

HCSDB Issue Brief

Beau Smit, Amy Gehrke, and Nancy Clusen

Comparing Plan Ratings: USFHP Versus TRICARE Prime/Select

The U.S. Department of Defense offers several health plan options to eligible beneficiaries under TRICARE, which is operated by the Defense Health Agency (Military Health System n.d.). Beneficiaries under age 65 can choose from two primary plans, depending on their beneficiary category: (1) TRICARE Prime, a managed care option, and (2) TRICARE Select, a fee-for-service option (TRICARE 2018a). Although beneficiaries enrolled in Select receive their care from TRICARE-participating civilian providers, Prime enrollees can receive care from civilian providers or from military clinics and hospitals.

In select areas of the United States, another option—the Uniformed Services Family Health Plan (USFHP)—is available through a network of private physicians affiliated with one of six community-based, not-for-profit health care systems (TRICARE 2018b). Active duty family members, retirees under age 65, reservists, and their family members can participate in USFHP as long as they live in one of the specified regions.

An important part of USFHP's mission is to ensure member satisfaction. In a recent Senate briefing, representatives from the USFHP Alliance (2016) reported a 91.5 percent satisfaction rate among its beneficiaries. Given this exemplary performance, we sought to compare USFHP with Prime and Select in terms of users' satisfaction with their health care, access to care, and interactions with their doctors. Documenting these differences will lay the groundwork for the Defense Health Agency to further investigate the gaps in satisfaction between USHFP and Prime and Select, including markets where these gaps are the largest.

This Issue Brief compares USFHP with Prime and Select in terms of users' satisfaction with their health care, access to care, and interactions with their doctors.

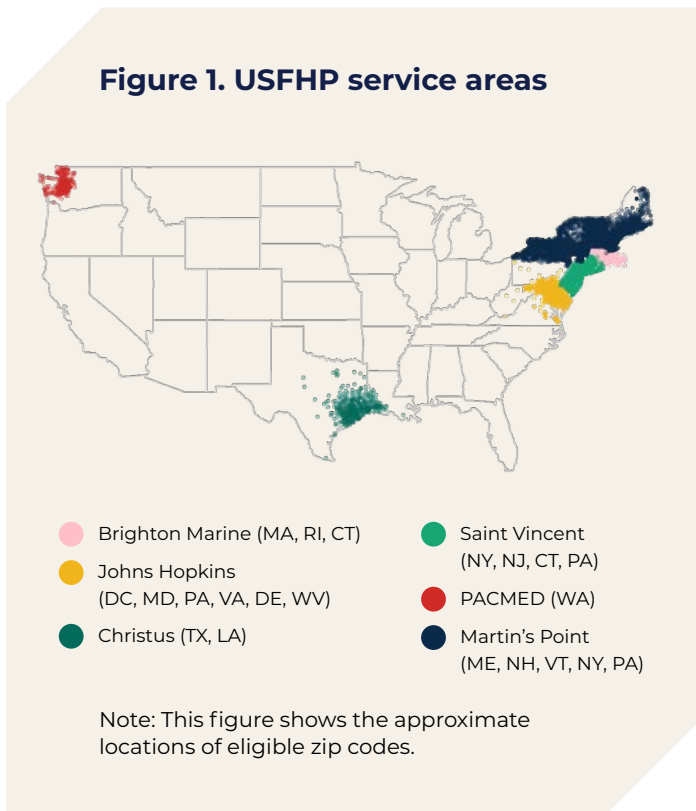
- USFHP users rated their health care significantly higher than did Prime enrollees receiving care at MTFs, but the same as Prime enrollees receiving civilian care and Select enrollees.
- USFHP users reported better access to their personal doctor, routine, and urgent care than did Prime enrollees receiving care at MTFs, but similar access compared to Prime enrollees receiving civilian care and Select enrollees.
- USFHP users rated their personal doctor significantly higher than did Prime enrollees receiving care at MTFs, but the same as Prime enrollees receiving civilian care and Select enrollees. USFHP, Prime, and Select enrollees rated their specialists similarly.
- USFHP users were more likely than Prime or Select users to report that their doctors explained things in an easily understandable way and showed respect.

