Money Matters
Analysis by the LFC Economists

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Healthcare Gross Receipts Taxation

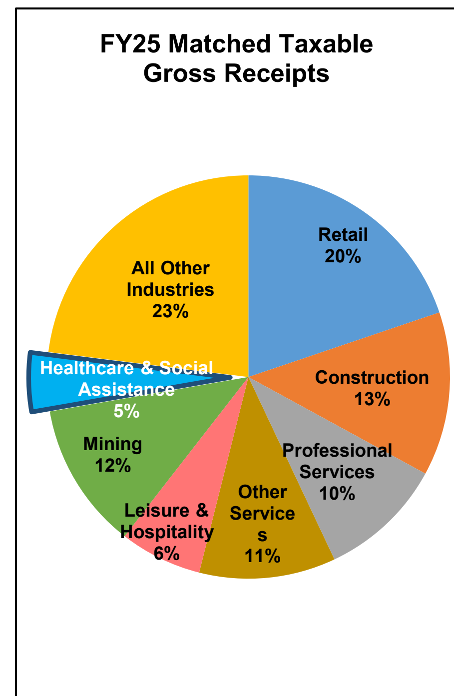
THIS REPORT provides a reference for GRT on healthcare in New Mexico, including statutory background, current rules, and their implications for providers, insurers, patients, and public finance.

New Mexico's gross receipts tax (GRT) is unique among state revenue systems. Where most states levy a sales tax that applies primarily to goods at final sale, New Mexico applies its GRT broadly to both goods and services, including healthcare. The original intent of this design was to maintain a broad tax base that allowed for lower tax rates while generating stable revenue. Over time, lawmakers have carved out exemptions and deductions for healthcare providers, creating a patchwork of rules that attempt to balance provider concerns, local government revenue needs, and federal restrictions.

This brief explains how New Mexico's GRT applies to healthcare today, examining practitioners, hospitals, Medicaid, Medicare, and the treatment of medical goods and equipment. It reviews the statutory basis of major deductions and exemptions, describes the local government impacts of hold-harmless provisions, compares New Mexico to other states, and outlines policy considerations and options facing the Legislature.

The Gross Receipts Tax Framework

When the GRT was enacted in 1966, it was deliberately structured as a tax on nearly all receipts of businesses in New Mexico, not just the retail sale of goods. This made the base broader than a traditional sales tax. Healthcare, legal, accounting, and other professional services were included in the base from the start.



One of the benefits of this design is stability. Because services now make up more than two-thirds of consumer spending, taxing services ensures more consistent revenues in the modern economy than in states relying on taxation of goods[1]. But the structure also results in "pyramiding," where multiple businesses or steps in a supply chain pay tax on their purchases. In healthcare, providers may sometimes face pyramiding in the GRT paid on inputs like billing services or medical supplies, in addition to paying tax on some patient receipts.

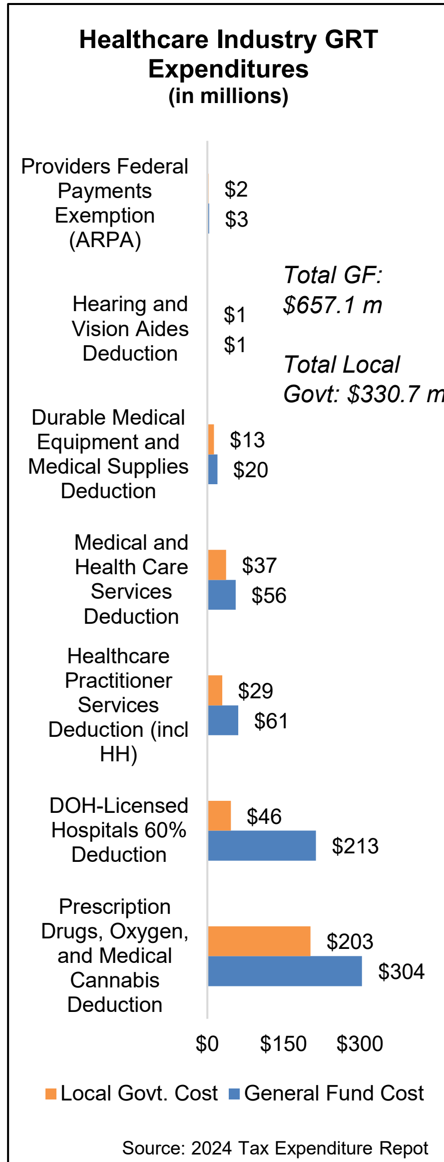
Although the GRT was originally implemented without carve-outs, the Legislature has gradually adopted deductions to address policy concerns. For healthcare, the largest provisions are the healthcare practitioner deduction adopted in 2004 (§ 7-9-93), the 60 percent hospital deduction, originally adopted in 1991 (§ 7-9-73.1), and the exemption for prescription drugs and oxygen adopted in 1998 (§ 7-9-73.2).

