TRICARE Consumer Watch

Region 9◆Quarter 2 CY 2003

Region 9: Sample size-2,540 Response rate-24.6% **MHS: Sample size-45,000 Response rate-28.1%**

Inside Consumer Watch

TRICARE Consumer Watch is a brief summary of what TRICARE Prime enrollees in your region say about their healthcare. Data are taken from the Health Care Survey of DoD Beneficiaries (HCSDB). The HCSDB uses questions from the Consumer Assessment of Health Plans Survey (CAHPS), a survey designed to help consumers choose among health plans. Every quarter, a representative sample of TRICARE beneficiaries are asked about their care in the last 12 months and the results are adjusted for age and health status and reported in this publication.

Scores are compared with averages taken from the 2002 National CAHPS Benchmarking Database (NCBD), which contains results from surveys given to beneficiaries by civilian health plans.

Health Care

Prime enrollees were asked to rate their healthcare from 0 to 10, where 0 is worst and 10 is best.

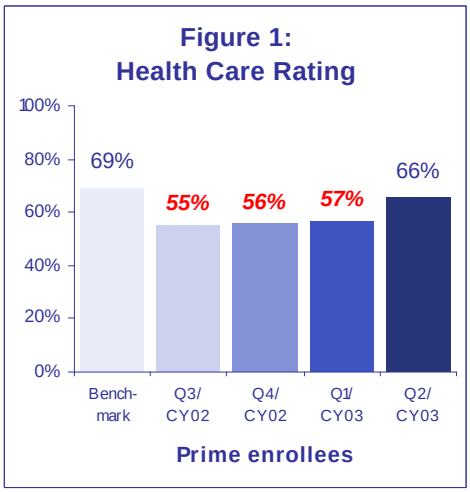
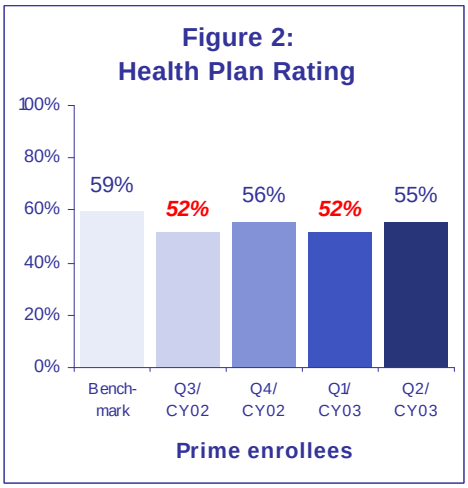


Figure 1 shows the percentage who rated their healthcare 8 or above in the survey fielded in the 2nd quarter of 2003, describing the period April 2002 to March 2003, and each of the 3 previous quarters. Numbers in red italics are significantly different from the benchmark (p<.05). Health care ratings depend on things like access to care, and how patients get along with the doctors, nurses, and other care providers who treat them.

Health Plan

Prime enrollees were asked to rate their health plan from 0 to 10, where 0 is worst and 10 is best. Figure 2 shows the percentage who rated their plan 8 or above for each reporting period.

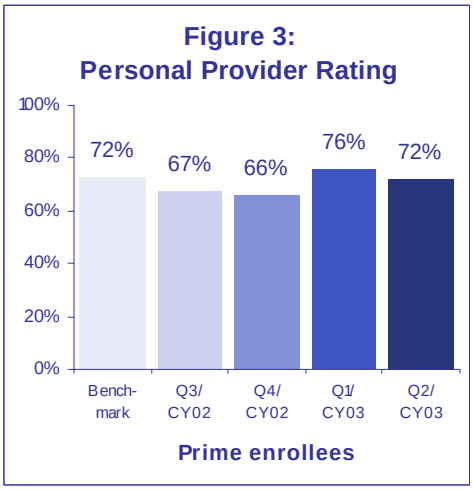


Health plan ratings depend on access to care and how the plan handles things like claims, referrals and customer complaints.

