TRICARE Consumer Watch

Region 1◆Quarter 1 CY 2003

Region 1: Sample size-5,587 Response rate-35.6% **MHS: Sample size-45,000 Response rate-31.0%**

Inside Consumer Watch

TRICARE Consumer Watch is a brief summary of what TRICARE Prime enrollees in your region say about their healthcare. Data are taken from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB uses questions from the Consumer Assessment of Health Plans Survey (CAHPS), a survey designed to help consumers choose among health plans. Every quarter, a representative sample of TRICARE beneficiaries are asked about their care in the last 12 months and the results are adjusted for age and health status and reported in this publication.

Scores are compared with averages taken from the 2002 National CAHPS Benchmarking Database (NCBD), which contains results from surveys given to beneficiaries by civilian health plans.

Health Care

Prime enrollees were asked to rate their healthcare from 0 to 10, where 0 is worst and 10 is best.

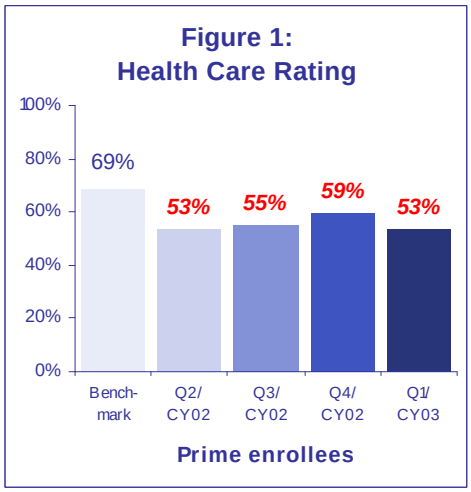
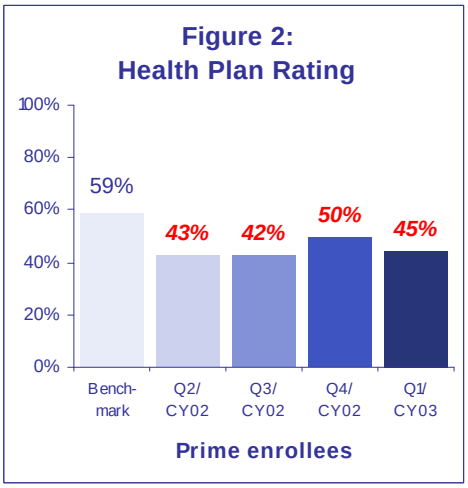


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 1st quarter of 2003, describing the period January 2002 to December 2002, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark (p<.05). Health care ratings depend on things like access to care, and how patients get along with the doctors, nurses, and other care providers who treat them.

Health Plan

Prime enrollees were asked to rate their health plan from 0 to 10, where 0 is worst and 10 is best. Figure 2 shows the percentage who rated their plan 8 or above for each reporting period.

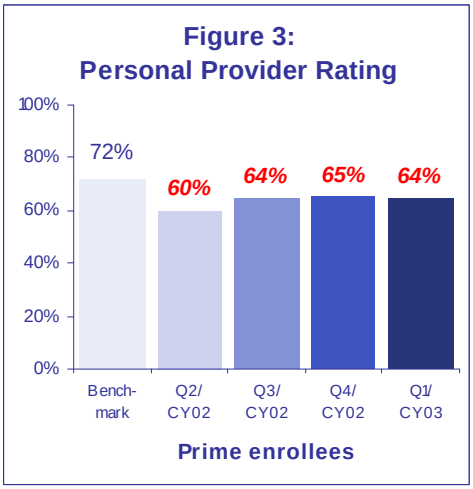


Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

Personal Provider

Prime enrollees who have a personal provider were asked to rate their personal provider from 0 to 10, where 0 is worst and 10 is best.

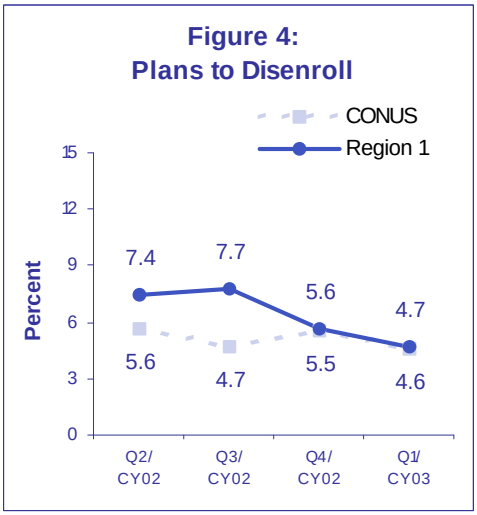
Figure 3 shows the percentage who rated their doctor 8 or above for each reporting period. Personal doctor ratings depend on how the patient gets along with the one doctor responsible for their basic care.



