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78th LEGISLATIVE ASSEMBLY
SENATE COMMITTEE ON HEALTH CARE

State Capitol
900 Court St. NE, Rm. 453
Salem, OR 97301
503-986-1535
FAX 503-986-1814

The Senate Health Care Committee heard and voted on Senate Bill 37, 38, 39, and 42 on March 11, 2015.

Below are responses to questions posed at Appendix D, on page 101 of the Legislative Revenue Office's Research Report No. 2-15, *2016 Expiring Tax Credits* (RR 2-15):

Senate Bill 37: Extends the sunset tax credits for rural medical care.

The committee recommended this rural medical provider tax credit. We discussed modifying the definition of rural, declining the incentive over time, means testing, using federal definitions, adjusting the value according to the distance from an urban center and adjusting the value according to the specialty. We were not opposed to doing any of these modifications.

1. *What is the public policy purpose of this credit? Is there an expected timeline for achieving this goal?*

The purpose of the rural practitioner tax credit is to encourage medical providers to serve rural Oregonians, reach underserved, cover as many communities as possible.

2. *Who (groups of individuals, types of organizations or businesses) directly benefits from this credit? Does this credit target a specific group? If so, is it effectively reaching this group?*

Eligible physicians, optometrists, nurses, physician assistants, and dentists receive a $5,000 credit annually to maintain a rural practice. Medical staff of hospitals qualify if hospitals are not within the boundaries of a metropolitan statistical area, the population of county is less than 75,000, or the hospital is located 30 or more miles from the closest hospital within the major population center. Approximately 1,800 providers use the credit each year. The amount used averaged 80 percent of the potential maximum and 94 percent of the amount claimed.

3. *What is expected to happen if this credit fully sunsets? Could adequate results be achieved with a scaled down version of the credit? What would be the effect of reducing the credit by 50%?*

A $5,000 tax credit may not provide a sufficient incentive to individuals above a certain level of income. However, a credit that is high enough to affect decision-making behavior may be cost prohibitive. Allowing it to sunset would make it marginally more difficult to attract and retain qualified medical professionals to rural areas. In a survey by the Oregon Rural Health Association, roughly 45 percent of respondents indicated that the tax credit was 'very important' in their decision to practice in rural Oregon.

4. *What background information on the effectiveness of this type of credit is available from other states?*

Alabama, Georgia, Louisiana, New Mexico, Colorado (recently inactive), Maine and Oklahoma. Collective information for these states: amount of credit ranges from $3,000 to $5,000; some variance by specialty and definitions of rural; contingent upon number of hours worked; non-refundable; and includes limit on number of years eligible to claim.

5. *Is use of a tax credit an effective and efficient way to achieve this policy goal? What are the administrative and compliance costs associated with this credit? Would a direct appropriation achieve the goal of this credit more efficiently?*

The cost to the taxpayer is $45 per year. Cost of Department of Revenue is minimal. The Oregon Rural Health Association bares the cost of processing tax applications. This is a marginal cost.

6. *What other incentives (including state or local subsides, federal tax expenditures or subsidies) are available that attempt to achieve a similar policy goal?*

Direct spending: Medicaid Primary Care Loan Repayment Program ($35,000 annually for three years) for providers who serve Medicaid patients in underserved areas. The Scholars for Healthy Oregon Initiative covers tuition and fees for students in medical education. The Oregon State Loan Forgiveness ($35,000/year) makes loans to students in rural training programs.

Senate Bill 38: Extends the sunset for tax credit for expenses in lieu of nursing home care.

The committee sends this tax credit to you with no recommendation. We discussed adjusting the incentive level for the age of the taxpayer and adjusting the incentive level for quality of the benefits.

1. *What is the public policy purpose of this credit? Is there an expected timeline for achieving this goal?*

A tax credit against personal income is available for care providers to pay for food, clothing, medical care, and transportation to prevent the elderly from being placed or maintained in a nursing home. To qualify, household income of the taxpayer must be no more than $17,500. The amount of credit is for $250 or eight percent of expenses, whichever is less.

2. *Who (groups of individuals, types of organizations or businesses) directly benefits from this credit? Does this credit target a specific group? If so, is it effectively reaching this group?*

This credit was created in 1979 to support people at high risk for a nursing home The person receiving the care must have household income of $7,500 or less, be certified by the Department of Human Services, receive no medical assistance from the Seniors and People with Disabilities Division, be at least 60 years of age, and not receive any home-care services under Oregon Project Independence.

3. *What is expected to happen if this credit fully sunsets? Could adequate results be achieved with a scaled down version of the credit? What would be the effect of reducing the credit by 50%?*

   Only 40 people on average use the credit. It is already a small amount ($250 per year). If Oregon Project Independence (direct subsidy) were to serve as a benchmark program, the tax credit would need to be significantly increased. As described above, average OPI benefits are $332 per month so the tax credit would need to be changed from $250 per year to $250 per month.

4. *What background information on the effectiveness of this type of credit is available from other states?*

   Two other states, Montana (2,500 for one qualifying family member) and New Mexico ($2,800 for unreimbursed expenses), have similar programs.

5. *Is use of a tax credit an effective and efficient way to achieve this policy goal? What are the administrative and compliance costs associated with this credit? Would a direct appropriation achieve the goal of this credit more efficiently?*

Only 40 people on average use the credit. Given the current cost of health care, it seems unlikely this credit would make the difference between in-home care and nursing home care.

