FISCAL IMPACT REPORT

BILL NUMBER: CS/House Bill 137/HHHCS
SHORT TITLE: Stocking of Certain Drugs in Pharmacies
SPONSOR: House Health and Human Services Committee
LAST UPDATE: **ORIGINAL DATE:** 2/5/2026 **ANALYST:** Chenier

APPROPRIATION*
(dollars in thousands)

FY26	FY27	Recurring or Nonrecurring	Fund Affected
	$1,500.0	Recurring	General Fund

*Amounts reflect most recent analysis of this legislation.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
DOH		$127.8	$127.8	$255.6	Recurring	General Fund

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

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Department of Health
Health Care Authority
Regulation and Licensing Department

SUMMARY

Synopsis of the HHHC Substitute to House Bill 137

The House Health and Human Services Committee substitute for House Bill 137 (HB137/HHHCS) appropriates $1.5 million from the general fund to the Health Care Authority (HCA) to increase Medicaid reimbursement rates for buprenorphine prescriptions.

This bill aims to improve access to medications that treat opioid use disorder by ensuring that pharmacies keep adequate supplies of buprenorphine, a key treatment drug. It requires pharmacies to regularly calculate how much buprenorphine they dispense and to maintain a minimum stock based on recent patient demand, with additional requirements depending on whether the pharmacy is community-based or not. Pharmacies are given limited flexibility if they temporarily fall below required stock levels, so long as they promptly reorder medication or seek

higher distribution limits from wholesalers.

The bill also increases transparency and oversight of the drug supply chain by requiring wholesale drug distributors to report when they deny or delay pharmacy orders for buprenorphine or refuse to raise a pharmacy's ordering threshold. These reports must include reasons for the denial or delay and are submitted monthly to the state board, which then shares the data with the Department of Health (DOH). DOH must analyze this information and publish a public, twice-yearly report on statewide access to buprenorphine, while protecting pharmacy identities and complying with privacy laws.

To enforce compliance, the bill establishes graduated penalties for both pharmacies and wholesale distributors, beginning with notices and escalating to corrective plans and fines for repeated violations. Pharmacies would be protected from penalties when shortages are caused solely by distributor actions, provided they can show they followed required procedures.

The effective date of the provisions of this act is September 1, 2026.

FISCAL IMPLICATIONS

The appropriation of $1.5 million contained in this bill is a recurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of FY27 shall revert to the general fund.

DOH states the bill requires pharmacies to collect and report data on availability of specific pharmaceuticals for treatment of opioid use disorder. This data would be reported to DOH for analysis. DOH is required to prepare a biannual report. DOH estimates it would require one full-time epidemiologist position to gather and analyze data for this reporting requirement. The current midpoint salary for epidemiologists is $44.21 per hour or $91.9 thousand per year. With benefits calculated at 39 percent, the total annual cost is $127.8 thousand. The legislation does not create such a position nor provide any funding to the department; the appropriation would be to the Health Care Authority (HCA).

HCA states currently Medicaid reimburses for medications using a standardized algorithm, largely established by federal regulations, that pays at the lowest reference price (based on industry standards) plus a dispensing fee of $10.30. Federal approval would be required to revise the reimbursement methodology for buprenorphine; however, it is unlikely the federal Centers for Medicare and Medicaid Services would allow HCA to reimburse buprenorphine prescriptions in this fashion. An alternative model that incentivizes data reporting by pharmacies may be easier to implement.

The Regulation and Licensing Department (RLD) states all employees assigned to fulfill the duties of the Board of Pharmacy, administratively attached to RLD, are employed by RLD and compensated through the RLD. The Board of Pharmacy reports it expects to incur additional administrative expenses related to compliance and reporting obligations, with an estimated need for an additional full-time inspector (at approximately $200 thousand per year) and an additional administrative staff member (at approximately $80 thousand per year). HB137 does not dedicate funding or personnel to the Board of Pharmacy/RLD to cover those new requirements. Funding for operations of the Board of Pharmacy comes from the pharmacy fund, a nonreverting fund established by Section 61-11-19 NMSA 1978. A sufficient appropriation from the pharmacy

fund to RLD would be necessary each fiscal year to cover the increased staffing the Board of Pharmacy would require if HB137 were enacted.

SIGNIFICANT ISSUES

DOH provides the following:

In 2024, the total number of drug overdose deaths in New Mexico was 746, with 64 percent (474 deaths) involving opioids (nmhealth.org/data/view/substance/2889/). This represented a decrease based on previous years. However, based on recent provisional CDC data, the number of overdose deaths in the state has recently begun to increase.

