State of New Mexico
LEGISLATIVE FINANCE COMMITTEE
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David Abbey
Director

MEMORANDUM

TO: Senator John Arthur Smith, Chairman
Representative Luciano "Lucky" Varela, Vice-Chairman

FROM: Charles Sallee, Deputy Director
Jack Evans, Lead Program Evaluator

RE: Status Report on the LFC evaluation, *Impact of Financing Health Care through Tax Code Policy and Local Counties*

DATE: October 21, 2011

This is a status report on our program evaluation of the impact of financing health care through tax code policy and through locally-funded programs. Today, staff will provide you with an overview of the evaluation's first objective, healthcare tax expenditures.

The second part of the study deals with earmarked revenues used to finance healthcare programs, including the County Indigent Fund, the County-Supported Medicaid Fund and the Sole Community Provider Hospital program. There is additional information required to complete this section of the evaluation. A final report on these topics will be presented to the Committee in December.

STATUS REPORT: HEALTHCARE TAX EXPENDITURES

October 21, 2011

This is a summary of LFC findings and recommendations regarding New Mexico healthcare tax preferences. It represents part of a larger study, *The Impact of Financing Health Care through Tax Code Policy and Local Counties,* which will be presented to the LFC in December 2011.

BACKGROUND

Healthcare as part of the New Mexico economy. Each year, New Mexico spends an increasingly large portion of its available revenues on the provision of healthcare. For FY12, estimated spending on healthcare will total over $4.5 billion through various state-run healthcare programs, including public employees. Expenditures for Medicaid alone are estimated to reach $3.7 billion in all funds, with county and federal funding sources, including $980 million from the general fund.

The healthcare sector is one of the fastest growing of the New Mexico economy. At this time, healthcare employment represents approximately 15 percent of the workforce and the Department of Workforce Solutions estimates that this sector will account for 24 percent of employment growth through 2019.

Table 1. Top Five NM Industries by Percent Growth 2009-2019 Projected

Industry Title	Annual Avg. Percent Change	Total Percent Change
Health Care and Social Assistance	2.17%	23.90%
Other Services (Except Government)	1.25%	13.20%
Educational Services	1.18%	12.50%
Real Estate and Rental and Leasing	1.17%	12.40%
Accommodation and Food Services	1.17%	12.30%

Source: NMDWS Economic Research and Analysis Bureau

Nationally, healthcare spending accounts for 16 percent of U.S. gross domestic product. This is the highest among all industrialized nations, and the rate of total U.S. healthcare spending has grown faster than inflation and growth in national income. This rapid growth in spending, in combination with a significant economic downturn, has strained both public and private insurance programs according to a Kaiser Family Foundation report in March 2010.

According to the U.S. Centers for Medicare and Medicaid Services (CMS), national healthcare expenditures surpassed $2.3 trillion in 2008, more than three times $714 billion spent in 1990 and over eight times the $253 billion in 1980. The Kaiser Family Foundation reports that Medicare and Medicaid account for a large share of healthcare spending, but have increased at a slower rate than private insurance. Medicare per capita spending grew 6.8 percent annually

between 1998 and 2008, versus 7.1 percent annual growth for private health insurance spending. Medicaid also grew at a slower rate than private spending, but this amount is planned to increase as more individuals become eligible. National healthcare reform is expected to be fully implemented by 2019. At that time, it is anticipated that 92 percent of U.S. residents will be covered by healthcare insurance programs, resulting in a reduction in the uninsured of 32 million people and an increase in Medicaid coverage of about 16 million people.

The federal Affordable Care Act (ACA), as it is currently envisioned, will play a significant role in the future of New Mexico's healthcare economics and service delivery. At a legislative hearing earlier this year, the HSD testified that by 2014 130 thousand to 175 thousand more New Mexicans will be eligible for Medicaid through the Affordable Care Act. Even without the impact of the ACA, the state will see a 20 percent growth in Medicaid enrollment by 2019, according to HSD.

Tax Expenditures. In addition to direct expenditures, New Mexico contributes a significant amount of revenue through healthcare tax expenditures. Tax expenditures, in the form of tax credits, deductions, exclusions, exemptions and deferrals, often play an important role in public policy goals. On the other hand, tax expenditures often have unclear goals resulting in government's inability to exactly measure their impact. Since anyone who meets the statutory eligibility requirements can take a tax credit, deduction or exemption, they function similar to entitlement spending and can only be changed through legislative action. The TRD estimated that in FY13, all of New Mexico's tax expenditures will result in over $922 million in foregone revenue.

Table 2. New Mexico Major Tax Expenditures
(in millions)

Target of Tax Expenditures	Number of Provisions	Estimated FY12 General Fund Impact
Economic Development	20	($84.6)
Poverty, Health, Education	30	($367.5)
Renewable Energy	13	($24.8)
All Other	36	($445.9)
Total	**99**	**($922.8)**

Source: LFC, TRD

There are almost twenty tax expenditures related to healthcare, and an estimated $290 million annually in foregone revenue can be attributed to these healthcare tax expenditures. These expenditures are typically intended to reinforce health policy goals such as increasing access to healthcare services, recruiting and retaining healthcare professionals, or encouraging health-related companies to do business in New Mexico. The overriding question with healthcare tax expenditures centers on whether or not New Mexico could better utilize this foregone revenue through direct appropriations, and whether sufficient accountability exists for these tax expenditures.

