

# PROJECT REPORT

## Health Care Survey of DoD Beneficiaries 2005 Annual Report

*May 2006*

*Kristin Andrews*

*Katherine Bencio*

*Sarah Davis*

*Meredith Lee*

*Judy Ng*

*Emily Sama Martin*

*Eric Schone*



**MATHEMATICA**  
Policy Research, Inc.





*Project Officer:  
LCDR Kimberley  
Marshall, Ph.D.*

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600 Maryland Avenue, S.W., Suite 550  
Washington, DC 20024-2512  
(202) 484-9220  
[www.mathematica-mpr.com](http://www.mathematica-mpr.com)



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# Executive Summary

The Health Care Survey of DoD Beneficiaries (HCSDB) Annual Report describes results from a worldwide survey of beneficiaries eligible for care 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 leadership of the MHS. Results are compared to benchmarks from civilian health plans reporting their survey results to the National CAHPS Benchmarking Data Base (NCDB). According to the 2005 HCSDB Annual Report:

- Between 2001 and 2005 the proportion of retirees and their family members under age 65 with civilian coverage dropped from 45 percent to 35 percent.
- The proportion of Prime enrollees giving their health plan a rating of 8 or above on a scale from 0 to 10 increased from an adjusted rate of 50 percent in 2003 to 54 percent in 2004.
- Prime enrollees are more likely to report problems finding a personal doctor they are happy with or getting to see a specialist than the civilian norm.
- Relative to the civilian norm, beneficiaries who rely on Standard/Extra are more likely to report problems finding a personal doctor, but do not have problems getting to see specialists.
- Beneficiaries with Medicare and TRICARE for Life give high ratings to most aspects of their care.
- Beneficiaries who rely on civilian health plans are satisfied with most aspects of their health care. The proportion of eligible women relying on civilian plans who receive Pap smears lies below the *Healthy People 2010* goal of 90 percent.
- Since 2003, the proportion of active duty family members getting most of their care from MTFs has fallen from 62 percent to 56 percent.
- At MTFs, the proportion that reports it can usually or always get enough time with their physician or can get routine appointments when they want, has fallen relative to the civilian benchmark.
- Eighty percent of Prime enrollees who use civilian providers report getting routine appointments when they want them, and 84 percent report their doctor spends enough time with them. These rates are similar to civilian benchmarks.
- Since 2002, the proportion of active duty family members reporting they have no problem getting the treatment or counseling they need for personal or family problems has fallen from 75 to 63 percent.
- Teenage children are more likely than younger children to go without exercise, to watch 3 or more hours a day of television, eat fast food and ride their bicycles or rollerblade without wearing a helmet.
- Active duty parents are more likely to report that their children wear helmets when bicycling or rollerblading than are retired parents.
- Parents of children with special health care needs (CSHCN) enrolled in Prime are less likely than other CSHCN parents in the MHS to find a personal doctor for their child, or to interact with a doctor who understands how the child's needs affect the family.
- As measured by body mass index, the obesity rate in MHS adults ranges from 21 percent of active duty to 33 percent of retirees under age 65. Though over half of active duty respondents have a BMI between 25 and 30, which is overweight according to CDC guidelines, fewer than half with that BMI consider themselves overweight.
- Among those with deployed spouses, 58 percent of reservist spouses and 46 percent with other active duty spouses have sought information, focus groups or counseling for help in coping. Reservists' spouses are significantly less likely than other spouses of deployed active duty personnel to find these resources very helpful.

- The proportion of beneficiaries filling a prescription in the past 3 months who used MTF pharmacies ranges from 36 percent of retirees and their family members over age 65 to 77 percent of active duty. Fifty six percent of the retirees and their family members over age 65 use retail network pharmacies, while 36 percent use mail order.
- Fifty-seven percent of deactivated reservists and 55 percent of their family members continue to use TRICARE. Among those without coverage before activation, 82 percent of reservists and 87 percent of family members use TRICARE.



# Chapter 1. Introduction

## 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 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 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 2005, 200,000 beneficiaries from both inside and outside the United States were sampled for the adult survey. A total of 35,000 beneficiaries worldwide were sampled for the child survey. Sampling methods are described in the *2005 HCSDB Adult Sample Report* and *2005 Child Sample Report*. Synovate 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 *2005 HCSDB Codebook and Users Guide*.

Questions in the 2005 HCSDB were developed by TMA or were taken from other public domain health care surveys. Many questions were taken from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey,<sup>1</sup> 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 2005, questions were added to address the adequacy of TRICARE's civilian network, beneficiaries' height and weight, pharmacy benefits, beneficiaries' need and use for behavioral health, reservists' health coverage, beneficiaries' opportunities to obtain civilian insurance and a number of other topics.

## About this Report

This report presents results for all surveys administered in 2005. These results are frequently compared to results from 2003, and 2004. The report 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.

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 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 received from 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 start of TRICARE for Life

in October 2001, TRICARE Standard has been second payer to Medicare, and has paid most costs left over after Medicare.

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. Chapters 3 through 6 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. Chapter 7 describes beneficiaries' experiences seeking care from different types of health care providers, including military, civilian and VA providers. The results in these chapters are presented as percentages calculated using adjusted sampling weights. 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.

Chapters 8 through 10 present results from the survey that bear on particular topics. These include use of civilian health insurance, health related behaviors of children, use of mental health benefits, and services provided to children with special health care needs (CSHCN).

Results from CAHPS questions are compared to results from the National CAHPS Benchmarking Database (NCBD) for 2004, 2003, and 2002. The NCBD assembles results from CAHPS surveys administered to hundreds of civilian health plans. Mean rates are calculated from these results and 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 *2005 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 2003 with results from 2004 and 2005, we performed two adjustments to

rates calculated from previous years. First, we compared results from the 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 *2005 HCSDB Technical Manual*.<sup>2</sup>

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 2005 concerned 1) overweight among MHS eligible beneficiaries, 2) deployment related stress, 3) use of pharmacy benefits, and 4) reservists' coverage. These issue briefs make up the last four chapters of this report.

## Notes

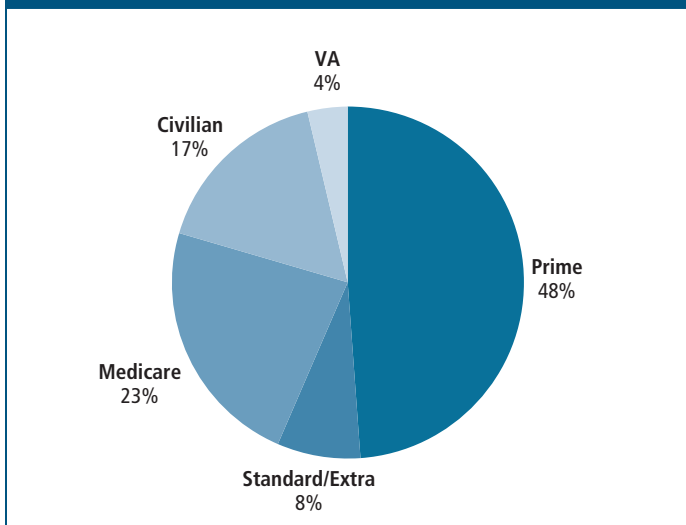
<sup>1</sup>Before 2005, that survey was known as the Consumer Assessment of Health Plans Survey.

<sup>2</sup>Methods differ slightly from the methods used in the *TRICARE Beneficiary Reports*. In the *Beneficiary Reports*, separate benchmarks are presented for each year, while in the *Annual Report*, the change in the benchmark from past to current years is added to past scores so that all scores may be compared to the current benchmark. In the *Annual Report*, different benchmarks are reported for each beneficiary group, while in the *Beneficiary Reports*, the difference between a beneficiary group's benchmark and the benchmark for all beneficiaries is added to the group's score so that all scores may be compared to the same benchmark.

## Chapter 2. Beneficiaries' Choices of Health Plan and Use of Civilian Insurance

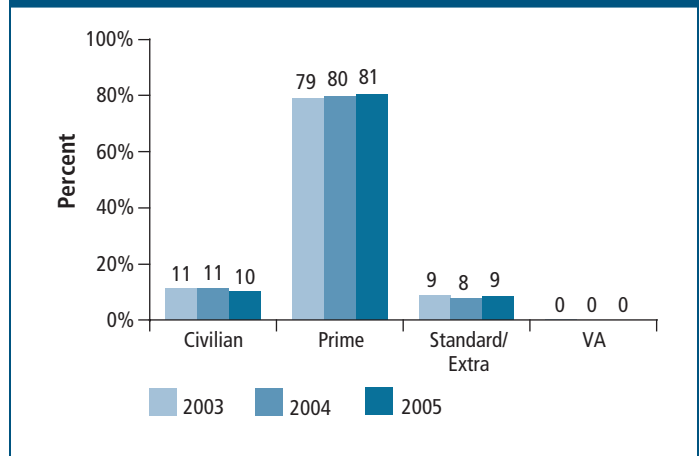
Beneficiaries of the MHS are covered by a wide range of health plans, most of them provided or supplemented by the Department of Defense. Active duty personnel are largely restricted to TRICARE Prime, but their dependents may choose from Prime, Standard/Extra, or civilian policies. Retirees also may 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. 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.<sup>1</sup> Together those four coverage types are responsible for about 96 percent of eligible beneficiaries.

Figure 1. Health plan used for most care 2005



Almost all active duty personnel 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 the options described above. As shown by Figure 2, four-fifths of active duty family members who

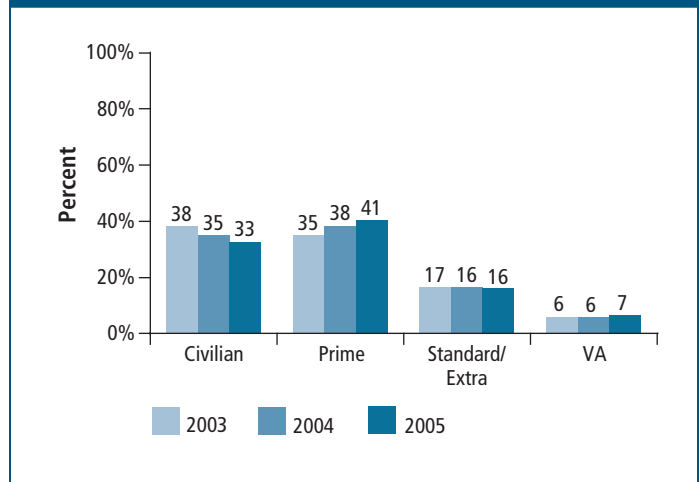
Figure 2. Active duty family members choice of health plan



responded to the survey are covered by Prime. The remaining one-fifth are divided among civilian plans and Standard/Extra, with 10 percent covered by civilian plans and 9 percent by Standard/Extra.

Retired beneficiaries under age 65 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. Since 2003, the proportion that chooses Prime has increased from 35 to 41 percent.

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



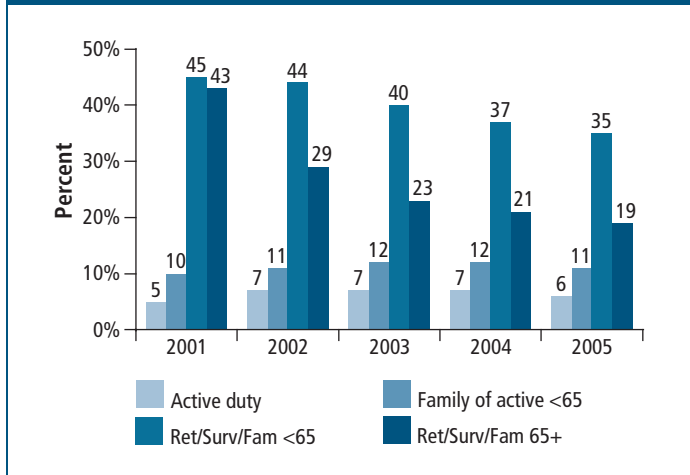
That increase has been accompanied by a drop of a similar size in the proportion using civilian coverage, which has fallen from 38 percent to 33 percent.

When beneficiaries have civilian coverage, their civilian plan is primarily responsible for the beneficiaries' health costs, unless it is a designated TRICARE supplemental plan. For plans other than supplemental plans, TRICARE steps in to pay deductibles and coinsurance remaining from the primary source of coverage. Within the past 5 years, accelerating costs have made it more expensive for beneficiaries to carry both TRICARE and civilian coverage. The proportion of civilian employees of private firms that must pay at least a partial premium for coverage has increased from 68 percent to 79 percent for single coverage and from 86 percent to 91 percent for family coverage. Premium shares of employees have risen from \$360 per year to \$610 per year for single coverage and from \$1788 to \$2713 for family coverage. Among civilian employees in general, these increases have not reduced participation. About 83 percent of eligible employees accepted their firms' insurance in both 2001 and 2005.<sup>2</sup>

By contrast, the proportion of TRICARE eligible beneficiaries that carries civilian coverage has fallen during this time. As shown in Figure 4, between 2001 and 2005 the proportion of retirees under 65 with civilian coverage has dropped from 45 percent to 35 percent.

TRICARE for Life has also reduced the number of beneficiaries carrying civilian coverage. With TRICARE now covering most expenses uncovered by Medicare, beneficiaries eligible for Medicare and TRICARE have little incentive to retain civilian plans. Also shown in Figure 4, the proportion with Medicare

**Figure 4. Civilian insurance coverage by beneficiary category: 2001–2005**



who also carry civilian coverage underwent a steep drop when TRICARE for Life came into effect, falling from 43 percent to 23 percent between 2001 and 2003, and has continued to fall more gradually since then, reaching 19 percent in 2005.

Figure 5 shows offer and take-up rates for civilian coverage measured by supplemental questions fielded in July, 2005. The results indicate that one third of active duty family members and nearly three fifths of retirees and their dependents are offered civilian coverage. Of those who are offered it, 37 percent of active duty family members and 61 percent of retirees and their families under 65 report that they take up the civilian option.

**Figure 5. Offer and take-up of civilian coverage by beneficiary category**

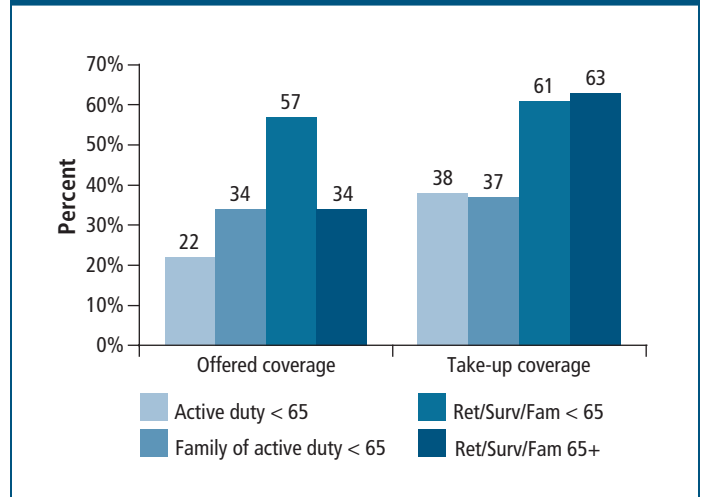
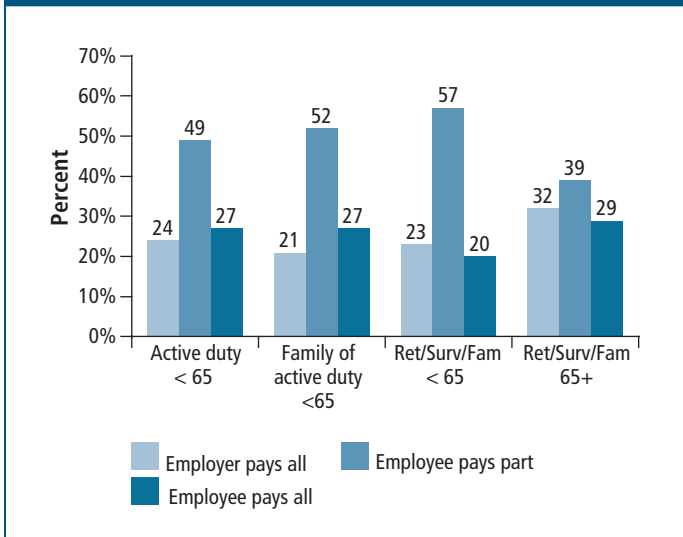


Figure 6 shows that in most cases those who elect to use their civilian coverage must pay at least a part of the premium. Over two-thirds of those who take up the offered coverage in each beneficiary group report that they pay at least a partial premium. However, about a fifth in each group report that they pay the entire premium for their civilian plan. That includes 23 percent of the retirees under age 65 and 32 percent of the retirees age 65 and over with civilian coverage. It is surprising that this number of beneficiaries would pay full price for civilian care. TRICARE Standard/Extra can currently be obtained at no cost and the enrollment fee now charged to retirees for TRICARE Prime is substantially less than are premiums for most civilian plans. It is likely that some, at least, of this group are actually paying less than the full premium.

Figure 6. Payment for civilian coverage



Though the rise in premium costs borne by beneficiaries has probably caused some retirees to switch to TRICARE, results from the HCSDB indicate that many continue to pay amounts greater than Prime enrollment fees or the cost sharing they would incur from using Standard alone. Planned increases in the cost of enrollment in Prime, enrollment fees for TRICARE Standard/Extra, and increases in cost sharing for retiree users may counteract this trend for some users.

### Notes

<sup>1</sup>Civilian plans include private civilian insurance and Medicaid.

<sup>2</sup>Claxton, Gary, Isadora Gil, Benjamin Finder et al. Employer Health Benefits: 2005 Annual Survey. Kaiser Family Foundation and Health Research and Educational Trust, 2005 Menlo Park, CA and Chicago, IL.

## Chapter 3. TRICARE Prime Enrollment

As described above, TRICARE Prime is the form of coverage most used by MHS beneficiaries, providing coverage to about half of the adult population eligible to receive care through TRICARE and about two thirds of eligible children.

As shown in Figure 7, health plan ratings for Prime have continued to improve in recent years. The proportion giving their health plan a high rating increased from an adjusted rate of 50 percent in 2003 to 54 percent in 2005. By contrast, the rating that Prime enrollees give the health care they receive has not improved, and lies further below the civilian benchmark than does the health plan rating. While the proportion of Prime enrollees giving their health plan a high rating is about 3 percent below the benchmark, the proportion with high health care ratings is about 14 percent below.

