HOUSE BILL 338

57TH LEGISLATURE - STATE OF NEW MEXICO - SECOND SESSION, 2026

INTRODUCED BY

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AN ACT

RELATING TO TAXATION; EXTENDING THE SUNSET DATE FOR A GROSS RECEIPTS TAX DEDUCTION FOR HEALTH CARE PRACTITIONERS AND EXPANDING THE DEDUCTION TO INCLUDE COINSURANCE.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. Section 7-9-93 NMSA 1978 (being Laws 2004, Chapter 116, Section 6, as amended) is amended to read:

"7-9-93. DEDUCTION--GROSS RECEIPTS--CERTAIN RECEIPTS FOR SERVICES PROVIDED BY HEALTH CARE PRACTITIONER OR ASSOCIATION OF HEALTH CARE PRACTITIONERS.--

A. Receipts of a health care practitioner or an association of health care practitioners for commercial contract services or medicare part C services paid by a managed care organization or health care insurer may be deducted from gross receipts if the services are within the scope of practice

of the health care practitioner providing the service. Receipts from fee-for-service payments by a health care insurer may not be deducted from gross receipts.

B. Prior to July 1, [~~2028~~] 2031, receipts from coinsurance, a copayment or a deductible paid by an insured or enrollee to a health care practitioner or an association of health care practitioners for commercial contract services pursuant to the terms of the insured's health insurance plan or enrollee's managed care health plan may be deducted from gross receipts if the services are within the scope of practice of the health care practitioner providing the service.

C. The deductions provided by this section shall be applied only to gross receipts remaining after all other allowable deductions available under the Gross Receipts and Compensating Tax Act have been taken.

D. A taxpayer allowed a deduction pursuant to this section shall report the amount of the deduction separately in a manner required by the department.

E. The deductions provided by this section shall be included in the tax expenditure budget pursuant to Section 7-1-84 NMSA 1978 with an analysis of the cost of the deductions.

F. As used in this section:

(1) "association of health care practitioners" means a corporation, an unincorporated business entity or other

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legal entity organized by, owned by or employing one or more health care practitioners; provided that the entity is not:

(a) an organization granted exemption from the federal income tax by the United States commissioner of internal revenue as organizations described in Section 501(c)(3) of the United States Internal Revenue Code of 1986, as that section may be amended or renumbered; or

(b) a health maintenance organization, a hospital, a hospice, a nursing home or an entity that is solely an outpatient facility or intermediate care facility licensed pursuant to the [~~Public Health Act~~] Health Care Code;

(2) "commercial contract services" means health care services performed by a health care practitioner pursuant to a contract with a managed care organization or health care insurer other than those health care services provided for medicare patients pursuant to Title 18 of the federal Social Security Act or for medicaid patients pursuant to Title 19 or Title 21 of the federal Social Security Act;

(3) "copayment" or "coinsurance" means [~~a fixed dollar~~] an amount that a health care insurer or managed care health plan requires an insured or enrollee to pay upon incurring an expense for receiving medical services;

(4) "deductible" means the amount of covered charges an insured or enrollee is required to pay in a plan year for commercial contract services before the insured's

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health insurance plan or enrollee's managed care health plan begins to pay for applicable covered charges;

(5) "fee-for-service" means payment for health care services by a health care insurer for covered charges under an indemnity insurance plan;

(6) "health care insurer" means a person that:

(a) has a valid certificate of authority in good standing pursuant to the New Mexico Insurance Code to act as an insurer, a health maintenance organization or a nonprofit health care plan or prepaid dental plan; and

(b) contracts to reimburse licensed health care practitioners for providing basic health services to enrollees at negotiated fee rates;

(7) "health care practitioner" means:

(a) a chiropractic physician licensed pursuant to the provisions of the Chiropractic Physician Practice Act;

(b) a dentist or dental hygienist licensed pursuant to the Dental Health Care Act;

(c) a doctor of oriental medicine licensed pursuant to the provisions of the Acupuncture and Oriental Medicine Practice Act;

(d) an optometrist licensed pursuant to the provisions of the Optometry Act;

(e) an osteopathic physician licensed

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pursuant to the provisions of the Medical Practice Act;

(f) a physical therapist licensed pursuant to the provisions of the Physical Therapy Act;

(g) a physician or physician assistant licensed pursuant to the provisions of the Medical Practice Act;

(h) a podiatric physician licensed pursuant to the provisions of the Podiatry Act;

(i) a psychologist licensed pursuant to the provisions of the Professional Psychologist Act;

(j) a registered lay midwife registered by the department of health;

(k) a registered nurse or licensed practical nurse licensed pursuant to the provisions of the Nursing Practice Act;

(l) a registered occupational therapist licensed pursuant to the provisions of the Occupational Therapy Act;

(m) a respiratory care practitioner licensed pursuant to the provisions of the Respiratory Care Act;

(n) a speech-language pathologist or audiologist licensed pursuant to the Speech-Language Pathology, Audiology and Hearing Aid Dispensing Practices Act;

(o) a professional clinical mental

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health counselor, marriage and family therapist or professional art therapist licensed pursuant to the provisions of the Counseling and Therapy Practice Act who has obtained a master's degree or a doctorate;

(p) an independent social worker licensed pursuant to the provisions of the Social Work Practice Act; and

(q) a clinical laboratory that is accredited pursuant to 42 U.S.C. Section 263a but that is not a laboratory in a physician's office or in a hospital defined pursuant to 42 U.S.C. Section 1395x;

(8) "managed care health plan" means a health care plan offered by a managed care organization that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in the plan other than those services provided to medicare patients pursuant to Title 18 of the federal Social Security Act or to medicaid patients pursuant to Title 19 or Title 21 of the federal Social Security Act;

(9) "managed care organization" means a person that provides for the delivery of comprehensive basic health care services and medically necessary services to individuals enrolled in a plan through its own employed health care providers or by contracting with selected or participating health care providers. "Managed care organization" includes

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only those persons that provide comprehensive basic health care services to enrollees on a contract basis, including the following:

(a) health maintenance organizations;

(b) preferred provider organizations;

(c) individual practice associations;

(d) competitive medical plans;

(e) exclusive provider organizations;

(f) integrated delivery systems;

(g) independent physician-provider organizations;

(h) physician hospital-provider organizations; and

(i) managed care services organizations; and

(10) "medicare part C services" means services performed pursuant to a contract with a managed health care provider for medicare patients pursuant to Title 18 of the federal Social Security Act."

SECTION 2. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 2026.

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