Congressional Research Service
Informing the legislative debate since 1914

Military Medical Care: Frequently Asked Questions

Updated October 25, 2021

Congressional Research Service
https://crsreports.congress.gov
R45399

CRS REPORT
Prepared for Members and
Committees of Congress

Congressional Research Service
Informing the legislative debate since 1914

SUMMARY

R45399

October 25, 2021

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

Military Medical Care: Frequently Asked Questions

Military medical care is a congressionally authorized entitlement that has expanded in size and scope since the late 19th century. Chapters 55 and 56 of Title 10, U.S. Code entitle certain health benefits to military personnel, retirees, and their families. These health benefits are administered by a Military Health System (MHS). The primary objectives of the MHS, which includes the Defense Department's hospitals, clinics, and medical personnel, are (1) to maintain the health of military personnel so they can carry out their military missions, and (2) to be prepared to deliver health care during wartime. Health care services are delivered through either Department of Defense (DOD) medical facilities, known as *military treatment facilities* (MTFs), as space is available, or through networks of participating civilian health care providers. As of 2020, the MHS operates 721 MTFs, employs nearly 61,000 civilians and 78,000 military personnel, and serves 9.6 million beneficiaries across the United States and in overseas locations.

Since 1966, civilian care for millions of military retirees, as well as dependents of active duty military personnel and retirees, has been provided through a program still known in law as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), more commonly known as TRICARE. TRICARE has three main benefit plans: a health maintenance organization option (TRICARE Prime), a preferred provider option (TRICARE Select), and a Medicare supplement option (TRICARE for Life) for Medicare-eligible retirees. Other TRICARE plans include TRICARE Young Adult, TRICARE Reserve Select, and TRICARE Retired Reserve. TRICARE also includes a pharmacy program and optional dental and vision plans. Options available to beneficiaries vary by the sponsor's duty status and geographic location.

This report answers selected frequently asked questions about military health care, including the following:

- How is the Military Health System structured?
- How is the MHS Funded?
- What is TRICARE?
- What are the different TRICARE plans and who is eligible?
- What are the costs of military health care to beneficiaries?
- What is the relationship of TRICARE to Medicare?
- How does the Affordable Care Act affect TRICARE?
- When can beneficiaries change their TRICARE plan?
- What is the Medicare Eligible Retiree Health Care Fund, which funds TRICARE for Life?

This report does not address issues specific to veterans or the Veterans Health Administration. Veterans' health issues are addressed in CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*, by Sidath Viranga Panangala and Jared S. Sussman.

Contents

Background 1
Questions and Answers 2
1. How is the Military Health System Structured? 2
MHS Governance Entities 2
Defense Health Agency 4
Military Service Medical Departments 5
2. How is the Military Health System Funded? 6
3. What is the Medicare-Eligible Retiree Health Care Fund (MERHCF)? 8
4. What are Military Treatment Facilities? 9
5. What is TRICARE? 10
TRICARE Regional Managed Health Care Support Contracts 10
6. Who Is Eligible for TRICARE? 11
7. What are the Different TRICARE Plans? 12
TRICARE Prime 12
TRICARE Select 14
TRICARE Reserve Select 17
TRICARE Retired Reserve 18
TRICARE Young Adult 18
TRICARE for Life 18
8. When can beneficiaries enroll in or change their TRICARE plan? 19
9. What is the DOD Pharmacy Benefits Program? 19
Prescriptions Filled Through Military Treatment Facilities 20
Prescriptions Filled Through Retail Pharmacies 21
Prescriptions Filled by Mail Order 21
Co-payment Adjustments 22
10. Who Pays First When a Beneficiary is Enrolled in TRICARE and Other Health Insurance (OHI)? 22
11. How Are Priorities for Care in Military Treatment Facilities Assigned? 23
12. What are DOD's Access to Care Standards? 23
13. How Does the Patient Protection and Affordable Care Act Affect TRICARE? 24
14. How does DOD Determine What Health Care Services are Covered by TRICARE? 24
15. How does DOD Determine the TRICARE Reimbursement Rates? 25
Reimbursement for Inpatient Care 25
Reimbursement for Hospital-based Outpatient Care 26
Reimbursement for Outpatient Care and Health Care-Related Services 26
16. What DOD Health Benefits are Available to Reservists? 26
17. Have Military Personnel Been Promised Free Medical Care for Life? 27
18. Does TRICARE Cover Abortion? 28
19. What is DOD's policy on Use Animals in Medical Research or Training? 29

Figures

Figure 1. Military Health System Governance 4
Figure 2. Military Health System Organizational Structure 6
Figure 3. FY2022 Unified Medical Budget Request 8

Figure 4. TRICARE Regions in the United States 11
Figure 5. Eligible Beneficiaries, FY2020 12

Tables

Table 1. MHS Funding by Appropriations Bill, Title, and Account 7
Table 2. Cost Sharing Features for TRICARE Prime 13
Table 3. Cost Sharing Features for TRICARE Select 15
Table 4. Qualifying Life Events 19
Table 5. TRICARE Pharmacy Copayments, 2018-2027 22
Table 6. DOD Health Benefits Available to Members of the Reserve Component 27

Appendixes

Appendix. Glossary of Acronyms 30

Contacts

Author Information 31

Background

Military medical care is a congressionally authorized entitlement that has expanded in size and scope since the late 19th century. Chapters 55 and 56 of Title 10, U.S. Code entitle certain health benefits to military personnel, retirees, and their families. These health benefits are administered by a Military Health System (MHS). The primary objectives of the MHS, which includes the Defense Department's hospitals, clinics, and medical personnel, are (1) to maintain the health of military personnel so they can carry out their military missions, and (2) to be prepared to deliver health care during wartime. The MHS is one of the largest health systems in the United States and serves over 9.6 million beneficiaries.[1] The MHS is to maintain the health and wellness of military personnel so they can carry out their military missions, and to be prepared to deliver health care during wartime.[2] This mission is further defined in law as follows:

- "... 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 their dependents."[3]
- "To support the medical readiness of the armed forces and the readiness of medical personnel...."[4]
- Perform medical research that is "of potential medical interest to the Department of Defense."[5]
- Conduct "humanitarian and civic assistance activities in conjunction with authorized military operations...."[6]

Health care within the MHS is delivered through either Department of Defense (DOD) medical facilities, known as *military treatment facilities* (MTFs), as space is available, or through networks of participating civilian health care providers. The MHS operates 721 MTFs and employs nearly 61,000 civilians and 78,000 military personnel across the United States and in overseas locations.[7]

The MHS also covers dependents of active duty personnel, military retirees, and their dependents, including some members of the reserve components. Since 1966, civilian health care to millions of retirees, as well as dependents of active duty military personnel and retirees, has been provided through a program still known in law as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), but more commonly known as TRICARE.[8] A Medicare wrap-

[1] David J. Smith, Raquel C. Bono, and Bryce J. Slinger, "Transforming the Military Health System," *Journal of the American Medical Association*, vol. 318, no. 24 (2017), pp. 2427-2428; Department of Defense (DOD), *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress*, February 26, 2021, p. 31, https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/Annual-Evaluation-of-the-TRICARE-Program.

[2] For more information about the Military Health System's mission and strategic initiatives, see https://health.mil/About-MHS.

[3] 10 U.S.C. §1071.

[4] 10 U.S.C. §1073d.

[5] 10 U.S.C. §2358.

[6] 10 U.S.C. §401. *Humanitarian and civic assistance activities* includes medical, surgical, dental, and veterinary care, among others.

[7] DOD, *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress*, February 26, 2021, p. 31.

[8] The "TRI" in "TRICARE" originally referred to its initial three main benefit plan options: a health maintenance organization option (TRICARE Prime), a preferred provider option (formerly known as "TRICARE Extra"), and a fee-for-service option (formerly known as "TRICARE Standard").

around option (TRICARE for Life) for Medicare-eligible retirees was added in 2002. Other TRICARE plans include TRICARE Young Adult, TRICARE Reserve Select, and TRICARE Retired Reserve. TRICARE also includes a pharmacy program and optional dental and vision plans. Options available to beneficiaries vary by the sponsor's duty status and geographic location.

Questions and Answers

1. How is the Military Health System Structured?

Five primary DOD organizations participate in administering the MHS: Office of the Assistant Secretary of Defense for Health Affairs (ASD[HA]), Defense Health Agency (DHA), Army Medical Command (MEDCOM), Navy Bureau of Medicine and Surgery (BUMED), and Air Force Medical Readiness Agency (AFMRA). Each maintains separate and distinct responsibilities in executing the primary mission of the MHS:

- **Office of the ASD(HA).** Responsible for the development of MHS-wide policies, budget administration, and oversight activities.[9]
- **DHA.** Responsible for policy execution, administration and management of MTFs, coordination of Defense Health Program research funding, and the delivery of health care through the TRICARE program.[10]
- **Service Medical Departments (MEDCOM, BUMED, AFMRA).** Responsible for recruiting, organizing, training, and equipping military medical forces to DHA or combatant commanders for the provision of medical care or health services support.[11]

DOD has established a governance structure to facilitate the decisionmaking process, maintain oversight of DOD health care, and coordinate health programs, services, resources, and benefits within the MHS (see **Figure 1**).

MHS Governance Entities

Defense Health Board (DHB)

The DHB is chartered under the Federal Advisory Committee Act to advise the Secretary of Defense (SECDEF).[12] The Board provides "independent advice and recommendations to maximize the safety and quality of, as well as access to, health care" for DOD beneficiaries.[13] The

[9] DOD Directive 5136.01, *Assistant Secretary of Defense for Health Affairs (ASD(HA))*, updated August 10, 2017, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/513601p.pdf.

[10] 10 U.S.C. §1073c, §1073c note, and DOD Directive 5136.13, *Defense Health Agency (DHA)*, September 30, 2013, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodd/513613p.pdf.

[11] 10 U.S.C. §1073c note, §7036, §8077, and §9036.

[12] For more on federal advisory committees, see CRS Report R44253, *Federal Advisory Committees: An Introduction and Overview*, by Meghan M. Stuessy.

[13] DOD, *Defense Health Board Charter*, December 6, 2020, p. 1, https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/Defense-Health-Board.

