

PROJECT REPORT

Health Care Survey of DoD Beneficiaries 2009 Annual Report

September 2009

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Executive Summary

In this annual report for the Health Care Survey of Department of Defense (DoD) Beneficiaries (HCSDB), we describe results from a worldwide survey of beneficiaries eligible for health care coverage through the military health system (MHS). The survey contains questions about beneficiaries' ratings of their health care and health plan, access to care, choice of health plan, and other subjects relevant to the leaders and users of the MHS. We compare the results to benchmarks from civilian health plans featured in the National Consumer Assessment of Healthcare Providers and Systems (CAHPS) Benchmarking Database (NCBD).

Key results from the 2009 HCSDB report include the following:

- The proportion of eligible beneficiaries using direct care fell from 42 percent in 2006 to 40 percent in 2008. During that time, purchased care users increased from 17 percent to 20 percent, and users of other civilian insurance fell from 13 percent to 12 percent.
- Active duty family members' (ADFM's) use of direct care fell from 60 percent to 55 percent, while use of purchased care rose from 28 percent to 34 percent. From 2006 to 2008, retirees' use of other civilian insurance fell and their use of purchased care rose.
- Health plan ratings of both direct care and purchased care users rose from 2006 to 2008.
- Ratings of health care among direct care users were well below the civilian benchmark, while the ratings of purchased care users were slightly below the benchmark.
- Both direct care and purchased care users reported problems finding a personal doctor, and fewer than half of direct care users had a personal doctor.
- Compared to purchased care users, direct care users were more likely to report problems accessing a specialist, but they were less likely to report delays getting care while awaiting approval from their health plan.
- Among purchased care users, the correctness and timeliness of claims are similar to NCBD benchmarks.
- The customer service experience of direct care and purchased care users has improved substantially since 2006.
- Pap smear rates for direct care users exceeded the Healthy People 2010 goal though rates for both purchased care women and those who rely on other civilian insurance were below that goal. Mammography rates for all three groups also exceeded the Healthy People 2010 goal.
- From 2006 to 2008, the proportion of military treatment facilities (MTF) users reporting timely access to appointments fell from 62 percent to 60 percent, compared to a civilian benchmark of 81 percent.
- Timely appointments at civilian facilities financed by TRICARE and by civilian insurance met or exceeded the benchmark.
- MTF users were less likely to report that MTF staff are helpful and MTF doctors spend enough time with them compared to the civilian benchmark. Users of civilian insurance and Veterans Affairs (VA) facilities reported that staff and doctors meet the benchmarks for these measures.
- Active duty (AD) women and AD men did not differ with regard to rating their health care experiences. However, compared to AD men, AD women were more likely to have a personal doctor, more likely to have an emergency room (ER) visit, and more likely to report a perceived need for counseling.
- Women reservists reported more positive health care experiences than did non-reservist women and somewhat more negative experiences than did women reservist family members. However, women reservists did not consistently report either more positive or more negative experiences than did men reservists.
- Among retirees, satisfaction with access to or quality of care was at least as high in Base Realignment and Closure (BRAC) sites as in non-BRAC sites. There were also no changes in the level of satisfaction among retirees in BRAC sites from 2005 to 2008, apart from increased satisfaction with health plans.

- TRICARE Reserve Select (TRS) enrollees reported being as satisfied with their health care as Standard/Extra users on all measures except getting needed care. TRS enrollees also reported higher satisfaction than Prime users of military facilities and, to a lesser extent, Prime users of civilian facilities.
- Beneficiaries who rely on civilian coverage were more likely to trust their health care provider than those who use Standard/Extra. Those covered by Prime were least likely to trust their providers. Also, beneficiaries who use MTFs trust their providers less compared to those who use civilian treatment facilities (CTFs).
- Beneficiaries with Prime coverage were more likely than those using Standard/Extra or civilian coverage to believe that their health plan would pay for their care, but were less likely to believe their health plan's responses to their questions.
- Among adults, women were more likely to trust in their health care providers and their health plans than were men. ADFMs were more likely to trust their health plan or provider than were AD service members, but less likely than were retirees and their family members. Adults were more likely to trust their child's provider than their own, whatever their health plan or source of care.
- Since 2005, the share of retirees under age 65 with access to civilian coverage has not changed, but the share of those retirees who use TRICARE instead of a civilian plan has increased substantially.
- A substantial fraction of beneficiaries use tobacco in forms other than cigarettes. Those who use these alternative tobacco products were much less likely to be advised by their doctors to quit compared to cigarette smokers.
- Most beneficiaries eligible to use sick call reported doing so. Compared to beneficiaries not eligible to use sick call, those who used sick call reported similar trust in providers and greater satisfaction with choice of providers.
- AD beneficiaries reported greater problems regarding access to behavioral health care than did other TRICARE beneficiaries. Fewer than half of AD beneficiaries who make appointments for behavioral health care do so through TRICARE.

Chapter 1. Introduction

About the HCSDB

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

Samples are drawn from the Defense Enrollment Eligibility Reporting System (DEERS) and are stratified by the location of a beneficiary's home, health plan, and reason for eligibility. In 2008, 200,000 beneficiaries living inside or outside of the United States were sampled for the adult survey. A total of 35,000 beneficiaries worldwide were sampled for the child survey. The 2008 HCSDB Adult Sample Report and 2008 Child Sample Report describe the sampling methods. Synovate administers the survey, allowing beneficiaries to respond by mail or on a secure website.

Responses to the survey are coded, cleaned, edited, and assembled in a database. Duplicate and incomplete surveys are removed. A sampling weight is assigned to each observation, adjusted for nonresponse. The 2008 HCSDB Codebook and Users Guide describes the contents of the database.

Questions in the 2008 HCSDB were developed by TMA or were taken from other public domain health care surveys. Many questions were taken from the CAHPS Health Plan Survey, Version 3.0. CAHPS contains core and supplemental survey questions used by commercial health plans, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid programs to assess consumers' satisfaction with their health plans.

Most survey questions change little from quarter to quarter so that responses can be followed over time. Supplementary questions are added each quarter so as to learn more about the latest health policy issues. In 2008, the survey added questions about civilian and military health care facilities, the place where the AD respondent receives health care and advice, level of trust in medical providers, and several other topics.

About this Report

This report presents results for all surveys administered in 2008 and sometimes compares the results to those from 2006 and 2007. The report includes responses from all beneficiaries eligible for MHS benefits, including children, who reside in the United States. This report also contains results from two supplemental surveys that were administered in 2008. The first of these surveys focuses on beneficiaries living near MTFs that are undergoing changes due to the recommendation of the 2005 Base Closure and Realignment Commission. The second survey focuses on National Guard and Reserve personnel and their family members and their experiences with TRS.

Beneficiaries are eligible for military health benefits if they are currently on AD or are dependents of AD personnel. National Guard and Reserves mobilized for more than 30 days and their dependents are eligible, as are retirees and those who are the dependents of a retiree. In addition, inactive members of the National Guard and Reserves and their dependents may purchase coverage through TRS, as long as they are not eligible for the Federal Employees Health Benefits (FEHB) Program. MHS beneficiaries may receive care from MTFs financed and operated by the uniformed services or from civilian facilities reimbursed by DoD.

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. AD personnel and their family members are automatically eligible for free enrollment in Prime. Retirees under age 65 may enroll if they pay a premium. TRICARE Standard offers cost sharing for care received from civilian doctors on a fee-for-service basis. TRICARE Extra

offers enhanced cost sharing for fee-for-service care provided by network doctors. TRS resembles Standard and Extra. Many retirees and some AD dependents also have non-military coverage. For beneficiaries with civilian insurance, including Medicare, the civilian payer has primary responsibility. Since the inception of TRICARE for Life in October 2001, TRICARE Standard has been second payer to Medicare and has paid most costs left over after Medicare has paid.

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

Chapters 4 through 8 present results from the survey on several topics, including women's health care preferences, health care experiences of women reservists, the impact of the 2005 BRAC recommendations on retirees' perceptions of access to and quality of health care, changes in enrollment of TRS and comparisons of health care experiences of TRS enrollees versus those of ADFMs, and trust in health care providers and health plans.

Results from CAHPS questions are compared to results from the National CAHPS Benchmarking Database (NCBD) for 2006. The NCBD assembles results from CAHPS surveys administered to hundreds of civilian health plans. Mean rates are calculated from the results and adjusted for age and health status to correspond to the characteristics of beneficiaries shown in the graph. For example, benchmarks in graphs presenting civilian health plan ratings are adjusted to the age and health status of beneficiaries using civilian health plans while the same benchmarks for Prime users are adjusted to the age and health status of beneficiaries who use Prime. For preventive care measures, such as the proportion of women screened for cervical cancer, results are compared with *HP2010* goals or with rates from nationally-representative surveys. *HP2010* goals are set by the government to promote good health through healthy behavior, such as immunization, screening for illness, and avoiding unhealthy habits. The 2008 HCSDB Technical Manual describes the benchmarks in more detail.

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

The issue briefs for 2008, which are included in this report, concerned (1) MHS beneficiaries' access to behavioral health care, (2) AD beneficiaries' experience at sick call, (3) tobacco use in the MHS, and (4) retirees' use of civilian coverage. These issue briefs make up the last four chapters of this report.

Chapter 2. Beneficiaries' Choices of Health Plan

MHS beneficiaries are covered by a wide range of health plans, most of them provided or supplemented by DoD. AD personnel are largely restricted to TRICARE Prime, but their dependents may choose from Prime, Standard/Extra, or civilian policies. Retirees also may choose Prime, Standard/Extra, or civilian coverage, with a substantial minority eligible for Veterans Administration care. Medicare-eligible retirees are eligible for TRICARE for Life, which provides TRICARE benefits to pay deductibles and coinsurance left over from Medicare. Beneficiaries who rely on Prime may enroll to a primary care manager at a military facility (direct care) or to the managed care network (purchased care). The great majority of Prime enrollees are enrolled to direct care. As shown in Figure 1, 40 percent were AD or were MTF enrollees in 2008. As shown in Figure 2, direct care use has fallen since 2006, when 42 percent were enrolled.

Purchased care users are defined here as those who are enrolled to the TRICARE civilian network, or who report they rely on Standard or Extra for most of their care. As shown in Figure 1, they make up 20 percent of respondents, increasing from 17 percent in 2006. During the period from 2006 to 2008, beneficiaries switched from civilian insurance and direct care to purchased care.

As shown in Figure 3, the majority of ADFMs (55 percent) are direct care users, but 34 percent use purchased care. Approximately one in ten family members of AD personnel

Figure 1. Health plan used for most care 2008

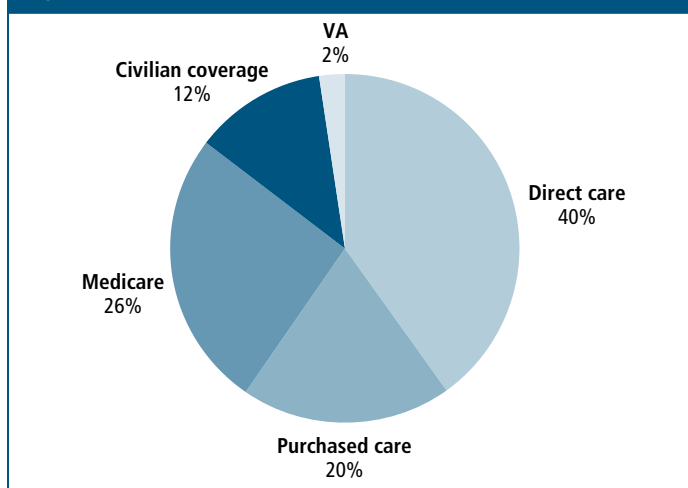


Figure 2. Health plan used for most care 2006

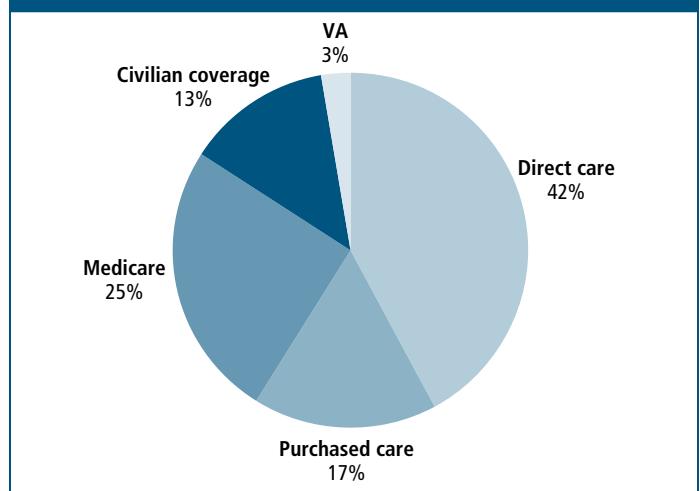
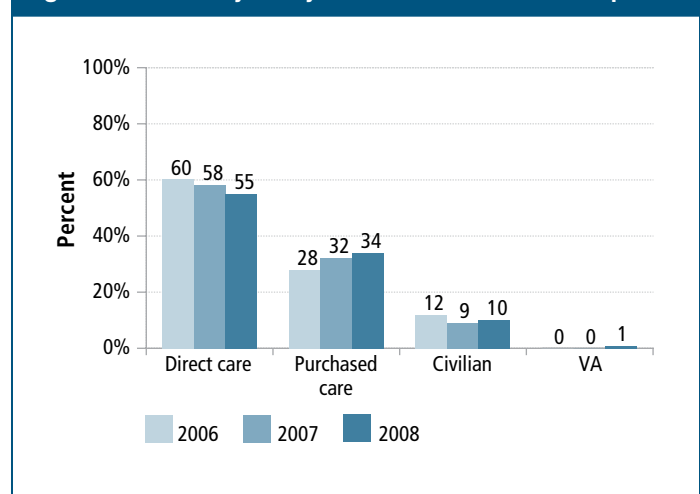


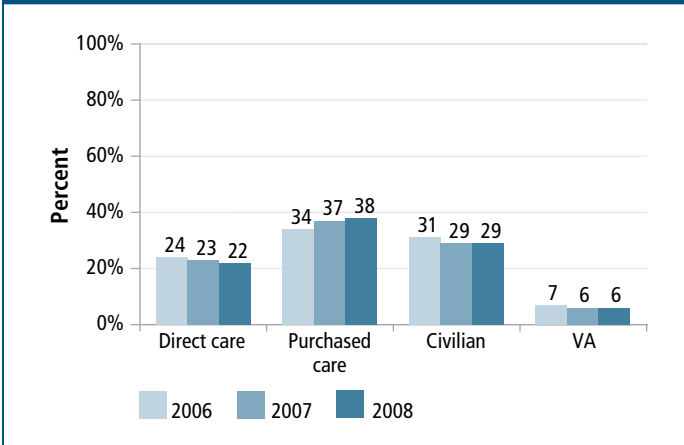
Figure 3. Active duty family members choice of health plan



report relying on alternative civilian insurance. Between 2006 to 2008, about 6 percent of AD dependents switched from direct care or civilian insurance to purchased care.

Figure 4 indicates that about one-quarter (22 percent) of retirees and their family members choose direct care as their health plan, while a little over a third (38 percent) rely on purchased care. Purchased care use rose from 34 percent to 38 percent between 2006 and 2008. Retirees have shifted away from both direct care and other civilian insurance.

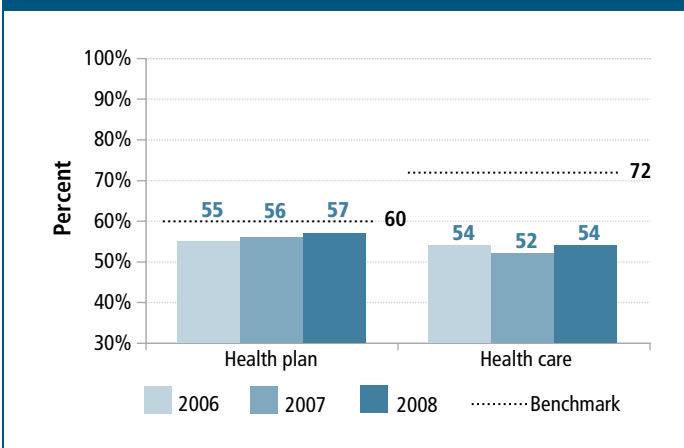
Figure 4. Retired, less than 65 choice of health plan



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

As shown in Figure 5, when asked to rate their health plan, direct care Prime enrollees give ratings slightly below their adjusted benchmarks. Fifty-seven percent rate their plan 8 or above. Since 2006, the proportion giving direct care Prime a high rating rose from a level of 55 percent. Fifty-four percent of direct care enrollees give their health care a high rating, which is well below the civilian benchmark, and approximately the same proportion as in 2006.

Figure 5. Direct care health plan and health care ratings



By contrast, purchased care users, as shown in Figure 6, rate their health plan approximately the same as the adjusted benchmark. This rate (65 percent) has increased from 60 percent in 2006. Their health care ratings are slightly below their adjusted civilian benchmark. Seventy-two percent rate their health care 8 or above, approximately the same as in 2006. As shown in Figure 7, beneficiaries who use civilian health insurance coverage give ratings to both their health plans and health care that do not differ significantly from adjusted civilian benchmarks.

Figure 6. Purchased care health plan and health care ratings

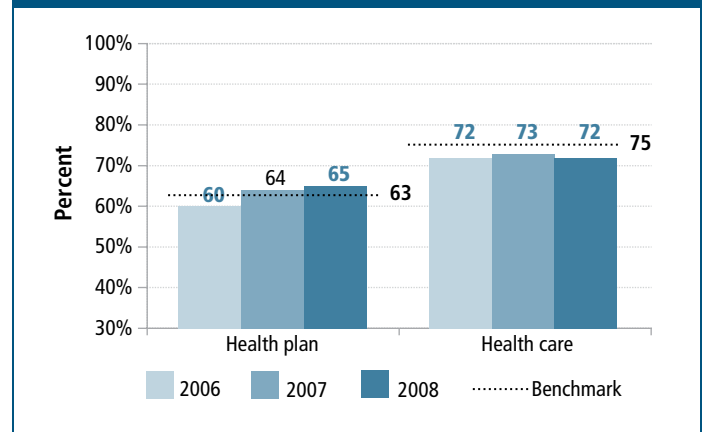
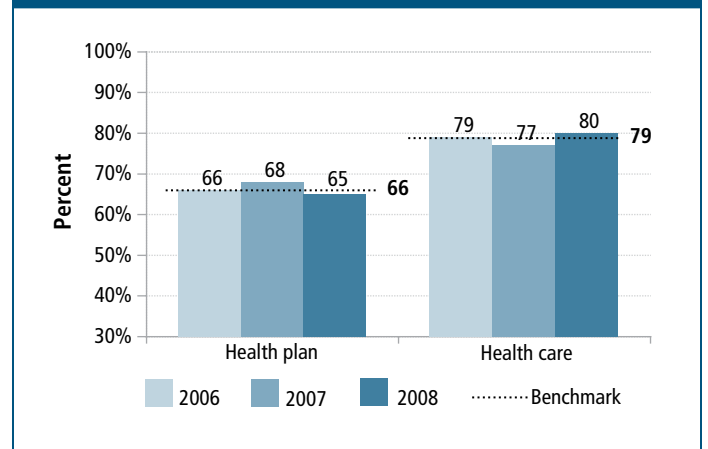


Figure 7. Beneficiaries with civilian coverage health plan and health care ratings

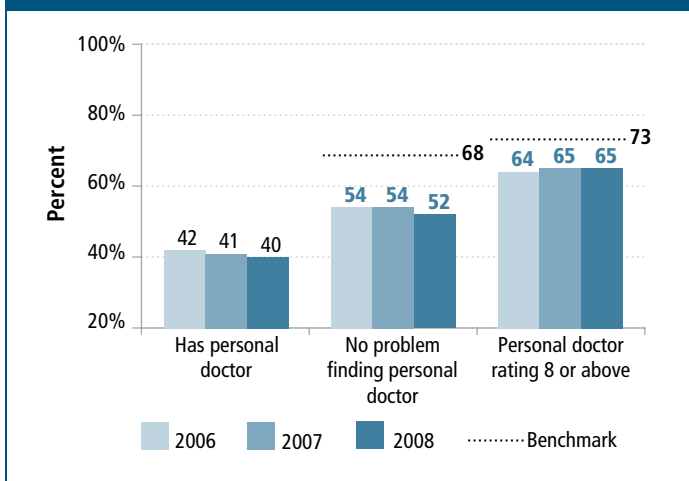


As shown in Figure 7, the proportion of beneficiaries relying on civilian coverage that gives its health plan a high rating is 65 percent, approximately the same as the adjusted benchmark, approximately the same as 2006. The proportion giving its health care a high rating is 80 percent, not significantly different from the benchmark, and approximately the same as in 2006.

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

As shown in Figure 8, 40 percent of direct care users report they have a personal doctor. In spite of programs like “Personal Doctor by Name” this proportion has not increased, and has even declined slightly since 2006. Fifty-two percent of direct care users report no problem finding a personal doctor, well below their adjusted benchmark of 68 percent and less than the 2006 rate (54 percent). Sixty-five percent give their personal doctor a rating of 8 or above on a 0 to 10 scale, also below the benchmark rate. Rates for finding personal doctors and ratings of personal doctors are virtually identical across the three years.

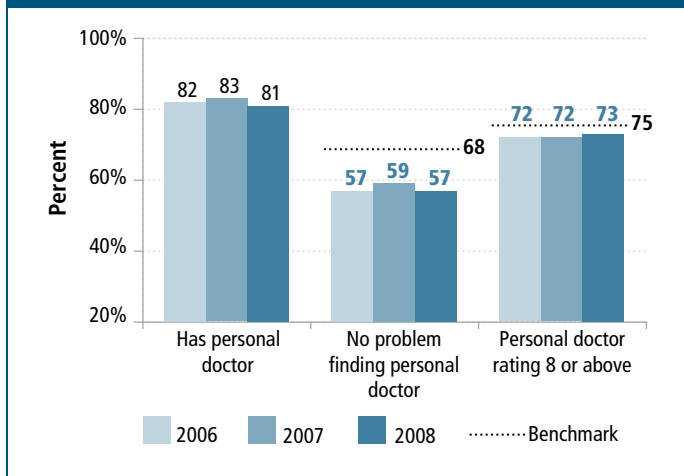
Figure 8. Direct care personal doctors



By contrast, purchased care users, shown in Figure 9, are twice as likely as direct care users to have a personal doctor. Eighty-one percent report they have a personal doctor, approximately the same as the 2006 rate. Purchased care users do report problems accessing a personal doctor. Fifty-seven percent report they had no problems finding a personal doctor they are happy with, significantly below the adjusted benchmark. However, the proportion giving their personal doctor a high rating, 73 percent, is close to the adjusted benchmark, and is approximately the same as the rate in 2006.

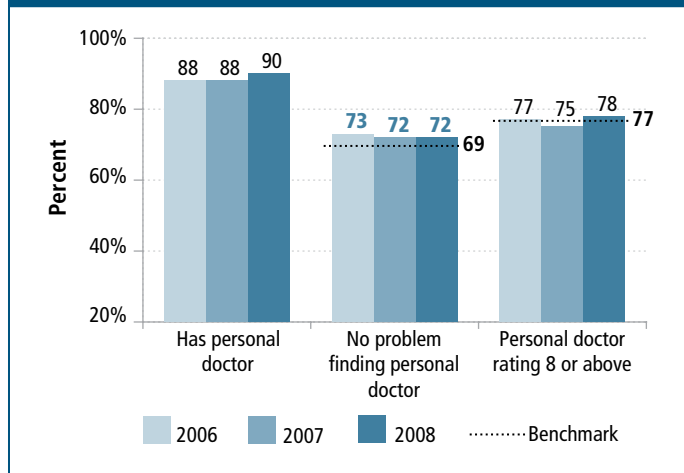
Beneficiaries relying on civilian coverage are more likely than either group of TRICARE users to have a personal doctor. As shown in Figure 10, 90 percent report they have one doctor

Figure 9. Purchased care personal doctors



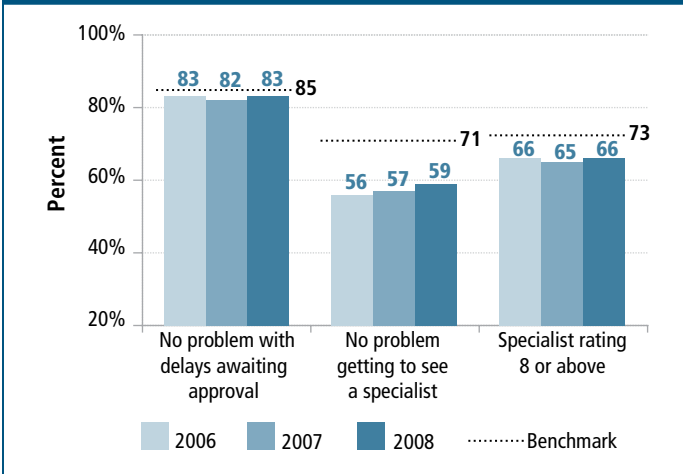
they consider their personal doctor. Seventy-two percent of the group with civilian coverage report they have no problem finding a personal doctor, slightly above the adjusted benchmark. Seventy-eight percent give their personal doctor a high rating. These rates have changed little since 2006.

