Space Available Beneficiaries and TRICARE Prime: Identification of Factors that Influence Enrollment

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14. ABSTRACT
Despite efforts to encourage beneficiaries of the National Naval Medical Centers (NNMC) to enroll with TRICARE Prime, over 21,000 beneficiaries received their care on space-available basis. Care provision on a space-available basis can result in undesirable outcomes for the organization and for the individual beneficiary, many of which may be moderated by enrollment with TRICARE. A questionnaire was developed and administered to 850 randomly selected eligible beneficiaries in order to gain an understanding of the factors that affect a beneficiarys decision to enroll in TRICARE Prime. Beneficiaries reported different reasons for not enrolling in Prime and for disenrolling. Descriptive analysis also revealed that half of the respondents do not intend to enroll with Prime. Multinomial logistic regression analysis indicates that females and beneficiaries with sponsor rank classification of officer are twice as likely to report that they do not intend to enroll with Prime compared with those that are unsure about their decision ($\psi = 2.068$, $p < .05$; $\psi = 2.073$, $p < .10$). These findings have important implications for marketing efforts and planning at the organizational level.

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Abstract

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Beneficiaries reported different reasons for not enrolling in Prime and for disenrolling. Descriptive analysis also revealed that half of the respondents do not intend to enroll with Prime. Multinomial logistic regression analysis indicates that females and beneficiaries with sponsor rank classification of officer are twice as likely to report that they do not intend to enroll with Prime compared with those that are unsure about their decision ($\psi = 2.068$, $p < .05$; $\psi = 2.073$, $p < .10$). These findings have important implications for marketing efforts and planning at the organizational level.

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Introduction

Overview of National Naval Medical Center

National Naval Medical Center (NNMC) is located in Bethesda, Maryland, approximately eight miles northwest of the District of Columbia. With approximately 5,000 staff members (includes active-duty, civilians, and contractors), the medical center is one of the largest in the National Capital Area (NCA). The primary mission of NNMC is to ensure operational readiness of Uniformed Members and to provide primary and specialty care to them and to their families. In addition, NNMC provides medical care for authorized government officials including the President, Vice-President, members of Congress, Justices of the Supreme Court, foreign military and embassy personnel, and other beneficiaries as designated by the Secretary of the Navy. NNMC also serves as a Graduate Medical Education (GME) teaching facility and as a referral center for military medical facilities worldwide.

Conditions that Prompted the Study

In response to rapidly rising costs and beneficiary concerns about access to military health care, the Department of Defense (DoD) implemented its own healthcare reform program called TRICARE (GAO-02-284, 2002). The goals of TRICARE were to provide better access and high quality medical care while containing costs. TRICARE currently offers healthcare coverage to approximately 6.6 million active-duty and retired military personnel under age 65, and their dependents and survivors. An additional 1.5 million retirees aged 65 and over can also obtain

medical care on a space-available basis (GAO-02-284).

As an integral part of the Military Health System (MHS), NNMC offers beneficiaries in the catchment area three health plans: TRICARE Prime, TRICARE Extra, or TRICARE Standard. Among the three options, TRICARE Prime is the only one that requires enrollment. Although active-duty military members are required to enroll in TRICARE Prime, active-duty family members, retirees and their family members can select any of the three options.

TRICARE Prime, a managed care option similar to a civilian health maintenance organization (HMO), offers less out-of-pocket costs than any of the other TRICARE options. Except for retirees and their family members, TRICARE Prime enrollees do not have to pay enrollment fees, annual deductibles or co-payments for services received in the TRICARE network. Enrollees have guaranteed access to care and are assigned to a primary care manager who is responsible for managing their healthcare needs and for coordinating referrals for specialty care. TRICARE Prime also offers portability, which allows enrollees to move from one TRICARE region to another without the need to disenroll in one region and reenroll in another, except when moving to and from an overseas assignment. And finally, TRICARE Prime requires less paperwork, especially for services received outside a military treatment facility (MTF).

TRICARE Extra and TRICARE Standard options are available for all TRICARE beneficiaries who choose not to enroll in TRICARE Prime. Beneficiaries who choose either plan do not have to pay annual enrollment fees; however, they are responsible for annual

deductibles and co-payments. These beneficiaries may see any provider they choose, and the government will share the costs with the beneficiaries after deductibles are met (TRICARE Handbook, 2003).

Approximately 109,597 beneficiaries reside within the NNMC catchment area[1] and are eligible to receive care within the military healthcare system (TRICARE Operations Center Eligibility Reports, 2002). As shown in Figure 1, 45% of the eligible beneficiaries are retirees and their family members; many are under the age of 65. Approximately 26% of this population is composed of active-duty military and 24% is composed of active-duty family members.

Despite the number of eligible beneficiaries in the area, not all of them can be enrolled in TRICARE Prime. For example, beneficiaries age 65 and over are not generally enrolled in TRICARE Prime. Also, other beneficiaries, including foreign military personnel and embassy diplomats are eligible to receive care but cannot enroll in TRICARE Prime.

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[1] The TRICARE Operations Center defines catchment area as a 40-mile radius around an MTF. In the case of NNMC, it should be noted that the NNMC catchment area overlaps with two other large MTFs and several branch clinics.

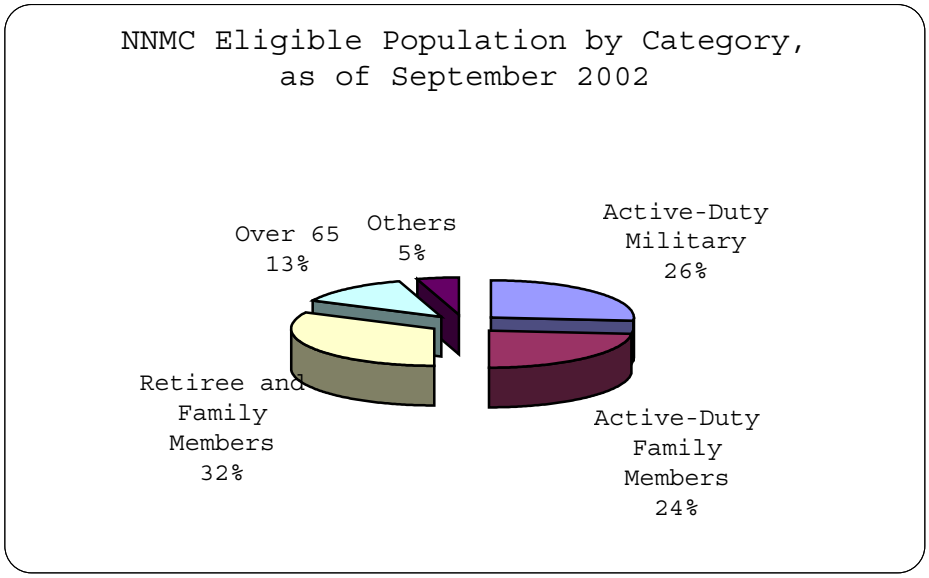

Figure 1. Percentage of eligible beneficiaries in the NNMC catchment area.

As of December 2002, the number of beneficiaries enrolled at NNMC was 31,456, including 27,024 enrolled in TRICARE Prime and 4,432 enrolled in TRICARE Plus (TRICARE Program and Beneficiary Category Enrollment Reports, 2002). TRICARE Plus is the newest primary care enrollment program offered to retirees via invitation at selected MTFs. This program allows beneficiaries, not enrolled in Prime, an opportunity to enroll with their local MTF, provided they meet certain criteria established by participating MTFs. NNMC's eligibility criteria are restricted to patients 65 years and older. In addition, eligible beneficiaries can only enroll in TRICARE Plus if capacity exists for the participating MTF. As of December 2002, the maximum allowable enrollment at NNMC was set at 37,180 (NNMC Clinic PCM Enrollment Report, 2002). Therefore, capacity existed for up to approximately 5,700 additional enrollees at NNMC.

TRICARE Northeast or Region 1 was one of the last TRICARE regions to implement TRICARE. As shown in Figure 2, the percentage of beneficiaries enrolled in TRICARE Prime increased substantially from October 1997 through October 2002 (TRICARE Program and Beneficiary Category Enrollment Reports, 2002). However, despite aggressive efforts by NNMC to encourage the eligible, non-enrolled population to enroll in TRICARE Prime, a considerable portion of these beneficiaries have opted to remain with civilian healthcare organizations and, at times, have sought care at NNMC on a space-available basis.

