REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-I-11

Subject: Physician Tax Credits for Uncompensated Care

Presented by: Thomas E. Sullivan, MD, Chair

At the American Medical Association's (AMA) 2010 Interim Meeting, the House of Delegates adopted as amended Council on Medical Service Report 2-I-10, "Physician Tax Credits for Uncompensated Care." The second recommendation of the report asked that the AMA "study methods, including potential tax credits or deductions, to support physicians who provide uncompensated or under-compensated care" (Policy D-385.961, AMA Policy Database). The Board of Trustees referred this issue to the Council on Medical Service for a report back at the 2011 Interim Meeting.

This report provides background on the issue of providing physicians tax credits for uncompensated care, summarizes relevant AMA reports and policy, and highlights innovative programs and strategies by states and communities that assist and incentivize physicians in providing charitable care.

BACKGROUND

According to the 2007-2008 Physician Practice Information (PPI) Survey, a joint effort led by the AMA and more than 40 national medical specialty societies, 53.5 percent of physicians provided charity care in their most recent week of practice, and 82.2 percent incurred bad debt for services rendered in the prior year. These results were similar to those of the Community Tracking Study Physician Survey conducted by the Center for Studying Health System Change, which found that 59 percent of physicians provided some charity care in 2008. The Community Tracking Study reveals a trend toward physician charity care not increasing to match the needs of the uninsured. Between 1996-1997 and 2004-2005, the survey found an 18-percent decrease in the amount of physician charity care relative to the number of uninsured Americans. The survey also found that levels of charity care are highest among physicians in solo or small group practices, which is a concern with physicians continuing to join larger group practices or seek hospital employment.

According to the Urban Institute, physicians' donated time and foregone profits were estimated to account for roughly 13.6 percent ($7.8 billion) of uncompensated care provided to uninsured individuals in the US in 2008. However, with the enactment of the Patient Protection and Affordable Care Act (ACA, PL 111-148), the Urban Institute also estimates that the costs associated with uncompensated care would be cut by 61 percent, due to the projected increase in coverage. The Congressional Budget Office estimates that the combined coverage provisions in the ACA would expand health insurance coverage by 32 million by 2016. At the same time, an estimated 21 million non-elderly individuals living in the US would remain uninsured. Therefore, while the ACA will reduce the amount of uncompensated care, there still will be millions of individuals who will continue to depend on physicians willing to care for them, regardless of their ability to pay.

AMA REPORTS AND POLICY

Council on Medical Service Report 2-I-10 followed the precedent set by Council on Medical Service Report G-A-82, Board of Trustees Reports N-I-89 and 49-I-93, Council Report 2-A-98, and Council Report 5-I-02, and outlined the long-standing concerns associated with pursuing tax deductions and/or credits for physicians who provide uncompensated care. It also reviewed the various proposals submitted by members of the Federation. The report concluded that seeking tax deductions and/or credits for the provision of uncompensated care continues to be inconsistent with broader AMA values focused on covering the uninsured and physicians receiving prompt and adequate payment for services rendered. Current and long-standing AMA Policy H-180.965, unequivocally 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.

Policy H-160.961 stresses that treating indigent patients remains an ethical obligation for physicians. Policy H-160.922 urges physicians to share in the provision of uncompensated care to the uninsured indigent. Policy H-380.994 affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner.

Policy H-160.971 supports communicating to the public the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens, and publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care. Policy H-160.923 supports the transitional redistribution of public funds currently spent on uncompensated care provided by institutions for use in subsidizing private health insurance coverage for the uninsured.

