OVERVIEW STATEMENT BY

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FOR HEALTH BUDGETS AND FINANCIAL POLICY

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

MODELING AND BUDGETING FOR HEALTH CARE IN THE DEPARTMENT OF DEFENSE

JUNE 23, 2005

NOT FOR PUBLIC RELEASE UNTIL
10:00 AM ON JUNE 23, 2005

Mr. Chairman and distinguished members of this committee, I want to thank you for the opportunity to discuss modeling and budgeting for health care costs in the Military Health System.

The Department of Defense (DoD) offers the TRICARE benefit to approximately nine million eligible beneficiaries. 19% of this population is made up of Uniformed Services personnel (Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service and National Oceanic and Atmospheric Administration); their family members make up another 27%. Retirees, their family members and survivors account for 54% of our beneficiaries.

Approximately 20% of our beneficiaries are entitled to Medicare. DoD's share of their health care costs are paid from the DoD Medicare Eligible Retiree Health Care Fund, an accrual type fund established by Congress that began operations in Fiscal Year 2003.

For the rest of our beneficiaries, we must estimate and budget for the cost of their care as well as for the myriad of military unique readiness health care activities performed by the medical services of the Army, Navy and Air Force. We have three distinct missions in the Military Health System (MHS): Deploying a healthy and fit force, which involves force health protection activities such as the development and administration of vaccines and improving, medical surveillance, deployment health appraisals, and other health promotion activities (smoking cessation, etc.) to maintain the fitness of our war fighters; deploying a ready medical force capable of combat health support, which involves the movement into the theater of operations of field and fleet medical units such as combat support hospitals and aeromedical evacuation assets; and managing beneficiary care through the administration of the TRICARE benefit.

TRICARE, the Military Health Plan

TRICARE offers our beneficiaries a variety of options for obtaining health care coverage. TRICARE Prime is a health maintenance organization type option that requires enrollment. active duty personnel are required to use military treatment facilities (MTF) unless assigned to a remote location where there is no nearby MTF. In these cases, active duty personnel are enrolled in TRICARE Prime Remote and assigned a private sector primary care provider. Retirees, retiree family members and survivors have three options; TRICARE Prime, TRICARE Extra, and TRICARE Standard. Those age 65 and over may choose TRICARE for Life or TRICARE Plus. For TRICARE Prime, retirees and their family members under age 65 pay an annual enrollment fee ($230 for an individual and $460 for a family). Enrollees have the option of enrolling with a primary care manager at a local MTF if one is available or with a primary care manager in the private sector who is a part of the TRICARE network established under three regional Managed Care Support Contracts. Care in the TRICARE network requires nominal copays whereas care in the MTFs does not. TRICARE Extra is a preferred provider organization type benefit where private sector network providers agree to accept reduced fees in exchange for being included in the network. TRICARE Extra offers reduced beneficiary out of pocket costs compared to TRICARE Standard but has a more limited choice of providers. TRICARE Standard is a fee for service benefit that offers the greatest choice of providers but includes higher deductibles and cost shares than other TRICARE options. Outpatient pharmacy services are offered free at MTF pharmacies and with three tiered copays through the TRICARE Retail Pharmacy network, and the TRICARE Mail Order Pharmacy program. Copays are lowest for generic drugs included in the TRICARE formulary, higher for name brand drugs in the formulary, and highest for drugs not included in the uniform formulary.

We have now transitioned to new regional TRICARE Managed Care Support Contracts which include incentives for care referred by the contractor back to local MTFs, helping us to ensure maximum utilization of our in house care services.

The challenges we face as we prepare our annual budget requests include predicting how many of our eligible beneficiaries will use their TRICARE benefit, what option they will select, how often they will require care or prescriptions, what inflation rates will impact our procurement of services from the private sector, and the impact of recently enacted changes in benefits.

The expansion of benefits, such as those for Reservists and our senior retirees, contributes to the growing size of our budget. At Congress' direction, we implemented new TRICARE Reserve benefits that facilitate the individual medical readiness of members of the National Guard and Reserve, and contribute to the maintenance of an effective Reserve Component force. The National Guard and Reserve are doing an outstanding job and they deserve an outstanding benefit. We provide that to them. We have made permanent their early access to TRICARE upon notification of call-up, and their continued access to TRICARE for six months following active duty service for both individuals and their families. We have implemented the TRICARE Reserve Select (TRS) coverage for Reserve Component personnel and their families who meet the requirements established in law. TRS is a premium-based health care plan, at very attractive rates, available to eligible members of the National Guard and Reserves who have been activated for a contingency operation, on or after September 11, 2001.

