



March 2018

# DEFENSE HEALTH CARE

## TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved

# GAO Highlights

Highlights of [GAO -18-361](#), a report to congressional committees

## Why GAO Did This Study

DOD provides health care, including mental health care, to eligible beneficiaries through TRICARE. Beneficiaries who use TRICARE Prime, a managed care option, must enroll to receive care. Prior to Jan. 1, 2018, beneficiaries did not need to enroll for TRICARE Standard, a fee-for-service option, or TRICARE Extra, a preferred provider organization option (referred to as nonenrolled beneficiaries). Although the TRICARE Standard and Extra options were terminated effective Jan. 1, 2018, the new TRICARE Select option has similar benefits for obtaining care from network and nonnetwork providers.

The National Defense Authorization Act (NDAA) for Fiscal Year 2008 directed DOD to conduct surveys of nonenrolled beneficiaries and civilian providers about access to care under the TRICARE Standard and Extra options. It also directed GAO to review the surveys' results. Additionally, the NDAA for Fiscal Year 2017 included a provision for GAO to review access to care under TRICARE Extra. This report addresses both provisions.

GAO analyzed DOD's surveys to determine (1) nonenrolled beneficiaries' access to care, (2) nonenrolled beneficiaries' ratings of TRICARE, (3) civilian providers' awareness and acceptance of TRICARE, and (4) nonenrolled beneficiaries' access by individual geographic area. GAO interviewed agency officials, analyzed the 2012-2015 surveys, and compared them to DOD's 2008-2011 surveys and to surveys of Medicare and Medicaid beneficiaries. In commenting on a draft of this report, DOD concurred with GAO's findings.

View [GAO-18-361](#). For more information, contact Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov).

March 2018

## DEFENSE HEALTH CARE

### TRICARE Surveys Indicate Nonenrolled Beneficiaries' Access to Care Has Generally Improved

## What GAO Found

The Department of Defense's (DOD) most recent surveys of TRICARE beneficiaries and civilian health care providers show that access to care has generally improved for nonenrolled beneficiaries who used the TRICARE Standard and Extra options. Specifically, GAO found the following:

- Nonenrolled beneficiaries reported improved access to care in the most recent 4-year survey (2012-2015), compared to the prior survey (2008-2011). For example, a lower percentage of nonenrolled beneficiaries reported that they experienced problems finding a civilian provider in the most recent survey (29 percent) than those in the prior survey (31 percent). In addition, a higher percentage of nonenrolled beneficiaries (90 percent) reported that they were usually or always able to obtain a non-urgent appointment as soon as they thought they needed compared to the prior survey (87 percent).
- The percentage of nonenrolled beneficiaries who reported positive experience ratings of TRICARE ranged from 71 to 83 percent over five categories, including ratings of primary, specialty, and mental health care providers. These ratings were generally higher than the prior survey. When compared to other federal health plans, nonenrolled TRICARE beneficiaries' positive experience ratings of primary and specialty care providers were lower than those of Medicare fee-for service beneficiaries, but higher than those of Medicaid beneficiaries.
- The percentage of civilian providers who were aware of TRICARE increased from 82 percent in the prior survey to 84 percent. However, the percentage who accepted new TRICARE patients decreased from 58 percent to 55 percent. According to GAO's analysis of survey data, this overall decrease was mainly attributable to a decrease in mental health care providers' acceptance rates, as the acceptance rates for primary and specialty care providers remained unchanged. Network providers reported both higher awareness and acceptance of TRICARE than providers not in the network (referred to as nonnetwork providers). The biggest gap in both awareness and acceptance between network and nonnetwork providers was for mental health care providers:
  - About 96 percent of network mental health care providers reported awareness of TRICARE compared to 72 percent of nonnetwork mental health care providers.
  - About 79 percent of network mental health care providers reported accepting new TRICARE patients compared to 30 percent of nonnetwork mental health care providers.
- GAO's analysis of both the beneficiary and provider surveys identified locations in New York, Washington, Texas, and Washington, D.C. where access to providers may be particularly problematic. Specifically, in these locations, beneficiaries reported more problems finding providers who accepted TRICARE and providers reported lower acceptance of TRICARE, compared to national averages.

---

# Contents

---

---

Letter		1
	Background	7
	Nonenrolled TRICARE Beneficiaries Reported Generally Experiencing Fewer Problems Accessing Care, and More Reported Obtaining Care when Desired	12
	Nonenrolled Beneficiaries' Positive Ratings of TRICARE Have Generally Increased over Time and Vary Compared to Other Federal Health Plans	21
	Civilian Providers' Reported Awareness of TRICARE Has Generally Increased over Time, While Mental Health Providers' Acceptance of New TRICARE Patients Has Decreased	25
	DOD's Surveys of Nonenrolled Beneficiaries and Civilian Providers Collectively Indicate That Specific Geographic Locations May Have Access Problems	31
	Agency Comments	33
Appendix I	Comments from the Department of Defense	34
Appendix II	GAO Contact and Staff Acknowledgments	35
Tables		
	Table 1: Summary of Basic TRICARE Options Prior to January 1, 2018	8
	Table 2: Locations with Both Potential Problems of Beneficiaries Not Finding Providers and Providers Not Accepting New TRICARE Patients, 2012-2015	32
Figures		
	Figure 1: Percentage of Nonenrolled TRICARE Beneficiaries by Beneficiary Category, September 2016 (Number of Beneficiaries)	7
	Figure 2: Percentage of Nonenrolled TRICARE Beneficiaries by Location, September 2016 (Number of Beneficiaries)	10
	Figure 3: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider over Time, by Provider Type	13

---

---

---

Figure 4: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider, by Provider Type and Location Type (2012-2015)	15
Figure 5: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider, by Provider Type and Network Status (2012-2015)	17
Figure 6: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Specialty or Mental Health Care Provider over Time, by Provider Type and Network Status	18
Figure 7: Comparison of Nonenrolled Beneficiaries' Estimated Positive Ratings of Their TRICARE Experiences, over Time	22
Figure 8: Nonenrolled TRICARE Beneficiaries' Estimated Experience Ratings Compared to Those of Medicare Fee-For-Service and Medicaid Beneficiaries	23
Figure 9: Civilian Providers' Reported Awareness of TRICARE, by Provider Type and Network Status (2012-2015)	27
Figure 10: Civilian Providers' Reported Acceptance of New TRICARE Patients, by Provider Type and Network Status (2012-2015)	30

---

---

## Abbreviations

CAHPS	Consumer Assessment of Healthcare Providers and Systems
DOD	Department of Defense
HHS	Department of Health and Human Services
HSA	Hospital Service Area
NDA	National Defense Authorization Act
NDA 2008	National Defense Authorization Act for Fiscal Year 2008
NDA 2012	National Defense Authorization Act for Fiscal Year 2012
NDA 2017	National Defense Authorization Act for Fiscal Year 2017
PSA	Prime Service Area
VA	Department of Veterans Affairs

This is a work of the U.S. government and is not subject to copyright protection in the United States. The published product may be reproduced and distributed in its entirety without further permission from GAO. However, because this work may contain copyrighted images or other material, permission from the copyright holder may be necessary if you wish to reproduce this material separately.



March 29, 2018

The Honorable John McCain  
Chairman  
The Honorable Jack Reed  
Ranking Minority Member  
Committee on Armed Services  
United States Senate

The Honorable Mac Thornberry  
Chairman  
The Honorable Adam Smith  
Ranking Minority Member  
Committee on Armed Services  
House of Representatives

In fiscal year 2016, the Department of Defense (DOD) offered health care services, including mental health care, to more than 9 million eligible beneficiaries in the United States and abroad through TRICARE, DOD's regionally structured health care program.<sup>1</sup> Under TRICARE, beneficiaries may obtain care either from military hospitals and clinics, referred to collectively as military treatment facilities, or from civilian providers.<sup>2</sup> However, since TRICARE's inception in 1995, beneficiaries in some locations—particularly those who did not enroll in TRICARE's managed care option—have raised concerns about difficulties finding civilian providers who will accept them as patients.

The number and type of civilian providers available to serve TRICARE beneficiaries can vary depending on a beneficiary's location and choice of coverage—which prior to January 1, 2018, consisted of TRICARE's three

---

<sup>1</sup>Eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve servicemembers and their dependents, and retirees and their dependents and survivors, among others. Active duty personnel include Reserve component members on active duty for at least 30 days.

<sup>2</sup>Through individual agreements between military treatment facilities and the Department of Veterans Affairs' (VA) medical centers, eligible beneficiaries also may receive certain types of care from VA medical centers in some locations.

---

basic plans: Prime, Extra, and Standard.<sup>3</sup> Beneficiaries who used TRICARE Prime, a managed care option, had to enroll and could obtain care through military treatment facilities or TRICARE's network of civilian providers.<sup>4</sup> DOD uses contractors, called managed care support contractors, to develop networks of civilian providers (network providers) to ensure adequate access to care for all TRICARE beneficiaries in geographic areas called Prime Service Areas (PSA).<sup>5</sup> Although some network providers may be located outside of PSAs, contractors are not required to develop networks in these areas (which we refer to as non-PSAs).

Beneficiaries did not need to enroll to receive care under TRICARE Standard, a fee-for-service option, or TRICARE Extra, a preferred provider organization option. These beneficiaries—referred to as nonenrolled beneficiaries—could choose to receive care either through TRICARE Standard when they saw nonnetwork civilian providers or through TRICARE Extra when they saw network civilian providers. The National Defense Authorization Act for Fiscal Year 2017 (NDAA 2017) terminated both the TRICARE Standard and Extra options and established a self-managed preferred provider option called TRICARE Select beginning January 1, 2018.

In response to nonenrolled beneficiaries' concerns about access to care, the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) directed DOD to conduct a multi-year survey (2008-2011) of nonenrolled beneficiaries and a multi-year survey (2008-2011) of civilian providers to determine the adequacy of access to health care providers, including mental health care providers, for nonenrolled beneficiaries.<sup>6</sup> The National Defense Authorization Act for Fiscal Year 2012 (NDAA 2012) directed

---

<sup>3</sup>The National Defense Authorization Act for Fiscal Year 2017 included a number of changes to the TRICARE program, including the termination of TRICARE Standard and Extra and the establishment of a new option, TRICARE Select, which took effect on Jan. 1, 2018.

<sup>4</sup>Active duty personnel are required to use TRICARE Prime.

<sup>5</sup>PSAs are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military outpatient or inpatient treatment facility or a Base Realignment and Closure site, which is a military installation that has been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

<sup>6</sup>See Pub. L. No. 110-181, § 711(a), 122 Stat. 3, 190-191. (2008).

