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Testimony of

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In Opposition to HB 2125

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I am here today to discuss problems with the Rural Medical Provider Tax Credit. In short, the tax credit is not the right tool to address the need for improving access to care in Oregon's rural areas.

Before you decide whether to extend the sunset on the Rural Medical Provider Tax Credit, consider the following.

This tax credit is just one of many subsidies for rural providers.

Oregon has insurance subsidies and loan forgiveness and repayment programs targeted to rural or underserved areas. Are they all necessary? How much should be spent to entice a medical provider to locate to or to stay in a rural area? A recent Oregon Health Policy Board study found, "a provider may be receiving $40,000 annually in loan assistance in addition to having a portion of their medical insurance premium paid and receiving a $5,000 tax credit…Because program rules and eligibility criteria are designed and applied independently, the resources of financial incentives may be spread unevenly or inefficiently."[1] Notably, Oregon is one of only two states that have tried to use a tax credit to address the problem.

The credit is primarily a reward, not an incentive.

There is no solid analysis showing that "but for" this credit we'd have fewer rural medical providers. There is nothing in the criteria to obtain the credit that ensures it is being used only as an incentive, not a reward. While there may be anecdotal evidence that someone chose to work in a rural area due to the credit, anecdotal evidence does not equate to data showing correlation or causation.

By definition, a portion of the credit is a reward, not an incentive. I am specifically referring to the fact that someone can apply for and obtain the credit retroactively (up to three years). Anyone who applied to get the credit retroactively certainly did not need an incentive to practice in a rural area.

There's no time limit. A doctor can be practicing in a rural area literally for decades and still get the credit. It is not just a reward, its ongoing compensation not tied to its

[1] *Financial Incentive Programs in Oregon*, Oregon Health Policy Board Healthcare Workforce Committee, July 2014, p. 7.

original purpose. Once a doctor plants roots in the community, why should taxpayers continue to subsidize the practice?

The credit is not means tested. The tax credit tool assumes that an impediment to practicing in rural areas is that the doctor earns less. If a doctor is not struggling financially, why subsidize? The credit should not be available for taxpayers with $250,000 or more of adjusted gross income for single filers and $500,000 or more of adjusted gross income for joint filers.

That the problem persists after 25 years shows the credit is not working.

Even though the credit was first created in 1989 and later expanded, we are still hearing about problems attracting an adequate number of providers to rural medical practices. After nearly 25 years, the persistence of the same problem suggests the credit is not the proper tool to increase the medical provider workforce in rural areas. Throwing money at the problem with a reward has not worked.

The definition for what constitutes "rural practice" is inadequate.

Few doctors likely work a standard 40 hour week, so the suggestion that committing 20 hours a week to "rural" work makes someone a rural medical provider makes no sense. Does that include travel to and from the rural areas or the hours of "charting" that doctors will do on evenings and weekends?

Moreover, the definition needs to be tweaked to get doctors into what I will call Oregon's "frontier" communities, not merely "rural" places. It is Oregon's frontier communities that are in greatest need of medical providers, and this credit has failed to fix that problem over the last 25 years.

The definition of rural in this legislation differs from the definition of rural in the rural emergency providers tax credit (ORS 315.622). Oregon should define the geography of the problem similarly across the multiple programs that are trying to address the problem.

A doctor could live in the Salem or the Portland metro area and get the subsidy for years on end for practicing in Woodburn or Silverton. That makes no sense.

At $5,000 the credit exempts too much income from taxation.

At $5,000 the credit exempts approximately the first $60,000 in taxable income, and almost double that of a married couple who both qualify.[2] Because taxable income is

[2] Here's the calculation using the 2015 tax table set forth in LRO's 2015 Basic Facts publication. Take the $5,000 and subtract $522, the taxes associated with the 5% and 7% brackets on income up to $8,250 for a single filer. Take the remaining $4,494 and divide that by 0.09 (the 9% tax) and add the result to $8,250 (the base income for the $522). That totals $58,006. Using the joint filer brackets, if one medical professional is a joint filer, the result is $60,478. If both joint filers are rural medical professionals, the result is $116,033.

approximately 70 percent of gross income (greater at the highest income levels), that means a rural medical provider earning about $83,000 would pay no income taxes.

A working family of three who have poverty level total income – gross income, not taxable income – of about $20,090– still must pay taxes even *after* taking advantage of the personal exemption and earned income tax credits.

Yet, under this bill's scheme, a medical provider can have *taxable income* of more than twice the *gross income* of the working poor household and fully escape taxation. That seems like a misplaced priority.

At $5,000 the credit is two and a half times the tax liability of the typical Oregonian.

I've heard pollsters say that most people don't know how much they pay in income taxes; they may recall the size of the check they wrote when they filed in April (i.e. what was still owed), but they don't know the bottom line total income tax bill.

The $5,000 rural medical tax credit is equal to about three times the tax liability of the typical taxpayer. The pre-tax credits tax liability of the typical taxpayer – the approximate median taxpayer – was about $1,923 in 2012. The $5,000 tax credit is about two and a half times that level.

The credit's tail gives lawmakers time to find a solution

Under current law, the sunset only impacts new applicants until 2023. If you let the credit sunset and make no other changes to the statutes, the credit continues for 8 more years for any provider eligible before January 1, 2014. That is generous and minimizes any threat that there will soon be an exodus of rural providers if the credit sunsets.

This tail buys the legislature time to better study the issue of how ensure that there are an adequate number of medical providers in Oregon's rural and frontier communities under our transformed health care system and the Affordable Care Act.

Summary

Whichever way you look at it, the Rural Medical Provider Tax Credit is an oversized tax credit that provides too much financial reward to people who can be extremely well off, and after 25 years has failed to solve the problem it was meant to address. The spending is a misplaced priority.