TRICARE Behavioral Health Parity Reform: Impact on Mental Health Care Use Among Service Members and Their Families

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Disclosure

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Roadmap

I. Background & Study Aims
II. Methods
III. Results
IV. Discussion

I. Background & Study Aims

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TRICARE's Behavioral Health Parity

- Mental health coverage has lagged behind medical/surgical coverage in the U.S general population
  - MHPAEA (2008) required most private and public plans to close this gap
  - TRICARE was not covered
- In October 2016, TRICARE enacted its own parity mandate for all beneficiaries impacting

Primary Focus	Eliminate treatment limits & cost-sharing barriers; expand provider network
Target Population	~9.5 million TRICARE beneficiaries (Active Duty Service Members and dependents)
Key Mechanism	**Demand-side: remove visit/day limits & cost-sharing. Supply-side: streamline provider certification**
Policy Goal	Expand access to behavioral health care by removing financial and administrative barriers

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Abbreviations: MHPAEA, Mental Health Parity and Addiction Equity Act

The 2016 Mandate: Demand-Side and Supply-Side Changes

Demand-Side Changes

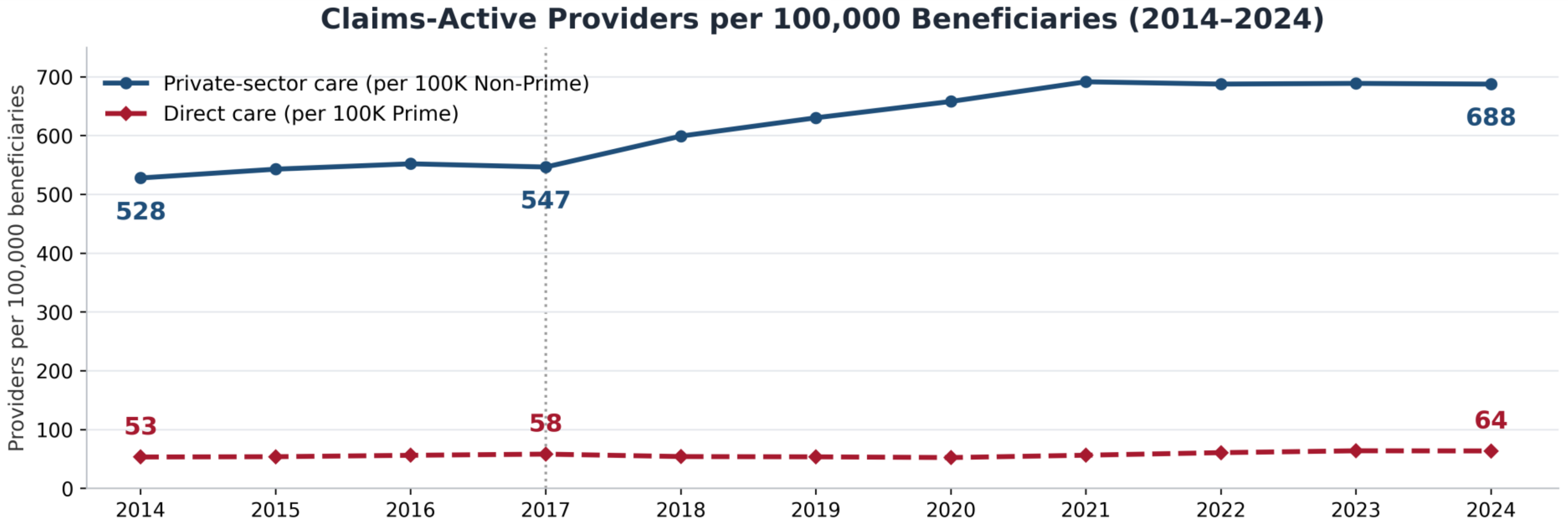
- Outpatient copay (dependents/retirees): $25 → $12 / visit
- Inpatient day limit elimination: 30 days/yr adults, 45 days/yr children
- Residential treatment limit elimination: 150 days/yr
- Outpatient/SUD session caps elimination: 2 sessions/week; 60-visit SUD cap

