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H.R. 3633, PROTECTING HEALTH CARE PROVIDERS FROM INCREASED ADMINISTRATIVE BURDENS ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON WORKFORCE PROTECTIONS

COMMITTEE ON EDUCATION AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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H.R. 3633, PROTECTING HEALTH CARE PROVIDERS FROM INCREASED ADMINISTRATIVE BURDENS ACT

Thursday, March 13, 2014
House of Representatives,
Subcommittee on Workforce Protections,
Committee on Education and the Workforce,
Washington, D.C.

The subcommittee met, pursuant to call, at 10:08 a.m., in Room 2175, Rayburn House Office Building, Hon. Tim Walberg [chairman of the subcommittee] presiding.

Present: Representatives Walberg, Kline, DesJarlais, Rokita, Bucshon, Hudson, Courtney, Fudge, and Pocan.

Staff present: Janelle Belland, Coalitions and Members Services Coordinator; Molly Conway, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Christie Herman, Professional Staff Member; Benjamin Hoog, Senior Legislative Assistant; Marvin Kaplan, Workforce Policy Counsel; Nancy Locke, Chief Clerk; James Martin, Professional Staff Member; Daniel Murner, Press Assistant; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Alissa Strawcutter, Deputy Clerk; Alexa Turner, Legislative Assistant; Joseph Wheeler, Professional Staff Member; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Jody Calemine, Minority Staff Director; Melissa Greenberg, Minority Staff Assistant; Eunice Ikene, Minority Staff Assistant; Brian Kennedy, Minority Senior Counsel; Brian Levin, Minority Deputy Press Secretary/New Media Coordinator; Richard Miller, Minority Senior Labor Policy Advisor; Megan O'Reilly, Minority General Counsel; Michael Zola, Minority Deputy Staff Director; and Mark Zuckerman, Minority Senior Economic Advisor.

Chairman WALBERG. A quorum being present, the subcommittee will come to order. Good morning. I would like to welcome our guests and thank our witnesses for being with us as we discuss H.R. 3633, the *Protect Health Care Providers from Increased Administrative Burdens Act.*

The bill is a result of the Committee's continued oversight of the Department of Labor, which shed light on an unprecedented effort by the Office of Federal Contract Compliance Programs (OFCCP) to exert jurisdiction over health care providers who participate in certain federal programs. H.R. 3633 would rein in this executive overreach, prevent an administrative nightmare for health care

providers, and help some of the nation's most vulnerable citizens maintain access to care.

OFCCP is responsible for enforcing federal nondiscrimination and affirmative action requirements on federal contractors. Today's discussion isn't about whether we support the important policies that the agency enforces. No one should be denied because of their—denied employment because of their gender, their disability, race, or religion. All employers have a moral and legal obligation to provide a work environment free of discrimination, including those who receive taxpayer dollars. The goal of our oversight and the legislation is to ensure the agency does its job effectively and responsibly.

In the past, we have encouraged OFCCP to streamline the myriad of requirements federal contractors must follow. As one witness from St. Jude Children's Hospital testified, the current regulatory scheme is, quote—"all stick and no carrot," end quote. Simplifying the process would strengthen the rights of workers by making it easier for employers to understand their responsibilities and comply with the law.

Workers, employers, and taxpayers would be better served if OFCCP spent its time improving the current regulatory structure rather than unilaterally imposing a broken system on more workplaces. Yet that is precisely what the agency is trying to do, by exerting jurisdiction over hospitals and other health care providers who see patients covered by various federal programs, such as TRICARE and the Federal Employee Health Benefits Program.

As a result of the bipartisan concerns addressed in this legislation, the Department of Labor proposed, earlier this week, a limited delay of its regulatory overreach. In a letter to the Committee leadership, Secretary Perez promised a five year moratorium of new OFCCP enforcement activities against TRICARE providers.

[The information follows:]

SECRETARY OF LABOR
WASHINGTON, D.C. 20210

March 11, 2014

The Honorable John Kline
Chairman
Committee on Education and the Workforce

The Honorable George Miller
Senior Democratic Member
Committee on Education and the Workforce

The Honorable Tim Walberg
Chairman
Subcommittee Workforce Protections
U.S. House of Representatives
Washington, DC 20515-6100

The Honorable Joe Courtney
Ranking Member
Subcommittee Workforce Protections

Dear Chairman Kline, Chairman Walberg, Congressman Miller, and Congressman Courtney:

Thank you for sharing your concerns regarding access to high quality health care for Uniformed Service members, retirees and their families through the Department of Defense (DoD) TRICARE program. I share your concerns and want to ensure continued access for our military and their families while continuing to safeguard civil rights protections for millions of Americans. The purpose of this letter is to memorialize the terms of a proposal that I made last week to address an issue involving TRICARE subcontractors

As you are aware, the Office of Federal Contract Compliance Programs (OFCCP) enforces Executive Order 11246, Section 503 of the Rehabilitation Act, and the Vietnam Era Veterans Readjustment Assistance Act, which impose certain equal opportunity obligations on those entities that do business with the federal government. OFCCP achieves its mandate by, among other things, conducting compliance evaluations and investigating complaints of civil rights violations.

Congress addressed the definition of contract for the purpose of determining who is a subcontractor under the TRICARE program in Section 715 of the 2012 National Defense Authorization Act (NDAA). Recent events have brought to my attention the difference in understanding of congressional intent regarding Section 715 between the Department of Labor and members of your committee. You have made clear that, in your judgment, Congress intended to eliminate entirely OFCCP's jurisdiction over TRICARE subcontractors. The Department, based on a good faith reading of the provision and its legislative history, read Section 715 as a more narrow limitation that preserved one aspect of OFCCP's jurisdiction. Our discussions helped me understand the basis for your concern about OFCCP's interpretation of the NDAA amendment and the confusion that may exist in the TRICARE subcontractor community.

I believe that, as we have discussed, in lieu of legislative action, we can come to a workable administrative solution that addresses your concerns and provides greater clarity for the TRICARE subcontractor community while maintaining important civil rights protections prohibiting Federal contractors and subcontractors from discriminating on the basis of race, color, religion, sex, national origin, disability, and protected veteran status.

The Department can achieve those goals by having OFCCP exercise prosecutorial discretion over the next five years to limit its enforcement activities with regard to TRICARE subcontractors while it engages in extensive outreach and technical assistance to inform TRICARE participants of their responsibilities and works with other Federal agencies to clarify the coverage of health care providers under Federal statutes applicable to contractors and subcontractors. The elements of this initiative include the following steps:

- OFCCP will issue a directive establishing a five-year moratorium on enforcement of the affirmative obligations required of all TRICARE subcontractors.

- OFCCP will administratively close open and scheduled compliance evaluations for TRICARE subcontractors.

- During the five-year moratorium OFCCP will:
  - Provide information, materials, and technical assistance training to TRICARE subcontractors on how to develop cost effective affirmative action plans, record keeping, and applicant tracking systems;

  - Conduct regional and national webinars that cover OFCCP's legal authorities, jurisdiction, and Federal contractor and subcontractor obligations;

  - Convene listening sessions to learn about the unique issues facing TRICARE subcontractors in order to provide relevant and targeted technical assistance under all OFCCP legal authorities; and

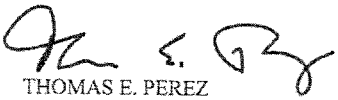
  - Work with DoD, the Office of Personnel Management, and the White House Office of Federal Procurement Policy to clarify that those health-care providers that participate as subcontractors in TRICARE and the Federal Employees Health Benefits Program (FEHBP) may, in certain circumstances, be subcontractors for purposes of the laws that OFCCP enforces.

- The moratorium will not extend to 1) holders of prime contracts with the Federal government where the contractor is also a TRICARE subcontractor; or 2) TRICARE subcontractors that hold a separate, independent, non-health care-related Federal subcontract.

- The moratorium does not cover TRICARE subcontractors' obligation to refrain from discrimination. As appropriate, complaints of discrimination will continue to be investigated.

I hope the steps outlined above address the concerns of the Committee. Again, I appreciate the opportunity to engage in candid discussions with you to seek a mutual solution to the issues you raised.

Sincerely,



THOMAS E. PEREZ

Chairman WALBERG. Without objection, this letter will be included in the hearing record. Hearing no objection, it will be included.

While we welcome this development, it is ironic the Secretary's letter refers to a law that includes specific language stating health care providers in TRICARE are not subcontractors. This law was enacted after the department took action against a Florida hospital. Regardless of any statutory ambiguity the administration thinks exists, the will of Congress is clear: OFCCP interference in TRICARE must stop.

While I appreciate the Secretary's response and attempt to address it with a workable solution—and I say that sincerely and have appreciated the conversations with Secretary Perez—I truly believe the Secretary's letter may have convinced some to withhold and even withdraw early support from the bill.

But I have asked my colleagues, aren't you concerned about what happens five years from now? Does this letter offer TRICARE providers the long-term certainty they need? What about those who serve seniors through Medicare, or those who serve federal employees, both noticeably absent from this moratorium. If OFCCP intends to regulate TRICARE providers, it can just as easily impose its will on other federal programs, as well.

At a recent hearing, the senior Democratic member of the subcommittee commended a witness for, and I quote—"raising some important issues about the impact on programs that help our TRICARE military retirees and active duty folks in terms of making sure that we maintain access for hospital services," end quote.

Our colleague then expressed the desire to, quote—"work out some of the kinks revealed during the hearing." And I must admit that my colleague has attempted to do that. But I am honestly disappointed to say the kinks we discussed in December still exist, despite the Secretary's letter.

If the Secretary has accomplished anything he has signaled to our TRICARE providers the day of reckoning is only delayed. Any sensible provider will use these few years to decide whether it is in their best interest to continue operating in a TRICARE network. Many may decide the administrative burden looming on the horizon is simply too much to bear.

As a result, veterans, servicemembers, and their families will lose access to care. Let me repeat that. As a result of the department's policy, veterans, servicemembers, and their families will lose access to care; maybe not now, but soon.

As policymakers, we shouldn't accept political half-measures that merely kick the can down the road. The American people expect better.

However, it is my hope we can continue working together, and we will, to provide a lasting solution to this problem not just for our active and retired military service personnel, but also for our seniors and the men and women who serve in the federal workforce. H.R. 3633 provides the long-term solution they, and their families, deserve.

I will now yield to our distinguished colleague, the senior Democratic member of the subcommittee, Representative Courtney, for his opening remarks.

[The statement of Chairman Walberg follows:]

Good morning. I'd like to welcome our guests and thank our witnesses for being with us as we discuss H.R. 3633, the Protecting Health Care Providers from Increased Administrative Burdens Act.

The bill is the result of the committee's continued oversight of the Department of Labor, which shed light on an unprecedented effort by the Office of Federal Contract Compliance Programs to assert jurisdiction over health care providers who participate in certain federal programs. H.R. 3633 would rein in this executive overreach, prevent an administrative nightmare for health care providers, and help some of the nation's most vulnerable citizens maintain access to care.

OFCCP is responsible for enforcing federal nondiscrimination and affirmative action requirements on federal contractors. Today's discussion isn't about whether we support the important policies the agency enforces. No one should be denied employment because of their gender, disability, race, or religion. All employers have a moral and legal obligation to provide a work environment free of discrimination, including those who receive taxpayer dollars.

The goal of our oversight and the legislation is to ensure the agency does its job effectively and responsibly. In the past we've encouraged OFCCP to streamline the myriad requirements federal contractors must follow. As one witness from St. Jude Children's Hospital testified, the current regulatory scheme is "all stick and no carrot." Simplifying the process would strengthen the rights of workers by making it easier for employers to understand their responsibilities and comply with the law.

Workers, employers, and taxpayers would be better served if OFCCP spent its time improving the current regulatory structure, rather than unilaterally imposing a broken system on more workplaces. Yet that is precisely what the agency is trying to do by asserting jurisdiction over hospitals and other health care providers who see patients covered by various federal programs, such as TRICARE and the Federal Employee Health Benefits Program.

As a result of the bipartisan concerns addressed in this legislation, the Department of Labor announced earlier this week a limited delay of its misguided approach. In a letter to the committee, Secretary Perez promised a five year delay of new OFCCP enforcement activities against TRICARE providers.

Without objection, the letter will be included in the hearing record.

While we welcome this development, it's ironic the secretary's letter refers to a law that includes specific language stating health care providers in TRICARE are not subcontractors. This law was enacted after the department took action against a Florida hospital. Regardless of any statutory ambiguity the administration thinks exists, the will of Congress is clear: OFCCP interference in TRICARE must stop.

The secretary's letter may have convinced some to withhold and even withdraw earlier support for the bill. But I have to ask my colleagues: Aren't you concerned about what happens five years from now? Does this letter offer TRICARE providers the longterm certainty they need? What about those who serve seniors through Medicare or those who serve federal employees, both noticeably absent from this so-called moratorium? If OFCCP intends to regulate TRICARE providers, it can just as easily impose its will on other federal programs as well. And can someone please explain how a letter from one administration can control the actions of another?

At a recent hearing, the senior Democratic member of the subcommittee commended a witness for "[raising] some important issues about the impact on programs that help our TRICARE military retirees and active duty folks, in terms of making sure that we maintain access for hospital services." Our colleague then expressed a desire to "work out some of the kinks" revealed during the hearing. I am disappointed to say the kinks we discussed in December still exist, despite the secretary's letter.

If the secretary has accomplished anything, he has signaled to our TRICARE providers the day of reckoning is only delayed. Any sensible provider will use these few years to decide whether it's in their best interest to continue operating in a TRICARE network. Many may decide the administrative burden looming on the horizon is simply too much to bear. As a result, veterans, service members, and their families will lose access to care. Let me repeat that: As a result of the department's policy, veterans, service members, and their families will lose access to care. Maybe not now, but soon.

As policymakers, we shouldn't accept political half-measures that merely kick the can down the road. The American people expect better. I am disappointed my friend and colleague, Representative Courtney, is no longer a cosponsor of this important legislation. However, it is my hope we continue working together to provide a lasting solution to this problem, not just for our active and retired military service personnel, but also for our seniors, and the men and women who serve in the federal

workforce. H.R. 3633 provides the long-term solution they and their families deserve.

I will now yield to our distinguished colleague, the senior Democratic member of the subcommittee, Representative Courtney, for his opening remarks.

Mr. COURTNEY. Well, thank you, Mr. Chairman. And I thank you for your kind words. I have nowhere to go but downhill after those nice compliments. And I would just say that, you know, to me this is a situation of whether you want to look at it as a glass half full or half empty in terms of the movement that has occurred from the Department of Labor since the last hearing that took place.

I think it is important, though, to sort of set the context for what happened in 2011, when the NDAA was enacted, with language which called for the department to withhold enforcement through OFCCP. Mr. Kline and I were conferees on that measure, and it was in response to real-life concrete issues out there with TRICARE access for veterans. Again, I have the honor of representing the largest military installation in New England, with the Groton sub base 8,000 sailors. We hold veterans in active duty council meetings that my office organizes on a regular basis. And it has been a chronic issue in terms of finding providers who accept TRICARE coverage and, frankly, has absolutely nothing to do with OFCCP.

The GAO has been studying this issue for years. And they, in fact, just issued an updated report in 2013, where they talked about provider acceptance for TRICARE where, again, it is lower than Medicare, far lower than Medicare, and lower than Medicaid in some instances, which is saying something in terms of the aversion that—whether it is—well, hospitals, by and large, because of their 501(c)(3) status, almost have to accept patients. But frankly, the provider community in an outpatient basis, it is a real problem. And I have talked to everyone from specialists to dentists, primary care docs who, in many instances, just provide free care because they just want to avoid the hassle of dealing with TRICARE.

And, again, it has absolutely nothing to do with OFCCP. However, in the context of that chronic finding that has been going on here at the Armed Services Committee, in 2011 the Committee, through conference, included language which again said, you know, we are not gonna try and create another obstacle or another barrier for providers in TRICARE. And the language was enacted. By the way, you have to give credit. This was a Senate initiative, but the House did accept, in conference, the language. We acceded to that language.

So fast forward, we had the hearing recently. And it is clear that the Florida case and other actions by the department, the department really was not reading the language in a way that I think was clear congressional intent. There was "may" language instead of "shall" language; there was some disparity they were pointing to in terms of report language that was attached to the NDAA. And the agency was still sort of chugging forward.

We also, though, had an intervening event. Which is, we have a new Secretary of Labor, who was just confirmed in late December, who, in my opinion has really responded to the oversight function

of this subcommittee, as the Chairman and I discussed the other day.

They issued new rules on OSHA for the grain elevator issue that this subcommittee raised, and pulled back the department in terms of that complaint which we heard here. And I believe the letter which he submitted a couple days ago is, in fact, exactly the same type of approach that Secretary Perez has signaled in the short time that he has been in office. Again, the letter clearly states that they will issue a five year moratorium. Any enforcement actions or compliance actions will be suspended. And he has personally told me that the Florida case will be withdrawn. And I want to make sure that is absolutely crystal clear on the record.

Again, this is a letter. This is not a stipulated judgment that, you know, is entered in front of a judge. But there is no question the good faith that the Secretary has exercised in the last couple of months—and frankly, I think it is time that, you know, he is a former legislator, by the way—he really respects the legislative branch. And he worked for Senator Kennedy. He has made it clear that he does not regard us as the enemy or as a, you know, entity that should just be sort of overlooked. And I frankly think we should approach this as a glass half-full. That, in fact, five years is a long time in terms of this administration will be long gone in five years.

There will be who knows in the White House, in the Secretary of Labors. It is without prejudice, everybody retains all their rights in terms of whatever sort of view of the NDAA language that is on the books. And that we should, frankly, continue to engage him on whether or not there are issues regarding Medicare or FEHBP. This is not a person who is taking the attitude that, you know, he will not listen or talk or discuss with the Congress.

So based on that, I am willing to reward good behavior. And I am willing to step back from this legislation and embrace the good faith that he has exercised. And also, at the same time, recognize that the OFCCP has done great work in terms of opening up opportunities for women, for minorities and for disabled veterans, which I am sure we are gonna hear from our witness today about the fact that is part of their charge—is not only to try and create obstacles. I mean, it is the complete opposite. If they have actually tried to create employment opportunities for disabled veterans and veterans and the recent initiative—which, again, is gonna try and sort of push contractors to get that unemployment rate for veterans down—is, in my opinion, something that we want federal taxpayer money to be accomplishing.

So in any case, I want to thank the Chairman again. I do not regard, you know, the efforts of this subcommittee to be sort of a partisan, you know, witch hunt kind of thing. It was a sincere effort to move forward and try and fix a problem. In my opinion, the Secretary has met us halfway and I think we should, you know, take a bow, or you should take a bow, for your work on this issue. And that we should continue to build on that momentum to try and, again, get smarter policy that accomplishes the goals that we all want.

And with that, I yield back.

Chairman WALBERG. I thank the gentleman. And I would concur that this subcommittee, our effort will be to move policy forward in the right direction. And part of that is pushing, where necessary, to get further. But also a reality of what is possible. And for that reason, we have the hearing today to give us more information.

Pursuant to committee rule 7(c), all members will be permitted to submit written statements to be included in the permanent hearing record. And without objection, the hearing record will remain open for 14 days to allow statements, questions for the record and other extraneous material referenced during the hearing to be submitted in the official hearing record.

It is now my pleasure to introduce our distinguished witnesses. Mr. Curt Kirschner is a partner at Jones Day in San Francisco, California. What is the weather out there? Never mind. And is testifying on behalf of the American Hospital Association.

Mr. Thomas Carrato—did I get that close?

Mr. CARRATO. Yes, sir.

Chairman WALBERG. Is president of Health Net Federal Services in Arlington, Virginia. Mr. Carrato retired as a rear admiral in the Commissioned Corps of the United States Public Health Service. Ms. Fatima Goss Graves serves as the vice president for education and employment at the National Women's Law Center in Washington, D.C. Welcome. Mr. David Goldstein is a shareholder with the firm Littler Mendelson in—it is too cold to speak—Minneapolis, Minnesota. Mr. Chairman, help me with that Minnesota stuff.

Mr. KLINE. [Off mike.]

Chairman WALBERG. Thank you. Before I recognize each of you to provide your testimony, let me briefly explain our lighting system. And I think I will be brief on that. It is like a traffic light, as you know. You will have five minutes to give your testimony. We will try to keep as close to that as possible, and you will help me if you will. When the light turns yellow you have a minute left. When it is red, wrap up as quickly as possible. We will hold that policy for our subcommittee members, as well, under their questioning.

That being said, Mr. Kirschner we welcome you and recognize you for five minutes of testimony.

STATEMENT OF MR. CURT KIRSCHNER, PARTNER, JONES DAY, SAN FRANCISCO, CA (TESTIFYING ON BEHALF OF THE AMERICAN HOSPITAL ASSOCIATION)

Mr. KIRSCHNER. Good morning, Chairman Walberg, Ranking Member Courtney, and distinguished members of the subcommittee. My name is Curt Kirschner, and I am a partner in the Jones Day law firm. Today, I am testifying on behalf of the American Hospital Association in support of H.R. 3633, the *Protecting Health Care Providers from Increased Administrative Burdens Act.* A more thorough discussion of the AHA's support of the bill is included in written testimony submitted to the subcommittee, which I request be introduced into the record.

In my oral comments today, I wanted to explain why, from the AHA's perspective, H.R. 3633 remains an important bill to be introduced and why, in our view, the DOL's proposal is insufficient. H.R. 3633 will clarify that hospitals are not subject to the OFCCP's

jurisdiction solely as a result of their participation in Medicare, TRICARE, or the Federal Employees Health Benefit Program, also known as FEHBP.

Previously, OFCCP has acknowledged in its own internal directives that it does not have jurisdiction over hospitals that treat beneficiaries of these federally-funded plans. More recently, however, the OFCCP rescinded those directives and sought to expand its jurisdiction over health care providers based solely on their participation in these programs. I had the opportunity to appear before the subcommittee last December, where I offered testimony demonstrating that the OFCCP's assertion of jurisdiction over hospital providers in these circumstances is inconsistent with both federal law and regulations.

Moreover, the OFCCP has not given any reasonable explanation for its shifting position. The only recent relevant legal change is the one cited by the Chairman, which is Congress' adoption, in 2011, of section 715 of the *National Defense Authorization Act,* which explicitly sought to preclude OFCCP jurisdiction over hospitals participating in TRICARE. Despite this statute, the OFCCP continues to assert jurisdiction over TRICARE providers. And that is true, despite the fact that the DOL has now said there may be a moratorium on enforcement. They are still asserting jurisdiction over the providers.

The agency's continuing attempts to circumvent the NDAA confirm the need for legislation placing clear limits on the OFCCP's jurisdiction. The OFCCP proposes an alternative to H.R. 3633, which is a vaguely-defined, case by case basis to determine jurisdiction. As best as the AHA can tell, the OFCCP, under this approach, attempts to distinguish between hospitals that participate in fee-for-service plans from those that participate in managed care plans under these federally-funded programs. From the perspective of America's hospitals, this is a distinction without a difference.

Fee-for-service plans and managed care plans are simply different mechanisms for reimbursing health care providers for the care that they provide to their patients; in this case, servicemembers, federal employees, and their families. Under any of these plans, the role of the hospital is essentially the same. That is, to provide quality care for the plan participant. The OFCCP has provided no guidance regarding which of the nearly 300 FEHBP plans, and more than 10 TRICARE plan options, contain sufficient elements of managed care such that a hospital participating in that plan would be deemed to be a federal subcontractor.

Already, Florida Hospital of Orlando and three hospitals affiliated with the University of Pittsburgh Medical Center have spent years in litigation after refusing to concede to the OFCCP's jurisdiction. The AHA urges Congress to clarify the law so that hospitals are not forced to choose between submitting to the OFCCP's burdensome regulations on the one hand, or spending years bogged down in costly legal proceedings on the other. The OFCCP's expansionist agenda is forcing hospitals to make another difficult choice: whether to provide care to family servicemembers and federal employees at all.

Rather than risk a jurisdictional claim from the OFCCP, some hospitals may simply decide to opt out of federally-funded health

plans, further straining the available provider networks. The DOL's proposal contained in this March 11 letter is not a solution, in our view. The proposal does not address at all the role of FEHBP and Medicare programs. Even for TRICARE, the letter assumes federal contractor status of hospital providers, despite NDAA 715, and merely delays the enforcement of the OFCCP's ambiguous standards, potentially asserting jurisdiction over conduct that occurs during that five year period.

In sum, at a time when lowering health care costs is one of the nation's top policy concerns, H.R. 3633 would clarify, once and for all, that participation in a federally-funded health benefit program does not subject hospitals to the OFCCP's jurisdiction. The AHA urges Congress to pass this important bill.

Thank you for the opportunity to provide these comments to the subcommittee.

[The statement of Mr. Kirschner follows:]

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Statement
of the
American Hospital Association
before the
Subcommittee on Workforce Protections
of the
Education and Workforce Committee
of the
U.S. House of Representatives

Hearing on the
"Protecting Health Care Providers from Increased Administrative Burdens Act."

March 13, 2014

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement to the Education and Workforce Committee's Subcommittee on Workforce Protections in support of H.R. 3633, the Protecting Health Care Providers from Increased Administrative Burdens Act.

H.R. 3633 is a bipartisan bill that has been narrowly crafted to accomplish one important outcome: to ensure that hospitals and other health care providers cannot be classified as federal contractors or subcontractors, and subjected to an extensive federal regulatory scheme, simply because they provide care to patients covered by a federally funded health benefit plan. In particular, H.R. 3633 will clarify that hospitals are not subject to the jurisdiction of the Office of Federal Contract Compliance Programs (OFCCP) solely as a result of their participation in Medicare; TRICARE, the health care program for military service members and their families; or the Federal Employees Health Benefit Program (FEHBP), which provides health insurance options to civilian government employees and their families.

The OFCCP has acknowledged that it does not have jurisdiction over hospitals participating in Medicare or the FEHBP. Within the past few years, however, the agency has laid the groundwork for a jurisdictional land grab based on essentially meaningless distinctions between the ways health care providers participate in federally funded health benefit programs. If Congress does not act, the OFCCP's self-serving definition of its own authority will convert, virtually overnight, a majority of our nation's hospitals into federal contractors, without advance notice to or agreement by those hospitals.

As explained in the AHA's testimony before this Subcommittee on December 4, 2013, the OFCCP's position is inconsistent with the law and with the views of the federal agencies that administer TRICARE and the FEHBP.[1] In addition, it will impose significant administrative burdens on America's hospitals, which already are and will remain subject to the requirements of federal, state and local antidiscrimination laws.

This executive overreach demands a clear and targeted congressional response. The AHA urges Congress to pass H.R. 3633 for three reasons:

1. The bill clearly defines the limits of OFCCP's jurisdiction without disturbing the agency's authority over institutions that have voluntarily entered into federal contracts;
2. The bill will prevent needless and costly litigation over the classification of health care providers as federal contractors and subcontractors; and
3. The bill removes obstacles to hospitals and other health care providers from providing health care services to members of the military, federal employees and their families.

H.R. 3633 CLEARLY DEFINES THE LIMITS OF OFCCP JURISDICTION

The OFCCP plainly has jurisdiction over hospitals that voluntarily enter into contracts or subcontracts with the federal government. Thus, for example, a hospital that entered into a contract to conduct research on behalf of the National Institutes of Health is required to comply with OFCCP regulations and, therefore, must develop annual affirmative action plans, implement sophisticated job applicant tracking systems, and engage in targeted outreach to women, minorities, individuals with disabilities, and veterans, in accordance with the OFCCP's numerous regulations.

In the AHA's view, however, the OFCCP's assertion of jurisdiction over hospitals that participate in federally funded health benefits programs has no basis in law. In fact, the OFCCP itself once agreed with this position. In 2003, the Department of Labor's Administrative Review Board (ARB) found that the OFCCP did not have jurisdiction over hospitals that provided services to federal employees covered by a fee-for-service plan through the FEHBP (*In re Bridgeport Hosp.*, ARB Case No. 00-034, 2003 WL 244810, at *1 (DOL Adm. Rev. Bd. Jan. 31, 2003)). In response to the ARB's ruling, the OFCCP issued a formal policy statement conceding that it "cannot use FEHBP coverage as a basis to assert jurisdiction over a health care provider" (*see* OFCCP Directive No. 262 (2003)). Likewise, the OFCCP has clarified that it "considers health care institutions that provide services to Medicare and Medicaid beneficiaries as recipients of federal financial assistance and not as contractors" (*see* OFCCP Directive No. 189 (1993)).

These previous statements regarding the OFCCP's jurisdiction are consistent with Congress's own definition of a federal procurement contract in the Federal Grant and Cooperative Agreement Act of 1977 (Grant Act). The Grant Act explains that a federal procurement contract has "the principal purpose of [acquiring] property or services *for the direct benefit or use of the*

[1] *See generally Examining Recent Actions by the Office of Federal Contract Compliance Programs: Hearing Before the Subcomm. on Workforce Protections, House Comm. on Education and the Workforce*, 113th Cong. 9-11 (2013) (prepared Testimony of F. Curt Kirschner, American Hospital Association), available at http://edworkforce.house.gov/uploadedfiles/kirschner_statement_and_testimony.pdf ["2013 Testimony"].

United States Government." Clearly, hospitals participating in TRICARE, FEHBP and Medicare do not receive reimbursements because they are providing services for the benefit of the government. Instead, the "beneficiaries" of these payments are the service members, federal employees and retirees who receive medical care. The most logical reading of the Grant Act, thus, cannot be stretched to define health care providers participating in federally funded health benefit programs as federal contractors.

Regulations promulgated by the agencies responsible for TRICARE and the FEHBP agree with this conclusion. For more than 25 years, the Office of Personnel Management, which administers the FEHBP, has explicitly excluded from its definition of subcontractor "providers of direct medical services . . . pursuant to [a] health benefits plan." Similarly, Department of Defense regulations designate TRICARE reimbursements as a form of federal financial assistance, which does not constitute a federal contract subject to OFCCP regulations.

Now, the OFCCP is taking a different position – one that not only creates unnecessary interagency conflict but also clashes with congressional directives. In 2006, the agency filed administrative complaints in *OFCCP v. UPMC Braddock*, seeking to enforce its affirmative action regulations against three hospitals affiliated with the University of Pittsburgh Medical Center. The OFCCP based its assertion of jurisdiction on the fact that the hospitals had an HMO contract to provide health care services to FEHPB participants. The hospitals objected to the agency's line of reasoning, arguing that providing health care services to patients should not convert the hospitals into federal contractors. Eight years later, the case remains pending before the D.C. Circuit.

In another, well-publicized case, *OFCCP v. Florida Hospital of Orlando*, the agency has claimed that Florida Hospital is a covered federal subcontractor solely as a result of its agreement to provide health care services to TRICARE beneficiaries. Congress acted to head off this assertion of jurisdiction by passing Section 715 of the National Defense Authorization Act for Fiscal Year 2012 (NDAA), which President Obama signed into law in 2011. The NDAA included a provision expressly exempting TRICARE network providers from federal contractor status.

Instead of honoring and enforcing this new law, however, the OFCCP continued to pursue a finding of federal contractor status against Florida Hospital. The agency argued – contrary to congressional intent – that the NDAA did not act as a complete bar to its jurisdiction over TRICARE providers. In briefing to the ARB, the OFCCP even suggested that the Secretary of Labor's authority *exceeds* that of Congress, complaining that the NDAA "usurped" the secretary's authority to determine which providers are subcontractors under the laws that OFCCP enforces (*see* OFCCP's Resp. to ARB's Request for Briefing on the Impact of Sec. 715 of the NDAA, ARB Case No. 11-011 (filed Mar. 13, 2012)).

The ARB initially rejected the OFCCP's arguments. In response to the agency's petition for a rehearing, however, the ARB reversed its previous stance and ultimately agreed that the NDAA did not entirely foreclose the OFCCP's assertion of jurisdiction over Florida Hospital. Five years after the agency first brought its action, the case remains pending before an administrative law judge (ALJ) to determine whether TRICARE reimbursements constitute a federal contract or federal financial assistance, over which the OFCCP does not have jurisdiction.

The OFCCP's persistent attempts to circumvent the NDAA confirm the need for legislation that places clear limits on the agency's jurisdiction. The Protecting Health Care Providers from Increased Administrative Burdens Act unambiguously states that the OFCCP cannot treat hospitals and other health care providers as federal contractors or subcontractors simply because the government reimburses them for providing health care services to participants in TRICARE, the FEHBP or any other federally funded health benefit program. At the same time, H.R. 3633 would not interfere with the OFCCP's rightful jurisdiction over hospitals and other health care providers that have voluntarily entered into government contracts and subcontracts. These organizations would still be subject to the affirmative action regulations enforced by the agency.

H.R. 3633 WILL PREVENT NEEDLESS AND COSTLY LITIGATION OVER THE CLASSIFICATION OF HEALTH CARE PROVIDERS AS FEDERAL SUBCONTRACTORS

The OFCCP's proposed alternative to the clear boundaries set by H.R. 3633 is a "case by case" approach to determining the federal subcontractor status of health care providers. Disturbingly, the agency has not articulated any clear standards that would govern this *ad hoc* approach, stating only that it will act "in keeping with its regulatory principles . . . and OFCCP case law." This vague explanation inevitably will lead to confusion and jurisdictional disputes. Indeed, under the OFCCP's approach, the vast majority of hospitals and health care providers are unlikely to realize that they may be considered federal subcontractors until the OFCCP notifies them of an impending compliance audit. This outcome is particularly unfair given that many hospitals agreed to participate in federally funded health benefit programs with the understanding that they would not thereby become subject to OFCCP jurisdiction. For example, in *UPMC Braddock*, the hospitals' HMO contracts explicitly provided that they were not federal subcontractors.

While the OFCCP has refused to offer any identifiable standard for judging who is a federal subcontractor, the agency's prior statements indicate that it will attempt to distinguish between hospitals that have entered into traditional fee-for-service agreements and those that participate in so-called "managed care" components of TRICARE, the FEHBP and Medicare Parts C and D. "Managed care" includes agreements between hospitals and health maintenance organizations (HMOs), preferred provider organizations (PPOs) and similar health plans, which make the provision of health care services a contract requirement. The OFCCP contemplates that hospitals providing services under these types of agreements are federal subcontractors subject to its jurisdiction. By contrast, the OFCCP has not asserted – and, given the *Bridgeport* decision, cannot assert – jurisdiction over participants in fee-for-service plans.

Unfortunately for America's hospitals, the OFCCP's position sets up a distinction without a difference. From the perspective of hospitals, fee-for-service plans, HMOs and PPOs are simply different mechanisms for accomplishing the same goal of reimbursing the health care providers for delivering care to patients. A hospital's responsibilities to care for a patient do not vary in any material way depending on the type of plan in which that patient is enrolled. Indeed, the only real difference for a hospital between providing care for a patient covered by an HMO and a patient covered by a fee-for-service plan is likely to be the contracted reimbursement rate. While

the plan administrators of managed care plans may have different responsibilities with respect to their covered participants than administrators of a fee-for-service plan, those administrator responsibilities generally are not passed through to the hospitals. Regardless of the type of plan involved, the role of the hospital remains the same, i.e., to provide care for the patient.

Even assuming, *arguendo*, that the OFCCP has articulated a meaningful distinction, it cannot explain how this distinction will practically be applied. Private pure fee-for-service plans, with no "managed" components to control costs, are on the verge of extinction. The plans that remain vary widely in organization and administration.

The three federally funded health benefit plans at issue are no exception to this trend. Together, they offer federal employees, retirees and their families hundreds of plan options, many of which include both fee-for-service and managed care components. TRICARE, for example, offers an overlapping mix of more than 10 plan options, including a traditional fee-for-service option (containing little, if any, managed care components), PPOs and HMOs. The FEHBP includes almost 300 plan options, running the gamut from pure indemnity plans to restrictive HMOs, with numerous options in between. Medicare includes both traditional indemnity plans under Parts A and B, as well as managed care components under Parts C and D.

The OFCCP has provided no guidance regarding which of these health plan options contain sufficient elements of "managed care" such that the participating hospital would be considered a federal subcontractor. As the examples of *Florida Hospital* and *UPMC Braddock* demonstrate, it could take years to resolve this lack of clarity through litigation – if a resolution is possible at all. In the meantime, hospitals that receive audit demands based on their participation in federally funded health benefit programs are presented with a Hobson's choice between submitting to the OFCCP's burdensome regulations or spending years bogged down in costly legal proceedings.

Congress must act to define clearly the OFCCP's jurisdiction before additional hospitals are forced to bear these unnecessary expenses. H.R. 3633 will resolve the ambiguities that the OFCCP has created and curtail further litigation by clarifying that a hospital providing care under Medicare or through any of the plans offered by FEHBP or TRICARE is not considered a federal subcontractor based on this fact alone.

H.R. 3633 Removes Obstacles to Providing Health Care Services to Members of the Military, Federal Employees and Their Families

The OFCCP's expansionist agenda is forcing hospitals to make another difficult choice: whether to risk providing care to military service members and federal employees at all. As set forth above, hospitals that choose to continue providing care to FEHBP and TRICARE participants may be required to expend significant additional resources to comply with the OFCCP's complex regulatory scheme – even though these hospitals themselves hold no contracts with the federal government. The AHA previously explained in testimony to this committee that hospitals can spend hundreds of hours and tens of thousands of dollars simply updating and maintaining the Affirmative Action Plan required by the OFCCP. This time and capital

expenditure increases dramatically during audit years, and the OFCCP is conducting compliance reviews with increasing regularity.[2]

These additional administrative costs divert vital resources from hospitals' central mission of providing quality patient care. Faced with the risk of these increased burdens, some hospitals may decide to stop providing services to participants in TRICARE or the FEHBP, thus limiting the health care options available to federal employees, service members, and their families.

This possibility is particularly distressing given that the Department of Defense has already recognized and reported a trend that fewer health care providers are accepting new TRICARE patients.[3] The National Military Family Association (NMFA) recently warned Congress that a lack of long-term willingness by providers to remain in the TRICARE network could negatively affect beneficiary access in future years. The NMFA noted that providers have complained of uncertainties over the added requirements and expenses that their participation in TRICARE could incur.[4] The Military Officers Association of America, the nation's largest association of military officers, concurs in this assessment, proclaiming that "action is urgently needed to attract more providers to participate in TRICARE."[5] Yet despite this appeal, the OFCCP continues to seek to increase the cost of TRICARE participation by requiring some unspecified number of providers to comply with its affirmative action regulations.

Congressional action is needed to ensure that the OFCCP does not overstep its bounds and, in so doing, reduce access to quality and convenient care for service members, federal employees and their families. By clarifying that a hospital or other health care provider will not be subject to a crushing regulatory burden simply because it provides health care services to TRICARE or FEHBP participants, H.R. 3633 removes the disincentives that hospitals now have to treat patients who get their health insurance through a federally funded program.

CONCLUSION

At a time when lowering health care costs is one of the nation's top policy concerns, the OFCCP is making an aggressive jurisdictional land grab that will increase the administrative costs for hospitals and other health care providers. This assertion of jurisdiction runs counter to federal statutes, the regulations of OFCCP's sister agencies, and plain common sense. The AHA urges Congress to end the uncertainty that the OFCCP has created by passing H.R. 3633 and clarifying once and for all that participation in a federally funded health benefit program does not subject health care providers to OFCCP jurisdiction.

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[2] 2013 Testimony, *supra* n. 1, at 9-11 (2013).
[3] GAO Report 13-364, *TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries* (Apr. 2013), available at http://www.gao.gov/assets/660/653487.pdf.
[4] *Hearing Before the Subcomm. on Personnel, Senate Armed Services Comm.*, 113th Cong. 11-12 (2013) (Statement of the National Military Family Association), *available at* http://www.militaryfamily.org/assets/pdf/Testimony/NMFA-SASC-Personnel-testimony-4-17-13.pdf.
[5] Military Officers Association of America, *TRICARE Prime and TRICARE Standard Improvements* (Jan. 8, 2014), *available at* https://www.moaa.org/Main_Menu/Take_Action/Top_Issues/Serving_in_Uniform/TRICARE_Prime_and_TRICARE_Standard_Improvements.html.

