2026 New Mexico Health Care Affordability Snapshot

The Health Care Value Hub ("the Hub") is proud to launch the 2026 Health Care Affordability Policy Snapshot ("Affordability Snapshot"). The Affordability Snapshot provides legislators, consumer advocates, regulators and other interested parties a tool to compare their state's health policies across other states. The categories examined in this resource explore a variety of policy options that impact health care affordability. Policies were examined for whether they were active, implemented to a limited degree, or not active as of May 15, 2026. Sources for this information can be found in the downloadable ***Data and Source Document*** **available on the** Dashboard **page. Definitions and descriptions for each policy category can be found in the** ***Glossary*****.**

The Hub offers support dedicated to understanding health care policy and connecting advocates and other interested parties together to help build a patient-centered, high-value health care system. As a research-based organization, the Hub takes a comprehensive approach to improving affordability through policy analysis, translation, visualization, and collaborative engagement. We encourage advocates, legislators, and other stakeholders to share our findings to improve consumer health care affordability across the states.

Limits Facility Fees	**Facility Fee Transparency Laws**	**Established a Prescription Drug Affordability Board**	**Prescription Drug Upper Payment Limits**	**Slow Commercial Market Drug Price Growth with Inflation Penalties**	**Expanded Biologic Substitution Laws: Prescriber Permission Requirements**
Expanded Biologic Substitution Laws: Prescriber Notification Requirements	**Reference-Based Pricing in the Commercial Market**	**Implement Site Neutral Payments in the Commercial Market**	**Hospital Global Budgets**	**Strengthen Primary Care by Changing How Clinicians are Reimbursed**	**Medicaid-Medicare Integration**
Medical Loss Ratio (MLR) Remittances	**Medicaid Site Neutral Policies**	**Reduce High Hospital Costs in the State Employee Health Plan**	**Reduce High Drug Costs in the State Employee Health Plan**		

Key:

- State has passed legislation to implement these policies
- State has passed not legislation to implement these policies

Contain Health Care Costs in the Commercial Market

Facility Fees

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Limits Facility Fees		State does not prohibit providers from charging any facility fees	New Mexico passed HB 306 which prohibits facility fees for preventitve health care services, vaccination services, and telehealth services effective January 1, 2027.
Facility Fee Transparency Laws		State does not require providers to disclose facility fees to consumers and/or requires off-campus outpatient departments to identify the physical location where care was provided on claims forms	Beginning January 1, 2027, health care providers will be required to provide notice to patients at appointment scheduling and service delivery, post visible signs about facility fees, and provide itemized bills.

Contain Health Care Costs in the Commercial Market

Prescription Drug Affordability

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Established a Prescription Drug Affordability Board	✖	The state has not established or passed legislation to establish a prescription drug affordability board	-
Prescription Drug Upper Payment Limits	✖	The state does not have the authority to set upper payment limits for prescription drugs	-
Slow Commercial Market Drug Price Growth with Inflation Penalties	✖	State does not impose penalties on manufacturers that increase the price of a prescription drug in the commercial market beyond the rate of inflation	-

Contain Health Care Costs in the Commercial Market

Prescription Drug Affordability

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Expanded Biologic Substitution Laws: Prescriber Permission Requirements		State does not require express authorization for biologic substitution	-
Expanded Biologic Substitution Laws: Prescriber Notification Requirements		Pharmacists are required to notify prescribers of biologic substitution	Pharmacists in New Mexico are required to notify the prescribing physician of a substitution within five business days.

Contain Health Care Costs in the Commercial Market

Hospital Price Regulation

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Reference-Based Pricing in the Commercial Market		State does not use reference-based pricing tied to Medicare rates to regulate hospital pricing	New Mexico passed SB376 in 2025 authorizing reference-based pricing for the State Employee Health Plan and eventually to public school employee plans in 2026, but not for the broader commercial market.
Implement Site Neutral Payments in the Commercial Market		State has not implemented site neutral payments in the commercial market	-

Promote Effective, Affordable Health Care Delivery

Innovative Reimbursement Models

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Hospital Global Budgets	✖	State has not implemented hospital global budgets	-
Strengthen Primary Care by Changing How Clinicians are Reimbursed	●	State has established alternative payment models to incentivize primary care	New Mexico operates a primary care–focused value-based payment program, the Medicaid Primary Care Payment Reform Value-Based Payment (PCPR VBP) Program, developed by the New Mexico Health Care Authority. It is open to primary care practices in New Mexico and to border practices delivering services within 100 miles of the state line. The program supports primary care by letting practices step gradually from fee-for-service toward population-based payment at a pace matching their organizational capabilities and tolerance for financial risk. Tier 1, which began July 1, 2024, pays enhanced fee-for-service rates plus incentive payments to all participating providers; the full three-tier structure launched January 1, 2026, with Tier 3 offering full capitation and both upside and downside risk.
Medicaid-Medicare Integration	●	State integrates Medicare-Medicaid to coordinate care for the dually eligible population	New Mexico offers PACE, AIPs, CO D-SNPs, and HIDE SNPs as integrated care programs for dually eligible individuals.

