USU
Uniformed Services University

TRICARE'S BEHAVIORAL HEALTH PARITY AND MENTAL HEALTH AMONG MILITARY BENEFICIARIES

Jangho Yoon, PhD[1], Nilam Gibson, PhD[2] , Seungbeen Ghim, PhD[2]

[1]Department of Preventive Medicine and Biostatistics, School of Medicine, Uniformed Services University of the Health Sciences, Bethesda, MD, USA

[2]Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc, Bethesda, MD, USA

SUMMARY

- **In October 2016, TRICARE implemented behavioral health "parity" rules to expand existing behavioral health care benefits for 9.6 million military beneficiaries (81 F.R. 61068).**
- **The parity led to significant improvement in validated and self-assessed mental health status for civilian TRICARE beneficiaries (dependents and retirees) with mental and substance use disorders.**

AIMS

To examine the extent to which TRICARE's behavioral health parity implementation led to improvement in mental health status among civilian beneficiaries of the military health system.

BACKGROUND

- Mental Health Parity Act of 1996 (MHPA, P.L. 104-204) prohibited large group health plans from imposing annual/lifetime dollar limits on mental health benefits less favorable than medical/surgical benefits.
- Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, P.L. 110-343),[1,2] mandated quantitative/non-quantitative treatment limits (QTLs/NQTLs) for mental health/substance use disorders (MH/SUD).
  - Data from commercial health plans show that the MHPAEA led to a reduction or elimination of, QTLs and NQTLs for MH/SUD,[3,4,5] slight increase in SUD treatment,[6] increase in utilization and spending on out-of-network SUD services,[7] and modest increase in behavioral health spending and utilization.[8]
- On October 3, 2016, TRICARE implemented a full-scope change to existing behavioral health coverage (81 F.R. 61068) to: a) eliminate unnecessary QTLs and NQTLs; b) expand coverage of MH/SUD treatment (e.g., outpatient counseling, intensive outpatient programs, and treatment of opioid use disorder); and c) streamline regulations to be consistent with industry standards to increase the number and geographic coverage areas of TRICARE authorized providers.

METHODS

- **Data**: Medical Expenditure Panel Survey Household Component (MEPS-HC) Consolidated Data files linked with Event Data and Condition Data files for years 2010-2020.
- **Sample:** Non-active duty civilian TRICARE beneficiaries (n=2,830) and privately-insured (n=135,897) aged 18-64.
- **Outcome measures (mh)**: Validated and self-assessed mental health status.
  - SF-12v2 Mental Component Summary (MCS) scores.
  - Indicators for serious and moderate mental illnesses based on Kessler's non-specific psychological distress index (K-6); Patient Health Questionnaire (PHQ-2) for possible depression; Poor self-assessed mental health.
- **Econometric analysis:** Difference-in-differences (DD) and difference-in-differences-in-differences (DDD) models

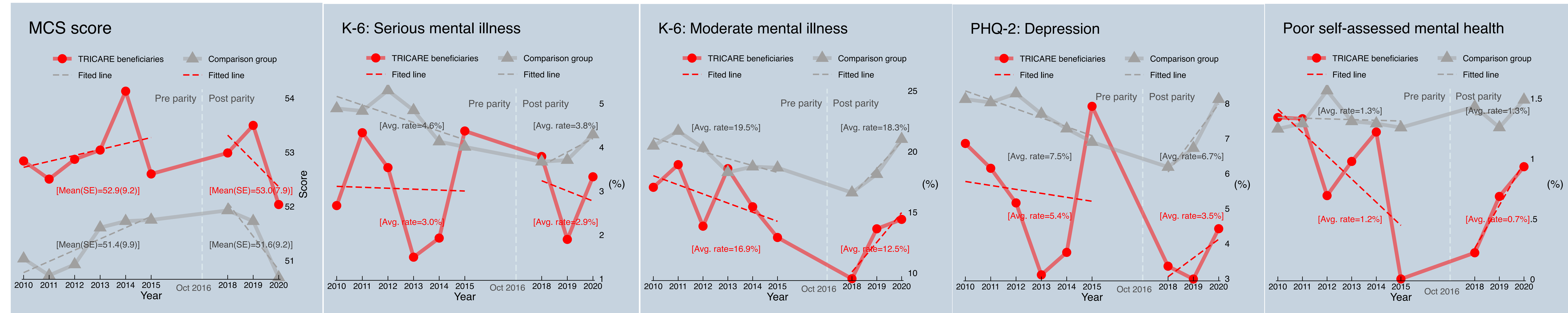
DD: $mh = g^{-1}(\beta_0 + \beta_1 \cdot tri{\times}post + \beta_2 \cdot policy + \beta_3 \cdot post + x' \cdot \beta + \varphi \cdot \tau + \rho \cdot \tau{\times}tri + \eta \cdot \tau{\times}post\,)$

