PROJECT REPORT

Health Care Survey of DoD Beneficiaries 2008 Annual Report

August 2008

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MATHEMATICA
Policy Research, Inc.

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TRICARE

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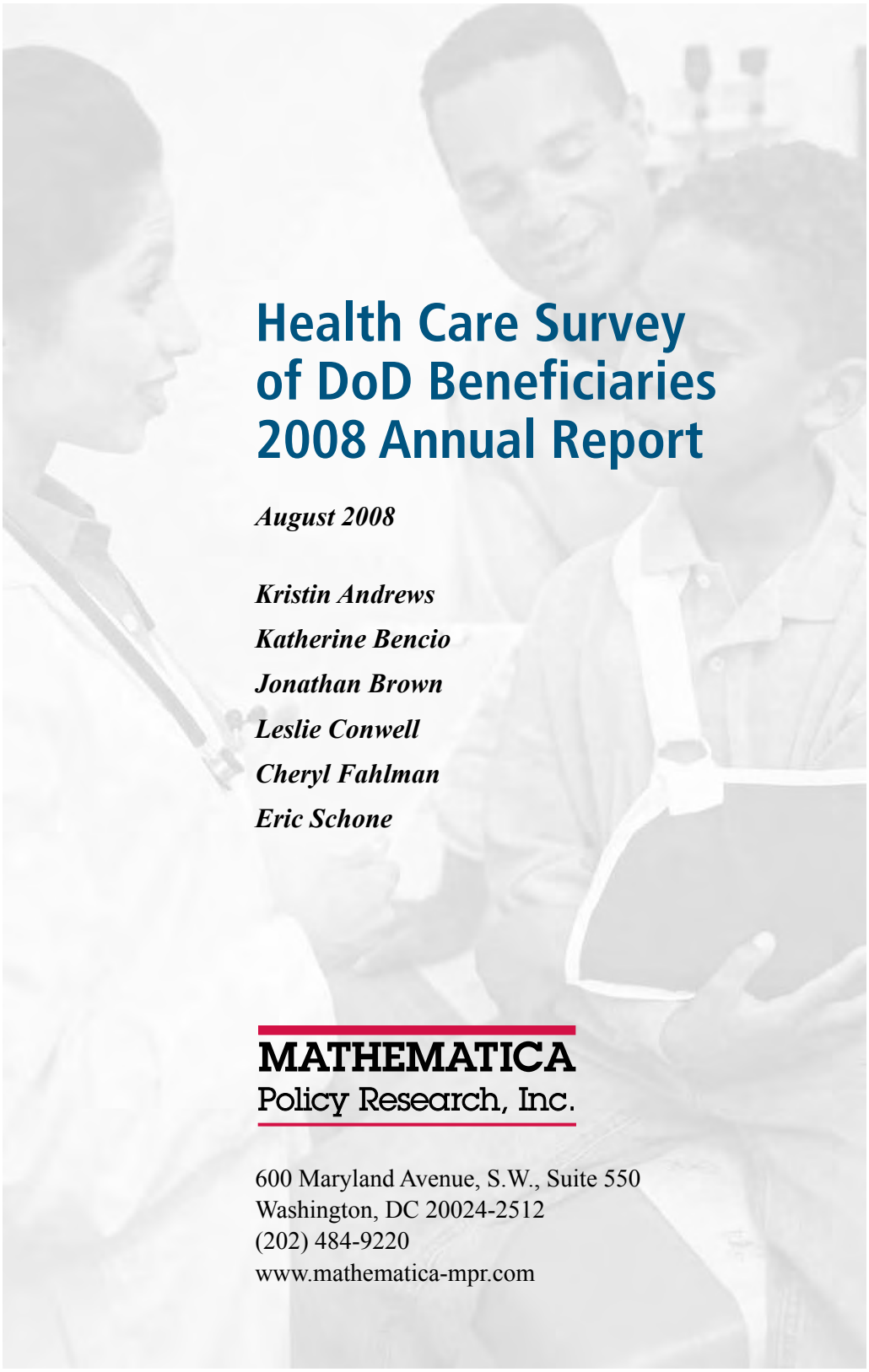

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Contents

Executive Summary

The Health Care Survey of DoD Beneficiaries (HCSDB) Annual Report describes results from a worldwide survey of beneficiaries eligible for health care coverage through the military health system (MHS). The survey contains questions about beneficiaries' ratings of their health care and health plan, access to care, choice of health plan, and other subjects relevant to the leaders and users of the MHS. Results are compared to benchmarks from civilian health plans reporting survey results to the National CAHPS Benchmarking Database (NCBD). According to the 2008 HCSDB Annual Report:

The proportion of eligible beneficiaries using direct care fell from 43 percent in 2005 to 41 percent in 2007. During that time purchased care users increased from 16 percent to 19 percent and other civilian insurance fell from 14 percent to 12 percent.

Active duty family members' use of direct care fell from 62 percent to 58 percent and purchased care rose from 28 percent to 32 percent. Retirees' use of other civilian insurance fell and purchased care rose during the same time.

Health plan ratings of both direct care and purchased care users rose from 2005 to 2007.

Direct care users' ratings of health care are well below the civilian benchmark, while purchased care users ratings are slightly below.

Both direct care and purchased care users report problems finding a personal doctor. Fewer than half of direct care users have a personal doctor.

Compared to purchased care users, direct care users are more likely to report problems getting to see a specialist and less likely to report delays getting care while awaiting approval from their health plan.

Claims handling correctness and timeliness of purchased care users have improved and now meet the civilian benchmark.

Direct care and purchased care users' customer service experience has improved substantially since 2005.

Pap smear rates for direct care users exceed the Healthy People 2010 goal and the rates for both purchased care women and those who rely on other civilian insurance. Mammography rates for all three groups exceed the Healthy People 2010 goal.

Military treatment facility (MTF) use has fallen: the proportion getting most of their care from MTFs fell from 40 percent in 2005 to 37 percent in 2007. Use of civilian facilities financed by TRICARE rose a similar amount during that time.

The proportion of MTF users reporting timely access to appointments fell from 64 percent to 61 percent from 2005 to 2007, compared to a civilian benchmark of 81 percent.

Timely appointments at civilian facilities financed by TRICARE and by civilian insurance exceed the benchmark.

MTF users are less likely to report MTF staff are helpful and MTF doctors spend enough time with them than the civilian benchmark. Users of civilian and VA facilities report staff and doctors meet the benchmarks for these measures.

Controlling for age, officers rate their care and interactions with doctors higher than do enlisted personnel, and their access lower.

Married and female personnel are least satisfied with their access to personal doctors compared to other active duty groups.

Retirees who use TRICARE and private civilian insurance report substantially similar health status, health-related lifestyles and use of preventive care. VA users report poorer health status, poorer health habits, and higher use of preventive services.

Fewer than 10 percent of beneficiaries report fair or poor mental health, but one-sixth report a need for treatment or counseling.

Need for treatment or counseling differs by gender, race and education. Access and ratings differ by race, but not gender or education. Access and ratings are lowest for American Indians and Alaska Natives and lowest for non-Latino Blacks.

Eighty percent of parents told by a doctor that their child needed to see a mental health specialist report their child had seen such a specialist. Among those who did not, the most often cited reason (18 percent) was inability to find such a specialist.

Parents with children enrolled in Prime report poorer communication with their doctors than do users of Standard/Extra

or civilian insurance. MTF users report poorer communication than users of civilian facilities.

The majority of reservists eligible for TRICARE Reserve Select have other coverage options. Many are uncertain of their eligibility status.

Colorectal screening of MHS beneficiaries increased between 2006 and 2007. The proportion compliant with American Cancer Society (ACS) guidelines increased from 67 percent to 71 percent. The proportion over 50 with colonoscopy in the past 10 years increased from 57 percent to 64 percent.

In recent years, demands on TRICARE's civilian network have increased and access problems have fallen. Since before the regional consolidation, the proportion of TRICARE users relying on the network has risen from 52 percent to 58 percent, while the proportion with problems finding personal doctors or specialists have fallen, as has the proportion finding their doctor has left the network.

Chapter 1. Introduction

About the HCSDB

The HCSDB is a worldwide survey of military health system (MHS) beneficiaries that has been conducted each year since 1995 by the Office of the Assistant Secretary of Defense/ TRICARE Management Activity (TMA). Congress mandated the survey under the National Defense Authorization Act for Fiscal Year 1993 (P.L. 102-484) to ensure regular monitoring of MHS beneficiaries' satisfaction with their health care options. The survey is administered each quarter to a stratified random sample of adult beneficiaries and once each year to the parents of a sample of child beneficiaries. Any beneficiary eligible to receive care from the MHS on the date the sample is drawn may be selected. Eligible beneficiaries include members of the Army, Air Force, Navy, Marines, Coast Guard, Public Health Service, National Oceanic and Atmospheric Administration, and activated members of the National Guard and Reserves. Although many of the beneficiaries use TRICARE Prime, TRICARE Standard, or TRICARE Extra, others rely on Medicare or civilian health insurance plans.

Samples are drawn from the Defense Enrollment Eligibility Reporting System (DEERS) and are stratified by the location of a beneficiary's home, health plan, and reason for eligibility. In 2007, 200,000 beneficiaries living inside or outside of the United States were sampled for the adult survey. A total of 35,000 beneficiaries worldwide were sampled for the child survey. The *2007 HCSDB Adult Sample Report* and *2007 Child Sample Report* describe the sampling methods. Synovate administers the survey, allowing beneficiaries to respond by mail or on a secure website.

Responses to the survey are coded, cleaned, edited, and assembled in a database. Duplicate and incomplete surveys are removed. A sampling weight is assigned to each observation, adjusted for nonresponse. The *2007 HCSDB Codebook and Users Guide* describes the contents of the database.

Questions in the 2007 HCSDB were developed by TMA or were taken from other public domain health care surveys. Many questions were taken from the Consumer Assessment of Health Programs and Systems (CAHPS) Health Plan Survey, Version 3.0. CAHPS contains core and supplemental survey questions used by commercial health plans, the Center for Medicare & Medicaid Services (CMS), and state Medicaid programs to assess consumers' satisfaction with their health plans.

Most survey questions change little from quarter to quarter so that responses can be followed over time. Supplementary questions are added each quarter so as to learn more about the latest health policy issues. In 2007, the survey added questions about care received from civilian physicians, such as TRICARE's civilian network, pharmacy benefits, beneficiaries' need for and use of behavioral health services, reservists' health coverage, the TRICARE Reserve Select benefit, colon cancer screening, and several other topics.

About this Report

This report presents results for all surveys administered in 2007 and sometimes compares the results to those from 2005 and 2006. The report includes responses from all beneficiaries eligible for MHS benefits, including children, who reside in the United States.

Beneficiaries are eligible for military health benefits if they are currently on active duty or are dependents of active duty personnel. National Guard and Reserves mobilized for more than 30 days and their dependents are eligible, as are retirees and those who are the dependents of a retiree. MHS beneficiaries may receive care from military treatment facilities (MTFs) financed and operated by the uniformed services or from civilian facilities reimbursed by the Department of Defense.

Eligible beneficiaries may choose from several health plan options. TRICARE Prime is a point-of-service HMO that centers on military facilities or civilian facilities that are members of TRICARE's civilian network. Active duty personnel and their family members are automatically eligible for free enrollment in Prime. Retirees under age 65 may enroll if they pay a premium. TRICARE Standard offers cost sharing for care received from civilian doctors on a fee-for-service basis. TRICARE Extra offers enhanced cost sharing for fee-for-service care provided by network doctors. Many retirees and some active duty dependents also have non-military coverage. For beneficiaries with civilian insurance, including Medicare, the civilian payer has primary responsibility. Since the inception of TRICARE for Life in October

2001, TRICARE Standard has been second payer to Medicare and has paid most costs remaining after Medicare.

The initial chapters of this report compare beneficiaries' coverage choices and providers. Chapter 2 describes the choices of eligible beneficiaries among different health plans and providers of care. Chapter 3 describes beneficiaries' experiences in seeking care from different types of health care providers, including military, civilian, and VA providers. The chapters present the results as percentages calculated with adjusted sampling weights. When results are compared between years or to an external benchmark, the difference is tested for statistical significance, thus accounting for the complex sample design. Results that differ significantly from an external benchmark ($p < .05$) are presented in boldface.

Chapters 4 through 8 present results from the survey on several topics, including retiree's use of preventive care, variations in the experience of active duty beneficiaries, children's behavioral health needs, communication between parents of child beneficiaries and their providers, and disparities in need for and access to behavioral health care.

Results from CAHPS questions are compared to results from the National CAHPS Benchmarking Database (NCBD) for 2006. The NCBD assembles results from CAHPS surveys administered to hundreds of civilian health plans. Mean rates are calculated from the results and adjusted for age and health status to correspond to the characteristics of beneficiaries shown in the graph. For example, benchmarks in graphs presenting civilian health plan ratings are adjusted to the age and health status of beneficiaries using civilian health plans while the same benchmarks for Prime users are adjusted to the age and health status of beneficiaries who use Prime. For preventive care measures, such as the proportion of women screened for cervical cancer, results are compared with *HP2010* goals. *HP2010* goals are set by the government to promote good health through healthy behavior, such as immunization, screening for illness, and avoiding unhealthy habits. The *2007 HCSDB Technical Manual* describes the benchmarks in more detail.

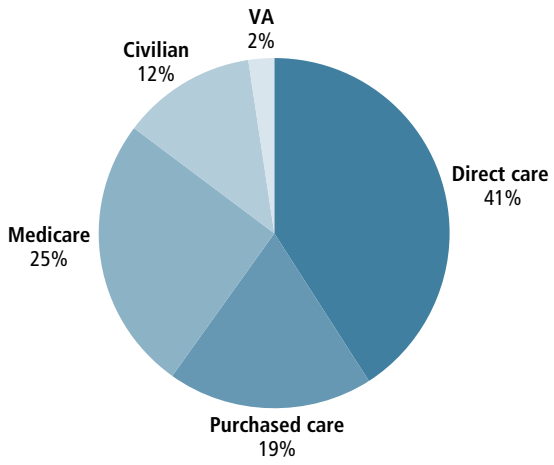
Other reports prepared from the HCSDB are the *TRICARE Beneficiary Reports, HCSDB Issue Briefs,* and *TRICARE Consumer Watch.* The *Beneficiary Reports* is an interactive Web-based document that compares TRICARE Regions, Services, and MTFs by using scores calculated from survey results. *Issue Briefs* are two-page reports that present HCSDB results from the survey administered in a particular quarter and address a topic of current interest. *Consumer Watch* contains a brief summary of results from the *Beneficiary Reports.* Both appear quarterly.

The issue briefs for 2007, which are included in this report, concerned (1) needs of deactivated reservists, (2) TRICARE Reserve Select, (3) colon cancer screening, and (4) use of TRICARE's civilian network. These issue briefs make up the last four chapters of this report.

Chapter 2. Beneficiaries' Choices of Health Plan

MHS beneficiaries are covered by a wide range of health plans, most of them provided or supplemented by the Department of Defense. Active duty personnel are largely restricted to TRICARE Prime, but their dependents may choose from Prime, Standard/Extra, or civilian policies. Retirees also may choose Prime, Standard/Extra, or civilian coverage, with a substantial minority eligible for Veterans Administration care. Medicare-eligible retirees are eligible for TRICARE for Life, which provides TRICARE benefits to pay deductibles and coinsurance left over from Medicare. Beneficiaries who rely on Prime may enroll to a primary care manager at a military facility (direct care) or to the managed care network (purchased care). The great majority of Prime enrollees are enrolled to direct care. As shown in Figure 1, 41 percent were active duty or MTF enrollees in 2007. As shown in Figure 2, direct care use has fallen since 2005, when 43 percent were enrolled.

Figure 1. Health plan used for most care 2007



Purchased care users are those who are enrolled to the TRICARE civilian network, or who rely on Standard or Extra for most of their care. As shown in Figure 1, they make up 19 percent of respondents, increasing from 16 percent in 2005. During the period from 2005 to 2007 beneficiaries switched from civilian insurance and direct care to purchased care.

As shown in Figure 3, the majority of active duty family members (58 percent) are direct care users, but 32 percent use purchased care.

Figure 2. Health plan used for most care 2005

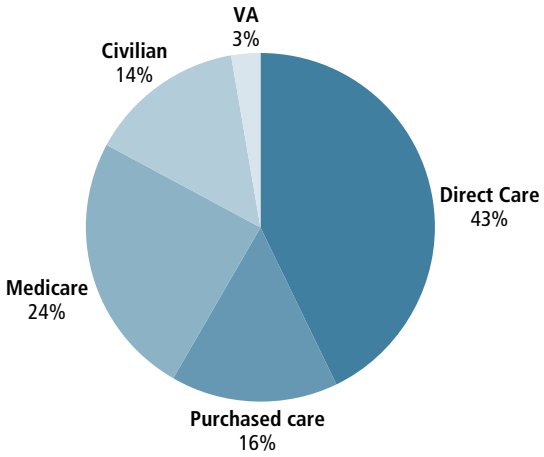
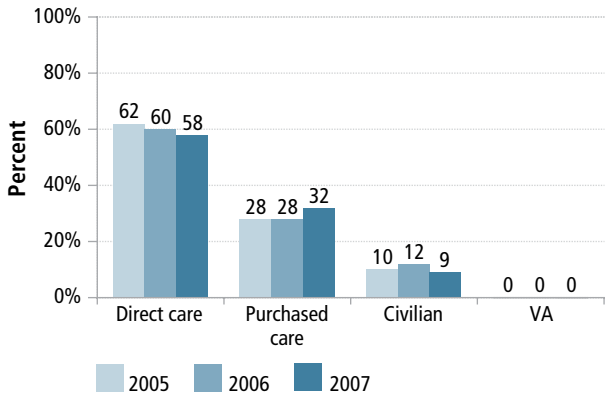


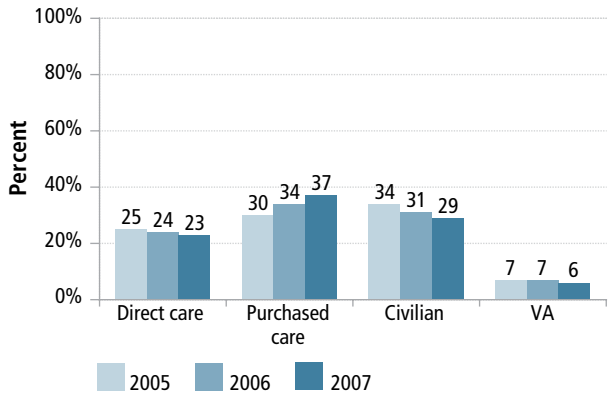
Figure 3. Active duty family members choice of health plan



Fewer than one in ten family members of active duty personnel report relying on alternative civilian insurance. Between 2005 to 2007, active duty dependents switched from direct care to purchased care.

