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

SPONSOR Ortiz y Pino **ORIGINAL DATE** 2/21/17 **LAST UPDATED** 2/25/17 **HB**

SHORT TITLE Health Care Tax Exemptions & Medicaid Fund **SB** 448

ANALYST Graeser

APPROPRIATION (dollars in thousands)

Appropriation					R or NR	Fund Affected
FY17	FY18	FY19	FY20	FY21		
	Up To $53,300.0	Up to $55,800.0	Up to $58,400.0	Up to $61,000.0	R	Medicaid Trust Fund

Parenthesis ( ) indicate expenditure decreases. ** R = recurring; NR = non-recurring

REVENUE (dollars in thousands)

Estimated Revenue					R or NR **	Fund Affected
FY17	FY18	FY19	FY20	FY21		
	$53,300.0	$55,800.0	$58,400.0	$61,000.0	R	Medicaid Trust Fund
	$160,900.0	$164,000.0	$167,600.0	$172,800.0	R	General Fund
	$141,800.0	$144,000.0	$144,000.0	$145,900.0	R	Local Government

Parenthesis ( ) indicate expenditure decreases. ** R = recurring; NR = non-recurring

TRD will report high impact for implementing the provisions of this bill. It is not as complex as some of the bills introduced this session so may not involve contract programmers or a supplemental appropriation.

Duplicates, Relates to, Conflicts with, Companion to: HB-202, HB 412, SB-123, SB-433, SB-448, SB 457 relate in some fashion to GRT taxes on hospitals and other healthcare practitioners

SOURCES OF INFORMATION

LFC Files

No Responses Received

SUMMARY

Synopsis of Bill

Senate Bill 448 imposes the Regular gross receipts tax, including the local option gross receipts tax on not-for-profit hospitals. A purpose of the bill is also to impose the government gross receipts tax

on governmental hospitals. However, see TECHNICAL ISSUES. The new imposition will probably be only on tangible personal property sold, and not services delivered by Governmental hospitals. The bill creates a Medicaid Trust Fund and transfers 2.4% of General Fund Gross receipts tax revenues to this new fund. Money in the fund is available for appropriation by the legislature only to support the state Medicaid program. The current 50% hospital deduction (7-9-73.1 NMSA 1978) and the for-profit hospital credit against the state gross receipts tax (7-9-96 NMSA 1978) are repealed.

Section 1 distributes the new money from imposing the governmental gross receipts tax on government hospitals to the general fund

Section 2 imposes the governmental gross receipts tax on governmental hospitals. However, "governmental gross receipts," as defined in 7-9-3.2 NMSA 1978 only includes "tangible personal property sold from facilities open to the general public.

Section 3 of the bill repeals the exemption from gross receipts tax for receipts of non-profit hospitals.

Section 4 of the bill creates a "Medicaid trust fund" within the "Statewide Health Care Act." The fund is self-earning and subject to appropriation only to support the State Medicaid program.

Section 5 of the bill distributes 2.4 percent of net taxable receipts attributable to the gross receipts tax to the Medicaid trust fund. The probable intent is to more than cover the current general fund cost of Medicaid and to have sufficient revenue in the Medicaid Trust Fund to restore previous cuts to hospitals and practitioners in Medicaid reimbursements.

Section 6 of the bill repeals 7-9-73.1 NMSA 1978 (the 50% Hospital deduction) and 7-9-96 NMSA 1978 (the credit that almost zeros the state gross receipts tax for hospitals).

The effective date of this bill is July 1. 2017. There is neither a delayed repeal nor any requirement that the revenues be reported to a legislative interim committee. LFC recommends both be added.

FISCAL IMPLICATIONS

By earmarking general fund revenues for the purpose of funding Medicaid and restoring previous Medicaid cuts, this bill may be counter to the LFC tax policy principle of adequacy, efficiency, and equity. Due to the increasing cost of tax expenditures and earmarks, revenues may be insufficient to cover growing recurring appropriations.

The bill creates a new fund, although the transfers to the fund are not appropriated to an agency, but to support the state Medicaid program. This has many features of a continuing appropriations. The LFC has concerns with including continuing appropriation language in the statutory provisions for newly created funds, as earmarking reduces the ability of the legislature to establish spending priorities.