Board does not have a formal role in governing the MHS, rather, provides advice specifically on DOD:

- health care policy and program management;
- health research programs;
- requirements for the treatment and prevention of disease and injury;
- health promotion and wellness, including the effective and efficient delivery of high-quality health care services; and
- other health-related matters of special interest.[14]

The DHB is composed of no more than 19 members who are not full-time or permanent part-time federal officers or employees and are considered "eminent authorities" in public health, health system management, health care delivery, medical research, or other related disciplines.[15]

Military Health System Executive Review (MHSER)

The MHSER serves as a senior-level forum for DOD leadership input on strategic, transitional, and emerging issues. The MHSER advises the SECDEF and the Office of the Deputy Secretary of Defense (DEPSECDEF) about performance challenges and direction. The MHSER is composed of the following senior DOD leaders:

- Under Secretary of Defense (Personnel and Readiness) (USD[P&R]) (*Chair*);
- Principal Deputy Under Secretary of Defense (Personnel and Readiness);
- ASD(HA);
- Military Service Vice Chiefs;
- Military Department Assistant Secretaries for Manpower and Reserve Affairs;
- Director of Cost Assessment and Program Evaluation;
- Principal Deputy Under Secretary of Defense (Comptroller);
- Director of the Joint Staff; and
- Military Service Surgeons General (ex-officio members).[16]

Senior Military Medical Action Council (SMMAC)

The SMMAC is the highest governing body in the MHS, which presents enterprise-level guidance and operational issues for decisionmaking by the ASD(HA). The SMMAC is comprised of the following senior military health leaders:

- ASD(HA) (*Chair*);
- Principal Deputy Assistant Secretary of Defense (Health Affairs) (PDASD[HA]);
- Military Service Surgeons General;
- DHA Director;

[14] Ibid.

[15] Ibid, p. 2.

[16] DOD, *Plan for Reform of the Administration of the Military Health System*, October 25, 2013, p. 3, https://health.mil/Reference-Center/Reports/2013/11/25/Plan-for-Reform-of-the-Administration-of-the-Military-Health-System; and Email communication with DOD officials, August 25, 2021.

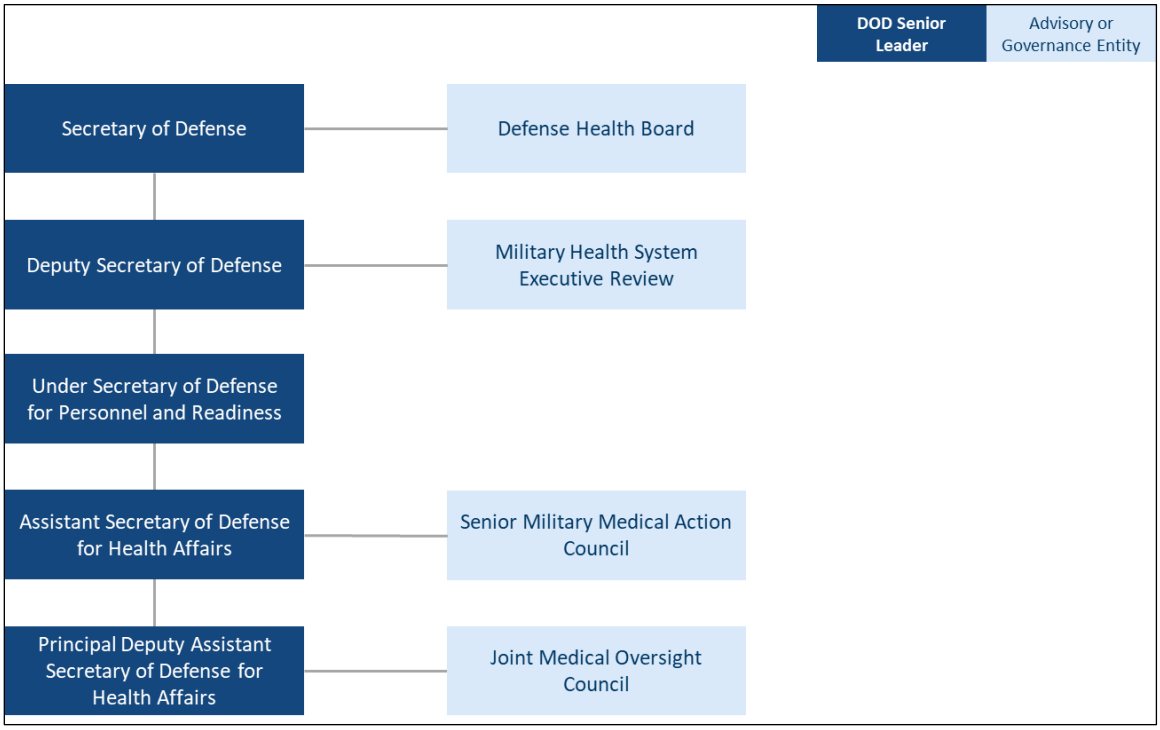
- Joint Staff Surgeon (JSS); and
- other attendees as required.[17]

Joint Medical Oversight Council (JMOC)

Reporting to the SMMAC is the JMOC, which ensures that actions are coordinated and aligned with MHS strategy, policies, directives, and initiatives. The JMOC is comprised of the following military health leaders:

- PDASD(HA) (*Chair*);
- Military Service Deputy Surgeons General;
- DHA Deputy Director; and
- JSS Representative.[18]

Figure 1. Military Health System Governance



Source: CRS graphic based on email communication with DOD officials, August 25, 2021.

Defense Health Agency

The DHA is a designated *Combat Support Agency* that focuses on enabling medical readiness of the Armed Forces and delivering a ready medical force to Combatant Commanders during peacetime and wartime.[19] Established in September 2013, the role of DHA is to

[17] Ibid.

[18] Email communication with DOD officials, August 25, 2021.

[19] A *Combat Support Agency* (CSA) is defined in DOD Directive 3000.06 as an organization, designated by 10 U.S.C.

- manage the TRICARE program;
- manage and execute the Defense Health Program appropriation and the Medicare Eligible Retiree Health Care Fund (MERHCF);
- support coordinated management of military health care markets to create and sustain a cost-effective, coordinated, and high-quality health care system;
- exercise management responsibility for shared services, functions, and activities of the MHS;
- exercise authority, direction, and control over MTFs within the National Capital Region;[20] and
- support the effective execution of the DOD medical mission.[21]

Pursuant to 10 U.S.C. §1073c, as amended, DHA is also responsible for administering all MTFs and coordinating Defense Health Program funding for Research, Development, Test, and Evaluation (RDT&E) programs.[22] The DHA Director leads the organization and is appointed by and reports to the ASD(HA). The Director is typically a general or flag officer in the grade of Lieutenant General/Vice Admiral.

Military Service Medical Departments

The military service medical departments (i.e., MEDCOM, BUMED, AFMRA) are established under each respective military department to recruit, organize, train, and equip military medical personnel, maintain medical readiness of the Armed Forces, and advise their military service chief on medical matters. The medical departments are led by a Surgeon General,[23] who also functions as the principal advisor to their respective military service secretary and service chief for all health and medical matters.[24]

---

§193 or the Secretary of Defense, to "provide and plan for the optimum support capabilities attainable within existing and programmed resources to the operational commanders within the parameters of the CSA's statutory responsibility and its chartering DOD Directive."

[20] MTFs in the National Capital Region include Walter Reed National Military Medical Center, Fort Belvoir Community Hospital, DiLorenzo TRICARE Health Clinic, Tri-Service Dental Clinic, Family Health Center Fairfax, and Family Health Center Dumfries.

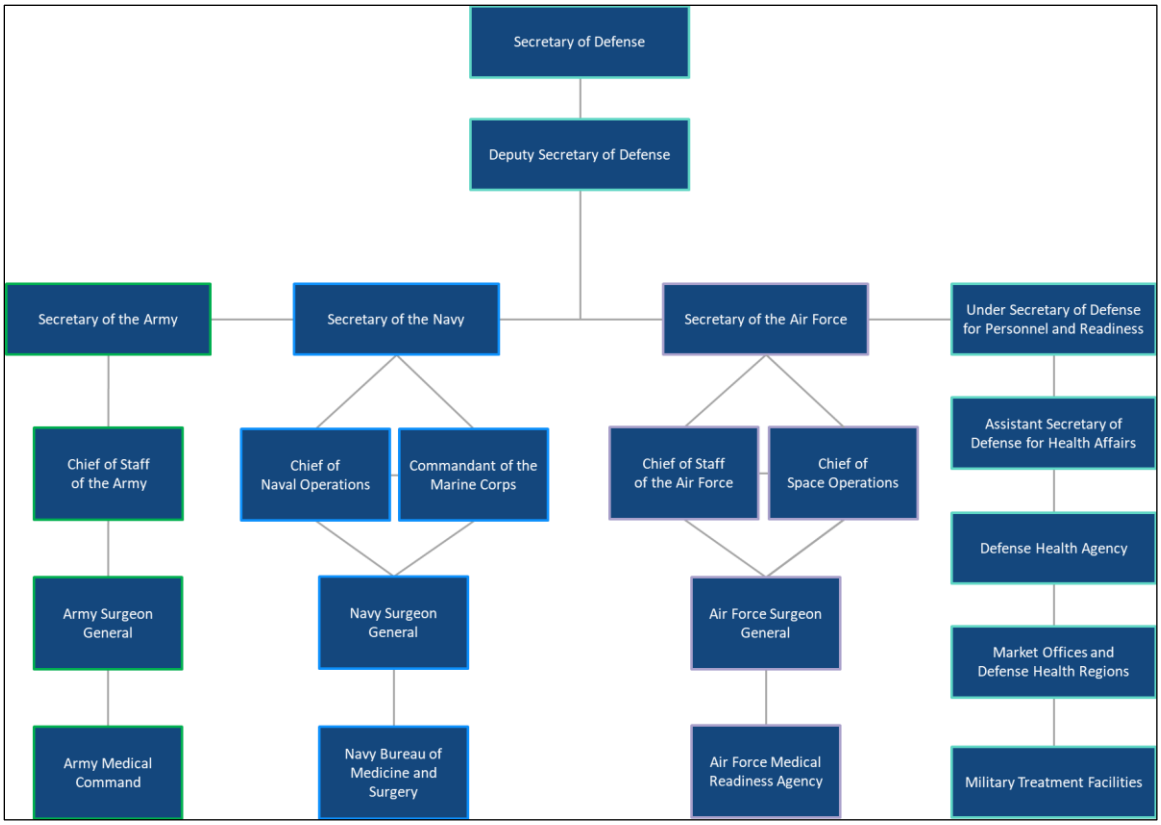
[21] DOD, DOD Directive 5136.13, *Defense Health Agency*, September 30, 2013; DOD, "Plan 3: Implementation Plan for the Complete Transition of Military Medical Treatment Facilities to the Defense Health Agency," June 24, 2019.

[22] Prior to October 1, 2021, certain MTFs were administered by the respective military service medical departments or the DHA. Section 702 of the FY2017 NDAA (P.L. 114-328) and Section 711 of the FY2019 NDAA (P.L. 115-232) directed the transfer of administration and management of MTFs from the military service medical departments to the DHA no later than September 30, 2021. For more, see CRS In Focus IF11273, *Military Health System Reform*, by Bryce H. P. Mendez.

[23] Service Surgeons General are typically general or flag officers in the grade of Lieutenant General or Rear Admiral (Upper Half).