DDD:$mh = g^{-1}(\beta_0 + \beta_1 \cdot b{\times}tri{\times}post + \beta_2 \cdot tri{\times}post + \beta_3 \cdot policy + \beta_4 \cdot post + x' \cdot \beta + \varphi \cdot \tau + \rho \cdot \tau{\times}tri + \eta \cdot \tau{\times}post\,)$

  - tri=TRICARE beneficiary; $post$=years 2018-2020; b=behavioral health condition; x'=covariates; τ=linear time trend.
  - Estimated linear probability models and adjusted estimates for the multistage complex survey design of MEPS.

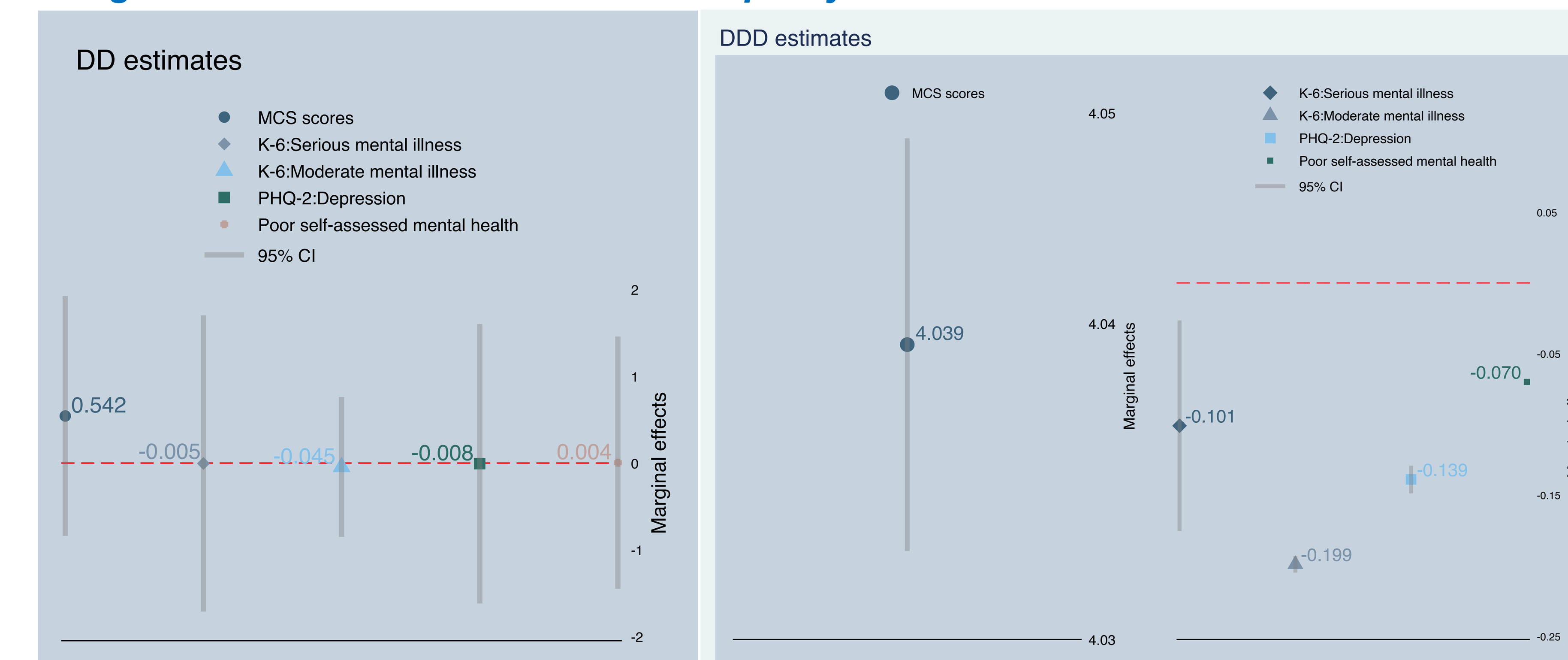
MAIN FINDINGS

Figure 1. Trends in mental health, 2010-2020



Note: Adjusted for sampling weights, stratification, and primary sampling units of MEPS.

Figure 2. Effects of behavioral health parity on mental health



Mental health outcome measures	Effect of parity by income level:				
	Poor	Near poor	Low	Middle	High
MCS	–1.0709 (6.3244)	–6.1984** (2.2022)	–1.1367 (1.9247)	1.9986 (1.8012)	5.5064** (1.6741)
K-6: Serious mental illness	–0.2953*** (0.0536)	0.6758*** (0.0737)	–0.2553*** (0.0593)	–0.0894 (0.1208)	–0.0318 (0.0496)
K-6: Moderate mental illness	0.5039* (0.2052)	–0.7161*** (0.1505)	–0.1458 (0.1864)	–0.2114 (0.1297)	–0.2727*** (0.0708)
PHQ-2: Depression	0.1090 (0.3085)	0.4625*** (0.0732)	–0.2061 (0.1228)	–0.1102 (0.1166)	–0.1294** (0.0478)
Poor self-assessed mental health	–0.1361*** (0.0197)	–0.1631** (0.0562)	–0.1037*** (0.0159)	–0.0659*** (0.0113)	–0.0309*** (0.0056)
n	18,433	5,413	16,209	37,014	44,914

Note: Estimates are adjusted for multistage, complex survey design. All models are fully specified with gender, race/ethnicity, education, marital status, census region, family income, physical health status, chronic conditions.

