Defense Health Agency

TSS Issue Brief

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Beneficiary Access to Mental Health Care: Trends Under TRICARE's PPO Health Plan

The Military Health System (MHS) serves roughly 9.6 million beneficiaries, including military personnel, retirees, and family members. TRICARE-insured family members of active duty personnel, retirees and their dependents, and inactive reservists and their families have increasingly relied on civilian providers, rather than military facilities, over the past decade. At the same time, TRICARE coverage options for non-active duty beneficiaries have changed, and national health care policies have changed in ways that affect the U.S. health care system as a whole—and might have affected access to providers. This issue brief, along with two others focusing on primary and specialty care, explores these topics.[1] It presents recent trends in self-reported access to mental health care among non-active duty beneficiaries of TRICARE's preferred provider organization (PPO) plan. It also discusses trends in the acceptance of new TRICARE patients by civilian mental health care providers, including physicians and a variety of non-physician practitioners.

Background

Changes to TRICARE's PPO options might have affected beneficiary experiences. On January 1, 2018, TRICARE's Standard and Extra plans, which in combination resembled a PPO, were replaced by TRICARE Select, a single PPO plan that provides access to both network and non-network care. Before 2018, beneficiaries who were not enrolled in Prime (TRICARE's health maintenance organization plan) could choose to use Standard or Extra benefits at the point of service. But to use Select coverage, beneficiaries had to enroll in Select during open enrollment, which occurs once a year, essentially locking Select users into a health plan with a network of civilian providers. Under Select, and previously under the Standard/Extra combination, civilian providers who elect to treat TRICARE patients are reimbursed according to a fee schedule similar to Medicare's. These providers may also contract with TRICARE's managed care support contractors to join TRICARE's civilian network, through which beneficiaries receive lower-cost care through TRICARE Prime and Select.

- **This issue brief presents recent trends in (1) self-reported access to needed mental health care or counseling among users of TRICARE's PPO plan and (2) the acceptance of new TRICARE patients by civilian mental health care providers.**
- **Recent changes to TRICARE coverage, TRICARE contracts, and the U.S. health care system overall might have affected access to care for TRICARE's PPO users, who increasingly rely on civilian providers.**
- **We found that:**
  1. **Nationwide, self-reported access to mental health care and TRICARE acceptance by mental health providers fell from 2012–2015 to 2017–2020.**
  2. **No state showed significant improvement from 2012–2015 to 2017–2020 and some showed substantial declines.**

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

Changes to U.S. health care policy intensified the demand for health care and strained provider capacity. In 2010, the Affordable Care Act (ACA) brought sweeping changes to the U.S. health care industry that could have reduced the capacity of civilian providers—and thus curbed their ability and willingness to accept TRICARE patients. In particular, 26 states expanded Medicaid eligibility in 2014 to cover low-income childless adults (the number of states has since grown to 38). Evidence on the ACA's impact on access to care indicates that cost-related barriers to obtaining care declined after 2014, reflecting an increase in insurance coverage, but difficulty in getting appointments and long wait times for care increased (Miller and Wherry 2019). Although the ACA had a major positive impact on the use of primary or preventive care, evidence also suggests that it increased the use of ambulatory mental health care services (Miller and Wherry 2017; Breslau et al. 2020).

Data and methods

To assess trends in access to care for TRICARE PPO users, we used data from the TRICARE Select Surveys. The TRICARE Select Survey of Beneficiaries (TSS-B) and of Providers (TSS-P) have both been fielded annually from 2008 to 2020 in three four-year cycles. Among other topics, the TSS-B asks non-Prime beneficiaries about their experience accessing care, and the TSS-P asks physicians and nonphysician mental health care providers about their acceptance of TRICARE patients. Each survey cycle covered the entire U.S. over four years—first in 2008–2011, then in 2012–2015, and most recently in 2017–2020.

To examine changes in access, we compared national and state-level estimates from the two most recent TSS survey cycles (2012–2015 and 2017–2020).[2] Note that the TSS reflects respondents' experience with health care in the year before completion of the survey; the 2014 Medicaid expansions began to take effect toward the end of the 2012–2015 cycle and continued to be enacted through 2020 in states that adopted the expansions later.

