Progress Report

Program Evaluation Unit
Legislative Finance Committee
October 26, 2016

Select Healthcare Tax Expenditures

The Evaluation: The evaluation, *The Impact of Financing Health Care through Tax Code Policy and Local Counties*, (December 2011) reviewed various healthcare financing mechanisms through both direct investment and tax expenditures. The report highlighted five tax expenditures: the Rural Healthcare Practitioner Tax Credit, the Hospital Gross Receipts Tax Credit, the Pre-emption of Taxes for Those Subject to Premium Tax, the New Mexico Medical Insurance Pool Assessment Tax Deduction, and the Health Care Practitioner Gross Receipts Tax Deduction. The evaluation found these tax expenditures lack a clearly defined purpose, adequate reporting requirements from taxpayers, and measureable outcome analysis. Moreover, New Mexico was one of seven states without a formal review of tax expenditures.

AT A GLANCE

As part of a 2011 LFC evaluation of healthcare financing, staff reviewed the five largest healthcare tax expenditures. While these tax expenditures cost the state approximately $160 million in foregone revenue annually, the report found few had clearly defined goals and none had quantifiable outcome measurement. Furthermore, inconsistency in tax data collection and management makes oversight agencies including the Taxation and Revenue Department (TRD), the Department of Health (DOH), and the Office of Superintendent of Insurance (OSI) rely heavily on estimates to analyze tax expenditures, leading to inconsistent data on how these policies impact the state's revenues.

The evaluation made various recommendations to increase reporting and transparency, provide safeguards such as caps and sunset provisions, and increase evaluation around the impact of these healthcare tax policies.

In light of more New Mexicans gaining health coverage through the Affordable Care Act, which in turn has lead to significant growth in the health care industry as well as increased state obligations in paying for Medicaid, the role of healthcare tax policy takes on greater importance. To date, the health care industry benefits from favorable tax policy, while the state is unable to quantify the benefits to the state and the public of these healthcare tax expenditures, nor does the state see the benefit of the industry's growth through increased tax revenue. As the state faces a difficult revenue situation, assessing the impact and value of healthcare tax expenditures is vital.

Progress Reports foster accountability by assessing the implementation status of previous program evaluation report recommendations and need for further changes.

NEW MEXICO LEGISLATIVE FINANCE COMMITTEE

Background

There are almost twenty tax expenditures related to health care, and an estimated $290 million annually in foregone revenue can be attributed to these healthcare tax policies. Tax expenditures, in the form of tax credits, deductions, exclusions, exemptions and deferrals, often play an important role in public policy goals. In the case of health care, tax 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.

The 2011 LFC evaluation that reviewed select healthcare tax expenditures identified characteristics a tax expenditure should have to ensure effectiveness. As shown in Table 1 below, while all of the healthcare tax expenditures LFC staff analyzed meet some of these criteria, many lack a clearly stated goal and none have a clear way to measure if the tax expenditure is working. Moreover, data on many of these credits is not readily collected by the agency charged with oversight, or the agency relies on estimates as opposed to actual foregone revenue data.

Table 1. Healthcare Tax Expenditure Scorecard

Tax Expenditure	FY11 Foregone Revenue (in millions)	FY15 Foregone Revenue (in millions)	Clear Health Goal	Clear Eligibility Criteria	Quantifiable Goal Measurement
Rural Healthcare Practitioner Tax Credit	$6.4	$6.4*	Yes	Yes	No
Hospital GRT Credit	$41.1	$37.2	No	Yes	No
Pre-emption of Other Taxes for Those Subject to Premium Tax	N/A	$43.7	No	Yes	No
NMMIP Assessment Deduction	$55.0	$34.4*	Yes	Yes	No
Health Care Practitioner GRT Deduction	$38.8	$38.7	No	Yes	No

Note: Rural Healthcare Practitioner Tax Credit foregone revenue based on FY14 data, NMMIP Assessment Deduction based on CY15 data, and Pre-emption of Other Taxes based on FY15 data..

