From Coverage to Care: TRICARE Behavioral Health Parity and Shifts in Substance Use Disorder Treatment Within Active-Duty Military

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SUMMARY

This study evaluated changes in SUD treatment utilization among active-duty service members (ADSMs) following implementation of the TRICARE behavioral health parity rule in October 2016.

Parity was associated with increased ambulatory SUD treatment utilization.

- Emergency department utilization remained relatively unchanged.

Findings suggest that expanded behavioral health coverage may increase use of outpatient SUD treatment without increasing reliance on acute care.

INTRODUCTION

Substance use disorders (SUDs) among U.S. ADSMs contribute to adverse physical and mental health outcomes, increased health care utilization, and reduced military readiness.

In October 2016, TRICARE implemented a comprehensive behavioral health parity rule that:

1. Required behavioral health benefits to be comparable with medical and surgical benefits.
2. Reduced treatment limitations
3. Expanded access to behavioral health providers and services.

However, the extent to which this policy changed SUD utilization among ADSMs remains unclear.

STUDY AIM

To examine the impact of the parity policy on SUD treatment utilization among ADSM.

METHODS

Data: Military Health System Data Repository medical claims data from 2014–2024, comprising 16,712,105 person-quarter observations.

Study Population: ADSMs eligible for care

Policy Exposure: Implementation of the TRICARE behavioral health parity rule in October 2016.

Outcomes: SUD-related ambulatory and emergency department (ED) utilization, measured as any utilization and number of visits.

Study Design: Quasi-experimental using an interrupted time series framework

Statistical Analysis: Segmented regression models with individual fixed effects estimated immediate changes in SUD treatment utilization and changes in post-policy trends.

- Count outcomes were modeled using negative binomial regression, with models accounting for temporal trends and repeated observations.
- Covariates were age, sex, race/ethnicity, and rank

RESULTS

Figure 1. Quarterly Proportion of Any SUD-Related Use

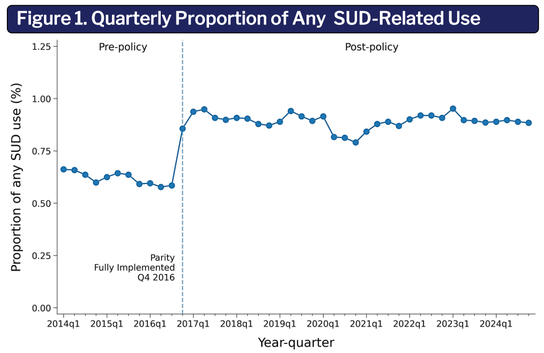

Figure 2. Quarterly Mean Number of Ambulatory SUD Visits

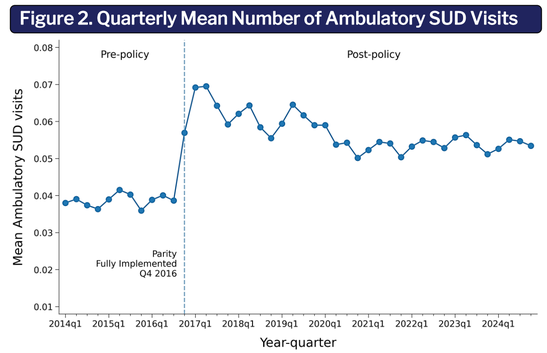

Figure 3. Quarterly Mean SUD Emergency Department Visits

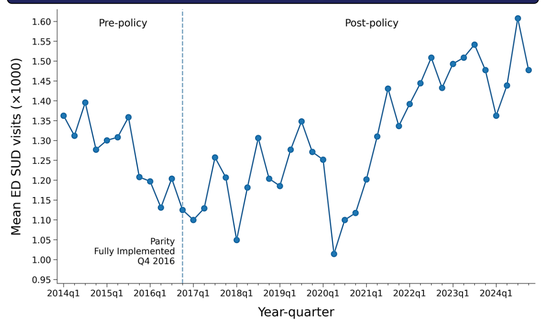

Table 1. Estimated Effect of TRICARE Behavioral Parity

Outcome	Parameter	IRR (95% CI)	% change (95% CI)	P value
Ambulatory visits, all person-quarters	Pre-parity trend (t)	1.01 (1.00-1.01)	+0.9% (+0.4% to +1.3%)	<.001
	Immediate parity level change	1.38 (1.33-1.42)	+37.5% (+33.4% to +41.8%)	<.001
	Post-parity slope change per quarter	0.98 (0.98-0.99)	-1.7% (-2.2% to -1.3%)	<.001
ED visits, all person-quarters	Pre-parity quarterly trend (t)	0.98 (0.98-0.99)	-1.6% (-2.2% to -1.1%)	<.001
	Immediate parity level change	0.93 (0.89-0.96)	-7.5% (-11.1% to -3.6%)	<.001
	Post-parity slope change per quarter	1.03 (1.02-1.03)	+2.7% (+2.2% to +3.3%)	<.001

RESULTS (*cont.*)

There were 451,127 ambulatory and 70,507 ED visits that received SUD diagnosis (2.70% and 0.42% of total person-quarters).

Trends are presented as the proportion of beneficiaries with any SUD-related utilization (Fig. 1), the mean number of ambulatory SUD visits (Fig. 2), and the mean number of SUD ED visits (Fig. 3).

Adjusted regression models estimating the effect of TRICARE behavioral health parity policy on SUD treatment utilization are presented in Table 1.

Immediate Post-Parity: Ambulatory visit counts increased by 37.5% (95%CI, 33.4%, 41.8%), while ED visits decreased by 7.5% (95%CI=3.6%,11.1%).

Long-Term: Ambulatory visit counts declined by 1.7% per quarter (95% CI, 1.3%–2.2%), whereas ER visit counts increased by 2.7% per quarter (95% CI, 2.2%–3.3%).

CONCLUSIONS

Parity was associated with increased ambulatory SUD treatment utilization among ADSMs. ED utilization did not increase, suggesting no greater reliance on acute care.

Limitations: Medical claims capture health care utilization but may not reflect unmet treatment needs, care received outside the MHS, or the clinical severity of SUD.

Findings suggest parity may shift SUD treatment toward ambulatory care.

Stigma reduction and enhanced care coordination may be necessary to translate parity-driven SUD care access gains into lasting improvements in SUD care access among ADSM.

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