Findings

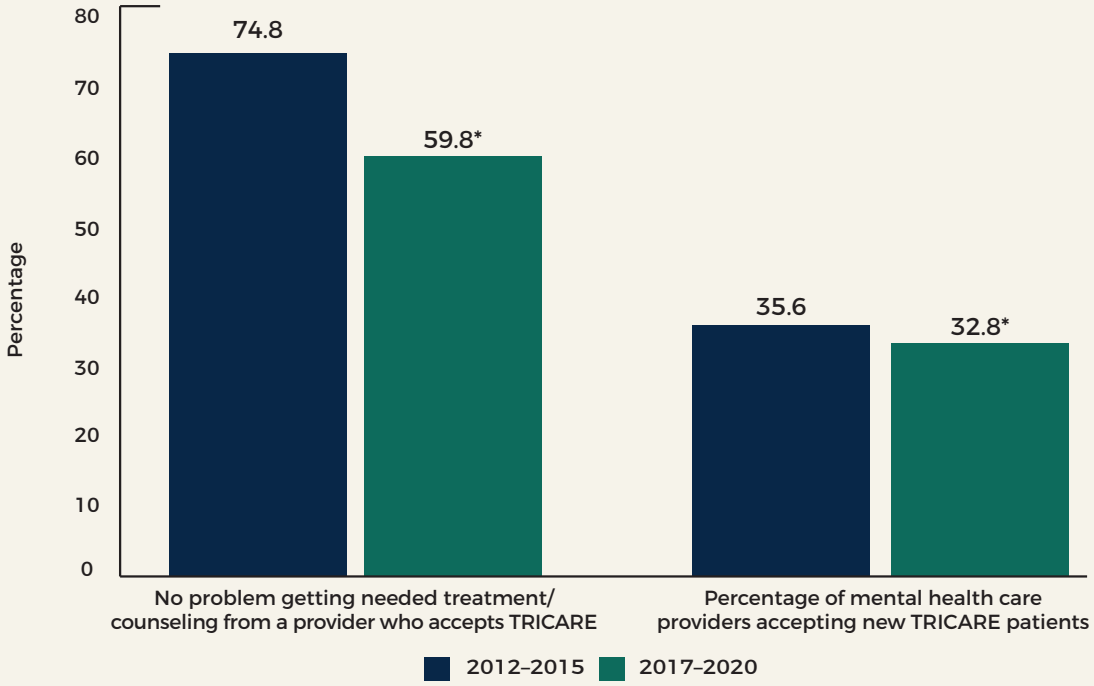
Nationwide, self-reported access to treatment or counseling and acceptance of TRICARE patients by mental health care providers fell from 2012–2015 to 2017–2020.

Access to needed mental health care among TRICARE PPO users fell sharply from 2012–2015 to 2017–2020. Mental health care providers' acceptance of new TRICARE patients also declined modestly over the same period. Figure 1 (on page 3) shows the share of PPO users who reported no problem getting needed treatment or counseling, along with the share of mental health care providers who accepted new TRICARE patients in the two most recent TSS survey cycles.

At the state level, some states saw large declines in self-reported access to mental health care from 2012–2015 to 2017–2020.

Several states experienced large, statistically significant declines in self-reported access to mental health care among TRICARE PPO users. Access did not always decline at the state level, though no state saw a statistically significant increase. Most states had no statistically significant differences between access measures.

Figure 1. National rates of access to mental health providers for TRICARE PPO users, 2012–2015 and 2017–2020