Figure 4 indicates that about one-quarter (23 percent) of retirees and their family members choose direct care as their health plan, while a little over a third (37 percent) rely on purchased care. Purchased care use rose from 30 percent to 37 percent between 2005 and 2007. Retirees have shifted away from both direct care and other civilian insurance, but primarily from other civilian insurance, which fell from 34 percent to 29 percent, continuing a longstanding decline.

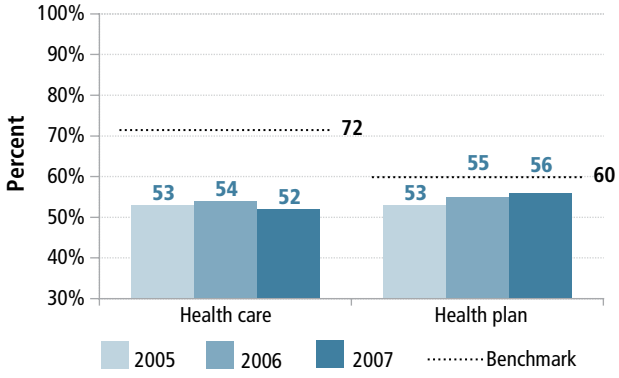
Figure 4. Retired, less than 65 choice of health plan



Graphs in this section present ratings of different aspects of care and measures of access reported by users of three health plan types: TRICARE Prime through direct care, TRICARE through purchased care, and other civilian insurance. The measures are presented over a three-year period for each health plan, and are shown in comparison with civilian benchmarks, which are taken from the National CAHPS Benchmarking Database, adjusted for age and health status.

As shown in Figure 5, when asked to rate their health plan, direct care Prime enrollees give ratings slightly below their adjusted benchmarks. Fifty-six percent rate their plan 8 or above. Since 2005, the proportion giving direct care Prime a high rating rose from a level of 53 percent. Fifty-two percent of direct care enrollees give their health care a high rating, which is well below the civilian benchmark, and approximately the same proportion as in 2005.

Figure 5. Direct care health care and health plan ratings



By contrast, purchased care users, as shown in Figure 6, rate their health plan approximately the same as the adjusted benchmark. This rate has increased from 57 percent in 2005. Their health care ratings are slightly below their adjusted civilian benchmark. Seventy-three percent rate their health care 8 or above, approximately the same as in 2005. As shown in Figure 7, beneficiaries who use civilian health insurance coverage give ratings to both their health plans and health care that do not differ significantly from adjusted civilian benchmarks.

Figure 6. Purchased care health care and health plan ratings

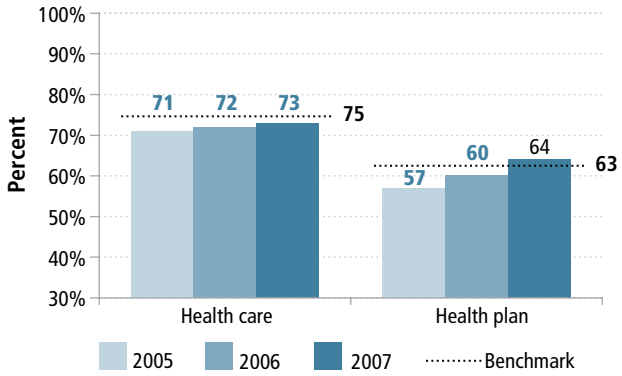
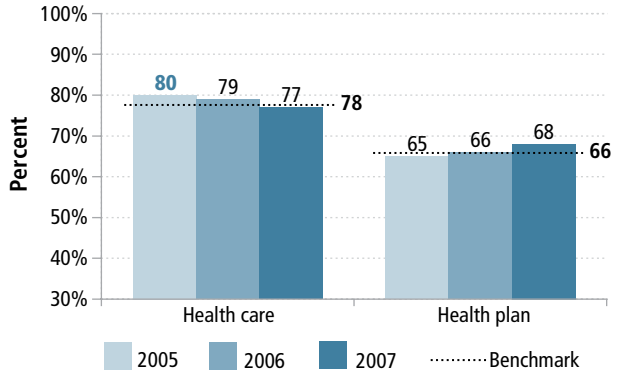


Figure 7. Beneficiaries with civilian coverage health care and health plan ratings

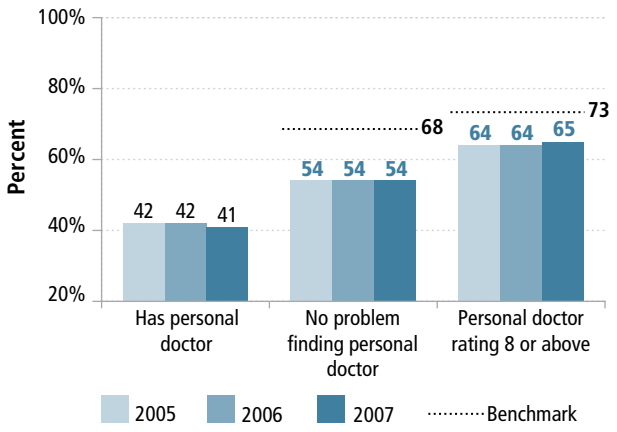


As shown in Figure 7, the proportion of beneficiaries relying on civilian coverage that gives its health plan a high rating is 68 percent, approximately the same as the adjusted benchmark, increasing slightly from 2005, when the rate was 65 percent. The proportion giving its health care a high rating is 77 percent, not significantly different from the benchmark, and slightly lower than the 2005 rate.

The graphs that follow contrast the three health plans in terms of beneficiaries relation to their personal doctor and access to specialists. The options differ substantially in the likelihood of having a personal doctor, and in ease of getting referrals to specialists.

As shown in Figure 8, 41 percent of direct care users report they have a personal doctor. In spite of programs like "Personal Doctor by Name" this proportion has not increased, and has even declined slightly since 2005. Fifty-four percent of direct care users report no problem finding a personal doctor, well below their adjusted benchmark of 68 percent. Sixty–five percent give their personal doctor a rating of 8 or above on a 0 to 10 scale, also below the benchmark rate. Rates for finding personal doctors and ratings of personal doctors are virtually identical across the three years.

Figure 8. Direct care personal doctors



By contrast, purchased care users, shown in Figure 9, are twice as likely as direct care users to have a personal doctor. Eighty-three percent report they have a personal doctor, approximately the same as the 2005 rate. Purchased care users do report problems accessing a personal doctor. Fifty-nine percent report they had no problems finding a personal doctor they are happy with, significantly below the adjusted benchmark. However, the proportion giving their personal doctor a high rating, 72 percent, is close to the adjusted benchmark, and is approximately the same as the rate in 2005.

Beneficiaries relying on civilian coverage are more likely than either group of TRICARE users to have a personal doctor. As shown in Figure 10, 88 percent report they have one doctor they consider their personal doctor. Seventy-two percent of the group with civilian coverage report they have no problem finding a personal doctor, slightly above the adjusted benchmark. Seventy-five percent give their personal doctor a high rating. These rates have changed little since 2005.

Figure 9. Purchased care personal doctors

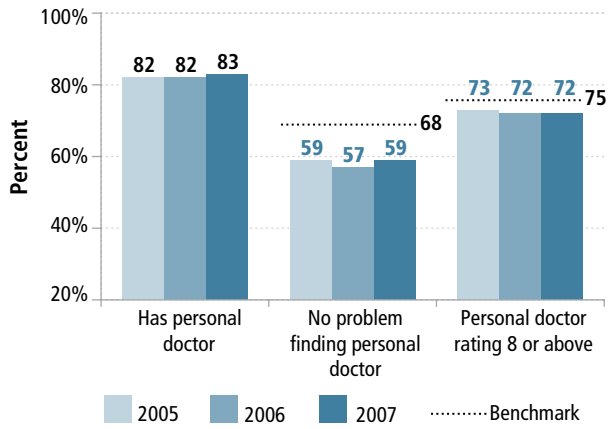
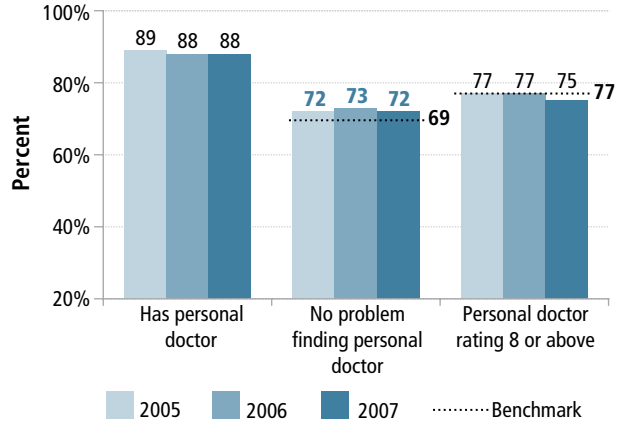
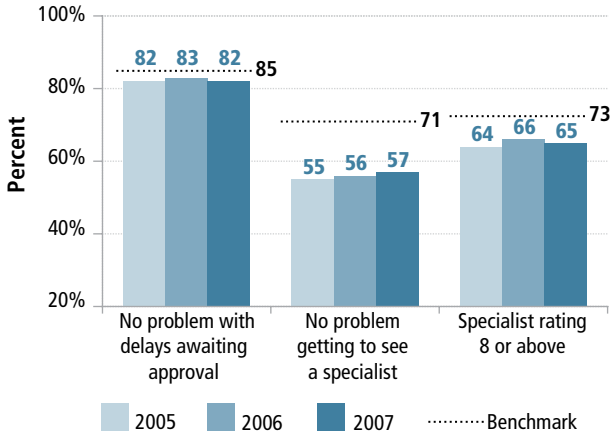


Figure 10. Beneficiaries with civilian coverage personal doctors



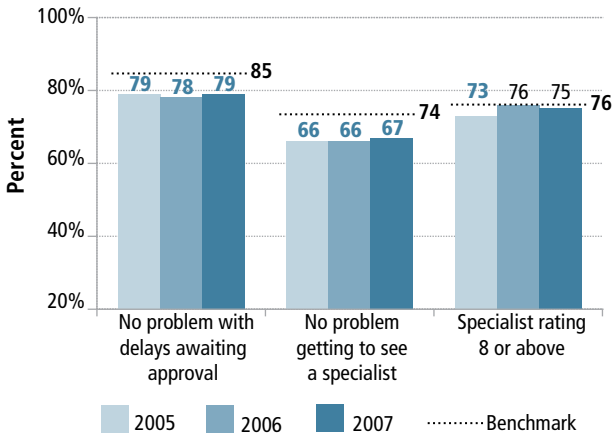
Eighty-two percent of direct care enrollees report no problem with delays while awaiting approval from their health plan for care tests or treatment. As shown in Figure 11, this rate is slightly below the adjusted benchmark, and approximately the same as in 2005. Direct care users are much more likely to encounter problems getting access to specialists than they are to complain of delays. Fifty-seven percent report no problem getting to see a specialist compared to a benchmark of 71 percent. The rate with no problem has increased slightly from 2005, when it was 55 percent. The proportion giving high ratings to specialists is similar to the proportion rating its personal doctor highly, 65 percent, which is below the benchmark of 73 percent.

Figure 11. Direct care access to specialists



Purchased care users are more likely than direct care users to experience delays awaiting approval. As shown in Figure 12, 79 percent report such delays. However, the proportion of purchased care users reporting no problem getting referrals to specialists, 67 percent, is higher than the rate for direct care users, although it is still substantially below the adjusted benchmark. Seventy-five percent give their personal doctor a high rating, similar to the benchmark.

Figure 12. Purchased care access to specialists



As shown in Figure 13, beneficiaries who rely on their civilian coverage, are less likely than beneficiaries relying on TRICARE to report access problems. Ninety percent report no problem getting approvals from their health plan, similar to the benchmark rate. Eighty-one percent report no problem accessing specialists, and 80 percent give their specialist a high rating. These rates are all similar to or higher than the corresponding benchmarks, though slightly below the 2005 rates.

Figure 13. Beneficiaries with civilian coverage access to specialists

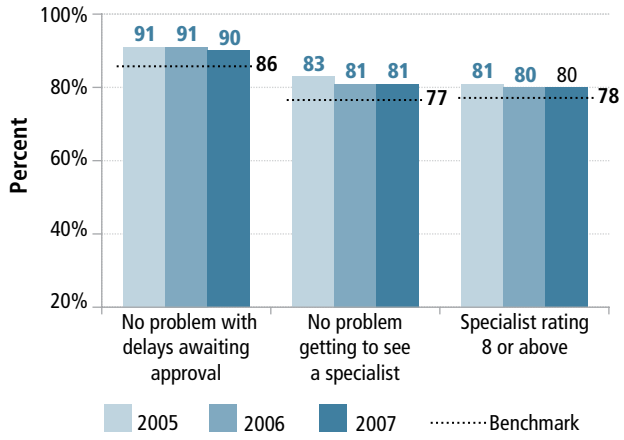
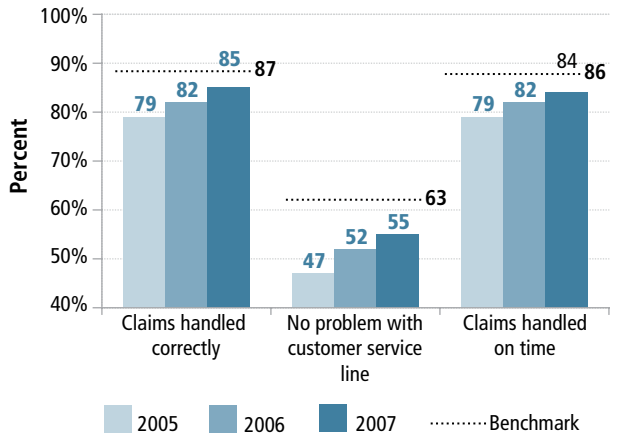


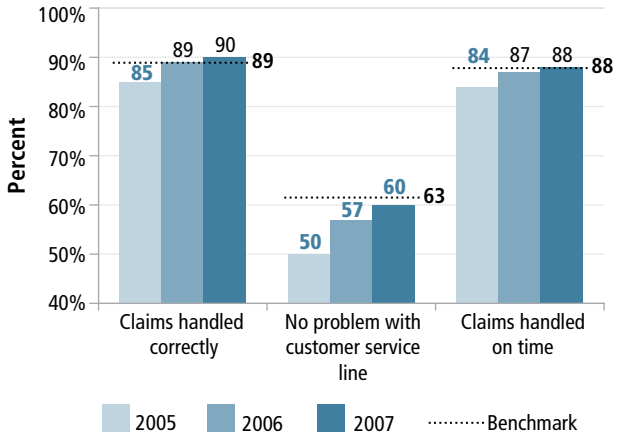
Figure 14 shows that beneficiaries enrolled to direct care report consistent improvement in their interactions with their health plans' claims handling and customer service. The proportion reporting that their claims are usually or always handled correctly has risen from 79 percent in 2005 to 85 percent in 2007, compared to a benchmark of 87 percent. Similarly, timely claims handling has increased from 79 to 84 percent, compared to an 86 percent benchmark. Though still below the benchmark rate, the proportion reporting no problem getting customer service help is 55 percent, compared to the level in 2005 of 47 percent.

Figure 14. Direct care claims handling and customer service



Purchased care users, as shown in Figure 15, have experienced improvements similar to those of direct care users, and their rates for correct claims handling (90 percent) and timely claims handling (88 percent), are similar to the adjusted civilian bench-

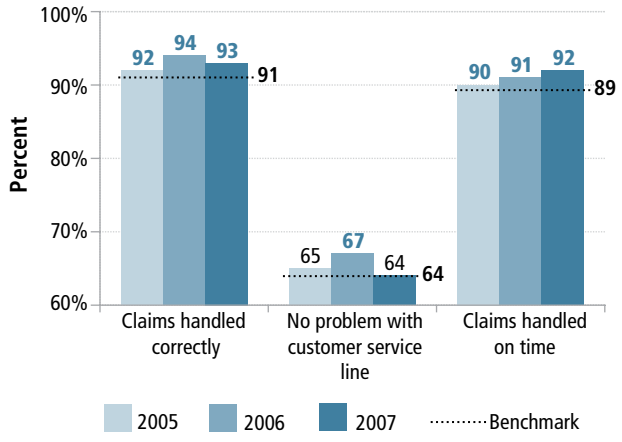
Figure 15. Purchased care claims handling and customer service



marks. The proportion reporting they receive customer service help with no problem has increased from 50 percent to its current level of 60 percent.

