

BILL: **Am. Sub. H.B. 4**

DATE: **June 29, 1999**

STATUS: **As Enacted – Effective October 14, 1999**

SPONSOR: **Rep. Gardner**

(Certain provisions effective April 11, 2000, and May 1, 2000)

LOCAL IMPACT STATEMENT REQUIRED: **Yes**

CONTENTS: **Establishes procedures for enrollee appeals of health care coverage decisions, and creates Ohio income tax deductions for purchase of medical care insurance and for long-term care insurance, and for medical expenses above the 7.5% AGI floor**

State Fiscal Highlights

STATE FUND	FY 1999	FY 2000	FUTURE YEARS
General Revenue Fund			
Revenues	- 0 -	Loss of \$47.3 million	Loss of \$50.2 million in FY 2001 – increasing in subsequent years
Expenditures	- 0 -	-0-	Potential negligible increase*
State Colleges and Universities			
Revenues	- 0 -	- 0 -	- 0 -
Expenditures	- 0 -	Potential negligible increase*	Potential negligible increase*

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

* *The potential effect on governmental expenditures resulting from the bill depends primarily on a complex interplay of market reactions to the events the bill could generate in the health care marketplace.*

- The bill will provide tax relief to an estimated 320,000 Ohio taxpayers in tax year 1999, and an estimated 342,000 in tax year 2000. The state tax revenue loss is projected to be \$52.8 million in FY 2000 and \$56.1 million in FY 2001. The state GRF bears \$47.3 million and \$50.2 million of that cost, respectively.
- The long-term care insurance deduction may reduce state Medicaid payments for nursing home care in the future, although the amount of such savings is the subject of considerable debate by scholars.
- The additional administrative burden on HICs and insurers resulting from the bill could result in negligible increases in premium rates. This however depends on how HICs choose to recoup these costs. In essence there could be a negligible increase in state costs of providing employee health benefits. State employee fiscal year 2000 health benefits have been contracted.
- While the bill increases the regulatory workload of the Department of Insurance, a spokesperson for the department states that the department can absorb any additional costs resulting from the bill.

Local Fiscal Highlights



LOCAL GOVERNMENT	FY 1999	FY 2000	FUTURE YEARS
Political Subdivisions			
Revenues	- 0 -	See below	See below
Expenditures	- 0 -	Potential negligible increase*	Potential negligible increase*
LLGSF (distributed primarily for libraries)			
Revenues	- 0 -	Loss of \$3.0 million	Loss of \$3.2 million in FY 2001 – increasing in subsequent years
Expenditures	- 0 -	- 0 -	- 0 -
LGF and LGRAF (distributed to counties, municipalities, townships, special districts)			
Revenues	- 0 -	Loss of \$2.5 million	Loss of \$2.7 million in FY 2001 – increasing in subsequent years
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 potential effect on governmental expenditures resulting from the bill depends primarily on a complex interplay of market reactions to the events the bill could generate in the health care marketplace.*

- The reduction in state income tax revenues reduces distributions to the three local government funds (which receive 10.5% of state income tax revenue) by \$5.5 million in FY 2000 and \$5.9 million in FY 2001.
- The additional administrative burden on HICs and insurers, resulting from the bill could result in negligible increases in premium rates. This however depends on how HICs choose to recoup these costs. In essence there could be a negligible increase in local government costs of providing employee health benefits.

Detailed Fiscal Analysis

The bill establishes procedures for enrollee appeals of health care coverage decisions by health insuring corporations (HIC) and insurers, and modifies current law to require HICs and insurers to establish internal review programs, and affords enrollees access to external review of coverage decisions under certain conditions. The bill also requires that HICs allow female enrollees to obtain obstetric and gynecological services from participating obstetricians and gynecologists without a referral.

Effects on Health Care Premiums Paid by Public Employers

LBO believes that most health plans have functioning internal review systems in place, and that the state's current employee benefits program includes a significant portion of the policy thrust of the bill and as such should not encounter any major cost increases. However, HICs and insurers could experience an increase in the rate of internal appeals per enrollee, as a result of greater knowledge of the appeals process and the availability of external reviews. In addition, by placing several administrative type responsibilities on HICs and insurers, resulting from the appeals process, the bill creates a potential for increased premium rates due to increased administrative costs. This however depends on how HICs and insurers choose to recoup these costs, if any. In essence there could be a negligible increase in state and local government costs of providing employee health benefits. We also believe that the state's &

local government benefit plans are comprehensive enough, not to warrant public sector employees from resorting to the use of the external appeal process provided by the bill.