AMA policy is also supportive of the continued promotion of community service and volunteerism by its membership (Policy H-405.991). Policy H-160.940 supports organized efforts to involve volunteer physicians, nurses and other appropriate providers in programs for the delivery of health care to the indigent and uninsured and underinsured through free clinics. In order to facilitate physician volunteerism, numerous policies address the vital issues of liability and licensure. Policy H-435.976 states that the AMA endorses the concept of liability protection for medical volunteer services and to promote legislative efforts to achieve that goal. Specifically, Policy H-435.949 urges states to adopt legislation that provides for liability relief for volunteer physicians who serve at free clinics, deliver pro bono care, or volunteer in times of disaster. Policy H-275.922 encourages the Federation of State Medical Boards to develop a process among the various state licensure boards that would make it possible for a physician who holds an unrestricted license in one state/district/territory to participate in short-term (less than 90 day) physician volunteerism in another state/district/territory in which the physician volunteer does not hold an unrestricted license. Policies D-275.984 and D-160.991 state that the AMA and its Senior Physician Group will support initiatives to grant special state licenses for senior physicians who wish to volunteer their services to the uninsured or indigent, as well as federal and state-based charitable immunity laws that protect physicians wishing to volunteer their services in free medical clinics and other venues.

The second recommendation of Council on Medical Service Report 2-I-10 asked that the AMA "study methods, including potential tax credits or deductions, to support physicians who provide uncompensated or under-compensated care" (Policy D-385.961). The Council welcomes this

opportunity to explore innovative programs or strategies that states or communities use to help physicians who provide uncompensated care, consistent with Policy H-165.985[7] which supports the development of state funds for reimbursing providers of uncompensated care.

PHYSICIAN VOLUNTEERISM: ROOM FOR INNOVATION

Many of the remaining uninsured following the full implementation of the ACA will continue to rely on physicians who provide them care at no cost, either in a volunteer clinic or office-based setting. As previously outlined by the Council and the Board of Trustees, federal tax rules currently prohibit a deduction for professional services delivered to individuals under any circumstances. According to IRS Publication 526, "Charitable Contributions," deductions can only be taken for out-of-pocket expenses incurred when volunteering for a charitable organization, and the publication explicitly states that the value of time and services is not deductible as a charitable contribution. This means that there is no mechanism whereby physician services would be approved as deductible, although physicians can deduct out-of-pocket expenses incurred from providing uncompensated care. Even if care were being delivered through a charitable or non-profit organization, and the value of that care could be quantified in some standardized manner, the tax rules would have to be fundamentally changed to allow physicians to deduct the value of the services they provide. Indirect or overhead costs associated with providing care (e.g., rent, insurance, administrative services) would also be ineligible as charitable contributions, although they may already be fully deductible as business expenses, depending on how the practice entity is organized.

Despite the restrictions at the federal level for physicians to receive tax credits or deductions for the professional services they provide at no cost, there are innovative programs and strategies that are ongoing in states and communities that assist and incentivize physicians in providing charitable care. The Council believes that these programs could serve as models for physicians who are or want to become involved in volunteer opportunities, and for those who have an interest in advocating at the state and local levels for improved support for physicians who provide charitable care. The following examples of such programs provide a snapshot of ongoing volunteer programs with physician participation.

Neighborhood Assistance Program, Virginia

Virginia's Neighborhood Assistance Program (NAP) provides state tax credits to incentivize individuals and businesses, including licensed physicians, to contribute professional services directly to approved nonprofit organizations that serve the poor, such as free clinics. Tax credits under the NAP are capped at $11.9 million per year, with $4.9 million set aside for approved education proposals and the remaining $7 million for approved non-education proposals. Health care services donated by physicians must be provided without charge and within the scope of their licensure. These state tax credits can be applied against the state income tax liability of physicians who donate health care services to an approved NAP organization. Tax credit amounts are equal to 40 percent of the value of professional services rendered. As NAP organizations are allocated a defined amount of tax credits to disburse, the value of donated services must be agreed to by the physician and the approved NAP organization before the physician provides any donated health care services. Ultimately, the value of donated health care services of physicians "shall not exceed the lesser of the reasonable cost for similar services from other providers," and is capped at $125 per hour. In order to be eligible to receive the state tax credit, a minimum value of $1,000 of services must be donated. Approved NAP organizations administer necessary paperwork and issue supporting tax documentation to physicians who donate professional services to be used in their income tax filings.