This bill has been a particularly difficult item to score. Definitive data from the Centers for Medicare and Medicaid Services (CMS) have only been published through 2009 – prior to the implementation of the Affordable Care Act. Fairly complete data are available for Medicaid reimbursements, but the allocation of these expenditures to relevant tax status categories was

difficult. Some relevant data which otherwise might be available from TRD are covered by confidentiality requirements surrounding certain taxpayer information.

LFC staff have prepared a comprehensive model of the healthcare sector and have cross validated these data from numerous sources, including:

- The 1991 – 2009 comprehensive compendium of healthcare costs by sector from CMS -- these data include an estimate of total healthcare costs for all residents of New Mexico, Medicaid costs, and Medicare costs;
- 2012 Economic Census of the Healthcare and Social Services sector, sub-allocated into for-profit entities and not-for-profit entities and further sub-allocated into patient care revenues, grants, appropriations and other sources of income;
- TRD's RP-80 GRT history for calendar 2012 and the period June 2015 through May 2016, with differences between aggregate state totals and the sum of the detail reallocated to the redactions for confidentiality;
- Some updated information available from Kaiser Family Foundation;
- Extensive history and forecasts from HSD on Medicaid enrollments and expenditures;
- Extensive data from hospital cost reports (CMS) with a comprehensive analysis assembled by LFC staff for the SM-37 investigation;
- IHS Global-Insight forecasts of national healthcare services and tangibles inflation and natural growth; and
- 2015 and 2016 editions of the TRD Tax Expenditure Report.

There is some disagreement between the Hospital Association and the LFC estimate. However, the hospital cost reports are submitted for different purposes than the CRS-1 reports submitted to the Taxation and Revenue Department. There is some indication that the Governmental Hospitals are including other sources of income and counting these funds as net patient care revenues.

However, this bill makes no attempt to constrain the tax base for either the non-profits, or the for profit hospitals. Therefore, the base for this estimate is assumed to be equal to that reported in the 2015 CMS Hospital Cost Reports. The FFY 2015 cost reports indicate the following for, in effect, taxable gross receipts. These numbers are then used as the base.

Not-for-Profit Hospitals	Government Hospitals	For-Profit Hospitals
$2,340,761,097	$1,266,661,485	$2,605,939,337

($ thousands)				
FY18	FY19	FY20	FY21	
2,007,921.8	2,103,835.6	2,209,219.3	2,306,173.6	Dec CREG Gen Fund GRT
214,200.0	219,800.0	226,000.0	233,800.0	Increased state revenues from hospitals
53,300.0	55,800.0	58,400.0	61,000.0	Medicaid Trust Fund
160,900.0	164,000.0	167,600.0	172,800.0	Net Increase in General Fund
141,800.0	144,000.0	144,000.0	145,900.0	Increased local revenues from hospitals

In more detail, the model forecasts the fiscal impact for FY 18.

	FY 2018		
$ thousands	Not-for-Profit Hospitals	Government Hospitals	For-Profit Hospitals
Patient Care Revenue	$2,271,202	$1,003,292	$1,938,987
Unknown Difference	$150,519	$309,611	$779,267
Sale of Goods	$24,465	$10,807	$5,053
Net Taxable	$2,446,186	$10,807	$2,723,307
State tax rate	4.050%	5.000%	4.050%
Local tax rate	3.177%	0.000%	3.177%
State revenue	$99,074	$540	$110,298
Local Revenue	$77,726	$0	$86,531
Current State Revenue	$0	$0	-$4,260
Current Local Revenue	$0	$0	$22,384
Increase in State Revenue	$99,100	$540	$114,558
Increase in Local Revenue	$77,700	$0	$64,146

If the technical issue is resolved, then the governmental hospitals would contribute an additional $66 million growing to $72 million by FY 21.

