LFC Requester:	Harry Rommel

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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(Analysis must be uploaded as a PDF)

SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: *02/12/2026*
Bill Number: *STBTC/SHPAC/SB20*

Check all that apply:
Original __ Correction __
Amendment __ Substitute X_

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Short Title: PRIOR AUTHORIZATION & PRESCRIPTION DRUGS
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	FY27		

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	FY27	FY28		

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27*	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Total	$0	$1,800-$2,600	$0	$1,800-$2,600	Nonrecurring	RHCA Benefit Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

Duplicates/Conflicts with/Companion to/Relates to:
Duplicates/Relates to Appropriation in the General Appropriation Act

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:

Senate Bill 20s amends the Prior Authorization Act to explicitly apply its requirements to pharmacy benefit managers (PBMs) that have direct contracts with entities subject to the Health Care Purchasing Act and modifies prior authorization and step therapy rules for prescription drugs. The bill adds medications prescribed to treat serious mental illness to the list of conditions for which prior authorization and step therapy are prohibited, except when a generic, biosimilar, or interchangeable biologic is available. The bill further limits the ability of a health insurer or PBM to require reauthorization of chronic maintenance medications to no more than once every three years.

The bill applies to health benefit plans issued pursuant to the Health Care Purchasing Act, under which the New Mexico Retiree Health Care Authority (RHCA) administers benefits.

Amendment in Context – 12/11/26:

The Senate Tax, Business and Transportation Committee Substitute for Senate Bill 20 amends the Prior Authorization Act to apply prior authorization requirements to pharmacy benefits managers (PBMs) that contract directly with entities subject to the Health Care Purchasing Act (HCPA), including the New Mexico Retiree Health Care Authority (RHCA). The bill prohibits prior authorization for certain prescription drugs used to treat specified conditions, shortens prescription drug prior authorization timelines, limits reauthorization of chronic maintenance medications, and establishes additional compliance requirements.

The committee substitute modifies the original bill by narrowing the definition of "serious mental illness," reducing prescription drug prior authorization determination timelines from seven days to three business days, adding limited clinical exceptions, adding an exception for certain weight loss or cosmetic-use medications, narrowing PBM applicability to HCPA entities, and delaying implementation to January 1, 2027.

FISCAL IMPLICATIONS

Amendment in Context – 12/11/26

The committee substitute reduces the timeframe for prescription drug prior authorization determinations from seven days to three business days. If a determination is not issued within this timeframe, the request is deemed granted. This shortened window increases the risk of automatic approvals for high-cost specialty medications when complete clinical documentation is not yet received. For a self-funded plan such as RHCA's non-Medicare population, even a small increase in specialty drug approvals may result in measurable upward pressure on pharmacy trend.

The committee substitute moderates fiscal exposure compared to the original version; however, the shortened prescription drug determination timeline increases operational and financial risk to self-funded plans.

Original

The fiscal impact of Senate Bill 20 on the RHCA is measurable but not material when evaluated in the context of RHCA's total annual pharmacy and medical claims expenditures. While the estimated impact represents a relatively small percentage of total claims costs, it contributes to upward cost pressure within the self-funded non-Medicare plans. Additional analysis and implementation experience would be required to more precisely quantify any resulting cost increases associated with these changes.

Limiting prior authorization for chronic maintenance medications to once every three years materially reduces RHCA's ability to confirm ongoing medical necessity, adjusting therapy based on changes in a member's health status, and preventing avoidable utilization.

From a member perspective, reduced prior authorization frequency may lessen administrative burden and delays in accessing prescribed medications, which could improve continuity of care and treatment adherence for affected members.

Increased pharmacy costs associated with SB 20 would ultimately be borne by members through higher premiums and cost-sharing, particularly impacting non-Medicare retirees whose coverage is fully self-funded by RHCA.

In addition to lost savings, implementation of SB 20 would require custom pharmacy benefit configuration and ongoing system maintenance outside standard PBM operations. These non-standard configurations increase administrative costs, operational complexity, and compliance risk. Based on pharmacy benefit manager analysis, this provision is estimated to result in an initial loss of $1.8 million to $2.6 million in pharmacy savings.

While the immediate rebate and utilization impact associated with adding serious mental illness medications to step therapy and prior authorization prohibitions is limited, step therapy is a foundational tool used by PBMs to negotiate manufacturer rebates. Further statutory expansion of step therapy prohibitions could significantly increase net pharmacy costs over time.

Pharmacy Benefit Managers (PBMs) operate under a defined set of criteria and regulatory expectations for prior authorizations, medical-necessity determinations, and safety-related dispensing controls. In addition, PBMs use prior authorization to ensure that medications are clinically appropriate, cost effective, and aligned with plan rules. These include both clinical and regulatory requirements, such as diagnosis must match FDA approved or evidence-based indications. In addition, auto approval of medical necessity within ~~seven days~~ three days (amended) may not be appropriate without documentation from the provider.

The National Committee for Quality Assurance (NCQA), which evaluates health plans through its Health Plan Accreditation program, supports policies that ensure step therapy protocols are transparent and evidence-based and include a straightforward process for exceptions when medically necessary. It advocates patient protection and timely access to appropriate medications.

SIGNIFICANT ISSUES
Mandated limitations on pharmacy utilization management tools reduce RHCA's ability to control rising drug costs and initial reconfiguration costs will both place additional pressure on member premiums.

PERFORMANCE IMPLICATIONS
None

ADMINISTRATIVE IMPLICATIONS
The bill would require custom pharmacy benefit configuration and require post review of multi-year authorization periods to ensure compliance with statutory requirements versus current rules in place.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None identified

TECHNICAL ISSUES
RHCA administers Medicare-related pharmacy coverage through an Employer Group Waiver Plan (EGWP) governed by federal Medicare Part D requirements. Further legal review may be necessary to determine whether state-imposed prior authorization timelines and restrictions apply to Medicare-regulated coverage or whether federal preemption applies.

OTHER SUBSTANTIVE ISSUES
SB20 conflicts with the statutory authority granted to the New Mexico Retiree Health Care Authority Board of Directors under Sections 10-7C-5 and 10-7C-6 NMSA 1978, which vest the Board with responsibility for plan design, benefit administration, and premium determination. Mandated benefit administration requirements may limit the Board's ability to manage pharmacy benefits in a fiscally responsible manner.

ALTERNATIVES
None

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
If the substitute is not enacted, existing prior authorization authority and timelines would remain in place. RHCA would retain current utilization management flexibility for prescription drugs, including specialty medications and chronic maintenance drugs, subject to existing state and federal law.

AMENDMENTS
None