TRICARE Consumer Watch

Region 11 ◆ Quarter 2 CY 2004

HEALTH PROGRAM ANALYSIS & EVALUATION DIRECTORATE

Region 11: Sample size-1,674 Response rate-30.9% **MHS: Sample size-50,000 Response rate-28.9%**

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 includes questions from the Consumer Assessment of Health Plans Survey (CAHPS). 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. In 2004, a new version of CAHPS (3.0) is used. Some new questions cannot be compared with the old ones.

Scores are compared with averages taken from the 2003 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: Health Care Rating

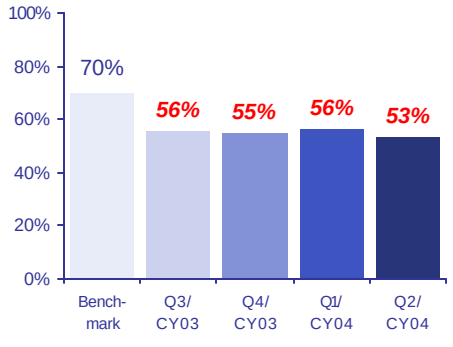
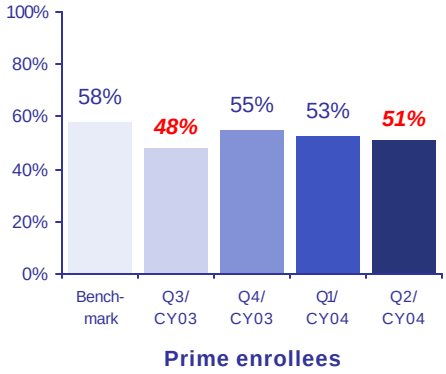


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 2nd quarter of 2004, describing the period April 2003 to March 2004, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark (p<.05). Health care ratings 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.

Figure 2: Health Plan Rating



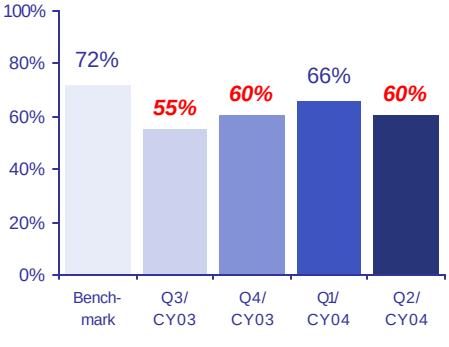
Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

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.

Figure 3: Personal Provider Rating

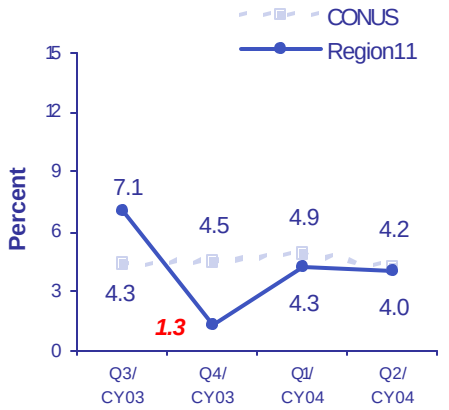


Plans to Disenroll

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.

Figure 4: Plans to Disenroll

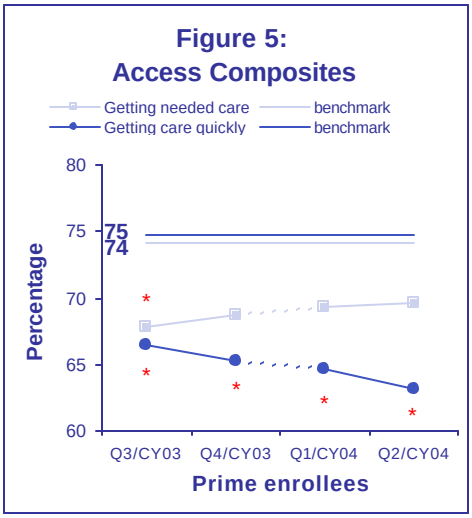


Health Care Topics

Health Care Topics scores average together results for related questions. Each score represents the percentage who "usually" or "always" got treatment they wanted or had "no problem" getting a desired service. Asterisks show values significantly different from the NCBD benchmark ($p < .05$). Hatched lines show where CAHPS 3.0 scores cannot be compared to CAHPS 2.0.

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.



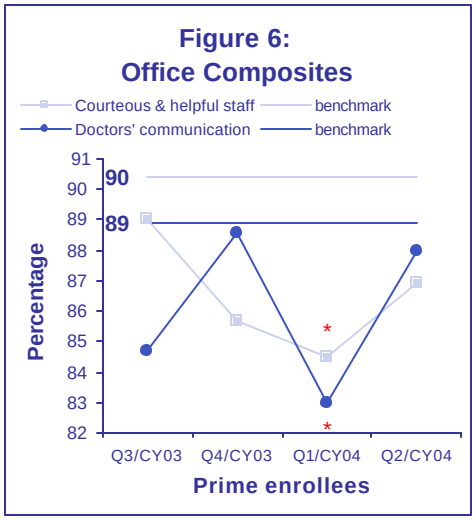
"Getting care quickly" scores concern how long patients wait for an appointment or wait in the doctor's office.

