



## Legislative Fiscal Bureau

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Joint Committee on Finance

Paper #324

### **Electronic Medical Records Tax Credit (General Fund Taxes -- Individual and Corporate Income Taxes)**

#### *Bill Agency*

[LFB 2007-09 Budget Summary: Page 164, #15]

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#### **CURRENT LAW**

Costs related to the operation of a business are deductible as business expenses if the expenses are ordinary and necessary and connected to the trade and business of the taxpayer. Business expenses are deductible in computing the taxable income of all taxpayers including sole proprietors, corporations, limited liability companies (LLCs), partnerships, estates and trusts, and employees. Generally, the costs of computer hardware are depreciated, while the costs of computer software are amortized.

The deduction for depreciation allows taxpayers to recover, over a period of years, the cost of capital assets used in a trade or business or for the production of income. The deduction is an allowance for the wear and tear, deterioration, or obsolescence of the property. To be depreciable, the property must have a determinable life of more than one year, and it must decline in value through use or the passage of time. Only property used in a trade or business or held for the production of income is eligible for a depreciation deduction. The amount to be recovered by depreciation is the cost or other appropriate basis of the property. The life over which the depreciable basis of property is recovered depends upon the type of asset that is depreciated and the system of depreciation that is used.

Because state depreciation provisions are referenced to the federal Internal Revenue Code (IRC) in effect on December 31, 2000, tangible depreciable property currently placed in service is generally subject to the Modified Accelerated Cost Recovery System (MACRS). Under

MACRS, the cost of property is recovered by using accelerated methods of cost recovery and statutory recovery periods and conventions. The deduction is computed by first determining the MACRS basis of the property. Each item of eligible property is then assigned to a specific class and each class establishes a recovery period over which the cost of the property is recouped using the applicable depreciation method and convention. Depreciation tables may be used by multiplying the basis of the assets by the applicable percentage for the applicable year of the recovery period. Alternatively, the deduction can be calculated using the appropriate method, recovery period, and convention.

Under MACRS, computers and peripheral equipment are classified as five-year property, and the cost is deducted over five years using the 200% declining balance method of computing annual deductions. Federal law defines a computer as a programmable, electronically activated device that is capable of accepting information, applying prescribed processes to the information, and supplying the results of such processes with or without human intervention. A computer consists of a central processing unit with extensive storage, logic, arithmetic, and control capabilities. A computer does not include typewriters, calculators, adding and accounting machines, duplicating machines, or equipment of a kind used primarily for the user's amusement or entertainment. Related peripheral equipment is any auxiliary machine which is designed to be controlled by the central processing unit of a computer.

Amortization provisions allow a taxpayer to annually deduct a portion of certain capital expenses that are not ordinarily deductible. Typically, these expenses are not otherwise deductible because: (a) they relate to assets that are not depreciable because the assets have an unlimited or indefinite life; or (b) they pertain to organizational or investigative expenses that were incurred before the taxpayer went into business. The deduction for amortization is similar to the straight-line method of depreciation in that a fixed portion of the cost of the asset or expense is deducted each year over a specified amortization period.

Computer software that is readily available for purchase by the general public, is subject to a nonexclusive license, and has not been substantially modified can be amortized. Computer software may be considered readily available to the general public even though it is not sold through a retail distribution system. Also, computer software is not considered substantially modified if the cost of the modifications does not exceed the greater of 25% of the purchase price or \$2,000. Most computer software is amortized using the straight-line method over three years. Software acquired in certain transactions related to business acquisitions is subject to amortization rules. Computer software whose cost is included, without being separately stated, in the cost of the computer hardware or other tangible property, is treated as part of the cost of the hardware or other tangible property, and depreciated as part of the cost of the hardware or property. Under federal law, computer software includes all programs designed to cause a computer to perform a desired function. It also includes any database or similar item that is in the public domain and is incidental to the operation of the qualifying software. Under federal law, taxpayers can expense all or a portion of the costs of software, rather than treat it as a capital expenditure subject to depreciation. However, off-the-shelf computer software is not eligible for this treatment under state law.

## **GOVERNOR**

Create an electronic medical records tax credit under the individual income and corporate income and franchise taxes. The tax credit would equal 50% of the amount paid by a health care provider in a tax year for information technology hardware or software that is used to maintain medical records in an electronic form. Tax credits not entirely used to offset income and franchise taxes could be carried forward up to 15 years to offset future tax liabilities. The maximum total amount of electronic medical records tax credits that could be claimed in a tax year would be \$10 million. The credit would first be available for tax years beginning after December 31, 2008.