6. *What other incentives (including state or local subsides, federal tax expenditures or subsidies) are available that attempt to achieve a similar policy goal?*

Oregon Project Independence (OPI) provides a direct benefit to individuals who are age 60 or older or have been diagnosed with Alzheimer's disease or a related disorder. If they receive Medicaid assistance they are not eligible for the program. The average OPI benefit is just under $10,000. Whereas OPI provides benefits directly to individuals receiving care, this tax credit is much smaller ($250 per year), from a policy perspective it augments the OPI program. In 2013 the Legislature created the Elderly Medical Subtraction which is a means-tested policy that allows taxpayers above a certain age to deduction a limited amount medical expenses.

Senate Bill 39: Extends the tax credit for long-term care insurance premiums.

The committee sends the long term care insurance premium tax credit to you with no recommendation. We discussed adjusting for age and quality of benefits, if it is the right amount and which entities (businesses or people) should receive it. It was noted that long-term care insurance is difficult to incentivize.

1. *What is the public policy purpose of this credit? Is there an expected timeline for achieving this goal?*

The purpose is to reduce the reliance of elderly clients on the Medicaid system through the purchase of long-term care insurance. Oregon tax payers are encouraged to purchase it at younger ages to reduce out-of-pocket costs of elderly.

2. *Who (groups of individuals, types of organizations or businesses) directly benefits from this credit? Does this credit target a specific group? If so, is it effectively reaching this group?*

For individuals, the credit is available for insurance purchased for themselves, their dependents, or their parents. For businesses, the credit is available for insurance purchased for employees in Oregon. The number of corporations claiming is under 10 each year, the rest are used by individuals. Claimants have grown by roughly 11,000 people over 7 years. Only 19 percent of the claimants are under the age of 60 and they use about 14 percent of the total amount of tax credits.

3. *What is expected to happen if this credit fully sunsets? Could adequate results be achieved with a scaled down version of the credit? What would be the effect of reducing the credit by 50%?*

One disadvantage is the limitation on the size of the credit used. The maximum income tax credit is the lesser of 15 percent of the premiums paid or $500 per insured person. Of the 33,700 full-year filers claiming the tax credit in 2012, only 6,272 were able to use the maximum $500 amount.

4. *What background information on the effectiveness of this type of credit is available from other states?*

Colorado, Maine, Maryland, Minnesota, New York, North Carolina, North Dakota and Virginia have similar credits. Key characteristics include that credit is a percentage of premiums paid up to a dollar amount, some are limited to tax payers with lower incomes, the credit amount can be larger for older taxpayers, its usually limited to one contract per tax payer, and usually tied to federal law.

5. *Is use of a tax credit an effective and efficient way to achieve this policy goal? What are the administrative and compliance costs associated with this credit? Would a direct appropriation achieve the goal of this credit more efficiently?*

The administrative cost is estimated to be minimal. One study concluded that while there are a number of factors that affect purchase, state income tax credits have a slight positive impact. A study commissioned by AARP looked at state incentives and found that the number of policy holders exceeded the number of taxpayers claiming the incentive. Another author found differing impacts for high-income and low-income taxpayers in response to the incentives, and concluded that tax incentives are ineffective in reducing the costs of Medicaid. Given that the Oregon tax credit is only 15 years old, it may be too early to expect a significant cost savings and such an estimate is empirically difficult at this time.

6. *What other incentives (including state or local subsides, federal tax expenditures or subsidies) are available that attempt to achieve a similar policy goal?*

None specific to insurance.

Senate Bill 42: Extends the tax credit for the loss of limb function.

The committee recommends this loss of limbs tax credit. We briefly discussed veteran utilization and why the drop in utilization occurred recently.

1. *What is the public policy purpose of this credit? Is there an expected timeline for achieving this goal?*

Individuals with a permanent and complete loss of function of at least two limbs are allowed a credit of $50 against personal income taxes, or $100 if both taxpayers on a joint return are eligible.

2. *Who (groups of individuals, types of organizations or businesses) directly benefits from this credit? Does this credit target a specific group? If so, is it effectively reaching this group?*

The tax credit goes to individuals with loss of limb function. The usage rate is about 70 percent. Up until 2012, the use of the tax credit was relatively stable with about 500 people claiming around $25,000 each year. In 2012 the number of claimants fell by 20 percent.

3. *What is expected to happen if this credit fully sunsets? Could adequate results be achieved with a scaled down version of the credit? What would be the effect of reducing the credit by 50%?*

The size compared to disability related costs is minor.

4. *What background information on the effectiveness of this type of credit is available from other states?*

   Several states have similar credits. Some characteristics are that it is often linked with the elderly, there is a clear definition of disability, and the credit could be for the person taking care of a disable person, and state credit is sometimes simple percentage of federal credit.

5. *Is use of a tax credit an effective and efficient way to achieve this policy goal? What are the administrative and compliance costs associated with this credit? Would a direct appropriation achieve the goal of this credit more efficiently?*

The administrative costs are mostly born by Department of Revenue and taxpayers and are minimal. It is easy to administer, but small compared to disability related costs.

6. *What other incentives (including state or local subsides, federal tax expenditures or subsidies) are available that attempt to achieve a similar policy goal?*

The severe disability tax credit is for those with loss of limbs, permanent blindness, or a mental condition that prevents a person from earning a living. The credit is indexed to inflation and was $191 in 2014. The elderly or permanently disabled tax credit can be for as much as $5,000 for single filers and $7,500 for joint filers. The child with a disability tax credit is for a dependent child who is eligible for early intervention services, or who is diagnosed for special education purposes as being autistic, mentally retarded, multi-disabled, visually impaired, hearing impaired, deaf-blind, orthopedically impaired, other health impaired, or as having serious emotional disturbance or traumatic brain injury. The credit is indexed to inflation and was $191 in 2014.