MHS Funding

We face tremendous challenges in funding a benefit design that does not always reward the efficient use of care. Further, we are increasingly out of step with the benefit design approaches and trends of the private sector. We must address these issues, engage in constructive dialogue, and do what is right for our current and our future generations. Our primary goal is to ensure the military has a high quality, yet affordable, health benefit program for the long term.

Defense Health Program (DHP) costs continue to rise due to increased utilization of the MHS. The Fiscal Year 2006 DHP funding request is $19.8 billion to finance the MHS mission. Our funding growth is the result of expanded benefits for our beneficiaries, to include the Reserve Components; increased health care costs in the private sector; increased utilization of health care services and pharmaceuticals; the inherent design of the current benefit structure (e.g., no copayments for active duty family members, no non-availability statements, decreased catastrophic caps, etc.); and the decision of eligible beneficiaries, principally our retirees, to drop private insurance coverage and rely upon TRICARE.

DoD has taken several actions to better manage resources. The MHS is implementing performance-based budgeting, focusing on the value of services delivered rather than using old cost reimbursement methods. We are introducing an integrated pharmacy benefits program that uses a standardized formulary that is clinically and fiscally sound. Quality management programs continue to ensure that care provided is clinically appropriate and within prescribed standards.

With the phased implementation of a new Prospective Payment budgeting approach, we are moving to performance-based budgeting for our MTFs. We intend to base MTF budgets on

workload output such as hospital admissions and clinic visits, rather than on historical resource levels such as number of staff employed, supply costs, and other materials. We will pay a "competitive market price" for these outputs, providing financial incentives and rewards for efficient health care delivery. In addition to paying for heath care delivered, we are also developing methods to determine the cost to our MTFs of maintaining a medically ready force as well as a ready medical force. Some of these costs are included in the costs of health care delivered, but others are above this amount. Once fully implemented, PPS should allow for better management and performance of all three of the MHS missions.

Our pharmacy budget has increased five-fold since Fiscal Year 2001 and now stands at $5.5 billion ($1.9 billion of this amount is not in our budget request as it is funded by the DoD Medicare Eligible Retiree Health Care Fund). The redesign of our pharmacy programs into a single, integrated program, beginning in June 2004, simplifies and allows us to more effectively manage this program. We are standardizing formulary management, achieving uniform access to all medications, enhancing portability, and involving beneficiaries in formulary decision-making. We will promote the use of more cost-effective products and points of service.

We strive continuously to improve the quality of care delivered throughout the MHS, employing sound management practices and metrics to ensure appropriateness of care through a variety of quality management programs. We monitor the health of our population using Healthy People 2010 goals as a benchmark. and we measure the quality of care provided using Joint Commission on Accreditation of Health care Organizations Oryx indicators.

Sharing Initiatives with DVA

We continue to explore new avenues of partnership with the Department of Veterans Affairs. Our Executive Council structure serves as the setting in which the Departments jointly

set strategic priorities, monitor the implementation of those priorities and ensure that appropriate accountability is incorporated into all joint initiatives.

The Joint Executive Council developed a Joint Strategic Plan for FY 2005 that includes goals and objectives for the year, as well as performance metrics in the following areas:

- Leadership Commitment and Accountability
- High Quality Health Care
- Seamless Coordination of Benefits
- Integrated Information Sharing
- Efficiency of Operations
- Joint Contingency/Readiness Capabilities

We have worked closely with the VA to develop and implement the demonstrations projects and the Joint Incentive Fund (JIF) projects requested by Congress. Seven demonstrations are now underway, twelve incentive fund projects are in varying stages of initiation and 56 new JIF proposals have been submitted for review.

