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Analysis of the Use of Annuities to Shelter Assets in State Medicaid Programs

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ANALYSIS OF THE USE OF ANNUITIES TO SHELTER ASSETS IN STATE MEDICAID PROGRAMS

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Introduction

The Medicaid program is the largest publicly funded source of long-term care coverage in the nation. Over the last several years, an increasing percentage of those who enter long-term care (LTC) facilities, as well those who receive home care on a long-term basis, have had a substantial portion of their costs paid for by the Medicaid program. Individuals who might have paid for long-term care costs themselves or would have purchased private long-term care insurance have turned to various methods of estate planning and asset sheltering activities as a means of qualifying for Medicaid coverage of their long-term care expenses. Program costs are split by the federal and state governments, so that any increase in the long-term care population, in conjunction with this population's move to shelter assets, leads directly to increases in both federal and state Medicaid budgetary costs.

Married couples can usually protect certain assets from consideration as a means for paying for nursing home costs. These assets would include a home, a vehicle, and monies put aside for a small amount of life insurance and for burial purposes. Medicaid statutes include protections against spousal impoverishment to ensure that when one spouse enters a nursing home, the other spouse—the community spouse—has sufficient income and assets to prevent impoverishment, thereby negating any need for financial asistance from the federal or state government.

In this report, the CNA Corporation (CNAC) and our partner, the University of Minnesota (U of MN) present on one such financial instrument that has been used as a means of sheltering assets, thereby potentially increasing costs to the Medicaid program. These instruments are commonly referred to as Medicaid annuities and can potentially reduce the assets held by the insti-

tutionalized spouse by converting these assets into an income stream for the community spouse. The main effect is that assets that could have been used to pay for nursing home costs have essentially been transferred to the community spouse, which in turn, means that the Medicaid program has to step in to pay for the nursing home costs of the institutionalized spouse. Annuities may also be used by a single individual in order to maximize the individual's bequest to his or her heirs.

Has this sheltering of assets occurred on a wide enough scale to lead to major impacts on the Medicaid program? We'll report on some previous information that's been gathered on this question, but it's clear that gaps in the knowledge of Medicaid annuity use and program costs remain. This report has been designed to help fill that gap by answering two important questions related to the Medicaid program:

- How widespread is the use of Medicaid annuities in sheltering assets in order for individuals to qualify for the Medicaid program?
- How much money is the use of annuities costing the program?

We will answer these and other questions in the course of our analysis, undertaken at the request of the Center for Medicare and Medicaid Services (CMS). To do this, we have designed a study plan that includes interviews with key participants, as well as the analysis of data gathered directly from State Medicaid files. We have developed a model that uses the case file data to determine the potential effects of annuities. In the course of our analysis, project activities to understand and quantify the effects of Medicaid annuities have included:

- Designing and developing interviews to be used with state Medicaid directors, state policy staff, and county eligibility staff
- Designing focus group interview questions and protocols
- Reviewing the literature

- Gathering information from interviews of state and county personnel as well as consumer and industry representatives
- Sampling Medicaid case data on state reporting systems to determine costs
- Conducting the focus groups with potential Medicaid applicants/recipients to determine knowledge and attitudes toward the use of annuities
- Analyzing the information, and answering the research questions regarding the effects of these annuities
- Recommending changes in federal and state policies.

Later sections of this report will describe these activities in more detail.

Questions

We have designed this study to answer several research questions related to the use of annuities to shelter resources (assets) and the potential and real effects on the Medicaid program. In addition to the two questions pertaining to the incidence and cost effects of the use of annuities, there are several related questions that we've explored as part of the study. These include:

- How robust is the market for annuities for Medicaid estate planning purposes? What measures describe the state of the market? What factors result in a stronger annuity market in one state over another?
- How has the use of annuities changed over time?
- To what extent have states made changes in their laws, regulations, or policy manuals to inhibit the use of annuities by Medicaid program applicants?
- What types of changes have state programs made or are contemplating making? What are the perceived impacts of these changes, and have states documented the financial impact of these changes?

- Are future potential Medicaid recipients aware of how annuities can be used to shelter assets from Medicaid asset limits? What are their attitudes regarding the use of annuities to shelter assets? How might changes in federal or state policy change their attitudes and behavior toward the use of annuities?
- What are the characteristics of the typical annuity purchaser who is also a Medicaid recipient in terms of his/her demographics, healthcare needs, and financial position?
- What are the characteristics of the typical annuity purchased in terms of the amount, initial cost, payout period, and interest rate?
- Under what circumstances can we generalize what we found for the annuity holders in the states studied and apply the findings to other states across the country?
- What is the cost to state and federal Medicaid systems of asset sheltering through the use of Medicaid-friendly annuities?
- How can federal and state policies be changed to inhibit the use of annuities as an asset-sheltering device?

Summary of results

In reporting the findings of our analysis, we will focus on summarizing the three main parts of the analysis: the interviews we conducted, the focus groups with potential nursing home beneficiaries, and the modeling and simulation of actual Medicaid case files.

We interviewed state Medicaid policy officials, county eligibility workers, and consumer and industry representatives. The state and county representatives—drawn from the five states and 11 counties that participated in our study—were, perhaps not surprisingly, concerned with the use of Medicaid annuities to avoid spend down. Most of them believed that annuities are now, or will be in the future, a problem that subverts the Medicaid program from one that takes care of those in need to one that provides benefits to middle class families. However, state officials

and county eligibility workers acknowledge that the problem of avoiding asset spend down goes beyond annuities and that restricting annuities may in turn give rise to some other method of artificial impoverishment by Medicaid applicants. Consumer representatives felt that the more important issue was protecting consumers from predatory practices, and industry representatives felt that annuities were a good way of protecting the community spouse and allowing him or her to maintain his or her standard of living.

Turning to the results from focus groups conducted with those consumers who are not yet in nursing homes, but are potential users, we were most interested in what they thought of purchasing annuities to avoid using assets to pay for their nursing home care. We found that many of the participants expressed the desire to pay their own way and that it wasn't "right" to have others—their children or other taxpayers—pay for care that they could probably afford. Some were outraged that such financial instruments exist. Nonetheless, some felt that although they could afford it now, perhaps in the future, if it really remains legal and aboveboard, it might provide them with an alternative if they were unable to afford the cost. In other words, it appears that many individuals would prefer not buy an annuity, but might consider doing so if circumstances warranted.

Finally, we also collected Medicaid case files and used the information they contained to estimate two key measures of the effect of annuities on the Medicaid program. One was the incidence rate, which measures the proportion of the non-poor Medicaid beneficiaries in nursing homes who have them. The other measure is how much these annuities affected the costs of the Medicaid program.

Table 1 shows what we found for the five states in our study. The results are based on a model we developed that takes various factors into account, including resource and income constraints on Medicaid eligibility, state policies where the beneficiaries reside, and nursing home lengths of stay and costs. Based on these factors and the specific information contained on beneficiaries in the case files, we could then estimate the cost not only to these states but, with some additional assumptions, to other states with similar annuity policies. The incidence rates vary from less than

one percent in Nebraska and Pennsylvania to more than 3 percent in Missouri. The costs as shown are the total over the entire stay in a nursing home, which we assume is 30 months. If the costs were annualized by dividing by 2.5, we would then obtain a cost for these five states of about $13 million per year.

Table 1. Summary of annuities effects on the Medicaid program

	Incidence rate (in percent)	Projected cost to Medicaid ($M)
Arizona	2.3	15.3
Maryland	1.3	12.8
Pennsylvania	0.4	8.4
Nebraska	0.3	1.0
Missouri	3.3	26.5
Total		**64.4**

In addition to estimating the costs of these five states, we then examined the policies towards annuities in place in all 50 states and the District of Columbia. We grouped them based on their restrictiveness towards the use of annuities for sheltering assets. Based on our assumed grouping of states with similar policies to the five in our study, we could then apply what we found for the five states that participated in our study and extrapolate these figures to apply to other states in the U.S. Some of the states have such restrictive policies that they generally allow few, if any, annuities. But, for the remaining states, which totaled 43 (including the five above) and the District of Columbia, we estimate that annuities are costing the Medicaid program almost $200 million on an annual basis.

Background and approach

Statement of the problem

Elderly or disabled individuals who enter a nursing facility can find their assets quickly depleted. They often turn to Medicaid, a means-tested government healthcare program, to pay for their nursing facility expenses. To be eligible for Medicaid, applicants must meet specific income and resource (asset) standards. Those with assets must "spend down" many of these assets berfore they become eligible. The eligibility determination process for elderly and disabled individuals who have entered a nursing facility can be quite complicated. This is particularly true when the institutionalized individual has a spouse who remains in the community. As we show below, current law permits half of the couple's total countable assets to be protected with a maximum cap of just over $92,000. There are also processes in place to ensure that additional assets can be protected for the community spouse in the event that the community spouse's income prove insufficient for his or her needs.

At the same time, it was clear that these protections sometimes led to abuse of the system. In 1993, Congress passed the Omnibus Budget Reconciliation Act (OBRA), which incorporated several new provisions designed to reduce the cost growth in Medicaid long-term care by ensuring that those who could pay would not abuse the system. OBRA's trust and transfer section required that states "look back" 36 months (60 months for transfers to trusts) when determining eligibility for Medicaid long-term care services. If the look-back uncovered transfers of assets inappropriately made to other persons, including children, penalties could be assessed, including disallowing payments for long-term care for a period of time.

Unfortunately, the Act did not define or lay down rules specifying how annuities should be dealt with, other than by providing a definition of a "trust" that would include various legal instru-

ments that could potentially include annuities. In 1994, CMS (under its previous name, the Health Care Financing Administration) issued Transmittal No. 64 that addressed the issues of annuities as a potential transfer of assets for less than fair market value. We will describe some of the state rules that pertain to annuities, at least for the states that participated in our study, later when we discuss the result of our interviews with State Medicaid officials. However, the federal rules did specify a couple of requirements, including the following:

First, annuities have to be "actuarially sound," which means that the annuity's projected return would have to be paid to the annuitant within the person's expected remaining lifetime. If the annuity did not meet this criterion, the state could consider the annuity to be a transfer at less than full market value and it could then impose a penalty. Of course, defining an individual's life expectancy is not without controversy. Most states use the Supplemental Security Income (SSI) tables to specify an individual's life expectancy, but the tables may be inaccurate given the person's specific medical condition.

A second legal argument for not counting Medicaid annuities is that because they are "irrevocable and not assignable," they cannot be redeemed or sold. Therefore, they have no market value. Various states contend that they do have value and have examined ways to determine the value or have imposed other restrictions on annuities—mainly regarding the treatment of balloon payments at the end of the annuity period and the designation of annuities as part of the recoverable portion of a Medicaid beneficiary's estate—but little uniformity exists.

Thus, annuities may be used not only as a valid tool that's part of an individual's long-term retirement plan, but also as a means of sheltering assets that otherwise could be used to pay for nursing home or other long-term care. Given the relatively high chance of needing LTC—recent research has estimated the chances to be as high as 43 percent for those 65 and older—and its high cost—with estimates ranging from 36,000 to as much as $60,000 or more per year—the incentive is certainly present to shift these costs to a government program such as Medicaid. The annuity effectively converts excess resources into an income stream for the community spouse or, in some cases, the institutional-

ized individual's children—when they are less than 18 or older than 18, but disabled. Not only is income generated for the annuity's beneficiary, but also the resources used to purchase the annuity would not be included in the determination of Medicaid eligibility. Therefore, it can be argued that the purchase was not part of a valid retirement plan, but rather a scheme to protect assets and lead to instant eligibility for Medicaid payments covering the individual's long-term care.

The issue for this study was to determine whether annuities represent more than a potential loophole. Our study has been designed to provide an estimate of the extent to which annuities have been used in the recent past and whether they actually shelter significant amounts of money that could have been used to pay for nursing home care. The presence of an annuity, even one that meets the definition of what we refer to as a Medicaid annuity, does not automatically shelter income from the program. Some light can be shed on these issues from the literature, much of which we've already discussed through a review we conducted (and is available on request). We won't review the relevant literature again in this report, but we will refer to the literature that is most relevant to our current study.

For example, an earlier analysis [1] conducted by the American Public Human Services Association was based on surveys of state Medicaid directors (many of whom we spoke with during the course of this analysis). It reported that most states felt that annuities are a major source of asset-sheltering activity. The survey attempted to elicit state opinion on the extent of the annuity problem, as well as steps they have taken to address the issue. About 70 percent of the states responded to the survey. One question asked these directors for their estimates of the federal/state cost of allowing couples to shelter excess resources in commercial annuities. For these 70 percent of responding states, the estimate was more than $637 million. If the average of those surveys was used and extrapolated as if all the surveys had been returned, the potential total cost would have been more than $1.16 billion.

There are some problems with this analysis. First, Medicaid annuities are used by Medicaid recipients, but the analysis uses the number of private LTC patients who have community spouses to

calculate the number of patients who use annuities. Second, single recipients can also benefit from annuities, though to a lesser extent than a married couple, and do purchase them, but they have been excluded from the analysis. Third, the Medicaid annuity would shelter assets that could have been used to pay for private nursing home care. The cost to Medicaid, therefore, would be related to the difference between what Medicaid paid for the patient with the annuity and what it would have paid had the patient not purchased the annuity. We will explicitly calculate these values based on the case files we collected as part of this analysis and we will show that the difference is not simply the difference represented by the entire Medicaid payment after average income payments have been made, as was assumed in [1].

The current study will take a somewhat different approach from the previous study, which relied on surveys of state officials alone to estimate the cost of annuities to the Medicaid program. In the next section, we'll describe our approach to uncovering the potential effects of annuities based on interviews with various state and county officials and from sampling the Medicaid case files of several states to see how often and what size annuities are being purchased. Then, we'll provide some background on Medicaid eligibility rules, the different kinds of annuities sold today, and which ones we take note of in our analysis.

Analytical approach

In this section, we'll outline the approach and methods we used to answer the questions posed above. In addition to an early review of the relevant literature on long-term care, annuities, Medicaid eligibility, and the use of annuities as a way to shelter assets, we undertook the following several major efforts as part of our analysis:

- Designed interview questions for State and County personnel as well as for consumer and industry representatives

- Designed interview questions and protocols for conducting focus groups of potential long-term care and annuity users
- Recruited five states and two or three counties within each state as participants in our data gathering activities
- Conducted the interviews and focus groups
- Gathered Medicaid case file data of those LTC Medicaid beneficiaries with and without annuities
- Analyzed the case file data in order to quantify:
  - The incidence of annuity use
  - The costs to the program, based on an analysis of the actual costs relative to those the program would have faced in the absence of these annuities.

We'll turn to brief descriptions of these efforts in this chapter with more detailed discussions of the findings from each in later chapters. We'll begin with our approach to recruiting five states that would provide both the officials to be interviewed and the data detailing the use and costs of Medicaid annuities.

Recruiting states for the study

One of the first tasks necessary for conducting the analysis was the recruitment of states that would actively participate in the study. From these states, we hoped to learn about their specific concerns, policies, and actual use by Medicaid beneficiaries of annuities. We suggested that a total of five states be recruited mainly for two reasons. First, we realized that given the somewhat limited scope of the study, we were constrained in the number that we could visit and from which we could gather case file data, especially given the dispersed nature of the data (held in county offices). Second, we recognized that the study would be more effective if we could extrapolate the findings to other states, even nationwide, in order to estimate the total effect of annuities on the entire Medicaid program.

We began our search for representative states by looking across regions, at states with both large and small nursing home populations and Medicaid beneficiaries, as well as examining differ-

ent policies concerning Medicaid annuity use. Some states had few rules regulating the use of Medicaid annuities; others had severely restricted their use. It became clear after speaking with several state Medicaid directors that some of the states, such as New Jersey and Louisiana, have already made it very difficult to purchase annuities and shelter assets. Some of these policy changes have been made recently and these regulations may not hold up in the courts. However, even if they are only temporarily successful, the recent regulations might well mean that few if any Medicaid annuities had been purchased and we would learn little other than the state laws and regulations had been successful, at least in the short run, in limiting annuity purchases. Second, even though several small states expressed concerns about Medicaid annuities being a potential problem, it was clear that the study would require counties that had sufficient numbers of Medicaid beneficiaries in nursing homes. It soon became clear that the use of annuities was not very common (to be defined in this study, but still only a few percent); therefore, it would take large Medicaid populations for us to find enough annuities to enable us to draw reasonable conclusions on what we found.

Many state officials we spoke to expressed interest in the study. However, several of them felt their people were over burdened with work already, or when they passed our request through their chain of command, we often received no clear decision and had to move on to recruit other states. We did find five states that were interested in participating in the study, which meant that we would do the following with their help:

- Interview one or more state Medicaid officials to ask questions on the use of annuities in their state as well as to understand their perceptions of the use of these financial instruments over the last several years.
- Choose two counties in which we would interview their eligibility workers as well as arrange to visit.
- Send a CNAC study team member in order to examine as many Medicaid LTC case files as possible during an approximately one-week visit to the state.

The five states we recruited for the study were drawn from the East, Midwest, and West. As we said above, we had originally

asked several other states from both the South and Northwest to participate, but the recruitment of these states was not successful. Nonetheless, we believe we have five representative states from the U.S. that did agree to participate. We list the five states and the two counties from each (three from Missouri) below:

- Maryland
  - — Montgomery County (suburb of Washington, D.C.)
  - — Baltimore County
- Pennsylvania
  - — Alleghany County (includes Pittsburgh and surrounding areas)
  - — Erie County
- Nebraska
  - — Lancaster (includes Lincoln)
  - — Douglas (includes Omaha)
- Missouri
  - — St. Louis County
  - — St. Charles County (suburb of St. Louis)
  - — Jefferson County
- Arizona
  - — Maricopa County (includes Phoenix)
  - — Pima County (includes Tucson).

Designing and conducting the interviews

Once a state agreed to participate in the study, we set up a telephone interview with that state's Medicaid Director or his or her designee. The interviews typically took less than one hour. We created a series of interview guides, presented in Appendix A, from which we drew questions (the guides were usually sent ahead to the officials so they could see the kinds of issues we were interested in). During the discussion we asked these officials to suggest two counties within their state for us to continue

the interview process as well as which were likely to provide suitable sites for data collection. After the interviews were over, we prepared a written summary of each discussion. We will provide more details on what we learned in the next chapter when we discuss the interviews with those we call "key informants."

We next interviewed the county workers, asking fairly similar questions, but the focus changed a bit to how these individuals conduct their interviews and then to determine whether the use of financial instruments, including annuities, were valid tools used by a Medicaid beneficiary to provide income either for his/her spouse or him or herself. Finally, we also created guides when we spoke with consumer and industry representatives. Here, the focus was on their view of the annuity market and whether annuities seemed to be a reasonable tool for Medicaid beneficiaries as well their views on current or proposed changes in state and federal policies.

Designing and conducting the focus groups

The purpose of the focus groups was to gain insight into the knowledge and attitudes of potential Medicaid recipients regarding the use of annuities. In particular, we were interested in understanding their attitudes related to the use of annuities as a method for sheltering assets so as to meet Medicaid eligibility. We conducted a total of five focus groups, in each of five states. Although we tried to conduct a focus group in each state that participated in the study, the difficulty of recruiting the fifth and final state meant that we substituted participants from Minnesota for Arizona, which was the last state recruited for the study.

In general, when we began, we planned to recruit participants with the following characteristics:

- They will live in one of the five states
- They will be 65 to 80 years of age
- They will not be current Medicaid recipients
- They will live within a narrow geographic area (so that no one needs to drive more than about 30 minutes in one direction).

We felt a knowledge of annuities was not a prerequisite, but we tried to ensure that most focus group participants knew about the use of annuities. One of the purposes of the focus groups was to determine the extent of the participants' knowledge of Medicaid eligibility and concerns that they may have about the consequences and costs of long-term care. Currently, Medicaid annuities are generally a legal way to help qualify for Medicaid and we wanted to explore how they would react to a method that allows them not to have to spend down most of their assets before qualifying for Medicaid. Even if they first learned about annuities in the focus group discussion, valuable information could be learned from their reactions.

Further details will be provided later when we turn to the results of these focus group interviews. We will also provide further details on who was recruited, who typically showed up for the focus group sessions, and what we learned.

Collecting county Medicaid case files

As we said above, once all of the states and counties were chosen, we coordinated visits to the specific county offices that held Medicaid case files. In four of the states, we usually sent one study team member for approximately a week to go through case files at the state's two selected county offices and examine the case files on as random a basis as possible. It turned out that we visited three counties in Missouri (all reasonably close to one another) and we sent two people to Arizona for about three days each because one of the counties (Maricopa) had three different offices and it would have been hard for one person to visit four offices in a week's time.

We found that it took somewhat longer to go through the files than we first had planned. In every case, we had to go through paper files. The longer the beneficiary had been in a nursing home or receiving home-care, the larger the file, and the longer it took to go through. Also, distinguishing among those with annuities took time. In some cases, the annuity contract was in the file and the purchase price, date of purchase, length of the payout period, name of the annuity's beneficiary, and income it generated were clearly specified; in other cases, this information

was not clear and it took time to determine them. In some, although relatively few cases, we were missing some important variables and had to infer a piece of information. For example, we might observe the purchase price and length of payout period, but not the income. Annuities don't usually provide a high rate of return, so we could at least estimate the income stream as though the return were zero or small.

When we found a beneficiary who had recently purchased an annuity (within what's called the "look-back" period, which we assumed was equal to three years of the beneficiary's submitting the application), we copied the relevant parts of the file so that we would have a permanent record of the beneficiary's demographic characteristics as well as those characteristics of the annuity that we listed above. For those individuals without an annuity, we kept a record of some basic characteristics, such as their age and marital status. How we used these data is explained in the next section.

Analyzing the data and measuring the impact of Medicaid annuities

The focus of the analysis of the Medicaid case files was to determine the proportion of elderly LTC Medicaid beneficiaries who held Medicaid annuities and what effect the purchase of these annuities had on Medicaid spending. By keeping track of how many annuities we found relative to the total number of Medicaid LTC beneficiaries, we can determine what we refer to as the "incidence" of Medicaid annuities in the county. We then extrapolate the county incidence rate to the state as a whole.

In addition to using the case files to determine the incidence rate, we use them to determine the effect of the annuities. We developed a simple simulation model that takes account of the various federal and state policies on resource and income limits when there is, or is not, a community spouse. We also use the average nursing home costs in each state and an average length of stay to project the costs to Medicaid under each case (i.e., the base case assuming there was an annuity and the alternative if it had not been purchased and was therefore a part of the family's resources).

With these two important pieces of information—the annuity incidence rate and the Medicaid cost effect—we can then estimate how much annuities cost the Medicaid program nationwide. However, we need to use the five states we have estimates for and match them up to other states so we can extrapolate the findings to as many states as possible. We categorize the various states by certain key characteristics pertaining to annuity purchases by their Medicaid beneficiaries, perhaps the most important being the restrictiveness of the states' policies toward the purchase of annuities.

Thus, our analysis includes the following steps:

- Use the county case files we collected to project the annuity Medicaid cost effect
- Use these same files to determine the county incidence rate and then project the implications across the state
- Categorize all states by specific characteristics as similar to those in the study and derive a nationwide Medicaid cost effect.

Determining eligibility

Recognizing that the high cost of long-term care was depleting family savings, Congress enacted provisions that would allow the states to provide Medicaid to persons in institutions who have too much income to qualify for SSI benefits, but not enough to cover expensive long-term care. It also wanted to prevent what has been called "spousal impoverishment," or the notion that the spouse of someone in long-term care, whether in an institution or undergoing home care, should have sufficient income and resources to pay for his or her needs. In our analysis, we pay particular attention to the various federal or state laws and regulations that dictate how the assets of a family in which one spouse might require a nursing home or extensive home care and the implications of financial instruments like Medicaid annuities that are sometimes used to provide income to the community spouse.

Resource eligibility

The spousal impoverishment provisions apply when one member of a couple enters a nursing facility or other medical institution and is expected to remain there for at least 30 days. In determining resource eligibility, all the assets owned by the institutionalized individual (either in whole or in part) are divided into countable versus non-countable assets. Non-countable assets include the home (in most circumstances), household goods, one automobile, pre-paid burial funds, a small amount of life insurance, and any assets that are considered "inaccessible" for one reason or another. Countable resources include cash, bank accounts, stocks and bonds, and property other than the home.

For a person who is one-half of a married couple, the assets available to pay for nursing facility care are subject to the requirements of the spousal impoverishment rules, which protect community spouses. The share of assets belonging to the community spouse is one-half of the couple's combined resources, subject to a maximum dollar amount. From a couple's countable resources, a Protected Resource Amount (PRA) is subtracted. In 2004, the PRA was the greatest of:

- The spousal share, up to a maximum of $92,760
- The state spousal resource standard, which a state can set an any amount between a minimum of $18,552 and $92,760
- Any amount transferred to the community spouse as directed by a court order, or
- An amount designated by a state hearing officer to raise the community spouse' protected resouces up to a minimum monthly maintenance needs standard.

Anything remaining after the PRA is subtracted from the couple's combined resources is available to the institutionalized spouse as countable resources. Further, this remainder is considered to be available to pay for LTC services, other than a limit on assets, which for the institutionalized spouse was $2000 in 2004 ($3,000 for a married couple who might be applying to-

gether for Medicaid services other than for nursing home benefits). If the amount of countable resources is then below the state's resource standard, he or she is eligible for Medicaid.

Income eligibility

Applicants for Medicaid must also meet an income test. In most States, there is no set standard for income eligibility when applying for nursing home benefits; the standard is that the applicant's income has to be less than the cost of nursing home care. Applicants can also qualify for Medicaid in some states if their income is at or below 300 percent of the Federal SSI standard. These states are referred to as "income-cap" states. In FY 2004, the income limit was $1,692. In these states, applicants with monthly incomes above $1,692 can assign excess income to a Qualified Income (or Miller) Trust and meet the Medicaid income test. The community spouse's income is not considered available to the institutionalized spouse and the two individuals are not considered a couple for income eligibility purposes. Should an individual already be in a nursing home, another process is used to determine how much this individual must contribute for their nursing home/institutional care. This process also determines how much of the income of the institutionalized spouse is protected for use by the community spouse.

The income eligibility determination process begins with the determination of the total income of the institutionalized spouse. From the total income of the institutionalized spouse, the following items would have been deducted in 2004:

- A personal needs allowance of at least $30
- A community spouse's monthly income allowance between $1,515 (effective 7/1/03) and $2,319
- A family monthly income allowance, if there are other family members living in the household
- An amount for medical expenses incurred by the institutionalized spouse.

The community spouse's monthly income allowance is the amount of the institutionalized spouse's income that is actually

made available to the community spouse. Any income the community spouse has that is separate from the institutionalized spouse would be deducted from the community spouse's monthly allowance. Similarly, any income of family members, such as dependent children, would be deducted from the family monthly income allowance. Anything remaining for the institutionalized spouse would be contributed for his or her long-term care costs.

Types of annuity products offered

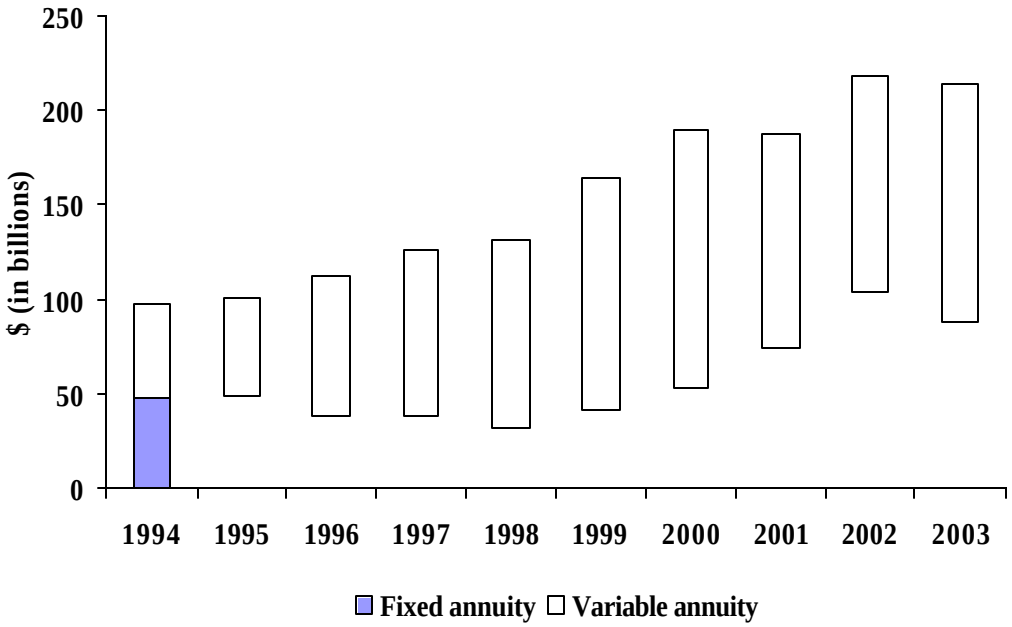
An annuity is a contract between an individual (referred to as the "annuitant") and an insurance company. The annuitant pays the insurance company either a single payment or a series of payments, and in return, the insurance company agrees to pay the annuitant, or a designated beneficiary, an income for a specified time period. The time period can start immediately or can begin at a later date.

There are two basic types of annuities that can be purchased—fixed and variable. Fixed annuities earn a guaranteed rate of interest for a specific time period, such as one, three or five years. Once the guaranteed period is over, a new interest rate is set for the next period. Variable annuities offer a range of investment options (called "subaccounts"), which can include stocks, bonds, and money market instruments. The return on a variable annuity is not guaranteed and can rise or fall depending on the value of the underlying investment option.

Fixed annuities have been around a lot longer than their variable annuity counterparts. Fixed annuities were the dominant annuity product until about 10 years ago when there were large increases in the sales of variable annuities, partly as a result of a booming stock market. Sales of fixed annuities peaked at $47.7 billion in 1990 and have remained flat in the decade following. When interest rates fall, fixed annuities, which often must have their rate of return set above state-mandated minimums, become a more difficult product to sell to consumers. That was the case in 2003; a period when interest rates were at historic lows. Figure 1 shows the growth in both variable and fixed annuities over the 10-year period ending in 2003.

Annuities can also be deferred or immediate. Deferred annuities accumulate money over time and generally begin payouts after retirement. Distribution of payments for immediate annuities typically begins within a month of purchase. The income payments received from fixed immediate annuities are based on the purchase amount of the annuity, the annuitant's age, and the interest rate environment at the time of purchase.

Figure 1. Total industry annuity sales



Source: 2004 Annuity Fact Book, National Association for Variable Annuities (NAVA)

Medicaid-friendly annuities are typically fixed, single premium immediate annuity (SPIA) instruments. A purchaser of an immediate annuity has several options for receiving income. The main types used in Medicaid-planning are:

- **Life only annuities**: In this type of annuity, the insurer makes periodic payments to the annuity beneficiary for the life of the annuitant only. This produces the largest periodic payment for the beneficiary, but no provision is made for heirs because the contract terminates on the death of the annuitant. A substantial loss can occur if the annuitant dies early.

- **Life annuities with refund provisions**: There are two types of refund provisions that can allow the annuity to provide for heirs if the annuitant dies within a pre-set number of years. The annuity can be set to pay for "life with 'X' years certain," which would pay for either the life of the annuitant or a set number of years, whichever is greater. Or, the annuity can be set to pay for "life with installment refund," which guarantees that the total annuity payments will at least be equal to the premium paid to the insurer. In a Medicaid-friendly annuity, the "X years certain" guaranteed cannot be longer than the actuarial life expectancy of the annuitant.

- **Period certain annuities**: The payment period for these annuities is not dependent upon the life of the annuitant. Payment is guaranteed and will be made to either the original beneficiary or, in the event of the original beneficiary's death, to the remainder beneficiary. Again, the length of the period certain cannot be greater than the actuarial life expectancy of the annuitant.

- **Interest only annuities**: These annuities generally make only interest payments during the life of the annuity contract, making a lump-sum payment at the end of the annuity contract period. Several States have moved to prohibit the purchase of this type of annuity by Medicaid applicants.

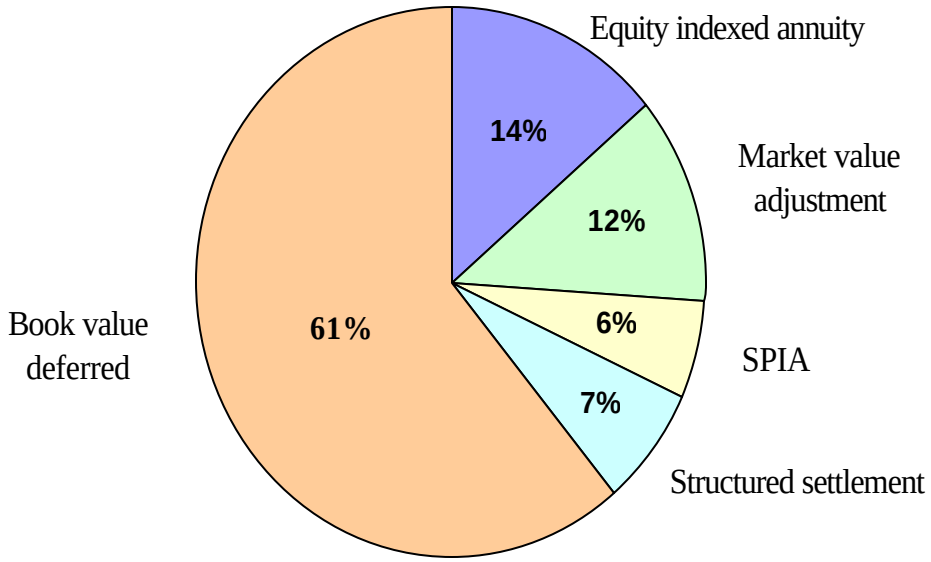
When a guarantee period is chosen the dollar amount of the periodic payment will be less. One industry representative interviewed noted that guarantee periods are economically irrational, but people still chose them if they are hoping to maximize their bequest to heirs.

As we noted above, Medicaid annuities are typically SPIAs. This type of annuity is not likely to vary by State. However, there are rules that vary by State related to the maximum age of an annuitant. Insurance companies are prohibited from selling annuities to very aged individuals because the annuitant—or their beneficiaries—would be unlikely to get a return on his/her purchase. The maximum issue age is typically in the late 80s, but can go as high as 94 years of age.

In addition to SPIAs, there are several other fixed annuity products. As we indicated earlier, the 1990s saw increasing sales of variable annuities and product innovation in that market as well. The major fixed-annuity innovation during the period was the *equity-indexed* annuity, which is designed to allow investors the benefits of investing in the stock market with a protected investment floor if there is a downturn in the market. This annuity usually provides the contract owner with an investment return that is a prescribed percentage of the return of an index (such as the S&P 500) while guaranteeing no less than a stated fixed return on the investment. Other innovations included a longer interest guarantee period or a choice of multiple guarantee periods, and a market value adjustment (MVA) feature. The *MVA* annuity contains an adjustment that is added or subtracted from the accumulated value upon surrender based on changes in interest rates since the time of purchase. In general, if interest rates have fallen (risen) since purchase, the adjustment will tend to be positive (negative). For a *book-value deferred* annuity, surrender values do not fluctuate with market conditions.

Figure 2 presents a chart with the percentages of sales for each of the fixed annuity types discussed above. As the figure shows, SPIAs made up about six percent of all fixed annuities in 2003. That would mean that total sales of SPIAs (which would include those purchased by Medicaid beneficiaries) were about $5.25 billion in 2003.

Figure 2. Fixed annuity sales components, 2003



Source: 2004 Annuity Fact Book, NAVA

Interviews with key informants

This study of the use of annuities to avoid asset spend down collected data and information through three data gathering activities: key informant interviews; focus groups of retirees and near retirees; and a review of Medicaid case files. This chapter of our report presents the findings from key informant interviews. In following chapters, we'll discuss the focus groups and the gathering and analysis of Medicaid case files.

We'll begin here with a description of our interview process, including the number and type of people interviewed. We'll show the Medicaid program characteristics related to the eligibility determination process for the States participating in this study and some selected characteristics of the counties from which the case data were collected. We've divided this chapter into six sections:

- A discussion of the interview process with the following participants:
- Consumer representatives
- Industry representatives
- State Medicaid officials
- County eligibility workers
- The marketing of annuity products
- The treatment of annuities in determining Medicaid eligibility
- Perceptions of annuity use
- State administrative issues such as data availability, budgeting, and legal challenges and
- Policy recommendations suggested by consumer and industry representatives, state policymakers, and county eligibility workers.

The interview process and participants

We conducted interviews with four types of individuals: consumer representatives, industry representatives, State Medicaid officials, and county eligibility workers. All interviews were conducted by phone. Two project staff participated in each interview—one led the interview and a second took notes. Although the structure of the interviews was informal, a prepared interview guide was available for each type of key informant from which the lead interviewer could ask questions (an example can be found in Appendix A). Table 2 presents the total number of interviews conducted for each type of key informant and the number of individuals who participated in these interviews.

Table 2. Number of key informant interviews conducted by type

Type of interview	Number of interviews	Number of participants
Consumer Representative	2	2
Industry Representative	2	2
State Medicaid Officials	5	17
County Eligibility Workers	12	40

Consumer representatives

The consumer advocacy group representatives interviewed were from the Michigan Medicare/Medicaid Assistance Program (MAPP) and the Healthcare and Elder Law Program Corporation (H.E.L.P.). H.E.L.P. is located in California. Both organizations are non-profit corporations and work with low and moderate-income elderly clients. MMAP is a state health insurance counseling program established in 1984. The typical MMAP client is a Medicare beneficiary who wants to apply for Medicaid. MMAP staff members provide direct counseling on eligibility for Medicaid and help individuals apply for the program. H.E.L.P. assists older adults work through the financial challenges associated with healthcare. More than half of the clients seen by H.E.L.P. are concerned about nursing home care.

Industry representatives

Finding industry representatives willing to be interviewed for this study was somewhat difficult. We talked to two individuals;

the Director of Research at TIAA-CREF and an elder law attorney in Maryland. TIAA-CREF is the biggest issuer of annuities in the United States. They sell qualified (i.e., pension plan) annuities. These are annuities that are purchased with tax-deferred dollars; for instance, as part of a 401K plan. Medicaid annuities are "non-qualified" annuities. The non-qualified annuity market is very, very small compared to the qualified annuity market. The representative from TIAA-CREF was able to provide us with an overview of the annuities market and describe the various characteristics of annuity products. The second industry representative interviewed was an elder law attorney from Maryland and in practice since 1985. He is one of the most active members of the elder law bar from Maryland and the District of Columbia who deals with Medicaid LTC issues. Among the Medicaid issues he deals with are eligibility planning, applications and appeals, and maximizing spousal benefits.

State Medicaid officials

Five states participated in this study. They are: Maryland, Nebraska, Missouri, Pennsylvania, and Arizona. We discussed the process by which these states were recruited in the previous section. The Medicaid officials interviewed in each State generally held administrative or policy positions. In one instance, Medicaid legal counsel also participated in the interview. Our interviews with State officials started with a discussion of the Medicaid eligibility requirements and the rules surrounding the determination process for long-term care applicants in each state. Table 2 presents a number of these characteristics by State.

The characteristics shown in Table 3 are all related to the eligibility determination process and may impact (to a greater or lesser extent) an applicant's decision to avoid spend down. All states in our sample use the authority granted in section 1902(r)(2) of the Social Security Act to liberalize their eligibility determination methodologies. Most of the 1902(r)(2) changes are small and serve to simplify the administrative process more than anything else. For example, Nebraska uses 1902(r)(2) authority to disregard up to $10 in interest income. Missouri uses 1902(r)(2) authority to raise income limits and Arizona allows for more favorable treatment of burial funds and life insurance.

Arizona also uses it to disregard the value of oil, mineral, and timber rights. An exception is Pennsylvania's use of 1902(r)(2) to grant a $6,000 asset disregard to Medicaid applicants applying for long-term care services. This asset disregard was established to help those applying for long-term care benefits who wanted to remain in their homes and receive community-based services. In order to have a true choice between nursing home and community-based care, the Pennsylvania Medicaid program realized that people who stay in the community need to have assets available that can be used for the upkeep of their homes. Because medicaid rules require the States to apply eligibility determination uniformly across all applicants, Pennsylvania's asset disregard expands the asset limits for all LTC recipients regardless of whether the pindividual enters a nursing facility or remains in the community.

Table 3. Characteristics of the Medicaid eligibility determination process by state (2004 values)

	Maryland	Nebraska	Missouri	Pennsylvania	Arizona
Uses 1902(r)(2)	Yes	Yes	Yes	Yes	Yes
Follows 209(b)	No	No	Yes	No	No
Asset limit (single individual)	$2,500	$4,000	$999.99	$8,000 ($2,000 with a $6,000 asset disregard)	$2,000
Community spouse asset allowance	$18,552 (min) $92,760 (max)	$18,552 (min) $92,760 (max)	$18,552 (min) $92,760 (max)	$18,552 (min) $92,760 (max)	$18,552 (min) $92,760 (max)
CS minimum monthly maintenance needs allowance	$1,692 with a cap of $2,319	$1,692 with a cap of $2,319	$1,692 with a cap of $2,319	$1,692 with a cap of $2,319	$1,692 with a cap of $2,319
Income first vs. resource-first	Income-first	Resource first	Resource first	Resource first	Income-first
Avg. monthly cost of a nursing home stay	$4,300	$4,000, but a facility specific amount is used to calculate the penalty period.	$2,685	$5,787	$4,028 (urban) $3,744 (rural) Both Maricopa and Pima counties are considered urban.

Another special provision of the law allows States to use more stringent requirements for Medicaid eligibility than are used for SSI eligibility. States that use this authority to make eligibility requirements more restrictive are called 209(b) States. Of our five

States, only one —Missouri—is a 209(b) State. Using 209(b) authority, it has set its asset limit at $999.99.

We don't show income limits in table 2. In all states (with the exception of Arizona), there is essentially no set income limit for individuals applying for long-term care services. They simply must have a monthly income that is less than the cost of their nursing home care. Arizona is an "income-cap" state. People in need of nursing home care face an income limit currently set at $1,737 a month. Persons with an income above this limit can still be eligible, however, if they establish an approved Qualified Income Trust (or "Miller Trust") and assign to it income they receive in excess of the cap amount. There are established asset limits, however, and these vary by State from a low of $999.99 in Missouri to a high of $8,000 in Pennsylvania. In all States, a married applicant faces the same asset limit as does a single individual.

Community spouse requirements are the same across all five States, all of which follow the minimum the Federal spousal impoverishment rules require. When a married individual applies for Medicaid benefits, the couple's assets are divided into countable and non-countable assets. Countable assets are divided between the community spouse and the institutionalized spouse. The Community Spouse Resource Allowance is the share of the couple's assets that the community spouse is allowed to keep. It equals one-half of all countable assets subject to a minimum and maximum. In our five States, the minimum is currently $18,552 and the maximum is $92,760. If countable assets are less than $18,552, all assets are protected for the community spouse. For countable assets between $18,552 and $37,104, the community spouse keeps the minimum of $18,552. For countable assets between $37,104 and $185,520, the community spouse keeps half of the couple's countable assets. Above $185,520, the community spouse keeps the maximum of $92,760. The countable assets assigned to the institutionalized spouse must be spent down to the asset limit before the institutionalized spouse will be eligible for Medicaid. Although our study States all have the same Community Spouse Asset Allowance requirements, other States have more liberal rules that set the minimum equal to the maximum of $92,760. In these States, community spouses keep all countable assets up to $92,760.

The Community Spouse Minimum Monthly Maintenance Needs Allowance is also set at the same level in all five states in this study. During 2004, the allowance was $1,562 per month with a cap of $2,319 per month. If a community spouse has a monthly income that is less than $1,562, income that is in the name of the institutionalized spouse can be assigned to the community spouse to ensure a minimum needs allowance of $1,562. If special circumstances exist, such as high housing costs, this monthly maintenance needs allowance can be raised to as much as $2,319. A community spouse or the institutionalized spouse can request a hearing to increase the amount of income that the community spouse is entitled to keep. States differ in the aggressiveness with which they oppose these requests. Maryland has a reputation for challenging all requests for increases in the monthly income allowance, which has discouraged couples from even requesting hearings. Elder law attorneys in that State see the purchase of an annuity as the only way to get more money for their client's community spouse, possibly encouraging the purchase of "Medicaid" annuities. Other States apparently do little to challenge requests for increases in a community spouse's monthly income allowance. In Missouri, eligibility workers suggested that when couples ask for a hearing, "99.9 percent of the time they get what they are asking for."

The community spouse is entitled to receive income from the institutional spouse to bring him or her up to the minimum monthly maintenance needs allowance. The source of this income is an important issue for the community spouse. States differ on how they address this issue; some States are "income-first" States and others are "resource-first" States. Income-first States require that the income needed to bring a community spouse up to the minimum monthly allowance comes first from the income of the institutionalized spouse. (Maryland is the only income-first State among those participating in this study.) The problem for the community spouse is that when the institutionalized spouse passes away this income stream ends; leaving the community spouse with less income than the minimum allows. Resource-first States allow the income needed to bring a community spouse up to the minimum monthly allowance to be generated through the purchase of an income producing asset (such as an annuity) using the resources assigned to the institutionalized spouse. These resources are then not subject to spend

down, and an income producing asset is purchased that will be available to the community spouse even after the institutionalized spouse has passed away.

In some resource-first states, Medicaid eligibility staff will actually calculate the dollar amount of resources that have to be liquidated by the couple and used to purchase an annuity in order for the community spouse to meet his or her monthly income allowance. Given the low interest rates that are currently being paid on most types of investments today, substantial resources may be transferred from the institutionalized spouse to the community spouse to attain the minimum monthly income allowance in resource-first States. One interviewee pointed out that Missouri requires that invested resources have a rate of return that is as high (or higher) as that received on six-month Treasury notes, which is currently only about one percent. The interviewee noted "You could invest a half a million dollars at that rate and not meet the monthly maintenance allowance for the community spouse."

Finally, table 3 also shows the average monthly cost of a nursing home stay in each State. This is the dollar amount the States use when calculating the penalty period associated with transfers of assets for less than fair market value. The monthly cost of a nursing home stay varied from a low of $2,685 in Missouri to a high of $5,787 in Pennsylvania. We should note, however, that some states—Arizona would be included in this group—pay a capitated rate under Medicaid for nursing home stays (or for home healthcare episodes as well), which is considerably lower than the private pay rate shown in the table.

We asked one additional question about state programs, which is not shown on the table, about whether annuity remainder amounts were subject to estate recovery. In all States included in this study, remainder amounts can be recovered only if the remainder beneficiary is the annuitant's estate. If an individual is listed as the remainder beneficiary (which is almost always the case), the remainder amount is not part of the probate estate and is not recoverable.

County Medicaid eligibility workers

State Medicaid officials helped us select two counties in each State (three in Missouri) for on-site data collection. In general, State officials did not believe we would find large numbers of annuity cases. Therefore, it was mutually agreed that we should visit more prosperous counties with large populations in order to increase the likelihood of finding annuity cases during our brief (generally about two days) visits to each county Medicaid office. Table 4 lists the counties visited for data collection and presents data on population and median income per capita. While a small number of counties were visited, these counties accounted for 12.7 percent of the population in Pennsylvania, 26.8 percent of the population in Missouri, 30.7 percent of the population in Maryland, 41.7 percent of the population in Nebraska, and 76.3 percent of the population in Arizona. Median income per capita was almost always higher in the counties we visited than in the State as a whole.

Before the on-site data collection, we conducted telephone conference calls with eligibility workers and their supervisors in each county. Between two and five workers participated in each telephone call. Overall we spoke with a total of 40 county eligibility workers.

Marketing annuities

In our interviews with consumers and industry representatives, we discussed various issues involving the marketing of annuities to senior citizens. In the qualified (pension plan) market, annuities are sold as part of retirement savings programs. This is not true of non-qualified annuities. Medicaid-friendly annuities are usually marketed directly to the elderly. They are marketed through several mediums; the most prominent being through seminars. One of our interviewees noted that companies selling annuities through seminars appear to be "coming out of the word work" in her State. They hold seminars at local senior centers and libraries. Seniors are invited to these seminars by mail or in newspaper advertisements. The invitations say the seminars are open to those 55 and older, but our interviewee called one of these companies saying she would like to attend on behalf of her parents and she was allowed to attend.

Table 4. Characteristics of counties selected for data collection (Population, 2000)

	Number	Percent of state population	Median income per capita, 1998
Maryland			
Montgomery County	873,341	16.5%	$42,393
Baltimore County	754,292	14.2%	$32,269
Statewide	5,296,486	100%	$30,557
Nebraska			
Lancaster County	250,291	14.6%	$27,487
Douglas County	463,585	27.1%	$32,671
Statewide	1,711,263	100%	$25,924
Missouri			
Jefferson County	198,099	3.5%	$20,843
St. Charles County	283,883	5.1%	$26,570
St. Louis County	1,016,315	18.2%	$36,800
Statewide	5,595,211	100%	$25,150
Pennsylvania			
Allegheny County	1,281,666	10.4%	$31,665
Erie County	280,843	2.3%	$23,622
Statewide	12,281,054	100%	$27,469
Arizona			
Maricopa County	3,072,149	59.9%	$27,254
Pima County	843,746	16.4%	$27,723
Statewide	5,130,632	100.0%	$24,206

Source: County and City Data Book, 2000.

In describing the seminar, our interviewee noted that the presenter "was really pushing annuities." The presenter initially talked about different ways to finance long-term care, touching briefly on long-term care insurance, but stated that it often doesn't address the needs of the elderly and suggested that purchasing an annuity is a better option. Annuities were presented pretty much as the single solution to all problems. The presenter talked about how annuities can help the elderly protect their assets from "being taken" by the State should nursing home care be needed. The presenter painted a dismal picture of the Medicare and Medicaid programs.

Our interviewee went to this seminar hoping to learn how accurately the seminar presented the State Medicaid eligibility rules, particularly with regard to annuity use. She found the presenter was "somewhat accurate." The presenter wasn't from her State, but was hired and trained by a company to go state-to-state selling annuities through seminars. After the seminar, our interviewee contacted the State's insurance bureau to file a complaint about the company's marketing practices.

Companies that sell annuities to the elderly also often advertise in newspapers. These advertisements generally say the following:

- Seniors need to plan for their future;
- Seniors need help to protect their home and assets from being taken by the State;
- The company can show seniors ways to avoid losing their assets when applying for Medicaid and,
- They can show seniors how to avoid probate.

The advertisements provide an 800-telephone number and, in small print, list the name of the company. This 800-number usually goes to a line that takes reservations for seminars.

Those we interviewed about the marketing of annuities noted that this marketing technique could be abusive, especially when annuities are being sold by someone who doesn't know Medicaid rules. Some annuities can be counterproductive as far as Medicaid is concerned. Several of our interviewees noted that there is a greater need for consumer protection. From a conventional consumer protection standpoint, there clearly are problems of abusive practices, e.g., where buyers are urged to purchase a Medicaid annuity without regard to the timing and use of the annuity. For instance, an annuity that would help a community spouse in one case would waste money (so far as the consumer is concerned) in another. Individuals are often encouraged to buy an annuity as a means of ensuring eligibility for Medicaid before the need for nursing home care is certain. But, purchasing an annuity locks up assets and most financial planners would recommend that the elderly not take that step until it is certain that nursing home care is needed (i.e., after the individual actually enters the nursing home). Also, in many situations, every penny of the annuity income stream goes to pay for nursing home care, and the seller gets a commission. One interviewee noted that Medicaid annuities should only be sold in the context of an intelligent Medicaid eligibility plan, and that the representation that an annuity is a 'Medicaid' annuity should be prohibited.

California appears to have had severe problems with the sale of annuities to the elderly. We interviewed a representative from an

organization that provides financial planning help to the elderly with low and moderate incomes who face significant healthcare costs. This interviewee noted that there are annuities acceptable to the MediCal program. These are immediate annuities, which generally don't pay much in terms of commission. As a consequence, salesmen do not push these hard. Instead, salesmen try to sell the elderly deferred annuities, which have much bigger commissions, but do not meet MediCal rules for an acceptable annuity.

When the elderly are sold a deferred annuity, they generally can get their money back, so it is not a transfer of assets and no penalty period is imposed. The deferred annuity is treated as a countable resource. The problem for the elderly is the surrender charges. Surrender charges can last for seven to nine years and start as high as 13 percent. For instance, if you want to get your money back in the first year after purchasing an annuity, the insurance company will take a 13 percent penalty from your investment. If you want to get your money back in the second year, it will take an 11 percent penalty from your investment and so on and so forth. You will have to keep the annuity for seven (or nine) years, before you can get your money back without paying any penalty.

California has recently passed a law regarding annuity sales, which our interviewee suggested is a step in the right direction. Among the requirements of the new law are the following:

- Before an insurance agent visits a senior's home to sell an annuity or life insurance, the agent must provide written notice in 14-point type that states the purpose of the visit, lists the names of anyone accompanying the sales person and his/her insurance license information, advise seniors that they may invite others (such as family members or attorneys) to attend the meeting, and let seniors know that they are free to end the meeting at any time.
- Salespeople are prohibited from using inaccurate presentations to persuade seniors to purchase replacement polices. (Agents often receive commissions for selling a replacement policy or annuity: replacement policies often start a new several-year period when the policy or annuity cannot be surrendered without penalty.)

- An annuity sale to a senior that is supposed to help the senior qualify for Medi-Cal assistance is prohibited, if the senior's purpose in purchasing the annuity is to affect Medi-Cal eligibility and:
  - — The senior's assets are equal to or less than the Medi-Cal community spouse resource allowance or
  - — The senior would otherwise qualify for Medi-Cal, or
  - — After the purchase of the annuity, the senior or the senior's spouse would not qualify for Medi-Cal.
- If a senior purchases an annuity in order to qualify for Medi-Cal, and the senior or the senior's spouse still does not qualify after purchase, then the senior may cancel the annuity and receive a refund.[1]

An additional consumer protection issue for the elderly is the financial soundness of the insurance company that is selling the annuity. Purchasers of an annuity are putting their money at risk. If the insurance company becomes insolvent, the elderly could lose their investment.

Having said that the marketing and sale of annuities to the elderly can be abusive, our interviewees also pointed out that an immediate annuity can sometimes make sense for the elderly, particularly when they are not confident that they know how to invest and manage their retirement savings. Sometimes the elderly just need some certainty, and in those cases an immediate annuity might make sense. When the issue is qualifying for Medicaid, annuities are best purchased only after a spouse has been admitted to a nursing home. Because immediate annuities lock up funds at a fixed rate, they may not be a good way for the elderly to achieve their financial planning goals. However, when individuals are in tight situations and need help getting Medicaid benefits for a spouse, annuities may be the most attractive choice.

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[1] This information on the contents of the California law can be found at the website:

http://www.help4srs.org/consumer/annuityprotection.htm .

Treatment of annuities in the Medicaid eligibility determination process

All States included in this study have written polices regarding how annuities are to be handled in the Medicaid eligibility determination process. These written policies are usually contained in the State's administrative manual for eligibility workers. We were able to find written policy statements on-line in three of the five states that participated in our study. These policy statements come from either the State's policy manual, or in Arizona's case, from State statute. We present these materials in appendix B.

Table 5 presents a description of each State's policies related to the review of annuities during the Medicaid eligibility determination process.[2] All five States in this study use the SSI life expectancy tables (following CMS guidance) to determine if the length of the annuity contract period is in line with Federal regulations that state that annuities must be actuarially sound. Maryland and Nebraska both suggested that they would like to use something other than the SSI tables, but have not been able to implement this change. Pennsylvania has argued in administrative hearings that something (for instance, a terminal illness) makes use of the SSI life expectancy tables inappropriate.

Availability of the annuity is used as a criterion for whether the annuity does or does not qualify as a countable asset in all States. Annuities must be irrevocable. If an annuity has not been annuitized (i.e., the annuity income stream has not started), the annuity is considered revocable and is treated as a countable asset. Although balloon payment annuities are generally seen as an abuse, not all States have prohibited their use. Maryland continues to accept balloon payment annuities. Missouri apparently has no specific policy against balloon annuities. Interviewees

[2] We note here that the information in the table comes from our interviews with state Medicaid officials. County caseworkers were also asked these same questions about the treatment of annuities in the eligibility determination process. In a few instances, the responses of county eligibility workers were inconsistent with those provided by state officials.

noted that they have not seen this type of annuity often in Missouri and said they believed that balloon payment annuities would not be allowed if they occurred.

Table 5. State policies for defining acceptable Medicaid annuities

Does the State have a policy for:	Arizona	Maryland	Missouri	Nebraska	Pennsylvania
How is contract period of annuity (i.e., life expectancy) determined?	SSI tables	SSI tables	SSI tables	SSI tables	SSI tables
Must annuity be irrevocable?	Yes	Yes	Yes	Yes	Yes
Are balloon payments allowed?	No	Yes	No	No	No
Who is allowed to receive the income stream from annuity?	Annuitant or his/her spouse	Annuitant or his/her spouse	Annuitant or his/her spouse	Annuitant or his/her spouse	Annuitant, his/her spouse, or for benefit of disabled child
Policy stating who can be listed as the annuitant's remainder beneficiary?	None	None	None	Generally, this is spouse or their estate and remainder amount must go into probate.	None
When payments from annuity must begin?	Immediately	Immediately	Immediately	Immediately	Looks at who annuitant is. If annuitant is institutionaized spouse, they will challenge deferred annuity. If community spouse is annuitant, it may impact spousal impoverishment calculations.
From whom the annuity can be purchased?	Commercial company	Insurance company only	No restrictions	No restrictions	A private annuity may be acceptable if it is held "in trust."

The annuitant, his or her spouse, and (in Pennsylvania, a disabled child) are the only persons who can receive the income stream from an annuity purchased in order to qualify for Medicaid. Note that if the annuitant is a single individual, the income stream produced by the annuity will go directly to the nursing home. In most States, anyone can be listed as the annuitant's remainder beneficiary. The exception was in Nebraska, which stated that the remainder beneficiary is generally the spouse or

the annuitant's estate. Nebraska officials also said that remainder amounts must be referred to probate. This is important because assets in probate are subject to estate recovery.

All five States require that payments associated with a Medicaid annuity begin immediately (within one or two months of the purchase of the annuity). Three of the five have no restrictions on where an annuity can be purchased. This allows for the purchase of private annuities, generally from family members. Maryland and Arizona require that annuities be purchased from a commercial insurance company.

When asked if the States have changed policies regarding annuities in recent years, both Maryland and Nebraska Medicaid officials answered that they have wanted to change their program's treatment of annuities, but were stymied either by the State legislature (Maryland) or by the State's current administration (Nebraska). Pennsylvania has made one recent change in policy. In April 2002, as a result of a court decision (Mertz v. DPW, see below), Pennsylvania decided to require that all annuities be forwarded to the Office of Legal Counsel for review unless the potential penalty period associated with the annuity has already expired. Arizona passed legislation in 1999 that changed the state statute regarding the treatment of annuities in the ALTCS eligibility determination process. (See Appendix B for a copy of the revised statute.)

At the county level, the review of an annuity typically works as follows. First, the caseworker must determine if the annuity is revocable or irrevocable. If it is not clear based on the contract, he or she will contact the issuer to determine this. In most cases, the caseworker will obtain a copy of the annuity contract for the case file. In Arizona, the issuer is asked to complete an Annuity Verification form. If the annuity is revocable, then the applicant can access the principal and the annuity is treated as a countable resource. If it is irrevocable, then they must determine whether the purchaser is getting a full return on their investment. If they are getting a full return, the annuity is not a transfer of assets for less than fair market value and is acceptable for helping the applicant qualify for Medicaid. If the purchaser is not getting a full return, the annuity is treated as a transfer of assets subject to a penalty period of ineligibility. Determination of a fair/full re-

turn is based on the length of the annuity contract compared to the life expectancy of the annuitant as listed in the SSI tables.

As noted above, in Pennsylvania, all annuities must be sent to the Office of Legal Counsel for review. In other states, caseworkers make their own decisions about whether to forward annuity contracts to the State office for review. In Maryland, the county workers noted that most annuities are reviewed, and most decisions are made, by caseworkers, although they do have the option of sending complicated annuities to the State for review. Missouri caseworkers stated that they send annuities to the State for review if needed information is not in the annuity contract. State officials in Nebraska said all contracts (both annuities and trusts) are to be sent to the central office for review. But one Nebraska county noted doing reviews themselves, whereas the second said it sends all annuities to the State for review because county staff feel that annuity contracts are simply too variable for them to make consistent decisions about the acceptability of annuities. This varied among local offices in Arizona as well, with some offices doing their own reviews and other offices sending annuity contracts to the State office for review.

Perceptions of annuity use

We asked all those we interviewed about their perceptions of annuity use—how often annuities are used by Medicaid applicants seeking to avoid asset spend down, whether annuity use is growing or declining, and what types of Medicaid applicants are most likely to purchase a Medicaid annuity. Neither of our consumer representatives seemed to believe that Medicaid annuities were used often or that they constituted much of a problem for State Medicaid programs. Both organizations have been asked by clients or their children about the purchasing of annuities to qualify for Medicaid, but in general these organizations work with low to moderate-income individuals who are not financially sophisticated, so this has not been a big issue for their clientele. Both consumer representatives, however, talked at length about the marketing of annuities to the elderly and the consumer protections needed to ensure that the elderly are not mislead into buying annuities that are inappropriate for them. They have

seen tremendous increases in this marketing, which uses avoidance of Medicaid spend down as a selling point. It seems likely that this will result in greater use of annuities by those applying for long-term care benefits from Medicaid.

Our industry representative interviewees also were unable to speak to the question of whether the market for Medicaid annuities was growing or declining. The elder law attorney we spoke with told us that the number of older persons buying annuities in his practice over the past four or five years has remained relatively stable. He specializes in maximizing income and resources for community spouses, so the elderly in his practice who purchase annuities usually do so with Medicaid eligibility in mind.

Comments about the current status of retirement savings for the baby-boom generation from our other industry interviewee suggest that we may see an upsurge of Medicaid annuity purchases in the not-too-distant future. This interviewee noted that the baby-boom generation is the first to save for retirement through vehicles like 401k plans. (The 401k program is only about 20 years old. Previously, most retirement was funded through employer pension plans.) People who have 401k accounts have access to substantial savings at retirement. Once they retire, they must have a plan for dispersing those savings. Tens of millions of American workers participate in 401k plans, but only 20 percent of these plans include annuity options. Most have no pay out design at all. When these individuals reach retirement, they will be on their own to make decisions about what to do with their money. Our interviewee sees this as a real national problem because most people are ill-equipped to manage such a sizable amount of money on their own. The implication for the Medicaid program is that as the baby-boom generation retires there will be a large number of people with access to significant funds. Much of these funds will be countable assets, which they can use to purchase a Medicaid annuity should the need for nursing home care arise.

Clearly, the States that have agreed to participate in this study believe that annuity use is now or will in the not too distant future, become a problem for the Medicaid program. State officials in Nebraska report that there are not many current cases,

but they believe that it will become a significant problem. They note that trusts were used excessively. Now because trusts have been restricted, they believe that applicants will turn to annuities and to the incorporation of assets, such a family farm or business. The most recent cases they have seen in Nebraska are spousal impoverishment cases. After a spouse has entered the nursing home, the couple looks for a way to spend down quickly. Of cases seen recently, annuity amounts are typically between $40,000 and $100,000.

State Medicaid officials in Pennsylvania say that they currently only occasionally sees annuities that are used to shelter assets. As we noted above, Pennsylvania has been aggressive in trying to challenge those who would use annuities as an asset sheltering device. As a result of the State's aggressiveness on this issue, elder law attorneys will often not recommend annuities to their clients, or will have their clients sign a release stating that the annuity may be challenged by the State. The State's position has also made annuities unattractive for those with less than substantial assets. State officials believe that the annuities seen by the program are typically for $100,000 or more. They recently saw one for $500,000, but that application was withdrawn. State staffs feel that elder law attorneys are waiting for the State to change their rules before pressing forward with more use of annuities. Annuity use is seen in both couples and single individuals, but the amount of available resources has to be substantial – typically about $120,000 to $150,000. The applicants have to be sophisticated enough to seek financial planning help.

State staff in Missouri didn't feel that annuities are used very often. However, they did note that annuity use might be largely invisible to them since the local offices make almost all decisions on the acceptability of annuities. One likely reason few annuities are passed on for review at the state level is that the elderly use elder law attorneys when purchasing annuities and these attorneys make sure that the annuities meet all the necessary requirements for approval. State staff noted that Missouri has a strong presence of elder law attorneys who like to tell people that Medicaid is no longer just for the poor. Elder law attorneys have been very active in the St. Louis area for several years and they are now seeing much more of them in Central Missouri as well. The most active elder law attorneys advertise on television

and one law firm has hired a former colleague of theirs. Most applicants with annuities in Missouri will either be a single individual with high assets or a married person whose community spouse has a high income. Based on the average age of the nursing home population in the state, they suggest the applicant will be in his/her mid-70's and will be in the nursing home until he/she dies.

In Maryland, the State officials interviewed said they have no sense of how often the purchase of annuities allows an individual to qualify for Medicaid while avoiding asset spend down. However, the bad press and unfairness associated with the individual cases that are publicized have helped to encourage the perception that annuity use is a problem in the State. The interviewees felt that most cases were single individuals. The annuity allows a larger portion of the person's assets to go to heirs. The average length of stay in the nursing home is two and one-half years, which is generally less than the life expectancy of the annuitant based on the SSI tables. While the annuitant remains in the nursing home, the annuity's income stream is used to offset Medicaid payments for care, but a single annuitant will generally have more left over for heirs if they purchase an annuity than if they did not. Unlike in other States, Maryland state officials felt that spouses represent a minimal number of annuity cases. The interviewees thought that, in general, individuals purchase annuities worth between $100,000 and $300,000. They felt purchasing annuities for less would probably not be worth it and if more money is available, it is more likely that the elderly will pay for their own care. Estate planners know when it is to their client's benefit to recommend a Medicaid annuity.

Arizona was able to provide some actual data on the number of active nursing home cases with annuities. They requested an ad hoc report from their computer system for us. It provides current point-in-time numbers for those LTC recipients who receive annuity payments. For single individuals, the data showed 331 LTC recipients with an annuity. The monthly income received from the annuity was on average $380.99, with a minimum of $8.93 and a maximum of $5,000. No data is available on the purchase price of these annuities. For community spouse cases (where the community spouse is the annuitant and is receiving income), the data showed that there are 136 cases with an annu-

ity. The monthly income received from the annuity is on average $2,120.57, with a minimum of $3.90 and a maximum of $16,660.83. In our on-site review of case files in Arizona, we discovered that not all of these cases represented actual "Medicaid" annuities. This was particularly true for single individual cases in which the annuities were often purchased several years prior to the start of the look-back period as part of a retirement package. This was less true for the community spouse cases. This was the first time Arizona had queried their system for these data. When asked if it thought that the problem of annuity use was increasing, it answered that annuity use has been fairly popular in Arizona and that it has stayed constant over recent years.

We asked county caseworkers about there perceptions of annuity use as well, which we present in table 6. In general, their responses mirror that of State officials in that counties in Maryland and Missouri appear to be seeing more annuities than those in Nebraska and Pennsylvania. Regarding the typical dollar amount of Medicaid annuities, State officials have suggested that annuities are only attractive to people who have enough assets to make the purchase of an annuity 'worth it' but whose assets are not so large that they will be readily able to pay for their own care. The discussions with caseworkers suggest this analysis may not be true. People are purchasing Medicaid annuities with as little as $20,000 and our own review of case files have uncovered annuities worth as much as $850,000. The likelihood of someone making an annuity purchase may have less to do with the amount of countable resources available to pay for care, than with whether the applicant has consulted an attorney and with his/her own sense of entitlement.

In general, when applicants do purchase annuities, these annuities are hardly ever found to be an inappropriate transfer of assets. This is particularly true when applicants have purchased the annuity on the advice of elder law attorneys. These attorneys are aware of the rules and know how to set annuities up correctly. And if the annuity is set up inappropriately, for instance if the payment period does not match the annuitant's life expectancy, then the applicant can just work with the insurance company to fix what is wrong with the annuity to make it acceptable. Sometimes annuities are used when an applicant has an inappropriate trust and money is then moved from the trust into an annuity to

try to fix things. If an annuity is found to be a transfer of assets, it is almost always the case that the associated penalty period has expired by the time the individuals applied for Medicaid.

Table 6. Caseworker perceptions of the incidence of annuity use and the size of annuities

State/county	Percent of applicants who have purchased annuities	Typical dollar amount of Medicaid annuities
Maryland		
Montgomery County	In a caseload of about 2,000 LTC recipients, 5% have Medicaid annuities	$150,000
Baltimore County	75% of cases where there is a community spouse	Range from $10,000 to $250,000 with 90% of them for $50,000 or more
Nebraska		
Lancaster County	5% to 10% of LTC cases	$10,000 to $20,000,although they recently had one case that had a $60,000 annuity
Douglas County	Less than 1%	$50,000
Missouri		
Jefferson County	Less than 1%	Most cases are over $50,000
St. Charles County	15% to 20%	$50,000 to $100,000
St. Louis cCounty	5% of current applicants (100% of those who hire attorneys)	$20,000 to $80,000, although they have cases with annuities of $500,000
Pennsylvania		
Allegheny County	1%	Caseworkers were unable to suggest a typical amount
Erie County	Have seen few annuities. One caseworker noted in 21 years of service, she has seen maybe 10 to 20 annuities.	$20,000 to $40,000
Arizona		
Maricopa County Glendale office Mesa office Phoenix South office	 1% to 2% Suggested no specific percentage 5% to 8%	 $60,000 to $100,000 $40,000 $100,000
Pima County	Approximately 1%	$25,000

In describing the typical applicant who has purchased a Medicaid annuity, caseworkers generally agree that these individuals and/or couples are financially savvy and often have the assistance of a financial planner or attorney. Some caseworkers pointed to affluent couples as those most likely to purchase an annuity, but others find that single applicants with significant resources are the most typical. All are likely to have educated children. In the case of a single applicant, the applicant may sell his or her home and purchase an annuity with the proceeds,

thereby avoiding the possibility of the home being subject to estate recovery.

Finally, those who use annuities are also likely to have done other things to avoid spending their assets on nursing home care. Among these are:

- Establishing joint ownership of assets
- Giving money to a disabled child
- Purchasing a new car
- Paying for home repairs
- Systematic disposals following what is known as 'the rule of halves'
  - A Medicaid applicant can gift approximately one-half of his or her estate, which will result in a penalty period during which time the retained assets will cover the cost of his or her care
- Other types of gifting plans, including monthly gifting based on the average cost of nursing home care
- This works as follows. For example, in Missouri, the average monthly cost of nursing home care is about $2,700. For each month that a person pays for nursing home care, he/she can give a gift equal to $3,780. This amount is 1.4 times greater than $2,700. The 1.4 will be rounded down to 1 and only one month penalty will be imposed, which is equal to the month already paid for out of private funds. This must be done on a month-by-month basis, instead of all at once, or the "rounding" advantage will not work. That is, if he/she made a gift of $45,360 ($3,780 x 12) at one time, the amount of the penalty would be 17 months instead of 12 months. Monthly gifts allow for a greater share of a Medicaid recipient's money to be transferred with a minimum penalty period. Giving monthly gifts also has the advantage of ensuring you won't give away money that will be needed for care during a penalty period.

State administrative issues

We talked to State Medicaid officials about several State administrative issues related to annuity use, including the availability of state-level data on the number of Medicaid applicants who have purchased annuities, whether the State has conducted any analysis of annuity-related issues, whether the State acknowledges the use of annuities in budget forecasts, and whether the State has been involved in any legal cases related to use of annuities to qualify for Medicaid.

Four of the five states that we interviewed noted that they collect no State-level data on the number of Medicaid applicants who have purchased annuities in order to avoid asset spend down. As noted above, Arizona's data system allows the Medicaid office to identify cases in which the recipient receives an annuity payment. However, the system does not distinguish between annuity payments from retirement accounts or pensions and those from SPIAs purchased to avoid asset spend down. In all States, local Medicaid office case records do include copies of annuity contracts and State officials noted these case files would be able to provide the data we needed for our study.[3] States also do not acknowledge the use of annuities when forecasting estimates of Medicaid eligibles or during the budgeting process. Pennsylvania noted that they completed the American Public Human Services Association survey on the role of annuities in Medicaid financial planning. Assuming that 10 percent of private pay long-term care residents are married with a spouse in the community, then Pennsylvania would have about 2,300 potential Medicaid recipients who are likely to use an annuity to shelter assets if allowed. Officials then estimated for that survey that the federal/state cost of allowing couples to shelter excess resources in annuities in Pennsylvania would equal about $105 million.

[3] States have not conducted any analyses of annuity-related issues themselves, but are interested in knowing how often annuities are being used to qualify for Medicaid in their States. This is one reason why they agreed to participate in this study.

Of the five States interviewed, only Pennsylvania has been involved in legal cases related to the use of annuities to qualify for Medicaid. Maryland, Missouri, and Nebraska have policies that are essentially friendly to annuities. Their current policies generally follow the Federal regulations and these States have not felt comfortable pursuing more restrictive policies when opponents can use the Federal rules to argue against the State in court. Missouri noted, however, that if legislation related to the process for determining Medicaid eligibility for nursing home care that is currently being considered by the State legislature is passed, the State could face a legal challenge. In Maryland, the Department of Health and Mental Hygiene has wanted to make policy changes that would implement restrictions on annuities, but they have so far been unable to make any such changes, as the State legislature will not allow restrictions that are not supported by Federal policy. Arizona has faced no legal challenges to the current State statute regarding annuities. Prior to passing this statute, State personnel sat down with elder law attorneys to discuss the proposed statute. The elder law attorneys didn't like the statute, but agreed that the State had the authority to make the proposed changes.

Pennsylvania noted that it has been involved in three court cases related to annuity use (Note that much of the descriptions below comes directly from the court decisions.):

1. **Bird v. the Department of Public Welfare (DPW)**. In this 1999 case, an applicant petitioned the Court to review a denial of Medicaid benefits. In order to qualify for Medicaid, Mrs. Bird (the institutionalized spouse) assigned her right, title, and interest in seven certificates of deposit to Mr. Bird, who then purchased a private annuity from an irrevocable trust that had been created by their two daughters. The annuity was purchased for $143,400 and would, over a period of six years, reap a return of $144,000. The Court agreed with DPW that the purchase of the annuity was for less than fair consideration, was made with the intent to qualify Mrs. Bird for Medicaid, and was contrary to the provisions and intent of the Medicare Catastrophic Coverage Act. DPW's decision to deny Medicaid benefits to Mrs. Bird was upheld.

2. **Dempsey v. DPW**. This 2000 case also involved an applicant who petitioned the Court to review a denial of Medicaid benefits. At the time of Mrs. Dempsey's admission to a nursing home,

the couple's resource assessment showed $404,630 of countable resources. One year later, Mr. Dempsey transferred $340,000 of these assets to purchase a single premium, irrevocable annuity that would pay him income of $6,300 per month for five years. Two months later, Mr. Dempsey bought a second, similar annuity for $25,000 that would pay him an income of $730 a month for five years. Three months later, Mrs. Dempsey applied for Medicaid to pay her nursing home costs. The County Assistance Office denied the Dempsey application and determined that Mrs. Dempsey would be ineligible for Medicaid for almost six years as a result of what the CAO presumed was a transfer of $365,000 of countable assets for less than fair market consideration and for the impermissible purpose of qualifying for Medicaid.

In their appeal, the Dempsey's argued that DPW erred by presuming that the transfer of their assets to the annuities was a disqualifying event when the annuities were actuarially sound in accordance with relevant federal guidelines. The court, however, determined that the "actuarial soundness" of an annuity in accordance with life expectancy tables does not render a transfer of assets to such an annuity a matter beyond the review of DPW in its determination of whether a Medicaid applicant for nursing home care should be granted or denied. The court stated that the Dempseys were simply relying on the fact that the annuities appear to be actuarially sound in accordance with federal guidelines. A federal guideline, however, cannot overturn the provisions of a federal statute. The court determined that the provisions of the Medicare Catastrophic Coverage Act establishing the community spouse resource allowance take precedence and affirmed the DPW decision.

3. **Mertz v. DPW**. This 2001 case was decided in federal court. An administrative hearing upheld DPW's decision to deny Medicaid benefits to Mrs. Mertz, who was in a nursing home, and she filed for a temporary restraining order in federal court. She asked that the court declare DPW's decision that she was ineligible for Medicaid because of her husband's purchase of annuities with joint assets to be "illegal, null and void." In this case, DPW made an express finding of fact that the annuities were purchased for fair market value, but DPW concluded that it could nevertheless penalize Mrs. Mertz upon a determination

that the purchase of the annuities reflected a transfer of assets for the purpose of qualifying for Medicaid assistance.

The court, however, found that federal law provides for a period of ineligibility predicated upon a transfer of assets during the look back period only for transfers made for less than fair market value and even then subject to certain exceptions. The court stated that a couple may effectively convert countable resources into income of the community spouse which is not countable in determining Medicaid eligibility for the institutionalized spouse by purchasing an irrevocable actuarially sound commercial annuity for the sole benefit of the community spouse. The court further noted that this is a loophole apparently discerned by lawyers and exploited by issuers who advertise such annuities as a means to qualify for Medicaid benefits. While acknowledging that the practice is inconsistent with an apparent purpose of the Medicare Catastrophic Coverage Act and the whole thrust of the Medicaid program, the court noted that it was not the role of the court to compensate for an apparent legislative oversight by effectively rewriting a law. The court concluded that it is for Congress to determine if and how this loophole should be closed.

These three cases indicate that Pennsylvania has been successful in opposing annuities in State court, but not in Federal court. Pennsylvania's Medicaid legal staff noted that the State cannot supercede federal law. There are two sections in the U.S. code that are of particular relevance to the annuities issue: Section 1396(p)—Liens, adjustments and recoveries, and transfers of assets, and Section 1396(r)(5)—Treatment of income and resources for certain institutionalized spouses. The federal law related to spousal impoverishment says couples can transfer assets to a community spouse, but the community spouse can keep only a certain amount. However, if you take all the assets and create an income stream for the community spouse, as long as the annuity is actuarially sound, the community spouse can receive an extraordinary income stream while making the institutionalized spouse eligible for Medicaid. This can essentially allow anyone with a spouse to qualify for Medicaid. Pennsylvania has vigorously opposed annuities. As a result, the elder law bar is reluctant to support/recommend using Medicaid annuities to

qualify for long-term care. It has taken a wait and see attitude with regard to annuity use.

State Medicaid officials worry that if Federal law is not changed, it is only a matter of time before the floodgates are opened on annuity use in Pennsylvania. They believe the number of annuities seen by the Pennsylvania Medicaid program will increase "exponentially" if CMS makes no changes. Elder law attorneys are "chomping at the bit" to recommend annuities to their clients. Pennsylvania has been able to keep its finger in the dike, primarily because of the active intervention of their legal counsel. However, it increasingly sees attorneys coming in with applicants and trying to push the envelope on this issue. The Medicaid program's legal counsel has talked to CMS about this issue, and believes that CMS thinks its hands are tied since the treatment of annuities is based on federal law. DPW's legal counsel, however, believes there is room within federal law to interpret the use of annuities to be constrained by the spousal impoverishment law.

Finally, we note an interesting case that was recently decided in Baltimore County, Maryland. The State was not a party to this case, but the outcome of the case does have some implications for the State's annuity policy. In this case (Oak Crest Village, Inc. v. Sherwood R. Murphy), a continuing care retirement community (CCRC) sued a resident who purchased a $450,000 annuity in order to qualify for Medicaid. The beneficiary of the annuity was the annuitant's community spouse who receives about $3,000 a month in income from the annuity. Residents who enter a CCRC sign a contract with the CCRC for a lifetime of care. The resident makes a deposit when entering the community and pays a monthly fee depending on the level of assistance/care required. As part of the contract, residents agree to not divest themselves of their assets upon entry. If, over time, the resident's health status deteriorates, the CCRC expects to provide care for that resident in a skilled facility at the facility's private pay rate. When assets are divested or spent down, the community continues to provide care, but might receive only the Medicaid rate if the resident is Medicaid eligible. In this case, the CCRC sued the resident, claiming he had divested himself of his assets in order to qualify for Medicaid and avoid paying the private pay rate for care in the CCRC, but the resident

won. The court found that purchase of an annuity was not an asset divestment.

The CCRC is trying to compel the State to be more restrictive in its policy towards annuity purchase to avoid spend down. The community has apparently had a 'town meeting' that described the situation and informed residents of how when one person purchases an annuity and applies for Medicaid, costs go up for all other residents. The State has received several letters from residents of the community asking the State to take action to prevent this abuse, but until Federal policy is changed, it is unlikely that Maryland will change its policy.

Policy recommendations

Although most of those interviewed offered at least one recommendation for addressing the use of annuities by Medicaid applicants to avoid asset spend down, a few were reluctant to suggest that annuities were such a problem that changes to Medicaid policy were needed. Both the consumer representatives felt that the real issue was protecting consumers from predatory marketing practices by those annuity salesmen willing to take advantage of the elderly. One of the consumer representatives noted that he wasn't sure that annuity use is really significant in terms of the cost to the government. He suggested that the current rules regarding Medicaid annuities seemed well thought out; that the rules related to actuarial soundness (i.e. life expectancy) and level payouts are good. Because he does not see any reason to change the rules regarding Medicaid qualifying annuities, he is concerned that someone will come to the conclusion that this is a big problem that's really costing the government money and will try to change the rules when it isn't necessary.

This is similar to the position of one of the industry representatives, who agreed there was a need for consumer protection and that annuities have been used abusively in some cases (particularly where balloon annuities are used), but believes that an outright prohibition would be inadvisable. Immediate annuities sometimes make sense for the elderly. And, for some Medicaid applicants in tight situations, annuities can be the best way to

ensure community spouses are able to maintain their standard of living after their spouse enters the nursing home. Caseworkers also noted that sometimes there are legitimate uses of annuities. One example is when a person is in a car accident and receives an insurance payment. He/she may stay in a nursing home for six months. An annuity helps to insure that he/she will not be impoverished when he/she returns to the community.

Although they noted that there are legitimate uses for annuities, caseworkers were much more likely to say that the State and/or Federal government should be making greater efforts to police annuity use. In fact, there was only one county (Douglas County, Nebraska) in which caseworkers stated that annuity use was not a problem and who saw no need for policy changes. In one other local office—Maricopa County's Glendale office—caseworkers suggested that they saw only a small number of annuities and that State and Federal governments could focus on more fraudulent practices that present even bigger problems. Several caseworkers noted that given the current state of the rules, every resident in the nursing home could be having his/her care paid for by Medicaid if he/she understood the system. They feel this has to change. If the status quo is allowed to continue, no one will have an incentive to purchase long-term care insurance. Medicaid is the payer of last resort, but has been turned into an long-term care payer for the middle/upper classes.

In many ways, the caseworkers are reacting to what they see as the unfairness of letting people who have resources and can pay for nursing home care enroll in Medicaid. They understand that Medicaid is a program for the needy, and it upsets them to hear marketing pitches from attorneys and others that say anyone can receive Medicaid to pay for LTC. One county in Missouri had a recent case where an eighty-one year old individual was collecting $8,500 per month from the purchase of a $500,000 annuity while his institutionalized wife was receiving Medicaid. In Missouri, the average monthly payment for nursing home care is $2,685. It is this type of case that caseworkers would like to stop. They believe that as state budgets become tighter and tighter, Medicaid dollars are stretched thin and payments made for LTC for the middle class take away dollars for healthcare services

(such as vision and dental care) to the poor. Caseworkers would like to see states and the federal government adopt policies that would encourage more individuals to pay their own way. One method suggested by several caseworkers is to apply a cap to the dollar amount of an annuity that will be considered a non-countable asset.

Caseworkers also noted that the timing of annuity purchases often fairly clearly suggests a move to shift responsibility for nursing home expenses to the Medicaid program. They think instances in which applicants buy annuities the day of (or the day after) they apply for Medicaid should not be allowed. They have had cases where the applicant says "we just came from the insurance office" or where the insurance company faxes over a copy of the annuity before the actual application is received. They would like to restrict annuity purchases after people have entered the nursing home or annuities that were purchased when an applicant pooled all their assets to complete the purchase. They feel there can be only one reason for these annuity purchases and that is to avoid asset spend down requirements.

Spousal impoverishment

Everyone we spoke with recognized that the Federal spousal impoverishment rules serve an important purpose and no one wants to go back to the days before these rules took effect. But when we asked whether spousal impoverishment standards are sufficient to protect the interests of the community spouse, most county workers saw these standards as being more than sufficient for many but unequal in their impact on poor vs. middle class couples.

The consumer representatives interviewed tended to think that the spousal impoverishment rules worked well for most people. In California, where the minimum equals the maximum community spouse resource amount, the resource rules work just fine. The income rules, however, don't always work as well. Some people may have bigger monthly expenses, particularly people with large medical expenses. For these people, the income limits might not be enough, and although the fair hearing rules can allow a community spouse to hold onto more money, that is not automatic.

The elder-law attorney we interviewed made a similar argument. He views Maryland's Medicaid program as being very harsh on community spouses. It can be very hard for a Maryland community spouse to get by on the maximum monthly income allowance allowed by the Maryland Medicaid program, particularly in the DC suburbs where the cost of living is high. Taxes and insurance alone are overwhelming (property taxes on an average home can easily be $500 or more a month), which does not even including utilities, insurance, etc. let alone other living expenses. This situation makes annuities very attractive to couples when one of them enters the nursing home. The elder-law attorney we interviewed would like to see changes to the rules regarding the community spouse monthly income allowance standard that would require States to take into account the actual cost of living in local areas.

Most caseworkers see spousal impoverishment standards as at least sufficient and often very generous. Community spouses may have a $200,000 house on 80 to 100 acres, which is not a counted resource. Many couples applying for Medicaid also reach the maximum resource standard. Community spouses can have large monthly income (sometimes achieved through annuities), and caseworkers have suggested that maybe there should be some way of going after that income. Caseworkers also see inequity in the system. They feel spousal impoverishment standards have created an opening that allows married applicants to pass money on to their children that is not available to single applicants. They have also suggested that these standards would be more fair to the working poor if States used the maximum standard only (i.e., community spouses would get to keep everything under the maximum amount while anything above would have to be spent down). The resource amounts appear to be getting more and more unfair to the working poor over time. Currently, the same percentage increase is applied to the minimum and the maximum resource standard each year; a process that disproportionately benefits those with relatively more wealth.

State policy changes

Three states—Arizona, Maryland and Missouri—noted that they have tried (or are trying) to make changes through legislation to their policies regarding annuity use. As we noted above, Arizona passed legislation regarding the treatment of annuities in the eligibility determination process in 1999. In recent years, Maryland has tried and failed to make policy changes related to the use of annuities even though the Medicaid program recognizes the problems annuity use can cause. The State has talked about increasing the look-back period to 5 years (up from 3 years) and starting the penalty period with the date of entry into a nursing home instead of the date of disposal of the assets. Current State legislation will require Maryland's Department of Health and Mental Hygiene to request a waiver from the Federal government before making either of these changes. This legislation is unlikely to pass and even it if did, our interviewees felt that a waiver would probably not be approved.

Maryland was prompted to pursue these changes because of the anecdotal cases in which individuals with hundreds of thousands of dollars have become eligible for Medicaid due to the purchase of an annuity. Some of these cases are so egregious that they make it into the newspaper and people wonder why the State allows such things to happen. Maryland would be willing to make changes to restrict the use of Medicaid annuities, but it needs to be assured that these changes will receive federal support. Recently, Maryland has been looking into the issue of whether the deposits made to CCRCs by the elderly when they enter the community are countable assets. Elder-law attorneys think these deposits do not meet the definition of accessible. Maryland has written a letter to CMS asking for an opinion, but has received no answer. Maryland Medicaid would like to be aggressive in restricting annuities, but the political climate is such that the legislature will not allow changes to State annuity policy that conflict with current Federal policy.

Missouri has just recently turned its attention to the issue of the use of annuities to shelter assets. Two bills have been introduced into the legislature regarding Medicaid and annuities. State officials suggested that these proposed bills are the result of elder-law attorneys advertising on television. They noted "When peo-

ple start advertising, its gets the legislature's attention. (They watch TV, too.)" [4]

Missouri has looked very closely at what Louisiana is doing and they would like to try to do something similar. It would like to make these changes by administrative rule, but it does not know whether this is possible. For years, its policy has been based on guidelines from CMS with no state statute authority. The interviewees feel that any change will need State legislation to back it up. Missouri is also interested in the issue of selling an irrevocable annuity on the secondary market. Louisiana has moved forward on this issue believing that even if the annuity is irrevocable it is still an asset because someone will buy it. Missouri still has questions about whether it can declare that annuities are always an available resource, but it is looking into the issue. Missouri also wants to be able to make a distinction between legitimate purchasers of annuities and those who purchase annuities to shelter assets. In general, it feels that it knows the difference when looking at a case file, but understand that it would be very hard to put decision criteria into law or regulation.

Interviewee policy recommendations

Both consumer representatives and one industry representative would like to see government do a better job of monitoring the marketing of annuities to the elderly and enforcing the laws and regulations that already exist. They have made the following recommendations regarding consumer protection:

- The Medicaid program should work with State insurance administrations to get a "better handle" on the monitoring and regulating of annuities.
- Policies are needed that promote education for the elderly related to when annuities are appropriate for persons applying for the Medicaid program and to educate the elderly about illegal sales practices. The elderly, annuity salesmen, and consumer representatives need to be made

[4] We provide a copy of the bill in Appendix B.

aware of the statutes regarding illegal sales practices that are currently in place.

- The representation that an annuity is a "Medicaid" annuity should be prohibited.

Caseworkers suggested that they would like to see more consumer protection for the elderly in their relationships with elder-law attorneys. They have seen seniors who received advice from attorneys that was not correct. They have also dealt with attorneys whom they felt were not looking out for their customers. Caseworkers noted that attorneys often "get a kick-back" from the annuity companies for selling annuities and will charge the applicant for filling out the Medicaid application – something that the caseworkers will help the applicant with for free. They also noted that it is sometimes hard to tell whether the elder care attorney is working for the applicant or for the applicant's adult children.

State and county officials offered the following list of recommended changes to Federal policy:

- Change what is meant by actuarially sound. It is "nutty" to apply the current life expectancy test to elderly persons entering a nursing home. The average stay for the elderly is two-and-one-half years and maybe this information could be used to determine the appropriate payout period for a Medicaid annuity. Or, this issue could be addressed by requiring documentation from a doctor regarding life expectancy.
- Do not permit the use of balloon payments. An industry representative also suggested this type of annuity is inappropriate and should be curtailed.
- Specify the circumstances under which an annuity was purchased that define it as an annuity purchased for the purpose of Medicaid planning only. Allow States to look at the intent behind the transfer.
- Somehow cap (or limit) the yearly increase in the maximum spousal resource allowance. Currently, the same percent increase is applied to the minimum and the

maximum; a process that has benefited those with relatively more wealth.

- Allow annuities to be treated as trusts. Currently, CMS won't say that annuities are like trusts. (One of the industry representatives interviewed, when asked if annuities should be treated like trusts responded that "such a change would be quite unfortunate.")
- Allow States to treat the full amount of an annuity as a countable resource.
- Start the penalty period with the date of entry into a nursing home instead of the date of disposal of the assets. One consumer representative who works with individuals who have had a penalty period imposed noted that most often the penalty period has passed before the individual enters the nursing home. It is often the case that the period is over before the senior has even considered going into a nursing home or applying for Medicaid, suggesting that the penalty period is not doing what it is designed to do. She stated that in her experience, the penalty period has no influence on Medicaid eligibility or on who pays for nursing home care.
- Allow States the ability to recapture the annuity remainder amount at time of death by making the State the remainder beneficiary.
- Extend the look-back period for all transfers of assets to five years. In States like Nebraska, many transfers are done early as families try to avoid estate taxes.
- Sections 1396p and 1396r(5) of the U.S. code must be changed to ensure that the amount allowed a community spouse be restricted as in 1369r(5) so that the use of annuities are constrained by spousal impoverishment law.

Both Pennsylvania and Arizona State Medicaid officials discussed this last point in detail. They pointed out that there are two sections in the U.S. code that are of particular relevance to the annuities issue: Section 1396p—*Liens, adjustments and recover-*

ies, and transfers of assets and Section 1396r(5) – *Treatment of income and resources for certain institutionalized spouses.*[5]

The federal law related to spousal impoverishment says couples can transfer assets to a community spouse, but the community spouse can keep only a certain amount. However, if a couple takes all the assets assigned to the institutional spouse and creates an income stream for the community spouse using an annuity, as long as the annuity is actuarially sound, the community spouse can receive an extraordinary income stream while making the institutionalized spouse eligible for Medicaid.

Arizona and Pennsylvania have suggested that that Sections 1396p and 1396r(5) must be changed to correct this problem. They would like to see the statute modified to limit the amount that can be transferred for the benefit of the community spouse to the community spouse maximum resource allowance amount as in 1369r(5). Arizona Medicaid officials noted that they tried to interest their State's congressional delegation in this issue, but were unsuccessful.

Although states have numerous suggestions on how policies regarding annuities might be changed, they also realize that what is needed is a policy that logically integrates the treatment of annuities, disposals, joint ownership, and other assets that pass outside of probate. They understand that restricting annuities may in turn give rise to some other method of artificial impoverishment on the part of Medicaid applicants. An integrated policy might help to stop the seemingly unending development of new methods for avoiding asset spend down.

[5] These are sections 1917 and 1924 of the Social Security Act, respectively.

Focus group results

Background and objective

This section summarizes senior citizens' attitudes toward the use of annuities to shelter assets in order to become eligible for Medicaid. As we've stated earlier, Medicaid estate planning by individuals and couples to shelter assets to avoid the asset spend down that would be required for Medicaid assistance has important potential financial implications on state and federal expenditures.

The specific objective for this part of the study was to gain insights into the knowledge and attitudes of potential Medicaid recipients regarding the use of annuities as a method for sheltering assets. To accomplish this goal, we conducted qualitative research with a focus group format. We felt that focus groups would provide a rich source of data and information concerning attitudes and motives from the population most likely to use Medicaid annuities.

Research methods

The purpose of the focus group research methodology was to gain insight into the knowledge and attitudes of potential Medicaid recipients regarding the use of annuities as a method for sheltering assets. We conducted five focus groups, one in each of four participating states selected for the study and a fifth—Minnesota—that was conducted before the others and well before the final state agreed to participate. The locations for the focus groups were:

- Baltimore, Maryland
- Minneapolis, Minnesota

- Springfield, Missouri
- Omaha, Nebraska
- York, Pennsylvania.

We note that the Minneapolis focus group served as a pilot for the others that followed.

Subject Recruitment

We acquired a master list of potential participants from a commercial firm based on geographic and demographic parameters. From the list of potential participants, we contacted candidates by phone and screened and recruited them using a personal and repetitive process. The recruiters followed a structured telephone script. Candidates agreeing to participate were sent a follow-up letter confirming the purpose, time, date, and place of the focus group. The letter included a name and number to contact.In addition, each participant received a reminder phone call the day before the focus group.

We established criteria for focus group participants based on feedback from an expert panel as well as from discussions internally and with our CMS project officers. Each person who was invited to participate in one of the focus groups had to meet the following qualifications:

- Adults 65–80 years of age living within a narrow geographical area of the state where each focus group was held
- Neither the participant nor the spouse/partner could have ever been a recipient of Medicaid assistance
- Total assets for participant and spouse/partner (if spouse/partner is still living) must be at least $100,000 and less than $500,000 (total assets do not include the value of the principal dwelling, any pension and retirement income for participant and spouse/partner from places of employment or any Social Security benefits received).

We conducted the focus groups between January 21 and May 14, 2004. We set a target of eight individuals in each focus group. In order to achieve this goal, we scheduled a few "extras" for each group session in the event of no-shows. Typically, we recruited a total of 10 focus group participants under the assumption that 2 would not show up. A total of 37 persons participated in the research. To thank the participants for their time and assistance, we provided a gratuity of $75 to each person.

We considered several issues in setting parameters for focus group recruitment. First, we did not require knowledge of annuities as a prerequisite for selection, but an effort was made to ensure that most focus group participants knew about the use of annuities. One of the purposes of the focus groups was to determine the extent of the participants' knowledge of Medicaid eligibility and any concerns they may have about the consequences and costs of long-term care. Currently, Medicaid annuities represent a legal way to help qualify for Medicaid. We wanted to explore how participants would react to a method that allows them not to have to spend down most of their assets before qualifying for Medicaid. Even if they first learn about annuities in the focus group discussion, valuable information would be learned about their reaction to what it allows them to do.

A second issue regarding who should participate was whether only one spouse should be allowed in the group. Purchasing an annuity makes the most financial sense when there is a community spouse. One model for the group protocols might be to include only the person in charge of financial decisions. However, it may be difficult to tell who that is and whether it would matter if long-term care was indicated for the person in charge. We decided to include only one spouse.

A third issue concerns the level of family assets. The recruitment screening process ensured that only families with substantial assets were represented. The low income/low assets couples clearly have fewer incentives to prepare for asset substitution and we did not include them in our focus groups.

Conducting the Focus Groups

A total of 37 volunteer subjects participated in the 5 focus groups. A profile of the focus group participants in each of the 5 states is presented in Table 7. We had two age groups—65 to 74 and 75 to 80—and most participants were in the younger of these two groups. Slightly more than one-half of the participants were female and most had assets in the $100,000 to $250,000 range. All participants signed a consent form before the focus group session. At least two researchers attended each group. The focus group interviews were guided by a set of focused questions (both the consent form and the questions are provided in Appendix C). In each session, one researcher moderated the group. The other researcher captured the data by taking notes and taping. Four of the focus group sessions were held in market research facilities. One session was held in a hotel. All focus groups were audio and/or video taped.

Table 7. Selected characteristics of focus group participants in five cities

	Edina, MN	Springfield, MO	Omaha, NE	York, PA	Baltimore, MD	Total
Number	8	6	5	9	9	37
Age						
65 to 74	6	3	4	9	5	27
75 to 80	2	3	1	0	4	10
Male	4	3	2	4	4	17
Female	4	3	3	5	5	20
Assets						
< $250K	7	2	2	5	6	22
> $250K	1	4	3	4	3	15

The following five research questions were explored in the focus groups:

1. Do focus group participants accurately understand annuities and how they can be used to shelter assets that could otherwise be counted as available to pay for long-term care costs?

2. Are annuities perceived as a valid investment instrument, a mechanism to shelter assets, or both?

3. Do the focus group participants believe it is within both the spirit and letter of the law to use annuities to shelter assets? If so, why and if not, why not? What factors influence those perceptions?

4. To what extent do focus group participants believe that they may enter a nursing home at some point in the future? What do they believe would be the potential consequences of entering a nursing home for their household?

5. What sources of information are identified by focus group participants regarding annuities to shelter assets and what is the perceived credibility of those sources?

The researchers took measures to ensure that focus group participants understood that the annuities under discussion were a legal device used by many who have faced financial decisions surrounding the payment for long-term care services. We made a systematic effort to avoid influencing responses by suggesting that they were not being asked about their attitudes toward something illegal or immoral. To make people more comfortable in the focus group setting and with our topic, the questions started with attitudes and beliefs regarding their possible need for long-term care services in the future, knowledge of the cost of long-term care services, knowledge of Medicare reimbursement related to long-term care, and knowledge of Medicaid eligibility rules for those who need long-term care services.

During each discussion group, we provided participants with a description of the type of annuity that could be used to shelter "assets so as to meet Medicaid eligibility" as well as a worksheet for identifying the countable and non-countable assets that are currently being used to determine Medicaid eligibility. Participants were then asked their reactions to this type of annuity and how they might feel about being able to shelter some of their assets in order to qualify for Medicaid. At this point, each focus group was told the actual Medicaid eligibility rules in their state and given a brief description of how people applying for Medicaid use annuities. A written explanation was distributed and read to the participants in each session. We then proceeded to ask about their attitudes toward "spend down" requirements and the use of financial planners, their knowledge of annuities or other methods for avoiding spend down, their attitudes toward the use of annuities, and how policy changes might influence their behavior with regard to financial planning options.

After the focus group discussion, we administered a questionnaire to gather financial status information. This was done at the end of the session to avoid any discomfort of the participants during the focus group discussion phase. The purpose of the questionnaire was to gather pertinent background information about household financial status to ascertain the influence of the participants' asset base and income on the perceived advantage of annuities as a financial instrument to shelter assets. The questionnaire was confidential, but not anonymous. An identifier on the questionnaire was included to analyze the influence of factual financial status as a determinant of attitudes toward using annuities.

Summary of findings

Future need for and means of financing long-term care

Senior citizens (i.e., those 65 to 80 years of age) from the five states where the focus groups were conducted have a similar outlook about a future that may require long-term care for themselves and/or a spouse/partner and a way to pay for such care:

- Some have made plans, such as acquiring assets they expect will have to be used, if needed, to pay for long-term care.
- Some have purchased long-term care insurance as a way to prepare for the possibility of needing long-term care.
- A few understand there is a possibility that their children may care for them (as they did for one or more of their own parents). However, this is not an attractive option to most.
  - — One participant summarized this feeling by observing, "People don't keep people at home anymore. The care demands so much and the expense is exorbitant!"
  - — Another viewed being taken into a child's home as less than beneficial for both parties: "My daughter has said

we can move in with her, but there's no house big enough for two families."

— A third senior said, "People don't want to live in the houses of their kids."

"We had hoped to take care of ourselves!" seems to be the typical attitude of seniors. Several related experiences of knowing friends or family members who have required long-term care and lament the costs that were incurred as a result of needing such care. Some shared stories of an acquaintance who had to sell his home and use the proceeds from the sale to pay for nursing home care, or of someone who was required to sell a deceased person's home and other belongings and give the money to the nursing home, the state, or some other party claiming that the money was owed to them for the care that was provided.

Only a few of the senior citizens acknowledged they have given little or no thought to long-term care. One senior mentioned that "I've never really thought about long-term care." A majority of the participants, however, have given serious thought to the possibility of needing some type of long-term care.

After hearing that a portion of the discussion would be about whether or not they or their spouse/partner may, in the future, need to enter a nursing home for long-term care, the response of several was to mention that they have purchased or have looked into purchasing long-term care insurance. Long-term care insurance seems to be uppermost in the minds of some of the seniors when the topic of long-term care was broached.

A few reported that they, or their spouse/partner, developed some health problems that may require admission to a nursing home and have inquired about acquiring long-term care insurance, only to find that such insurance is no longer available to them because of the medical problem. Others have anticipated that long-term care may be needed and have purchased insurance, while they still qualified for it, to prepare them for the possible eventuality facing them.

Long-term care Insurance

When discussing long-term care insurance, the topic of cost was foremost in their minds. Insurance policies differ as to what is covered, for how long, and the age at which the insurance was purchased, and each item affects the cost they pay for the coverage. Among the thoughts expressed about long-term care insurance by the seniors in the focus groups were the following:

- "I'd like to get some information about the cost of the insurance."
- "I'm definitely in the market for long-term health insurance."
- "My insurance man hounded me so much saying, 'I have to protect my assets.'"
- "My wife and I have two policies. A three-year and a two-year based on economics and averages. Based on reports I've read, nursing home costs keep going up."
- "I took out long-term insurance in 1992 just for peace of mind for my son so he would know I'm taken care of."
- "We do have a long-term care policy. We began to think about a policy with the change of status of his parents. Then, we began to think when we saw how expensive it is and what a drain it is on their resources. We ended up projecting what an average cost would be for a nursing home in fifteen years. We would use up our savings in just a few months if we were paying the full amount for our nursing home care. You buy insurance with the hope that you wouldn't ever need to use it. We look at long-term care the same way as why we insure our house, our car and health: just in case you ever need it."
- "You have to be in good health to get long-term care—and young."
- "My wife can't get it. If anything happened to me, we would be in a bad way at this particular time."

We note that the topic of long-term care insurance was generally the first topic mentioned by the participants in answer to a question regarding what they might expect the cost of long-term care to be. It seems that paying for the eventuality of long-term care raises the issue of purchasing long-term care insurance for most of the participants. Equally as important to the seniors, but secondary in their thoughts, are the assets that they have accumulated to "get them through their retirement years." A few of the participants, who they have given some thought to the idea of long-term care insurance, have concerns about the viability of the companies offering the policies. Some of there responses were:

- "I think about it a lot. I pray about it a lot. I also hear a lot of bad things about these companies. Is it worth the risk of giving money to one of these companies for benefits, if all they are going to do is go out of business or deny people their claims?"
- "I've thought about it for many years. But when I started thinking about it, I didn't have enough money. Then, when I had enough money, there were so many bad things I heard about long-term health insurance companies. I'm on the fence about it. I know if I don't, it would wipe us out - $150 a day/$4,500 a month."

Cost of Long-term care

The expected cost of long-term care was a worry for the participants. The participant quoted above who anticipates a monthly cost of $4,500 assumes that such a payment "would wipe us out." One participant's wife is in a nursing home that charges "$115 a day." Others mention daily costs of up to $150, and some assume they would pay even more if they wanted a private room or wished to go to a "private pay" facility. "You're going to get what you pay for" is how one senior sums up the relationship between the payment level and quality. Anecdotally, several of the participants had stories to share about long-term care costs. The following comment seems to summarize the thoughts of many of the participants: "I have a friend whose father ended up in a nursing home in a little town in Wyoming, and it still costs a

couple of thousand a month. In the year-and-a-half he was there, he went through a hundred thousand dollars."

Reliance on Medicaid for long-term care

A few of the focus group participants mentioned that one of the possible ways to pay for long-term care was to rely on Medicaid. This, however, is an unwelcome option for most of the participants because they hope they will never be at the point in their lives when they are not able to "pay their own way" – either through using up the assets they have accumulated during their lifetime or by relying upon the assistance that will be provided by the long-term care insurance some have purchased. Of course, they acknowledge that they might be cared for by one of their children (an option that each would prefer to avoid), or they could secure a "reverse mortgage" on their home and use that money to pay for long-term care.

As a final resort, the participants acknowledged that Medicaid may need "to come to the rescue," but that could only happen when they have almost nothing left in personal wealth or assets:

- "If you have assets, you need the long-term insurance. If you don't have any assets, you don't need the long-term insurance because Medicaid will cover everything."
- "If you use up your assets, Medicaid will step in."
- "Medicaid is very little, unless you're on a poverty level."
- "Medicaid is when you're completely broke!"
- "Medicaid only lets you have about $2,500 worth of assets."

The option to have Medicaid pay for their long-term care is unwelcome. If a person reaches the time when Medicaid will need to pay for long-term care, one participant believes that "the county or state will take over all your assets," leaving nothing for the patient. The participants believe that if they were in need of receiving assistance from the Medicaid program, their worldly assets would have already been used up (or would be used upon their death to pay back costs incurred for such care – "You can keep your home, but when you die, they can go back and collect on your house.") As a result, their options for being taken care

of would be severely limited. Their choice of a nursing home would be limited to those that will accept Medicaid patients, and they would expect that a single room would no longer be an option. In addition, some believe the areas in the nursing homes where the Medicaid patients are housed are "partially below par" from those where the other patients are housed. Several also assume that Medicaid recipients are unwelcome at many nursing homes: "Nursing homes really don't want the Medicare and Medicaid patients. They have to take a percentage – like 15 percent but after that, they can say, 'we don't want you.'"

The thought of "having nothing left" is very troubling to the participants. Most acknowledged they have worked for decades to be able to fund their later years. However, many recognized that were they to need the care of a long-term care facility, they would likely end up spending their assets and may need to have the cost of their care eventually provided by Medicaid.

Several of the senior citizens said they would like to think that they would have "something to pass down to their children or grandchildren." Most, however, have tried to raise their children to "be able to support themselves" by giving them an education or training for a career. As seniors who have reached this stage in their lives, they feel satisfied with what they have been able to provide to their children and do not feel an obligation to "leave them something." Were there assets remaining upon the death of the participants, however, they would be proud and delighted to have these assets go to their families. They would much prefer this option over having to use up all their assets to pay for long-term care."

Annuities

When the topic of annuities was introduced to the focus group discussion, some participants knew very little about annuities while others reported having purchased annuities to help fund their retirement:

- "My annuity was in the form of an IRA"
- "I've got an IRA annuity and just regular annuities"

- "I've got a couple. They pay out so much a month. It keeps getting interest every month. I got them just because I wanted some assets."

Annuities were viewed as a means of receiving some income during their retirement years. No one mentioned having purchased an annuity as a way of anticipating paying for long-term care. There are some, however, who question the value of putting their money into annuities. They felt that an annuity is not a "very wise investment" and have avoided investing any money in annuities. One senior who had purchased two annuities noted that were he to do it again, he would do "something else with the money." Among those who have limited knowledge of annuities, an annuity did not seem to be a very sound investment option for them:

- "I've never heard anything good about annuities. The cost is very high – the benefit is very low. The only real guarantee is you're going to lose your tail."
- "I've heard most of the time it's not a good investment. It costs a lot to get into it, and the chances of getting your money out of it are slim. Even insurance people have told that to me. I've always been talked out of them."

Medicaid annuities

After being informed about the possibility of being able to use annuities to help pay for long-term care, the participants seem were quite surprised that something like this exists. No one mentioned ever having heard of this before, and some questioned if this would be an "ethical" thing to do. Typical attitudes were:

- "How about the moral aspect of this stuff? Is it morally right for me who has the money and I can pay for a long-term plan – to plan to eliminate that so you pay for my wife's or my long-term care? Is it right for us to do that if we can handle doing that ourselves? No, I don't think it's right. If I can handle it, I should handle it. I don't have a right – and, if fact, it's a great privilege – if I can get you to pay my bill for me. And that's really what's happening here. Now that's my opinion. If you can afford it,

shouldn't you do it on your own? Or, should you 'connive' to get someone else to do it for you?"

- "I think it would be different if you have money coming in each month, or are just living on social security. That would make a big difference. Morally, you'd have to make sure you had enough money for yourself or if someone is living with you."

The issue of ethics engaged the participants. One senior stated, "It may not be ethical, not morally right." Another said, it "seems fraudulent!" Instead, several presumed that it is their moral right to "pay for my own care, if I can afford it." This statement seems to summarize the majority's position on the topic. A person who has the means to pay for his/her own care certainly should do so, and "Medicaid should only be available to people who really need it."

For many, the idea of sheltering certain assets in order to have Medicaid pay for long-term care causes them to wonder what will happen to Medicaid and who will eventually end up paying for this. The most frequently mentioned concern is that their "kids and grandkids" will be the ones who will be asked to shoulder the burden for the enormous amount of money that will be spent by the government. To pay for the long-term care of all the people who could just as well pay for their own but opt to shelter their wealth and "live off the government" is not an expense most of the participants would want to pass down to the younger generations.

Several believed that those who can afford to pay for their care should be paying for it. A few said they might consider this option, but several are reluctant to believe that the government would allow such a program to exist. One participant believed that there may be some merit to this type of financial planning: "I doubt it would have been a moral issue for me; I would have jumped at the opportunity." Another maintained it might be a "good way to get around the government." Yet, others believe this is almost "too good to be true!" "If it's too good to be true, it probably is!" noted one participant. Others wanted to know why, if this is possible, an insurance person or financial advisor has not mentioned this to them as a part of their financial planning.

If they have not heard anything about this option and if some insurance companies are, in fact, offering such a product, several wondered if those insurance companies are financially sound. They claimed to be suspicious of an insurance company that has this product but has done little to promote or sell it. Several wondered why they have never heard of this before.

Even if this were an option they might consider, several questions remain. How long do they have to spend down their assets to get to the necessary amount? What would happen to a spouse's assets if they were to require long-term care sometime in the future? As a single senior, how would their sheltered assets get passed on to an heir? What would happen to a person's assets if they somehow got better and were able to leave the nursing home? In fact, the option raises as many questions as it might answer for the participants.

Some suggested that they would not want to be in a long-term care facility as a Medicaid recipient. For a few, it carried a type of stigma: "You don't want to be a Medicaid recipient if you don't have to." Several also wondered how the quality of their care would suffer if they were a Medicaid patient. One recalled hearing about a nursing home that "housed" the Medicaid patients in the hallways! Others believed that nursing homes simply do not like having to care for Medicaid recipients. In addition, some have heard that nursing homes have a limit on the number of beds allocated to Medicaid recipients, so they believe the options open to them as a Medicaid patient would be severely limited and they may end up in a nursing home that they did not like.

Focus group summary

Sheltering certain assets in an annuity as a means of qualifying for Medicaid coverage for long-term care did not appeal to most of the participants. This is a proud generation who believes that, if they have worked hard to provide for their senior years, they should then spend that money on long-term care should that need arise for them. To expect the government to pay for their long-term care only suggests that it is really their "kids and grandkids" who will be paying for it "the long-run." Most of the

participants would much rather do what is "moral and right," which mean paying for their own care, if they have the means to do so. A few of the seniors may choose to look into the option discussed, hoping to be able to pass some of their accumulated assets on to their children.

Typical of their overall attitudes were the following statements:

- "It has to do with preservation of your estate; it has nothing to do with nursing care. This is a way to qualify you for Medicaid."
- "Sounds like the same thing as just converting assets into your children's name."
- "I was just trying to leave something for my kids. That's what I was thinking about."
- "If I can afford it, I would just as soon provide it myself. I see this as a way of preserving an estate – passing on an estate."

Whether or not a person chooses to pursue this option is a clear matter of choice. For those who believe they have a moral obligation to pay their own way and are not concerned about leaving part of their estate to their families, they will likely not look into this option. However, for those who hope that when they die they still have some type of estate left to pass along, this may be a way to do it "with the government's blessings."

Medicaid case file data and analysis

In this section, we turn to the data that we collected from visiting county Medicaid offices and how we used those data in our analysis. As we'll show, we had to determine which cases represented annuities that met the criteria to support their use as an instrument for sheltering assets, what that meant for Medicaid eligibility and program cost, and finally how we could then apply that to other states that were not part of the study.

Specifically, in describing these issues and our approach, we focus on the following:

- Collecting the case file data
- Developing the model to determine the incidence and effects of annuities on Medicaid program expenditures
- Applying the data in the models and extrapolating to other states and the nation as a whole.

Medicaid case file data

Data issues

We've already described the procedures that we used to collect the Medicaid data from each county that we visited as part of the study. In order to obtain estimates of the incidence of use in each of these counties, we examined as many cases as we could in a relatively short visit and retained the number of cases where the application included an annuity and where it did not. The ratio of cases with annuities to the total is our simple estimate of the incidence of annuity use in that county. In a later section, we will describe the procedures we used to extrapolate across the rest of the state and then to the nation in total based on what we observe from the five states in the study.

There are several data issues that we had to deal with and overcome to obtain reasonable estimates. As we mentioned when we described how we collected the data, several days or even a week of going through case files from two, and sometimes three, counties or local offices did not allow us to go through quite as many cases as we would have liked. It took time to examine the case files and, after finding a case with an annuity, we then reproduced the original application, the annuity contract, and any other relevant information for later use in our analysis. Despite this, we were able to examine several hundred case files in most of the states and could then compare the number of *valid* annuity cases to that total number of Medicaid cases.[6]

In some counties, the state or local officials helped us by "pulling" annuities from their case files. This was useful for collecting enough examples of how annuities could be used for sheltering assets, but without the "denominator" of the total number of cases, it becomes more difficult to estimate the annuity incidence rate. As we'll explain, however, we took extra effort to find reasonable estimates that we could use. A second point is that not every annuity pulled from the file, whether we collected it ourselves or had the case handed to us, met the definition of a Medicaid annuity as we define it in this study. In many cases, the annuity met the definition of a variable annuity or pension. In other cases, the annuity might have been purchased well before the look-back period, which we assumed was three years from the date of application. As an example of differences in the kinds of annuities that we encountered, one of the local offices in Arizona collected all of its annuity case files. However, after the study team member went through the files in detail, he concluded that only 17 of those 31 cases represented Medicaid annuities for the purpose of our study.

The Medicaid eligibility application forms that we used contained most of the information needed to estimate the cost to Medicaid of an annuity. They contained information on the annuitant's (1) assets, (2) income, (3) annuity premium (or pre-

[6] By valid annuitites, we're making a distinction between the SPIAs that we said include those used to shelter assets from pensions or other variable annuities that provide retirement income.

mia), and (4) the monthly (or in a few cases, annual) payment from the annuity. We found Medicaid applications from both single individuals and individuals with a spouse who was living in the community. Using these data, along with information on the average monthly private nursing facility payment, the average monthly Medicaid payment, and the specific Medicaid eligibility parameters appropriate to each of the states, we could derive estimates of the expected Medicaid spending with the annuity and then an alternative case where we assumed it had not been purchased. The difference between these two estimates represents the Medicaid expenditures that were due to the purchase of an annuity.

Estimating the county incidence rate

As we've indicated, we gathered case files of those applicants both with and without annuities in the file. In four of the states—all but Arizona—the process mainly relied on one of the study team members going through files and keeping track of both kinds of cases (i.e., those with and without annuities). However, in one of these states, Missouri, county eligibility workers pulled some annuity cases and handed them to us. Specifically, we were given two annuity cases in Jefferson County and 10 cases in St. Charles County.

In the case of Arizona, we visited four different offices (three in the Phoenix area) and the local workers pulled cases for us. As we've noted, this was useful for finding as many annuity cases as possible, but made estimating the incidence rate more difficult. Therefore, we had to go back to the office contacts we had made and ask for some additional assistance in deriving rates for the two counties. For example, in the Glendale office of Maricopa County, we were handed "all" cases of annuities in that office. For Glendale, as we've already mentioned, some of the case files pulled were for non-Medicaid annuities. At the Mesa office, the study's contact pulled 43 community spouse cases and 9 non-community spouse cases for review, out of a total of 50 possible community spouse and 77 non-community spouse cases. It was possible to determine the number of valid annuity cases from the state's data that had been used to list cases with an annuity's income stream. We estimated the total number of valid annui-

ties in the Mesa office by applying the percentage of cases reviewed that had valid annuities (36 of 43 community spouse cases and 3 of 9 non-community spouse cases) to the total number of potential cases. In both the Glendale and Mesa offices, cases, we then had to derive a denominator pertaining to their total number of LTC Medicaid patients.

To derive an estimate, we began with the total number of eligibility interviewers and the average number of cases each handled. We recognized that not all of the cases handled by eligibility workers were relevant to our study. Sampled cases would include only those whose basis for eligibility implied that they could have had sufficient assets for an annuity purchase. For example, we would not have sampled cases of recipients who were SSI-eligible and, therefore, would not have any assets for the purchase of an annuity. We used data reported by the state of Arizona to derive the percentage of of all cases falling into the appropriate category of its elderly LTC beneficiaries. From these data, we estimated that about 13.8 percent of all Medicaid cases were in the appropriate group, i.e., the LTC beneficiaries that would be candidates for considering the purchase of a Medicaid annuity. Finally, in the the case of the Phoenix South office, we went back and it independently provided an incidence rate for their office.

In table 8 below, we present our estimates of the number of annuity cases (i.e., individuals holding annuities) in each of the 11 counties (13 offices in total) from the 5 states. The numbers shown in the table represent the cases that we found, validated, and used in the analysis. The offices that we visited may have contained additional cases that we didn't have time to find during our visit. In other words, based on what we reviewed and copied for use in this analysis, there were a total of 72 Arizona Medicaid beneficiaries with one or more annuities.

Therefore, unlike the other states in our study, we derived the numerator of the incidence rate in each Maricopa County office and either derived the total number of cases for the denominator or were provided with the overall incidence rate and then derived the total number of cases (the procedure we followed for the Phoenix South office in Maricopa County). These values are also shown in the table. For Missouri, we estimated the inci-

dence rate using only 5 of the 15 annuity cases we had in St. Charles County and 6 of the 8 we had in Jefferson County. The other 12 cases were given to us and, therefore, were not drawn from the files in a random manner.[7]

Table 8. Estimating the incidence of annuities from case file data, by county, 2004

Office or county	Number of annuity cases	Total number of cases	Incidence rate (percent)
Arizona			
Maricopa—Glendale	17	1,270	1.3
Maricopa—Phoenix So.	9	514	1.8
Maricopa—Mesa	39	759	5.4
Pima	7	639	1.1
Maryland			
Montgomery	3	398	0.7
Baltimore	9	539	1.7
Pennsylvania			
Allegheny	2	282	0.7
Erie	0	168	0.0
Nebraska			
Lancaster	1	373	0.3
Douglas	1	374	0.3
Missouri			
St. Louis	5	118	4.2
St. Charles	5	183	2.7
Jefferson	6	192	3.1

As the table indicates, we include a total of 104 annuities from these 13 offices and find incidence rates ranging from 0 percent in Erie County, Pennsylvania to 5.4 percent in the Mesa office of Maricopa County, Arizona. In two of the states, Pennsylvania and Nebraska, we found very few annuities in the files. Pennsylvania has tried to limit the use of annuities and seems to have succeeded, if our lack of success in finding them is representative of the rest of the files. Maryland shows a few annuities, but one possibly surprising fact is the higher incidence of their use in Baltimore than in Montgomery County. The latter is one of

[7] We note that we do include all annuity cases in the model used to estimate the effects of the annuities on Medicaid. All of the cases represent valid Medicaid annuity cases, but we only include in the incidence rate those we found using random sampling of all cases or provided by the office as their best estimate.

the wealthiest counties in the country and we had expected to find more annuities there than we did.

Table 9 provides the state-wide rate based on each of the counties within the state based on the values shown in the previous table. The last row shows the overall rate aggregated over all 5 states. We estimate that Missouri has the highest rate of annuity use, about 3.2 percent, followed by Arizona, with an overall rate of 2.4 percent. Pennsylvania and Nebraska have the lowest rates, with 0.4 percent and 0.3 percent, respectively.

Table 9. Projecting the state incidence rate

	No. of annuity cases	No. of cases	Incidence rate (percent)
Arizona	72	3,182	2.3
Maryland	12	937	1.3
Pennsylvania	2	450	0.4
Nebraska	2	747	0.3
Missouri	16	493	3.2
5 state total	**104**	**5,809**	**1.8**

Annuity cost

Turning to the characteristics of valid Medicaid annuities purchased by Medicaid recipients, table 10 shows the average purchase price and average dollar amount of the income stream generated by the annuities.[8] We've also provided the range in prices we observed in our collected data. Clearly, there is a wide variance in purchase price and the average for an office or county may be quite different from the median purchase price. Some of the annuities are in the low tens of thousands of dollars, while others are several hundred thousand dollars, which can skew the average The smallest annuity cost that we found was less than $1,000, although the usual value averaged between $40,000 to $50,000. At the upper end, we also observe annuities

[8] Note that the number of annuities listed here differs from the values shown in table 8, in which we derive the incidence rates. Here, we list all annuities separately, including those that, as we explained, were handed to us, as well as multiple annuities held by one person. For example, we found one individual who held four separate annuities. For the derivation of the incidence rate we only counted him once.

as large as $300,000 and in one case, we found an annuity in Maryland for $860,000. But, these large annuities were more the exception than the rule.

The table also shows the monthly income generated by the annuity. The income depends on the purchase price as well as on the length of time, usually designated in months or years, that the annuity is in force. This contract length varies and there doesn't seem to be one period that dominates the others, mainly because it is based on the life expectancy of the annuitant as reported in the SSI life expectancy tables. We see some as few as 3 years and some as long as 12 to 15 years. If the purchase price is high and the length of the term relatively short, a large monthly income can be generated. For example, in the Mesa office located in the Phoenix area, we observed an annuity purchased for $375,000 with a three-year term. This led to a monthly income for the annuities' beneficiary, the community spouse, of $10,495 per month. Clearly, this case was a good example of sheltering assets and converting it to income for the community spouse.

Table 10. Average annuity purchase prices and income

	Total number of annuities	Average purchase price	Range (low to high)	Average monthly income
Arizona				
Maricopa—Glendale	17	$58,665	$11,000 - $143,000	$737
Maricopa—Phoenix So.	13	$104,339	$5,000 - $300,000	$2,323
Maricopa—Mesa	41	$79,992	$10,000 - 375,000	$2,045
Pima	11	$66,033	$689 - $250,000	$2,407
Maryland				
Montgomery	3	$337,000	$15,000 - $860,000	$5,220
Baltimore	9	$120,515	$24,000 - $228,000	$1,435
Pennsylvania				
Allegheny	2	$37,500	$15,000 - $60,000	$700
Erie	0	--	--	--
Nebraska				
Lancaster	1	$11,000	$11,000	$184
Douglas	1	$101,467	$101,467	$573
Missouri				
St. Louis	5	$27,067	$17,000 - $43,500	$310
St. Charles	15	$102,073	$22,300 - $332,169	$1,239
Jefferson	8	$115,091	$10,000 - $346,259	$1,139

It makes sense that most annuities would be purchased when there is a community spouse, especially if he/she is being used to shelter assets from the Medicaid program. To see if this is, indeed, the case, table 11 presents some of the demographic characteristics of the Medicaid beneficiaries whose case files we collected both those with annuities and those without. Specifically, we focus on whether the recipient has a community spouse present as well as the gender and age of the recipient. We break the age into two groups—those under 75 and those over 75.

Table 11. Demographic characteristics of Medicaid LTC beneficiaries in participating states (in percent)

Medicaid beneficiaries	Arizona	Maryland	Pennsylvania	Nebraska	Missouri
With annuities					
Married	86	92	100	50	60
Male	34	58	50	0	50
< 75	14	42	0	0	27
75+	86	58	100	100	73
Without annuities					
Married	16	12	15	18	14
Male	28	17	20	28	19
< 75	37	31	12	23	20
75+	63	69	88	77	80

We note again that we had many more observations of Medicaid beneficiaries without an annuity. In two of the states, Pennsylvania and Nebraska (table 8), we found only two annuities in each state, so the percentages in table 11 are based on very small samples. Nonetheless, some clear patterns are still evident. The table indicates that across all states, the percentage of applicants with the community spouse present is much higher when there is an annuity, ranging from 60 percent in Missouri to 92 percent in Maryland (we exclude the value for Pennsylvania because of the small sample size). For those without annuities, all values are within the 12 to 18 percent range. Those with annuities appear to be more likely to be male, but we can't conclude definitively whether they are younger.

Modeling program cost effects

In this section, we'll provide details on the set of equations and key variables that we used to model how the use of annuities af-

fected the costs of state and federal Medicaid programs. We will describe the important relationships and assumptions that we made to be able to derive what the costs would have been had the family not purchased an annuity. In addition to explaining how our simple simulation model provides an estimate of the cost of the program, we will also focus on:

- The rules governing minimums and maximums on asset holdings and income
- Nursing home or home care costs (the latter is particularly relevant for Arizona), both private pay and Medicaid
- Assumptions concerning the length of time that Medicaid had to pay for long-term care.

A simulation model for estimating annuities' effects on Medicaid

As part of the project, we had to develop a simple set of relationships that would allow us to estimate the implications of an annuity on Medicaid spending. Our approach was to set up a simple set of equations that would rely on input data drawn from the specific case files we collected. We could then determine the cost to the program under two cases:

- The base case, in which the annuity was paid for from joint (or if not married, the individual's) assets as determined from the case file
- The "counterfactual" case, which is the assumed case where there was no annuity and the amount paid for the annuity (i.e., the premium amount) was part of the joint (individual) assets.

To reiterate, the base case refers to our interpretation of the current case file where the family unit (an individual or a married couple) has purchased an annuity, typically for the community spouse, or if there isn't a spouse, for the patient or any children. In the case when the annuity's beneficiary is the community spouse or the institutionalized spouse, the annuity does reduce the amount of assets required for spend down. However, in most cases when the beneficiaries are the children of an insti-

tutionalized applicant—exceptions usually referring to dependent or disabled children—the annuity would constitute a transfer and would not be exempt from spend down.

The simulation first estimates the expected Medicaid expenditures under the base case (i.e., assuming the presence of the annuity) by determining the countable assets and spending them down according to the average private monthly nursing facility payment, net of the patient's available income. Once the patient has spent down to the appropriate amount (based on the state's asset spend down limit), we assume Medicaid will cover the remainder of the stay (net of the months that were disallowed because of divesting assets during the 36-month "look back" period). We assumed that each of these remaining months will cost Medicaid the Medicaid monthly payment rate, net of the patient's available income, and the total cost to Medicaid will be the sum of Medicaid expenditures for these remaining months.

The simulation then calculates the Medicaid costs under the alternative case, in which the annuity premium is included as part of the countable assets and any annuity income paid to the patient was simply omitted. If the annuity income had been paid to the community spouse, this income was also omitted, but care was taken to preserve the spouse's minimum income allowance. The augmented assets were spent down according to the private monthly rate, net of the patient's available income, to determine the number of private months that must be paid. Any remaining LTC months would be assigned to Medicaid minus any months that were disallowed because of divestiture in the previous 36 months. Each of these months would cost Medicaid the Medicaid monthly rate, net of the patient's available income, and their sum represented Medicaid expenditures without the annuity.[9]

[9] To reiterate, we assume that Arizona's Medicaid costs would be unaffected by any payments from patient income because of their LTC capitated payments. Any income above the limits would be paid to the nursing home directly.

Modeling resource constraints

In this and the following sections, we discuss the model in more detail and, when appropriate, provide the specific mathematical equations that we used in order to clarify the calculations. In reality, both assets and income eligibility rules apply and must be accounted for simultaneously. For ease of exposition, we'll examine them in sequence. We'll begin with the asset or resource eligibility process and we'll assume the presence of a community spouse because that is the more complicated case.

Denote the countable financial assets as *CFA* and the community spouse allowance as *CSA*. The *CFA* includes bank accounts and other financial assets, but not the home, car, or life insurance (up to a limit). Let us assume the 2004 CS asset allowance minimum of $18,552 and the maximum of $92,760 for purposes of this illustration. Under the base case, the annuity would not be counted as part of the *CFA* as long as it met the specific criteria we've discussed throughout this analysis. If the *CFA* is less than $18,552, all of it would go to the community spouse, but, let's examine the possible cases for amounts greater than that.

We'll start with the case when the *CFA* < $37,104. Then the *CSA* would be given by the following simple mathematical equation:

$$CSA = \max(CFA/2, \$18{,}552) \qquad (1)$$

This equation states that the countable assets are divided in half and the community spouse receives the larger of that amount or $18,552. Let's assume that the *CFA* was equal to $32,000. The community spouse receives the larger of half of that—equal to $16,000—or $18,552. The institutional spouse is only entitled to retain the asset spend down limit, denoted by *ASD*, which let us assume for this state is $2,000. He/she receives $2,000, but must contribute to the *CSA* to make up the difference between $18,552 and $16,000.

Let us turn to the implications for spend down. In simple mathematical terms, the amount of spend down, denoted by *SD*, would be given by:

$$SD = CFA - CSA - ASD \qquad (2)$$

In the current case, when the *CFA* was assumed to be $32,000, then spend down would be equal to $32,000 less the sum of $18,552 plus $2,000, or $11,448.

Let's turn next to the case when *CFA* ≥ $37,104. Then, the community spouse is provided with

$$CSA = \min(CFA/2, \$92{,}760) \qquad (3)$$

The maximum amount provided to the community spouse is $92,760 and everything above that must be used by the institutionalized spouse to pay for his/her LTC. The amount of spend down would still be given by equation 2, but must include equation 3 for the calculation of the *CSA*.

Suppose the *CFA* were $120,000. Half of the assets would be $60,000, but the institutionalized spouse (i.e., the Medicaid recipient) is only entitled to keep the asset spend down limit, or $2,000. Then the institutional spouse would have to spend down $58,000 before qualifying for Medicaid. If the *CFA* were $200,000, the community spouse receives $92,760, but now the amount of spend down by the institutional spouse would be equal to $200,000 less the sum of $92,760 and $2,000, or $105,240.

Income constraints and the costs of LTC

For brevity, we won't provide all of the other relationships or equations in the model, but rather briefly outline what the model does. With the exception of Arizona, as long as the family income is less than the cost of LTC, the spouse requiring LTC would meet the income eligibility requirements. The model then uses the family income and calculates anything left over after subtracting the personal needs allowance of the institutional spouse, any health insurance premiums that must be paid, and the community spouse minimum income. Anything greater than that amount must be paid to the nursing home, thereby reducing the cost to the Medicaid program. Because Arizona is an income-cap state, and provides a capitated payment for LTC, as long as the recipient is declared eligible for Medicaid any income that could be paid for LTC goes directly to the LTC contractor and has little effect on the state payment.

As long as there are spend down amounts to be paid, we assume that nursing home costs would be equal to the number of months of spend down as calculated at the nursing home private pay amount. Once spend down occurs and the beneficiary is now eligible the nursing home cost to Medicaid would be equal to the remaining months of care at the Medicaid rate less any contributions of income from the institutionalized spouse.

In a later section, we'll discuss our assumed values for nursing home costs and length of stays, but the cost of the annuity to the Medicaid program results from taking some of the assets that could have been used for spend down and converting them into a stream of income for the community spouse, exempting it from any payment for the LTC of the institutionalized spouse. If the annuity was purchased by the institutionalized spouse and he/she remains the beneficiary (this would include the case if the beneficiary were a child, other than one who is disabled or a minor), we include the income stream to his monthly income and adjust the cost to Medicaid appropriately.

Resource and income constraints

The model has been designed to capture the effects of the rules governing resource and income eligibility. Table 12 provides the assumptions on resource and income limits that we assumed in the model. It shows that the values are the same for all five states that participated in our study. These values pertain to fiscal year 2004 values. For example, although the maximum community spouse allowance was $92,760 in all five states in 2004, the value in 2000 was several thousand dollars less than that and we used the appropriate value for determining eligibility in our calculations.[10]

[10] We recognize that many of the variables required by our model, e.g., nursing home costs, resource limits, and income, vary and usually grow with inflation. We considered changing all values and inflating to the year in which all data were collected—2004—but then felt so many adjustments might lead to error. Therefore, we decided not to adjust most values, but rather to leave them in the current year dollars of when the application for Medicaid were made, tending to understate the cost to the Medicaid program.

Table 12. Asset and income assumptions (FY2004)

	Arizona	Maryland	Pennsylvania	Missouri	Nebraska
CS spouse allowance Minimum - Maximum	$18,552 $92,760	$18,552 $92,760	$18,552 $92,760	$18,552 $92,760	$18,552 $92,760
Asset spend down limit	$2,000	$2,500	$8,000	$1,000	$4,000
CS minimum income allowance (monthly)	$1,515, $2,319 max	$1,515, $2,319 max	$1,515, $2,319 max	$1,562, $2,319 max	$1,515, $2,319 max
Personal needs allowance (monthly)	$30	$50	$50	$50	$50
Divestiture penalty	$4,028 (urban) $3,744 (rural)	$4,300	$5,787	$2,685	Facility specific, but about $4,000

Nursing home stays and costs

In this section, we turn to a discussion of two key values that we needed in the model to estimate the cost of nursing home stays—the length of the stay and its cost. One assumption is that during spend down before eligibility, the private pay rate would apply, but it changes to the Medicaid rate when the applicant becomes eligible for the program. For example, in Arizona, the private pay rate is slightly over $4,000, but once the recipient becomes eligible LTC costs change to the state-imposed capitated rate of $2,700 in urban areas or $2,500 in rural areas.

Let's examine the length of time that we assume individuals would be in a nursing home. Note that we only observe how long they had been up to the time of our examining the case files. In other words, we know that recipients were receiving care and payments for their long-term care at the time we collected the data. But we don't know the entire completed stay, only the number of months up to the time when we collected the case file. These are all current cases and so presumably the stay will continue up through some unknown future time, either when the beneficiary is discharged from the nursing home or more likely, the beneficiary dies.

We needed to determine the length of stay in order to calculate a cost to the program of the annuities held by the LTC benefici-

aries. Several choices were open to us. One would be to assume an overall average number of months regardless of how long they had been receiving benefits thus far. Some patients might have been in LTC less than this average; others might have been in for a lot longer. A second alternative could be to use the actual number of months we observe.

We decided to assume that that the length of stay in the model would be the same for all—2.5 years, or 30 months. This was supported by the calculations of the average length of stay (from the date of the initial admission) in three empirical studies: 2.5 years [2], 2.4 years [3], and 2.7 years [4]. Thus, if we project that spend down of existing assets would take a total of 12 months, then the amount that Medicaid would have to pay for this recipient would total 18 months at the assumed Medicaid rate.

Next, we turn to the assumed rates we used in the model. Table 13 shows the values for the monthly Medicaid payments as well as the private pay amounts. We note that the average Medicaid payment for nursing facility care apparently exceeds the average private payment in all states, which is counterintuitive because the private per diem rate is expected to exceed the Medicaid per diem. The average private payment represents the total private expenditures divided by the total private patient days for 2002. The average Medicaid payment represents the total Medicaid expenditures divided by the total Medicaid patient days for the same year.

Although the private per diem rate almost always exceeds the Medicaid per diem at every level of severity in the same nursing facility, the average Medicaid payment could exceed the average private payment because of differences in patient behavior. For example, nursing facility patients typically enter as private patients and spend down to Medicaid. Over this time period, the patient often becomes more debilitated and, as a result, might qualify for a higher Medicaid rate than was paid as a private patient when they were less debilitated, or those patients who expect to pay for their entire stay as a private patient, being more cost conscious that Medicaid patients, might simply prefer to be admitted to a nursing facility with a lower per diem for both private and Medicaid patients. Thus, the average payment for pri-

vate patients in the state might be lower, even though the per diem is higher.

Table 13. Nursing home costs assumed in the simulation model

	Arizona	Maryland	Pennsylvania	Missouri	Nebraska
Average monthly Medicaid payment	$2,700	$5,215	$4,594	$3,232	$3,389
Average monthly private payment	$4,028	$4,628	$5,559	$2,878	$3,263

Estimates of the cost to Medicaid, by county and state

County cost estimates

With estimates of (1) the rate of annuity use, and (2) the Medicaid cost per annuitant, we can estimate the cost of annuities to Medicaid. A simple estimate of the cost of the annuity to Medicaid, one that represents an upper bound, is the purchase price of the annuity itself. In other words, if a $100,000 annuity were purchased by the Medicaid recipient, the purchase reduces the total assets of the family unit by $100,000, which could have been used to pay for the LTC. However, only under certain circumstances would the entire amount of an annuity be used for spend down. For example, large annuities would not reduce spend down dollar for dollar, given the average Medicaid payment rate and the 30-month stay we have assumed in our calculations.

To be more specific, let us denote the upper bound of the annuity's cost effect on Medicaid by CE^{UB}, the purchase price of the annuity by *PP*, and the maximum cost of a nursing home stay by the product of 30 (our assumed average length of stay) and the Medicaid payment rate, *MP*. We can then represent the upper bound effect of an annuity by the following simple expression:

$$CE^{UB} = \min(PP, 30 \times MP) \qquad (4)$$

In other words, without using the model described earlier to calculate our *best* estimate of the annuity's effect on Medicaid, the upper bound effect would the lesser of the purchase price and the direct payments that Medicaid makes for the LTC of this recipient. If the Medicaid payment rate were $4,000 per month, and the annuity purchase price were $175,000, the up-

per bound cost effect would be the lesser of $120,000 and $175,000, or $120,000.

Our model takes all such factors that might reduce the annuities' impact on Medicaid and calculates a more specific dollar value effect on the program. We can then compare what we derive from our model—i.e., the dollar effect on the program, which we denote as *CE*—with the upper bound given by equation 4. We compare the two values by simply calculating their ratio. A value of this ratio that is smaller than one means that the various constraints and other factors that the model takes into account lead to a smaller effect than simply calculating the upper bound.

Table 14 presents what we found by county. Under the base case in Pima County, for example, we calculate that the individuals who had purchased Medicaid annuities cost the program an average of almost $55,000 for their LTC expenses. That's the average value we calculate of current cases we collected. Under the counterfactual case, in which we assume the annuity was not purchased, leaving greater resources that could have been used for spend down, the cost to the program was almost $40,000. Thus, the purchase of the annuities in Pima County, which averaged about $58,000 across the 9 cases, cost the program about $15,000 per case. This implies that cost to the program relative to the average purchase price was about 25 percent.

Extrapolating to the state

Tables 12 and 13 list most of the important variables that we require for the simple calculation of the effects of annuities on state Medicaid spending, but we also require an estimate of the nursing home population in the state. In our search for an estimate, we found two different sources of the Medicaid LTC populations. One estimate came from the Medicaid Statistical Information System (MSIS) that can be found on the CMS Web site and listed values by state for FY2001 [5]. It pertains to the number of aged Medicaid recipients who received nursing home services in selected eligibility categories. A second estimate was included as part of study undertaken by the University of California, San Franciso and used the On-Line Survey, Certification, and Reporting (OSCAR) system that contains information from

the state surveys of all (about 17,000) certified nursing facilities in the U.S. [6].

Table 14. Calculating the annuities effects on Medicaid, by county

	CE	CE^{UB}	Ratio of *CE* to CE^{UB} (in percent)
Arizona			
Maricopa	$29,445	$59,546	49.5
Pima	$53,004	$81,000	65.4
Maryland			
Montgomery	$71,200	$102,483	69.5
Baltimore	$48,400	$107,814	44.9
Pennsylvania			
Allegheny	$31,828	$37,500	84.9
Erie	--	--	--
Nebraska			
Lancaster	$26,700	$51,700	51.6
Douglas	$51,500	$96,960	53.1
Missouri			
St. Louis	$23,000	$28,280	81.3
St. Charles	$35,768	$73,282	48.8
Jefferson	$23,864	$57,580	41.4

After examining the two estimates, we thought that the MSIS estimate was more directly related to the population—the medically needy—that we were interested in. This group includes those beneficiaries most likely to consider the purchase of Medicaid annuities. We thought the OSCAR estimate of nursing home residents might include not only the medically needy but those receiving SSI benefits. It turns out, however, that the OSCAR estimate's values for most individual states and in total was usually smaller than than that from MSIS. Because we cannot be sure which estimate is more appropriate for this analysis, we rely on both. The two estimates were reasonably close but, in total, MSIS implies a nursing home population about 15 percent larger than that derived from the OSCAR estimate. Because the estimates drawn from the OSCAR system contained several years of values, we used its ratio of 2003 to 2001 values in order to derive a MSIS estimate for 2003. The MSIS estimate is still the one we believe to be the more accurate of the two. Nonetheless, we have decided to calculate the state effects from both estimates of Medicaid nursing home residents and derive a range for our

state estimates, thereby providing at least one measure of sensitivity to alternative assumptions.

Table 15 shows the two estimates of nursing home residents for the five states in the study. We present the lower estimate from OSCAR first and then the MSIS estimate. For these five states, note that the OSCAR estimate is much lower in general, but especially for Arizona, due in part, we believe, to its not including those residents in home care. Therefore, we use the MSIS estimate only for Arizona in our results. In total, OSCAR yields a Medicaid-supported nursing home population in our study states of just under 100,000 and the MSIS estimate is more than 138,000.

Table 15. Estimates of Medicaid nursing home population

	OSCAR NH estimate	MSIS NH estimate
Arizona	7,325	21,685
Maryland	13,805	18,487
Pennsylvania	49,026	59,148
Nebraska	6,789	10,008
Missouri	22,509	29,206
5 state total	**99,454**	**138,534**

Table 16 presents the results assuming the two different estimates of the states' nursing home residents. Because one of the estimates for Arizona apparently only includes nursing home residents, but not those in home care, we rely on the larger value in both cases. The table presents the model-derived *CE* and together with the incidence rate, we can then project the number of annuity cases in each of the five states as well as the cost effects on Medicaid.

Table 16. Projecting the annuity effects on Medicaid, by state

	CE	Incidence rate (%)	Projected number of annuity cases		Projected cost ($M)	
			If based on			
			OSCAR estimate	MSIS estimate	OSCAR estimate	MSIS estimate
Arizona	$31,224	2.3	491	491	15.3	15.3
Maryland	$54,119	1.3	177	237	9.6	12.8
Pennsylvania	$31,828	0.4	218	263	6.9	8.4
Nebraska	$39,100	0.3	18	27	0.7	1.0
Missouri	$28,001	3.3	731	948	20.5	26.5
Total			**1,635**	**1,965**	**53.6**	**64.4**

The results in the table indicate that we would project a total number of Medicaid annuity cases across the five states between 1,635 and 1,965. Again, we assume the same value for Arizona, but in all other cases, the number of annuities we project based on the two alternative Medicaid nursing home counts, which we label NH estimates 1 and 2, differ by about 19 percent, with estimate 2 being higher in all four states. In terms of the cost effects on the program, we estimate the cost to the five states to range between just under $54 million and a little more than $64 million,or a difference between the two estimates of almost $11 million.

We should point out that these cost estimates represent a cost to the Medicaid program over the assumed 30-month stay in LTC. To annualize these values to a 12-month period, we simply divide each cost value by 2.5. Table 17 shows the new 12-month values, which range from a low of only about $400,000 in Nebraska to almost $11 million in Arizona.

Table 17. Projecting the annualized annuity effects on state costs ($M)

	If based on	
	OSCAR estimate	**MSIS estimate**
Arizona	6.1	6.1
Maryland	3.8	5.1
Pennsylvania	2.8	3.4
Nebraska	0.3	0.4
Missouri	8.2	10.6
Average	**21.4**	**25.8**

We turn next to the state-specific costs to the Medicaid program, given by *CE*, and compare our estimates to the upper bound effect, which we defined as the minimum of the purchase price of the annuity or the total payments made by Medicaid over the average 30-month stay. Table 18 compares our CE estimate to the upper bound effect, given by CE^{UB} below. We showed earlier that Arizona and Missouri had the largest incidence rates of the five states in our study and generally most of the largest annuities. We calculated an average effect on Medicaid of about $31,000 and $28,000 in these two states. We also calculated upper bound estimates of just over $60,000 in both states, resulting in ratios of the simulation model cost effect to the upper bound cost effect of about 52 and 46 percent, respectively. Maryland,

the other state for which we had several annuities, fell in this range as well.

Table 18. Comparing the state annuity effects, model-derived versus upper bound

	CE	CE^{UB}	Ratio of CE/CE^{UB} (in percent)
Arizona	$31,224	$60,108	51.9
Maryland	$54,119	$106,518	50.8
Pennsylvania	$31,828	$37,500	84.9
Nebraska	$39,100	$56,234	69.5
Missouri	$28,001	61,131	45.8

Grouping states by their annuity policies

Having obtained estimates for the five states that participated in the study, we then wanted to extrapolate the findings to other states. Recognizing that characterizing states as "similar" to those in our study has to be done with care, we tried to find those characteristics that would allow for this type of extrapolation. One characteristic might be the size of the Medicaid population; another might be the average income of the state's population.

We believe, however, that the most important characteristic for explaining the level of annuity use in the various states is their policies toward annuities. States with restrictive policies will tend to have fewer annuities; those with less restrictive policies will tend to have more. However, even this characteristic won't be the only factor. Arizona passed legislation to restrict annuity use, but the evidence we presented earlier is that it continues to have a relatively high incidence rate.

Therefore, we propose to group states by taking into account the available information about state policies on annuties and the presence or absence of a strong Medicaid estate planning industry. [11] The groupings would be as follows:

[11] Information on the Medicaid estate planning industry in the states comes from a survey of state Medicaid officials conducted by The Center for Long-Term Care Financing (Seattle, WA), which can be accessed at http://www.centerltc.org/survey_responses.pdf.

- Group 1: States that do not allow the use of annuities at all.
- Group 2: States that work to limit or restrict annuity use. Pennsylvania would be included in this group.
- Group 3: States in which annuities are permitted with the only restriction likely to be concerning the use of balloon annuities. This group would also include states with no information as the default group. Nebraska and Maryland would probably fall in this group.
- Group 4: States that have an active medicaid estate planning industry that promotes annuity use. Arizona and Missouri would fall in this group.

Using this grouping methodology for all states, we can derive a total population of all Medicaid-supported nursing home residents for each of the four groups, shown below in table 19. Appendix D shows each state's assumed group and its nursing home population. From the values shown there, we count 7 states in groups 1, 2, and 4, and 30 states in group 3 (we include the district of Columbia). Two of the states in our study—Arizona and Missouri—fall in group 4, another two—Maryland and Nebraska—fall in group 3, and the final state—Pennsylvania—falls in the group 2, the latter our assumed second most restrictive group of states. Note that we excluded those seven states that fall in the first group, because we believe they have all but regulated Medicaid annuities away as options for sheltering assets.

Table 19. Estimates of the total Medicaid-supported nursing home population

	Annuity restrictiveness group	OSCAR NH estimate	MSIS NH estimate
		Total across all states	
Arizona, Missouri	4	76,541	111,800
Maryland, Nebraska	3	491,021	538,511
Pennsylvania	2	218,018	267,194
State totals		**785,580**	**917,505**

Extrapolating to all states

With the number of nursing home residents provided above, we can use those values to extrapolate our results to the other states. Table 20 presents our extrapolated values to 43 states and

the District of Columbia. In the case of group 4, represented by Arizona and Missouri, we used a weighted average of their annuities to determine the group incidence rate and *CE*. However, for group 3, which is the largest group of states, represented by Maryland and Nebraska, we ended up using only the vaoues for Maryland. We found so few annuities in Nebraska that we felt we would likely understate the final cost implications for other states if we included the Nebraska values. Given the incidence rates and the nursing home estimates for each group, we can derive an estimate of the cost implications for the program across all states represented by the five in our study.

Table 20. Projecting the annuity effects on Medicaid, all states

	CE	Incidence rate (%)	Projected number of annuity cases		Projected cost ($M)	
			If based on			
			OSCAR estimate	MSIS estimate	OSCAR estimate	MSIS estimate
Group 2	$31,828	0.4	969	1,188	30.8	37.8
Group 3	$54,119	1.3	6,288	6,897	340.3	373.2
Group 4	$30,638	2.4	1,833	2,677	56.2	82.0
Total			**9,090**	**10,761**	**427.3**	**493.1**

As shown in the table, we project a total of between about 9,100 to more than 10,700 annuities across the U.S. and a total cost effect on the Medicaid program of between $427 million and almost $500 million. The largest group of states, those we refer to as group 3, represent just under two-thirds of the annuities and about three-quarters of the costs.

Finally, table 21 summarizes the findings by providing the annualized value, assuming the Medicaid-supported LTC estimate derived from MSIS. We also compare this value with the upper bound estimate, also calculated across all states in the three groups and also on an annual basis. The results show an annual estimate of the costs to the program of just under $200 million. This can be compared with the upper bound estimate derived across all states of about $376 million.

We can also compare our estimate with the value derived in [1]. Our estimate is much less than this alternative value, which was based on surveys of state Medicaid Directors. The latter estimate suggested an annual cost of Medicaid annuities of more than a billion dollars. Even the larger of the two estimates we derive

(based on the larger nursing home estimate) was less than $200 million, about one-sixth of the alternative estimate.

Table 21. Projecting the annualized annuity effects on Medicaid, all states

	Projected cost ($M)	Upper bound (CE^{UB})
Group 2	15.1	17.8
Group 3	149.3	293.8
Group 4	32.8	64.6
State totals	**197.2**	**376.2**

Conclusions and recommendations

From our interviews with consumer and industry representatives, state Medicaid policy officials, and county eligibility workers, we conclude the following:

- Although most of those interviewed offered at least one recommendation for addressing the use of annuities by Medicaid applicants to avoid asset spend down, there were a few interviewees who were reluctant to suggest that annuities were such a large problem that changes to Medicaid policy were needed.
- The consumer representatives interviewed felt that the real issue was protecting consumers from predatory marketing practices by salesmen willing to take advantage of the elderly. One of the industry representatives noted that an outright prohibition of annuities would be inadvisable because in some situations annuities are the best way to ensure that community spouses are able to maintain their standard of living after a spouse enters the nursing home.
- There was no universal recommendation concerning the policing of annuity use. Caseworkers were much more likely to suggest strongly regulating annuity use than were consumer and industry representatives. Only a few of the caseworkers felt that annuity use was not a problem and a few others felt that state and federal governments could focus on more fraudulent practices that present even bigger problems.
- Most county workers saw the federal spousal impoverishment rules as important but as more than sufficient for many, as well as unequal in their impact on poor versus middle class couples. One issue that might warrant attention is adjusting the standards for differences in the cost of living in various geographic areas.

- Caseworkers view the ability to purchase an annuity and qualify for Medicaid as removing any incentive to purchase long-term care insurance. They also react strongly to what they view as the unfairness of letting people who have resources and can pay for nursing home care enroll in Medicaid. They believe that Medicaid is a program that should benefit only the needy and disagree with attorneys and others who say that anyone can receive Medicaid to pay for LTC.

- In general, although all five states in the study currently use the SSI life expectancy tables (following CMS guidance) to determine if an annuity is actuarially sound, they do not feel these tables accurately represent the life expectancy of nursing home residents and would like to change this method to be more accurate. Based on their recommendations, we might recommend that other information, such as the average nursing home length of stay or documentation from a doctor regarding life expectancy, might be a better data source for determining the appropriate payout period.

- We were unable to conclude from those interviewed whether annuity use is growing or declining. We can say that the interviewees generally believe that annuity use is now, or soon will be, more of a problem for the Medicaid program. Those interviewed noted:

  — They are seeing a tremendous increase in the marketing of annuities to the elderly that uses avoidance of asset spend down as a selling point

  — Trusts were used excessively but are now restricted. They believe that applicants will turn to annuities and to the incorporation of assets, such a family farm or business, to achieve the same ends

  — The baby-boom generation is the first to save for retirement through vehicles like 401(k) plans, which suggests that they will have access to substantial savings at retirement. The implication for the Medicaid program is that much of these funds will be countable assets, and may lead to the purchase of Medicaid annuities should the need for nursing home care arise.

- State Medicaid officials in Pennsylvania and Arizona pointed to two sections in the U.S. code that are of particular relevance to the annuities issue—Section 1396p and Section 1396r(5)—that they feel contradict one another, allowing for the current use of annuities to circumvent community spouse income standards. They would like to see the statute modified (or a rule promulgated) to limit the amount that can be transferred for the benefit of the community spouse.
    - The states in our study believe they are themselves unable to change their programs' treatment of annuities without first being assured that these changes will receive federal support, or else that any changes made will result in unwinnable lawsuits.
    - States realize that what is needed is a policy that logically integrates the treatment of annuities, disposals, joint ownership, and other assets that pass outside of probate. They understand that restricting annuities may in turn give rise to some other method of artificial impoverishment on the part of Medicaid applicants. An integrated policy might help to stop the seemingly unending development of new methods for avoiding asset spend down.

Turning to the major conclusions from the focus groups, we can state that:

- Seniors apparently understand that Medicare doesn't pay for nursing home care, and that Medicaid does pay for nursing home care for those with few assets.
- Seniors want to pay their own way and don't feel it's "right" to buy annuities with the intention of sheltering assets so that others (i.e., their children or other taxpayers) would have to pay for their nursing home care instead.
- However, we discovered that after hearing more about annuities seniors were not too concerned about being able to afford nursing home care "today," at this time in their lives, but that paying for nursing home care could become a future problem. They began to consider annuities as an alternative and some felt that if it were truly legal and

aboveboard, it might represent a reasonable financial instrument to consider.

Finally, based on case file data collected in 11 counties in 5 states and our development of a simple simulation model to estimate the effects on the Medicaid program, we found the following:

- The incidence rate—i.e., the percentage of Medicaid LTC beneficiaries who had purchased a Medicaid annuity out of all of the Medicaid LTC beneficiaries—was relatively low, ranging from less than half of one percent in Pennsylvania and Nebraska, to a high of about three-and-one-quarter percent in Missouri
- The effect of these annuities on the Medicaid programs in the five states in our study ranged from about $1 million in Nebraska to $26.5 million in Missouri. Note that these numbers pertain to the assumed 30-month average stay in a nursing home.
- When extrapolated to other states across the nation, we estimate that the costs range between about $427 and $493 million, depending on the estimate of Medicaid beneficiaries in nursing homes.
- In annual terms, we conclude that the cost of the program would be as high as about $200 million, using the higher of the two nursing home estimates.

Overall, our findings suggest that Medicaid annuities do lead to additional Medicaid costs for the federal and state governments, but our estimate is probably less than most Medicaid officials perceive it to be. We note that there is a significant gap between the amount of money invested in Medicaid annuities by beneficiaries and spouses compared to the actual financial impact that the annuity has on Medicaid costs. Finally, our estimate is also significantly less than the only other study we have seen on the issue [1], which estimated a cost at about six times as high.

Appendix A: State Medicaid Official Interview Guide

In this appendix, we present one example of the interview guides that we used when we spoke to state Medicaid officials, county eligibility workers, and consumer and industry representatives. We're only presenting the guide for the interviews with state officials, but it represents an example of the kind of questions we asked during the interview process.

Interviewee Name: **State:**
Title/Office:
Interview Date:

Introduction: We are conducting a study for CMS' Center for Medicaid and State Operations examining the use of annuities to shelter assets for the purpose of becoming Medicaid eligible. We would like to ask you some questions about your State's Medicaid eligibility requirements, State policies related to annuities, and your perceptions of annuity use.

State Eligibility Requirements

1) What eligibility categories do institutionalized individuals generally qualify for Medicaid under in your State? How many Medicaid beneficiaries are currently institutionalized in long-term care facilities in your State? What percentage are they of the total Medicaid population? What percentage of total Medicaid dollars do they consume?

2) What are the current income and asset limits for these individuals? How do these limits differ for individuals vs. couples?

3) What are the income and resource allowances for community spouses under the spousal impoverishment rules?

4) Describe the income and resource methodologies your State uses to determine Medicaid eligibility for aged, blind, and disabled individuals. Does your State use the more liberal methodologies allowed under sections 1902(r)(2) of the Social Security Act? Is your State a 209(b) State with eligibility criteria that are more restrictive than the federal SSI standard?

5) Does your State place liens on the homes of institutionalized individuals? How is the Medicaid program notified when an institutionalized Medicaid recipient dies? Does the Medicaid program receive a notice from the probate court? Is the program limited to recovering assets from the probate estate only? Is there a target population for estate recoveries? Does the program track the estate of a surviving spouse or dependent children?

6) What is the monthly cost of a nursing home stay used by your State for the purpose of determining the length of the penalty period when inappropriate transfers of assets have occurred?

Treatment of Annuities

7) Where are State policies regarding annuity use and Medicaid eligibility located? That is, are requirements written into in State law, included in Medicaid program administrative policies, or simply informal understandings of county eligibility workers? If written policies exist, can we receive a copy?

8) How has your State operationalized federal requirements that States ensure annuities be 'actuarially sound'?

9) Does your State have policies that define the characteristics of eligible annuities purchased by those applying for Medicaid such as:

a. How the length of the annuity (i.e., life expectancy) is determined?
b. Whether an annuity must be irrevocable?
c. Whether balloon payments are allowed?

d. Who is allowed to receive the income stream from the annuity?
e. Who can be listed as the annuitant's remainder beneficiary
f. When payments from the annuity must begin
g. From whom the annuity can be purchased
h. Other policies defining eligible annuities?

10) How are annuity remainder amounts treated under the State's estate recovery program?

11) Has your State changed policies related to the use of annuities in recent years? What prompted this change?

Perceptions of the Use of Annuities and the Interaction between Medicaid Eligibility Requirements and the Attractiveness of Annuities

12) How frequently do you believe annuities are being used to shelter assets for Medicaid eligibility purposes? Is annuity use perceived to be a significant problem in this State?

13) What are the characteristics of the typical Medicaid applicant who uses annuities as an asset-sheltering device? Are annuity users more likely to be single or married? What is the typical age, gender, and level of assets owned? Are there other characteristics of the typical Medicaid applicant who uses annuities as an asset-sheltering device?

Data Availability

14) Do you have any state-level data available on the number of Medicaid applicants who have purchased annuities? What data are available for estimating the cost of annuity use to the State?

15) Has your State conducted any analyses of annuity-related issues? If so, what were the results? Has the State specifically analyzed the impact of any changes to their annuity policies?

16) What types of data collection and/or review would you like to see conducted on this issue by your State? …by the Federal Medicaid program?

Budgeting

17) Does your State acknowledge the use of annuities when forecasting estimates of Medicaid eligibles or during the budgeting process?

Legal challenges

18) Has your State faced any legal challenges related to State policies regarding the use of annuities by Medicaid applicants? What have been the outcomes of these challenges?

19) Has your State been required to modify its policies as a result of legal challenges? If so, how?

20) Has the State participated in any administrative hearings related to your annuity policies? If so, what were the outcomes of these administrative hearings?

Policy Recommendations

21) What specific areas of federal law or policy hinder States in addressing issues arising from the use of annuities by Medicaid applicants and/or recipients?

22) How have federal laws or policies assisted States in ensuring that inappropriate use of annuities is penalized?

23) Do you feel that your state has been aggressive in trying to restrict annuities and, if so, are you concerned that federal rules have inhibited your flexibility in doing so?

24) What specific policy changes would you like to see at the Federal level? At the state level?

Appendix B: State Policies Related to Annuities

This appendix provides state statutes regarding their respective annuity policies for three of the five states and in the case of Missouri, a proposed change in their regulations concerning the use of these financial instruments.

Missouri

State policies regarding annuities in the Medicaid eligibility determination process are included in the State's administrative manual for eligibility workers. It is online at:

http://www.dss.mo.gov/dfs/iman/index.html.

The relevant passages have been recreated below.

1030.030.00 Annuities
IM-73, December 20, 1995

An annuity must be evaluated to determine if it as available resource, a source of income or if a transfer of property has occurred. Many annuities are intended as retirement or investment plans, purchased without intent to gain eligibility for Medicaid. In other circumstances, some or all the funds used to purchase the annuity must be considered a transfer of property without fair and valuable consideration (Refer to Section 1040.020.35). Some annuities may be both a source of income and have a cash value that is an available resource.

1030.030.05 Definitions related to annuities
IM-73, December 20, 1995

Annuities involve persons in any of three capacities: as owner, as annuitant, or as beneficiary. The same person can hold any combination of capacities.

The **owner** is the person who buys the annuity or to whom the ownership has been transferred.

The **annuitant** is the person who will receive periodic payments from the annuity.

The **beneficiary** is the person who will receive benefits (a lump sum or periodic payments) after the annuity stops, either because the annuitant has died or the annuity's term has expired.

Other terms used in evaluating annuities:

Single Premium Annuity: An annuity purchased by making one single payment (premium) to fund the annuity.

Immediate Annuity: An annuity that begins periodic payments in the immediate next period. (For example, if an annuity will pay monthly, an immediate annuity begins paying the month following purchase.)

Deferred Annuity: An annuity, in which payments do not begin immediately. This is usually to allow for completing purchase of the annuity in installments or to allow for a later decision on how the annuity will pay out.

Start Date: The date on which the annuitant begins receiving payments from the annuity.

Period Certain Annuity: The period over which payments are guaranteed to be made to the annuitant, provided the annuitant lives for the entire period certain. If the annuitant dies before the period certain has expired, the beneficiary may receive the payments for the remainder of the period certain, or may receive a lump sum.

Life Annuity: Payments continue during the life of the annuitant, without regard to how long the annuitant lives.

1030.030.10 Annuities as an available resource
IM-73, December 20, 1995

The cash surrender value of an annuity owned by the claimant or spouse must be evaluated to determine its value as an available resource. The cash surrender value minus any surrender fees or other charges is counted as an available resource. Revocable annuities will always have a cash surrender value, irrevocable annuities generally will not.

Example: Mrs. Bodoni applied for Medicaid in June 2002. Mr. Bodoni bought an annuity for $50,000, also in June 2002, which can be surrendered with a 7% surrender charge in the first year. Consider $46,500 ($50,000 - $3,500) as an available resource.

If the claimant or the spouse is not the owner, then none of the annuity's CSV is a resource to the claimant. It does not matter whether the claimant or the spouse is also the annuitant.

Example: Herman Melior bought a $40,000 annuity for his daughter, Katherine. Katherine has applied for Medicaid. Since Katherine is not the owner of the annuity, do not consider any of its value as available to her.

Nebraska

Nebraska policies regarding the treatment of annuities are in the Nebraska Health and Human Services Manual. In the process for determining Medicaid eligibility, annuities are treated like trusts in the sense that both annuities and trusts are sent to the central office for review. They are not lengthy and can be found online at :

http://www.sos.state.ne.us/business/regsearch/Rules/Health_and_Human_Services_System/Title-468/Chapter-2.pdf.

The manual contains the following paragraph about annuities: 2-008.07A5c Annuities: An annuity may be treated as a trust in that it is a legal entity created by a grantor for the benefit of a designated beneficiary (ies). Where the client cannot access the principal, the annuity is unavailable. A determination must then be made if a deprivation has occurred. If the expected return on the annuity is commensurate with a reasonable estimate of the

life expectancy of the client, the annuity can be deemed actuarially sound and no deprivation has occurred. If the average number of years of expected life remaining for the client do not coincide with the life of the annuity (i.e., the client is not reasonably expected to live longer than the guarantee period of the annuity), a deprivation has occurred.

The look back period is the same for trusts, i.e., 60 months.

Arizona

Arizona Revised Statute 36-2934.02. Financial instruments; eligibility for the system

> A. The administration has sole authority to determine the effect of annuities, promissory notes, loan agreements and related financial instruments on a person's eligibility pursuant to this article.
>
> B. An irrevocable annuity purchased with an applicant's assets is treated as a transfer with uncompensated value pursuant to section 36-2934, subsection B unless it meets all of the following:
>
> 1. It is purchased from a life insurance company or another commercial company that sells annuities as part of the normal course of business.
>
> 2. It provides substantially equal monthly payments of principal and does not have a balloon or deferred payment of interest or principal.
>
> 3. It is an annuity currently issuing payments for the person or that person's spouse.
>
> 4. It will return the full principal and interest within the annuitant's life expectancy.
>
> C. An irrevocable annuity that meets the requirements of subsection B of this section is a transfer with compensated value.
>
> D. The fair market value of a promissory note, loan agreement or related financial instrument that is nego-

tiable, assignable and enforceable is a countable resource.

E. A promissory note, loan agreement or related financial instrument that does not comply with subsection D of this section is a transfer with uncompensated value. For a promissory note, loan agreement or related instrument that does comply with subsection D of this section, the difference between the outstanding principal balance and the fair market value is a transfer with uncompensated value.

Proposed Missouri statute

Current Bill Summary

SB 1300 - This act prohibits the sheltering of certain assets by individuals in long-term care facilities.

Assets used for the purchase of an annuity shall be treated by the Department of Social Services as an available resource unless:

-the annuity was purchased more the 5 years prior to the individual entering a long-term care facility; or

-the annuity is actuarially sound as measured against the Social Security Administration Life Expectancy Tables; and

-the annuity provides equal payments for its' duration; and

-the annuity provides Missouri with secondary or contingent beneficiary status in an amount equal to the medicaid expenditure made on the individual's behalf.

The Department shall have rule-making authority to implement this act.

In addition, the Department is required to enforce TEFRA liens on permanently institutionalized individuals, who the Department determines cannot reasonably be expected to be discharged and returned home.

APPENDIX C: Focus group discussion guide

I. Introduction

A. Moderator

B. Focus Group

C. Facility

1. Microphones / Audio Taping

2. Video Cameras / Video Taping

3. Observers

D. Notes from observers

E. Respondents

F. Topic For Focus Group

Long-term care

A. We're going to be talking about long-term care. Have any of you given any thought to whether or not you or your spouse or partner may, in the future, need to enter a nursing home for long-term care?

1. For those of you who don't believe you will enter a nursing home and need long-term care in the future, what are your reasons for feeling this way?

a. Why do you say that?

b. What else?

2. For those of you who do believe you will enter a nursing home and need long-term care in the future, what are your reasons for feeling that way?

a. Why do you say that?

b. What else?

3. Have you given any thought to how much long-term care may cost?

a. What have you heard or read about the cost?

b. What else?

4. Have you looked into how much long-term care would cost in this area?

a. Why? Why not?

b. What have you learned about the costs?

c. Approximately, how much does long-term care cost? Where did you learn about this?

5. Have you thought about how you might afford to pay for long-term care?

a. Have you done any planning? What?

b. Have you set aside any money for this? What?

B. If not mentioned previously: What, if anything, have you heard or read about Medicaid and reimbursement for long-term care?

1. Have you heard or read about Medicaid eligibility rules for reimbursement related to long-term care?

2. If yes: What have you learned? What else?

Annuities and Medicaid

A. Now lets spend some time talking about annuities. What, if anything, have you heard or read about annuities?

1. What benefits, if any, are there to annuities?

a. Why do you say that?

b. What else?

2. Do any of you own any annuities?

a. What were your reasons for investing in an annuity?

b. What do you expect as a return for this investment? What else?

B. Have any of you considered using annuities as a way of planning for long-term care?

1. If yes: What have you learned?

2. If yes: What, if anything, have you done? What else?

3. Have you heard of the idea of spending down your assets in order to qualify for Medicaid?

a. What have you heard?

b. What else?

C. Introduce the following information

1. Medicaid eligibility for the State

2. Information about annuities

3. Information about how pwople applying for Medicaid can use annuities

D. What are your reactions to the idea of using annuities as a way of planning for long-term care? Using annuities for Medicaid estate planning?

1. Why do you say that?

2. What else?

E. What, if anything, do you like about this idea?

1. Why do you say that?

2. What else?

F. What, if anything, do you not like so well about this idea?

1. Why do you say that?

2. What else?

G. Do you think this could be an effective way for people to plan for long-term care? For becoming eligible for Medicaid?

1. Why do you say that?

2. What else?

H. Do you think people should be able to use annuities in this way?

1. Why? What else?

2. Why not? What else?

Appendix D: Medicaid nursing home estimates

In this appendix, we present two estimates of the number of Medicaid nursing home beneficiaries in each of the states, including the 5 states that were part of our study (highlighted in table D-1). The two estimates came from [5] and [6], respectively and we decided to use both in order to provide a range for our estimates. The two estimates were reasonably close, but the MSIS estimate was higher overall by about 15 percent. That was not always the case, however, in each state. We should also point out that Arizona's values are very different and we surmise that the estimate in [6] only included nursing home residents and did not include those receiving benefits at home. Therefore, we rely only on the second, and higher, estimate.

In addition to the estimates of the beneficiaries, we also include the group values, 1 through 4, that we discussed in the section on how we extrapolated our findings on the Medicaid effects of annuities to other states. Our grouping were based on the restriveness of their annuity policies. Group 1 states do not allow the use of annuities, group 2 states restrict or limit their use, group 3 states are permitted with few restrictions, such as not allowing balloon annuities, and group 4 states have an active elder law bar and financial planning industry that promotes annuity use. For example, we classify Arizona and Missouri as group 4 states, Pennsylvania as a group 2 state, and Maryland and Nebraska as group 3 states.

Table D-1. Medicaid nursing home beneficiaries, by state

	2003 estimates		
State			Group number
Alabama	15,860	17,698	1
Alaska	476	407	3
Arizona	**7,325**	**21,685**	**4**
Arkansas	12,230	15,053	1
California	68,842	74,440	3
Colorado	8,947	7,359	1

Connecticut	17,388	19,853	1
Delaware	2,010	2,449	3
Dist.of Columbia	1,790	2,275	4
Florida	42,040	29,114	3
Georgia	26,151	31,504	4
Hawaii	1,961	1,247	3
Idaho	2,690	4,240	3
Illinois	44,963	41,133	3
Indiana	24,832	27,743	1
Iowa	12,635	17,118	3
Kansas	10,310	13,018	3
Kentucky	15,182	18,507	3
Louisiana	20,709	21,532	2
Maine	4,288	6,173	3
Maryland	**13,805**	**18,487**	**3**
Massachusetts	29,120	17,612	3
Michigan	27,500	31,977	3
Minnesota	18,693	27,770	2
Mississippi	10,549	12,894	3
Missouri	**22,509**	**29,206**	**4**
Montana	3,033	3,683	4
Nebraska	**6,789**	**10,008**	**3**
Nevada	2,664	2,847	1
New Hampshire	4,583	7,401	3
New Jersey	26,598	26,805	1
New Mexico	4,178	5,705	3
New York	78,822	113,169	3
North Carolina	25,176	15,227	3
North Dakota	3,298	4,274	2
Ohio	46,895	59,058	2
Oklahoma	13,934	33,467	3
Oregon	4,909	7,966	4
Pennsylvania	**49,026**	**59,148**	**2**
Rhode Island	2,506	3,402	3
South Carolina	10,824	15,480	4
South Dakota	3,764	4,657	3
Tennessee	21,789	10,884	3
Texas	58,089	69,987	2
Utah	2,876	3,663	3
Vermont	2,139	2,949	3
Virginia	17,231	20,013	3
Washington	12,625	15,903	3
West Virginia	6,885	1,328	3
Wisconsin	22,387	25,424	2
Wyoming	1,350	1,920	3
Total	897,181	1,034,863	

References

[1] Coates, Andrew, Michael Deily, Greg Elig, George Hoover, Kathy Plant, Dennis Priest, Betty Rice, Meredith Van Pelt. *The Role of Annuities in Medicaid Financial Planning: A Survey of State Medicaid Agencies*. Washington, DC: American Public Human Services Association, National Association of State Medicaid Directors, October, 2003.

[2] Liu, Korbin, Kenneth Manton. "Nursing Home Length of Stay and Spend down in Connecticut, 1977-1986," The Gerontologist vol. 31, no. 2, 1991, pp. 165-173.

[3] Bice, TW, C Pattee. "Nursing Home Stays and Spend Down in the State of Connecticut: 1978-1983 Admission Cohorts," Final Report. Hartford, CT: Connecticut Department of Health Services and the US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, October 1990.

[4] Murtaugh, Christopher M., Peter Kemper, Brenda C. Spillman, Barbara Lepidus Carlson. "The Amount, Distribution and Timing of Lifetime Nursing Home Use," Medical Care vol. 35, no. 3, March 1997, pp. 204-18.

[5] Center for Medicare & Medicaid Services. Medicaid Statistical Information System. Statistical Reports for 2001. Website: <http://www.cms.hhs.gov/medicaid/msis/msis99sr.asp>, accessible January 14, 2005.

[6] Harrington, Charlene, Carillo, Helen, and Crawford, Cassandra S. "Nursing Facilities, Staffing, residents, and Facility Deficiencies, 1997 through 2003." Can be accessed at http://www.nccnhr.org/public /245_1267_9316.cfm .

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