Adequate access to medication for opioid use disorder (MOUD) remains a key barrier in addressing this. In 2023, opioid overdose-related visits accounted for 72 percent of all drug overdose-related emergency visits. Despite the urgent need for treatment, many individuals are unable to access the necessary medications. Local pharmacies in New Mexico often report low to no stock of buprenorphine, a vital medication in MOUD, leaving patients without consistent access to prescriptions. Nationally, only 57.9 percent of pharmacies reported having buprenorphine/naloxone in stock when requested, with significant variability between states and pharmacy chains. New Mexicans face similar challenges in getting their prescriptions filled (Source NM).

Limited access to treatment leads to lost productivity, premature death, and higher healthcare costs due to both acute and chronic illnesses (SAMHSA). Expanding substance use disorder treatment services could yield positive economic benefits, reduce criminal justice costs, and help lower criminal activity (Science Direct). In 2021, one in fourteen individuals in New Mexico needed treatment, but only one in seven sought help due to barriers like stigma, limited availability, and eligibility restrictions.

Federal obstacles to bill implementation and reliable buprenorphine access

There have been significant efforts by the state and healthcare sectors to improve access to behavioral health and SUD treatment, but access to buprenorphine, considered the gold standard for opioid use disorder treatment, has been unreliable. Removing barriers to buprenorphine and promoting timely access to this medicine has been a stubborn problem that states have had difficulty solving on their own.

Access to buprenorphine is primarily related to the SUPPORT Act, passed by Congress, and several provisions of the master settlement agreement (MSA) for the Opioid Settlement. The SUPPORT Act was passed in an effort to monitor opioid distribution through the establishment of the suspicious order reporting system (SORS), which requires all [Drug Enforcement Agency (DEA)] registrants that distribute controlled substances to report suspicious orders to the DEA.

The relevant DEA regulations do not establish thresholds, nor do they require registrants to set thresholds or limits on controlled substance ordering. The DEA does not exclude medications for treatment of opioid use disorder from the requirements. Buprenorphine occupies a counterintuitive space because, while it shares a classification with opioids at the center of the addiction and overdose crisis, it is the gold standard for treatment and the long-term management of addiction.

The DEA does not have requirements in place to ensure pharmacies are able to receive adequate supplies to fill legitimate prescriptions.

The MSA for the Opioid Settlement imposes additional requirements on wholesale pharmacy distributors to place ordering limits on retail pharmacies. These include the use of data-driven systems to flag orders that exceed established thresholds. Once flagged, these orders are automatically cancelled. The manner of determining medication thresholds is proprietary information. If a pharmacy places an order exceeding its threshold, the distributors may cancel the order and potentially report the order as "suspicious" to state and federal law enforcement. Moreover, the settlement agreement prohibits distributors from informing individual pharmacies of their specific threshold levels, how they are calculated, or when existing orders approach them. This limits a pharmacy's ability to proactively request an increase to its buprenorphine threshold to ensure it can meet local needs. Wholesalers are prohibited from disclosing the algorithms used to determine the thresholds, which would help retail pharmacies avoid overstepping thresholds and triggering cancellations and audits. While the MSA allows for the temporary suspension of these thresholds during declared emergencies—such as the current national emergency related to fentanyl—wholesale distributors have not applied this provision to temporarily lift the thresholds for buprenorphine.

TECHNICAL ISSUES

DOH provides the following:

This bill mandates that retail pharmacies calculate the minimum daily buprenorphine stocking requirement by determining the average amount of buprenorphine dispensed to ultimate users per day in the previous 30 days, rounding to the nearest milligram. Retail pharmacies typically inventory based off of dispensing units (tablets/films etc). Amending language from nearest milligram to dispensing unit would be easier for pharmacies to implement.

Amend the definition of community-based pharmacy so that there is not undue hardship on locally owned independent pharmacies (as chain pharmacies, mail order pharmacies, hospital pharmacies etc. are excluded) OR remove pharmacy stocking requirements and penalties and leave only wholesale distributor reporting requirements in place. The current definition of community-based pharmacy has the potential to hinder independent pharmacy success and create a disadvantaged playing field for small business in New Mexico. The language in essence targets only independent pharmacies as chain pharmacies, mail order pharmacies, and hospital pharmacies are excluded from additional recordkeeping requirements, greater cost of staffing to meet these requirements, and penalties. Independent pharmacies will be at a disadvantage compared to their competitors who are excluded from the bill. New Mexico has the 2nd highest pharmacy shortage and many independent pharmacies are struggling due to decreased PBM reimbursement and preferred network inclusion.

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