Mental Health Opportunities and Challenges

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Agenda for Our Discussion Today

Impact of Behavioral Health

Strategies to Expand Access to Care

MHPAEA Background

Case Studies: Real-life Challenges and Strategies

Impact of Behavioral Health

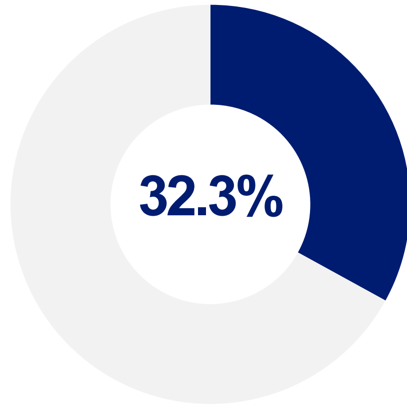
Prevalence in Client Data and Cost Impacts

		Medical		Pharmacy		Total	
Participants	**% of Total**	**PMPM**	**Risk Factor**	**PMPM**	**Risk Factor**	**PMPM**	**Risk Factor**
No Mental Health	65.2%	$340	0.7	$104	0.7	$444	0.7
Any Mental Health	34.8%	$718	1.5	$216	1.5	$934	1.5
Anxiety	8.4%	$833	1.8	$217	1.5	$1,050	1.7
Depression	5.3%	$1,029	2.2	$272	1.9	$1,301	2.1
Psychotic Disorders	0.9%	$1,559	3.3	$420	2.9	$1,979	3.2
Any Substance Use Disorder	7.2%	$1,055	2.2	$265	1.9	$1,320	2.1
Alcohol	0.7%	$1,879	4.0	$208	1.5	$2,087	3.4
Opioids	0.4%	$1,839	3.9	$408	2.9	$2,248	3.7

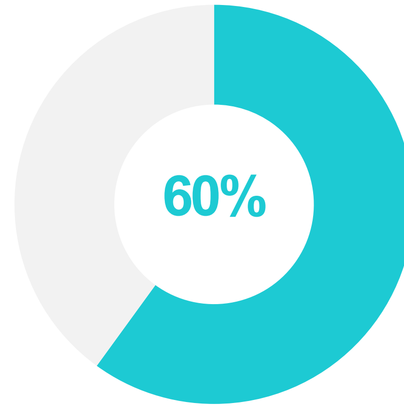
$6 Trillion is the projected annual global cost of mental health disorders in 2030 — more than the combined cost of diabetes and cancer

Source: SHAPE, Segal's health data warehouse

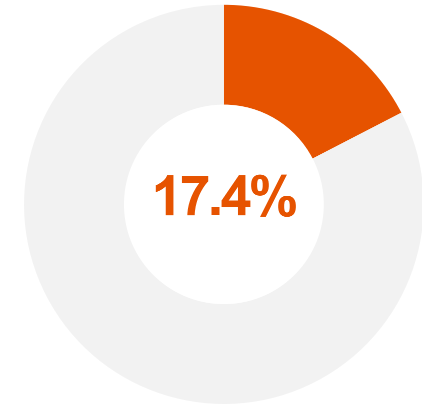
What's the Status of Behavioral Health?



32.3% of American adults have reported symptoms of **anxiety or depression** in 2023



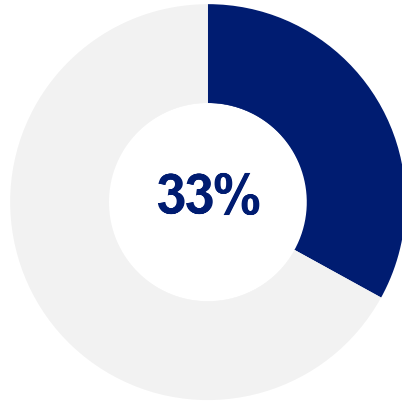
Nearly **60%** of adults with mental illness **did not receive mental health services** in the previous year



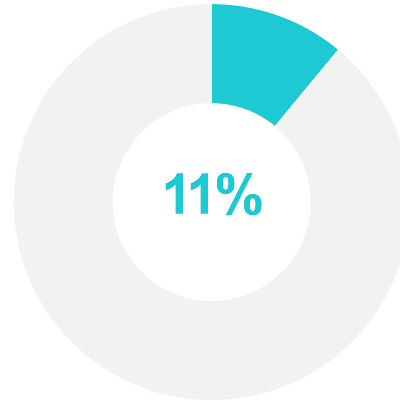
1 in 6 American children (ages 2–8) have been diagnosed with a behavioral health disorder

Sources: Time Special Edition 9/11/20 citing Anxiety and Depression Association of America; National Institute of Mental Health; World Economic Forum; National Alliance on Mental Illness; www.cdc.gov/suicide/facts; Kaiser Family Foundation

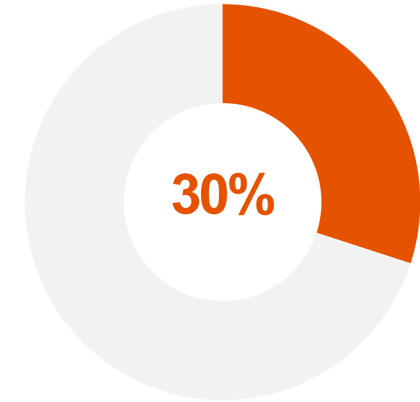
Why Focus on Behavioral Health Now?