## **DISCUSSION POINTS**

1. The Department of Commerce would be required to implement a program to certify health care providers as eligible to claim the electronic medical records tax credit. After certifying health care providers as eligible, Commerce would be required to allocate tax credits to individual claimants, subject to the annual total credit limit of \$10 million. Commerce would have to inform DOR of every health care provider that was certified and of the amount of tax credits allocated to each provider. Commerce would be required, in consultation with DOR, to promulgate rules to administer the certification and tax credit allocation process.

Partnerships, LLCs, and tax-option corporations could not claim the tax credit, but eligibility for, and the amount of, the credit would be based on the entity's payment of allowable information technology costs. A partnership, LLC, or tax-option corporation would be required to compute the amount of the tax credit each of its partners, members, or shareholders could claim and provide that information to them. Partners, members of LLCs, and shareholders of tax-option corporations would claim the credit in proportion to their ownership interest.

"Health care provider" would be defined under current law provisions and would mean a licensed nurse, chiropractor, dentist, physician, podiatrist, perfusionist, physical therapist, occupational therapist, occupational therapy assistant, physician assistant, respiratory care practitioner, dietician, athletic trainer, optometrist, pharmacist, acupuncturist, psychologist, social worker, marriage and family therapist, professional counselor, speech-language pathologist, audiologist, speech and language pathologist, massage therapist, bodyworker, a partnership of providers, a corporation or LLC of providers that offer health care services, an operational cooperative sickness care plan that directly provides services through salaried employees at its own facility, a hospice, a rural medical center, an inpatient health care facility, and a community-based residential facility.

The electronic medical records tax credit could first be claimed for tax years beginning after December 31, 2008, and would reduce income and franchise tax revenues by an estimated \$4.5 million in 2008-09 and \$10 million annually in 2009-10 and thereafter.

2. A 1999 study by the Institute of Medicine indicated that as many 98,000 people in

the United States die annually from medical errors, and a lack of coordinated care was a major factor. A 2006 Institute study found that drug-related errors harmed about 1.5 million people each year, and the extra medical costs of treating drug-related injuries that occur in hospitals amounted to \$3.5 billion annually. Other similar statistics further indicate that: (a) patients that have illnesses with known treatments, such as heart attack medications, receive appropriate care only 54.9% of the time (Hussey, et al. 2004); and (b) medical errors occur in approximately 7% of hospital admissions and lead to serious injury in about 3.7% of total hospitalizations (McGlynn, et al., 2003; Institute of Medicine, 1998). According to a 2005 report by the Oregon Health Policy Commission, quality and safety problems result in approximately 57,000 deaths, 41 million sick days, and \$11 billion in lost productivity annually. Though many factors contribute, a significant cause is inadequate access to information and resulting waste, fragmentation of care, and errors. For example, a 2005 study found that missing information compromised about 13% of all clinical encounters (Smith, et al.).

3. Numerous health care providers lack the information systems necessary to coordinate a patient's care with other providers, share required information, monitor compliance with preventive actions and disease management guidelines, and measure and improve performance. Also, consumers generally lack the information they need about costs or quality to make informed decisions about their care. Historically, health care providers have documented and delivered health care using paper records because of their simplicity, low implementation cost, and widespread acceptance. However, paper records have a number of disadvantages, including availability to only one person at one time, frequent illegibility, inability to be accessed from remote locations or at the time and place they may be needed, low utility in measuring quality of care, and segmentation because of multiple volumes and storage sites. Consequently, many health care industry participants and experts view electronic health records and health information interoperability as part of a solution to improve health care quality, safety, and reduce costs.

4. The terms "health information technology" (HIT), "electronic health records" (EHR), and "electronic medical records" (EMR) are frequently used terms associated with electronic data processing in the healthcare industry. HIT refers to the development of an information technology infrastructure in the industry. EHRs and EMRs are components of HIT. While there is currently no industry consensus on the difference between EHR and EMR and the two terms are often used interchangeably, there is a clear and functional distinction. An electronic medical record is the electronic replacement for paper charts, and is the legal record of inpatient and outpatient encounters within a single care delivery organization or physician practice. The EMR is used by health care practitioners to document, monitor, and manage health care delivery within the organization or practice, and is owned by the entity. The EHR is a longitudinal electronic record of patient information generated by one or more encounters in any care delivery setting. The EHR provides access to a patient's health information at the point of care and is typically accessed on a computer or over a network, and connects physicians and other caregivers. Included in EHR information are patient demographics, progress notes, problems, medications, medical history, immunizations, laboratory data, and radiology reports. The EHR can be established only if the EMRs of various care delivery organizations and physician practices have evolved to the level that can create and support an exchange of information between caregivers.