Source: 2015 NM Tax Expenditure Report and LFC Files

Using estimates to value tax expenditures can present problems in truly understanding the financial impact of foregone revenue on a state's budget. In the case of the healthcare tax expenditures reviewed in this progress report, TRD shows the Hospital GRT Deduction has decreased in the years since implementation of the Affordable Care Act. This data runs contrary to what one would expect when more New Mexicans are accessing the health care system and the industry is growing. This then raises concerns about possible underreporting of foregone revenue, whereas the data reported by TRD shows declining foregone revenue when the reality may be that use of this deduction may be increasing.

The Pew Center on the States released a brief in 2015 focusing on ways to strengthen accountability of tax expenditures such as:

- Establish a clear goal or purpose;
- Identify outcome measures that determine success;
- Develop a reasonable timeframe for analysis;
- Compare the results to other economic development strategies; and
- Identify opportunities for improvement.

Rural Healthcare Practitioner Tax Credit

The Rural Healthcare Practitioner's Tax Credit was enacted in 2007 for medical service providers working in high-need rural areas of the state. The credit is offered in two tiers: one for licensed physicians, dentists, clinical psychologists, optometrists, and podiatrists for $5 thousand and the other for nurse practitioners, dental hygienists, physicians assistants among others for $3 thousand available to be taken annually against personal income taxes. Providers wishing to leverage the credit submit an application to the Department of Health (DOH) for approval.

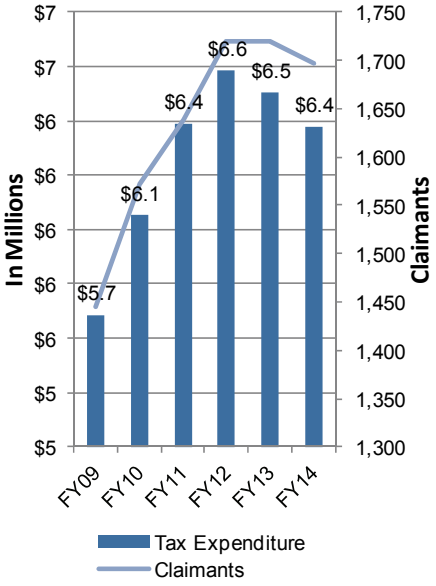
Various pieces of data are collected on the application that could be used to understand the effectiveness of this tax credit in retaining rural medical practitioners including practice address and type (clinic, hospital, etc.), how many years the taxpayer has applied for the credit, and the practitioner's specialty. However, DOH was only readily able to provide two pieces of information: the types of providers applying for the credit and the approved amount. Based on this information alone, it is extremely difficult to ascertain whether the credit is achieving its goal. While more providers applied for the credit in CY14 than in CY07, based on the data DOH readily has available, tracking individual provider behavior is possible, but not without extensive review of paper applications.

The New Mexico Health Care Workforce Committee, who is now tasked with reviewing the credit, noted in their 2014 report that collaboration between DOH, TRD (as the custodian of tax records), and perhaps other agencies would be required to analyze total impact of the Rural Healthcare Practitioner Tax Credit. The committee also highlighted workforce reporting from licensure boards through the Regulation and Licensing Department may be impacted by inadvertent exclusion of some healthcare provider specialties.

The committee noted other ways to train, support, and retain rural providers such as increasing primary care training through the state, increasing residency slots, and using the University of New Mexico Health Extension Rural Office Academic Extension Hubs as training and support for rural practitioner retention. The committee also identified all state and federal programs for recruitment and retention including loan-for-service, tuition waiver, and loan repayment programs, noting it supports the Higher Education Department's efforts to regain federal matching funds in FFY18 to bolster the state's loan repayment program.

While the Rural Healthcare Practitioner Tax Credit is well designed in that it has a specific purpose and various data are collected that could be used to analyze effectiveness, a lack of electronic record keeping impedes analysis of this credit's impact on recruiting and retaining rural health practitioners in a timely fashion.