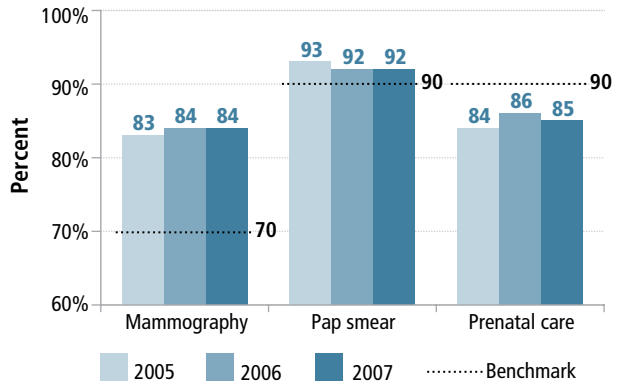
Beneficiaries who rely on their civilian coverage report claims handling and customer service experiences similar to or exceeding the civilian benchmarks, as shown in Figure 16. Rates have not changed substantially between 2005 and 2007.

Figure 16. Beneficiaries with civilian coverage claims handling and customer service



In contrast to the low ratings given to their health care and certain features of their health plans, women enrolled to MTFs are equally or more likely than are other enrollment groups to report that they get appropriate preventive care. As shown in Figure 17, direct care users 84 percent of direct care women over 40 received mammography within the past two years,

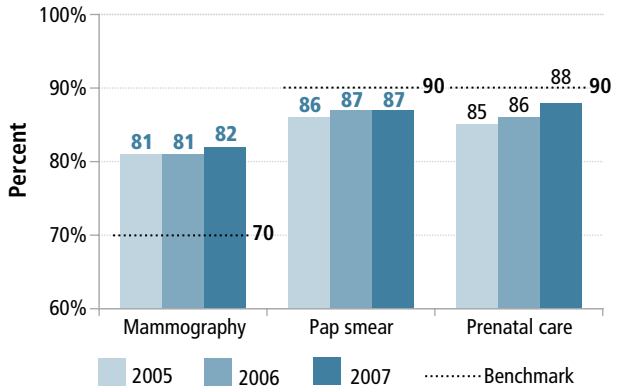
Figure 17. Direct care cancer screening and prenatal care



exceeding the *HP2010* goal of 70 percent. Ninety-two percent of direct care women over 18 received Pap smears in the past 3 years, exceeding the Healthy People goal of 90 percent. Only the proportion receiving first trimester prenatal care, 85 percent, falls short of the *HP2010* goal.

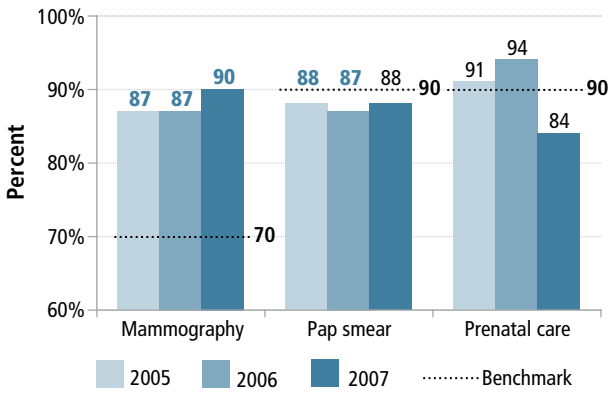
By contrast, as shown in Figure 18, though purchased care women exceed the *HP2010* goal for mammography, 87 percent have Pap smears within the recommended interval, which is less than the target rate. Eighty-eight percent received recommended prenatal care.

Figure 18. Purchased care cancer screening and prenatal care



As shown in Figure 19, the mammography rate of women who rely on civilian insurance exceeds the *HP2010* goal, like that of their TRICARE counterparts, but their Pap smear rate is slightly below the 90 percent target. The prenatal care rate for beneficiaries with civilian coverage is 84 percent, below the *HP2010* goal and lower than in previous years.

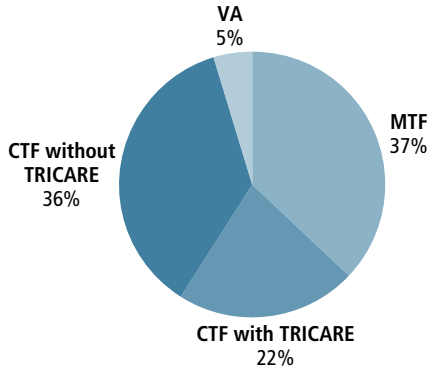
Figure 19. Beneficiaries with civilian coverage cancer screening and prenatal care



Chapter 3. Beneficiaries' Sources of Health Care

Beneficiaries who use civilian insurance, TRICARE for Life, or TRICARE Standard/Extra receive care primarily from civilian providers. Prime enrollees, however, may get care either from civilian managed care support contractors or from military treatment facilities (MTFs) operated by the uniformed services. Thus, the proportion of beneficiaries that gets care primarily from MTFs is less than the proportion enrolled in Prime. Figure 20 divides civilian care users into beneficiaries whose civilian care is covered primarily by a TRICARE plan and those whose care is covered through Medicare or other civilian insurance. The majority of eligible beneficiaries (58 percent) get care primarily from civilian facilities (CTFs). Another 5 percent use VA facilities and 37 percent rely on MTFs.

Figure 20. Patient's usual source of care 2007



As shown in Figure 21, MTF use has dropped since 2005. Forty percent in 2005 described MTFs as their usual source of care. The drop in MTF use corresponds to a 4 percent increase in the use of civilian facilities financed through TRICARE, most of which comes from TRICARE's civilian network, and a one percent drop in non-TRICARE use of civilian providers.Active duty personnel receive the great majority of their care through military providers. However, as shown by Figure 22, family members receive a substantial and growing proportion of their care from civilian providers. Fifty-six percent describe a military provider as their usual source of care, but 35 percent get most of their care from civilian providers, financed by TRICARE, and 9 percent from civilian providers and a civilian health plan. Between

Figure 21. Patient's usual source of care 2005

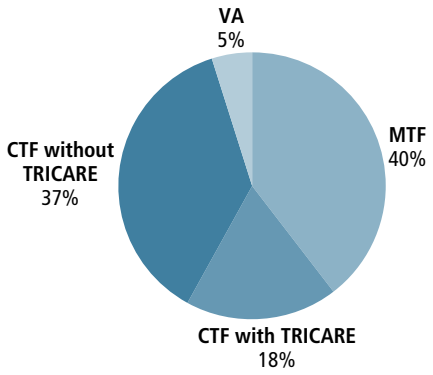
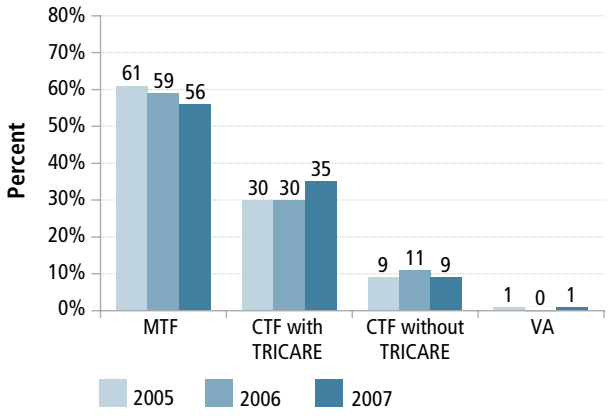


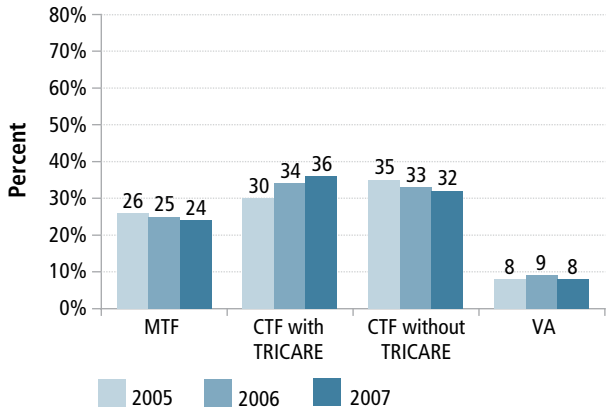
Figure 22. Active duty family members usual source of care



2005 and 2007, MTF use has dropped from 61 percent to 56 percent and CTF use, with and without TRICARE, has risen from 38 percent to 43 percent (not shown).

As shown in Figure 23, the sources of care used by retirees and their dependents has also shown a drop in MTF use but a more pronounced shift from civilian care covered by civilian insurance to civilian care covered by TRICARE. About one in four retirees and their beneficiaries list military providers as their usual source of care, and about two in three designate a civilian provider as their usual source of care. However, civilian providers covered by TRICARE increased from 30 percent to

Figure 23. Retired, less than 65 usual source of care

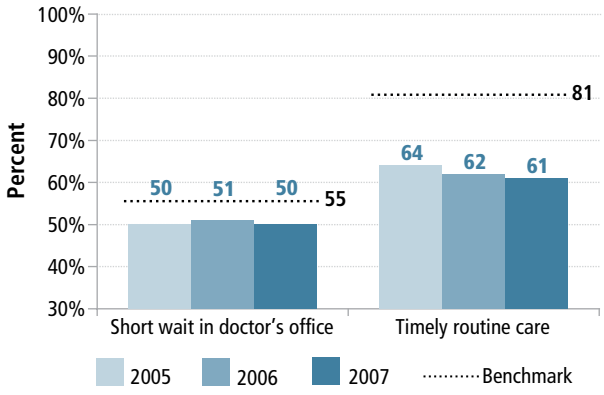


36 percent, while civilian providers reimbursed through private insurance fell from 35 percent to 32 percent during that time. Eight percent of retirees report that they get most of their care from VA providers.

Patients' experiences getting care are assessed using measures concerning the length of time beneficiaries must wait to receive care, either at the doctor's office, or when trying to get an appointment. Measures are presented for MTF users, users of civilian facilities covered by TRICARE or covered by civilian insurance, and VA users. Results for doctors' office waits are similar for all groups, but appointment availability differs.

As shown in Figure 24, MTF users are slightly more likely to experience long waits in a doctor's office compared to the adjusted benchmark. Fifty percent report they usually or always wait less than 15 minutes. By contrast, the proportion that reports consistent timely access to appointments is substantially

Figure 24. Patients' waits at MTFs



below the benchmark. Sixty-one percent report they can usually or always get an appointment when desired compared to a benchmark of 81 percent. The proportion with timely appointments has fallen from 64 percent in 2005.

About half of beneficiaries using their TRICARE coverage at civilian facilities, presented in Figure 25, usually or always experience short waits in the doctor's office, similar to their counterparts at MTFs. However, timely routine appointments to civilian doctors are more readily available than appointments at MTFs. Eighty-three percent report that they usually or always get appointments when they want, similar to the adjusted benchmark.

Figure 25. Patients' waits at civilian facilities with TRICARE

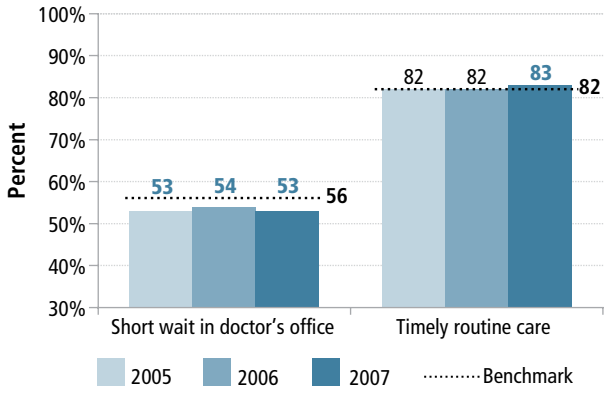
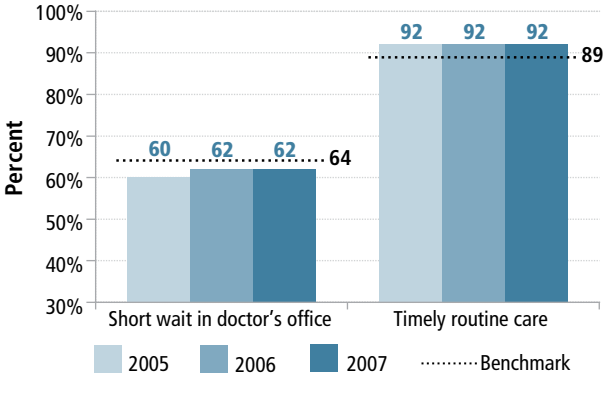


Figure 26 shows that beneficiaries who use civilian providers, when covered by private civilian insurance or Medicare, are, like beneficiaries with TRICARE coverage, able to get timely care in the doctors office and timely appointments. Rates for

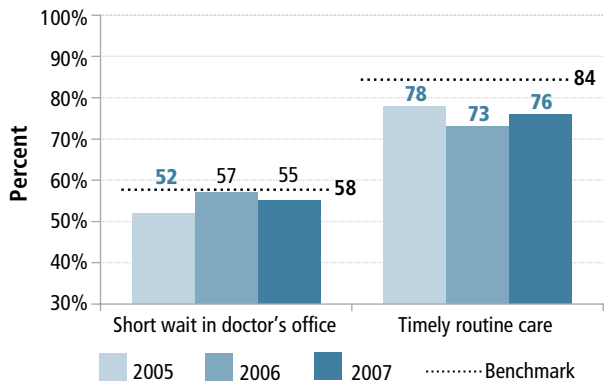
Figure 26. Patients' waits at civilian facilities without TRICARE



short waits in the office are slightly below and, for timely appointments, slightly above the adjusted benchmark.

Users of VA facilities, depicted in Figure 27, like direct care users, experience more difficulty than users of civilian providers, getting timely appointments. The proportion that usually or always gets appointments when desired is 76 percent, below the adjusted benchmark of 84 percent.

Figure 27. Patients' waits at VA facilities



Another important aspect of beneficiaries' experiences with their providers is their interaction with both the office staff they encounter in the doctor's office and with doctors themselves. Figure 28 describes beneficiaries' impressions of the helpfulness of direct care office staff and the amount of time that doctors spend with them. At MTFs the proportion reporting helpful staff and the proportion reporting that doctors spend enough time with them are below the benchmark. Eighty percent report that staff are usually or always helpful, and 77 percent report that doctors usually or always spend enough time with them. The rates have not changed between 2005 and 2007.

Figure 28. Patients' experiences at MTFs

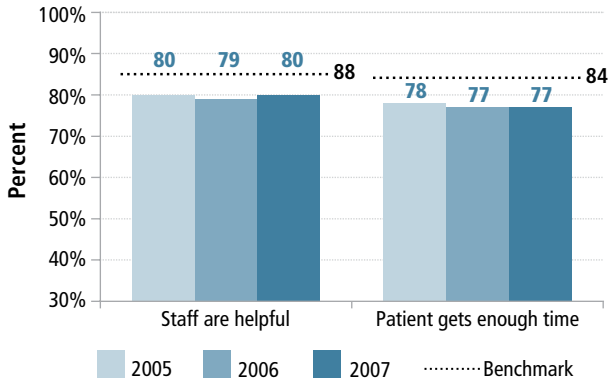


Figure 29 indicates that beneficiaries who use their TRICARE coverage at civilian facilities are more likely to report helpful staff and more likely to report they get enough time with a doctor, compared to MTF users. Rates for both measures are similar to adjusted benchmarks. Figure 30 shows that the results are also similar to the benchmarks when beneficiaries use their civilian health insurance coverage to see civilian providers.

Figure 29. Patients' experiences at civilian facilities with TRICARE

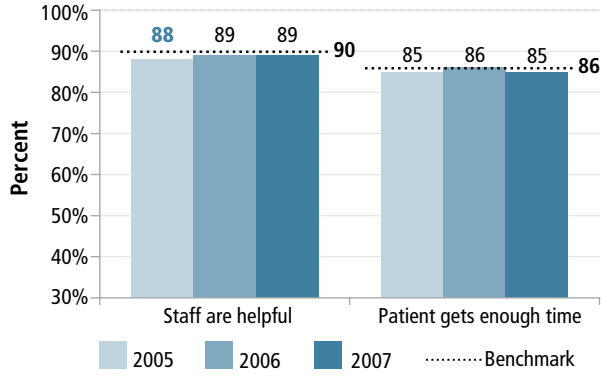
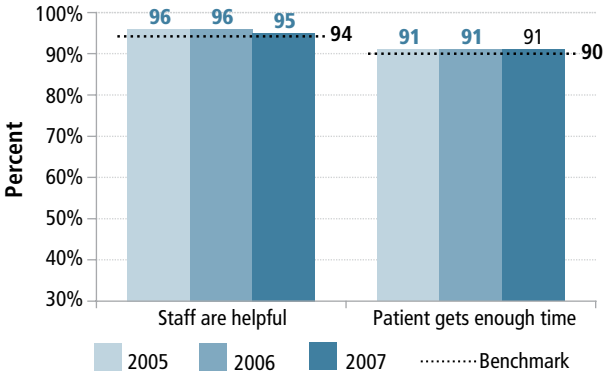
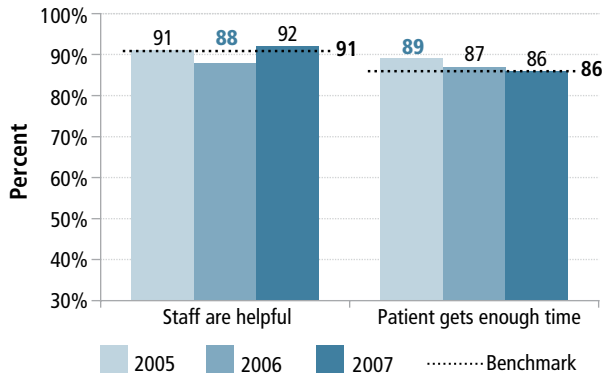


Figure 30. Patients' experiences at civilian facilities without TRICARE



As shown in Figure 31, 92 percent of VA users report that office staff are usually or always helpful and 86 percent report that doctors spend enough time with them. These are similar to adjusted benchmarks and similar to rates in past years.

