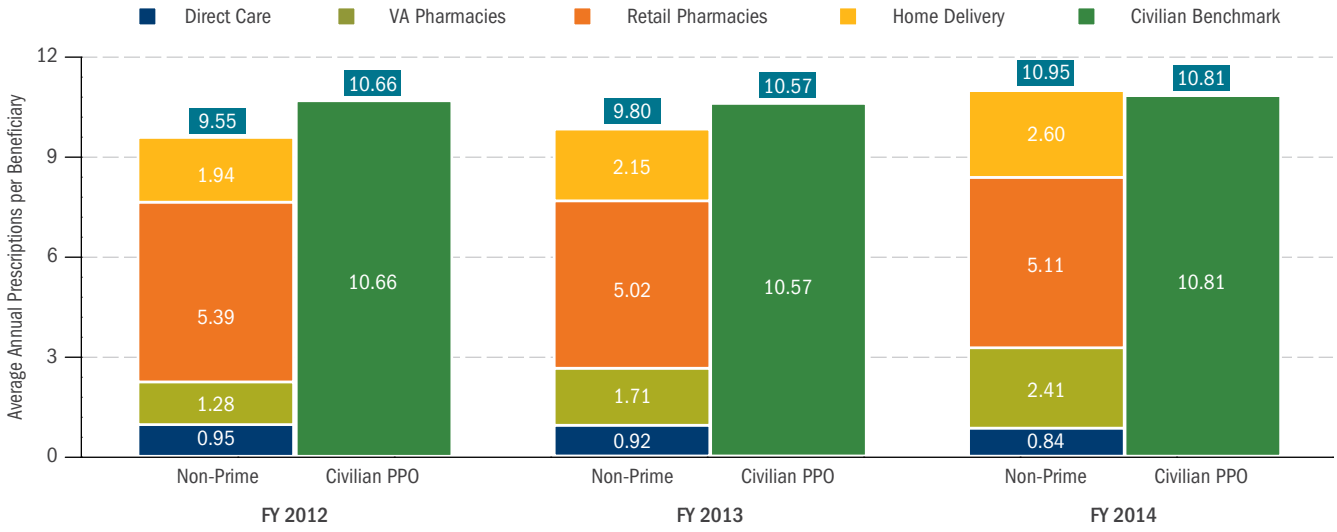
Non-Enrolled Beneficiaries

This section compares the prescription drug utilization of beneficiaries not enrolled in TRICARE Prime with that of participants in civilian employer-sponsored PPO plans. For the first time in this report, prescriptions filled at VA pharmacies are included (i.e., prescriptions filled as part of a beneficiary's VA benefit and paid for by the VA). Prescriptions that were filled at a VA pharmacy under the TRICARE benefit have always been included with retail pharmacy prescriptions. 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 17 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 prescription utilization rate (direct care, VA, and purchased care combined) for non-enrolled beneficiaries increased by 15 percent between FY 2012 and FY 2014. During the same period, the civilian PPO benchmark rate increased by 1 percent. In FY 2014, the TRICARE prescription utilization rate for non-enrollees was about the same as the civilian PPO rate.
- The direct care prescription utilization rate for non-enrolled beneficiaries increased by 5 percent from FY 2012 to FY 2014, whereas the utilization rate at retail pharmacies decreased by 5 percent (because of greater reliance on home delivery services).
- Prescription utilization rates for non-Prime enrollees at VA pharmacies almost doubled between FY 2012 and FY 2014. Not all of the increase is a result of higher utilization—a portion is due to improved data sharing between the VA and DoD pharmacy systems.
- Non-enrollee home delivery prescription utilization increased by 34 percent from FY 2012 to FY 2014. Historically, home delivery utilization has been small compared to other sources of prescription services. However, in FY 2014, home delivery accounted for 34 percent of per capita 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, 1/15/2015, and Truven Health Analytics Inc., MarketScan® Commercial Claims and Encounters (CCAE) database, 12/16/2014

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2014 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.

LOWER COST

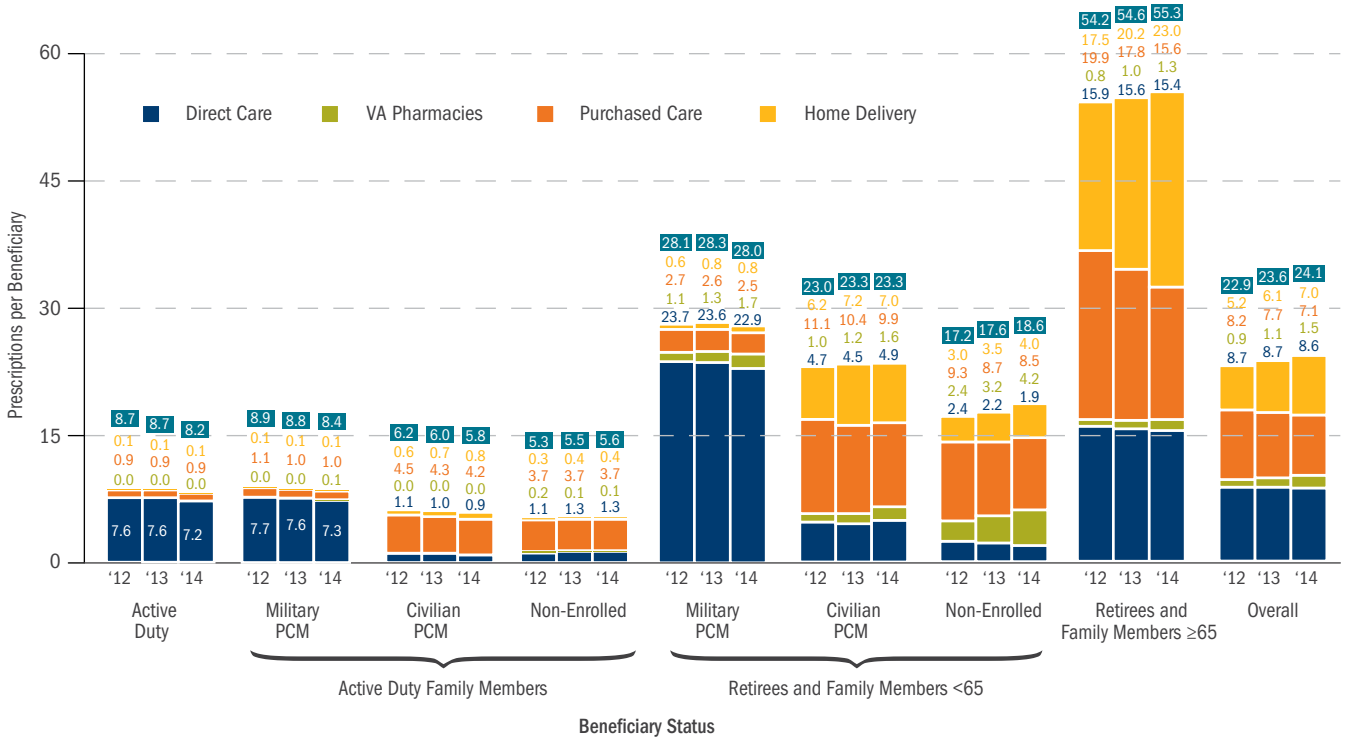
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

Prescriptions include all initial and refill prescriptions filled at military pharmacies, VA pharmacies (for DoD/VA dual-eligible beneficiaries), retail pharmacies, and home delivery. VA prescriptions include those filled as part of a beneficiary's VA benefit and paid for by the VA. Prescriptions that were filled at a VA pharmacy under the TRICARE benefit have always been included with retail pharmacy prescriptions. Prescription counts from all sources were normalized by dividing the total days supply for each by 30 days.