Table 3. New Mexico Tax Preferences for Healthcare

Statute	Adopted	Tax	Description	Foregone Revenue* (millions)
7-2-5.6	1995	PIT	Medical savings accounts exemption	$0.2
7-2-5.9; 7-2-18.13	2005	PIT	Over 65 uncompensated medical care exemption	$0.2
7-2-18.5	***2004***	***GRT***	***Medical Service Provider Deduction***	***$50.0***
7-2-18.22	***2007***	***PIT***	***Rural healthcare practitioner credit***	***$6.5***
7-2-35	2000	PIT	Uncompensated care exemption (Low Income)	$3.5
7-2-36	2005	PIT	Organ donation expense deduction	$0.1
7-9-73	1970	GRT	Prosthetic devise deduction	$1.0
7-9-73.1	1993	GRT	50% hospital receipts deduction	$20.0
7-9-73.2	1998	GRT	Prescription drugs deduction	$35.0
7-9-77.1	1998	GRT	Medicare medical services deduction	$22.0
7-9-96.1	***2007***	***GRT***	***Hospital GRT credit***	***$12.5***
7-9-16	1970	GRT	Non profit nursing home exemption	$1.0
7-9-96.2	2007	GRT	Unreimbursed service credit	$2.0
7-9-99; 100	2006	GRT	Hospital construction deduction	$0.7
7-9-111	2007	GRT	Hearing and vision aids deduction	$1.6
59A-54-10	***1978***	***Ins. Premium***	***NMMIP assessment deduction***	*****49.6***
59fA-6-6; 7-9-24	***1969***	***CIT. GRT***	***Other tax pre-emption for health and life insurers***	***$83.6***
				$289.5

* Foregone Revenue estimated for FY13

Source: LFC

** Based on 2010 actuals

The evaluation examined five New Mexico tax expenditures, based on size or potential impact of the expenditure, to determine how effective they are in meeting healthcare goals. The tax expenditures include the following:

- Rural Healthcare Practitioner Credit
- Hospital-Related GRT Tax Expenditures
- Pre-emption of all other taxes for insurance companies subject to Premiums Tax
- NMMIP Assessment Tax Deduction for Insurance Carriers
- Medical Service Provider Deduction

NEW MEXICO'S HEALTHCARE TAX EXPENDITURES ACCOUNT FOR AN ESTIMATED $290 MILLION IN FOREGONE REVENUE, BUT THEIR TRUE IMPACT IS DIFFICULT TO MEASURE

New Mexico's healthcare tax expenditures lack a clearly defined purpose, adequate reporting requirements from taxpayers, and measurable outcome analysis. There are few specified goals associated with healthcare tax expenditures. Most healthcare tax expenditures only have implied goals and are not specifically targeted. Not having a specifically targeted outcome makes it difficult to ascertain if the expenditure is effective. In addition to clearly defined goals, effective tax expenditures should have clear eligibility criteria and measures that are quantifiable. Of the five tax expenditures selected for review in this evaluation, only one had a specifically stated outcome goal, but none had ways to accurately measure the impact of the provision. However, all five clearly spelled out who is eligible to take the tax credit or deduction.

Table 4. Healthcare Tax Expenditure Scorecard

Tax Expenditure	Foregone Revenue	Clear Health Goal	Clear Eligibility Criteria	Quantifiable Goal Measurement
Rural Practitioner Tax Credit	$6.5 million	*Yes*	*Yes*	*No*
Pre-emption for Those Subject to Premium Tax	$83.6 million	*No*	*Yes*	*No*
NMMIP Assessment Deduction	$49.6 million	*Yes*	*Yes*	*No*
Deduction for Medical Service Providers	$50 million	*No*	*Yes*	*No*
Hospital Credit for GRT	$12.5 million	*No*	*Yes*	*No*

Source: LFC Analysis of FIRs, TRD data, and applicable statutes

The TRD does not systematically collect data on existing tax expenditures, instead relying on forecasting to gauge impact. Currently, neither the Combined Reporting System (CRS) forms for gross receipts taxes, nor the corporate income tax return form, ask for detailed data on which tax credits or deductions are being taken by the taxpayer. Both forms ask for total deductions only. Furthermore, both forms are only two pages in length, with minimal data reporting requirements. This lack of data forces all tax expenditure analysis to be performed on forecasted data, with zero visibility to actual impact of the expenditure. At the LFC hearing in August 2011, TRD officials explained that there is a balance between requiring more information from taxpayers, to measure program effectiveness, and the need to ensure that a tax incentive does not impose a burden on taxpayers, and thus deters participation. For example, small businesses may construe reporting requirements associated with a tax credit as red tape, and thus decide that it is not worth the trouble to participate.

New Mexico is now one of seven states without a formal review of tax expenditures. However, this could change now that the governor has charged the TRD with the responsibility to conduct a comprehensive analysis of all tax expenditures. Additional data will be required to conduct the comprehensive analysis of all tax expenditures, including return on investment analysis and a tax expenditure budget.

Foregone revenue associated with tax expenditures is reported inconsistently. The TRD points out that tax return data is unavailable for many tax provisions and most GRT deductions and exemptions are not separately stated on the return. Data is actually available only for credits affecting small numbers of taxpayers. As a result, information on healthcare tax expenditures is based largely on forecasts. The amount of projected foregone revenue may depend upon who does the forecasting and what assumptions are made. Inconsistencies in projections of foregone revenue – particularly in the NMMIP Assessment Tax Deduction for Insurance Carriers and the Deduction for Medical Service Providers were observed during this evaluation. Although minimizing the amount of information required from taxpayers reduces administrative and compliance costs, it also has further complicated the development of reliable information for sound public policy decisions.

There is a lack of information regarding the interaction of healthcare tax expenditures with other subsidies. To date, there has not been analysis conducted looking at all public healthcare funding, including tax credits and deductions, hold harmless payments, federal matching programs such as Medicaid and the Sole Community Provider Program, and county-funded programs, such as those for indigent care. Public financing of healthcare in New Mexico is a patchwork quilt of various mechanisms, whose effectiveness cannot be adequately measured due to lack of collected data, resources for analysis, and clearly defined goals for success. Without looking at the system as a whole, there is no way to determine if certain financing instruments are more effective than others in providing healthcare to New Mexicans.

It is very difficult to determine if healthcare outcomes occur because of or in spite of the tax expenditure. In completing this study, LFC was unable to independently determine the effectiveness of the selected tax expenditures due first to a lack of baseline data, and subsequently due to a lack of actual data as opposed to forecasted data. Poor data collection permeates many programs related to healthcare including tax expenditures, the HED's Loan for Service program, and other healthcare funding programs such as the Sole Community Provider Program. Without good baseline and results data, a causal relationship between the programs in question and any changes in the target population cannot be confirmed.

