

Evaluation of the TRICARE Program



FY 2005
Report to Congress



Evaluation of the **TRICARE** Program

March 1, 2005

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



I am pleased to provide Congress with this annual report assessing the effectiveness of TRICARE performance between Fiscal Years (FY) 2002 and 2004 in improving the access to and quality of health care received by our beneficiaries. This report responds to the National Defense Authorization Act (NDAA) for FY 1996 (Section 717) requiring such an assessment following the 1994 evolution, development, and deployment of the TRICARE managed care program.

This report reflects my commitment to a disciplined focus on performance results based on targeted metrics. Similar to last year's evaluation, this report presents many of the Balanced Scorecard metrics I rely on to measure near- and mid-term performance in those areas determined as critical to our longer-term TRICARE goals. I firmly believe the linkage of TRICARE performance through standardized metrics assessed over

time, and, where relevant, comparison with civilian-sector benchmarks, is critical to achieving my vision for a world class Military Health System (MHS).

The mission of the MHS in supporting the security of our nation is reflected in our commitment to individual and unit medical readiness to ensure the health and well-being of our Active Component (AC) and mobilized Reserve and Guard personnel. The Surgeons General of the Army, Navy, and Air Force and I are fully committed to the philosophy that the health and well-being of our fighting forces extends to the care and wellness of their family members, retirees, and their family members. These beneficiaries are integral to the readiness mission and to the recruitment and retention of soldiers, sailors, airmen, and marines. The successful performance of our TRICARE health benefits program is instrumental in accomplishing this mission.

MISSION

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

VISION

A world class health system that supports the military mission by fostering, protecting, sustaining, and restoring health.

KEY PRIORITIES AND GOALS

- Improve force health protection and medical readiness;
- Improve performance of the TRICARE health program;
- Improve coordination, communication, and

In 2004, I emphasized the following key TRICARE priorities:

- Ensure a smooth transition to new TRICARE contracts as we consolidated regions and contractors, while implementing a new governance and organizational structure.
- Ensure TRICARE is readily accessible to the family members of National Guard and Reservists who are mobilized and
- collaboration with other key entities; and
- Address issues related to the attraction, retention, and appropriate training of military medical personnel.
- deployed in support of the Global War on Terrorism.
- Engage DoD leadership to create a culture of change embracing healthy communities and lifestyles.
- Emphasize "managing the business" and critical programs to ensure adequate funding and to promote increased efficiencies.

MHS STRATEGY ARCHITECTURE

I rely on a Balanced Scorecard approach as a useful framework for translating our MHS strategy into operational objectives to drive performance improvement in our system. This Balanced Scorecard is predicated on seven perspectives or “themes” underlying our MHS strategy as shown below: Stakeholders, Financial, External Customers, Readiness, Quality, Efficiency, and Learning and Growth (for our internal customers). These themes provide the framework for this year’s Report, and their supporting metrics are reflected throughout. Although we track these metrics every month, they are presented in this report on an annual basis to provide clearer understanding of critical long-term trends in our performance.

MHS STRATEGY ARCHITECTURE

STAKEHOLDER PERSPECTIVE

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

Goal:

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

FINANCIAL PERSPECTIVE

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

Goals:

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

EXTERNAL CUSTOMER PERSPECTIVE

Our customers are the Armed Forces and all those entrusted to our care.

Goals:

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

INTERNAL PERSPECTIVE

READINESS THEME

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

Goals:

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

QUALITY THEME

Ensure benchmark standards for health and health care are met.

Goals:

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

EFFICIENCY THEME

Obtain maximum effectiveness from the resources we are given.

Goals:

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

LEARNING AND GROWTH PERSPECTIVE (INTERNAL CUSTOMERS)

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

Goals:

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

EXECUTIVE SUMMARY: KEY FINDINGS FY 2004

Stakeholder Perspective

Beneficiary and Plan Enrollment Trends

- The number of beneficiaries eligible for DoD medical care increased from 8.7 million at the end of FY 2002 to 9.2 million by the end of FY 2004. The increase is largely due to the mobilization of large numbers of Guard/Reserve members and the extension of benefits to their family members. The number differs from last year's estimate of 9.1 million beneficiaries (Ref. page 15).
- Because of base closures and changes in the beneficiary mix over time, there has been a downward trend in the number of beneficiaries living in MTF catchment areas (i.e., within about 40 miles of a military hospital). This trend has implications for the proportion of workload performed in direct and purchased care facilities.
 - Active duty family members (ADFM) and retirees and family members under age 65 experienced the largest declines in the number living in catchment areas (decreasing by 16.9 percent and 17.5 percent, respectively, since 1998) (Ref. page 18).
 - The continued mobilization of National Guard and Reserve members has contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when called to active duty and their families continue to live there.
- Over 5 million beneficiaries, or about 70 percent of the MHS population eligible for TRICARE Prime, were enrolled by the end of FY 2004 (Ref. page 19).

Financial Perspective

Unified Medical Program Funding Trends

- The Unified Medical Program (UMP) increased from \$26.7 billion in FY 2003 to \$30.2 in FY 2004 and is programmed to reach almost \$31 billion in FY 2005 (est.). FY 2003 and FY 2004 funding includes the receipts from the Uniform Services DoD Medicare-Eligible Retiree Health Care Fund, known as the "Accrual Fund," as well as

funding in support of the Global War on Terrorism (GWOT) (Ref. page 21).

- In constant FY 2005 dollars, FY 2005 funding is currently programmed at less than the previous year's purchasing value, reflective of the GWOT funding the previous year (Ref. page 21).
- UMP expenditures rose from 6.7 percent of DoD Total Obligational Authority (TOA) in FY 2002 to 7.6 percent estimated for FY 2005, when the Accrual Fund is included. When the Accrual Fund is excluded, the UMP, while still increasing between FY 2003 and FY 2005, actually grew at a lower rate in FY 2005 (6.3 percent) than in FY 2002 (6.7 percent) (Ref. page 22).
- The UMP experienced a large increase in Defense Health Program Operations and Maintenance in FY 2002 due to commencement of the TFL program. TFL was subsequently funded by the accrual fund beginning in FY 2003. In FY 2003 and FY 2004 the rates of growth in UMP expenditures were 12.5 and 13.4 percent, respectively (including GWOT and TFL funding) (Ref. page 22).

MHS Workload Trends and Impact of New Benefits from FY 2002 to FY 2004

- Overall MHS workload increased for all major components of care between FY 2002 and FY 2004. Total inpatient dispositions (direct and purchased care combined) increased by 7 percent between FY 2002 and FY 2004 and an intensity-weighted measure of dispositions increased by 8 percent (both excluding TFL workload). Total outpatient encounters increased by 12 percent and an intensity-weighted measure of encounters increased by 5 percent. Finally, total MHS prescription workload (direct, retail, and mail-order combined) increased by 13 percent, excluding the TRICARE Senior Pharmacy (TSRx) benefit workload, discussed below (Ref. pages 23–24).
- Direct care inpatient and outpatient workloads remained essentially unchanged between FY 2002 and FY 2004, while direct care prescription workload rose by 3 percent in FY 2003 and by another 2 percent in FY 2004 (Ref. page 23–24).

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2004 (CONT'D)

- For inpatient, outpatient, and prescription drug care costs, the proportion of total health care costs provided in DoD facilities declined between FY 2002 and FY 2004. Overall, the proportion of direct care costs to total costs (direct and purchased care) declined from 65 percent to 60 percent during this time, with the greatest percentage shift occurring for prescription drugs (Ref. page 25).
- Most DoD Medicare-eligible beneficiaries have already taken advantage of the TFL benefit, with about 80 percent filing health care claims in each year from FY 2002 to FY 2004 (Ref. page 26).
- The percentage of TFL-eligible beneficiaries filing at least one claim for prescriptions under the TSRx benefit continued to rise, from 57 percent in FY 2002 to 70 percent in FY 2004 (Ref. page 26).
- Prescription drugs (direct and purchased care) accounted for more than half (53 percent) of the \$4.7 billion in TFL/TSRx expenditures in FY 2004 (Ref. page 27).

External Customer Perspective

Overall Customer Satisfaction With TRICARE

- MHS beneficiary satisfaction with the overall TRICARE plan, as well as with one's health care and primary and specialty care physicians, continues to improve each year, but still trails the respective civilian benchmark (Ref. page 29).
 - In FY 2004, MHS beneficiaries enrolled with civilian network providers reported a higher level of satisfaction than the civilian benchmark (Ref. page 30).
 - Satisfaction with TRICARE increased for all beneficiary groups between FY 2003 and FY 2004, and the satisfaction levels for Active Duty Family Members (ADFM) and retirees were about the same as or higher than the civilian benchmarks (Ref. page 31).

Building Healthy Communities

- The MHS has made steady progress in the 22-year period studied (from 1980 to 2002) in reducing substance use and its associated problems. Although there has not been

a notable drop in alcohol substance abuse during this 22-year period, there has been a statistically significant reduction in cigarette smoking and use of illicit drugs. There is, however, an increase in reported smoking and heavy alcohol use since the last survey in FY 1998 (Ref. page 32).

Meeting Preventive Care Standards

- Over the past three years, the MHS has met or exceeded targeted Healthy People 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories) and testing for cholesterol. Efforts continue for achieving such standards for Pap smears, prenatal exams, flu shots (for people age 65 and older) and blood pressure screenings. Other areas, including breast exams, smoking-cessation counseling, and prostate exams, continued to be monitored in the absence of specified Healthy People 2010 standards (Ref. page 34).

Internal Customer Perspective: Readiness

- While the overall MHS rate of dental readiness for Classes 1 and 2 has generally increased since the metric was established, and remains high at almost 93 percent, the target rate of 95 percent continues to be elusive, although the gap is slowly narrowing (Ref. page 35).
- TRICARE has continued to support the Global War on Terrorism, which began shortly after the September 11, 2001 attacks, through the TRICARE Reserve Family Demonstration Project (TRFDP). This program waived certain administrative and financial requirements to facilitate access to TRICARE for family members of mobilized Reservists. As a result of the mobilization of over 322,000 Reservists, 587,000 family members were eligible for the TRFDP benefit from September 2001 to May 2004 (Ref. page 36).
 - During this period of time, a total of almost \$293M was spent for purchased care services for these family members: DoD paid about \$209M (72 percent), patients paid more than \$18M (6 percent), and patients' other health insurance paid \$48M

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2004 (CONT'D)

(16 percent). DoD waived over \$17M in patient cost shares specifically authorized by the Demonstration (Ref. page 37).

Internal Customer Perspective: Quality

Access To Care

- **Overall Outpatient Access.** Access to and use of outpatient services remains high, with Prime enrollees reporting they had at least one outpatient visit in the past year increasing slightly between FY 2002 and FY 2004. This measure lags, but is close to the civilian counterparts in managed care plans (Ref. page 39).
- **Availability and Ease of Obtaining Care.** While MHS beneficiary ratings improved between FY 2002 and FY 2004 in terms of “getting necessary care,” ratings declined from FY 2003 to FY 2004 for two other categories: “waiting for a routine appointment” and “waiting less than 15 minutes to see a doctor.” The civilian benchmark similarly declined, which may be influenced by changes in the CAHPS survey questions (Ref. pages 40).
- **Obtaining a Provider of Choice.** While the majority (62 percent) of MHS beneficiaries reported in FY 2003 they were able to obtain a provider of choice, a level close to the civilian benchmark, MHS beneficiaries reported less success at obtaining the personal doctor or nurse of their choice in FY 2004. MHS and their civilian counterparts rated “Getting a referral to a specialist” lower in FY 2004 than in prior years. The decrease in FY 2004 may, in part, be affected by the change in the survey question (Ref. page 42).
- **Customer Service.** MHS beneficiaries reported an increased level of satisfaction between FY 2002 and FY 2004 with customer service responsiveness, ease of understanding written materials, and dealing with paperwork. The MHS levels lag behind the civilian benchmark (Ref. page 43).

Special Study: Comparing Access to TRICARE for Family Members of Active Component and Mobilized Reservists

- Two special studies examined differences in AC and Reserve Component (RC) family

member access to, and satisfaction with, TRICARE. Although RC and AC members report comparable levels of satisfaction with the health *care* they received, Reservists’ family members report higher levels of satisfaction with their overall health *plan* than their AC family member counterparts (Ref. pages 44–45).

- RC and AC families report comparable satisfaction with customer services for the past three years. In FY 2003, however, RC family members reported greater satisfaction with the processing of their claims than did their AC family counterparts (Ref. page 45).

Claims Processing

- Beneficiary satisfaction with TRICARE claims processing is, for the most part, improving over time. There is, however, a slight decrease in reported satisfaction with claims processed properly between FY 2003 and FY 2004. In FY 2004, MHS beneficiaries reported claims were processed properly (83 percent, compared to FY 2003’s level of 84 percent) and in a reasonable period of time (81 percent, compared with FY 2003’s level of 80 percent) (Ref. page 46).
- In spite of the challenges brought on by the claims processing volume trebling since FY 2001, the processing of retained claims within 30 days exceeded the TRICARE goal of 95 percent over the past three years (Ref. page 47).
- The percentage of the over 45 million non-TFL claims filed electronically increased to over 56 percent by mid-FY 2004. Electronic filing has increased in all categories of claims (e.g., professional and pharmacy), except for a minor decrease in institutional claims. It should be noted that pharmacy continues to dominate with almost 97 percent filed electronically (Ref. page 48).

Special Study: Assessment of TRICARE Standard Provider Availability

- The FY 2004 National Defense Authorization Act (section 723) required the DoD to survey at least 20 market areas annually “to determine how many health care providers are accepting new patients under TRICARE Standard.” Of providers who reported accepting new patients, the

EXECUTIVE SUMMARY: KEY FINDINGS FOR FY 2004 (CONT'D)

percentages of those accepting any new TRICARE patients ranged from a low of about 81 percent (Utica, NY) to a high of almost 92 percent (Atlanta, GA) (Ref. page 49).

MTF Survey Results from Joint Commission on Accreditation of Healthcare Organizations

- JCAHO is the nationally recognized organization that provides an accreditation status based on onsite surveys conducted at least every three years. Over the past four years, MHS inpatient and outpatient (ambulatory) facilities have in general achieved JCAHO ratings higher than, or comparable to, civilian institutions (Ref. page 51).

Direct Care Appointment Access

- The MHS met its goal of 82 percent of patients reporting satisfaction with making MTF appointments by telephone in FY 2003. As a result, the goal was raised in FY 2004 to 84 percent, which has not yet been met (Ref. page 52).

Satisfaction With MTF Care

- MHS beneficiaries responding to a survey regarding their specific direct care visit(s) reported nearly 88 percent satisfaction with their MTF encounter in FY 2004. The MHS goal of at least 90 percent continues to remain elusive (Ref. page 52).

Internal Customer Perspective: Efficiencies

Support Contract Management

- With respect to contract efficiency, administrative expenses related to contract management declined from 17.3 percent of total contract revenue in FY 2002 to 14.6 percent in FY 2004. The overall estimated expenses incurred by DoD for the health services and support contracts increased by 64 percent, from \$4.7B in FY 2002 to \$7.7B in FY 2004 (Ref. page 55)

MTF Market Share Trends

- The percentage of inpatient and outpatient workload accomplished in MTFs relative to all TRICARE workload in catchment areas has declined (from FY 2002 to mid-FY 2004) by 6 percentage points each (Ref. page 56).

Health Care Services Utilization

- Utilization of inpatient, outpatient, and prescription services by Prime enrollees was about 60 percent, 44 percent, and 30 percent higher, respectively, than that of civilian HMO enrollees in FY 2004 (Ref. pages 57, 63, and 66).

Beneficiary Family Out-of-Pocket Costs

- TRICARE beneficiaries have much lower out-of-pocket costs than their civilian counterparts.
 - For enrolled family members under 65 years of age, costs were about \$3,000 less than their civilian HMO counterparts in FY 2004. This difference is largely due to the insurance premium costs incurred by civilians (Ref. page 70).
 - For Medicare-eligible MHS beneficiaries in FY 2004, costs were \$2,500 less than their civilian counterparts. The lower costs were due to the TFL and TSRx benefits programs, which enabled MHS seniors to reduce their expenses for supplemental insurance, deductibles, and copayments (Ref. page 72).
 - MHS seniors paid about half as much for their health care as their civilian counterparts in FY 2002–2004 (Ref. page 73).

Learning and Growth Perspective

- The newly established Center for Health Care Management Studies developed an initial agenda of studies to better understand the complex determinants of health care quality and health system improvement. Two studies were completed in 2004 addressing the effectiveness of TRICARE customer communications and improving MTF pharmacy compliance by beneficiaries.

WHAT IS TRICARE?

TRICARE responds to the challenge of maintaining medical combat readiness while providing the best health care for all eligible personnel. TRICARE brings together the world-wide health care resources of the Army, Navy, and Air Force (often referred to as “direct care”) and supplements this capability with networks of civilian health care professionals (referred to as “purchased care”) to provide better access and high quality service while maintaining the capability to support military operations. In addition to receiving care from MTFs, where available, TRICARE offers beneficiaries three primary options:

- **TRICARE Standard** is the traditional indemnity benefit (also known as fee for service, or FFS), formerly known as CHAMPUS, open to all eligible Department of Defense (DoD) beneficiaries, except active duty service members (and, until recently, Medicare-eligibles). No enrollment is required to obtain care from civilian providers. This option requires payment of an annual deductible (individual or family) and cost-sharing.
- **TRICARE Extra** is based on a Preferred Provider Organization (PPO) model in which beneficiaries eligible for TRICARE Standard may decide to use preferred civilian network providers on a case-by-case basis (i.e., they may switch between the Standard and Extra benefit). Like Standard, no enrollment is required but, by using network providers, beneficiaries reduce their cost sharing by 5 percent. Under Extra, authorized contracted providers file claims for the beneficiary.
- **TRICARE Prime** is the HMO-like plan in which beneficiaries enroll in this benefit option where it is offered. 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. Prime offers enrollees additional benefits such as access standards in terms of maximum allowable waiting times to obtain an appointment, emergency services (24 hours per day, 7 days per week), and waiting times in doctors’ offices; as well as preventive and wellness services (e.g., routine eye exams, immunizations, hearing tests, mammograms, Pap tests, prostate examinations). A point-of-service (POS) option permits enrollees to seek care from non-network providers, but with significantly higher cost sharing than under Standard.



NEW BENEFITS AND PROGRAMS IN FY 2004

TRICARE continues to evolve, offering new programs, refining and enhancing existing benefits and programs, and changing its organizational structure to improve the overall efficiency and effectiveness of this Tri-Service health care organization. New benefits, services and programs implemented or scheduled for implementation in FY 2004 include the following:

Organizational/Structural/Contractual Changes: Next Generation of Contracts

➤ Reflecting DoD’s commitment to providing MHS beneficiaries with continuous, uninterrupted access to high quality care, a series of significant structural changes in 2004 were directed to better serve MHS beneficiaries. These changes involved the deployment of the TRICARE Next Generation of Contracts and consolidation of the regional structure between June and November 2004. This next generation of TRICARE contracts consists of a suite of services, awarded competitively, to provide beneficiaries with the highest quality of care, a higher level of customer service and added value in all aspects of the world class TRICARE benefit. These new contracts are making a strong program better, building on the best aspects of a system developed over the last 10 years, and providing a system of incentives for improvements in quality care, access and claims payments for the military’s 9.2 million TRICARE beneficiaries. In addition to three regional contracts for health services and support, the Department awarded separate contracts for mail order pharmacy, retail pharmacy, retiree dental care, the Uniformed Services Family Health Plan, TRICARE global remote overseas, TRICARE health care for Puerto Rico, marketing and education programs, information services, national quality monitoring, and claims processing for Medicare-eligible beneficiaries.

Consolidated Regions and Contracts

➤ TRICARE Management Activity (TMA) replaced its regional managed care support service contracts, and other medical and dental contracts as they expired, with the next generation of TRICARE contracts. Under this next generation of contracts, TMA included incentives for the health services and support contractors with respect to superior and measurable performance in customer service, quality of care, and access to care. The seven contracts covering 11 regions were replaced by three contracts covering three consolidated regions to improve portability and reduce the

administrative costs of negotiating change orders and providing government oversight across contracts. Additionally, the reduction in the number of contracts has been designed to improve TMA’s responsiveness and allow for a uniform implementation period. The three regional contracts each have Integrated Health Care Delivery and Administrative Services requirements to include network functions, health care functions, claims processing, enrollment, provider certification, and related administrative services.

TRICARE Regional Governance

- TMA also consolidated and replaced the previous Lead Agent support structure with a TRICARE Regional office governance infrastructure to complement the three U.S. regions, and to support the overseas benefit as well.
 - Procedures were established to ensure that claims sent to a former contractor by beneficiary providers would be automatically forwarded to the new region claims contractor.

Key objectives in the new regional contracts include:

- Optimization of the delivery of health care services in the direct care system for all MHS beneficiaries (active duty personnel, MTF enrollees, civilian network enrollees, and non-enrollees).
- Achievement of beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world class health care as well as customer-friendly program services.
- Attainment of “best value health care” services in support of the MHS mission utilizing commercial practices when practical.

The new regional contracts include strong financial incentives for excellent performance, including:

- Clear incentives for maximizing referrals into MTFs.

NEW BENEFITS AND PROGRAMS IN FY 2004 (CONT'D)

- Establishment of an incentive award fee pool to be administered by the TRICARE Regional Director.
- Performance on an extensive list of specific, measurable items such as claims processing timeliness, network adequacy, and telephone responsiveness.

The new contract structure carves out certain elements so that contractors can focus on their core competencies. The carve-out elements include:

- **The TRICARE Dual-Eligible Fiscal Intermediary Contract.** This contract is designed to perform claims processing and customer service functions for DoD beneficiaries who also are eligible for Medicare. For most claims filed by this clearly defined population, TRICARE is second payer to Medicare.
- **Pharmacy services** are available to beneficiaries through one of three venues: MTFs, the TRICARE Mail Order Program (TMOP), and contracted retail pharmacies.
 - The **TMOP benefit** contract replaced a previous national mail order pharmacy contract. In September 2003, the ASD(HA) announced award of the TRICARE Retail Pharmacy contract for a Pharmacy Benefit Manager to provide a nationwide network of retail pharmacies to fill prescriptions for TRICARE beneficiaries in the 50 United States, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.
 - The **national retail pharmacy services** contract is designed to integrate the various retail pharmacy programs currently available. With this contract, TMA seeks to solve many beneficiary portability issues, reduce administrative costs, and provide a consistent benefit. The new retail pharmacy program will be fully portable, allowing beneficiaries access to network pharmacies while traveling outside of their regions. The single contract will better serve TRICARE beneficiaries, be simpler for the government to administer, and make the program more accountable. The transition to the retail pharmacy contract began October 1, 2003, with turnover of responsibility for delivery of retail pharmacy services nationwide on April 1, 2004.
- **Marketing/Education Contract.** TMA is developing a separate contract to create a national suite of TRICARE Marketing and Education products that will provide a uniform message and reinforce the fact that TRICARE is a single, portable benefit.
- **Local Support Contracts.** MTF commanders will be able to contract for services beyond the national contracts. A Local Support Contracts team will create task order vehicles for appointing and scheduling support.
- **Making TRICARE Easier.** Several changes were implemented in 2004 to reduce the administrative burden on beneficiaries, including:
 - A **Universal Prime Enrollment** and PCM change form replaced the multiple versions used prior to the regional consolidation to facilitate enrollment, re-enrollment and transferring enrollment.
 - **Payment options for retirees**, their families, survivors and eligible former spouses were enhanced with the addition of monthly payments to the existing quarterly and annual payment options.
 - To simplify the enrollment billing process and better track catastrophic caps for beneficiaries and regional contractors, TRICARE Prime enrollment years were changed to be based on fiscal years rather than the anniversary date of enrollment. This will facilitate management of families with split enrollments and simplify tracking for those who change regions.
 - **Elimination of Nonavailability Statements.** In FY 2004 (December 30, 2003), beneficiaries living within a catchment area were no longer required to obtain a Nonavailability Statement (NAS) from the local MTF prior to obtaining reimbursable inpatient care from civilian sources (the only exception remaining for MTF authority to issue NASs is for inpatient mental health services).
- **Improving Access to TRICARE for Families of Mobilized Reservists.** RC personnel called to active duty for more than 30 consecutive days are eligible for TRICARE, the same as any active duty service member. Families of these individuals are also eligible for TRICARE. For RC members and their

NEW BENEFITS AND PROGRAMS IN FY 2004 (CONT'D)

families, therefore, the entire spectrum of TRICARE options becomes available, including: TRICARE Standard, Extra, and Prime; TRICARE Prime Remote for Active Duty Family Members (TPRADFM); the TRICARE Dental Program, and the TRICARE Pharmacy Program. Changes over the past 2 years have been designed to enhance access to health care for RC members and their families.

- **Temporary Reserve Health Benefit Program.** The NDAA for FY 2004 authorized three new temporary provisions to expand TRICARE health and dental coverage for RC members and families. Two of these benefits were implemented in FY 2004, and due to expire December 31, 2004.
 - **Section 703: “Early TRICARE Benefit.”** This authorizes health care benefits that begin before the RC member goes on active duty. RC members and families may be reimbursed for medical/dental care given during the 60 days before an RC sponsor's delayed-effective-date order for activation. Benefits under this program were originally designed to be in effect November 6, 2003 to December 31, 2004, the date the temporary benefit was scheduled to end. However, the benefit was made permanent by NDAA 2005.
 - **Section 704: Extending TRICARE eligibility for RC Members leaving the Service.** This temporary benefit permits RC members who leave active duty and return to civilian life to use the Transitional Assistance Management Program (TAMP), which provides a longer period of TRICARE health care coverage than previously. The previous “after-service” coverage of 60 or 120 days (depending on the RC member's time on active duty) has been extended to 180 days for all RC members leaving active duty. While originally established as a temporary benefit with expiration on December 31, 2004, NDAA 2005 has since made this a permanent benefit.
- **Continuation of the TRICARE Reserve Family Demonstration Program (TRFDP).** To ensure the continuity of care for family members of the reservists mobilized in support of federal contingency operations, the TRFDP has been extended through October 31, 2005. The demonstration, which began on September 14, 2001, was due to end November 1, 2004. The demonstration benefits were designed to enhance continuity of care for those family members using the TRICARE Standard or Extra options to see their civilian providers by waiving the annual deductible and authorizing payment to nonparticipating providers up to 115 percent of the TRICARE maximum allowable charge. NDAA 2005 changed the eligibility from being on active duty less than one year to being on active duty for more than 30 days. This paves the way for the Secretary to make the benefits permanent by issuing regulatory changes.
- **Greater opportunity for enrollment in the Prime option.** Enrollment in the TRICARE Prime option became easier for Reservists and their families with the reduction in the requirement from 179 to 30 days for sponsors’ orders to active duty (March 10, 2003).
 - **TRICARE Prime Remote (TPR)** Enrollment in Prime also became easier for reserve families residing remotely from military installations or civilian provider networks. Family members residing with their sponsors in a TPR location at the time of the sponsor’s activation may enroll in the TPRADFM program (March 2003).
- **FY 2005 Benefits Changes.** The benefits changes noted above in FY 2003 and FY 2004 will be extended next year, and should further enhance participation in TRICARE by Reservists and their family members. For example, the NDAA for FY 2005, signed by the President, improves significantly the overall health benefits available to members of the Guard, Reserves and their families, and makes permanent several of the TRICARE benefits authorized “temporarily” under defense legislation last year while extending secretarial authorization for others.

NEW BENEFITS AND PROGRAMS IN FY 2004 (CONT'D)

- For RC members with delayed effective date orders to serve on active duty in support of a contingency operation for more than 30 days, the new legislation permanently authorizes TRICARE eligibility for up to 90 days prior to the date prescribed in the orders for eligible members and their families.
 - It also makes permanent a 180-day transitional TRICARE health benefit after deactivation for TAMP eligible members and their families. Members must also now receive a comprehensive physical examination within a year of separating from active duty service.
 - Finally, Reservists will be offered the opportunity to purchase TRICARE Standard health care coverage for themselves and their family members after they demobilize, if they were called to active duty after September 11, 2001, to serve for more than 30 days in support of a contingency operation, and served or will continuously serve for 90 or more days. When the new health coverage program is implemented by April 26, 2005, Reserve members will be able to purchase the new coverage on a self-only or self and family basis. The coverage under this program will begin once the member's eligibility for 180 days of transitional TRICARE coverage under the TAMP program ends. Access to this benefit coverage will be based on the member signing a service agreement to continue serving in the selected reserve after the active duty service ends: members may purchase one whole year of coverage for themselves and their eligible family members for each year in the service agreement up to one whole year for every 90 days of consecutive active duty service. Members who served on active duty in support of a contingency operation for 90 days or more on or after September 11, 2001, and were released from active duty before October 28, 2004, or within 180 days of that date, may enter into an agreement to serve continuously in the selected reserve for a period of one or more years and begin participation in this program at that time. These members must enter into this agreement to serve in the selected reserve within one year of October 28, 2004.
- **TRICARE For Life (TFL) and TRICARE Senior Pharmacy (TSRx).** These two key programs for Medicare beneficiaries continue to grow in acceptance and use by the MHS seniors. By way of background, when DoD beneficiaries become entitled to Medicare Part A and B, they can use TFL (since October 1, 2001) provided they purchase Part B. Although these beneficiaries are not eligible for TRICARE Prime, they are eligible to use Medicare, network, and non-network providers, as well as MTFs on a space-available basis.
- Under TFL, TRICARE acts as second payer to Medicare for benefits payable by both Medicare and TRICARE. Beneficiaries can use a participating or nonparticipating Medicare provider and claims will automatically be sent to TRICARE after Medicare pays its portion. There are no enrollment fees for TFL. Beneficiaries are only required to pay the Medicare Part B premium. TRICARE is first payer for TRICARE benefits not covered by Medicare, such as outpatient prescription drugs (via the TSRx program, which began April 1, 2001).
 - TSRx offers access to a complete pharmacy benefit provided through either direct care military facilities or purchased care civilian facilities, including contracted network pharmacies and a national mail order program.