Lowered the cost and quantity barriers to seeking care

Supply-Side Changes

- Expanded civilian provider network
- Expanded reimbursement: IOPs, PHPs, & OTPs
- Broader coverage: Residential only → outpatient/office-based treatment
- Eased prior authorization and PCM referral requirements

Expanded network capacity to deliver that care



Abbreviations: IOP, Intensive Outpatient Program; PHP, Partial Hospitalization Program; OTP , Opioid Treatment Program

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Study Aims

- Evaluate the impact of the 2016 TRICARE parity mandate
    I. System-wide utilization: how much total care TRICARE delivered
    II. Within-person intensity: whether ever-users are getting more care
- Compare across three populations
    I. Active Duty Service Members (ADSM)
    II. TRICARE Prime dependents
    III. TRICARE Select/non-Prime dependents

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II. Methods

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Data

Military Health System Data Repository (MDR) → Military treatment facilities (MTFs) + Private-sector care

Person-quarter panel — 11 years (Q1 2014 - Q4 2024)

1,798,922
Active Duty Service Members

1,640,106
TRICARE Prime dependents

603,616
TRICARE Select/non-Prime dependents

Outcomes measured as person-quarter counts

- **Ambulatory mental health visits**
- **Psychiatric ER visits**

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Empirical Approach: Two Questions, Two Models

System-Wide Model

Pooled PPML with person-level cluster-robust SEs

How much total care did TRICARE deliver?

- Full beneficiary population
- Combines new entrants with within-person change

Captures total system burden

Ever-User Model

Person fixed-effects PPML with person-level cluster-robust SEs

Are people already in care receiving more of it?

- Restricted to beneficiaries with ≥1 visit, 2014–2024 (**Ever-User only**)
- Isolates within-person change via individual fixed effects

Captures treatment intensity

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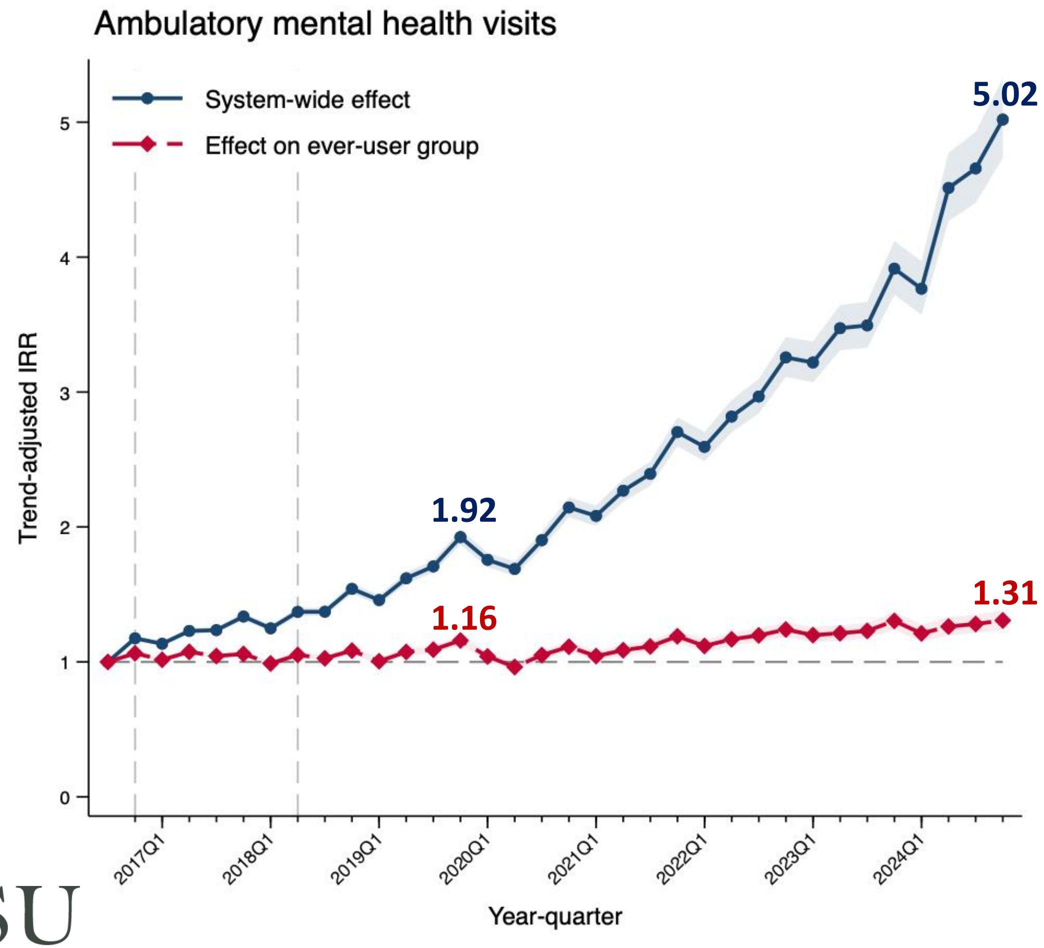
III. Results