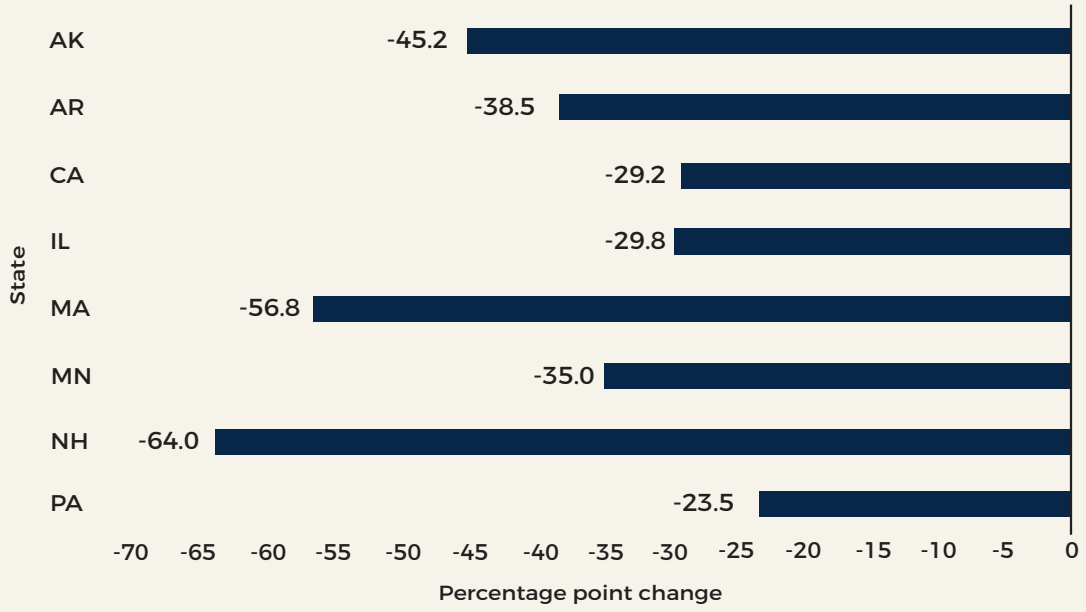


*The change between the 2012–2015 and 2017–2020 survey cycles was statistically significant ($p < 0.05$).
Note: The proportion of beneficiaries who reported no problem getting treatment or counseling was measured in the TSS-B while the proportion of PCPs who accepted new TRICARE patients was measured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

TRICARE PPO users who reported no problem getting treatment or counseling for a mental health problem from a provider who accepts TRICARE. As shown in Figure 2 (on page 4), eight states had statistically significant decreases in this measure. New Hampshire saw the largest drop—from 78 to 14 percent (64 percentage points)—and seven other states saw statistically significant decreases, from 24 to 57 percentage points.

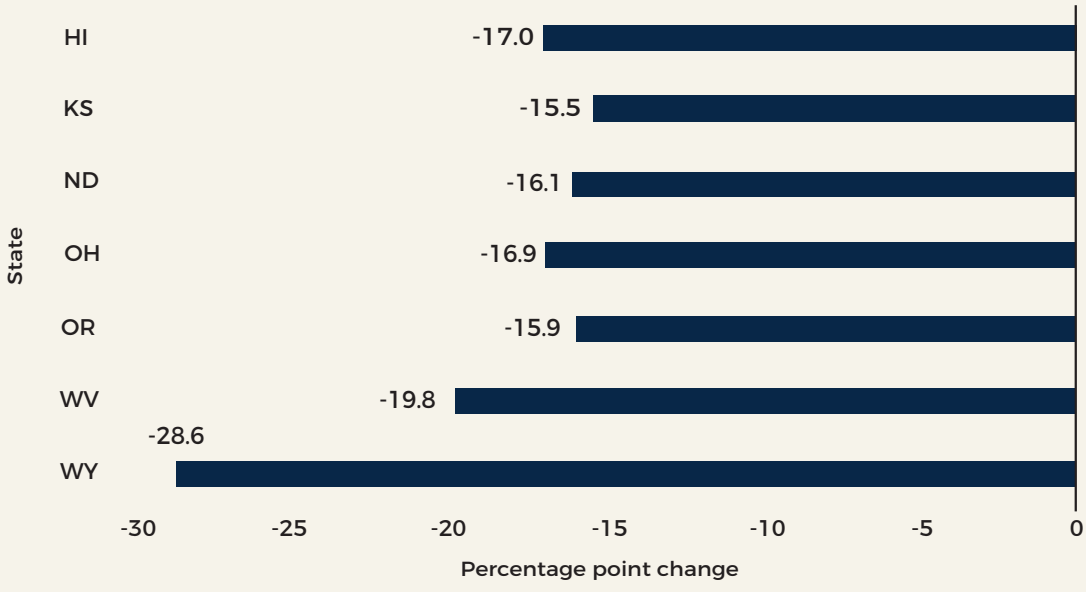
Acceptance of new TRICARE patients among mental health care providers. Seven states had significant declines in the percentage of mental health care providers accepting new TRICARE patients (Figure 3, on page 4) . The largest decline occurred in Wyoming, where the acceptance rate dropped 29 percentage points from 2012–2015 to 2017–2020 (72 to 43 percent). None of the states saw acceptance rates increase significantly. But compared with the national average, many states had higher rates of TRICARE acceptance among mental health care providers during both periods; nationally, 36 percent of mental health care providers accepted new TRICARE patients in 2012–2015, and 33 percent did in 2017–2020. Eight states had significantly higher rates than the national average in 2017–2020: Alabama, Iowa, Montana, Nebraska, South Carolina, South Dakota, Tennessee, and Virginia. In New Jersey and New York, the rate was significantly lower than the national average during both periods.

Figure 2. State-level changes in the percentage of TRICARE PPO users who had no problem getting needed treatment or counseling from a provider who accepts TRICARE, 2012–2015 to 2017–2020



Note: The states shown had a statistically significant change ($p < 0.05$) from 2012–2015 to 2017–2020.