With regard to the provisions of the bill permitting female enrollees to obtain care from obstetricians or gynecologists, we do not expect any cost increases, since many health plans already allow access to specialists in a way similar to what the bill will achieve. Thus a negligible cost increase may result from higher administrative costs associated with having a greater number of providers in the “network” from whom additional billings and payments have to be processed, along with related utilization review costs.

LBO contacted the Department of Administrative Services for an estimate of the impact of the bill on health care premiums paid by public employers and subsequently state benefits costs, and at the time of writing this analysis, DAS could not confirm our analysis.

While the bill increases the regulatory workload of the Department of Insurance, a spokesperson for the department states that the department can absorb any additional costs resulting from the bill.

Ohio Income Tax Deductions

The bill specifies that taxpayers cannot “double-dip” in their use of the three proposed deductions. For example, a taxpayer cannot claim an Ohio deduction for medical care insurance and then claim the same amount as a medical expenses deduction in excess of the 7.5% of federal adjusted gross income (FAGI) floor.

In estimating the impact of these deductions, LBO has had to disentangle federal tax data that lumps these expenses together. Federal tax data for tax years 1992 through 1996 shows that on average, there are about 140,000 Ohio returns annually that claim the medical expenses deduction. These taxpayers have medical and/or medical insurance expenses that exceed 7.5% of FAGI. So, the 140,000 taxpayers include taxpayers claiming deductions – at least in part – for medical insurance and long-term care insurance (LTCI). In estimating the impact of the deductions, LBO has therefore adopted the following procedure: estimate the insurance deductions first, and calculate the medical expenses deduction as a remainder.

Summary of Tax Revenue Impacts in HB 4. As Introduced <i>amounts in millions of \$</i>		
	FY 2000	FY 2001
1. LTCI deduction (all funds)	(\$14.2)	(\$16.2)
2. Medical expenses deduction in excess of 7.5% of FAGI Floor (all funds)	(\$24.2)	(\$24.9)
3. Health insurance deduction - not offered through employer (all funds)	(\$14.4)	(\$15.0)
Total All Deductions	(\$52.8)	(\$56.1)
GRF	(\$47.3)	(\$50.2)
LLGSF	(\$3.0)	(\$3.2)
LGF	(\$2.2)	(\$2.4)
LGRAAF	(\$0.3)	(\$0.3)

As the table above shows, LBO estimates that the combined impact of all three medical care and insurance deductions is a revenue loss of \$52.8 million in FY 2000 and \$56.1 million in FY 2001. The GRF bears 89.5% of the cost, or \$47.3 million in FY 2000 and \$50.2 million in FY 2001, while the three local government funds (LGFs) bear the other \$5.5 million and \$5.9 million, respectively.

The sections that follow contain detail about the estimates for each of the three proposed deductions.

Estimated Revenue Loss, CY 1999 - 2000 [FY 2000 - 2001]				
Calendar Year	OTI Amount	estimated avg. marginal tax rate	Premiums in FAGI	Estimated Revenue Loss
1999	\$0-\$20,000	3.500%	\$ 62,571,253	\$ 2,189,994
	\$20,000-\$40,000	4.457%	\$ 137,060,841	\$ 6,108,802
	\$40,000 and over	6.000%	\$ 98,326,255	\$ 5,899,575
	Total		\$ 297,958,350	\$ 14,198,371
2000	\$0-\$20,000	3.500%	\$ 71,331,374	\$ 2,496,598
	\$20,000-\$40,000	4.457%	\$ 156,249,677	\$ 6,964,048
	\$40,000 and over	6.000%	\$ 112,092,160	\$ 6,725,530
			\$ 339,673,212	\$ 16,186,176

LTCI Deduction

LBO has estimated elsewhere (see the fiscal note for HB 33) that the LTCI deduction will benefit an estimated 186,000 long-term care (LTC) insurance policyholders in CY 1999, and an estimated 212,000 in CY 2000. The proposed deduction 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. Finally, the total state tax loss is estimated at \$14.2 million in FY 2000, and \$16.2 million in FY 2001. The GRF will bear \$12.7 million and \$14.5 million of that loss, respectively. The three local government funds (the LLGSF, LGF, and LGRAF) will lose an estimated \$1.5 million in FY 2000 and \$1.7 million in FY 2001.