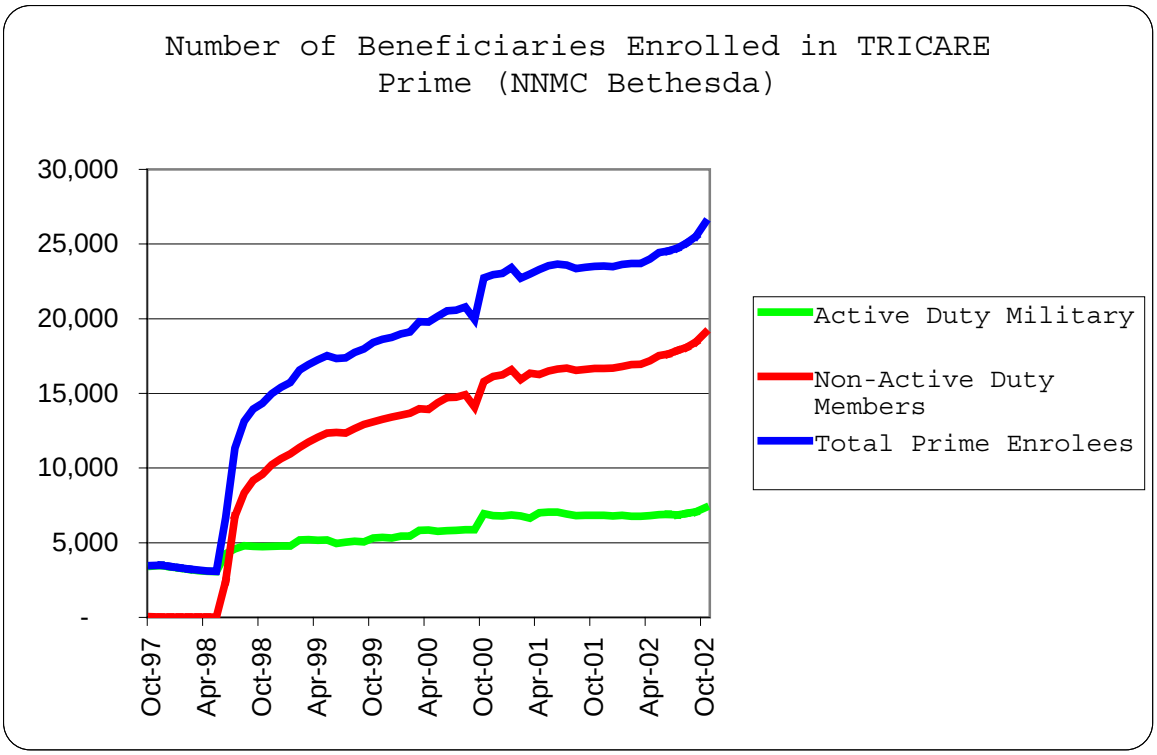

Figure 2. Number of beneficiaries enrolled in TRICARE Prime (NNMC Bethesda), October 1997 to October 2002.

Due to the current world crisis that our country is involved with, approximately 1,000 medical personnel permanently assigned to NNMC were deployed to the U.S. Naval Hospital Ship Comfort. The deployment of these personnel substantially limited the hospital's ability to meet its beneficiaries' healthcare needs. Given constrained resources, prioritization of care becomes increasingly critical in order to maintain a ready force.

Given these constraints and the intention of providing consistently high quality health care services to the nation's military members and their families, NNMC sent out informational brochures to its beneficiaries reiterating its commitment to meeting their medical needs while establishing temporary guidelines on priority of care. The new guidelines gave active-duty personnel and eligible beneficiaries enrolled with TRICARE Prime priority to receive care at NNMC, and limited non-enrolled beneficiaries' ability to receive care. Nonetheless, the number of patients seen at NNMC on a space-available basis for fiscal year (FY) 2002, and the workload associated with them, still deserves attention. In FY 2002, over 21,000 patients were seen at NNMC on a space-available basis generating over 113,000 visits (NNMC Composite Health Care System (CHCS) Ad Hoc Query, 2003). Of those, 44% or a total of 9,421 patients were not eligible to enroll in TRICARE Prime. This subpopulation includes over 3,600 retirees and retiree family members age 65 and older, and over 5,700 patients seen on the basis of their status.[2]

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[2] These patients include congressman, senators, foreign military

On the other hand, 56% or a total of 11,759 beneficiaries eligible to enroll in TRICARE Prime received care at NNMC on a space-available basis (NNMC CHCS Ad Hoc Query, 2003). Although half of these patients were non-active duty members between the ages of 18-64, 25% were non-active duty patients between the ages of 0-17. Interestingly, 28% of patients seen at NNMC on space-available basis were active-duty members.

Statement of the Problem

Since GME is one of the primary missions of NNMC, attracting more Prime patients to support utilization of specialty care clinics is essential. As a GME teaching facility, NNMC relies heavily on its primary care clinics to provide a steady flow of possible specialty cases, many of which come from its older eligible yet non-enrolled beneficiaries. Providing care on a space available basis also affects the ability of hospital administrators to forecast resource requirements for routine health care services. Further, the provision of care on a space available basis also has potentially adverse outcomes for the patients seeking such care—space available care may lack a degree of continuity and consistency provided under a plan (like TRICARE Prime) that offers assigned primary care managers. However, despite aggressive efforts by NNMC to encourage eligible beneficiaries to enroll in TRICARE Prime, a considerable portion of these

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personnel, embassy diplomats, and other beneficiary categories (NNMC CHCS Ad Hoc Query, 2003).

beneficiaries have opted to remain with civilian healthcare organizations and, at times, have sought care at NNMC on a space-available basis. Because gaining an understanding the reasons behind beneficiary choice can provide a direction for administrative planning and ultimately organizational performance, NNMC's leadership have tremendous incentives to determine the forces that guide choice. This current research project was motivated by NNMC's interest in the factors associated with a beneficiary's choice to disenroll from TRICARE Prime or to enroll with another plan.

Literature Review

When TRICARE was initiated at NNMC in 1997, a huge marketing effort was conducted to encourage eligible beneficiaries to enroll with or switch to TRICARE. To a great extent, switching plans in the military health service system depends upon a beneficiary's provider preference, and switching to TRICARE afforded beneficiaries the option of choosing between care provided by a civilian subcontractor or by the MTF (Jennings & Loan, 1999). According to Cunningham & Kohn (2000), switching healthcare plans may only be beneficial to the extent that it results from consumers' decisions and preferences about what type of health plan best suits their healthcare needs. However, switching healthcare plans may also disrupt medical care, which could prove detrimental to continuity of care, access, and quality (Burstin, Swartz, O'neil, Orav, & Brennan, 1999).

People switch plans for a variety of reasons. In a study to identify reasons why people switch healthcare plans, Cunningham

and Kohn (2000) found that the two most common reasons why people switch plans were due to change in employment and change in employer plan offerings. Those who voluntarily changed plans either switched to a less costly plan or did so for better services, preferred doctors, better quality, and more convenient locations (Cunningham & Kohn, 2000; Murray, Dwore, Gustafson, Parsons, & Vorderer, 2000).

However, the same findings cannot be validated in the military healthcare system. In a study to evaluate military beneficiaries' motivation for choosing a military managed care system over a civilian managed care system, loyalty was cited as the number one reason for changing their healthcare plan to TRICARE (Jennings & Loan, 1999). In addition to loyalty, lower premiums, distance to a medical facility, and continuity of care were also cited as reasons for changing one's health plan to TRICARE (Jennings & Loan). Negative past experiences with military health care, loyalty to the civilian system, and poor timing were factors that encouraged many beneficiaries to remain with their civilian health care plan (Jennings & Loan).

With competition increasing among healthcare plans as a result of better-informed consumers, consumer satisfaction with health care is perhaps one of the most commonly used indicators of quality care and patient attitudes. In fact, the use of consumer satisfaction data have become increasingly important to the purchasers of health plans, major employers, government agencies, and to the health plans that find themselves in an increasingly competitive marketplace (Schauffler & Rodriguez,

1994). These data, gathered through consumer satisfaction surveys, are used in health plan assessments and have provided consumers, providers, healthcare organizations, and treatment facilities vital information about how well health plans and providers meet the needs and expectation of the people they serve. And as competition for enrollees among health plans increases, consumer satisfaction research is expected to take on added significance as a quality indicator, as an outcome measure, and as a marketing tool (Schauffler & Rodriguez).

Several factors have stimulated research relating to consumer satisfaction (Cleary & Mcneil, 1988). Consumers are becoming more knowledgeable about the care that they receive; prompting healthcare providers as well as healthcare plans to be more attentive to their patients. An increasing number of institutions are also becoming more involved in health services research, and governmental support through such agencies as the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ) has increased. As a result, more healthcare organizations are becoming focused on meeting their customers' needs.