**Figure 7. Prime enrollees' health care and health plan ratings**

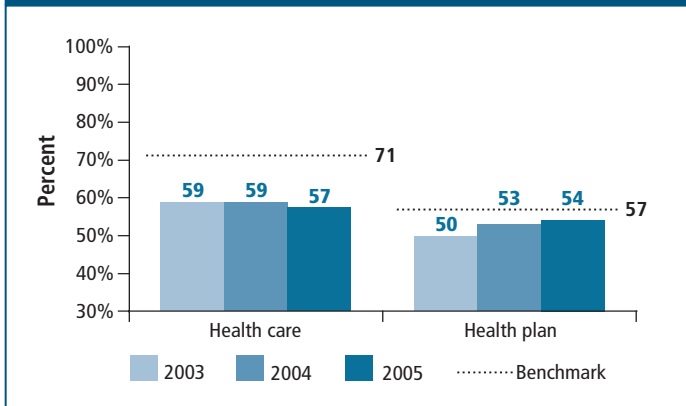
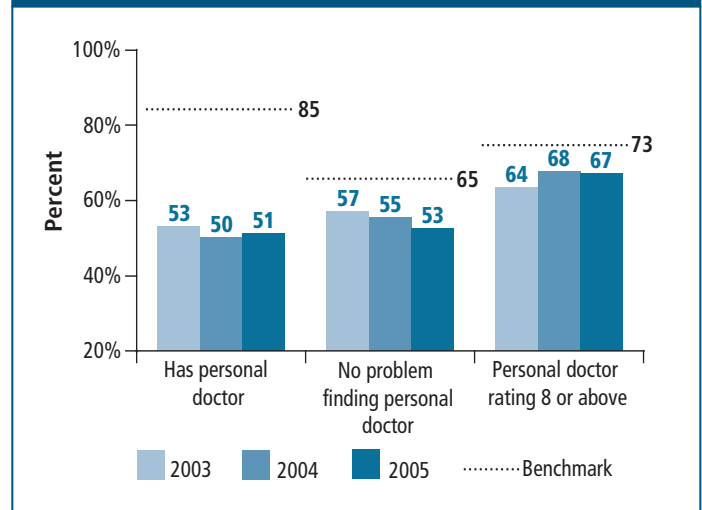


Figure 8 shows that the proportion of Prime enrollees with a personal doctor continues to lie far below civilian norms, and that proportion shows no sign of increasing. More than 80 percent of beneficiaries in the benchmark database identify a single person as their personal doctor or nurse, compared to about half of Prime enrollees. Since 2003, the proportion of Prime enrollees with a personal doctor has remained at slightly above 50 percent. Prime enrollees also are more likely than the civilian norm to report problems in finding a personal doctor they are happy with. In 2005, 53 percent of Prime enrollees reported no problem finding a personal doctor, compared to a civilian norm of 65 percent. Relative to the NCBDB benchmark,

**Figure 8. Prime enrollees' personal doctors**

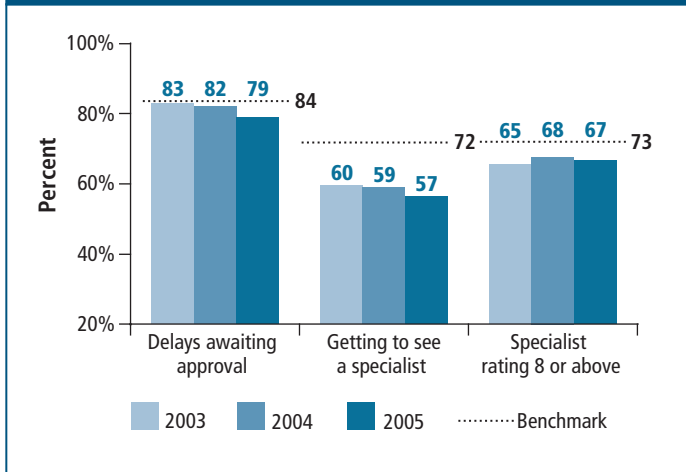


problems have worsened, dropping by 4 percent. However, while problems finding a personal doctor have not diminished since 2003, ratings of personal doctors, for those who have them, have risen slightly. The proportion giving their personal doctor a high rating has increased from 64 to 67 percent in that time, compared to a benchmark of 73 percent.

Besides problems finding a personal doctor, Prime enrollees report problems getting specialized treatments, problems that have worsened relative to the benchmark value. Figure 9 shows that Prime beneficiaries report delays in approvals that are close to the NCBDB benchmark, but are further below that norm in 2005 than in 2003. Seventy-nine percent report no problems with delays, compared to an 84 percent benchmark, a decrease relative to the benchmark of 4 percent. Prime enrollees are more likely to report problems seeing specialists than they are to report delays in treatment. Fifty-seven percent of Prime enrollees reported problem-free access to specialists, compared to 72 percent in the NCBDB. However, beneficiaries are less likely to give their specialists low ratings than to report problems in seeing them. Sixty-seven percent of beneficiaries rate their specialist at 8 or above, compared to a 73 percent NCBDB benchmark.

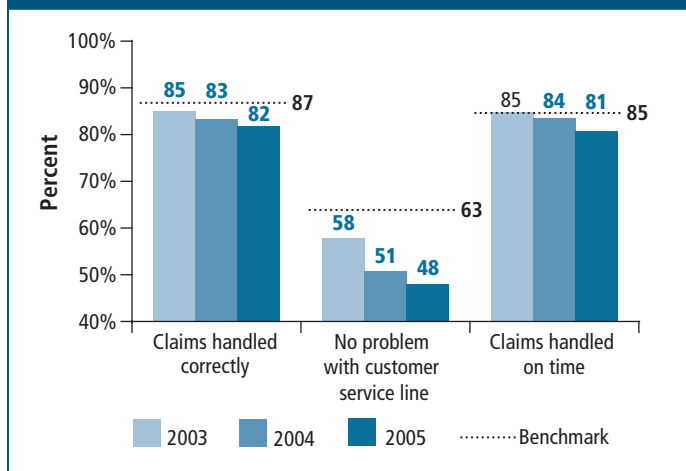
Figure 10 shows how the health plan is handling claims and customer inquiries. The results indicate that claims handling scores lie slightly below the civilian standards, while handling

**Figure 9. Prime enrollees' access to specialists**



of customer service inquiries lags farther behind. At 81 percent the proportion of claims usually or always handled on time lies below a civilian benchmark of 85 percent, while the 82 percent who report claims usually or always correctly processed compares to an NCBD benchmark of 87 percent. Relative to the benchmark, these rates represent a decline of 3 to 4 percent in both measures, though the change is due to increases in NCBD rates. Fewer than half of beneficiaries report they encounter no problems using TRICARE's customer service line, which marks a drop both alone and in relation to civilian benchmarks.

**Figure 10. Prime enrollees' claims handling and customer service**



**Figure 11. Prime enrollees' cancer screening and prenatal care**

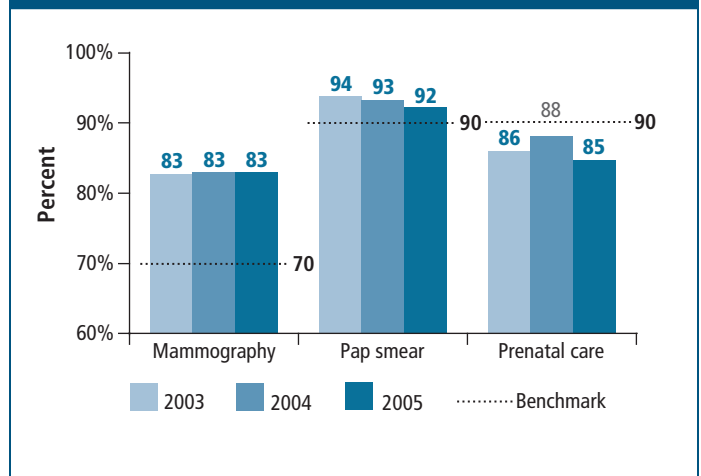


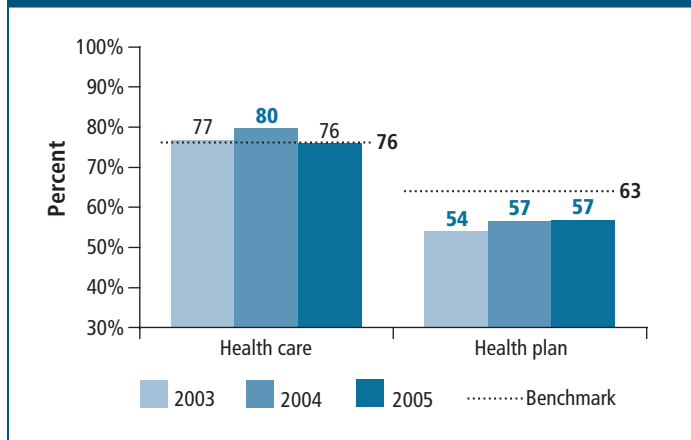
Figure 10 shows that, compared to *HP2010* goals, women in Prime continue to receive cancer screening—both Pap smears and mammography—at rates exceeding the target. However, the proportion of pregnant or recently pregnant enrollees reporting that they received prenatal care in their first trimester was below the *HP2010* goal of 90 percent.

## Chapter 4. Standard/Extra Users

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, about 8 percent of adult beneficiaries choose to rely primarily on Standard/Extra, though for others, TRICARE Standard is second payer. Those who choose not to enroll in Prime are automatically covered by Standard. 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. As shown in Figure 12, the proportion giving their health plan a rating of 8 or above is 57 percent, which is below the NCBDB benchmark, while the proportion rating their health care 8 or above now matches the benchmark at 76 percent.

**Figure 12. 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 NCBDB norm, in this case 83 percent, compared to 90 percent, as shown in Figure 13. The proportion who say they have no difficulty finding a personal doctor, also lies below the norm. Sixty-two percent report no difficulty in finding a personal doctor, compared to 67 percent in the NCBDB. Eighty percent give their personal doctor a high rating, which exceeds the benchmark rate.

**Figure 13. Standard/Extra users’ personal doctors**

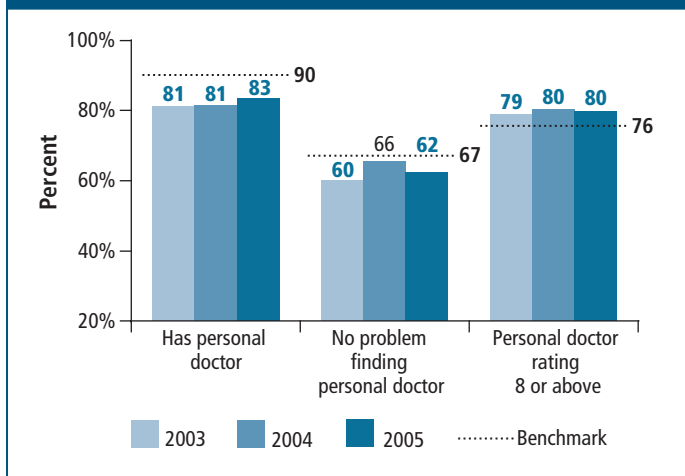


Figure 14 shows that access to specialized care does not present particular problems for Standard/Extra users. Eighty-nine percent report no delays awaiting approval and 76 percent report no problems in seeing specialists, similar to civilian standards. The proportion giving their specialists high ratings is 79 percent, also similar to the NCBDB benchmark.

**Figure 14. Standard/Extra users’ access to specialists**

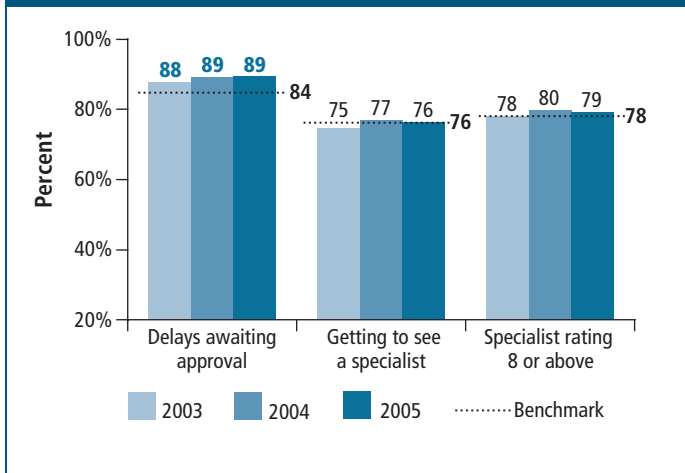
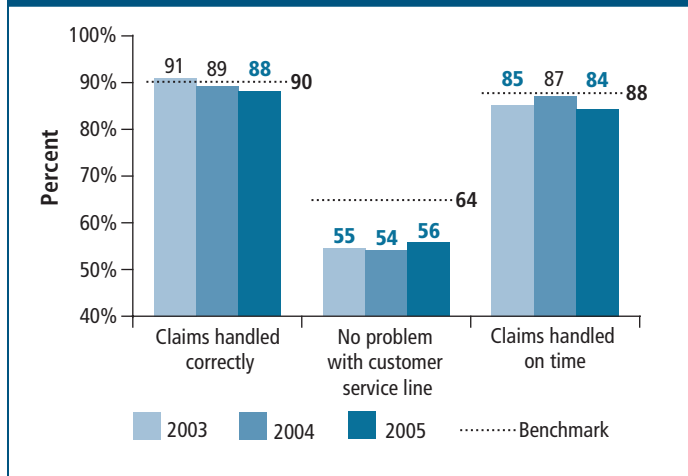




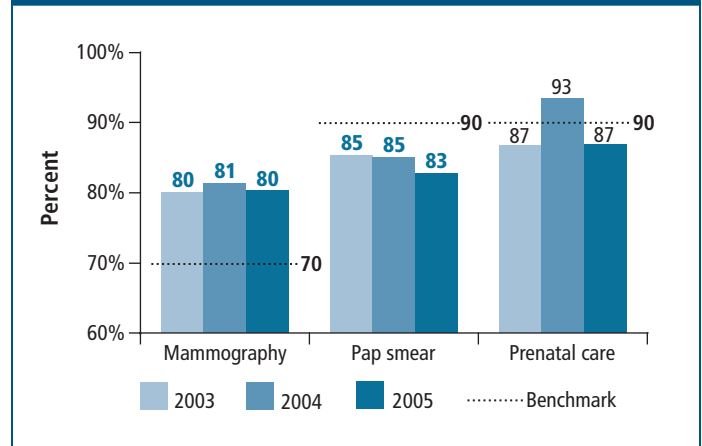
Figure 15 indicates that Standard/Extra users rate claims handling and customer service below civilian norms. The proportion that reports claims are usually or always handled correctly and the proportion reporting that claims handling is usually or always on time are both slightly below the civilian standard. The proportion reporting no problem with the customer service line is substantially below the benchmark.

**Figure 15. Standard/Extra users' claims handling and customer service**



Cancer screening results in Figure 16 show that Standard/Extra users receive Pap smears at a lower rate than the *HP2010* goal, while mammography rates exceed that goal. Mammography rates and the prenatal screening rate were the same in 2003 and 2005, while Pap smear rates showed a slight decline.

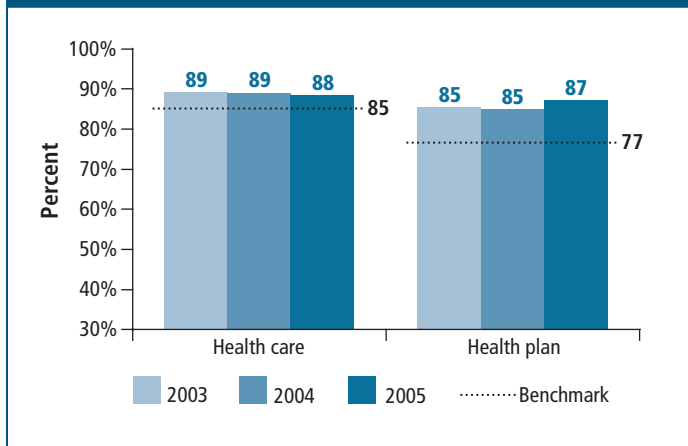
**Figure 16. Standard/Extra users' cancer screening and prenatal care**



# Chapter 5. Medicare and TRICARE For Life

The 2000 National Defense Authorization Act (NDAA) entitled beneficiaries who pay their Medicare Part B Premium to receive coverage from TRICARE for most costs not covered by Medicare. With this new coverage, satisfaction among Medicare-eligible TRICARE beneficiaries with their health care and health plans increased. Ratings of both health care and health plan by beneficiaries with Medicare coverage have remained high during the period of this report. The proportion rating their health care 8 or above, shown in Figure 17, stood at 88 percent in 2005, while the proportion rating their health plan 8 or above rose from 85 to 87 percent.

**Figure 17. Medicare health care and health plan ratings**



As indicated by Figure 18, the proportion of Medicare beneficiaries with a personal doctor is 94 percent, which is similar to age- and health status-adjusted benchmarks. About 76 percent report no problem finding a personal doctor they are happy with, which is similar to the norm for those with civilian coverage, but lower than the proportion in 2003. Personal doctor ratings have remained high, with the proportion rating their personal doctor 8 or above reaching 86 percent in 2005.

**Figure 18. Medicare personal doctors**

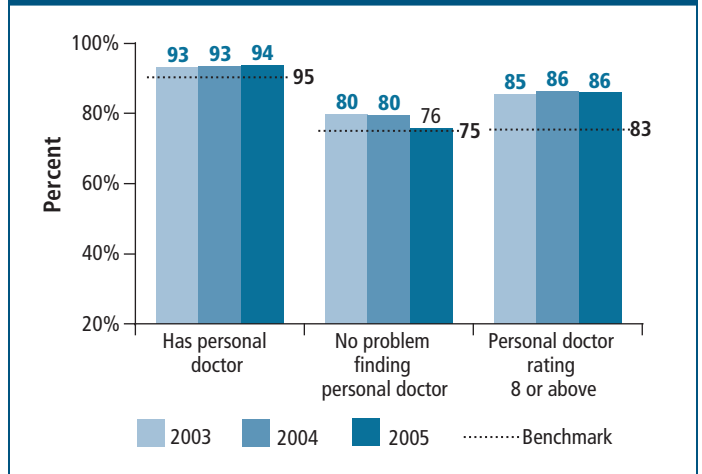


Figure 19 demonstrates that beneficiaries of TRICARE for Life encounter few problems when seeking specialized care. Fewer than 5 percent report problems with delays awaiting approval for treatment. Eighty-eight percent report that they experience no problems in seeing a specialist. Specialist ratings are also high, with 88 percent rating their specialist 8 or above.

