ISSUE BRIEF

MATHEMATICA Policy Research, Inc.

TIMELY INFORMATION FROM MATHEMATICA

Improving public well-being by conducting high-quality, objective research and surveys

NOVEMBER 2009
NUMBER 6

TRENDS IN INSURANCE COVERAGE

Practical Lessons for Health Reform from the Military Health System

by Thomas Croghan, Kristen Purcell, and Kate Stewart

Many current health reform proposals focus on universal coverage, insurance reform, and cost control. Mathematica presented studies on the military health system at the AcademyHealth 2009 annual research meeting that have timely implications for health care reform. The findings suggest universal coverage with comprehensive health insurance benefits is unlikely to solve many of the problems in our current system without other changes. Policymakers must continue to address important issues such as racial and ethnic disparities, timely access to needed care, and dissatisfaction with care received.

Covering a Diverse Population

The Department of Defense (DoD) operates one of the largest health care systems in the nation, covering more than 9.5 million active duty, retiree, and dependent beneficiaries. Mirroring the challenges faced by public and private health plans, the military health system (MHS) seeks to provide equitable, high quality, affordable health care to a diverse population while reducing spiraling cost growth. Unlike other health plans, the system must also guarantee the medical readiness of its active duty beneficiaries and provide care for the wounded, roles that require greater flexibility and integration than are typical in civilian health plans.

To achieve its mission, the MHS provides medical care through a network of military clinics and hospitals as well as more than 1,700 acute care civilian hospitals, 300,000 civilian physicians, and 60,000 pharmacies across the globe. Uniformed services personnel, retirees, and their dependents are entitled to receive health insurance coverage through TRICARE, the MHS insurance program. MHS administrators have taken steps to improve access to care, including eliminating or reducing premiums and deductibles, doing away with co-payments for active duty beneficiaries and their dependents, and providing lifelong comprehensive health benefits to Medicare-eligible beneficiaries.

A Window into Universal Coverage

The MHS provides an opportunity to examine proposed solutions to vexing problems of interest to policymakers thinking about expansions in health care coverage to socioeconomically diverse populations. All MHS beneficiaries receive a high-quality health insurance benefit and have access to a broad network of providers in this system, which eliminates many variations complicating research on health care.

The MHS also offers health services researchers a window into the challenges that a future health system might face if affordable health insurance is available to all Americans. In addition, innovation is constantly occurring in the system, providing opportunities to study the effects that reforms might have under conditions of universal coverage.

Next, we review the lessons our studies suggest for the architects of our nation's health care system in the future.

Lesson 1: Universal coverage alone will not solve health care disparities. Research indicates that significant racial and ethnic disparities in child health exist across the country, particularly in the prevalence, treatment, and outcomes of children with asthma. These disparities are often attributed to differences in health coverage, access to care, and socioeconomic factors. To investigate the presence or absence of disparities in the MHS, we conducted a retrospective, cross-sectional, cohort study of children

enrolled in TRICARE Prime, a benefit similar to what health maintenance organizations (HMOs) offer. The TRICARE benefit is designed for MHS beneficiaries who primarily use military treatment facilities for health care. The data analyzed include claims in 2007 for all inpatient, outpatient, and prescription drug services delivered by military ("direct-care") or civilian ("purchased-care") providers. Analyses measured differences in asthma prevalence, treatment, and asthma-related potentially avoidable hospitalization (PAH) and non-injury-related emergency department (ED) use for Hispanic, non-Hispanic white, and non-Hispanic African American children with asthma ages 2 to 4, 5 to 10, and 11 to 17 years.

Despite universal health insurance coverage and access to military treatment facilities for these groups, we found evidence of racial and ethnic differences in asthma prevalence, treatment, and outcomes. Compared with white children, African American children were significantly more likely to be diagnosed with asthma, more likely to have an asthma-related hospitalization and/or ED visit, and less likely to visit an asthma specialist. However, they were more likely to have filled a prescription for asthma-related medications, especially controller medications such as inhaled corticosteroids (see table). Although not as dramatic as the differences between African American children and white children, significant differences existed between Hispanic children and white, non-Hispanic children. In particular, Hispanic children in all age groups were more likely than white, non-Hispanic children to be diagnosed with asthma, more likely to have an asthma-related hospitalization and ED visits, less likely to see an asthma specialist, and less likely to fill a prescription for an asthma-related medication.

