FISCAL IMPACT REPORT

SPONSOR Steinborn/Hamblen/Sharer/Brandt/Hickey **LAST UPDATED** 02/21/2025
ORIGINAL DATE 02/18/2025
SHORT TITLE Gross Receipts Tax Changes **BILL NUMBER** Senate Bill 295
ANALYST Faubion

REVENUE*
(dollars in thousands)

Type	FY25	FY26	FY27	FY28	FY29	Recurring or Nonrecurring	Fund Affected
GRT Deductions	$0.0	($77,000.0) to ($102,111.5)	($80,100.0) to ($103,130.6)	($83,300.0) to ($106,061.1)	($86,500.0) to ($108,982.7)	Recurring	General Fund
Local Government GRT	$0.0	($83,500.0) to ($102,111.5)	($86,800.0) to ($105,082.7)	($90,200.0) to ($108,068.6)	($93,800.0) to ($111,045.5)	Recurring	Local Governments
Local Hold Harmless	$0.0	($21,600.0) to ($24,070.0)	($19,100.0) to ($20,270.0)	($16,700.0) to ($18,440.0)	($14,100.0) to ($17,610.0)	Recurring	General Fund
Local Hold Harmless	$0.0	$21,600.0 to $24,070.0	$19,100.0 to $20,270.0	$16,700.0 to $18,440.0	$14,100.0 to $17,610.0	Recurring	Local Governments

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

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY25	FY26	FY27	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
Medicaid GRT Reimbursement - HCA	**$0.0**	**$130,320.0 to $491,200.0**	**$135,190.0 to $504,100.0**	**$995,300.0**	Recurring	**General Fund**
Implementation - HCA	**$0.0**	**$45.0**	**$0.0**	**$45.0**	Nonrecurring	**General Fund**
Implementation - HCA	**$0.0**	**$450.0**	**$0.0**	**$450.0**	Nonrecurring	**Federal Funds**
TRD - Implementation	**$14.6**	**$0.0**	**$0.0**	**$14.6**	Nonrecurring	**General Fund**
Total	**$14.6**	**Up to $491,695.0**	**Up to $504,100.0**	**$995,809.6**	Recurring	**General Fund**

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

Duplicates House Bill 344
Relates to Senate Bill 249

Sources of Information

LFC Files

Agency Analysis Received From
Health Care Authority (HCA)
Department of Health (DOH)

Taxation and Revenue Department (TRD)
New Mexico Attorney General (NMAG)

SUMMARY

Synopsis of Senate Bill 295

Senate Bill 295 provides gross receipts tax deductions for the sale of medical equipment, supplies, and drugs and for most healthcare services, excluding those for Medicaid patients and for nonhospital healthcare practitioners. The bill also removes the sunset date for deductions on co-payments or deductibles paid by insured individuals to healthcare practitioners and extends deductions to payments from patients for services not contracted through managed care organizations or insurers. Additionally, it mandates that healthcare providers receiving Medicaid reimbursement be reimbursed for all applicable gross receipts taxes.

The effective date of this bill is July 1, 2025.

Payment/ Service Type	Current Law	Under Senate Bill 295
Private Insurance Contracted Services (Managed Care, PPO, HMO)	☑ Deductible from GRT	☑ Still Deductible from GRT (No change)
Fee-for-Service Payments by Private Insurers	❌ Taxable (Subject to GRT)	☑ Now Deductible
Direct-Pay Health Care Services (Non-Contracted)	❌ Taxable (Subject to GRT)	☑ Now Deductible
Medicaid-Covered Services	❌ Taxable (Subject to GRT)	❌ Still Taxable, but providers will be reimbursed for GRT paid
Medical Equipment, Supplies, and Drugs (Sold to Providers)	❌ Taxable (Subject to GRT)	☑ Now Deductible when sold to providers for use in practice
Medical Equipment, Supplies, and Drugs (Sold to Patients)	☑ Deductible from GRT	☑ Still Deductible from GRT (No change)
Hospital Services	❌ Taxable (Subject to GRT with 60 percent deduction)	❌ Still Taxable (No change)
Home Health Care Services	❌ Taxable (Subject to GRT) unless part of a managed care contract	☑ Now Deductible if provided by licensed practitioners
Nursing Home Care Services	❌ Taxable (Subject to GRT)	❌ Still Taxable (Nursing homes explicitly excluded)
Dental Services	❌ Taxable (Subject to GRT)	☑ Now Deductible (Applies to dentists and dental hygienists)
Medicaid-Paid Medicare Coinsurance	❌ Taxable (Subject to GRT)	❌ Still Taxable, but GRT is reimbursed to providers
Medicare Part C (Medicare Advantage) Payments	☑ Deductible from GRT	☑ Still Deductible from GRT (No change)
Medicare Part A & B Service Payments	❌ Taxable (Subject to GRT)	❌ Still Taxable (No new deduction added)

