FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 13

SHORT TITLE: Health Care Gross Receipts Deduction

SPONSOR: Figueroa/Steinborn/ Campos

LAST UPDATE: **ORIGINAL DATE:** 1/21/2026 **ANALYST:** Faubion

REVENUE*

(dollars in thousands)

Type	FY26	FY27	FY28	FY29	FY30	Recurring or Nonrecurring	Fund Affected
GRT	$0	($18,250.0)	($19,150.0)	($35,300.0)	($36,300.0)	Recurring	General Fund
GRT	$0	($16,100.0)	($16,850.0)	($30,800.0)	($31,650.0)	Recurring	Local Governments
Hold Harmless	$0	($5,250.0)	($4,600.0)	($7,000.0)	($5,550.0)	Recurring	General Fund
Hold Harmless	$0	$5,250.0	$4,600.0	$7,000.0	$5,550.0	Recurring	Local Governments
Net GRT	**$0**	**($23,500.0)**	**($23,750.0)**	**($42,350.0)**	**($41,850.0)**	**Recurring**	**General Fund**
Net GRT	**$0**	**($10,850.0)**	**($12,250.0)**	**($23,800.0)**	**($26,100.0)**	**Recurring**	**Local Governments**

Parentheses indicate revenue decreases.
*Amounts reflect most recent analysis of this legislation.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*

(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
TRD	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Nonrecurring	General Fund
Total	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Indeterminate but minimal	Nonrecurring	General Fund

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Sources of Information

LFC Files
Taxation and Revenue Tax Expenditure Report

Agency or Agencies Providing Analysis
Health Care Authority

Agency or Agencies That Were Asked for Analysis but did not Respond
Taxation and Revenue Department
Department of Health
NM Municipal League
NM Counties

Because of the short timeframe between the introduction of this bill and its first hearing, LFC has yet to receive analysis from some state, education, or judicial agencies. This analysis could be updated if that analysis is received.

SUMMARY

Synopsis of Senate Bill 13

Senate Bill 13 (SB13) proposes to expand the gross receipts tax (GRT) deduction for healthcare practitioners in New Mexico by including coinsurance paid by patients, in addition to the existing deduction for co-payments and deductibles paid directly by patients under their health insurance or managed care plans. A co-pay is a fixed dollar amount a patient pays for a service, while coinsurance is a percentage of the total cost. The bill also extends the sunset on the co-pay, deductible, and coinsurance GRT deduction from June 30, 2028, to June 30, 2031. The effective date of this bill is July 1, 2026.

FISCAL IMPLICATIONS

Estimating the full impact of this bill is challenging due to significant gaps in available data on both healthcare spending and taxation within private insurance and managed care plans. Without detailed, provider-level financial data, it is difficult to determine how much taxable revenue will be newly deductible and how that will affect state and local revenues. Key missing data include practice type, tax district and corresponding GRT rate, and payer distribution (i.e., the share of payments coming from Medicaid, Medicare, private coinsurance, private co-payments, and direct pay). Additionally, because healthcare spending patterns fluctuate with policy changes, patient demographics, and economic conditions, even historical data may not provide an accurate projection. Without a comprehensive dataset integrating tax filings, reimbursement rates, and healthcare expenditures, any fiscal estimate remains highly uncertain, making it difficult to assess the impact on state and local finances.

To estimate the fiscal impact of this bill to the general fund and to local governments, LFC staff relied on multiple data sources and assumptions. Baseline costs were anchored to the Taxation and Revenue Department's *Tax Expenditure Report*, using historical claims associated with the existing gross receipts tax deduction for qualifying healthcare practitioner services. To estimate the incremental impact of expanding the deduction to additional forms of patient cost-sharing and to extend the sunset on existing provisions beginning in FY29, LFC incorporated national healthcare spending data to approximate the share of total payments attributable to patient cost-sharing and then attributable to co-payments, coinsurance, and deductibles. These amounts were then grown forward using S&P's forecast for healthcare spending growth to reflect expected utilization and cost trends over the forecast period. This approach assumes claimant behavior and eligibility remain consistent with existing deduction use, adjusted only for statutory changes in scope.

To estimate the hold harmless distributions associated with this bill, LFC staff used existing gross receipts tax deduction claim data reported in the *Tax Expenditure Report* to approximate the portion of foregone revenue attributable to local governments. Because the expanded deduction reduces gross receipts tax collections for both the state and local governments, LFC applied the current statutory distribution of gross receipts tax revenues between the state general

fund and local governments to the estimated revenue loss to determine the local government impact. Estimated hold harmless payments were then calculated by allocating the local share of the revenue loss based on historical claim patterns and applying the hold harmless phase-down schedule to reflect the gradual reduction in compensation over time.

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 substantial 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.

SIGNIFICANT ISSUES

Co-payments (co-pays), coinsurance, and deductibles are all forms of patient cost-sharing, but they represent different payment structures. A co-pay is a fixed dollar amount a patient pays at the time a service is received, such as $30 for an office visit, regardless of the total cost of care. Coinsurance is a percentage of the total allowed charge that the patient is responsible for paying, typically after meeting a deductible; for example, with 20 percent coinsurance on a $1,000 service, the patient pays $200 and the insurer pays the remaining $800. A deductible is the amount a patient must pay out-of-pocket in a plan year before insurance coverage begins to apply.

Under current law for privately insured services (excluding Medicaid, Medicare, and other federal programs), the portion of the payment made by the insurance company for services provided under commercial managed care contracts (an agreement between a healthcare provider and a health insurer or managed care organization that sets negotiated payment rates and terms for services provided to enrolled patients, typically in exchange for inclusion in the insurer's provider network and adherence to cost and care-management rules) is deductible from gross receipts. In addition, patient payments in the form of co-pays and deductibles are also deductible. However, amounts paid by patients as coinsurance and payments made under fee-for-service insurance arrangements—whether paid by the insurer or the patient—remain subject to gross receipts tax. This bill would bring coinsurance payments into the existing deduction.

