FISCAL IMPACT REPORT

BILL NUMBER: House Bill 249
SHORT TITLE: Electronic Medical Records Tax Credit

SPONSOR: Jones/Herndon

LAST UPDATE: 02/06/26 **ORIGINAL DATE:** 02/05/26 **ANALYST:** Graeser

REVENUE*
(dollars in thousands)

Type	FY26	FY27	FY28	FY29	FY30	Recurring or Nonrecurring	Fund Affected
PIT	$0	**($20,000.0) to ($33,600.0)**	**($20,000.0) to ($33,600.0)**	**($20,000.0)to ($33,600.0)**	**($20,000.0)to ($33,600.0)**	Recurring	General Fund

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
DoH	Choose an item.	$200.6	$180.6	$381.2	Recurring	**General Fund**
TRD -- ASD	Choose an item.	**$2.7**	**$0**	$2.7	Nonrecurring	**General Fund**
TRD -- ITD		**$33.2**	**$0**	$33.2	Nonrecurring	**General Fund**

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

Conflicts with House Bill 142

Sources of Information

LFC Files

Agency or Agencies Providing Analysis
Health Care Authority
Department of Health
Taxation and Revenue Department

SUMMARY

Synopsis of House Bill 249

House Bill 249 (HB249) creates the "electronic medical records income tax credit." (EMRTC). The credit is equal to the costs of adopting and using an electronic medical records system, with a limit on annual credits allowed of $6,000 per health care practitioner. Tax credits are not

refundable and cannot be carried forward. This means that for most of the health practitioners eligible for this credit and whose tax liability is less than the amount of the credit will effectively have their state income tax liability zeroed out but would not receive the full amount of the credit.

Eligible health care practitioners for the tax credit include those who employ ten or fewer people, and who provide health care for at least 1,584 hours for the taxable year. The tax credit could not exceed the amount the practitioner paid toward their electronic medical system. Eligible professionals for the Electronic Medical Records Tax Credit include Midwives, Physicians, Physician Assistants, Psychologists, Registered Nurses, Pharmacists, Licensed Clinical Social Workers, Professional Mental Health Counselors, Marriage and Family Therapists, Alcohol and Drug Abuse Counselors, Professional Art Therapists, and Physical Therapists

Health Care practitioners who claim the rural health care practitioner tax credit may not claim this credit.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, which is May 20, 2026. The provisions of the bill are applicable for tax years beginning on or after January 1, 2026. The tax credits expire for expenditures after December 31, 2030

FISCAL IMPLICATIONS

This bill creates a tax expenditure with a cost that is difficult to determine but likely significant. 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 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. 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.

The Taxation and Revenue Department has estimated the cost of this proposal:

FY26	FY27	FY28	FY29	FY30	Recurring or Non-Recurring	Fund(s) Affected
--	($33,600)	($33,600)	($33,600)	($33,600)	NR	General Fund

A health care practitioner cannot claim this credit and the rural health care practitioner tax credit (RHCPTC). Because a taxpayer cannot claim both credits, TRD assumed that taxpayers located in rural areas are assumed to have a stronger incentive to claim the RHCPTC and therefore not claim the credit proposed in this bill. Because of this assumption, TRD's methodology is based on taxpayers in non-rural areas.

To estimate the number of taxpayers in non-rural areas, TRD used data from the Bureau of Labor Statistics (BLS) Quarterly Census of Employment and Wages (QCEW) survey to find that the share of establishments with 10 or fewer employees observed across all industries is approximately 80 percent. TRD then assumes New Mexico health care

establishments with 10 or fewer health care practitioners is similar to the share of establishments with 10 or fewer employees observed across all industries. TRD estimates the number of potentially eligible establishments in urban dominated counties using establishment NAICS Code 62 (Health Care and Social Assistance) in the counties of Bernalillo, Doña Ana, Sandoval, Santa Fe, and San Juan. The data indicates that these counties have approximately 5,600 health care facilities with 10 or fewer health care practitioners.

TRD assumes that for each small health care practice of 10 or less employees, there will be one primary taxpayer who will claim the credit. TRD used the U.S. Bureau of Labor Statistics' (BLS) Occupational Employment and Wage Statistics (OEWS) to estimate the average income associated with health-care practitioner specialties listed in the bill. BLS statistics showed an annual income range from $248,350 to $400,000. The tax liability of a health practitioner with income in the low range is over the $6,000 maximum credit amount, regardless of filing status.

