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F I S C A L I M P A C T R E P O R T

SPONSOR Sandoval **ORIGINAL DATE** 02/21/13 **LAST UPDATED** **HB** 375

SHORT TITLE Expand Health Care Deductions Receipt Types **SB**

ANALYST Walker-Moran

REVENUE (dollars in thousands)

Estimated Revenue					Recurring or Nonrecurring	Fund Affected
FY13	**FY14**	**FY15**	**FY16**	**FY17**		
	($8,700.0)	($8,900.0)	($9,100.0)	($9,400.0)	Recurring	General Fund
	($7,200.0)	($7,400.0)	($7,600.0)	($7,800.0)	Recurring	Hold Harmless Distributions
	($15,900.0)	**($16,300.0)**	**($16,700.0)**	**($17,200.0)**	**Recurring**	**TOTAL**

(Parenthesis ( ) Indicate Revenue Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Taxation and Revenue Department (TRD)
Human Services Department (HSD)
Aging and Long-Term Services Department (ALTSD)
Attorney General's Office (AGO)

SUMMARY

Synopsis of Bill

House bill 375 amends section 7-9-93 NMSA 1978, gross receipt deduction for certain services provided by health care practitioner. The deduction is expanded to include: receipts from payments of copayments or deductibles by an insured or enrollee in a managed care health plan.

The purpose of the deduction is to encourage health care practitioners to locate and remain in New Mexico and to reduce the tax burden paid by health care practitioners.

The TRD shall annually report to the revenue stabilization and tax policy committee.

Four definitions are added to this section: copayment, deductible, fee-for-service, and managed care health plan.

The types of providers already included in this deduction are:

Chiropractic physician
Dentist
Dental Hygienist
Doctor of Oriental Medicine
Optometrist
Osteopathic physician
Physical therapist
Physician
Physician assistant
Podiatrist
Psychologist
Registered lay midwife
Registered Nurse or licensed practical nurse
Registered occupational therapist
Respiratory care practitioner
Speech –language pathologist or audiologist
Professional clinical mental health counselor
Independent social Worker
Clinical laboratory

The effective date of this bill is July 1, 2013. There is no sunset date. The LFC recommends adding a sunset date.

FISCAL IMPLICATIONS

This bill may be counter to the LFC tax policy principle of adequacy, efficiency and equity. Due to the increasing cost of tax expenditures revenues may be insufficient to cover growing recurring appropriations.

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

This bill will further narrow the gross receipts tax base and would move New Mexico away from the tax policy goal of a gross receipts tax with a broad equitable base and a low rate.

TRD: The data for this analysis comes from the Centers for Medicare and Medicaid Services (CMS), the Centers for Disease Control (CDC) and the Health Care Cost Institute. Co-pays, deductibles, and co-insurance accounted for about 12.1% of medical spending nationally in 2011 growing 4.6% from 2010. The impact was estimated by applying the relative size of the expenditures covered in the legislation to the size of currently deducted gross receipts, resulting in an estimated 19% increase in the health care providers' gross receipts tax deduction. That amounts to about $213 million in deductions, which would translate into about $8.7 million in reduced revenue and $7.2 million in hold harmless distributions in FY14. The impact is grown based on Global Insight's forecast Health Care CPI.

SIGNIFICANT ISSUES

As reported by HSD:
The intent of the bill seems to be to allow "co-pays" and "deductibles" charged by health care practitioners to receive the same gross receipts tax deductions that are taken on reimbursements for services from managed health care providers and insurers. Currently, the Gross Receipts tax deduction for medical services does not include Medicaid. (NMSA 7-9-93 provides a deduction for health providers and insurers for "commercial contract services" or Medicare part C services.

"Commercial contract services" is defined to exempt Medicaid -- page 3, lines 16 and 17).