Based on survey data from the Health Insurance Association of America (HIAA), about 25% of the purchasers of long-term care insurance pay annual premiums that exceed 7.5% of their total annual income. Presumably then, for these purchasers premiums also exceed 7.5% of FAGI.

Fiscal Year	GRF	LLGSF	LGF	LGRAF
2000	\$ 12,707,542	\$ 809,307	\$ 596,332	\$ 85,190
2001	\$ 14,486,627	\$ 922,612	\$ 679,819	\$ 97,117

If 25% of the Ohio LTCI policyholders pay premiums greater than 7.5% of FAGI, then it is possible – although not necessarily the case – that 46,500 taxpayers itemizing medical deductions on their federal returns in tax year 1999, and 53,000 in tax year 2000, are itemizing on the basis of their LTCI premiums. Of course, it is possible that these taxpayers also have other medical costs that they are deducting. However, it seems unlikely that these taxpayers would hit the 7.5% of FAGI limit without LTCI, because they should not be paying out-of-pocket nursing home expenses at the same time that they are paying LTCI premiums.

Calendar Year	Policies in Effect	Individual, Group, and Life-Rider
1999	212,100	186,224
2000	241,795	212,296

The estimated number of Ohio LTCI policyholders paying premiums in excess of 7.5% of FAGI potentially reduces the number of taxpayers eligible for the medical expenses deduction from 140,000 down to 93,500 in tax year 1999 and 87,000 in tax year 2000.

Medical Care Insurance Deduction

The federal tax code already allows an exclusion from FAGI of health insurance premiums for the self-employed. In tax years 1999 and 2000, this exclusion is set at 60% of the premiums. Current Ohio law then exempts the remaining 40% in calculating Ohio adjusted gross income (OAGI). The deduction proposed in this bill would be in addition to the existing deduction for health insurance premiums for the self-employed. The Ohio Department of Taxation’s *Tax Expenditure Report* for FY 2000-2001 puts the estimated revenue loss from the existing deduction at \$6.9 million in FY 2000 and \$7.7 million in FY 2001.

Based on data provided by an official with the federal Joint Committee on Taxation (JCT) who is researching tax deductions for insurance purchases, LBO estimates that in tax year 1999, about 100,000 Ohioans, not self-employed and not covered under a government-subsidized plan, are purchasing their own health insurance. The average annual premium is estimated to be \$3,240, so the total amount of deductible premiums would be \$324.0 million. At an estimated average marginal tax rate of 4.457% (the rate for Ohio Taxable Income (OTI) between \$20,000 and \$40,000), the estimated tax loss would be \$14.4 million. For tax year 2000, both the number of qualifying Ohioans and the annual premium are projected to increase by about 2%, increasing the revenue loss to \$15.0 million.

	TY 99 (FY 2000)	TY 00 (FY 2001)
Ohioans claiming deduction	100,000	102,000
estimated annual premium	\$3,240	\$3,300
total deductible premiums	\$324,000,000	\$336,600,000
Marginal Tax Rate	4.457%	4.457%
Estimated Revenue Loss	\$14,440,680	\$15,002,262
GRF	\$12,924,409	\$13,427,024
LGFs	\$1,516,271	\$1,575,238

Medical Care Expenses

LBO's estimates of this provision assume, although this is not clear from the bill language, that insurance purchases and expenses covered by insurance cannot be used to help the taxpayer reach the 7.5% of FAGI floor. LBO further assumes that some of the 140,000 Ohio taxpayers who claim the federal deduction will not be eligible for this state deduction because they are receiving the LTCI deduction, and some will not be eligible because they are claiming the self-employed health insurance deduction or medical care insurance deduction. The basic federal data on Ohioans claiming the federal deduction is shown in the table below.

Ohioans Claiming Federal Medical Expenses Deduction. Tax Year 1996			
	Ohio returns	Ohio amount	average
\$0 - \$20,000	44,503	\$400,371,000	\$8,996.49
\$20,000 - \$30,000	30,529	\$151,252,000	\$4,954.37
\$30,000 - \$50,000	38,761	\$187,956,000	\$4,849.10
\$50,000 - \$75,000	18,390	\$116,245,000	\$6,321.10
\$75,000 - \$100,000	4,983	\$45,782,000	\$9,187.64
\$100,000 - \$200,000	2,625	\$41,168,000	\$15,683.05
over \$200,000	411	\$17,334,000	\$42,175.18
Total	140,202	\$960,108,000	\$6,848.03

However, subtracting the estimated 60,000 taxpayers who will instead be claiming the LTCI deduction or the medical care insurance deduction for Ohio purposes leaves an estimated 80,000 taxpayers who are expected to claim about \$830 million in deductions. The average deduction for these taxpayers is much higher than the \$6,848/year shown in the table because the remaining taxpayers are primarily elderly ones with long-term care expenses not reimbursed by insurance.