[24] Statutory duties assigned to the Service Surgeons General are described in 10 U.S.C. §7036, §8077, and §9036.

Figure 2. Military Health System Organizational Structure



Source: CRS graphic based on 10 U.S.C. §7036, §8077, §9036; and DOD, "Plan 3: Implementation Plan for the Complete Transition of Military Medical Treatment Facilities to the Defense Health Agency," June 24, 2019.

2. How is the Military Health System Funded?

The ASD(HA) prepares and submits a *unified medical budget* that includes resources for all DOD medical activities under his or her responsibility.[25] The unified medical budget is primarily discretionary funding for all fixed MTFs and military medical activities, including costs for real property maintenance, environmental compliance, minor construction, base operations support, health care delivery, medical personnel and accrual payments to the Medicare Eligible Retiree Health Care Fund (MERHCF).[26] The unified medical budget does not include funding associated with combat support medical units/activities; in these instances the funding responsibility is typically assigned to combatant or military service commands.

While DOD submits its funding request for the MHS in a unified medical budget, Congress historically appropriates these funds in several accounts within the annual Defense appropriations bill and the Military Construction, Veterans Affairs, and Related Agencies appropriations bill (see **Table 1**).

[25] For more on the unified medical budget and MHS funding requests, see CRS In Focus IF11856, *FY2022 Budget Request for the Military Health System*, by Bryce H. P. Mendez.

[26] "Fixed" MTFs refer to the medical facilities defined in 10 U.S.C. §1073d and does not include deployable MTFs or other medical platforms. See question "3. What is the Medicare-Eligible Retiree Health Care Fund (MERHCF)?" for a discussion of the MERHCF.

Table 1. MHS Funding by Appropriations Bill, Title, and Account

Appropriations Bill	Title	Account	Description
Defense appropriations bill	Operation & Maintenance (O&M)	Defense Health Program (DHP)	Funds MTF care; private sector care; procurement activities; and medical research, development, test, and evaluation activities
Defense appropriations bill	Military Personnel (MILPERS)	MILPERS accounts by various military services	Funds active and reserve component medical personnel (doctors, nurses, medics, technicians, and other health care providers) and accrual payments to the MERHCF
Military Construction, Veterans Affairs, and Related Agencies appropriations bill	Department of Defense	Military Construction, Defense-Wide (MILCON)	Funds major MHS construction products

Source: CRS analysis of historical congressional appropriations and congressional justification documents accompanying DOD's annual budget request.

In the past, Congress appropriated funds for war-related military health care in supplemental appropriations bills or designated certain funds for Overseas Contingency Operations/Global War on Terrorism in the annual Defense appropriations bill. For FY2022, DOD requests war-related military health care funding in the DHP account only.

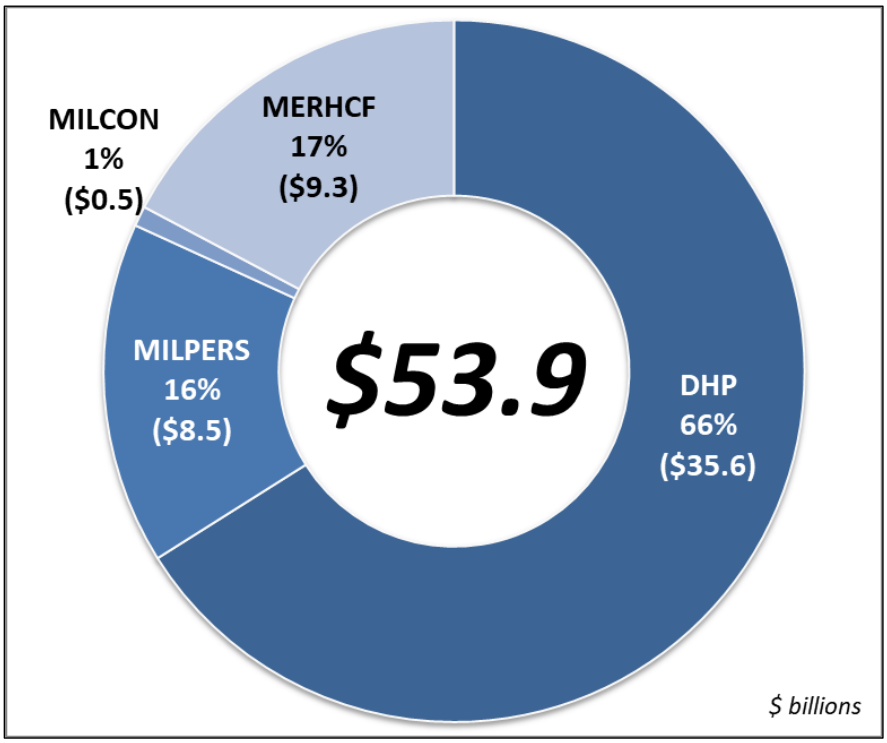
As illustrated in **Figure 3**, the President's FY2022 unified medical budget request totals $53.9 billion and includes the following:[27]

- $35.6 billion for the DHP;
- $8.5 billion for MILPERS;
- $0.5 billion for medical MILCON; and
- $9.3 billion for accrual payments to the MERHCF.

[27] DOD, *FY 2022 Budget Request Overview*, May 2021, p. 5-5, Figure 5.2, https://comptroller.defense.gov/Portals/45/Documents/defbudget/FY2022/FY2022_Budget_Request_Overview_Book.pdf.

Figure 3. FY2022 Unified Medical Budget Request

(billions)



Source: Department of Defense, *FY 2022 Budget Request Overview*, May 2021, p. 5-5.

Notes: Graphic adapted by CRS.

Other resources are made available to the MHS from third-party collections[28] authorized by 10 U.S.C. §1097b(b) and a number of other reimbursable program and transfer authorities.[29]

3. What is the Medicare-Eligible Retiree Health Care Fund (MERHCF)?

The Floyd D. Spence NDAA for FY2001 directed the establishment of the Medicare-Eligible Retiree Health Care Fund to pay for Medicare-eligible retiree health care beginning on October 1, 2002, via a program called TRICARE for Life.[30] Prior to this date, Medicare-eligible beneficiaries could only receive space-available care in an MTF. The MERHCF covers Medicare-eligible beneficiaries, regardless of age.

The FY2001 NDAA also established an independent three-member DOD Medicare-Eligible Retiree Health Care Board of Actuaries appointed by the Secretary of Defense. Historically, Congress appropriates annual discretionary funds to the military departments within DOD and

[28] *Third-party collections* are funds collected from additional health insurance payers for beneficiary care delivered by an MTF. For more on third-party collections, see 32 C.F.R. §199.12.

[29] *Third-party collections* are funds collected from additional health insurance payers for beneficiary care delivered by an MTF. For more on third-party collections, see 32 C.F.R. §199.12 and question "10. Who Pays First When a Beneficiary is Enrolled in TRICARE and Other Health Insurance (OHI)?".

[30] P.L. 106-398 §712.

other federal agencies that administer a uniformed service and serve as the accrual deposits into the MERHCF based upon estimates of future TRICARE for Life expenses.[31] Mandatory transfers out are made to the Defense Health Program based on estimates of the cost of care to be provided each year.[32] As of September 30, 2019, the fund had assets of over $277.8 billion to cover future expenses.[33]

The board is required to review the actuarial status of the fund, report annually to the Secretary of Defense, and report to the President and Congress on the status of the fund at least every four years. The DOD Office of the Actuary provides all technical and administrative support to the board. The Secretary of Defense delegates operational oversight responsibilities and management of the MERHCF to the ASD(HA). The Defense Finance and Accounting Service provides accounting and investment services for the fund.

4. What are Military Treatment Facilities?

By law, DOD is required to maintain MTFs to "support the medical readiness of the armed forces and the readiness of medical personnel."[34] MTFs are typically located on or near military installations in the United States or overseas.[35] The DHA Director, after reviewing nominations from the military services, appoints a civilian director or military commander to lead an MTF.[36] There are three types of MTFs that vary in clinical scope and size.

- **Medical Centers.** Facilities that provide multi-specialty inpatient and outpatient care in "areas with a large population" of beneficiaries, serves as a tertiary referral center, administers graduate medical education programs, and has comprehensive trauma care capabilities.[37]
- **Hospitals.** Facilities that provide limited-specialty inpatient and outpatient care in "areas where civilian health care facilities are unable to support the health care needs" of beneficiaries.[38]

[31] 10 U.S.C. §1116. Federal agencies that contribute to the MERHCF are DOD (Air Force, Army, Marine Corps, Navy, and Space Force), Department of Health and Human Services (Public Health Service), Department of Homeland Security (Coast Guard), and Department of Commerce (National Oceanic and Atmospheric Administration). According to the Congressional Budget Office (CBO), congressional appropriations for accrual payments into the MERHCF are "classified as discretionary spending." Transfers out of the MERHCF are "classified in the budget as mandatory spending because they can be made without further appropriations. For more on the spending categories associated with the MERHCF, see CBO, *A Review of CBO's Estimate of Spending From the Department of Defense's Medicare-Eligible Retiree Health Care Fund*, October 2020, p. 3, https://www.cbo.gov/system/files/2020-10/56653-MERHCF.pdf.

[32] 10 U.S.C. §1113.

[33] DOD, *Valuation of the Medicare-Eligible Retiree Health Care Fund*, February 2021, p. 4, https://media.defense.gov/2021/Feb/23/2002587387/-1/-1/0/MERHCF%20VAL%20RPT%202019.PDF.

[34] 10 U.S.C. §1073d.

[35] For more on MTF locations, see https://tricare.mil/MTF.

[36] 10 U.S.C. §1073c(a)(2).

[37] 10 U.S.C. §1073d(b). DOD defines medical center trauma capabilities as those with at least the following five critical wartime specialties: anesthesiology, critical care/trauma medicine, emergency medicine, general surgery, and orthopedic surgery. For more see, DOD, *Restructuring and Realignment of Military Medical Treatment Facilities*, February 19, 2020, p. 19, https://www.health.mil/About-MHS/OASDHA/Defense-Health-Agency/Congressional-Relations/Restructuring-and-Realignment-of-Military-Medical-Treatment-Facilities.

[38] 10 U.S.C. §1073d(c).

- **Ambulatory Care Centers.** Facilities that provide outpatient primary care required to "maintain medical readiness."[39]

5. What is TRICARE?

Section 1072(7) of Title 10, U.S. Code defines TRICARE as the

> various programs carried out by the Secretary of Defense under this chapter and any other provision of law providing for the furnishing of medical and dental care and health benefits to members and former members of the uniformed services and their dependents....