**Figure 19. Medicare access to specialists**

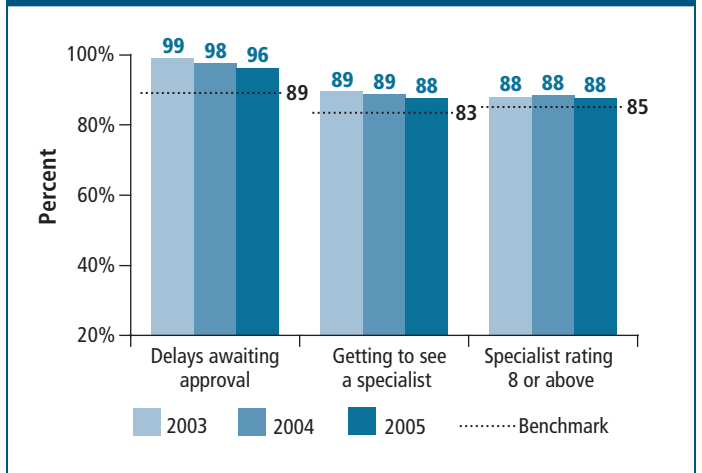


Figure 20 shows that TRICARE’s Medicare beneficiaries are satisfied with the way that their claims are handled. Ninety-seven percent report that claims are usually or always handled correctly, while 95 percent say that claims handling is usually or always timely, both exceeding the NCBD benchmark. By contrast the proportion who have not encountered problems with a customer service line, at 69 percent is similar to the NCBD benchmarks, and indicates a decline, relative to the benchmark, since 2003.

The preventive care received by Medicare beneficiaries, shown in Figures 21, 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.

Figure 20. Medicare claims handling and customer service

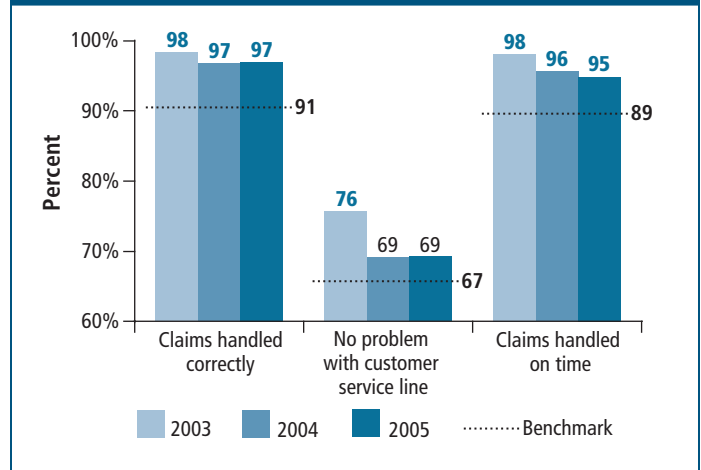
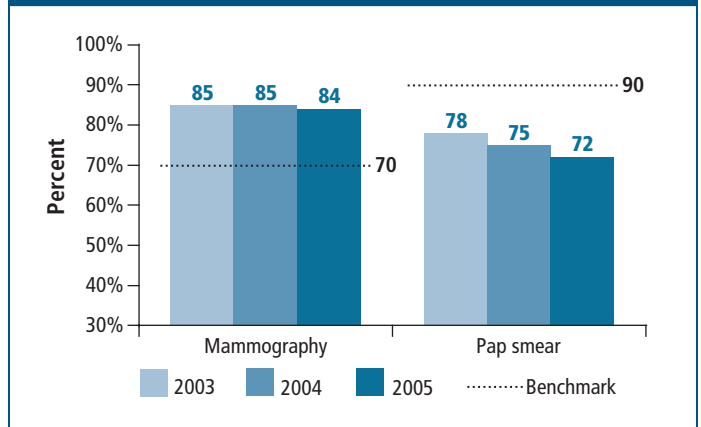


Figure 21. Medicare cancer screening



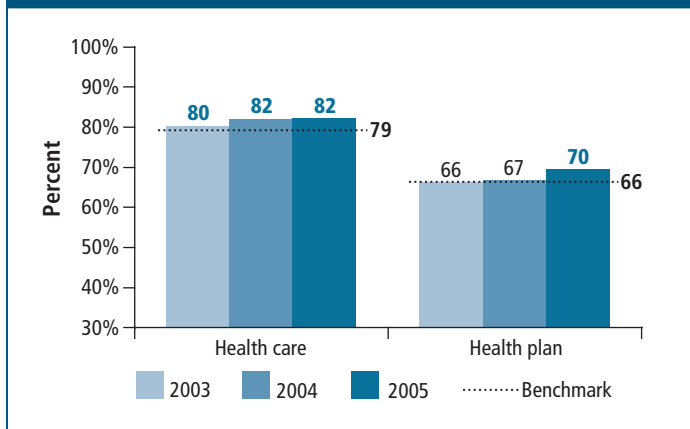
# Chapter 6. Civilian Health Plans

Civilian health plans are the third most common source of coverage among MHS beneficiaries. As described in Chapter 2, a majority of retirees are offered civilian coverage, generally through their new employer, and over one third rely on their civilian coverage for most care. 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.

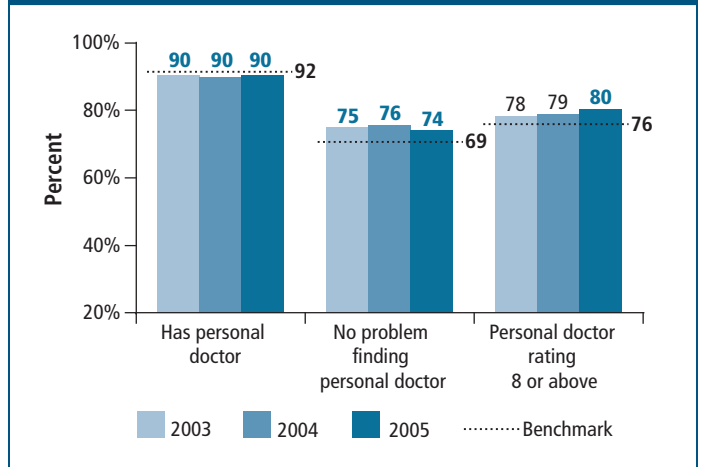
Figure 22 shows that beneficiaries who have elected civilian coverage rate their health care and health plan similarly to non-military beneficiaries with civilian coverage. Seventy percent give their health plan and 82 percent give their health care high ratings. Health plan ratings have increased by 4 percent compared to the NCBDB benchmark since 2003, while health care ratings have increased by 2 percent. 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 92 percent of beneficiaries contained in the NCBDB (Figure 23). MHS eligibles with civilian coverage are approximately as likely as beneficiaries in the NCBDB 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

**Figure 22. Beneficiaries with civilian coverage health care and health plan ratings**

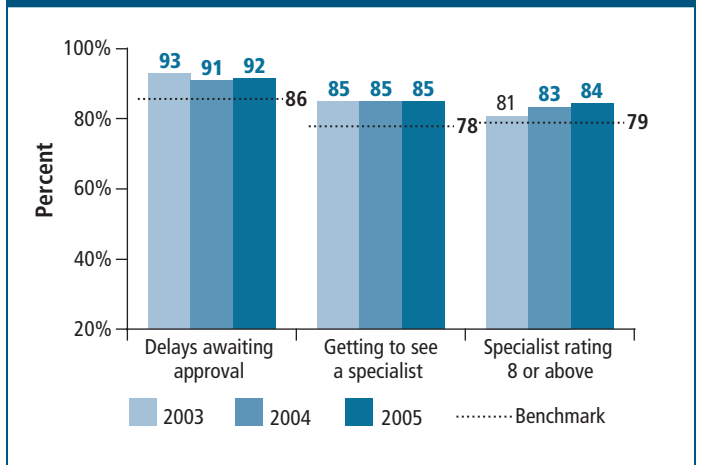


**Figure 23. Beneficiaries with civilian coverage personal doctors**

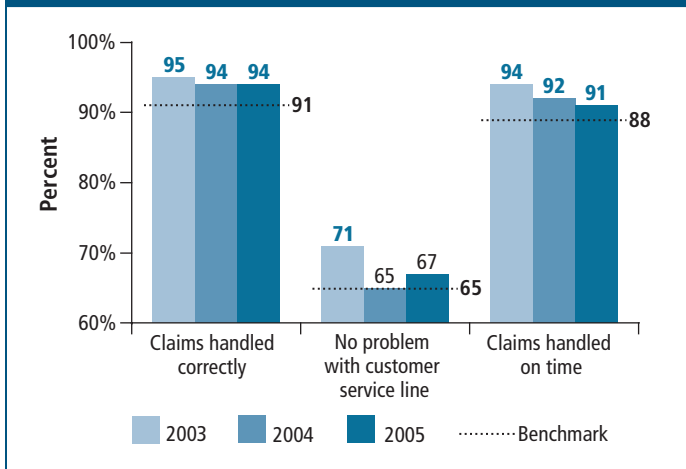


than are beneficiaries in the NCBDB, as shown in Figure 24. Ninety-two percent of MHS eligibles with civilian coverage report no problems with delays while waiting for approval and 85 percent report no problems getting to see a specialist. Specialist ratings exceed the benchmark and have improved since 2003. Similarly, as shown in Figure 25, beneficiaries report timely and correct claims handling over 90 percent of the time. Only 67 percent can get the information they need from their plan’s customer service line, but that is similar to the norm in other civilian plans.

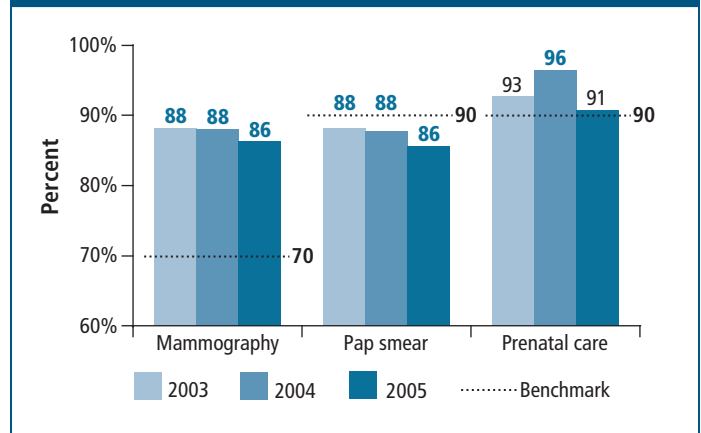
**Figure 24. Beneficiaries with civilian coverage access to specialists**



**Figure 25. Beneficiaries with civilian coverage claims handling and customer service**



**Figure 26. Beneficiaries with civilian coverage cancer screening and prenatal care**

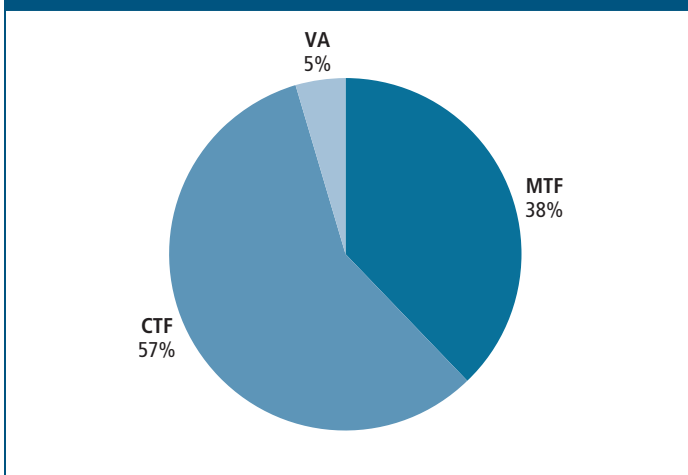


Nearly 90 percent of women over 40 with civilian coverage get mammographies, exceeding the *HP2010* goal (Figure 26). However, the Pap smear rate of 86 percent is below the *HP2010* goal of 90 percent and reflects a decline of 2 percent from its rate in 2003. Ninety-one percent of pregnant women received prenatal care, similar to the *HP2010* goal.

## Chapter 7. Beneficiaries' Usual Source of 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. As shown in Figure 27, the majority of eligible beneficiaries (57 percent) get care primarily from civilian facilities. Another 5 percent use VA facilities and 38 percent rely on MTFs.

Figure 27. Patient's usual source of care 2005



Results in Figure 28 indicate that active duty families have shifted from MTFs to civilian providers in recent years. Since 2003, the proportion getting most of their care from MTFs has fallen from 62 percent to 56 percent, continuing a decline observed in previous years. The decline in MTF use has been accompanied by increasing use of civilian providers, which are now the usual source of care for 43 percent of active duty families. Figure 29 shows that, among retirees, two-thirds of whom use civilian facilities, no shift is apparent since 2003. Eight percent of retirees say that they get most of their health care from VA facilities, and 25 percent from MTFs.

Figure 28. Active duty family members usual source of care

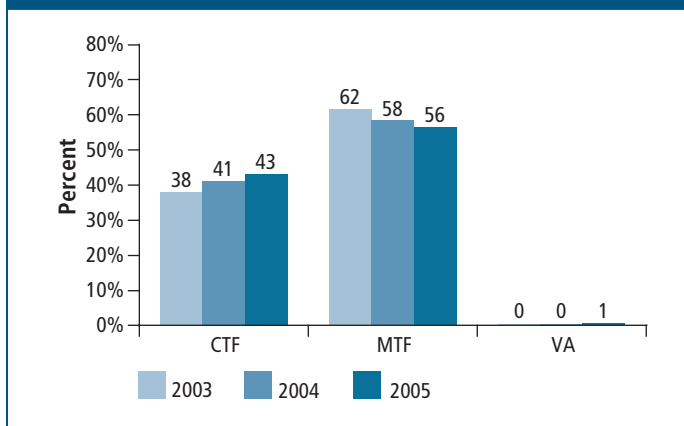
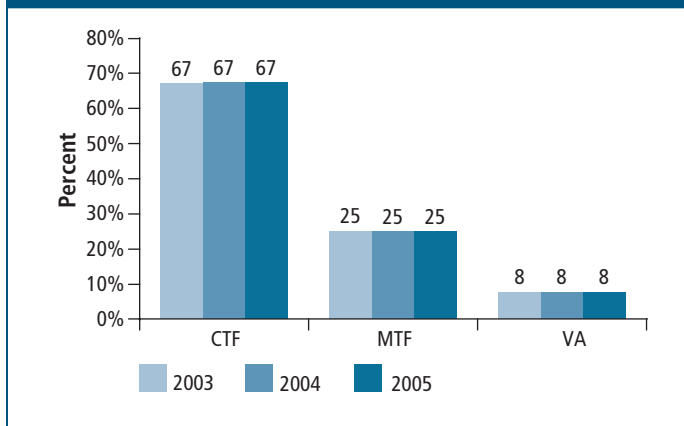


Figure 29. Retired, less than 65 usual source of care



Figures 30 and 31 present several measures related to the functioning of a clinic or hospital for the two fifths of 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.

The measures suggest a downward trend, though that trend appears to be bottoming out for some measures. As shown in Figure 30, the

Figure 30. Patients' experiences at MTFs

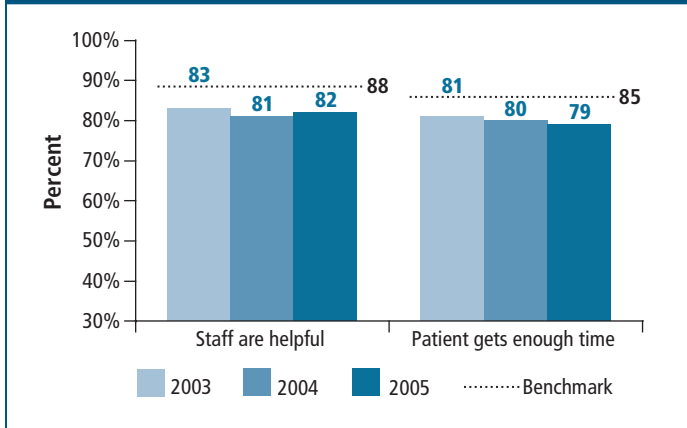


Figure 32. Patients' experiences at civilian facilities

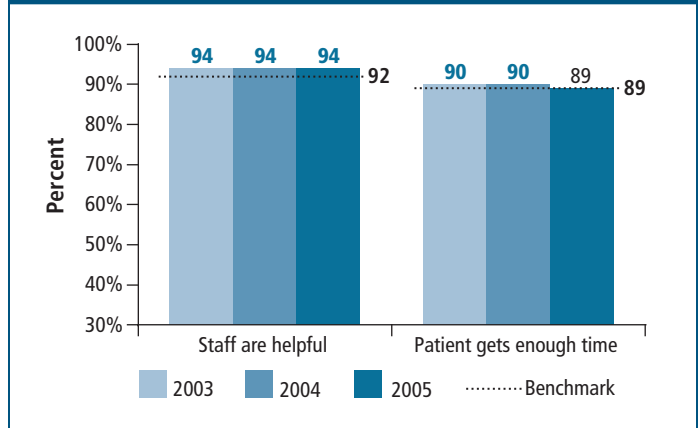


Figure 31. Patients' waits at MTFs

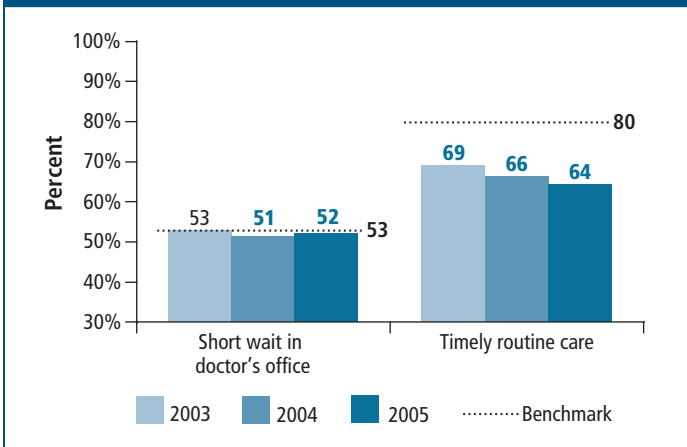
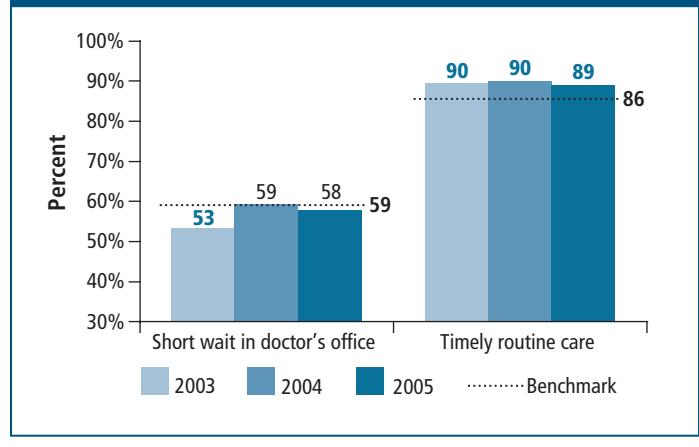


Figure 33. Patients' waits at civilian facilities



proportion reporting that staff are usually or always helpful declined between 2003 and 2005 from an adjusted value of 83 percent to 82 percent, but increased from a value of 81 percent in 2004. The proportion reporting that they get enough time with their physicians declined steadily from 81 to 79 percent, compared to an 85 percent NCBD benchmark.