According to Carlson, Blustein, Fiorentino, & Prestianni, (2000), research studies have shown that a number of factors influence consumer satisfaction. In the development of the widely used Patient Satisfaction Questionnaire (PSQ), Ware and his fellow researchers identified seven dimensions of care, which include Access to Care, Availability of Resources, Technical Quality, Overall Satisfaction, Financial Aspects of

Care, Continuity of Care, and Humanness (Ware, Snyder, Wright, & Davies, 1984). The Agency for Health Care Policy and Research, in collaboration with Harvard University, RAND, and Research Triangle Institute, also developed a new set of questionnaires that could be used to assess health plans and services. The survey instrument, referred to as Consumer Assessment of Health Plans, evaluates health plans based on six dimensions of health plan performance: getting needed care, getting care quickly, communication, office staff, customer service, and claims processing. These six dimensions of performance are then categorized into four global ratings namely, health plan, quality of care, personal doctor, and specialists (Zaslavsky, Beaulieu, Landon, $ Cleary, 2000).

Previous studies have also been conducted to determine whether consumer satisfaction ratings vary by healthcare plan type. Since healthcare plans offer different options ranging from low cost with limited coverage to high cost with comprehensive benefits, consumer satisfaction relating access, quality, and cost will differ. For example, Davis, Collins, Schoen, and Morris (1995) found that fee-for-service (FFS) plans produced greater satisfaction than managed care plans for aspects related to access to care, availability of resources, quality, and overall satisfaction. However, Davis et al. also found that HMOs generated greater satisfaction than FFS plans for aspects related to financing of care.

Several studies conducted to examine factors that influence consumer’s choice of health plan have shown varied results.

Earlier studies by Moustafa, Hopkins, and Klein (1971) showed that consumer choice was based on an interaction between the characteristics of consumers and the characteristics of plans.[3] On the other hand, a meta-analysis by Mechanic (1989) on healthcare plan choice showed that consumers based their choices on established patient/physician relationships, costs, and perceived needs. Also, a study to examine the experiences with managed care by families with employer-based health plans in Boston, Los Angeles, and Miami revealed that respondents considered cost and provider preference as the most important influences in health plan choices (Davis, Collins, Schoen, & Morris, 1995).

The role of disenrollment as an indicator of patient satisfaction with healthcare plans has also been studied for the past three decades. These studies often involved not only looking at who switches from one type of plan to another, but also at the reasons why people choose one type of plan over another (Booske, Sainfort, & Hundt, 1999). One common feature of previous disenrollment studies was a distinction made between two forms of disenrollment – voluntary and mandatory. Voluntary disenrollment usually refers to a conscious decision to leave a

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[3] Consumer characteristics in this study included family size; family income, education level, and health status, while characteristics of plans included insurance coverage, costs, and benefits (Moustafa, Hopkins, & Klein, 1971).

health plan. Previous studies have shown that factors typically associated with voluntary disenrollment include dissatisfaction with health care plan features, inaccessibility, and high costs. On the other hand, mandatory disenrollment occurs due to loss of insurance eligibility, changes in employment, or changes in geographic location (Boxerman & Hennelly, 1983; Mechanic, Weiss, & Cleary, 1983).

Consumer information is usually measured by means of personal interviews, telephone surveys, Internet surveys, or mailed questionnaires. Personal interviews and telephone surveys have a higher response rate, but are expensive, and patients may feel inhibited about making negative comments about the medical care they received (Nettleman, 1998). Mailed surveys are also expensive, and typically result in lower response rates. Internet surveys are inexpensive and easy to analyze, but require the consumer to have access to a computer (Nettleman). However, many organizations and researchers favor mailed surveys over personal and telephone interviews because they can provide an inexpensive method of gathering information.

Purpose

The purpose of this study is to identify patient-related variables that explain why some eligible beneficiaries elect to receive their primary care at NNMC, yet still choose not to enroll in TRICARE Prime.

The objectives of this study are to select, modify and administer a survey instrument that would provide unbiased data related to the delivery of health care to NNMC's non-enrolled population; to identify factors associated with beneficiaries' enrollment decisions; and to present the findings to the leadership.

Methods and Procedures

Survey Approval

The first step for this project was to obtain approval to conduct this survey from the NNMC Institutional Review Board (IRB). According to CDR Patricia Kelley, NNMC Nurse Researcher and a senior member of the Command's IRB, the Board reviews clinical studies involving human subjects (P. Kelley, personal communication, September 22, 2002). Since this study was determined to be a marketing tool to increase enrollment at NNMC, no IRB approval would be required for conducting this survey (NNMC Instruction 6500.3A, 2002).

Survey Instrument

A variety of survey instruments have been developed to gather data related to patient satisfaction. In the early 1970s, Ware, Snyder, Wright, and Davies developed a popular patient satisfaction instrument (Ware, Snyder, Wright, & and

Davies, 1984). This instrument, referred to as the Patient Satisfaction Questionnaire, was developed under contract with the U.S. Department of Commerce over several years in a variety of studies (Ware et al., 1984). This survey instrument has been extensively tested over several years with thousands of respondents and has scored well for internal consistency measures, test-retest measures and content, convergent, and discriminant validity measures (Roberts & Tugwell, 1987).

As mentioned earlier, the Agency for Health Care Policy and Research with the help of other institutions developed a new set of questionnaires that could be used to assess health plans and services. The survey instrument, referred to as Consumer Assessment of Health Plans or CAHPS, has also been tested for its reliability and validity using cognitive and psychometrics testing techniques (Zaslavsky, Beaulieu, Landon, & Cleary, 2000).

For this research project, I developed a survey questionnaire by adapting questions from the two aforementioned survey instruments and from health care surveys previously used by the DoD to evaluate patient satisfaction. Content validity was also conducted to determine whether the items listed in questions 13, 18, and 22 adequately represented the objective of those questions. Content validity was conducted on these three questions specifically because these were the only questions that contain similarly scaled items asking respondents to rate factors associated with their current healthcare plan or that refer to their decision-making process. Finally, a group of 10

health care users at NNMC were asked to review the instrument for its content and clarity before being printed in its final form. Based on their responses, several questions were rephrased or eliminated to improve the questionnaire's utility.

Reliability of the survey instrument used in this study was evaluated by performing a Cronbach's alpha. An 18-item analysis was done on questions 18 and 22 since they both ask participants to rate factors affecting their decision to use NNMC for medical care in the future, as well their decision to enroll with TRICARE Prime. The analysis revealed a high degree of internal consistency with alpha coefficients of 0.9110 and 0.9701 for question numbers 18 and 22, respectively.

The names and addresses of the subjects included in this study were obtained from NNMC CHCS and M2 (formerly ARS-Bridge); and while there may be occasional problems with individual records obtained from CHCS, they are generally assumed to be reliable and accepted to be reliable and valid, and therefore, suitable for use in this research project.

MHS Survey Policy

The second step for this project is to submit the survey instrument to TRICARE Management Activity (TMA) for review and approval. The MHS Survey Policy Guidance of 2000, which is governed by several DoD instructions including DoDI 1100.13 (Surveys of DoD Personnel), states that all healthcare-related surveys involving military personnel from more than one DoD component shall require the approval of the Defense Manpower Data Center. In addition, this directive requires the Office of

the Assistant Secretary for Defense for Health Affairs (OASD (HA)) and TMA to coordinate all healthcare-related surveys with DMDC for review. However, according to Kim Frazier of the Directorate for Survey Oversight and Information Control at TMA, the survey instrument conformed to the guidance for exemption from licensing and, therefore, did not require any review and approval (K. Frazier, personal communication, March 10, 2003).[4]

Setting and Sample Size

The third step for this project is identification of the target population and making valid inferences given a sample. To determine the target population, the names and addresses of Space 'A' beneficiaries were first acquired through a series of ad hoc queries from the NNMC CHCS. The ad hoc reports provided the patient's full name, age, patient category, and complete mailing address. The resulting database listed 21,180 patients who have sought care at NNMC on a space-available basis. The data was then compiled into the EXCEL software to search for any errors that might invalidate the data. Beneficiaries who were not eligible to enroll in TRICARE Prime were eliminated from the database. Active-duty members, who should have been automatically enrolled in TRICARE Prime, were excluded from the initial list. Beneficiaries under 18 years of age were also

[4] The MHS Survey Policy Guidance of 2000 states that "Military treatment facilities may conduct local-level surveys of beneficiaries and assigned personnel to address the need for more specific information on clinic operations and/or services within the specific MTF."

eliminated from the database to ensure only consenting adults would participate. Finally, for the purposes of conducting this survey, only beneficiaries living within NNMC's catchment area, with two or more visits were included in the final list. As a result, a target population of 2,926 patients was obtained.

