Tax Credits for Review in 2021

This is the primary section of the report, containing detailed information on each tax credit scheduled to be reviewed in 2021. In total, there are eleven such tax credits. To provide some context, the table below shows the cost to extend the tax credits for the current and following two biennia. These estimates are for current law, meaning the cost to extend reflects the estimated cost of extending the credit sunset date without otherwise modifying the credit. The cost to extend amount in 2021-23 is roughly half the cost in 2023-25. This is due to the credits sunsetting midway through the 2021-23 biennium.

Estimated Cost of Extending Tax Credits

$ Millions

Tax Expenditure Report Number and Credit name	ORS	Sunset Date	--------Biennium-------- 2021-23	2023-25	2025-27
Scheduled for Review by the 2021 Legislature					
1.404 Employee Training in Eligible Counties	**315.523**	2023	< 50K	< 50K	< 50K
1.407 Child with a Disability	**316.099**	2022	$4.9	$10.2	$10.6
1.408 Rural Medical Providers	**315.613-619**	2022	$1.2	$4.4	$6.1
1.410 Severe Disability	**316.752-771**	2022	$4.8	$9.7	$9.7
1.422 Public University Venture Development Fund	**315.640**	2022	$0.3	$0.5	$0.4
1.425 Working Family Household and Dependent Care	**315.264**	2022	$31.9	$63.8	$63.8
1.426 Contributions to the Office of Child Care	**315.213 (318.031)**	2022	< 50K	< 50K	< 50K
1.427 Individual Development Account Contributions	**315.271**	2022	$6.6	$13.6	$13.9
1.430 Bovine Manure for Biofuel	**315.176**	2022	$3.3	$5.5	$5.8
1.445 Oregon Life and Health IGA Assessments	**734.835**	2022	$0.7	$0.9	$0.5
1.449 Oregon Veterans' Home Physician	**315.624**	2022	< 50K	< 50K	< 50K
SUBTOTAL			**$53.6**	**$108.6**	**$110.8**

The remainder of the report consists of separate reviews for each tax credit. Each review consists of subsections related to the credit's policy purpose, description, policy analysis, similar incentives available in Oregon, and discussion of related credits available in other states. The policy purpose of a credit is generally not stated in statute. The purpose identified in this report is based on documentation from implementing or modifying legislation and related committee discussions. Generally, the purposes are inferred from historical records. When Oregon statute provides a clear statement of the policy intent, such policy purpose is cited in this report. The description provides detail on how the tax credit works under current law. The policy analysis describes academic research on relevant incentives if available, provides some discussion of the credit' history, and an analysis of available data. Often the primary sources of data are certifications and tax returns. The review also includes a summary of similar incentives in Oregon (direct spending program information is generally provided by the Legislative Fiscal Office).

Statute requires this report to provide information on the public policy purpose or goal of each tax credit. The most basic of this information is simply the stated public policy purpose. Also required is information on the expected timeline for achieving that purpose, the best means of measuring its achievement, and whether or not the use of a tax credit is an effective and efficient way to achieve that goal. However, Oregon statute does not generally contain policy purposes or goals for tax credits. Consequently, statute does not generally identify timelines or metrics related to such goals. In the few cases where statute does provide a purpose or a goal, it is included in this report. The more common approach has been to rely on bill documentation and written testimony for the implementing legislation. This information is the basis for the purpose statements included in this report.

Rural Medical Providers

ORS 315.613, 315.616	Year Enacted:	1989	Transferable:	No
315.619	Length:	1-year	Means Tested:	Yes
	Refundable:	No	Carryforward:	None
TER 1.408	Kind of cap:	Taxpayer	Inflation Adjusted:	No

Policy Purpose

Bill documentation for the implementing legislation (1989 SB 438) states that the primary issue discussed was the "[f]light of physicians, physician's assistants and nurse practitioners from areas served by rural hospitals and the difficulty in finding replacements." This language suggests that the ***policy purpose is a combination of the retention and recruitment of certain medical professionals in rural areas.*** One of the major points discussed was how to limit the eligibility of the tax credit to communities that were having or were expected to have problems with the adequate provision of medical care.

Bill documentation describes a "three-pronged attack" to address the problems and shortages of medical care in rural communities. Along with the tax credit, SB 438 implemented a loan repayment program with the State Scholarship Commission for practitioners who agreed to operate a practice in a rural area. The third piece of the policy was financial assistance for rural hospitals by requiring that they receive the same level of Medicaid reimbursement even if they weren't considered remote.

The 2015 Legislature extended the sunset of the credit to 1/1/2022 with certain modifications enacted. The ***cumulative purpose of the modifications is to more efficiently expend (through the tax system) limited funds aimed at retaining specified medical providers in rural areas.*** The 2015 revenue impact statement stated the ***policy purpose of the credit as "to improve access to certain health care providers in rural areas".***[3]

Description

Distance	Credit
10-20 miles	$3,000
20-50 miles	$4,000
50 or more miles	$5,000

Certain medical providers are allowed a non-refundable tax credit equal to either $3,000, $4,000 or $5,000 against their personal income taxes.[4] Eligible providers include physicians, dentists, podiatrists, optometrists, physician assistants, nurse practitioners and certified registered nurse anesthetists. The value of the tax credit depends on a medical provider's distance from a community with a population of 40,000 or more. The credit is also limited to providers with adjusted gross income up to $300,000.[5] There are three exceptions to the limit: physicians who practice as a general surgeon, physicians who specialize in obstetrics, or physicians who specialize in family or general practice and provide obstetrical services. The requirements for eligibility vary by type of provider.

