

Fiscal Note & Local Impact Statement

123rd General Assembly of Ohio

BILL: **H.B. 88**

DATE: **March 18, 1999**

STATUS: **As Introduced**

SPONSOR: **Rep. Terwilleger**

LOCAL IMPACT STATEMENT REQUIRED: **Yes**

CONTENTS: **Allows a tax credit for long-term care insurance policies; requires state to pay a portion of long-term care insurance premiums for certain state employees; allows DAS to create a self-insured long-term care insurance program**

State Fiscal Highlights

STATE FUND	FY 1999	FY 2000	FUTURE YEARS
General Revenue Fund			
Revenues	- 0 -	Loss of \$61.5 million	Loss of \$70.1 million in FY 2001, increasing annually thereafter
Expenditures	- 0 -	Potential increase	Potential increase
Other State Funds with Personnel Costs			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Potential increase	Potential increase
General Services Fund 125			
Revenues	- 0 -	Potential increase	Potential increase
Expenditures	- 0 -	Potential increase up to \$30,000 or more	Potential increase up to \$30,000 or more

Note: The state fiscal year is July 1 through June 30. For example, FY 2000 is July 1, 1999 – June 30, 2000.

- The proposed credit would benefit an estimated 186,000 000 long-term care (LTC) insurance policyholders in CY 1999, and an estimated 212,000 in CY 2000.
- The proposed credit will confer a tax advantage on an estimated \$298 million in LTC insurance premiums in CY 1999, and an estimated \$340 million in CY 2000.
- The total state tax loss is estimated at \$68.7 million in FY 2000, and \$78.3 million in FY 2001. The GRF will bear \$61.5 million and \$70.1 million of that loss, respectively.
- Expert opinion is divided on how much the state can expect to see in Medicaid savings if the private insurance market is stimulated through federal and state tax incentives.
- Costs for the state could increase up to the hundreds of thousands or several millions of dollars if a significant number of employees participate in the state's long-term care insurance program. If all eligible



state employees participated (about 45,000), the cost would be about \$6.3 million per year for all state funds. About half of this cost would be paid by the GRF.

- Up to \$30,000 or more could be expended through the Department of Administrative Services' Fund 125 for administrative costs related to a self-insured long-term care program.

Local Fiscal Highlights

LOCAL GOVERNMENT	FY 1999	FY 2000	FUTURE YEARS
LLGSF (primarily used for funding libraries)			
Revenues	- 0 -	Loss of \$3.9 million	Loss of \$4.5 million in FY 2001, increasing annually thereafter
Expenditures	- 0 -	- 0 -	- 0 -
LGF and LGRAF (funds go to all local governments)			
Revenues	- 0 -	Loss of \$3.3 million	Loss of \$3.8 million in FY 2001, increasing annually thereafter
Expenditures	- 0 -	- 0 -	- 0 -

Note: For most local governments, the fiscal year is the calendar year. The school district fiscal year is July 1 through June 30.

- The proposed credit leads to income tax losses for the three local government funds of approximately \$7.2 million in FY 2000, and \$8.2 million in FY 2001.

Detailed Fiscal Analysis

The bill creates a tax credit of 25% for taxpayers' premiums for long-term care insurance and provides for the state to pay 25% of the premiums for long-term care insurance for certain employees.

Long-Term Care Tax Credit Provisions

In prior work for H.B. 33, LBO has estimated the number of long-term care insurance (LTCI) policies in effect that were sold to individuals, through the individual and group-association markets, and through life insurance riders. Our forecasts of the number of such LTCI policies in effect, the average annual premiums, and the amount of premiums that are not excluded from FAGI (i.e. not sold through the employer-sponsored market) are summarized in Table 1.