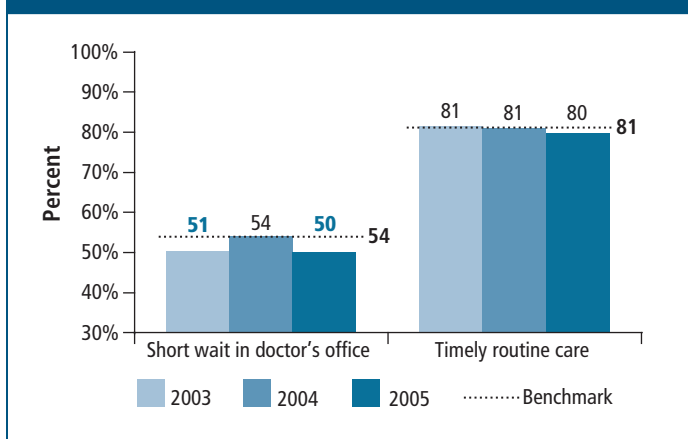
Availability of routine appointments also trends downward. The proportion of beneficiaries reporting they could usually or always get appointments when they want them, shown in Figure 31, declined steadily from an adjusted value of 69 to 64 percent, compared to a benchmark of 80 percent. Waits in the doctor's office are less of a problem than waits for appointments, compared to the NCBD. The rate for MTFs is 52 percent, compared to a benchmark rate of 53 percent. Though lower than the adjusted rate in 2003, the rate in 2005 is higher than its rate in 2004.

Beneficiaries generally report more positive experiences at civilian facilities than at military ones, as shown in Figure 32. The proportion of MHS beneficiaries who see civilian providers and report staff are helpful (94 percent) exceeds the NCBD benchmark. The proportion reporting that they get enough time with their physicians (89 percent) is similar to the benchmark.

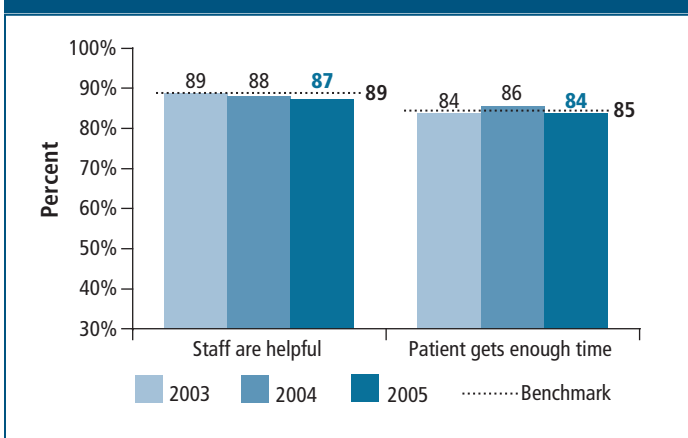
According to beneficiaries' reports, availability of appointments from civilian providers exceeds the norm from the NCBD. Eighty-nine percent reported that they could get an appointment when they wanted it, as shown in Figure 33. That percentage is similar to percentages in 2003 and 2004. Users of civilian facilities report waits in the doctor's office similar to the NCBD benchmark. Fifty-eight percent usually or always wait less than 15 minutes, nearly identical to an adjusted benchmark of 59 percent.

Users of civilian providers include beneficiaries with Medicare coverage, civilian insurance, users of Standard/Extra and Prime enrollees. Figures 34 and 35 show the experiences with civilian providers of Prime enrollees, who receive care from TRICARE’s managed care support contractors, or if living in remote locations, through TRICARE Prime Remote. Prime enrollees who see civilian providers report less positive experiences than do other users of civilian providers, but report better interactions in the doctor’s office and better access to routine care than do MTF users. Eighty percent of Prime civilian facility users report that routine appointments are readily available (Figure 34) and 84 percent report that doctors spend enough time with them (Figure 35). Eighty-seven percent report that staff are helpful. Fifty percent report short waits in the doctor’s office, a rate that is below the civilian benchmark.

**Figure 34. Prime enrollees’ waits at civilian facilities**

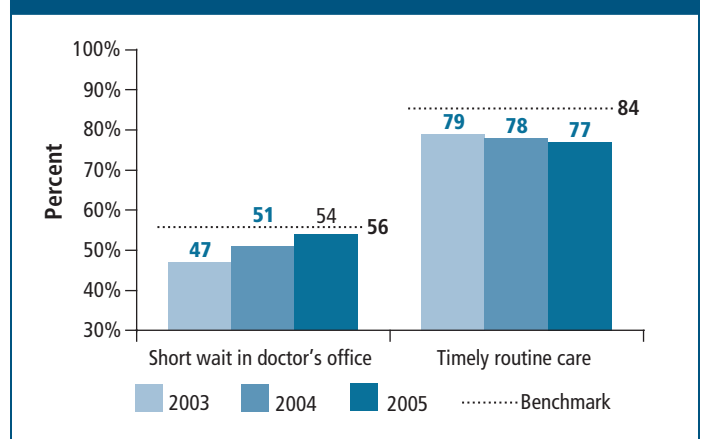


**Figure 35. Prime enrollees’ experiences at civilian facilities**



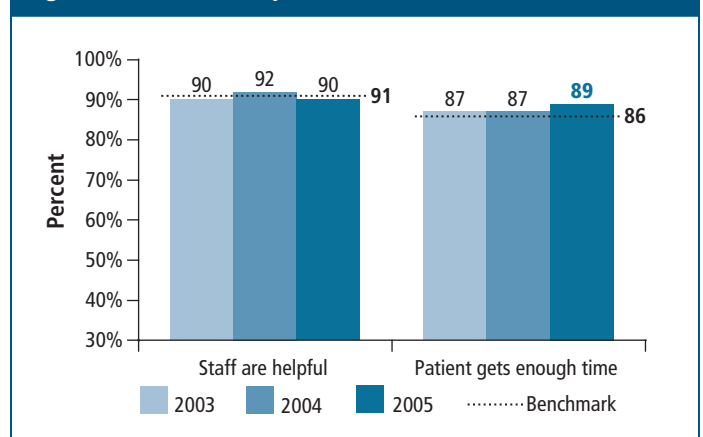
About 5 percent of MHS eligible beneficiaries get most of their health care from VA facilities. As shown in Figure 36, the proportion who usually or always encounter short waits in VA doctors’ offices has increased in recent years and at 54 percent is not significantly different from the benchmark of 56 percent. Waits for routine appointments at VA facilities fall short of the NCBDB benchmark. Seventy-seven percent say that appointments are usually or always available when wanted, while the benchmark is 84 percent.

**Figure 36. Patients’ waits at VA facilities**



As shown by Figure 37, beneficiaries who use the VA give high marks to office staff for helpfulness, and to physicians for the amount of time spent with patients. Ninety percent report that staff are usually or always helpful, similar to the adjusted NCBDB benchmark. Eighty-nine percent report that they get sufficient time with doctors at the VA, compared to a benchmark of 86 percent.

**Figure 37. Patients’ experiences at VA facilities**





## Chapter 8. Mental Health Needs and Access

Recent news reports and the scholarly literature have described the level of stress experienced by military beneficiaries, and raised concerns that mental health needs are going untreated.<sup>1</sup> Questions were added to the HCSDB to measure the need for treatment and counseling and beneficiaries' perception of barriers to access.

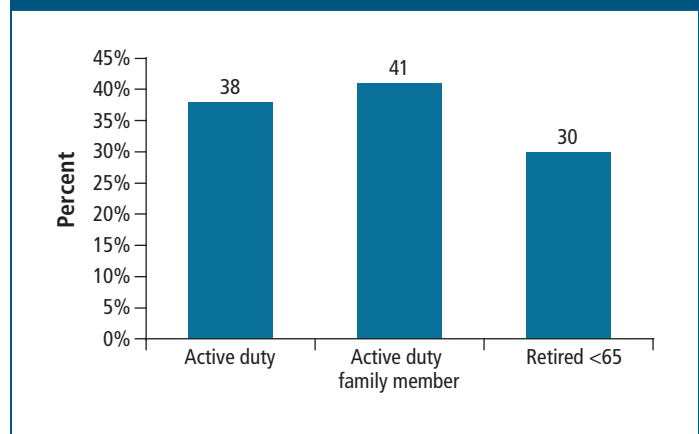
Like civilian coverage, TRICARE's coverage of outpatient and inpatient mental health services is subject to limits and restrictions. Active duty service members must receive behavioral health services at an MTF if possible. Non-active duty TRICARE beneficiaries can make eight outpatient mental health visits per year with a TRICARE network provider without referral or authorization. However, to exceed eight visits in a year, these beneficiaries must get authorization from their regional contractor. Coverage of inpatient mental health care is capped. For adults, the annual limit is 30 days in a given year, for children under 19 it is 45 days.

In some dimensions, TRICARE's mental health benefits appear less generous than civilian plans'. For example, according to a recent Kaiser Family Foundation Employer Health Benefits Survey,<sup>2</sup> almost half (45 percent) of employees in all plans reported inpatient mental health limits comparable to TRICARE's (21 to 30 days annually). However, a similar proportion (42 percent) reported more generous inpatient coverage limits than TRICARE's (31 or more days, or unlimited days, annually).

Many civilian plans also limit the number of covered outpatient visits. One-third (32 percent) of employees in civilian health plans reported annual outpatient visit limits of 20 visits or less. The remainder of employees in civilian plans reported more generous limits for outpatient care (e.g., 31 percent reported 21 to 30 visits annually, while 19 percent reported unlimited visits annually). Prime enrollees must receive authorization when they exceed eight visits. If beneficiaries see the authorization requirement as a significant barrier, they may see access in Prime as limited even compared to civilian plans that offer firm caps on outpatient care.

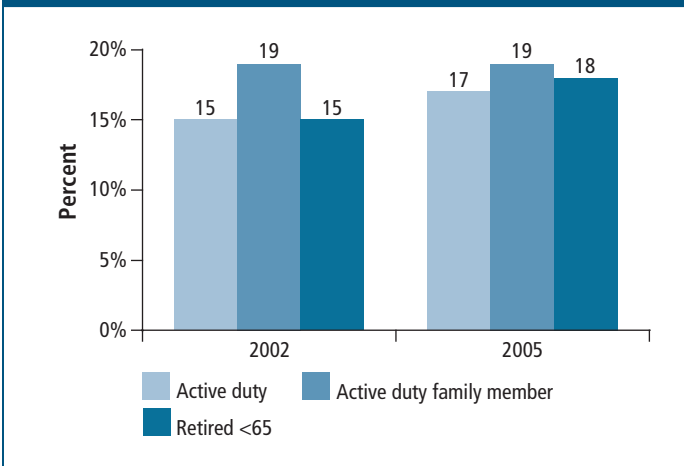
The HCSDB fielded in April 2005 includes questions about beneficiaries' current levels of stress. Most beneficiaries report that they now experience the same amount or less than the amount of stress they usually experience. However, as shown in Figure 38, active duty personnel (38 percent) and active duty family members (41 percent) are more likely than retirees (30 percent) to report that they now experience more or much more stress than usual. Due to a higher enrollment in Prime by active duty and their families than by retirees, this means that enrollees in Prime report increased stress compared to users of Standard/Extra or other health insurance (not shown).

**Figure 38. Increased stress in personal life, by beneficiary category**



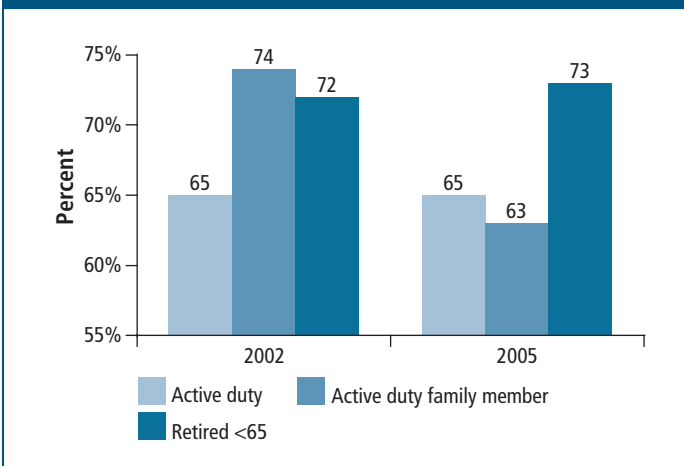
In spite of these concerns, fewer than 10 percent of all beneficiaries report that their mental or emotional health is fair or poor, as was the case in 2002 (not shown). The proportion that reports a need for treatment or counseling for personal or family issues, shown in Figure 39, is somewhat greater, ranging from 17 percent of active duty to 19 percent of active duty family members, and that proportion has risen between 2002 and 2005. For example, among active duty beneficiaries, the proportion that needs treatment increased from 15 percent to 17 percent, while rates among retirees it increased from 15 percent to 18 percent.

**Figure 39. Needed treatment or counseling by beneficiary category and year**



According to Figure 40, active duty and active duty family members are more likely to encounter problems getting needed treatment or counseling than are retirees. Sixty-five percent of active duty beneficiaries and 63 percent of family members who need treatment or counseling report no problems gaining access compared to 73 percent of retirees. For active duty family members, this level of access represents a drop from 2002, when 74 percent reported no problems getting the treatment or counseling they needed.

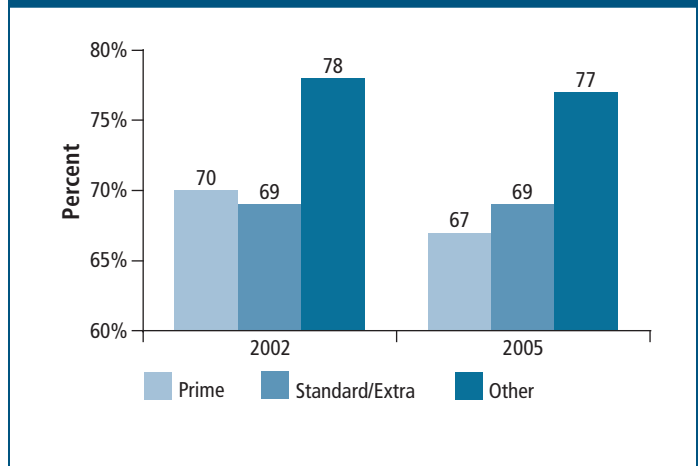
**Figure 40. No problems getting treatment or counseling by beneficiary category and year**



Beneficiaries' reports of access problems also vary by coverage type, with beneficiaries who rely on TRICARE plans reporting poorer access. Sixty-seven percent of Prime enrollees, 69 percent of Standard/Extra enrollees, and 77 percent of enrollees in other health insurance programs report no problems

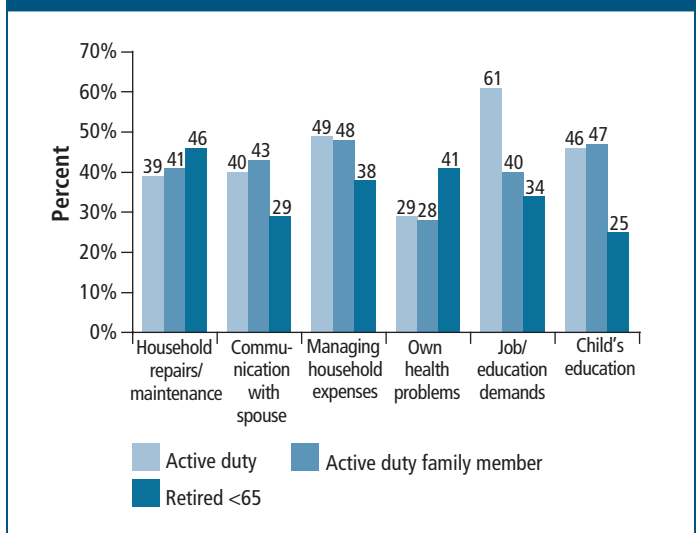
getting treatment in 2005 (Figure 41). The proportion of Prime enrollees without access problems has fallen since 2002, when 70 percent reported they had encountered no problems getting treatment or counseling.

**Figure 41. No problems getting treatment or counseling, by health plan and year**



Some stresses faced by military families are unique, but many are same stresses as those that affect civilian families. Figure 42 shows factors that concern MHS beneficiaries. Active duty personnel most often mention their own job or education as a source of concern. Sixty-one percent consider their own job or education to be a moderate to very large concern. Nearly half of active duty personnel also express concern over household finances (49 percent) and their child's education (46 percent). These two

**Figure 42. Moderate or major sources of concern, by beneficiary category**



issues are also chief sources of concern for family members of active duty personnel. Forty-seven percent of active duty family members express at least moderate concern over their children's education or over family finances. Over forty percent of both active duty personnel and their family members are also concerned about communication with their spouse.