Personal Provider

Prime enrollees who have a personal provider were asked to rate their personal provider from 0 to 10, where 0 is worst and 10 is best.

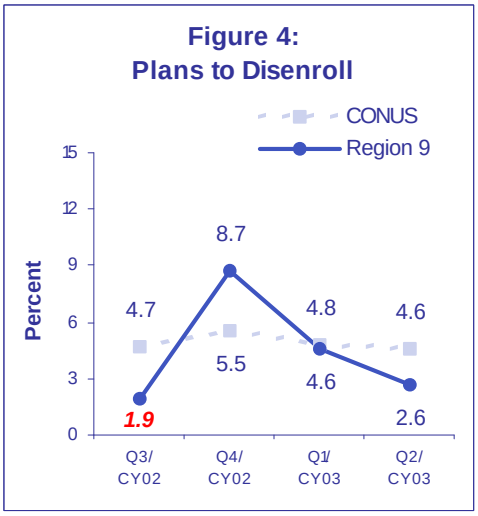
Figure 3 shows the percentage who rated their doctor 8 or above for each reporting period. Personal doctor ratings depend on how the patient gets along with the one doctor responsible for their basic care.



Plans to Disenroll

Enrollees were asked whether they plan to disenroll from Prime. Figure 4 shows the percentage of retirees and family members of active duty or retirees who plan to disenroll. Regional values differing significantly from CONUS (p < .05) are shown by red italics.

These groups have the option to disenroll if they choose, so their planned disenrollment rate is an overall measure of satisfaction with Prime.

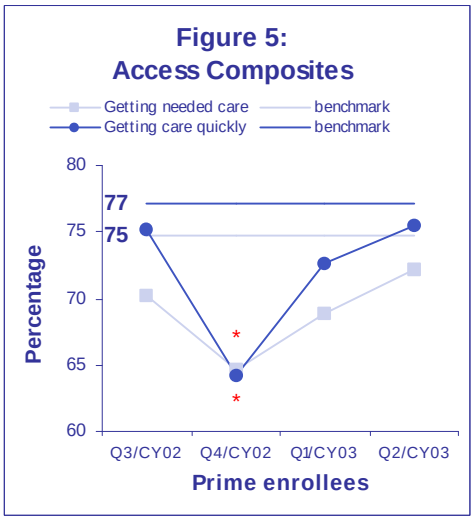


Health Care Topics

Health Care Topics scores average together the results of related questions. Each score represents the percentage who "usually" or "always" got the treatment they wanted or had "no problem" getting the desired level of service for each reporting period. Asterisks indicate values that are significantly different from the NCBD benchmark ($p < .05$).

Figure 5 (Access Composites) includes the composites "Getting needed care" and "Getting care quickly."

Scores in "Getting needed care" are based on patients' problems getting referrals and approvals and finding a good doctor.



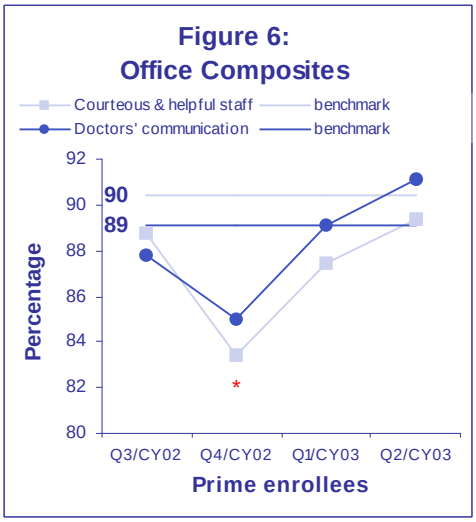
"Getting care quickly" scores concern how long patients wait for an appointment or wait in the doctor's office.

Figure 6 (Office Composites) includes the composites "Courteous and helpful office staff" and "How well doctors communicate."