There is little certainty regarding the financial impact of these tax expenditures as they are open-ended. As the healthcare sector continues to grow so will the amount of foregone revenue associated with these tax expenditures. These tax expenditures act as entitlement programs that are removed from the oversight of associated with normal expenditures. There is currently little opportunity for public policymakers to exercise control over these growing expenses.

TRD officials testified in August 2011 that one alternative the state should be prepared to consider with tax expenditures versus direct spending is why the tax code would be used rather than direct spending if it is a matter of spending public money to achieve a public purpose.

While the Rural Healthcare Practitioner Tax Credit has a clear goal and is being utilized by rural healthcare providers, its true impact is elusive. The tax credit is intended to increase the recruitment and retention of rural healthcare practitioners in New Mexico. This is an important objective as both the U.S. in general, and New Mexico specifically, are facing a growing shortage of physicians and other healthcare practitioners. According to the Association of Medical Colleges, in 2008, New Mexico ranked 32nd among all states with a rate of 227 active physicians per 100 thousand of population. The national average is 254.5 physicians per 100 thousand in population. New Mexico ranks 49th nationally in per capita dentists.

This program began in 2007 and was modeled after a similar tax credit program in Oregon. Initially, the number of anticipated professionals claiming the credit was underestimated by 25 percent. When the projections were made, they did not factor in the number of healthcare practitioners who live in urban areas but practice in rural areas. The original concept also included a $3 million cap on the program, which was not included in the final version of HB 638. Hence, the state has foregone more revenue than originally anticipated.

The program provides a personal income tax credit to healthcare practitioners who provide services in rural underserved areas. The credit may be carried forward for three years if the credit exceeds tax liability. The maximum allowable credit for physicians, dentists, osteopathic physicians, clinical psychologists, podiatrists and optometrists is $5 thousand. The maximum allowable credit for dental hygienists, physician assistants, certified nurse-midwives, certified registered nurse anesthetists, certified nurse practitioners or clinical nurse specialists is $3 thousand. The DOH determines whether the practitioner's application qualifies for the credit and issues a certificate to the TRD. The credit is effective for tax years beginning with 2007.

Data collected by the New Mexico Health Policy Commission reveals a slowly growing physician population that is getting older and that is still insufficient to meet projected healthcare needs. The number of licensed physicians in New Mexico grew from 4,478 in 2007 to 4,689 in 2009 – a 4.7 percent increase. New Mexico has the distinction of ranking 4th nationally with 27.2 percent of active physicians age 60 or older, when the national average is 24.7 percent. In 2009, 47.9 percent of New Mexico licensed physicians were age 55 and over. The Health Policy Commission estimates that New Mexico is short 400 to 600 full time primary care physicians, and that the current nursing shortage of 1 thousand nurses will triple by 2015.

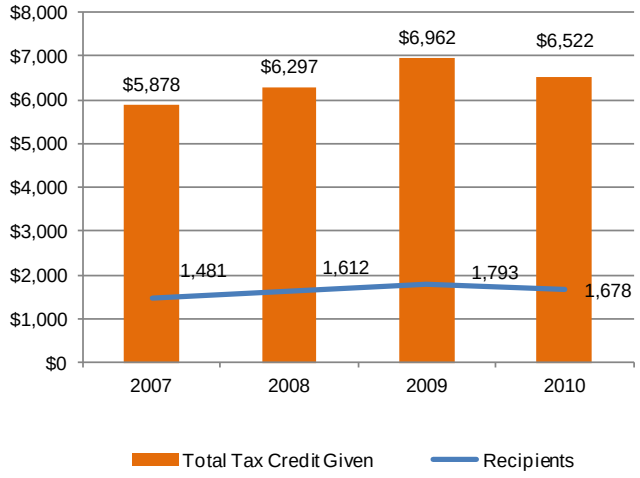
There are certain aspects to consider when looking at healthcare practitioner recruitment and retention. According to New Mexico Health Resources, on average, a current rural primary care physician earns $160 thousand to $180 thousand annually. In 2011, a new medical graduate is looking at an average starting salary of $202 thousand per year. Fifty percent of physicians remain in a particular rural location for three years, twelve percent leave within one year. Those who stay tend to do so because of loan repayment programs, although HED does not track length of stay for those in the State Loan Repayment Program.

The State Loan Repayment Program (SLP) is administered by the NMHED. Awards range from $25 thousand to a maximum of $35 thousand, depending on whether the funding source is federal or exclusively state general fund. Over 200 individuals apply each year for the SLP.

However, the number of new awards under the state program has declined in recent years because of increased debt load of eligible participants. The SLP funded about 112 applicants in the last five years with approximately 12 new awards in 2011.

The National Health Service Corps (NHSC) also has a completely federally-funded loan repayment program that awards up to $170 thousand over five-year periods. Fewer awards are expected with continued federal deficit shortfalls.

Graph 1. Rural Provider Tax Credit Program Growth
(Dollars in thousands)



Source: NM Health Resources

The Rural Healthcare Practitioner Tax Credit has a clear goal but evidence that it is achieving this goal is anecdotal. This tax expenditure's goal is the recruitment and retention of healthcare professionals in rural, underserved areas of the state. Although well liked by those taking the credit or using it to recruit or retain professionals, it remains difficult to say if it is directly accomplishing its goal other than anecdotally. For example, it's unclear that a $5 thousand tax credit would be the deciding factor in where an individual making $180 thousand per year chooses to work. The number of rural healthcare providers is growing, but New Mexico still has a troubling shortage of healthcare practitioners, a problem that will impact the implementation of national healthcare reform.

In practice, the tax credit program is better understood as a retention tool, rather than a recruitment tool. There are a number of retention incentives for healthcare providers in the form of loan repayment programs – either through the federal government or through the state. According to New Mexico Healthcare Resources, there are no incentive programs other than the tax credit program for mid-career health professionals who have little or no debt.