REPORT APPROACH AND SCOPE

This report continues to take the approach used in last year's report of comparing TRICARE with civilian-sector benchmarks (where available), and presenting trend data over the most recent three fiscal years. This report summarizes

nationwide trends under TRICARE, and unless otherwise noted, compares the Continental U.S. (CONUS) regions of TRICARE with comparable U.S. civilian-sector benchmarks.



TRICARE WORLDWIDE PROGRAM OPERATIONS

System Characteristics

TRICARE FACTS AND FIGURES—PROJECTED FOR FY 2005

Total Beneficiaries	9.1 million
Direct Care System:	
Military Facilities	
Inpatient Facilities (Hospitals & Medical Centers)	70 (52 in U.S.)
Ambulatory Medical Clinics	411 (309 in U.S.)
Ambulatory Dental Clinics	417
Veterinary Facilities	259
Total Military Health System Personnel	130,800 (90,000 military)
Total Unified Medical Program (UMP):	\$31 billion*
(Includes estimated FY 2005 outlay for the Accrual Fund)	\$5.9 billion**
<small>* Includes direct and private sector care funding, Military Personnel, military construction and accrual fund. ** The Uniform Services Medicare Eligible Retiree Health Care Fund, implemented in fiscal year 2003, is an accrual fund that pays for health care provided to Medicare-eligible beneficiaries, including payment for the TRICARE for Life benefit first implemented in fiscal year 2002.</small>	

TRICARE is administered on a regional basis. Until June 2004, the U.S. had been divided into 11 geographical health services regions (Regions 1–12, with 7/8 a combined region), as well as TRICARE Europe, TRICARE Pacific, and TRICARE Latin America. A senior military officer was designated as the Lead Agent for each region. Regional Lead Agents and their support staff helped coordinate primary and referral direct and purchased care within their regions.

To better serve MHS beneficiaries, and consistent with the next generation of TRICARE contracts, the 12 U.S. regions, with seven support contractors, were successfully consolidated through a time-phased process into three health services regions, each supported by a TRICARE Regional Office (TRO) and contractor as depicted on the next page. The new contracts were phased in from June through November 2004. Each of the three TRICARE regions in the United States has a regional contractor that helps coordinate medical services available through the MTFs and through a network of civilian hospitals and providers. The regional contractors are responsible for a variety of functions, including:

- establishing TRICARE provider networks.
- operating TRICARE service centers.
- providing customer service to beneficiaries.
- providing administrative support, such as enrollment, disenrollment, and claims processing.
- communicating and distributing educational information to beneficiaries and providers.

The regional contractors work with the TROs to manage TRICARE at a regional level. Both the regional contractors and the TROs receive overall guidance from TMA.

TRANSITION OF TRICARE HEALTH SERVICE REGIONS IN 2004 FROM 12 TO 3 REGIONS



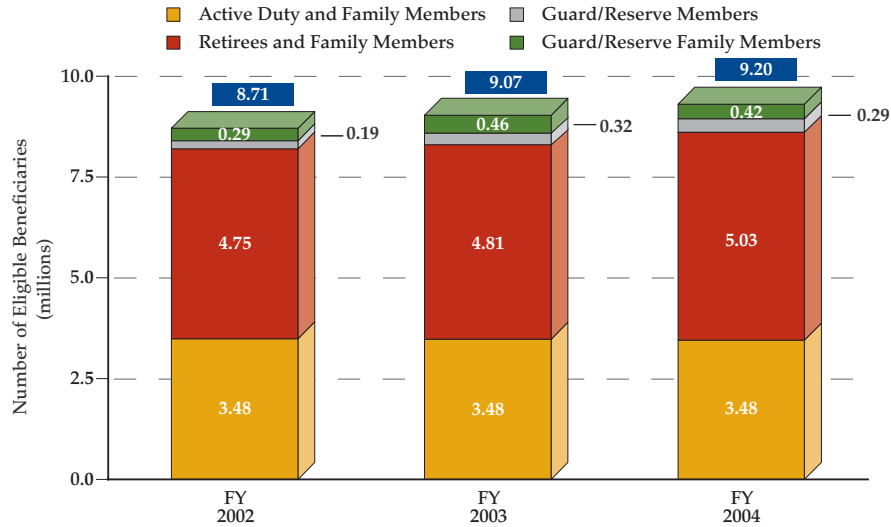
Source: OASD(HA)/TMA; Comptroller Information System final reports for President's Budget Submissions

BENEFICIARY TRENDS AND DEMOGRAPHICS

Number of Eligible Beneficiaries Between FY 2002 and FY 2004

The number of beneficiaries eligible for DoD medical care increased from 8.7 million at the end of FY 2002 to 9.2 million by the end of FY 2004. The increase is largely due to the mobilization of large numbers of Guard/Reserve members and the extension of benefits to their family members. The number differs from last year's estimate of 9.1 million beneficiaries.

TRENDS IN THE NUMBER OF ELIGIBLE BENEFICIARIES BY BENEFICIARY GROUP



Source: Defense Enrollment Eligibility Reporting System (DEERS), 1/5/2005

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

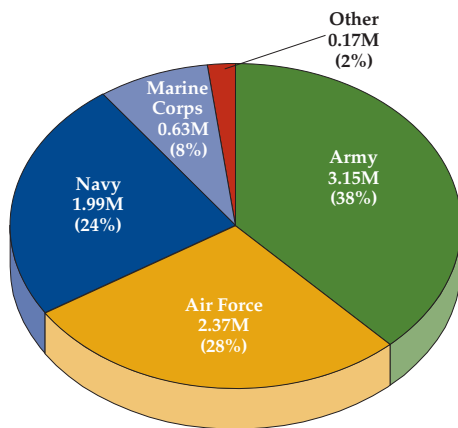
Eligible Beneficiaries at the End of FY 2004

Of the 9.20 million eligible beneficiaries at the end of FY 2004, 8.34 million (about 91 percent) are stationed or reside in the Continental United States (CONUS) and 0.86 million are stationed or reside outside the Continental United States (OCONUS). 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 for both CONUS and OCONUS.

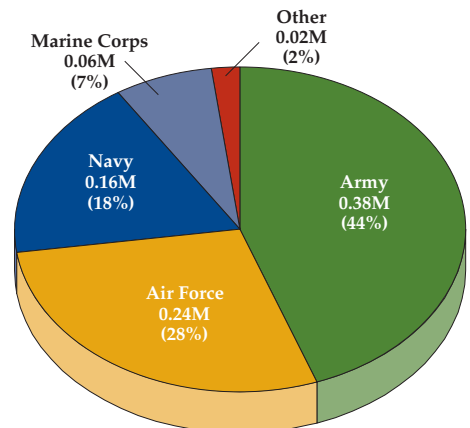
Whereas retirees and their family members comprise the largest percentage of the eligible population (57 percent) in CONUS, active duty personnel (including Guard/RC members on active duty for at least 30 days) and their family members comprise the largest percentage (73 percent) of the eligible population OCONUS.

BENEFICIARIES ELIGIBLE FOR DoD HEALTH CARE BENEFITS AT THE END OF FY 2004

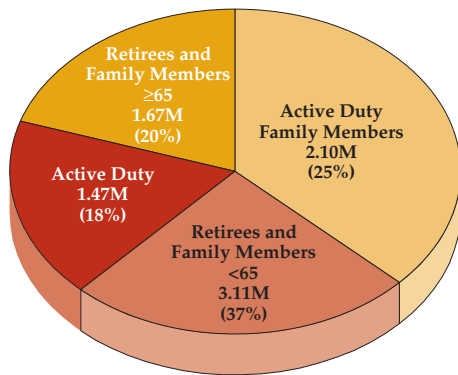
SERVICE BRANCH (CONUS)



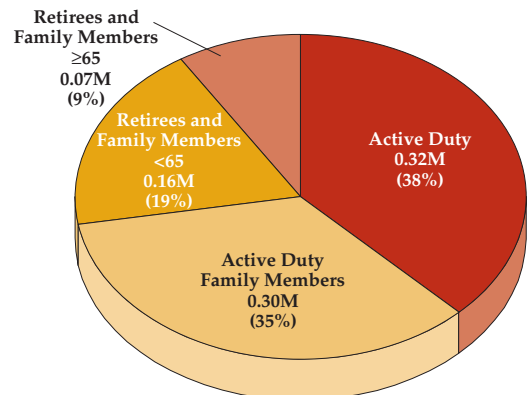
SERVICE BRANCH (OCONUS)



BENEFICIARY CATEGORY (CONUS)



BENEFICIARY CATEGORY (OCONUS)



Source: DEERS, 1/5/2005

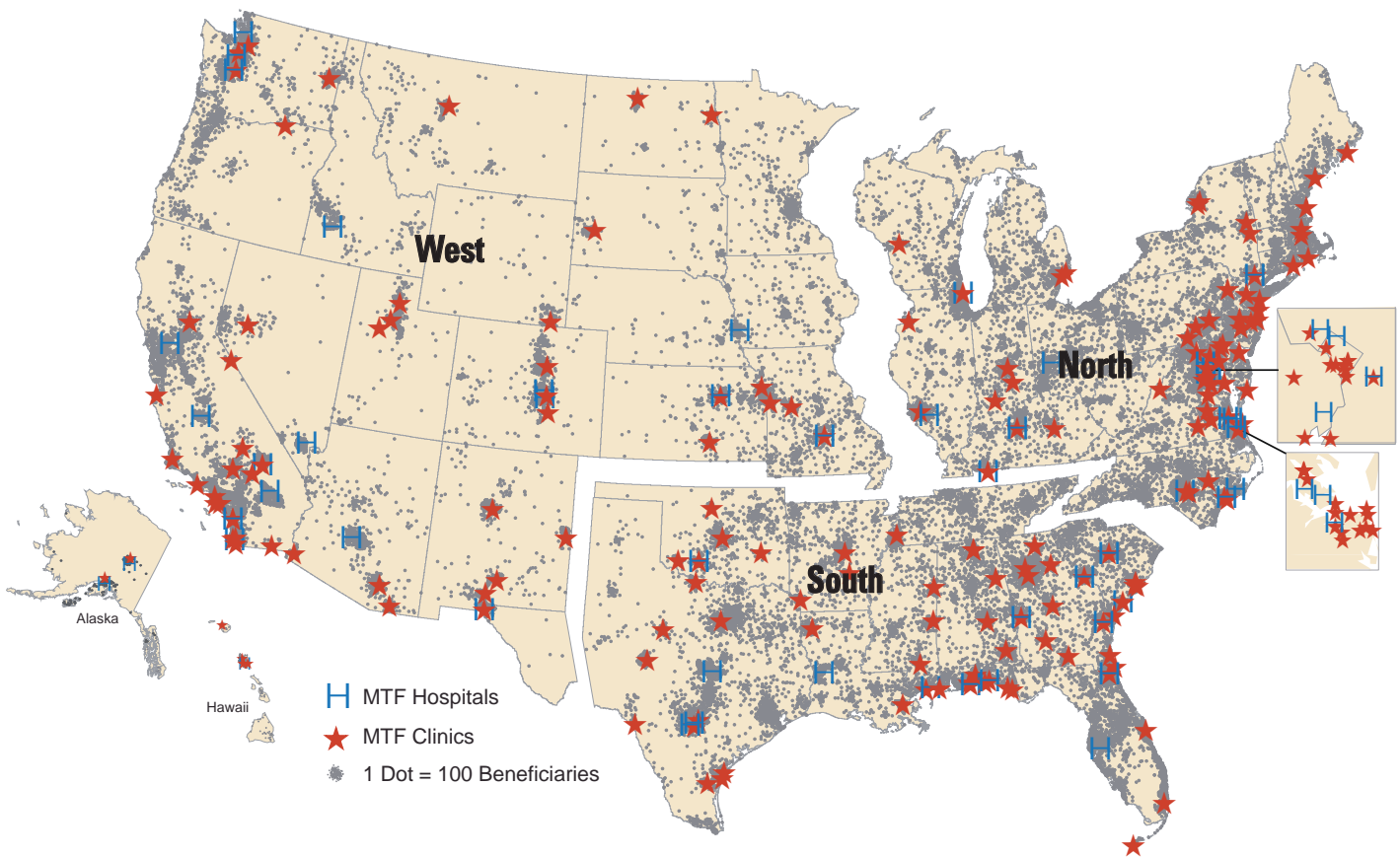
Note: Percentages may not add to 100 percent due to rounding.

BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

Locations of U.S. Military Medical Treatment Facilities (Hospitals and Ambulatory Care Clinics) in FY 2004

The map below presents the geographic diversity of that proportion of the MHS beneficiary population residing within the United States (90 percent of the total 9.20 million beneficiaries). An overlay of the major DoD MTFs (medical centers and community hospitals, as well as medical clinics) reflects the extent to which the MHS population does and does not reside near the direct care system.

MHS POPULATION DISTRIBUTION IN THE U.S. RELATIVE TO MILITARY MEDICAL TREATMENT FACILITIES (HOSPITALS AND AMBULATORY CARE CLINICS) IN FY 2004, BY TRICARE REGION



Source: MTF information from TMA Portfolio Planning Management Division; population, residential and GIS information from TMA/HPA&E, 12/22/2004

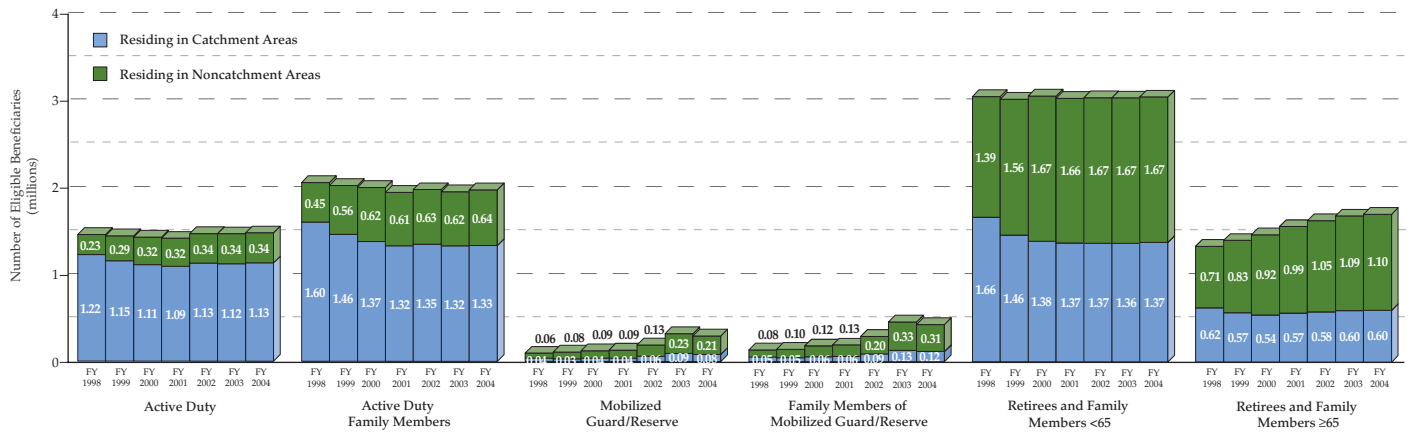
BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

Eligible Beneficiaries Living in Catchment Areas

A catchment area is defined as the area within approximately 40 miles of a military hospital, allowing for natural geographic boundaries and transportation accessibility. Noncatchment areas lie outside catchment area boundaries. Because of Base Realignment and Closure (BRAC) actions and changes in the beneficiary mix over time, there has been a downward trend in the number of beneficiaries living in catchment areas. This trend has implications for the proportion of workload performed in direct care and purchased care facilities.

- The overall percentage of beneficiaries living in catchment areas declined from 64 percent in FY 1998 to 52 percent in FY 2004.
- Retirees and family members age 65 and older experienced the largest decline in the percentage living in catchment areas, from 47 to 35 percent.
- Active duty personnel and their family members and retirees and family members under age 65 each experienced a decline of about 10 percentage points in the number living in catchment areas.
- The recent call-ups of National Guard and Reserve members have contributed disproportionately to the total number of beneficiaries living in noncatchment areas. Most Guard/Reserve members already live in noncatchment areas when called to active duty and their families continue to live there.

TREND IN THE NUMBER OF ELIGIBLE BENEFICIARIES LIVING IN AND OUT OF MTF CATCHMENT AREAS



Source: DEERS, 1/5/2005

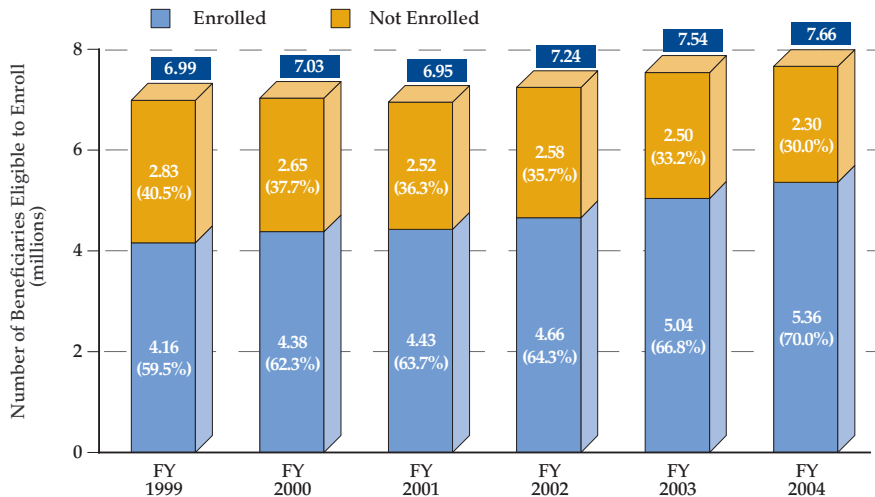
BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

Eligibility and Enrollment in TRICARE Prime

Eligibility for and enrollment in TRICARE Prime was determined from the Defense Enrollment Eligibility Reporting System (DEERS). For the purpose of this presentation, all active duty personnel are considered to be enrolled. The eligibility counts exclude most beneficiaries age 65 and over (some were eligible for TRICARE Senior Prime in FY 2001 and early FY 2002) but include beneficiaries living in remote areas where Prime may not be available. As such, the enrollment rates displayed below may be somewhat understated.

- TRICARE Prime enrollment, both in raw numbers and as a percentage of those eligible to enroll, has steadily increased since FY 1999.
- Beneficiaries enrolled in TRICARE Plus (a primary care enrollment program that is offered at selected MTFs) are excluded from the enrollment counts below; they are included in the non-enrolled counts. The number of beneficiaries enrolled in TRICARE Plus increased from 155,920 at the end of FY 2003 to 163,326 at the end of FY 2004.
- By the end of FY 2004, 70 percent of all eligible beneficiaries were enrolled in Prime (5.36 million enrolled of the 7.66 million eligible to enroll).

HISTORICAL END-OF-YEAR ENROLLMENT NUMBERS



Source: DEERS, 1/5/2005

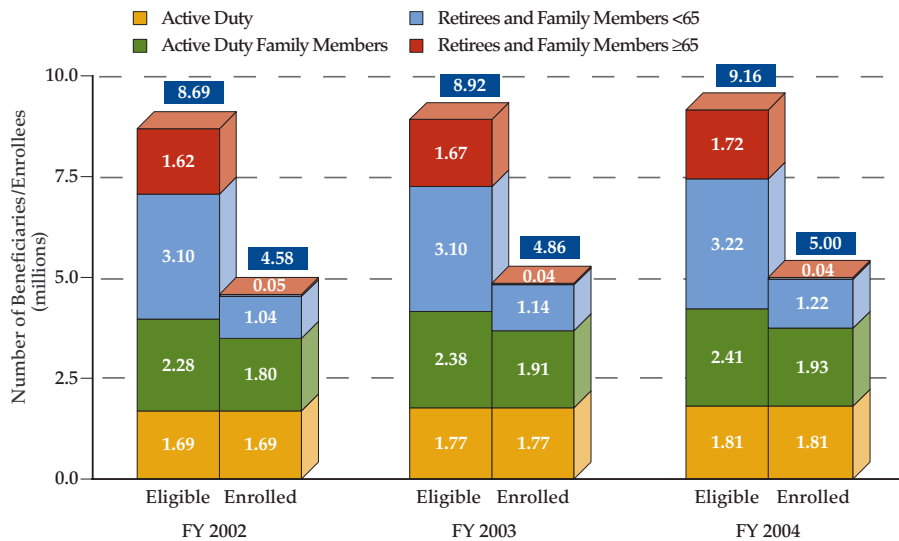
BENEFICIARY TRENDS AND DEMOGRAPHICS (CONT'D)

Average Eligibles and Enrollees Between FY 2002 and FY 2004

The average numbers of eligibles and TRICARE Prime enrollees by beneficiary category from FY 2002 to FY 2004 were determined from DEERS. The eligible counts include all beneficiaries eligible for some form of the military health care benefit and therefore include those who may not be eligible to enroll in Prime. TRICARE Plus enrollees are not included in the enrollment counts.

- The percentage of active duty family members enrolled in TRICARE Prime has remained steady at about 80 percent.
- The percentage of retirees and family members under age 65 enrolled in TRICARE Prime increased from 33.5 percent in FY 2002 to 38.1 percent in FY 2004. The increase is due primarily to formerly non-MHS-reliant retirees dropping their private health insurance because of rising premiums.

AVERAGE NUMBER OF ELIGIBLES AND ENROLLEES BETWEEN FY 2002 AND FY 2004 BY BENEFICIARY CATEGORY

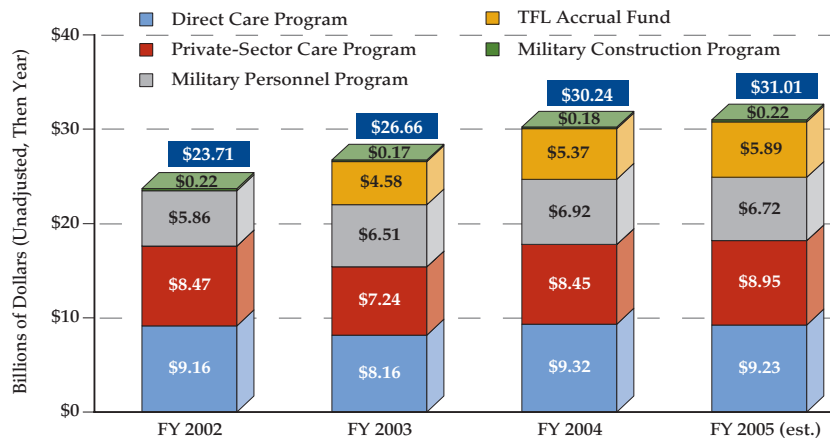


Sources: DEERS and MHS administrative data, 1/5/2005

UNIFIED MEDICAL PROGRAM FUNDING

As shown in the first chart below, in terms of unadjusted expenditures (i.e., “then-year” dollars, unadjusted for inflation), the Unified Medical Program (UMP) increased from \$26.7 billion in FY 2003 to \$30.2 billion in FY 2004. It is programmed to reach almost \$31 billion in FY 2005. The FY 2003 and FY 2004 funding includes the receipts from the Uniform Services Medicare-Eligible Retiree Health Care Fund (the “Accrual Fund”). This fund (effective October 1, 2002) supports the TFL benefit, which began in October 2001.

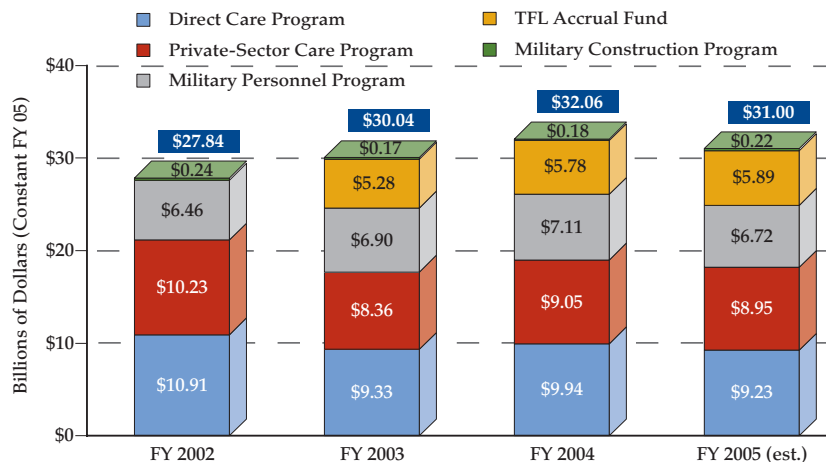
**FY 2002 TO FY 2005 (EST.) UNIFIED MEDICAL PROGRAM (\$ BILLIONS)
(UNADJUSTED, THEN-YEAR DOLLARS)**



Notes: Percentages may not add due to rounding.

1. FYs 2000–2003 reflect Comptroller Information System actual execution; FYs 2004–2005 reflect the FY 2005 current estimate as of 5 Jan. 2005.
2. TRICARE for Life (TFL) and other NDAA enhancements commenced in FY 2002 resulting in an approximate \$4B increase.
3. The FY 03 funding includes \$596.8M for GWOT. The FY 04 funding includes \$658.4 M for GWOT, \$278 M for NDAA Reserve Health Care Benefit, and \$683M Title IX two year GWOT funding programmed to be obligated in FY 2005.

**FY 2002 TO FY 2005 (EST.) UNIFIED MEDICAL PROGRAM
(CONSTANT FY 2005 DOLLARS)**



Notes: Percentages may not add due to rounding.

1. FYs 2000–2003 reflect Comptroller Information System actual execution; FYs 2004–2005 reflect the FY 2005 current estimate as of 5 Jan. 2005.
2. TRICARE for Life (TFL) and other NDAA enhancements commenced in FY 2002 resulting in an approximate \$4B increase.
3. The FY 03 funding includes \$596.8M for GWOT. The FY 04 funding includes \$658.4 M for GWOT, \$278 M for NDAA Reserve Health Care Benefit, and \$683M Title IX two year GWOT funding programmed to be obligated in FY 2005.
4. Source of data for deflators: (1) OSD Comptroller table for MilPers, Procurement, RDT&E and MILCON; and (2) TMA for DHP O&M and TFL Accrual fund.

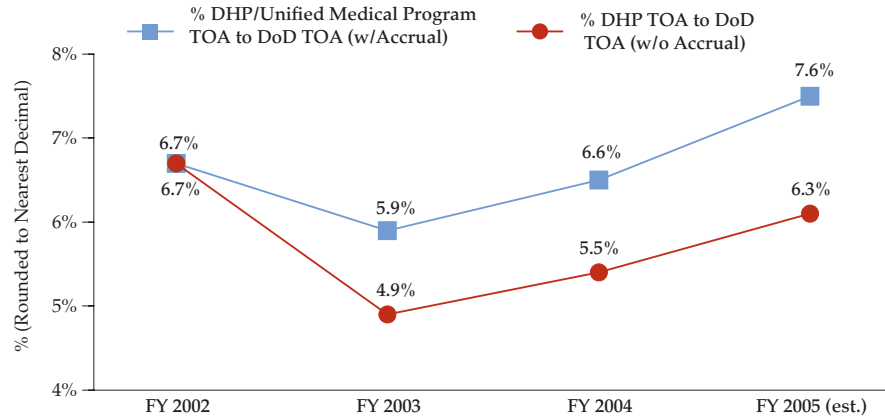
However, as reflected in the chart to the left, when actual expenditures or projected funding are adjusted for inflation based on constant FY 2005 dollars, FY 2005 funding is currently programmed at less than the previous year’s purchasing value.

UNIFIED MEDICAL PROGRAM FUNDING

UMP Share of Defense Budget

Unified Medical Program expenditures rose from 6.7 percent of DoD TOA in FY 2002 to 7.6 percent estimated for FY 2005, including the Accrual Fund. When the Accrual Fund is excluded, the UMP, while still increasing between FY 2003 and FY 2005, actually increased at a lower rate in FY 2005 (6.3 percent) than in FY 2002 (6.7 percent).

UMP EXPENDITURES AS A PERCENTAGE OF DEFENSE BUDGET: FY 2002–FY 2005 (EST.)

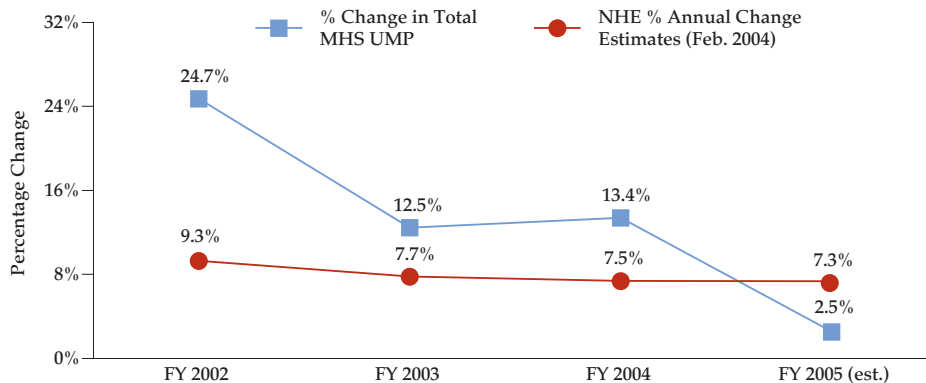


Source: Comptroller Information System reports and FY 2006–2011 Budget Estimate Submissions as of 1/5/2005

Comparison of Unified Medical Program and National Health Expenditures Over Time

The UMP experienced a large increase in Defense Health Program Operations and Maintenance in FY 2002 due to commencement of the TFL program. TFL was subsequently funded by the accrual fund beginning in FY 2003. In FY 2003 and FY 2004, UMP expenditures rose 12.5 percent and 13.4 percent, respectively (including GWOT and TFL funding), higher than changes in National Health Expenditures (NHE) over the same period (unadjusted, then-year dollars). The UMP rate of growth, as currently programmed for FY 2005, is expected to be less than 3 percent over the previous year, which appears lower than NHE projected growth in FY 2005 (see footnote below).