Medicare Part A & B Coinsurance (Self-Paid by Patient)	❌ Taxable (Subject to GRT)	☑ Now Deductible (Now falls under direct-pay deductions)
Medicare Part A & B Coinsurance (Paid by Private Secondary Insurance)	❌ Taxable (Subject to GRT)	☑ Now Deductible (Covered under fee-for-service insurance deductions)
Medicare Part A & B Coinsurance (Paid by Medicaid for Dual-Eligible Patients)	❌ Taxable (Subject to GRT)	❌ Still Taxable, but GRT is reimbursed to providers
Hold Harmless Provisions for Deductions	☑ Applies to current deductions under 7-9-93	☑ Applies to all new deductions except medical supply sales

FISCAL IMPLICATIONS

Estimating the full impact of Senate Bill 295 is challenging due to significant gaps in available data on both healthcare spending and taxation across private insurance, self-pay, Medicare, and Medicaid. Without detailed, provider-level financial data, it is difficult to determine how much taxable revenue will be newly deductible and how that will affect state and local revenues. Key missing data include practice type, eligible purchases, tax district and corresponding GRT rate, and payer distribution (i.e., the share of payments coming from Medicaid, Medicare, private insurance, and direct pay). Additionally, because healthcare spending patterns fluctuate due to policy changes, patient demographics, and economic conditions, even historical data may not provide an accurate projection. Without a comprehensive dataset integrating tax filings, reimbursement rates, and healthcare expenditures, any fiscal estimate remains highly uncertain, making it difficult to assess the impact on state and local finances.

This bill creates or expands a tax expenditure with a cost that is difficult to determine but likely significant. LFC has serious concerns about the substantial risk to state revenues from tax expenditures and the increase in revenue volatility from erosion of the revenue base. The committee recommends the bill adhere to the LFC tax expenditure policy principles for vetting, targeting, and reporting or action be postponed until the implications can be more fully studied.

Deductions. To assess the fiscal impact of these changes, LFC analyzed GRT tax data from the Taxation and Revenue Department's (TRD) RP-500 and RP-80 reports. These reports provide detailed taxable gross receipts within the healthcare industry, categorized by six-digit NAICS codes, and disbursements to the state, counties, and municipalities, allowing for a comparison of receipts before and after the new deductions. Because these reports capture all taxable receipts, including Medicaid-related revenues, without disaggregating by payment type, LFC adjusted the estimates by applying the distribution of healthcare spending by payer type—Medicaid, Medicare, and private pay— in New Mexico using data from the U.S. Centers for Medicare and Medicaid Services (CMS) and the New Mexico Health Care Authority (HCA). This approach enabled LFC to identify which subsectors would experience additional deductions and to estimate the share of total GRT affected within those subsectors.