- The total (direct, VA, retail, and home delivery) number of prescriptions per beneficiary increased by 3 percent from FY 2012 to FY 2014, exclusive of the TFL benefit. Including TFL, the total number of prescriptions increased by 5 percent.
- The average direct care prescription utilization rate decreased by 1 percent between FY 2012 and FY 2014. However, the rate increased by 25 percent for non-enrolled ADFMs and by 3 percent for RETFMs under age 65 with a civilian PCM. Declines in the direct care prescription utilization rate were experienced by all other beneficiary groups.
- Average per capita prescription utilization through VA pharmacies increased by 74 percent from FY 2012 to FY 2014 but still accounts for only a small portion (6 percent) of total beneficiary utilization. Not all of the increase is a result of higher utilization—a portion is due to improved data sharing between the VA and DoD pharmacy systems.
- Average per capita prescription utilization through retail pharmacies decreased by 14 percent overall. Declines occurred for every beneficiary group except non-enrolled ADFMs, who had a 1 percent increase. The largest decline was for seniors (22 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 35 percent between FY 2012 and FY 2014, to the point where it now accounts for 50 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 32 percent of total purchased care prescription drug utilization, whereas for seniors it accounts for 60 percent.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FY)



Source: MHS administrative data, 1/15/2015

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

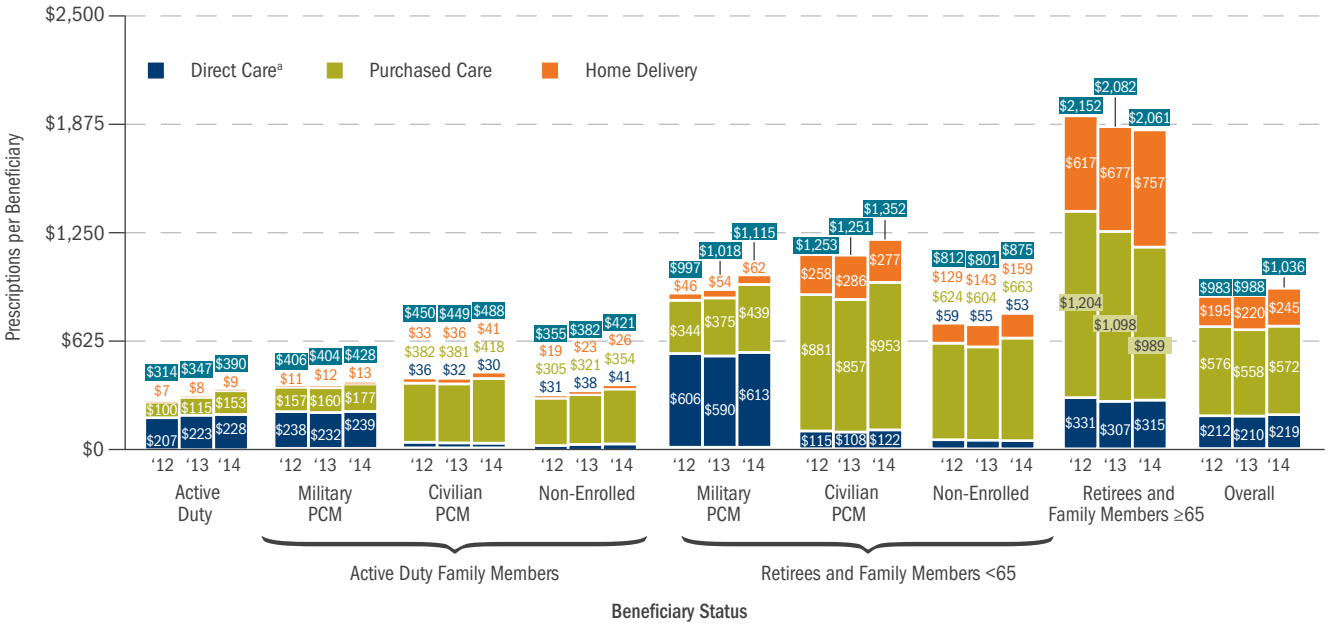
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS *(CONT.)*

Prescription Drug Cost by Beneficiary Status

Although the drug refunds referenced on page 29 have slowed the overall growth of retail prescription drug costs, the refunds are not reflected in the chart below because they cannot be attributed to specific beneficiary groups. Exclusive of refunds, overall MHS prescription drug costs (in then-year dollars) per beneficiary (far right columns below), including TFL, increased by 5 percent from FY 2012 to FY 2014.

- Exclusive of TFL, per capita prescription drug costs rose by 10 percent between FY 2012 and FY 2014. The largest increase (24 percent) occurred for ADSMs.
- Direct care costs per beneficiary increased by 3 percent, while retail pharmacy costs increased by 11 percent excluding TFL and decreased by 1 percent including TFL.
- Home delivery costs per beneficiary increased by 16 percent excluding TFL and by 26 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, 1/15/2015

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

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

LOWER COST

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).

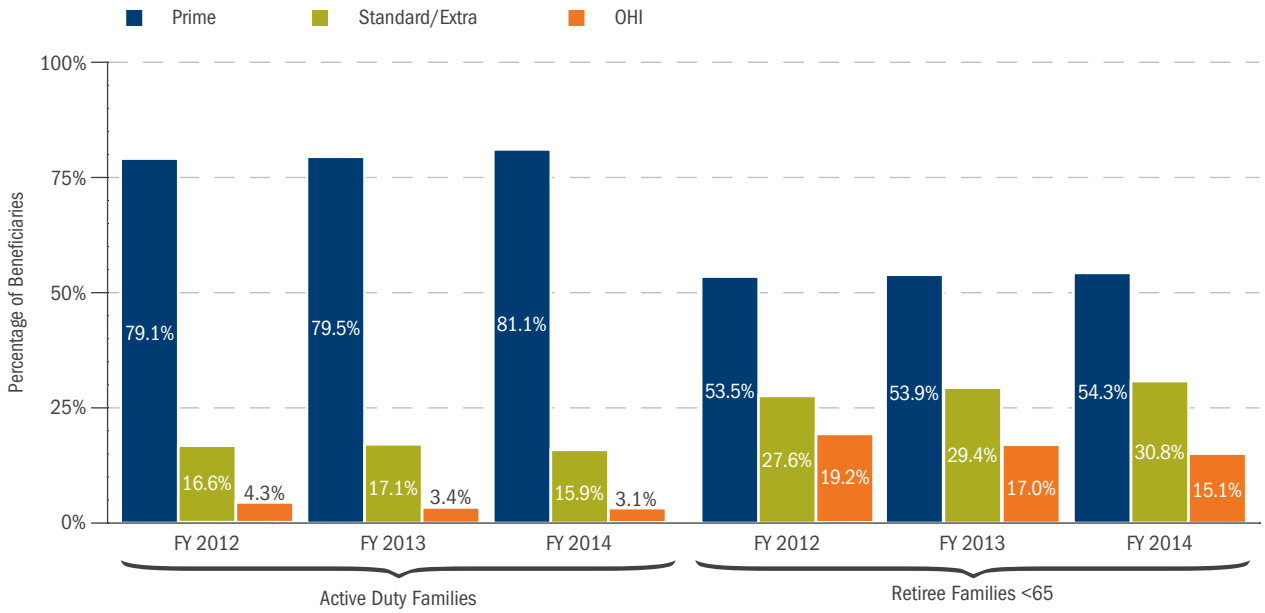
Health Insurance Coverage of MHS Beneficiaries Under Age 65

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 2014, 81.1 percent of Active Duty families and 54.3 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 2014, 15.9 percent of Active Duty families and 30.8 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2014, 3.1 percent of Active Duty families and 15.1 percent of retiree families were in this group.

HEALTH INSURANCE COVERAGE OF BENEFICIARIES UNDER AGE 65



Source: Insurance coverage in FYs 2012–2014 based on DEERS and Health Care Survey of DoD Beneficiaries (HCSDB) responses; as of 12/31/2014

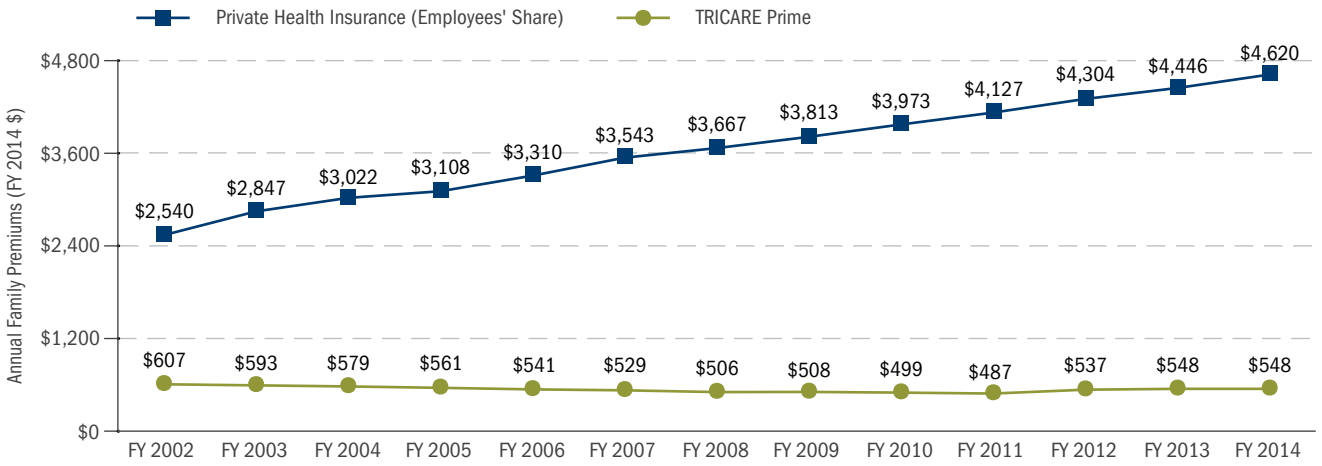
Note: The Prime group includes HCSDB respondents enrolled in Prime based on DEERS plus enrollees in the USFHP. The Standard/Extra group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes HCSDB respondents with private health insurance (i.e., Federal Employees 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 due to rounding.