The tax credit program has grown much larger than originally expected and the state has seen a much larger loss of tax revenue than anticipated. As originally conceived, the program would have had a $3 million cap. This did not survive in the final legislation that passed as HB 638. Foregone revenue associated with this tax expenditure has averaged $6.3 million per year. Originally, fewer healthcare professionals were expected to take the credit since, at the time, it was not known that 25 percent of practitioners live in urban areas and work, at least part time, in

rural areas. It would be in New Mexico's interest to continue to explore if there are more effective and economical recruitment and retention tools.

An accurate count of rural practitioners is not currently available. At this time, there is no mechanism for accurately collecting information on the number of physicians practicing in rural areas – other than from the rural healthcare practitioner tax credit program. So it is difficult to compare the numbers of rural practitioners before and after the implementation of the credit in 2007. Most information regarding healthcare practitioner distribution is gathered from licensure data. As practice addresses are not verified, it is not possible to determine if a person is licensed but not practicing, o is practicing in multiple locations, in different counties, or in another state. It is also not possible to determine the number of hours an individual is working based on licensure data.

Other methods to recruit and retain healthcare professionals may be more effective. For example, the Colorado Rural Outreach Program (CROP) provides grants to recruit new healthcare professionals or retain the ones already on staff by repaying portions of the healthcare professional's educational loans, or by giving a retention bonus if all educational loans are paid off. These grants require local matching funds, equal to the proposed award amount, up to a maximum of $10 thousand, making the total possible award $20 thousand. Rural healthcare professionals who are eligible include physicians, nurse practitioners, physician assistants, nurses, providers of mental health services, providers of dental health services, allied health professionals, physical therapists and pharmacists. The same healthcare professional can be awarded up to three times, but preference is given to new applicants. CROP grants may also be used for recruitment.

Contracts with managed care organizations spell out a responsibility to comply with state access to Access to Service requirements. The MCO must demonstrate that its network is sufficient to meet the healthcare needs of enrolled members. These administrative rules spell out that there should be one primary care provider per 1.5 thousand members and that 90 percent of rural residents shall travel no farther than 45 miles, 60 miles for residents of frontier areas, to access a provider.

The DOH healthcare work group was established under the Health Care Work Force Data Collection, Analysis and Policy Act passed in 2011. This legislation directs the New Mexico Department of Health to collect and analyze data on the state's healthcare work force utilizing enhanced data collection from all healthcare licensing/regulatory boards. The bill also requires that a work group be established to explore the use of provider incentives and to develop a plan for provider recruitment and retention. In January 2011, the HPC released a study that recommended 12 areas to explore to decrease healthcare workforce shortages in the state (see **Appendix B**). These strategies include a mix of additional stipends and rural community contracts, enhanced scholarships and loan repayment programs, expanded federally subsidized graduate medical education residencies, and expansion of mid-level provider programs in medical and oral health areas.

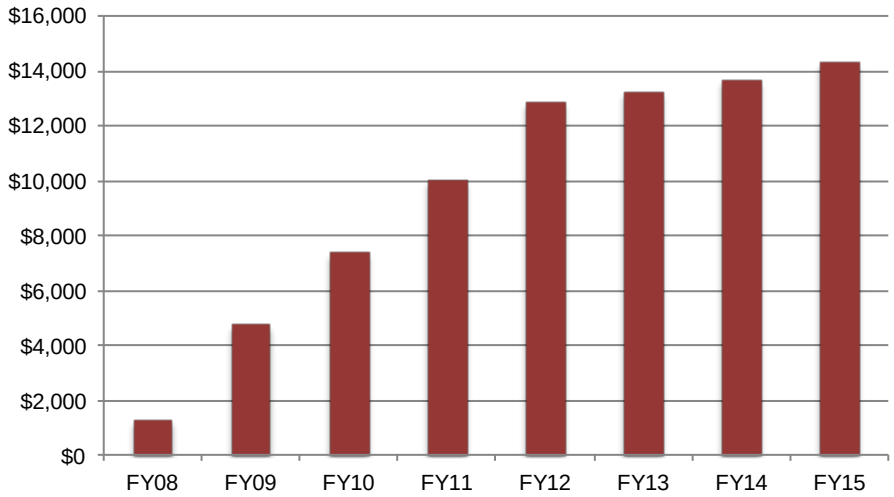
The Hospital GRT Tax Credit results in for-profit hospitals paying zero state GRT by FY12 and going forward – resulting in an estimated $12.5 million in foregone revenue growing to $14 million by FY15. A report by the Hilltop Institute of the University of Maryland, commissioned by the HSD, looked at aggregate revenues and expenses for New Mexico's hospitals for the years 2006 to 2008. The overall net profit margin of New Mexico's hospitals of 9.8 percent exceeded the net profit margins in the hospitals in four benchmark states (Arizona, Colorado, Oklahoma and Texas), as well as the national average of 2.6 percent. In 2008, New Mexico hospitals' total net revenue was $3.4 billion and net profits amounted to over $337 million.

This tax credit was apparently instituted to level the playing field for for-profit hospitals. About half of New Mexico's hospitals are for-profit. For-profit hospitals compete with nonprofit hospitals in New Mexico and hospitals in neighboring states that do not pay gross receipts tax. The New Mexico Hospital Association reported that HB 638 would remove a competitive disadvantage against New Mexico's for-profit hospitals.

New Mexico law allows for-profit hospitals to qualify for a 50 percent gross receipts tax deduction. In 2007, HB 638 effectively reduced the gross receipts tax paid by for-profit hospitals from 50 percent of the normal state rate to zero once it is fully phased-in in FY12. Specifically, HB 638 created a gross receipts tax credit that equals approximately 20 percent of the state gross receipts tax rate in FY08, 40 percent in FY09, 60 percent in FY10, 80 percent in FY11, and the entire state gross receipts tax rate in FY12 and beyond.

All of the state's for-profit hospitals are currently located within municipal areas, where the state tax rate is 3.775 percent. Therefore, the credit eliminates the state gross receipts tax paid by for-profit hospitals once it is fully phased in. The bill does not apply to local option gross receipts taxes, so for-profit hospitals will still pay a little over 1 percent local gross receipts tax. No evidence is available to suggest that reducing the GRT liability of New Mexico for-profit hospitals has resulted in reduced costs to patients or insurance plans.

