HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 947 Long-Term Care Coverage
SPONSOR(S): Legg
TIED BILLS: **IDEN./SIM. BILLS:** SB 1924

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Elder & Long-Term Care Committee		DePalma	Walsh
2) Insurance Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

House Bill 947 directs the Agency for Health Care Administration to amend the Medicaid state plan to establish the Florida Long-Term Care Partnership Program, in compliance with the requirements of the Social Security Act as amended by the federal Deficit Reduction Act of 2005.

The bill also provides that, for purposes of determining Medicaid eligibility, assets or resources in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under an approved Florida Long-Term Care Partnership Program policy shall be disregarded. Essentially, this enables Floridians to qualify for coverage of the substantial costs associated with provision of long-term care services under Medicaid without first being required to substantially exhaust --- or “spend down” --- assets and resources.

The bill provides an effective date of July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – Floridians' participation in a long-term care insurance partnership program could reduce Medicaid spending on long-term nursing facility services presently provided to Medicaid-eligible individuals without long-term care insurance coverage.

Safeguard Individual Liberty – The bill restructures the method used for Medicaid asset determinations by providing a mechanism for individuals to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust or "spend down" personal resources and assets.

Promote Personal Responsibility – The structure of the Florida Long-Term Care Partnership Program could provide incentives for individuals in the state to purchase long-term care insurance coverage.

Empower Families – Individuals ineligible for the long-term care services provided by Medicaid --- but also with income levels making private long-term care coverage unaffordable --- would be able to purchase long-term care from participating providers under the partnership program.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Long-Term Care

"Long-term care" refers to a broad range of assistive medical, personal and social services needed by individuals who are unable to meet their basic living needs for an extended period of time, often as result of accident, illness or frailty. Frequently, such individuals demonstrate an inability to move about, dress, bathe, eat, use a toilet or follow medication schedules. Consequently, assistance is often necessary to help with daily household cleaning, meal preparation, shopping, bill paying, medical visits, and administration of medication. Additional long-term care disabilities may be attributable to cognitive impairment associated with stroke, depression, dementia, Alzheimer's disease, Parkinson's disease and other medical conditions affecting the brain.

In testimony provided before the United States Senate Special Committee on Aging in March, 2002, the Comptroller General of the U.S. indicated that long-term care expenditures for persons of all ages totaled $137 billion in 2000, and announced that spending on long-term care services for the nation's elderly population is projected to nearly quadruple to $379 billion by 2050.[1] In 2005, roughly nine million individuals 65 and older required long-term care services, and by 2020 it is projected that 12 million older Americans will need some form of long-term care assistance.[2] A study by the U.S. Department of Health and Human Services says that people who reach age 65 will likely have a 40 percent chance of entering a nursing home, and about 10 percent of those entering a nursing home facility will stay there five or more years.[3]

---

[1] *Aging Baby Boom Generation Will Increase Demand and Burden on Federal and State Budgets*, GAO-02-544T, March 21, 2002, statement of Comptroller General of the United States before the U.S. Senate Special Committee on Aging, available at: http://www.gao.gov/new.items/d02544t.pdf.

[2] *Long-Term Care*, accessed February 17, 2006, the Official U.S. Government Site for People with Medicare, available at: http://www.medicare.gov/LongTermCare/Static/Home.asp.