LBO also received additional information from the IRS, Statistics of Income Division (SOI) on medical expense deductions by age of taxpayer and by size of deduction. Taxpayers who take this deduction can be split along several dimensions. Based on the information that we received, LBO was able to separate taxpayers along two dimensions: elderly *vs.* non-elderly taxpayers, and taxpayers above and below \$6,000 in annual deductions. Many of the elderly taxpayers have large deductions (above \$20,000/year) which are presumably from nursing home costs and/or other long-term care expenses. All of the taxpayers that we eliminated from the dataset because of the overlap with the proposed insurance tax deductions fall into the \$6,000 and below category.

Estimated Revenue Impact of Medical Expenses Deduction <i>amounts in millions of \$</i>		
	Tax Yr 99 (FY 2000)	Tax Yr 00 (FY 2001)
Total	\$24.2	\$24.9
GRF	\$21.7	\$22.3
LGFs	\$2.5	\$2.6

LBO then did rough simulations of tax liability with and without the medical expenses deduction for elderly and non-elderly taxpayers, using the information in the table above about the FAGI of claimants. Although the elderly represent a large amount of deductions claimed, because they receive the retirement income credit and the senior citizen credit, and some of them have Social Security retirement income that is not in FAGI, their tax liability even without the medical expenses deduction is not that large. So, when LBO simulated the tax change for elderly taxpayers, the estimated loss was \$11.2 million. The estimated revenue loss for non-elderly taxpayers was \$13.0 million, for a total of \$24.2 million. Based on an estimate of 3% growth in the deduction, the tax loss for tax year 2000 (FY 2001) is \$24.9 million.

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APPENDIX – BEHAVIORAL IMPACTS

Medicaid and LTCI Deductions

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:

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.

- 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 1986. 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 non-housing 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 is undoubtedly other research of which LBO is not yet aware with different estimates of potential Medicaid savings.

Health Insurance Deduction and Uncompensated Care Costs

The Ohio State University Department of Statistics, on contract with the Ohio Department of Health (ODH), has estimated that the percentage of total persons without health insurance in Ohio in 1995 was 11.2% (+/-1.2%) in 1995. This figure is somewhat lower than the corresponding Census Bureau estimate based on the Current Population Survey (CPS), which was 11.8%. The OSU Department of Statistics estimates are based on the CPS estimates but are adjusted for actual enrollments in Medicare and Medicaid. If the 11.2% figure is correct, then about 1,250,000 Ohioans lacked health insurance in 1995.

Based on CPS data, the Employee Benefit Research Institute (EBRI) estimates that 13.1% of Ohio's non-elderly population, or 13.1%, lacked health insurance coverage in 1997. This was significantly lower than the national rate of 18.3%. Ohio also ranks better than the nation in the percentage of children without insurance, 10.3% vs. 15.0%. Ohio ranks third among all states (at 79.6%), behind only Wisconsin and Pennsylvania, in rate of employment-based health insurance coverage.

Will the bill induce some currently uninsured Ohioans to purchase health insurance? If so, how many? Two RAND corporation researchers studied one of the groups targeted by this bill, workers who do not receive health insurance coverage from their employer. The economists found that the price elasticity of demand was in the range of -0.3 to -0.4, meaning that a 10 percent decrease in the price of health insurance would lead to an increase of 3% to 4% in the number of persons who purchase insurance.³

The proposed income tax deduction would reduce the price of health insurance by a percentage equal to the marginal tax rate that the taxpayer faces. LBO assumes that the workers without insurance fall into the \$20,000 to \$40,000 Ohio taxable income (OTI) bracket, where the marginal tax rate is 4.457%. So, the tax deduction leads to a 4.457% decrease in the after-tax price, which then increases purchases by 1.3% (-4.457% x -0.3) to 1.8% (-4.457% x -0.3). Since we started with the assumption

³ M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics*, vol. 14 no.1, May 1995, pps.47-63.

that 100,000 Ohioans were purchasing their own health insurance, this translates into an increase of 1,300 to 1,800 households.