Defense Health Agency

TSS Issue Brief

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Beneficiary Access to Primary Care: Trends Under TRICARE's PPO Health Plan

The Military Health System serves more than 9 million beneficiaries, including military personnel, retirees, and family members. Over the past decade, TRICARE-insured family members of active duty personnel, retirees and their dependents, and inactive reservists and their families have increasingly relied on civilian providers for health care. At the same time, TRICARE coverage options for non-active duty beneficiaries have changed, and national health care policies have changed in ways that affect the U.S. health care system as a whole—and might have affected access to these providers. This issue brief explores these topics, presenting recent trends in self-reported access to a personal doctor among non-active duty beneficiaries of TRICARE's preferred provider organization (PPO) plan. It also discusses trends in the acceptance of new TRICARE patients by civilian primary care providers (PCPs).

Background

Changes to TRICARE's PPO options might have affected beneficiary experiences. On January 1, 2018, TRICARE's Standard and Extra plans, which in combination resembled a PPO, were replaced by TRICARE Select—a single PPO plan that provides access to both network and non-network care. Before 2018, beneficiaries who were not enrolled in Prime (TRICARE's health maintenance organization plan) could choose to use Standard or Extra benefits at the point of service. But to use Select coverage, beneficiaries had to enroll in Select during open enrollment, which occurs once a year, essentially locking Select users into a health plan with a network of civilian providers. Under Select, and previously under the Standard/Extra combination, civilian providers who elect to treat TRICARE patients are reimbursed according to a fee schedule similar to Medicare's. These providers may also contract with TRICARE's managed care support contractors to join TRICARE's civilian network, through which beneficiaries receive lower-cost care through TRICARE Prime and Select.

- **This issue brief presents recent trends in self-reported access to a personal doctor among users of TRICARE's PPO plan and the acceptance of new TRICARE patients by civilian primary care providers.**
- **Recent changes to TRICARE coverage and the U.S. health care system overall might have affected access to care for TRICARE's PPO users, who increasingly rely on civilian providers.**
- **We found that:**
  1. **Nationwide, self-reported access to care and TRICARE acceptance by providers fell from 2012–2015 to 2017–2020.**
  2. **State trends varied in terms of access to personal doctors from 2012–2015 to 2017–2020; some states showed improvement, and some showed declines.**

Changes to U.S. health care policy intensified the demand for health care and strained provider capacity. In 2010, the Affordable Care Act (ACA) brought sweeping changes to the U.S. health care industry that could have affected the capacity of civilian providers and, therefore, their ability and willingness to accept TRICARE patients. In particular in 2014, 26 states expanded Medicaid eligibility to cover low-income childless adults (the number of states has since grown to 38). Evidence on the ACA's impact on access to care indicates that cost-related barriers to obtaining care declined after 2014, reflecting an increase in insurance coverage, but difficulty in getting appointments and long wait times to receive care increased (Miller and Wherry, 2019).

Data and methods

To assess trends in access to care for TRICARE PPO users, we used data from the TRICARE Select Surveys. The TRICARE Select Survey of Beneficiaries (TSS-B) and of Providers (TSS-P) have both been fielded annually from 2008 to 2020 in three four-year cycles. Among other topics, the TSS-B asks non-Prime beneficiaries about their experiences accessing care, and the TSS-P asks physicians about their acceptance of TRICARE patients. Each survey cycle covered the entire U.S. over four years—first in 2008–2011, then in 2012–2015, and most recently in 2017–2020.