More generally, TRICARE is a health insurance-like program that pays for care delivered by civilian providers. TRICARE has three main benefit plans: a health maintenance organization option (TRICARE Prime), a preferred provider option (TRICARE Select), and a Medicare wrap-around option (TRICARE for Life) for Medicare-eligible retirees. Other TRICARE plans include TRICARE Young Adult, TRICARE Reserve Select, and TRICARE Retired Reserve. TRICARE also includes a pharmacy program and optional dental or vision plans. Options available to beneficiaries vary by the beneficiary's relationship to a sponsor, sponsor's duty status, and geographic location.

The foundations of TRICARE began with the Dependents Medical Care Act of 1956 (P.L. 84-569), which provided a statutory basis for dependents of active duty members, retirees, and dependents of retirees to seek care at MTFs. The 1956 act allowed DOD to contract for a health insurance plan for coverage of civilian hospital services for active duty dependents. Due to growing use of MTFs by eligible civilians and resource constraints, Congress adopted the Military Medical Benefits Amendments in 1966 (P.L. 89-614), which allowed DOD to contract with civilian health providers to provide non-hospital-based care to eligible dependents and retirees. Since 1966, civilian care to millions of retirees and dependents of active duty military personnel and retirees has been provided through a program still known in law as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), but since 1994 more commonly known as TRICARE.[40]

TRICARE Regional Managed Health Care Support Contracts

TRICARE within the United States (not including certain U.S. commonwealths or territories) is overseen by two DHA regional offices and administered through two managed care support contracts. Each contractor is required to perform tasks organized under a variety of categories, including: claims processing, management of enrollment processes, health care finder and referral services, establishment and maintenance of adequate provider networks, customer services for beneficiaries and network providers, and medical management of certain beneficiary populations.[41]

- **DHA Regional Office—East** oversees the East Region, which includes Alabama, Arkansas, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Mississippi, New Hampshire, New Jersey, New York,

[39] 10 U.S.C. §1073d(d).

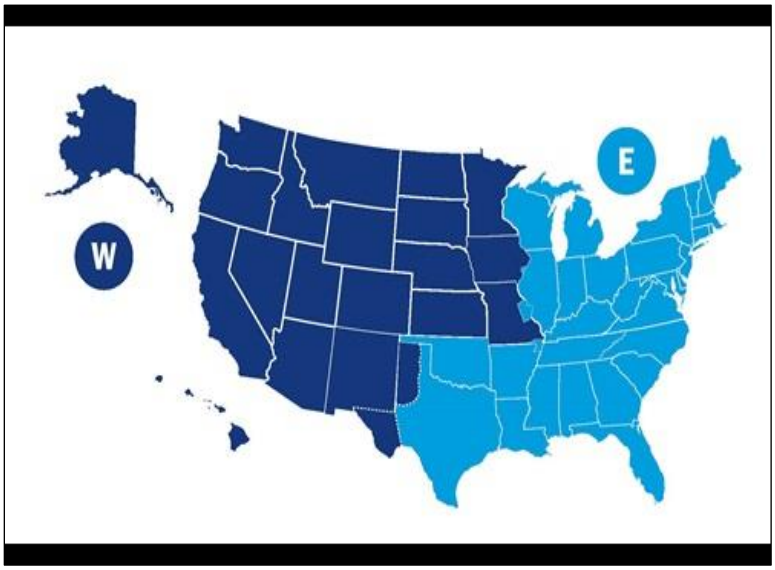
[40] P.L. 103-337 §738. For more on the history of TRICARE, see Michelle Dolfini-Reed and Jennifer Jebo, *The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations*, Center for Naval Analyses, Alexandria, VA, July 2000, https://www.cna.org/CNA_files/PDF/D0000437.A3.pdf.

[41] DOD, *Request for Proposals – Section C: Description/Specifications/Work Statement* (HT9402-15-R-0002), April 24, 2015, https://sam.gov/opp/10c30f5ad057f790a2c5811139ddd4b6/view.

North Carolina, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Vermont, Virginia, West Virginia, Wisconsin, and portions of Iowa, Missouri, Tennessee, and most of Texas. The East region contractor is Humana Military.

- **DHA Regional Office—West** oversees the West Region, which includes Alaska, Arizona, California, Colorado, Hawaii, Idaho, most of Iowa, Kansas, Minnesota, most of Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, western portions of Texas, Utah, Washington, and Wyoming. The West region contractor is HealthNet Federal Services.

Figure 4. TRICARE Regions in the United States



Source: DOD, Defense Health Agency, *TRICARE Regions*, accessed August 12, 2021, https://www.tricare.mil/About/Regions.

These two contracts were recompeted in 2015, and after resolving bid protests, the new contracts known as *T-2017* became operational in 2017. Both contracts are scheduled to end in 2023.[42] The total value of the T-2017 contracts is $58 billion.[43]

TRICARE outside of the United States (including certain U.S. commonwealths and territories) is overseen by the TRICARE Overseas Program Office and administered by the health services support contractor, International SOS.

6. Who Is Eligible for TRICARE?

Eligibility for TRICARE is determined by the uniformed services and recorded in the Defense Enrollment Eligibility Reporting System (DEERS).[44] All eligible beneficiaries must have their eligibility status recorded in DEERS.

[42] U.S. Government Accountability Office (GAO), *GAO Decision in the Matter of UnitedHealth Military & Veteran Services LLC; WellPoint Military Care Corporation; Health Net Federal Services, LLC*, B-411837.2, November 9, 2016, https://www.gao.gov/assets/690/681207.pdf.

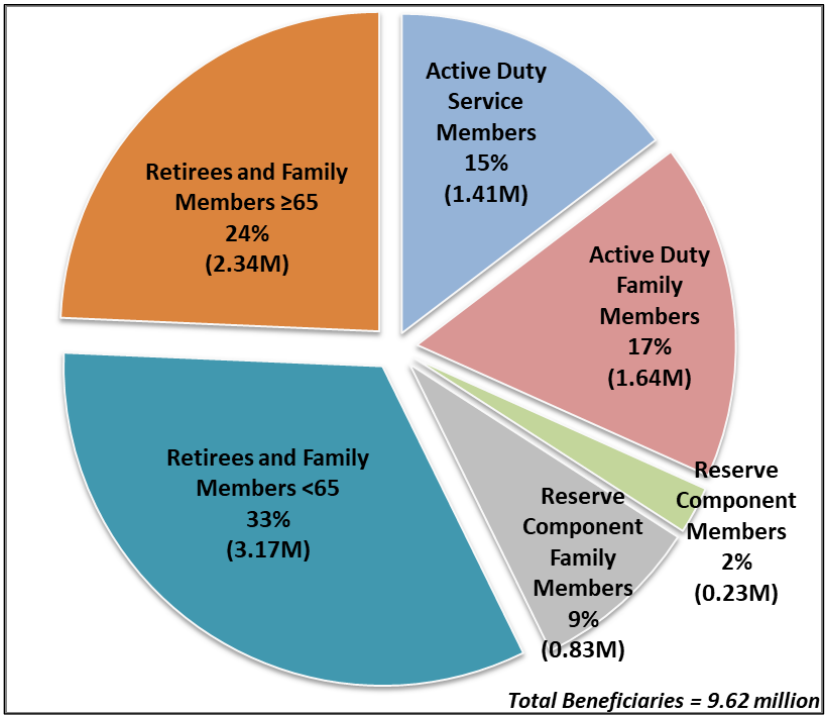
[43] DOD, "Contracts for July 21, 2016," accessed August 6, 2021, https://www.defense.gov/Newsroom/Contracts/Contract/Article/852455/.

[44] For more on the Defense Enrollment Eligibility Reporting System, see https://milconnect.dmdc.osd.mil/milconnect/public/faq/DEERS-About_DEERS.

TRICARE beneficiaries can be divided into two main categories: sponsors and dependents. *Sponsor* refers to the person who is serving or who has served on active duty or in the National Guard or Reserves. *Dependent* is defined in 10 U.S.C. §1072 and includes a variety of familial relationships, (e.g., spouses [including same-sex spouses], children, certain unremarried former spouses, and dependent parents).

Figure 5 illustrates the major categories of eligible beneficiaries.

Figure 5. Eligible Beneficiaries, FY2020



Source: DOD, *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress*, February 26, 2021, p. 33.

7. What are the Different TRICARE Plans?

TRICARE Prime

TRICARE Prime is a managed health care option similar to a health maintenance organization (HMO) program. This plan features a military or civilian primary care provider who manages a beneficiary's overall health care and facilitates referrals to specialists. Referrals generally are required for specialty care visits. Enrollees receive first priority for appointments at MTFs and pay less out-of-pocket than beneficiaries enrolled in other TRICARE plans. TRICARE Prime does not have an annual deductible.

Active duty servicemembers are required to use TRICARE Prime. Active duty servicemembers, their dependents, and transitional survivors[45] are exempt from the annual enrollment fee. Retired

[45] Dependents of active duty servicemembers who have died are deemed *transitional survivors*. This status is granted for the first three years after the sponsor dies. After the third year, dependents are then deemed as *survivors of active duty servicemembers* and are subject to the cost sharing requirements for retirees.

servicemembers, their families, survivors of active duty servicemembers, eligible former spouses, and others are required to pay an annual enrollment fee, which is applied to the annual catastrophic cap.[46]

TRICARE Prime is offered only in geographic areas designated as a *Prime Service Area* (PSA). PSAs are typically near an MTF and former military locations subjected to Base Realignment and Closure (BRAC).[47]

Table 2 shows the costs and fees associated with TRICARE Prime.

Table 2. Cost Sharing Features for TRICARE Prime

	Group A[a]	Group B[b]
Annual Enrollment Fee	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $303/single $606/family	*Retirees, their families, others:* $366/single $732/family
Annual Deductible	$0	$0
Preventive Care Visit	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $0	*Retirees, their families, others:* $0
Primary Care Outpatient Visit	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $21	*Retirees, their families, others:* $21
Specialty Care Outpatient Visit	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $31	*Retirees, their families, others:* $31

[46] The *catastrophic cap* is an annual maximum limit that a beneficiary pays out-of-pocket for TRICARE cost sharing. In general, point of service charges, TRS, TRR, and TYA premiums, non-TRICARE covered benefits, and balance billing charges do not apply to the catastrophic cap.

[47] 32 C.F.R. §199.17(b)(1) authorizes the DHA Director to designate geographic locations in which TRICARE Prime may be offered. Health Affairs Policy 11-008 requires PSAs to be established within a 40-mile radius from an MTF or BRAC installation. 32 C.F.R. §199.17(b)(1) also authorizes active duty servicemembers and their dependents assigned to remote locations outside of a PSA to participate in TRICARE Prime Remote (TPR), a similar option to TRICARE Prime. For more information about TPR, see https://tricare.mil/primeremote.