Figure 31. Patients' experiences at VA facilities



Chapter 4. Variations in Active Duty Health Care Experiences

Results from the HCSDB have consistently indicated that active duty personnel rate TRICARE and their health care lower than do other beneficiary groups.[1] In 2007, to investigate the reasons for the low ratings TMA initiated focus groups with active duty personnel, conducted by Mathematica Policy Research, Inc. Participants in these focus groups described many different reasons for dissatisfaction. During focus groups, active duty beneficiaries reported that their families' experiences weighed heavily on their own health care ratings, and indicated that they perceived providers in the system to sometimes offer perfunctory care and to fail to respect the legitimacy of their health problems.[2]

These results suggest that active duty beneficiaries who differ in rank and in marital status may have different impressions of the system. Therefore, this chapter uses selected questions from the HCSDB to present the variations in active duty personnel's satisfaction with care, access to care, and interactions with providers, according to beneficiaries' age, rank, marital status, and sex. Because age affects ratings strongly, analysis of rank, sex, and marital status is stratified by age.

As shown in Figures 32 through 34, characteristics of active duty respondents vary considerably by age. Though the proportion that is female is fairly consistent, ranging from 15 percent for the group aged 35 through 49, to 21 percent for the group aged 50 to 64, the proportion of officers in the respondent pool increases steadily, from 4 percent for age 18 to 24, to 51 percent in the 50 to 64 age group. The proportion that is married also increases with age, from 38 percent in the 18 to 24 age group to 83 percent in those aged 50 to 64.

Figure 35 shows that ratings of health care and personal doctors increase with age. By both measures, the oldest age group offers substantially higher ratings to both their doctors and their health care. The lowest ratings are given by the group aged 25 through 34. The proportion rating their health care 8 or above ranges from 43 percent in the 25 to 34 age group to 71 percent in the group aged 50 through 64. The proportion giving a high rating

Figure 32. Gender by age grouping for active duty population

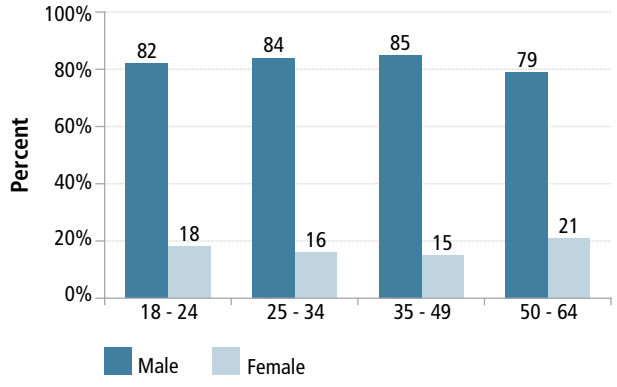


Figure 33. Rank by age grouping for active duty population

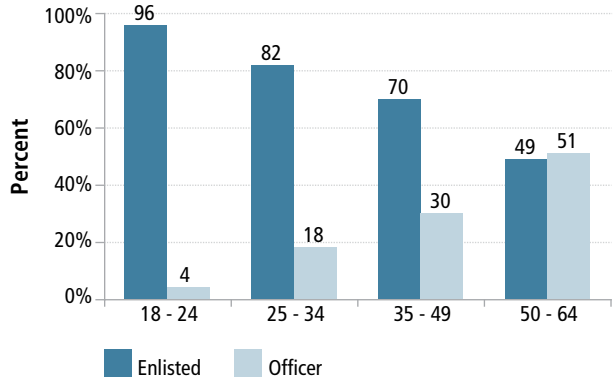


Figure 34. Marital status by age grouping for active duty population

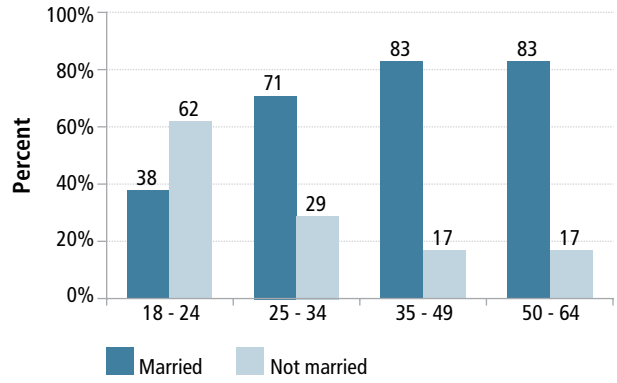
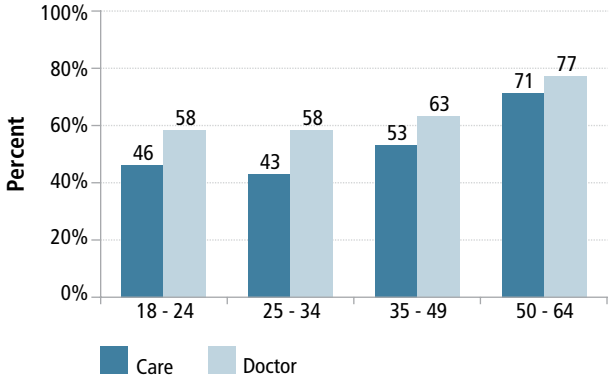


Figure 35. Age and satisfaction measures



to their personal doctor ranges from 58 percent of those aged 18 through 34 to 77 percent of those aged 50 to 64.

Figure 36 shows a similar pattern for beneficiaries' assessment of their interactions with doctors. The proportion that reports doctors always treats them with respect ranges from 46 percent in the 25 through 34 age group to 62 percent in the group aged 50 through 64, and the proportion reporting that they always get enough time with their doctor ranges from 32 percent of those aged 25 through 34 to 48 percent of those aged 50 through 64.

Figure 36. Age and doctor measures

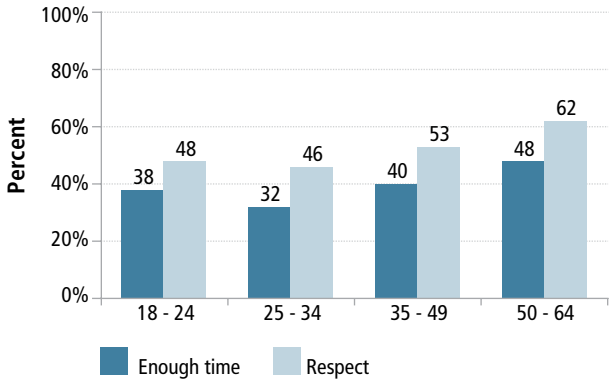
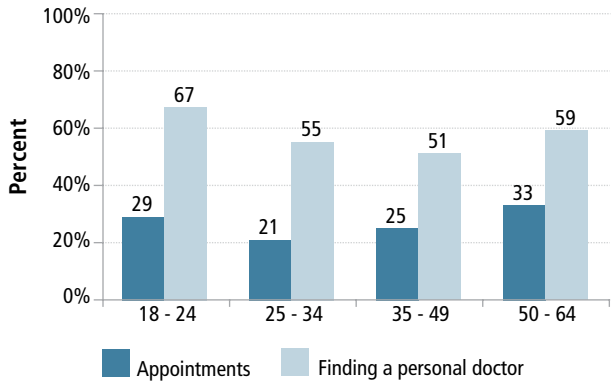


Figure 37 indicates that the proportion reporting appointments are always available when desired is lowest in the group aged 25 through 34 (21 percent) and highest in the oldest age group (33 percent). By contrast, Figure 37 shows that satisfaction with access to personal doctors is highest in the youngest age group. Sixty-seven percent of active duty beneficiaries aged 18 through 24 report no problem finding a personal doctor, compared to 51 percent in the group aged 35 through 49.

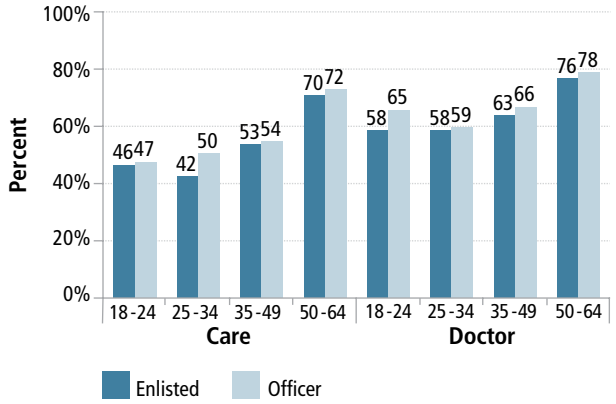
Figure 37. Age and access measures



General Satisfaction

Figure 38 indicates that ratings of health care differ according to whether the active duty beneficiary is an officer or enlisted person. In this figure, officers and warrant officers are compared to enlisted personnel. Controlling for age, a significantly higher proportion of officers than enlisted personnel give their health

Figure 38. Age and rank and satisfaction measures



care a high rating. The pattern is similar for personal doctors' ratings, though the age-stratified difference is not statistically significant. Figure 39 indicates that the difference in ratings by marital status does not exhibit a consistent pattern. In both the youngest and oldest groups, ratings for both health care and personal doctors appear to be higher for the unmarried, a pattern that is not visible in the middle age groups. Figure 40 shows that health care and personal doctor ratings do not differ consistently by the sex of the beneficiary, though males in the younger age groups appear to rate their personal doctors higher than do

Figure 39. Age and marital status and satisfaction measures

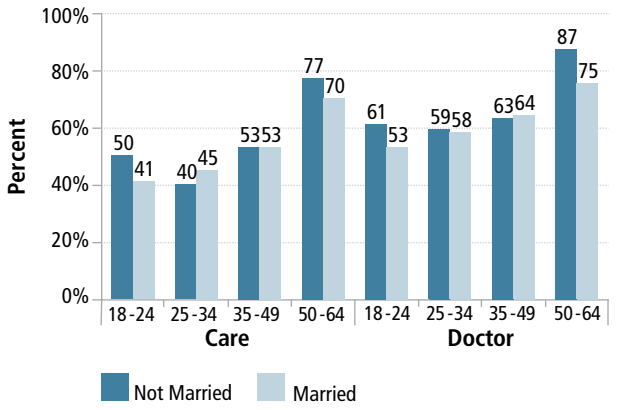
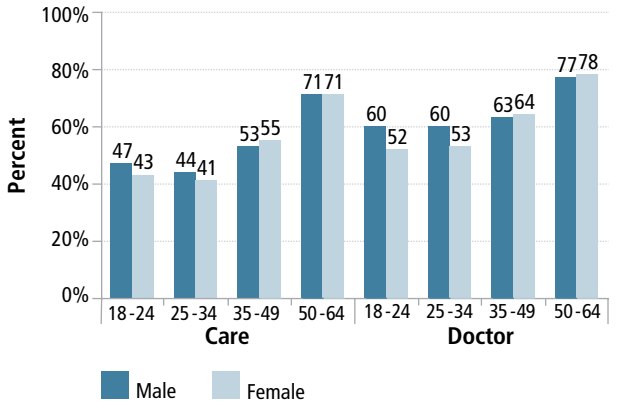


Figure 40. Age and gender and satisfaction measures

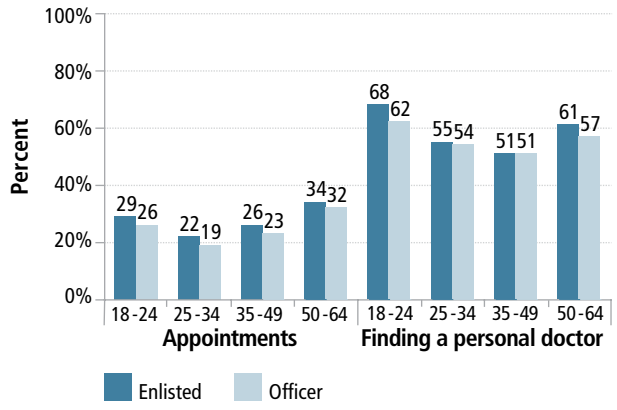


their female counterparts. The proportion of males giving their personal doctors ratings of 8 or higher exceeds the proportion of females by 8 percent in the group aged 18 to 24, and by 7 percent in the group aged 25 through 34.

Access

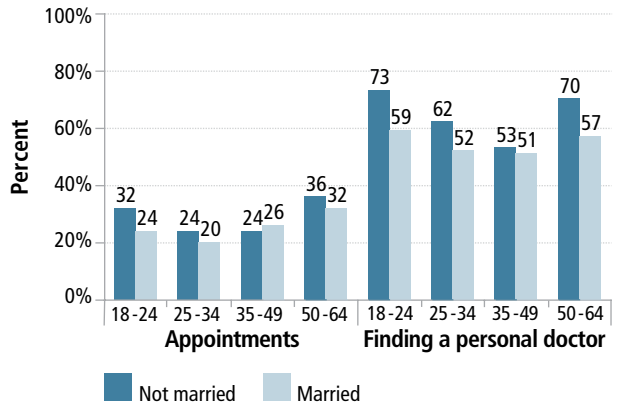
Results in Figure 41 show that officers do not report superior access, measured either by ability to find a satisfactory personal doctor, or ability to make appointments when desired, compared to enlisted personnel. In fact, although the age-stratified difference by rank in the proportion of those with no problem finding a personal doctor is not statistically significant, a higher proportion of enlisted personnel in all age groups report problem-free access, and enlisted personnel are significantly more likely (not shown) than officers to report they can get appointments when desired than are officers, controlling for age.

Figure 41. Age and rank and access measures



Results in Figure 42 show that married personnel are significantly less satisfied with their ability to find a personal doctor than are unmarried personnel. The difference by marital status is 10 percent or greater in all age groups but 35 to 49. By contrast, the ability to get appointments shows no consistent pattern by

Figure 42. Age and marital status and access measures



marital status. Figure 43 indicates that female personnel are substantially less satisfied with their ability to find a personal doctor than are male personnel, a difference that is pronounced in all age groups.

Interactions with Providers

According to Figure 44, officers report more favorably about their interactions with doctors than do enlisted personnel.

In particular, enlisted personnel between the ages of 25 to 34 and 50 to 64 were less likely than officers to report their providers always spent enough time with them (31 percent versus

Figure 43. Age and gender and access measures

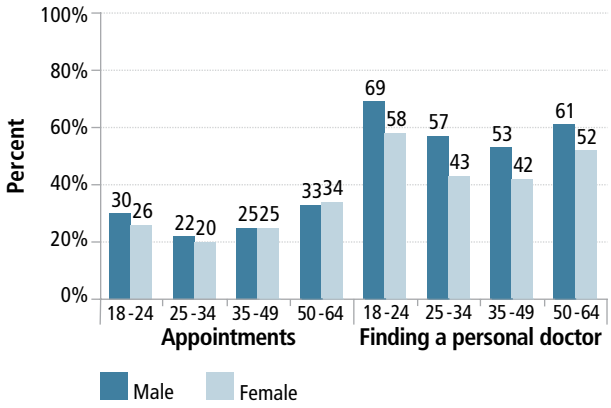
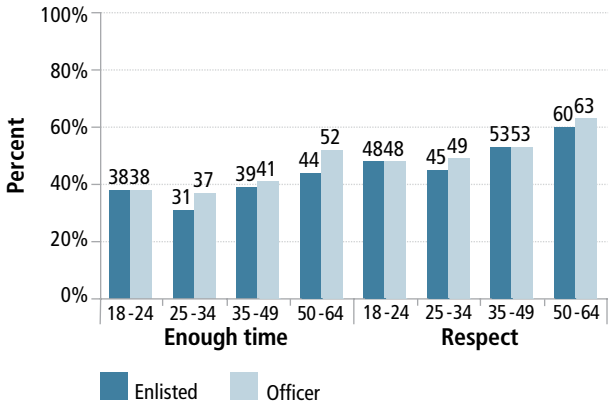


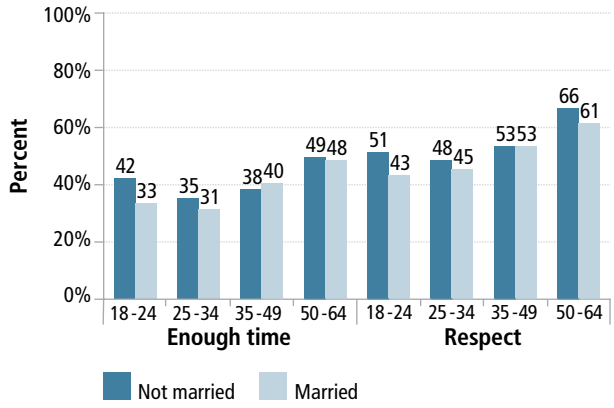
Figure 44. Age and rank and doctor measures



37 percent, and 44 percent versus 52 percent, respectively). The age-stratified difference by rank is significant. Though the proportion of enlisted personnel that report always being treated with respect is less that than the proportion of officers in all age groups, the differences and the overall age-stratified difference are not significant.