---

DOD to continue both of these surveys for an additional 4-year period (2012-2015).<sup>7</sup>

The NDAA 2008 also included a recurring provision for us to review a series of issues related to the adequacy of access to care for nonenrolled TRICARE beneficiaries, including information gleaned from the beneficiary and civilian provider surveys, and to report on these issues on a biannual basis.<sup>8</sup> We have issued a series of reports in response to this provision, including two reports that focused on DOD's beneficiary and civilian provider surveys.<sup>9</sup> In addition, the NDAA 2017 directed us to conduct a review of the network of civilian providers that provide care to nonenrolled beneficiaries under the TRICARE Extra option.<sup>10</sup>

This report addresses provisions in both the NDAA 2008, as amended, and the NDAA 2017 for us to report on the adequacy of access to care for nonenrolled TRICARE beneficiaries. Specifically, it describes

1. what the results of the most recent 4-year beneficiary survey indicate about access to care for nonenrolled beneficiaries;
2. what the results of the most recent 4-year beneficiary survey indicate about nonenrolled beneficiaries' ratings of their experience with TRICARE;

---

<sup>7</sup>Pub. L. No. 112-81, § 721(a), 125 Stat. 1298, 1478 (2011).

<sup>8</sup>This reporting time frame was amended in the NDAA 2012 to biennial reporting instead of biannual reporting. The National Defense Authorization Act for Fiscal Year 2015 amended GAO's reporting requirements to issue two remaining reports—one in 2017 and one in 2020.

<sup>9</sup>For the reports on DOD's surveys, see GAO, *Defense Health Care: TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries*, [GAO-13-364](#) (Washington, D.C.: Apr. 2, 2013) and *Defense Health Care: 2008 Access to Care Surveys Indicate Some Problems, but Beneficiary Satisfaction Is Similar to Other Health Plans*, [GAO-10-402](#) (Washington, D.C.: Mar. 31, 2010). Other reports in response to this provision include *Defense Health Care: More-Specific Guidance Needed for Assessing Nonenrolled TRICARE Beneficiaries' Access to Care*, [GAO-14-384](#) (Washington, D.C.: Apr. 28, 2014); *Defense Health Care: DOD Lacks Assurance That Selected Reserve Members Are Informed About TRICARE Reserve Select*, [GAO-11-551](#) (Washington, D.C.: June 3, 2011); and *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, [GAO-11-500](#) (Washington, D.C.: June 2, 2011).

<sup>10</sup>Pub. L. No. 114-328, § 701(g)(2), 130 Stat. 2000, 2188 (2016).

- 
3. what the results of the most recent 4-year civilian provider survey indicate about civilian providers' awareness and acceptance of TRICARE; and
  4. what the collective results of the most recent 4-year beneficiary and civilian provider surveys indicate about access to care for nonenrolled beneficiaries by geographic area.

To determine what the results of the most recent 4-year beneficiary survey indicate about access to care for nonenrolled beneficiaries, we obtained and analyzed survey data from DOD's TRICARE Standard Surveys of Beneficiaries for 2012-2015. Specifically, we analyzed these data to determine whether nonenrolled beneficiaries were able to obtain an appointment as soon as they wanted, how quickly they were able to get an appointment to see a provider, and if they had a problem finding a provider that would accept TRICARE.<sup>11</sup> We compared these data across location types, provider types, and providers' network status, where applicable. We also compared these results to DOD's 2008-2011 survey results to identify any changes in beneficiaries' access over time.

To determine what the results of the most recent 4-year beneficiary survey indicate about nonenrolled beneficiaries' ratings of their experience with TRICARE, we obtained and analyzed the 2012-2015 nonenrolled beneficiary survey data that indicated beneficiaries' ratings of certain aspects of their TRICARE experiences, such as their ratings of health care, health plan, and primary, specialty, and mental health care providers.<sup>12</sup> We compared these data by providers' network status, where applicable. We also obtained and analyzed data from the Department of Health and Human Services' (HHS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys for the 2013-2015 time period to compare nonenrolled TRICARE beneficiaries' ratings to those of

---

<sup>11</sup>For mental health care, the survey question asked beneficiaries how much of a problem it was to get the "treatment or counseling you needed through your health plan," and not necessarily to find a provider that would accept TRICARE.

<sup>12</sup>DOD reports beneficiaries' ratings as positive if they are on an 8, 9, or 10 on a 0-10 point scale. We did the same in our analysis.

---

Medicare fee-for-service and Medicaid beneficiaries.<sup>13</sup> Additionally, we compared the results of DOD's 2012-2015 beneficiary surveys to DOD's 2008-2011 survey results to identify any changes in beneficiaries' ratings of experiences over time.

To determine what the results of the most recent 4-year civilian provider surveys indicate about civilian providers' awareness and acceptance of TRICARE, we obtained and analyzed survey data from DOD's TRICARE Standard Surveys of Providers for 2012-2015. We compared these data by location type, provider type, and providers' network status, where applicable. We compared these results to the results from DOD's 2008-2011 surveys to identify any changes in provider awareness and acceptance over time.

To determine what the collective results of the most recent 4-year beneficiary and civilian provider surveys indicate about access to care for nonenrolled beneficiaries, we compared the results of our analyses of the 2012-2015 beneficiary and provider survey data by specific geographic regions, where possible, in order to identify locations with high percentages of nonenrolled beneficiaries who experienced problems finding civilian providers and low percentages of civilian providers who were accepting new TRICARE patients.<sup>14</sup> We conducted this analysis by individual location type and provider type.

For each objective, we assessed the reliability of the data from the surveys—including DOD's 2012-2015 nonenrolled beneficiary and civilian provider surveys and HHS's CAHPS survey—by speaking with knowledgeable officials and reviewing relevant documentation. DOD calculated the response rates for its 2012-2015 nonenrolled beneficiary surveys and civilian provider surveys to be about 25 percent and 39

---

<sup>13</sup>DOD based its nonenrolled beneficiary survey questions on HHS's CAHPS survey, which allows for comparisons between the surveys. HHS's CAHPS survey is an annual, national survey of beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program. According to a CAHPS official, the CAHPS survey for Medicare and Medicaid beneficiaries was not conducted in 2012. Therefore, for each of the Medicare fee-for-service and Medicaid surveys, we combined the 2013-2015 annual data into one point estimate in order to compare the results to DOD's 4-year beneficiary surveys over a similar period.

<sup>14</sup>Similar to our report on the prior 4-year surveys, we correlated survey results for which both (1) beneficiaries reported more problems finding civilian providers than the national average and (2) civilian providers reported less acceptance of new TRICARE patients than the national average. See [GAO-13-364](#).

---

percent, respectively.<sup>15</sup> We verified that the surveys' results were representative of the areas surveyed by reviewing DOD's nonresponse analyses for these surveys and by interviewing DOD officials.<sup>16</sup> We determined that all data used in this report were sufficiently reliable for our purposes. However, our analyses have some limitations. In our collective analyses of DOD's beneficiary and provider surveys, we were not able to compare survey results among all of the individual geographic locations due to low numbers of respondents in some areas. Specifically, we excluded individual locations that had less than 30 respondents to the beneficiary survey or less than 50 respondents to the provider survey, depending on the survey questions we analyzed. Due to the low numbers of respondents who indicated that they needed mental health care, we were unable to identify specific geographic locations in which nonenrolled beneficiaries experienced problems finding mental health providers.

We conducted this performance audit from March 2017 to March 2018 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

---

<sup>15</sup>For the 4 years of the nonenrolled beneficiary survey, DOD mailed 146,125 surveys and received 35,242 complete and eligible responses, 19,415 of which were from nonenrolled TRICARE beneficiaries. DOD considered complete and eligible responses as those where TRICARE beneficiaries who answered at least half of the DOD-identified "key" questions. Over the 4 years of the 2012-2015 civilian provider survey, DOD mailed 192,129 surveys to physician and mental health providers, and received 50,331 complete and eligible responses. DOD considered the survey complete if the provider answered three DOD-identified "key" questions that asked about the providers' locations of practice and awareness and acceptance of TRICARE.

<sup>16</sup>DOD concluded that the results of the beneficiary survey nonresponse analyses suggested that although there were some differences in the demographic profiles between respondents and nonrespondents, they were not associated with systematic differences in satisfaction with care.

From the results of the civilian provider survey nonresponse analyses, DOD concluded that there were only slight differences between respondents and nonrespondents in terms of the type of provider. For both the beneficiary and provider surveys, DOD officials also told us that the final post-survey weights used in their analyses accounted for the key characteristic differences in survey respondents compared with nonrespondents identified through the nonresponse analyses for both types of surveys.

---

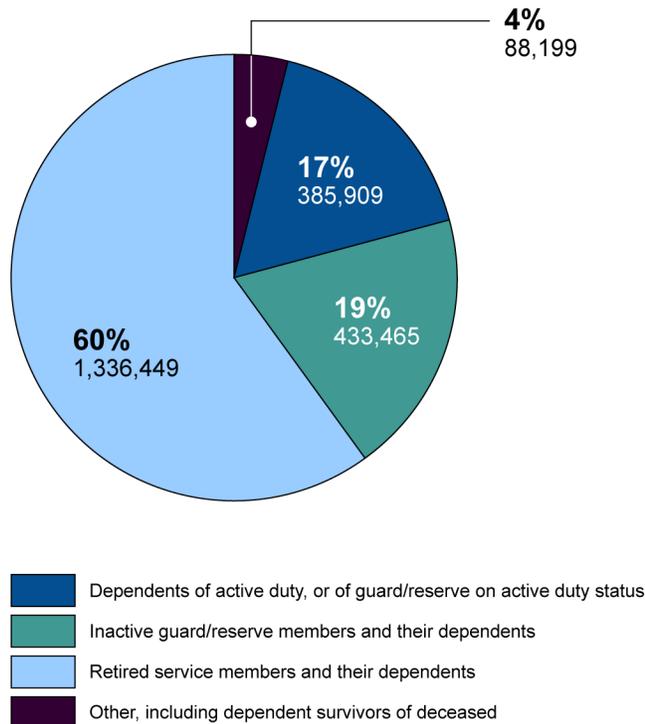
---

## Background

### Composition of TRICARE's Nonenrolled Beneficiary Population

In fiscal year 2016, DOD identified about 2.2 million nonenrolled TRICARE beneficiaries who fell into four categories: (1) retired servicemembers and their dependents, (2) inactive guard/reserve servicemembers and their dependents, (3) dependents of active duty, or of guard/reserve on active duty status, and (4) other beneficiaries, such as dependent survivors of deceased servicemembers. Retired servicemembers and their dependents made up the majority of nonenrolled beneficiaries at the end of fiscal year 2016 (approximately 60 percent). (See fig. 1.)

**Figure 1: Percentage of Nonenrolled TRICARE Beneficiaries by Beneficiary Category, September 2016 (Number of Beneficiaries)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

---

## TRICARE's Benefit Options

Prior to January 1, 2018, TRICARE provided benefits through three basic options for its non-Medicare-eligible beneficiary population—TRICARE Prime, Standard, and Extra.<sup>17</sup> These options varied by enrollment requirements, choices in civilian and military treatment facility providers, and the amount beneficiaries must contribute toward the cost of their care. (See table 1.)