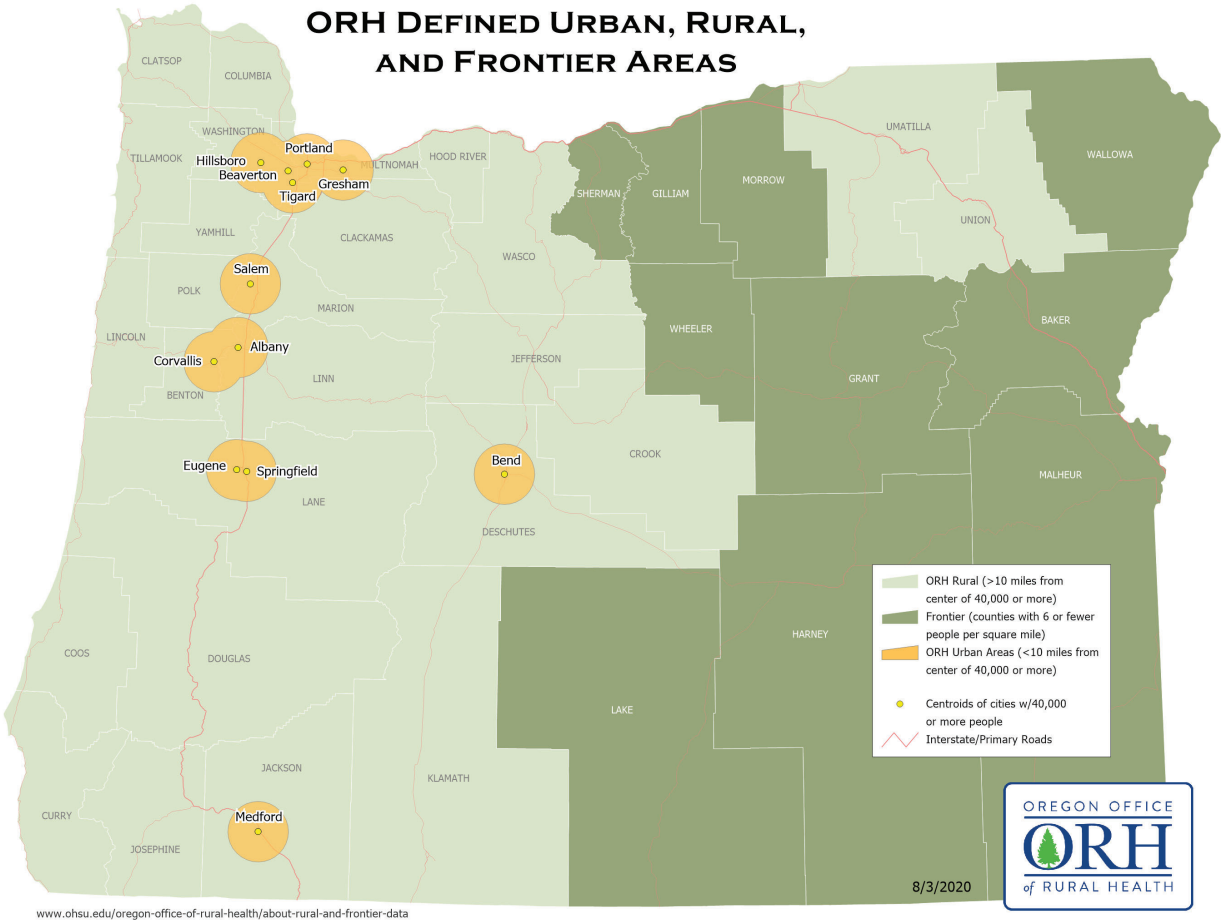
To receive the credit the provider must work a minimum of 20 hours per week, averaged over the month, in a qualifying rural area. They must also be willing to serve a Medicare and medical assistance (Medicaid) base equal to their county's population of such patients up to 20 percent for Medicare and 15 percent for medical assistance patients. For this program, rural is defined as any area at least ten miles from a population center of 40,000 or more. Currently, there are six such population centers: the Portland Metropolitan Statistical Area (MSA), Salem, Eugene/Springfield, Medford, Bend, and Corvallis/Albany. In

[3] HB 2171-A (2015)
[4] The total credit amount can reach $10,000 if both taxpayers on a joint return qualify.
[5] Adjusted gross income limit of $300,000 is applicable to both single and joint filers.

addition, physicians on staff at a hospital in an MSA are not eligible, with the exception of those working in Florence in Lane County and Dallas in Polk County. A qualifying taxpayer may claim both this credit and the Oregon Veterans' Home Physician credit.

Despite the current sunset of January 1, 2022, there is a grandfather clause allowing taxpayers that meet the eligibility requirements for tax year 2021 to continue using the credit for any tax year through 2031. Additionally, there is a ten-year lifetime limit on using the credit though the ten-year limit only applies to tax years beginning on or after 2018.[6]

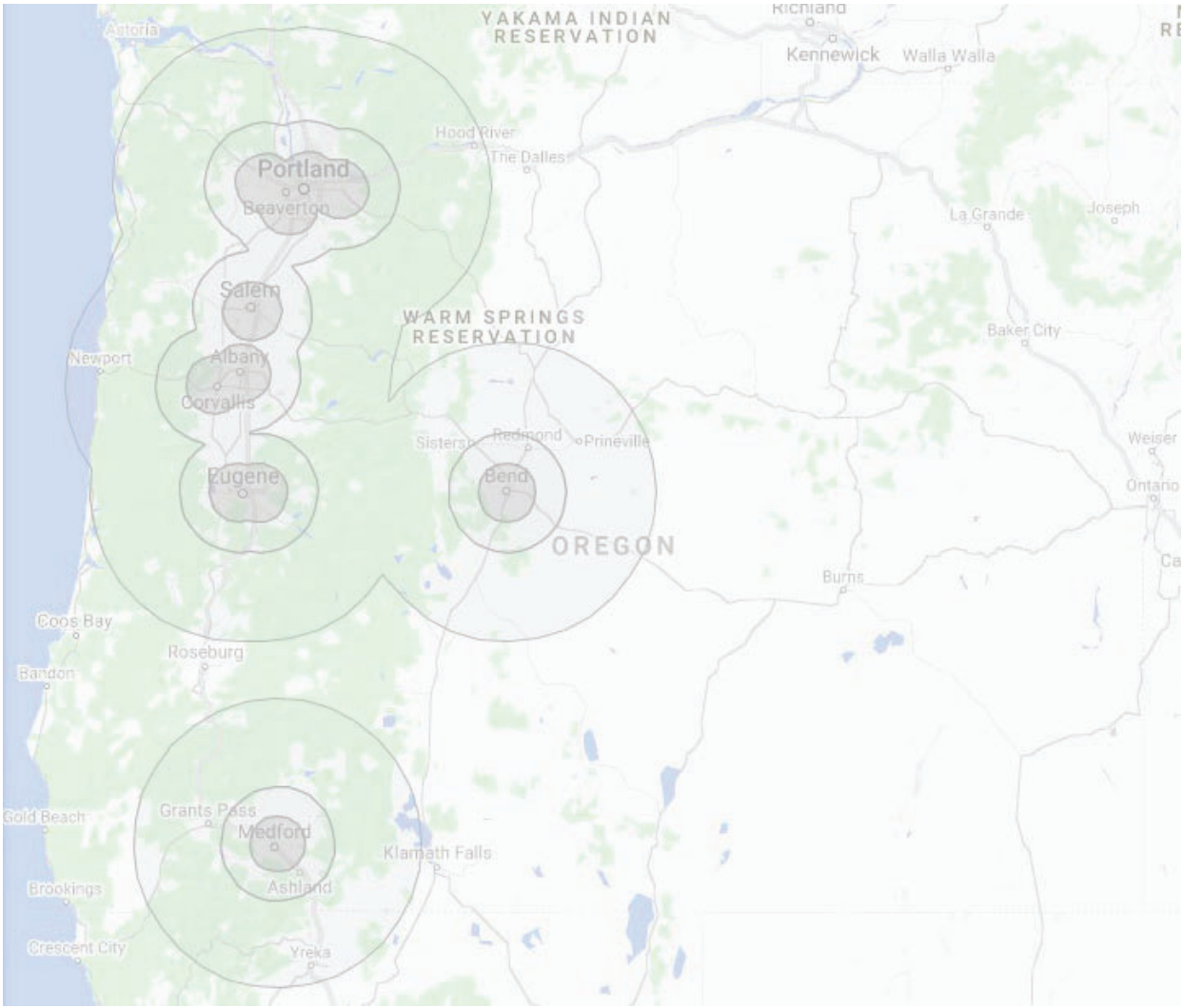
Below is a map from the Office of Rural Health (ORH) that shows the geographic areas covered by the tax credit. The areas that are considered urban fall within 10 miles of the Portland MSA, Salem, Corvallis/Albany, Eugene/Springfield, Bend, and Medford. All other parts of the state are places where medical professionals are eligible for the tax credit.



