MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1224

2001 HOUSE FINANCE AND TAXATION

HB 1224

2001 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1224

House Finance and Taxation Committee

❑ Conference Committee

Hearing Date January 23, 2001

Tape Number	Side A	Side B	Meter #
1		X	1,277
Committee Clerk Signature	Janice Stein		

Minutes:

REP. AL CARLSON, CHAIRMAN, Opened the hearing.

REP. TODD PORTER, DIST. 34, MANDAN, Introduced the bill. See attached written testimony.

REP. RENNER Asked how many people carry long term insurance?

REP. PORTER Stated he would refer that question to Mr. Poolman, Commissioner of Insurance.

JIM POOLMAN, NORTH DAKOTA COMMISSIONER OF INSURANCE, Testified in support of the bill. Submitted a handout relating to financing long-term care. He stated the average North Dakotan does not take advantage of this credit because it is not on the short-form. The dollars could be recouped back when people take advantage of the long term care insurance. Mr. Poolman gave a history of the tax credit. There is a fiscal note attached to the bill, our numbers on the fiscal note are a little different than the Tax Department's. We estimated a total

number of long care insured of 20,000. There are currently about 1,400 that take advantage of the credit on the long form. We figure an estimated reduced income to the general fund of approximately 3.7 million. I know there is a concern out there of increasing the length of the short-form. I think it is a good idea of the legislature to look at the short-form, if you are worried about this issue. If you are worried about the length of the short-form and availability of credits and other things. I believe this is a significant policy change, and we can recoup some of those dollars back. We will do our part on the regulatory side or bureaucratic side, but we would also like some participation from you from the public policy side. People don't buy long term care insurance when they are young, the trouble with that is, when they buy it when they are older, when they see there might be a need, it kind of does damage to the risk pool out there. Medicare covers long term care facilities only for a short period of time, when it comes to a short stay, while recovering from an acute illness. The bill does have significant impact to the general fund, especially in a year when you are scraping for dollars for programs, but I firmly believe, and I heard it out on the campaign trail while running for insurance commissioner, is that people are concerned about long term care. People are concerned about the cost, we will address that from our side, and hope we can get your help on that also.

REP. WINRICH You estimated about 20,000 long term care insured in the state, and that 1400 of those currently use the long-form and take the credit? Do you have any projection of how this might increase the number of insured and generate the possible savings to the state budget?

JIM POOLMAN I thought about that when discussing this with the tax department. The potential significant increase because of the increase of long term care insurance, and then those

folks taking the tax credit, but on the back end looking at that, I can't give you that answer. I suppose we could do some study and research, we will try to get you some numbers on that.

REP. CARLSON Stated that there have been at least five other requests to move various credits to the short-form. As a committee, we will have to deal with that issue. If you add up the fiscal effect of all of those changes and moves to the short-form, your number would look relatively small.

REP. HERBEL Have there been any studies at all in a time element which it took to recoup that money?

JIM POOLMAN I have not seen them. It is very hard to prove what exactly, that fiscal note will be. I think common sense tells us that the more people we move to a private pay system of long term insurance versus medicaid, there is going to be a significant impact.

REP. SCHMIDT I have been looking at long term care insurance, at my age, these guys follow me around. For a good policy, which is about $3,000, if this bill would be passed, what kind of credit would I get.

JIM POOLMAN Your credit would be $100, no matter what the premium is.

SHELLY PETERSON, NORTH DAKOTA LONG TERM CARE ASSOCIATION, Was unable to testify, but submitted written testimony in support of the bill. See attached testimony.

DONNITA WALD, ATTORNEY WITH THE STATE TAX OFFICE Appeared to give comments. She stated they had no quarrel with Mr. Poolmen's numbers. They are in compliance. No problem with the tax credit.

REP. BRANDENBURG Asked whether there was any way of telling, by the people who have long term insurance, how much savings there would be on the back end.