To ensure proper sampling, a random number feature in Microsoft EXCEL was used to arbitrarily select subjects to survey and ensure an unbiased sample was draw. Given a desired confidence level of 95% and a 5% margin of error, a total of 850 beneficiaries were randomly selected to provide a response rate of 40% or the equivalent of 350 subjects (Dillman, 1999).[5]

Surveying Process

The actual surveying instrument was mailed to each of the subjects. The survey packet contained the survey questionnaire, a personal letter from the NNMC Commanding Officer, and a return, self-addressed, stamped envelope. Four weeks after the

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[5] The following formula was used to choose the appropriate number of completed samples needed for this study: $Ns = (Np)(p)(1-p)/(np-1)(B/C)^2 + (p)(1-P)$

Where: Ns = completed sample size needed for desired level or precision

Np = size of population

P = proportion of population expected to choose one of the two response categories

B = acceptable amount of sampling error

C = Z statistic associated with the confidence level

Thus: $350 \sim 2926\ (.5)(.5)/(2926-1)(.05/1.96)^2 + (.5)(.5)$.

survey was sent out, a thank you/follow-up postcard was mailed to all the subjects to acknowledge their participation and to remind them to complete the survey if they have not done so.

Results

Although 61 of the 850 survey packets were returned as undeliverable, 253 surveys were completed and returned, which represented a usable return rate of 29.76%. However, only 180 or 71% of the respondents were eligible to enroll and thus, were able to complete the survey; the rest were either not eligible to enroll or have already enrolled with TRICARE Prime by the time they received the survey.

Demographics

Table 1 summarizes the demographic characteristics of the 180 TRICARE Prime-eligible respondents. As shown in Table 1, the majority of the respondents were female (53%). In addition, more than 75% of the respondents were between the ages of 45-64; the remaining 20% of respondents were between the ages of 18-44. And as seen in past military health care studies, the majority of the beneficiaries who responded were married (74%), while one-fourth were either single, divorced, or widowed. Additionally, the number of respondents who reported their health status as "very good" to "excellent" (51%) was almost the same as the number of respondents who reported their health status as "poor" to "good" (49%).

More than 85% of the respondents reported their beneficiary status as either “retiree” or “retiree family member,” and 15% reported their status as active duty family member. Also, approximately 43% of the respondents reported their sponsor’s branch of service as “Navy,” and 60% reported their sponsor’s rank between “O4-O6.”

Table 1

Sample Demographic Characteristics

Demographics	Results Frequency	Percentage
n=180		
Gender		
Male	84	46.7
Female	96	53.3
Age Group		
18-24	5	2.8
25-34	6	3.3
35-44	29	16.1
45-54	59	32.8
55-64	81	45.0
Marital Status		
Single	27	15.1
Married	134	74.4
Divorced	11	6.1
Widowed	8	4.4
Health Status		
Poor	4	2.2
Fair	18	10.0
Good	65	36.1
Very Good	49	27.2
Excellent	44	24.4
Sponsor Branch of Service		
Army	40	22.3
Navy	77	42.8
Marine Corps	31	17.2
Air Force	15	8.3
Coast Guard	8	4.4
Public Health Service	9	5.0

Table 1 (continued)

Sample Demographic Characteristics

Demographics	Results Frequency	Percentage
n=180		
Sponsor Rank		
E1-E4	9	5.0
E5-E6	18	10.0
E7-E9	30	16.6
W1-W5	1	0.6
O1-O3	11	5.1
O4-O6	108	60.0
O7-O10	3	1.7
Beneficiary category		
Active Duty Family Member	25	13.9
Retired Service Member	96	53.3
Family Member of Retired/Deceased Service Member	59	32.8

Health Care Plan Used

Approximately 74% of the respondents used TRICARE Standard or TRICARE Extra as their primary health care insurance last year, while 23% were enrolled either with a private health insurance plan, with United States Family Health Plan (USFHP), or with Federal Employees Health Benefits Plan (FEHBP). Interestingly, about 3% of the respondents do not have any primary health care insurance plan for their medical needs.

Intent to Enroll with TRICARE Prime

When asked about their intention to enroll with TRICARE Prime in the future, approximately 52% of respondents do not plan to enroll with Prime in the next 12 months. On the other hand, 26% of the respondents plan to enroll with Prime, while approximately 22% were still unsure whether to enroll with TRICARE Prime or not.

Understanding of TRICARE Benefits

Respondents were asked to rate their understanding of TRICARE benefits. As shown in Figure 3, the majority of respondents (57%) have a "Poor" to "Fair" understanding of their TRICARE benefits. On the other hand, only nine percent of the respondents rated their level of understanding of TRICARE as "Excellent."

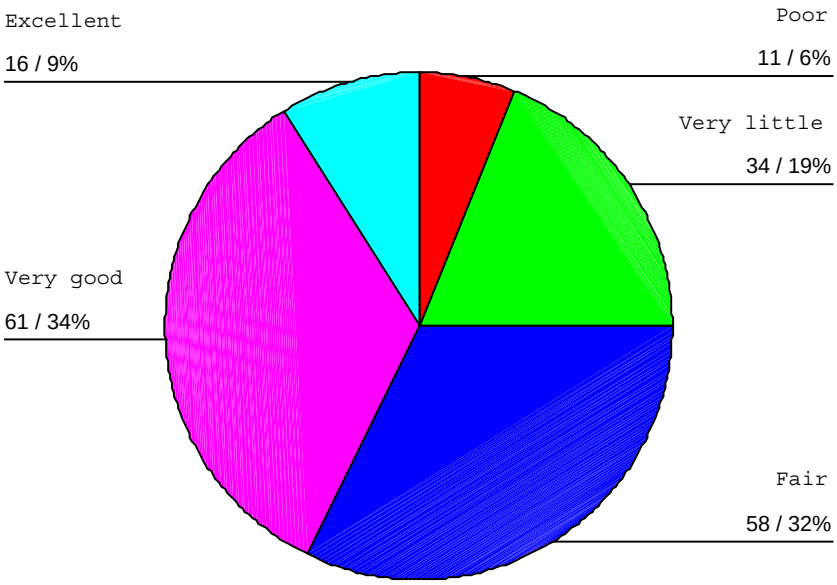

Figure 3. Number of respondents by level of understanding of TRICARE benefits (n = 180).

Sources of TRICARE Information

Figure 4 shows a comparison of the different sources that respondents used to obtain information regarding TRICARE. As depicted in the table, the majority of the respondents cited "Mailed Information," "TRICARE website" and "military care provider" as the top three sources of TRICARE information. Respondents also identified other sources of information, which included written publications, such as journals and newspapers, command briefings, the NNMC Patient Call Center, and civilian health care provider.

