

# **Evaluation of the TRICARE Program**

FY 2002 Report to Congress

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## **PREFACE**

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The FY 2002 evaluation of the TRICARE program was performed jointly by the CNA Corporation and the Institute for Defense Analyses (IDA) for the Office of the Assistant Secretary of Defense (Health Affairs). The objectives of the evaluation were to assess: (1) the effectiveness of the TRICARE program in improving beneficiaries' access to health care, (2) the impact of TRICARE on the quality of health care received by Military Health System (MHS) beneficiaries, and (3) the effect of TRICARE on health care costs to both the government and MHS beneficiaries.

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The authors would like to acknowledge the support of Lt. Col. Pradeep Gidwani, Ms. Patricia Golson, and Dr. Richard Guerin of the TRICARE Management Activity (Health Program Analysis and Evaluation) in providing oversight for this task and facilitating data collection. The authors would also like to thank The Altarum Institute for providing and processing much of the data required for the cost evaluation.



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## **EXECUTIVE SUMMARY**

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The 104th Congress, through enactment of the National Defense Authorization Act for fiscal year (FY) 1996, Section 717, directed the Secretary of Defense to arrange for an ongoing, independent evaluation of the TRICARE program. The legislation requires that the evaluation assess the effectiveness of the TRICARE program in meeting the following objectives:

- improve the access to and quality of health care received by eligible beneficiaries,
- keep both government and beneficiary costs at levels the same as or lower than before TRICARE was implemented, and
- identify noncatchment areas in which the health maintenance organization (HMO) option of the program (i.e., TRICARE Prime) is available or proposed to become available.

Because the FY 1998 Report to Congress extensively addressed the issue of extending the Prime option to noncatchment areas, we did not re-evaluate that issue this year.

### **New Focus**

All previous TRICARE evaluations have taken the approach of comparing TRICARE in the evaluation year with the traditional benefit of direct care and CHAMPUS in FY 1994 adjusted for known, measurable changes that would likely have occurred even in the absence of TRICARE. The FY 1994 baseline has served its purpose but is now too far removed from present-day TRICARE experience to continue serving as a useful benchmark. Significant changes have occurred since 1994 in business and medical practices and in technological innovation. Some of these changes would likely have occurred with or without TRICARE, making a “before and after” comparison of TRICARE with the traditional health care benefit difficult to interpret.

In this year’s evaluation, we change our focus from a “before and after” comparison to a look at recent trends in access, quality, utilization, and costs. We evaluate the nationwide trends under TRICARE, i.e., for all eleven Health Service Regions (HSRs) combined—1 (Northeast), 2 (Mid-Atlantic), 3 (Southeast), 4 (Gulf South), 5 (Heartland), 6 (Southwest), 7/8 (TRICARE Central), 9 (Southern California), 10 (Golden Gate), 11 (Northwest), and 12 (Hawaii). We do not evaluate TRICARE in Alaska or any of the overseas programs. Starting with the FY 2000 Report to Congress, the evaluation of access and quality has included some comparisons with civilian-sector benchmarks. In the FY 2002 evaluation, we include civilian benchmarks for utilization and costs as well.

### **Access to Care**

The evaluation of access and quality of care used data from FY 2000 and FY 2001. Measures derived from Health Care Surveys of DoD Beneficiaries, and the National

CAHPS Benchmarking Database (NCBD) formed the basis of comparison.<sup>1</sup> These surveys sampled representative cross sections of all DoD beneficiaries in each respective year, and those in commercial health plans serving the general population. To isolate the effects of the TRICARE program, it was necessary to control for beneficiary population differences that could affect access, such as health status and various demographic characteristics. These effects were controlled using statistical regression analysis.

In general, satisfaction with access to care under TRICARE lags that estimated for commercial plans serving the general population. We estimate that DoD beneficiaries would have greater satisfaction with access had they been in those civilian plans. In addition, DoD beneficiary satisfaction with access generally fell from FY 2000 to FY 2001. Three kinds of access measures were used to reach these conclusions: realized access, availability, and the process of obtaining care.

The data in Table ES-1 indicate that DoD showed an increase in realized access and achieved access levels comparable to those of civilian plans, as measured by having an outpatient visit. However, performance for DoD fell with respect to emergency room (ER) visits. DoD beneficiaries were more likely to use the ER than those in the general population.

Satisfaction of DoD beneficiaries with availability and ease of obtaining care lags the general population in FY 2001. There has also been a perception of decreased satisfaction with access for DoD beneficiaries over time. A greater proportion of the DoD population reported longer waits to get an appointment from 2000 to 2001. Waiting time to see a provider at the doctor's office has also increased.

**Table ES-1. Summary of Changes in Perceived Access to Care  
(Proportion of Population)**

Measure	FY 2000		FY 2001		Trend	
	DoD	NCBD	DoD	NCBD	00-01	DoD vs. NCBD
<u>Realized Access</u>						
Having an outpatient medical visit	0.84	0.88	0.86	0.87	+	=
Use of the emergency room	0.25	0.20	0.27	0.20	-	-
<u>Availability</u>						
Access to care when needed	0.77	0.80	0.77	0.82	=	-
Getting care quickly	0.79	0.79	0.75	0.80	-	-
<u>Obtaining Care</u>						
Waited to see provider no more than 15 minutes	0.85	0.84	0.77	0.82	-	-

+ = Indicates DoD improvement and DoD same as NCBD.  
 -- Indicates DoD performance decline and NCBD surpasses DoD.  
 =- Indicates DoD performance steady and NCBD surpasses DoD.

<sup>1</sup> The NCBD is funded by the U.S. Agency for Healthcare Research and Quality and administered by Westat under Contract No. 290-01.003.

## Quality of Care

This evaluation considered two major aspects of quality: meeting national standards, and perceived quality of care. DoD has adopted as its standard the national health-promotion and disease-prevention objectives specified by the U.S. Department of Health and Human Services in *Healthy People 2010*.<sup>2</sup> Care levels under TRICARE were compared with these national standards. As Table ES-2 shows, most of the goals are being met or are nearly being met under TRICARE. Shortfalls are in the area of counseling for the use of tobacco products and flu shots for those 65 and over. The DoD health care system has failed to meet its goals in the area of tobacco use in previous evaluations.<sup>3</sup>

**Table ES-2. Meeting Quality-of-Care Goals in FY 2001  
(Proportion of Population)**

Outcome	DoD Goal	DoD Beneficiaries
<u>Met or Exceeded Goal</u>		
Mammogram past 2 years (age 50+)	0.60	0.86
Breast exam past year (age 40+)	0.60	0.68
Cholesterol test past 5 years	0.75	0.81
PAP smear past 3 years	0.85	0.88
Know results of blood pressure check	0.90	0.89
First trimester care	0.90	0.88
<u>Shortfalls</u>		
Flu shot (age 65+)	0.90	0.70
Smoking counseling	0.75	0.60

Also examined were beneficiaries' perceptions of the quality of their health care under TRICARE. As Table ES-3 shows, the general pattern of results suggests that DoD beneficiaries were less satisfied with the quality of their care than those in the general population with commercial health plans. The changes in perceived quality between 2000 and 2001 were about one percentage point and not statistically significant.

<sup>2</sup> Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, 1991.

<sup>3</sup> Peter H. Stoloff, Philip M. Lurie, Matthew S. Goldberg, Richard D. Miller, and Ravi Sharma, *Evaluation of the TRICARE Program: FY 1998 Report to Congress*, 18 September 1998.

Peter H. Stoloff, Philip M. Lurie, Lawrence Goldberg, and Matthew S. Goldberg, *Evaluation of the TRICARE Program: FY 1999 Report to Congress*, 31 October 1999.

Peter H. Stoloff, Philip M. Lurie, Lawrence Goldberg, and Michele Almendarez, *Evaluation of the TRICARE Program: FY 2000 Report to Congress*, 31 October 2000.

**Table ES-3. Measures of Perceived Quality of Care—All Evaluated Regions Combined (Proportion of Population Having Favorable Ratings in FY 2001)**

Satisfaction Measure	DoD	Benchmark
Overall health care rating	0.67	0.76
Primary care manager rating	0.72	0.79
Specialty care rating	0.74	0.80

Notes: All differences in perceived satisfaction levels between DoD and NCBD benchmark were statistically significant ( $p < .05$ ). Rating measures are proportions of populations receiving ratings of 8 or better, on a 10-point scale.

## Satisfaction With Filing Medical Claims

The rate of claim filing for Military Health System (MHS) beneficiaries (66 percent in FY 2001) was lower than that observed under plans serving the general population (71 percent in FY 2001). This represents a 7-percentage-point increase in the claim filing rate for DoD beneficiaries from the previous year. At the same time, MHS beneficiaries tend to express a lower level of satisfaction with their claims processing experience than the general population (86 versus 88 percent). However, the level of DoD satisfaction with claims processing did rise by 2 percentage points from the previous year. Having a problem with a claim is a major cause of dissatisfaction with one’s health plan. Those who experienced problems with claims processing were considerably more likely to rate their health plan *lower* than those who did not have problems with claims (17 percent vs. 60 percent satisfied with their plan).

## Child Health Care

The pattern of results of satisfaction with access and quality of care indicators for children parallels that of adults. We found that:

- realized access was not as good for children of DoD beneficiaries as it was for children in comparable civilian plans, but is improving over time,
- satisfaction with most components of access and quality of care was higher for the general population,
- levels of satisfaction with access and quality were maintained or improved from FY 2000 through FY 2001, and
- levels of satisfaction with children’s health care were generally lower for those enrolled in Prime.

## Cost to the Government

We estimated the trends in TRICARE utilization and government costs from FY 1999 to FY 2001. To make costs comparable, we inflated FY 1999 and FY 2000 costs to FY 2001 dollars. Unlike past evaluations, we made no adjustments for changes in the composition or size of the beneficiary population because they did not change much between FY 1999 and FY 2001. Table ES-5 summarizes the findings with regard to government costs for the TRICARE regions covered by this evaluation.

**Table ES-5. Trend in TRICARE Costs  
(Millions of FY 2001 Dollars)**

Source	FY 1999	FY 2000	FY 2001
Direct Care	\$8,954	\$8,882	\$8,999
Purchased Care	4,037	4,501	4,944
Other Government Costs	2,207	2,027	2,007
<b>Total Government Cost</b>	<b>\$15,198</b>	<b>\$15,409</b>	<b>\$15,950</b>

Notes: Excludes Alaska and overseas. Numbers do not always total exactly because of round-off error.

We attempted to provide as complete an accounting of MHS costs as possible. However, it was not possible to develop a complete reconciliation between DoD information systems and the Defense Health Program (DHP), partly because DHP obligations translate into outlays over a multi-year time frame. In addition, there is no standard crosswalk between DoD information systems and any particular subset of program elements that make up the DHP. Consequently, the costs identified do not align completely with the FY 2001 DHP, which was \$17.23 billion. The total worldwide costs identified from DoD information systems were \$17.13 billion. Thus, we were able to reconstruct the DHP to within \$100 million.

Direct care costs include the cost of providing health care services at Military Treatment Facilities (MTFs) as well as administrative and overhead costs. TRICARE had its biggest impact on outpatient costs (net of prescription drugs), which declined by \$258 million (7 percent) from FY 1999 to FY 2001. There was also a modest decline of \$87 million in inpatient costs (5 percent). These reductions were achieved by corresponding reductions in both inpatient and outpatient utilization, suggesting that MTFs have not been successful in recapturing network workload. Moreover, the reductions were partially offset by an increase of \$102 million in prescription drug costs associated with MTF outpatient visits. In addition, there was an increase of \$285 million in Special Programs costs resulting from performing services other than direct patient care. Much of the latter increase is due to services (inpatient, outpatient, and ancillary) provided at the request of network providers. Overall, direct-care costs were roughly constant over the evaluation time interval.

Civilian-sector care under TRICARE is arranged by Managed Care Support (MCS) contractors, who supplement the care provided at MTFs. MCS and other purchased-care costs under TRICARE were \$907 million higher in FY 2001 than they were in FY 1999. Purchased-care costs increased for all types of services (inpatient, outpatient, and prescriptions). The increase in inpatient costs was the most modest, rising only 6 percent. However, outpatient costs rose by 25 percent and prescription costs by 74 percent. Much of the increase in prescription costs can be attributed to the TRICARE Senior Pharmacy benefit introduced in mid-FY 2001. Other major contributors to the overall increase in purchased-care costs are the catastrophic cap reduction from \$7,500 to \$3,000 for non-active-duty families, the elimination of copayments for enrolled active-duty family members, and the TRICARE Prime Remote program (including the waived charges benefit for active-duty family members).

Prescription costs continued the pattern of the past several years, increasing by \$539 million throughout the evaluated TRICARE regions. This increase includes prescriptions filled at MTF pharmacies in connection with MTF visits (up \$102 million), prescriptions written by civilian physicians but filled at MTF pharmacies (up \$75 million), and prescriptions filled at MCS network pharmacies (up \$266 million). In addition, the National Mail Order Pharmacy benefit increased costs by another \$96 million. The pattern of escalating prescription costs is not unique to TRICARE, however. Prescription costs have been spiraling ever higher in the civilian sector as well, and TRICARE is not immune to the factors that have been driving up prescription costs. These factors include physicians' increasing reliance on drug therapy to treat chronic conditions (e.g., diabetes, elevated cholesterol); direct marketing of drugs to consumers; the growing use of newer, expensive prescription drugs that do not have generic equivalents; and an aging and less healthy beneficiary population.

For the first time, this evaluation compares several TRICARE performance measures with roughly comparable civilian-sector benchmarks. We were able to obtain commercial health plan utilization and cost statistics<sup>4</sup> by age group and sex, which allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

The pattern of utilization and costs among Prime enrollees is most directly comparable to that of a civilian HMO, whereas the pattern among nonenrollees is most directly comparable to that of a civilian Preferred Provider Organization (PPO). Table ES-6 summarizes the trend in systemwide costs per participant under TRICARE with those of commercial plans. The costs displayed for civilian plans are weighted averages of HMO and PPO costs, using the percentage of health care costs incurred under TRICARE on behalf of Prime enrollees and on behalf of nonenrolled MHS-reliant beneficiaries (i.e., beneficiaries enrolled in Prime or nonenrolled beneficiaries under age 65 without private health insurance), as the weights.

**Table ES-6. Comparison of TRICARE Costs With Civilian Plan Benchmarks  
(FY 2001 Dollars)**

Cost per Participant	FY 1999	FY 2000	FY 2001
<b>TRICARE</b>			
Total Cost	\$2,825.78	\$2,863.82	\$2,894.08
Government Cost	\$2,713.14	\$2,745.30	\$2,780.26
<b>Civilian Plans</b>			
Total Cost	\$2,050.67	\$2,155.05	\$2,243.87
Employer Cost	\$1,848.21	\$1,944.94	\$2,005.14

Table ES-6 shows that overall costs under TRICARE are significantly higher than under comparable civilian health care plans. One reason for the difference is that

<sup>4</sup> The civilian benchmarks are based on claims data from a variety of health plan types offered by large self-insured employers. The source of the claims data is the MarketScan<sup>®</sup> Database, The MEDSTAT Group, Inc., Ann Arbor, MI.

TRICARE provides a more generous benefit than most commercial health care plans. Another is that the MHS has a readiness mission,<sup>5</sup> which adds considerable expense to the cost per participant when burdened on actual health care costs. The MHS also has more levels of management overhead (HA, TMA, Lead Agents, Service SG staff, etc.) than most commercial managed care organizations (MCOs) and spends a considerable amount of money on developing and maintaining information systems that are able to support the unique requirements of military medicine and the readiness mission.

Although the cost per member is higher for military beneficiaries, Table ES-6 also shows that the military sector has been better able to control health care costs per participant than have civilian MCOs. Whereas the cost per Prime enrollee has remained relatively constant over the period from FY 1999 to FY 2001, civilian MCO costs have risen 12 percent over the same time period (net of inflation).

## **Cost to Covered Beneficiaries**

To evaluate costs to both TRICARE-eligible and Medicare-eligible beneficiaries, we used the beneficiary family as the unit of analysis. This is because insurance decisions are made on a family basis, and because deductibles are capped for families. TRICARE can affect beneficiaries' out-of-pocket costs by

- eliminating deductibles and lowering copayments for Prime enrollees,
- increasing the utilization of health care services by Prime enrollees as a result of lower per-visit costs,
- forcing nonenrollees to seek more costly care under TRICARE Standard or from the private sector by reducing space-available care at MTFs,
- inducing enrollees to drop and nonenrollees to add supplemental or other private health insurance coverage, and
- assessing an enrollment fee on retirees and their family members.

Consequently, out-of-pocket costs for TRICARE-eligible beneficiaries include deductibles and copayments for purchased care, TRICARE Prime enrollment fees, and premiums for supplemental and other private health insurance.

Out-of-pocket costs decreased from FY 1999 to FY 2001 for every type of beneficiary family, particularly for active-duty families enrolled with a civilian PCM. The latter group of beneficiaries benefited from the elimination of copayments in mid-FY 2001.

Out-of-pocket expenses for TRICARE-eligible families in FY 2001 were about \$2,000 lower than for comparable civilian families with employer-sponsored health insurance. Expenses were lower for TRICARE-eligible beneficiaries because they have relatively low deductibles and copayments and they pay little or no insurance premiums.

Out-of-pocket expenses for Medicare-eligible military families were about the same as for their civilian-sector counterparts (about \$4,200 in FY 2001). MTF utilization by

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<sup>5</sup> Readiness requirements that have no civilian analogue include deployments, readiness training, military-unique medical training, fitness for duty evaluations, flight and diving medicine, etc. The government incurs substantial cost to meet these requirements, but it has proven very difficult to quantify the cost.

Medicare-eligible military families was small and therefore had a negligible impact on their out-of-pocket expenses. These results suggest that Medicare-eligible military families will likely save at least \$4,000 under the new TRICARE for Life benefit. Because civilian-sector drug costs continue to rise while TRICARE Senior pharmacy copayments remain minimal, their savings will likely increase in FY 2002 and beyond.

## Overall Conclusions

In general, satisfaction with access to care under TRICARE lags that estimated for commercial plans serving the general population. We estimate that DoD beneficiaries would have greater satisfaction with access had they been in those civilian plans. In addition, DoD beneficiary satisfaction with access generally fell from FY 2000 to FY 2001.

Despite lagging commercial civilian plans, TRICARE has shown improvement from FY 2000 to FY 2001, as evidenced by increased satisfaction with:

- one's health plan (all sources of care),
- overall quality of care (Prime enrollees),
- communication with doctors,
- courtesy and respect shown by office staff,
- customer service, and
- claims processing.

In addition, quality-of-care standards have mostly been maintained under TRICARE. Most of the quantifiable *Healthy People 2010* goals examined were met, or nearly met, for the DoD health care beneficiary population as a whole.

Total government costs continue to rise because of benefit enhancements and rising prescription drug utilization (even without the TRICARE Senior Pharmacy benefit). However, the government has been successful in controlling the average cost per MHS-reliant beneficiary, which increased by only 2 percent (inflation-adjusted) from FY 1999 to FY 2001. This implies that most of the increase in total government costs is attributable to seniors and to an increase in the number of enrolled beneficiaries,<sup>6</sup> whose consumption of health care resources is much greater than nonenrolled beneficiaries.

The average cost per MHS-reliant beneficiary is considerably higher under TRICARE than in the commercial sector. Reasons for the difference include a more generous benefit under TRICARE, greater MHS management overhead, and the MHS's readiness mission. However, commercial-sector costs have been increasing at a steady rate while benefits have been eroding.

Beneficiaries continue to save under TRICARE as more of the cost of health services has shifted to the government. Compared to their counterparts in the civilian-sector, they receive a more generous benefit at lower cost.

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<sup>6</sup> The number of enrolled non-active-duty beneficiaries increased by about 15 percent from FY 1999 to FY 2001.

# 1. INTRODUCTION

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The 104th Congress, through enactment of the National Defense Authorization Act (NDAA) for fiscal year (FY) 1996, Section 717, directed the Secretary of Defense to arrange for an ongoing, independent evaluation of the TRICARE program. The legislation requires that the evaluation assess the effectiveness of the TRICARE program in meeting the following objectives:

- improve the access to and quality of health care received by eligible beneficiaries,
- keep both government and beneficiary costs at levels the same as or lower than before TRICARE was implemented, and
- identify noncatchment areas in which the health maintenance organization (HMO) option of the program (i.e., TRICARE Prime) is available or proposed to become available.

Because the FY 1998 Report to Congress and others extensively addressed the issue of extending the Prime option to noncatchment areas,<sup>1</sup> we did not re-evaluate that issue this year.

The legislation further states that the Secretary may use a Federally Funded Research and Development Center to conduct the evaluation. The Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) selected the CNA Corporation and the Institute for Defense Analyses (IDA) to conduct the evaluation.

All previous TRICARE evaluations have taken the approach of comparing TRICARE in the evaluation year with the traditional benefit of direct care and CHAMPUS in FY 1994 adjusted for known, measurable changes that would likely have occurred even in the absence of TRICARE. The FY 1994 baseline has served its purpose but is now too far removed from present-day TRICARE experience to continue serving as a useful benchmark. Significant changes have occurred since 1994 in business and medical practices and in technological innovation. Some of these changes would likely have occurred with or without TRICARE, making a “before and after” comparison of TRICARE with the traditional health care benefit difficult to interpret.

In this year’s evaluation, we change our focus from a “before and after” comparison to a look at trends in utilization and costs from FY 1999 to FY 2001. We evaluate the nationwide trends under TRICARE, i.e., for all eleven Health Service Regions (HSRs) combined—1 (Northeast), 2 (Mid-Atlantic), 3 (Southeast), 4 (Gulf South), 5 (Heartland), 6 (Southwest), 7/8 (TRICARE Central), 9 (Southern California), 10 (Golden Gate), 11 (Northwest), and 12 (Hawaii). We do not evaluate TRICARE in Alaska or any of the overseas programs. The trends begin in FY 1999 because that is the first year in which all 11 Health Service Regions were operational for at least one full year. Starting with the

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<sup>1</sup> A catchment area is an approximately 40-mile-radius region around a military hospital, allowing for natural geographic boundaries and transportation accessibility. Noncatchment areas lie outside catchment area boundaries.

FY 2000 Report to Congress, the evaluation of access and quality has included some comparisons with civilian-sector benchmarks. In the FY 2002 evaluation, we include civilian benchmarks for utilization and costs as well.

This report continues in the next chapter with some background information about the TRICARE program, including descriptions of new benefits and enhancements that have occurred in FY 2001-02. That section is followed by the findings regarding the impact of TRICARE on beneficiary access to health care and on the quality of health care. Then come the findings regarding government and beneficiary costs, respectively. The main text presents the evaluation results for all TRICARE regions combined; the appendices present additional details by region.

## 2. BACKGROUND

TRICARE is the DoD's regionally-based managed-care program for delivering health care to eligible members of the Uniformed Services and their families, survivors, and retired members and their families. Congress has mandated that the program be modeled on HMO plans offered in the private sector and other similar government health-insurance programs. In addition, beneficiaries enrolled in the HMO-like option (the network option) are to have reduced out-of-pocket costs and a uniform benefit structure. Congress further directed that the TRICARE program be administered so that the costs incurred by the DoD are no greater than the costs that would otherwise have been incurred under the traditional benefit of direct care and CHAMPUS.

The program offers three choices. TRICARE-eligible beneficiaries can:

- receive care from TRICARE-authorized civilian providers under "TRICARE Standard" (same as standard CHAMPUS),
- use a network of authorized civilian contract providers on a case-by-case basis under "TRICARE Extra," or
- enroll in a network option called "TRICARE Prime."

TRICARE is administered on a regional basis. Excluding overseas programs, the country is divided into 11 geographical regions, as shown in Figure 2-1, and a Military Treatment Facility (MTF) commander in each region is designated as Lead Agent. The Lead Agents are responsible for coordinating care within their regions. They ensure the appropriate referral of patients between the direct-care system and civilian providers and have oversight responsibility for delivering care to both active-duty and non-active-duty beneficiaries.

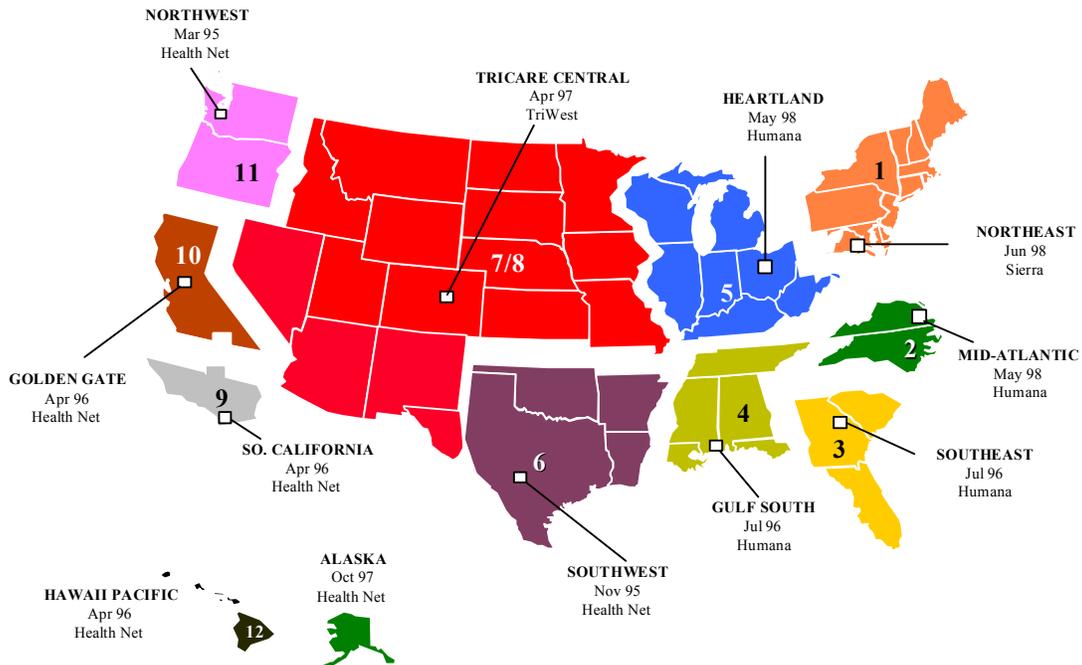


Figure 2-1. TRICARE Health Service Regions, Lead Agents, and Contractors

Because of the size and complexity of the program, the DoD phased in the implementation of TRICARE region-by-region over approximately a 3-year period. Health care is arranged under Managed Care Support (MCS) contracts that supplement the care provided in MTFs. Table 2-1 shows the MCS health care delivery start dates and the number of beneficiaries enrolled under active contracts, by region, as of April 2002.

**Table 2-1. TRICARE Enrollment Status (April 2002)**

TRICARE Region	Prime Start Date	Beneficiary Population	Prime Enrollment		
			Active Duty	Active-duty Family Members	Retirees and Family Members
1. Northeast	Jun 98	1,137,522	145,970	189,926	167,510
2. Mid-Atlantic	May 98	898,618	136,186	227,039	89,580
3. Southeast	Jul 96	1,096,918	122,036	194,413	180,856
4. Gulf South	Jul 96	633,922	57,474	105,431	97,772
5. Heartland	May 98	719,573	65,162	112,187	76,428
6. Southwest	Nov 95	1,017,275	125,897	208,545	186,423
7/8. Central	Apr 97	1,139,886	143,539	212,566	165,041
9. Southern California	Apr 96	623,089	101,086	143,888	82,391
10. Golden Gate	Apr 96	271,550	21,545	38,952	42,736
11. Northwest	Mar 95	387,239	42,700	80,468	75,979
12. Pacific (HI/AK)	Apr 96 <sup>a</sup>	214,361	48,327	79,898	23,317
13. Europe	Oct 96	259,189	110,946	124,886	6,297
14. Western Pacific	Oct 96	167,924	91,387	57,850	1,546
15. Latin America	Oct 96	45,102	6,251	11,740	21
Worldwide		8,612,168	1,218,506	1,787,789	1,195,897

Note: Eligible beneficiary population as of 1 February 2002 from the MHS Management Analysis and Reporting Tool (M2): the Defense Enrollment Eligibility Reporting System (DEERS) population summary file. Enrollment figures as of April 2002 from TRICARE Operation Center Enrollment Report: M2-EBC DEERS summary and detail files.

<sup>a</sup> Prime start date for Alaska was October 1997.

## 2.1 The Three TRICARE Options

TRICARE offers beneficiaries three options—Standard, Extra, and Prime. The following subsections provide descriptions of each option. Table 2-2 shows the cost-sharing features of the three options.

### 2.1.1 Standard

TRICARE Standard is the name for the health care option formerly known as CHAMPUS (a DoD-administered indemnity plan). All persons eligible for military health care, except active-duty members and most Medicare-eligible beneficiaries, can use TRICARE Standard. No enrollment is required. Under this option, eligible beneficiaries can choose any TRICARE-authorized physician they want for health care, and the government will pay a percentage of the cost. Some eligible beneficiaries may occasionally have to pay for their health care first and then apply for reimbursement.

For active-duty families, TRICARE Standard pays 80 percent of the CHAMPUS Maximum Allowable Charge (CMAC) for outpatient health care after the annual

deductible has been met. For retirees and their families, TRICARE Standard pays 75 percent of the CMAC.

Active-duty family members pay \$11.90 per day at civilian hospitals. Retiree families pay considerably more: \$414 per day or 25 percent of the charges, whichever is less. Also, retiree families must pay 25 percent of the cost for any separately billed physician and professional fees, which can amount to an additional, several hundred dollars per day.

Beneficiaries can seek care from a military hospital or clinic before receiving care from civilian sources (beneficiaries residing in a catchment area *must* first seek care from a military hospital for inpatient care and for selected outpatient procedures). Beneficiaries receiving health care services, including pharmacy benefits at the MTF incur no or nominal costs. However, TRICARE Prime enrollees receive first priority for care in MTFs.

### **2.1.2 Extra**

Military health care beneficiaries, except active-duty and most Medicare eligibles, can use a network of authorized contracted providers under TRICARE Extra. Like TRICARE Standard, no enrollment is required for TRICARE Extra. Beneficiaries simply use the network providers, who have agreed to charge a discounted rate for medical treatment and procedures. The rates are discounted from the CMACs, as agreed upon with the MCS contractor.

As with TRICARE Standard, the government shares the costs of health care. For using this network of authorized contracted providers, the government pays an additional 5 percent of outpatient costs incurred. This saving applies equally to active-duty families and retirees, raising the government's cost shares to 85 percent and 80 percent, respectively. Health-care providers participating in the Extra network also agree to use the allowable rate schedule (based on a discount from the CMAC rates), so the beneficiaries do not incur any additional charges.

Another advantage of TRICARE Extra is that authorized contracted providers will file claims for the patient. The authorized contracted provider is paid directly by the MCS contractor, requiring the patient to pay only the cost share at time of treatment.

Beneficiaries can also use a combination of health care professionals—some who are part of the Extra network and others who are not. Because there is no formal enrollment in either TRICARE Standard or TRICARE Extra, beneficiaries are free to switch back and forth among providers as they prefer. Beneficiaries can continue to seek care from a military hospital or clinic on a space-available basis. They can also seek care from civilian sources subject to the same restrictions for beneficiaries residing in catchment areas.

**Table 2-2. TRICARE Cost-Sharing Features**

	TRICARE Prime	TRICARE Extra	TRICARE Standard
<b>Choice of civilian doctors, hospitals, clinics</b>	Must choose from government-approved network	Can choose from government-approved network for lower cost	Unlimited
<b>Annual enrollment fees</b>			
All active duty <sup>a</sup>	None	None	None
Retirees	Individual: \$230 Family: \$460	None	None
<b>Annual outpatient deductibles</b>			
E-4 and below <sup>a</sup>	None	Individual: \$50 Family: \$100	Individual: \$50 Family: \$100
All other active duty <sup>a</sup>	None	Individual: \$150 Family: \$300	Individual: \$150 Family: \$300
Retirees	None	Individual: \$150 Family: \$300	Individual: \$150 Family: \$300
<b>Catastrophic cap</b>			
All active duty <sup>a</sup>	\$1,000	\$1,000	\$1,000
Retirees	\$3,000	\$3,000	\$3,000
<b>Copayments for visit to civilian doctor</b>			
E-4 and below <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
All other active duty <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
Retirees	\$12	20 percent <sup>b</sup>	25 percent <sup>c</sup>
<b>Prescription drugs (retail network)<sup>d</sup></b>			
Generic	\$3 for up to a 30-day supply	\$3 for up to a 30-day supply	\$3 for up to a 30-day supply
Brand name	\$9 for up to a 30-day supply	\$9 for up to a 30-day supply	\$9 for up to a 30-day supply
<b>Mail order pharmacy</b>			
Generic	\$3 for up to a 90-day supply	\$3 for up to a 90-day supply	\$3 for up to a 90-day supply
Brand name	\$9 for up to a 90-day supply	\$9 for up to a 90-day supply	\$9 for up to a 90-day supply

**Table 2-2 (Continued)**

	TRICARE Prime	TRICARE Extra	TRICARE Standard
<b>Copayments at civilian hospitals for inpatient care</b>			
All active duty <sup>a</sup>	\$0	Greater of \$25 or \$11.90 per day; for mental health, \$20.00 per day.	Greater of \$25 or \$11.90 per day; for mental health, \$20.00 per day.
Retirees	\$11 per day (\$25 minimum per stay); \$40 per day for mental health	Lesser of \$250 per day or 25 percent of hospital charges, plus 20 percent of professional fees; for mental health, 20 percent of all charges <sup>b</sup>	Lesser of \$414 per day or 25 percent of hospital charges, plus 25 percent of professional fees; for mental health, lesser of \$154 per day or 25 percent of all charges <sup>c</sup>
<b>Ambulance service</b>			
E-4 and below <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
All other active duty <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
Retirees	\$20	20 percent <sup>b</sup>	25 percent <sup>c</sup>
<b>Ambulatory surgery</b>			
All active duty <sup>a</sup>	\$0	\$25	\$25
Retirees	\$25	20 percent <sup>b</sup>	25 percent <sup>c</sup>
<b>Medical equipment patient takes home</b>			
E-4 and below <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
All other active duty <sup>a</sup>	\$0	15 percent <sup>b</sup>	20 percent <sup>c</sup>
Retirees	20 percent <sup>b</sup>	20 percent <sup>b</sup>	25 percent <sup>c</sup>

Source: Adapted from *TRICARE Special: A User's Guide*, Special Section in *Army Times*, *Navy Times*, *Air Force Times*, March 4, 2002; Summary of TRICARE Prime Cost Sharing at [www.tricare.osd.mil/beneficiary/tricarecost.htm](http://www.tricare.osd.mil/beneficiary/tricarecost.htm) and TRICARE Handbook (January 2002).

<sup>a</sup> Figures in the table apply to active-duty family members only.

<sup>b</sup> Percentages are applied to the negotiated amount, which is less than the CMAC.

<sup>c</sup> Percentages are applied to the CMAC. In addition, for non-authorized contracted providers, beneficiaries pay the excess above the CMAC; however, providers are forbidden by law from charging more than 115 percent of the CMAC.

<sup>d</sup> Non-network pharmacy cost sharing is the greater of \$9 or 20 percent of the total cost. Existing deductibles and point-of-service penalties apply.

### **2.1.3 Prime**

All active-duty military personnel are required to enroll in TRICARE Prime. All other persons eligible for military health care, except Medicare-eligibles, can enroll in TRICARE Prime where available. Enrollment is open at all times and is not restricted to any “open season”.<sup>2</sup> There are also no restrictions on enrollment based on pre-existing medical conditions.

Each enrollee chooses or is assigned a Primary Care Manager (PCM). The PCM is a health-care professional or medical team that patients see first for their health-care needs. PCMs are supported by military and civilian medical specialists to whom patients are referred if they need specialty care. Referrals are facilitated by a Health Care Finder (HCF), a contractor employee who coordinates with the PCM to help beneficiaries find specialty care in the civilian community when the needs of the patient cannot be met by the MTF (HCF services are available to all beneficiaries, not just those enrolled in Prime). Depending on the enrollees’ status, the locale, and the availability of medical professionals, they can either select a PCM at a nearby military hospital or clinic or request a civilian professional who is a member of the contracted Prime network in a nearby community. In some cases, the MTF Commander may either direct patients to a military PCM if there is unused capacity at an MTF or assign them a civilian PCM if MTF capacity is exceeded.<sup>3</sup>

All beneficiaries enrolled in TRICARE Prime are guaranteed access to care according to strict time standards. Emergency services are available within the Prime service area 24 hours per day, 7 days per week. Primary care should be available within a 30-minute drive from the beneficiary’s home. The maximum waiting times for primary-care appointments are 1 day for acute care; 1 week for routine, non-urgent care; and 4 weeks for health maintenance and preventive care. Specialty care should be available within a 1-hour drive from home, and the maximum waiting time for specialty-care appointments is 4 weeks.

Individual retirees and their family members pay \$230 per year to enroll in Prime, with a maximum fee of \$460 per family. Enrolled active-duty family members make no copayments while retirees and their families make nominal copayments. Prime enrollees are not required to meet a deductible. TRICARE Prime covers a variety of preventive and wellness services. All clinical preventive services are free under Prime, whether performed at an MTF or at a network facility. Examples of such services include eye examinations, immunizations, hearing tests, mammograms, Pap smears, prostate examinations, and other cancer-prevention and early-diagnosis examinations.

Non-active-duty Prime enrollees can seek care from non-network providers through a point-of-service (POS) option, but they must pay a substantial penalty in the form of an even higher cost share than under TRICARE Standard.

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<sup>2</sup> The effective month of enrollment depends on whether the application is received by the 20th of the month.

<sup>3</sup> Throughout this report, the term “military PCM” refers to a provider at a military facility, regardless of whether the provider is in the uniformed services or a civilian. Similarly, the term “civilian PCM” refers to a provider at a network facility.

### **2.1.4 Overseas Programs**

TRICARE overseas programs have been implemented in Europe, the Western Pacific, Alaska, and Latin America under agreements with individual providers rather than through at-risk contractors. On October 1, 1999, the TRICARE Prime option was extended to Puerto Rico as well. TRICARE overseas offers two options: Prime and Standard. The Prime option is currently open to all active-duty personnel and family members who choose to enroll. The Prime benefit is the same as in the United States, except that the copayment is waived (except in Alaska) for family members who must obtain care from host-nation sources.

## **2.2 New Benefits and Programs**

With the passage of the FY 2001 NDAA, Congress created two striking new benefits for Medicare-eligible uniformed services retirees, their spouses, and survivors who are age 65 and over. These new benefits are referred to as:

- TRICARE Senior Pharmacy, and
- TRICARE for Life.

In addition, selected MTFs introduced a primary care access program for seniors called TRICARE Plus. Brief descriptions of these programs follow.

### **2.2.1 TRICARE Senior Pharmacy**

Section 711 of the FY 2001 NDAA established a pharmacy benefit for seniors referred to as the TRICARE Senior Pharmacy (TSRx) program. To be eligible for this benefit, beneficiaries must be eligible for Medicare Part A and enrolled in Medicare Part B.<sup>4</sup> The only additional requirement is that beneficiaries be registered in the Defense Enrollment Eligibility Reporting System (DEERS).

On April 1, 2001, eligible beneficiaries began receiving pharmacy benefits including access to MTF pharmacies, the National Mail Order Pharmacy (NMOP) program, and TRICARE network and non-network civilian pharmacies. Retirees can still obtain prescription drugs at military pharmacies without having to pay a copayment. The NMOP offers generic drugs for \$3.00 and brand name drugs for \$9.00 for a 90-day supply. Beneficiary copayments for drugs purchased in retail stores in the TRICARE network are the same but are limited to a 30-day supply. The TSRx program extends pharmacy benefits to over 1.5 million Medicare-eligible beneficiaries, including retirees formerly covered under the Base Realignment and Closure pharmacy benefit and the Pharmacy Redesign Pilot Program. From 1 October 2001 through 15 April 2002, 8.2 million prescriptions were processed through the TRICARE retail pharmacy networks, and the NMOP program provided over \$415 million in prescription benefits for the age 65 and over beneficiary population.

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<sup>4</sup> Beneficiaries who turned 65 before April 1, 2002 are not required to have Medicare Part B to participate in the TRICARE Senior Pharmacy benefit.

### 2.2.2 TRICARE for Life

Section 712 of the FY 2001 NDAA established Medicare wraparound coverage for senior beneficiaries. To be eligible for this benefit, beneficiaries and family members must qualify for Medicare Part A, purchase Medicare Part B, and have up-to-date information in DEERS. This new program, called TRICARE for Life (TFL) began on 1 October 2001. From that date forward, TRICARE became second payer for eligible beneficiaries who receive care from Medicare providers. Beneficiaries eligible for TFL may still receive care at MTFs on a space-available basis.

Medicare pays its share of each claim and electronically forwards the remaining balance for secondary payment to TRICARE. Table 2-3 shows payment responsibilities for beneficiaries and the Medicare and TFL programs.

**Table 2-3. TRICARE for Life Program Payment Matrix**

Type of Service	Medicare Payment	TRICARE Payment	Beneficiary Payment
Services covered by both Medicare and TRICARE	Medicare pays its authorized amount	TRICARE pays remaining out-of-pocket costs	Nothing
Services covered by Medicare and not TRICARE	Medicare pays its authorized amount	Nothing	Medicare copayments
Services covered by TRICARE and not MEDICARE	Nothing	TRICARE pays its authorized amount	TRICARE cost share and annual deductible up to \$3,000 catastrophic cap
Services not covered by Medicare or TRICARE	Nothing	Nothing	Responsible for all costs

For services covered by both TRICARE and Medicare, TRICARE pays the beneficiary's share of the cost (i.e., Medicare deductibles and copayments). For services covered only by Medicare, (such as chiropractic), TRICARE pays nothing and the beneficiary is responsible for Medicare cost shares. For services covered only by TRICARE (such as pharmacy and care overseas), Medicare pays nothing and the beneficiary is responsible for the TRICARE Standard cost shares.

If a beneficiary has other health insurance, TRICARE becomes the third payer. Between 1 October 2001 and 15 April 2002, TRICARE processed nearly 12 million TFL claims.

### 2.2.3 TRICARE Plus

TRICARE Plus is a new program that allows some beneficiaries to enroll for primary care services at selected MTFs. All beneficiaries eligible for care in military treatment facilities (except those enrolled in TRICARE Prime, a civilian HMO, or Medicare HMO) can seek enrollment for primary care services at MTFs where enrollment capacity exists. As such, TRICARE Plus is a military treatment facility primary care access program, not

a health plan. There is no lock-in and no enrollment fee. Further, nonenrollment in TRICARE Plus has no effect on TFL benefits or other existing programs.

Starting October 2001 and phasing in at selected MTFs, TRICARE Plus availability is based on local MTF capacity and is not guaranteed. Participants in TRICARE Senior Prime (Medicare Subvention Demonstration) and those who had a PCM at an MTF immediately preceding October 2001 were given priority for enrollment in TRICARE Plus.

Advantages to participating in the TRICARE Plus program include: primary care services located at the MTFs, enrollees not locked into a network option, no enrollment fees, and the same access standards as Prime for primary care. Disadvantages to the program include: available only at MTFs based on local capacity, no guarantee for access to specialty care in the MTF, no portability with other MTFs and continued enrollment not guaranteed since the program is based on MTF capacity.

## **2.3 Enhanced Benefits—FY 2001**

In addition to the TFL program, the FY 2001 NDAA produced several significant benefit enhancements. The major enhancements are:

- reduction of the catastrophic cap for non-active-duty families,
- elimination of copayments for active-duty family members enrolled in TRICARE Prime for care from a civilian provider after April 1, 2001,
- expansion of TRICARE Prime Remote (TPR) coverage, and
- reimbursement of travel expenses under certain conditions for non-active-duty Prime enrollees and TPR family members.

Other enhancements include benefits for congressional medal of honor recipients, the extension of medical and dental benefits to survivors, and school physicals. Brief descriptions of the major benefit enhancements follow.

### ***2.3.1 Reduction of Catastrophic Cap for Non-Active-Duty Families***

Under the FY 2001 NDAA, the catastrophic loss cap (i.e., the maximum amount families have to pay for TRICARE-covered medical expenses) was reduced from \$7,500 to \$3,000 for non-active duty families (i.e., retirees, their family members, and survivors). For nonenrolled beneficiaries, the cap applies to their liabilities for annual deductibles and copayments based on TRICARE Standard or Extra allowable charges for covered medical care received in any one fiscal year. Beneficiaries enrolled in Prime have an enrollment year catastrophic cap in addition to the catastrophic loss protection based on the fiscal year (each enrollment year begins on the Prime enrollment anniversary date). Prime enrollment fees accrue toward the catastrophic cap for the latter group of beneficiaries. The beneficiary is responsible for any charges, up to the legal limit, in excess of those TRICARE determines to be reasonable, or allowable, for covered care. The cap does not apply to charges for services that are not covered, to the yearly accumulation of what non-contracted providers of care may bill above the allowable charges for care received, or to services received under the POS option.

For active-duty families, the catastrophic cap remains at \$1,000 per fiscal and/or enrollment year, depending on whether the beneficiaries use Standard/Extra or are enrolled in Prime.

### **2.3.2 Elimination of Enrolled Active-Duty Family Member Copayments**

The FY 2001 NDAA contains a provision for the elimination of copayments for active-duty family members enrolled in TRICARE Prime. As of April 2001, active-duty family members enrolled in TRICARE Prime no longer have to make copayments for the care they receive from civilian network providers. Prior to this date, family members of active-duty members in paygrades E-1 to E-4 and paygrades E-5 and above paid \$6 and \$12, respectively, for such visits. In addition, family members no longer have to pay the \$11 per day civilian inpatient charge or the \$11.45 per day MTF inpatient charge.

Active-duty family members still have to make copayments for the NMOP program and at network pharmacies, but these charges are nominal. To avoid copayments for care received from civilian network providers, Prime enrollees must obtain authorization from their PCM before seeking care from civilian providers. While they retain the right to seek civilian care without authorization from their PCM, Prime enrollees are then responsible for POS charges.

### **2.3.3 Expansion of TRICARE Prime Remote Coverage**

Section 731 of the FY 1998 National Defense Authorization Act directs the DoD to provide TRICARE Prime-like benefits to active-duty members nationwide who work and live more than one hour's drive from a military hospital or clinic.

In 1998, DoD issued a policy that members who meet the distance criteria above are immediately eligible for TRICARE benefits (with no deductible or cost-shares). Concurrently, DoD initiated contract modifications with every TRICARE managed care support contractor to introduce a standardized benefit for active-duty members nationwide. This contract modification, known as the "TRICARE Prime Remote" program, began October 1, 1999. As of March 2002, there were 59,270 active-duty service members enrolled in the program, out of 59,340 eligible (99.8 percent). The 2001 NDAA expanded eligibility for the program to all Uniformed Services, hence allowing active-duty members in the U.S. Public Health Service and the National Oceanographic and Atmospheric Administration to enroll. The implementation date for the latter was August 1, 2001.

The TRICARE Prime Remote (TPR) program provides active-duty members with a TRICARE Prime-like benefit when stationed away from traditional sources of military health care. Where civilian network Prime service areas exist, active-duty members are enrolled to a civilian PCM. Where there are no Prime networks, active-duty members may use any TRICARE authorized provider in the local community. No pre-authorization is required for primary care. A joint service office, known as the Military Medical Support Office (MMSO), provides the medical readiness reviews and fitness for duty oversight for specialty health care delivered by civilian providers. MMSO, based at Great Lakes Naval Station, IL, provides 24-hour, 7 day per week coverage. The managed care support contractors provide enrollment services, Health Care Finder support, and claims

processing functions for service personnel enrolled in TPR. Active-duty members bear no costs for obtaining health care from civilian sources.