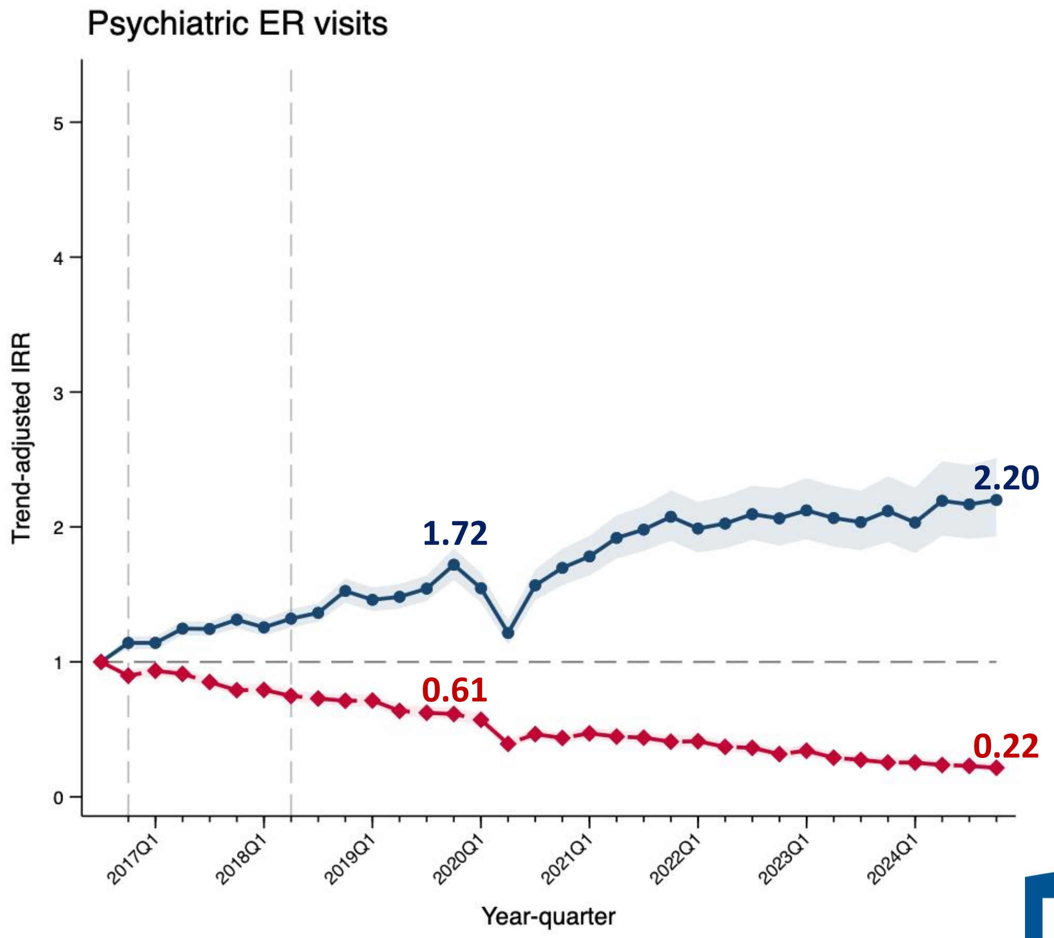
Study Populations: Three Structurally Distinct Groups