DONNITA WALD I don't know how they would do that.

REP. HERBEL Will that $100 credit really become a factor in buying long term insurance. It was not a factor when I bought long term insurance.

REP. CARLSON I agree with you, I surely wouldn't buy long term care insurance for the tax credit, it would be for my family, if I bought it.

HOWARD SNORTLAND, AARP. Testified in support of the bill. Stated he bought long term care insurance in 1990. He stated the first couple years the premium was the same, then it increased by twenty five percent each year, until finally, it went up to forty percent, so we dropped it. I became a plaintive in a class action suit for fraud, against Accelleration Commonwealth. They settled, and we received our premiums back. Even though my experience has not been good, I still think it is a good idea.

REP. DROVDAL When you had long term insurance, did you use the short-form or the long-form?

HOWARD SNORTLAND As long as I can remember, I used the short form.

TERRY WEISZ, NORTH DAKOTA ASSOCIATION OF INSURANCE, LIFE UNDERWRITERS Testified in support of the bill. He appeared in support of the bill for a couple reasons. A number of years ago, we couldn't find in our crystal ball what effect it could be if every one had long term care policy, but there certainly is a benefit. When you go to the grocery store, you get a coupon, not everybody sends or brings that coupon in, and it works the exactly same way with insurance. If there is a possible tax credit, it may motivate some people, who wouldn't have normally bought it. The total effect, is a pie in the sky.

With no further testimony, the hearing was closed.

COMMITTEE ACTION, 1-23-01, TAPE #2, SIDE B, METER #1863

Committee members mentioned that there probably should be changes made to the long form versus all of the exemptions to the short form. If changes were made to the long form, it would be more appealing to the taxpayers.

REP. RENNER Made a motion for a **do not pass, because of the high fiscal note.**

REP. RENNERFELDT Second the motion. **Motion carried.**

14 yes 0 no 1 absent

REP. KELSH Was given the floor assignment.

FISCAL NOTE

Requested by Legislative Council
01/15/2001

Bill/Resolution No.: HB 1224

Amendment to:

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	1999-2001 Biennium		2001-2003 Biennium		2003-2005 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues			($4,600,000)			
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

1999-2001 Biennium			2001-2003 Biennium			2003-2005 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2. **Narrative:** *Identify the aspects of the measure which cause fiscal impact and include any comments relevant to your analysis.*

HB 1224 allows the tax credit for long-term care insurance premiums to be claimed on the short form, Form 37-S.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

HB 1224 is estimated to reduce state general fund revenues by approx. -$2.3 million per year, or -$4.6 million per biennium.

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, of the effect on the biennial appropriation for each agency and fund affected and any amounts included in the executive budget. Indicate the relationship between the amounts shown for expenditures and appropriations.*

Name:	Kathryn L. Strombeck	**Agency:**	Tax Department

RETAKE

DATRUE

2705 Twin City Dr
Mandan, ND 58554
701-663-8930

FISCAL NOTE

Requested by Legislative Council
01/15/2001

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Name:	Kathryn L. Strombeck	Agency:	Tax Department

Phone Number:	328-3402	Date Prepared: 01/22/2001

Date: 1-23-01
Roll Call Vote #: 1

2001 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1224

House FINANCE & TAXATION Committee

☐ Subcommittee on _____

or

☐ Conference Committee

Legislative Council Amendment Number _____

Action Taken Do Not Pass

Motion Made By Rep. Renner Seconded By Rep. Rennerfeldt

Representatives	Yes	No	Representatives	Yes	No
CARLSON, AL, CHAIRMAN	✓		NICHOLAS, EUGENE	A	
DROVDAL, DAVID,V-CHAIR	✓		RENNER, DENNIS	✓	
BRANDENBURG, MICHAEL	✓		RENNERFELDT, EARL	✓	
CLARK, BYRON	✓		SCHMIDT, ARLO	✓	
GROSZ, MICHAEL	✓		WIKENHEISER, RAY	✓	
HERBEL, GIL	✓		WINRICH, LONNY	✓	
KELSH, SCOT	✓				
KROEBER, JOE	✓				
LLOYD, EDWARD	✓				

Total (Yes) 14 No 0

Absent 1

Floor Assignment Rep Kelsh

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1224: Finance and Taxation Committee (Rep. Carlson, Chairman) recommends **DO NOT PASS** (14 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1224 was placed on the Eleventh order on the calendar.