Healthcare Practitioners

For nearly four decades, healthcare practitioners operating outside of a hospital such as physicians, dentists, and nurse practitioners paid GRT on all receipts, whether from patients, insurers, or Medicare Advantage plans. Because

[1] Federal Reserve Economic Data (FRED)

provider reimbursement rates are set by contracts with insurers or government programs, many providers argued they had no ability to increase charges to cover GRT liability. In 2004, the Legislature responded by enacting the healthcare practitioner deduction.



The 2004 legislation allowed providers to deduct receipts from "commercial contract services" — essentially, payments from private health insurers and managed care organizations for in-network contract services. It also allowed deductions for Medicare Part C (Medicare Advantage) payments, which are also contract-based. The idea was to exclude those receipts where providers had no control over reimbursement levels.

At the same time, the Legislature explicitly excluded "fee-for-service" (FFS) payments from the deduction even if paid by an insurer. Under FFS arrangements, providers are reimbursed per service without an overarching contract. Lawmakers determined that because these payments were not subject to the same rate constraints and practitioners could pass the tax on, they should remain taxable. The result is in-network contract payments remain deductible, but out-of-network or FFS payments from insurers remain subject to the GRT.

Throughout this time, patient cost-sharing has been a recurring issue. Originally, copayments, deductibles, and coinsurance were all taxable. Because providers cannot increase these charges beyond what the insurance contract specifies, providers paid the GRT without a corresponding charge to patients. In 2023, legislation added a temporary deduction for copayments and deductibles on commercial insurance contracts scheduled to expire in 2028. As of the timing of this publication, coinsurance remains taxable and paid by providers unable to pass on the tax to customers because of insurance contracts.

Because the 2004 deduction for practitioners significantly reduced the GRT base, the Legislature paired it with "hold-harmless" payments to municipalities and counties. These payments backfilled local revenue losses caused by the deduction. In 2013, as a result of rapidly growing and unforeseen costs associated with the hold-harmless payments lawmakers voted to phase out the subsidy over 15 years, ending in 2030. To offset this phase-out of funds, cities and counties were authorized to impose up to 0.375 percent in new GRT increments which many local governments adopted contributing to rising local GRT rates. In 2019 and 2022, lawmakers revised the GRT increment and hold-harmless frameworks, consolidating local GRT increments and creating different rules for hold harmless depending on population size, poverty levels, and whether a locality had enacted a hold-harmless increment by mid-2019. As a result, many small municipalities continue to receive the full state hold harmless distribution while also having the authority to levy new GRT increments.

Hospitals

Unlike the practitioner GRT structure, the hospital GRT structure applies uniformly regardless of payer, service type, or nonprofit status. All hospital receipts are subject to gross receipts tax, with a 60 percent deduction allowed across the board. The remaining 40 percent is taxable. This deduction applies equally to Medicare Part A, Medicaid, private insurers, and patient self-pay. Unlike practitioners, hospitals do not receive additional exemptions for

specific services or for patient cost-sharing; their tax relief comes exclusively through the 60 percent deduction.

Medical Goods, Equipment, and Drugs

The gross receipts tax applies differently to medical goods depending on whether they are sold to providers for use in their practice or to patients for their personal use. When healthcare providers purchase medical supplies and equipment for use in delivering services, such as syringes, gloves, exam tables, or surgical instruments, those transactions are treated as taxable business inputs. Because the provider is the final consumer of the items in the eyes of the tax code, no resale deduction applies.