Chairman WALBERG. Thank you.

And now we turn to Mr. Carrato for your five minutes of testimony. Thank you.

STATEMENT OF MR. THOMAS CARRATO, PRESIDENT, HEALTH NET FEDERAL SERVICES, ARLINGTON, VA

Mr. CARRATO. Great. Chairman Walberg, Ranking Member Courtney, distinguished members of the Committee, thank you for the opportunity to testify on efforts to expand the jurisdiction of the Office of Federal Contract Compliance Programs. Classifying TRICARE network providers as federal subcontractors poses significant issues for the TRICARE program, our network providers, and the beneficiaries we jointly serve. Appreciate the opportunity to address this issue today.

Health Net Federal Services provides physical and behavioral health care services to the Department of Defense and the Department of Veterans Affairs, among others. These programs include TRICARE, the DOD's Military Family Life Counseling Program, and the VA's patient-centered Community Care Program. We have watched the legal action involving OFCCP with great concern. I don't want to focus on legal arguments or litigation. The issue I want to address is how will OFCCP's position affect TRICARE beneficiaries and our ability to provide military members and their families access to high-quality providers, especially in locations far from military treatment facilities. Our primary concern is not a legal point or an argument about the limits of an agency's jurisdiction, but how can we best serve our customer and our beneficiaries.

OFCCP has asserted that providers of health care services in our managed care networks are federal subcontractors. We firmly believe that they are not subcontractors, and that any attempt to classify them as such will have significant negative impact on the ability of TRICARE beneficiaries to obtain high-quality accessible medical care. The risk for TRICARE is twofold. The first is that we will have difficulty getting providers to join our networks. Providers sign contracts with us and not the federal government. They may not be willing or able to shoulder the additional burdens of OFCCP compliance.

The second risk is that if OFCCP is successful, instead of assuming the burden of compliance, providers will leave our networks. There are 55 sole community hospitals and 151 critical access hospitals in our TRICARE network. If any of those left it would leave a significant gap in access that would impact military families and the military member. We require all of our providers, as part of their contract, to adhere to all state, federal and local laws, including any applicable affirmative action laws. We believe expanding OFCCP's jurisdiction over TRICARE will make it more difficult to build and retain provider networks.

Ultimately, this will mean fewer options for the military members, families and retirees who rely on TRICARE, and will significantly limit their ability to obtain the level of care they need from a provider of their choice. Health Net believes that to ensure military beneficiaries have ready access to needed health care services providers in TRICARE networks must be exempted from the OFCCP regulation. The uncertainty that currently exists in the law

continues to negatively affect our ability to provide high-quality, accessible health care for millions of our nation's most deserving citizens, the men and women of our uniform services, and their families.

Thank you for your time. I am prepared to answer any questions you may have.

[The statement of Mr. Carrato follows:]

TESTIMONY BY

RADM THOMAS CARRATO, USPHS (RET.)

PRESIDENT

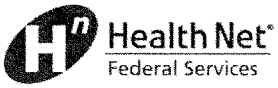
HEALTH NET FEDERAL SERVICES

BEFORE THE SUBCOMMITTEE ON WORKFORCE PROTECTIONS

OF THE EDUCATION AND THE WORKFORCE COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

March 13, 2014



Biography of RADM Thomas Carrato, USPHS (Ret.)

Thomas Carrato is President of Health Net Federal Services, responsible for the daily leadership and management of Health Net's Government Services Division. His responsibilities include the management and oversight of Health Net's Department of Defense and Department of Veterans Affairs lines of business including the DoD's TRICARE program for the North Region and the worldwide Military & Family Life Counseling contract.

Mr. Carrato has over 30 years of experience, success and accomplishments in both the public and private health care sector as senior executive, chief operating officer and clinician. He served as Assistant Surgeon General of the United States, Regional Health Administrator for the U.S. Department of Health and Human Services, Deputy Assistant Secretary of Defense for Health Plan Administration, and Group Vice President for a publicly traded government services company. Mr. Carrato joined Health Net in March 2006 as Vice President and DoD Program Executive.

Previously, Mr. Carrato served as Deputy Assistant Secretary of Defense for Health Plan Administration and Executive Director of the TRICARE Management Activity where he directed and managed worldwide operations and performance of the TRICARE health plan. In an earlier role as the Department of Health and Human Services' Regional Health Administrator for Region IV, Mr. Carrato was the Department's principal representative, providing advice and participating in policy development and implementation of key health care initiatives in the southeastern United States. He managed regionally based programs of the Office of Public Health and Science including the Offices of Emergency Preparedness, Minority Health, Women's Health, and Population Affairs.

Mr. Carrato holds a Master of Science in Accounting from Georgetown University and is a licensed Certified Public Accountant. In addition, he holds a Master of Social Work from the University of South Carolina and is a licensed clinical social worker.

Mr. Carrato, retired as a Rear Admiral in the Commissioned Corps of United States Public Health Service. His decorations include the Defense Distinguished Service Medal and the Public Health Service Distinguished Service Medal.

Health Net Federal Services, LLC Corporate Profile

In partnership with DoD, Health Net Federal Services, LLC serves as the Managed Care Support Contractor in the TRICARE North Region, providing health care and administrative support services for three million active-duty family members, military retirees and their dependents in 23 states. We also deliver a broad range of customized behavioral health and wellness services to military services members and their families, including Guardsmen and reservists. These services include the Military and Family Life Counseling (MFLC) Program providing non-medical, short-term problem solving counseling, rapid response counseling to deploying units, embedded counselors in military units, and reintegration counseling.

In collaboration with VA, Health Net supports Veterans' physical and behavioral health care needs through Community Based Outpatient Clinics (CBOCs) and the Patient-Centered Community Care (PCCC) Program. PCCC provides eligible veterans with coordinated, timely access to health care through a comprehensive network of approved non-VA specialty care providers. Health Net administers PCCC in three of the six PCCC regions covering all or parts of 37 states; Washington, DC; Puerto Rico; and the U.S. Virgin Islands.

Testimony of Mr. Thomas Carrato

Chairman Walberg, Ranking Member Courtney, Members of the committee, thank you for the opportunity to testify on efforts to expand the jurisdiction of the Office of Federal Contract Compliance Programs (OFCCP). Classifying TRICARE network providers as federal subcontractors poses significant issues for the TRICARE program, our TRICARE network providers and the beneficiaries we jointly serve. I appreciate the opportunity to address this issue in this forum.

Health Net Inc. (Health Net) is a publicly traded company delivering health care insurance and health care coverage in the public and private sectors to over 5.3 million beneficiaries in 39 states, the District of Columbia, and multiple U.S. territories. Health Net Federal Services, LLC, a wholly owned subsidiary of Health Net, has been a managed care support (MCS) contractor for Department of Defense (DoD) programs for 26 years. Through our programs, Health Net Federal Services provides physical and behavioral health care services to the Department of Defense and the Department of Veterans Affairs (VA), among others, including TRICARE, the DoD Military & Family Life Counseling program, VA's Patient Centered Community Care program, and several VA Community Based Outpatient Clinics (CBOCs).

We have watched with great interest and concern as the legal action between OFCCP and Florida Hospital of Orlando has progressed through the administrative law process. The issues addressed by the Administrative Law Judge and Administrative Review Board have focused on two questions: 1) whether the providers in the networks of TRICARE managed care support contractors are performing the tasks or functions necessary to the performance of the TRICARE contract and 2) whether TRICARE is a Federal Financial Assistance (FFA) program. Those issues are currently the subject of litigation, and I don't want to focus on the legal arguments in that litigation. The issue that I would like to address is "How will the OFCCP's position affect TRICARE beneficiaries and our ability to provide military members and their families access to high quality providers, especially in rural areas and areas far from military treatment facilities (MTF)?" The primary concern for us is not a legal point or an argument about the limits of an agency's jurisdiction, but simply how we can best serve our customer and our beneficiaries.

OFCCP has asserted that the providers who make up our managed care networks and provide health care services to TRICARE beneficiaries are federal subcontractors. We firmly believe that they are not subcontractors and, more importantly for my comments today, that any attempt to classify them as such will have significant negative impact on the ability of TRICARE beneficiaries to obtain high quality, accessible medical care.

We build networks of providers for the TRICARE program. Those providers see patients and provide treatment and medical care. We build these networks in areas that are urban and rural, densely populated and sparsely populated. Many of our providers are large hospitals and medical groups. There are also several thousand providers in our network that may fit into the category of smaller providers for whom compliance with OFCCP requirements would be cost prohibitive. We fear, and legitimately so, that these providers may be forced to stop providing services to military beneficiaries under the TRICARE program because they cannot bear the administrative costs and burdens associated with providing that service if they are deemed "subcontractors" for OFCCP purposes.

The risk for TRICARE providers and, by extension, TRICARE beneficiaries and the TRICARE program is twofold. The first risk is that managed care support contractors will have difficulty getting providers to join our networks. Providers execute provider agreements with us for the provision of health care services and not the federal government; they may not be willing or prepared to shoulder the additional burdens of federal contractor compliance. The second risk is the real possibility that providers will leave TRICARE contractor networks instead of assuming the burden of OFCCP compliance. There are 55 sole community hospitals (SCH) and 151 critical access hospitals in our TRICARE network. If any of those hospitals left our network, it would leave a significant gap in access that would impact military members and their families.

In addition to the two risks to the TRICARE program, there potentially is a third risk: expansion of OFCCP regulation, or even simply the threat of expansion, to other health care programs in other agencies. As an example of these risks, a large hospital group that is part of our TRICARE network has approached us with concerns over OFCCP regulation. That same hospital group has not joined our preferred provider network designed to support other government programs, including Department of Veterans Affairs programs that provide access to care for veterans, due to concerns about potential OFCCP regulation there as well.

The American Hospital Association did an excellent job of detailing what compliance entails in their previous testimony before this committee. The AHA also has done an excellent job detailing the costs of OFCCP compliance, both in terms of time and capital, something with which we are intimately familiar as a federal contractor.

Notwithstanding the issue of OFCCP compliance, we require our providers as part of their contract with us to adhere to any and all state, federal, and local laws that apply to them and their operations, which would include any applicable affirmative action laws. For example, private employers with 15 or more employees are subject to the stringent anti-discrimination laws of Section 504 of the Rehabilitation Act and Title VI of the Civil Rights Act of 1964, enforced by the Office of Civil Rights of the Department of Health and Human Services. The TRICARE regulation (32 CFR 199) explains that payment will not be made to a provider found to "practice discrimination in the admission of patients to its services on the basis of race, color, or national origin."

We believe expanding OFCCP's jurisdiction over TRICARE will make it much more difficult to build and retain provider networks. Ultimately, this will mean fewer options for the military members, families, and retirees who rely on TRICARE. We believe it will limit their ability to obtain the level of care they need from a provider of their choice. As the administrative burdens of participating in TRICARE outpace the benefits, it will become increasingly difficult to recruit and retain highly qualified practitioners in-network. This effect will be felt most prominently in rural and sparsely populated regions where there already are shortages of providers and managed care support contractors already face difficulty with recruitment and retention. It will also have significant impact on our ability to provide services that are already in critically short supply such as psychiatry, neurosurgery, and dermatology. Programs such as

VA's Patient-Centered Community Care program that employ a similar model to TRICARE could face similar difficulties attracting and retaining providers.

Health Net believes that in order to ensure military beneficiaries have ready access to needed health care services providers in TRICARE networks must be exempted from OFCCP regulation. While we believe that ultimately the courts will agree with the position that industry and the Department of Defense have taken – that TRICARE providers do not satisfy the OFCCP's definition of a subcontractor – the uncertainty that currently exists in the law continues to negatively affect our ability to provide high-quality, accessible health care for millions of our nation's most deserving citizens, the men and women of our armed forces and their families. Thank you for your time. I am prepared to answer any questions that you might have for me.

Chairman WALBERG. Thank you.

Ms. Graves, we recognize you for your five minutes of testimony. Thank you for being here.

STATEMENT OF MS. FATIMA GOSS GRAVES, VICE PRESIDENT FOR EDUCATION AND EMPLOYMENT, NATIONAL WOMEN'S LAW CENTER, WASHINGTON, D.C. (MINORITY WITNESS)

Ms. GRAVES. Thank you. Thank you, Chairman Walberg, Ranking Member Courtney and distinguished members of the subcommittee. Thank you for the opportunity to testify today on the important topic of civil rights obligations of federal contractors and subcontractors.

Over the last 40 years, the National Women's Law Center has been involved in virtually every major effort to secure and defend women's legal rights and equal opportunity in the workplace. And I am pleased to continue that work today by speaking about the key role that civil rights enforcement plays in ensuring equal opportunity for American workers.

I will begin with some background on the Office of Federal Contracts Compliance Programs enforcement. For nearly 50 years, the federal government has operated with the long-standing principle that companies that have the privilege of profiting from doing business with the federal government should not be permitted to discriminate in employment.

And this is for good reason. The taxpayer dollars used to buy goods and services from companies simply should not support discrimination. And the many federal contractors that play by those rules should not have to compete at a disadvantage with those who do discriminate. So the important work done by OFCCP in enforcing these nondiscrimination obligations also helps employers tap into a diverse pool of talent that leaves them and the broader economy stronger. OFCCP's measures require that federal contractors take notice of race and gender and disability and protected veteran status in the course of formulating policies designed to foster equal opportunity.

These measures require that contractors not discriminate, that they take affirmative steps to ensure a diverse workplace, and that they document these steps. And these steps are directly related to increasing employment opportunities and ensuring nondiscrimination. By requiring that contractors take appropriate steps to document employment practices, OFCCP is able to affirmatively assess whether there are indicators of discrimination. And in turn, through the process of record-keeping and data collection and analysis, an employer can engage in a self-evaluation that may prompt it to self-correct its own unfair practices.

And at the very least, both OFCCP and federal contractors will have the data that they need to track progress in providing equal employment opportunities. It is worth noting that few contractors are actually subject to an OFCCP affirmative compliance review. Only about 4,000 compliance reviews are conducted each year out of about 170,000 contractor establishments, which amounts to around a 2 percent chance of being reviewed. And only federal contractors and subcontractors that have at least 50 employees and at least 50,000 in contract dollars are required to develop affirmative

action plans. These are the plans that help contractors identify and analyze potential problems in the contractor's workforce.

So the systematic approach to civil rights complaints that OFCCP takes, both historically and currently, helps to improve opportunities for a wide range of workers. Studies that have assessed the effective Executive Order 11246 have indicated that the makeup of federal contract workforces changed significantly in the years following the issuance of the executive order. One study of over 70,000 federal contractors found that female employment by federal contractors increased by over 15 percent between 1974 and 1980, while it rose by only 2 percent in non-federal contractor settings.

And throughout the years, OFCCP has implemented a number of initiatives that have aided in the integration of the workforce in industries such as construction, in higher education, mining, ensuring opportunity in sectors with long histories of unfair treatment in hiring, promotion, and compensation. For example, in 1975, pursuant to a legal settlement reached with the National Women's Law Center, OFCCP targeted hiring and employment practices for women in colleges and universities around the country, improving opportunities for women in higher education.

And it is measures like these that have really strengthened American businesses considerably and made them more effective. Moreover, OFCCP's current strategic priorities, especially its focus on pay discrimination, its focus on opening opportunities in high-wage occupations like construction, the new regulations for veterans and for persons with disabilities, these all follow in that same tradition. In sum, the key role that OFCCP has played in improving economic security for workers and their families really cannot be overstated. The OFCCP process has expanded opportunities for workers over time, has made federal contracting more efficient, and has strengthened businesses.

Thank you again for the opportunity to be here today, and I look forward to any questions.

[The statement of Ms. Graves follows:]

Testimony of Fatima Goss Graves
Vice President for Education & Employment
National Women's Law Center

House Committee on Education and the Workforce
Subcommittee on Workforce Protections

Hearing on H.R. 3633: "Protecting Health Care Providers from Increased Administrative Burdens Act" March 13, 2014

Chairman Walberg, Ranking Member Courtney, and members of the Subcommittee:

Thank you for the opportunity to testify before the Subcommittee on the important topic of the civil rights obligations of federal contractors and subcontractors. Over the last 40 years, the National Women's Law Center has been involved in virtually every major effort to secure and defend women's legal rights to equal opportunity in the workplace. I am pleased to continue that work today by speaking about the key role that civil rights enforcement plays in ensuring equal opportunity for American workers, and a stronger, more diverse federal contractor workforce.

1) **Background on the Office of Federal Contract Compliance Programs.**

For nearly fifty years, the federal government has operated with the longstanding principle that companies that have the privilege of profiting from doing business with the federal government should not be permitted to discriminate in employment. This is for good reason – the taxpayer dollars used to buy goods and services from companies simply should not support discrimination. And the many federal contractors that play by the rules should not have to compete at a disadvantage with those that discriminate. The important work done by the Office of Federal Contracts Compliance Programs (OFCCP) in enforcing these nondiscrimination obligations helps employers tap into a diverse pool of talent that will leave them and the broader economy stronger.

OFCCP administers and enforces the civil rights of all those employed by federal contractors and subcontractors, covering approximately one-fourth of the civilian workforce, and more than 200,000 businesses with contracts totaling almost $700 billion. Its authority includes Executive Order 11246, which prohibits government contractors from discriminating in employment decisions on the basis of race, color, religion, sex, or national origin, and also requires contractors to take affirmative action to ensure that equal opportunity is provided in all aspects of employment. In addition to the Executive Order, OFCCP's jurisdiction extends to enforcement of Section 503 of the Rehabilitation Act, which requires nondiscrimination and affirmative action for qualified individuals with disabilities, and the Vietnam Era Veterans Readjustment Assistance Act (VEVRAA), which requires nondiscrimination and affirmative action for special

and disabled veterans of any war, campaign, or expedition in which a campaign badge has been authorized.

One of the distinguishing features of OFCCP enforcement is its in-depth compliance reviews. OFFCP is not limited to merely responding to complaints – it proactively addresses discrimination by bringing systemic investigations, conducting compliance reviews of selected contractors, and providing guidance to contractors on affirmatively promoting equal opportunity in the workplace and complying with the laws under its jurisdiction. By focusing on large, systemic problems, OFCCP has ensured that workers receive fair treatment in hiring and promotions and that the employment decisions made by contractors reflect our society's nondiscrimination norms.

OFCCP's affirmative action measures require that federal contractors that have the privilege of doing business with the federal government take notice of race and gender in the course of formulating policies designed to foster equal opportunity. Put simply, these measures require that contractors 1) not discriminate, 2) take affirmative steps to ensure a diverse workplace, and 3) document these steps. These provisions essentially require self-analysis, recordkeeping, and reporting.

The steps required to comply with an OFCCP audit are directly related to increasing employment opportunities and ensuring nondiscrimination. By requiring that contractors take appropriate steps to document employment practices, OFCCP is able to affirmatively assess whether there are indicators of discrimination. In turn, through the process of record-keeping, data collection and analysis, an employer can engage in a self-evaluation that may prompt it to correct unfair practices. At the very least, both OFCCP and federal contractors will have the data that they need to track progress in providing equal employment opportunities.

Moreover, few contractors are ever subject to an OFCCP affirmative compliance review. Only about 4,000 compliance reviews are conducted each year. This means that contractors have about a 2 percent chance of being reviewed – an extremely small percentage when contrasted with 700 billion spent in federal contract dollars.

2) <u>Civil rights enforcement is especially important during difficult economic times.</u>

The most recent data on women and families economic stability shows that, although the economy continued its slow recovery in 2012, poverty rates for most groups were statistically indistinguishable from 2011, leaving poverty among women and children at or near historically high levels. Poverty rates for women were once again higher than for men, and were especially high for women of color, women who head families, foreign-born women, and women 65 and older living alone. The gender wage gap was unchanged for the year and the decade, undermining women's ability to support themselves and their families. And income inequality remained stark.

These statistics highlight what's at stake for workers seeking to obtain employment in this lopsided recovery. Although women are typically paid less than men in the same occupation, occupational segregation – the fact that the work women do is undervalued because it is

women's work – also contributes to women's economic insecurity. Fields like construction and manufacturing that are nontraditional for women and minorities typically offer higher pay, higher benefits, and more opportunities for advancement than do traditionally female fields. Indeed, in the construction workforce, earnings can be 30 percent higher than in occupations traditionally held by women,[1] yet women make up only 2.6 percent of construction workers.[2] And women of color hold only a tiny percentage of the jobs in these fields, comprising less than one percent of each workforce. Detecting and eliminating discriminatory barriers to employment – especially in high-wage fields – is therefore essential for women and their families.

Moreover, unequal access to high-paying jobs is compounded by broader pay disparities between male and female workers. Although the wage gap has narrowed since 1964, when women working full-time earned approximately 59 cents for every dollar earned by men,[3] the gap persists and has remained stagnant over the last decade. According to the most recent data available from the U.S. Census Bureau, the typical woman working full-time made only 77 percent of male full-time workers' earnings.[4] The wage gap is even larger for many women of color, who make only 64 cents (African American women) and 54 (Hispanic women) cents on the dollar when compared to white, non-Hispanic men.[5] Moreover, unequal pay harms women and their families even after women leave the jobs that pay them less, as the persistence of the wage gap results in women's loss of retirement income and lower savings.

3) **Civil Rights Enforcement Ensures Better Opportunities for Women and Minorities, Which in Turn Increases the Effectiveness of American Businesses.**

The federal government's historic and current role in addressing discrimination has improved opportunities for a wide range of workers. Into the 1960s, "[w]hole industries and categories of employment were, in effect, all-white, all-male."[6] Studies that assessed the effect of Executive Order 11246 indicate that the makeup of the federal contractor workforce changed significantly in the years following the Executive Order.[7] One study of over 77,000 federal contractors found that female employment by federal contractors increased by 15.2 percent between 1974 and 1980, while it rose by only 2.2 percent in non-federal contract settings.[8] Another study of 86,000 federal contractors found that both minority and female employment increased significantly faster in contractor than in noncontractor establishments in those same six years: 12 percent faster for black females, 4 percent faster for black males, and 8 percent faster for other minority males.[9]

Throughout the years, OFCCP has implemented a number of initiatives that have aided in the integration of the workforce in industries such as construction, higher education, and mining, ensuring equal opportunity for women in sectors with a long history of unfair treatment in hiring, promotions, and compensation. For example, in 1975, pursuant to a legal settlement reached with the National Women's Law Center, OFCCP targeted hiring and employment practices for women in colleges and universities around the country, improving opportunities for women in higher education.[10]

Measures like these have strengthened American businesses considerably and made them more effective. A body of social science research has shown that diverse workforces perform better than more homogenous workforces on a variety of measures, such as enhanced innovation, team

productivity, and quality decisionmaking.[11] Teams that bring together employees with a diverse range of perspectives and expertise improve business productivity on a range of measures. These teams are "more innovative, can develop clearer strategies, can respond more aggressively to competitive threats, and can be quicker to implement certain types of organizational change than functionally homogeneous teams."[12] As the racial and ethnic makeup of the United States changes rapidly and American businesses extend into ever-diversifying global markets, major American corporations have expressed broad consensus about the importance of a workforce exposed to a diverse environment.[13]

* * *

The key role that OFCCP has played in improving economic security for workers and their families cannot be overstated. It is the key agency in ensuring that federal dollars are not wasted on discrimination and that companies that have the great privilege of doing business with the federal government do not discriminate and take steps to achieve a diverse workforce. This process in turn has expanded opportunities for workers over time, has made federal contracting more efficient, and has strengthened businesses.

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[1] NWLC calculations from Bureau of Labor Statistics, Current Population Survey, 2011 Annual Averages, Table 39. Median weekly earnings of full-time wage and salary workers by detailed occupation and sex, available at http://www.bls.gov/cps/cpsaat39.pdf.

[2] Bureau of Labor Statistics, Current Population Survey, 2013 Annual Averages, Table 11. Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity, available at http://www.bls.gov/cps/cpsaat11.pdf

[3] NWLC calculations from U.S. Census Bureau, Census Bureau CPS Data (ASEC), Historical Tbl. P-38: Full-Time, Year-Round Workers by Median Earnings and Sex in 1964, available at http://www.census.gov/hhes/www/income/data/historical/people/index.html (last visited Oct. 4. 2011).

[4] National Women's Law Center (NWLC) calculations from U.S. Census Bureau, Current Population Survey, 2013 Annual Social and Economic Supplement, Table PINC-05: Work Experience in 2012 – People 15 Years Old and Over by Total Money Earnings in 2012, Age, Race, Hispanic Origin, and Sex, *available at* http://www.census.gov/hhes/www/cpstables/032013/perinc/pinc05_000.htm (last visited Oct. 18, 2013).

[5] *Id.*

[6] George Stephanopoulos & Christopher Edley, Jr., Affirmative Action Review (1995), *available at* http://clinton4.nara.gov/WH/EOP/OP/html/aa/aa-lett.html; *see generally* Desmond King, Separate and Unequal: Black Americans and the U.S. Federal Government (1995).

[7] *See* Jonathan S. Leonard, *The Impact of Affirmative Action on Employment*, 2 J. of Labor Econ. 439 (1984) [hereinafter Leonard]; Sacha E. de Lange, *Toward Gender Equality: Affirmative Action, Comparable Worth, and the Women's Movement*, 31 N.Y.U. Rev. L. & Soc. Change 315, 328 (2007) (citing Citizens' Commission on Civil Rights, Affirmative Action to Open the Doors of Job Opportunity: A Policy of Fairness and Compassion That Has Worked 123-24 (1984)) [hereinafter Citizen's Commission].

[8] *See generally,* Leonard.

[9] *See generally,* Citizen's Commission.

[10] *WEAL v. Weinberger*, Civ. No. 74-1720 (D.D.C., filed Nov. 26, 1974), subsequently WEAL v. Califano.

[11] *See, e.g. Cedric Herring, Does Diversity Pay?: Race, Gender, and the Business Case for Diversity,* 74 Am. Sociological Rev. 208, 219 (2009).
[12] J. Stuart Bunderson & Kathleen M. Sutcliffe, *Comparing Alternative Conceptualizations of Functional Diversity in Management Teams: Process and Performance Effects*, 45 Acad. Mgmt. J. 875, 875 (2002).
[13] *Grutter v. Bollinger*, 539 U.S. 306, 330 (2003) ("These benefits are not theoretical but real, as major American businesses have made clear that the skills needed in today's increasingly global marketplace can only be developed through exposure to widely diverse people, cultures, ideas, and viewpoints.").

Chairman WALBERG. Thank you.

Now, Mr. Goldstein, we recognize you for your testimony.

STATEMENT OF MR. DAVID GOLDSTEIN, SHAREHOLDER, LITTLER MENDELSON P.C., MINNEAPOLIS, MN

Mr. GOLDSTEIN. Thank you, Chairman Walberg, Ranking Member Courtney, distinguished members of the Committee. Thank you for this opportunity to testify. I have a deep personal sense of the importance and the history of this Congress. And, accordingly, it is a great honor to be here today.

I am a shareholder in the Minneapolis office of Littler Mendelson. I am speaking to you today on my own behalf and not on behalf of my firm. I have represented government contractors in connection with OFCCP compliance for over 25 years. Like most of my clients, I believe in the importance of equal employment opportunity and in the importance of diversity in our workplaces. I believe it is essential to the success of our businesses. Accordingly and, again, like most of my clients, I support the basic mission of the OFCCP.

In recent years, there has been a significant controversy regarding OFCCP's efforts to assert jurisdiction over health care providers. One of the arguments that the OFCCP has asserted in support of jurisdiction over health care providers has been providers' participation in TRICARE, the program designed to provide health care benefits to members of the military and their families. Whether it is good policy to impose additional regulations on health care providers at this time is a question on which reasonable people can disagree. Indeed, it appears that there are differences of opinion regarding this issue between executive agencies within the current administration.

The Department of Defense and the Office of Personnel Management have expressed a belief in the importance of being able to contract with providers to offer health care services for the military and federal employees without having to subject these providers to OFCCP's regulations. These agencies believe, correctly I think, that imposing such requirements limits the number of providers that are willing to offer such services. The OFCCP, on the other hand, believes that it needs to regulate such providers, arguing that it can do so without imposing unreasonable burdens.

Other individuals are testifying today regarding the merits of this debate. I am here, though, because I understood this issue to have been resolved, at least with regard to TRICARE, when Congress passed the *National Defense Authorization Act* for fiscal year 2012. That measure included language that was widely and reasonably understood as putting an end to this debate by providing that the OFCCP could not exercise jurisdiction based on providers' participation in TRICARE. This was a very important outcome because it appeared to provide health care providers with certainty, and allowed them to decide what to do.

I can tell you that during this period of uncertainty regarding OFCCP jurisdiction my colleagues and I spent a great deal of time discussing with health care clients the costs and burdens that come with OFCCP compliance. We see, we actually see, health care providers making decisions not to participate in TRICARE and in

other programs and arrangements because the costs of compliance are simply greater than the benefits of participation. And we are talking not only about financial costs of compliance, but also how OFCCP regulations impact the ways in which providers deliver services to their patients.

For now, OFCCP is continuing in its efforts to establish jurisdiction over TRICARE participants through litigation against a particular health care provider, Florida Hospital of Orlando, which has disputed OFCCP's assertion of jurisdiction based on TRICARE. To outside observers, the OFCCP's continued pursuit of TRICARE jurisdiction, even after Congress has acted, is shocking. The Florida hospital case is still working its way through administrative proceedings. We are likely years away from a final judicial decision. In the meantime, providers remain uncertain as to their obligations should they agree to participate in TRICARE.

The interests of health care providers, their patients, including members of the military, federal employees and their families, as well as taxpayers would be best served by a final resolution—a final resolution—of the TRICARE issue. I believe that this final resolution came from Congress in December 2011. Ideally, the Department of Labor would accept this and stop fighting against the fact that Congress has already spoken. Absent that, the best option would be passage of the *Protecting Health Care Providers from Increased Administrative Burdens Act.*

The third best option would be to let the courts finally resolve this issue by letting Florida Hospital go through to a resolution. By contrast, the proposal offered by the Department of Labor in its letter of March 11, 2014 represents neither a compromise nor a positive step. To the extent that the department's proposal would not end the Florida Hospital litigation and does not represent commitment by the OFCCP to relinquish its claims of jurisdiction over TRICARE participants in non-audit contexts such as complaint procedures, nothing is being resolved. On the other hand, the extent that the department's proposal would end the Florida Hospital litigation and, therefore, prevent a final resolution of the issue in the courts, I am personally concerned.

It has taken more than five years for the Florida Hospital case to get to the point where it is now. A final determination may still be years away, but at least it is on the horizon. The Department of Labor's proposal, on the other hand, means at least five more years of uncertainty. And those are five more years during which health care providers are going to remain on the sidelines and not participate in programs that may subject them to OFCCP's jurisdiction. And finally, accepting this proposal would reinforce a very disturbing trend that contractors have seen at the OFCCP in the context of compliance reviews, and that is an indifference by the agency to the letter of the law when, in its judgment, the letter of the law is inconsistent with the agency's goals.

Thank you, and I look forward to answering any questions you may have.

[The statement of Mr. Goldstein follows:]

Testimony of

David J. Goldstein, Esq.

before the

United States House of Representatives
Committee on Education and the Workforce
Subcommittee on Workforce Protections

March 13, 2014

Chairman Walberg and Ranking Member Courtney, thank you for the opportunity to offer testimony to the members of this Committee. I have a deep personal sense of the history and importance of Congress. Accordingly, it is a great honor to appear before this Committee today.

I am a shareholder in the Minneapolis office of Littler Mendelson. I am speaking to you today on my own behalf and not on behalf of my firm I have represented government contractors in connection with OFCCP compliance for over 25 years. Like most of my clients, I believe in the importance of equal employment opportunity. Also, like most of my clients, I believe that diversity in the workplace is essential to the success of our businesses. Accordingly, like most of my clients, I support the basic mission of the OFCCP.

In recent years, there has been significant controversy regarding OFCCP's efforts to assert jurisdiction over healthcare providers. One of the arguments that the OFCCP has asserted in support of jurisdiction over healthcare providers has been providers' participation in TRICARE – the program designed to provide healthcare benefits to members of the military and their families.

Healthcare providers are already highly regulated. The cost of healthcare is a significant issue facing this country. Under these circumstances, whether it is good policy to impose additional regulations on healthcare providers is a question on which reasonable people can disagree. Indeed, it appears there are differences of opinion regarding this issue between executive agencies within the current administration. The Department of Defense and the Office of Personnel Management have expressed a belief in the importance of being able to contract with providers to offer healthcare services for the military and federal employees without having to subject those providers to the OFCCP's regulations. These agencies believe – and I believe they are correct in this regard – that imposing such requirements limits the number of providers that are willing to offer such services.

The OFCCP, on the other hand, believes that it needs to regulate such providers and that it can do so without imposing an unreasonable burden.

Other individuals are testifying today regarding the merits of this debate. I am here because I understood this issue to have been resolved, at least with regard to TRICARE when Congress passed the National Defense Authorization Act for Fiscal Year 2012. This measure included language that was very widely and reasonably understood as putting an end to this debate and providing that the OFCCP could not exercise jurisdiction based on providers participation in TRICARE.

This was a very important outcome because it appeared to provide healthcare providers with certainty and allowed them to decide what to do. I can tell you that during this period of uncertainty regarding OFCCP jurisdiction, my colleagues and I

spend a great deal of time discussing with healthcare clients the costs and burdens that come with OFCCP compliance. We see many healthcare providers making decisions not to participate in certain programs and arrangements because the costs of compliance are simply greater than the benefits of participation. And we are talking not only about the financial costs of compliance, but also how OFCCP regulation impacts the ways in which providers deliver services to their patients.

To outside observers, it was very surprising when the OFCCP continued to pursue TRICARE jurisdiction even after Congress had acted. The OFCCP did this by continuing litigation against a particular healthcare provider, the Florida Hospital of Orlando, which had been disputing OFCCP's assertion of jurisdiction based on TRICARE. The OFCCP continued to pursue this litigation through proceedings before the Department of Labor's Administrative Review Board (ARB) and practitioners were not surprised when the ARB found in favor of the hospital and held that the OFCCP could not assert jurisdiction based on TRICARE in light of the Congressional action.

After that decision, I think it is fair to say that most practitioners in this area were astounded when the OFCCP indicated that it would not accept defeat on this issue and would continue to pursue the matter. As far as I know, the ARB's decision to accept re-hearing of the Florida Hospital case and its subsequent reversal of its original decision are unprecedented. Its decision in this regard, has been widely criticized. The Florida Hospital case is still working its way through administrative proceedings. As already mentioned, obtaining a final decision with regard to this issue is very, very important to providers. Providers need to know what their obligations will be before they decide to

enter into relationships that may subject them to OFCCP jurisdiction. Unfortunately, it appears that a final judicial resolution of this issue may still take several years.

The interests of healthcare providers and their patients, including members of the military, military families, and federal employees – as well as taxpayers – would be best served by a final resolution of the TRICARE issue. I believed that this final resolution came from Congress in December 2011. The ideal resolution would be for the Department of Labor to accept the role of the Congress and stop fighting against the fact that Congress has already spoken. The second best option is for the courts to finally resolve the issue. The proposal offered by the Department of Labor in its letter of March 11, 2014 presents neither a compromise nor a positive step.

To the extent that the Department of Labor's proposal would not end the Florida Hospital litigation and does not represent a commitment by the OFCCP to relinquish its claims of jurisdiction over TRICARE participants in non-audit contexts, such as complaint investigations, nothing is really being resolved.

On the other hand, to the extent that the Department of Labor's proposal would end the Florida Hospital litigation and, therefore, prevent the final resolution of this issue in the courts, I am personally concerned. It has taken more than five years for the Florida Hospital case to get to the point where it is now (the Administrative Complaint was filed on December 18, 2008). A final determination may still be years away. The Department of Labor's proposal means that there will be at least five more years of uncertainty and probably more. It means that many healthcare providers will decline to participate in programs or opportunities that may subject them to OFCCP

jurisdiction. And finally, accepting this proposal would reinforce a very disturbing trend that contractors have seen at the OFCCP in the context of compliance reviews. And that is an indifference by the agency to the letter of the law when, in its judgment, the letter of the law is inconsistent with the agency's goals.

Sitting here, as I already mentioned, with a sense of reverence for this institution, I am very, very disturbed to see an executive agency continuing to pursue a policy that has been explicitly addressed and rejected by the Congress.

Thank you and I look forward to answering any questions you may have.

Chairman WALBERG. Thank you. I thank each of the panelists for your testimony. Without objection, I would submit two letters from the American Hospital Association and the American Health Care Association for the record. Both of these organizations express their support for H.R. 3633.

[The information follows:]

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December 6, 2013

The Honorable Tim Walberg
Chairman
Committee on Education and the Workforce Subcommittee on Workforce Protections
United States House of Representatives
2181 Rayburn House Office Building
Washington, DC 20510

Dear Chairman Walberg:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health care systems and other health care organizations, and our 43,000 individual members, I am writing to express our support for your legislation, the *Protecting Health Care Providers from Increased Administrative Burdens Act* (H.R. 3633). This bill will help ensure the continuing availability of a robust network of hospital care for TRICARE and Federal Employees Health Benefit Program (FEHBP) participants by clarifying the Office of Federal Contract Compliance's (OFCCP) role and its oversight and enforcement activities over hospitals that provide services to military families, federal employees and other recipients of care under federal health reimbursement programs.

For many years, the OFCCP's policy has been that hospitals providing health care services to participants in federally funded health benefit programs, including TRICARE, FEHBP and Medicare, are not considered federal contractors. TRICARE is the health care program for military service members and their families; the FEHBP is the health care program for civilian employees and their families. Medicare is the health care program for individuals 65 years or older. The OFCCP's previous position was consistent with the position taken by the agencies specifically charged with administering these programs. Its current position is unprecedented and, if accepted, would convert a majority of our nation's hospitals into "federal contractors" overnight, without advance notice to or agreement by those hospitals.

Recently, however, the OFCCP has undertaken an aggressive attempt to expand the agency's jurisdiction over hospitals by asserting that hospitals' participation in managed care networks offered through TRICARE, FEHBP and even Medicare Parts C and D effectively makes them "federal subcontractors" and, thus, subject to OFCCP's burdensome regulatory scheme. OFCCP has continued to pursue this policy despite Congress' previous passage of language in the *National Defense Authorization Act for Fiscal Year 2012* (NDAA) [P.L. 112-81] that specifically exempted TRICARE network providers from federal contractor status. These continued actions by OFCCP make passage of this bill critically important for the nation's hospitals.

Hospitals are subject to myriad anti-discrimination laws and regulations, including anti-discrimination regulations that are appropriately enforced by many federal, state and local agencies. Subjecting hospitals to additional paperwork burdens and the costs associated with OFCCP regulations makes little sense at a time when hospitals are being asked to do more with less reimbursement. It effectively would divert financial resources from patient care in order to satisfy the OFCCP's administrative requirements, forcing hospitals to make difficult choices about their ongoing participation in various federal health care reimbursement programs that OFCCP argues is the basis for the agency's oversight and enforcement.

The OFCCP's attempt to expand its jurisdiction and its real lack of clear guidance for providers has forced hospitals to engage in ongoing lengthy and costly litigation to remove the uncertainty surrounding scope of OFCCP's jurisdiction.

H.R. 3633 will provide clear direction for OFCCP policy and ensure that the burdens of complying with OFCCP's unnecessary and costly regulatory scheme does not come at the cost of reducing hospitals' robust participation in networks of care for TRICARE, FEHBP and Medicare patients and threaten access for our nation's military families, federal employees and other federal health care program beneficiaries.

Thank you for introducing this legislation. The AHA looks forward to working with you to ensure its enactment.