2001 TESTIMONY

HB 1224

TESTIMONY ON HB 1224

TODD PORTER, STATE REPRESENTATIVE

DISTRICT 34 MANDAN

Good morning, Chairman Carlson and members of the House Finance and Tax Committee. For the record, my name is Todd Porter, State Representative from Mandan.

HB 1224 is a simple house cleaning measure.

Currently long term care insurance has a $100.00 tax credit if an individual files their state taxes on the long form. This bill would allow the same $100.00 tax credit on the short form.

I understand this bill creates a fiscal note of $5,000,000.00 from the tax department, however I believe we need to look past the fiscal note and look at the long term savings that this bill would provide if it promotes the purchase of long term insurance in North Dakota. I also believe that we need to look at the Department of Human Services and see the long term cost savings to the general fund if our citizens have long term care insurance and stay off the Medicaid system. This offset will not be seen in the next biennium, but it will be seen in the future.

I encourage your support of this measure and your foresight into the future of North Dakota.

I would be happy to answer any questions at this time.

The Jerome Levy Economics Institute of Bard College

Public Policy Brief

HIGHLIGHTS

No. 59A, February 2000

Jim Poolman - NAD - His Commissioner
HB 1234

Financing Long-Term Care

Walter M. Cadette

During the next 30 years, the nursing-home population will more than double as the baby boom ages and as advances in medicine extend life expectancy. Many more Americans will live long enough to require years of home care or, in all too many cases, years of institutionalized care.

The nation is not equipped to deal with this problem. By default more than by design, it has fashioned a welfare model for financing long-term care, pushing Medicaid far afield of its original purpose of providing for the medical care of the indigent. Most long-term care is financed either out-of-pocket, which can be done only by those with substantial savings, or by Medicaid, which pays for nursing-home care for those who are too poor to begin with or who have "spent down" their assets to the maximum level allowed for eligibility. Private insurance finances only a fraction (7 percent) of long-term care (Braden et al. 1998). Strikingly, more than a third of the Medicaid budget goes to long-term care, mostly to pay for stays in nursing homes. Medicaid pays, in whole or in part, for the care of two out of three nursing-home residents.

Insurance—public or private or some combination of the two—would be a far better way to meet the nation's long-term care needs. Indeed, long-term care is almost perfectly suited to an insurance model in that an extended nursing-home stay is a low-probability but high-consequence event—the classic insurance risk. However, the private insurance market has failed to take hold for many reasons.

- [redacted]
- Costs are greatly higher than they might be. There is little pooling, which distributes insurance risk and thus lowers cost. [redacted]

The full text of this paper is published as Levy Institute Public Policy Brief No. 59.

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LEVY INSTITUTE

- Adverse selection makes it even harder for insurers to generate economies from pooling. When insurers cannot readily distinguish low risks from high, the coverage they offer to low-risk consumers is too little to be attractive to high-risk consumers. Alternatively, adequate coverage for high-risk consumers is too expensive to appeal to low-risk consumers. An "equilibrium" price is hard, if not impossible, to strike.

The remedy for such market failure is to attract consumers when they are relatively young, before health problems that might give rise to the need for long-term care begin to surface. The earlier the insurance is bought, the less the insured will know about the risk of disability later in life, which will limit adverse selection and make it less difficult for buyer and seller to strike an equilibrium price. The earlier the insurance is bought, however, the greater the risk created by the passage of time and therefore the higher the risk premium. Variability in the future price of care is a risk insurers cannot diversify.