---

**Table 1: Summary of Basic TRICARE Options Prior to January 1, 2018**

TRICARE option	Description
TRICARE Prime	This is TRICARE's managed care option and requires enrollment. All active duty servicemembers are required to use this option, while other TRICARE beneficiaries may choose it. Prime enrollees receive most of their care from providers at military treatment facilities and also may receive care from network civilian providers. This option has the lowest out-of-pocket costs for beneficiaries, as care provided at military treatment facilities does not have an associated copayment.
TRICARE Standard and Extra	TRICARE beneficiaries who chose not to enroll in TRICARE Prime were able to obtain health care from nonnetwork providers (TRICARE Standard) or network civilian providers (TRICARE Extra). The TRICARE Standard option was designed to provide beneficiaries with maximum flexibility in selecting providers, but beneficiaries who obtained care from a network provider through TRICARE Extra paid lower copayments than they would if they had chosen a nonnetwork provider under the TRICARE Standard option. TRICARE Standard and Extra beneficiaries could also receive care from military treatment facilities, though they had a lower priority for receiving care than TRICARE Prime beneficiaries.

---

Source: GAO summary of Department of Defense TRICARE documentation. | GAO-18-361

The NDAA 2017 made specific changes to the TRICARE program that became effective on January 1, 2018. These changes included terminating the TRICARE Standard and Extra options, establishing a new option called TRICARE Select, and ensuring that 85 percent of TRICARE Select beneficiaries are covered by the network of civilian providers.

---

<sup>17</sup>TRICARE also offers TRICARE for Life to TRICARE beneficiaries who are eligible for Medicare and enroll in Part B. Under the TRICARE for Life program, TRICARE processes claims after they have been adjudicated by Medicare.

---

TRICARE Select has similar benefits to TRICARE Standard and Extra for obtaining care from nonnetwork and network providers, but unlike these options, TRICARE Select requires enrollment.

---

## TRICARE Networks and Locations

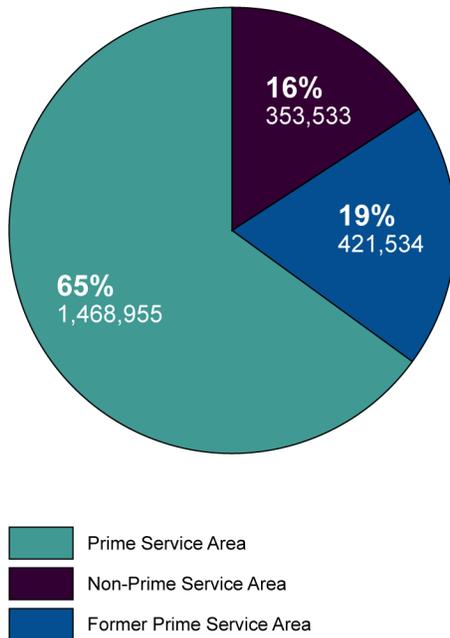
Under TRICARE, DOD uses managed care support contractors to develop networks of civilian providers to serve all TRICARE beneficiaries in PSAs, which are typically within an approximate 40-mile radius of a military outpatient or inpatient treatment facility or Base Realignment and Closure sites. Although some network providers may be located in non-PSAs, contractors are not required to develop networks in these areas. Previously, contractors had the option of developing additional PSAs (and civilian provider networks) in areas that were not located near military treatment facilities or Base Realignment and Closure sites. However, on October 1, 2013, DOD eliminated these additional PSAs, referred to in the survey analyses as “former PSAs,” and as a result, the managed care support contractors were no longer required to develop and maintain networks of civilian providers in these areas.<sup>18</sup>

In fiscal year 2016, approximately 65 percent of the 2.2 million nonenrolled beneficiaries that were eligible for TRICARE Standard and Extra (1.47 million) lived in PSAs. Of the remaining nonenrolled beneficiaries (775,000), about 19 percent lived in former PSAs and about 16 percent lived in non-PSAs. (See fig. 2.) Nonenrolled beneficiaries who live in former PSAs and non-PSAs may still have access to network providers, even though contractors are not required to develop networks in these areas. About 57 percent of these beneficiaries (445,000) filed at least one TRICARE claim with a network civilian provider during fiscal year 2016.

---

<sup>18</sup>Managed care support contractor officials told us that they did not have plans to eliminate the networks of providers that were already established in those locations.

**Figure 2: Percentage of Nonenrolled TRICARE Beneficiaries by Location, September 2016 (Number of Beneficiaries)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Note: The Department of Defense requires its TRICARE contractors to develop networks of civilian providers (network providers) in geographic areas called Prime Service Areas, which are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military outpatient or inpatient treatment facility or a Base Realignment and Closure site. Contractors are not required to develop networks outside of these areas, which we refer to as non-Prime Service Areas. Previously, contractors had the option of developing additional Prime Service Areas (and civilian provider networks), in areas that were not located near military treatment facilities or Base Realignment and Closure sites. However, on Oct. 1, 2013, DOD eliminated these additional areas, which are referred to as “former Prime Service Areas”.

## DOD’s Implementation of Mandated Beneficiary and Civilian Provider Survey Requirements

The NDAA 2008 directed DOD to survey nonenrolled beneficiaries and civilian providers in at least 20 PSAs in each of four fiscal years, 2008 through 2011, as well as 20 non-PSAs. To do this, DOD divided the country into 80 distinct PSAs and 80 distinct non-PSAs and surveyed 20 PSAs and 20 non-PSAs each year. At the end of the 4-year period, each year’s survey results were combined and weighted to develop estimates of access to health care, including mental health care, at the service area, state, and national levels. Additionally, the NDAA 2008 required DOD to consult with representatives of TRICARE beneficiaries and providers of health care, including mental health care, to identify locations where nonenrolled beneficiaries have experienced significant access-to-care problems and to survey both beneficiaries and health care providers, including mental health care providers, in these areas. Based on these

---

consultations, DOD designated certain Hospital Service Areas (HSA) to include in its beneficiary and provider surveys.<sup>19</sup>

DOD used a similar methodology for determining its locations in the 2012-2015 surveys. However, as a result of DOD's changes to PSAs on October 1, 2013, 28 of the 80 non-PSAs surveyed were former PSAs. DOD also surveyed both nonenrolled beneficiaries and civilian providers in a total of 30 HSAs. As a result, DOD collectively surveyed 190 geographic locations over the 4-year period.<sup>20</sup> Furthermore, we previously reported that DOD's implementation of its 2008-2011 nonenrolled beneficiary and civilian provider surveys generally addressed the requirements outlined in the NDAA 2008.<sup>21</sup> DOD made several minor revisions to the methodologies of the 2012-2015 surveys, but we determined that none of those changes altered DOD's compliance with the NDAA 2008, as amended.

---

<sup>19</sup>According to DOD officials, representatives of TRICARE beneficiaries and health care providers suggested cities and towns where access should be measured, and DOD then identified HSAs corresponding to each city and town. HSAs, as defined by a Dartmouth University study, are collections of zip codes organized into more than 3,000 geographic regions in which Medicare beneficiaries seek the majority of their care from one hospital or a collection of hospitals. HSAs have non-overlapping borders and contain all U.S. zip codes without gaps in coverage. The HSAs included in the beneficiary and civilian provider surveys are within the PSAs or non-PSAs surveyed.

<sup>20</sup>The 80 PSAs, 52 non-PSAs, and 28 former PSAs covered the entire country. Even though the 30 HSAs are contained within the surveyed PSAs, non-PSAs, or former PSAs, DOD counts them as separate locations, totaling 190 surveyed areas.

<sup>21</sup>See [GAO-10-402](#) and [GAO-13-364](#). For more detailed information on DOD's methodology for the surveys, see Appendix II in [GAO-10-402](#) and Appendix I in [GAO-13-364](#).

---

---

---

Nonenrolled  
TRICARE  
Beneficiaries  
Reported Generally  
Experiencing Fewer  
Problems Accessing  
Care, and More  
Reported Obtaining  
Care when Desired

---

Nonenrolled TRICARE  
Beneficiaries Reported  
Generally Experiencing  
Fewer Problems  
Accessing Care than in  
the Prior Survey

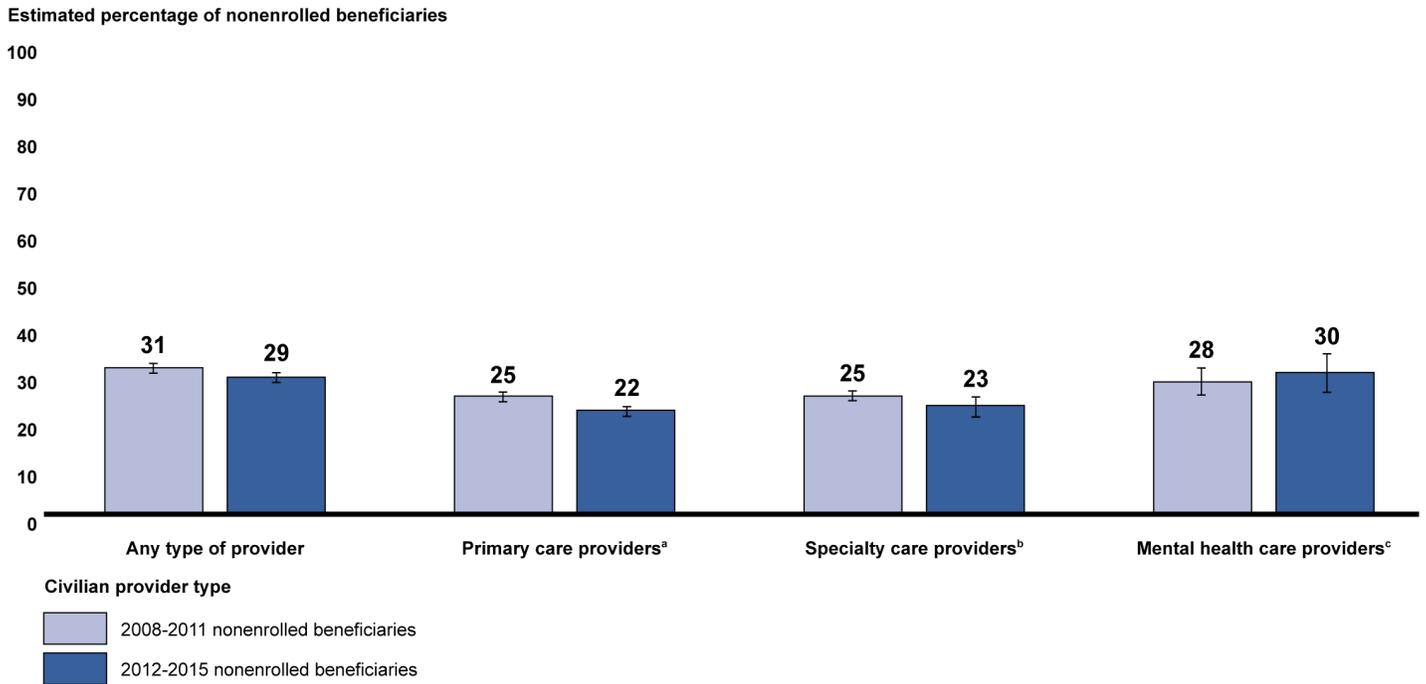
**Nonenrolled beneficiary survey results over time.** Nationwide, a lower percentage of nonenrolled beneficiaries reported that they experienced problems finding any type of provider in the 2012-2015 survey (29 percent) when compared to the prior 2008-2011 survey (31 percent).<sup>22</sup> Specifically, fewer nonenrolled beneficiaries reported that they experienced problems finding a primary care provider than in the prior survey (22 percent in 2012-2015 compared to 25 percent in 2008-2011).<sup>23</sup> However, there was no significant statistical difference over time in the percentage of beneficiaries who reported experiencing problems finding a specialty care or mental health care provider. (See fig. 3.)

