PROJECT REPORT

Health Care Survey of DoD Beneficiaries 2004 Annual Report

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Chapter 1: Introduction

The TRICARE Annual Report presents a summary of results from the Health Care Survey of DoD Beneficiaries (HCSDB) for 2004. According to the 2004 HCSDB:

- Health plan ratings, personal doctor ratings, and specialist ratings for all TRICARE Prime enrollees have improved from their levels in 2002.
- Health care ratings of Prime enrollees are lower relative to civilian benchmarks than enrollees' ratings of doctors and health plan and have not improved since 2002.
- More than 60 percent of active duty Prime enrollees do not have a personal doctor or nurse.
- Active duty Prime enrollees rate their doctors, their health plan and their health care lower and report more problems getting access to specialists than do other enrollees.
- Since 2002, health plan ratings of TRICARE Standard/Extra users have improved relative to civilian benchmarks. Ratings of doctors and health care now equal or exceed civilian benchmarks.
- Compared to 2002, military treatment facility (MTF) users report longer waits for appointments and longer waits in doctors' offices. They report less helpful staff and less time with doctors.
- Since 2002, the proportion of active duty family members using MTFs has fallen from 64 percent to 58 percent.
- Breast and cervical cancer screening rates of Prime enrollees exceed *Healthy People 2010 (HP2010)* goals, but first trimester prenatal care and hypertension and cholesterol screening rates do not.
- Prime enrollees in the north (New England, the Midwest, and Mid-Atlantic) who rely on TRICARE's civilian network for most of their care are more likely than network users from other regions to report problems finding network specialists or getting needed care.
- Fifty-three percent of Prime enrollees referred to a civilian specialist by a military primary care manager (PCM) report that their PCM usually or always knew enough about their specialty care, compared to 68 percent referred by a civilian PCM to a civilian specialist.
- Thirty-nine percent of reservists' families retain reservist civilian coverage after becoming eligible for TRICARE. Of reservist family members who retain the reservist's civilian coverage, 30 percent do so even though the employer pays none of the premium.
- According to their parents, 40 percent of MHS children 6 to 11 and 47 percent of children 12 to 17 watch 3 or more hours of television per day
- Parents of children with special healthcare needs who use TRICARE report more problems finding a personal doctor, seeing specialists and getting needed care than do other TRICARE parents.

About the HCSDB

The HCSDB is a worldwide survey of military health system (MHS) beneficiaries 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 military health system 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 mobilized 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 on civilian health insurance plans.

The 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 2004, 200,000 beneficiaries from both inside and outside the United States were sampled for the adult survey. A total of 35,000 beneficiaries from the United States were sampled for the child survey. Sampling methods are described in the *2004 HCSDB Adult Sample Report and 2004 Child Sample Report.* The National Research Corporation administers the survey, allowing beneficiaries to respond by mail or on a secure website.

Responses to the survey are coded, cleaned, and edited and assembled in a database. Duplicate and incomplete surveys are removed. A sampling weight is assigned to each observation, adjusted for non-response. The contents of the database are described in the *2004 HCSDB Codebook and Users Guide.*

Questions in the 2004 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 Plans Survey (CAHPS), Version 3.0. CAHPS contains core and supplemental survey questions that are used by commercial health plans, the Center for Medicare and Medicaid Services (CMS), and state Medicaid programs to assess consumer 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 to learn more about the latest health policy issues. In 2004, questions were added to address the adequacy of TRICARE's civilian network, beneficiaries' experiences with referrals, beneficiaries' perceptions of patient safety, reservists' health coverage, and a number of other topics.

About This Report

This report presents results for all surveys administered in 2004, 2003, and 2002. It includes responses from all beneficiaries eligible for MHS benefits, including children, who reside in the US.

Beneficiaries are eligible for military health benefits if they are currently active duty or are dependents of active duty. Groups eligible due to active duty status include National Guard and Reserves mobilized for more than 30 days and their dependents. Beneficiaries also are eligible if they have retired following a career in the uniformed services or are the dependents of a retiree. MHS beneficiaries may receive care from military facilities or MTFs that are financed and operated by the uniformed services, or from civilian facilities that are reimbursed by the Department of Defense.

This report is organized based on the coverage options of beneficiaries. Chapter 2 describes the choices of eligible beneficiaries among different health plans and providers of care. Subsequent chapters describe satisfaction with health care, access to care, and preventive care received by beneficiaries using different coverage options including Prime, Standard and Extra, TRICARE for Life, and civilian coverage. The results are presented as percentages calculated using adjusted sampling weights. Other graphs present results according to the most used type of facility. When

results are compared between years or to an external benchmark, the difference is tested for statistical significance, accounting for the complex sample design. Results that differ significantly from an external benchmark ($p < .05$) are bolded.

Results from CAHPS questions are compared to results from the National CAHPS Benchmarking Databases (NCBD) for 2003, 2002, and 2001, which assemble results from surveys administered to hundreds of civilian health plans. Benchmarks are 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. Benchmarks are described in more detail in the *2004 HCSDB Technical Manual.*

In 2004, questions from version 3.0 of CAHPS were used for the first time. Prior to 2004, CAHPS version 2.0 questions were used. With this change, the wording of several questions used in this report also changed. To compare results from 2004 with results from 2003 and 2002, we performed two adjustments to rates calculated from previous years. First, we compared results from the 2001 and 2002 NCBD, based on CAHPS 2.0, with results from the 2003 NCBD, based on CAHPS 3.0. We adjusted each proportion from our report in 2002 and 2003 by adding the change in the estimated benchmark to these earlier numbers. For two other questions, we performed an additional adjustment by estimating a shift factor to account for differences in the effect of the question wording between HCSDB respondents and other CAHPS respondents. The methodology is described in the *2004 HCSDB Technical Manual.*

Other reports prepared from the HCSDB are the *TRICARE Beneficiary Reports* and *TRICARE Consumer Watch*. The *Beneficiary Reports* is an interactive web-based document that compares TRICARE Regions, Services, and MTFs using scores calculated from survey results. The *Consumer Watch* contains a brief summary of results from the *Beneficiary Reports* and issue briefs that use survey questions to address health policy issues affecting the MHS. Both appear quarterly.

Often based on supplementary survey questions, the issue briefs investigate special topics of immediate interest to beneficiaries and MHS leadership. The issue briefs for 2004 concerned 1) beneficiaries' perceptions of the adequacy of TRICARE's civilian networks, 2) smoking and smoking cessation under TRICARE, 3) referrals to specialists under TRICARE Prime, and 4) reservists' coverage. Two children's issue briefs cover experiences of children with special health care needs and factors affecting childhood obesity. These issue briefs make up the last six chapters of this report.

Chapter 2: Beneficiaries' Choices of Health Plan and Provider Type

Beneficiaries of the military health system are covered by a wide range of health plans, most of them provided or supplemented by the Department of Defense. Active duty 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 through CHAMPVA. Medicare-eligible retirees are eligible for TRICARE for Life, which provides TRICARE benefits to pay deductibles and coinsurance left over from Medicare. Figure 1 shows the proportion of adults covered by each of these options. Beneficiaries were asked which health plan they relied on for most of their care. According to their responses, Prime is the plan most used by MHS eligibles, covering nearly half, while Medicare/TRICARE for Life provides coverage for the second largest group, 23 percent of eligible beneficiaries. Standard/Extra provides care for only about 8 percent of respondents, substantially less than the 17 percent who are covered by civilian plans. Together those four coverage types are responsible for 97 percent of eligible beneficiaries.

Almost all active duty are covered by Prime and almost all retirees age 65 and over are covered by TRICARE for Life. Active duty family members and younger retired families choose among several options. As shown by Figure 2, four-fifths of active duty family members who responded to the survey are covered by Prime. The remaining one-fifth are divided among civilian plans and Standard/Extra, with 11 percent covered by civilian plans and 8 by Standard/Extra.

Retired beneficiaries also are more likely to choose Prime than Standard/Extra. As shown in Figure 3, a little more than half of retired respondents rely on a TRICARE plan, and that group chooses Prime by two to one over Standard/Extra. Most of the remaining beneficiaries, nearly two-fifths of all retirees and their family members, have civilian insurance of some kind.

Beneficiaries who use civilian insurance, TRICARE for Life, or TRICARE Standard/Extra receive care primarily from civilian providers. Prime enrollees,

Figure 1: Health plan used for most care 2004

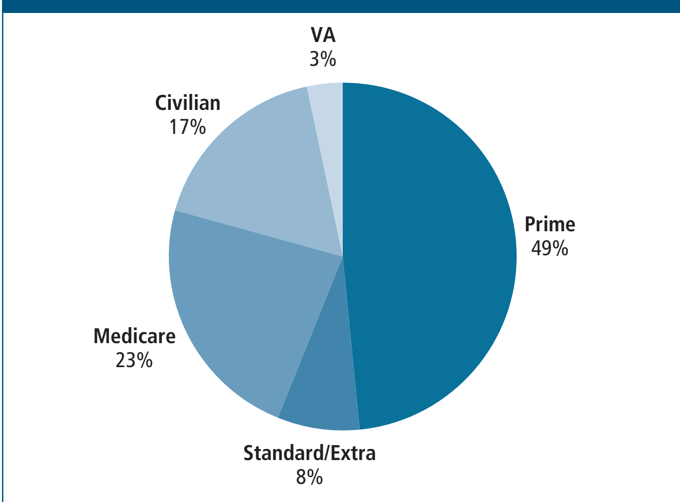


Figure 2: Active duty family members choice of health plan

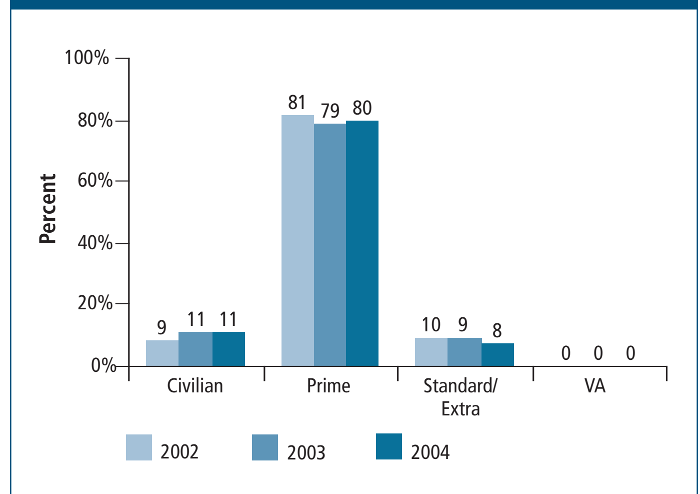
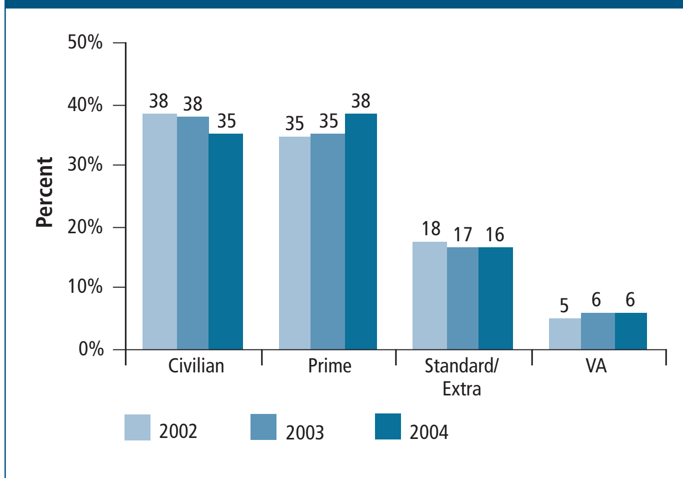


Figure 3: Retired, less than 65, choice of health plan



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. As shown in Figure 4, the majority of eligible beneficiaries (56 percent) get care primarily from civilian facilities. Another 5 percent use VA facilities and about two-fifths rely on MTFs.

Results in Figure 5 indicate that active duty families have shifted from MTFs to civilian facilities in recent years. Since 2002, the proportion getting most of their care from MTFs has fallen from 64 percent to 58 percent, with a corresponding shift to civilian facilities. Figure 6 shows that, among retirees, two-thirds of whom use civilian facilities, no shift is apparent. Notably, 8 percent of retirees say that they get most of their health care from VA facilities, a higher proportion than the 6 percent of retirees who reported that they relied on the VA as a health plan.

Figure 4: Patient's usual source of care 2004

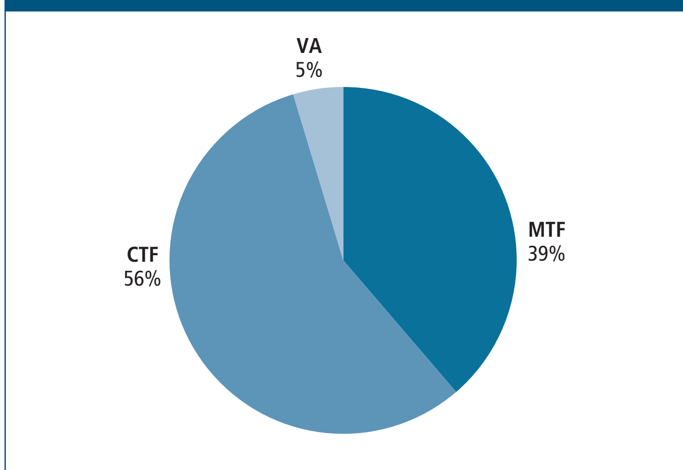


Figure 5: Active duty family members usual source of care

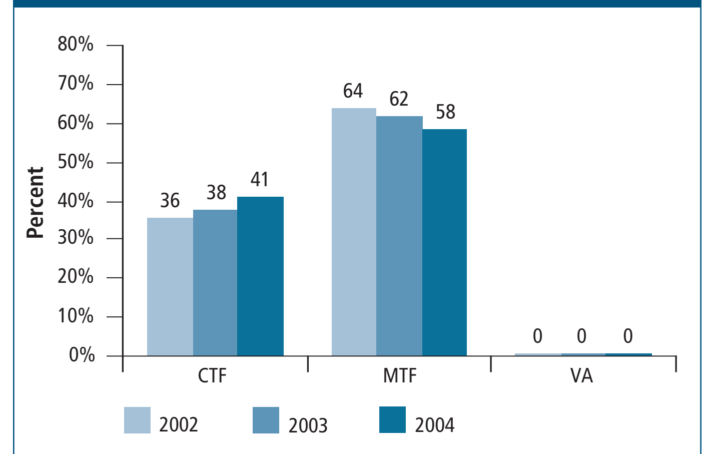
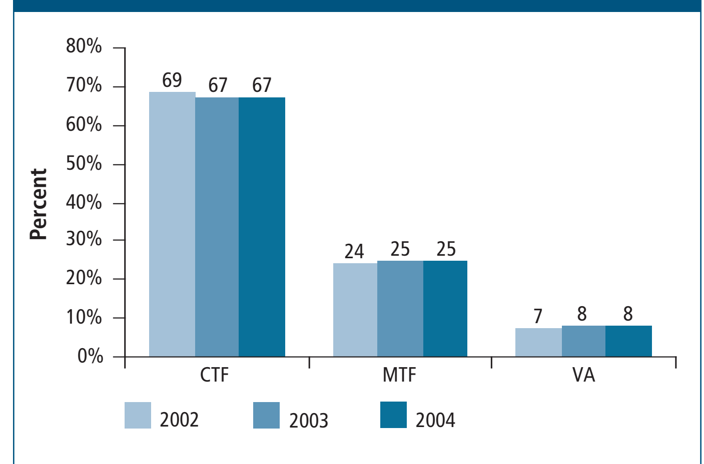


Figure 6: Retired, less than 65, usual source of care



Chapter 3: TRICARE Prime Enrollees' Ratings of Doctors and Health Plan Improve

TRICARE Prime is the health plan through which most MHS care is delivered. This chapter describes how beneficiaries rate Prime and the care they receive through Prime. It also describes how beneficiaries perceive their access to both primary care physicians and specialists, factors which are strongly influenced by the number and type of doctors employed by the health plan and the policies governing referrals and use of doctors for primary care.