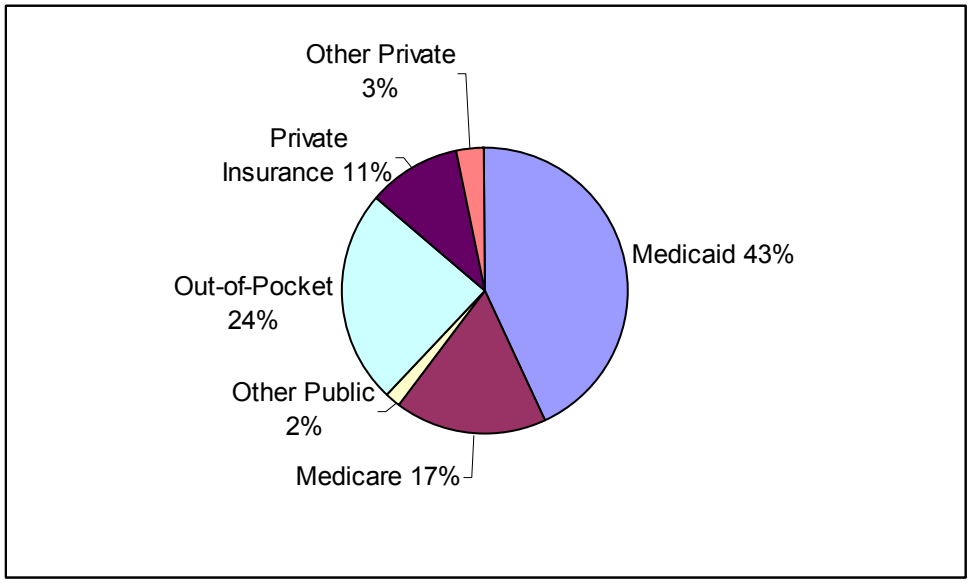
[3] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, March 2005.

Long-Term Care Financing

The costs associated with long-term care services are substantial. The average cost of a nursing home stay is more than $55,000 per year, and as much as $100,000 in some urban areas. Hourly home care agency rates average $37 for a licensed practical nurse, and $18 for a home health aide.[4]

Medicaid is now the primary payer of long-term care services in the United States (see figure 1),[5] and, as a result, state and federal governments bear a tremendous financial burden for provision of these services. The state of Florida is particularly affected, as it has the highest proportion of individuals age 65 to 84 of any state in the nation, and this elderly population is expected to grow 130 percent by 2025.[6] In FY 2002-03, Florida Medicaid spent $3.2 billion (or 28 percent of its total Medicaid budget) on four core long-term care services: nursing homes, Intermediate Care Facilities for Persons with Developmental Disabilities, Home and Community-Based Services waivers, and assistive care services.[7] Florida Medicaid currently pays for nearly two-thirds of all nursing home days for the state's frail elders.

Figure 1. Sources of Long-Term Care Payments, 2003



Source: *Medicaid and Long-Term Services and Supports for Older People*, AARP Public Policy Institute 2005

Seniors often believe that Medicare, the nearly universal source of acute health care coverage for individuals 65 and older, pays for a vast array of long-term care services.[8] However, many common long-term care needs (e.g., bathing, dressing, and other household chores) do not require skilled help and, therefore, are not generally covered by Medicare.[9] Consequently, many seniors are left

[4] *Long-Term Care Insurance*, September 2004, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/health/fs7r_ltc.pdf.
[5] *Medicaid and Long-Term Services and Supports for Older People*, February 2005, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/post-import/fs18r_medicaid_05.pdf.
[6] *Model Long-Term Care System: Analyzing Long-Term Care Initiatives in Florida*, November 2003, Florida Senate Interim Project 2004-144, available at: http://www.flsenate.gov/data/Publications/2004/Senate/reports/interim_reports/pdf/2004-144hc.pdf.
[7] *Medicaid Long-Term Care: Overview and Update*, December 15, 2004, Agency for Health Care Administration presentation to the Senate Health and Human Services Appropriations Committee, available at: http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/ltc_overview_and_update_121504.pdf.
[8] *Medicaid and Long-Term Services and Supports for Older People*, AARP Public Policy Institute, *supra*.
[9] *Long-Term Care Insurance*, AARP Public Policy Institute, *supra*.

attempting to "spend down" their assets in an effort to satisfy Medicaid asset and income criteria, thereby gaining eligibility for Medicaid services.