Graph 2. Hospital GRT Forecasted Credit Taken
(In thousands)



Source: TRD

The pre-emption of all other taxes for insurance companies subject to the premium tax results in a large amount of foregone revenue with unclear policy goals. Under the premium tax statute, health and life insurers pay 4 percent tax on gross premiums received from their insured in lieu of paying other taxes. Premium tax and the associated pre-emption are administered by the Insurance Division of the PRC (DOI). While there is not a clearly defined purpose to this tax expenditure, it is implied that the pre-emption makes New Mexico a more attractive business environment in which insurers can operate.

The pre-emption of all other taxes for insurers created foregone GRT revenue for tax year 2010 of $83.6 million. While the premium tax is high in comparison to other states, insurers still receive a substantial benefit from paying 4 percent on premiums instead of the state GRT rate of 5.125 percent. For example, for FY10, foregone state GRT revenue for health and life insurers under the pre-emption based on gross premiums totaled $83.6 million.

New Mexico's premium tax is more competitive when compared to other state taxation policies for insurers. When comparing insurer tax burden in New Mexico to other states, looking at premium tax rates alone could paint a false picture of how competitive New Mexico's premium tax rate is. In New York, for example, insurers are subject to various taxes including corporate income tax and premium tax. While their premium tax rate is between 0.7 percent and 1.75 percent, the overall tax rate for insurers can be as high as 7.96 percent. In Maine, there is no premium tax, but insurers are subject to the corporate income tax rate, which is as high as 8.93 percent. Having a pre-emption to other taxes for insurers in New Mexico offsets the impact of having a higher premium tax. Additional state tax rates related to insurers are listed in **Appendix D**.

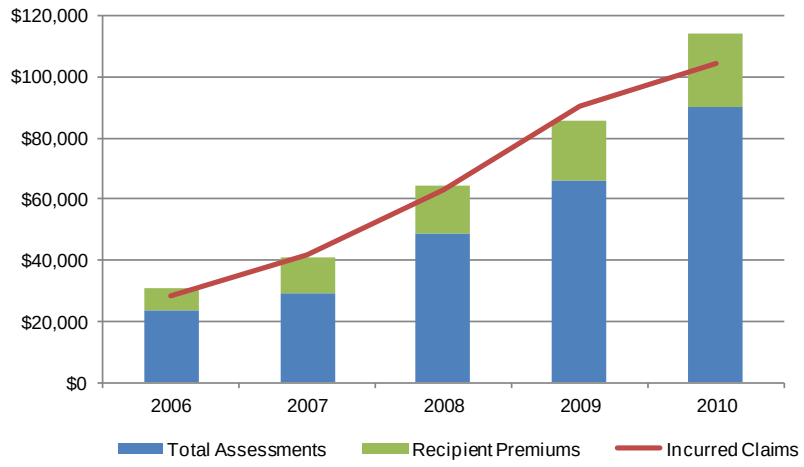
There are exclusions to the premium tax which result in large amounts of foregone revenue to the state. Under the premium tax statute, health insurers pay 4 percent tax on gross premiums received from their insured. However, administrative services only (ASO) contracts are not subject to premium tax, as they are considered service contracts under the Service Contract Regulation Act. An example of a large ASO contract is the GSD-administered plan for state employees. Under this contract, the state assumes the entire risk for healthcare claims and maintains reserves from the general fund and from employee premiums to pay claims. Under the ASO agreement, insurers provide administrative services which include processing claims, advice on plan design, and printing of benefits booklets. In FY11, the state paid $12.4 million for these services, which was not subject to premium tax, resulting in foregone tax revenue of $496 thousand.

MCOs pay premium tax for Medicaid programs, making the state a significant contributor to premium tax revenue going into the general fund. In FY10, Medicaid programs spent approximately $2.3 billion tasking MCOs to run the Salud!, CoLTS, and the Behavioral Health managed care programs. This resulted in an estimated $152 million coming back to the state general fund in premium tax revenue.

The NMMIP Assessment Tax Deduction for insurance carriers accounted for $49.6 million in foregone revenue for tax year 2010, but will no longer be needed after national healthcare reform is implemented in 2014. All health and life insurers operating within the state of New Mexico are subject to paying an assessment fee to subsidize premiums paid into the New Mexico Medical Insurance Pool (NMMIP). Any surplus assessment funds after all claims are paid are then reimbursed to insurers. The assessment is the only specifically earmarked fee, bypassing the general fund and going directly to the New Mexico Medical Insurance Pool. Therefore, health and life insurers pay the base premium tax of 3 percent, a surtax of 1 percent specific to health and life premiums only, and the NMMIP assessment. Associated with the NMMIP assessment is a premium tax deduction administered by the Insurance Division of the PRC. Insurers subject to the NMMIP assessment are able to deduct 50 percent, and in some cases 75 percent, of total assessments paid off of their premium tax obligation.

The NMMIP assessment accounted for $90 million in state revenue earmarked for a specific purpose in tax year 2010. In 2010, assessments to insurers accounted for $90.2 million, an increase of 37 percent over 2009. These funds bypass the general appropriation process and are not subject to legislative scrutiny.

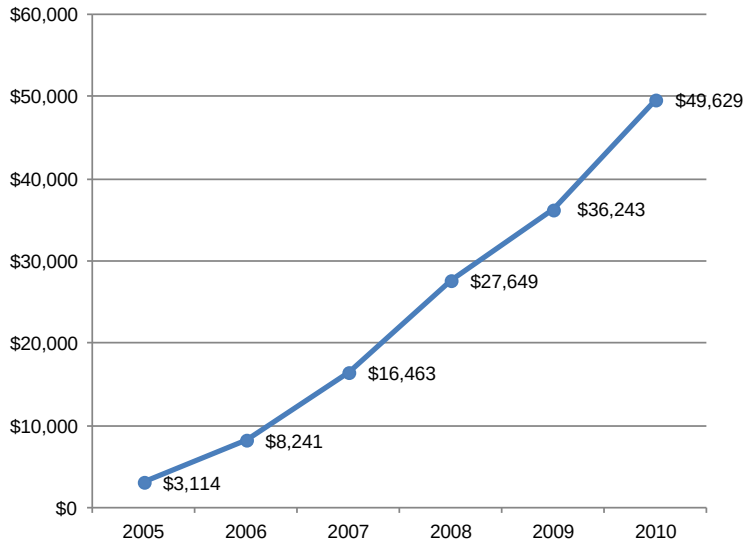
Graph 3a. NMMIP Claims and Assessments
(In thousands)