According to the CDC, suicide rates have **increased 33%** in the past 20 years



11.3% of Americans age 18+ were diagnosed with alcohol use disorder in 2022



During the pandemic, opioid-related deaths **increased 30%,** and another **15%** in 2021

Overdose deaths were **> 100,000** in both 2022 and 2023

Alcohol remains the #1 substance for SUD-related deaths

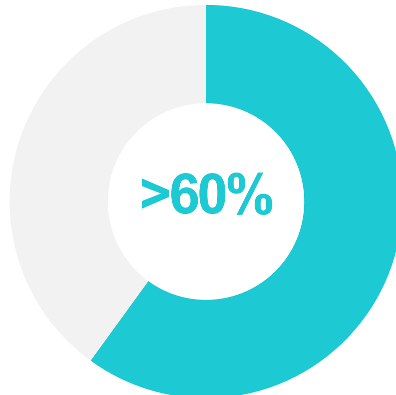
Sources: Time Special Edition 9/11/20 citing Anxiety and Depression Association of America; National Institute of Mental Health; World Economic Forum; National Alliance on Mental Illness; www.cdc.gov/suicide/facts https://www.niaaa.nih.gov/alcohols-effects-health/alcohol-topics/alcohol-facts-and-statistics/alcohol-use-disorder-aud-united-states-age-groups-and-demographic-characteristics CDC and National Institute of Mental Health/April, 2023.

Key Data points to Consider

10 years
General Practitioner

11 years
Psychiatrist

The **median lag time** between symptom onset and first contact for treatment



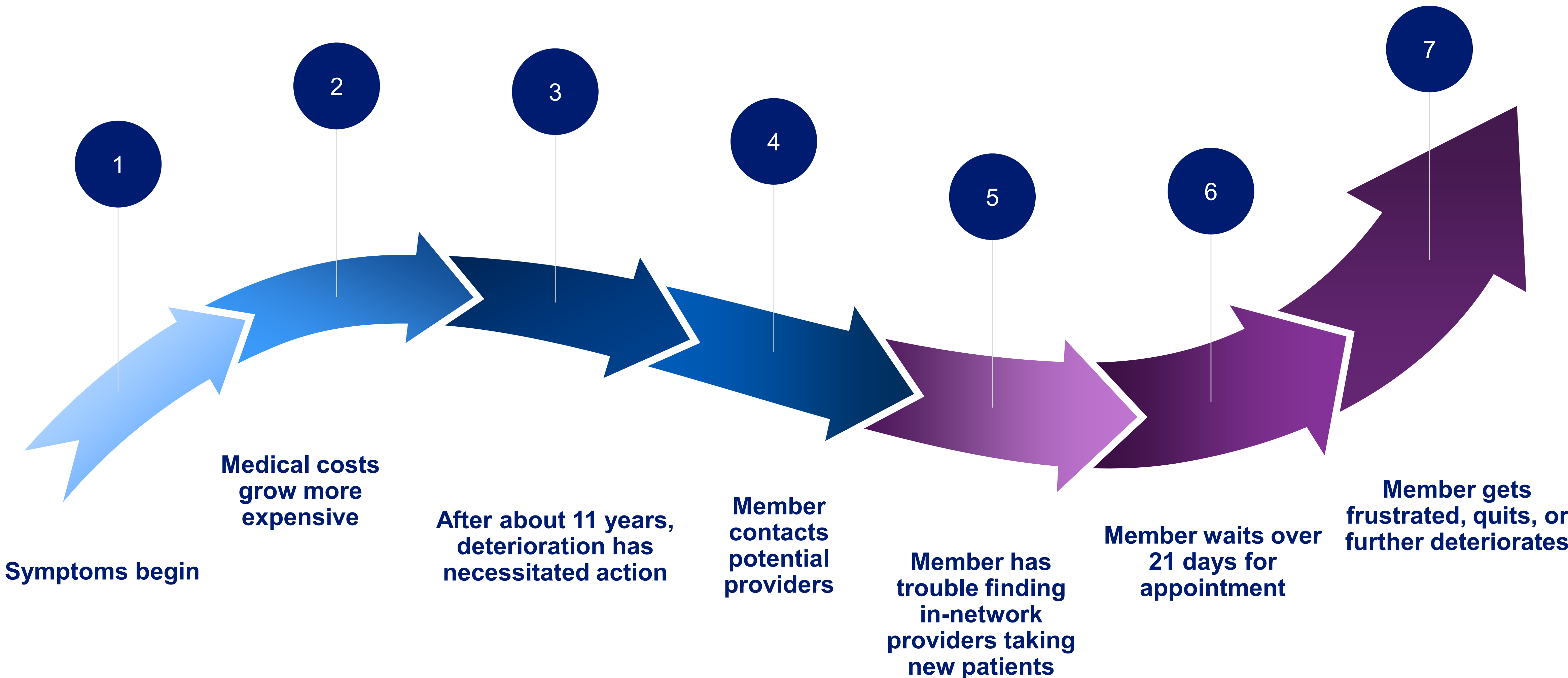
>60% of adults with substance use disorder are employed

ages
25-34

Higher prevalence and acuity of mental illness (and the most likely to be uninsured)