---

<sup>22</sup>The margins of error for these estimates are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>23</sup>The margins of error for the estimates of beneficiary problems finding civilian primary care providers are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

**Figure 3: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider over Time, by Provider Type**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number.

Within provider types, the differences in estimates between the 2008-2011 survey and the 2012-2015 survey are statistically different at the 95 percent confidence level for “any type of provider” and primary care providers.

<sup>a</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: In the last 12 months, how much of a problem was it to find a personal doctor who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>b</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: “In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>c</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: “In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

Nonenrolled TRICARE beneficiaries who reported they experienced problems accessing a TRICARE provider were surveyed on the reasons for their problems. “Dr. was not accepting TRICARE payment” was the most-reported reason among all three provider types—primary care, specialty care, and mental health—and was reported by about 50 percent of respondents.

Some of the other top reasons reported were that the

- doctor was not taking any new TRICARE patients;
- doctor was not taking any new patients;
- travel distance was too long; or
- wait time for an appointment was too long

These top reasons were similar for both network and nonnetwork providers.

Source: GAO analysis of Department of Defense data. | GAO-18-361

---

---

**Nonenrolled beneficiary survey results by type of location.**

Nonenrolled beneficiaries in non-PSAs reported experiencing fewer problems finding primary and specialty providers than those in PSAs, which is similar to what we reported for the prior survey.<sup>24</sup> For example, about 20 percent of beneficiaries in non-PSAs reported that they had problems finding specialty care providers compared to 24 percent in PSAs.<sup>25</sup> Regarding beneficiaries in former PSAs, the only statistically significant difference among the three provider types was for problems finding a primary care provider. Specifically, fewer (about 19 percent) nonenrolled beneficiaries in non-PSAs reported experiencing problems finding a primary care provider to accept TRICARE, compared to 24 percent in former PSAs.<sup>26</sup> (See fig. 4.) DOD officials told us that they were unsure of the exact reasons for the difference between PSAs and non-PSAs. However, they explained that PSAs are often located in more populated areas, where TRICARE beneficiaries may not make up a large market share for local civilian providers, who may have a wide array of patients with other health plans.

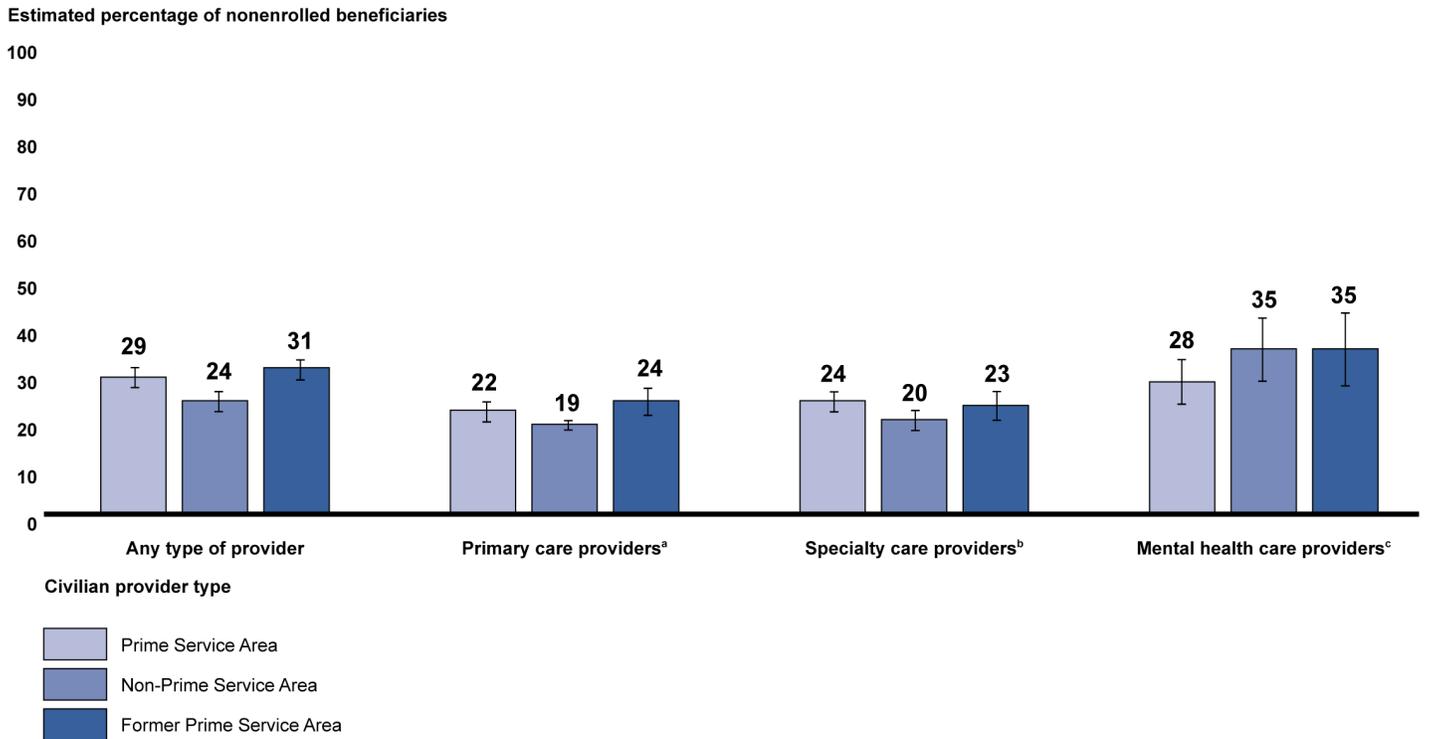
---

<sup>24</sup>See [GAO-13-364](#).

<sup>25</sup>The margins of error for these estimates are within plus or minus 2 percentage points at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>26</sup>The margins of error for these estimates are within plus or minus 3 percentage points at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

**Figure 4: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider, by Provider Type and Location Type (2012-2015)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number.

The Department of Defense requires its TRICARE contractors to develop networks of civilian providers (network providers) in geographic areas called Prime Service Areas, which are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military outpatient or inpatient treatment facility or a Base Realignment and Closure site. Contractors are not required to develop networks outside of these areas, which we refer to as non-Prime Service Areas. Previously, contractors had the option of developing additional Prime Service Areas (and civilian provider networks), in areas that were not located near military treatment facilities or Base Realignment and Closure sites. However, on October 1, 2013, DOD eliminated these additional areas, which are referred to as “former Prime Service Areas”.

Within provider types, the following differences in estimates between location types are statistically different at the 95 percent confidence level: within “any type of provider” and primary care providers, the estimates for non-Prime Service Areas are less than those for Prime Service Areas or former Prime Service Areas; within specialty care providers, the estimate for non-Prime Service Areas is less than Prime Service Areas.

<sup>a</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: In the last 12 months, how much of a problem was it to find a personal doctor who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>b</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: “In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>c</sup>Respondents answered “a big problem” or “a small problem” to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or

---

counseling you needed through your health plan? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

**Nonenrolled beneficiary survey results by network status.**

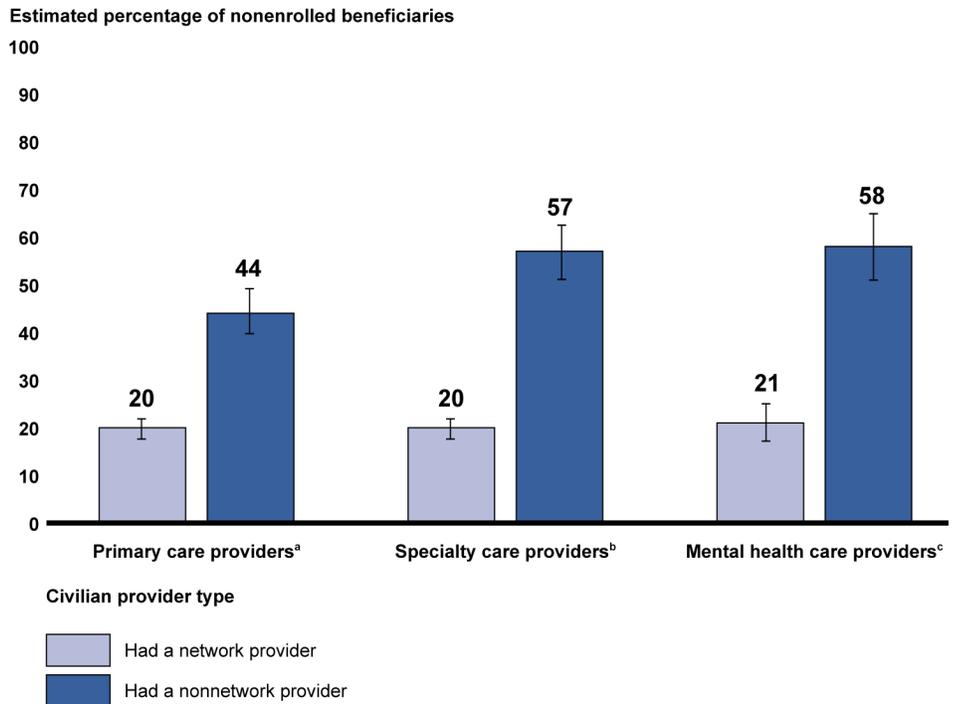
Nonenrolled beneficiaries with network providers reported experiencing fewer problems finding civilian providers, compared to nonenrolled beneficiaries with nonnetwork providers. For example, 20 percent of the nonenrolled beneficiaries who used a network civilian primary care provider reported that they had a problem finding a primary care provider that would accept TRICARE compared with the 44 percent of nonenrolled beneficiaries who used a nonnetwork civilian primary care provider.<sup>27</sup>

(See fig. 5.)

---

<sup>27</sup> The margins of error for the estimates of nonenrolled beneficiaries’ problems finding civilian primary care provider (by network status) at the 95 percent confidence level are within plus or minus 5 percentage points. These estimates are significantly different from each other at the 95 percent confidence level.

**Figure 5: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Civilian Provider, by Provider Type and Network Status (2012-2015)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number.

Within each provider type, the differences in estimates between network and nonnetwork providers are statistically different at the 95 percent confidence level.

Due to the wording of the questions, we could not determine the problems finding “any type of provider” by network status.