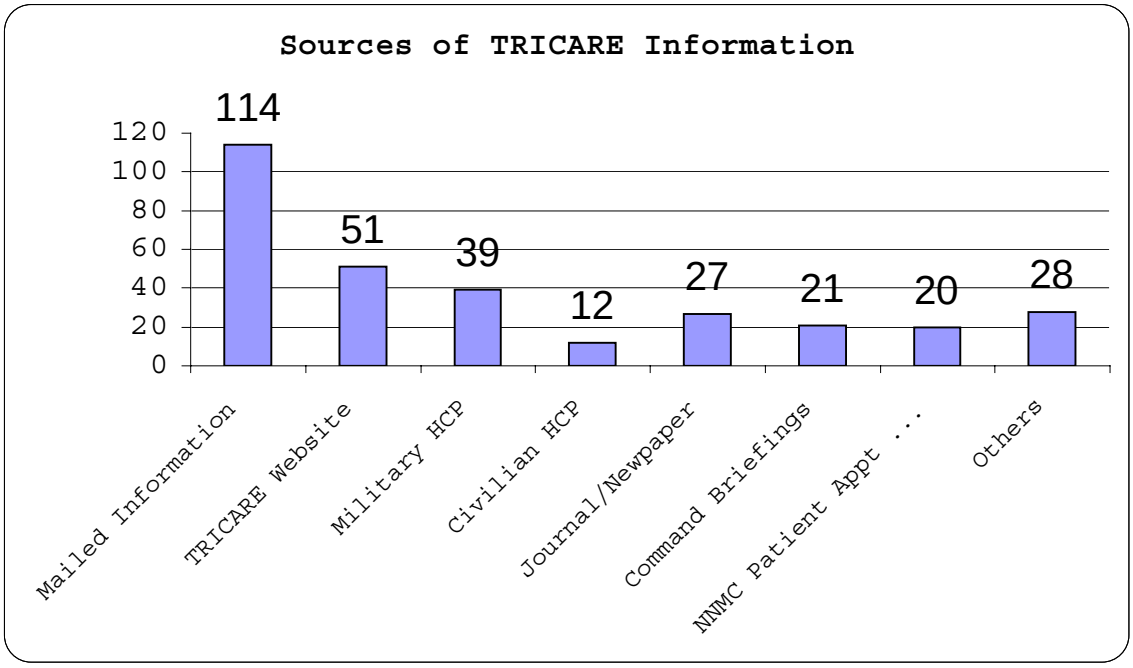

Figure 4. Sources of TRICARE Information. **

** Note: Some respondents have multiple sources of information.

Reasons for Not Enrolling with and Disenrolling from Prime

Tables 2 and 3 show categories of responses to the open-ended questions along with the frequency of each response. When eligible beneficiaries were asked why they have not enrolled with TRICARE Prime, the five most frequently cited reasons were (a) their present health care insurance provides the best option for their health care needs, (b) resentment against the government for reneging its promise of free health care for life and against government's policy of forcing one to enroll by default, (c) lack of flexibility to see own provider or a specialist, (d) difficulty in getting an appointment, and (e) convenience, travel time, or location of MTF.

Table 2

Reasons for Not Enrolling with TRICARE Prime

Reasons	Frequency
1. Present health care insurance is the best option	39
2. Broken promise of free health care for life/ being forced to enroll by default	20
3. Lack of flexibility to choose own provider or to see a specialist whenever possible	19
4. Difficulty in getting an appointment	19
5. Convenience, travel time, location of MTF	18
6. Affordability/Ability to pay	12
7. Continuity of care is impacted or limited	11
8. Have not had the time to enroll or research the benefits of TRICARE Prime	11
9. Need for a primary care provider to manage ones health care needs	10
10. Dissatisfaction with previous visit or with the level of care received at NNMC	9
11. Distrust for military medicine/residents/ physician assistants/foreign-educated providers	8
12. Ability to receive care on space-available basis	8
13. Cost-savings with TRICARE Prime is not worth it	8
14. Inability to find someone to explain to me how TRICARE works	7
15. Amount of paperwork involved with claims	3

On the other hand, when eligible beneficiaries were asked why they have disenrolled with TRICARE Prime, the two most common responses were (a) difficulty in getting an appointment or services, and (b) convenience, travel time, or location of MTF (see Table 3).

Table 3

Reasons for Disenrolling from TRICARE Prime

Reasons	Frequency
1. Difficulty in getting an appointment or services	5
2. Convenience, travel time, location of MTF	5
3. Present health care insurance is the best option	3
4. Broken promise of free health care for life	2
5. Continuity of care is impacted or limited	2
6. Affordability/Ability to pay	2
7. Amount of paperwork involved with claims	1
8. I get better prescription drugs from civilian care	1

The last open-ended question, "What needs to be done for you to enroll or reenroll with TRICARE Prime" offered beneficiaries an opportunity to provide feedback about TRICARE Prime and the services that NNMC provides. However, only 20 of 180 beneficiaries provided responses that could have been useful for NNMC in its attempt to recapture enrollees within its catchment area. The following categories of responses were received from the respondents:

1. Flexibility to choose my own provider.
2. Ease in obtaining non-availability statements.
3. More information on the costs and benefits of enrolling with TRICARE Prime.
4. Better services or availability of services or resources.
5. Ease in getting an appointment without any regard to retirement status.

6. Ease in getting an appointment within access standards.
7. Ability to switch between TRICARE Prime and TRICARE Standard anytime.
8. Guaranteed assignment to NNMC.

Factors Associated with Intent to use NNMC and Intent to Enroll

Eligible beneficiaries were also presented with a variety of factors associated with their intent to use NNMC for future medical needs. The beneficiaries were then asked to rate these factors using a 5-point Likert scale (1 = not important at all, 2 = not very important, 3 = somewhat important, 4 = important, and 5 = very important). Table 4 summarizes the responses to the 18 items with mean scores and standard deviations.

As shown in Table 4, the top five factors rated highly by eligible beneficiaries were as follows: (a) availability of medical care when needed, (b) skills, training, and experience of providers, (c) thoroughness of examination, diagnosis, and treatment, (d) overall quality of care and services, and (e) availability of medical appointment for medical care when needed. On the other hand, the five factors that received the lowest rating by respondents: (a) out-of-pocket costs, (b) convenience of location of treatment, (c) time spent waiting in the clinic to see a provider, (d) availability of assigned personal provider, and (e) ease of paperwork claims.

Table 4

Importance of Factors Associated with Intent to Use NNMC for Future Healthcare Needs

Factors		N*	M	SD
Technical Quality	Total	175	4.63	0.648
Skills, experience, and training of providers		174	4.67	0.716
Thoroughness of examination, diagnosis, and treatment		172	4.65	0.707
Availability of health care services needed to complete medical care		175	4.59	0.751
Quality of Care	Total	177	4.63	0.697
Overall quality of care and services		177	4.63	0.697
Availability of Resources	Total	178	4.51	0.560
Availability of resources needed to provide complete medical care		177	4.60	0.733
Access to specialists		172	4.59	0.699
Access to primary care clinics		176	4.31	0.887
Access to Care	Total	178	4.30	0.588
Availability of medical care when needed		172	4.72	0.575
Availability of medical appointment for medical care when needed		176	4.63	0.620
Convenience of location of treatment		178	3.97	0.971
Time spent in the clinic waiting to see a provider		175	3.93	0.932
Humanness	Total	177	4.34	0.732
Attention given by providers listening to you		174	4.50	0.751
Explanation of medical procedures and tests		174	4.26	0.961
Courtesy shown to you by healthcare providers and staff members		177	4.24	0.839

Table 4 (continued)

Importance of Factors Associated with Intent to Use NNMC for Future Healthcare Needs

Factors		N*	M	SD
Continuity of Care	Total	178	4.05	0.882
Ability to see the same provider during each visit		176	4.18	0.914
Availability of an assigned personal provider		178	3.92	1.033
Financial Aspects of Care	Total	178	3.97	0.972
Out-of-pocket costs to you		177	4.13	1.071
Ease of paperwork claims		174	3.82	1.113

*Note: The number of responses, which ranged from 172 to 178, varied because some respondents failed to answer some of the questions.

Additionally, eligible beneficiaries were presented with a group of factors associated with their intent to enroll with TRICARE Prime in the future. The beneficiaries were then asked to rate these factors using a 5-point Likert scale (1 = not important at all, 2 = not very important, 3 = somewhat important, 4 = important, and 5 = very important). Table 5 summarizes the responses to the 18 items with mean scores and standard deviations.

As shown in Table 5, the top five factors rated highly by eligible beneficiaries were as follows: (a) availability of medical care when needed, (b) availability of medical appointment for medical care when needed, (c) availability of health care services needed to complete medical care, (d) access

to specialists, (e) access to primary care clinics. Conversely, the five factors that received the lowest rating by respondents: (a) time spent waiting in the clinic to see a provider, (b) courtesy shown to you by health care providers and staff members, (c) out-of-pocket costs, (d) explanation of medical procedures and tests, and (e) ease of paperwork claims.

Table 5

Importance of Factors Associated with Intent to Enroll with TRICARE Prime in the Future

Factors		N*	M	SD
Availability of Resources	Total	163	4.30	0.987
Access to specialists		158	4.33	1.126
Access to primary care clinics		160	4.31	1.088
Availability of resources needed to provide complete medical care		163	4.29	1.169
Technical Quality	Total	161	4.29	1.086
Availability of health care services needed to complete medical care		161	4.34	1.146
Skill, experience, and training of providers		159	4.26	1.214
Thoroughness of examination, diagnosis, and treatment		160	4.24	1.212
Quality of Care	Total	162	4.27	1.180
Overall quality of care and services		162	4.27	1.180
Access to Care	Total	163	4.17	0.964
Availability of medical care when needed		157	4.47	1.004
Availability of appointment for medical care when needed		162	4.43	0.996
Convenience of location of treatment		160	3.91	1.186
Time spent in the clinic waiting to see a provider		161	3.89	1.233
Continuity of Care	Total	160	4.01	1.159
Ability to see the same provider during each visit		157	4.08	1.203
Availability of an assigned personal provider		160	3.94	1.204

Table 5 (continued)

Importance of Factors Associated with Intent to Enroll with TRICARE Prime in the Future

Factors		N*	M	SD
Humanness	Total	162	3.93	1.177
Attention given by providers listening to you		158	4.08	1.210
Courtesy shown to you by healthcare providers and staff members		162	3.88	1.230
Explanation of medical procedures and tests		160	3.81	1.348
Financial Aspects of Care	Total	162	3.79	1.155
Out-of-pocket costs to you		161	3.88	1.283
Ease of paperwork claims		157	3.70	1.268

*Note: The number of responses, which ranged from 157 to 163, varied because some respondents failed to answer some of the questions.

