NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Healthcare Gross Receipts Tax Explainer

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The Tenets of the GRT

- Broad Base, Low-Rate Approach
  - Applies to most goods and services, unlike many states that exempt services.
  - Intended to spread the tax burden widely, allowing for a lower rate.
- Business Input Taxation
  - GRT applies at multiple stages of production/distribution, not just final consumption.
  - Creates pyramiding: tax is embedded in prices as businesses pay tax on inputs.
- Minimal Exemptions/Targeted Deductions
  - Historically few carve-outs; deductions and exemptions added over time (e.g., health care, manufacturing inputs).
  - Policy trade-off between broad simplicity, fairness, and sector-specific relief.
- Neutrality Goal vs. Economic Distortions
  - Broad base meant to avoid favoritism across industries.
  - But pyramiding and selective exemptions can distort effective tax burdens.
- Revenue Stability
  - Because GRT covers goods and services, it provides a more stable base than sales taxes that rely primarily on goods.

How States Tax Healthcare Services

- Broad Gross Receipts Systems
  - New Mexico (GRT), Hawaii (GET): Healthcare services are taxable, with some deductions, exemptions, and other carve-outs
- Other GRT/CAT States
    - Washington (B&O), Oregon (CAT), Ohio (CAT): Healthcare providers taxed on gross receipts, though rates/exemptions vary.
- Targeted Provider Taxes
  - Most States: Narrow taxes on hospitals, nursing homes, or MCOs — mainly to fund Medicaid.
- Traditional Sales Tax States
  - Most states exclude healthcare services and other services entirely; rely on provider/MCO taxes instead of broad service taxation.

Private Insurance for Healthcare Practitioners

- Healthcare practitioners are taxed on all fee-for-service payments, patient coinsurance payments, and non-insured payments.
  - **Fee-for-service:** A payment model in which a healthcare provider bills and is reimbursed separately for each service, test, or procedure delivered, with payment tied directly to the number and type of services rendered. In practice, most in-network providers are paid under negotiated contract rates (so not FFS), while out-of-network providers are more likely to be reimbursed on a fee-for-service basis, with insurers paying a portion of the charge and patients responsible for the balance.
  - **Coinsurance:** The percentage of an allowed medical charge that a patient must pay after meeting their deductible, in contrast to a copay (a fixed dollar amount) or full coverage where the insurer pays 100%.
  - **Non-insured:** non-eligible services (cosmetic or elective) or non-insured individuals. Practitioner can pass the tax on to patient.

What is a Healthcare Practitioner?

- A healthcare practitioner means a person licensed or certified by the state of New Mexico to provide medical or health services in one of these professions:
  - Doctor of medicine (MD)
  - Doctor of osteopathy (DO)
  - Doctor of dental surgery (DDS) / dental medicine (DMD) / dental hygienist
  - Doctor of podiatry (DPM)
  - Doctor of optometry (OD)
  - Doctor of chiropractic (DC)
  - Psychologist
  - Physician assistant
  - Nurse (including nurse practitioners, certified nurse anesthetists, midwives, etc.)
  - Clinical mental health counselor, marriage and family therapist, social worker
  - Other licensed allied health professionals (physical, occupational, and speech therapists, etc.)
  - *Key: It is limited to individual licensed practitioners and their associations, not institutions.*

- Entities that are not included in this definition and therefore do not get the healthcare practitioner deductions:
  - Hospitals
  - Nursing homes
  - Intermediate care facilities
  - Ambulatory surgical centers
  - Dialysis centers
  - Some clinical laboratories
  - Behavioral health facilities
  - *Key note: many of these groups have specific deductions for Medicare payments in 7-9-77.1*

Why Providers "Eat" the GRT on Certain Payments

- Currently, providers almost never pass applicable GRT for coinsurance or fee-for-service payments through to the patient:
  - Contracts with insurers fix the allowed charge and the patient's share (e.g., copay, deductible, coinsurance). Plan rules prohibit "balance billing" patients beyond those amounts.
  - Even though the provider owes GRT on those receipts, they cannot add GRT on top of the fixed payment from the patient.
  - As a result, the provider must remit the tax out of the reimbursement they receive, effectively lowering their net payment.