The 1998 law did not require, and the current contract modification does not include, the extension of “TRICARE Prime-like benefits” to family members who accompany their active-duty sponsors to remote duty locations. A separate provision of the law (Section 712) required the DoD to study alternatives to extending the Prime-like benefit to family members who accompany the active-duty member to remote sites. In August, 1999, the ASD(HA) submitted a report to Congress outlining TPR’s actions to date and providing the cost estimate for extending TRICARE Prime copayments to remote family members. A provision to extend TPR coverage to active-duty family members was included in the 2001 NDAA (Section 722), and is scheduled for implementation in September 2002. Eligibility is restricted to active-duty family members residing with their TPR-eligible active-duty sponsors. In the interim, since October 30, 2000, active-duty families remain eligible for TRICARE Standard with a provision of the law providing authority to waive TRICARE deductibles, cost shares, and copayments for family members eligible for the TRICARE Prime Remote for Active Duty Family Members program until the program with enrollment is fully implemented.

### **2.3.4 Prime Travel Benefit**

The FY2001 NDAA provides for the reimbursement of reasonable travel expenses for non-active-duty Prime enrollees and TPR family members when referred for medically-necessary specialty care more than 100 miles from the location of their PCM. Prime beneficiaries may be reimbursed for their actual expenses pertaining to transportation, lodging, meals and incidentals. This benefit does not apply to expenses incurred by active-duty service members, active-duty family members residing with their sponsors overseas, or travel costs of beneficiaries referred under DoD Specialized Treatment Services/Centers of Excellence programs, which are reimbursed by other travel entitlements.

## **2.4 Enhanced Benefits—FY 2002**

Selected improvements to the TRICARE program in FY 2002 NDAA include enhanced benefit coverage for prosthetic devices, durable medical equipment, rehabilitative therapy, and hearing aids for active-duty family members and improved health care services and access for active-duty members whose dependents have extraordinary medical conditions. Other provisions include improvements in the home health care and skilled nursing facility benefits, clarification regarding travel reimbursement for families in Prime and the waiver of non-availability statements for maternity care. Additional details on travel reimbursement and maternity care are summarized below.

### **2.4.1 Non-Medical Attendant Reimbursement**

The FY 2002 NDAA authorizes one parent, guardian or another adult family member (age 21 years or older) to travel with a non-active duty Prime enrolled patient as a non-medical attendant. To be eligible for reimbursement, the patient must travel more than 100 miles from their primary care manager’s location to referred specialty care. Non-

medical attendant reimbursement was implemented on April 1, 2002, retroactive to December 28, 2001.

### **2.4.2 Maternity Care**

Currently, TRICARE generally requires, except for emergencies, maternity patients who live in an MTF's catchment area and who are not enrolled in TRICARE Prime, to get all of their maternity care (both inpatient and outpatient) from that MTF. If the MTF cannot provide the needed maternity care, it will issue a non-availability statement (NAS) to the patient, who may then seek care from a civilian source. The FY 2002 NDAA authorizes nonenrolled women to access childbirth services at civilian hospitals without the need for a NAS. This feature will be implemented when the new TRICARE contracts take effect, or by the end of FY 2003, whichever comes first.

## **2.5 Supplemental Programs**

Beginning in FY 1999, the DoD implemented several new programs that could affect the interpretation of TRICARE utilization and cost trends. The programs are:

- TRICARE Senior (Medicare subvention) demonstration,
- TRICARE Senior Supplement demonstration,
- TRICARE Dental Program, and
- Federal Employees Health Benefits Program demonstration.

Brief descriptions of each program follow.

### **2.5.1. Medicare Subvention Demonstration**

In February 1998, the Department of Health and Human Services (DHHS), the Health Care Financing Administration (now called the Centers for Medicare and Medicaid Services), and the DoD completed a Memorandum of Agreement to conduct a demonstration, or test project, under which the DHHS would reimburse the DoD from the Medicare Trust Fund for certain health care services provided to Medicare-eligible military (dual-eligible) beneficiaries enrolled in the Medicare Subvention demonstration. The program, called TRICARE Senior Prime (TSP), was authorized by Section 1896 of the Social Security Act, amended by Section 4015 of the Balanced Budget Act of 1997 (Public Law 105-33) and amended a second time by the Balanced Budget Refinement Act of 1999. The demonstration was ultimately designed to test the feasibility of establishing Medicare managed-care plans within the DoD TRICARE program for dual-eligible beneficiaries. These TSP plans were expected to expand access to military health care services, enhance the quality of health care delivery, and maintain budget neutrality. The statute authorized the DoD and the DHHS to conduct a 3-year Medicare Subvention Demonstration, which was later extended for an additional year. The demonstration ended December 31, 2001 and was replaced by the new TRICARE for Life benefit.

Under Medicare subvention, the DoD, for the first time, was able to enroll its Medicare-eligible retirees into the TRICARE program (as a TSP beneficiary), and receive Medicare reimbursement. The Secretary of Defense and the Secretary of Health and Human Services selected six demonstration sites, encompassing ten MTFs, to test this

TRICARE initiative in 1998. Table 2-3 shows the health care delivery start dates, the number of eligible beneficiaries enrolled by open enrollment and “aging-in” to the program, and MTF capacity for this program by region.

**Table 2-4. TRICARE Senior Prime Status ( December 2001)**

Region/ Demonstration Site	Eligible Population <sup>a</sup>	Start Date	Enrollment			
			Open	Open and Age-In	TSP Capacity at Facility	Open as Percentage of Capacity <sup>b</sup>
1. Dover AFB	3,905	1/1/99	994	1,154	1,500	66.3%
4. Keesler AFB	7,361	12/1/98	2,814	3,704	3,100	90.8
6. Brooke Army Medical Center/ Wilford Hall Medical Center	34,148	10/1/98	9,795	13,198	10,000	98.0
Texoma (Sheppard AFB/Fort Sill)	7,067	12/1/98	2,138	2,710	2,700	79.2
7/8.Ft. Carson/Air Force Academy/Peterson AFB	13,689	1/1/99	3,132	4,470	3,200	97.9
9. Naval Medical Center, San Diego	35,619	11/1/98	3,923	5,093	4,000	98.1
11. Madigan Army Medical Center	21,709	9/1/98	3,261	5,052	3,300	98.8

<sup>a</sup> Beneficiary counts reflect total number of open eligibles as of second quarter, FY 1998.

<sup>b</sup> The number of enrolled TSP members may exceed TSP capacity, as “age-in” does not count towards TSP capacity.

The MTFs participating in the demonstration were required to apply and be approved as Medicare+Choice organizations. Military retirees enrolling in the demonstration must have received some care from military providers in the past or have become Medicare-eligible after December 31, 1997. TSP enrollees had to be age 65 or older, live within the geographic service area, be a dual-eligible beneficiary eligible for care in the MTF, and eligible for Medicare on the basis of age. Also, enrollees had to have Medicare Part A and B coverage, continue to pay monthly Medicare Part B premiums, and agree to have all their care provided by or coordinated through their PCM. The TRICARE Prime enrollment fee did not apply to beneficiaries enrolled in TRICARE Senior Prime.

Health care delivery under TRICARE Senior began on September 1, 1998 at Madigan Army Medical Center. All six demonstration sites had begun health care delivery as of January 1, 1999. Because this program was available at only a few sites with small enrollment and terminated December 31, 2001, its impact on this year’s evaluation should be minimal. The more than 35,000 individuals that remained enrolled in TSP through December 31, 2001 were rolled over to the TRICARE Plus program effective January 1, 2002.

### **2.5.2 TRICARE Senior Supplement Demonstration**

The DoD implemented the TRICARE Senior Supplement Demonstration Program in the Santa Clara County area in California and the Cherokee County area in Texas. The purpose of the demonstration was to facilitate DoD payments on behalf of Military Health System (MHS) beneficiaries receiving Medicare benefits while enrolled in the

TRICARE Program as a supplement to Medicare. The Supplement Demonstration, which offered enrolled members benefits similar to TRICARE Extra and Standard, served as secondary payer for Medicare coverage, reducing or eliminating most out-of-pocket expenses, and providing reimbursement for some services not covered by the Medicare program. Benefits of enrollment included access to the National Mail Order Pharmacy, use of TRICARE civilian network pharmacies, coverage for certain diagnostic and preventive services, extended mental health coverage, and coverage for health care services delivered outside the continental United States.

To be eligible for the program, an enrollee had to be a retired member of the Uniformed Services, a family member of a retired member of the Uniformed Services, or a survivor of a member of the Uniformed Services who died while on active duty for a period of more than 30 days. The enrollee also had to be age 65 or older, eligible for Medicare Part A (Hospital Insurance), enrolled in Medicare Part B (Supplemental Medical Insurance), and reside in one of the demonstration sites. While enrolled in the demonstration, enrollees may not receive health care, including pharmacy services, in military hospitals or clinics. Each eligible beneficiary who enrolled in the TRICARE Program under the TRICARE Senior Supplement Demonstration Program paid an annual enrollment fee of \$576.

The continuous open enrollment period began on March 1, 2000 and was initially scheduled to end on December 31, 2002. The passage of the new TRICARE for Life health care and pharmacy benefits in the FY 2001 NDAA replaced the TRICARE Senior Supplement Demonstration project effective October 1, 2001. Medicare-eligible military retirees became eligible for all TRICARE health care benefits at that time. On April 1, 2001, individuals who are enrolled in the TRICARE Senior Supplement Demonstration project received the same prescription benefit as those individuals who are using the TRICARE Senior Pharmacy program with one exception. TRICARE Senior Supplement Demonstration enrollees were prohibited from using pharmacy services at the MTFs during the demonstration program.

### **2.5.3 TRICARE Dental Program**

The TRICARE Dental Program (TDP), awarded to United Concordia Companies, Inc. in April 2000, was implemented on February 1, 2001. The TDP replaces the TRICARE Family Member Dental Plan (TFMDP) and the TRICARE Selected Reserve Dental Program (TSRDP); the TRICARE Retiree Dental Program remains a separate program. Active-duty personnel are not eligible for the TDP; they receive dental care from military dental treatment facilities.

Active-duty family members together with Selected Reserve (SELRES) and Individual Ready Reserve (IRR) sponsors and/or their families may enroll in the TDP. Sponsors must have at least 12 months remaining on their service commitments at the time they or their families enroll. The 12-month enrollment commitment is waived for families of Reservists called to active duty for certain contingency operations. Reservists who are ordered to active duty for a period of more than thirty consecutive days have the same benefits as active-duty service members.

Monthly premium rates (as of February 1, 2002) for active-duty family members, SELRES or IRR (special mobilization category) sponsors and/or family members on

active duty orders for greater than thirty consecutive days are \$7.90 for single enrollment and \$19.74 for family enrollment. Family members of SELRES or IRR (special mobilization category) sponsors with thirty days or less of active orders and IRR (other than Special Mobilization Category) and their family members pay a monthly rate of \$19.75 for a single enrollment and \$49.36 for family enrollment.

The 5-year TDP contract contains many enhancements to the TFMDP. The lock-in period for enrollment has decreased to 12 months and incorporates a contingency lock-in waiver for reservists called up to active duty with less than 12 months remaining. It increases the annual maximum benefit coverage to \$1,200 and the lifetime maximum for orthodontic care to \$1,500. It also decreases cost shares for some procedures for junior enlisted personnel (paygrade E-1 to E-4). Enrollment in the TDP is voluntary and portable worldwide. The contractor handles all enrollments and directly bills enrollees for premiums in the absence of a payroll account. The TDP is a comprehensive benefit package that builds on the TFMDP benefit package. Some of the additions to the TDP benefit package include general anesthesia, intravenous sedation, occlusal guards, athletic mouthpieces, an additional oral evaluation per year, pulp vitality tests, sealants to age 19, and orthodontic coverage for children to age 21 (23 if enrolled in college). The TDP offers sponsors the opportunity to enroll children at age 1 and strongly encourages diagnostic and preventive dental care for children prior to the mandatory enrollment age of 4 years old.

The TDP emphasizes through positive contract incentives, diagnostic and preventive care, the advancement of pediatric and adolescent oral health and increased utilization by beneficiaries. The TDP contains many of the features of the former TFMDP, but it also integrates the principal themes of increasing both enrollment and utilization while encouraging early preventive dental care for the good of the beneficiaries' overall health.

#### ***2.5.4 Federal Employees Health Benefits Program Demonstration***

The DoD and the Office of Personnel Management (OPM), in accordance with the National Defense Authorization Act for FY 1999, developed a demonstration program that allows some MHS beneficiaries to enroll with the Federal Employees Health Benefits Program (FEHBP) for their health care. Approximately 130,000 beneficiaries are eligible to participate in this program. The demonstration gives the DoD an opportunity to collect valuable information about the cost and feasibility of alternative approaches to improving the access to health care for those beneficiaries. Benefit coverage began in January 2000 and ends in December 2002.

The DoD initially selected the following eight sites for the FEHBP demonstration:

- Dover Air Force Base, Delaware;
- Commonwealth of Puerto Rico;
- Fort Knox, Kentucky;
- Greensboro/Winston-Salem/High Point, North Carolina;
- Dallas, Texas;
- Humboldt County, California area;
- Naval Hospital, Camp Pendleton, California; and
- New Orleans, Louisiana.

In 2001, DoD and OPM expanded the FEHBP demonstration to areas surrounding Coffee County, Georgia and Adair County, Iowa. The new sites in the South include parts of Georgia, Florida and South Carolina. The Midwest locations include the entire state of Iowa (except within the Offutt Air Force Base catchment area), parts of Minnesota, South Dakota, Nebraska, Kansas and Missouri. Benefit coverage for new participants began in January 2001 and ends in December 2002.

Under the demonstration, eligible beneficiaries can join the FEHBP during the enrollment open season in November of each year. Eligible beneficiaries include retirees over the age of 65 who are Medicare-eligible and their family members, former spouses of military members who have not remarried, and family members of deceased members or former members. Medicare eligibility is not required for the family members of retirees and the latter two groups.

Beneficiaries who enroll in an FEHBP plan must pay any applicable premiums to receive benefits. During the demonstration, enrollees cannot use MTF services, TRICARE network pharmacies, or the NMOP. Premiums are based on a separate risk pool for MHS beneficiaries. The government's contribution is computed the same as it is currently done under the FEHBP.

Enrollment in the FEHBP demonstration peaked at 7,500 (less than 6 percent of eligible beneficiaries). As of August 1, 2002, there were 3,456 beneficiaries remaining in the FEHBP demonstration.

## **2.6 Next Generation of TRICARE Contracts**

TRICARE currently has seven Managed Care Support Contracts that provide health care services to over eight million beneficiaries in 11 Health Service Regions. These contracts have reached the end of their planned existence; many are now operating under non-renewable extensions.

On August 1, 2002, the DoD released a request for proposals for the next generation of managed-care contracts. Under the new contracting structure, the United States will be divided into North, South and West regions. Health care delivery in each region will be covered under a separate contract. The new contracts aim to contain costs to the government and improve TRICARE services by adopting industry best practices, decreasing program complexity, increasing competition, and implementing acquisition reform.

The current regional TRICARE contracts call for the contractors to provide all aspects of health-care delivery, administrative services, pharmacy, marketing, and member education. Under the new contracting proposal, separate contracts will be let to handle health care delivery and administrative services, pharmacy services, beneficiary education and marketing, billing for Medicare-eligible beneficiaries, retiree dental care, and national quality monitoring. The separate contracts are intended to provide greater uniformity of services to beneficiaries across the country. The new contracts will be phased in over the next several years.

### **3. ACCESS TO AND QUALITY OF HEALTH CARE UNDER TRICARE**

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The FY 1998, 1999, 2000, and 2001 evaluations measured changes in the TRICARE regions from a FY 1994 pre-TRICARE baseline. In summary, the results of the earlier evaluations showed that under TRICARE:

- access improved and
- most quality-of-care goals were met or nearly met.

The approach taken in all four previous TRICARE evaluations was to compare access, quality, and costs under TRICARE with estimates of what those attributes would have been had the traditional benefit of direct care and CHAMPUS been continued. This approach arose out of our interpretation of the words “improving” and “increasing” to mean relative to the former military health care benefit. Our interpretation received explicit concurrence from the original OASD (HA) sponsor’s office and implicit concurrence from the subsequent TRICARE Management Activity (TMA) sponsor. Consequently, the baseline for all previous evaluations has been FY 1994, the last full year under the former health care system, adjusted for inflation, Base Realignment and Closure actions, and population shifts.

The Introduction provided a rationale for refocusing the evaluation from a “before and after” comparison to a look at trends in access, quality, and costs over the past few years and a comparison with civilian-sector benchmarks. We believe this approach is consistent with the language of the current congressional tasking.

#### **3.1 Methods and Data Sources**

##### **3.1.1 General Method**

In this year’s evaluation of TRICARE’s effects on the access to and quality of health care, we compare the DoD population with the general U.S. population, having commercial health plans (i.e., excludes Medicare and Medicaid), using health care system performance metrics from the National CAHPS<sup>5</sup> Benchmarking Database (NCBD). In addition, we examine several issues unique to the DoD population, such as intention to enroll and disenroll from TRICARE Prime, for which there is no external benchmark.

##### **3.1.2 Data Sources (DoD Surveys)**

The data come from two sources: (1) the 2000 and 2001 administrations of the Health Care Survey of DoD Beneficiaries and (2) the NCBD for the same time period. We use two consecutive years of data to gauge trends.

The focus of the DoD surveys, prior to 1998, was the perceived access to and quality of health care. The DoD surveys sampled representative cross-sections of all beneficiaries—

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<sup>5</sup> Consumer Assessment of Health Plans Survey.

regardless of whether they had used the health care system. This permits the possible identification of lack of access as the reason for not using the military health care system.

In 1998, the DoD decided to adopt alternative measures of satisfaction from the CAHPS. This was an effort to allow the comparison of the DoD population with civilians enrolled in commercial health care plans. The CAHPS is a standardized survey questionnaire used by civilian plans to monitor various aspects of access to and satisfaction with health care. It was developed by a consortium of the Harvard Medical School, RAND, and the Research Triangle Institute and sponsored by the Agency for Health Care Policy and Research. It has been tested in the field and evaluated for validity and reliability. The questions and reporting formats were tested to ensure that the answers can be compared across plans and demographic groups.

### **3.1.2.1 What CAHPS Is Designed To Do**

The philosophy behind CAHPS is to provide a tool to inform health care consumers about what other people think about their health plans. Such information would be useful for those choosing a health plan. CAHPS is structured to:

- focus on information that consumers want when choosing a plan and present this information in easily understood formats;
- address consumers' need for more detailed information by covering specific plan features, such as access to care and quality of patient/physician interaction;
- include questions that are targeted to persons with chronic conditions or disabilities, children, and Medicaid and Medicare beneficiaries;
- provide standardized questionnaires for assessing experience across different populations and care delivery systems; and
- improve the utility and value of the survey questions through a combination of cognitive and psychometric testing that enhances the reliability and thus the comparability of results across different plans and population groups.

The CAHPS survey goes beyond statements of overall satisfaction by measuring and reporting on consumer experience with specific aspects of their own health plans that are the basis of satisfaction. CAHPS survey questions are used to form six composites:

- getting needed care,
- getting care quickly,
- how well doctors communicate,
- courteous and helpful office staff,
- customer service, and
- claims processing.

Each composite contains two to five questions relating to experiences with receiving health care. Additionally, CAHPS asks respondents to use an 11-point scale, anchored with "worst" and "best," to rate their:

- personal physician,
- specialty care,

- health plan, and
- health care.

We use many of the CAHPS metrics to measure trends in satisfaction with access, quality of care, and the TRICARE health plan overall.

### **3.1.3 CAHPS Scoring Methodology**

CAHPS items used to form composites typically describe a situation, such as being able to make an appointment with fewer than three telephone calls. The response scale for such items includes the following alternatives: never, sometimes, most of the time, all of the time. Responses of “most of the time,” and “all of the time” are scored as 1, while other responses are scored as 0. Composites are then formed from the dichotomously-scored items as the average of the item averages.

#### **3.1.3.1 Case-Mix Adjustments**

When comparing health plans on the basis of the ratings by individuals covered by those plans, it is important to adjust the data for patient characteristics known to be related to systematic biases in the way people respond to survey questions. This is called case-mix adjustment. For example, if you know that people of a particular age group are reluctant to report problems and persons of that group are disproportionately enrolled in certain plans, it is desirable to account for that when comparing data among plans. However, it is important to recognize that differences in patterns of responses may reflect real differences in quality of care as well as systematic biases. There is no way to separate these two types of differences based purely on statistical analysis of satisfaction data. The most popular method for adjusting the data to account for such differences is regression. Health status and age are characteristics frequently found to be associated with patient reports about the quality of their medical care. People in worse health tend to report lower satisfaction and more problems with care than do people in better health. Older patients tend to report more satisfaction and fewer problems than do younger patients, although this association is usually not as strong as the one between health status and ratings.

Some CAHPS field test results confirm these general findings. For example, field tests revealed that consumer ratings about health care were consistently higher for those in better health. Health status may be related to ratings of care because sicker persons are more likely to give negative ratings in general (response tendency), because some people are likely to give negative ratings about anything, including their health and the medical care they receive (leading to correlated error), or because they get worse care. There is the same ambiguity with the age association.

#### **3.1.3.2 Rating Metrics**

Respondents are asked to rate various aspects of their health care on a scale from 0 to 10, where 0 equated to “worst health care” and 10 to “best health care.” The most straightforward summary of a person’s ratings is the mean rating. While it is possible to test for the statistical significance of the difference in mean ratings for the populations, it is difficult to interpret the meaning of the difference in terms of the scale metric. For example, on average, DoD beneficiaries rated their health care 7.8, while the average

rating in the general population was 8.6. Though this difference is statistically significant, it has little practical meaning.

As an aid for interpretation, we used the distribution of ratings in the two populations. That is, we determined the proportion of people in a given population assigning a rating of 0, 1, 2, . . . , 10. We then compared these proportions across populations. Because the distribution of ratings was skewed toward the favorable end of the scale, most of the ratings were in the range of 5 to 10. The population with the greater mean rating also had a greater proportion of responses associated with ratings of 8, 9, and 10. This gives rise to an alternate metric—the proportion of a particular subpopulation with ratings of 8 or greater. Ratings of 8+ are considered to be “favorable ratings.” Although this, too, is an arbitrary metric, it is used by both TMA and the private sector as a benchmark to compare survey results.

### **3.1.4 Effects of Time Enrolled in Health Plan**

The current DoD survey has incorporated the core CAHPS items as measures of health care system performance. The wording of the CAHPS questions does pose some ambiguity.

The DoD (and CAHPS) surveys were not specifically designed to measure changes over time. This is evident from the context in which perceptions about interactions with the health care system are elicited. Respondents are asked to evaluate access on the basis of their experiences over the past 12 months. This practice poses somewhat of a problem when trying to isolate experiences since enrolling in Prime—which may have occurred within the past 12 months. For example, a response to the question, “Did you have trouble gaining access to health care during the past 12 months?” could be describing access before *or* after enrolling in Prime or both before *and* after enrolling in Prime.

While we could not determine whether those enrolled in Prime for fewer than 6 months were responding to encounters with the medical system before or after enrollment, we were able to compare responses of these enrollees with those who were enrolled for more than 6 months (98 percent of Prime enrollees had been enrolled more than 6 months before being surveyed). We found significant differences for 2 of the 10 measures examined, as shown in Table 3-1.<sup>6</sup>

Based on the response patterns of these two groups of Prime enrollees, the responses of Prime enrollees who had been in the plan less than 6 months will tend to underestimate the magnitude of the long-term effect of being in Prime. Nevertheless, we used the data for these “new” enrollees along with those who had been enrolled for the entire period to

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<sup>6</sup> We performed regression analyses to test the significance of the coefficient of an indicator variable whose value was set to 0 if an individual had been enrolled less than 6 months when responding to the survey, or to 1 if the individual had been enrolled for 6 or more months. The demographic control variables were also included.

ensure both a broad coverage of Prime enrollees and a sufficient sample size for statistical analysis.<sup>7</sup>

**Table 3-1. Effect of Time In Prime on CAHPS Measures  
(Proportion of Enrollee Group)**

CAHPS Measure	Months Enrolled	
	< 6	≥ 6
Care when needed composite	0.69	0.68
Care quickly composite	0.69	0.68
Staff courtesy composite	0.91	0.86 <sup>a</sup>
Doctor communication composite	0.86	0.85
Customer service composite	0.49	0.50
Claims processing composite	0.80	0.72 <sup>a</sup>
Plan rating	0.42	0.47
Care rating	0.51	0.56
Doctor rating	0.59	0.63
Specialty care rating	0.64	0.64

<sup>a</sup> Significant difference on measure for those enrolled less than 6 months (p < 0.05).

### 3.1.5 Subpopulations

The DoD and CAHPS surveys of the general population, as reported in the NCBD, used different categorizations to define the type of health plan an individual used. In this section, we describe the health plans represented and how we formed common groups for comparisons.

#### 3.1.5.1 DoD Health Plan Groups

We placed DoD health care beneficiaries into five mutually exclusive and exhaustive *subpopulation* groups based on their active-duty status and source of health care:

- *Active duty*. Composed of survey respondents who were on active duty (AD) when they completed a survey. All AD respondents are considered to be enrolled with a military primary care manager (PCM).
- *Prime—military PCM*. Composed of survey respondents, including AD, who enrolled in Prime with a military PCM before responding to the survey.<sup>8</sup>
- *Prime—civilian PCM*. Composed of non-AD survey respondents who enrolled in Prime with a civilian PCM, before responding to the survey.
- *All civilian care*. Composed of nonenrolled respondents who reported never having used an MTF, but did receive health care from a non-DoD source, during the survey recall period.

<sup>7</sup> It was not possible to use a variable, such as time enrolled in Prime, to control for bias associated with the ambiguity. The analysis compares future Prime enrollees in 1994 (those who will subsequently enroll) with Prime enrollees in 1999. A time-enrolled variable does not apply to those in the 1994 survey group; i.e., there would be zero variance for this group.

<sup>8</sup> Includes those in the samples who may have also disenrolled before responding to the survey.

- *Other nonenrolled.* Composed of nonenrolled respondents who received some of their care at MTFs as space-available care during the survey recall period and who may have received some of their care at civilian facilities, through the TRICARE Extra network.

Table 3-2 shows the distribution of subpopulations in the 11 regions represented in the survey samples. Note that 11 percent of the nonenrolled DoD sample did not report using any health care during the FY 2001 reporting period.<sup>9</sup>

**Table 3-2. Distribution of DoD Subpopulations Estimated from the FY 2001 Sample—All Evaluated Regions Combined**

Military Status (Source of Care)	Proportion of Survey Population
Active duty	0.22
Non-active-duty	
Prime care, military PCM	0.17
Prime care, civilian PCM	0.06
Civilian-only care	0.40
Other not enrolled/MFT-SA	0.04
Total	0.89

### 3.1.5.2 NCBD Health Plan Groups

The National CAHPS survey uses a more generic taxonomy to describe health plans. Table 3-3 shows the four plan types used and the proportion of the 2001 NCBD represented by each plan.

**Table 3-3. Distribution of NCBD Commercial Subpopulations in the FY 2001 Sample**

Plan Type	Proportion of Sample (n= 165,500)
Health maintenance organization (HMO)	0.73
Point of service (POS)	0.05
HMO/POS (a combination of HMO and POS)	0.13
Preferred Provider Organization (PPO)/Fee for Service (FFS)	0.09

The data suggest that the NCBD is dominated by HMO plans (73 percent of the sample).<sup>10</sup> From a geographic perspective, the 270 adult commercial plans<sup>11</sup> in the NCBD 2000 are distributed across 41 states, Guam, Puerto Rico, and Washington, DC. Seventy-

<sup>9</sup> All Prime enrollees responding to the survey are included in either the Active Duty, or Prime care categories.

<sup>10</sup> Annual Report of the National CAHPS Benchmarking Database 2000. September 2001. Agency for Healthcare Research and Quality, Rockville, MD, <http://www.ahrq.gov/qual/ncbd2000/NCBDrepa.htm>.

<sup>11</sup> The NCBD consists of several databases representing different populations. We use data from the adult and child commercial populations, but not from the Medicaid or Medicare populations.

three percent of these plans are offered through the Federal Employee Health Benefits Program administered by the U.S. Office of Personnel Management.

Data were not available to determine the extent to which the types of plans included in the NCBD are representative of the mix of plan types in general for the commercial population. Nor was it possible, based on the data available, to determine the representativeness of survey respondents to the U.S. population as a whole.

### 3.1.5.3 DoD-NCBD health plan crosswalk

We re-grouped the NCBD populations to more closely match the sources of care represented by TRICARE. Table 3.4 shows the NCBD health plans that were “matched” with the DoD active-duty status/source of care groupings.

**Table 3-4. Health Plan Cross-Walk**

DoD Group	NCBD Plan(s)
Active duty	HMO
Prime–military PCM	HMO
Prime–civilian PCM	HMO+HMO/POS
Civilian only care	POS/FFS
Other care	POS+PPO

We used regression analysis<sup>12</sup> to determine the statistical significance of the changes of the outcome variables over time and as the basis for estimating average values within subpopulations (as determined by military status and source of care) for a given year. We accomplished this by using interaction terms between the year-of-survey variable and indicator variables for the various subpopulations. We estimated separate regression equations for each region and type of health plan, and an overall regression equation aggregating over all regions and plans.

We structured the regression models to isolate the effects of certain sources of variation in the access measures.<sup>13</sup> The sources of variation accounted for include:

- health status,
- age,
- gender,
- education, and
- race/ethnicity.

These controls, combined with indicator variables for time and population (DoD/NCBD), composed the explanatory variables used in the regression analyses.

We weighted the survey data to adjust the sample composition to reflect the actual composition of the population more closely.<sup>14</sup> The weight assigned to each respondent is

<sup>12</sup> Logistic regression was used for dichotomous outcome measures, and ordinary least squares linear regression was used for continuous measures, such as “number of days waited for appointment.”

<sup>13</sup> These were the measures common to the DoD and CAHPS surveys.

<sup>14</sup> Unit weights were used for the NCBD data as sample weights were unavailable.

related to the inverse probability of being in the sample. Using weighted data in regression analysis will often result in incorrect estimates of the standard errors and, hence, the significance levels of the coefficients. Although the weights have the desired effect of changing the means of the variables, they have the undesirable effect of underestimating the standard errors. To correct the standard errors for design effects and possible lack of independence of errors produced by weighting and sample stratification, we used the procedure suggested by Huber<sup>15</sup> and White.<sup>16,17</sup>

### **3.1.6 Presentation Scheme**

Over the course of the evaluation, we attempted to identify TRICARE effects that were common to the regions examined. The results shown in this section are aggregate results that combine the data across regions. Appendices B and C show the results of parallel analyses performed at the regional level. However, significant departures from the aggregate results are identified.

Tables showing breakouts by subpopulation summarize results by beneficiary active-duty status and source of care. Although active-duty personnel are Prime enrollees, they are broken out separately. The column labeled *total* represents an estimate for the entire beneficiary population, regardless of source of care or military status.

## **3.2 Subpopulation Characteristics**

Population demographics and health status can moderate people's perceptions about health care and are related to the need for services. For example, analysis of the changes in "satisfaction with getting access to care when needed" shows a 2-percentage-point difference between the DoD and NCBD populations in FY 2001. The age of the beneficiary is related to satisfaction—each year of age contributes 0.5 percentage point to the satisfaction level. The difference in the average ages of the DoD and NCBD populations is about 4 years, which contributes 2 percentage points of the difference in satisfaction. Therefore, the "age-adjusted effect" is actually a 4-percentage-point difference, after adjusting for age differences in the DoD and NCBD populations.

Table 3-5 shows the differences in demographics between populations as measured by the survey samples. In particular, DoD beneficiaries were:

- older,
- more likely to be male, and
- physically healthier (self-reported).

We statistically controlled for these and the other changes in this analysis.

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<sup>15</sup> Peter J. Huber, "The behavior of maximum likelihood estimates under non-standard conditions." In *Proceedings of the Fifth Berkeley Symposium in Mathematical Statistics and Probability*. Berkeley, California: University of California Press, 1, 221–233, 1976.

<sup>16</sup> Halbert White, "A heteroskedasticity-consistent covariance matrix estimator and a direct test for heteroskedasticity." *Econometrica* 48: 817–838, 1980.

<sup>17</sup> Halbert White, "Maximum likelihood estimation of misspecified models." *Econometrica* 50: 1–25, 1982.

**Table 3-5. Comparison of Control Variables Between the FY 2000 and FY 2001 DoD and NCBP Populations (Proportion of Population)**

Measure	FY2000		FY2001	
	DoD	NCBD	DoD	NCBD
Age (years)	51	47	51	47
General health (1-5 scale)	3.48	2.36	2.58	2.37
Proportion male	0.55	0.39	0.53	0.40
Education				
< 8th	0.01	0.01	0.01	0.01
High school (non-graduate)	0.04	0.04	0.03	0.04
High school graduate	0.26	0.27	0.26	0.27
Some college	0.40	0.34	0.40	0.34
College graduate	0.12	0.16	0.13	0.17
Graduate school	0.17	0.17	0.17	0.16
Race/ethnicity				
Hispanic	0.05	0.05	0.06	0.09
White	0.80	0.83	0.80	0.76
Black	0.09	0.09	0.09	0.08
Asian	0.04	0.03	0.04	0.04
Other	0.01	0.01	0.01	0.02

### 3.3 Changes in Access

In general, satisfaction with access to care under TRICARE lags that estimated for commercial plans serving the general population. We estimate that DoD beneficiaries would have greater satisfaction with access had they been in those civilian plans. In addition, DoD beneficiary satisfaction with access generally fell from FY 2000 to FY 2001.

We examined three categories of access to reach this conclusion:

- realized access, based on use of the health care system in general,
- availability and ease of obtaining care, and
- efficiency of the process of receiving care.

We developed a set of measures for each of these categories.

One class of measures, related to both the use and quality of care, has been termed *realized access*. These measures are used to indicate the ability of (1) people to gain entry to the health care system and (2) the system to maintain the health of the population. Medical visits for preventive care (well-care) are discussed in Section 3.4, “Changes in Quality of Care.” Here, we examine visits for illness and injury, with a focus on the kind of facility where the visit took place—an emergency room, or a doctor’s office or clinic.

The *availability* set of measures addresses the issue of whether people are able to get care when they feel they need it. Measures of availability that we examined include:

- being able to get care,
- being able to see a particular doctor, and
- having access to one’s provider by telephone.

Having a usual source of care should improve one's ability to obtain care, and it is often the first step in gaining access to the system. Under the Prime option, all enrollees are assigned a PCM and, therefore, do have a usual source of care other than the emergency room.

Another measure of the availability of care is being able to visit the facility of choice. With the inception of the Prime option came a priority system for appointments at the MTF. Active-duty personnel and those enrolled in Prime get first priority for appointments. This could potentially squeeze out others depending on space-available appointments.

We also used the following additional measures of health care availability:

- access to health care when needed,
- access to specialists, and
- availability of advice over the telephone.

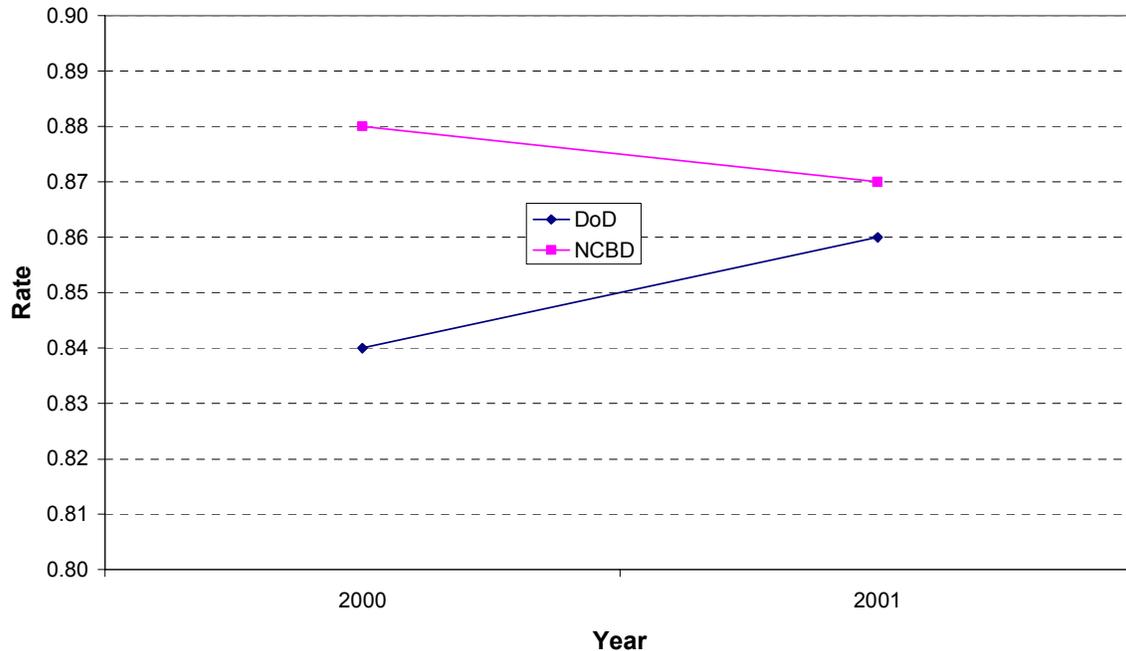
Another set of access measures, called *process*, is related to the process of gaining entry into the health care system. These process measures focus on administrative aspects of access, including making an appointment and waiting time to see a provider after arriving for the appointment. We examined the following process measures of access:

- time waiting to see a provider (time between making an appointment and when the visit took place, and time waiting in office),
- ease of making an appointment,
- getting information about one's health plan, and
- ease of filing claims.

### **3.3.1 Realized Access**

We evaluated two aspects of realized access: general use of the health care system (medical visits for illness or injury) and use of the emergency room for medical care.

Figure 3-1 shows FY 2000–2001 trends in outpatient visits for the TRICARE (DoD) and the civilian (NCBD) populations as a whole. A greater proportion of TRICARE beneficiaries had a medical visit from FY 2000 to FY 2001, and were more likely to have seen a doctor in the current year.



(Statistically significant DoD increase in 2001; DoD same as NCBD in 2001)

**Figure 3-1. Having a Doctor Visit (Proportion of Population)**

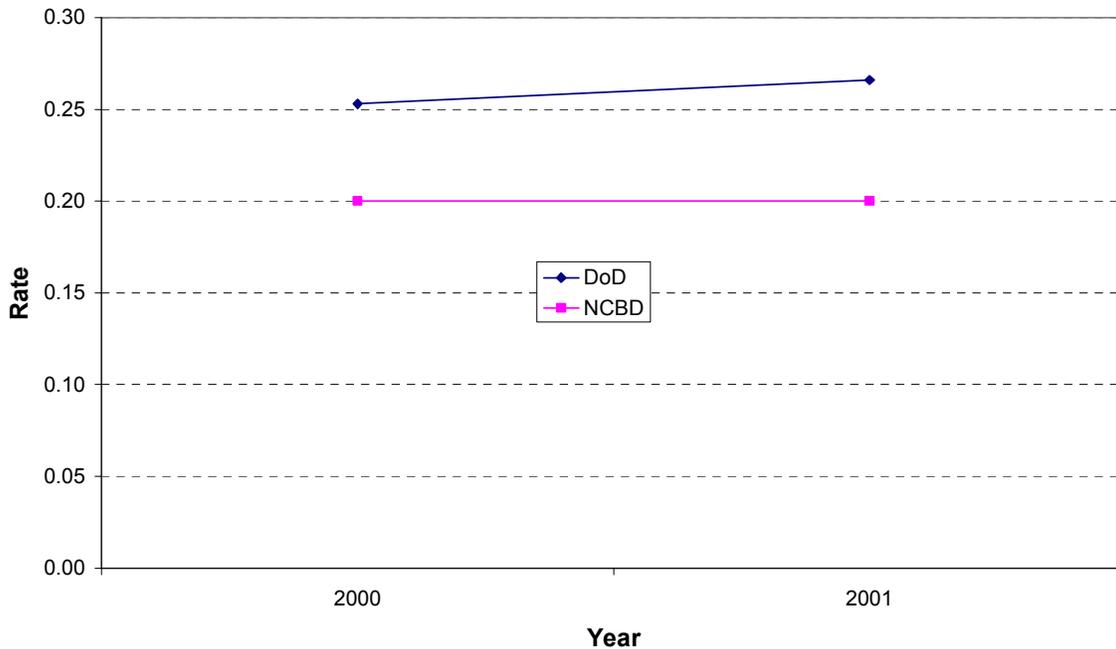
Table 3-6 shows that access for Prime enrollees, as measured by the use of medical care (outpatient visits), rose for those with a civilian PCM. TRICARE beneficiaries using civilian-only sources of care were more likely to have seen a doctor in FY 2001 than individuals in POS/FFS civilian plans (NCBD line).

**Table 3-6. Proportion of Adult Beneficiaries Having an Outpatient Visit**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBD
	DoD	NCBD	DoD	NCBD		
All	0.84	0.88	0.86	0.87	+	same
Active duty	0.80	0.80	0.78	0.79	–	same
Prime–military PCM	0.86	0.85	0.83	0.84	–	same
Prime–civilian PCM	0.85	0.90	0.90	0.89	+	same
Civilian-only care	0.91	0.90	0.88	0.88	–	same
Other	0.98	0.88	0.95	0.88	–	+

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

Emergency room (ER) use is another indicator of access. Lacking easy access to a “regular” source of care could result in the use of the ER for this purpose. Figure 3-2 shows an increase in ER utilization over time for TRICARE and a significantly greater rate of ER use than for comparable civilian health plans. A similar pattern is observed when the data are broken down by source of care (Table 3-7).



(Statistically significant DoD increase in 2001; DoD exceeded NCBD in 2001)

**Figure 3-2. Emergency Room Use (Proportion of Adult Population)**

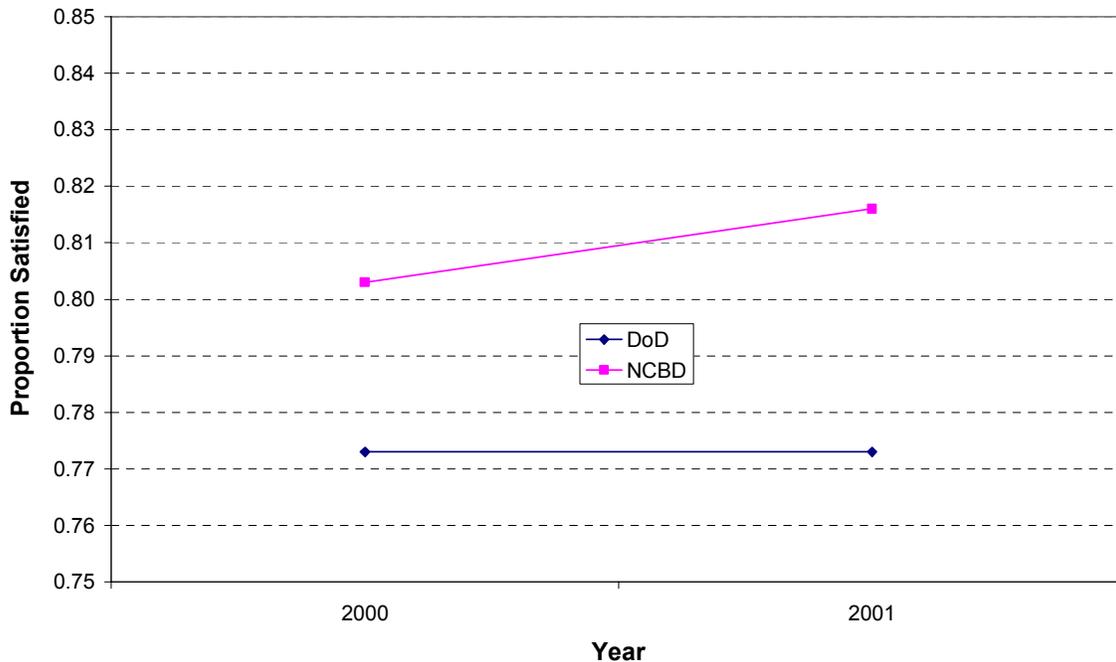
**Table 3-7. Proportion of Adult Beneficiaries Using the Emergency Room (FY 2000–FY 2001)**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBD
	DoD	NCBD	DoD	NCBD		
All	0.25	0.20	0.27	0.20	–	–
Active duty	0.25	0.19	0.28	0.18	–	–
Prime–military PCM	0.29	0.20	0.30	0.20	none	–
Prime–civilian PCM	0.24	0.19	0.23	0.19	none	–
Civilian-only care	0.22	0.23	0.25	0.20	–	–
Other	0.32	0.18	0.34	0.22	none	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

### 3.3.2 Availability of Care

There had been a perception of increased availability of care from the pre-TRICARE era of 1994 through 1999. A greater proportion of the DoD beneficiary population reported that they were able to get care when they felt they needed it. This trend seems to have leveled off in 2000 and 2001. By comparison, there was a rising trend for those non-DoD beneficiaries with civilian plans. In Figure 3-3, we see that satisfaction with the ability to get care when needed rose from FY 2000 to FY 2001, and exceeded levels observed for DoD beneficiaries.



**Figure 3-3. Getting Care When Needed (CAHPS Composite)—  
All Sources of Care and Evaluated Regions Combined (Adults)**

This pattern was observed for all sources-of-care groups with the exception of those DoD beneficiaries using civilian-only care (Table 3-8), where the DoD and NCBBD subpopulations had comparable levels of access.

**Table 3-8. Percentage Adults Satisfied With Getting Care When Needed**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBBD
	DoD	NCBD	DoD	NCBD		
All	0.77	0.80	0.77	0.82	same	–
Active duty	0.68	0.75	0.66	0.76	same	–
Prime–military PCM	0.71	0.75	0.69	0.76	–	–
Prime–civilian PCM	0.66	0.75	0.66	0.78	same	–
Civilian-only care	0.86	0.88	0.86	0.86	same	none
Other	0.75	0.85	0.76	0.89	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

We examined several additional measures of availability of care. While civilian health plans outperformed TRICARE on each, levels of satisfaction for DoD beneficiaries improved with respect to ease of getting a doctor they were happy with and being able to get referrals to specialists. On the other hand, they were less satisfied with their ability to get care they thought necessary. Table 3-9 gives the details.