Figure 10. Beneficiaries with civilian coverage personal doctors



As shown in Figure 11, 83 percent of direct care enrollees report no problem with delays while awaiting approval from their health plan for care tests or treatment. This rate is slightly below the adjusted benchmark, and approximately the same as in 2006. Direct care users are much more likely to encounter problems getting access to specialists than they are to complain of delays. Fifty-nine percent report no problem getting to see a specialist compared to a benchmark of 71 percent. The rate with no problem has increased slightly from 2006, when it was

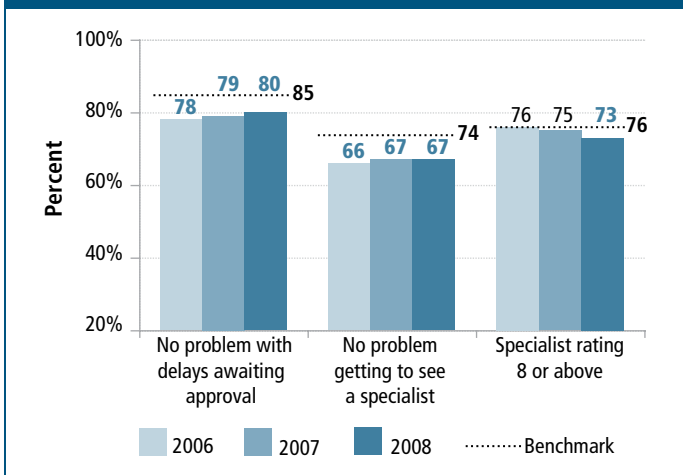
Figure 11. Direct care access to specialists



56 percent. The proportion giving high ratings to specialists is similar to the proportion rating its personal doctor highly, 66 percent, which is below the benchmark of 73 percent.

Purchased care users are more likely than direct care users to experience delays awaiting approval. As shown in Figure 12, 80 percent report such delays. However, the proportion of purchased care users reporting no problem getting referrals to specialists, 67 percent, is higher than the rate for direct care users, although it is still substantially below the adjusted benchmark. Seventy-three percent give their personal doctor a high rating, slightly below the benchmark, decreasing from 76 percent in 2006.

Figure 12. Purchased care access to specialists



As shown in Figure 13, beneficiaries who rely on their civilian coverage, are less likely than beneficiaries relying on TRICARE to report access problems. Ninety percent report no problem getting approvals from their health plan, above the benchmark rate. Eighty-one percent report no problem accessing specialists, and 81 percent give their specialist a high rating. These rates are all similar to or higher than the corresponding benchmarks, and similar to the 2006 rates.

Figure 13. Beneficiaries with civilian coverage access to specialists

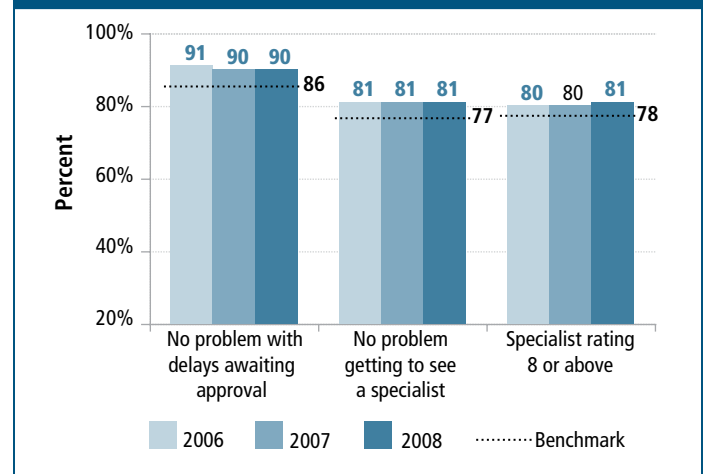
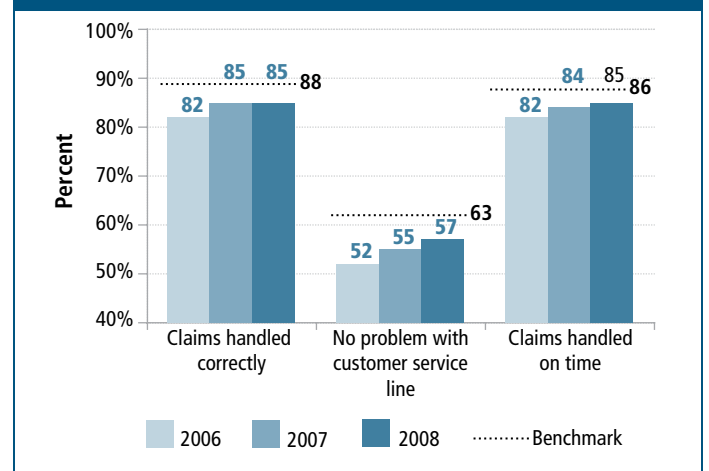


Figure 14 shows that beneficiaries enrolled to direct care report improvement in their interactions with their health plans' claims handling and customer service. The proportion reporting that their claims are usually or always handled correctly has risen from 82 percent in 2006 to 85 percent in 2008, compared to a benchmark of 88 percent. Similarly, timely claims handling

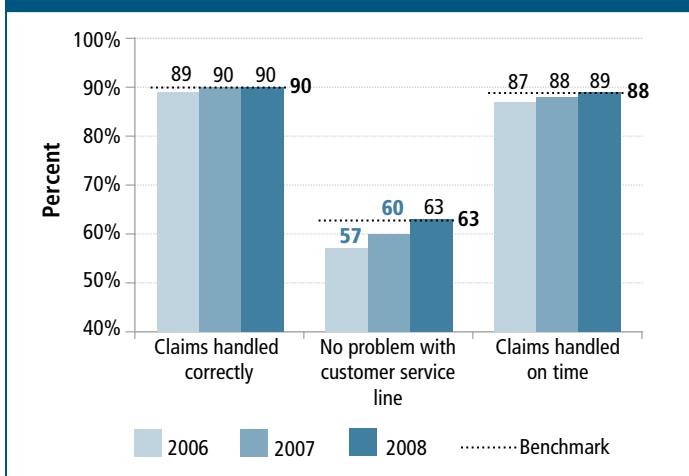
Figure 14. Direct care claims handling and customer service



has increased from 82 to 85 percent, compared to an 86 percent benchmark. Though still below the benchmark rate, the proportion reporting no problem getting customer service help is 57 percent, compared to the level in 2006 of 52 percent.

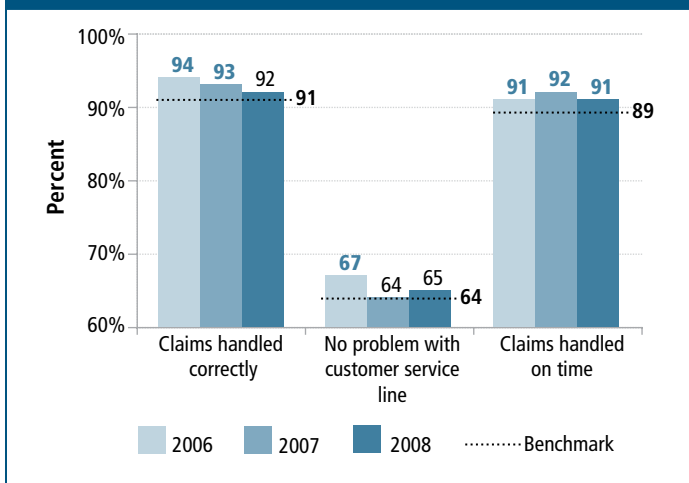
Purchased care users, as shown in Figure 15, have experienced improvements similar to those of direct care users, and their rates for correct claims handling (90 percent) and timely claims handling (89 percent), are similar to the adjusted civilian benchmarks. The proportion reporting they receive customer service

Figure 15. Purchased care claims handling and customer service



help with no problem has increased from 57 percent to its current level of 63 percent.

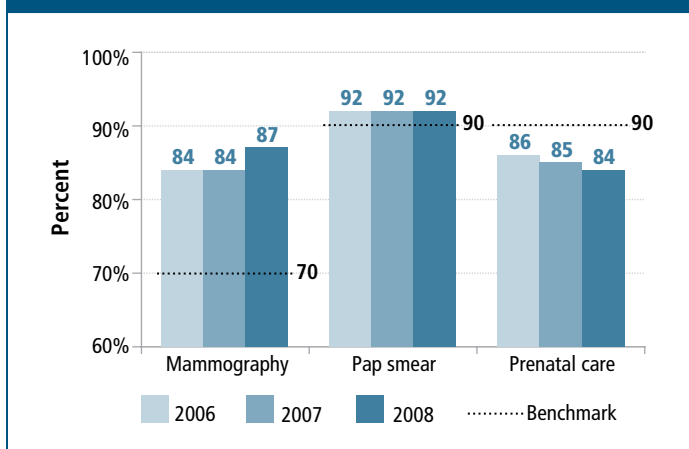
Figure 16. Beneficiaries with civilian coverage claims handling and customer service



Beneficiaries who rely on their civilian coverage report claims handling and customer service experiences similar to or exceeding the civilian benchmarks, as shown in Figure 16.

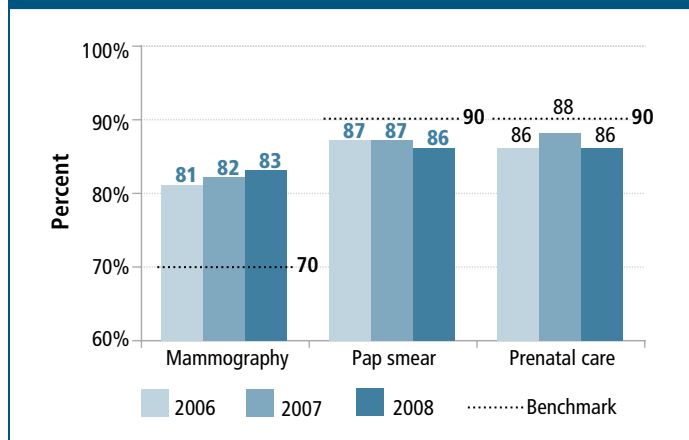
In contrast to the low ratings given to their health care and certain features of their health plans, women enrolled to MTFs get preventive care at rates similar to other enrollment groups. As shown in Figure 17, 87 percent of direct care women over 40 received mammography within the past two years, exceeding the *HP2010* goal of 70 percent. Ninety-two percent of direct

Figure 17. Direct care cancer screening and prenatal care



care women over 18 received Pap smears in the past 3 years, exceeding the Healthy People goal of 90 percent. Only the proportion receiving first trimester prenatal care, 84 percent, falls short of the *HP2010* goal.

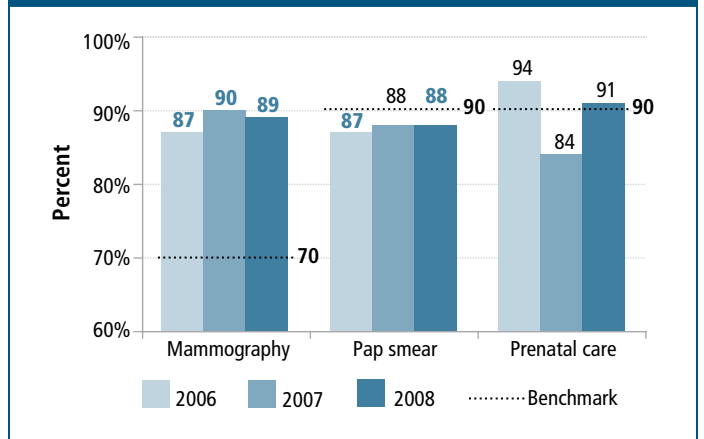
Figure 18. Purchased care cancer screening and prenatal care



By contrast, as shown in Figure 18, though purchased care women exceed the *HP2010* goal for mammography, 86 percent have Pap smears within the recommended interval, which is less than the target rate. Eighty-six percent received recommended prenatal care.

As shown in Figure 19, the mammography rate of women who rely on civilian insurance exceeds the *HP2010* goal, like that of their TRICARE counterparts, but their Pap smear rate is slightly below the 90 percent target. The prenatal care rate for beneficiaries with civilian coverage is 91 percent, which is similar to the *HP2010* goal.

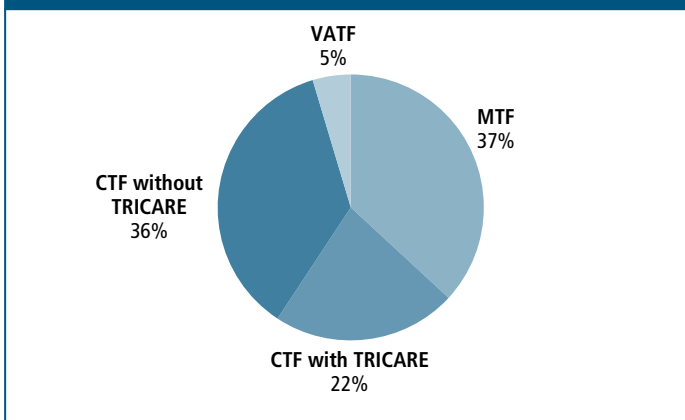
Figure 19. Beneficiaries with civilian coverage cancer screening and prenatal care



Chapter 3. Beneficiaries' Sources of Health Care

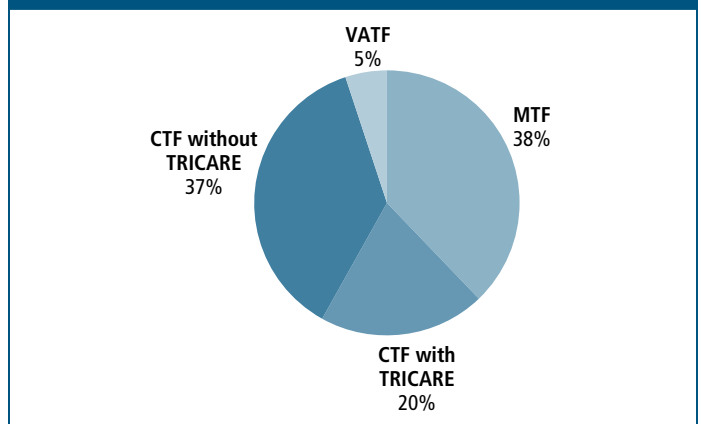
Beneficiaries who use civilian insurance, TRICARE for Life, or TRICARE Standard/Extra receive care primarily from civilian providers. Prime enrollees, however, may get care either from civilian managed care support contractors or from MTFs operated by the uniformed services. Thus, the proportion of beneficiaries that gets care primarily from MTFs is less than the proportion enrolled in Prime. Figure 20 presents the type of facility that beneficiaries report provided most of their care over the past 12 months. It divides civilian facility (CTF) users into beneficiaries whose civilian care is covered primarily by a TRICARE plan and those whose care is covered through Medicare or other civilian insurance. The majority of eligible beneficiaries (58 percent) get care primarily from civilian facilities. Another 5 percent use VA facilities and 37 percent rely on MTFs. The proportion reporting they use a civilian facility primarily financed by TRICARE is somewhat higher than the proportion using purchased care as defined by health plan in Figure 1. The difference is due in part to active duty, whose health plan we classified as direct care, but who may get most of their care from civilian providers.

Figure 20. Patient's usual source of care 2008



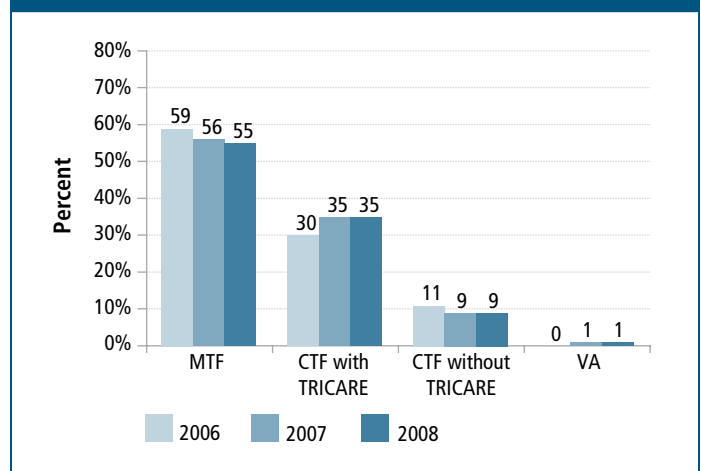
As shown in Figure 21, use of the civilian network has risen since 2006. Twenty percent in 2006 described civilian providers financed by TRICARE as their usual source of care. The increase in purchased care use does not appear to come from any one source, as use of VA, MTF and non-TRICARE civilian providers have all fallen, but not statistically significantly.

Figure 21. Patient's usual source of care 2006



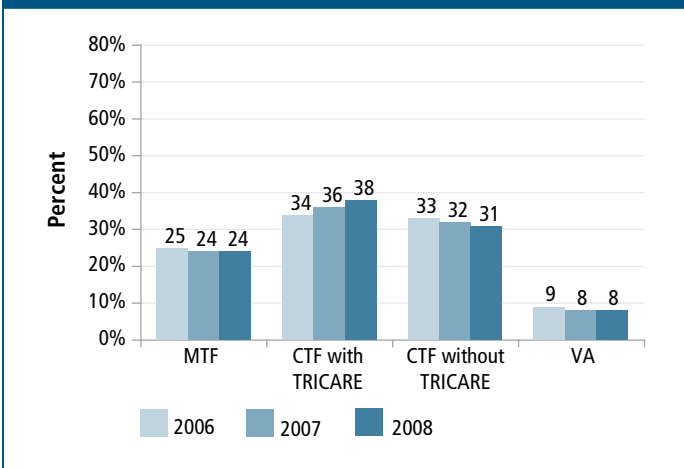
AD personnel receive the great majority of their care through military providers. However, as shown by Figure 22, family members receive a substantial and growing proportion of their care from civilian providers. Fifty-five percent describe a military provider as their usual source of care, but 35 percent get most of their care from civilian providers, financed by TRICARE, and 9 percent from civilian providers and a civilian health plan. Between 2006 and 2008, MTF use has dropped from 59 percent to 55 percent and CTF use, with and without TRICARE, has risen from 41 percent to 44 percent.

Figure 22. Active duty family members usual source of care



As shown in Figure 23, the sources of care used by retirees and their dependents under age 65 has shown a shift from civilian care covered by civilian insurance to civilian care covered by TRICARE. About one in four retirees and their beneficiaries list military providers as their usual source of care, and about two in three designate a civilian provider as their usual source of care. However, use of civilian providers covered by TRICARE increased from 34 percent to 38 percent, while civilian providers reimbursed through private insurance fell from 33 percent to 31 percent during that time. Eight percent of retirees report that they get most of their care from VA providers.

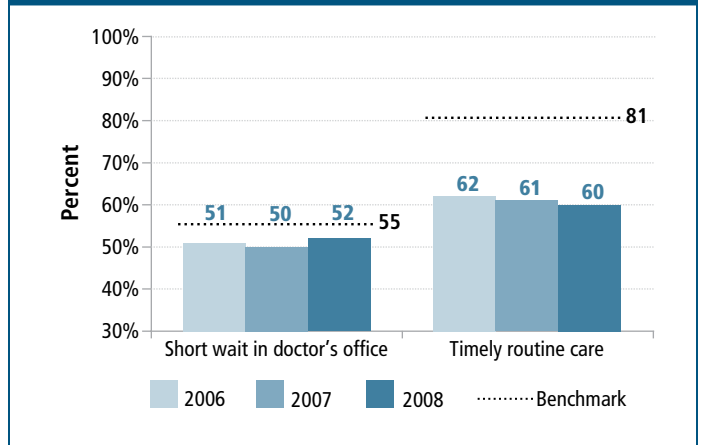
Figure 23. Retired, less than 65 usual source of care



Measures in this section concern the length of time beneficiaries must wait to receive care, either at the doctor’s office, or when trying to get an appointment. Measures are presented for MTF users, users of VA facilities, and users of civilian facilities covered by TRICARE or covered by civilian insurance. Results for doctors’ office waits are similar for all groups, but appointment availability differs.

As shown in Figure 24, MTF users are slightly more likely to experience long waits in a doctor’s office compared to the adjusted benchmark. Fifty-two percent report they usually or always wait less than 15 minutes. By contrast, the proportion that reports consistent timely access to appointments is substantially below the benchmark. Sixty percent report they can usually or always get an appointment when desired compared to a benchmark of 81 percent. The proportion with timely appointments has fallen from 62 percent in 2006.

Figure 24. Patients’ waits at MTFs



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

Figure 25. Patients’ waits at civilian facilities with TRICARE

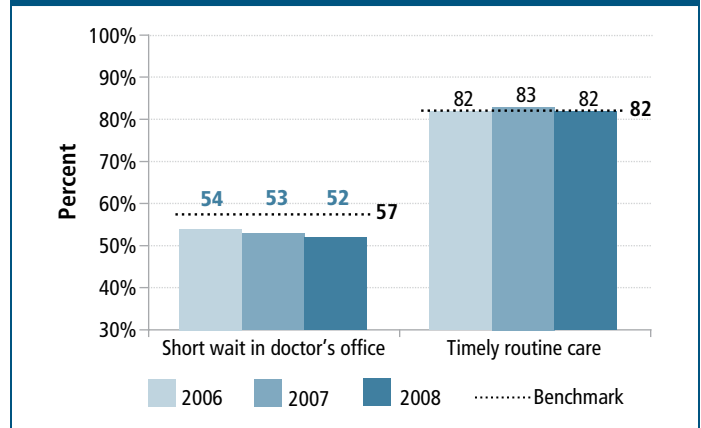
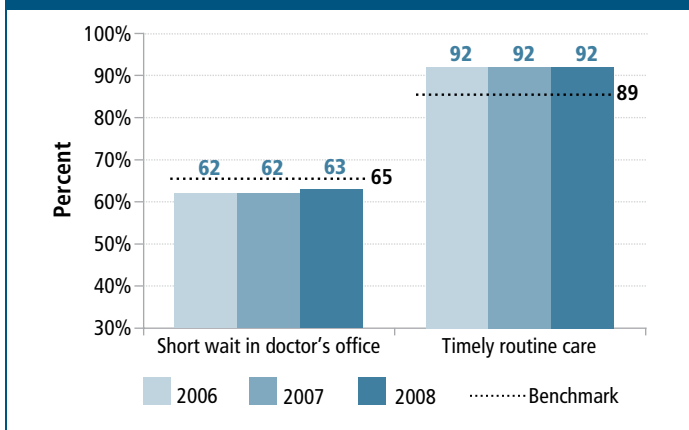


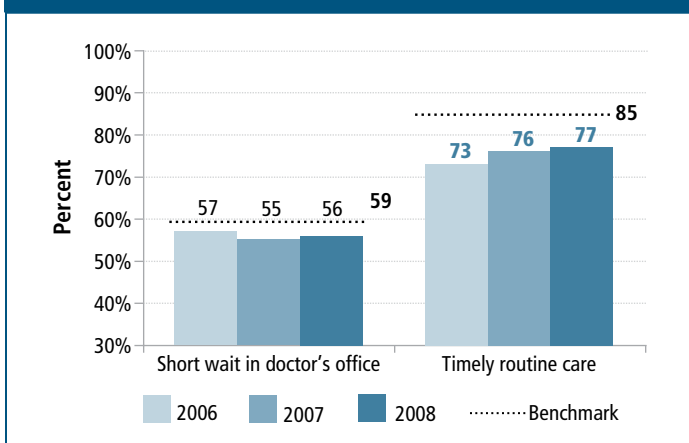
Figure 26 shows that beneficiaries who use civilian providers, when covered by private civilian insurance or Medicare, are, like beneficiaries with TRICARE coverage, able to get timely care in the doctor’s office and timely appointments. Rates for short waits in the office are slightly below and, for timely appointments, slightly above the adjusted benchmark.