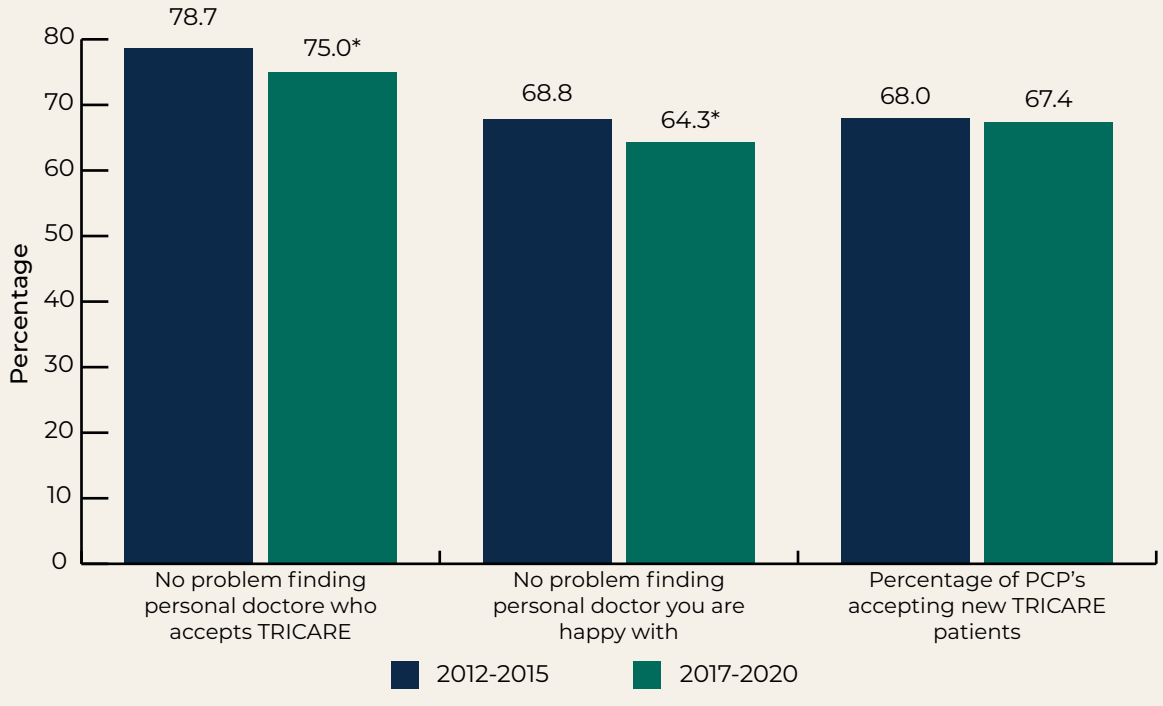
To examine changes in access, we compared national and state-level estimates from the two most recent TSS survey cycles (2012–2015 and 2017–2020).[1] Note that the TSS reflects respondents' experience with health care in the year before completion of the survey; the 2014 Medicaid expansions began to take effect toward the end of the 2012–2015 survey cycle and continued to be enacted through 2020 in states that adopted the expansions later.

Findings

Nationwide, self-reported access to personal doctors and TRICARE acceptance by PCPs fell from 2012–2015 to 2017–2020.

Access to personal doctors among TRICARE PPO users fell significantly from 2012–2015 to 2017–2020. PCPs' acceptance of new TRICARE patients also declined modestly over the same period, though this decline was not statistically significant. See Figure 1 which shows PPO users' responses to two access measures, no problem finding a personal doctor who accepts TRICARE and no problem finding a personal doctor with whom they are happy, as well as the proportion of PCPs who accepted new TRICARE patients in the two most recent TSS survey cycles.

Figure 1. National rates of access to primary care for TRICARE PPO users, 2012–2015 and 2017–2020



Note: the proportions of beneficiaries who reported no problem finding a personal doctor who accepts TRICARE and no problem finding a personal doctor with whom they are happy were measured in the TSS-B while the proportion of PCPs who accepted new TRICARE patients was measured in the TSS-P

