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: 1/26/26 **Bill Number:** SB0130 **Original** X **Amendment** **Substitute**
Short Title: NO COST-SHARING OF CERTAIN DRUGS
Sponsor: Sen. Hickey
Name and Code Number: HCA 630
Person Writing: JoLou Trujillo-Ottino
Phone: 505-795-3464 **Email:** jolou.trujillo-ottino@hca.nm.gov

SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	**FY27**		
$0.0	$0.0	NA	NA

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**		
$0.0	**$0.0**	**$0.0**	NA	NA

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid	$0.0	$13.9	$13.9	$27.8	Recurring	General Fund
Medicaid	$0.0	$34.8	$34.8	$69.6	Recurring	Federal Fund
TOTAL Medicaid	**$0.0**	**$48.7**	**$48.7**	**$97.4**	**Recurring**	
State Health Benefits	$0.0	$16.3	$32.5	$48.8	Recurring	State General Fund (through State Health Benefits Fund)
State Health Benefits	$0.0	$8.8	$17.5	$26.3	Recurring	Cost to Employees (Premiums)
TOTAL State Health Benefits	**$0.0**	**$73.8**	**$98.70**	**$172.5**	**Recurring**	
State Health Benefits	$0.0	($20.0)	($40.0)	($60.0)	Recurring	Cost to Employees (Cost Sharing)

(Parenthesis ( ) Indicate Expenditure Decreases)

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis:

Senate Bill 130 is intended to strengthen access to preventive cardiovascular care by removing cost-sharing barriers for clinically appropriate screenings and medications. The bill prohibits cost sharing for generic cholesterol-lowering medications and extends that protection to second-line therapies when first-line options are ineffective or not tolerated, as determined by a prescribing provider. It also expands and standardizes coverage for coronary artery calcium (CAC) screening and cholesterol lipid panels to support earlier detection and more precise cardiovascular risk management.

In addition, the bill limits insurer discretion to deny follow-up cardiac testing based solely on CAC results and assigns the Board of Pharmacy authority to establish rules and protocols consistent with evidence-based standards of care. The bill applies broadly across most group and individual health plans, including public employee plans, with appropriate exceptions for plan types subject to federal requirements.

FISCAL IMPLICATIONS

Medicaid

In 2025 there were 839 total Medicaid claims for code 75571 (327 in 2023). This code is the most applicable to the current proposed screening, showing 728 paid claims in 2025 (219 in 2023). The paid claims relate to age and medical necessity (not based on guideline criteria). Many of the denied claims would potentially be covered under the proposed legislation. The current New Mexico Medicaid Fee-for-Services rate for code 75571 is $116.19. The analysis does not account for adding CAC in a more complicated cardiovascular radiologic work-up (i.e., CPT 75572-75574). Under the proposed legislation utilizations would be expected to increase, although it is not clear to what extent. Estimating that the total approved CAC test would be 1.5 times total requested tests in 2025, the state would expect 1,258 tests to be performed annually or an increase of 419 tests. This represents a cost of $48,683.61, of which $13,889.43 would be supported by state funds and $34,794.17 supported by federal funds.

This bill also removes cost sharing (i.e. copays) from CAC tests. Currently New Mexico Medicaid does not have cost- sharing with its members. Under new federal regulations for Medicaid, cost sharing may be required for specific encounters.

SHB

SB0130 mandates coverage for coronary artery calcium screening every five years with no cost sharing for eligible members who have previously received coronary artery calcium score of zero.

Currently, coronary artery calcium screening is covered for eligible State Health Benefits (SHB) members between the ages of 45-65 and who have an intermediate risk of developing coronary heart disease. The scans are covered only once every five years for eligible members who have previously received a heart artery calcium score of zero.

SB0130 removes the current member cost sharing for those receiving coronary artery calcium screening.

Based on the estimated prevalence of coronary artery disease in the SHB population for which coronary artery calcium screening is indicated, we project this bill will result in an additional cost to the plan up to $50,000 and reduced cost sharing to members up to $40,000 annually. The plan and member costs are not direct offsets since we would expect a slight increase in procedure frequency given coverage for every four years for members who previously received a heart artery calcium score of zero.

No fiscal implications for ITD.

SIGNIFICANT ISSUES

As drafted, the bill requires cost-free coronary artery calcium screenings and cholesterol lipid panels for health plan enrollees over 49 years-old, except for those with diagnosed symptoms or a "strong family history" of coronary artery disease. "Strong family history" is not defined. Nationally, efforts to increase health screen accessibility more commonly use family history to expand, not limit, eligibility for cost-free screenings. This provision, along with the provision limiting cost-free CAC screenings and cholesterol lipid panels to those without diagnosed coronary

artery disease symptoms, was not present in SB278, considered in last year's legislative session.

Coronary artery calcium screening (CAC) has been proved to be most effective in patients with a moderate risk of cardiovascular disease where it is unclear if the patient should start cholesterol lowering therapy. The American Heart Association recommends selective use of coronary artery calcium screening using a risk stratification tool and in conjunction with the goals of the patient. The US Preventative Service Task Force, the federal agency where most guideline recommendations come from, states there is insufficient evidence to recommend for or against coronary artery calcium screening in asymptomatic adults. The American Academy of Family Physicians recommends coronary artery calcium screening for patients at intermediate risk of developing cardiovascular disease in the next 10 years. There are no guidelines currently that recommend coronary artery calcium screenings for every patient over 45 years old, regardless of risk of cardiovascular disease.

https://www.aafp.org/pubs/afp/issues/2022/0700/diagnostic-tests-coronary-artery-calcium-scoring.html#:~:text=Coronary%20artery%20calcium%20(CAC)%20is,coronary%20arteries%20at%20each%20slice

Currently as written, the bill would allow all members on cholesterol lowering medication to pursue second line agent with no cost sharing since the term "cholesterol" is vague and could be interpreted to mean total cholesterol instead of a specific subtype of cholesterol. The American Heart Association no longer provides a total cholesterol recommendation; however, anything lower than 200 is considered desirable. First line agents are often a class of generic oral medications and significantly cheaper than newer second line injectable agents.

No significant issues for ITD.

PERFORMANCE IMPLICATIONS
None.

ADMINISTRATIVE IMPLICATIONS
Medicaid
New Mexico Medicaid would need to determine what, if any, prior authorization criteria currently exist within the Managed Care plans and issue guidance to remove such criteria. This would be done with a letter of direction and then direction via a supplement would need to be delivered to the providers.

SHB: None

ITD: None

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
A similar bill was considered as SB278 during the 2025 Regular Session. Legislation on CAC screening was first enacted as HB126 in the 2020 Regular Session.

TECHNICAL ISSUES
None.

OTHER SUBSTANTIVE ISSUES
The United States Preventive Services Taskforce, the primary source used by clinicians in determining screening recommendations, has found that there is insufficient evidence to recommend Coronary Artery Calcium tests for asymptomatic individuals. The American Heart Association recommends this test for select individuals after shared decision making. The individuals for whom they recommend it largely align with the existing statute.

ALTERNATIVES
None.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
None.

AMENDMENTS
None.