We are especially pleased with our work with the Department of Veterans Affairs for the seamless, responsive and sensitive support to Soldiers, Sailors, Airmen and Marines as they return to duty or transition from active duty to veteran status. An important aspect of this transition is having the individual medical records available when a separated service member presents at a VA hospital for the first time. We made significant strides forward by transferring DoD electronic health information of service members who leave active duty to a central repository at the VA Austin Automation Center. Some examples of data transfer provided through this repository include: VA clinicians and claims adjudicators have access to DoD

laboratory results, radiology results, outpatient pharmacy data, allergy information, discharge summaries, consult reports, admission, disposition and transfer information, elements of the standard ambulatory data records and demographic data. To date, we have transferred this electronic health information on more than 2.9 million separated service members to this repository, and the VA has accessed more than 1 million of those records. We believe that this collaborative effort with the VA has been going extremely well and together, the DoD and VA are improving services to our veterans.

Modeling and Budgeting for Health Care

The DHP consists of three appropriations: Operation and Maintenance (O&M), Procurement, and Research, Development, Test and Evaluation (RDT&E). O&M, which comprises approximately 97% of the DHP budget request, is available for obligation for one fiscal year and is used to pay for the majority of our day to day operations. In recognition of the volatility of health care expenditures and the changes that occur in our program each year, Congress has allowed up to 2% of the DHP O&M appropriation to be carried over from one fiscal year into the next, essentially making that portion of the appropriation available for obligation for two fiscal years. Approximately 80% of the DHP resources are dedicated to provision of medical and dental care in both the direct care system and the private sector; the balance funds military unique requirements and specific readiness missions. Procurement, which comprises approximately 2% of the DHP budget request, is available for obligation for three fiscal years and is used to pay for the acquisition of specific items or systems with a unit cost of $250,000 or more. RDT&E. which comprises less than 1% of the DHP appropriation, is available for obligation for two fiscal years and is used to pay for the development of new systems, such as basic and applied research, advanced technology development, demonstration and validation. engineering development, developmental and operational testing, and the

evaluation of test results. We typically receive about $400 million above our DHP RDT&E request to fund Congressional interest items. All DHP appropriations are allocated in accordance with guidance provided by the Secretary of Defense and more detailed guidance provided by the Assistant Secretary of Defense (Health Affairs).

In addition, DoD also budgets for two more appropriations not included in the DHP. The Military Personnel Appropriation pays for military personnel assigned to MHS activities, such as hospitals and clinics, and the Military Construction appropriation pays for new construction or major modification of MTFs, medical research facilities, and other medical buildings.

The DHP O&M appropriation is divided into seven Budget Activity Groups (BAGs). Funding within each BAG is further separated into commodities and inflated at specified OMB inflation rates.

BAG 1 – In-House Care – Funds patient care and pharmacy services in Medical and Dental Treatment Facilities world wide. This BAG is further divided into three major categories: health care delivered in MTFs, dental care and pharmaceuticals.

This budget activity group comprises about 27% of the total O&M appropriation. Budgeting for health care in MTFs is currently undergoing a phased transition to the Prospective Payment System, the performance based budgeting process previously described. For the Fiscal Year 2006 DHP budget. 50% of this category will be funded through prospective payment and 50% based on historical resource levels such as number of staff employed. supply costs, contracts, and other categories adjusted for inflation using OMB inflation rates. We plan to base our Fiscal Year 2007 budget request on 75% implementation of Prospective Payment and move to full implementation in Fiscal Year 2008. The DHP-resourced medical services of the Military

Departments (Army, Navy and Air Force; health care services for the Marines are provided by the Navy) develop detailed business plans to determine the amount and type of inpatient and outpatient workload that they will produce and be funded for by Prospective Payment during the budget year.

Budgeting for dental care currently is based on historical resource levels adjusted for inflation but we plan to develop and implement a prospective payment process for this category in the near future.

Pharmacy, as previously mentioned, has been an area of significant cost growth in recent years. For the In-House Care BAG, budgets are based on historical costs adjusted both for inflation and for actuarially derived trends in utilization; the development of new drugs has resulted in increased numbers of prescriptions for existing TRICARE users, and the previously mentioned effect of beneficiaries who were not using TRICARE but are now dropping their private insurance has also increased demand for pharmaceuticals.

BAG 2 – Private Sector Care – Funds patient care and pharmacy services purchased from private sector providers (Managed Care Support Contracts, Retail and Mail Order Pharmacy, Supplemental Care, Purchased Dental Care, the Uniformed Services Family Health Plan, and other requirements).

This budget activity group comprises about 53% of the total O&M appropriation. Private Sector Care requirements depend heavily on accurate estimates of workload produced by MTFs, as well as accurate actuarial forecasts of private sector health care cost growth, increased utilization of health care services by TRICARE users. and increased numbers of TRICARE beneficiaries who use TRICARE as their primary insurance. In addition. changes to the

TRICARE benefit directed by Congressional action have a significant impact on the funding required in the budget.