Methods

This analysis includes data from 2016 to 2019 of the Health Care Survey of Department of Defense Beneficiaries. We weighted all responses in the analysis to make the sample more accurately reflect the population in the Military Health System. We present results for three plan types:

1. USFHP
2. Prime (users receive care at military treatment facilities [MTFs])
3. Prime (users receive civilian care) or Select

We used three criteria to ensure that our samples for USFHP, Prime, and Select were comparable. First, because active duty service members are not eligible for USFHP, we removed them from our sample. We then removed beneficiaries age 65 and over because USFHP only accepts beneficiaries under age 65.¹ Finally, we limited our sample to only those geographic areas served by USFHP to control for any differences in access and quality of care across markets. Figure 1 shows the six areas served by USFHP.

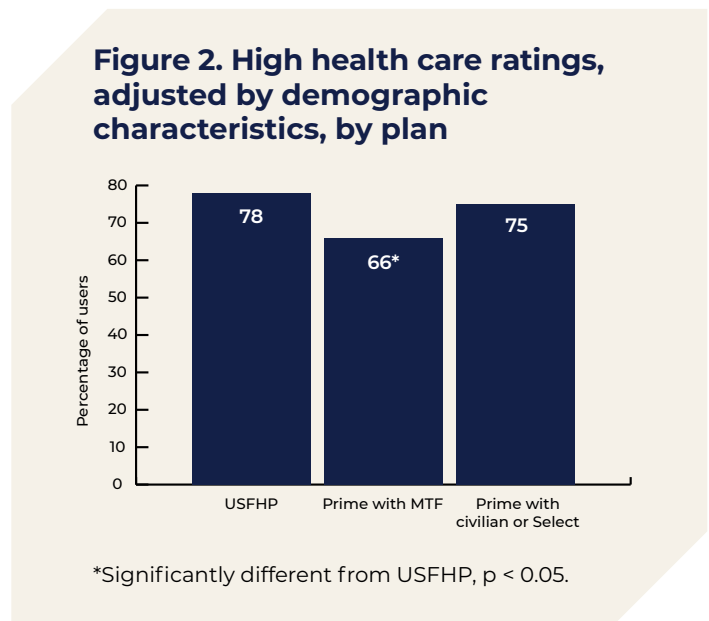


Other demographic characteristics may also be associated with beneficiaries' ratings of their health care. We therefore used a logistic regression to model the probability that respondents in each plan rated the care they received highly (a score of 8 or above on a scale of 0 to 10), while controlling for age, gender, race/ethnicity, education, self-reported physical health, and sponsor's rank (enlisted versus officer/warrant officer) as a proxy for income.

In addition to the health plan used, self-reported physical health and age were significant predictors of health care ratings, but gender, education, race/ethnicity, and sponsor's rank were not significant predictors. We removed gender, education, race/ethnicity, and sponsor's rank from the final model. On average, healthier beneficiaries and older beneficiaries rated their health care more highly than unhealthy beneficiaries and younger beneficiaries, respectively.

Health care ratings

Controlling for demographic characteristics, USFHP users were significantly more likely to rate their health care highly compared with Prime enrollees who receive care at MTFs (78 percent versus 66 percent). But there was no significant difference between USFHP users, Prime enrollees receiving civilian care, and Select enrollees (75 percent) (Figure 2).

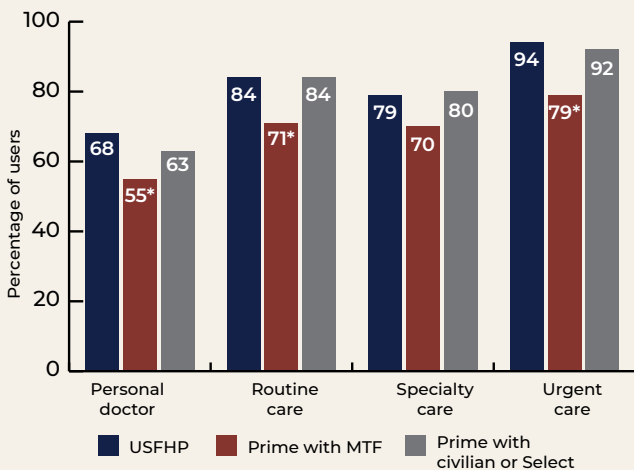


Access to care

USFHP users reported better access to care on several measures compared with Prime enrollees who receive care at MTFs, but access was similar between USFHP users, Prime enrollees receiving civilian care, and Select enrollees. USFHP users were significantly more likely than Prime enrollees using MTFs to report having no problem finding a personal doctor they were happy with (68 percent versus 55 percent). They were also more likely to report usually or always being able get routine and urgent care when needed, compared with Prime enrollees using MTFs (84 percent versus 71 percent for routine care and 94 percent versus 79 percent for urgent care). However, they were equally likely to report accessing specialty care when needed (79 percent versus 70 percent) (Figure 3).