Plans to Disenroll

Enrollees were asked whether they plan to disenroll from Prime. Figure 4 shows the percentage of retirees and family members of active duty or retirees who plan to disenroll. Regional values differing significantly from CONUS (p < .05) are shown by red italics.

These groups have the option to disenroll if they choose, so their planned disenrollment rate is an overall measure of satisfaction with Prime.

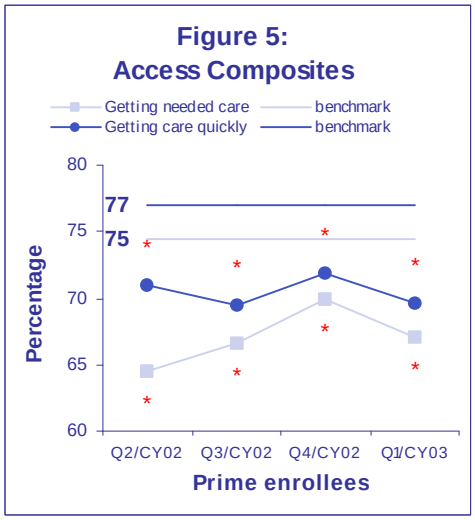


Health Care Topics

Health Care Topics scores average together the results of related questions. Each score represents the percentage who "usually" or "always" got the treatment they wanted or had "no problem" getting the desired level of service for each reporting period. Asterisks indicate values that are significantly different from the NCBD benchmark ($p < .05$).

Figure 5 (Access Composites) includes the composites "Getting needed care" and "Getting care quickly."

Scores in "Getting needed care" are based on patients' problems getting referrals and approvals and finding a good doctor.



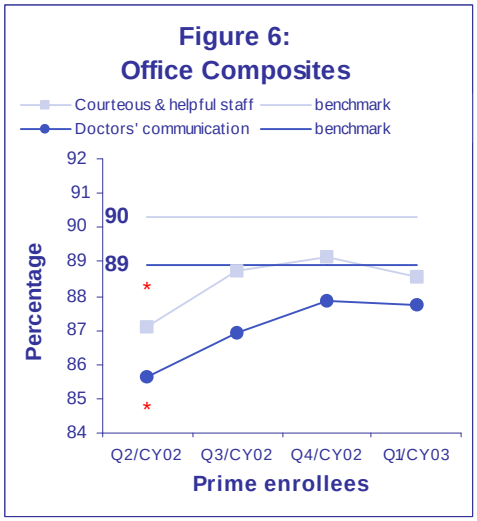
"Getting care quickly" scores concern how long patients wait for an appointment or wait in the doctor's office.

Figure 6 (Office Composites) includes the composites "Courteous and helpful office staff" and "How well doctors communicate."

Scores in "How well doctors communicate" are based on whether the doctor spends enough time with patients, treats them respectfully and answers their questions. "Courteous and helpful staff" scores measure both the courtesy and helpfulness of doctor's office staff.

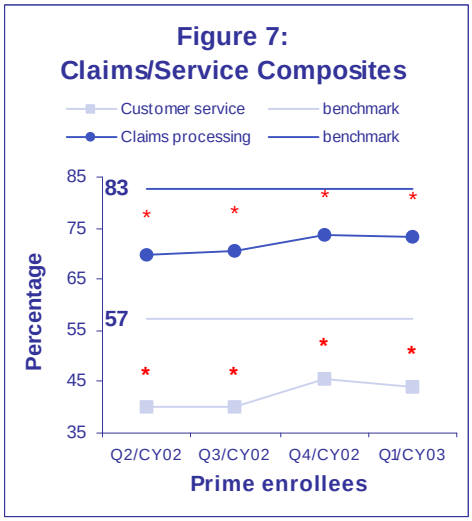
Figure 7 (Claims/Service Composites) includes composite scores for "Customer service" and "Claims processing."

Scores in the "Customer service" composite concern patients' ability to get information from phone lines and written materials, and the manageability of the health plan's paperwork. "Claims processing" scores are based on both the timeliness and correctness of plan's claims handling.



Preventive Care

The preventive care table compares Prime enrollees' rates for several types of preventive care with goals from Health People 2010, a government initiative to improve Americans' health by preventing illness. The table shows the most recent four quarters of data for four measures of preventive care.