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

Retirees and Family Members Under Age 65 Returning to 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, $539 in FY 2013, and $548 in FY 2014. In constant FY 2014 dollars, the private health insurance premium increased by $2,080 (82 percent) from FY 2002 to FY 2014, whereas the TRICARE premium declined by $59 (–10 percent) during this period.

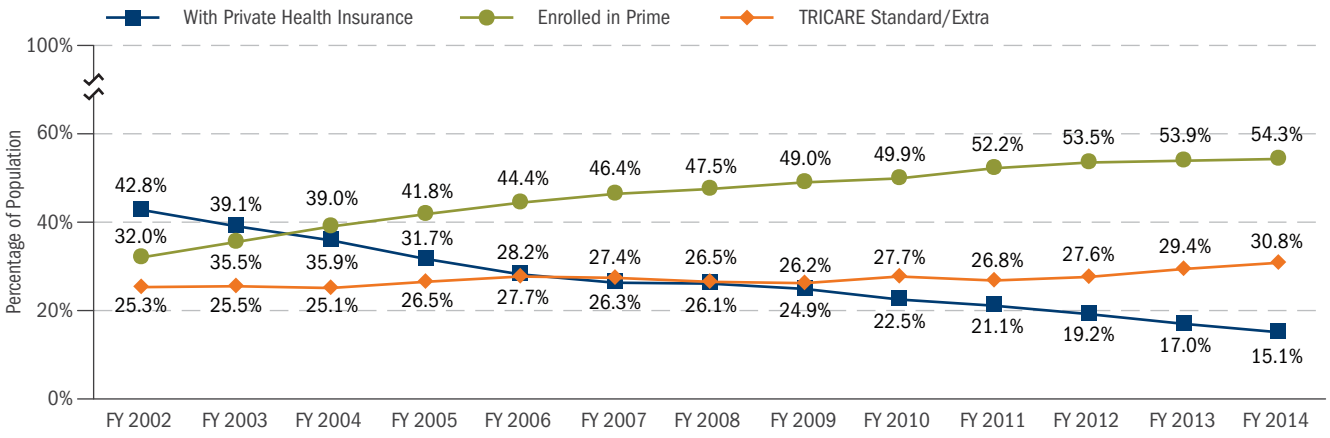
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Employees' share of insurance premium for typical employer-sponsored family health plan in FYs 2002–2013 from the Insurance Component of the Medical Expenditure Panel Surveys (MEPS) 2001–2013; OHI premiums in FY 2014 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2014

Between FY 2002 and FY 2014, 27.7 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 884,500 retirees and family members under age 65 are now relying primarily on TRICARE instead of on private health insurance.

TREND IN RETIREE (<65) HEALTH INSURANCE COVERAGE



Sources: Insurance coverage in FYs 2002–2014 based on DEERS and HCSDB responses; as of 12/31/2014

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 OHI to TRICARE, see Goldberg et al., Technical Review Version, "Demand for Health Insurance by Military Retirees," IDA Document D-5098, Log: H14-001368/1, December 2014 (draft; publication forthcoming).

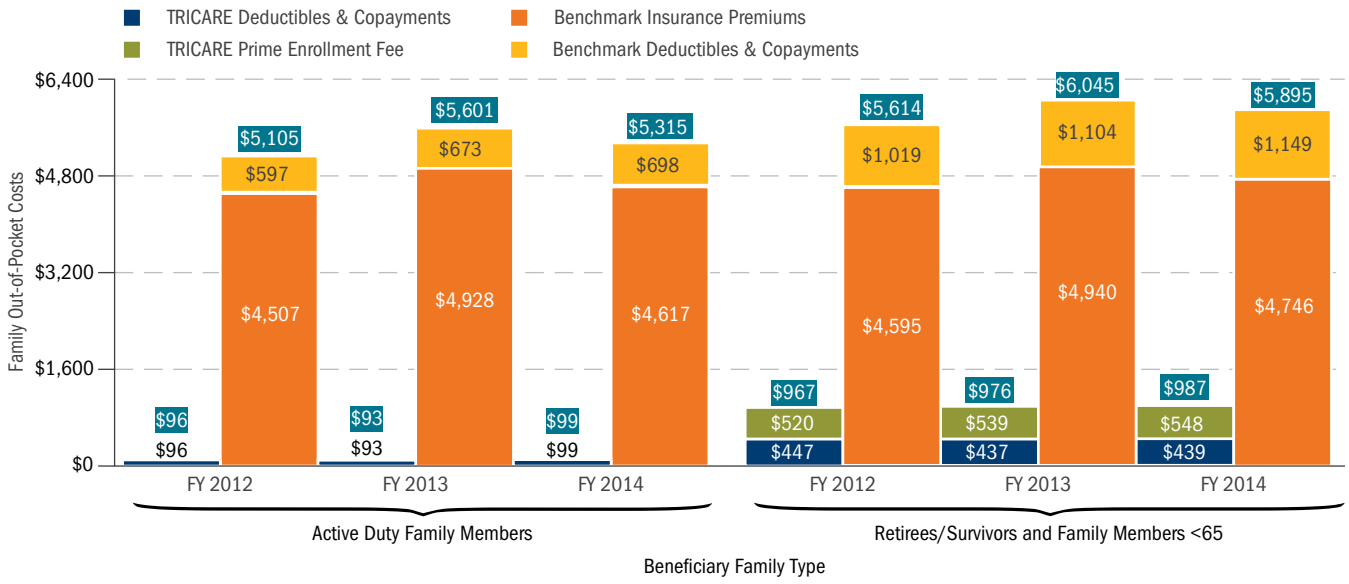
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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

In FYs 2012–2014, 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 2014, costs for civilian counterparts were:
  - $5,200 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 2012–2014 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 MEPS, actual MEPS in FY 2012 and projected MEPS in FYs 2013–2014; civilian benchmark insurance premiums in FYs 2012–2013 from the 2011–2013 Insurance Component of the MEPS; OHI premiums in FY 2014 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; as of 12/31/2014

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.