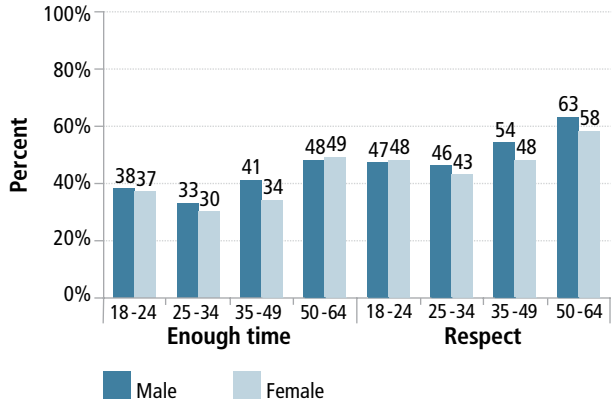
Married beneficiaries between the ages of 18 to 24 were less likely than unmarried beneficiaries to report feeling that providers always respected what they had to say (43 percent versus 51 percent; see Figure 45). Similarly, married beneficiaries between the ages of 18 to 24 and 25 to 34 were less likely than unmarried beneficiaries to report that providers always spent enough time with them (33 percent versus 42 percent, and 31 versus 35 percent). By both measures, controlling for age, married beneficiaries were significantly less satisfied than unmarried beneficiaries with their doctor-patient relations.

Figure 45. Age and marital status and doctor measures



The age-stratified differences in satisfaction with patient-doctor relations between males and females, presented in Figure 46, are not statistically significant. However, in most age groups, the proportion of females reporting they always get enough time or are treated with respect appears to be lower than the proportion of males.

Figure 46. Age and gender and doctor measures



These results indicate that active duty personnel perceive the quality of health care provided substantially differently depending on their age, rank, and marital status. In most cases the oldest age group is the most satisfied and the group aged 25 through 34 appears least satisfied. Results contrasting officers and enlisted show that officers and enlisted are unhappy with different aspects of their care. Though officers rate their care and interactions with doctors higher than do enlisted personnel, they are less satisfied according to access measures.

Married personnel appear less satisfied than unmarried personnel by several measures. In particular, married personnel report they are less satisfied with their ability to find a personal doctor. Female beneficiaries are also substantially less satisfied than are their male counterparts. This difference may reflect greater dissatisfaction with the scarcity of personal doctors in the MHS among female beneficiaries. The dissatisfaction of married active duty personnel may reflect the unhappiness of the wives of this predominantly male group with the availability of personal doctors. This dissatisfaction may be due to the specialty of the available providers or to the fact that in most cases a stable patient-doctor relationship does not exist. By the same token, greater dissatisfaction among married beneficiaries with patient-doctor interactions may also reflect the experience of their spouses. Future surveys will investigate the reasons for these differences.

Chapter 5. Health Status and Health-Related Behavior of Retirees

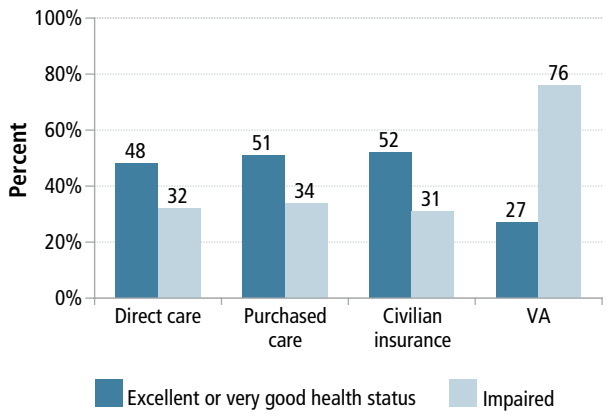
As retirees age, healthy lifestyle choices and regular receipt of preventive care services are an increasingly important component of preserving health and reducing morbidity and mortality. Overcoming obesity and tobacco addiction can reduce or delay a person's risk of mortality from heart disease and some cancers, as well as other diseases. Similarly, earlier detection of cancer may improve the likelihood of survival. For instance, the CDC estimates that mammography screening can reduce mortality from breast cancer 20 to 35 percent in women aged 50 to 69 and up to 20 percent in women aged 40 to 49.

People who have health insurance and a usual source of care are more likely to receive preventive services.[3] Among people with health insurance coverage, there is some evidence to suggest that those who are enrolled in managed care options are more likely to receive preventive services than those enrolled in fee-for-service options.[4,5] Other research has found that a physician recommendation is strongly associated with receiving preventive care.[6-10]

This chapter presents results from the HCSDB fielded in FY 2007, describing health status and preventive care of retirees under the age of 65. Preventive care is compared between those with direct care and those with purchased care, civilian insurance, or VA benefits.

Self-reported health status is strongly correlated with physical and mental health and with chronic conditions. As seen in Figure 47, approximately half of non-VA retirees reported themselves as having excellent or very good health (48 percent versus 51 percent and 52 percent, respectively). Retirees with direct care were somewhat less likely than retirees with purchased care or civilian insurance to report excellent or very good health. Only 27 percent of retirees who primarily use their VA benefits reported excellent or very good health.

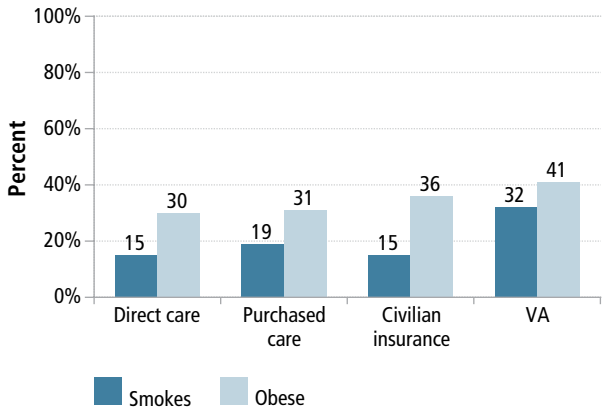
Figure 47. Self-reported health status



Functional limitations are another indication of health status. Retirees with direct care and retirees with purchased care reported similar levels of impairment (32 percent versus 34 percent, respectively). In contrast, over 75 percent of VA retirees reported an impairment or health problem.

Lifestyle factors such as obesity and tobacco use are important determinants of health. Obesity is related to activity limitation and to premature mortality due to diabetes and heart disease, while smoking contributes to heart disease, cancer, and pulmonary disease. As shown in Figure 48, obesity rates among MHS beneficiaries range from 30 percent for direct care users to 41 percent for those with VA benefits. Retirees with civilian insurance and VA benefits reported obesity at a rate significantly higher than did retirees with direct care.

Figure 48. Lifestyle factors



Like obesity, smoking appears to be most prevalent among beneficiaries who rely on the VA for their health plan. Thirty-two percent report that they currently smoke. Among other MHS beneficiaries, smoking rates range from 15 percent with direct care to 19 percent with purchased care.

As shown in Figure 49, over 70 percent of all retirees who smoke reported being advised by their doctor to quit smoking in the past 12 months. VA smokers were more likely to be advised to quit smoking than those with other insurance (90 percent). Among other health plans, counseling rates vary from 72 percent with civilian insurance to 77 percent of direct care users.

Figure 49. Advised to quit smoking

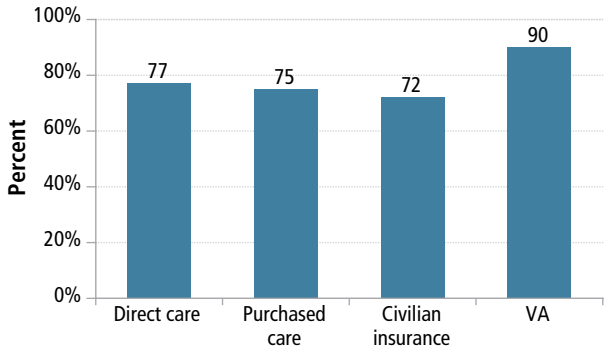
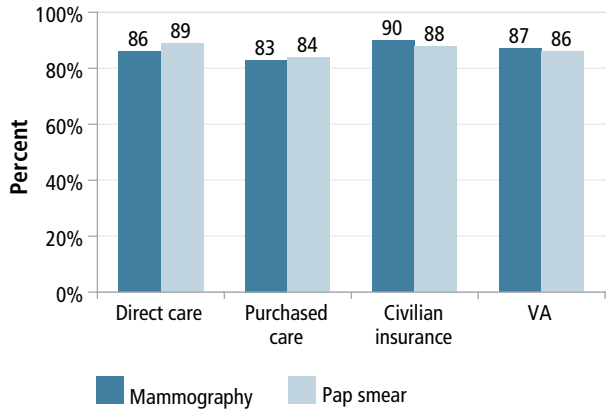


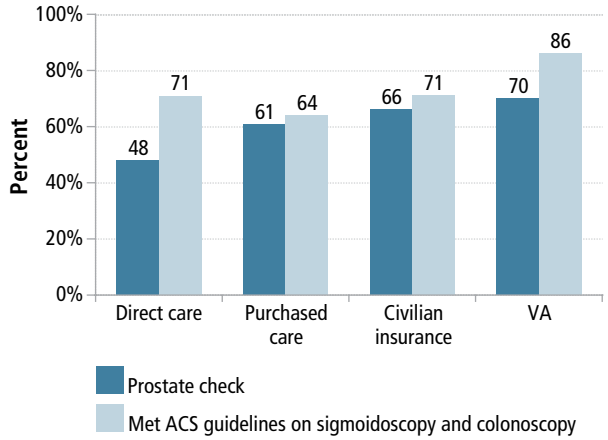
Figure 50 shows that a high proportion of retired women and female dependents of retirees in all health plans receives appropriate cancer screening. Mammograms every two years are recommended for women aged 40 or higher to detect breast cancer. The cervical cancer recommendation for women aged 30 and older is a Pap smear every three years, assuming no history of cervical cancer and three previous normal tests. The mammography rate is lowest for women who rely on purchased care (83 percent) and highest for those with civilian insurance (90 percent). The Pap smear rate ranges from 84 percent for women using purchased care to 89 percent who rely on direct care.

Figure 50. Women cancer screening



The American Cancer Society (ACS) recommends screening for colon and rectal cancer beginning at the age of 50, assuming no other risk factors, and offers a choice of annual fecal occult blood tests, sigmoidoscopy at five year intervals, or a colonoscopy every 10 years. As shown in Figure 51, among retirees aged 50 to 65, those with purchased care were less likely than those with direct care to have met the ACS screening guidelines (64 percent versus 71 percent). Approximately 86 percent of retirees with VA benefits reported meeting the ACS screening guidelines, higher than retirees with any other health insurance.

Figure 51. Cancer screening



Evidence for the benefits of prostate cancer screening is weak, and, unlike screening for the other cancers described in this chapter, the American Preventive Services Task Force does not recommend prostate cancer screening. Nonetheless, many beneficiaries reported having received a prostate check in the past two years. This screening rate is lowest among direct care beneficiaries (48 percent), and substantially higher among purchased care users and users of civilian health insurance. The highest rate was reported by VA users (70 percent).

Results from this chapter indicate some substantial differences in health status, lifestyle, and preventive care use among retirees using different health plans. Users of direct care, purchased care, and civilian health insurance report generally good health and lifestyle indicators and preventive care comparable to those of the civilian population. VA users differ substantially from other beneficiaries, in their poorer health status, less healthy lifestyle, and—as reflected in colon cancer and prostate screening—greater use of preventive care.

Among users of other health plans, there is no appreciable difference in health status. However, users of purchased care appear slightly less likely to receive recommended screenings or to have a healthy lifestyle than direct care users. Direct care users are less likely than users of purchased care or civilian health plans to have undergone a prostate check. The difference may be due to a more guideline-driven and less customer- or profit-driven approach to health care among direct care providers.

Chapter 6. Disparities in Use of Behavioral Health Services

Behavioral health care has been a source of increasing concern to MHS leadership in recent years. Research has documented barriers to access for active duty personnel, and needs for treatment by returning veterans of the conflicts in the Middle East. Results from the HCSDB have also indicated that family members of active duty personnel suffer stress, both related to deployment and other aspects of military life, that may result in the need for treatment or counseling. The 2007 HCSDB Annual Report compared needs and access to care of active duty and other beneficiary groups, finding that active duty personnel did not report greater needs or more unmet needs than their family members or than retirees.

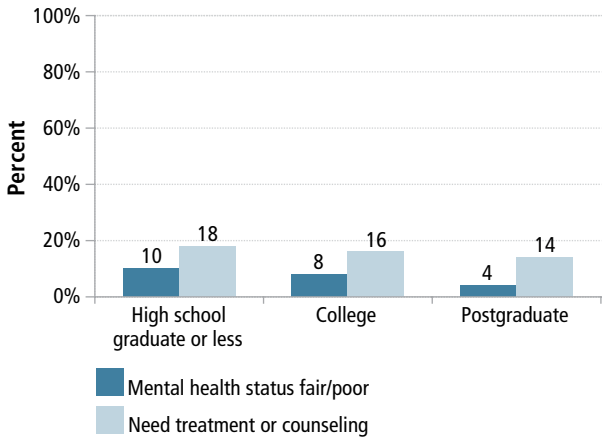
This chapter investigates the relation between mental health needs and access to treatment in the military health system and education, sex, and race, all of which are predictors of utilization of mental health services. Research suggests disparities in the civilian world that result in more mental health treatment for the educated, females, and whites. Compared to people without a high school education, people who graduated from high school typically report better mental health status and higher utilization of mental health services among those requiring services.[11] Higher use may result because people with higher levels of education also have higher levels of health literacy, or "the ability to read, understand, and act on health care information."[12] Women appear to be more likely than men to receive treatment for mental health problems.[13,14] There are few reliable nationwide estimates of racial and ethnic differences in mental health,[15] but evidence suggests that non-Hispanic blacks (hereafter referred to as blacks) are less likely to suffer from depression and other psychiatric disorders than non-Hispanic whites (hereafter referred to as whites).[16] Other research suggests that blacks requiring treatment are less likely to receive it.[17]

Data from the HCSDB fielded in 2006 and 2007 are analyzed in this chapter to determine whether behavioral health needs and access to behavioral health treatment vary within the MHS by sex, education, and race.

Needs

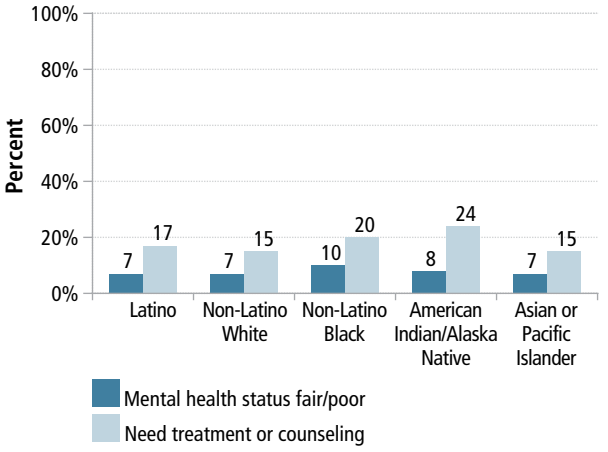
The survey contains two measures of need for behavioral health care: self-rated mental or emotional health, and need for treatment or counseling for personal or family problems. As seen in Figure 52, higher education appears to be associated with better mental health. Beneficiaries with a postgraduate education are less likely to report fair or poor mental health (4 percent) compared to those with either a high school degree or less (10 percent) or with a college education (8 percent). Beneficiaries with a postgraduate education were also less likely to report needing treatment or counseling services than people with a high school or college education (14 percent versus 18 and 16 percent, respectively).

Figure 52. Mental health needs by education



Mental health status and satisfaction also vary by race and ethnicity. As shown in Figure 53, the proportion reporting fair or

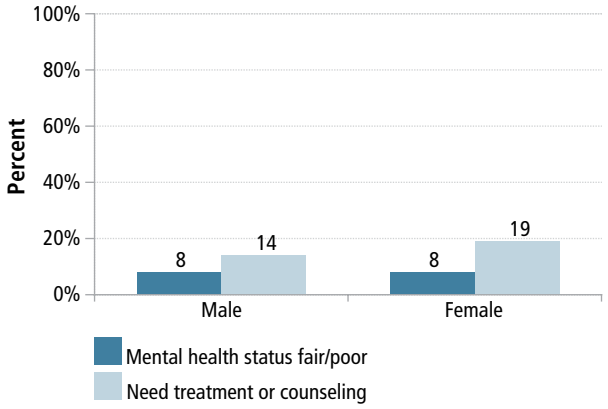
Figure 53. Mental health needs by race



poor mental health is highest for blacks (10 percent). Reported need for treatment or counseling shows a somewhat different pattern. Approximately 15 percent of whites and Asians or Pacific Islanders reported needing treatment or counseling services. In contrast, the proportion of blacks, Latinos, and American Indians/Alaskan Natives (AIAN) who reported needing treatment or counseling services was higher than the proportion of whites, ranging from 17 percent for Latinos to 24 percent for AIAN.

Women experience greater need than men for behavioral health care, though they are equally likely to report poor or fair mental health status. As seen in Figure 54, women were no more likely than men to report having fair or poor mental health but more likely to report needing treatment or counseling services (19 percent versus 14 percent).

Figure 54. Mental health needs by gender



Experiences with Care

The survey contains two measures of beneficiaries' experience seeking behavioral health care: reports of problems getting care, and rating of treatment received on a scale from 0 to 10. Figure 55 indicates that differences in access by educational status are small. The proportion reporting no problem getting needed treatment or counseling ranges from 65 percent of postgraduates to 70 percent with high school education or less, a difference that is not statistically significant. Similarly, ratings of care are almost indistinguishably different among education groups. The proportion rating its care 8 or above ranges from 52 percent with college education to 54 percent with high school education or less.