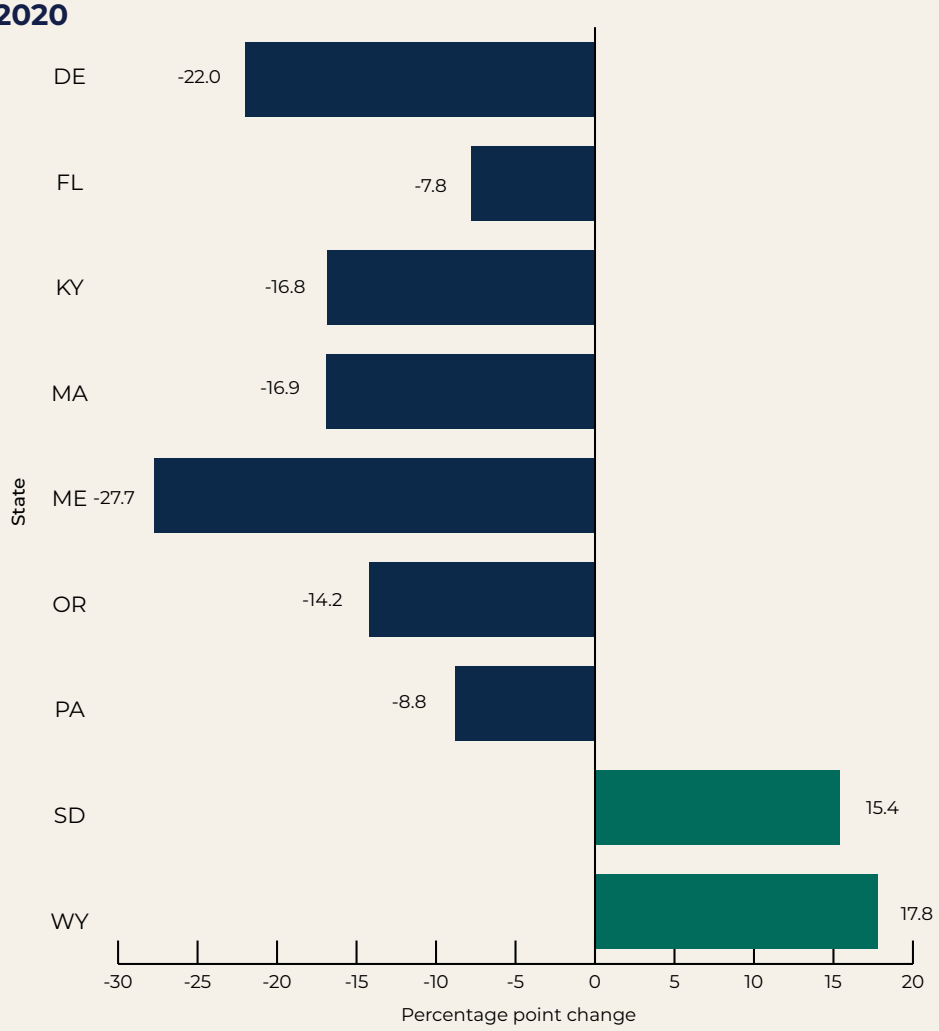
*The change between the 2012–2015 and 2017–2020 survey cycles was statistically significant ($p < 0.05$).

At the state level, some states saw increases and some saw declines in access to personal doctors from 2012–2015 to 2017–2020.

Access to a personal doctor did not always decline at the state level. Measures of access to personal doctors rose in some states and decreased well more than they did nationally in some others. But most states had no statistically significant differences in access measures.

TRICARE PPO users who reported no problem finding a personal doctor who would accept TRICARE. As shown in Figure 2, nine states had statistically significant changes in this measure. Maine had the largest drop—from 92 percent to 64 percent (28 percentage points)—and six other states had statistically significant decreases, from 9 to 22 percentage points. In two states (South Dakota and Wyoming), the percentage of beneficiaries who reported no problem finding a personal doctor who would accept TRICARE rose significantly (increases of 15 and 18 percentage points, respectively). Texas had percentages lower than the national average during both periods, and Iowa, Nebraska, and Wisconsin had percentages higher than the national average in both periods, though none of these states saw statistically significant changes and do not appear in Figure 2.