	Group A[a]	Group B[b]
Urgent Care Center Visit	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $31	*Retirees, their families, others:* $31
Emergency Room Visit	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $63	*Retirees, their families, others:* $63
Inpatient Admission (Hospitalization)	*ADSMs, ADFMs, Transitional Survivors:* $0	*ADSMs, ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $158/admission	*Retirees, their families, others:* $158/admission
Maximum Annual Out-of-Pocket Charge (Catastrophic Cap)	*ADSMs* *$0*	*ADSMs* *$0*
	ADFMs, Transitional Survivors: $1,000 per family	*ADFMs, Transitional Survivors:* $1,058 per family
	Retirees, their families, others: $3,000 per family	*Retirees, their families, others:* $3,703 per family

Source: DOD, *TRICARE Costs and Fees 2021*, October 2021, https://tricare.mil/-/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2021.pdf.

Notes: ADSM = active duty servicemember; ADFM = active duty family member.

a. Group A includes beneficiaries whose uniformed services sponsor entered initial military service prior to January 1, 2018.

b. Group B includes beneficiaries whose uniformed services sponsor entered initial military service on or after January 1, 2018.

TRICARE Select

TRICARE Select is a self-managed, preferred provider option (PPO) available worldwide for eligible beneficiaries. Active duty servicemembers and TRICARE for Life beneficiaries are not eligible for this plan. TRICARE Select allows beneficiaries greater flexibility in managing their own health care and does not require a referral for specialty care. This plan allows enrollees to use authorized, non-network civilian providers, but at a higher out-of-pocket cost than using a network civilian provider. Some services may require prior authorization (e.g., hospice care, home health services, applied behavioral analysis).

TRICARE Select features an annual enrollment fee, deductibles, and fixed co-pays when receiving care from a network provider or paying a percentage of the allowable charge when receiving care from a TRICARE-authorized, non-network provider. Eligible beneficiaries residing outside of the United States may still enroll in TRICARE Select, however the availability of network providers may be limited based on geographic location.

Table 3 outlines the costs and fees associated with TRICARE Select.

Table 3. Cost Sharing Features for TRICARE Select

	Group A[a]	Group B[b]
Annual Enrollment Fee	*ADFMs, Transitional Survivors:* $0	*ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $150/single $300/family	*Retirees, their families, others:* $474/single $948/family
Annual Deductible	*Sponsor is E-4 and below* $50 (Individual) $100 (Family)	*Sponsor is E-4 and below* $52 (Individual) $105 (Family)
	Sponsor is E-5 and above $150 (Individual) $300 (Family)	*Sponsor is E-5 and above* $158 (Individual) $317 (Family)
	Retirees, their families, others: $150 (Individual) $300 (Family)	*Retirees, their families, others:* $158 Network/$317 Non-Network (Individual) $317 Network/$634 Non-Network (Family)
Preventive Care Visit	*ADFMs, Transitional Survivors:* $0	*ADFMs, Transitional Survivors:* $0
	Retirees, their families, others: $0	*Retirees, their families, others:* $0
Primary Care Outpatient Visit	*ADFMs, Transitional Survivors:* $22 Network 20%[c] Non-Network	*ADFMs, Transitional Survivors:* $15 Network 20%[c] Non-Network
	Retirees, their families, others: $30 Network 25%[c] Non-Network	*Retirees, their families, others:* $26 Network 25%[c] Non-Network

	Group A[a]	Group B[b]
Specialty Care Outpatient Visit	*ADFMs, Transitional Survivors:* $34 Network 20%[c] Non-Network	*ADFMs, Transitional Survivors:* $26 Network 20%[c] Non-Network
	Retirees, their families, others: $46 Network 25%[c] Non-Network	*Retirees, their families, others:* $42 Network 25%[c] Non-Network
Urgent Care Center Visit	*ADFMs, Transitional Survivors:* $22 Network 20%[c] Non-Network	*ADFMs, Transitional Survivors:* $21 Network 20%[c] Non-Network
	Retirees, their families, others: $30 Network 25%[c] Non-Network	*Retirees, their families, others:* $42 Network 25%[c] Non-Network
Emergency Room Visit	*ADFMs, Transitional Survivors:* $93 Network 20%[c] Non-Network	*ADFMs, Transitional Survivors:* $42 Network 20%[c] Non-Network
	Retirees, their families, others: $125 Network 25%[c] Non-Network	*Retirees, their families, others:* $84 Network 25%[c] Non-Network
Inpatient Admission (Hospitalization)	*ADFMs, Transitional Survivors:* $20.15/day or $25/admission (whichever is greater)	*ADFMs, Transitional Survivors:* $63/admission Network $20%[c] Non-Network
	Retirees, their families, others: $250/day or up to 25% hospital charge (whichever is less); plus 20% separately billed services; Network $1,034/day or up to 25% hospital charge (whichever is less); plus 25% separately billed services; Non-Network	*Retirees, their families, others:* $185/admission Network 25%[c] Non-Network
Inpatient Admission (MTF Hospitalization)	$20.15/day (subsistence charge)	

	Group A[a]	Group B[b]
Maximum Annual Out-of-Pocket Charge (Catastrophic Cap)	*ADSMs* *$0*	*ADSMs* *$0*
	ADFMs, Transitional Survivors: $1,000 per family	*ADFMs, Transitional Survivors:* $1,058 per family
	Retirees, their families, others: $3,500 per family	*Retirees, their families, others:* $3,703 per family

Source: DOD, *TRICARE Costs and Fees 2021*, October 2021, https://tricare.mil/-/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2021.pdf.

Notes: "Network" means a provider in the TRICARE network. "Non-Network" means a TRICARE-authorized provider not in the TRICARE network. ADSM = active duty servicemember; ADFM = active duty family member.

a. Group A includes beneficiaries whose uniformed services sponsor entered initial military service prior to January 1, 2018.

b. Group B includes beneficiaries whose uniformed services sponsor entered initial military service on or after January 1, 2018.

c. Percentage of TRICARE maximum-allowable charge after deductible is met.

TRICARE Reserve Select

The TRICARE Reserve Select (TRS) program was authorized by Section 701 of the Ronald W. Reagan NDAA for FY2005 (P.L. 108-375).[48] TRS is a premium-based health plan available worldwide for qualified Selected Reserve members of the Ready Reserve and their families.[49] Servicemembers are not eligible for TRS if they are on active duty orders, covered under the Transitional Assistance Management Program,[50] eligible for or enrolled in the Federal Employees Health Benefits Program (FEHBP), or currently covered under the FEHBP through a family member.[51]

In general, TRS mirrors the benefits, costs, and fees established for TRICARE Select. The government subsidizes the cost of the program with members paying 28% of the cost of the program in the form of premiums. For CY2021, the monthly premiums are $47.20 for member-only and $238.99 for member and family coverage.[52]

[48] 10 U.S.C. §1076d.

[49] For more on the Ready Reserve and Selected Reserve see Question 2 of CRS Report RL30802, *Reserve Component Personnel Issues: Questions and Answers*, by Lawrence Kapp and Barbara Salazar Torreon.

[50] The *Transitional Assistance Management Program* (TAMP) provides an additional 180 days of premium-free coverage for TRICARE Prime or TRICARE Select. Beneficiaries are eligible for TAMP if their sponsor is subject to certain transitional events, such as involuntary separation under honorable conditions, demobilizing member of the Reserve Component, sole survivorship discharge, or transition from the Active Component to the Reserve Component. For more information about TAMP, see https://tricare.mil/tamp.

[51] 10 U.S.C. §1076d specifies that members of the Selected Reserves who are "eligible to enroll in a health benefits plan under chapter 89 of title 5" are not eligible to enroll in TRICARE Reserve Select. For more on the limits on TRICARE eligibility for reservists, see CRS Report R45968, *Limits on TRICARE for Reservists: Frequently Asked Questions*, by Bryce H. P. Mendez and Barbara Salazar Torreon.

[52] DOD, *TRICARE Costs and Fees 2021*, October 2021, p. 2, https://tricare.mil/-

TRICARE Retired Reserve

Section 705 of the NDAA for FY2010 (P.L. 111-84) authorized a TRICARE coverage option for so-called *gray area* reservists, defined as those who have retired but are too young to draw retirement pay.[53] The program established under this authority is known as *TRICARE Retired Reserve* (TRR). Previously, such individuals were not eligible for any TRICARE coverage.

TRR is a premium-based health plan that qualified retired members of the National Guard and Reserve under the age of 60 may purchase for themselves and eligible family members. TRR differs from TRS in that there is no government subsidy. As such, retired Reserve Component members who elect to purchase TRR must pay the full cost of the calculated premium plus an additional administrative fee. For CY2021, the monthly premiums are $484.83 for member-only and $1,165.01 for member and family coverage.[54] Upon reaching the age of 60, retired Reserve Component members and their eligible family members become eligible to purchase TRICARE Prime or TRICARE Select.

TRICARE Young Adult

Section 702 of the Ike Skelton NDAA for Fiscal Year 2011 (P.L. 111-383) extended TRICARE eligibility for dependents, allowing unmarried children up to age 26, who are not otherwise eligible to enroll in an employer-sponsored plan, to purchase TRICARE coverage.[55] The option established under this authority is known as *TRICARE Young Adult* (TYA). Unlike insurance coverage mandated by the Patient Protection and Affordable Care Act (P.L. 111-148), TYA provides individual coverage, rather than coverage under a family plan. A separate premium is charged. The law requires payment of a premium equal to the cost of the coverage as determined by the Secretary of Defense on an appropriate actuarial basis.[56] For CY2021, the monthly premiums are $459 for TYA Prime and $257 TYA Select.[57]

TRICARE for Life

TRICARE for Life (TFL) was created as supplemental coverage for Medicare-eligible military retirees by Section 712 of the Floyd D. Spence NDAA for FY2001 (P.L. 106-398). TFL functions as a secondary payer, or *wrap-around*, to Medicare. As a *wrap-around*, TFL will pay the out-of-pocket costs for Medicare-covered services as well as those only covered by TRICARE. Prior to the creation of TFL, coverage for Medicare-eligible individuals was limited to space-available care in MTFs. TFL cost sharing for beneficiaries is limited and there is no enrollment charge or premium.

To participate in TFL, TRICARE-eligible beneficiaries must enroll in and pay monthly premiums for Medicare Part B.[58] TRICARE-eligible beneficiaries who are entitled to Medicare Part A based

---

/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2021.pdf.

[53] 10 U.S.C. §1076e. For more on military retirement, see CRS Report RL34751, *Military Retirement: Background and Recent Developments*, by Kristy N. Kamarck.

[54] DOD, *TRICARE Costs and Fees 2021*, October 2021, p. 2, https://tricare.mil/-/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2021.pdf.

[55] 10 U.S.C. §1110b.

[56] P.L. 111-383 §702.

[57] DOD, *TRICARE Costs and Fees 2021*, October 2021, p. 2, https://tricare.mil/-/media/Files/TRICARE/Publications/Misc/Costs_Sheet_2021.pdf.