Sincerely,

Rick Pollack
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February 3, 2014

The Honorable Tim Walberg
Chairman
Committee on Education and the Workforce Subcommittee on Workforce Protections
United States House of Representatives
2181 Rayburn House Office Building
Washington, DC 20510

Dear Chairman Walberg:

On behalf of the members of the American Health Care Association and National Center for Assisted Living (AHCA/NCAL) that provide essential care to approximately one million individuals in more than 12,000 not for profit and for profit member facilities, I am writing to express our support for your legislation, the Protecting Health Care Providers from Increased Administrative Burdens Act (H.R. 3633). This crucial legislation clarifies that certain recipients of payments from the Federal Government related to the delivery of health care services to individuals shall not be treated as Federal contractors by the Office of Federal Contract Compliance Programs (OFCCP) based on the work performed or actions taken by such individuals that resulted in the receipt of such payments.

AHCA/NCAL, its affiliates, and member providers advocate for the continuing vitality of the long term care provider community. We are committed to developing and advocating for public policies which balance economic and regulatory principles to support quality care and quality of life. We cannot support actions that harm the services provided to the poor and most vulnerable citizens in our communities. Therefore, we are in opposition to the OFCCP's recent aggressive attempts to expand the agency's jurisdiction over nursing centers and other key health care providers by asserting that these providers' participation in managed care networks offered through TRICARE, the Federal Employee Health Benefits Program and Medicare Parts C and D effectively makes them "federal subcontractors" and, thus, subject to OFCCP's often crushing regulatory burden.

In particular, as H.R. 3633 moves forward in Congress, we want to ensure that it is clearly defined that managed care networks are safe from OFCCP's jurisdiction.

The American Health Care Association and National Center for Assisted Living (AHCA/NCAL) represent more than 12,000 non-profit and proprietary skilled nursing centers, assisted living communities, sub-acute centers and homes for individuals with intellectual and development disabilities. By delivering solutions for quality care, AHCA/NCAL aims to improve the lives of the millions of frail, elderly and individuals with disabilities who receive long term or post-acute care in our member facilities each day.

It is evident that H.R. 3633 will provide much needed direction for OFCCP policy to ensure that the financial and administrative burdens of complying with the agency's regulatory scheme do not threaten access to quality patient care.

Thank you for the opportunity to weigh in on this important matter. AHCA/NCAL looks forward to working with you and the cosponsors of H.R. 3633 on advancing this legislation.

Sincerely,

Mark Parkinson
AHCA/NCAL President & CEO

Chairman WALBERG. Hearing none, they will be part of the record.

Mr. Kirschner, as we have discussed, the Secretary of Labor has proposed limiting OFCCP's enforcement activities for five years by instructing OFCCP to not initiate compliance audits for TRICARE providers, though the letter calls them subcontractors, and closing any open or scheduled compliance audits. OFCCP will also provide information, materials and technical assistance training to TRICARE providers during this five year period. At the end of the five year delay, OFCCP will begin conducting compliance audits at TRICARE hospitals and health care providers.

OFCCP will also continue taking the position in litigation that TRICARE providers are subcontractors. On the basis of that, in your opinion, does this proposal address the problems you have described and negate the need for the *Protecting Health Care Providers from Increased Administrative Burdens Act?*

Mr. KIRSCHNER. Not at all. While we appreciate Secretary Perez's efforts to try to address the situation, we believe that what the Secretary has outlined in his letter does not really address in any substantive way the concerns that the AHA has brought forward. First of all, the letter does not at all address the FEHBP or Medicare Part C and D. So those very significant programs would be left unaddressed. For example, the FEHBP has more than 8 million participants in it seeking care at hospitals all across the country. That would be unaddressed by this issue.

Even with respect to TRICARE, section 715 of the NDAA, we believed, answered this question already by saying that there isn't contractor status for providers under TRICARE. Secretary Perez's letter assumes that they are contractors, and essentially just kicks the can down the road for enforcement. What America's hospitals need is greater clarity about whether they are or are not contractors. And in our view, under the regulations, under the statutes that are applicable, participants in TRICARE should not be considered to be federal contractors any more than participants in FEHBP or Medicare.

Chairman WALBERG. Thank you.

Mr. Carrato, referencing the letter from the Secretary of Labor again, do you believe a five year moratorium will provide TRICARE providers needed relief and certainty? And secondly, how do you foresee the impact of this delay, And maybe more importantly, in enforcement affecting the decisions of TRICARE providers to remain in your network?

Mr. CARRATO. I concur with the comments from Mr. Kirschner. It doesn't solve the problem. It kicks the can down the road. I think the fundamental issue is one of the points made by Mr. Kirschner, and that is the classification of TRICARE providers. When you get into the area of classifying them as subcontractors, that brings on a host of additional burden. And the uncertainty that the five year moratorium would bring, it does leave providers on the sideline. And we are actually starting to see this present itself more as we are building the network to support the VA's new Patient-Centered Community Care program, where we are required to build networks of providers.

And more and more of our hospital providers are delaying decisions or just flatly telling us no. And this is one of the reasons they cite.

Chairman WALBERG. Thank you.

Mr. Goldstein, again going on that train of thought, for the record, will this delay of compliance audits specifically, while training hospitals in what they need to do for the future, will it alleviate the uncertainty hospitals? And secondly, will hospitals still have to make the tough decisions whether to sign up to care for TRICARE and federal employee health benefits patients and, ultimately, likely face OFCCP regulation?

Mr. GOLDSTEIN. It does not help the problem, Mr. Chairman. There are hospitals that are sitting on the sidelines now, unwilling to participate in TRICARE pending a resolution of the Florida Hospital of Orlando litigation. The proposal from the Secretary of Labor merely says there is no resolution for at least five years down the road, and also makes it clear that OFCCP is continuing to take the position that the military authorization Act did not take away its jurisdiction. So it means at least five, and maybe 10, years more of uncertainty during which providers are not willing to provide services to our servicemen and women and their families.

Chairman WALBERG. Thank you.

I now recognize, for five minutes of questioning, my ranking member and friend, Mr. Courtney.

Mr. COURTNEY. Great. Thank you, Mr. Walberg.

Mr. Goldstein, can you tell me who is gonna be taking the oath of office for President in January of 2017?

Mr. GOLDSTEIN. I cannot.

Mr. COURTNEY. And let me ask you this. Will it be Barack Obama?

Mr. GOLDSTEIN. Not without a constitutional amendment.

Mr. COURTNEY. Right. And the likelihood of that happening is zero between now and then.

Mr. GOLDSTEIN. I would agree on that.

Mr. COURTNEY. That is a really pretty safe assumption? Okay.

And the proposal from the Secretary of Labor, Ms. Graves, was for a five year moratorium. Is that correct?

Ms. GRAVES. That is right.

Mr. COURTNEY. And if we do the math, okay, we are talking about 2019 is when this issue could be revisited in terms of any type of enforcement on it. Isn't that your understanding?

Ms. GRAVES. That is correct.

Mr. COURTNEY. And there will be a new President. And since the Secretary of Labor serves at the will of the President there will actually be a new Secretary of Labor in place at that point. Isn't that correct?

Ms. GRAVES. That is right.

Mr. COURTNEY. Okay. You know, I don't know, maybe it is my Irish-Catholic upbringing but, you know, our fatalism says that there is no such thing as perfect certainty in life. But a five year moratorium in terms of audit, given the fact that pushes this well beyond the end date of this administration, would seem to suggest that this issue really is being, I think, pretty dramatically dealt

with by the Secretary in terms of any of the issues that people are concerned about. Isn't that correct, Ms. Graves?

Ms. GRAVES. Yes, I think so. And I think it provides the Department of Labor an opportunity to provide training and outreach and additional clarity for contractors.

Mr. COURTNEY. Thank you. Now, you know, you talked about some of the new initiatives by OFCCP in terms of trying to protect classes of the population that frankly have struggled in terms of employment opportunities. And one of the groups that you mentioned was veterans. Can you talk about that in terms of OFCCP's advocacy for veterans over the years, disabled veterans and certainly now, recently, all veterans?

Ms. GRAVES. Well, really importantly, last year OFCCP put out new regulations around the administration of the statute that requires nondiscrimination and that contractors take affirmative steps with regard to protected veterans. So that requires contractors to establish hiring benchmarks, and conduct overreach and recruitment. And they have been engaged, not only just in putting out those regs, but taking the additional steps of providing training and outreach to make sure that people really understand them.

Mr. COURTNEY. And again, that didn't happen out of context. I mean, it was because there actually is a real problem out there in terms of the nagging higher unemployment for veterans versus the rest of the population. And the OFCCP, I think, is responding to that in terms of using the contracting, you know, precedence as a way of trying to bring that unemployment rate down. I mean, isn't that the whole history that led up to the new rules?

Ms. GRAVES. Absolutely. It is absolutely connected to the extraordinary high rates of veteran—high unemployment rates of veterans.

Mr. COURTNEY. And so, you know, when we talk about this agency—which, you know, we have heard today that somehow it is sort of, you know, looking for a power grab or jurisdiction—I mean, in terms of its history as far as veterans are concerned, in fact it is really the opposite. I mean, they have actually been out there trying to, again, create opportunities for veterans, again, consistent with their history of advocating for diversity in the workforce. Isn't that correct?

Ms. GRAVES. Right. And I think it is important to think about what jurisdiction means. What it means is that the contractor then has an obligation to really think about these protected categories of workers, and conduct outreach and recruitment. So this is absolutely tied to the employment opportunities for veterans and, you know, on the basis of race and sex and disability, as well.

Mr. COURTNEY. Great. Thank you.

So my time is almost up, Mr. Chairman. I want to enter into the record the GAO report which came out last April which, again, was on the question of TRICARE challenges in terms of—I will get it here somewhere, but—okay, the multiyear surveys indicate problems with access to care for non-enrolled beneficiaries. And I would actually like to point to, again, the section which talks about provider acceptance of TRICARE. And this goes back well before this administration. Forty-one percent, only 41 percent, of mental

health providers in this report have expressed a willingness to take TRICARE.

And it has absolutely nothing to do with OFCCP. There is a chronic issue of reimbursement and complexity in terms of interacting with—and, again, I have worked with Health Net and they have done good work with my caseworkers out there. But, you know, there are much bigger problems out there in terms of what I am hearing from providers than the fact that, again, there is a Florida case which will be withdrawn. Which, you know, in 25 years in practice I always thought a withdrawn case by the other side was actually a good thing. But I guess, you know, some people view it differently. But anyway, I have asked that be admitted to the record.

[The information follows:]

United States Government Accountability Office

GAO

Report to Congressional Committees

April 2013

DEFENSE HEALTH CARE

TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries

GAO-13-364

GAO
Accountability * Integrity * Reliability
Highlights

Highlights of GAO-13-364, a report to congressional committees

April 2013

DEFENSE HEALTH CARE

TRICARE Multiyear Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries

Why GAO Did This Study

DOD provides health and mental health care through its TRICARE program. TRICARE offers three basic options. Beneficiaries who choose TRICARE Prime, an option that uses civilian provider networks, must enroll. Beneficiaries who do not enroll in this option may obtain care from nonnetwork providers under TRICARE Standard or from network providers under TRICARE Extra. In addition, qualified National Guard and Reserve servicemembers may purchase TRICARE Reserve Select, a plan whose care options are similar to those of TRICARE Standard and TRICARE Extra. GAO refers to servicemembers who use TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select as nonenrolled beneficiaries.

The National Defense Authorization Act for Fiscal Year 2008 directed DOD to conduct annual surveys over fiscal years 2008 through 2011 of both beneficiaries and civilian providers to determine the adequacy of access to health and mental health care providers for nonenrolled beneficiaries. It also directed GAO to review these surveys. This report addresses (1) what the results of the 4-year beneficiary surveys indicate about the adequacy of access to care for nonenrolled beneficiaries; (2) what the results of the 4-year civilian provider surveys indicate about civilian providers' awareness and acceptance of TRICARE, and (3) what the collective results of the surveys indicate about access to care by geographic area. To do so, GAO interviewed DOD officials, obtained relevant documentation, and analyzed the data for both surveys over the 4-year period.

View GAO-13-364. For more information, contact Debra A. Draper at (202) 512-7114 or draperd@gao.gov.

What GAO Found

In its analysis of the 2008-2011 beneficiary survey data, GAO found that nearly one in three nonenrolled beneficiaries experienced problems finding a civilian provider who would accept TRICARE and that nonenrolled beneficiaries' access to civilian primary care and specialty care providers differed by type of location. Specifically, a higher percentage of nonenrolled beneficiaries in Prime Service Areas (PSA), which are areas with civilian provider networks, experienced problems finding a civilian primary care or specialty care provider compared to those in non–Prime Service Areas (non-PSA), which do not have civilian provider networks. GAO found that the top reasons reported by nonenrolled beneficiaries for why they experienced access problems—regardless of type of provider—were that the providers were either not accepting TRICARE payments or new TRICARE patients. Additionally, GAO's comparison of the Department of Defense's (DOD) beneficiary survey data to related data from a Department of Health and Human Services survey showed that nonenrolled beneficiaries' satisfaction ratings for primary and specialty care providers were consistently lower than those of Medicare fee-for-service beneficiaries.

GAO's analysis of the 2008-2011 civilian provider survey data found that about 6 in 10 civilian providers were accepting new TRICARE patients and the most-cited reason for not accepting new TRICARE patients was that the civilian providers were not aware of the TRICARE program. Civilian physicians' acceptance of TRICARE has also decreased over time. Specifically, when compared to DOD's 2005-2007 civilian physician survey results, civilian physicians' acceptance of new TRICARE patients has decreased. This was also true whether they were accepting any new patients or new Medicare patients. Civilian providers' awareness and acceptance of TRICARE also differed by provider type, as fewer civilian mental health care providers were aware of TRICARE or accepting new TRICARE patients than other types of providers. For example, only an estimated 39 percent of civilian mental health care providers were accepting new TRICARE patients, compared to an estimated 67 percent of civilian primary care providers and an estimated 77 percent of civilian specialty care providers. The analysis also showed that civilian providers' awareness and acceptance of TRICARE differ by location type, as civilian providers in PSAs were less aware of TRICARE and less likely to accept new TRICARE patients than those in non-PSAs.

GAO's analysis of the collective results of the beneficiary and civilian provider survey results indicates specific geographic areas, including areas in Texas and California, where nonenrolled beneficiaries have experienced considerable access problems. In each of these areas, although almost all civilian providers were accepting new patients, less than half were accepting new TRICARE patients. In most of these areas, civilian providers most often cited reimbursement concerns as the reasons why they were not accepting any new TRICARE patients.

In commenting on a draft of this report, DOD concurred with GAO's overall findings.

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Abbreviations

BRAC	Base Realignment and Closure
CAHPS	Consumer Assessment of Healthcare Providers and Systems
DEERS	Defense Enrollment Eligibility Reporting System
DOD	Department of Defense
HHS	Department of Health and Human Services
HSA	Hospital Service Area
NDAA	National Defense Authorization Act
NDAA 2008	National Defense Authorization Act for Fiscal Year 2008
non-PSA	non–Prime Service Area
OMB	Office of Management and Budget
PSA	Prime Service Area
TMA	TRICARE Management Activity
TRS	TRICARE Reserve Select

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United States Government Accountability Office
Washington, DC 20548

April 2, 2013

The Honorable Carl Levin
Chairman
The Honorable James Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Howard "Buck" McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

In fiscal year 2012, the Department of Defense (DOD) offered health care services, including mental health care services, to about 9.7 million eligible beneficiaries in the United States and abroad through TRICARE, DOD's regionally structured health care program.[1] Under TRICARE, beneficiaries may obtain care either from military hospitals and clinics, referred to as military treatment facilities, or from civilian providers.[2]

DOD's TRICARE Management Activity (TMA), which oversees the program, uses managed care support contractors[3] to develop networks of civilian providers—referred to as network providers—to serve all TRICARE beneficiaries in geographic areas called Prime Service Areas

[1]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. Active duty personnel include Reserve component members on active duty for at least 30 days.

[2]Through individual agreements between military treatment facilities and the Department of Veterans Affairs' medical centers, eligible beneficiaries may also receive certain types of care from Department of Veterans Affairs' medical centers in some locations.

[3]TMA uses managed care support contractors in each of the three TRICARE regions (North, South, and West) to develop networks of civilian providers and to perform other customer-service functions, such as processing claims and assisting beneficiaries with finding providers.

(PSA).[4] The contractors use estimates of the number of TRICARE users, among other factors, to develop provider networks and ensure adequate access to care for beneficiaries. 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).

The number and type of civilian providers available to serve TRICARE beneficiaries can vary depending on a beneficiary's location and choice of coverage among TRICARE's three basic plans—TRICARE Prime, TRICARE Standard, and TRICARE Extra.[5] Beneficiaries who use TRICARE Prime, a managed care option, must enroll and can obtain care through military treatment facilities or TRICARE's civilian provider network. Beneficiaries do not need to enroll to receive care under TRICARE Standard, a fee-for-service option, or TRICARE Extra, a preferred provider organization option; they can choose to receive care through TRICARE Standard when they are seeing nonnetwork civilian providers and through TRICARE Extra when they are seeing network civilian providers.[6] We use the term "nonenrolled beneficiaries" for beneficiaries who are not enrolled in TRICARE Prime and who use the TRICARE Standard or Extra options, or TRICARE Reserve Select (TRS).[7]

[4]These geographic areas are determined by the Assistant Secretary of Defense for Health Affairs and are defined by a set of five-digit zip codes, usually within an approximate 40-mile radius of a military treatment facility. In addition to developing networks of civilian providers in PSAs, the managed care support contracts also require the contractor to develop civilian provider networks at all Base Realignment and Closure (BRAC) sites, which are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

[5]TRICARE offers several other plans, including TRICARE Reserve Select (TRS) for certain National Guard and Reserve servicemembers, and TRICARE Young Adult (Prime and Standard options) for servicemembers' dependents up to age 26. 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.

[6]All beneficiaries may obtain care at military treatment facilities, although priority is given to active duty personnel and then to beneficiaries enrolled in TRICARE Prime.

[7]We include TRS beneficiaries in our definition of nonenrolled beneficiaries because, although they must enroll in the plan, they can receive care from network or nonnetwork providers similarly to TRICARE Standard and Extra beneficiaries. We did not include TRICARE Young Adult-Standard Option beneficiaries in our analysis because this plan did not become available until May 2011.

Since TRICARE's inception in 1995, nonenrolled beneficiaries in some locations have complained about difficulties finding civilian providers who will accept them as patients. In response to these concerns, the National Defense Authorization Act (NDAA) for Fiscal Year 2004 directed DOD to monitor access to care for nonenrolled TRICARE beneficiaries through a survey of civilian providers.[8] The act also directed GAO to review the processes, procedures, and analyses used by DOD to determine the adequacy of the number of network and nonnetwork civilian providers and the actions DOD has taken to ensure access to care for beneficiaries who were not enrolled in TRICARE Prime. In December 2006, we reported that TMA and contractor officials used various methods to evaluate access to care, including the survey of civilian providers, and according to those officials, their methods indicated that access was generally sufficient for nonenrolled beneficiaries.[9]

Nonetheless, concerns about the ability of TRICARE beneficiaries, particularly nonenrolled beneficiaries, to access health care and mental health care continued. In light of these continued concerns about access to civilian providers, the NDAA for Fiscal Year 2008 (NDAA 2008) directed DOD to conduct annual surveys over 4 years of both beneficiaries and civilian providers to determine the adequacy of access to health care and mental health care providers for nonenrolled beneficiaries.[10] It also directed GAO to review these surveys along with other factors such as DOD's outreach, marketing, and education efforts, and provider reimbursement issues. We have issued several reports that address the topics covered in this mandate, including a March 2010 report on the methodology and results of the first year of DOD's 4-year beneficiary and provider surveys.[11] In our initial review of the surveys, we

[8]See Pub. L. No. 108-136, § 723, 117 Stat. 1392, 1532-34 (2003), and S. Rep. No. 108-46, at 330 (2003).

[9]GAO, *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option*, GAO-07-48 (Washington, D.C.: Dec. 22, 2006).

[10]See Pub. L. No. 110-181, § 711(a), 122 Stat. 3, 190-91, and S. Rep. No. 110-77, at 359-60 (2007).

[11]We have previously issued three reports that address the issues covered in this mandate. See GAO, *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); *Defense Health Care: Access to Civilian Providers under TRICARE Standard and Extra*, GAO-11-500 (Washington, D.C.: June 2, 2011); 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).

reported that a higher percentage of nonenrolled beneficiaries in the surveyed PSAs experienced problems accessing care from civilian primary care providers than those in the surveyed non-PSAs. However, we could not reach any generalizable conclusions about the civilian provider survey because it had not generated sufficient survey responses during the first year. The NDAA for Fiscal Year 2012 extended DOD's annual beneficiary and provider surveys for another 4 years, from fiscal years 2012 through 2015.[12] As of early January 2013, TMA had mailed the 2012 beneficiary and civilian provider survey instruments.

This report addresses DOD's beneficiary and civilian provider surveys for the first 4-year survey period, covering fiscal years 2008 through 2011. Specifically, it addresses (1) what the results of the 4-year beneficiary surveys indicate about the adequacy of access to care for nonenrolled beneficiaries, (2) what the results of the 4-year civilian provider surveys indicate about civilian providers' awareness and acceptance of TRICARE, and (3) what the collective results of the 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 4-year beneficiary surveys indicate about the adequacy of access to care for nonenrolled beneficiaries, we obtained and analyzed survey data on access to civilian primary,[13] specialty,[14] and mental health care[15] from TMA's TRICARE Standard Surveys of Beneficiaries for 2008 through 2011. For the purposes of our analysis, we analyzed survey results for those nonenrolled beneficiaries who reported using TRICARE Standard, TRICARE Extra, or TRS the most in the last year. Because the overall response rate for the 4 years

[12]See Pub. L. No. 112-81, § 721(a), 125 Stat. 1298, 1479 (2011).

[13]We use the term "civilian primary care" to refer to instances where respondents indicated that their personal doctor or nurse was a civilian.

[14]We use the term "civilian specialty care" to refer to instances where respondents indicated that they had seen a civilian specialist within the last year.

[15]We use the term "civilian mental health care" to refer to instances where respondents indicated that they had received treatment or counseling for a personal or family problem from a civilian provider within the last year.

was about 38 percent,[16] we verified that TMA's survey results were representative of the areas surveyed by reviewing TMA's nonresponse analyses and interviewing TMA officials.[17] We also obtained and analyzed the Department of Health and Human Services' (HHS) Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for the same 2008-2011 period in order to compare nonenrolled TRICARE beneficiaries' satisfaction with their health care, health plan, and primary and specialty care providers to that of Medicare fee-for-service, Medicaid, and commercially insured beneficiaries.[18] We assessed the reliability of these data by obtaining information from knowledgeable officials and reviewing related documentation, and we determined that TMA's 4-year beneficiary survey data and HHS's CAHPS data were sufficiently reliable for our purposes.

To determine what the results of the 4-year civilian provider surveys indicate about civilian providers' awareness and acceptance of TRICARE, we obtained and analyzed the survey data from TMA's TRICARE Standard Surveys of Providers for 2008 through 2011. Because the overall response rate was about 42 percent,[19] we verified that TMA's

[16]For the 4 years of surveys, TMA mailed 176,841 surveys and received 66,590 returned surveys that were complete and eligible responses. Complete and eligible responses included those TRICARE beneficiaries who answered at least half of the TMA-identified "key" questions.

[17]A nonresponse analysis is used to verify that nonrespondents to the survey would not answer differently from those who did respond and that the respondents are representative of the target population, thus ensuring that the results can be generalized to the population from which the sample was chosen. TMA concluded that the results of the beneficiary survey nonresponse analyses suggested that although there were some differences in the demographic profile, they were not associated with systematic differences in satisfaction with care. TMA officials also told us that the final postsurvey weights used in their analysis accounted for the key-characteristic differences in survey respondents compared with nonrespondents identified through the nonresponse analyses.

[18]HHS's CAHPS survey is a national survey of beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program. We limited our CAHPS analysis to Medicare fee-for-service, Medicaid, and commercial CAHPS surveys, and pooled the data for each from 2008 through 2011 in order to compare the results to TMA's 4-year beneficiary surveys over the same period. We did not adjust the CAHPS survey data for factors that could affect the various beneficiary groups' ratings, such as age or health status.

[19]For the 4 years of surveys, TMA mailed 194,774 surveys and received 82,111 returned surveys that were complete. A survey was considered complete if the provider answered three TMA-identified "key" questions that asked about the providers' location of practice and awareness and acceptance of TRICARE.

civilian provider survey results were representative of the areas surveyed by reviewing TMA's nonresponse analyses and interviewing TMA officials.[20] We compared the civilian provider survey results to those of a national survey of physicians conducted in 2008 by the Center for Studying Health System Change to compare civilian providers' acceptance of any new TRICARE patients to providers' acceptance of any new Medicare (fee-for-service or managed care), Medicaid, and commercially insured beneficiaries.[21] We also compared the results of TMA's 4-year civilian provider survey to those of TMA's 2005-2007 civilian physician survey to identify any changes in physicians' awareness and acceptance over time.[22] We assessed the reliability of these data by speaking with knowledgeable officials and reviewing related documentation, and we determined that these data were sufficiently reliable for our purposes.

To determine what the results of the collective analysis of the 4-year beneficiary and civilian provider surveys indicate about access to care for nonenrolled beneficiaries, we compared the results of our analyses of the 4-year beneficiary and provider survey data by specific geographic regions where possible, in order to identify areas with both high percentages of nonenrolled beneficiaries who experienced problems finding civilian providers and low percentages of civilian providers who were accepting new TRICARE patients. Specifically, we identified areas where the estimated percentage of nonenrolled beneficiaries that

[20]From the results of the civilian provider survey nonresponse analyses, TMA concluded that although there were some demographic and response differences between respondents and nonrespondents, the differences were not large or systematic. TMA officials also told us that the final postsurvey weights used in their analysis accounted for the key-characteristic differences in survey respondents compared with nonrespondents identified through the nonresponse analyses.

[21]The Center for Studying Health System Change is a nonpartisan health policy research organization that conducts research and analysis focused on the U.S. health care system to inform the thinking and decisions of policymakers in government and private industry. The 2008 Health Tracking Physician Survey covered a wide variety of physician and practice dimensions, from basic physician demographic information, practice organization, and career satisfaction, to insurance acceptance, compensation arrangements, information-technology use, and charity care provision.

[22]TMA's 2005-2007 civilian physician survey was sent to physicians only and did not include nonphysician mental health providers. Therefore, when comparing to TMA's 2005-2007 civilian physician survey, we show the results of TMA's 2008-2011 civilian provider survey results for civilian physicians only, which consist of civilian primary care and specialty care physicians, including psychiatrists.

experienced problems finding a civilian provider was either at or above the national estimate for nonenrolled beneficiaries, using the 95 percent confidence limits. For these geographic areas, we then looked at civilian provider acceptance of new TRICARE patients and identified areas where the percentage of civilian providers that were accepting any new TRICARE patients was at or below the national estimate, using the 95 percent confidence limits.

Our analyses have some limitations. In our analyses of TMA's beneficiary and provider surveys we report survey results for some individual areas, but we were unable to compare survey results among all of the individual geographic areas surveyed because of low numbers of respondents in some areas. Similarly, in our analysis of TMA's beneficiary survey we were unable to identify specific geographic areas in which nonenrolled beneficiaries experienced problems finding mental health care providers because of the low numbers of respondents who indicated that they needed mental health care.

We conducted this performance audit from June 2012 through February 2013 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.

Background

Under TRICARE, beneficiaries have choices among various benefit options and may obtain care from either military treatment facilities or civilian providers. When nonenrolled beneficiaries receive care from civilian providers, they have the option of seeing either network or nonnetwork providers. The NDAA 2008 directed DOD to conduct surveys of beneficiaries and civilian providers to assess nonenrolled beneficiaries' access to care.

TRICARE's Benefit Options

TRICARE provides benefits through several basic options for its non-Medicare-eligible beneficiary population. These options vary by enrollment requirements, choices in civilian and military treatment facility providers, and the amount beneficiaries must contribute toward the cost of their care. Table 1 provides a summary of some of these benefit options.

Table 1: Summary of TRICARE Options

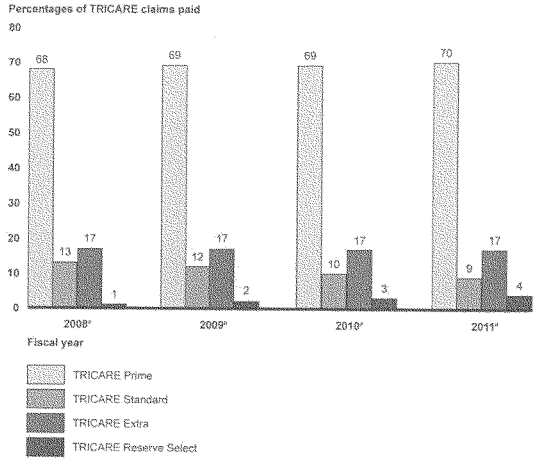
TRICARE option	Description
TRICARE Prime	This managed care option requires enrollment, and all active duty servicemembers are required to use this option, while other TRICARE beneficiaries have a choice. TRICARE Prime enrollees receive most of their care from providers at military treatment facilities and also may receive care from network civilian providers. This option has the lowest out-of-pocket costs for beneficiaries.
TRICARE Standard and TRICARE Extra	TRICARE beneficiaries who choose not to enroll in TRICARE Prime may obtain health care from nonnetwork providers (under TRICARE Standard) or network civilian providers (under TRICARE Extra). The TRICARE Standard option is designed to provide beneficiaries with maximum flexibility in selecting providers, but beneficiaries who obtain care from a network provider, through TRICARE Extra, pay lower copayments than they would under the TRICARE Standard option. TRICARE Standard and Extra beneficiaries also may receive care from military treatment facilities, though they have a lower priority for receiving care than do TRICARE Prime beneficiaries.
TRICARE Reserve Select (TRS)	TRS is a premium-based health plan that certain National Guard and Reserve members may purchase.[a] TRS beneficiaries may obtain health care from either nonnetwork or network providers, similarly to beneficiaries using TRICARE Standard or Extra, respectively, and will pay lower copayments for using network providers.

Source: GAO summary of DOD TRICARE documentation.

[a]To be eligible for TRS, the beneficiary must be a member of the Selected Reserve of the Ready Reserve, and not eligible for or enrolled in the Federal Employees Health Benefits program, either under their own eligibility or through a family member who is enrolled in a family plan.

Claims data from fiscal years 2008 to 2011 show that the percentages of the number of outpatient claims paid for TRICARE Prime and TRS have gradually increased, while the percentage of claims paid for TRICARE Standard has declined. (See fig. 1.) The percentage of claims paid for TRICARE Extra has remained steady over the same period.

Figure 1: Percentage of Outpatient Claims Paid for TRICARE Prime, TRICARE Standard, TRICARE Extra, and TRICARE Reserve Select for Fiscal Years 2008 through 2011



Source: GAO analysis of TMA data.

Notes: All percentages may not add up to 100 percent because of rounding. Claims were for outpatient services provided in an office or other setting outside of an institution. Claims for services rendered at hospitals, military treatment facilities, and other institutions were excluded. TRICARE for Life and TRICARE Young Adult claims were excluded, as well as claims for medical supplies and from chiropractors and pharmacies.

[a]Percentages calculated on the basis of total number of outpatient claims: 23,995,179 claims in fiscal year 2008; 26,950,329 claims in fiscal year 2009; 29,857,355 claims in fiscal year 2010; and 32,012,220 claims in fiscal year 2011.

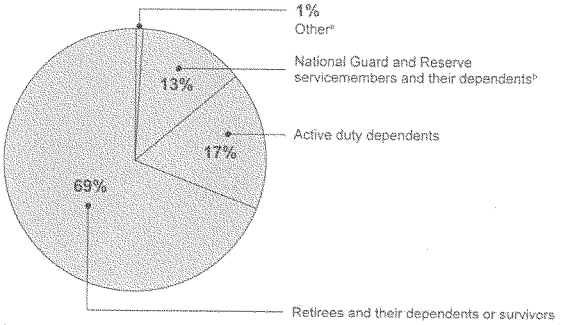
Starting on September 30, 2013, the number of PSAs will be reduced, and as a result, the TRICARE Prime option will be available to fewer beneficiaries. The targeted PSAs are those that are not in close proximity to existing MTFs or BRAC locations and will predominantly affect retirees and their dependents. According to a TMA official, this change is

expected to affect about 171,000 retirees and dependents (37,000 in the North region, 36,000 in the West region, and 98,000 in the South region), with an estimated savings to DOD of $45 million to $56 million annually.[23]

Composition of TRICARE's Nonenrolled Beneficiary Population

In fiscal year 2011, TMA identified about 2 million nonenrolled beneficiaries (approximately one-fourth of the total eligible TRICARE population), who fell into three main categories: (1) retirees and their dependents or survivors, (2) active duty dependents, and (3) National Guard and Reserve servicemembers and their dependents.[24] (See fig. 2.)

Figure 2: Types of Nonenrolled TRICARE Beneficiaries



Source: GAO analysis of TMA data.

Notes: Nonenrolled beneficiaries are beneficiaries not enrolled in TRICARE Prime who are eligible for TRICARE Standard or Extra, as well as TRICARE Reserve Select enrollees. Data are for nonenrolled beneficiaries as of December 31, 2010.

[a]Other nonenrolled beneficiaries include family members of deceased servicemembers and secretarial designees.

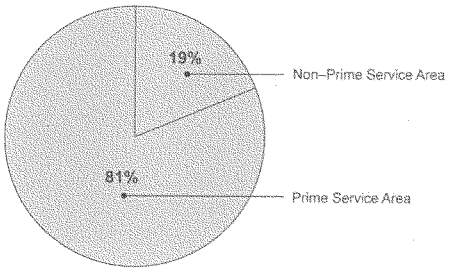
[23]TMA officials estimate that the shift from TRICARE Prime to TRICARE Standard will increase the out-of-pocket costs of a retiree family of three, for example, by about $700 per year.

[24]Although TMA can identify which beneficiaries have not enrolled, it does not have complete information on which beneficiaries intend to use their benefits.

[b]Limited to deactivated National Guard or Reserve servicemembers and their dependents. Dependents of activated National Guard or Reserve servicemembers are included in the "active duty dependents" category.

Most of these nonenrolled beneficiaries lived in PSAs—areas where TRICARE managed care support contractors have developed provider networks. (See fig. 3.)

Figure 3: Geographic Location of Nonenrolled TRICARE Beneficiaries



Source: GAO analysis of TMA data.

Note: Nonenrolled beneficiaries are beneficiaries not enrolled in TRICARE Prime who are eligible for TRICARE Standard or Extra, as well as TRICARE Reserve Select enrollees. Data are for nonenrolled beneficiaries as of December 31, 2010.

TRICARE Network and Nonnetwork Civilian Providers

In order for network and nonnetwork civilian providers to be authorized to provide care and be reimbursed under TRICARE, they must meet the licensing and certification requirements of TRICARE regulations and practices for their area of health care. Individual TRICARE-authorized civilian providers can include health care providers, such as primary care physicians and specialists, as well as mental health care providers, including clinical psychologists. Table 2 provides a comparison of network and nonnetwork civilian providers.

Table 2: Comparison of TRICARE Network and Nonnetwork Civilian Providers

Network Civilian Providers:	Nonnetwork Civilian Providers:
• Are TRICARE-authorized providers who enter contractual agreements with the TRICARE regional managed care support contractors in their areas to provide health care and mental health care to TRICARE beneficiaries.	• Are TRICARE-authorized providers who do not have contractual agreements with regional managed care support contractors to provide care to TRICARE beneficiaries.
• Have agreed to accept TRICARE reimbursement rates. By law, TRICARE maximum allowable reimbursement rates generally must mirror Medicare rates, but network providers may agree to accept lower reimbursements as a condition of network membership.	• May choose to accept the TRICARE reimbursement rate as payment in full for their services, or may charge up to 15 percent more than the TRICARE reimbursement rate for their services on a case-by-case basis (with the difference paid by the beneficiary).
• Are not obligated to accept all TRICARE beneficiaries seeking care. For example, a network civilian provider may decline to accept TRICARE beneficiaries as patients because the provider's practice does not have sufficient capacity.	• May accept TRICARE beneficiaries as patients on a case-by-case basis.
• Have agreed to meet TRICARE Management Activity's access to care standards for TRICARE Prime enrollees. For example, these providers are required to offer urgent care appointments within 24 hours.	• Are not required to meet TRICARE's access to care standards.

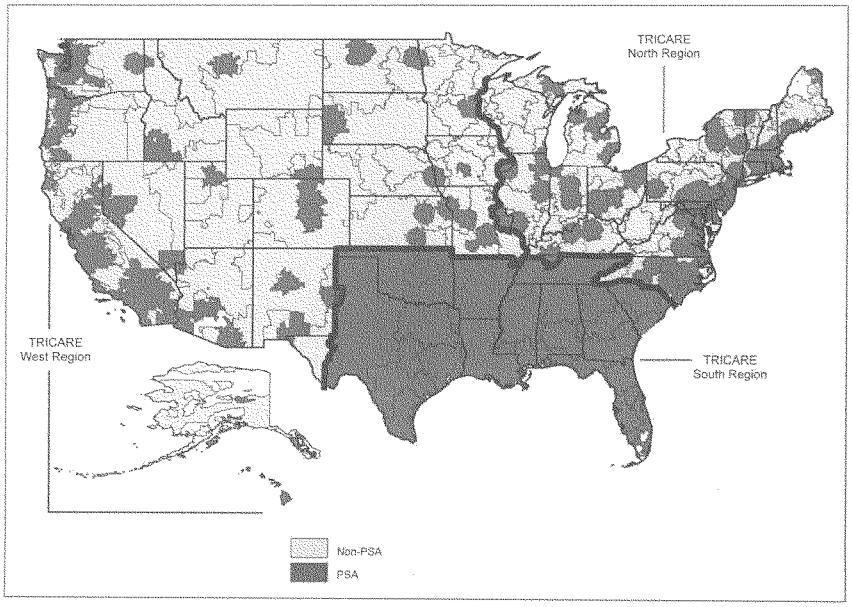
Source: GAO.

DOD's Implementation of the NDAA 2008 Beneficiary and Civilian Provider Survey Requirements

The NDAA 2008 directed DOD to conduct surveys of beneficiaries and civilian providers in at least 20 PSAs and 20 non-PSAs in each of 4 fiscal years, 2008 through 2011.[25] Fig. 4 shows the 80 PSAs and 80 non-PSAs surveyed over the 4-year period of 2008 through 2011.

[25]In designing the beneficiary and civilian provider surveys, DOD defined 80 distinct PSAs and 80 distinct non-PSAs (representing the entire country), and surveyed 20 of each in fiscal years 2008 through 2011. This allowed DOD to survey the entire country over a 4-year period. 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 and mental health care at individual service area, regional, and national levels.

Figure 4: Prime Service Areas (PSA) and Non–Prime Service Areas (non-PSA) Surveyed for TRICARE Management Activity's 4-Year Beneficiary and Provider Surveys, 2008-2011



Source: GAO analysis of TMA data (data); MapInfo (map).

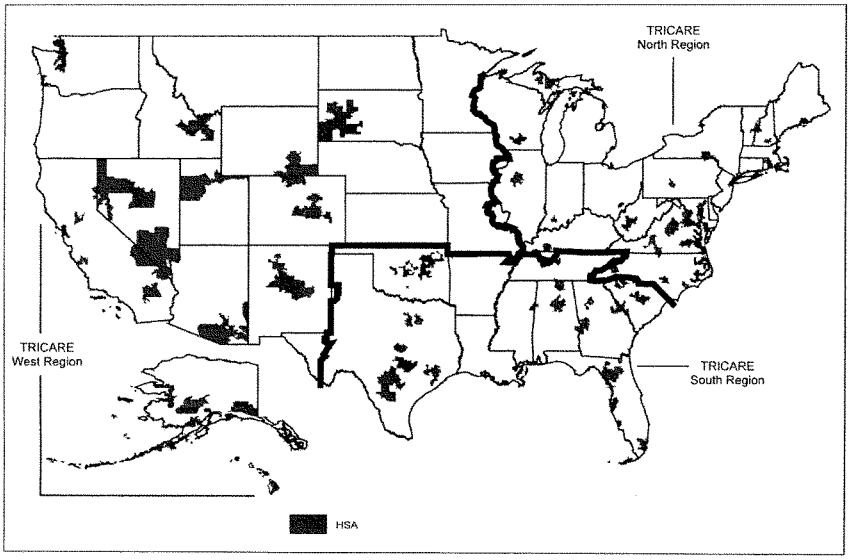
The NDAA 2008 also required DOD to consult with representatives of TRICARE beneficiaries and health care and mental health care providers to identify locations where nonenrolled beneficiaries have experienced significant access-to-care problems—which TMA uses Hospital Service Areas (HSA) to define—and to survey health care and mental health care

providers in these areas.[26] Fig. 5 shows the 71 HSAs identified as problem areas by providers and beneficiary groups.[27] (See app. I for TMA's methodology in implementing the beneficiary and civilian provider surveys.)