By contrast, when goods are sold directly to patients, the taxability of the product depends on the type of item and whether it is prescribed. Prescription drugs and oxygen were exempted from GRT in 1998. This exemption covers insulin, oxygen for human use, and other prescribed medications. Medical cannabis and psilocybin products were included in 2021 and 2025.

Durable medical equipment and prosthetic devices are addressed under a related statute (§ 7-9-73.3) and are deductible from GRT when they are sold pursuant to a valid prescription written by a licensed practitioner. For example, sales of wheelchairs, hospital beds, hearing aids, prosthetic limbs, and oxygen delivery systems are not subject to tax when prescribed but are when purchased without a prescription or are used as general equipment by providers in their practices.

Medicaid

Medicaid is a major healthcare payer in New Mexico and receipts from Medicaid are subject to GRT for several reasons. First, Medicaid payments represent a large and stable revenue stream, making them an important component of the tax base. Second, because Medicaid is so significantly funded by the federal government, taxing these receipts allows New Mexico to capture federal dollars and export taxes, a strategy that helps pay for state and local services with federal funding. As of 2025, the federal Medicaid match was 71.7 percent, meaning the federal government pays nearly 72 percent of the state's Medicaid bills, all of which is taxed[2].

In effect, the GRT on Medicaid is embedded in the payments the state makes to managed care organizations (MCOs) from both state and federal dollars to cover the costs of Medicaid services. The MCOs then negotiate reimbursement contracts with providers, who are responsible for remitting the tax. Because a specific, line-item reimbursement is not always given to providers from insurance reimbursements, some providers argue reimbursement levels do not adequately account for GRT, leaving them to pay without recompense.

In 2025, the Legislature passed Senate Bill 249, which restructured this system. Beginning in 2026, Medicaid payments must reimburse providers directly for the GRT liability, and payments must itemize the GRT component separately. This change ensures providers are fully reimbursed for their tax liability, though patient cost-sharing (coinsurance, deductibles, and copayments) for Medicaid-covered services remains taxable.

Key Medicare & Medicaid Terms

Medicaid
A joint federal–state program providing health coverage to low-income individuals. In New Mexico, the federal government pays about 72% of costs (the "federal match"). Medicaid pays providers through managed care organizations (MCOs), which then reimburse practitioners and hospitals.

Medicare
A federal health insurance program primarily for people age 65+ and certain younger individuals with disabilities. It is divided into several parts:

- **Medicare Part A**
  Covers inpatient hospital care, skilled nursing facilities, and some home health/hospice services. Payments primarily go to hospitals.
- **Medicare Part B**
  Covers outpatient services such as physician visits, diagnostic tests, and durable medical equipment. Payments primarily go to practitioners and clinics.
- **Medicare Part C (Medicare Advantage)**
  Private insurance plans approved by Medicare that bundle Part A and B (and often Part D drug coverage). Payments flow through private insurers under contract with the federal government.
- **Medicare Part D**
  Prescription drug coverage offered through private plans approved by Medicare.
- **Medigap (Medicare Supplement Insurance)**
  Private insurance policies that cover patient cost-sharing under Medicare Part B (such as deductibles and coinsurance). Medigap does not replace Medicare — it supplements it.

[2] "Medicaid's Federal Medical Assistance Percentage (FMAP)." Library of Congress

Medicare

Medicare receipts are treated differently depending on the program. Receipts from Medicare Part B are deductible, which include payments from the federal government to practitioners, hospices, and nursing homes. Medicare Part A receipts, which flow primarily to hospitals, are not deductible but are partially relieved through the broad 60 percent hospital deduction. Medicare Part C (Medicare Advantage) payments are deductible, aligning them with commercial insurance contract payments. Supplemental Medigap policies and any patient-paid portion of Medicare-covered services, however, are excluded and remain taxable.

By exempting Part B payments, the state avoids directly taxing federal reimbursements, which could otherwise raise constitutional concerns under the doctrine of federal immunity from state taxation. Courts have long held that states cannot single out the federal government as the sole payer of a tax. By aligning Part C payments with commercial insurance contracts, the state maintains consistency across public and private insurers. This consistency is important not only to avoid discrimination against federal programs but also to ensure compliance with federal rules, such as the Centers for Medicare & Medicaid Services' requirements that provider taxes be broad-based and uniformly applied to qualify for federal matching funds.