**Table 3-9. Availability Measures of Access—All Sources of Care and Evaluated Regions Combined (Adults)**

Availability Measure	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBD
	DoD	NCBD	DoD	NCBD		
Ease of getting a personal doctor or nurse patient is happy with	0.67	0.69	0.69	0.71	+	–
Ease of getting a referral to a specialist that patient needed to see	0.82	0.88	0.81	0.88	same	–
Ease of getting care patient or a doctor believed necessary	0.79	0.84	0.78	0.85	–	–
Lack of delays in health care while waiting for approval from your health plan	0.85	0.84	0.84	0.85	same	none

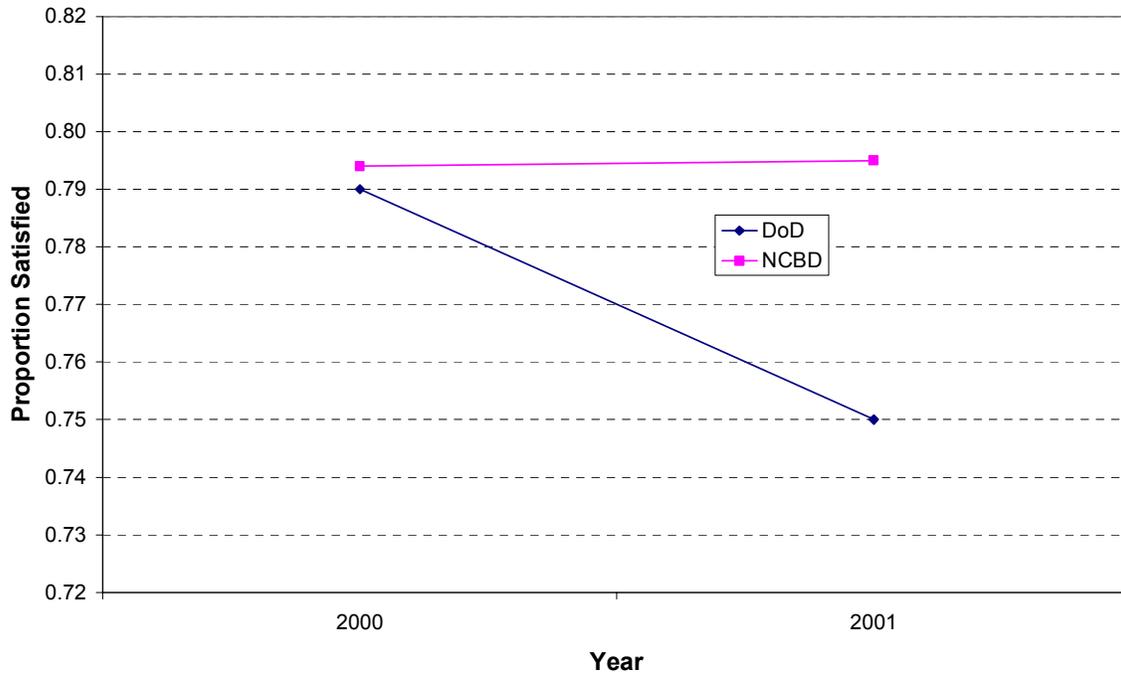
<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

### 3.3.3 Process of Obtaining Care

Measures that reflect the process of obtaining care are the ease of making an appointment, the waiting time between making the appointment and seeing the health care provider, and being able to get advice or speak to the doctor on the phone. Figure 3-4 compares TRICARE with NCBD from FY 2000 to FY 2001 for the CAHPS composite of these measures. While DoD and civilian plans were on a par during FY 2000, satisfaction with processes of obtaining care has declined for DoD beneficiaries in FY 2001 (Table 3-10). When we examine changes among subpopulations (Table 3-11), we see that the lowest levels of DoD satisfaction are for Prime beneficiaries using the MTF.

### 3.3.4 Effects of Provider Type on Perceptions of Prime Enrollees

In general, more people are enrolled with military PCMs (77 percent) than with civilian PCMs. The DoD did not have an explicit policy of assigning a particular physician to a Prime enrollee until December 1999. In many cases, people were assigned to military clinics with no specific PCMs. However, if a person was allowed to enroll in the non-military network of civilian providers, he or she was typically able to choose a particular provider as PCM.



**Figure 3-4. Getting Care Quickly (CAHPS Composite)—  
All Sources of Care and Evaluated Regions Combined (Adults)**

**Table 3-10. Process Measures of Access—  
All Sources of Care and Evaluated Regions Combined (Adults)**

Process Item	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBD
	DoD	NCBD	DoD	NCBD		
Getting the help or advice over the phone during regular office hours when needed	0.67	0.69	0.69	0.71	same	–
Getting an appointment for regular or routine health care as soon as wanted	0.82	0.88	0.81	0.88	–	–
Getting needed care right away for an illness or injury as soon as wanted	0.79	0.84	0.78	0.85	same	–
Waited in the doctor’s office or clinic no more than 15 minutes past appointment to see the person you went to see	0.85	0.84	0.84	0.85	–	–

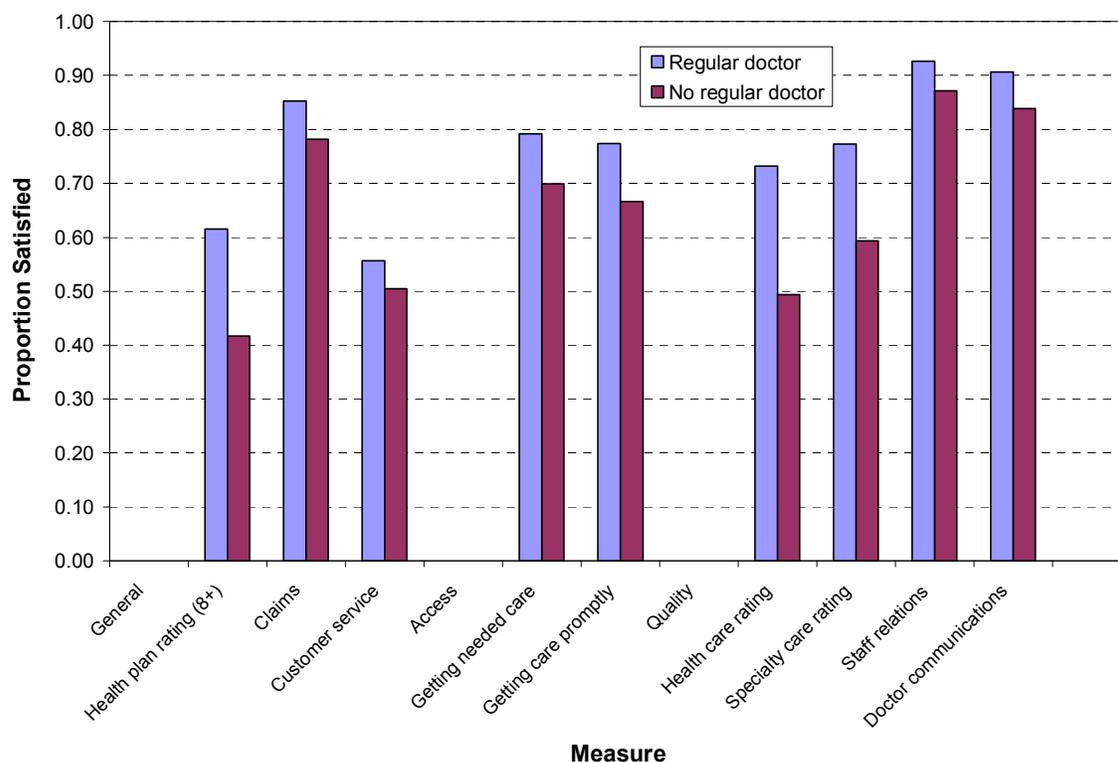
<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

**Table 3-11. CAHPS “Getting Care Quickly” Composite—All Regions Combined (Adults)**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD Improvement	DoD – NCBD
	DoD	NCBD	DoD	NCBD		
All	0.79	0.79	0.75	0.80	–	–
Active duty	0.75	0.75	0.64	0.75	–	–
Prime–military PCM	0.74	0.75	0.67	0.75	–	–
Prime–civilian PCM	0.77	0.79	0.74	0.75	–	same
Civilian-only care	0.84	0.84	0.81	0.80	–	same
Other	0.75	0.82	0.74	0.84	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

Our previous TRICARE evaluation showed that, in 1997, free choice of a PCM had a profound effect on satisfaction with many aspects of the military health care system. The results indicated that Prime enrollees with military providers report greater levels of access than those with civilian providers, and those who get to choose their providers have higher satisfaction with the health care system. Unfortunately, the current survey data do not have information about choice of a PCM. Therefore, the effect of choice of PCM type could not be directly examined here. However, survey respondents were asked if they had “one person you think of as your personal doctor or nurse.” We contrast satisfaction and access on the basis of having a *personal* physician or nurse, namely, a PCM (Figure 3-5).



**Figure 3-5. Effects of Having a Personal Physician on Various Aspects of Satisfaction**

About 70 percent of beneficiaries are estimated to have had a personal physician or nurse in FY 2001. This percentage varied by active-duty status and health plan. Only 39 percent of active-duty personnel, and 66 percent of non-active-duty Prime enrollees had a personal doctor or nurse. Having a personal health care provider had several positive effects:

- better satisfaction with one's health plan;
- better perceived quality of care;
- fewer problems with claims, customer relations, and relations with provider's staff; and
- greater levels of self-reported access.

### **3.4 Changes in Quality of Care**

Quality of care has many dimensions. This evaluation considers two major aspects of quality: (1) meeting national standards and (2) satisfaction with quality of care as perceived by DoD and civilian plan beneficiaries. In a departure from the established methodology, we evaluate standards from the perspective of the DoD population only, during FY 2000 and FY 2001. This approach was necessary because of a lack of comparable case-mix adjusted data for those in commercial plans.

#### **3.4.1 Meeting Standards Under TRICARE**

TRICARE Prime offers additional enhanced benefits that are not covered under TRICARE Standard. These enhanced benefits include such services as periodic examinations and preventive-care procedures. Counseling on well-care issues, such as nutrition, exercise, and substance abuse, are integrated into routine office visits. In addition, Prime offers increased continuity of care through the selection of a PCM, who either provides or coordinates all the beneficiary's health care services.

DoD has adopted as its standard the national health-promotion and disease-prevention objectives specified by the United States Department of Health and Human Services in *Healthy People 2010*.<sup>18</sup> We compared care levels under TRICARE with these national standards, the NCBHD (smoking cessation only) and data published by the Centers for Disease Control (immunizations, smoking prevalence, and smoking cessation).<sup>19</sup> Prime covers specific well-care procedures at stated frequencies that tend to coincide with or exceed these national goals. We compared beneficiaries' survey responses with the national objectives in the following areas:

- smoking cessation counseling,
- prenatal care (first trimester),
- blood pressure (BP) checks,
- cholesterol screening,

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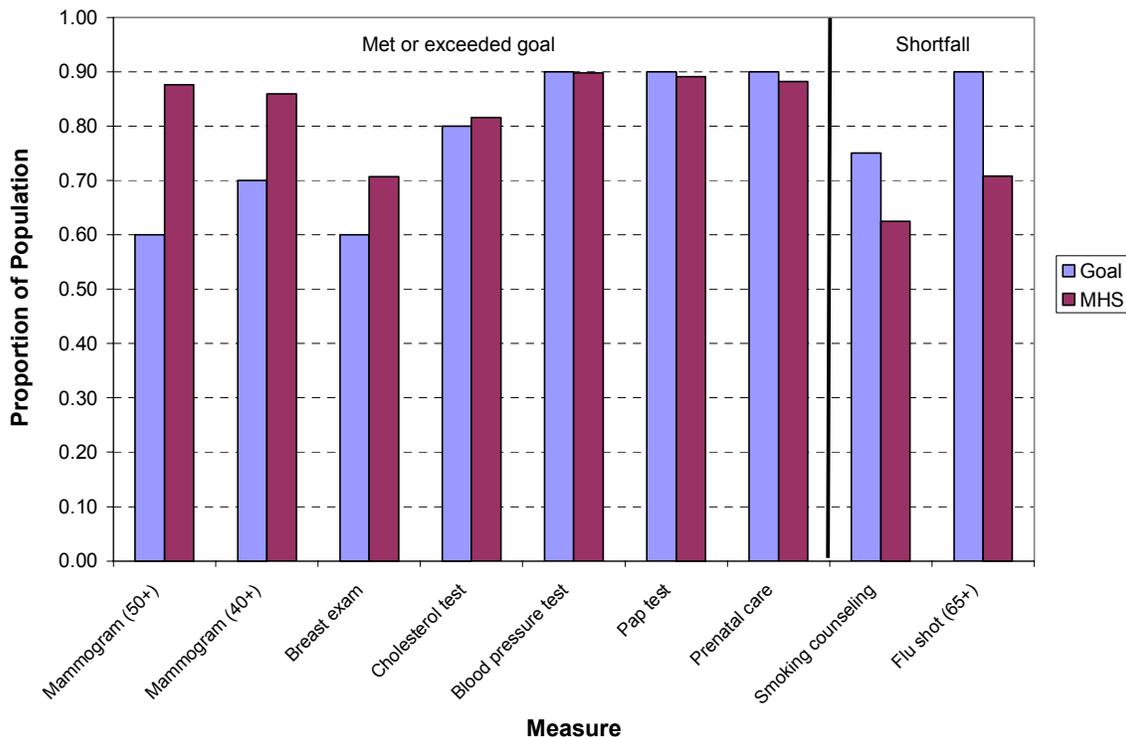
<sup>18</sup> Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, 1991.

<sup>19</sup> National Health Interview Survey (NHIS), Centers for Disease Control, National Center for Health Statistics, 1999.

- mammograms, and
- Pap smears.

*Healthy People 2010* identifies both current national care levels and target levels for the year 2010. It identifies outcome targets for such things as smoking cessation and immunizations. In 1987, for example, 30 percent of the 20- to 24-year-olds were regular cigarette smokers. The national target is to reduce that percentage to 15 percent by 2000. In addition, *Healthy People 2010* identifies targets for frequency of well-care procedures. For example, by 2010, the national objective is for 90 percent of the adult population to have had their blood pressure checked by a trained professional within the previous 2 years. We compared the care levels under TRICARE with these national targets and available benchmarks.

Figure 3-6 shows the average levels achieved, for those goals met and not met, respectively, in the 11 TRICARE regions combined along with the *Healthy People 2010* goals. Results are shown for the total population only. Subpopulation results are shown in Table 3-12, and regional statistics are given in Appendix C. These data indicate that TRICARE is meeting (or nearly meeting) most of the *Healthy People 2010* goals examined for the DoD population as a whole. Shortfalls include counseling for the use of tobacco products and flu shots for those over 65. In our previous evaluation (FY 2001), we had identified shortfalls in goals for counseling for smoking cessation and flu shots as well.



Note: All differences between level achieved and goal statistically significant ( $p < 0.05$ ). Red bars to the left of vertical dotted line represent areas where MHS performance meets or exceeds goal (blue bar); red bars to the right of dotted line represent areas where MHS performance does not meet goal.

**Figure 3-6. Achievement of *Healthy People 2010* Goals in FY 2001  
(Entire Population, Averaged Across TRICARE Regions and Source of Care)**

**Table 3-12. Healthy People 2010 Goal Achievement by Military Status and Source of Care—  
All Evaluated Regions Combined (Proportion Meeting Goal in 2001)**

Measure	Goal		Military Status/Source of Care					Total
			Active Duty	Non-Active Duty				
				Prime		Civilian	Other Non- enrolled	
				Mil PCM	Civ PCM			
Criteria	Met <sup>a</sup>	All	Mil PCM	Civ PCM	Civilian	Other Non- enrolled	All	
Mammogram (50+)	0.60	Yes	0.97	0.91	0.86	0.87	0.86	0.88
Mammogram (40+)	0.70	Yes	0.81	0.86	0.84	0.86	0.84	0.86
Breast exam	0.60	Yes	0.76	0.70	0.67	0.72	0.62	0.71
Cholesterol test	0.80	Part	0.75	0.72	0.81	0.90	0.81	0.82
BP test	0.90	Part	0.85	0.87	0.90	0.94	0.89	0.90
Pap test	0.90	Part	0.97	0.93	0.90	0.85	0.86	0.89
Prenatal care	0.90	Part	0.88	0.89	0.92	0.90	0.72	0.88
Smoking counseling	0.75	No	0.57	0.60	0.67	0.65	0.62	0.60
Flu shot (65+)	0.90	No	0.70	0.72	na	0.71	0.67	0.71

<sup>a</sup> “Yes” indicates goal met or exceeded in each subgroup; “Part” indicates goal met or exceeded in some subgroups; “No” indicates goal not met in any subgroup. “na” indicates insufficient data for estimate.

When we compare current (FY 2001) levels of preventive care with FY 2000 estimates, there were few statistically significant changes.<sup>20</sup> Exceptions were lower levels of flu shots and BP tests, but improvements in the use of counseling for smokers in FY 2001 (Table 3-13).

**Table 3-13. Trends in Preventive Care**

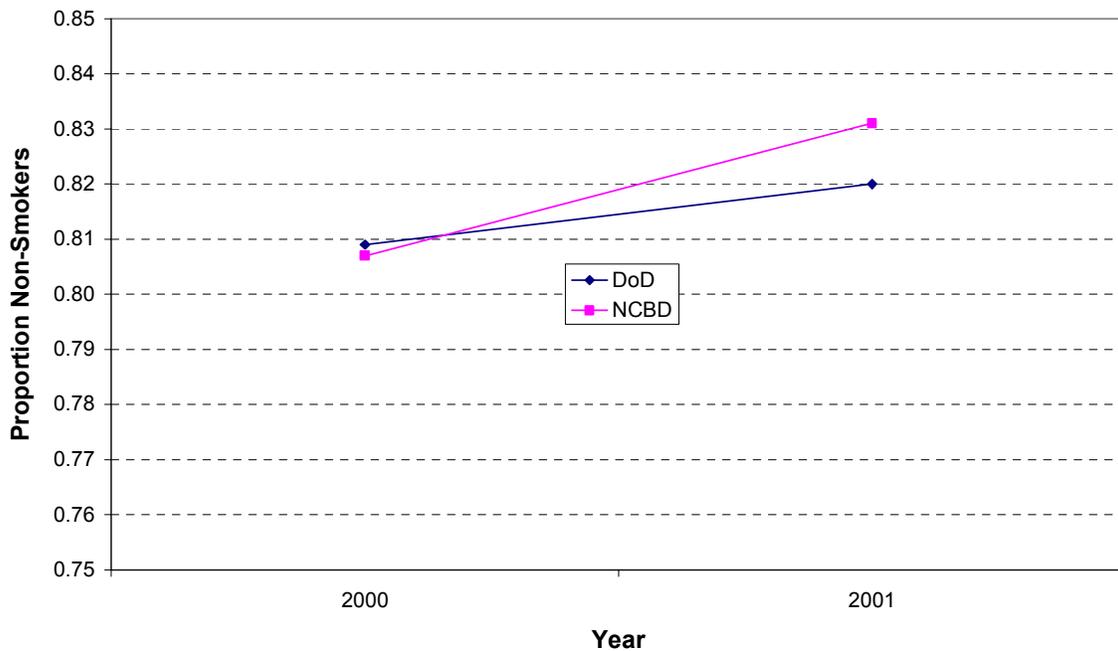
Measure	Source of Care/Military Status									
	All		Prime— Military PCM		Prime— Civilian PCM		Civilian Only		Other	
	FY 20 00	FY 20 01	FY 20 00	FY 20 01	FY 20 00	FY 20 01	FY 20 00	FY 20 01	FY 20 00	FY 20 01
Flu shot	0.78	0.70*	0.75	0.72	na	na	0.79	0.71*	0.80	0.67*
Prenatal care	0.87	0.88	0.89	0.89	0.91	0.88	0.79	0.90	0.76	0.72
Mammogram (40+)	0.85	0.84	0.86	0.85	na	na	0.87	0.87	0.88	0.84*
Mammogram (50+)	0.86	0.86	0.90	0.91	0.86	0.86	0.88	0.88	0.89	0.86
Pap test	0.88	0.88	0.94	0.94	0.88	0.97*	0.86	0.85*	0.85	0.86
BP test	0.93	0.89*	0.92	0.86*	0.93	0.85*	0.97	0.94*	0.94	0.89*
Physical exam	0.50	0.52	0.59	0.57	0.70	0.51	0.60	0.50*	0.70	0.68*
Breast check	0.70	0.68	0.72	0.71	0.68	0.76	0.74	0.72	0.70	0.62*
Cholesterol	0.82	0.81	0.76	0.74*	0.80	0.75*	0.90	0.90	0.83	0.81*
Smoking advice	0.56	0.60*	0.56	0.60*	0.58	0.57	0.62	0.66*	0.63	0.61

\* indicates statistically significant change over time ( $p < 0.05$ );

“na” indicates not available—insufficient data for estimate.

<sup>20</sup> The FY 2000 values were adjusted to differences in the demographic characteristics of the two populations. The baseline used for the adjustments were FY 2001 DoD health care beneficiary population characteristics.

We were able to compare the TRICARE population over time with the general population for two smoking-related preventive care measures. Figure 3-7 shows prevalence for non-smoking and Figure 3-8 shows changes in counseling or advice on smoking cessation given to smokers. Prevalence for smoking was similar in both populations, with little change over time for DoD beneficiaries. As Figure 3-8 shows, the level of counseling given to DoD beneficiaries for smoking cessation significantly improved. However, the level did not match that achieved in the NCBBD population. (Table 3-13 shows a breakdown of these data by source of care/active-duty status category.)



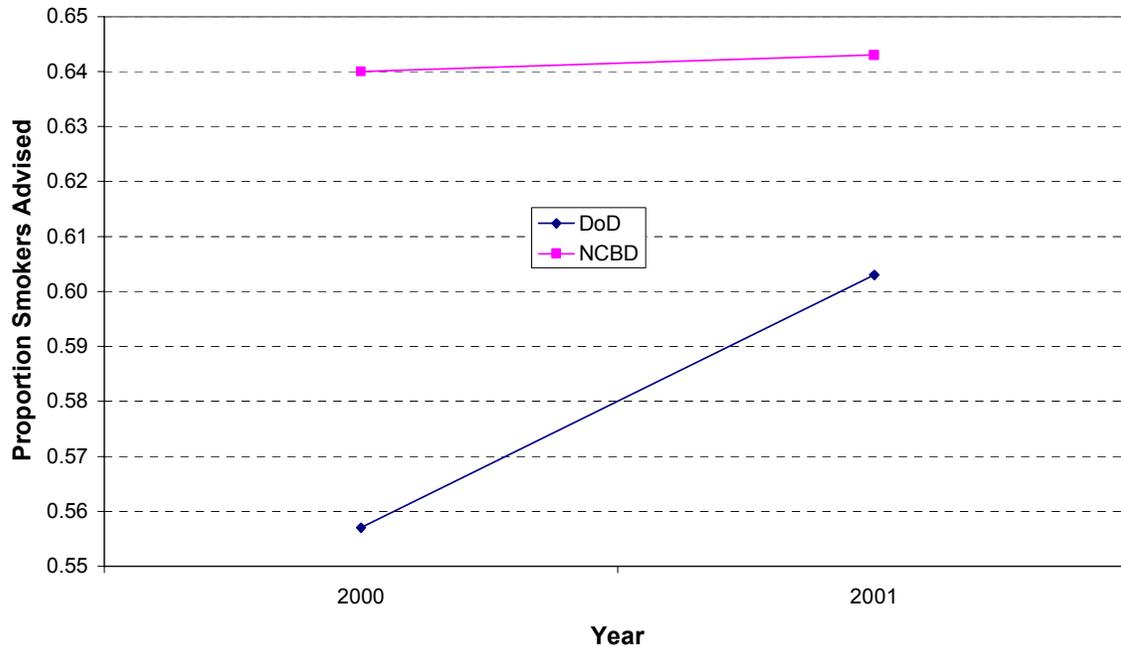
Differences between populations in FY 2001 statistically significant ( $p < .05$ )

**Figure 3-7. Prevalence for Non-smoking: DoD vs. General Population (All Regions and Sources of Care Combined)**

### 3.4.2 Perceptual Measures of Quality of Care

We examined changes in beneficiaries’ perceptions of quality under TRICARE, and in civilian health plans, based on their survey responses. The perceptual measures examined include beneficiaries’ ratings of:

- overall quality of health care (CAHPS “Health Care” rating),
- rating of one’s physician (CAHPS “PCM” rating),
- rating of health plan’s specialty care (CAHPS “Specialty Care” rating),
- ability of doctors to communicate with patients (CAHPS “Doctor Communication” composite), and
- courtesy and friendliness of provider’s staff.



Differences between populations in FY 2001 statistically significant ( $p < .05$ ).

**Figure 3-8. Advice for Smoking Cessation: DoD vs. General Population (All Regions and Sources of Care Combined)**

**Table 3-13. Smoking Related Behaviors: DoD vs. General Population (All Regions and Sources of Care Combined)**

Measure	Source of Care	FY				Changes <sup>a</sup>	
		2000		2001		DoD Improvement	DoD – NCBD
		DoD	NCBD	DoD	NCBD		
Proportion of Non-smokers	All	0.81	0.81	0.82	0.83	same	–
	Active duty	0.78	0.79	0.78	0.78	same	same
	Prime (military PCM)	0.80	0.80	0.79	0.80	same	same
	Prime (civilian PCM)	0.77	0.79	0.80	0.81	+	–
	Civilian-only	0.84	0.83	0.85	0.87	same	–
	Other	0.81	0.83	0.87	0.87	+	–
Proportion receiving smoking cessation advice	All	0.56	0.64	0.60	0.64	+	–
	Active duty	0.53	0.52	0.57	0.52	+	+
	Prime–military PCM	0.58	0.60	0.60	0.60	+	same
	Prime–civilian PCM	0.58	0.66	0.67	0.67	+	same
	Civilian-only care	0.62	0.65	0.65	0.70	+	–
	Other	0.63	0.71	0.62	0.68	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

The results in Table 3-14 show that those in civilian plans rate all subjective quality attributes examined higher than do DoD beneficiaries, and that these ratings did not change from FY 2000 to FY 2001.

**Table 3-14. Comparison of Perceptual Measures of Quality of Care: DoD vs. NCB, FY 2000–FY 2001 (All Sources of Care and Active Duty Status Combined)**

Measure	FY				Changes	
	2000		2001		DoD (00–01)	DoD – NCBD (01)
	DoD	NCBD	DoD	NCBD		
<i>Rating</i>						
Satisfaction with quality of care	0.66	0.76	0.67	0.76	same	–
Satisfaction with PCM	0.74	0.78	0.72	0.79	same	–
Satisfaction with specialist	0.73	0.80	0.74	0.80	same	–
<i>Composite</i>						
Doctor communication	0.88	0.91	0.91	0.92	+	same
Staff courtesy	0.91	0.93	0.93	0.93	+	same

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

While we observed little or no improvement in overall satisfaction with quality of care for the DoD population as a whole from FY 2000 to FY 2001, we see significant improvement for those in Prime (Table 3-15). However, satisfaction of Prime enrollees with their PCM and specialty care declined from FY 2000 to FY 2001 (about a 2-percentage-point drop).

### **3.5 Satisfaction with Filing Medical Claims Under TRICARE**

When seeking care outside the managed care network, a medical claim must be filed for reimbursement.<sup>21</sup> In our previous evaluations, we identified problems with claims processing as the number one dissatisfier associated with satisfaction with one’s health plan. Table 3-16 shows an estimate of the number of claims filed by or for those in DoD and civilian plans in FY 2000 and FY 2001.<sup>22</sup> The estimates shown for those in commercial civilian plans (NCBD), are case-mix adjusted to account for demographic differences in the populations.

<sup>21</sup> In principle, those enrolled in Prime and nonenrollees using the Extra network do not have to file claims. Participating providers in the Extra network and providers receiving referrals from PCMs of Prime enrollees are supposed to handle the necessary claims filing. Before TRICARE, filing a CHAMPUS claim was the responsibility of the patient.

<sup>22</sup> Information on the proportion of beneficiaries who had to file their own claims was not available from the survey data.

**Table 3-15. Differences in Perceived Overall Quality of Care Dependent on Source of Care (Proportion of Subpopulation with Favorable CAHPS “Health Care” Ratings)**

Satisfaction Measure (Rating)	Source of Care	FY				Changes <sup>a</sup>	
		2000		2001		DoD (00–01)	DoD – NCBD (01)
		DoD	NCBD	DoD	NCBD		
Quality of care	All	0.66	0.76	0.67	0.76	same	–
	Active duty	0.44	0.62	0.48	0.63	+	–
	Prime–military PCM	0.52	0.64	0.54	0.65	+	–
	Prime–civilian PCM	0.62	0.73	0.64	0.74	+	–
	Civilian-only care	0.78	0.82	0.78	0.84	same	–
	Other	0.77	0.82	0.72	0.82	–	–
PCM	All	0.74	0.78	0.72	0.79	same	–
	Active duty	0.60	0.66	0.57	0.67	–	–
	Prime–military PCM	0.68	0.70	0.64	0.71	–	–
	Prime–civilian PCM	0.67	0.75	0.62	0.76	–	–
	Civilian-only care	0.79	0.80	0.78	0.83	same	–
	Other	0.77	0.80	0.77	0.84	same	–
Specialty care	All	0.73	0.80	0.74	0.80	same	–
	Active duty	0.60	0.66	0.57	0.67	–	–
	Prime (military PCM)	0.68	0.70	0.64	0.71	–	–
	Prime (civilian PCM)	0.67	0.75	0.62	0.76	–	–
	Civilian-only	0.79	0.80	0.78	0.83	same	–
	Other	0.77	0.80	0.77	0.84	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

**Table 3-16. Estimated Proportion Filing a Medical Claim**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD (00–01)	DoD – NCBD (01)
	DoD	NCBD	DoD	NCBD		
All	0.59	0.73	0.66	0.71	+	–
Active duty	0.25	0.65	0.38	0.61	+	–
Prime–military PCM	0.30	0.65	0.42	0.61	+	–
Prime–civilian PCM	0.73	0.70	0.80	0.67	+	+
Civilian-only care	0.84	0.70	0.89	0.72	+	+
Other	0.66	0.73	0.55	0.83	–	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

About two-thirds (66 percent) of DoD beneficiaries filed (or had filed) a claim in 2001. In general, a greater proportion of DoD beneficiaries had to file a claim in FY 2001—an increase of 7 percent from the previous year. These rates are lower than

those in comparable civilian plans. Because they were referred to out-of-network providers, about 80 percent of Prime enrollees with a civilian PCM filed more claims in FY 2001. This was nearly double the rate of claims filing for Prime enrollees having a military PCM (42 percent). Presumably, referrals by military PCMs are more likely to be within the military system, where no claim has to be filed.

Using data from the NCBD, we compare satisfaction with claims processing experience of those under TRICARE to those with civilian plans in Table 3-17.

**Table 3-17. Satisfaction with Claims Processing (Proportion of Subpopulation)**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD (00–01)	DoD – NCBD (01)
	DoD	NCBD	DoD	NCBD		
All	0.83	0.86	0.86	0.88	+	–
Active duty	0.62	0.77	0.67	0.79	+	–
Prime–military PCM	0.70	0.76	0.73	0.79	+	–
Prime–civilian PCM	0.75	0.82	0.78	0.85	+	–
Civilian-only care	0.85	0.91	0.83	0.92	same	–
Other	0.85	0.91	0.83	0.92	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

The results suggest that overall there are fewer problems with claims under civilian plans. Within the MHS, those not enrolled using a mix of space-available care and civilian providers (other nonenrolled, presumably using TRICARE Extra), had fewer problems with claims than Prime enrollees did. However, we do see significant increases in satisfaction with claims processing in FY 2001 for DoD beneficiaries under managed care. We observed some regional differences in claims filing experiences (see Appendix B). These differences are partially the result of differences in procedures followed by the managed care contractor responsible for processing claims in a given region.<sup>23</sup>

### 3.6 TRICARE Senior Prime

During FY 2001, Medicare-eligible DoD beneficiaries were offered the option of joining TRICARE Prime. In this section, we examine some of the characteristics of this eligible subpopulation—as related to their intentions to enroll in TRICARE Prime. This can provide some insights into the correlates of demand for MHS care for these beneficiaries.

<sup>23</sup> CHAMPUS claims were handled differently in 1994 and 1999. In 1994, before TRICARE, claims were filed directly with a fiscal intermediary who processed claims for the beneficiary’s state of residence. In 1999, each region under TRICARE has a contractor responsible for handling claims. Procedures can vary from region to region.

We looked at the probability of enrollment for those who are not currently enrolled in Prime but would be eligible under TRICARE for Life (TFL). Overall, about 26 percent of that group expressed a desire to enroll. We examined the mediating effects on enrollment intentions of the following measures (predictors) available from the DoD Survey data:

- personal characteristics (demographics),
- satisfaction with current health plan (items related to access and quality of care and problems with claims),
- private insurance coverage,
- utilization of existing health care benefits, and
- distance from an MTF.

Table 3-18 shows the marginal effects of the variables that have a statistically significant effect on propensity to enroll. We show the probability of enrollment when the value of the predictor is *true* and when it is *false*. For example, the probabilities of enrollment for those with and without private health insurance are 0.23 and 0.29, respectively. Thus, those currently *without* private health insurance are more likely to enroll in Prime.

**Table 3-18. Predictors of Enrollment for Beneficiaries Age 64 and Older (Probability of Enrollment, Given Value of Predictor)**

Predictor	Probability of enrollment when predictor is:	
	False	True
Treated courteously by office staff	0.04	0.27
Prompt care for illness or injury	0.09	0.27
Provider listens carefully	0.43	0.26
Happy with provider	0.39	0.23
Delays in health care waiting for approval from health plan	0.25	0.41
Advice on phone during office hours	0.40	0.25
Claims handled properly	0.14	0.27
Provider respects what patient says	0.16	0.27
Satisfactory health plan rating	0.33	0.24
Got care promptly	0.18	0.27
Private health insurance	0.29	0.23
Live out of catchment	0.23	0.28
Number of outpatient visits (civilian providers)	0.33	0.31

The significant predictors of enrollment, associated with current health plan characteristics, for beneficiaries age 64 and older are summarized below. We separate the predictors into three categories: (1) “dissatisfiers” with current plan leading to intention to enroll in Prime; (2) positive characteristics of current plan (suggesting an incidental factor); and (3) characteristics of individuals who are likely to enroll. We focus on those current plan dissatisfiers and personal characteristics (i.e., demographics) associated with intent to enroll.

Dissatisfiers:

- doctor doesn't listen carefully to patient,
- dissatisfaction with current health plan,
- delays in care due to approval process,
- inability to get advice over the phone during office hours, and
- couldn't get provider one was happy with.

Incidental satisfiers:

- quick access to care,
- claims processed correctly,
- provider respects what patient has to say, and
- number of visits to civilian providers (each visit decreases the probability of enrollment by 0.014).

Personal characteristics:

- currently has private medical insurance coverage, and
- lives out of catchment area.

These results suggest that dissatisfaction with specific access and quality-of-care issues associated with their current health care, along with low civilian health care utilization and proximity to an MTF, are the major motivating factors for desire to enroll in Prime by Medicare eligibles. The data show that those with fewer visits to civilian doctors are more likely to drop their civilian health plans in favor of Prime.

### **3.7 Probability of Disenrollment**

Why do beneficiaries disenroll from Prime? Here we look at the probability of enrolled beneficiaries disenrolling from Prime, based on their responses to the FY 2001 DoD survey (Table 3-19). Only 6 percent are estimated to intend to disenroll. We found that disenrollment intentions were related to:

- having private insurance,
- having a problem with claims,
- experiencing delays in getting approval for a referral,
- having *unfavorable* ratings of their health plan (TRICARE Prime),
- lack of choice of a PCM,
- lack of respect from office staff, and
- poor communication with doctor.

**Table 3-19. Probability of Disenrollment (FY 2001 Data)**

Predictor	Probability of disenrollment when predictor is:	
	False	True
Has private insurance	0.05	0.11
Treated courteously by office staff	0.10	0.06
Delays in health care waiting for approval from health plan	0.09	0.05
Satisfactory health plan rating	0.08	0.05
Advice on phone during office hours	0.08	0.05
Got care promptly	0.08	0.05
Claims handled properly	0.08	0.05
Happy with provider choice	0.07	0.05
Understood provider explanations	0.08	0.06
Claims handled in reasonable time	0.07	0.05
Got necessary care	0.07	0.06
Got care promptly	0.07	0.06

The driving factors underlying intention to disenroll in Prime are related to having private insurance, problems with access and claims, and communications issues with the doctors and administrative staff of the MTF. We interpret these results to mean that while quality and access issues are reasons for disliking Prime and wanting to disenroll, having private insurance may be a necessary condition for choosing a different health plan.

### **3.8 Satisfaction with Health Plan**

In this section, we explore levels of satisfaction for DoD beneficiaries and civilian benchmarks. We also examine predictors of health plan satisfaction for DoD beneficiaries.

#### **3.8.1 Levels of Satisfaction With Health Plan**

Table 3-20 shows estimates for changes in beneficiary ratings of their health plan from FY 2000 to the current year (FY 2001). These data indicate improved satisfaction levels for each DoD “plan,” but a substantial gap exists between each DoD plan and its civilian health plan benchmark.<sup>24</sup>

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<sup>24</sup> Those in civilian plans also gave higher ratings to their plans in FY 2001—a 2-percentage-point increase. The DoD increase was 5 percentage points.

**Table 3-20. Health Plan Ratings (Proportion of Population with *Favorable* Rating)**

Source of Care	FY				Changes <sup>a</sup>	
	2000		2001		DoD (00–01)	DoD – NCBD (01)
	DoD	NCBD	DoD	NCBD		
All	0.51	0.65	0.56	0.67	+	–
Active duty	0.31	0.54	0.39	0.56	+	–
Prime–military PCM	0.41	0.53	0.47	0.53	+	–
Prime–civilian PCM	0.43	0.61	0.49	0.63	+	–
Civilian-only care	0.62	0.75	0.65	0.77	+	–
Other	0.54	0.72	0.61	0.73	+	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference;  $p < 0.05$ .

### 3.8.2 Predictors of Satisfaction With Health Plan

What factors contribute to how well beneficiaries rate their health plans? We examined the contributions of perceived access to care (including getting referrals to specialists and getting routine appointments), problems with claims processing, and quality of care as predictors of health plan rating. Once again, we used the “proportion 8+” metric to indicate a “satisfied” rating. We used a logistic regression model to relate the predictors of the health plan rating for each subpopulation.

To assess the effect of a given predictor, or characteristic, we compared the difference in the average health plan rating of those with and without the characteristic. For example, we estimated that 68 percent of beneficiaries rate their health plan with a value of 8 and above when they rate their quality of health care 8+. Alternatively, this value falls to 31 percent for those with quality of health care rating below 8 (unsatisfactory). Thus, the marginal effect of satisfaction with quality of health care on health plan rating is a change of 37 percentage points. We assessed the effect of other variables, such as “access to appointments,” on the health plan rating in a similar manner.

The results in Table 3-21 indicate that satisfaction with health care (i.e., quality of care), and having had a problem with customer service and claims processing have the greatest impact on health plan rating. For all DoD health care beneficiaries, regardless of their source of care (including active-duty personnel), satisfaction with quality of care was the biggest discriminator of satisfaction with one’s health plan. The relative importance of the other predictors varies with beneficiary health plan/source of care. Appendix D gives detailed results showing the effects of other factors.

**Table 3-21. Predictors of Health Plan Rating by Source of Care  
(DoD Population, FY 2001, All Sources of Care Combined)**

Predictor	Estimated Proportion Satisfied With Health Plan When Predictor is:		Absolute Difference
	False	True	
Satisfactory health care rating	0.31	0.68	0.37
No problem to get the help you needed when you called your health plan's customer service	0.47	0.63	0.16
No problem with paperwork for health plan	0.47	0.63	0.16
Claims handled in a reasonable time	0.45	0.58	0.13
Easy to find or understand information in the written materials	0.49	0.61	0.12
Claims handled correctly	0.47	0.57	0.10
Satisfactory doctor rating	0.49	0.58	0.09
Happy with personal doctor or nurse you get	0.51	0.58	0.07
No delays in health care while you waited for approval from your health plan	0.50	0.57	0.07
Satisfactory specialty care rating	0.51	0.57	0.06
Used ER	0.54	0.59	0.05
Doctor listens carefully	0.60	0.55	0.05

### 3.9 Children's Health Care

CAHPS surveys of children's health care are administered on a limited basis.<sup>25</sup> However, these were sufficient data to compare satisfaction with children's health care for the DoD and general populations by condensing the source-of-care groups, as shown in Tables 3-22 through 3-24. We found:

- realized access was not as good for children of DoD beneficiaries as for children in commercial health plans,
- satisfaction with most components of access and quality of care was higher for children in the general population,
- levels of satisfaction were mostly improved or maintained from FY 2000 through FY 2001 for DoD children's health care, and
- levels of satisfaction were generally lower for those enrolled in Prime.

<sup>25</sup> DoD administers the survey to parents of children for a single quarter in a given year. About 6,000 survey responses in FY 2000, and 10,000 in FY 2001 for DoD children were used in the analysis. Somewhat fewer children's survey responses were available from the NCBID (3,000 in FY 2000 and 9,000 in FY 2001). The smaller numbers of surveys limited breakdowns by the extensive source-of-care categories used in the analysis of adult surveys. These smaller numbers precluded breakdowns by TRICARE region.

**Table 3-22. Children’s Use of Health Care  
(DoD vs. General Population, FY 2000–FY 2001)**

Measure	Source of Care	FY				Changes <sup>a</sup>	
		2000		2001		DoD Improvement	DoD – NCBBD
		DoD	NCBD	DoD	NCBD		
Outpatient Visit	All	0.87	0.94	0.88	0.91	same	–
	Prime/HMO	0.88	0.91	0.89	0.92	same	same
	Other	0.86	0.92	0.86	0.92	same	–
ER Use	All	0.33	0.17	0.32	0.16	same	+
	Prime/HMO	0.37	0.18	0.34	0.17	same	+
	Other	0.26	0.17	0.27	0.19	same	+

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

**Table 3-23. Children’s CAHPS Composites  
(DoD vs. General Population, FY 2000–FY 2001)**

Composite	Source of Care	FY				Change <sup>a</sup>	
		2000		2001		DoD Improvement	DoD – NCBBD
		DoD	NCBD	DoD	NCBD		
Needed care	All	0.77	0.85	0.79	0.87	+	–
	Prime/HMO	0.73	0.82	0.77	0.86	+	–
	Other	0.83	0.88	0.84	0.90	same	–
Care quickly	All	0.79	0.83	0.76	0.85	–	–
	Prime/HMO	0.75	0.79	0.73	0.84	–	–
	Other	0.86	0.85	0.82	0.90	–	–
Staff courtesy	All	0.88	0.95	0.90	0.95	+	same
	Prime/HMO	0.84	0.93	0.87	0.94	+	–
	Other	0.94	0.96	0.94	0.97	same	–
Doctor communication	All	0.88	0.95	0.89	0.95	+	–
	Prime/HMO	0.85	0.92	0.87	0.95	+	–
	Other	0.93	0.96	0.92	0.97	–	–
Customer service	All	0.50	0.59	0.48	0.61	same	–
	Prime/HMO	0.53	0.60	0.50	0.63	same	same
	Other	0.47	0.59	0.46	0.50	same	–
Claims	All	0.78	0.86	0.80	0.89	same	–
	Prime/HMO	0.75	0.87	0.77	0.89	same	same
	Other	0.80	0.86	0.82	0.87	same	same

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

**Table 3-24. Children’s CAHPS Ratings  
(DoD vs. General Population, FY 2000–FY 2001)**

Rating	Source of Care	FY				Change <sup>a</sup>	
		2000		2001		DoD Improvement	DoD – NCBD
		DoD	NCBD	DoD	NCBD		
Doctor	All	0.71	0.81	0.72	0.84	same	–
	Prime/HMO	0.67	0.78	0.68	0.83	same	–
	Other	0.76	0.82	0.78	0.87	same	–
Specialty Care	All	0.72	0.74	0.71	0.76	same	same
	Prime/HMO	0.68	0.75	0.69	0.76	same	same
	Other	0.79	0.74	0.74	0.76	same	same
Health Care	All	0.64	0.81	0.66	0.83	+	–
	Prime/HMO	0.57	0.77	0.61	0.82	+	–
	Other	0.75	0.83	0.75	0.88	same	–
Plan	All	0.48	0.69	0.53	0.72	+	–
	Prime/HMO	0.48	0.68	0.54	0.73	+	–
	Other	0.48	0.71	0.51	0.67	same	–

<sup>a</sup> “+” indicates statistically significant, positive difference; “–” indicates statistically significant, negative difference; p < 0.05.

### 3.10 Areas of Possible Concern

While the general pattern of results shows that TRICARE has made improvements in access to care from FY 2000 to FY 2001 and that most quality-of-care goals are being met, this study has identified several problem areas. These are summarized in the subsections that follow.

#### 3.10.1 Satisfaction With Military versus Civilian Care

Levels of satisfaction with most aspects of access and quality were lower for DoD beneficiaries using civilian-only care, as compared to their counterparts in the general population having point-of-service commercial health plans. In principle, the health plans for these two groups should be similar, yet those who are eligible for DoD health benefits and don’t use them are less satisfied with their health plans. This could reflect higher expectations on the part of DoD beneficiaries.

Those who, in principle, could use military sources of care but do not are also different in a more subtle way—they *chose* their civilian health care plan and chose *not* to use the military system. This “taste” for civilian care possibly accounts for some of the differences in satisfaction. While it is possible to “adjust” the data and statistically predict the outcomes of a subpopulation on the basis of different demographics, it is not possible to account for the factors underlying the choice of the source of health care with the available data.

### **3.10.2 Shortfalls in Meeting Quality-of-Care Goals**

While most *Healthy People 2010* goals were being met, a few were not. Some of these shortfalls are described below.

#### **3.10.2.1 Tobacco Use**

Our previous evaluations have shown that the use of tobacco products (cigarettes and smokeless tobacco) is prevalent among the enlisted population. While not a mitigating circumstance, prevalence of the use of tobacco products by youth in the general population is also high.

TRICARE did not meet its goals for counseling cigarette smokers. While it may be difficult to achieve a reduction in the use of tobacco products, providing counseling services is a matter of enforcing policy. If the counseling is to be provided by a health care professional, this requires some interaction between the health care professional and the smoker. This could be done during an outpatient visit. However, many smokers, particularly otherwise healthy ones, may not regularly have an outpatient visit. An alternative approach for providing smoking counseling to the active-duty population is to have a counselor visit the workplace or provide training for unit counseling. However, providing unit-level training would likely be expensive and require considerable resources.

#### **3.10.2.2 Flu Shots**

TRICARE did not meet its goal for influenza immunizations for those over 65. This goal had been met in previous years.

### **3.10.3 Claims Processing**

Having a problem with a claim is a major cause of dissatisfaction with one's health plan. The rate of claim filing for MHS beneficiaries, though lower than for those in commercial civilian plans, is on the rise (59 percent in FY 2000 vs. 66 percent having a claim in FY 2001). At the same time, MHS beneficiaries tend to experience more problems than the general population with claims processing. This was true for those enrolled in Prime, especially active-duty personnel, who expect less paperwork and associated problems. On the positive side, satisfaction with claims processing rose by 3 percent from FY 2000 to FY 2001 for DoD beneficiaries.<sup>26</sup>

### **3.10.4 Children's Health Care**

Satisfaction with access to health care for children using the MHS was significantly lower when compared to the benchmark. While there was some improvement in being able to get needed care for DoD children (up 2 percent from FY 2000), satisfaction with being able to get appointments without long waits dropped by 3 percentage points.

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<sup>26</sup> This was a 2-percent rise in the satisfaction rate with claims processing for those with commercial civilian plans.

### **3.10.5 Emergency Room Use**

Use of the ER for care rose by 2 percentage points over the period of analysis. At the same time, the rate of use of the ER was greater than for those in the general population with commercial civilian plans.

### **3.11 What Went Right**

Despite lagging commercial civilian plans, the net effect of TRICARE is improvement from FY 2000 to FY 2001, as evidenced by increased satisfaction with:

- one's health plan (all sources of care),
- overall quality of care (Prime enrollees),
- communication with doctors,
- courtesy and respect shown by office staff,
- customer service, and
- claims processing.

In addition, quality-of-care standards have mostly been maintained under TRICARE. Most of the quantifiable *Healthy People 2010* goals examined were met, or nearly met, for the DoD health care beneficiary population as a whole.



## **4. COST TO THE GOVERNMENT**

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This chapter considers the trends in TRICARE utilization and government costs from FY 1999 to FY 2001. To make these quantities comparable, we inflated FY 1999 and FY 2000 costs to FY 2001 dollars. Unlike past evaluations, we made no adjustments for changes in the composition or size of the beneficiary population because they did not change much between FY 1999 and FY 2001. Because major benefit enhancements (such as the TRICARE Senior Pharmacy benefit introduced in April 2001) have an impact on the trends, we separate the impact of benefit enhancements from the collective impact of any other factors when summarizing the trends. We also display the trends in TRICARE utilization and costs against comparable civilian-sector benchmarks.