Figure 26. Patients' waits at civilian facilities without TRICARE



Users of VA facilities, depicted in Figure 27, like direct care users, experience more difficulty than users of civilian providers getting timely appointments. The proportion that usually or always gets appointments when desired is 77 percent, below the adjusted benchmark of 85 percent.

Figure 27. Patients' waits at VA facilities



Another important aspect of beneficiaries' experiences with their providers is their interaction with both the office staff they encounter in the doctor's office and with doctors themselves. Figure 28 describes beneficiaries' impressions of the helpfulness of direct care office staff and the amount of time that doctors spend with them. At MTFs the proportion reporting helpful staff and the proportion reporting that doctors spend enough time with them are below the benchmark. Eighty-one percent report that staff are usually or always helpful, and 77 percent report that doctors usually or always spend enough time with them. The rates have not changed appreciably between 2006 and 2008.

Figure 28. Patients' experiences at MTFs

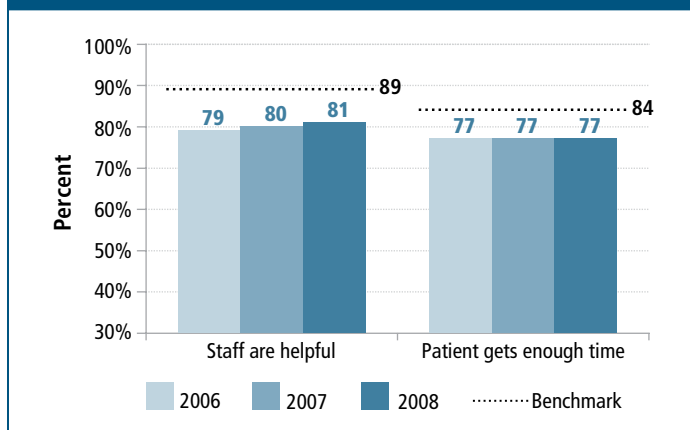
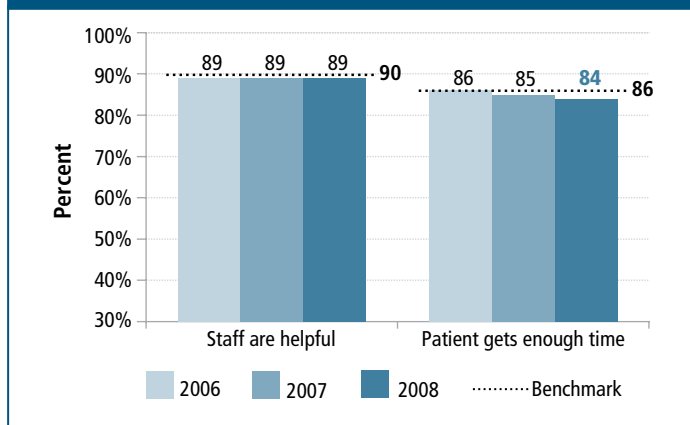


Figure 29 indicates that beneficiaries who use their TRICARE coverage at civilian facilities are more likely to report helpful staff and more likely to report they get enough time with a doctor, compared to MTF users. Eighty-nine percent report that staff are helpful, similar to the adjusted benchmark, and 84 percent, that they are able to spend enough time with their physician, slightly below the benchmark rate. Figure 30 shows that the results are also close to the benchmark when beneficiaries use their civilian health insurance coverage to see civilian providers.

Figure 29. Patients' experiences at civilian facilities with TRICARE



As shown in Figure 31, 91 percent of VA users report that office staff are usually or always helpful and 87 percent report that doctors spend enough time with them. These are similar to adjusted benchmarks and similar to rates in past years.

Figure 30. Patients' experiences at civilian facilities without TRICARE

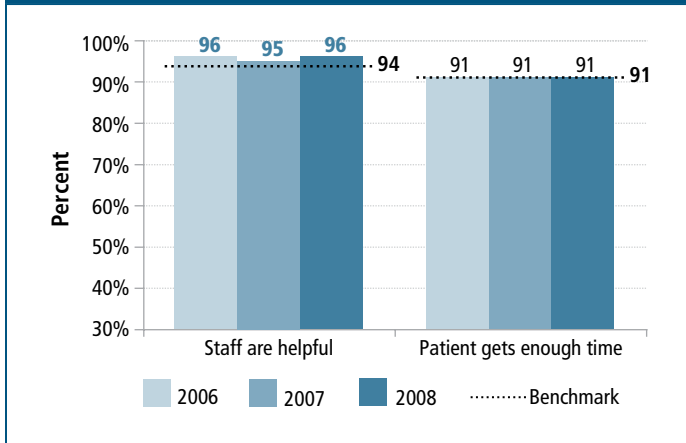
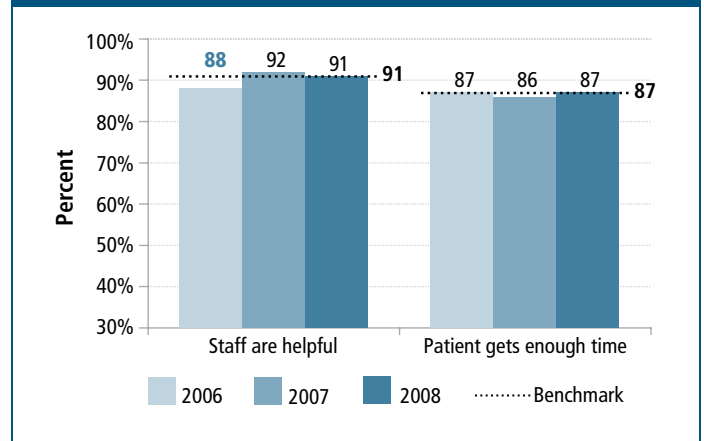


Figure 31. Patients' experiences at VA facilities



Chapter 4: Women's Health Care Experiences

DoD officials report that some AD women have concerns about seeking health care due to perceived attitudes of command personnel.¹ Anecdotally, these officials indicated that some line commanders may not understand the importance of women's health care and that, in some cases, women beneficiaries also lack pertinent knowledge. Specifically, some commanders and beneficiaries lack awareness of health care services available to women through DoD (TRICARE offers the full range of health care services for women, and covered benefits are in line with two of the largest FEHB plans²). Commanders and beneficiaries also may not realize the importance of women's health due to its effect on readiness. DoD officials also indicated that some women beneficiaries were dissatisfied with the care they received due to certain expectations—for example, that their providers would be female and that routine gynecological exams would be performed by a gynecologist rather than a primary care provider.

In the few studies that have been conducted on military women and their health care experiences, researchers have focused on Veterans Health Administration (VHA) services for women veterans. Female and male VHA users generally report similar health care quality, but where differences exist, males report higher satisfaction.³ Problems with ease of use have been shown to affect women's use of VHA care. (However, it is interesting to note that problems accessing women-specific care or problems with skills and sensitivity of medical staff have not been found to influence use.)⁴

In this chapter, we expand upon current knowledge of health care for military women by focusing on the health care experiences of AD and ADFM women in TRICARE. A companion chapter (Chapter 5) focuses on the health care experiences of women reservists.

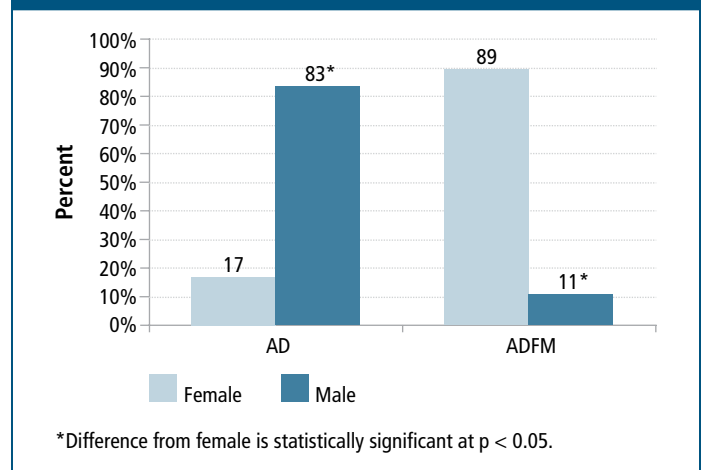
The HCSDB survey includes eight CAHPS survey items that focus on a range of health care experiences. These items include four health care access ratings (overall rating of health care as well as whether the respondent has problems getting care, is able to get appointments quickly, and is able to get urgent care quickly) and four other health care needs and access items (whether the respondent has a personal doctor, whether the respondent uses ER services, and two behavioral health items). We compare responses of AD women on these items with those

of ADFM women and AD men to better understand the health care experiences of women beneficiaries.

Women Beneficiaries vs. Men Beneficiaries

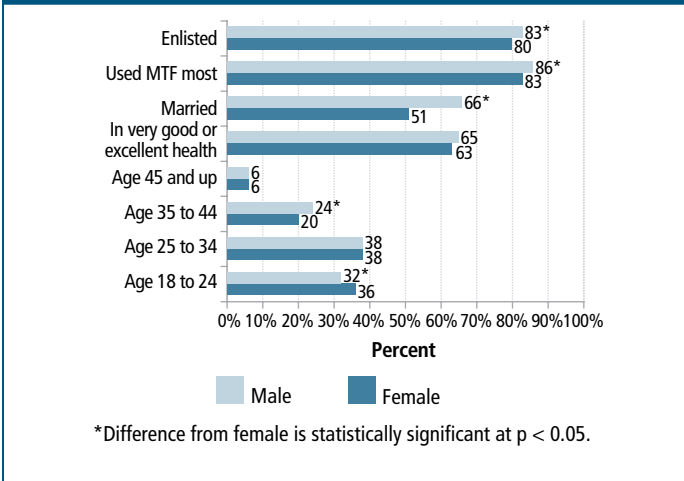
Women and men beneficiaries differ in ways that could affect their health care access ratings. The most significant difference is that most AD beneficiaries are men, while most ADFMs are women (Figure 32). Overall, AD beneficiaries rate their health care experiences lower than do ADFMs (analysis not shown). Women beneficiaries may therefore provide higher ratings simply because they are primarily ADFMs, rather than because of a true gender difference. To ensure that our comparisons are valid, we compared AD women either to AD men (to examine gender differences) or to ADFM women (to examine beneficiary group differences).

Figure 32. Gender differences in beneficiary group



Women and men beneficiaries may also have different characteristics that influence their ratings. Beneficiaries who are older, married, or healthier typically provided higher ratings of their health care experiences, while those who used MTFs most (rather than CTFs) or who were enlisted (rather than officers or warrant officers) provided lower ratings (analysis not shown). When comparing AD women to AD men on these demographic characteristics (Figure 33), we found no gender difference in the percentage who rated their own health as very good or excellent. AD women were younger overall and much less likely to be married (51 per-

Figure 33. AD gender differences



cent vs. 66 percent), characteristics that are associated with *lower* health care experience ratings. On the other hand, AD women were less likely to use MTFs most (83 percent vs. 86 percent) and less likely to be enlisted (80 percent vs. 83 percent), characteristics that are associated with *higher* ratings. Overall, then, any differences in ratings between AD women and AD men are likely not due to systematic differences in these characteristics.

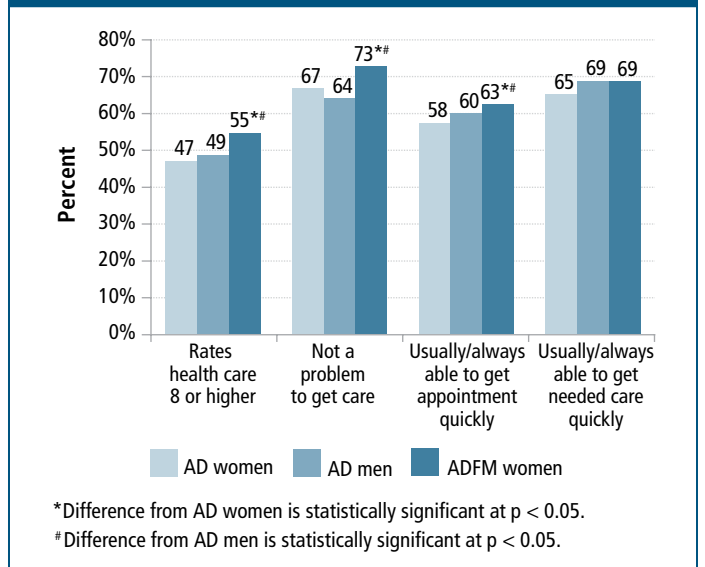
Health Care Access Ratings

To consider beneficiary group differences and gender differences together, we compared AD women, AD men, and ADFM women on health care access ratings (Figure 34). National benchmarks were obtained from the NCBDB. The benchmarks, shown in Table 1, were adjusted for age and health status to be comparable to AD and ADFM adults. Survey responses were also adjusted for age and health status.

Table 1. Benchmarks for health care rating and access

Item	Women	Men
Rates health care 8 or higher (on a scale of 0 to 10)	70	70
Not a problem to get care (vs. a small/big problem)	81	81
Usually/always able to get appointment quickly (vs. never/sometimes)	78	80
Usually/always able to get urgent care quickly (vs. never/sometimes)	86	85

Figure 34. Gender differences in health care access



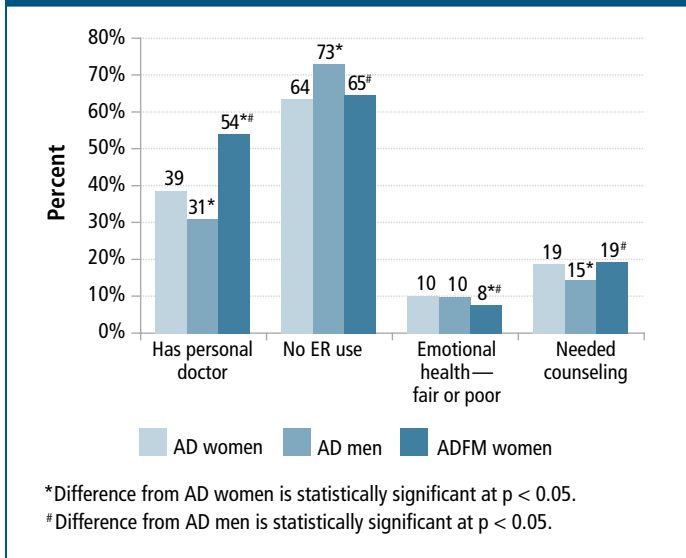
Overall, ADFMs provided higher ratings and reported better access than did AD beneficiaries, and there were no AD gender differences. Figure 34 shows that ADFM women (55 percent) were more likely to provide high ratings of their health care compared to AD women (47 percent) and AD men (49 percent). Similarly, ADFM women (73 percent) were more likely to report having no problems getting care compared to AD women (67 percent) and AD men (64 percent). ADFM women (63 percent) were also more likely to report usually or always being able to get a needed appointment quickly compared to AD women (58 percent) and AD men (60 percent). The three groups did not differ with regard to usually or always being able to get urgent care quickly. The ratings provided by all three groups were substantively lower than the benchmarks.

Other Health Care Needs and Access Items

As in Figure 34, to consider beneficiary group differences and gender differences together, we compared AD women, AD men, and ADFM women on four health care needs and access items (Figure 35).

We obtained national benchmarks for two of the items from the NCBDB. The benchmarks were adjusted for age and health status to be comparable to AD and ADFM adults, and survey responses were also adjusted for age and health status.

Figure 35. Gender differences in health care needs



AD women (39 percent) were more likely than AD men (31 percent) to have a personal doctor. However, AD women were less likely to have a personal doctor compared to ADFM women (54 percent). This gender difference parallels that in the benchmarks, shown in Table 2. The ratings provided by all three groups were far lower than the benchmarks.

Table 2. Benchmarks for personal doctor and ER use

Item	Women	Men
Has a personal doctor	84	77
No ER use	78	77

AD men (73 percent) were more likely to have no ER visits compared to AD women (64 percent) and ADFM women (65 percent)—that is, women were more likely than men to visit the ER. This gender difference does not appear in the benchmarks. Access, as measured by avoidance of ER care appears to be substantively lower than the benchmarks for all three groups.

Benchmarks are not available for the two CAHPS behavioral health items because they are not part of the reporting set (the items health plans are required to report) and thus are not in the NCBID. These items are (1) self-rated mental or emotional health status of fair/poor (vs. good/very good/excellent) and (2) needed treatment or counseling for personal or family problems (yes vs. no).

AD women (10 percent) and AD men (10 percent) were more likely than ADFM women (8 percent) to rate their own mental health as fair or poor—that is, being an AD beneficiary is

associated with poorer self-rated mental health. However, AD women (19 percent) and ADFM women (19 percent) were more likely than AD men (15 percent) to report needing treatment or counseling for a personal or family problem—that is, women were more likely than men to report needing counseling.

Conclusions

Following is a summary of key findings:

- For the six items for which there were national benchmarks, survey responses were substantively lower than the benchmarks. With regard to having a personal doctor, the survey responses were much lower than the benchmarks.
- There were no differences between AD women and AD men with regard to rating their health care experiences. However, ADFM women provided higher health care access ratings than did AD women, in line with the overall AD-ADFM differences seen in ratings.
- For women, being AD decreased the likelihood of having a personal doctor, but AD women were more likely than AD men to have a personal doctor. This gender difference parallels that in the benchmarks—that is, women generally report greater access to a personal doctor than do men.
- Both AD women and ADFM women were more likely than AD men to have an ER visit. This gender difference is not reflected in the benchmarks, suggesting the need to further examine the reasons for greater ER use among women beneficiaries.
- Being AD is associated with poorer self-rated mental health (no gender difference), and being a woman is associated with a greater likelihood of having a perceived need for counseling (no AD-ADFM difference).

Overall, there were no differences between AD women and AD men with regard to rating their health care experiences. Compared to AD men, AD women were more likely to have a personal doctor, more likely to have an ER visit, and more likely to report a perceived need for counseling. Survey responses were substantively lower than national benchmarks, especially with regard to having a personal doctor.

Chapter 5: Health Care Experiences of Women Reservists

In this chapter, we describe the health care experiences of activated reservist women who have transitioned into the MHS.

In focus groups,⁵ deployed women report that they are generally satisfied with health care received during deployment in Iraq and Afghanistan, whether they are AD or reservist. However, women often report feeling vulnerable about potentially serious health issues both before deployment (because other preparations for rapid deployment may take precedence over health issues) and after deployment (because of deployment-related health issues). In addition, male and female reservists reported access problems before, during, and after deployment due to lack of information and documentation.

This chapter builds upon these observations through a more systematic examination of the health care experiences of women reservists. We compare different groups of women using CAHPS measures of health care access and experience, three types of preventive care used by women (Pap smears, mammography, and prenatal care), and two indicators of healthy behavior—obesity and smoking status—that can vary based on access to health care. In a companion chapter (Chapter 4), we conduct a broader examination of the health care experiences of women in TRICARE.

We compare responses of activated women reservists to those in several other groups (such as regular AD women, ADFM women, and men reservists) to examine the effects of reserve status and how it might vary by member status (AD vs. ADFM) and by gender. Due to the small number of deployed women in the sample, we were unable separately to compare deployed and non-deployed reservist women to their AD counterparts.

Characteristics of Reservist Women

In Table 3, we compare activated women reservists to regular AD women by age, officer status, health status, marital status, and usual source of care. In general, we found few differences between the two groups. There were no differences with regard to the percentage who rated their own health as very good or excellent or the percentage who were married. Reservists were somewhat more likely to be enlisted (84 percent vs. 80 percent), a characteristic associated with *lower* health care experience ratings, but they were also older, a characteristic associated

Table 3. Characteristics of reservist women

Characteristic	Activated Reservists	Regular AD
Age 18 to 24	22%	39%*
Age 25 to 34	32%	40%*
Age 35 to 44	30%	18%*
Age 45+	16%	4%*
Very good or excellent self-rated health	65%	63%
Married	46%	52%
Used MTF most	57%	88%*
Enlisted	84%	80%*

*Difference from activated reservists is statistically significant at $p < .05$.

with *higher* ratings. The greatest difference is the proportion receiving most of their care over the previous 12 months from MTFs (versus care from civilian providers). Only 57 percent of reservist women, compared to 88 percent of regular AD women, reported relying on MTFs for most of their care, a difference that may reflect reservists' civilian coverage before activation or their greater use of civilian care following activation. Compared to regular AD women, reservists' low MTF use means that their health care is more likely to come from the civilian health care system and to involve transitions in and out of civilian care.

Experiences of Reservist Women and Women Reservist Family Members

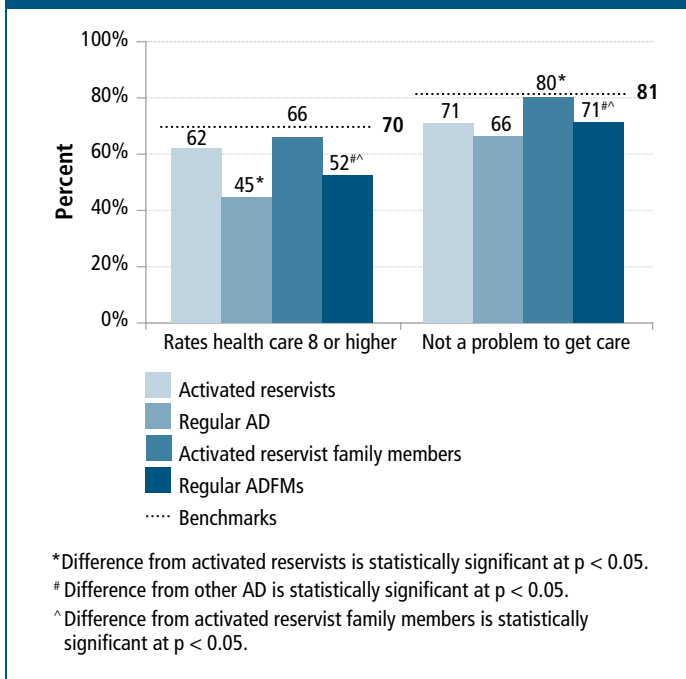
In Figures 36 through 41, we compare women reservists, regular AD women, women who were reservist family members, and regular ADFM women. Additional analyses (not shown) were conducted to examine the nature of the separate and combined effects of reserve status and beneficiary group.

For purposes of comparison, we use horizontal lines in the figures to indicate national benchmarks for women. Benchmarks for the CAHPS items were obtained from the NCBDB and were adjusted for age and health status to be comparable to AD and ADFM adults. No benchmark is available for needed counseling because it is not part of the reporting set (the items health plans are required to report) and thus does not appear in the NCBDB. Benchmarks for the preventive care and healthy behavior items

were obtained from the National Center for Health Statistics, adjusted for age to be nationally representative.