Mammography is the proportion of women over age 40 who received a mammogram in the past two years. Pap smear is the proportion of women over 18 who received a pap smear for cervical cancer screening in the past three years. Hypertension indicates the proportion of all beneficiaries whose blood pressure was checked in the past two years and who know whether their blood pressure is too high. Prenatal care shows the proportion of women pregnant in the past 12 months who received prenatal care in the first trimester.

Rates that are significantly different ($p < .05$) from the Healthy People 2010 goal are shown by red italics.

Preventive Care

Type of Care	Qtr 2 CY 2002	Qtr 3 CY 2002	Qtr 4 CY 2002	Qtr 1 CY 2003	Healthy People 2010 Goal
Mammography (women ≥ 40)	*82*	*85*	*84*	*88* (207)	70
Pap Smear (women ≥ 18)	91	*96*	*95*	*93* (485)	90
Hypertension Screen (adults)	*91*	*92*	*90*	*92* (1098)	95
Prenatal Care (in 1st trimester)	91	87	79	94 (41)	90

Issue Brief: Network Adequacy

Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries. This quarter, the issue brief concerns beneficiaries' perceptions of the adequacy of TRICARE's civilian networks.

Like other health plans, TRICARE provides care through networks of physicians and other health care providers who contract to treat its beneficiaries. TRICARE's contracts with civilian health plans require the plans to establish "adequate" networks. Plans must include primary physicians and specialists proportional to the number of Prime enrollees living nearby who use civilian doctors. They also must meet contractual standards for timely access to appointments. In recent years, beneficiary groups have complained of access problems and physicians have cited low reimbursement and administrative burdens as reasons for avoiding TRICARE patients (G.A.O., 2003). This issue brief describes how TRICARE beneficiaries view the adequacy of their civilian networks.

Background

In the civilian health care market, increasing numbers of consumers and providers have pushed back against the most restrictive forms of managed care and their cost-containment strategies. Health plans have responded by expanding networks and loosening restrictions. Rather than traditional HMOs, health plans now offer looser managed care products such as open HMOs, PPOs and point-of-service plans, which feature broader provider networks and more affordable use of out-of-network providers. Health plans have increased the stability of their networks by reducing doctors' exposure to financial risk.

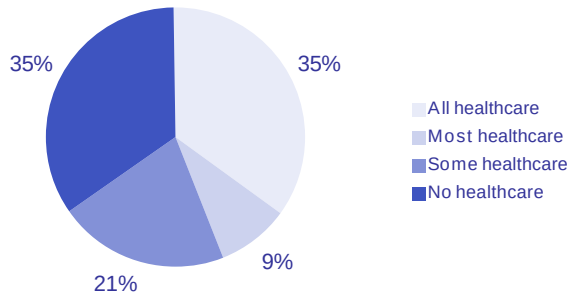
Movement away from restrictive managed care reflects the importance consumers attach to access and freedom of choice. Surveys of adult health plan enrollees in the general population also point to networks as a critical element in consumer's satisfaction with their health plans. For example, when choosing between two competing health plans, access to specialists and participation of one's own physician in the network are among the most important factors weighed by consumers (Harris, 2002).

Other trends have weakened networks, however. Contract disputes and insolvencies of large provider organizations have made networks less stable (Short et al, 2001). In 2001, about 13 percent of the insured in a national sample said they either delayed care or left medical needs unmet due to access problems. Of those reporting problems, about half cited the high cost of care, even though cost was reduced by health insurance. A third reported they could not make a timely appointment and 12 percent could not find a conveniently located doctor. A survey of civilian health plans found that 9 percent of those that visited a doctor in the past year had to spend more than 30 minutes traveling to the doctor's office (Reschovsky, 2000).

Findings

The TRICARE civilian network currently provides much, if not most of the care for retired beneficiaries and their dependents and for active duty dependents who choose TRICARE. Of non-active duty beneficiaries who received care from a TRICARE plan in the past year, 35 percent say they use only the civilian network, while another 30 percent use the civilian network for some or most of their healthcare.

Figure 1:
Proportion of Care From the Civilian Network



Beneficiaries who try to use the civilian network report a variety of access problems. The frequency of access problems appears to exceed the frequency of problems encountered in civilian plans, and may be preventing beneficiaries who would otherwise prefer it, from using the network. Among the non-active duty beneficiaries who wanted care, a total of 30 percent reported problems and 9 percent reported big problems in getting the care they wanted from the civilian network. Among those who did not use the civilian network but have tried to use it, 42 percent reported big problems getting the care they wanted, suggesting that problems getting care from the network had kept them from using it.