### **4.1 Methods and Data Sources**

#### **4.1.1 Data Sources**

We based the evaluation of government and beneficiary costs on data from several sources. For each month of each year of the evaluation, we categorized beneficiaries enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) database according to their enrollment status (enrolled with a military PCM, enrolled with a civilian PCM, or unenrolled), beneficiary status (active-duty member, active-duty family member, retiree/family member <65, or retiree/family member ≥65), and catchment or noncatchment area of enrollment or residence. Because beneficiaries can move, change PCMs, and enroll or disenroll during the course of a year, categorizing and enumerating beneficiaries on a monthly basis allows us to partition an individual beneficiary's eligibility interval into different stages. Dividing the number of eligible beneficiaries in each month by 12 and summing across the months in each year, we were able to determine the number of eligible person-months in each beneficiary and enrollment category.

We obtained the health care experience of eligible beneficiaries by aggregating Standard Inpatient Data Records (SIDRs—MTF hospitalization records); Standard Ambulatory Data Records (SADRs—MTF outpatient records); Health Care Service Records (HCSRs—purchased-care claims information) for inpatient, outpatient, and prescription services; and NMOP claims within each beneficiary category. Costs recorded on HCSRs are broken out by source of payment (government, beneficiary, or private insurer). Although the SIDR and SADR data indicate the enrollment status of beneficiaries, the DEERS enrollment file is considered to be more reliable. We therefore classified MTF discharges as Prime or space-available by matching the discharge dates to the DEERS enrollment file.

#### **4.1.2 Direct Care Data**

MTFs record inpatient stays in the SIDR data. As with purchased-care claims, the SIDR data remain incomplete until several months have elapsed beyond the end of the fiscal year. To adjust for incompleteness, we reconciled the SIDR data with data from the

Medical Expense and Performance Reporting System (MEPRS), which were virtually complete at the time the data were extracted.

Since we have dropped the FY 1994 baseline in this evaluation, we are able for the first time to use SADR data on MTF outpatient visits in conjunction with MEPRS data to categorize utilization and costs by enrollment status and beneficiary category. We applied a method similar to that used for reconciling SIDR and MEPRS data to adjust the SADR data for completeness.

We developed the direct-care costs from MEPRS, which records costs and workload by workcenter at each MTF. MEPRS classifies final operating costs into five accounts:

- A (Inpatient),
- B (Outpatient),
- C (Dental),
- F (Special Programs), and
- G (Readiness).

MEPRS also records intermediate operating costs in accounts D (Ancillary Services, e.g., pharmacy, pathology, and radiology) and E (Support Services, e.g., base operations and real property maintenance). However, these costs are fully allocated or “stepped down” to the five final operating accounts, so they need not be considered separately in this analysis. In particular, most pharmacy costs are recorded in the three-digit account DAA (Pharmacy) and are stepped down to the final operating accounts.

#### **4.1.3 Purchased Care Data**

The purchased-care claims data from FY 1999 and FY 2000 are essentially complete as of this writing. However, because some claims are not received and processed until well after the close of the fiscal year, the FY 2001 data were not yet complete at the time of data collection. To account for the lag in the submission of claims, TMA appends a factor to the HCSR records<sup>27</sup> to estimate the total expected government cost when all claims have been processed. We applied these completion factors to the appropriate cost and utilization elements in FY 2001 to estimate a full year of claims experience.

#### **4.1.4 Summary of Findings**

The tables and figures in this section display results in terms of the beneficiary group and enrollment status of military health care beneficiaries. Considerations of space and clarity of exposition preclude displaying the information in greater detail. We can better put the displays in context, however, by knowing something about the composition of beneficiaries within and among beneficiary groups and enrollment status (i.e., enrolled with a military PCM, enrolled with a civilian PCM, or nonenrolled). Table 4-1 shows the distribution of beneficiaries in Regions 1 through 12 by enrollment status and beneficiary group. Beneficiaries are broken out by these characteristics because they are probably the most influential in determining utilization patterns.

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<sup>27</sup> The factor, based on historical claims filing and processing lags, was adjusted in December 2001 to reflect improved claims processing.

**Table 4-1. Distribution of Beneficiary Population in Regions 1 Through 12 by Beneficiary Group, Enrollment Status, and Year**

Beneficiary Group	Enrollment Status	FY 1999	FY 2000	FY 2001
Active Duty	Military PCM	1,556,044	1,541,643	1,527,937
Active Duty	Civilian PCM	7,576	32,172	45,899
Active-Duty Family Members	Military PCM	1,349,707	1,405,175	1,426,138
Active-Duty Family Members	Civilian PCM	178,489	206,180	225,424
Active-Duty Family Members	Nonenrolled	637,558	545,912	513,985
Retirees <65 and Family Members	Military PCM	514,103	591,684	650,374
Retirees <65 and Family Members	Civilian PCM	206,507	240,714	265,473
Retirees <65 and Family Members	Nonenrolled	2,290,322	2,185,435	2,118,303
Retirees ≥65 and Family Members	Military PCM	21,963	32,836	38,653
Retirees ≥65 and Family Members	Civilian PCM	1,121	1,606	2,133
Retirees ≥65 and Family Members	Ineligible	1,342,439	1,388,769	1,462,599
<b>Total</b>	<b>All</b>	<b>8,105,830</b>	<b>8,172,125</b>	<b>8,276,916</b>

Note: Beneficiary population is measured as total eligible person-months during each year, *not* the number of beneficiaries at a fixed point in time.

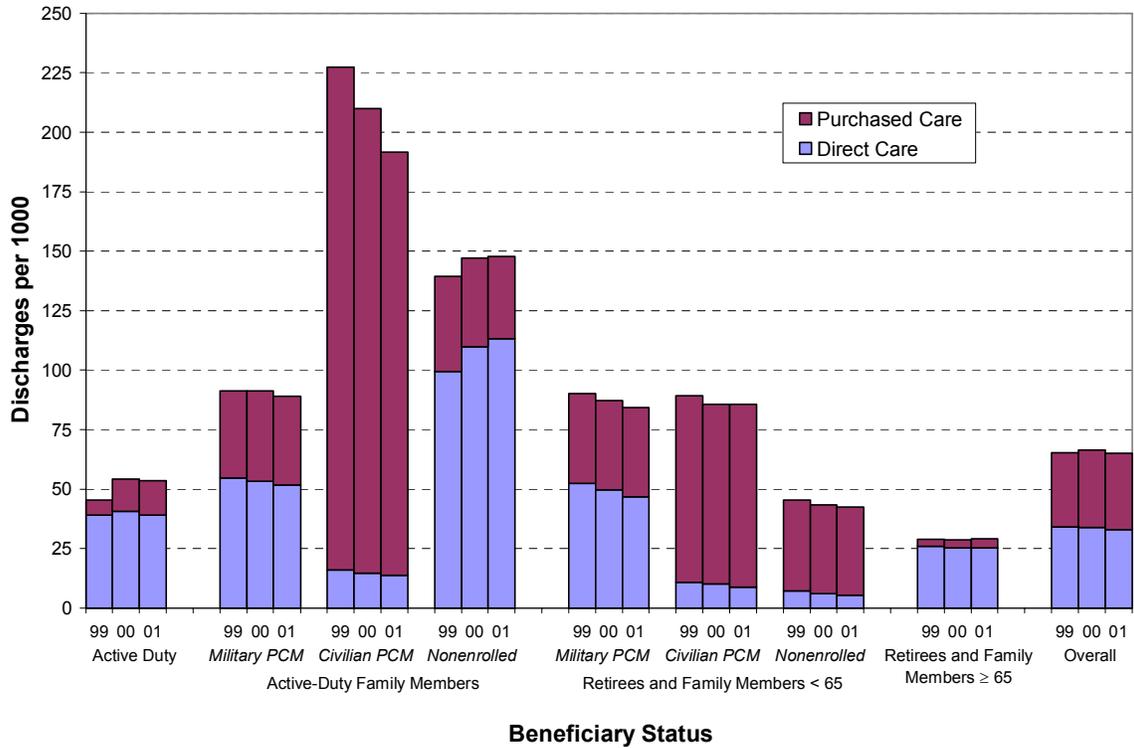
The results that follow are presented somewhat differently from past TRICARE evaluations. Rather than separately display direct and purchased care utilization and costs, we display them together in the form of stacked bar charts. This scheme allows the reader to visualize the overall pattern of utilization and costs for each beneficiary group.

The following subsections summarize the trends in inpatient, outpatient, and prescription utilization and costs. The results, which we present for all evaluated TRICARE regions combined, may mask differences across regions.

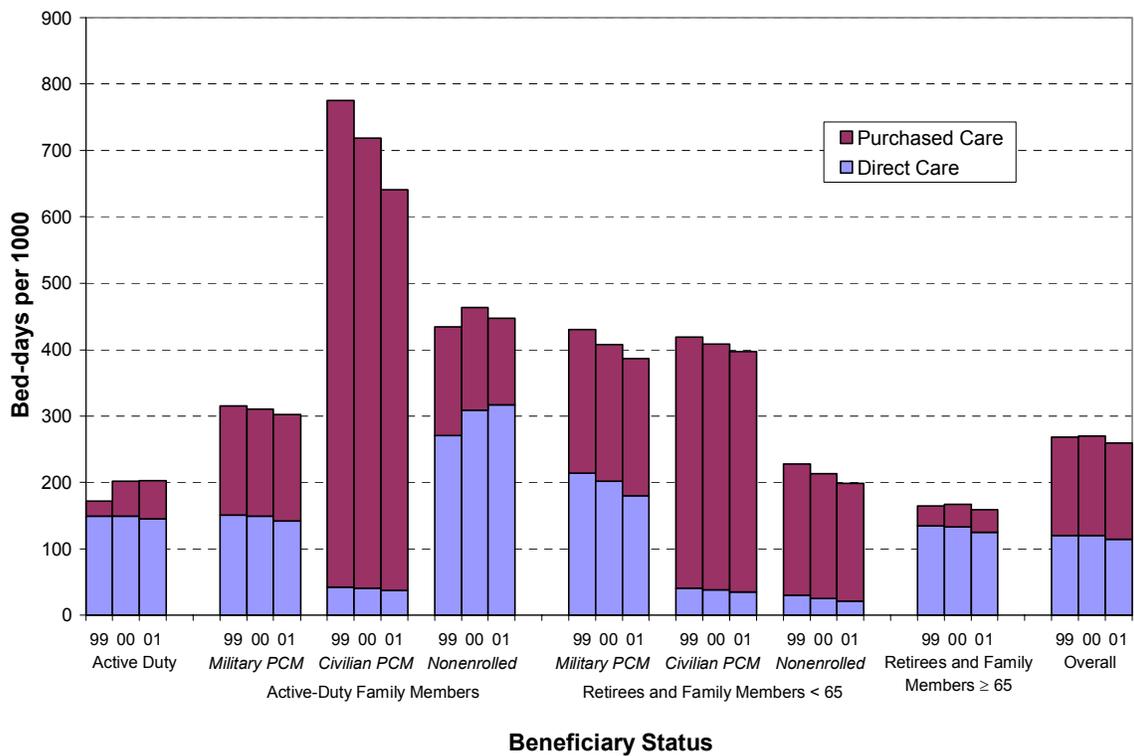
#### **4.1.4.1 Inpatient Utilization and Costs**

In theory, managed care programs apply utilization management (UM) initiatives to reduce the incidence of unneeded hospitalizations. Utilization management includes prospective reviews by physicians, discharge planning, disease management programs, demand management programs, and other techniques to exercise clinical oversight. If a hospitalization is deemed necessary, managed care programs additionally apply quality management to reduce the length of stay without compromising the health of the patient. In theory, TRICARE should contain government costs by reducing the incidence of inpatient admissions and lengths of stay of Prime enrollees, thereby freeing available bed-days to recapture more costly network workload. Additional government savings could come from discounts the MCS contractor negotiates with civilian network hospitals and physicians.

We measure inpatient utilization in two ways: (1) as the number of discharges per 1000 covered lives, and (2) as the number of bed-days per 1,000 covered lives. Figure 4-1 shows the trend in the number of discharges by beneficiary group and enrollment type from FY 1999 to FY 2001. Total utilization is broken down by direct and purchased sources of care. Figure 4-2 shows the corresponding trend in bed-days. Because the patterns exhibited for bed-days are similar to those for discharges, the discussion that follows applies to both discharges and bed-days.



**Figure 4-1. Average Annual Inpatient Discharges per Beneficiary**



**Figure 4-2. Average Annual Inpatient Bed-Days per Beneficiary**

Of note is that for non-active-duty beneficiaries enrolled with a military PCM, almost as much inpatient workload is referred to the network as is done in the direct-care system. Moreover, the trends show a slight increase in the amount of care referred to the network between FY 1999 and FY 2001. In contrast, almost all inpatient workload for non-active-duty beneficiaries enrolled with a civilian PCM is performed in the network, with little workload referred to the direct-care system.

Active-duty service members' utilization of direct-care inpatient services remained roughly constant over the evaluation time interval but their utilization of purchased-care inpatient services more than doubled. The reasons for the increase in purchased-care utilization are the downsizings of some military hospitals to clinics and the introduction in FY 2000 of the TRICARE Prime Remote (TPR) program, which provides health care coverage through civilian providers for Uniformed Service Members who are on remote assignment (determined by the Lead Agents but usually defined as more than 50 miles or an hour's drive from a military hospital).

Enrolled active-duty family members exhibited slight declines in direct-care inpatient utilization. However, active-duty family members with a military PCM experienced only a slight decline in purchased-care utilization, whereas those with a civilian PCM experienced a dramatic decline. On the other hand, nonenrolled active-duty family members experienced an increase in their direct-care utilization but a moderate decrease in their purchased-care utilization. The increase in their direct-care utilization was sufficiently large, however, so that their total utilization increased.

All retiree groups showed a slight decline in direct-care inpatient utilization, whereas their purchased-care utilization was essentially unchanged. Overall, there was a slight decline in the number of direct-care discharges/bed-days, a slight increase in the number of purchased-care discharges, and a slight decrease in the number of purchased-care bed-days. There is therefore no evidence to suggest that MTFs have been able to recapture any additional network workload over the evaluation time interval.

Because MTFs do not bill beneficiaries for a hospital stay, the SIDRs contain no information on cost. Rather, they contain a measure of relative resource consumption for each discharge. This measure, called a Relative Weighted Product (RWP), is computed by applying what is referred to as the TRICARE Grouper<sup>28</sup> and associated weights that reflect the resources expended relative to the nationwide average. It is normalized so that a procedure that consumes the nationwide average amount of resources receives an RWP of 1.0.

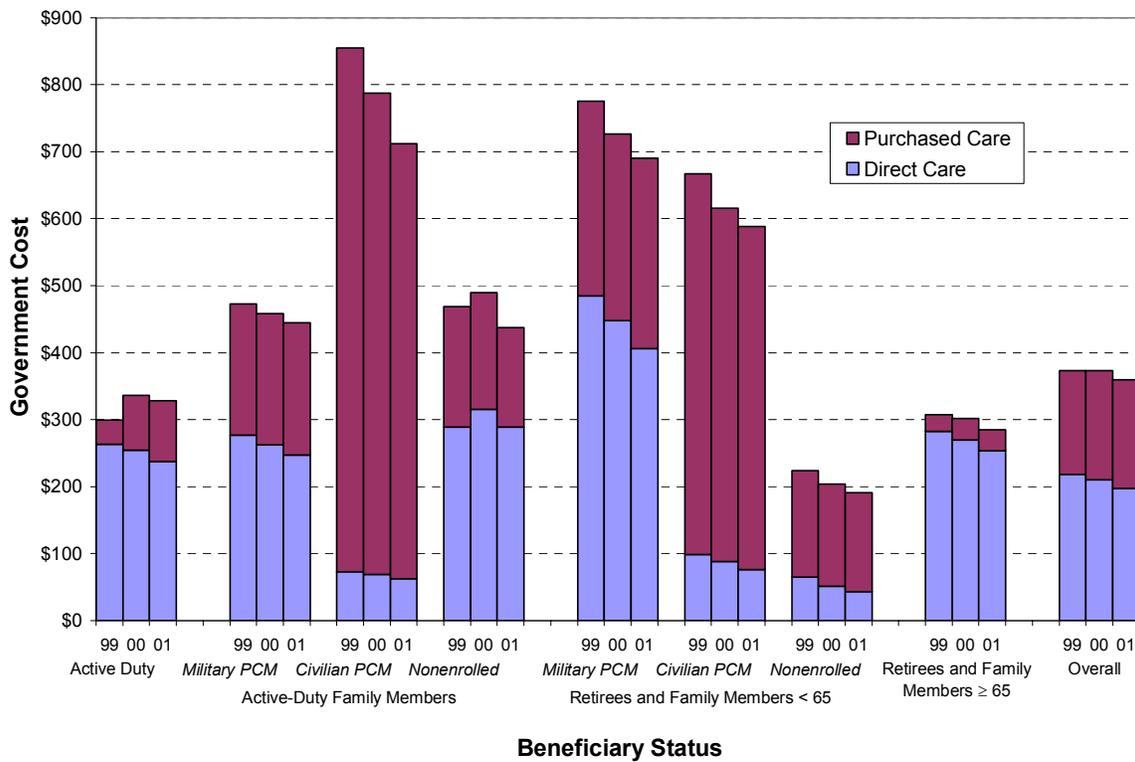
We computed the cost of a discharge by multiplying the RWPs by the average cost per RWP. To compute the average cost per RWP, we first obtained total inpatient costs from MEPRS. However, MEPRS records only total discharges and bed-days, not RWPs. Consequently, we had to obtain total RWPs from the SIDRs and scale them to the total number of discharges recorded in MEPRS (the scale factor for most MTFs was slightly over 1.0). Because we collected a summary of SIDR discharge totals by beneficiaries' enrollment or residence area rather than individual SIDR discharge records, we were able

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<sup>28</sup> Produced by 3M Health Information Systems, the TRICARE Grouper takes account of the length of stay, diagnoses, treatments, complications, and co-morbidities associated with a hospitalization to assign procedures to Diagnosis Related Groups (DRGs).

to compute only a region-specific cost per RWP, not an MTF-specific cost. However, since discharges are aggregated across all MTFs in the evaluated regions, this should not pose much of a problem with cost estimation accuracy.

Figure 4-3 shows the trend in inpatient costs per beneficiary. Purchased-care inpatient costs include both institutional and professional services charges. We inflated institutional costs by the Centers for Medicare and Medicaid Services (CMS) Hospital Input Price Index (1-year inflation of 3.7 percent and 2-year cumulative inflation of 8 percent) and professional services costs by the Medicare Economic Index (1-year inflation of 2.2 percent and 2-year cumulative inflation of 5 percent). We inflated MTF inpatient costs using the CMS Hospital Input Price Index plus a factor for medical intensity and technology (a 1-year total of 4.4 percent and a 2-year total of 9.5 percent).



**Figure 4-3. Average Inpatient Cost per Beneficiary**

For all but active-duty service members, total inpatient costs declined from FY 1999 to FY 2001 (though not always uniformly). Direct-care inpatient costs for active-duty service members declined but purchased-care costs increased more than two-fold because of the introduction of the TPR program. Total inpatient costs decreased by 6 percent for active-duty family members with a military PCM and by 11 percent for retirees and family members with a military PCM. Government costs decreased the most for beneficiaries with a civilian PCM, declining by 17 percent for active-duty family members and by 12 percent for retirees and family members. Direct-care costs for nonenrolled active-duty family members increased but were offset by a decrease in purchased-care costs. On the other hand, both direct- and purchased-care inpatient costs

decreased for nonenrolled retirees and family members, for a cumulative decline of 12 percent. Overall, total government inpatient costs declined by 4 percent.

#### 4.1.4.2 Outpatient Utilization and Costs

We measured direct-care outpatient utilization as the number of “countable visits” as defined by TMA on the SADR. Excluded are telephone consultations, appointments scheduled but not kept, etc. To measure purchased-care outpatient utilization, we employed an algorithm that produced somewhat lower visit counts than recorded on the HCSRs. We observed that in some cases, the HCSRs recorded an inordinate number of visits for a single person on a single day (e.g., there were cases where the HCSRs recorded over 20 visits in a single day). Multiple visits can occur on a single day by counting clinical encounters (e.g., office visit, x-ray, lab tests, etc.) as separate visits. Our algorithm treats all services provided on a single day in a single location as a single visit. In over 90 percent of the cases, our algorithm produced the same visit count as on the HCSRs but substantial differences occurred in the remaining cases.

Because somewhat inconsistent methods are used to count visits on SADR and on HCSRs, direct- and purchased care visits per beneficiary are not completely comparable. To test how comparable they are, we applied our HCSR visit count algorithm to the SADR and produced visit counts that were very similar to the SADR numbers. Figure 4-4 compares the average annual outpatient utilization per beneficiary by beneficiary status and enrollment type from FY 1999 to FY 2001.

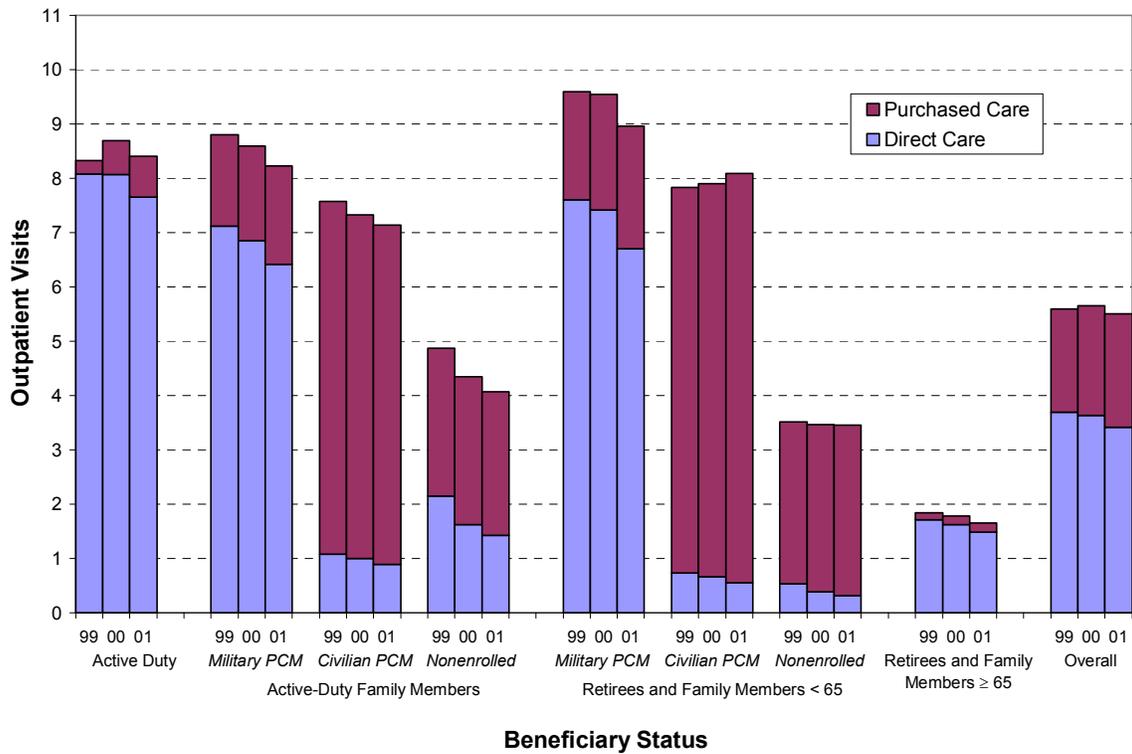


Figure 4-4. Average Annual Outpatient Utilization per Beneficiary

Not unexpectedly, beneficiaries enrolled with a military PCM have the highest overall outpatient utilization. This result is mostly attributable to lower beneficiary cost shares (lower out-of-pocket costs tend to increase utilization) for beneficiaries enrolled with a military PCM. Beneficiaries with a civilian PCM have the next highest utilization, followed by nonenrolled beneficiaries. Retirees and family members age 65 and over have the lowest utilization because they rely primarily on Medicare and private insurance to cover their health care needs.

Most notable in Figure 4-4 is the downward trend in direct-care outpatient workload from FY 1999 to FY 2001. Direct-care outpatient workload has declined for every beneficiary group and enrollment status, particularly for beneficiaries with a military PCM. Overall, direct-care outpatient workload has decreased by 7 percent. At the same time, network workload has increased by 10 percent, suggesting that rather than recapturing purchased-care workload (as TRICARE is intended to do), the direct-care system may be losing market share to the network.

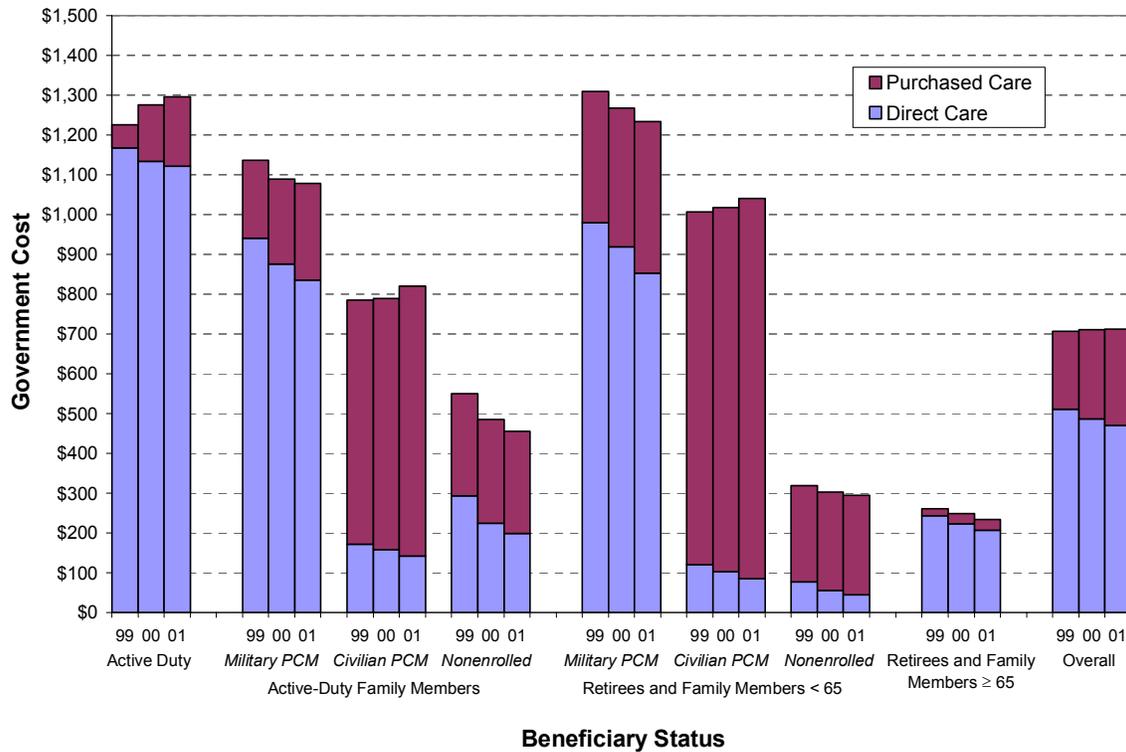
Over the evaluation time interval, there has been an increase in the number of ambulatory surgeries, which are more resource-intensive than the typical office visit. One reason the total number of visits may be declining is a greater percentage of ambulatory surgeries. To examine this possibility, we computed the number of case-weighted visits by summing Relative Value Units (RVUs)<sup>29</sup> rather than raw visits. By this measure, direct-care outpatient workload declined by only 1.3 percent. Therefore, it appears that although the MTFs may not be recapturing network workload, neither are they losing market share.

Figure 4-5 shows the trend in the average outpatient cost per beneficiary. We applied a method analogous to that used to estimate MTF inpatient costs to derive a region-specific cost per RVU. We inflated FY 1999 and FY 2000 purchased-care costs by the Medicare Economic Index (1-year inflation of 2.2 percent and 2-year cumulative inflation of 5 percent) because that index is one of the factors used by TMA–Aurora in setting its maximum allowable charges. We inflated direct-care costs using the CMS Hospital Input Price Index plus a factor for medical intensity and technology (a 1-year total of 4.4 percent and a 2-year total of 9.5 percent). Although the latter index is a hospital price index, we used it to inflate MTF outpatient costs because most MTF outpatient care is provided in a hospital setting.

The general trends in cost are similar to those observed for outpatient utilization. For most beneficiary groups, the MTF outpatient cost per beneficiary declined more or less in proportion to the drop in workload, but the network cost per beneficiary increased at a somewhat greater rate than the increase in utilization. An exception occurs for active-duty family members with a civilian PCM. Total utilization for these beneficiaries decreased from FY 1999 to FY 2001 but government costs increased somewhat, most likely because of the elimination of copayments for enrolled active-duty family members in FY 2001.

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<sup>29</sup> RVUs are a measure of resource intensity recorded on the SADRs somewhat analogous to RWPs on the SIDRs.



**Figure 4-5. Average Outpatient Cost per Beneficiary**

The total government cost can be expressed as the product of the total number of visits and the average cost per visit. Over the period from FY 1999 to FY 2001, the average cost per MTF visit held steady at about \$137 per visit. In contrast, the average government cost per network visit increased from \$103 to \$116 over the same time period. The network cost per visit is lower than the MTF cost for several reasons. First, the government incurs the entire expense of treating beneficiaries in MTF hospitals and clinics whereas that expense is shared by beneficiaries using network facilities (the beneficiary share being much greater for nonenrollees than for enrollees). Second, most military outpatient care is performed in a hospital setting, which tends to be more expensive than care performed in a clinic or doctor's office. Third, the network costs reflect the \$230 per individual/\$460 per family enrollment fee paid by retirees that serve to reduce the price of the MCS contract.

#### 4.1.4.3 Prescription Utilization and Costs

Until recently, there had been no centralized patient-level accounting system with information on MTF prescription workload and costs. This changed with the introduction of the Pharmacy Data Transaction Service (PDTS), which was fully deployed in June 2001. The PDTS data repository contains detailed information on drug utilization and pharmacy expenditures for the entire DoD pharmacy benefit. We will rely on the PDTS in future TRICARE evaluations to break out MTF pharmacy utilization and costs by beneficiary category and enrollment status but there are insufficient data to perform that breakout for the interval FY 1999 to FY 2001.

The direct-care prescriptions that we consider in this section are those associated with MTF outpatient visits. We do not consider prescriptions written by civilian physicians but filled at MTFs in this section. Prescription workload and costs for the latter are recorded in the MEPRS Special Programs accounts and cannot be broken out beyond workcenter. In particular, we cannot determine which beneficiary groups are using the MTFs to fill their civilian prescriptions. A summary of the overall trends in Special Programs prescription costs is presented in Section 4.2.1.

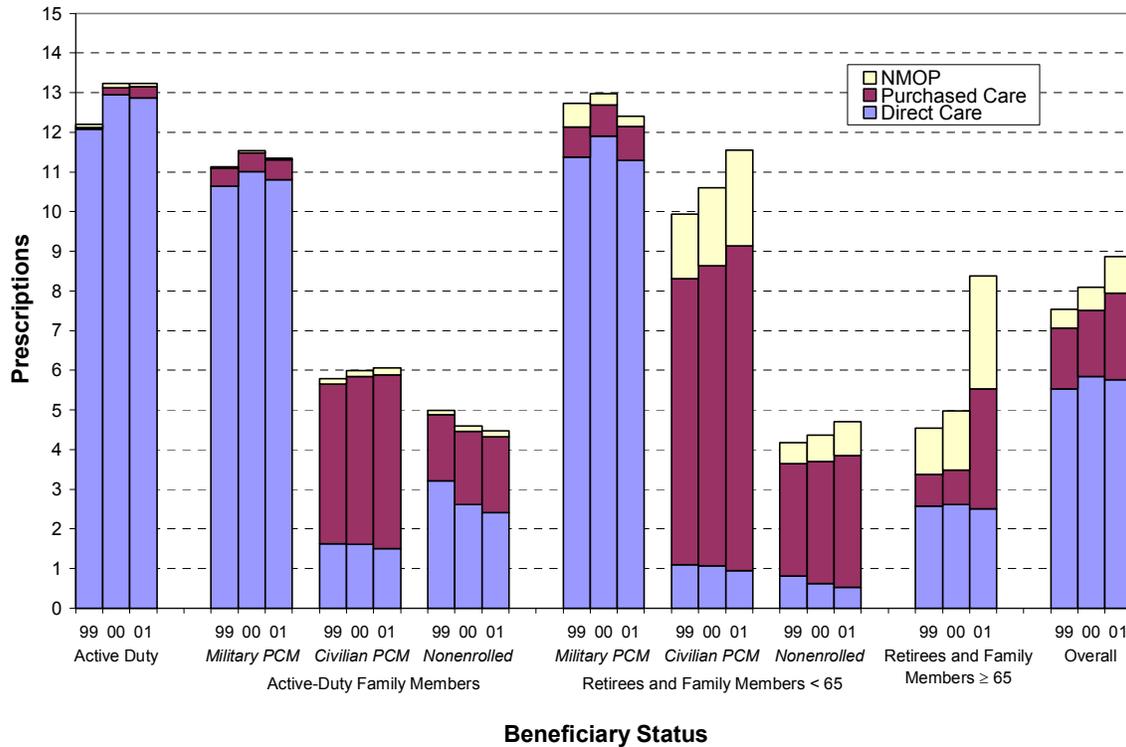
For this year's evaluation, we employ an alternative procedure to estimate MTF prescription utilization and costs by beneficiary category and enrollment status. The procedure is based on the assumption that MTF prescription utilization is correlated with the utilization of MTF outpatient services. This assumption seems reasonable because an office visit is usually required before a physician will write an initial prescription. To test the validity of this assumption, we aggregated MEPRS visit and prescription counts in outpatient workcenters by the parent MTF and ran a regression of prescriptions against visits. The result was a very high correlation between prescriptions and visits ( $R^2 = 0.95$ ), indicating that it is reasonable to allocate prescriptions in proportion to visits.

The number of prescriptions filled at network pharmacies or through the NMOP are based on individual-level claims data that allow us to identify beneficiary group and enrollment status. As indicated in the previous paragraph, total direct-care prescriptions from MEPRS outpatient accounts are allocated to beneficiary groups and enrollment status in proportion to the number of outpatient visits they generate.

Figure 4-6 shows the trends in average annual purchased-care prescription utilization per beneficiary. Prescriptions include all initial and refill prescriptions identified in MEPRS outpatient accounts, filled at network pharmacies, or filled through the NMOP. Note, however, that prescription utilization is difficult to quantify since prescriptions come in different forms (e.g., liquid or pills), quantities, and dosages. Moreover, NMOP and MTF prescriptions can be filled for up to a 90-day supply whereas the limit for network prescriptions is only 30 days. In an attempt to normalize prescription counts from different sources, we obtained data from the DoD Pharmacoeconomic Center on the average days supply by point of service. The average days supply, derived from the PDTS, are 41 days for MTF prescriptions, 28 days for retail prescriptions, and 76 days for NMOP prescriptions. Using retail prescriptions as the base (for later comparison with civilian-sector benchmarks), we standardized the prescription counts from other points of service using the ratio of their average days supply to that for retail prescriptions.

The patterns show a substantial increase in prescription utilization by all beneficiary groups except nonenrolled active-duty family members. As more beneficiaries enroll in Prime, those who choose not to enroll should find it increasingly difficult to obtain access to direct care. Fewer visits to MTFs therefore result in fewer prescriptions being written. Consequently, nonenrolled beneficiaries have shifted their prescription utilization from MTFs to the retail network or the NMOP. In the case of nonenrolled active-duty family members, the increase in purchased-care utilization is not enough to offset the decrease in direct-care utilization. This is presumably because there can be substantial copayments and a deductible associated with retail prescriptions. For nonenrolled retirees and family members, the increase in purchased-care utilization more than offsets the decrease in

direct-care utilization. Many of these beneficiaries have private or supplemental insurance coverage, which mitigates the patient cost share.



**Figure 4-6. Average Annual Prescription Utilization per Beneficiary**

Not surprisingly, direct-care utilization of prescriptions has increased for beneficiaries with a military PCM and purchased-care utilization of prescriptions has increased for beneficiaries with a civilian PCM. The largest increases are exhibited by enrolled retirees and family members and by senior retirees and family members. The increase for the latter group of beneficiaries is due almost exclusively to the introduction of the TRICARE Senior Pharmacy (TSRx) benefit in April 2001.

Overall, prescription utilization continues to grow at a steady rate. A variety of factors influence this growth, including increased availability of and dependence on medications for treatments, increases in promotion of prescription drugs by pharmaceutical manufacturers, introduction of the TSRx program, and an aging beneficiary population.

Figure 4-7 shows the impact of TRICARE on purchased-care prescription costs. We inflated FY 1999 and FY 2000 direct-care costs by the Producer Price Index (PPI) for Prescription Preparations (1-year inflation of 3.7 percent and 2-year cumulative inflation of 6.8 percent) and purchased-care costs by the Consumer Price Index (CPI) for prescription drugs (1-year inflation of 5.1 percent and 2-year cumulative inflation of 9.9 percent). The trend in prescription drug costs is similar to that for utilization, with costs increasing significantly for all beneficiary groups except nonenrolled active-duty family members. However, the magnitude of the increase in costs exceeds that for utilization.

Overall, prescription utilization increased by 18 percent from FY 1999 to FY 2001 but corresponding costs increased by 38 percent. The average cost for an MTF prescription increased by 7 percent, the cost of a network prescription increased by 15 percent, and an NMOP prescription increased by 7 percent. In addition, there has been a tendency towards more NMOP utilization per beneficiary, which increases the cost to the government because NMOP prescriptions are typically for up to a 90-day supply.

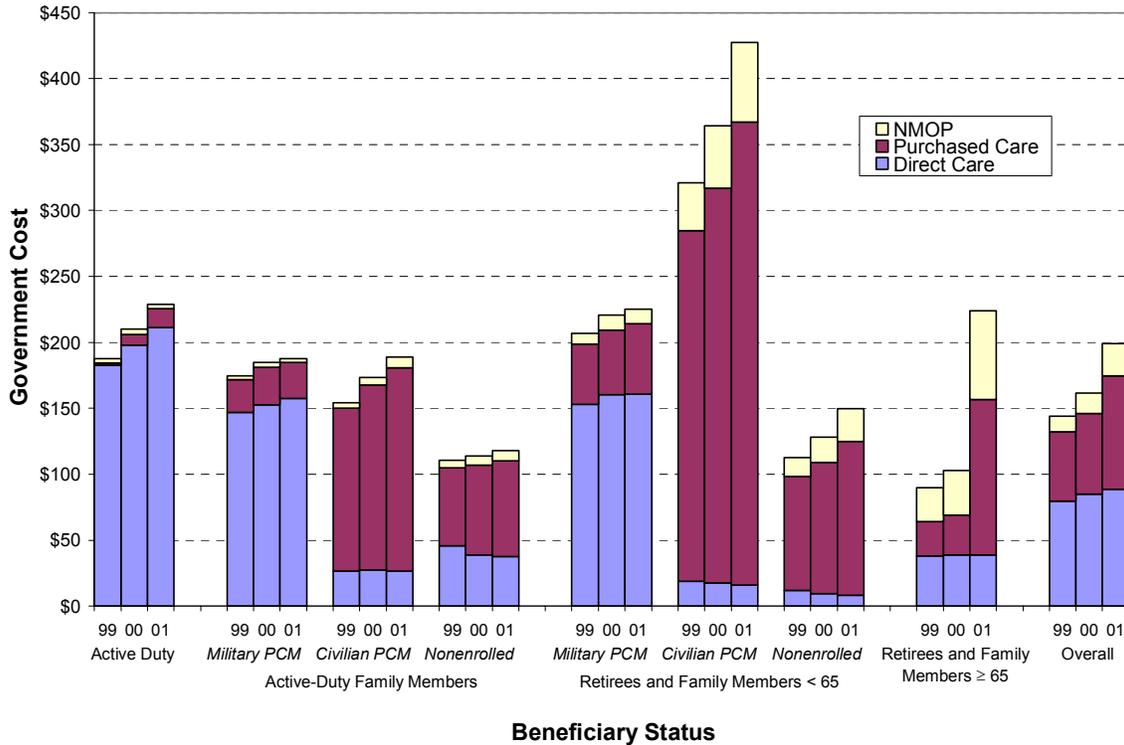


Figure 4-7. Average Prescription Cost per Beneficiary

## 4.2 Cost to the Government

In addition to the direct costs of delivering health care, the government incurs substantial indirect and overhead costs to support the MHS. The indirect costs are distributed into three general categories:

- costs incurred at MTFs;
- costs for purchased care, including at-risk and not-at-risk health care costs, NMOP, and administrative costs; and
- system-wide costs developed from the DoD budget (specifically, the Future Years Defense Program (FYDP)).

The MCS contractor collects all Prime enrollment fees (for beneficiaries having both military and civilian PCMs), and the resulting revenue reduces the net contract price. The MCS costs reported in subsequent tables are net of this revenue.

The MTFs also collect revenue from third-party collections and inpatient subsistence charges. Third-party collections are already captured in the MEPRS EBH subaccount (Third-Party Collection Administration) and are stepped down to the final operating accounts. Inpatient subsistence charges are currently zero for retired enlisted personnel, \$7.50 per day for active-duty personnel and retired officers, and \$10.85 per day for all other beneficiaries. Because so few beneficiaries are hospitalized in an MTF during a given 1-year window, these charges contribute a negligible offset to total direct-care cost.

Table 4-2 summarizes TRICARE costs within the above categories in the interval FY 1999 to FY 2001. We made an effort to provide as complete an accounting of MHS costs as possible. However, as noted in the Section 733 Study:<sup>30</sup>

It is impossible to develop a complete reconciliation between MEPRS and the FYDP, partly because FYDP obligations translate into outlays over a multi-year time window. In addition, there is no standard crosswalk between MEPRS and any particular subset of PEs [Program Elements]....

Consequently, the costs identified by the IDA study team do not align completely with the DHP—the portion of the DoD appropriation that provides funding for peacetime military medical and dental care, training of medical personnel, and readiness of all medical units. The DHP for FY 2001 was \$17.23 billion, whereas total worldwide costs identified from DoD information systems were \$17.13 billion. Thus, we were able to reconstruct the DHP to within \$100 million.

The following subsections provide a detailed discussion of Table 4-2 as well as a description of the content of each cost category.

#### **4.2.1 Direct-Care Costs**

The pharmacy costs associated with inpatient and outpatient care are recorded in the DAA account of MEPRS and stepped down to the final operating accounts shown in Table 4-2. For this evaluation, we have included pharmacy costs stepped down to the inpatient accounts but removed pharmacy costs from the outpatient accounts. We report drugs associated with outpatient care separately as outpatient drugs. The remaining costs in the outpatient accounts are directly associated with the production of visits.

Table 4-2 reveals that both inpatient and outpatient direct-care costs decreased somewhat in the FY 1999 to FY 2001 time interval. The decreases in cost are consistent with the corresponding loss of MTF market share in both inpatient and outpatient workload.

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<sup>30</sup> Matthew S. Goldberg et al., “Cost Analysis of the Military Medical Care System: Final Report,” Institute for Defense Analyses, Paper P-2990, September 1994.

**Table 4-2. Comparison of Baseline with TRICARE Costs in Evaluated Regions**

Source	Account/Program Element	FY 1999	FY 2000	FY 2001
Direct Care	Inpatient	\$1,636.3	\$1,590.9	\$1,548.5
	Outpatient (Visits)	3,885.4	3,729.1	3,627.9
	Outpatient (Drugs)	595.1	637.8	697.0
	Dental	687.1	668.3	662.9
	Special Programs	1,476.0	1,554.0	1,760.5
	Readiness	186.2	217.7	211.9
	Military Pay Adjustment	153.2	152.0	154.0
	Military Construction	296.3	293.9	297.8
	Contractor Administrative Cost	38.7	37.8 <sup>a</sup>	38.2
	<b>Subtotal</b>	<b>\$8,954.4</b>	<b>\$8,881.5</b>	<b>\$8,998.7</b>
Purchased Care	Inpatient	\$1,186.2	\$1,242.9	\$1,256.9
	Outpatient	1,500.4	1,700.4	1,871.7
	Retail Prescriptions	398.7	463.6	664.3
	Mail Order Prescriptions	88.8	118.9	185.0
	Other Services	12.3	12.3	11.4
	Salaried Resource Sharing	76.1	117.7	140.8
	Capital Construction/DME	88.2	138.3	111.5
	Special and Emergent Care	7.3	1.5 <sup>a</sup>	0.0
	Other Pass-Through Costs	2.2	1.1 <sup>a</sup>	0.4
	Administrative Cost	676.7	704.4 <sup>b</sup>	701.8
	<b>Subtotal</b>	<b>\$4,037.0</b>	<b>\$4,501.3</b>	<b>\$4,943.8</b>
Other DHP Costs <sup>c</sup>	Armed Forces Health Scholarship	\$124.9	\$127.1	\$129.1
	Armed Forces Institute of Pathology	51.7	52.2	52.4
	Examining Activities–Health Care	39.9	42.2	40.4
	Management Headquarters	56.4	55.0	76.0
	Medical Combat Support–Active	632.9	307.7	570.1
	Medical Development	35.4	244.8	0.0
	MHS IM/IT	242.6	283.6	286.3
	Other Health Activities	436.6	361.1	353.8
	Other Procurement, Replacement	345.4	279.3	232.2
	TRICARE Management Activity	132.7	135.7	140.4
USUHS	108.5	137.8	126.7	
	<b>Subtotal</b>	<b>\$2,206.9</b>	<b>\$2,026.7</b>	<b>\$2,007.2</b>
<b>Overall</b>	<b>Total Government Cost</b>	<b>\$15,198.3</b>	<b>\$15,409.5</b>	<b>\$15,949.7</b>

Note: Costs exclude Alaska and overseas.

<sup>a</sup> Weighted average of 2 option years for each TRICARE region, where weights are proportions of those years that fell within FY 1999.

<sup>b</sup> Allocated to TRICARE regions by share of total purchased-care operating cost.

<sup>c</sup> Allocated to TRICARE regions by share of total MHS operating cost.

Pharmacy costs in the evaluated TRICARE regions increased from \$974 million in FY 1999 (after adjusting FY 1999 costs for inflation in the PPI for prescription preparations) to \$1,173 million in FY 2001, an increase of 20 percent over inflation. Costs are for prescriptions associated with outpatient care (B accounts) and special programs (F accounts).

No major changes to the direct-care dental benefit have occurred under TRICARE. Inflation-adjusted FY 1999 dental costs (using the PPI for Dental Services) were \$687 million. Dental costs declined to \$668 million in FY 2000 and to \$663 million in FY 2001.

Special programs costs increased from \$1,476 million to \$1,761 million in the interval from FY 1999 to FY 2001.<sup>31</sup> Table 4-3 details the major drivers of this increase, using a change of at least \$10 million as the cutoff. Subaccounts are sorted in descending order of change between FY 1999 and FY 2001.