A different set of issues affects retirees than active duty families, reflecting retirees' changing responsibilities. Retirees most often cite household maintenance as a source of concern (46 percent), something that is frequently but less often cited by active duty family members and active duty personnel themselves. Health concerns are much more often mentioned by retirees (41 percent) than by other beneficiary categories, making it retirees' second most often mentioned concern.

Most of the stresses that affect TRICARE beneficiaries are not likely to lead them to seek mental health treatment. Other resources, such as support groups and social and family services, financial advice and assistance are available to help with these concerns and provide a valuable complement to mental health benefits available through TRICARE. More detailed follow-up is needed to learn why beneficiaries perceive barriers to their access to mental health care, and the extent to which these other resources compensate for such barriers.

## Notes

<sup>1</sup> Hoge, C.W. et al. "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care." *New England Journal of Medicine*. 2004; 351(1): 13-22.

<sup>2</sup>The Kaiser Family Foundation Employer Health Benefits survey is an annual national survey of private and public employers of three or more workers. The survey gathers information on health insurance premiums, enrollment, benefits, employee cost-sharing, retiree coverage, and other employer-sponsored health insurance data. The 2004 results of mental health benefits in employer-sponsored plans are available online at [www.kff.org](http://www.kff.org).

## Chapter 9. Health-Related Behaviors of Children in the Military Health System

**P**ersonal behavior is known to have important effects on health. For example, physical inactivity, and unhealthy eating habits promote diseases such as hypertension, obesity and type II diabetes, and safety equipment can prevent unintentional injuries such as those resulting from motor vehicle crashes. Children, who make up 2 million of the 9 million beneficiaries covered by TRICARE, may develop habits that can affect their health far into adulthood.

Recent trends in risky behaviors among children have raised alarms. In the past three decades, childhood obesity, which is promoted by physical inactivity and unhealthy eating habits, has increased rapidly. The prevalence of obesity more than doubled for children aged 6-11 years (from 7 to 15.3 percent between 1976 and 2000), and more than tripled for children aged 12-19 years (from 5 to 15.5 percent between 1976 to 2000).<sup>1,2</sup> Type II diabetes, a consequence of obesity, has become more common among children and adolescents.<sup>3</sup>

At the same time, children and teenagers are exercising less. A 2003 CDC survey showed that about one in three high school students did not get enough exercise, and that physical activity declined as children got older.<sup>4</sup> Over one-third (38 percent) of high school students also reported watching more than three hours of television a day.<sup>5</sup>

Obesity is not the only health problem affected by children's behavior. Accidents are the leading cause of death among children in the United States.<sup>6</sup> In 2004, 1,638 children aged 14 and younger died as occupants in motor vehicle crashes, and approximately 214,000 were injured. Of those killed, half were not using safety belts or car seats.<sup>7</sup> In 1998, 300 children and adolescents died of bicycle-related injuries, and an estimated 430,000 were injured.<sup>8</sup> Yet only 25 percent of U.S. children aged 5-14 years reported always wearing a helmet while bicycling.<sup>9</sup>

Substance abuse and risky sexual activity among teenagers are also health challenges. Alcohol consumption contributes to accidents, homicides and suicides (the three leading causes of death in adolescents), and high-risk sexual behavior, including not using contraception and substance use before intercourse, leads to pregnancy and sexually transmitted disease.<sup>10</sup>

Recognizing the importance of changing behavior in improving health, recent initiatives from the health care community have aimed

to improve health by promoting healthy behavior. For example, Healthy People 2010 objectives include many that focus on behaviors, such as: physical inactivity and fitness, substance abuse and sexually transmitted disease, and injury prevention. In 2005, the DoD, facing similar health challenges, launched *Healthy Choices* initiatives to promote healthy behaviors. *Healthy Choices* initiatives include three demonstration projects targeted at adults focusing on three behaviors: alcohol use, smoking cessation, and weight management. The DoD also established a health promotions website, Healthy Choices for Life, that increases awareness among beneficiaries about healthy behaviors, including the potential role of adults in reinforcing healthy child behaviors through education.<sup>11</sup>

The 2005 HCSDB measures key health risk behaviors among children of military families, including physical activity, watching television and playing videogames, eating fast food, using seat belts, and wearing a helmet when biking and rollerblading.

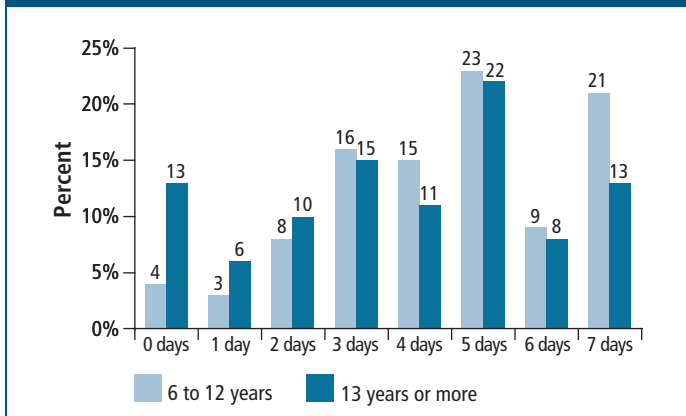
Results from the survey show that, for children served by the MHS, unhealthy behaviors of all sorts are more common among adolescents than among younger children. They also show that children of active duty are more likely than are children of retirees and Prime enrollees are more likely than children in other enrollment groups to take important safety measures, according to their parents.

### Exercise

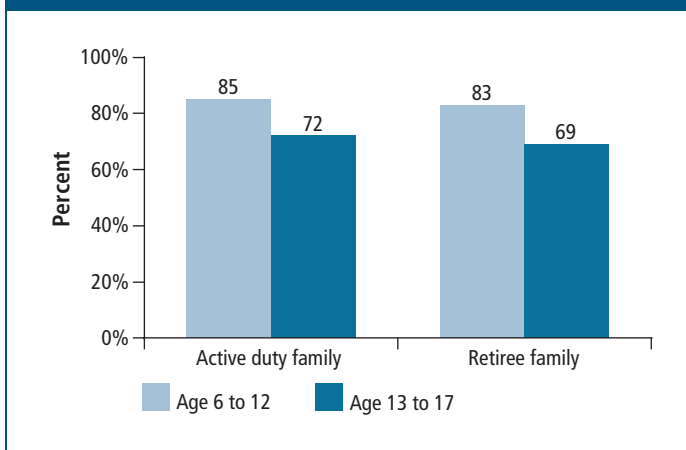
Figure 43 shows the number of days per week that children exercise, defined as participating in vigorous physical activity for at least 20 minutes, according to their parents. The results indicate that physical activity decreases with age. The proportion of children with no exercise rises from 4 percent of children aged 6 to 12 to 13 percent of teenagers. Similarly, the proportion exercising at least 3 days per week falls from 84 percent of children aged 6 to 12 to 69 percent in the teenage group.

As shown in Figure 44, age differences in exercise are evident in both active duty and retired families, while the family's beneficiary category is not itself significantly related to exercise frequency. Eighty-five percent of children with an active duty parent in the younger age group exercise at least 3 times per week compared to 83 percent of retirees' children, while in the teenage group, 72 percent of children with an active duty parent exercise compared to 69 percent of retirees' children.

**Figure 43. Days per week child participated in vigorous physical activity, by age**



**Figure 44. Vigorous physical activity 3 or more times in past week, by beneficiary category**

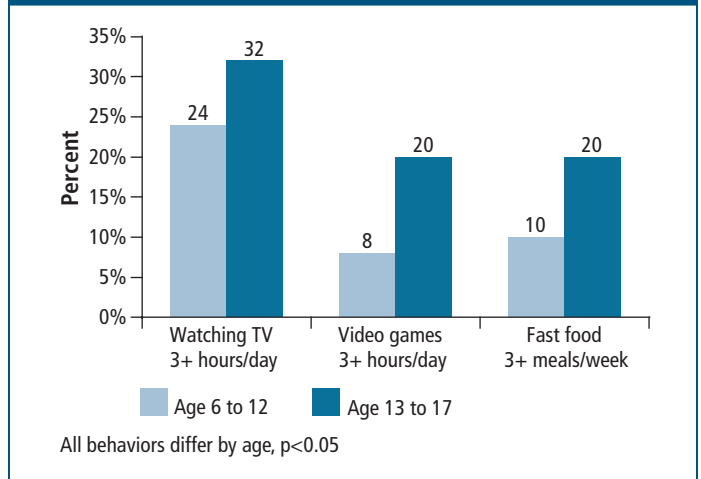


**Leisure Activities and Eating Habits**

Figure 45 shows how leisure activities and eating habits that may promote obesity increase with age. Watching television 3 or more hours per day increases with age, from 24 percent of children aged 6 to 12, to 32 percent of teenagers. Video game use increases still more. The proportion playing three or more hours per day increases from 8 percent among children aged 6 to 12 to 20 percent of children 13 to 17. Teenagers also eat more often in fast food restaurants than do younger children. Twenty percent of teenagers compared to 10 percent of children aged 6 to 12 eat 3 times per week or more in fast food restaurants.

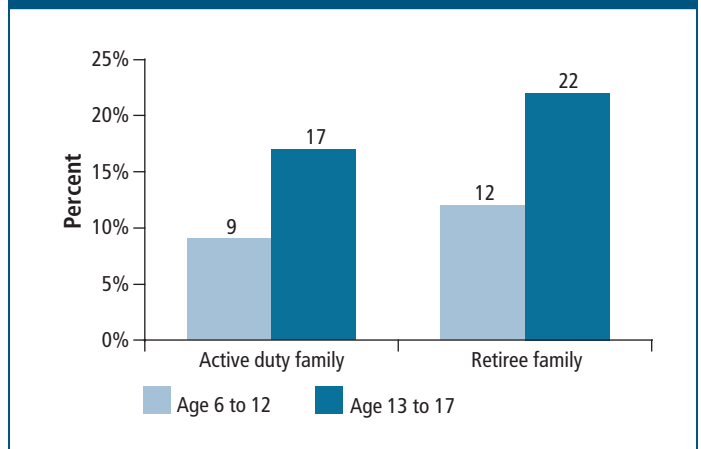
By contrast with exercise and leisure activities, the number of fast food meals varies by beneficiary category. Though exercise (shown in Figure 44), and television watching and video game playing do not vary significantly with beneficiary group (not

**Figure 45. Leisure activities and eating habits by age**



shown), the results in Figure 46 indicate that children of retirees in both age groups are more likely to eat fast food than are children in active duty families. Nine percent of children aged 6 to 12 with an active duty parent eat at fast food restaurants 3 or more times per week compared to 12 percent of children in that age group with a retired parent. Among teenagers, 22 percent with a retired parent eat 3 or more fast food meals per week while 17 percent with an active duty parent eat fast food as often.

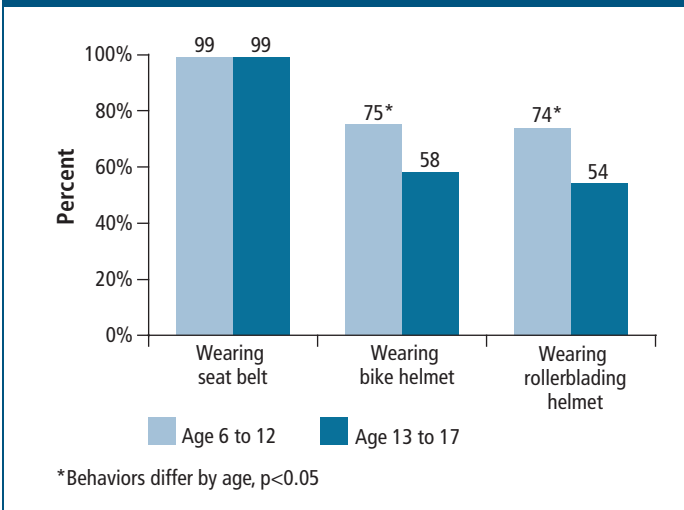
**Figure 46. Fast food 3 or more times in past week, by beneficiary category**



**Safety Habits**

As shown in Figure 47, children’s behavior gets riskier with age. Safety belt use is almost universal and changes little with age. Ninety-nine percent of both teenagers and younger children usually or always wear safety belts according to their parents. However, teenagers use helmets when biking or rollerblading

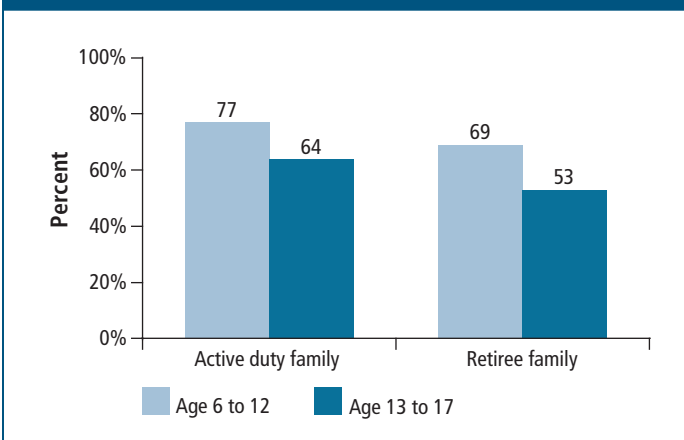
**Figure 47. Safety habits by age**



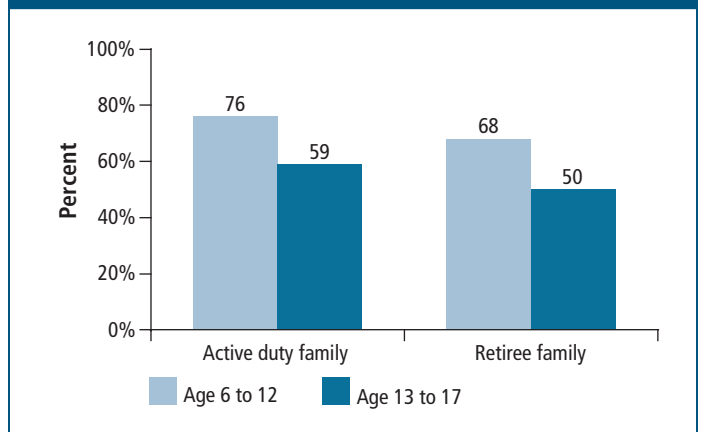
less often than younger children. The proportion of children usually or always wearing a helmet when bicycling falls from 75 percent among younger children to 58 percent of teenagers, while the proportion that usually or always wears a helmet when rollerblading falls from 74 percent to 54 percent.

Figure 48 shows that in both age groups, reported use of bicycle helmets is greater among children with an active duty parent than among children with a retired parent. Among children aged 6 to 12, 77 percent with an active duty parent usually or always wear a bicycle helmet, compared to 69 percent with a retired parent. Among teenagers, 64 percent with an active duty parent use helmets, compared to 53 percent with a retired parent. Children in active duty families are also more likely to wear a helmet when rollerblading than are retirees' children, as shown in Figure 49.

**Figure 48. Child usually or always wore bike helmet, by beneficiary category**



**Figure 49. Child usually or always wore rollerblade helmet, by beneficiary category**



These survey results show that unhealthy behavior increases with age among children in the MHS population as in the civilian population, and that this relation persists across beneficiary categories and health plans. Older children may require more creative interventions to encourage healthy habits, such as safety measures, exercise and healthy eating. In addition, the results suggest that Prime enrollees and children from active duty families are more likely to take safety measures than are other enrollment groups and children of retirees. If parents' reports are correct, this finding suggests that it is possible to influence health-related behaviors and that Prime, or the active duty environment promote child safety. By understanding how they promote safety, we may be able to develop strategies that encourage other healthy behaviors.

**Notes**

<sup>1</sup>Institute of Medicine Fact Sheet, *Childhood Obesity in the United States: Facts and Figures*, Washington, DC: Institute of Medicine, September 2004.

<sup>2</sup>American Obesity Association: *Childhood Obesity, Prevalence and Identification*, Washington, DC: American Obesity Association, [www.obesity.org/subs/childhood/prevalence.shtml](http://www.obesity.org/subs/childhood/prevalence.shtml). Accessed March 18, 2006.

<sup>3</sup>National Center for Chronic Disease Prevention and Health Promotion, *Diabetes Public Health Resource: Diabetes Projects – Children and Diabetes*, Centers for Disease Control and Prevention (CDC) Diabetes Program, Atlanta, GA: U.S. Department of Health and Human Services, [www.cdc.gov/diabetes/projects/cda2.htm](http://www.cdc.gov/diabetes/projects/cda2.htm). Accessed March 18, 2006.

<sup>4</sup>Centers for Disease Control and Prevention (CDC), *National Youth Risk Behavior Survey (YRBS) 1991-2003: Trends in Prevalence of Physical Activity*, Atlanta, GA: U.S. Department of Health and Human Services, [www.cdc.gov/HealthyYouth/physicalactivity.index.htm](http://www.cdc.gov/HealthyYouth/physicalactivity.index.htm). Accessed March 18, 2006.

<sup>5</sup>Centers for Disease Control and Prevention (CDC), Division of Adolescent and School Health, *Physical Activity and the Health of Young People*, Atlanta, GA: U.S. Department of Health and Human Services, March 2005.

<sup>6</sup>National Institutes of Health, *Understanding Mechanisms of Health Risk Behavior Change in Children and Adolescents, PA-04-121*, Bethesda, MD: U.S. Department of Health and Human Services, July 6, 2004, <http://grants.nih.gov/grants/guide/pa-files/PA-04-121.html>. Accessed March 18, 2006.

<sup>7</sup>Centers for Disease Control and Prevention (CDC), National Center for Injury Prevention and Control, *Child Passenger Safety: Fact Sheet*, Atlanta, GA: U.S. Department of Health and Human Services, [www.cdc.gov/ncipc/factsheets/childpas.htm](http://www.cdc.gov/ncipc/factsheets/childpas.htm). Accessed March 18, 2006.