[6] For example, a taxpayer who had used the credit for 12 years prior to tax year 2018 would be eligible to use the credit for ten years beginning with 2018.

The following map is also from the Office of Rural Health and displays through a series of concentric circles the areas of the state where the credit is available and at what amount. The innermost circle displays the urban areas of the state where the credit is unavailable. The first annulus displays areas where the credit is equal to $3,000. The credit in areas within the second annulus is equal to $4,000 and the credit is equal to $5,000 in areas outside all the concentric circles.

Rural Medical Providers Credit Value

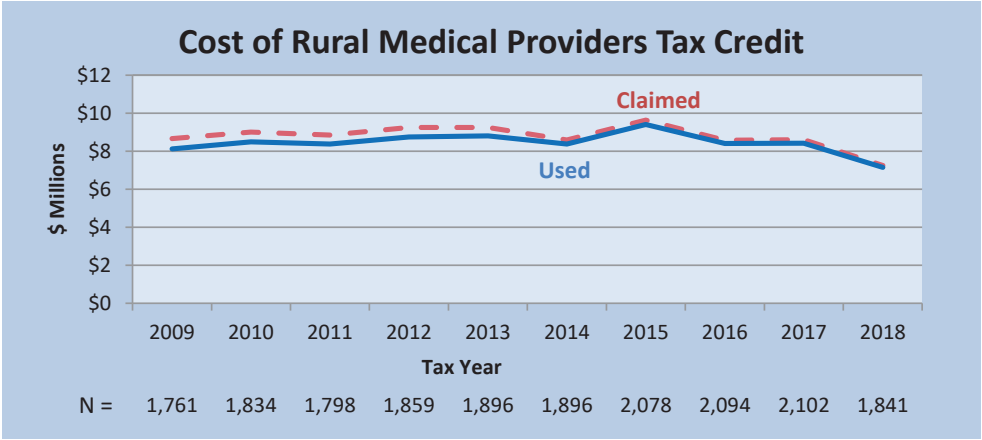


(Office of Rural Health, 2020)

Policy Analysis

Two recent policy changes influenced the amount of the credit being used annually. Beginning with tax year 2016, the amount of the credit was modified to be equal to be $3,000 to $5,000 depending on distance from a major population center. This allowed for a total reduction in amount of credit claimed while number of taxpayers claiming the credit continued to increase. Applicable beginning in tax year 2018 and with some exceptions (see credit description prior), taxpayers with an adjusted gross income in excess of $300,000 no longer qualify for the credit. This change reduced the overall number of taxpayers claiming the credit.

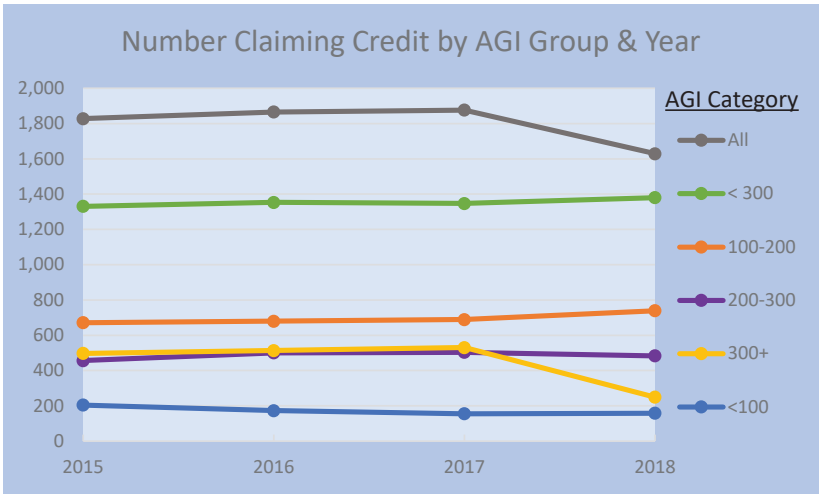
The chart below shows credit claimed and used amount since 2009. The red dashed line displays the credit amount claimed on tax returns whereas the blue line displays the amount used to actually reduce tax liability. The amount used averaged about 96 percent of the amount claimed. Between 2009 and 2018, the amount claimed on tax returns declined by 16.4 percent, from $8.7 million to $7.2 million. Over the same period the number of taxpayers claiming the credit grew by 4.5 percent, from 1,761 to 1,841. For years 2016 through 2018, about 150 tax returns each year were joint returns where both taxpayers were eligible for the tax credit.



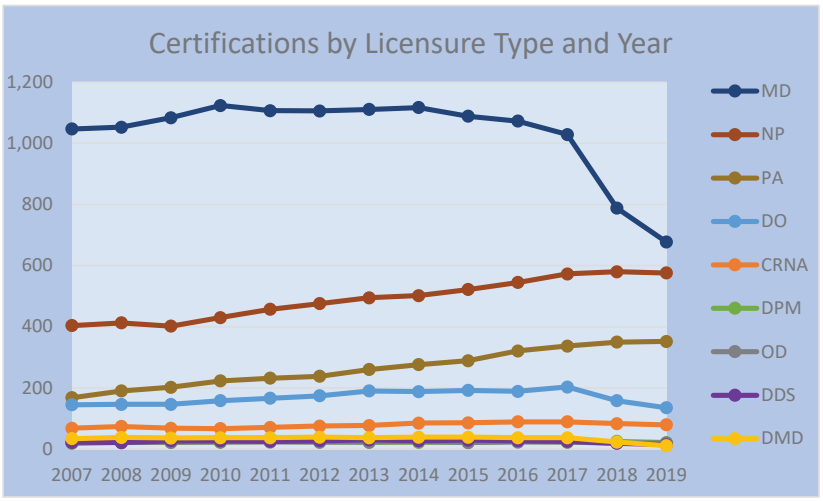
As previously described in the policy purpose section, the purpose of recent policy modifications to the credit was to more efficiently expend limited funds aimed at retaining specified medical providers in rural areas. To that end, an exploration of recent tax credit return and certification data is warranted. The intent is to examine whether recent policy changes affected the retaining of specified medical providers in rural areas.