We have developed a Private Sector Care Requirements Model that takes these factors (as well as many others) into account in forecasting budgetary requirements for this BAG.

BAG 3 – Consolidated Health Support – Funds entrance examining activities, occupational health, veterinary services, aeromedical evacuation, the Armed Forces Institute of Pathology and other military unique health activities.

This budget activity group comprises about 6% of the total O&M appropriation. The primary cost drivers are the volume of force health protection activities, aeromedical evacuation requirements, and volume of entrance examinations (recruits). Budgeted amounts are based on historical resource levels adjusted for inflation using OMB inflation rates, plus any new missions or initiatives directed by senior leaders ("programmatic" changes) or by Congress. For example, the recently directed increases in Army and Marine end strength drive increased requirements for military service entrance examination activities.

BAG 4 – Information Management/Information Technology (IM/IT) – Funds both the Central and non-central, Service Medical IM/IT programs. The Central program funds system program management, system and infrastructure sustainment, annual software licensing and equipment lease costs. The non-central funds provide for unique military service and Tri-service systems, communications and computing infrastructure, information assurance, long haul/wide area communications, office automation, video-teleconferencing, and other technical activities.

This budget activity group comprises about 4% of the total O&M appropriation. The primary cost drivers are the phased fielding requirements of corporate information systems, life

cycle replacement costs of these systems, and internally or externally directed security requirements.

BAG 5 – Management Activities – Funds the military department medical commands and the TRICARE Management Activity.

This budget activity group comprises about 1% of total O&M. We project requirements primarily based on the historic funding baseline adjusted for inflation at OMB rates.

BAG 6 – Education and Training – Funds the Health Professions Scholarship Program, the Uniformed Services University of the Health Sciences and other education and training programs.

This budget activity group comprises about 2% of total O&M. The primary cost drivers are the number and composition of our medical force structure (military and civilian) and the projected recruiting requirements for clinical professionals through the Health Professions Scholarship Program (HPSP), the Health Professions Loan Repayment Program (HPLRP), the Financial Assistance Program (FAP) and the Uniformed Services University of the Health Sciences (USUHS). The major areas of concern within this budget activity group are the escalating costs of tuition and the recruiting and retention rates of clinical personnel.

The military service medical departments have student output models that drive the requirements for in-house training requirements. This is based on personnel being promoted, separated or retiring. Additionally, we have an Intraservice Training Review Organization (ITRO) that manages additional training requirements from the Services and determines the most efficient means to train them. Many medical courses have been consolidated and are structured to be used by all military services to achieve more cost effective use of available resources.

Total Student Allocations are determined by law with the Assistant Secretary of Defense (Health Affairs) determining the number of funded student allocations. Service force management offices determine requirements for student allocation by analyzing specialty outputs (retirement, separation) and inputs (direct accessions, military academies, the Reserve Officer Training Corps). These numbers are entered into a Force Management Tool to determine requirements for each specialty.

BAG 7 – Base Operations/Communications – Funds Facility Restoration, Modernization and Sustainment, Real Property Services, Communications, Environmental and Base Operations Support costs.

This budget activity group comprises about 6% of total O&M. While this BAG supports many facilities-related activities. it is worth noting how the specific process by which we fund the normal maintenance of our existing DHP infrastructure. We in the DHP are responsible for a large, diverse inventory of facilities with a replacement value of approximately $19 billion. To properly sustain this inventory, we use the Facilities Sustainment Model (FSM) that integrates:

- Real property inventories
- Unit cost factors for sustainment differentiated between facility types by using DoD\Facility Analysis Category (FAC) codes
- Business rules for assigning sub-organization and fund source responsibilities
- Forecasts of planned inventory changes, such as new construction and disposals

For each of the FAC codes, a unit cost factor for sustainment was developed based upon commercial cost benchmarks and tailored to the specific facility composition. The FSM itself combined the standardized inventory and unit cost factors with a host of business rules to

generate an objective, auditable facilities sustainment requirement in sufficient detail to be useful to all MHS users.

DHP Procurement Appropriation

Roughly half of DHP procurement funding supports the purchase of information systems, and half supports purchase of medical and dental equipment. Requirements are driven by lifecycle replacement, new technology advances, and construction of new or renovation of existing facilities.

