REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-02
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Subject: Tax Relief for Physicians Serving Uninsured and Underinsured Patients (Resolution 202 and Substitute Resolution 208, I-01 and Resolutions 106 and 122, A-02)

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Referred to: Reference Committee J
(Bryan Pechous, MD, Chair)

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At the 2001 Interim Meeting, the House of Delegates referred Resolution 202 and Substitute Resolution 208. Introduced by the American Society of General Surgeons, Resolution 202 calls for the AMA to "immediately draft and seek introduction of legislation in the current congressional session that would allow physicians to deduct uncompensated services to indigent patients, using the Medicare fee schedule, for tax purposes." Substitute Resolution 208 calls for the AMA to "rescind Policy H-180.965, which states that the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured."

At the 2002 Annual Meeting, the House of Delegates referred two similar resolutions, Resolutions 122 and 106. Introduced by the Illinois delegation, Resolution 122 calls on the AMA "to seek changes in the federal tax code to allow physicians to deduct the unpaid costs involved in the delivery of medical services." Introduced by the District of Columbia delegation, Resolution 106 calls for the AMA "to rescind Policies H-180.965, Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured, and H-160.969, Tax Deduction for Care Provided the Indigent." The Board of Trustees assigned all of these resolutions for consideration by the Council on Medical Service for a report back to the House of Delegates at the 2002 Interim Meeting.

This report reviews the extensive AMA policy and initiatives related to the problem of uncompensated care and discusses the numerous arguments for and against supporting tax relief for the provision of such care.

## AMA POLICY AND INITIATIVES

Tax deductions and/or credits for physicians who provide uncompensated care has been a recurrent issue for the House of Delegates. Proposals seeking a tax credit or deduction for physicians for provision of this type of care have been rejected by the House on at least a dozen occasions over the past 20 years. In addition, Council on Medical Service Report G (A-82), Board of Trustees Reports N (I-89) and 49 (I-93), and Council on Medical Service Report 2 (A-98) have detailed the drawbacks of such proposals.

Current and long-standing AMA Policy H-180.965 (AMA Policy Database) clearly states that the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for

the provision of care to the medically uninsured and underinsured. Policy H-160.969 states that the AMA does not believe that it should seek a special income tax deduction for providing medical care to the indigent. Both policies have been reaffirmed by the House on multiple occasions in recent years.

The AMA has long supported conveying to the public the problems associated with the ever increasing regulations involving uncompensated care, as well as the detrimental effect that such care has on the availability of necessary health care services to many citizens. There are various types of uncompensated care, such as care for which payment is not expected; care for which payment is expected but not received; and care which must be provided due to government mandate. The AMA has been active in publicizing the programs currently instituted to address uncompensated care and in pursuing additional solutions for dealing with the problem (Policy H-160.971).

At a time when health costs are surging, public and Congressional support for expanding health insurance coverage for the uninsured has been renewed as a national priority. The recent recession, combined with double-digit increases in health insurance premiums, is likely to yield the largest increase in the uninsured in a decade. It is predicted that the issue will heat up even more in the last quarter of 2002 when the Census Bureau announces the number of uninsured for 2001, which may climb above 40 million, from 38.4 million in 2000.

As detailed in Council on Medical Service Report 8 (I-02), the AMA adopted an incremental approach to health system reform in 1994, that was targeted by patient care needs and guided by a set of priorities that included insurance reform, medical savings accounts, tort reform, antitrust reform, opposition to Medicare and Medicaid cuts, and support for the "Patient Protection Act" (Policy H-165.895). At the 1996 Interim Meeting, the House adopted policy supporting individually selected and owned health insurance as the preferred method for people to obtain health insurance coverage (Policy H-165.920[5]).

At the 1998 Annual Meeting, the House adopted the 17 recommendations in Council Report 9, thereby establishing comprehensive policy as to how a system of individually selected and owned health insurance should be structured based on a premise of pluralism of health care delivery systems and financing mechanisms (Policy H-165.920). In response to growing debate about health insurance tax credits, Council Report 4 (A-00) presented a series of principles for structuring such credits (Policy H-165.865).

In adopting the recommendations in Council on Medical Service Report 10 (A-02), the House reiterated and strengthened the AMA's resolve making expanded coverage through the use of refundable tax credits "a top strategic, communications, and legislative priority for 2003." One of the important impacts of the AMA proposal is that it would provide a critical way to achieve payment for many previously uncompensated services.

## ARGUMENTS IN SUPPORT OF TAX RELIEF

### The High Cost of Providing Services

With physician income decreasing in some specialties and geographic regions, professional liability insurance premiums rising in most areas, and physicians having little ability to "pass

through" any of their costs to the patient, the overall cost of providing services has grown significantly for many physicians. Those physicians whose practices have a high proportion of Medicare and Medicaid services may have little or no choice of alternatives. Frequently, physicians are unable to collect full payment for their services, and nearly all physicians have been impacted by the 5.4% cut in Medicare payments rates during 2002. Accordingly, tax relief, in the form of tax credits or deductions for the provision of uncompensated care, may be a way to compensate physicians for their time and service and defray some of the cost of providing services to these patients.