- Example
  - Allowed charge = $100.
  - Insurer pays $80 (deductible under § 7-9-93).
  - Patient coinsurance = $20 (taxable).
  - Provider must remit GRT on the $20 (maybe $1.50), but cannot collect extra from the patient by contract, so they pay the $1.50 tax themselves out of the $100 (effectively 1.5% tax).

Hold Harmless on Healthcare Practitioner Deduction

- What is Hold Harmless?
  - State backfill to cities/counties to offset lost revenue from new GRT deductions (e.g., food, § 7-9-93 health care).
  - Began 2015 → ends 2030 (15-year phase-down).
  - Applies only to § 7-9-93 in health care (healthcare practitioners), not § 7-9-77.1 (Medicare) or § 7-9-73.1 (hospitals).
  - Local governments losing HH must rely on new "hold-harmless increments" to make up lost revenue, essentially raising the GRT rate on other industries. Statute allowed up to 0.375% HH local increment, now consolidated into general increments.

Why and how do we tax Medicaid?

- Revenue stability: Medicaid is one of the largest payer sources in NM health care, and taxing these receipts helps sustain state and local GRT revenues.
- Outsourcing the tax to the federal government: Because Medicaid is federally and state funded, a large portion of the GRT, ~72%, is effectively borne by the federal government, bringing outside dollars into NM's revenue base.
- Mechanics: GRT is built into Medicaid reimbursement rates paid by the state to managed care organizations (MCOs). MCOs then negotiate provider contracts that account for GRT, but providers remain legally responsible for remitting the tax to the state.

Medicaid & GRT: The Problem and the Fix

- The Problem (Before SB 249):
  - Providers were required to pay GRT on Medicaid receipts.
  - GRT was built into capitation payments from the state to MCOs, but not itemized for providers.
  - Providers had to negotiate GRT reimbursement with MCOs — often resulting in generalized or averaged GRT rates.
  - Result: Some providers ended up being over- or under-reimbursed for GRT.

- The Fix (SB 249 – 2025):
  - Medicaid must reimburse providers directly for GRT owed on Medicaid services.
  - GRT must be itemized separately in provider reimbursements.
  - Removes ambiguity and ensures providers are made whole on Medicaid GRT liability.
  - Goes into effect January 1, 2026

- *Exception*: all patient-paid portions of Medicaid coinsurance, deductibles, and copays are still subject to the GRT and likely being paid by providers.

The state largely does not tax healthcare services provided under Medicare

- General Rule: Receipts of health care practitioners and certain facilities are deductible from gross receipts when payments are made directly by the U.S. government or a Medicare Administrative Contractor (MAC) for services covered under Medicare.
- Covered Entities:
  - Health care practitioners (e.g., physicians, dentists, nurses, etc.)
  - Hospices
  - Nursing homes
  - Other facilities specifically listed in the statute
- Scope of Deduction:
  - Applies to Medicare Part B receipts (professional services, outpatient care, physician services).
  - Medicare Part A (hospital/facility payments) is not included here — instead, hospitals fall under the separate 60% deduction (§ 7-9-73.1).
  - Medicare Part C (Medicare Advantage) is deductible separately under commercial contract services deduction (§ 7-9-93).