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.

This bill would further align New Mexico's tax treatment of healthcare services with that of most other states, where healthcare services are generally exempt from sales tax or gross-receipts–type taxes altogether. Unlike New Mexico, which broadly taxes services and then relies on targeted deductions to provide relief, most states exclude physician and other healthcare practitioner services from their tax base, reducing administrative complexity and avoiding tax costs embedded in patient care. By expanding the deduction to additional forms of patient cost-sharing that practitioners cannot control or pass through, the bill reduces out-of-pocket tax liability for providers, improves parity with out-of-state practice environments, and may modestly improve provider margins in a state that competes nationally for healthcare workforce supply.

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, medical malpractice issues, quality of life concerns, and national competition for healthcare workers (see LFC brief, Physician Survey to Address Shortages). 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.

This bill would further erode gross receipts tax revenues shared with local governments, with the largest impacts concentrated in jurisdictions with the greatest volume of healthcare activity. Because healthcare receipts are heavily concentrated in larger cities—where physician practices, specialty clinics, and consolidated provider groups are most prevalent—most of the foregone local revenue would be borne by urban municipalities and counties. LFC analysis shows healthcare GRT collections are highly centralized geographically, meaning deductions disproportionately reduce revenues for larger cities that rely more heavily on healthcare-related receipts to fund core services, while smaller jurisdictions experience more limited effects.

LFC analysis of Health Care Authority (HCA) and federal Centers for Medicare and Medicaid Services (CMS) data suggests that, of the nearly 19 thousand individual physicians practicing in the state, only about 5,000—roughly 26 percent—operate as sole proprietors. A sole proprietor is an individual who owns and operates their medical practice independently and is not employed by, or practicing through, a separate legal entity, such as a corporation, partnership, hospital system, or group practice. Because the gross receipts tax deduction applies not only to individual practitioners but also to qualifying "associations of healthcare practitioners," many physicians who practice within larger organizational structures—including physician groups, management service organizations, and private equity-backed practices—may benefit from the deduction when services are billed under managed care or commercial insurance contracts. While hospitals and health maintenance organizations are explicitly excluded, the statutory definitions allow a substantial share of care delivered through corporate or investor-owned practice models to qualify for the deduction.

Healthcare practitioners that would benefit from this bill already receive substantial gross receipts tax relief under current law. According to the LFC analysis of tax data, healthcare-related deductions and exemptions are among the largest in the tax code, costing the general fund approximately $657 million and local governments about $331 million annually, with between 55 and 65 percent of the healthcare tax base deducted before tax is applied. For offices of physicians specifically, about 55.5 percent of gross receipts are currently deducted, reflecting the long-standing deduction for commercial contract services and Medicare Part C payments enacted in 2004, as well as more recent temporary deductions for patient co-payments and deductibles. As a result, the effective gross receipts tax rate on healthcare services statewide is approximately 3.25 percent, below the statewide average. These existing provisions already significantly reduce tax liability for practitioners—particularly those operating under managed care and commercial insurance contracts—and the bill would build on this framework by further expanding deductible patient cost-sharing amounts.

Additionally, Medicaid receipts are now fully reimbursed for gross receipts tax liability following legislation enacted during the 2025 session. Beginning in FY26, Medicaid payments

must separately itemize and reimburse providers for the full amount of GRT owed on Medicaid-covered services, ensuring that practitioners are no longer required to absorb the tax within negotiated reimbursement rates. This change effectively removes Medicaid GRT as a net cost to providers, while preserving the tax base and associated state and local revenues.

This bill narrows the gross receipts tax (GRT) base. Many New Mexico tax reform efforts over the last few years have 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—when a tax is assessed on multiple steps and results in a tax on a tax —and force consumers and businesses to pay higher taxes on all other purchases without an exemption, deduction, or credit.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is met with the bill's requirement to report annually 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

The Taxation and Revenue Department (TRD) will update forms, instructions, and publications to amend this deductible.

OTHER SUBSTANTIVE ISSUES

Healthcare Practitioner Taxation History. 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 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 these payments should remain taxable because they were not subject to the same rate constraints and practitioners could pass the tax on. 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, co-payments, 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 co-payments 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.

Current Healthcare Gross Receipts Taxation

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

In assessing all tax legislation, LFC staff considers whether the proposal is aligned with committee-adopted tax policy principles. Those five principles:

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

In addition, staff reviews whether the bill meets principles specific to tax expenditures. Those policies and how this bill addresses those issues:

Tax Expenditure Policy Principle	Met?	Comments
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.	✓	This bill was discussed at the Revenue Stabilization ad Tax Policy Committee during the 2025 interim.
Targeted: The tax expenditure has a clearly stated purpose, long-term goals, and measurable annual targets designed to mark progress toward the goals. Clearly stated purpose Long-term goals Measurable targets	✗	There are no stated purposes, goals, or targets.
Transparent: The tax expenditure requires at least annual reporting by the recipients, the Taxation and Revenue Department, and other relevant agencies	✓	The deductions must be reported publicly in the TER. The deductions do have an expiration date.
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. Public analysis Expiration date	✓	
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. Fulfills stated purpose Passes "but for" test	?	There are no stated purposes, goals, or targets with which to measure effectiveness or efficiency.
Efficient: The tax expenditure is the most cost-effective way to achieve the desired results.	?	
Key: ✓ Met ✗ Not Met ? Unclear		

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