COMPARISON OF CHANGE IN ANNUAL UNIFIED MEDICAL PROGRAM AND NATIONAL HEALTH EXPENDITURES OVER TIME: FY 2002–FY 2005 (EST.)



Sources: Unified Medical Program and DHP Expenditures: Comptroller Information System final reports for President’s Budget Submissions (percentages, above, from data derived from the chart on the previous page entitled “FY 2002 to FY 2005 (est.) Unified Medical Program”).

National Health Expenditures: Heffler, S. Smith, Keehan S. et al. U.S. Health Spending Projections for 2004–2014: *Health Affairs*. 23 February 2005 W5–75. Actual expenditures (in \$Billions): 2002 (\$1,559.0), 2003 (\$1,678.9), 2004 (\$1,804.7 projected), 2005 (\$1,936.5 projected).

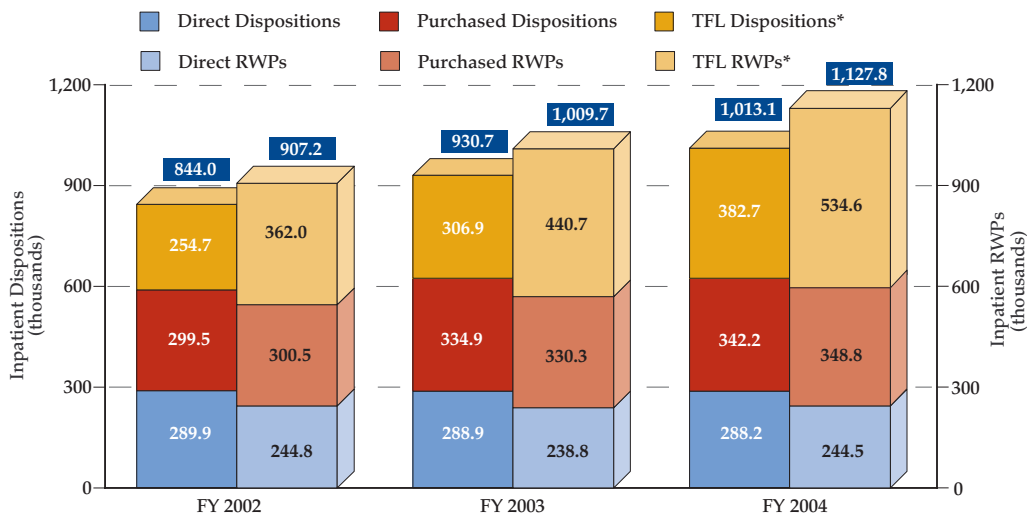
MHS WORKLOAD TRENDS

MHS Inpatient Workload

Total MHS inpatient workload is measured two ways: as the number of inpatient dispositions and as the number of Relative Weighted Products (RWPs). The latter measure reflects the relative resources consumed by a hospitalization as compared to the average of all hospitalizations. It gives greater weight to procedures that are more complex and involve greater lengths of stay. Total inpatient workload (direct and purchased care combined) increased between FY 2002 and FY 2004 (dispositions increased by 7 percent and RWPs by 9 percent), excluding the effect of TFL.

- Direct care inpatient workload has remained essentially constant the past three years.
- Purchased care inpatient dispositions increased by 14 percent excluding TFL workload and by 31 percent including TFL.
- Purchased care inpatient RWPs increased by 16 percent excluding TFL workload and by 33 percent including TFL.
- While not shown, about 18 percent of direct care inpatient dispositions and 16 percent of RWPs were performed OCONUS during FY 2002–2004. Purchased care and TFL inpatient workload performed OCONUS were negligible (1 percent or less).

TRENDS IN MHS INPATIENT WORKLOAD



Source: MHS administrative data, 1/31/2005

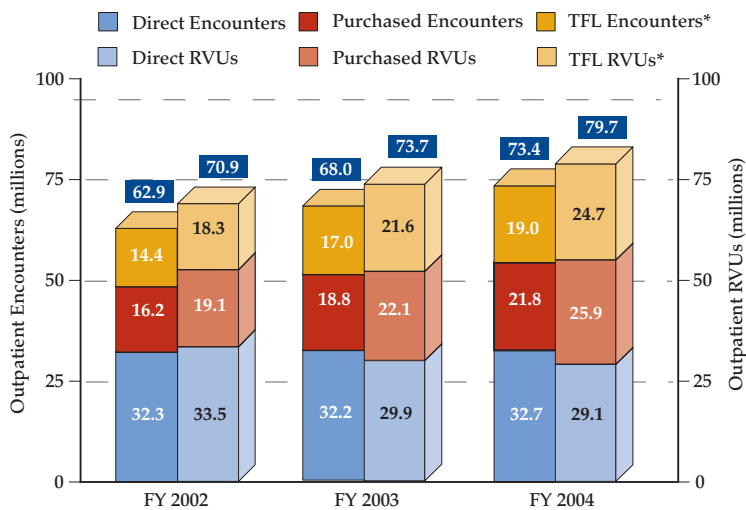
* Purchased care only.

MHS WORKLOAD TRENDS (CONT'D)

MHS Outpatient Workload

Total MHS outpatient workload is measured two ways: as the number of encounters (outpatient visits and ambulatory procedures) and as the number of RVUs. The latter measure reflects the relative resources consumed by an encounter as compared to the average of all encounters. Total outpatient workload (direct and purchased care combined) increased between FY 2002 and FY 2004 (encounters increased by 12 percent and RVUs by 5 percent), excluding the effect of TFL.

TRENDS IN MHS OUTPATIENT WORKLOAD



Source: MHS administrative data, 1/31/2005

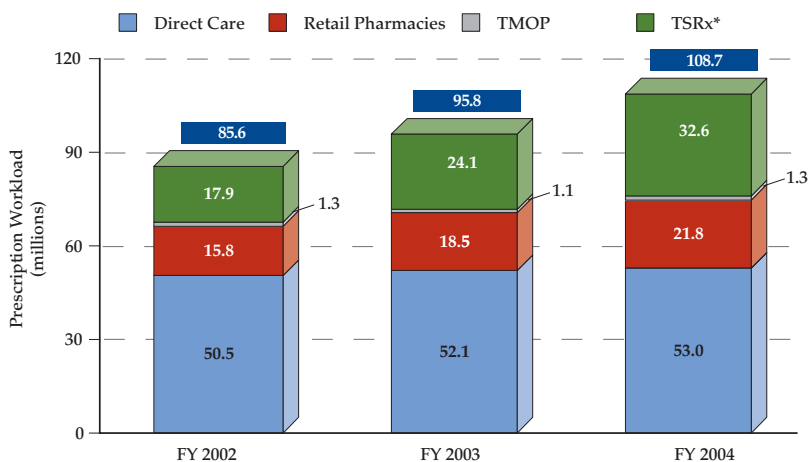
* Purchased care only.

- Direct care outpatient encounters were essentially constant the past 3 years but RVUs declined by 13 percent, indicating less intensive workload being performed in MTFs.
- Excluding TFL workload, purchased care outpatient encounters increased by 34 percent, and RVUs by 36 percent. Including TFL workload, encounters and RVUs increased by the same percentages (i.e., 34 percent and 36 percent, respectively).
- While not shown, about 14 percent of direct care outpatient workload (both encounters and RVUs) was performed OCONUS. Purchased care and TFL outpatient workload performed OCONUS were less than 2 percent of the total.

MHS Prescription Drug Workload

Prescription drugs include all initial and refill prescriptions filled at military pharmacies, retail pharmacies, and TMOP (formerly the National Mail Order Pharmacy). Prescription workload is shown as actual prescription counts, unadjusted for differences in the average days supply from these sources. Total MHS prescription workload (direct, retail, and mail-order combined) increased by 13 percent from FY 2002 to FY 2004, excluding the effect of the TRICARE Senior Pharmacy (TSRx)* benefit.

TRENDS IN MHS PRESCRIPTION WORKLOAD



Source: MHS administrative data, 1/31/2005

* Purchased care only.

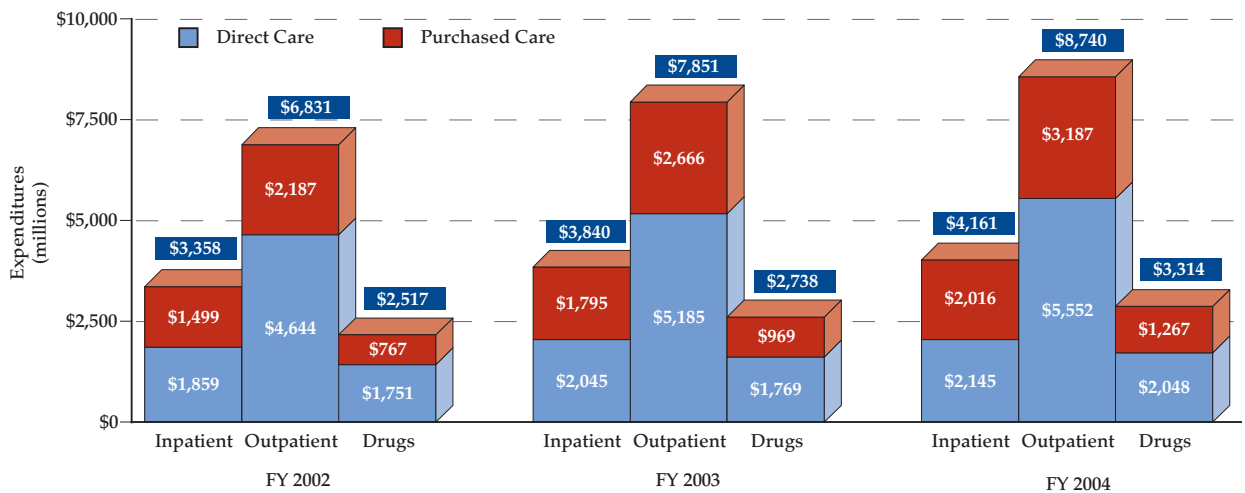
- Direct care prescription workload increased by 3 percent FY 2003 and by another 2 percent in FY 2004.
- Retail prescription workload increased by 38 percent from FY 2002 to FY 2004 (17 percent in FY 2003 and 18 percent in FY 2004), excluding the impact of the TSRx benefit. Including the impact of TSRx, purchased care prescription workload increased by 26 percent in FY 2003 and by another 28 percent in FY 2004.
- While not shown, just under 10 percent of direct care prescriptions were issued OCONUS. Purchased care prescriptions issued OCONUS accounted for less than 1 percent of the total.

MHS COST TRENDS

Total MHS costs increased between FY 2002 and FY 2004 for all three major components of health care services: inpatient, outpatient and prescription drugs, although the relative proportions remained about the same.

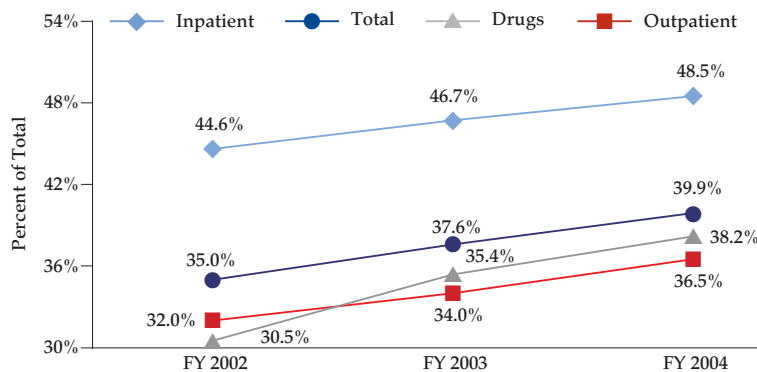
- The share of DoD expenditures on outpatient care relative to total expenditures on inpatient and outpatient care remained at about 67–68 percent from FY 2002 to FY 2004. For example, in FY 2004, DoD expenses for inpatient and outpatient care totaled \$12,901 million, of which \$8,740 million was for outpatient care for a ratio of $\$8,740/\$12,901 = 68$ percent.
- In the interval from FY 2002 to FY 2004, DoD spent an average of about \$2 for outpatient care for every \$1 spent on inpatient care.
- For inpatient, outpatient, and prescription drug care, the proportion of total expenses for care provided in DoD facilities fell. Overall, the proportion of total expenses for care provided in DoD facilities fell from 65 percent in FY 2002 to 60 percent in FY 2004.

TREND IN DoD EXPENDITURES FOR HEALTH CARE



Source: MHS administrative data, 1/31/2005
 Note: TFL purchased care costs are excluded from the above calculations.

TREND IN PURCHASED CARE COST AS PERCENTAGE OF TOTAL COST BY TYPE OF SERVICE



Source: MHS administrative data, 1/31/2005
 Note: TFL purchased care costs are excluded from the above calculations.

- Between FY 2002 and FY 2004, the purchased care share of total MHS costs (direct plus purchased) increased for inpatient, outpatient, and prescription drug services.

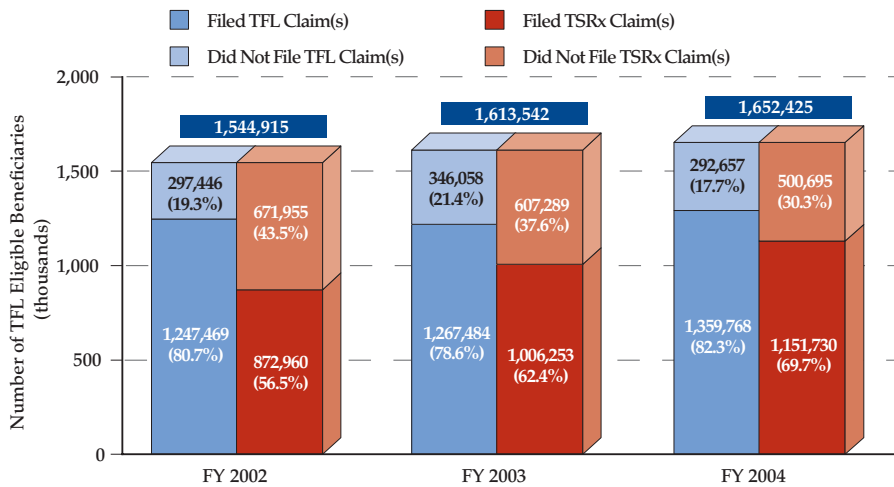
IMPACT OF TRICARE FOR LIFE (TFL) IN FY 2002–2004

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

TRICARE for Life and TRICARE Senior Pharmacy Beneficiaries Filing Claims

- There were 1.83 million Medicare-eligible DoD beneficiaries by the end of FY 2004, compared with 1.76 million at the end of FY 2003 and 1.70 million at the end of FY 2002.
 - At the end of FY 2004, 1.65 million DoD Medicare eligible beneficiaries were eligible for the TFL and TSRx benefits, whereas the remainder were ineligible for TFL because they did not have Medicare Part B coverage.
- The percentage of TFL-eligible beneficiaries who filed at least one claim increased slightly between FY 2002 and FY 2004.
 - The reasons some beneficiaries do not file claims are varied, including: not receiving any care at all, retaining Medicare supplemental insurance that pays for most costs not covered by Medicare, and maintaining enrollment in a Medicare risk HMO that has small or no enrollment fees and copayments.
- The percentage of TFL-eligible beneficiaries who filed at least one TSRx claim has steadily increased from FY 2002 to FY 2004 (from 57 percent to 70 percent).

TFL-ELIGIBLE BENEFICIARIES FILING TFL AND TSRx CLAIMS IN FY 2002 TO 2004



Source: MHS administrative data, 1/31/2005

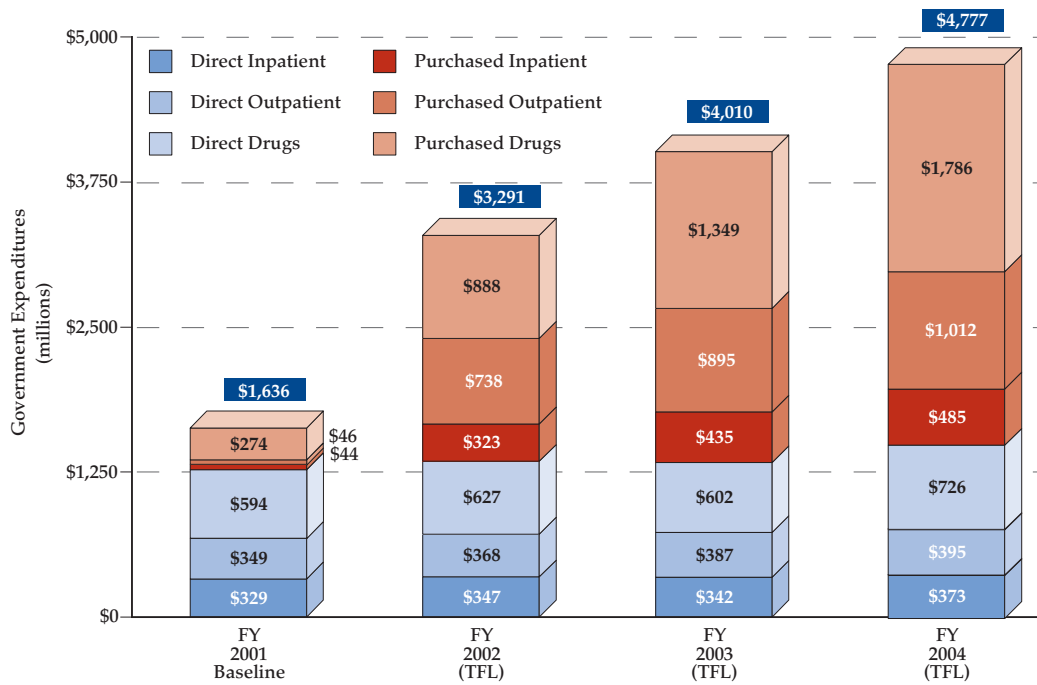
IMPACT OF TRICARE FOR LIFE IN FY 2002–2004 (CONT'D)

DoD Expenditures for TRICARE for Life and TRICARE Senior Pharmacy

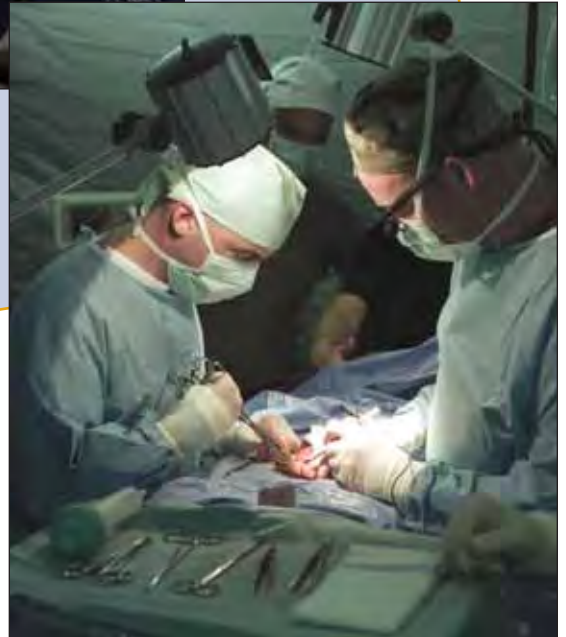
In order to estimate the effect of TFL and TSRx on DoD costs, baseline expenses are defined as those DoD spent for the care of MHS seniors in FY 2001. Most baseline inpatient and outpatient expenses were incurred by beneficiaries enrolled in TRICARE Senior Prime (ended December 2001) and the Uniformed Services Family Health Plan (which continues). Most prescription expenses were incurred by beneficiaries using the TSRx program, which began in April 2001.

- TFL had very little impact on DoD direct care inpatient and outpatient expenses from FY 2002 to FY 2004. However, DoD expenses for direct care prescription drugs increased by 16 percent over the same time period.
- Purchased care TFL expenditures increased from FY 2002 to FY 2004 for inpatient, outpatient, and prescription drugs. The most dramatic increase was for prescription drugs, where DoD costs more than doubled in two years.

DoD EXPENDITURES ON BEHALF OF TFL-ELIGIBLE BENEFICIARIES



Source: MHS administrative data, 1/31/2005



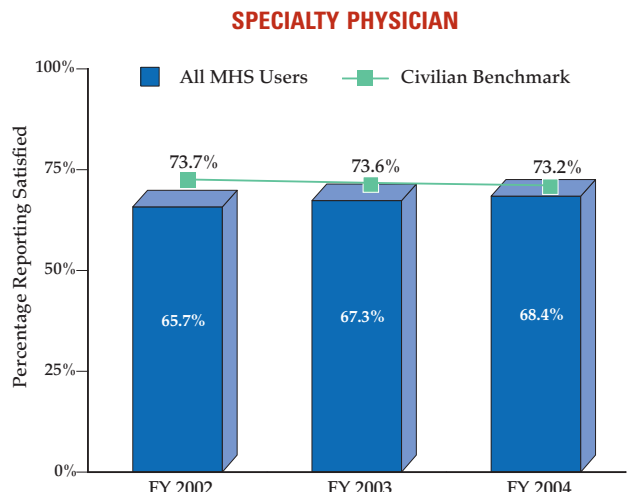
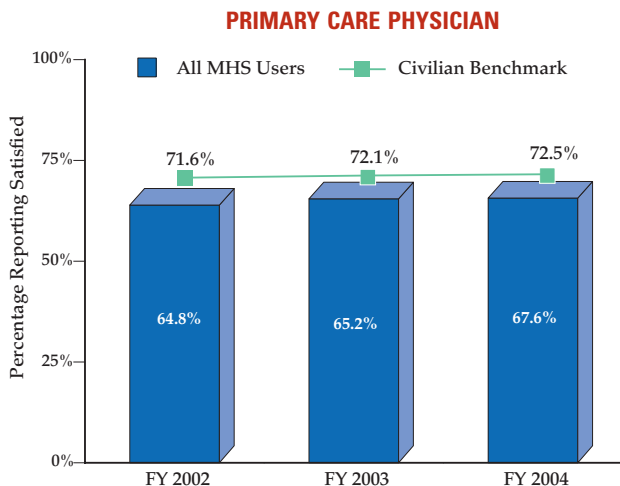
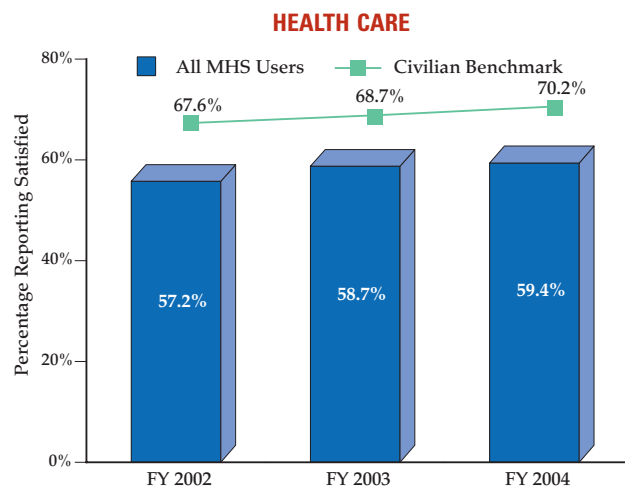
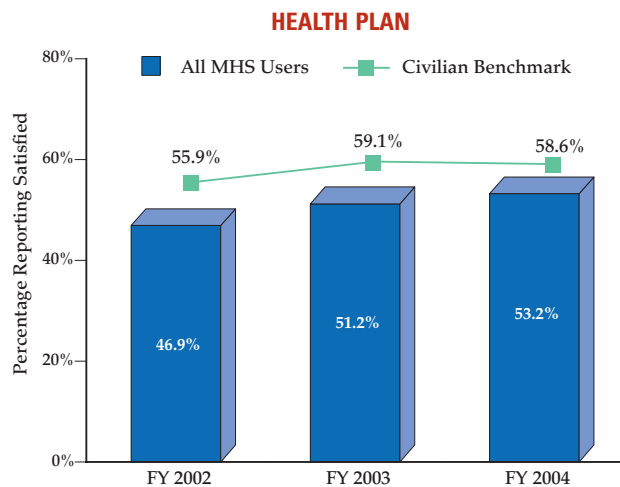
The External Customer perspective focuses on scanning the health care environment for relevant benchmarks, applying their metrics, and striving to meet or exceed those standards. The metrics presented here focus on Customer Satisfaction and health promotion activities through Building Healthy Communities. Unless otherwise stated, all charts in this and subsequent sections refer to populations in the 3 TRICARE regions.

CUSTOMER SATISFACTION WITH KEY ASPECTS OF TRICARE

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

- Satisfaction with the overall TRICARE plan, as well as with health care, one's personal physician, and specialty physicians continues to improve each year (the change in the "health care" ratings over time is not statistically significant).
- MHS rates continue to lag civilian benchmarks.

TRENDS IN SATISFACTION RATINGS OF KEY HEALTH PLAN ASPECTS



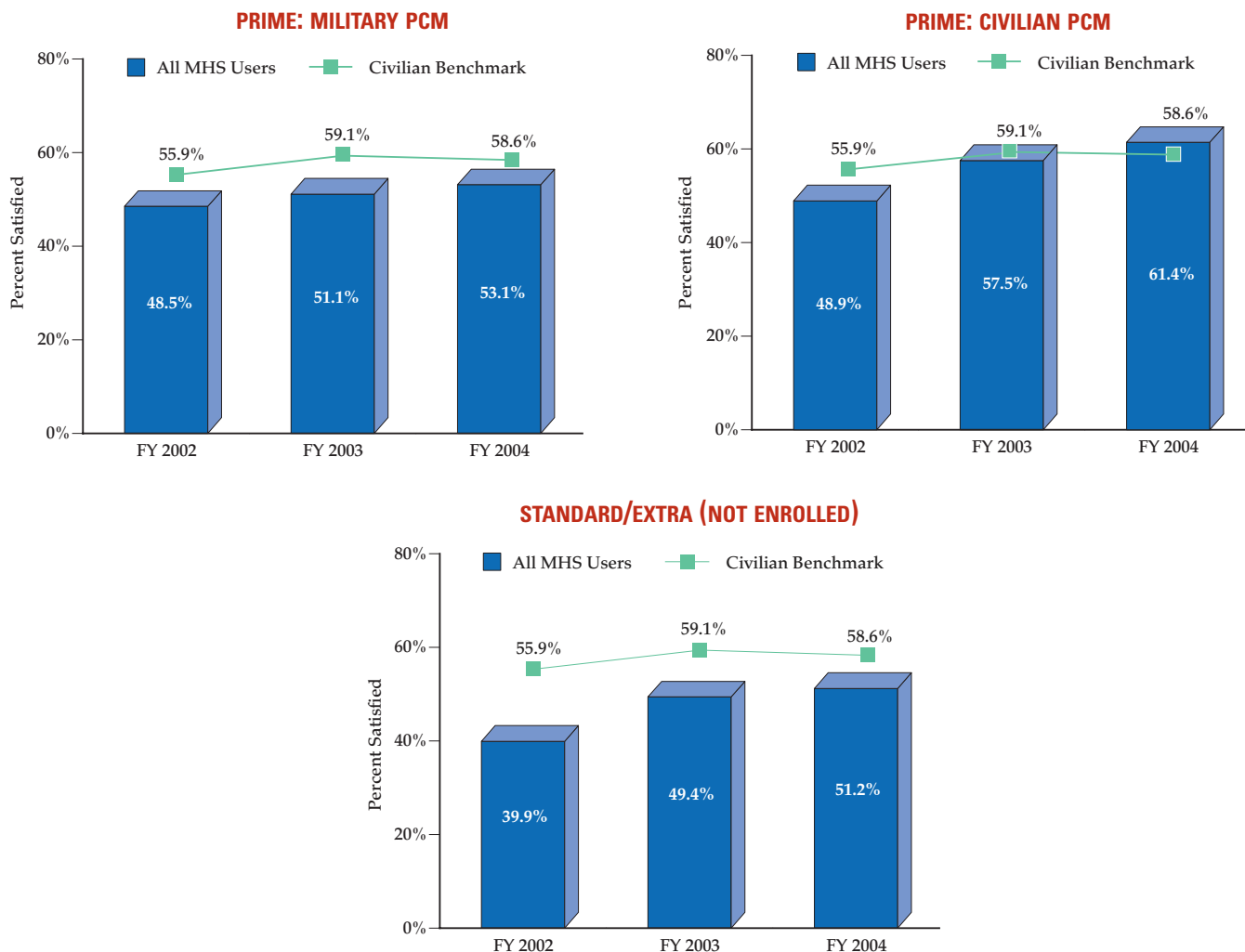
Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with "Satisfied" defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. "All MHS Users" applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION WITH TRICARE BASED ON ENROLLMENT STATUS

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

- Overall satisfaction with the TRICARE plan continuously improved each year for Prime enrollees (with either military or civilian PCMs) and non-enrollees alike between FY 2002 and FY 2004.
- In the past 2 years (FY 2003 and FY 2004), MHS beneficiaries enrolled with civilian network providers reported the same or higher level of satisfaction than their civilian counterparts.
- MHS beneficiaries enrolled with military PCMs and those not enrolled at all generally reported lower levels of satisfaction compared to their civilian plan counterparts.