DHP RDT&E Appropriation

The DHP RDT&E Appropriation represents less than 1% of the total DHP appropriation and has historically primarily supported information management and information technology development efforts. Beginning in Fiscal Year 2006, the DHP RDT&E appropriation will also fund medical research laboratories transferred from the line Navy; the Armed Forces Radiobiology Research Institute transferred from the Director, Defense Research and Engineering; and two new initiatives - the Epidemiologic Outbreak System, and the SuperVision program. The Epidemiologic Outbreak System will provide a bio-defense system for early threat warning, rapid threat identification, and focused treatment and outbreak containment. SuperVision, a human performance enhancement program, will maximize war-fighter effectiveness to operate under adverse conditions. We typically receive about $400 million above our request to fund Congressional interest medical research.

Military Personnel (MILPERS) appropriation

MILPERS costs are estimated by the military services using a "composite" or "programming" rate that takes many factors into account, such as authorized end strength, grade mix, promotion timing, separation/retention rates, pay raises, recruiting costs, travel and

temporary duty costs, and contributions to the DoD Medicare Eligible Retiree Health Care Fund, among other factors.

Military Construction (MILCON) appropriation

The MILCON Appropriation provides for the design and construction of projects that allow us to replace or update our current facilities. Additionally, modernization work over the O&M Appropriation limit of $750,000 (or $1,500,000 if the project is strictly to alleviate health or safety deficiencies) is included in this account. As part of the life cycle cost analysis of our medical facilities, we monitor the facilities' recapitalization rate. Recapitalization is a combination of restoration and modernization. Restoration returns performance to original levels or, alternatively, to the level defined by the normal degradation curve. Modernization, on the other hand, raises performance to a new level, beyond the original level. An example is the incorporation of force-protection enhancements into modernization projects at defense facilities. The modernized facilities will perform better, due to the addition of force-protection features, than they did originally.

Since recapitalization can include restoration and modernization, as well as replacement, we employ both MILCON and O&M to keep our facilities current with modern health care practices and market conditions. The cost of maintaining and upgrading facilities is a major component of the operations and capital budgets of medical facilities. The DoD target rate for recapitalization is equal to the estimated service life of facilities (50 years for medical facilities and 67 years on average for all DoD facilities). The ability to retain our critical medical infrastructure base in a safe, secure, fiscally and operationally efficient manner is a challenge. Even when optimally maintained, facilities eventually either physically wear out or become

functionally obsolete. Appropriate investments are required to "reset" the life expectancy of our aging infrastructure.

Conclusion

We operate an incredibly complex and capable health care system--one that provides world class health care both at fixed facilities here in the United States and abroad and within the deployable units world wide that support the Global War on Terrorism. It is our enduring responsibility to ensure we maintain a healthcare system that delivers a fit and ready force on the battlefield, and also secures the well-being of families and other beneficiaries here at home. We face many challenges in meeting these missions in a cost effective manner without degrading the support we provide to current and retired members of our Nation's Uniformed Services and their families. We are exercising prudent management in our cost control efforts but increasing demand, added benefits and high inflation for health care services tend to obscure our efforts, particularly when we are estimating costs for services to which our beneficiaries are entitled by law within the limits of the rules of appropriations law.

We are exercising our strategic and business planning processes to ensure we effectively address readiness, capital needs, and changing infrastructure. We continue to pursue higher levels of system efficiency and clinical effectiveness and deploy information technologies and management systems that support greater performance, clarity and accountability. We are implementing critical new cost control initiatives such as prospective payment and improved Managed Care Support Contracts.

The military medical community has often been a powerful influence in building national relationships that foster freedom and liberty. Today, we also directly support our Service members who fight to help others secure their freedom. Our MHS is truly a precious national

asset. The reason military medicine has succeeded and why it will continue to succeed goes beyond 'hard work' -- it goes to the will and character of the American people. We are confident that our mission -- caring for the Uniformed Service members who keep this Nation safe and secure, and to care for their families -- has no greater calling or cause.

Thank you.

