FISCAL IMPACT REPORT

SPONSOR Senate Health and Public Affairs Committee
LAST UPDATED 3/13/2025
ORIGINAL DATE 2/23/2025
SHORT TITLE No Behavioral Health Cost Sharing
BILL NUMBER CS/Senate Bill 120/SHPACS/aSFC
ANALYST Hernandez/Sallee

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
RHCA	See Fiscal Implications				Recurring	RHCA Benefits Fund
HCA	See Fiscal Implications				Recurring	State Health Benefits Fund
NMPSIA	See Fiscal Implications				Recurring	NMPSIA Benefits Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files

Agency Analysis Received From
Department of Health (DOH)
Health Care Authority (HCA)
Office of Superintendent of Insurance (OSI)
University of New Mexico (UNM)
Public School Insurance Authority (NMPSIA)
Retiree Health Care Authority (RHCA)

SUMMARY

Synopsis of SFC Amendment to Senate Bill 120

The Senate Finance Committee (SFC) amendment to the Senate Health and Public Affairs Committee (SHPAC) substitute for Senate Bill 120 (SB120) makes two changes to the bill. First, it clarifies that only services provided in-network are part of the no cost-sharing provisions. Second, it strikes language including urgent care and emergency room visits, excluding them from the prohibition against cost sharing.

Synopsis of SHPAC Substitute for Senate Bill 120

The Senate Health and Public Affairs Committee substitute for SB120 amends parts of the Health Care Purchasing Act and New Mexico Insurance Code to permanently eliminate behavioral health services cost sharing by striking the 2027 sunset date. Cost sharing is defined in existing statute as a copayment, coinsurance, deductible or any form of financial obligation on

an enrollee in a group health plan, outside of the premium. The SHPAC substitute makes clear that SB120 applies only to health insurance plans and not supplemental plans designed to supplement medical plans or high-deductible plans. The committee substitute for SB120 also explicitly lists coverage for therapy, emergency department visits, and urgent care visits.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns if enacted, or June 20, 2025.

FISCAL IMPLICATIONS

SB120 eliminates the sunset currently established to automatically end the program in January 2027, which means baseline costs for FY26 and half of FY27 are unaffected. Should the sunset remain, health plan enrollees would resume paying their share of the costs in January 2027 and group plans would see a drop in behavioral healthcare costs. However, SB120 would eliminate the sunset and health plans would continue to cover the full cost of behavioral health services; thus, costs would initially be higher under SB120 starting in FY28, although the cost of behavioral healthcare likely would decline over time as enrollees turn away from higher cost emergency behavioral health programs.

Agency analyses for cost estimates start assuming increased costs in FY26, in conflict with when cost sharing will sunset. Agencies did not provide additional information on how they determined their costs or analysis on whether they could realize savings on other areas of health spending as a result of potentially better access to behavioral health.

Both the Public School Insurance Authority (NMPSIA) and the Retiree Health Care Authority (RHCA) report that the agencies are already paying for behavioral health costs in urgent care centers and hospitals under the current law. As such, all fiscal analyses below include that cost and do not change based on the committee substitute, which specifically includes outpatient behavioral health services for urgent care and hospitals.

The Health Care Authority (HCA) states the agency built the cost of fully covering behavioral health services into the baseline rates of the group health benefit for the state and local government employees covered by the State Health Benefit (SHB) plan, meaning permanently eliminating cost sharing would not increase their costs. In addition, the department states, “Even if the law were to sunset, SHB would likely maintain the policy because of its positive impacts on patients, providers, and the health system as a whole.” As a result, the department stated SB120 would have no additional financial impact for the HCA.

However, both NMPSIA, which provides a healthcare coverage plan for most school districts, and RHCA, which covers state retirees, list additional operating costs associated with the permanent elimination of behavioral health cost sharing.

For the half of FY27 that applies to SB120, RHCA projected that the cost could vary between $370 thousand and $740 thousand. This means that for FY28, the cost is likely between $740 thousand and $1.48 million.

NMPSIA states that for FY27, the expected cost of SB120 is $1.3 million for the half of the fiscal year that SB120 impacts—meaning that for FY28, the cost to NMPSIA is likely $2.6 million. The agency further states that:

> At this juncture, there isn't any analysis prepared as to the overall impact on enrollees' general health or offsetting reductions in total costs for members the cost-sharing restrictions mandated by [the original bill]. Induced utilization for behavioral health services may level off or vary from our assumptions depending upon members' continued utilization patterns for behavioral health services. Based upon recent experience, we include and recommend ongoing higher induced utilization. To the extent actual utilization varies from our assumptions, cost impacts will vary.

SIGNIFICANT ISSUES

A study published in *JAMA*, a respected, peer-reviewed publication of the American Medical Association, examined New Mexico's no-cost behavioral health program instituted in 2021 and found there was a $6.37 reduction in average out-of-pocket spending for patients who used mental health or substance use disorder (SUD) medications. The second major finding was that there was not an increase in the volume of prescriptions dispensed—meaning that more New Mexicans did not seek mental health or SUD medications as a result of the no-cost behavioral health program.

Plans likely had near-term increased cost when cost-sharing was initially eliminated because patients no longer paid for part of the costs through co-pays or other cost-sharing. For example, if a behavioral health prescription cost $1,000 and the patient would normally be responsible for $200 then the plan would have experienced an increase by paying for the patients' portion. However, the premise of eliminating cost-sharing is that the $200 patient cost was resulting in a patient not seeking care and possibly ending up using other high-cost health services, such as the emergency room. Without the financial barrier, patients would be more likely to pursue less expensive treatment, saving the health plan the costs of more expensive care. Whether a plan experiences the savings in the same year remains unclear, and it is not uncommon for plans to raise concerns over whether prevention programs actually pay for themselves. However, no data was provided in agency analyses to support either viewpoint.

The Office of Superintendent of Insurance (OSI) has not found cost savings or overall net neutral costs because its analysis was early in the program. SB120 would continue to benefit patients by lowering their costs but could impact overall plan cost.

OSI notes it required carriers to provide details on the impact on rates when behavioral health cost sharing was eliminated and only one carrier indicated a minimal rate impact for 2025. All other carriers indicated that behavioral health cost sharing elimination had no impact on rates: "Members who received behavioral health services avoided spending $7,156,200 in FY23 and $8,163,602 in FY24."

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