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# New State Law Eliminates All Copays, Coinsurance, and Deductibles for Mental Health and Substance Use Disorder Services

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Patient access to behavioral health and substance use disorder services has increasingly become the subject of legislation. Although the federal Mental Health Parity and Addiction Equity Act[1] (MHPAEA), introduced in 2008, requires mental health and substance use disorder benefits (MH/SUD) to be provided in parity with medical or surgical benefits, the law does not mandate any particular benefit structure for MH/SUD services. As a result, states have enacted or strengthened their own mental health parity laws by supplementing the requirements of the MHPAEA.[2] New Mexico is the most recent state to do so.

On April 8, the governor of New Mexico signed Senate Bill 317 — "No Behavioral Health Cost Sharing" — into law. Sponsored by Sen. Martin Hickey (D), the former CEO of health insurance carrier New Mexico Health Connections, the law prohibits imposing "cost-sharing by health insurers on behavioral health services covered by an individual or group health insurance policy, health care plan, or certificate of health insurance."[3] The provisions of the bill will go into effect on January 1, 2022 and end on December 31, 2026.

The bill defines "behavioral health services" as "professional and ancillary services for the treatment, habilitation, prevention and identification of mental illnesses, substance abuse disorders and trauma spectrum disorders, including inpatient, detoxification, residential treatment and partial hospitalization, intensive outpatient therapy, outpatient and all medications, including brand-name pharmacy drugs when generics are unavailable."[4]

The bill also defines "cost sharing" as "copayment, coinsurance, deductible[,] or any other form of financial obligation of an enrollee other than a premium or a share of a premium, or any combination of any of these financial obligations, as defined by the terms of a group health plan."[5]

Under the provisions of the bill, the Office of the Superintendent of Insurance (OSI) is required to collect and report data on the effects of eliminating cost sharing for behavioral health services on providers and patients within the state.[6] This information would then be reported annually to the Legislative Finance Committee (LFC) and the interim Legislative Health and Human Services Committee (LHHS).[7] The LFC would then report to the governor and LHHS the effects of eliminating cost sharing both in terms of costs for behavioral health services and health and social outcomes.[8]

Along with prohibiting cost sharing by health insurers on behavioral health services, the bill will establish the Health Care Affordability Fund, replacing "a recently phased-out federal fee on insurance companies."[9] This new

fund will increase New Mexico's existing surtax on insurance companies from 1% to 3.75% and is expected to generate about $165 million in new revenue annually.[10] By collecting this revenue, New Mexico plans to increase access to care and close the coverage gap for those who cannot afford private insurance.[11]

"Mental health issues and substance use disorders plague our state," said Sen. Martin Hickey.[12] "With this law in place, financial barriers will no longer get in the way of treatment, giving more people access to the care they need. This is a big deal for patients and will ultimately lower the costs of healthcare and incentivize the expansion of services as patients seek out and remain in therapy without those financial barriers in place."[13]

Some studies have shown that improving access to behavioral health services could reduce the overall cost of health care. As the bill prohibits cost sharing for all behavioral health services for at least five years, the access to, and the utilization of, these behavioral health services would ostensibly increase.[14] In turn, the increased use of these services may lead to improved adherence to behavioral health treatment regimens, like medication use.[15] By improving adherence to treatments, the bill anticipates that improved outcomes will result in lower health care costs, like the costs for emergency rooms and inpatient hospital admissions.[16]

Nascent literature on behavioral health services for individuals with both MH/SUD and chronic physical health comorbidities indicates that improved access to behavioral health services may also reduce overall health care spending. Many individuals with MH/SUD conditions have comorbidities, such as diabetes, hypertension, and COPD. Studies have found that "mental health disorders are associated with substantially higher resource utilization and health care costs among patients with chronic diseases."[17] Moreover, the medical costs for treating patients with MH/SUD conditions and chronic medical comorbidities is approximately "two to three times higher on average compared to the costs" for those without both MH/SUD and chronic medical comorbidities.[18]

Prior to the bill's passage, however, New Mexico's OSI warned that eliminating cost sharing for behavioral services could result in higher insurance premiums. The OSI speculated that, if waiving cost sharing for certain services did not ultimately result in overall lower health care expenditures, insurers may increase insurance premiums for all members because "they are no longer able to charge cost-sharing to the users of the particular set of services and the insurers overall expenditures have gone up."[19] Thus, the full cost of services would be spread across the members via higher premiums.[20]

According to the OSI, no other state has implemented such an expansive constraint on cost sharing for behavioral health services. As the data comes in, New Mexico's new approach will provide valuable insights that may very well shape policies and legislation regarding MH/SUD around the country. It is certainly an experiment that all MH/SUD stakeholders will watch closely.

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[1] The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law on October 3, 2008 and became effective for plan years beginning on or after October 3, 2009. The MHPAEA greatly expands on an earlier law, the Mental Health Parity Act of 1996 (MHPA '96).

[2] *See* this link. (*last visited* April 28, 2021).

[3] *See* this link.

[4] *See* text of Senate Bill 317 at this link.

[5] *Id.*

[6] *Id*.

[7] *Id*.

[8] *Id*.

[9] *See* this link.

[10] *Id*.

[11] *Id*.

[12] *Id*.

[13] *Id*.

[14] *See* this link.

[15] *Id*.

[16] *Id*.

[17] *See* Sporinova, B et al. Association of Mental Health Disorders With Health Care Utilization and Costs Among Adults With Chronic Disease. JAMA Network Open. 2019;2(8):e199910. doi:10.1001/jamanetworkopen.2019.9910.

[18] *See* Melek, S et al. Potential Economic Impact of Integrated Medical-Behavioral Healthcare, Updated Projections for 2017. Milliman Research Report at this link. (*last visited* April 27, 2021); *see also* Melek, S et al. Addiction and Mental Health vs. Physical Health: Widening Disparities in Network use and Provider Reimbursement, A deeper analytical dive and updated results through 2017 for 37 million employee and dependents at this link. (*last visited* April 27, 2021).

[19] *See* this link.

[20] *Id*.

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