Characteristic	Active Duty Service Members	TRICARE Prime Dependents	TRICARE Select/Non-Prime Dependents
N	1,798,922	1,640,106	603,616
Age, mean (years)	26.8	19.4	21.9
Female, %	16.0	69.3	75.8
Ever had ambulatory MH visit, %	**37.0**	**36.3**	17.9
Mean ambulatory MH visits/quarter	0.30	0.47	0.19
Ever had psychiatric ER visit, %	**5.9**	**5.9**	2.7
Mean psychiatric ER visits/quarter	0.01	0.01	0.01
Ever diagnosed with SMI, %	**16.3**	**14.4**	**9.0**

Trend-Adjusted Incidence Rate Ratios

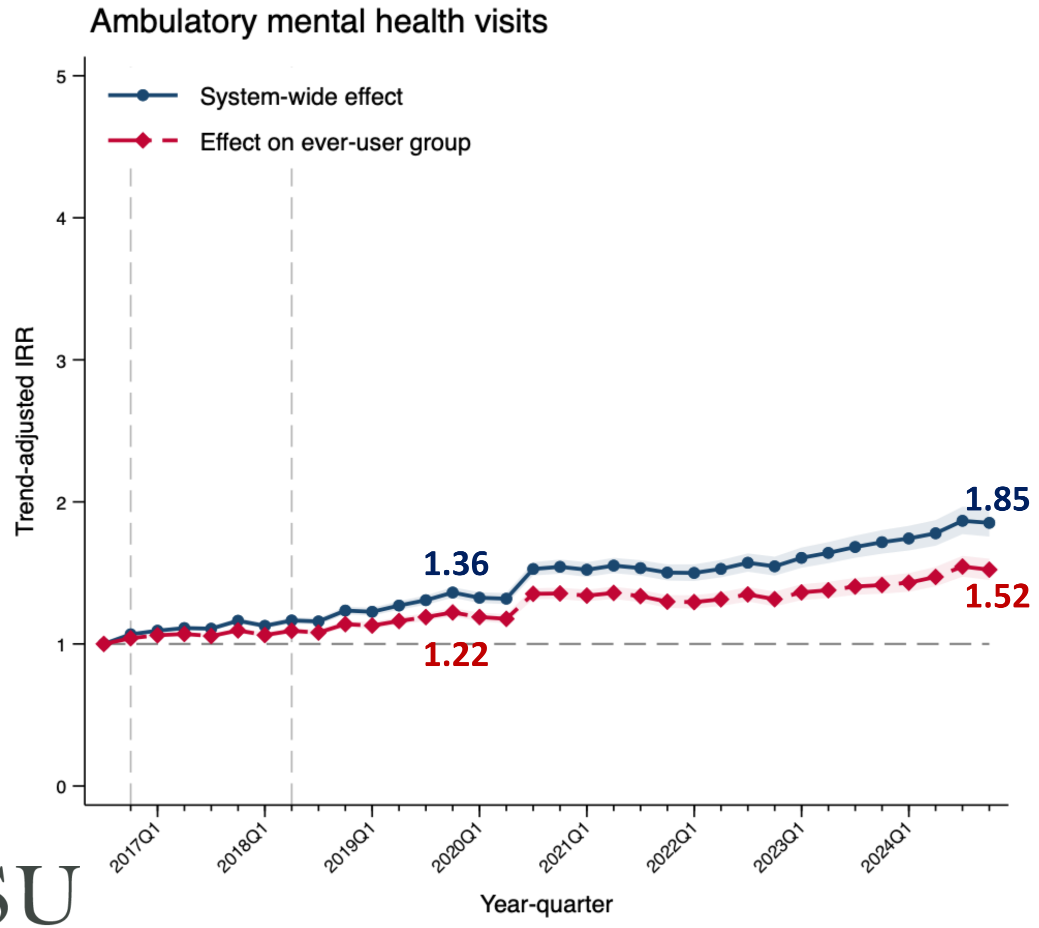
Active Duty Service Members