As is often the case, estimating the impacts of individual policies is challenging. There are several factors that influence the decision-making process of medical professionals regarding where to practice, including wage level, quality of life, and access to certain amenities. In addition, this tax credit is not the only incentive currently in place designed to improve access to health care for rural Oregonians. The analytical challenge is to untangle each of these effects. Given current data restrictions, the goal here is to examine potential identifiable impacts resulting from recent policy changes made to the credit (change to credit amount and AGI limit).

The chart to the right displays the number of Oregon resident taxpayers claiming the credit categorized by taxpayer's adjusted gross income (AGI). As displayed, the total number of taxpayers claiming the credit declined in 2018 aligning with the AGI qualification limit that became effective the same year. As displayed, the decline was driven by those taxpayers with AGI greater than $300,000 being made ineligible for the credit beginning in 2018.[7] For taxpayers with AGI less than $300,000 the number claiming the credit increased slightly from 1,331 in 2015 to 1,380 in 2018. In 2017, about 530 taxpayers claiming the credit had AGI greater than $300,000. In 2018, about 250 taxpayers with an AGI greater than $300,000 claimed the credit, a reduction of about 53% from 2017.



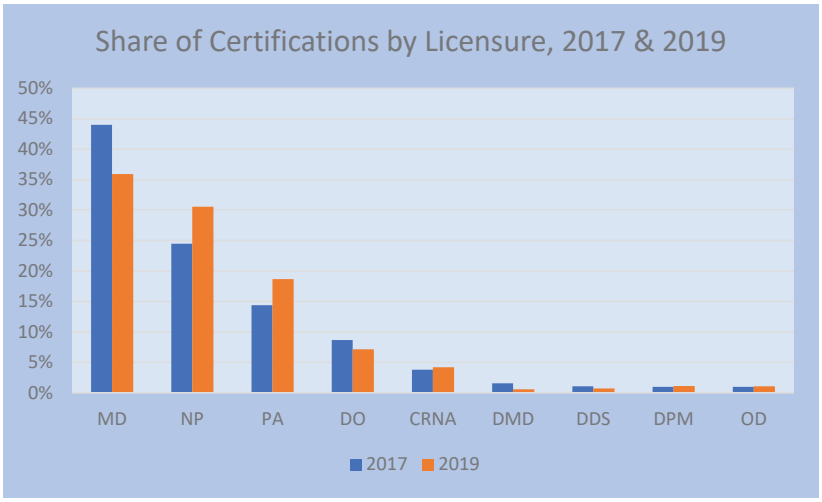
Tax credit certification data provided by the Office of Rural Health displays the trends in licensures being certified for the tax credit. The chart below displays the number of respective practitioners certified for the credit each year for years 2007-2019.[8] As shown, the top four provider types certified for the credit are: Doctor of Medicine (MD), Nurse Practitioner (NP), Physician Assistant (PA) and Doctor of Osteopathic Medicine (DO). The AGI limitation is clearly visible beginning in 2018 for both the MD and DO provider types. The following two charts examine the recent change in certified provider type.



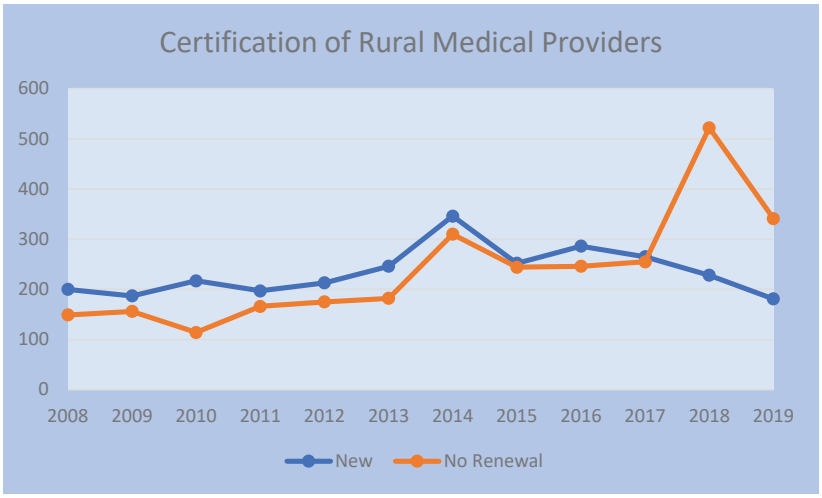
MD	Doctor of Medicine
NP	Nurse Practitioner
PA	Physician Assistant
DO	Osteopathic
CRNA	Nurse Anesthetists
DPM	Podiatrist
OD	Optometry
DDS	Dental Surgery
DMD	Dentist

[7] As previously mentioned, the $300K AGI limitation does not apply to a physician who practices as a general surgeon, specializes in obstetrics or specializes in family or general practice and provides obstetrical services.
[8] 2018 represents the most recent year of available tax return data, whereas certification data is available up to 2019.

The chart to the right displays the change in overall share of certifications by provider type. As shown, the share of certifications has shifted following the 2018 initiation of the $300K AGI limitation. Compared with 2017, the overall share of MDs and DOs declined whereas the share of NPs, PAs and CRNAs all increased.