TRENDS IN SATISFACTION WITH TRICARE BASED ON ENROLLMENT STATUS



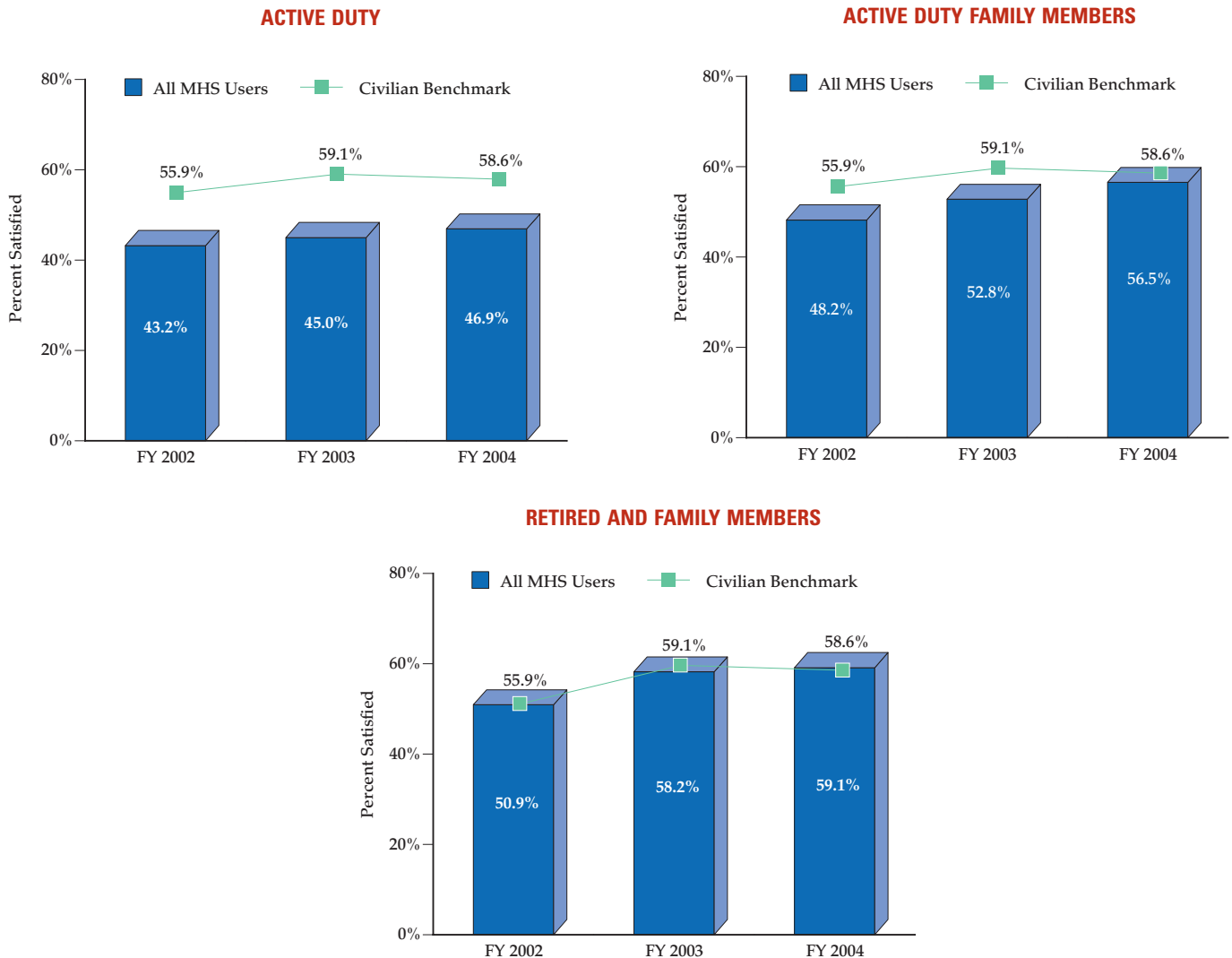
Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

SATISFACTION BY BENEFICIARY CATEGORY

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

- Satisfaction with TRICARE improved for active duty personnel and their family members between FY 2003 and FY 2004, and, while improved for retirees and their family members between FY 2002 and FY 2003, did not change appreciably in the past two years.
- In general, the rates for active duty personnel and their family members continued to lag civilian counterparts for the past 3 years.
- Satisfaction of retired DoD beneficiaries over the past 2 years (FY 2003 and FY 2004) is comparable to the general population using a commercial plan (no statistical difference).

TRENDS IN SATISFACTION WITH HEALTH PLAN BY BENEFICIARY CATEGORY



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Ratings are on a 0–10 scale, with “Satisfied” defined as a rating of 8 or better. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

BUILDING HEALTHY COMMUNITIES

DoD Triennial Survey of Health-Related Behaviors Among Military Personnel

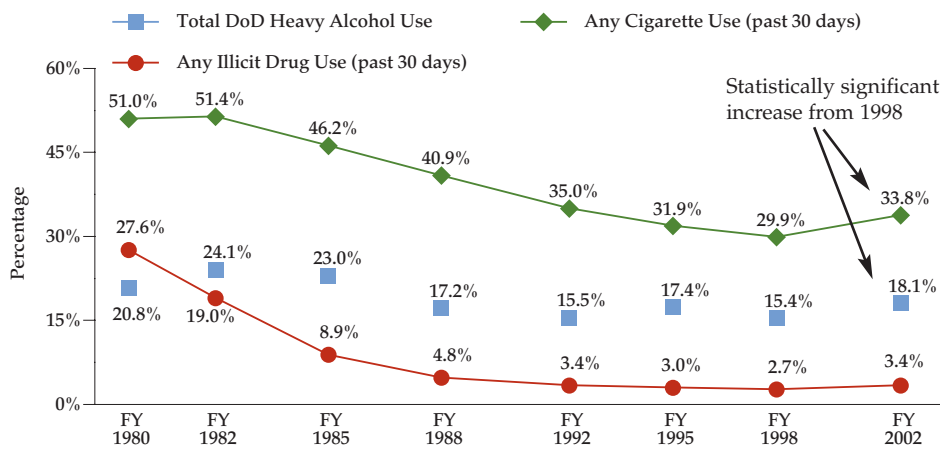
The results of the 2002 DoD Survey of Health-Related Behaviors Among Military Personnel study were released in early FY 2004. This is the eighth in a series of surveys of active duty military personnel, with previous studies conducted in 1980, 1982, 1985, 1988, 1992, 1995 and 1998. All of these surveys investigated the prevalence of alcohol use, illicit drug use, and tobacco use, as well as negative consequences associated with substance use. The survey has evolved over time, with revisions and additions to accommodate new areas of concern (e.g., mental health of the active force, oral health, and gambling behaviors), as well as including Healthy People 2010 objectives.*

Reported Substance Use by DoD Personnel

Overall findings reflect that the DoD has made steady progress during the 22 years studied from 1980 to 2002 in combating substance abuse and its associated problems. There is, however, continued opportunity for further improvements in some areas, particularly in heavy alcohol use.

- As shown below, for the 22-year period studied, there has been a statistically significant reduction in reported cigarette smoking (from about one-half the population in 1980 to about one-third in 2002) and use of any illicit drugs (from slightly over one-quarter of the population in 1980 to less than 4 percent in 2002). The change in reported heavy alcohol use, however, was not significant over the same time frame.
- However, comparisons of survey findings between 1998 and 2002 showed increases in the rates of heavy alcohol use and cigarette smoking, but no change in illicit drug use.

TRENDS IN TOTAL DoD REPORTED SUBSTANCE USE (IN THE PAST 30 DAYS): FY 1980–2002



Note: Consistent with most recent Report's Executive Summary (Figure ES-1, p ES-2) data presented are unadjusted; i.e., not standardized to the 1980 DoD or Service-specific distribution by age, education, and marital status (defined in Table 4-2, pp. 4-5).

"Heavy Alcohol Use" was defined as drinking five or more drinks per typical drinking occasion at least once a week in the 30 days prior to the survey, consistent with the definition used in other national surveys of civilians, such as the NHSD (2002 DoD Survey of Health Related Behaviors Among Military Personnel, 2-15).

"Any Illicit Drug Use" was defined as nonmedical use of any of 12 categories of drugs: marijuana/hashish, phenylcyclidine (PCP), lysergic acid diethylamide (LSD) or other hallucinogens, cocaine, amphetamines or other stimulants, tranquilizers or other depressants, barbiturates or other sedatives, heroin or other opiates, analgesics or other narcotics, inhalants, designer drugs, anabolic steroids, and gamma hydroxybutyrate (GHB) (2002 DoD Survey of Health-Related Behaviors Among Military Personnel, 2-17).

* R.M. Bray, et al., Nov. 2003. 2002 Department of Defense Survey of Health-Related Behaviors Among Military Personnel, ES-1.

** IBID, ES-3.

Military vs. Civilian Comparisons.

After adjusting for sociodemographic differences between military and civilian populations, standardized comparisons showed substantial differences in substance use between the military and civilian populations**:

- Younger military personnel (ages 18–25) were more likely to report heavy alcohol use than their civilian counterparts, while older military personnel (ages 26–55) reported usage similar to their civilian counterparts (not shown in graph below).
- Military personnel were less likely to use any illicit drugs in the past 30 days than their civilian counterparts (about 3 percent compared to about 12 percent, respectively).
- Both populations reported similar smoking rates.

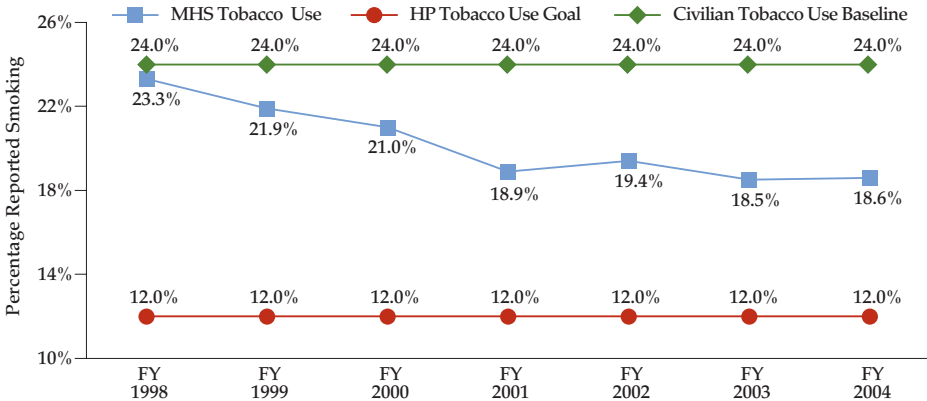
HEALTHY PEOPLE 2000 AND 2010 BENCHMARKS

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

Tobacco Use

The MHS improved over the 5-year period between 1998 and 2003 in approaching the HP 2010 goal of a 12 percent rate of tobacco use for individuals smoking at least 100 cigarettes in a lifetime, and smoking in the last month. MHS beneficiaries report usage at about three-quarters that of the adjusted civilian usage baseline.

BUILDING HEALTHY COMMUNITY TRENDS: TOBACCO USE



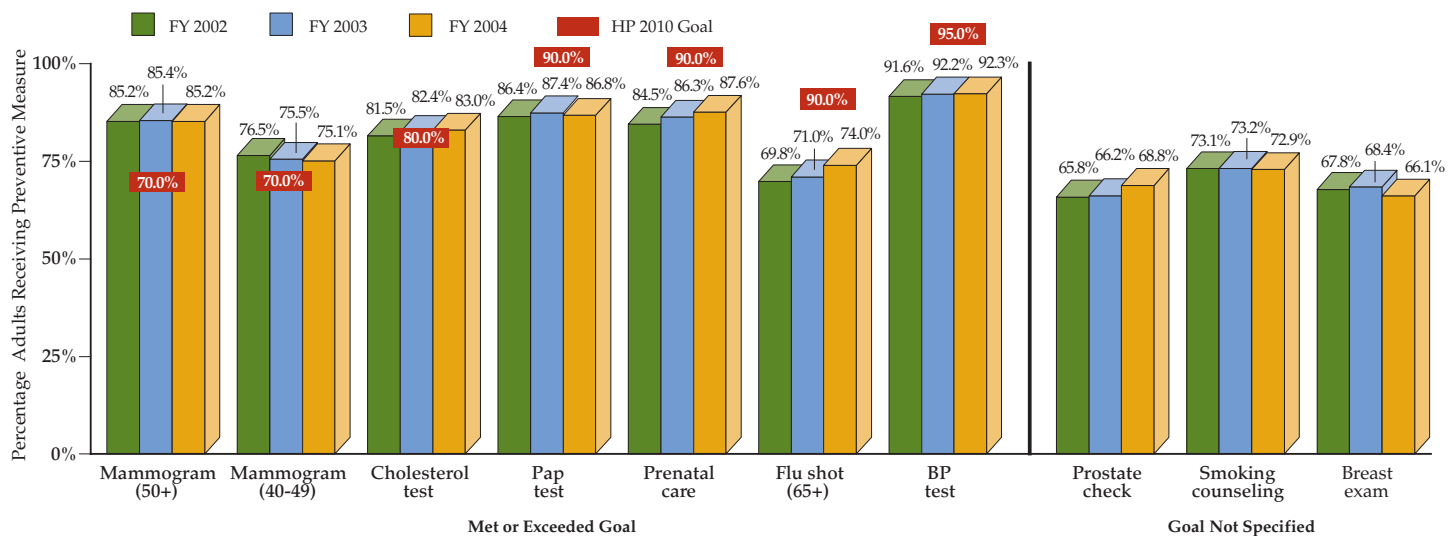
Source: MHS data: Health Care Survey of DoD Beneficiaries

* HP 2010 goal and civilian use baseline: U.S. Department of Health and Human Services. *Healthy People 2010*: <http://www.healthypeople.gov/document/html/objectives/27-01.htm>, accessed 1/4/2005. Civilian tobacco use is based on the 1998 baseline, age adjusted to the year 2000 standard population.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS

- The MHS has set as goals selected national health-promotion and disease-prevention objectives specified by the Department of Health and Human Services in Healthy People 2010. These goals and objectives go beyond restorative care and speak to the need to institutionalize population health within the MHS. Over the past 3 years, the MHS has met or exceeded targeted Healthy People 2010 goals in providing mammograms (for ages 40–49 years as well as 50+ categories) and testing for cholesterol.
- Efforts continue toward achieving Healthy People 2010 standards for Pap smears, prenatal exams, flu shots (for people age 65 and older), and blood pressure screenings.
- Still other areas continue to be monitored in the absence of specified Healthy People standards, such as breast exams (for those age 40 and over), smoking-cessation counseling, and prostate exams.

TRENDS IN MEETING PREVENTIVE CARE STANDARDS, FY 2002–2004



Source: Health Care Survey of DoD Beneficiaries and the National CAHPS Benchmarking Database

MHS TARGETED PREVENTIVE CARE OBJECTIVES

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

Cholesterol test: People who had a cholesterol screening in last five years.

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

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

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

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

MHS GOALS NOT SPECIFIED BY CURRENT HEALTHY PEOPLE 2010 TARGETS

Prostate check: Men age 50 or older who had a prostate exam in last 12 months.

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

Breast exam: Women age 40 or older who had a breast exam in last 12 months.

Most health care readiness metrics focus on those unique aspects germane to each of the Services, and are presented by the Surgeons General as appropriate to their combat leadership. Other readiness metrics are classified and presented elsewhere, as appropriate. Finally, we are in the process of developing and standardizing several common baseline measures that will need to mature over the next year. One such measure that has helped define one critical aspect of medical readiness comes from our dental community.

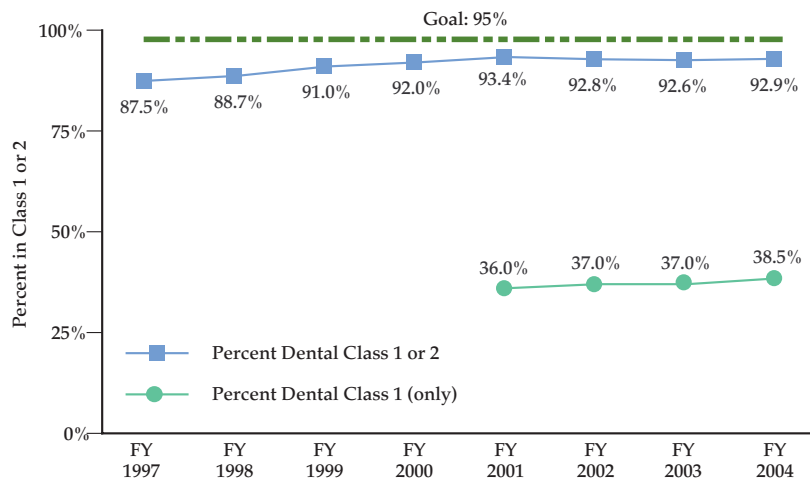
DENTAL READINESS

In 1996, the Service Dental Corps Chiefs established a goal of maintaining at least 95 percent of all active duty personnel in Dental Class 1 or 2. While a measure of dental readiness, this goal also effectively measures active duty access to necessary dental services. Patients in Dental Classes 1 or 2 have a current dental examination, and do not require dental treatment (Class 1) or require nonurgent dental treatment or reevaluation for oral conditions which are unlikely to result in dental emergencies within 12 months (Class 2—see note below chart). The results for FY 1997 to FY 2004 are presented below.

- While the overall MHS rate of dental readiness for Classes 1 and 2 has generally increased since the metric was established, the target rate of 95 percent continues to be elusive, although the gap is slowly narrowing.
- In addition, Dental Class 1 percentages demonstrate a less than optimal state of dental health (Dental Class 1) for active duty personnel.

DENTAL READINESS

Active Duty Dental Readiness: Percent Dental Class 1 or 2



Data source: The Services' Dental Corps—DoD Dental Readiness Classifications

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

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

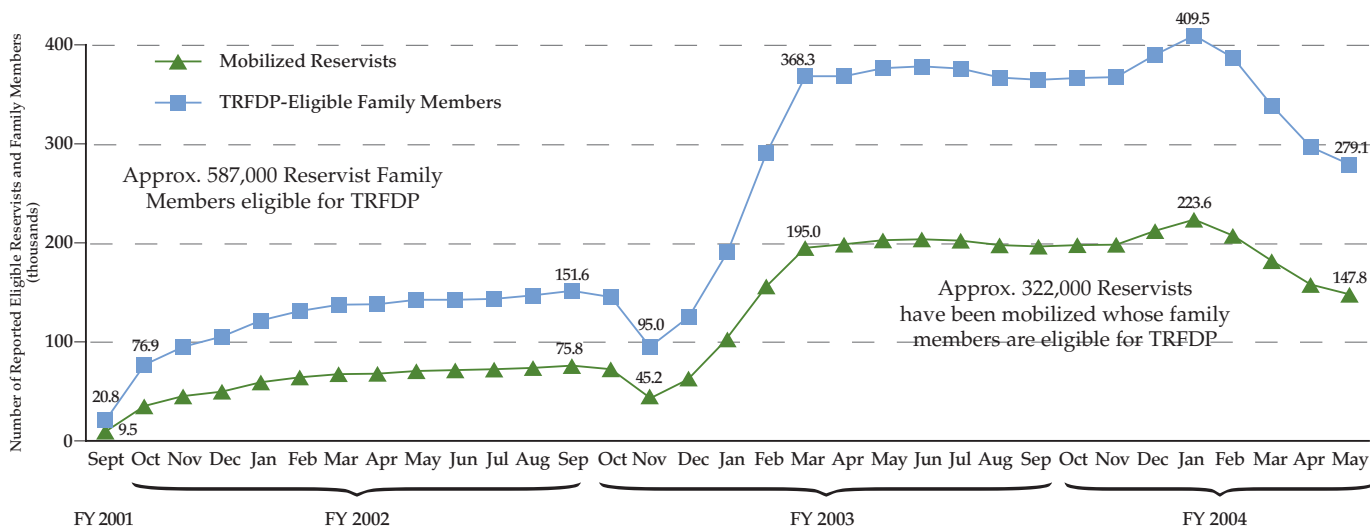
SPECIAL STUDY: TRICARE SUPPORT FOR FAMILIES OF MOBILIZED RESERVISTS

TRICARE has continued to support the Global War on Terrorism which began shortly after September 11, 2001 through a rapidly deployed health benefits demonstration project known as the TRICARE Reserve Family Demonstration Project (TRFDP). This Demonstration supported the family members of mobilized Reservists using TRICARE Standard (the indemnity option) by waiving certain administrative and financial requirements expected to present obstacles to a group of beneficiaries who would not be familiar with TRICARE, yet who were likely to be involved with other health insurance for their own civilian providers. Two of these financial requirements were: (1) waiver of the annual deductible (\$150 for families of enlisted grades E4 and below; \$300 for those families of senior enlisted and all officers); and (2) waiver of the TRICARE maximum allowable charge (TMAC) so DoD pays up to 115 percent of TMAC, less the applicable copayment, for demonstration participants who are covered by TRICARE Standard and receive care from non-participating providers who bill in excess of the TMAC.

➤ Between September 2001 and May 2004, over 322,000 National Guard and Reservists were mobilized for Operations Noble Eagle, Enduring Freedom, and Iraqi Freedom. As a

result of their mobilization for active duty, their 587,000 family members were eligible for the TRFDP benefit during this period of time.

MONTHLY MOBILIZED GUARD AND RESERVISTS AND TRFDP: ELIGIBLE FAMILY MEMBERS (SEPT. 2001–MAY 2004)

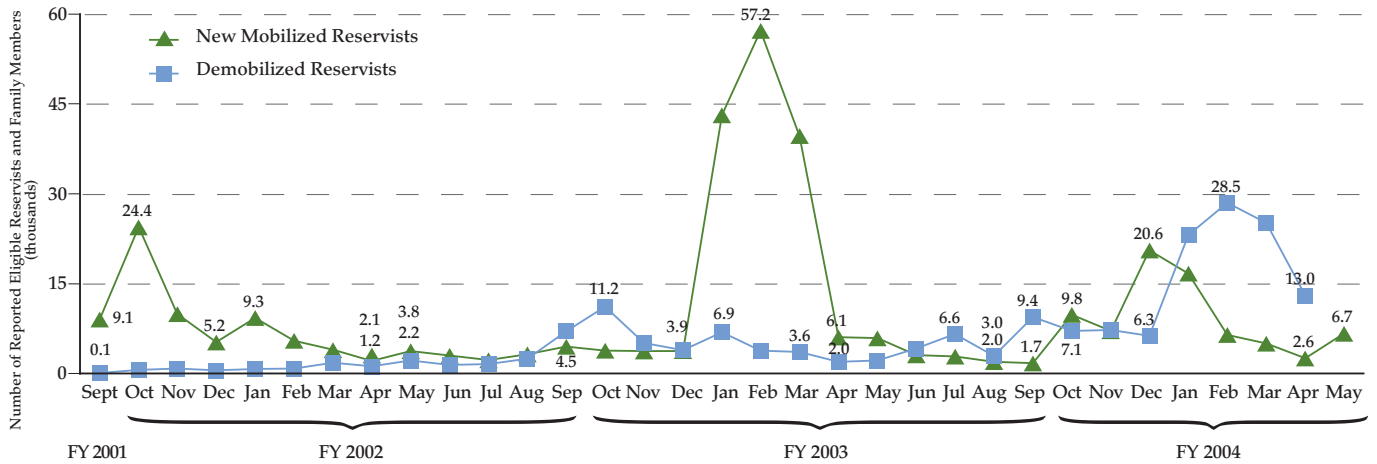


Source: DEERS data

Trend in Mobilized and Demobilized Reservists, Sept. 2001 to May 2004

Unlike the graph on the previous page, which shows the number of Reservists and their family members eligible for the TRFDP Benefits each month, the graph below depicts the additional or new mobilizations in a given month, as well as the new demobilizations for that month. As readily shown, the initial mobilizations for Noble Eagle and Enduring Freedom peaked in early 2001, and again with the build up of reserve forces for Iraqi Freedom beginning in 2003. These peaks thus indicate when family members would most likely begin considering using the TRICARE benefit. On the other hand, the smaller peaks in demobilized Reservists (end of 2002 and January–March 2004) reflect when the sponsors and their family members could begin to use the post-separation from active service TAMP benefits.

TREND IN MOBILIZED AND DEMOBILIZED RESERVISTS (SEPT. 2001–MAY 2004)

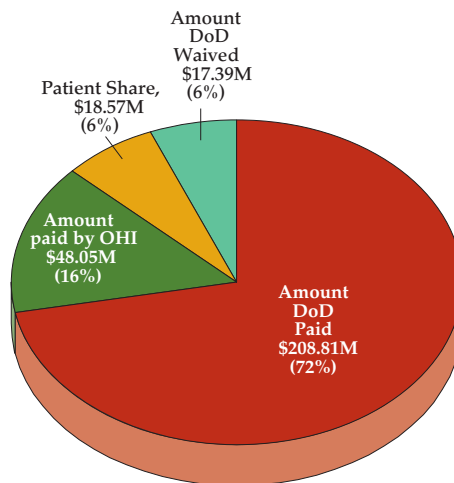


Source: DEERS data, 12/12/2004

Composition of all Payments for TRFDP Purchased Care Services

- During this time, a total of almost \$293 million was spent for purchased care services for these family members, paid by the DoD (\$209 million, or 72 percent), patients (\$18 million, or 6 percent) and patients’ other health insurance (OHI, \$48 million, or 16 percent). The DoD waived over \$17 million in patient cost shares specifically authorized by the Demonstration.

COMPOSITION OF ALL PAYMENTS FOR TRFDP PURCHASED CARE SERVICES (\$M), (SEPT. 2001–MAY 2004)



Source: MHS administrative data: Government waived costs (<http://www.tricare.osd.mil/tps/>); other costs, special study by TMA/HPA&E, 12/12/2004



QUALITY

Quality metrics in 2004 addressed several patient-focused areas: (1) self-reported access to MHS care overall, (2) satisfaction with various aspects of the MHS (e.g., the availability and ease of obtaining care, getting providers of choice, and receiving responsive customer service), (3) quality and timeliness of claims processing (both patient reported as well as tracking through administrative systems), (4) Joint Commission accreditation results for MTFs, (5) access to and satisfaction with MTF care, and (6) two special studies this year (one comparing AC and RC family member access to care and the other assessing access to TRICARE Standard civilian providers).

Access to MHS Care

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

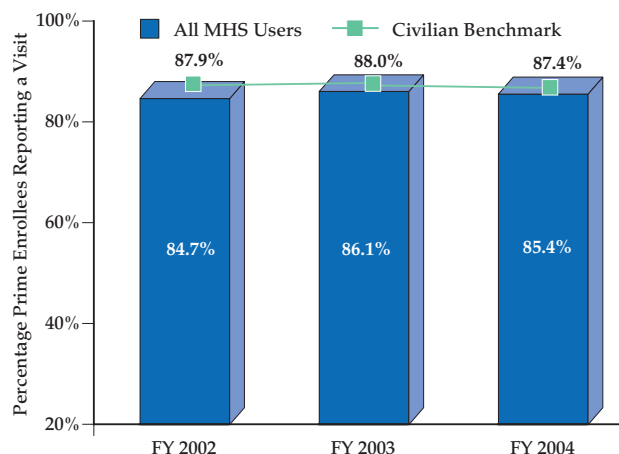
- Access based on reported use of the health care system in general.
- Availability and ease of obtaining care, and getting a provider of choice.
- Responsive customer service.
- Quality and timeliness of claims processing.

Overall Outpatient Access

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

- Access to and use of outpatient services remains high.
- Prime enrollees reporting they had at least one outpatient visit in the past year increased between FY 2002 and FY 2003, comparable to their civilian counterparts enrolled in managed care plans.

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



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

ACCESS TO MHS CARE (CONT'D)

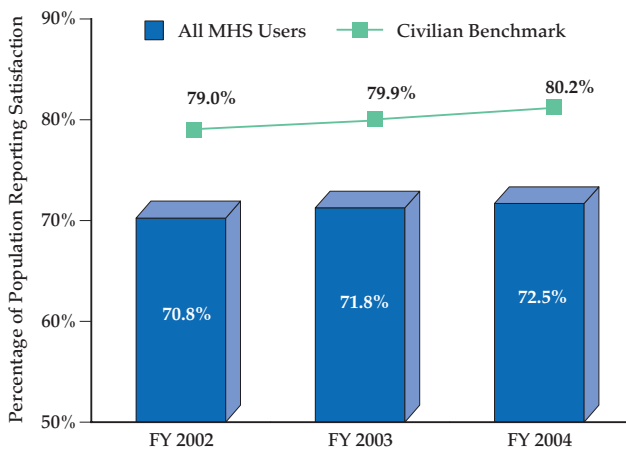
Availability and Ease of Obtaining Care

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

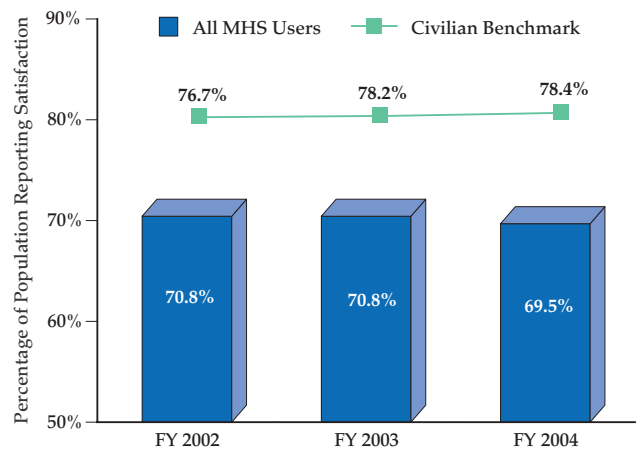
- While MHS beneficiary ratings for getting necessary care appear to be improving, MHS ratings declined between FY 2002 and FY 2004 in the two other categories shown below: waiting for routine appointments and waiting less than 15 minutes to see the doctor. The civilian benchmark similarly declined between FY 2003 and FY 2004, which may be influenced by the change in CAHPS survey questions (see note below).
- While MHS beneficiary-reported waiting times were comparable to civilians in FY 2002, their reported satisfaction diminished faster than their counterparts in FY 2004.