For this cohort of children enrolled in the MHS, universal comprehensive health insurance coverage did not eliminate racial and ethnic disparities. Although the source of the differences in prevalence and outcome is not clear, our results suggest that both need- and preference-based factors are involved. For example, although African American children with asthma are more likely to receive inhaled corticosteroids, reflecting their increased need, some observed differences also appear to result from factors unrelated to preference or need. For example, despite their greater need, African American children with asthma are less likely to receive care from specialists. These factors, and others unrelated to health care such as environmental exposure and genetic predisposition, require further exploration. What is clear

TABLE 1

ASTHMA-RELATED DIAGNOSES, OUTCOMES, AND TREATMENTS, BY RACE AND ETHNICITY

	Hispanic	African American, non-Hispanic	White, non-Hispanic	*p*-value
All children, N	76,044	182,484	564,372	
Diagnosed with asthma, N (%)	6,107 (8.0)	17,495 (9.6)	35,664 (6.3)	<0.0001
Outcomes among children diagnosed with asthma, %				
ED use for asthma	21.2	24.9	18.0	<0.0001
Preventable hospitalization for asthma	1.96	2.64	1.32	<0.0001
Treatments among children diagnosed with asthma, %				
Outpatient care				
Specialist visits for asthma, any	9.6	9.6	12.9	<0.0001
Prescription drug use				
Any asthma drug prescription	70.9	76.0	73.4	<0.0001
Any inhaled corticosteroids	31.1	34.7	31.9	<0.0001

N = number

CHOICES ARE LIMITED

Beneficiaries assigned to a military treatment facility are normally assigned to a specific primary care manager. Those with a civilian primary care manager report receiving a short list of providers from which to choose. They often discover that many providers on the list no longer accept TRICARE or are not taking new patients:

> I was under the impression that I could select a doctor at my own will. And as long as they accepted TRICARE Prime, I was in. And that's not how it worked for me. I was given a list that I had to select off of. That's a whole different process than, you know, pick the doctor of your liking. So I went down the list and called and a lot of them were not accepting new patients at the time. So I had to get in where I could.

from our study is that universal health insurance did not eliminate disparities in health care for children with asthma. Eliminating these disparities will likely require a multifaceted approach encompassing both medical and public health interventions.

Lesson 2: Align expectations with experience. Understanding patients' experiences and their perceptions of care can provide critical information to improve health care delivery and health outcomes. Research has shown that having a regular source of treatment from a primary care provider is one important determinant of patient experiences and perceptions. A quarterly survey of TRICARE enrollees, the Health Care Survey of DoD Beneficiaries, assesses patient experiences among all categories of beneficiaries, including uniformed services personnel, retirees, and dependents. Our prior analyses of the survey showed that TRICARE satisfaction scores for getting timely care when needed fall significantly below civilian benchmarks.

To better understand these findings, Mathematica conducted 20 focus groups with active duty dependents, retirees, and retiree dependents in regions served by four military treatment facilities to hear in beneficiaries' own words the attitudes and beliefs they held about access to and delivery of services provided within the MHS. In particular, participants cited provider choice as a key component of their experiences. The idea of choice has long been a hallmark of the American health care system. Americans often take as a point of pride that they choose their doctors, hospitals, and health plans, but health care choices in this country are often much more constrained than we commonly believe. For example, choice of health plan is limited by employers, choice of providers is limited by insurers, and choice of treatment is limited by the doctors we select.

When enrolling in TRICARE Prime, all beneficiaries are normally asked to "choose" a primary care manager. Yet we heard from many participants that their choice is severely limited, a constraint that significantly reduced their satisfaction. The initial assignment to either a military or civilian primary care manager is often completely out of a patient's control. In fact, although the conventional wisdom suggests that many beneficiaries opt for civilian care, the reality appears to be that many or most are "pushed out" of their local military treatment facility because active duty personnel receive priority over other beneficiaries, resulting in overcrowding and provider shortages.