As an alternative to Medicaid impoverishment or complete self-financing, a market for private long-term care insurance has developed, and grown, in recent years. However, the premiums typically associated with high-quality private insurance coverage exceed the resources of many Americans.[10] In 2001, the average annual premium of long-term care insurance, if bought at age 65, exceeded $2,300[11] and most estimates indicate that only 10% to 20% of seniors can presently afford private long-term care insurance.[12]

In response, states have adopted several strategies to encourage younger individuals to purchase private long-term care insurance. States frequently offer tax incentives to individuals or employers to purchase private long-term care coverage; however, tax deductions tend to be small, and often don't constitute a significant savings for either employers or individual purchasers. Alternatively, many states have begun offering long-term care insurance to state employees and retirees as part of state benefits packages. Finally, several states have explored the possibility of public/private insurance partnerships between state government and private insurance companies. Under this approach, individuals with moderate income are encouraged to purchase private long-term care insurance to fund their long-term care needs rather than divesting their assets and relying on Medicaid assistance --- effectively reducing or delaying the need for Medicaid assistance.

Long-Term Care Partnership Program

The Long-Term Care Partnership Program began in 1987 as a demonstration project funded through the Robert Wood Johnson Foundation (RWJF).[13] As part of the demonstration project, four out of the original eight states with RWJF planning grants --- California, Connecticut, Indiana and New York --- ultimately implemented partnership programs.

With the help of the National Program Office, located at the University of Maryland Center on Aging, states participating in the planning phase of the partnership programs developed strategies to encourage the purchase of private long-term care insurance policies. The states recognized that, in addition to decreasing the costs of these policies, it was equally important to increase the quality of coverage being offered in order to broaden the market for long-term care insurance.

Ultimately, a unique approach emerged, whereby individuals purchasing a state-certified long-term care insurance "partnership" policy first rely on benefits from their private long-term care insurance policy to cover long-term care costs. Thereafter, if insurance benefits are exhausted, such policyholders are allowed to protect some or all of their assets from Medicaid "spend-down" requirements during the eligibility determination process (though certain other income requirements must still be satisfied).[14] Essentially, the logic supporting long-term care partnership programs is a general desire to encourage the purchase of a limited, and therefore more affordable, amount of long-term care coverage, together with an assurance that purchasers could potentially receive additional long-term care services, if needed, through the Medicaid program after their insurance coverage has been exhausted.[15]

---

[10] *Private Long-Term Care Insurance: the Medicaid Interaction*, May 2004, AARP Public Policy Institute, available at: http://assets.aarp.org/rgcenter/health/ib68_ltc.pdf.

[11] *Long-Term Care Insurance in 2002*, June 2004, America's Health Insurance Plans, available at: http://www.ahip.org/content/default.aspx?bc=39|341|328|454. This premium is for a policy purchased at age 65, and providing a $150 daily benefit, 5 percent compound inflation protection, four years of coverage and a 90-day elimination period.

[12] *State Cost Containment Initiatives for Long-Term Care Services for Older People*, May 2000, Congressional Research Service, available at: http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RL30752.pdf.

[13] For more information on the Robert Wood Johnson Foundation, visit http://www.rwjp.org.

[14] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), September 9, 2005, U.S. Government Accountability Office, available at: http://www.gao.gov/new.items/d051021r.pdf.

[15] *The Long-Term Care Partnership Program: Issues and Options*, December 2004, The Brookings Institution Retirement Security Project, available at: https://www.brookings.edu/dybdocroot/views/papers/200412retirement.pdf.

What follows is a description of the structural features of each state's program.

New York's "Total Assets" Model

New York's program requires the purchase of a comprehensive long-term care insurance policy, covering a minimum of three years of nursing home care and six years of home and community-based care or a combination of the two, but offers total asset protection for all of the purchaser's assets at the time of Medicaid eligibility determination. While this model requires a greater initial premium commitment from enrollees than other models (discussed below), New York's approach provides 100% protection of assets if participants exhaust their policies and require Medicaid services. The underlying premise of such a "total assets model" was that the period of insurance coverage should be equal to, or exceed, the time during which a person would be penalized by having to pay for long-term care if forced to transfer assets to become Medicaid eligible (when the program in New York began, this period was 30 months).

California and Connecticut's "Dollar-for-Dollar" Models

The programs in California and Connecticut have dollar-for-dollar models in which the dollar amount of protected assets is equivalent to the dollar value of the benefits paid by the long-term care insurance policy. For example, an individual purchasing a long-term care insurance policy with $300,000 total coverage would have $300,000 of assets protected if benefits were exhausted and such person eventually applied for Medicaid assistance.