Balance Constrained State Budgets

Medicaid Costs

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Medical Loss Ratio (MLR) Remittances		State requires MLR remittances for its Medicaid managed care population	-
Medicaid Site Neutral Policies		State has not enacted Medicaid site neutral payment legislation	-

Balance Constrained State Budgets

State Employee Health Plan (SEHP) Costs

Key: State has active policy or program | Policy or program partially implemented | No active policy or program | No source or limited information found

Policy	Icon	Status as of June 2026	Summary
Reduce High Hospital Costs in the State Employee Health Plans (SEHP)		State caps reimbursement rates for inpatient and outpatient hospital services for members of the State Employee Health Plan.	New Mexico passed legislation in 2025 authorizing hospital price caps in the state employee health plan. the statute delegates the exact cap to agency rulemaking, targeting 200% of Medicare reimbursements for in-network services and 175% for out-of-network services.
Reduce High Drug Costs in the State Employee Health Plan (SEHP)		State has not implemented a cost- control strategy to reduce the cost of prescription drugs for members of the State Employee Health Plan.	-

Glossary

Limits Facility Fees

Facility fees are charges for services provided in outpatient and physician office settings that hospitals own. These fees increase the out-of-pocket costs for care and are becoming increasingly more common as the rate of health system consolidation has accelerated. Some states prohibit providers from charging a facility fee for specified procedures or care settings, including evaluation and management services (E&M) both on-campus and off-campus; evaluation and management services (E&M) available off-campus only; off-campus sites owned by non-profit hospitals; distant sites; telehealth visits; preventive care services; freestanding emergency departments; or other, more narrow prohibitions.

Alternatively, states may have laws that limit patient financial responsibility for facility fees, for example by prohibiting insurers from requiring a separate copayment on facility fees for outpatient services provided at an off-campus location; prohibiting providers from billing a patient who has not met their deductible an outpatient facility fee that is higher than their insurer's negotiated rate; prohibiting providers from billing a patient for more than their cost-sharing obligation for an outpatient facility fee; or limiting the amount insurers or patients are required to pay for telehealth services.

Facility Fee Transparency Laws

In states that allow facility fees, some states have laws that require providers to disclose facility fees to consumers and/or require off-campus outpatient departments to identify the physical location where care was provided on claims forms by providing the unique national provider identifier number (NPI) requirement or another location descriptor.

Established a Prescription Drug Affordability Board

A prescription drug affordability board (PDAB) is a state-level entity tasked with evaluating the prices of high-cost medications to ensure they are reasonable and do not create barriers to access. These boards often have the authority to review price increases, set upper payment limits, and recommend strategies to contain drug costs while maintaining patient access to necessary treatments.

Prescription Drug Upper Payment Limits

Upper Payment Limits are the capped and maximum prices that can be charged for specific drugs, that have been determined by the PDAB. This price is set to allow the drugs to remain cost-effective, prevent price gouging, and that the drugs will remain accessible to the public and have lower cost for consumers.

Slow Commercial Market Drug Price Growth with Inflation Penalties

Prescription drug prices are high and rising rapidly. In the Medicaid and Medicare programs, if a drug manufacturer increases a drug's price beyond the rate of inflation, they must pay a financial penalty (rebate) to the government. However, the commercial market lacks similar protections; drug manufacturers face no financial penalties for steep price increases for brand-name drugs. As a result, there is no limit on how fast prices for brand-name drugs can rise in this market, leaving employers and consumers vulnerable to greater year-over-year price increases. States can implement an inflation penalty mechanism similar to that used in Medicaid and Medicare to disincentivize excessive drug price increases in the commercial market. Under this approach, if a manufacturer raises the price of a drug beyond the rate of inflation, states could require the manufacturer pay a financial penalty (rebate). This policy would create a strong disincentive for steep price hikes and align price growth containment strategies across public and private markets.

Expanded Biological Substitution Laws: Prescriber Permission Requirements

Biosimilar drugs may be substituted for prescribed biologics in many circumstances; however, the regulations governing the substitution process vary by state. In most states a pharmacist may, with the consent of a patient, dispense biosimilar or interchangeable biologic products to save on costs. This section reviews state laws related to biologic substitutions and whether or not a pharmacist needs a provider's explicit permission to dispense substitutions.