SIGNIFICANT ISSUES

The Medicaid budget for FY 18 currently stands at $915 million. Sequestering in excess of $50 million to the Medicaid Trust Fund, but not allowing HSD to independently draw on these funds – either to address funding shortfalls or to restore some of the recent cuts to the hospitals and practitioners – may be somewhat problematical. The funds in the Medicaid Trust Fund are not earmarked to be under the control of HSD, but must be appropriated by the legislature. If the bill passes effective July 1, 2017, the revenues will not have been appropriated in this session. An entire year could pass before any of these funds could be used for the intended purpose. The Hospital Association announced that the not-for-profits and the governmental hospitals were willing to contribute a net of 1% of their revenues to support Medicaid. A caveat was that at least a portion of these new taxes would be used to restore at least some of two rounds of Medicaid reimbursement cuts.

PERFORMANCE IMPLICATIONS

The LFC tax policy of accountability is approximately met. Although TRD is not required to report annually to an interim legislative committee, the annual budget process would have access to all data regarding the productivity of the new taxes imposed on the hospitals.

The impact on the three classes of hospitals is shown in a table at the end of this review.

In summary, the total new taxes collected from the hospitals is as follows:

ADMINISTRATIVE IMPLICATIONS

TRD will report high impact for implementing the provisions of this bill. It is not as complex as some of the bills introduced this session so may not involve contract programmers or a supplemental appropriation.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP

HB-202, HB 412, SB-123, SB-433, SB-448, SB 457 relate in some fashion to GRT taxes on hospitals and other healthcare practitioners

TECHNICAL ISSUES

The intent of the bill may have been to impose the governmental gross receipts tax on governmental hospitals licensed by the Department of Health. However, the bill does not amend the definition of Governmental Gross Receipts (7-9-3.2 NMSA 1978) to include patient care revenues. Only the "sale of tangible personal property … from facilities open to the general public" are currently included in the definition of "governmental gross receipts." This interpretation has been used in determining the fiscal impact of this bill.

7-9-3.2. Additional definition. (2004)
A. As used in the Gross Receipts and Compensating Tax Act, "governmental gross receipts" means receipts of the state or an agency, institution, instrumentality or political subdivision from:
(1) the sale of tangible personal property other than water from facilities open to the general public.

This bill does not contain a delayed repeal date. LFC recommends adding either a delayed repeal date or a requirement for periodic review.

OTHER SUBSTANTIVE ISSUES

Dr. James Peach, a professor at NMSU and an acknowledged tax expert has prepared a report entitled, " Taxing New Mexico's Health Care Sector ." This report is posted on the LFC website.

Hospital Name	1 total patient revenues	2 less contractual allowances and discounts on pt accounts	3 net patient revenues
	G-3 line 1	G-3 line 2	G-3 line 3
For profit hospitals			
ALTA VISTA REGIONAL HOSPITAL	$158,849,066	$121,909,218	$36,939,848
ARTESIA GENERAL HOSPITAL	$173,241,398	$116,159,376	$57,082,022
CARLSBAD MEDICAL CENTER	$315,197,516	$221,926,482	$93,271,034
CIBOLA GENERAL HOSPITAL	$59,862,199	$29,577,445	$30,284,754
EASTERN NEW MEXICO MEDICAL CTR	$447,205,090	$324,461,884	$122,743,206
GILA REGIONAL MEDICAL CENTER	$203,864,089	$132,489,721	$71,374,368
GUADALUPE COUNTY HOSPITAL	$15,165,443	$9,057,755	$6,107,688
LEA REGIONAL HOSPITAL	$222,995,235	$148,244,114	$74,751,121