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

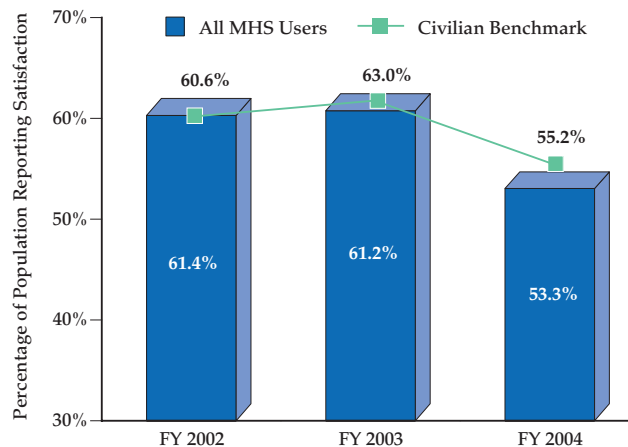
GOT NECESSARY CARE



WAITED FOR ROUTINE APPOINTMENT



WAITED LESS THAN 15 MINUTES TO SEE DOCTOR



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to “waiting... to see the doctor” may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

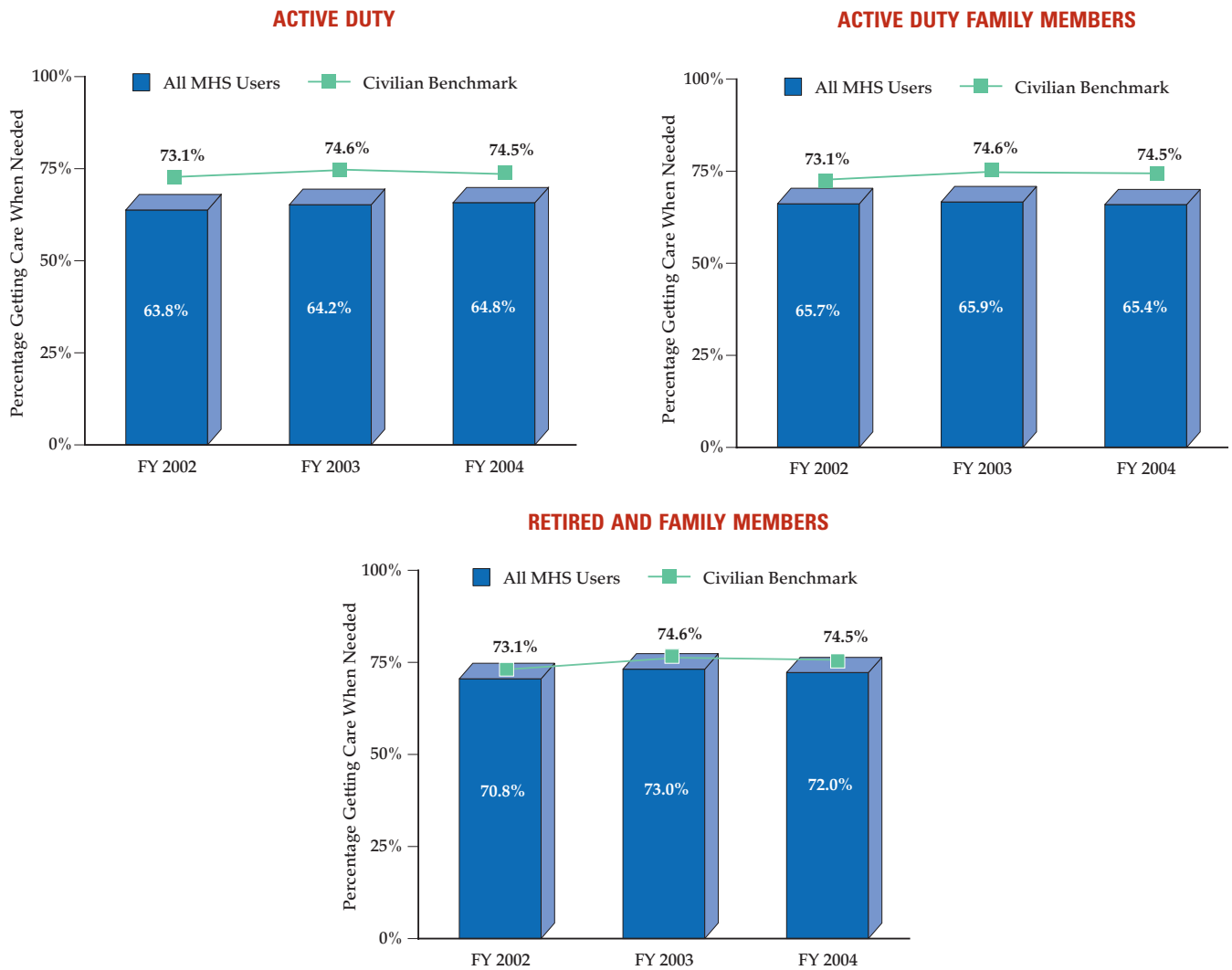
ACCESS TO MHS CARE (CONT'D)

Ability to Obtain Care by Beneficiary Category

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

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

TRENDS IN AVAILABILITY OF OBTAINING CARE BY BENEFICIARY CATEGORY (ALL SOURCES OF CARE)



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

ACCESS TO MHS CARE (CONT'D)

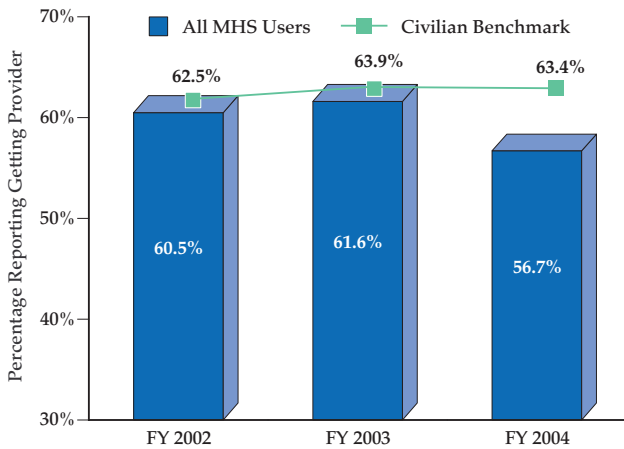
Opportunity to Get a Health Provider of Choice

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

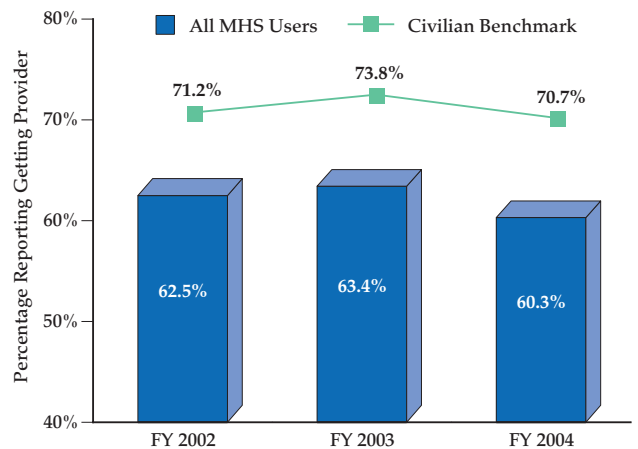
- The majority (62 percent in FY 2003) of MHS beneficiaries are able to get a personal provider they are happy with. The decrease in FY 2004 may, in part, be affected by the change in the survey question.
- The DoD trends in getting access to personal or specialty providers continue to lag comparable commercial health plans.

TRENDS IN GETTING ACCESS TO PERSONAL OR SPECIALTY PROVIDERS

GETTING A PERSONAL DOCTOR OR NURSE OF CHOICE



GETTING A REFERRAL TO A SPECIALIST



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to “... getting a personal doctor of choice” may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

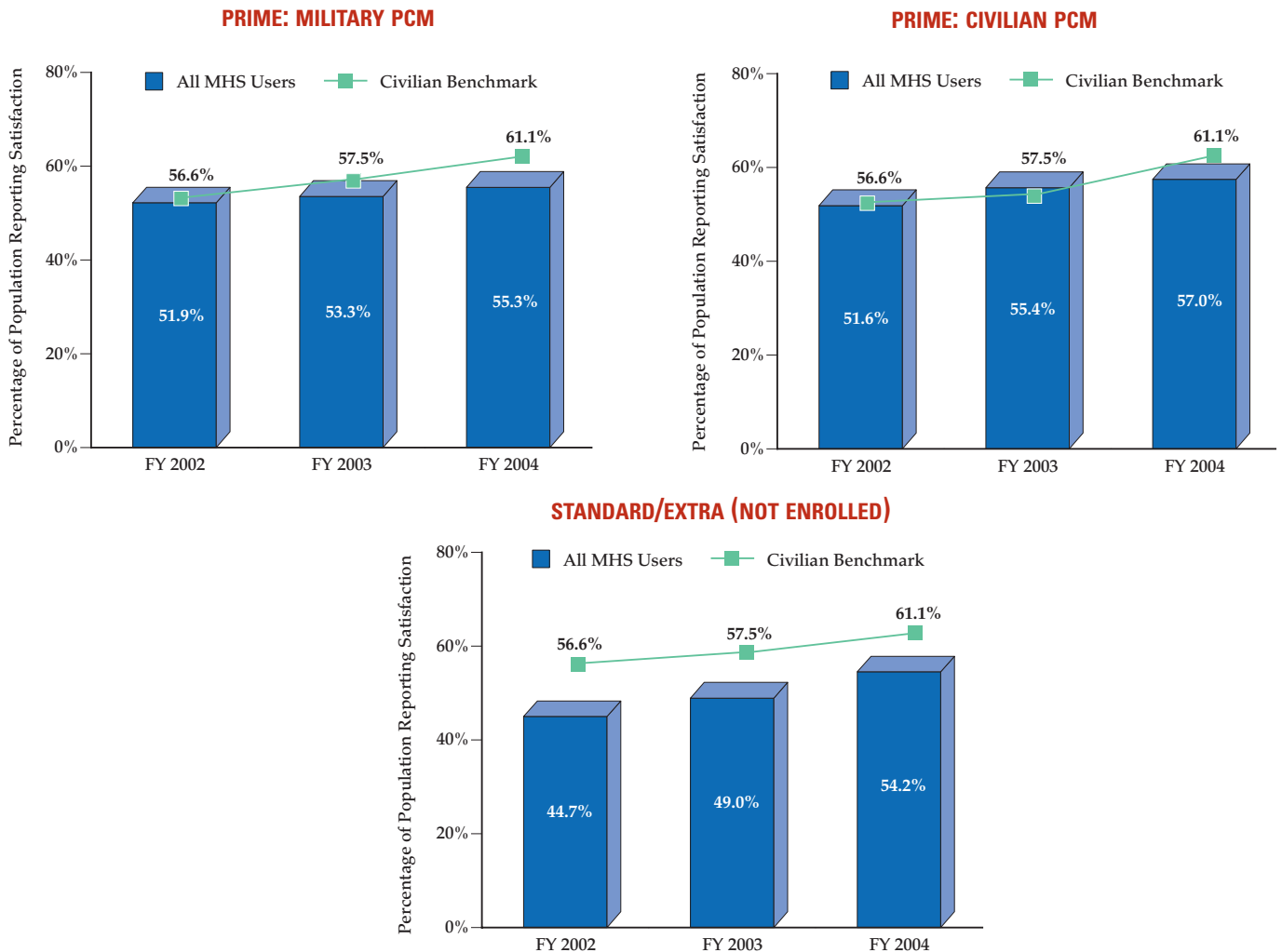
ACCESS TO MHS CARE (CONT'D)

Satisfaction with Customer Service

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

- MHS customer service responsiveness, beneficiary ease of understanding written materials, and dealing with paperwork improved between FY 2002 and FY 2004. Enrollees and non-enrollees alike reported higher levels during this time.
- Those enrolled in Prime (with either a military or a civilian provider) reported fewer problems with customer service compared to those who were not enrolled.
- Ratings for TRICARE customer service were not as high as those reported by enrollees in commercial plans.

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



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology. Also note the change in the responses to “... paperwork” may have been influenced by the CAHPS 2.0 to 3.0 question change between FY 2003 and FY 2004.

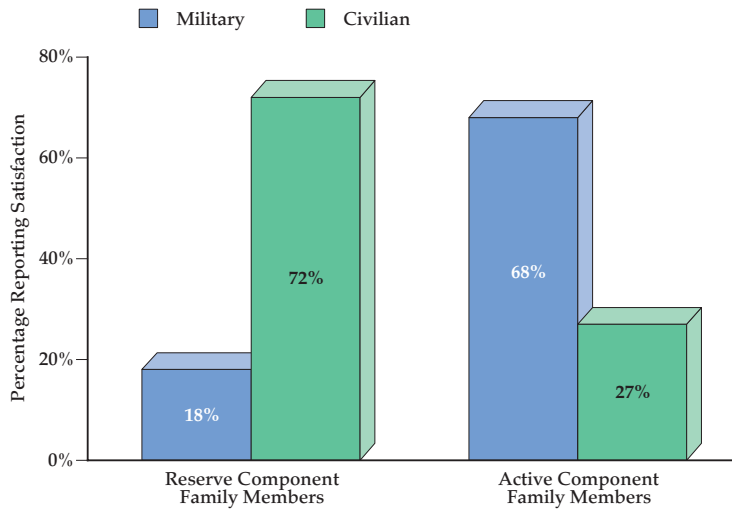
SPECIAL STUDY: COMPARISON OF ACTIVE COMPONENT AND MOBILIZED RESERVE COMPONENT FAMILY MEMBER ACCESS TO TRICARE

Two special studies were accomplished to examine differences in AC and RC family member access to, and satisfaction with, TRICARE. Both studies used the HCSDB. One study analyzed prior HCSDB results (FY 2001 to FY 2003) to assess differences in family member responses. The second study added supplemental questions to the HCSDB and specifically targeted a sample of 4,000 Reservists in the fielding of the routine, fourth quarter 2003 survey. Some of the key results of these studies follow, addressing three areas: (1) primary or usual source of care; (2) overall satisfaction with the health plan and health care delivered, and (3) satisfaction with customer service and claims processing.

Reliance on TRICARE: Usual Source of Care

As expected from a population that tends to reside at a distance from MTFs*, the 2003 supplemental survey found the majority (72 percent) of Reservists' families report their health care is usually provided by civilian sources, whereas the majority (68 percent) of AC family members report receiving their care from military sources.

COMPARISON OF MOBILIZED RESERVE AND ACTIVE COMPONENT FAMILY MEMBER USUAL SOURCE OF CARE



Source: 2003 4th Quarter Supplemental HCSDB Survey (n = 4,000)

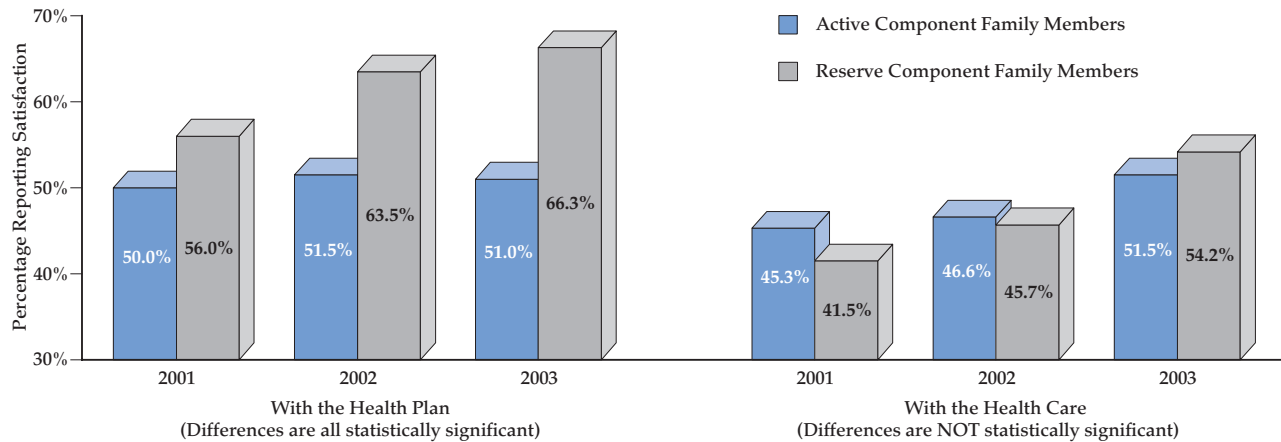
* GAO found most reservists (70%) lived and worked more than 50 miles from an MTF, compared to only 5 percent of the AC. GAO-02-829, Sept 6, 2002.

SPECIAL STUDY: COMPARISON OF ACTIVE COMPONENT AND MOBILIZED RESERVE COMPONENT FAMILY MEMBER ACCESS TO TRICARE (CONT'D)

Satisfaction with Health Plan and Care

While RC and AC family members report comparable levels of satisfaction with the health *care* they receive, Reservists' family members report higher levels of satisfaction with their overall health *plan* than their AC family member counterparts.

COMPARISON OF MOBILIZED RESERVE AND ACTIVE COMPONENT FAMILY MEMBER SATISFACTION RATES WITH THE HEALTH PLAN AND HEALTH CARE



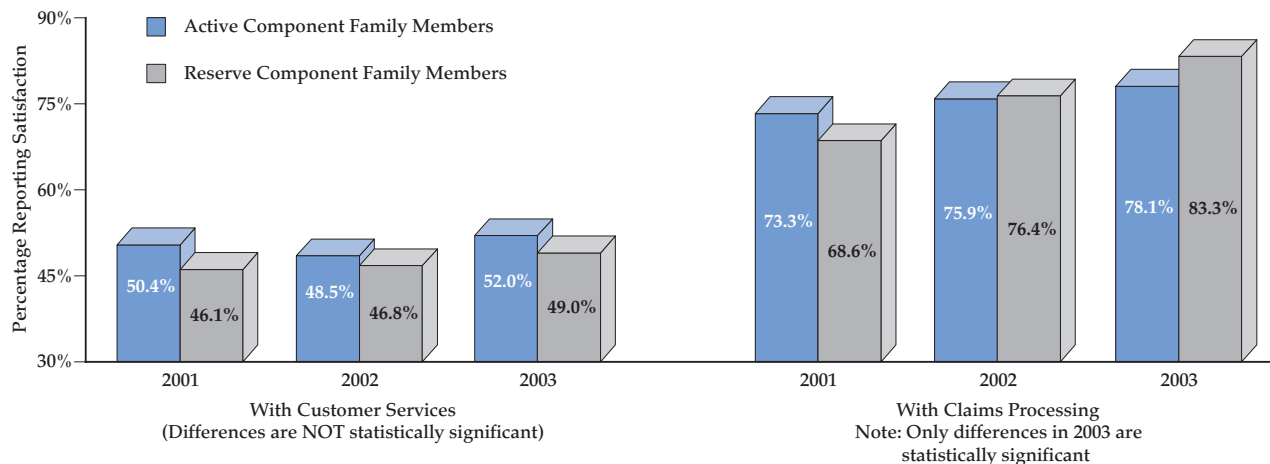
Source: Health Care Survey of DoD Beneficiaries (2001–2003)

Satisfaction with Customer Service and Claims Processing

In general, AC and RC family members report similar rates of satisfaction with the customer services they receive and the processing of their claims.

- However, in 2003, RC family members reported greater satisfaction with the processing of their claims than did their AC family counterparts.

COMPARISON OF MOBILIZED RESERVE AND ACTIVE COMPONENT FAMILY MEMBER SATISFACTION WITH CUSTOMER SERVICE AND CLAIMS PROCESSING



Source: Health Care Survey of DoD Beneficiaries (2001–2003)

CLAIMS PROCESSING

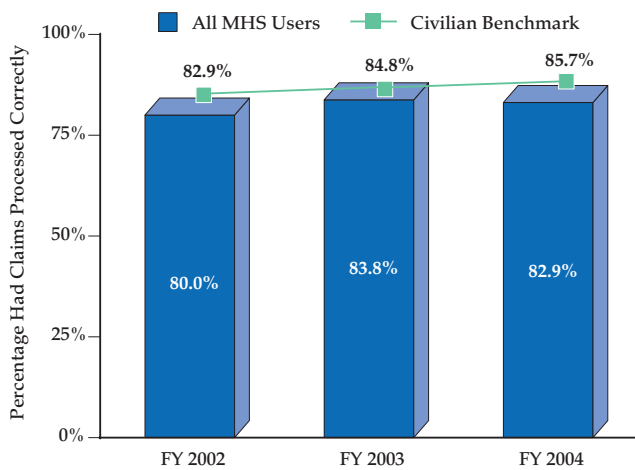
Beneficiary Perceptions of Claims Filing Process

MHS beneficiaries increasingly report that their claims are processed properly (about 83 percent) and in a reasonable period of time (81 percent in FY 2004). MHS satisfaction levels, however, continue to lag behind the civilian benchmark.

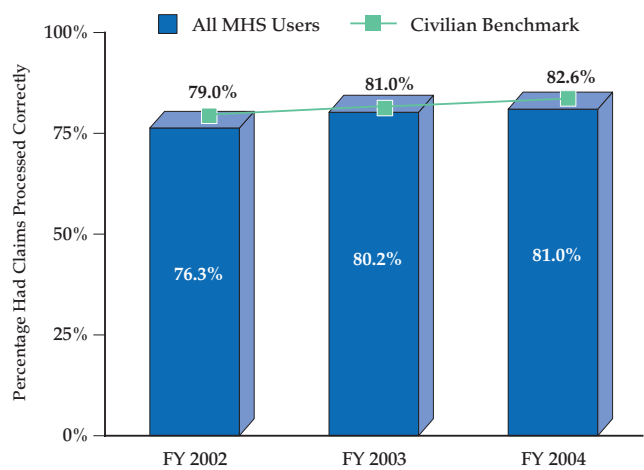
Beneficiary satisfaction with TRICARE claims processing is, for the most part, improving over time. There is, however, a slight decrease in reported satisfaction with claims processed properly between FY 2003 and FY 2004. MHS beneficiaries reported the same level of satisfaction as civilian patients with their claims processing time in FY 2003, but slightly less so in FY 2004.

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

CLAIMS PROCESSED PROPERLY (IN GENERAL)



CLAIMS PROCESSED IN A REASONABLE TIME



Note: DoD data were derived from the 2002–2004 DoD Health Care Survey of DoD Beneficiaries (HCSDB) and adjusted for age and health status. Civilian benchmark is obtained from the National CAHPS Benchmarking Database. “All MHS Users” applies to Survey respondents in the 50 United States. See Appendix (Methods and Data Sources) for more detailed discussion of the HCSDB methodology.

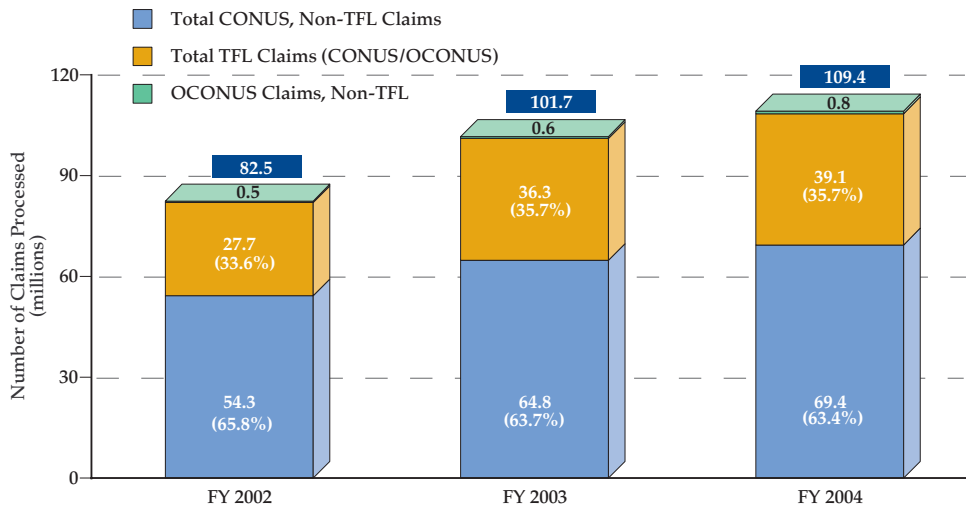
CLAIMS PROCESSING (CONT'D)

Administratively Tracked Claims Filing Process

Despite the challenges of claims processing volume almost trebling since FY 2001 (38.8 million claims, not shown, increasing to 109.4 million in FY 2004), claims processing turnaround time continues to exceed TRICARE goals.

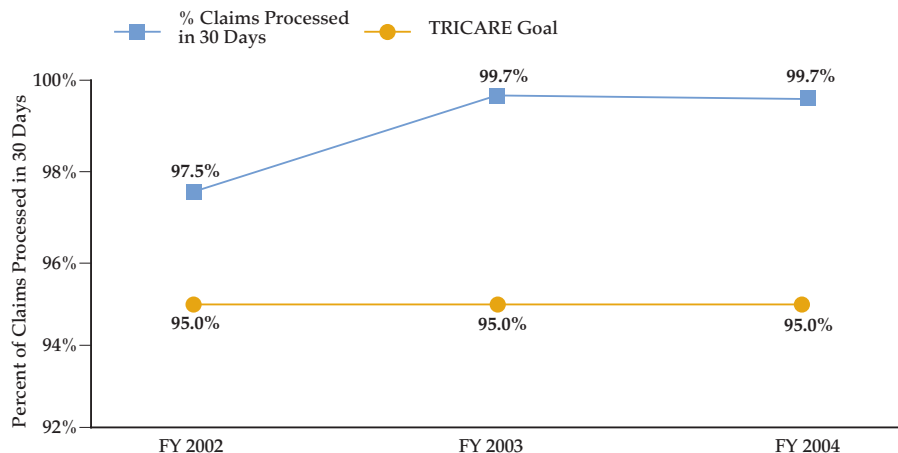
- The first chart below reflects the overall increase in claims processed of about 33 percent since FY 2002. While TFL and CONUS non-TFL claims increased 28 percent and over 41 percent respectively, the bulk of processed claims remain non-TFL (almost two-thirds, or 63.5 percent).
- As shown in the second chart below, the processing of retained claims within 30 days exceeded the TRICARE goal of 95 percent over the past three years.
- Although not shown on the graph, almost 100 percent of claims are now being processed within 60 days.
- The number of claims filed increased notably between FY 2001 and FY 2002 with the introduction of the TFL (October 2001) and TSRx (April 2001) benefits.

NUMBER OF TRICARE TFL AND NON-TFL CLAIMS PROCESSED



Source: MHS administrative data, 1/12/2005

PERCENTAGE OF TRICARE RETAINED CLAIMS PROCESSED WITHIN 30 DAYS



Source: MHS administrative data, 12/16/2004

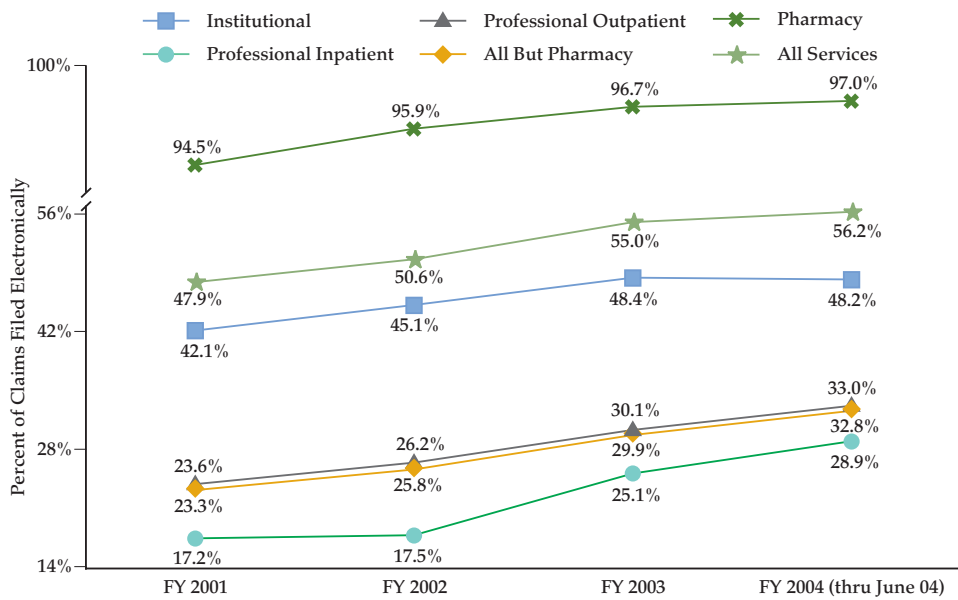
CLAIMS PROCESSING (CONT'D)

Trends in Electronic Claims Filing

Electronic claims submissions use more efficient technology requiring less transit time between the provider and payer, are usually less prone to errors or challenges, and usually result in more prompt payment to the provider.

- The percentage of the over 45 million non-TFL claims processed electronically increased to over 56 percent by mid-FY 2004, up almost 6 percentage points from 50.6 percent in FY 2002. TFL claims are excluded because TRICARE is second payer to Medicare, and, as such, the TFL claims are predominantly electronic, irrespective of MHS involvement.
- Pharmacy claims continue to reflect the bulk of electronic claims. When these claims are excluded from consideration, the percentage of remaining claims (institutional and professional inpatient and outpatient services) has increased by almost 7 percent since FY 2002, reaching 33 percent by June 2004.

EFFICIENCY OF PROCESSING TRICARE CLAIMS: PERCENTAGE OF CLAIMS FILED ELECTRONICALLY



Source: MHS administrative data

SPECIAL STUDY: VIABILITY ASSESSMENT OF TRICARE STANDARD PROVIDER AVAILABILITY

Market Areas

The FY 2004 National Defense Authorization Act (section 723) required the Department to “conduct surveys in the TRICARE market areas in the U.S. to determine how many health care providers are accepting new patients under TRICARE Standard in each such market area.” In this legislation:

- At least 20 market areas are required to be surveyed annually, although “market area” was not specifically defined,
- The Department must prioritize those six market areas with the greatest access problems,
- DoD must consult with representatives of TRICARE beneficiaries/providers to help identify initial market areas.