TRD describes their methodology as the following:

> This bill expands the current GRT deduction under 7-9-93 NMSA 1978 for certain health receipts to fee-for-service payments and for any out-of-pocket payments by patients made directly to the provider. (Note that deductibles and co-payments are already deductible. The new deductible would apply to payments outside of any insurance plan or managed care plan.) Although a precise fiscal impact would require crucial unknown information

like the number and type of services provided as well as the corresponding fee, TRD benchmarked a fiscal impact based on minimal assumptions. TRD used data from the RP80 GRT report and retrieved taxable GRT by NAICS codes in the associated health practitioner fields to identify the proportion of taxpayers that might claim the deduction. Then, TRD used data from the Centers for Medicare & Medicaid Services on private health expenditures in New Mexico, 1991-2020, to estimate the tax base. The fiscal impact was grown using the average annual percentage growth of private health expenditures from 1991 to 2020 and the statewide effective GRT rate was applied to the forecast for the outlook. The fiscal impact includes the effects of this deduction on the distributions to municipalities pursuant to Section 7-1-6.4 NMSA 1978 as the majority of the taxable base will be in municipalities. The fiscal impact also accounts for the impact of the hold harmless payments to municipalities and counties per Sections 7-1-6.46 and 7-1.6.47 NMSA 1978 under the benchmark fiscal impact.

The bill provides deductions related to gross receipts for healthcare practitioners' medical equipment, supplies, and drug purchases. TRD used data from the RP80 GRT report and retrieved taxable GRT by NAICS codes to identify the taxpayers that might claim the deduction for selling medical equipment and drugs to healthcare practitioners. TRD assumed this deduction does not apply to the sale of medical equipment and drugs to hospitals, so the contribution of hospitals to the industry was deducted from the associated tax base for this deduction. The revenue impact also assumed that the taxable sales of medical equipment and drugs to the public is marginal; therefore, those sales were ignored. Finally, TRD interpreted the language to mean that the medical equipment must be used during the course of treatment by the medical professional, and not simply sold on to the patient. The fiscal impact was grown using S&P's current price index of consumer spending on healthcare and based on the statewide effective GRT rate with a split between the general fund and local governments. The fiscal impact includes the effects of this deduction on the distributions to municipalities pursuant to Section 7-1-6.4 NMSA 1978 as the majority of the taxable base will be in municipalities.

Local Hold Harmless. The new deductions outlined in Section 7-9-93 are subject to hold harmless provisions, meaning the state must compensate local governments for some of the lost GRT revenue resulting from these exemptions. This includes deductions for healthcare services provided under commercial contracts with insurance companies and managed care organizations (MCOs), as well as proposed deductible fee-for-service insurance payments and direct-pay patient receipts. The deductions introduced in Section 7-9-93.1, which cover receipts from the sale of medical equipment, supplies, and drugs, are not subject to hold harmless provisions, meaning local governments will not receive compensation for the tax revenue lost from these exemptions. The state will be required to pay approximately $15 million to $20 million per year to local governments for the hold harmless provision.

GRT Reimbursement for Medicaid Receipts. To estimate the GRT reimbursement for Medicaid receipts, LFC applied the share of Medicaid payments—as reported by the U.S. Centers for Medicare and Medicaid Services (CMS)—to total statewide GRT healthcare receipts. This analysis was conducted separately for state, municipal, and county-level revenues and focused on the healthcare service subsectors that would require Medicaid reimbursement. These subsectors were identified using RP-80 and RP-500 reports, which detail taxable gross receipts in the healthcare industry. By integrating payer distribution data with statewide taxable healthcare receipts, LFC estimated the expected Medicaid GRT reimbursements across different levels of

government. LFC identified $257 million of nonhospital healthcare gross receipts tax revenue in FY24. CMS and HCA data attribute between 30 and 50 percent of nonhospital spending to Medicaid. To account for the large deductions already offered to private-pay healthcare, LFC assumed 50 percent of taxable receipts are from Medicaid. Therefore, to reimburse Medicaid gross receipts for nonhospital Medicaid services costs the state around $130 million each year. This includes both the state GRT increment and local GRT increments. This estimate should be considered a low-end estimate. HCA and CMS data report Medicaid spending for nonhospital healthcare between $2.5 billion and $7.5 billion. If GRT applied to 70 percent of this spending to account for administrative and MCO costs, this would bring the Medicaid reimbursement costs to $180 million to $400 million.