[58] Medicare Part B is covers medically necessary outpatient services and equipment (e.g., physicians' and nonphysician

on age, disability, or diagnosis of End Stage Renal Disease (ESRD), but decline Part B, lose eligibility for TRICARE benefits.[59] Individuals who choose not to enroll in Medicare Part B upon becoming eligible may elect to do so later during the special enrollment period or an annual enrollment period; however, the Medicare Part B late enrollment penalty may apply (see question "13. How Does the Patient Protection and Affordable Care Act Affect TRICARE?").[60]

8. When can beneficiaries enroll in or change their TRICARE plan?

In general, eligible beneficiaries may enroll in a TRICARE health plan during the annual open enrollment season, which DHA typically designates during a four-week period between November and December.[61] Eligible beneficiaries may also enroll, change, or terminate their enrollment within 90 days after a Qualifying Life Event (QLE).[62] **Table 4** identifies military or family-related life changes that are deemed a QLE:

Table 4. Qualifying Life Events

Military Changes	Family Changes
• Permanent change of station/moving • Initial military commissioning or enlistment • Reserve Component member activation/deactivation • Injured on active duty • Separating from active duty • Retiring • Military-directed change of primary care manager • Change in overseas command-sponsorship	• Marriage • Divorce • Having a baby or adopting • Children going to college • Children becoming adults • Change in Medicare or Medicaid eligibility • Moving • Death in Family • Loss or gain of other health insurance

Source: 32 C.F.R. §199.17(o) and DOD, TRICARE Policy Manual 6010.60-M, *Eligibility and Enrollment*, "TRICARE Prime and TRICARE Select Enrollment," updated September 11, 2019, https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-08-10/AsOf/TP15/C10S2_1.html.

Notes: Adapted by CRS.

9. What is the DOD Pharmacy Benefits Program?

Section 701 of the NDAA for FY2000 (P.L. 106-65) directed the creation of an "effective, efficient, integrated pharmacy benefits program," also known as the DOD pharmacy benefits program.[63] Features of the program include

services, outpatient hospital services, durable medical equipment, clinical laboratory tests, ambulance services, and limited prescription drugs and biologics). Participation in Medicare Part B is voluntary, however enrollment and monthly premiums are required for those who opt-in. For more information on Medicare Part B, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[59] 10 U.S.C. §1086(d).

[60] CRS Report R40082, *Medicare Part B: Enrollment and Premiums*, by Patricia A. Davis.

[61] DOD, TRICARE Policy Manual 6010.60-M, *Eligibility and Enrollment*, "TRICARE Prime and TRICARE Select Enrollment," updated September 11, 2019, https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-08-10/AsOf/TP15/C10S2_1.html.

[62] Ibid.

[63] 10 U.S.C. §1074g.

- availability of pharmaceutical agents for all therapeutic classes;
- establishing a uniform formulary based on clinical effectiveness and cost-effectiveness; and
- assuring the availability of clinically appropriate pharmaceutical agents to uniformed servicemembers, retirees, and family members.

The program dispenses pharmaceuticals to eligible beneficiaries through three venues: MTF pharmacies, TRICARE retail pharmacies, and the TRICARE Mail Order Program. Currently, MTF pharmacies are administered and managed by each military service medical department (i.e., MEDCOM, BUMED, and AFMRA), while the TRICARE retail and mail order pharmacy programs are managed by the DHA. Since 2003, DOD has contracted a pharmacy benefits manager, *Express Scripts, Inc.* (ESI), to administer the TRICARE pharmacy programs.[64] ESI maintains a national network of retail pharmacies and a home-delivery program, and it processes pharmacy claims on behalf of beneficiaries. There are no additional costs to participate in the DOD pharmacy benefits program.

The program is required to maintain a formulary of pharmaceutical agents (hereinafter also referred to as *drugs* or *medications*) in the complete range of therapeutic classes. This is known as the *Uniform Formulary*. Selection of drugs for inclusion on the formulary is based on the relative clinical and cost effectiveness of the agents in each class.[65] The law further specifies that the formulary is to be maintained and updated by a Pharmacy and Therapeutics Committee whose membership is composed of representatives of both MTF pharmacies and health care providers.[66]

A Beneficiary Advisory Panel (BAP) is required to review and comment on formulary recommendations presented by the Pharmacy and Therapeutics Committee prior to those recommendations going to the DHA Director for approval.[67] The BAP is composed of representatives of nongovernmental organizations and associations that represent the views and interests of a large number of eligible beneficiaries, contractors responsible for the TRICARE retail pharmacy program, contractors responsible for the national mail-order pharmacy program, and TRICARE network providers.

Prescriptions Filled Through Military Treatment Facilities

At an MTF, TRICARE beneficiaries may fill prescriptions from a civilian or military provider without a co-payment. Enrollment in a specific TRICARE plan is not required to fill a prescription at an MTF. As of May 2021, 159 MTF pharmacies accept electronic prescriptions from civilian health care providers.[68]

---

[64] Express Scripts, Inc., "Express Scripts Awarded TRICARE Pharmacy Program Contract," press release, June 27, 2008, https://globenewswire.com/news-release/2008/06/27/380555/145445/en/Express-Scripts-Awarded-TRICARE-Pharmacy-Program-Contract.html.

[65] 10 U.S.C. §1074g(a)(2)(A).

[66] 10 U.S.C. §1074g(b). The *Pharmacy and Therapeutics Committee* meets at least quarterly and its minutes are publicly available at the Defense Health Agency Pharmacy Operations Division website: https://health.mil/About-MHS/OASDHA/Defense-Health-Agency/Operations/Pharmacy-Division/DoD-Pharmacy-and-Therapeutics-Committee.

[67] The *Beneficiary Advisory Panel* (BAP) is a federal advisory committee established by 10 U.S.C. §1074g(c). For more information on the BAP, see https://health.mil/bap.

[68] DHA provides a publicly-available list of MTF pharmacies that accept electronic prescriptions from civilian providers. See https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/Pharmacy-Program/Electronic-Prescribing.

MTFs are required to stock a subset of the Uniform Formulary known as the *Basic Core Formulary*. Additional drugs on the Uniform Formulary may also be carried by individual MTFs in order to meet local requirements. Nonformulary drugs are generally not available through MTFs. Certain Uniform Formulary-covered pharmaceuticals, however, may not be carried due to national contracts with pharmaceutical manufacturers.[69] The DHA's Pharmacy Operations Division collaborates with the Defense Supply Center Philadelphia (DSCP) in coordination with the Department of Veterans Affairs (VA) Pharmacy Benefits Management Strategic Health Group and the VA National Acquisition Center in Hines, Illinois, in developing contracting strategies and technical evaluation factors for national pharmaceutical contracting initiatives.[70]

Prescriptions Filled Through Retail Pharmacies

TRICARE beneficiaries may also fill prescriptions through retail pharmacies. DOD contracts for a TRICARE pharmacy benefit manager to administer both the retail and mail order options. The current contractor is ESI, to which DOD awarded a potential eight-year contract in 2021.[71] Among other matters, ESI maintains a national network of retail pharmacies that beneficiaries may use without having to file a claim for reimbursement. Beneficiaries may also use non-network pharmacies. However, at non-network pharmacies, beneficiaries pay the full price of the medication up front and then file a claim for reimbursement.

DOD requires prescriptions to be filled with generic drugs when available.[72] These are defined as medications approved by the Food and Drug Administration that are clinically the same as brand-name medications. Brand-name drugs that have a generic equivalent are only dispensed after the prescribing health care provider completes a clinical assessment that indicates the brand-name drug should be used in place of the generic medication and ESI grants a *prior authorization*.

Prescriptions Filled by Mail Order

TRICARE beneficiaries may arrange for home delivery of prescription drugs through the mail by registering with ESI. DOD negotiates drug prices with pharmaceutical manufacturers. The prices for drugs dispensed by mail order are considerably lower than drugs dispensed through retail pharmacies. In recent years, use of home delivery as compared to retail pharmacies by TRICARE beneficiaries decreased from 65% in FY2017 to 49% in FY2020.[73] DOD attributes this decrease in use of the home delivery program to congressionally directed co-payment increases.[74]

---

[69] Assistant Secretary of Defense (Health Affairs) Memorandum, "TRICARE Pharmacy Benefit Program Formulary Management," December 22, 2004, https://www.health.mil/Reference-Center/Policies/2005/12/19/Clarification-to-HA-Policy-04-032--TRICARE-Pharmacy-Benefit-Program-Formulary-Management--December-2.

[70] The VA has authority delegated from the General Services Administration to manage the medical care sections of the Federal Supply Schedule, which includes pharmaceuticals. For more information on the delegation of authority authorized in Federal Acquisition Regulation Subpart 8.402(a), see https://www.acquisition.gov/far/8.402.
https://www.acquisition.gov/far/8.402.

[71] ESI was awarded the TRICARE pharmacy benefit manager contract, which includes a base year, seven one-year option periods, and options for a phase-out period. The estimated value of the contract is $4.3 billion. For more on the contract award, see https://www.defense.gov/Newsroom/Contracts/Contract/Article/2721522/ and https://sam.gov/opp/abe6e87ba52841ad814589f30934c63c/view.

[72] 32 C.F.R. §199.21(j).

[73] DOD, *Evaluation of the TRICARE Program: Fiscal Year 2021 Report to Congress*, February 26, 2021, p. 52.

[74] Ibid.

Co-payment Adjustments

Section 702 of the NDAA for FY2018 (P.L. 115-91) adjusted pharmacy co-payment amounts. The co-payment amounts for 2018 to 2027 are codified in 10 U.S.C. §1074g(a) and are listed in **Table 5**. After 2027, the Secretary of Defense is authorized to set and adjust cost sharing amounts to "reflect changes in the costs of pharmaceutical agents and prescription dispensing, rounded to the nearest dollar."[75]

Table 5. TRICARE Pharmacy Copayments, 2018-2027

	Retail *Generic* (30-day supply)	Retail *Brand* (30-day supply)	Mail Order *Generic* (90-day supply)	Mail Order *Brand* (90-day supply)	Mail Order *Nonformulary* (90-day supply)
2018	$11	$28	$7	$24	$53
2019	$11	$28	$7	$24	$53
2020	$13	$33	$10	$29	$60
2021	$13	$33	$10	$29	$60
2022	$14	$38	$12	$34	$68
2023	$14	$38	$12	$34	$68
2024	$16	$43	$13	$38	$76
2025	$16	$43	$13	$38	$76
2026	$16	$48	$14	$44	$85
2027	$16	$48	$14	$44	$85

Source: 10 U.S.C. §1074g(a)(6)(A).

Notes: Retail pharmacy co-payments are applicable when using a network pharmacy. Additional cost sharing is applied when using a non-network pharmacy.