<sup>8</sup>Schieber, RA, and JJ Sacks. "Measuring Community Bicycle Helmet Use Among Children." *Public Health Reports*, Volume 116 (March-April 2001): 113-121.

<sup>9</sup>Schieber and Sacks, *ibid*.

<sup>10</sup>Pergamit, MR, L. Huang, and J. Lane. "The Long-Term Impact of Adolescent Risky Behaviors and Family Environment." Report submitted to the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, August 2001. Chicago: IL, National Opinion Research Center (NORC), University of Chicago, <http://aspe.hhs.gov/hsp/riskybehav01>. Accessed March 18, 2006.

<sup>11</sup>*Healthy Choices for Life* at <http://www.tricare.osd.mil/healthy-choices/default.cfm>, accessed March 31, 2006.

## Chapter 10. Medical Homes in the MHS for Children with Special Health Care Needs

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.”<sup>1</sup> According to the American Academy of Pediatrics (AAP), health services for CSHCN are best provided through the “medical home.”<sup>2</sup> A medical home is a health plan or provider that offers “accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective” care.

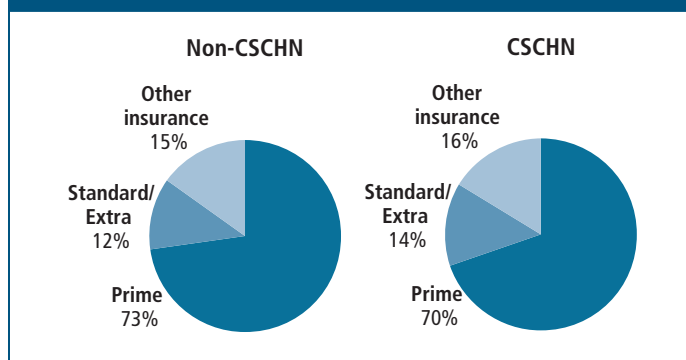
The HCSDB Child Questionnaire includes a battery of 12 questions designed to identify CSHCN. The questions ask about needs for prescription drugs, a higher than normal use of services, use of special therapy and about emotional, developmental or behavioral problems and limitations. Children with any of these characteristics due to a condition lasting at least 12 months are considered CSHCN. The questionnaire also includes questions that measure the extent to which CSHCN in the MHS receive care with the features of a medical home

Overall, their parents’ responses indicate that more CSHCN than non-CSHCN get care with the characteristics of a medical home, such as care from a personal doctor or help coordinating providers. On the other hand, parents of CSHCN are more likely than are parents of non-CSHCN to report problems with access to care, and, in particular, delays waiting for approval. In several dimensions, parents of CSHCN enrolled in Prime are less likely than are parents using other coverage to find medical home characteristics in their child’s care.

### Choice of Health Plan

As shown in Figure 50, in 2005, most TRICARE children, whether CSHCN or non-CSHCN are enrolled in TRICARE Prime. However, the proportion of Prime enrollees among non-CSHCN (73 percent) is greater than among CSHCN (70 percent). TRICARE users, those who rely on Prime or TRICARE Standard/Extra, make up 85 percent of non-CSHCN and 84 percent of CSHCN.

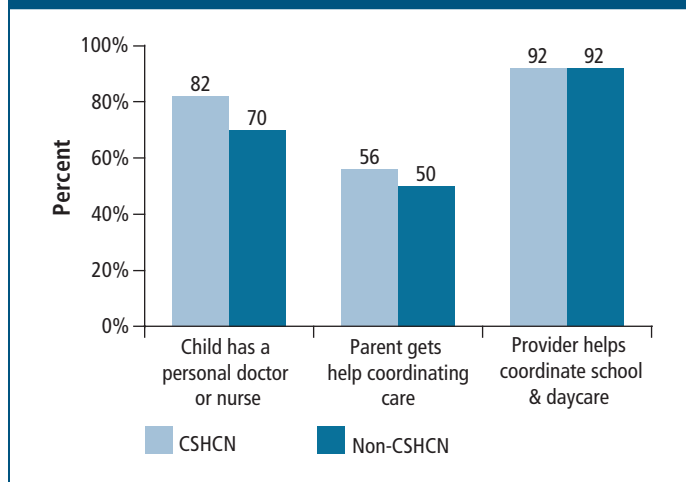
Figure 50. Choice of health plan by CSHCN and non-CSHCN



### Continuous, Coordinated Care

Figure 51 measures the extent to which care provided by TRICARE is continuous, and coordinated. For example, 82 percent of parents with CSHCN report that their child has a personal doctor or nurse, compared to only 70 percent of parents with non-CSHCN. Even fewer, only about half of parents of both CSHCN and non-CSHCN, report getting help coordinating different providers of care, though parents of CSHCN (56 percent) are more likely than parents of non-CSHCN (50 percent) to report getting help. Parents are more likely to report having a provider who helps contact school or daycare services for their child (92 percent of both groups) than they are to get help coordinating providers.

Figure 51. Continuous, coordinated care

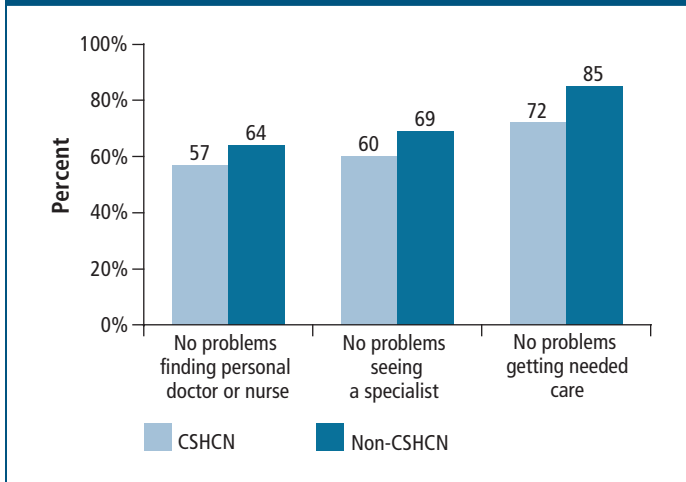




### Access to Care

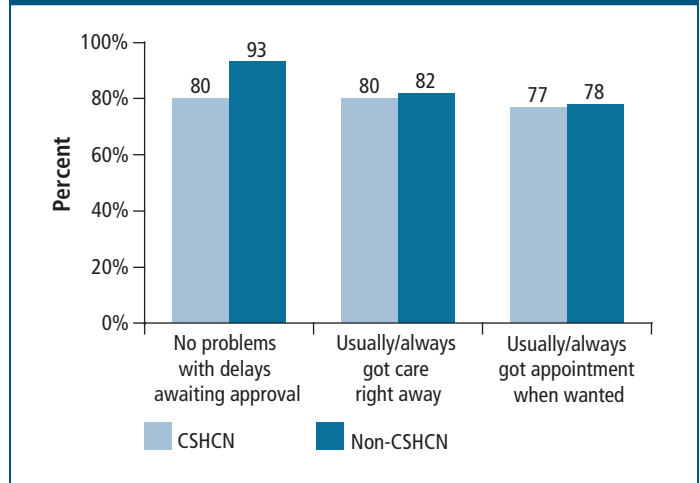
Other dimensions of a medical home are accessibility and comprehensiveness of health care. In contrast to their greater likelihood of finding a personal doctor or getting help coordinating their child’s care, parents of CSHCN report more access problems than do parents of non-CSHCN. Both groups experience problems finding a personal doctor. As shown in Figure 52, 64 percent of parents of non-CSHCN feel it is not a problem to find their child a personal doctor or nurse they are happy with, while only 57 percent of parents of CSHCN feel this way. Both groups report problems getting access to specialists, though parents of CSHCN are more likely to report problems (69 percent compared to 60 percent). More than one in four of parents of CSHCN who rely on TRICARE report problems getting the care that their child needs, substantially greater than the proportion of parents of non-CSHCN.

**Figure 52. Accessible comprehensive care**



As shown in Figure 53, parents of CSHCN are also more likely to report that comprehensive care is not continually available, but is subject to delays. While most (93 percent) parents of non-CSHCN experience no problems with delays waiting for approvals, only 80 percent of parents of CSHCN encounter no problems. About one in five of both CSHCN and non-CSHCN report delays in getting access to urgent care, and to routine appointments. Eighty percent of CSHCN and 82 percent of non-CSHCN usually or always get urgent care when needed, while 77 percent of CSHCN and 78 percent of non-CSHCN usually or always get routine appointments when desired.

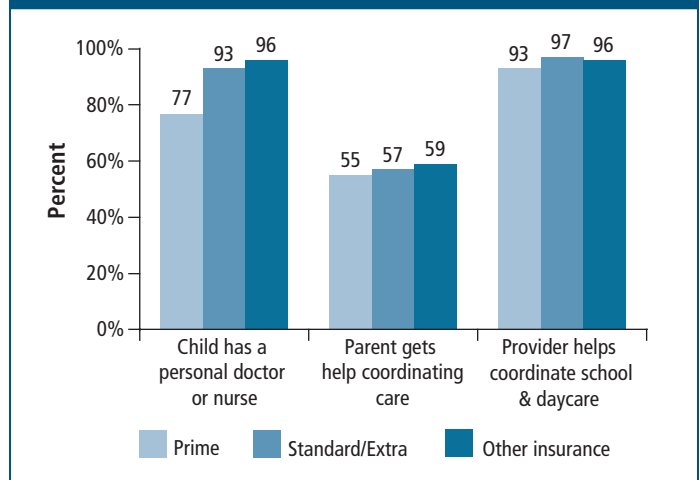
**Figure 53. Delays obtaining care**



### Which Health Plan Provides a Medical Home for CSHCN?

These and other metrics also indicate whether parents of CSHCN enrolled in TRICARE Prime are as likely to report their care has the features of a medical home as users of TRICARE Standard/Extra or other insurance plans. In particular, as shown in Figure 54, parents of CSHCN enrolled in Prime are much less likely than those using Standard/Extra or other insurance plans to have a personal doctor or nurse (77 percent for Prime compared to 93 and 96 percent for Standard/Extra and other insurance, respectively). CSHCN enrolled in Prime are slightly less likely than those using Standard/Extra or other insurance plans to get help coordinating care, though only about half of parents in any of these three groups report getting help

**Figure 54. Continuous, coordinated care for CSHCN, by health plan**



coordinating care. By contrast more than 90 percent of each group receive the help they need from their doctors in contacting their child’s school or daycare.

Family-centered care is delivered by providers who understand the effect of the child’s condition on the family, and who involve the family in decisions about the child’s care. As shown in Figure 55, parents of CSHCN enrolled in Prime are substantially less likely than parents using Standard/Extra or other insurance plans to report that their doctor understands the effects of their child’s condition on family life (78 percent for Prime compared to 87 percent for Standard/Extra or 93 for other insurance plans). Though most parents of CSHCN in all enrollment groups report their doctors usually or always involve the family as much as they want to be involved, those in Prime are slightly less likely to be satisfied with their involvement (92 percent for Prime compared to 94 for Standard/Extra or 96 percent for other insurance plans).

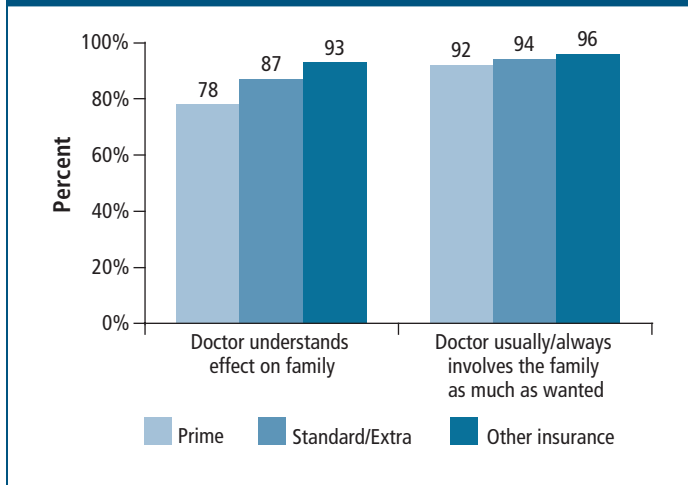
According to their parents, CSHCN enrolled in Prime are less likely to receive care with the features of a medical home than users of Standard/Extra or other health insurance plans: in particular, Prime enrollees are less likely to have a personal doctor or nurse, or to interact with a doctor who understands the impact of their condition on their family. These results suggest that an effort to identify a personal doctor for each special needs child may assist in providing the family-centered, continuous, coordinated care especially important to these children.

**Notes**

<sup>1</sup>Mathematica Policy Research Inc., *HCSDB Issue Brief: Experiences of Children with Special Health Care Needs in TRICARE*, Princeton, NJ: Mathematica Policy Research, Inc., January 2005.

<sup>2</sup>American Academy of Pediatrics: Medical Home Initiatives for Children with Special Needs Project Advisory Committee, “The Medical Home,” *Pediatrics*, 110.1 (July 2002): 184-186.

**Figure 55. Family-centered, compassionate care for CSHCN, by health plan**



**Conclusion**

Parents of CSHCN are more likely than parents of non-CSHCN to describe their care as possessing several of the characteristics of a “medical home.” However, CSHCN families, because they have greater needs for specialists and special treatments, report more problems accessing needed care than non-CSHCN families. In particular, CSHCN families are likelier than non-CSHCN families to report problems finding a personal doctor or specialist for their child.

## Issue Briefs

**T**hese issue briefs first appeared in TRICARE *Consumer Watch*:

- *Overweight Beneficiaries in the Military Health System* appeared in the May 2005 *Consumer Watch*
- *Deployment-related Stress* appeared in the August 2005 *Consumer Watch*
- *TRICARE Pharmacy Options* appeared in the November 2005 *Consumer Watch*
- *Transitional Coverage for Reservists* appeared in the February 2006 *Consumer Watch*



# Issue Brief: Overweight Beneficiaries in the Military Health System

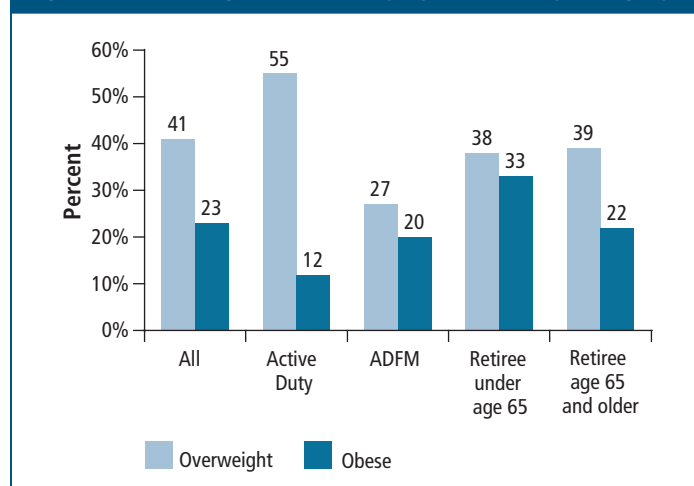
As among civilians, weight problems appear to be increasing among MHS beneficiaries. Excess weight is implicated in many diseases and chronic conditions, including hypertension, type 2 diabetes, heart disease, stroke, and arthritis. Hence, the prevalence of overweight is a key indicator of population health.

## Prevalence

The most commonly used measure of overweight is the body mass index (BMI), which is calculated from weight divided by the square of height. A BMI of 25 or more is considered to indicate overweight, while a BMI of 30 or above indicates obesity (NHLBI, 1998). Classification based on BMI is not very accurate because weight increases when fat is replaced with muscle, but it is widely used because information on height and weight is easy to get. In this brief, we will refer to a BMI between 25 and 30 as overweight to distinguish it from obesity, which is a BMI of 30 or above.

From the HCSDDB, we collect self-reported height and weight and use them to calculate the BMI of respondents. Figure 1 shows that nearly two-thirds of all MHS beneficiaries are overweight (41%) or obese (22%) according to their BMI. In particular, nearly two thirds of active duty are classed as overweight or obese. However, only 12 percent of active duty are obese. Obesity is much higher among retirees under 65, 33 percent of whom are obese.

**Figure 1. Overweight and obesity by beneficiary category**



Most active duty classed as overweight do not consider their weight to be a problem. As shown by Figure 2, only about 40 percent of active duty who are overweight according to their BMI consider themselves overweight. Men, who make up the majority of active duty, are less likely than women to think their weight too high, whether overweight or obese. For men and active duty, measured overweight may be overstated due to muscle. Family members of active duty and retirees and their family members who are overweight are more likely than active duty to consider their weight a problem. In contrast with the overweight, most obese beneficiaries in all categories do believe that their weight is too high.

**Figure 2. Classify self as overweight by BMI class and beneficiary category**

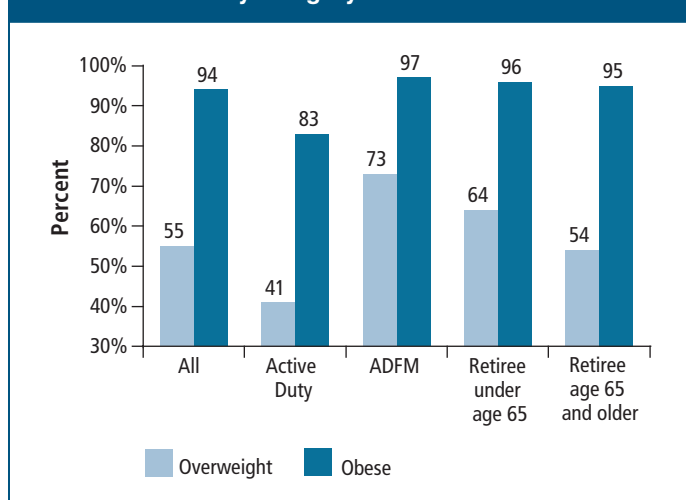


Table 1 indicates that overweight beneficiaries (middle columns) are not significantly more likely than beneficiaries of normal weight (first columns) to rate their health as fair or poor. Beneficiaries under age 65, including active duty, who are classed as overweight by BMI are more likely to report limitations in their activities due to their health. Compared to the overweight, the obese are much more likely than those of

normal weight to rate their health as fair or poor and to report activity limitations.