LOS ALAMOS MEDICAL CENTER	$113,757,406	$59,006,327	$54,751,079
LOVELACE MEDICAL CTR DOWNTOWN	$1,208,160,145	$964,551,343	$243,608,802
LOVELACE ROSWELL REGIONAL HOSPITAL	$191,145,506	$145,762,526	$45,382,980
LOVELACE WESTSIDE HOSPITAL	$241,249,902	$187,990,225	$53,259,677
LOVELACE WOMEN'S HOSPITAL	$596,531,636	$442,084,884	$154,446,752
MEMORIAL MEDICAL CENTER	$782,877,466	$557,358,408	$225,519,058
MIMBRES MEMORIAL HOSPITAL	$115,975,203	$78,872,069	$37,103,134
MINERS' COLFAX MEDICAL CENTER	$25,538,925	$6,147,381	$19,391,544
MOUNTAIN VIEW REGIONAL MEDICAL CTR	$726,901,363	$529,400,202	$197,501,161
NOR-LEA GENERAL HOSPITAL	$142,466,128	$85,136,959	$57,329,169
ROOSEVELT GENERAL HOSPITAL	$62,579,299	$39,042,554	$23,536,745
SIERRA VISTA HOSPITAL	$30,189,103	$15,660,211	$14,528,892
UNIVERSITY OF NEW MEXICO HOSPITAL	$1,673,085,166	$761,329,820	$911,755,346
UNM SANDOVAL REGIONAL MEDICAL CTR	$156,115,274	$80,844,317	$75,270,957
For profit subtotal	**$7,662,952,558**	**$5,057,013,221**	**$2,605,939,337**
Not for profit hospitals			
CHRISTUS ST VINCENT HOSPITAL	$1,031,810,315	$657,463,399	$374,346,916
DR DAN TRIGG MEMORIAL HOSPITAL	$26,399,345	$13,243,223	$13,156,122
ESPANOLA HOSPITAL	$184,327,063	$114,826,460	$69,500,603
GERALD CHAMPION REGIONAL MED CTR	$416,142,101	$293,810,285	$122,331,816
HOLY CROSS HOSPITAL	$106,220,007	$60,670,173	$45,549,834
LINCOLN COUNTY MEDICAL CENTER	$91,372,304	$51,728,362	$39,643,942
PLAINS REGIONAL MEDICAL CTR - CLOVIS	$277,956,742	$185,058,299	$92,898,443
PRESBYTERIAN HOSPITAL - ABQ	$2,980,869,237	$1,741,748,843	$1,239,120,394
REHOBOTH MCKINLEY CHRISTIAN HOSPITAL	$136,190,353	$88,769,358	$47,420,995
SAN JUAN REGIONAL MEDICAL CENTER	$655,179,079	$394,392,682	$260,786,397
SOCORRO GENERAL HOSPITAL	$57,783,080	$31,808,820	$25,974,260
UNION COUNTY GENERAL HOSPITAL	$24,601,993	$14,570,618	$10,031,375
Not for profit subtotal	**$5,988,851,619**	**$3,648,090,522**	**$2,340,761,097**
Government hospitals			
ARTESIA GENERAL HOSPITAL	$173,241,398	$116,159,376	$57,082,022
CIBOLA GENERAL HOSPITAL	$59,862,199	$29,577,445	$30,284,754
GILA REGIONAL MEDICAL CENTER	$203,864,089	$132,489,721	$71,374,368
GUADALUPE COUNTY HOSPITAL	$15,165,443	$9,057,755	$6,107,688
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UNIVERSITY OF NEW MEXICO HOSPITAL	$1,673,085,166	$761,329,820	$911,755,346
UNM SANDOVAL REGIONAL MEDICAL CTR	$156,115,274	$80,844,317	$75,270,957
Just government subtotal	**$2,542,107,024**	**$1,275,445,539**	**$1,266,661,485**
	$16,193,911,201	$9,980,549,282	$6,213,361,919

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL

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

1. **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 (RSTP), to review fiscal, legal, and general policy parameters.
2. **Targeted**: The tax expenditure has a clearly stated purpose, long-term goals, and measurable annual targets designed to mark progress toward the goals.
3. **Transparent**: The tax expenditure requires at least annual reporting by the recipients, the Taxation and Revenue Department, and other relevant agencies.
4. **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.
5. **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.
6. **Efficient:** The tax expenditure is the most cost-effective way to achieve the desired results.

LFC Tax Expenditure Policy Principle	Met?	Comments
Vetted	✘	
Targeted		
Clearly stated purpose	✘	
Long-term goals	✘	
Measurable targets	✘	
Transparent	✓	
Accountable		
Public analysis	✓	
Expiration date	✓	
Effective		
Fulfills stated purpose	?	No purpose stated
Passes "but for" test		
Efficient	✘	

Key: ✓ Met ✘ Not Met ? Unclear

LG/jle/sb/jle