5. One of the more widely referenced studies that estimated the potential national benefits that would result from widespread adoption of health information technology was conducted by the RAND Health Information Technology Project Team between 2003 and 2005. The study collected data from a number of sources, such as surveys and interviews, analyzed information technology costs and benefits in other industries, and developed mathematical models for estimating the costs and benefits of HIT implementation in health care. The "potential" benefits assumed interconnected and interoperable electronic medical records systems adopted widely and used effectively, and after a successful implementation period and associated process changes and resource reductions. The study measured estimated efficiency savings, safety benefits, health benefits, costs of implementation and net benefits from widespread use of HIT systems.

A simulation model projected annual efficiency savings would be \$77 billion, after average annual savings of \$42 billion during implementation. The largest savings would be generated by reducing hospital lengths-of-stays, reducing nurses' administrative time, and more efficient drug and radiology usage. Benefits from improved safety would result largely from alerts and reminders generated by computerized physician order entry (CPOE) systems for medications. The system would provide immediate information to a physician, including potential adverse reactions to certain medications. The study estimated that CPOE could eliminate 200,000 adverse drug events and save about \$1 billion per year in inpatient settings. About \$3.5 billion could be saved by eliminating adverse drug events in ambulatory settings.

The RAND study measured health benefits by analyzing two kinds of interventions used to enhance health: disease prevention and chronic disease management. HIT would assist disease prevention by scanning patient records for risk factors and recommending preventive services, such as vaccinations. The effects of disease prevention were estimated by increasing five selected preventive services as follows: (a) increased influenza vaccinations at an estimated cost of \$134 million to \$327 million annually would prevent 5,200 to 11,700 deaths; (b) increased pneumonia vaccinations costing \$90 million per year would prevent between 15,000 and 27,000 deaths; (c) increasing breast cancer screening for \$1 to \$3 billion annually would prevent between 2,200 and 6,600 deaths each year; (d) increased cervical cancer screening costing \$152 million to \$456 million each year would prevent 533 deaths each year; and (e) increasing colorectal cancer screening at a cost of \$1.7 billion to \$7.2 billion could prevent 17,000 to 38,000 deaths. A program of HIT-enhanced prevention and disease management could also change the incidence of chronic conditions and their complications. The HIT system can be used to identify patients requiring tests and other services, and patients could use remote monitoring systems. Effective disease management can reduce the need for hospitalization. Considering potential long-term illnesses such as cardiovascular disease, cerebrovascular disease/stroke, diabetes, emphysema, and cancers associated with smoking, the study estimated how combinations of lifestyle changes and medications that reduced the incidence of these conditions would affect health care use, spending, and outcomes. The estimated combined savings from long-term prevention and management, and reduced acute care due to disease management was \$147 billion a year.

RAND estimated the cumulative costs for 90% of hospitals to adopt a HIT system to be \$98 billion, with average yearly costs of \$6.5 billion during a 15-year implementation period. The

cumulative costs for 90% of physicians to adopt HIT systems was an estimated \$17.2 billion, with an average annual cost of \$1.1 billion during the implementation period. The authors indicate that, because process changes and benefits take time to develop, net savings would initially be low, and then rise steeply. Over fifteen years the cumulative potential net efficiency and safety savings from hospital systems could be nearly \$371 billion; while the potential cumulative net savings from physician practice HIT systems would be \$142 billion.

A 2005 review (Chaudhry et al., 2005) of empirical studies from four benchmark medical institutions found that implementation of a multifunctional HIT system had the following effects: (a) increased delivery of care in adherence to medical guidelines and protocols, particularly in the domain of preventive health; (b) enhanced capacity to perform surveillance and monitoring for disease conditions and care delivery, based on large-scale screening and aggregation of data; (c) reductions in rates of medication errors; (d) decreased utilization for potentially redundant or inappropriate care; and (e) mixed effects on time requirements on medical personnel.

6. The current enthusiasm about HIT is not new. In the 1960s innovators such as Lawrence Weed implemented clinical computing systems designed to revolutionize practice. Soon after, the COSTAR system was installed at a Boston health maintenance organization. In the late 1960s, Lockheed Corporation developed its system, which was installed at Mayo Clinic and elsewhere, but subsequently was abandoned. TDS and a descendant system were recently criticized for causing medication errors. Many hospitals purchased total hospital information systems that were at best partial. Thus, historically, many providers have spent substantial amounts to upgrade health information technology (Himmelsteine and Woolhandler, 2005).