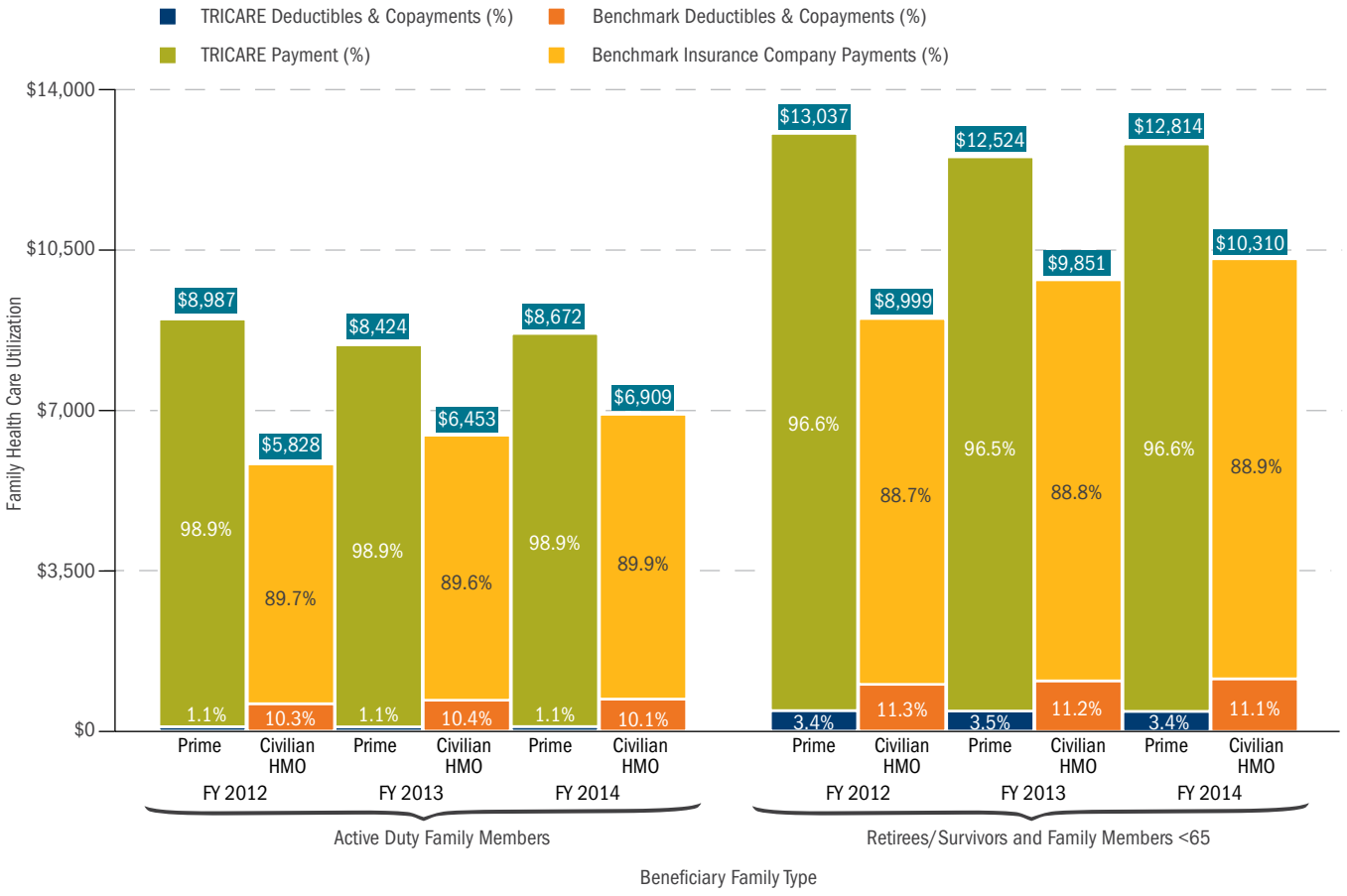
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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 2012–2014, 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 2014, the coinsurance rate for Active Duty families was 1.1 percent versus 10.1 percent for civilian counterparts.
  - In FY 2014, the coinsurance rate for retiree families was 3.4 percent versus 11.1 percent for civilian counterparts.
- TRICARE Prime enrollees had about 25 percent higher health care utilization than civilian HMO counterparts.
  - In FY 2014, Active Duty families consumed $8,700 of medical services versus $6,900 by civilian counterparts (25.5 percent higher).
  - In FY 2014, retiree families consumed $12,800 of medical services versus $10,300 by civilian counterparts (24.3 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 2012–2014 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 MEPS, actual MEPS in FY 2012, and projected MEPS in FYs 2013–2014; as of 12/31/2014. Dual-eligible retirees obtain some care at the Veterans Administration (VA), which is not included in MHS administrative data. Using regression analyses, the Institute for Defense Analyses estimated utilization at the VA in FYs 2012–2014 for retirees enrolled in Prime and included these estimates in total utilization, e.g., $380 per retiree family in FY 2014.

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

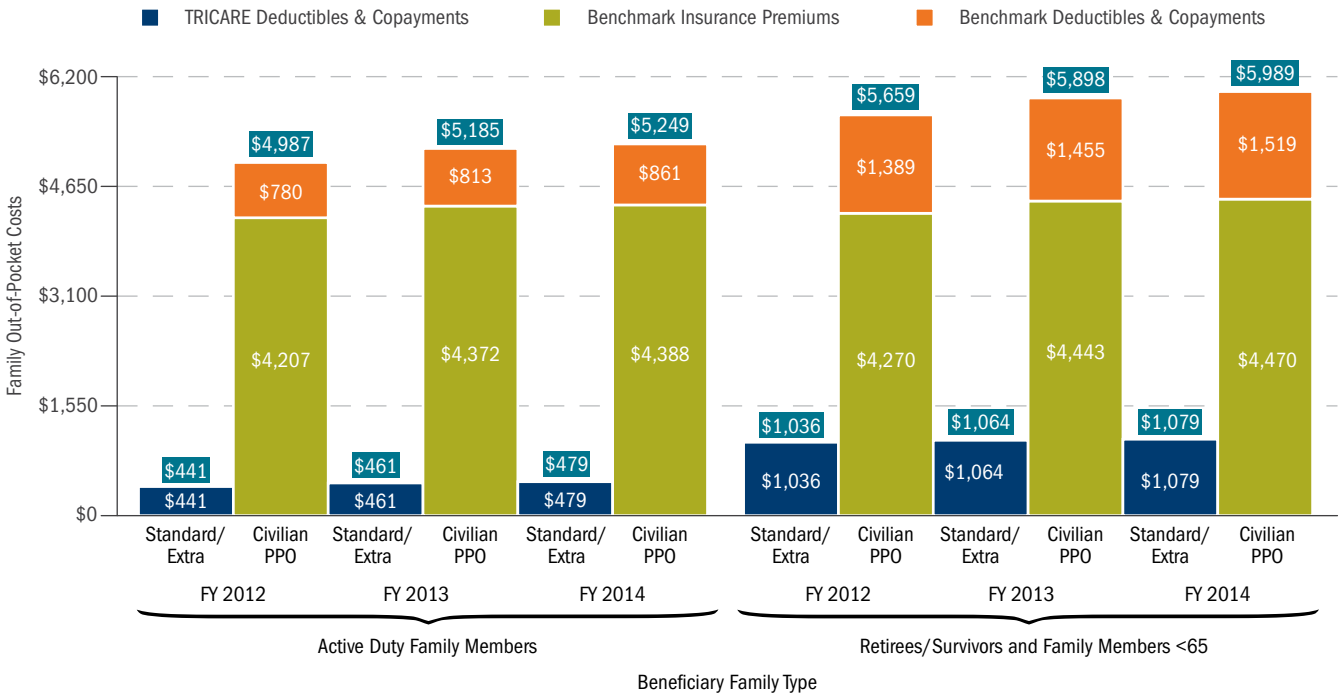
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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

From FY 2012 to FY 2014, civilian counterparts had much higher out-of-pocket costs than did TRICARE Standard/Extra users.

- Civilian PPO counterparts paid more for insurance premiums, deductibles, and copayments.
- In FY 2014, 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 2012–2014 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 MEPS, actual MEPS in FY 2012, and projected MEPS in FYs 2013–2014; civilian benchmark insurance premiums in FYs 2012–2013 from the 2011–2013 Insurance Component of the MEPS; OHI premiums in FY 2014 forecasted by the Institute for Defense Analyses based on trends in premiums from Kaiser Family Foundation surveys; insurance coverage from HCSDB, FYs 2012–2014; as of 12/31/2014

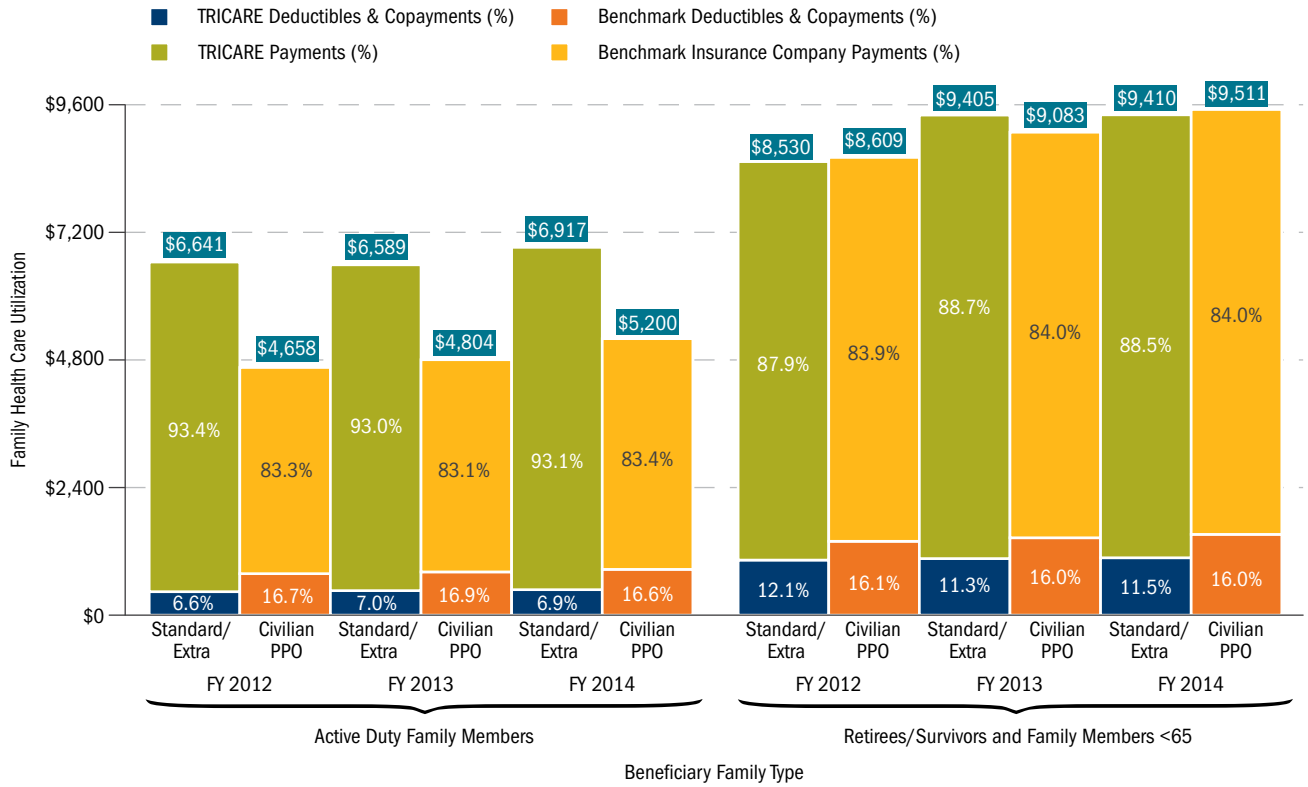
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (UNDER AGE 65) *(CONT.)*