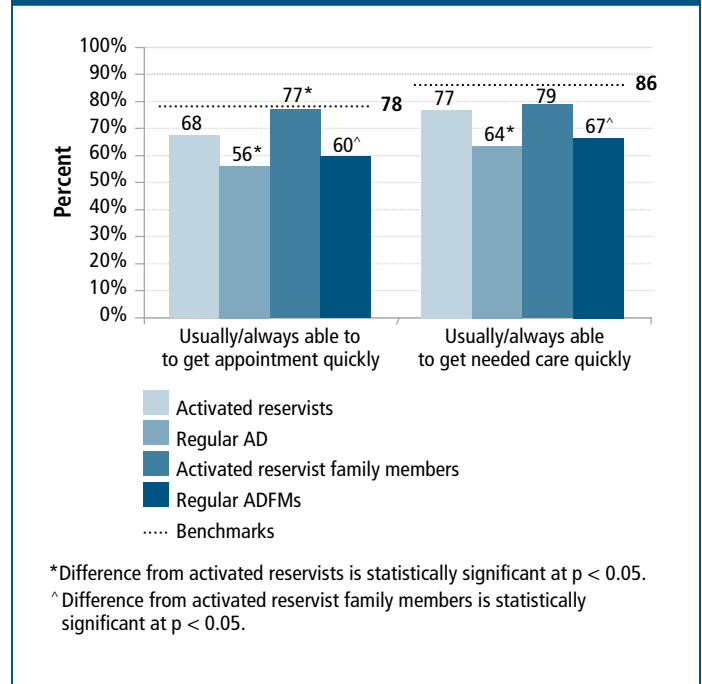
In Figure 36, we compare the four groups of women on how they rated their health care and whether they reported problems getting care. Reservists and reservist family members rated their health care higher and reported less difficulty getting care than did regular AD women and regular ADFMs; the higher scores of reservists on these two items may reflect their older age and their reduced likelihood of using MTFs, although further investigation is warranted (see Table 3). Reservist and regular AD women also had lower scores than did female reservist family members and ADFM women. In addition, for health care ratings, the difference between reservist family members (66 percent) and ADFMs (52 percent) was less than that between reservists (62 percent) and regular AD women (45 percent) due to the especially low ratings by regular AD women. On the other hand, reservist family members (80 percent) were more likely than ADFMs (71 percent) to report not having a problem getting care, whereas the difference between reservists and regular AD women was not significant.

Figure 36. Women's health care ratings



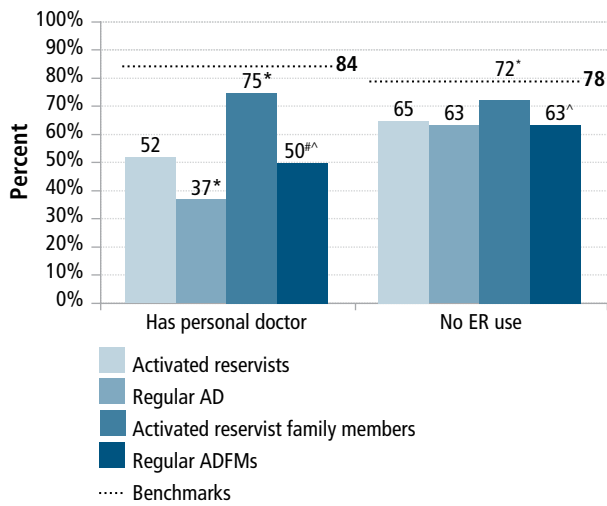
In Figure 37, we compare the four groups on their ability to get appointments and urgent care quickly. Again, reservists and reservist family members had higher scores than did regular AD women and regular ADFMs. For the ability to get an appointment quickly, the difference between reservist family members (77 percent) and ADFMs (60 percent) was greater than that between reservists (68 percent) and regular AD women (56 percent).

Figure 37. Women's health care access



In Figure 38, we compare the four groups on **ER nonuse and whether they have a personal doctor**. Reservists and their family members were more likely than their non-reservist counterparts to report no ER use. Reservist family members (72 percent) were more likely than ADFMs (63 percent) to report no ER use, whereas the difference between reservists and regular AD women was not significant. **Reservists and** their family members were also more likely than their non-reservist counterparts to report having a personal doctor. The difference between reservist family members (75 percent) and ADFMs (50 percent) was also greater than that between reservists (52 percent) and regular AD women (37 percent).

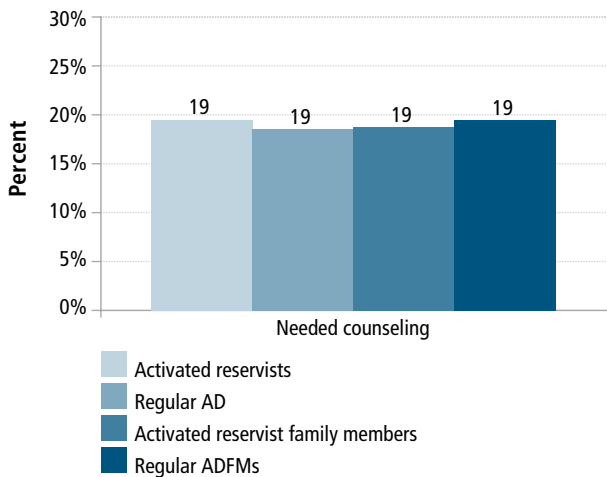
Figure 38. Women’s providers



*Difference from activated reservists is statistically significant at $p < 0.05$.
 # Difference from other AD is statistically significant at $p < 0.05$.
 ^ Difference from activated reservist family members is statistically significant at $p < 0.05$.

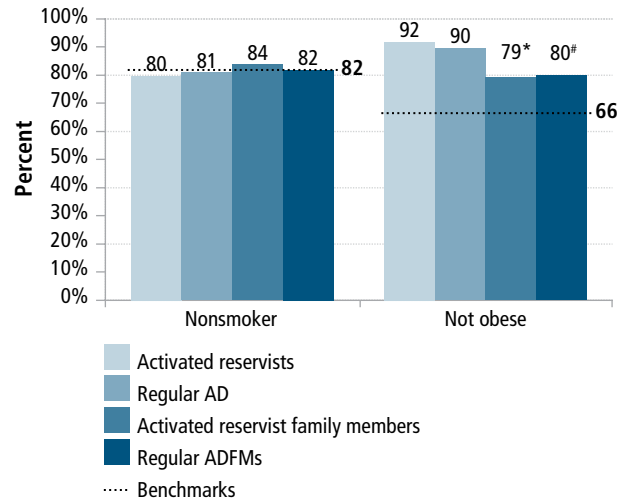
Figure 39 shows that there were no differences among the four groups with regard to perceived need for counseling.

Figure 39. Women’s counseling needs



In Figure 40, we compare the four groups on two prevention items—nonsmoking status and non-obese status. There were no differences among the four groups with regard to percentage of nonsmokers. Reservist and regular AD women were less likely to be obese than were family members.

Figure 40. Women’s healthy behaviors



*Difference from activated reservists is statistically significant at $p < 0.05$.
 # Difference from other AD is statistically significant at $p < 0.05$.

In Figure 41, we compare the groups on three women’s health items—recent Pap smear, recent mammogram, and appropriate prenatal care. There were no differences between the groups with regard to the percentage who received appropriate prenatal care. With regard to percentages who had a recent Pap smear or a recent mammogram, there were no broader differences either (1) between members (reservist or regular AD) and family (reservist or regular AD) or (2) between reservists and reservist family members compared to regular AD and ADFMs.

The only group differences were that reservist family members were less likely than ADFMs to have had a recent Pap smear (90 percent vs. 94 percent), and AD women were more likely than ADFMs to have had a recent mammogram (87 percent vs. 80 percent).

Figure 41. Women’s preventive care

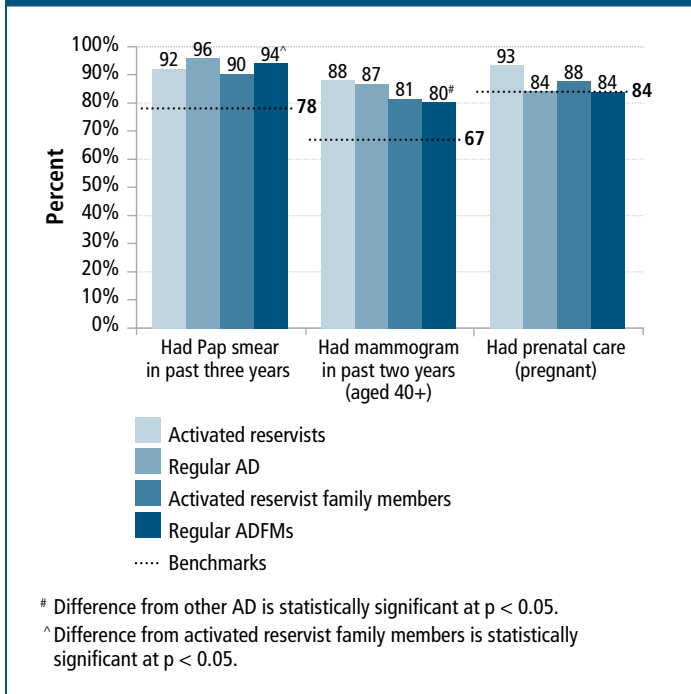
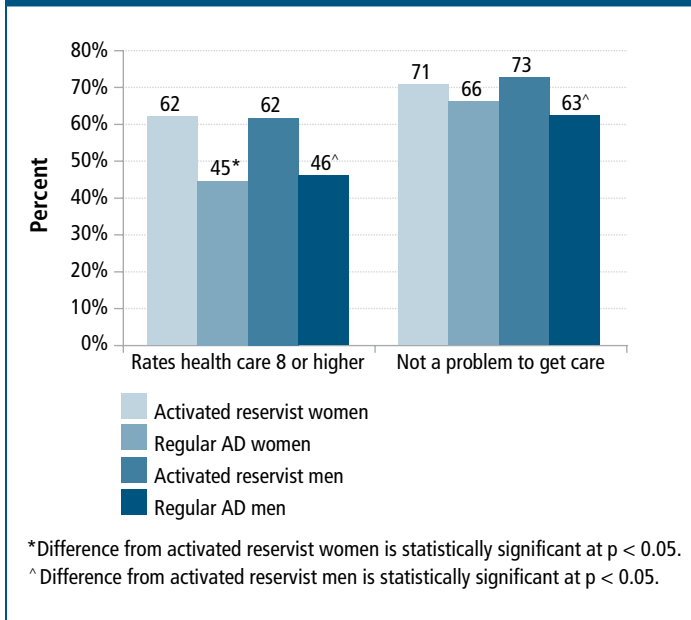


Figure 42. Gender differences in health care ratings



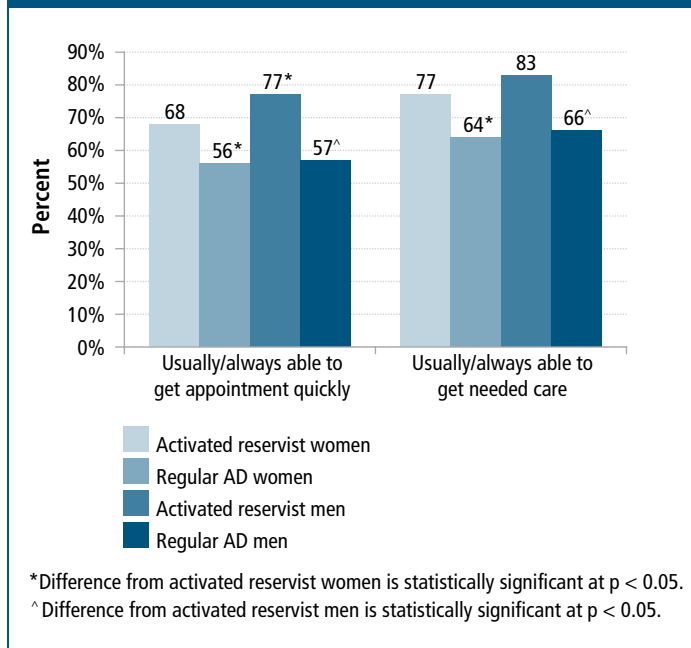
Experiences of Reservist Women and Reservist Men

In Figures 42 through 45, we compare women reservists, regular AD women, men reservists, and regular AD men. Additional analyses (not shown) were conducted to examine the nature of the separate and combined effects of reserve status and gender.

Figure 42 shows how the four groups rated their health care and whether they reported problems getting care. Reservists rated their health care higher and reported less difficulty getting care than did regular AD beneficiaries.

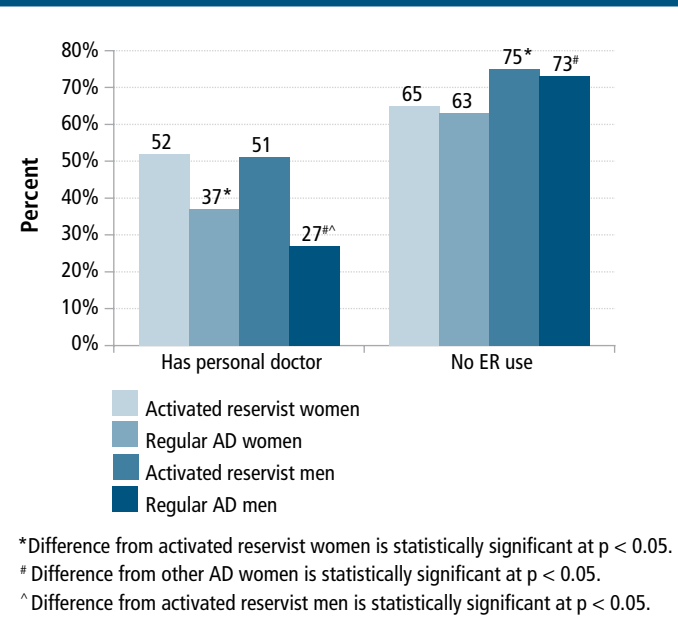
In Figure 43, we compare the four groups on their ability to get appointments and urgent care quickly. Again, reservists had higher scores than did regular AD beneficiaries for both items. More men reported being able to get an appointment quickly than did women. In addition, the difference between women reservists (68 percent) and regular AD women (56 percent) was less than the difference between men reservists (77 percent) and regular AD men (57 percent) due to the especially high scores of the reservist men.

Figure 43. Gender differences in health care access



In Figure 44, we compare the four groups on ER nonuse and having a personal doctor. Women reported greater ER use than did men. Reservists were also more likely than regular AD ben-

Figure 44. Gender differences in provider use



efficiaries—and women were more likely than men—to report having a personal doctor. In addition, the difference between women reservists (52 percent) and regular AD women (37 percent) was less than the difference between men reservists (51 percent) and regular AD men (27 percent), due to the especially low scores of the AD men.

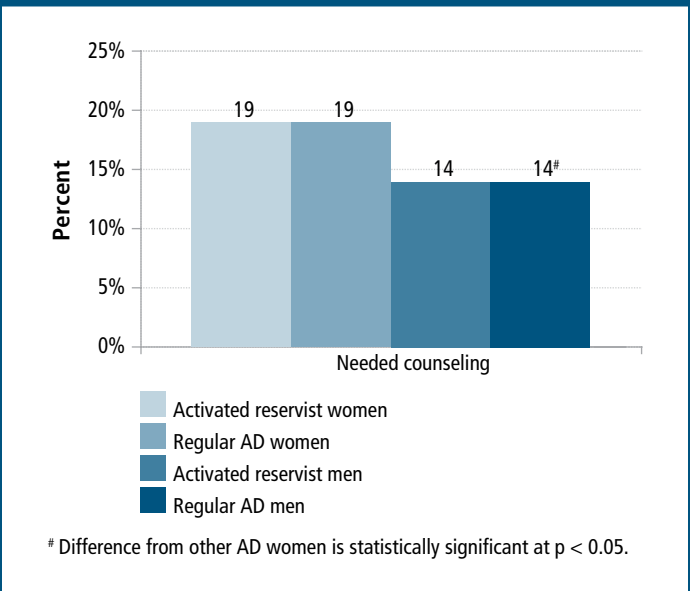
Figure 45 shows that, for needed counseling, there were no broader differences either between reservists and regular AD beneficiaries or between women and men. The only group difference was that AD women (19 percent) reported a greater need for counseling than did AD men (14 percent).

Conclusions

Following is a summary of key findings:

- Compared to other (non-reservist) AD women, reservists were older overall and much more likely to use MTFs most.
- In general, women reservists and reservist family members reported higher health care ratings and greater health care access (that is, they had fewer problems getting care, could get appointments and urgent care quickly, and had a personal doctor) than did regular AD women and regular ADFMs.

Figure 45. Gender differences in counseling needs



- AD women had lower health care ratings and reported greater difficulty getting care than did female family members, but AD women were less likely to be obese.
- Compared to their male counterparts, women reservists and regular AD women reported greater difficulty getting an appointment quickly but were more likely to report having a personal doctor and using ER services.
- National benchmarks for women were indicated in Figures 36, 37, 38, 40, and 41. CAHPS scores provided by women survey respondents were consistently lower than the benchmarks. Smoking prevalence for survey respondents was similar to the national benchmarks. However, survey respondents were much less likely to be obese and much more likely to have had a recent Pap smear, mammogram, or appropriate prenatal care, relative to the benchmarks.

Overall, women reservists reported more positive health care experiences than did regular AD women and somewhat more negative experiences than did women reservist family members. However, women reservists did not consistently report either more positive or more negative experiences than did men reservists.

Chapter 6: Effect of the 2005 BRAC on Satisfaction with Health Care Services Among Retirees

The 2005 BRAC represented the fourth and largest round of closures and realignments, with more than 812 recommended actions that included closure of 22 military installations and major realignment of 29 military installations. Besides reducing excess capacity, the 2005 BRAC was intended to transform the military and increase joint operations. The BRAC Commission's recommendations had a direct impact on 26 MTFs, including the closure of 6 military installations and major realignment of 5 military installations.^A

In making decisions to close and realign numerous MTFs, the BRAC Commission sought to ensure continued access to high-quality care. The Commission also aimed to avoid the problems associated with the 1995 BRAC, which TRICARE Management Activity noted had resulted in anger and frustration among retirees and their family members, in part because they were geographically tied to the affected locations. Retirees under age 65 were particularly affected because these beneficiaries relied on direct care at the MTFs. In contrast, retirees age 65 and over were affected less because MTFs were no longer accepting Medicare-eligible retirees. The closure of MTFs following the 1995 BRAC caused many retirees to lose access to direct care at MTFs, and network inadequacies made it difficult to find civilian providers who would accept TRICARE, particularly in medically underserved areas.

A primary goal of the BRAC recommendations was to “[maintain or improve] access to care for all beneficiaries, including retirees, using combinations of the Direct Care and TRICARE systems”. As a result, many of the 2005 BRAC recommenda-

tions involved eliminating duplicate services and consolidating direct care at MTFs in multiple service market areas, with the goal of preserving options for direct care. In addition, in recent years TRICARE has added options to help reduce problems with access to care. For example, TRICARE has been increasing its network of civilian providers, offering more provider options for retirees under age 65 and for ADFMs. Initiated in 2001, TRICARE for Life also provided supplemental insurance for retirees age 65 and over with Medicare. This program further enhances access to prescription drugs through a network of retail pharmacies.

In 2008, TMA funded the BRAC Collateral Survey as a preliminary assessment of the impact of the 2005 BRAC on beneficiary satisfaction and access to health care services. This survey contained questions directly related to BRAC as well as questions on perceptions of care from the HCSDB. These latter questions allow comparisons of perceptions of care between beneficiaries in BRAC sites and beneficiaries in unaffected sites who responded to the HCSDB during quarters 1 and 2 of FY 2008; the responses can also be compared to HCSDB survey responses in FY 2005. The target population for this study was adult MHS beneficiaries most likely to be affected by BRAC. This group was likely to include beneficiaries who were relying on a BRAC-affected MTF to provide medical services during retirement—particularly AD beneficiaries close to retirement—as well as their family members and retired beneficiaries enrolled in TRICARE Prime.

This chapter describes how perceptions of health care access and quality among beneficiaries in sites affected by BRAC (BRAC sites) compare to beneficiaries in areas not affected by BRAC (non-BRAC sites). Additional comparisons examine whether BRAC beneficiaries' perceptions have changed since the announcement of the 2005 BRAC recommendations. This chapter focuses on the following beneficiary groups: (1) retirees and family members under age 65 who are enrolled in Prime with either civilian or military providers; (2) retirees and family members under age 65 who are not enrolled in Prime (that is, they either rely on Standard/Extra, civilian insurance, or other options); and (3) retirees and family members age 65 and over, who are enrolled in Medicare and are not eligible to receive care at an MTF. All perceptions of health care access and quality are

^AThe BRAC medical sites were AHC Ft. McPherson, GA; Air Force Academy, Colorado Springs, CO; Andrews AFB, MD; Bethesda Naval National Medical Center, MD; BMC, Athens, GA; BMC, Barstow, CA; BMC, Ingleside, TX; BMC NAS Brunswick, ME; BMC NSA New Orleans, LA; BMC Willow Grove, Hatboro, PA; Brooke Army Medical Center, Fort Sam Houston, TX; Brooks City Base, San Antonio, TX; Cherry Point, NC; DeWitt Army Hospital, NCA; Fort Eustis, VA; Great Lakes, IL; Keesler Medical Center, Biloxi, MS; MacDill, FL; Marietta, GA; Monroe AHC, Ft. Monroe, VA; NBHC, Pascagoula, MS; Patterson AHC, Ft. Monmouth, NJ; Scott AFB, IL; Selfridge AHC, MI; Walter Reed Medical Center, Washington, DC; and Wilford Hall Medical Center, TX.

adjusted for age, sex, health status, and education. Only results that are significant at $p < 0.05$ are reported in the text.

Perceptions of Care Among Beneficiaries in BRAC and Non-BRAC Sites

In 2008, beneficiaries in BRAC-affected areas had mostly positive perceptions of health care access and quality. Perceptions of care were generally most positive among retirees and family members over age 65 and least positive among retirees and family members under age 65 who were enrolled in Prime, although perceptions in this latter group still tended to be more positive than those of AD personnel and their family members (data not shown).

Nearly all measures of access to and satisfaction with care were statistically similar in BRAC and non-BRAC sites across retiree groups in 2008.

The only statistical difference occurred in the proportion of Prime retirees and family members under age 65 who reported that doctors communicate well: 90 percent in BRAC sites versus 88 percent in non-BRAC sites (Figure 46). Otherwise, a similar proportion of beneficiaries in BRAC and non-BRAC sites reported always getting needed care (Figure 47), getting care quickly (Figure 48), and office staff always being courteous and helpful (Figure 49). In addition, approximately the same proportion of retirees in BRAC and non-BRAC sites assigned a rating of 8 or higher (on a scale of 0 to 10) to their overall health care (Figure 50), to their personal doctors and specialists (Figures 51 and 52), and to their health plan (Figure 53).