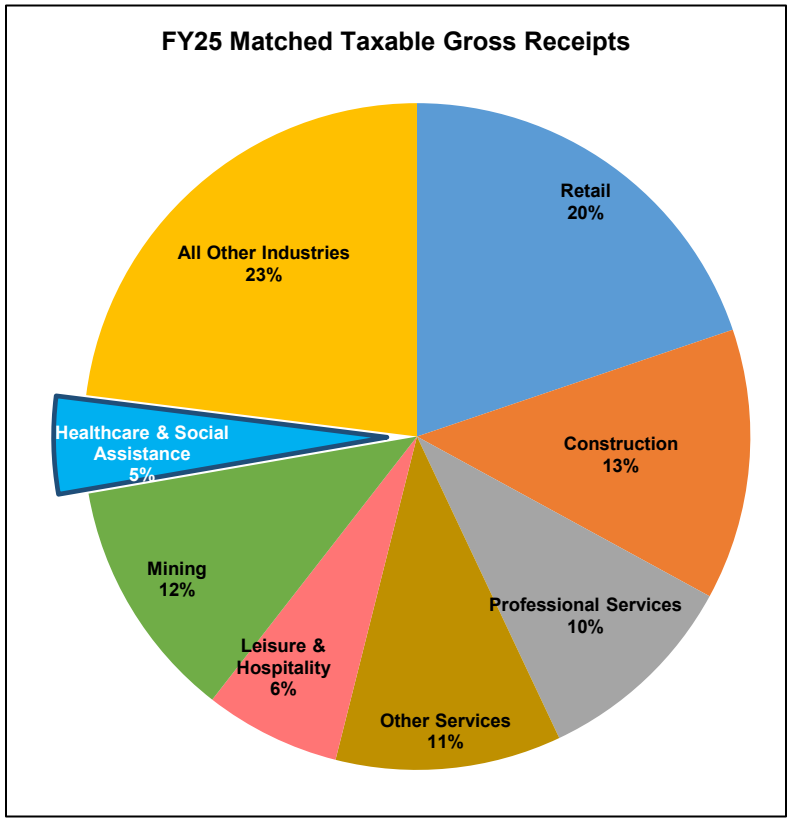
Taxation of Hospitals

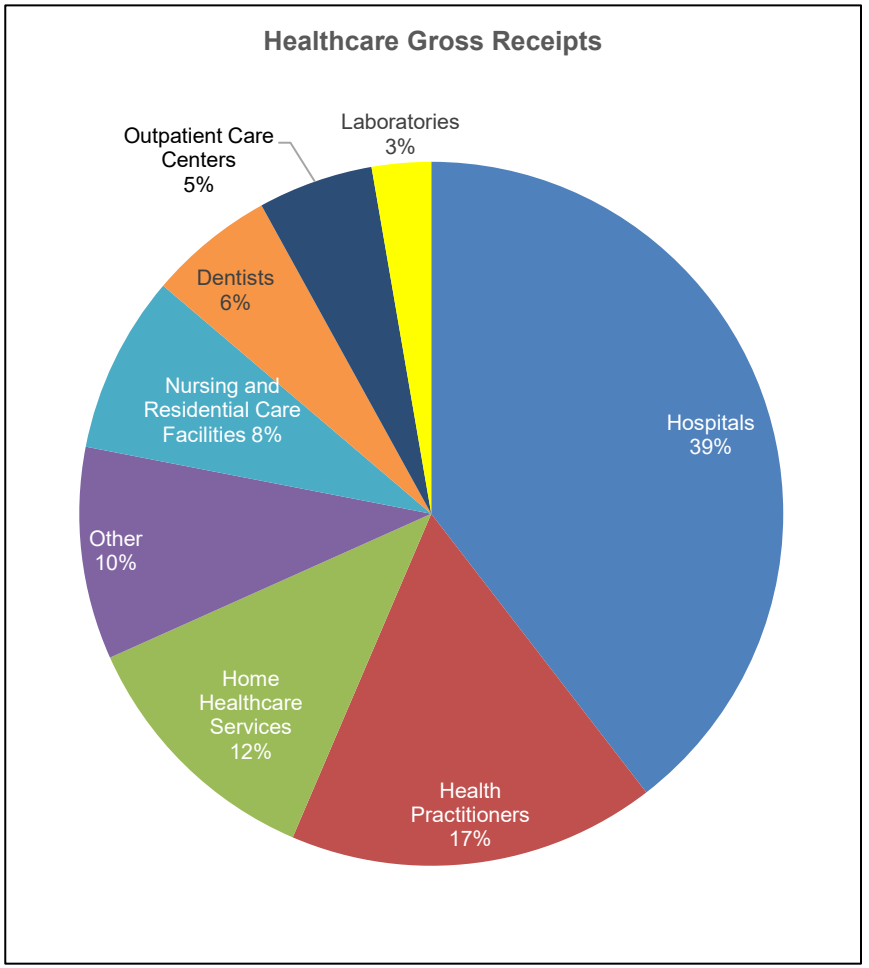
- 60% Deduction (§ 7-9-73.1): Licensed hospitals deduct 60% of gross receipts; remaining 40% taxable.
- Applies to All Payers: Medicare Part A, Medicaid, private insurance, and patient self-pay all treated the same.
- Lawmakers adopted a uniform 60% deduction to balance fairness across types while preserving revenue.
- Distinct from Practitioners: Hospitals do not receive the § 7-9-93 contract/cost-sharing deductions; their relief is through the broad 60% rule only.