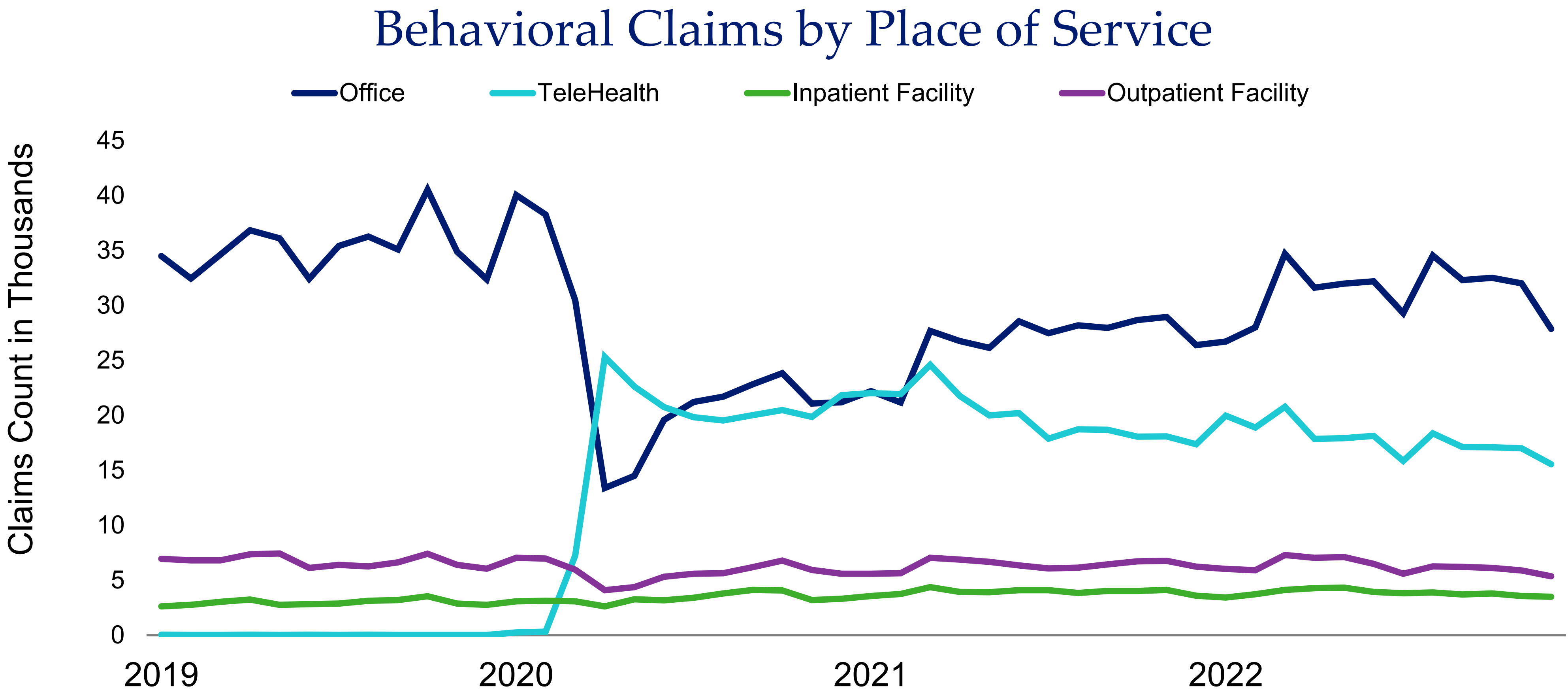
Sources: Delays in Treatment of Mental Disorders and Health Insurance Coverage Health Services Research 2004 Apr; 39(2): 221–224. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361004
Kessler et. Al., 1994.

A Typical Behavioral Health Journey



Sources: https://www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Mental-Health-Screening

