

Misaligned

Why more spending can't buy better mental healthcare

The most common mental health benefits cost more than they save. This report explains why — and the new standard employers should demand instead.

- Half of adults with mental illness remain untreated — despite decades of investment in access
- Matching treatment to acuity in a stepped-care model reduces total costs by 22%
- An AI-native approach unlocks acuity-matched behavioral health delivery at scale

Employers won the access-era of behavioral health. Smarter allocation will define the next

Over the last decade, U.S. employers turned mental health care into an essential health benefit. They expanded employee assistance programs (EAPs), added virtual therapy access, and helped move mental health from a private struggle to a workplace priority.

That work mattered, but the market has entered a more complicated phase. The question is no longer whether support is available; it's whether the system matches the right level of care to the right person.

The current system fails that test. Dominant models continue to route employees toward the same narrow option — one-on-one sessions with a human therapist — regardless of acuity, preference, or likelihood of improvement.

The economics reinforce the mismatch: EAPs tolerate low engagement, session-based models reward volume, and neither reliably rewards improvement.

The cost of success

79%

EAP referrals now route to mental health counseling¹

90%

Of workers report a mental health challenge, the most since 2019²

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Mental health is now a top 5 driver of commercial spend^{3,4}

This mismatch is now showing up in cost. Mental health ranks among the top drivers of commercial spend, with large employers facing another 10–20% trend increase in 2026.^{3,4}

More spending on the same model is not a sustainable answer — and rising

spend has not translated into a healthier workforce.

The next era will be defined by allocation — matching varying levels of support to demonstrated employee needs — and ensuring reimbursement is tied to measurable outcomes.

The therapy-first model fails three populations differently

Behavioral health needs span a continuum, but the dominant benefit isn't built to meet those needs.

Most employer-sponsored models offer one structured pathway: a fixed number of sessions with a licensed clinician, followed by referral if the need exceeds the cap.

That design made sense when access was the primary problem, but it's poorly matched to a workforce whose needs range from everyday stress to serious clinical risk.



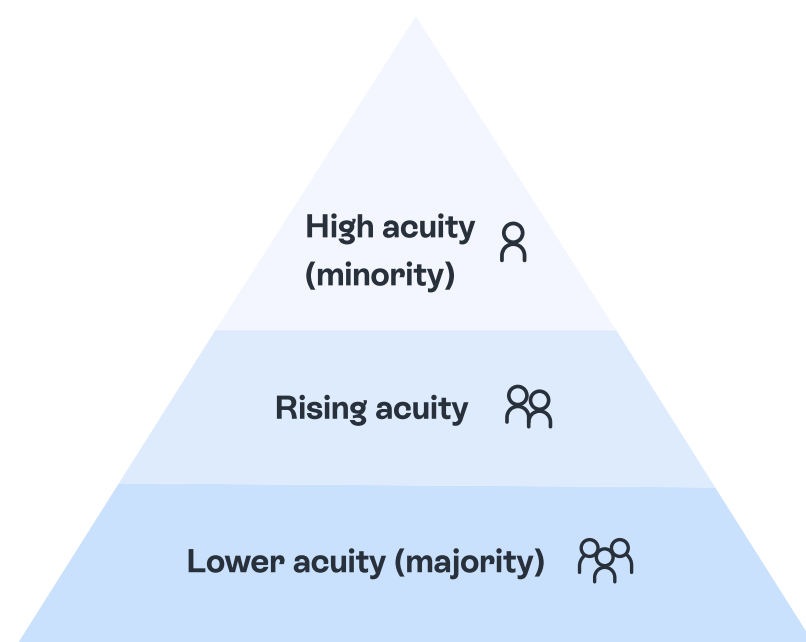
The mismatch looks different at every level of acuity

High acuity employees

These employees need far more than either short-term EAP sessions or the newer blended-care platforms are built to provide. Designed around therapy and digital content for depression and anxiety, these models still refer the highest-acuity cases into a fragmented external system, often through primary care, where many are never connected with an appropriate specialist.⁵

Rising acuity employees

These employees are not in clinical distress, but the strain is building — through stress, burnout, sleep disruption, or low mood. Many fear being routed into more care than they want. Most benefits give them two choices: do nothing, or enter therapy. Too often, they choose nothing.⁶



Lower acuity employees

Most employees seeking support fall into this group. The default pathway often routes them into structured therapy, where engagement and improvement are uneven. When asked, many prefer digital, self-directed support — exactly what most benefits still don't offer.⁷

Industry pricing models preserve the status quo

Employer behavioral health is dominated by two payment structures: PEPM and session-based pricing. Each distorts care in a different direction. Both share the same flaw: revenue is disconnected from whether employees actually get better.

PEPM-based

A low-utilization EAP is, by design, the most profitable EAP. Employers pay a fixed fee whether employees use the benefit or not.

Mental health now dominates the requests that do come in — 79% of EAP referrals route to counseling, up from 71% the prior year.¹

Session-based

Under session-based payment models, revenue increases with every therapy session delivered.

A vendor that resolves needs faster, or routes employees to lower-intensity care, earns less.

Model	Rewarded for	Not accountable for
PEPM/EAP	Low engagement	Whether anyone improved
Session-based	Volume of sessions	Whether care was necessary

The result is a market that pays for access and activity, but has no built-in mechanism to reward improvement.

Two constraints keep the system from self-correcting

Misallocation persists because the market is held in place by two structural forces.

1. The way care is paid for

As noted, PEPM vendors that drive more engagement watch their margins shrink, while session-based vendors that reduce clinically unnecessary therapy visits see revenue fall.

In both models, clinically appropriate behavior can be economically penalized.