TRD notes their methodology as follows:

> The bill provides that healthcare providers receiving Medicaid reimbursement will be compensated for all applicable gross receipts taxes they are required to pay. (See Technical Issues.) TRD used data from the Health Care Authorities (HCA) September 2024 forecast to determine the aggregate spending for services subject to GRT in FY2024. These services include fee-for-service, services for Medicaid recipients on the Traditional and Mi Via waivers (See Other Issues) and services paid through managed care. Under fee-for-services, TRD removed categories that are not subject to GRT, such as federal and Indian Health Services hospital services. For direct payments under managed care, TRD assumed that 85 percent of the managed care capitations are for direct medical services (also known as medical loss ratio). Per HCA, the current percentage is at 90 percent under Turquoise Care, which is higher than the federal required 85 percent. TRD assumed 85 percent as the portion of direct healthcare services, as the Turquoise Care 90 percent includes quality improvement expenditures which may not always be direct healthcare services for Medicaid recipients. TRD then removed the GRT portion from both fee-for-service and managed care to arrive at the base expenditures for services. This base was grown by S&P's forecasted consumer spending index through the forecast outlook. TRD applied a statewide effective GRT rate to the tax base to arrive at the total reimbursement amount.

This bill would require the Medicaid program to provide an itemized list that includes information on the service items that are paid and the associated GRT amounts. The itemization requirement would require a system change and training given to providers and the MCOs. To comply with the itemization required by this bill, a system change would be needed in addition to training providers and the Medicaid managed care organizations (MCOs) to submit claims for reimbursement with the tax amount recorded by line. The system change would be made at a cost of $450 thousand at a 90 percent federal financial participation rate; the general fund cost is $45 thousand.

In summary, if the revenue losses and costs associated with this bill were instead directed toward higher Medicaid reimbursement rates, the state could unlock over $900 million in federal matching funds, resulting in a total increase of more than $1.2 billion in additional Medicaid funding. This shift would significantly expand resources for healthcare providers serving Medicaid patients, enhancing access to care while maximizing federal investment in New Mexico's health system.

TRD will need to update forms, instructions, and publications. Implementing this bill will have a low impact on TRD's Information Technology Division (ITD), approximately 220 hours or about one and a half months and $14,661 of staff workload costs.

SIGNIFICANT ISSUES

Individual practitioners or groups of practitioners operating outside of a hospital setting can benefit from these deductions. The bill targets smaller practices and independent healthcare providers, not large health systems or hospital networks. A healthcare practitioner is defined as a licensed professional who provides medical, therapeutic, or mental health services. The bill lists specific types of practitioners eligible for the gross receipts tax deductions:

- Chiropractic Physicians,
- Dentists and Dental Hygienists,
- Doctors of Oriental Medicine,
- Optometrists,
- Osteopathic Physicians,
- Physical Therapists,
- Physicians and Physician Assistants,
- Podiatric Physicians,
- Psychologists,
- Registered Lay Midwives,
- Registered Nurses and Licensed Practical Nurses,
- Occupational Therapists,
- Respiratory Care Practitioners,
- Speech-Language Pathologists and Audiologists,
- Mental Health Counselors, Marriage and Family Therapists, Art Therapists,
- Independent Social Workers,
- Clinical Laboratories (but not labs in hospitals or physicians' offices), and
- Naturopathic Doctors.

Hospitals, nursing homes, hospices, and outpatient facilities are not considered healthcare practitioners under this bill. Organizations with federal 501(c)(3) tax-exempt status (e.g., nonprofit hospitals or clinics) are also excluded but are generally not subject to the GRT.

This bill narrows the GR) base. Many New Mexico tax reform efforts over the last few years have focused on broadening the GRT base and lowering the rates. Narrowing the base leads to continually rising GRT rates, increasing volatility in the state’s largest general fund revenue source. Higher rates compound issues with tax pyramiding, when a tax itself is taxed, and force consumers and businesses to pay higher taxes on all other purchases without an exemption, deduction, or credit.