[26]TMA identified HSAs to include in its survey sampling locations on the basis of the recommendations of groups representing TRICARE beneficiaries and civilian providers, which identified specific cities and towns in which these groups were aware of beneficiaries having problems accessing civilian TRICARE providers. HSAs, as defined by a Dartmouth College study, are collections of zip codes organized into over 3,000 geographic regions in which Medicare beneficiaries seek the majority of their care from one hospital or a collection of hospitals, and have nonoverlapping borders and contain all U.S. zip codes without gaps in coverage. The HSAs surveyed in the beneficiary and civilian provider surveys are within the 80 PSAs or 80 non-PSAs surveyed.

[27]Of the 71 HSAs, all were included for the civilian provider survey, but only 55 HSAs were included for the beneficiary survey. According to TMA officials, the 16 HSAs that were included in the 2011 civilian provider survey were not included in the 2011 beneficiary survey due to funding issues.

Figure 5: Hospital Service Areas (HSA) Surveyed for TRICARE Management Activity's (TMA) 4-Year Beneficiary and Provider Surveys, 2008-2011



Source: GAO analysis of TMA data (data); MapInfo (map).

Note: For the 4-year provider surveys, TMA surveyed a total of 71 HSAs from 2008 to 2011, shown above. Fifty-five of these 71 HSAs were also surveyed for the beneficiary survey from 2008 to 2010, but according to TMA officials, no HSAs were surveyed for the 2011 beneficiary survey because of funding issues.

The NDAA 2008 also required that specific types of information be requested in the surveys. For example, the beneficiary survey must include questions to determine whether nonenrolled beneficiaries have difficulties finding a provider who will accept TRICARE, and the civilian provider survey must include questions to determine whether civilian providers are aware of TRICARE. (See apps. II and III for the 2011 beneficiary and civilian provider survey instruments, respectively.) Table 3

lists the NDAA 2008 requirements for DOD's beneficiary and civilian provider surveys.

Table 3: Requirements for Annual Beneficiary and Provider Surveys Contained in the National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008)

Requirement	Requirement description
Survey goals	1. Determine the number of health care providers in TRICARE Prime Service Areas (PSA) that are accepting new patients under TRICARE Standard and Extra
	2. Determine the number of health care providers in TRICARE non–Prime Service Areas (non-PSA) that are accepting patients under TRICARE Standard and Extra
	3. Determine the availability of mental health care providers in TRICARE PSAs and TRICARE non-PSAs
Survey area selection	4. Survey beneficiaries and providers in at least 20 TRICARE PSAs in each fiscal year to determine the availability of health care providers accepting new patients under TRICARE Standard and Extra
	5. Survey beneficiaries and providers in 20 non-PSAs in which significant numbers of beneficiaries who are members of the Selected Reserve reside, to determine the availability of health care providers accepting new patients under TRICARE Standard and Extra
	6. Survey beneficiaries and providers in at least 40 total PSAs and non-PSAs to determine the availability of mental health care providers
	7. In prioritizing areas to be surveyed, give a high priority to surveying beneficiaries and providers located in geographic areas with high concentrations of members of the Selected Reserve
	8. In prioritizing areas to be surveyed, consult with representatives of TRICARE beneficiaries and health care and mental health care providers to identify locations where nonenrolled beneficiaries are experiencing significant levels of access-to-care problems under TRICARE Standard or Extra and give a high priority to surveying health care and mental health care providers in these locations
Beneficiary survey content	9. Include questions in beneficiary surveys seeking information to determine whether they have difficulties in finding health care and mental health care providers willing to provide services under TRICARE Standard or Extra
Provider survey content	10. Include questions in provider surveys to determine the following: • Whether the provider is aware of the TRICARE program • What percentage of the provider's current patient population uses any form of TRICARE • Whether the provider accepts patients for whom payment is made under the Medicare program for health care and mental health care services • If the provider accepts Medicare patients, whether the provider would accept new Medicare patients
Benchmarks	11. Establish benchmarks to determine the adequacy of the availability of health care and mental health care providers to beneficiaries eligible for TRICARE

Source: GAO analysis of legislation.

Note: Data are based on review of the NDAA 2008 § 711(a).

We previously reported that TMA generally addressed the requirements outlined in the NDAA 2008 during the implementation of its 2008 beneficiary and provider surveys, but because of methodological considerations TMA used a different—but acceptable—approach for its selection of survey areas.[28] We also found that TMA's methodology for both of the surveys was consistent with the Office of Management and Budget (OMB) standards for statistical surveys that we reviewed. Since then, TMA has made several minor revisions to the surveys' methodologies for 2009 through 2011, but none of these changes are inconsistent with the NDAA 2008 requirements.

Nearly One in Three Nonenrolled Beneficiaries Experienced Problems Accessing Care, and They Rated Their Satisfaction with Care Generally Lower than Medicare Fee-for-Service Beneficiaries

[28]We previously reported that, according to a TMA official responsible for implementing the surveys, TMA did not give a high priority to areas where higher concentrations of Selected Reserve servicemembers live because it decided to randomly select the areas to be surveyed in order to produce results that could be generalized to the populations from which the survey samples were selected. Since TMA planned to survey the entire United States over the 4-year period, its 4-year survey results would include any locations with a higher concentration of Selected Reserve servicemembers. See GAO-10-402.

Nearly One in Three Nonenrolled Beneficiaries Experienced Problems Finding Civilian Providers Who Would Accept TRICARE; Those in PSAs Experienced More Problems Finding Primary and Specialty Care than Those in Non-PSAs

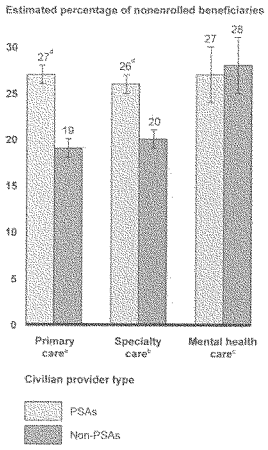
Overall, during 2008-2011, an estimated one in three nonenrolled beneficiaries (about 31 percent) experienced problems finding any type of civilian provider—primary, specialty, or mental health care provider—who would accept TRICARE. Specifically:

- an estimated 25 percent of nonenrolled beneficiaries experienced problems finding a civilian primary care provider;
- an estimated 25 percent of nonenrolled beneficiaries experienced problems finding a civilian specialty care provider; and
- an estimated 28 percent experienced problems accessing a civilian mental health care provider.[29]

Overall, access to civilian primary care and specialty care providers differed for nonenrolled beneficiaries located in PSAs compared to those in non-PSAs. Specifically, we found that more nonenrolled beneficiaries in PSAs experienced problems finding civilian primary care and specialty care providers compared to those in non-PSAs. (See fig. 6.) However, access to civilian mental health care providers did not differ for nonenrolled beneficiaries in PSAs and non-PSAs.

[29]The margins of error for the estimates of beneficiary problems finding civilian primary, specialty, and mental health care providers at the 95 percent confidence level are plus or minus 1, 1, and 3 percentage points, respectively. These estimates are not significantly different from each other at the 95 percent confidence level.

Figure 6: Estimated Percentages of Nonenrolled TRICARE Beneficiaries Who Experienced Access Problems, by Civilian Provider Type, in Prime Service Areas (PSA) and Non–Prime Service Areas (non-PSA), 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

[a]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 or nurse who would accept TRICARE? Answer choices were "A big problem," "A small problem," or "Not a problem."

[b]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."

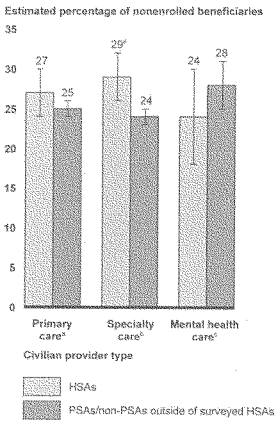
[c]Respondents answered "a big problem" or "a small problem" to the question that asked: Based on the following: In the last 12 months, how much of a problem, if any, was it to get the treatment or counseling you needed through your health plan? Answer choices were "A big problem," "A small problem," or "Not a problem."

[d]Within provider type, the difference in estimates between PSAs and non-PSAs is significantly different at the 95 percent confidence level.

TMA also surveyed beneficiaries in HSAs in response to access concerns about these specific areas. We found that more nonenrolled beneficiaries in HSAs experienced problems accessing civilian specialty care than those in the areas outside of the surveyed HSAs.[30] (See fig. 7.) However, there were no statistical differences in the estimated percentages of nonenrolled beneficiaries who experienced problems finding civilian primary or mental health care providers between the HSAs and the locations surveyed outside of these areas.

[30]Each surveyed HSA was part of a PSA or non-PSA (depending on the location), and because HSAs were not mutually exclusive of the PSAs or non-PSAs, we did not compare the results from nonenrolled beneficiaries in HSAs to nonenrolled beneficiaries in PSAs or non-PSAs. Instead, we compared the results for the nonenrolled beneficiaries in the surveyed HSAs to those nonenrolled beneficiaries in the areas outside the surveyed HSAs.

Figure 7: Estimated Percentages of Nonenrolled TRICARE Beneficiaries Who Experienced Access Problems, by Civilian Provider Type, in Hospital Service Areas (HSA) and Prime Service Areas (PSA)/non-PSAs Outside of Surveyed HSAs, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

Each surveyed HSA was part of a PSA or non-PSA (depending on the location), and because HSAs were not mutually exclusive of the PSAs or non-PSAs, we did not compare the results from nonenrolled beneficiaries in HSAs to nonenrolled beneficiaries in PSAs or non-PSAs. Instead, we compared the results for the nonenrolled beneficiaries in the surveyed HSAs to those nonenrolled beneficiaries in the collective areas outside the surveyed HSAs.

[a]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 or nurse who would accept TRICARE? Answer choices were "A big problem," "A small problem," or "Not a problem."

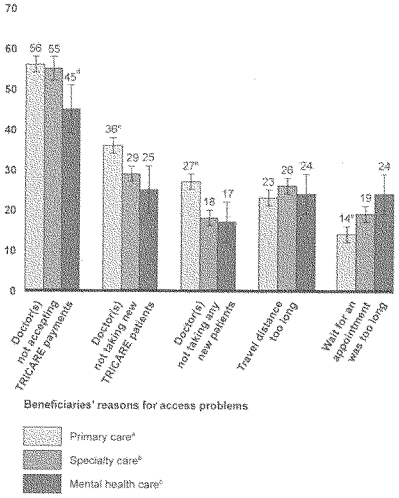
[b]Respondents answered "a big problem" or "a small problem" to the question that asked: In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE? Answer choices were "A big problem," "A small problem," or "Not a problem."

[c]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."

[d]The estimates of nonenrolled beneficiaries who experienced problems finding a civilian specialty care provider between HSAs and PSAs/non-PSAs outside of the surveyed HSAs are significantly different at the 95 percent confidence level.

The top two reasons reported by nonenrolled beneficiaries—regardless of type of care—for why they believed they experienced problems accessing a provider included "doctors not accepting TRICARE payments" and "doctors not accepting new TRICARE patients." (See fig. 8.)

Figure 8: Top Five Reasons Reported by Nonenrolled Beneficiaries Who Experienced Problems Accessing Civilian Primary, Specialty, or Mental Health Care, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

Estimated percentages are out of the total estimated number of nonenrolled beneficiaries who experienced any problems accessing civilian primary, specialty, or mental health care providers.

Percentages across problem types do not add up to 100 percent because respondents were able to select more than one response, and only the top five responses for primary and specialty care are shown.

In addition to the responses above, the top five responses for mental health care included "Other," with an estimated 21 percent of nonenrolled beneficiaries (plus or minus 5 percentage points) indicating "Other" as a reason for having problems finding a provider.

Unless otherwise noted below, differences in estimates within each problem type are not significantly different at the 95 percent confidence level.

[a]Based on the following: "What problems did you encounter in finding a personal doctor who would accept TRICARE?"

[b]Based on the following: "What problems did you encounter in finding a specialist who would accept TRICARE?"

[c]Based on the following: "In the last 12 months, what problems did you encounter in finding treatment or counseling?"

[d]The difference in estimates between mental health care and other care types is statistically significant at the 95 percent confidence level.

[e]The difference in estimates between primary care and other care types is statistically significant at the 95 percent confidence level.

Nonenrolled Beneficiaries' Satisfaction Did Not Differ across Types of Areas, but Was Generally Lower than That of Medicare Fee-for-Service Beneficiaries

Our analysis of the 4-year survey data showed that nonenrolled beneficiaries' ratings for specific satisfaction measures were similar when compared between PSAs and non-PSAs, and between surveyed HSAs and the areas outside of the surveyed HSAs. Specifically, our analysis of beneficiaries' ratings for four measures—satisfaction with primary care providers, specialty care providers, health care, and health plan—indicated no substantial differences between area types.[31] For example, we found that about 80 percent of nonenrolled beneficiaries in both PSAs and non-PSAs rated their primary care provider as an 8 or higher on a scale from 0 to 10.[32]

Additionally, we found that nonenrolled TRICARE beneficiaries' satisfaction ratings for several of these measures were generally lower than those of Medicare fee-for-service beneficiaries and varied compared to Medicaid and commercially insured beneficiaries during the same

[31]In our comparison across location types for all of the satisfaction measures in our analysis, there was one statistical difference at the 95 percent confidence level for nonenrolled beneficiaries' 8-10 ratings of their health care in PSAs (about 79 percent) compared to those in non-PSAs (about 82 percent). Additionally, there was one statistical difference at the 95 percent confidence level for nonenrolled beneficiaries' 8-10 ratings of their health plan in the surveyed HSAs (about 63 percent) compared to those in the areas outside of the surveyed HSAs (about 66 percent). However, for the purposes of our analyses, we determined that although these were statistical differences, they were not substantial differences.

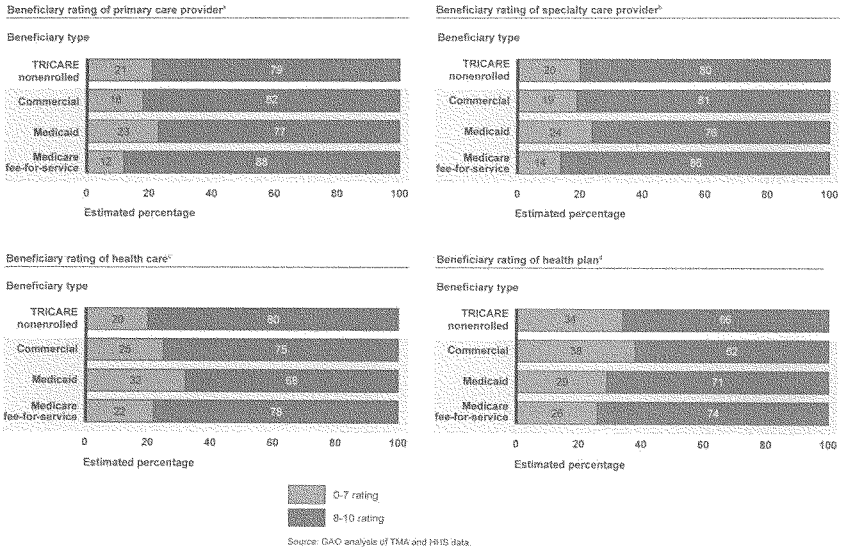
[32]On the scale of 0 to 10, 0 is the worst possible and 10 is the best possible.

4-year period,[33] according to HHS's 2008-2011 CAHPS surveys.[34] (See fig. 9.) For example, we found that fewer nonenrolled TRICARE beneficiaries rated their primary care provider, specialty care provider, and health plan as an 8 or higher compared to Medicare fee-for service beneficiaries.

[33]We divided the rating scale into two categories on the basis of the ratings scale used by TMA to analyze the satisfaction measures for TRICARE beneficiaries (0 to 7 and 8 to 10), where 0 is considered the worst possible and 10 is the best possible. The CAHPS commercial survey asks beneficiaries about their experiences over the last 12 months, whereas the Medicare and Medicaid surveys ask about the beneficiaries' experiences over the last 6 months.

[34]We found similar results in our analysis of the first year of TMA's 2008-2011 survey data and 2008 CAHPS data for Medicare fee-for-service and commercially insured beneficiaries. Specifically, in March 2010, we reported that, although there were no statistically significant differences in the estimated ratings for nonenrolled TRICARE beneficiaries and other beneficiary types, the estimated ratings for nonenrolled beneficiaries in surveyed areas (using categories of 0-6 and 7-10) were slightly lower than estimated ratings of Medicare fee-for-service beneficiaries across three of the satisfaction measures—primary care provider, specialty care provider, and health plan. See GAO-10-402.

Figure 9: Nonenrolled TRICARE Beneficiaries' Estimated Satisfaction Ratings Compared to Those of Commercially Insured, Medicaid, and Medicare Fee-For-Service Beneficiaries, 2008-2011



Source: GAO analysis of TMA and HHS data.

Note: All estimates between nonenrolled TRICARE beneficiaries and other beneficiary groups are significantly different at the 95 percent confidence level. We did not adjust the CAHPS survey data for factors that could affect the various beneficiary groups' ratings, such as age or health status.

[a]TRICARE beneficiaries were asked "Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible, what number would you use to rate your personal doctor or nurse?" Commercial, Medicare, and Medicaid beneficiaries were asked this question of their personal doctor only. Our analysis is limited to TRICARE nonenrolled beneficiaries who indicated that their personal doctor or nurse was a civilian.

[b]TRICARE and commercial 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 TRICARE nonenrolled beneficiaries who indicated that they had seen a civilian specialist in the last 12 months.

[c]TRICARE and commercial 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.

[d]TRICARE, commercial, Medicare, and Medicaid 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' Acceptance of New TRICARE Patients Has Decreased over Time; Mental Health Providers Report Lower Awareness and Acceptance than Other Provider Types

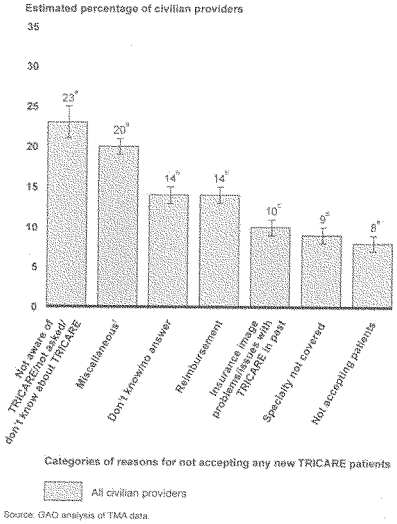
Nationwide, an estimated 82 percent of civilian providers indicated they were aware of the TRICARE program, but only an estimated 58 percent were accepting new TRICARE patients, according to our analysis of the 2008 through 2011 civilian provider survey results.[35] When compared to a national provider survey, civilian providers' acceptance of new TRICARE patients was less than providers' acceptance of other types of beneficiaries. Specifically, a survey of physicians in 2008 by the Center for Studying Health System Change found that about 96 percent of physicians accepted new commercially insured beneficiaries, about 86 percent accepted new Medicare beneficiaries, and about 72 percent accepted new Medicaid beneficiaries.[36]

According to the TRICARE survey results, when asked the reasons for not accepting new TRICARE patients, the most-cited category by those civilian providers who were not accepting any new TRICARE patients was that the provider "was not aware of the TRICARE program/not asked/don't know about TRICARE." (See fig. 10 for the top 7 categories of reasons for why civilian providers were not accepting new TRICARE patients.) Additionally, while nonenrolled beneficiaries cited that providers were not accepting TRICARE for payment as the top reason why any providers were unwilling to accept them as patients, the providers cited it as the third highest reason in addition to "don't know/no answer."

[35]The margins of error for civilian providers' awareness of TRICARE and acceptance of new TRICARE patients are both within plus or minus 1 percentage point at the 95 percent confidence level.

[36]*2008 HSC Health Tracking Physician Survey*, Center for Studying Health System Change. The survey results were based on a 2008 national survey of 4,720 physicians. The margins of error for physicians' acceptance of new commercially insured beneficiaries, new Medicare beneficiaries (fee-for-service and managed care beneficiaries), and new Medicaid beneficiaries are all plus or minus 1 percentage point at the 95 percent confidence level. The differences in estimates between civilian providers' acceptance of new TRICARE patients and providers' acceptance of new commercially insured, Medicare, and Medicaid beneficiaries are significant at the 95 percent confidence level.

Figure 10: Top Seven Categories of Reasons for Not Accepting New TRICARE Patients Reported by Civilian Providers That Were Not Accepting Any New TRICARE Patients, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

Estimated percentages are out of the total estimated number of civilian providers who were not accepting any new TRICARE patients.

Percentages across problem types do not add up to 100 percent because respondents were able to select more than one response, and only the top seven responses are shown.

[a]For these two categories of reasons, the differences in estimates between them and the other categories of reasons, as well as between each other, are statistically significant at the 95 percent confidence level.

[b]For these two categories of reasons, the differences in estimates between these categories of reasons and the others are statistically significant at the 95 percent confidence level. However, the differences between the two categories of reasons are not statistically significant at the 95 percent confidence level.

[c]For the category "insurance image problems/issues with TRICARE in past," the differences in estimates between this category of reasons and all others (except for "specialty not covered") are statistically significant at the 95 percent confidence level.

[d]For the category "specialty not covered," the differences in estimates between this category of reasons and the others (except for "insurance image problems/issues with TRICARE in past" and "not accepting patients") are statistically significant at the 95 percent confidence level.

[e]For the category "not accepting patients," the differences in estimates between this category of reasons and all others (except for "specialty not covered") are statistically significant at the 95 percent confidence level.

[f]The "miscellaneous" category includes reasons such as "not a provider/signed provider," and "working as locum tenens," which means that the provider substitutes for the regular provider when that regular provider is absent.

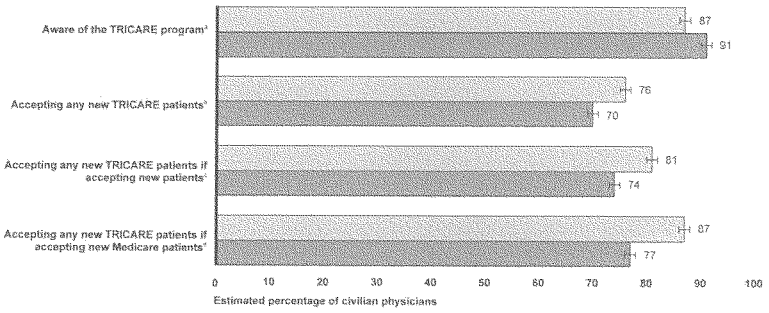
When we compared the results of TMA's 2008-2011 civilian provider survey (excluding nonphysician mental health providers) to the results of its 2005-2007 civilian physician survey,[37] we found that although civilian physicians' awareness has increased over time, their acceptance of new TRICARE patients has decreased over time.[38] This was also true whether they were accepting any new patients or new Medicare patients. For example, civilian physicians' acceptance of any new TRICARE patients has decreased from about 76 percent in 2005-2007 to an estimated 70 percent in 2008-2011.[39] (See fig. 11.)

[37]TMA's 2005-2007 civilian physician survey was sent to physicians only and did not include nonphysician mental health providers. Therefore, when comparing to TMA's 2005-2007 civilian physician survey, we show the results of TMA's 2008-2011 civilian provider survey for civilian physicians only, which consist of civilian primary care and specialty care physicians, including psychiatrists.

[38]In accordance with the NDAA 2008, TMA identified benchmarks for analyzing the results of the beneficiary and provider surveys. To benchmark its provider survey, TMA compared the results of its 2008-2011 surveys with the results of its 2005, 2006, and 2007 physician surveys. A TMA official noted that TMA was unaware of any external benchmarks that would be applicable to its surveys of providers.

[39]The margins of error for civilian physicians' acceptance of any new TRICARE patients from the 2008-2011 surveys and the 2005-2007 surveys are both within plus or minus 1 percentage point at the 95 percent confidence level.

Figure 11: Civilian Physicians' Awareness and Acceptance of TRICARE over Time in TRICARE Management Activity's (TMA) Surveys



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

A statistically significant difference exists between civilian physicians from the 2005-2007 surveys and those from the 2008-2011 surveys for each of the questions at the 95 percent confidence level.

Civilian physicians consist of civilian primary care and specialty care physicians, including psychiatrists.

[a]Respondents answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

[b]Respondents answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

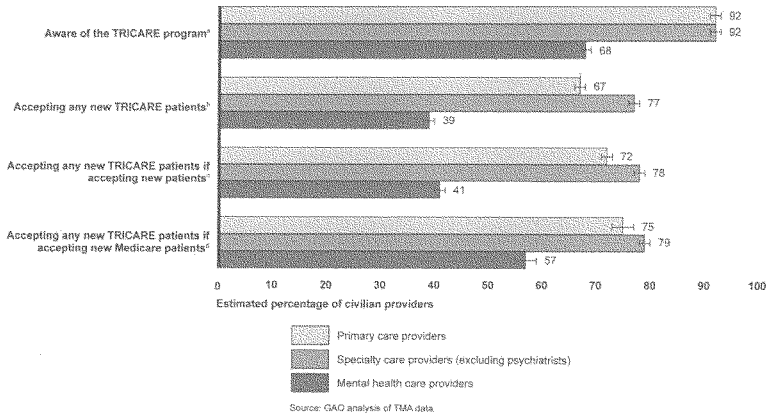
[c]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

When analyzed further by provider type, we found that civilian primary and specialty care providers had higher awareness and acceptance of TRICARE than civilian mental health care providers. (See fig. 12.) Specifically, only an estimated 39 percent of civilian mental health providers were accepting new TRICARE beneficiaries, compared to an

estimated 67 percent of civilian primary care providers and an estimated 77 percent of civilian specialty care providers.[40]

Figure 12: Civilian Providers' Awareness and Acceptance of TRICARE, by Type of Provider, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

With the exception of primary care providers' and specialty care providers' awareness of the TRICARE program, a statistically significant difference exists between primary care providers, specialty care providers, and mental health care providers for each question at the 95 percent confidence level.

[a]Respondents answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

[b]Respondents answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

[c]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard

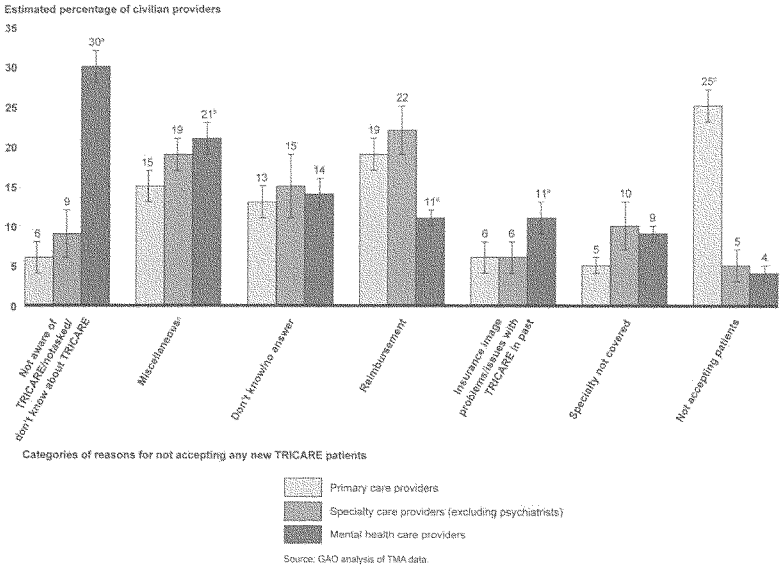
[40]The margins of error for civilian mental health care, primary care, and specialty care providers' acceptance of new TRICARE patients were each within plus or minus 1 percentage point at the 95 percent confidence level. For acceptance of new TRICARE beneficiaries, the differences in estimates between provider types are significant at the 95 percent confidence level.

patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

The categories of reasons cited for not accepting new TRICARE patients also differed by provider type. For example, civilian mental health care providers more often cited "not aware of TRICARE/not asked/don't know about TRICARE" than civilian primary or specialty care providers. Additionally, the top category of reasons cited by civilian primary care providers was that they were "not accepting patients" while the top category of reasons cited by specialty providers was "reimbursement." (See fig. 13 for the top categories of reasons for civilian providers not accepting new TRICARE patients, by provider type.)

Figure 13: Top Categories of Reasons Reported by Civilian Providers for Not Accepting New TRICARE Patients, by Provider Type, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

Estimated percentages are out of the estimated number of civilian primary care, specialty care, and mental health care providers who were not accepting any new TRICARE patients.

Percentages across problem types do not add up to 100 percent because respondents were able to select more than one response, and only the top seven responses are shown (ranked by the overall categories of reasons reported by all civilian providers, regardless of area).

Unless otherwise noted below, differences in estimates within each problem type are not significantly different at the 95 percent confidence level.

[a]For the categories "not aware of TRICARE/not asked/don't know about TRICARE," "reimbursement," and "insurance image problems/issues with TRICARE in past," the differences in estimates between mental health care providers and other provider types are statistically significant at the 95 percent confidence level.

[b]For the category "miscellaneous," the difference in estimates between mental health care providers and primary care providers is statistically significant at the 95 percent confidence level.

[c]For the categories "specialty not covered," and "not accepting patients," the differences in estimates between primary care and other provider types are statistically significant at the 95 percent confidence level.

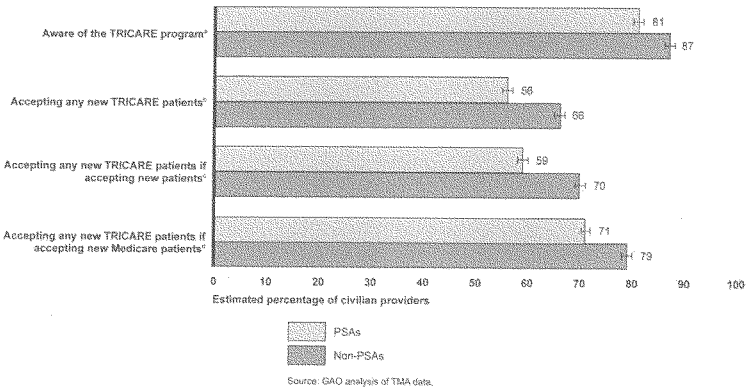
[d]The "miscellaneous" category includes reasons such as "not a provider/signed provider," and "working as locum tenens," which means that the provider substitutes for the regular provider when that regular provider is absent.

We also found that providers' awareness and acceptance of TRICARE differed by type of area. Similar to TMA's nonenrolled beneficiary survey, which showed that nonenrolled beneficiaries in PSAs generally experienced more problems finding providers than their counterparts in non-PSAs, our analysis of the 2008 through 2011 civilian provider survey indicated that civilian providers in PSAs were less aware of TRICARE and less accepting of new TRICARE patients than civilian providers in non-PSAs. Specifically, an estimated 81 percent of civilian providers in PSAs were aware of the TRICARE program, compared to an estimated 87 percent of civilian providers in non-PSAs,[41] and an estimated 56 percent of civilian providers in PSAs were accepting any new TRICARE patients, compared to an estimated 66 percent of those providers in non-PSAs.[42] (See fig. 14.)

[41]The margins of error for civilian providers' awareness of TRICARE in PSAs and non-PSAs are both within plus or minus 1 percentage point at the 95 percent confidence level. The differences in estimates are significant at the 95 percent confidence level.

[42]The margins of error for civilian providers' acceptance of new TRICARE patients in PSAs and non-PSAs are both within plus or minus 1 percentage point at the 95 percent confidence level. The differences in estimates are significant at the 95 percent confidence level.

Figure 14: Civilian Providers' Awareness and Acceptance of TRICARE in Prime Service Areas (PSA) and non–Prime Service Areas (non-PSA), 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

A statistically significant difference exists between civilian providers in PSAs and those in non-PSAs for each of the questions at the 95 percent confidence level.

[a]Respondents answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

[b]Respondents answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

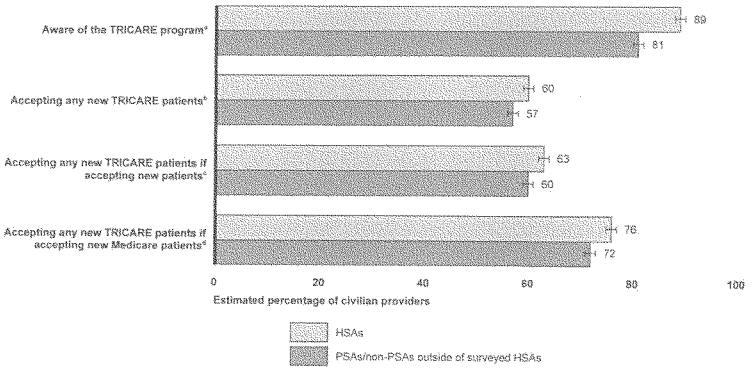
[c]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents providers' indications that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

Civilian providers in HSAs were more frequently aware of TRICARE and accepting of new TRICARE beneficiaries than civilian providers in the

PSAs and non-PSAs outside of these HSAs.[43] (See fig. 15.) These HSAs represented locations that were identified by beneficiary and provider groups to TMA as potentially having access problems.

Figure 15: Civilian Providers' Awareness and Acceptance of TRICARE, by Hospital Service Areas (HSA) and Prime Service Areas/non–Prime Service Areas (PSA/non-PSA) outside of the Surveyed HSAs, 2008-2011



Source: GAO analysis of TMA data.

Notes: Error bars display 95 percent confidence intervals for estimates.

Each HSA is part of a PSA or non-PSA (depending on the location); and because HSAs are not mutually exclusive of the PSAs or non-PSAs, we did not compare the results from nonenrolled beneficiaries in HSAs to nonenrolled beneficiaries in PSAs or non-PSAs. We compared the results for the nonenrolled beneficiaries in the surveyed HSAs to those nonenrolled beneficiaries in the areas outside of HSAs.

The difference in estimates between HSAs and PSAs/non-PSAs outside of surveyed HSAs for each question is statistically significant at the 95 percent confidence level.

[a]Respondents answered yes to the following question: "Is the provider aware of the TRICARE health care program?"

[43]Each HSA is part of a PSA or non-PSA (depending on the location), and because HSAs are not mutually exclusive of the PSAs or non-PSAs, we did not compare the results from civilian providers in HSAs to civilian providers in PSAs or non-PSAs. Instead, we compared the results for the civilian providers in the surveyed HSAs to those civilian providers in the areas outside of HSAs.

[b]Respondents answered "for all claims" or on a "claim-by-claim basis" to the following question: "As of today, is the provider accepting new TRICARE Standard patients?"

[c]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]Respondents answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

Collective Results of TMA's Beneficiary and Civilian Provider Surveys Indicate Specific Geographic Areas Where Nonenrolled Beneficiaries Have Experienced Access Problems

An analysis of the collective results of the multiyear beneficiary and civilian provider surveys indicated particular geographic areas where nonenrolled beneficiaries are experiencing considerable access problems. These locations are defined as areas where (1) the percentage of nonenrolled beneficiaries who experienced difficulties finding a civilian provider was at least the national estimate and (2) the percentage of civilian providers who were accepting any new TRICARE patients was at or below the national estimate.[44] Using these criteria, we identified a number of areas where beneficiaries were having access problems, mostly in Texas.[45] (See app. IV for detailed information about these areas and how they were determined.)

In determining areas where nonenrolled beneficiaries were experiencing access problems to any type of civilian provider, we first identified 24 individual areas (out of the 215 individual areas surveyed by the 2008-2011 beneficiary surveys)[46] where the estimated percentage of

[44]We used the individual area's estimate and margin of error at the 95 percent confidence level to determine whether it was above or below the national estimates. Specifically, for nonenrolled beneficiary problems, we used the lower confidence limit of the estimate: If the individual area's lower confidence limit was equal to or greater than the national estimate, then we included it as an area. Additionally, for civilian providers' acceptance of TRICARE, we used the upper confidence limit of the estimate: If the upper limit of the estimate was equal to or less than the national estimate, then we included it as an area.

[45]A particular geographic area's exclusion from the lists of problem areas below does not necessarily indicate that nonenrolled beneficiaries were not experiencing access problems in that area. Because we took a conservative methodological approach and used the margins of error at the 95 percent confidence limit to determine whether a geographic area met our criteria of a problem area, there may be other areas where nonenrolled beneficiaries are experiencing access problems.

[46]For the 2008-2011 beneficiary survey, 80 PSAs, 80 non-PSAs, and 55 HSAs were surveyed. Because the beneficiary survey did not include the 16 HSAs selected to be surveyed in 2011, they are not included in this analysis. However, the 2011 civilian provider survey did include these 16 HSAs. See app. V to see a list of these 16 HSAs and civilian providers' acceptance of any new TRICARE patients in these areas.

nonenrolled beneficiaries who experienced difficulties finding any type of civilian provider met or exceeded the national estimate (31 percent). Of these, we identified 2 PSAs where the estimated percentage of civilian providers who were accepting any new TRICARE patients was at or below the national estimate (58 percent)—Central/Southern-Central Coastal California and Northeastern Texas. Additionally, we identified 2 HSAs that also met these criteria, one of which is contained within the Northeastern Texas PSA. Table 4 shows each of these areas with the estimated percentage of (1) nonenrolled beneficiaries who experienced problems finding any type of civilian provider and (2) civilian providers who were accepting any new TRICARE patients.

Table 4: Areas Where the Percentage of Nonenrolled Beneficiaries Who Experienced Problems Finding a Civilian Provider Was at Least the National Estimate and Where the Percentage of Civilian Providers Who Were Accepting Any New TRICARE Patients Was at or below the National Estimate, 2008-2011

Area name	Estimated percentage of beneficiaries with a problem finding any type of civilian provider (margin of error)[a]	Estimated percentage of civilian providers accepting new TRICARE patients (margin of error)[b]
Prime Service Areas (PSA)		
1. Central/Southern-Central Coastal California	48 (12)	45 (8)
2. Northeastern Texas	47 (10)	53 (6)
Hospital Service Areas (HSA)		
1. Austin, Texas	58 (18)[c]	46 (6)
2. Dallas/Ft. Worth, Texas[d]	48 (14)	50 (6)

Source: GAO analysis of TMA data.

Notes: The margin of error is at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the civilian provider survey.

Areas in this table had an estimated 31 percent or more of nonenrolled beneficiaries who were having difficulties finding any type of civilian provider who will accept TRICARE (the national estimate, or greater) and equal to or less than an estimated 58 percent of civilian providers who were accepting new TRICARE patients (the national estimate or less). Both determinations were made using the estimates' margins of error at the 95 percent confidence level.

Estimated percentages and margins of error have been rounded to the nearest whole number.

[a]Estimated percentage is based on the number of nonenrolled beneficiaries who responded "a big problem" or "a small problem" to any one of the following three questions: (1) "In the last 12 months, how much of a problem was it to find a personal doctor or nurse who would accept TRICARE?"; (2) "In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE?"; or (3) "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?" We also limited nonenrolled beneficiary responses to those who indicated their provider was a civilian provider.

[b]Estimated percentage is based on the number of civilian providers who answered "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?"

[c]This estimate has a relative margin of error of 30 percent or greater.