USFHP users were just as likely as Prime enrollees receiving civilian care or Select enrollees to report having no problem finding a personal doctor they were happy with. USFHP users were also just as likely as Prime enrollees receiving civilian care or Select to report usually or always getting routine, specialty, and urgent care when needed (Figure 3).

Figure 3. Access to urgent, routine, and specialty care, by plan

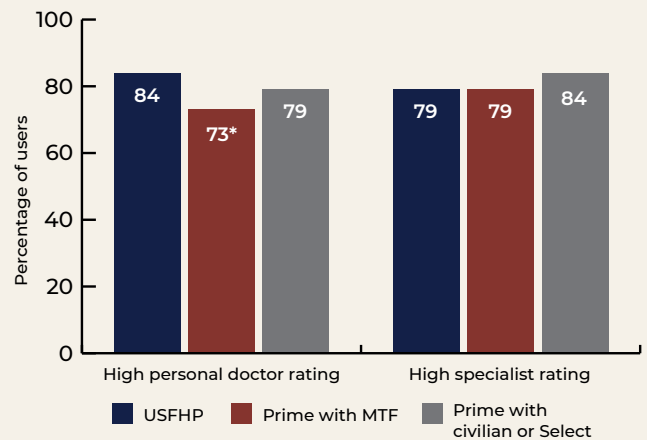


*Significantly different from USFHP, $p < 0.05$.

Satisfaction with care

USFHP users were more satisfied with their personal doctors than were Prime enrollees receiving care at MTFs; however, the two groups were equally satisfied with their specialists. Eighty-four percent of USFHP users rated their personal doctor highly (a score of 8 or above on a scale of 0 to 10), compared with only 73 percent of Prime enrollees using MTFs. But there was no difference between USFHP users, Prime enrollees receiving civilian care, and Select enrollees in terms of satisfaction with their personal doctors or specialists (Figure 4).

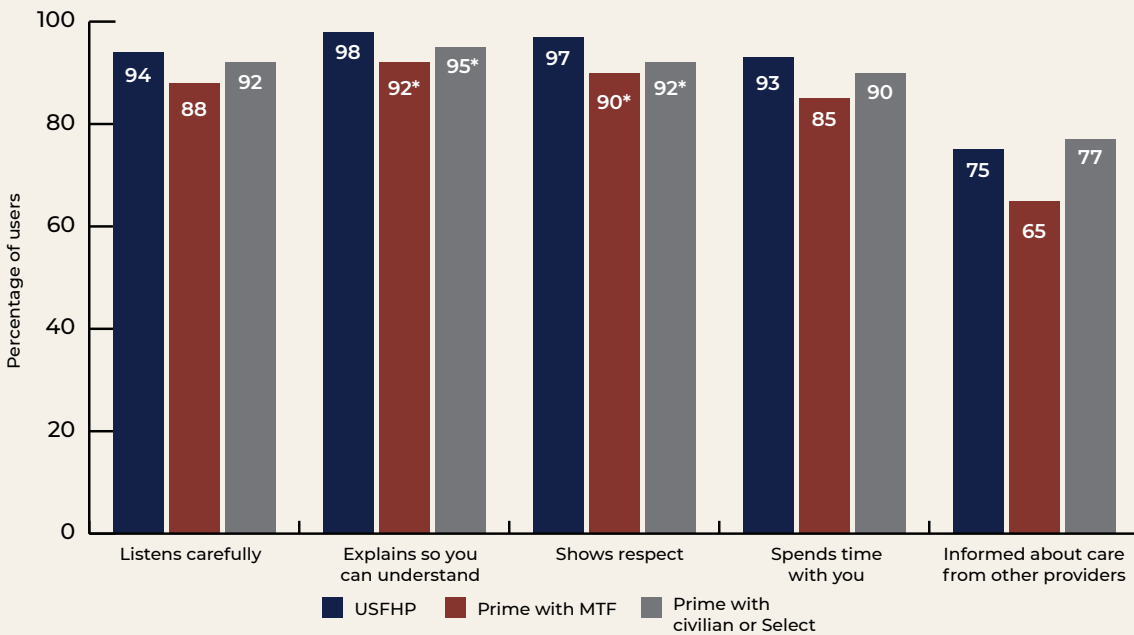
Figure 4. High ratings of personal doctors and specialists, by plan



*Significantly different from USFHP, $p < 0.05$.