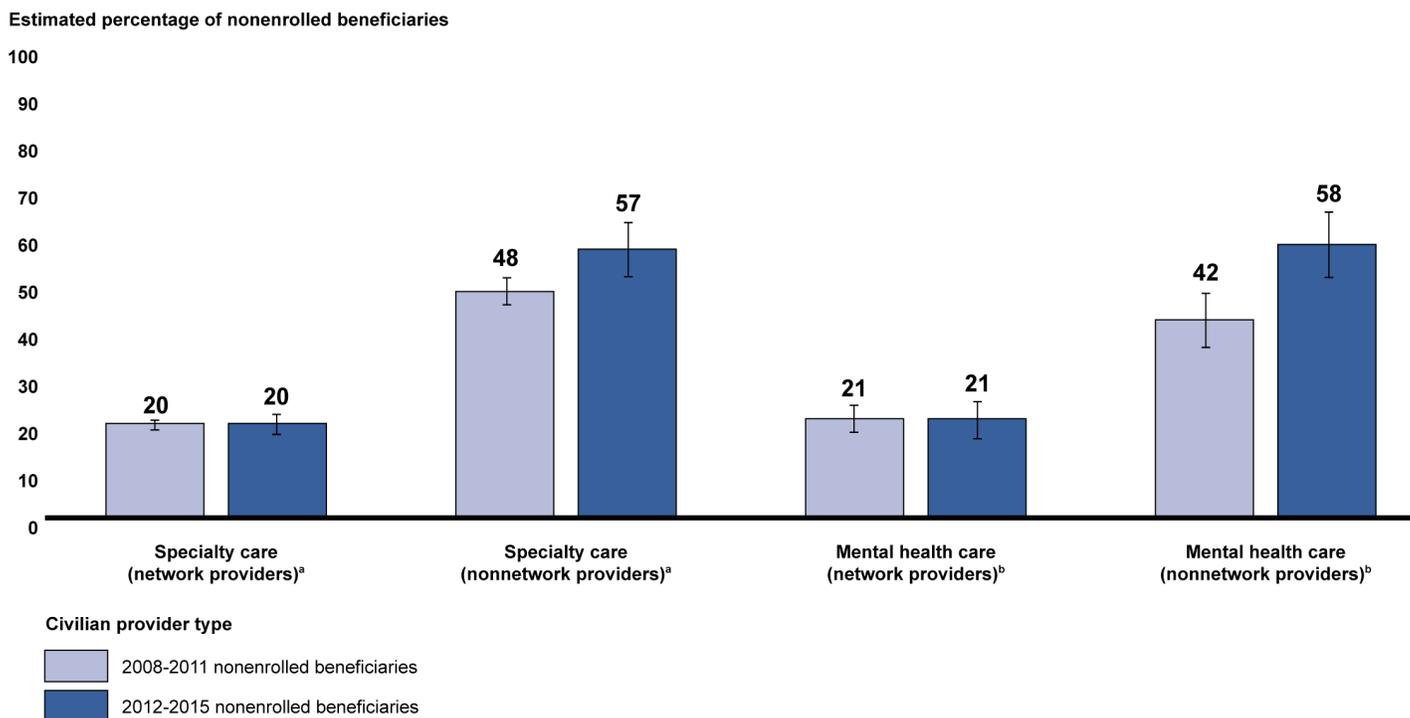
<sup>a</sup>For the providers’ network status, respondents answered either “yes” or “no” to the question that asked: Is your personal doctor part of the TRICARE civilian provider network? In addition, respondents answered either “a big problem” or “a small problem” to the question that asked: In the last 12 months, how much of a problem was it to find a personal doctor who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>b</sup>For the providers’ network status, respondents answered either “yes” or “no” to the question that asked: In the last 12 months, was the civilian specialist you saw most part of the TRICARE civilian provider network? In addition, respondents answered “a big problem” or “a small problem” to the question that asked: “In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

<sup>c</sup>For the providers’ network status, respondents answered either “yes” or “no” to the question that asked: In the last 12 months, did you receive this treatment or counseling from a provider in TRICARE’s civilian network? In addition, respondents answered “a big problem” or “a small problem” to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were “a big problem,” “a small problem,” or “not a problem.”

In addition, when compared with the results of the last survey (2008-2011), the percentages of nonenrolled beneficiaries who reported that they experienced problems finding a specialty care or mental health care provider increased in the most recent survey (2012-2015) for beneficiaries who used nonnetwork providers, but there were no changes over time if their specialty care or mental health care providers were in the network.<sup>28</sup> (See fig. 6.)

**Figure 6: Nonenrolled TRICARE Beneficiaries Who Reported Experiencing Problems Finding a Specialty or Mental Health Care Provider over Time, by Provider Type and Network Status**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number.

Within specialty health care and mental health care nonnetwork providers, the differences in estimates between the 2008-2011 and 2012-2015 surveys are statistically different at the 95 percent confidence level.

<sup>28</sup>Changes over time for problems finding a primary care provider were not significant at the 95 percent confidence level. Twenty percent of nonenrolled beneficiaries with network primary care providers and 44 percent of those with nonnetwork primary care providers reported problems finding a primary care provider in the 2012-2015 survey.

---

<sup>a</sup>For the providers' network status, respondents answered either "yes" or "no" to the question that asked: In the last 12 months, was the civilian specialist you saw most part of the TRICARE civilian provider network? In addition, respondents answered "a big problem" or "a small problem" to the question that asked: In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE? Answer choices were "a big problem," "a small problem," or "not a problem."

<sup>b</sup>For the providers' network status, respondents answered either "yes" or "no" to the question that asked: In the last 12 months, did you receive this treatment or counseling from a provider in TRICARE's civilian network? In addition, respondents answered "a big problem" or "a small problem" to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were "a big problem," "a small problem," or "not a problem."

---

## More Nonenrolled TRICARE Beneficiaries Reported Obtaining Appointments as Soon as Desired

Compared to the prior survey, a higher percentage of nonenrolled beneficiaries reported that they were able to obtain appointments as soon as they desired. Specifically, the percentage of nonenrolled beneficiaries who made non-urgent appointments for health care and reported that they were able to usually or always obtain an appointment as soon as they thought they needed increased from 87 percent in the 2008-2011 survey to 90 percent in the 2012-2015 survey.<sup>29</sup> However, the most commonly reported length of time they waited between making an appointment and actually seeing a provider did not change from the 2008-2011 surveys—most respondents in both surveys reported they were able to get appointments within 3 days (about 54 percent for both years' surveys).<sup>30</sup>

The 2012-2015 survey also asked specific questions about how easy it was to get an appointment with specialty care providers and mental health care providers:<sup>31</sup>

- Of those nonenrolled beneficiaries who tried to make an appointment with a civilian specialty care provider, 84 percent reported it was

---

<sup>29</sup>The margins of error for these estimates are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>30</sup>The margins of error for these estimates are within plus or minus 1 percentage point at the 95 percent confidence level. Respondents had the option of picking time frames for how long they had to wait, such as "same day," "1 day," or "2-3 days," all the way up to "31 days or longer."

<sup>31</sup>The survey asked this question for specialty care providers and for mental health care providers, but did not ask about the ease in obtaining primary care appointments.

---

“usually easy,” or “always easy,” to get appointments.<sup>32</sup> These results also varied by network status, as a higher percentage of those who used a network specialty care provider reported that they found it “usually easy” or “always easy” to get appointments (85 percent) compared to those that used a nonnetwork specialty care provider (74 percent).<sup>33</sup>

- Of those nonenrolled beneficiaries that received treatment or counseling from a civilian mental health care provider, 73 percent reported that when they needed treatment or counseling right away, they usually or always saw someone as soon as they wanted.<sup>34</sup> We found that this result did not change since the prior survey, nor did we find any statistically significant differences between beneficiaries’ responses for seeing a network versus a nonnetwork mental health provider.

---

<sup>32</sup>We could not compare this estimate to see how it has changed over time as the previous survey did not ask this question. The margin of error for this estimate is within plus or minus 1 percentage point at the 95 percent confidence level.

<sup>33</sup>The margins of error for these estimates are within plus or minus 7 percentage points at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>34</sup>The margin of error for this estimate is within plus or minus 10 percentage points at the 95 percent confidence level.

---

---

## Nonenrolled Beneficiaries' Positive Ratings of TRICARE Have Generally Increased over Time and Vary Compared to Other Federal Health Plans

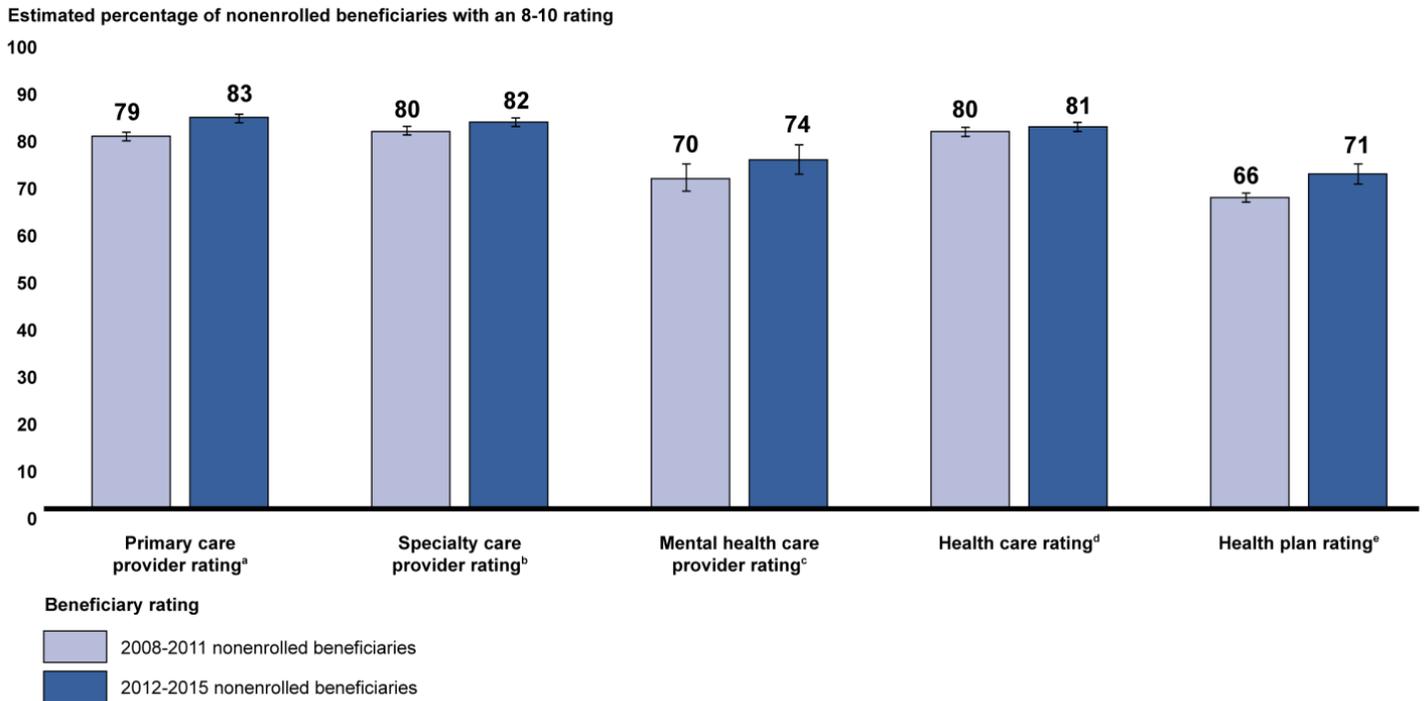
**Ratings of TRICARE over time.** Nonenrolled beneficiaries' positive ratings of TRICARE have generally increased since the previous survey. Specifically, over time, nonenrolled beneficiaries' positive ratings of five different categories related to TRICARE have either increased (primary care rating, specialty care rating, and health plan rating) or remained the same (mental health care rating and health care rating).<sup>35</sup> (See fig. 7.) Furthermore, nonenrolled beneficiaries' positive ratings of their mental health care providers were lower than their ratings for their primary and specialty care providers. We also found that there were no significant differences at the 95 percent confidence level for nonenrolled beneficiaries' ratings of primary care, specialty care, or mental health care providers based on their network status.<sup>36</sup>

---

<sup>35</sup>We refer to "positive ratings" as those nonenrolled beneficiaries rated their experiences between an 8 and a 10 on an ascending 0-10 scale for each of these categories.