Figure 55. Mental health care by education

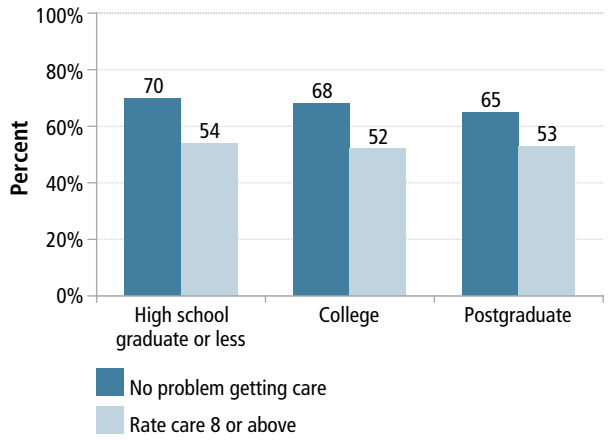


Figure 56 indicates that AIAN experience the greatest problem of any racial or ethnic grouping getting access to treatment or counseling. Only 55 percent of AIAN reported no problem getting needed treatment or counseling. By contrast, blacks were least likely to report problems (74 percent reported no problem). AIAN were most likely to rate their care low (41 percent) of all races and ethnicities, and blacks were most likely to give their care a high rating (58 percent).

Figure 56. Mental health care by race

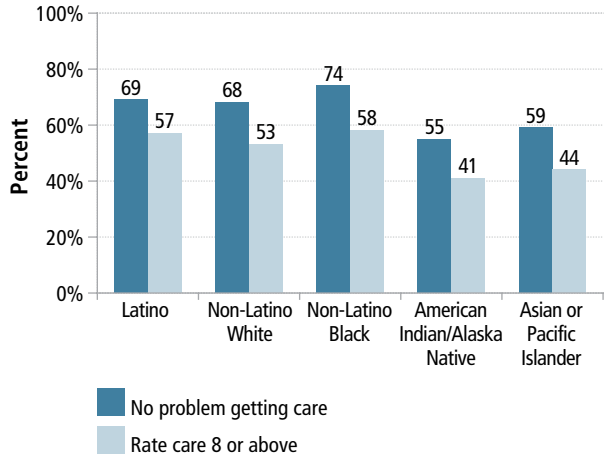
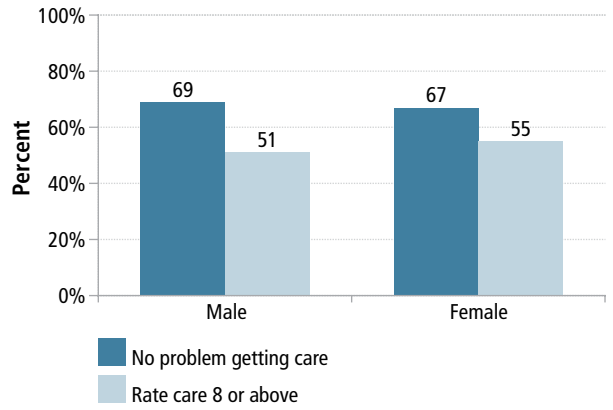


Figure 57 shows that care-seeking experiences differ little between males and females. Sixty-nine percent of men and 67 percent of women reported no problem getting care, while 55 percent of women and 51 percent of men gave their care a high rating. Neither difference is statistically significant.

Figure 57. Mental health care by gender



Conclusions

The results show that fewer than 10 percent of beneficiaries report fair or poor mental health but that about one-sixth need some sort of treatment or counseling during the year. According to HCSDB results, needs for treatment or counseling in the MHS population vary by education level, race, and gender.

The results also indicate that most beneficiaries who need it have no problems getting the care they need, and rate their care 8 or above on a 0 to 10 scale. However, results also show that access to care, though it does not vary significantly by education or gender, does vary by race, as do beneficiaries' ratings of their care. The results suggest that additional investigation of providers' cultural sensitivities, or of the specific needs of different ethnic populations, may improve the delivery of care in the MHS.

Chapter 7. Mental Health Status and Service Use of Children in the MHS

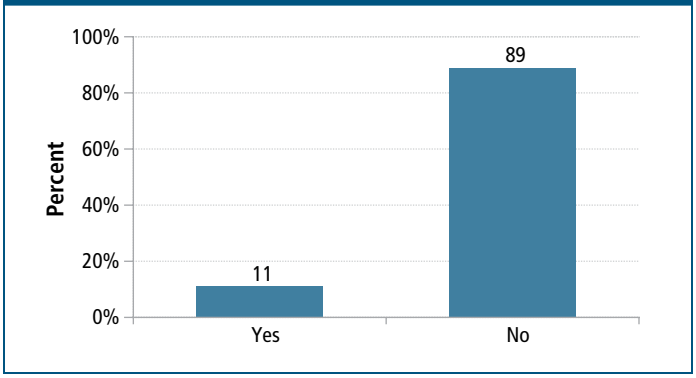
Nationally, only half of children with a mental health problem received mental health services during the past year and as many as 80 percent do not receive care from a psychologist, psychiatrist, or other mental health specialist provider.[18,19] Depression and anxiety are particularly under-recognized and untreated mental health problems among children.[20,21]

Children do not receive mental health services for several reasons including inadequate insurance coverage and high out of pocket costs,[22] scarcity of mental health care providers,[23] and the negative perceptions that parents sometimes have toward child mental health services.[24]

Questions were added to the 2007 HCSDB child questionnaire in order to assess the use of services and medications for mental health problems among DoD children. Parents reported whether their children had emotional, developmental, or behavioral problems and whether their children were receiving medications or specialty care for these problems. In addition, parents reported whether mental health services met the child's needs and whether the parent perceived barriers to receiving specialty mental health care.

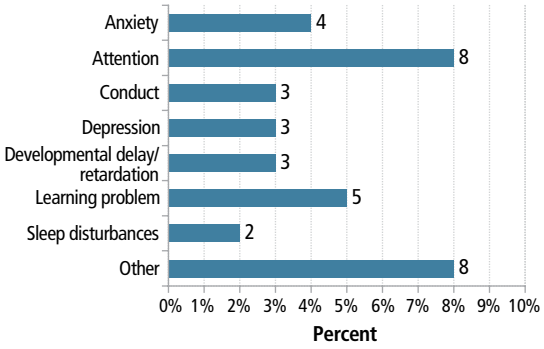
Eleven percent of parents reported that their child had an emotional, developmental, or behavioral problem for which the child needed or received treatment or counseling during the past 12 months (Figure 58). This proportion is slightly lower than the 13 to 23 percent of children with mental health problems identified in the civilian community using the Diagnostic Interview Schedule for Children (DISC) and the Child Behavior Checklist.[25-27] The proportion identified in the HCSDB was also less than the 18 percent of children age 6 to 17 years who were identified using the DISC among a small sample of families living on a military post.[28] However, rates are not directly comparable. Those studies used well-validated, comprehensive measures of mental disorder that were not contained in the HCSDB.

Figure 58. Any emotional, developmental, or behavioral problem that requires treatment



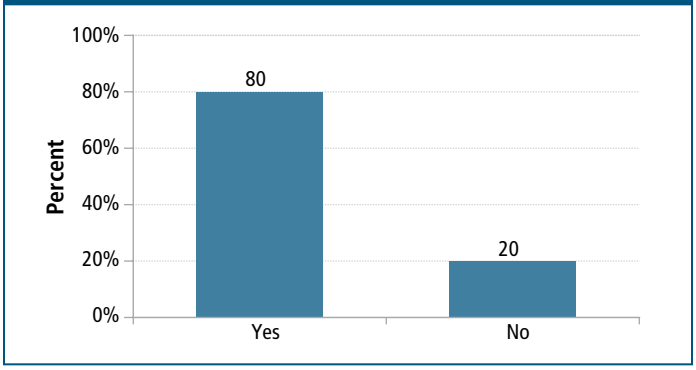
In response to a question where parents were invited to list problems with which their child that had been diagnosed, 21 percent of parents reported that a health professional had identified one or more emotional, developmental, or behavioral problems (not shown), a rate more comparable to that found in previous studies. Problems with attention (8 percent), learning (5 percent), and anxiety (4 percent) were the most commonly reported, while sleep disturbance (2 percent) was the least commonly reported (Figure 59). Eight percent reported that a health professional told them their child had been diagnosed with some type of emotional, developmental, or behavioral problem, other than the listed types. These children may have had an unspecified mental health problem not meet diagnostic criteria for a disorder as have been found in other studies.[29]

Figure 59. Proportion of children with mental health problem as identified by health professional



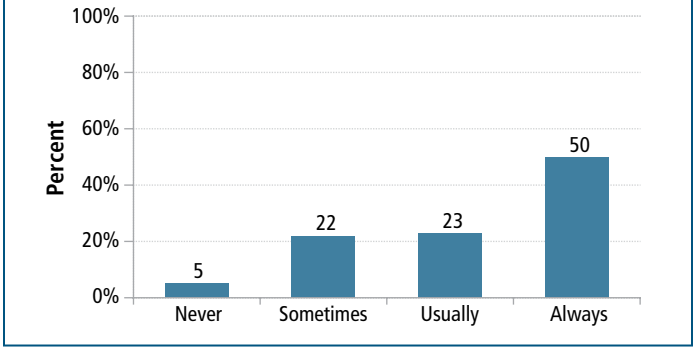
Among children with a personal doctor whose parent reported that the child required any specialty health care during the past 12 months, 20 percent of parents reported that either the parent or a doctor thought that the child needed to visit a mental health counselor, psychologist, psychiatrist, or mental health social worker during the past 12 months. Among these children, nearly 80 percent had at least one visit to a mental health specialist in the past 12 months (Figure 60).

Figure 60. Visited mental health specialist when parent or doctor thought child needed speciality mental health care



Across all health plans, 50 percent of parents with a child who visited a mental health specialist during the past 12 months reported that this care always met their child's needs, 23 percent reported that care usually met their child's needs, 22 percent reported that care sometimes met their child's needs, and 5 percent reported that care never met their child's needs (Figure 61).

Figure 61. Received needed care from mental health specialist



As shown in Figure 62, parents' ratings of their children's mental health varied according to their health plan. Sixty percent of parents whose child uses Standard/Extra reported that child mental health services always met their child's needs compared with 49 percent of parents of children enrolled in Prime. The proportion of parents who responded that mental health services never or sometimes met their child's needs was less among Standard/Extra users compared to Prime enrollees.

Parents of the 20 percent of children who did not receive specialty mental health services in spite of a need perceived by parent or doctor reported their reasons for not receiving care (Figure 63). Eighteen percent reported not being able to locate a mental health specialist in the child's health plan or network, 14 percent reported that there were not enough mental health

Figure 62. Child received needed care from mental health specialist by health plan

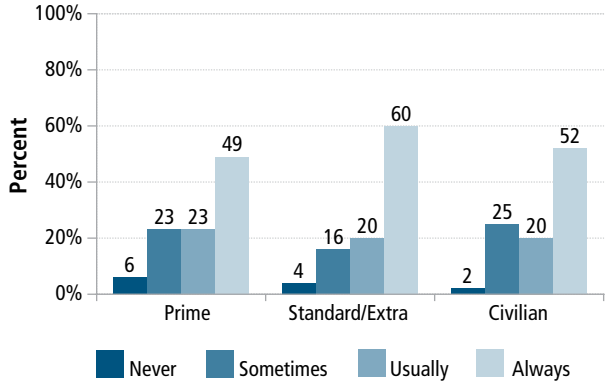
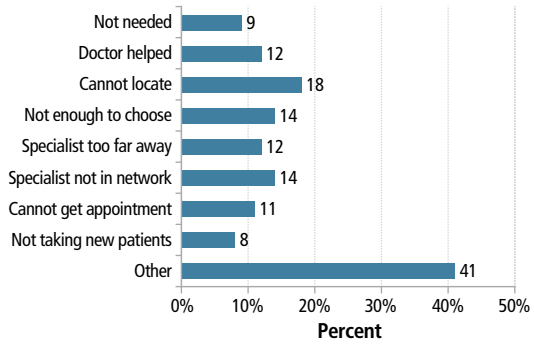


Figure 63. Reasons for not visiting child mental health specialist during past 12 months



specialists in the network, 12 percent reported that a specialist was located too far away, and 12 percent reported that the child's regular doctor or nurse was able to help with the problem instead of a specialist. Nine percent reported not visiting a specialist because the parent believed that such care was unnecessary. Forty-one percent of parents reported an unspecified "other" reason.

Among children who had a behavioral, emotional, or developmental problem that required counseling or treatment (as reported by the parent), 51 percent received medication for this problem during the past 12 months (not shown).

In sum, according to the HCSDB, a lower proportion of children were identified by their parent or a health professional as having an emotional, developmental, or behavior problem than in previous community-based epidemiological studies using standard measures of mental health. This finding may be due to differences in the survey instrument used to identify mental health problems. It also may be due to tendency, found in some

research, for health professionals' to under-identify mental health problems.[30,31]

The survey findings suggest that among children with a personal doctor who needed to consult a mental health specialist during the preceding 12 months, most had seen such a specialist. Most of these parents reported that the specialist or specialists usually or always met their child's needs, though parents of children covered by Standard/Extra were more likely than parents of children enrolled in Prime to report this. Parents of children who required but did not receive mental health services reported several reasons for not visiting a mental health specialist. These reasons included the inability to locate a specialist and the proximity of specialists. Many parents reported an "other" unspecified reason for not visiting a mental health specialist, which may merit further investigation.

Chapter 8. Quality of Communication with Children's Health Care Providers

The quality of communication between health providers and patients has a direct influence on patient satisfaction, treatment compliance, and health status.[32] The characteristics of physician communication that contribute to positive health outcomes include friendliness, courtesy, empathy, reassurance, and the clear explanation of health problems and treatments.[32] In addition, visits that are for a longer duration of time and that include shared decision-making between the physician and patient lead to positive health outcomes.[33,34]

Communication in pediatric health care settings is especially important because parents typically have concerns about their child's physical, social, and emotional development.[35] Such concerns require providers to carefully explain child development and health conditions in a manner that parents can understand and that reduces parental anxiety.[36,37] In addition, because many children are able to report on their health conditions, direct communication between the health provider and child, while less common, contributes to parental satisfaction with care and positive outcomes.[38-41]

As part of the 2007 HCSDB child questionnaire, parents reported their perceptions of communication with their child's doctors and other health providers. Parents also reported their perceptions of whether health providers spent enough time with their child and were able to communicate with their child.

Most parents reported positive interactions with their child's health providers (Figure 64). Between 94 to 97 percent of parents across health plans reported that the child's provider usually or always explained things in a manner that the parent could understand. Ninety to 96 percent of parents across health plans reported that their child's provider usually or always respected what the parent had to say. In all three plans, parents appear to be less satisfied with the time their physician could spend with their child than with the physician's explanations and respectfulness.

Parents with children enrolled in a civilian health plan or Standard/Extra reported more positive interactions with their child's providers than parents with children enrolled in Prime, by all measures. For example, 86 percent of parents with a child enrolled in Prime reported that the provider usually or always spends enough time with their child, compared with 91 percent of parents with a child enrolled in Standard/Extra and 93 percent of parents with a child enrolled in a civilian plan.

Parents' satisfaction with physicians' efforts to address their concerns about their children's health also varies by health plan. Figure 65 presents the proportion of parents in each health plan that report they usually or always got specific information from their provider, that their providers usually or always made it easy to discuss their concerns, and that their provider usually or always answered their questions. By all three measures, parents with children enrolled in Standard/Extra or a civilian plan reported more satisfactory interactions with their children's doc-

Figure 64. Interaction with doctor, by health plan

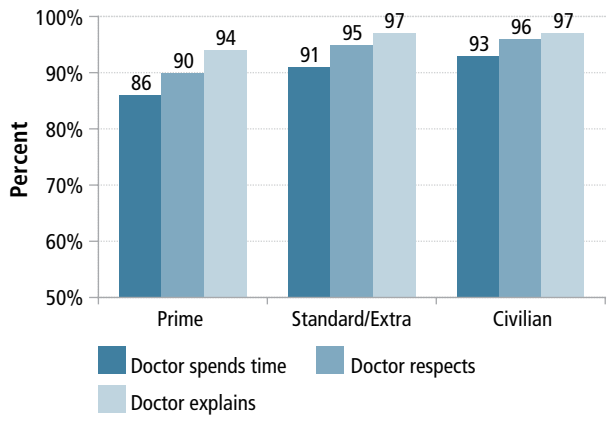
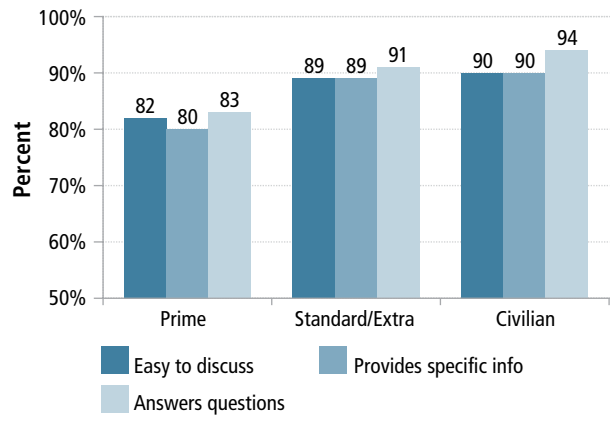


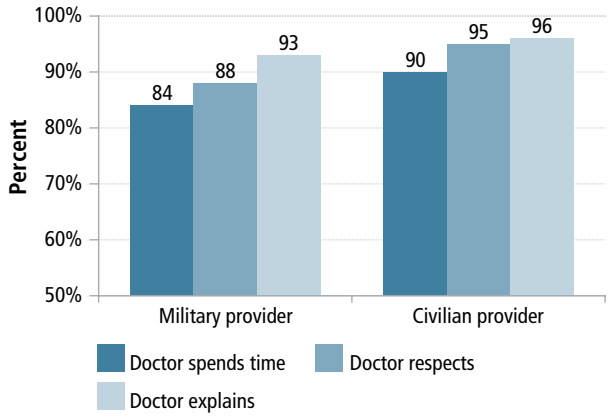
Figure 65. Doctors' ability to address parents' concerns, by health plan



tors. For example, 94 percent of parents with a child enrolled in a civilian plan reported that the provider usually or always answered the parent's questions, compared with 83 percent of parents with children enrolled in Prime. However, for all health plans, fewer parents reported that it was easy to discuss their concerns or to get specific information from their doctor than said they could get their doctor to answer questions.