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.

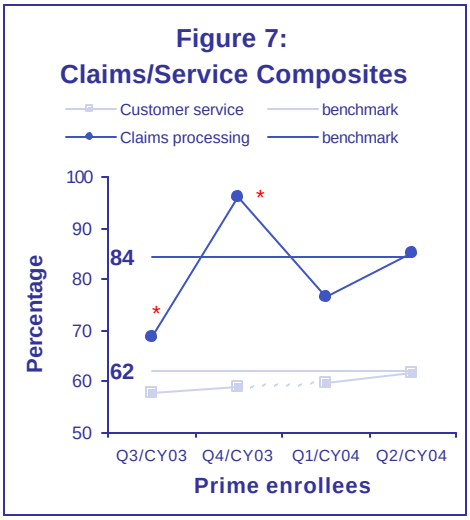
Figure 7 (Claims/Service Composites) includes composite scores for "Customer service" and "Claims processing."

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 five 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. Cholesterol screen is the proportion of all adults whose cholesterol was tested in the previous 5 years.

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

Preventive Care

Type of Care	Qtr 3 CY 2003	Qtr 4 CY 2003	Qtr 1 CY 2004	Qtr 2 CY 2004	Healthy People 2010 Goal
Mammography (women ≥ 40)	*83*	*84*	*92*	*87* (72)	70
Pap Smear (women ≥ 18)	93	*98*	*96*	94 (163)	90
Hypertension Screen (adults)	*90*	95	*90*	*91* (318)	95
Prenatal Care (in 1st trimester)	.	.	.	. .	90
Cholesterol Screen (adults)	*77*	*82*	*80*	*74* (313)	90

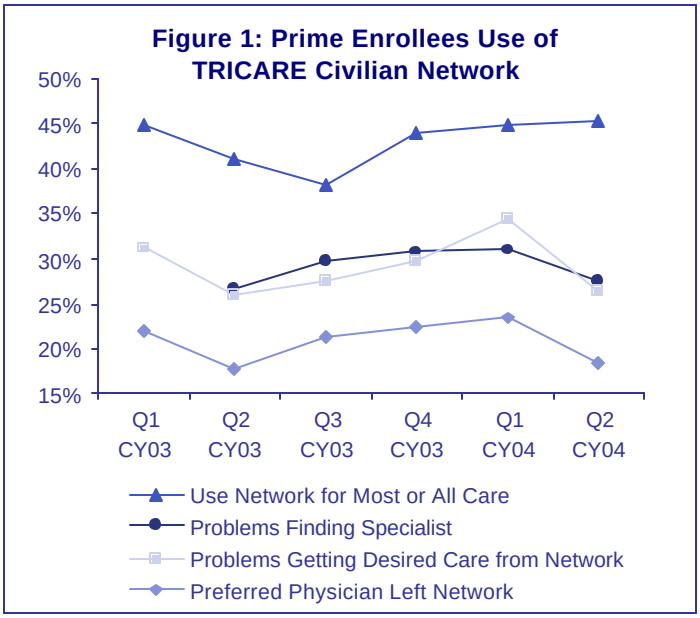
Issue Brief: TRICARE Civilian Network

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 describes Prime enrollees' perceptions of the TRICARE Civilian Network.

When Prime, TRICARE's health maintenance organization (HMO) option, was phased in between 1994 and 1997, HMOs were growing in popularity, enrolling increasing numbers of beneficiaries with private insurance, Medicare or Medicaid. HMOs lowered costs to consumers by negotiating payment discounts with providers, restricting patients' choice of doctor and treatments, and requiring doctors to bear financial risk for their patients' costs. In recent years, however, patients have demanded a greater choice of providers and fewer restrictions on use. By withdrawing or threatening to withdraw from health networks, providers have capitalized on demand for choice and have been rewarded by increases in practice revenue and reduced oversight from health plans[1]. HMOs forced to make higher payments to providers and to reduce constraints on patients' use now face higher costs. HMOs have responded by raising the premiums paid by beneficiaries and their employers and raising charges to patients seeking care, making HMOs less attractive to consumers. Between 1999 and 2003, the proportion of American employees covered by HMOs or point-of-service (POS) health plans declined from 52 percent to 41 percent[2]. Among Medicare beneficiaries, the proportion with HMO coverage dropped from 17 percent to 12 percent[3]. In commercial markets, preferred provider organizations (PPOs) are now the most popular type of health plan, with a 54 percent share[4].

At present, HMO expansion continues under Medicaid, where containing costs is more important than beneficiary choice. Medicaid HMOs have preserved their momentum by permitting their provider networks to narrow and by focusing on Medicaid business. Networks have narrowed because of low payment rates and administrative burdens and because Medicaid HMOs continue to employ risk-based contracts with their physicians [5].

