LFC Requester:	ALLEGRA HERNANDEZ

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

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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: *1/28/26*
Bill Number: *SB130*

Check all that apply:
Original *X* Correction __
Amendment __ Substitute __

Sponsor: Martin Hickey
Short Title: NO COST-SHARING OF CERTAIN DRUGS

Agency Name and Code Number: New Mexico Retiree Health Care Authority - 34300
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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	$135,000 - $270,000	$295,000 - $585,000	$430,000 - $855,000	Recurring	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:

This legislation expands access to cardiovascular prevention and cholesterol management services by eliminating cost sharing for a range of evidence-based screenings and medications across most health coverage types in New Mexico, including group health coverage offered under the Health Care Purchasing Act. It prohibits copayments, deductibles, and coinsurance for generic cholesterol-lowering medications and, when medically necessary, for second-line therapies if generic options are ineffective or not tolerated.

The bill also broadens eligibility for coronary artery calcium (CAC) screenings and comprehensive lipid panels, removes cost sharing for these services for adults age forty-nine and older, and extends coverage to younger individuals with a strong family history of coronary artery disease or provider-diagnosed symptoms. It standardizes these coverage requirements across group plans, insurers, HMOs, and nonprofit health plans, while preserving exceptions for certain plan types such as catastrophic or high-deductible plans.

Additionally, the legislation expands the responsibilities of the Board of Pharmacy by directing it to establish clinical protocols that allow pharmacists to assess cardiovascular risk and prescribe lipid-lowering or plaque-reducing therapies consistent with standards of care. These provisions aim to improve early detection, prevention, and treatment of heart disease statewide.

FISCAL IMPLICATIONS

The fiscal impact of Senate Bill 130 on the New Mexico Retiree Health Care Authority (NMRHCA) is expected to include higher plan liabilities resulting from the elimination of cost-sharing for cholesterol-related screening, treatment, and medications. Under the bill, members who do not achieve adequate cholesterol control or who experience adverse reactions to generic medications may advance to second-line therapies, including brand-name drugs, without any cost-sharing. Removing these member cost obligations is likely to increase utilization, which may place upward pressure on premiums and overall agency expenditures with 100% of member costs shifting to the Plan. Although manufacturer rebates may offset a portion of the gross cost, increased utilization combined with the elimination of cost sharing could lead to higher net pharmacy spend for the NMRHCA pre-Medicare population.

The anticipated cost increases stem in part from mandatory coverage of statins, which are widely prescribed to manage cholesterol and reduce cardiovascular risk. Additionally, the bill requires that coronary calcium screening and lipid panel testing be provided at no cost to eligible members aged forty-nine and older, as well as to members of any age with a strong family history of coronary artery disease or symptoms diagnosed as such by their health care provider.

The cost impact projections and assumption below pertain only to our Commercial plans.

- Based on the text of the Bill, coronary calcium screening and lipid panel testing would be offered without member cost-sharing to eligible group health plan members who are older

than forty-nine, as well as members of any age with a "strong family history of coronary artery disease or symptoms that are diagnosed as coronary artery disease by the eligible insured's health care provider."

  - In this way, SB130 is an expansion of an earlier bill, HB126 (effective January 1, 2021), which required coverage of these scans for individuals ages 45 to 65 at risk of CAD. For these members, HB126 allows cost-sharing based on current plan designs.

- NMRHCA's Pre-Medicare members aged 50 and older plus members younger than 50 who have coronary artery disease (CAD). Based on public prevalence data on CAD for this age group, assumption is that 2% of this population may have CAD.

- Not all members would ultimately undergo screening. We modeled two scenarios. On the low end, we assumed that 10% of members would receive a coronary calcium screening and that 70% of members would receive a lipid test. On the high end, we assumed that 50% and 90% of eligible members would receive calcium and lipid screening, respectively.

- Pricing information for calcium screenings and lipid tests were based on a combination of publicly available sources and consultant's intelligence sources.
  - Current utilization of these tests is unknown, though utilization is low in other groups. Additionally, the group's actual CAD prevalence is not known. To reflect these uncertainties and to provide a cushion for new induced utilization, we assumed that the full allowed costs of future tests would revert to the Plan.
  - For cholesterol testing, we assumed $50 as a reasonable cost for a typical panel and applied plan design factors to reflect what members currently pay for these tests and what costs might revert to the Plan if SB 130 were passed. This actuarial value was assumed to be about 23%.

- The estimated annual trend is 14% for allowed pharmacy costs, which accounts for both drug cost increases and growth in utilization.

Medicare Advantage and Medicare Part D are governed by federal laws (Medicare Modernization Act) and CMS (Centers for Medicare & Medicaid Services) regulations. State laws cannot directly change their benefit structures.

SIGNIFICANT ISSUES

Cholesterol-lowering medications are typically prescribed by healthcare providers based on an individual's cholesterol levels, risk factors for cardiovascular disease, and overall health profile. According to Harvard Health, about one in four Americans aged 45 and older take a statin. While statins are the most common type of cholesterol-lowering drugs, there are several other options available:

1. **Statins**: These are the most commonly prescribed cholesterol-lowering medications. They work by inhibiting an enzyme involved in cholesterol production in the liver. Examples include atorvastatin (Lipitor), simvastatin (Zocor), and rosuvastatin (Crestor).
2. **Ezetimibe**: This medication reduces the absorption of cholesterol from the intestines. It can be used alone or in combination with statins. An example is ezetimibe (Zetia).
3. **PCSK9 Inhibitors**: These newer medications help the liver absorb more LDL cholesterol from

the blood. Examples include alirocumab (Praluent) and evolocumab (Repatha).
4. **Bile Acid Sequestrants**: These drugs bind to bile acids in the intestines, preventing their reabsorption and promoting the removal of cholesterol from the body. Examples include cholestyramine (Questran) and colesevelam (Welchol).
5. **Fibrates**: Primarily used to reduce triglycerides, fibrates can also have a modest effect on increasing high-density lipoprotein (HDL) cholesterol. Examples include fenofibrate (Tricor) and gemfibrozil (Lopid).
6. **Niacin**: Also known as vitamin B3, niacin can help lower LDL cholesterol and triglycerides while raising HDL cholesterol. It is available both as a prescription and as an over-the-counter supplement.

To ensure that cholesterol-lowering medications are prescribed and utilized effectively, the agency may need to consider strategies such as collaborating with healthcare providers and implementing patient education initiatives.

PERFORMANCE IMPLICATIONS
The bill may improve access to preventive cardiovascular screening and reduce financial barriers to medication adherence for retirees. Over time, these changes could contribute to improved cardiovascular outcomes. However, near-term utilization increases are expected as cost sharing is eliminated and additional prescribing pathways become available.

ADMINISTRATIVE IMPLICATIONS
None

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
None

TECHNICAL ISSUES
None

OTHER SUBSTANTIVE ISSUES
The bill directs the Board of Pharmacy to adopt protocols allowing pharmacists to assess cardiovascular risk and prescribe certain therapies. This expanded access point could increase utilization beyond traditional physician-based prescribing patterns.

In addition, SB130 conflicts with the authority granted to the Board of Directors under 10-7C-5. Authority Created and 10-7C-6 Board created; membership; authority for the New Mexico Retiree Health Care Authority, as it relates to administration of the Retiree Health Care Act.

ALTERNATIVES
None

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
None

AMENDMENTS
None