Scores in "How well doctors communicate" are based on whether the doctor spends enough time with patients, treats them respectfully and answers their questions. "Courteous and helpful staff" scores measure both the courtesy and helpfulness of doctor's office staff.

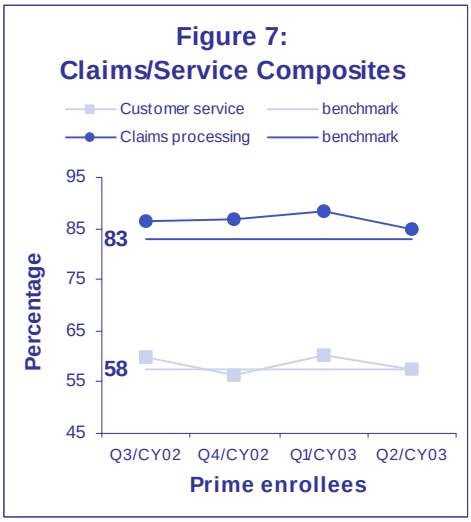
Figure 7 (Claims/Service Composites) includes composite scores for "Customer service" and "Claims processing."

Scores in the "Customer service" composite concern patients' ability to get information from phone lines and written materials, and the manageability of the health plan's paperwork. "Claims processing" scores are based on both the timeliness and correctness of plan's claims handling.



Preventive Care

The preventive care table compares Prime enrollees' rates for several types of preventive care with goals from Health People 2010, a government initiative to improve Americans' health by preventing illness. The table shows the most recent four quarters of data for four measures of preventive care.



Mammography is the proportion of women over age 40 who received a mammogram in the past two years. Pap smear is the proportion of women over 18 who received a pap smear for cervical cancer screening in the past three years. Hypertension indicates the proportion of all beneficiaries whose blood pressure was checked in the past two years and who know whether their blood pressure is too high. Prenatal care shows the proportion of women pregnant in the past 12 months who received prenatal care in the first trimester. Cholesterol screen is the proportion of all adults whose cholesterol was tested in the previous 5 years.

Rates that are significantly different ($p < .05$) from the Healthy People 2010 goal are shown by red italics.

Preventive Care

Type of Care	Qtr 3 CY 2002	Qtr 4 CY 2002	Qtr 1 CY 2003	Qtr 2 CY 2003	Healthy People 2010 Goal
Mammography (women ≥ 40)	79	*85*	65	73 (52)	70
Pap Smear (women ≥ 18)	91	*95*	94	93 (177)	90
Hypertension Screen (adults)	*91*	*85*	*89*	*88* (312)	95
Prenatal Care (in 1st trimester)	*95*	82	.	*98* (33)	90
Cholesterol Screen (adults)	*72*	*74*	*72*	*71* (308)	90

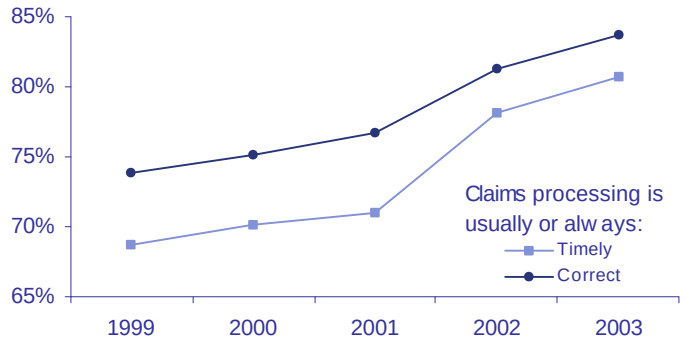
Issue Brief: Claims Processing and Customer Service in TRICARE

Each quarter, we publish a brief discussion, or issue brief, of a health policy issue relevant to users of TRICARE, based on data from the Health Care Survey of DoD Beneficiaries. This quarter, the issue brief concerns claims processing and customer service in TRICARE.