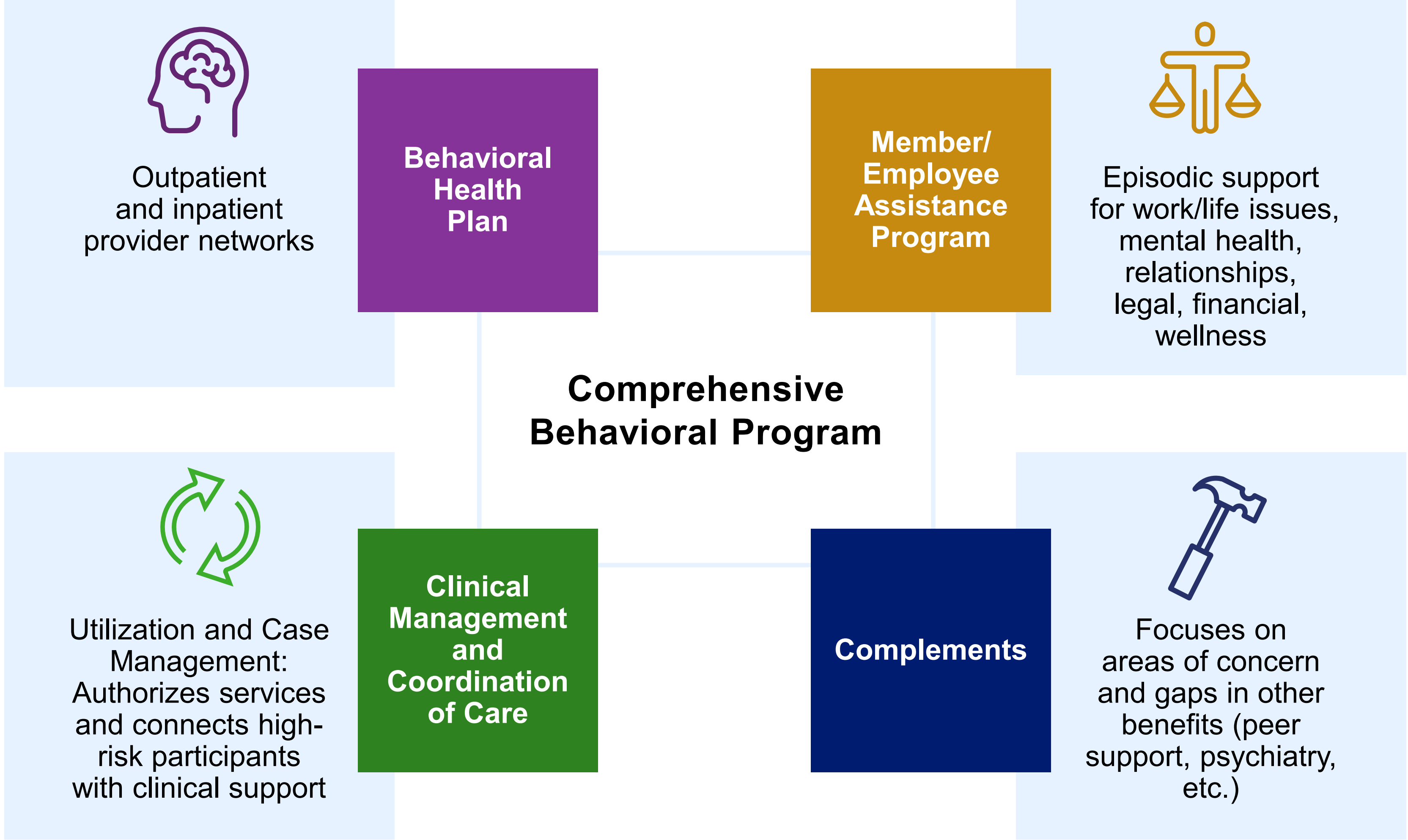
The Pandemic Effect



Segal has observed greater demand for timely mental health treatment, particularly for minors' substance use treatment, personality disorders, mood disorders, and impulse control disorders.

Strategies to Expand Access to Care

How Plans Expand Behavioral Health Program Access



When to Consider New Vendor(s)

You need a new Behavioral Health Network Provider when:

- There is lack of collaborative opportunities - use of technology to include PCP or other data sources (medical / BH / SUD / PBM) for patient management
- There is no presence of legal experts or mental health clinicians on the account management team
- It is not following ASAM guidelines for the treatment of SUD
- It is not reviewing utilization and making recommendations at least annually

You need a new Benefit Administrator when:

- There are high number of appeals/complaints
- There is high out-of-network utilization, fraud, abuse
- There is deterioration in mental health profile of the population - high incidence of suicide, SUD, MH/SUD co-morbidities
- It is not recommending benefit, technology, or other enhancements or innovations

Marketplace Trends in Behavioral Health

Gamification	EAP/MAP with SUD	Provider Networks	Neuroscience	Education
Tools tailored by age and developmental issues Biofeedback video games available at case rates FDA-approved video games that treat ADHD for kids who aren't responding well to therapies or are having trouble staying engaged	Complement existing resources Optional additional therapy integrated with (billed through) current health network Cognitive Behavioral Therapy/Acceptance & Commitment Therapy – exercises before or between therapy sessions Comprehensive digital SUD treatment using a referral to centers of excellence Ongoing SUD coaching/ support/care navigation billed as claims or as case rate	Strong emphasis on DEI for provider recruiting, exclusive provider network, culture and language options (even platform) Customized network for unlimited therapy, a portion billed through health plan Access to specialists: SUD, pediatric issues, adolescent, family counseling, medication management, peer groups, etc.	Digital neurodiagnostic tools involving personalized assessments and access to clinicians Frequent interactions to monitor symptoms (mood, behavior, habits, sleep, relationships, etc.) Coaching, robust self-service education, therapy, psychiatry	Mental health self-care platform to educate about best practices, evidence-based treatment options, and empower individuals No login required Focused on prevention and early intervention Personalized based on needs and learning style Links to benefit resources Complements benefits

Carefully Review Solutions for: compliance, reimbursement, and information security

Marketplace Trends: Substance Use Disorder

Center of Excellence Direct Contract

Offers direct contracting for a yearlong program including inpatient detox, intensive outpatient, peer support, and a vetted national center of excellence

A network provider for most health plan networks

Coaching Based on Substance

Coaching digital programs that use medication-assisted treatment for tobacco, alcohol, and other substances

Tackling all addictions at once is an evidence-based approach

Available through health plans, employers, and PBMs

Subject to a minimum group size

Self-Monitoring Tools

Mobile app and self-monitoring device for alcohol and tobacco

Can integrate with physicians and medication prescribers

Offers contingency management: incentives for abstinence through debit card cash rewards

Lived Experience with Clinical Support

Offers virtual support, educational material, and peer coaching for mental health issues that lead to substance use

Includes family support

Focuses on workforce education on non-threatening topics like stress/coping techniques

At-Home Recovery

At-home services for recovery, available through some health plans

Privacy and convenience of being treated in your home, without missing work and family obligations

Not available in all states

Carefully Review Solutions for: compliance, reimbursement, and information security

Which Plan Design Components Could Enhance Your Program?