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

Comparison with Other States

New Mexico's broad taxation of healthcare is unusual. Most states exempt healthcare services entirely from their sales tax base. Instead, many states levy provider-specific taxes — often called "provider assessments" — on hospitals, nursing facilities, or managed care organizations. These assessments are typically used to increase federal Medicaid matching funds. According to the

Kaiser Family Foundation, 49 states and the District of Columbia impose at least one type of healthcare provider tax or fee, including New Mexico.

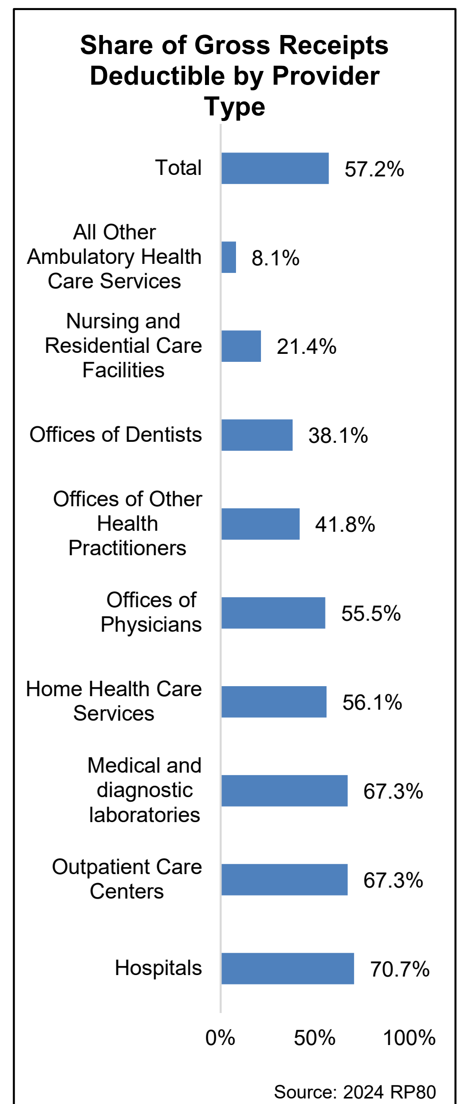
A small number of states, however, operate broad-based gross receipts or commercial activity taxes like New Mexico's. Hawaii imposes its General Excise Tax (GET) on nearly all receipts, including healthcare services, though it also offers some healthcare-specific exemptions. Washington's Business & Occupation (B&O) tax applies to gross receipts of most businesses, including healthcare, though rates vary by category. Oregon and Ohio impose commercial activity taxes that also reach healthcare services.

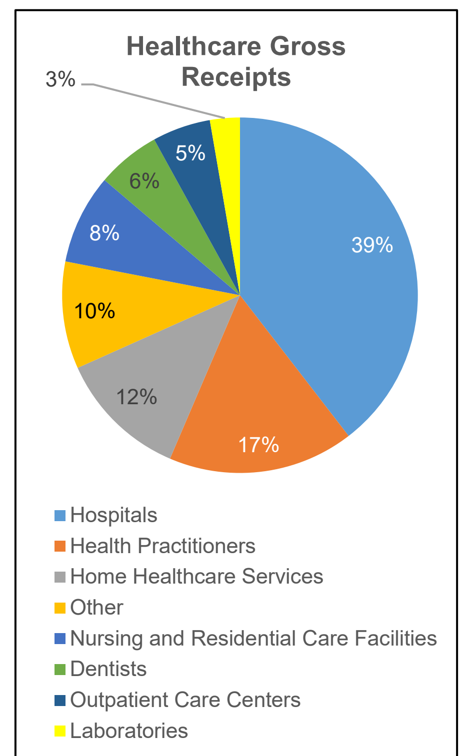
New Mexico thus belongs to a very small group of states that broadly tax healthcare receipts. Most other states avoid doing so through sales tax systems but make up revenue through targeted provider assessments to achieve the same goal. Recent federal policies have begun to limit and require a phase-down of state provider assessments to reduce federal expenses. Unlike most other states, New Mexico's GRT structure will continue to allow for significant taxation of federal dollars. However, New Mexico's provider tax created in the Healthcare Delivery and Access Act of 2024 will be phased out under recent federal policy changes, similar to many other states' provider assessments across the country.