Health plan ratings for Prime have improved in recent years. As shown in Figure 7, the proportion giving their health plan a high rating increased from an adjusted rate of 51 percent in 2002 to 53 percent in 2004. Health plan ratings are higher relative to the civilian benchmark than are health care ratings. While the proportion of Prime enrollees giving their health care a high rating is about 12 percent below the benchmark, plan ratings are about 5 percent below.

Figure 8 shows one of the ways in which Prime differs from civilian plans. An important difference between Prime and civilian plans is the low proportion of Prime users with personal doctors. More than 80 percent of beneficiaries in the benchmark database

Figure 7: Prime enrollees' health care and health plan ratings

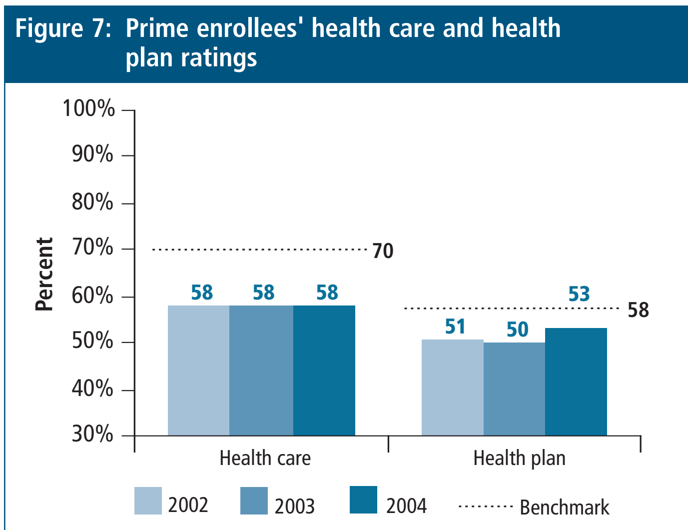
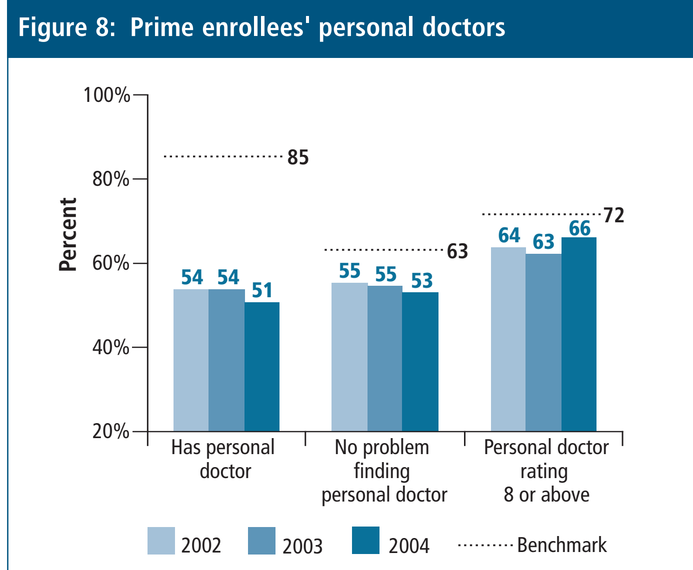


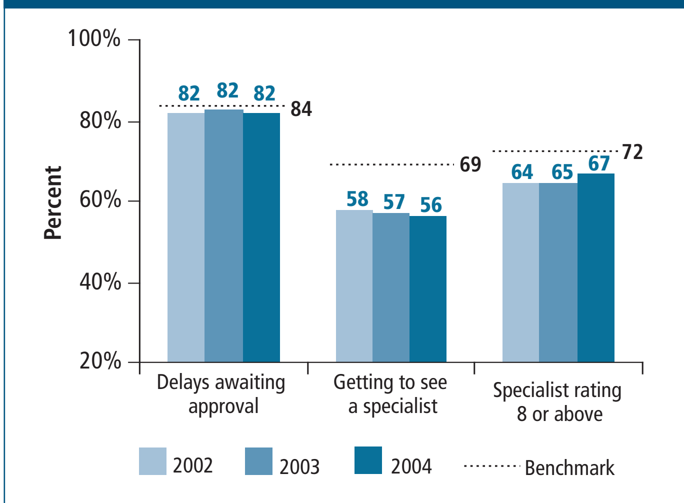
Figure 8: Prime enrollees' personal doctors



identify a single person as their personal doctor or nurse, compared to about half of Prime enrollees. Though efforts have been made to promote a personal doctor-patient relationship, the proportion with a personal doctor has not increased since 2002. Prime enrollees also are more likely than the civilian norm to report problems in finding a personal doctor they are happy with. In 2004, 53 percent of Prime enrollees reported no problem finding a personal doctor, compared to a civilian norm of 63 percent. However, while problems finding a personal doctor have not diminished since 2002, ratings of personal doctors, for those who have them, have risen slightly. The proportion giving their personal doctor a high rating has increased from 64 to 66 percent in that time.

Problems seeing a specialist or getting approval for treatments are other ways in which the staffing of a health plan or its policies for referrals or utilization management may affect beneficiaries. Figure 9 shows that Prime beneficiaries report delays in approvals that are similar to civilian norm. In 2004, 82 percent reported no problems with delays, compared to an

Figure 9: Prime enrollees' access to specialists



84 percent benchmark. Prime enrollees were more likely to report problems seeing specialists than they were to report delays in treatment. Fifty-six percent of Prime enrollees reported problem-free access to specialists, compared to 69 percent in the NCBD. However, beneficiaries were less likely to give their specialists low ratings than to report problems in seeing them. In 2004, 67 percent of beneficiaries rated their specialist at 8 or above, compared to a 72 percent NCBD benchmark. Prime enrollees giving high ratings to specialists increased from an adjusted value of 64 in 2002 to its current level.

Preventive care provided to Prime enrollees exceeds *HP2010* goals in several dimensions and falls short in others. Figure 10 shows that, compared to *HP2010* goals, women in Prime receive cancer screening—both Pap smears and mammography—at rates exceeding the target in each year from 2002 to 2004. However, the proportion of pregnant or recently pregnant enrollees reporting that they received prenatal care in their first trimester was below the *HP2010* goal of 90 percent.

Figure 11 shows that the rate for hypertension screening, defined as the proportion of beneficiaries whose blood pressure was checked in the past 12 months and who know whether it is too high, is below the goal set for all adults, as is the proportion

Figure 10: Prime enrollees' cancer screening and prenatal care

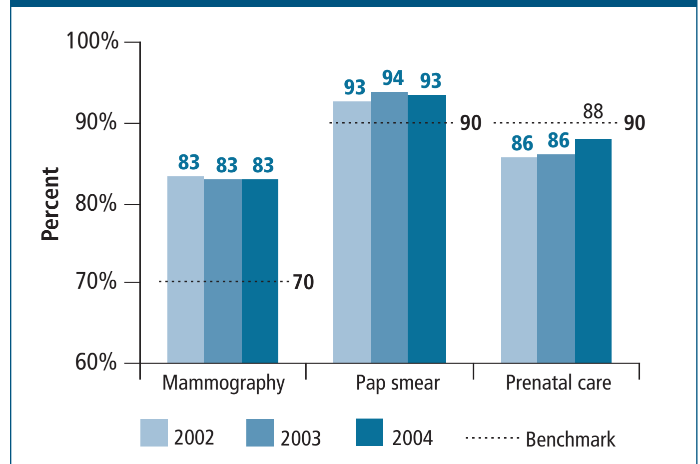
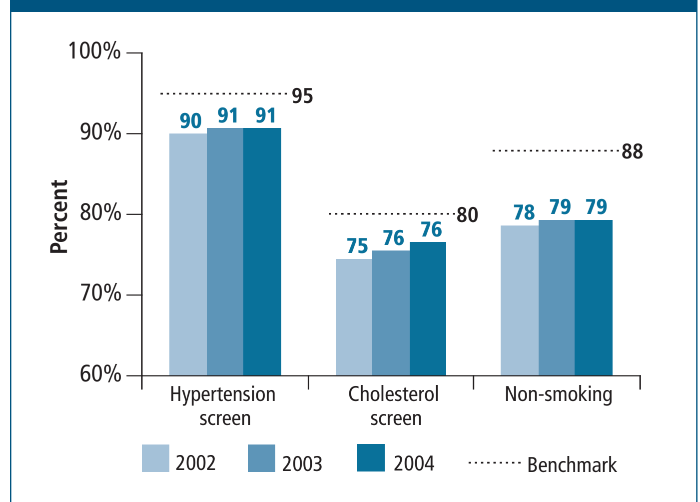


Figure 11: Prime enrollees' preventive care



whose cholesterol was checked in the past 5 years. Both of these screens, though appropriate for all ages, reflect conditions that increase in prevalence and impact with age, and younger beneficiaries are less likely to receive them. Prime, with its predominantly younger population comprised of active duty and their families, is less likely to achieve these goals than are plans with older population groups. Similarly, the non-smoking rate for Prime enrollees is 79 percent, compared to an *HP2010* goal of 88 percent. However, smoking rates fall with age, and the low non-smoking rate reflects in part the young population.

Chapter 4: Most Active Duty Prime Enrollees Do Not Have Personal Doctors

Though active duty are predominantly enrolled in Prime, their experience is different from other Prime enrollees. They are restricted to military facilities for the most part, and may receive care through sick call or in other ways that have no equivalents in the civilian health care system. As shown by Figure 12, this group rates their health care quite low. Only 51 percent give their health care a rating of 8 or higher, compared with a civilian norm of 68 percent. Health plan ratings also are below the civilian norm, with 46 percent giving their plan a high rating, compared to a civilian norm of 57.

Active duty are less likely than are other Prime users to have a personal doctor or nurse. As shown by Figure 13, only 37 percent report having a single personal doctor or nurse, a decline from rates reported in 2002 of 40 percent, and less than half of the civilian norm. Though active duty are less likely than other Prime users to have identifiable personal doctors or nurses, they are no more likely than other enrollees to report problems finding a personal doctor. Fifty-four percent report no problem finding a personal doctor or nurse, compared to a norm of 63 percent. However, active duty do give their doctors low ratings, as far below the benchmark as the ratings they give their health plan. Among active duty with a personal doctor, 60 percent rate their doctor 8 or higher, compared to a norm of 71 percent.

Figure 14 shows that active duty are more likely to report problems getting to see specialists than in finding a personal doctor. Fifty percent report no

Figure 12: Active duty health care and health plan ratings

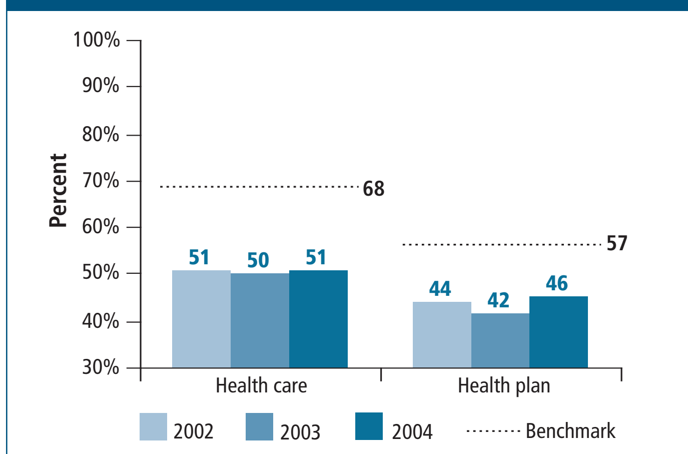


Figure 13: Active duty personal doctors

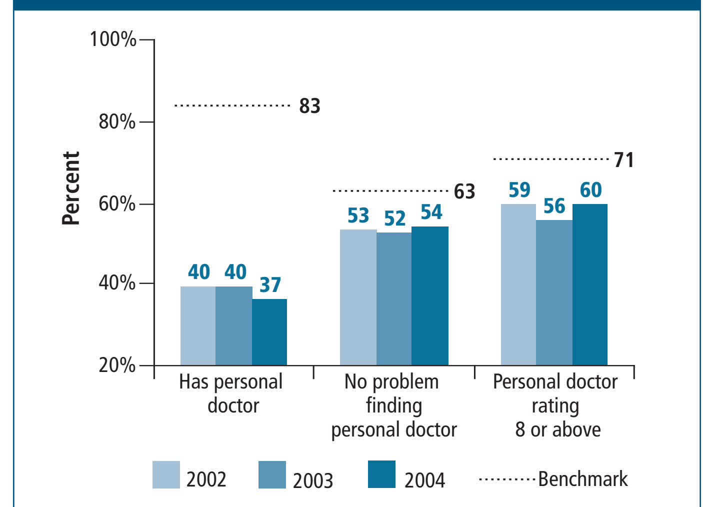
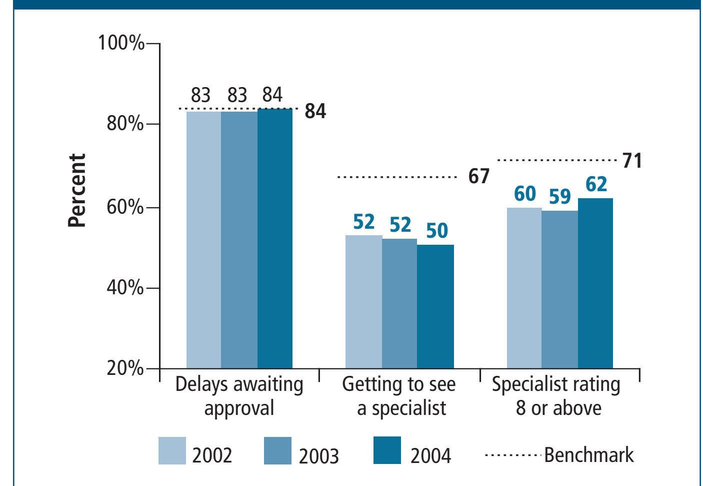


Figure 14: Active duty access to specialists



problem getting to see a specialist, compared to a civilian rate of 67 percent, and 62 percent rate their specialist at 8 or above, 9 percent below the benchmark. However, 84 percent report that delays while awaiting approval for treatment are no problem, similar to the civilian benchmark.

Like other Prime enrollees, active duty exceed *HP2010* goals for cancer screening—both mammography and Pap smears—and fall short of the goal for prenatal care (Figure 15). The rate for hypertension screening (90 percent) and cholesterol screening (77 percent), presented in Figure 16, also are less than the *HP2010* goals of 95 percent and 80 percent, respectively. The non-smoking rate of 78 percent among active duty is the lowest of all enrollment groups.

