FISCAL IMPACT REPORT

SPONSOR Schmedes/Moores **LAST UPDATED** **ORIGINAL DATE** 3/3/23

SHORT TITLE Health Practitioner Gross Receipts **BILL NUMBER** Senate Bill 448

ANALYST Graeser

REVENUE
(dollars in thousands)

Estimated Revenue					Recurring or Nonrecurring	Fund Affected
FY23	FY24	FY25	FY26	FY27		
	Up to $10,000)	Up to $20,500)	Up to $31,500)	Up to $32,400)	Recurring	General Fund
	Up to $6,700)	Up to $13,600)	Up to $21,000)	Up to $21,600)	Recurring	Local Governments
	Up to $3,100)	Up to $5,400)	Up to $7,100)	Up to $6,100)	Recurring	General Fund - Hold Harmless distributions under 7-1-6.46 and 7-1.6.47 NMSA 1978
	Up to $3,100	Up to $5,400	Up to $7,100	Up to $6,100	Recurring	Local Governments - Hold Harmless distributions under 7-1-6.46 and 7-1.6.47 NMSA 1978

Parenthesis ( ) indicate revenue decreases.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

FY23	FY24	FY25	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
5.6			5.6	Nonrecurring	General Fund (TRD Operating)

Parenthesis ( ) indicate expenditure decreases.

Sources of Information

LFC Files

Responses Received From
Taxation and Revenue Department (TRD)
New Mexico Municipal League (NMML)
Department of Health (DOH)
Department of Human Services (HSD)

SUMMARY

Synopsis of Senate Bill 448

Senate Bill 448 expands the medical services gross receipts tax deduction (7-9-93 NMSA 1978) to add receipts from a copayment or deductible paid by a patient to a healthcare practitioner for commercial contract services provided under the health insurance. The deduction is phased-in

with 33 1/3 percent prior to July 1, 2024, 66 and 2/3 percent beginning July 1, 2024, and prior to July 1, 2025, and 100 percent beginning July 1, 2025. Licensed healthcare practitioners who can take this deduction are listed in Section 1(E)(6) as chiropractic physician, dentist or dental hygienist, doctor of oriental medicine, optometrist, osteopathic physician, physical therapist, physician or physician assistant, podiatrist, psychologist, registered midwife, registered nurse or nurse practitioner, respiratory care practitioner, speech-language pathologist or audiologist, professional clinical mental health counselor, marriage and family therapist, or professional art therapist, independent social worker, and clinical laboratory that is accredited pursuant to 42 USC Section 263a, but not in a physician's office or in a hospital.

This deduction would be separately reported and TRD would compile the data in the annual *Tax Expenditure Report*.

This bill is effective July 1, 2023.

FISCAL IMPLICATIONS

This bill creates or expands a tax expenditure with a cost that is difficult to determine but likely significant. LFC has serious concerns about the significant risk to state revenues from tax expenditures and the increase in revenue volatility from erosion of the revenue base. The committee recommends the bill adhere to the LFC tax expenditure policy principles for vetting, targeting, and reporting or action be postponed until the implications can be more fully studied. The deduction for copays and deductibles for some programs is a small step to uniform and universal deduction for all medical services, but the state should determine if there are tax policy reasons for expanding this deduction in small increments.

TRD has created an estimate for the impact of this deduction. As noted above, the impact of many gross receipts tax deductions and exemptions are difficult to analyze. The impacts of this bill contain more uncertainty than many other deductions. From TRD:

> The fiscal impact relies upon average spending in copayments and deductibles of $113 and $693, respectively. But there is high variability in copayments and deductibles depending on the type and number of visits to the doctor and whether it is an employer-sponsored or marketplace plan. For example, the number of visits to the doctor varies drastically by age group, with babies and the elderly population averaging more visits compared to children and adults. Additionally, TRD assumed that the proportion of enrollees in a health insurance plan with a deductible is 89 percent. Thus, 89 percent of the insured population was assumed to pay deductible and 11 percent the copayment. It is essential to mention that a more precise estimate of the fiscal impact would require access to data such as total spending per person in New Mexico for services that count toward the deductible and for services covered with a copay. Finally, the lost revenue estimate is based on the growth rate of the real consumer spending for healthcare produced by the firm IHS Markit and on the effective gross receipts tax rate. The fiscal impact also accounts for the impact to the hold harmless payments to municipalities and counties under Sections 7-1-6.46 and 7-1.6.47 NMSA 1978.

HSD notes that Medicaid payments will remain taxable, as will payments by the uninsured.

> There is no fiscal impact to the New Mexico Medicaid program. Copayment and deductible paid by Medicare Part C pursuant to Title 18, Medicaid (Title XIX) and the Children's Insurance Program (CHIP) (Title XXI) and fee-for-service payment are still

subject to GRT. Only receipts from a copayment or deductible paid by an insured or enrollee to a healthcare practitioner or an association of healthcare practitioners for commercial contract services pursuant to the terms of the insured's health insurance plan or enrollee's managed care health plan are deducted from gross receipts.

SIGNIFICANT ISSUES

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

Estimating the cost of tax expenditures is difficult. Confidentiality requirements surrounding certain taxpayer information create uncertainty, and analysts must frequently interpret third-party data sources. The statutory criteria for a tax expenditure may be ambiguous, further complicating the initial cost estimate of the expenditure's fiscal impact. Once a tax expenditure has been approved, information constraints continue to create challenges in tracking the real costs (and benefits) of tax expenditures.