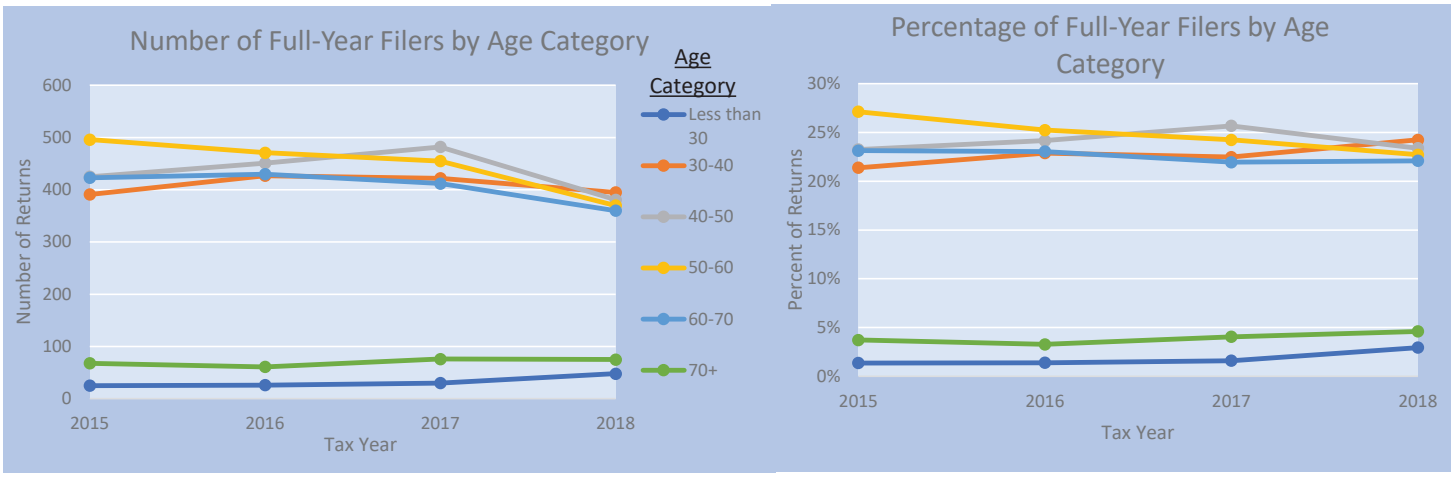
The chart below displays the number of new providers being certified for the credit each year along with the number of providers not renewing their credit certification (the "churn" in the credit). A new provider certification refers to a provider first being certified for the tax credit whereas the providers labeled "not renewing" is a computed number based on the number of providers certified the previous year (both new and renewing providers) minus the number of providers renewing in the current year. As displayed, for years 2008-2016 the number of new provider certifications slightly outpaced the number of no renewals causing an overall increase in the number of certified providers each year. Beginning in 2018, the number of non-renewals increased reflective of the AGI limitation first effective in 2018. As the $300,000 AGI limitation is not indexed to inflation, the limitation is expected to affect more providers each year that would otherwise qualify for the credit.



An examination of tax return data provides a way in which to examine potential change in age of tax credit claimants. The charts on the following page display the age of the return filer[9] at time of return filing by both number of returns and percentage of overall returns filed. Again, the overall reduction that occurred in 2018 due to the AGI limitation is visible in the left chart. As displayed, most age groups saw a decline in overall claims for the credit with the exception of the under 30 category where an increase occurred (70+ was largely flat). Looking at the overall share (right chart) it can be seen that the change in credit claimants decreased in the 50-60 group while increasing in the less than 30 and 30-40 age groups. It is perhaps

[9] For joint returns, this is the individual's whose name is reported first on the return. As such, the age reported here may not match the provider's age as it could be the provider's spouse.

unsurprising that the AGI limit would tend to affect younger taxpayers less than those in their prime working age.



Recent changes to credit amount and AGI qualification limit

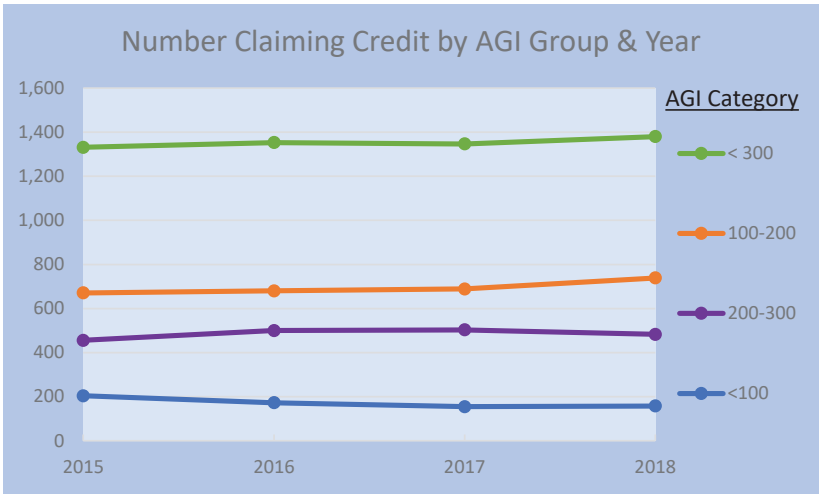
The recent changes to the tax credit provide an opportunity to examine the credit's influence on rural medical provider behavior. Of course, a medical provider's decision to begin or continue practicing in a rural area can be influenced by multiple factors and incentive programs other than the tax credit. As changes to the credit are relatively recent, existing data can only begin to look for potential behavioral changes in the retention and recruitment of providers. Having said that, an examination of the number of providers in rural areas following the recent credit changes can provide some insight into the credit's potential impact on retaining and/or recruiting providers to rural areas. For context, a brief examination of a survey of rural medical providers receiving the credit prefaces the examination of the number of rural providers.

In 2013, the Office of Rural Health surveyed providers receiving the tax credit.[10] About 70% of respondents were licensed MDs and about two-thirds of providers surveyed were not employed by a hospital. About 85% of respondents identified the tax credit as "important" or "very important" in the provider's initial decision to practice in rural Oregon whereas about 95% identified the credit as "important" or "very important" in their decision to remain in practice in rural Oregon. When asked what impact capping the credit at $250,000 annually would have, nearly 11% of respondents stated they "would leave my community as soon as possible", 30% would "begin looking for other opportunities" and 33% would "consider leaving". About 25% stated capping the credit would have little impact or no impact on their decision to continue practicing in their rural community. The survey results should be viewed in consideration of the survey's reliance on self-reporting and associated potential response bias. Nonetheless, the survey results indicate a potential noticeable impact on rural providers could occur if the credit (as it existed in 2013 at time of the survey) was modified.

