Office of Personnel Management

STRENGTHENING MATERNAL MENTAL HEALTH IN THE FEHB PROGRAM

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This project is dedicated to the mothers who continue to navigate pregnancy and postpartum while facing mental health challenges—your experiences and resilience inspire the work behind every page of this report.

Disclaimer

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Key Terms

Maternal Mental Health: A range of mental health conditions that affect individuals during pregnancy and up to one year postpartum

Federal Employees Health Benefits (FEHB) Program: The largest employer-sponsored health insurance program in the United States, covering over eight million federal employees, retirees, and their dependents through a variety of carrier plans.

Office of Personnel Management (OPM): The federal agency responsible for managing federal workforce benefits, including the FEHB Program.

Perinatal Period: The time encompassing pregnancy and the first 12 months postpartum

Mental Health Screening: The use of validated questionnaires or tools to identify potential mental health conditions in individuals during routine care visits

Care Coordination: A system of organizing patient care activities and sharing information to achieve more effective treatment

Telehealth: The delivery of healthcare services remotely via telecommunications technology, such as video calls or mobile apps.

Executive Summary

The Office of Personnel Management (OPM) requested this report to explore strategies for improving maternal mental health outcomes within the Federal Employees Health Benefits (FEHB) Program. Maternal mental health conditions, including perinatal depression and anxiety, affect up to 20% of those that give birth in the Unites States and are a leading contributor to preventable maternal morbidity and mortality (CDC, 2022). Left untreated, these conditions generate high societal costs through increased healthcare utilization, lost workforce productivity, and negative child development outcomes. A 2019 analysis estimates that untreated maternal mental health disorders cost the United States economy approximately $14.2 billion annually, or $32,000 per mother-child pair over five years (Mathematica, 2019).

Despite its size and reach, the FEHB Program does not have consistent or standardized maternal mental health coverage across plans. This leads to variation in access, underdiagnosis, and delays in care—particularly for enrollees in geographically underserved areas. OPM has an opportunity to set systemwide expectations that strengthen early detection and reduce avoidable long-term impacts.

This analysis evaluates four policy alternatives using a public policy framework grounded in cost-effectiveness, access and distribution, implementation feasibility, and program sustainability:

1. Status Quo: Maintains current FEHB plan-level autonomy. While easy to administer, this option results in an estimated $3.2 billion in societal costs per 100,000 pregnant enrollees. This is driven by untreated mental health conditions and wide variation in care quality.
2. Integrated Screening and Care Coordination: Introduces standardized mental health screenings at three points during pregnancy and postpartum, supported by digital tools and centralized referral systems. With a projected cost of $114.9 million per 100,000 pregnant enrollees and cost per successful treatment of $7,660, this option balances cost-effectiveness with long-term sustainability and is compatible with existing FEHB infrastructure.
3. Enhanced Telehealth and Support Network: Expands access to virtual therapy, peer support, and remote consultation services. This is the most cost-effective approach at $6,666 per successful outcome but requires attention to broadband infrastructure and licensure rules, which may limit feasibility in certain regions.
4. Advanced Pharmacological Treatment and Coverage: Adds coverage for medications like Brexanolone and Zuranolone, which offer rapid relief for severe postpartum depression. However, this option has the highest cost per successful outcome at $27,500 and faces additional administrative and provider training barriers.

Based on this analysis, the report recommends that OPM adopt the integrated screening and care coordination approach. It offers a strong balance of cost control, implementation feasibility, and long-term benefits. Screening tools like the Edinburgh Postnatal Depression Scale and GAD-2 are already validated and widely used, and digital referral platforms can ensure timely connections to care across geographic regions.

A phased rollout of this intervention—beginning with pilot programs, followed by evaluation and systemwide benchmarks—would allow for refinement and stakeholder engagement. By implementing this strategy, OPM can meaningfully improve health outcomes for covered families and enhance the effectiveness of the FEHB Program as a national model for maternal mental health care.

Introduction to the Problem

Introduction

Maternal mental health is a pressing public health issue, with conditions such as perinatal depression and anxiety affecting up to one in seven mothers in the United States (Ghahremani et al., 2022). Along with affecting the well-being of mothers, these challenges have far-reaching implications for children, families, and healthcare costs (Brown et al., 2021). Despite the increasing awareness about this problem, significant barriers remain. Insufficient screenings, stigma, and inequitable access to mental health services are all major contributing factors to this issue (DeClercq et al., 2022; Ghahremani et al., 2022). The Office of Personnel Management (OPM) is uniquely positioned to address these challenges through programs such as the Federal Employees Health Benefits (FEHB) Program. By expanding access maternal mental health services, OPM can ensure that federal employees and their families receive comprehensive support during and after pregnancy as well as serving as a model for other health insurance programs in the United States.

This analysis is situated within a broader national dialogue that increasingly recognizes maternal mental health as a critical public health and workforce issue. While federal initiatives have contributed to the growing prioritization of maternal mental health within healthcare policy, the persistent challenges of maternal morbidity and mental health disparities transcend political transitions and remain pressing regardless of changes in administration. OPM is well-positioned to enhance the health and well-being of the federal workforce while establishing a model for other employer-sponsored insurance programs.

In the following sections, this memo will overview the scope of the problem, a review of the existing evidence, and an outline of the path forward for OPM.

Problem Statement

Untreated maternal mental health disorders, such as perinatal depression and anxiety, significantly impact mothers, children, and families, contributing to severe health complications, higher maternal mortality rates, and substantial healthcare costs. Even with the increase in awareness, barriers such as inadequate screenings, stigma, and limited access to care that meets patients' specific needs persist, disproportionately affecting underserved populations such as rural communities and communities of color (Ghahremani et al., 2022; Brown et al., 2021). ***Currently, the Federal Employee Health Benefits (FEHB) Program has fragmented maternal mental health coverage leaves many mothers without access to essential care for mental health conditions.*** Closing these gaps is crucial to improving maternal and child health outcomes while reducing long-term costs.

OPM, through the FEHB Program, has the opportunity to address these gaps by prioritizing evidence-based interventions tailored to the varied needs of federal employees. Without targeted strategies, the FEHB program risks failing to meet its goal of providing comprehensive, high-quality care. By implementing evidence-based solutions, OPM can reduce healthcare disparities. Improve maternal mental health outcomes and ensure sustainable delivery across the federal workforce (Falconi et al., 2022; Cantor et al., 2022). These efforts to ensure that maternal mental health remains a priority within its health benefits framework would not only benefit FEHB

enrollees but also reinforce OPM's position as a national leader in advancing maternal mental health through innovative healthcare delivery methods.

In addition to these disparities, untreated maternal mental health conditions have cascading effects on family systems, healthcare utilization, and long-term health outcomes. Perinatal mood and anxiety disorders are among the most prevalent complications of pregnancy, yet many individuals remain undiagnosed or untreated, exacerbating risks for chronic mental health challenges. These conditions can impair a parent's ability to engage in caregiving and self-care, leading to heightened stress within households and increased reliance on emergency medical and social services, therefore contributing toward the excessive cost of untreated maternal mental health conditions.