Indiana's "Hybrid" Model

Although originally adopting a dollar-for-dollar approach structurally similar to the partnership programs in California and Connecticut, in 1998 the state adopted a hybrid model allowing purchasers to obtain dollar-for-dollar protection up to a certain state-defined benefit level; all policies with benefits above that threshold amount provide total asset protection for the policyholder.

A few common features of the partnership policies implemented by these four participant states include incorporation of an inflation protection rider and a non-forfeiture clause. Because states have been targeting citizens in their 50s and 60s, inflation protection (which is typically waived for policyholders purchasing long-term care insurance after a certain age) is essential to maintaining the value of the policy until the policyholder needs the insurance, which could potentially be decades later.[16] Similarly, non-forfeiture clauses are often a necessary mechanism for protecting the investments of policyholders in the event they can no longer afford premiums. Because individuals pay their insurance premiums for years in advance of needing long-term care services, both California and New York concluded it was important that policyholders have the ability to maintain some portion of their policy benefits if they cannot continue to pay premiums.[17]

Success of Long-Term Care Partnership Programs

The four states utilizing partnership programs vary in how their respective programs protect policyholders' assets, and analysis of such programs' success is complicated because the information collected by the states is not standardized. However, based on the most recently-available data compiled by the Government Accountability Office, there are 172,477 active partnership policies insured by a total of seventeen participating insurance companies throughout these four states.[18] The percentage of partnership policyholders who were first-time policyholders of long-term care coverage was 94% in California, 92% in Connecticut, 94% in Indiana and 95% in New York.[19]

[16] *Ibid.*
[17] *Ibid.*
[18] *Overview of the Long-Term Care Partnership Program* (GAO-05-1021R), U.S. Government Accountability Office, *supra*.
[19] *Ibid*.

The total number of partnership policies purchased each year has increased significantly since the programs' implementation. In recent years, however, a decline in the number of policies purchased has been observed. State partnership officials report that such a decline – or leveling off – is likely reflective of overall trends in the long-term care insurance market, and not specific to the partnership policies.[20]

Data from the partnership states do indicate that the program attracts upper middle-class individuals to purchase coverage. In the three states surveying a sample of partnership policyholders – California, Connecticut and Indiana – the majority of policyholders reported that their total assets were greater than $350,000.[21]

Perhaps most importantly, less than 1% of active partnership policyholders (1,209 total) are currently accessing their long-term care insurance benefits. Since the programs began, a total of 251 policyholders in the four states have exhausted their long-term care insurance benefits, and just 119 (47%) have accessed Medicaid funds.

Still, upon implementation of the partnership programs, several criticisms were initially leveled by both stakeholders and industry analysts alike.[22] Many were troubled that a public assistance program such as Medicaid would endorse private insurance products, which they believed to be beyond the scope and mission of the Medicaid program. Likewise, others were concerned that partnership arrangements would actually increase Medicaid spending, rather than reduce it, if wealthy individuals who would have purchased similar insurance policies anyway participate in the partnership, keep their assets, and are allowed access to Medicaid funds traditionally earmarked for lower-income Americans. Because the partnership policies have thus far been more attractive to higher-income individuals, there is an additional concern that such policies might not be insuring those individuals most likely to otherwise spend down their assets and resources to become Medicaid-eligible.

The Government Accountability Office reports that it is difficult to determine whether and to what extent the Long-Term Care Partnership Program has resulted in cost savings to the Medicaid program, because there is insufficient data to determine if policy purchasers would have accessed Medicaid had they not purchased long-term insurance coverage.

Buoyed by concerns of the morality and wisdom of possibly directing Medicaid funds at upper- and middle-class citizens, the criticisms detailed above initially gave rise to federal opposition to long-term care partnership policies, ultimately resulting in the Omnibus Budget Reconciliation Act of 1993 (OBRA). OBRA amended section 1917 of the Social Security Act – effectively placing restrictions on further attempts to replicate the insurance partnership model – by requiring that any states implementing partnership programs after May 14, 1993 must recover assets from the estates of all persons receiving services under Medicaid upon death.[23] The result of this provision was that, for states wishing to replicate the various asset protection models, the asset protection component of the policies remains in effect, but only while the policyholder is alive.