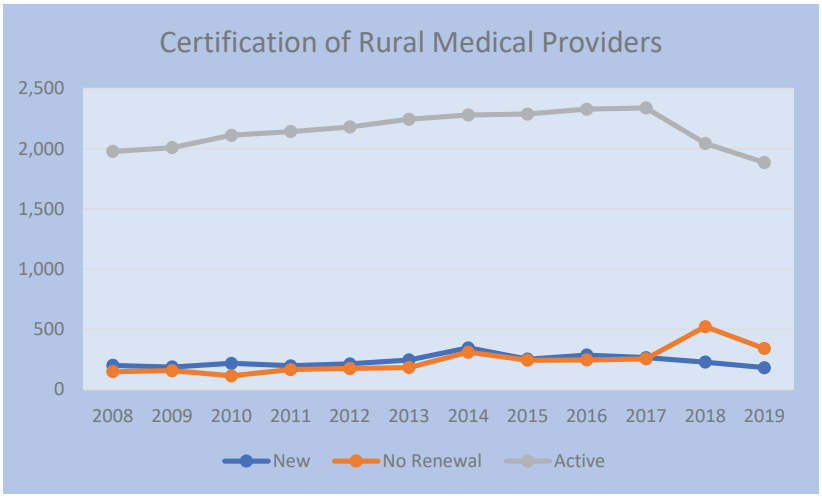
The first recent change to the credit was the modification to credit amount. Beginning with tax year (TY) 2016, the credit amount went from a flat value of $5,000 to a value of $3,000, $4,000 or $5,000. The average credit amount claimed in TY 2016 was about 87% of the TY 2015 average amount indicating that

[10] Survey results provided by Office of Rural Health (Office of Rural Health, 2013).

credit recipients were affected by the change in credit value.[11] The chart below displays the number of taxpayers claiming the credit in each year where the taxpayer had AGI less than $300,000.[12] No clear discernable reduction appears to have occurred following changes in credit amount. Unfortunately, data availability does not allow for an in-depth comparison between taxpayers qualifying for the full $5,000 and those qualifying for a lesser amount. Nonetheless, early tax return information does not indicate mass exodus by providers receiving the lesser credit amount. Examination of corresponding credit certification data (displayed graphically two pages back) again does not indicate a clear change in the number of new certificates or those choosing to not renew their credit certification in years 2016 and 2017 (years prior to AGI limit change).



Beginning with tax year 2018, credit qualification was limited to providers with an AGI less than or equal to $300,000.[13] This change in qualification is clearly identifiable in the credit return (see charts on previous pages) and certification data. The chart to the right displays by year the number of new credit certifications, no renewals (those previously certified that did not renew their certification) and active certifications (sum of new and those renewing). The decline in the number of active providers certified for the credit is clearly visible beginning in 2018. This corresponds with an increased number of providers not renewing and a decrease in the number of new providers. This change in credit participation is to be expected as the AGI limitation decreases the pool of rural providers that may qualify for the credit. Credit return and certification data however do not provide insight into whether retention/recruitment of providers to rural areas was affected by recent changes to the credit. To provide insight into the question of retention/recruitment, other sources of data are required.



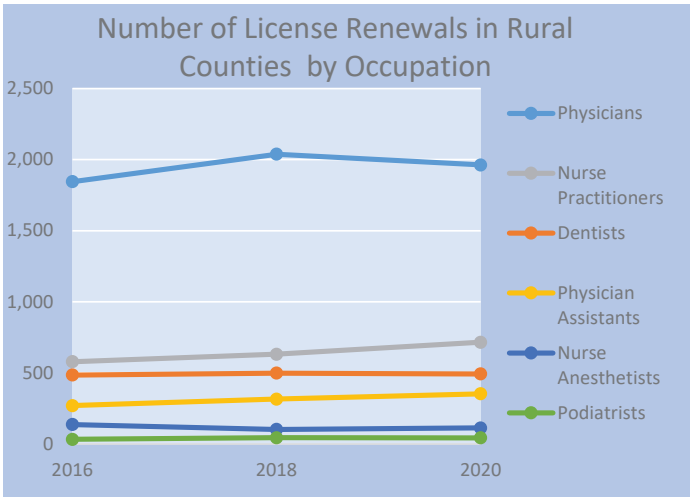
[11] If credit recipients were evenly distributed by distance from population center, average credit amount claimed in TY 2016 would have been expected to be about 80% of TY 2015.
[12] Credit availability became limited for taxpayers with AGI in excess of $300,000 beginning in tax year 2018.
[13] Not all providers are subject to AGI limitation, see description section for details.

Oregon's Health Care Workforce Reporting Program (WRP) administered by the Oregon Health Authority's (OHA) Office of Health Analytics provides an informal way of examining whether a change in the number of rural medical providers occurred during the period in which changes to the credit became effective.[14] The WRP data tracks the health license renewal of various health licenses. OHA's website cautions against statewide license comparisons between years though data from specific occupations may be compared, with caution. Examination of WRP data performed for this report is based on data downloaded from OHA website in fall of 2020. Analysis of occupation data was done only for occupations in which data was available in all three years examined. This examination of underlying data is not definitive though it does provide the basis for an informal analysis. Data is available at the county level which allows for an examination by county but to bifurcate data by urban and rural, an entire county must be assigned as either urban or rural.[15]

The two tables below display the number of licenses renewed by occupation and year, for counties identified as rural and urban. The chart below displays number of license renewals in rural counties only over years 2016, 2018 and 2020. In both rural and urban counties, the number of licenses renewed increased in each year reported. While the number of physicians in rural counties increased between 2016 and 2020, the number from 2018 to 2020 decreased. Upon closer examination, the decrease in the number of renewed licensed physicians was relatively widespread in counties identified as rural. By contrast, the increase between 2018 and 2020 in urban counties was also widespread amongst the urban counties. This examination is an initial look at the data following recent tax changes. Other factors are undoubtedly affecting rural providers and refinement of data analysis is an ongoing effort.

Number Renewing License by Occupation - Rural			
	Number Renewing by Year		
Occupation	2016	2018	2020
Nurse Anesthetists	137	102	113
Dentists	485	498	493
Nurse Practitioners	579	631	716
Physician Assistants	270	316	353
Physicians	1,845	2,039	1,963
Podiatrists	32	44	43
Total	***3,348***	***3,630***	***3,681***

Number Renewing License by Occupation - Urban			
	Number Renewing by Year		
Occupation	2016	2018	2020
Nurse Anesthetists	389	340	353
Dentists	2,434	2,465	2,540
Nurse Practitioners	2,471	2,588	3,025
Physician Assistants	1,226	1,538	1,780
Physicians	10,736	11,974	12,438
Podiatrists	137	145	153
Total	***17,393***	***19,050***	***20,289***

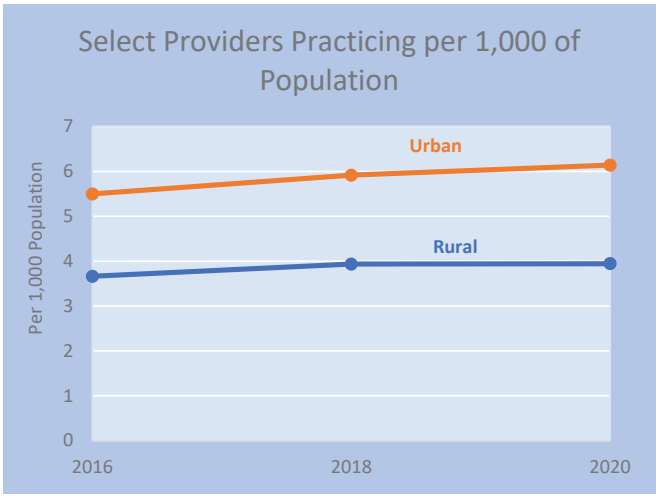


(Oregon Health Authority, 2020)