Thus, all eligible practitioners with a small practice would have sufficient liability in one tax year to claim the entire $6,000 credit. According to EHRinPractice[1], which aggregates industry research on electronic health records costs, practices spend on average $1,200 per year per user on their electronic medical record system, paying more per user than larger practices that benefit from economies of scale. For a typical small practice with three physicians and four support staff, annual system costs alone would reach approximately $8,400; and factoring in training, data migration, and support payments, total annual costs exceed $10 thousand. Based on the estimates, TRD assumes that the eligible practices will claim at the maximum amount, with an average of $6,000 per practice every tax year. TRD assumes the same number of eligible taxpayers every year for the fiscal impact outlook.

LFC has built a rough model to estimate the plausible scope of this tax credit.

The 2022 Economic Census produced by the U.S. Census Bureau shows the number of establishments, total annual revenue, number of employees and total annual payroll costs for various medical occupations.

2022 NAICS code	Meaning of NAICS code	Number of establishments	Revenue ($1000)	Annual payroll ($1000)	Number of employees	Average Annual Payroll	Average employees per establishment
621111	Offices of Physicians (except Mental Health Specialists)	866	$2,253,192	$877,845	10,646	$82,500	12.3
621112	Offices of Physicians, Mental Health Specialists	56	$31,171	$11,132	162	$68,700	2.9
6212	Offices of Dentists	721	$812,220	$300,633	5,745	$52,300	8
6213	Offices of other health practitioners	1,221	$716,668	$286,098	6,810	$42,000	5.6
62131	Offices of chiropractors	198	$60,629	$22,690	640	$35,500	3.2
62132	Offices of Optometrists	89	$86,257	$30,247	702	$43,100	7.9
62133	Offices of Mental Health Practitioners (except Physicians)	247	$117,487	$51,741	1,456	$35,500	5.9
62134	Offices of Physical, Occupational and Speech Therapists, and Audiologists	314	$274,035	$119,619	2,739	$43,700	8.7

[1] https://www.ehrinpractice.com/ehr-cost-and-budget-guide.html

62139	Offices of All Other Health Practitioners	373	$178,260	$61,801	1,273	$48,500	3.4
621391	Offices of Podiatrists	41	$39,483	$15,643	339	$46,100	8.3
621399	Offices of All Other Miscellaneous Health Practitioners	332	$138,777	$46,158	934	$49,400	2.8

Note that the average employees per establishment is close to or under the 10 or fewer health practitioner limit for. employee. A typical establishment has between 1.5 and 2.0 support staff per physician or other lead health practioners. The LFC model assumes one health care practitioner – usually a nurse or PA per lead practitioner (per American Medical Association recommendations) and one non-medical employee – typically receptionist, scheduler or billing clerk – per lead practitioner. This means that all establishments, on average, have 10 or fewer eligible health practitioners and will qualify as small establishments whose practitioners will all qualify.

Also, dentists, chiropractors, optometrists, speech therapists, podiatrists and audiologists do not qualify for this credit.

Practitioners claiming the rural health practitioner's income tax credit are not eligible for this electronic medical records tax credit.

TRD notes in the 2025 Tax Expenditure Report that 4,592 RHPTC claims were made for the 2024 tax year. This number was over double the 2023 claims because the "full-time" work requirements were reduced from 2,080 hours to 1,584 hours in 2024 legislation. As TRD, LFC assumes that practitioners in rural areas will continue to claim the RHCPTC rather than this proposed credit.

RHCPTC	**2023**	**2024**	**% change from prior year**
Claims	2,044	4,592	125%
Total Cost	$7,172,000	$13,964,000	95%
Average claim	$3,509	$3,041	-13%
Source: 2025 New Mexico Tax Expenditure Report			

Subtracting the RHCPTC claimants from the otherwise eligible based on size of establishment yields the following table.