In TRICARE, claims processing and customer service have long been the source of dissatisfaction and complaints among both beneficiaries and providers[1] and a cause of network instability among providers.[2] In response to beneficiary complaints and congressional mandates, TRICARE adopted claims processing standards similar to those in Medicare and the commercial market. Claims administrators must pay 95 percent of routine claims within 30 days of receipt, and 100 percent of routine claims within 60 days of receipt.[3] More recently, congress mandated that 50 percent of claims, and all claims from high-volume providers, be electronically submitted.[4]

TRICARE beneficiary ratings of claims handling timeliness and correctness have risen steadily in recent years, and are now similar to the commercial norm. As shown in Figure 1, since 1999, the percentage of TRICARE users who think TRICARE's claims handling is usually or always timely has increased from 69 to 81. The percentage who think claims are usually or always processed correctly has improved from 74 to 84. Despite this improvement, providers and TRICARE administrators continue to express frustration with the speed and accuracy of claims processing.[5] Electronic processing lags: Wisconsin Physicians Service (WPS) notes that 53 percent of its TRICARE claims are submitted electronically, compared with 62 percent in the commercial market and 88 percent for Medicare.[6] Continued improvement in TRICARE's claims handling performance will require increasing the proportion of claims filed electronically and adjudicated automatically.

Figure 1:
TRICARE Claims Processing



Beneficiaries or their providers file TRICARE claims for care from civilian providers through one of TRICARE's Managed Care Support Contractors. The claims are administered by one of two subcontractors: Palmetto Government Benefits Administrators (PGBA), which processes 85 percent of TRICARE claims, and WPS.

Once received by the claims administrator, the speed with which claims are processed depends on whether they are adjudicated automatically or by a claims adjudicator. In 2000, 47 percent of TRICARE claims were automatically adjudicated, compared with current rates of 66 to 75 percent for industry leaders such as Humana and Anthem.[7,8] One reason TRICARE claims are less often adjudicated automatically is TRICARE's complexity. TRICARE's three plan options each have different benefits, co-payments, and adjudication procedures; provider reimbursement rules are complicated and frequently change, and since TRICARE is often a second payer, TRICARE payments often depend on members' other health insurance policies.[9]

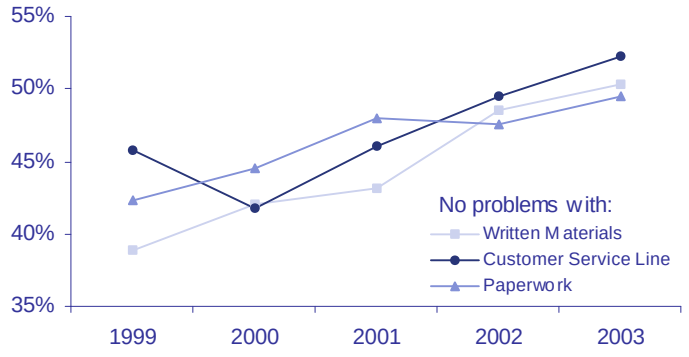
Technological and regulatory changes should increase electronic submission and speed adjudication of claims. These new developments include:

- HIPAA's universal standards for electronic claims. Many physicians submit paper claims for TRICARE patients because of the cost of modifying their computer systems to file electronic TRICARE claims, which differ from other electronic claims.[9] However, starting October 16, 2003, universal claims standards will remove this barrier and increase rates of electronic submission.[10]
- Financial incentives. Following current practice in Medicare, as of 2000, TRICARE contractors are allowed to provide financial incentives to their providers for electronic claims filing. DoD also allows providers to demand that interest be paid on claims unprocessed after 30 days.[11]
- Reduced utilization management requirements. Requirements such as preauthorization and certification complicate claims processing and are frequent sources of error.[12] As TRICARE and the rest of the health care industry drop these requirements, they will reduce error and delay.[4]
- The T-Nex program. By collapsing TRICARE's 11 CONUS regions and 7 managed care support contracts into three regions, with one managed care organization in charge of each region, T-Nex will simplify adjudication and increase electronic filing and claims processing.[5]

- Web-based claims filing. Since July 2002, PGBA has operated a web-based TRICARE claims processing system, XpressClaim, that permits real-time claims adjudication. The system permits claims to be submitted, edited, and, in many cases, adjudicated while the patient is in the doctor's office.