Taxation of Medical Goods and Equipment

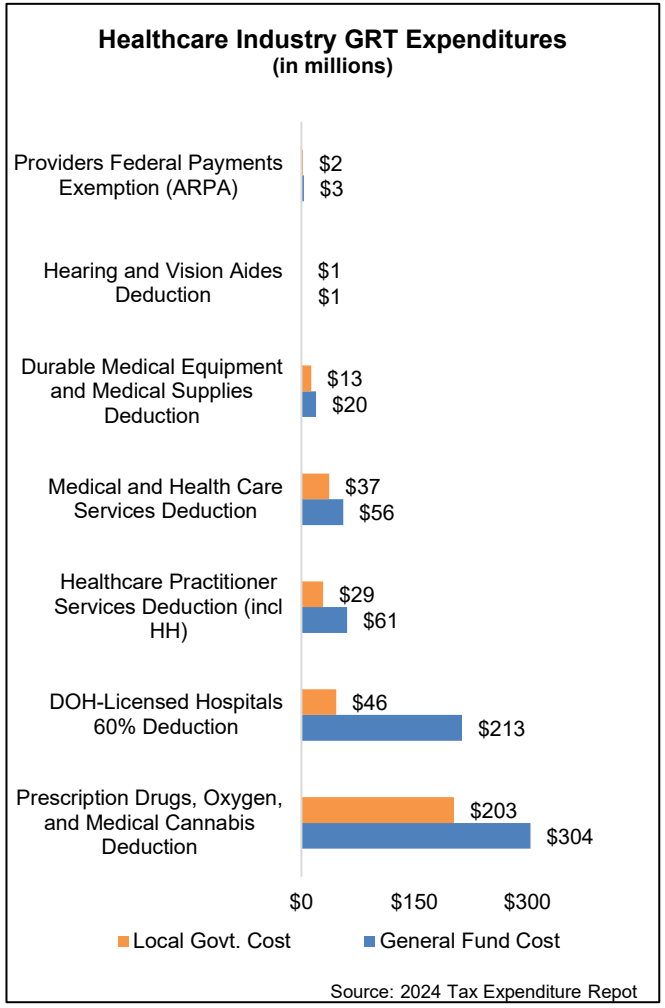
- Provider Purchases (inputs): Taxable — supplies and equipment used in delivering care like gloves, syringes, exam tables, etc.
- Patient Purchases with Prescription: Deductible — prescription drugs (§ 7-9-73.2), oxygen, durable medical equipment, prosthetics, etc. (§ 7-9-73.3).
- Patient Purchases without Prescription: Taxable — over-the-counter braces, bandages, non-prescribed devices.

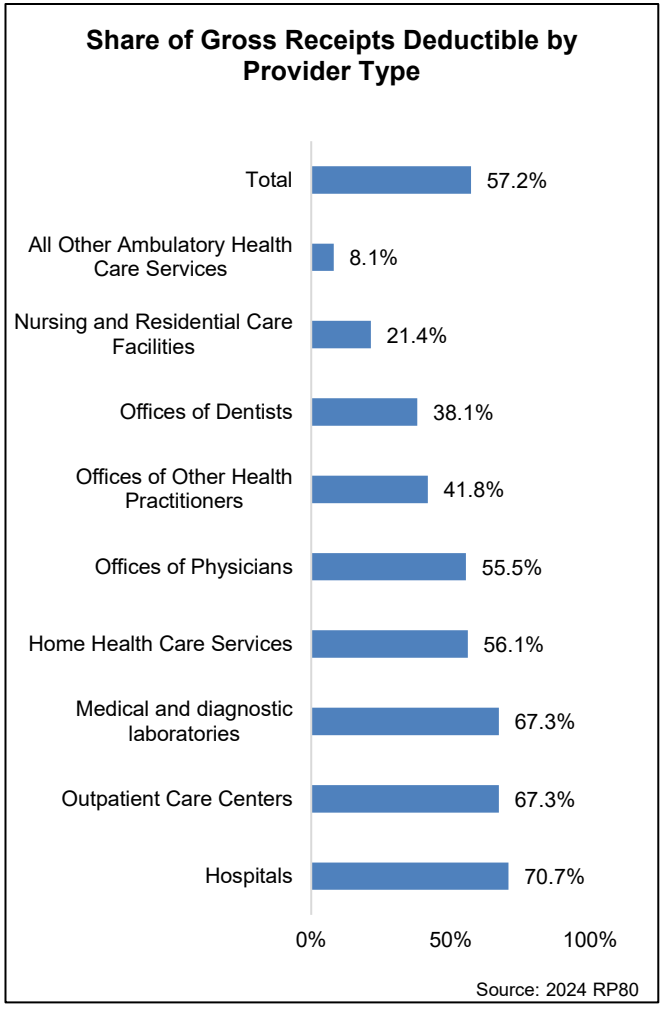
Nearly $10.5 billion was spent in the healthcare sector in FY25, resulting in ~$192m in GRT for the state and ~$182m for locals.



