FISCAL IMPACT REPORT

BILL NUMBER: CS/CS/Senate Bill 20/SHPACS/STBTCS

SHORT TITLE: Prior Authorization & Prescription Drugs

SPONSOR: Senate Tax Business and Transportation Committee

LAST UPDATE: 02/11/2026 **ORIGINAL DATE:** _____ **ANALYST:** Rommel

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
HCA	No fiscal impact	Indeterminate but minimal	Indeterminate but minimal		Recurring	Other state funds
OSI	No fiscal impact	No fiscal impact	No fiscal impact		Recurring	Other state funds
NMPSIA	No fiscal impact	$1,057.0	$1,168.0	$2,225.0	Recurring	Other state funds
RHCA	No fiscal impact	$1,800.0 to $2,600.0	No fiscal impact	$1,800.0 to $2,600.0	Nonrecurring	Other state funds
Total	No fiscal impact	**$2857.0 to $3,657.0**	**$1168.0**	**$4,025.0 to $4,825.0**		**Other state funds**

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

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Health Care Authority
Office of the Superintendent of Insurance
Retiree Health Care Authority
New Mexico Public School Insurance Authority

SUMMARY

Synopsis of STBTC Substitute of SHPAC Substitute for SB20

The Senate Tax, Business and Transportation Committee substitute for Senate Health and Public Affairs Committee substitute for Senate Bill 20 (SB20/SHPACS/STBTCS) relates to pharmaceutical benefits, amending the Prior Authorization Act, 59A-22B NMSA 1978. The bill adds language as follows:

1) Adds the definition of “chronic maintenance drug” to mean a medication taken regularly for chronic health conditions;
2) Amends the definition of "pharmacy benefits manager” to mean a person licensed by the superintendent as a pharmacy benefits manager pursuant to the provisions of the Pharmacy Benefits Manager Regulation Act (59A61 NMSA 1978);

3) Adds the definition of "serious mental illness" to mean a mental condition that significantly impairs daily functioning and requires comprehensive treatment, and enumerates several disorders within the definition, such as major depression, schizophrenia, bipolar disorder, posttraumatic stress disorder, and more;
4) Amends 59A-22B-4 and 59A-22B-5 NMSA 1978 to include pharmacy benefit managers under the Office of Superintendent of Insurance (OSI)'s regulatory authority;
5) Amends 59A-22B-8 NMSA 1978 to include "serious mental illness" to the list of conditions for which prior authorization for prescription drugs or step therapy—the requirement that a patient try a cheaper drug first—is prohibited. It further adds pharmacy benefit managers to the entities subject to the provisions of the section;
6) Requires that medical necessity determinations shall be automatically approved within three business days for standard determinations and 24 hours for emergency determinations;
7) Requires that prior authorization shall be deemed granted for prescription drug determinations not made within three business days and for all other determinations not made within seven days, with provisions for expedited adjudication; and
8) Prohibits prior authorization for chronic maintenance drugs for a period of three years after the initial authorization, with certain exceptions, and stipulates that prior-authorization requirements apply only to pharmacy benefit managers (PBMs) that have direct contracts with entities covered under the Health Care Purchasing Act, rather than all PBMs statewide.

The bill expands definitions and enforcement authority, requiring the Office of the Superintendent of Insurance (OSI) to collect, monitor, and publicly report prior authorization data and complaints for both insurers and pharmacy benefit managers (PBMs).

The effective date of SB20/SHPACS/STBTCS is January 1, 2027.

FISCAL IMPLICATIONS

Cost estimates are based on analysis provided by respondent agencies. Administrative fiscal impact to OSI and the Health Care Authority (HCA) are minimal; however, the bill would likely result in an increase on pharmacy spending to the extent that current state health benefits (SHB)'s pharmacy benefit managers expenses rely on prior authorization or step therapy in these categories.