As shown by Figure 2, ratings of TRICARE customer service and paperwork have also improved, but more slowly than have claims handling ratings. Forty-six percent of TRICARE users in 1999 reported no problem getting help from the customer service phone line, compared to 52 percent in 2003, while the proportion reporting no problems with TRICARE paperwork has increased from 42 percent to 50 percent in the same period. The proportion able to find the information they need in TRICARE's written materials has increased most, from 39 percent to 50 percent.

Figure 2:
TRICARE Customer Service



Much of the information and assistance that beneficiaries need can be found on the new interactive TRICAREonline website, as well as the TRICARE, WPS, or PGBA websites. The websites contain tools to perform many services for enrollees and providers besides claims submission. Beneficiaries can enroll in TRICARE Prime, set up appointments with a primary care manager, check the status of their claims, check out of pocket expenses, send secure mail to the claims administrator, and access plan information on such things as benefits and lists of network providers.[13] Beginning next year, beneficiaries will be able to fill prescriptions on the web.

Increased website use may produce claims handling and customer service improvements. Beneficiaries who use these services and on-line plan information will have fewer problems with paperwork or written materials and less need for other forms of customer service. They will make fewer mistakes about their benefits and, as a result, have fewer problems with their claims. Simultaneously, use of the website for other purposes will spur electronic claims filing.

TRICARE can encourage website use by incorporating features useful to enrollees and providers and by arranging these features so that they are easily found and used. The design, accessibility and usability of TRICARE's website could greatly influence beneficiaries' claims handling and customer service experiences and, ultimately, their satisfaction with TRICARE.

Notes

[1] "TRICARE Provider Network Connects Military, Local Communities", http://www.tricare.osd.mil/plaintalk/plain_talk_2001_06.html

[2] Defense Health Care: Claims Processing Improvements Are Underway but Further Enhancements Are Needed (Letter Report, 08/23/1999, GAO/HEHS-99-128): Washington, DC: General Accounting Office, August 1999.

[3] The Managed Care Support Contractors Operations Manual, March 2001.

[4] FY2001 Defense Authorization Act (Public Law 106-398, 10/30/00).

[5] Tieman, J. "Marching Orders" in Modern Healthcare, May 19, 2003.

[6] http://www.wpsic.com/edi/edi_home.shtml

[7] Defense Health Care: Observations on Proposed Benefit Expansion and Overcoming TRICARE Obstacles (Testimony, 03/15/2000, GAO/T-HEHS/NSIAD-00-129): Washington, DC: General Accounting Office, March 2000.

[8] "Insurers Boost Electronic Transactions In Bid to Cut Administrative Costs", Managed Care Week 13 (6). Washington, DC: Atlantic Information Services, February 10, 2003.

[9] Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs (Testimony, 06/2//2000, GAO/T-HEHS-00-138): Washington, DC: General Accounting Office, June 2000.

[10] "Marry Internet, HIPAA Strategies to Pull Ahead in E-Commerce", Managed Care Week, Washington, DC: Atlantic Information Services, May 1, 2000.

[11] FY2000 Defense Authorization Act (Public Law 106-65, 10/5/99).

[12] McElfatrick R.L., and Eichler, R.S.,"Chapter 21: Claims and Benefits Administration", p.504, in Kongstvedt, P.R., Essentials of Managed Health Care 4th ed., Gaithersburg, MD: Aspen, 2001.

[13] www.tricareonline.com, various webpages