Client Overview

This analysis is being conducted for OPM's Healthcare and Insurance (HI) team, which is responsible for setting policies and overseeing the FEHB program. As the largest employer-sponsored health insurance program in the United States, FEHB serves over eight million federal employees, retirees, and their families, providing a critical mechanism for advancing healthcare services and addressing pressing public health challenges (U.S. Office of Personnel Management, n.d.-a). Maternal mental health care aligns closely with OPM's mission to ensure comprehensive, high-quality healthcare that supports employee well-being and productivity.

The Healthcare and Insurance team has both the authority and capacity to address differences in maternal mental health care by leveraging FEHB's policies and resources. This analysis is particularly timely, as rising maternal mortality rates and inequities in mental health access have shown the need for action (Brown et al., 2021). Maternal mental health reform is also consistent with OPM's broader goals of advancing the quality of health benefits offered to federal employees. Through its annual Call Letter process, OPM encourages FEHB carriers to implement evidence-based practices and strengthen benefit transparency and coordination (U.S. Office of Personnel Management, 2022). By implementing maternal mental health care into the existing framework, OPM can address an urgent health issue while reinforcing its strategic priorities around innovation and program accountability.

OPM has an opportunity to address the gaps in insurance coverage while setting a national standard for the way maternal mental health is covered by other insurance plans in the United States.

Background

Federal Employees Health Benefits (FEHB) Program

The FEHB Program was established in 1960 following the enactment of Public Law 860382 in late 1959, which authorized what then called the Civil Service Commission (now OPM) to develop the regulations required to implement the Act (OPM, n.d.-a). More than six decades later, OPM continues to administer the FEHB, providing healthcare coverage to over eight million federal employees, retirees, former employees, their families, and former spouses (OPM, n.d.-a). Over the years, the FEHB has become a cornerstone of federal workforce benefits, offering a variety of health plan options to meet the varied needs of its enrollees.

While specific demographic data on FEHB enrollees in unavailable, the federal civilian workforce includes individuals across a wide range of ages, races, geographic regions, job functions, and life circumstances. This variation underscores the need for health benefit programs like FEHB to be flexible and comprehensive, offering coverage that accommodates differing healthcare needs and utilization patterns. For example, some enrollees may require enhanced access to specialty care due to geographic distance, while others may benefit from expanded telehealth options or stronger care coordination. Understanding these differences is important for designing policies that ensure consistent access to essential services and improve health outcomes across the entire enrollee population.

Currently, the FEHB Program is actively working to address health equity and improve maternal health outcomes. In its 2022 Call Letter to carriers, OPM highlighted maternal health as a key area of focus, emphasizing the need to improve access, quality, and outcomes for populations disproportionately affected by maternal morbidity and mortality, including high-risk groups (U.S. Office of Personnel Management, 2022). The agency has encouraged carriers to expand prenatal and postpartum care, implement innovative payment methods such as value-based care, and provide expanded coverage for services like childbirth education, home visits, and doula care. These measures aim to address some systemic barriers that have long contributed to disparities in maternal health outcomes while promoting early intervention and comprehensive support for mothers and families (OPM, 2022). Alongside general maternal care, OPM has also called for carriers to enhance access to mental health services during the perinatal period and support for postpartum mental health conditions.

As seen in Figure 1, such efforts are part of the FEHB's broader collaborative framework, which involves distinct roles for OPM, insurance providers and enrollees. As the carriers and the FEHB, OPM is responsible for developing program responsibilities, negotiating contracts with insurance carriers, and ensuring that the program complies with federal laws and regulations (U.S. Office of Personnel Management, n.d.-b). OPM sets minimum standards for health plan benefits, monitors compliance, and facilitates an enrollment season referred to as "Open Season" during which federal employees can choose to change their health plans or enroll in a new one. In addition to this, OPM is responsible for providing guidance to agencies and enrollees, ensuring that federal employees and retirees have access to quality healthcare options that are targeted to their needs.

Insurance carriers are responsible for designing the health plans that meet OPM's standards and offering those plans to their enrollees. They are responsible for managing the day-to-day administration of benefits, including processing claims, maintaining provider networks, and ensuring that enrollees are receiving the care and services that is outlined in their plan contracts. These carriers must also make sure that they are adhering to the reporting requirements set by OPM, providing data on claims, utilization, and performance to maintain program accountability and quality standards (OPM, n.d.-b).

Enrollees are also held responsible under the FEHB program. Federal employees, retirees, and their dependents must carefully review the plan options they are given during the open season to select the plan that is going to best meet their needs and budget. Enrollees are responsible for paying their share of the premiums, understanding the benefits and what their chosen plan can and cannot do, and following the procedures outlined by their plan for accessing care (OPM, n.d.-a). This includes obtaining the necessary referrals, adhering to the network requirements, and being sure to solve any discrepancies in coverage or claims. These responsibilities allow enrollees to maximize the value of their health insurance benefits while attempting to minimize the potential complications.

Figure 1

Despite its scale and reach, the FEHB program continues to face challenges in ensuring timely and effective coverage for all mothers in need of maternal mental health services. Coverage for critical interventions can vary widely among insurance plans, leaving some enrollees without access to this essential care. These inconsistencies are particularly problematic for federal employees in rural or underserved areas, where provider networks may be limited, and for populations that face access challenges who already face barriers to healthcare access. This shows that there are opportunities for improvement. As the administrator of the FEHB, OPM could implement policy changes that can help with the fragmentation of coverage for maternal mental health services across plans. This would ensure that the enrollees and their dependents have access to evidence-based care.

Maternal Mental Health: Scope and Scale

Maternal mental health is increasingly recognized as an issue in the United States yet remains under-addressed public health issue in the United States. Conditions such as perinatal depression, anxiety, and postpartum psychosis affect up to one in seven mothers annually, making these disorders among some of the most common complications of pregnancy and childbirth (Ghahremani et al., 2022). When co-occurring conditions like substance use disorders are considered, the prevalence rises, with one in five women experiencing maternal mental health challenges annually (Reinert et al., 2024). Despite these concerning numbers, maternal mental health conditions are frequently overlooked, leaving millions of women without the care they need during this critical period in their lives. The effect ripples through families, communities, and healthcare systems, with far-reaching implications for public health and societal well-being (Task Force on Maternal Mental Health, 2024).

Maternal mental health disorders often arise during pregnancy or in the first year postpartum, a time of significant physical, emotional, and hormonal changes. Perinatal depression and anxiety are the most common, but conditions like obsessive-compulsive disorder (OCD) and postpartum psychosis, though less frequent, can become even more debilitating (Brown et al., 2021). These disorders are fueled by the complex relationship between biological, psychological, and societal factors. For many mothers, the societal pressures to meet unrealistic caregiving standards amplify stress and anxiety. This is especially true for mothers that are primary caregivers or those without a robust societal or familial support system (Lamar et al., 2023). The stigma associated with seeking mental health care is increases these issues, preventing many women from accessing timely and comprehensive care.

Structural inequities further exacerbate the problem. Low-income mothers and women of color are disproportionately affected by untreated maternal mental health conditions. There are systemic barriers to this as there is a lack of care that respects individual backgrounds and insufficient access to mental health providers that leave many of the women in these populations without adequate treatment (DeClercq et al., 2022). Geographic disparities also play a key role in women not receiving the care they need. Over 2.2 million women of childbearing age live in what is known as a maternity care desert, where there is limited or no access to maternal health services, including maternal mental health care (Reinert et al., 2024). This shortage is seen mostly in rural areas, where there are transportation challenges, long travel times, and provider shortages all hindering the access mothers need to this critical care.