[d]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

For the overlapping PSA and HSA (Northeastern Texas and Dallas/Fort Worth), we found that although a high percentage of civilian providers were accepting new patients (between 95 and 97 percent), only about half of these providers were accepting any new TRICARE patients. (See table 5.) For the remaining PSA (Central/Southern-Central California) and HSA (Austin, Texas), between 92 and 98 percent of civilian providers were accepting new patients, and less than half of those providers were accepting any new TRICARE patients. Further, of the civilian providers in all of these areas who were accepting new Medicare patients, between 65 and 70 percent were also accepting any new TRICARE patients. Reimbursement was the most cited reason for providers not accepting new TRICARE patients for all of the areas except the PSA in California for which "not aware of the TRICARE program" was the most cited reason.

Table 5: Civilian Providers' Estimated Percentage of Acceptance of New Patients and New TRICARE Patients, by Problem Area, 2008-2011

Area name	Estimated percentage of civilian providers accepting any new TRICARE patients (margin of error)[a]	Estimated percentage of civilian providers accepting any new patients (margin of error)	Estimated percentage of civilian providers accepting any new TRICARE patients, if accepting any new patients (margin of error)[b]	Estimated percentage of civilian providers accepting any new TRICARE patients, if accepting new Medicare patients (margin of error)[c]
Prime Service Areas (PSA)				
1. Central/Southern-Central Coastal California	45 (8)	92 (5)	48 (8)	66 (10)
2. Northeastern Texas	53 (6)	97 (2)	55 (6)	70 (7)
Hospital Service Areas (HSA)				
1. Austin, Texas	46 (6)	98 (2)	47 (6)	65 (8)
2. Dallas/Ft. Worth, Texas[d]	50 (6)	95 (3)	53 (6)	70 (7)

Source: GAO analysis of TMA data.

Notes: The margin of error is at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the civilian provider survey.

Areas in this table had an estimated 31 percent or more of nonenrolled beneficiaries who were having difficulties finding any type of civilian provider who will accept TRICARE (the national estimate, or greater) and equal to or less than an estimated 58 percent of civilian providers who were accepting new TRICARE patients (the national estimate or less). Both determinations were made using the estimates' margins of error at the 95 percent confidence level.

Estimated percentages and margins of error have been rounded to the nearest whole number.

Each surveyed HSA was part of a PSA or non-PSA (depending on the location).

[a]Estimated percentage is based on the number of civilian providers who answered "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?"

[b]Estimated percentage is based on the number of civilian providers who answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[c]Estimated percentage is based on the number of civilian providers who answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

When analyzing this data by type of provider (primary care, specialty, and mental health), we found four areas where the percentage of civilian primary care providers who were accepting any new TRICARE patients was at or below the national estimate, but did not find similarly low-percentage areas for civilian specialty care providers. Because of the low numbers of survey responses, we are unable to report survey results for access problems to civilian mental health care providers.

Civilian Primary Care Providers

In determining areas where nonenrolled beneficiaries experienced access problems to civilian primary care providers, we first identified 21 individual areas where the estimated percentage of nonenrolled beneficiaries who experienced difficulties finding a civilian primary care provider met or exceeded the national estimate (25 percent). Of these, we identified 2 PSAs where the estimated percentage of civilian primary care providers who were accepting any new TRICARE patients was at or below the national estimate (67 percent)—Northeastern Texas and Eastern-Central Texas. We also identified 2 HSAs that met these criteria, each of which was contained in one of the PSAs we identified. Table 6 shows each of these areas with the estimated percentage of (1) nonenrolled beneficiaries who experienced problems finding a civilian primary care provider and (2) civilian primary care providers who were accepting any new TRICARE patients.

Table 6: Areas Where the Percentage of Nonenrolled Beneficiaries Who Experienced Problems Finding a Civilian Primary Care Provider Was at Least the National Estimate and Where the Percentage of Civilian Primary Care Providers Who Were Accepting Any New TRICARE Patients Was at or below the National Estimate, 2008-2011

Area name	Estimated percent of beneficiaries with a problem finding a civilian primary care provider (margin of error)[a]	Estimated percent of civilian primary care providers accepting new TRICARE patients (margin of error)[b]
Prime Service Areas (PSA)		
1. Northeastern Texas	40 (10)	48 (10)
2. Eastern-Central Texas	38 (12)[c]	53 (10)
Hospital Service Areas (HSA)		
1. Austin, Texas[d]	56 (18)[c]	42 (11)
2. Dallas/Ft. Worth, Texas[e]	40 (14)[c]	51 (12)

Source: GAO analysis of TMA data.

Notes: The margin of error is at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the civilian provider survey.

Areas in this table had an estimated 25 percent or more of nonenrolled beneficiaries who were having difficulties finding a civilian primary care provider who will accept TRICARE (the national estimate, or greater) and equal to or less than an estimated 67 percent of civilian primary care providers who were accepting new TRICARE patients (the national estimate or less). Both determinations were made using the estimates' margins of error at the 95 percent confidence level.

Estimated percentages and margins of error have been rounded to the nearest whole number.

[a]Estimated percentage is based on the number of beneficiaries who responded that they used TRICARE Standard, TRICARE Extra, or TRICARE Reserve Select the most in the last 12 months, and of those, the number who responded "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?" We also limited nonenrolled beneficiary responses to those who indicated their provider was a civilian provider.

[b]Estimated percentage is based on the number of civilian primary care providers who answered "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?"

[c]These estimates have relative margins of errors that are 30 percent or greater.

[d]The Austin, Texas, HSA is part of the Eastern-Central Texas PSA.

[e]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

As we similarly found in the areas where nonenrolled beneficiaries were having access problems for any type of civilian provider, we found that between 94 and 97 percent of civilian primary care providers in the Northeastern Texas PSA/Dallas/Ft. Worth HSA and the Eastern-Central Texas PSA/Austin, Texas, HSA were accepting new patients, but only around half of them were accepting new TRICARE patients.[47] (See

[47]Austin, Texas, HSA is part of the Eastern-Central Texas PSA, and the Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

table 7.) Further, of the civilian primary care providers in the two PSAs who were accepting new Medicare patients, between 59 and 68 percent were accepting any new TRICARE patients.[48] Reimbursement was the most cited reason by civilian primary care providers for not accepting any new TRICARE patients in each of these areas except for the Dallas/Ft. Worth, Texas, HSA, for which "don't know/no answer" was the most cited reason.

Table 7: Civilian Primary Care Providers' Estimated Percentage of Acceptance of New Patients and New TRICARE Patients, by Problem Area, 2008-2011

Area name	Estimated percentage of civilian primary care providers accepting any new TRICARE patients (margin of error)[a]	Estimated percentage of civilian primary care providers accepting any new patients (margin of error)	Estimated percentage of civilian primary care providers accepting any new TRICARE patients, if accepting any new patients (margin of error)[b]	Estimated percentage of civilian primary care providers accepting any new TRICARE patients, if accepting new Medicare patients (margin of error)[c]
Prime Service Areas (PSA)				
1. Northeastern Texas	48 (10)	95 (5)	51 (11)	59 (13)
2. Eastern-Central Texas	53 (10)	96 (4)	55 (10)	68 (15)
Hospital Service Areas (HSA)				
1. Austin, Texas[d]	42 (11)	97 (4)	43 (11)	—[e]
2. Dallas/Ft. Worth, Texas[f]	51 (12)	94 (6)	54 (12)	—[e]

Source: GAO analysis of TMA data.

Notes: The margin of error is at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the civilian provider survey.

Areas in this table had an estimated 25 percent or more of nonenrolled beneficiaries who were having difficulties finding any type of civilian provider who will accept TRICARE (the national estimate, or greater) and equal to or less than an estimated 67 percent of civilian providers who were accepting new TRICARE patients (the national estimate or less). Both determinations were made using the estimates' margins of error at the 95 percent confidence level.

Estimated percentages and margins of error have been rounded to the nearest whole number.

[a]Estimated percentage is based on the number of civilian primary care providers who answered "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?"

[b]Estimated percentage is based on the number of civilian primary care providers who answered yes to questions that asked the following: "As of today, is the provider accepting any new patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this

[48]We do not present the estimates for the percentage of civilian primary care providers in the two HSAs that were accepting any new TRICARE patients, if they were accepting new Medicare patients, because the number of responses was below 50.

question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[c]Estimated percentage is based on the number of civilian primary care providers who answered yes to questions that asked the following: "As of today, is the provider accepting new Medicare patients?" and "As of today, is the provider accepting new TRICARE Standard patients?" The yes response to this question represents the providers' indication that they were accepting new TRICARE Standard patients on either a "claim-by-claim basis" or "for all claims."

[d]The Austin, Texas, HSA is part of the Eastern-Central Texas PSA.

[e]Because the number of responses was below 50, we do not present the estimates and margins of error for these locations.

[f]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

Civilian Specialty Care Providers

In determining areas where nonenrolled beneficiaries are experiencing access problems to civilian specialty care providers, we first identified nine individual areas where the estimated percentage of nonenrolled beneficiaries who experienced difficulties finding a civilian specialty care provider met or exceeded the national estimate (25 percent). Unlike the collective results for "any civilian provider" and "civilian primary care providers," when we examined civilian specialty care providers' responses for these areas, we did not identify any geographic areas where the estimated percentage of civilian specialty care providers who were accepting any new TRICARE patients was at or below the national estimate (77 percent) when accounting for the margins of error at the 95 percent confidence limit. For the nine areas where the estimated percentage of beneficiaries who experienced difficulties finding a civilian specialty care provider met or exceeded the national estimate, the percentage of civilian specialty care providers who were accepting new TRICARE patients ranged from 75 to 86 percent.[49]

Civilian Mental Health Care Providers

Because of the low numbers of survey responses for beneficiaries who said they needed civilian mental health care, we are unable to report correlated survey results for access problems to civilian mental health

[49]One of the nine areas, the Alaska non-PSA, had less than 50 civilian specialty care provider respondents to the question that asked about acceptance of any new TRICARE patients. Therefore, its estimate is not included in this range.

care providers.[50] However, given the nationwide shortage of certain types of mental health providers and the survey results that only 39 percent of civilian mental health care providers were accepting new TRICARE patients, access to mental health care providers is a concern for all TRICARE beneficiaries, including those who use the TRICARE Standard and Extra options.

Agency Comments and Our Evaluation

In reviewing a draft of this report, DOD concurred with our overall findings and provided technical comments, which we incorporated where appropriate. (See app. VI.)

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 members have any questions about this report, please contact me at (202) 512-7114 or 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 members who made key contributions to this report are listed in appendix VII.

Debra A. Draper
Director, Health Care

[50]In order for nonenrolled beneficiaries to respond 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?," they needed to have answered "yes" to the question that asked "in the last 12 months, did you need any treatment or counseling for a personal or family problem?" Additionally, nonenrolled beneficiaries had to have responded that their mental health care provider was a civilian provider.

Appendix I: TRICARE Management Activity's Methodology for the 2008-2011 Beneficiary and Civilian Provider Surveys

The National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) directed the Department of Defense (DOD) to determine the adequacy of the number of health care and mental health care providers that currently accept nonenrolled beneficiaries as patients under TRICARE, DOD's health care program. We use the term "nonenrolled beneficiaries" for beneficiaries who are not enrolled in TRICARE Prime and who use the TRICARE Standard or Extra options, or TRICARE Reserve Select (TRS).[1] The NDAA 2008 also included specific requirements related to the number and priority of areas to be surveyed, including the populations to be surveyed each year, content for each type of survey, and the use of benchmarks. Within DOD, the TRICARE Management Activity (TMA), which oversees the TRICARE program, has the lead responsibility for designing and implementing the nonenrolled beneficiary and civilian provider surveys. The following information describes TMA's methodology, including its actions to address the requirements for each of the following: (1) survey area, (2) sample selection, (3) survey content, and (4) the establishment of benchmarks.

Survey Area Selection

The NDAA 2008 specified that DOD survey beneficiaries and providers in at least 20 TRICARE Prime Service Areas (PSA),[2] and 20 geographic areas in which TRICARE Prime is not offered—referred to as non–Prime Service Areas (non-PSA)—each fiscal year, 2008 through 2011. The NDAA 2008 also required DOD to consult with representatives of TRICARE beneficiaries and health care and mental health care providers to identify locations where nonenrolled beneficiaries have experienced significant access-to-care problems, and give a high priority to surveying health care and mental health care providers in these areas. Additionally,

[1]TRICARE Prime is an option that includes the use of civilian provider networks and requires enrollment. TRICARE beneficiaries who do not enroll in this option may obtain care from nonnetwork providers through TRICARE Standard, or from network providers through TRICARE Extra. We included TRS beneficiaries in our definition of nonenrolled beneficiaries because, although they must enroll in the plan, they can receive care from nonnetwork or network providers similar to TRICARE Standard and Extra beneficiaries. We did not include TRICARE Young Adult-Standard Option beneficiaries in our analysis because this plan did not become available until May 2011.

[2]PSAs are geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five-digit zip codes, usually within an approximate 40 mile radius of a military treatment facility. The managed care support contracts require the contractor to develop civilian provider networks at all Base Realignment and Closure (BRAC) sites, which are military installations that have been closed or realigned as a result of decisions made by the Commission on Base Realignment and Closure.

the NDAA 2008 required DOD to give a high priority to surveying areas in which a high concentration of Selected Reserve servicemembers live.

In designing the 2008 through 2011 nonenrolled beneficiary and civilian provider surveys, TMA defined 80 PSAs and 80 non-PSAs that allowed it to survey the entire country over a 4-year period, and subsequently develop estimates of access to health care and mental health care at service area and national levels. TMA identified the 80 PSAs by collecting zip codes where TRICARE Prime was offered from officials within each of the three TRICARE Regional Offices. TMA grouped these zip codes into 80 nonoverlapping areas so that each area had roughly the same number of TRICARE-eligible beneficiaries. Because non-PSAs had not previously been defined, TMA sought to define them by grouping all zip codes not in PSAs into one large area using Hospital Referral Regions,[3] which are groupings of Hospital Service Areas (HSA).[4] TMA divided the large area into 80 non-PSAs so that each area had roughly the same number of TRICARE-eligible beneficiaries.

To identify locations where nonenrolled beneficiaries and health care and mental health care providers have identified significant levels of access-to-care problems under TRICARE Standard and Extra, TMA spoke with groups representing beneficiaries and health care and mental health care providers, as well as officials at the TRICARE Regional Offices. These groups suggested cities and towns where access should be measured (in addition to the larger PSAs and non-PSAs), and HSAs corresponding to

[3]The Hospital Referral Region designation is derived from a Dartmouth College study that groups HSAs into distinct sets by documenting where patients were referred for major cardiovascular surgical procedures and for neurosurgery. Each HSA was examined to determine where most of its residents went for these services. The result was the aggregation of the more than 3,000 HSAs into 306 Hospital Referral Regions. A TMA official noted that TMA endorsed the Hospital Referral Region methodology in part because it is based on the medical observations of all Medicare beneficiaries, and TRICARE reimbursement rates are based on Medicare reimbursement rates. In addition, TMA used this methodology in its survey of civilian providers during fiscal years 2005 through 2007. In 2006, we reviewed the methodology TMA used for the 2005 civilian provider survey. GAO, *Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option*, GAO-07-48 (Washington, D.C.: Dec. 22, 2006).

[4]HSAs are collections of zip codes organized into over 3,000 geographic regions in which Medicare beneficiaries seek the majority of their care from one hospital or a collection of hospitals. HSAs have nonoverlapping borders and contain all U.S. zip codes without gaps in coverage.

each city and town were then identified. On the basis of the groups' recommendations, multiple lists were created and sorted in priority order: 21 HSAs were surveyed in the 2008 surveys;[5] 9 HSAs in the 2009 surveys; 25 HSAs in the 2010 surveys; and 16 HSAs in the 2011 civilian provider survey. This resulted in a total of 55 HSAs surveyed for the nonenrolled beneficiary survey, and 71 HSAs surveyed in the civilian provider survey (the 71 HSAs includes the same 55 HSAs surveyed for the nonenrolled beneficiary survey and an additional 16 that were selected for the 2011 fielding).[6] Although the NDAA 2008 required DOD to give a high priority to surveying areas in which a high concentration of Selected Reserve servicemembers live, TMA officials decided to randomly select areas for the surveys in order to produce results that could be generalized to the populations in the areas surveyed and to survey the entire United States over the 4-year period—an approach we deemed acceptable in our previous report.[7]

[5]Because of timing issues, the 21 HSAs were not identified in time to be included with the 2008 fielding of the nonenrolled beneficiary survey. Therefore, TMA surveyed these 21 HSAs in the 2009 fielding of the nonenrolled beneficiary survey, along with the 9 HSAs scheduled to be surveyed during the 2009 fielding. Although the 21 HSAs were not actually surveyed during the 2008 fielding, TMA included them when it presented the results of the 2008 nonenrolled beneficiary survey. The civilian provider survey was not affected by these issues.

[6]Of the 71 HSAs, all were included for the civilian provider survey, but only 55 HSAs were included for the beneficiary survey. According to TMA officials, the 16 HSAs that were included in the 2011 civilian provider survey were not included in the 2011 beneficiary survey because of funding issues.

[7]See GAO, *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).

Survey Sample Selection

Nonenrolled Beneficiary Survey Sample Selection

TMA selected its sample of beneficiaries who met its criteria for inclusion in the beneficiary survey using DOD's Defense Enrollment Eligibility Reporting System (DEERS),[8] a database of DOD beneficiaries who may be eligible for military health benefits. TMA determined a beneficiary's eligibility to be included in the nonenrolled beneficiary survey if DEERS indicated that the individual met five criteria:

1. eligible for military health care benefits as of the date of the sample file extract;
2. age 18 years old or older;
3. not an active duty member of the military;
4. residing in one of the 20 randomly selected PSAs or 20 randomly selected non-PSAs to be surveyed that year; and
5. not enrolled in TRICARE Prime, or is enrolled in TRS.[9]

From this database, TMA randomly sampled 1,000 beneficiaries from each PSA and non-PSA—a sample size that would achieve TMA's desired sample error rate.[10] For the 2008, 2009, and 2010 survey fieldings, TMA used a sample size between approximately 40,000 and 50,000 beneficiaries. Because of budgetary constraints, the sample size of the 2011 nonenrolled beneficiary survey was decreased to around 34,000.[11] Because of this reduction, the 2011 sample was further

[8]DEERS is a database that contains the service-related and demographic data that are used to determine eligibility for military benefits, including health care, for all active duty servicemembers, military retirees, and the dependents and survivors of active duty servicemembers and military retirees. As individuals join the military, the various agencies enter information about them into DEERS and update this information as an individual's status changes. The individual servicemember is responsible for providing information to DEERS on dependents, and for reporting changes concerning dependents.

[9]TMA's sample included retirees not enrolled in Medicare, dependents of active duty personnel, and beneficiaries enrolled in TRS in fiscal year 2008.

[10]TMA desired a sample error of plus or minus 5 percent at the 95 percent confidence level.

[11]This reduction was achieved by eliminating the HSAs from the 2011 nonenrolled beneficiary survey area selection.

stratified by using claims data to identify beneficiaries who would likely self-report as TRICARE Standard and Extra users.[12] After receiving the returned surveys, TMA identified the responses that it considered complete and eligible on the basis of whether the beneficiary had answered at least half of TMA's identified "key" questions. Table 8 shows the number of nonenrolled beneficiary surveys mailed, by fiscal year.

Table 8: Number of Beneficiary Surveys Mailed, Returned, and Complete and Eligible, by Fiscal Year

Fiscal year	Final count mailing attributed to this year	Complete and eligible surveys returned[a]	Complete and eligible responses from nonenrolled beneficiaries who used TRICARE Standard, Extra or TRICARE Reserve Select[b]
2008	51,568	20,431	6,936
2009	40,996	16,767	5,690
2010	46,063	16,793	6,027
2011	38,214	12,599	5,397
Total	**176,841**	**66,590**	**24,050**

Source: TMA.

[a]TRICARE Management Activity (TMA) identified the responses that it considered complete and eligible based on whether the beneficiary had answered at least half of TMA's identified "key" questions.

[b]Complete and eligible responses from a nonenrolled beneficiary that used TRICARE Standard, Extra, or TRICARE Reserve Select are those that were complete and eligible, and the respondent answered that he or she used TRICARE Standard or Extra or TRICARE Reserve Select in response to the following question: "Which health plan did you use for all or most of your health care in the last 12 months?"

Civilian Provider Survey Sample Selection

For each survey fielding, TMA selected the civilian provider sample within the same 20 PSAs and 20 non-PSAs that had been randomly selected for that year's nonenrolled beneficiary survey, as well as civilian providers in the HSAs identified by beneficiary and provider groups as having significant levels of access-to-care problems under TRICARE Standard and Extra. TMA used the American Medical Association Physician Masterfile to select a sample of physicians who were licensed, office-based civilian medical doctors or licensed civilian doctors of osteopathy within the specified locations who were engaged in more than 20 hours of patient care each week. The American Medical Association Physician

[12]According to a TMA official, using TRICARE claims data would help to increase the proportion of TRICARE users to those that used other health insurance.

Masterfile is a database of physicians in the U.S.—Doctors of Medicine and Doctors of Osteopathic Medicine—that includes data on all physicians who have the necessary educational and credentialing requirements. This "Masterfile" did not differentiate between TRICARE's network and nonnetwork civilian providers, which TMA deemed acceptable to avoid any potential bias in TMA's sample selection. As such, TMA selected this file because it is widely recognized as one of the best commercially available lists of providers in the United States and contained more than 940,000 physicians along with their addresses, phone numbers, and information on practice characteristics, such as their specialty.[13] According to TMA, the American Medical Association updates physicians' addresses monthly and other elements through a rotating census methodology involving approximately one-third of the physician population each year. Although the Masterfile is considered to contain most providers, deficiencies in coverage and inaccuracies in detail remain. Therefore, TMA attempted to update providers' addresses and phone numbers and ensure that providers were eligible for the survey by also using state licensing databases, local commercial lists, and professional society and association lists.

For its 2008 and 2009 mental health care provider sample selection, TMA selected a sample of mental health care providers from two sources: the American Medical Association's Masterfile of psychiatrists, and LISTS, Inc.—a list of names with contact information assembled from state licensing boards. For the 2010 and 2011 mental health care provider sample selections, TMA also used mental health specialty areas from the National Plan and Provider Enumeration System database maintained by the Centers for Medicare & Medicaid Services, in addition to data from LISTS, Inc., and the psychiatrist data from the American Medical Association's Masterfile. According to TMA, it selected these sources for mental health care providers because they have been identified as the most comprehensive databases for these health care providers.

From these data sets, TMA planned to randomly sample about 800 providers (400 each of physicians and mental health care providers) from each PSA, non-PSA, and HSA—a sample size that would achieve TMA's desired sample error rate.[14] In those instances where there were

[13]TMA did not include all physician specialist types, such as epidemiologists and pathologists, in its survey.

[14]TMA desired a sample error of plus or minus 5 percent at a 95 percent confidence level.

not 800 providers in a single area, TMA selected all of the providers in that area to receive surveys. As the PSA and non-PSA regions were formed on the basis of the number of beneficiaries and not the number of civilian providers, some regions with a large number of civilian providers were sampled at relatively low rates in 2008, 2009, and 2010. To improve the precision of national estimates, in 2011 TMA selected six areas to oversample: (1) Southeastern N.Y. and Northern N.J. (New York City); (2) Los Angeles, Calif.; (3) Eastern Mass. (Boston); (4) Northeastern/Central Ohio (Cleveland); (5) Southeastern/Northern Mich. (Detroit); and (6) Northwestern/Northeastern/Central-Eastern Ill. and Southwestern Wisc. (Chicago). Therefore, in 2011, a supplemental sample of 4,800 providers was drawn for these 6 PSAs, thereby increasing the numbers of eligible providers in each area:

- 1,600 providers from the two 2008 PSAs (Los Angeles, California, and Southeastern New York/Northern New Jersey);
- 800 providers from the one 2009 PSA (Eastern Massachusetts); and
- 2,400 providers from the three 2010 PSAs (Northeastern/Central Ohio, Southeastern/Northern Michigan, and Northwestern/Northeastern/Central-Eastern Illinois/Southeastern Wisconsin).

Upon receipt of the returned surveys, TMA identified the responses that it considered complete and eligible based on the following criteria for respondents: (1) if the provider answered "yes" to the questions that asked whether the provider offers care in an office-based location or private practice; (2) for the nonphysician mental health survey, if the provider responded he or she was one of the six TRICARE participating specialties: certified clinical social worker, certified psychiatric nurse specialist, clinical psychologist, certified marriage and family therapist, pastoral counselor, or mental health counselor; and (3) the provider had to have completed three key questions on the physician survey instrument, or three key questions on the nonphysician mental health provider survey instrument. Table 9 shows the number of civilian provider surveys mailed, by fiscal year.

Table 9: Number of Civilian Physician and Nonphysician Mental Health Provider Surveys Mailed, Returned, and Complete and Eligible, by Fiscal Year

	Final count mailing attributed to this year	Completed surveys returned[a]	Complete and eligible responses[b]
2008 total	40,589	18,557	11,358
Physician	20,193	9,123	7,628
Nonphysician mental health	20,396	9,434	3,730
2009 total	52,234	20,726	14,017
Physician	23,031	9,243	8,036
Nonphysician mental health	29,203	11,483	5,981
2010 total	51,358	22,564	14,822
Physician	25.095	11,278	9,183
Nonphysician mental health	26,263	11,286	5,639
2011 total (supplement total)[b]	50,593 (4,800)	20,264 (1,649)	13,156 (1,052)
Physician[c]	24,498 (2,400)	10,279 (829)	8,266 (657)
Nonphysician mental health[c]	26,095 (2,400)	9,985 (820)	4,890 (395)
Overall total	**194,774**	**82,111**	**55,019**

Source: GAO analysis of TMA data.

[a]TRICARE Management Activity (TMA) considered a survey complete if the provider completed three key questions on the physician survey instrument, or three key questions on the non-physician mental health provider survey instrument that asked about the providers' location of practice and awareness and acceptance of TRICARE.

[b]TMA considered a survey complete and eligible if: (1) the provider completed three key questions on the physician survey instrument, or three key questions on the non-physician mental health provider survey instrument; (2) the provider answered "yes" to the questions that asked whether the provider offers care in an office-based location or private practice; and (3) for the non-physician mental health survey, if the provider responded they were one of the six TRICARE participating specialties: certified clinical social worker, certified psychiatric nurse specialist, clinical psychologist, certified marriage and family therapist, pastoral counselor, or mental health counselor.

[c]As the Prime Service Area and non–Prime Service Area regions were formed based on the number of beneficiaries and not the number of civilian providers, some regions with a large number of civilian providers were sampled at relatively low rates in 2008, 2009, and 2010. To improve the precision of national estimates, TMA selected six regions to oversample in 2011. These numbers are not included in the 2008, 2009, and 2010 counts.

Beneficiary and Provider Survey Content

Nonenrolled Beneficiary Survey Content

The NDAA 2008 required that the beneficiary survey include questions to determine whether TRICARE Standard and Extra beneficiaries have had difficulties finding physicians and mental health care providers willing to provide services under TRICARE Standard or TRICARE Extra. TMA's 2008 nonenrolled beneficiary survey included 91 questions that addressed, among other things, health care plans used; perceived access to care from a personal doctor, nurse, or specialist; the need for treatment or counseling; and ratings of health plans. TMA based some of its 2008 nonenrolled beneficiary survey questions on those included in the Department of Health and Human Services' Consumer Assessment of Healthcare Providers and Systems (CAHPS), a national survey of beneficiaries of commercial health insurance, Medicare, Medicaid, and the Children's Health Insurance Program. Over the 4 years of the nonenrolled beneficiary survey fielding, TMA added three additional questions to the original 91 questions in the 2008 nonenrolled beneficiary survey that covered topics about the beneficiaries' flu-shot history, and what they liked and disliked about TRICARE Standard and Extra. Additionally, in 2011, "TRICARE Young Adult" and "TRICARE Retired Reserve" were added to the response selections for the question that asked about the health plan the beneficiary used. (See app. II for a copy of the 2011 beneficiary survey instrument.)

When TMA began mailing the beneficiary survey, it included a combined cover letter and a questionnaire to all beneficiaries in its sample—with the option of having beneficiaries complete the survey by mail or Internet. The cover letter provided information on the options available for completing the survey, as well as instructions for completing the survey by Internet. If the beneficiary did not respond to the mailed questionnaire, TMA mailed a second combined cover letter and questionnaire 4 weeks later encouraging the beneficiary to complete the survey.

Civilian Provider Survey Content

For the civilian provider survey, the NDAA 2008 required questions to determine: (1) whether the provider is aware of TRICARE; (2) the percentage of the provider's current patient population that uses any form of TRICARE; (3) whether the provider accepts Medicare patients for health care and mental health care; and (4) if the provider accepts

Medicare patients, whether the provider would accept new Medicare patients. TMA obtained clearance for its provider survey from the Office of Management and Budget (OMB) as required under the Paperwork Reduction Act.[15] Subsequent to this review, OMB approved an 11-item questionnaire for physicians (including psychiatrists) and a 12-item questionnaire for nonphysician mental health providers. The mental health care providers' version of the survey includes an additional question about what type of mental health care the provider practiced. Beginning with the 2009 civilian provider survey, an additional follow-up question was added that asked the provider what type of practice they practiced in if the provider indicated that they were not in private practice. Although a civilian provider's indication that the provider was not in private practice still made the provider's responses ineligible for the survey, the additional information from these nonprivate practice civilian providers could be used by TMA to glean additional information about civilian providers. (See app. III for a copy of the 2011 civilian provider survey instruments.)

When TMA began mailing the provider survey, it included a combined cover letter and a questionnaire to each provider in the sample. The providers had the option of completing the survey by mail, fax, or Internet. The cover letter provided information on the options available for completing the survey, as well as instructions for completing the survey by Internet. If the provider did not respond to the mailed questionnaire, TMA mailed a second combined cover letter and questionnaire about 4 weeks later encouraging the provider to complete the survey.

Survey Benchmarks

In accordance with the NDAA 2008, TMA identified benchmarks for analyzing the results of the beneficiary and civilian provider surveys. Because TMA based some of its 2008 beneficiary survey questions on those included in the CAHPS surveys, it was able to compare the results of those questions with its 2008 through 2011 beneficiary survey results. To benchmark its provider survey, TMA compared the results of its 2008 through 2011 surveys with the results of its 2005, 2006, and 2007

[15]The Paperwork Reduction Act requires that all federal agency activities that involve collecting information from the public involving 10 or more people be approved by OMB to ensure that collection of this information will have a minimum burden on the public. See 44 U.S.C. §§ 3507 and 3508.

provider surveys. A TMA official noted that TMA was unaware of any external benchmarks that would be applicable to its surveys of providers.

Analyses of Survey Results

Analysis of Nonenrolled Beneficiary Survey Results

In analyzing the results of the nonenrolled beneficiary survey, TMA representatives conducted yearly nonresponse analyses because the overall response rate for the surveys was around 38 percent.[16] To conduct this analysis for the 2008, 2009, and 2010 survey years, TMA did the following: (1) compared key beneficiary demographic characteristics of respondents to those of nonrespondents (e.g., beneficiary gender and age) and (2) interviewed a sample of beneficiaries who did not respond to the original survey or the follow-up second mailing and compared their responses with the original survey respondents. Because of budgetary constraints during the 2011 survey year, TMA only compared key beneficiary demographic characteristics of respondents to those of the nonrespondents. The results of TMA's nonresponse analyses indicated that respondents to the nonenrolled beneficiary survey differed substantially from the surveyed population in some demographic characteristics. For example, the analyses indicated that retirees, dependents of retirees, and dependents of survivors were overrepresented in the study, and dependents of active duty servicemembers, dependents of Guard/Reserve personnel, and dependents of inactive guard personnel were underrepresented in the study. Additionally, in each of the years in which TMA representatives conducted follow-up interviews (2008-2010), they found some response differences between survey respondents. For example, each year in follow-up interviews of nonrespondents, they found these beneficiaries rated their primary care provider and health plans more favorably than beneficiaries who responded to the survey. According to TMA representatives, they used a weighting scheme to reflect the survey

[16]OMB's guidance suggests that if response rates are below 80 percent, agencies should conduct a nonresponse analysis. Such an analysis is used to verify that nonrespondents to the survey would not answer differently from those who did respond and that the respondents are representative of the target population, thus ensuring that the results can be generalized to the population from which the sample was chosen.

population proportions to correct any bias as a result of survey nonresponse.

Analysis of Civilian Provider Survey Results

In analyzing the results of the provider survey, TMA conducted a nonresponse analysis because the overall response rate to the surveys was about 42 percent. To conduct this analysis for the 2008, 2009, and 2010 surveys, TMA did the following: (1) compared key provider demographic characteristics of respondents to those of nonrespondents (for example, provider type and area) and (2) interviewed a sample of physicians and mental health care providers who did not respond to the survey, follow-up second mailing, or follow-up telephone calls and compared their responses with the survey respondents. Because of budgetary constraints during the 2011 survey year, TMA only compared key provider demographic characteristics of respondents to those of the nonrespondents. The results of TMA's nonresponse analyses indicated that there are some demographic differences between respondents and those who did not respond. For example, the analyses indicated that in some years psychiatrists were underrepresented in the survey samples. Overall, however, the results were consistent among the nonresponse analyses and indicated little variation between respondents and nonrespondents. As TMA used in the weighting scheme for the nonenrolled beneficiary survey, TMA used a weighting scheme to reflect the survey population proportions to correct any bias as a result of survey nonresponse.

Appendix II: Beneficiary Survey Instrument

The National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) directed the Department of Defense (DOD) to determine the number of health care and mental health care providers that currently accept nonenrolled beneficiaries as patients under TRICARE, DOD's health care program. For the purpose of this report, we use the term "nonenrolled beneficiaries" for beneficiaries who are not enrolled in TRICARE Prime and who use the TRICARE Standard or Extra options, or TRICARE Reserve Select (TRS).[1] Specifically, the NDAA 2008 specified that DOD conduct surveys of beneficiaries each fiscal year, 2008 through 2011. The NDAA 2008 also required that the beneficiary survey include questions seeking information from nonenrolled beneficiaries to determine whether they have had difficulties finding health care and mental health care providers willing to accept them as patients.

For the 2008 fielding of the beneficiary survey, 91 questions were included in the survey instrument. Over the next 3 years of the beneficiary survey's fielding, TRICARE Management Activity (TMA) used the same 91 questions and added these additional questions:

- For the 2009 survey fielding and beyond, TMA added Question #81, which asked "When did you last have a flu shot?" for a total of 92 questions in 2009;
- For the 2010 survey fielding and beyond, TMA added two questions (Questions #75 and #76) that asked what the beneficiary liked and disliked about TRICARE Standard and Extra, respectively, for a total of 94 questions in 2010 and 2011.

In addition, for the 2011 survey instrument, "TRICARE Young Adult" and "TRICARE Retired Reserve" were added to the response selections for Question #2, which asked "By which health plan are you currently covered?"

Following is the actual survey instrument from the 2011 fielding that TMA used to obtain information from nonenrolled beneficiaries.

[1]We include TRS beneficiaries in our definition of nonenrolled beneficiaries because, although they must enroll in the plan, they can receive care from network or nonnetwork providers similarly to TRICARE Standard and Extra beneficiaries. We did not include TRICARE Young Adult-Standard Option beneficiaries in our analysis because this plan did not become available until May 2011.

July 21, 2011

Dear

We need your help! The Department of Defense needs your help in completing the enclosed *June 2011 Health Care Survey of DoD Beneficiaries*. Our mission is to provide beneficiaries with the highest quality health care that we can. To accomplish this, we need to know what we are doing right and what needs improvement. We depend on you to keep us informed. By sharing your thoughts and feelings about your health care experiences, you can help us make health care better for all beneficiaries and their families. If you have already completed the survey online, we thank you and please disregard this letter.

This survey asks about your experiences and satisfaction with the health care services you have received in the past 12 months. You are one of a few military beneficiaries who have been selected for this study. You have been chosen as part of a scientific sample of health plan members. To get accurate results, we need to get answers from you and other people we ask to take part in this survey. We hope you will take the time to answer these questions. Most people find it takes only 15 minutes to answer these questions.

Of course, what you have to say is private. Your answers will be part of a pool of information from others like you. What you write will be used only by this study. You may choose to fill out this survey or not. If you choose not to, this will not affect the benefits you get. Your responses are important to us even if you do not receive your health care through the military.

For your convenience, you can also complete the survey online by using the link and password below. If your installation's server blocks the survey site, you can complete the survey online using a civilian internet source:

www.synovate.net/healthsurvey11
ID: 5100010
Password: 9999999

If you have questions about the survey, need the survey sent to your new address or do not wish to participate, please contact the Survey Processing Center. You can reach them by email at **survey-dodq2@synovate.net**; by calling **1-877-236-2390**; or sending a fax to **1-800-409-7681**. Please reference your *ID* number, **12345678**, in all communication.

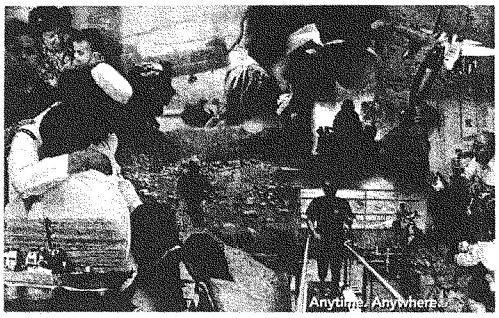
For information about the legitimacy of the survey, please go to the TRICARE Web site at www.tricare.mil/hpac/home and click on the List of Approved Surveys. The DoD Report Control Symbol for this survey is RCS# DD-HA(A) 1942 . Thank you for your time and assistance in this very important effort.

Sincerely,

Thomas V. Williams, Ph.D.
Director, Health Program Analysis and Evaluation Directorate
Office of the Assistant Secretary of Defense (Health Affairs)/TRICARE Management Activity

31L9-60

RCS: DD-HA(A) 1942



Health Care Survey of DoD Beneficiaries

JUNE 2011

TRICARE

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

Authority: 10 U.S.C., Chapter 55; Section 706, Public Law 102-484; E.O. 9397.

Purpose: This survey helps health policy makers gauge beneficiary satisfaction with the current military health care system and provides valuable input from beneficiaries that will be used to improve the Military Health System.

Routine Uses: None

Disclosure: Voluntary. Failure to respond will not result in any penalty to the respondent. However, maximum participation is encouraged so that data will be as complete and representative as possible.

YOUR PRIVACY

Your participation in this survey effort is very important. Your responses are confidential and your participation is voluntary. The number on the back of this survey is ONLY used to let us know if you returned your survey so we don't have to send you reminders.

This is your opportunity to tell officials of your opinions and experiences with the current military health care system. It is also an opportunity to provide feedback and identify areas where improvements are needed.

The survey processing center removes all identifying information before sending the results to the Department of Defense.

Your information is grouped with others and no individual information is shared. Only group statistics will be compiled and reported. No information about you as an individual will be disclosed.

SURVEY INSTRUCTIONS

Answer all the questions by checking the box to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

☑ Yes → *GO TO QUESTION 9*
☐ No

Please return the completed questionnaire in the enclosed postage-paid envelope within ***seven days***. If the envelope is missing, please send to:

Office of the Assistant Secretary of Defense (Health Affairs)
TMA/HPAE
c/o Synovate Survey Processing Center
PO Box 5030
Chicago, IL 60680-4138

SURVEY STARTS HERE

As an eligible TRICARE beneficiary, please complete this survey even if you did not receive your health care from a military facility.

Please recognize that some specific questions about TRICARE benefits may not apply to you, depending on your entitlement and particular TRICARE program.

This survey is about the health care of the person whose name appears on the cover letter. The questionnaire should be completed by that person. If you are not the addressee, please give this survey to that person.

1. Are you the person whose name appears on the cover letter?

☐ Yes → *GO TO QUESTION 2*
☐ No → *Please give this questionnaire to the person addressed on the cover letter.*

2. By which of the following health plans are you currently covered?

MARK ALL THAT APPLY.

