Defense Health Agency

**TSS** Issue Brief

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# Beneficiary Access to Specialists: Trends Under TRICARE's PPO Health Plan

The Military Health System (MHS) serves roughly 9.6 million beneficiaries, including military personnel, retirees, and family members. TRICARE-insured family members of active duty personnel, retirees and their dependents, and inactive reservists and their families have increasingly relied on civilian providers, rather than military facilities, over the past decade. 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 providers. This issue brief, along with two others focusing on primary care and mental health, explores these topics.[1] It presents recent trends in self-reported access to specialists 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 specialists.

## 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 (1) self-reported access to specialists among users of TRICARE's PPO plan and (2) the acceptance of new TRICARE patients by civilian specialists.**
- **Recent changes to TRICARE coverage, TRICARE contracts, 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 specialists and TRICARE acceptance by specialists fell from 2012–2015 to 2017–2020.**
  2. **State trends varied in terms of access to specialists from 2012–2015 to 2017–2020; some states showed improvement, and some showed declines.**

*New TRICARE contracts might have reduced reimbursement for providers.* In 2017, MHS negotiated and enacted new TRICARE contracts with civilian provider networks. Several key changes associated with these new contracts might have affected providers: geographic TRICARE service regions were changed from three to two regions (East and West, eliminating the South and North regions), new contractors were selected to administer civilian provider networks in nearly all areas, and, as in prior contracts, contractors were encouraged to negotiate discounts in provider reimbursement rates (Government Accountability Office [GAO] 2020). The shake-up of provider networks and reimbursement schedules could have made specialists reluctant to accept new TRICARE patients.

*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 reduced the capacity of civilian providers—and thus curbed their ability and willingness to accept TRICARE patients. In particular, 26 states expanded Medicaid eligibility in 2014 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 for care increased (Miller and Wherry 2019). Although the ACA had a major positive impact on utilization of primary or preventive care, its impact on use of specialty care was less pronounced. This means that the correlation between ACA policy adoption and access to specialty care among TRICARE PPO users might be weaker than it is for primary care (Wherry and Miller 2016).

## 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).[2] 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 cycle and continued to be enacted through 2020 in states that adopted the expansions later.

## Findings

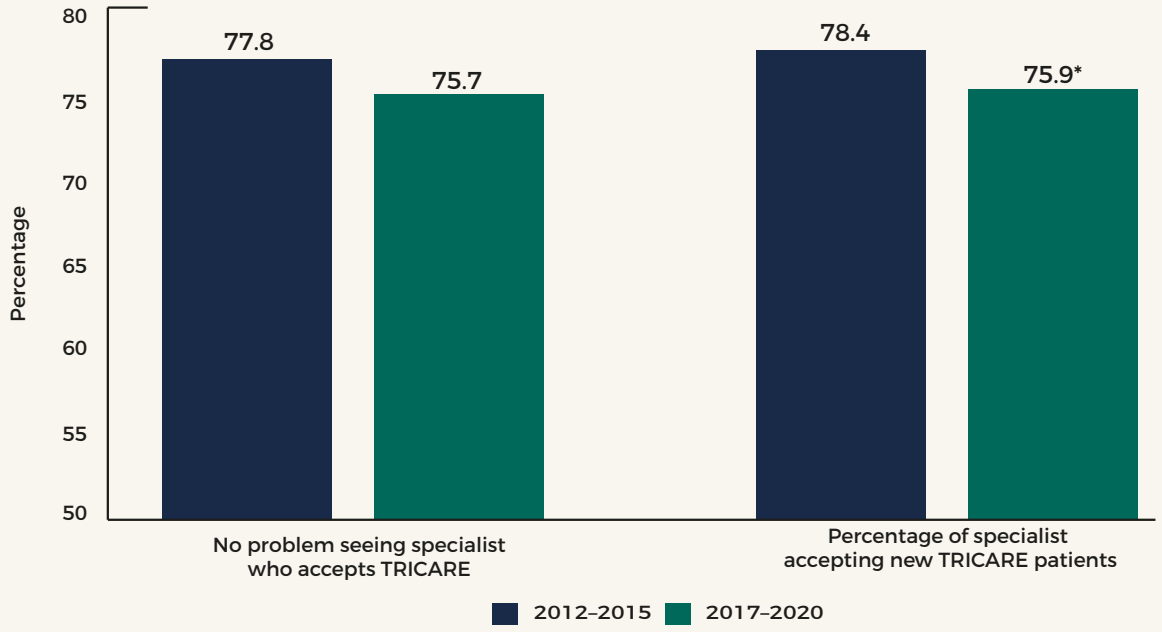
**Nationwide, self-reported access to specialists and acceptance of TRICARE patients by specialists fell from 2012–2015 to 2017–2020.**