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

In FYs 2012–2014, 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 2012–2014.

- In FY 2014, 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 2014, Active Duty families had a coinsurance rate of 6.9 percent versus 16.6 percent for civilian counterparts.
  - In FY 2014, the coinsurance rate for retiree families was 11.5 percent versus 16.0 percent for civilian counterparts.
- In FY 2014, health care utilization for TRICARE Standard/Extra families was higher (Active Duty) or similar (retiree) to that of civilian PPO counterparts.
  - In FY 2014, Active Duty families consumed $6,900 of medical services versus $5,200 by civilian counterparts (33 percent greater).
  - In FY 2014, both retiree families and civilian counterparts consumed about $9,500 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 2012–2014 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 MEPS, actual MEPS in FY 2012, and projected MEPS in FYs 2013–2014; as of 12/31/2014. Dual-eligible retirees obtain some care at the VA, which is not included in MHS administrative data. Using regression analyses, the Institute for Defense Analyses estimated utilization at the VA in FYs 2012–2014 for retirees not enrolled in Prime and included these estimates in total utilization, e.g., $473 per retiree family in FY 2014.

LOWER COST

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

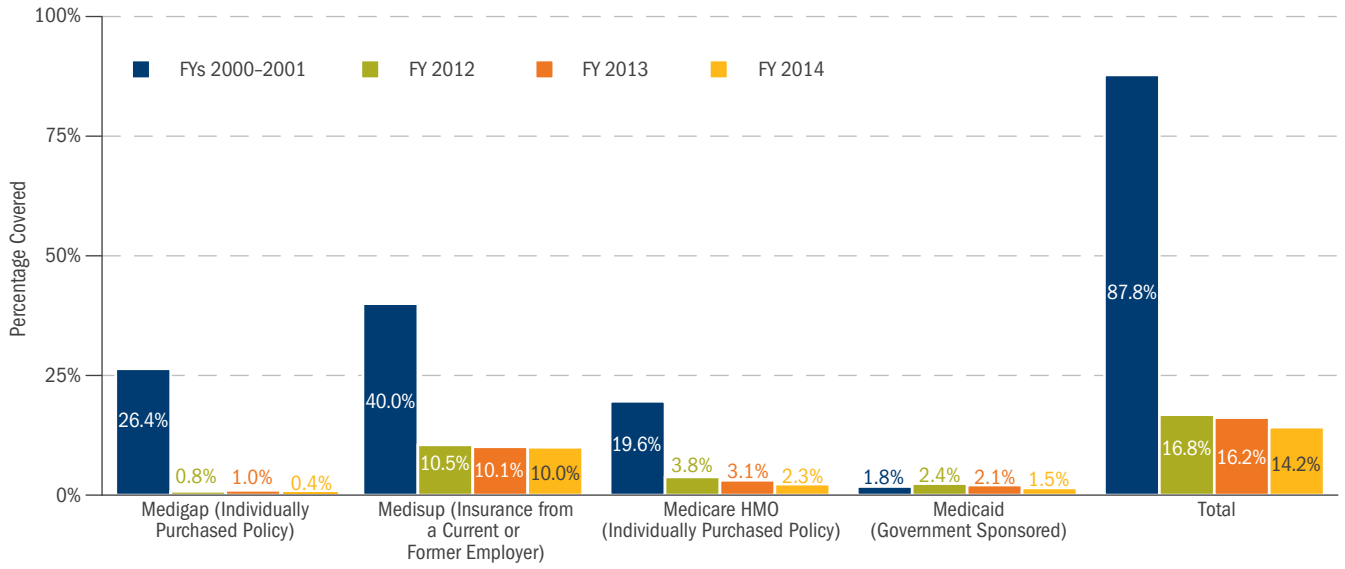
Out-of-pocket costs for retirees 65 and older (seniors) and their families include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and insurance premiums. In April 2001, DoD expanded drug benefits for seniors; on October 1, 2001, DoD implemented the TRICARE for Life (TFL) 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.[1] 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 14.2 percent in FY 2014.
- Why do 14.2 percent 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 2012–2014 HCSDB; as of 12/31/2014

[1] Medigap is an individually purchased policy that covers Medicare deductibles and co-pays. Medisup is group insurance from a current or former employer: it includes those with Medicare who are covered either by FEHBP, a civilian HMO such as Kaiser, or other civilian health insurance such as Blue Cross. Individually obtained HMO policies include Medicare Advantage, USFHP, and TRICARE Senior Prime (until December 2001). About 2 percent are covered by government sponsored Medicaid. About 1 percent of TRICARE seniors have OHI and are not covered by Medicare; these are excluded from the above figure; as of 12/31/2014.

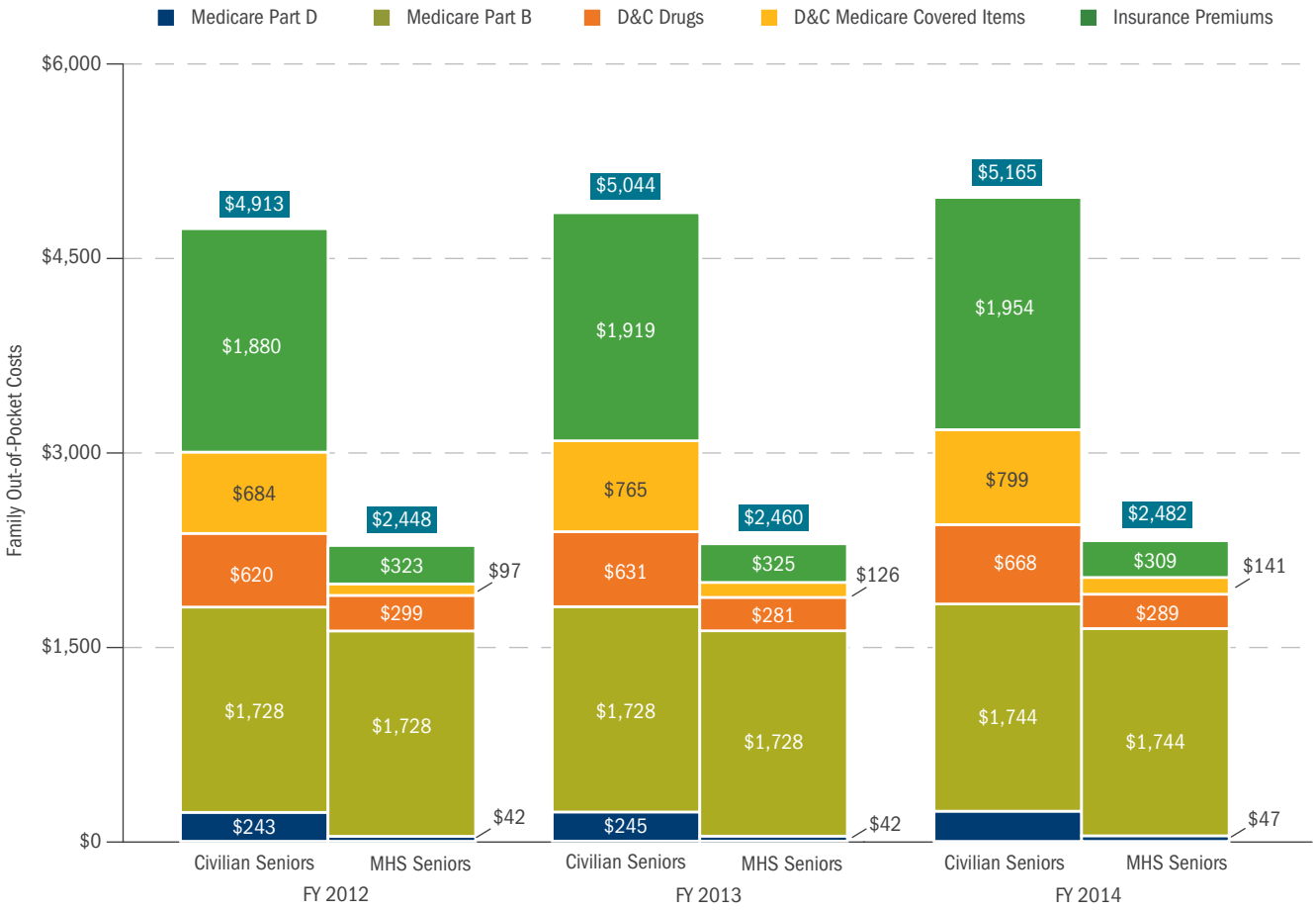
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