Figure 15: Active duty cancer screening and prenatal care

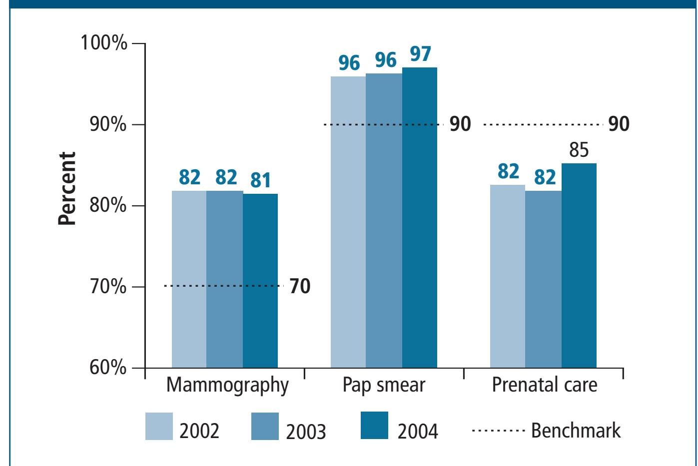
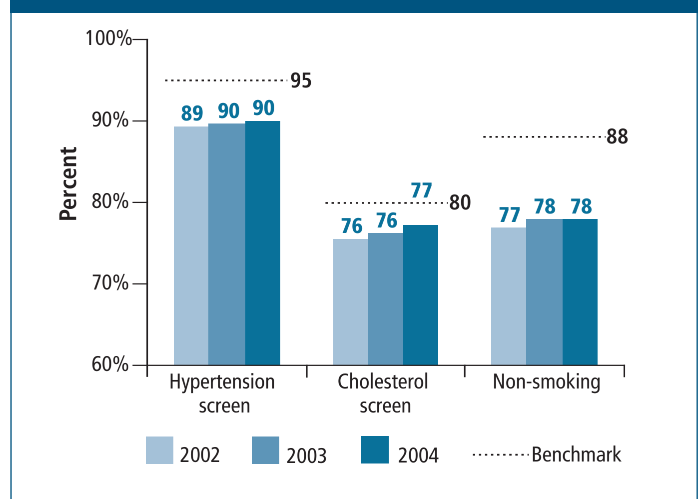


Figure 16: Active duty preventive care

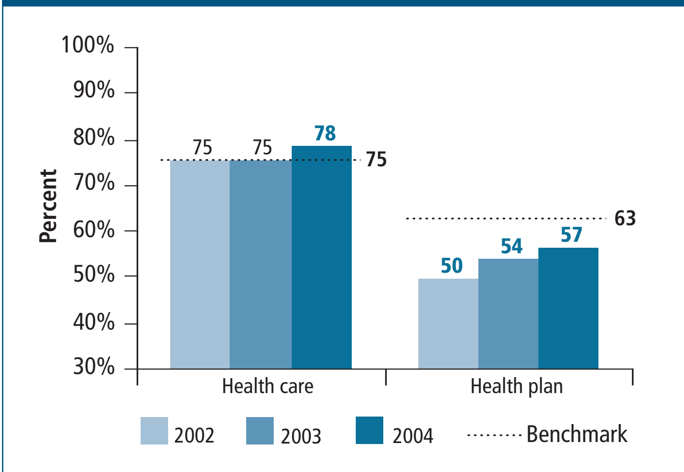


Chapter 5: Standard/Extra Users' Health Plan Ratings Are Improving

Standard/Extra is TRICARE's PPO option. Beneficiaries may pay coinsurance to see any provider who accepts TRICARE, or may see members of TRICARE's civilian network at a lower cost. As described in Chapter 2, this option is the fourth most frequently chosen coverage type among eligible beneficiaries, used by about 8 percent. However, it is the alternative to Prime for active duty family members and retirees under age 65 who choose coverage from the Department of Defense. Recent legislation has reduced the cost to active duty family members of using Standard/Extra. Ratings of health care, health plan, and personal and specialist doctors under Standard/Extra all have increased.

Beneficiaries covered by Standard/Extra are more likely to rate their health care highly than their health plan, but health plan ratings have improved since 2002. As shown in Figure 17, the proportion giving their health plan a rating of 8 or above has risen from 50 to 57 percent, while the proportion rating their health care 8 or above now exceeds the civilian benchmark at 78 percent.

Figure 17: Standard/extra users' health care and health plan ratings



Like other TRICARE groups, the proportion of Standard/Extra beneficiaries who say they have a personal doctor is lower than the NCBD norm, in this case 82 percent, compared to 91 percent, as shown in Figure 18. The proportion with personal doctors, though lower than the benchmark, does not appear to be due to unusual difficulties in finding a personal doctor, either in the network or outside of it. Sixty-four percent report no difficulty in finding a personal doctor, compared to 65 percent in the NCBD. Seventy-nine percent give their personal doctor a high rating, an increase of 4 percent since 2002.

Figure 19 shows that neither delays awaiting approval nor problems finding specialists appear to be great problems for Standard/Extra users. Eighty-nine percent report no delays awaiting approval and 74 percent report no problems in seeing specialists, similar to civilian standards. The proportion giving their specialists high ratings has improved from 73 to 79 percent since 2002.

Figure 18: Standard/extra users' personal doctors

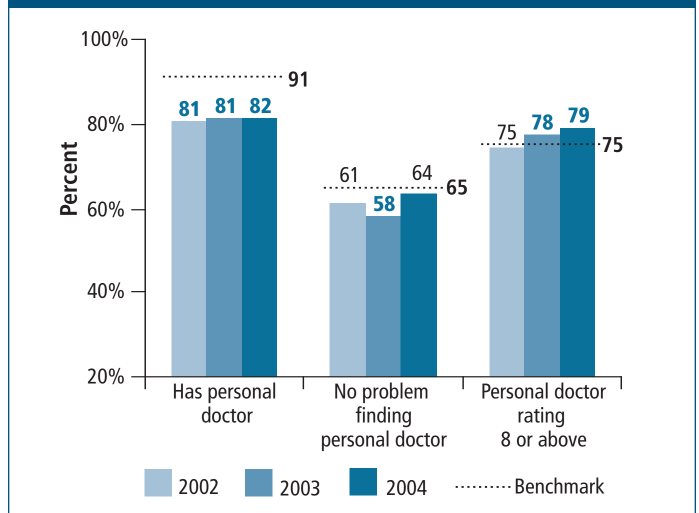


Figure 19: Standard/extra users' access to specialists

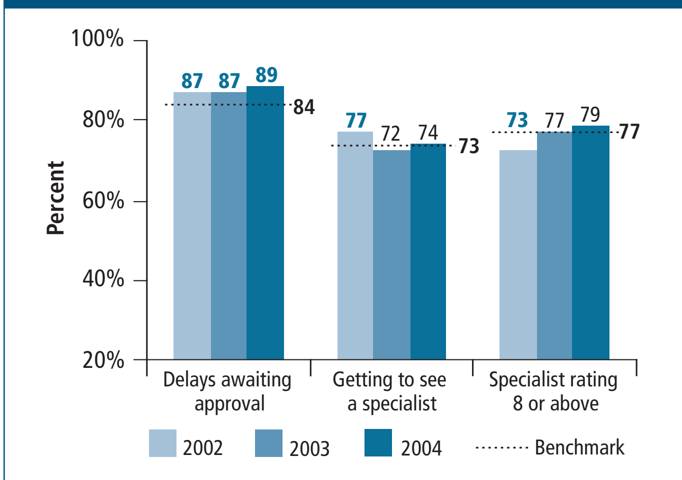
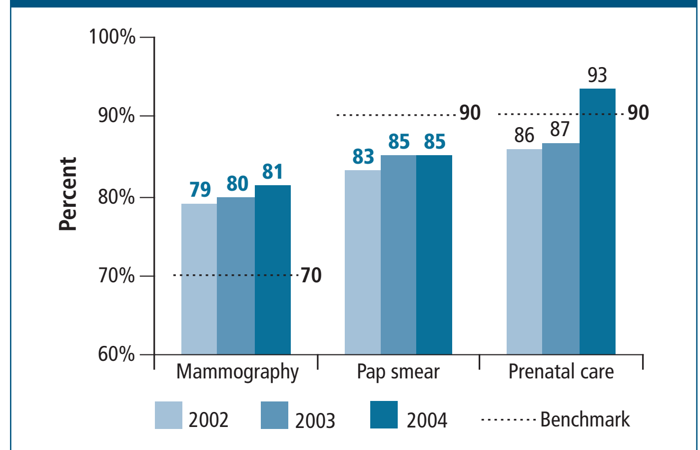
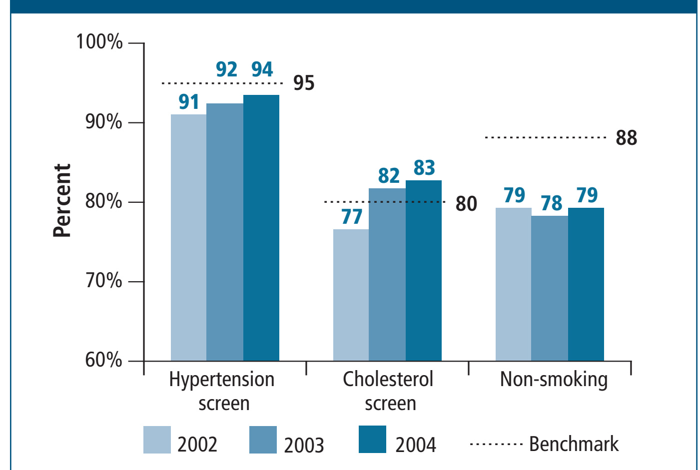


Figure 20: Standard/extra users' cancer screening and prenatal care



Cancer screening results in Figure 20 show that Standard/Extra users receive Pap smears at a lower rate than the *HP2010* goal, while mammography rates exceed that goal. Both mammography rates and the prenatal screening rate were higher in 2004 than in 2002. Similarly, as shown by Figure 21, the proportion of people who have had blood pressure tests and know whether their pressure is too high, and the proportion receiving cholesterol screening, has increased. The proportion with blood pressure screening is similar to the *HP2010* goal. The non-smoking rate for Standard/Extra users is 79 percent, well below the target level.

Figure 21: Standard/extra users' preventive care



Chapter 6: Medicare and TRICARE for Life

The 2000 National Defense Authorization Act (NDAA) entitled beneficiaries who pay their Medicare Part B Premium to coverage from TRICARE for most costs not covered by Medicare. Since then, satisfaction with health care and their health plans among Medicare-eligible TRICARE beneficiaries has increased. Ratings of both health care and health plan by beneficiaries with Medicare coverage have continued to increase during the period of this report. The proportion rating their health care 8 or above, shown in Figure 22, rose from 86 to 89 percent between 2002 and 2004, while the proportion rating their health plan 8 or above rose from 82 to 85 percent.

As indicated by Figure 23, the proportion of Medicare beneficiaries with a personal doctor is 94 percent, which is similar to age- and health status-adjusted benchmarks. About 80 percent report no problem finding a personal doctor they are happy with, which is similar to the norm for those with civilian coverage. Similarly, personal doctor ratings improved, with the proportion rating their personal doctor 8 or above rising from an adjusted value of 83 percent to 85 percent, in the period from 2002 to 2004.

Figure 24 demonstrates that access to specialists is also not a problem for beneficiaries of TRICARE for Life. Fewer than 5 percent report problems with delays awaiting approval for treatment. Eighty-seven percent report that they experience no problems in seeing a specialist, which is well above the NCBD. Specialist ratings are also high, with 87 percent rating their specialist 8 or above.

Figure 22: Medicare health care and health plan ratings

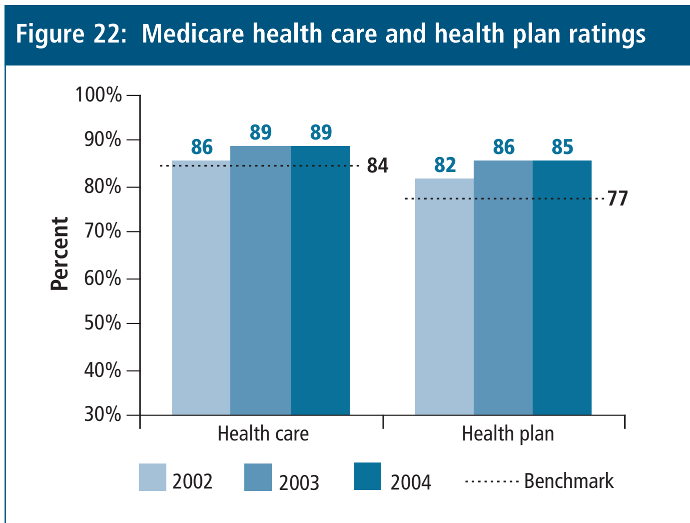


Figure 23: Medicare personal doctors

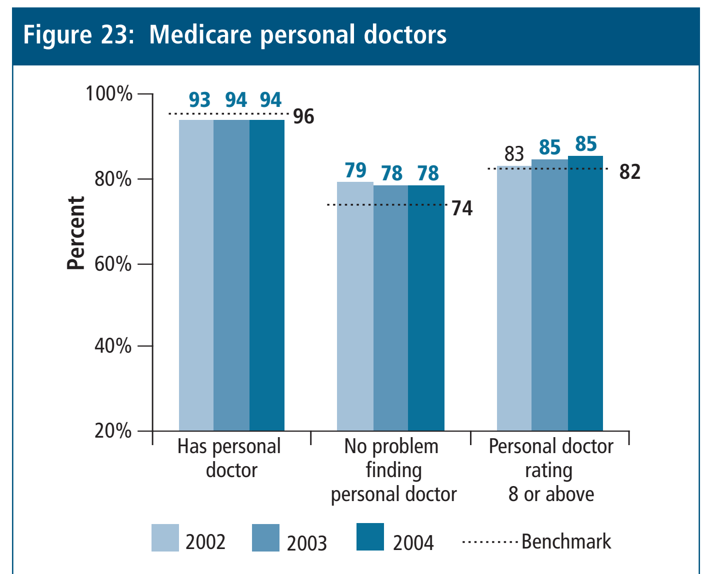
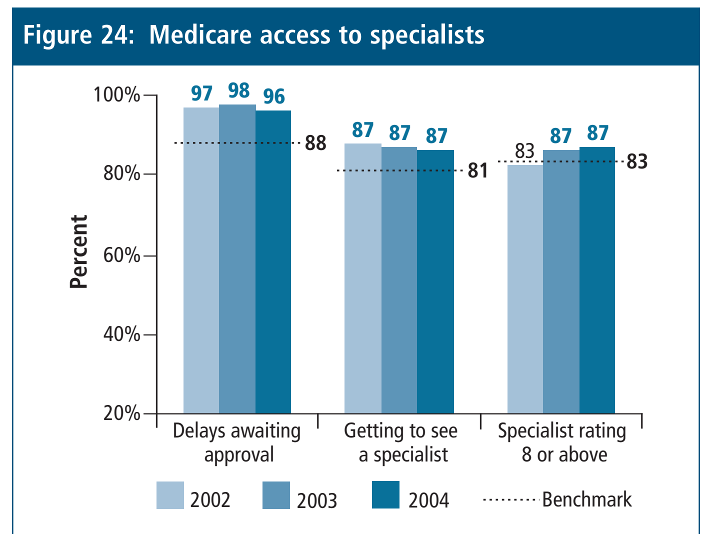


Figure 24: Medicare access to specialists



The preventive care received by Medicare beneficiaries, shown in Figures 25 and 26, is consistent with the age profile of this group. The mammography rate exceeds the *HP2010* goal of 70 percent by a wide margin, though the Pap smear rate is less than 80 percent. However, many physicians do not recommend routine Pap smears for women over 70 years of age. Similarly hypertension screening and cholesterol screening exceed *Healthy People 2010* goals. The high rate of screening for hypertension and hypercholesterolemia reflect their increased prevalence and greater concern about the problem of heart disease as beneficiaries become older.

Figure 25: Medicare cancer screening

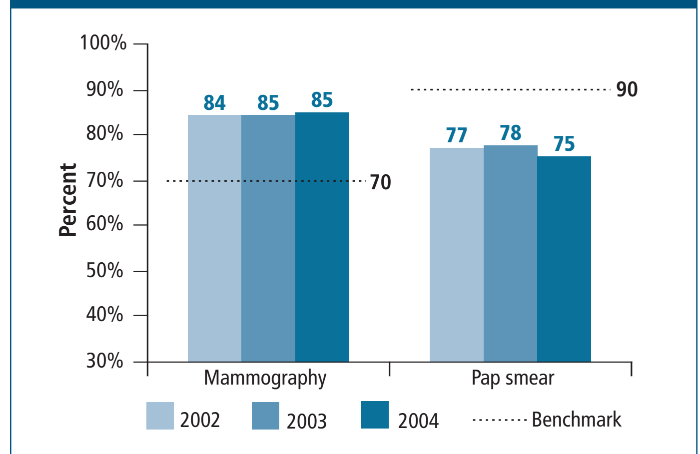
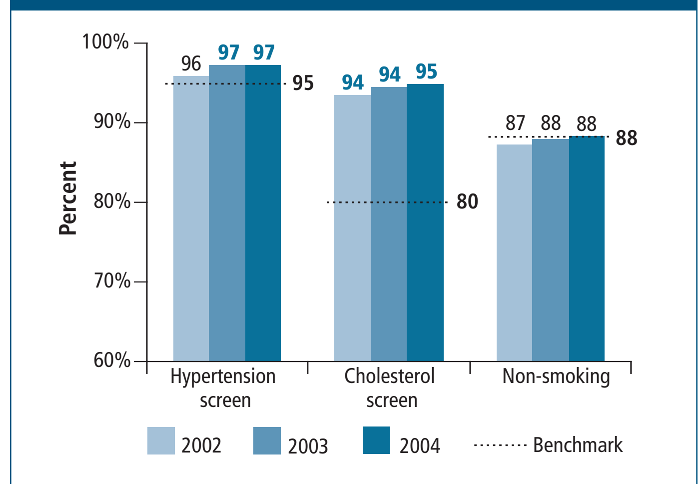


Figure 26: Medicare preventive care



Chapter 7: Civilian Health Plans

Civilian health plans are the third most common source of coverage among MHS beneficiaries. Because many beneficiaries pursue careers after retirement, retirees are likely to have civilian coverage, with at least some employer cost sharing. Similarly, active duty family members with civilian employment may use their employer-provided coverage in preference to TRICARE. They make that choice based on the relative cost of the two options and the attractiveness of the benefits.