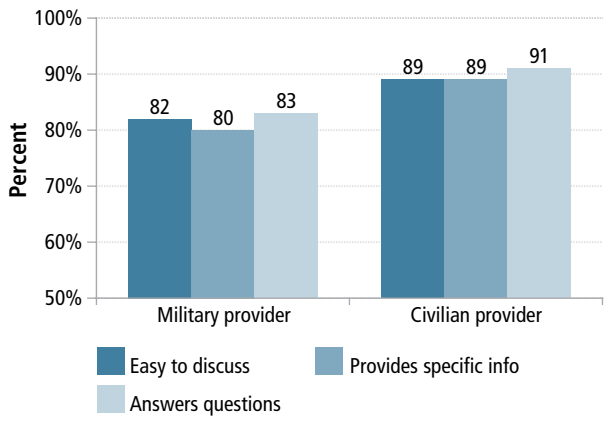
The difference between health plans appears primarily due to differences in interactions with civilian and military providers. As shown in Figure 66, parents of children who get most of their

Figure 66. Interaction with doctors



care from military facilities are less likely than parents using civilian facilities to report that their doctor usually or always spends enough time with their child, explains things so that they can understand, or treats them with respect. Similarly, as shown in Figure 67, in all dimensions of their ability to discuss their concerns with their doctor, parents of children that usually see

Figure 67. Doctors' ability to address parents' concerns



civilian doctors were about 10 percent more likely to report that their interactions were usually or always satisfactory.

In sum, most parents reported positive perceptions of communication with their child's health care providers and few parents reported that their child's provider never or only sometimes spends enough time with their child, respects what the parent has to say, explains things in a manner that the parent and/or child can understand, answers questions, and gives specific information. However, there was some variation across health plans and provider types in parents' communication with providers. Parents with children enrolled in Prime consistently reported worse communication with the provider than those with children using Standard/Extra or a civilian plan. Similarly, parents perceived civilian doctors as communicating better with them about their children's health in all dimensions.

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Issue Briefs

These issue briefs were first available on TRICARE's website:

- *Needs of Deactivated Reservists*
- *TRICARE Reserve Select*
- *Colorectal Cancer Screening*
- *TRICARE Civilian Network Use 2003–2007*

Issue Brief: Needs of Deactivated Reservists

Because they have been activated to support contingency operations in Bosnia, Afghanistan and Iraq, many members of the National Guard and Reserves have become eligible for TRICARE health benefits in recent years. However, more recently, demands placed on the reserve component have lessened. Between January 19, 2005 and January 24, 2007, the number of active reservists has fallen from 192,507 to 91,344.[1,2] As the number of active reservists declines, benefits extended to the recently deactivated have taken on greater importance. When deactivated, reservists and their family members are eligible for Transitional Assistance Medical Program (TAMP) coverage, which provides transitional TRICARE coverage for 180 days. They may also enroll in TRICARE Reserve Select (TRS), which enables them to purchase continued TRICARE coverage while they remain in the reserves.

In October 2006, the TRS eligibility was expanded for qualified members of the National Guard and Reserve and their family members.[3] All reservists can now purchase TRICARE coverage paying a premium in one of three tiers. The lowest cost tier is for reservists who commit to serve in the Selected Reserves after deactivation, a higher tier is for reservists who have not made such a commitment but who are unable to get health insurance through work, and the highest tier is for reservists who simply prefer to be covered by TRICARE. The expansion in TRS extends coverage to reservists and their family members who might otherwise lose their health insurance when the reservist is no longer active, but makes more complex an already complicated program. New legislation will eliminate premium tiers and enable all reservists to purchase TRS at the same price.[4]

Results from the HCSDB, shown in Figure 1, indicate that deactivated reservists and their family members now make up a majority of TRICARE-eligible reservists. Sixty percent of reservists who responded to the survey report they were deactivated in the past 12 months compared to 40 percent who are currently active. Thirty-seven percent with a reservist family member report that the reservist is active compared to 63 percent who report that reservist recently deactivated.

As shown in Figure 2, 12 percent of reservists deactivated in the past 12 months and 27 percent of family members of recently deactivated reservists do not know whether they are eligible for coverage after they or the reservist in their family, is deactivated.

Figure 1. Activation status of eligible reservists

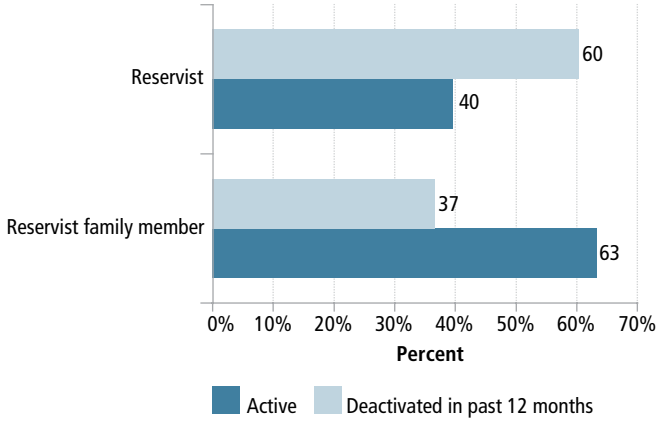
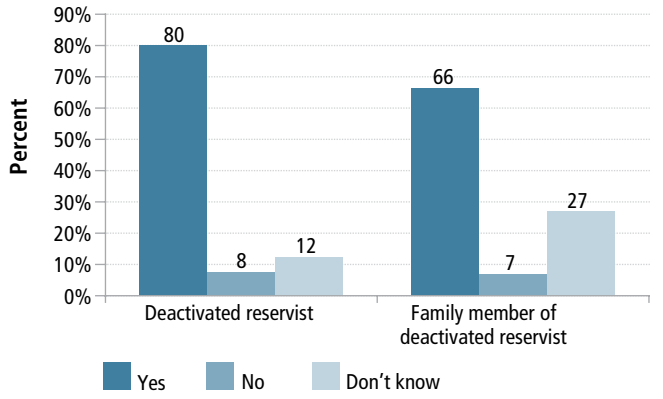
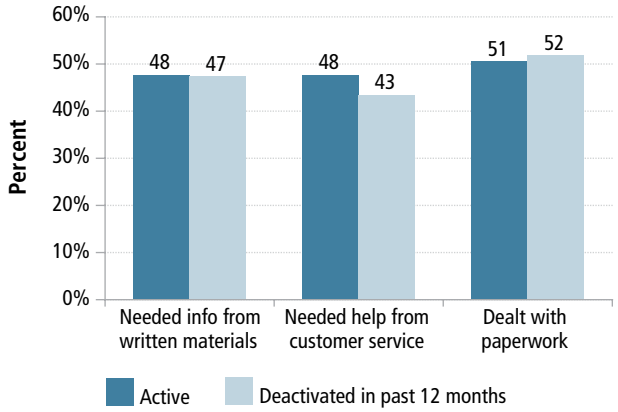


Figure 2. Eligibility for benefits of deactivated reservists



Because of the complexity of their benefit offerings, newly deactivated beneficiaries are equally or more likely to have needs for customer service or to complete paperwork related to their TRICARE benefits. As shown in Figure 3, approximately half of both currently active and recently deactivated beneficiaries have searched for information about their benefits, consulted with customer service or completed paperwork related to their coverage in the past 12 months.

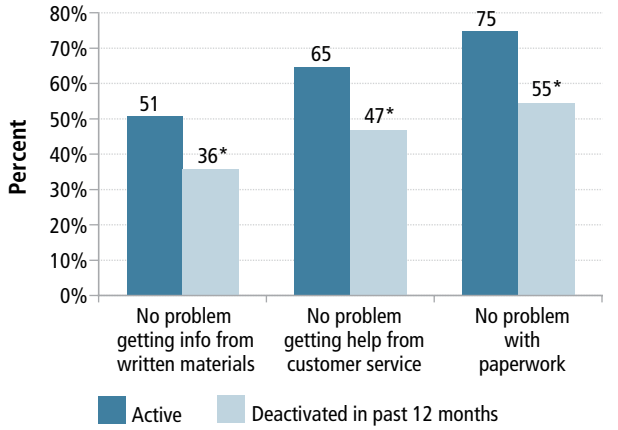
Figure 3. Assistance needs of reservists by activation status



Though their needs are similar, deactivated reservists and their family members experience more problems getting the help and information they need and more problems completing their paperwork than do active reservists. As shown in Figure 4, little more than a third of deactivated reservists or family members of deactivated reservists report that they can find the information they need in TRICARE's written materials or websites, compared to half of active reservists or their family members.

Similarly, deactivated reservists and their families are substantially less likely (47 percent) than their active counterparts (65 percent) to report getting needed help from customer service without problems, and only 55 percent of the deactivated component can complete their paperwork with no problem, compared to three-fourths of active reservists.

Figure 4. No problem getting assistance by activation status



*Differs from active reservists' rate, p<0.05

Conclusion

During 2006 TRICARE eligibility was expanded for reservists and their family members after deactivation. The program is structured so that the reservist received the information during the training prior to deployment and at debriefings when they are demobilized, while family members received information from other sources such as family support programs.[4] These methods apparently do not successfully convey all of the needed information and some reservists and family members report they are unsure of their TRICARE eligibility status after deactivation. Similarly, findings from the HCSDB suggest that needs for information and other customer service help among recently deactivated reservists and their family members, are not met as well as the needs of active reservists. As the proportion of deactivated reservists eligible for TRICARE benefits rises, so does the importance of a strategy to provide information about transitional TRICARE benefits and coverage options under TRS.

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From the Health Care Survey of DoD Beneficiaries, fielded October, 2006, N=12,684; Reservists or family members activated in support of contingency operations =880.

Issue Brief: TRICARE Reserve Select

TRICARE reserve select (TRS) is a health plan for qualified members of the National Guard and Reserves and their families. TRS began with the National Defense Authorization Act (NDAA) of 2004 and has expanded over the last three years so that virtually all reservists and their family members now qualify for the program. Health care benefits are similar to TRICARE Standard and Extra. Beneficiaries currently pay premiums based on a three-tiered system, in which the share of coverage costs borne by beneficiaries varies with their qualifications.[1] Under the NDAA of 2007, the three-tier premium will be eliminated, and all enrollees will pay a premium equal to 28 percent of the cost of coverage, which is the lowest payment rate in the three-tiered system.

TRS was designed with three goals in mind: to eliminate disruptions in coverage that occur when beneficiaries are activated and deactivated, to provide coverage for reservists who lack it, and to provide a benefit to reservists that encourages them to continue their service. Results from the 2007 Health Care Survey of DoD Beneficiaries (HCSDB) suggest that many beneficiaries are unsure about their eligibility, and that few choose this coverage. As a result, the program may not be achieving its objectives.

History of TRS

Historically, reservists and their dependents have been eligible for TRICARE only while the reservist was serving on active duty. However, the National Defense Authorization Act (NDAA) of 2004 began to extend TRICARE eligibility to reservists and their family members who were not on active duty.[2] Only those that were either eligible for unemployment compensation or were ineligible for health care coverage from their civilian employer qualified for the first version of TRS. At the same time, transitional TRICARE benefits were extended to reservists for a period before and after activation.

The NDAA of 2005 allowed more reservists to purchase TRS. Besides those that qualified in 2004, select reservists that had been mobilized since September 11, 2001, and who continually served for 90 days or more in support of a contingency operation were granted a one-time opportunity to sign up for extended coverage before they left their current active duty assignment.[3] These reservists could qualify for one additional year of coverage for each additional 90-day active duty assignment they agreed to serve.

Under the 2006 NDAA, almost all reservists may qualify for TRS by agreeing to serve in the Selected Reserve, but are grouped in tiers, depending on their qualifications. Premiums range from 28 percent of the value of the coverage in tier 1 to 85 percent in tier 3.[4] Beneficiaries in the first tier qualify through activation in support of contingency operations, while beneficiaries in the second tier, who pay 50 percent of costs, qualify through unemployment or lack of access to other coverage.

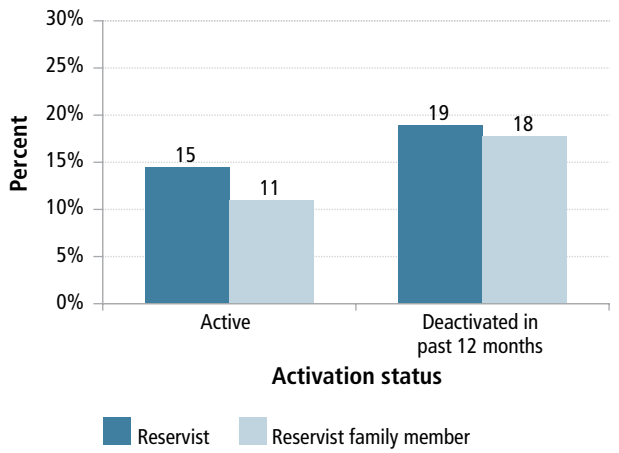
In spite of the rapid expansion of eligibility, enrollment in TRS has increased slowly. The slow take-up may be due to a number of factors, including, for tiers 2 and 3, the high premiums, for tier 1, the brief period during which beneficiaries are qualified and must decide to enroll, and, for all tiers, the availability to most reservists of civilian coverage.

To encourage enrollment, the NDAA of 2007 reduces the premium to reservists who currently qualify for TRS in tier 2 or tier 3 to the 28 percent of coverage cost faced by tier 1 enrollees.[5] The 2007 NDAA also eliminates the service agreement. Reservists that qualify for TRS will remain eligible for the duration of their service in the reserves.[5]

Survey Results

Figure 1 shows TRS coverage among reservists and their family members who are currently active in or recently deactivated

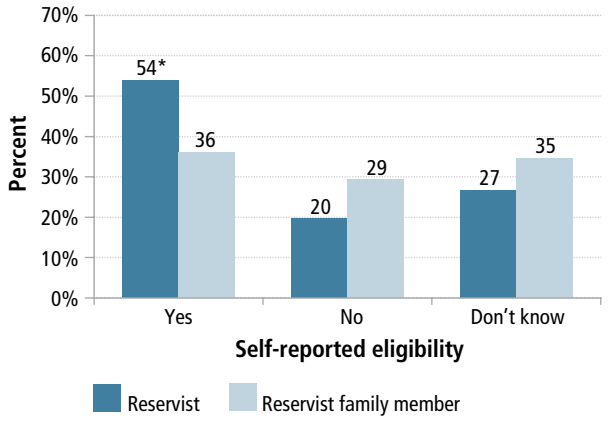
Figure 1. TRS coverage and reserve status



from contingency operations. Only a small proportion of each group reports it is covered by TRS.

Figure 2 shows how reservists recently deactivated from supporting contingency operations and their family members view their eligibility. Family members of recently deactivated reservists are approximately equally divided between those who report they are eligible, are not eligible and do not know of their eligibility. By contrast, a majority of recently deactivated reservists report they are eligible, indicating that reservists are more aware of their eligibility than are their families, but that uncertainty is widespread in both groups.

Figure 2. Eligibility for TRS of deactivated reservists



*Differs from family member, p<0.05

Figure 3 shows reasons for electing TRS. The most commonly stated reason is lack of other coverage. However, for approximately half of those who select TRS, the most important reasons are the attractiveness of the benefits, and the lower cost of TRICARE compared to other options.

Figure 3. Reasons for enrolling in TRS

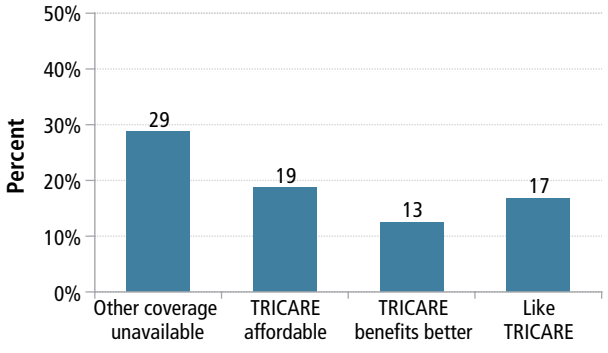
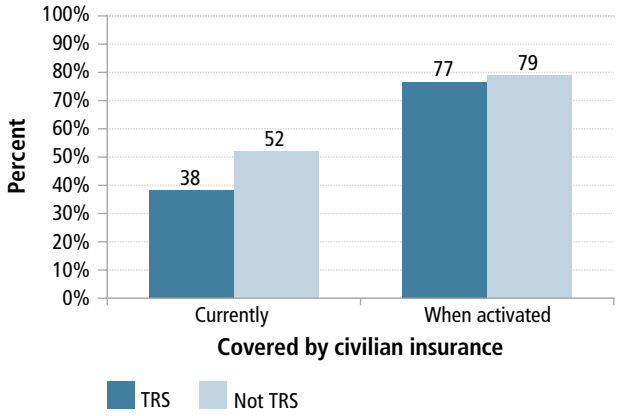


Figure 4 shows other coverage available to beneficiaries who select TRS. Beneficiaries who report they have TRS are no less likely than those who do not select it to have had civilian coverage before activation. Beneficiaries who elect TRS coverage are slightly less likely to report that they currently have other civilian coverage than are beneficiaries who do not ($p<0.10$), but many of those who choose TRS have other options.

