VOLUME 77 ◆ NUMBER 7

Employee Benefit Plan Review

Employee Mental Health Is a Priority for Employee Benefit Plans

By Christine Cooper

Employer-sponsored health plan claims experience confirms that an increasing percentage of covered participants are receiving mental and behavioral health support, coupled with an increase in service utilization, per patient.

According to the Mental Health in America: A 2022 Workplace Report[1] sponsored by the Society for Human Resource Management (SHRM), 78% of organizations currently offer, or plan to offer, mental health resources beyond their health plan's coverage. This growth is commensurate with the significant increase in mental health and behavioral conditions attributable to COVID dislocations. This response is also consistent with alarming statistics that show how mental health and behavioral issues impact workplace productivity.

The Affordable Care Act (ACA)[2] has helped expand access to mental health services by requiring most insurance plans to provide "Essential Health Benefits" – which include treatment of mental health conditions. Most individual and small employer health insurance plans, including all plans offered through the Health Insurance Marketplace, cover mental and behavioral health, as well as substance abuse.

Prioritized employer support reflects higher utilization of mental and behavioral health services treating post-pandemic residual stress, anxiety and depression. The critical need for additional support was highlighted by President Biden when he declared a national mental health crisis during his 2022 State of the Union address, unveiling an ambitious plan that received bipartisan support to provide for the nation's mental and behavioral health needs.[3] The U.S. Surgeon General also released a framework[4] for mental health and well-being in the workplace, outlining guidance for policies, processes and practices to support workers.

However, even with federal support, workers are still finding it challenging to access and pay for mental health and behavioral services. Many are financially fragile and continue to be strained by premium increases and unanticipated out-of-pocket expenses. Add on the concerns over stigma, and some employees feel compelled to use more expensive out of network providers and/or pay out-of-pocket for their mental health and behavioral care needs.

In light of these challenges, advisors, consultants and claims administrators are well-positioned to support plan sponsors and plan administrators. By incorporating compliant and strategic solutions, a best practices plan design will optimize plan value for participants – ensuring plan participants can access the timely and affordable help they need and deserve.

Why Employers Should Care About the Mental Health of Their Employees

The Associated Press reported estimates that show untreated mental illness may cost companies up to $300 billion annually,[5] largely because of higher absenteeism, greater "presenteeism"[6] and increased medical and disability expenses. These conditions impact both direct costs, such as increases in medical and disability benefits spend, as well as indirect costs affecting productivity due to absenteeism and presenteeism. Employees who experience mental health issues are on average unproductive 35%[7] of the workday, while employees who require clinical care for mental health episodes submit up to four times the number of claims and expenses.

Addressing mental and behavioral health issues is even more critical for younger workers. According to Mind Share Partners' 2021 Mental Health at Work Report,[8] millennials and Gen Z respondents were significantly more likely to report experiencing mental health symptoms than older workers. Data[9] from other research confirms that 68% of Millennials and 81% of Gen Z have left jobs for reasons attributable to mental health.

Providing Mental Health Coverage as A Benefit

Providing employees with benefits that are both adequate yet financially sustainable has never been easy. Today, it is especially challenging given the current economic and social conditions.

According to a report by the Kaiser Family Foundation (KFF),[10] 39.5 million Americans received mental health and substance use disorder benefits through their employer-sponsored health insurance plans in 2020, up from 36.6 million in 2019 and 33.3 million in 2018.

National surveys[11] of employers and employees provide insights into the mental health needs of the U.S. workforce and how employers can best address them. McKinsey highlights several points of disconnect between employer and employee perspectives on workplace mental health. Its national survey revealed differences in three areas: level of employer support for mental health, employee access to mental illness and substance use disorder treatment and workplace stigma. The disconnect is most pronounced when it comes to perceived benefits for frontline employees and access to care for employees with a substance use disorder.

The National Alliance of Healthcare Purchaser Coalitions polled 221 employers[12] that provide coverage to more than 10 million employees and their dependents and found that just 31% are satisfied with network access for behavioral healthcare services. Only 34% of employers said that their behavioral healthcare directories accurately reflect the available, network providers.

This study confirmed health plan and vendor performance was lacking when it came to securing an adequate network of providers and managing access so that it is both timely and affordable.

Mental Health Parity

Federal parity rules[13] require health plans that offer behavioral health coverage to ensure that financial requirements, such as deductibles, copayments, coinsurance, out-of-pocket limits, as well as treatment limits on these benefits, are no more restrictive than those on medical and surgical benefits.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)[14] requires that health insurance plans provide equal coverage for mental and physical illnesses. This is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations when compared to medical/surgical benefits.