Nevertheless, interest in the partnership program had grown well beyond the four states initially experimenting with a partnership model to long-term care coverage. At least 16 states (including Florida) have passed legislation to implement a partnership program once restrictions imposed by OBRA were withdrawn or waived.

---

[20] *Ibid*.
[21] *Ibid*. In a policyholder survey, California and Connecticut instructed policyholders to exclude the value of homes and cars when reporting assets, while Indiana instructed policyholders to include the value of their homes.
[22] *The Long-Term Care Partnership Program: Issues and Options*, The Brookings Institution Retirement Security Project, *supra*.
[23] Beneficiaries participating in established or approved partnership programs as of May 14, 1993 were exempted from this requirement.

Chapter 2005-252, L.O.F., enacting CS/SB 1208, amends s. 409.905, F.S., by providing that, for purposes of eligibility determinations for nursing facility services funded by Medicaid, individuals who are beneficiaries of approved long-term care partnership program insurance policies with exhausted policy benefits shall have their total countable assets reduced by $1 for each $1 of benefits paid out under such policy.

The legislation further created s. 409.9102, F.S., directing the Agency for Health Care Administration (AHCA) to establish the Florida Long-term Care Partnership Program ("the Program"), which shall:

- provide incentives for an individual to obtain insurance to cover the costs of long-term care;
- establish standards for long-term care insurance policies for designation as approved long-term care partnership program policies in consultation with the Office of Insurance Regulation (OIR);
- provide a mechanism to qualify for coverage of the costs of long-term care needs under Medicaid without first being required to substantially exhaust his or her resources, including a reduction of the individual's asset valuation by $1 for each $1 of benefits paid out under the individual's approved long-term care partnership program policy as a determination of Medicaid eligibility;
- provide and approve long-term care partnership plan information distributed to individuals through insurance companies offering approved partnership policies; and
- alleviate the financial burden on the state's medical assistance program by encouraging the pursuit of private initiatives.

Additionally, AHCA was directed to develop a plan for the Program's implementation, and to present the plan in the form of recommended legislation to the President of the Senate and the Speaker of the House of Representatives prior to the commencement of the 2006 legislative session.

Both the amendments to s. 409.905, F.S., and the creation of s. 409.9102, F.S., were to take effect contingent upon amendment of s. 1917(b)(1)(c) of the Social Security Act by the United States Congress to delete the "May 14, 1993" deadline for approval by states of long-term care partnership plans.

The Federal Deficit Reduction Act of 2005

On February 8, 2006, President Bush signed the federal Deficit Reduction Act of 2005 ("the Deficit Reduction Act") into law. Among numerous other changes made to Medicaid and Medicare, the Deficit Reduction Act amends s. 1917(b)(1)(C)(ii) of the Social Security Act to allow groups of individuals in states with plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. For purposes of the Social Security Act, the term "qualified state long-term care insurance partnership" means a Medicaid state plan amendment providing for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under an approved long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

- (I) the policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged;
- (II) the policy is a qualified long-term care insurance policy (as defined in s. 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the state plan amendment;
- (III) the policy meets the requirements of the long-term care insurance model regulation and the long-term care insurance model Act, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);
- (IV) if the policy is sold to an individual who:

    - has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;
    - has attained age 61 but has not attained age 76 as of the date of purchase, the policy provides some level of inflation protection; and
    - has attained age 76 as of the date of purchase, the policy may (but is not required to) provide some level of inflation protection;
- (V) the State Medicaid agency under s. 1902(a)(5) of the Social Security Act provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;
- (VI) the issuer of the policy provides regular reports including notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information appropriate to the administration of such partnerships; and
- (VII) the state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Deficit Reduction Act also requires the Secretary of Health and Human Services to develop, no later than January 1, 2007, standards for the uniform reciprocal recognition of long-term care insurance policies among states with qualified state long-term care insurance partnerships, so that benefits paid under such policies will be treated the same by all such states.