Figure 1 (on page 3) shows the share of PPO users who reported no problem finding a specialist who accepts TRICARE patients and the share of specialists who accepted new TRICARE patients in the two most recent TSS survey cycles. Both access to specialists and specialists' acceptance of new TRICARE patients fell from 2012–2015 to 2017–2020, though the drop was only statistically significant for acceptance.

**At the state level, some states saw increases and some saw decreases in access to specialists from 2012–2015 to 2017–2020.**

Access to a specialist did not always decline at the state level. Measures of access rose in some states and decreased well more than the national average in some others. But most states had no statistically significant changes in access measures.

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

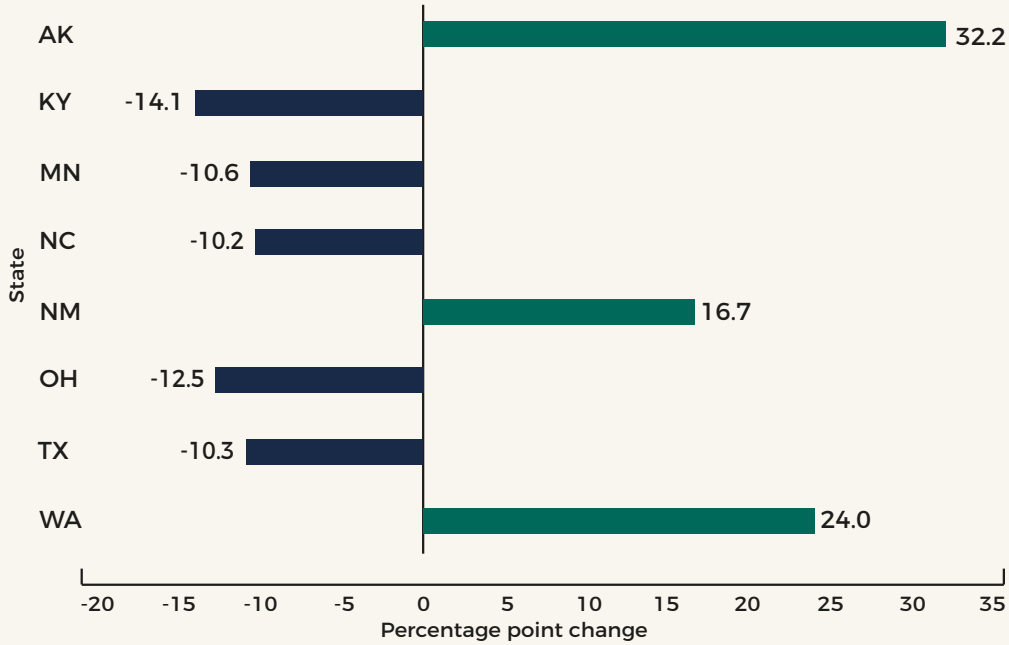



Note: The proportion of beneficiaries who reported no problem finding a specialist who accepts TRICARE was measured in the TSS-B while the proportion of Specialists who accepted new TRICARE patients was measured in the TSS-P .
*The change between the 2012–2015 and 2017–2020 survey cycles was statistically significant ($p < 0.05$).

*TRICARE PPO users who reported no problem finding a specialist who would accept TRICARE.* As shown in Figure 2 (on page 4), eight states had statistically significant changes in this measure. Five states (Kentucky, Minnesota, North Carolina, Ohio, and Texas) saw a significant decrease in specialist access over time, with the largest decline—from 86 to 72 percent—in Kentucky. Three states (Alaska, New Mexico, and Washington) significantly increased their specialist access.