Figure 27 shows that beneficiaries who have elected civilian coverage rate their health care and health plan similarly to non-military beneficiaries with civilian coverage. Sixty-six percent give their health plan and 81 percent give their health care high ratings. Health care ratings have increased by 4 percent since 2002. Beneficiaries are approximately as likely to have a personal doctor or nurse as beneficiaries in the benchmark database, 90 percent of civilian MHS eligibles compared to 91 percent of beneficiaries contained in the NCBD (Figure 28). MHS eligibles with civilian coverage are more likely than beneficiaries in the NCBD to report that they had no problem finding a personal doctor or nurse they were happy with.

Beneficiaries with civilian insurance are less likely to report problems getting to see a specialist or delays while awaiting approval than are beneficiaries in the NCBD, as shown in Figure 29. Ninety percent of MHS eligibles with civilian coverage report no with

Figure 28: Beneficiaries with civilian coverage personal doctors

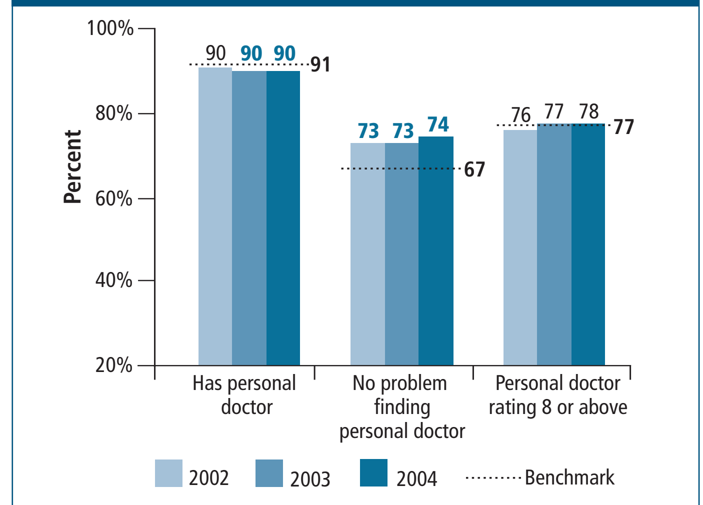


Figure 27: Beneficiaries with civilian coverage health care and health plan ratings

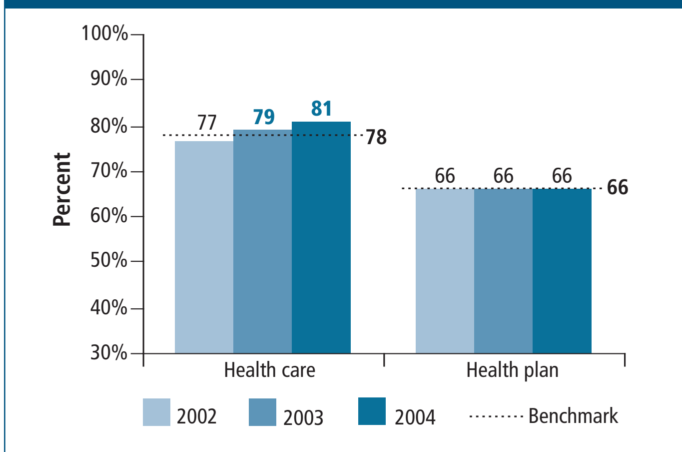
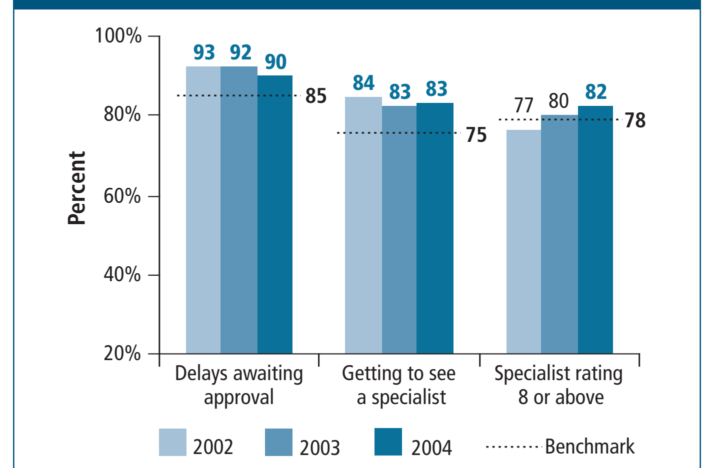


Figure 29: Beneficiaries with civilian coverage access to specialists



delays while waiting for approval and 83 percent report no problems getting to see a specialist. These rates are well above the standards in the NCBD, perhaps reflecting the mix of HMO, PPO, and other types of civilian plans among MHS beneficiaries with civilian care, compared to the HMO enrollees contained in the NCBD.

Nearly 90 percent of women over 40 with civilian coverage get mammographies, exceeding the *HP2010* goal (Figure 30). However, the Pap smear rate of 88 percent is below the *HP2010* goal of 90 percent and reflects a decline of 2 percent from its rate in 2002. Prenatal care rates have increased substantially among those reporting civilian coverage. From 91 percent in 2002, the rate has increased to 96 percent.

Hypertension and cholesterol screening among those with civilian coverage, shown in Figure 31, are consistent with *HP2010* goals of 95 percent and 80 percent, respectively. However, the non-smoking rate of 84 percent is still below the *HP2010* goal.

Figure 30: Beneficiaries with civilian coverage cancer screening and prenatal care

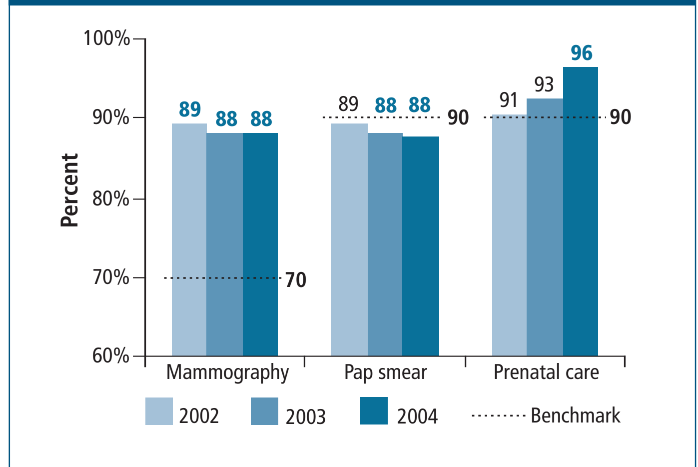
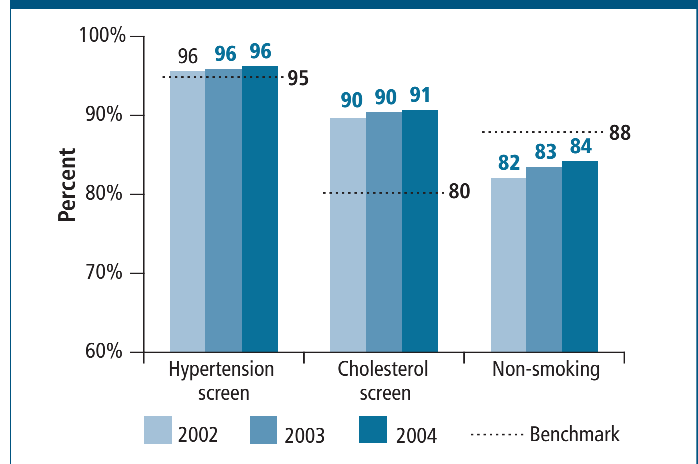


Figure 31: Civilian preventive care



Chapter 8: Care at MTFs, Civilian Facilities, and the VA

About two-fifths of MHS eligibles get their care from MTFs, but the majority of those who rely on a TRICARE plan to provide their health care use MTFs. Figures 32 and 33 report several measures related to the functioning of a clinic or hospital for beneficiaries who use MTFs for most of their health care. These measures include the availability of appointments, waits in the doctor's office, helpfulness of office staff, and length of time spent with doctors.

All measures show slight worsening. As shown in Figure 32, the proportion reporting that staff are usually or always helpful declined from an adjusted value of 84 percent to 81 percent, compared to a benchmark of 88 percent. The proportion reporting that they get enough time with their physicians declined from 81 to 79 percent, compared to an 83 percent benchmark.

Routine appointments also appear to be less readily available. The proportion of beneficiaries reporting they could usually or always get appointments when they want them, shown in Figure 33, declined from an adjusted value of 69 to 65 percent, compared to a benchmark of 79 percent. Waits in the doctor's office are less of a problem than waits for appointments, compared to civilian norms. The rate for MTFs is 51 percent, compared to a civilian norm of 52 percent. Yet in 2002 and 2003, long waits at MTFs were better than or comparable to the civilian norm.

Beneficiaries generally report more positive experiences at civilian facilities than at military ones, as shown in Figure 34. The proportion of MHS beneficiaries at civilian facilities reporting that staff are helpful (93 percent) exceeds the civilian benchmark. The proportion reporting that they get enough time with their physicians (89 percent) is also slightly above the civilian norm. There is no evidence of any worsening trend in physicians' availability or staff helpfulness.

According to beneficiaries' reports, availability of appointments at civilian facilities exceeds the norm from the NCBD. Eighty-nine percent reported that they could get an appointment when they wanted it, as shown in Figure 35. That percentage is nearly identical to percentages in 2002 and 2003. Users of civilian facilities report waits in the doctor's office similar to the NCBD benchmark. Fifty-nine percent

Figure 32: Patients' experiences at MTFs

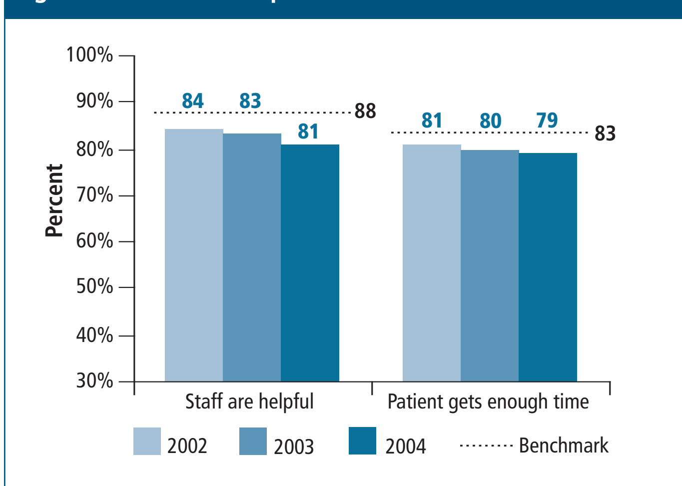


Figure 33: Waiting for care at MTFs

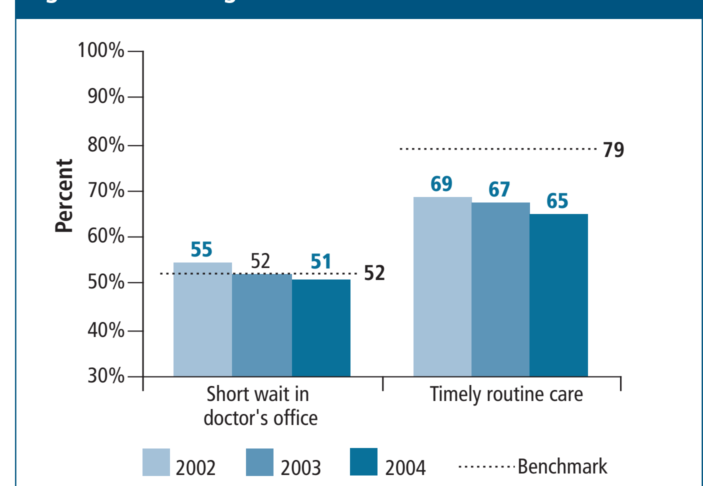


Figure 34: Patients' experiences at civilian facilities

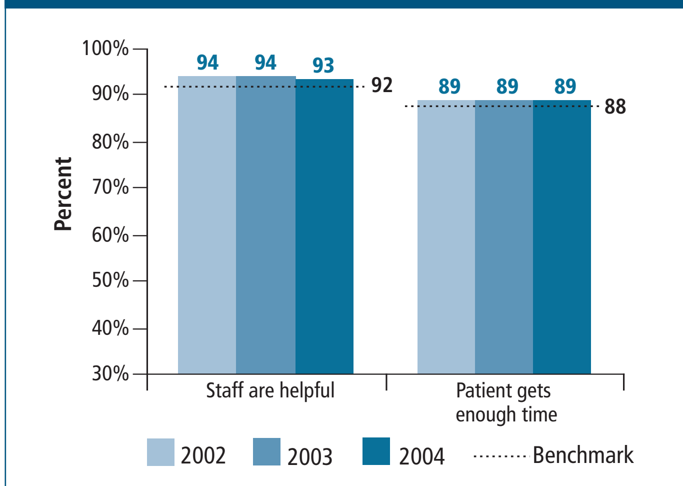


Figure 36: Prime enrollees' experiences at civilian facilities

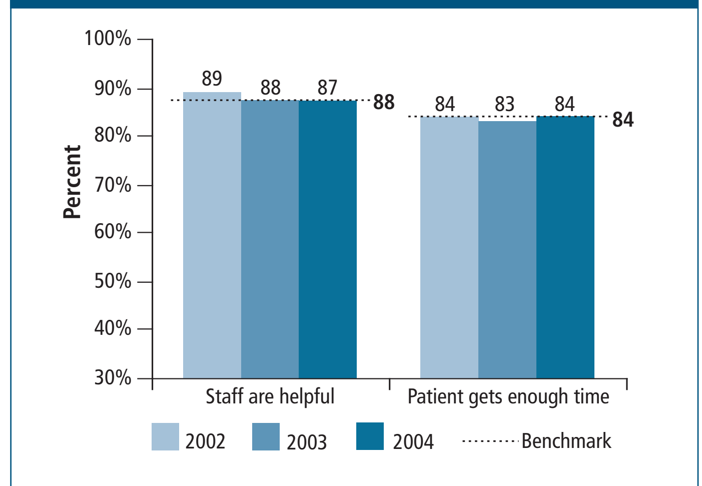


Figure 35: Waiting for care at civilian facilities

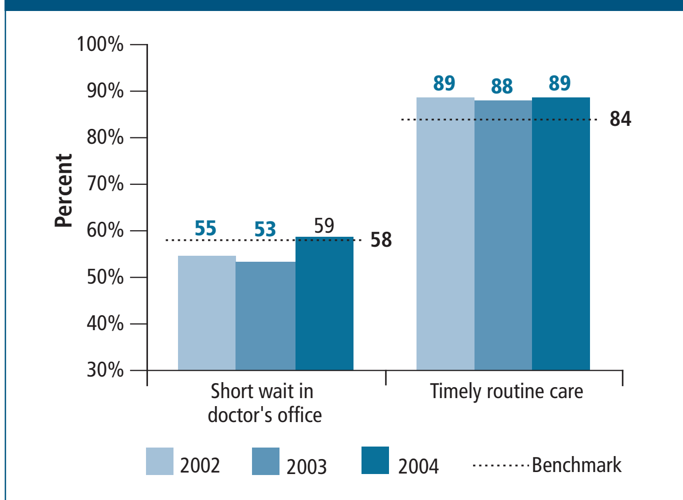
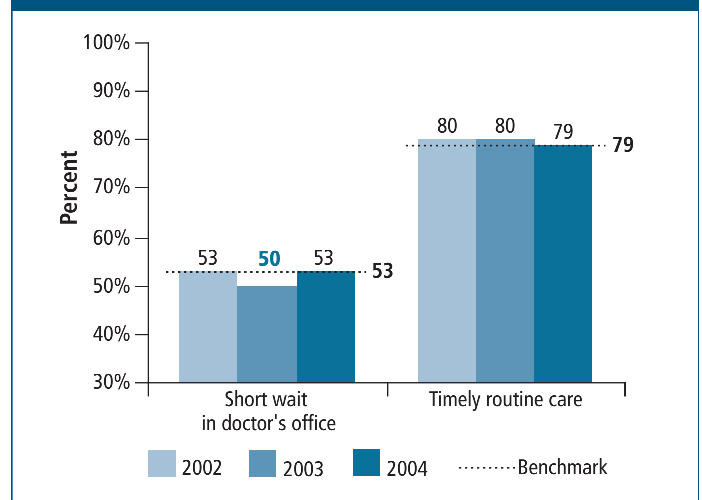


Figure 37: Prime enrollees' waits at civilian facilities



usually or always wait less than 15 minutes, compared to an adjusted benchmark of 58 percent.