Figure 3. State-level changes in the percentage of mental health care providers who accept new TRICARE patients, 2012–2015 to 2017–2020



Note: The states shown had a statistically significant change ($p < 0.05$) from 2012–2015 to 2017–2020.

Discussion

Access to mental health care declined consistently between the two most recent TSS survey cycles. These declines in self-reported access are consistent with earlier findings from GAO on access to mental health care among active duty beneficiaries in Prime. In 2016, GAO released a report on access to mental health care for active duty personnel, reservists, and deployed civilians from the Department of Defense (GAO 2016). GAO found that mental health care provided by MHS was meeting access-to-care standards for most types of mental health appointments. However, about one-third of service members said they had problems accessing care, which could indicate a disconnect between government standards and beneficiaries' expectations about access. For TRICARE PPO users, although acceptance of new TRICARE patients fell only modestly at the national level, self-reported access to mental health care providers declined dramatically.

The declines in access to mental health care among PPO users between 2012–2015 and 2017–2020 might be a result of several factors, including changes to TRICARE's provider network contracts and coverage options. Some mental health care providers might have stopped accepting new TRICARE patients owing to changes in networks or lower reimbursement rates relative to past contracts. In fact, low reimbursement and lack of coverage for one's specialty were among the common reasons cited by mental health care providers for not accepting new TRICARE patients in 2012–2015, though they were not the most common reasons (Anand et al. 2020). Because Select is an enrollment-based plan rather than a set of benefits that can be accessed at the point of service (as Standard/Extra was), the change to Select could have induced more demand for civilian providers by essentially locking TRICARE beneficiaries into plans that rely more heavily on these providers, without an accompanying increase in acceptance of TRICARE patients.

TRICARE beneficiaries might also have more trouble finding civilian providers because of heightened demand stemming from the ACA. Medicaid expansions and other ACA provisions likely strained the capacity of civilian providers, as previously uninsured patients sought more services. Indeed, some of the state-level trends in access described in this brief align with patterns of state adoptions of Medicaid expansions. Although not conclusive, this could indicate a negative relationship between Medicaid expansion and access to care for TRICARE beneficiaries. Of the seven states that saw significant declines in the share of mental health care providers accepting new TRICARE patients, all but one had expanded Medicaid eligibility by 2020. All eight states with significant declines in the share of beneficiaries who had no problem accessing mental health care had expanded Medicaid eligibility by 2020 (five expanded eligibility in 2014).

While the overall trend in access to mental health care among TRICARE PPO users is negative, there might be different trends by provider type. TRICARE's mental health provider networks include a range of provider types such as clinical psychiatrists, social workers, certified therapists and counselors, and pastoral counselors. It is likely that changes to TRICARE contracts and to the national health care system affected different provider types differently, and this analysis does not explore whether changes in access are associated with changes in the supply of any individual mental health provider type. It is also possible that the availability of and access to some provider types improved while access to others declined.

Finally, changes in TSS sampling and survey methods between the 2012–2015 and 2017–2020 cycles could have affected our findings. However, we adjusted our TSS measures to account for changes in the sample over time, and the comparisons we made between time periods and across states likely reflect real variations in access and acceptance.

References

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Breslau, J., B. Han, J. Lai, and H. Yu. "Impact of the Affordable Care Act Medicaid Expansion on Utilization of Mental Health Care." Medical Care, vol. 58, no. 9, September 2020, pp. 757–762.

GAO. "DoD Is Meeting Most Mental Health Care Access Standards, but It Needs a Standard for Follow-Up Appointments." Report to congressional Committees, GAO-16-416. Washington, DC: GAO, 2016.

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Wherry, L.R., and S. Miller. "Early Coverage, Access, Utilization, and Health Effects Associated with the Affordable Care Act Medicaid Expansions: A Quasi-Experimental Study." Annals of Internal Medicine, vol. 164, no. 12, June 2016, pp. 795–803.

Sources

2012–2015 and 2017–2020 TRICARE Select Survey of Beneficiaries. N = 35,242 and 27,719 in 2012–2015 and 2017–2020, respectively. The response rate was 20.6 percent in 2012–2015 and 19.7 percent in 2017–2020. The 2012–2015 survey was fielded from January 2013 to January 2016. The 2017–2020 survey was fielded from November 2016 to March 2020.

2012–2015 and 2017–2020 TRICARE Select Survey of Providers. N = 50,331 and 38,258 providers in 2012–2015 and 2017–2020, respectively. The response rate was 38.9 percent in 2012–2015 and 27.8 percent in 2017–2020. The 2012–2015 survey was fielded from December 2012 to January 2016. The 2017–2020 survey was fielded from January 2017 to January 2020.

Endnotes

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

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