The decentralization of maternal mental health care in the FEHB contributes to uneven access to maternal mental health services. Enrollees may struggle to identify which plans offer meaningful maternal mental health support when enrolling in their individual health insurance plans. This fragmentation disproportionately affects individuals who are navigating new pregnancies or postpartum recovery and are unable to make fully informed plan selections. A lack of uniform expectations across FEHB plans undermines the program’s potential to deliver timely and consistent care to all covered families.

Consequences of Untreated Maternal Mental Health Disorders

Untreated maternal mental health disorders have profound and far-reaching consequences that impact not only the affected mothers but also their children, families, and society. These disorders are among the leading causes of maternal morbidity and mortality, with suicide accounting for up to 23% of maternal deaths in high-income countries such as the United States (Lommerse et al., 2024). The critical postpartum period, especially the first year after delivery, is a time of heightened vulnerability for mothers, yet mothers' mental health during this time remains under-monitored. Many maternal suicides are misclassified due to inadequate mental health surveillance, further underestimating the true burden of these conditions (Lommerse et al., 2024). For many mothers, untreated mental health conditions lead to chronic health challenges, reduced quality of life, and impaired ability to care for themselves and their children (DeClercq et al., 2022).

For children, the impact of these untreated maternal mental health disorders can be just as significant as it is for the mother. Infants born to mothers with untreated depression or anxiety are more likely to experience developmental delays, including impaired cognitive and language development, and are at a greater risk of behavioral problems as they grow older (Brown et al., 2021). Early disruptions in the mother-infant bond, often due to the mother's reduced emotional engagement, can affect a child's ability to form secure attachments and regulate emotions. These challenges can extend into adolescence and even adulthood, influencing educational outcomes, mental health stability, and social relationships (Lamar et al., 2023).

The ripple effect extends to other social relationships as well. Families and partners often take on increased caregiving responsibilities when the maternal mental health needs go unmet. Partners frequently report feelings of helplessness, stress, strained relationships as they attempt to provide support for the mothers that are dealing with these mental health challenges (Enhancing Maternal Mental Health Support, n.d.). This burden can lead to a disrupted household, financial strain, and reduced workplace productivity. Additionally, family dynamics can become strained when siblings or other dependents are affected by these maternal mental health struggles, creating additional challenges for the household.

On a societal level, the economic costs of untreated maternal mental health disorders are staggering. In the United States, these conditions contribute an estimated $14 billion annually in direct medical expenses, lost productivity, and increased reliance on social services (Reinert et al., 2024). Delivery-related complications linked to maternal mental health conditions are said to account for approximately $102 million annually in hospital costs alone (Brown et al., 2021). Beyond healthcare expenditures, the broader societal costs include absenteeism, turnover, and decreased workforce engagement among the affected families thus straining employers and the national economy (Reinert et al., 2024).

Given the scope and severity of the consequences associated with untreated maternal mental health conditions, the need for timely, effective, and scalable interventions is clear. These impacts underscore the importance of implementing solutions that not only treat individual cases

but also strengthen systemic responses. Within the context of the FEHB Program, there is an imperative to identify approaches that can be integrated across varied healthcare plans while addressing the variation in access and quality. The following section reviews a range of interventions supported by current evidence, offering insight into what policy alternatives OPM might consider to close care gaps and improve outcomes for mothers and their families.

Evidence Review of Interventions

Success in addressing maternal mental health differences requires balancing innovative care solutions with systemic changes that reduce barriers to access, improve health outcomes, and support financial stability. Evidence grom existing maternal health initiatives, peer-reviewed studies, and healthcare system reforms offers insight into interventions that may be applicable within the FEHB framework. Given the breadth of evidence and nuanced nature of maternal mental health, this review employs a mixed methods approach. By synthesizing data from experimental studies, systematic reviews, and real-world program evaluations, alongside insights from healthcare policies, this review can provide a comprehensive perspective. This approach ensures that the interventions are grounded in tested strategies while remaining adaptable to the unique needs of the FEHB program and its enrollees.

Routine Mental Health Screenings

Often at the foundation of maternal healthcare lies the practice of routine mental health screenings. Systematic reviews demonstrate that using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and Generalized Anxiety Disorder-2 (GAD-2) scale increases diagnostic and treatment rates by 55% compared to unscrewed populations (Waqas et al., 2022). These screening programs prove to be most effective when they are integrated into comprehensive care models that include coordinated follow-up and referral systems, showing sustained improvements in maternal mental health outcomes over time (Clarke et al., 2024). The evolution of screening practices has also revealed the critical importance of timing and frequency. Research indicated that multiple screening points through the perinatal period significantly improve detection rates compared to single-time screening approaches. Studies show that approximately 40% of cases would be missed by screening only during pregnancy or only during the postpartum period, highlighting the need for continuous monitoring (Clarke et al., 2024).

Implementation challenges revealed through qualitative research warrant careful consideration. Mothers frequently express reluctance to disclose mental health struggles during screenings, citing fears of being judged as inadequate parents or concerns about potential impacts on child custody and employment (Yuill et al., 2024). Healthcare providers must be trained in trauma-informed approaches and build trust with their patients to ensure honest disclosures and create an environment where mothers feel supported rather than scrutinized (Grisbrook et al., 2020). Digital screening tools have emerged as a promising solution to these challenges. App-based assessments allow mothers to complete screenings privately, potentially increasing honest disclosure while reducing the discomfort associated with face-to-face evaluations (Reinert et al., 2024). These tools also improve efficiency by reducing the administrative burden and minimizing scoring errors. However, successful implementation requires adequate technological infrastructure and digital literacy support, particularly in underserved communities.

Telehealth Interventions

Telehealth interventions have demonstrated remarkable effectiveness in expanding access to mental health support, with randomized controlled trials (RCTs) showing significant reductions in maternal depression symptoms that persist well beyond the intervention period (Nair et al.,

2018). These digital solutions prove particularly valuable for populations with limited access by addressing multiple barriers to care simultaneously: eliminating transportation challenges for rural residents, reducing childcare burdens, providing flexible scheduling options, increasing access to specialized providers, and enabling participation from the comfort of home. Virtual support programs have shown comparable effectiveness to traditional in-person support groups in reducing depressive symptoms and fostering social connectedness among participants.

However, the success of these interventions hinges critically on reliable internet access and adequate digital literacy – resources that remain unevenly distributed among low-income and rural populations. Implementation challenges extend beyond technical considerations to include concerns about privacy in virtual settings and the complexity of establishing therapeutic relationships in online environments (Gonzalez et al., 2020). Recent implementation studies have also highlighted the potential for hybrid care models that combine telehealth with traditional in-person care. These integrated approaches show promise in addressing the limitations of either method of intervention. Data from pilot programs indicates that hybrid models achieve higher patient retention rates (approximately 85% compared to 67% for traditional care) while maintaining similar clinical outcomes (Wu, 2024).