Figure 4. Civilian coverage of TRS enrollees



Conclusion

One important reason for the low take-up rate for TRS appears to be the other coverage available to reservists. The majority appears to have access to civilian coverage and many may be unwilling to pay for TRICARE. Changes to the TRS program that simplify coverage and reduce its cost are likely to increase the take up of TRS in this group. The reduction in premiums may encourage beneficiaries to select TRS in addition to any civilian coverage that may be available to them. Similarly, because many beneficiaries are currently uncertain of their eligibility status or mistakenly believe that they are ineligible, simplifying enrollment will also likely increase take-up.

Sources

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From the Health Care Survey of DoD Beneficiaries, fielded January, 2007, N=12,892; Reservists or family members N=1,357.

Issue Brief: Colorectal Cancer Screening

Guidelines from the American Cancer Society (ACS) and U.S. Preventive Services Task Force for colorectal cancer screening call for men and women age 50 and above to have fecal occult blood testing (FOBT) each year, sigmoidoscopy every five years or colonoscopy every 10 years.[1] In recent years, government and private sector health insurance benefits have been enriched to include all of these options. In 2001, Medicare benefits were extended to include colonoscopies at 10-year intervals. Similarly, in March, 2006, TRICARE benefits were enriched to include colonoscopies every 10 years. TRICARE also covers annual FOBT and sigmoidoscopy every three to five years. Most civilian plans offer similar benefits, and some states have mandated coverage of screening colonoscopies.

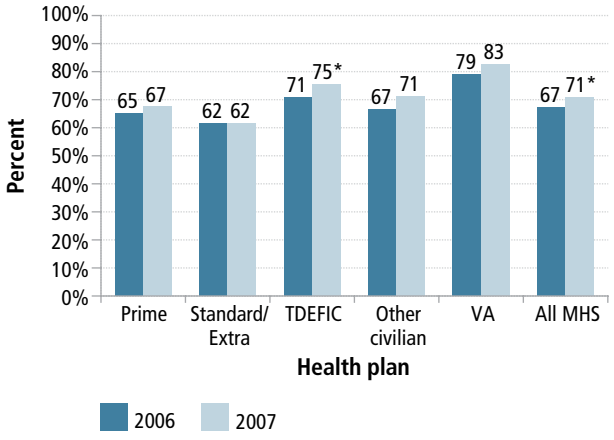
Evidence from the HCSDB fielded in 2006, shortly before colonoscopy benefits were enriched, showed that among TRICARE beneficiaries, those with Medicare (TDEFIC) and those who get care from Veterans Administration (VA) Providers were most likely to have colorectal cancer screening.[2] Colonoscopy rates of VA users were similar to those of other beneficiary groups. Their high screening rates were due primarily to their higher FOBT and sigmoidoscopy rates.

Screening Rates Have Increased

Enriched colonoscopy benefits have now been in place more than a year. Evidence from the HCSDB fielded in 2007 indicates that screening rates have increased for TRICARE beneficiaries during that time. Figure 1 shows that, across all health plans, compliance with ACS screening guidelines in 2007 is the same or greater than compliance in 2006. Overall, compliance has risen from 67 percent to 71 percent ($p<0.05$).[3]

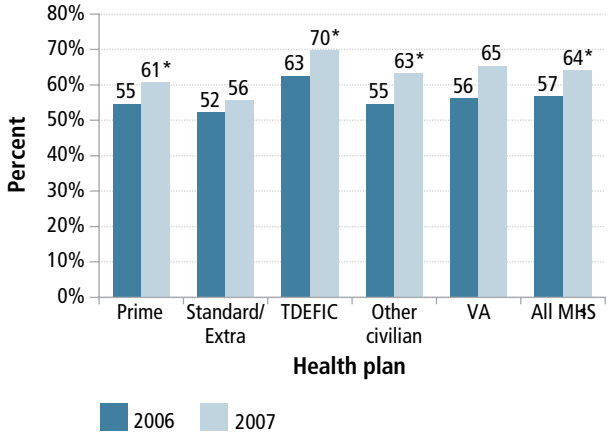
Screening rates increased among all beneficiaries because of rising colonoscopy rates, as shown in Figure 2. The increase in colonoscopy affects all TRICARE enrollment groups. Among Prime enrollees, the proportion with colonoscopy in the previous 10 years rose from 55 percent to 61 percent, and among Standard/Extra users, from 53 percent to 56 percent (not significant). However, rates increased significantly for beneficiaries who rely on other civilian insurance (55 percent to 63 percent) and for TDEFIC (63 percent to 70 percent) as well. Overall, the colonoscopy rate has risen from 57 percent to 64 percent.

Figure 1. Compliance with ACS guidelines by health plan



*Change is significant, $p<0.05$

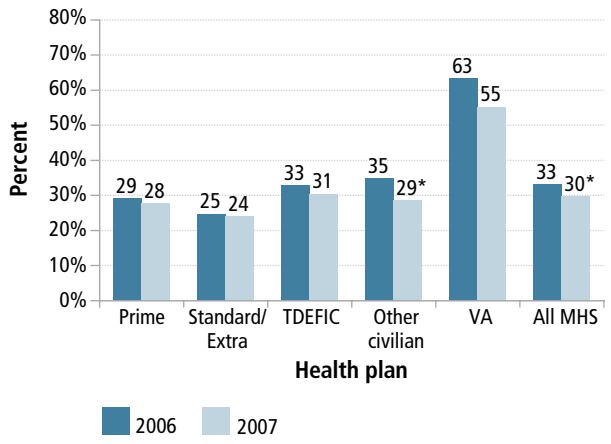
Figure 2. Colonoscopy within 10 years by health plan



*Change is significant, $p<0.05$

Colonoscopy rates apparently have increased at the expense of less invasive alternatives, such as FOBT. As shown in Figure 3, the proportion of beneficiaries with FOBT in the past two years has fallen or stayed the same for all health plans. The decrease is greatest for beneficiaries who do not rely on TRICARE. For example, among beneficiaries who get most of their care through civilian health insurance, the FOBT rate fell from

Figure 3. Fecal occult blood testing within 2 years, by health plan



*Change is significant, p<0.05

35 percent to 29 percent. Except for VA, all rates are less than the Healthy People 2010 goal of 50 percent.

Table 1 shows that increasing compliance with ACS guidelines, rising colonoscopy rates and falling FOBT rates are found at civilian facilities, military facilities and VA facilities as well. For each provider type, the FOBT rate has fallen, while the colonoscopy rate has risen, increasing overall compliance with guidelines. VA users are still significantly more likely than MTF users or users of civilian facilities to be screened for colon cancer, and their higher screening rate is still due to the greater use of less invasive tests such as FOBT and sigmoidoscopy.

Table 1. Screening by usual source of care

	MTF		Civilian Facility		VA Facility	
	2006	2007	2006	2007	2006	2007
	Percent					
ACS Compliant	71	75	68	72*	80	83
FOBT within 1 year	19	16	17	15*	44	35
Sigmoidoscopy within 5 years	31	27	27	25	45	41
Colonoscopy within 10 years	59	67*	59	66*	57	66

*Change is significant, p<0.05

Results in Table 2 show that active duty screening rates have risen substantially, though active duty make up only a small part of the population age 50 and over. Their compliance with ACS guidelines has risen from 54 percent to 71 percent. The increase is due primarily to colonoscopy, which has risen from 42 percent to 64 percent. However, unlike other groups, there is no evidence that active duty FOBT rates are falling.

Table 2. Screening by beneficiary category

	ACS Compliant		FOBT within 2 years		Colonoscopy within 10 years	
	2006	2007	2006	2007	2006	2007
	Percent					
Active Duty	53	71*	24	29	42	64*
Active Duty Family Members	50	56	22	19	44	51
Retirees Under Age 65	65	68	33	29*	54	60*
Retirees Over Age 65	69	74*	34	31	60	68*

*Change is significant, p<0.05

Conclusion

Colorectal cancer is the second leading cancer-related cause of death in the United States. Over 50,000 die each year of colon or rectal cancer.[4] More than half of these deaths may be preventable if regular cancer screening is begun by age 50.[5]

Results from the HCSDB show that overall compliance with guidelines for colon cancer screening has improved among TRICARE beneficiaries in the past year due to an increase in colonoscopy. This shift has occurred across health plans, beneficiary groups and usual sources of care. Based on clinicians' assumptions of the number of cancers prevented and cured following screening in the U.S. population, a rise in the screening rate of this size, if sustained, will save more than 50 lives per year in the MHS population.[6]

The rise in the screening rate may be due in part to the enrichment of the TRICARE colonoscopy benefit. That shift, however, is greatest for Medicare enrollees and those who rely on other non-TRICARE coverage. Active duty screening rates have risen faster than rates of other beneficiary groups, suggesting that promotion of screening among active duty personnel has also played a role. VA users are most compliant because of FOBT, an indication that promoting FOBT in addition to colonoscopy may increase the number of patients screened and of lives saved.

Sources

[1]A high contrast barium enema every 5 years is a fourth option. http://www.cancer.org/docroot/CRI/content/CRI_2_4_3X_Can_colon_and_rectum_cancer_be_found_early.asp.

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[3]These rates are not age adjusted, however all rates in this report were compared to age adjusted rates and no substantial changes were observed.

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Issue Brief: TRICARE Civilian Network Use 2003–2007

TRICARE's civilian networks include providers who are contracted to serve TRICARE beneficiaries in the Standard/Extra, as well as Prime enrollees who opt to receive treatment from civilian providers. Networks are maintained by managed care plans that contract to maintain provider networks and provide services to TRICARE beneficiaries. The network in each TRICARE region is maintained by a single contractor. Since 2003, TRICARE's civilian networks have gone through several changes, including a new set of access and network adequacy standards, a switch from 12 regional networks to 3, and a new generation of managed care contracts.

The managed care contracts assign to contractors the responsibility of maintaining adequate provider networks. Network adequacy may defined in several ways: beneficiary travel distance, waiting times for appointments or urgent care, the number of providers of different specialties in a market area, and beneficiaries satisfaction with care.[1] Network adequacy is monitored by regional contractors responsible for establishing and maintaining the provider networks and by TMA, which administers their contracts.

In 2004, the new round of TRICARE Civilian Provider Network contracts established the new regional networks and a new set of adequacy standards. The new standards focus more on beneficiary satisfaction than did previous standards.[2]

The Health Care Survey of DoD Beneficiaries (HCSDB) contains questions designed to measure beneficiaries' experiences getting care through TRICARE's civilian network. This issue brief describes HCSDB results concerning beneficiaries' reported access to network care from 2003-2007, before and after the new standards and set of contracts were implemented in 2004.

Current Results

Sixty percent of non-active duty Prime enrollees and users of TRICARE Standard or Extra report they get most or all of their care from TRICARE's civilian network. The proportion is higher for Standard/Extra users (76 percent) than Prime enrollees (55 percent). Network use is greatest in the south region, where 62 percent report relying on network providers for most or all of their care. Similar proportions of Prime and Standard/Extra users report problems finding personal doctors or specialists in the network, but Prime enrollees are more likely to report problems getting the care they need from the network as shown in Table 1.

Table 1. Network use by region and plan, FY 2007

	Total	North	South	West	Prime (Non-Active Duty)	Standard/Extra
			Percent			
Use Network for Most or All Care	60	60	62	56	55	76
Problems Getting Desired Care from Network	25	27	25	23	27	20
Problems Finding Personal Doctor or Nurse	25	28	24	22	25	26
Problems Finding Specialist	27	30	27	23	26	29
Preferred Physician Left Network	17	15	19	16	17	17

For most measures of access, beneficiaries in the north region are most likely to report problems finding providers or getting care from the network. However, beneficiaries from the south are most likely to report that a physician they wanted to see had left the network.

Trends

Figure 1 presents results from surveys fielded in each year since 2003, which preceded the reorganization of the civilian networks. The results show that network use has grown steadily since that time. The proportion of non-active duty TRICARE users that relies on the network for most or all of their care has increased from 51 percent to 60 percent. The results also suggest that reported access problems were greatest in 2005, the year following the award of new contracts, when 33 percent reported problems finding specialists in the network and 29 percent reported problems finding needed care. Since that time access problems have declined to their current level. Turnover in the network, indicated by the proportion of beneficiaries reporting that a desired physician has left the network, declined between the time of reorganization to the time following it from 21 percent to 17 percent.

Figure 1. Trends in network use Prime and Standard/Extra users

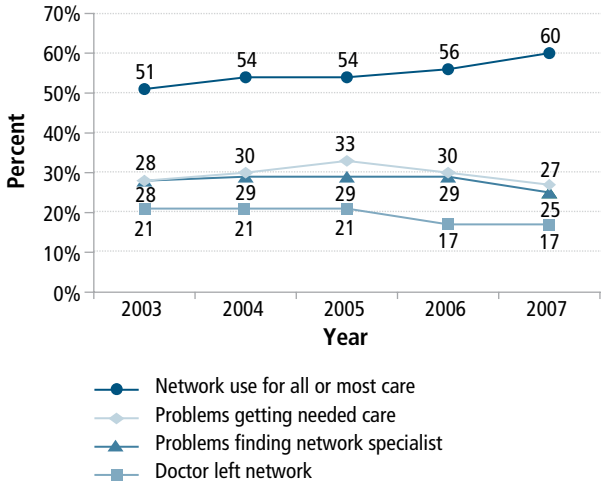
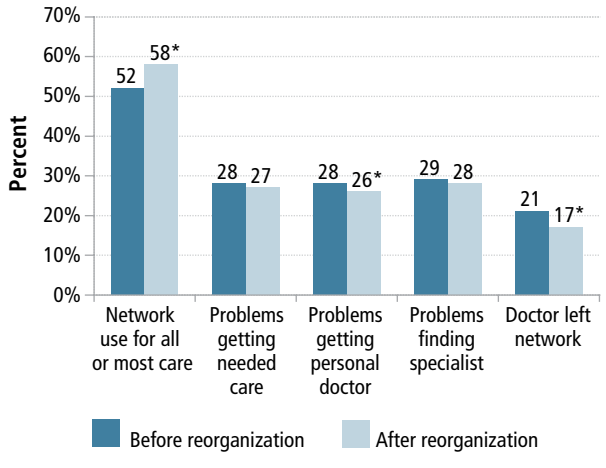


Figure 2 shows how measures compare between the time of the new contract and the time following it. In this graph, the period before reorganization covers surveys fielded in 2003 and the first two quarters of 2004. The period after reorganization consists of the years 2006 and 2007. The results show that the proportion of beneficiaries relying on the network increased significantly during this time period, and the proportion reporting problems finding a personal doctor from the network declined. Problems getting needed care and finding a specialist also declined, though the change is not significant. Network turnover, indicated by doctors leaving the network, fell significantly.

Figure 2. Change in network access

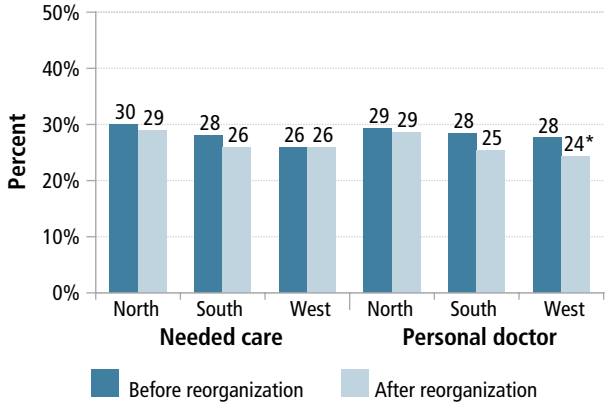


*Change is significant, p<0.05

Trends by Region

Figure 3 presents the change in reported access to network care by region. The increase in network use has affected all regions (not shown). All regions show a slight, not statistically significant, decrease in problems getting care from the network. Problems finding a personal doctor have dropped most in the west region ($p<.05$) and least in the north.

Figure 3. Change in network access problems, by region



*Change is significant, p<0.05

Conclusion

Results from the HCSDB indicate that, following a transition period in which access problems appear to have increased, users of TRICARE's civilian network appear to be experiencing fewer problems finding the care they need and the doctors they want to see. During this time demands on the civilian network have increased, as the proportion of TRICARE users that rely on the network has increased. Additional years of data will be needed to determine whether the change constitutes a trend, but it is encouraging that reported network access problems have declined even as demands have increased. The growing reliance of TRICARE beneficiaries on the network demonstrates the importance of continuing efforts to monitor access to care through network providers.

Sources

[1]Mathematica Policy Research, Inc. A Review of Network Adequacy Oversight Activities Across the Military Health System. May 2006.

[2]United States General Accounting Office. GAO/HEHS-00-64R. Military Health Care: TRICARE's Civilian Provider Networks. March 12, 2000.

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