Working with the Office of Management and Budget to ensure sufficiency in the design and efficiency in the administration of the survey, market areas were selected where there was a minimum population of 1,000 non-enrolled, under age 65, nonactive duty beneficiaries. Two rounds of telephonic surveys were conducted between April and September 2004. The following market areas were studied:

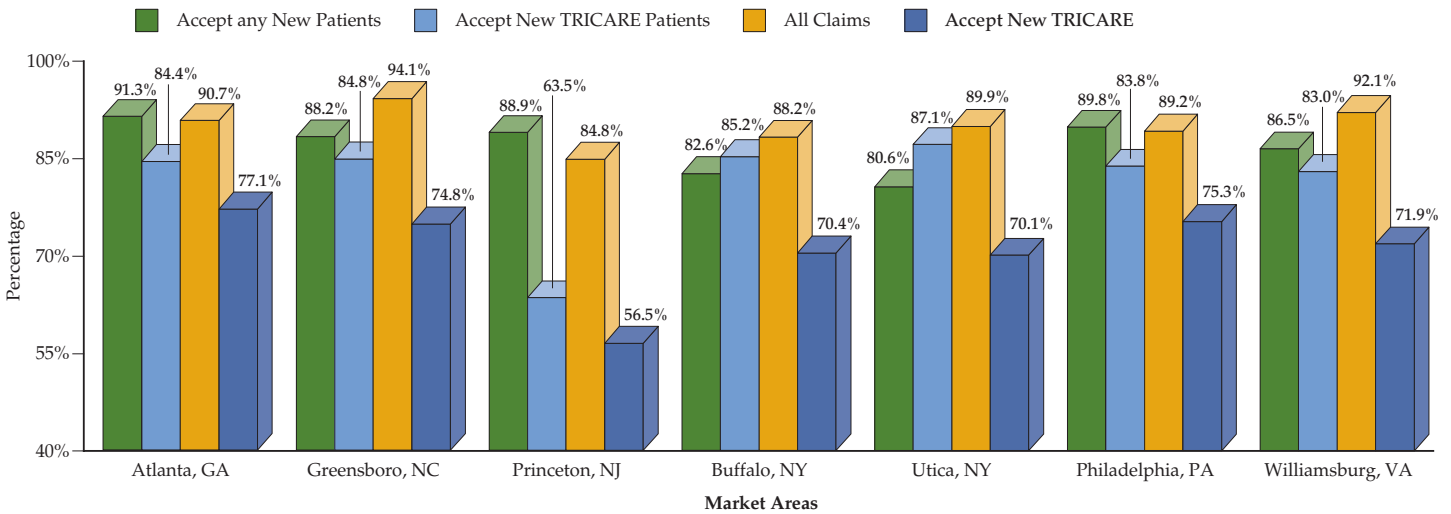
- Round 1:
 - Boise, ID
 - Anchorage, AK
 - Colorado Springs, CO
 - Rochester, NY
 - Las Vegas, NV
 - Fredericksburg, VA
 - Philadelphia, PA
 - Cheyenne, WY
 - Jackson, MS
 - Meridian, MS
- The results of responding providers in the market areas identified above indicate that, overall (not shown):
 - Although there are regional differences, the percentages of civilian providers who report accepting new TRICARE Standard patients are high, reaching almost 95 percent in Fayetteville, TN.
 - Of these, the great majority (reaching almost 94 percent in Fredericksburg, VA and Greensboro, NC) accepts TRICARE Standard for all patients.
- As an example of the nature of the findings, the chart on the next page presents the results of part of the second round:
 - Among providers who report accepting new patients (first column), those accepting any new TRICARE patients range from a low of about 81 percent (Utica, NY) to a high of 91 percent (Atlanta, GA).
 - Among those providers (in column one) accepting any new patients, the percentage of those accepting new TRICARE Standard patients (second column) range from a low of about 64 percent (Princeton, NJ) to a high of 87 percent (Utica, NY).
 - Of those providers who accept new TRICARE Standard patients (column two), the percentage of those accepting TRICARE Standard reimbursement as payment in full on all claims (instead of on a claim-by-claim basis—third column) range from a low of almost 85 percent (Princeton, NJ) to a high of 94 percent (Greensboro, NC).
 - Finally, when looking at all responding providers (i.e., those accepting any new patients as well

SPECIAL STUDY: VIABILITY ASSESSMENT OF TRICARE STANDARD PROVIDER AVAILABILITY (CONT'D)

- as those not accepting new patients—fourth column), the overall percentage of total providers accepting new TRICARE Standard patients ranges from a low of about 57 percent (Princeton, NJ) to a high of 77 percent (Atlanta, GA).
- Also, while not shown in the chart below, the two rounds of surveys found that, of the physicians responding:
 - About 28 percent cited reimbursement as reason for not accepting TRICARE.
 - 21 percent to 24.8 percent claimed they were too busy to accept TRICARE.
 - About 9 percent take other forms of TRICARE.
 - A range of 9 percent to almost 21 percent only accept certain insurance.

PROVIDER ACCEPTANCE OF TRICARE STANDARD

PROVIDERS ACCEPTING TRICARE PATIENTS AND PAYMENT



Source: 2004 Survey on Continued Viability of TRICARE Standard., TMA/HPA&E and the NRC+Picker Group

Notes on reading the graph above:

- Column one is the percentage of providers in each market area who reported accepting any new patients.
- Column two is a subset of column one; of those providers who reported accepting any new patients in each market area, column two is the percentage of those providers who accepted new TRICARE Standard patients.
- Column three is a subset of column two; of those providers who reported accepting new TRICARE Standard patients in each market area, column three is the percentage of payment of all claims divided by the total number of providers accepting new TRICARE patients.
- Column four is NOT a subset of any other column; column four is the percentage of all providers in each market area (including those who weren't accepting any new patients) who reported accepting new TRICARE Standard patients.

MILITARY TREATMENT FACILITY SURVEY RESULTS BY THE JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO)

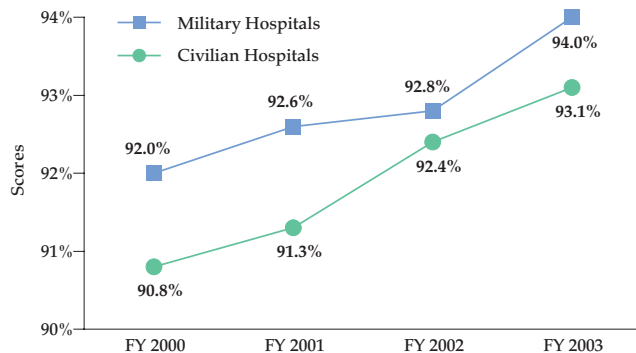
Military Treatment Facility Survey Results by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

In the United States, the JCAHO is the nationally recognized organization that surveys health care settings using pre-established, published criteria and provides an accreditation status based on onsite surveys conducted at least every three years. Participation in the JCAHO survey process has been an institutionalized aspect of quality for the MHS for many years. Typically, survey scores for MTFs exceed 90 (out of a possible score of 100) even if there are requirements for improvement identified in some areas. A transformation in the preparation for a JCAHO survey is currently underway. The current emphasis is on sustained performance, using the JCAHO standards as the benchmark for health care practice in our institutions. Having adopted the model of continuous process improvement, MTFs are expected to be in a state of accreditation readiness.

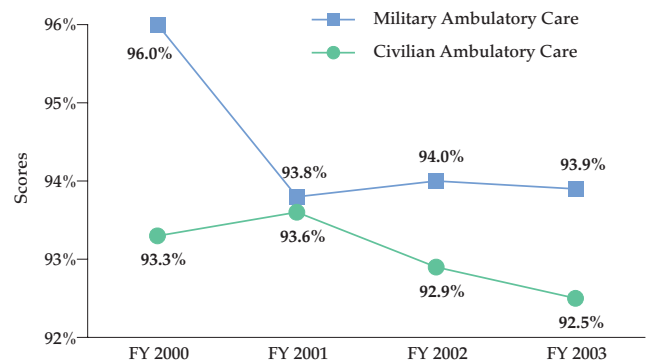
- Consistent with the military service adage of “train as we fight” for wartime or military operations other than war, the intent of the accreditation process today is to ensure that health care organizations:
 - Establish and maintain mechanisms to perform important processes and functions.
 - Measure those processes and functions to assess effectiveness.
 - Influence the continuous improvement in the performance of those important processes and functions.
- In general, MHS inpatient and outpatient (ambulatory) facilities have achieved high and consistent JCAHO ratings since FY 2001.

ACCREDITATION

AVERAGE JCAHO SCORES FOR HOSPITAL ACCREDITATION



AVERAGE JCAHO SCORES FOR AMBULATORY ACCREDITATION

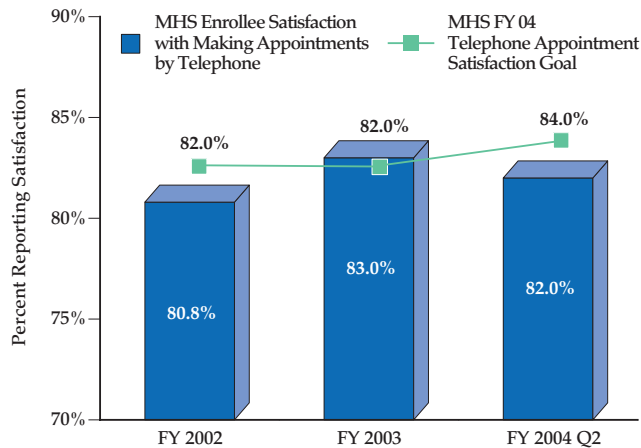


Source: OASD(HA)/TMA, Office of the Chief Medical Officer, October 8, 2004

APPOINTMENT ACCESS IN THE DIRECT CARE SYSTEM

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

SATISFACTION WITH MAKING APPOINTMENTS BY TELEPHONE IN THE DIRECT CARE SYSTEM



The MHS goal was raised in FY 2004 to 84 percent from 82 percent the previous year, when patients reporting satisfaction exceeded the 82 percent goal in FY 2003. The new FY 2004 goal of 84 percent was not achieved this year.

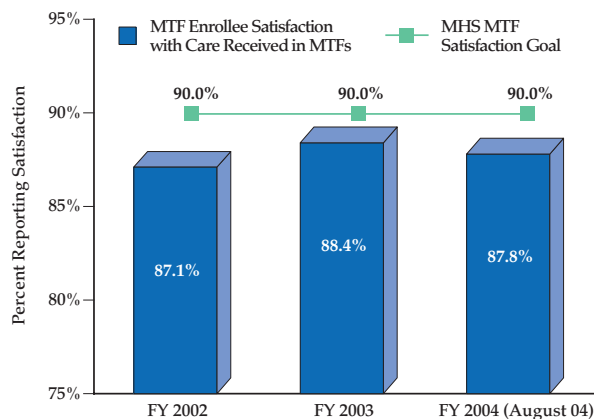
Source: DHP Performance Contract (Q-2 Report), Satisfaction with Access, 11/19/2004

SATISFACTION WITH CARE RECEIVED IN THE DIRECT CARE SYSTEM

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

The MHS goal of at least 90 percent satisfaction continues to be elusive.

SATISFACTION WITH THE MTF ENCOUNTER IN THE DIRECT CARE SYSTEM



Source: DHP Performance Contract (Q-4, 11th month Report), Satisfaction with Access, 11/22/2004

TRICARE DENTAL PROGRAMS CUSTOMER SATISFACTION

The overall TRICARE Dental benefit is comprised of several delivery programs serving the MHS beneficiary population.

- The TRICARE Dental Program (TDP) is a voluntary, premium-sharing dental insurance program that is available to eligible active duty family members, selected reserve and individual ready reserve members, and their family members. The TDP services over 700,000 contracts covering 1,734,187 lives. The FY 2004 composite average enrollee satisfaction for the TDP measured 94 percent, which included satisfaction ratings for Network Access (94 percent), Provider Network Size and Quality (92 percent), Claims Processing (95 percent), Enrollment Process (95 percent), and Written and Telephonic Inquiries (93 percent).
- The TRICARE Retiree Dental Program (TRDP) is a full premium insurance program open to retired uniformed service members and their families. In FY 2004, the TRDP demonstrated an 11.9 percent increase in enrollees with over 380,000 contracts serving 816,520 lives. The FY 2004 overall enrollee satisfaction was 88.5 percent.

Active Duty Dental Customer Satisfaction

- The Military Dental Treatment Facilities (DTFs) are responsible for the dental care of 1.79 million active duty service members, as well as eligible OCONUS family members. During FY 2004, the Tri-Service Center for Oral Health Studies collected 124,417 DoD Dental Patient Satisfaction Surveys from the Services' DTFs. The overall DoD satisfaction with the DTFs was 96.1 percent, while the overall DoD satisfaction with the quality of treatment provided was 96.3 percent. Additionally, 96 percent of the patients surveyed answered that they would return to the DTF for future dental care.



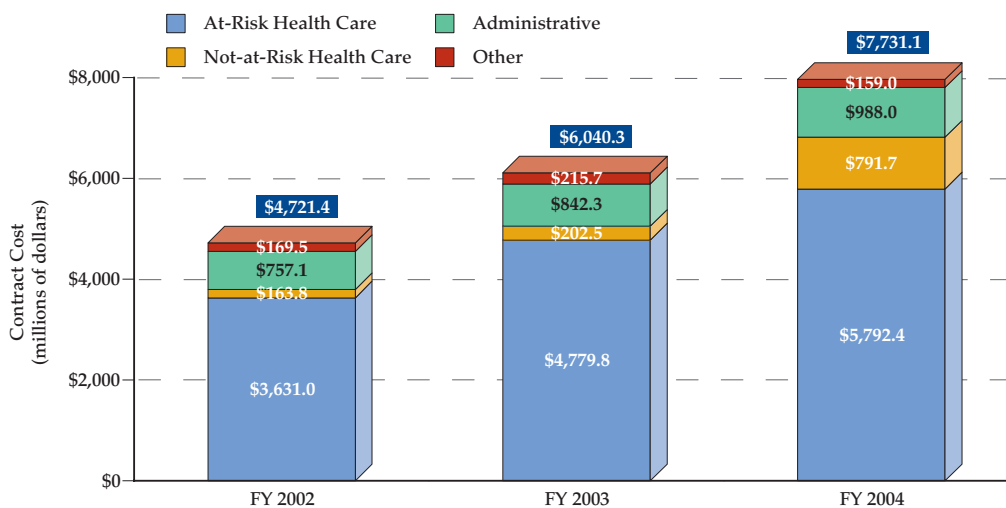
SYSTEM PRODUCTIVITY: SUPPORT CONTRACT MANAGEMENT

Health Services and Support Contract Costs

The cost of purchased care to the DoD is determined by the value of the fixed-price health services and support contracts (including change orders and bid-price adjustments), plus costs for which the contractor is not at risk (e.g., care referred to the network on behalf of MTF-enrolled beneficiaries in TRICARE Region North (previously Regions 1, 2, and 5), and payments by the contractor for active duty service members enrolled in TRICARE Prime Remote). Actual contract costs were determined for each option period (which vary from region to region) and allocated to fiscal year based on how the option periods and fiscal years overlapped. The exception occurs in FY 2004, when the Managed Care Support Contracts were replaced by the new Health Service and Support Contracts (at varying times during the year, depending on region). FY 2004 costs were determined by annualizing the portion of the final option periods that extended into that year. Also, because retail pharmacy was carved out of all the contracts effective June 1st, the Managed Care Support prices reflect this carveout based on the contract modifications negotiated with each contractor. Health care and administrative expenses for TFL/TSRx claims are excluded from the chart below as they are funded by the Medicare-Eligible Retiree Health Care Fund.

- The total estimated expense incurred by the DoD for the health services and support contracts increased from \$4,722 million in FY 2002 to \$7,732 million in FY 2004. This represents an increase of 64 percent. The total includes miscellaneous contract pass-through costs, such as capital construction and direct medical education (labeled as “Other” below).
- Administrative expenses declined from 17.3 percent of total contract revenue (the sum of at-risk health care and administrative expenses) in FY 2002 to 14.6 percent in FY 2004.

HEALTH SERVICES AND SUPPORT CONTRACT COSTS

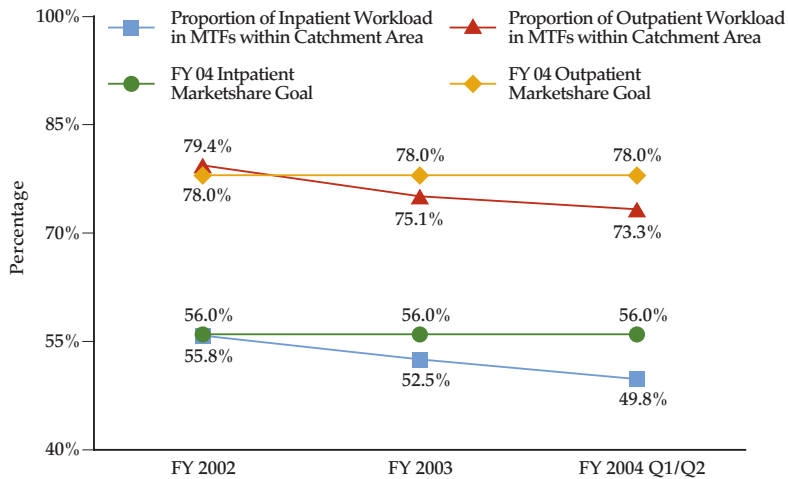


Source: TMA Contract Cost Data, 12/30/2004

SYSTEM PRODUCTIVITY: MTF MARKET SHARE TRENDS

As a measure of enrollment market share, the percentage of both inpatient and outpatient workload for TRICARE Prime enrollees accomplished in MTFs relative to all Prime workload in catchment areas (a radius of 40 miles for hospitals and 20 miles for ambulatory care facilities) has declined over the past 3 years.

PERCENTAGE OF ENROLLEE WORKLOAD PERFORMED BY MTFs IN CATCHMENT AREAS



From FY 2002 to FY 2004 (2nd Quarter), MTF inpatient and outpatient workload market shares have declined by about 6 percentage points each.

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

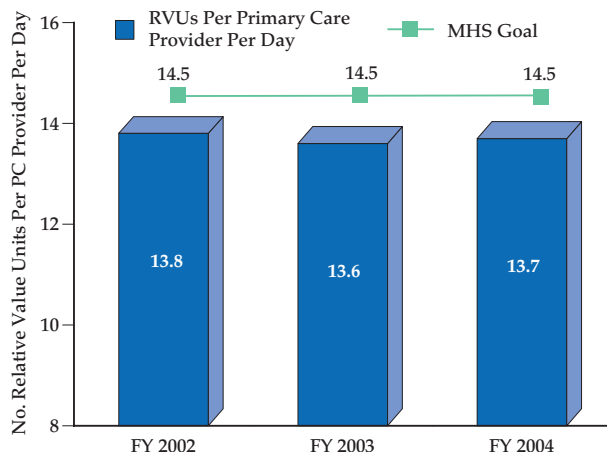
Source: MHS administrative data reported in the Annual Defense Review, 11/22/2004.

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

SYSTEM PRODUCTIVITY: MTF PROVIDER PRODUCTIVITY

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

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



Over the past 3 years, MTF primary care productivity has declined only slightly, from 13.8 RVUs per primary care provider in FY 2002, to 13.7 so far in FY 2004 (through the second quarter). Similar to the market share analysis above, no adjustments have been made to account for the effects of deploying military providers and support staff, nor for the influx of mobilized National Guard and Reservists and their family members.

Source: MHS administrative data reported in the Annual Defense Review, 11/22/2004. Measure is defined as the number of RVUs per FTE provider per 8-hour day in U.S. military clinics.

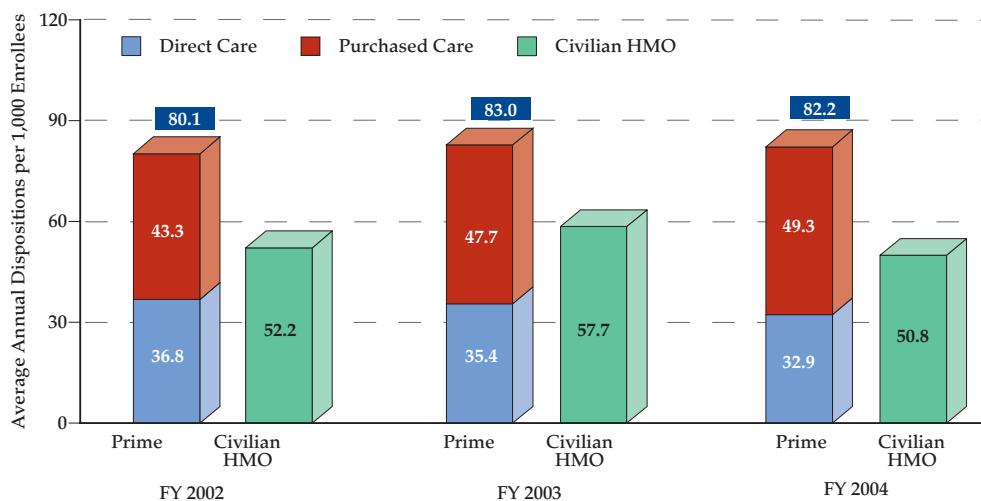
INPATIENT UTILIZATION RATES AND COSTS

TRICARE Prime Inpatient Utilization Rates Compared with Civilian Benchmarks

This section compares the inpatient utilization of TRICARE Prime enrollees with that of civilian HMO enrollees. Inpatient utilization is measured as the number of dispositions because the civilian-sector data do not contain a measure of RWPs.

- The TRICARE Prime enrollee inpatient utilization rate (direct and purchased care combined) was more than 60 percent higher than the civilian HMO enrollee utilization rate in FY 2004 (82.2 discharges per thousand Prime enrollees compared with 50.8 per 1,000 civilian HMO enrollees).
- The Prime enrollee utilization rate remained steady at just over 80 discharges per 1,000 enrollees, while the rate of their civilian counterparts increased in FY 2003 but dropped back down to about 51 discharges per 1,000 enrollees in FY 2004.
- Direct care utilization decreased by 11 percent from FY 2002 to FY 2004.
- Purchased care utilization increased by 10 percent in FY 2003, and by another 3 percent in FY 2004.

INPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/31/2005

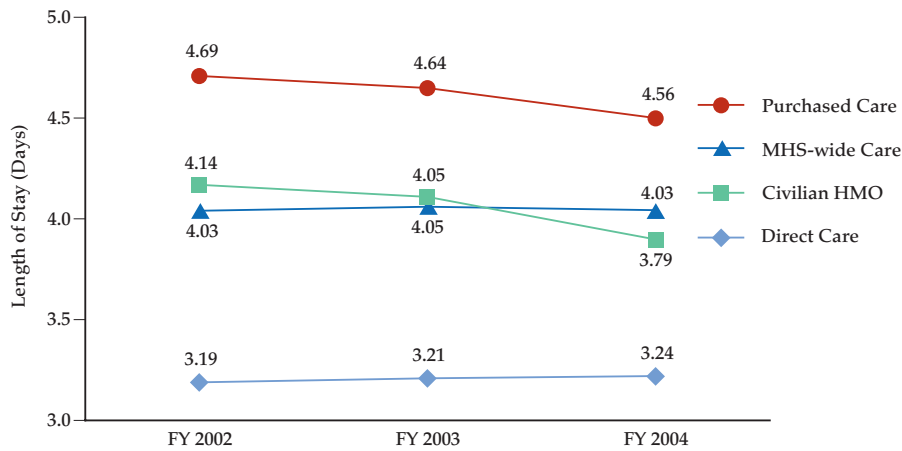
Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2004 civilian data are based on 2 quarters of data, which were seasonally adjusted and annualized.

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Average Lengths of Hospital Stays

- Average lengths of stay in DoD facilities (direct care) remained essentially constant during the period from FY 2002 to FY 2004.
- Average lengths of stay in TRICARE network facilities (purchased care) declined slightly during the period from FY 2002 to FY 2004 but remained above those in DoD facilities. Hospital stays in network facilities are longer on average than in DoD facilities because network facilities perform more complex procedures (as determined by RWPs—a measure of inpatient resource intensity).
- Average lengths of stay in benchmark civilian facilities have declined over the past 3 years and are now lower than in MHS facilities (DoD and network facilities combined).

INPATIENT UTILIZATION: TRENDS IN TRICARE AVERAGE LENGTH OF STAY



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 12/28/2004

Note: Beneficiaries age 65 and over were excluded from the above calculations. Further, the civilian data for each year were adjusted to reflect the age/sex distribution of MHS inpatient dispositions (direct and purchased care combined). FY 2004 civilian data are based on 2 quarters of data, which were seasonally adjusted and annualized.

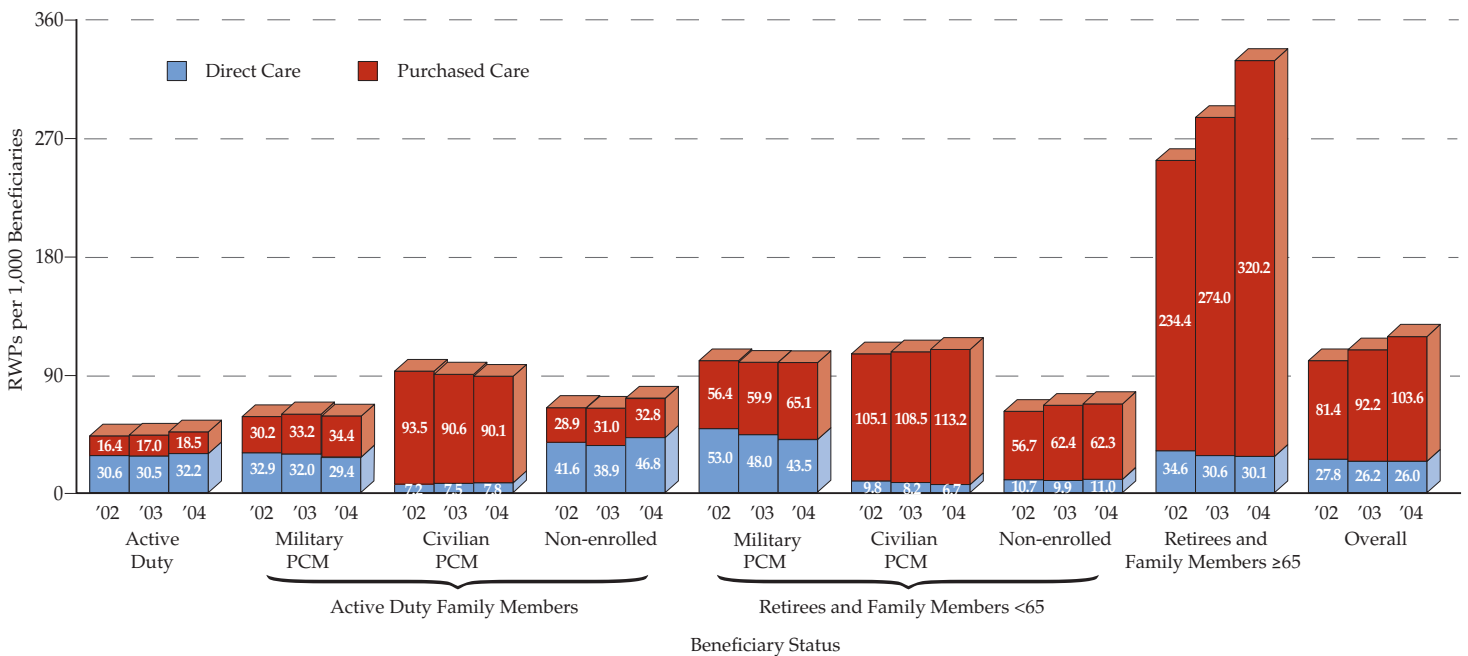
INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Inpatient Utilization Rates by Beneficiary Status

When breaking out inpatient utilization by beneficiary group, RWPs per capita should more accurately reflect differences across beneficiary groups than discharges per capita.

- Direct care inpatient utilization rates (RWPs per 1,000 beneficiaries) declined or remained about the same for all beneficiary groups except non-enrolled ADFMs.*
- Purchased care inpatient utilization rates increased for all beneficiary groups except active duty family members with a civilian PCM.
- The TFL inpatient utilization rate increased by 17 percent in FY 2003 and again in FY 2004.
- Excluding Medicare-eligible beneficiaries (for whom Medicare is likely their primary source of care and TRICARE has become second payer), about two-thirds of all inpatient workload was performed in the network.
- In FY 2002, 45 percent of inpatient workload (RWPs) generated by beneficiaries enrolled with a military PCM (including active duty personnel) was referred to the network. That percentage increased to 50 percent by FY 2004.

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



Source: MHS administrative data, 1/31/2005

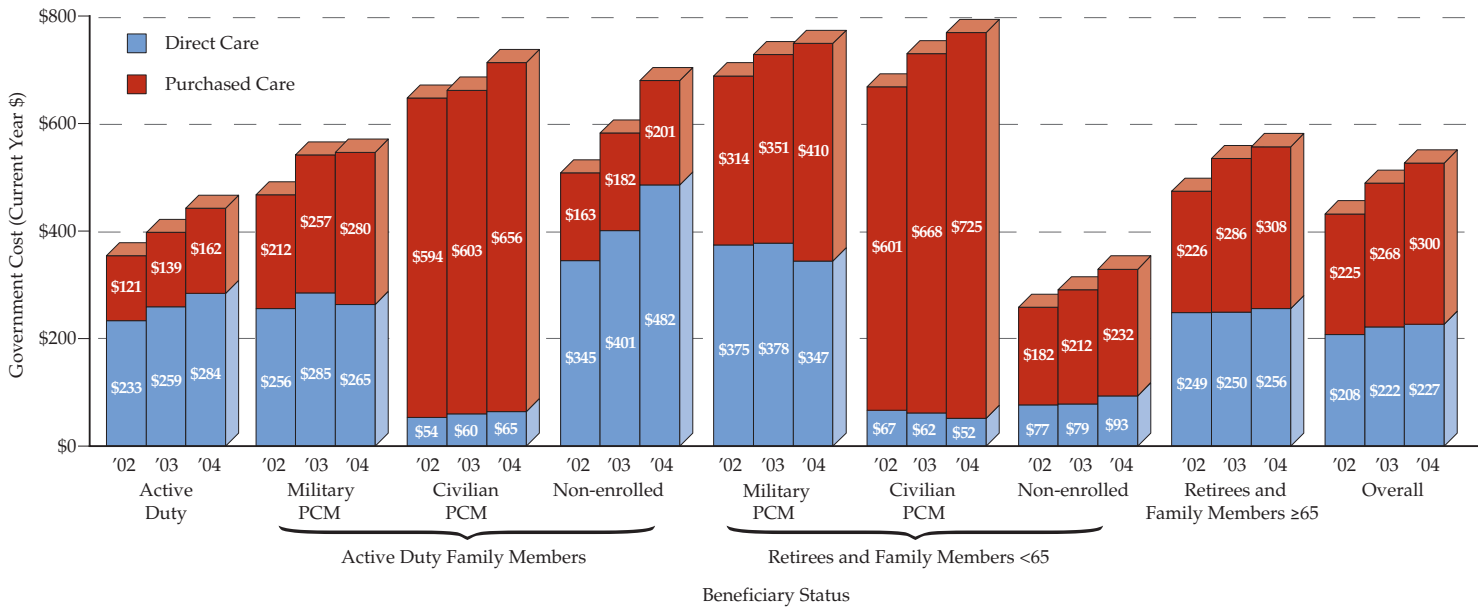
* The basis for this statement is the collection of stacked bars labeled "Retirees and Family Members ≥65." Although the vast majority of TFL-eligible beneficiaries are retirees and family members ≥65, there are a small number of beneficiaries age 65 and older who are not eligible for TFL and an even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

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Inpatient Cost by Beneficiary Status

- Overall MHS inpatient costs (in then-year dollars) per beneficiary (far right columns below) increased by 13 percent in FY 2003 and by another 8 percent in FY 2004. Most of the increases were due to higher purchased care costs.
- In FY 2004, total MHS inpatient costs per beneficiary increased for all beneficiary groups.