Source: Leif Associates on behalf of NMMIP/NMMIP

New Mexico Insurers' effective tax rate should be an estimated 3.5 percent once the NMMIP assessment deduction is applied, but data issues at the DOI made this unverifiable. New Mexico has the second highest premium tax rate on health insurers at 4 percent, ranking behind Tennessee, whose rate is 5.5 percent. However, insurers subject to the NMMIP assessment receive a reduction to their effective premium tax rate through a 50 percent tax deduction. For tax year 2010, health insurers operating in NM collected $2.7 billion in premiums, which would have generated $107 million at the 4 percent premium tax rate. This left a total tax liability for insurers of $52.7 million, of which DOI reported collecting $51 million. In obtaining this data, there were concerns over data integrity within the DOI database tracking premium taxes and premiums written in New Mexico. In 2005, LFC completed a report emphasizing data integrity and reporting concerns within DOI. This continues to be a significant concern in the accurate measurement of tax expenditures for taxes that fall under DOI management.

Graph 3b. NMMIP Assessment Credit Growth Rate
(In thousands)



Source: Leif Associates on behalf of NMMIP

If NMMIP is no longer required as a result of healthcare reform, both the NMMIP assessment and the corresponding deduction should be addressed statutorily. If New Mexico dissolves NMMIP and moves the members of the pool into Medicaid or a state healthcare exchange, both the assessment and the tax deduction need to be reviewed. The premium tax revenue gained by eliminating the NMMIP tax deduction could potentially bring $49 million back into the general fund based on 2010 data.

The GRT tax deduction for medical service providers, coupled with a corresponding hold harmless for local governments, represents a double impact where the state is losing revenue through a tax expenditure and a direct general fund expenditure to localities.

In 2004, HB 625 repealed the gross receipts tax for food and certain medical services, while also creating new distributions to cities and counties. The hold harmless distribution was created to offset local option GRT revenue losses due to this repeal. In reference to medical services, HB 625 states:

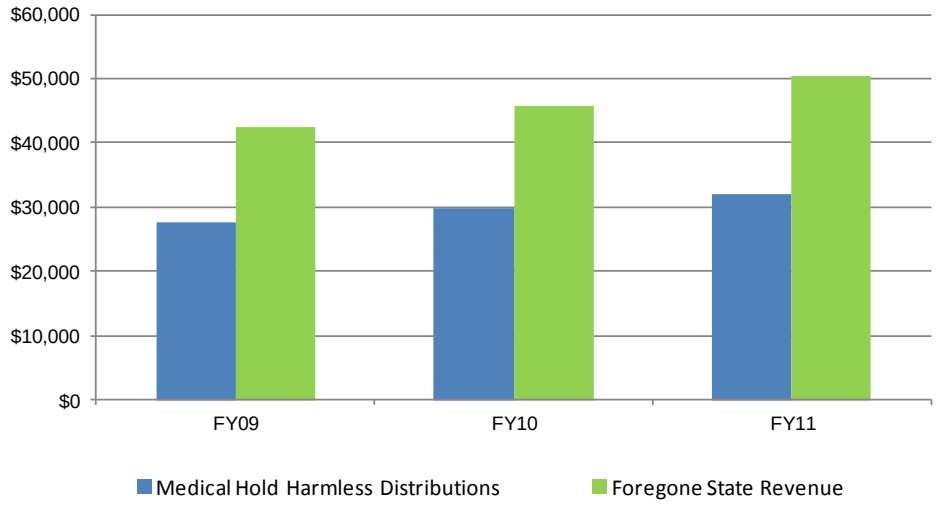
> Receipts from payments by a managed healthcare provider or healthcare insurer for commercial contract services or Medicare part C services provided by a health care practitioner… may be deducted from gross receipts.

Tax code states that this deduction, while named as being for managed care, refers to providers who receive payments from any organized plan network, including HMO and PPO plans. Therefore, virtually all medical services are exempt from GRT.

Total general fund impact for foregone GRT revenue plus hold harmless payouts to municipalities under the medical GRT repeal totaled $82 million for FY11. While counties and municipalities are receiving general fund support from the state to offset lost GRT for medical services, the state is losing the opportunity to appropriate these funds to federally matched programs which could potentially alleviate county burdens. For example, with the

plans to redesign Medicaid, the Legislature could designate these hold harmless funds to offset any associated costs for program changes.

Graph 4. Estimated State Foregone Revenue from Medical Care Deductions and Hold Harmless Payouts
(In thousands)



LFC Analysis of TRD data

The purpose of the medical service provider deduction is not clearly defined. Similar to other tax expenditures reviewed in this evaluation, the medical service provider deduction does not have a specific and measureable purpose. However, in the fiscal impact report completed by LFC, it was speculated first that eliminating the tax would increase provider take home pay, facilitating recruitment and retention of providers in New Mexico. Second, providers practicing under managed care plans would not be able to pass the tax burden on to consumers. Third, the deduction would also correct the fact that New Mexico was one of only two states in 2004 that taxed health providers' receipts under a sales or gross receipts tax, which sent a bad signal regarding the state's medical business climate.

Recommendations

The TRD should work to collect data on the financial impact of healthcare tax expenditures through a more detailed and transparent CRS form, rather than relying solely on forecasting. Options include allowing additional form sections for taxpayers to detail credits and deductions being taken, as this data should be readily available, or asking for the five largest tax expenditures to be detailed on the CRS form. This will provide fundamental data for the analysis of tax expenditures and ultimately for the development of a tax expenditure budget. It is expected that there will be tradeoffs for collecting more information. It will involve more effort on the part of taxpayers and TRD could incur additional administrative costs. These are important considerations, however, we feel that the need for additional data is paramount.