Calendar Year	Policies in Effect	Individual, Group, and Life-Rider	Average Annual Premium	Total Premiums in FAGI
1999	212,100	186,224	\$ 1,600	\$ 297,958,350
2000	241,795	212,296	\$ 1,600	\$ 339,673,212

Under this bill, there would be a non-refundable income tax credit (with no carryforward) equal to 25% of annual premiums paid, up to a cap of \$500. So, for the average premium in Table 1, the credit would be \$400 and the \$500 cap would not apply. However, there are some taxpayers, who purchased policies when they were older and the policy was more costly, or who bought a more expensive policy, for whom the \$500 cap would apply. Anyone with annual premiums above \$2,000 would be affected by the cap.

Based on data from the Health Insurance Association of America (HIAA), we estimate that about 25% of non-employer sponsored policies currently in effect carry premiums greater than \$2,000 annually.

Calendar Year	Type of Taxpayer	Non-Exempt Policies in Effect	Average Annual Premium	Total Premiums in FAGI
1999	below the cap	139,668	\$ 1,300	\$ 181,568,370
	above the cap	46,556	\$ 2,500	\$ 116,389,980
	total	186,224		\$ 297,958,350
2000	below the cap	159,222	1,300	\$ 206,988,363
	above the cap	53,074	2,500	\$ 132,684,848
	total	212,296		\$ 339,673,212

As shown in Table 2, LBO estimates that about 140,000 policies in CY 1999 and 159,000 policies in CY 2000 would not be affected by the cap, while about 47,000 policies in CY 1999 and 53,000 policies in CY 2000 would be affected by the cap.

Calendar Year	Type of Taxpayer	Non-Exempt Policies in Effect	Annual Tax Credit	Total Tax Credit
1999	below the cap	139,668	\$ 325	\$ 45,392,092
	above the cap	46,556	\$ 500	\$ 23,277,996
	total	186,224		\$ 68,670,088
2000	below the cap	159,222	\$ 325	\$ 51,747,091
	above the cap	53,074	\$ 500	\$ 26,536,970
	total	212,296		\$ 78,284,061

As Table 3 shows, the estimated annual tax credit for CY 1999 is \$68.7 million, while the estimated annual credit for CY 2000 is \$78.3 million. Without the cap on the credit, the estimated losses would be \$74.5 million and \$84.9 million.

Finally, Table 4 shows the estimated tax revenue losses by fiscal year and by fund. The state GRF would lose \$61.5 million in FY 2000 and \$70.1 million in FY 2001.

Fiscal Year	Total Tax Credit	GRF	LLGSF	LGF	LGRAF
2000	\$ 68,670,088	\$ 61,459,729	\$ 3,914,195	\$ 2,884,144	\$ 412,021
2001	\$ 78,284,061	\$ 70,064,234	\$ 4,462,191	\$ 3,287,931	\$ 469,704

Uncertainties of the Estimates

It should be clear by now that the estimated tax revenue losses are built on data from 1996, in a market that is changing and growing rapidly. It is possible that:

- Policies bought will increase faster than LBO has assumed due to HIPAA.
- Other federal tax benefits will be implemented, which will cause policy purchases to increase faster.
- The tax incentive created in this bill will induce some purchases over and above what is assumed in the estimates.
- Average annual premiums will exceed the \$1,600 estimate here. Average annual premiums rose fairly sharply from 1991 to 1994, but HIAA reports that premiums for leading sellers declined somewhat in 1995 and 1996. For that reason LBO held estimated average premiums steady.

Comparing a Deduction and a Credit

The 25% credit obviously offers greater tax relief than a deduction, and therefore results in greater revenue losses to the state GRF and the three LGFs. A quick comparison of a deduction and a credit for taxpayers above and below the \$500 credit cap is presented in Table 5, below.

Assumed Premium	Tax Savings from Deduction	Tax Savings from 25% Credit	Difference, credit minus deduction
\$ 1,300	\$ 78	\$ 325	\$ 247
\$ 2,500	\$ 150	\$ 500	\$ 350

this example assumes that the taxpayer faces a marginal tax rate of 6.0%.