Chart 1. Rural Healthcare Practitioner Tax Credit FY09-FY14



Source: 2014 and 2015 NM Tax Expenditure Reports

The Oregon Rural Practitioner Tax Credit:

- Up to $5,000 personal income tax credit
- Eligible providers include physicians (MDs and DOs), nurse practitioners, and physicians assistants (PAs)
- Requires an application
- Credit amount increases based on distance from populated areas of 40 thousand residents
- Applicants must serve Medicare and Medicaid patients in proportion to total number of these patients in their county of practice
- Applicants must average 20 hours per week of patient care
- Eligibility for providers employed at rural or critical access hospitals
- Includes a grandfather and sunset clause

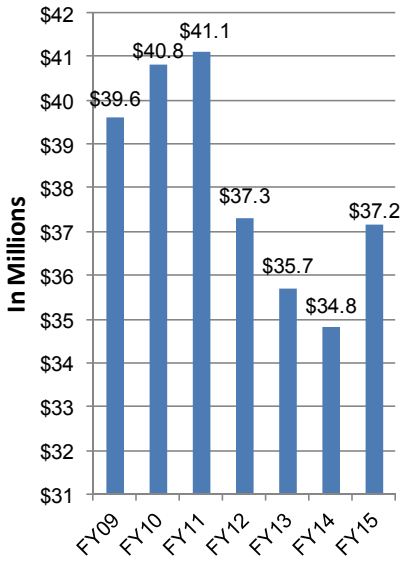
Note: Statute revisions effective January 2016.

Source: State of Oregon

Methods for recruiting and retaining rural healthcare practitioners include:

- Tuition reimbursement
- Loan for service
- Incentives and bonuses
- Rural residency programs
- Recruiting students from rural areas
- Expanding rural health clinics and FQHCs
- Medicaid funding for critical access hospitals
- Enhanced Medicaid rates
- 24-hour nurse helplines to increase rural access

Chart 2. Hospital GRT Deduction FY09-FY15



Source: 2014 and 2015 NM Tax Expenditure Reports

The 2011 LFC evaluation also recommended looking at alternatives for recruiting healthcare practitioners to rural areas such as grants, bonuses, and increased rural residency opportunities.

A 2013 NCSL brief on improving rural health mentioned all of these options and further recommended increasing the number of rural health clinics (which receive higher Medicare and Medicaid reimbursement) and creating workforce pipeline programs to recruit students from rural communities that may return to those communities to practice.

With about 40 percent of New Mexicans enrolled in Centennial Care, leveraging Medicaid funding and its approximately 3:1 federal matching dollars could present a significant opportunity to address rural practitioner shortages over the long run. In a 2000 document, the U.S. Department of Health and Human Services Health Resources and Services Administration (now the Centers for Medicare and Medicaid) outlined various ways Medicaid could be used to support rural health services. New Mexico already implements many of the suggestions for using Medicaid in rural areas including rural health clinics, federally qualified health centers, and telemedicine. Medicaid dollars also support rural hospitals through the Safety Net Care Pool. While Medicaid alone may not be able to fully support rural practitioner recruitment and retention, it could compliment other tools such as increased residency slots and loan-for-service programs.

HRSA also recommended paying rural providers more generous rates than non-rural providers to offset smaller patient volumes in rural areas. This could make rural healthcare practices more financially viable.

Hospital Gross Receipts Tax Deduction and Credit

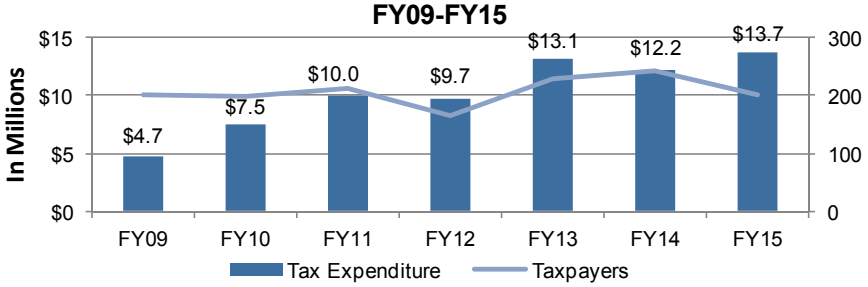
Two tax expenditures targeted specifically to hospital gross receipts exist today: a gross receipts tax deduction and a gross receipts tax credit for hospitals licensed through the Department of Health. As noted in the 2011 LFC evaluation, the apparent intent of these tax expenditures was to level the playing field between for-profit and non-profit hospitals operating in New Mexico.
The Hospital Gross Receipts Tax Deduction allows for-profit hospitals to take a 50 percent gross receipts tax deduction after all other applicable deductions are applied. Deductions reached an estimated high of $41 million in FY11, dropping 15 percent by FY14 to $35 million. However, FY15 data shows the projected foregone revenue from this deduction at $37 million, as it was in FY12. It is important to note these figures are estimates, as there is no statutory reporting requirement for this deduction. Plus, TRD's method for estimating impact of this deduction based on self-reported industry codes could be excluding taxpayers not properly categorized as hospitals.