**Table 4-3. MEPRS F Subaccount Trends in Evaluated Regions  
(Millions of FY 2001 Dollars)**

Subaccount	Description	FY 1999	FY 2000	FY 2001
FCC	Support to Non-Federal External Providers	\$437.4	\$519.0	\$605.9
FCA	Purchased/Referred Care	187.8	186.7	238.3
FDB	Base Operations – Medical Installations	111.7	130.8	139.8
FCE	Support to Other Federal Agencies	23.7	26.0	50.0
FAM	Graduate Medical Education Intern and Resident Expenses – Physicians Program	90.6	93.0	116.8
FDG	Travel Expenses En Route to Permanent Duty Station	0.1	1.4	14.4
FBI	Immunizations	59.0	68.3	73.0
FBN	Hearing Conservation Program	0.0	7.6	12.2
Other	All Other F Subaccounts	770.5	761.7	794.4
	Subtotal	1,680.8	1,794.3	2,044.7
	Revised Financing Adjustment	-204.8	-240.4	-284.2
	Total	\$1,476.0	\$1,553.9	\$1,760.5

By far, the largest contributor to the increase in F-account costs was the FCC subaccount, covering expenses incurred by an MTF in providing inpatient, outpatient, and ancillary services support to beneficiaries at the request of civilian providers external to the MTF. The majority of expenses in the FCC subaccount are for prescriptions written by civilian physicians but filled at MTFs. The next largest contributor was the FCA subaccount, covering supplemental care for services purchased from civilian sources. The increase in prescription costs is consistent with what we found in previous TRICARE evaluations and with what is happening in the civilian economy; the increase in purchased/referred care is related to revised financing contracts in Regions 1, 2, and 5, where MTFs must purchase care for their enrollees if they are referred to the network.

The FCD account records the costs associated with personnel loaned between MTFs and prescriptions written by a physician at one MTF but filled by the pharmacy at another. In the former case, the personnel costs are recorded in both the FCD account of the lending MTF and in the A or B account of the borrowing MTF. Thus, to the extent that FCD includes borrowed labor, these costs are double-counted. However, the prescription costs embedded in FCD are counted only once (at the pharmacy that fills the prescription), and must be included for a complete analysis. Using Stepdown Assignment Statistics (data assignment factors that measure the amount of services rendered by intermediate work centers to other work centers), we were able to separate borrowed

<sup>31</sup> Non-prescription expenses in the former figure were adjusted for inflation using the DoD outlay deflator for Operations and Maintenance less fuel and pay. The source is Office of the Under Secretary of Defense (Comptroller), “National Defense Budget Estimates for FY 2003,” Table 5-9, p. 51. Prescription expenses were adjusted by the PPI for prescription preparations.

labor costs from prescription costs in the FCD account. Hence, we include the FCD prescription costs in our comparisons, but the remainder is excluded because it would duplicate personnel costs already recorded in the A and B accounts. Although not separately displayed in Table 4-3, the FCD account adjustments are reflected in the totals.

In the Revised Financing Regions (Regions 1, 2, and 5), purchased-care government costs for MTF enrollees are charged to an F account in MEPRS. However, TMA has not provided any guidance to the MTFs on which specific accounts to charge these expenses and, consequently, there is no uniformity in how they are charged. We therefore cannot determine exactly how much MTFs in the Revised Financing Regions spent to reimburse contractors for care referred to the network. We can, however, estimate this quantity from Health Care Service Records filed by the MCS contractors. The estimates range from \$205 million in FY 1999 to \$284 million in FY 2001. Because these totals are already included under purchased-care costs, we would be double-counting them if we included them as a direct-care cost as well. We have therefore subtracted these costs, referred to as the “Revised Financing Adjustment,” from the total in Table 4-3.

MEPRS estimates military personnel costs by applying standard DoD Comptroller pay factors to full-time equivalent labor utilization. However, these pay factors are based on the average of bonuses and special pays across an entire Military Service and are not specific to the medical occupations. Thus, they may understate the pay of military physicians, who earn more than the typical officer of the same rank. Conversely, they may overstate the pay of medical enlisted personnel, who do not receive as much sea pay or hazardous-duty pay as their non-medical counterparts. We obtained the military pay adjustment in Table 4-2 by substituting medical-specific pay factors for the generic pay factors used internally to MEPRS. The pay adjustment turns out to be almost identical in each year of the evaluation interval, so the net effect of this adjustment on the trend is negligible.

Minor military construction is funded by the Operations and Maintenance (O&M) appropriation, is included in the MTF budget, and is reported in MEPRS. However, major military construction is centrally funded by the Military Construction (MilCon) appropriation and initial outfitting of investment equipment for medical construction projects is funded through the Other Procurement, Construction/Initial Outfitting PE of the DHP. Neither MilCon nor initial outfitting costs is included in the MTF budget nor reported in MEPRS. During the Section 733 Study, IDA developed a military-construction adjustment factor.<sup>32</sup> We updated that factor for use in the current study. The actual MilCon and Initial Outfitting appropriations tend to be volatile from one year to another, as major construction projects (e.g., building a new hospital or adding a new wing to an existing hospital) are started or completed. Instead, we determined that a fund could be established, earning interest at the 30-year Treasury rate, to generate enough revenue to eventually replace every MTF in the continental United States after a 40-year life span. This fund would require annual deposits equal to 3.5 percent of reported MEPRS operating costs. Thus, we adopted a 3.5-percent factor as a smooth estimate of military construction costs. Because the MEPRS costs are similar in the evaluation years, the net effect of this adjustment on the comparison is small.

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<sup>32</sup> Matthew S. Goldberg et al., “Cost Analysis of the Military Medical Care System: Final Report,” Institute for Defense Analyses, Paper P-2990, September 1994.

Finally, Contractor Administrative Cost represents services that the MTFs chose to purchase through the MCS contractor rather than directly from the civilian economy. For example, the Region 11 Lead Agent paid the MCS contractor to install and maintain a region-wide clinic appointment system. These costs remained essentially constant between FY 1999 and FY 2001.

On balance, direct-care costs were \$44 million higher in FY 2001 than they were in FY 1999.

## **4.2.2 Purchased-Care Costs**

### **4.2.2.1 Health Care Costs**

Because the actual cost to the government is determined by the value of the fixed-price MCS contracts, including change orders and bid-price adjustments (BPAs), the purchased care claims do not accurately reflect the true government cost. In particular, the claims submitted by network subcontractors report costs estimated from the TRICARE Standard price schedules (e.g., the CMAC and DRG rates) rather than true costs.<sup>33</sup> However, the claims are still useful for allocating costs to regions,<sup>34</sup> beneficiary groups, and inpatient, outpatient, and prescription services. To reconcile the HCSR cost totals with the MCS contracts, we scaled the former to conform to the sum of the at-risk health care portion of the MCS contracts and not-at-risk costs<sup>35</sup> obtained from the MHS Management Analysis and Reporting Tool (M2), less the costs for salaried resource sharing arrangements that do not appear on the claims.<sup>36</sup> This procedure resulted in only slight adjustments of 2 to 3 percent (depending on the year) to the HCSR totals.

All the at-risk health care prices (including profit) reported here are current as of the most recent BPA. The costs for Region 11 are current through BPA 7; the costs for Region 6 and Regions 9, 10, and 12, through BPA 6; the costs for Regions 3, 4, and 7/8, through BPA 5; and the costs for Regions 1, 2, and 5, through BPA 12. Note that Regions 1, 2, and 5 receive quarterly BPAs instead of the annual BPAs of the older contracts. The first BPA updates the health care prices for actual base period data (the Data Collection Period—the year immediately preceding the first contract option period) and for revised government projections of the beneficiary population and MTF utilization in the option periods. Subsequent BPAs account for the impact of actual data for the previous option period, including risk sharing, and reflect the impact of updated projections for

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<sup>33</sup> Some network subcontractors are funded through capitated arrangements with the MCS contractors. Their capitated payments do not exactly correspond to the total government costs reported on the purchased care claims.

<sup>34</sup> With the exception of Regions 1, 6, and 11, the MCS contracts cover more than one region. A single contract covers Regions 2 and 5, another covers Regions 3 and 4, and a third covers Regions 9, 10, and 12.

<sup>35</sup> There are many program costs reflected on the HCSRs for which the contractors are not at risk. For example, care referred to the network on behalf of MTF-enrolled beneficiaries in Regions 1, 2, and 5; the TRICARE Senior pharmacy program; and numerous demonstration programs.

<sup>36</sup> There are two components to the purchased-care portion of resource sharing costs: (1) expenditures for physician services on a fee-for-service basis, and (2) salaries for physicians contracted to provide services at MTFs. The former are already included in the purchased-care claims; the latter, though included in the MCS contract price, are not included in the purchased-care claims.

population and MTF utilization for the present and future option periods, but not actual data or risk sharing for those option periods.<sup>37</sup> The health care prices, and the administrative prices shown, also reflect the most current settled contract modifications.

As determined from the most recent purchased-care claims, purchased-care costs increased for all major health care services between FY 1999 and FY 2001. In particular, outpatient costs increased by \$371 million and retail prescription costs by \$266 million. In addition, mail-order prescription costs increased by another \$96 million, bringing the total purchased-care pharmacy increase to \$362 million, an increase of 74 percent. Overall, purchased health care costs increased by \$868 million (27 percent).

There are several additional cost elements for which the government is responsible but for which the MCS contractors are not at risk. These include capital construction and direct medical education (DME),<sup>38</sup> special and emergent care, and other pass-through costs. We obtained the amounts paid for these items directly from TMA.

#### **4.2.2.2 Administrative Costs**

By design, the MCS contracts include numerous administrative functions to support TRICARE in both the direct- and purchased-care settings. The Contractor Administrative Cost of \$677 million in FY 1999 (adjusted for inflation) includes the fiscal intermediary function performed under the MCS contract. It also includes the following functions introduced under TRICARE:

- *Peer Review Organizations* (a panel of physicians who monitor hospitals to assure the medical necessity and quality of services provided to beneficiaries);
- *UM for referrals* (a process that determines the need for specialty care and directs referrals to the appropriate provider);
- *Case management* (a collaborative process that evaluates and implements options and services to meet complex health needs through communication and available resources to promote quality, cost-effective outcomes);
- *Health Care Information Line* (a free, 24-hour telephone line that beneficiaries can call to receive pre-recorded information on various health topics or medical advice and assistance from registered nurses);
- *Handbooks and newsletters* (literature that provides information about health issues and benefits); and
- *TRICARE Service Centers* (offices staffed by Health Care Finders and a Beneficiary Services Representative who can help beneficiaries with health care questions).

Some of the functions above are designed to reduce the utilization of beneficiaries using the MTFs, thereby freeing space to recapture some workload into the MTFs that

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<sup>37</sup> Additional BPAs will eventually be negotiated to reflect actual workload and cost experience during Option Periods 2 through 5. In principle, subsequent BPAs may involve either increases or decreases in contract costs.

<sup>38</sup> DME includes stipends for residents, salaries for teaching personnel, and overhead for residency programs.

had previously been purchased from the civilian sector. If these efforts are successful, the net effect should be an overall reduction in MHS costs because direct care has been shown to be cheaper than purchased care.<sup>39</sup> However, any potential net beneficial impact of the above administrative functions has been masked by the introduction of substantial new and enhanced benefits between FY 1999 and FY 2001.

Managed Care Support Contract (MCSC) administrative costs can be classified as “MTF-related,” “network-related,” or “non-Lead-Agent-related.” MTF-related expenses cover administrative efforts assigned to the contractor that were historically viewed as an MTF function and the contractor’s efforts are not likely to achieve a net change in network health care costs. For example, in some contracts, the Lead Agent requirements include the contractor taking over appointment scheduling at the MTFs. Network-related expenses cover those Lead Agent requirements, if any, that were not historically viewed as an MTF function (e.g., the Lead Agent might require the contractor to establish the Prime option in some noncatchment area that would otherwise not have received that option). A second type of network-related Lead Agent requirement is contractor support of MTF UM activities that are expected to reduce network health care costs. All other administrative expenses, including claims processing, are classified as non-Lead-Agent-related.

To compare MCSC administrative expenses with civilian-sector benchmarks, we computed non-Lead-Agent-related expenses as a percentage of revenue (i.e., the value of the at-risk health care portion of the MCSC plus the value of most not-at-risk benefits plus the value of the administrative portion of the contract<sup>40</sup> less MTF-related and network-related expenses). Milliman USA conducts an annual survey of commercial HMOs and publishes a report displaying selected utilization and financial statistics. The latest report shows trends in administrative expenses since 1994.<sup>41</sup> In addition, the Sherlock Company performs a detailed evaluation of administrative expenses of Blue Cross/Blue Shield plans by function and by product line; the latest year for which results are available is 2000.<sup>42</sup> That report displays administrative expenses for a variety of health plans, including HMOs and PPOs. The results show that average HMO and PPO administrative expenses as a percentage of revenue are virtually identical, although there is much greater variation in PPO expenses. Combining the results of the above-cited studies, Figure 4-8 compares MCSC administrative expenses with those of commercial HMOs and PPOs between FY/CY 1999 and 2001.

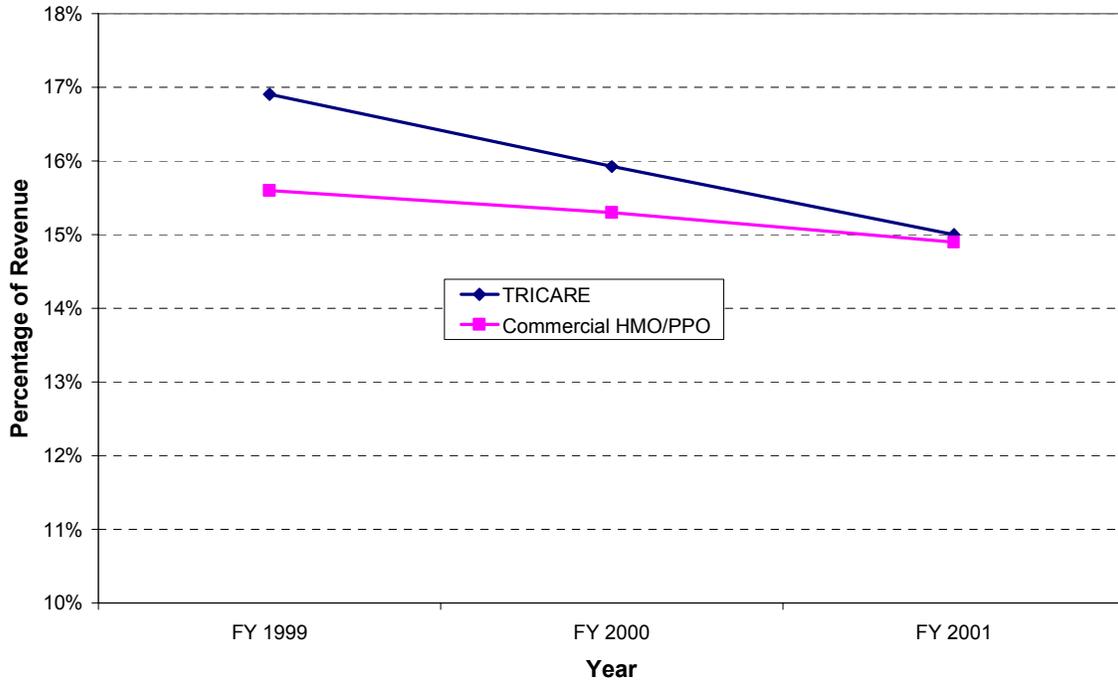
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<sup>39</sup> Matthew S. Goldberg, Ted Jaditz, and Viki Johnson, “Efficiency Analysis of Military Medical Treatment Facilities,” The CNA Corporation, CNA Annotated Briefing D0004561.A2/Final, October 2001.

<sup>40</sup> Contract administrative expenses include the cost of administering not-at-risk benefits TMA decided to negotiate as part of the aggregate fixed price administrative portion of the contract, e.g., supplemental care, active-duty TPR, and TSP, but not the TFL or TSRx administrative charges that are priced per claim.

<sup>41</sup> Milliman USA Incorporated, *2001 HMO Intercompany Rate Survey*, October 8, 2001, Chart 3a, p. 6.

<sup>42</sup> The Sherlock Company, *2001 Sherlock Expense Evaluation Report – Blue Cross Blue Shield Plans Edition*, August 2001. Although the report was published in 2001, the results are based on 2000 data. A summary of the report’s findings can be found online at <http://www.sherlockco.com/seerbackground.htm> (February, 2002). Accessed and available on May 8, 2002.



**Figure 4-8. Comparison of TRICARE Administrative Costs With Commercial Plans**

The percentage of revenue spent on MCSC administrative services declined from 16.9 percent in FY 1999 to 15 percent in FY 2001. Over the same time period, administrative expenses for commercial HMO and PPO plans declined from 15.6 to 14.9 percent. Thus, MCSC administrative expenses have been declining faster than in the civilian sector, to the point where they are virtually identical in FY 2001. The government imposes requirements on MCSC claims processing procedures that are highly detailed and generally require more record keeping and reporting than a typical private-sector contract. This may account for the high MCSC administrative expenses in FY 1999. It is difficult to say why administrative expenses have decreased since then. Among the possibilities are that the MCS contractors have become more efficient in managing their administrative expenses or that health care costs have simply increased at a greater rate than administrative expenses.

#### **4.2.3 Other DHP Costs**

We estimated several other costs of running the DoD health-care system that cannot easily be allocated into either direct or purchased care categories. Some of these costs, such as TMA and Management Headquarters, represent system-wide management and administrative expenses in support of the MHS. Other costs, such as MHS Information Management/Information Technology (IM/IT), primarily support direct care at MTFs but also support centralized management and training functions. We identified all costs from the DHP (see Appendix E for a description of the PEs used) and then allocated them to the evaluated TRICARE regions based on their share of total direct-care operating costs. The net effect of the other DHP costs is a \$200-million decline from FY 1999 to FY 2001. The primary driver of the decrease is a reduction in the procurement of investment equipment.

#### 4.2.4 Civilian-Sector Benchmarks

In this section, we compare several TRICARE performance measures with roughly comparable civilian-sector benchmarks. We face several difficulties in making these comparisons. First, the beneficiary populations served in the military and civilian sectors may differ considerably. Also, differences in the size and structure of civilian managed care organizations, as well as in the benefits and cost sharing arrangements they offer, can make comparison of utilization and costs with TRICARE difficult to interpret. Further complicating the comparisons is that TRICARE is not a single homogeneous plan, but rather a blend of HMO (Prime), PPO (Extra), and indemnity (Standard) plans. Government costs under TRICARE also depend on whether the care is provided in-house or by the MCS contractor.

Because of the above considerations, it is not necessarily the case that TRICARE is more (less) efficient than the civilian managed care models if TRICARE scores higher (lower) on the selected benchmarks. Also, because of interdependencies among benchmarks, differences in performance on a single benchmark can have varying interpretations. For example, civilian managed care models could show higher costs along with higher levels of satisfaction with access and quality of care. However, the higher costs could be associated with investment in the technology and infrastructure responsible for better access and quality of care. One benchmark should not be considered independently of another unless we can control for differences in technology, infrastructure, and other factors. The relationships among costs, technology, and individuals' perceptions of quality are complex and are usually not considered when benchmarking data.

The pattern of utilization and costs among Prime enrollees is most directly comparable to that of a civilian HMO, whereas the pattern among nonenrollees is most directly comparable to that of a civilian PPO. Furthermore, care is provided under TRICARE in a mix of direct and purchased care settings, which have different civilian-sector analogues. The civilian analogue to direct care, which the government produces "in-house," is the cost to the HMO or PPO to provide health care services whereas the civilian analogue to purchased care is the amount the HMO or PPO charges its members for coverage under its health plan. Table 4-4 summarizes the civilian analogues we used to construct rough equivalents to their TRICARE counterparts. We weight the civilian analogues for each TRICARE option in proportion to the government's expenditures on direct and purchased care.

**Table 4-4. Government Costs and Their Civilian Analogues**

TRICARE Plan	Government Cost	Civilian Analogue
Prime	Direct-care cost per enrollee	HMO cost per member
	Purchased-care cost per enrollee	Insurance premiums per HMO member
Non-Prime	Direct-care cost per user	PPO cost per participant
	Purchased-care cost per user	Insurance premiums per PPO participant

We researched numerous sources of civilian benchmark data and settled on the MarketScan<sup>®</sup> Commercial Claims and Encounters (CCAЕ) database maintained and provided by The MEDSTAT Group, Inc. MEDSTAT is a health information company that provides decision support systems, market intelligence, benchmark databases, and research

for managing the purchase, administration, and delivery of health services and benefits. We felt that their data offered advantages that no other vendor could match (e.g., claims-based rather than survey-based data, data on a variety of health plan types offered by large self-insured employers, data current through 3 quarters of FY 2001, and the flexibility to customize data requests). Other well-known sources, such as the Health Plan Employer Data and Information Set (HEDIS) suffer from shortcomings such as lack of data currency (most offer data through CY 2000), HMO coverage only, or utilization but no cost data.

The CCAE database contains the healthcare experience of several million individuals (annually) covered under a variety of health plans, including preferred provider organizations, point of service plans, health maintenance organizations, and indemnity plans. The database links inpatient services and admissions, outpatient claims and encounters and, for most covered lives, outpatient pharmaceutical drug data<sup>43</sup> and individual-level enrollment information. We tasked MEDSTAT to compute quarterly benchmarks for HMOs<sup>44</sup> and PPOs, broken out by several sex/age group combinations (we requested the same age groups used in the HEDIS dataset). The quarterly breakout allowed us to derive annual benchmarks by fiscal year and to estimate FY 2001 data to completion. The breakouts by sex and age group allowed us to apply DoD-specific population weights to the benchmarks and aggregate them to adjust for differences in the DoD and civilian beneficiary populations. We excluded individuals age 65 and over from the calculations because most of them are covered by Medicare and Medigap policies rather than by a present or former employer's insurance plan.

Table 4-5 compares selected utilization and cost statistics for TRICARE Prime enrollees (military and civilian PCMs combined) with their civilian HMO counterparts. We estimated the annual cost per member by calculating the percentage of total health care costs incurred by Prime enrollees (the percentage varied from 67 percent in FY 1999 to 71 percent in FY 2001) and then applying that percentage to total MHS costs (less dental) displayed in Table 4-2 divided by the number of enrolled person-years.

Table 4-5 shows that for each type of health care service (inpatient, outpatient, and prescriptions), utilization by enrolled military beneficiaries is much greater than their counterparts covered by a civilian HMO plan. On the other hand, the cost per unit of service in the military is lower than in the civilian sector for each type of service. However, the lower cost per unit of service is not enough to make up for the far greater utilization by Prime enrollees, resulting in the total cost per member (the sum of inpatient, outpatient, and prescription costs plus administrative expenses) being much higher for Prime enrollees. The higher utilization by enrolled military beneficiaries is due at least in part to the TRICARE benefit, which is more generous both in terms of covered services and in beneficiary cost sharing than those offered by most civilian HMO plans.

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<sup>43</sup> The MEDSTAT pharmacy data contain information on average days supply, which allowed us to standardize military and civilian prescription counts.

<sup>44</sup> Because most HMOs are capitated, i.e., reimbursed on a per-member rather than a per-service basis, the medical claims do not contain reliable information on costs per unit of service. To rectify that situation, MEDSTAT analyzed fee-for-service claims and determined the mean payments for every procedure within beneficiary demographic groups. They then matched HMO claims by demographics and procedure code and applied the mean payment derived from the fee-for-service claims.

Another possibility is that civilian HMO plans have a financial incentive to apply UM more aggressively, resulting in lower utilization per member.

**Table 4-5. Comparison of TRICARE Prime With Civilian HMO Benchmarks**

Performance Measure	FY 1999	FY 2000	FY 2001
<b>Visits per member</b>			
TRICARE Prime	8.61	8.67	8.35
Civilian HMO	5.30	5.57	5.65
<b>Average cost per visit</b>			
TRICARE Prime			
Total cost	\$141.64	\$140.76	\$146.06
Government cost	\$136.03	\$134.49	\$139.63
Civilian HMO	\$178.81	\$176.99	\$177.29
<b>Discharges per 1,000 members</b>			
TRICARE Prime	80.20	83.22	81.42
Civilian HMO	45.45	53.47	54.01
<b>Bed-days per 1,000 members</b>			
TRICARE Prime	307.43	316.09	308.67
Civilian HMO	215.02	243.70	255.65
<b>Average cost per discharge</b>			
TRICARE Prime			
Total cost	\$6,322.97	\$6,177.47	\$6,131.18
Government cost	\$6,021.48	\$5,849.36	\$5,804.35
Civilian HMO	\$8,074.20	\$7,859.43	\$8,430.40
<b>Prescriptions per member</b>			
TRICARE Prime	11.44	12.03	11.91
Civilian HMO	5.40	5.82	6.07
<b>Average cost per prescription</b>			
TRICARE Prime			
Total cost	\$17.61	\$18.44	\$19.91
Government cost	\$16.83	\$17.59	\$19.01
Civilian HMO	\$52.04	\$54.29	\$56.63
<b>Cost per member</b>			
TRICARE Prime			
Total cost	\$3,014.72	\$3,030.78	\$3,048.60
Government cost	\$2,933.20	\$2,938.77	\$2,957.46
Civilian HMO			
Total cost	\$1,844.48	\$1,985.62	\$2,069.15
Employer cost	\$1,709.56	\$1,839.22	\$1,893.45

Although the cost per member is higher for military beneficiaries, Table 4-5 also shows that the military sector has been better able to control health care costs per member than have civilian HMOs. Whereas the cost per Prime enrollee has remained relatively constant over the period from FY 1999 to FY 2001, civilian HMO costs have risen 15 percent over the same time period (net of inflation).

Table 4-6 compares selected utilization and cost statistics for the TRICARE non-Prime options (i.e., TRICARE Standard/Extra and space-available MTF care) with their

civilian PPO counterparts. The difficulty in making this comparison is that most employees covered by a civilian insurance plan use that plan exclusively for their care, whereas beneficiaries eligible for military health care often have other sources of health insurance as the primary payer (particularly retirees). If we were to include all nonenrolled beneficiaries, we would get a biased picture of utilization and costs because only part (or none) of the care of privately-insured beneficiaries is received within the MHS and only part (or none) of the cost for that care is incurred by the government. To make the military utilization and cost statistics as commensurate as possible with the civilian statistics, we included only those nonenrollees for whom there was a record of having used the MHS and for whom there was no record of private insurance coverage, i.e., nonenrolled beneficiaries who are reliant on the MHS for all their care.

**Table 4-6. Comparison of TRICARE Non-Prime With Civilian PPO Benchmarks**

Performance Measure	FY 1999	FY 2000	FY 2001
<b>Visits per participant</b>			
TRICARE non-Prime	4.78	4.62	4.66
Civilian PPO	6.04	6.50	6.88
<b>Average cost per visit</b>			
TRICARE non-Prime			
Total cost	\$148.54	\$149.57	\$149.33
Government cost	\$118.15	\$117.06	\$117.45
Civilian PPO	\$206.63	\$210.40	\$210.36
<b>Discharges per 1,000 participants</b>			
TRICARE non-Prime	89.14	95.02	97.05
Civilian PPO	68.71	68.34	77.01
<b>Bed-days per 1,000 participants</b>			
TRICARE non-Prime	357.50	372.21	364.92
Civilian PPO	316.43	277.90	324.60
<b>Average cost per discharge</b>			
TRICARE non-Prime			
Total cost	\$5,607.70	\$5,314.09	\$4,967.94
Government cost	\$5,004.35	\$4,761.10	\$4,481.77
Civilian PPO	\$10,630.42	\$9,431.07	\$9,293.19
<b>Prescriptions per participant</b>			
TRICARE non-Prime	6.06	6.35	6.91
Civilian PPO	9.56	10.20	10.44
<b>Average cost per prescription</b>			
TRICARE non-Prime			
Total cost	\$34.22	\$37.59	\$39.37
Government cost	\$27.72	\$30.67	\$33.16
Civilian PPO	\$49.78	\$51.61	\$51.33
<b>Cost per participant</b>			
TRICARE non-Prime			
Total cost	\$2,104.60	\$2,102.07	\$2,136.35
Government cost	\$1,873.16	\$1,862.61	\$1,911.35
Civilian PPO			
Total cost	\$2,837.72	\$2,928.07	\$3,100.67
Employer cost	\$2,377.43	\$2,427.30	\$2,552.81

With the exception of inpatient care, utilization by non-Prime beneficiaries is considerably lower than by their civilian counterparts. One reason for this disparity may be that the great majority of nonenrolled military beneficiaries are retirees, who have to pay a \$230 per individual/\$460 per family fee if they want to enroll in Prime. The subset of these beneficiaries who do not have private insurance coverage (and are probably poorer on average than those with private insurance coverage) may decide not to enroll in Prime if their expected out-of-pocket costs are lower than the enrollment fee. Consequently, nonenrolled MHS-reliant beneficiaries are likely a biased subset of the general nonenrolled beneficiary population because lower expected out-of-pocket costs translate into lower expected utilization. Although it may be possible to partially correct this bias for the eligible military population, it is likely that a similar bias exists in the choice of civilian HMO or PPO plans but we have no information on which to base a correction for the latter.

As with civilian HMOs, the cost per unit of service in civilian PPOs is higher than in the military for each type of health care service, particularly for inpatient stays. The fact that the cost per inpatient stay in a civilian PPO is almost double that for a nonenrolled military beneficiary while average bed-days are lower suggests that more complex procedures are being performed in the civilian sector. Although we have no statistics on the complexity of civilian-sector inpatient procedures, we are able to compare the complexity of procedures performed for nonenrolled with enrolled military beneficiaries and find that the complexity index (as measured by average RWPs) for nonenrollees is about half that for enrollees.

Table 4-6 also shows that, analogous to the trend observed for HMOs, the military sector has been better able to control health care costs per beneficiary than have civilian PPOs. Whereas the cost per nonenrolled military beneficiary has remained relatively constant over the period from FY 1999 to FY 2001, civilian PPO costs have risen 10 percent over the same time period (net of inflation).

Table 4-7 summarizes the trend in systemwide costs per participant under TRICARE with those of commercial plans. The costs displayed are weighted averages of the costs in Tables 4-5 and 4-6, using the percentage of health care costs incurred under TRICARE on behalf of Prime enrollees and on behalf of nonenrolled MHS-reliant beneficiaries as the weights.

**Table 4-7. Comparison of TRICARE Costs With Civilian Plan Benchmarks (FY 2001 Dollars)**

Cost per Participant	FY 1999	FY 2000	FY 2001
TRICARE			
Total cost	\$2,825.78	\$2,863.82	\$2,894.08
Government cost	\$2,713.14	\$2,745.30	\$2,780.26
Civilian plans			
Total cost	\$2,050.67	\$2,155.05	\$2,243.87
Employer cost	\$1,848.21	\$1,944.94	\$2,005.14

Table 4-7 shows that overall costs under TRICARE are significantly higher than under comparable civilian health care plans. One reason for the difference is that

TRICARE provides a more generous benefit than most commercial health care plans. Another is that the MHS has a readiness mission, which adds considerable expense to the cost per participant when burdened on actual health care costs. The MHS also has more levels of management overhead (HA, TMA, Lead Agents, Service SG staff, etc.) than most commercial managed care organizations and spends a considerable amount of money on developing and maintaining information systems that are able to support the unique requirements of military medicine and the readiness mission.

#### 4.2.5 Summary

Overall, MHS costs in the evaluated TRICARE regions increased by \$751 million from FY 1999 to FY 2001. The bulk of this increase occurred in the purchased-care sector, which saw an increase of \$907 million but was partially offset by a decrease of \$200 million in other DHP costs (mostly procurement of investment equipment). Some of the increase in purchased-care costs can be explained by the implementation of new and enhanced benefits during the evaluation time interval. Because it is beyond the scope of this effort, we did not attempt to rigorously derive the individual impact of each benefit enhancement on government costs. There are many factors, such as changes in MTF workload, beneficiaries' private insurance coverage, etc., that can influence the utilization and cost of services that we did not attempt to sort out. We were able, however, to obtain rough estimates of the impact of the most significant benefit enhancements. These are summarized in Table 4-7 below.

**Table 4-7. Impact of Benefit Enhancements on Government Costs  
(Millions of FY 2001 Dollars)**

Benefit	Amount
TRICARE Prime Remote (TPR)	\$33.7
Interim TPR for active-duty family members (ADFM)	11.0
TRICARE Senior Pharmacy	159.2
Elimination of enrolled ADFM copayments	54.1
Catastrophic cap reduction	35.0
Simplified pharmacy copayment structure	27.0
Administrative costs	24.1
<b>Total</b>	<b>\$344.1</b>

Benefit enhancements account for almost half the increase in government costs from FY 1999 to FY 2001. The large increase in costs comes despite the fact that many of the above benefits were not implemented until mid-FY 2001. The impact of benefit enhancements can only be expected to increase with a full year of operation and the introduction of the TFL benefit in FY 2002.

In addition to the above costs, costs rose by approximately another \$380 million due to increased prescription drug utilization and rising drug prices. Sources of the cost increase, net of the TSRx benefit, include prescriptions filled at MTF pharmacies in connection with MTF visits (up \$102 million), prescriptions written by civilian physicians but filled at MTF pharmacies (up \$75 million), and prescriptions filled at MCS network pharmacies (up \$145 million). In addition, the National Mail Order Pharmacy benefit increased costs by another \$58 million.

## 5. COST TO COVERED BENEFICIARIES

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In addition to direct care, MHS beneficiaries less than 65 years of age are eligible for purchased care under TRICARE. While MTF charges are negligible, TRICARE beneficiaries can incur significant out-of-pocket expenses for care received in the network or from using the point-of-service option. Out-of-pocket expenses include deductibles and copayments (D&C), enrollment fees, and insurance premiums. This chapter examines the trend in family out-of-pocket costs from FY 1999 to FY 2001. We also compare the out-of-pocket costs of TRICARE-eligible families with those of corresponding civilian families covered by employer-sponsored health insurance plans.<sup>45</sup> Prime enrollees are compared with civilians in HMO plans and nonenrolled families are compared with civilians in non-HMO plans.

We measure the D&C of MHS beneficiaries using annual data on *all* TRICARE claims from FY 1999 to FY 2001. D&C for those covered by employer-sponsored health insurance are measured using data from the Medical Expenditure Panel Surveys (MEPS). The MEPS provides projected data from FY 1999 to FY 2001 for the U.S. non-institutionalized population on the cost, utilization, and financing of health services. Data on insurance coverage of MHS beneficiaries are obtained from the Health Care Surveys of DoD Beneficiaries spanning the FY 1999 to FY 2001 time interval. Data on insurance premiums are obtained from various private-sector surveys discussed later in the paper.

MHS beneficiaries 65 and older (seniors) have health coverage under Medicare, but Medicare requires substantial deductibles and copayments and it does not cover outpatient drugs. To reduce out-of-pocket expenses and increase utilization, some MHS seniors seek health care and drugs at MTFs. But MTF health care is available to most MHS seniors only on a space-available basis. Dissatisfied with this, MHS seniors lobbied Congress for a better benefit. Congress responded with two new programs: MHS seniors are now reimbursed for Medicare out-of-pocket costs under the TRICARE For Life (TFL) benefit (October, 2001) and drugs are covered under the TRICARE Senior Pharmacy (TSRx) program (April, 2001). Because the years covered by this evaluation precede the TFL benefit, we will estimate how much seniors were spending on health care prior to TFL and, consequently, how much they can expect to save under TFL.

Section 5.1 analyzes the out-of-pocket expenses of TRICARE-eligible beneficiaries and is organized as follows. We first review the cost-sharing features of TRICARE. Next, we discuss TRICARE supplemental and employer-sponsored health insurance—features, premiums, and coverage of MHS beneficiaries. Then we present the computational methodology for estimating out-of-pocket expenses under TRICARE. Finally, we estimate out-of-pocket expenses for counterpart civilian families and compare them with beneficiary expenses under TRICARE.

Section 5.2 analyzes out-of-pocket expenses in FY 1999–FY 2001 for MHS seniors and is organized similarly to section 5.1. First we review the cost-sharing features of

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<sup>45</sup> About 10 percent of the counterpart families we refer to as having employer-sponsored insurance are covered by an individually-purchased private insurance policy.

Medicare. Because of Medicare's substantial deductibles and copayments, most Medicare enrollees are covered by Medicare supplemental insurance. We therefore include a discussion of Medicare supplemental insurance: types, features, premiums and coverage of MHS beneficiaries. Then we estimate Medicare out-of-pocket expenses in FY 1999–FY 2001 for MHS seniors who do not use MTFs for any of their care and the impact of space-available care at MTFs on their out-of-pocket costs. Finally, we compare out-of-pocket expenses for MHS seniors with their civilian counterparts. Section 5.3 summarizes the analyses of out-pocket expenses for TRICARE- and Medicare-eligible beneficiaries.

## **5.1 Out-of-Pocket Expenses of TRICARE-Eligible Beneficiaries**

### **5.1.1 *Deductibles and Copayments Under TRICARE***

Cost-sharing features of TRICARE were presented previously in Table 2-2. The cost to the beneficiary depends on the TRICARE plan selected and sponsor's status. There are no deductibles under TRICARE Prime. For nonenrolled family members of junior-enlisted personnel (paygrades E1 to E4), the annual outpatient deductible is \$50 per individual and \$100 per family. For all other beneficiaries (excluding active-duty members, who receive essentially all their care at military facilities), the deductible is \$150 per individual and \$300 per family.

Unlike Prime, there are substantial copayments under TRICARE Standard/Extra, especially for retirees.<sup>46</sup> For example, in FY 2001 a retiree paid up to \$401 per day for a hospital stay under TRICARE Standard and \$250 under TRICARE Extra. For outpatient surgery and a doctor's visit, copayments were 25 percent under TRICARE Standard and 20 percent under TRICARE Extra. Until April 2001, TRICARE Prime enrollees paid \$11 per day in the hospital. After April 2001, in-network copayments for enrolled active-duty family members were eliminated.

Under Prime, retirees pay an annual enrollment fee of \$230 per individual or \$430 per family. There is no enrollment fee for active-duty family members.

Under all TRICARE options, there is an annual catastrophic cap, which varies by sponsor type. The catastrophic cap is \$1,000 per year for active-duty families and \$3,000 for retiree families. In addition to the catastrophic loss protection based on the fiscal year, Prime enrollees have an enrollment year catastrophic cap. Each enrollment year begins on the Prime enrollment anniversary date.

### **5.1.2 *TRICARE Supplemental Insurance***

Under TRICARE Standard and Extra, the beneficiary pays a deductible before the government shares in the cost. Under all plans, beneficiaries face the prospect of copayments, but these are very limited under Prime if the beneficiary uses MTF or network providers exclusively. While catastrophic caps limit financial losses, the

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<sup>46</sup> There are large "point-of-service" copayments if an enrollee uses an out-of-network provider without prior authorization.

beneficiary may not be prepared to pay the maximum liability under a plan. To cover this risk, some beneficiaries purchase a TRICARE supplemental policy.

Table 5-1 gives the average annual cost of TRICARE supplemental policies in 1999–2001 for active-duty and retiree families. The cost of a TRICARE supplemental policy is a function of enrollment status and sponsor type: the premium is smaller for those enrolled in Prime and for active-duty families. For retiree families, the premium is a function of the age of the insured adults.

For active-duty families in 1999, the annual premium for a spouse was \$105 for a Standard/Extra policy and \$83 for a Prime policy; for a child it was \$98 for a Standard/Extra policy and \$51 for a Prime policy. For retirees and spouses age 45–49, a Standard supplemental policy in 1999 cost \$276 for the sponsor, \$336 for the spouse, and \$207 for each child. The premiums are relatively low for active-duty family members because they obtain most of their care at MTFs. For retirees, the cost of a Standard/Extra supplemental policy is higher because of greater utilization of purchased care, higher copayments, and a larger catastrophic cap. For all supplementals, premiums increased slightly in 2000 and then declined more or less to the cost in 1999.

**Table 5-1. Average Annual Cost of TRICARE Supplemental Policies, FY 1999–FY 2001**

Beneficiary Group	Family Member	Standard/Extra Supplemental <sup>a</sup>			Prime Supplemental <sup>a</sup>
		1999	2000	2001	1999–2001
Active-duty families	Sponsor	na	na	na	na
	Spouse	\$105	\$110	\$107	\$83
	Each child	98	98	99	51
Retiree and spouse under 40	Sponsor	224	238	229	75
	Spouse	271	274	258	101
	Each child	188	212	207	60
Retiree and spouse 40–44	Sponsor	236	252	238	75
	Spouse	287	298	268	101
	Each child	188	212	207	60
Retiree and spouse 45–49	Sponsor	276	299	279	88
	Spouse	336	351	309	116
	Each child	188	212	207	60
Retiree and spouse 50–54	Sponsor	361	387	360	115
	Spouse	425	449	393	136
	Each child	188	212	207	60
Retiree and spouse 55–59	Sponsor	446	478	445	124
	Spouse	503	534	479	148
	Each child	188	212	207	60
Retiree and spouse 60–64	Sponsor	537	555	518	154
	Spouse	585	603	548	160
	Each child	188	212	207	60

Note: Average cost of policies with no deductible for inpatient and outpatient services for 18 companies. Sources are the *Army Times*, Special Section, “CHAMPUS/TRICARE User’s Guide,” March 1999, March 2000, and March 2001.

<sup>a</sup> Data are for Prime supplemental policies offered by the Military Benefits Association. Premiums for other companies were not given in the *Army Times*.

### 5.1.3 Employer-Sponsored Health Insurance

Some TRICARE beneficiaries purchase private health insurance through civilian employers. In this case, TRICARE is the second payer and virtually all costs above the TRICARE deductible are paid by either the private insurance policy or TRICARE. However, most families who purchase such a policy “opt out” of the TRICARE system entirely (i.e., they do not bother to file any purchased-care claims).

In the civilian economy, approximately three out of four full-time employees are covered by employer-sponsored group health plans.<sup>47</sup> Most employers pay at least part of the policy cost.<sup>48</sup> Unlike TRICARE supplemental insurance, the contribution of the employee is not based on his/her age; all are charged the same amount.

Table 5-2 gives the total monthly premium for employer-sponsored health insurance from 1999 to 2001. Data are from annual surveys of employers by the Kaiser Family Foundation. For family coverage, the average premium for all types of plans was \$478 per month in 1999; it increased to \$588 in 2001—a 23 percent increase in 2 years. For family coverage, the average monthly premium in 2001 for an HMO was \$545; for a PPO, it was \$600. Premiums for these plans also increased by about 23 percent between 1999 and 2001.

**Table 5-2. Total Monthly Premium for Employer-Sponsored Insurance, 1999–2001**

Insurance Type	1999		2000		2001	
	Single	Family	Single	Family	Single	Family
FFS	\$202	\$491	\$238	\$608	\$238	\$640
HMO	169	445	181	487	200	545
PPO	195	488	210	538	228	600
POS	198	496	202	539	222	588
All plans	189	478	202	529	221	588

Source: Kaiser Family Foundation, Employer Health Benefits Annual Surveys, 1999–2001.

Table 5-3 gives the employee’s share of the total monthly premium in Table 5-2. For family coverage in 2001, it was \$150 for All Plans, \$158 for an HMO, and \$157 for a PPO. The employee paid 25.5 percent of the total monthly premium (All Plans).

**Table 5-3. Employee’s Monthly Premium for Employer-Sponsored Insurance, 1999–2001**

Insurance Type	1999		2000		2001	
	Single	Family	Single	Family	Single	Family
FFS	\$20	\$119	\$27	\$119	\$19	\$103
HMO	30	140	28	135	32	158
PPO	34	146	29	143	31	157
POS	48	158	29	141	29	142
All plans	35	145	28	138	30	150

Source: Kaiser Family Foundation, Employer Health Benefits Annual Surveys, 1999–2001.

<sup>47</sup> Bureau of Labor Statistics, “Employee Benefits in Medium and Large Private Establishments, 1997,” Press Release USDL-99-02, January 7, 1999, p. 2.

<sup>48</sup> *Ibid*, p. 10.

According to the Kaiser Family Foundation surveys, the average deductible for an individual with employer-sponsored health insurance was \$245 in 1999; typically, the coinsurance rate was 20 percent.<sup>49</sup> The deductible of \$245 is higher than for nonenrolled retirees under TRICARE Standard (\$150). However, hospital copayments were lower under employer-sponsored insurance compared to TRICARE Standard.

#### 5.1.4 Insurance Coverage of MHS Beneficiaries

The Health Care Surveys of DoD Beneficiaries collected data on TRICARE Supplemental policy coverage in 1999, and other health insurance (OHI) coverage in 1999 and 2001 (Table 5-4). OHI is essentially employer-sponsored insurance. For families enrolled in Prime in 1999, only 2.9 to 5.4 percent (depending on beneficiary status) purchased a Prime Supplemental policy. Nonenrolled families purchased TRICARE supplemental policies more often (11.6 to 19.7 percent).

**Table 5-4. Insurance Coverage of TRICARE Beneficiaries**

Beneficiary Group	Enrollment Status	TRICARE Supplemental Insurance (%)	Other Health Insurance (%)		
		FY 1999	FY 1999	FY 2000 <sup>a</sup>	FY 2001
Active-duty family members, E1–E4	Military PCM	3.2	3.3	3.9	4.5
	Civilian PCM	5.4	7.4	7.9	8.3
	Nonenrolled	11.6	24.6	23.8	22.9
Active-duty family members, E5 and above	Military PCM	3.5	6.5	6.4	6.3
	Civilian PCM	2.9	9.2	9.2	9.2
	Nonenrolled	13.6	28.4	29.2	30.0
Retirees and family members	Military PCM	5.0	17.1	14.8	12.4
	Civilian PCM	4.5	11.3	10.7	10.1
	Nonenrolled	19.7	66.8	65.8	64.7

Source: Health Care Surveys of DoD Beneficiaries, 1999–2001.

<sup>a</sup> FY 2000 estimated as the average of FY 1999 and FY 2001.

Less than 10 percent of active-duty families enrolled in Prime were covered by OHI from 1999 to 2001. The incidence was somewhat greater for retirees enrolled in Prime (10.1 to 17.1 percent). The most important finding is the high OHI coverage rates of nonenrolled families. About 25 percent of active-duty families and about 66 percent of retiree families not enrolled in Prime were covered by OHI from 1999 to 2001.

#### 5.1.5 Methodology for Computing Out-of-Pocket Expenses Under TRICARE

We compute out-of-pocket expenses as the sum of expected D&C, insurance, and enrollment fees. The unit of observation is the “beneficiary family,” defined as the subset of family members who are eligible for purchased care under TRICARE. We exclude

<sup>49</sup> For example, Kaiser Family Foundation, Employer Health Benefits, 1999 Annual Survey, p. 61.

individuals ineligible for care under TRICARE, and active-duty sponsors with no dependents because they receive essentially all their care at MTFs.

TRICARE families are grouped by their enrollment status:

- sponsor enrolled in Prime with a military PCM,
- sponsor enrolled in Prime with a civilian PCM, or
- no family members enrolled in Prime.

We group by enrollment status because it affects D&C, enrollment fees, and supplemental insurance premium costs.

Families are further classified by sponsor's status:

- active-duty enlisted family members, sponsor's paygrade E-4 or below;
- active-duty enlisted family members, sponsor's paygrade E-5 or above, or active-duty warrant or commissioned officer; or
- eligible retiree family.

We group by sponsor type because it affects deductibles and TRICARE supplemental insurance premiums.

TRICARE purchased-care claims (inpatient, outpatient, and prescriptions) indicate how much the government paid for each beneficiary. They also identify the billed amount, allowable charges, and OHI payments for a purchased-care claim. We used the claims data to estimate the D&C liability, i.e., the beneficiary's obligation for the *balance* of the allowable charge net of OHI reimbursements. Data on all TRICARE claims were used to estimate the average D&C liability per family annually from 1999 to 2001.

Legally, other health insurance must pay before TRICARE. Most families with OHI do not bother to file for reimbursements from TRICARE as a second payer. Those that file have a relatively large claim amount—which is probably why they file. If the beneficiary has a TRICARE supplemental policy, TRICARE pays first, and the supplemental policy reimburses the policyholder directly. However, the purchased-care claims records do not include the amounts paid by TRICARE supplemental policies.