Users of civilian facilities include beneficiaries with many different coverage types: TRICARE for Life enrollees, users of civilian health plans, Standard/Extra users, and Prime enrollees who rely on the civilian network. Figures 36 and 37 show the experiences at civilian facilities of a more homogenous group, the Prime enrollees. Prime enrollees who use civilian facilities report less positive experiences than do other users of civilian providers, but more positive experiences than do MTF users. Seventy-nine percent of Prime civilian facility users report that routine appointments are readily available (Figure 37) and 84 percent report that doctors spend enough time with them (Figure 36). Eighty-seven percent report that staff are helpful. Fifty-three percent report short waits in the doctor's office, similar to the benchmark. Rates for all aspects of care, including waits in the doctor's office, waits for routine care, helpfulness of staff and time with doctors are similar to the benchmarks and none of these rates have changed significantly from their values in 2002.

Figure 38: Patients' experiences at VA facilities

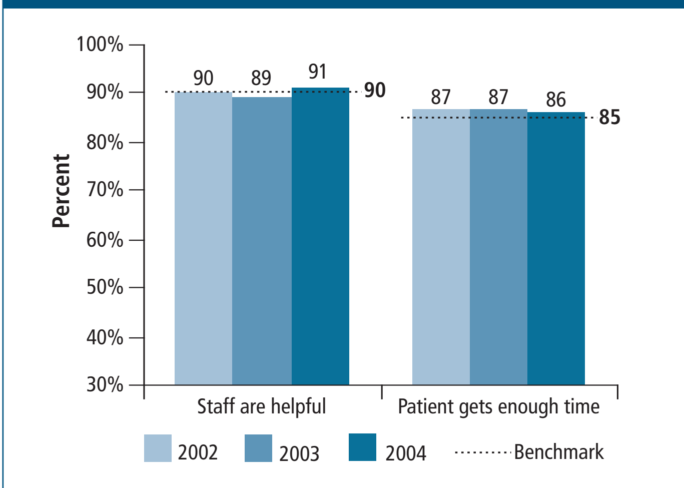
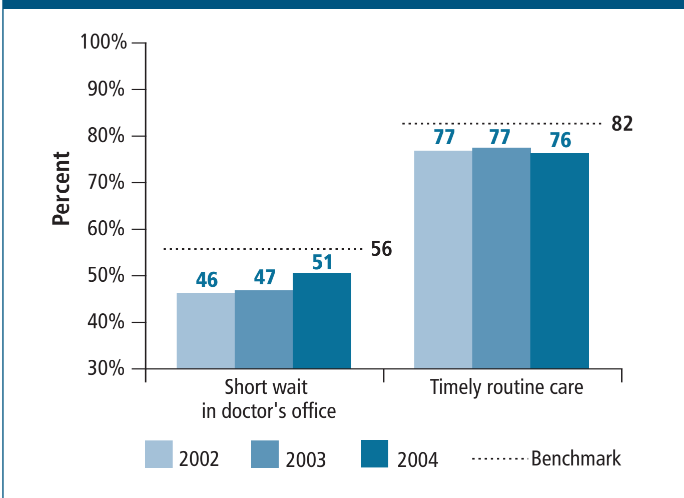


Figure 39: Waiting for care at VA facilities



As shown by Figure 38, beneficiaries who use the VA give high marks for helpfulness of office staff, and time with their doctors. Ninety-one percent report that staff are usually or always helpful, similar to the adjusted NCBD benchmark. Eighty-six percent report that they get sufficient time with doctors at the VA, compared to a benchmark of 85 percent. In neither case has the rating changed substantially since 2002.

Waits for routine appointments at VA facilities fall short of the benchmark, as shown in Figure 39. Seventy-six percent say that appointments are usually or always available, while the benchmark is 82 percent. The proportion that usually or always experiences short waits in the doctor's office (51 percent) is less than the benchmark of 56 percent.

Issue Briefs

These issue briefs first appeared in TRICARE Consumer Watch:

- *Smoking and Smoking Cessation Policies* appeared in May 2004
- *Network Adequacy* appeared in August 2004
- *Referrals to Specialists* appeared in November 2004
- *Reservists' Insurance Coverage* appeared in March 2005

These issue briefs first appeared on the Health Care Survey of DoD Beneficiaries website:

- *Experiences of Children with Special Health Care Needs in TRICARE* appeared in January 2005
- *Overweight Children in the Military Health System* appeared in January 2005

Issue Brief: Smoking and Smoking Cessation Policies

The armed forces have long had a reputation as an environment in which tobacco use is accepted and common.[1] Cigarettes were included as part of the K-rations and C-rations provided to the military during World War II.[2] Drill instructors and company commanders used smoking breaks as both reward and punishment. Early studies found that rates of tobacco use among the military were higher than those of civilians. However, beginning in the 1970s, the Department of Defense (DoD) changed its policies to discourage tobacco use and smoking rates have since declined substantially.

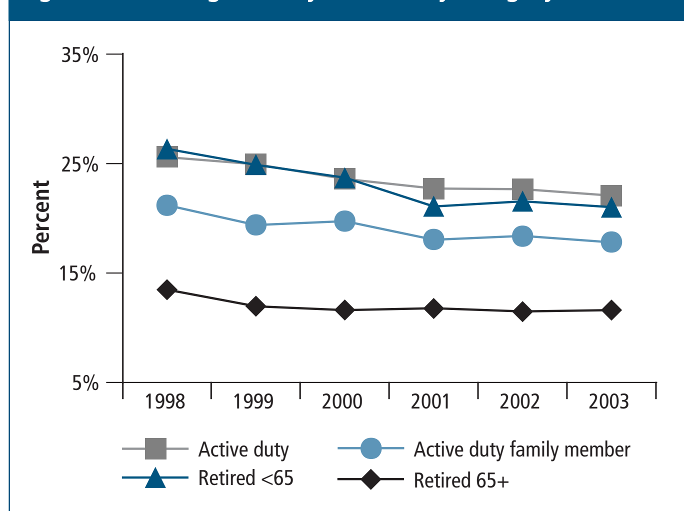
The DoD took its first major step to reduce smoking by discontinuing cigarettes in K-rations and C-rations to soldiers and sailors in 1975.[3] Then in 1986, a new DoD policy ended promotional activities by tobacco companies aimed primarily at DoD personnel; established a system to monitor use of tobacco products in DoD facilities; initiated smoking prevention and cessation programs; and proposed establishment of a Health Promotion Coordinating Committee.[4] That same year, tobacco use during boot camp was banned.[3] In 1996, tobacco prices in military commissaries were increased, resulting in a one-year tobacco sales drop of 20 percent.[5] In 1997, an executive order banned smoking, effective in 1998, in all interior space owned, rented or leased by the executive branch,[6] except, temporarily, for certain Morale, Welfare, and Recreation (MWR) facilities. By December 2002, all DoD facilities were mandated smoke free.

In 1999, the DoD established the Alcohol Abuse and Tobacco Use Reduction Committee (AATURC). The Committee developed a strategic plan to reduce the smoking rate, promote a tobacco-free lifestyle, educate commanders on how to encourage healthy lifestyles, and reduce access to tobacco.[7] Since its creation, the Committee has supported policies to bring tobacco prices at commissaries within 5 percent of local prices, helped to make MWR facilities smoke-free, and coordinated with the American Legacy Foundation to develop a DoD anti-tobacco marketing program.[8]

Besides regulations and price increases to reduce tobacco use, the military health system (MHS) offers medical assistance. Tobacco cessation programs and medications are available from military treatment facilities (MTFs) of all services, though medication availability depends on the MTF's budget. In 2001, the MHS established a clinical practice guideline for cessation in the primary care setting. The guideline assists providers in detecting symptoms, assessing treatment readiness, determining the appropriate setting and intensity of treatment, and delivering individualized interventions.[9]

Figure 1 shows smoking rates calculated from the HCSDB for each beneficiary category, standardized to their age and sex distribution for 2003. Smoking rates for all groups declined between 1998 and 2003. The

Figure 1: Smoking rates by beneficiary category



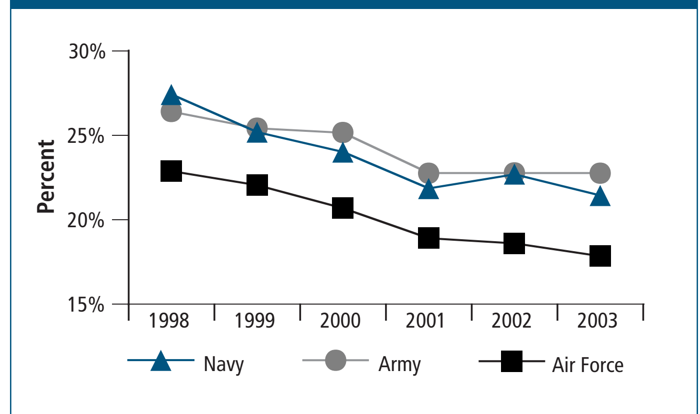
active duty rate fell from 26 percent to 22 percent and the rate for family members of active duty fell a similar amount, from 21 to 18 percent. Most of the measured drop in smoking rates occurred between 1998 and 2001, as rates changed little between 2001 and 2003.

As shown in Figure 2, the proportion of smokers who were counseled to quit increased for each beneficiary group. That increase was smallest for active duty, whose rate went from 63 to 67 percent.

Each branch of service provides resources to encourage cessation. Each service offers similar provider training courses, for example, on prescribing nicotine replacement therapy medication and encouraging cessation. The Army and Navy offer links to smoking cessation resources on wellness-promotion websites. For example, the US Army Center for Health Promotion and Preventive Medicine and the Navy's Environmental Health Center provide websites with resources for both clinicians and patients.

Figure 3 shows smoking rates by service affiliation of the beneficiary's sponsor. These rates are age-sex standardized to be comparable between services. All smoking rates have fallen, with the largest apparent drop experienced by the Navy. Navy rates fell from 27 percent to 21 percent. The Air Force rate was lowest of the services in each year, falling from 23 percent to 18 percent. Figure 4 shows how many have been counseled to quit by service.

Figure 3: Smoking rates by sponsor service affiliation



Counseling rates have increased for all three services, but differences between the services appear to have narrowed over time. Air Force counseling rates were highest in each year from 1999 to 2003, but the spread between the highest and lowest rate decreased from 8 percent to 3 percentage points.

Figure 5 shows that Standard/Extra users' age-sex adjusted smoking rates are highest compared to Prime and civilian insurance users and have increased since 2001. As shown by Figure 6, counseling rates have increased for all enrollment groups. Counseling rates were lowest for Standard/Extra users compared to Prime users and users of civilian insurance before 2003, when the rate jumped from 60 to 72 percent.

Although tobacco cessation programs and medications are available at MTFs, TRICARE policy specifically excludes reimbursement for cessation-related expenses.[10] However, AATURC has encouraged TRICARE to add a cessation benefit. In 2003, TRICARE proposed a demonstration program for such a benefit, to be piloted in a limited area in 2004 or 2005, covering counseling and prescription and over-the-counter medications with preauthorization.[10]

Figure 2: Counseled to quit by beneficiary category

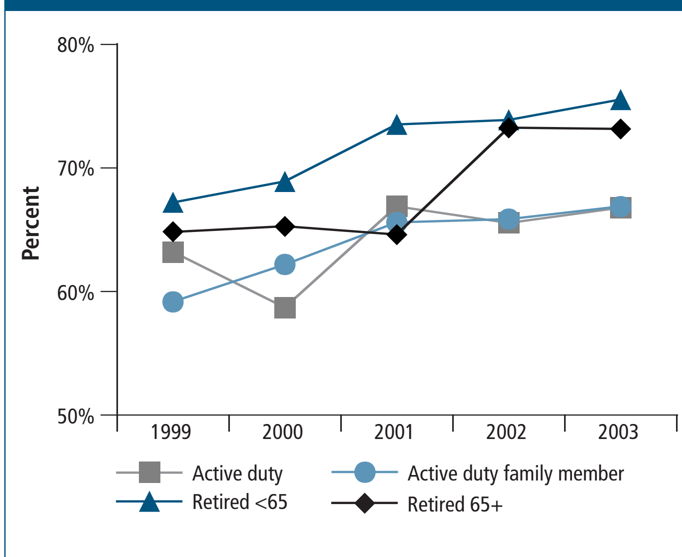


Figure 4: Counseled to quit by sponsor service affiliation

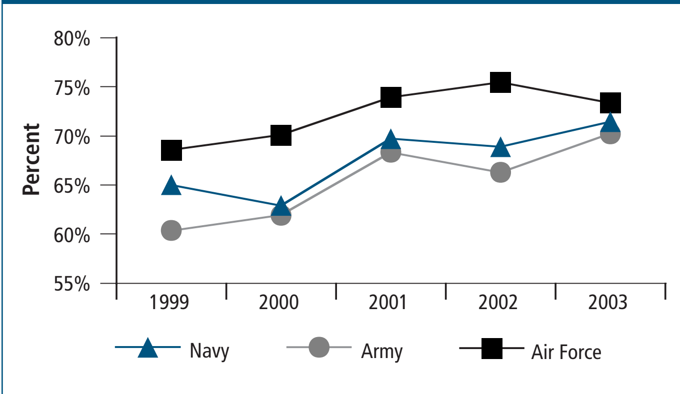


Figure 5: Smoking rates by enrollment group

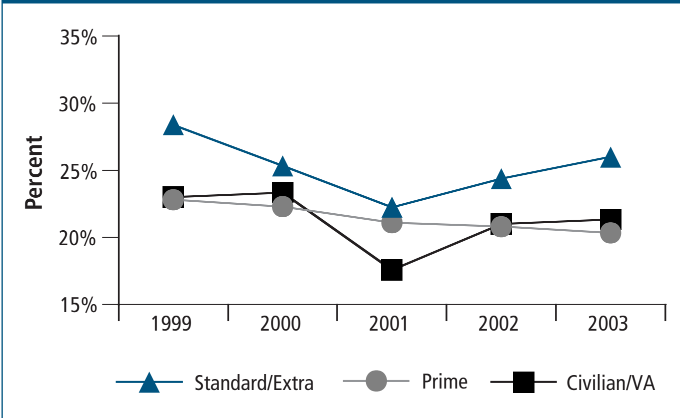
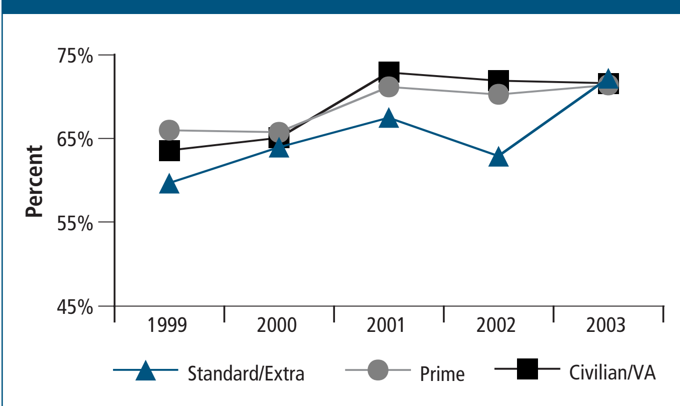


Figure 6: Counseled to quit by enrollment group



Notes

[1]Bray, Robert, Laurel Hourani, Kristine Rae, et al. "2002 Department of Defense Survey of Health Related Behaviors Among Military Personnel."