A Hilltop Institute report found between 2006 and 2008, New Mexico hospitals' net profit margin was 9.8 percent, exceeding profit margins for comparison states and the national average of 2.6 percent.

Moreover, for-profit hospitals can take an additional credit against state gross receipts equal to 3.775 percent if located in a municipality or 5 percent if located in an unincorporated area once the credit was fully phased-in in FY12. The credit also stipulates it is to be taken after all applicable deductions.

Different than the Hospital GRT Deduction, TRD is able to quantify the amount and number of taxpayers using this credit.

Chart 3. Hospital GRT Credit FY09-FY15



Source: 2014 and 2015 NM Tax Expenditure Reports

In FY09, hospitals claimed $4.7 million in credits, growing to $9.7 million in FY12, the first year of full implementation. Foregone revenue jumped 34 percent in FY13 to $13 million, growing to almost $14 million in FY15. TRD is able to accurately analyze this credit, as it is reported separately on tax forms.

Select Tax Rates on Insurers:

NM: 3% plus 1% surtax for Health and Life

ME: 8.93%

NY: Up to 7.96%

Pre-emption of Other Taxes for Those Subject to Premium Tax

Premiums collected by insurance companies, including MCOs administering Medicaid, are subject to a 3 percent premium tax instead of the 5.125 percent state gross receipts tax. Moreover, health and life insurers are subject to a 1 percent surtax, bringing the total premium tax rate to 4 percent. Premium tax collection is overseen by the Office of Superintendent of Insurance (OSI).

Premium tax collections increased between FY13 and FY15, primarily as a result of the Affordable Care Act (ACA). Increased numbers of insured through Medicaid expansion and the health insurance exchange generated more premiums and in turn higher premium tax revenues for the state.

LFC staff have expressed concerns over data coming out of OSI's premium tax reporting system, IDEAL, for the last 12 years, first in a 2005 evaluation of what is now OSI and again advising the agency of these concerns during the 2011 evaluation discussed in this progress report.

However, the premium tax and associated pre-emption of other taxes does create foregone revenue. Only looking at gross receipts tax, the state has lost, conservatively, an estimated $94 million between FY13 and FY15 by imposing a 4 percent tax on health and life insurers instead of the 5.125 percent gross receipts tax. Even so, the 2011 LFC evaluation found New Mexico's tax policy for insurers more competitive than other states.

A special audit released by the Office of the State Auditor in September 2016 found potential significant underpayment of premium taxes totaling an estimated $198 million between 2010 and 2015 from a sample of five health insurers.

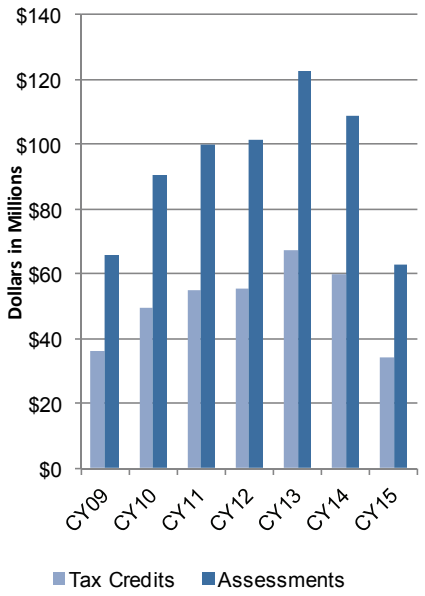
NMMIP Assessment Tax Deduction

Health and life insurers operating in New Mexico are subject to an assessment for the New Mexico Medical Insurance Pool (NMMIP). This revenue source bypasses the general fund, helping fund the payment of medical claims for NMMIP members. In conjunction with this assessment, health and life insurers can deduct 50 percent, and in some cases 75 percent, of the total assessment paid from their premium tax obligation. The 2011 LFC evaluation questioned whether NMMIP would be needed after implementation of the Affordable Care Act. This question was further addressed in a 2015 LFC evaluation on leveraging Medicaid, which recommended closure of NMMIP after transitioning all eligible clients to Medicaid.