Logistic Regression Analysis

A multinomial logistic regression analysis was performed to identify the statistical relationship between demographic characteristics and stated intent to enroll in TRICARE Prime. The dependent variable of this model is the three-category response (Q21) that asks respondents to indicate whether they intend to enroll in TRICARE Prime, do not intend to enroll, or are not sure. Model functions are defined as:

g_1 = logit (probability of stating "intend to enroll")

g_2 = logit (probability of stating "do not intend to enroll").

The referent category for the dependent variable is "not sure." The following demographic predictors were selected and recoded for the analysis: (a) Gender (0=male, 1=female); (b) Marital Status (0=unmarried, 1=married); (c) Sponsor Rank (0=enlisted, 1=officers); (d) Health Status (0=poor to good, 1= very good to excellent); (e) Age group in years (0=18-44, 1=45-64); and (f) Level of Understanding of TRICARE (0=poor to fair, 1=very good excellent. Table 6 shows the relationship between dependent variable and the six selected demographic variables.

The model showed satisfactory fit given the selected demographic variables ($\chi^2 = 51.015$, df = 12, $p < 0.0001$). Mixed findings emerged between these predictors and outcome variable. Given logit contrast g_1, none of the individual predictors were significant in predicting intention to enroll. However, significant differences emerged in contrast g_2. Based on individual Wald statistics, the strongest relationships emerged between gender and sponsor rank. Holding constant marital status, reported health status, age, and reported understanding of benefits, females were more than two times as likely to report that they had no intentions to enroll ($\psi = 2.068$, $p < .05$). Sponsor rank also indicated a significant relationship in this contrast ($\psi = 2.073$, $p < .10$).

Table 6

Summary Statistics of the Multinomial Logistic Regression Model: Intention to Enroll with TRICARE Prime as a Function of Selected Demographic Variables

Dependent Variables	Independent Variables	B	SE	Wald Test	Sig.	Odds Ratio	95% Confidence Interval for Odds Ratio Upper	Lower
Intend to Enroll with TRICARE Prime	Gender	0.641	0.452	2.010	0.156	1.898	0.783	4.603
	Marital Status	-0.101	0.502	0.041	0.840	0.904	0.338	2.418
	Sponsor Rank	-0.531	0.497	1.141	0.285	0.588	0.222	1.558
	Health Status	-0.507	0.462	1.205	0.272	0.602	0.243	1.489
	Age Group	-0.077	0.463	0.028	0.868	0.926	0.374	2.294
	Understanding of TRICARE	-0.174	0.466	0.139	0.709	1.190	0.478	2.964

Table 6 (continued)

Summary Statistics of the Multinomial Logistic Regression Model: Analysis of Intention to Enroll with TRICARE Prime as a Function of Selected Demographic Variables

Dependent Variables	Independent Variables	B	SE	Wald Test	Sig.	Odds Ratio	95% Confidence Interval for Odds Ratio Upper	Lower
Do not intend To Enroll with TRICARE Prime	Gender	0.727	0.367	3.932	0.047	2.068	1.008	4.243
	Marital Status	-0.350	0.408	0.374	0.391	0.705	0.317	1.569
	Sponsor Rank	0.729	0.421	2.996	0.083	2.073	0.908	4.730
	Health Status	-0.403	0.372	1.171	0.279	0.669	0.322	1.386
	Age Group	0.133	0.391	0.116	0.734	1.142	0.530	2.460
	Understanding of TRICARE	0.463	0.373	1.541	0.214	1.588	0.765	3.297

Overall Model Evaluation

Test	χ^2	df	p
Likelihood Ratio Test	51.015	12	<0.0001

Discussion

The results of this study show that the majority of non-enrolled eligible beneficiaries who receive medical care at NNMC on a space-available basis are retirees or family members of retirees who are between the ages of 45-64. Three out of four beneficiaries are currently enrolled with TRICARE Standard, and approximately half do not intend to enroll with TRICARE Prime. Healthcare users select a health care plan based on preferences that suit their medical needs. In addition, they select a plan that offers best services, the best quality of care, and more freedom to manage their health regardless of cost. Among the three options of TRICARE, TRICARE Prime is the least costly, however, it limits the beneficiaries' choice of their own primary care provider, which may explain why most beneficiaries have chosen not to enroll or have chosen to disenroll with TRICARE Prime.

Healthcare users were also offered a variety of reasons for not enrolling with or disenrolling from TRICARE Prime. However, the majority of the reasons for not enrolling and for disenrolling cannot be addressed at the local level. Only one, "Difficulty in getting medical appointment for medical care," had already been addressed with the creation of the Patient Appointment Call Center last year. Nevertheless, some of the reasons that some respondents have provided include negative

feedback and a glimpse of how some of NNMC’s beneficiaries perceive the care that NNMC provides. Some of them felt betrayed and frustrated with the medical care that they believed they were entitled to receive in return for the military services or sacrifices that they have offered to their country. Some of them do not trust military medicine, especially from a teaching hospital like NNMC.

When respondents were presented with a group of factors associated with their intent to use NNMC for future medical needs and intent to enroll with TRICARE Prime in the future, most respondents cited “Availability of medical care when needed” as the most important factor and “Ease of paper work claims” as the least important factor. Of the top five most important factors rated highly by respondents, “Availability of medical care when needed” and “Availability of medical appointment for medical care when needed” were the two factors frequently cited as most important. These results indicate that most Space ‘A’ beneficiaries considered “Accessibility to Care” a very important aspect for them to enroll with TRICARE Prime.

On the other hand, “Out-of-pocket costs” and “Ease of paper work claims” consistently received the lowest ratings, both of which might be associated with “Financial Aspects of Care.” Interestingly, this observation is consistent with the number of eligible beneficiaries who are currently enrolled with TRICARE

Standard. Although TRICARE Standard is more expensive than TRICARE Prime, some beneficiaries choose to enroll with Standard because it provides them more freedom to choose their own primary care provider.

When respondents were asked to rate their level of understanding of TRICARE benefits, a little over 50% rated their understanding of TRICARE benefits from poor to fair; a significant concern, considering that TRICARE information can be obtained not only from almost every MTF, but also from the Internet. However, because of the costs associated with sending TRICARE information to all the eligible beneficiaries in the NNMC catchment area, only those who have enrolled with TRICARE Prime could receive information on the benefits of enrolling with Prime. Those who rely on second hand information may not have an accurate description of how TRICARE works and how the three options benefit each beneficiary. In addition, since the majority of the Space 'A' users are retirees, not all of them may not have access to an computer and even if they do, some of them may not even know how to use a computer or navigate the Internet.

The multinomial regression analysis showed that Intent to Enroll with TRICARE Prime vary according to gender and sponsor rank. In fact, females are twice as likely as males to report that they do not intend to enroll with TRICARE Prime. This

finding suggests that females, who have different and perhaps more healthcare needs than men, would rather use their healthcare insurance because it probably offers more options that would meet their medical needs.

The regression analysis also revealed that families of officers are less likely to report an intention to enroll with TRICARE Prime compared to families of enlisted personnel. In the military, significant income differences can be observed between the officer and enlisted personnel. Therefore, the results of the analysis suggest that families of officers usually have more expendable resources to pay for their own health insurance, which probably provides more services and alternatives than TRICARE Prime.

Limitations of the Study

When interpreting the results of this research, several limitations must be considered, which may affect the potential utility of the study's findings.

First, the survey questionnaires were mailed out without questions 12 – 17. The missing questions were inadvertently excluded during printing and they were not discovered until the data were being entered into the SPSS software. Upon consultation with CDR Kelley, a decision was made to conduct a preliminary analysis of the data, to evaluate the implications of the missing questions, and to brief the researcher's preceptors. Although the missing questions might have provided

significant information, the preliminary analysis showed minimal effects on the overall objective of the survey. After the preliminary results were presented, preceptors gave permission to continue the study.

Second, since respondents who were already enrolled with TRICARE Prime were automatically excluded from participating in the survey, disparities in the decision-making process regarding TRICARE enrollment between that group and those who have not enrolled could not be determined.