In this context, the projected benefits of EHR by studies such as RAND, have been questioned. While a few of the components of HIT exist, nowhere is the total system in use, especially the interoperability functions. Computing systems often fail because of data capture, not because the designers do not understand the required computations. For example, how will data stored in multiple legacy systems be captured for the proposed interoperability of data? Hospitals, insurance companies, and government agencies will all have to develop and agree on the definitions and units in which thousands of data elements are measured. The benefit estimates assume computers can be programmed to influence medical practice in ways that will reduce costs and not detrimentally affect outcomes. Moreover, the benefit estimates assume EMRs will double patient compliance with advice to quit smoking and lose weight, or assure 100% participation in disease management programs. Estimated savings are based on expert opinions and extrapolations from small samples (Himmelsteine and Woolhandler, 2005).

The potential estimated benefits of HIT are based, in part, on the ability to introduce new efficiencies in health care delivery. Some studies have shown that EHR increased documentation time among physicians 17%, while CPOE increased it 98%. Studies also suggest that a possible outcome is the same providers serving the same patients, with fewer office visits. In order for EHR to generate clerical staff efficiencies, employment would need to be completely terminated, but evidence indicates that has not occurred. Ultimately, lower staffing ratios from EHR should enable insurers to reduce their fee schedules, but there is little evidence this is occurring among those

companies possessing EHR. Decision logic included in EHR can lead to greater intensity of service, corresponding increased costs, but little additional benefit to patients. The effectiveness of EHR in reducing omission-type error reductions through alerts and reminders is limited. EHR decision support has been shown to have no effect in certain cases, such as adherence to primary guidelines for asthma or angina management. The use of clinical laboratory and radiology services did not change conclusively over a two-year transition to EHR at Kaiser Permanente. Although EHR-based decision support and CPOE have been shown to decrease medication errors and reduce costs, not all reports on CPOE have been positive. In one pediatric intensive care unit, introduction of CPOE resulted in increased mortality rates due to delays and increased documentation time, and hampered communication among team members (Sidorov, 2006). Finally, in a report published in 2006 in the *Annals of Internal Medicine*, researchers affiliated with the Southern California Evidenced-Based Practice Center reported that they found few rigorous and generalizable studies on the effects of health information technology.

7. There is no comprehensive, current database that identifies the level of HIT development by health care providers for either the U.S. or Wisconsin. There are a number of surveys and studies that provide information about the level of HIT usage nationally for various industry sectors. A 2007 survey by the American Hospital Association (*Continued Progress, Hospital Use of Information Technology, 2007*) reported that 68% of hospitals in the U.S. had fully or partially implemented EHRs in 2006. A total of 11% had fully implemented EHRs, and were more likely to be large, urban, and/or teaching hospitals. In 2006, 46% of community hospitals reported moderate or high use of HIT. In 10% of hospitals, physicians routinely used CPOE to electronically order medications at least 50% of the time. In the survey, 51% of hospitals were using real-time drug interaction alerts and about one-half (49%) of hospitals shared electronic patient data, with the most common partners being private-practice physician offices, laboratories, payers, and other hospitals. According to the report, larger hospitals, those in urban areas, and hospitals with positive financial margins used more health information technology. In addition, large and urban hospitals showed greater rates of growth in information technology usage than smaller, rural hospitals.

A 2005 study, based on a random sample of approximately 34,500 medical groups, found that 15% of practices used EHRs (Gans, Kralewski, Kammons, and Dowd, 2005). Smaller practices had lower EHR adoption rates, with about 20% of those with 21 or more physicians having adopted the technology, compared to about 12% with five or fewer physicians. About 60% of practices indicated they planned to adopt EHR technologies within two years. However, the small practices were not planning such investments. Another study, based on a survey conducted between 1995 and 2005, found that approximately 24% of physicians used EHRs, but only 9% used systems that had functionalities such as electronic prescribing (Jha et al., 2005). Again, adoption rates varied by practice size, with small practices having much lower adoption rates. About 88% of respondents indicated that they were currently addressing EHRs and/or planned to take action within six months. Accenture conducted a 2005 survey of executives of hospitals, health insurance plans, physician groups, health technology vendors, and other health organizations (*Electronic Health Records Survey, Achieving High Performance in Health Care*). Nearly 30% of respondents indicated that they had already developed, or were in the process of implementing, EHRs.