NMMIP's client pool shrunk 61 percent and total claims dropped 46 percent from CY13 to CY15, during which time the ACA was implemented. This has reduced the need for assessments on insurers from $122 million in CY13 to $67 million in CY15. Due to this reduction in assessments, NMMIP tax deductions declined 49 percent from $67 million in CY13 to $34 million in CY15. Using CY13 as a benchmark, client pool attrition has resulted in a revenue gain to the general fund through increased premium tax collections of approximately $40 million since Medicaid expansion took effect.

The NMMIP board created a three-year plan to move all eligible clients to other insurance options including Medicaid and insurance exchange plans, retaining only the most critical enrollees. However, the board chose to delay implementation of this plan and has yet to decide when this process will begin.

Chart 4. NMMIP Assessments and Tax Credits CY09-CY15



Source: NMMIP

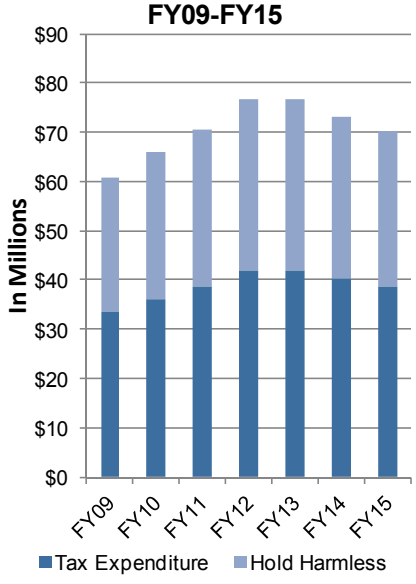
Health Care Practitioner Gross Receipts Tax Deduction and Hold Harmless

In 2004, the Legislature repealed gross receipts tax for food and medical services, also creating a hold harmless payment to local governments to offset lost revenue from local GRT on these two categories. In the specific case of medical services, the deduction applies to providers paid for services through any organized plan network, including MCOs, HMOs, and PPOs. The intent of this tax expenditure is not clearly defined in statute, but legislative analysis of the bill speculated eliminating the tax would increase provider take home pay, which could enhance recruitment and retention. Moreover, providers would not be able to pass the tax burden on to patients, increasing citizen disposable income.

The 2011 LFC evaluation found the health care practitioner GRT tax deduction and the associated hold harmless payments to local governments resulted in a double impact to the general fund through both foregone revenue and direct expenditures. Between FY09 and FY15, total impact of this tax policy was $494 million.

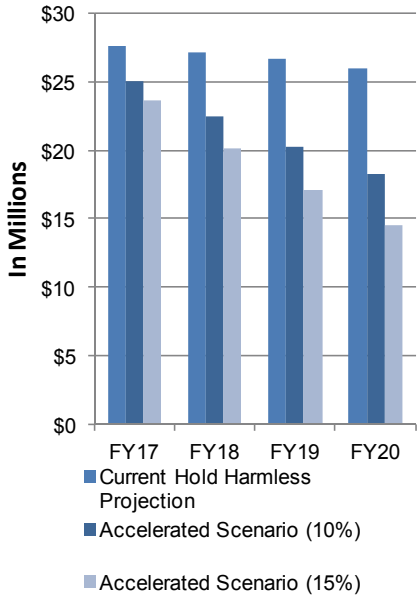
In 2013, the Legislature repealed the hold harmless payments for local governments, phasing the payments out completely in 2029.

Chart 5. Health Care Practitioner GRT Deduction and Hold Harmless FY09-FY15



Source: 2014 and 2015 NM Tax Expenditure Reports

Chart 6. Projected Medical Hold Harmless Payments FY17-FY20



Source: TRD, LFC Files

However, subsequent LFC evaluations pointed out the stepping down of hold harmless payments was not occurring as intended due to growth in factors determining the hold harmless payment outpacing annual reductions as stipulated in the repeal legislation. This could create a fiscal cliff where counties and municipalities would see a large reduction in hold harmless payments all at once as opposed to the gradual decline in revenue stipulated in statute. LFC staff recommended accelerating the pace of stepping down the payments to minimize impact on local governments. This would also retain more dollars in the general fund.