Military Health Plans

☐ TRICARE Prime (including TRICARE Prime Remote and TRICARE Overseas)
☐ TRICARE Extra or Standard (CHAMPUS)
☐ TRICARE Plus
☐ TRICARE for Life
☐ TRICARE Supplemental Insurance
☐ TRICARE Reserve Select
☐ TRICARE Retired Reserve
☐ TRICARE Young Adult
☐ Continued Health Care Benefit Program (CHCBP) (a COBRA-like premium-based health care program)

Other Health Plans

☐ Medicare
☐ Federal Employees Health Benefit Program (FEHBP)
☐ Medicaid or other state health insurance
☐ A civilian HMO (such as Kaiser)
☐ Other civilian health insurance (such as Blue Cross)
☐ Uniformed Services Family Health Plan (USFHP)
☐ The Veterans Administration (VA)
☐ Government health insurance from a country other than the US
☐ Not sure

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3. Which health plan did you use for all or most of your health care in the last 12 months?

MARK ONLY ONE ANSWER.

- ☐ TRICARE Prime
- ☐ TRICARE Extra or Standard (CHAMPUS)
- ☐ TRICARE Plus
- ☐ TRICARE Reserve Select
- ☐ TRICARE Retired Reserve
- ☐ TRICARE Young Adult
- ☐ Continued Health Care Benefit Program (CHCBP) (a COBRA-like premium-based health care program)
- ☐ Medicare (may include TRICARE for Life)
- ☐ Federal Employees Health Benefit Program (FEHBP)
- ☐ Medicaid or other state health insurance
- ☐ A civilian HMO (such as Kaiser)
- ☐ Other civilian health insurance (such as Blue Cross)
- ☐ Uniformed Services Family Health Plan (USFHP)
- ☐ The Veterans Administration (VA)
- ☐ Government health insurance from a country other than the US
- ☐ Not sure
- ☐ Did not use any health plan in the last 12 months → *GO TO QUESTION 5*

For the remainder of this questionnaire, the term health plan refers to the plan you indicated in Question 3

4. How many months or years in a row have you been in this health plan?

- ☐ Less than 6 months
- ☐ 6 up to 12 months
- ☐ 12 up to 24 months
- ☐ 2 up to 5 years
- ☐ 5 up to 10 years
- ☐ 10 or more years

5. Many beneficiaries who are eligible for TRICARE also have the opportunity to obtain other civilian health insurance through their job or a family member's job, through COBRA, or through retirement coverage from a previous job, or from some other group. COBRA lets beneficiaries pay to keep their coverage temporarily when they leave their job.

Do you have the opportunity to obtain civilian health insurance for yourself through some civilian group?

- ☐ Yes
- ☐ No → *GO TO QUESTION 9*

6. What options do you have for obtaining civilian coverage?

MARK ALL THAT APPLY.

- ☐ Through my current employer
- ☐ Through COBRA from my previous employer
- ☐ Through retirement coverage from my previous employer
- ☐ Through a family member's current employer
- ☐ Through COBRA from a family member's previous employer
- ☐ Through retirement coverage from a family member's previous employer
- ☐ Through another organization
- ☐ Through a government program
- ☐ Don't know

7. Are you now covered by a civilian health insurance policy?

- ☐ Yes
- ☐ No → *GO TO QUESTION 9*

8. Are you alone covered or are you and others in your household covered by the civilian health insurance policy?

- ☐ I alone am covered
- ☐ I and at least one other person in my household are covered

9. Have you used TRICARE for any health care (not including for prescription drugs) in the past 12 months?

- ☐ Yes → *GO TO QUESTION 11*
- ☐ No

10. Why haven't you used TRICARE?

MARK ALL THAT APPLY.

- ☐ I have a greater choice of doctors with my civilian plan
- ☐ My personal doctor is not available to me through TRICARE
- ☐ My TRICARE regular doctor is no longer available to me
- ☐ My TRICARE specialist is no longer available to me
- ☐ My preferred doctors do not accept TRICARE
- ☐ I prefer civilian hospitals
- ☐ There are no military facilities near me
- ☐ I have to travel too far to see my TRICARE doctor
- ☐ I get better customer service with civilian plans
- ☐ TRICARE benefits are poor compared to my civilian plan
- ☐ It is easier for me to get care through my civilian plan
- ☐ I do not want to pay the premium for TRICARE
- ☐ I pay less for civilian care than I would for TRICARE
- ☐ I have not needed health care
- ☐ Another reason

3

YOUR PERSONAL DOCTOR OR NURSE

The next questions ask about your own health care. Do not include care you got when you stayed overnight in a hospital. Do not include the times you went for dental care visits.

11. A personal doctor or nurse is the health provider who knows you best. This can be a general doctor, a specialist doctor, a nurse practitioner, or a physician assistant. Do you have one person you think of as your personal doctor or nurse?

- ☐ Yes
- ☐ No → *GO TO QUESTION 15*

12. Using any number from 0 to 10, where 0 is the worst personal doctor or nurse possible, and 10 is the best personal doctor or nurse possible, what number would you use to rate your personal doctor or nurse?

- ☐ 0 Worst personal doctor or nurse possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best personal doctor or nurse possible
- ☐ I don't have a personal doctor or nurse

13. How long does it take you to travel to your personal doctor or nurse?

- ☐ Less than 15 minutes
- ☐ 15 to 30 minutes
- ☐ 31 minutes to 60 minutes (1 hour)
- ☐ 61 minutes to 90 minutes
- ☐ 91 minutes to 120 minutes (2 hours)
- ☐ More than 120 minutes (2 hours)

14. Did you have the same personal doctor or nurse before you joined this health plan?

- ☐ Yes → *GO TO QUESTION 16*
- ☐ No

15. Since you joined your health plan, how much of a problem, if any, was it to get a personal doctor or nurse you are happy with?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

16. Where is your personal doctor or nurse located?

MARK ONLY ONE ANSWER.

- ☐ A military facility – This includes: Military clinic, Military hospital, PRIMUS clinic, NAVCARE clinic → *GO TO QUESTION 18*
- ☐ A civilian facility – This includes: Doctor's office, Clinic, Hospital, Civilian TRICARE contractor
- ☐ Uniformed Services Family Health Plan facility (USFHP)
- ☐ Veterans Affairs (VA) clinic or hospital
- ☐ I do not have a personal doctor or nurse

17. In the last 12 months, did you try to find a personal doctor or nurse who was located at a military treatment facility?

- ☐ Yes
- ☐ No → *GO TO QUESTION 20*

18. How much of a problem, if any, was it to find an available personal doctor or nurse at a military treatment facility?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem → *GO TO QUESTION 20*

19. What is the biggest problem you encountered trying to find a personal doctor or nurse at a military treatment facility?

MARK ONLY ONE ANSWER.

- ☐ The military facilities near me have downsized or closed
- ☐ The wait for an appointment at the military treatment facilities near me is too long
- ☐ The waiting rooms at the military facilities near me are crowded or uncomfortable
- ☐ The staff at the military treatment facilities near me are not helpful or courteous
- ☐ I have had problems communicating with doctor(s) at the military treatment facilities
- ☐ Another reason

20. Is your personal doctor or nurse a civilian?

- ☐ Yes
- ☐ No → *GO TO QUESTION 23*
- ☐ I do not have a personal doctor or nurse → *GO TO QUESTION 23*

21. The TRICARE civilian provider network is made up of the doctors, clinics, hospitals and other health care providers who are part of DoD's preferred provider pool. Is your personal doctor or nurse part of the TRICARE civilian provider network?

- ☐ Yes
- ☐ No

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22. What is the specialty of your personal doctor or nurse?

MARK ONLY ONE ANSWER.

- ☐ Family Medicine or General Practitioner
- ☐ Internist
- ☐ Pediatrician
- ☐ OB-GYN
- ☐ Geriatrician or Geriatric Nurse
- ☐ Preventive Medicine
- ☐ Nurse Practitioner or Physician's Assistant
- ☐ Other specialty .....

23. In the last 12 months, how much of a problem was it to find a personal doctor or nurse who would accept TRICARE?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem → *GO TO QUESTION 25*

24. What problems did you encounter in finding a personal doctor who would accept TRICARE?

MARK ALL THAT APPLY.

- ☐ Travel distance too long
- ☐ Problems communicating with doctor
- ☐ Doctor(s) not taking any new patients
- ☐ Doctor(s) not taking new TRICARE patients
- ☐ Doctor(s) not accepting TRICARE payments
- ☐ Could not find the specialty I wanted
- ☐ Did not like doctor(s)
- ☐ Wait for an appointment was too long
- ☐ Could not find information about doctors
- ☐ Other

GETTING HEALTH CARE FROM A SPECIALIST

When you answer the next questions, do not include dental visits.

25. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and others who specialize in one area of health care.

In the last 12 months, did you or your doctor think you needed to see a specialist?

- ☐ Yes
- ☐ No → *GO TO QUESTION 27*

26. In the last 12 months, how much of a problem, if any, was it to see a specialist that you needed to see?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem
- ☐ I didn't need a specialist in the last 12 months

27. In the last 12 months, did you see a specialist?

- ☐ Yes
- ☐ No → *GO TO QUESTION 38*

28. 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?

- ☐ 0 Worst specialist possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best specialist possible
- ☐ I didn't see a specialist in the last 12 months

29. How long does it take you to travel to the specialist you saw most in the past 12 months?

- ☐ Less than 15 minutes
- ☐ 15 to 30 minutes
- ☐ 31 minutes to 60 minutes (1 hour)
- ☐ 61 minutes to 90 minutes
- ☐ 91 minutes to 120 minutes (2 hours)
- ☐ More than 120 minutes (2 hours)

30. In the last 12 months, did you see a civilian specialist?

- ☐ Yes
- ☐ No → *GO TO QUESTION 38*

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31. **In the last 12 months, was the civilian specialist you saw most the same doctor as your personal doctor?**

- ☐ Yes
- ☐ No

32. **In the last 12 months, was the civilian specialist you saw most part of the TRICARE civilian provider network?**

- ☐ Yes
- ☐ No

33. **In the last 12 months, what was the specialty of the civilian specialist you saw most?**

MARK ONLY ONE ANSWER.

- ☐ Surgeon
- ☐ Cardiologist (heart doctor)
- ☐ Allergist
- ☐ Dermatologist (skin doctor)
- ☐ Rheumatologist (specialist of the joints)
- ☐ Endocrinologist (thyroid, hormone and diabetes specialist)
- ☐ Urologist (specialist of the urinary tract and male reproductive system)
- ☐ Oncologist (cancer specialist)
- ☐ Orthopedist (specialist of the bones, muscles and their connected tissues)
- ☐ Ear, nose and throat specialist
- ☐ Obstetrician/Gynecologist
- ☐ Ophthalmologist
- ☐ Other _____

34. **In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE?**

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem → *GO TO QUESTION 36*

35. **What problems did you encounter in finding a specialist who would accept TRICARE?**

MARK ALL THAT APPLY.

- ☐ Travel distance too long
- ☐ Problems communicating with doctor
- ☐ Doctor(s) not taking any new patients
- ☐ Doctor(s) not taking new TRICARE patients
- ☐ Doctor(s) not accepting TRICARE payments
- ☐ Could not find the specialty I wanted
- ☐ Did not like doctor(s)
- ☐ Wait for an appointment was too long
- ☐ Could not find information about doctors
- ☐ Other

CALLING DOCTORS' OFFICES

36. **In the last 12 months, did you call a doctor's office or clinic during regular office hours to get help or advice for yourself?**

- ☐ Yes
- ☐ No → *GO TO QUESTION 38*

37. **In the last 12 months, when you called during regular office hours, how often did you get the help or advice you needed?**

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I didn't call for help or advice during regular office hours in the last 12 months

YOUR HEALTH CARE IN THE LAST 12 MONTHS

38. **In the last 12 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office?**

- ☐ Yes
- ☐ No → *GO TO QUESTION 41*

39. **In the last 12 months, when you needed care right away for an illness, injury, or condition, how often did you get care as soon as you wanted?**

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I didn't need care right away for an illness, injury or condition in the last 12 months

40. **In the last 12 months, when you needed care right away for an illness, injury, or condition, how long did you usually have to wait between trying to get care and actually seeing a provider?**

- ☐ Same day
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4-7 days
- ☐ 8-14 days
- ☐ 15 days or longer
- ☐ I didn't need care right away for an illness, injury or condition in the last 12 months

6

41. A health provider could be a general doctor, a specialist doctor, a nurse practitioner, a physician assistant, a nurse, or anyone else you would see for health care.

In the last 12 months, not counting the times you needed health care right away, did you make any appointments with a doctor or other health provider for health care?

- ☐ Yes
- ☐ No → *GO TO QUESTION 44*

42. In the last 12 months, not counting times you needed health care right away, how often did you get an appointment for health care as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no appointments in the last 12 months

43. In the last 12 months, not counting the times you needed health care right away, how many days did you usually have to wait between making an appointment and actually seeing a provider?

- ☐ Same day
- ☐ 1 day
- ☐ 2-3 days
- ☐ 4-7 days
- ☐ 8-14 days
- ☐ 15-30 days
- ☐ 31 days or longer
- ☐ I had no appointments in the last 12 months

44. In the last 12 months, how many times did you go to an emergency room to get care for yourself?

- ☐ None
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

45. In the last 12 months, (not counting times you went to an emergency room), how many times did you go to a doctor's office or clinic to get care for yourself?

- ☐ None → *GO TO QUESTION 58*
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5 to 9
- ☐ 10 or more

46. In the last 12 months, did you or a doctor believe you needed any care, tests, or treatment?

- ☐ Yes
- ☐ No → *GO TO QUESTION 48*

47. In the last 12 months, how much of a problem, if any, was it to get the care, tests or treatment you or a doctor believed necessary?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem
- ☐ I had no visits in the last 12 months

48. In the last 12 months, did you need approval from your health plan for any care, tests, or treatment?

- ☐ Yes
- ☐ No → *GO TO QUESTION 50*

49. In the last 12 months, how much of a problem, if any, were delays in health care while you waited for approval from your health plan?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem
- ☐ I had no visits in the last 12 months

50. In the last 12 months, how often were you taken to the exam room within 15 minutes of your appointment?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

7

51. In the last 12 months, how often did office staff at a doctor's office or clinic treat you with courtesy and respect?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

52. In the last 12 months, how often were office staff at a doctor's office or clinic as helpful as you thought they should be?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

53. In the last 12 months, how often did doctors or other health providers listen carefully to you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

54. In the last 12 months, how often did doctors or other health providers explain things in a way you could understand?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

55. In the last 12 months, how often did doctors or other health providers show respect for what you had to say?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

56. In the last 12 months, how often did doctors or other health providers spend enough time with you?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always
- ☐ I had no visits in the last 12 months

57. 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?

- ☐ 0 Worst health care possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health care possible
- ☐ I had no visits in the last 12 months

58. In the last 12 months, where did you go most often for your health care?

MARK ONLY ONE ANSWER.

- ☐ A military facility – This includes: Military clinic, Military hospital, PRIMUS clinic, NAVCARE clinic
- ☐ A civilian facility – This includes: Doctor's office, Clinic, Hospital, Civilian TRICARE contractor
- ☐ Uniformed Services Family Health Plan facility (USFHP)
- ☐ Veterans Affairs (VA) clinic or hospital
- ☐ I went to none of the listed types of facilities in the last 12 months

TREATMENT OR COUNSELING

59. In the last 12 months, did you need any treatment or counseling for a personal or family problem?

- ☐ Yes
- ☐ No → *GO TO QUESTION 74*

8

60. In the last 12 months, what type of provider did you want to see most for this treatment or counseling?

MARK ONLY ONE ANSWER.

- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Psychotherapist
- ☐ Social worker
- ☐ Mental health counselor
- ☐ Marriage or family therapist
- ☐ Your personal doctor or nurse
- ☐ Other _____
- ☐ Don't know

61. In the last 12 months, did you receive treatment or counseling for a personal or family problem?

- ☐ Yes
- ☐ No → *GO TO QUESTION 65*

62. In the last 12 months, did you receive this treatment or counseling from a civilian provider?

- ☐ Yes
- ☐ No → *GO TO QUESTION 64*

63. In the last 12 months, did you receive this treatment or counseling from a provider in TRICARE's civilian network?

- ☐ Yes
- ☐ No

64. In the last 12 months, what type of provider did you see most often for this treatment or counseling?

MARK ONLY ONE ANSWER.

- ☐ Psychologist
- ☐ Psychiatrist
- ☐ Psychotherapist
- ☐ Social worker
- ☐ Mental health counselor
- ☐ Marriage or family therapist
- ☐ Your personal doctor or nurse
- ☐ Other _____
- ☐ Don't know

65. 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?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem → *GO TO QUESTION 67*

66. In the last 12 months, what problems did you encounter in finding treatment or counseling?

MARK ALL THAT APPLY.

- ☐ Travel distance too long
- ☐ Problems communicating with doctor
- ☐ Doctor(s) or counselor(s) not taking new patients
- ☐ Doctor(s) or counselor(s) not taking new TRICARE patients
- ☐ Doctor(s) or counselor(s) not accepting TRICARE payments
- ☐ Could not find the specialty I wanted
- ☐ Did not like doctor(s) or counselor(s)
- ☐ Wait for an appointment was too long
- ☐ Could not find information about doctors or counselors
- ☐ Other

67. In the last 12 months, did you need treatment or counseling right away?

- ☐ Yes
- ☐ No → *GO TO QUESTION 69*

68. In the last 12 months, when you needed treatment or counseling right away, how often did you see someone as soon as you wanted?

- ☐ Never
- ☐ Sometimes
- ☐ Usually
- ☐ Always

69. In the last 12 months, did you need approval for any treatment or counseling?

- ☐ Yes
- ☐ No → *GO TO QUESTION 71*

70. In the last 12 months, how much of a problem, if any, were delays in treatment or counseling while you waited for approval?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

71. In the last 12 months, did you call customer service to get information or help about treatment or counseling?

- ☐ Yes
- ☐ No → *GO TO QUESTION 73*

72. In the last 12 months, how much of a problem, if any, was it to get the help you needed when you called customer service?

- ☐ A big problem
- ☐ A small problem
- ☐ Not a problem

9

73. 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?

- ☐ 0 Worst treatment or counseling possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best treatment or counseling possible
- ☐ I didn't receive treatment or counseling in the last 12 months

YOUR HEALTH PLAN

The next question asks about your experience with your health plan. By your health plan, we mean the health plan you marked in Question 3.

74. 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?

- ☐ 0 Worst health plan possible
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10 Best health plan possible

Even if you do not use TRICARE Standard or Extra, we'd like to know what you like and dislike about these plans compared to civilian plans.

75. What do you like about TRICARE Standard and Extra?

MARK ALL THAT APPLY.

- ☐ I have a better choice of doctors with TRICARE than with a civilian plan
- ☐ My preferred personal doctor is only available to me through TRICARE
- ☐ I want to be sure I can always use military health care
- ☐ I get better customer service with TRICARE than with civilian plans
- ☐ It is easier to get care through TRICARE than a civilian plan
- ☐ The premium for TRICARE is lower than the premium for civilian coverage
- ☐ Copays and deductibles cost less through TRICARE than a civilian plan
- ☐ Civilian benefits are poor compared to TRICARE
- ☐ Other _____

76. What do you dislike about TRICARE Standard and Extra?

MARK ALL THAT APPLY.

- ☐ I have a better choice of doctors with a civilian plan than with TRICARE
- ☐ My preferred personal doctor is not available to me through TRICARE
- ☐ I worry about losing access to civilian coverage
- ☐ I get better customer service with civilian plans than with TRICARE
- ☐ It is easier to get care through a civilian plan than TRICARE
- ☐ The premium for TRICARE is too high
- ☐ Copays and deductibles cost more through TRICARE than a civilian plan
- ☐ TRICARE benefits are poor compared to a civilian plan
- ☐ Other _____

PREVENTIVE CARE

Preventive care is medical care you receive that is intended to maintain your good health or prevent a future medical problem. A physical or blood pressure screening are examples of preventive care.

77. When did you last have a blood pressure reading?

- ☐ Less than 12 months ago
- ☐ 1 to 2 years ago
- ☐ More than 2 years ago

78. Do you know if your blood pressure is too high?

- ☐ Yes, it is too high
- ☐ No, it is not too high
- ☐ Don't know

79. Have you ever smoked at least 100 cigarettes in your entire life?

- ☐ Yes
- ☐ No → *GO TO QUESTION 82*
- ☐ Don't know → *GO TO QUESTION 82*

80. Do you now smoke every day, some days or not at all?

- ☐ Every day
- ☐ Some days
- ☐ Not at all → *GO TO QUESTION 82*
- ☐ Don't know → *GO TO QUESTION 82*

81. In the last 12 months, on how many visits were you advised to quit smoking by a doctor or other health provider in your plan?

- ☐ None
- ☐ 1 visit
- ☐ 2 to 4 visits
- ☐ 5 to 9 visits
- ☐ 10 or more visits
- ☐ I had no visits in the last 12 months

10

82. When did you last have a cholesterol screening, that is, a test to determine the level of cholesterol in your blood?

- ☐ Less than 12 months ago
- ☐ 1 to 2 years ago
- ☐ More than 2 but less than 5 years ago
- ☐ 5 or more years ago
- ☐ Never had a cholesterol screening

83. When did you last have a flu shot?

- ☐ Less than 12 months ago
- ☐ 1 to 2 years ago
- ☐ More than 2 years ago
- ☐ Never had a flu shot

84. Are you male or female?

- ☐ Male → *GO TO QUESTION 88*
- ☐ Female

85. When did you last have a Pap smear test?

- ☐ Within the last 12 months
- ☐ 1 to 3 years ago
- ☐ More than 3 but less than 5 years ago
- ☐ 5 or more years ago
- ☐ Never had a Pap smear test

86. Are you under age 40?

- ☐ Yes → *GO TO QUESTION 88*
- ☐ No

87. When was the last time your breasts were checked by mammography?

- ☐ Within the last 12 months
- ☐ 1 to 2 years ago
- ☐ More than 2 but less than 5 years ago
- ☐ 5 or more years ago
- ☐ Never had a mammogram

ABOUT YOU

88. In general, how would you rate your overall health now?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

89. Are you limited in any way in any activities because of any impairment or health problem?

- ☐ Yes
- ☐ No

90. What is the highest grade or level of school that you have completed?

- ☐ 8th grade or less
- ☐ Some high school, but did not graduate
- ☐ High school graduate or GED
- ☐ Some college or 2-year degree
- ☐ 4-year college graduate
- ☐ More than 4-year college degree

91. Are you of Hispanic or Latino origin or descent?

Mark "NO" if not Spanish/Hispanic/Latino.

- ☐ No, not Spanish, Hispanic, or Latino
- ☐ Yes, Mexican, Mexican American, Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, other Spanish, Hispanic, or Latino

92. What is your race?

Mark ONE OR MORE races to indicate what you consider yourself to be

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)
- ☐ Native Hawaiian or other Pacific Islander (e.g., Samoan, Guamanian, or Chamorro)

11

93. What is your age now?

- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or older

94. Which of the following income ranges is closest to your family's (2010) total income from all sources? Your best estimate would be fine.

- ☐ Less than $10,000
- ☐ $10,000 to $24,999
- ☐ $25,000 to $49,999
- ☐ $50,000 to $74,999
- ☐ $75,000 to $99,999
- ☐ $100,000 to $124,999
- ☐ $125,000 to $149,999
- ☐ $150,000 and above
- ☐ Don't know

THANK YOU FOR TAKING THE TIME TO COMPLETE THE SURVEY! Your generous contribution will greatly aid efforts to improve the health of our military community.

Return your survey in the postage-paid envelope. If the envelope is missing, please send to:

Office of the Assistant Secretary of Defense (HA)
TMA/HPAE
c/o Synovate Survey Processing Center
PO Box 5030
Chicago, IL 60680-4138

Questions about the survey?

Email: **survey-dodq2@synovate.net**

Toll-free phone (in the US, Puerto Rico and Canada):
1-877-236-2390, available 24 hours a day
Toll-free fax (in the US and Canada): 1-800-409-7681

When calling or writing, please provide your name, address, and the 8-digit number above your address on the envelope.

Questions about your TRICARE coverage?

For additional information on TRICARE, or if you are not sure about your benefits, or if you don't have a primary care manager, contact the TRICARE Service Center in your region:

North: 1-877-874-2273
South: 1-800-444-5445
West: 1-888-874-9378
Outside the US: 1-888 777-8343

The website is:
www.tricare.mil/contactus

Veterans: Contact the US Department of Veterans Affairs at **1-877-222-VETS**, or go to **www.va.gov**

Appendix III: Survey Instruments for Civilian Physicians and Nonphysician Mental Health Care Providers

The National Defense Authorization Act for Fiscal Year 2008 (NDAA 2008) directed the Department of Defense (DOD) to determine the number of health care and mental health care providers that currently accept nonenrolled beneficiaries as patients under TRICARE, DOD's health care program. For the purpose of this report, we use the term "nonenrolled beneficiaries" for beneficiaries who are not enrolled in TRICARE Prime and who use the TRICARE Standard or Extra options, or TRICARE Reserve Select (TRS).[1] Specifically, NDAA 2008 directed DOD to survey providers each fiscal year, 2008 through 2011. The NDAA 2008 also required that the provider survey include questions seeking information to determine (1) whether the provider is aware of the TRICARE program, (2) the percentage of the provider's current patient population that uses any form of TRICARE, (3) whether the provider accepts Medicare patients, and (4) if the provider accepts Medicare patients, whether the provider would accept new Medicare patients. DOD implemented two versions of its provider survey, one for physicians, including psychiatrists, and one for nonphysician mental health providers.[2]

For the 2008 fielding of the civilian provider survey, 11 and 12 questions were included in the physician and nonphysician mental health provider survey instruments, respectively. Over the next 3 years of the civilian provider survey's fielding, TRICARE Management Activity (TMA) generally used the same questions, but made the following adjustments to the survey instruments:

- Beginning with the 2009 fielding of both survey instruments and beyond, TMA adjusted Question #1 which asked the provider whether they provided health care to patients in an office-based practice (for physicians) or a private practice (for nonphysician mental health care providers) so that a "no" response would no longer instruct the provider to stop answering the survey at that point. Instead, the

[1]We include TRS beneficiaries in our definition of nonenrolled beneficiaries because, although they must enroll in the plan, they can receive care from network or nonnetwork providers similarly to TRICARE Standard and Extra beneficiaries. We did not include TRICARE Young Adult-Standard Option beneficiaries in our analysis because this plan did not become available until May 2011.

[2]Nonphysician mental health providers include: (1) certified marriage and family therapists, (2) mental health counselors, (3) pastoral counselors, (4) certified psychiatric nurse specialists, (5) clinical psychologists, and (6) certified clinical social workers.

revision directed the provider to the newly added Question #1a that asked the provider what type of practice they were in (if they answered "no" to Question #1).

- For the 2010 and 2011 fieldings of the physician survey instrument, TMA also adjusted Question #1 from "Does [the provider] provide treatment to patients through an office-based practice?" to "Does [the provider] provide treatment to patients through private practice?"

Following are the actual survey instruments from the 2011 fielding that TMA used to obtain information from physicians and nonphysician mental health care providers.

OMB NO.: 0720-0031
EXPIRATION DATE: 10/31/2013

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

TRICARE MANAGEMENT ACTIVITY
HEALTH PROGRAM ANALYSIS AND EVALUATION DIRECTORATE

UNIQUE ID
FOR: [Title] [Insert Provider Name]
Street Address
City, State, and Zip

June 24th 2011

Dear BILLING MANAGER for [Title] [Insert Provider Name],

Hello! The physician named above has been selected to participate in a very important survey effort. In support of U.S. military men and women, Congress has directed the Department of Defense to survey civilian physicians across the U.S. to determine whether military service members and their families have access to the health care they need. A substantial amount of health care to service members and their families is delivered by private, civilian physicians like [Title] [Insert Provider Name], and we need your help.

We are asking you to please answer the questions on the back of this letter on behalf of the physician above and return it ***within five days***. There are several ways to complete this survey, which should only take five minutes of your time:

- Complete the survey on the reverse side of this letter and return it via postal mail in the enclosed postage paid envelope
- Complete the survey on the reverse side of this letter and fax it to 1-800-585-9446
- Complete the survey on the internet at the following URL: http://www.dodcv08.com
  Your unique login name: xxxxxxxx **Your unique password:** xxxxxxxx

We recognize that there may be more than one provider in your office and ask that you complete the survey for the provider listed above. Since we may survey more than one provider in your office, please complete each survey for the appropriate provider named above. If you are not the appropriate person to answer these questions, please pass this on to the person in your office most familiar with the [Title] [Insert Provider Name]'s billing and insurance.

Thank you in advance for your cooperation and help as we examine this important issue that impacts our American service men and women. If you have questions about this survey, please call Synovate between the hours of 8AM and 5PM Eastern Time at 1-800-228-6764.

Sincerely yours,

Thomas V. Williams, Ph.D.
Director, Health Program Analysis and Evaluation Directorate
Office of the Assistant Secretary of Defense (Health Affairs) TRICARE Management Activity

SURVEY QUESTIONS ON REVERSE SIDE

We estimate this survey will take an average five (5) minutes to complete, including the time for reviewing instructions, getting the needed data, and completing and reviewing the survey. You may send comments regarding our estimate or any other aspect of this survey, including suggestions for reducing the completion time, to Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division (OMB Number 0720-0031). The OMB number above is currently valid, and you are not required to respond, unless this number is displayed. This Official DoD survey may be confirmed at the TRICARE website http://www.tricare.mil/hpae/home/, click on the List of Approved Surveys, and find "Survey of Civilian Provider Acceptance of TRICARE Standard."

PRIVACY ACT STATEMENT

According to the Privacy Act of 1974 (Public law 93-579), the Department of Defense is required to inform you of the purposes and use of this survey. Please read carefully. Authority: Section 711 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law (P.L.) 110-181

Purpose: Mandated by Congress, this confidential survey of civilian providers helps TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Standard health care benefit option, and will provide valuable aggregated input to help improve the Military Health System.

Routine Uses: Those disclosures generally permitted under 5.U.S.C. 552a(b) of the Privacy Act.

Disclosure: Providing information in this questionnaire is voluntary. There is no penalty if you choose not to respond. However, maximum participation is encouraged so that data will be as complete and representative as possible. You may notice a number on this survey: this number is used only to let us know if you returned the survey to minimize sending you reminders.

OMB NO.: 0720-0041
EXPIRATION DATE: 12/31/2011

Q1. Does [Title] [Insert Provider Name] provide treatment to patients through *private practice*? (By this we mean that the provider is working in a setting where he/she can decide or influence the decision regarding which insurance to accept.)

- ☐ Yes → (Go to Q2)
- ☐ No, does not provide treatment, or has retired → (Thank you, please return the questionnaire)
- ☐ No, not in private practice → (Go to Q1a)

Q1a. What type of practice is [Title] [Insert Provider Name] in? (please choose one)

- ☐ Government: *Federal, State or other municipality*
- ☐ School, University or other academic institution
- ☐ Hospital staff
- ☐ Contractor providing services exclusively to government clients
- ☐ Rehab Facility, Nursing Home, or Home Health Provider
- ☐ Closed Panel HMO
- ☐ Other _____

Q2. Is [Title] [Insert Provider Name] *aware* of the TRICARE health care program?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q3. As of today, is [Title] [Insert Provider Name] a contracted member of the TRICARE network of health care providers?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q4. As of today, is [Title] [Insert Provider Name] accepting new *TRICARE Standard* patients?

- ☐ No →(Go to Q5)
- ☐ Yes, on a claim by claim basis only →(Go to Q6)
- ☐ Yes, for all claims →(Go to Q6)
- ☐ I Don't know →(Go to Q6)

Q5. If you answered "no" to Q4 above, why is [Title] [Insert Provider Name] not accepting new TRICARE Standard patients?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

_____

_____

Q6. What percentage of patients seen by [Title] [Insert Provider Name] use any form of TRICARE? If unsure, please write down your best guess.

- ☐ None. Dr. [Insert Last Name] has no TRICARE patients
- ☐ _____ percent use some form of TRICARE
- ☐ I Don't Know

Q7. Does [Title] [Insert Provider Name] accept any Medicare patients?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q8. As of today, is [Title] [Insert Provider Name] accepting *new* Medicare patients?

- ☐ Yes → Thank you, please return the questionnaire
- ☐ No →(Go to Q9)
- ☐ I Don't Know →(Go to Q10)

Q9. If you answered "no" to Q8 above, why is [Title] [Insert Provider Name] not accepting new Medicare patients?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

_____

_____

Q10. Does [Title] [Insert Provider Name] accept any insurance plans?

- ☐ Yes
- ☐ No

Q11. As of today, is [Title] [Insert Provider Name] accepting *any* new patients?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Thank you for taking the time to complete this survey. Please put this in the enclosed postage-paid envelope and return it to the Survey Processing Center or fax the survey to Synovate at 1-800-585-9446. If you have any questions about TRICARE, its specific health plans, or the benefits it provides, please visit the TRICARE web site at www.tricare.osd.mil for assistance.

OMB NO.: 0720-0031
EXPIRATION DATE: 12/31/2011

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

TRICARE MANAGEMENT ACTIVITY
HEALTH PROGRAM ANALYSIS AND EVALUATION DIRECTORATE

[Unique Provider ID Number]
FOR: [Title] [Insert Provider Name]
Street Address
City, State, and Zip

June 24th 2011

Dear [Title] [Insert Provider Name],

Hello! You have been selected to participate in a very important survey effort. In support of U.S. military men and women, Congress has directed the Department of Defense to survey civilian mental and behavioral health care providers across the U.S. to determine whether military service members and their families have access to the care they need. A substantial amount of mental and behavioral health care provided to our military and their families is delivered by private, civilian providers like yourself. The DoD has contracted Synovate to conduct this survey.

We are asking you to please answer the questions on the back of this letter and return it ***within five days***. We suggest that the survey be completed by the person in your office who is most knowledgeable about billing and insurance. We recognize that there may be more than one provider in your office and ask that this survey be completed for the provider listed above. There are several ways to complete this survey, which should only take five minutes of your time:

- Complete the survey on the reverse side of this letter and return it via postal mail in the enclosed postage paid envelope
- Complete the survey on the reverse side of this letter and fax it to 1-800-585-9446
- Complete the survey on the internet at the following URL: http://www.dodcv08.com
  Your unique login name: xxxxxxxx **Your unique password:** xxxxxxxx

Thank you in advance for your cooperation and help as we examine this important issue that impacts our American service men and women. If you have questions about this survey, please call Synovate between the hours of 8AM and 5PM Eastern Time at 1-800-228-6764.

Sincerely yours,

Thomas V. Williams, Ph.D.
Director, Health Program Analysis and Evaluation Directorate
Office of the Assistant Secretary of Defense (Health Affairs) TRICARE Management Activity

SURVEY QUESTIONS ON REVERSE SIDE

We estimate this survey will take an average five (5) minutes to complete, including the time for reviewing instructions, getting the needed data, and completing and reviewing the survey. You may send comments regarding our estimate or any other aspect of this survey, including suggestions for reducing the completion time, to Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division (OMB Number 0720-0031). The OMB number above is currently valid, and you are not required to respond, unless this number is displayed. This Official DoD survey may be confirmed at the TRICARE website http://www.tricare.mil/hpae/home/, click on the List of Approved Surveys, and find "Survey of Civilian Provider Acceptance of TRICARE Standard."

PRIVACY ACT STATEMENT

According to the Privacy Act of 1974 (Public law 93-579), the Department of Defense is required to inform you of the purposes and use of this survey. Please read carefully. Authority: Section 711 of the National Defense Authorization Act for Fiscal Year 2008 (Public Law (P.L.) 110-181

Purpose: Mandated by Congress, this confidential survey of civilian providers helps TRICARE health policy makers gauge civilian provider awareness and acceptance of the TRICARE Standard health care benefit option, and will provide valuable aggregated input to help improve the Military Health System.

Routine Uses: Those disclosures generally permitted under 5.U.S.C. 552a(b) of the Privacy Act.

Disclosure: Providing information in this questionnaire is voluntary. There is no penalty if you choose not to respond. However, maximum participation is encouraged so that data will be as complete and representative as possible. You may notice a number on this survey: this number is used only to let us know if you returned the survey to minimize sending you reminders.

OMB NO.: 0720-0021
EXPIRATION DATE: 10/31/2013

Q1. Does [Title] [Insert Provider Name] provide treatment or counseling to patients through *private practice*? (By this we mean that the provider is working in a setting where he/she can decide or influence the decision regarding which insurance to accept.)

- ☐ Yes → (Go to Q2)
- ☐ No, does not provide treatment or counseling, or has retired → (Thank you, please return the questionnaire)
- ☐ No, not in private practice → (Go to Q1a)

Q1a. What type of practice is [Title] [Insert Provider Name] in? (Please choose one)

- ☐ Government: *Federal, State or other municipality*
- ☐ School, University or other academic institution
- ☐ Hospital staff
- ☐ Contractor providing services exclusively to government clients
- ☐ Rehab Facility, Nursing Home, or Home Health Provider
- ☐ Closed Panel HMO
- ☐ Other _____

Q2. What type of health care provider is [Title] [Insert Provider Name]? MARK ALL THAT APPLY.

- ☐ Certified Clinical Social Worker
- ☐ Certified Psychiatric Nurse Specialist
- ☐ Clinical Psychologist
- ☐ Certified Marriage and Family Therapist
- ☐ Pastoral Counselor
- ☐ Mental Health Counselor
- ☐ Other _____

Q3. Is [Title] [Insert Provider Name] *aware* of the TRICARE health care program?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q4. Is [Title] [Insert Provider Name] *a contracted member* of the TRICARE network of health care providers?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q5. As of today, is [Title] [Insert Provider Name] *accepting new TRICARE Standard* patients?

- ☐ No → (Go to Q6)
- ☐ Yes, on a claim by claim basis only → (Go to Q7)
- ☐ Yes, for all claims → (Go to Q7)
- ☐ I Don't know → (Go to Q7)

Q6. You answered "no" to the question above. Why is [Title] [Insert Provider Name] *not accepting new TRICARE Standard* patients?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

_____
_____
_____
_____

Q7. *What percentage of patients* seen by [Title] [Insert Provider Name] use *any form of TRICARE*? If unsure, please write down your best guess.

- ☐ None: [Insert Provider Name] has no TRICARE patients
- ☐ _____ percent use some form of TRICARE
- ☐ I Don't Know

Q8. Does [Title] [Insert Provider Name] accept *any Medicare patients*?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Q9. As of today, is [Title] [Insert Provider Name] accepting *new Medicare patients*?

- ☐ Yes → Thank you, please return the questionnaire
- ☐ No → (Go to Q10)
- ☐ I Don't Know → (Go to Q11)

Q10. You answered "no" to the question above. Why is [Title] [Insert Provider Name] *not accepting new Medicare patients*?

Please list all the reasons. If you need additional space, please include a separate sheet of paper.

_____
_____
_____
_____

Q11. Does [Title] [Insert Provider Name] accept *any insurance plans*?

- ☐ Yes
- ☐ No

Q12. As of today, is [Title] [Insert Provider Name] accepting *any new* patients?

- ☐ Yes
- ☐ No
- ☐ I Don't Know

Thank you for taking the time to complete this survey. Please put this in the enclosed postage-paid envelope and return it to the Survey Processing Center or fax the survey to Synovate at 1-800-585-9446. If you have any questions about TRICARE, its specific health plans, or the benefits it provides, please visit the TRICARE web site at www.tricare.osd.mil for assistance.

Appendix IV: Areas Where Nonenrolled Beneficiaries Had Problems Accessing Civilian Providers, 2008-2011

The 2008-2011 beneficiary survey indicated individual areas where nonenrolled beneficiaries experienced problems finding "any civilian provider," civilian primary care providers, and civilian specialty care providers.[1] We define these locations as areas where the percentage of nonenrolled beneficiaries who experienced difficulties finding a civilian provider was at the national estimate or higher.