# Claims per Establishment	Possible Total Qualified	Less Rural Claims	Net potential Claims	Limited to Current Tax	
7.4	6,410	3,740	2,670	$4,801,995	$6,133,324
1.7	100	60	40	$59,906	$72,427
3.5	860	500	360	$278,604	$264,195
1.2	380	220	160	$152,426	$159,732
0.3	110	60	50	$52,865	$57,656
		4,592	3,280	$5,345,796	$6,687,334

It is assumed that all claimants will qualify for the full $6,000 credit for two reasons:

1. The Affordable Care Act (ACA) encouraged adoption of electronic health records (EHRs) by reinforcing the HITECH Act's "meaningful use" incentive program, which provided Medicare and Medicaid financial incentives to providers who adopted certified EHR technology. Starting in 2015, Medicare reimbursements were reduced for eligible professionals who failed to demonstrate "meaningful use" of certified EHR technology.
2. Including initial setup costs, a typical medical practice incurs costs up to $10 thousand. Costs per provider for small practices can easily average $500 per month or 3 percent to 7 percent of collections. The most common pricing arrangement is Cloud-Based Subscription paying monthly per provider. Mid-Range costs for larger practices and hospitals are around $140 - $450+/provider/month (e.g., athenahealth, eClinicalWorks). The emphasis in this bill is on practices with 10 or fewer practitioners, so LFC suggests that the $500/month/practitioner is appropriate. $500/ month is $6,000 per year.

If all the resulting potential claimants have sufficient liability to cover the cost of the credit, the total general fund costs would exceed $20 million annually. However, the tax credits are not refundable, nor may they roll over to future tax years. There may be some claimants that have insufficient liability to exhaust the credit.

As with the TRD model, LFC used the U.S. Bureau of Labor Statistics' (BLS) Occupational Employment and Wage Statistics (OEWS) to estimate the average income associated with health-care practitioner specialties listed in the bill. BLS statistics showed an annual income range from $248,350 to $400,000. The tax liability of a health practitioner with income in the low range is over the $6,000 maximum credit amount, regardless of filing status.

The RHCPTC is $5,000 for doctors and $3,000 for other medical support staff, with a more expansive definition of eligible support staff. The biggest difference is that the RHPTC also applies to health practioners working in hospitals and other large practices, as well as pharmacists, and other allied health care professions. There may be some transition from the RHCPTC to the EMRTC. This could explain the difference between the TRD estimate and the LFC estimate.

SIGNIFICANT ISSUES

HB249 does not allow dentists to claim electronic medical records tax credit. This is a significant issue because dentists are often sole proprietors of their own small businesses in New Mexico and would otherwise be eligible for the tax credit.

HB249 excludes pharmacists, occupational therapists, speech and language pathologists and numerous other health professionals.

Most health professionals have long-since adopted electronic medical record software. The Affordable Care Act (ACA, also known as Obamacare) encouraged and was later required through reductions in Medicare and Medicaid reimbursements for eligible professionals who failed to demonstrate "meaningful use" of certified EHR technology. Currently, an overwhelming percentage of medical practitioners maintain record keeping on electronic medical records systems.

HB249 says that a health care practitioner claiming the Electronic Medical Records Tax Credit could also not claim the Rural Health Care Practitioner Tax Credit. HB142 proposes significant increases in the credits as follows.

	Current credit	**HB 142**
Physician Osteopathic physician Dentist Psychologist Podiatric physician Optometrist	$5,000 if work 1,584 hours in rural area $2,500 if work 792 hours in rural area	$10,000 if work 1,584 hours in rural area $5,000 if work 792 hours in rural areas or 1,584 in urban areas $2,500 if work 792 hours in urban area
Physician assistant	$3,000 if work 1,584 hours in rural area $1,500 if work 792 hours in rural area	$10,000 if work 1,584 hours in rural area $5,000 if work 792 hours in rural areas or 1,584 in urban areas $2,500 if work 792 hours in urban area
Midwife Registered nurse Pharmacist Clinical social worker Independent social worker Mental health counselor Clinical mental health counselor Marriage and family therapist Professional art therapist Alcohol and drug abuse counselor Dental hygienist Physical therapist	$3,000 if work 1,584 hours in rural area $1,500 if work 792 hours in rural area	$7,500 if work 1,584 in rural area $3,750 if work 792 hours in rural area $3,000 if work 1,584 hours in urban area $1,500 if work 792 hours in urban area
Emergency medical physician	No credit	$10,000 if work 1,444 hours in rural or urban $5,000 if work 720 hours in rural or urban

Department of Health (DoH) points out several policy points, perhaps relevant to the increase proposed in the RHPTC proposal of HB142, rather than for this bill. The comments follow:

> There are approximately 2.1 million New Mexicans and about 538,970 are living in rural areas (25% of New Mexicans) (2020 Decennial Census). The cost of health care, including paying for health insurance and out-of-pocket expenses, tops the list of the public's economic anxieties. Most adults (55%) say their health care costs have gone up in the past year, including at least one in five who say they have increased at a faster rate than food or utilities. A majority (56%) of the public say they expect health care costs for them and their families to become even less affordable in the coming year. (KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and the 2026 Midterms | KFF).
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> HB142 could help to improve the health of populations in rural and underserved areas by providing an incentive that could increase the number of healthcare providers in those areas.
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> Providing health care and public health services in rural areas poses challenges such as the ability to hire and maintain health care providers. Rural communities throughout the country, but especially in the West, face challenges in health care due to many factors including aging populations, closure and/or downsizing of hospitals (https://pubmed.ncbi.nlm.nih.gov/33011448/), aging out of local health providers (https://pubmed.ncbi.nlm.nih.gov/36205415/) and loss of younger people and changes

in local economies away from extractive and agricultural economies. Rural and frontier communities face transportation and isolation. These and other issues create circumstances in which every community is unique in the strength of each of the factors and which ones affect unique health care issues especially health workforce shortages:

1. Health workforce shortages: Rural areas struggle with a shortage of healthcare professionals, including doctors, nurses, and specialists. Attracting and retaining healthcare providers in rural communities can be challenging due to factors such as limited career opportunities, lower reimbursement rates, and a lack of infrastructure. (https://pubmed.ncbi.nlm.nih.gov/35760437/) The labor force participation rate shows a more robust effect on healthcare spending, morbidity, and mortality than the unemployment rate. (https://pubmed.ncbi.nlm.nih.gov/24652416/); and
2. Financial constraints: Rural communities have limited financial resources, making it challenging to invest in healthcare infrastructure, recruit healthcare professionals, and offer affordable healthcare services to residents.

Subsequent to the 2015 Medicare and Medicaid penalties for failure to adopt EMR, analysts have determined that EMR-driven efficiencies have resulted in 2 ½ year payback periods and continuing returns on investment (ROI). This tax credit fails the "but-for" test since the initial and monthly costs of EMR software would occur because they would be incurred even without this credit.

TRD notes a number of tax policy and public policy points invoked by the provisions of this bill.

New Mexico continues to face persistent healthcare workforce and provider shortages. Materials from the Legislative Finance Committee[2] note that 32 of 33 New Mexico counties have some combination of Health Professional Shortage Area (HPSA) designations, and that HPSA data is used as a guide for provider recruitment and incentive programs. A New Mexico Medical Society presentation[3] to the Legislative Health and Human Services Committee reported that since 2013, New Mexico has lost 308 primary care physicians, 37 OB-GYNs, and 20 general surgeons (among other categories). These shortages can contribute to longer wait times, reduced access, and higher pressure on remaining practitioners.

At the same time, TRD has concerns regarding the credit. The bill defines "electronic medical records system" broadly, and qualifying costs (e.g., subscription vs. implementation vs. maintenance) may require additional guidance to ensure consistent certification and auditability.

PIT represents a consistent source of revenue for many states. For New Mexico, PIT is approximately 16 percent of the state's recurring general fund revenue. While this revenue source is susceptible to economic downturns, it is also positively responsive to economic expansions. New Mexico is one of 41 states, along with the District of Columbia, that impose a broad-based PIT (New Hampshire and Washington do not tax wage and salary income). Like several states, New Mexico computes its income tax based on the federal definition of "adjusted gross income" and ties to other statues in the federal tax code. This is referred to as "conformity" to the federal tax code. The PIT

[2] https://www.nmlegis.gov/handouts/LHHS%20062525%20Item%204%20Health%20Care%20Workforce.pdf
[3] https://www.nmlegis.gov/handouts/LHHS%20071023%20Item%208%20NMMS.pdf

is an important tax policy tool that has the potential to further both horizontal equity by ensuring the same statutes apply to all taxpayers, and vertical equity, by ensuring the tax burden is based on taxpayers' ability to pay.

While tax incentives can support specific industries or promote desired social and economic behaviors, the growing number of such incentives complicates the tax code. Introducing more tax incentives has two main consequences: (1) it creates special treatment and exceptions within the code, leading to increased tax expenditures and a narrower tax base, which negatively impacts the general fund; and (2) it imposes a heavier compliance burden on both taxpayers and TRD. Increasing complexity and exceptions in the tax code is generally not in line with sound tax policy.