Support recommendations in the LFC staff brief on the inventory of New Mexico's tax expenditures presented to the LFC on August 19, 2011:

- TRD leads development of tax expenditure report
- New healthcare tax expenditures subject to thorough review
- Consider caps and/or sunset provisions

Support the work of the DOH in implementing SB14. Given the lack of good information on rural healthcare providers, the DOH work group should consider the following:

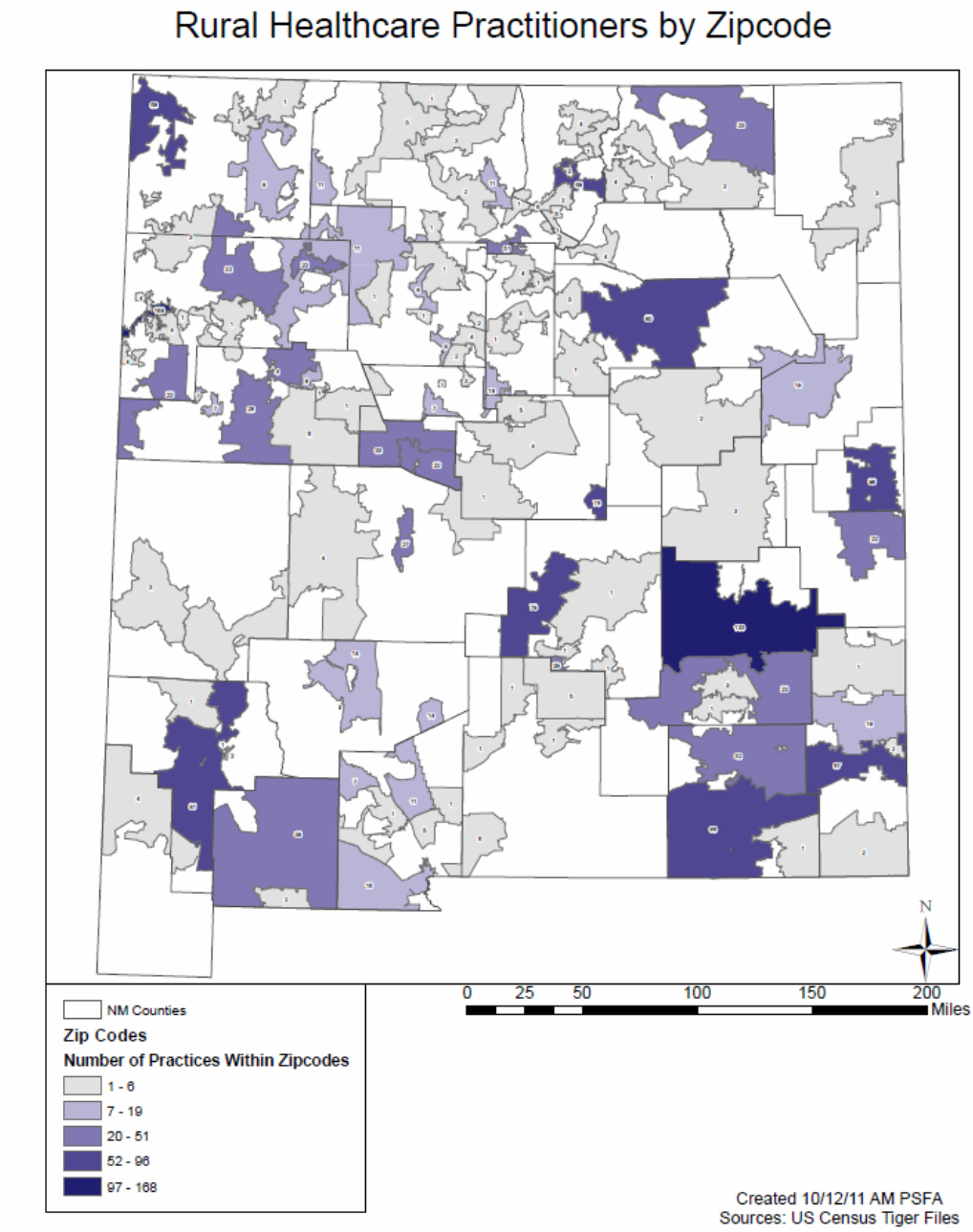
- Progressively narrow the tax credit to practices in the neediest areas of the state;
- Survey providers taking tax expenditure to validate that the Rural Healthcare Practitioner Credit indeed attracts and retains healthcare professionals in rural areas;
- Explore direct expenditure alternatives (grants, bonuses, etc.) to the Rural Healthcare Practitioner Credit;
- Look at the HPC 2011 report on ways to recruit and retain providers – cite the report and suggest following up on some of its recommendations;
- Review devices, such as incentive bonuses, to keep providers in rural areas beyond the average 3 years;
- Recommend the funding of additional rural residency programs; and
- Continue to evaluate the effectiveness of the Rural Healthcare Practitioner Credit by monitoring rural placement trends and rates of retention.

The DOH work group should make legislative recommendations no later than September 1, 2012.

At the time that the DOH workgroup makes its recommendations, the Legislature should consider capping the Healthcare Provider Tax Credit at $15 million per year.

The Legislature should work to phase out the hold harmless provision of the medical service providers deduction for GRT, and redistribute these funds to federally-matchable programs as the need for local financing of healthcare diminishes.