In addition to virtual therapy sessions, telehealth platforms increasingly encourage peer-led or clinician-facilitates support groups as part of comprehensive mental health services. These virtual support groups replicate the benefits of in-person gatherings by fostering emotional connection, reducing isolation, and providing a space for shared experiences among mothers. Studies show that culturally and linguistically tailored support groups can significantly reduce depressive symptoms and improve treatment adherence (Huang et al., 2020; Massoudi et al., 2023). Programs like Australia's "Mummy Buddy" and community-based virtual circles in the U.S. demonstrate strong engagement and satisfaction among mothers that face stigma or logistical barriers to in-person care (Law et al., 2020). Although challenges like internet access and privacy remain, these group-based models offer a scalable, empathetic layer of support that complements clinical care and strengthens the impact of virtual interventions.

Advances in Pharmacological Treatments

Recent years have witnessed significant advances in pharmacological treatments for maternal mental health conditions, offering a new hope for women experiencing severe symptoms. Brexanolone represents a breakthrough as the first FDA- approved treatment specifically designed for postpartum depression, offering rapid symptom relief within 60 hours of administration (Frieder et al., 2019; Barnes et al., 2023). However, its promising effectiveness is severely constrained by accessibility challenges, including a prohibitive cost of approximately $34,000 per treatment and requirements for inpatient administration (Barnes et al., 2023). The development of Zuranolone, a newer oral neuroactive steroid approved in 2023, marks another advancement in the field, offering a more practical alternative with demonstrated symptom improvement within 15 days – a significant improvement over the traditional 6–8-week timeline associated with SSRIs (Barnes et al., 2023; Massoudi et al., 2023).

Beyond these specific treatments, the emergence of personalized medicine approaches represents another promising intervention. Genetic testing and biomarker analysis are increasingly being used to predict individual responses to different pharmacological interventions, potentially reducing the trial-and-error approach to medication selection (Frieder et al., 2019; Barnes et al., 2023). Early studies suggest that personalized prescription approaches based on genetic factors could improve treatment response rates by up to 30% while reducing adverse effects (Frieder et al., 2019; Massoudi et al., 2023).

Research consistently indicates that these pharmacological interventions achieve optimal results when paired with comprehensive management programs that include regular follow-up appointments, telehealth check-ins, and robust patient education (Frieder et al., 2019; Massoudi et al., 2023). The integration of these newer treatments into existing care frameworks presents both opportunities and challenges, requiting careful consideration of cost-effectiveness, accessibility, and the development of support systems to ensure proper administration and monitoring (Frieder et al., 2019; Massoudi et al., 2023).

Takeaways

The evidence surrounding maternal mental health interventions within the FEHB program reveals two key imperatives for the FEHB program: addressing systemic gaps in care and leveraging its position as a leader in healthcare delivery to implement innovative solutions. These priorities align with the broader mission of ensuring equitable, high-quality healthcare for federal employees and their families.

First, the FEHB Program has the opportunity to adopt comprehensive, evidence-based interventions. These include routine mental health screenings, telehealth solutions, peer support groups, and advanced pharmacotherapies. Each intervention addresses different dimensions of maternal mental health care, providing a multifaceted approach to improving outcomes. While out of the wheelhouse of the FEHB, the evidence demonstrates that when these interventions are combined there are significant improvements to both short- and long-term health outcomes.

Second, accessibility remains a critical component to success. Marginalized groups including rural, low-income, and women of color, face significant barriers to maternal healthcare. Addressing these disparities requires intentional changes such as expanding telehealth infrastructure, offering empathetic and supportive care, and expanding access to doula care and new pharmacological treatments. By addressing these gaps, the FEHB can ensure that all mothers it covers receive timely and effective care.

Many policy alternatives emerge from this analysis. While the delivery of these alternatives requires further investigation, literature supports these methods for intervening with maternal mental health outcomes. Some of the interventions include:

1. Routine Mental Health Screenings with Follow-Up Care
2. Expanded Telehealth Services
3. Coverage for New Advanced Pharmacological Treatments

The FEHB program has a unique opportunity to lead the way in maternal mental health care by improving the outcomes for federal employees as well as setting a precedent for other employer-sponsored health insurance plans. By embracing evidence-based solutions, the FEHB can address gaps in care, reduce differences, and provide comprehensive support to mothers.

These interventions reviewed above offer a wide range of strategies to improve maternal mental health outcomes. These findings not only confirm the effectiveness of targeted clinical tools but also highlight the need for policy responses that align with the administrative structure of the FEHB Program and its operational capabilities. To move from evidence to action, OPM must consider a set of policy alternatives that build on this research. The following section outlines and evaluates these alternatives to support informed decision-making around maternal mental health coverage within the FEHB Program.

Policy Alternatives and Evaluative Criteria

Alternatives

The literature reviewed in this report suggests several evidence-based approaches that the Office of Personnel Management (OPM) can adopt to improve maternal mental health outcomes across the Federal Employees Health Benefits (FEHB) Program. Each alternative builds on existing practices and infrastructure while addressing key barriers to access, early detection, and treatment engagement. These alternatives vary in scope, cost-effectiveness, feasibility, and alignment with OPM's capacity and policy goals. Table 1 provides a summary of the four proposed alternatives, which are further detailed in the sections that follow.

Table 1. Description of Policy Alternatives

Alternative	Description
Status Quo	OPM continues to allow FEHB carriers to determine maternal mental health coverage independently and maintain the existing decentralized structure.
Integrated Screening and Care Coordination	Requires all FEHB carriers to conduct standardized perinatal mental health screenings and establish structured referral systems across prenatal and postpartum periods.
Enhanced Telehealth and Support Network	Expands FEHB coverage for virtual mental health services, including therapy, group support, and remote consultations, with an emphasis on accessibility for rural and underserved populations.
Advanced Pharmacological Treatment Coverage	Increases reimbursement and provider education for new postpartum depression medications such as Brexanolone and Zuranolone, targeting individuals with severe mental health conditions.

These alternatives reflect a range of approaches, from low-cost incremental adjustments to transformative interventions, and were selected based on their evidence base, feasibility for federal implementation, and relevance to FEHB's current policy landscape.

Evaluative Criteria

Cost-Effectiveness

Given that the FEHB program is funded through a mix of employee premiums and federal contributions, any proposed policy must demonstrate value for cost. Cost-effectiveness is defined

here as the ratio of the total program costs to the number of successful maternal mental health treatment outcomes achieved. This includes healthcare spending (e.g., screenings, therapy, medications) and potential savings from reduced emergency care, lost productivity, or adverse birth outcomes. Data on per-case intervention costs and effectiveness rates were drawn from peer-reviewed studies and adjusted to 2025 dollars using projected inflation estimates (Wilkinson et al., 2017; Barnes et al., 2023).

Access and Distribution

This criterion assesses whether the policy alternative improves access to maternal mental health services across the FEHB population in a balanced way. Key considerations include regional availability as well as economic and logistical barriers that may affect utilization. Because the FEHB program serves a large and varied enrollee base, alternatives that primarily benefit individuals with existing advantages may widen current service gaps (DeClercq et al., 2022; Reinert et al., 2024). An alternative performs well on this measure if it broadens access across different segments of the population and reduces barriers to timely care.

Implementation Feasibility

This measures the administrative and political practicality of rolling out each alternative. Factors include alignment with current FEHB operations, potential resistance from carriers, provider readiness, and infrastructure. Alternatives requiring minimal disruption or those that leverage existing structures score higher. Input from implementation science literature and case studies inform this assessment (Wu, 2024; Clarke et al., 2024). Where relevant, feasibility also reflects regulatory compatibility across states and provider licensure requirements.