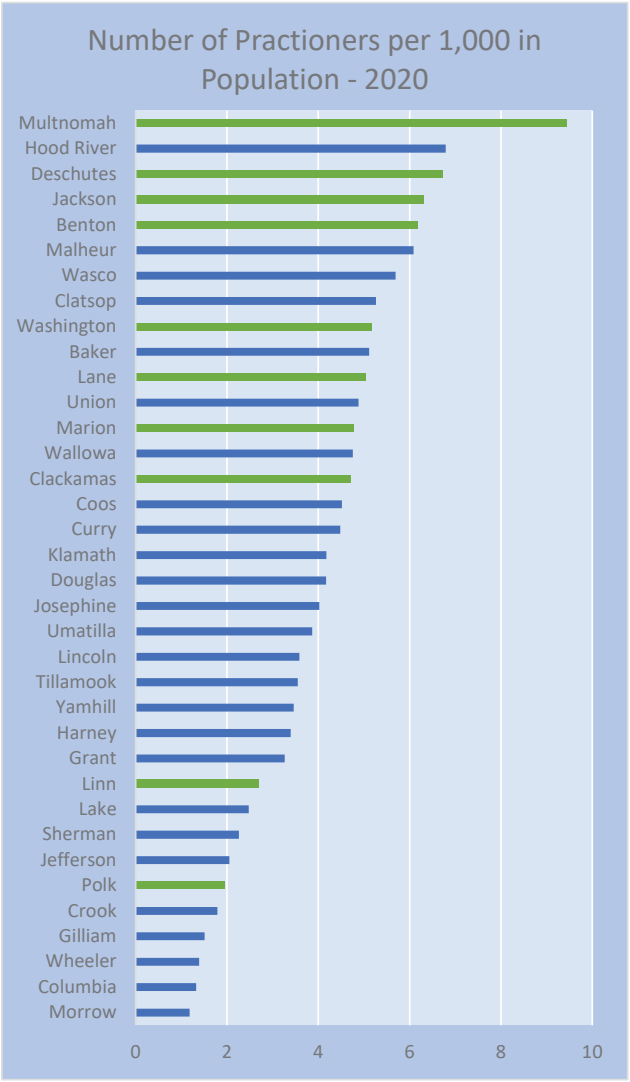
[14] See https://www.oregon.gov/oha/hpa/analytics/Pages/Health-Care-Workforce-Reporting.aspx

[15] The following ten counties were labeled as urban reflective of county classification for credit purposes: Benton, Clackamas, Deschutes, Jackson, Lane, Linn, Marion, Multnomah, Polk and Washington.

Examining the license renewals on a per capita basis provides another way in which to view recent changes and examine differences between counties and the urban/rural distinction. The left chart below displays the number of providers per 1,000 in county population delineated between urban and rural counties. As displayed, both urban and rural counties experienced increases on a per capita basis since 2016 though urban counties increased at a faster pace than rural counties. The chart to the right displays the number of providers per 1,000 population by county in 2020 (urban counties identified in green). As displayed, individual counties vary in the number of providers per capita. When focusing only on the physician category, per capita numbers followed the trend in overall counts where physicians per 1,000 of population increased in rural counties from 2.020 in 2016 to 2.211 in 2018. In 2020, physicians per 1,000 of population decreased to 2.104. This still represents a net increase from 2016 but is a metric to continue tracking as the 2020 decline corresponded with the AGI credit limit that became effective with the 2018 tax year.



(Oregon Health Authority, 2020)



General analysis and further considerations

The policy discussion at the time the tax credit was adopted focused on the loss of certain medical professionals from rural areas. The tax credit was part of a larger policy goal of mitigating that loss, which also included a direct subsidy (i.e. loan repayment) and an attempt to increase the Medicaid income (via reimbursement) for rural hospitals. Given such a focused goal, examining the number of such professionals before and after the implementation of the policies would be a next step in evaluating the policy's degree of success or failure. As the credit has been in place for over thirty years, such before and after analysis is no longer relevant. Continued examination of medical providers practicing in rural areas continues to provide a way in which to measure availability of such services to rural residents.

In an attempt to evaluate the optimal structure of the tax credit, it's important to acknowledge that this is an incentive where the beneficiaries of the tax credit (the medical providers) are distinct from the beneficiaries of the health policy (the rural Oregonians seeking health care services). The tax credit is a de facto increase in the wages paid to its recipients, thereby increasing the returns to labor with the hope of increasing the supply of labor for medical services. If the intent of the policy is more (or better) medical services provided to rural Oregonians, then measuring and evaluating that additional health care would be at the core of the policy analysis. Certainly, the cost of that additional health care would be of interest to stakeholders. And the analysis could include all aspects of those additional costs. For the sake of clarity, it's important to keep such distinctions clear.

Proponents of the credit may contend that allowing the credit to sunset would make it marginally more difficult to retain and/or attract qualified medical professionals to rural areas. If providers were practicing in an area as a direct result of the credit, then it is likely that some number of them will cease to do so if the credit were to sunset. However, this effect may be moderated by a certain level of inertia that comes from being invested in the life of a community, as a result of a brick and mortar business location or a residence. In addition, any exit by professionals is likely to happen gradually over time and be difficult to quantify outside of other influencing factors.

One option to better understand the impact of the tax credit would be to examine the ability of medical systems to retain and attract medical providers. For example, examining length of time to fill open positions could indicate whether difficulty exists in ability to attract qualified providers to rural areas. Survey work could also aid in the understanding of why providers chose to locate in a rural area or exit surveys could seek to understand why providers left rural areas to continue practicing in an urban setting. Surveys of officials who are involved with the recruitment of medical professionals to rural areas, and who may collect information regarding decisions about where to practice and/or reside could also be helpful.

Other States

Policymakers and other stakeholders are often interested in how other states address these policy issues. Several other states were identified as currently having a tax credit for rural medical providers (some are limited only to physicians). The states are: Alabama, Georgia, Louisiana, Maine (limited to 10 providers), and New Mexico. When analyzed collectively, the information below summarizes the policy options used by these states in designing their specific credits. Other states have also proposed larger one-time credits available to medical providers establishing a new practice in rural areas.