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

About 87 percent of TRICARE senior families use MHS healthcare. 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 MHS 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 2014, out-of-pocket costs for MHS senior families were 52 percent less than those of their "before TFL" civilian counterparts.
- In FY 2014, MHS senior families saved about $2,700 as a result of TFL and added drug benefits.

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



Sources: TRICARE senior family deductibles and copayments for MHS users in FYs 2012–2014 from MHS administrative data on all TRICARE senior families. For MHS non-users and civilian benchmark senior families, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2012, and projected MEPS in FYs 2013–2014; Medicare Part B and Medicare HMO premiums in FYs 2012–2014 from the Centers for Medicare and Medicaid Services; Medigap premiums in FYs 2012–2014 from Weiss Research, Inc.; Medisup premiums in FYs 2012–2014 from Tower Perrin Health Care Cost Surveys; Medicare Part D premiums in FYs 2012–2014 from Kaiser Family Foundation Surveys; Medicare supplemental insurance coverage, before and after TFL from HCSDB, FYs 2000, 2001, 2012–2014; as of 12/31/2014.

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.

LOWER COST

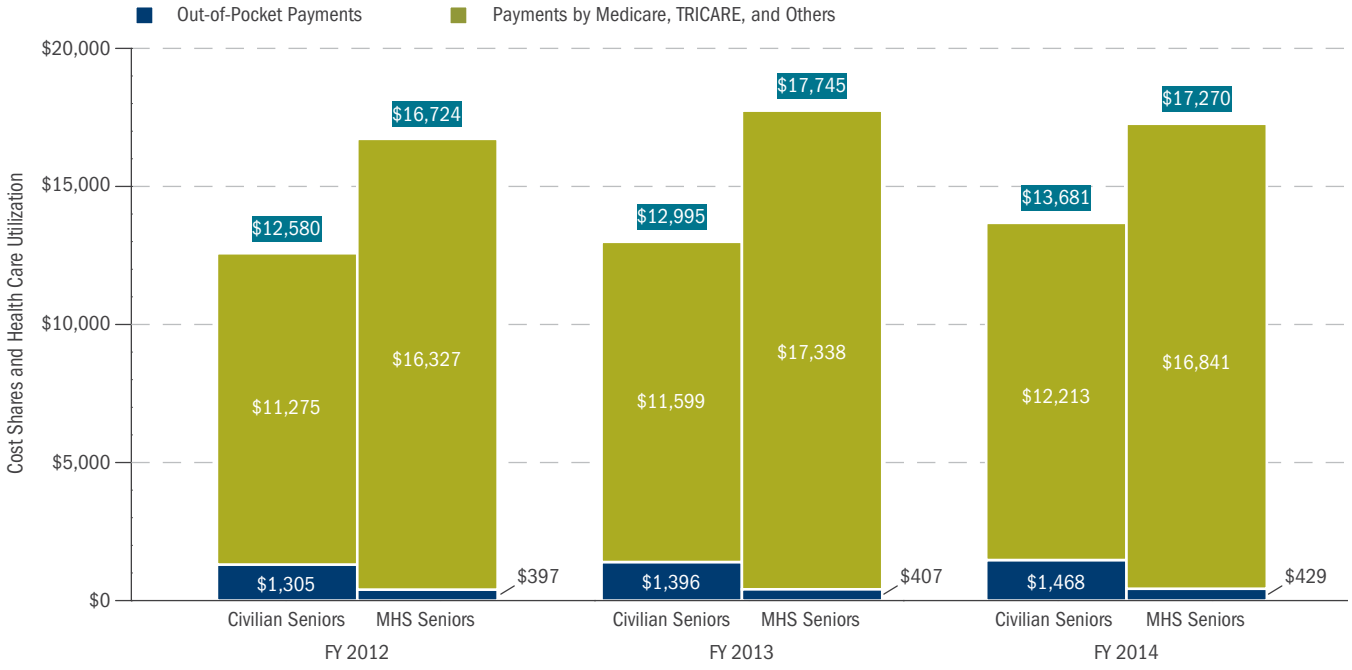
BENEFICIARY FAMILY HEALTH INSURANCE COVERAGE AND OUT-OF-POCKET COSTS (MHS SENIOR BENEFICIARIES) *(CONT.)*

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 2014, the coinsurance rate for MHS seniors was 2.5 percent; it was 10.7 percent for civilian counterparts.
- TRICARE senior families have relatively high health care utilization.
  - In FY 2014, MHS families consumed about 26 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 MHS users in FYs 2012–2014 from MHS administrative data on all TRICARE senior families. For MHS non-users and civilian benchmark senior families, utilization, deductibles and copayments by type of Medicare supplemental coverage from the Household Component of the MEPS, actual MEPS in FY 2012, and projected MEPS in FYs 2013–2014; Medicare supplemental insurance coverage, before and after TFL, from HCSDB, FYs 2000, 2001, 2012–2014; as of 12/31/2014.

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

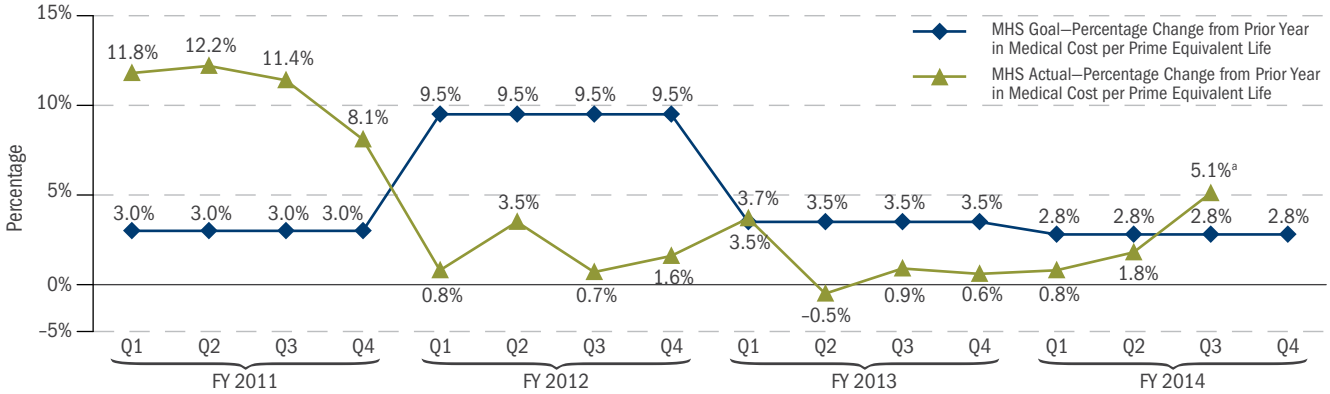
SYSTEM PRODUCTIVITY: MHS MEDICAL COST PER PRIME ENROLLEE

The goal of this financial and productivity metric supports the Quadruple Aim of managing lower costs. This metric, focusing on per capita costs, examines the extent to which MHS stays below a targeted annual rate of increase based on industry practice, including 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—the highest cost pharmacy venue. OPPS and refunds have provided short-term pricing decreases, but, as they are fully phased in, pricing will stabilize and utilization will again become a cost driver, as appears to be occurring as FY 2014 progresses.
- 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, unnecessary emergency department visits, 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 expected higher average premiums 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 around 1 percent and jumped to almost 4 percent in the last quarter of FY 2013. Starting in FY 2013, the MHS goal is 1 percentage point below the survey, so the goal for FY 2013 was reduced to an expected annual increase of 3.5 percent, and further reduced to 2.8 percent in FY 2014.
- The medical cost per member has remained below the goal for two consecutive years, 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 military providers produced only limited cost increases in the most expensive part of the care delivery process for the Department. While a preliminary third-quarter FY 2014 to FY 2013 comparison shows an increase due to utilization, the year to date remains below the goal. 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.