Obviously, the credit provides a greater incentive to purchase LTCI than a deduction. Unfortunately, LBO does not have any estimates of how much more LTC insurance would be purchased under a 25% credit than under a deduction.

The Impact on Medicaid Spending

Part of the rationale for offering tax incentives for LTC insurance is to avoid future Medicaid costs. LBO does not have the resources to independently estimate future Medicaid savings by stimulating the private LTC insurance market, but here we report the estimates of some other researchers. The estimates below are not the result of a state income tax incentive, but of increased insurance purchases due to a number of factors such as federal tax incentives, state tax incentives, improved consumer education, etc.

To get an idea of the different results one can get in terms of Medicaid savings, based on the different assumptions one uses in simulation, one can look at the work of the American Council of Life Insurance (ACLI) and of economists at the Brookings Institution. The ACLI begins with the assumption that all individuals 35 years of age and older in the year 2000 who can afford an LTC insurance policy actually purchase one (affordability is defined as spending up to 2% of income for ages 35-44, up to 3% of income for ages 45-54, up to 4% of income for ages 55-59, and up to 5% of income over age 60).¹ The ACLI then compared a simulation of national Medicaid expenditure in CY 2030 under current long-term care trends with a simulation assuming this increased purchase of LTC insurance. By CY 2030, national Medicaid expenditure under the increased insurance assumption was \$106 billion, a savings of \$28 billion, or 21%, from the current trends simulation.

In contrast, the Brookings economists simulated four different private long-term care insurance options using the Brookings-ICF Long-Term Care Financing Model. Their simulations showed that the market penetration and ability to finance long-term care of private insurance aimed at the elderly is likely to remain extremely limited. Even under the assumption that the elderly with only minimal assets will spend a substantial portion of their income for policies, only one in five elderly people could have a policy in 2018. Because of limited market penetration, private insurance bought by the elderly is unlikely to substantially ease the burden of out-of-pocket long-term care costs. Moreover, because private insurance is bought mostly by upper-middle and upper-income elderly with substantial assets, it will have little impact on Medicaid nursing home spending. For policies sold to the elderly, the projected Medicaid nursing home savings were only 2-4 percent by CY 2018.²

The Brookings economists did find substantial Medicaid nursing home savings – on the order of 32% by CY 2018 – in what they described as an optimistic simulation of employer-sponsored LTC insurance. The employer-sponsored LTCI simulation assumed the following:

- All persons purchase insurance policies that cover two or four years of nursing home and home care and pay an initial indemnity value of \$60 per day for nursing home care and \$30 per visit for home care in 1996. Indemnity values increase by 5.5% per year on a compound basis. Premiums for nonelderly persons increase by 5.5% per year until age 65 and are then level. All nondisabled person who meet affordability criteria buy as much as insurance as they can afford.
- Persons as young as age 40 purchase group or individual long-term care insurance policies. Nonelderly purchase policies if premiums are between 2% and 4% of income (depending on age). Elderly persons purchase policies if they can afford them for 5% or less of income and if they have \$10,000 or more in nonhousing assets.

Based on this research, stimulating the private LTC insurance market for individuals could result in Medicaid savings of anywhere from 2-4% in CY 2018 to 21% in CY 2030. There

¹ Janemarie Mulvey and Barbara Stucki, *Who Will Pay for the Baby Boomers' Long-Term Care Needs?*, American Council of Life Insurance, April 1998.

² These results are summarized in "Can Private Insurance Solve the Long-Term Care Problems of the Baby Boom Generation?," The Urban Institute, Testimony presented at "The Cash Crunch: The Financial Challenge of Long-Term Care for the Baby Boom Generation," a hearing held by the Special Committee on Aging, United States Senate, Washington, D.C., March 9, 1998.

is undoubtedly other research of which LBO is not yet aware with different estimates of potential Medicaid savings.