Budgetary Inflation Rates Applied to the Defense Health Program

FY05-06 Inflation Rates																
Budget Activity Group	IHC	PSC	CHS	IM	MA	E&T	BOS	Budget Activity Group	IHC	PSC	CHS	IM	MA	E&T	BOS
Travel of Persons	0.021	0.021	0.021	0.021	0.021	0.021	0.021	MAC SAAM	-0.052	-0.052	-0.052	-0.052	-0.052	-0.052	-0.052
DFSC Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097	MSC Cargo	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010	-0.010
Service Fund Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097	MTMC Port Handling	0.045	0.045	0.045	0.045	0.045	0.045	0.045
Army Sup & Mat	0.025	0.025	0.025	0.025	0.025	0.025	0.025	MTMC Other	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Navy Sup & Mat	0.077	0.077	0.077	0.077	0.077	0.077	0.077	Commercial Transportation	0.02	0.02	0.02	0.02	0.02	0.02	0.02
AF Sup & Mat	0.057	0.057	0.057	0.057	0.057	0.057	0.057	Civ Pay Reimburs Host	0.026	0.026	0.026	0.026	0.026	0.026	0.026
DLA Sup & Mat	0.012	0.012	0.012	0.012	0.012	0.012	0.012	Foreign Nat Ind Hire	0.026	0.026	0.026	0.026	0.026	0.026	0.026
GSA Sup & Mat	0.021	0.021	0.021	0.021	0.021	0.021	0.021	Separation Liability	0.026	0.026	0.026	0.026	0.026	0.026	0.026
Local Proc Sup & Mat	0.021	0.021	0.021	0.021	0.021	0.021	0.021	Rental Pay to GSA	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Army Fund Equipt	0.025	0.025	0.025	0.025	0.025	0.025	0.025	Purchased Utilities	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Navy Fund Equipt	0.077	0.077	0.077	0.077	0.077	0.077	0.077	Purchased Communica	0.021	0.021	0.021	0.021	0.021	0.021	0.021
AF Fund Equipt	0.057	0.057	0.057	0.057	0.057	0.057	0.057	Rents non GSA	0.021	0.021	0.021	0.021	0.021	0.021	0.021
DLA Fund Equipt	0.012	0.012	0.012	0.012	0.012	0.012	0.012	Postal Svcs	0.000	0.000	0.000	0.000	0.000	0.000	0.000
GSA Fund Equipt	0.021	0.021	0.021	0.021	0.021	0.021	0.021	Supplies & Mat	**0.035**	**0.035**	0.021	0.021	0.021	0.021	0.021
Army Depot Cmd Maint	0.007	0.007	0.007	0.007	0.007	0.007	0.007	Printing & Reproduct	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Naval Surface War Ctr	0.027	0.027	0.027	0.027	0.027	0.027	0.027	Equipt Maint Contract	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Data Automat Ctr Navy	0.000	0.000	0.000	0.000	0.000	0.000	0.000	Facility Maint Contract	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Fleet Aux Ships Navy	0.114	0.114	0.114	0.114	0.114	0.114	0.114	Pharmacy	0.101	0.101	0.101	0.101	0.101	0.101	0.101
Naval Rsch Lab	0.034	0.034	0.034	0.034	0.034	0.034	0.034	Equipt Purchases	**0.035**	**0.035**	0.021	0.021	0.021	0.021	0.021
Naval Civil Engnr Ctr	0.016	0.016	0.016	0.016	0.016	0.016	0.016	Overseas Purchases	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Naval Pub & Prnt Svc	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	-0.001	Other Depot Maint	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Nav Pub Wrks Ctr: Utilities	0.038	0.038	0.038	0.038	0.038	0.038	0.038	Contract Consultants	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Nav Pub Wrks Ctr: Pub Wrks	0.029	0.029	0.029	0.029	0.029	0.029	0.029	Mgmt & Prof Spt Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Naval Shipyards	0.057	0.057	0.057	0.057	0.057	0.057	0.057	Studies Analysis Eval	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Airlift Svcs Trng & Ops	0.380	0.380	0.380	0.380	0.380	0.380	0.380	Engineering Tech Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Communications Svc	-0.131	-0.131	-0.131	-0.131	-0.131	-0.131	-0.131	Fuel	0.097	0.097	0.097	0.097	0.097	0.097	0.097
Def Finance & Acct Svc	-0.027	-0.027	-0.027	-0.027	-0.027	-0.027	-0.027	Grants	0.021	0.021	0.021	0.021	0.021	0.021	0.021
Cost Reimbursible Svc	0.021	0.021	0.021	0.021	0.021	0.021	0.021	Other Contracts	**0.070**	**0.070**	0.021	0.021	0.021	0.050	0.021
MAC Cargo	0.020	0.020	0.020	0.020	0.020	0.020	0.020	Other Costs	**0.035**	**0.070**	0.021	0.021	0.021	0.021	0.021