Key characteristics of other states

- Amount of credit generally ranges from $3,000 to $5,000
- Non-refundable or refundable
- Carryforward or carryback allowed/disallowed
- Some variance by specialty, with larger credit for certain practitioners
- Contingent upon number of hours worked
- Includes limit on the number of years eligible to claim
- Requires connection to a small or rural hospital
- Varying definitions of rural
    - Community, county, or area
    - Number of people or people per square mile
    - Distance to a hospital or city of a certain size

Similar Incentives Available in Oregon

The Legislative Fiscal Office identified two direct spending programs that shared some level of policy relationship to the credit. The two spending programs along with each program's 2019-21 legislatively adopted budget amount is detailed in the following table.

	2019-21 Legislatively Adopted Budget ($M)	
Direct Spending Program	***General Fund***	***Other Funds***
Healthcare Provider Incentive Fund	$17.7	$10.0
Area Health Education Centers	$4.5	

The Healthcare Provider Incentive Fund supports access to care for rural and other underserved communities by offering various incentives to both students and health care providers who commit to serving patients in underserved areas of the state. These incentives include the following: student loan repayment, primary care loan forgiveness, subsidies for rural medical practitioner insurance, and scholarships. The Oregon Health Authority administers the program in partnership with the Oregon Office of Rural Health.

Area Health Education Centers work to improve healthcare for rural and underserved populations by educating current and potential rural health care students, and the Office of Rural Health coordinates the statewide effort to provide healthcare in rural Oregon. The Office of Rural Health works with rural practice sites to recruit and retain providers and manages provider incentive programs.

Administrative Costs

The administrative and compliance costs of this credit are born by the ORH, the DOR, and taxpayers. There is an annual $45 fee that claimants must pay the ORH, which provides the office with roughly $175,000 per biennium for its budget. The cost to the taxpayer is $45 per year ($90 if a joint return with two eligible taxpayers) plus the marginal cost of maintaining the certification paperwork in case of a tax audit. The cost to the DOR appears to be minimal. The largest share of the cost is likely born by ORH because they are required to process tax credit applications each year.

Appendix A: Legislative History

This appendix contains the legislative history for each tax credit included in this report. Statutory changes can be technical in nature or policy oriented. Text in bold identifies changes that are more policy oriented.

Statute	Tax Expenditure (TE) Name and TE Number (Number aligns with Governor's Tax Expenditure Report)				
315.613-619	**1.408 Rural Medical Providers**				
	Year	**Bill**	**Chapter**	**Section(s)**	**Policy**
	1989	**SB 438**	**893**	**2-6a**	**Created: $5,000 for ten years if 60% of practice is rural | Available TYs 1990-93 | For physicians, physician assistants and nurse practitioners**
	1991	**HB 2162**	**877**	**16-18**	**Modify hospital requirements | Extended to 1/1/95 | Clarify time calculation | Add certified registered nurse anesthetists**
	1995	**HB 2255**	**746**	**36-38**	**Establish qualification deadline of 12/31/01 | Add podiatric physicians & surgeons and**
	1997	**HB 3140**	**787**	**3**	**Add optometrist (up to five by 7/1/99)**
	1999	**SB 530**	**459**	**1**	**Remove 10-year limit | Add rural critical access hospitals to qualification**
	1999	HB 2267	**582**	10	Change registered to licensed
	1999	SB 1093	**802**	**4**	Grammar change
	2001	HB2206	**509**	**12**	Remove 2001 eligibility deadline | Modify B hospital requirements
	2003	HB 2424	**46**	39-40	Internal reference changes
	2005				Moved from ORS 316.143/144/146 to 315.613/616/619
	2009	HB 2009	**595**	205	Reference change
	2009	**HB 2067**	**913**	**25**	**Add sunset of 1/1/2014 and grandfather clause if eligible in 2013**
	2013	**HB 3367**	**750**	**10-12**	**Extend sunset to 1/1/2016 | Change 60% requirement to 20 hrs./wk. | Add certain rural referral centers | Add eligibility requirement pertaining to Medicare and medical assistance patients being served**
	2015	**HB 2171**	**701**	**18-19**	**Extend sunset to 1/1/2018 | Modifies credit to $3,000-$5,000 depending on distance from a population center**
	2015	HB 3396	**829**	7-7a	Extend sunset to 1/1/2018 | Statutory language and definitional modifications
	2016	SB 1507	29	1	Technical corrections
	2017	**HB 2066**	**610**	**13-14**	**Extend sunset to 1/1/2022 | Create income cap of $300,000 (non-surgeons) | Limit credit to no more than 10 years per taxpayer**
	2019	**HB 2847**	**495**	**1**	**Expands list of hospitals whose medical staff may qualify for credit**
315.624	**1.449 Oregon Veterans' Home Physician**				
	Year	**Bill**	**Chapter**	**Section(s)**	**Policy**
	2007	**HB 3201**	**843**	**3,9**	**Created with 1/1/12 sunset**
	2009	HB 2067	913	52	Extend sunset to 1/1/2016
	2015	HB 2171	701	12	Extend sunset to 1/1/2022
315.264	**1.425 Working Family Household and Dependent Care**				
	Year	**Bill**	**Chapter**	**Section(s)**	**Policy**
	2015	**HB 2171**	**701**	**3,5**	**Created credit through combination of policies contained in expiring 'Child and Dependent Care' & 'Working Family Child Care' credits | Established sunset of 1/1/2022**
	2017	**SB 162**	**638**	**2**	**Extends to non-married taxpayers | Limits expenses to income earned in OR | Requires earned income to claim credit**
	2018	**HB 4028**	**111**	**7**	**Limits amount of employment-related expenses to lesser amount attributable to either spouse on a combined return**
315.271	**1.427 Individual Development Account Contributions**				
	Year	**Bill**	**Chapter**	**Section(s)**	**Policy**
	1999	**HB 3600**	**1000**	**12**	**Enacting legislation | Credit equal to lesser of: 25% of donation, $25,000**
	2001	**HB 3391**	**648**	**1**	**Modified credit equal to lesser of: 75% of donation or $75,000**
	2007	HB 2094	765	1,98	Add sunset of 1/2/2016 | Refined definitions | IRC update
	2009	HB 2067	913	48	Extend donation sunset to 1/1/2016
	2015	**HB 2171**	**701**	**7-8**	**Modified credit equal to percentage of donation as determined by fiduciary organization, not to exceed 70% | Limited total credits per tax year to $7.5 million | Extend sunset to 1/1/2022**
	2016	**SB 1507**	**29**	**2**	**Total credit to a taxpayer per tax year limited to $500,000**
	2019	**HB 2164**	**579**	**49a,49b**	**Credit donation percentage limited to 90%, applicable beginning with TY 2019**