Most recently, in May 2016 the state Administrative Hearings Office (AHO) issued a ruling that could greatly impact foregone revenue from this tax deduction. A rehabilitation hospital operating in the state attempted to claim the health care practitioner deduction, and was denied by TRD based on the hospital not meeting the definition of a health care practitioner. However, AHO ruled in favor of the rehabilitation hospital stating the deduction is clearly for services provided by a healthcare practitioner, but there is no statutory restriction as to which taxpayer may use the deduction in Section 7-9-93 NMSA 1978. This ruling sets a precedent that would allow other types of hospitals and medical facilities that employ or contract with providers who meet the statutory definition of health care practitioner to take this deduction against gross receipts taxes. Without clarifying in statute who may take this deduction, the state stands to lose approximately $6 million in additional hold harmless payments. The Legislature took action to clearly define who is eligible to claim the health care practitioner tax deduction during the 2nd Special Session of the Fifty-Second Legislature and the Governor signed the bill into law.

Future Policy Implications

In completing this progress report, LFC staff identified additional issues related to some of the aforementioned healthcare tax expenditures, resulting in the following new recommendations:

The Legislature should consider the following:

Eliminate the Rural Healthcare Practitioner Tax Credit and applying the revenue to strengthening and maintaining the rural healthcare network through Medicaid;

Transfer responsibility for premium tax collection to the Taxation and Revenue Department in light of persistent operational issues first identified by LFC staff in 2005; and

Reform health care tax expenditures by eliminating the NMMIP Premium Tax Deduction while keeping NMMIP open, repeal the Hospital GRT Credit and Deduction and the Health Care Practitioner GRT Deduction, and replace them with a flat tax rate for all hospitals and providers at a rate lower than the GRT rate.

Status of Key Recommendations

Finding:
The Rural Healthcare Practitioner Tax Credit program has grown much larger than originally expected and the state has seen a much larger loss of tax revenue than anticipated.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The Legislature should consider capping the Rural Healthcare Provider Tax Credit at $15 million per year.				The Legislature has not acted on this recommendation.

Finding:
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.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The Legislature should work to phase out the hold harmless provision of the Health Care Practitioner GRT Deduction, and redistribute these funds to federally-matchable programs as the need for local financing of healthcare diminishes.				The Legislature has not acted on this recommendation.

Finding:
TRD does not systematically collect data on existing tax expenditures, instead relying on forecasting to gauge impact.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
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.				TRD states it's able to collect foregone revenue data on the Rural Healthcare Practitioner Tax Credit, the Hospital GRT credit, and the Health Care Practitioner GRT Deduction. However, TRD does not administer the NMMIP Assessment Deduction nor the Preemption of Other Taxes for Those Subject to Premium Tax. Statutory change would be required for TRD to collect data on these tax expenditures.

Finding:
It is very difficult to determine if healthcare outcomes occur because of or in spite of the tax expenditure and there is little certainty regarding the financial impact of these tax expenditures as they are open-ended.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
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.				TRD states it has implemented all of the recommendations from the 2011 LFC staff brief including leading development of a tax expenditure report which has been published annually since 2012 and reviewing proposed tax expenditure costs and benefits.

Status of Key Recommendations

Finding:
The Rural Healthcare Practitioner Tax Credit program has grown much larger than originally expected and the state has seen a much larger loss of tax revenue than anticipate and in practice, the Rural Practitioner Tax Credit program is better understood as a retention tool, rather than a recruitment tool.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider progressively narrowing the Rural Healthcare Practitioner Tax Credit to practices in the neediest areas of the state .				The New Mexico Health Care Workforce Committee recommended in their 2014 report they advised a lack of data impedes this analysis . TRD and DOH should collaborate on this instead.

Finding:
The Rural Healthcare Practitioner Tax Credit has a clear goal but evidence that it is achieving this goal is anecdotal.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider surveying providers taking the tax expenditure to validate that the Rural Healthcare Practitioner Credit indeed attracts and retains healthcare professionals in rural areas.				The New Mexico Health Care Workforce Committee advised licensure boards would most likely be in the best position to survey providers.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider continuing to evaluate the effectiveness of the Rural Healthcare Practitioner Credit by monitoring rural placement trends and rates of retention.				The New Mexico Health Care Workforce Committee has also recommended this but states they could only perform this analysis if taxpayer data were provided where individual taxpayer behavior could be identified.