Gross Receipts Tax Deduction for Medical Equipment, Supplies, and Drugs. The bill allows businesses to deduct from their gross receipts tax any revenue generated from selling medical equipment, supplies, and drugs to healthcare practitioners or associations of healthcare practitioners. While some medical equipment and drugs are already deductible under existing law when sold directly to patients, this bill broadens these deductions to cover healthcare providers purchasing supplies and equipment for use in their practice. For example, a doctor's office buying exam gloves, syringes, or diagnostic tools for in-house use would now get a GRT deduction.

Granting private doctors' offices a GRT deduction for medical equipment, supplies, and drugs under could raise concerns about equity when compared to other essential, non-healthcare service

providers that remain subject to GRT on their equipment and supply purchases. This preferential tax treatment might create disparities across industries, especially for professions that also serve critical public needs but do not receive similar tax relief.

Gross Receipts Tax Deduction for Healthcare Services. Healthcare providers can deduct from gross receipts tax payments from providing most healthcare services. This includes payments from insurers and payments received directly from patients for services not covered under managed care organization or healthcare insurance. This deduction does not apply to services provided to Medicaid patients, though those are offset through reimbursement of GRT as proposed in this bill. This bill makes most healthcare receipts deductible, whether they come from insurance contracts, fee-for-service payments, or direct-pay services. Medicare Advantage (Part C) coinsurance payments are fully deductible under this proposal, while Traditional Medicare (Part A & B) coinsurance payments are deductible if paid by the patient or a secondary private insurer. However, if Medicaid covers the Medicare coinsurance for dual-eligible patients, those payments are not deductible, though providers will be reimbursed for GRT paid on them.

Contract services refer to healthcare services provided under formal agreements between providers and insurance companies or managed care organizations, where providers agree to negotiated rates in exchange for being considered in-network, offering patients lower out-of-pocket costs through copays and deductibles. These contracts often require adherence to specific guidelines, such as preauthorizations and utilization reviews. In contrast, fee-for-service refers to payments made to providers who do not have contracts with insurers, allowing them to set their own rates independently. While insurers may reimburse part of the cost, patients typically face higher out-of-pocket expenses and may be subject to balance billing for the difference between what the provider charges and what the insurer pays. Under current New Mexico law, receipts from contract services are deductible from GRT, but fee-for-service payments were not deductible and subject to tax. This bill removes this distinction, making both contracted and fee-for-service receipts deductible from GRT, expanding tax relief to providers across different payment models and potentially increasing the prevalence of non-contracted, flexible care options.

By making both insurance-covered and direct-pay healthcare services deductible from GRT, this bill offers broad tax relief to healthcare providers across different payment models, potentially boosting profits for both traditional insurance-based practices and cash-based, noncontracted providers. While this could lower operational costs and encourage more flexible care models, there is no guarantee these savings will be passed on to patients through reduced fees or insurance premiums. Additionally, the bill might incentivize more providers to shift toward direct-pay models, potentially benefiting higher-income providers and patients more than those in vulnerable populations.

Removal of Sunset Date for Deductions on Copayments and Deductibles. The bill removes the expiration date, previously set for July 1, 2028, on tax deductions for copayments or deductibles paid by insured patients to healthcare practitioners.

Local Hold Harmless. The new deductions included in Section 7-9-93 NMSA 1978 are subject to hold harmless provisions, meaning the state must compensate local governments for some of the lost GRT revenue resulting from these exemptions. This includes deductions for healthcare services provided under commercial contracts with insurance companies and managed care organizations, as well as proposed deductible fee-for-service insurance payments and direct-pay patient receipts. The deductions introduced in Section 7-9-93.1 NMSA 1978, which cover receipts

from the sale of medical equipment, supplies, and drugs, are not subject to hold harmless provisions, meaning local governments will not receive compensation for the tax revenue lost from these exemptions. By expanding deductions to include direct-pay arrangements and fee-for-service payments, the bill significantly broadens the scope of tax-exempt healthcare spending that is subject to the hold harmless provision. This expansion will reduce GRT revenue not only at the local level but also at the state level, while the state remains obligated to make hold harmless payments to local governments.

