Congressional Research Service
Informing the legislative debate since 1914

IN FOCUS

Updated December 13, 2018

Defense Primer: Military Health System

The Department of Defense (DOD) operates a health care delivery system that in fiscal year (FY) 2019 will serve an estimated 9.4 million beneficiaries. In the President's 2019 budget request of $50.6 billion, 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-like program known as TRICARE. Purchased care accounts for approximately 60% of the total cost of care delivered through the Military Health System (MHS).

Purpose

The fundamental reason for an MHS is to support 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 MHS 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 members of those services, and for their dependents" (10 U.S.C. §1071). In addition, the resources of the MHS may be used to provide humanitarian assistance (10 U.S.C. §401) 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 MHS Organizations

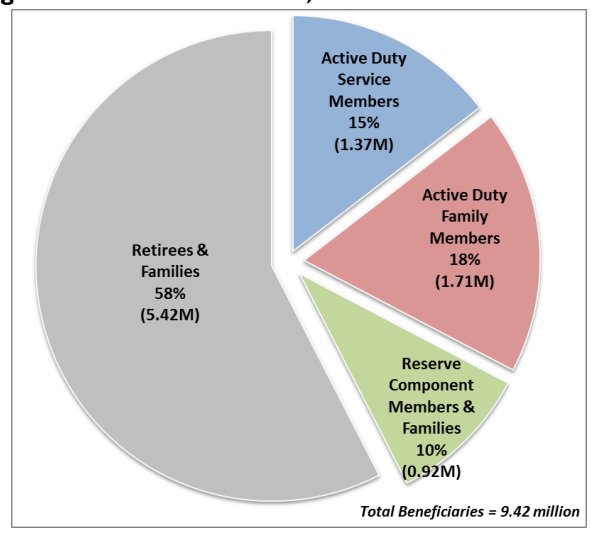
- Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA))
- Defense Health Agency (DHA)
- Surgeons General of the Army, Navy, and Air Force

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 MHS (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

In FY2017, there were 9.42 million total MHS beneficiaries.

Figure 1. MHS Beneficiaries, FY2017



Source: Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress*, Washington, DC, 2018, p. 18.

Note: Numbers may not add up to total because of rounding.

Military Treatment Facilities (MTFs)

On October 1, 2018, administration and management of the MTFs began to transfer from each Military Department to the DHA. Most MTFs are currently administered by each respective Service Surgeon General and provide a wide range of clinical services depending on its size, mission, and level of capabilities. These include inpatient and outpatient medical care, dental, and veterinary services. There are a total of 681 MTFs, with 126 located overseas. The facilities are generally on or near a U.S. military base and are typically staffed by military, civil service, and contract personnel.

TRICARE Options

With the exception of active duty service members (who are assigned to the TRICARE Prime option and pay no out-of-pocket costs for TRICARE coverage), MHS beneficiaries may have a choice of TRICARE plan options depending upon their status (e.g., active duty family member, retiree, reservist, child under age 26 ineligible for family coverage, Medicare-eligible, etc.) and geographic location. Each plan option has different beneficiary cost-sharing features. Cost sharing may include an annual enrollment fee, annual deductible, monthly premiums, copayments, and an annual catastrophic cap. Pharmacy

copayments are established separately and are the same for all beneficiaries under each option. 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 at an MTF. Certain 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 Select

TRICARE Select is a self-managed, preferred-provider option. This plan allows beneficiaries greater flexibility in managing their own health care and typically does not require a referral for specialty care. Eligible beneficiaries must enroll annually and may be subject to an enrollment fee, annual deductible, and copayments depending on their status. Lower out of pocket costs are associated with care delivered by a TRICARE network provider.

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

Most health-related spending in DOD is reported as the *unified medical program*. The unified medical program for FY2019 consists of requests for $33.7 billion in discretionary funding for the Defense Health Program budget account under Operation & Maintenance in the annual defense appropriation, $8.9 billion in Military Personnel, $0.4 billion for Military Construction, and $7.5 billion for accrual payments to the Medicare-Eligible Retiree Health Care Fund that finances TRICARE for Life. The two largest budget activity groups under the annual Defense Health Program appropriation are "In-House Care" (also called "Direct Care") with an FY2019 request for $9.7 billion and "Purchased Care" with an FY2019 request for $15.1 billion. Health-related DOD spending that is not reflected in the unified medical program includes medical activities covered by overseas contingency operations and medical research performed by the Defense Advanced Research Projects Agency or other military research agencies.

Current Challenges

There are a number of perceived areas for potential improvement within the MHS, many of which have recently attracted congressionally directed reform efforts and ongoing oversight activities.

MHS Modernization

The FY2017 NDAA reassigned responsibilities for administering MTFs from each respective Service Surgeon General to the DHA. Congress directed this reform to enhance medical force readiness, improve access and quality of care, and create a better experience for beneficiaries. DOD must implement this organizational change by September 30, 2021.

Access and Quality

DOD continues to focus on improving access to care to meet defined standards, expanding the use of telehealth services, enhancing the health care experience for beneficiaries, and ensuring quality of care meets or exceeds defined benchmarks. As directed in the FY2017 NDAA, DOD has also expanded access to primary care and urgent care services, reduced requirements for prior authorization and referrals, and is developing high performance military-civilian partnerships to deliver integrated health care.

Sustaining Wartime Medical Readiness Skills

As U.S. combat operations decline, sustaining readiness of the medical force continues to be an ongoing challenge for DOD. The FY2017 NDAA created new authorities for the Secretary of Defense to expand partnerships with certain civilian health care systems and Veterans Affairs medical facilities, and to expand access to care at MTFs to non-beneficiaries for the purposes of preserving core clinical competencies, combat casualty care capabilities, and enhancing wartime medical readiness skills.

Implementing a New Electronic Health Record

In 2015, DOD awarded a $4.3 billion contract to develop a modern, interoperable electronic health record that can be utilized in all care settings, including austere operational environments and in MTFs. Initial deployment of this system began in February 2017 in the Pacific Northwest and is designed to be a multi-year rollout across the MHS.

Relevant Statutes, Regulations, and Policies

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

Title 32, Code of Federal Regulations, Part 199 – Civilian Health and Medical Program of the Uniformed Services

Department of Defense Directive 6010.04, *Healthcare for Uniformed Services Members and Beneficiaries*, June 1, 2018.

CRS Products

CRS Report R45399, *Military Medical Care: Frequently Asked Questions*, by Bryce H. P. Mendez

CRS Report R45343, *FY2019 National Defense Authorization Act: Selected Military Personnel Issues*, by Bryce H. P. Mendez et al.

CRS In Focus IF10349, *Congressionally Directed Medical Research Programs Funding for FY2019*, by Bryce H. P. Mendez

Other Resources

Defense Health Agency, *Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress*, 2018.

Bryce H. P. Mendez, Analyst in Defense Health Care Policy

IF10530

Disclaimer