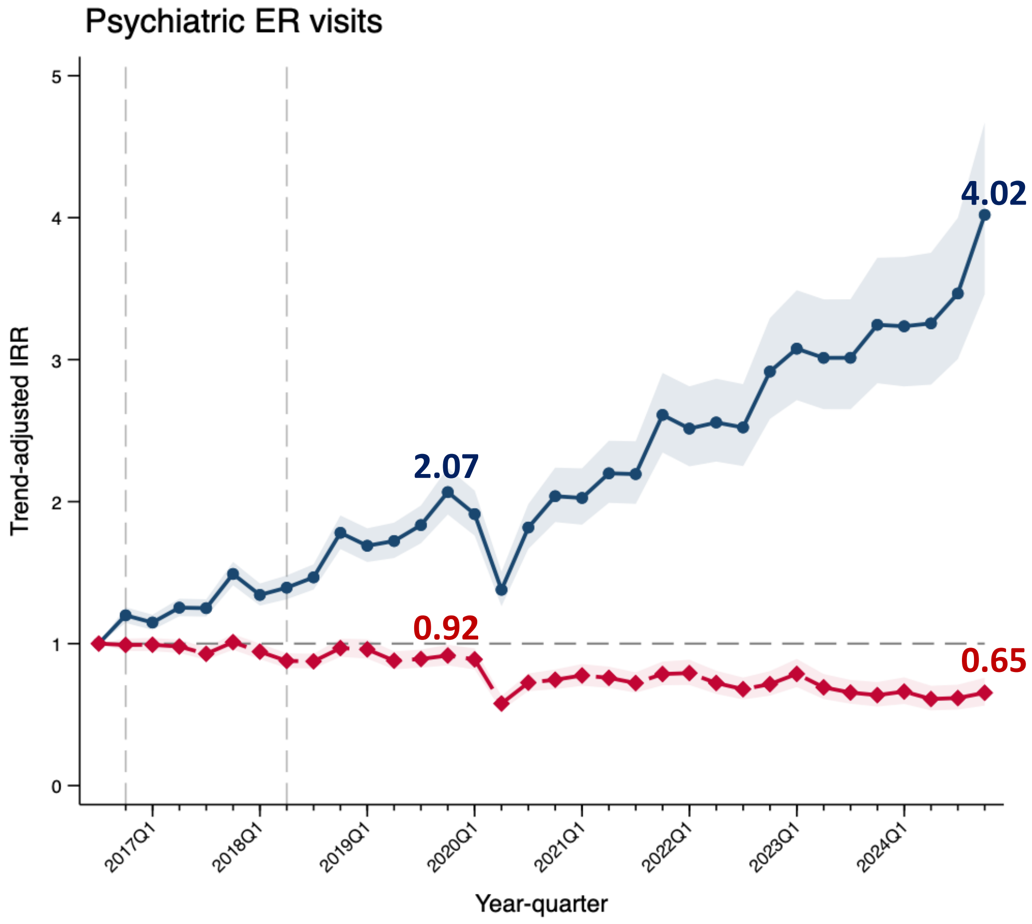




Trend-Adjusted Incidence Rate Ratios

TRICARE Prime Dependents





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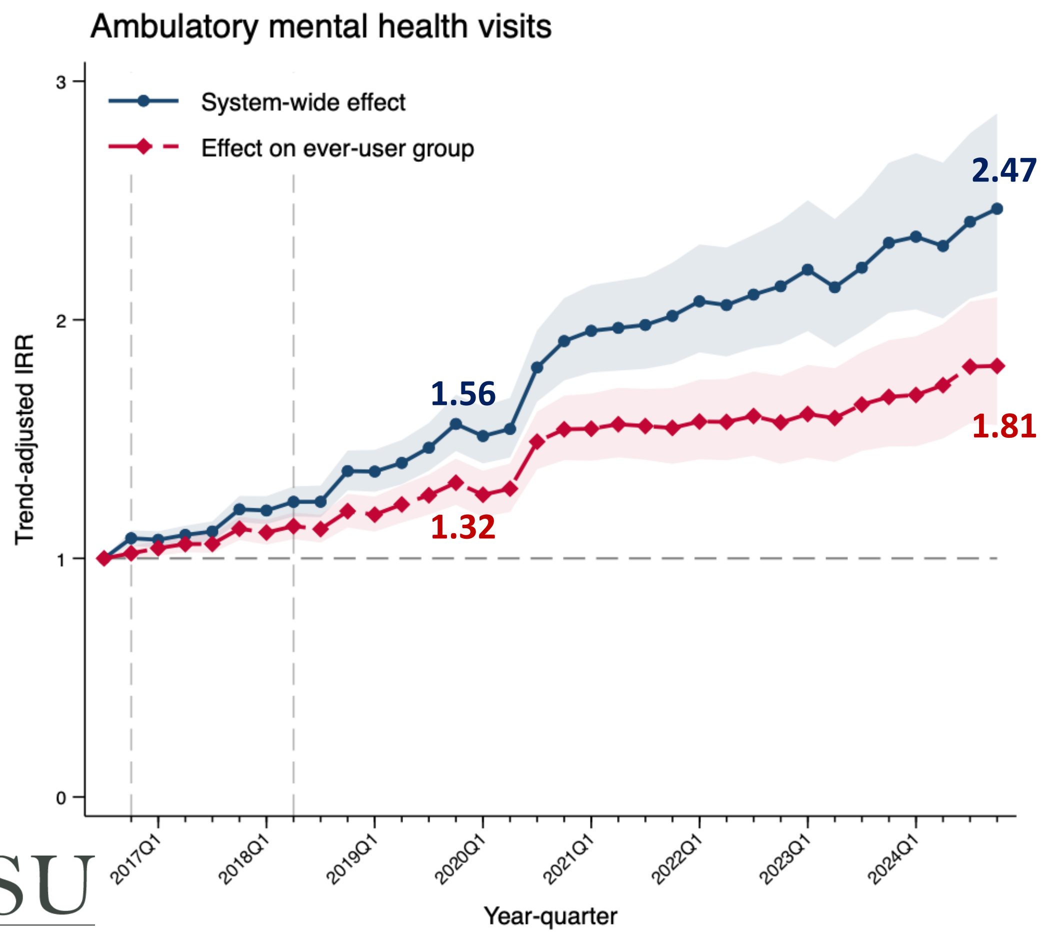
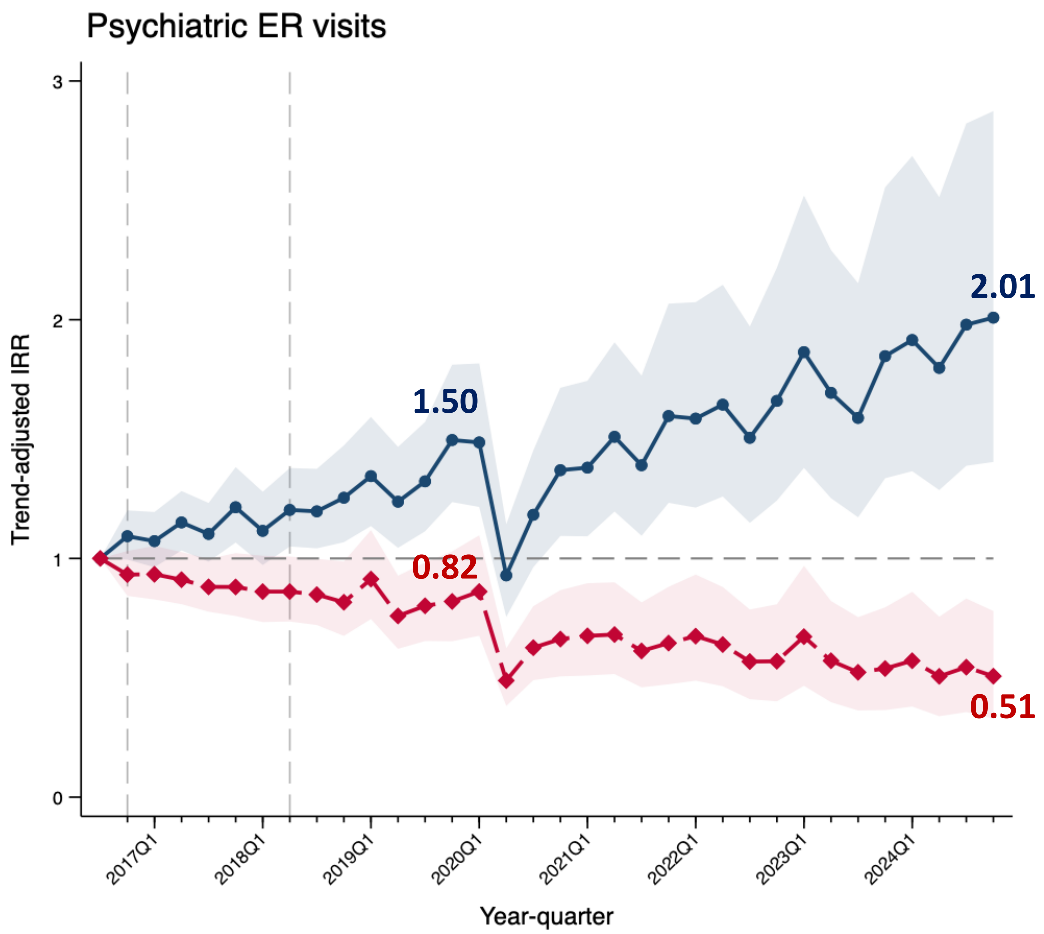
Trend-Adjusted Incidence Rate Ratios