Figure 46. Doctors communicate well as reported by retirees, by BRAC and non-BRAC sites

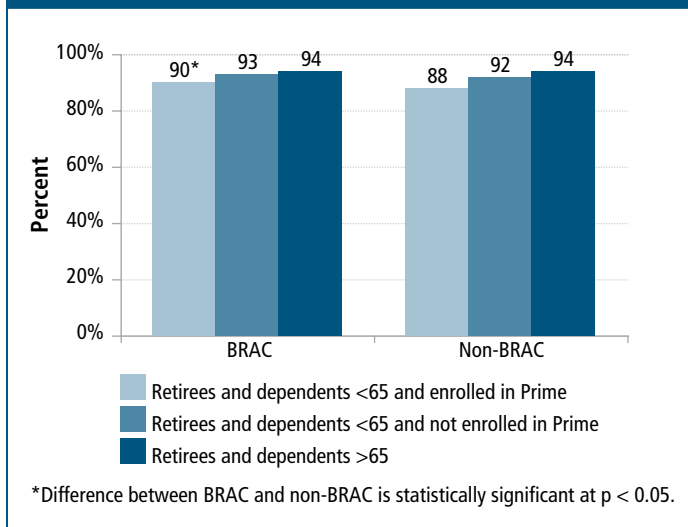


Figure 47. Getting needed care among retirees, by BRAC and non-BRAC sites

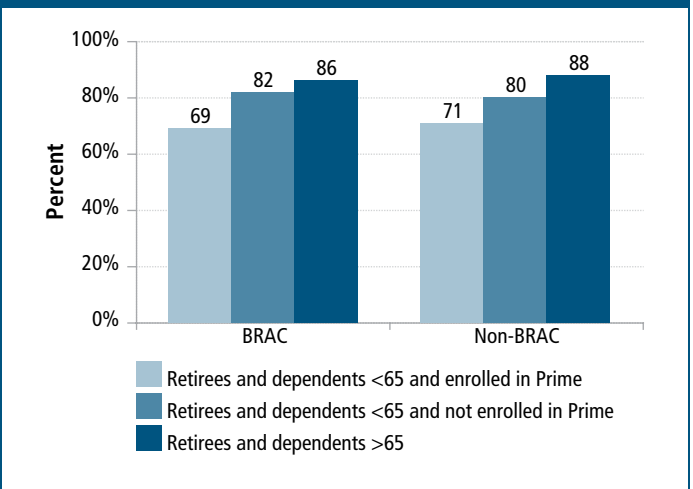
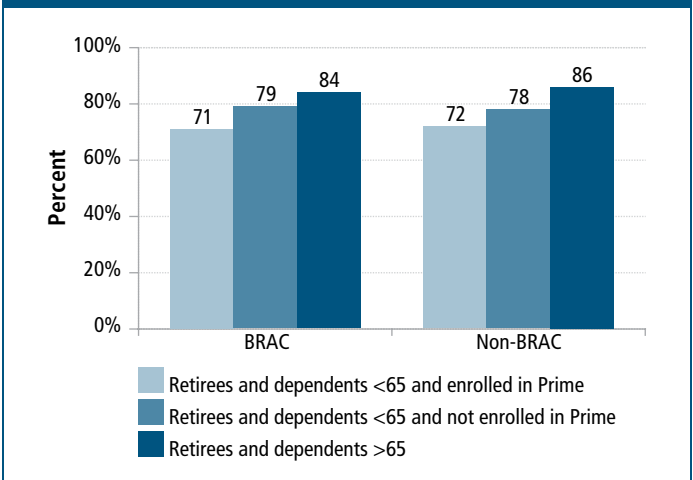


Figure 48. Getting care quickly among retirees, by BRAC and non-BRAC sites



Changes in Perceptions of Care Among Beneficiaries in BRAC Sites From 2005 to 2008

Comparing the results of the 2008 BRAC Collateral Survey to data collected in 2005 reveals that, so far, the 2005 BRAC does not appear to be associated with changes in retirees' satisfaction with and access to health care services. Reported satisfaction was generally stable between 2005 and 2008 among retirees in BRAC sites; the most notable change was increased satisfaction with health plans (Figure 54). Specifically, 63 percent of Prime retirees and family members under age 65 assigned a rating of 8 or higher to their health plan in 2005, compared to 69 percent in 2008. Similarly, 62 percent of retirees and family

Figure 49. Courteous and helpful office staff as reported by retirees, by BRAC and non-BRAC sites

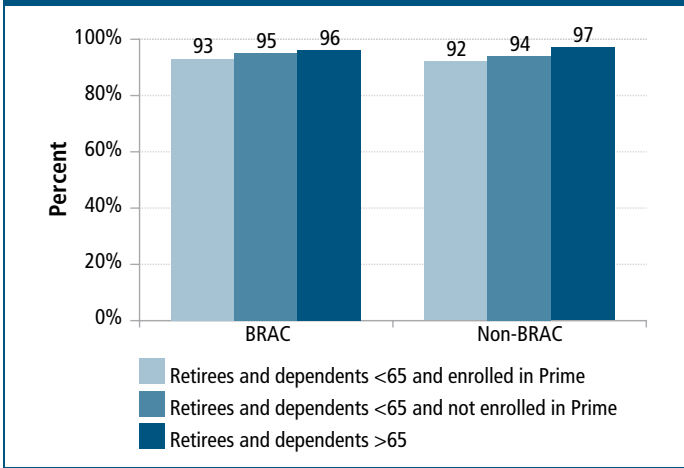


Figure 52. Rating of 8+ for specialists among retirees, by BRAC and non-BRAC sites

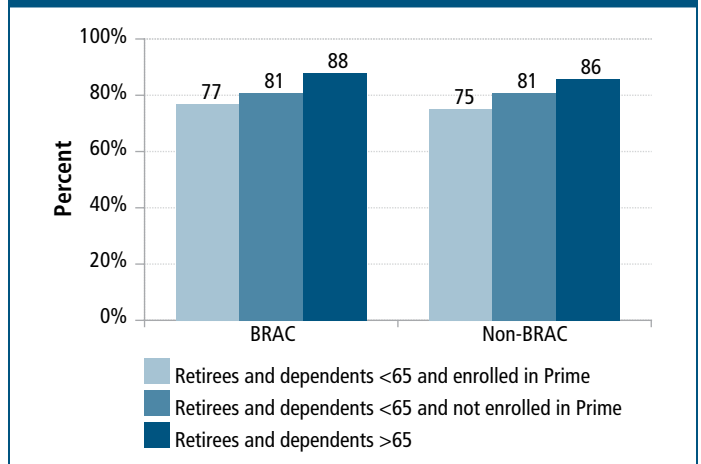


Figure 50. Rating of 8+ for overall health care among retirees, by BRAC and non-BRAC sites

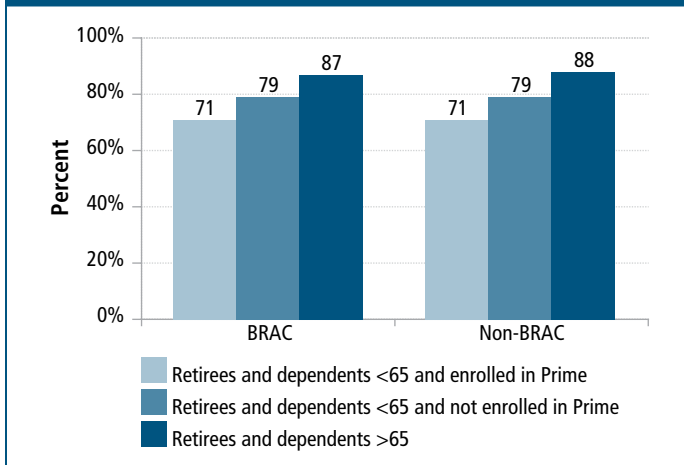


Figure 53. Rating of 8+ for health plans among retirees, by BRAC and non-BRAC sites

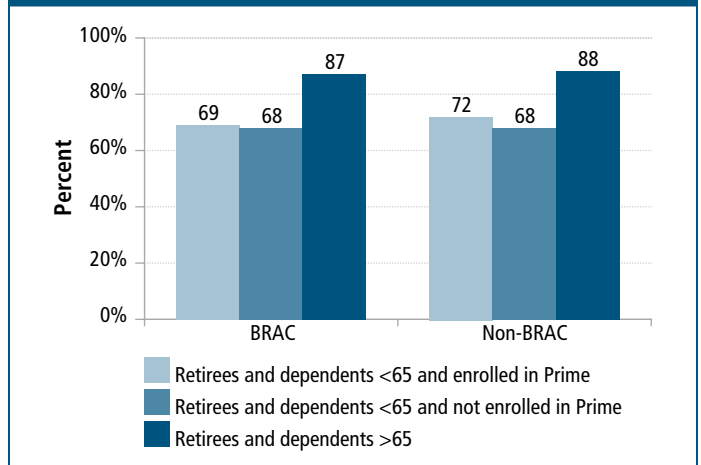
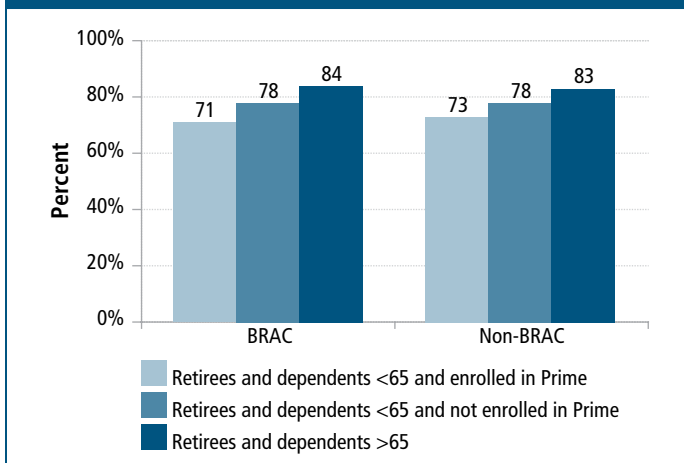


Figure 51. Rating of 8+ for personal doctor among retirees, by BRAC and non-BRAC sites

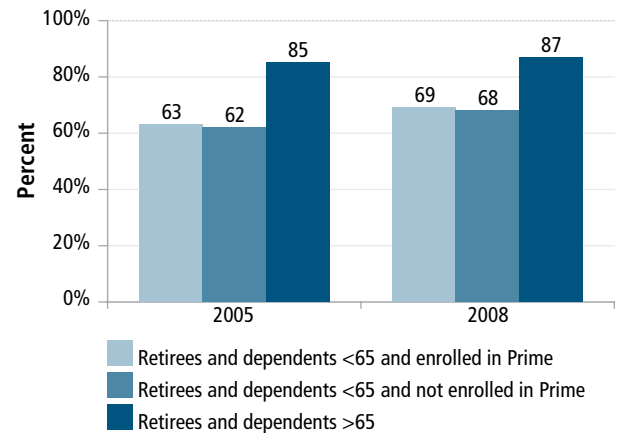


members under age 65 who were not enrolled in Prime assigned a rating of 8 or higher to their health plan in 2005, compared to 68 percent in 2008. For all other measures of health care, the ratings were statistically similar between 2005 and 2008 across beneficiary groups.

Conclusion

Currently, there is little evidence that retirees in BRAC sites are becoming less satisfied with their access to or quality of care. Indeed, these findings suggest that satisfaction is at least as high in BRAC sites as in non-BRAC sites. There have also been no changes in the level of satisfaction among retirees in BRAC sites from 2005 to 2008, apart from increased satisfaction with health plans. However, given that not all BRAC recommendations have been implemented yet, these findings should be considered a preliminary assessment and used as a baseline in future analyses.

Figure 54. Rating of 8+ for health plan among retirees in BRAC sites, 2005 and 2008



Chapter 7: Satisfaction with Health Care Services Among TRS Enrollees

TRS Enrollees Versus Other TRICARE Beneficiaries

TRS is a premium-based health plan for qualified members of the Selected Reserve, including the National Guard, the Reserves, and their families. The benefits design of TRS is similar to two existing TRICARE options, Standard and Extra, which both resemble a preferred provider organization (PPO) benefit in the civilian insurance market. Eligibility for TRS has expanded since its creation in 2004 so that virtually all reservists and their family members now qualify for the program. Previous complicated requirements for eligibility and cost-sharing were dropped, effective October 1, 2007, making all members of the Selected Reserve and their family members eligible for TRS except those who are already eligible for the FEHB Program. One year after these changes were implemented, TRS enrollment more than doubled, although less than 10 percent of the Selected Reserve had purchased TRS coverage. This chapter includes an overview of TRS; a summary of enrollment trends since the October 2007 changes; and health care ratings of TRS enrollees compared to ADFMs, whose benefits resemble those of TRS enrollees.

Background

Reservists and their family members may obtain medical and dental benefits through TRICARE by being activated for a contingency operation or by enrolling in TRS. Reservists who are activated for a contingency operation—including those with delayed effective date orders—and their families are eligible to receive the same medical and dental benefits as nonenrolled AD personnel, with no premium required. Eligibility for this coverage continues for 180 days past the deactivation date. At that point, purchasing TRS coverage has been an option since 2005 for reservists who had served in a post-9/11 contingency operation for more than 30 days and their families if the reservists agreed to serve in the Selected Reserves for one year or longer.

In 2006, TRS eligibility was expanded to include reservists who had not served in such an operation and their family members. Eligibility was tiered: reservists who had served in a post-9/11 contingency operation were in tier 1 and paid only 28 percent of total premium costs. In fiscal year 2006, this translated into

\$81 per month for member-only coverage and \$253 per month for member plus family coverage. Tier 2 reservists – those who had no civilian options for health insurance – paid 50 percent of premiums, or \$145 a month for member-only coverage and \$451 for member plus family coverage. Those in tier 3 – who typically had civilian insurance options – paid 85 percent of premiums, or \$247 a month for member-only coverage and \$767 for member plus family coverage. Upon meeting the annual deductible for outpatient services, TRS members paid 15 percent for TRICARE network provider care or 20 percent for non-network care.

Enrollment Patterns and Experiences with TRS Prior to Expanded Eligibility

The 2006 HCSDB annual report includes findings related to reservists' experiences with TRS before eligibility was expanded in 2007.¹⁰ These findings showed that (1) most reservists are happy with their civilian coverage and revert to it when they are able and (2) government and private employers make it easier for activated reservists to continue their civilian coverage by waiving their premium contributions for civilian insurance. The findings further revealed that many reservists and their families retain their civilian plan even when covered by TRICARE. It was also noted that TRICARE coverage fills a gap for the minority who do not have coverage through their civilian job and for those who must pay all of their civilian premiums—a possible incentive to remain in the Reserves.

But despite the benefits of TRS, enrollment has been low. As of May 2007, only 4 percent of the Selected Reserves had enrolled in TRS, raising questions about whether DoD was meeting its goals for the program.¹¹ A 2007 RTI International study conducted on behalf of DoD indicated that tier 1 enrollment, which accounted for 93 percent of all TRS enrollment in 2007, peaked in October 2006 at 32,806 covered lives. Tier 1 enrollment declined slowly but steadily after October, dropping to 29,846 covered lives in May 2007.¹² New enrollees continued to join the program during this period, but this was outweighed by enrollees who dropped coverage. According to the RTI study, over half of the reservists who dropped TRS coverage did so because

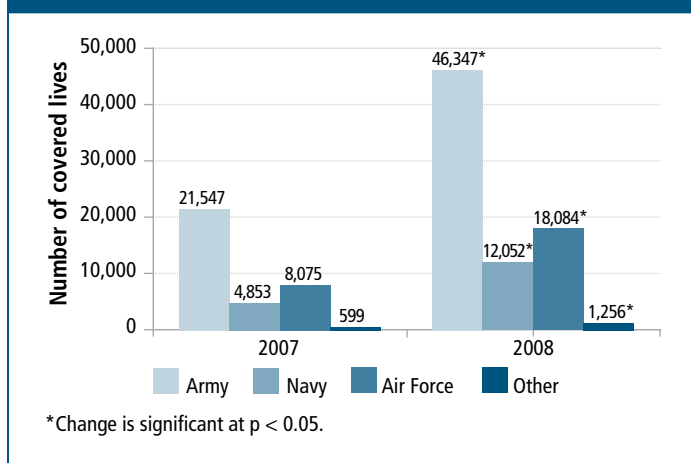
they were called to AD. Several factors are thought to have contributed to low enrollment, including the eligibility structure, high premiums, and service agreements.

Beginning October 1, 2007, the TRS program discontinued its tiered premiums and dropped the eligibility requirements related to service agreements and post-9/11 contingency operations. Now, all reservists and family members are eligible for TRS except those eligible for insurance through the FEHB Program. All TRS reservists pay 28 percent of premiums.

Enrollment in TRS Since the October 1, 2007 Changes

In spring 2008, a survey was sent to a sample of reservists to assess their awareness of TRS and their reasons for deciding whether to purchase TRS coverage. The survey results, along with administrative data and TRS enrollment reports, indicate that since these changes went into effect, enrollment in TRS has increased from 35,074 covered lives in October 2007 to 77,739 covered lives in September 2008. The number of enrolled reservists and family members ages 18 to 34 more than doubled during this period, although this group still represents a small proportion of total TRS enrollment. In addition, TRS enrollment reports indicate that enrollment more than doubled across all branches between October 2007 and September 2008, with increases of 148 percent for the Navy, 124 percent for the Air Force, and 115 percent for the Army, the last of which already had high enrollment (see Figure 55).^B

Figure 55. TRS enrollment in 2007 and 2008, by service branch



^BDue to limited sample sizes, Marines are included with Navy.

Factors Associated with TRS Enrollment^C

There are several characteristics that are common to TRS enrollees. First, the Army is overrepresented in TRS, accounting for 50 percent of the Selected Reserves but 61 percent of TRS enrollees. In contrast, the Navy is underrepresented, accounting for 23 percent of the Selected Reserves but just 13 percent of TRS enrollees. Second, Selected Reserve officers are more likely to purchase TRS coverage than enlisted personnel, although enlisted personnel still represent the majority of TRS enrollees. TRS enrollees are more likely to be white, to have at least a college degree, and to be age 35 and older, characteristics associated with officer status. They also are more likely to self-report very good or excellent health and are less likely to have the option to purchase civilian health insurance.

Among eligible reservists who do not purchase TRS coverage, most report that they have civilian insurance options that are more affordable. Conversely, more than half of those who purchased TRS coverage said that TRS was more affordable than other insurance options. Seven percent of reservists report that they have no civilian options *and* are unable to afford TRS coverage.

A substantial proportion of eligible reservists (45 percent) appear to not purchase TRS coverage because they are not aware of it. Those who are unaware of TRS tend to be younger, poorer, and less educated than those who are aware. They also are more likely to be Navy reservists and to have no options for civilian insurance.

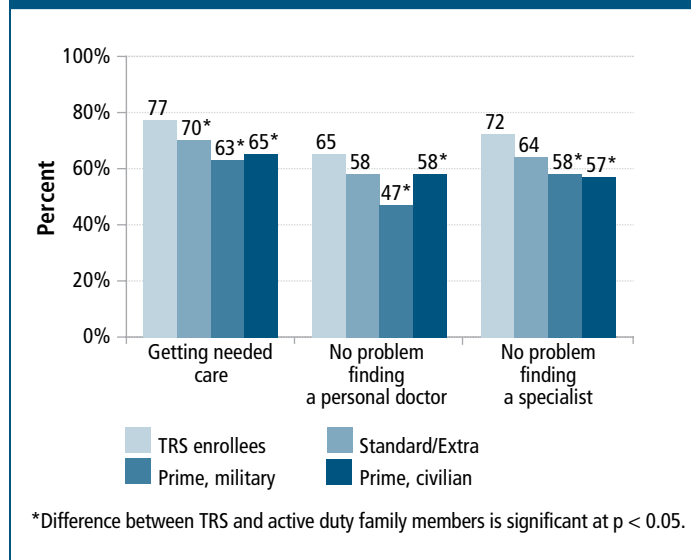
Ratings of Health Care Services

The spring 2008 survey also contained questions about reservists' perceptions of health care services. The responses were combined with HCSDB data to compare the experiences and perceptions of TRS enrollees to those of ADFMs, whose benefits—particularly Standard/Extra—are similar to TRS. As an additional source of comparison, perceptions of care by ADFMs who are (1) enrolled in Prime with a primary care manager at an MTF, (2) enrolled in Prime with a civilian gatekeeper, or (3) enrolled in Standard/Extra are reported separately. Typically, satisfaction scores are lower among Prime users than among users of Standard/Extra, which offers an expanded network of civilian providers.

^CThese data are based on the Collateral Survey. Responses to the survey are weighted to represent the Selected Reserve population, including adjustments for nonresponse. The survey asks respondents whether they are eligible for FEHB plans. Those who are eligible for FEHB plans are not eligible for TRS. Similar information is not available from administrative data. The survey data also includes more detailed information on sociodemographic characteristics, particularly for family members, than administrative data.

Because TRS is similar to Standard/Extra, it makes sense that TRS enrollees and Standard/Extra users have similar perceptions of health care services. TRS enrollees are more likely to report getting routine care than Standard/Extra users (77 versus 70 percent, respectively) (Figure 56). But for all other measures, there is no statistical difference between TRS enrollees and Standard/Extra users in perceptions of health care services.

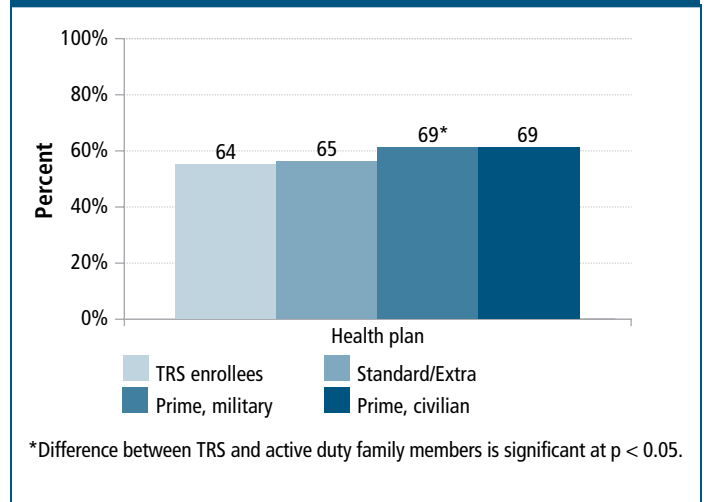
Figure 56. Getting routine care, TRS versus active duty family members



Overall, compared to Prime enrollees who obtain care from a military provider, TRS enrollees tend to have a better perception of health care services on nearly all measures. The one exception is ratings of health plans: TRS enrollees were less likely than Prime military users to assign a rating of 8 or higher to their health plan (64 versus 69 percent, respectively) (Figure 57). Compared to Prime enrollees who obtain care from civilian providers, TRS enrollees had better perceptions of care on measures related to getting care quickly and on ratings of personal doctors. Additional details on TRS compared to Prime enrollees are below.

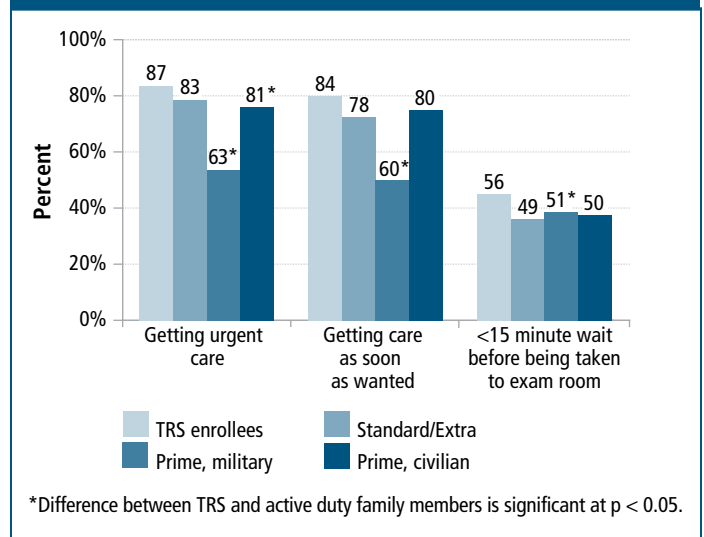
TRS enrollees were more likely to report getting routine care than family members enrolled in Prime and using military or civilian providers (77 percent versus 63 and 65 percent, respectively) (Figure 56). Similarly, TRS enrollees were more likely than Prime military or civilian users to report no trouble finding personal doctors (65 percent versus 47 and 58 percent, respectively) or seeing a specialist (72 percent versus 58 and 57 percent, respectively).

Figure 57. Rating of health plan, TRS versus active duty family members



A larger percentage of TRS enrollees reported being able to get care quickly compared to Prime military or civilian users (87 percent versus 63 and 81 percent, respectively). TRS enrollees were also more likely than Prime military users to report getting routine care as soon as wanted (84 versus 60 percent, respectively) and being taken to an exam room within 15 minutes of the appointment time (56 versus 51 percent, respectively) (Figure 58), although only about half of the beneficiaries were satisfied with the wait time. TRS enrollees did not differ significantly from civilian users in the latter two measures.

Figure 58. Getting care quickly, TRS versus active duty family members



TRS enrollees were more satisfied with their doctors and medical care than Prime military users. They were more likely than Prime military users to report that doctors always communicated well (92 versus 83 percent, respectively) and that office staff members were always courteous and helpful (95 versus 87 percent, respectively) (Figure 59). In addition, they were more likely than Prime military users to assign a rating of 8 or higher on a scale from 0 to 10 to their overall health care (77 versus 63 percent, respectively), to their personal doctor (76 versus 69 percent, respectively), and to their specialist (74 versus 69 percent, respectively) (Figure 60). For these measures, the only statistical difference between TRS enrollees and Prime civilian users was the percentage who assigned a rating of 8 or higher to their personal doctor (76 versus 69 percent, respectively).