[2]Conway, Terry. "Tobacco Use and the United States Military: A Longstanding Problem." *Tobacco Control*. Volume 7, 1998.

[3]Williams, Larry. "Tobacco Cessation and the Department of Defense/Department of Veterans Affairs Populations." Presentation at the 2004 TRICARE Conference in Washington, DC. January 28th, 2004.

[4]Department of Defense. "DoD Directive Number 1010.10." March 11, 1986. At http://www.sbasap.com/files/d101010p.pdf.

[5]Philpott, Tom. "Commissary Director Beale Interviewed." Naval Affairs. Fleet Reserve Association. At http://www.fra.org/navalaffairs/9904/na9904a.html.

[6]Kozaryn, Linda. "DoD to Phase Out Smoking at Recreation Facilities." *American Forces Information Service*. April 14, 2000.

[7]AATURC. "Tobacco Use Prevention Strategic Plan." April 2, 1999. At www.tricare.osd.mil/hpp/aaturc_actionplan_tobacco.html.

[8]Messelheiser, Dean . "DoD Tobacco Use Cessation: What's Working Now and the Challenges Ahead." Presentation at the 2004 TRICARE Conference in Washington, DC. January 28th, 2004.

[9]Tobacco Use Cessation Workgroup. "VHA/DoD Clinical Practice Guideline to Promote Tobacco Use Cessation in the Primary Care Setting." At http://www.oqp.med.va.gov/cpg/TUC/G/TUC_CPG.pdf.

[10]Grissom, Joyce. "Benefits and Administrative Programs Under Development." Presentation at the Region 3 TRICARE Management Activity Conference on August 7, 2003.

Issue Brief: TRICARE Civilian Network

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

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

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

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

Retirees and their dependents and the family members of reservists are the heaviest users of the civilian network. As shown in Table 1, 49 percent of retired enrollees and their family members get most or all of their care from the network, compared to 37 percent of active duty dependents. Among active duty dependents, 61 percent of reservist family members rely on the civilian network. Though retirees

Figure 1: Prime enrollees use of TRICARE civilian network

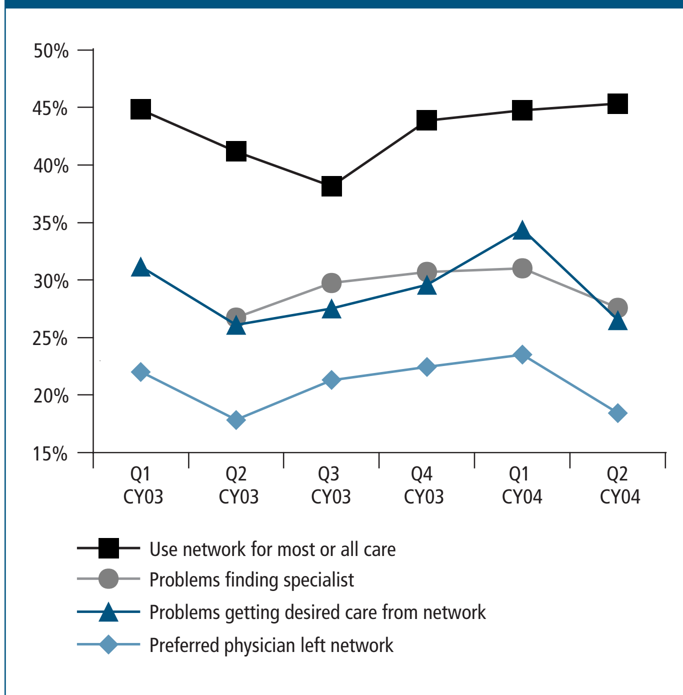


Table 1. Network use by beneficiary category: Q3 CY03 to Q2 CY04

	Retirees and dependents	Active duty family member	Of active duty family members: Reservist	Of active duty family members: Other active duty
Use network for most or all care	49%	37%	61%	33%
Problems finding specialist	28%	32%	37%	32%
Problems getting desired care from network	27%	33%	35%	32%
Preferred physician left network	23%	19%	25%	18%

report fewer problems than do active duty families in finding the care or specialist they want from the network, they are more likely to report that a doctor they wanted to see had dropped out. Reservists are more likely than other active duty family members to encounter problems finding care or specialists they want, and are also more likely to report wanting to see a doctor who had left the network.

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

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

Table 2. Network use by catchment area residence: Q3 CY03 to Q2 CY04

	In catchment	Out of catchment
Use network for most or all care	31%	62%
Problems finding specialist	30%	30%
Problems getting desired care from network	29%	30%
Preferred physician left network	19%	24%

Table 3. Network use by region: Q3 CY03 to Q2 CY04

	North	South	West
Use network for most or all care	40%	48%	43%
Problems finding specialist	33%	30%	26%
Problems getting desired care from network	34%	29%	27%
Preferred physician left network	22%	23%	21%

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

Notes

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

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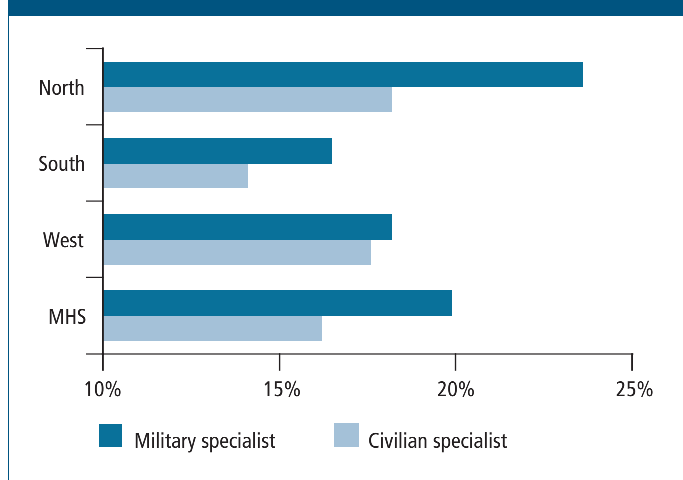
[6]United States General Accounting Office. Oversight of the TRICARE Civilian Network Should Be Improved. July, 2003.

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

Issue Brief: Referrals to Specialists

Under TRICARE Prime, military and civilian physician networks both provide care to enrolled patients. By permitting patients to get care from both sources, Prime increases patients' access to health care resources. However, combining the two networks creates challenges in care coordination and management. HPA&E recently conducted focus groups with physicians and patients to learn about problems with referrals to specialists under Prime.[1] Both doctors and patients described barriers affecting access to specialists and communication between primary care managers (PCMs) and specialists. Questions were added to the HCSDB to learn more about these barriers.

Figure 1: Waiting more than 4 weeks to see a specialist



Access to specialists

Before obtaining an appointment with a specialist, TRICARE enrollees must consult their PCM for a referral. Referrals from the PCM may be directed to a particular specialist or clinic, or to a particular specialty. In either case, TRICARE Access to Care standards require that the enrollee be provided an appointment within four weeks.[2]

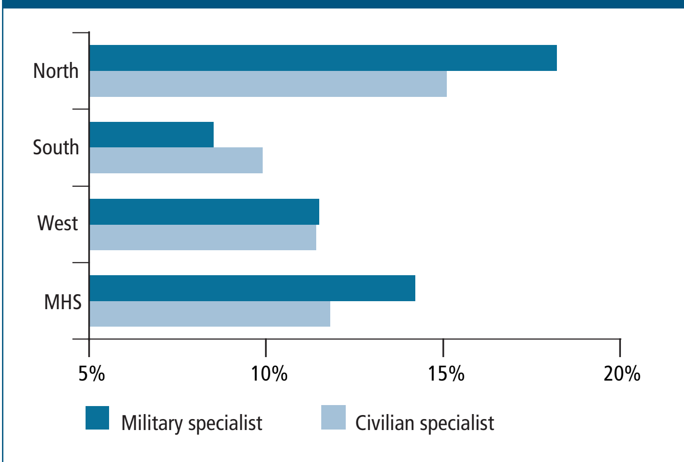
Figure 1 shows the proportion of enrolled patients who obtained appointments with civilian and MTF specialists within 4 weeks, by region. In spite of access standards, many enrollees report long waits for both direct care and civilian appointments. One sixth of those seeing civilian specialists and one fifth of those seeing military specialists report a wait of longer than 4 weeks. In the north, waits for military specialists are particularly long.

Twenty-four percent in the north report waiting more than 4 weeks to see a military specialist compared to 17 percent in the south and 18 percent in the west. There is less regional variation in waiting times for civilian specialists. In both the north and west region, 18 percent report waits of more than 4 weeks, compared to 15 percent in the south.

Patients who are referred to specialists may see a civilian specialist who is convenient to them or consult a direct care specialist. However, patients are referred to direct care specialists in preference to purchased care specialists if direct care specialists are available. In some regions, the civilian network may contain few members in the desired specialty. In regions where PCMs are reluctant to make referrals to civilian specialists or where the civilian network is weak, patients may be forced to travel long distances if their local MTF does not staff many specialists.

Figure 2 shows that travel times are longest in the north region. Eighteen percent report traveling over two hours to see a specialist at a MTF. Patients in that region are also likely to spend a long time traveling to see civilian specialists, with 15 percent reporting trips of more than two hours. Overall, Prime patients are only slightly more likely to make long trips for MTF specialty care (14 percent) than for civilian care (12 percent). The results indicate that

Figure 2: Traveling more than 2 hours to see a specialist



preferences for MTF care do not greatly increase the patient's travel burden.

Communication with specialists

PCMs are responsible for managing the care the patient receives from all sources. By awareness of all the patient's specialty care, the PCM can avoid unnecessary tests and treatments and manage all chronic and acute conditions. Focus groups revealed that both doctors and patients were concerned that communication between PCMs and specialists was poor. HCSDB results also indicate problems.

As shown in Table 1, information gets from specialists to PCMs by different routes depending on whether the referring PCM and specialist are military or civilian. PCMs learn about the patient's treatment by talking to the specialist 37 percent of the time when both specialist and PCM are civilian and 20 percent of the time when the PCM is military and the specialist is a civilian. Military PCMs communicate with civilian specialists most often through the patient. Twenty-seven percent of patients with military PCMs report that they are responsible for keeping their PCM informed about their treatment from specialists. By contrast when the specialist is military, neither civilian nor military PCMs are likely to communicate directly

Table 1. How PCMs and specialists communicate

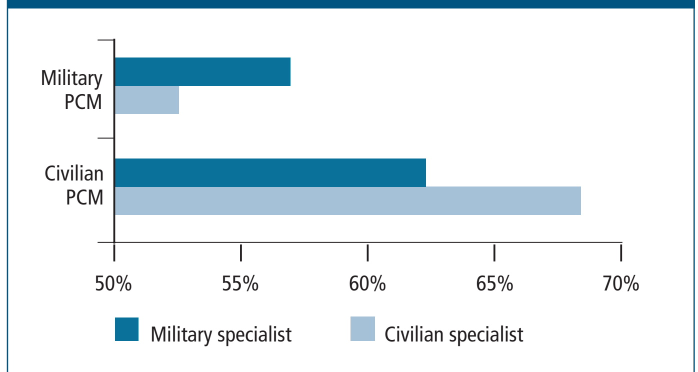
		Communication method*		
		By patient record	Through patient	Doctor to doctor
PCM	Specialist		Percent	
Military	Military	34	19	11
	Civilian	15	27	20
Civilian	Military	24	23	14
	Civilian	11	20	37

*Omitted categories: Don't know, PCM does not keep track.

with the specialist. Military PCMs are most likely to refer to the patient record (34 percent), while civilian PCMs most often refer to the patient record (24 percent) or the patient (23 percent).

As a result, many patients do not feel that their PCM gets enough information about their specialty care. As shown in Figure 3, only 52 percent of patients think their military PCM usually or always knows enough about their care from civilian specialists. Communication is rated best when both PCM and specialist are civilian. Sixty-eight percent with civilian PCMs think that their PCM usually or always knows enough about their care from civilian specialists. Whether the specialist is from direct care or purchased care, patients with civilian PCMs feel that their PCM is better informed about their specialty care than do patients with military PCMs.

Figure 3: PCM usually/always knows enough about the care received from a specialist, by PCM



Conclusions

Long waits for appointments and long trips to see specialists vary by region, and appear to be most frequent in the north. These problems may be explained by weaknesses in the civilian network. Strengthening the civilian network may help to overcome them. Communication problems are greatest when civilian specialists provide care to patients of military PCMs. To ensure high quality care, more must be done to break down barriers between the military and civilian networks.

Notes

[1]Cohen, R, Zeidman, E and Schone, E. *The TRICARE Referral and Authorization Process: Findings from Focus Groups with Providers and Beneficiaries.* Mathematica Policy Research, Washington DC. July, 2004.

[2]United States General Accounting Office. *Factors Affecting Contractors' Ability to Schedule Appointments (GAO-00-137).* Washington, DC: July 2000.

Issue Brief: Reservists' Insurance Coverage

In recent years, both the number of mobilized reservists called to active duty, and the length of their deployments, have increased dramatically. As of December 31, 2003, there were 183,746 mobilized reservists, and the average length of duty was 319 days.[1,2] Mobilization results in many changes in the lives of reservists and their families, one of which is how the reservist and his or her family may receive their health care.

When tours of duty are 30 days or less, the Uniformed Services Employment and Reemployment Rights Act of 1994 protects reservists' employer-provided health benefits, but if the length of duty is 31 days or more, civilian coverage continues only if the employee pays for coverage or the employer agrees to continue it. Reservists mobilized for more than 30 days are covered by TRICARE Prime, and most receive their care at military treatment facilities (MTFs). Dependents of reservists mobilized for more than 30 days are entitled to network or MTF care from TRICARE Prime, to TRICARE Standard/Extra, or TRICARE Prime Remote if they do not live near MTFs.

As the number of military reservists called to active duty, and their length of service increases, congress has taken steps to improve reserve members' health benefits. Congress has produced legislation to promote the goals of ensuring that reservists have continuous coverage, that their financial burdens are reduced, and that disruption in the doctor-patient relationship is avoided.[3]

To promote continuous coverage, the National Defense Authorization Act (NDAA) of 2005 makes permanent two provisions included in the 2004 NDAA, allowing reservists and their families to become eligible for TRICARE benefits up to 90 days before and retain them as long as 180 days after, mobilization.[4] The 2005 NDAA also extends coverage by allowing reservists who commit to continued service in the Selected Reserves to purchase TRICARE Standard for themselves and family members after they demobilize.[5] TRICARE is providing the benefit under the name TRICARE Reserve Select, beginning in April, 2005.[6]

The 2005 NDAA reduces reservists' financial burdens by waiving deductibles for reservists called to active duty for more than 30 days, to ensure that mobilized reservists do not pay deductibles for both private health insurance and TRICARE. The legislation also extends a waiver allowing physician payments 15 percent above TRICARE's maximum for reservists' family members to avoid disrupting patient-doctor relationships.