Problems Finding Any Provider

We identified 24 individual areas (out of the 215 individual areas surveyed by the 2008-2011 beneficiary surveys)[2] where the percentage of nonenrolled beneficiaries who experienced problems finding any type of provider who would accept TRICARE met or exceeded the national estimate.[3] We then identified 49 additional areas where the percentage of nonenrolled beneficiaries who experienced these problems was less than the national estimate.[4] The remaining 130 areas had estimates that ranged from 18 to 50 percent, but because of their confidence intervals, were neither above nor below the 31 percent threshold.[5] Figure 16 shows the geographic distribution of these three categories of areas.

[1]"Any civilian provider" means the nonenrolled beneficiary had problems finding a civilian primary, specialty, or mental health care provider who would accept TRICARE patients.

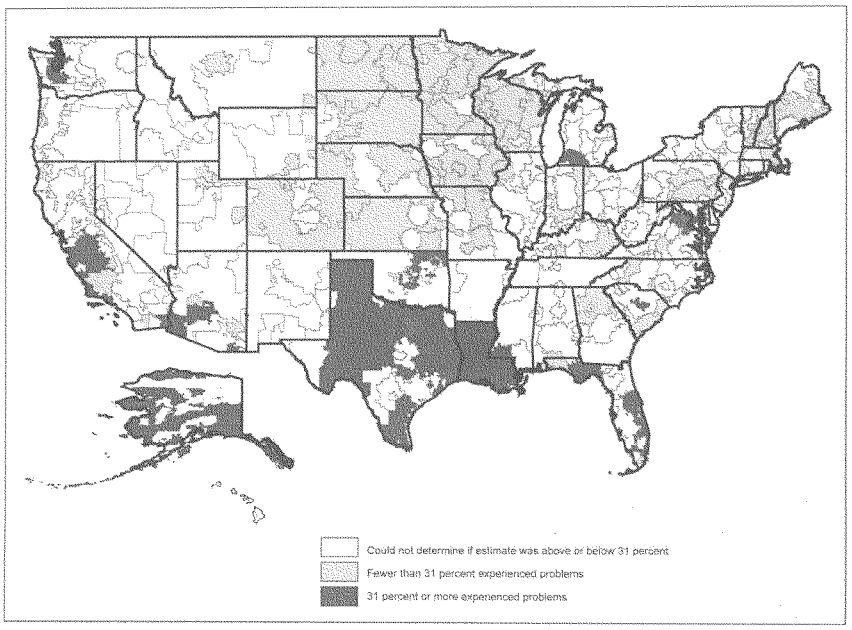
[2]For the beneficiary survey, 80 Prime Service Areas (PSA), 80 non–Prime Service Areas (non-PSA), and 55 Hospital Service Areas (HSA) were surveyed. Because the beneficiary survey did not include the 16 HSAs selected to be surveyed in 2011, we cannot include them in this analysis. However, the 2011 civilian provider survey did include these 16 HSAs. See app. V to see a list of these 16 HSAs and civilian providers' acceptance of any new TRICARE patients in these areas.

[3]An estimated 31 percent of nonenrolled beneficiaries experienced problems finding any civilian provider nationally (i.e., a civilian primary, specialty, or mental health care provider). To determine whether an area had at least 31 percent of nonenrolled beneficiaries who experienced problems finding any type of civilian provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the lower limit of the estimate. If the lower limit was 31 percent or above, then we included it as an area.

[4]To determine whether an area had less than 31 percent of nonenrolled beneficiaries who experienced problems finding any type of civilian provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the upper limit of the estimate. If the upper limit was below 31 percent, then we included it as an area.

[5]Twelve areas (all HSAs) were not included because they had less than 30 respondents.

Figure 16: Estimated Percentage of Nonenrolled Beneficiaries Who Experienced Problems Finding a Civilian Primary, Specialty, or Mental Health Care Provider, 2008-2011



Source: GAO analysis of TMA data (data); MapInfo (map).

Notes: Nationwide, an estimated 31 percent of nonenrolled beneficiaries experienced problems finding any civilian provider (i.e., a civilian primary, specialty, or mental health care provider).

We used the lower 95 percent confidence limit to identify areas for which 31 percent or more of nonenrolled beneficiaries experienced problems finding any civilian provider. We used the upper 95 percent confidence limit to identify areas for which fewer than 31 percent of nonenrolled beneficiaries experienced problems. Areas depicted in white indicate areas that did not fall into either of the above categories due to their 95 percent confidence interval.

We excluded areas from our analysis with fewer than 30 respondents combined for the three survey questions that asked if beneficiaries had problems finding a personal doctor or nurse, specialist, or treatment and counseling within the last 12 months.

TRICARE Management Activity did not identify additional Hospital Service Areas to survey for its 2011 beneficiary survey.

Table 10 lists the 24 individual areas where at least 31 percent of nonenrolled beneficiaries experienced problems finding any type of provider who would accept TRICARE patients, and the area's corresponding estimated percentage of civilian providers who would accept new TRICARE patients.

Table 10: Prime Service Areas (PSA), Non–Prime Service Areas (non-PSA), and Hospital Service Areas (HSA) with 31 Percent or More of Nonenrolled Beneficiaries Experiencing Problems Finding Any Type of Provider, and the Willingness of Civilian Providers in the Corresponding Areas to Accept New TRICARE Patients, 2008-2011

Area	Area type	Estimated percentage of beneficiaries with a problem finding any type of provider (margin of error)[a]	Estimated percentage of civilian providers accepting new TRICARE patients (margin of error)[b]
1. Austin, TX[c]	HSA	58 (18)[d]	46 (6)
2. Anchorage, AK[e]	HSA	56 (20)[d]	68 (4)
3. AK	PSA	51 (17)[d]	75 (4)
4. AK	non-PSA	51 (15)	70 (14)
5. Central-Eastern TX	PSA	49 (12)	59 (5)
6. Western-Central WA	PSA	48 (15)[d]	52 (8)
7. Dallas/Ft. Worth, TX[f]	HSA	48 (14)	50 (6)
8. Central/Southern-Central Coastal CA	PSA	48 (12)	45 (8)
9. Fredericksburg, VA[g]	HSA	48 (11)	74 (6)
10. Columbia/Sumter, SC	HSA	47 (13)	72 (6)
11. Prince William Co., VA[h]	HSA	47 (11)	74 (6)
12. Southern-Central AZ	PSA	47 (11)	59 (7)
13. Northeastern TX	PSA	47 (10)	53 (6)
14. Central-Northern VA	PSA	45 (8)	75 (4)
15. Fairfax Co., VA[i]	HSA	44 (10)	60 (5)
16. Northeastern OK	PSA	43 (12)	57 (6)
17. Washington, D.C.	PSA	43 (11)	55 (7)
18. Central-Southern MD	PSA	43 (9)	53 (6)
19. Southern AZ PSA; Southeastern CA	PSA	42 (10)	60 (5)
20. Southeastern FL	PSA	42 (9)	58 (6)
21. Southwestern MI	non-PSA	41 (11)	66 (7)
22. LA; Southwestern MS	PSA	41 (9)	60 (7)
23. Western-Central/ Northern/Southern TX	PSA	41 (9)	68 (7)
24. Central-Northern/Central-Eastern FL	PSA	40 (9)	71 (6)

Source: GAO analysis of TMA data.

Notes: The margins of error are at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the civilian provider survey.

To be included in this table, areas had an estimated 31 percent or more of nonenrolled beneficiaries who were having difficulties finding a provider who would accept TRICARE as payment (using the estimate's margin of error at the 95 percent confidence level).

Estimated percentages and margins of error have been rounded to the nearest whole number.

Each surveyed HSA was part of a PSA or non-PSA (depending on the location).

[a]Estimated percentage is based on the number of nonenrolled beneficiaries who responded "a big problem" or "a small problem" to any one of the following three questions: (1) "In the last 12 months, how much of a problem was it to find a personal doctor or nurse who would accept TRICARE?"; (2) "In the last 12 months, how much of a problem was it to find a doctor with this specialty who would accept TRICARE?"; or (3) "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?"

[b]Estimated percentage is based on the number of civilian providers who answered "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?"

[c]Although most of the Austin, Texas, HSA is within the Eastern-Central Texas PSA, one of its zip codes is part of the Western-Central/Northern/Southern Texas PSA.

[d]These estimates have relative margins of error that are 30 percent or greater.

[e]The Anchorage, Alaska, HSA is part of the Alaska PSA and the Alaska non-PSA.

[f]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

[g]The Fredericksburg, Virginia, HSA is part of the Central-Northern Virginia PSA.

[h]The Prince William County, Virginia, HSA is part of the Central-Northern Virginia PSA and the Central-Southern Maryland PSA.

[i]The Fairfax, Virginia, HSA is part of the Central-Southern Maryland PSA and the Washington, D.C. PSA.

Problems Finding Civilian Primary Care Providers

We identified 21 individual areas where the percentage of nonenrolled beneficiaries who experienced problems finding a civilian primary care provider who would accept TRICARE patients met or exceeded the national estimate.[6] We then identified 50 additional areas where the percentage of nonenrolled beneficiaries who experienced these problems was less than the national estimate.[7] The remaining 129 areas had

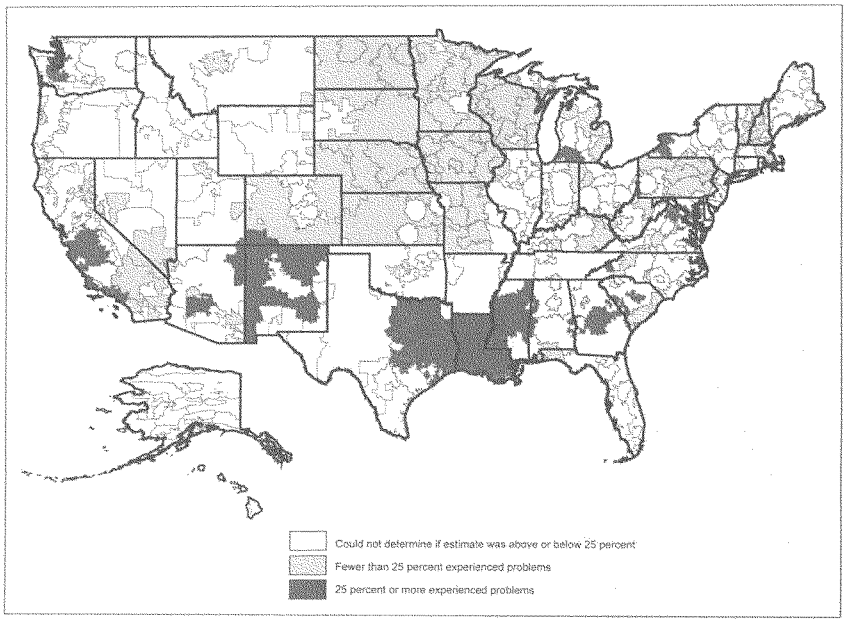
[6]Nationwide, the estimated percentage of nonenrolled beneficiaries who experienced problems finding a civilian primary care provider was 25 percent. To determine whether an area had 25 percent or more of nonenrolled beneficiaries who experienced problems finding a provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the lower limit of the estimate. If the lower limit was 25 percent or above, then we included it as an area.

[7]To determine whether an area had fewer than 25 percent of nonenrolled beneficiaries who experienced problems finding a provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the upper limit of the estimate. If the upper limit was below 25 percent, then we included it as an area.

estimates that ranged from 13 to 44 percent, but because of their confidence intervals, were neither above nor below the 25 percent threshold.[8] Figure 17 shows the geographic distribution of these three categories of areas.

[8]Fifteen areas (1 PSA and 14 HSAs) were not included because they had less than 30 respondents.

Figure 17: Estimated Percentage of Nonenrolled Beneficiaries Who Experienced Problems Finding a Civilian Primary Care Provider, 2008-2011



Source: GAO analysis of TMA data (data); MapInfo (map).

Notes: Nationwide, an estimated 25 percent of nonenrolled beneficiaries experienced problems finding a civilian primary care provider.

We used the lower 95 percent confidence limit to identify areas for which 25 percent or more nonenrolled beneficiaries experienced problems finding a civilian primary care provider. We used the upper 95 percent confidence limit to identify areas for which fewer than 25 percent of nonenrolled beneficiaries experienced problems. Areas depicted in white indicate areas that did not fall into either of the above categories.

We excluded areas from our analysis with fewer than 30 respondents to the survey 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?"

TRICARE Management Activity did not identify additional Hospital Service Areas to survey for its 2011 beneficiary survey.

Table 11 lists the 21 individual areas where at least 25 percent of nonenrolled beneficiaries experienced problems finding a civilian primary care provider who would accept TRICARE patients, and the areas' corresponding estimated percentage of civilian primary care providers who would accept new TRICARE patients.

Table 11: Prime Service Areas (PSA), Non–Prime Service Areas (non-PSA), and Hospital Service Areas (HSA) with 25 Percent or More of Nonenrolled Beneficiaries Experiencing Problems Finding a Civilian Primary Care Provider, and the Willingness of Civilian Primary Care Providers in the Corresponding Areas to Accept New TRICARE Patients, 2008-2011

Area	Area type	Estimated percent of beneficiaries with a problem finding a primary care provider (margin of error)[a]	Estimated percent of primary care providers accepting new TRICARE patients (margin of error)[b]
1. Austin, TX[c]	HSA	56 (18)[d]	42 (11)
2. Western-Central WA	PSA	47 (16)[d]	60 (13)
3. Prince William Co., VA[e]	HSA	44 (12)	80 (10)
4. Southern-Central AZ	PSA	44 (12)	67 (13)
5. Los Angeles, CA	PSA	42 (14)[d]	69 (9)
6. Columbia/Sumter, SC	HSA	42 (13)[d]	84 (8)
7. Central-Eastern TX	PSA	41 (13)[d]	67 (9)
8. Dallas/Ft. Worth, TX[f]	HSA	40 (14)[d]	51 (12)
9. Northeastern TX	PSA	40 (10)	48 (10)
10. LA; Southwestern MS	PSA	39 (10)	71 (11)
11. Asheville, NC	HSA	38 (11)[d]	68 (11)
12. Southwestern MI	non-PSA	38 (11)[d]	79 (9)
13. Central GA	PSA	38 (12)[d]	77 (9)
14. Eastern-Central TX	PSA	38 (12)[d]	53 (10)
15. Washington, D.C.	PSA	38 (11)	59 (14)
16. Central/Southern-Central Coastal CA	PSA	37 (12)[d]	64 (12)
17. Western NY	non-PSA	37 (12)[d]	64 (13)
18. Central MS	PSA	35 (11)[d]	88 (7)
19. Central-Northern VA	PSA	35 (8)	82 (6)
20. Central-Southern MD	PSA	33 (9)	69 (10)
21. Northern/Central/Western NM; Northeastern AZ; Southwestern CO	non-PSA	33 (8)	66 (12)

Source: GAO analysis of TMA data.

Notes: The margins of error are at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the provider survey.

To be included in this table, areas had an estimated 25 percent or more of nonenrolled beneficiaries who were having difficulties finding a civilian primary care provider who would accept TRICARE as payment (using the estimate's margin of error at the 95 percent confidence level).

Estimated percentages and margins of error have been rounded to the nearest whole number.

Each surveyed HSA was part of a PSA or non-PSA (depending on the location).

[a]Estimated percentage is based on the number of nonenrolled beneficiaries who responded "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?"

[b]Estimated percentage is based on the number of civilian primary care providers who answered "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?"

[c]The Austin, Texas, HSA is part of the Eastern-Central Texas PSA.

[d]These estimates have relative margins of error that are 30 percent or greater.

[e]The Prince William County, Virginia, HSA is part of the Central-Northern Virginia PSA and Central-Southern Maryland PSA.

[f]The Dallas/Ft. Worth, Texas, HSA is part of the Northeastern Texas PSA.

Problems Finding Civilian Specialty Care Providers

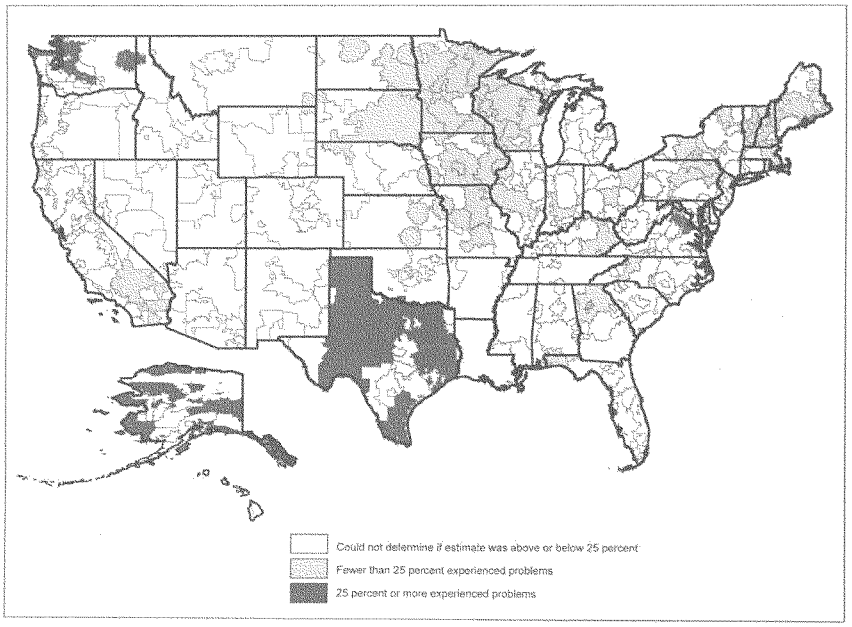
We identified nine individual areas where the percentage of nonenrolled beneficiaries who experienced problems finding a civilian specialty care provider who would accept TRICARE patients met or exceeded the national estimate.[9] We then identified 34 additional areas where the percentage of nonenrolled beneficiaries who experienced these problems was less than the national estimate.[10] The remaining 144 areas had estimates that ranged from 14 to 47 percent, but because of their confidence intervals, were neither above nor below the 25 percent threshold.[11] Figure 18 shows the geographic distribution of these three categories of areas.

[9]Nationwide, the estimated percentages of nonenrolled beneficiaries who experienced problems finding a civilian specialty care provider was 25 percent. To determine whether an area had 25 percent or more of nonenrolled beneficiaries who experienced problems finding a civilian specialty care provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the lower limit of the estimate. If the lower limit was 25 percent or above, then we included it as an area.

[10]To determine whether an area had fewer than 25 percent of nonenrolled beneficiaries who experienced problems finding a civilian specialty care provider who would accept TRICARE, we used the margins of error at the 95 percent confidence level to determine the upper limit of the estimate. If the upper limit was below 25 percent, then we included it as an area.

[11]Twenty-eight areas (2 PSAs, 2 non-PSAs, and 24 HSAs) were not included because they had less than 30 respondents.

Figure 18: Estimated Percentage of Nonenrolled Beneficiaries Who Experienced Problems Finding a Civilian Specialty Care Provider, 2008-2011



Source: GAO analysis of TMA data (data); Maptitude (map).

Notes: Nationwide, an estimated 25 percent of nonenrolled beneficiaries experienced problems finding a civilian specialty care provider.

We used the lower 95 percent confidence limit to identify areas for which 25 percent or more of nonenrolled beneficiaries experienced problems finding a civilian specialty care provider. We used the upper 95 percent confidence limit to identify areas for which fewer than 25 percent of nonenrolled beneficiaries experienced problems. Areas depicted in white indicate areas that did not fall into either of the above categories.

We excluded areas from our analysis with fewer than 30 respondents to the survey 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?"

TRICARE Management Activity did not identify additional Hospital Service Areas to survey for its 2011 beneficiary survey.

Of the nine individual areas where at least 25 percent of nonenrolled beneficiaries experienced problems finding a civilian specialty care provider who would accept TRICARE patients, one of the areas had less than 50 civilian specialty care respondents to the civilian provider survey—TMA's threshold for reporting civilian provider survey results. Therefore, we only included eight areas in our collective analysis of access to specialty care in the beneficiary and civilian provider survey results. Table 12 lists these eight individual areas and the area's corresponding estimated percentage of civilian specialty care providers that would accept new TRICARE patients.

Table 12: Prime Service Areas (PSA), Non–Prime Service Areas (non-PSA), and Hospital Service Areas (HSA) with 25 Percent or More of Nonenrolled Beneficiaries Experiencing Problems Finding Civilian Specialist Providers, and the Willingness of Civilian Specialist Providers in the Corresponding Areas to Accept New TRICARE Patients, 2008-2011

Area	Area type	Estimated percent of beneficiaries with a problem finding a specialty care provider (margin of error)[a]	Estimated percent of civilian specialty care providers accepting new TRICARE patients (margin of error)[b]
1. AK	PSA	49 (17)[c]	83 (6)
2. Northwestern/Central/Central-Eastern WA	PSA	45 (17)[c]	84 (8)
3. Central-Eastern TX	PSA	42 (15)[c]	76 (8)
4. Central-Northern VA	PSA	40 (9)	85 (6)
5. Northeastern TX	PSA	39 (13)[c]	75 (7)
6. Western-Central/ Northern/Southern TX	PSA	39 (12)[c]	79 (11)
7. Prince William Co., VA[d]	HSA	50 (13)	86 (8)
8. Fredericksburg, VA[e]	HSA	38 (12)[c]	78 (9)

Source: GAO analysis of TMA data.

Notes: The margins of error are at the 95 percent confidence level. Areas were considered only if they had at least 30 respondents for the beneficiary survey and at least 50 respondents for the provider survey.

To be included in this table, areas had an estimated 25 percent or more of nonenrolled beneficiaries who were having difficulties finding a civilian specialty care provider who would accept TRICARE as payment (using the estimate's margin of error at the 95 percent confidence level).

Estimated percentages and margins of error have been rounded to the nearest whole number.

Each surveyed HSA was part of a PSA or non-PSA (depending on the location).

[a]Estimated percentage is based on the number of nonenrolled beneficiaries who responded "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?"

[b]Estimated percentage is based on the number of civilian specialty care providers who answered "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?"

[c]These estimates have relative margins of error that are 30 percent or greater.

[d]The Prince William County, Virginia, HSA is part of the Central-Northern Virginia PSA.

[e]The Fredericksburg, Virginia, HSA is part of the Central-Northern Virginia PSA.

Problems Finding Civilian Mental Health Care Providers

Because of the low number of nonenrolled beneficiary responses to the questions about civilian mental health care,[12] we are unable to identify specific geographic areas where nonenrolled beneficiaries have access problems to civilian mental health care providers. Of the 215 areas surveyed in the 4-year beneficiary survey, only 5 areas had 30 or more respondents—TMA's threshold for reporting beneficiary survey results—who indicated that they needed mental health care and received it from a civilian provider. Additionally, for those 5 areas that did have at least 30 nonenrolled beneficiary responses, the margins of error were between 10 and 25 percentage points.

[12]In order for nonenrolled beneficiaries to respond 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?," they needed to have answered "yes" to the question that asked "In the last 12 months, did you need any treatment or counseling for a personal or family problem?" Additionally, nonenrolled beneficiaries had to have responded that their mental health care provider was a civilian provider.

Appendix V: Civilian Provider Acceptance of Any New TRICARE Patients in Hospital Service Areas Surveyed in Fiscal Year 2011

The TRICARE Management Activity (TMA) fielded its provider and beneficiary surveys to the same Hospital Service Areas (HSA) each year with one exception. Because of resource constraints, the 2011 fielding of the beneficiary survey did not include any HSAs. However, 16 HSAs were included in the 2011 fielding of the provider survey. Because beneficiaries were not surveyed for these HSAs, they are not included in our collective analysis of the beneficiary and civilian provider survey results. Table 13 lists the 16 HSAs that were surveyed in the 2011 civilian provider survey fielding and the estimated percentage of civilian providers who were accepting any new TRICARE patients.

Table 13: Hospital Service Areas (HSA) Surveyed in 2011, and the Estimated Percentage of Civilian Providers Who Were Accepting Any New TRICARE Patients

HSA	Estimated percent of civilian providers accepting new TRICARE patients (margin of error)[a]
1. Oklahoma City, OK	51 (10)
2. Madison, WI	52 (9)
3. Athens, OH	52 (10)
4. Tucson, AZ	56 (5)
5. Tulsa, OK	58 (9)
6. Nashville, TN	65 (7)
7. Lihue/Waimea/Wailuku, HI	66 (7)
8. Birmingham, AL	67 (6)
9. Laramie, WY	71 (14)
10. Hopkinsville, KY	72 (11)
11. Tacoma, WA	75 (8)
12. Augusta, GA	80 (5)
13. Rapid City, SD	81 (6)
14. Columbus, GA	84 (6)
15. Hampton/Newport News, VA	85 (4)
16. Petersburg/Hopewell, VA	91 (6)

Source: GAO analysis of TMA data.

Notes: The margins of error are at the 95 percent confidence level. Areas were considered only if they had at least 50 respondents for the civilian provider survey.

[a]Estimated percentage is based on the number of civilian providers who answered "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?"

Appendix VI: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAR 27 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's response to the Government Accountability Office (GAO) Draft Report, GAO-13-364, "DEFENSE HEALTH CARE: TRICARE Multi-year Surveys Indicate Problems with Access to Care for Nonenrolled Beneficiaries," dated February 25, 2013, (GAO Code 291045). Thank you for the opportunity to review and comment on the draft report.

Overall, I concur with the draft report's findings and conclusions. The report does not contain any recommendations, 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 on this matter are Dr. Richard Bannick (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Dr. Bannick may be reached at (703) 681-3638, and Mr. Zimmerman may be reached at (703) 681-4360.

Sincerely,

Jonathan Woodson, M.D.

Appendix VII: GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Jennie Apter; Linda Galib; Giselle Hicks; Jeff Mayhew; Lisa Motley; Dan Ries; and Eric Wedum made key contributions to this report.

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Chairman WALBERG. Without objection? Hearing none, it will be admitted. I thank the gentleman.

Now I recognize my good friend and colleague, NASCAR colleague, from North Carolina, Mr. Hudson.

Mr. HUDSON. Thank you, Mr. Chairman. And I am a proud supporter of this bill. And, frankly, I am outraged by the arrogance and the overreach by this agency, OFCCP. Congress clearly signaled our intent. And to paraphrase one of my colleagues, Congress doesn't pass suggestions, Congress doesn't pass things that we hope will happen. Congress passes laws. And the law has to be followed, Mr. Chairman, and the law was made very clear in 2011.

And the response from this agency was Congress has overstepped their bounds by telling us what we can do. That is outrageous. And now the response is, from the Secretary, well, we will do a moratorium for five years so we won't violate the intent of Congress for five years. But at the end of the five years, the heck with what Congress passed because we don't have to follow the law. And, frankly, that is outrageous, Mr. Chairman.

But I will address my question to Mr. Kirschner. You know, I travel my district in North Carolina. We have got rural hospitals that are, frankly, dealing with a lot of costs due to compliance with regulations and laws from the state and federal level. And, frankly, these hospitals are struggling. And with the cost of Obamacare, the uncertainty created by the new health care law and, frankly, having this regulation hanging over their head is just one more burden.

And what I guess my question to you, Mr. Kirschner, would be could you highlight what some of the burdens and the regulations that have to do with nondiscrimination, federal workforce compliance that hospitals have to deal with anyway? What are the costs in time and resources that are involved with complying with the law the way it exists now?

Mr. KIRSCHNER. The American Hospital Association is deeply concerned about the survival rate of hospitals, particularly those in rural areas. Hospitals, on average, spend approximately 20 percent of their revenues on administrative overhead already, separate from the OFCCP compliance. There are any number of laws that are applicable to them and will remain applicable: Title VII, state nondiscrimination laws, the *Americans with Disabilities Act,* FMLA, the NLRA. There is a whole alphabet soup of laws that will remain applicable.

In addition, there is oversight provided by HHS and the Office of Civil Rights that is applicable specifically to hospitals that will remain. So there is a lot of oversight already and nondiscrimination obligations that exist for every hospital.

To become a federal contractor then imposes a whole new scheme of obligations that non-federal contractors do not have to comply with. There may be some underlying similarities with respect to nondiscrimination compliance, but there is a reporting obligation for federal contractors that other employers do not have to do.

There is a variance in terms of the estimate of hours per time that will take. There was a reference earlier to the St. Jude Medical Center's prior testimony that said that there is hundreds and

hundreds of extra hours that are necessary just due to compliance with the recordkeeping obligations of the OFCCP.

So the added burden is really the concern that we have, where hospitals may be unknowingly and unclearly becoming federal contractors despite what Congress has said in section 715 of the NDAA and, in our view, the OFCCP's very vague and ambiguous standards for what makes you a federal contractor.

Mr. HUDSON. Well, I appreciate that. And it is stunning to think about 20 percent cost going towards just compliance. That is—you know, you think about any business—and a hospital is a business, whether it is a for-profit or not-for-profit hospital—in the business of taking care of their patients. And, frankly, we have a large TRICARE population, Mr. Chairman, in North Carolina in my district. And I want there to be incentives for people to provide- for more providers to engage in TRICARE.

And so I appreciate the testimony of the witnesses today. And, Mr. Chairman, again, I am very supportive of this legislation. I thank you for your work.

And I will yield back the balance of my time.

Chairman WALBERG. I thank the gentleman.

And now I recognize my friend and colleague from the great state of Ohio, and sharer of the Great Lake Erie, for her five minutes.

Ms. FUDGE. Thank you very much, Mr. Chairman. I thank all of you for being here today.

Ms. Graves, you cite in your testimony a study that found female employment by federal contractors increased seven times as much between 1974 and 1980. A period which includes the establishment of OFCCP in 1978. That increase is significantly higher than in periods where there was not federal contracting settings such as we have today. Do you think that the health care industry could benefit from the unique responsibilities and enforcement mechanisms of OFCCP, like the affirmative action plan?

Ms. GRAVES. Well, certainly. You know, to begin with, there is clear, documented discrimination based on race and sex in the health care industry. There have been a number of studies that have talked about that, that have talked about the wage gap between male and female physicians, the race discrimination that occurs among physicians. But beyond that, diversity in the health care workforce is very much tied to the core purpose in providing quality patient care. There is evidence that diversity in the health care field absolutely improves patient care.

The other thing is that OFCCP is slightly different from some of the other agencies because of its affirmative enforcement scheme. And this is especially important when we are talking about types of discrimination that is difficult to detect. So hiring discrimination, pay discrimination, these types discrimination the individuals are not as likely to know that they have experienced it.

Ms. FUDGE. Thank you very much.

Mr. Kirschner, in your testimony from December 14, 2013 you cited the testimony of Ms. Dana Bottenfeld—Bottenfield. And she talked about the frustration she had with affirmative action plan procedures. Do you further agree with her testimony that she believes that these procedures, these affirmative action plans, are important?

Mr. KIRSCHNER. I am not familiar with the extent that—the specific quote that you are referring to from the December testimony.

Ms. FUDGE. I am quoting from you.

Mr. KIRSCHNER. I know that. I am generally familiar with her testimony. I would say that four hospitals that have knowingly agreed to become federal contractors—and they accept the obligations that flow with that—then it is important for those hospitals to comply with the law. Which would include having affirmative action programs and otherwise complying with the OFCCP.

Ms. FUDGE. Thank you very much. So you agree with her testimony.

Mr. Carrato, in your testimony you indicate that you are proud to be the longest-serving managed care contractor. And, certainly, I know that is important, and I applaud you, as well, and congratulate you. Health Net is justified to feel this way and I agree, having served the Department of Defense and the Veterans Administration for 25 years or better. A high-quality product is provided by your company. Do you think that some of the pride that you feel may also be a result of meeting and exceeding the high standards that are embedded in any federal contract, including those requirements enforced by OFCCP?

And I ask that because I think it is very important for us to understand we are using taxpayers' dollars, we are held to a higher standard and should be held to a higher standard. And that it is not an entitlement to do business with the federal government. And so I ask the question because since you have been so successful that means that you have at least met, and/or exceeded, the requirements of a contract.

Mr. CARRATO. Yes. You know, Health Net Federal Services is a federal contractor. And we are a federal contractor. Certainly, affirmative action and diversity in the workplace we have benefited from. We understand the issue of veterans' unemployment. We have joined with the White House supporting the joining forces effort. We are committed to, you know, employing veterans. And we are committed to diversity.

The issue today is the hospitals and providers that are in our network. I think the issue is classification. As network providers, they are required, as Mr. Kirschner said, to comply with, and we enforce that in our contracts with all affirmative action state-local regulation. We just believe that OFCCP classifying them as contractors and subcontractors just brings additional regulatory burden. And as they are making a business decision whether to continue to support our men and women in uniform and our veterans, many are staying on the sidelines. And most, if not all, are very concerned. And this five year moratorium will not alleviate those concerns.

Ms. FUDGE. Well, certainly I disagree.

But I yield back, Mr. Chairman. My time has expired.

Chairman WALBERG. I thank the gentlelady.

And now I recognize the distinguished chairman of the Education and Workforce Committee, Mr. Kline.

Mr. KLINE. Thank you, Mr. Chairman. Thanks to the witnesses for being here today. Mr. Goldstein, real pleasure to see you. I know you hated to leave balmy Minnesota to come out here, but—

Mr. GOLDSTEIN. To windy Washington.

Mr. KLINE. A sacrifice you are willing to make. Good to see you all, and thanks for the testimony.

I hate that we are in this position. Because I can't speak for the Ranking Member, but I think that he and I both believed that we had addressed this in the *National Defense Authorization Act.* And, certainly, I believe that the will of Congress was made pretty clear in terms of OFCCP's jurisdiction here. And yet here we are. We have got a lawsuit in Florida, we have got you here, we have hospitals—I am going to get to you in just a minute, Mr. Kirschner. A lot of uncertainty out there about what they are supposed to do. And the Secretary has said he is going to have a moratorium on enforcement.

The law doesn't go away, the interpretation doesn't go away, a subcontract is still a subcontract. But for five years, they are not going to enforce it. Although they are apparently going to have people helping hospitals to understand how they are going to have to comply in five years from now. So I was struck a little bit, that, apparently, the suggestion—at least it was implied, or I inferred, that the solution here would be to have a better President, a better Secretary of Labor and then this will go away.

That is a terrible position for us to be in. It is a terrible position for the providers to be in. So it seems to me that Congress is going to have to speak again, hence this legislation to make it clearer that jurisdiction of OFCCP doesn't apply here. It matters—and we have had this discussion many times in this Committee and the full Committee—how we write laws. And the clearer we are and the more explicit we are, the less chance there is for misinterpretation. We have, oh, I think it is a couple of million people now employed by the federal government in the bureaucracies.

We have tens of thousands of pages of regulations that come every year that individuals and businesses and unions and everybody has to read, understand, and try to deal with. But when we write law and we think we are being clear about it, and we still get in this position, I, and I think many of my colleagues, are fairly frustrated. So I want to get to the impact, and I am going to go to you, Mr. Kirschner, because you mentioned it earlier. This isn't a question of just deciding to be nondiscriminatory. This is a question of additional reporting, additional paperwork—a burden, if you will—added to everything that was already there, all those things you talked about earlier, state law and the ADA and all of those things, this is added on to that.

And so you have got providers who, by a couple of testimony here, are actively considering or have already considered not providing the service for TRICARE, for example. And as somebody who had his health care provided by TRICARE and whose family did for many years, I would—-—that would be very, very painful. That would be an awful thing to happen. So can you again talk about what this OFCCP jurisdiction is doing to that workload.

And by the way, the moratorium, as I said, doesn't change the law. It just changes whether or not they are going to enforce the law. But could you address that for us one more time again, what happens here and why hospitals are saying we don't want to do this?

Mr. KIRSCHNER. Sure. If a hospital is a federal contractor, then there is a whole scheme of regulations that do apply to them, ranging from how they track intake of applicants and how they report that, how they create reports related to affirmative action and other items. And these are done in a very particular way, as required by the OFCCP, that is unrelated to the normal business operations of the hospital. So it is not as if the hospital has its reports that it just has to turn over to the OFCCP. Rather, the OFCCP requires the hospitals to maintain information and gather information in a way unrelated to anything else that they do.

There are hundreds of hours that are required to be done by the hospital just to comply on a regular basis with the OFCCP regulations. And when there is an audit, those audits can last for years and they can be very time-consuming.

Mr. KLINE. So I see my time is about to expire. So there is a legitimate business decision that is going to have to be made based on cost in dollars and cost in time. And we are going to have people who will suffer. I see my time has expired.

I yield back.

Chairman WALBERG. You—you may continue, Mr. Chairman. I just wanted to have that opportunity to say that to you, and recognize the next time I have that opportunity you would—

Mr. KLINE. No, let me be clear here. I yield back.

[Laughter.]

Chairman WALBERG. I thank the Chairman.

Now I recognize my friend and colleague from Indiana, Mr. Rokita.

Mr. ROKITA. I thank the Chair and I thank the witnesses, and good morning to each of you.

I want to quickly go to Mr. Kirschner here, and just simply ask if you had anything to add about Ms. Graves' testimony. It was characterized that you agreed with what she was saying, at an early on question. Did you want anything else on the record?

Mr. KIRSCHNER. My statement is that to the extent that a hospital or other contractor has an obligation, as a bona fide contractor, to comply with an affirmative action program I think that is legitimate. But what I don't think is legitimate is that if a hospital signs up for a contract, and is told in that contract that they are not a federal contractor, has no clear knowledge that they are a contractor, and then after the fact the OFCCP comes in and says, "Oh, by the way, for the last X number of years you may not have known this, but you were a federal contractor and you have been out of compliance with the law for years."

That is the situation we are trying to clarify and, with support of this bill, to make it clear that providers under these federally-funded health plans are not federal contractors.

Mr. ROKITA. Yes, that we are going to follow the rule of law, not the rule of man.

Mr. KIRSCHNER. Right.

Mr. ROKITA. Yes, thanks. I am getting that sense here at the hearing today. It is a shame, though, and I associate my comments with the full Committee Chairman, that we have to say again what we intended the first time.

Mr. Goldstein, you note in your testimony, you talked about, the Florida Hospital of Orlando case. And, you know, one of the reasons we are here today is that the board took, what you say was, an unprecedented action. If I understand it right, the ALJ initially agreed with the hospital that they weren't going to be contractors or subcontractors. And then the full board, the review board, then kicked it back down, where it now sits at the ALJ level. Can you expand on that? Why is this so unprecedented?

Mr. GOLDSTEIN. What happened is, the administrative review board originally agreed with Florida Hospital and found that OFCCP did not have jurisdiction because of the congressional action. It was done and it would have resolved the issue, and it would have been clear TRICARE does not create OFCCP jurisdiction.

Mr. ROKITA. Yes.

Mr. GOLDSTEIN. OFCCP asked the administrative review board, which basically represents the judgment of the Department of Labor—asked it for reconsideration. Which, in my experience—

Mr. ROKITA. Which is not unusual. Oh, that is unusual.

Mr. GOLDSTEIN. In my experience, that is very unusual.

Mr. ROKITA. Okay.

Mr. GOLDSTEIN. If not unprecedented, and the ARB granted that reconsideration which, again, is very unusual if not unprecedented. And in a divided opinion, found that this act of Congress did not, in the judgment of three of the board members, divest OFCCP of jurisdiction. Sent the case back down to an administrative law judge for further proceedings, basically delaying the final day when a federal district court gets to determine what did Congress actually mean when it enacted section 715.

Mr. ROKITA. So when you say "unprecedented," do you mean that it is unprecedented within the jurisdiction and precedential decisions of the Department of Labor's administrative review board? Or within federal government agencies, as a whole?

Mr. GOLDSTEIN. To my knowledge, within the ARB; I don't know the answer with regard to federal agencies as a whole.

Mr. ROKITA. Okay, thank you.