Figure 59. Doctor's communication and office staff, TRS versus active duty family members

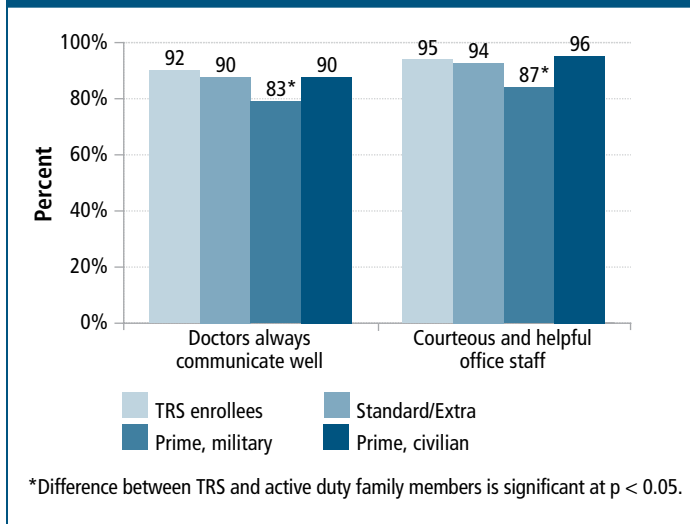
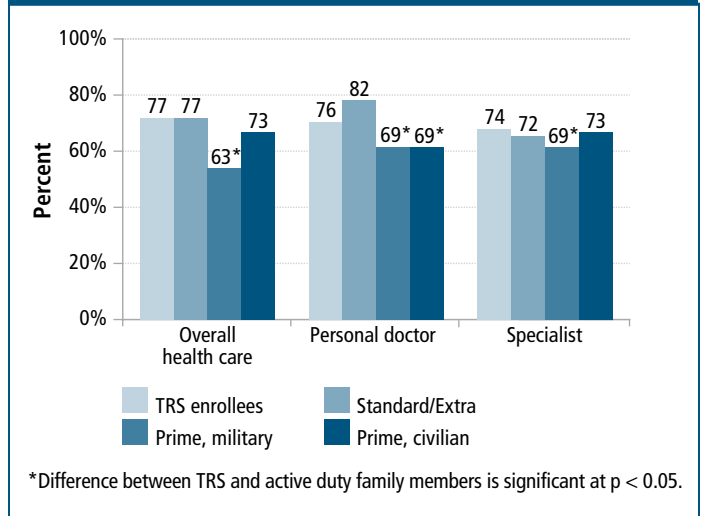


Figure 60. Overall rating of health care, personal doctor, and specialist, TRS versus family members of active duty



Conclusions

Overall, TRS enrollees are as satisfied with their health care as Standard/Extra users on all measures except getting needed care. TRS enrollees also reported higher satisfaction than Prime military users and, to a lesser extent, Prime civilian users. These findings suggest that TRS enrollees are at least as satisfied with their health care services as ADFMs, possibly because TRS—like Standard/Extra—offers enhanced access to civilian providers.

Chapter 8: Trust in Health Care Provider and in Health Plan for Own Care and Children's Care

Trust in one's health care provider and health plan can have a positive influence on patient attitudes and behavior. Researchers have found that trust in one's provider is associated with adherence to treatment recommendations, less provider switching, greater perceived effectiveness of care, and improvement in self-reported health. Furthermore, trust in one's plan is associated with fewer complaints and less plan switching. Interestingly, trust is predicted primarily by a patient's actual experiences and only marginally by patient demographics. In other words, a patient's positive health care experiences generally lead to greater trust, and greater trust leads to more positive outcomes, such as more healthful behavior and fewer resources wasted on dissatisfied patients.

Overall, those who are AD, have Prime coverage, or mostly use MTFs report less satisfaction with their health care experiences than do ADFMs, retirees, those with Standard/Extra or civilian coverage, or those who use CTFs most (analyses not shown). In addition, the relationship between AD beneficiaries and their providers is unique because AD beneficiaries are not assured confidentiality. This lack of assurance is of special concern to them because disclosure of medical issues could compromise their careers. Trust and satisfaction are related to one another, but trust has a stronger influence on patient behavior than satisfaction does.

In this chapter, we examine how provider trust and plan trust—for oneself and for one's children—differ by beneficiary group (AD vs. ADFM vs. retiree), health plan (Prime vs. Standard/Extra vs. civilian), usual source of care (MTF vs. CTF), demographics (ethnicity and gender), and whether the children's parents are retirees. Because adults over age 65 are covered by Medicare, they are excluded from the analyses in this chapter.

The HCSDB survey includes a five-item provider trust scale and a five-item plan trust scale, which are shortened versions of scales developed to assess provider trust and plan trust. Each shortened scale includes four specific items and one overall assessment of trust. Respondents rated each item on a five-point scale, from strongly disagree to strongly agree. In this chapter, the score for each item is the proportion of respondents reporting that they agree or strongly agree with the item.

For provider trust, the four specific items are:

1. Belief that the provider cares more about convenience than the patient's medical needs
2. Belief that the provider is extremely thorough and careful
3. Trust in the provider's medical treatment decision
4. Belief that the provider is honest about all available treatment options

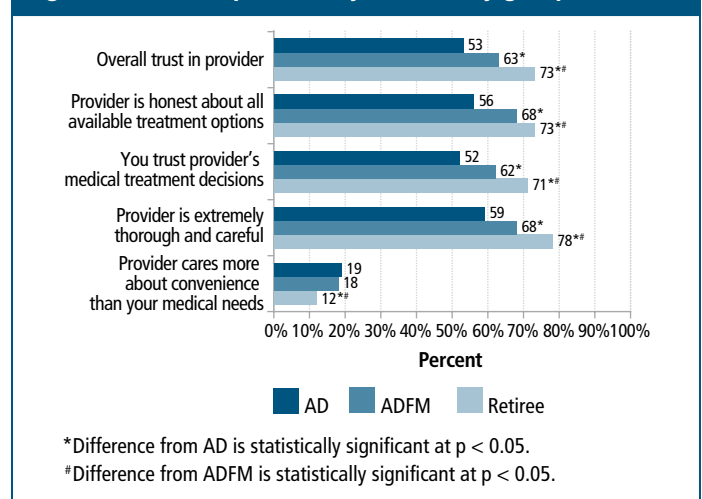
For plan trust, the four specific items are:

1. Belief that the plan cares more about saving money than the patient's needs
2. Feeling the need to double-check everything the plan does
3. Belief that the plan will pay for everything it's supposed to
4. Belief that the plan will give straight answers to questions

Adults—Trust in Health Care Provider

Figure 61 compares levels of provider trust across beneficiary groups. Retirees had the greatest overall provider trust (73 percent), followed by ADFMs (63 percent) and AD beneficiaries (53 percent). The same pattern held for belief that the provider is extremely thorough and careful, trust in the provider's treatment decisions, and belief that the provider is honest about all

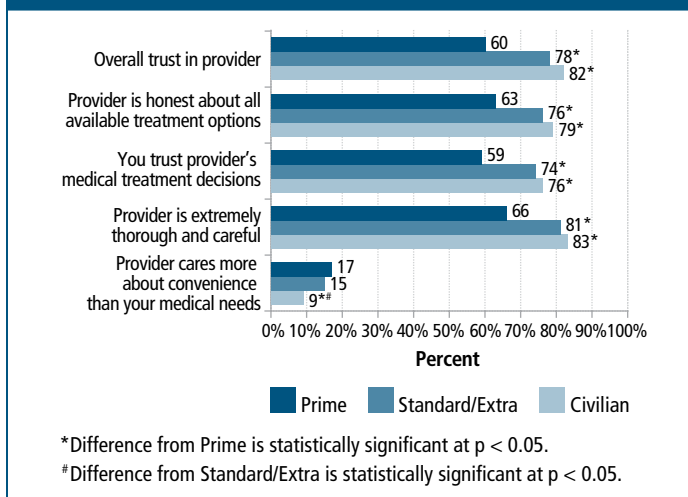
Figure 61. Trust in provider by beneficiary group



available treatment options. Likewise, retirees were less likely to believe that the provider cares more about convenience than the patient’s medical needs (12 percent) and thus had greater trust than AD beneficiaries (19 percent) or ADFMs (18 percent).

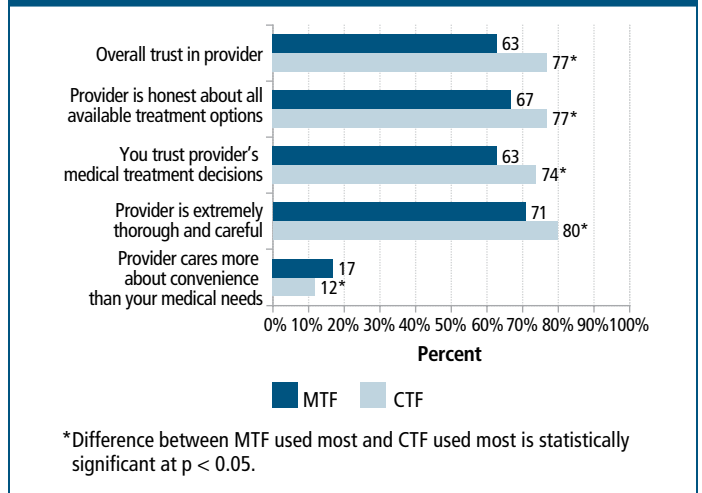
Figure 62 compares levels of provider trust across health plans. Those with civilian coverage had the greatest overall provider trust (82 percent), followed by those covered by Standard/Extra (78 percent) and Prime (60 percent). The same pattern held for the belief that the provider is thorough, trust in the provider’s decisions, and the belief that the provider is honest about treatment options. Similarly, those with civilian coverage were less likely to believe that the provider cares more about convenience than the patient’s needs (9 percent) and thus had greater trust than those covered by Prime (17 percent) or Standard/Extra (15 percent).

Figure 62. Trust in provider by health plan



In Figure 63, we compare levels of provider trust by usual source of care. (Because all AD beneficiaries are covered by Prime and get most of their care from MTFs, they are excluded from this figure.) Those who used CTFs most had greater trust than those who used MTFs most on all five items—overall provider trust (77 percent vs. 63 percent), belief that the provider cares more about convenience than the patient’s needs, belief that the provider is thorough, trust in the provider’s decisions, and belief that the provider is honest about treatment options.

Figure 63. Trust in provider by usual source of care



Adults—Trust in Health Plan

Figure 64 compares levels of plan trust across beneficiary groups. The pattern of responses is similar to that for provider trust (Figure 61). Retirees had the greatest overall plan trust (60 percent), followed by ADFMs (55 percent) and AD beneficiaries (48 percent). The same pattern held for belief that the plan will give straight answers to questions. Retirees also had the greatest trust that the plan will pay for everything it’s supposed to (58 percent), compared to AD beneficiaries (52 percent) and ADFMs (52 percent). We observed a similar pattern for the belief that the plan cares more about saving money than the patient’s treatment needs. However, there were no differences between AD beneficiaries, ADFMs, and retirees on feeling the need to double-check everything the plan does.

Figure 64. Trust in plan by beneficiary group

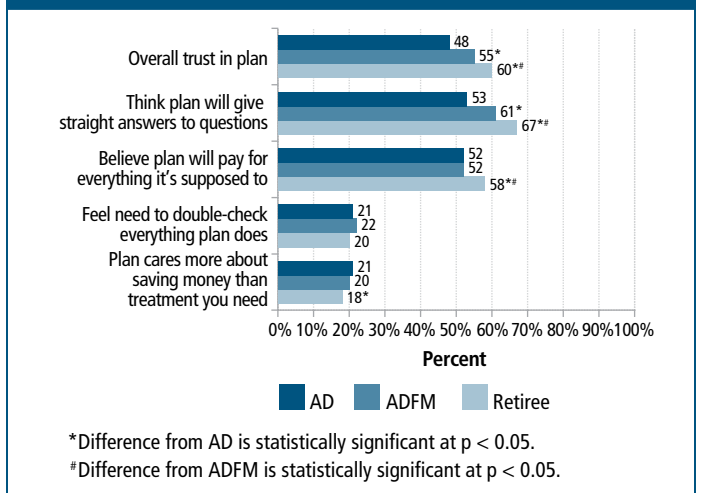


Figure 65 compares levels of plan trust across health plans. The pattern of responses differs from that for provider trust (Figure 62) and across the five items. With regard to overall plan trust, there were no differences between those with Prime coverage, Standard/Extra coverage, and civilian coverage. For belief that the plan will give straight answers, those with Standard/Extra coverage (67 percent) had greater trust than did those with Prime coverage (60 percent). Those with Prime coverage had greater trust than did those with civilian coverage that the plan will pay for everything it's supposed to (55 percent vs. 50 percent). However, there were no differences between those with Prime, Standard/Extra, and civilian coverage for (1) believing that the plan cares more about saving money than the patient's needs and (2) feeling the need to double-check.

Figure 65. Trust in plan by health plan

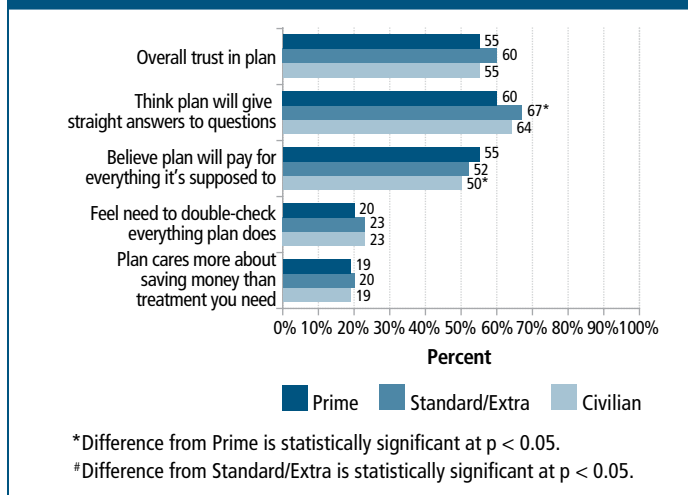
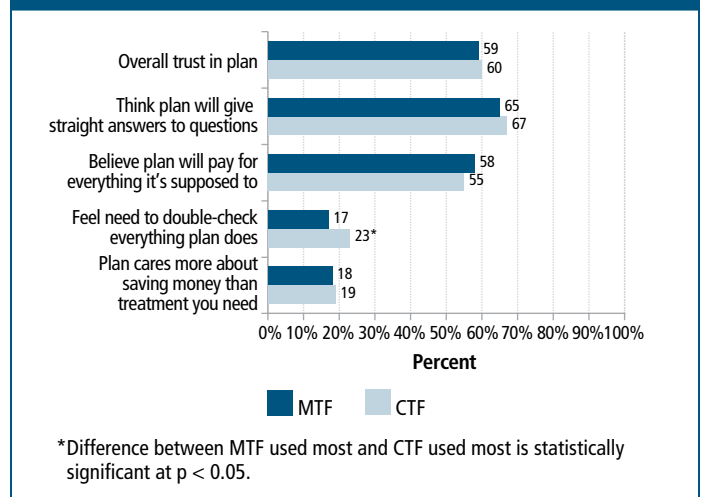


Figure 66 compares levels of plan trust by usual source of care (again, only for non-AD respondents). The pattern of responses differs from that for provider trust (Figure 63). Those who used MTFs most were less likely to feel the need to double-check everything the plan does (17 percent) compared to those who used CTFs most (23 percent). However, there were no differences between the two groups with regard to the other four items.

Figure 66. Trust in plan by usual source of care



Adults—Demographic Variations

To examine demographic variations, we compared levels of provider trust and plan trust by ethnic and gender group. Figure 67 shows that there were no differences among Hispanic, black, and white beneficiaries with regard to overall provider trust and overall plan trust. Figure 68 shows that women had greater overall provider trust than did men (68 percent vs. 62 percent) as well as greater overall plan trust (58 percent vs. 54 percent). This difference may arise because women are less likely to be active duty service members than are men.

Figure 67. Trust in provider and plan by ethnicity

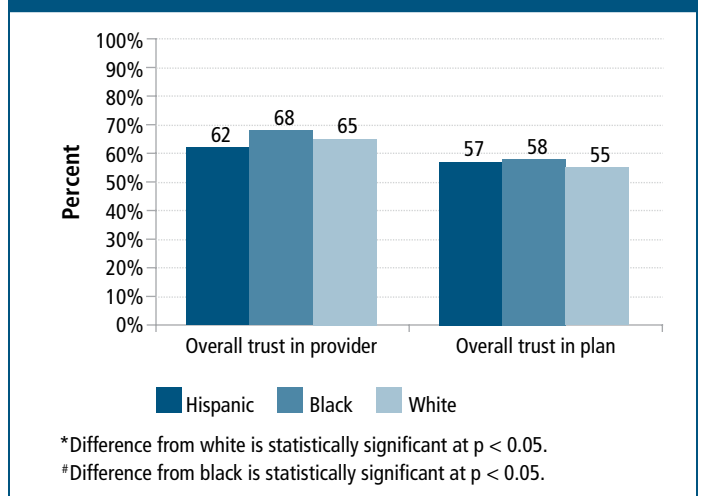
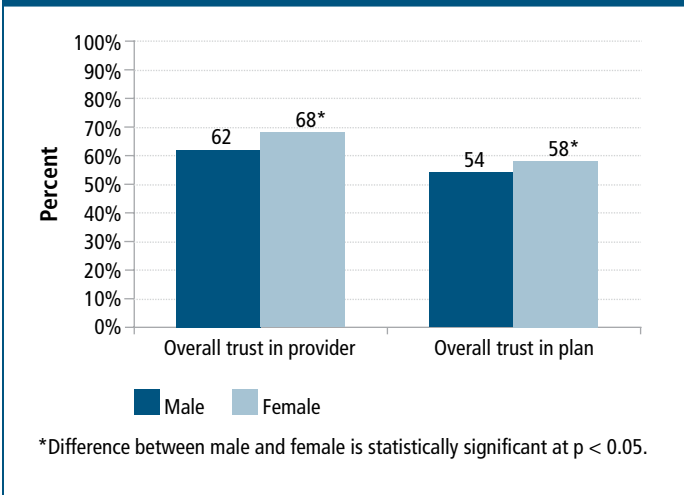


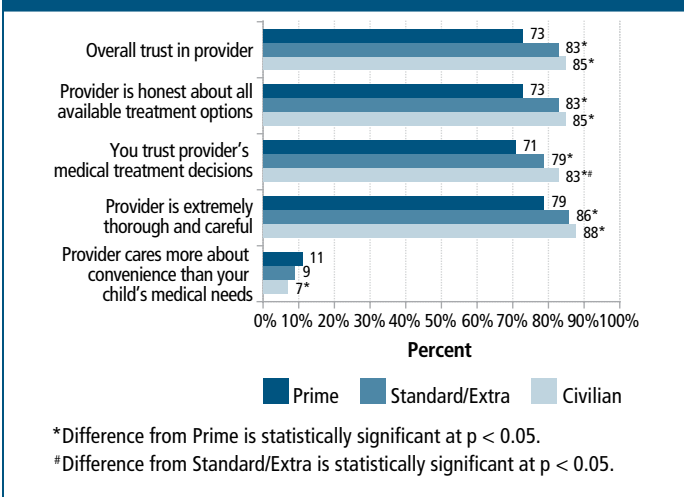
Figure 68. Trust in provider and plan by gender



Children—Trust in Health Care Provider

Figure 69 compares levels of provider trust across health plans with regard to care provided to one’s children. The pattern of responses is similar to that for adults (Figure 62) but with fewer differences between those with civilian coverage and those with Standard/Extra coverage. Those with civilian coverage (85 percent) and Standard/Extra coverage (83 percent) had greater overall provider trust than did those with Prime coverage (73 percent). The same pattern held for belief that the provider is thorough and belief that the provider is honest about treatment options. For trust in the provider’s decisions, those with civilian coverage had the greatest trust (83 percent), followed by those with Standard/Extra coverage (79 percent) and Prime coverage (71 percent). Those with civilian coverage were

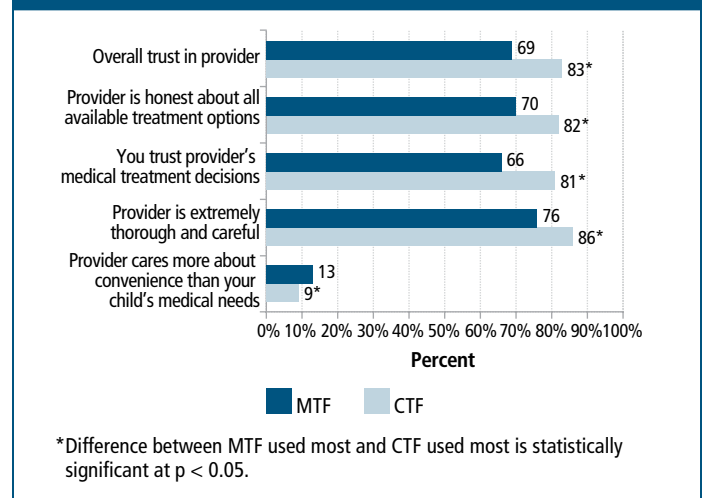
Figure 69. Trust in child’s provider by health plan



also less likely to believe that the provider cares more about convenience than the patient’s needs (7 percent) compared to those covered by Prime (11 percent).

Figure 70 compares levels of provider trust by usual source of care (for children of non-AD respondents only). The pattern of responses is identical to that for adults (Figure 63)—on all five items, those who used CTFs most had greater provider trust than those who used MTFs most.

Figure 70. Trust in child’s provider by usual source of care



Children—Trust in Health Plan

Figure 71 compares levels of plan trust across health plans. The pattern of responses differs from that for adults (Figure 65) and across the five items. For overall plan trust, those with Prime coverage (63 percent) had greater trust than did those with Standard/Extra coverage (57 percent). Those with Prime coverage (15 percent) or civilian coverage (14 percent) were less likely to believe that the plan cares more about saving money than the patient’s treatment compared to those with Standard/Extra coverage (18 percent). Those with Prime coverage were also less likely to feel a need to double-check (19 percent) compared to those with Standard/Extra coverage (26 percent) or civilian coverage (23 percent). The same pattern held for those who believe the plan will pay for everything it’s supposed to. However, those with civilian coverage (67 percent) had greater trust that the plan will give straight answers compared to those with Prime coverage (63 percent) or Standard/Extra coverage (61 percent).

Figure 71. Trust in child's plan by health plan

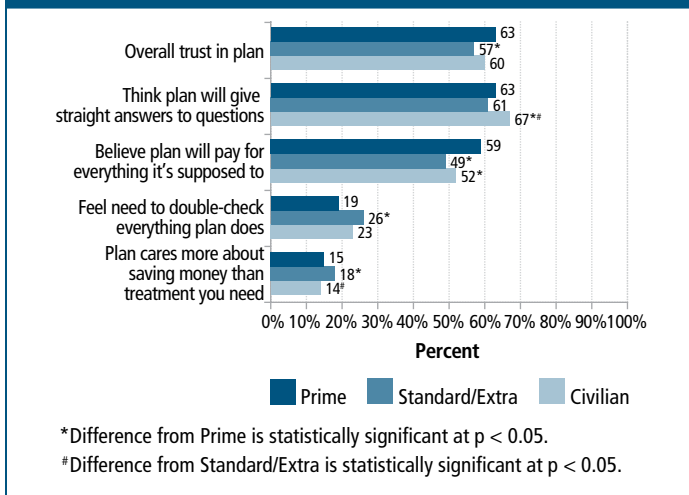
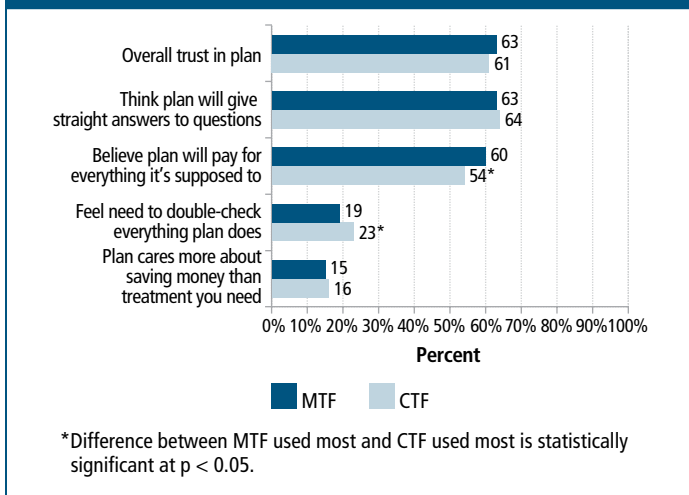


Figure 72 compares levels of plan trust by usual source of care (for children of non-AD respondents only). The pattern of responses is similar to that for adults (Figure 66). With regard to overall plan trust, there were no differences between those who used MTFs most and those who used CTFs most. Those who used MTFs most were less likely to feel a need to double-check (19 percent vs. 23 percent) and also had greater trust that the plan will pay for everything it's supposed to. There were no differences between the two groups in believing that the plan cares more about saving money than the patient's needs and that the plan will give straight answers.