<sup>36</sup>Due to the survey questions' wording for ratings with "health care" or "health plan," we could not analyze these ratings by the nonenrolled beneficiaries' reported providers' network status.

**Figure 7: Comparison of Nonenrolled Beneficiaries' Estimated Positive Ratings of Their TRICARE Experiences, over Time**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Percentages show the beneficiaries' reported ratings of 8-10 on a 0-10 scale. Bars display 95 percent confidence levels for estimates, rounded to a whole number.

Other than ratings of mental health care and health care, the differences in estimates between the 2008-2011 and the 2012-2015 survey results are statistically significant at the 95 percent confidence level.

<sup>a</sup>For the 2012-2015 survey, beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst personal doctor possible, and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" The 2008-2011 survey question was the same, except it asked the beneficiary to rate the "personal doctor or nurse." Our analysis is limited to nonenrolled beneficiaries who indicated that their personal doctor was a civilian.

<sup>b</sup>Beneficiaries were asked "We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible, and 10 is the best specialist possible, what number would you use to rate the specialist?" Our analysis is limited to nonenrolled beneficiaries who indicated that they had seen a civilian specialist in the last 12 months.

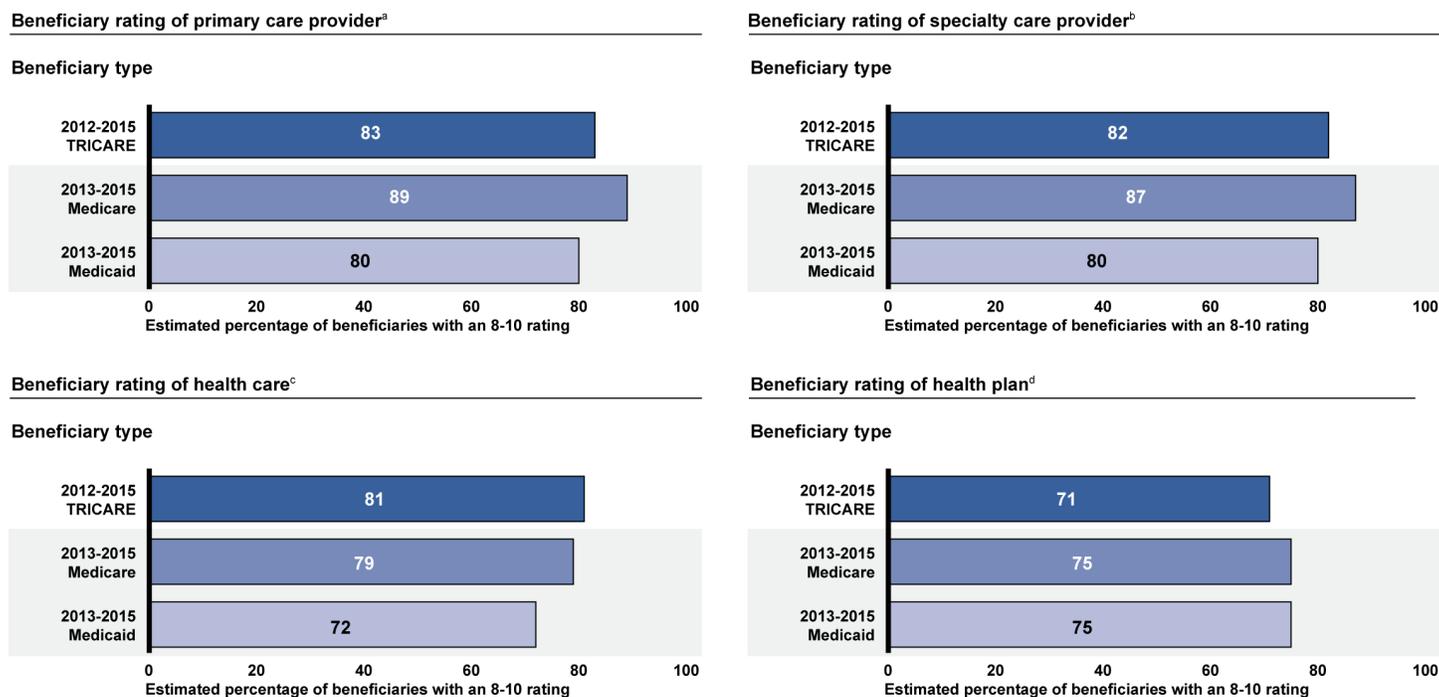
<sup>c</sup>Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst treatment or counseling possible, and 10 is the best treatment or counseling possible, what number would you use to rate all your treatment or counseling in the last 12 months?" Our analysis is limited to nonenrolled beneficiaries who indicated that they had seen a civilian mental health care provider.

<sup>d</sup>Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"

<sup>e</sup>Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"

**Ratings of TRICARE compared to other federal health plans.** When we compared these results to those of the 2013-2015 CAHPS surveys, we found that nonenrolled TRICARE beneficiaries' positive experience ratings for primary care providers and specialty care providers were lower than those of Medicare fee-for-service beneficiaries and higher than those of Medicaid beneficiaries, which is similar to what we found for the previous survey.<sup>37</sup> We also found that TRICARE beneficiaries' positive experience ratings for their health care were higher than that of both Medicare fee-for-service beneficiaries and Medicaid beneficiaries, but TRICARE beneficiaries' positive experience ratings for their health plan were lower than both of these groups. (See fig.8.)

**Figure 8: Nonenrolled TRICARE Beneficiaries' Estimated Experience Ratings Compared to Those of Medicare Fee-For-Service and Medicaid Beneficiaries**



Source: GAO analysis of the Departments of Defense's and Health & Human Services' data. | GAO-18-361

Notes: Percentages show the beneficiaries' reported ratings of 8-10 on a 0-10 scale.

<sup>37</sup>We could not compare nonenrolled beneficiaries' positive ratings of their mental health care provider to those of Medicare or Medicaid beneficiaries, as the latter two surveys did not contain a relevant question. See [GAO-13-364](#) for previous trends.

---

For the 2012-2015 nonenrolled beneficiary survey, margins of error were within 2 percentage points for each rating estimate, at the 95 percent confidence level. For the 2013-2015 Medicare and Medicaid surveys, margins of error were within 0.3 percentage points for each rating estimate, at the 95 percent confidence level. Within rating categories, all differences in estimates between 2012-2015 nonenrolled beneficiary survey results and 2013-2015 Medicare and Medicaid beneficiaries' results are statistically significant at the 95 percent confidence level.

Estimates for Medicare and Medicaid beneficiaries are from the Department of Health and Human Services' 2013 through 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to Medicare and Medicaid beneficiaries. These surveys are administered to determine how beneficiaries rate their experiences in receiving care in the Medicare and Medicaid programs.

<sup>a</sup>Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst personal doctor possible, and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?" Our analysis is limited to nonenrolled beneficiaries who indicated that their personal doctor was a civilian.

<sup>b</sup>TRICARE beneficiaries were asked "We want to know your rating of the specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible, and 10 is the best specialist possible, what number would you use to rate the specialist?" Medicare and Medicaid beneficiaries were asked the same question, but only in reference to the last 6 months. Our analysis is limited to nonenrolled beneficiaries who indicated that they had seen a civilian specialist in the last 12 months.

<sup>c</sup>TRICARE Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst health care possible, and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?" Medicare and Medicaid beneficiaries were asked the same question, but only in reference to the last 6 months.

<sup>d</sup>Beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst health plan possible, and 10 is the best health plan possible, what number would you use to rate your health plan?"

---

---

## Civilian Providers' Reported Awareness of TRICARE Has Generally Increased over Time, While Mental Health Providers' Acceptance of New TRICARE Patients Has Decreased

---

### Civilian Providers' Awareness of TRICARE Has Generally Increased over Time, with Network Providers Reporting Higher Awareness than Nonnetwork Providers

**Provider awareness over time, by provider type and by location type.** Nationwide, a higher percentage of civilian providers reported that they were aware of TRICARE in the 2012-2015 civilian provider survey (84 percent) than those from the 2008-2011 civilian provider survey (82 percent).<sup>38</sup> Specifically, since the previous survey, we found that awareness increased for specialty care providers (from 92 to 94 percent) and mental health care providers (from 68 to 74 percent).<sup>39</sup>

In addition, when we analyzed these results by location type, we found that civilian providers in both PSAs and non-PSAs reported higher awareness of TRICARE since the previous survey (from 79 to 82 percent in PSAs and from 87 to 89 percent in non-PSAs).<sup>40</sup> Awareness among

---

<sup>38</sup>When rounded, the margins of error for civilian providers' awareness of TRICARE are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>39</sup>Awareness among primary care providers remained unchanged since the last survey. When rounded, the margins of error for the specialty care and mental health care providers' awareness of TRICARE are within plus or minus 2 percentage points at the 95 percent confidence level. Within each provider type, the differences in estimates are significant at the 95 percent confidence level.

<sup>40</sup>When rounded, the margins of error for civilian providers' awareness of TRICARE by location type are within plus or minus 1 percentage point at the 95 percent confidence level. Within each location type, the differences in estimates are significant at the 95 percent confidence level.