CONCLUSIONS

- TRICARE's behavioral health parity led to significant improvement in validated and self-assessed mental health status among civilian beneficiaries of the military health system (dependents and retires) who received diagnoses of mental and substance use disorders.
- The parity led to greater improvement in self-assessed mental health for those with lower family income.
- However, income-dependent effects of the parity on other validated mental health measures were not robust and warrant close monitoring and investigation.

DISCLAIMER: The contents, views or opinions expressed in this presentation are those of the authors and do not necessarily reflect official policy or position of Uniformed Services University of the Health Sciences, the Department of Defense, the Departments of the Army, Navy, or Air Force, or the Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc.

Funding: DHA Military Health Systems Research HT94022310001 (PI: Yoon, J).

Contact: Jangho Yoon (jangho.yoon@usuhs.edu)

REFERENCES: 1. NCSL. *Mental Health Benefits: State Laws Mandating or Regulating*. Dec., 30, 2015. 2. CMS. *The Mental Health Parity and Addiction Equity Act (MHPAEA)*. 3. U.S. GAO. *Mental Health and Substance Use.*GAO-12-63, November 30, 2011. 4. Thalmayer et al. (2017). *Psych Serv*, *68*(5), 435-442. 5. Thalmayer et al. (2018). *HSR*, *53*(6), 4584-4608. 6. Busch et al. (2014). *AJMC*, *20*(1), 76-82. 7. McGinty et al. (2015). *Heal Aff*, *34*(8), 1331-1339. 8. Harwood et al. (2017). *Med Care*, *55*(2), 164-172.