Healthcare GRT Revenue

The state recorded nearly $10.5 billion of gross receipts spent on the healthcare sector in New Mexico in FY24[3]. Despite its significance in overall economic activity in New Mexico, healthcare represents only a modest share of New Mexico's gross receipts tax revenue due to significant exemptions, deductions, and credits. In fiscal year 2025, taxable healthcare spending represented about five percent of all taxable spending in the state, generating roughly $192 million for the general fund and $182 million for local governments.

Healthcare related GRT revenues are not evenly distributed across the state. Nearly half of all healthcare GRT comes from Bernalillo County, with Doña Ana and Santa Fe Counties following at 17.6 percent and 7.6 percent, respectively, while most other counties each contribute only about one percent. Cities show a similar pattern: Albuquerque far surpasses all other municipalities, with Las Cruces and Santa Fe capturing somewhat larger shares than their peers.

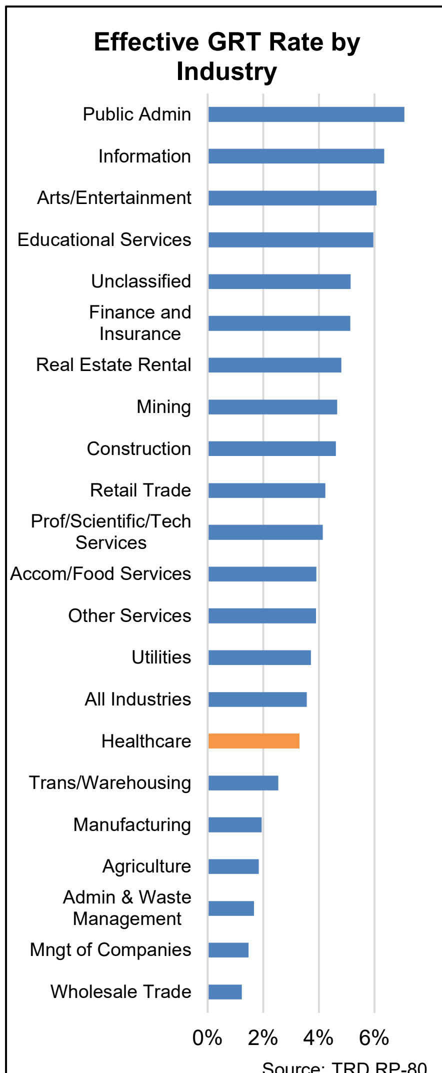




[3] TRD RP-80 Report. Gross Receipts.

When spending is measured by industry category, hospital services make up the largest share, accounting for almost 40 percent of healthcare gross receipts. Practitioner offices make up just under 17 percent, and home healthcare services represent another 11 percent. Nursing care facilities, dentist offices, and all other categories contribute smaller portions.

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%**



Despite this sizable base, much of the potential revenue never reaches state or local governments. Healthcare deductions are among the largest in the tax code with the 2024 Tax Expenditure Report identifying healthcare as the second largest category of tax expenditures, just behind citizen benefits, with deductions costing the general fund about $657 million and local governments $331 million. Altogether, between 55 and 65 percent of the healthcare tax base is deducted before tax is applied.

However, the extent of deductions varies across provider types. In 2024, hospitals deducted more than 70 percent of their receipts, while physician offices deducted just over half. Dental offices deducted about 38 percent, and non-physician practitioners deducted around 42 percent.

Overall, after deductions, the effective gross receipts tax rate on healthcare services in New Mexico is 3.25 percent, including both state and local rates. This is slightly below the statewide average effective rate of 3.56 percent. Rates vary widely by industry, from 1.23 percent in wholesale trade to 7.08 percent in public administration. Healthcare's effective rate is among the lowest, with only a handful of industries that also have significant targeted deductions showing lower effective rates.

Policy Considerations

The Legislature faces significant tradeoffs in with respect to healthcare taxation. On one hand, targeted deductions boost provider incomes and may support access to and affordability of care if they encourage more providers to practice in the state and they pass savings onto patients. On the other, deductions narrow the GRT base, erode revenue stability, and add complexity to taxpayer compliance and tax administration.