LOWER COST

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, dated 12/15/2014 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 2014 data are reported through June 2014 and are preliminary.

[a] Q3 FY 2014 actual represents preliminary reporting and is likely to decrease as data mature.

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 based on 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 2012–FY 2014) 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:
  - Surveys—Compiled 11/21/2014; results as of 10/1/2014 (HCSDB, APLSS, PSS), 08/31/2014 (SDA), and 3/31/2014 (TROSS)
  - Eligibility/enrollment data—12/17/2014
  - MHS workload/costs—1/15/2015
  - Web site uniform resource locators—1/9/2015
- The Defense Health Agency (DHA) 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

Comparison of DHA and Service Surveys: This report presents for the first time beneficiary-self-reported survey data from multiple sources, and, in so doing, offers different perspectives on how MHS assesses the beneficiary experience. Results on various survey-based measures include the Health Care Survey of DoD Beneficiaries (HCSDB), TRICARE Outpatient Satisfaction Survey (TROSS), Army Provider Level Satisfaction Survey (APLSS), Navy Patient Satisfaction Survey (PSS) and Air Force Service Delivery Assessment (SDA). The Service surveys results are not easily comparable to each other because of differences in questions and survey design, but do provide a high volume of results for reporting at the MTF, clinic, and provider level. Results from the TROSS and HCSDB compare beneficiary ratings of access using direct and purchased care venues.

- **The DHA HCSDB** is sent to a randomized sample of all MHS-eligible users and non-users via postal mail and e-mail with responses by mail and Web. Survey results are reported quarterly, with almost 41,000 respondents of about 202,000 beneficiaries surveyed in FY 2012 (21 percent raw response rate) and 26,621 respondents of about 151,000 beneficiaries surveyed in FY 2013 (almost 18 percent raw response rate across three quarters). Results can be estimated from the HCSDB for all beneficiary groups eligible for MHS benefits, whether they use direct care, purchased care, or other health insurance available to them, and are compared to benchmark results from a national sample of commercial civilian health plans administering the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan survey.
- **The DHA TROSS** is sent to a randomized sample of MHS beneficiaries following their outpatient

encounter in either direct or purchased care. Survey results are reported monthly with about 131,000 responses from about 590,000 annually surveyed in FY 2013 (22 percent raw annual response rate). Metric scores are compared to benchmarks established by the CAHPS Clinician and Group Surveys (C&GS).

- **Services Surveys:**
  - The APLSS is sent by postal mail and e-mail to approximately 2.5 million beneficiaries annually who have used Army military treatment facilities (MTFs), receiving about 675,000 responses (27 percent response rate) via mail, Web, or telephone.
  - The Air Force SDA surveys by telephone about 600,000 beneficiaries who have used Air Force (AF) MTFs, receiving about 189,000 responses (32 percent response rate).
  - The Navy PSS is sent by postal mail to about 1 million beneficiaries annual who have used Navy MTFs with about 200,000 replying by mail or Web (20 percent response rate).
- The results of the Services' outpatient surveys generally tend to reflect higher overall ratings by beneficiaries than reflected in the TROSS survey results, which may be due to the time horizon of the surveys. Although the Service and TROSS surveys are sent to beneficiaries following an outpatient visit, the Service surveys ask the beneficiary to rate the experience of care provided on that day of care by that provider, at that location; the TROSS, conforming to CAHPS protocol, asks the beneficiary to rate the experience of care in the past 12 months given the specific outpatient visit (provider, date, place). The HCSDB follows CAHPS-Plan protocol by similarly asking about the beneficiary's experience with care over the past 12 months if care was received during that time. Although the TROSS and HCSDB can compare responses across Services and between direct and purchased care, as well as to the CAHPS benchmark, because the same survey and methodology are used, their design is to report at the MTF level and higher; in other words, they have more of an enterprise focus.

Health Care Survey of DoD Beneficiaries (HCSDB)

The HCSDB was developed by the TRICARE Management Activity (TMA) to fulfill the 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 was conducted on a quarterly basis (every January, April, July, and October). Due to budget reductions, the HCSDB was not fielded in July 2013 and July 2014, so the annual results are based on three fiscal quarters, compared with FY 2012, which was 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 administered in 2012 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.

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*. About three-fourths of HCSDB questions have been closely modeled on the CAHPS program, in wording, response choices, and sequencing. 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.

Results provided from HCSDB in FYs 2012 and 2013 were based on questions taken from the CAHPS Version 4.0 Questionnaire, while the FY 2014 fielding of the HCSDB was based on CAHPS Version 5.0. Rates are compared with the most recent benchmarks of the same version available at the beginning of the survey year. The HCSDB results for FY 2012 and FY 2013 (using CAHPS Version 4.0) were benchmarked to CAHPS Version 4.0 surveys conducted in 2011 and results for FY 2014 (using CAHPS Version 5.0) were benchmarked to CAHPS Version 5.0 surveys conducted in 2013. Because of the changes in the questionnaire, changes in rates are only meaningful when compared to changes in the relevant benchmark. CAHPS Version 4.0 benchmarks were obtained from the National CAHPS Benchmarking Database (NCBD). CAHPS Version 5.0 benchmarks were obtained from the National Committee for Quality Assurance (NCQA).

Although the benchmark data files for CAHPS Versions 4.0 and 5.0 were obtained from different organizations, their contents and specifications are consistent, and the same selection criteria and methods were used to calculate benchmarks from both. The NCBD collects CAHPS results voluntarily submitted by participating health plans and is funded by AHRQ and administered by a contractor. NCQA's file also contains voluntarily submitted health plan survey results. Only health maintenance organization (HMO), preferred provider organization (PPO), and HMO/point-of-service (POS) plans from either source are used in the calculation of the benchmark scores. Both benchmarks and TRICARE results are adjusted for age and health status. Differences between 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. Tests are performed using a z-test and standard errors are calculated using SUDAAN to account for the complex stratified sample. If p is less than 0.05, the difference is significant.

The HCSDB has been reviewed by an Internal Review Board (and found to be exempt) and is licensed by DoD. Beneficiaries' health plans are identified from a combination of self-reported 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 FYs 2011, 2012, 2013, and 2014 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.

Preventable admission rates are calculated using both direct (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 2015 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 2014, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2014 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.

DRG Grouping Methodology

In the section that displays the "Top 25" inpatient diagnosis groups, Diagnosis Related Groups (DRGs) are grouped into descriptively (but not necessarily clinically) similar categories using a code set available on *www.findacode.com/code-set.php?set=DRG*, an online database of medical billing codes and information. The site lists DRGs within each Major Diagnostic Category (MDC), with headings above diagnostically related DRGs. These headings provide a broad description of the DRGs underneath and distinguish between medical and surgical DRGs, but do not distinguish among DRGs with different (or any) levels of complications and co-morbidities. For the purposes of this report, the DRGs were too detailed and the MDCs too broad to provide the reader with a general sense for the most common inpatient diagnoses MHS confronts; therefore, the headings were used as the basis for broadening the groupings in this report into descriptively related categories, without regard for whether they are medical or surgical, whether there are complications or not, or which parts of the body are affected. For example, the "ECMO or Tracheostomy" group includes DRGs 003, 004, 011, 012, and 013. The description for each of those DRGs includes the words "ECMO" or "Tracheostomy"—some with complications, some without; some for face, mouth, and neck; and some for other parts of the body. Once all the groups were formed, they were numbered sequentially following the order in which they were presented on the Web site. This resulted in a reduction from 818 DRGs to 284 DRG groups.