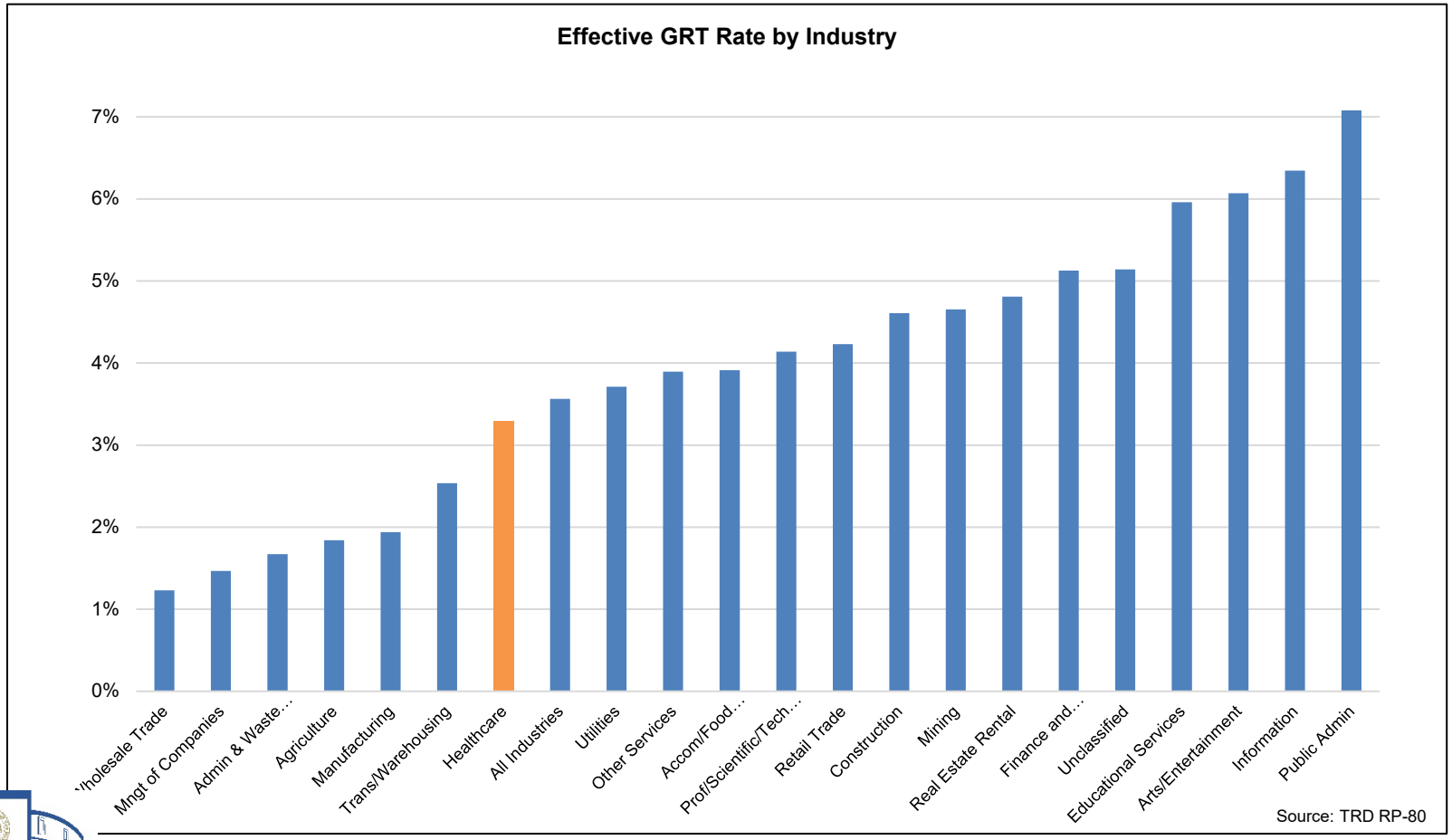


An estimated 55% to 65% of healthcare receipts are deductible.