While GRT relief or simplicity may improve provider margins, tax policy alone is not yet proven to resolve physician shortages which are also influenced significantly by limited training pipelines and national competition for healthcare workers.

Furthermore, every deduction adopted in the healthcare sector has ripple effects in other parts of the economy. As the GRT base narrows, pressure builds to increase the rate in the future, shifting costs onto other businesses and consumers without special interest deductions. Policymakers must weigh the benefits of targeted relief against the simplicity of taxpayers and administrators to follow the tax code and the risks of eroding one of the state's most stable revenue sources.

Policy Options

Maintain the Status Quo. Providers continue to remit GRT on taxable receipts such as coinsurance, fee-for-service payments, and self-pay. Hospitals continue under the 60 percent deduction, and Medicaid remains taxable and directly reimbursed. This approach maintains stable revenues but leaves provider concerns unresolved.

Require Insurers to Pay GRT. New Mexico could shift liability from providers to insurers, but this would only apply to fully insured health insurance plans. Federal law under Employee Retirement Income Security Act (ERISA) prohibits the state from imposing requirements on self-funded employer plans (see sidebar). As a result, this option would be a partial fix, covering an estimated 60 percent of the private insurance market. Insurers might also respond by offsetting their liability by reducing reimbursement rates or increasing premiums.

Deduct All Insurance-Covered Receipts. The state could allow deductions for all receipts tied to insured services, including coinsurance and FFS payments when linked to insurance coverage. Linking the deduction to insurance-covered services ensures only medically necessary services are included. This would simplify compliance and eliminate tax on amounts providers cannot pass-on. However, this approach is costly to the state and local governments and could also trigger federal scrutiny for targeting federally funded services. If Medicaid remains taxable while all other insurance receipts are exempt, the Centers for Medicare & Medicaid Services may argue to classify the GRT as a "provider tax," subjecting New Mexico to strict federal rules and potentially reducing federal match or other costly reprisals.

Deduct All Healthcare Receipts. The broadest option would exempt all healthcare receipts, including elective and cash-pay services. This would fully eliminate all GRT obligations on providers but would result in the maximum revenue lost for both the state and local governments and eliminate the ability to capture federal dollars through taxation.

ERISA and Private Insurance Models

Private health coverage in the United States generally falls into two categories:

- Fully insured plans: Employers purchase coverage from an insurance company, which assumes the financial risk of paying claims. These insurers are regulated under state insurance laws and subject to state taxes and assessments.
- Self-funded (or employer-funded) plans: Employers themselves assume the financial risk for employee health claims. They may hire a third-party administrator (TPA)—often an insurance company—to process claims, but the employer ultimately pays for the care.

ERISA sets national standards for employer-sponsored benefit plans, including health coverage. ERISA contains two interlocking provisions in 29 U.S.C. § 1144:

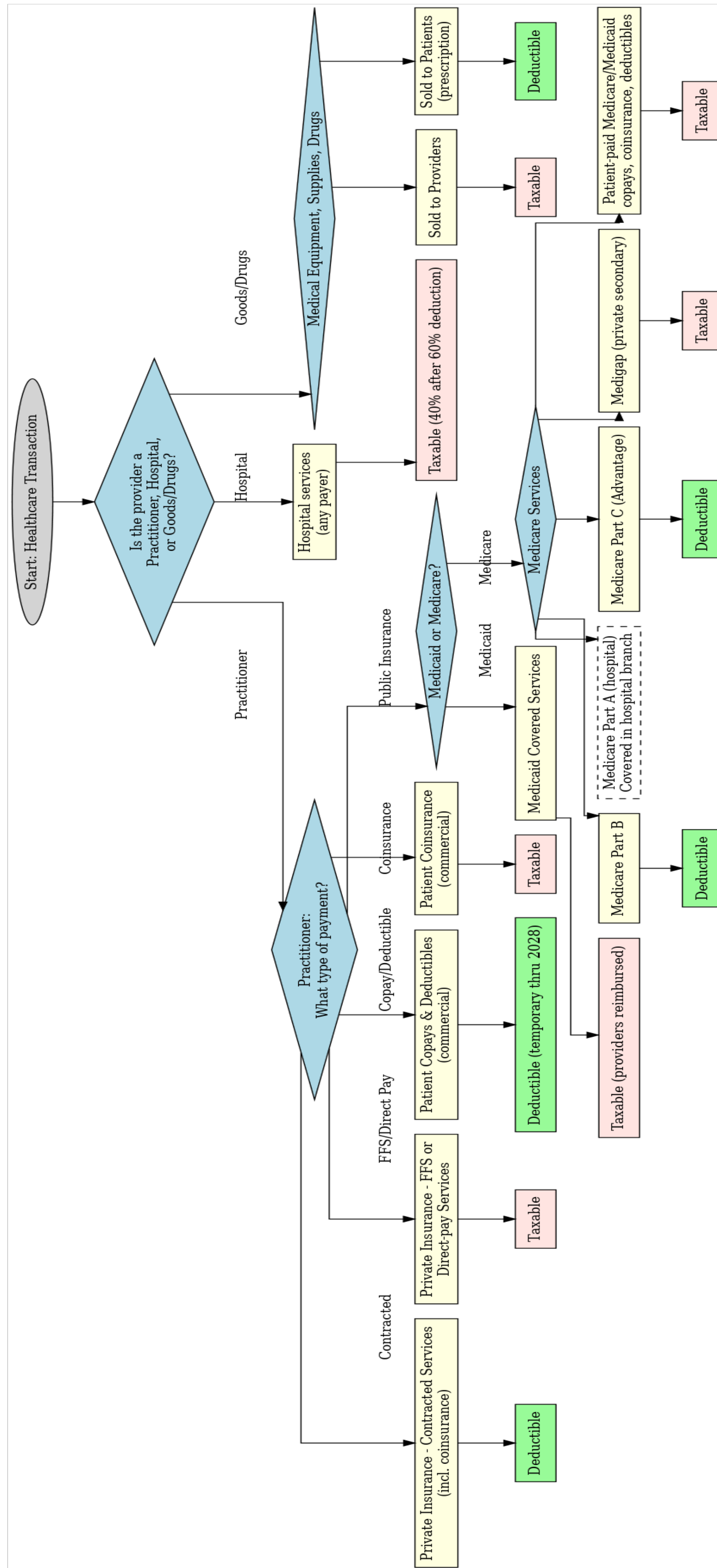
- Preemption clause: Provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." This broadly blocks state laws that affect plan design, funding, administration, or taxation.
- Deemer clause: Specifies that self-funded ERISA plans may not be "deemed" to be insurers. This prevents states from applying insurance regulations or premium taxes to self-funded employer plans.

Because of these provisions, states may tax healthcare providers directly, but they cannot require self-funded employer health plans to absorb or pass through those taxes in reimbursement rates. For example, a state could not mandate that an insurer or TPA include the GRT as part of the reimbursement paid to providers under a self-funded plan since that would interfere with the plan's funding structure and claims administration, areas protected by ERISA preemption.

In contrast, states can impose such requirements on fully insured plans, because insurers are subject to state insurance regulation.

Appendices

	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%**



Start: Healthcare Transaction
Is the provider a Practitioner, Hospital, or Goods/Drugs?
Goods/Drugs
Hospital
Practitioner
Medical Equipment, Supplies, Drugs
Sold to Patients (prescription)
Deductible
Sold to Providers
Taxable
Hospital services (any payer)
Taxable (40% after 60% deduction)
Practitioner: What type of payment?
Contracted
FFS/Direct Pay
Copay/Deductible
Coinsurance
Public Insurance
Private Insurance - Contracted Services (incl. coinsurance)
Deductible
Private Insurance - FFS or Direct-pay Services
Taxable
Patient Copays & Deductibles (commercial)
Deductible (temporary thru 2028)
Patient Coinsurance (commercial)
Taxable
Medicaid or Medicare?
Medicaid
Medicare
Medicaid Covered Services
Taxable (providers reimbursed)
Medicare Services
Medicare Part A (hospital) Covered in hospital branch
Medicare Part B
Deductible
Medicare Part C (Advantage)
Deductible
Medigap (private secondary)
Taxable
Patient-paid Medicare/Medicaid copays, coinsurance, deductibles
Taxable