F I S C A L I M P A C T R E P O R T

BILL NUMBER: CS/House Bill 306/HHHCS
SHORT TITLE: Prohibit Certain Health Care Facility Fees
SPONSOR: House Health and Human Services Committee
LAST UPDATE: 02/11/2026 **ORIGINAL DATE:** 02/06/2026 **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	No fiscal impact	No fiscal impact		Recurring	Other state funds
OSI	No fiscal impact	No fiscal impact	No fiscal impact		Recurring	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

Agency or Agencies That Were Asked for Analysis but did not Respond
Department of Health

SUMMARY

Synopsis of HHHC Substitute for HB306

The House Health and Human Services Committee substitute for House Bill 306 (HB306/HHHCS) creates the "Fair Pricing for Routine Medical Care Act" which sets limits when facility fees may be charged to patients for certain services; strengthens billing transparency requirements for facility fees; and requires statewide reporting of facility fee data to New Mexico's all-payer claims database (APCD).

The limitation on charges does not apply to any rural hospital or a hospital's clinics in rural areas. The bill requires a hospital or health system that charge a facility fee to provide notice at scheduling and at the time of service (including the amount); to post English/Spanish signage at check-in; and to provide a standardized, itemized, consumer-friendly bill. Hospitals and health systems that charge facility fees must also report facility fee data to the APCD for each of the prior three calendar years, including counts and totals charged to patients and summary

information on common and highest-average-charge billing codes. If a patient declines, cancels or reschedules an appointment because the facility fee is too high or may not be covered by the patient's insurance plan, the hospital or health system shall not impose a cancellation fee, no-show fee, or other penalty for that appointment.

HB306/HHHCS requires that, beginning January 1, 2027, a hospital or health system generally shall not charge, bill, or collect a facility fee directly from a patient for: (1) preventive health care services provided in an outpatient setting (including services accessed from the patient's vehicle); (2) vaccination services provided in an outpatient setting (including services accessed from the patient's vehicle); or, (3) telehealth services.

FISCAL IMPLICATIONS

The Health Care Authority (HCA) notes no fiscal impact to the agency. Medicaid patients are not permitted to be charged facility fees because state and federal rules require that Medicaid providers must accept the state's reimbursement as payment in full.

The Office of Superintendent of Insurance (OSI) does not expect that these costs will be indirectly passed to consumers through higher premiums but is unsure if cost-sharing structures of the plans will be impacted.

SIGNIFICANT ISSUES

Facility fees are extra charges added by hospitals or health systems when care is provided in an outpatient setting, even if the patient is not inside a hospital building. These fees are separate from the professional fee that pays the doctor or clinician providing the service. They are intended to cover the hospital's overhead costs, such as equipment, staffing, building maintenance, and emergency readiness. According to the American Hospital Association, facility fees help pay for the costs of delivering patient care other than physician services, including maintaining 24/7 emergency and trauma capabilities and supporting hospital infrastructure. They also include overhead such as space, equipment, and non-clinical staff, even when care occurs in hospital-owned outpatient clinics rather than inside a hospital.

Hospitals and health systems that charge facility fees are required to report data related to the fees to the all-payer claims database. The data must include:

(1) the number of times facility fees were charged to patients;
(2) the total dollar amount of facility fees charged to patients;
(3) the twenty-five most common billing codes for which a facility fee was charged, including the total amount charged to patients for each of those codes;
(4) the twenty-five billing codes with the highest average patient charges and the total amount charged to patients for each billing code; and
(5) any other data that is requested by the Department of Health.

HCA provides the following:

> Preventive services in the bill are those defined by the US Preventive Services Task Force (USPSTF). Most preventive services are required to be provided with no patient co-pay, deductible, or coinsurance to encourage patient access. Charging facility fees for these services undermines this requirement and may deter patients from seeking the

preventive care they need.

Preventive services recommended by USPSTF are widely understood as "no-cost preventive care" in most private coverage because the policy intent is to remove financial barriers to early detection and prevention. Federal law (Affordable Care Act Section 2713) generally requires most non-grandfathered private health plans to cover USPSTF A and B recommended preventive services without patient cost-sharing, reflecting an evidence-based policy goal: remove cost barriers so people are more likely to obtain early screening, counseling, and prevention that can avert more serious illness and downstream costs.

When facility fees are added on top of preventive services, services that are intended to be low- or no-cost to encourage access, patients face unexpected charges, which discourage individuals from seeking preventive care, reduce follow-through on recommended screenings, and worsen affordability and trust in routine health care.

The bill's transparency provisions (advance notice including the amount, English/Spanish signage, and standardized itemized bills) are intended to improve consumer understanding of facility fee charges and provide a clear pathway for customer questions or disputes.

OTHER SUBSTANTIVE ISSUES

HCA further notes:

The bill preserves facility fees for inpatient and emergency department services and allows facility fees to be billed to insurers when permitted. Although plan design can still determine whether any allowed charges translate into patient cost-sharing, the bill's patient-facing limitation and transparency requirements are intended to reduce surprise billing practices and improve predictability for routine care. Except in providing treatment to uninsured patients, the bill includes rural exceptions intended to protect access in underserved areas, including the facilities listed below:

- Alta Vista Regional Hospital, Cibola General Hospital, Dr. Dan C. Trigg Memorial Hospital, Gila Regional Medical Center, Holy Cross Medical Center , Lincoln County Medical Center, Mimbres Valley Medical Center, Miners' Colfax Medical Center, Nor-Lea General Hospital, Rehoboth McKinley Christian Hospital, Socorro General Hospital, Sierra Vista Hospital, Union County General Hospital, Guadalupe County Hospital, Roosevelt General Hospital, Carlsbad Medical Center, Christus Southern New Mexico, Covenant Health Hobbs Hospital, Los Alamos Medical Center, Presbyterian Española Hospital

According to 2024 KFF data, 211.3 thousand (10.2 percent) of New Mexicans are uninsured. The FY2026 federal appropriations bill (H.R.7148), which became law on Feb. 3, 2026, includes a provision to require hospitals to obtain and bill under a unique national provider identifier for each off-campus outpatient department in order to receive Medicare payments. The provision will provide greater transparency to the types of charges and billing practices occurring at off-site campuses and facilities. This requirement will go into effect beginning in January 2028.

HLR/cf/ct/hg/sgs