After deductions, healthcare services have an effective tax rate of ~3.3%, among the lowest across industries.



Most healthcare spending and revenue originates in Bernalillo and Dona Ana counties.

	Matched Taxable Gross Receipts (2025)	% of Statewide Total
Bernalillo	$2,059,397,928	45.6%
Catron	$1,487,081	0.0%
Chaves	$151,073,869	3.3%
Cibola	$51,237,129	1.1%
Colfax	$12,052,205	0.3%
Curry	$61,045,557	1.4%
De Baca	$1,062,947	0.0%
Dona Ana	$747,244,442	16.5%
Eddy	$71,481,177	1.6%
Grant	$35,516,897	0.8%
Guadalupe	$2,842,552	0.1%
Harding	$65,838	0.0%
Hidalgo	$3,255,807	0.1%
Lea	$102,051,701	2.3%
Lincoln	$15,462,235	0.3%
Los Alamos	$45,930,389	1.0%
Luna	$66,140,128	1.5%
McKinley	$86,020,755	1.9%
Mora	$1,332,278	0.0%
Otero	$85,442,658	1.9%
Quay	$9,000,455	0.2%
Rio Arriba	$23,915,847	0.5%
Roosevelt	$25,789,601	0.6%
San Juan	$197,324,543	4.4%
San Miguel	$51,511,292	1.1%
Sandoval	$196,568,793	4.4%
Santa Fe	$264,246,238	5.9%
Sierra	$24,382,403	0.5%
Socorro	$14,159,109	0.3%
Taos	$31,916,397	0.7%
Torrance	$3,227,187	0.1%
Union	$5,968,440	0.1%
Valencia	$68,599,394	1.5%
Total	**$4,516,753,272**	**100%**

Policy Option: Status Quo

- Policy Option: Status Quo - Providers Remit GRT
  - Concept: New Mexico imposes gross receipts tax (GRT) on provider receipts. Practitioners remit GRT on taxable amounts such as coinsurance, fee-for-service payments, and patient cost-sharing.
  - Reality in Practice: Patient responsibility amounts (copays, deductibles, coinsurance) are contractually fixed, so providers cannot add GRT on top. They must remit tax out of what they receive, effectively reducing net reimbursement.
  - Bottom Line: Under the current structure, GRT increases provider costs and lowers take-home reimbursement, especially in practices with significant insurance and patient cost-sharing.

Policy Option: Require Insurers to Pay GRT

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- Two Ways Large Employers Provide Health Benefits
  - Fully insured plan:
    - Employer buys a group insurance policy from a carrier (e.g., Presbyterian, BCBS).
    - The insurer bears the risk of paying claims.
    - This policy is subject to state insurance law → NM can regulate and apply a GRT rule here.

  - Self-funded ERISA plan with an insurance carrier as third-party administrator (TPA):
    - Employer pays claims out of its own funds.
    - The "insurance company" (BCBS, United, etc.) is just acting as a TPA — they process claims, manage the network, but do not bear the risk.
    - Because the employer bears the financial risk, this is a self-funded ERISA plan → not subject to state insurance rules, even though a traditional insurer is the administrator. NM can not dictate GRT payment structure.

Policy Option: Require Insurers to Pay GRT

- Policy Option: Require Insurers to Pay GRT
- Concept: Shift gross receipts tax (GRT) liability from providers to health insurers, so practitioners don't absorb the tax on coinsurance and fee-for-service payments.
  - Fully Insured Plans and State and Local Government Plans: NM could apply this to state-regulated insurers (Blue Cross, Presbyterian, Cigna, etc.) and local government plans (even if self-funded) under ERISA's savings clause.
  - ERISA Self-Funded Plans: Federal deemer clause prevents states from treating self-funded employer plans as insurers → preemption blocks NM from requiring them to pay GRT.
  - Result: Policy would only reach a portion of the market (~40% of private insurance). Most large employer plans (~60%) would be exempt under ERISA.
  - Bottom Line: ERISA limits make this a partial solution — effective for fully insured plans, but providers would still "eat" the GRT for self-funded ERISA patients.