D&C costs under TRICARE are a function of *purchased care* utilization. Table 5-5 reports average purchased-care utilization rates *per beneficiary* family for outpatient visits, drug prescriptions, and hospital bed-days in the in FY 1999 to FY 2001 time interval. For Prime enrollees, utilization is lowest for those with a military PCM because beneficiaries obtain most of their care at MTFs. Utilization is relatively low for nonenrollees because of higher copayments; another and perhaps more important reason is that many have OHI and do not use TRICARE Standard/Extra to obtain health care.

It would be misleading to include OHI and non-OHI families in a single comparison with civilian benchmarks. As a result, we categorize families without OHI as “users” of TRICARE; we consider families with OHI as “non-users” whether or not they file for TRICARE reimbursements. We separately compare out-of-pocket expenses of TRICARE user and non-user families with civilian benchmarks.

**Table 5-5. TRICARE Utilization per Beneficiary Family From FY 1999 to FY 2001**

Sponsor Type	Enrollment Status	FY 1999			FY 2000			FY 2001		
		Visits	Drugs	Bed-Days	Visits	Drugs	Bed-Days	Visits	Drugs	Bed-Days
Active-duty family members, E1–E4	Military PCM	4.22	1.22	0.64	4.50	1.34	0.67	4.40	1.38	0.65
	Civilian PCM	18.15	8.29	1.54	17.37	10.00	1.40	13.09	7.91	0.86
	Nonenrolled	3.29	1.19	0.39	2.90	1.08	0.35	2.69	1.08	0.32
Active-duty family members, E5+	Military PCM	5.66	2.46	0.48	6.21	2.72	0.49	6.49	2.89	0.48
	Civilian PCM	22.46	15.62	0.96	22.70	19.80	1.02	18.41	16.05	0.71
	Nonenrolled	6.64	3.80	0.42	5.26	2.76	0.34	5.61	3.05	0.33
Retirees and family members	Military PCM	5.17	2.21	0.48	5.57	2.37	0.45	5.71	2.49	0.45
	Civilian PCM	15.97	16.04	0.80	16.56	17.10	0.75	17.12	18.46	0.71
	Nonenrolled	3.92	4.17	0.28	3.97	4.46	0.25	4.16	4.98	0.24

Initially, we estimated D&C *per beneficiary* family. This was done by summing D&C for purchased-care claims for all eligible family members. We can identify OHI families who file purchased-care claims, but not the non-filers. To estimate D&C costs *per user* family, we excluded claims of families with OHI. A further correction is required because of the OHI non-filers. Families with OHI who do not file have zero values for purchased care claims. This results in an understatement of the average D&C for users of the system. To correct for this bias, the estimate of D&C for user families was adjusted upward based on the percent of TRICARE eligibles with OHI who do not file for TRICARE reimbursements.

For TRICARE user families, we include the cost of TRICARE supplemental insurance and enrollment fees. Expected insurance costs equal the frequency of supplemental coverage times the premium for a typical family. Premiums are based on sponsor type, enrollment status, and family demographics. We also include enrollment fees for retirees who enroll in Prime. By definition, OHI premiums are zero for user families.

We assume a TRICARE supplemental policy covers all expenses above the plan deductible. For those with a supplemental policy, we assume D&C equals the minimum of expected D&C under TRICARE and the TRICARE deductible for the family.

For non-user families that do not file for TRICARE reimbursements, we assume D&C equals the expected D&C for civilian families with similar demographics. For “partial-user” families, i.e., those that file for TRICARE reimbursements, we assume D&C equals the minimum of expected D&C under TRICARE and the TRICARE deductible for the family.<sup>50</sup>

For non-user families, we include the cost of private insurance, i.e., the employee’s share of employer-sponsored family coverage. For those in a civilian HMO, we use the HMO premium; for those not in an HMO, we use the premium for a PPO plan. For retirees with OHI, we assume an enrollment fee of \$460 per year if enrolled in Prime and zero otherwise. We assume TRICARE supplemental insurance is zero for all non-user families.

<sup>50</sup> Partial users are assumed to have the same D&C as TRICARE users with a supplemental policy.

To estimate average TRICARE Supplemental premiums for MHS beneficiaries and average D&C costs for civilian families, we control for TRICARE family demographics in the FY 1999 to FY 2001 time interval. Based on data from DEERS, Table 5-6 profiles TRICARE-eligible families (excluding the active-duty member) by beneficiary group in 1999.<sup>51</sup> For example, the typical nonenrolled retiree family had 2.17 eligibles, consisting of a sponsor, 0.56 spouses, and 0.61 children. The sponsor was about 48 years old, the spouse 47, and the child 13. About 96 percent of retiree sponsors are male and 99 percent of spouses are female.

**Table 5-6. Demographic Profile of TRICARE Families in 1999**

Beneficiary Group	Enrollment Status	Eligible Family			Sponsor Age	Spouse Age	Child Age	Sponsor Gender	Spouse Gender
		Family Size	Spouse	Child				(% Male)	(% Female)
Active-duty family members, E1-E4	Military PCM	1.79	0.84	0.95	–	24.61	3.80	–	94.3
	Civilian PCM	1.74	0.74	1.00	–	25.90	4.38	–	95.0
	Nonenrolled	1.70	0.80	0.89	–	24.33	4.18	–	89.1
Active-duty family members, E5+	Military PCM	2.49	0.86	1.60	–	33.82	8.61	–	94.3
	Civilian PCM	2.26	0.87	1.38	–	37.45	10.81	–	95.0
	Nonenrolled	2.37	0.84	1.51	–	34.98	9.16	–	89.1
Retirees and family members	Military PCM	2.86	0.74	1.11	42.98	43.15	12.25	95.0	98.0
	Civilian PCM	2.65	0.74	0.90	46.04	44.83	12.45	96.7	98.7
	Nonenrolled	2.17	0.56	0.61	48.45	46.89	13.07	95.8	98.9

“–” indicates not applicable.

We also computed estimates of out-of-pocket expenses for all beneficiaries as weighted averages of expenses for users and non-users.

### **5.1.6 Expected Out-of-Pocket Expenses of TRICARE-Eligible Families**

Table 5-7 displays out-of-pocket expenses for *user* families under TRICARE from FY 1999 to FY 2001. In FY 1999, total expenses were lowest for those with a military PCM and highest for those with a civilian PCM; for junior-enlisted families expenses were \$91 for those with a military PCM, \$378 for those with a civilian PCM, and \$208 for nonenrollees. Expenses were greater for junior enlisted with a civilian PCM because of greater D&C costs driven by high utilization. For retirees, expenses were also highest for those with a civilian PCM. But the higher costs for retirees were due to enrollment fees rather than higher D&C costs.

<sup>51</sup> Family demographics are similar in 2000 and 2001.

**Table 5-7. Expected Out-of-Pocket Expenses for User Families**

Beneficiary Group	Enrollment Status	Deductibles and Copayments					Enrollment Fees			TRICARE Supplemental Insurance Premiums			Total			
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2000	2001	2000	2001	
Active-duty family members, E1-E4	Military PCM	\$83	\$80	\$64	\$0	\$0	\$0	\$8	\$8	\$8	\$8	\$8	\$8	\$91	\$88	\$72
	Civilian PCM	364	285	169	0	0	0	14	14	14	14	14	14	378	299	183
	Nonenrolled	97	83	66	0	0	0	111	123	116	123	116	208	206	182	
Active-duty family members, E5 and above	Military PCM	128	122	99	0	0	0	11	11	11	11	11	139	133	110	
	Civilian PCM	472	431	202	0	0	0	9	9	9	9	9	481	440	211	
	Nonenrolled	214	153	143	0	0	0	163	178	172	178	172	377	331	315	
Retirees and family members	Military PCM	154	152	144	460	460	460	14	14	14	14	14	628	626	618	
	Civilian PCM	433	442	423	460	460	460	12	11	11	11	11	905	913	894	
	Nonenrolled	435	435	430	0	0	0	348	360	329	360	329	783	795	759	

Expenses have been falling since FY 1999 because of declines in D&C costs especially for active duty families with a civilian PCM. The decline in their D&C costs was especially large in FY 2001 because in-network copayments were eliminated in April 2001. Enrolled retiree families also experienced small drops in expenses between FY 1999 and FY 2001.

Table 5-8 reports expected out-of-pocket for *non-user* families. Total expenses are much larger than for user families. For example, for the small number of junior enlisted families enrolled in Prime with a military PCM who are covered by OHI, total out-of-pocket expenses were \$2,106 in FY 2001 vs. only \$72 for a similar TRICARE user family. Costs are relatively high because the family pays an OHI premium and files infrequently for TRICARE reimbursements.

Except for those with a civilian PCM, TRICARE non-user families have higher D&C expenses than TRICARE users.<sup>52</sup> Non-user families with a civilian PCM have lower D&C expenses because most file for TRICARE reimbursements.

TRICARE non-user families have out-of-pocket expenses that are \$1,462 to \$2,270 higher than TRICARE user families. This is primarily because TRICARE non-user families pay OHI insurance premiums (e.g., about \$1,900 in FY 2001).

Table 5-9 shows average out-of-pocket expenses per beneficiary family. The cost is much higher than the cost per user family, especially for nonenrollees. This is because many nonenrollees are covered by OHI—an expensive alternative to TRICARE.

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<sup>52</sup> Those that do not file for TRICARE reimbursements are assumed to have higher D&C costs equal to those of counterpart civilian families given subsequently in Table 5-12.

**Table 5-8. Expected Out-of-Pocket Expenses for Non-User Families**

Beneficiary Group	Enrollment Status	Deductibles and Copayments			Enrollment Fees			TRICARE Supplemental Insurance Premiums			Total		
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2000	2001
Active-duty family members, E1-E4	Military PCM	\$138	\$181	\$210	\$0	\$0	\$0	\$1,680	\$1,620	\$1,896	\$1,816	\$1,801	\$2,106
	Civilian PCM	142	146	153	0	0	0	1,680	1,620	1,896	1,822	1,766	2,049
	Nonenrolled	378	437	489	0	0	0	1,752	1,716	1,884	2,130	2,153	2,373
Active-duty family members, E5 and above	Military PCM	200	221	244	0	0	0	1,680	1,620	1,896	1,880	1,841	2,140
	Civilian PCM	108	33	50	0	0	0	1,860	1,620	1,896	1,788	1,653	1,946
	Nonenrolled	570	622	701	0	0	0	1,752	1,716	1,884	2,322	2,338	2,585
Retirees and family members	Military PCM	418	393	295	460	460	460	1,680	1,620	1,896	2,558	2,473	2,651
	Civilian PCM	115	42	0	460	460	460	1,680	1,620	1,896	2,255	2,122	2,356
	Nonenrolled	697	747	812	0	0	0	1,752	1,716	1,884	2,449	2,463	2,696

**Table 5-9. Expected Out-of-Pocket Expenses for All Beneficiary Families**

Beneficiary Group	Enrollment Status	Deductibles and Copayments			Enrollment Fees			TRICARE Supplemental and OHI Insurance Premiums			Total		
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2000	2001
Active-duty family members, E1-E4	Military PCM	\$84	\$83	\$71	0	0	0	\$63	\$71	\$93	\$147	\$154	\$164
	Civilian PCM	348	275	168	0	0	0	137	140	170	485	415	338
	Nonenrolled	166	167	163	0	0	0	515	501	521	681	668	684
Active-duty family members, E5 and above	Military PCM	133	128	108	0	0	0	119	114	129	252	242	237
	Civilian PCM	438	394	188	0	0	0	162	157	183	600	551	371
	Nonenrolled	315	290	311	0	0	0	614	627	686	929	917	997
Retirees and family members	Military PCM	199	188	162	460	460	460	299	251	247	958	899	869
	Civilian PCM	397	399	381	460	460	460	200	183	201	1,057	1,042	1,042
	Nonenrolled	610	640	677	0	0	0	1,286	1,252	1,335	1,896	1,892	2,012

### 5.1.7 Expected Out-of-Pocket Expenses of Civilian Counterpart Families

In this section we estimate out-of-pocket costs for civilian families with demographics and insurance plans similar to those of TRICARE-eligible families. To estimate costs, we use adjusted projections of health care expenditures from the MEPS.<sup>53</sup> Table 5-10 shows the categories of information we selected from the MEPS to adjust the civilian beneficiary population to conform to the TRICARE-eligible population. The counterparts in MEPS of junior enlisted families are adults ages 18–29 and children ages 0 to 10; for senior enlisted families, they are adults ages 30–44 and children ages 0–17; for retirees, they are adults ages 45–64 and children ages 0–17. We use data only for individuals that have either employment-related or individually-purchased private health insurance.

**Table 5-10. Information Selected From the Medical Expenditure Panel Surveys**

Category	Information Selected
Years covered	1999 to 2001
Gender	Male, female
Age groups Active-duty family members, E1-E4 Active-duty family members, E5+ Retirees	Adults 18–29 and children (0–10) Adults 30–44 and children (0–17) Adults 45–64 and children (0–17)
Insurance type	Employment related private insurance Individually-purchased private insurance
Health Maintenance Organization (HMO)	Yes, no
Deductible and copayment expenses	Hospital Physician Drug Other medical equipment

Counterparts of those enrolled in Prime are civilians in an HMO; counterparts of TRICARE Standard/Extra families are civilians not enrolled in an HMO. MEPS D&C expenses are for health care covered by TRICARE (i.e., inpatient hospital stays, outpatient hospital surgeries, physician’s expenses, drugs, and other medical equipment).

Table 5-11 reports expected D&C costs and total health care expenditures per person in 1999 for adult males (M), adult females (F), and children (C) that correspond to TRICARE

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<sup>53</sup> MEPS data underestimate total and out-of-pocket health care expenses. The Medicare Current Beneficiary Survey (MCBS) is a widely used and respected source of data on health expenditures for Medicare enrollees. MCBS (1997) estimates total and out-of-pocket Medicare expenses that are about 28 percent higher than that obtained from MEPS (1997). The Consumer Expenditure Surveys (CES) undertaken by the Bureau of Labor Statistics also gather data on household out-of-pocket expenditures for health care. CES (1999) yields higher out-of-pocket expenses compared to MEPS (1999) for the under 65-year-old population. To correct for the downward bias, we multiply MEPS projections by the ratio of CES to MEPS out-of-pocket expenses in 1999 (i.e., by 1.23).

family members, by sponsor type, i.e., junior enlisted, senior enlisted, and retirees. Expected D&C for a civilian counterpart family is the weighted sum of D&C's from MEPS, where the weights equal the expected number of adult males, adult females, and children in a TRICARE-eligible family (Table 5-6). D&C and total health care expenditures increase with age (see Table 5-6). Given, sponsor type, D&C and total expenditures are greater for adult females compared to adult males, and they are less for children.

**Table 5-11. Expected Deductibles and Copayments and Total Health Care Expenditures in 1999 for Civilian Counterparts of TRICARE Families**

Insurance Type	Expense Items	Junior Enlisted			Senior Enlisted			Retirees		
		M	F	C	M	F	C	M	F	C
HMO	Visits	\$37	\$66	\$46	\$44	\$88	\$49	\$59	\$99	\$49
	Hospital	4	9	5	3	23	5	59	24	5
	Drugs	25	66	29	46	88	28	78	179	28
	Other medical equipment	2	0	1	2	2	5	12	8	5
	D&C	68	141	81	95	201	87	208	310	87
	Total health care expenditures	791	1,415	686	1,007	1,885	868	1,597	2,325	868
Non-HMO	Visits	63	113	90	66	166	90	133	229	90
	Hospital	4	12	9	8	30	10	25	57	10
	Drugs	37	87	33	45	102	36	115	219	36
	Other medical equipment	1	11	2	1	3	1	5	8	1
	D&C	105	223	134	120	301	137	278	513	137
	Total health care expenditures	628	2,246	625	816	2,101	827	1,731	2,849	827

Table 5-12 reports expected out-of-pocket expenses (i.e., D&C and insurance) for civilian families. Counterparts of junior enlisted families enrolled in Prime are enrolled in civilian HMOs: they had D&C costs of \$317 to \$326 in FY 2001. Counterparts of nonenrolled junior enlisted families participate in non-HMO plans with higher deductibles and copayments: they had D&C costs of \$525 in FY 2001. Insurance premiums were \$1,884 to \$1,896, so their out-of-pocket expenses were \$2,213 to 2,409. Counterparts of senior enlisted families and retirees have higher costs because of greater utilization (older adults and larger families).

### **5.1.8 Comparison of Out-of-Pocket Expenses Under TRICARE With Employer-Sponsored Health Insurance**

In FY 2001, out-of-pocket expenses for TRICARE-user families were at least \$1,856 lower than for comparable civilian families with employer-sponsored health insurance (Table 5-13). Expenses were lower for TRICARE users because of low D&C costs and because they pay little or no insurance premiums. For non-TRICARE user families, costs were a few hundred dollars less than for their civilian counterparts with OHI because of TRICARE reimbursements (Table 5-14). On average, out-of-pocket costs were \$982 to \$2,207 lower for TRICARE beneficiary families compared to their civilian counterparts with employer-sponsored insurance (Table 5-15).

**Table 5-12. Expected Out-of-Pocket Expenses for Civilian Counterpart Families**

Beneficiary Group	Enrollment Status	Deductibles and Copayments			Insurance Premiums			Total		
		1999	2000	2001	1999	2000	2001	1999	2000	2001
Active-duty family members, E1-E4	Military PCM	\$282	\$306	\$326	\$1,680	\$1,620	\$1,896	\$1,962	\$1,926	\$2,222
	Civilian PCM	266	287	317	1,680	1,620	1,896	1,946	1,907	2,213
	Nonenrolled	401	463	525	1,752	1,716	1,884	2,153	2,179	2,409
Active-duty family members, E5 and above	Military PCM	465	503	548	1,680	1,620	1,896	2,145	2,123	2,444
	Civilian PCM	440	492	540	1,680	1,620	1,896	2,120	2,112	2,436
	Nonenrolled	651	712	797	1,752	1,716	1,884	2,403	2,428	2,681
Retirees and family members	Military PCM	781	866	917	1,680	1,620	1,896	2,461	2,486	2,813
	Civilian PCM	755	807	854	1,680	1,620	1,896	2,435	2,427	2,750
	Nonenrolled	911	996	1110	1,752	1,716	1,884	2,663	2,712	2,994

**Table 5-13. Difference in Expected Out-of-Pocket Expenses: TRICARE Users vs. Civilian Counterparts**

Beneficiary Group	Enrollment Status	Deductibles and Copayments			Prime Enrollment Fees			Insurance Premiums			Total	
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2001
Active-duty family members, E1-E4	Military PCM	-\$199	-\$226	-\$262	\$0	\$0	\$0	-\$1,672	-\$1,612	-\$1,888	-\$1,871	-\$2,150
	Civilian PCM	98	-2	-148	0	0	0	-1,666	-1,606	-1,882	-1,568	-2,030
	Nonenrolled	-304	-380	-459	0	0	0	-1,641	-1,593	-1,768	-1,945	-2,227
Active-duty family members, E5 and above	Military PCM	-337	-381	-449	0	0	0	-1,669	-1,609	-1,885	-2,006	-2,334
	Civilian PCM	32	-61	-338	0	0	0	-1,671	-1,611	-1,887	-1,639	-2,225
	Nonenrolled	-437	-559	-654	0	0	0	-1,589	-1,538	-1,712	-2,026	-2,366
Retirees and family members	Military PCM	-627	-714	-773	460	460	460	-1,666	-1,606	-1,882	-1,833	-2,195
	Civilian PCM	-322	-365	-431	460	460	460	-1,668	-1,609	-1,885	-1,530	-1,856
	Nonenrolled	-476	-561	-680	0	0	0	-1,404	-1,356	-1,555	-1,880	-2,235

**Table 5-14. Difference in Expected Out-of-Pocket Expenses: TRICARE Non-Users vs. Civilian Counterparts**

Beneficiary Group	Enrollment Status	Deductibles and Copayments												
		Prime Enrollment Fees			Insurance Premiums			Total						
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2000	2001	
Active-duty family members, E1-E4	Military PCM	-\$144	-\$125	-\$116	\$0	\$0	\$0	\$0	\$0	\$0	\$0	-\$144	-\$125	-\$116
	Civilian PCM	-124	-141	-164	0	0	0	0	0	0	0	-124	-141	-164
	Nonenrolled	-23	-26	-36	0	0	0	0	0	0	0	-23	-26	-36
Active-duty family members, E5 and above	Military PCM	-265	-282	-304	0	0	0	0	0	0	0	-265	-282	-304
	Civilian PCM	-332	-459	-490	0	0	0	0	0	0	0	-332	-459	-490
	Nonenrolled	-81	-90	-96	0	0	0	0	0	0	0	-81	-90	-96
Retirees and family members	Military PCM	-363	-473	-622	460	460	460	0	0	0	0	97	-13	-162
	Civilian PCM	-640	-765	-854	460	460	460	0	0	0	0	-180	-305	-394
	Nonenrolled	-214	-249	-298	0	0	0	0	0	0	0	-214	-249	-298

**Table 5-15. Difference in Expected Out-of-Pocket Expenses: All TRICARE Beneficiaries vs. Civilian Counterparts**

Beneficiary Group	Enrollment Status	Deductibles and Copayments											
		Enrollment Fees			Insurance Premiums			Total					
		1999	2000	2001	1999	2000	2001	1999	2000	2001	1999	2000	2001
Active-duty family members, E1-E4	Military PCM	-\$198	-\$223	-\$255	\$0	\$0	\$0	-\$1,617	-\$1,549	-\$1,803	-\$1,815	-\$1,772	-\$2,058
	Civilian PCM	82	-12	-149	0	0	0	-1,543	-1,480	-1,726	-1,461	-1,492	-1,875
	Nonenrolled	-235	-296	-362	0	0	0	-1,237	-1,215	-1,363	-1,472	-1,511	-1,725
Active-duty family members, E5 and above	Military PCM	-332	-375	-440	0	0	0	-1,561	-1,506	-1,767	-1,893	-1,881	-2,207
	Civilian PCM	-2	-98	-352	0	0	0	-1,518	-1,403	-1,713	-1,520	-1,561	-2,065
	Nonenrolled	-336	-422	-486	0	0	0	-1,138	-1,089	-1,198	-1,474	-1,511	-1,684
Retirees and family members	Military PCM	-582	-678	-755	460	460	460	-1,381	-1,369	-1,649	-1,503	-1,587	-1,944
	Civilian PCM	-358	-408	-473	460	460	460	-1,480	-1,437	-1,695	-1,378	-1,385	-1,708
	Nonenrolled	-301	-356	-433	0	0	0	-466	-464	-549	-767	-820	-982

Figure 5-1 depicts costs per active-duty and retiree beneficiary family from FY 1999 to FY 2001 versus their civilian counterparts. Given sponsor status, the cost difference is greatest for those enrolled in Prime with a military PCM. It is almost as great for those enrolled in Prime with a civilian PCM. It is smaller but still substantial for nonenrollees. The cost difference is larger for active-duty families. For example, in FY 2001, out-of-pocket costs for active-duty families enrolled in Prime with a military PCM were \$2,174 lower than those of their civilian counterparts enrolled in a civilian HMO. For active-duty families enrolled in Prime with a civilian PCM, costs were \$2,056 lower; for nonenrolled active-duty families, costs were \$1,700 below those of their civilian counterparts in non-HMO plans.

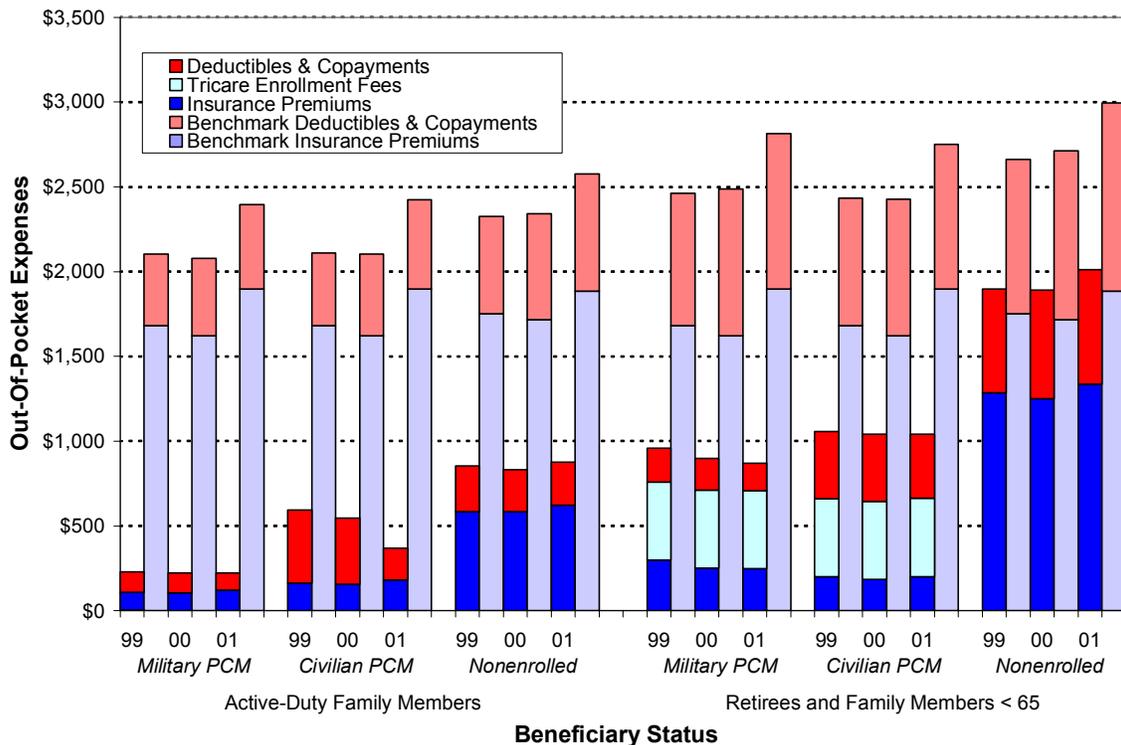


Figure 5-1. Out-of-Pocket Costs for All TRICARE Beneficiaries vs. Civilian Counterparts

## 5.2 Cost to Medicare-Eligible Beneficiaries

### 5.2.1 Introduction

MHS beneficiaries 65 and older (seniors) have health coverage under Medicare, but Medicare has substantial deductibles and copayments and it does not cover outpatient drugs. To increase utilization and lower out-of-pocket expenses, some seniors seek health care and drugs at MTFs. Unlike pharmacy benefits, MTF health care is available to seniors on a space-available basis, which limits its usefulness. Congress enhanced benefits for seniors in 2001 by adding two new programs: TRICARE For Life (October 2001) reimburses seniors for Medicare out-of-pocket costs; and the TRICARE Senior

Pharmacy program (April 2001) reimburses them for drugs purchased at retail pharmacies. This report does not evaluate these new programs.

What were Medicare out-of-pocket expenses for MHS seniors in FY 1999–FY 2001? According to DoD Surveys of Healthcare Beneficiaries, 16 percent of MHS seniors said they obtained *some* health care at MTFs in FY 2001; 54 percent said they filled *some* prescriptions at an MTF pharmacy.<sup>54</sup> For the 84 percent with no MTF health care (i.e., non-users), we estimate Medicare out-of-pocket expenses with data from MEPS on expenses of counterpart Medicare enrollees. For the 46 percent of MHS seniors who do not fill prescriptions at an MTF, we also estimate out-of-pocket expenses for health care not covered by Medicare (drugs, glasses, dental, etc.).

Did MTF users have lower Medicare out-of-pocket expenses than non-users? To answer this question, we compare the Medicare cost-sharing liability<sup>55</sup> (CSL) for MHS seniors with that for typical Medicare enrollees in FY 1998.<sup>56</sup>

Did MTF health care and pharmacy benefits significantly increase utilization of Medicare covered services and prescription drugs? To answer this question, we compare MTF and civilian expenses for Medicare-covered services and drugs per beneficiary in FY 1999–FY 2001.

### **5.2.2 Deductibles and Copayments Under Medicare**

Medicare provides basic health care benefits for hospital and medical services. Part A covers inpatient hospital services, short-term care in skilled nursing facilities, post-institutional home health care, and hospice care. Part B covers physician services, outpatient hospital services, home health care not covered by Part A, and a variety of other services such as an ambulance, diagnostic tests, and durable medical equipment. Individuals eligible for Social Security are eligible for Medicare when they reach age 65. For most people 65 or older Part A is free, but there is a monthly premium for Part B. The premium was \$45.50 in 1999 and 2000 and \$50 in 2001.

Most Medicare benefits require cost sharing. Under Part A, the deductible per inpatient episode was \$768 in 1999, \$776 in 2000, and \$792 in 2001. Coinsurance expenses after 60 days in the hospital were \$192 per day in 1999, \$194 in 2000, and \$198 in 2001. For Part B services, there is a \$100 deductible and 20 percent coinsurance for most allowable charges. Medicare benefits are limited: there is no coverage for outpatient drugs, no catastrophic cap, and the beneficiary is liable for 100 percent of non-allowable charges. Because of cost sharing, Medicare enrollees incur substantial out-of-pocket

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<sup>54</sup> Estimates of MTF utilization rates from quarterly surveys undertaken in January, April, July, and October 2001. MTF health care was obtained most often by those without supplemental insurance coverage. In contrast, drugs were obtained at the MTF pharmacy at about the same rates by seniors with and without insurance.

<sup>55</sup> The amount left unpaid by Medicare. It includes payments from all other sources such as supplemental insurance, Medicaid, and out-of-pocket.

<sup>56</sup> Data were not available from The Health Care Financing Administration on Medicare expenses of MHS seniors and typical Medicare enrollees in FY 1999–2001.

expenses for Medicare-covered services. According to CMS, in FY 1998 the average Medicare CSL per Medicare enrollee was \$840.<sup>57</sup>

### 5.2.3 Individually-Purchased Medicare Supplemental Insurance

To cover out-of-pocket expenses, many Medicare enrollees individually purchase Medicare supplemental insurance (Medigap policy). Ten standard plans are now available, Plans A through J.<sup>58</sup> Table 5-16 summarizes the benefits under each plan. All include “Basic Benefits”: coinsurance under Parts A and B, 365 days of hospital care after Medicare benefits end, and the first three pints of blood each year. Plan A provides only Basic Benefits. Plans B-J cover the Part A deductible; Plans C, F, and J also cover the Part B deductible and other expenses. Plans H-J provide limited coverage for drugs.

**Table 5-16. Benefits for Standard Medigap Policies**

Medigap Benefits	Policy Type									
	A	B	C	D	E	F	G	H <sup>a</sup>	I <sup>a</sup>	J <sup>b</sup>
Basic Benefits	√	√	√	√	√	√	√	√	√	√
Part A: Inpatient Hospital Deductible		√	√	√	√	√	√	√	√	√
Part A: Skilled Nursing Facility Coinsurance			√	√	√	√	√	√	√	√
Part B: Deductible			√			√				√
Foreign Travel Emergency			√	√	√	√	√	√	√	√
At-Home Recovery				√			√		√	√
Part B: Excess Charges						100%	80%		100%	100%
Preventive Care					√					√
Prescription Drugs								√ Basic Coverage	√ Basic Coverage	√ Extended Coverage

Source: Health Care Financing Administration, “Medicare Supplemental Insurance (Medigap) Policies and Protections,” July 1999, p. 3.

<sup>a</sup> After a \$250 per-year deductible, Plans H and I pay 50 percent of prescription drug costs up to a maximum of \$1,250 per year.

<sup>b</sup> After a \$250 per-year deductible, Plan J pays 50 percent of prescription drug costs up to a maximum of \$3,000 per year.

<sup>57</sup> *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement, 2000, p. 122. Estimate includes younger Medicare beneficiaries with end-stage renal disease. The average cost-sharing liability for aged Medicare enrollees was almost the same—\$837 per enrollee. Beneficiaries incur even larger D&C expenses for non-covered services. For evidence, see Kaiser Family Foundation, “Medicare Chart Book,” second edition, Fall 2001, p. 45.

<sup>58</sup> Prior to January 1, 1992, non-standard policies were sold and many of these are still in force.

Premiums vary even for standard Medigap policies because of differences in underwriting guidelines. Some companies base the premium on the current age of the policyholder, others on the age of the policyholder when the policy was first issued, with an adjustment for inflation. For others, the premium is a function of location and not the age of the policyholder. Given underwriting, premiums are a function of regional differences in medical costs.

The National Association of Insurance Commissioners (NAIC) collects data on Medicare supplemental insurance—on premiums earned and the number of covered lives by company and policy type. The U.S. General Accounting Office (GAO) recently used NAIC’s data to estimate the distribution of policies and annual premiums nationally in 1999 (Table 5-17). The average annual premium for all policies was \$1,322. The premium varies by policy type. For Standard Medigap policies (Plans A–J), the cost ranges from a low of \$877 for a “bare bones” Plan A, to \$1,704 for a “deluxe” Plan I. Using the percentage of covered lives as weights, we estimate the cost in 1999 for a typical standard Medigap policy was \$1,184. The typical non-standard policy cost more—\$1,573. Three states are exempt from plan standards: Massachusetts, Minnesota, and Wisconsin. The cost of a Medigap policy in these three states was \$1,405.

**Table 5-17. Distribution of Medicare Supplemental Insurance Policies and Average Premiums in 1999**

Medigap Plan	Covered Lives (Percentage)	Average Annual Premium Earned Per Covered Life
A	2.7	\$877
B	8.0	1,093
C	15.9	1,151
D	3.8	1,032
E	1.5	1,067
F	23.4	1,217
G	1.5	980
H	1.5	1,379
I	1.5	1,704
J	2.7	1,669
Pre-standard (policies originally sold before July 31, 1992)	32.9	1,573
Plans in exempt states <sup>a</sup>	4.5	1,405
Total <sup>b</sup>	100.0	\$1,322

Source: GAO Testimony, “Medicare: Cost-Sharing Policies Problematic for Beneficiaries and Program,” Statement of William J. Scanlon, Director, Health Care Issues, GAO-01-713T, May 9, 2001, Table 3, page 10.

<sup>a</sup> Massachusetts, Minnesota, and Wisconsin have alternative plans in effect and waivers that exempt them from selling the national standard Medigap plans.

<sup>b</sup> Data reported by insurers to NAIC do not include plan type for policies representing less than 9 percent of Medigap policy covered lives. These plans are not included in the plan distribution or average premiums reported in the table.

The distribution of *standard* Medigap policies in 1999 is given in Table 5-18. The most popular policy was Plan F (37.4 percent) followed by Plan C (25.4 percent). These two accounted for 62.8 percent of the standard Medigap policies in force. Only 9.1 percent of policyholders purchased a plan that covered drugs (H, I, or J). Of those with a standard Medigap policy, 95.7 percent did not pay the Part A deductible and 67.1 percent did not pay the Part B deductible.

**Table 5-18. Distribution of Standard Medigap Policies in 1999**

Plan	Percent of Policies
A	4.3
B	12.8
C	25.4
D	6.1
E	2.4
F	37.4
G	2.4
H	2.4
I	2.4
J	4.3

Source: Table 5-17.

To adjust for regional differences in premiums, we obtained state-level data on premiums for standard Medigap policies by plan in 1999 from Weiss Ratings, Inc.<sup>59</sup> The policyholder is assumed to be a 65-year-old male. Using data from Weiss Ratings on premiums and NAIC on the mix of policies (weights), we estimated the weighted average cost of a standard Medigap policy by state in 1999 (Table 5-19). Premiums range from a low of \$1,041 in North Dakota to a high of \$1,770 in Florida. To estimate the cost of a Medigap policy for MHS seniors, we use Table 5-19 and state-level data on the population of seniors.

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<sup>59</sup> Data from Weiss Ratings, Inc. web site ([http://www.weissratings.com/news/ins\\_medigap](http://www.weissratings.com/news/ins_medigap)), Medigap Insurance News Release, 3/26/01, "Prescription Drugs Costs Boost Medigap Premiums Dramatically." Data were available for all states except New Hampshire. We used the average for all states for New Hampshire.

**Table 5-19. Annual Premiums for Medigap Policies by State in 1999**

State	Medigap <sup>a</sup>	State	Medigap
AK	\$1,178	MT	\$1,049
AL	1,332	NC	1,047
AR	1,352	ND	1,041
AZ	1,264	NE	1,105
CA	1,445	NH	1,226
CO	1,132	NJ	1,057
CT	1,360	NM	1,100
DC	1,355	NV	1,331
DE	1,154	NY	1,539
FL	1,770	OH	1,209
GA	1,293	OK	1,181
HI	1,150	OR	1,130
IA	1,051	PA	1,398
ID	1,301	RI	1,201
IL	1,214	SC	1,164
IN	1,044	SD	1,122
KS	1,137	TN	1,117
KY	1,166	TX	1,262
LA	1,304	UT	1,042
MA	1,405	VA	1,103
MD	1,157	VT	1,184
ME	1,345	WA	1,249
MI	1,283	WI	1,405
MN	1,405	WV	1,151
MO	1,175	WY	1,166
MS	1,157	All	na

Note: Premium is for a 65-year-old male.

#### **5.2.4 Employer-Sponsored Insurance for Medicare Eligibles**

According to Kaiser Family Foundation surveys of employers, about 40 percent of employers with 200 or more employees offered group health coverage to retirees in 1999.<sup>60</sup> Retirees must meet minimum requirements for eligibility (e.g., age 55 with 10 to 15 years of service). Health benefits are similar for active and retired employees.<sup>61</sup> For example, in 1999 the average deductible for a retiree was \$245 and the copayment was 20 percent. Unlike most Medigap policies, the employer-sponsored plans include drug coverage, a major benefit for Medicare eligibles.<sup>62</sup>

<sup>60</sup> Kaiser Family Foundation, "Employer Health Benefits, 1999 Annual Survey," p. 118. (Available at <http://www.kff.organization/content/1999/1538/kff.pdf>.)

<sup>61</sup> Benefits depend on the design of the plan vis-à-vis Medicare. Most employers use the "Carve-out Method" which results in the same benefit for active and retired workers. See Hewitt Associates, "Retiree Health Trends and Implications of Possible Medicare Reforms," September 1997. (Available at [http://www.kff.organization/content/archive/1318/retiree\\_fs.html](http://www.kff.organization/content/archive/1318/retiree_fs.html).)

<sup>62</sup> Retiree utilization of prescription drugs is more than double that of active workers. Moreover, drug expenses have been increasing sharply. Because the drug benefit accounts for 40–60 percent of the health plan cost for retirees [Hewitt, p. 22], health policy premiums for retirees have been increasing more rapidly than for active workers.

In 1999, about one-third of Medicare eligibles had health coverage from a former or *current* employer.<sup>63</sup> We estimate that in 1996, 6 to 7 percent of Medicare eligibles were active employees not covered by Medicare.<sup>64</sup>

A Medicare supplemental (Medisup) policy is employer-sponsored insurance for a retired Medicare-eligible employee. In contrast to health insurance for active employees, Medicare is the primary insurer. As a result, a Medisup policy is less expensive than a health policy for active employees, but a greater share of cost is passed on to retirees.

Table 5-20 gives the average Medisup premium paid by retirees for single coverage, and the premium for active employees (given earlier) for comparison purposes. Data on Medisup premiums are from surveys of employers by Towers Perrin.<sup>65</sup> The average cost to the beneficiary in 1999–2001 for a Medisup policy was \$720; for an active employee it was \$372. The Medisup premium increased by about 11 percent a year in 1999–2001, primarily because of rising drug costs. The premium for active employees fluctuated because of changes in the labor market.

**Table 5-20. Employee’s Cost of Employer-Sponsored Health Insurance for Medicare-Eligibles, 1999–2001**

Year	Active Employees (15%) <sup>a</sup>	Retired Employees (85%) <sup>b</sup>	Average
1999	\$420	\$648	\$614
2000	336	720	663
2001	360	792	728
1999–2001	\$372	\$720	\$668

<sup>a</sup> Data from surveys of employers by The Kaiser Family Foundation, 1999–2001. In parenthesis is IDA’s estimate of the percent of Medicare eligibles with employer-sponsored health insurance who are active employees.

<sup>b</sup> Data from surveys of employers by Towers Perrin, 1999–2001. In parenthesis is IDA’s estimate of the percent of Medicare eligibles with employer-sponsored health insurance who are retired.

Assuming that 15 percent of MHS seniors are still working, the average premium for employer-sponsored coverage in 1999–2001 was \$668.<sup>66</sup> For convenience, we refer to this premium as the cost of a “Medisup policy.”

<sup>63</sup> Data from the 1999 Medicare Current Beneficiary Survey, published by Kaiser Family Foundation, “Medicare Chart Book,” Second Edition, Fall 2001, p. 37. (Available at [http://www.kff.org/content/2001/1622/Medicare\\_Chart\\_Book.pdf](http://www.kff.org/content/2001/1622/Medicare_Chart_Book.pdf))

<sup>64</sup> This estimate was based on data from the Bureau of Labor Statistics: the labor force participation rate of older workers, the health benefit participation rate of full and part-time workers, and the marital status of the Medicare population.

<sup>65</sup> Towers Perrin, Health Care Cost Surveys, 1999–2001.

<sup>66</sup> About 40 percent of MHS seniors have employer-sponsored health insurance (Table 5-23). If 6 percent are active employers, then 15 percent are active employees and 85 percent are retired.

### 5.2.5 Medicare HMOs<sup>67</sup>

A “Medicare risk HMO” contracts with CMS to provide Medicare-covered services to HMO enrollees. Medicare prepays a monthly amount (capitation fee) to the HMO for each enrollee, regardless of his/her actual health care utilization. In return, the HMO provides the enrollee with all medically necessary Medicare-covered services. The provider assumes the risk of expenses above the capitation fee; hence the name “Medicare risk HMO.” The program began in 1983 and increased steadily in the 1990s. About 17 percent of all Medicare beneficiaries were enrolled in a Medicare HMO in December 1999.<sup>68</sup>

Enrollment in a Medicare risk HMO sharply reduces out-of-pocket expenses because the HMO covers most of the Medicare deductibles and copayments. The plan usually has its own small copayments for visits (\$5 to \$10 per visit), but out-of-pocket expenses are relatively low. The typical plan goes beyond Medicare and offers limited drug coverage and preventive care not covered by Medicare.

Most Medicare risk HMOs do not charge an enrollment premium to cover Medicare services; however, the individual must enroll in Medicare Part B and pay that premium to Medicare.<sup>69</sup> In December 1998, 70 percent of risk HMO plans did not charge a premium; 17 percent charged less than \$40 per month while 13 percent charged more.<sup>70</sup>

Although over 300 Medicare risk HMOs existed in December 1998, not all beneficiaries have access to one. In June 1996, only 63 percent of all Medicare beneficiaries lived in an area served by at least one risk plan. About half had access to two or more plans. Medicare risk HMOs are concentrated in urban areas and the three western states of Arizona, California, and Oregon. Enrollment rates are higher in those states. In December 1996, 34 percent of Medicare beneficiaries in Arizona, 35 percent in California, and 27 percent in Oregon, were enrolled in Medicare risk HMOs. The only eastern states where the Medicare risk HMO enrollment rate topped 10 percent were Florida (22 percent), Massachusetts (14 percent), Pennsylvania (16 percent), and Rhode Island (12 percent).

Table 5-21 presents data from CMS on Medicare risk HMO enrollment premiums by state in 1999. Nationally, the average annual premium per enrollee was \$137. The premium varied from a low of \$16 in Louisiana to a high of \$1,443 in Minnesota. Data were not available for twelve states because they did not have Medicare risk HMOs. We use the data in Table 5-21 to estimate HMO enrollment premiums for MHS seniors, given their state of residence.

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<sup>67</sup> Unless otherwise noted, information in this section is from the HCFA websites at <http://www.hcfa.gov/stats/monthly.htm> and <http://www.hcfa.gov/stats/geos.htm> unless otherwise noted.

<sup>68</sup> Estimate from the 1999 Medicare Current Beneficiary Survey, published by Kaiser Family Foundation, “Medicare Chart Book,” Second Edition, Fall 2001, p. 37. (Cited previously.)

<sup>69</sup> Nearly all Medicare-eligible beneficiaries do so anyway.

<sup>70</sup> Data from Phillip Doer, HCFA, MMCG, by fax, 5/25/01.

**Table 5-21. Annual Premiums per Medicare Enrollee for a Medicare HMO by State in 1999**

State	Medicare HMO <sup>b</sup>	State	Medicare HMO
AK	na	MT	na
AL	na	NC	\$339
AR	\$243	ND	na
AZ	206	NE	na
CA	135	NH	130
CO	230	NJ	267
CT	342	NM	186
DC	na	NV	213
DE	360	NY	238
FL	83	OH	167
GA	62	OK	162
HI	823	OR	622
IA	na	PA	262
ID	420	RI	115
IL	147	SC	540
IN	438	SD	na
KS	345	TN	199
KY	256	TX	63
LA	16	UT	na
MA	33	VA	295
MD	172	VT	na
ME	649	WA	341
MI	243	WI	181
MN	1,443	WV	579
MO	203	WY	na
MS	na	All	137

Besides Medicare risk HMOs, 4.8 percent of MHS seniors enrolled in a DoD-sponsored managed care plan (i.e., the Uniformed Services Family Health Plan or TRICARE Senior Prime).<sup>71</sup> These plans were available in relatively few areas. There is no enrollment fee for these plans if the beneficiary enrolls in Medicare and pays the Medicare Part B premium.

### **5.2.6 Medicaid**

Medicaid is a Federal/State entitlement program that provides medical assistance for individuals with low incomes and resources. It is the largest source of funding for medical services for poor people in the United States.<sup>72</sup> For the elderly poor, Medicaid is essentially a Medicare supplemental policy with no premiums.

<sup>71</sup> DoD HMO enrollment rates estimated from Health Care Surveys of DoD Beneficiaries in 2001 (see Table 5-23).

<sup>72</sup> For more discussion on the Medicaid program, see *Health Care Financing Review, Medicare and Medicaid Statistical Supplement, 2000*, pp. 11–18.

### 5.2.7 Medicare Supplemental Insurance Premiums for MHS Seniors

Table 5-22 estimates average Medicare supplemental premiums for single coverage for MHS seniors in 1999–2001. The estimates for HMOs and Medigap policies take into account state-level differences in premiums and the population distribution of seniors. Regional data were not available on Medisup policies. Table 5-22 includes national-level estimates given previously in Table 5-20.

**Table 5-22. Estimates of Annual Medicare Supplemental Insurance Premiums: Single Coverage for MHS Seniors in FY 1999–FY 2001**

Year	HMO <sup>a</sup>	Medisup <sup>b</sup>	Medigap <sup>c</sup>
1999	\$170	\$614	\$1,293
2000	254	663	1,422
2001	332	728	1,565
1999–2001	252	668	1,427

<sup>a</sup> Assumes 24 percent in DoD managed care plan with no premium. Changes in Medicare risk HMO premiums in 2000–2001 from Lori Achman and Marsha Gold, “Out-of-Pocket Health Care Expenses for Medicare HMO Beneficiaries: Estimates by Health Status,” Mathematica Policy Research, Inc., Report 494, February 2002.

<sup>b</sup> Employer-sponsored insurance for active and retired Medicare-eligible employees.

<sup>c</sup> From Weiss Associates, Medigap policy inflation rate 10 percent in 1999–2001.