TRICARE Select/Other Non-Prime Dependents





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Ambulatory Visits: System-Wide vs. Ever-User Effects

Milestone	Effect Measure (IRR)	Population		
		Active Duty	Prime dependents	Select/Non-Prime dependents
2 Years Post-Parity (Q2 2018)	System-Wide	1.37	1.17	1.85
	Ever-User	1.05	1.09	1.52
3 Years Post-Parity (Q4 2019)	System-Wide	1.92	1.36	1.56
	Ever-User	1.16	1.22	1.32
8 Years Post-Parity (Q4 2024)	System-Wide	5.02	1.85	2.47
	Ever-User	1.31	1.52	1.81

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Psychiatric ER: System-Wide vs. Ever-User Effects

Milestone	Effect Measure (IRR)	Population		
		Active Duty	Prime dependents	Select/Non-Prime dependents
2 Years Post-Parity (Q2 2018)	System-Wide	1.32	1.39	1.20
	Ever-User	0.75	0.88	0.86
3 Years Post-Parity (Q4 2019)	System-Wide	1.72	2.07	1.50
	Ever-User	0.61	0.92	0.82
8 Years Post-Parity (Q4 2024)	System-Wide	2.20	4.02	2.01
	Ever-User	0.22	0.65	0.51

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IV. Discussion

Discussion

- **Primary effect: More beneficiaries entered mental health care**
- **Expanded access more than treatment intensity**
  - Up to 5× increase in system-wide ambulatory visits
  - Only 16–81% increase among existing users
- **Earlier outpatient care may have reduced crisis care**
  - Psychiatric ED use declined among ever-users
  - Implies a shift from crisis-driven to planned outpatient care
- **Effects followed the policy design**
  - Largest gains were in TRICARE Select / non-Prime: Self-referral + cost-sharing reduction
  - Smallest gains were in Active Duty: Organizational and career-related barriers likely remained

Policy Implications and Key Takeaway

Key takeaway: Parity expanded **system access** more than **treatment intensity**

1. **Measure reach and intensity separately**
   System-wide growth and within-person intensity capture different policy effects

2. **Largest gains among Select/non-prime dependents**
   Smallest gains among Active Duty Service Members, suggesting persistent career- and stigma-related barriers

Policy consideration: Additional strategies for ADSM

Limitations and Future Directions

- Compositional change over an 11-year period
  - Pooled estimates affected by beneficiary turnover
  - Ever-user estimates less susceptible to turnover
- TRICARE Prime treated as one group
  - Direct care vs. private-sector PCM differences not evaluated
- Study period included COVID-19 pandemic
  - Long-term estimates include pandemic effects
- Future work
  - Stratify TRICARE Prime by PCM (Direct care vs. private-sector)
  - Extend follow-up beyond 2024

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Thank you!
Questions?

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