Civilian Coverage Prior to Mobilization

Results from the HCSDB describe the health insurance coverage of reservists and their families before and after mobilization, who bears the cost of coverage, and how access to primary care and specialist physicians has changed. Table 1 shows that most reservists and their family members are covered under the reservist's policy before mobilization. Sixty-two

Table 1. Civilian insurance coverage of reservists and family members of reservists before mobilization

	Reservist	Family members of reservist
Civilian insurance through reservist's policy	62%	62%
Civilian insurance through family member's policy	14%	24%
No civilian health insurance	24%	13%

percent of mobilized reservists are covered under their own policy and the same percentage of family members had coverage through the reservist's policy. A total of 76 percent of reservists and 87 percent of family members surveyed had civilian coverage. The difference is because only 14 percent of reservists but 24 percent of family members have coverage through a non-reservist family member's policy.

Keeping Civilian Coverage after Activation

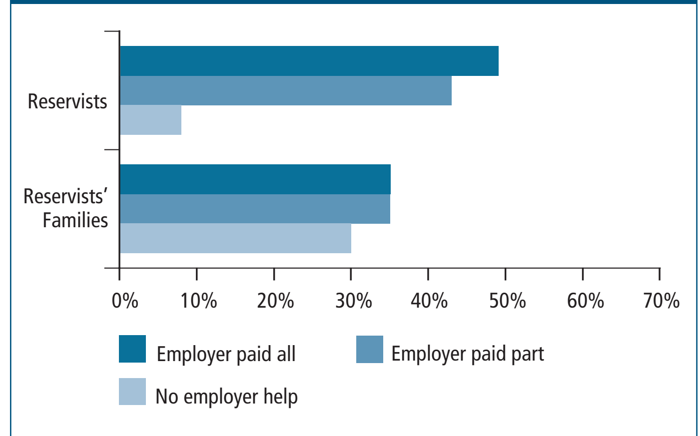
Table 2 indicates that most reservists and their families rely on TRICARE following mobilization. Sixty percent of family members say they rely on TRICARE only, and another 21 percent use both civilian coverage and TRICARE. Substantial proportions continue to carry civilian coverage, including 30 percent of reservists and a total of 40 percent of family members.

As shown in Figure 1, continuing civilian coverage, even with TRICARE benefits, may represent a financial burden. Of reservists who keep their civilian coverage, more than half pay at least partial premiums. Forty-three percent receive a partial subsidy from their employer, while 8 percent receive no contribution. Family members are still more likely to keep their reservist's civilian coverage, even when they must pay for it. Nearly two thirds of those who retain their civilian coverage pay at least part of the premium and 30 percent retain coverage even though the reservist's employer provides no assistance.

Table 2. Reservists retaining civilian coverage

Reservists	
Kept civilian coverage	30%
Dropped coverage	70%
Reservists' families	
Use only civilian coverage	19%
Use civilian coverage and TRICARE	21%
Use only TRICARE	60%

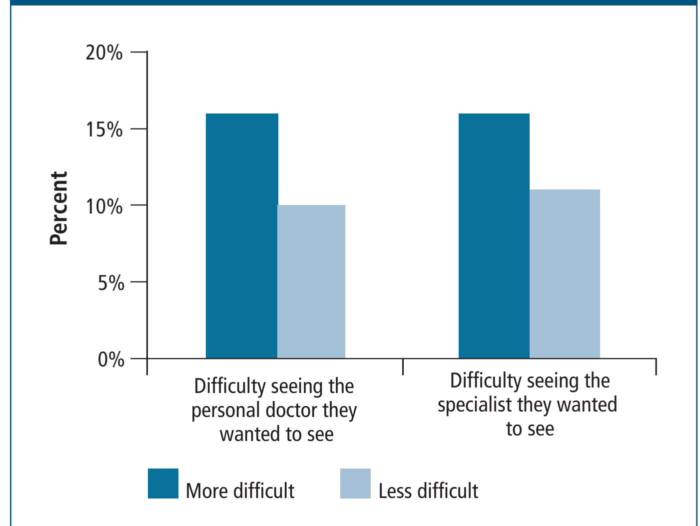
Figure 1: Employer contributions for reservists retaining civilian coverage



Reservist Family Members' Access Under TRICARE

As shown in Figure 2, most family members using TRICARE thought that the difficulty in seeing their personal doctor or preferred specialist was the same after mobilization as it was before the reservist was mobilized. However, more report that access to personal doctors and specialists has worsened than report that it has improved.

Figure 2: Family members' access to physicians under TRICARE following mobilization



Conclusion

Findings from the HCSDB indicate that nearly nine out of ten reservist family members were covered by civilian insurance when their reservist was mobilized, 62 percent through the reservist's policy. Though most of those covered by their reservist's insurance rely on TRICARE for coverage following mobilization, 40 percent use civilian coverage for all or part of their care. Nearly a third of those who retain civilian coverage do so even when they must bear the full price of coverage. They retain coverage in spite of recent efforts to relieve them of financial burdens and to make relying on TRICARE easier.

Most family members who rely on TRICARE report that their access to physicians has improved or stayed the same since mobilization. However, substantial numbers report that access to personal doctors and specialists has worsened. Helping beneficiaries who face poorer access under TRICARE or who are unwilling to give up civilian coverage even when they must bear its full premium are specific goals of recent legislation and TRICARE Reserve Select. Monitoring access and coverage decisions will indicate whether these efforts have been successful.

Notes

[1]Department of Defense. "National Guard and Reserve Mobilized." Weekly News Release. Accessed at http://www.defenselink.mil/releases/archive.html. Retrieved 2/28/05.

[2]Office of the Secretary of Defense, Reserve Affairs, Employer Support of the Guard and Reserve. "Congressional Response." Prepared for House Report 108-187. March 31, 2004

[3]FY 2005 National Defense Authorization Act.

[4]These two provisions were to expire on Dec 31, 2004. Eligibility begins as soon as reservists receive their orders for activation or 90 days before activation (whichever is later), as long as their activation is for more than 30 days.

[5]Reservists must be called or ordered to active duty on or after September 11, 2001. For each period of 90 consecutive days of active-duty service, the reservist is entitled to one year of TRICARE coverage while in a non-active duty status.

[6]"Coming Soon-TRICARE Reserve Select Health Plan for Certain National Guard and Reserve Members." News Release, March 25, 2005. At http://www.tricare.osd.mil/news/2005/news0506.cfm.

HCSDB Issue Brief: Overweight Children in the Military Health System

In recent years, pediatricians have raised the alarm that a "pandemic" of childhood obesity is affecting American youth. Excess body weight in children can lead to many health problems, including type 2 diabetes, once an adult disease, which has become increasingly common in children. Overweight youth are also likely to become overweight adults, risking numerous health problems, including cancer, respiratory conditions, and cardiovascular disease, as well as premature death.[1] The Centers for Disease Control and Prevention (CDC) has established standards for children's weight based on the the distribution of children's height and weight during the 1970s. According to these standards, children are overweight if their body mass index (BMI), an index calculated from their weight and height, is at or above the 95th percentile for children of their age and gender. Children are at risk for becoming overweight if their BMI is above the 85th percentile but below the 95th percentile.

Prevalence

In the Health Care Survey of DoD Beneficiaries for children, parents are asked to report the estimated height and weight of a selected child. As shown in Figure 1, among DOD beneficiaries ages 6 to 17, BMI's from parental reports indicate that approximately 13 percent of children are overweight, and another 17 percent are at risk for becoming overweight.

Within the sample of children 6 to 17, more boys are overweight than girls (16 percent compared to 11 percent), and children whose reporting parent is less educated are more often overweight than are children whose parent has at least some college (16 percent compared to 13 percent with a high school education). More black children are overweight and at risk for being overweight than are children of other races or ethnicities.

Figure 1: Percent of children age 6 to 17 at, below, or over normal weight

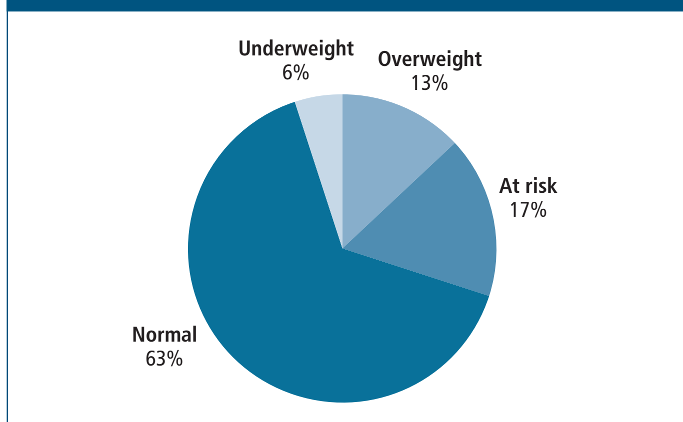
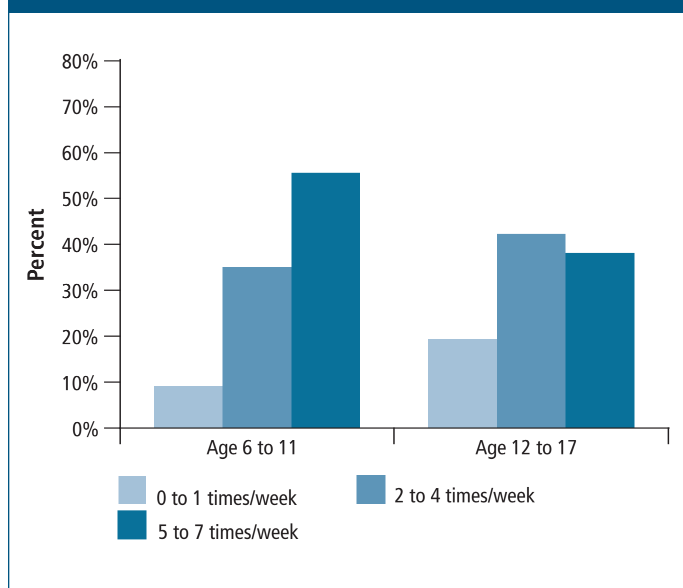


Figure 2: Frequency of vigorous exercise



Physical Activity

Obesity arises when energy intake in the form of food exceeds energy expended through physical activity. Causes of obesity may be divided into those that reduce energy expenditure and those that increase intake. To identify the role of these factors, questions in the HCSDB ask about children's exercise, television watching and consumption of fast foods.

According to their parents, children become less active as they get older. Fifty-six percent of children aged 6 to 11 and 38 percent aged 12 to 17 are vigorously active for at least 20 minutes 5 or more days per week, where vigorous activity means exercise that causes heavy breathing or sweating. Nine percent of younger children and 19 percent in the older group are vigorously active once per week or less.

Children who are overweight according to their parents exercise less often than children of normal weight. As shown in Figure 3, 49 percent of overweight children age 6 to 11 and 57 percent who are of normal weight exercise vigorously 5 or more days a week, while 27 percent of overweight older children and 40 percent who are of normal weight exercise that frequently.

Watching Television

Television watching and similar activities can substitute for physical activity, contributing to obesity. According to their parents, 40 percent of children 6 to 11 and 47 percent of children 12 to 17 watch 3 or more hours of television a day. Only 8 percent of the older group and 9 percent of the younger group watch one hour or less. Among overweight children, television watching is still more frequent: 58 percent in the older group and 49 percent in the younger watch 3 or more hours.

As shown in Figure 5, television watching is highest among black children. Comparing overweight children with children of normal weight by race, 71 percent of overweight black children watch television 3 or more hours per day, compared to 36 percent of white children of normal weight.

Eating Fast Food

Obesity is also promoted when, through an unhealthy diet, energy intake is increased compared to energy expended. One indicator for an unhealthy diet may be how often a child eats at a fast food restaurant. As shown by Figure 6, among DOD

Figure 3: Obesity and frequent vigorous exercise

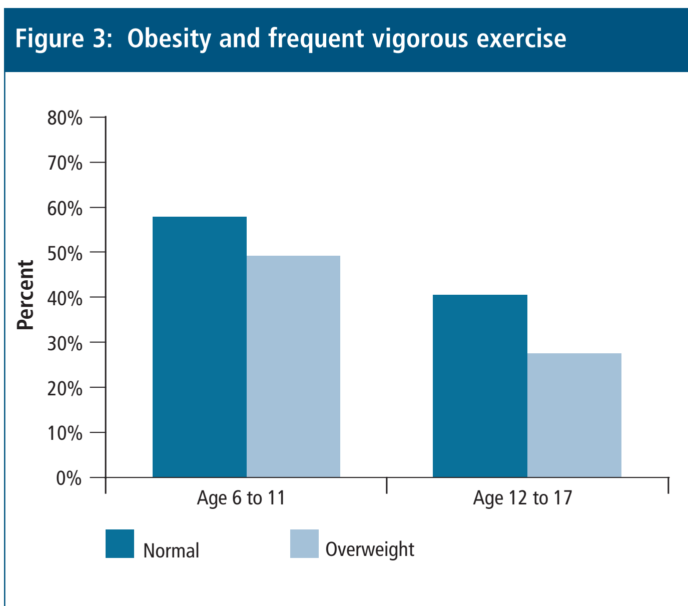


Figure 4: Daily television watching

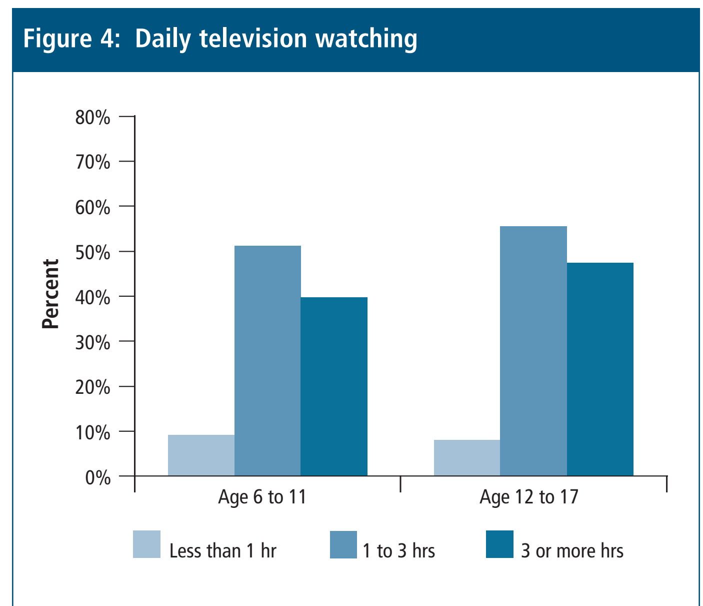


Figure 5: Frequent television watching by race/ethnicity and weight

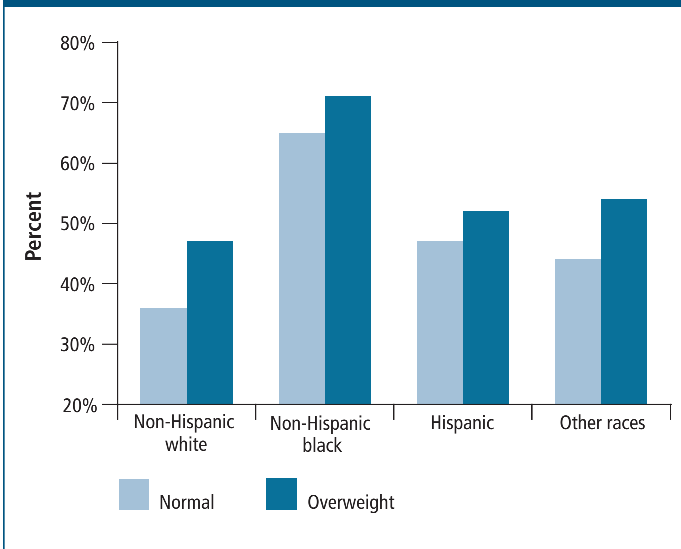
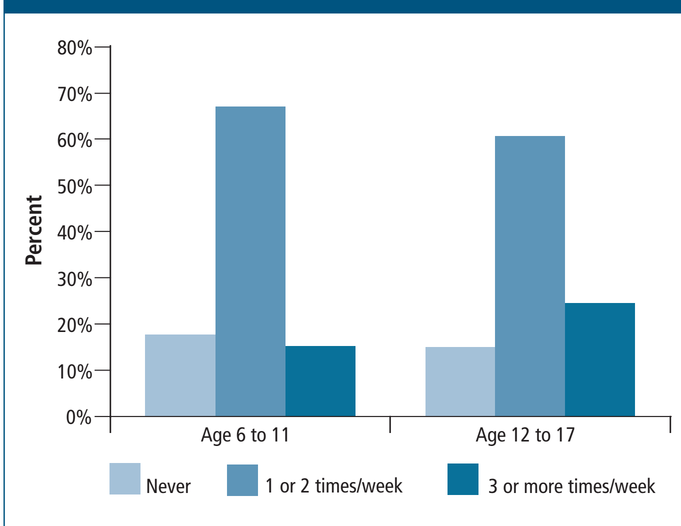


Figure 6: Fast food consumption



beneficiaries ages 6 to 11, 18 percent never eat fast food and 15 percent eat it three or more times a week. Among children 12 to 17, 15 percent never eat fast food and 25 percent eat it three times a week or more. Fast food does not appear to be strongly associated with obesity, however. About a quarter of adolescent children of all weight categories eat fast food frequently, as do 20 percent of obese and 15 percent of normal weight among children 6 to 11.