The Consolidated Appropriations Act, 2021[15] amended MHPAEA, in part, by expressly requiring group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical benefits and MH/SUD benefits and that impose non-quantitative treatment limitations (NQTLs) on MH/SUD benefits to perform and document their comparative analyses of the design and application of NQTLs.

More recently, the Biden administration is specifically focused on ensuring NQTLs do not apply disproportionately[16] to mental health and behavioral services.

Strengthening behavioral health parity protections is just one part of a larger policy discussion that includes addressing provider shortages,[17] inadequate crisis *infrastructure*,[18] and inadequate coordination and integration of primary care and mental health care. All of these issues contribute to the access and coverage challenges that mental health and behavioral health parity was supposed to address. Evaluating what an adequate network of mental health providers looks like, one that addresses the full spectrum of employee needs, will be key to developing enforceable standards of care.

Most recently, the Biden administration has proposed new regulatory guidance incorporating dramatically different and heightened parity compliance standards for mental health benefits – evaluating outcomes and utilization by focusing on network adequacy and benefit differences between in-network and out-of-network mental health providers – comparing utilization of mental health services with all other medical services.

Taking Strategic Action and a Holistic Approach

Plan sponsors and their benefits advisors should take strategic action to ensure that their plans incorporate

the most effective, affordable and holistic strategies available to address today's inflation, economic challenges and mental health needs. It is also recommended that benefit specialists focus on helping plan participants build savings as part of a 'health and wealth' strategy that optimizes financial preparedness.

Mercer's Health on Demand 2023 Survey Report[19] notes that to make coverage more affordable for employees in terms of lowering out-of-pocket costs and deductibles, many plan sponsors are turning to cost-effective and convenient remote care through digital health technologies and innovations, including virtual behavioral healthcare solutions, and taking advantage of alternatives deployed through Employee Assistance Programs (EAP).

Additional strategies include effectively designed acquisition cost-based pharmacy pricing, HSA-capable coverage, reference-based pricing and adequate participant protections against balance billing.

Other strategies take advantage of price transparency to capitalize on cost containment initiatives and to fully optimize value by putting participants as healthcare consumers in the driver's seat, giving them control over economic purchasing power and decision-making.

Health Savings Accounts

Health Savings Accounts (HSAs) can play a vital role in that process as a tax-efficient source of funds to cover out-of-pocket medical costs in current and future years. With its unique tax advantages and ease of use, the HSA is a great companion to expanded mental health resources.

Reference-Based Pricing

As noted earlier, seldom is the network of mental health providers adequate. And, even where the network is adequate, some/many network providers are not accepting new patients. Forced to access treatment from out-of-network providers, participants experience increased out-of-pocket expenses. Those increased costs typically include two components: (1) separate and higher deductibles and lower coinsurance, and (2) no control over provider fees – sometimes resulting in excessive charges.

Reference-based pricing (RBP) is an appropriate strategy. A "pure" RBP design eliminates the dependency on a network's ability to negotiate a price for a specific provider in a specific location for specific services. Since there are neither in or out of network providers, there is no requirement to determine a median in-network rate or contracted rates. So "pure RBP" design avoids the cost of direct contracting and network access fees. Since in-network charges also tend to vary substantially from provider to provider, pure RBP also ensures the reference price applies in every situation.

"Pure" RBP should include participant representation to manage any balance billing. "Done right," "pure RBP" will, over time, lower the cost of coverage in turn, lowering both employee and employer contributions.

Alternative Programs

An EAP is a voluntary, work-based program that typically offers free and confidential assessments, short-term counseling, referrals, and follow-up services to employees who have personal and/or work-related mental health or behavioral conditions. The EAP is an employee benefit that is often separate from health coverage. Typically, employers pay all costs when offering an EAP – so there typically isn't any copay or deductible.

According to a National Institute for Mental Health[20] survey, roughly half of adults with depression or anxiety conditions have sought help from an EAP in the past year. And more than 70% of people who have received treatment for substance use disorder say they did so through an EAP. Today, 32% of human resources professionals say offering mental health resources such as employee assistance programs is a high priority.

Value of a Medical Billing Partner

Benefits professionals, plan sponsors and third-party administrators are benefiting from partnerships with tech-enabled medical billing support services that provide valuable cost-management insights through proprietary data-driven solutions. Real-time price information of provider services enables plan participants to make the most advantageous cost-benefit decisions regarding their care options.

Notes

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Christine Cooper, a member of the Board of Editors of *Employee Benefit Plan Review*, is chief executive officer of aequum LLC and co-managing member of the law firm of Koehler Fitzgerald LLC, where she leads the firm's healthcare practice.