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FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 13

SHORT TITLE: Health Care Gross Receipts Deduction

SPONSOR: Figueroa/Steinborn/ Campos

LAST ORIGINAL
UPDATE: 1/23/2026 **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

NM Municipal League

Taxation and Revenue Department

Agency or Agencies That Were Asked for Analysis but did not Respond

Department of Health

NM Counties

SUMMARY

Synopsis of Senate Bill 13

Senate Bill 13 (SB13) proposes to expand the gross receipts tax (GRT) deduction for healthcare practitioner services in New Mexico by including coinsurance paid by patients to the existing deduction for co-payments and deductibles paid directly by patients under private health insurance or managed care plans. The bill also extends the sunset on the existing co-pay and deductible 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, copays, and deductibles. To estimate the incremental impact of expanding the deduction to coinsurance 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. As noted in the table on page one, the fiscal impact increases in FY29 as a result of the extension of the sunset for the deduction on copays and deductibles, while the impact in FY27 and FY28 only represents the inclusion of coinsurance in the existing deduction.

The existing healthcare practitioner services deduction, and therefore also this proposed expansion of that deduction, is subject to a hold harmless payment to local governments as outlined in Sections 7-1-6.46 and 7-1-6.47 NMSA 1978. These payments are calculated based on statutory formulas rather than on a dollar-for-dollar replacement of actual foregone revenue, meaning they do not fully reimburse local governments for revenue losses. Over time, the Legislature has placed these payments on a statutory phase-down schedule, gradually reducing the amount of compensation provided to cities and counties and shifting a greater share of the fiscal impact of deductions onto local governments over time.

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.

The Taxation and Revenue Department (TRD) used data from the RP80 GRT report for FY25 and retrieved taxable GRT by NAICS codes in the associated health practitioner fields to identify the proportion of taxpayers that might claim the deduction. Then, TRD used data from the Centers for Medicare & Medicaid Services (CMS) on private health expenditures in New Mexico, 1991 to 2020, to estimate the tax base. An average percentage of 30 percent on coinsurance for the patient is also applied. The fiscal impact was grown using the average annual percentage growth of private health expenditures from 1991 to 2020. The statewide effective GRT rate for health care services was applied to the forecast for the fiscal impact that includes the effects of this deduction on the distributions to municipalities, pursuant to Section 7-1-6.4 NMSA 1978, as the majority of the taxable base is in municipalities. The fiscal impact also accounts for the impact of the partial hold harmless payments to municipalities and counties per Sections 7-1-6.46 and 7-1.6.47 NMSA 1978 based on the estimated fiscal impact. The current Consensus Revenue Estimating Group's (CREG) December 2025 forecast accounts for a revenue increase from the current sunset of this deduction on July 1, 2028. The revenue impact for fiscal years 2029 and 2030 includes the loss of revenue from the sunset extension from July 1, 2028, to July 1, 2031.

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

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.

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.

The Legislature faces significant tradeoffs 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 those providers 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 to practitioners for gross receipts tax following legislation enacted during the 2025 session. Beginning in calendar year 2026, 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 cost to providers, while preserving the tax base and associated state and local revenues.

TRD notes the following policy issues:

Rising health care spending is one of the most considerable fiscal challenges facing state governments and patients who cope with growing medical costs. Hence, any fiscal incentive to reduce health care costs will positively affect health care consumers by reducing healthcare spending. Studies have shown that low health care spending by individuals contributes to increasing disposable income for workers, boosting job growth. Lower health care spending also affects state and local budgets because it results in lower health insurance spending for state and local government employees, and these deductions and the lost tax revenue will ease the governments costs of health insurance spending.

While tax incentives can support specific industries or promote desired social and economic behaviors, the growing number of such incentives complicate 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. This proposal adds additional gross receipts eligible to be deducted under Section 7-9-93 NMSA 1978 increasing complexity for taxpayers and the administration of the tax code. Increasing complexity and exceptions in the tax code is generally not in line with sound tax policy.

The National Institute of Health’s (NIH) National Center for Biotechnology Information published a study that predicts that nationwide the demand for doctors will outpace the supply so that by 2030, 34 states will have physician shortages. This shortage is more prominent for states in the South and West regions of which Mississippi and New Mexico will have the severest shortage. Their study predicts a shortage of 2,118 physicians in New Mexico by 2030 due in part to a higher percentage of physicians over 60 years of age compared to other states. It is unclear how the deductions of this bill will directly reduce patient costs and improve the present challenges the U.S. health system faces. Furthermore, diverting resources from the general fund to allow almost every payment to a healthcare practitioner to be subject to a deduction from GRT implies tradeoffs that might limit the State's capacity to invest in expanding healthcare access.

The New Mexico Municipal League raised concerns that the gross receipts tax deduction in this bill would substantially reduce local government GRT revenues, which fund more than two-thirds of municipal general fund operations and support essential services such as public safety, infrastructure, and employee compensation. The Municipal League noted that although the bill includes a sunset date in FY31, sunsets are frequently extended or repealed, creating the risk of a permanent, recurring revenue loss at a time of heightened fiscal uncertainty due to reductions in federal funding. Municipalities have limited alternative revenue options, and additional deductions may increase pressure to raise tax rates, with disproportionate impacts on lower-income residents. The Municipal League also warned that reduced revenues could negatively affect municipal debt service coverage ratios and bond ratings, increasing borrowing costs. Finally, the Municipal League questioned whether the deduction would meaningfully address provider shortages, citing LFC survey data suggesting malpractice costs and litigation, rather than tax policy, are more significant drivers of physician retention, and emphasized that strong local revenues are critical to maintaining the public safety and quality of life needed to attract and retain healthcare providers.

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 and 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.
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.	☑	The deductions do have an expiration date.

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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		

JF/hg/sgs/ct/cf