Long-term care is almost perfectly suited to an insurance model in that an extended nursing-home stay is a low-probability but high-consequence event—the classic insurance risk. However, the private insurance market has failed to take hold.

Medicaid itself acts as a major, if not the most important, impediment to the growth of the long-term care insurance market. Even high-income families presumably ask themselves, "Why pay for insurance when Medicaid insures virtually everyone against an extended nursing-home stay?" Medicaid has become, in effect, universal long-term care insurance—albeit with an outsized deductible (all of the insured's financial assets but for several thousand dollars in the case of those who are unmarried) and a similarly outsized co-payment (all of a nursing home resident's income but for a small allowance for personal items such as a haircut and a magazine subscription). Asset and income limits are designed to ensure that Medicaid funds go to those with the greatest need, but, in practice, many nonpoor families become eligible through elaborate estate planning designed to circumvent those limits.

It is hard to imagine a system more conducive to abuse of the elderly. Spend-down requirements and the incentive to surrender assets to children deprive the elderly of the freedom to make their own decisions about their care and of the ability to live independently should they no longer need institutional care. Spending down to qualify for Medicaid in a nursing home, while reasonable in a welfare model, has made some elderly vulnerable to their children's greed as well as to their own infirmities.

Moreover, Medicaid beneficiaries are more likely to be refused entry into the best facilities because those facilities cannot cover the cost of caring for a resident with the amount a state reimburses under Medicaid (typically 20 percent to 30 percent less than the private-pay charges). With most nursing homes privately owned and operated, it is a straightforward business decision to accept the private payer and turn away the Medicaid beneficiary.

Replacing a welfare model with an insurance model would ameliorate, if not remedy, these problems. A safety net would have to remain in place—whether in the form of subsidized insurance for those with low and moderate income or Medicaid much as it currently exists. Clearly, however, an insurance model cannot be developed as long as most Americans needing long-term care can turn to a safety net in the first instance. Medicaid or other safety net funds have to be reserved for those in greatest need.

One option would be for government to subsidize the premiums of those who purchase long-term care insurance—either directly or, more likely as a practical matter, through the tax system. For example, subsidies could be keyed to income under an income-scaled tax-credit arrangement or they could be extended to all purchasers through tax deductibility of premiums. The purchase of insurance would be voluntary; the insurance, although subsidized, would be bought like any other private insurance.

Inadequate pooling and adverse selection would remain under just about any kind of voluntary system for promoting long-term care insurance. A system of tax deductibility,

moreover, would create serious problems of its own. The tax exclusion of employment-based health benefits has been a major force behind the rapid rise in health care costs over the years. It has pushed health insurance in the direction of increasingly comprehensive benefits and then, as moral hazard would have predicted, overuse of those benefits as if they were "free."

A second option would be to require Americans to carry long-term care insurance. The argument for compulsory private insurance is the same as for compulsory participation in Social Security and Medicare. Voluntary saving is inadequate to finance retirement and medical care for the elderly; meeting those needs is a desirable social objective; it is reasonable, therefore, to impose forced saving.

As a practical matter, private insurance coverage could not be mandated unless it could be made affordable. The idea would be to require all adult Americans to carry a specified amount of long-term care insurance (enough, say, to make a claim for Medicaid unlikely) or to demonstrate that they can pay for their own care through out-of-pocket or private insurance payments. Income-scaled tax credits could make premiums affordable for those with low and moderate income. For example, the credits (which could be refundable when there is no tax liability) might pay 100 percent of the premium for a couple whose adjusted gross income was $20,000, 50 percent at an income of $60,000, and nothing at $100,000.

Requiring Americans to carry insurance would end the routine claim on Medicaid for long-term care. It would greatly reduce the price of the insurance by bringing into the market young and middle-aged adults to form a large risk pool. Tax credits to make such a requirement affordable would target subsidies more effectively than would tax deductibility.