Neighborhood Investment Program, West Virginia

West Virginia's Neighborhood Investment Program (NIP) facilitates charitable giving to local nonprofit organizations that have been approved by the NIP. Through the NIP, nonprofit organizations, including health clinics, can apply for tax credit vouchers. Once their applications are approved, NIP-approved nonprofit organizations then distribute the tax credits to businesses and individuals who donate to their respective organizations. The legislature in West Virginia allocates $3 million annually for NIP tax credits. To receive a tax credit under the NIP, individuals and businesses can contribute cash, personal property, real estate, stock and in-kind professional services. Tax credit amounts are equal to up to 50 percent of the value of such contributions. Although the professional services of physicians are eligible for tax credits under the NIP, the services cannot account for more than 25 percent of the total contribution of any physician. Therefore, in order to receive a tax credit under NIP, a physician must also donate cash, property or stock with a value three times greater than the donation of professional services. Under the NIP, the minimum donation a physician can make is $500; the maximum is $200,000.

Project Access, Sedgwick County, Kansas

Project Access of Sedgwick County, Kansas, is an example of a physician-led initiative to provide needed health care services to low-income and uninsured residents in the US. The Sedgwick County, Kansas project is similar to other programs named "Project Access" led by physicians in communities across the country. Project Access of Sedgwick County coordinates donated medical care and services provided by physicians, hospitals and pharmacies for uninsured, low-income residents of the country. Sixty percent of the physician members of the Medical Society of Sedgwick County are currently participating in Project Access and have agreed to provide donated care to 10 to 20 patients annually. Of the 603 physicians currently participating, 178 are primary care physicians and 425 are specialists. In addition, under the program, approximately 50 physicians volunteer at six safety net clinics. Since September 1, 1999, Project Access has enrolled 10,295 patients, with approximately 840 patients seen daily.

Volunteer Initiatives of National Medical Specialty Societies

Several national medical specialty societies have established volunteer initiatives through which members can research different opportunities in their communities, across the country and abroad. Also, such programs assist physicians in finding and getting matched to opportunities that best meet their specializations, interests and needs. In 2004, the American College of Surgeons (ACS) launched Operation Giving Back, a volunteer initiative that provides ACS members with information and resources to learn more about volunteering, as well as a searchable database through which surgeons can access available volunteer opportunities. Likewise, the American College of Physicians (ACP) has a volunteer networking database through which ACP members can learn more about volunteer opportunities from their colleagues.

Senior Physicians Group, American Medical Association

The Senior Physicians Group of the AMA, which has approximately 57,000 senior physician members, is active in facilitating the volunteerism of senior physicians in communities across the US. The Senior Physicians Group provides general resources on physician volunteerism and links to volunteer opportunities, including those at free clinic and community education organizations. The Senior Physicians Group has historically worked on the issues of licensure and liability so that physicians who are either retired or semi-retired from practice can volunteer their services to the indigent and uninsured with appropriate protections in place.

CONCLUSION

The Council believes that the health insurance coverage expansion provided for in the ACA will help to limit the care that is provided by physicians without compensation, because physicians will get paid for the services they provide to the newly insured. However, the Council recognizes that providing care without being compensated remains a serious issue for physicians, with an estimated 21 million nonelderly individuals living in the US who will remain uninsured by 2016. Therefore, physicians across the country will continue to provide uncompensated and undercompensated care to low-income and uninsured patients, in some cases to the further financial detriment of their practices.

The Council notes the importance of physicians providing charity care in their offices and volunteering their time and services at free clinics and nonprofit organizations. AMA policy states that treating indigent patients remains an ethical obligation for physicians, supports physicians in sharing in the provision of uncompensated care to the uninsured indigent, and encourages the continued promotion of community service and volunteerism by its membership. As physicians continue to serve the indigent and uninsured, the Council believes that existing initiatives at the state and community levels, including those highlighted in this report, can serve as models to ensure that the provision of charitable care by physicians is recognized and supported.

That being said, the Council reiterates its belief that in this political and economic environment, in which there are budgetary pressures to spend health care dollars in the most effective and efficient manner, that limited available resources should be directed toward expanding health insurance coverage for all Americans. Instead of promoting the concept of tax deductions and/or credits for the provision of uncompensated care, the Council continues to stress that the focus of AMA policy and advocacy should be on advocating for legislative and regulatory changes that would ensure that physicians get paid for services rendered.

References for this report are available from the AMA Division of Socioeconomic Policy Development.