Finally, the integrity of the CHCS data was always questionable since many military beneficiaries do not update their addresses in the DEERS system. As a result, 61 of the 850 surveys or 7% were returned as undeliverable.

Conclusions and Recommendations

Conclusions

The purpose of this study is to identify patient-related variables that explain why some eligible beneficiaries elect to receive their primary care at NNMC, yet still choose not to enroll in TRICARE Prime. Although the survey instrument used in this study did not include questions that may have provided pertinent information, inferences can still be made to explain why some eligible beneficiaries choose not to enroll with TRICARE Prime.

Most eligible beneficiaries choose to go to NNMC for their medical care for a variety of reasons. However, most of them would probably stay with their primary health care plan because it probably provides them the best services, the best quality of

care, and the freedom to manage their own health needs. And although half of the respondents do not intent to enroll with TRICARE Prime, NNMC’s marketing team should probably focus its efforts on those who have indicated an intention to enroll (26%) and those who are still unsure (22%). NNMC may have difficulty maintaining capacity to accommodate those willing to enroll; however, enticing eligible beneficiaries to enroll with TRICARE Prime will ensure a steady flow of specialty cases to support NNMC’s GME program, which is the hospital’s primary mission.

NNMC should also aggressively market TRICARE and the health care services that NNMC offers to its beneficiaries. The Internet might be a very good source of information regarding TRICARE, however, not everybody has access to a computer, and even if they do, some may not know how to use a computer or navigate the Internet. Educating older beneficiaries, especially those who have chosen to stay with the military for a promise of free health care for life, may be a difficult task. Given the right resources, however, NNMC may be able to convince at least some if not all of them to switch to TRICARE Prime.

The results of this study may not provide NNMC’s marketing team all the information needed to recapture space ‘A’ beneficiaries back into TRICARE Prime. However, some of the information gathered in this research project, e.g., factors associated with intent to use NNMC and with intent to enroll with TRICARE Prime, can provide a glimpse of how to entice eligible beneficiaries to enroll with TRICARE Prime.

Recommendations for Future Research

Focus groups should have been employed before conducting a survey to identify and to categorize reasons for not enrolling with or disenrolling from TRICARE Prime. Many respondents did not answer the open-ended questions; some of them may not have the time to write what they think or some may not care at all. Perhaps, providing them a list of choices would have been very helpful and could have provided additional information that would meet the objectives of this study.

A follow-up survey may be conducted in the future to include questions on the costs that Space 'A' beneficiaries pay for private health insurance and the types of health care services that they usually asked for at NNMC. The costs for enrolling with TRICARE Prime is generally assumed to be less expensive than a civilian health insurance. Understanding the decision-making process of non-enrollees and trying to find out what motivates them to pay higher premiums for their health insurance will provide useful information when making decisions about implementing any operational changes in the future.

Appendix A

NNMC Survey

Space 'A' Beneficiaries and TRICARE Prime 50

National Naval Medical Center

8901 Wisconsin Avenue, Bethesda, Maryland 20889-5600

[serial no]

Dear Healthcare Beneficiary,

National Naval Medical Center (NNMC), Bethesda, MD wishes to provide you the best and most convenient health care. In an effort to help us accomplish this goal, we ask that you please take a few minutes to complete and return the enclosed survey. Your feedback will allow us to measure your level of satisfaction with NNMC and with the current military healthcare system, and will be used to make improvements.

All information obtained through this study will remain completely confidential. Your anonymity is assured; and your name and social security numbers are not required.

Please use the enclosed self-addressed, stamped envelope to return your completed survey to NNMC no later than 2 weeks from receipt. If you have any questions, please contact ENS Diaz at 301-295-5877 (email: MVDiaz@bethesda.med.navy.mil).

Thank you for your time and cooperation. Your input is critical for the success of our endeavor, and is greatly appreciated. We look forward to receiving your response.

Sincerely,

D. C. ARTHUR,
Rear Admiral, Medical Corps
U.S. Navy
Commander

Privacy Act Notice

According to the Privacy Act of 1974 (Public Law 93-579), the Department of Defense is required to inform you of the purposes and use of this survey. Please read it carefully.

Authority: DoDI 1100.13

Purpose: The purpose of this questionnaire is to collect data to examine your experiences and opinions regarding your healthcare plan and the services you have received at NNMC. Responses to this survey will allow us to measure your level of satisfaction with NNMC and with the current military health care system, and will be used to make improvements.

Uses: None

Disclosure: Your participation in this survey is totally voluntary and your answers will be kept completely confidential. Failure to respond will NOT result in any penalties to you.

* *

Instructions for Completing the Survey

- Unless otherwise specified in the instructions for a question, ONLY ONE ANSWER should be marked.
- Many of the statements request your judgment or opinion. Select the response that is most correct for you.
- Please insert your completed survey into the enclosed self-addressed, stamped envelope and return.

National Naval Medical Center Bethesda, MD
Patient Survey Form

1. Our records indicate that you are eligible for TRICARE benefits, is this true?

   _____ Yes

   _____ No (Skip the remaining questions and please return the survey in the envelope provided.)

2. Are you currently enrolled with TRICARE Prime?

   _____ Yes (Skip the remaining questions and please return the survey in the envelope provided.)

   _____ No

3. Were you enrolled in TRICARE in the past?

   _____ Yes
   _____ No

4. Age group as of last birthday

   _____ 18-24
   _____ 25-34
   _____ 36-45
   _____ 46-55
   _____ 56-64
   _____ Over 65 (Skip the remaining questions and return the survey in the envelope provided.)

5. Gender

   _____ Male
   _____ Female

6. Marital Status

   _____ Single
   _____ Married
   _____ Divorced
   _____ Widowed

7. Sponsor branch of military service

_____ Army
_____ Navy
_____ Air Force
_____ Marine Corps
_____ Coast Guard
_____ Public Health Service
_____ Other (please specify) _____

8. Beneficiary category

_____ Family member of active duty service member
_____ Retired service member
_____ Family member of retired/deceased member
_____ Other (please specify) _____

9. Sponsor's rank group

_____ E1 to E3
_____ E4 to E6
_____ E7 to E9
_____ W1 to W5
_____ O1E to O3E
_____ O1 to O3
_____ O4 to O6
_____ O7 to O10

10. Please describe your general health status.

_____ Poor
_____ Fair
_____ Good
_____ Very Good
_____ Excellent

11. Which plan did you use for all or most of your healthcare in the past 12 months?

_____ TRICARE Standard
_____ TRICARE Extra
_____ Federal Employees Health Benefit Program (FEHBP)
_____ Uniformed Services Family Health Plan (USFHP)
_____ HMO plan (such as Kaiser)
_____ Other civilian health insurance (such as Blue Cross)
_____ None (Go to question 15)

12. How long have you been with your current healthcare plan?

_____ Less than 6 months
_____ 6 to 12 months
_____ 1 to 3 years
_____ Over 3 years

13. How would you rate your current or primary healthcare plan based on the following statements?

	Not important at all	Not very important	Somewhat important	Important	Very Important
Explanation of medical procedures and tests	1	2	3	4	5
Availability of resources needed to provide complete medical care	1	2	3	4	5
Availability of healthcare services needed to complete medical care	1	2	3	4	5
Overall quality of care and services	1	2	3	4	5
Skill, experience, and training of providers	1	2	3	4	5
Out-of-pocket costs to you	1	2	3	4	5
Thoroughness of examination, diagnosis, and treatment	1	2	3	4	5
Time spent in the clinic waiting to see a provider	1	2	3	4	5
Access to specialists	1	2	3	4	5
Courtesy shown to you by the healthcare provider and staff members	1	2	3	4	5
Attention given by providers listening to you	1	2	3	4	5
Availability of appointment for medical care when needed	1	2	3	4	5
Availability of medical care when needed	1	2	3	4	5
Access to primary care clinics	1	2	3	4	5
Ability to see the same provider during a visit	1	2	3	4	5
Convenience of location of treatment	1	2	3	4	5
Ease of paperwork claims	1	2	3	4	5
Availability of an assigned personal provider	1	2	3	4	5

14. How satisfied are you with your current or primary healthcare plan?

_____ Very dissatisfied
_____ Dissatisfied
_____ Neutral
_____ Satisfied
_____ Very satisfied

15. Approximately how many visits to NNMC have you made in the past 12 months?

_____ 1-5 visits
_____ 6-10 visits
_____ Over 10 visits

16. How satisfied were you with the overall medical care that you have received at NNMC during the past 12 months?

_____ Very dissatisfied
_____ Dissatisfied
_____ Neutral
_____ Satisfied
_____ Very satisfied

17. What best describe your intention to use NNMC for healthcare in the next 12 months?

_____ I intend to use NNMC for healthcare in the next 12 months.
_____ I do not intend to use NNMC for healthcare in the next 12 months.
_____ Not sure

18. When making your decision regarding how much you intend to use NNMC for your future healthcare needs, how important was each of these factors?