Disproportionate Burden and Fundamental Fairness

Providing health care coverage for the uninsured and underinsured is a real concern to the practicing physician. According to the AMA's Socioeconomic Monitoring System survey, nearly two-thirds (64.6%) of all physicians provided charity care (defined as uncompensated care) in 1999. In addition, disproportionate financial and liability burdens are placed on physicians who are required by law, via emergency services or other governmental mandates, to provide uncompensated services. Monies previously available to offset unreimbursed care have been diminishing to support the administration of government entities. For physicians, a major disincentive to providing uncompensated care is the inability to account for the financial losses related to providing such care. The physicians who continue to care for the uninsured and underinsured do so at increasing cost to their practice.

The issue of fundamental fairness also has been cited by some who advocate tax relief for the provision of uncompensated care. It is likely that no other profession provides more services without remuneration than does the medical profession. For example, pro bono or charity work provided by attorneys, while voluntary, is often strongly encouraged and financially supported by their employers. Physicians have no such support system currently in place.

Avoiding Negative Policy Positions

A final argument favoring tax relief that has been utilized is that negative policies should be avoided by the AMA whenever possible and, therefore, it may preferable to be neutral on the issue. Tax deductions or credits have been considered by various state governments and may be considered by more in the future, so remaining neutral on the issue could allow for flexibility to support future state legislative actions. For example, a bill introduced in Georgia in 1997 proposed amending its tax code to provide for income tax credits "for physicians who provide certain medical care to certain indigent persons." More recently, a bill introduced in California in 2001 (SB 486) would give tax credits for physicians and attorneys who provide indigent/charity care through charitable organizations. Neither of these bills was passed by.

ARGUMENTS IN OPPOSITION TO TAX RELIEF

Changing the Internal Revenue Code

Congress writes tax laws, which become part of the Internal Revenue Code that is amended annually. Presently, the code is over 4,500 pages long. Many tax laws are passed for purposes other than raising money for the federal government. A social goal using a tax law, for example, may be Congress's attempt to alleviate the housing problem by giving tax breaks to those who

invest in low-income housing. Similarly, an economic goal is found in allowing rapid tax write-offs to buyers of new business equipment to stimulate manufacturing. In addition, there are often purely political reasons for tax laws. Many special interest groups, such as oil companies, broadcasters, insurance companies, and even major league baseball clubs, have gotten tax laws passed that are designed to give them special treatment.

Nonetheless, the political feasibility of getting "special provisions" to the tax code are frequently difficult to achieve. Currently, under the tax code, charitable contributions can be made only to tax-exempt charitable organizations, and not to individuals. Deductions can only be taken for out-of-pocket expenses, and not for time or services rendered. Accordingly, seeking tax deductions or credits for physicians who provide uncompensated care faces significant political obstacles.

In addition, changing the Internal Revenue Code in this manner for physicians would set a precedent, and likely create a domino effect as other professions and individuals seek to be able to deduct the costs of voluntarily rendered services, something that has never been allowed in the U.S. It would clearly be a targeted tax policy, one that is often viewed as unfair because it does not apply equal tax treatment to similarly situated taxpayers. Targeted tax policies also have the unintended effect of increasing the power of the government by allowing the government the discretion to become increasingly involved in taxpayers' activities and spending choices. Further, activities that are more efficiently administered in the market place, often become complicated with increased governmental bureaucracy.

Physician Interaction with the Internal Revenue Service

Congress has given the Internal Revenue Service (IRS) the power to interpret and enforce the tax code through a series of IRS regulations. These regulations are expanded versions of some, but not all, tax code provisions with illustrations of how the law is applied in different situations. The regulations are about four times the length of the tax code itself. The IRS also publishes revenue rulings, revenue procedures, and letter rulings, which provide guidance in much the same manner as the regulations. Such guidance is sought because there are many situations where it is not clear exactly how the tax law should be applied.

Perhaps the greatest concern with seeking a targeted tax deduction for the provision of uncompensated care is mandated government involvement in the physician-patient financial relationship. The potential intrusion of the IRS into the physician's practice to determine the appropriate tax deduction and the suitable recipients of such care is a stumbling block that may be impossible to overcome. For example, will physicians want "appropriate" and "suitable" care to be defined and interpreted by the federal government through IRS regulations? There is also the high probability that tax relief would result in increased scrutiny by the IRS and have the potential to increase physicians' risk of liability. The potential also exists that the necessary documentation the IRS would need from physician practices would compromise patient confidentiality.

The United States has the dubious honor of having the most complex income tax laws in the world. The IRS was created to see that the laws are followed and enforced. Yet, given the high number of revenue rulings and letter rulings that the IRS produces annually, it is clear that the tax code is full of contradictions and many unclear provisions. In fact, it may be easier to pass targeted tax relief for physicians than to actually administer it, let alone teach physicians and tax professionals how to apply it.