10. Who Pays First When a Beneficiary is Enrolled in TRICARE and Other Health Insurance (OHI)?

In general, TRICARE is a secondary payer of health care claims when beneficiaries are dually enrolled in other health insurance (OHI) programs (e.g., employer-sponsored insurance, private health insurance, Medicare), or covered by liability insurance policies or third-party payers. Section 1079(i)(1) of Title 10, U.S. Code and 32 C.F.R. §199.8 generally prohibits TRICARE from serving as the primary payer for health care claims of beneficiaries with OHI. Typically, when a health care provider bills for services rendered, the beneficiary's OHI policy will first pay a specified amount according to their benefit plan. TRICARE then pays the remaining cost of TRICARE-covered services other than specified out-of-pocket costs (e.g., co-payments). In certain instances, TRICARE serves as the primary payer when a beneficiary is

- enrolled in Medicaid;
- enrolled in certain federal health programs (e.g., Indian Health Service); or

[75] 10 U.S.C. §1074g(a).

- eligible for a State Crime Victims Compensation program.[76]

11. How Are Priorities for Care in Military Treatment Facilities Assigned?

Title 10 of the U.S. Code assigns general priorities for MTF care. "A member of the uniformed services on active duty" is the only TRICARE beneficiary group entitled to care in any MTF.[77] Dependents of active duty personnel are also entitled to receive MTF care on a space-available basis.[78] Military retirees and their dependents do not have an entitlement or right to MTF care, although they may receive care on a space-available basis (see question "17. Have Military Personnel Been Promised Free Medical Care for Life?").[79]

DOD issued regulations and implementation policy to clarify the basic priorities for MTF care:

> Priority 1: Active-duty servicemembers;
>
> Priority 2: Active-duty family members enrolled in TRICARE Prime;
>
> Priority 3: Retirees, their family members and survivors enrolled in TRICARE Prime;
>
> Priority 4: Active-duty family members not enrolled in TRICARE Prime and TRICARE Reserve Select enrollees; and
>
> Priority 5: All other eligible persons.[80]

MTF commanders are also authorized to grant certain exceptions to these priority groups. These may include care required by law or DOD policy (e.g., employees exposed to health hazards, occupational health, workplace injuries, medical emergencies), patients needed to support the clinical case mix of a Graduate Medical Education program, overseas or remote geographic location, or other extraordinary cases.

12. What are DOD's Access to Care Standards?

In 1995, DOD established access to care standards to ensure beneficiaries enrolled in TRICARE Prime receive timely care in an MTF or from a civilian health care provider. The current access to care standards, outlined in DOD regulation and implementation policy, include the following:

- *Urgent/Acute Care*: Beneficiary must be offered an appointment to visit an appropriate health care provider within 24 hours and within a 30-minute drive-time from the beneficiary's residence;
- *Routine Care*: Beneficiary must be offered an appointment to visit an appropriate health care provider within one week and within a 30-minute drive-time from the beneficiary's residence;

[76] 32 C.F.R. §199.8. For more on State Crime Victims Compensation programs, see https://www.benefits.gov/benefit/4416 and CRS Report R42672, *The Crime Victims Fund: Federal Support for Victims of Crime*, by Lisa N. Sacco.

[77] 10 U.S.C. §1074.

[78] 10 U.S.C. §1076.

[79] 10 U.S.C. §1074.

[80] DOD clarified the basic priorities for MTF care in 32 C.F.R. §199.17(d) and Department of Defense, Health Affairs Policy 11-005, *TRICARE Policy for Access to Care*, February 23, 2011.

- *Well-Patient Visit/Preventive Care*: Beneficiary must be offered an appointment to visit an appropriate health care provider within four weeks;
- *Specialty Care*: Beneficiary must be offered an appointment to visit an appropriate health care provider within four weeks and within a one-hour drive-time from the beneficiary's residence;
- *Office Wait Times*: In non-emergency circumstances, office waiting times shall not exceed 30 minutes; and
- *Access to Primary Care Manager*: Beneficiary must have access to their primary care manager or designee by telephone, 24 hours a day, 7 days a week.[81]

13. How Does the Patient Protection and Affordable Care Act Affect TRICARE?

In general, the Patient Protection and Affordable Care Act (ACA)[82] does not directly affect TRICARE administration, health care benefits, eligibility, or cost to beneficiaries.[83] Section 3110 of the ACA did open a special Medicare Part B enrollment window to enable certain individuals to gain eligibility for TFL.[84] The ACA also waived the Medicare Part B late enrollment penalty during the 12-month special enrollment period (SEP) for military retirees, their spouses (including widows/widowers), and dependent children who are otherwise eligible for TRICARE and are entitled to Medicare Part A based on disability or end-stage renal disease, but had previously declined Part B. The ACA required the SECDEF to identify and notify individuals of their eligibility for the SEP. Section 3110 of the ACA was amended by the Medicare and Medicaid Extenders Act of 2010[85] to clarify that Section 3110 applies to Medicare Part B elections made on or after the date of enactment of the ACA, which was on March 23, 2010.

14. How does DOD Determine What Health Care Services are Covered by TRICARE?

Chapter 55 of Title 10, U.S. Code authorizes TRICARE coverage of specific health care services.[86] For health care services not specified in statute, TRICARE may only cover services that are

> medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction as assessed or diagnosed by a physician, dentist, clinical psychologist, certified marriage and family therapist, optometrist, podiatrist,

[81] DOD access to care standards are stipulated in 32 C.F.R. §199.17(p)(5) and further elaborated in Department of Defense, Health Affairs Policy 11-005, *TRICARE Policy for Access to Care*, February 23, 2011.

[82] P.L. 111-148.

[83] CRS Report R41198, *TRICARE and VA Health Care: Impact of the Patient Protection and Affordable Care Act (ACA)*, by Sidath Viranga Panangala and Don J. Jansen.

[84] P.L. 111-148 §3110.

[85] P.L. 111-309 §201.

[86] Various statutes in Chapter 55 of Title 10, U.S. Code require TRICARE coverage of specific health care services (e.g., certain preventive services, hospice care, forensic examinations following a sexual assault or domestic violence, wigs for patients with chemotherapy-induced alopecia).

> certified nurse-midwife, certified nurse practitioner, certified clinical social worker, or other class of provide as designated by the Secretary of Defense...[87]

Periodically, DOD reviews certain non-covered health care services to determine whether "safety and efficacy have been proven to be comparable or superior to conventional therapies."[88] DOD uses a "hierarchy of reliable evidence" to review and determine whether a non-covered health care service has shifted from "unproven" to a "nationally accepted medical practice."[89] TRICARE coverage policy is revised once DOD determines a health care service is "proven."[90]

15. How does DOD Determine the TRICARE Reimbursement Rates?

In general, DOD utilizes reimbursement methods similar to those of Medicare for inpatient care, outpatient care, and other related services. Sections 1079(h) and 1079(i) of Title 10, U.S. Code require that payment levels for health care services provided under TRICARE be aligned with Medicare's fee schedule "to the extent practicable." DHA has the authority to grant exceptions to Medicare's fee schedule when "adequate access to care would be impaired" or when an existing Medicare rate does not exist.[91]

Reimbursement for Inpatient Care

The CHAMPUS Diagnosis Related Groups (DRG)-based payment system is used to reimburse civilian hospitals and other health care facilities for providing inpatient care to TRICARE beneficiaries. To ensure standardization with U.S.-based medical coding and reimbursement classifications, DOD adopted the same DRG coding scheme and nomenclature as Medicare's Inpatient Prospective Payment System.[92] Reimbursement rates assigned to each DRG are determined by DOD and updated annually. In general, rates are calculated in a similar manner as those published by the Centers for Medicare and Medicaid Services (CMS).[93]

---

[87] 10 U.S.C. §1079(a)(12).

[88] 32 C.F.R. §199.2 and §199.4(g)(15); and DOD, TRICARE Policy Manual 6010.60-M, "Unproven Drugs, Devices, Medical Treatments, and Procedures," Chapter 1, Section 2.1, updated August 13, 2021, https://manuals.health.mil/pages/DisplayManualHtmlFile/2021-08-13/AsOf/TP15/C1S2_1.html.

[89] Ibid. The "Hierarchy of Reliable Evidence" includes published literature on "well controlled studies of clinically meaningful endpoints" and formal technology assessments, national professional medical associations' reports or policy positions, and reports of national expert opinion organizations.

[90] DOD, TRICARE Policy Manual 6010.60-M, "Unproven Drugs, Devices, Medical Treatments, and Procedures," Chapter 1, Section 2.1, updated August 13, 2021.

[91] 32 C.F.R. §199.14(j)(1)(iv)(C).

[92] 32 C.F.R. §199.14(a)(1)(i)(A). *Diagnosis Related Groups* (DRGs) is a method of assigning a predetermined cost of inpatient care for a specific diagnosis. Costs assigned to each DRG are determined prospectively by the U.S. Centers for Medicare and Medicaid Services (CMS), and accounts for severity of illness, prognosis, treatment difficulty, need for intervention, and resource intensity. Additional cost adjustments may be made for geographic or other factors impacting wage differences. The DRG-based payment system is required by 42 U.S.C. §1395ww for all civilian health care facilities that participate in Medicare. For more information about DRGs, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/MS-DRG-Classifications-and-Software.

[93] When calculating TRICARE rates, various provisions in 32 C.F.R. §199.14 and §199.17 direct the same or similar methodologies used by CMS for the Medicare program. For more on how CMS calculates DRG rates, see Medicare Payment Advisory Commission (MEDPAC), "Hospital Acute Inpatient Services Payment System," *Payment* Basics, October 2016, http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_hospital_final.pdf. TRICARE DRG rates are available at

Reimbursement for Hospital-based Outpatient Care

Hospital-based outpatient services are reimbursed using the TRICARE outpatient prospective payment system (OPPS).[94] Modeled after Medicare's OPPS program, TRICARE pays for hospital-based outpatient services on a rate-per-service basis.[95] Each service is assigned a Health Care Procedure Coding System (HCPCS) code and descriptor, then categorized into an Ambulatory Payment Classification (APC) group based on clinical and cost similarities. A reimbursement rate is assigned to each group, which applies to any service in the APC. DOD publishes quarterly updates for TRICARE APC reimbursement rates, which are consistent with those published by the CMS.[96]

Reimbursement for Outpatient Care and Health Care-Related Services

Other outpatient care and services provided in a nonhospital setting are reimbursed using the *allowable charge method*.[97] By law (10 U.S.C. §1097b) and federal regulation (32 C.F.R. §199.14), civilian health care providers treating TRICARE patients cannot be reimbursed more than 115% of charges authorized by the DOD fee schedule, also known as the *CHAMPUS Maximum Allowable Charge* (CMAC). CMAC rates are updated annually, calculated on a national basis, and then adjusted for locality differences.[98]

TRICARE reimburses health care providers at the CMAC rate or the billed charge, whichever is lower. In some instances, TRICARE may reimburse above the CMAC rate in localities where "excessive balance billing" occurs or to ensure "adequate beneficiary access to care."[99]

16. What DOD Health Benefits are Available to Reservists?

In recent years, especially as members of the Reserve Component[100] have had a larger role in combat operations overseas, Congress has enlarged the health benefits available for members of the Reserve Component. Typically, DOD health benefits for members of the Reserve Component vary based on their duty status, which are outlined in **Table 6**.