---

civilian providers in locations now designated as former PSAs remained statistically unchanged at the 95 percent confidence level (89 percent in 2012-2015). However, despite some increases in awareness, civilian providers in PSAs reported lower awareness than those in non-PSAs and former PSAs in the 2012-2015 surveys.<sup>41</sup>

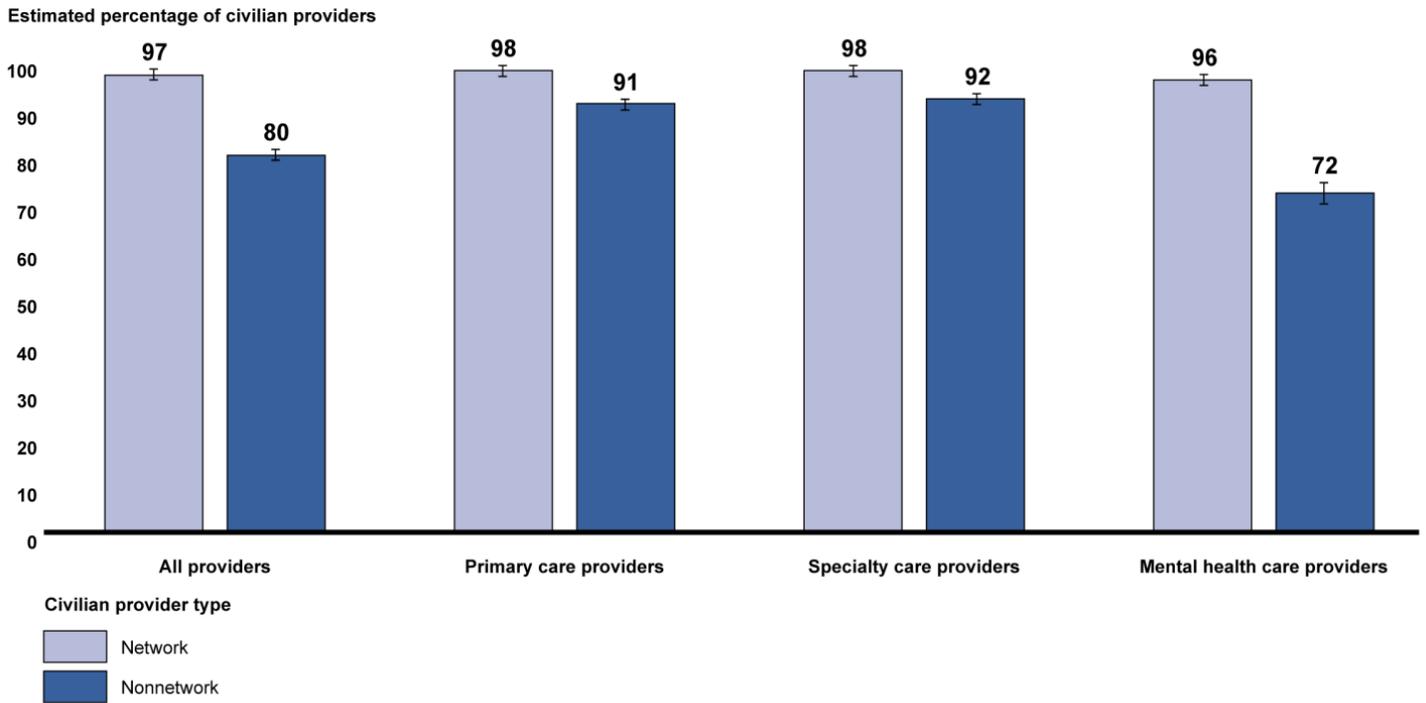
**Provider awareness by network status.** Providers within the TRICARE network reported higher awareness of TRICARE than nonnetwork providers, regardless of individual provider type. (See fig. 9.) Among individual provider types, the biggest difference in awareness between network and nonnetwork providers was for mental health care providers, with 96 percent of network mental health care providers reporting awareness of TRICARE compared with 72 percent of nonnetwork mental health care providers.<sup>42</sup>

---

<sup>41</sup>We previously reported that civilian providers in PSAs had lower awareness of TRICARE than those in non-PSAs. See [GAO-13-364](#).

<sup>42</sup>When rounded, the margins of error for mental health care providers' awareness of TRICARE are within plus or minus 2 percentage points at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

**Figure 9: Civilian Providers' Reported Awareness of TRICARE, by Provider Type and Network Status (2012-2015)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number. Within provider types, the differences between the network and nonnetwork providers are statistically significant at the 95 percent confidence level. Respondents answered “yes” to the survey question that asked “Is provider aware of the TRICARE health care program?”

---

---

Civilian Mental Health  
Care Providers’  
Acceptance of New  
TRICARE Patients Has  
Decreased; Network  
Providers Reported Higher  
Acceptance than  
Nonnetwork Providers

**Provider acceptance over time, by provider type and location type.**

Nationwide, we found an overall decrease reported in civilian providers’ acceptance of new TRICARE patients in the 2012-2015 civilian provider survey (55 percent) compared to the 2008-2011 civilian provider survey (58 percent).<sup>43</sup> However, when we analyzed acceptance by provider type, we found that the overall decrease was mainly attributable to a decrease in mental health care providers’ acceptance rates, as primary and specialty care providers’ acceptance rates remained unchanged.<sup>44</sup> Specifically, mental health care providers’ TRICARE acceptance rate decreased from 39 to 36 percent.<sup>45</sup> However, this low acceptance rate may not be an issue unique to TRICARE, as we have previously reported that there is a nationwide shortage of mental health professionals.<sup>46</sup>

In addition, when we analyzed results for all civilian providers by location type, we found that civilian providers in PSAs and non-PSAs reported lower acceptance rates of new TRICARE patients since the previous survey (from 55 to 53 percent in PSAs, and from 66 to 62 percent in non-PSAs).<sup>47</sup> Acceptance among civilian providers in locations now designated as former PSAs remained statistically unchanged at the 95 percent confidence level (60 percent in 2012-2015). Similar to our findings on providers’ awareness, we found that civilian providers in PSAs

---

<sup>43</sup>When rounded, the margins of error for all civilian providers’ acceptance of new TRICARE patients are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>44</sup>Primary care providers’ acceptance of new TRICARE patients was 67 percent in 2008-2011 and 68 in 2012-2015, and specialty care providers’ acceptance of new TRICARE patients was 77 percent in 2008-2011 and 78 percent in 2012-2015. However, these differences for primary and specialty care were not statistically significant at the 95 percent confidence level.

<sup>45</sup>When rounded, the margins of error for civilian mental health providers’ acceptance of new TRICARE patients are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>46</sup>See GAO, *VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed*, [GAO-16-24](#) (Washington, D.C.: Oct. 28, 2015).

<sup>47</sup>When rounded, the margins of error for civilian providers’ acceptance of new TRICARE patients are within plus or minus 1 percentage point at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level. Acceptance rates of new TRICARE patients did not change for former PSAs.

---

reported lower acceptance rates than those in non-PSAs and former PSAs.<sup>48</sup>

Of the 17 percent of network providers who reported that they were not accepting new TRICARE patients, some of the top reasons cited were

- not accepting any new patients,
- reimbursement, and
- do not know/no answer

Of the 53 percent of nonnetwork providers who reported that they were not accepting new TRICARE patients, some of the top reasons cited were

- not aware of TRICARE/Not asked/Don't know,
- miscellaneous, and
- specialty not covered

A Department of Defense official told us that some examples of "miscellaneous" are "in a private practice", and "not a preferred provider."

Source: GAO analysis of Department of Defense data. | GAO-18-361

**Provider acceptance by network status.** When we analyzed civilian providers' acceptance of new TRICARE patients by providers' network status, we found that network providers reported higher acceptance of new TRICARE patients than nonnetwork providers, regardless of provider type. (See fig. 10.) Among individual provider types, the biggest difference in acceptance between network and nonnetwork providers was for mental health care providers with 79 percent of network mental health care providers reporting acceptance of new TRICARE patients compared with 30 percent of nonnetwork mental health care providers.<sup>49</sup> Of those mental health care providers that were not accepting new TRICARE patients, one of the top reasons reported by those not in the network was a lack of awareness of TRICARE. Due to the relatively small number of network mental health providers who provided reasons for not accepting new TRICARE patients, it was not possible to identify one primary reason; however, some of the reasons they cited include reimbursement, not accepting new patients, and specialty was not covered.<sup>50</sup>

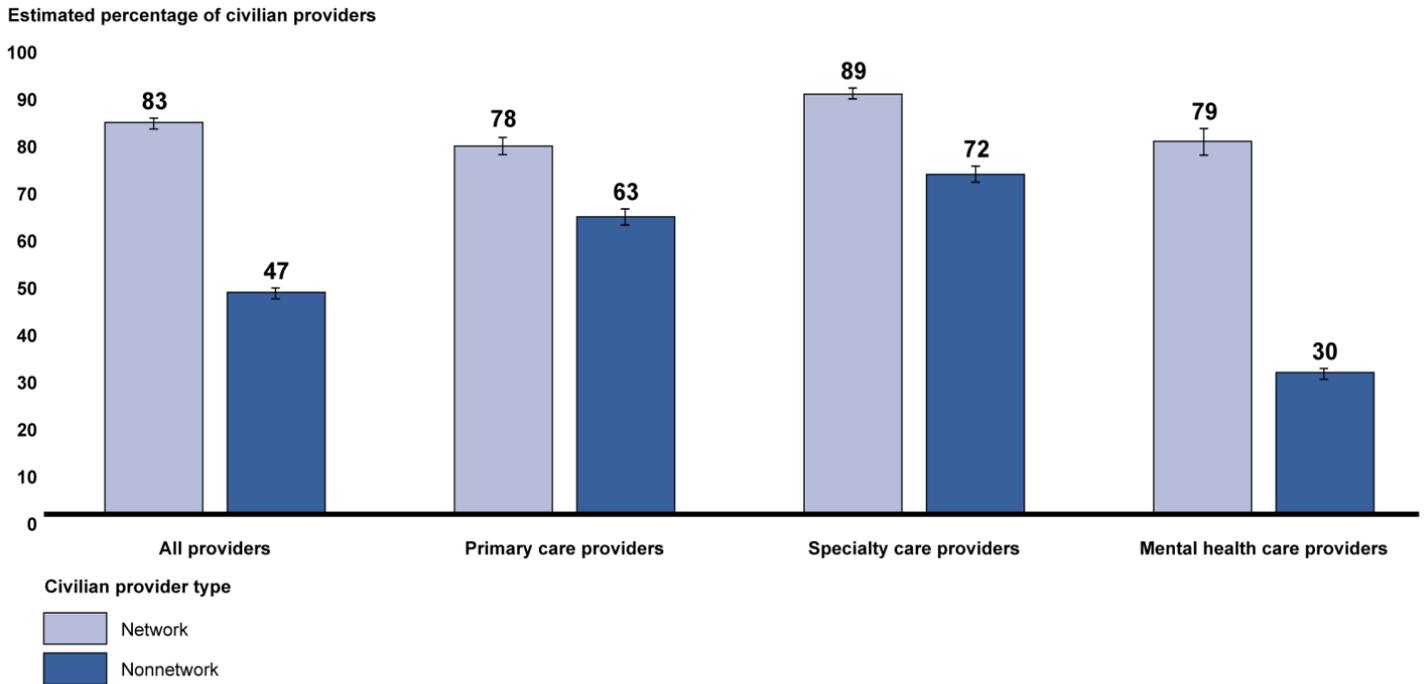
---

<sup>48</sup>We previously reported that civilian providers in PSAs had lower awareness of TRICARE than those in non-PSAs. See [GAO-13-364](#).