Administrative Burden to Physicians

It is probable that tax credits or deductions for uncompensated care would result in an increased administrative burden for physician practices. On top of the HIPAA and privacy standards that will be implemented next year, new IRS regulations would clearly add more administrative hassles for physicians. Targeted tax relief for physicians would create a labyrinth of deductions, exclusions, and credits that would further complicate the tax code, raising both the IRS's administrative costs and physicians' compliance costs. For example, the IRS estimates that taxpayers spent 5.1 billion hours in 1995 complying with corporate and individual income tax laws. These unrecorded costs, which include the time spent reading, understanding, filing, and consulting professionals, may well exceed the recorded administrative costs incurred by the IRS. As a final point, seeking tax credits or deductions for uncompensated care would likely necessitate moving from a cash to an accrual accounting system, which would be a significant business change and additional administrative burden for most physician practices.

Public and Congressional Responses

Given the current state of the economy, with many individuals impacted by unemployment and rising health insurance premiums, there likely would be a negative response on the part of the public to physicians receiving a tax credit or deduction for treatment of the indigent. As determined by the House of Delegates at the 2002 Annual Meeting, the AMA's two top priorities are medical liability reform and restoring the 5.4% Medicare payment cut to physicians. Both of these issues are directly related to maintaining access to care for patients. Patients have been extremely supportive of these concerns because they have experienced first-hand how their ability to receive quality care is being affected. Advocating for tax relief for treating the uninsured is not likely an issue patients will rally behind, as it would be viewed as providing benefits to a few individuals at the expense of the rest of the taxpaying population. In addition, the likely Congressional response to the anticipated effect of such a change on current federal budgets would not be favorable, as well.

Medical Professionalism

Finally, one of the other strongest arguments that traditionally has been made in opposition to supporting tax deductions or credits for the provision of uncompensated care is that it will be viewed as seriously altering a time-honored code of medical professionalism. Treating indigent patients remains an ethical obligation for physicians, and the AMA has extensive long-standing policy that supports this type of commitment. Most notably, Policy H-160.961 states:

> "Each physician has an obligation to share in providing care to the indigent. The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions. All physicians should work to ensure that the needs of the poor in their communities are met. Caring for the poor should become a normal part of the physician's overall service to patients…In addition to meeting their obligation to care for the indigent, physicians can devote their energy, knowledge and prestige to designing and lobbying at all levels for better programs to provide care for the poor."

DISCUSSION

As previously noted, both the Board of Trustees and the Council on Medical Service have studied the issue of tax relief for physicians for the provision of uncompensated care numerous times over the past 20 years. Given the current environment of decreasing payment levels and increasing practice costs, the Council recognizes that providing care without being compensated remains a serious and considerable problem that needs to be addressed.

However, as detailed in this report, the Council believes that seeking tax deductions and/or credits for the provision of uncompensated care would not be a sound policy position for the AMA. The Council continues to believe that current policy is viable and should not be rescinded. Establishment of tax credits or deductions would necessitate the creation of new IRS regulations, and would likely result in increased scrutiny by the IRS, as well as an increased risk of liability. In addition, given the heavy handedness of the Office of the Inspector General over the past several years, the Council does not believe it is wise to advocate for what would clearly be an increased IRS presence in physician offices and the injection of a whole secondary bureaucracy into health care decision-making. Finally, the Council believes that seeking such tax relief conflicts with physicians' long-standing ethical responsibility to treat indigent patients.

The AMA has established policy that the Council continues to believe has potential for providing some assistance to physicians. For example, AMA Policy H-160.965 urges all jurisdictions to provide physicians with protection from liability for uncompensated care for the indigent. Further, Policy H-165.992 encourages state medical associations to seek the enactment of legislation in their jurisdictions which would: (a) establish programs to provide publicly funded vouchers for assisting uninsured and underinsured low income individuals in the purchase of state risk pool coverage, with different levels of beneficiary premium cost-sharing based on ability to pay; and (b) establish state indigent care pools funded by general revenues from which funds would be distributed to providers in proportion to the volume of uncompensated care rendered, providing adequate and equitable reimbursement for provided services. The Council believes these type of state legislative remedies may be better received by both Congress and the American public.

While the Council does not support tax credits or deductions for uncompensated care, the Council believes it is important for the AMA to continue to explore alternative methods of compensation for physicians who regularly treat the indigent or uninsured. Although caring for the poor should be a regular part of the physician's practice, the economic challenges of the current practice environment suggest the need for some type of solution. In this regard, the Council continues to believe that the policies adopted by the House of Delegates over the past five years to facilitate the expansion of coverage to the uninsured will have the secondary effect of achieving payment for many previously uncompensated services.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 202 (I-01), Substitute Resolution 208 (I-01), Resolution 106 (A-02), and Resolution 122 (A-02), and that the remainder of this report be filed:

1. That the AMA continue to explore alternative methods of compensation for physicians who treat the indigent or uninsured or underinsured. (Directive to Take Action)