ABBREVIATIONS

ABA	Applied Behavior Analysis | 8
AC	Active Component | 33
ACA	Affordable Care Act | 7
AD	Active Duty | 11
ADE	Adverse Drug Event | 55
ADFM	Active Duty Family Member | 11
ADSM	Active Duty Service Member | 5
AHRQ	Agency for Healthcare Research and Quality | 50
AMI	Acute Myocardial Infarction | 43
APLSS	Army Provider Level Satisfaction Survey | 35
ASD	Autism Spectrum Disorder | 8
BACB	Behavior Analyst Certification Board | 41
BCBA	Board Certified Behavior Analyst | 41
BCaBA	Board Certified Assistant Behavior Analyst | 41
BMI	Body Mass Index | 65
BPSM	Basic Patient Safety Manager | 55
BRAC	Base Realignment and Closure | 18
C&G	Clinician and Group | 50
CAC	Children's Asthma Care | 43
CAD	Catchment Area Directory | 17
CAHPS	Consumer Assessment of Healthcare Providers and Systems | 35
CAPER	Comprehensive Ambulatory/Professional Encounter Record | 101
CC	Complication/Co-morbidity | 82
CCAE	Commercial Claims and Encounters | 78
CDC	Centers for Disease Control and Prevention | 27
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services | 5
CHF	Congestive Heart Failure | 68
CLABSI	Central Line-Associated Bloodstream Infection | 55
CMS	Centers for Medicare and Medicaid Services | 23
CMSP	Clinical Measures Steering Panel | 66
CoP	Communities of Practice | 55
COPD	Chronic Obstructive Pulmonary Disease | 68
CPT	Current Procedural Terminology | 46
CY	Calendar Year | 4
DACT	Defense Advisory Committee on Tobacco | 69
DCoE	Defense Centers of Excellence | 8
DEERS	Defense Enrollment Eligibility Reporting System | 7
DHA	Defense Health Agency | 3
DHHS	Department of Health and Human Services | 66
DHP	Defense Health Program | 13
DM	Disease Management | 66
DMDC	Defense Manpower Data Center | 59
DoD	Department of Defense | 2
DRG	Diagnosis Related Group | 25
DTF	Dental Treatment Facility | 64
EASIV	Expense Assignment System IV | 101
EBP	Evidence-Based Practice | 55
ECHO	Extended Care Health Option | 41
EFMP	Exceptional Family Member Program | 10
EHHC	ECHO Home Health Care | 41
EIA	Educational Interventions for Autism Spectrum Disorders | 41
EIC	External Independent Contractor | 77
eMSM	Enhanced Multi-Service Market | 52
ER	Emergency Room | 27
FDA	Food and Drug Administration | 46
FEHBP	Federal Employees Health Benefits Plan | 92
FTE	Full-Time Equivalent | 62
FY	Fiscal Year | 7
GAO	Government Accountability Office | 59
GRDFM	Guard/Reserves and Family Members | 15
HA	Health Affairs | 33
HAC	Hospital-Acquired Conditions | 55
HBI	Healthy Base Initiative | 66
HBV	Hepatitis B Virus | 7
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems | 51
HCSDB	Health Care Survey of DoD Beneficiaries | 35
HCUP	Healthcare Cost and Utilization Project | 72
HEDIS	Healthcare Effectiveness Data and Information Set | 66
HF	Heart Failure | 43
HIPAA	Health Insurance Portability and Accountability Act | 62
HIV	Human Immunodeficiency Virus | 7
HMO	Health Maintenance Organization | 78
HP	Healthy People | 65
HRET	Health Research and Educational Trust | 101
IDES	Integrated Disability Evaluation System | 7
IHI	Institute for Healthcare Improvement | 7
IMR	Individual Medical Readiness | 33
IOC	Initial Operational Capability | 1
LDT	Laboratory Developed Test | 8
LJWG	Laboratory Joint Working Group | 46
LOS	Length of Stay | 78
LVS	Left Ventricular Systolic | 44
MCSC	Managed Care Support Contractor | 9
MDC	Major Diagnostic Category | 106
MDR	MHS Data Repository | 17
MEC	Minimum Essential Coverage | 7
MED/SURG	Medical/Surgical | 78
MEPS	Medical Expenditure Panel Surveys | 93
MERHCF	Medicare-Eligible Retiree Health Care Fund | 13
MHS	Military Health System | 2
MS-DRG	Medicare Severity Diagnosis Related Group | 25
MTF	Military Treatment Facility | 4
NADFM	Non-Active Duty Family Member | 42
NAL	Nurse Advice Line | 37
NCBD	National CAHPS Benchmarking Database | 35
NCQA	National Committee for Quality Assurance | 35

ABBREVIATIONS *(CONT.)*

NCR	National Capital Region | 3
NDAA	National Defense Authorization Act | 7
NHANES	National Health and Nutrition Examination Survey | 71
NHE	National Health Expenditures | 23
NIS	National Inpatient Sample | 72
NMCPHC	Navy and Marine Corps Public Health Center | 9
NOTO	Number of Times Occurred | 54
NPI	National Provider Identifier | 62
NPS	National Prevention Strategy | 65
OASD	Office of the Assistant Secretary of Defense | 33
OB	Obstetric | 26
OB/GYN	Obstetrician/Gynecologist | 78
OCO	Overseas Contingency Operations | 22
OCONUS	Outside the Continental United States | 64
OHI	Other Health Insurance | 20
OLW	Operation Live Well | 65
O&M	Operations and Maintenance | 22
OPPS	Outpatient Prospective Payment System | 31
OTC	Over-the-Counter | 11
OTC Demo	Over-the-Counter Demonstration | 11
PB&E	Program, Budget, and Execution | 22
PCI	Percutaneous Coronary Intervention | 44
PCM	Primary Care Manager | 5
PCMH	Patient-Centered Medical Home | 36
PDTS	Pharmacy Data Transaction Service | 29
PEP	Projections of Eligible Population | 16
PfP	Partnership for Patients | 55
PH	Psychological Health | 23
PI	Program Integrity | 77
PL	Public Law | 1
PN	Pneumonia | 43
POD	Pharmacy Operations Directorate | 88
POS	Point-of-Service | 5
PPO	Preferred Provider Organization | 79
PRISM	Provider Requirement Integrated Specialty Model | 17
PSA	Prime Service Area | 7
PSM	Patient Safety Manager | 55
PSP	Patient Safety Program | 54
PSR	Patient Safety Reporting | 54
PSS	Patient Satisfaction Survey | 35
PSYCH	Mental Health | 78
PTSD	Post-Traumatic Stress Disorder | 8
RA/OA	Rheumatoid/Osteoarthritis | 72
RC	Reserve Component | 4
RCCPDS	Reserve Components Common Personnel Data System | 60
RDT&E	Research, Development, Test and Evaluation | 22
RETFMs	Retirees and Family Members | 14
RVU	Relative Value Unit | 26
RWP	Relative Weighted Product | 25
SADR	Standard Ambulatory Data Record | 101
SCIP	Surgical Care Improvement Project | 43
SecDef	Secretary of Defense | 69
SIDR	Standard Inpatient Data Record | 105
SMHC	Supervised Mental Health Counselors | 8
T2	National Center for Telehealth and Technology | 9
TAMP	Transitional Assistance Management Program | 5
TBI	Traumatic Brain Injury | 7
TCMHC	TRICARE Certified Mental Health Counselors | 8
TDP	TRICARE Dental Program | 5
TED	TRICARE Encounter Data | 58
TED-I	TRICARE Encounter Data-Institutional | 73
TTFL	TRICARE for Life | 6
TMA	TRICARE Management Activity | 28
TPharm4	TRICARE Pharmacy Program, Fourth Generation | 6
TPR	TRICARE Prime Remote | 5
TRDP	TRICARE Retiree Dental Program | 5
TRISS	TRICARE Inpatient Satisfaction Survey | 35
TRO	TRICARE Regional Office | 5
TROSS	TRICARE Outpatient Satisfaction Survey | 35
TRR	TRICARE Retired Reserve | 5
TRS	TRICARE Reserve Select | 5
TSC	TRICARE Service Centers | 6
TYA	TRICARE Young Adult | 5
UCC	Urgent Care Center | 8
UMP	Unified Medical Program | 22
USCG	United States Coast Guard | 8
USD(P&R)	Under Secretary of Defense for Personnel and Readiness | 33
USFHP	Uniformed Services Family Health Plan | 5
VA	Department of Veterans Affairs | 77
VAE	Ventilator-Associated Event | 55
VTE	Venous Thromboembolism | 55
WPS	Wisconsin Physicians Service |6

The **Evaluation of the TRICARE Program: Fiscal Year 2015 Report to Congress** is provided by the Defense Health Agency, Decision Support Division, 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.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program*.

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