<sup>49</sup>When rounded, the margins of error for civilian mental health providers' acceptance of new TRICARE patients are within 3 percentage points at the 95 percent confidence level. The difference in estimates is significant at the 95 percent confidence level.

<sup>50</sup>The relatively low number of responses that provided reasons for why they were not accepting new TRICARE patients resulted in large margins of error.

**Figure 10: Civilian Providers' Reported Acceptance of New TRICARE Patients, by Provider Type and Network Status (2012-2015)**



Source: GAO analysis of Department of Defense data. | GAO-18-361

Notes: Bars display 95 percent confidence levels for estimates, rounded to a whole number.

Within provider types, the differences between the network and nonnetwork providers are statistically significant at the 95 percent confidence level.

Respondents answered “for all claims” or on a “claim-by-claim basis” to the survey question that asked “As of today, is the provider accepting new TRICARE Standard patients?”

---

---

## DOD's Surveys of Nonenrolled Beneficiaries and Civilian Providers Collectively Indicate That Specific Geographic Locations May Have Access Problems

Our analysis of the 2012-2015 nonenrolled beneficiary and civilian provider surveys indicated that beneficiaries may have difficulty accessing a primary care provider, a specialty care provider, or both in 6 out of the 190 specific geographic locations that were surveyed. For the 6 locations we identified, beneficiaries reported higher levels of problems finding providers, and providers reported lower rates of accepting TRICARE patients.<sup>51</sup>

- Primary care. We identified two locations where access to primary care providers may be particularly problematic. (See table 2.) In these two locations, the percent of beneficiaries who reported that they had problems finding a primary care provider was at or above the 2012-2015 beneficiary survey's national average of 22 percent, and also where the percent of primary care providers who reported that they were accepting new TRICARE patients was at or below the 2012-2015 civilian provider survey's national average of 68 percent.<sup>52</sup>
- Specialty care. We identified five locations where access to specialty care providers may be particularly problematic. (See table 2.) In these five locations, the percent of beneficiaries who reported that they had problems finding a specialty care provider was at or above the 2012-2015 beneficiary surveys' national average of 23 percent, and also where the percent of specialty care providers who reported that they were accepting new TRICARE patients was at or below the 2012-2015 civilian provider surveys' national average of 78 percent.<sup>53</sup>

---

<sup>51</sup>Because of the low numbers of survey responses for beneficiaries who said they needed civilian mental health care and responded to the question about whether they had a problem finding a civilian mental health care, we are unable to report correlated survey results for access problems to civilian mental health care providers.

<sup>52</sup>We excluded any individual locations that had less than (1) 30 respondents to the nonenrolled beneficiary survey questions about difficulties finding a specific type of provider, or (2) 50 respondents to the civilian providers' survey question about acceptance of new TRICARE surveys.

<sup>53</sup>We excluded any individual locations that had less than (1) 30 respondents to the nonenrolled beneficiary survey questions about difficulties finding a specific type of provider, or (2) 50 respondents to the civilian providers' survey question about acceptance of new TRICARE surveys.

**Table 2: Locations with Both Potential Problems of Beneficiaries Not Finding Providers and Providers Not Accepting New TRICARE Patients, 2012-2015**

Locations	Potential access problems with primary care <sup>a</sup>	Potential access problems with specialty care <sup>b</sup>
<b>Prime Service Areas (PSAs)</b>		
1. Bremerton/Seattle/Coupeville/Renton, Washington	✓	—
2. Brooklyn/Manhattan/Bronx/Jamaica, New York	✓	✓
3. Fort Worth/Dallas/Arlington/Denton, Texas	—	✓
4. Washington, DC/Rockville/Bethesda/Lanham, Maryland	—	✓
<b>Former PSAs</b>		
5. Dallas/McKinney/Amarillo/Rowlett, Texas	—	✓
<b>Hospital Service Area (HSA)</b>		
6. Dallas/Fort Worth, Texas <sup>c</sup>	—	✓

Source: GAO analysis of Department of Defense data. | GAO-18-361

Note: We included locations where the percentage of nonenrolled beneficiaries who experienced problems finding a civilian provider was at or above the 2012-2015 beneficiary surveys' national average and where the percentage of civilian providers who were accepting any new TRICARE patients was at or below the 2012-2015 civilian provider surveys' national average. Both determinations were made using the estimates' margins of error at the 95 percent confidence level. We identified and excluded any areas that had fewer than 50 respondents for the civilian provider surveys or 30 respondents for the question nonenrolled beneficiary surveys.

<sup>a</sup>Inclusion in this category was based on (1) nonenrolled beneficiaries' responses of "a big problem" or "a small problem" to the question that asked "In the last 12 months, how much of a problem was it to find a personal doctor or nurse who would accept TRICARE?" and (2) civilian primary care providers' responses of "for all claims" or a "claim-by-claim basis" to the question that asked "As of today, is the provider accepting new TRICARE Standard patients?"

<sup>b</sup>Inclusion in this category was based on (1) nonenrolled beneficiaries' responses of "a big problem" or "a small problem" to the question that asked "In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE?" and (2) civilian specialty care providers' responses of "for all claims" or a "claim-by-claim basis" to the question that asked "As of today, is the provider accepting new TRICARE Standard patients?"

<sup>c</sup>The Dallas/Fort Worth, Texas, HSA is part of both the Dallas/McKinney/Amarillo/Rowlett, Texas Former PSA and the Fort Worth/Dallas /Arlington/Denton, Texas PSA.

When we compared this analysis to our analysis of the 2008-2011 beneficiary and provider surveys, the "Dallas/Fort Worth, Texas" HSA was identified in both results. Using data from the prior survey, our analysis identified it as being potentially problematic for primary care, but using data from the more recent survey, we identified specialty care access as being potentially problematic.<sup>54</sup> DOD officials told us that their

<sup>54</sup>See [GAO-13-364](#).

---

past analysis of beneficiaries' complaints in this location centered on appointment wait times exceeding beneficiaries' preferences and on drive times to providers' offices. Officials explained that although there was a wide range of network specialty care providers in this location, TRICARE beneficiaries were a very small percentage of the overall population. Furthermore, this location is home to a number of large corporations that have health care plans that reimburse providers more than TRICARE. DOD officials added that due to these factors, providers in this location do not give preference to TRICARE beneficiaries, and drive times in this location are often long due to the traffic patterns and overall congestion of a large urban area.

---

## Agency Comments

In reviewing a draft of this report, DOD concurred with our overall findings. DOD's written response is reprinted in appendix I.

---

We are sending copies of this report to the Secretary of Defense and appropriate congressional committees. The report is also available at no charge on GAO's website at <http://www.gao.gov>.

If you or your staff has any questions regarding this report, please contact Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



Debra A. Draper  
Director  
Health Care

# Appendix I: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 15 2013

Ms. Debra A. Draper  
Director, Health Care  
U.S. Government Accountability Office  
441 G. Street, N.W.  
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense response to the Government Accountability Office (GAO) Draft Report, GAO-18-361, "Defense Health Care: TRICARE Surveys Indicate Non-Enrolled Beneficiaries' Access to Care Has Generally Improved." Thank you for the opportunity to review and comment on the draft report.

Overall, I concur with the draft report's findings and conclusion. The report does not contain any recommendation, and I have no significant technical changes to offer, other than what we have provided to the analysts.

I thank you for your detailed review of our survey methodology and processes. My points of contact for this matter are Dr. Richard Bannick (functional) and Ms. Joyce Forrest (audit liaison). Dr. Bannick may be reached at (703) 681-3636 or [Richard.r.bannick.civ@mail.mil](mailto:Richard.r.bannick.civ@mail.mil), and Ms. Joyce Forrest may be reached at (703) 681-6741 or [joyce.forrest2.civ@mail.mil](mailto:joyce.forrest2.civ@mail.mil).

Sincerely,

A handwritten signature in cursive script, appearing to read "Tom McCaffery".

for Tom McCaffery  
Acting

---

# Appendix II: GAO Contact and Staff Acknowledgments

---

---

**GAO Contact:**

Debra A. Draper at (202) 512-7114 or [draperd@gao.gov](mailto:draperd@gao.gov).

---

---

**Staff Acknowledgments:**

In addition to the contacts named above, Bonnie Anderson, Assistant Director; Jeff Mayhew, Analyst-in-Charge; Amy Andresen; and Jennie Apter made key contributions to this report. Also contributing were Zhi Boon, Jacquelyn Hamilton, Vikki Porter, and Eric Wedum.

---

---

## GAO's Mission

The Government Accountability Office, the audit, evaluation, and investigative arm of Congress, exists to support Congress in meeting its constitutional responsibilities and to help improve the performance and accountability of the federal government for the American people. GAO examines the use of public funds; evaluates federal programs and policies; and provides analyses, recommendations, and other assistance to help Congress make informed oversight, policy, and funding decisions. GAO's commitment to good government is reflected in its core values of accountability, integrity, and reliability.

---

## Obtaining Copies of GAO Reports and Testimony

The fastest and easiest way to obtain copies of GAO documents at no cost is through GAO's website (<https://www.gao.gov>). Each weekday afternoon, GAO posts on its website newly released reports, testimony, and correspondence. To have GAO e-mail you a list of newly posted products, go to <https://www.gao.gov> and select "E-mail Updates."

---

## Order by Phone

The price of each GAO publication reflects GAO's actual cost of production and distribution and depends on the number of pages in the publication and whether the publication is printed in color or black and white. Pricing and ordering information is posted on GAO's website, <https://www.gao.gov/ordering.htm>.

Place orders by calling (202) 512-6000, toll free (866) 801-7077, or TDD (202) 512-2537.

Orders may be paid for using American Express, Discover Card, MasterCard, Visa, check, or money order. Call for additional information.

---

## Connect with GAO

Connect with GAO on [Facebook](#), [Flickr](#), [Twitter](#), and [YouTube](#).  
Subscribe to our [RSS Feeds](#) or [E-mail Updates](#). Listen to our [Podcasts](#).  
Visit GAO on the web at <https://www.gao.gov>.

---

## To Report Fraud, Waste, and Abuse in Federal Programs

Contact:

Website: <https://www.gao.gov/fraudnet/fraudnet.htm>

Automated answering system: (800) 424-5454 or (202) 512-7470

---

## Congressional Relations

Orice Williams Brown, Managing Director, [WilliamsO@gao.gov](mailto:WilliamsO@gao.gov), (202) 512-4400, U.S. Government Accountability Office, 441 G Street NW, Room 7125, Washington, DC 20548

---

## Public Affairs

Chuck Young, Managing Director, [youngc1@gao.gov](mailto:youngc1@gao.gov), (202) 512-4800 U.S. Government Accountability Office, 441 G Street NW, Room 7149 Washington, DC 20548

---

## Strategic Planning and External Liaison

James-Christian Blockwood, Managing Director, [spel@gao.gov](mailto:spel@gao.gov), (202) 512-4707 U.S. Government Accountability Office, 441 G Street NW, Room 7814, Washington, DC 20548



Please Print on Recycled Paper.