It is difficult to quantify the effect of SB20 on pharmaceutical costs without a rigorous analysis of payer claims. While OSI reports on prior authorization requests, approvals and denials, the data does not delineate the types of medications subject to prior authorization. Moreover, authorizations may vary between plans and PBMs, further complicating estimates.

The Department of Health (DOH) maintains the all-payer claims database (APCD), which collects claims data from insured patients who receive care in New Mexico. Any time an insured person receives care for medical, dental or pharmaceutical care, the care setting submits a claim for services to be paid to the insurance company. The APCD include claims data for public insurers such as Medicare and Medicaid, patient eligibility information, and healthcare provider information for physicians and facilities. However, the data available for analysis from the APCD is limited by regulatory requirements, e.g., the federal Health Insurance Portability and Accountability Act and rules promulgated by DOH.

OSI notes:

Extending the duration for which a prior authorization for a chronic maintenance drug remains valid is expected to have minimal impact on premiums. However, as currently drafted, the provisions eliminating prior authorization and step therapy protocols for drugs related to "serious mental illness" are anticipated to increase premiums if utilization related to the conditions specified in the bill increases. Additional time is needed to assess the extent of potential premium increases, which will depend on expected utilization and the cost differences between generic medications and second-line step therapy drugs for various conditions.

HCA notes:

This bill will likely result in modest upward pressure on pharmacy spending to the extent that current state health benefits (SHB)'s PBM spend relies on [prior authorization] or step therapy in these categories. Removing [prior authorizations] and step therapy for the specified drug categories that were previously more tightly managed may increase utilization. A more robust analysis is needed to quantify these impacts. In the medium-term, the bill could have some potential offsetting savings in total cost of care if improved adherence and stability reduce high-cost acute episodes, especially in mental health.

The Retiree Healthcare Authority (RHCA) notes:

Increased pharmacy costs associated with SB20 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 SB20 would require custom pharmacy benefit configuration and ongoing system maintenance outside standard PBM operations. These nonstandard 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.

The Public School Insurance Authority (NMPSIA) notes:

The primary fiscal impact is associated with the loss of utilization management savings that result from prior authorization requirements. Our PBM indicates that prior authorization has already been removed for most of the drug categories addressed in the bill, with the exception of drugs treating serious mental illness. Therefore, the projected impact is limited to the population defined as having severe mental illness under the bill for our PBM data resulting in a minimal impact of less than $30 thousand over FY27 and FY28. Medical carriers reported that step therapy and prior authorization requirements are currently in place for certain mental health conditions, though specific denials data analysis is still underway. A 1 percent allowance for increased utilization has been included in projections to account for the removal of this control. Medical drug prior authorization changes account for the majority of projected agency spend at $2.1 million over FY27 and FY28. More research will be underway to better understand this impact, additionally, the impact is projected to increase due to a financial data lag from one of the two medical carriers at the time of the agency analysis submittal.

Additional clarification may be needed to fully assess the impact across all benefit types. Overall, the fiscal impact is expected to result from increased utilization due to reduced

prior authorization controls rather than from new benefit mandates.

SIGNIFICANT ISSUES

A 2023 U.S. Health and Human Services Office of the Inspector General report expressed concern that some people enrolled in Medicaid managed care may not be receiving all medically necessary healthcare services intended to be covered based on: (1) the high number and rates of denied prior authorization requests by some managed care organizations (MCOs), (2) the limited oversight of prior authorization denials in most states, and (3) the limited access to external medical reviews.[1]

Four states (Arkansas, Texas, Vermont, and West Virginia) have enacted comprehensive prior exemption laws while several other states have at least some requirements waiving prior authorizations for certain services (e.g., for certain prescription drugs).[2] Specifics vary from state to state, but in general they aim to reduce volume of prior authorization requirements, reduce patient care delays, increase public access to data, and improve transparency about which medications and procedures require prior authorization.