If the intent of the legislation is to continue the exemption of Medicaid for this gross receipts tax deduction, the new section C of the bill should be amended. Section C (HB 375 page 2, lines 12-17) which relates to the "co-pays" and "deductibles" is broader – applying to any "managed care health plan" -- than Section B that only applies to "commercial contract services." Section C should be amended to exempt Medicaid, or the definition of "managed care health plan" (page 6, line 13) can also be amended to exempt Medicaid.

Currently, Medicaid for-profit providers receive additional payments (above the fee schedule) to cover gross receipts tax on services paid by the Medicaid Fee for Service Program. However, the majority of Medicaid payments are currently made through Medicaid managed care organizations; and beginning January 1, 2014, virtually all payments will be made through managed care organizations. Managed care organizations typically pay for-profit providers higher fees to cover gross receipts tax at negotiated amounts as part of their contracts with the providers. When the Medicaid program negotiates and establishes capitation payment amounts, the necessary amount to allow the managed care organization to appropriately reimburse providers for gross receipts tax is included in those amounts.

According to ALTSD:
As of 2012, New Mexico has 329,994 Medicare beneficiaries in which 89,270 or 27% who are enrolled in a Medicare Part C plan or as it is referred to Medicare Advantage Plan.
240,724 or 63% of Medicare beneficiaries have Original Medicare which is not the same as Medicare Private Fee-for-Service Plan.

A Medicare Private Fee-for-Service Plan is a Medicare Advantage Plan offered by a private insurance company. In a Medicare Private Fee-for-Service Plan, Medicare pays a set amount of money every month to the private insurance company to provide health care coverage to people with Medicare on a fee-for-service arrangement. Also, the insurance company, rather than the Medicare Program, decides how much the beneficiary will pay for the services they receive.

HB 375 does not mention if Original Medicare receipts will be included in the deductible.

The definition of fee-for-service in HB375 is not the same as Medicare fee for service definition. A Medicare Private Fee-for-Service Plan is a Medicare Advantage Plan offered by a private insurance company which is the same as the bill refers to Medicare Part C.

PERFORMANCE IMPLICATIONS

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

ADMINISTRATIVE IMPLICATIONS

As reported by TRD:
This bill adds a new section to expand the medical gross receipts deduction under Section 7-9-93. It requests that taxpayers report each deduction provided by this new section separately and

TRD present an annual report on the amount of deductions and number of taxpayers claiming the deductions and other information.

Providing a separate schedule by changing CRS-1 Form to track this medical deduction will be the most efficient way in terms of cost and functionality. It will involve changes to CRS return documents (GenTax), EDCR, CRSNET and data extracting process. Total hours: 700 Hours.

Adding a new rate type for tracking medical deductions is more complicated than for regular gross receipts deductions, because medical deductions involve distributions to local government with special distribution rules. This would require significant changes in more places across the system, add difficulties in system maintenance at a cost of 1500 hours.

Currently, taxpayers are having difficulty getting the appropriate deduction on the correct line of the CRS-1 Form for the medical deduction under Section 7-9-93 since there are other sections in the act that provide medical deductions: Section 7-9-77.1 and Section 7-9-73 and Section 7-9-73.2. To add another deduction that has to be accounted for separately will add an even greater reporting burden on the industry.

TRD will not be able to implement the GenTax modifications necessary to record and claim the tax deduction until at least October 1, 2013, after the effective date of the legislation.

TECHNICAL ISSUES

AGO points out a signification legal issue: We understand the word "insured," as used in the new subsection (C), to include those insured under an indemnity insurance plan. If so, we suggest a clarification below.

AGO points out drafting errors:
1. The word "deducible" on line 20 of page one should be "deductible."
2. Lines 23-25 on page 3 and line 1 on page 4 appear to require clarification to comport with intent, as we understand it. Perhaps it should read: "(3) 'deductible,' for purposes of subsection C, means the amount of covered charges an insured or enrollee is required to pay in a plan year before the insured's indemnity insurance plan or enrollee's managed care health plan begins to pay for applicable covered charges."

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

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

EWM/blm