Defense Health Program Operation and Maintenance Appropriation
Program Element Account Structure – Fiscal Year 2006 President's Budget ($000s)

In-House Care BAG		
0807700	MEDCENs, Hospitals & Clinics (CONUS)	2,700,578
0807900	MEDCENs, Hospitals & Clinics (OCONUS)	258,361
0807701	Pharmaceuticals, In-House (CONUS)	1,753,317
0807901	Pharmaceuticals, In-House (OCONUS)	113,411
0807715	Dental Care Activities - CONUS	327,440
0807915	Dental Care Activities - OCONUS	57,233
Private Sector Care BAG		
0807702	Pharmaceuticals - Purchase Health Care	182,133
0807703	Pharmaceuticals - National Retail Rx	1,537,925
0807723	TRICARE Managed Care Support Contracts	4,759,574
0807738	MTF Enrollees - Purchased Care	1,655,830
0807741	Dental - Purchased Care	252,449
0807742	USFHP	278,307
0807743	Supp Care - Health Care	744,174
0807745	Supp Care - MMSO Dental	118,687
0807747	CHE / CAP	186,782
0807749	Overseas Purchased Health Care	207,025
0807751	Misc Purchased Healthcare	270,770
0807752	Misc Support Activities	18,771
Consolidated Health Support BAG		
0801720	Examining Activities	43,341
0807714	Other Health Activities	446,774
0807705	Military Public/Occupational Health	236,071
0807760	Veterinary Services	22,310
0807724	Military Unique - Other Medical	299,643
0807725	Aeromedical Evacuation System	54,412
0807785	AFIP	60,038

Information Management BAG		
0807781	Service Medical IM/IT	366,102
0807793	Tri-Service IM/IT	475,452
Management Activities BAG		
0807798	Management Headquarters	55,435
0807709	TRICARE Management Activity	171,522
0901200	BMMP Domain Management & Systems Integration	2,425
Education and Training BAG		
0806722	HPSP	170,623
0806721	USUHS	95,541
0806761	Other Education and Training	177,298
Base Operations/Communications BAG		
0806276	Facilities Restoration and Modernization - CONUS	132,086
0806376	Facilities Restoration and Modernization - OCONUS	51,480
0806278	Facilites Sustainment - CONUS Health Care	274,707
0806378	Facilites Sustainment - OCONUS Health Care	49,152
0807779	Real Property Services - CONUS	253,929
0807979	Real Property Services - OCONUS	24,991
0807795	Base Communications - CONUS	41,156
0807995	Base Communications - OCONUS	7,304
0807796	Base Operations - CONUS	249,449
0807996	Base Operations - OCONUS	24,893
0807753	Environmental Conservation	374
0807754	Pollution Prevention	597
0807756	Environmental Compliance	26,181
0807790	Visual Information Systems	11,084

Total DHP Operation and Maintenance **19,247,137**

Private Sector Care Requirements Model

Overview

The Private Sector Care (PSC) Requirements Model currently divides PSC into the following 12 Program Elements (PE's):

- 807702 TRICARE Mail Order Pharmacy (TMOP)

- 807703 Retail Pharmacy

- 807723 Managed Care Support (MCS) contracts (the recently awarded T-Nex regional MCS contracts, excluding Military Treatment Facility (MTF) Primary Care Manager (PCM) enrollee care and non-underwritten care)

- 807738 MTF PCM enrollee care for non-active duty (these costs are also included in the T-Nex MCS contracts' underwriting provisions, except for MTF enrollees in Alaska)

- 807741 Dental – non-active duty

- 807742 Uniformed Services Family Health Plan (USFHP)

- 807743 Supplemental Care - Health Care (primarily purchased health care for active duty)

- 807745 Supplemental Care – Dental (for active duty)

- 807747 Continuing Health Education/Capital Investment (CHE/CAP) payments made to civilian hospitals for a portion of their costs related to graduate medical education and capital investments

- 807749 Overseas Purchased Health Care

-807751 Miscellaneous Purchased Health Care (includes Reserve Select health care costs, demonstrations, and other miscellaneous health care cost items)

-807752 Miscellaneous Support Activities (e.g., the Marketing & Education contract, the National Quality Monitoring Program contract)

The PSC Requirements Model does not include costs associated with the DoD Medicare Eligible Retiree Health Care Fund.