Expanded Biological Substitution Laws: Prescriber Notification Requirements

As mentioned in Expanded Biologic Substitution Laws: Prescriber Permission Requirements, pharmacists often have the authority to substitute biosimilar or interchangeable biologics for prescribed biologics, although regulations surrounding the process of substitution vary between states. This section reviews the requirements pharmacists must meet in terms of notifying the original prescriber of a substitution once it has occurred.

Glossary

Reference-Based Pricing in the Commercial Market

Reference-based pricing establishes set service costs based on a predetermined reference rate. For the purposes of this product, reference-based pricing refers to a payment model in which health costs are evaluated against the Medicare reimbursement rate for the same service.

Implement Site-Neutral Payments in the Commercial Market

Site neutral payments require hospitals to charge patients the same amount they would pay an independent physician's office for the same routine medical services when they are administered in a hospital-owned outpatient facility, This policy is a response to hospitals and health systems buying up local physician practices, rebranding them as hospital-owned offices and clinics, and then increasing prices for the same services and care. This commercial market distortion leads to higher costs for employers and patients, and incentivizes health systems to buy up additional physician offices and increase prices.

Hospital Global Budgets

Global budgets are an alternative payment model in which providers, typically hospitals, are paid a prospectively set, fixed amount for the total number of services they provide during a given period of time. Providers are responsible for expenditures in excess of the set amount, creating an incentive to reduce unnecessary utilization and invest in prevention.

Strengthen Primary Care by Changing How Clinicians are Reimbursed

Fee-for-service reimbursement systematically undervalues primary care by rewarding the volume of discrete procedures and visits rather than the relationship-building, prevention, and chronic disease management that define high-quality primary care. Alternative payment models, such as population-based payments, offer a more effective approach by giving primary care practices stable, predictable funding tied to the needs of the patients they serve rather than the number of services they bill. When primary care clinicians are no longer dependent on volume to stay financially viable, they can invest in the kinds of activities that improve health and reduce overall spending: proactive outreach to high-need patients, care coordination across providers, and time spent on prevention and managing chronic conditions before they escalate. Research consistently shows that stronger primary care is associated with lower total health care costs, fewer hospitalizations, and better outcomes. By shifting toward alternative payment models; whether through state employee health plans, Medicaid, or requirements on private insurers, states can realign financial incentives to support the kind of primary care that keeps people healthier and out of higher-cost settings.

Medicaid-Medicare Integration

Integrating Medicaid and Medicare programs enhances care coordination and service delivery for individuals who are dually eligible and enrolled in both programs. By streamlining benefits and aligning administrative processes, states can address the complex health care needs of this population more effectively. Several states have established integrated care initiatives for this population, such as financial alignment demonstrations and the establishment of Programs of All-Inclusive Care for the Elderly (PACE).

Medical Loss Ratio (MLR) Remittances

The medical loss ratio (MLR) is the ratio of spending insurance premiums on health care and quality improvement initiatives and administrative costs and profit by managed care organizations (MCOs). MCOs generally must meet an MLR threshold of 85%. If the MCO fails to meet the MLR threshold, it may have to pay back remittances to the state. States with MLR remittance laws enforce MLR standards which help guarantee that Medicaid beneficiaries receive value for the funds allocated to their care. This improves transparency and trust in managed care systems. Returned funds can be reinvested into Medicaid programs and used for expanding coverage or enhancing benefits without increasing state budgets.

Medicaid Site-Neutral Policies

Site-neutral policies standardize reimbursement rates across care settings (e.g., hospital outpatient departments vs. physician offices), reducing incentives for providers to steer patients toward higher-cost settings. Aligning payments helps curb unnecessary spending and mitigates cost growth in Medicaid programs, which is critical for states managing tight budgets.

Reduce High Hospital Costs in the State Employee Health Plan (SEHP)

States can cap reimbursement rates for inpatient and outpatient hospital services for members of State Employee Health Plans (SEHPs) in order to reduce state spending on employee health benefits. Plans include those under Public Employees Benefits Boards (PEBB) and School Employees Benefits Boards (SEBB). Caps can be set in reference to a benchmark, such as a percentage of the Medicare payment rate, or through another mechanism.

Reduce High Drug Costs in the State Employee Health Plan (SEHP)

States can implement cost-control strategies to reduce high drug costs in State Employee Health Plans (SEHPs) in order to lower overall spending on employee health benefits. Strategies can include negotiating prices through pharmacy benefit managers (PBMs), promoting the use of generics or preferred drugs through formularies, and applying utilization management tools such as prior authorization or step therapy. These approaches aim to control costs while maintaining access to necessary medications.