Defense Primer: Military Health System

The Department of Defense (DOD) administers a statutory health entitlement (under Chapter 55 of Title 10, U.S. Code) through the Military Health System (MHS). The MHS offers health care benefits and services through its TRICARE program to approximately 9.62 million beneficiaries composed of servicemembers, military retirees, and family members. Health care services are available through DOD-operated hospitals and clinics, referred to collectively as military treatment facilities (MTFs), or through civilian health care providers participating in the TRICARE program.

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. §4001).

Organization

The Under Secretary of Defense for Personnel and Readiness (USD[P&R]) is the principal staff assistant and advisor to the Secretary of Defense and to the 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)
- Army Medical Command, Navy Bureau of Medicine and Surgery, and the Air Force Medical Readiness Agency

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 DOD Directive 5136.01). Reporting to the USD(P&R) through the ASD(HA), the Defense Health Agency (DHA) is a joint 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 FY2021, there were 9.62 million total MHS beneficiaries (see Figure 1).

Figure 1. MHS Beneficiaries, FY2021

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
<th>Total beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Duty Service Members</td>
<td>15%</td>
<td>1.41M</td>
</tr>
<tr>
<td>Retirees and Family Members 65+</td>
<td>24%</td>
<td>2.35M</td>
</tr>
<tr>
<td>Reserve Component Family Members</td>
<td>9%</td>
<td>0.87M</td>
</tr>
<tr>
<td>Reserve Component Members 2%</td>
<td></td>
<td>0.22M</td>
</tr>
</tbody>
</table>

Total Beneficiaries = 9.62 million


Note: Numbers may not add up to total due to rounding.

Military Treatment Facilities (MTFs)

DHA administers all MTFs worldwide. Generally, these facilities are located on or near a U.S. military base. There are three types of MTFs that provide a range of clinical services depending on facility size, mission, and level of capabilities: (1) medical centers, (2) hospitals, and (3) ambulatory care centers. MTFs are typically staffed by military, civil service, and contract personnel. In FY2021, there were 706 MTFs, with 144 located overseas.

TRICARE Options

With the exception of active duty servicemembers (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) 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. Beneficiaries 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 (PPO). 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, certain retired TRICARE beneficiaries must
enroll in Medicare and pay Medicare Part B premiums to
retain TRICARE coverage. The coverage provided is
known as TRICARE for Life. There is no enrollment fee or
premium; beneficiaries pay no out-of-pocket costs for
services covered by both Medicare and TRICARE for Life.

Budget
Congress historically funds the MHS through several
accounts in the annual Defense appropriations bill. These
include the Operation & Maintenance account for the
Defense Health Program and the services’ Military
Personnel accounts for military personnel costs and the
Medicare-Eligible Retiree Health Care Fund (MERHCF).
Congress also funds MHS construction projects through the
Defense-wide Military Construction account within the
annual Military Construction, Veterans Affairs and Related
Agencies appropriations bill. Together, DOD refers to these
funds as the Unified Medical Budget (UMB). The FY2023
request for the UMB is $55.8 billion—about 7.2% of
DOD’s total budget request. The request includes $36.9
billion for the Defense Health Program, of which $9.9
billion would be for MTF care (also called “In-House
Care”) and $18.5 billion would be for “Private Sector
Care.” Also included in the request are $8.7 billion in the
Military Personnel account, $0.5 billion for Military
Construction, and $9.7 billion for accrual payments to the
MERHCF.

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

MHS Modernization
The FY2017 NDAA (and subsequent legislation) directed
several modernization efforts, including (1) reassignment
of responsibilities for administering MTFs from the Service
Surgeons General to the DHA Director; (2) evaluation and
realignment of MHS staffing to the DHA; and (3)
evaluation and restructuring the mission and scope of each
MTF. Congress directed these reforms to streamline the
MHS; enhance medical force readiness; and improve
access, quality, and experience of care for beneficiaries. On
October 6, 2022, DHA announced that they are “fully
responsible for health care delivery in the Department of
Defense.”

Reductions in Military Medical Personnel
In a 2021 report to Congress, DOD described a plan to
reduce its active duty medical force by 12,801 positions
(i.e., billets) in order to “support the operational medical
requirements to meet the National Security Strategy (NSS),
National Defense Strategy (NDS), and Defense Planning
Guidance.” DOD plans to implement these reductions
between FY2023 and FY2027 by removing already vacant
positions, attrition, retraining or converting billets, or “force
management actions.”

Sustaining Wartime Medical Readiness Skills
Sustaining readiness of the medical force remains 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.

TRICARE’s Next Generation Contracts
In July 2016, DHA awarded its current generation of
TRICARE contracts (i.e., T-2017). Shortly after, multiple
bid protests were filed with the Government Accountability
Office and in the U.S. Court of Federal Claims,
subsequently delaying the contract start dates by three
months. In April 2021, DHA released a request for
proposals for TRICARE’s next generation contracts, called
T-5. The T-5 contracts could exceed the total value of the
T-2017 contracts ($58 billion in 2016). DHA anticipates
awarding the T-5 contracts in November 2022.

Relevant Statutes and Regulations
Title 10, U.S. Code, Chapter 55 – Medical and Dental Care
Title 10, U.S. Code, Chapter 56 – DOD MERHCF
Title 32, Code of Federal Regulations, Part 199 – Civilian Health
and Medical Program of the Uniformed Services

CRS Products
CRS Report R45399, Military Medical Care: Frequently Asked
Questions, by Bryce H. P. Mendez
CRS In Focus IF12087, FY2023 Budget Request for the Military
Health System, by Bryce H. P. Mendez
CRS In Focus IF11273, Military Health System Reform, by Bryce
H. P. Mendez
CRS Insight IN11719, TRICARE’s Next Generation Contracts: T-5,
by Bryce H. P. Mendez

Other Resources
DHA, Evaluation of the TRICARE Program: Fiscal Year 2022 Report
to Congress, 2022.
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