TRD notes policy issues relating to the taxation of healthcare services:

> Rising healthcare spending is one of the most considerable fiscal challenges facing state governments and continues to be a concern for patients who cope with growing out-of-pocket costs. In 2020, employee deductibles in New Mexico were about 7.4 percent of the state's median income, representing the highest proportion in the country. This is a concern, especially if we consider that New Mexico is at the bottom of the ranking of median income. Hence, any fiscal incentive to reduce healthcare costs will positively affect health insurance consumers. However, reducing healthcare costs by constraining the main underlying drivers of healthcare costs should be a priority for state governments. Different studies have shown that low healthcare spending contributes to increasing disposable income for workers, lowering premiums and deductibles, and boosting job growth. Lower healthcare spending also affects state budgets because it results in lower health insurance spending for government employees and reduces lost tax revenue due to the deductions to ease the burden of health insurance spending.
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> The recent GRT state rate reduction to 5 percent and the additional rate drop to 4.875 percent on July 1, 2023, are aimed to benefit all taxpayers and support fewer tax incentives. While tax incentives may support particular industries or encourage specific social and economic behaviors, the proliferation of such incentives complicates the tax code. Adding more tax incentives: (1) creates special treatment and exceptions to the code, growing tax expenditures and/or narrowing the tax base, with a negative impact on the general fund; and, (2) increases the burden of compliance on both taxpayers and TRD. Adding complexity and exceptions to the tax code does not comport generally with the best tax policy.

DOH also focuses on a bigger picture:

> New Mexico had an estimated total population of 2,102,656 in 2019. This population was unevenly distributed across its 33 counties. Seven counties were classified as parts of

federal metropolitan statistical areas (MSAs) and contained about two-thirds of the total state population. It should be noted that several counties with MSAs are large in extent and contain remote census tracts that are considered rural/frontier by the federal Office of Rural Health Policy (*New Mexico Primary Care Needs Assessment*, June 7, 2021, page 2[1])

Under current healthcare reimbursement systems, communities with a large proportion of low-income residents and rural communities may not generate sufficient paying demand to assure that providers will practice in these locations (*2020-2022 New Mexico State Health Improvement Plan*, page 11[2]). The rural-to-urban migration of health professionals inevitably leaves poor, rural, and remote areas underserved and disadvantaged. Skilled health professionals are increasingly taking job opportunities in the labor market in high-income areas as the demand for their expertise rises.

Since the demands for healthcare services and providers continues to increase, providing incentives to healthcare providers who work in rural areas may help stabilize and improve healthcare services (*2020-2022 New Mexico State Health Improvement Plan*, page 12). SB448 could encourage more healthcare providers to provide services in rural areas of the state.

HSD also notes a significant issue:

Section 1(A) stated, "Receipts of a healthcare practitioner or an association of healthcare practitioners for commercial contract services or Medicare part C services paid by a managed care organization or healthcare insurer may be deducted from gross receipts if the services are within the scope of practice of the healthcare practitioner providing the service". However, only receipts from a copayment or deductible paid by an insured or enrollee to a healthcare practitioner or an association of healthcare practitioners for commercial contract services pursuant to the terms of the insured's health insurance plan or enrollee's managed care health plan are deducted from gross receipts. Copayment and deductible paid by Medicare Part C will still subject to the gross receipts tax.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is met with the bill's requirement for TRD to report annually to an interim legislative committee regarding the data compiled from the reports from taxpayers taking the deduction and other information to determine whether the deduction is meeting its purpose.

ADMINISTRATIVE IMPLICATIONS

TRD will need to make information system changes and update forms, instructions, publications. These changes will be incorporated into annual tax year implementation. This bill will have an impact on TRD's Information Technology Division of approximately one month for an estimated staff workload cost of $5,554.

[1] https://www.nmhealth.org/publication/view/general/6782/
[2] https://www.nmhealth.org/publication/view/plan/5311

POSSIBLE QUESTIONS

Does the bill meet the Legislative Finance Committee tax policy principles?

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

Does the bill meet the Legislative Finance Committee tax expenditure policy principles?

1. **Vetted**: The proposed new or expanded tax expenditure was vetted through interim legislative committees, such as LFC and the Revenue Stabilization and Tax Policy Committee, to review fiscal, legal, and general policy parameters.
2. **Targeted**: The tax expenditure has a clearly stated purpose, long-term goals, and measurable annual targets designed to mark progress toward the goals.
3. **Transparent**: The tax expenditure requires at least annual reporting by the recipients, the Taxation and Revenue Department, and other relevant agencies.
4. **Accountable**: The required reporting allows for analysis by members of the public to determine progress toward annual targets and determination of effectiveness and efficiency. The tax expenditure is set to expire unless legislative action is taken to review the tax expenditure and extend the expiration date.
5. **Effective**: The tax expenditure fulfills the stated purpose. If the tax expenditure is designed to alter behavior – for example, economic development incentives intended to increase economic growth – there are indicators the recipients would not have performed the desired actions "but for" the existence of the tax expenditure.
6. **Efficient:** The tax expenditure is the most cost-effective way to achieve the desired results.

LFC Tax Expenditure Policy Principle	Met?	Comments
Vetted	✘	The issue of taxation of medical services should be thoroughly debated in the interim.
Targeted		
Clearly stated purpose	✘	None stated.
Long-term goals	✘	
Measurable targets	✘	
Transparent	✓	
Accountable		
Public analysis	✘	
Expiration date	✓	
Effective		

Fulfills stated purpose	✘	
Passes "but for" test	✘	
Efficient	✘	
Key: ✓ Met ✘ Not Met ? Unclear		

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