Problems Getting Care

	All Beneficiaries	Beneficiaries with no care from network
Big problem	9%	43%
Small problem	21%	17%
No problem	70%	40%

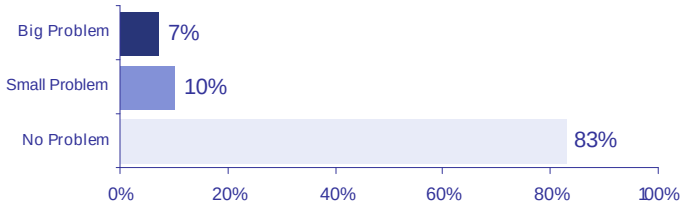
Many beneficiaries who use the civilian network report problems finding care that is convenient. Of those who tried to find a doctor in the civilian network, 30 percent encountered problems and 12 percent encountered big problems in finding a doctor who was convenient to visit. One-fifth of the beneficiaries who had big problems finding a convenient doctor elected not to use the civilian network.

Problems Finding Convenient Doctor

	All Beneficiaries	Of whom: Beneficiaries with no care from network
Big problem	12%	21%
Small problem	18%	5%
No problem	70%	2%

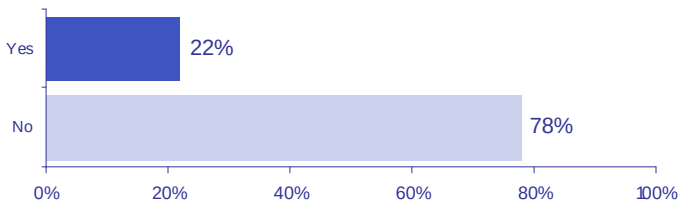
Access to other health care services appears to be a lesser problem in TRICARE: of non-active duty beneficiaries who tried to use labs or x-ray facilities in the network, 17 percent had problems and 7 percent had big problems in finding convenient locations.

Figure 2: Problems Finding Lab/X-ray



For many, the ability to continue seeing doctors with whom they have established relationships is a crucial component of health care quality. For that reason, the stability of physician networks is at least as important as its range of specialists and geographic coverage. In recent surveys, only 1 percent of all privately insured persons in a national sample reported they had been forced to change their primary doctors because that doctor left their network (Reed, 2000). By contrast, results from the HCSDB show that 22 percent of beneficiaries who tried to use doctors from the civilian network found that a doctor they wanted to see was no longer a network member. This suggests TRICARE's problems are greater, though the HCSDB finding includes not only primary doctors, but also specialists, than those of civilian plans who are often harder for beneficiaries to access.

Figure 3: Wanted to see doctor who left network



Conclusions

Access limitations, inconveniently located doctors, and doctors who leave the network all appear to affect TRICARE's civilian network to a greater degree than they affect networks serving privately insured populations. The effects of network instability may worsen when new contracts are negotiated in the coming year. Like our HCSDB findings, evidence collected by G.A.O. also indicates TRICARE network problems. G.A.O. attributes problems to low reimbursement for physicians, and a staffing formula that underestimates the needs of network users for care, particularly from specialists (G.A.O., 2003).

Besides increasing reimbursement and the number of network specialists required per beneficiary, TRICARE can take measures to reduce the effects of instability. Regulators are fighting network instability in civilian markets by closely monitoring providers' financial health, and employers by including performance guarantees in their contracts to reduce physician turnover (Short et al, 2001). Regulations and contracts that increase burdens on providers may increase upward pressure on health costs. Like those in the civilian world, TRICARE's decision makers have to weigh the benefits in access, convenience and continuity of care against the added costs.

References

Harris, K.M. Can High Quality Overcome Consumer Resistance to Restricted Provider Access? Evidence from a Health Plan Choice Experiment (2002). *Health Services Research*, 37 (3):551.

Reed, M.C. Why People Change Their Health Care Providers. Data Bulletin #16 (2000). Center for Studying Health System Change.

Reschovsky, J.D. Do HMOs Make a Difference? Access to Health Care. *Inquiry* (1999/2000), 36:390.

Short, A.C., Mays, G.P., Lake, T.K. Provider Network Instability: Implications for Choice, Costs and Continuity of Care. Issue Brief #39 (2001). Center for Studying Health System Change.

Strunk, B.C., Cunningham, P.J. Treading Water: Americans' Access to Needed Medical Care, 1997-2001. Tracking Report #1 (2002). Center for Studying Health System Change.

United States General Accounting Office. Oversight of the Adequacy of TRICARE's civilian network has weaknesses. Testimony. March 27, 2003.