TRICARE Prime now confronts a health care market where provider payments have increased and physicians are willing to withdraw from networks that are restrictive or offer low payment rates. Policy makers are concerned that low TRICARE payments may result in decreased access for military beneficiaries. In response, payment rates for physicians in Alaska and Idaho were increased, which helped contractors to recruit more specialists in those areas[6]. However, payment increases alone may not solve network problems. Though managed care contractors complain that low reimbursement hinders recruitment, most physicians who leave the network cite other reasons[7].



Results from the HCSDB, shown in Figure 1, indicate that the proportion of non-active duty enrollees who rely on the civilian network has remained about 40 percent or above since the beginning of 2003. In each quarter, about 30 percent of enrollees who have tried to use the network reported problems getting the care they want from it and 30 percent who needed a specialist reported problems finding a network specialist. Twenty percent learned that a doctor they wanted to see had left the network. The survey results do not give evidence of worsening problems.

Table 1.
Network Use by Beneficiary Category:
Q3 CY03 to Q2 CY04

	Retirees and Dependents	Active Duty Family Member	Of Active Duty Family Members	
			Reservist	Other Active Duty
Use Network for Most or All Care	49%	37%	61%	33%
Problems Finding Specialist	28%	32%	37%	32%
Problems Getting Desired Care from Network	27%	33%	35%	32%
Preferred Physician Left Network	23%	19%	25%	18%

Retirees and their dependents and the family members of reservists are the heaviest users of the civilian network. As shown in Table 1, 49 percent of retired enrollees and their family members get most or all of their care from the network, compared to 37 percent of active duty dependents. Among active duty dependents, 61 percent of reservist family members rely on the civilian network. Though retirees report fewer problems than do active duty families in finding the care or specialist they want from the network, they are more likely to report that a doctor they wanted to see had dropped out. Reservists are more likely than other active duty family members to encounter problems finding care or specialists they want, and are also more likely to report wanting to see a doctor who had left the network.

More reservist families may use the network because fewer of them live near a MTF. Enrollees who live at an inconvenient distance from military facilities are most likely to be civilian network users. As shown in Table 2, 62 percent of enrollees living outside a MTF catchment area report getting all or most of their care from the network. These remote users are no more likely to report problems seeing network specialists but are more likely to report wanting to use a physician who left the network than are enrollees living a short drive from a MTF.

Table 2.
Network Use by Catchment Area Residence:
Q3 CY03 to Q2 CY04

	In Catchment	Out of Catchment
Use Network for Most or All Care	31%	62%
Problems Finding Specialist	30%	30%
Problems Getting Desired Care from Network	29%	30%
Preferred Physician Left Network	19%	24%

Table 3 indicates that the region where the enrollees are least likely to use the network and the region with the greatest access problems is the north (New England, the Midwest and Mid-Atlantic). Forty percent of enrollees in the north use the civilian network for all or most care compared with 43 percent in the west (the Pacific coast, Southwest and Great Plains) and 48 percent in the south. Thirty-three percent in the north report problems finding a network specialist compared to 30 percent in the south and 26 percent in the west. Similarly, 34 percent in the northern region report problems getting the care they want compared to 29 percent of southerners and 27 percent of westerners.

Table 3.
Network Use by Region:
Q3 CY03 to Q2 CY04

	North	South	West
Use Network for Most or All Care	40%	48%	43%
Problems Finding Specialist	33%	30%	26%
Problems Getting Desired Care from Network	34%	29%	27%
Preferred Physician Left Network	22%	23%	21%

Recent developments in health care markets that have weakened managed care and strengthened providers' positions have left enrollees more vulnerable to shortages of doctors in the TRICARE network. Network use is lowest and network problems have been greatest in the north. Retirees and reservists' families appear to be most sensitive to problems with the civilian network because they are more likely to rely on it. Though there is no evidence from the HCSDB that network problems are increasing, reservists are likely to make up a growing part of the enrolled population, increasing the populations' sensitivity to network access problems. The new generation of managed care support contracts creates an opportunity to overcome these problems.

REFERENCES

[1] White, Justin, Robert E. Hurley and Bradley C. Strunk. Getting Along or Going Along? Health Plan-Provider Contract Showdowns Subside. Issue Brief No. 74 Center for Studying Health System Change. January, 2004

[2] Kaiser Family Foundation and Health Research Education Trust. Employer Health Benefits: 2003. Menlo Park, California and Chicago, Illinois, 2003.

[3] Gold, Marsha and Lori Achman. Shifting Medicare Choices, 1999-2003. Monitoring Medicare+Choice Fast Facts. December, 2003.

[4] KFF & HRET. op. cit.

[5] Draper, Debra A., Robert E. Hurley and Ashley C. Short. 2004. Medicaid Managed Care: The Last Bastion of the HMO? *Health Affairs* 23(2): 155-167.

[6] United States General Accounting Office. Oversight of the TRICARE Civilian Network Should Be Improved. July, 2003.

[7] U.S. GAO op. cit.