To explore why USFHP users rate their personal doctors more highly than do Prime enrollees receiving care at MTFs, we examined several measures of personal doctors' communication. Prime enrollees using MTFs, Prime enrollees receiving civilian care, and Select enrollees were just as likely as USFHP users to report that their personal doctor usually or always listened carefully, spent enough time with them, and was informed about care received from other providers. However, USFHP users were more likely than Prime or Select users to report that their doctors explained things in an easily understandable way and showed respect (Figure 5).

Figure 5. Personal doctors' communication, by plan



*Significantly different from USFHP, $p < 0.05$.

Conclusion

Our findings partly support USFHP's claim to offer "exceptional member satisfaction—the best in all of TRICARE" (TRICARE 2016). USFHP users are significantly more likely than Prime enrollees who use MTFs to rate their health care highly, even after controlling for demographic differences. However, Prime enrollees who receive civilian care and Select enrollees are just as likely as USFHP users to rate their care highly. And although USFHP users reported better access and greater satisfaction on some measures than did Prime enrollees using MTFs, there was virtually no difference between USFHP and Prime enrollees receiving civilian care and Select enrollees.

Furthermore, despite USFHP's superior performance on several measures, we cannot be certain that USFHP itself caused these higher health care ratings. Other, unobserved factors may be driving beneficiaries' choice of plan and their satisfaction that we cannot directly assess with the data and methods we used.

Our analysis focused only on the regions where USFHP is available, but regional differences could still exist. In future analyses, we recommend exploring the differences between USFHP, Prime, and Select in each of the six regions. This will enable the Defense Health Agency to examine market-specific differences and to use USFHP as a model for improving ratings among Prime enrollees who are receiving care at MTFs in those markets.

References

Military Health System. "Elements of the MHS." n.d. Available at <https://www.health.mil/About-MHS/MHS-Elements>. Accessed August 27, 2019.

TRICARE. "About Us." Last updated June 2018a. Available at <https://www.tricare.mil/Plans/HealthPlans>. Accessed August 27, 2019.

TRICARE. "US Family Health Plan." Last updated December 2018b. Available at <https://www.tricare.mil/Plans/HealthPlans/USFHP>. Accessed August 27, 2019.

USFHP Alliance. "Update to the US Family Health Plan Alliance Brief to Senate Staff." March 17, 2016. Available at <http://www.usfhpnw.org/about/news/2016/Q3/us-family-health-plan-alliance>. Accessed August 27, 2019.

Sources

"FY2016 Health Care Survey of Department of Defense Beneficiaries." N = 28,548. The response rate was 9.6 percent. The Q1 survey was fielded from October 7, 2015, to January 19, 2016. The Q2 survey was fielded from January 7 to March 31, 2016. The Q3 survey was fielded from March 15 to June 15, 2016.

"FY2017 Health Care Survey of Department of Defense Beneficiaries." N = 44,218. The response rate was 12.3 percent. The Q1 survey was fielded from October 12, 2016, to January 31, 2017. The Q2 survey was fielded from January 9 to March 31, 2017. The Q3 survey was fielded from March 1 to May 15, 2017. The HEDIS survey was fielded from February 6 to April 24, 2017.

"FY2018 Health Care Survey of Department of Defense Beneficiaries." N = 45,456. The response rate was 12.5 percent. The Q1 survey was fielded from October 18, 2017, to January 31, 2018. The Q2 survey was fielded from January 3 to March 30, 2018. The Q3 survey was fielded from March 1 to May 18, 2018. The HEDIS survey was fielded from February 14 to April 30, 2018.

"FY2019 Health Care Survey of Department of Defense Beneficiaries." N = 26,917. The response rate was 8.9 percent. The Q1 survey was fielded from October 5, 2018, to January 31, 2019. The Q2 survey was fielded from January 4 to March 29, 2019. The Q3 survey was fielded from March 5 to May 21, 2019.

Endnotes

¹ Beneficiaries enrolled by September 30, 2012, can remain in USFHP regardless of age. After September 30, 2012, USFHP only accepts new members under age 65. Military retirees who are under age 65 and enroll after September 30, 2012, will be required to leave the plan and transition to Medicare once they turn 65.