LFC Requester:	Harry Rommel

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

WITHIN 24 HOURS OF BILL POSTING, UPLOAD ANALYSIS TO
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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: *February 11, 2026* *Check all that apply:*
Bill Number: *HB306 HHS sub* Original __ Correction __
Amendment __ Substitute _x_

Sponsor: Rep. Szczepanski
Short Title: Prohibit Certain Health Care Facility Fees

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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

Appropriation		Recurring or Nonrecurring	Fund Affected
FY26	FY27		

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	FY27	FY28		
	~500	~500	Recurring	UNMH operating

(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		~(4,000)	~(4,000)	~(8,000)	recurring	UNMH operating

(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:

Original bill

HB 306 prohibits hospitals and health systems from charging facility fees directly to patients for certain outpatient services, beginning January 1, 2027. Specifically, the bill bars patient-billed facility fees for preventive services, vaccinations, and telehealth, while allowing facility fees to continue for inpatient care, hospital emergency departments, and freestanding emergency departments, and permitting facility fees to be billed to insurers pursuant to contract or law. The prohibition does not apply to critical access hospitals, sole community hospitals in rural areas, or community clinics affiliated with rural sole community hospitals.

The bill also establishes new billing transparency and consumer-notification requirements for providers affiliated with hospitals or health systems that charge facility fees, including advance notice of potential fees, posted signage in English and Spanish, and standardized, itemized patient bills that clearly identify facility fees and provide dispute contact information.

Finally, HB 306 requires hospitals and health systems to report detailed facility-fee data to the state All-Payer Claims Database, including historical data on frequency, total dollar amounts, and common billing codes associated with facility fees, to support statewide monitoring of the prevalence and cost of these charges.

HHS Substitute

The original bill applied to a "health care provider or health system." The substitute narrows the prohibition to a "hospital or health system," clarifying that the regulated billing entity is the institutional provider rather than individual clinicians.

The substitute replaces exemptions for critical access hospitals, sole community hospitals in rural areas, and affiliated rural community clinics with a broader exemption for hospitals or hospital clinics located in a rural area.

The substitute adds a new categorical prohibition on charging facility fees directly to uninsured patients, regardless of service type.

With regard to transparency, the substitute:

- Requires disclosure that the facility fee may not be covered in whole or in part by insurance;
- Requires signage to identify services for which facility fees are prohibited and to disclose the uninsured exemption; and
- Prohibits cancellation or no-show penalties when a patient declines or reschedules due to the facility fee.

FISCAL IMPLICATIONS

The bill is expected to result in a recurring UNMH operating revenue decrease of approximately **$500,000** beginning in FY27, along with an additional recurring operating impact of approximately **$4.0 million** per year primarily associated with the requirement to generate

itemized statements for all patients rather than summary statements only for patients with an outstanding balance. These costs reflect billing system modifications, expanded statement production, compliance programming, and increased revenue cycle workload.

The substitute adds a categorical prohibition on charging facility fees directly to uninsured patients, which may modestly increase the fiscal impact by further reducing self-pay collections.

SIGNIFICANT ISSUES

This legislation imposes potentially high administrative costs on UNMH. The substitute bill addresses none of UNM's original concerns.

Patient cost-sharing obligations are sometimes governed by federal law. HB 306 prohibits a health care provider or health system from charging, billing, or collecting a facility fee from a patient for preventive services provided in an outpatient setting. However, for Medicare beneficiaries, federal CMS rules may require patient cost-sharing in certain circumstances, even when a visit is preventive and does not become diagnostic. For example, when preventive services are furnished in a hospital outpatient or other provider-based setting, Medicare may assess coinsurance or deductible amounts associated with the facility component of the visit, notwithstanding the preventive nature of the service. In addition, diagnostic visits routinely require patient cost-sharing, and similar compliance concerns arise when visits scheduled as preventive become diagnostic after a patient raises a new medical issue during the encounter. Federal law generally prohibits the routine waiver of Medicare cost-sharing, as such waivers may be construed as an inducement to influence a patient's choice of provider or care setting. These issues can be addressed by clarifying that HB 306 does not require or authorize the waiver of patient charges that must be assessed under federal law, including Medicare cost-sharing. **See Amendment 1 below**.

Section 4 - Billing Transparency and Patient Notification - requires hospitals to provide an estimate of all facility fees (not just preventative care) to all (not just self-pay) patients at the time of the appointment. Facility fees are not flat, uniform charges. Amounts often depend upon multiple variables that differ by patient and encounter, including the services ultimately provided, the patient's insurer, and features of the patient's specific policy. Hospitals can advise patients that a facility fee may be charged but often cannot provide an estimate of that fee in advance of the actual visit. **See Amendment 3 below**.

In addition to clinic office visits, the provisions of this bill apply to preventative services such as mammograms, colonoscopies and other resource intensive screening exams. These services require significant investment from hospitals for radiology equipment and procedure space.

Although suppression of a facility fee is not equivalent to waiving all charges for a visit, absent explicit statutory authorization, mandatory non-billing of a facility fee—particularly for self-pay patients—could be viewed as partial debt forgiveness. Because public hospitals are subject to the anti-donation clause of the New Mexico constitution and state audit requirements, ambiguity as to whether non-billing constitutes an impermissible donation or forgiveness of debt may create compliance and reporting concerns. This can be addressed by clarifying that non-billing of a facility fee pursuant to HB 306 is authorized by statute and does not constitute debt forgiveness. **See Amendment 2 below.**

The committee substitute defines "preventive health care service" as "a service recommended by the United States preventive services task force." However, the United States Preventive Services

Task Force (USPSTF) does not publish a single list of uniformly "recommended" services; rather, it assigns letter grades reflecting the strength of evidence and magnitude of net benefit. Grade A services have high certainty of substantial net benefit and are strongly recommended. Grade B services have high certainty of moderate benefit or moderate certainty of moderate-to-substantial benefit and are recommended. Grade C services are recommended only for selective use based on individual clinical circumstances, reflecting small net benefit. Grade D services are not recommended, and "I statements" indicate insufficient evidence to assess benefit or harm.

As drafted, the phrase "recommended by the USPSTF" could be interpreted to include Grade C services or future recommendations whose scope is uncertain, potentially expanding the prohibition beyond the commonly understood preventive services framework used in federal law. Federal coverage mandates under the Affordable Care Act are limited to USPSTF Grade A and B services. Clarifying the statute to reference Grade A and Grade B services specifically would align the bill with established federal preventive coverage standards, reduce interpretive ambiguity, and provide clearer guidance to hospitals and health systems regarding billing compliance. See **Amendment 4 below.**

PERFORMANCE IMPLICATIONS

ADMINISTRATIVE IMPLICATIONS

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

TECHNICAL ISSUES

OTHER SUBSTANTIVE ISSUES

ALTERNATIVES

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

AMENDMENTS

1. Add the following new subsection to Section 3 (Limitations on Charges):

E. Nothing in this section shall be construed to require a health care provider or health system to waive, reduce, or fail to collect any patient cost-sharing amount that is required under federal law or federal program rules, including coinsurance, deductibles, or copayments imposed under the federal Medicare program.

2. Add the following to Section 3:
Nothing in this section shall be construed to require a health care provider or health system to waive or forgive payment for health care services, and the non-billing of a facility fee pursuant to this section shall not be considered debt forgiveness.

3. Amend Section 4(A) to delete the phrase "and indicate the amount of the facility fee".

4. Section 2
H. 'preventive health care service' means a service ~~recommended by the United States preventive~~

~~services task force~~ that has received a grade of ‘A’ or ‘B’ from the United States preventive services task force as of January 1, 2027.