



## Defense Primer: Military Health System

The Department of Defense (DOD) operates a healthcare delivery system that in fiscal year (FY) 2017 will serve an estimated 9.4 million beneficiaries both on the battlefield and off. With a 2017 budget request of \$49 billion, the DOD's unified medical program represents about 8% of DOD's total budget. Beneficiaries may obtain care from DOD-operated and staffed medical and dental facilities (referred to collectively as "military treatment facilities") or through care from civilian providers purchased through an insurance program known as TRICARE. Purchased care accounts for approximately 52% of the total cost of care delivered through the military health system. The conference report version of the National Defense Authorization Act for Fiscal Year 2017 (P.L. 114-328, herein "2017 NDAA") makes significant changes to many of the features described below that DOD will need to implement in the coming months.

### Purpose

The underlying reason DOD has a military health system is medical readiness. The medical readiness mission involves promoting "a healthy and fit fighting force that is medically prepared to provide the Military Departments with the maximum ability to accomplish their deployment missions throughout the spectrum of military operations." The military health system also serves to "create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former member of those services, and for their dependents" (10 U.S.C.1071). In addition, the resources of the military health system may be used to provide humanitarian assistance (10 U.S.C. 2561) and to perform medical research (10 U.S.C. 2358).

### Organization

The Under Secretary of Defense for Personnel and Readiness (USD(P&R)) is the principal staff assistant and advisor to the Secretary and Deputy Secretary of Defense for Total Force Management as it relates to readiness issues including health affairs (see 10 U.S.C. 136).

### Key Military Health System Organizations

- Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA) )
- Defense Health Agency (DHA)
- Surgeons general of the Army, Navy, and Air Force

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) reports to the USD(P&R). The ASD(HA) is the principal advisor to the Secretary of Defense on all "DoD

health policies, programs and activities" and has primary responsibility for the military health system (see Department of Defense Directive 5136.01). Reporting to the USD(P&R) through the ASD(HA), the Defense Health Agency (DHA) is a joint, integrated combat support agency whose purpose is to enable the Army, Navy, and Air Force medical services to provide a medically ready force and a ready medical force to combatant commands in both peacetime and wartime.

### Beneficiaries

Military retirees and their families are estimated to account for about 57% of the 9.4 million total military health system beneficiaries in FY2015. An estimated 3.3 million active duty service members and their family members accounted for 35% of the total with reserve component members and their families primarily making up the remainder.

### Tricare Options and Beneficiary Cost Sharing

With the exception of active duty service members (who are assigned to the TRICARE Prime option and pay nothing out of pocket for TRICARE coverage, TRICARE beneficiaries, depending upon their status (active duty family member, retiree, reservist, child under age 26 ineligible for family coverage, Medicare-eligible, etc.) and geographic location, military health system beneficiaries may have a choice of plan options. Each plan option has different beneficiary cost-sharing features. Cost sharing may include, depending upon the option, an annual enrollment fee, annual deductible, monthly premiums, copayments, and an annual catastrophic maximum. Pharmacy copayments are established separately and are the same under each option. The 2017 NDAA renames and consolidate some of the options effective January 2018. Several of the current major plan options are listed below.

#### TRICARE Prime

TRICARE Prime is a health maintenance organization (HMO)-style option in which beneficiaries typically get most care through military treatment facilities. Retirees may be eligible to enroll in this option if they live within or near a designated "Prime Service Area." TRICARE Prime features an annual enrollment fee for retirees but does not have an annual deductible and has minimal copayments.

#### TRICARE Standard/Extra

TRICARE Standard and Extra may be used in tandem. They do not require enrollment or an annual enrollment fee but do have an annual deductible and copayments which vary depending upon the provider type and plan participation.

**TRICARE for Life**

In general, a retired TRICARE beneficiary must enroll in Medicare and pay Medicare Part B premiums in order to retain TRICARE coverage. The coverage provided is known as TRICARE for Life. There is no enrollment fee or premium and beneficiaries pay no out-of-pocket costs for services covered by both Medicare and TRICARE for Life.

**Budget**

Much, but not all, health-related spending in DOD is reported as the “unified medical program.” The unified medical program for FY2017 consists of requests for \$35.5 billion in discretionary funding for the Defense Health Program budget account under Operation & Maintenance in the annual defense appropriation, \$8.6 billion in Military Personnel, \$0.3 billion for Military Construction, and \$6.4 billion for accrual payments to the Medicare-Eligible Retiree Health Care Fund that finances a program known as “TRICARE for Life” that acts as supplemental coverage to Medicare. The two largest budget activity groups under annual Defense Health Program appropriation are “In-House Care” (also called “Direct Care”) with an FY2017 request for \$9.3 billion and “Purchased Care” with an FY2017 request for \$16 billion Health related DOD spending that is not reflected in the unified medical program includes military health personnel such as medics and corpsmen and medical research performed by the Defense Advanced Research Projects Agency (DARPA).

**Challenges**

A number of recent reviews and reports have made recommendations to address perceived areas of potential improvement within the military health system.

**Quality**

In May 2014, Secretary of Defense Chuck Hagel directed a comprehensive review of the military health system that focused on access to care, safety, and the quality of care. The final report identified: (1) a major gap in the ability of the military health system to analyze system wide health care information; (2) the absence of measures for evaluating office waiting times; (3) a need for improvement in a significant number of areas on measures of hospital quality; (4) surgical complication rates that were statistically higher than expected in 8 of 17 participating military treatment facilities in 2013 and persistent poor performance in three; (5) lower averages in 5 of the 12 domains in the national Hospital Survey on Patient Safety Culture; and (6) that fewer than 30 percent of staff actively reports patient safety events as required and, that overall, the reviewers could not validate that current processes provide an accurate indication of the military health system’s rate of harm.

In response, the military health system has focused on (1) improving access to medical care to meet defined standards; (2) ensuring that the quality of its health care meets or exceeds defined benchmarks; and (3) creating a culture of safety with effective processes for ensuring safe and reliable care of beneficiaries.

**Military Health System Modernization**

Related to quality, some military treatment facilities lack a sufficient volume of patients to provide medical

practitioners sufficient opportunity to maintain skills. After an internal DOD review identified military treatment facilities that could be downsized, Congress requested additional information in the 2013 NDAA (P.L. 113-291). In response, DOD issued a review of the military health system modernization study that identified staffing in a number of medical specialties that was not supported by the available workload. DOD has undertaken efforts to “recapture” workload from purchased care in order to provide sufficient experience to military providers.

**Combat Medicine**

The final report of the Military Compensation and Retirement Modernization Commission expressed concern with the ability of the military health system to sustain “combat medical capabilities with the typical mix of cases seen in the military health care system during peacetime.” The report recommended dedicated oversight of medical readiness through the creation of a joint medical component within a newly established joint readiness command, as well as a medical directorate in the Joint Staff. The report further recommended establishing the means to measure essential medical capabilities (EMCs) to promote and maintain critical capabilities within the military medical force. In addition, the report recommended that DOD should be granted additional authorities to attract EMC-related cases in to military treatment facilities to best support their mission as a training platform for military medical personnel. President Obama’s message to Congress did not endorse the Commission’s health recommendations but instead proposed to work with Congress to develop additional reform proposals. The 2017 NDAA creates new organizations within the military health system to address these concerns.

**Relevant Statutes**

Title 10, U.S. Code, Chapter 55 – Medical and Dental Care  
 Title 10, U.S. Code, Chapter 56 – Department of Defense Medicare-Eligible Retiree Health Care Fund

**CRS Products**

CRS Report R44577, *FY2017 National Defense Authorization Act: Selected Military Personnel Issues*, by Kristy N. Kamarck et al.  
 CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Don J. Jansen  
 CRS In Focus IF10349, *Congressionally Directed Medical Research Program Funding for FY2015 and FY2016*, by Don J. Jansen  
 CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*, coordinated by Elayne J. Heisler

**Other Resources**

DOD, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress*, 2016.

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