Finding:
Other methods to recruit and retain healthcare professionals may be more effective.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider looking at the Health Policy Commission 2011 report on ways to recruit and retain providers – cite the report and suggest following up on some of its recommendations.				The New Mexico Health Care Workforce Committee recommended in their 2014 report that financial incentives for recruiting health care professionals should be maintained and expanded on the basis of demonstrated efficacy. NMHCWFC recommended they be funded to develop appropriate outcome measures, to collect data, and conduct analyses.

Status of Key Recommendations

Finding:
Other methods to recruit and retain healthcare professionals may be more effective.

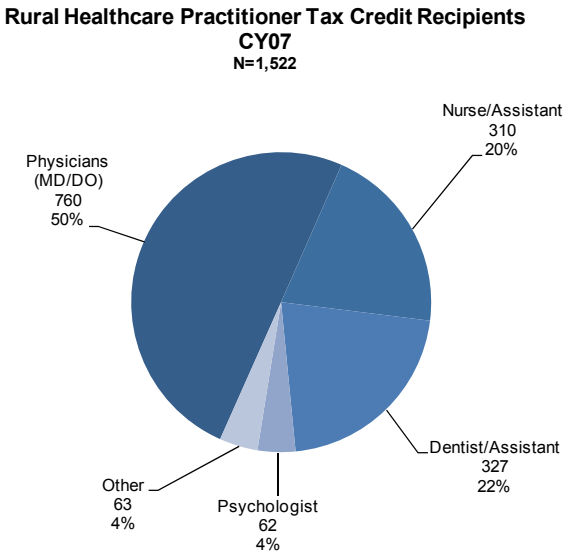
Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider exploring direct expenditure alternatives (grants, bonuses, etc.) to the Rural Healthcare Practitioner Credit.				The New Mexico Health Care Workforce responded a state agency should review other recruitment and retention tools for rural providers.

Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider reviewing devices, such as incentive bonuses, to keep providers in rural areas beyond the average three years.				The New Mexico Health Care Workforce Committee recommended extending loan repayment programs beyond three years.

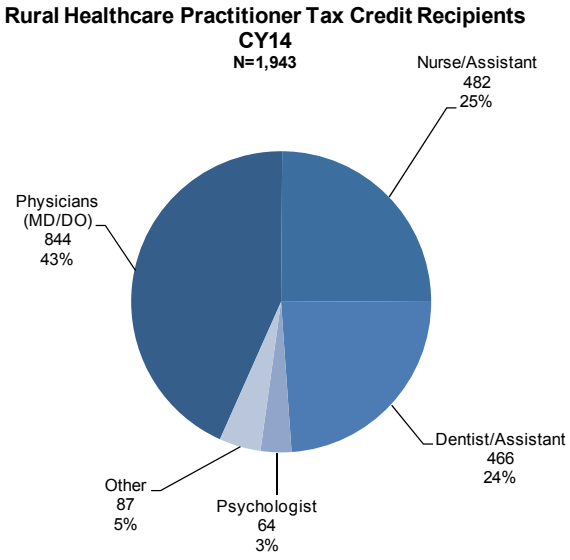
Recommendation	Status			Comments
	No Action	Progressing	Complete	
The DOH SB14 work group, now the New Mexico Health Care Workforce Committee should consider recommending the funding of additional rural residency programs.				The New Mexico Health Care Workforce Committee recommended in their 2014 report that the state should explore more options to increase the number of funded residency positions, especially for practice in rural or underserved areas, which would involve developing more primary care training locations through the state. The committee again recommended in 2016 the state explore options for increasing the number of residency positions, particularly for practice in underserved and rural areas.

Appendix A: Rural Healthcare Practitioner Tax Credit Recipients

Below is a breakout by provider category for taxpayers applying for the Rural Healthcare Practitioner Tax Credit. Total applicants went up 28 percent between CY07 and CY14, this increase was driven mostly by physicians and dental assistants.



Source: DOH



Source: DOH