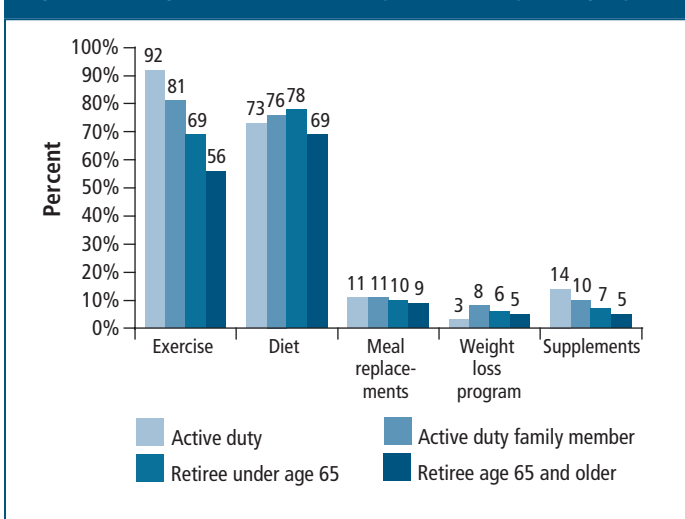
**Table 1. Health status and activity limitations by weight and beneficiary category**

	Normal		Overweight		Obese	
	Poor/ fair health	Limited	Poor/ fair health	Limited	Poor/ fair health	Limited
	Percent					
Active Duty	7	18	6	25*	14*	36*
ADFM	5	13	8	17*	15*	24*
Retiree under age 65	13	24	15	35*	25*	47*
Retiree age 65 and older	26	43	24	41*	34*	62*

\*Greater than normal at p > 0.05

Most beneficiaries who are obese consider their weight to be too high and most (82 percent, not shown) are trying to lose weight. Figure 3 indicates that most who are trying to lose weight do so through both diet and exercise. Among active duty, exercise is favored. More than 90 percent of active duty who are trying to lose weight are using exercise compared to 73 percent using diet control. Retirees and their dependents use diet more often than

**Figure 3. Weight loss methods by beneficiary category**

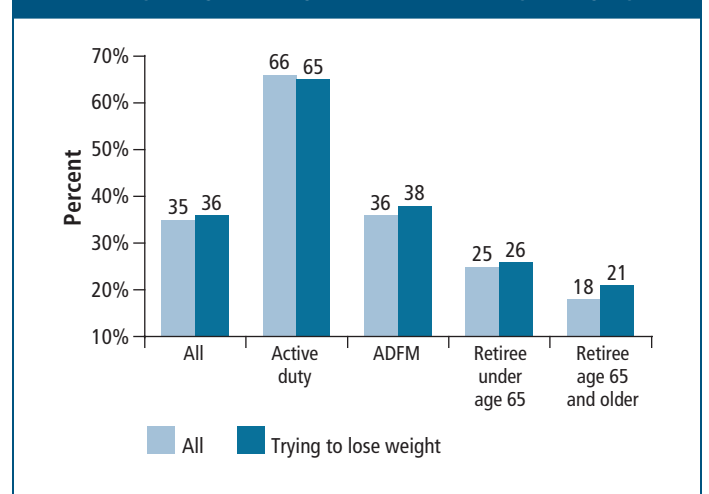


exercise as a method of weight reduction, though a majority, even of retirees over 65, tries to lose weight through exercise. Approximately 10 percent of beneficiaries trying to lose weight in each beneficiary group use meal replacements as part of their regimen, while smaller numbers participate in weight reduction programs. Active duty are more likely than other groups to use dietary supplements (14 percent) as a weight loss method and less likely to use weight loss programs.

**Exercise**

Exercise offers health benefits besides weight reduction. These benefits include strengthening bones, muscles and joints, reducing stress and anxiety and lowering the use of health care services. Results from the HCSDB indicate that two-thirds of active duty take at least 20 minutes of vigorous exercise three or more times per week. Other beneficiary groups exercise substantially less. Among active duty family members about one third get as much vigorous exercise as active duty, and among retirees under age 65 only 25 percent do. There is little difference in the frequency of vigorous exercise between those trying to lose weight and those who are not, in spite of the many who report they are using exercise to reduce their weight.

**Figure 4. Vigorous exercise at least 3 times a week by weight loss goal and beneficiary category**



**Conclusion**

The prevalence of overweight and obesity in the MHS population is similar to their prevalence in the civilian population. Nearly two thirds of civilians report they are overweight or obese according to their BMI, and over 30 percent are obese (CDC, 2004). Most active duty are overweight according to the BMI methodology, yet fewer than half of these consider their

weight to be too high. According to their responses, the prevalence of overweight does not reflect an unhealthy active duty lifestyle. Most active duty vigorously exercise on a frequent basis, and their overweight may be due to muscle, not fat. Even among non-active duty family members the prevalence of vigorous exercise exceeds the Healthy People 2010 goal of 30 percent, and the proportion of civilians exercising vigorously (USHHS, 2000).

The prevalence of obesity and its adverse consequences for health increase among retirees and their dependents. Although this group may be more physically vigorous than its civilian counterparts, exercise levels decline following retirement. The earlier reliance of active duty and their families on exercise to maintain weight control may result in problems with obesity when their lifestyles become less active. Encouragement to maintain an active lifestyle among retirees and more attention to diet among active duty may reduce these problems.

### Sources

Health Care Survey of DoD Beneficiaries, fielded January, 2005.

National Heart Lung and Blood Institute (NHLBI). "Clinical Guidelines on the Identification, Evaluation and Treatment of Overweight and Obesity in Adults: The Evidence Report." Rockville, MD: The National Institutes of Health, 1998.

Centers for Disease Control and Prevention (CDC). National Center for Health Statistics, National Health and Nutritional Examination Survey 1999-2002. Washington, DC: Health, United States, 2004. <http://www.cdc.gov/nchs/data/hus/hus04.pdf>

U.S. Department of Health and Human Services. *Healthy People 2010*. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

# Issue Brief: Deployment-related Stress

Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries (HCSDB). This quarter, the issue brief concerns deployment-related stress.

Along with the usual stresses faced by American families, military families face stresses unique to military service. Some are related to deployment, including separation from deployed spouses, and the exposure of a family member to the dangers of combat. Spouses of Guard or Reserve members may be less prepared than other active duty spouses to cope with deployment-related stress.

## Stress and Its Impact

Results from the HCSDB, shown in Table 1, indicate that spouses of active duty deployed to a combat zone, experience more stress than do other active duty family members. Sixty-three percent with deployed spouses reported “more” or “much more” stress than usual, compared to 36 percent of other active duty family members. Sixty-eight percent of deployed reservists’ spouses reported increased stress, as did 60 percent of other deployed active duty spouses. Other active duty are labeled

“Active Duty” here and throughout to distinguish them from activated reservists.

Unlike stress, self-reported mental health status differs little between those whose spouse has been deployed and those whose spouse has not. Compared to large differences in stress, differences are small and not statistically significant in the proportion rating mental health fair or poor (7 percent when spouse is deployed, compared to 5 percent when spouse is not), or seeking treatment or counseling (21 percent when spouse is deployed, compared to 18 percent).

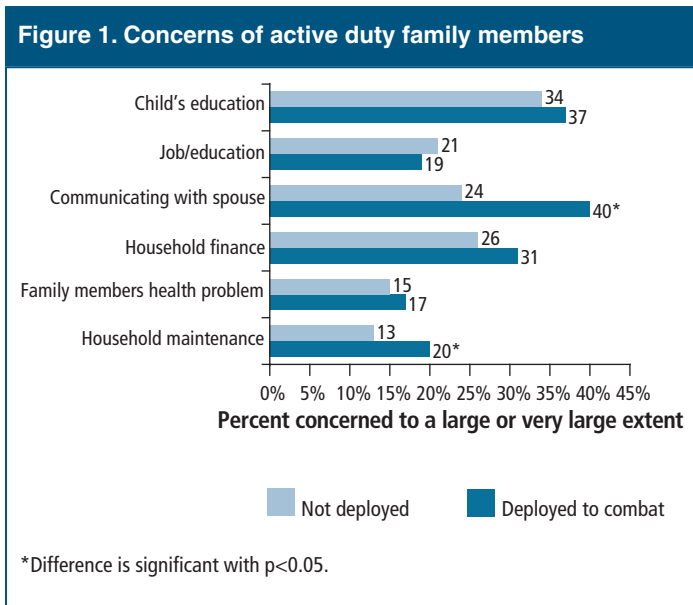
## Sources of Stress

Leading concerns identified by survey respondents are shown in Figure 1. Other than the risks of combat, the issues that concern spouses of active duty who are deployed and of those who are not are similar. Communicating with one’s spouse and maintaining one’s home become substantially greater sources of stress for spouses of deployed. Other concerns, such as children’s education, household finance and one’s own job or education are equally prevalent in both groups.

**Table 1. Stress, Mental and Emotional Health: Active Duty Family Members**

	Among those who do NOT have a deployed spouse	Among those who have a deployed spouse	Among those whose deployed spouse is	
			Guard/ Reserve	Active Duty
	Percent			
More or much more stress than usual	36	63*	68	60
Self-reported mental health — fair/poor	5	7	7	6
Needed counseling for a personal or family problem	18	21	24	19

\*Difference is significant with p<0.05





**Resources Available**

The Office of the Assistant Secretary of Defense for Personnel and Readiness and the branches of service offer or support programs and resources for military families to help them cope with these sources of stress. In addition, TRICARE benefits include psychiatrists, counselors and social workers for those who need professional help.

Examples of resources provided to cope with deployment include:

**Military OneSource**<sup>1</sup> is a 24-hour information and referral phone counseling service specifically for active duty TRICARE members and their dependents. The OneSource website houses a family assistance center including a library of articles on topics such as Parenting, Readiness, Education, Disability, Financial Planning. The OneSource website also offers a locator service (for child care, etc.) and educational materials.

**The Deployment Connections**<sup>2</sup> website delivers deployment-related information and services to all active duty and reserve personnel and their dependents. Website users can access information on their benefits and privileges, what to expect during deployment, and resources available to family members.

*A Family Readiness Handbook*,<sup>3</sup> provided to all families of deployed personnel, includes information for families on where to look for support groups, counseling, and other resources.

Families of deployed personnel may also turn to **Family Readiness Groups**, support groups sponsored by the branches of service.

Previous surveys of reservists and their spouses indicated that reservists and their families are less likely than other active duty to be aware of resources available to them. DoD and the services have responded with outreach specifically directed at reservists, including a *Guide to Reservist Family Member Benefits* and family readiness toolkits for reservists (GAO, 2003).

**Getting Help**

The resources available to assist beneficiaries in coping with their deployed spouses' absence include information, support groups, and counseling. As shown in Table 2, half of the family members surveyed have tried to get some kind of help. Fifty percent have sought information, 28 percent have tried support groups and 10 percent have sought counseling to help cope with deployment. Reservist spouses are most likely to seek help. In particular, 40 percent of reservist spouses tried support groups, compared to 23 percent of other active duty spouses.

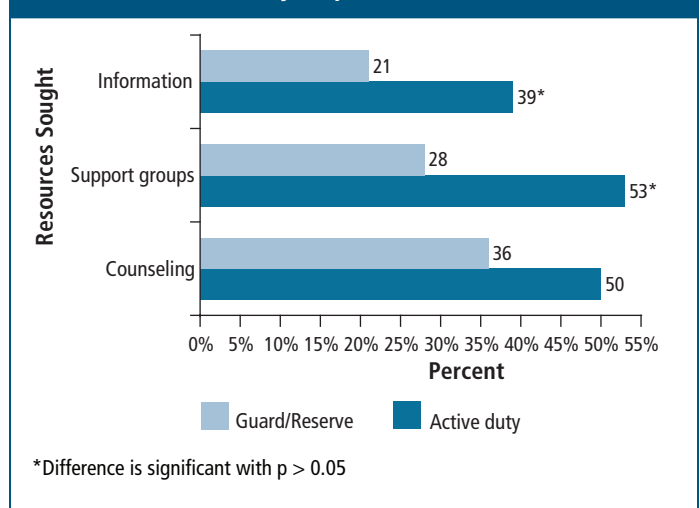
**Table 2. Resource use: Percent who sought a resource to help deal with spouse's deployment**

	Among those who have a deployed spouse	Among those whose deployed spouse is	
		Guard/reserve	Active duty
		Percent	
Information	50	58	46
Support groups	28	40	23*
Counseling	10	14	8

\*Difference is significant with p > 0.05

Most users found the resources provided them to be at least somewhat helpful (not shown). However, reservist families appear to find these resources less helpful than do other active duty families. Only 28 percent of reservist spouses who tried them found their support groups very helpful, compared to 53 percent of other active duty spouses. Similarly, while 39 percent of other active duty spouses found information provided to them to be very helpful, only 21 percent of reservist spouses did.

**Figure 2. Helpfulness of resources: Percent finding the resource "very helpful"**



## Conclusion

Results from the HCSDB survey indicate that spouses of active duty personnel currently deployed to a combat zone face much more stress but do not suffer poorer mental health compared to other active duty family members. To beneficiaries in this situation, DoD, TRICARE and the branches of the armed services provide informational resources and access to support groups and counseling. Most users found these resources to be at least somewhat helpful. However, though they were equally or more likely to look for help compared to other active duty spouses, spouses of reservists find the information provided to them and the support groups less helpful. Our findings suggest that continued efforts by the DoD and services to reach reservists and target support to them are needed.

## Notes

<sup>1</sup><http://www.militaryonesource.com>

<sup>2</sup><http://www.deploymentconnections.dod.mil>

<sup>3</sup><http://www.hooah4health.com/deployment/familymatters/FSGhandbook.htm>

## Sources

Health Care Survey of DoD Beneficiaries, fielded April, 2005. N= 2,512 family members of undeployed active duty, 526 family members of deployed, 145 family members of deployed Guard/Reserve, 381 family members of other deployed active duty.

U.S. GAO. *DoD Needs More Data to Address Financial and Health Care Issues Affecting Reservists*. Washington D.C., September, 2003.

## Issue Brief: TRICARE Pharmacy Options

The military health system (MHS) offers its beneficiaries several options that completely or partly cover the cost of drugs. Options include military treatment facility (MTF) pharmacies, pharmacies in TRICARE's retail network, TRICARE's mail-order pharmacy (TMOP), and non-network pharmacies. In fiscal year (FY) 2002, the Department of Defense (DoD) spent an estimated \$3 billion on outpatient pharmacy (excluding physician administered drugs)<sup>1</sup> and costs for 2005 exceed \$5 billion.<sup>2</sup> Costs to DoD differ depending on the pharmacy option beneficiaries choose; the cost of drugs dispensed through MTF pharmacies and the TMOP is typically lower.<sup>3</sup>

Until recently, military retirees and their family members age 65 and over could obtain TRICARE prescription benefits only by filling prescriptions at MTFs. In 2001, Congress expanded coverage to these beneficiaries to match coverage available to beneficiaries under age 65. Under the TRICARE Senior Pharmacy program (TSRx), retired seniors can now fill their prescriptions at MTF pharmacies, retail pharmacies, the TMOP, or non-network retail pharmacies like other TRICARE beneficiaries.

### Pharmacy Choices

Results from the HCSDB fielded in July, 2005 show that active duty and their families use MTFs more than other pharmacy options, but retirees and their families use the retail network more. The HCSDB asked beneficiaries if they had filled prescriptions in the past 3 months and the type of pharmacy at which they were filled. As shown in Table 1, 77 percent of active duty beneficiaries who filled a prescription reported that they filled one or more at MTF pharmacies, as did 64 percent of active duty family members. In both groups, fewer than half used the retail network.

Among retirees and their dependents, retail network use exceeded MTF use. Fifty-three percent of retirees and their dependents under age 65 and 56 percent age 65 or above reported that they filled prescriptions at a retail network pharmacy, while fewer than half from either retiree group used MTF pharmacies.

The lower cost option of filling prescriptions by mail was not often used by any beneficiary group. Thirty-four percent of retirees and their dependents age 65 or over who filled a prescription and 18 percent of those under 65 used mail order. Only

**Table 1. Pharmacies used in the past 3 months by beneficiary category**

	Percent using pharmacy type		
	MTF	Retail network	TRICARE mail order pharmacy
	Percent		
Active duty	77	26*	6*
Active duty family members	64	43*	7*
Retirees and family, <65	49	53*	18*
Retirees and family, 65 and over	36	56*	34*

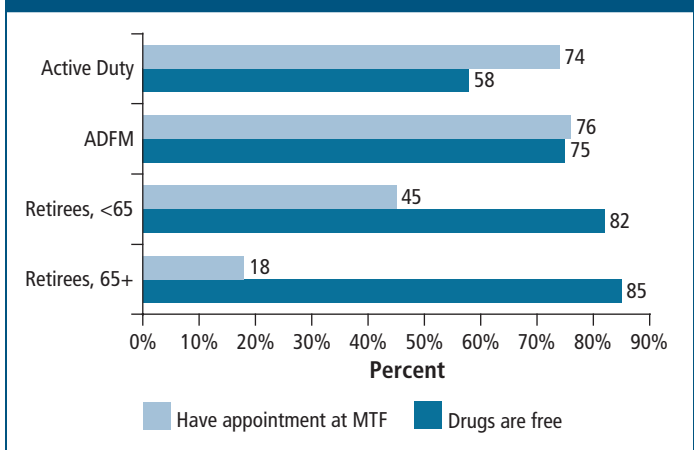
\*Differs from percentage using MTF, p<0.05

6 percent of active duty beneficiaries and 7 percent of their family members with prescriptions used the mail-order option.