Conclusion

As in the civilian population, the number of overweight children indicated by the HCSDB suggests that obesity is a growing problem in the MHS. Behavior that makes children more likely to be overweight, such as not exercising enough, watching many hours of television and eating unhealthily are more common among older children. Black children also appear to be at greater risk for these reasons. Programs or communications to promote a healthy lifestyle may be especially important for these groups.

Notes

[1]U.S Surgeon General. “Overweight and Obesity: Health Consequences.” The U.S. Surgeon General’s Call to Action to Prevent and Decrease Overweight and Obesity. Retrieved 12/13/04. http://www.surgeongeneral.gov/topics/obesity/calltoaction/factsheet03.pdf.

HCSDB Issue Brief: Experiences of Children with Special Health Care Needs in TRICARE

Children with special health care needs (CSHCN) are "children who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally." Among children whose parents responded to the Health Care Survey of DoD Beneficiaries (HCSDB), 26 percent who use TRICARE Prime or Standard/Extra for most of their care were identified from survey responses as CSHCN.[1] Many CSHCN need a wide range of services and may be at risk for poor health outcomes because their care, coordination of needed services, or access to care are inadequate. Recent studies of CSHCN showed that 7 percent do not obtain needed specialty care (Mayer, et al. 2004); 11 percent do not receive needed therapy services; and 9 percent do not receive needed mobility aids (Dusing, et al. 2004).

According to American Academy of Pediatrics (AAP) guidelines, doctors and health plans serving CSHCN should be particularly attentive to the need for "accessible, comprehensive, continuous, compassionate and family-centered" care (American Academy of Pediatrics, 1999). Doctors and nurses must work to overcome families' lack of information about resources, and to coordinate medical and non-medical services. With TRICARE, active duty parents of children with special needs are served by programs that provide access to needed services, assist parents when they must change duty stations, and provide financial and other assistance purchasing needed services or equipment (GAO, 2001).

[1]HCSDB questions that identify CSHCN concern children's need for prescription medicine; use of care or educational services; or limitations in their ability to do the things most children of the same age can do. The questions are widely used by researchers into children's health to identify CSHCN.

Health Care Ratings

Most parents who rely on TRICARE give high marks for the health care their children receive. As shown in Table 1, among both CSHCN and non-CSHCN, about half of parents who respond give the highest ratings (9 or 10) on a 1 to 10 scale to their personal doctor or nurse (53 percent for CSHCN and 50 percent for others), specialist (55 percent for CSHCN compared to 52 percent), and overall health care (53 percent for both).

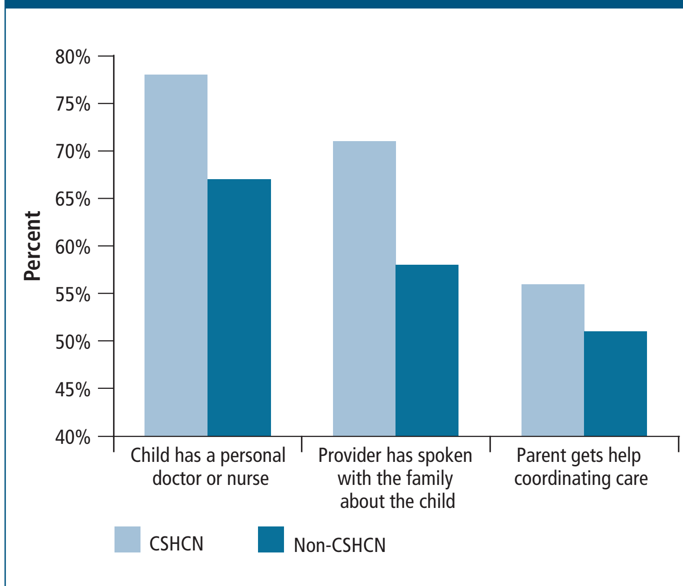
In several dimensions of care that are particularly important to CSHCN, their parents report better care than do parents of non-CSHCN. As shown in Figure 1, 78 percent of CSHCN have a personal doctor or nurse compared to 67 percent of non-CSHCN. Similarly, parents of CSHCN are more likely than non-CSHCN parents to report that their child's personal doctor has spoken with the family about how the child is feeling, growing, or behaving. However, these results also indicate that of CSHCN, who are the children most in need of a personal doctor, more than 20 percent did not have one.

Figure 1 also shows that 56 percent of families with CSHCN who got care from more than one type of provider or used more than one type of service got help coordinating their child's care compared to 51 percent of families with non-CSHCN. Though

Table 1. Health care of CSHCN and non-CSHCN

	CSHCN	Non-CSHCN
	Percent	
Health care rated 9 or above	53	53
Personal doctor rated 9 or above	53	50
Specialist rated 9 or above	55	52

Figure 1: Primary care for CSHCN and non-CSHCN



parents of CSHCN were more likely than parents of non-CSHCN to get help coordinating care, their responses indicate that nearly half of both CSHCN and non-CSHCN did not get the help they needed.

Another dimension of care particularly important to CSHCN is "family-centeredness." Table 2 shows that, for families that have had to make decisions about their child's health care, families with CSHCN and non-CSHCN report very similar experiences. About four-fifths of both groups say their doctors consistently involve the family as much as the family wants in decisions about their child's care. Approximately three-fourths of parents for both populations, report their doctors offer choices about the child's health care; 80 percent of parents report that these doctors discuss the pros and cons of their child's treatment options; but only 71 percent of CSHCN parents and 70 percent of non-CSHCN, say their doctors ask what choice the family prefers.

Table 2. Getting help with children's special needs

Doctors usually or always …	CSHCN	Non-CSHCN
	Percent	
Involve the family	82	81
Offer choices	77	76
Discuss pros and cons	80	80
Ask family what they prefer	71	70

Access to Care

Many parents report that children who rely on TRICARE for their health care encounter access problems. As they do in the civilian population, CSHCN in TRICARE encounter problems more frequently than do other children. For example, as shown in Figure 2, 51 percent of parents with non-CSHCN felt it was a problem to find their child a personal doctor or nurse with whom they were happy but 67 percent of families with CSHCN reported that problem. More parents of CSHCN than parents of non-CSHCN also report it is a problem to see a specialist or to get tests or treatments that their doctor thinks are needed.

Similarly, when children need special services, more CSHCN than non-CSHCN encounter problems meeting their needs. As shown in Figure 3, parents of CSHCN report more problems getting prescription medicine (25 percent compared to 17 percent), special medical equipment (41 percent compared to 25 percent), and special therapy (60 percent compared to 43 percent).

Figure 2: Problems obtaining needed care by CSHCN and non-CSHCN

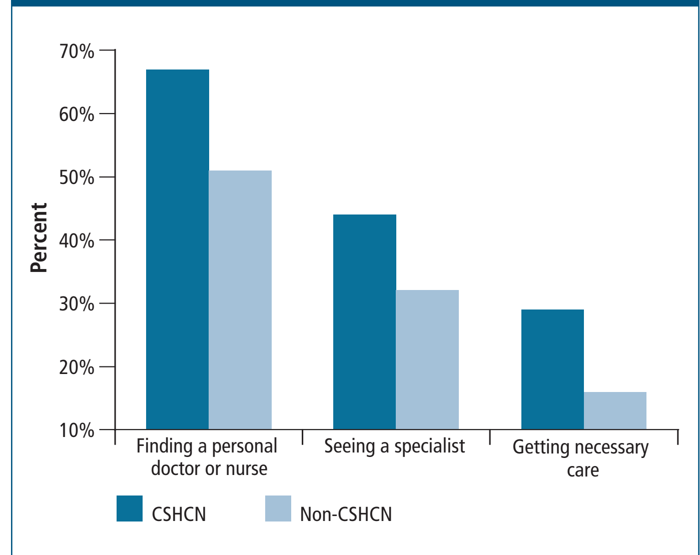
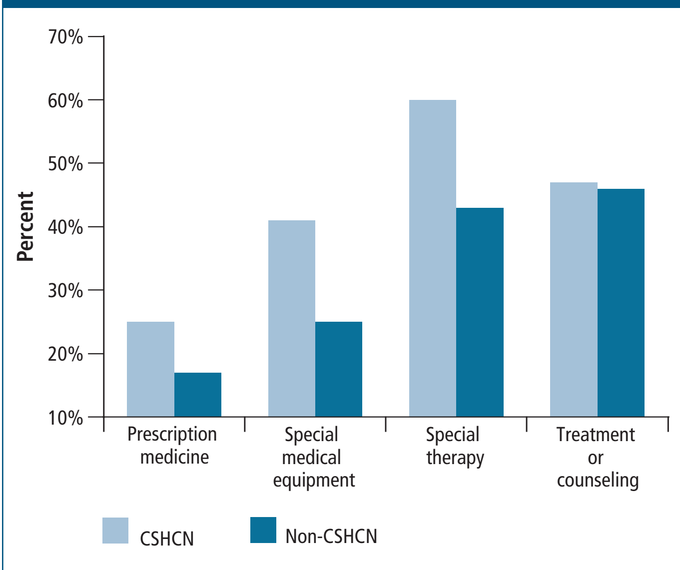


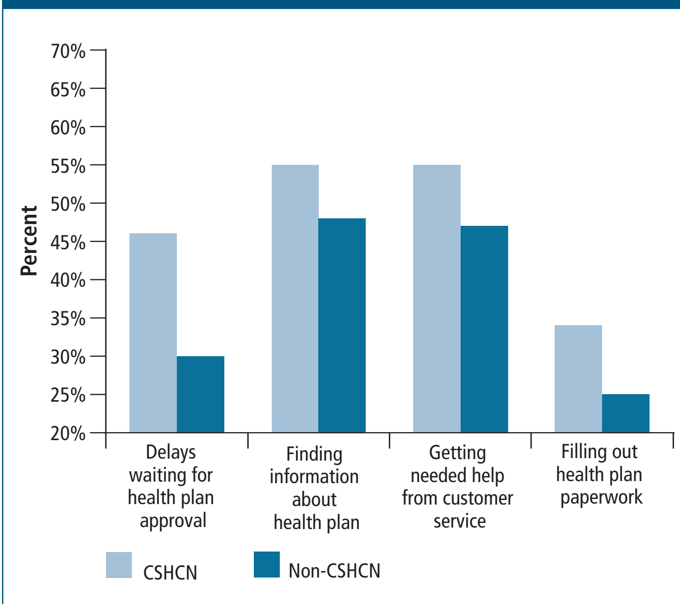
Figure 3: Problems obtaining special services by CSHCN and non-CSHCN



Because they must interact frequently with their health plans to get access to the treatments their children need, parents of CSHCN experience more problems with their health plans than do parents of non-CSHCN.

As shown by Figure 4, families with CSHCN are more likely than other families to encounter delays caused by waiting for health plan approval. Forty-six percent of CSHCN parents report problems with delays compared to 30 percent of non-CSHCN parents. Compared to other families, more families with CSHCN encounter problems in finding information about how their health care plan works (55 percent compared to 48 percent), getting needed help from customer service lines (55 percent compared to 47 percent), and dealing with paperwork (34 percent compared to 25 percent).

Figure 4: Problems with health plan service by CSHCN and non-CSHCN



Choice of Health Plan

From the health plan choices available through TRICARE, 16 percent of CSHCN rely on TRICARE Standard/Extra for most of their care compared to 11 percent of non-CSHCN (Figure 5). Fewer CSHCN than non-CSHCN are enrolled in TRICARE Prime (69 percent compared to 74 percent). As shown in Table 3, parents of CSHCN rate health care from their health plans similarly to parents of non-CSHCN but care from Standard/Extra is rated higher than care from Prime by parents from both groups.

Forty-four percent of both populations gave the best ratings (a 9 or 10 on a 1 to 10 scale) to care received through TRICARE Prime and 59 percent of both populations gave high ratings to care received through TRICARE Standard/Extra. By contrast, health plan ratings are higher from parents relying on

Figure 5: Choice of health plan

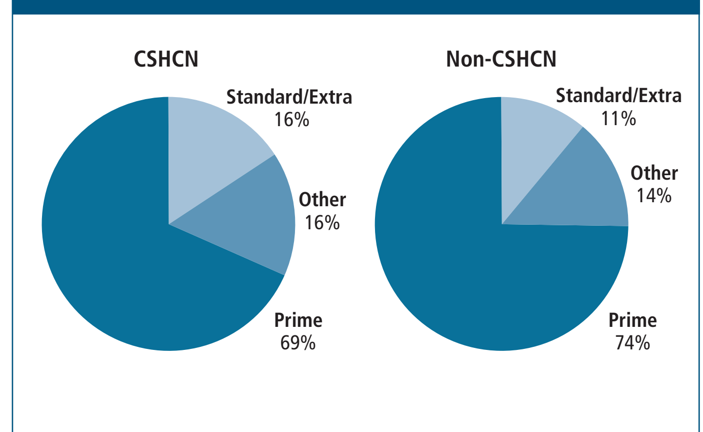


Table 3. Health care and health plan features

	Prime		Standard/Extra	
	CSHCN	Non-CSHCN	CSHCN	Non-CSHCN
	Percent			
Health care				
Health care rated 9 or above	44	44	59	59
Child has personal doctor or nurse	75	66	89	78
Provider understands condition affects family	74	67	86	85
No problem getting needed care	70	83	79	88
No problem seeing a specialist	55	67	64	78
Health plan				
Health plan rated 9 or above	41	44	30	31
No problem with paperwork	68	77	59	64
No problem with delays awaiting approval	52	69	62	80
No problem with customer service	46	54	41	45

Prime for their children's care than from parents relying on Standard/Extra.

In spite of large differences in ratings of health care and health plan between Prime and Standard/Extra, ratings of their plans by CSHCN parents are generally consistent with ratings by non-CSHCN parents. As shown in Table 3, parents of children enrolled in TRICARE Standard/Extra, whether CSHCN or non-CSHCN, are less likely to report access problems, and are more likely to report favorably on interactions with doctors and the family centeredness of their care than parents of children enrolled in TRICARE Prime. Parents of children enrolled in Prime rate their health plan higher than do Standard/Extra users and have fewer problems getting information about their health benefits. However, Prime enrollees are more likely than Standard/Extra users to experience delays waiting for approval.

Conclusion

The quality of health care for CSHCN who are enrolled in TRICARE or who use TRICARE Standard/Extra appears to be equal to, or better than, that of other children who use these health plans. However, care can be improved in many ways important to children with special health care needs. Many CSHCN, particularly in Prime, do not have a personal doctor, and their parents do not get information or help in coordinating care that they need. Also, like children in civilian health plans, more CSHCN than non-CSHCN encounter problems in accessing needed care and interacting with their health plan. Parents of CSHCN who use Standard/Extra rate their child's health care and access to care higher than do Prime users, but have more problems than Prime users getting information and dealing with paperwork. For parents who rely on Prime to provide care for their CSHCN, the goal of coordinated, family-centered care may be promoted by ensuring that such children have a personal doctor.

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