A third option would be social insurance (a universal, compulsory program administered by the government and financed out of general or earmarked taxes). It would represent a clear change from the welfare model, but it would require a steep increase in taxation. Wiener, Illston, and Hanley (1994) have estimated that funding a comprehensive plan for long-term care by means of payroll taxes would require a tax rate (without a ceiling on taxable wages) of almost 3 percent today and almost 4 percent by 2018—roughly double the rate required by today's publicly funded long-term care. The tax rate, moreover, would rise sharply thereafter to reach almost 8 percent by 2048 when the demand for long-term care would peak. The 8 percent of payroll by 2048 compares with an estimated 3.5 percent if current programs were continued—still roughly double the cost of current policy but on a much larger base.

The nation could move a long way in the direction of an insurance model without launching a comprehensive social insurance plan or without making a commitment to a similarly costly subsidization of private insurance. One approach would be to limit public funding through social insurance or subsidized private insurance to "front-end" coverage—to expenses incurred in, say, the first six months or year in a nursing home. Social insurance, which could be applied to bills for home or institutional care, would end after that initial period; any subsidies to buy the requisite private insurance would be limited to premiums on policies that had quite short payoff periods.

An alternative would be to fund the "back end" through the public sector. Social insurance or subsidized private insurance would kick in only after a specified initial period. It would be a form of "catastrophic" coverage, with people responsible for funding the front end on their own. (Seamless coverage would be provided by a combination of subsidized and unsubsidized insurance, just as supplementary health insurance policies finance the acute care Medicare does not reimburse.)

However useful in limiting the public cost of moving to an insurance model, both front-end and back-end approaches are far from ideal. The few nursing-home residents in a position to return to independent living would benefit from front-end coverage, but others would not. And it is not at all clear that such limited coverage would do all that much to spur the development of an insurance market for the back end. The net overall effect could well be quite small, leaving the nation with Medicaid as the mainstay of long-term care financing.

The back-end approach has more promise for encouraging a move away from the welfare model, in particular, by encouraging people to buy supplementary policies. But

many low- and moderate-income Americans would not be in a position to do so; they would still have to turn to Medicaid to pay the front-end costs. This approach, moreover, would benefit heirs in a way wholly inconsistent with the use of public funds. The problem of inheritance protection raises a serious question about any social insurance mechanism, which by its nature distributes benefits as an earned right without regard to income. It points up the need to limit subsidization to those with low and moderate income, lest the subsidies serve only to enrich heirs.

An Integrated Plan

The policy choices are far from straightforward. Clearly, however, universal insurance has the virtue of putting responsibility for long-term care on society as a whole rather than on those relatively few individuals unlucky enough to require expensive, often institutionalized, care at the end of their lives. And it has the virtue of ending the use of Medicaid for purposes those welfare funds are ill-suited to finance. On balance, a new blend of public money, private insurance, and other private saving is called for. An effective solution is one that would:

Medicaid itself acts as a major, if not the most important, impediment to the growth of the long-term care insurance market. Even high-income families presumably ask themselves, "Why pay for insurance when Medicaid insures virtually everyone against an extended nursing-home stay?"

1. *Integrate front-end care into Medicare, creating a Medicare Part C, building on the Medicare practice of reimbursing care following acute illness.* The disabled elderly would be reimbursed by Medicare for the first six months or a year of home or institutional care, ending the wholly artificial distinction that now exists between rehabilitation after an acute illness and the kind of care required by a chronic condition.

2. *Mandate back-end insurance coverage and support it with income-scaled tax credits.* The income scaling would make long-term care insurance affordable, minimize use of public money for estate protection, and target subsidies appropriately. Moreover, even if heavily subsidized, insurance that is private would be fully funded, an especially important feature because of the unfavorable demographics on the horizon.