Mr. Carrato, thank you for your testimony today. The Department of Labor—of course, and the reason why we are here—stated TRICARE providers are subcontractors of the federal government. I guess what I am wondering, though—and I want you to expand on it—they seem to be the moose on the table, the Department of Labor. But do other federal agencies consider TRICARE providers to be federal contractors? I mean, that is to say are there broader issues associated with the OFCCP's—

Mr. CARRATO. Yes, there are much broader issues. And I think, historically, this question has come up as to how to classify providers. And in addition to OFCCP regulation, there are a host of flow-down provisions that would flow to federal contractors: you know, the FAR, the DFAR, which requires certain cost accounting systems, disclosure statements. So there would be—if TRICARE providers were, indeed, classified as contractors, there would be a host of additional burdens. So to my knowledge today, no other federal agency—to include the Department of Defense—considers them subcontractors.

Mr. ROKITA. Oh, and I am just thinking about this, I guess. That if they were considered ultimately, legally, contractor to subcontractors, now they would be subject to the President's new executive order on raising the minimum wage.

Mr. CARRATO. Correct.

Mr. ROKITA. Which would have costs as well.

Mr. CARRATO. All flow-down provisions.

Mr. ROKITA. Right. Mr. Kirschner?

Mr. KIRSCHNER. Yes. If I may just add to that, the Department of Defense actually has its own regulation classifying providers in TRICARE as not federal contractors. So it is not just that they haven't taken a position, but they have taken a position contrary to that taken by the OFCCP. And the Office of Personnel Management, similarly, has a regulation classifying participants in the FEHBP program as not federal contractors. And the OFCCP has disagreed with them, as well.

Mr. ROKITA. Rule of law versus rule of man.

Mr. Chairman, I yield back.

Chairman WALBERG. I thank the gentleman.

I recognize now a second distinguished representative from Indiana, the birthplace of my first two kids, Mr. Bucshon.

Mr. BUCSHON. Thank you very much. Thanks to the panel for being here today, and I will give you my background. I was a cardiovascular and thoracic surgeon prior to coming to Congress in 2010, and have been in the health care industry for 30 years since I went to medical school in the mid-1980s. And my wife is also a physician, an anesthesiologist, who currently continues to practice medicine.

And, you know, I have recruited physicians, I have recruited all kinds of other health care employees as the president of my medical group. And so when, Ms. Graves, you commented and you made the allegation that the health care industry has purposefully continued to discriminate based on sex and race and other things I take offense to that. Because I think that I would like you to submit, for the record, evidence, which you have specifically on the health care industry, that there is discrimination. That is not a question. So I know you turned your mike on, but I am not asking for a response.

Ms. GRAVES. Oh, it wasn't a question? Oh.

Mr. BUCSHON. But whatever hearing I go to, whatever subject, when I hear people make allegations that may or may not be substantiated I always ask witnesses, regardless of the subject, to submit their evidence and data to the subcommittee and to my personal office to back up those claims.

Because my wife has been hired by multiple different hospitals and she gets paid the exact same amount as any other anesthesiologist that they hire. I have hired a female cardiovascular and thoracic surgeon for my practice, paid exactly the same as the male cardiovascular and thoracic surgeons, as are any of the other employees.

So if you would, for the record, submit the evidence that you have that proves what your claim, that there is still discrimination.

Ms. GRAVES. I would be pleased to do that.

Mr. BUCSHON. Thank you.

Mr. Carrato, in your testimony your expressed concerns about Health Net's ability to provide military members and their families access to high-quality providers, especially in rural areas and areas far from military treatment facilities, where there are already shortages of providers. And I would just like to say, in Evansville, Indiana there is a VA clinic but there is no VA hospital, and patients have to go to St. Louis, which is about three hours away, for surgery if they needed that, for heart surgery.

You mentioned that specialties are already in short supply—psychiatry, neurosurgery, and dermatology, for example. Could you elaborate on the extent of the shortages and the access issues already?

Mr. CARRATO. Certainly. And as you well know, there are certain specialties in short supply. You know, adolescent psychiatry, dermatology. And as a business decision, providers need to make a decision how to titrate their panel of patients. And the reimbursement rates, as Mr. Courtney mentioned, don't make TRICARE the most attractive payer to participate in. So any additional burden or regulation makes our ability to recruit and retain providers much more difficult. And it essentially is supply and demand.

And in certain rural areas where we place our military installations—you know, Watertown, New York, Fayetteville, North Carolina, rural Indiana, as you said—there is not the abundance of providers, and they have to make a business decision. They have to decide what payers that they want to support.

Mr. BUCSHON. Thank you, very much. Because I do represent a very rural area. And not only for military veterans, but for everyone, access to health care providers, particularly specialists, is becoming a critical issue across our nation, not only for—again, for people in the military.

And in my medical practice I had the opportunity to treat many veterans. And frequently, if they were requested by the VA to be transferred to another facility I did it for free, and wrote it off, and got my hospital to do the same. Because I didn't feel it was fair that their families and them had to travel three hours for heart surgery, when I could do it, you know, down the street.

Mr. CARRATO. Right.

Mr. BUCSHON. And so I am going to go on the record and say that since I have been in medical practice and in Congress I support the ability for military veterans to have a card in their pocket and get health care at their facility of choice, regardless of whether that is the VA system or private facilities, if there is not access to the appropriate VA care within a reasonable area around them.

With that, Mr. Chairman, I yield back.

Chairman WALBERG. I thank the gentleman. I thank the panel for your response to our questions and, for our colleagues, the questions that you had, hoping leading to greater understanding.

So now I recognize the Ranking Member, Mr. Courtney, for his closing remarks.

Mr. COURTNEY. Thank you, Mr. Chairman. And, again, I want to again tip my hat to you and your staff in terms of, again, flushing this issue out. And, in my opinion, resulting in accomplishing real change in terms of what was clearly an issue about interpretation of a statute that Congress acted on and I think had clear intent.

And a new Secretary of Labor who listened, and has really talked to people and interacted with people.

You know, I think, in my sort of final thoughts here I just want to make the observation that if H.R. 3633 were to pass the House, pass the Senate and be signed into law by the President—which I frankly think there is a high level of skepticism in my mind that actually would happen—the fact of the matter is, is the next day we would still have a terrible challenge in terms of access to health care for TRICARE.

I mean, the issues that have been identified by GAO, the issues that I have heard over and over again in the last seven years in terms of retirees and veterans who qualify for TRICARE, getting access to care is all about reimbursement and doctors and providers' willingness to basically lose their shirts every time they take on a new patient.

And, again, the GAO study clearly demonstrates that. Again, I think every person on this subcommittee, if, you know, we were given the opportunity to really kind of, again, boost the financial support for that program there would be strong support for it. In fact, the Senate had a measure a couple days ago Senator Sanders proposed which, again, would have a historic new investment in terms of veterans health care services. In my opinion, that is clearly the best way to strengthen the network of access for veterans in this country.

You know, the focus here today, obviously, though is on the question of OFCCP jurisdiction. Again, I think that the Secretary could have, you know, gone into the Washington, D.C. crouch and listened to the lawyers, maybe, and his agency and said I am not gonna extend myself to try and listen to people and do anything. But the fact is, is that, as in the case of OSHA recently, he has really shown a willingness to listen to Congress and to react.

And to come out with something that—again, I am disappointed, frankly, that people have dismissed here today some of the witnesses about the value of it. A five year moratorium, again, takes this out of the scope of this administration. Nobody is stipulating to anything in terms of, you know, you are not being subject to a court order or relinquishing your legal position here in terms of the interpretation of the prior bill. Which, by the way, the language of that is different than H.R. 3633.

It is not like we are just re-passing that language. I mean, there is "shall" language now in this as opposed to "may" language before. So, you know, again I have been around enough lawyers to know that people can fight over, you know, a couple words, or commas even sometimes in terms of the way statutes get written. But the fact is, is I think that this Secretary has shown a willingness to, in my opinion, give a very robust area of certainty on whether or not OFCCP jurisdiction is gonna, in fact, apply towards TRICARE providers.

And, frankly, I don't think he is done in terms of that dialogue and that discussion. That, you know, we are, I think, gonna still see him in our Committee rooms and in our offices, and is willing and open to continue this discussion as far as other programs are concerned in terms of Medicare and FEHBP. This is not someone

though, in my, you know, estimation has shown, you know, again, just a rigidity or unwillingness to talk and interact with people.

So I practiced law for over 20 years. I was with a bunch of litigators who were fearless and loved, you know, the conflict and going into the courtroom. But we had a sign that hung in our office that was a quote from Abraham Lincoln, which said, "Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often the real loser in fees, expenses and waste of time." And, you know, I would remind you of that quote in order to what the Secretary did in terms of where we are today.

Again, I respect the Chairman's passion on this issue. And it may be that this issue is gonna come to the floor. But, again, this is a Congress whose batting average isn't that great in terms of getting across the finish line. And I think it is gonna run into resistance maybe further along in the process. And I think, in the meantime, you can take credit for accomplishing something here in terms of having the department reevaluate its position.

As the Secretary said, I did the forensics. He did the forensics to understand better what the Armed Services Committee did and he made an adjustment. And I think that is a great accomplishment, and something that you should be very proud of.

And with that, I yield back.

Chairman WALBERG. I thank the gentleman. And I would concur with much of your sentiment there. And it is not a purpose of this hearing to necessarily push forward a piece of legislation. And you are right, we don't have a great record of getting our colleagues on the other side of the Capitol to take up legislation—good, bad or indifferent—and move it forward. However, it is important to have the discussion.

I also certainly applaud the Secretary. This little note paper is my notes I took sitting in my red 2006 Hemi Dodge 2500, three-quarter ton pickup truck outside of a town hall in Grand Ledge, Michigan, on the banks of the Grand River, when the Secretary was willing to call me and talk about this issue. So I appreciate that very much. And we have had open dialogue in my office and in my pickup truck. And wherever he was, I have no idea, at that point in time. But we discussed that.

And we need to continue discussing it. I appreciated the letter that he sent. It didn't include every item that we discussed that afternoon. That would have been included in the letter. So there is certainly more discussions I will have with him, and ask why. We can assume things. But for the record, and in the reality, we want to make sure things are solid, buttoned up, and move forward. But I think it even goes beyond that. I am willing to give credit where credit is due, and enabling ability to help us work together is great.

But in the end, we want to make sure we have a framework in place that not only encourages economic growth, the opportunity for health care to be there and available. Certainly, everyone in this subcommittee and on the full Committee would never, never countenance anything that denied employment because of an individual's gender or their disability, their race, or their religion, or the fact that they were military veterans. But on the other side of the ledger, we want to make sure that we don't put so much uncer-

tainty in place, at the very least, that decisions are made that will take away opportunities for people to have the type of care that, in this country, they ought to have.

That would have the opportunity to have employment in facilities that are viable and growing and moving forward and, in fact, expanding to meet the needs of this great citizenry we represent. I think, as well, this is an opportunity to make sure that the dialogue, the debate that we even had yesterday on the floor of the House, pushing back on our executive, making decisions and, in fact, rewriting laws without the authority that the Constitution gives, regardless of party, the issue of the separations of power. The authority that the people have. As Washington said, I believe it was, when asked about our government, "Here, the people rule."

And we are the elected representatives of the people to represent them and, on their behalf, make laws. And expect those laws—good, bad or indifferent—until changed, to be the law of the land. And that is my concern. That we have not got to that point right now with OFCCP, and their description, definition of who a subcontractor is or a provider. And they are, in fact, as I believe, going against what was decided by law in the NDAA provision.

So this is a worthy discussion to continue. We will go on. I am certain I will talk with the secretary. I am certain that we will push for adequate solution.

But I also want to make sure that we don't have simply five years of uncertainty. And ultimately, decisions made on the basis of the fact that we can't just be uncertain for five years. We are gonna make decisions now that impact, sadly, in negative ways the people that we ought to be serving.

So I appreciate this hearing today. We will certainly continue on in various ways. But we want to move forward for the good our country, for the good of our citizens and so that everybody has opportunity equal to all.

There being no further business, the Committee stands adjourned.

[Additional Submissions by Ms. Graves follow:]

Supplemental Testimony of Fatima Goss Graves
Vice President for Education & Employment
National Women's Law Center

House Committee on Education and the Workforce
Subcommittee on Workforce Protections

Supplemental Testimony Following Hearing on H.R. 3633: "Protecting Health Care Providers from Increased Administrative Burdens Act," March 13, 2014

Chairman Walberg, Ranking Member Courtney, and members of the Subcommittee:

Thank you again for the opportunity to testify before the Subcommittee on the important topic of the civil rights obligations of federal contractors and subcontractors. During the Hearing on H.R. 3633 on March 13, 2014, I was asked by Representative Bucshon to provide additional information on discrimination in health care. The following supplemental testimony provides a brief overview of the documented discrimination experienced by health professionals.

1) **Ensuring Equal Opportunity Is Especially Important in the Health Care Industry, Where Many Health Care Workers Report That They Have Experienced Discrimination in the Workplace.**

The federal government has a vital interest in ensuring that its health care contracts support a health care workforce that is free from discrimination and that effectively serve this country's diverse patient population. Yet employment discrimination remains pervasive in the health care industry and women and people of color remain especially underrepresented in many health care occupations.

Hispanics, for example, are underrepresented in every single health care occupation listed by the Bureau of Labor Statistics, including physicians and surgeons (5 percent), nurse practitioners (3 percent), dentists (3 percent), and pharmacists (5 percent).[1] African-Americans are underrepresented in almost three quarters of health care occupations listed by the Bureau of Labor Statistics.[2] They make up only 7 percent of physicians and surgeons, 4.5 percent of nurse practitioners, 2 percent of dentists and 3.3 percent of dental hygienists, zero percent of chiropractors, and 5 percent of paramedics.[3] Women are disproportionately represented in the health care industry overall, yet they are significantly underrepresented in a range of health care occupations, including physicians and surgeons (34 percent), paramedics (31 percent), and chiropractors (22 percent).[4]

Despite efforts to address discrimination and improve diversity, national surveys continue to reveal pervasive discrimination in the health care workforce. Surveys of physicians from the 1990s indicated that almost half of all non-majority physicians reported experiencing

discrimination based on race and ethnicity.[5] Over a decade later, a 2006-2007 national survey showed that a substantial proportion of non-majority physicians report experiencing racial or ethnic discrimination at work.[6] Specifically, the survey found that compared to 7 percent of white physicians, 71 percent of black physicians, 44 percent of Asian physicians, 63 percent of "other" race physicians, and 27 percent of Hispanic/Latino(a) physicians reported experiencing discrimination sometimes, often, or very often during their medical career.[7]

Moreover, new research indicates a persistent and growing gap in earnings between male and female physicians over the last 20 years.[8] In 1987-1990 the gap in earnings between male and female physicians was substantial, with men earning $33,840 (20 percent) more than their female counterparts on average. But by 2006-2010, the gender gap had increased to $56,019 (25.3 percent).[9] Another study showed that this pay gap is not explained by gender differences in choice of specialties. Among general internists and pediatricians, for example, female physicians of all races/ethnicities had significantly lower incomes than their white male counterparts.[10] That study, which adjusted for multiple factors including work effort, physician characteristics, and practice characteristics, also found a trend toward a widening of the income gap over time.[11] The same study found that female family practice physicians had much lower incomes than male physicians in family practice.[12]

Recent cases illustrate some of the illegal discrimination that health care workers experience—including racially hostile workplaces, sexual harassment, and retaliation. For instance, the Seventh Circuit Court of Appeals recently rejected a nursing home's argument that it could discriminate against its Black employees to cater to the racial preferences of its residents.[13] Specifically, the court found that the nursing home created a hostile and "racially charged" work environment in which coworkers directed "racial slurs" at the plaintiff on multiple occasions by "acced[ing] to a patient's racial preferences" when it did not allow plaintiff to provide care to a resident who did not want care from a Black nursing assistant.[14] In another case, the EEOC reached a settlement with a hospital in a class race and sex discrimination lawsuit alleging that the hospital segregated a class of Black female employees in job assignments based on their race, retaliated against at least one female employee for objecting to unlawful employment practices, and required Black female medical technicians to perform assignments not required of their male Asian-Indian counterparts.[15]

Female health care workers also report being treated differently from their male colleagues, including facing pressure to conform to sex stereotypes and sexual harassment.[16] For example, nearly 30 percent of female medical faculty members reported experiencing serious forms of harassment—such as unwanted sexual advances or threats—compared to 3 percent of male faculty.[17]

As women and people of color continue to confront discrimination in the health care field, the Department of Labor OFCCP's important work in enforcing nondiscrimination obligations has a strong nexus to the federal government's vital interest in ensuring that it contracts with health care institutions that are free from discrimination and thus well-equipped to improve patient care.

2) **Enforcing Civil Rights Laws Can Reduce Disparities in Health Care Treatment and Outcomes.**

The efficiency benefits of diverse workforces are particularly apparent in the health care field, where workforce diversity is associated with reduced health care disparities and improved patient care. Diversity in the health care workforce can thus help hospitals achieve their core purpose in providing quality patient care, especially in light of the challenges of caring for the country's diverse patient population. Numerous sources highlight the importance of a diverse workforce as a key strategy for improving cultural competency, reducing language barriers, and addressing health care discrimination.

a) **Health care disparities exist based on race, national origin, sex and sex stereotypes, and disability.**

Racial disparities exist in receipt of cancer diagnosis and treatment; treatment of HIV/AIDS; and diabetes, mental health, and cardiovascular care, among others.[18] In each of these areas, "African Americans, Hispanic Americans, and American Indians tend to receive less and lower quality health care than whites, resulting in higher mortality rates."[19] For example, one study found that door-to-drug and door-to-treatment times were significantly longer for nonwhite cardiac patients than for white patients.[20] The study's authors concluded that differential treatment inside the hospital played a role in the disparity.[21] Another recent study reported that African-American children who go to an emergency room with stomach pain are less likely than white children to receive pain medication and more likely to spend long hours in the emergency room.[22]

Discrimination on the basis of national origin, which encompasses discrimination on the basis of limited English proficiency (LEP),[23] also creates unequal access to health. There are approximately 25 million individuals in this country with Limited English Proficiency ("LEP"), of whom 84 percent are of Hispanic or Asian origin.[24] LEP is often compounded with the "cumulative effects of race and ethnicity, citizenship status, low education, and poverty," resulting in more barriers to access.[25] Language barriers may lead individuals to delay or forego crucial health services.[26] Language barriers also increase risks to patient safety, through poor exchanges of important information, misunderstandings about a physician's instructions, or difficulty obtaining information.[27]

Sex discrimination, which includes discrimination based on pregnancy, gender identity, and sex stereotypes, takes many forms and occurs at every step in the health care system—from obtaining insurance coverage to receiving proper diagnosis and treatment. This discrimination seriously harms women and threatens their health, causing them to pay more for health care and to risk receiving improper diagnoses and less effective treatments. Studies have found that women receive inadequate care when gender bias inappropriately influences medical decision-making. For example, a recent study of emergency room patients reporting similar symptoms found that men were more likely than women to receive morphine to help treat pain.[28] Indeed, the Institute of Medicine has recognized that gender disparities in pain care result from "neglect, dismissal and discrimination from the health care system."[29] While progress has been made, past and current exclusion of women in medical research continues to negatively affect advances in

women's health. Intentional exclusion and under-inclusion of women in clinical trials, including the failure to adequately recruit women to participate in medical research, is a long-standing and well-documented problem.[30] Research that uses an exclusively male model to evaluate and understand women's health needs means that women cannot receive medical care of the same quality provided to men.

Discrimination based on gender identity, gender expression, and sexual orientation is also a persistent problem in our health care system. LGBT individuals consistently face health care discrimination, including verbal abuse, physical abuse, and outright refusals of treatment. This is especially true for transgender and gender nonconforming individuals.[31]

People with disabilities experience significant health disparities and barriers to health care, as compared with people who do not have disabilities.[32] In fact, people with disabilities are 2.5 times more likely to have unmet health care needs than non-disabled peers. Individuals with all types of disabilities report discriminatory physical, programmatic, and attitudinal barriers to accessing health care in hospitals, clinics, diagnostic facilities, and practitioners' offices of all sizes throughout the country.[33] According to the Alliance for Disability in Healthcare Education, "Without training, healthcare providers tend to: underestimate the abilities of patients with disabilities; grossly underestimate the quality of life of patients with disabilities; minimize the patient's capacity to contribute to their own care; and minimize the extent and importance of the patient's expertise in [their] own condition.[34] Moreover, scientific evidence is lacking about effective treatments for people with disabilities, especially those who develop common conditions of aging (e.g., cancer, heart disease, diabetes) because they are routinely excluded from clinical trials and creating comparative effectiveness research aimed at people with disabilities presents complex challenges.[35]

b) Diversity in the Health Care Workforce Is Associated with Reduced Health Disparities and Improved Patient Care for an Increasingly Diverse Patient Population.

The Institute of Medicine, among other institutional bodies, prioritizes increasing the number of minority health professionals as a critical component for addressing health disparities and improving patient care.[36] Diversity in the health care system can counteract biases and combat discrimination by improving cultural and linguistic competency, thereby improving provider-patient communication and patient care.[37] A diverse health care workforce can also broaden research agendas, ensuring studies address health conditions and health care delivery issues of particular importance to underserved minorities.[38] In addition, minority physicians are often more likely to choose to become primary care practitioners and to decide to serve underserved areas and care for individuals who are uninsured or underinsured.[39] A diverse health care workforce can also lead to more diverse enrollment in clinical trials that aim to lessen health disparities.[40] Studies suggest that researchers who share common language or cultural beliefs with minority patients can more successfully break down the barriers of fear and distrust of health professionals and the health care system that can keep minority populations from participating in research trials.[41]

In particular, the federal government has a vital interest in contracting with health care institutions that are equipped to serve the interests of the growing population of patients with LEP. Research has established that care improves when patients are treated by medical staff that speaks their language. In a 2006 review of evidence regarding diversity in the health professions, the Department of Health and Human Services found that "non-English speaking patients experience better interpersonal care, greater medical comprehension, and greater likelihood of keeping follow-up appointments when they see a language-concordant practitioner, particularly in mental health care."[42]

* * *

Addressing discrimination and improving diversity in the health care workforce are key strategies to improving patient care and reducing health disparities—goals the federal government has an important interest in advancing. "Racial inequity in health care delivery and in minority access to the health professions has lasted for centuries in no small part due to systemic, or institutional, racism."[43] A lack of diversity into the health care workforce "contributes to the gap in health status and impaired access to health care experienced by a significant portion of our population."[44] A "health workforce that is culturally sensitive and focused on patient care" benefits not only minority patients, but can also "improve patient access, patient satisfaction, and improve quality of care for all patients.[45] The federal government therefore has a vital interest in having its health care contracts support a health care workforce that is free from discrimination and that effectively serves this country's diverse patient population.

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[1] U.S. Dep't of Labor, Bureau of Labor Statistics, Household Data Annual Averages, Table 11: Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity (2012) (last accessed December 20, 2013) *available at* http://www.bls.gov/cps/cpsaat11.pdf (under "Healthcare practitioners and technical occupations").
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] Marcella Nunez-Smith, et al., *Race/Ethnicity and Workplace Discrimination: Results of a National Survey of Physicians*, 24 J. Gen Intern Med. 1198, 1198 (Sept. 2009).
[6] *Id.*
[7] *Id.*
[8] Seth A. Seabury et al., *Trends in the Earnings of Male and Female Health Care Professionals in the United States, 1987 to 2010*, 173 JAMA Intern Med. 1748 (Sept. 2013).
[9] *Id.*
[10] William B. Weeks et al., *How Do Race and Sex Affect the Earnings of Primary Care Physicians?*, 28 Health Affairs 557 (2009).
[11] *Id.*
[12] *Id.*
[13] *Chaney v. Plainfield Healthcare Center*, 612 F.3d 908, 913-15 (7th Cir. 2010). *See also EEOC v. Central Park Lodges Long Term Care, Inc., d/b/a Linden Grove Health Care Center*, No. 04-5627 RBL (W.D. Wash. consent decree filed May 13, 2005) (EEOC obtained a settlement against nursing facility in Washington State for alleged violations of Title VII, including that the White care management team complied with racial preferences of white family that no "colored girls" care for the resident, the frequent use of racial slurs, and the assignment of white nurses to day shifts and black nurses to night shifts, among other allegations).
[14] *Id.* at 913, 915.
[15] *EEOC v. Jackson Park Hosp. & Med. Ctr.*, No. 11 C 04743 (N.D. Ill. Nov. 21, 2011).

[16] *See, e.g.*, Liz Kowalczyk, *Female Surgeons Note Gains, Subtle Gender Bias*, Boston Globe (Feb. 25, 2013), *available at* http://www.bostonglobe.com/lifestyle/health-wellness/2013/02/25/female-surgeons-say-explicit-gender-bias-rare-but-subtler-obstacles-still-exist-boston/U5044WUVVCKbxlqX0OLTRI/story.html; Phyllis S. Carr et al., *Faculty Perceptions of Gender Discrimination and Sexual Harassment in Academic Medicine*, 132 Annals of Internal Med. 889 (2000) [hereinafter *Gender Discrimination*].
[17] *Gender Discrimination* at 893.
[18] Brian D. Smedley, Adrienne Y. Stith & Alan R. Nelson, eds., Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* 5 (2003) [hereinafter *Unequal Treatment*].
[19] The Sullivan Commission on Diversity in the Healthcare Workforce, *Missing Persons: Minorities in the Health Professions* i (Sept. 2004), *available at* http://www.aacn.nche.edu/media-relations/SullivanReport.pdf [hereinafter Sullivan Report].
[20] Elizabeth H. Bradley et al., *Racial and Ethnic Differences in Time to Acute Reperfusion Therapy for Patients Hospitalized with Myocardial Infarction*, 292 J. Am. Med. Ass'n 1563 (2004).
[21] *Id.* at 1572.
[22] Tiffani Johnson et al., *Association of Race and Ethnicity with Management of Abdominal Pain in the Emergency Department*, 132 Pediatrics 851 (2013).
[23] *Lau v. Nichols*, 414 U.S. 563 (1974).
[24] U.S. Census Bureau, American Community Survey, Selected Social Characteristics in the United States: 2011 American Community Survey 1-Year Estimates (25,303,308 speak English less than "very well"); Kaiser Family Foundation, Overview of Health Coverage for Individuals with Limited English Proficiency, 1-2 (2012), *available at* http://kaiserfamilyfoundation.files.wordpress.com/ 2013/01/8343.pdf (noting that 66 percent of individuals with LEP are Hispanic and 18 percent are Asian).
[25] Kaiser Family Foundation, Overview of Health Coverage for Individuals with Limited English Proficiency, at 3.
[26] *Unequal Treatment* at 640-41.
[27] Sullivan Report at 21-23.
[28] B. Lord, et al., *The Impact of Patient Sex on Paramedic Pain Management in the Pre-hospital Setting*, 27(5) Am. J. of Emerg. Med. 525 (2009).
[29] Instit. of Med., *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, 77 (2011), *available at* http://www.nap.edu/download.php?record_id=13172 (quoting (Campaign to End Chronic Pain in Women, *Chronic Pain in Women: Neglect, Dismissal, and Discrimination*, 4 (May 2010), *available at* http://www.endwomenspain.org/resources).
[30] Soc'y for Women's Health Res., *SWHR Timeline,* http://www.womenshealthresearch.org/site/DocServer /Copy_of_timeline_2010.pdf?docID=4741 (last visited Sept. 17, 2013). 17, 2013). In 1993, Congress enacted the National Institutes of Health Revitalization Act of 1993 which requires, among other things, that women and minorities be appropriately included in NIH clinical trials. 42 U.S.C. §§ 283-300 (2012). The next year, Congress created the Office of Women's Health in the Food and Drug Administration (FDA) which has a mission of protecting and advancing the health of women through policy, science and outreach, and advocacy for the inclusion of women in clinical trials as well as sex/gender and subpopulation analyses. *See* U.S. G.A.O. *Women's Health: Women Sufficiently Represented in New Drug Testing, but FDA Oversight Needs Improvement* (2001) (describing inclusion of women in FDA activities); Miriam F. Kelty, N.I.H. Training, *Sex/Gender and Minority Inclusion in NIH Clinical Research: What Investigators Need to Know*, (March 2009), *available at* http://www.nihtraining.com/cc /ippcr/current/ downloads/WomMin.pdf. (describing inclusion of women and minorities in clinical research conducted by NIH).
[31] Jaime M. Grant et al., Injustice at Every Turn: A Report of the National Transgender Discrimination Survey 73 (2011) *available at* http://transequality.org/PDFs/NTDS_Report.pdf.
[32] See, e.g.: The National Council on Disability, (2009). *The Current State of Health Care for People with Disabilities*. Retrieved from website: http://www.ncd.gov/publications/2009/Sept302009;
Reis, J. P., Breslin, M. L., Iezzoni, L. I., & Kirschner, K. L. (2004). *It Takes More Than Ramps to Solve the Crisis of Healthcare for People with Disabilities.* Informally published manuscript, Rehabilitation Institute of Chicago, Chicago, IL, Retrieved from www.tvworldwide.com/events/hhs/041206/PPT/RIC_whitepaperfinal82704.pdf.
[33] Disabilities are diverse. As the Surgeon General said in his 2005 Call to Action to Improve the Health and Wellness of Persons with Disabilities stated: "Some disabilities are visible; others are not. Some are physical, some visual or auditory, some developmental or cognitive, and some mental or behavioral. Some persons are born with

one or more disabilities; others acquire a disability during the course of a lifetime . . . . No single disabling condition necessarily affects one person in exactly the same way as it does another."

[34] Havercamp, S. M. (Ohio State University Nisonger Center); Robey, K. (Matheny Medical and Educational Center and UMDNJ – New Jersey Medical School); & Smeltzer, S. (Villanova University College of Nursing); *Approaches to training healthcare providers on working with patients with disabilities*. Webinar at AUCD. Retrieved from http://www.aucd.org/docs/Approaches to Training Healthcare Providers.pdf (Accessed on July 18, 2013).

[35] *Identifying effective health care services for adults with disabilities: Why study designs and outcome measures matter*. (2011). Presentation at the Mathematica Policy Research Center on Health Care Effectiveness (CHCE) Issue Forum, http://www.mathematica-mpr.com/CHCE/forum_archives/July_2011/powerpoint.pdf.

[36] *Unequal Treatment* at 14; *see also* Sullivan Report at iv.

[37] Sullivan Report at 18-23.

[38] Jordan J. Cohen, et al. *The Case for Diversity in the Health Care Workforce*, 21 Health Affairs 90, 94-95 (2002); Am. Assoc. of Pediatrics, *Policy Statement: Enhancing Pediatric Workforce Diversity and Providing Culturally Effective Pediatric Care: Implications for Practice, Education, and Policy Making*, http://pediatrics.aappublications.org/content/132/4/e1105.full# (published online Sept. 30, 2013).

[39] Testimony of Louis W. Sullivan, Health Care Disparities: A Briefing Before the U.S. Commission on Civ. Rts., 4 (Dec. 2010), *available at* http://www.usccr.gov/pubs/Healthcare-Disparities.pdf (citing study); Health Resources & Servs. Admin. Bur. of Health Professions, U.S. Dep't of Health & Human Services, The Rationale for Diversity in the Health Professions: A Review of the Evidence, 16 (Oct. 2006), *available at* http://bhpr.hrsa.gov/healthworkforce/reports/diversityreviewevidence.pdf (citing study).

[40] Testimony of Louis W. Sullivan, Health Care Disparities: A Briefing Before the U.S. Commission on Civ. Rts., 4 (Dec. 2010), *available at* http://www.usccr.gov/pubs/Healthcare-Disparities.pdf (citing source).

[41] *Unequal Treatment* at 22; Amer. Assoc. of Med. Coll. *Diversity in Medical Education: Facts & Figures 2008*, 11-12 (2008), *available at* https://members.aamc.org/eweb/upload/Diversity%20in%20Medical%20Education%20Facts%20and%20Fig%202008.pdf (citing studies).

[42] Health Resources & Services Admin. Bur. of Health Professions, U.S. Dep't of Health & Human Services, The Rationale for Diversity in the Health Professions: A Review of the Evidence 2 (Oct. 2006), available at http://bhpr.hrsa.gov/healthworkforce/reports /diversityreviewevidence.pdf.

[43] Sullivan Report at 40.

[44] Sullivan Report at iv.

[45] Sullivan Report at 3, 15.

[Additional Submissions by Chairman Walberg follow:]

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April 3, 2014

The Honorable Tim Walberg
Chairman
Committee on Education and the Workforce
United States House of Representatives
2181 Rayburn House Office Building
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BY EMAIL TO:
molly.conway@mail.house.gov

Re: H.R. 3633, the Protecting Health Care Providers from Increased Administrative Burdens Act

Dear Chairman Walberg:

The Association of Federal Health Organizations ("AFHO") appreciates receiving your staff's invitation to submit this statement for the record of the Subcommittee on Workforce Protection's March 13, 2014, hearing. We wish to express our support for H.R. 3633, the Protecting Health Care Providers from Increased Administrative Burdens Act. AFHO is a trade association of Federal Employees Health Benefit ("FEHB") plan carriers that serve over 75% of the FEHBP's total enrollment [1]

H.R. 3633 is a welcome legislative response to the Labor Department's Office of Federal Contractor Compliance Programs ("OFCCP") enforcement actions seeking to treat hospitals as TRICARE and FEHB Program subcontractors that must comply with the affirmative action program requirements of various Executive Orders and federal laws. Our statement principally seeks to illustrate how these enforcement efforts against FEHBP carriers are at odds with long-standing understandings and practice in the FEHBP.

The FEHB Act, 5 U.S.C. Ch. 89, authorizes the U.S. Office of Personnel Management ("OPM") to enter into contracts with qualified carriers for health benefit plans, not for health care services. FEHB plan contracts are health insurance contracts under which the carrier or its underwriter bears the risk that the premiums will be sufficient to fund the benefit costs and related administrative expenses.

All FEHB plan contracts include three affirmative action clauses that flow down to subcontractors at specified dollar thresholds; Section 5.19 Equal Opportunity (Federal Acquisition Regulation ("FAR") § 52.222-26) , Section 5.22 Equal Opportunity for Veterans (FAR § 52.222-35), and Section 5.23 Affirmative Action for Workers with Disabilities (FAR 52.222-36). However, none of these clauses defines the term subcontractor.

[1] AFHO members reserve the right to comment separately to the Committee on this bill.

Furthermore, FAR Chapter 1, Part 2, does not include a definition of the term "subcontractor." However, OPM has defined that term in its implementing Federal Employees Health Benefits Acquisition Regulation ("FEHBAR") since the FEHBAR's inception in 1987 as follows:

> Subcontractor means any supplier, distributor, vendor, or firm that furnishes supplies or services to or for a prime contractor or another subcontractor, except for providers of direct medical services or supplies pursuant to the Carrier's health benefits plan.

The FAR expressly authorized OPM to create this definition for FEHBP purposes. 48 C.F.R. Subpart 1.3.

In 2005, OPM created a new class of contracts for experience rated FEHBP carriers known as the large provider agreement. At the time, OPM explained that

> Large Provider Agreements include mail order pharmacy services, pharmacy benefit management services, mental (behavioral) health and/or substance abuse management services, preferred provider organizations (including organizations that own and/or contract with direct providers of medical services and supplies), utilization review services, and/or large case or disease management services. Large Provider Agreements do not include carriers' contracts with hospitals

70 Fed. Reg. 31,374, 31,375 (June 1, 2005, emphasis added.)

OPM's decision to exclude health care providers from the FEHBP definitions of subcontractor and large provider draws support from the Federal Grants and Cooperative Agreement Act of 1978, 31 U.S.C. Ch. 63. The Grant Act, which is referenced in the FAR's definition of the term "Contract" (48 C.F.R. § 1-2.201), was passed to provide agencies, such as OPM and OFCCP, with guidelines for classifying the various relationships between the federal government and federal fund recipients. We agree with the American Hospital Association's ("AHA") December 4, 2014, testimony to this Committee on this point (p. 8):

> Under the Grant Act, TRICARE, FEHBP and Medicare reimbursements do not qualify as federal "procurement contracts" but instead are forms of federal financial assistance. Under the Grant Act, a procurement contract exists where the principal purpose of the relationship is to acquire "property or services for the direct benefit or use of the United States Government." [31 U.S.C. § 6302.] Clearly, health benefit plan reimbursements are not for the direct benefit or use of the government. Instead, common sense and the language of the relevant legislation establishes that, literally, the "beneficiaries" of TRICARE are the service members, veterans and eligible dependents who receive medical services – that is, the benefits of the program. Likewise, the "beneficiaries" of FEHBP are federal employees, retirees and their families. These arrangements are analogous to Medicare, where the government makes payments to hospitals for the benefit of "that portion of the public entitled to Medicaid or Medicare coverage."

Subsequently, in March 2003, OFFCP issued Directive No. 263, which was consistent with OPM's subcontractor definition. That directive expressed the following policy:

> Based on the [Labor Department Administrative Review Board] ARB decision [in the *Bridgeport Hospital* case], OFCCP cannot use FEHBP coverage as a basis to assert jurisdiction over a health care provider.

Citation: http://tinyurl.com/nw3zobd The *Bridgeport Hospital* case concerned a contract between the hospital and a Blue Cross Blue Shield Federal Employee Plan carrier. ARB No. 00-034 (Jan. 31, 2003),

available at http://tinyurl.com/pgxqm7s.[2] For these reasons, AFHO members have neither included the affirmative action clauses in subcontracts with hospitals and other health care providers nor required their network vendors or prescription benefit managers to include those clauses in their provider agreements.

Nevertheless, beginning in January 2004, OFCCP sought to apply the affirmative action clauses to a contract between the UPMC Braddock medical facility and a FEHBP comprehensive medical plan carrier. OFCCP commenced an enforcement action in November 2006. In May 2009, the ARB sustained the OFFCP's. *OFCCP v. UPMC Braddock*, DOL ARB No. 08-048 (May 29, 2009), available at http://tinyurl.com/o2szw7d. The U.S. District Court for the District of Columbia later affirmed the ARB's decision. *UPMC Braddock v. Solis*, 934 F Supp 2d 238 (DDC March 30, 2013). That decision has been appealed to the U.S. Court of Appeals for the District of Columbia Circuit (No. 13-5158).

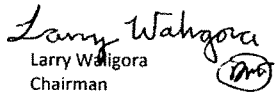
These decisions override OPM's longstanding FEHBAR determination that providers and large providers are not subcontractors and raise the specter that hospitals and large medical groups may be deterred from joining FEHBP carriers' networks in order to avoid the OFCCP's burdensome affirmative action program requirements, about which the American Hospital Association has testified so effectively before this Committee. Federal and postal employees, annuitants, and their families who depend upon the FEHBP for their health care coverage would be the losers in that case since many high quality, affordable healthcare providers may no longer participate in the networks upon which they rely.

We would also note that the Secretary of Labor's offer to create a five year long moratorium on OFCCP enforcement actions against TRICARE providers in order to acclimate those healthcare providers to OFFCP's new enforcement policy, that you announced at the March 13, 2014, hearing, would not prevent the OFCCP from ultimately creating an impediment to building the highest-quality networks to serve those who rely on the FEHBP.

For all of these reasons, AFHO supports the enactment of HR 3633 which ends the uncertainty that the OFCCP has created and costly related litigation by clarifying once and for all that participation in a federally funded health benefit program, like the FEHBP, does not subject health care providers to OFCCP jurisdiction. This legislation will provide the best assurance to active and retired federal and postal employees and their dependents that the OFCCP will not threaten the quality of the providers in FEHBP carriers' networks. Healthcare providers are, and if H.R. 3633 is enacted, would remain subject to federal, state, and local employment discrimination law.

Thank you again soliciting this statement. Should you wish to discuss them further, please contact me.

Sincerely,



Larry Waligora
Chairman

cc: AFHO Board of Directors
David M. Ermer
John O'Brien (OPM)
Jonathan Foley (OPM)

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[2] In December 2010, OFCCP "obsoleted" Directive No. 262 based on the agency's enforcement actions, not on a change in the law. See OFCCP Directive No. 293 and Notice of Rescission No. 301.

[Whereupon, at 11:33 a.m., the subcommittee was adjourned.]

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