2. Clinician supply creates a ceiling

Any model that depends on licensed-clinician hours as the default unit of care will ration support. In an equitable system, high-acuity cases would get clinician time first. But when every need is pointed toward the same scarce resource, care often goes first-come, first-served — or to those best able to navigate and pay.

That constraint is tightening. Demand for behavioral health care is projected to outpace the provider workforce for years, leaving fewer clinician hours for the people who need them most.⁸

Access-based models are cost additive

+\$2.10

Net new spending added by blended-care mental health solutions

≈ \$25M

For every million covered members, per year

Employers have tried to spend their way out of the problem, paying for more sessions, more virtual therapy, more entry points into clinician-led care. But subsidizing access to the current model only makes it more expensive to sustain.

A 2025 Peterson Health Technology Institute review of fifteen employer-sponsored virtual mental health platforms found that blended-care solutions — those combining digital content with clinician-led care — were cost additive, increasing total spending by \$2.10 per member per month.⁹

“Premiums would be three times higher [with universal access to therapy]...it’s just not a model that can be sustained.”

Rhonda Robinson Beale

Deputy Chief Medical Officer of Mental Health Services, UnitedHealth Group¹⁰

When benefits are lacking, employees turn to AI

When employer-sponsored care doesn't offer an appropriate option, employees find one elsewhere. Increasingly, that means general-purpose AI.

In a 2025 survey of U.S. adults with ongoing mental health conditions, nearly half reported using AI tools for mental health support. The most common reasons were access and affordability — not novelty.

People are turning to these tools for anxiety and depression because they are available, affordable, and immediate in ways the formal system is not.¹¹

General purpose AI isn't clinically safe

A 2025 peer-reviewed comparison of licensed therapists and general-purpose chatbots concluded that LLM-based chatbots are not safe for mental health conversations, particularly in crisis.

They defaulted to directive advice and generic responses without the clinical inquiry a proper assessment requires.¹²

And, because general-purpose tools are optimized for engagement rather than well-being, the features that make them feel supportive can foster dependency rather than recovery.¹³

Why employees turn to AI tools for mental health

- ✓ On demand access
- ✓ Affordability
- ✓ Low commitment
- ✓ Perceived privacy and anonymity



"General-purpose chatbots are unsuitable to safely engage in mental health conversations, particularly in crisis situations."

Scholich T, Barr M, Stirman SW, and Raj S

A Comparison of Responses from Human Therapists and LLM-Based Chatbots. JMIR Ment Health. 2025

A better model: matched care at scale

The evidence has pointed in the same direction for decades: behavioral health care works best when intensity matches need.

Internet-delivered CBT has been shown to be non-inferior to face-to-face care for anxiety and depressive disorders¹⁴ — the population that makes up much of any employer's covered lives. Stepped-care models have cut total costs by 22% and hospital costs by 50% in a randomized trial.¹⁵

The principle is straightforward: use the least intensive effective intervention first, escalate when needed, and preserve specialists for the cases that require specialist care.

The National Institute for Health and Care Excellence (NICE) has recommended a least-intrusive-first approach for less severe depression since 2022.¹⁶

Delivery was always the challenge

Lower-intensity, continuous support cannot scale if every touchpoint with employees requires clinician time.

Clinically governed AI — built on evidence-based protocols, overseen by licensed clinicians, with clear escalation to human care — changes the constraint, not as a therapist replacement, but as the dynamic infrastructure necessary for matched care.

Always-on support for every day needs, early risk identification, and a clear path to human-led care when clinical escalation is warranted.

Savings using a stepped care approach

22% Reduction in total mental health spending¹⁵

50% Reduction in hospital costs¹⁵

The clinical reality	What changes with AI
✓ Most people don't need therapy first ✓ Care should escalate as acuity rises ✓ Specialty time is finite and expensive	✓ Support is available before needs escalate ✓ Acuity is monitored continuously over time ✓ Now it can be preserved for those who need it

The new standard employers should demand

For much of the last decade, value in behavioral health was measured by access: how fast employees could get an appointment, how many used the benefit, and whether they were satisfied.

But employers don't evaluate other high-cost health categories on access alone. In MSK, diabetes, cancer, or cardiovascular care, they ask hard

questions on whether interventions delivered improved health, function, utilization, and cost.

It's time for behavioral health to meet the same bar. The test is practical: can the benefit identify who needs therapy, who needs a lighter alternative, who needs escalation — and deliver that care in a measurable way?

Evaluation criteria



Validated outcomes

Published outcomes and real-world data, not simply vendor-reported engagement or satisfaction.



Architecture built for acuity

The benefit should assess need, provide lower-intensity support when appropriate, and escalate care when needed.



Economics tied to value

Pricing should reward measurable improvement, not underuse, session volume, or activity alone.

Proof from a decade of acuity-matched care

Pelago built its substance use model around a simple validated premise: different people need different paths. It's now applying that logic to behavioral health broadly, using clinical AI to reach the populations that structured therapy has consistently failed to serve.¹⁷

Independently validated ROI¹⁸

5.7 : 1

Annual medical savings per participant¹⁸

\$ 11,829

The access era is over. The allocation era requires a new approach

The access era normalized mental health as part of healthcare. It expanded options, pushed the market to respond, and changed the culture of work and care.

But the next era of behavioral health will be judged by a harder test: not whether support exists, but whether the system can improve outcomes at a cost employers can defend.

Employees are already turning to AI for mental health support — not because employers pushed them there, but because the current system left a gap. The responsibility now is to make it safe, effective, and accountable.

What that looks like in practice

That means matching support intensity to clinical need and preserving licensed clinicians for the patients who need them most. The economics should reflect the same shift: benefits buyers should expect pricing tied to improvement on validated outcomes, not utilization volume. Clinically governed AI is what makes this new model viable at population scale.

The question now facing employers is whether to use AI to prop up a failing care model, or build a better one.

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