3. *Cut back Medicare reimbursement for routine health care to finance Medicare front-end long-term care coverage.* The financial stress Medicare faces as the baby boom ages is an opportunity to rethink the scope of the care it finances. Some scaling back of Part A and Part B benefits for the routine care of middle- and high-income beneficiaries would offer scope for a Part C; a shift to more catastrophic coverage would make the program as a whole more consistent with the logic and purpose of insurance.

4. *Tighten Medicaid eligibility.* Any effort to shift to an insurance model will fail unless Medicaid rules are stiffened. The object is not to deny needed support to the disabled elderly, but to make it more difficult for people to turn to Medicaid first.

Such an integrated plan could be implemented in stages. A pilot project could be designed to test, first, whether it would be necessary to impose a mandate in order to shift to an insurance model and, second, what it would take by way of tax credits or other subsidy to achieve that outcome. A generous enough tax credit might well spur enough demand for long-term care insurance to make a mandate unnecessary. Chances for the success of a voluntary program would rise even further if access to Medicaid was considerably more difficult than it is today.

There is ample time to put in place a financing structure for long-term care that would be more equitable and efficient than today's reliance on Medicaid. The surge in long-term care related to the baby boom generation is still some time off and the federal government (ultimately the taxpayer) is already the major payer. Eventually, though, the nation must be ready to cope with a quantum jump in the demand for long-term care and to finance it in a sensible way. Ready or not, that jump is on its way.

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About the Author

As a senior scholar at the Levy Institute, Walter M. Cadette has written on health care finance and regulation, Social Security reform, and public capital formation. He is also chairman of the investment committee of the Holy Cross Health System and an adjunct professor at Columbia University. He is a retired vice president of J.P. Morgan & Co. Incorporated, where he was editor of and frequent contributor to its publications *Global Data Watch* and *World Financial Markets*. Cadette's Levy Institute publications include several briefs: *Prescription for Health Care Policy* (No. 30); *Safeguarding Social Security* (No. 34); with S Jay Levy, *Overcoming America's Infrastructure Deficit* (No. 40); and *Regulating HMOs* (No. 47). He received a B.A. from Fordham College and an M.A. from Georgetown University and did further study in economics and finance at New York University.

Testimony on HB 1224
House Finance and Taxation Committee
January 23, 2001

Chairman Carlson and members of the House Finance and Taxation Committee, thank you for the opportunity to submit some brief written comments on HB 1224. I am unable to attend the hearing and appreciate the opportunity to submit written comments.

We are supportive of HB 1224 and urge the Committee a "DO PASS" action. HB 1224 rewards individuals who are planning and preparing for their long term care needs. Two out of five North Dakotans will spend time in a nursing facility, as a resident, if they are fortunate to reach the age of 65. North Dakota's fast growing segment of our population is the group age 85 and older. This age group in North Dakota is projected to almost double in the next two decades. Today the number of individuals 85 plus are 11,240 and in 2020 it is projected to be 20,000. The 85 plus age group is the largest group utilizing and in need of nursing facility care today.

Currently Medicaid pays for every 56 out of 100 nursing facility residents. The 2001-2003 Department of Human Services budget requests $264,593,946 for nursing facility care, for approximately 3,700 individuals. If this current trend continues unchecked, Medicaid will be called upon to bear the full burden of long term care. For the twenty year period 1981 through the biennium ending on June 20, 2001, Medicaid expenditures for nursing facility care grew from $54.9 million to a projected June 20, 2001 total of $240 million.

The North Dakota Long Term Care Association would like to see a shift in how long term care is financed, from public dollars to private resources. Expansion of long term care insurance as a viable payment option needs to be encouraged. Personal responsibility and planning for one's long term care, needs to be rewarded.

HB 1224 rewards positive behavior.

Thank you for your thoughtful consideration of HB 1224.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501
(701) 222-0660