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



Source: MHS administrative data, 1/31/2005

INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Leading Inpatient Diagnoses by Volume

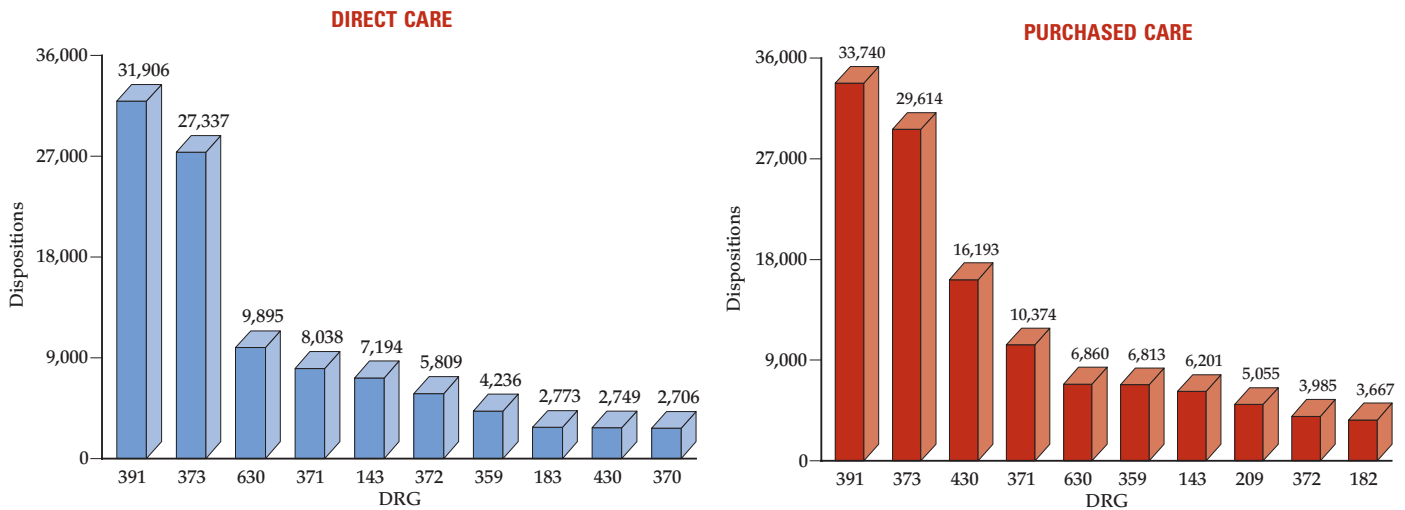
In military hospitals (direct care), the top 10 Diagnosis-Related Groups (DRGs) in terms of dispositions (discharges from the hospital) accounted for 41 percent of all direct care inpatient dispositions (down from the 42 percent reported last year).

- Half of these DRGs were associated with childbirth.
- The top two procedures, associated with normal childbirth, together account for more volume than the next eight procedures combined.

In contract network hospitals (purchased care), the top 10 DRGs accounted for 39 percent of all purchased care inpatient dispositions, the same as reported in last year's report. TFL dispositions are excluded.

- Of the top 10 DRGs, four were related to childbirth.
- Similar to that noted for direct care (above), the top two purchased care procedures are associated with normal childbirth, and together account for more volume than the next eight procedures combined.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2004 BY VOLUME



Source: MHS administrative data, 12/30/2004

DRG	DESCRIPTION
143	Chest pain
182	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 with complicating circumstances
183	Esophagitis, gastroenteritis, and miscellaneous digestive disorders age >17 without complicating circumstances
209	Major joint and limb reattachment procedures of lower extremity (includes hip, knee, ankle replacements)
359	Uterine and adnexa procedure for non-malignancy without complicating circumstances
370	Cesarean section with complicating circumstances
371	Cesarean section without complicating circumstances
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
630	Neonate, birth weight >2499g, without significant operating room procedure, with other problems

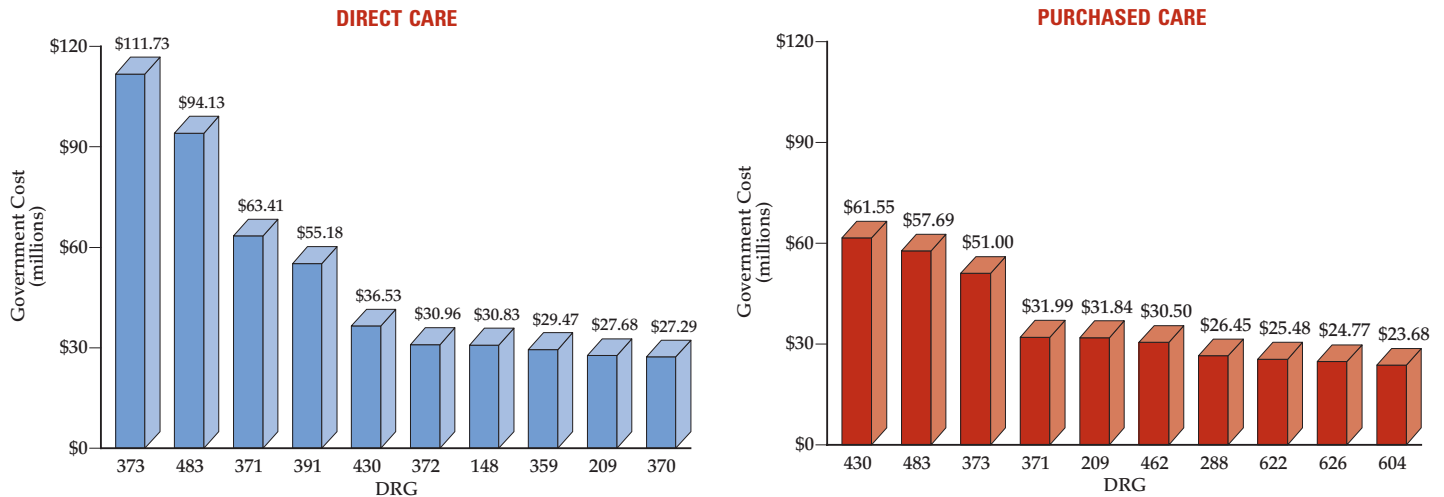
INPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Leading Inpatient Diagnoses by Cost

The leading diagnoses in terms of cost in FY 2004 were determined from institutional claims only, i.e., they include hospital charges but not attendant physician, laboratory, drug, or ancillary service charges.

- In military hospitals (direct care), the top 10 DRGs in terms of cost accounted for 27 percent of all direct care inpatient costs (compared with 26 percent last year).
 - Half of these DRGs were associated with childbirth.
 - Although not one of the top 10 diagnoses in terms of volume, tracheostomies (except for face, mouth, and neck diagnoses) ranked second in terms of total inpatient expenditures at DoD facilities in FY 2004 because of their long average hospital stay (41 days).
- In contract network hospitals (purchased care), the top 10 DRGs accounted for 24 percent of all purchased care inpatient costs, the same as reported last year. TFL claims are excluded.
 - Psychiatric conditions accounted for the greatest MHS expenditures for a single DRG at network facilities, followed by tracheostomies and normal childbirth.

TOP 10 DIRECT CARE AND PURCHASED CARE DRGs IN FY 2004 BY COST



Source: MHS administrative data, 12/30/2004

DRG	DESCRIPTION
148	Major small and large bowel procedures with complications and comorbidities
209	Major joint and limb reattachment procedures of lower extremity (includes hip, knee, ankle replacements)
288	Operating room procedures for obesity
359	Uterine and adnexa procedure for non-malignancy without complicating circumstances
370	Cesarean section with complicating circumstances
371	Cesarean section without complicating circumstances
372	Vaginal delivery with complicating diagnoses
373	Vaginal delivery without complicating diagnoses
391	Normal newborn
430	Psychoses
462	Rehabilitation
483	Tracheostomy with mechanical ventilation 96+ hours or PDx except face, mouth and neck diagnoses
604	Neonate, birth weight 750-999g, discharged alive
622	Neonate, birth weight >2499g, with significant operating room procedure, with multiple major problems
626	Neonate, birth weight >2499g, without significant operating room procedure, with multiple major problems

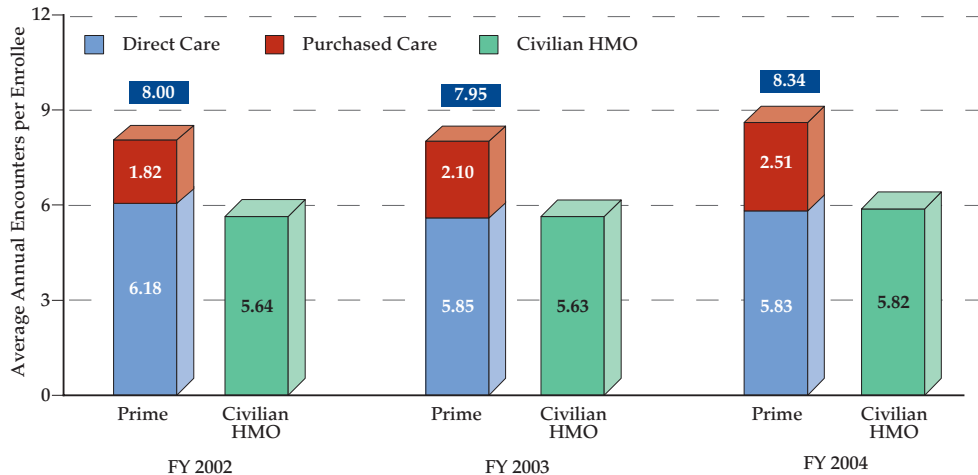
OUTPATIENT UTILIZATION RATES AND COSTS

TRICARE Outpatient Utilization Rates Compared with Civilian Benchmarks

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

- The total TRICARE Prime outpatient utilization rate (direct and purchased care utilization combined) increased from 8.0 encounters per enrollee in FY 2002 to 8.3 in FY 2004.
- Civilian outpatient utilization increased at a slightly lower rate than under TRICARE. Consequently, the disparity between total TRICARE Prime outpatient utilization and the levels observed in civilian HMOs widened in FY 2004. In FY 2004, Prime enrollee outpatient utilization was 44 percent higher than in civilian HMOs.
- Direct care outpatient utilization by Prime enrollees declined by 5 percent from FY 2002 to FY 2003 but leveled off in FY 2004, whereas purchased care outpatient utilization increased by 38 percent.

OUTPATIENT UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/31/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2004 civilian data are based on 2 quarters of data, which were seasonally adjusted and annualized. There are differences in how the military and civilian sectors define encounters.

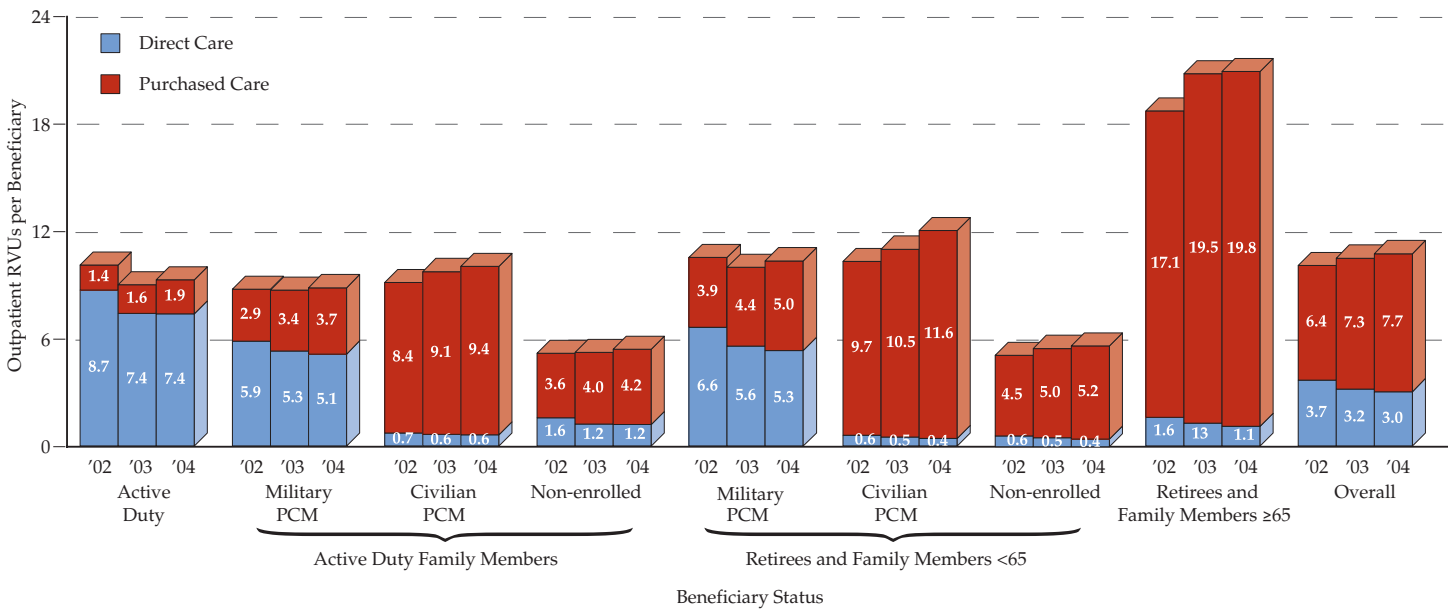
OUTPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Outpatient Utilization Rates by Beneficiary Status

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

- Direct care outpatient utilization declined between FY 2002 and FY 2004 for all beneficiary groups. Most of the decline occurred in FY 2003 and was most pronounced for beneficiaries enrolled with a military PCM (including active duty service members).
- Purchased care outpatient utilization increased for all beneficiary groups, especially those enrolled in Prime.
- After a sharp increase in FY 2003, TFL utilization per beneficiary leveled off in FY 2004.*

AVERAGE ANNUAL OUTPATIENT RVUs PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/31/2005

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

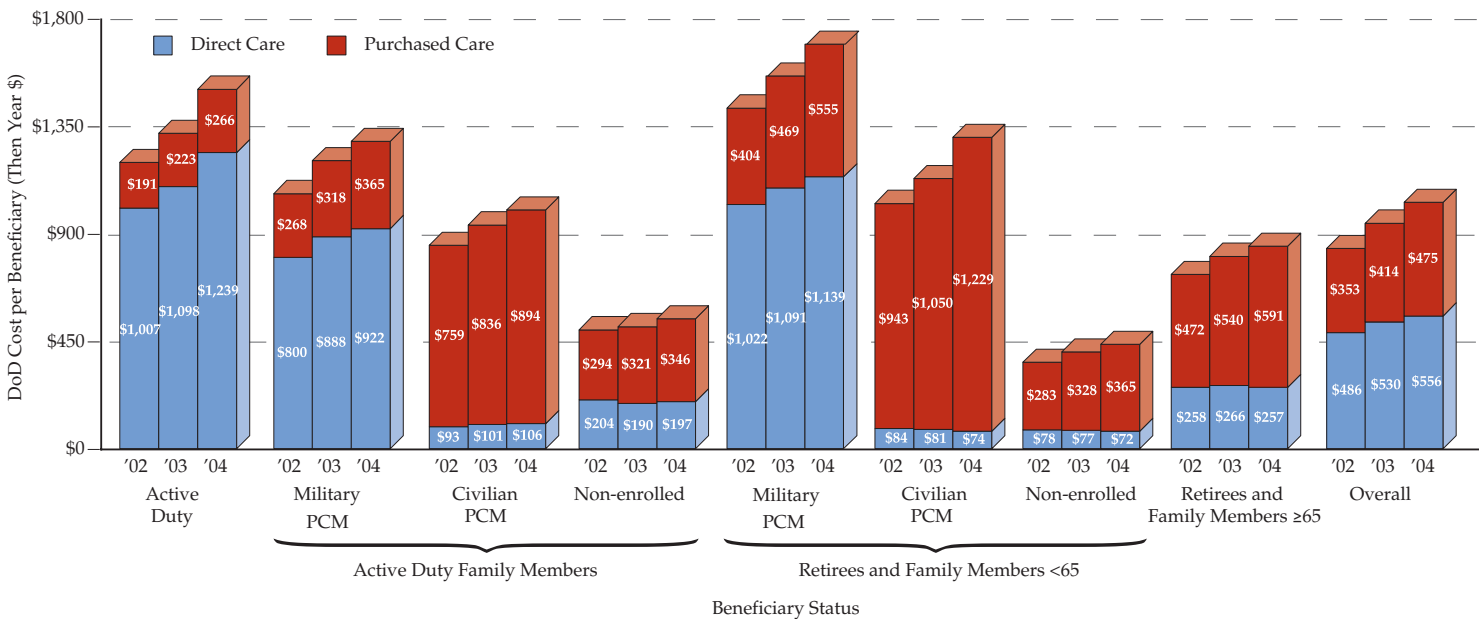
OUTPATIENT UTILIZATION RATES AND COSTS (CONT'D)

Outpatient Cost by Beneficiary Status

Even though direct care outpatient utilization rates declined for all beneficiary groups, DoD medical costs continued to rise.

- DoD purchased care costs increased by 17 percent in FY 2003 and by another 15 percent in FY 2004. The largest increases in FY 2004 were for active duty service members (19 percent) and retirees and family members with a military
- TFL outpatient cost per beneficiary increased by 9 percent in FY 2004.*
- PCM (18 percent). Most active duty service members using purchased care are enrolled in TRICARE Prime Remote.

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



Source: MHS administrative data, 1/31/2005

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

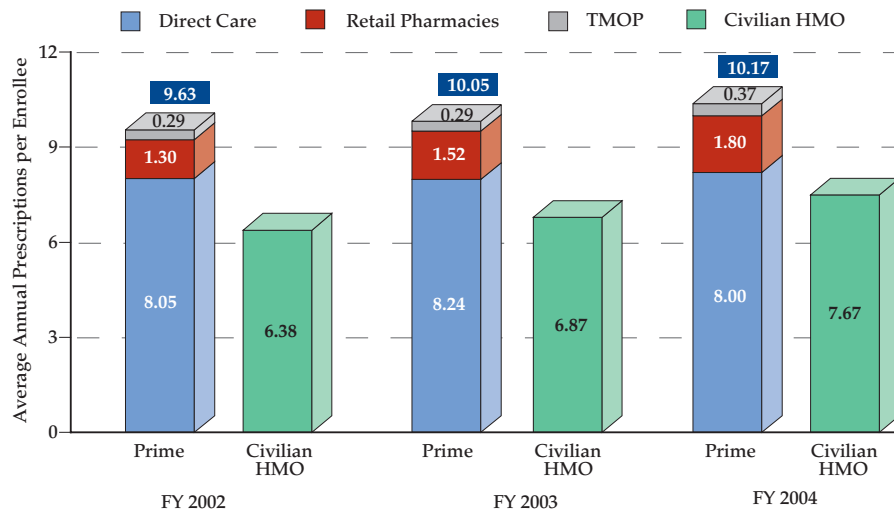
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS

TRICARE Prime Prescription Drug Utilization Rates Compared with Civilian Benchmarks

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

- The total prescription utilization rate for TRICARE Prime enrollees rose by 6 percent between FY 2002 and FY 2004. Although the civilian HMO benchmark rate rose by 20 percent during the same period, the TRICARE Prime prescription utilization rate is still more than 30 percent higher than the civilian HMO rate.
- Prescriptions filled for Prime enrollees at DoD pharmacies remained virtually unchanged, whereas prescriptions filled at retail pharmacies increased by 39 percent from FY 2002 to FY 2004.
- Enrollee mail order prescription utilization increased by almost 30 percent from FY 2002 to FY 2004. Nevertheless, TMOP utilization remains small compared to other sources of prescription services.

PRESCRIPTION UTILIZATION RATES: TRICARE PRIME VS. CIVILIAN HMO BENCHMARK



Sources: MHS administrative data and The Medstat Group, Inc., MarketScan® Commercial Claims and Encounters database, 1/31/2005

Note: The civilian data for each year were adjusted to reflect the age/sex distribution of the MHS beneficiary population. FY 2004 civilian data are based on 2 quarters of data, which were seasonally adjusted and annualized.

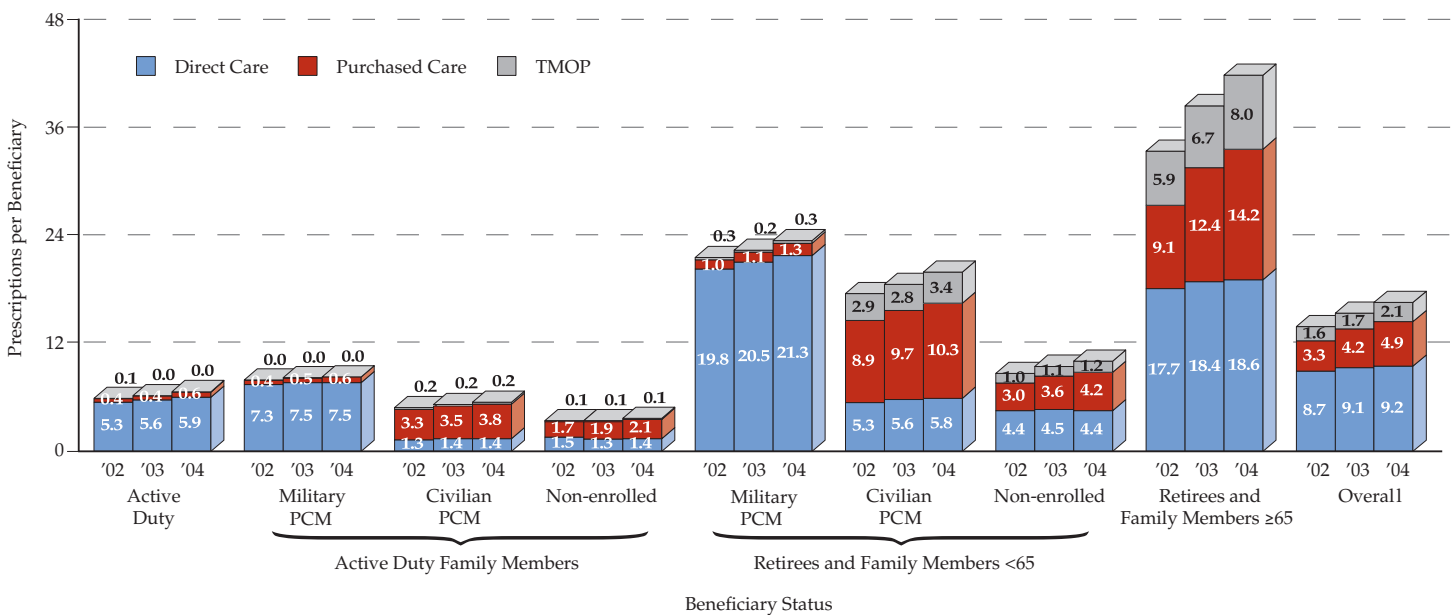
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS (CONT'D)

TRICARE Prescription Drug Utilization Rates by Beneficiary Status

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

- The total number of prescriptions per beneficiary (from all sources: direct, retail, and TMOP) increased by 13 percent from FY 2002 to FY 2004, exclusive of the TSRx benefit. Including TSRx, the total number of prescriptions increased by 19 percent.
- Direct care prescription utilization rose slightly or remained constant for all beneficiary groups.
- Average prescription utilization through nonmilitary pharmacies (civilian retail and mail order) increased for all beneficiary groups but most notably for beneficiaries enrolled with a civilian PCM and non-enrolled retirees and family members. These beneficiaries are most reliant on network or mail-order pharmacies to fill their prescriptions.

AVERAGE ANNUAL PRESCRIPTION UTILIZATION PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/31/2005

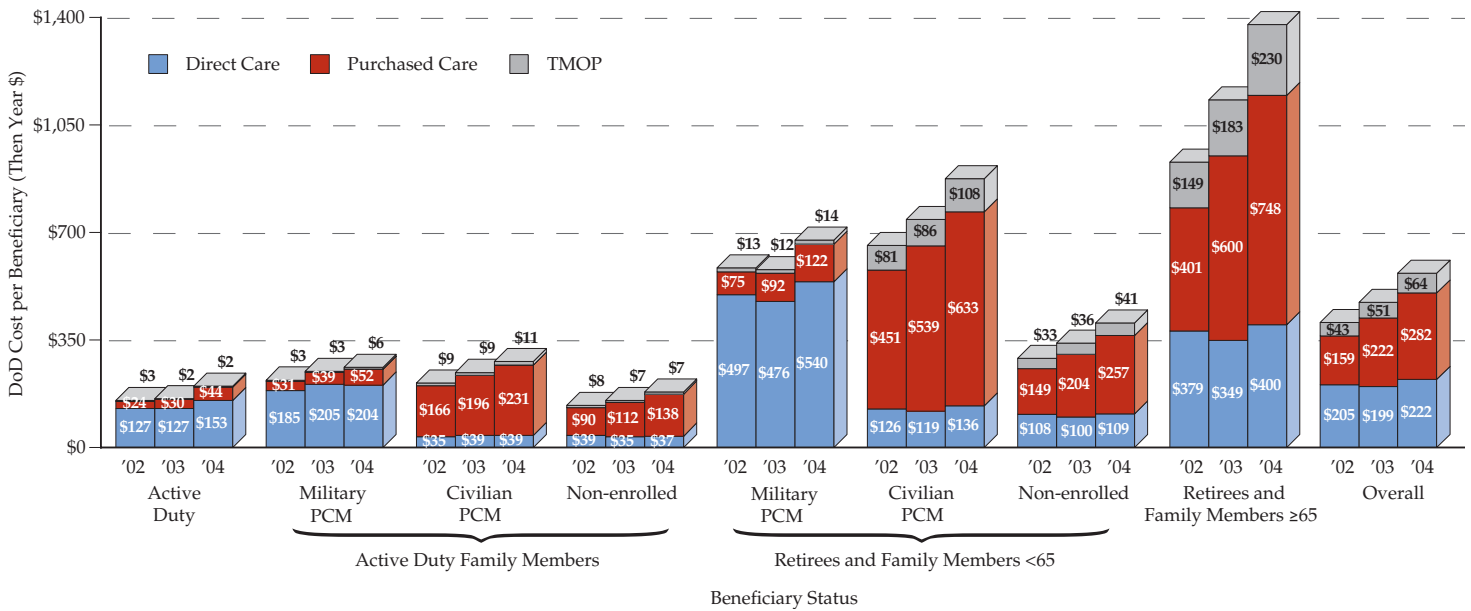
PRESCRIPTION DRUG UTILIZATION RATES AND COSTS (CONT'D)

Prescription Drug Cost by Beneficiary Status

Prescription drug costs continued to rise at the fastest rate of any medical service, increasing by 31 percent exclusive of the TSRx benefit and by 40 percent including TSRx.

- Direct care costs were relatively steady but retail pharmacy costs rose by 66 percent exclusive of TSRx and by 77 percent including TSRx.
- TMOP costs increased as well but at a slower rate than retail pharmacy, increasing by 28 percent exclusive of TSRx and by 47 percent including TSRx.

AVERAGE ANNUAL PRESCRIPTION COSTS PER BENEFICIARY (BY FISCAL YEAR)



Source: MHS administrative data, 1/31/2005

BENEFICIARY FAMILY OUT-OF-POCKET COSTS

Out-of-pocket costs are computed for *families* of MHS beneficiaries and compared with those of civilian counterparts. MHS families are grouped into (1) beneficiaries under age 65, and (2) beneficiaries age 65 and older (seniors). Costs include deductibles and copayments for medical care and drugs, TRICARE enrollment fees, and premiums for various types of insurance. Civilian counterparts are civilian families with the same demographics as the typical MHS family. TRICARE and Medicare do not cover dental care and glasses. These costs are excluded since they are the same for MHS beneficiaries and their civilian counterparts.