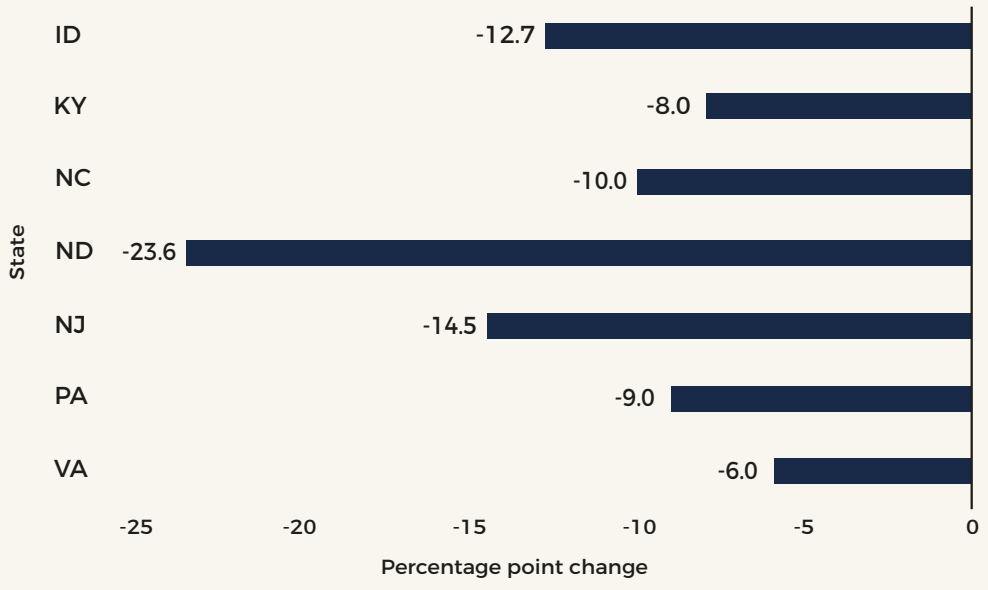
*Acceptance of new TRICARE patients among specialists.* Similar to the national trend, seven states saw a significant drop in their percentage of specialists accepting new TRICARE patients between 2012–2015 and 2017–2020 (Figure 3, on page 4). North Dakota had a particularly large decrease, from 85 percent in the earlier period to 62 percent later. In no state did acceptance rates rise significantly.

## Figure 2. State-level changes in the percentage of TRICARE PPO users who had no problem finding a specialist 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.

## Figure 3. State-level changes in the percentage of specialists 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 results described in this brief are consistent with prior results, suggesting a decline in access to specialists over a period that spans the introduction of Select. In 2020, GAO used 2017–2019 TSS data to compare beneficiaries' experience in the first year of TRICARE Select (2018) to beneficiaries' experience in the last two years of Standard/Extra (2016 and 2017). The agency concluded that beneficiaries rated their TRICARE health care and health plans similarly before and after the introduction of Select, though the percentage who reported problems accessing specialists increased under Select. Because Select is an enrollment-based plan rather than a set of benefits that can 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 rely more heavily on them. Any increase in demand for civilian specialists induced by the launch of Select was not accompanied by an increase in the supply of specialists accepting new TRICARE patients (Figure 1), which might have hindered access to specialty care for Select users in recent years.

The declines in access to specialists between 2012–2015 and 2017–2020 could also be a result of changes to TRICARE's physician network contracts. Some specialists might have stopped accepting new TRICARE patients because of changes in physician networks or lower reimbursement rates in contracts that took effect in 2017. Although the new contracts were designed to improve access and care delivery for TRICARE beneficiaries, contractors were encouraged to seek agreements for discounted reimbursement rates for providers.

TRICARE beneficiaries might also have more trouble finding civilian providers because 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 described in this brief align with patterns of state adoptions of Medicaid expansions. Although not conclusive, this could indicate a negative relationship between Medicaid expansion and access to care for TRICARE beneficiaries. Of the seven states that saw significant declines in the share of specialists accepting new TRICARE patients, all but one 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 adjusted our TSS measures to account for changes in the sample over time, and the comparisons we made between time periods and across states likely reflect real variations in access and acceptance.

## References

GAO. "Defense Health Care: Plans Needed to Ensure Implementation of Required Elements for TRICARE's Managed Care Support Contracts." Report to Congressional Committees, GAO-20-197. Washington, DC: GAO, 2020.

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.

Wherry, L. R., and S. Miller. "Early coverage, access, utilization, and health effects associated with the Afford able Care Act Medicaid expansions: a quasi-experimental study." Annals of internal medicine, vol. 164, no. 12, June 2016, p.p. 795-803.

## 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 Issue Briefs are available at: https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Health-Care-Program-Evaluation/MHS-Patient-Satisfaction-Surveys/Health-Care-Survey-of-DoD-Beneficiaries/Survey-Reports-and-Documents.

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