The three most significant PE's are the MCS contracts (807723), MTF PCM enrollee care for non-active duty (807738), and Retail Pharmacy (807703). These three PEs account for approximately three-fourths of the PSC total.

Underlying Contractor Health Care Costs:

- The most significant portion of the costs in the T-Nex MCS and retail pharmacy contracts is the underlying health care cost paid by the contractors to civilian providers.

- In developing its projected trends for these underlying health care costs, our analysis includes consideration of the following:

    1. Recent trends in the contractors' health care costs (due to attraction of new users, volume trends, inflation);

    2. Recent and projected trends in private sector employer health plans and the national health care sector in general; and

    3. Effects of planned changes in the TRICARE program (benefit changes, change in provider reimbursement policies, contract transitions, etc.).

- Using our claims database, we decompose the historical trends in its underlying health care costs to determine what factors would be ongoing versus one-time effects. Factors accounted for include:

    1. Global War on Terrorism (GWOT) effects (e.g., mobilized reservists, to be excluded from future projections);

    2. Changes in the number of TRICARE eligibles under age 65 based on Defense Enrollment Eligibility Reporting System (DEERS) data;

    3. Changes in the percentage of retiree eligibles under age 65 who actually use their TRICARE benefit (the "users" trend effect, discussed in more detail below); and

    4. Changes in the cost per user (including changes in unit costs and volume of services per user).

- We assess these elements distinctly for pharmacy versus non-pharmacy costs.

Attraction of New TRICARE Users:

- One of the trend effects we consider is the past and future trend in the percentage of TRICARE-eligible retirees and retiree family members under age 65 who actually use

TRICARE rather than other health insurance (OHI), typically sponsored by the retiree or retiree spouse's current employer.

1. To measure this effect, we define a user as an individual with at least one MTF or TRICARE civilian physician visit during the year.

2. The most recent data indicate that the user rate among eligible retirees under age 65 and their family members increased approximately three percent in 2002, four percent in 2003, and four percent in 2004.

- This increasing users trend among retirees under age 65 is driven by two factors:

1. Private sector employer plans are increasing employee premium contributions, deductibles, copays, etc. Thus, employees' out-of-pocket costs are increasing, making OHI coverage less attractive to many retirees.

2. Meanwhile, TRICARE's benefit has become more generous and attractive over time. Recent benefit changes have lowered out-of-pocket costs for many services, and TRICARE has not raised its deductibles, enrollment fees, or remaining copays since the benefit was first implemented. Adding the TRICARE for Life (TFL) benefit also meant retirees no longer had to stay in their employer's OHI plan to qualify for an employer-sponsored "wrap-around" benefit once they became eligible for Medicare.

Trends in private sector employer health plans and the national health care sector.

- Evidence of civilian employer health plan cost trends is available from the Federal Employees' Health Benefit Plan (FEHBP) and several annual surveys of employer health plans.

1. FEHBP premiums increased 13% in 2002, 11% in 2003, 10% in 2004, and 8% (estimated) in 2005.

2. The annual Kaiser Family Foundation-Health Research and Educational Trust survey indicates that health care costs among large, self-insured employers increased 9% in 2001, 12% in 2002, 12% in 2003, and 11% in 2004. Trends for self-insured employers are especially relevant because there is no effect from the "health insurance underwriting cycle."

- We also monitor trend projections made by the Centers for Medicare and Medicaid Services (CMS). Recent CMS projections are less relevant for TRICARE, however, because CMS's model assumes downward pressure on utilization trends because of employers raising deductibles, copays, etc., a dampening effect that would not apply to TRICARE.

Effects of Planned Changes In The TRICARE Program:

- We also make adjustments for a given year if significant program changes are planned. Examples can include benefit changes, changes in provider reimbursement policies, or scheduled contract transitions.

Projected Requirements For The Other PSC Program Elements:

- For the other PSC PE's, our requirements methodology:

    1. Reviews actual historical expenditures and trends;

    2. Adjusts this baseline for one-time effects; and

    3. Applies future trend assumptions for the out-year projections.