Beneficiaries' sense that their choices are limited is exacerbated by their perception that physicians find TRICARE a difficult organization to work with, both in terms of administrative burdens and low reimbursements. They presume that these issues prevent high quality, highly sought-after civilian doctors from accepting TRICARE, which ultimately limits beneficiaries' choice of provider.

MORE OPTIONS ARE DESIRED

Lack of provider choice is especially frustrating for those with chronic medical conditions. Making an informed selection of a primary care manager is critical to receiving the care they need and maintaining continuity in their treatment regimen. As one woman explained:

> I am the mother of a specialty child. He has Down's, and he's also autistic. So from our aspect, it is very, very frustrating that we cannot be assigned to the pediatrician, because she's the one who is most knowledgeable. He loves her. They have a good relationship. But I can't see her because we're not assigned to her. Then I have to see some other guy, and then I've got to explain his history for the past 11 years. It's very frustrating.

This woman and many beneficiaries like her view assignment to a primary care manager, rather than informed choice of one, as serving the needs of TRICARE rather than the patient.

Focus group participants wanted to have a choice not only among providers but also between a primary care manager at the military treatment facility

and one in the civilian network. These findings are consistent with studies of primary care "gatekeeper" models demonstrating that a lack of choice erodes the trust necessary for a patient to establish an ongoing relationship with a doctor.

Lesson 3: Strengthening primary care could improve access to and satisfaction with health care. Beneficiaries were concerned about access to and continuity of care from their primary care manager. In particular, few direct care participants—those receiving care from military providers—felt they had a "personal" doctor or that their care was being actively managed. They noted that because of rotations and deployments, primary care managers could in many instances be switched abruptly, sometimes without notice. This was in contrast to their experiences with the civilian-based purchased care system, which they felt provides better opportunities for long-term doctor-patient relationships and better access to physicians.

COMMUNICATION IS KEY

Among direct care participants in the focus groups, communication with a primary care manager was highly valued but rare:

> I had the fortune of having Captain [X] as our provider and he just left. Breaks my heart. He had an internet email service … and about 95 percent of our care could be taken care of with emails. And now that that's gone, it's going to be really difficult.

Consistent with the findings of prior research on managed care systems, continuity of care and access to physicians are central to how patients perceive their health care experiences. Our study reveals that these issues are particularly salient in the military direct care system, reinforcing past studies that demonstrate the importance of the relationship between patients and their physicians.

Looking Ahead

Even if current health care reform proposals focused on universal coverage, insurance reform, and cost control are successful, some of the most vexing problems in the current system are likely to persist. Universal coverage in the military health system has not eliminated racial and ethnic disparities, so a more multifaceted approach may be required. Reforms should also emphasize primary care enhancements more than current proposals, which highlight payment reforms to reduce workforce shortages, do. Other efforts that fall under the rubric of the patient-centered medical home will help to establish the infrastructure needed for better coordination among providers. Facilitating the relationship between patients and their physicians is a core issue for patients. Further, although research demonstrates the consequences of restricting choice as a cost containment mechanism, current proposals have been criticized as lacking sufficient cost controls. Health plans may have to use the few tools at their disposal, including restricting networks that limit beneficiary choices, to slow the growth of costs.

Innovation in the military system's delivery of health care is relevant to both public and private insurers. Because the military system is government-run, the lessons it suggests are relevant for the "public option" being debated as part of health care reform. In particular, some policymakers are concerned that a government-operated insurance plan will have a significant competitive advantage over private plans. Although our research does not address price or premium competition, it does suggest that a government-run plan would not necessarily enjoy a competitive advantage. Despite the richness of its benefit, the military system faces considerable challenges with access, patient satisfaction, care coordination, and other primary care functions.

Our research also suggests steps that policymakers can take either during the development or implementation of reforms. First, our disparities findings point to the need for a broad-based approach to this problem, including attention to individual, health care system, and public health and environmental factors. Second, our studies highlight the importance that patients place on having a personal doctor who is available when needed. Current proposals that provide payment incentives to expand the primary care workforce and create patient-centered medical homes should be enhanced and strengthened. Finally, choices in health plan, provider, and treatment should be either made real, or promises regarding these choices should be modified to fit reality.

For more information, contact Thomas Croghan, M.D. and senior researcher, at tcroghan@mathematica-mpr.com, (202) 554-7532.