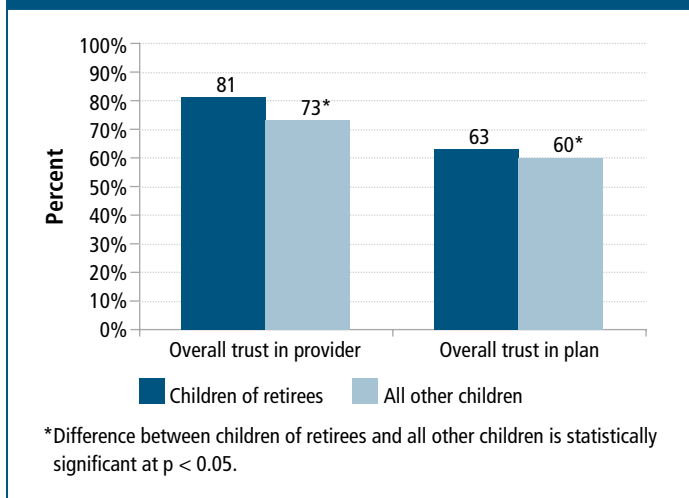
Figure 72. Trust in child's plan by usual source of care



Children of Retirees vs. All Other Children

Children of retirees have different health care coverage through their parents than do other children, and adult retirees reported greater trust than did other beneficiary groups (see Figures 61 and 64). Therefore, Figure 73 compared children of retirees with all other children, and found that children of retirees had greater overall provider trust (81 percent vs. 73 percent) and greater overall plan trust (63 percent vs. 60 percent).

Figure 73. Trust in provider and plan by children of retirees vs. all other children

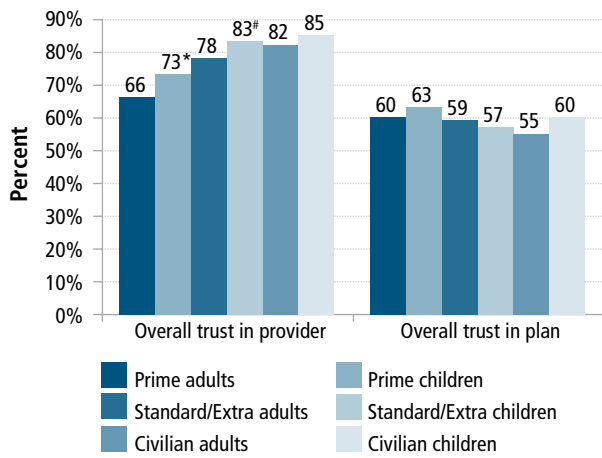


Adults vs. Children

Because AD adults have different health care coverage than do other adults, AD adults were excluded from this set of comparisons. Figure 74 shows that adults had greater overall provider trust regarding their children's care than their own care among those with Prime coverage (73 percent vs. 66 percent) and those with Standard/Extra coverage (83 percent vs. 78 percent). However, there were no such differences among those with civilian coverage. There were also no differences with regard to overall plan trust, regardless of coverage.

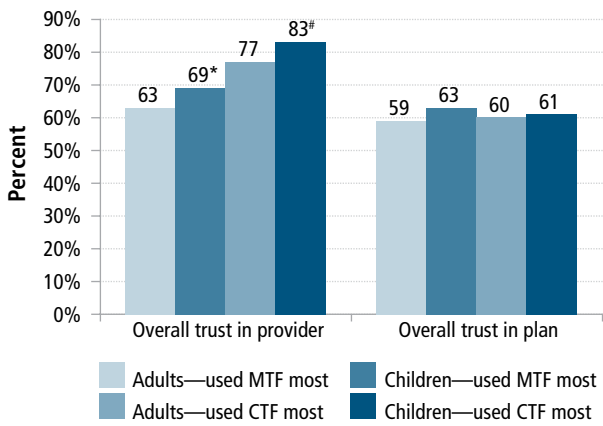
Similarly, Figure 75 shows that adults had greater overall provider trust regarding their children's care compared to their own care among those who used MTFs most (69 percent vs. 63 percent) and those who used CTFs most (83 percent vs. 77 percent). However, there were no such differences with regard to overall plan trust.

Figure 74. Trust in provider and plan



*Difference from Prime adults is statistically significant at $p < 0.05$.
 # Difference from Standard/Extra adults is statistically significant at $p < 0.05$.

Figure 75. Trust in provider and plan by usual source of care



*Difference from adults who used MTF most is statistically significant at $p < 0.05$.
 # Difference from adults who used CTF most is statistically significant at $p < 0.05$.

External Comparison

A survey with a nationally representative sample of adults provides summed scores for each 5-item scale, converted to a 100-point scale. For provider trust, the resulting external comparison score is 78, and for plan trust, the resulting comparison score is 58.

Scores were computed using the same algorithm for adults and subgroups of adults in the HCSDB sample. Figure 76 shows adult provider trust scores compared to the external survey score, and Figure 77 shows adult plan trust scores compared to the external survey score. Overall, provider trust appears to be lower than the external comparison score, and plan trust is higher than the external comparison score.

Figure 76. Adult provider trust vs. external comparison score

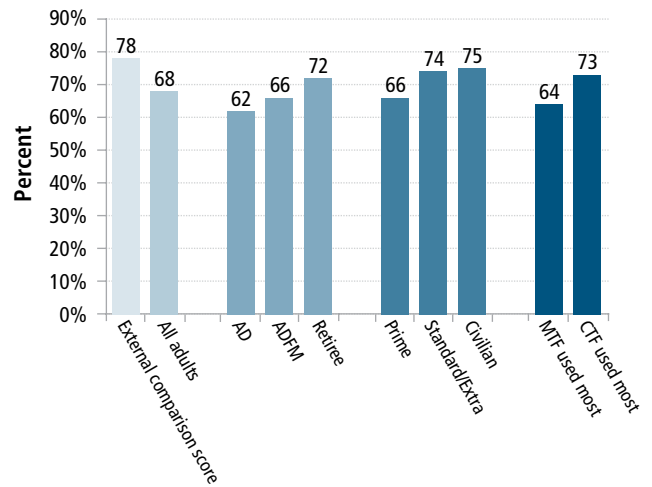
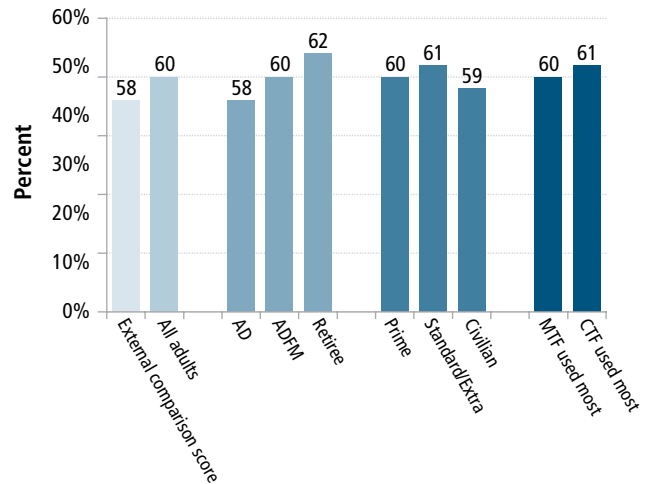


Figure 77. Adult health plan trust vs. external comparison score



Conclusions

Following is a summary of key findings.

1. **Group Differences.** Among adults, women reported greater trust than did men, but there were no ethnic differences. Retirees and children of retirees generally reported greater trust, and AD beneficiaries tended to report less trust, with ADFMs generally in between the two. Adults had greater provider trust regarding their children's care compared to their own care, but there were no such differences with regard to plan trust. The lower trust among AD beneficiaries is of particular concern because it may make it more difficult for providers to identify and treat medical issues, thus compromising the military readiness mission.
2. **Health Plan Differences (Provider Trust).** With regard to provider trust for their own care, those with civilian coverage generally reported greater trust, and those with Prime coverage tended to report less trust, with those with Standard/Extra generally in between the two. Similarly, with regard to children's care, those with Prime coverage tended to report less provider trust compared to those with Standard/Extra or civilian coverage. This pattern is similar to the pattern of satisfaction levels.
3. **Health Plan Differences (Plan Trust).** Some of our findings on provider trust differed from our findings on plan trust. For example, with regard to plan trust for their own care, those with Prime coverage were more likely to believe that the plan would pay for everything it's supposed to. Those with Prime coverage also reported *greater* plan trust with regard to their children's care. On the other hand, they were less likely to believe that their plan would give straight answers to questions with regard to their own care or their children's care.
4. **Source-of-Care Differences.** Regarding their own care and their children's care, those who used MTFs most reported less provider trust than did those who used CTFs most. As a result, beneficiaries may choose CTFs more. Among those who are restricted from choosing, lower trust may negatively influence patient behavior. With regard to plan trust, there were fewer such differences; where differences existed, they were in the opposite direction—that is, those who used MTFs most generally reported greater trust in their health plan than did those who used CTFs most. This pattern of findings suggests that MTFs should focus on building provider trust.

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²⁰Dugan, Elizabeth, Felicia Trachtenberg, and Mark A. Hall. “Development of Abbreviated Measures to Assess Patient Trust in a Physician, a Health Insurer, and the Medical Profession.” *BMC Health Services Research*, vol. 5, 2005, pp. 64-70.

Issue Briefs

*T*hese issue briefs were first available separately on TRICARE's website:

- *Retirees' Use of Civilian Coverage*
- *Tobacco Use in the MHS*
- *Active Duty Beneficiaries' Experience at Sick Call*
- *MHS Beneficiaries' Access to Behavioral Health Care*

Issue Brief: Retirees' Use of Civilian Coverage

Health care spending by the Department of Defense (DOD) more than doubled from 2000 to 2005. Increases are projected to continue in coming years and health care will consume 12 percent of the total defense budget by 2015.¹ Spending has grown due to the overall increase in health care costs, new benefits such as TRICARE for Life, and the growing share of retirees, dependents, and survivors in the beneficiary population.² These beneficiaries are older, and have more health problems and higher health care costs compared with active duty personnel. TRICARE's cost sharing has not changed since 1995. As a result, while beneficiaries paid 27 percent of the cost of their care in 1995, in 2005 they paid only 12 percent.¹

Spending has also increased because retirees with other coverage options increasingly use TRICARE rather than civilian coverage. Several factors are responsible for this change, but cost appears to be most important. A survey conducted in 2005 found that only about half of military retirees with access to civilian coverage used it. Among those with access to civilian coverage who opted not to use it, most mentioned the cost, including the higher copays (58 percent) and deductibles (57 percent), of civilian plans. Five percent reported that their employer offered them an incentive to use the military coverage.³

The reported use of incentives is symptomatic of efforts by state and local governments and private employers to encourage their military employees to use TRICARE. Many have offered supplemental insurance reducing employees' cost sharing under TRICARE. To reduce cost shifting, a provision was added to the 2007 Defense Authorization Act, making TRICARE the second payer for beneficiaries with employer-sponsored health insurance. The provision also prohibits employers with 20 or more employees from offering financial incentives to their employees to use TRICARE rather than the employer's health plan. CBO estimated that this provision would save \$119 million in 2008 and \$700 million in 2008-2011.⁴

Retirees enrolled in Prime pay only \$230 per year for single coverage or \$460 for family coverage, compared with the average private-sector employee contribution to health insurance premiums of \$723 for single coverage or \$2,585 for family coverage in 2005.⁵ To bring its costs into line with civilian alternatives, DoD has proposed higher enrollment fees for

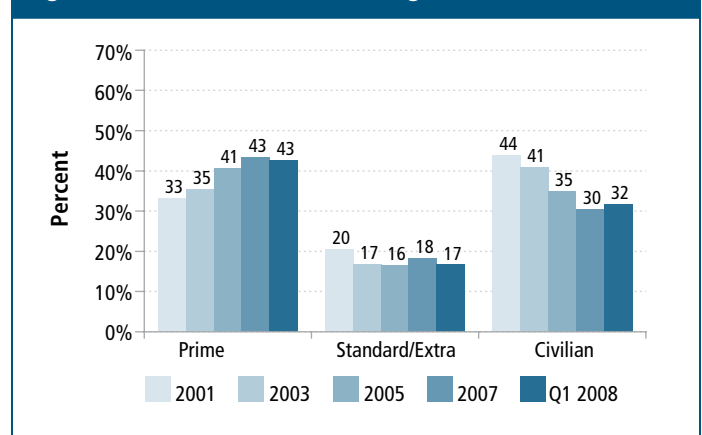
TRICARE Prime and an enrollment fee and higher deductibles for TRICARE Standard and Extra. However, Congress did not approve these changes for 2008.⁶

In the 2005 and 2008 HCSDB, beneficiaries were asked about their civilian coverage options. This issue brief addresses the change in uptake of civilian coverage since 2005 and beneficiaries' reasons for choosing TRICARE.

Use of TRICARE vs. Civilian Care

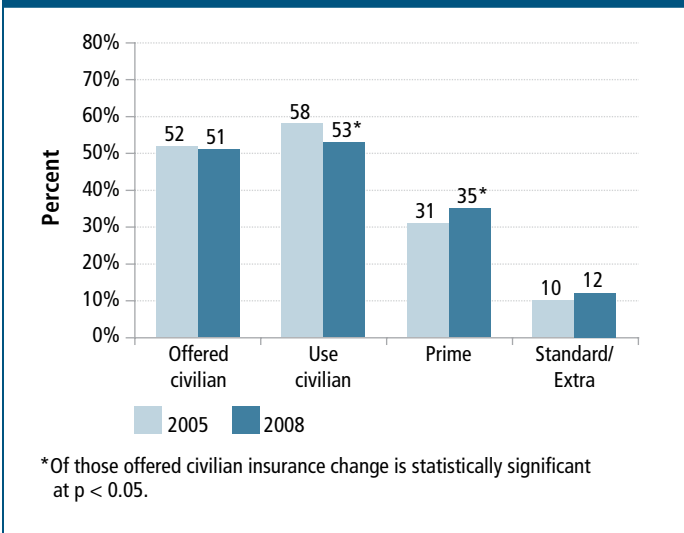
As shown in Figure 1, retirees' use of TRICARE has grown substantially since 2001. In FY 2001, 54 percent used TRICARE Prime or Standard/Extra for most or all of their health care, increasing to 69 percent in Q1 FY 2008 ($p < 0.05$). During the same period, the proportion with civilian coverage dropped from 44 to 32 percent ($p < 0.05$).

Figure 1. Health insurance coverage



The drop does not appear to be due to declining availability of civilian coverage. As shown in Figure 2, the proportion with access to civilian coverage did not change significantly between 2005 and 2008. Slightly more than half of those surveyed reported access to civilian coverage in both 2005 (52 percent) and 2008 (51 percent). However, significantly fewer with the option of civilian coverage now use it. That proportion dropped from 58 percent to 53 percent. The decline has corresponded to a rise in the proportion relying on TRICARE Prime (increasing from 31 percent to 35 percent, $p < 0.05$) and Standard/Extra (10 percent to 12 percent).

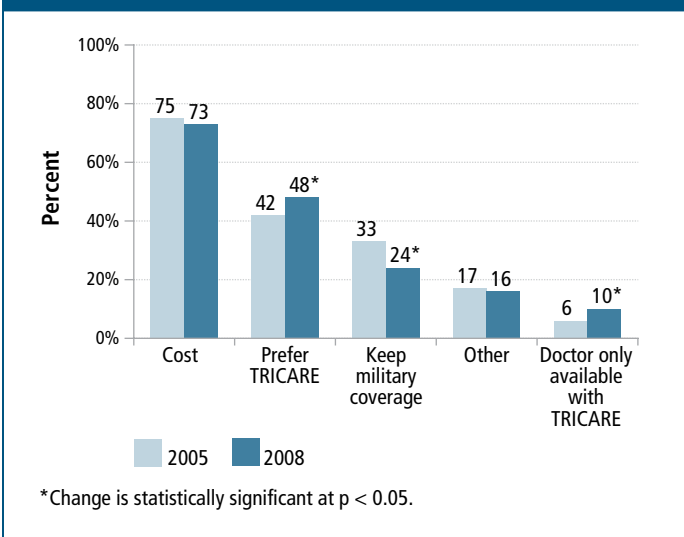
Figure 2. Offer and take up of civilian insurance



Reasons for Using TRICARE

Both cost and preference for TRICARE play a role in the decision to opt out of civilian coverage. Among those with access to civilian coverage, the majority of TRICARE users in 2005 and 2008 cite either the lower price of TRICARE or desire to avoid the premium for civilian coverage (Figure 3). Fewer, but nearly half, report they use TRICARE because they prefer some aspect of TRICARE, a proportion that has increased significantly since 2005. Twenty-four percent report opting out of civilian coverage to ensure continuing access to the military health system, fewer than in 2005, when 33 percent cited that reason. Finally, 4 percent indicate that their employer or a family members

Figure 3. Reasons for not using civilian coverage

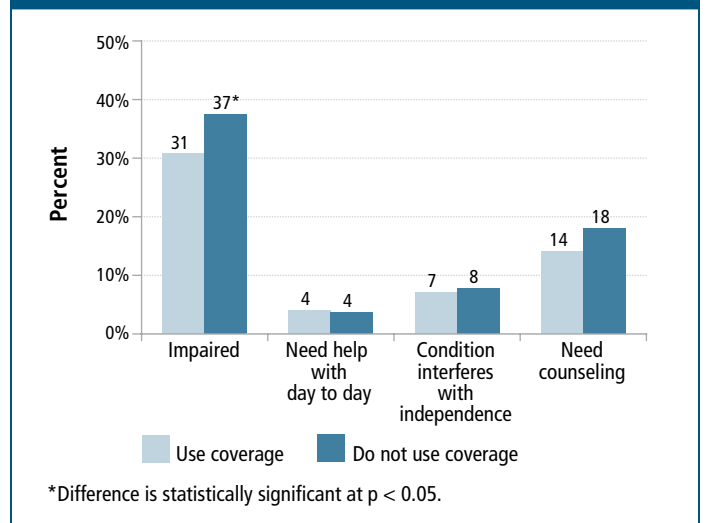


employer pays them not to take employer coverage (not shown, question not asked in 2005).

Another factor that could influence coverage choices and costs of MHS beneficiaries is their health. Civilian plans with pre-existing coverage restrictions may be less desirable than TRICARE. Conversely, access to specialists needed for treatment of particular illnesses or conditions may be greater with civilian coverage.

As shown in Figure 4, beneficiaries with a civilian coverage option who do not use it are more likely to have an impairment limiting their activities, but not a condition that results in a need for day to day help. Beneficiaries who need treatment or counseling for personal or family problems are less likely to use their civilian coverage, but the difference is not statistically significant.

Figure 4. Health care needs, by civilian coverage use



Conclusions

Since 2005, the share of retirees under age 65 with access to civilian coverage has not changed, but the share of those retirees who use TRICARE instead of a civilian plan has increased significantly. TRICARE continues to assume a growing burden of care, and cost, for its retirees, a trend observed in the HCSDB since 2001. Though a substantial number of TRICARE users with other options report preferring TRICARE over civilian coverage, the most often-cited reason for choosing TRICARE, both now and in 2005, is its lower cost. Poor health may also contribute to beneficiaries' choice of TRICARE. Because cost is the single most important factor affecting beneficiaries' health plan choice, increasing the cost of TRICARE is likely to shift beneficiaries back to their civilian coverage. The effect would

be limited because retirees have other reasons for choosing TRICARE, including those with high expected costs.

Sources

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Issue Brief: Tobacco Use in the MHS

Although cigarette smoking receives the most attention in the US, other forms of tobacco are widely used. These alternative forms include smokeless tobacco, such as chew and snuff, and non-cigarette smoking tobacco, such as cigars, pipes, bidis, and kreteks.¹ Like cigarettes, alternative tobacco products contain carcinogens, and promote cancer of the mouth and throat. Other oral health problems like lesions, recession of the gums, and gum disease are also caused by tobacco in these forms.^{2,3} Like cigarettes, alternative tobacco products can lead to nicotine addiction. Among TRICARE beneficiaries, use of all forms of tobacco is also very costly, and is estimated to add \$1.6 billion per year in medical care costs to the US Department of Defense.⁴

Prevalence of Tobacco Use: Total US vs. TRICARE

Nationwide, according to SAMSHA, 3.3 percent of adults used smokeless tobacco in 2005, compared to 20.5 percent of the nation's adults who reported smoking cigarettes.⁵ An additional 24.3 percent reported being former smokers. In that same year, 17.9 percent of adult TRICARE beneficiaries described themselves as current smokers. An additional 27.5 percent reported being a former smoker.^{6,7}

In 2006, the Department of Defense launched an educational campaign called "Quit Tobacco—Make Everyone Proud". The campaign targets junior enlisted service members with advertising in 13 U.S. metropolitan markets containing 28 major military installations, and features a website with live help and educational materials on quitting tobacco use. This approach targets the group of military personnel with the highest incidence of tobacco use - younger, active duty beneficiaries.^{4,8}

Tobacco Use by Age and Beneficiary Group

According to the HCSDB fielded in January 2008, active duty beneficiaries and beneficiaries under the age of 35 are most likely to use tobacco, including alternative tobacco products. TRICARE beneficiaries aged 18-to-24 report the highest smoking rate⁹ (26 percent), the greatest use of other forms of tobacco (13 percent), and greatest use of smokeless tobacco (8 percent) (Table 1). The only form of tobacco use not significantly associated with age is non-cigarette tobacco smoking.

Table 1. Tobacco use by age group

Age Group	Smoke Cigarettes	Total	Use other forms of tobacco:	
			Use chewing tobacco or snuff	Use non-cigarette tobacco products** but not smokeless tobacco
Total Age 18-64	21	8	4	3
Age 18 to 24	26	13	8	5
Age 25 to 34	24	9	7	3
Age 35 to 44	16*	8*	4*	3
Age 45 to 54	20*	5*	2*	3
Age 55 to 64	18*	4*	1*	3

*Significantly different from the 18 to 24 age group at $p < 0.05$.

**For example, cigars, pipes, bidis, or kreteks

Similarly, active duty beneficiaries have higher rates of tobacco use in all forms compared with active duty family members and retirees and their dependents (Table 2). They use smokeless tobacco, in particular, at a much higher rate than do other groups. Over a tenth of active duty respondents report smokeless tobacco use, compared to less than a half of one percent of active duty family members and 2 percent of retirees and their dependents.

Table 2. Tobacco use by beneficiary group

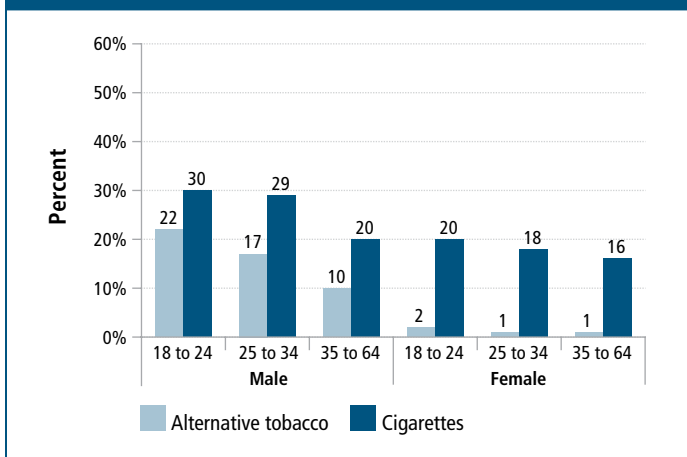
Beneficiary Group	Smoke Cigarettes	Total	Use other forms of tobacco:	
			Use chewing tobacco or snuff	Use non-cigarette tobacco products** but not smokeless tobacco
Total	21	8	4	3
Active Duty <65	26	17	11	6
Family of Active Duty <65	19*	2*	0*	1*
Retiree, Survivor, Family <65	18*	4*	2*	3*

*Significantly different from Active Duty beneficiaries at $p < 0.05$.