---

https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/Diagnosis-Related-Group-Rates.

[94] 32 C.F.R. §199.14(a)(6)(ii).

[95] For more information on Medicare's *Outpatient Prospective Payment System* (OPPS), see http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_16_opd_final.pdf.

[96] Quarterly TRICARE APC reimbursement rate updates are available at https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/Outpatient-Prospective-Payment-System. Reimbursement rates for TRICARE-specific APCs are updated on an annual basis instead of quarterly.

[97] Outpatient care and services provided in a nonhospital setting can include laboratory services, rehabilitation therapy, radiology, durable medical equipment, certain drugs, professional provider services, facility charges, and ambulance services.

[98] Locality configurations and adjustments are made in the same manner as Medicare's Fee Schedules. For more information on Medicare's Fee for Service localities, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Locality.html. CMAC rates are available at https://health.mil/Military-Health-Topics/Business-Support/Rates-and-Reimbursement/CMAC-Rates.

[99] 32 C.F.R. 199.14(j)(1)(iv). *Balance billing* occurs when a health care provider or facility bills a patient for the difference between what was charged and the allowed reimbursement rate.

[100] For additional information on Reserve Component pay and benefits, see CRS Report RL30802, *Reserve Component Personnel Issues: Questions and Answers*, by Lawrence Kapp and Barbara Salazar Torreon.

Health benefits for members of the National Guard who are activated by their governor for state active duty (e.g., disaster response duty) varies from state to state and may include eligibility for their state's employee health insurance program.

Table 6. DOD Health Benefits Available to Members of the Reserve Component

Duty Status of Reserve Component Member	DOD Health Benefit	Statutory Reference
Serving on active duty ≥30 consecutive days	Same health benefits as regular active component members (i.e., TRICARE Prime)	10 U.S.C. §1074
	TRICARE Prime coverage up to 180 days prior to activation if orders are in support of a contingency operation	10 U.S.C. §1074
Selected Reservist (i.e., drilling reservist)	Eligible to enroll in TRICARE Reserve Select, a premium-based, preferred provider organization-structured health plan	10 U.S.C. §1076d
	Eligible to enroll in the premium-based TRICARE Dental Plan	10 U.S.C. §1076a
Illness or injury during inactive duty training, including travel to/from drill site	Illness or injury-specific care at an MTF or TRICARE-authorized provider	10 U.S.C. §1074 10 U.S.C. §1074a
Separating from a period of >30 consecutive days of active duty while supporting a contingency operation	Transitional Assistance Management Program—180 days of eligibility for premium-free TRICARE Prime or TRICARE Select, beginning on the day of separation from active duty	10 U.S.C. §1145
Retired Reservist (not yet eligible to receive retirement pay)	Eligible to enroll in TRICARE Retired Reserve, a premium-based, preferred provider organization-structured health plan	10 U.S.C. §1086
	Eligible to enroll a dental plan offered by the Federal Employee Dental and Vision Program (FEDVIP)	10 U.S.C. §1076c
Retired Reservist (eligible to receive retirement pay, but not yet eligible for Medicare)	Same health benefits as retirees of the active component who are not yet eligible for Medicare (e.g., TRICARE Prime or TRICARE Select)	10 U.S.C. §1097
	Eligible to enroll a dental plan offered by the Federal Employee Dental and Vision Program (FEDVIP)	10 U.S.C. §1076c
Retired Reservist (eligible to receive retirement pay and enrolled in Medicare Part B)	TRICARE for Life	10 U.S.C. §1086

17. Have Military Personnel Been Promised Free Medical Care for Life?

Some military personnel and retirees maintain that they and their dependents were promised "free medical care for life" at the time of their enlistment. Such promises may have been made by military recruiters and in recruiting brochures; however, if they were made, they were not based upon laws or official regulations.[101] In 1993, the Deputy Assistant Secretary of Defense for Health

[101] Under current laws and federal regulations only active duty personnel are entitled to military health care. Active duty dependents also have an entitlement to care, however, may be seen in an MTF on a space-available basis. Retirees

Affairs acknowledged this notion in a statement to the House Committee on Armed Services and attempted to clarify that an entitlement to free medical care for life does not exist:

> We have a medical care program for the life of our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and it is pervasive. We spend an incredible amount of effort trying to reeducate people that that is not their benefit.[102]

Federal courts have held that current statutes or regulations do not grant a *right* or *promise* for free medical care for retirees and their dependents.[103] In *Sebastian v. U.S.*, the U.S. Court of Appeals for the Eleventh Circuit ruled as follows:

> Nothing in these regulations provided for unconditional lifetime free medical care or authorized recruiters to promise such care as an inducement to joining or continuing in the armed forces. While the Retirees argue that the above mentioned section 4132.1 gave those of them who served as officers in the Navy and Marine Corps the right to free unconditional medical care, we cannot agree. The [1922 Manual of the Medical Department of the United States Navy] Manual provided guidelines for the Navy's Medical Department, but did not create any right in such officers to the free unconditional lifetime medical care they claim. It related only to hospital care, not the broader services that these Retirees seek, and covered only the period when it was in effect. In any event, in view of the general pattern of the military regulations that provides medical care to retirees only when facilities and personnel were available, we decline to read into the creation of such an enduring and broad right to unconditional free lifetime medical care.
>
> In sum, we conclude that the Retirees have not shown that they have a right to the health care they say was "taken" by the government. Since the basic premise of their claim fails, their taking claim necessarily also fails.[104]

In 2002, an appeal of *Schism v. U.S.* also held that a legal, contractual *right* to free health care for life does not exist:

> The promise of such health care was made in good faith and relied upon. Again, however, because no authority existed to make such promises in the first place, and because Congress has never ratified or acquiesced to this promise, we have no alternative but to uphold the judgement against the retirees' breach-of-contract claim.[105]

18. Does TRICARE Cover Abortion?

10 U.S.C. §1093 provides that "Funds available to the Department of Defense may not be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of an act of rape or incest."[106]

---

and their dependents have no such entitlement, but may be seen in an MTF on a space-available basis. See question "11. How Are Priorities for Care in Military Treatment Facilities Assigned?"

[102] H.Rept. 103-13.

[103] See Coalition of Retired Military Veterans, et al. v. United States of America, U.S. Dist. of South Carolina, C.A.#2:96-3822-23, Dec. 10, 1997: 11-12; Sebastian v. United States, 185 F.3d 1368, 1372 (Fed. Cir. 1999); or Schism and Reinlie v. United States, 2002 WL 31549178 (Fed.Cir. (Fla.)), November 18, 2002.

[104] *Sebastian v. U.S.*, 185 F.3d 1368 (11th Cir. 2002).

[105] *Schism and Reinlie v. U.S.*, 239 F.3d 1280 (11th Cir. 2001).

[106] The clause "or in a case in which the pregnancy is the result of an act of rape or incest" was added by Section 704 of the National Defense Authorization Act for Fiscal Year 2013 (P.L. 112-239).

19. What is DOD's policy on Use Animals in Medical Research or Training?

Yes. DOD policy is that live animals will not be used for training and education or medical research purposes except where, after exhaustive analysis, no alternatives are available.[107] The policy also requires that training or research procedures used "cause the least pain or distress to the minimum number of animals" and include a "non-terminal disposition," when possible.[108]

[107] DOD, DOD Instruction 3216.01, *Use of Animals in DoD Programs*, March 20, 2019, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/321601p.pdf.

[108] Ibid, p.4. "Non-terminal disposition" refers to the repurposing of an animal subject through adoption, retirement, or interagency transfer when it is no longer needed for training or research.

Appendix. Glossary of Acronyms

Glossary of Acronyms

ACA	Affordable Care Act	**MHS**	Military Health System
ADFM	Active Duty Family Member	**MHSER**	Military Health System Executive Review
ADSM	Active Duty Service Member	**MILCON**	Military Construction
AFMRA	Air Force Medical Readiness Agency	**MILPERS**	Military Personnel
APC	Ambulatory Payment Classification	**MTF**	Military Treatment Facility
ASD(HA)	Assistant Secretary of Defense (Health Affairs)	**NDAA**	National Defense Authorization Act
BAP	Beneficiary Advisory Panel	**O&M**	Operations & Maintenance
BUMED	Navy Bureau of Medicine and Surgery	**OHI**	Other Health Insurance
CBO	Congressional Budget Office	**OPPS**	Outpatient Prospective Payment System
CDMRP	Congressionally Directed Medical Research Program	**PAC**	Policy Advisory Council
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services	**PDASD(HA)**	Principal Deputy Assistant Secretary of Defense (Health Affairs)
CMAC	CHAMPUS Maximum Allowable Charge	**QLE**	Qualifying Life Event
CRS	Congressional Research Service	**RDT&E**	Research, Development, Testing, and Evaluation
CSA	Combat Support Agency	**SECDEF**	Secretary of Defense
DEERS	Defense Enrollment Eligibility Reporting System	**SEP**	Special Enrollment Period
DEPSECDEF	Deputy Secretary of Defense	**SMMAC**	Senior Military Medical Action Council
DHA	Defense Health Agency	**TAMP**	Transitional Assistance Management Program
DHB	Defense Health Board	**TFL**	TRICARE for Life
DHP	Defense Health Program	**TRR**	TRICARE Retired Reserve
DOD	Department of Defense	**TRS**	TRICARE Reserve Select
DSCP	Defense Supply Center Philadelphia	**TYA**	TRICARE Young Adult
ESI	Express Scripts, Inc.	**USD(P&R)**	Under Secretary of Defense (Personnel and Readiness)
FEHBP	Federal Employee Health Benefits Program	**USFHP**	Uniformed Services Family Health Plan
FY	Fiscal Year		
GAO	Government Accountability Office		
HCPCS	Healthcare Common Procedure Coding System		
IPPS	Inpatient Prospective Payment System		
JMOC	Joint Medical Oversight Council		
MEDCOM	Army Medical Command		
MERHCF	Medicare-Eligible Retiree Health Care Fund		

Author Information

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

Disclaimer

This document was prepared by the Congressional Research Service (CRS). CRS serves as nonpartisan shared staff to congressional committees and Members of Congress. It operates solely at the behest of and under the direction of Congress. Information in a CRS Report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to Members of Congress in connection with CRS's institutional role. CRS Reports, as a work of the United States Government, are not subject to copyright protection in the United States. Any CRS Report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS Report may include copyrighted images or material from a third party, you may need to obtain the permission of the copyright holder if you wish to copy or otherwise use copyrighted material.