Reimbursement for Gross Receipts Taxes Paid by Medicaid Providers. This bill mandates that healthcare providers receiving Medicaid reimbursements in New Mexico will also be directly reimbursed for any GRT they are required to pay. Currently, GRT is included in the reimbursement rates paid to Medicaid managed care organizations (MCOs), which then negotiate contracts with providers to determine how GRT is covered. The state does not directly pay GRT but factors it into MCO payments, leaving providers responsible for paying the tax to the state and negotiating reimbursement through their MCO contracts.

Current MCO contract requirements cite the following provisions regarding GRT:

- [In capitation rate] The contractor's capitation rate will be established by HCA. HCA's actuaries will develop components of the capitation rates to include the medical services components, premium tax, gross receipts tax for provider payments, and the administrative expense portion of the capitation rates.
- [In provider agreements] Address how GRT will be accounted for when reimbursing providers (i.e., whether the GRT will be built into the negotiated contract rate or paid separately and identify the amount of GRT that will be paid on Medicaid claims).
- [In provider payments] The contractor shall negotiate with providers on how GRT will be accounted for when reimbursing providers and consider GRT when establishing reimbursement rates (i.e. whether GRT will be built into the negotiated contract rate or paid separately and identify the amount of GRT that will be paid on Medicaid claims).
- [In special reimbursement] The contractor shall be reimbursed for paid claims at either the established Medicaid fee schedule or the contracted rate in the provider agreement, whichever is greater, as of the date of service, plus GRT as applicable. HCA shall reimburse the contractor with state funds for state-funded services and state funds and federal match for federally funded services via invoicing methodology.
- Unless otherwise noted in … this agreement, the contractor shall reimburse all providers at or above the state plan approved fee schedule for all services reimbursed at a fee-for-service payment methodology exclusive of applicable taxes and negotiated amounts.

HCA oversees MCO compliance with these contractual provisions, including through provider rate audits to ensure conformance with the contract.

The bill aims to standardize GRT reimbursement by ensuring providers are directly compensated, regardless of contract terms. However, this could lead to the state effectively paying GRT twice—once in the capitated payments to MCOs and again through direct reimbursement to providers—unless capitation rates are adjusted. This double payment would increase Medicaid costs without additional federal matching funds. Maintaining GRT on Medicaid services benefits the state because it shifts part of the tax burden to the federal government, with New Mexico's federal Medical assistance percentage (FMAP) matching rate covering approximately 73.47 percent of Medicaid costs in FY24. Removing GRT from the MCO reimbursement rate would reduce the

state's ability to leverage federal funds and increase the Medicaid program's reliance on state revenues.

The Attorney General's Office notes that, because the bill proposes to reimburse healthcare providers for GRT that the providers are required to pay, at least insofar as the state portion of Medicaid is concerned, this may implicate the Anti-Donation Clause.

TRD notes the following policy issues:

> The U.S. health system has been facing significant challenges related to persistent workforce shortages and severe fractures in the supply chain for drugs and equipment, which have increased health services costs for patients. New Mexico is not detached from these challenges. The state has implemented a series of social and tax policies to improve healthcare coverage and attract healthcare workers while reducing healthcare practitioners' financial constraints.
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> While tax incentives can support specific industries or promote desired social and economic behaviors, the growing number of such incentives complicate the tax code. Introducing more tax incentives has two main consequences: (1) it creates special treatment and exceptions within the code, leading to increased tax expenditures and a narrower tax base, which negatively impacts the general fund; and (2) it imposes a heavier compliance burden on both taxpayers and TRD. This proposal adds an additional deduction to Sections 7-9-77.1 and 7-9-93 NMSA 1978, increasing complexity for taxpayers and the administration of the tax code. Increasing complexity and exceptions in the tax code is generally not in line with sound tax policy.
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> The National Institute of Health's (NIH), National Center for Biotechnology Information, published a study that predicts that nationwide the demand for doctors will outpace the supply so that, by 2030, 34 of 50 states will have physician shortages. This shortage is more prominent for states in the South and West regions of which Mississippi and New Mexico will have the severest shortage. Their study predicts a shortage of 2,118 physicians in New Mexico by 2030 due in part to a higher percentage of physicians over 60 years of age compared to other states. The study discusses solutions that reach nationwide including: increasing the number of medical school graduates; increasing equitable federal funding for graduate medical education (GME); attracting foreign-trained doctors; increasing utilization of mid-level providers and increasing uptake of emerging medical technology. Without a nationwide solution, New Mexico will continue to compete with other states for a smaller pool of physicians. It is unclear how the deductions and reimbursements of this bill will directly reduce patient costs and improve the present challenges the U.S. health system faces. Furthermore, diverting resources from the general fund to allow almost every payment to a healthcare practitioner to be subject to a deduction from GRT implies tradeoffs that might limit the state's capacity to invest in expanding healthcare access.
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> New Mexico is one of the few states that taxes medical services, including those funded by Medicaid. Federal law, though, allows for federal match, federal financial participation, of the GRT that is included in payments to healthcare providers and in negotiated service rates paid through Managed Care. So, while medical professionals accepting patients in New Mexico under the Medicaid program must file GRT returns and pay the GRT, that GRT portion of the payment along with the service portion is subsidized by the federal FFP and state reimbursement match. In reimbursing healthcare providers for the GRT portion as

proposed in Section 3 of the bill, the general fund loses revenue without compensation from a federal match. The GRT FFP subsidization allows for increased revenue to the state general fund which aids in increasing healthcare service rates to healthcare providers. Increasing the overall service rates to healthcare providers through appropriations to HCA would represent a more efficient use of state funds and make it more attractive for medical professionals to practice in New Mexico.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is met with the bill's requirement to report annually in the tax expenditure budget regarding the data compiled from the reports from taxpayers taking the deductions.

TECHNICAL ISSUES

TRD notes the following:

In section 3, the proposal states on line 17, that the "health care provider shall be reimbursed . . ." but does not state by whom, or the source of those reimbursements.

TRD also notes that there are no definitions of "health care provider" and "health care services" under Section 3. As noted in the revenue impact, certain populations of Medicaid recipients receive a variety of special needs services which may or may not fall under the intended scope of Section 3. These terms may further clarification and definition to establish the scope of the reimbursement.

The new deduction in Section 2, Subsection A seems duplicative with the current 7-9-93, except for the addition of certain healthcare providers, such as naturopathic doctors. TRD notes that the definition of "managed care health plan" differs between Section 7-9-93 NMSA 1978 and the new proposed Section 7-9-93.1 NMSA 1978 without clear understanding as to why. In addition, the definitions in Section 2 for the following words are not needed as they are not referenced in the new deduction section: "copayment", "deductible", "health care insurer", "managed care health plan", and "managed care organization." TRD suggest for clarity in the tax code that the new material in Section 7-9-93 NMSA 1978 be included under the new Section 7-9-93.1 so that all the deductions under 7-9-93 are for services under commercial contract services and all the deductions under Section 7-9-93.1 NMSA 1978 are for services not covered under commercial contract services, and that all definitions be reconciled.

ADMINISTRATIVE IMPLICATIONS

The Medicaid program currently factors in GRT when calculating capitation rates for MCOs and pays providers GRT on fee-for-service (FFS) claims. However, in accordance with federal regulations, HCA is not legally allowed to be involved in provider reimbursement negotiations between MCOs and Medicaid providers who are subject to collecting and remitting the GRT to the state.

For most provider types and services, the Medicaid paid amount includes GRT, but this amount is not identified separately on the claim. GRT is generally calculated and remitted to providers at the

header paid amount. The itemization required by this bill could be challenging and complex to achieve for Mi Via providers and institutional services. The Medicaid program reimburses providers rendering services to Medicaid recipients at either a line level or header level, depending on reimbursement methodology.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

Senate Bill 295 relates to Senate Bill 249, which requires medical providers to be reimbursed for GRT paid for healthcare services. This bill also duplicates House Bill 344.