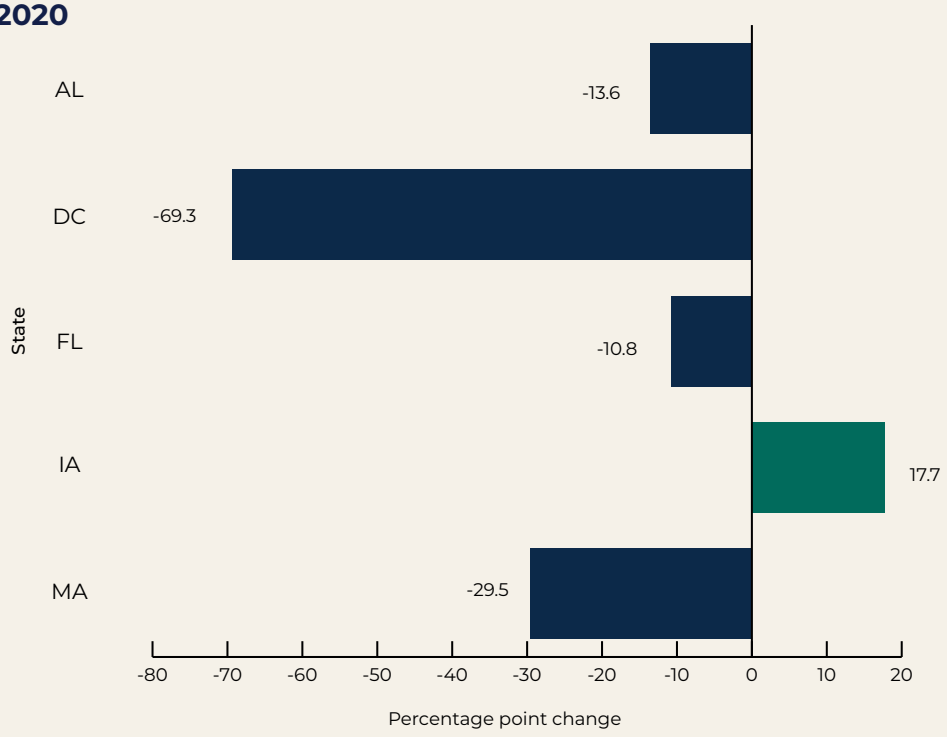
Figure 2. State-level changes in the percentage of TRICARE PPO users who had no problem finding a personal doctor who accepts TRICARE, 2012–2015 to 2017–2020



Note: The states shown had a statistically significant change ($p < 0.05$) from 2012–2015 to 2017–2020.

TRICARE PPO users who reported no problem finding a personal doctor with whom they are happy. The percentage of PPO users who said they had no problem finding a personal doctor they liked also fell significantly in several states (Figure 3). Iowa was the only state that had a significant increase over time. Nebraska and Pennsylvania had percentages greater than the national average during both periods, though they did not see statistically significant changes over time. No states were below the national average during both periods.

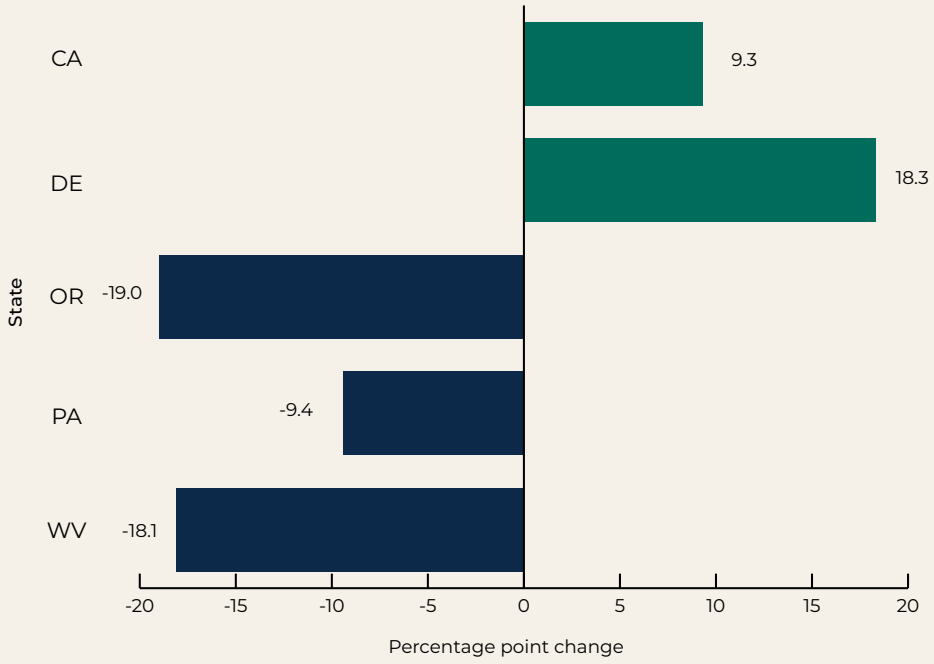
Figure 3. State-level changes in the percentage of PPO users who had no problem finding a personal doctor with whom they were happy, 2012–2015 to 2017–2020