The proposed bill erodes horizontal equity in state income taxes. By basing the credit on a profession and their associated costs, taxpayers in similar economic circumstances are no longer treated equally. This tax credit does include a sunset date. TRD supports sunset dates for policymakers to review the impact of tax expenditures to evaluate the credit.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is met with the bill's requirement to report annually to an interim legislative committee regarding the data compiled from the reports from taxpayers taking the credit and other information to determine whether the credit is meeting its purpose. This provision is implemented in the annual tax expenditure report required by 7-1-84 NMSA1978.

ADMINISTRATIVE IMPLICATIONS

TRD reports a small to moderate administrative impact.

TRD will update forms, instructions and publications and make information system changes. Staff training to administer the credit will take place. This implementation will be included in the annual tax year changes.

For TRD's Administrative Services Division (ASD), implementing this bill will require two existing FTEs 40 hours, split between pay-band eight and 10 positions. Pay band eight hours are estimated at time and ½ due to the extra hours worked to implement this bill.

This bill will have a moderate impact on TRD's Information Technology Division (ITD), approximately 480 hours or three months and $33,220 of staff workload costs. The estimate includes an electronic data exchange between TRD and Department of Health (DOH).

HB249 proposes that DOH issue certificates of claimants' eligibility for a tax credit through verification of practitioners' self-kept records of payments toward their electronic medical records systems for the tax year.

DOH has submitted the following estimate of operating budget impact. LFC has deleted FY26 costs and moved the initial costs of 1 FTE to FY 27.

	FY 26	FY 27	FY 28	3 Year Total Cost	Recurring or Non-recurring	Fund Affected
Total		$200.6	$180.6	$381.2	Recurring	SGF

The proposed legislation does not include any appropriation for the DOH administrative support, including electronic data exchange to New Mexico Taxation and Revenue Department, for the Electronic Medical Records Tax Credit. A Full-Time Equivalent (FTE) position would be necessary. Pay Band 6 - $30.20/hr. x 2080 hours x 0.4395 = 90,424 + Office Setup $6,150 + Rent $4,000 = $100,574 (2080 hours are the standard full-time hours per year). The proposed legislation also does not include any appropriation for building an online application system, application maintenance and support, hosting and operations, and system enhancements. Initial build costs are at least $100 thousand then post launch budget (maintenance, hosting, enhancements) is estimated $65 thousand-$80 thousand per year. This is based on the Rural Health Care Practitioner Tax Credit Online Application Portal.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB142 would significantly increase the Rural Health Practitioner Tax Credit. HB249 provides that claimants for the RHPTC are not eligible for the Electronic Medical Records Tax Credit. These credits do not directly conflict, but the revenue estimate of HB249 would be rendered inaccurate if HB142 passes.

TECHNICAL ISSUES

TRD has several technical suggestions:

TRD suggests adding on page 3, line 4, “and tax year” after the word “credit” so that it reads: “providing the amount of tax credit and tax year for which the taxpayer is”, so that it is clear what tax year the credit may be applied to.

On page 3 in subsection (E), the proposal restricts the use of the credit if the taxpayer has claimed the RHCPTC but does not clarify if the restriction is for the same tax year, or if the taxpayer can never take this proposed credit if the taxpayer has ever taken the rural health care practitioner credit. TRD suggests clarifying the proposal to restrict the two credits in the same tax year by adding on page 3, line 10 after the word credit, “for the same tax year” so that it reads “practitioner tax credit for the same tax year shall not be eligible for the…”

On page 4, the bill provides a definition of “health care institution,” which is the definition used in the Uniform Health Care Decision Act. For purposes of health-based credits in the personal income tax, the credits use the term “health care facility” as “a hospital, outpatient facility diagnostic and treatment center, freestanding hospice or other similar facility at which medical care is provided.” For uniformity purposes, TRD suggests using this definition.

TRD notes that the definition of “electronic medical records system” is vague and could apply to a large range of products from Microsoft Excel to sophisticated commercial patient medical record systems. The loose definition could be used to stack different software products that a clinic may purchase or lease in one year so as to reach the

maximum amount of $6,000 per year.

OTHER SUBSTANTIVE ISSUES

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.	✘	
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	✘	No purpose stated;
Long-term goals	✘	
Measurable targets	✘	
Transparent: The tax expenditure requires at least annual reporting by the recipients, the Taxation and Revenue Department, and other relevant agencies	✓	
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.		Positive ROI without the credit
Fulfills stated purpose	✘	
Passes "but for" test	✘	
Efficient: The tax expenditure is the most cost-effective way to achieve the desired results.		EMR is not a major cost factor in a typical medical practice
Key: ✓ Met ✘ Not Met ? Unclear		

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