8. The RAND study (Hillestad et al., 2005) estimated that HIT could save about \$81 billion (\$77 billion from efficiency and \$4.5 billion from safety) through improvements in health care delivery efficiencies from using EMR systems and improvements, and disease management could more than double this amount (\$162 billion). However, networked, complex EHRs, which potentially could transform health care have been adopted relatively slowly. There are a number of barriers to developing such a system that are frequently identified. Generally, the initial acquisition and implementation cost is viewed as the most significant barrier to establishing EHR systems. Respondents to the American Hospital Association (AHA) survey identified the ongoing costs of deploying and maintaining information systems as the greatest barrier. Surveys conducted by the Medical Records Institute (2005), American Academy of Family Physicians (2004), and Accenture (2005) all list cost of implementing EHR systems as the most prominent barrier to EHR systems deployment.

Other barriers to implementation include the risk of investing in systems that can have slow and uncertain financial returns for health care providers. Providers that implement EHR systems express concerns about system performance factors such as the ability of software to meet the provider's needs, ability of the system to integrate with the existing billing and claims system, ease of input of historical medical records and other data, future system component obsolescence, and the lack of common standards. In general, providers are unsure of the return on investment. Another barrier is a disconnect between the entities that pay for EHR systems and those that benefit. Many of the financial benefits of EHR systems accrue to insurance companies and purchasers of health care, rather than to the provider groups and networks that invest in them. However, this would not be the case for integrated delivery systems. Acceptance by clinical staff, particularly physicians, is another concern. Nearly one-half (46%) of respondents to the Accenture survey listed physician resistance to change as a major implementation barrier to their organization. Implementation of EHR systems can also cause a workflow disruption and reduced staff productivity during system changeovers. A 2006 survey conducted by the Journal of American Medical Informatics Association (JAMIA) of over 1,300 physicians in Massachusetts found that 81% of respondents expressed concerns about loss of productivity that would result from adopting health information technology. Concern about security and privacy of electronic personal information is a significant issue in developing EHRs. A January, 2007, Government Accountability Office (GAO) report indicated that a lack of a comprehensive privacy protection strategy by the Department of Health and Human Services for confidential health information could delay adoption and use of electronic medical records (*Health Information Technology, Early Efforts Initiated but Comprehensive Privacy Approach Needed for National Strategy, 2007*). A significant barrier to implementation of EHRs is concern about the interoperability of individual health information technology systems. Information-exchange networks have not been fully developed. Almost 80% of respondents to the AHA survey listed interoperability of EHRs with current information technology systems as a barrier to implementation. A main recommendation from participants in the Accenture survey was the need to develop uniform standards for interoperability and data exchange to be used by all entities in the health care delivery system.

9. Theoretically, a business will evaluate alternative new investments based on the present value or rate of return on that investment. If an investment generates a return or present



value in excess of a specified threshold amount, the business will make the investment. As a result, if investment in HIT generates an acceptable return, health care providers can be expected to fund the development and implementation of EHM systems through the normal functioning of capital markets. The AHA survey shows that 68% of hospitals have implemented EHRs at some level, while 60% of medical groups in another study indicated their intentions to adopt EHR systems (Gans, et al., 2005). More than 70% of the hospital, health insurance plan, health technology vendor, and other health organization executives believed that EHRs would have a positive financial effect on their organizations (Accenture 2005). AHA reported that hospitals in its survey made investments in health information technology because of the quality and safety improvements that could be realized. Case studies of individual or small group primary care practices found that although initial costs for implementing EHR software averaged \$44,000 per full-time equivalent provider and ongoing costs averaged \$8,500 a year, the average practice paid for its EHR costs in 2.5 years (Miller et al., 2005).

In competitive markets, prices transmit accurate signals of the benefits and costs of goods that are produced and consumed. However, many economic activities provide incidental benefits or costs, and the market deals poorly with the incidental side effects of economic activities. The price system only allocates resources efficiently when all of the costs and benefits of economic activity are included in profit calculations. A private firm is forced by competition to produce at the lowest cost possible, and has no motivation to take into account any benefits it does not receive. When the social benefit exceeds the private benefit of an investment, the investment made by the individual firm will be less than the amount that would be socially optimal. Because of the market's inability to effectively deal with external costs and benefits, an appropriate government policy would be to provide subsidies to firms equal to the difference between the private benefits (costs) and the social benefits (costs).