- Education/training/workshops for stakeholders, employee onboarding, safety and suicide Prevention, DOT regulation compliance
- Drug-free/Recovery-friendly workplace policies
- EAP visits and tools addressing trauma, stress, anxiety, relationships, lifestyle benefits
- Virtual mental health and telehealth
- Access to screening tools and evidence-based, interactive programs
- Onsite clinics or Assistance Programs
- Prepaid features for easy access and perceived privacy for employees and dependents
- Care navigation pointing to network resources
- Referrals to network clinicians

- Coverage of medication-assisted treatment
- Prescriber network
- Coverage of family counseling
- Utilization and case management that includes family and health advocacy
- Screenings for social determinants of health
- Monitoring medical necessity and evidence-based care
- Specialty networks and targeted solutions
- Potential bundled pricing and performance guarantees

Attention: MHPAEA provisions and NQTLs
Network quality, size, and reimbursement

- Peer support and coaching: consider digital options.
- Family support and caregiving resources
- Age-appropriate and 1st language resources
- Ongoing education and prevention
- Support local community efforts, keep the issues in sight, break the stigma, and talk about it!
- Create an ambassador group
- Spotlight success stories
- Listen and destigmatize asking for help

Mental Health Parity and Addiction Equity Act (MHPAEA) Background

Overview of 2013 Final Regulations

MHPAEA requires parity between medical/surgical (med/surg) benefits and mental health (MH) and substance use disorder (SUD) benefits

Regulations set out parity standards in the following areas:

- Quantitative parity analysis (financial requirements & treatment limits)
- Parity with respect to non-quantitative treatment limits (e.g., medical management)
- Certain designs specifically prohibited (e.g., separate deductibles or out-of-pocket limits)

No requirement to provide MH or SUD coverage (but IF covered, must cover in every classifications where med/surg services are provided)

Strengthening Parity in Mental Health/Substance Use Disorder

Enacted December 27, 2020

Requires group health plans to perform and document comparative analyses of the design and application of nonquantitative treatment limitations (NQTLs)

Plans were required to be prepared to make these comparative analyses available to the Departments of Labor and/or Health and Human Services upon request beginning 45 days after the date of enactment (February 10, 2021)

Strengthening Parity in MH/SUD

Plans generally have been working with benefit administrators to collect documented NQTL comparative analyses regarding administrative activities

DOL, HHS, and Treasury issued initial guidance regarding the new requirements on April 2, 2021 under FAQ Set 45

2023 MHPAEA Guidance

The Departments issued a package of guidance:

- Proposed rules published on August 3, 2023
- Technical release seeking information and comments with respect to guidance for proposed data collection and evaluation requirements for nonquantitative treatment limitations related to network composition
- The 2023 MHPAEA Comparative Analysis Report to Congress
- Enforcement Fact Sheet regarding fiscal year 2022 enforcement results
- Press Release announcing guidance

Mental Health Proposed Rule

The August 3, 2023, proposed rules would amend the 2013 final rules to include additional requirements related to documented NQTL comparative analyses

Proposed applicability for plan years beginning on and after January 1, 2025

Proposed Rule Comments

Public comments were solicited with the Departments receiving over 9,500 comments

Comment letters are accessible for viewing by the public https://www.regulations.gov/docket/EBSA-2023-0010/comments?filter=

Proposed Rule Comments

Comments from employers and plan sponsors tend to raise questions and concerns about:

- Named Fiduciary Certification
- Plan accountability for Network Adequacy
- Changes to 2013 final regulations, including application of substantially/all predominant testing to NQTLs
- Concerns about how to align delivery of clinically appropriate care within the MHPAEA construct
- Concerns about timing and administrative feasibility for implementation of compliance with the proposed rule

Case Studies: Real-life Challenges and Strategies

Case Study #1

Version 1/2

Reliance on high-acuity treatments (high-cost claimants with BH and disproportionate residential treatment)

Limited use of early interventions (limited SUD medication prescribing, low office visits, and low percentage of engagement)

High cost of services (outpatient and inpatient totals per claimant are significant, with high out-of-network use)

Implications: Work with carrier on health plan considerations, address benefit plan design, and implement MAP/SUD solutions

Version 2/2

Case Study #1

Reliance on high-acuity treatments (high-cost claimants with BH and disproportionate residential treatment)

Limited use of early interventions (limited SUD medication prescribing, low office visits, and low percentage of engagement)

High cost of services (outpatient and inpatient totals per claimant are significant, with high out-of-network use)

Implications: Work with carrier on health plan considerations, address benefit plan design, and implement MAP/SUD solutions

Case Study #1: Details

Analysis of behavioral health plan experience showed:

1. Limited use of early interventions and reliance on high-acuity treatments

- Only 5 psychiatrist visits per thousand participants are used for substance use disorder (SUD), but higher levels of SUD treatment were costing the Fund $13 PEPM; residential treatment for SUD is disproportionately high compared to partial hospitalization and intensive outpatient
- Underutilization of medication: participants spent only half the expected benchmark on behavioral health
- Medication-assisted therapy (used for alcohol and other substance use disorders) pharmacy spend has been limited to only one medication (suboxone), whereas evidence-based prescribing and coverage individualizes medication options based on the patient's unique needs
- The majority of behavioral health high-cost claimants had a diagnosis of alcohol dependence, demonstrating consistent barriers in delivering effective, early intervention

Case Study #1: Details

2. High cost of services

- Outpatient totals appeared well-aligned to benchmarks
  - However, the average of outpatient total per claimant is almost double that of benchmarks
  - At the same time, the number of claimants accessing services is much lower than the benchmark
  - Taken together, these facts illustrate that poor outpatient utilization is concealing high outpatient unit costs
- Inpatient unit cost is also a concern: the average inpatient stay costs 1.3x benchmarks
- High out-of-network utilization contributes to high average unit costs:
  half of claims are out-of-network
- Particular network gaps are:
  - residential treatment centers
  - outpatient visits
  - inpatient admissions