OTHER SUBSTANTIVE ISSUES

While this bill aims to reduce operational costs for healthcare providers by expanding GRT deductions, there is a significant concern that these savings may primarily increase profits for well-compensated healthcare professionals and insurance companies rather than lower healthcare costs for patients. The bill includes no mechanisms to ensure that providers pass tax savings on to patients through reduced service fees, and insurers are not obligated to adjust premiums or copays, even if their reimbursement costs decrease. Given that many healthcare professionals, especially specialists, already command high salaries, these deductions could widen income disparities within the healthcare sector without addressing affordability issues for patients.

Moreover, the structure of the healthcare market—marked by opaque pricing, limited patient choice in provider networks, and high-deductible insurance plans—means patients are unlikely to see direct benefits from these tax breaks. Providers may reinvest savings into profit-generating activities, such as elective procedures or advanced technology, which often lead to higher rather than lower costs. Without regulatory oversight or price transparency reforms, this bill risks bolstering the financial standing of already lucrative healthcare practices and insurers, while failing to tackle the underlying drivers of high patient costs.

While the bill provides uniform GRT deductions for healthcare providers, it fails to account for the vast differences in profit margins across various professions. High-margin fields like optometry, which benefit from both clinical services and profitable retail sales (e.g., eyeglasses, contact lenses), stand to gain significantly from deductions on medical equipment and supplies, potentially boosting already substantial profits. In contrast, low-margin professions like speech-language pathology (SLPs), which rely on lower reimbursement rates and have fewer opportunities for additional revenue, will see minimal financial benefit from the same deductions. By offering equal tax relief to professions with unequal financial realities, the bill risks exacerbating disparities within the healthcare sector, favoring more lucrative industries while leaving critical but underfunded services with insufficient support.

In assessing all tax legislation, LFC staff considers whether the proposal is aligned with committee-adopted tax policy principles. Those five principles:

- **Adequacy**: Revenue should be adequate to fund needed government services.
- **Efficiency**: Tax base should be as broad as possible and avoid excess reliance on one tax.
- **Equity**: Different taxpayers should be treated fairly.
- **Simplicity**: Collection should be simple and easily understood.
- **Accountability**: Preferences should be easy to monitor and evaluate

In addition, staff reviews whether the bill meets principles specific to tax expenditures. Those policies and how this bill addresses those issues:

Tax Expenditure Policy Principle	Met?	Comments
Vetted: The proposed new or expanded tax expenditure was vetted through interim legislative committees, such as LFC and the Revenue Stabilization and Tax Policy Committee, to review fiscal, legal, and general policy parameters.	✗	No record of an interim committee hearing can be found.
Targeted: The tax expenditure has a clearly stated purpose, long-term goals, and measurable annual targets designed to mark progress toward the goals. Clearly stated purpose Long-term goals Measurable targets	✗	There are no stated purposes, goals, or targets.
Transparent: The tax expenditure requires at least annual reporting by the recipients, the Taxation and Revenue Department, and other relevant agencies	✓	The deductions must be reported publicly in the TER. The deductions do not have an expiration date.
Accountable: The required reporting allows for analysis by members of the public to determine progress toward annual targets and determination of effectiveness and efficiency. The tax expenditure is set to expire unless legislative action is taken to review the tax expenditure and extend the expiration date. Public analysis Expiration date	✗	
Effective: The tax expenditure fulfills the stated purpose. If the tax expenditure is designed to alter behavior – for example, economic development incentives intended to increase economic growth – there are indicators the recipients would not have performed the desired actions "but for" the existence of the tax expenditure. Fulfills stated purpose Passes "but for" test	?	There are no stated purposes, goals, or targets with which to measure effectiveness or efficiency.
Efficient: The tax expenditure is the most cost-effective way to achieve the desired results.	?	
Key: ✓ Met ✗ Not Met ? Unclear		

JF/rl/hg/rl/Sl2