	Not important at all	Not very important	Somewhat important	Important	Very Important
Explanation of medical procedures and tests	1	2	3	4	5
Availability of resources needed to provide complete medical care	1	2	3	4	5
Availability of healthcare services needed to complete medical care	1	2	3	4	5
Overall quality of care and services	1	2	3	4	5
Skill, experience, and training of providers	1	2	3	4	5
Out-of-pocket costs to you	1	2	3	4	5
Thoroughness of examination, diagnosis, and treatment	1	2	3	4	5
Time spent in the clinic waiting to see a provider	1	2	3	4	5
Access to specialists	1	2	3	4	5
Courtesy shown to you by the healthcare provider and staff members	1	2	3	4	5
Attention given by providers listening to you	1	2	3	4	5
Availability of appointment for medical care when needed	1	2	3	4	5
Availability of medical care when needed	1	2	3	4	5
Access to primary care clinics	1	2	3	4	5
Ability to see the same provider during a visit	1	2	3	4	5
Convenience of location of treatment	1	2	3	4	5
Ease of paperwork claims	1	2	3	4	5
Availability of an assigned personal provider	1	2	3	4	5

19. How would you rate your current understanding of the benefits of enrolling in TRICARE Prime?

_____ Poor
_____ Little
_____ Fair
_____ Very Good
_____ Excellent

20. What are your sources of information about TRICARE? (Please choose all that apply)

_____ Command briefings
_____ Mailed information
_____ A military healthcare provider
_____ A civilian healthcare provider
_____ NNMC Patient Appointment Call Center
_____ Journal/Newspaper
_____ Website
_____ Others (please specify) _____

21. What best describes your intentions to enroll in TRICARE Prime in the next 12 months?

_____ I intend to enroll in TRICARE Prime in the next 12 months?
_____ I do not intend to enroll in TRICARE Prime in the next 12 months?
_____ Not sure

22. When making your decision regarding your intention to enroll in TRICARE Prime in the next 12 months, how important was each of these factors?

	Not important at all	Not very important	Somewhat important	Important	Very Important
Explanation of medical procedures and tests	1	2	3	4	5
Availability of resources needed to provide complete medical care	1	2	3	4	5
Availability of healthcare services needed to complete medical care	1	2	3	4	5
Overall quality of care and services	1	2	3	4	5
Skill, experience, and training of providers	1	2	3	4	5
Out-of-pocket costs to you	1	2	3	4	5
Thoroughness of examination, diagnosis, and treatment	1	2	3	4	5
Time spent in the clinic waiting to see a provider	1	2	3	4	5
Access to specialists	1	2	3	4	5
Courtesy shown to you by the healthcare provider and staff members	1	2	3	4	5
Attention given by providers listening to you	1	2	3	4	5
Availability of appointment for medical care when needed	1	2	3	4	5
Availability of medical care when needed	1	2	3	4	5
Access to primary care clinics	1	2	3	4	5
Ability to see the same provider during a visit	1	2	3	4	5
Convenience of location of treatment	1	2	3	4	5
Ease of paperwork claims	1	2	3	4	5
Availability of an assigned personal provider	1	2	3	4	5

23. Your opinions and comments are very important to us. Please feel free to share with them in the space below.

    Also, can you tell us why you have not enrolled in TRICARE Prime?
    Or why you have disenrolled with TRICARE Prime?
    Or what needs to be done for you to enroll or re-enroll in TRICARE Prime?

This ends the survey. Please return the survey in the envelope provided. Thank you

References

Dillman, Don A. (1999). Mail and Internet surveys: The tailored design method (2nd ed.). New York, NY:

Booske, B.C., Sainfort, F., & Hundt, A.S. (1999). Eliciting consumer preferences for health plans. Health Services Research, 34(4), 840-854.

Boxerman, S.B., & Hennelly, V.D. (1983). Determinants of disenrollment: Implications for HMO managers. Journal of Ambulatory Care Management, 6(2), 12-23.

Carlson, M.J., Blustein, J., Fiorentino, N., & Prestianni, F. (2000). Socioeconomic status and dissatisfaction among HMO enrollees. Medical Care, 38(5), 508-516.

Cleary, P.D., & Mcneil, B.J. (1988). Patient satisfaction as an indicator of quality care. Inquiry, 25, 25-36.

Cunningham, P.J., & Kohn, L. (2000). Health plan switching: Choice or circumstance. Health Affairs, 19(1), 158-164.

Davis, K., Collins, K.S., Schoen, C., & Morris, C. (1995). Choice matters: Enrollees views of their health plans. Health Affairs, 14(2), 99-112.

Dellana, S.A., & Glascoff, D.W. (2001). The impact of health insurance type on satisfaction with health care. Health Care Management Review, 26(2), 33-46.

Jennings, B.M., & Loan, L.A. (1999). Patient satisfaction and loyalty among military healthcare beneficiaries enrolled in a managed care program. Journal of Nursing Administration, 29(11), 47-55. Retrieved November 10, 2002 from http://gateway1.ovid.com.

Mechanic, D. (1989). Consumer choice among health insurance options. Health Affairs, 8(1), 138-148.

Mechanic, D., & Weiss, N. (1983). The growth of HMOs: Issues of enrollment and disenrollment. Medical Care, 21, 338-347.

Mechanic, D., Weiss, N., & Cleary, P.D. (1983). The growth of HMOs: Issues of enrollment and disenrollment. Medical Care, 21(3), 338-347.

Military Health Services (MHS) Survey Policy Guidance (2000). Retrieved March 27 from http://www.tricare.osd.mil/tricaresurveys/downloads/SurveyPolicy

Moustafa, A.T., Hopkins, C.E., & Klein, B. (1971). Determinants of choice and change of health insurance plan. Medical Care, 9(1), 32-41.

Murray, B.P., Dwore, R.B., Gustafson, G., Parsons, R.J., & Vorderer, L.H. (2000). Enrollee satisfaction with HMOs and its relationship with disenrollment. Managed Care Interface, 13(11), 55-61.

NNMC CHCS Ad Hoc Query (2003) [Electronic File]. Bethesda, MD: National Naval Medical Center [Andrea Briggs, National Naval Medical Center].

NNMC Clinic PCM Enrollment Report (2002) [Electronic File]. Bethesda, MD: National Naval Medical Center [Andrea Briggs, National Naval Medical Center].

NNMC Instruction 6500.3A (2002). Institution Review Board.

Nettleman, M.D. (1998). Patient satisfaction - what's new? Clinical Performance and Quality Health Care, 6(1), 33-37.

Roberts, J.G., & Tugwell P. (1987). Comparison of questionnaires determining patient satisfaction with medical care. Health Services Research, 22, 637-654.

Schauffler, H.H., & Rodriguez, T. (1994). Availability and utilization of health promotion programs and satisfaction with health plan. Medical Care, 32(12), 1182-1196.

TRICARE Handbook, 2003. Retrieved October 12, 2003 from http://www.tricare.osd.mil/tools/TricareHandbook/.

TRICARE Operations Center Eligibility Reports, 2002. Retrieved December 27, 2002 from http://www.tricare.osd.mil/tools/Eligibility/TOC/.

TRICARE Program and Beneficiary Category Enrollment Reports, 2002. Retrieved December 27, 2002 from http://www.tricare.osd.mil/tools/Enroll/Excel/ChildDMIS_EnrollmentReport_0067.xls.

U.S. General Accounting Office. (2001). Medicare subvention demonstration: Greater access improved enrollee satisfaction but raised DoD costs (GAO-02-68). Retrieved November 15, 2002 from http://www.gao.gov.

U.S. General Accounting Office. (2002). Medical Subvention Program: Pilot satisfies enrollees, raises cost and management issues for DOD health care (GAO-02-284). Retrieved November 15, 2002 from http://www.gao.gov.

Ware, J.E., Snyder, M.K., Wright, W.R., & Davies, A.R. (1984). Defining and measuring patient satisfaction with medical

care. Evaluation and Program Planning, 6, 247-263.

Zaslavsky, A.M., Beaulieu, N.D., Landon, B.E., & Cleary, P.D. (2000). Dimensions of consumer-assessed quality of medicare managed-care health plans. Medical Care, 38(2), 162-174.