Targeted Recommendations for Case Study #1

Limited use of early interventions and reliance on high-acuity treatments		Recommended Solutions
Lack of early intervention and risk detection	Existing program struggles to detect and engage with emerging-risk patients, both prior to needing acute care and post discharge in order to ensure health improvements	Enhance the in-house resources and promote mental health benefits and prevention of disorders Add additional access points for outpatient/office visits and self-care resources
Clinical management	Utilization of high-cost settings for acute care suggests opportunities for outreach to members and families about benefits and care options	Provide emerging risk outreach following inpatient SUD stays and offer care navigation assistance to patients and families Improve network substance use disorder care navigation, especially for partial hospitalization and intensive outpatient programs

Targeted Recommendations for Case Study #1

High Cost of Services		Recommended Solutions
Utilization of high-cost services	High out-of-network utilization Out-of-network providers cost more to the Fund and the participant, and the quality of their treatment cannot be assured	Best-in-Class Centers of Excellence direct-contract for referrals and treatment of substance use disorder Complementary programs offer self-monitoring and evidence-based treatment referrals

It is estimated that **70%** of individuals who need support do not receive it. Recent current events have led to a surge in demand for services, and a need for personalized care.

Perceived lack of privacy and stigma are barriers to seeking support. Introducing virtual access and a personalized approach can increase interest, trust, and engagement.

* 2015 NAMI Mental Health Study.

Segal's Classification of SUD Complements

SUD Enhancements (spanning Navigation to SUD Treatment, Peer Support, and SUD Resources)

Innovative EAP/MAP	Navigation to SUD Treatment	Peer Support	SUD Resources
• Limited-benefit program with no-cost counseling and/or coaching sessions, up to a limit • Work-life benefits such as legal/financial consultations • Often includes training sessions on mental health topics and critical incident support • 24/7 access to clinicians for crisis support • SUD treatment often includes SAP and educational material • Innovative options may include medication prescribing and special programming for certain conditions	• Assessments and referrals to appropriate levels of care to centers of excellence or local partners (as a voluntary carveout) • Increased access to outpatient (sometimes virtual) and/or inpatient levels of care through special contracting • Typically includes aftercare support such as care navigation, coaching, and/or peer groups • Various payment and management arrangements	• Coaching from individuals with a similar lived experience • Typically coupled with long-term peer group support • Often also includes family advocacy coaching and support • May include proactive outreach	• Self-educational resources and assessments • Toolkits for organizations

Case Study #1

Recommended Program Scenarios

Based on the finalists selected, the following Scenarios represent combinations for a best-in-class behavioral health program

Innovative MAP with Navigation to SUD Treatment (Tier 1)

Scenario A
Vendor E (MAP) + Vendor C (SUD)
Innovative MAP with Centers of Excellence for SUD

Scenario B
Vendor D (MAP) + Vendor D's Integrated Health Plan Enhancement (SUD) Innovative MAP with built-in self-monitoring tools and Centers of Excellence for SUD

Innovative MAP, Navigation to SUD Treatment, & Peer Support (Tier

Scenario C
Scenario B (Vendor D MAP & SUD) + Vendor A Innovative MAP with built-in self-monitoring tools and Centers of Excellence for SUD plus local SUD navigation/coaching

Scenario D
Scenario B (Vendor D MAP & SUD) + Vendor B Innovative MAP with self-monitoring tools and Centers of Excellence for SUD, plus coaching and individualized care plans with a focus on involving family

Innovative MAP, Navigation to SUD Treatment, Peer Support, & Onsite Clinician Navigators (Tier 3)

Scenario E
Vendor E (MAP) + Vendor A + onsite Vendor E clinician (for MH)

Scenario F
Scenario D (Vendor D MAP & SUD + Vendor B) + onsite Vendor D clinician (for MH & SUD)

Case Study #1: Scenario Considerations

MAP with Navigation to SUD Treatment (Tier 1)

Scenario A (Vendor E + Vendor C)	**Scenario B** (Vendor D and its Integrated Health Plan Enhancement)
This combination improves access to all levels of care for age 18+, but Vendor C may not coordinate seamlessly with other vendor resources because of Vendor C's reservations about ongoing coordination	This combination improves access to all levels of care for age 18+ in a single vendor, which maximizes efficiency for the Fund and clinical coordination
Both Vendor E's and Vendor C's programs are digitally-centric with no in-person access points available beyond occasional onsite trainings for each	Vendor D's programming is digitally-centric with limited in-person access points available (besides trainings and facilitation to in-person treatment for individuals)
Vendor E's robust self-education compensates for Vendor C's limited self-directed resources	Clinicians are unavailable 24/7 for routine phone referrals

Case Study #1: Scenario Considerations

Innovative MAP, Navigation to SUD Treatment & Peer Support (Tier 2)

Scenario C (Vendor D + Vendor A)	Scenario D (Vendor D + Vendor B)
Vendor D's programming is digitally-centric but treats higher levels of acuity, whereas Vendor A's less-acute, grassroots vision would resonate well with membership and be well-aligned with union objectives	Vendor B's unlimited monthly coaching and individualized participant care plans for age 13+ fills Vendor D's gap in adolescent treatment programs and in family coaching/support
Vendor A is age 13+, so it compensates for Vendor D's gap in adolescent treatment programs	Neither vendor has significant onsite presence beyond occasional training, although Vendor B's partner organizations sometimes visit participants
Vendor A would require administrative supervision, based on its newness and lack of familiarity with regulatory and operational constraints	Vendor D's full-bodied digital education compensates for Vendor B's limited interactive material
With this combination, there is no 24/7 access to clinicians for non-emergency, routine support	Vendor D's carefully-vetted clinical protocols and navigation compensate for Vendor B's lack of clinician involvement
Vendor D's robust self-education compensates for Vendor A's limited self-directed resources; Vendor A's coaching follow-up after higher levels of care supplements Vendor D's care navigation program	Vendor B offers robust outreach attempts: If a participant becomes unreachable, outreach will be made three times per week for first month, then at last once a week after the first month