APPENDIX A: PROVIDERS FILING FOR RURAL PRACTITIONER TAX CREDIT BY LOCATION



APPENDIX B: HEALTH POLICY COMMISSION RECOMMENDATIONS

In its January 2011 report, Recommendations to Address New Mexico Healthcare Workforce Shortages, the New Mexico Health Policy Commission recommended twelve strategies:

1. Expand New Mexico Health Services Corps to provide additional stipends and community contracts to encourage rural practice

2. Expand the New Mexico Health Professional Loan Repayment Program

3. Expand the New Mexico Loan-for-Service Program

4. Establish a Primary Care Physician conditional tuition waiver program

5. Promote legislation to tax alcohol, tobacco or sugared soft drinks to fund healthcare loan reimbursement programs

6. Explore ways to promote a more diverse healthcare workforce

7. Expand the number of federally subsidized Graduate Medical Education residency slots

8. Support the development of mid-level oral health providers

9. Promote legislation to create 60 lottery scholarship slots for Nurse Practitioners and Physician Assistants who agree to work in NM for 3 years

10. Create a state entity to coordinate health professional workforce needs and efforts

11. Support the DOH as it implements SB14 to track the health workforce

12. Expand New Mexico mid-level provider training programs

APPENDIX C: SUMMARY OF RURAL HEALTHCARE PRACTITIONER TAX CREDITS IN OTHER STATES

Alabama Rural Physician Tax Credit:

- Physicians
- Must practice and reside in communities of less than 25,000
- Must have admission privileges to small or rural hospital with emergency room – located more than 20 miles from another acute care hospital receiving Medicare rural reimbursement
- Credit is $5,000 per year
- Credit may be claimed for not more than five consecutive years

Georgia Rural Physicians Credit:

- Physicians licensed to practice medicine in Georgia
- Physician primarily admits patients to a rural hospital
- Physician practices in fields of family practice, obstetrics and gynecology, pediatrics, internal medicine or general surgery
- Must practice and reside in rural communities
- Must have admission privileges to small or rural hospital with emergency room – located more than 20 miles from another acute care hospital receiving Medicare rural reimbursement
- Credit is $5,000 per year
- Credit may be claimed for not more than five years
- No carryover or carry-back
- The credit cannot exceed the taxpayer's income tax liability

Louisiana Tax Credit for Physicians and Dentists

- Medical Doctor or Dentist
- Medical Doctor must practice within 20 miles of a community hospital not owned predominantly by other physicians. Both the hospital and office must be located more than 20 miles from the nearest incorporated city with a population in excess of 30,000
- Medical doctor shall have relocated from outside the service area of the hospital
- Credit: reduces tax by lesser of the tax due of $5,000 per year
- Credit: may be claimed for a maximum of 5 years
- Dentist must practice within an area designated a Dental Health Professional Shortage Area
- Dentist must agree to practice for not less than 3 years. The tax reduction shall continue to be available for two additional years.
- Practitioners must accept Medicaid and Medicare payments
- Credit available for only one relocation and only for a maximum of 5 years.

Oregon's rural practitioner state income tax credit

- Credit: Up to $5,000 income tax credit
- Partial year = pro-rated credit

- Eligible MDs, DOs, DPMs, NPs, PAs and CRNAs
- Must spend 60 percent or more of their practice in an eligible area of Oregon
- Eligible MDs, Dos, DPMs:
    - On the medical staff of rural hospital not in a Metropolitan Statistical Area (MSA),
    - On the medical staff of rural hospital in an MSA but is 30 or more highway miles from the major population center in the MSA,
    - On staff of a critical access hospital or
    - Not on staff of eligible hospital but practice deemed eligible by state
- Eligible NPs and PAs:
    - Practices are 60% or more “eligible
- Eligible CRNA:
    - Employed by, or have a contractual relationship with a qualifying Critical Access Hospital
- Once a practitioner is certified, the eligibility may be renewed each year if the practice site remains in an eligible area

APPENDIX D: STATE HEALTH PREMIUM TAX RATES RANKED

Rank	State	Tax Rate	Notes
1	PA	9.99%	Corporate Income Tax Rate
2	DC	9.98%	Tax Based on Net Profits
3	ME	8.93%	Corporate Income Tax Rate
4	TN	5.50%	Premium Tax Rate
5	SC	5.00%	Corporate Income Tax Rate
5	LA	5.00%	Premium Tax Rate
7	HI	4.265%/2.75%	Premium Tax Rate
8	WV	4.00%/3.00%	Premium Tax Rate
8	**NM**	**4.00%**	Premium Tax Rate
9	NV	3.50%	Premium Tax Rate
10	MS	3.00%	Premium Tax Rate
11	MT	2.75%	Premium Tax Rate
12	AK	2.70%	Premium Tax Rate
13	SD	2.50%	Premium Tax Rate
13	AR	2.50%	Premium Tax Rate
14	CA	2.35%/0.50%	Premium Tax Rate
15	GA	2.25%	Premium Tax Rate
15	OK	2.25%	Premium Tax Rate
15	UT	2.25%	Premium Tax Rate
16	AZ	2.00%	Premium Tax Rate
16	MD	2.00%	Premium Tax Rate
16	NH	2.00%	Premium Tax Rate
16	NJ	2.00%	Premium Tax Rate
16	RI	2.00%	Premium Tax Rate
16	WA	2.00%	Premium Tax Rate
16	MA	2.00%	Premium Tax Rate
16	VT	2.00%	Premium Tax Rate
16	MN	2.00%	Premium Tax Rate
16	DE	2.00%	Premium Tax Rate
16	MO	2.00%	Premium Tax Rate
17	NC	1.90%	Premium Tax Rate
18	NY	1.75%/0.7%	Total Insurer Tax Liability is 7.96%
18	TX	1.75%	Premium Tax Rate
18	CT	1.75%	Premium Tax Rate
18	ND	1.75%	Premium Tax Rate
18	FL	1.75%	Premium Tax Rate
19	AL	1.60%	Premium Tax Rate
20	KY	1.50%	Premium Tax Rate
20	ID	1.50%	Premium Tax Rate
21	IN	1.30%	Premium Tax Rate
22	IA	1.00%	Premium Tax Rate
22	KS	1.00%	Premium Tax Rate
22	OH	1.00%	Premium Tax Rate
22	OR	1.00%	Premium Tax Rate
22	NE	1.00%/0.50%	Premium Tax Rate
23	WY	0.75%	Premium Tax Rate
24	IL	0.40%	Premium Tax Rate
25	VA	0.00%	
N/A	PR	Data Not Available	
N/A	CO	Fee Based on Premium Volume	
N/A	WI	Proportionate to Business Share	

Source: NAIC/Individual State Insurance Depts & Taxation and Revenue Depts