Policy Option: Deduct All Insurance-covered Healthcare Provider GRT

- Policy Option: Deduct All Insurance-Covered Healthcare Provider GRT
- Concept: Deduct all receipts for services covered, in whole or part, by a private health insurance plan from GRT. Hospitals remain on 60% deduction unless changed.
- Pros:
  - Raises take home profit for providers.
  - Simplifies compliance (one clear rule).
  - Avoids ERISA preemption (state is choosing not to tax).
  - Insurance determine medical necessity.
- Cons:
  - Significant state & local revenue loss.
  - Creates disparity with hospital treatment.
  - Providers would still "eat" Medicare and Medicaid patient-paid portions.
  - Could trigger the federal government to determine the GRT is a "provider tax" if Medicaid is essentially the only entity still taxed within the healthcare system.

Policy Option: Deduct All Healthcare Provider GRT

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- Concept: Deduct or exempt all receipts for healthcare services from GRT. Hospitals remain on 60% deduction unless changed.
- Pros:
  - Raises take home profit for providers.
  - Simplifies compliance (one clear rule).
  - Avoids ERISA preemption (state is choosing not to tax).
- Cons:
  - Significant state & local revenue loss.
  - Creates disparity with hospital treatment unless addressed.
  - State loses Medicaid-paid taxes – federal government gains the most.
  - Elective and cosmetic treatments would likely be included in the exemption.

QUESTIONS?

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Appendix 1: What is taxed and what isn't?

Payment/Service Type		Current Law
Private Insurance for Healthcare Practitioners	Private insurance contracted service payments (managed care, PPO, HMO; including coinsurance)	❌ Deductible from GRT
	Private insurance and patient fee-for-service payments	✅ Taxable (Subject to GRT)
	Patient copays and deductibles	❌ Deductible from GRT
	Patient coinsurance	✅ Taxable (Subject to GRT)
	Direct-pay health care services (no insurance)	✅ Taxable (Subject to GRT)
Medicaid and Medicare for Healthcare Practitioners	Medicaid-covered services	✅ Taxable (Subject to GRT, providers reimbursed)
	Medicare-covered services	❌ Deductible from GRT
	Patient-paid Medicare or Medicaid coinsurance, copays, and deductibles	✅ Taxable (Subject to GRT)
	Medicare part B "medigap" paid by private secondary insurance	✅ Taxable (Subject to GRT)
	Medicare part C/Medicare advantage paid by private secondary insurance	❌ Deductible from GRT
Hospitals and Medical Equipment and Supplies	Hospital services regardless of payer	✅ Taxable (Subject to GRT with 60 percent deduction)
	Medical equipment, supplies, and drugs (sold to providers)	✅ Taxable (Subject to GRT)
	Medical equipment, supplies, and drugs (sold to patients)	❌ Deductible from GRT

Appendix 2: Healthcare NAICs Summary Table

NAICS Description	Gross Receipts	Share of Total Gross Receipts	Taxable Receipts	Share of Total Taxable Receipts	Receipts Deducted
Hospitals	$4,149,201,168	39.5%	$1,213,745,977	26%	70.7%
Outpatient Care Centers	$555,405,983	5.3%	$281,476,894	6%	49.3%
Medical and diagnostic laboratories	$285,152,412	2.7%	$93,287,078	2%	67.3%
Home Health Care Services	$1,244,831,526	11.9%	$546,084,292	12%	56.1%
Offices of Physicians	$858,726,324	8.2%	$382,271,467	8%	55.5%
Offices of Other Health Practitioners	$914,870,650	8.7%	$532,056,124	12%	41.8%
Offices of Dentists	$605,647,635	5.8%	$375,170,608	8%	38.1%
Nursing and Residential Care Facilities	$856,958,293	8.2%	$673,621,048	15%	21.4%
All Other Ambulatory Health Care Services	$1,023,535,582	9.8%	$493,086,751	11%	51.8%
Total	**$10,494,329,573**		**$4,590,800,239**		**56.3%**