Case Study #1: Scenario Considerations

Innovative MAP, Navigation to SUD Treatment, Peer Support, & Onsite Clinician Navigators (Tier 3)

Scenario E (Vendor E + Vendor A + onsite clinician)	Scenario F (Vendor D + Vendor B + onsite clinician)
Vendor E's programming is digitally-centric but treats higher levels of acuity, whereas Vendor A's less-acute, grassroots vision would resonate well with membership and be well-aligned with union objectives	Vendor B's unlimited monthly coaching and individualized participant care plans for age 13+ fills Vendor D's gap in adolescent treatment programs and in family coaching/support
Vendor A is age 13+, so it compensates for Vendor E's gap in adolescent treatment programs and also for non-alcohol treatment programs	Neither vendor has significant onsite presence beyond occasional training, although Vendor B's partner organizations sometimes visit participants
Vendor A would require administrative supervision to ensure compliance, based on its newness and lack of familiarity with regulatory restraints	Vendor D's robust digital education compensates for Vendor B's limited interactive material
With this combination, Vendor E's 24/7 access to clinicians for non-emergency, routine support compensates for Vendor A	Vendor D's carefully-vetted clinical protocols and navigation compensate for Vendor B's lack of clinician involvement
Vendor E's robust self-education compensates for Vendor A's limited self-directed resources; Vendor A's follow-up after higher levels of care supplements Vendor E's limited follow-up	Vendor B offers robust outreach attempts: if a participant becomes unreachable, outreach will be made three times per week for first month, then at last once a week after the first month
Vendor E's onsite clinician focuses more primarily on either care navigation or therapy (depending on the role chosen)	Vendor D's clinicians do a mix of therapy and care navigation, plus strategic organizational work (including trainings, consultation with leadership/managers, and promotional work)

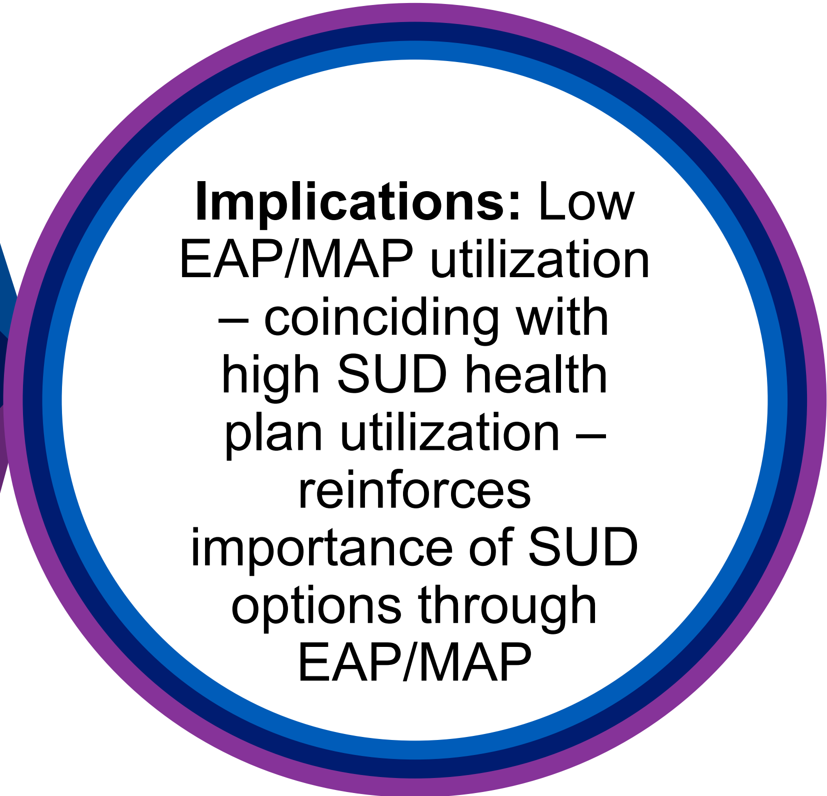
Case Study #2:

High Need and Low Engagement

Low utilization of Employee/Member Assistance Program

In one year, the Fund experienced a 12% increase in substance use treatment

Effect on Plan Health: Behavioral health drives high costs; yearly costs per member with MH and SUD were 1.6 and 2.3 times that of the total population, respectively



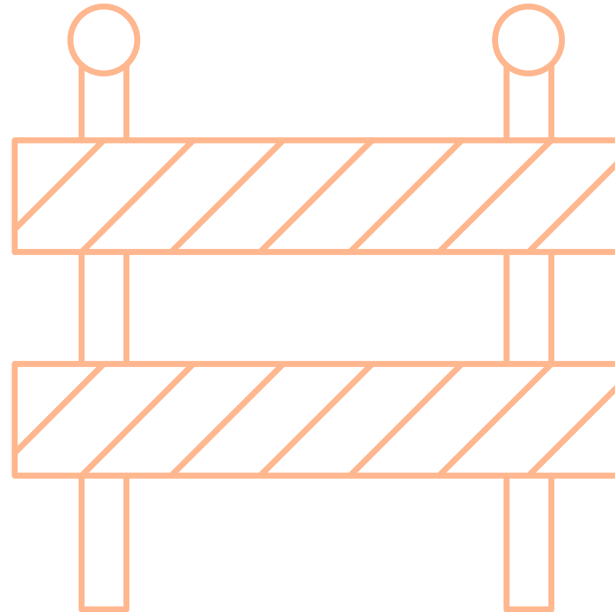
Implications: Low EAP/MAP utilization – coinciding with high SUD health plan utilization – reinforces importance of SUD options through EAP/MAP

Case Study #2

Barriers to Engagement

Removing barriers

What social barriers may prevent access to care for individuals, and how can you help address those barriers?