**For example, cigars, pipes, bidis, or kreteks

As shown in Figure 1, use of alternative tobacco products is confined largely to males. Among certain groups of males, alternative tobacco use approaches cigarette use. Of male beneficiaries between the ages of 18 and 24, 22 percent use smokeless tobacco, or smoke alternative tobacco products, while 30 percent smoke cigarettes. By contrast, only 2 percent of female beneficiaries in that age group use alternative tobacco products, much lower than the cigarette smoking rate for that group (20 percent). Of men aged 25 to 34, one-sixth use alternative tobacco products, compared to 1 percent of women.

Figure 1. Tobacco use by age and sex



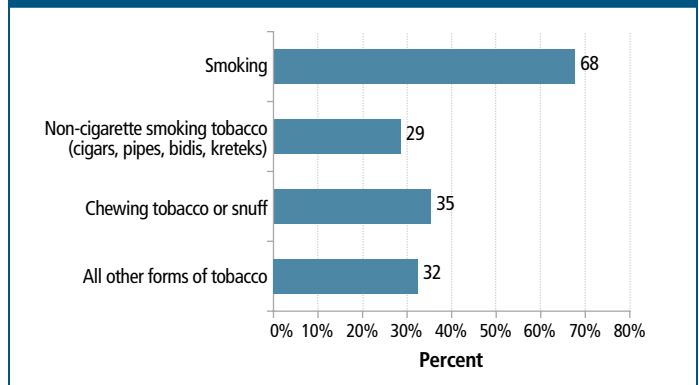
Tobacco Cessation Counseling

As shown in Figure 2, TRICARE beneficiaries who smoke cigarettes are more likely to be advised to quit than are beneficiaries who use other tobacco products. This discrepancy may indicate that providers are less likely to ask about use of alternative tobacco products, or that they are less likely to advise beneficiaries to quit when they know of their use. For example, 68 percent of cigarette smokers with office visits were advised to quit by a medical provider within the last year, compared with 35 percent of beneficiaries who use smokeless tobacco and 29 percent who smoke alternative tobacco products.

Conclusions

TRICARE’s efforts to reduce tobacco use have focused on cigarettes. However, results from the HCSDB indicate that a substantial fraction of beneficiaries use tobacco in forms other than cigarettes. In particular among young, male and active duty beneficiaries, who are the most likely to use tobacco, the rate of alternative tobacco use is more than half that of cigarettes. Results indicate that those who use alternative tobacco products

Figure 2. Counselled to quit by type of tobacco use



are much less likely to be advised to quit by their doctors than are cigarette users.

Less frequent advice may reflect the focus of TRICARE’s programs on cigarette smoking or may reflect the judgment of providers that most alternative tobacco products are less harmful to their patients than are cigarettes. Some providers may view substitution of alternative tobacco products for cigarettes as beneficial. Less frequent counseling may also reflect the concentration of alternative tobacco use among young men, which is the group least likely to get smoking cessation advice. Additional research on the impact of alternative tobacco products and of efforts to reduce their use is needed to develop guidance for providers and beneficiaries that will promote healthier lifestyles.

Notes

¹Bidis are small, brown, hand-rolled cigarettes from India and other southeast Asian countries. Kreteks are clove cigarettes made in Indonesia that contain clove extract and tobacco.

²Centers for Disease Control and Prevention, Fact Sheet: Smokeless Tobacco, April 2007. Available from: http://www.cdc.gov/tobacco/data_statistics/Factsheets/smokeless_tobacco.htm

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⁵Smokeless tobacco users report use in the past month. Cigarette smokers have smoked at least 100 cigarettes and currently smoke at least some days.

⁶“Department of Defense Anti-Tobacco Campaign Invades Military Markets,” March 20, 2008, No. 08-23. Available from: <http://www.tricare.mil/News/News.aspx?fid=379>

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⁸Quit Tobacco, Make Everyone Proud Website. Available from: <http://www.ucanquit2.org/>

⁹A smoker is defined as someone who has smoked at least 100 cigarettes, and currently smokes, or currently does not smoke but quit smoking less than 12 months ago.

Issue Brief: Active Duty Beneficiaries' Experience at Sick Call

In addition to care delivered at military treatment facilities (MTFs), sick call may provide same-day, on-site care to active duty personnel. Sick call is held at an appointed time each day, when those requiring medical attention report for examination and treatment. Recent focus groups reviewed active duty beneficiaries' experience with health care in the military health system (MHS), including sick call. Focus group participants described sick call as inefficient, due to long wait times and minimal care. However, some beneficiaries in units without sick call regretted its absence as a ready source of same-day care (Zeidman and Cohen, 2007).

To explore the general applicability of these focus group findings, questions were added to the HCSDDB for April, 2008 that identify who has access to sick call and how use of sick call is related to satisfaction with health care.

Characteristics of Sick Call Users

When sick call is available, over 4 in 5 respondents report they use it for all or most of their care, primarily younger and enlisted personnel. Seventy-five percent of active duty who use sick call as their usual source of care are under age 35, while 86 percent are enlisted (result not shown).

As shown in Table 1, compared with older beneficiaries, younger personnel are significantly more likely to use sick call as their main source of care. The percentage of sick call users is greatest among those aged 18 to 24. However, young beneficiaries are most likely to be in a unit that provides sick call. Among the active duty whose unit provides sick call, use varies little with age.

Officers are significantly less likely to use sick call compared with enlisted personnel and warrant officers. In units that provide sick call, officers are also significantly less likely to use sick call compared with enlisted personnel, but the difference in setting between officers and warrant officers is not statistically significant.

Satisfaction with Care and Provider Trust

While focus group participants complained about sick call, survey respondents who use sick call as their main source of care reported similar or greater trust in their providers and satisfaction with care compared with beneficiaries who do not use sick call. Sick call users' ratings of their health care are similar to

Table 1. Active duty beneficiaries whose unit provides sick call, and using sick call as their main source of care: By age group and rank

Age group	Unit provides sick call	Among those whose unit provides sick call	Total (among all active duty beneficiaries)
		Percent who use sick call for all or most of care	Percent who use sick call for all or most of care
Age 18 to 24	88	81	71
Age 25 to 34	74*	85	63*
Age 35 to 44	64*	82	52*
Age 45 to 54	60*	75	45*
Age 55 to 64	52*	69	36*
Officer	60	75	45
Enlisted	78 [#]	83 [#]	65 [#]
Warrant officer	76 [#]	86	65 [#]

*Significantly different from the 18 to 24 age group at $p < 0.05$.

[#]Significantly different from officers at $p < 0.05$.

ratings of non-sick call users. However, ratings by both groups are below civilian benchmarks (not shown).

As shown in Figure 1, sick call users have significantly less provider choice compared with the other two groups of non-sick-call users. However, they also reported higher satisfaction with their choice of providers than did non-users, both non-users who chose other providers, so presumably would rate sick call even lower, and those without the sick call option. Sick call users were more likely to report continuity of care, provider knowledge of their medical history and satisfactory access to tests and treatment, compared to non-users.

Trust in their providers appears to be lowest among beneficiaries who could use sick call but do not (Table 2), which may mean they trust sick call providers still less. Active duty who opt out of sick call were least likely to report that their health care provider is always thoughtful and thorough (52 percent), that they trust their provider's decisions about medical treatments (48 percent), that they have complete trust in their provider (48 percent), and that their provider is completely honest about treatment options (52 percent). Trust of both users and

Figure 1. Ratings of care by sick call use

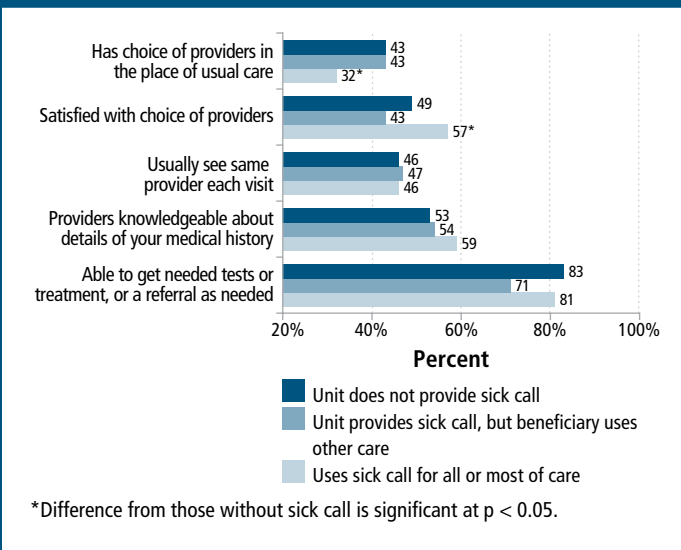


Table 2. Patient trust in provider and sick call use

Agree or strongly agree that:	Unit provides sick call		
	Sick call users	Other users	Sick call not available
Provider cares more about own convenience than about your medical needs	19	22	22
Provider is always thoughtful and thorough	61	52*	61
Trust provider's decisions about which medical treatments are best for you	55	48*	52
Provider is completely honest in telling you about treatment options for your condition	58	52*	57
You have complete trust in your provider	55	48*	54
Provider may not refer you to a specialist when needed	23	21	21
Trust provider to put your medical needs first when treating your medical problems	53	49	55
Provider strongly influenced by health plan rules when making decisions about your care	38	31*	33*

*Different from sick call users at ($p < 0.10$).

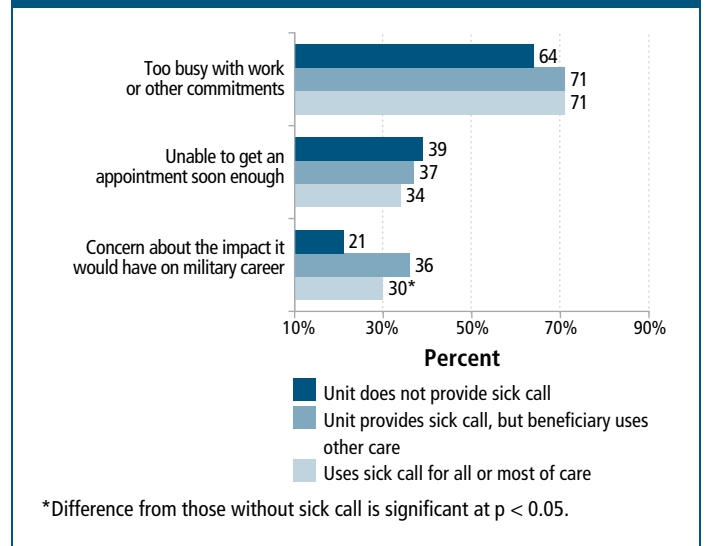
non-users are well below rates from civilian populations (Dugan et al., 2005). Sick call users were most likely to report they believe that their provider is strongly influenced by health plan rules when making decisions about their medical care (38 percent).

Delaying Needed Care

Overall, sick call users are significantly less likely (41 percent) to have postponed care within the last 12 months compared with the other two groups of non-sick call users (51 percent for each group, results not shown). All three groups cite similar reasons for postponing needed care: the most common reasons were time constraints, delay in getting an appointment, or fear for their military career.

As shown in Figure 2, sick call users are most likely to report they delayed getting needed care because they were too busy, particularly compared to those whose units do not provide sick call, (71 percent compared to 64 percent). Delays in care because of difficulties in getting an appointment do not differ significantly among the three groups. Those whose units provide sick call but who use other sources of care are the group most likely to delay needed care because of concern about their careers, particularly compared to those whose units do not provide sick call (36 percent compared to 21 percent).

Figure 2. Reasons for delaying care by sick call use



Conclusions

Beneficiaries who could use sick call but do not are likely less satisfied with sick call than with their chosen provider. Hence, their low ratings of care compared with sick call users likely conceal a low opinion of sick call, not a preference for that setting. However, HCSDB results show that the vast majority of those who can use sick call, do so. Sick call users' trust in providers is similar, and satisfaction with choice of provider is greater, compared to trust and satisfaction of beneficiaries without the sick call option. The results suggest deficiencies in trust and satisfaction among active duty personnel are not due to sick call, but to other aspects of military health care.

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Issue Brief: MHS Beneficiaries' Access to Behavioral Health Care

Beneficiaries of the military health system (MHS) are subject to unusual stresses, including deployment with potential injury or death, and the experience of family-members' deployment. Beneficiaries face barriers to receiving care for their personal and family problems, some self-imposed. Active duty personnel are subject to stigma and fear for their careers, while family members and retirees are affected by the reluctance of mental health providers to accept TRICARE insurance. Media reports of rising suicide rates and suicide attempts among active duty personnel have helped to focus attention on barriers to treatment affecting service members and their families.¹

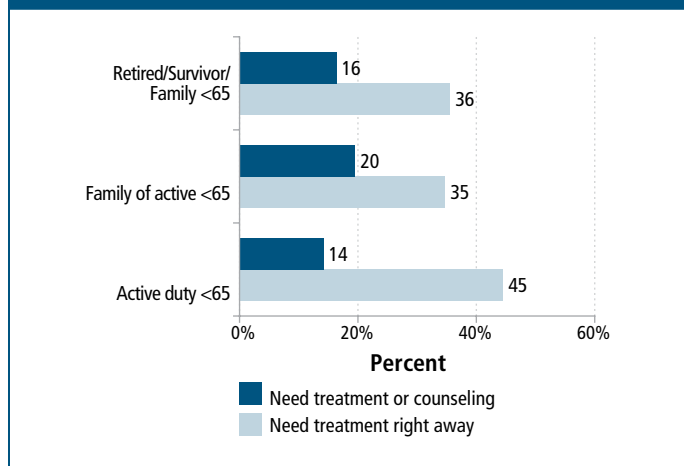
In response to recommendations of a task force established by the National Defense Authorization Act of 2006, the Department of Defense and the services are working to overcome these barriers: hiring new staff and supplementing existing staff with professionals from the Public Health Service, campaigning to destigmatize care-seeking and to better integrate behavioral health into the primary care provided to military beneficiaries. Standards for timely access to MTF and network care are being extended to behavioral health. For service members and their families, TRICARE has launched a Behavioral Health Provider Locator and an Appointment Assistance Service Center. Active duty and their family members may find information about support programs through OneSource, a website containing information for each of the services.^{2,3}

The Health Care Survey of DoD Beneficiaries fielded in July, 2008 contained questions about beneficiaries' need for and experience obtaining behavioral health services, and the effectiveness of assistance provided to help beneficiaries use their benefits.

Need for Routine and Emergency Counseling

Compared with other beneficiary groups, active duty personnel are least likely to report needing treatment or counseling within the last 12 months. As shown in Figure 1, 14 percent of active duty personnel, compared with 20 percent of family members and 16 percent of retirees reported they needed treatment or counseling in the past 12 months. Active duty personnel who need counseling are more likely than members of other beneficiary groups to report they need counseling on an urgent basis. Forty-five percent of active duty who needed treatment or

Figure 1. Behavioral health needs by beneficiary category



counseling reported they needed it right away, compared to 35 percent of family members and 36 percent of retirees.

As shown in Figure 2, active duty personnel are least likely to report good access to behavioral health services. Sixty-one percent of service members who needed care reported they had no problem getting it, compared to 70 percent of family members and 73 percent of retirees. However, by other measures, active duty access appears the same or better than access of

Figure 2. Access to treatment or counseling, by beneficiary category

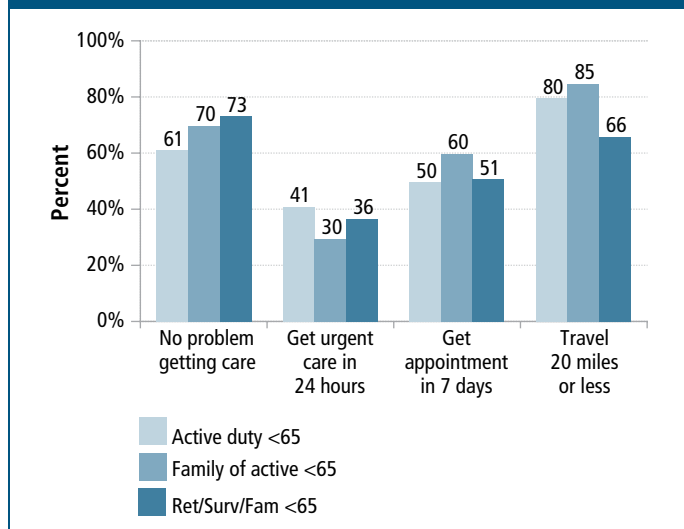
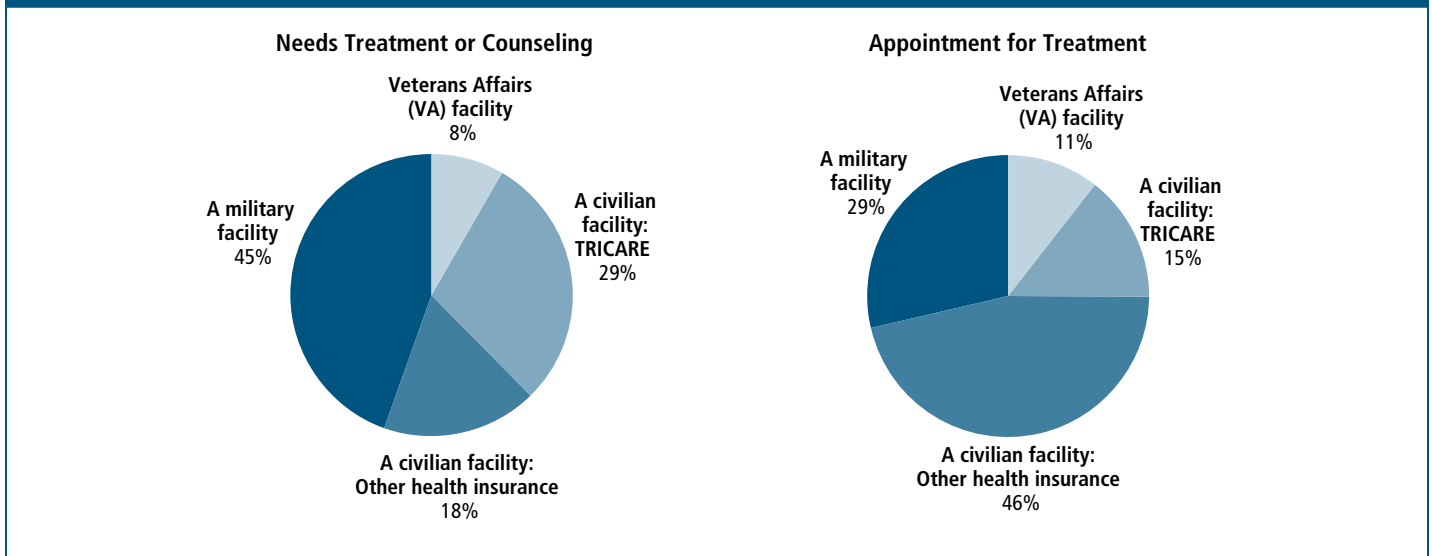


Figure 3. Sources of care and behavioral health needs



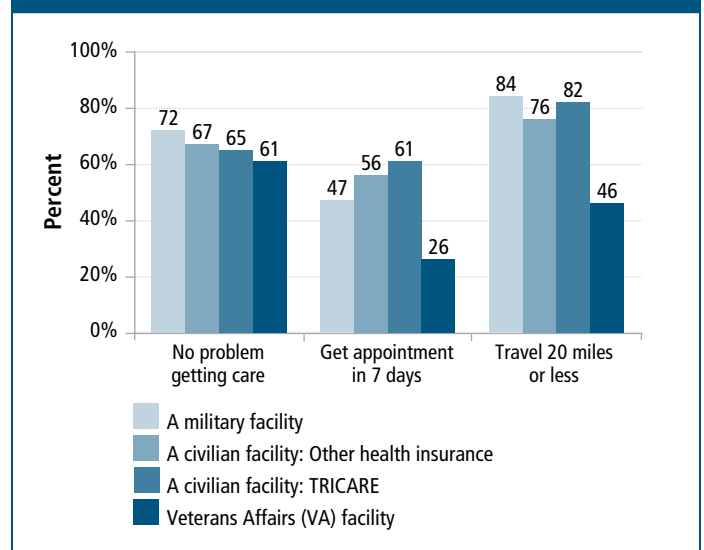
other beneficiary groups. Active duty personnel who sought counseling on an urgent basis were more likely than other beneficiary groups to report they obtained an appointment within 24 hours (41 percent, compared to 30 percent and 36 percent). Personnel who sought a routine appointment were equally likely to obtain one in 7 days compared to retirees, but not family members (50 percent compared to 51 percent and 60 percent). Active duty travel distances are similar to distances for their family members, and shorter than travel distances for retirees. Eighty percent of service members reported travelling 20 miles or less for care, compared to 85 percent of their family members and 66 percent of retirees.

Sources of Behavioral Health Care

Beneficiaries who need treatment or counseling are less likely to use MTFs or TRICARE’s civilian providers than are MHS beneficiaries in general. As shown in Figure 3, 45 percent of those who needed treatment or counseling are normally MTF users, 29 percent use TRICARE civilian providers, and 18 percent use civilian facilities without using TRICARE. Another 8 percent rely on the VA. However, for behavioral health, many with TRICARE coverage do not use TRICARE. Among those making an appointment for treatment or counseling, only 29 percent use MTFs, and 15 percent use TRICARE civilian providers. Eleven percent use VA providers, and nearly half rely on civilian providers without using TRICARE. Fewer than half of active duty beneficiaries who make appointments use TRICARE (not shown).

Access problems are approximately equally distributed among users of different facility types, as shown in Figure 4. The proportion with no problem getting needed care ranges from 61 percent of those using VA facilities to 72 percent using MTFs. However, MTF users and VA users are less likely than users of civilian facilities to get appointments within 7 days. Only 26 percent of VA users and 47 percent of MTF users reported they could get an appointment within 7 days, less than rates for users of civilian providers (61 percent for TRICARE providers and 56 percent for other civilian sources). Travel dis-

Figure 4. Access to treatment or counseling, by source of care



tances for TRICARE users are shorter than distances for other civilian providers or VA users. Eighty-four percent of MTF users and 82 percent who use TRICARE's civilian providers reported they traveled less than 20 miles for care while 76 percent of other civilian users and fewer than half of VA users traveled less than 20 miles.

Sources of TRICARE Access Problems

Overall, more than two fifths (44 percent) of beneficiaries under age 65 needing treatment or counseling made an appointment through TRICARE. These beneficiaries were asked to list reasons for access problems, if any (Figure 5). Their responses suggest that beneficiaries who use TRICARE may face shortages of mental health providers. The reason most often given was that the desired provider had no appointments available (21 percent). Eight percent reported that available appointments

were incompatible with their schedule. About 5 percent had problems because a desired provider did not accept TRICARE.

Conclusions

Active duty report more access problems than do other TRICARE beneficiaries. Their problems may be due to stigma or a culture that makes seeking care difficult, or to a shortage of providers. Measures such as travel distance and ability to see providers rapidly do not appear to show particular access problems for active duty personnel, though they are more likely than other beneficiaries to use MTFs, where waits for appointments are somewhat longer. The proportion of MHS beneficiaries using TRICARE for behavioral health care is lower than the proportion of TRICARE users overall. In addition, the specific access problems reported by TRICARE users suggest that it is sometimes difficult to find TRICARE providers. More research is needed to learn whether lower use of TRICARE than civilian providers is due to stigma or shortages.

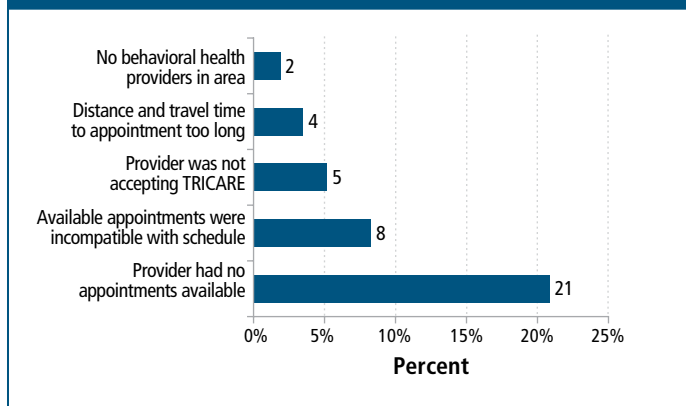
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Figure 5. Reasons for problems getting an appointment through TRICARE



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