State Employee Long-Term Care Benefits

This bill also requires the state to cover 25% of the premiums for long-term care coverage for state employees with at least five years of full-time service with the state. In addition, the bill allows the Department of Administrative Services (DAS) to create a self-insured program for long-term care insurance. If DAS decides to establish the state’s program, the department must contract with a third-party administrator and establish the program as a pre-tax benefit program. Lastly, provisions allow members of the Public Employees Retirement System, including non-state employees, to receive long-term care benefits from the state’s program.

The state already offers long-term care insurance to state employees through a contract with Aetna Insurance. According to DAS, only 1.5%, or 950 employees, participate in the long-term care program. Aetna determines the rates for the employees based on the age of the employees upon entrance in the program; the older the employee upon acceptance, the more expensive the rate.

As of March 1999, approximately 45,000 state employees have five or more years of service with the state. The bill would allow these employees to participate in the program, and the state would be responsible for paying 25% of their premiums for long-term care insurance. However, since the state would only be required to pay one-fourth of the insurance costs, the employees' portion may still be relatively expensive. Therefore, not all employees are likely to participate in the program.

Since the prices of the premiums are currently unknown, it is difficult to estimate the state’s costs. The following table presents a possible scenario of costs. The Average Premium Rate, column C, is the rate currently charged by Aetna in its long-term care program with the state.

Age Range (A)	Estimated # of Employees with ≥ 5 yrs. of Service (B) ³	Average Premium Rate (C)	Average Monthly Premium D = (C*\$122) ⁴	Average Annual Premium E = (D*12)	State Share F = E*B* [.25]
25-29	171	0.10	\$11.59	\$139.08	\$5,946
30-34	2,852	0.13	\$15.84	\$190.03	\$135,489
35-39	7,797	0.18	\$21.72	\$260.59	\$507,959
40-44	9,463	0.25	\$30.13	\$361.61	\$855,474
45-49	10,044	0.34	\$41.65	\$499.81	\$1,255,022
50-54	6,622	0.47	\$57.02	\$684.27	\$1,132,815
55-59	4,483	0.64	\$78.15	\$937.84	\$1,051,082
60-64	2,387	0.88	\$106.92	\$1,283.05	\$765,660
65-69	804	1.25	\$152.38	\$1,828.54	\$367,536
70-74	263	1.91	\$233.24	\$2,798.88	\$184,026
75-79	71	3.02	\$368.20	\$4,418.35	\$78,426
Totals	44,955				\$6,339,435

The maximum state share could reach \$6 million, but it is unlikely that all 45,000 eligible employees would participate in the program. Also, it is unlikely that all participants would choose the daily benefit rate of \$122. This amount reflects the average daily cost of nursing facility care; home care benefits are half the premiums of nursing home premiums. If even 10% of eligible employees participate at a \$66 daily benefit (50% of the average cost), the costs to the state could reach \$300,000.

Participation of members of the Public Employees Retirement System would not greatly affect costs to the state, as non-state members would be responsible for covering the costs of their insurance. Administration costs for these additional participants would be minimal for the state.

If DAS would choose to set up a self-insured long-term care program, human resources costs would approach \$30,000 for the department. The third party administration costs would be \$1-\$2 per member per month, assuming significant participation. Otherwise, the cost per individual member would be higher. There would be little costs associated with establishing a self-insured program as pre-taxed.

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³ Column B shows a rough estimate of the number of employees with five or more years tenure, calculated from a percentage of employees using DAS data for the number of employees with ten or more years tenure. The numbers for each age range are estimated, but the total number is approximately 45,000.

⁴ According to DAS, nursing facility care averaged \$122 a day in 1998, which would turn out to be about \$45,000 for a year of services. However, not all participants would opt for nursing home care as long-term care insurance also covers in-home care. In-home care benefits are about 50% of those of nursing facility care. This analysis gives an idea of maximum estimated costs to the state.