FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 87/ec
SHORT TITLE: Opioid Addiction Prevention

SPONSOR: Brandt
LAST UPDATE: **ORIGINAL DATE:** 1/28/2026 **ANALYST:** Chenier

APPROPRIATION*
(dollars in thousands)

FY26	FY27	Recurring or Nonrecurring	Fund Affected
$9,000.0		Nonrecurring	Opioid Crisis Recovery Fund

*Amounts reflect most recent analysis of this legislation.

Conflicts with appropriation in House Bill 2

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Health Care Authority
Department of Health

SUMMARY

Synopsis of Senate Bill 87

Senate Bill 87 appropriates $9 million from the opioid crisis recovery fund to the Department of Health (DOH) for expenditure in FY26 through FY31 to carry out the purposes of SB87. The bill creates an opioid addiction prevention pilot project at DOH to study ways to use nurse navigation to prevent opioid misuse, addiction, overdoses, and poisonings related to surgeries and other healthcare procedures through a contractor.

The bill also requires DOH to provide an annual report to the LFC and Legislative Health and Human Services (LHHS) on the project's success.

This bill contains an emergency clause and would become effective immediately on signature by the governor.

FISCAL IMPLICATIONS

The appropriation of $9 contained in this bill is a nonrecurring expense to the opioid crisis recovery fund. Although this bill does not specify future appropriations, multiyear appropriations, particularly if used to fund services and those services perform well, create an expectation the program will continue in future fiscal years; therefore, this cost could become recurring after the funding period.

The current version of House Bill 2 includes an appropriation of $21.8 million from the opioid crisis recovery fund and there would be no fund balance remaining in the fund for the appropriation contemplated in this bill. To increase the distribution from the recovery fund as contemplated in this bill, additional fund transfer language, transferring $9 million from the restricted fund to the recovery fund, would be required.

SIGNIFICANT ISSUES

The Health Care Authority provided the following:

> This bill looks to address the opioid crisis at a critical point of risk (after surgery) by promoting safer, evidence-based pain management that can significantly reduce unnecessary opioid exposure. By utilizing nurse navigation models and measuring outcomes, the goal is to prevent addiction before it starts while improving patient care and reducing long-term health and social costs.
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> Opioid Use Disorder (OUD), or symptom recurrence of active OUD, can be traced to acute pain management in some cases. The sudden cessation of opioid treatment may cause hyper analgesia, increasing the likelihood of an individual seeking to continue pain management with opioids. Reducing or eliminating the use of opioids to treat acute, post-operative pain will eliminate or mitigate opioid misuse, overdose, and opioid use disorder onset in those individuals seeking acute pain relief after surgery.
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> While the bill's intent is to ensure "clinical efficacy and immediate scalability," it also requires the Department of Health to contract with a third party that can demonstrate a proven track record across a detailed set of qualifications, including having an evidence-based model supported by peer-reviewed publication(s) and operating opioid-settlement-funded programs in a minimum of five other states.
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> These specifications may substantially narrow the pool of eligible vendors (potentially excluding otherwise qualified New Mexico partners or emerging models without multi-state settlement funding history), which could limit competition, see higher bid pricing, delay procurement timelines, or create implementation risk if only one or very few entities can meet all criteria. Consideration could be given to allowing the Department flexibility to accept equivalent experience or to structure procurement in a way that preserves the bill's evidence-based intent while avoiding unintended barriers to contracting and timely launch.

DOH Provided the following:

> In 2019, the non-fentanyl prescription opioids (NFPOs) overdose rate was lower than both heroin and methamphetamine. NFPOs have not been driving overdose rates and

have seen a downward trend since their peak in 2014 (NMDOH Bureau of Vital Records and Health Statistics [BVRHS], death certificate data; UNM GPS population estimates analyzed by the NMDOH Substance Use Epidemiology Section [SUES]). Additionally, since 2013, New Mexico's Prescription Monitoring Program (PMP) data shows a downward trend for prescriptions filled, MME dispensed, and patient count for both chronic and non-chronic fills (New Mexico Board of Pharmacy Prescription Monitoring Program data).

While the number of New Mexico prescribers who prescribe controlled substances increased to nearly 3,500, the number of providers not checking the PMP declined, from over 1,500 prescribers in Q1 2014 to 227 in Q1 2023 (New Mexico Board of Pharmacy Prescription Monitoring Program data). In Q1 2014, over 30,500 patients in New Mexico had overlapping prescriptions for opioids and benzodiazepines (a risky combination unless carefully managed by the provider and patient). In Q1 2023, fewer than 10,500 patients did. Similarly, in Q1 2014, there were over 59,000 high-dose opioid prescriptions filled, and in Q1 2023, only 19,050 (New Mexico Board of Pharmacy Prescription Monitoring Program data).

The data trend and the success of prescription opioids monitoring in New Mexico show that the overdose prevention and intervention programs in recent years have been effective. Impactful interventions include:

- Regulations from the New Mexico Medical Board that include mandatory use of the Prescription Monitoring Program (PMP), mandatory education, regulations for treating pain appropriately, offering or referring treatment for those with opioid use disorder, and mandatory co-prescribing of naloxone with opioid prescriptions for five or more days (Senate Bill 221 from 2019). The other licensing boards typically follow what the New Mexico Medical Board does, so their regulations are very similar. The boards follow up with providers who do not use the PMP as required by licensing board rules.
- Support for academic detailing (1:1 coaching and CME for New Mexico providers on pain management, safer prescribing, & proper use of the Prescription Monitoring Program).

In addition to the efforts to reduce prescription misuse and overdose, clinical guidelines have changed significantly and have been widely adopted in post-surgical settings across the country. Current clinical guidance on pain management focuses on providing non-opioid therapies as the first line of pain management. If the anticipated pain cannot be managed by non-opioid prescriptions or other non-pharmacological methods, recommendations significantly limit the number of days (less than three days in many circumstances) and limit MMEs. Significant effort has been made in clinical settings across the nation to educate providers on appropriate pain management guidelines. Together, these efforts have led to a reduction in prescription opioid misuse and overdose.

SB87 outlines specific requirements for a qualified third party to conduct the pilot by placing restrictions on who NMDOH could contract with. This language would severely limit the number of potential providers and would likely prevent NMDOH from contracting with local clinics and hospitals which may be able to provide unique and innovative approaches that are specifically designed to meet the unique needs of their patients and communities.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

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ALTERNATIVES

The appropriation language in this bill could be changed to appropriate directly from the opioid settlement restricted fund.

EC/sgs/cf/ct