OSI notes:

> OSI does not have authority to enforce laws that affect plan design or implementation for the Employee Retirement Income Security Act (ERISA) or other federally regulated insurance plans. As such, enforcing PBM violations of the Prior Authorization Act will be limited only to the PBMs that are servicing Interagency Benefits Advisory Committee, (IBAC) entities pursuant to the Health Care Purchasing Act. … Currently, only two PBMs serve IBAC entities, so reporting requirements for prior authorization will apply solely to those two PBMs.

HCA provides the following:

> Individuals with serious mental illness (SMI)s or substance use disorder (SUD)s benefit from early and uninterrupted access to drug therapy intervention, which increases stability and may reduce costly downstream utilization of needing high-cost crisis or emergency treatment (including psychiatric hospitalizations, emergency department visits, relapse or crisis episodes, and complications from untreated chronic conditions). This may result in savings on high-cost acute care, although expected increases in medication utilization costs.
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> Additionally, removing the PA process reduces the time spent by paid personnel reviewing PAs and eliminates the possibility of cost associated with peer review processes should PAs be denied and appealed.

RHCA notes:

> Limiting prior authorization for chronic maintenance medications to once every three years materially reduces RHCA's ability to confirm ongoing medical necessity, adjusting

[1] High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care https://oig.hhs.gov/documents/evaluation/3157/OEI-09-19-00350-Complete%20Report.pdf

[2] https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf

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 SB20 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. 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.

NMPSIA provides the following:

SB 20 directly benefits public school employees by reducing barriers to accessing medications for serious mental illness and chronic conditions. School staff often face demanding schedules, and prior authorization delays can disrupt their ability to manage their health while balancing work and life responsibilities. Our staff is always available to field questions and assist members with these types of issues, but even with support, navigating the prior authorization process is an additional burden on members. By limiting these requirements, the bill ensures that teachers, administrators, and support staff can receive timely treatment without unnecessary paperwork or delays, supporting both their well-being and their ability to focus on serving students. This streamlining of access helps members stay healthier and reduces stress.

ADMINISTRATIVE IMPLICATIONS

HCA does not include the definition of "chronic maintenance drug" or "serious mental illness" in NMAC 8.321.2 and may need to add the new definitions to these sections off the administrative code if this bill is enacted.

NMPSIA notes:

These changes to prior authorization requirements reduce the effectiveness of existing cost containment strategies, potentially increasing utilization and overall plan costs. Historically, premium rates, budgets, and forward-looking rate projections have not incorporated impacts from modifications to prior authorization or other utilization management controls. Going forward, it will be necessary to account for the financial effects of these types of changes in our agency budget and premium-setting processes. While the magnitude of the impact is difficult to quantify precisely, we will monitor utilization trends and plan cost drivers to ensure that premium rate adjustments and budgeting decisions reflect the evolving regulatory environment.

OSI notes:

Explicitly listing all qualifying diagnoses in rule, rather than relying on external references to other agencies, provides OSI with greater clarity and consistency for compliance, enforcement, and carrier review. OSI already collects, analyzes, and aggregates prior authorization data and prepares legislative reports.

OTHER SUBSTANTIVE ISSUES

RHCA notes that 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.

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

OSI provides the following:

> If this bill is not enacted, individuals covered under health plans subject to the Health Care Purchasing Act will face significant risks because state agencies currently contract directly with pharmacy benefit managers (PBMs), leaving the Office of Superintendent of Insurance (OSI) without authority to intervene when complaints arise. PBMs could evade mandated timelines for prior authorization decisions, delaying access to essential medications. They may impose unnecessary prior authorization requirements for drugs treating serious mental illnesses, which could severely impact patients' mental health, ability to work, attend school, and manage family responsibilities. Additionally, PBMs could require frequent prior authorizations for chronic maintenance drugs, creating administrative burdens for patients and providers, reducing care quality, and causing missed work or school. These delays and gaps in access to critical medications may result in adverse health complications, increased stress, and financial strain for patients and their families—without any recourse through OSI to resolve these issues.

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