In 1999–2001, the least expensive alternative was an HMO at \$252, but HMOs are not available in all counties, the choice of physicians is limited, and drug coverage varies. A Medisup policy covers drugs and preventive services at a moderate cost (\$668), but many MHS seniors do not qualify. At age 65, all Medicare-eligible beneficiaries can purchase a Medigap policy, but most do not cover drugs and are relatively expensive (\$1,427 on average).<sup>73</sup>

### 5.2.8 Medicare Supplemental Insurance Coverage of MHS Seniors

Previous studies find that the demand for Medicare supplemental insurance is a function of economic factors (income or wealth), socio-demographic factors and health status. Perhaps the most important determinant is economic—families with above-average

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<sup>73</sup> In 1998, 73 percent of Medicare beneficiaries had some drug coverage under their supplemental insurance (HMO, Medigap, Medisup, or Medicaid). See Kaiser Family Foundation, “Medicare Chart Book,” Second Edition, Fall 2001, p. 58.

income/wealth buy more supplemental insurance.<sup>74</sup> MHS seniors appear to behave similarly.<sup>75</sup>

What is the Medicare supplemental insurance coverage of MHS seniors? We answer this question with data from the Health Care Surveys of DoD Beneficiaries in 1999 and 2001 (Table 5-23). For comparison purposes, we present data on insurance coverage of all Medicare enrollees in 1999 from the Medicare Current Beneficiary Survey in that year.

**Table 5-23. Distribution of Insurance Choices by MHS Seniors in 1999–2001 and All Medicare Enrollees in 1999**

Source	Year	Basic Medicare	HMO	Medigap	Medisup	Medicaid
DoD Healthcare Surveys	1999	12.6%	19.6%	19.7%	45.4% <sup>a</sup>	2.7%
	2001	12.2	20.5	30.5	35.2 <sup>a</sup>	1.6
	Average 1999–2001	12.3	20.1 <sup>b</sup>	25.1	40.3	2.2
MCBS <sup>c</sup>	1999	14.4	17.3	24.3	33.1	10.9

<sup>a</sup> Includes about 2 percent of MHS seniors who also have a Medigap policy.

<sup>b</sup> Includes 4.8 percent enrolled in DoD sponsored HMOs.

<sup>c</sup> Source: 1999 Medicare Current Beneficiary Survey reported in Kaiser Family Foundation, Medicare Chart Book, Fall 2001, p. 82.

Respondents are grouped into five insurance types: (1) Basic Medicare, (2) Medicare Risk/DoD HMO, (3) Medigap, (4) Medisup,<sup>76</sup> and (5) Medicaid.<sup>77</sup> Changes in survey questions caused spurious shifts in the mix of Medigap vs. Medisup coverage in 1999 and 2001.<sup>78</sup> For each year from FY 1999 through FY 2001, we estimate the percentage having each type of insurance coverage as the average of survey responses in 1999 and 2001. The estimates are 12.3 percent with Basic Medicare, 20.1 percent with a Medicare risk/DoD HMO, 25.1 percent with a Medigap policy, 40.3 percent with a Medisup

<sup>74</sup> IDA is unaware of studies analyzing the demand for Medicare supplemental insurance by military beneficiaries. For evidence on the relationship between income/wealth and the demand for Medigap insurance for the entire Medicare population, see Susan L. Ettner, “Adverse Selection and the Purchase of Medigap Insurance by the Elderly,” *Journal of Health Economics*, 16 (1997), pp. 543–562; Lee A. Lillard, Jeannette Rogowski, and Raynard Kington, “Long-Term Determinants of Supplemental Health Insurance Coverage in the Medicare Population,” RAND, March 1996, DRU-1378-NIA; and Jessica A. Vistnes and Jessica S. Banthin, “The Demand for Medicare Supplemental Insurance Benefits: The Role of Attitudes Toward Medical Care and Risk,” *Inquiry* 34 (Winter 1997/98), pp. 311–324. Studies show that supplemental insurance increases health care utilization. See, for example, S. Christensen and J. Shenogle, “Effects of Supplemental Coverage on Use of Services by Medicare Enrollees,” *Health Care Financing Review*, Fall 1997.

<sup>75</sup> Based on preliminary analysis of data on supplemental insurance choices made by MHS seniors in 1998. Data from the Health Care Survey of DoD Beneficiaries in 1998.

<sup>76</sup> Includes active as well as retired employees.

<sup>77</sup> We used results only for Health Service Regions 3, 4, and 6–12 because TRICARE was not yet in effect in the other regions.

<sup>78</sup> However, the total Medigap plus Medisup coverage percentages are stable.

policy,<sup>79</sup> and 2.7 with Medicaid. Compared to all Medicare enrollees in 1999, more MHS seniors had some kind of Medicare supplemental insurance (HMO, Medigap, or Medisup) and fewer relied on Medicaid.<sup>80</sup> The data in Table 5-23 were used to estimate out-of-pocket expenses for MHS seniors.

### **5.2.9 Medicare Out-of-Pocket Expenses for MHS Senior Families With no MTF Utilization**

Most MHS seniors obtain health care only from civilian providers under Medicare. The FY 2001 quarterly Health Care Surveys of DoD Beneficiaries collected data on MTF utilization: 16 percent of MHS seniors said they used an MTF for *some* Medicare-covered health services; 54 percent said they filled *some* prescriptions at an MTF. For MTF non-users, Medicare and total out-of-pocket expenses should be similar to those of counterpart Medicare enrollees.

We used data from MEPS to estimate out-of-pocket expenses for Medicare enrollees with the insurance, age, and gender distribution of MHS seniors.<sup>81</sup> Estimates are for Medicare beneficiaries 65 and older not living in institutions (i.e., the MEPS sample). MEPS collects data on individuals rather than families. To estimate expenses at the family level, we aggregated costs for individuals with the gender and age characteristics of those in MHS senior families. In the FY 1999 to FY 2001 time period, the typical MHS senior family consisted of approximately 1.8 eligible members.

As noted previously, the Medicare Current Beneficiary Survey (MCBS) is the benchmark for health expenditures by Medicare enrollees. MCBS (1997) estimates total and out-of-pocket Medicare expenses that are about 28 percent higher than those obtained from MEPS (1997). To correct for this bias, we multiplied estimates from MEPS by 1.28.

Table 5-24 reports Medicare and non-Medicare D&C expenses for the typical MHS senior family in FY 1999–FY 2001. On average for that period, Medicare D&C expenses were \$640, the Part B premiums were \$984, and supplemental insurance expenses were \$1,210. Total Medicare out-of-pocket expenses (Medicare D&C, Part B premium, and supplemental insurance) were \$2,834. D&C expenses for services not covered by Medicare (drugs, eyeglasses, dental, etc.) were \$1,380. Most of the latter expenses (\$940) were for outpatient drugs. Total out-of-pocket expenses per family were \$4,214.

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<sup>79</sup> About 2 percent have both a Medigap and Medisup policy. These are included in the Medisup category only.

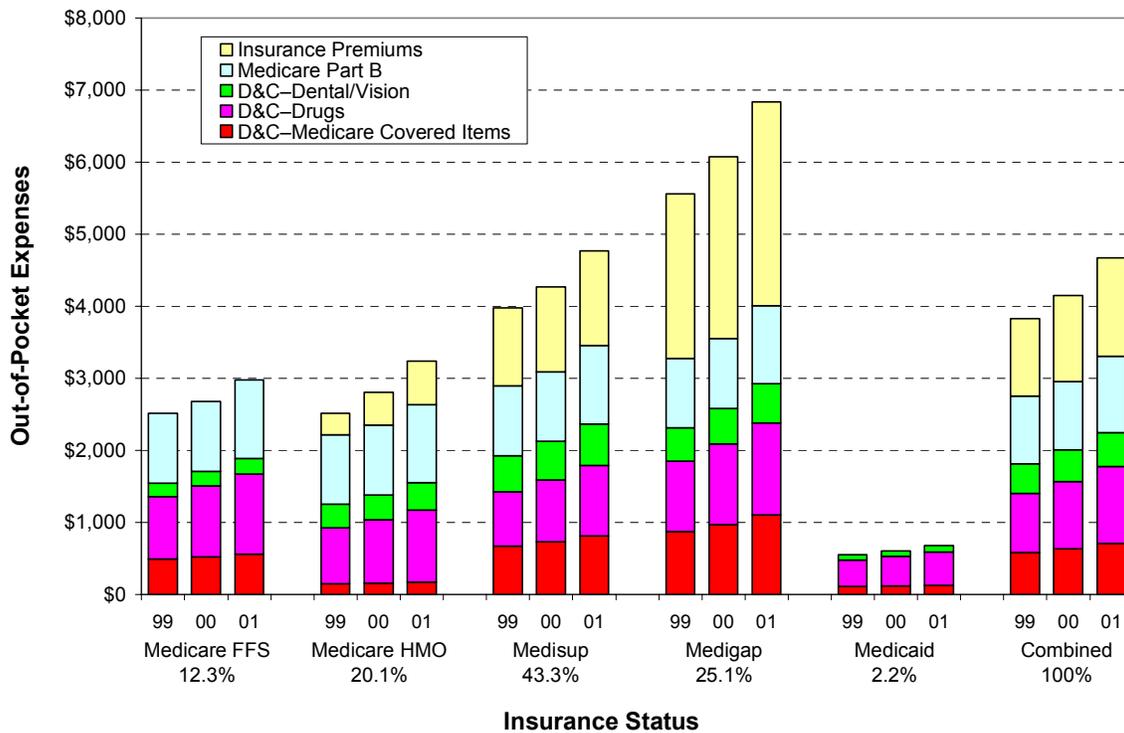
<sup>80</sup> The Health Care Survey of DoD Beneficiaries in 1998 collected data on family income. MHS seniors have higher incomes than the average Medicare enrollee. This is why MHS seniors have more supplemental insurance and fewer rely on Medicaid.

<sup>81</sup> MEPS does not include expenses for skilled nursing facilities. The average cost-sharing liability for skilled nursing facilities in CY 1998 was \$71 per Medicare enrollee. We added the average cost-sharing liability for skilled nursing facilities to Medicare D&C expenses in FY 1999, FY 2000, and FY 2001 after adjusting the former for inflation (2 percent annually). See *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement, 2000, p. 123.

**Table 5-24. Annual Out-of-Pocket Expenses per Counterpart Medicare Family in FY 1999–FY 2001**

Year	Medicare-Covered Services				Non-Medicare Services			All Services
	Medicare D&C	Part B	Insurance	Total	D&C Drugs	D&C Other	D&C Total	
1999	\$580	\$943	\$1,071	\$2,594	\$820	\$410	\$1,230	\$3,824
2000	633	948	1,199	2,780	936	435	1,371	4,151
2001	707	1,062	1,362	3,131	1,065	474	1,539	4,670
1999–2001	\$640	\$984	\$1,210	\$2,834	\$940	\$440	\$1,380	\$4,214

Figure 5-2 graphs total out-of-pocket expenses per MHS senior family by insurance status. Medigap and Medisup policyholders have the greatest expenses because of insurance premiums and relatively high D&C expenses. On average in FY 1999–FY 2001, out-of-pocket expenses were \$6,159 for families having a Medigap policy and \$4,337 for families with Medisup coverage. Expenses were lower for families with just basic Medicare (\$2,722) and for those in a Medicare HMO (\$2,849). Expenses were lowest for those under Medicaid (\$608); they typically have low D&C costs and no expenses for insurance or the Part B premium.



**Figure 5-2. Out-of-Pocket Expenses per Counterpart Medicare Family by Insurance Status in FY 1999–FY 2001**

### 5.2.10 Medicare Cost-Sharing Liability for MHS Seniors in FY 1998

Table 5-24 and Figure 5-2 presented estimates of out-of-pocket expenses for MTF non-users. In this section, we examine whether Medicare out-of-pocket expenses were significantly lower for MTF users. To shed light on this issue, we analyzed data previously obtained from the Health Care Financing Administration on the Medicare CSL for a random sample of MHS seniors in FY 1998 (we were unable to obtain more current data). Observations are for MHS seniors not enrolled in HMOs. We estimated the average CSL for MHS senior families in each health service region under TRICARE in FY 1998 (Regions 3, 4, and 6–12), and calculated a weighted average using the MHS senior population in each region as weights.<sup>82</sup> The average CSL for MHS senior families was \$1,457, as Table 5-25 shows.

**Table 5-25. Medicare Cost-Sharing Liability for MHS Senior Families and All Medicare Families in FY 1998**

MHS Seniors	Typical Medicare Enrollee	Percent Difference
\$1,457	\$1,478	-1.44%

We collected state-level data from CMS on the Medicare CSL for all Medicare enrollees in FY 1998, and estimated a weighted average in the states under TRICARE using the MHS senior population in the states as weights. Observations are also for those not enrolled in HMOs. The average CSL for all Medicare families was \$1,478.

The Medicare CSL of MHS senior families was just 1.44 percent below that of all Medicare-enrolled families in FY 1998 (i.e., \$21 less). Therefore, the Medicare D&C was about the same for MTF users and non-users.

### 5.2.11 Civilian vs. MTF Expenses for Medicare-Covered Services and Prescription Drugs in FY 1999–FY 2001

To put MTF utilization in perspective, we compare MTF expenses on behalf of seniors with total civilian expenses for Medicare-covered services and prescription drugs. Total expenses include payments from all sources: Medicare, insurance companies, Medicaid, out-of-pocket, etc. Using data from MEPS, we estimated total Medicare expenses per counterpart Medicare family in FY 1999–FY 2001 (i.e., Medicare enrollees with the insurance, age, and gender distribution of MHS seniors). Table 5-26 presents the results. Medicare expenses are for hospital stays, outpatient surgeries, outpatient visits, physicians, medical equipment, skilled nursing facilities, home health care, and other providers.<sup>83</sup> We also estimated total expenses for outpatient drugs for counterpart Medicare families.

<sup>82</sup> Inflates D&C by 9 percent to account for omission of costs for skilled nursing facilities.

<sup>83</sup> MEPS does not collect data on expenses for skilled nursing facilities care. To account for this, we increased Medicare expenses by the Medicare payment plus the CSL per enrollee in CY 1998, i.e., \$460. This was adjusted for inflation (2 percent annually) to yield \$469 in FY 1999, \$478 in FY 2000, and \$488 in FY 2001. For CY 1998 expenses, see *Health Care Financing Review*, Medicare and Medicaid Statistical Supplement, 2000, pp. 122 and 173.

**Table 5-26. Total Civilian Expenses per Counterpart Medicare Family vs. Total MTF Expenses per MHS Senior Family in FY 1999–FY 2001**

Fiscal Year	Total Civilian Expenses per Counterpart Medicare Family		MTF Expenses per MHS Senior Family		MTF/Total Civilian Expenses (%)	
	Medicare Services	Prescription Drugs	Medicare Services	Prescription Drugs	Medicare Services	Prescription Drugs
1999	\$7,322	\$1,700	\$876	\$148	12.0%	8.7%
2000	7,864	1,960	854	178	10.9	9.1
2001	8,623	2,271	823	409	9.5	18.0
1999–2001	\$7,936	\$1,977	\$851	\$245	10.7	12.4

On average in FY 1999–FY 2001, total Medicare expenses per counterpart Medicare family were \$7,936. MTF expenses incurred on behalf of MHS senior families (\$851) were 11 percent of this total.

Total expenses for outpatient drugs per counterpart Medicare family were \$1,977 in FY 1999–FY 2001. Total MTF pharmacy, retail pharmacy, and NMOP drug expenses averaged \$163 per MHS senior family in FY 1999–FY 2000 and \$409 in FY 2001. MTF expenses were 8.9 percent of the total in FY 1999–FY 2000; they increased to 18 percent in FY 2001 because of the new TSRx benefit introduced in April 2001.

MTF expenses are a small percentage of total civilian health care expenses for MHS senior families. For Medicare-covered services, MTF user families have slightly higher utilization than non-user families, but about the same out-of-pocket expenses. Pharmacy expenses per MHS senior family averaged just \$163 in FY 1999–FY 2000; total civilian expenses per counterpart Medicare family were \$1,830. Some MTF user families probably increased their drug utilization and most had some drug coverage. The MTF pharmacy benefit probably had little effect on out-of-pocket drug expenses before April 2001.

### **5.3 Summary**

Out-of-pocket expenses for TRICARE-user families were about \$2,000 less than comparable civilian families with employer-sponsored health insurance in FY 1999–FY 2001. Expenses were lower for TRICARE-user families because they have low D&C costs and they pay little or no insurance premiums.

Total out-of-pocket expenses for MHS senior families—MTF users and non-users—were about \$4,200 in FY 1999–FY 2001. Expenses were about \$2,800 for Medicare-covered services and about \$1,400 for other health care services (drugs, glasses, and dental).

# **APPENDICES**



## **APPENDIX A: APPROACH TO ESTIMATING AND CASE-MIX ADJUSTING CAHPS MEASURES**

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We discuss the procedure for estimating CAHPS measures from DoD Annual Beneficiary Survey data and the NCBD.

### **Method**

CAHPS composites were constructed by:

- Computing item scores as dichotomies (0/1).
- Regressing the case-mix adjusters (i.e., age, gender, health-status), along with indicator variables for health plan and year, on each of the CAHPS items used to form a particular composite.
- Shifting the estimated intercepts for plan-by-year combinations by a constant amount to force their mean to equal the mean of the unadjusted plan-by-year means.
- Iteratively apply the prediction equations from steps *b* and *c* to the item scores for those in the FY 2001 DoD sample. By turning on/off the intercept values for each plan-by-year combination, we obtain estimated CAHPS item scores for the NCBD and FY 2000 DoD population, with adjusters based on FY 2001 DoD population characteristics.
- Averaging the estimated items means to form particular composites for each plan-by-year combination.

CAHPS ratings are reported on an 11-point scale, and as the percentage of scores that fall within a particular interval, typically 8 to 10. Our estimates are based on the probability that a given CAHPS score, estimated from the DoD scales, will have a predicted value of 8 or higher. We do this by dichotomously scoring the ratings, then assigning a 0 to scores below 8, and a value of 1 to scores 8 and above. A logistic regression equation is then estimated using case-mix adjusters and indicator variables for plan-by-year combinations of regressors. Rating probabilities are then predicted by applying this equation.

### ***Missing Data and Item Weighting***

The construction of the CAHPS composites is complicated by missing data. Often, respondents to the surveys do not answer all of the questions used to build the scales.

To reflect the differing numbers of responses by item, each item is assigned a different weight in the composite score. Those items that receive a greater number of respondent answers will count more toward the composite score. The weighting procedure accounts for the different numbers of valid responses for each item within a composite but does so across all plans by standardizing the item weight. This approach prevents plans from faring worse or better just because they have fewer available valid responses because of skip patterns.

For each composite, a set of data-determined item weights are calculated which are used for all plans and years. The number of valid responses obtained for each item determines these weights. The weighting formula is:

$$n_{ip} = \text{the number of responses to item } i \text{ from plan/year } p;$$

$$n_i = \sum_p n_{ip} = \text{total number of valid responses obtained on item } i$$

$$w_i = n_i / \sum_j n_j = \text{weight for item } i.$$

## Hypothesis Testing

We want to test hypotheses about the difference between two composite (or item rating) means. The information needed to compute the means and error variances are available from the item-level regression analyses used to account for the case-mix adjusters. We form a t-statistic,<sup>84</sup> with a weighted sum of the regression coefficients in the numerator, and a weighted sum of error variances (squared standard errors) in the denominator:

$$t = \left( \sum_i w_i \times \beta_{ip1} - \sum_i w_i \times \beta_{ip0} \right) \div \sqrt{\left( \sum_i w_i^2 \times v_{ip1} + \sum_i w_i^2 \times v_{ip0} \right)}$$

where:

$\beta_{ip1}$  = the regression coefficient for the  $i$ th item representing the intercept for population/time-period 1 (FY 2001),

$\beta_{ip0}$  = the regression coefficient for the  $i$ th item representing the intercept for population/time-period 1 (FY 2000),

$v_{ip0}$  = the squared standard error associated with the above-mentioned regression coefficient (similarly for period 0),

and the weights are the same as shown in the weighting formula above.

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<sup>84</sup> The exposition is in terms of the linear regression model. For logistic regression, we would calculate a z-statistic.

## APPENDIX B: REGIONAL CAHPS DATA

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Table B-1 shows regional FY 2000—FY 2001 comparisons between the DoD beneficiary population and the general population insured under commercial health plans. Commercial health plans exclude those covered under Medicare and Medicaid. The data are broken down for the DoD population by source of health care and active duty status. The commercial civilian population data comes from the NCBD. The plans represented in the NCBD were matched to the DoD health plan taxonomy as shown in the table below.

DoD group	NCBD plan(s)
Active duty	HMO
Prime–military PCM	HMO
Prime–civilian PCM	HMO+HMO/POS
Civilian-only care	POS/FFS
Other	POS+PPO

Estimates are case-mix adjusted, based on FY 2001 DoD population characteristics. An entry of “na” indicates that there were too few observations to make a reliable estimate. Entries marked with an plus (+) indicate a statistically significant change ( $p < 0.05$ ), favoring DoD, i.e., DoD either showed improved performance over the time period, and/or surpassed the performance of those in the general population. Entries marked with an minus (–) indicate a statistically significant change ( $p < 0.05$ ), where DoD either showed decrement in performance over the time period, and/or its performance was surpassed by those in the general population. The metrics for CAHPS ratings estimates are shown as the probability of a rating being greater or equal to 8 ( $p(8+)$ ).

**Regional Mapping.** NCBD surveys contain city and state information for all respondents. To make regional comparisons to the DoD Beneficiary Survey, we needed to translate this geographic information to TRICARE regions. If a state is associated with exactly one TRICARE region, the region is determined by state alone. If the state is associated with multiple TRICARE regions, we use the city and state information to determine a zip code from 2000 U.S. census data. From the zip code, we were able to match each city and state to a catchment area ID. The catchment area ID allowed us to map the city and state to a TRICARE region.

**Table B-1. Smoking Counseling**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.58	0.66	0.62	0.69	same	+
	2	0.52	0.63	0.60	0.60	-	same
	3	0.56	0.63	0.60	0.59	same	same
	4	0.55	0.63	0.63	0.64	+	same
	5	0.52	0.65	0.63	0.66	-	same
	6	0.56	0.58	0.60	0.58	same	same
	7/8	0.57	0.63	0.61	0.63	same	same
	9	0.56	0.56	0.54	0.53	same	same
	10	0.60	0.60	0.60	0.63	same	same
	11	0.60	0.67	0.63	0.64	same	same
	12	0.62	0.63	0.49	0.69	-	+
	Active duty	1	0.57	0.53	0.66	0.56	same
2		0.51	0.50	0.59	0.47	same	+
3		0.50	0.43	0.56	0.38	same	+
4		0.58	0.46	0.57	0.48	same	same
5		0.40	0.64	0.48	0.67	same	+
6		0.56	0.41	0.58	0.42	same	+
7/8		0.62	0.54	0.60	0.53	same	same
9		0.51	0.48	0.50	0.41	same	same
10		0.62	0.53	0.56	0.49	same	same
11		0.46	0.56	0.67	0.55	+	same
12		0.55	0.67	0.42	0.72	same	+
Prime-military PCM		1	0.61	0.63	0.66	0.66	same
	2	0.52	0.61	0.60	0.58	-	same
	3	0.56	0.58	0.61	0.53	same	+
	4	0.61	0.59	0.62	0.60	same	same
	5	0.49	0.59	0.55	0.62	same	same
	6	0.57	0.51	0.59	0.52	same	+
	7/8	0.65	0.64	0.61	0.63	same	same
	9	0.59	0.55	0.52	0.48	same	same
	10	0.62	0.61	0.57	0.61	same	same
	11	0.56	0.66	0.65	0.64	same	same
	12	0.61	0.61	0.48	0.66	same	+
	Prime-civilian PCM	1	0.64	0.68	0.77	0.72	same
2		0.59	0.66	0.55	0.62	same	same
3		0.55	0.65	0.67	0.60	same	same
4		0.55	0.63	0.69	0.65	+	same
5		0.52	0.65	0.72	0.68	+	same
6		0.59	0.60	0.62	0.61	same	same
7/8		0.53	0.67	0.69	0.65	+	same
9		0.58	0.65	0.57	0.56	same	same
10		0.61	0.59	0.69	0.60	same	same
11		0.68	0.70	0.66	0.66	same	same
12		na	na	na	na		

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**Table B-1—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.62	0.69	0.61	0.79	same	+
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.63	0.62	0.70	0.64	same	same
	6	na	na	na	na		
	7/8	0.60	0.53	0.65	0.58	same	same
	9	na	na	na	na		
	10	na	na	na	na		
	11	na	na	na	na		
	12	na	na	na	na		
	Other	1	0.71	0.79	0.67	0.78	same
2		0.61	0.64	0.47	0.68	same	same
3		na	na	na	na		
4		na	na	na	na		
5		na	na	na	na		
6		0.69	0.86	0.63	0.65	same	same
7/8		0.62	0.64	0.69	0.62	same	same
9		na	na	na	na		
10		na	na	na	na		
11		na	na	na	na		
12		na	na	na	na		

**Table B-2. Getting Needed Care**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.79	0.85	0.79	0.86	same	+
	2	0.73	0.79	0.75	0.80	same	+
	3	0.78	0.78	0.77	0.79	same	+
	4	0.78	0.80	0.79	0.84	same	+
	5	0.78	0.84	0.79	0.84	same	+
	6	0.76	0.74	0.76	0.76	same	same
	7/8	0.77	0.78	0.77	0.77	same	same
	9	0.74	0.72	0.74	0.72	same	+
	10	0.78	0.76	0.78	0.76	same	same
	11	0.78	0.79	0.80	0.79	+	same
	12	0.77	0.84	0.76	0.85	same	+
	Active duty	1	0.63	0.79	0.66	0.80	-
2		0.61	0.74	0.63	0.78	same	+
3		0.63	0.68	0.66	0.68	same	same
4		0.69	0.74	0.68	0.78	same	+
5		0.65	0.76	0.62	0.77	same	+
6		0.65	0.68	0.68	0.68	-	same
7/8		0.67	0.73	0.67	0.71	same	+
9		0.64	0.71	0.66	0.68	same	same
10		0.75	0.68	0.71	0.70	same	same
11		0.66	0.76	0.70	0.75	same	+
12		0.70	0.81	0.70	0.80	same	+
Prime-military PCM		1	0.66	0.79	0.68	0.80	same
	2	0.65	0.72	0.65	0.75	same	+
	3	0.69	0.70	0.69	0.70	same	same
	4	0.72	0.75	0.71	0.78	same	+
	5	0.69	0.75	0.66	0.76	same	+
	6	0.69	0.70	0.70	0.69	+	same
	7/8	0.70	0.73	0.70	0.72	same	+
	9	0.71	0.69	0.69	0.66	same	same
	10	0.76	0.67	0.72	0.68	same	+
	11	0.73	0.75	0.75	0.73	same	+
	12	0.74	0.82	0.71	0.80	same	+
	Prime-civilian PCM	1	0.75	0.84	0.72	0.84	same
2		0.65	0.76	0.57	0.79	-	+
3		0.64	0.74	0.63	0.75	same	+
4		0.61	0.75	0.62	0.78	same	+
5		0.62	0.77	0.65	0.78	same	+
6		0.64	0.72	0.65	0.73	same	+
7/8		0.67	0.76	0.67	0.75	same	+
9		0.58	0.71	0.65	0.68	-	Same
10		0.63	0.70	0.63	0.69	same	+
11		0.70	0.79	0.72	0.78	same	+
12		0.65	0.87	0.67	0.85	same	+

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**Table B-2—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.89	0.86	0.89	0.88	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.87	0.96	0.88	0.88	same	same
	6	na	na	na	na		
	7/8	0.85	0.72	0.84	0.78	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.86	0.79	0.86	0.82	same	+
	12	na	na	na	na		
	Other	1	0.79	0.84	0.73	0.90	–
2		0.74	0.95	0.72	0.89	same	+
3		na	na	na	na		
4		0.78	0.77	0.76	0.85	same	+
5		0.78	0.85	0.81	0.88	same	+
6		0.75	0.75	0.80	0.90	same	+
7/8		0.74	0.80	0.78	0.82	same	same
9		0.68	0.71	0.70	0.83	same	+
10		0.72	0.75	0.79	0.88	same	+
11		0.75	0.77	0.75	0.86	same	+
12		na	na	na	na		

**Table B-3. Getting Care Promptly**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.63	0.82	0.77	0.81	-	-
	2	0.58	0.78	0.70	0.77	-	-
	3	0.60	0.73	0.73	0.74	-	same
	4	0.60	0.77	0.76	0.77	-	same
	5	0.62	0.82	0.76	0.82	-	-
	6	0.61	0.77	0.75	0.75	-	same
	7/8	0.63	0.78	0.77	0.75	-	-
	9	0.59	0.69	0.72	0.71	+	same
	10	0.64	0.77	0.78	0.76	+	-
	11	0.64	0.81	0.79	0.82	-	-
	12	0.59	0.79	0.73	0.81	-	-
	Active duty	1	0.57	0.79	0.65	0.78	-
2		0.55	0.70	0.61	0.70	-	-
3		0.56	0.65	0.61	0.64	-	same
4		0.57	0.70	0.66	0.71	-	-
5		0.56	0.77	0.62	0.77	-	+
6		0.56	0.71	0.64	0.69	-	-
7/8		0.58	0.74	0.68	0.71	-	-
9		0.53	0.67	0.63	0.68	-	same
10		0.59	0.72	0.68	0.69	-	same
11		0.59	0.75	0.67	0.75	-	-
12		0.57	0.73	0.68	0.73	-	same
Prime-military PCM		1	0.59	0.79	0.67	0.77	-
	2	0.55	0.74	0.61	0.74	-	-
	3	0.57	0.68	0.65	0.67	-	same
	4	0.60	0.72	0.71	0.73	-	-
	5	0.56	0.76	0.65	0.76	-	-
	6	0.59	0.73	0.68	0.70	-	-
	7/8	0.61	0.75	0.71	0.72	-	same
	9	0.55	0.65	0.65	0.66	+	same
	10	0.62	0.73	0.71	0.71	-	same
	11	0.61	0.76	0.71	0.76	-	-
	12	0.58	0.77	0.70	0.76	-	-
	Prime-civilian PCM	1	0.66	0.81	0.79	0.80	-
2		0.57	0.77	0.73	0.78	-	-
3		0.57	0.73	0.72	0.71	-	same
4		0.55	0.76	0.71	0.76	-	-
5		0.58	0.79	0.74	0.79	-	-
6		0.59	0.76	0.72	0.74	-	same
7/8		0.61	0.78	0.78	0.74	-	-
9		0.55	0.68	0.72	0.68	+	same
10		0.60	0.76	0.78	0.74	+	same
11		0.65	0.81	0.81	0.82	-	same
12		0.57	0.81	0.77	0.80	-	same

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**Table B-3—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.65	0.84	0.84	0.81	+	-
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.63	0.91	0.82	0.83	-	same
	6	na	na	na	na		
	7/8	0.64	0.77	0.82	0.75	+	-
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.67	0.78	0.84	0.81	+	same
	12	na	na	na	na		
	Other	1	0.66	0.81	0.73	0.84	-
2		0.60	0.89	0.70	0.80	-	-
3		na	na	na	na		
4		0.60	0.76	0.71	0.79	-	-
5		0.63	0.81	0.80	0.84	-	same
6		0.58	0.81	0.76	0.81	-	-
7/8		0.58	0.83	0.75	0.80	-	-
9		0.58	0.69	0.73	0.80	+	-
10		0.64	0.75	0.79	0.86	+	same
11		0.57	0.85	0.74	0.84	-	-
12		na	na	na	na		

**Table B-4. Staff Courtesy**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.92	0.94	0.93	0.94	-	+
	2	0.88	0.92	0.88	0.91	same	+
	3	0.91	0.91	0.91	0.91	same	same
	4	0.93	0.95	0.94	0.95	-	+
	5	0.91	0.95	0.91	0.94	same	+
	6	0.91	0.94	0.91	0.92	same	+
	7/8	0.92	0.93	0.92	0.91	same	+
	9	0.88	0.90	0.89	0.89	same	same
	10	0.94	0.92	0.93	0.92	same	same
	11	0.91	0.94	0.93	0.94	-	-
	12	0.87	0.91	0.88	0.93	same	+
	Active duty	1	0.86	0.91	0.87	0.91	same
2		0.80	0.87	0.82	0.87	same	+
3		0.80	0.83	0.82	0.83	same	same
4		0.86	0.89	0.89	0.90	+	same
5		0.82	0.87	0.82	0.87	same	+
6		0.80	0.88	0.84	0.86	-	-
7/8		0.85	0.87	0.87	0.86	-	same
9		0.81	0.86	0.82	0.86	same	same
10		0.88	0.85	0.86	0.85	same	same
11		0.79	0.89	0.84	0.88	-	same
12		0.82	0.90	0.84	0.91	same	+
Prime-military PCM		1	0.86	0.91	0.88	0.90	same
	2	0.82	0.88	0.82	0.87	same	+
	3	0.83	0.85	0.85	0.85	same	same
	4	0.88	0.90	0.90	0.91	+	same
	5	0.81	0.88	0.84	0.87	-	+
	6	0.85	0.89	0.87	0.87	-	same
	7/8	0.86	0.89	0.88	0.88	-	same
	9	0.81	0.85	0.83	0.85	same	same
	10	0.89	0.87	0.89	0.87	same	+
	11	0.86	0.90	0.87	0.89	same	+
	12	0.82	0.89	0.85	0.91	same	+
	Prime-civilian PCM	1	0.92	0.93	0.91	0.93	same
2		0.89	0.91	0.88	0.91	same	same
3		0.88	0.90	0.91	0.90	+	same
4		0.90	0.93	0.92	0.93	same	same
5		0.90	0.92	0.90	0.92	same	same
6		0.90	0.93	0.88	0.92	same	+
7/8		0.92	0.92	0.92	0.91	same	same
9		0.90	0.89	0.91	0.88	same	+
10		0.91	0.92	0.93	0.92	same	same
11		0.93	0.94	0.95	0.94	same	same
12		0.86	0.94	0.86	0.94	same	same

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**Table B-4—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.96	0.95	0.97	0.94	same	+
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.96	0.98	0.95	0.96	same	same
	6	na	na	na	na		
	7/8	0.96	0.91	0.95	0.93	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.96	0.96	0.97	0.96	same	same
	12	na	na	na	na		
	Other	1	0.94	0.94	0.93	0.95	same
2		0.94	0.97	0.88	0.93	–	+
3		na	na	na	na		
4		0.91	0.97	0.94	0.96	same	same
5		0.95	0.94	0.91	0.96	same	same
6		0.92	0.95	0.94	0.95	same	same
7/8		0.91	0.98	0.92	0.95	same	same
9		0.88	0.94	0.90	0.87	same	same
10		0.94	0.92	0.95	0.97	same	same
11		0.90	0.95	0.92	0.94	same	same
12		na	na	na	na		

**Table B-5. Doctor Communication**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.90	0.93	0.91	0.93	-	+
	2	0.84	0.90	0.87	0.89	-	-
	3	0.87	0.89	0.88	0.88	-	same
	4	0.89	0.93	0.90	0.93	-	-
	5	0.88	0.92	0.88	0.93	same	+
	6	0.88	0.91	0.89	0.91	-	-
	7/8	0.88	0.91	0.89	0.90	-	same
	9	0.85	0.86	0.87	0.86	+	-
	10	0.90	0.89	0.91	0.89	same	+
	11	0.88	0.91	0.90	0.91	-	same
	12	0.87	0.89	0.87	0.92	same	+
	Active duty	1	0.84	0.90	0.85	0.90	same
2		0.77	0.87	0.82	0.87	-	-
3		0.79	0.81	0.83	0.81	+	same
4		0.82	0.88	0.84	0.89	-	+
5		0.80	0.87	0.80	0.88	same	+
6		0.78	0.87	0.84	0.86	-	-
7/8		0.82	0.86	0.85	0.85	-	same
9		0.78	0.83	0.83	0.83	-	same
10		0.87	0.84	0.85	0.82	same	same
11		0.78	0.86	0.84	0.86	-	same
12		0.82	0.88	0.81	0.91	same	+
Prime-military PCM		1	0.85	0.90	0.86	0.90	same
	2	0.78	0.87	0.82	0.86	-	-
	3	0.82	0.84	0.84	0.83	+	same
	4	0.84	0.89	0.87	0.89	-	-
	5	0.79	0.86	0.82	0.87	-	+
	6	0.83	0.87	0.86	0.86	-	same
	7/8	0.83	0.87	0.86	0.86	-	same
	9	0.82	0.82	0.84	0.82	same	same
	10	0.87	0.86	0.88	0.84	same	+
	11	0.84	0.87	0.87	0.87	-	same
	12	0.84	0.88	0.84	0.91	same	+
	Prime-civilian PCM	1	0.88	0.92	0.89	0.92	same
2		0.85	0.90	0.86	0.90	same	+
3		0.85	0.88	0.85	0.88	same	+
4		0.85	0.90	0.91	0.90	+	same
5		0.85	0.89	0.89	0.90	-	same
6		0.85	0.90	0.88	0.90	-	-
7/8		0.88	0.90	0.89	0.89	same	same
9		0.83	0.85	0.90	0.84	+	-
10		0.89	0.90	0.91	0.89	same	same
11		0.89	0.91	0.93	0.91	+	-
12		0.87	0.92	0.85	0.94	same	+

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**Table B-5—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.93	0.94	0.94	0.94	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.93	0.98	0.93	0.97	same	+
	6	na	na	na	na		
	7/8	0.92	0.90	0.92	0.93	same	same
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.93	0.86	0.94	0.94	same	same
	12	na	na	na	na		
	Other	1	0.91	0.93	0.94	0.94	+
2		0.88	0.95	0.87	0.89	same	same
3		na	na	na	na		
4		0.90	0.97	0.87	0.94	same	+
5		0.89	0.94	0.93	0.94	–	same
6		0.89	0.93	0.93	0.94	–	same
7/8		0.87	0.95	0.89	0.92	same	same
9		0.85	0.89	0.92	0.89	+	same
10		0.87	0.88	0.86	0.93	same	+
11		0.86	0.92	0.85	0.94	same	+
12		na	na	na	na		

**Table B-6. Customer Service**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.46	0.61	0.49	0.63	-	+
	2	0.47	0.59	0.53	0.63	-	-
	3	0.52	0.58	0.56	0.60	-	-
	4	0.49	0.57	0.56	0.63	-	-
	5	0.47	0.61	0.48	0.63	same	+
	6	0.52	0.63	0.56	0.58	-	same
	7/8	0.51	0.56	0.54	0.57	-	+
	9	0.57	0.56	0.61	0.59	+	same
	10	0.57	0.62	0.62	0.62	+	same
	11	0.54	0.60	0.60	0.59	-	same
	12	0.56	0.66	0.57	0.67	same	+
	Active duty	1	0.31	0.54	0.38	0.58	-
2		0.39	0.52	0.46	0.59	-	+
3		0.42	0.48	0.47	0.51	same	same
4		0.38	0.54	0.46	0.58	-	+
5		0.37	0.55	0.37	0.58	same	+
6		0.40	0.56	0.46	0.51	-	-
7/8		0.38	0.49	0.45	0.51	-	-
9		0.43	0.54	0.52	0.56	-	same
10		0.49	0.44	0.56	0.48	same	same
11		0.44	0.52	0.48	0.53	same	same
12		0.50	0.65	0.52	0.66	same	+
Prime-military PCM		1	0.36	0.55	0.39	0.59	-
	2	0.47	0.54	0.48	0.60	same	+
	3	0.49	0.52	0.51	0.55	same	+
	4	0.47	0.54	0.53	0.58	-	-
	5	0.42	0.53	0.42	0.57	same	+
	6	0.49	0.56	0.53	0.51	-	same
	7/8	0.47	0.49	0.51	0.51	+	same
	9	0.52	0.52	0.56	0.53	same	same
	10	0.52	0.48	0.58	0.52	same	+
	11	0.56	0.53	0.56	0.53	same	same
	12	0.54	0.64	0.56	0.66	same	+
	Prime-civilian PCM	1	0.42	0.60	0.50	0.63	-
2		0.39	0.58	0.42	0.64	same	+
3		0.46	0.57	0.51	0.60	same	+
4		0.40	0.56	0.47	0.61	-	+
5		0.35	0.57	0.39	0.60	same	+
6		0.45	0.60	0.54	0.55	-	same
7/8		0.44	0.54	0.52	0.56	-	same
9		0.46	0.54	0.58	0.56	+	same
10		0.51	0.58	0.52	0.58	same	+
11		0.41	0.60	0.58	0.60	-	same
12		0.40	0.67	0.54	0.69	-	+

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**Table B-6—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.54	0.66	0.56	0.64	same	+
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.52	0.78	0.52	0.72	same	+
	6	na	na	na	na		
	7/8	0.55	0.54	0.56	0.61	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.58	0.66	0.62	0.59	same	same
	12	na	na	na	na		
	Other	1	0.48	0.64	0.53	0.61	same
2		0.48	0.71	0.58	0.64	–	same
3		na	na	na	na		
4		0.49	0.51	0.67	0.62	+	same
5		0.51	0.64	0.61	0.62	same	same
6		0.53	0.64	0.57	0.65	same	same
7/8		0.48	0.59	0.58	0.53	–	same
9		0.48	0.49	0.60	0.51	same	same
10		na	na	na	na		
11		na	na	na	na		
12		na	na	na	na		

**Table B-7. Claims Processing**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.81	0.88	0.82	0.89	same	+
	2	0.81	0.85	0.83	0.89	-	+
	3	0.85	0.84	0.85	0.85	same	same
	4	0.84	0.83	0.86	0.88	+	same
	5	0.81	0.88	0.81	0.90	same	+
	6	0.86	0.85	0.87	0.85	+	+
	7/8	0.82	0.87	0.83	0.87	same	+
	9	0.83	0.81	0.83	0.82	same	same
	10	0.86	0.90	0.89	0.90	same	same
	11	0.87	0.87	0.87	0.89	same	+
	12	0.81	0.89	0.83	0.92	same	+
	Active duty	1	0.54	0.76	0.62	0.79	-
2		0.62	0.72	0.65	0.80	same	+
3		0.67	0.73	0.69	0.71	same	same
4		0.59	0.81	0.76	0.84	-	same
5		0.55	0.83	0.61	0.85	same	+
6		0.65	0.76	0.72	0.75	same	same
7/8		0.57	0.75	0.70	0.75	-	same
9		0.67	0.76	0.62	0.72	same	same
10		0.68	0.75	0.73	0.76	same	same
11		0.67	0.78	0.77	0.80	same	same
12		0.67	0.78	0.67	0.82	same	+
Prime-military PCM		1	0.60	0.78	0.63	0.80	same
	2	0.64	0.73	0.71	0.80	-	+
	3	0.74	0.75	0.75	0.73	same	same
	4	0.72	0.77	0.79	0.79	+	same
	5	0.59	0.78	0.65	0.80	same	+
	6	0.75	0.77	0.80	0.76	+	+
	7/8	0.70	0.79	0.75	0.78	-	-
	9	0.71	0.76	0.69	0.71	same	same
	10	0.76	0.76	0.78	0.78	same	same
	11	0.79	0.81	0.79	0.84	same	+
	12	0.69	0.85	0.73	0.86	same	+
	Prime-civilian PCM	1	0.67	0.84	0.66	0.85	same
2		0.74	0.79	0.70	0.86	same	+
3		0.79	0.80	0.82	0.77	same	+
4		0.76	0.80	0.75	0.83	same	+
5		0.69	0.82	0.68	0.84	same	+
6		0.78	0.81	0.86	0.80	+	-
7/8		0.74	0.85	0.79	0.84	-	-
9		0.76	0.77	0.80	0.77	same	same
10		0.80	0.85	0.80	0.85	same	same
11		0.75	0.85	0.84	0.89	-	same
12		0.79	0.92	0.84	0.92	same	same

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**Table B-7—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.88	0.88	0.89	0.86	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.88	1.00	0.88	0.97	same	+
	6	na	na	na	na		
	7/8	0.88	0.79	0.86	0.90	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.92	0.91	0.90	0.82	same	+
	12	na	na	na	na		
	Other	1	0.87	0.91	0.83	0.92	same
2		0.85	0.95	0.81	0.89	same	+
3		na	na	na	na		
4		0.85	0.73	0.80	0.87	same	same
5		0.89	0.94	0.76	0.96	–	+
6		0.86	0.86	0.84	0.93	same	+
7/8		0.87	0.95	0.89	0.92	same	same
9		0.80	0.79	0.88	0.83	same	same
10		na	na	na	na		
11		na	na	na	na		
12		na	na	na	na		

**Table B-8. Doctor Visits**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.85	0.88	0.87	0.87	+	same
	2	0.83	0.87	0.85	0.87	same	-
	3	0.85	0.88	0.87	0.88	+	same
	4	0.86	0.89	0.89	0.88	+	same
	5	0.83	0.87	0.86	0.88	+	-
	6	0.85	0.89	0.87	0.86	same	same
	7/8	0.84	0.88	0.87	0.88	+	same
	9	0.82	0.94	0.83	0.88	same	-
	10	0.83	0.94	0.87	0.88	+	same
	11	0.86	0.88	0.85	0.86	same	same
	12	0.85	0.87	0.83	0.87	same	-
	Active duty	1	0.78	0.79	0.79	0.79	same
2		0.80	0.81	0.76	0.81	same	same
3		0.80	0.78	0.77	0.78	same	same
4		0.81	0.81	0.83	0.81	same	same
5		0.76	0.80	0.79	0.81	same	same
6		0.82	0.84	0.78	0.80	same	same
7/8		0.81	0.83	0.80	0.82	same	same
9		0.80	0.85	0.74	0.78	-	same
10		0.79	0.85	0.80	0.77	same	same
11		0.82	0.79	0.80	0.78	same	same
12		0.85	0.81	0.77	0.79	-	same
Prime-military PCM		1	0.87	0.84	0.84	0.84	-
	2	0.85	0.84	0.82	0.84	-	same
	3	0.86	0.85	0.83	0.85	-	-
	4	0.87	0.86	0.86	0.86	same	same
	5	0.84	0.84	0.84	0.85	same	same
	6	0.85	0.87	0.84	0.83	same	same
	7/8	0.87	0.86	0.84	0.86	-	same
	9	0.86	0.92	0.80	0.84	-	-
	10	0.82	0.92	0.85	0.85	same	same
	11	0.87	0.86	0.84	0.84	-	same
	12	0.86	0.85	0.83	0.84	same	same
	Prime-civilian PCM	1	0.84	0.90	0.90	0.89	+
2		0.81	0.89	0.90	0.89	+	same
3		0.85	0.88	0.90	0.89	+	same
4		0.86	0.91	0.93	0.90	+	same
5		0.77	0.88	0.90	0.89	+	same
6		0.88	0.91	0.90	0.88	same	+
7/8		0.84	0.90	0.89	0.90	+	same
9		0.86	0.97	0.87	0.91	same	same
10		0.88	0.96	0.89	0.90	same	same
11		0.87	0.90	0.88	0.88	same	same
12		0.89	0.90	0.90	0.88	same	same

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**Table B-8—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.98	0.86	0.95	0.87	–	+
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.98	0.90	0.95	0.88	–	+
	6	na	na	na	na		
	7/8	0.98	0.82	0.96	0.88	–	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.99	0.78	0.95	0.90	–	+
	12	na	na	na	na		
	Other	1	0.93	0.88	0.89	0.88	same
2		0.88	0.92	0.89	0.85	same	same
3		na	na	na	na		
4		0.88	0.92	0.90	0.88	same	same
5		0.94	0.90	0.86	0.89	same	same
6		0.91	0.85	0.89	0.87	same	same
7/8		0.89	0.94	0.88	0.87	same	same
9		0.92	1.00	0.89	0.86	same	same
10		0.91	1.00	0.94	0.86	same	+
11		0.81	0.86	0.83	0.87	same	same
12		na	na	na	na		