### Reasons for Pharmacy Choices

Active duty and their families are more likely to use MTFs than are retirees and their families due to their greater convenience to active duty families and active duty use of MTFs for their health care. As shown by Figure 1, active duty (74 percent) and active

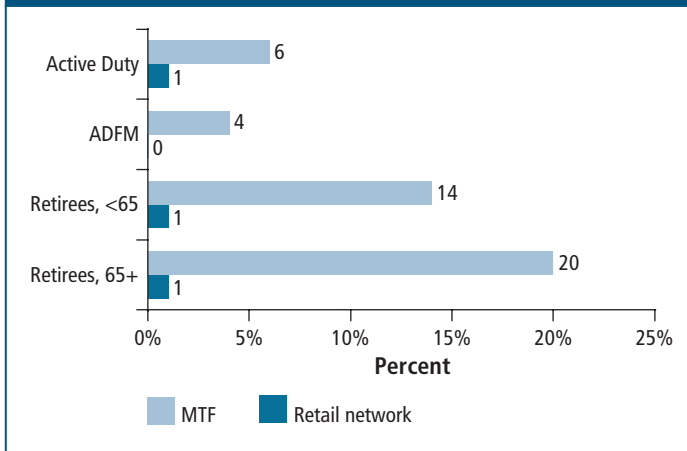
**Figure 1. Reasons for using MTF pharmacy by beneficiary category**



duty family member (76 percent) MTF pharmacy users are most likely to report that they used that pharmacy because they had a simultaneous MTF appointment. By contrast, 45 percent of retirees and family members under age 65 who used an MTF pharmacy and only 18 percent age 65 or above were combining an appointment with a pharmacy visit. However, a large majority of MTF users in all beneficiary categories mentioned that they used MTF pharmacies because prescriptions could be filled there at no cost.

Retirees who use MTFs to fill their prescriptions are more likely than active duty users to travel long distances. As indicated by Figure 2, 20 percent of retirees age 65 or over who used MTF pharmacies, traveled more than 40 miles to do so, as did 14 percent of retirees under age 65. However, only 6 percent of active duty and 4 percent of active duty family members traveled such a long distance. The distance traveled to fill prescriptions at MTFs is much greater than the distance traveled to use a network pharmacy. Only 1 percent of beneficiaries of any type said that they traveled more than 40 miles to use a network pharmacy. The small number who traveled such a long distance indicates that network pharmacies are located where they are easily accessible to retirees, though MTFs frequently are not.

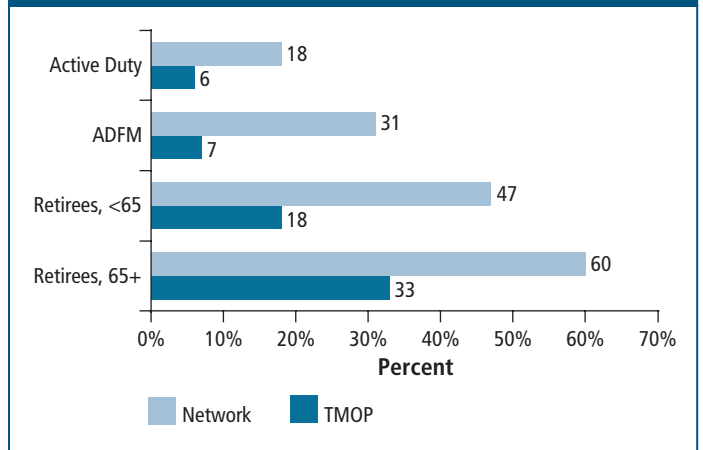
**Figure 2. Users traveling more than 40 miles to a pharmacy**



**TMOP or Retail Pharmacy**

As shown in Figure 3, even when beneficiaries are filling a prescription for drugs they are using for more than 90 days, they are much more likely to use a civilian pharmacy than mail order. Forty-seven percent of retirees and family members under age 65 and 60 percent over age 65 report that, in the past 3 months, they have filled a prescription at a civilian network pharmacy for a drug that they are taking for at least 90 days. Only

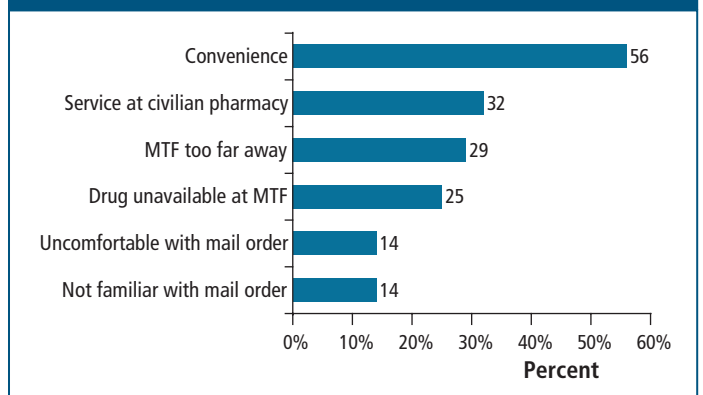
**Figure 3. Use of network and mail order pharmacies for long-term prescriptions**



18 percent of retirees under 65 and 33 percent who are 65 or over have used mail order.

The principal reason for filling these prescriptions at network pharmacies is convenience, mentioned by over half of those who have filled a long-term prescription at a network pharmacy. Most beneficiaries appear not to consider the mail-order option. Figure 4 shows the six most often cited reasons for using civilian network pharmacies. While 29 percent mention distance from an MTF and 25 percent cite unavailability of medications at MTFs, only 14 percent mention discomfort with mail order or unfamiliarity with mail order.

**Figure 4. Reasons for network pharmacy use**



## Conclusion

Though costs to DoD are lowest when beneficiaries use MTF pharmacies or TMOP, these options are now the second and third choices of retirees, behind network pharmacies. With additional base closures upcoming and a substantial proportion of retirees already traveling long distances to use MTF pharmacies, it is likely that use of MTFs relative to other options will decrease. MHS policy makers may save money if they can divert retirees to TMOP or MTFs, by increasing the cost to beneficiaries of using civilian pharmacies, by making more drugs available through TMOP or MTF pharmacies, by reducing TMOP cost-sharing, or by finding new ways of advertising to their retired beneficiaries the advantages of using mail order.

## Sources

<sup>1</sup>Malkin, JD, Joyce, G, Pace, J, Croghan, T. Determinants of Dispensing Location in the TRICARE Senior Pharmacy Program. National Defense Research Institute and Rand Health. 2005. Santa Monica, CA.

<sup>2</sup>Basu, Sandra “DoD Looks Closely at Its Formulary in the Face of Rising Drug Costs,” U.S. Medicine, June 2005.

<sup>3</sup>General Accounting Office. “Mail Order Pharmacies: DOD’s Use of VA’s Mail Pharmacy Could Produce Savings and Other Benefits.” Washington, DC: General Accounting Office. GAO-05-555. June 2005.

## Notes

Health Care Survey of DoD Beneficiaries, fielded July, 2005. N= 2,471 active duty, 1,835 family member, 3,062 retired and family members under 65, 2,025 retired and family member age 65 and over, pharmacy users.

## Issue Brief: Transitional Coverage for Reservists

During the last two years, TRICARE has expanded health benefits for reservists in the periods before and after they are activated for a contingency operation. In July 2004, the Department of Defense extended TRICARE benefits to reservists with delayed-effective-date active duty orders. Under “early” TRICARE, reservists and their families receive, without paying a premium, the same medical and dental benefits as non-enrolled active duty personnel.<sup>1</sup>

After deactivation, reservists may use TRICARE Standard, Extra, or Prime for up to 6 months through the Transitional Assistance Management Program (TAMP). Under the National Defense Authorization Act (NDAA) for 2005, eligibility under TAMP was permanently extended to 180 days effective October 28, 2004.<sup>2</sup>

After TAMP ends, certain reservists and their families may purchase TRICARE Reserve Select (TRS),<sup>3</sup> if they enter into a Service Agreement to serve in the Selected Reserves for one year or longer. Effective April 27, 2005, TRS offers comprehensive health coverage similar to TRICARE Standard/Extra.<sup>4</sup> In calendar year 2006, monthly premiums for TRS were \$81 for member-only coverage and \$253 for member and family member coverage.<sup>5</sup> Upon meeting the annual deductible for outpatient services, TRS members pay 15 percent for TRICARE network provider care or 20 percent for non-network care.<sup>6</sup>

### Coverage before and after activation

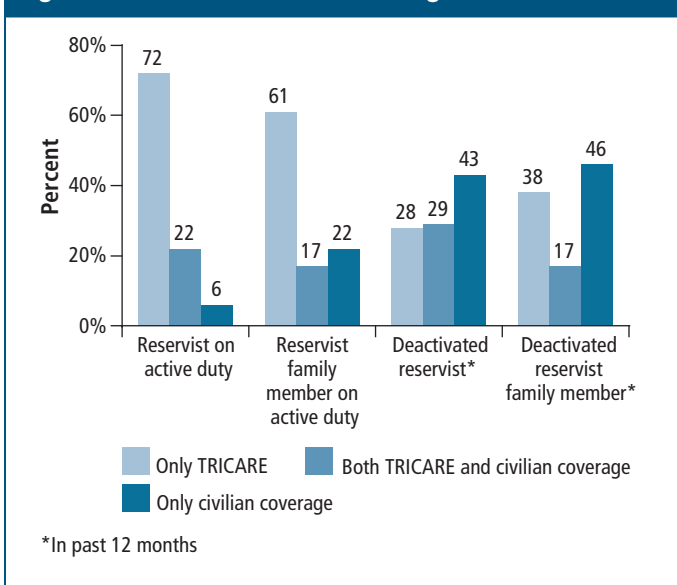
According to data from the 2005 HCSDB, before becoming eligible for TRICARE through activation for a contingency operation, roughly four in five reservists and reservist family members have civilian coverage, as shown in Table 1. Sixty percent of reservists have civilian coverage through their own policies, and 14 percent through a family member. By contrast, 40 percent of reservist family members have coverage through the policy of the reservist in their family and 41 percent through their own or a non-reservist family member’s policy.

Figure 1 shows that once reservists become eligible for TRICARE, about one in four retains civilian coverage during activation, including 6 percent who say that they have only civilian coverage. Among active reservists’ family members, about 40 percent retain civilian coverage, consisting of 17 percent covered by both TRICARE and civilian plans and 22 percent with only civilian coverage.

**Table 1. Civilian health insurance coverage prior to TRICARE eligibility**

Type of coverage	Reservist on active duty/ deactivated in past 12 months	Reservist family member on active duty/deactivated in past 12 months
Own policy	60	35
Policy of a reservist spouse or parent	5	40
Policy of a non-reservist in family	9	6
Did not have civilian insurance	26	20

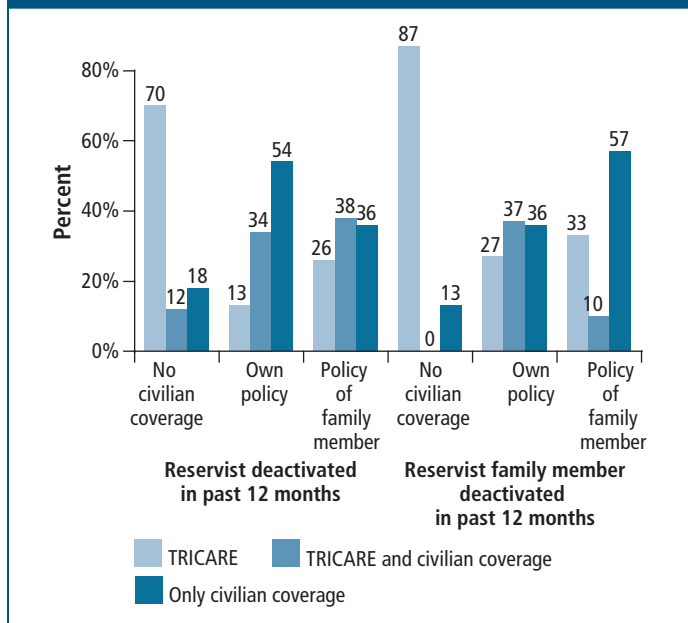
**Figure 1. Current health care coverage**



When deactivated, most reservists resume civilian coverage. About 43 percent report being covered by civilian health insurance alone, and 29 percent by both TRICARE and a civilian plan. Among reservist family members, 46 percent no longer use TRICARE and 17 percent use both TRICARE and civilian coverage.

As shown in Figure 2, most reservists who did not have civilian coverage before activation continue to rely on TRICARE, while those with civilian coverage before activation resume it when deactivated. Seventy percent of reservists and 87 percent of reservists' family members without civilian coverage prior to activation have only TRICARE coverage following deactivation. By contrast, 54 percent of reservists with their own civilian coverage go without TRICARE altogether when deactivated, as do 57 percent of family members covered by a reservist's civilian policy before activation.

**Figure 2. Health coverage after deactivation by coverage before activation**

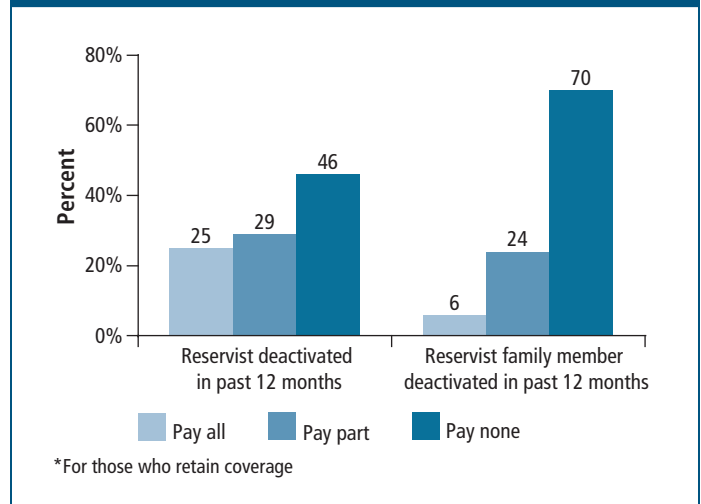


When covered by a non-reservist's civilian policy before activation, reservists and reservist's family members are less likely to drop TRICARE when deactivated. Only 36 percent of reservists covered by their family member's civilian policy before activation drop TRICARE after deactivation, as do 36 percent of reservist family members who had been covered through their own policy.

**Why civilian coverage?**

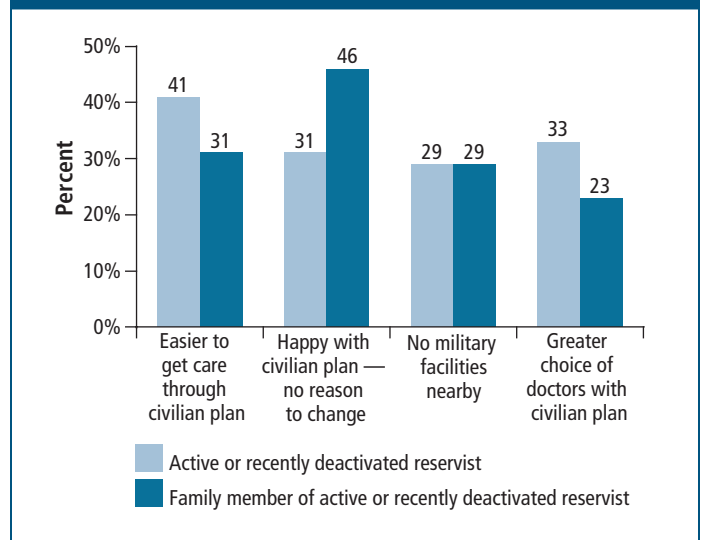
Figure 3 suggests that many deactivated reservists and their families who use civilian coverage do so because it imposes no additional costs. Forty-six percent of recently deactivated reservists with civilian coverage report that they do not pay any of the premium for their coverage, while 29 percent say they pay partial premiums. Similarly, 70 percent of recently deactivated reservists' family members say they do not pay premiums, and 24 percent say that they pay a share of their premium.

**Figure 3. Financial responsibility for civilian coverage premiums\***



The reasons most often cited for using civilian health insurance instead of TRICARE are highlighted in Figure 4. About 41 percent of active or recently deactivated reservists and 31 percent of family members who use only civilian coverage report that it is easier to get care through their civilian plan. A large number, 31 percent of reservists and 46 percent of family members, report that they simply see no reason to leave their civilian plan. About a third of both groups choose civilian care because they live far from an MTF, and a slightly smaller number because of the wider selection of doctors in their civilian plan.

**Figure 4. Reasons for not using TRICARE**



## Conclusion

Recent expansions of coverage to reservists will help reservists make transitions to and from active duty status. Most reservists are happy with their civilian coverage and revert to it when they are able. Continuity of civilian coverage appears to be eased by policies of some government and private employers to waive activated reservists' premium contributions. Many reservists and their families retain their civilian plan even when covered by TRICARE. For the minority who do not have coverage through their civilian job, TRICARE coverage fills a gap. For this group, and for those, also a minority, who must pay all of their civilian premiums, the TRS benefit may be an important inducement to remain in the reserves.

## Notes

<sup>1</sup>“ ‘Early’ TRICARE Benefit for Some Activated National Guard and Reserve Members and Family Members”, <http://www.tricare.osd.mil/factsheets/viewfactsheet.cfm?id=328>.

<sup>2</sup>“Transitional Assistance Management Program: A Transitional Health Care Benefit for Service Members and Their Families”, <http://www.tricare.osd.mil/factsheets/viewfactsheet.cfm?id=317>.

<sup>3</sup>“TRICARE Reserve Select”, <http://www.military.com>.

Reservists deactivated on or after April 27, 2005 who had been activated in support of a contingency operation on or after September 11, 2001, and who have served continuously on active duty for 90 days, are eligible.

<sup>4</sup>“Am I Eligible”, <http://www.tricare.osd.mil/reserve/reserve-select/TRS-Eligibility.cfm>.

<sup>5</sup>“New! TRICARE Reserve Select (TRS)”, <http://www.tricare.osd.mil/reserve/reserve-select/index.cfm>.

<sup>6</sup>“TRS Costs”, <http://www.tricare.osd.mil/reserve/reserve-select/TRS-costs.cfm>.

## Sources

Health Care Survey of DoD Beneficiaries, October, 2005. N= 284 reservists activated in support of contingency operations or recently deactivated, 237 family members of such active or recently deactivated reservists, and 60 who are both reservists and family members.









## **PRINCETON OFFICE**

PO Box 2393  
Princeton, NJ 08543-2393  
(609) 799-3535  
Fax: (609) 799-0005

## **WASHINGTON OFFICE**

600 Maryland Avenue, S.W., Suite 550  
Washington, DC 20024-2512  
(202) 484-9220  
Fax: (202) 863-1763

## **CAMBRIDGE OFFICE**

955 Massachusetts Avenue, Suite 801  
Cambridge, MA 02139  
(617) 491-7900  
Fax: (617) 491-8044

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