Note: The states shown had a statistically significant change ($p < 0.05$) from 2012–2015 to 2017–2020.

Acceptance of TRICARE among PCPs. In California and Delaware, the percentage of PCPs accepting new TRICARE patients in 2017–2020 was higher than in 2012–2015 (Figure 4), and the rate in Delaware rose from below the national average in 2012–2015 to above the national average in the later period. But in Oregon, Pennsylvania, and West Virginia, the percentage of PCPs accepting new TRICARE patients dropped significantly from the earlier to the later period. In 10 states, acceptance was significantly above the national average in both periods (Alabama, Arkansas, Iowa, Kansas, Kentucky, Mississippi, Missouri, South Carolina, Tennessee, and Virginia) and in 2 states (New York and Washington) acceptance was consistently below the national average, though these states did not see statistically significant changes.

Figure 4. State-level changes in the percentage of PCPs who accept new TRICARE patients, 2012–2015 to 2017–2020



Note: The states shown had a statistically significant change ($p < 0.05$) from 2012–2015 to 2017–2020.

Discussion

The changes in access to primary care seen between 2012-2015 and 2017-2020 may be a result of several factors, including the implementation of new TRICARE contracts in 2017 and the change from Standard/Extra to Select. Because Select is an enrollment-based plan rather than a set of benefits that could be accessed at the point of service (as Standard/Extra was), the change to Select could have induced more demand for civilian providers by essentially locking TRICARE beneficiaries into plans that relied more heavily on these providers.

TRICARE beneficiaries might also have more trouble finding civilian providers as a result of heightened demand stemming from the ACA. Medicaid expansions and other ACA provisions likely strained the capacity of civilian providers, as previously uninsured patients sought more services. Indeed, some of the state-level trends in access presented in this report align with patterns of state adoptions of Medicaid expansions; although not conclusive, this may indicate a negative relationship between Medicaid expansion and access to care for TRICARE beneficiaries. Of the seven states that saw statistically significant declines in the share of beneficiaries who report no problem finding a personal doctor, all but one had expanded Medicaid eligibility by 2020, whereas neither of the two states that saw statistically significant increases had expanded Medicaid eligibility by 2020.

Finally, changes in TSS sampling and survey methods between the 2012–2015 and 2017–2020 cycles could have affected our findings. However, we adjust our TSS measures to account for changes in the sample over time and the comparisons we make both between time periods and across states likely reflect real variations in access and acceptance.

References

Miller, S., and L.R. Wherry. "Four Years Later: Insurance Coverage and Access to Care Continue to Diverge Between ACA Medicaid Expansion and Non-Expansion States." *AEA Papers and Proceedings*, vol. 109, May 2019, pp. 327–333.

Sources

2012-2015 and 2017-2020 TRICARE Select Survey of Beneficiaries. N = 35,242 and 27,719 in 2012-2015 and 2017-2020, respectively. The response rate was 20.6 percent in 2012-2015 and 19.7 percent in 2017-2020. The 2012-2015 survey was fielded from January 2013 to January 2016. The 2017-2020 survey was fielded from November 2016 to March 2020.

2012-2015 and 2017-2020 TRICARE Select Survey of Providers. N = 50,331 and 38,258 providers in 2012-2015 and 2017-2020, respectively. The response rate was 38.9 percent in 2012-2015 and 27.8 percent in 2017-2020. The 2012-2015 survey was fielded from December 2012 to January 2016. The 2017-2020 survey was fielded from January 2017 to January 2020.

Endnotes

[1]TSS-B access measures were adjusted to account for changes in sample demographic characteristics between the two survey cycles.