**Table B-9. Emergency Room Visits**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.24	0.20	0.24	0.20	same	–
	2	0.25	0.21	0.28	0.22	–	–
	3	0.24	0.19	0.27	0.22	–	–
	4	0.24	0.21	0.25	0.21	same	–
	5	0.28	0.20	0.30	0.21	same	–
	6	0.26	0.22	0.28	0.21	same	–
	7/8	0.26	0.19	0.26	0.20	same	–
	9	0.26	0.21	0.25	0.20	same	–
	10	0.22	0.20	0.27	0.21	–	–
	11	0.26	0.21	0.30	0.19	–	–
	12	0.26	0.19	0.29	0.19	same	–
	Active duty	1	0.26	0.19	0.24	0.18	same
2		0.24	0.21	0.29	0.23	–	–
3		0.25	0.20	0.27	0.23	same	same
4		0.22	0.19	0.23	0.19	same	same
5		0.29	0.20	0.37	0.21	–	–
6		0.26	0.17	0.28	0.16	same	–
7/8		0.26	0.19	0.27	0.18	same	–
9		0.26	0.15	0.21	0.12	same	same
10		0.19	0.22	0.26	0.18	same	same
11		0.25	0.13	0.36	0.12	–	–
12		0.27	0.16	0.33	0.14	same	–
Prime–military PCM		1	0.26	0.20	0.26	0.19	same
	2	0.29	0.20	0.32	0.22	same	–
	3	0.28	0.19	0.29	0.22	same	–
	4	0.25	0.20	0.26	0.19	same	–
	5	0.33	0.22	0.37	0.23	same	–
	6	0.30	0.21	0.30	0.20	same	–
	7/8	0.29	0.20	0.29	0.20	same	–
	9	0.29	0.21	0.24	0.18	+	–
	10	0.23	0.23	0.29	0.20	same	–
	11	0.33	0.21	0.37	0.19	same	–
	12	0.28	0.17	0.32	0.15	same	–
	Prime–civilian PCM	1	0.21	0.18	0.23	0.18	same
2		0.23	0.20	0.26	0.21	same	same
3		0.24	0.19	0.22	0.22	same	same
4		0.27	0.20	0.23	0.20	same	same
5		0.32	0.20	0.25	0.20	same	–
6		0.24	0.22	0.23	0.21	same	same
7/8		0.23	0.19	0.28	0.18	same	–
9		0.24	0.19	0.23	0.18	same	same
10		0.20	0.18	0.19	0.18	same	same
11		0.19	0.18	0.20	0.17	same	same
12		0.20	0.16	0.12	0.15	same	same

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**Table B-9—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.21	0.22	0.21	0.17	same	–
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.24	0.22	0.27	0.21	same	–
	6	na	na	na	na		
	7/8	0.23	0.22	0.24	0.23	same	same
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.21	0.25	0.27	0.19	–	–
	12	na	na	na	na		
	Other	1	0.30	0.18	0.36	0.21	same
2		0.37	0.19	0.35	0.25	same	–
3		na	na	na	na		
4		0.35	0.26	0.31	0.24	same	same
5		0.33	0.18	0.44	0.22	same	–
6		0.32	0.18	0.28	0.18	same	–
7/8		0.29	0.20	0.33	0.23	same	–
9		0.30	0.21	0.24	0.28	same	same
10		0.24	0.17	0.27	0.26	same	same
11		0.40	0.19	0.50	0.18	same	–
12		na	na	na	na		

**Table B-10. Non-Smoking**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.84	0.83	0.84	0.83	same	same
	2	0.79	0.80	0.81	0.80	same	same
	3	0.81	0.83	0.80	0.85	same	+
	4	0.80	0.81	0.79	0.83	same	+
	5	0.77	0.80	0.77	0.81	same	+
	6	0.80	0.84	0.79	0.85	same	+
	7/8	0.81	0.83	0.82	0.85	same	+
	9	0.83	0.87	0.83	0.86	same	+
	10	0.84	0.88	0.80	0.89	-	+
	11	0.83	0.85	0.81	0.84	same	+
	12	0.83	0.81	0.81	0.84	same	same
	Active duty	1	0.83	0.79	0.85	0.79	same
2		0.76	0.81	0.79	0.82	same	same
3		0.77	0.77	0.79	0.79	same	same
4		0.80	0.74	0.81	0.76	same	+
5		0.73	0.75	0.73	0.75	same	same
6		0.78	0.80	0.77	0.80	same	same
7/8		0.80	0.83	0.80	0.85	same	same
9		0.77	0.79	0.79	0.80	same	same
10		0.79	0.83	0.79	0.83	same	same
11		0.82	0.76	0.77	0.75	same	same
12		0.80	0.73	0.73	0.75	same	same
Prime-military PCM		1	0.85	0.80	0.85	0.80	same
	2	0.78	0.77	0.79	0.77	same	same
	3	0.78	0.81	0.79	0.83	same	+
	4	0.80	0.79	0.81	0.82	same	same
	5	0.77	0.75	0.75	0.76	same	same
	6	0.80	0.82	0.79	0.82	same	+
	7/8	0.81	0.81	0.80	0.82	same	+
	9	0.81	0.82	0.81	0.82	same	same
	10	0.79	0.85	0.79	0.85	same	+
	11	0.81	0.82	0.80	0.80	same	same
	12	0.83	0.80	0.77	0.81	-	same
	Prime-civilian PCM	1	0.81	0.81	0.80	0.81	same
2		0.77	0.80	0.79	0.80	same	same
3		0.76	0.81	0.78	0.83	same	+
4		0.73	0.78	0.74	0.81	same	+
5		0.64	0.78	0.76	0.78	-	same
6		0.77	0.82	0.81	0.82	same	same
7/8		0.78	0.81	0.84	0.83	+	same
9		0.84	0.86	0.83	0.86	same	same
10		0.81	0.83	0.76	0.84	same	+
11		0.78	0.83	0.81	0.81	same	same
12		0.76	0.83	0.77	0.84	same	same

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**Table B-10—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.86	0.84	0.85	0.87	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.81	0.83	0.79	0.79	same	same
	6	na	na	na	na		
	7/8	0.83	0.83	0.85	0.90	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	na	na	na	na		
	12	na	na	na	na		
	Other	1	0.86	0.89	0.87	0.90	same
2		0.79	0.81	0.85	0.84	same	same
3		na	na	na	na		
4		0.75	0.76	0.75	0.76	same	same
5		0.79	0.84	0.88	0.84	+	same
6		0.82	0.84	0.76	0.88	same	+
7/8		0.77	0.85	0.78	0.87	same	+
9		0.83	0.90	0.84	0.86	same	same
10		0.80	1.02	0.83	0.91	same	same
11		0.75	0.91	0.84	0.91	same	same
12		na	na	na	na		

**Table B-11. Doctor Rating**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.75	0.80	0.76	0.81	same	+
	2	0.72	0.78	0.70	0.79	same	+
	3	0.74	0.76	0.72	0.77	same	+
	4	0.76	0.82	0.76	0.83	same	+
	5	0.74	0.79	0.71	0.80	same	+
	6	0.76	0.79	0.71	0.80	-	+
	7/8	0.74	0.74	0.72	0.75	same	+
	9	0.73	0.76	0.70	0.75	same	+
	10	0.72	0.78	0.72	0.76	same	+
	11	0.72	0.75	0.73	0.77	same	+
	12	0.72	0.79	0.69	0.81	same	+
	Active duty	1	0.65	0.67	0.61	0.68	same
2		0.56	0.60	0.56	0.61	same	same
3		0.60	0.59	0.56	0.59	same	same
4		0.61	0.70	0.57	0.70	same	+
5		0.59	0.69	0.59	0.71	same	+
6		0.56	0.71	0.54	0.70	same	+
7/8		0.61	0.65	0.56	0.66	same	+
9		0.61	0.64	0.59	0.61	same	same
10		0.55	0.67	0.56	0.65	same	same
11		0.64	0.75	0.65	0.76	same	+
12		0.63	0.68	0.57	0.70	same	+
Prime-military PCM		1	0.70	0.72	0.66	0.73	same
	2	0.69	0.68	0.61	0.69	-	+
	3	0.67	0.66	0.62	0.66	-	same
	4	0.69	0.76	0.65	0.76	same	+
	5	0.68	0.71	0.62	0.72	same	+
	6	0.69	0.73	0.64	0.72	-	+
	7/8	0.68	0.67	0.63	0.69	-	+
	9	0.67	0.68	0.63	0.66	same	same
	10	0.63	0.68	0.62	0.65	same	same
	11	0.69	0.73	0.70	0.73	same	same
	12	0.64	0.71	0.63	0.74	same	+
	Prime-civilian PCM	1	0.68	0.76	0.63	0.76	same
2		0.70	0.75	0.57	0.77	-	+
3		0.67	0.74	0.57	0.73	-	+
4		0.66	0.77	0.65	0.78	same	+
5		0.60	0.73	0.53	0.74	same	+
6		0.69	0.76	0.60	0.76	-	+
7/8		0.67	0.71	0.69	0.73	same	same
9		0.64	0.73	0.67	0.71	same	same
10		0.67	0.75	0.74	0.72	same	same
11		0.65	0.75	0.63	0.76	same	+
12		0.69	0.80	0.63	0.80	same	+

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**Table B-11—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.79	0.82	0.83	0.85	+	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.79	0.85	0.77	0.83	same	+
	6	na	na	na	na		
	7/8	0.78	0.74	0.78	0.76	same	same
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.75	0.73	0.75	0.76	same	same
	12	na	na	na	na		
	Other	1	0.82	0.80	0.75	0.86	same
2		0.71	0.84	0.84	0.82	-	same
3		na	na	na	na		
4		0.81	0.72	0.67	0.80	same	same
5		0.76	0.84	0.74	0.83	same	same
6		0.82	0.80	0.88	0.87	same	same
7/8		0.73	0.80	0.73	0.79	same	same
9		0.68	0.75	0.57	0.79	same	+
10		0.75	0.66	0.77	0.81	same	same
11		0.75	0.70	0.63	0.81	same	+
12		na	na	na	na		

**Table B-12. Health Care Rating**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.68	0.80	0.70	0.80	-	+
	2	0.59	0.73	0.61	0.72	-	+
	3	0.66	0.72	0.66	0.72	same	+
	4	0.70	0.80	0.71	0.81	same	+
	5	0.66	0.79	0.67	0.79	same	+
	6	0.68	0.75	0.69	0.75	same	+
	7/8	0.67	0.73	0.68	0.71	same	+
	9	0.62	0.68	0.63	0.67	same	+
	10	0.72	0.73	0.68	0.75	-	+
	11	0.67	0.71	0.70	0.75	-	+
	12	0.60	0.72	0.57	0.74	same	+
	Active duty	1	0.46	0.66	0.51	0.66	same
2		0.40	0.57	0.46	0.59	-	+
3		0.43	0.57	0.43	0.58	same	+
4		0.48	0.65	0.51	0.67	same	+
5		0.40	0.65	0.45	0.67	same	+
6		0.47	0.64	0.50	0.63	same	+
7/8		0.45	0.60	0.50	0.59	-	+
9		0.43	0.58	0.47	0.56	same	same
10		0.52	0.57	0.43	0.61	same	+
11		0.42	0.58	0.51	0.61	-	+
12		0.41	0.68	0.45	0.70	same	+
Prime-military PCM		1	0.52	0.68	0.55	0.68	-
	2	0.46	0.62	0.49	0.63	same	+
	3	0.54	0.59	0.52	0.60	same	+
	4	0.57	0.70	0.59	0.71	same	+
	5	0.47	0.64	0.52	0.65	-	+
	6	0.56	0.65	0.58	0.64	same	+
	7/8	0.53	0.61	0.58	0.61	-	-
	9	0.54	0.58	0.52	0.56	same	same
	10	0.57	0.57	0.53	0.61	same	+
	11	0.55	0.60	0.61	0.63	+	same
	12	0.50	0.65	0.49	0.68	same	+
	Prime-civilian PCM	1	0.65	0.76	0.67	0.77	same
2		0.59	0.70	0.53	0.72	same	+
3		0.56	0.70	0.62	0.71	-	+
4		0.63	0.76	0.63	0.78	same	+
5		0.57	0.70	0.55	0.72	same	+
6		0.63	0.73	0.66	0.73	same	+
7/8		0.65	0.71	0.64	0.70	same	+
9		0.60	0.67	0.66	0.65	same	same
10		0.66	0.70	0.67	0.72	same	same
11		0.63	0.72	0.67	0.75	same	+
12		0.66	0.78	0.57	0.79	same	+

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**Table B-12—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.79	0.84	0.81	0.84	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.77	0.85	0.78	0.87	same	+
	6	na	na	na	na		
	7/8	0.77	0.72	0.76	0.78	same	same
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.79	0.61	0.78	0.74	same	same
	12	na	na	na	na		
	Other	1	0.74	0.83	0.77	0.85	same
2		0.65	0.84	0.66	0.77	same	+
3		na	na	na	na		
4		0.72	0.81	0.68	0.81	same	+
5		0.72	0.86	0.78	0.84	same	same
6		0.69	0.79	0.76	0.84	same	+
7/8		0.66	0.87	0.71	0.77	same	same
9		0.59	0.68	0.59	0.73	same	+
10		0.73	0.71	0.67	0.78	same	same
11		0.68	0.73	0.69	0.81	same	same
12		na	na	na	na		

**Table B-13. Health Plan Rating**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.51	0.69	0.53	0.70	-	+
	2	0.42	0.61	0.50	0.63	-	-
	3	0.51	0.64	0.57	0.66	-	-
	4	0.52	0.66	0.60	0.71	-	-
	5	0.49	0.68	0.52	0.71	-	+
	6	0.53	0.62	0.58	0.64	-	-
	7/8	0.50	0.59	0.55	0.61	-	-
	9	0.53	0.60	0.58	0.60	-	same
	10	0.58	0.68	0.64	0.70	-	+
	11	0.54	0.61	0.59	0.64	-	+
	12	0.52	0.68	0.55	0.68	same	+
	Active duty	1	0.27	0.57	0.35	0.60	-
2		0.25	0.52	0.36	0.56	-	-
3		0.31	0.48	0.39	0.49	-	-
4		0.34	0.58	0.43	0.61	-	+
5		0.27	0.57	0.31	0.61	same	+
6		0.36	0.51	0.44	0.52	-	-
7/8		0.33	0.51	0.40	0.52	-	-
9		0.37	0.56	0.47	0.54	-	same
10		0.42	0.52	0.46	0.59	same	+
11		0.34	0.47	0.41	0.49	-	+
12		0.33	0.61	0.43	0.62	-	+
Prime-military PCM		1	0.34	0.56	0.39	0.59	-
	2	0.32	0.50	0.40	0.53	-	-
	3	0.41	0.50	0.46	0.52	-	+
	4	0.44	0.58	0.51	0.60	-	+
	5	0.35	0.55	0.40	0.59	same	+
	6	0.45	0.53	0.52	0.53	-	same
	7/8	0.43	0.49	0.49	0.50	-	same
	9	0.47	0.54	0.52	0.50	same	same
	10	0.50	0.49	0.53	0.55	same	same
	11	0.50	0.51	0.52	0.53	same	same
	12	0.43	0.60	0.49	0.63	same	+
	Prime-civilian PCM	1	0.49	0.64	0.52	0.66	same
2		0.35	0.60	0.36	0.63	same	+
3		0.44	0.59	0.45	0.61	same	+
4		0.42	0.61	0.46	0.65	same	+
5		0.34	0.60	0.38	0.64	same	+
6		0.46	0.60	0.53	0.60	-	+
7/8		0.44	0.57	0.54	0.59	-	same
9		0.43	0.60	0.57	0.57	-	same
10		0.46	0.62	0.53	0.63	same	+
11		0.41	0.61	0.51	0.64	-	+
12		0.49	0.73	0.58	0.73	same	+

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**Table B-13—Continued**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.64	0.76	0.64	0.76	same	+
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.61	0.85	0.61	0.79	same	+
	6	na	na	na	na		
	7/8	0.59	0.56	0.61	0.70	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.63	0.52	0.66	0.61	same	same
	12	na	na	na	na		
	Other	1	0.61	0.77	0.56	0.78	same
2		0.46	0.77	0.56	0.67	–	+
3							
4		0.50	0.63	0.56	0.73	same	+
5		0.55	0.75	0.55	0.73	same	+
6		0.54	0.68	0.68	0.79	–	–
7/8		0.50	0.70	0.64	0.67	–	same
9		0.50	0.57	0.50	0.69	same	+
10		0.56	0.50	0.63	0.74	same	same
11		0.54	0.58	0.58	0.64	same	same
12		na	na	na	na		

**Table B-14. Specialist Rating**

Source of Care / Military Status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
All	1	0.74	0.82	0.76	0.82	same	+
	2	0.69	0.79	0.70	0.78	same	+
	3	0.74	0.77	0.75	0.78	same	+
	4	0.76	0.85	0.79	0.84	same	+
	5	0.76	0.81	0.74	0.82	same	+
	6	0.73	0.81	0.73	0.80	same	+
	7/8	0.72	0.77	0.74	0.76	same	+
	9	0.71	0.73	0.70	0.75	same	+
	10	0.75	0.80	0.73	0.81	same	+
	11	0.72	0.78	0.76	0.81	-	+
	12	0.65	0.73	0.64	0.74	same	+
	Active duty	1	0.56	0.72	0.62	0.71	-
2		0.53	0.66	0.54	0.67	same	+
3		0.48	0.61	0.54	0.62	same	same
4		0.58	0.72	0.66	0.74	same	same
5		0.62	0.76	0.60	0.77	same	+
6		0.54	0.67	0.55	0.67	same	+
7/8		0.58	0.70	0.62	0.69	same	same
9		0.60	0.63	0.48	0.64	-	+
10		0.58	0.62	0.57	0.63	same	same
11		0.59	0.72	0.61	0.75	same	+
12		0.44	0.72	0.52	0.71	same	+
Prime-military PCM		1	0.62	0.74	0.65	0.73	same
	2	0.60	0.69	0.60	0.70	same	+
	3	0.60	0.66	0.59	0.67	same	+
	4	0.66	0.76	0.68	0.78	same	+
	5	0.64	0.73	0.63	0.74	same	+
	6	0.63	0.72	0.65	0.72	same	+
	7/8	0.64	0.70	0.67	0.69	same	same
	9	0.64	0.63	0.56	0.64	-	+
	10	0.61	0.66	0.61	0.67	same	same
	11	0.61	0.71	0.68	0.74	same	+
	12	0.55	0.66	0.57	0.66	same	+
	Prime-civilian PCM	1	0.73	0.79	0.72	0.78	same
2		0.58	0.75	0.66	0.76	same	+
3		0.65	0.75	0.72	0.76	same	same
4		0.68	0.81	0.72	0.81	same	+
5		0.70	0.75	0.63	0.76	same	+
6		0.68	0.77	0.74	0.77	same	same
7/8		0.68	0.74	0.69	0.74	same	same
9		0.64	0.67	0.75	0.70	+	same
10		0.67	0.75	0.75	0.76	same	same
11		0.73	0.77	0.72	0.80	same	same
12		0.72	0.79	0.70	0.78	same	same

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**Table B-14—Continued**

Source of care / military status	Region	FY 2000		FY 2001		DoD Improve- ment	DoD vs. NCBD
		DoD	NCBD	DoD	NCBD		
Civilian-only care	1	0.80	0.84	0.82	0.85	same	same
	2	na	na	na	na		
	3	na	na	na	na		
	4	na	na	na	na		
	5	0.81	0.81	0.81	0.88	same	+
	6	na	na	na	na		
	7/8	0.76	0.80	0.79	0.85	same	+
	9	na	na	na	na		
	10	na	na	na	na		
	11	0.79	0.78	0.82	0.81	same	same
	12	na	na	na	na		
	Other	1	0.80	0.84	0.80	0.87	same
2		0.73	0.89	0.80	0.80	same	same
3		na	na	na	na		
4		0.81	0.91	0.76	0.88	same	same
5		0.74	0.92	0.75	0.88	same	+
6		0.74	0.88	0.80	0.88	same	same
7/8		0.74	0.85	0.75	0.80	same	same
9		0.70	0.70	0.74	0.82	same	same
10		0.76	0.80	0.70	0.79	same	same
11		0.67	0.80	0.66	0.78	same	same
12		na	na	na	na		



## **APPENDIX C: REGIONAL QUALITY-OF-CARE INDICATORS**

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Table C-1 shows Health People 2010 preventive care measures for the DoD population, broken down by TRICARE region, source of care, and military status. The source of care dimension was collapsed into two categories: Prime with a military PCM, and a residual category, indicated as “other.” This was necessary due to data limitations.

Entries of “na” indicate insufficient data for estimate. Items marked with a “+” indicate the goal was exceeded. Items marked with a “-” indicate the goal was not met. Items with “=” indicate that the differences between the goal and level achieved was not statistically significant ( $p < 0.05$ ), and the goal was met. Progress from FY 2000—FY 2001 is indicated as plus (+) if there was a statistically significant increase in the level of care provides, a minus (-) if less care was provided, or as “same” if there was no evidence of a statistically significant change.

**Table C-1. Preventive Care Measures**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Flu shot (65+) (Goal is 0.90)	All	1	0.80	0.70	–	–
		2	0.78	0.70	–	–
		3	0.74	0.65	–	–
		4	0.76	0.71	same	–
		5	0.78	0.71	–	–
		6	0.79	0.67	–	–
		7/8	0.79	0.73	–	–
		9	0.77	0.69	–	–
		10	0.78	0.74	same	–
		11	0.79	0.72	–	–
		12	0.68	0.73	same	–
		Prime–military PCM		1	0.72	0.74
2	na			na	na	na
3	na			na	na	na
4	0.74			0.72	same	–
5	na			na	na	na
6	0.79			0.72	–	–
7/8	0.78			0.76	same	–
9	0.69			0.66	same	–
10	na			na	na	na
11	0.83			0.73	–	–
12	na			na	na	na
Prime–civilian PCM				1	na	na
		2	na	na	na	na
		3	na	na	na	na
		4	na	na	na	na
		5	na	na	na	na
		6	na	na	na	na
		7/8	na	na	na	na
		9	na	na	na	na
		10	na	na	na	na
		11	na	na	na	na
		12	na	na	na	na
		Other		1	0.82	0.71
2	0.80			0.73	–	–
3	0.76			0.65	–	–
4	0.78			0.71	–	–
5	0.82			0.74	–	–
6	0.80			0.67	–	–
7/8	0.81			0.74	–	–
9	0.80			0.71	–	–
10	0.78			0.76	same	–
11	0.81			0.73	–	–
12	0.72			0.79	same	–

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**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Prenatal care (Goal is 0.90)	All	1	0.83	0.88	same	=
		2	0.88	0.89	same	=
		3	0.90	0.88	same	=
		4	0.83	0.91	same	=
		5	0.78	0.86	same	=
		6	0.88	0.89	same	=
		7/8	0.82	0.88	same	=
		9	0.88	0.87	same	=
		10	0.74	0.80	same	=
		11	0.99	0.86	-	=
		12	0.75	0.96	same	+
		Prime–military PCM		1	0.87	0.87
2	0.90			0.89	same	=
3	0.95			0.87	same	=
4	0.80			0.92	same	=
5	0.80			0.85	same	=
6	0.88			0.88	same	=
7/8	0.84			0.89	same	=
9	0.88			0.89	same	=
10	na			na	na	na
11	0.99			0.91	same	=
12	na			na	na	na
Prime–civilian PCM				1	na	na
		2	na	na	na	na
		3	na	na	na	na
		4	na	na	na	na
		5	na	na	na	na
		6	na	na	na	na
		7/8	na	na	na	na
		9	na	na	na	na
		10	na	na	na	na
		11	na	na	na	na
		12	na	na	na	na
		Other		1	0.72	0.91
2	0.78			0.86	same	=
3	na			na	na	na
4	na			na	na	na
5	na			na	na	na
6	na			na	na	na
7/8	0.77			0.85	same	=
9	na			na	na	na
10	na			na	na	na
11	na			na	na	na
12	na			na	na	na

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**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Mammogram (40+) (Goal is 0.70)	All	1	0.87	0.85	same	+
		2	0.87	0.84	same	+
		3	0.87	0.84	same	+
		4	0.86	0.88	same	+
		5	0.82	0.82	same	+
		6	0.85	0.84	same	+
		7/8	0.87	0.82	–	+
		9	0.85	0.83	same	+
		10	0.88	0.85	same	+
		11	0.86	0.86	same	+
		12	0.80	0.83	same	+
		Prime–military PCM		1	0.87	0.86
2	0.84			0.85	same	+
3	0.90			0.83	–	+
4	0.87			0.87	same	+
5	0.83			0.87	same	+
6	0.87			0.84	same	+
7/8	0.89			0.85	same	+
9	0.86			0.83	same	+
10	0.93			0.88	same	+
11	0.86			0.90	same	+
12	0.79			0.89	same	+
Prime–civilian PCM				1	0.87	0.84
		2	0.96	0.77	same	+
		3	0.91	0.86	same	+
		4	0.85	0.85	same	+
		5	0.89	0.83	same	+
		6	0.88	0.84	same	+
		7/8	0.75	0.85	+	+
		9	0.89	0.81	same	+
		10	0.84	0.84	same	+
		11	0.83	0.86	same	+
		12	na	na	na	na
		Other		1	0.89	0.86
2	0.90			0.85	same	+
3	0.88			0.88	same	+
4	0.88			0.90	same	+
5	0.86			0.86	same	+
6	0.86			0.86	same	+
7/8	0.90			0.84	–	+
9	0.86			0.87	same	+
10	0.88			0.86	same	+
11	0.88			0.87	same	+
12	0.85			0.84	same	+

*Continued on next page*

**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Pap test (Goal is 0.90)	All	1	0.86	0.86	same	–
		2	0.91	0.90	same	=
		3	0.88	0.89	same	=
		4	0.89	0.89	same	=
		5	0.87	0.86	same	–
		6	0.87	0.88	same	=
		7/8	0.88	0.87	same	–
		9	0.89	0.88	same	=
		10	0.85	0.86	same	–
		11	0.88	0.86	same	–
		12	0.91	0.90	same	=
		Prime–military PCM		1	0.94	0.95
2	0.94			0.94	same	+
3	0.94			0.93	same	+
4	0.94			0.95	same	+
5	0.94			0.95	same	+
6	0.93			0.94	same	+
7/8	0.92			0.94	+	+
9	0.96			0.95	same	+
10	0.93			0.91	same	=
11	0.96			0.95	same	+
12	0.95			0.96	same	+
Prime–civilian PCM				1	0.87	0.89
		2	0.86	0.90	same	=
		3	0.85	0.89	same	=
		4	0.91	0.90	same	=
		5	0.85	0.95	+	+
		6	0.91	0.91	same	=
		7/8	0.83	0.91	+	=
		9	0.88	0.90	same	=
		10	0.89	0.87	same	=
		11	0.89	0.89	same	=
		12	0.88	0.94	same	+
		Other		1	0.85	0.84
2	0.91			0.86	–	–
3	0.88			0.87	same	–
4	0.88			0.87	same	=
5	0.86			0.82	same	–
6	0.84			0.85	same	–
7/8	0.87			0.84	same	–
9	0.83			0.85	same	–
10	0.82			0.84	same	–
11	0.83			0.81	same	–
12	0.91			0.84	same	=

*Continued on next page*

**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
BP test (Goal is 0.95)	All	1	0.94	0.91	–	–
		2	0.91	0.87	–	–
		3	0.93	0.89	–	–
		4	0.94	0.90	–	–
		5	0.92	0.90	–	–
		6	0.92	0.89	–	–
		7/8	0.93	0.90	–	–
		9	0.92	0.87	–	–
		10	0.93	0.90	–	–
		11	0.94	0.88	–	–
		12	0.94	0.86	–	–
		Prime–military PCM	1	0.94	0.87	–
	2		0.91	0.84	–	–
	3		0.92	0.84	–	–
	4		0.94	0.88	–	–
	5		0.92	0.86	–	–
	6		0.91	0.87	–	–
	7/8		0.92	0.87	–	–
	9		0.92	0.83	–	–
	10		0.90	0.88	same	–
	11		0.91	0.86	–	–
	12		0.97	0.84	–	–
	Prime–civilian PCM		1	0.94	0.91	same
		2	0.93	0.83	–	–
		3	0.92	0.90	same	–
		4	0.93	0.90	same	–
		5	0.89	0.92	same	=
		6	0.93	0.90	same	–
		7/8	0.93	0.90	same	–
		9	0.92	0.88	same	–
		10	0.89	0.88	same	–
		11	0.94	0.92	same	=
		12	0.91	0.88	same	–
		Other	1	0.97	0.94	–
	2		0.96	0.94	–	=
	3		0.97	0.93	–	–
4	0.97		0.93	–	=	
5	0.97		0.94	–	=	
6	0.96		0.93	–	–	
7/8	0.97		0.94	–	=	
9	0.96		0.94	–	=	
10	0.96		0.93	–	=	
11	0.98		0.93	–	–	
12	0.95		0.94	same	=	

*Continued on next page*

**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
General physical (Goal is 0.95)	All	1	0.60	0.59	same	—
		2	0.53	0.55	same	—
		3	0.60	0.57	—	—
		4	0.61	0.61	same	—
		5	0.58	0.56	same	—
		6	0.59	0.56	same	—
		7/8	0.58	0.57	same	—
		9	0.57	0.54	same	—
		10	0.58	0.57	same	—
		11	0.60	0.57	same	—
		12	0.52	0.50	same	—
		Prime–military PCM		1	0.50	0.50
2	0.49			0.51	same	—
3	0.51			0.51	same	—
4	0.53			0.56	same	—
5	0.51			0.50	same	—
6	0.52			0.51	same	—
7/8	0.53			0.54	same	—
9	0.52			0.51	same	—
10	0.54			0.53	same	—
11	0.51			0.52	same	—
12	0.46			0.46	same	—
Prime–civilian PCM				1	0.62	0.59
		2	0.54	0.48	same	—
		3	0.57	0.59	same	—
		4	0.64	0.54	—	—
		5	0.58	0.50	same	—
		6	0.57	0.59	same	—
		7/8	0.57	0.56	same	—
		9	0.58	0.52	same	—
		10	0.58	0.62	same	—
		11	0.62	0.58	same	—
		12	0.72	0.58	same	—
		Other		1	0.71	0.66
2	0.64			0.64	same	—
3	0.71			0.64	—	—
4	0.68			0.67	same	—
5	0.68			0.63	—	—
6	0.68			0.64	same	—
7/8	0.66			0.63	—	—
9	0.66			0.59	—	—
10	0.65			0.61	same	—
11	0.71			0.65	—	—
12	0.67			0.66	same	—

*Continued on next page*

**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Breast exam (Goal is 0.60)	All	1	0.75	0.71	same	+
		2	0.72	0.72	same	+
		3	0.70	0.66	same	+
		4	0.71	0.72	same	+
		5	0.69	0.68	same	+
		6	0.69	0.69	same	+
		7/8	0.70	0.66	same	+
		9	0.65	0.64	same	=
		10	0.66	0.66	same	+
		11	0.71	0.66	same	+
		12	0.70	0.67	same	+
		Prime–military PCM		1	0.73	0.75
2	0.73			0.71	same	+
3	0.69			0.64	same	=
4	0.76			0.75	same	+
5	0.70			0.76	same	+
6	0.71			0.71	same	+
7/8	0.73			0.70	same	+
9	0.72			0.71	same	+
10	0.74			0.68	same	=
11	0.75			0.72	same	+
12	0.75			0.76	same	+
Prime–civilian PCM				1	0.70	0.70
		2	0.65	0.68	same	+
		3	0.65	0.66	same	=
		4	0.67	0.65	same	=
		5	0.66	0.65	same	=
		6	0.66	0.70	same	+
		7/8	0.73	0.65	same	=
		9	0.55	0.67	same	=
		10	0.74	0.66	same	=
		11	0.76	0.65	same	=
		12	na	na	na	na
		Other		1	0.77	0.75
2	0.78			0.74	same	+
3	0.74			0.70	same	+
4	0.74			0.75	same	+
5	0.74			0.70	same	+
6	0.72			0.72	same	+
7/8	0.73			0.69	same	+
9	0.67			0.63	same	=
10	0.65			0.67	same	+
11	0.72			0.66	same	+
12	0.72			0.69	same	+

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**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Cholesterol test (Goal is 0.80)	All	1	0.84	0.85	same	+
		2	0.79	0.76	–	–
		3	0.83	0.83	same	+
		4	0.84	0.84	same	+
		5	0.81	0.80	same	=
		6	0.83	0.82	same	+
		7/8	0.81	0.82	same	+
		9	0.78	0.77	same	–
		10	0.86	0.87	same	+
		11	0.85	0.82	–	=
		12	0.77	0.75	same	–
		Prime–military PCM	Prime–military PCM	1	0.78	0.78
2	0.72			0.69	same	–
3	0.76			0.73	same	–
4	0.79			0.78	same	=
5	0.71			0.70	same	–
6	0.78			0.75	–	–
7/8	0.75			0.77	+	–
9	0.70			0.68	same	–
10	0.75			0.80	+	=
11	0.79			0.74	–	–
12	0.77			0.71	same	–
Prime–civilian PCM	Prime–civilian PCM			1	0.81	0.85
		2	0.74	0.69	same	–
		3	0.80	0.82	same	=
		4	0.83	0.80	same	=
		5	0.67	0.77	+	=
		6	0.82	0.83	same	+
		7/8	0.77	0.79	same	=
		9	0.80	0.79	same	=
		10	0.81	0.79	same	=
		11	0.83	0.86	same	+
		12	0.69	0.84	same	+
		Other	Other	1	0.91	0.90
2	0.90			0.84	–	+
3	0.91			0.91	same	+
4	0.90			0.89	same	+
5	0.90			0.87	same	+
6	0.90			0.90	same	+
7/8	0.88			0.88	same	+
9	0.88			0.90	same	+
10	0.92			0.93	same	+
11	0.91			0.88	same	+
12	0.84			0.85	same	+

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**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Non-smoker (Goal is 0.75)	All	1	0.57	0.62	same	–
		2	0.53	0.60	+	–
		3	0.56	0.60	same	–
		4	0.54	0.63	+	–
		5	0.54	0.62	+	–
		6	0.56	0.60	same	–
		7/8	0.57	0.61	same	–
		9	0.58	0.54	same	–
		10	0.61	0.60	same	–
		11	0.60	0.63	same	–
		12	0.64	0.49	–	–
		Prime–military PCM		1	0.56	0.66
2	0.53			0.60	same	–
3	0.55			0.61	same	–
4	0.58			0.62	same	–
5	0.45			0.55	same	–
6	0.57			0.59	same	–
7/8	0.61			0.62	same	–
9	0.56			0.52	same	–
10	0.60			0.56	same	–
11	0.49			0.66	+	–
12	0.66			0.48	–	–
Prime–civilian PCM				1	0.65	0.76
		2	na	na	na	na
		3	0.54	0.67	same	=
		4	0.53	0.70	+	=
		5	na	na	na	na
		6	0.59	0.62	same	–
		7/8	na	na	na	na
		9	na	na	na	na
		10	na	na	na	na
		11	na	na	na	na
		12	na	na	na	na
		Other		1	0.64	0.61
2	0.62			0.66	same	–
3	0.65			0.64	same	–
4	0.58			0.64	same	–
5	0.64			0.69	same	=
6	0.60			0.64	same	–
7/8	0.59			0.66	same	–
9	0.69			0.68	same	=
10	na			na	na	na
11	0.73			0.69	same	=
12	na			na	na	na

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**Table C-1—Continued**

Measure	Source of Care / Military Status	Region	FY 2000	FY 2001	DoD Change	Met Goal
Mammogram (50+)	All	1	0.86	0.86	same	+
		2	0.88	0.86	same	+
		3	0.87	0.85	same	+
		4	0.85	0.88	same	+
		5	0.83	0.84	same	+
		6	0.84	0.85	same	+
		7/8	0.87	0.84	same	+
		9	0.85	0.86	same	+
		10	0.88	0.88	same	+
		11	0.85	0.88	same	+
		12	0.83	0.83	same	+
		Prime–military PCM	1	0.92	0.92	same
	2		0.94	0.91	same	+
	3		0.93	0.89	same	+
	4		0.87	0.91	same	+
	5		na	na	na	na
	6		0.93	0.91	same	+
	7/8		0.86	0.90	same	+
	9		0.89	0.93	same	+
	10		na	na	na	na
	11		0.92	0.92	same	+
	12		na	na	same	na
	Prime–civilian PCM		1	0.84	0.86	same
		2	na	na	na	na
		3	0.85	0.88	same	+
		4	0.76	0.85	same	+
		5	na	na	na	na
		6	0.87	0.84	same	+
		7/8	0.79	0.92	+	+
		9	na	na	na	na
		10	na	na	na	na
		11	na	na	na	na
		12	na	na	na	na
		Other	1	0.88	0.87	same
	2		0.90	0.87	same	+
	3		0.89	0.88	same	+
4	0.88		0.90	same	+	
5	0.86		0.87	same	+	
6	0.85		0.86	same	+	
7/8	0.89		0.85	–	+	
9	0.87		0.88	same	+	
10	0.89		0.88	same	+	
11	0.86		0.88	same	+	
12	na		na	na	na	



## APPENDIX D: PREDICTORS OF SATISFACTION WITH HEALTH PLAN

Please note that empty cells in the table indicate that the predictor does not discriminate between a satisfactory or dissatisfactory health plan rating for that particular source of care/active duty status group.

**Table D-1. Predictors of Health Plan Rating by Source of Care ( DoD Population, FY 2001)**

Predictor/ Value of predictor	Source of Care/Active Duty Status									
	AD		Prime Dep Mil PCM		Prime Civilian PCM		Civilian Only		Other	
	False	True	False	True	False	True	False	True	False	True
Satisfactory health care rating	0.19	0.61	0.30	0.71	0.29	0.61	0.41	0.72	0.33	0.72
No problem with paperwork	0.30	0.50	0.46	0.64	0.40	0.58	0.56	0.72	0.48	0.69
Claims handled in a reasonable time	0.30	0.44	0.50	0.57	0.41	0.52	0.51	0.67	0.45	0.65
Get the help from health plan's customer service	0.34	0.46	0.47	0.63	0.40	0.59	0.54	0.72	0.52	0.67
Easy to find or understand information in the written materials	0.35	0.44	0.51	0.59	0.43	0.54	0.57	0.71	0.55	0.66
Satisfactory doctor rating	0.35	0.43	0.48	0.59	0.41	0.54	0.57	0.67	0.52	0.64
Claims handled correctly			0.45	0.58	0.41	0.51	0.53	0.66		
No delays in healthcare while you waited for approval from health plan	0.35	0.40	0.51	0.56	0.42	0.53	0.56	0.66	0.51	0.63
Gets a referral to a specialist that you needed to see									0.54	0.64
Office staff treated patient with courtesy and respect					0.58	0.48			0.53	0.61
Happy with choice of personal doctor or nurse	0.36	0.41	0.52	0.57	0.44	0.53	0.59	0.67		
Get needed help or advice during regular office hours					0.43	0.50				

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**Table D-1—Continued**

Predictor/ Value of predictor	Source of Care/Active Duty Status									
	AD		Prime Dep Mil PCM		Prime Civilian PCM		Civilian Only		Other	
	False	True	False	True	False	True	False	True	False	True
Satisfactory specialty care rating	0.35	0.42	0.52	0.57	0.45	0.51	0.60	0.66		
Doctor listens carefully	0.44	0.38					0.71	0.64		
More than \$500 OP costs	0.41	0.34	0.57	0.52			0.67	0.64		
Doctor explains things in a way patient could understand					0.55	0.49				
Private health insurance			0.56	0.50			0.63	0.67		
Wait in the doctors office or clinic not more than 15 minutes past appointment			0.52	0.57			0.62	0.67		
Used ER	0.38	0.42			0.48	0.53	0.64	0.67		
Live near an MTF	0.35	0.40								
Get appt for regular or routine healthcare as soon as wanted	0.36	0.41	0.52	0.57						
Male					0.51	0.46				
Get care for illness or injury as soon as wanted	0.37	0.40	0.52	0.56						
Gets the care you or a doctor believed necessary	0.37	0.41								
Health status (1-5 scale)	0.44	0.42	0.59	0.58	0.56	0.54	0.68	0.67		
Number OP visits							0.59	0.60	0.52	0.54

## APPENDIX E: SELECTED DHP PROGRAM ELEMENT DEFINITIONS

Table E-1. Selected DHP Medical Program Element Definitions

Program Element	Title	Description
0807798HP	Management Headquarters	Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following: Army: U.S. Army Medical Command Headquarters; Medical Material Agency. Navy: Bureau of Medicine and Surgery. Defense Agencies: Defense Medical Facilities Office, which is a component of the TRICARE Management Activity.
0807791HP	MHS Information Management/ Information Technology (IM/IT)	Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following: This program element contains funding for reliable, responsive standardized information systems support to health care providers, managers, and decision makers at all levels of the DoD through the following MHS IM/IT business areas: Clinical Logistics, Executive Information/Decision Support, resources, Theater, Infrastructure and the TRAC2ES Program. Oversees and maintains DoD Unified Medical Program resources for all medical activities.
0807709HP	TRICARE Management Activity (TMA)	Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following: Resources devoted to the operation of the TMA. This program element contains funding for TMA operating costs supporting delivery of patient care worldwide for members of the Armed Forces, family members, and others entitled to DoD health care. Oversees and maintains DoD Unified Medical Program resources for all medical activities.

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**Table E-1—Continued**

Program Element	Title	Description
0807785HP	Armed Forces Institute of Pathology (AFIP)	<p>Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identifiable and measurable to the following:</p> <p>Includes operation and maintenance of the AFIP as authorized under DoD Directive 5154.24. Includes expenses incurred in the conduct of the AFIP's assigned missions: serves as chief reviewing authority on the diagnosis of pathologic tissue for the Armed Services; conducts experimental, statistical and morphological research and investigation in the field of pathology; operates the Armed Forces Medical Examiner System; operates the National Museum of Health and Medicine; maintains a Medical Illustration Service; administers the drug testing quality control and proficiency testing programs for the DoD; administers implementation of the DoD Clinical Laboratory Improvement Program; operates the Defense Special Weapons Agency Registry.</p>
0801720HP	Examining Activities – Health Care	<p>Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following: Resources devoted to administering physical examinations and performing evaluations of medical suitability. Also includes resources at the Armed Forces Examination and Entrance Stations (AFEES) devoted to the Defense Medical Review Board.</p> <p>Excludes Service recruiting headquarters, career counselors assigned to AFEES, and mental/vocational testing performed by recruiting personnel.</p>
0806721HP	Uniformed Services University of the Health Sciences (USUHS)	<p>Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following:</p> <p>Resources associated with the establishment, operation, and maintenance of the USUHS. Includes instructors and instructional support.</p>
0806722HP	Armed Forces Health Professions Scholarship Program	<p>Includes costs specifically identified and measurable to the Armed Scholarship Program Forces Health Professions Scholarship, Financial Assistance Program, and other precommissioning professional scholarship programs.</p> <p>Excludes manpower authorizations and administrative support costs for the above programs, other health acquisition programs, and the Airman's Education Commissioning Program.</p>

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**Table E-1—Continued**

Program Element	Title	Description
0807714HP	Other Health Activities	<p>Includes manpower authorizations, peculiar and support equipment, necessary facilities and the associated costs specifically identified and measurable to the following:</p> <p>Organizations and functions that support the provision of health care for MHS beneficiaries to include activities such as management headquarters for regional lead agents, central medical laboratories, medical service squadrons, AMEED Field Procurement Offices, the Health Services Data Systems Agency, Navy Healthcare Support Offices, public affairs, and family advocacy among others.</p> <p>Excludes tactical medical units (including dental activities) other than described above; Armed Forces Institute of Pathology and Aeromedical Evacuation resources; AFEES; recovery, preparation, transportation, and internment of deceased military personnel; veterinary services; and functions which are integral to medical center/station hospital/clinic/dispensary operations.</p> <p>Excludes activities that provide support to the unique health care mission required by virtue of the military mission and not generally analogous to services provided under a civilian health benefit plan.</p>
0603115HP	Medical Development	<p>Funds to provide for advanced development of improved methods, equipment and systems for medical identification and protection of naturally occurring diseases and biological warfare.</p>
0807726HP	Medical Combat Support – Active	<p>Includes manpower and funding associated with deployable and employable combat support.</p>
0807720HP	Other Procurement, Construction/Initial Outfitting	<p>Funds procurement of investment equipment items within the Defense Health Program in support of medical military construction projects. This includes initial outfitting investment equipment for medical construction of projects supporting health care delivery (including dental care), health care training, and other health activities within the Army, Navy, Air Force and the Defense Field Activities (e.g., TMA and USUHS).</p>
0807721HP	Other Procurement, Replacement/Modernization	<p>Funds procurement of investment equipment for recurring replacement, modernization, new requirements, and developmental items within the Defense Health Program. This includes procurement of investment equipment in support of health care delivery (including dental care), health care information systems, training, and other health activities within the Army, Navy, Air Force and the Defense Field Activities (e.g., TMA and USUHS).</p>



## **ABBREVIATIONS**

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AD	Active Duty
ADFM	Active-Duty Family Members
ADS	Ambulatory Data System
AFB	Air Force Base
AFEES	Armed Forces Examination and Entrance Stations
AFIP	Armed Forces Institute of Pathology
AHA	American Hospital Association
ARS	All Region Server
BP	Blood Pressure
BPA	Bid Price Adjustment
BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Health Plans Survey
CCAE	Commercial Claims and Encounters
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS Maximum Allowable Charge
CMIS	CHAMPUS Medical Information System
CMS	Centers for Medicare and Medicaid Services
CPI	Consumer Price Index
CRI	CHAMPUS Reform Initiative
CSL	Cost Sharing Liability
D&C	Deductibles and Copayments
DEERS	Defense Enrollment Eligibility Reporting System
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DME	Direct Medical Education
DoD	Department of Defense
DRG	Diagnosis Related Group
ER	Emergency Room
FEHBP	Federal Employees Health Benefits Program
FTE	Full-Time Equivalent

FY	Fiscal Year
FYDP	Future Years Defense Program
GAO	General Accounting Office
HA	Health Affairs
HCF	Health Care Finder
HCSR	Health Care Service Record
HEDIS	Health Plan Employer Data and Information Set
HMO	Health Maintenance Organization
HSR	Health Service Region
IDA	Institute for Defense Analyses
IM/IT	Information Management/Information Technology
MCS	Managed Care Support
MCSC	Managed Care Support Contract
MEPRS	Medical Expense and Performance Reporting System
MHS	Military Health System
MilCon	Military Construction
MMSO	Military Medical Support Office
MSA	Metropolitan Statistical Area
MTF	Military Treatment Facility
NAIC	National Association of Insurance Commissioners
NAS	Nonavailability Statement
NCBD	National CAHPS Benchmarking Database
NDAA	National Defense Authorization Act
NMOP	National Mail Order Pharmacy
O&M	Operations and Maintenance
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OCHAMPUS	Office of the Civilian Health and Medical Program of the Uniformed Services
OHI	Other Health Insurance
OPM	Office of Personnel Management
PCM	Primary Care Manager
PDTS	Pharmacy Data Transaction Service
PE	Program Element
POS	Point of Service

PPI	Producer Price Index
RVU	Relative Value Unit
RWP	Relative Weighted Product
SA	Space-Available
SADR	Standard Ambulatory Data Record
SG	Surgeons General
SIDR	Standard Inpatient Data Record
TDP	TRICARE Dental Program
TFMDP	TRICARE Family Member Dental Plan
TMA	TRICARE Management Activity
TPR	TRICARE Prime Remote
TSP	TRICARE Senior Prime
TSRx	TRICARE Senior Pharmacy
TSRDP	TRICARE Selected Reserve Dental Program
UM	Utilization Management
USUHS	Uniformed Services University of the Health Sciences