The Deficit Reduction Act establishes a National Clearinghouse for Long-Term Care Information. Such Clearinghouse is responsible for:

- educating consumers with respect to the availability and limitations of coverage for long-term care under the Medicaid program, and providing contact information for obtaining state-specific information on long-term care coverage, including eligibility and estate recovery requirements under State Medicaid programs;
- providing objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care, and providing contact information for additional objective resources on planning for long-term care needs; and
- maintaining a list of states with state long-term care insurance partnerships under the Medicaid program that provide reciprocal recognition of long-term care insurance policies issued under such partnerships.

Effect of Proposed Changes

HB 947 amends s. 409.905(8), F.S., by revising Medicaid eligibility criteria for nursing and rehabilitative services, and providing that an individual who is a beneficiary of a Florida long-term care partnership program insurance policy and who has exhausted the policy's benefits shall have their countable assets reduced by an amount equal to the insurance benefit payments that are made to, or on behalf of, such individual. Additionally, the bill repeals s. 409.905(8), F.S., as amended by Chapter 2005-252, L.O.F.

The bill reenacts and amends s. 409.9102, F.S., as created by Chapter 2005-252, L.O.F., and directs AHCA to amend the Medicaid state plan establishing the Florida Long-Term Care Partnership Program in compliance with the requirements of the Social Security Act. In addition to incentivizing purchase of long-term care insurance and establishing standards for designation of such policies as approved long-term care partnership program insurance policies in consultation with the Office of Insurance Regulation, the bill also directs that the Program include a provision for the disregard of assets or resources in an amount equal to the insurance benefit payments that are made to, or on behalf of, an individual who is a beneficiary under an approved Florida long-term care partnership program

insurance policy as a determination of Medicaid eligibility. The bill provides for consultation with the Department of Children and Family Services during such Medicaid eligibility determinations.

The bill provides an effective date of July 1, 2006.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.905(8), F.S.; revises Medicaid eligibility criteria for nursing and rehabilitative services; provides for reduction of an individual's total countable assets by an amount equal to the insurance benefit payments made under a Florida long-term care partnership program insurance policy, if such policy benefits have been exhausted.

Section 2. Repeals s. 409.905(8), F.S., as amended by Chapter 2005-252, L.O.F., to remove the contingent effective date.

Section 3. Reenacts and subsequently amends s. 409.9102, F.S., as created by Chapter 2005-252, L.O.F.; directs the Agency for Health Care Administration to amend the Medicaid state plan establishing the Florida Long-Term Care Partnership Program, in compliance with the Social Security Act; provides for the disregard of assets or resources in an amount equal to the insurance benefit payments made to, or on behalf of, an individual who is a beneficiary under an approved long-term care partnership program policy; provides for consultation with the Department of Children and Families during determination of Medicaid eligibility.

Section 4. Amends s. 4 of Chapter 2005-252, L.O.F., by providing the act is effective upon becoming a law.

Section 5. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Potentially, the Agency for Health Care Administration could experience a fiscal effect if additional staff or contract funds are required to provide counseling to individuals planning for long-term care needs. However, if the legislation is successful in avoiding (or delaying) future Medicaid expenditures, the bill could result in savings or cost-avoidance to the state.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Because counties participate in the cost of nursing facility care for the Medicaid program, shifting a portion of the cost away from the Medicaid program could result in savings or cost-avoidance to individual counties.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

It is expected that an increased amount of approved long-term care insurance policies will be purchased as a result of this legislation. This renewed interest in long-term care coverage could potentially invigorate the state's insurance industry. However, depending on the criteria ultimately adopted for determination of which policies constitute "approved" Florida Long-Term Care Partnership policies, some insurers offering other long-term care coverage could experience reduced profitability.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The municipal/county mandates provision in section 18 of article VII of the Florida Constitution does not appear to be applicable, since the bill does not appear to require counties or municipalities to take action requiring the expenditure of funds, does not appear to reduce the authority that counties or municipalities have to raise revenue in the aggregate, and does not appear to reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The citation to s. 1921(b) of the Social Security Act is incorrect; it should read "s. 1917(b)."

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES