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MEMORANDUM

September 9, 2015

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Strengthening Medicaid Program Integrity and Closing Loopholes"

On Friday, September 11, 2015 at 9:15 a.m. in room 2322 of the Rayburn House Office Building, the Subcommittee on Health will hold a legislative hearing on six Medicaid legislative proposals. Four of the proposals under consideration address program integrity in the Medicaid program—H.R. 1570, which would make information about the territories publicly available on a website; draft legislation that would address treatment of terminated providers; draft legislation to address tracking of personal care services in Medicaid; and draft legislation that would exempt the creation of Medicaid Fraud Control Units (MFCU) from territories' Medicaid funding caps. The remaining two pieces of legislation under consideration—H.R. 2339 and H.R.1771 address eligibility rules in Medicaid. H.R. 2339 would change how lump sums are counted for purposes of eligibility in the Medicaid program, and H.R. 1771 would change how spousal income purchased through an annuity is considered for nursing home coverage eligibility.

More information on these legislative measures is provided below. For further background information on the Medicaid program, please refer to the Committee's memo from July 7, 2015.

I. MEDICAID PROGRAM INTEGRITY AND PROPOSED LEGISLATION

A. Background

States are the first line of defense against Medicaid fraud and improper payments. More specifically, state program integrity units are the primary governmental actors bearing initial responsibility for state program compliance with federal requirements, detecting improper

payments, recovering overpayments, and referring suspected cases of fraud and abuse to law enforcement agencies.[1]

In 2005, the Deficit Reduction Act expanded the oversight role of the Centers for Medicare and Medicaid Services (CMS) under the Medicaid program. Prior to then, states assumed primary oversight responsibilities. To implement the law, CMS created the Medicaid Integrity Group (MIG), which is within the agency's Center for Program Integrity. MIG responsibilities include educating providers on issues such as inappropriate billing practices, providing technical assistance to states, training state Medicaid program integrity staff, and periodically reviewing each state's Medicaid program integrity procedures and processes to ensure that they comply with federal requirements.

On the law enforcement side, State Medicaid Fraud Control Units (MFCU) located in state Attorneys General offices investigate and prosecute Medicaid fraud and work in conjunction with the Department of Health and Human Services Office of Inspector General (HHS-OIG) and the Department of Justice. The Health Care Fraud and Abuse Control Program (HCFAC), under the joint direction of the Attorney General and HHS-OIG, coordinates federal, state, and local law enforcement activities with respect to health care fraud and abuse.

The Affordable Care Act (ACA) included a number of provisions to strengthen program integrity in the Medicaid program. The most important provisions involve a shift from the traditional "pay and chase" model to a preventive approach, by keeping fraudulent suppliers out of the program before they can commit fraud.

On February 2, 2011, CMS issued final rules that dramatically changed how providers and suppliers enroll in the Medicaid and Medicare programs.[2] These regulations implement Section 6401 of the ACA, which requires the Secretary to establish procedures for conducting risk-based screenings of providers and suppliers in the Medicare, Medicaid, and CHIP programs. The final regulations require that all participating providers in the Medicaid and CHIP programs be screened upon enrollment and revalidated at least every five years. Based upon this requirement, state Medicaid agencies must complete the revalidation process of all providers by March 24, 2016.

In addition to enhanced screening of providers, the ACA strengthened provider termination authority; specifically, section 6501 of the ACA requires that effective January 1, 2011, each State must terminate the participation of a provider from its State Medicaid program

[1] U.S. Government Accountability Office, *Medicaid Program Integrity: Expanded Federal Role Presents Challenges to and Opportunities for Assisting States* (Dec. 7, 2011) (GAO-12-288T).

[2] The Department of Health and Human Services, *Medicare, Medicaid, and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers* (Feb. 2, 2011).

if that provider's participation was terminated from either Medicare or another state's Medicaid program.[3] This requirement strengthens Medicaid program integrity across States, so that providers found to warrant termination in one State may not continue to treat (or begin to treat) Medicaid beneficiaries in another State and receive Medicaid payments for doing so.

B. Medicaid Program Integrity Proposed Legislation

1. H.R. ____, the Ensuring Terminated Providers are Removed from Medicaid and CHIP Act.

This legislation implements OIG recommendations from two reports to strengthen authorities originally authorized under the ACA for terminating provider.[4]

The ACA required CMS to establish a process for sharing information about terminated providers. To meet this requirement, CMS established a Web-based portal accessible to states and the federal government. In its 2014 review, HHS-OIG found that as of June 1, 2013, the termination database established by CMS contained records on terminated providers submitted by CMS and 33 State Medicaid agencies and did not contain records from the remaining State Medicaid agencies. Contrary to CMS guidance, about one-third of the 6,439 records did not relate to providers terminated "for cause." Further, over half of these records did not contain National Provider Identifiers (NPI). Another one-third of these records did not identify the provider types and one quarter of them had no provider addresses.[5] HHS-OIG recommended that CMS: (i) require each State Medicaid agency to report all terminated providers, (ii) ensure that the shared information contains only records that meet CMS's criteria for inclusion, and (iii) take action to improve the completeness of records shared through the process. CMS concurred with all of the above-mentioned recommendations.

In their August 2015 report, the OIG found that despite the ACA requirement that States terminate any providers already terminated for cause in another State, there was continued participation from such providers in other States' Medicaid programs. Specifically, HHS-OIG's review showed that twelve percent (295 of 2,539) of providers terminated for cause in 2011, continued participating in other States' Medicaid programs, as late as January 2014. These Medicaid programs paid $7.4 million to 94 providers for services performed after each provider's

[3] ACA § 6501, Social Security Act § 1902(a) (39), 42 U.S.C. § 1396a (a).

[4] The Department of Health and Human Services' Office of the Inspector General published two reports that provide the basis for the provider terminations legislation under consideration for the hearing: *CMS System for Sharing Information About Terminated Providers Needs Improvement* (March 2014) (OEI-06-12-00031), and *Providers Terminated from One State Medicaid Program Continued Participating in Other States* (August 2015) (OEI-06-12-00030).

[5] *CMS System for Sharing Information About Terminated Providers Needs Improvement* (March 2014) (OEI-06-12-00031).

termination for cause by the initial State.[6] Consequently, HHS-OIG reiterated its prior recommendation that CMS implement mandatory reporting on provider terminations while additionally recommending that CMS: (i) work with States to develop uniform terminology to clearly denote "for cause" terminations, (ii) require that State Medicaid programs enroll all providers participating in Medicaid managed care, and (iii) furnish guidance to State agencies that termination is not contingent upon the provider's active licensure status. CMS concurred with all of these recommendations.

The proposed legislation would require states to report the termination of any individual or entity from the state's Medicaid/CHIP program to the Secretary within 14 business days from the date of termination. The legislation sets forward specific criteria for inclusion in the report, and would apply such requirements in both the managed care and fee-for-service space, and would also apply to the CHIP program. The legislation would also require the Secretary to develop uniform technology for states to use with respects to specifying reasons for termination. The Secretary would be required to ensure that information received from states regarding terminated providers was included in the Termination Notification Database within 14 business days of receipt. Two years following enactment, the Secretary would be vested with authority to terminate payment to providers 60 days after applicable terminations have been recorded in the database.

This legislation would prescribe mandatory HHS reporting criteria and timelines in statute. However, technical fixes are needed to ensure that intent of the legislation is achieved fully, and existing provider appeal processes are preserved.

2. H.R. ____, the Medicaid and CHIP Territory Fraud Prevention Act

Territories are subject to both a low federal matching rate in Medicaid (FMAP) and to an overall cap on the total amount of funding that the federal government annually provides to support the Medicaid program. If a territory's costs exceed the fixed dollar amount for a given year, then the territory would be responsible for 100 percent of any additional costs. The block grant structure of federal support to the territories has historically led to chronic underfunding, with territories unable to invest in fraud control activities that would save dollars in the long term due to constant immediate shortfalls in meeting the bare minimum for program administration.

This legislation would implement a proposal in the President's FY 2016 budget that would encourage territories to establish Medicaid Fraud Control Units (MFCU) to protect their Medicaid programs by exempting federal support for these units from the cap on Medicaid funding for the territories and by exempting territories from the statutory ceiling on quarterly federal payments for the units.[7]

3. H.R. 1570, the Medicaid and CHIP Territory Transparency and Information Act

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[6] *Providers Terminated from One State Medicaid Program Continued Participating in Other States* (August 2015) (OEI-06-12-00030).

[7] The Department of Health and Human Services, FY2016 Budget in Brief (February 2, 2015) (online at http://www.hhs.gov/about/budget/budget-in-brief/cms/program-integrity/index.html).

This legislation would require CMS to publish and update as necessary information on federal expenditures under Medicaid and CHIP in the territories, and other information and documents related to program design. At present, CMS does not have entire information sets on all the territories posted on its website; however, information pertaining to Puerto Rico, which administers the largest territory Medicaid program, is posted currently on Medicaid.gov, as are all of the states.

This legislation could unintentionally establish a website mandate that is overly prescriptive and could quickly become outdated, thereby compromising the Secretary's ability to update information on a real-time basis. In addition, some of the criteria in the legislation is not applicable to the territories, given the differences in their Medicaid programs compared to states.

4. H.R. 2446, Electronic Visit Verification System Required for Personal Care Services Under Medicaid

This legislative draft updates an earlier legislative version of H.R. 2446, which requires states to have in place a system for the electronic verification of visits conducted as part of personal care services. Personal care services (PCS) provide assistance to the elderly, people with disabilities, and individuals with chronic or temporary conditions so that they can remain in their homes and communities. PCS are currently offered as either a State plan optional benefit or through various demonstrations and waivers in all 50 States. It is critically important for beneficiaries to be able to "age in place" in their homes, and to ensure that PCS, and more broadly, all home and community based services, are high-quality and delivered to beneficiaries.

The legislation under consideration would require that if a state does not have an electronic visit verification system for personal care services in place by January 1, 2018, then that state's FMAP would be reduced in terms of amounts that can be expended for home and community based services. Specifically, the legislation applies a reduction to a state's FMAP for home and community based services of 0.25 percentage points in 2018 and 2019, 0.5 percentage points in 2020, 0.75 percentage points in 2021, and by a full percentage point in 2022, and for each year thereafter. The legislation specifies a minimum floor of information that must be gathered and electronically verified by any system a state chooses to put in place as well as specific matters for states to consider (e.g., minimum burden, HIPAA, best practices in use in the state) in the course of implementing the draft law. The legislation further clarifies that nothing in the legislation may be construed to limit or impede care, or beneficiary selection of caregiver, and that no particular or uniform system is required.

Ensuring beneficiaries actually receive quality PCS and other home and community based services to which they are entitled is an issue of serious importance. HHS-OIG has published an extensive body of work examining Medicaid PCS, and has found significant and persistent compliance, payment, and fraud vulnerabilities.[8] HHS-OIG's Office of Investigations and many State MFCUs report that the increasing volume of PCS fraud has become a top concern. For instance, in August 2012, HHS-OIG completed seven statewide audits and one

[8] Department of Health and Human Services, Office of the Inspector General, *Personal Care Services: Trends, vulnerabilities and recommendations for improvement*, (November 2012) (OIG-12-12-01).

citywide audit of PCS payments and identified over $582 million in questioned costs.[9] As emphasis on deinstitutionalization grows, so too does the need for PCS in Medicaid, which is the majority payer of long-term care services. For example, in 2011, Medicaid costs for PCS totaled approximately $12.7 billion, a 35-percent increase from 2005.[10]

These vulnerabilities demonstrate the need for CMS to take a more active role with States to combat these issues. An electronic visit verification system is one strategy. However, a full review of CMS's efforts in this area and HHS-OIG's body of recommendations is warranted. Further consideration of the structure of the penalty in the legislation under consideration is also warranted, as the lack of additional financial assistance to states on the front end to establish such a system, given the breadth of administrative priorities and minimal support in many state Medicaid programs already, may be concerning.

II. MEDICAID ELIGIBILITY AND RELATED LEGISLATION

Two additional pieces of legislation that will be discussed during the hearing address other aspects of Medicaid eligibility.

A. Medicaid Eligibility and Modified Adjusted Gross Income

The ACA created a streamlined approach to determine eligibility for Medicaid and Children's Health Insurance Program (CHIP) in addition to premium tax credits (PTCs) and cost-sharing subsidies (CSRs), which help individuals afford coverage. Prior to the ACA, states had widely varying rules regarding what income and assets were "countable" for purposes of eligibility for Medicaid, and what was not countable income ("disregards").

The ACA approach was designed to ensure that individuals would be able to qualify for (an) appropriate program(s) without gaps in, or duplication of, coverage. This approach also facilitates portability of coverage among health insurance programs in cases where an individual's income grows or shrinks, causing a particular beneficiary to either lose eligibility for one form of coverage and to gain eligibility for another. To accomplish these objectives and align Medicaid rules with income definitions found in the tax code, which are used in turn for determining premium tax credit eligibility under the ACA, the statute redefined the way that Medicaid counts income, and it eliminated the state patchwork of different asset test rules. These revisions to the healthcare laws were essential in coordinating Medicaid with Marketplace coverage and in reducing and streamlining administrative burdens incurred by the states.

Under the ACA, states were required to transition to a new income-counting rule based on Modified Adjusted Gross Income (MAGI), which established uniform standards for what income to include or disregard in determining Medicaid eligibility for most individuals. Under the Medicaid MAGI income-counting rules, a state will look at an individual's MAGI, deduct an amount equal to 5% of the Federal Poverty Level (FPL) (which the law provides as a standard disregard), and compare the resulting incomes to respective eligibility levels set by each state, in

[9] *Id., p.2*

[10] *Id., p.1*

coordination with CMS, to determine whether the individual meets the program's eligibility requirements.

1. H.R. 2339, to amend title XIX of the Social Security Act to clarify the treatment of lottery winnings and other lump sum income for purposes of income eligibility under the Medicaid program

Lump-sum income is income that an individual generally receives on a one-time basis, such as insurance or workers' compensation settlements for serious injuries, retroactive disability or unemployment compensation payments (to cover months when the individual was eligible but the state or federal agency was still processing their application), and one-time gifts from a friend or relative. Lump sum income can only be an amount that is given one time – if a payment occurs more than once, it will be counted as income. Under the ACA and longstanding federal Medicaid rules, a lump sum payment is counted in Medicaid as income in the month in which it is received (and as an asset after that for those Medicaid beneficiaries who remain subject to an asset test such as most elderly and disabled beneficiaries). But because the ACA's premium tax credits are based on annual rather than monthly income, lump-sum income that is taxable is included in a tax-filer's annual income level used to calculate the filer's eligibility for a premium tax credit.

H.R. 2339 would undermine the streamlined, coordinated eligibility approach the ACA established and encumber the states with additional administrative burdens. The bill would require states to count "lump sum income" that an individual may receive as though it were income that the individual is receiving for one to 20 years after actual receipt. H.R. 2339 would alter the Medicaid rules in this area by allowing states to consider lump sums between $20,000 and $50,000 as monthly income for a period of up to a year. People who receive a lump sum of more than $50,000 could have a portion of that income attributed as monthly income for up to 20 years, depending on the length of time the state chooses. In cases where a Medicaid enrollee is a child, that child could be de-enrolled if a parent is found to have received any sort of lump sum income.

Moreover, under the ACA, people who apply for coverage at a Marketplace must first be screened for Medicaid eligibility, but that would become more difficult under H.R. 2339 as the Federally Facilitated Marketplace (FFM) that operates in 37 states would have to apply each state's differing rules on lump sum payments. This would complicate the federal Marketplace's work. The FFM, the State-Based Marketplaces, and state Medicaid agencies wouldn't be able to administer this provision without making system changes that would require some new investments by the federal government and the states.

H.R. 2339 refers to preventing lottery winners from receiving Medicaid. Yet the overwhelming bulk of people it would affect are people who have not won the lottery. The bill would count all lump sum income — including various personal injury awards, workers' compensation settlements, retroactive disability and unemployment compensation payments, and the like — as monthly income.

In addition, for that very small amount of individuals that may, in fact, win millions of dollars through the lottery, the system already has several checks in place for detecting which individuals have received higher incomes for a period of time. In the hypothetical case where payments are made in installments, said installments would automatically count as income. If the payment is in fact a lump sum, it is counted in the month received, but any savings, interest or investment from the sum would be counted as income thereafter. Moreover, CMS additionally requires that enrollees notify the state Medicaid agency immediately if they have a change of circumstance that affects their eligibility for Medicaid coverage.[11] Furthermore, CMS additionally requires that states annually redetermine Medicaid eligibility; as part of that process, states may "adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income."[12]

If H.R. 2339 were enacted, a substantial number of low-income people who receive a lump sum income could be determined ineligible for Medicaid because their income is too high, or deemed ineligible for premium tax credits in the Marketplace because their income is too low.

a. Income Eligibility Example #1

An individual enrolled in Medicaid who has income of $10,000 a year but was injured in an accident receives $25,000 in punitive damages from a lawsuit or other settlement. Under the proposed bill, the program would consider the one-time lump sum as monthly income for the next 12 months, and the individual would be deemed to have income of $2,917 from July 2015 through June 2016. Since that amount is well above the monthly income limit for Medicaid for a single individual, that person's Medicaid coverage would be terminated. Initially, the individual would be determined eligible for premium tax credits based on annual income of $35,000 for 2015. But when the individual seeks to renew his or her Marketplace coverage for 2016, during the next open enrollment period, the Marketplace would base his or her eligibility for premium tax credits on a projection of income for calendar year 2016, when no further lump-sum payments are expected. Assuming the individual's annual income is still $10,000, the Marketplace would deny the individual any premium tax credits for 2016, because his or her income would be too low. The Marketplace would then forward the individual's case to the Medicaid agency. But, because the Medicaid agency would count the individual's monthly income for the first six months of 2016 as still being $2,916, the individual would be ineligible for Medicaid until July 2016. Accordingly, the individual would be uninsured for the first half of 2016.

b. Income Eligibility Example #2

[11] *See* "Periodic Redeterminations of Medicaid Eligibility" §435.916.

[12] *See Id*.

People newly approved for Social Security disability benefits could be affected especially severely. Typically, it takes the Social Security Administration a long time (often a year or more) to process disability claims. Consequently, most people found eligible for disability benefits are owed back payments when their disability application is finally approved. These back payments, which come in a lump sum amount, can add up to thousands of dollars. Individuals with disabilities may be relying on these back payments to pay down debt that they incurred to pay for medical and other expenses while awaiting a determination from the Social Security Administration.[13] Under H.R. 2339, these retroactive disability payments would be counted as monthly income for a period of time after they are received, thereby making many low-income disabled people ineligible for Medicaid — including some people who would be ineligible for both Medicaid and premium tax credits for a number of months.

2. *H.R. 1771, To amend title XIX of the Social Security Act to count portions of income from annuities of a community spouse as income available to institutionalized spouses for purposes of eligibility for medical assistance*

In the absence of other viable public or private options to finance current and future Long-Term Supports and Services (LTSS) needs for people of all ages, Medicaid continues to be the major financing and delivery system for institutional and community-based LTSS for millions of Americans. The number of elderly Americans is expected to more than double in the next 40 years.[14] According to CMS National Health Expenditure Accounts data, total national spending on LTSS was $310 billion in 2013, with Medicaid covering 51 percent of total expenditures.[15] For individuals, the cost of nursing home care in particular can be overwhelming, averaging nearly $90,000 annually.[16]

Medicaid offers coverage for long-term care services to individuals whose assets—both income and resources— are insufficient to meet the costs of necessary medical services. To meet the financial eligibility criteria, individuals must have countable assets that fall below established standards, which vary by state, but are within standards set by the federal government. The financial eligibility standards differ based on whether an individual is married or single. Federal

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[13] People determined eligible for Social Security disability benefits must wait two years before becoming eligible for Medicare.

[14] Kaiser Family Foundation, *Medicaid and Long Term Services and Supports: A Primer* (May 8, 2015) (online at http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/).

[15] *Id.*

[16] Genworth, *Genworth 2014 Cost of Care Survey* (Richmond, VA: Genworth Financial, Inc., March 2014) (online at https://www.genworth.com/dam/Americas/US/PDFs/Consumer/corporate/130568_032514_CostofCare_FINAL_nonsecure.pdf).

law also limits Medicaid payments for long-term care for individuals who have transferred assets for less than "Fair Market Value" during a specified time period.

Congress has acted on multiple occasions to address financial eligibility requirements for Medicaid coverage for long-term care. Most recently, the Deficit Reduction Act of 2005 (DRA), enacted in February 2006, amended some existing provisions regarding asset transfers and introduced new requirements related to financial eligibility for Medicaid coverage for long-term care.[17] For example, the DRA extended the look-back period from 36 months to 60 months; the look-back period is the five-year window a state will review for inappropriate asset transfer. This policy was designed to further discourage "spending down" or transferring assets for Medicaid eligibility; if the state finds such a transfer, the state can apply a penalty period of ineligibility.

In most states, to be financially eligible for Medicaid coverage for long-term care, including nursing home care, individuals must have $2,000 or less in countable resources ($3,000 for a married couple). However, specific income and resource standards vary depending on the way an individual becomes eligible for Medicaid. Eligible individuals generally must contribute a portion of their income toward the costs of nursing home care but are allowed to retain a small personal needs allowance, which varies by state but must be at least $30 per month, to pay for the individual's clothing and other personal needs.

Specific rules, however, would apply to married individuals which are designed to protect the non-institutionalized spouse from impoverishment. Federal law requires states to use specific minimum and maximum income and resource standards in determining Medicaid eligibility for married applicants when one spouse is in an institution, such as a nursing home, and the other remains in the community. The resources of both the institutionalized spouse and the community spouse are considered when determining initial financial eligibility for Medicaid coverage for nursing home care. The community spouse may retain an amount equal to one-half of the couple's combined countable resources, up to the state-specified maximum resource level. These provisions enable the institutionalized spouse to become eligible for Medicaid, while leaving the community spouse with sufficient assets to avoid impoverishment. Income is treated differently from resources; a community spouse's income is not considered when determining financial eligibility for Medicaid coverage for nursing home care. Rather, the community spouse is allowed to retain all of his or her own income. States establish, within federal standards, a minimum amount of income—a minimum needs allowance—that a community spouse is entitled to retain. If the community spouse's income is less than the minimum needs allowance, then income from the institutionalized spouse can be transferred to the community spouse.

H.R. 1771 is based on a 2014 GAO review, "Medicaid: Financial Characteristics of Approved Applicants and Methods Used to Reduce Assets to Qualify for Nursing Home Coverage."[18] This review assessed financial characteristics of applicants approved for Medicaid

[17] *See* Pub. L. No. 109-171.

[18] Government Accountability Office, *Medicaid: Financial characteristics of approved applicants and methods used to reduce assets to qualify for nursing home coverage*. (May 2014) (GAO-14-473).

nursing home coverage, and methods used to reduce countable assets to qualify for Medicaid in a sample of Medicaid nursing home applications in three states. The report found that a very small proportion of married Medicaid long-term care beneficiaries in the sample studied used a strategy to qualify for Medicaid long-term care where they were able to reduce their countable assets by purchasing an irrevocable and nonassignable annuity that pays out income to the community spouse. Although annuities for the community spouse must be actuarially sound—that is, they must pay out during the community spouse's life expectancy—and must name the state as a remainder beneficiary, there are no other limitations on the time period in which annuities must pay out. While any portion of the income from the annuity that is not spent in the month it is received becomes a resource, a community spouse's resources are generally not assessed again after his or her spouse is initially deemed eligible, and thus would not affect the institutionalized spouse's eligibility.

This legislation requires that half of the income produced by Medicaid-compliant annuities be considered available to the institutionalized spouse. This treats the income produced from annuities more like combined resources (as the assets used to purchase the annuity would have been treated), rather than as income solely for the community spouse. This would apply to an annuity created in the 60-month lookback period.

Annuities are used as a vehicle for protecting community spouse assets while still qualifying for Medicaid coverage of LTSS, particularly for couples in which one spouse remained in the community. By purchasing a single premium annuity, couples convert assets to an immediate income stream for the community spouse. Because Medicaid does not count a community spouse's income (within state-specific limits) in determining the institutionalized spouse's Medicaid eligibility, by converting assets to income via an annuity a couple can conserve more of their resources for the community spouse.

Although there is a lack of data readily available to indicate how many people would be affected by this measure, this legislation could result in fewer couples pursuing annuities in the future and for existing annuities it would mean somewhat reduced income for the community spouse and increased payments to the Medicaid program.

III. WITNESSES

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