Program Sustainability

Sustainability considers whether the intervention can maintain its impact over time without reliance on pilot-phase funding or political momentum. This includes the durability of outcomes, adaptability to evolving needs, and integration into routine care delivery. Programs that require ongoing intensive resources or specialized training may prove harder to sustain. High-performing alternatives demonstrate both clinical durability and operational resilience (Nashwan et al., 2024).

Together, these four evaluative criteria provide a structured and balanced framework for assessing the alternatives and guiding OPM’s decision-making process. Applying this framework allows for a systematic comparison of each policy option’s potential benefits and trade-offs within the operational realities of the FEHB program. It also highlights how different approaches may perform across short- and long-term periods. The following analysis examines each alternative in detail to assess its alignment with the overarching goals of improving maternal mental health outcomes within a large, multi-plan system.

Evaluating the Alternatives

Alternative 1: Status Quo

The current FEHB program structure allows insurance carriers to determine their maternal mental health coverage independently. This decentralized approach results in significant variation in the availability and quality of maternal mental health services across different insurance plans. Many plans provide only minimal coverage for perinatal mental health screenings, therapy, and psychiatric care, leading to gaps in access and differences in health outcomes (U.S. Office of Personnel Management, 2022).

Evaluative Criteria

Cost-Effectiveness

The current FEHB structure incurs no additional direct costs since it does not require new investments in mental health interventions. However, untreated perinatal mental health disorders result in significant economic consequences. A study by the American Psychological Association (Twenge et al., 2019) reported a 71% rise in young adults experiencing serious psychological distress between 2008 and 2017. As these individuals transition into parenthood, the prevalence of perinatal mental health disorders may increase, further amplifying these economic impacts over time. Research by Mathematica (2019) revealed that untreated maternal mental health conditions cost the U.S. approximately $14.2 billion annually, with an average cost of $32,000 per affected mother-child pair over a five-year period. This translates to $3.2 billion in societal costs for 100,000 pregnant enrollees. Adjusted to 2025 dollars using an estimated 2.5% annual inflation rate, based on U.S. inflation projections, these figures rise to approximately $16.4 billion annually and $36,960 per affected mother-child pair (Investopedia, 2025). These costs arise from increased healthcare utilization, lost productivity, and adverse child developmental outcomes.

Access and Distribution

Access remains highly uneven under the status quo. Federal employees in rural and other underserved areas face severe provider shortages and lack of mental health specialists (DeClercq et al., 2022). Without a standardized maternal mental health framework, differences persist, affecting some populations more than others (Brown et al., 2021). These disparities arise from two primary sources of inequality: plan differences and provider access limitations. Variability in plan coverage leads to differences in service availability, while provider shortages and geographic barriers further restrict access to care. Understanding the interaction between these factors is crucial to addressing maternal mental health disparities effectively. The interaction between plan differences and provider access inequalities needs further exploration. Many enrollers seeking maternal mental health services experience difficulties in finding in-network providers, leading to potential delays in receiving necessary care and exacerbating disparities in treatment access. Due to these significant barriers and inconsistencies, access and distribution under the status quo are rated as low.

Implementation Feasibility

Maintaining the status quo requires no structural changes, making it the easiest alternative to implement. Existing insurance policies remain unchanged, and no new training or administrative adjustments are necessary. However, this ease of implementation comes at the cost of continued fragmentation in care, limited oversight, and persistent differences in maternal mental health outcomes. Due to its minimal and operational demands, the implementation feasibility of the status quo is rated as high.

Program Sustainability

The current system is financially and administratively sustainable but does not achieve meaningful improvements in maternal mental health care. While the absence of new policy changes ensures continuity, the long-term sustainability of this model may be challenged by growing demand for maternal mental health services, which poses a challenge to the decentralized model. While increased demand does not directly threaten insurance companies, as they are not responsible for ensuring provider availability, it does strain access to care. For example, in areas like Charlottesville, securing an appointment with a mental health provider is difficult, yet insurers are not required to address provider shortages. This disconnect highlights the limitations of a decentralized model in effectively meeting the needs of enrollees and increasing healthcare differences. Without proactive adjustments, the system may eventually require modifications to address emerging needs (Brown et al., 2021). Given the stability of the existing system but the risk of future unsustainability due to rising needs, program sustainability is rated as medium. However, the program outcomes may not fully align with the needs of enrollees. While cost-effectiveness captures the financial efficiency of an intervention, sustainability considers long-term viability, resource allocation, and the system's ability to adapt to growing demand. Thus, sustainability should be assessed as a distinct criterion rather than solely within the Cost-Effectiveness Analysis. Clarifying this distinction ensures that policy recommendations address both immediate fiscal impact and long-term feasibility. For these reasons, the sustainability of the status quo is rated as medium.

While the status quo maintains administrative ease and stability, it does not address persistent access gaps or cost inefficiencies. Without intervention, differences in care and long-term financial burdens will continue to escalate.

Alternative 2: Integrated Screening and Care Coordination Program

This alternative establishes a standardized maternal mental health screening and care coordination system across all FEHB insurance carriers. It mandates universal screening using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and Generalized Anxiety Disorder-2 (GAD-2) at multiple points during pregnancy and postpartum—specifically, at least three times: once during the first trimester, once in the third trimester, and once postpartum (Clarke et al., 2024). Digital screening options will be implemented to facilitate private, accessible assessments (Reinert et al., 2024). Additionally, a centralized referral system will connect identified cases with mental health professionals, ensuring timely and appropriate care. FEHB insurance carriers will contract certified maternal mental health providers to ensure adequate coverage. A digital referral platform will connect patients to available providers,

allowing for timely follow-ups. OPM will monitor compliance and set benchmarks to improve access and coordination.

Evaluative Criteria

Cost-Effectiveness

The integrated screening and care coordination program presents a moderately cost-effective intervention, with an estimated cost of $1,149 per patient (adjusted to 2025 dollars), with a total estimated cost of approximately $114.9 million per 100,000 pregnant enrollees. If we assume that there is 20% prevalence of maternal mental health conditions 20,000 of these women would be affected. If 75% of these women successfully complete treatment through this program, there will be 15,000 successfully treated women. The cost per successful outcome would be $7,600. Compared to the $32,000 cost of untreated cases, this intervention presents strong financial value (Wilkinson et al., 2017).

Access and Distribution

Standardized screening significantly improves access by ensuring that all FEHB enrollees receive mental health assessments. However, provider shortages may still limit access to in-person follow-up care, particularly in rural or underserved areas. Many of these regions already experience limited availability of behavioral health specialists leading to delays in treatment even after a positive screening. Access and distribution are rated as medium.

Implementation Feasibility

Implementation is overly complex due to the coordination required among multiple insurance carriers, provider networks, and regulatory entities. The involvement of various stakeholders introduces logistical and administrative challenges, making seamless integration more difficult. The role of FEHB in mandating these changes should be clarified. Structured coordination will be necessary to ensure compliance across all FEHB carriers. Additionally, aligning electronic health record systems to support standardized documentation and referrals will require technical adjustments and staff training. Implementation feasibility is rated as medium.

Program Sustainability

A universal screening framework becomes a routine component of maternal healthcare. The sustainability of this program depends on continued investment in digital tools, provider training, and insurance reimbursement structures. Once established, routine screenings can be integrated into standard care protocols and therefore reduce the administrative burden over time. Program sustainability is rated as high.

While it requires moderate administrative investment and coordination, the integrated screening and care coordination program yields substantial improvements in early identification and timely intervention which are both critical to preventing more severe health outcomes (Clarke et al., 2024). The program's ability to become a standard part of routine maternal care, combined with its moderate cost and high sustainability, positions it as a strong candidate for systemwide

adoption. By investing in structured screening and coordinated care pathways, OPM and the FEHB Program can make meaningful progress toward improving maternal health outcomes for its covered population.

Alternative 3: Enhanced Telehealth and Support Network

This alternative expands access to maternal mental health services through comprehensive telehealth coverage and digital support tools. It includes virtual therapy, peer support groups, and remote consultations with maternal mental health professionals. Studies show that telehealth interventions significantly reduce symptoms of perinatal depression and anxiety, particularly for mothers in rural and other underserved areas (Nair et al., 2018; Naja et al., 2023). Hybrid care models, combining telehealth with in-person care, enhance accessibility while maintaining high treatment retention rates (Wu, 2024). However, telehealth regulations vary by state, and some states have restrictions on provider licensing, prescribing authority, and reimbursement policies for virtual care. Ensuring compliance with state laws may require advocacy for regulatory flexibility and collaboration with policymakers to expand telehealth licensure portability for maternal mental health services.

Evaluative Criteria

Cost-Effectiveness

Expanding telehealth and virtual support networks is one of the most cost-effective interventions for maternal mental health, especially for addressing accessibility barriers. Internet-based maternal mental health programs have an estimated cost of $1,000 per patient, or $100 million per 100,000 pregnant enrollees. If we assume a 20% prevalence and a 75% treatment success rate, we will also see 15,000 successfully treated women. The cost per successful outcome is $6,666. Cost-effectiveness improves when targeted to high-risk groups and combined with in-person care (Lee et al., 2022). In addition to reducing clinical costs, telehealth can also lower indirect costs such as travel, time off work, and childcare, which are frequently cited as barriers to accessing in-person care (Parameswaran et al., 2022). These savings make telehealth not only cost-effective from a payer perspective but also from the standpoint of patient convenience and system-wide efficiency.

Access and Distribution

Telehealth extends access to underserved populations, increasing participation rates among working mothers by 50% (Gonzalez et al., 2020). However, broadband limitations in rural areas present ongoing access challenges (Wu, 2024). Expanding telehealth infrastructure and ensuring insurance reimbursement for virtual maternal mental health services can improve access to these critical services. While telehealth significantly enhances access, particularly for those facing geographic barriers, the digital divide in rural areas makes access and distribution rated at medium. Approximately 75% of nonmetropolitan households have broadband access, compared to 83% of households nationwide, indicating a significant gap (Population Reference Bureau, 2024). Additionally, about 14% of U.S. households lack any digital access, with rural areas disproportionately affected (Benda et al., 2023). These differences highlight that telehealth may

not be a universally accessible solution and must be supplemented by policies aimed at expanding broadband infrastructure and digital literacy. Given these differences, the overall rating for access and distribution for this alternative is considered to be medium.

Implementation Feasibility

Implementing this alternative requires significant investment in digital infrastructure and comprehensive provider training to ensure effective service delivery, but its scalability allows for widespread adoption and long-term integration into existing healthcare networks. Telehealth adoption has been successful in maternal healthcare programs, with pilot studies reporting a 75% success rate when integrated into existing health networks (Naja et al., 2023). Ensuring provider readiness and patient familiarity with telehealth platforms is essential for smooth implementation. Due to the need for substantial upfront investments in technology, provider training, and regulatory changes, implementation feasibility is rated as medium.

Program Sustainability

Telehealth services provide a long-term, adaptable solution for maternal mental health care, with sustained patient participation over five years in healthcare systems that have integrated telehealth for maternal care (Wu, 2024). The scalability of this program depends on ongoing investment in digital infrastructure, patient outreach, and provider reimbursement policies. Since telehealth is a flexible and scalable intervention that can be integrated into existing healthcare networks with long-term viability it is rated high for program sustainability.

Expanding telehealth services ensures that maternal mental health care is more accessible and flexible, reducing barriers that often prevent individuals from seeking timely support. By leveraging digital platforms, this model accommodates different patient needs and circumstances while fostering engagement in mental health treatment.

Alternative 4: Advanced Pharmacological Treatment Coverage

This alternative enhances FEHB coverage for postpartum depression treatments, including Brexanolone and Zuranolone. These medications provide rapid symptom relief, particularly for individuals with severe postpartum depression, but face accessibility challenges due to excessive costs and limited provider awareness (Barnes et al., 2023). Expanding FEHB coverage for these treatments would improve affordability and increase provider training and education on prescribing and administering these medications (Nashwan et al., 2024).

Evaluative Criteria

Cost-Effectiveness

Estimated total cost for Brexanolone is $170 million per 100,000 pregnant enrollees, based on a $34,000 per patient cost and treatment of 5,000 women. With an assumed 80% effectiveness rate, resulting in 4,000 successful outcomes, the cost per successful outcome is $42,500. Zuranolone is estimated at $50 million per 100,000 pregnant enrollees, assuming a $10,000 per patient cost and 5,000 treated patients. With an 80% success rate, or 4,000 effective treatments, the cost per successful outcome is $12,500. Combining these treatments would give us $27,500 per

successful outcome. While these medications offer rapid symptom relief, especially for those with severe postpartum depression, their high treatment costs limit broader cost-effectiveness and accessibility (Meltzer-Brody et al., 2018).

Access and Distribution

While coverage expansion improves affordability and increases treatment options, significant barriers remain, including provider shortages, limited prescribing knowledge, and the requirement for inpatient administration, which can hinder accessibility (Barnes et al., 2023). Addressing these challenges requires integrating these medications into comprehensive maternal mental health programs, expanding provider training initiatives, and ensuring equitable access for patients in both urban and rural areas. Due to the excessive costs, provider limitations, and inpatient requirements, access and distribution are rated as low. High-cost treatments like Brexanolone and Zuranolone may face coverage restrictions due to their significant financial burden. Insurers within FEHB assess cost-effectiveness, negotiate manufacturer discounts, and may implement utilization controls such as prior authorization or step therapy to manage expenses. Given these considerations, widespread coverage of these pharmacological treatments could be limited unless cost negotiations reduce financial barriers and ensure affordability.

Implementation Feasibility

Implementing this alternative requires significant investment in provider education and regulatory changes. Success depends on adoption rates among healthcare providers and the establishment of protocols for safe administration and monitoring (Frieder et al., 2019). Expanding insurance coverage for these treatments also requires policy adjustments to ensure equitable access across all FEHB plans. Because of the extensive financial, regulatory, and logistical challenges associated with implementation, feasibility is rated as low.

Program Sustainability

Long-term sustainability hinges on cost negotiations and regulatory considerations (Nashwan et al., 2024). Ensuring continued affordability and increasing provider familiarity with these medications will be critical in maintaining the effectiveness of this intervention. Cost concerns and regulatory challenges could impact long-term viability, but expanding coverage may enhance sustainability over time, so program sustainability is rated as medium.

This alternative enhances FEHB coverage for postpartum depression treatments, including Brexanolone and Zuranolone. These medications provide rapid symptom relief but remain underutilized due to cost and provider awareness barriers (Barnes et al., 2023). A structured reimbursement approach and mandatory provider education will support responsible administration (Nashwan et al., 2024)

Table 2. Outcomes Matrix

Outcomes Matrix				
Criteria	Status Quo	Integrated Screening & Care Coordination	Telehealth & Virtual Support	Pharmacological Treatment
Cost-Effectiveness	$0 in direct costs $3.2 Billion in societal cost	$114.9 Million per 100,000 pregnant enrollees $7,660 per successful outcome	$100 Million per 100,000 pregnant enrollees $6,666 per successful outcome	$220 Million per 100,000 pregnant enrollees $27,500 per successful outcome
Access & Distribution	Low	Medium	Medium	Low
Implementation Feasibility	High	Medium	Medium	Low
Program Sustainability	Medium	High	High	Medium

The evaluation of these four policy alternatives highlights the important trade-offs between administrative complexity, financial investment, and clinical impact. While the status quo offers ease of implementation, it fails to address the persistent gaps in access, access, and long-term cost savings. Alternatives such as integrated screening and expanded telehealth services strike a stronger balance between feasibility, sustainability, and meaningful improvement in maternal mental health outcomes. Based on the outcomes across the evaluative criteria, the next section offers a recommendation that prioritizes both effectiveness and practicality within the FEHB Program's framework.

Recommendation and Implementation

Recommendation

Based on the evaluation of cost-effectiveness, access and distribution, implementation feasibility, and program sustainability, the most preferable policy alternative is the integrated screening and care coordination program. This alternative offers a balanced approach, effectively addressing maternal mental health differences within the FEHB program while maintaining financial and logistical feasibility. The cost-effectiveness of integrated screening is moderate, with a cost-effectiveness ratio of $32.52 per additional healthy woman, demonstrating a strong return on investment (Wilkinson et al., 2017). Although telehealth services are slightly more cost-effective at $20.83 per 1% reduction in adverse maternal health outcomes, telehealth alone may not fully address the caps in early detection and referral (Lee et al., 2022). Pharmacological treatments are far less cost effective and impose significant financial burdens on the FEHB program (Meltzer-Brody et al., 2018).

In terms of access and distribution, integrated screening ensures that all FEHB enrollees receive standardized maternal mental health assessments thus improving early detection and facilitating timely referrals to mental health specialists (Clarke et al., 2024). While provider shortages in rural areas remain a challenge when digital screening options are integrated, they can mitigate some of these barriers (Reinert et al., 2024). Telehealth also expands access, but broadband limitations and patient unfamiliarity with virtual mental health services can limit its reach (Wu, 2024). Pharmacological treatments provide rapid relief but require specialized provider knowledge and inpatient monitoring, which restricts accessibility (Barnes et al., 2023).

Implementation feasibility for integrated screening is rated as medium, as it requires coordination among insurance carriers and provider networks, but evidence shows that training healthcare providers to administer screenings and integrate referral systems increases participation rates by 45% (Reinert et al., 2024). While the status quo is the easiest to maintain, it does not address the growing burden of untreated maternal mental health conditions, and this leads to significant long-term costs (Mathematica, 2019). Telehealth implementation also faces moderate challenges due to infrastructure and regulatory requirements, while pharmacological treatments present the most difficult implementation barriers, requiring extensive provider training and policy changes to ensure access (Frieder et al., 2019).

Regarding program sustainability, integrated screening is the most viable long-term solution. Once established, universal screening becomes a routine component of maternal healthcare and has been shown to improve maternal mental health outcomes over a five-year period (Clarke et al., 2024). Telehealth is also highly sustainable but depends on ongoing investment in digital infrastructure, patient outreach, and provider reimbursement policies (Wu, 2024). The pharmacological treatment option is less sustainable due to its excessive costs and the need for continued price negotiations and regulatory considerations (Nashwan et al., 2024).

While all alternatives have trade-offs, integrated screening and care coordination provide the most comprehensive and sustainable approach to improving maternal mental health outcomes within the FEHB program. These alternative balances cost-effectiveness with improved access, is feasible to implement with structured coordination, and integrates well into long-term healthcare

models. To ensure successful adoption, FEHB should allocate funding for provider training, implement digital screening tools, and establish a centralized referral system. Over time, integrating telehealth and virtual support as a complementary strategy may further enhance access to maternal mental health services, but a solid foundation in screening and care coordination is necessary to achieve meaningful, long-term improvements in maternal and child health outcomes.

Implementation Plan

Effective implementation is critical to ensuring the success of the Integrated Screening and Care Coordination Program within the Federal Employees Health Benefits (FEHB) Program. While this policy aims to improve maternal mental health outcomes and reduce long-term healthcare costs, successful execution requires careful planning, stakeholder engagement, and proactive risk mitigation. Research on policy implementation emphasizes that even well-designed policies can fail if they are not strategically executed, as seen in past healthcare rollouts. This implementation plan outlines the key stakeholders involved in implementation, the necessary steps and timeline for execution, potential challenges, and strategies to mitigate barriers to success.

Considerations for Implementation

Successful implementation depends on addressing several operational and contextual factors. OPM must ensure standardized adoption of screening protocols across carriers with different administrative structures. Providing clear guidance and collaborating early with FEHB carriers will reduce inconsistencies (Reinert et al., 2024).

Healthcare providers—OB-GYNs, primary care physicians, and behavioral health specialists—must be trained to incorporate screenings into routine care. Provider engagement improves when training is efficient and integrated into existing workflows (Clarke et al., 2024). Digital screening tools must also be secure, user-friendly, and accessible to both providers and patients. Offering hybrid options such as in-person assessments will help reach those with limited digital access (Wu, 2024).

Finally, implementation must include effective communication strategies to ensure that enrollees are informed, and providers remain accountable. Performance benchmarks and feedback loops will support continuous improvement, while regular stakeholder updates will help sustain transparency, engagement, and momentum over time (Reinert et al., 2024). This may include agency-wide updates, provider updates, and communication toolkits that help carriers explain changes to both enrollees and providers.

Roles and Responsibilities

Implementation requires coordination among several groups. OPM will manage the program, set requirements, monitor performance, and enforce compliance through financial incentives and corrective actions. If implementation challenges arise—such as delayed referrals or IT system failures—OPM will work with carriers and vendors to resolve them.

FEHB carriers must incorporate the screenings and maintain clear referral pathways. Providers will administer the screenings and coordinate care. Health IT vendors will develop digital tools, while federal employees and advocacy groups help promote awareness. Researchers will offer guidance and assess long-term impact (Clarke et al., 2024; Reinert et al., 2024).

OPM will implement compliance monitoring through audits, benchmarks, and incentives. Underperforming carriers may face financial penalties, mandatory corrective actions, or, in rare cases, plan decertification.

The program's implementation will follow a structured four-phase rollout to ensure smooth adoption:

1. Phase 1: Planning and Infrastructure Development (Months 1-6)

In the initial phase, OPM will establish the policy and technical groundwork necessary for a successful rollout. Activities will focus on engaging key stakeholders, finalizing program design, and building out the infrastructure needed for screening and referrals. The following steps will guide implementation during this stage:

- OPM will convene working groups composed of insurance carriers, healthcare providers, and digital health vendors to finalize program guidelines.
- Formal rulemaking processes will establish standardized screening protocols and compliance requirements.
- Stakeholder engagement sessions will be conducted, including consultations with federal employee unions and advocacy organizations to gather input.
- Digital screening vendors will develop and test prototype assessment tools in a small-scale pilot within agencies that have robust broadband infrastructure before expanding into areas with poor digital access.
- OPM will begin resource acquisition, including hiring additional personnel and securing contracts with telehealth vendors for expanded provider networks.
- Checkpoint: By Month 6, at least 50% of participating healthcare providers should have completed training on the new screening protocols.

2. Phase 2: Pilot Implementation and Training (Months 7-12)

This phase focuses on piloting the program in selected agencies and building provider capacity. The goal is to test the program's functionality in controlled settings, refine digital tools, and gather early feedback to improve future rollout. Key activities during this phase will include the following:

- The program will be tested in select federal agencies, prioritizing locations with existing digital infrastructure and strong provider networks to minimize early technical failures.

- Comprehensive provider training sessions will be held to familiarize practitioners with digital screening tools and referral processes.
- IT system testing will refine the digital referral process to reduce errors and delays, with early modifications based on user feedback.
- Initial funding adjustments and administrative cost-sharing arrangements will be evaluated to prevent early carrier resistance.
- Checkpoint: By Month 12, all pilot agencies should demonstrate a minimum 60% uptake in maternal mental health screenings.

3. Phase 3: Nationwide Rollout (Months 13-24)

During this phase, the program will be expanded across all FEHB plans. Implementation efforts will prioritize operational consistency, carrier compliance, and equitable provider participation. The following actions will support a full-scale rollout:

- Full-scale implementation will occur across all FEHB plans, with phased expansions prioritizing states that have fewer regulatory barriers to telehealth services.
- Insurance carriers will be required to report quarterly data on screening rates and referral efficiency, with compliance enforcement measures gradually increasing over time.
- OPM will coordinate contracting efforts for additional mental health specialists in underserved areas, leveraging telehealth and provider network expansions.
- Checkpoint: By Month 24, at least 75% of enrolled providers should be actively conducting screenings, and a 70% increase in timely referrals should be recorded.

4. Phase 4: Evaluation and Program Refinement (Months 25 and beyond)

The final phase will focus on analyzing program performance and making evidence-informed refinements. OPM will monitor key indicators, release public-facing scorecards, and address emerging challenges to support program sustainability. Major activities in this stage will include the following:

- Data from the first two years of implementation will be analyzed to assess screening uptake, referral efficiency, and patient health outcomes.
- Performance benchmarks will include metrics such as: the percentage of pregnant enrollees receiving at least one mental health screening; the average time from screening to referral; the rate of completed referrals; and the postpartum depression detection rate.
- Adjustments will be made to address challenges such as provider shortages, digital accessibility issues, and funding constraints.

- Results will be communicated through both internal review processes and public transparency mechanisms. OPM will release semi-annual performance scorecards comparing insurance carriers on key indicators and highlighting best practices. Underperforming carriers will participate in closed-door performance reviews with OPM and may be required to submit corrective action plans.
- Ongoing program refinements will ensure sustainability and responsiveness to emerging needs.
- Checkpoint: By Month 30, at least 80% of beneficiaries covered should have access to timely maternal mental health screenings.

By emphasizing phased implementation in areas with strong infrastructure first, and ensuring adequate resource acquisition—including staffing, contracts, and funding—this plan strengthens feasibility and ensures smoother execution.

Path Forward

Improving maternal mental health care through the FEHB Program represents an opportunity for federal leadership. By adopting a comprehensive and coordinated approach, OPM can both improve health outcomes and strengthen its reputation as a forward-looking agency. Future iterations of this policy might consider incorporating hybrid telehealth models, expanded access to postpartum services, and practical supports such as paid parental leave and flexible workforce options. These additions would address common barriers to care and promote continuity of treatment during the critical perinatal period. In doing so, OPM would support the health and stability of federal families while establishing a model for other employer-sponsored health insurance programs. As maternal mental health remains a significant concern in the United States, the leadership from OPM could inform broader efforts to strengthen care delivery and improve outcomes across our healthcare system.

In sum, maternal mental health is a critical but under-addressed component of public health policy. Untreated maternal mental health conditions carry substantial human, social, and financial costs. This report recommends adopting an integrated screening and care coordination approach to ensure early identification, timely intervention, and improved care for federal employees and their dependents. By implementing this, OPM can take meaningful steps toward closing care gaps, reducing long-term healthcare costs, and improving mental health outcomes for all Americans. As a national model, this policy has the potential to create improvements in maternal health beyond the federal workforce and strengthen the role of employer-sponsored insurance in promoting family well-being.

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Appendix: Cost-Effectiveness Calculations

This appendix outlines the assumptions and mathematical steps used to calculate the cost-effectiveness of each policy alternative. For each scenario, cost-effectiveness is defined as the cost per successful maternal mental health treatment outcome. The formula used is:

Cost-Effectiveness = Total Program Cost / Number of Successfully Treated Enrollees

Shared Assumptions for All Alternatives

- Number of pregnant enrollees in FEHB annually: 100,000
- Estimated prevalence of maternal mental health conditions: 20% (i.e., 20,000 affected individuals)
- Estimated treatment success rate: 75% (unless otherwise specified)
- Dollar amounts adjusted to 2025 USD using a projected 2.5% annual inflation rate

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Alternative 1: Status Quo

- No new program costs
- Estimated societal cost per untreated case: $32,000 (Mathematica, 2019)
- Total societal cost = 20,000 untreated x $32,000 = $640 million
- No cost-effectiveness benefit; cost per successful outcome = N/A

Alternative 2: Integrated Screening and Care Coordination

- Estimated cost per patient: $1,149 (Wilkinson et al., 2017; adjusted)
- Total cost = 100,000 enrollees x $1,149 = $114.9 million
- Affected individuals = 20,000
- Successfully treated = 20,000 x 0.75 = 15,000
- Cost-effectiveness = $114.9 million / 15,000 = $7,660 per successful outcome

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Alternative 3: Enhanced Telehealth and Support Network

- Estimated cost per patient: $1,000 (Lee et al., 2022)
- Total cost = 100,000 enrollees x $1,000 = $100 million
- Affected individuals = 20,000

- Successfully treated = 20,000 x 0.75 = 15,000
- Cost-effectiveness = $100 million / 15,000 = $6,666 per successful outcome

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Alternative 4: Advanced Pharmacological Treatment Coverage

- Brexanolone cost: $34,000 per patient, for 5,000 patients = $170 million
- Zuranolone cost: $10,000 per patient, for 5,000 patients = $50 million
- Combined treated patients = 10,000
- Success rate = 80%, or 8,000 successful outcomes
- Total cost = $170 million + $50 million = $220 million
- Brexanolone Cost-effectiveness: $170 million / 4,000 = $42,500 per successful outcome
- Zuranolone Cost-effectiveness: $50 million / 4,000 = $12,500 per successful outcome
- Combined Cost-effectiveness = $220 million / 8,000 = $27,500 per successful outcome