Engagement in treatment is impacted by:

1. Stigma and shame (both patient and provider biases)
2. Lack of care navigation and awareness about evidence-based treatments
3. Lack of training on identification and best practices for primary care providers
4. Shortage of quality specialty providers
5. Prioritizing medical stabilization over the chronic nature of diseases
6. Cost and social drivers of health

Case Study #2
Optimizing Engagement

Engagement will be optimized in programs that effectively address the following:

Ease of Access and Technology

Increasing consumer preference for telehealth and online scheduling

Improved time to care: telephonic or mobile app

Delivery of services via video, chat, and asynchronous email

Treatment innovations, such as Cognitive Behavioral Therapy (CBT) and digital self-monitoring tools

Medication prescribing and management via telehealth for chronic conditions

Provider Network Trends

Transitions by independent providers to telehealth since the pandemic

Shortages of providers specializing in pediatric issues and SUD

Personalized Care

Deskless workforce

High-risk (construction) and safety-sensitive occupations (issues for Business Agent/Managers)

First languages: English, Polish, and Spanish

Unique needs: age-appropriate for dependents, students, couples/families

Retirees

Out-of-area and seasonal residents who access care in different areas

Medicare limits on mental health and substance use disorder services

Case Study #2: Vendor Comparison

Substance Use and other Clinical Resources

Top Clinical Program Strengths

Vendor B's SUD program includes specialized assessment and longitudinal care follow-up with referrals to SUD partner programs.

Vendor A and Vendor B have the most stringent standards and protocols to ensure clinical provider quality.

Vendor A and Vendor B provide the most advanced user interface to select providers and self-schedule appointments that account for members' personal preferences.

Vendor A and Vendor B provide medication prescribing and continued therapy that are billed through claims integrated with the health plan.

Vendor A provides a program that supports union leadership in promoting behavioral health.

Vendor C coaches typically also cover wellness areas (weight management, tobacco cessation, fitness, etc.).

Clinical Program Concerns

Vendor C is the only bidder that currently does not include SUD-specific programs, although SUD coaching is on its roadmap.

Vendor C's digital platform is only available in English, Spanish and French (whereas Vendor A and Vendor B have more language options).

Vendor B has a wide variety of treatment options for SUD, but all its partner programs are billed through the health plan claims (rather than using the EAP/MAP visit limit).

Vendor B does not have 24/7 phone consultations (although crisis support is 24/7).

Case Study #2: Vendor Comparison

Financial, Access, and Administration

Financials

Traditional MAP costs should not be compared alongside Innovative MAP costs without first considering breadth of services and potential participant outcomes.

HIPAA Compliance/Security

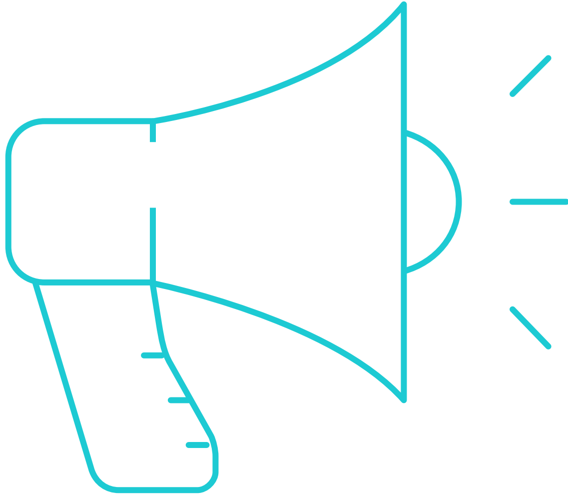
Geo-Access and Network

The pandemic and a migration of providers to virtual modalities has produced an increase in virtual MAP services. Look for sufficient appointment availability for both in-person and virtual care.

General Administration

- Eligibility files
- Real-time reports
- Invoicing

Case Study #2: Communication Tips



How are benefits and resources being communicated?

Is the communication strategy ongoing?

Does the communication strategy consider spouses and dependents?

Is the communication strategy tailored for each of the roles who encounter members?

Other Strategies Plans are Considering

1

Travel benefit
For inpatient stays at centers of excellence

2

Utilization management
Consider the need for UM for MH/SUD services (including partner inpatient facilities, intensive outpatient, and virtual care)

3

Out-of-network reimbursement
Confirm care navigators are educating about in-network resources and that reimbursement formulas are appropriate; track payments quarterly by type of service and network status

4

Medication coverage
Confirm the current coverage/ affordability for the most effective MH / SUD medications, and remove barriers to access

5

Cost share
Revisit deductible and other cost share for participants to reduce barriers to care

6

Expand access
Consider adding household members to MAP program beyond members and spouses/dependents

Takeaways

1. There is significant variation in the services and modalities offered by behavioral health vendors today
2. Behavioral health approaches should be tailored to the unique needs of the Plan
3. Not all behavioral health strategies require utilization of vendors, but some require combining multiple different vendors
4. Watch for the release of the final, updated parity guidance