The RAND study indicates that widespread adoption and effective use of EHR systems could save the U. S. health care system as much as \$162 billion. High initial costs of implementation and a disconnect between the entities that pay for EHRs and those that benefit have been identified as barriers to the widespread development of EHR systems. The study of medical groups found that, for physician groups that implemented EHRs, the average initial cost was approximately \$33,000 per physician with maintenance costs of about \$1,500 per physician. Because practices generally do not have retained earnings, capital equipment expenditures must be funded from physician salaries. The study indicates that the substantial initial cost of EHR systems is likely to limit adoption of EHR technologies (Gans et al., 2005). Similarly, a study of community health centers found that initial EHR costs averaged almost \$54,000 per employee, and that the evidence suggested that policies were needed to help afford EHRs. The AHA survey indicated that smaller, more rural hospitals were less likely to implement EHR technologies. The proposed electronic medical records tax credit would reduce the cost of investing in EHR technology. As a result, the rate of return or present value of such investments would increase and firms would be more likely to make such investments. Since widespread use and interoperability of EHRs will generate the most savings in the health care system, the proposed tax credit could be viewed as an appropriate component of state health care policy.

10. In general, all individuals and corporations over which Wisconsin has taxing jurisdiction are subject to the individual income and corporate income and franchise income taxes. However, there are certain types of entities that are specifically exempt, including governmental entities and nonprofit corporations or associations. As a result, most hospitals in the state and other nonprofit or governmental health care entities, such as community health centers, are exempt from state income and franchise taxes. Conversely, most physician groups or individual practices are subject to taxation. In addition, the income of nonprofit cooperative sickness care associations, nonprofit service insurance corporations, and religious, educational, benevolent, and other nonprofit corporations that is derived from health maintenance organizations (HMO) and limited service health organizations is subject to the state corporate income tax.

11. SB 40 includes provisions under DHFS that would provide \$10 million annually from the health care quality fund (HCQF) to fund initiatives to promote the adoption of health care quality and patient safety information technology and to develop exchanges of health information. To the extent this funding is used to subsidize adoption of EHR technologies in medical providers that are not subject to the state individual and corporate income and franchise taxes, it would contribute to widespread implementation of EHR, and increase the effectiveness of the medical records tax credit tax credit.

12. The maximum amount of electronic medical records tax credits that could be claimed under the bill is \$10.0 million in a tax year. Based on aggregate national cost and potential demand data and on discussions with officials in the Wisconsin health care industry it is estimated that the total maximum amount of tax credits would be claimed, particularly during the next two biennia. However, the lead time required to make such investments and their high initial costs could diminish the number of credit claims. Also, the Committee may not wish to commit \$10 million annually to this proposal. Therefore, the Committee may wish to reduce the maximum amount of tax credits that could be claimed to \$5.0 million for tax year. This would reduce state individual income and corporate income and franchise tax revenues by an estimated \$2.25 million in 2008-09 and \$5.0 million annually thereafter. On the other hand, if it is believed that the state should encourage rapid adoption of EHR technology, the effective date of the medical records tax credit could be moved up one year to apply to tax years beginning after December 31, 2007. This would reduce state individual income and corporate income and franchise tax revenues by an estimated \$4.5 million in 2007-08 and \$10.0 million in 2008-09 and thereafter.

## **ALTERNATIVES TO BILL**

1. Adopt the Governor's recommendation to create an electronic medical records tax credit under the individual income and corporate income and franchise taxes equal 50% of the amount paid by a health care provider in a tax year for information technology hardware or software that is used to maintain medical records in an electronic form, effective for tax years beginning after December 31, 2008.

<b>ALT 1</b>	<b>Change to Bill Revenue</b>	<b>Change to Base Revenue</b>
GPR	\$0	- \$4,500,000

2. Modify the Governor's recommendation to limit the maximum amount of medical records tax credit claims to \$5.0 million for each tax year.

<b>ALT 2</b>	<b>Change to Bill Revenue</b>	<b>Change to Base Revenue</b>
GPR	\$2,250,000	- \$2,250,000

3. Modify the Governor's recommendation to make the medical records tax credit first apply to tax years beginning after December 31, 2007.

<b>ALT 3</b>	<b>Change to Bill Revenue</b>	<b>Change to Base Revenue</b>
GPR	- \$10,000,000	- \$14,500,000

4. Delete provision.

<b>ALT 4</b>	<b>Change to Bill Revenue</b>	<b>Change to Base Revenue</b>
GPR	\$4,500,000	\$0

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