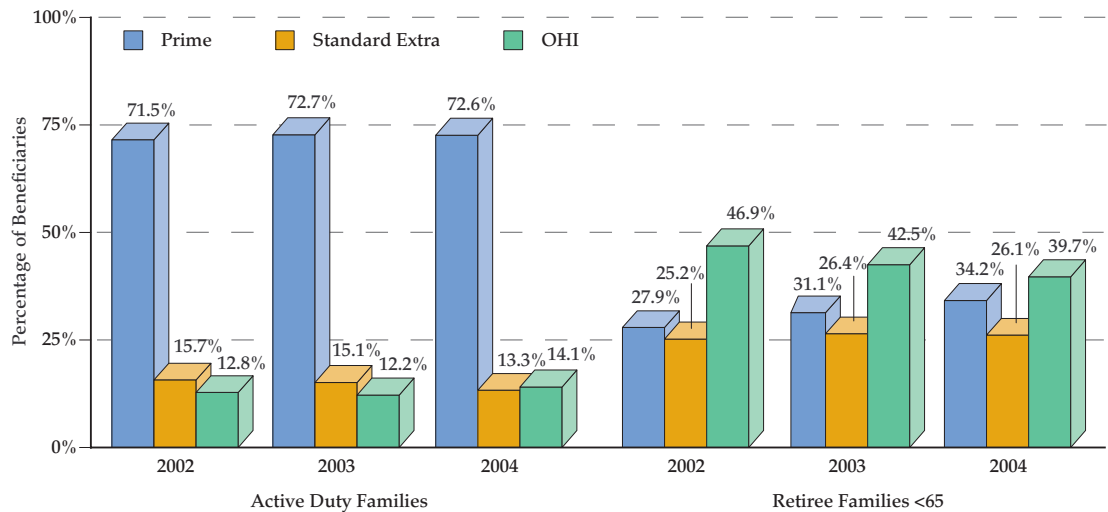
Health Insurance Coverage of MHS Beneficiaries Under Age 65

MHS beneficiaries have a choice of: (1) TRICARE Prime, (2) TRICARE Standard/Extra, and (3) other private health insurance (OHI). Some beneficiaries use OHI in combination with one of the TRICARE plans (in this case, TRICARE becomes second payer) whereas others opt out of TRICARE entirely. Civilian benchmark families are assumed to be civilian employees with employer-sponsored health insurance.

Beneficiaries are grouped based on the health plan they predominantly use for their care:

- **TRICARE Prime:** Family enrolled in TRICARE Prime and no OHI. In FY 2004, 72.6 percent of active duty families and 34.2 percent of retiree families were in this group.
- **TRICARE Standard/Extra:** Family not enrolled in TRICARE Prime and no OHI. In FY 2004, 13.3 percent of active duty families and 26.1 percent of retiree families were in this group.
- **OHI:** Family covered by OHI. In FY 2004, 14.1 percent of active duty families and 39.7 percent of retiree families were in this group.

HEALTH INSURANCE PLAN USERS



Source: 2002–2004 administrations of the Health Care Surveys of DoD Beneficiaries (HCSDB)

Note: The Prime group includes HCSDB respondents without OHI who are enrolled in Prime based on DEERS. The Standard/Extra beneficiary group includes HCSDB respondents without OHI who are non-enrollees based on DEERS. The OHI group includes those with OHI based on HCSDB responses, as of 12/1/2004.

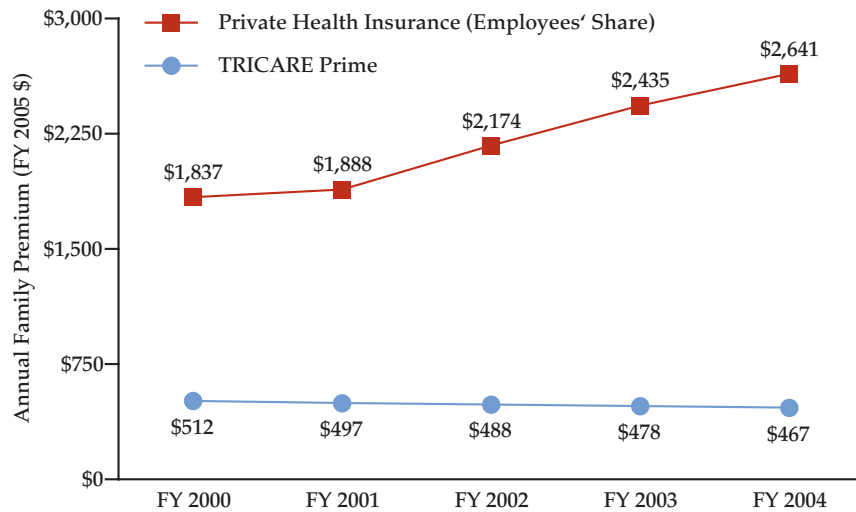
BENEFICIARY FAMILY OUT-OF-POCKET COSTS (CONT'D)

Retirees and Family Members Under Age 65 Returning to the MHS

Private health insurance premiums have continued to rise since FY 2000, while the TRICARE enrollment fee has remained fixed at \$460 per retiree family since the Program's inception. As shown in the top

chart, when private and TRICARE Prime premium costs are measured in constant year FY 2005 dollars, TRICARE is actually becoming cheaper for the enrollee, over time, and relative to civilian counterparts.

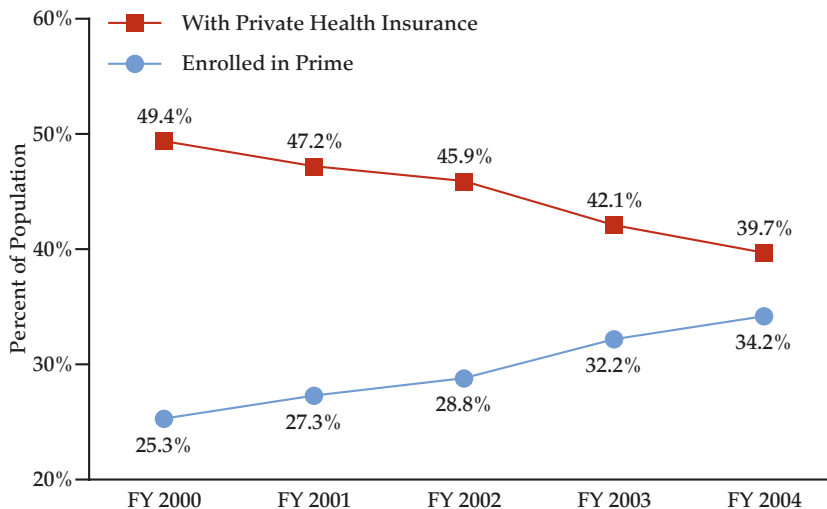
TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT FEE



Sources: Civilian insurance premiums; Kaiser Family Foundation Health Benefits Survey, 2000–04; Consumer Price Index: Bureau of Labor Statistics

The increasing disparity in premiums and other out-of-pocket expenses between the private sector and the MHS may induce beneficiaries to drop their private health insurance and enroll in Prime.

TREND IN PRIVATE INSURANCE PREMIUMS VS. TRICARE ENROLLMENT RATES



Sources: DEERS and Health Care Beneficiary Surveys of DoD Beneficiaries, 2000–2003, 1/6/2005

Note: The Prime enrollment rates above exclude those with other health insurance (about 5 percent of enrollees).

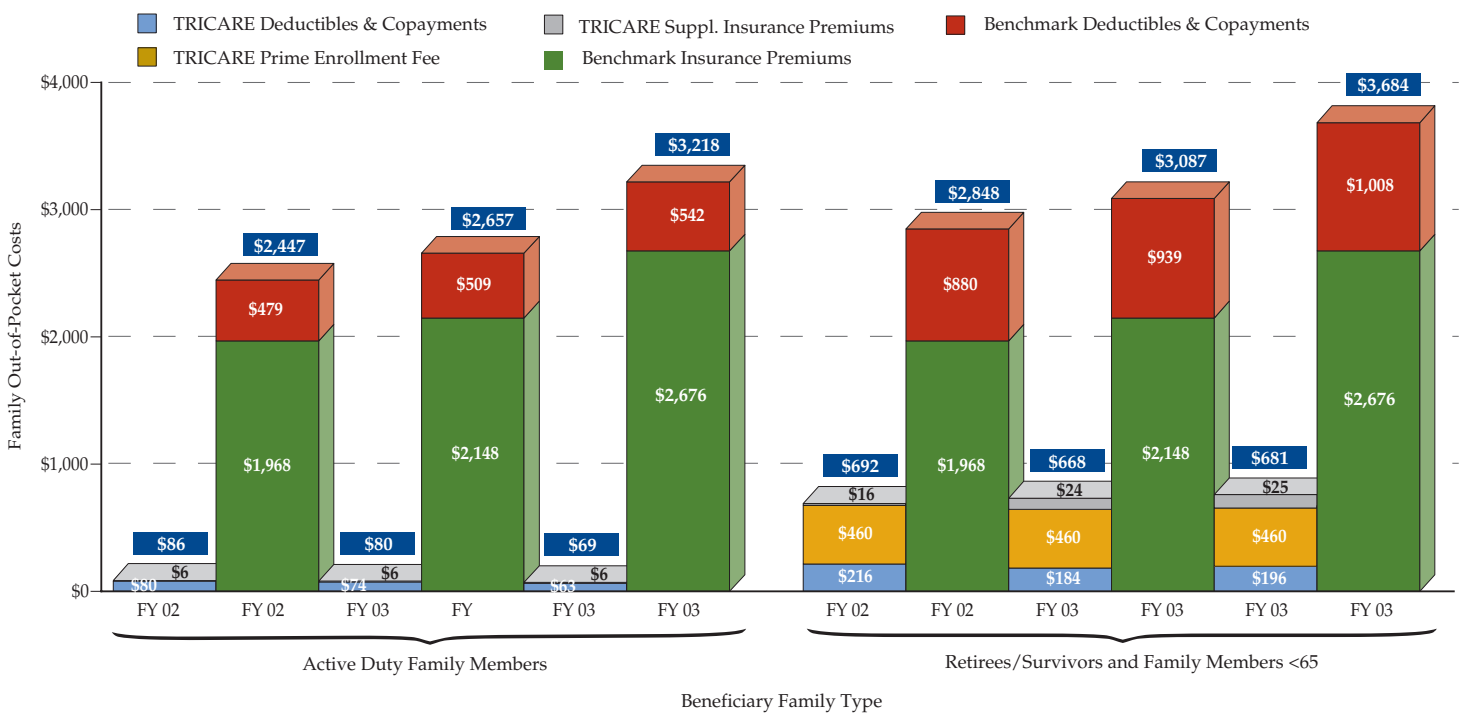
BENEFICIARY FAMILY OUT-OF-POCKET COSTS (CONT'D)

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

Out-of-pocket costs were substantially lower for TRICARE Prime enrollees than their civilian HMO counterparts in FY 2002–2004. Civilian HMO counterparts paid more for insurance premiums, deductibles, and copayments.

- The differential between enrolled active duty families and their civilian HMO counterparts rose from \$2,300 in FY 2002 to \$3,000 in FY 2004.
- For retiree families, the differential rose from \$2,100 to \$2,900.

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



Sources: DoD beneficiary expenditures for deductibles and copayments from MHS administrative data, 2002–04; civilian expenditures for deductibles and copayments from Medical Expenditure Panel Survey projections, 2002–04, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Kaiser Family Foundation Employer Health Benefits surveys, 2002–04; TRICARE supplemental insurance premiums from The Army Times, March Supplement, 2002–04; OHI and TRICARE supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, 2002–04. As of 1/6/2005.

BENEFICIARY FAMILY OUT-OF-POCKET COSTS (CONT'D)

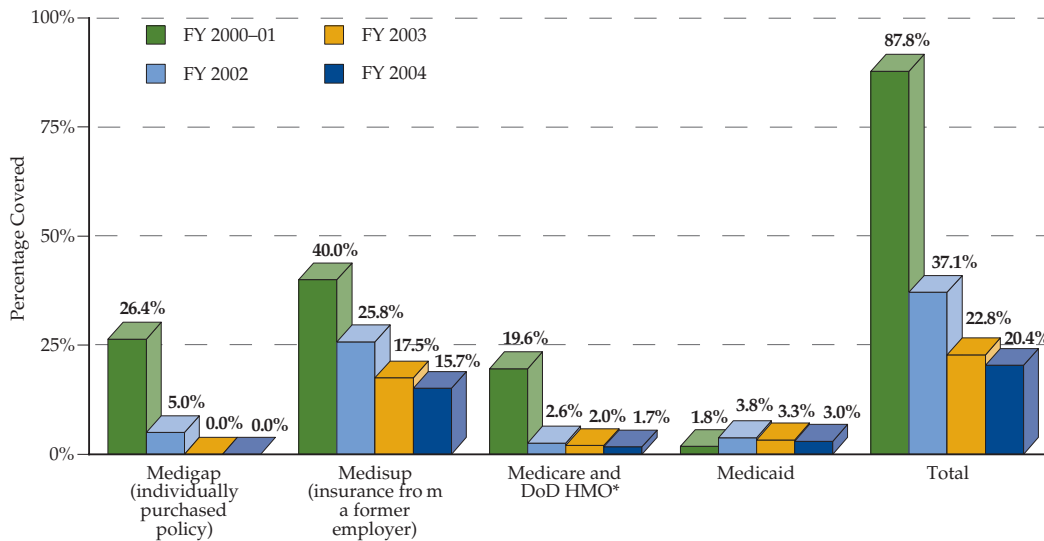
Health Insurance Coverage of MHS Senior Beneficiaries

Medicare provides insurance for medical care but there are substantial deductibles/copayments and it does not yet cover drugs. Until FY 2001, most MHS seniors purchased some type of Medicare Supplemental insurance. A small percentage were still active employees with employer-sponsored insurance (OHI); a handful were covered by Medicaid. Out-of-pocket costs include deductibles/copayments, and premiums for Medicare Part B, supplementary insurance, and OHI.

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

- Before TFL (FY 2000–2001), 87.8 percent of MHS seniors had some type of Medicare supplemental insurance or were covered by Medicaid.
- After TFL, the percentage of MHS seniors with supplemental insurance or Medicaid declined sharply to 37.2 percent in FY 2002 and to 22.8 percent in FY 2003. The percentage declined further to 20.4 percent in FY 2004.

MEDICARE SUPPLEMENTAL INSURANCE COVERAGE OF MHS SENIORS (PERCENT)



Source: 2001–2004 administrations of the Health Care Surveys of DoD Beneficiaries, 12/1/2004

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

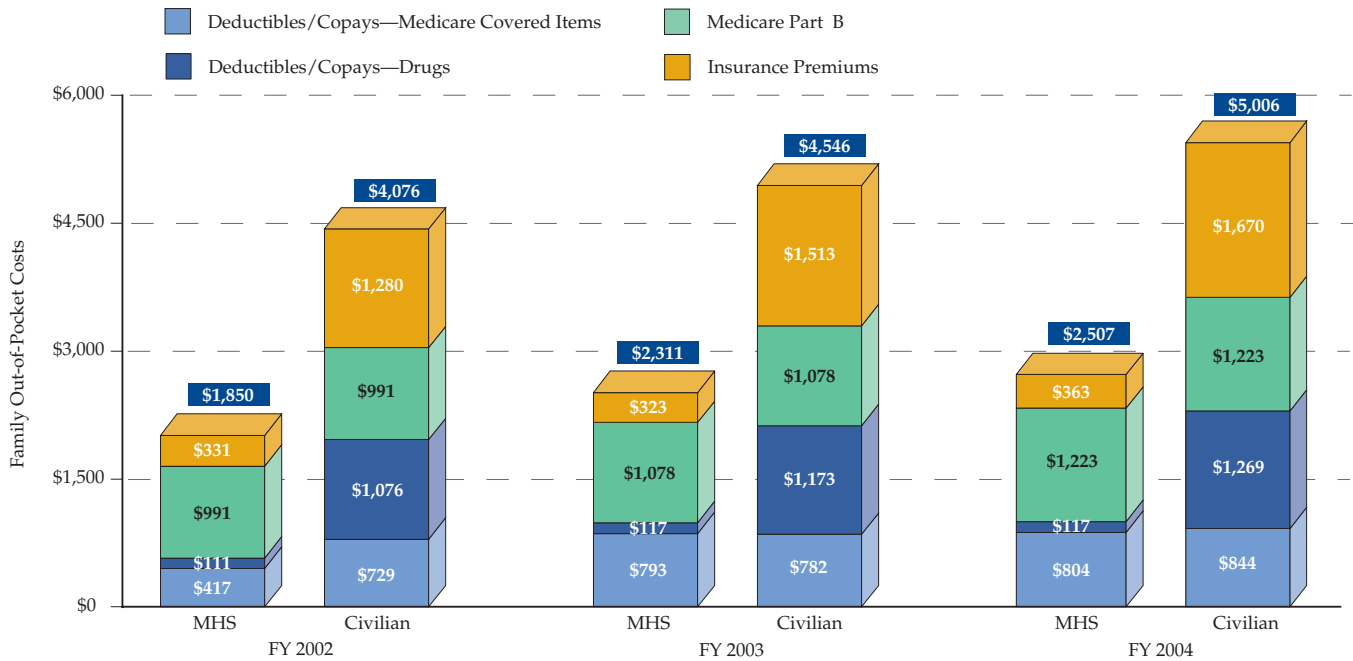
BENEFICIARY FAMILY OUT-OF-POCKET COSTS (CONT'D)

Out-of-Pockets Costs for MHS Senior Families vs. Civilian Counterparts

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

- MHS seniors paid about half as much for their health care as their civilian counterparts in FY 2002–04.
- In FY 2004, MHS seniors paid \$2,500 less for health care than their civilian counterparts.

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



Sources: DoD beneficiary expenditures from MHS administrative data; civilian expenditures from Medical Expenditure Panel Survey projections, 2002–2004, adjusted using Consumer Expenditure Surveys; civilian insurance premiums from Kaiser Family Foundation Employer Health Benefits surveys, 2002–2004; TRICARE supplemental insurance premiums from *The Army Times*, March Supplement, 2002–2004; OHI and TRICARE supplemental insurance coverage from Health Care Surveys of DoD Beneficiaries, 2002–04. As of 1/6/2005.



OASD(HA)/TMA CENTER FOR HEALTH CARE MANAGEMENT STUDIES

OASD(HA)/TMA Center for Health Care Management Studies

The Center for Health Care Management Studies (CHCMS) within the Health Program Analysis and Evaluation (TMA/HPA&E) Directorate was established in May 2003* to promote and protect the health of MHS beneficiaries. The Center is organized to achieve this mission by designing and directing health care studies that develop for MHS leadership the information required to make evidence-based decisions on outcomes, quality, access, cost, and use of health care services. Studies will complement the ASD(HA) business plan with research along six broad domains of interest:

- **Health Services:** How can we change the way services are delivered that optimizes health and resources?
- **Health Outcomes:** What are the best means of measuring the health outcomes for MHS care? Are there gaps in performance by beneficiary group, DRG, locale?
- **Finance and Insurance:** What can we discover about the current coverage of beneficiaries and preference associated with their use of MHS benefits? Are national trends affecting MHS utilization?
- **Force Readiness:** What services can be wrapped around the force, and in a way that promotes the delivery of high quality, effective health care services to forces at any stage of deployment? How can the MHS best organize to anticipate conflicting health system demands?
- **Health Plan Performance:** How can we best measure plan performance in ways that provide valid and reliable estimates of intra- and inter-plan performance?
- **Information Technology:** What developments are in place or envisioned that improve health care forecasting and managerial feedback?

An initial agenda of studies is beginning to develop the information needed to achieve a better understanding of the complex determinants of health care quality and health system improvement. Two studies have already been accomplished to identify methods of improving the way we communicate with customers and to achieve efficiencies of pharmacy benefits management.

1. Ensuring Cost-Effective Marketing of TRICARE Programs and Services

The purpose of this study was to gather information from TRICARE beneficiaries about their TRICARE information needs, usual sources of benefit information, and how they prefer to stay informed about TRICARE. The study was undertaken to help TMA develop more effective communication strategies that will meet beneficiary needs for health plan information.

The findings indicate a high level of awareness of TRICARE benefit information. Nearly three quarters of TRICARE users are aware of at least one principal source of TRICARE information. More than three of every four (78.7 percent) users of TRICARE services who look for information about TRICARE are satisfied or very satisfied with available information. An important finding of this study is that there are significant differences across beneficiary groups for their preferred method getting TRICARE information. Active duty personnel are more likely to prefer getting information face to face, Medicare eligible beneficiaries prefer mail, and spouses of active duty and activated Reservists prefer using the telephone to get answers.

* OASD(HA) Memorandum, May 29, 2004

2. Investigating Reasons for Failure to Pick Up Prescriptions at Military Pharmacies

The purpose of this study was to gather information from MTF pharmacy staff and TRICARE beneficiaries to identify the scope, consequences, and remedial actions that could be taken to prevent failure of beneficiaries to pick up prescribed medications at military pharmacies. The study was undertaken on behalf of the TMA Pharmacy Board of Directors to help MTF pharmacies promote adherence to prescribed regimens. Over 1,000 users of pharmacy services at six MTFs were surveyed by telephone to establish if they had not picked up prescriptions in the past and why they may have done so. This information was used to derive an estimated cost to these six MTFs for costs of noncompliance and strategies that could be taken to reduce those costs. Improved methods of communicating between pharmacy and physician, and between and pharmacy and patient were indicated to improve compliance and quality of care.

The Center also conducts analyses of topics that are relevant to both the MHS and national health services and healthy policy audience. A number of studies have been favorably considered for publication in peer-reviewed health care and health policy journals. These studies have been accepted for publication in 2004 for their relevance to important and pressing health care challenges both inside and outside of the MHS:

1. Effects of Maternal Characteristics on Cesarean Delivery Rates among U.S. Department of Defense Healthcare Beneficiaries, 1999–2002.
Journal: *Birth*
Date of Publication: March 2004
2. Provider Perceptions of Pharmacy Management—Lessons from the Military Health System.
Journal: *Medical Care*
Date of Publication: April 2004
3. A National Assessment of Children with Special Health Care Needs: Prevalence of Special Needs and Use of Health Care Services Among Children in the Military Health System.
Journal: *Medical Care*
Date of Publication: August 2004
4. The Effect of Pre-Existing Chronic Disease on Primary Cesarean Rates by Race for Births in U.S. Military Hospitals, 1999–2002.
Journal: *Birth*
Date of Publication: September 2004
5. Burden of Disease Associated with Overweight and Obesity among U.S. Military Retirees and their Dependents, Age 38–64, 2003.
Journal: *Preventive Medicine*
Date of Publication: October 2004
6. The Effect of September 11th Terrorist Attacks on the Self-Reported Health Status of DoD Healthcare Beneficiaries.
Journal: *Military Medicine*
Date of Publication: November 2004
7. The Effects of Managed Care on Primary and Repeat Cesarean Delivery Rates Among U.S. Department of Defense Healthcare Beneficiaries, 1999–2002.
Journal: *Birth*
Date of Publication: December 2004

GENERAL METHOD**General Method**

In this year's report, we compared TRICARE's effects on the access to and quality of health care received by the DoD population with the general U.S. population covered by commercial health plans (i.e., excluding Medicare and Medicaid). We made the comparisons using health care system performance metrics from the National Consumer Assessment of Health Plans Survey (CAHPS). In addition, we examined several issues unique to the DoD population, such as intention to enroll and disenroll from TRICARE Prime, for which there are no external benchmarks.

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

We made adjustments to both the CAHPS and CCAЕ 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 2002 to FY 2004) to gauge trends in access, quality, utilization, and costs.

Notes on methodology:

- Numbers in charts or text may not add to the expressed totals due to rounding.
- Unless otherwise indicated, all years referenced are federal fiscal years (1 October to 30 September).
- Unless otherwise indicated, all dollar amounts are expressed in then-year dollars for the fiscal year represented.
- All photographs in this document were obtained from Internet Web sites accessible by the public. These photos have not been tampered with other than to mask the individual's name.
- Differences between MHS survey-based data and the civilian benchmark, or MHS over time, were considered significant at less than or equal to 0.05.
- All workload and costs are based on completion factors attributable for direct and purchased care. The purchased care completion factors for FY 2004 may be inaccurate due to changes in the support contracts noted on page 8 of the report.
- Data were current as of:
 - HCSDB/CAHPS—December 22, 2004.
 - MHS Workload/Costs—January 31, 2005

DATA SOURCES**Health Care Survey of DoD Beneficiaries (HCSDB)**

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

The HCSDB is composed of two distinct surveys, the Adult and Child HCSDB, and both are conducted as large-scale mailed surveys. The Adult HCSDB is conducted once per calendar quarter every January, April, July, and October to a sample of all DoD beneficiaries worldwide. The Child HCSDB is conducted annually in the third quarter in July to a sample of DoD beneficiaries in the continental U.S. only.

Both surveys provide information on a wide range of health care issues such as the beneficiaries' ease of access to health care and preventative care services. In addition, the

DATA SOURCES (CONT'D)

surveys provide information on beneficiaries' satisfaction with their doctors, health care, health plan and the health care staff's communication and customer service efforts.

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

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

From 1998 to 2003, the HCSDB included questions from CAHPS 2.0. In 2003, CAHPS 3.0 was introduced. This version of CAHPS included changes to the wording of a number of questions. Because MHS decision makers monitor scores based on CAHPS questions to track TRICARE performance over time, a strategy for comparing scores before and after the transition was followed. First, the revised CAHPS 3.0 questions were not incorporated into the HCSDB until 2004, when resulting civilian benchmark data reflecting the new questions would be available. Then, responses to CAHPS questions in the DoD population were compared and contrasted with responses in the civilian benchmarking database. This assessment was done in order to discover any large, unexplained changes in responses after the 3.0 version was implemented and to see if the changes affected both populations similarly. As a result of these analyses, three questions, whose wording changed from 2.0 to 3.0, were found to have disproportional response changes between the DoD and civilian populations. These questions (and their pages in this report), are as follows:

- Waiting in the Doctor's Office (40).
- Finding a Personal Doctor (42).
- Paperwork, reflected in the composite measure, Customer Service (43).

Finally, models were developed and applied to these questions' responses that adjusted for differences between the two populations and allowed a more accurate comparison. This method also allowed for a more accurate trending of the responses pre and post CAHPS 3.0.

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

Relative Weighted Products (RWPs) and Relative Value Units (RVUs) are measures derived from inpatient and outpatient workload, respectively, to standardize differences in resource use as a means to better compare workload among institutions. RWPs, which are based on DRG weights and specific information on each hospital record, are calculated for all inpatient cases in MTFs and network hospitals. They reflect the relative

DATA SOURCES (CONT'D)

resource intensity of a given stay, with adjustments made for very short or very long lengths of stay and for transfer status. A comparison of total RWPs across institutions therefore reflects not only differences in the number of dispositions but in the case-mix intensity of the inpatient services performed there as well. "Relative value units" (RVUs) are used by Medicare and other third-party payers to determine the comparative worth of physician services based on the amount of resources involved in furnishing each service. The MHS uses a modified version to reflect the relative costliness of the provider effort for a particular procedure or service.

Access and Quality

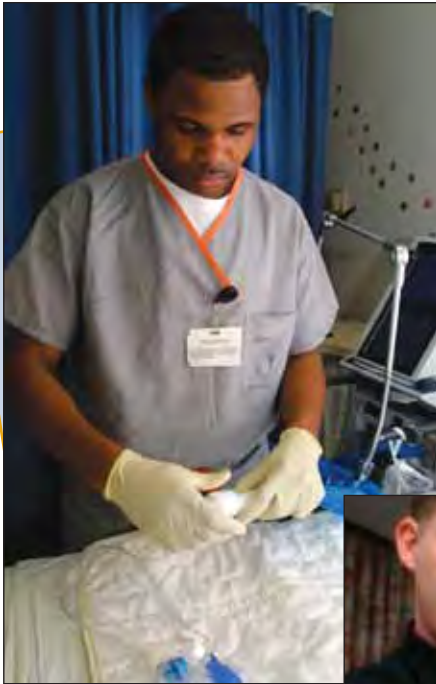
Measures of MHS access and quality were derived from the 2002, 2003, and 2004 administrations of the HCSDB. The comparable civilian-sector benchmarks came from the National CAHPS Benchmarking Database (NCBD) for the same time period. The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and is administered by Westat, Inc.

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

Utilization and Costs

Data on utilization and MHS and beneficiary costs came from several sources. We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased care claims information for the previous generation of contracts); TRICARE Encounter Data (TEDs—purchased care claims information for the new generation of contracts) for inpatient, outpatient, and prescription services; and TRICARE Mail Order Pharmacy (TMOP) claims within each beneficiary category. Costs recorded on HCSRs and TEDs were broken out by source of payment (DoD, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file. Final data pulls used for this report were completed between the end of December 2004 and the end of January 2005 as referenced above.

The CCAE database contains the health care experience of several million individuals (annually) covered under a variety of health plans, including preferred provider organizations, point of service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data and individual-level enrollment information. We tasked MEDSTAT to compute quarterly benchmarks for HMOs and PPOs, broken out by several sex/age group combinations. The quarterly breakout, available through the second quarter of FY 2004, allowed us to derive annual benchmarks by fiscal year and to estimate FY 2004 data to completion. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.



AC	Active Component
AD	Active Duty
ADFM	Active Duty Family Member
ASD	Assistant Secretary of Defense
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Health Plans Survey
CCAE	Commercial Claims and Encounters
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CONUS	Continental United States
DEERS	Defense Enrollment Eligibility Reporting System
DHP	Defense Health Program
DoD	Department of Defense
DRG	Diagnosis-Related Group
DTF	Dental Treatment Facility
DVA	Department of Veterans Affairs
FFS	Fee for Service
FTE	Full Time Equivalent
FY	Fiscal Year
GDP	Gross Domestic Product
HCSDB	Health Care Survey of DoD Beneficiaries
HCSR	Health Care Service Record
HMO	Health Maintenance Organization
HP	Healthy People
HPA&E	Health Program Analysis and Evaluation Directorate
IM/IT	Information Management/Information Technology
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
MHS	Military Health System
MTF	Military Treatment Facility
NAS	Nonavailability Statement
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
OASD	Office of the Assistant Secretary of Defense
OCONUS	Outside Continental United States
OHI	Other Health Insurance
O&M	Operations and Maintenance
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
POS	Point of Service
PPO	Preferred Provider Organization
RC	Reserve Component
RVU	Relative Value Unit
RWP	Relative Weighted Product
SADR	Standard Ambulatory Data Record
SIDR	Standard Inpatient Data Record
TOA	Total Obligational Authority
TAMP	Transitional Assistance Management Program
TDP	TRICARE Dental Program
TED	TRICARE Encounter Data
TFL	TRICARE for Life
TMA	TRICARE Management Activity
TMOP	TRICARE Mail Order Pharmacy
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TRDP	TRICARE Retiree Dental Program
TRFDP	TRICARE Reserve Family Demonstration Project
TRO	TRICARE Regional Office
TSRx	TRICARE Senior Pharmacy
UMP	Unified Medical Program
VA	Department of Veteran Affairs

