
Rethinking Annuities Amid Medicaid Reform

John Zepeda, J.G. Wentworth

Provided by:

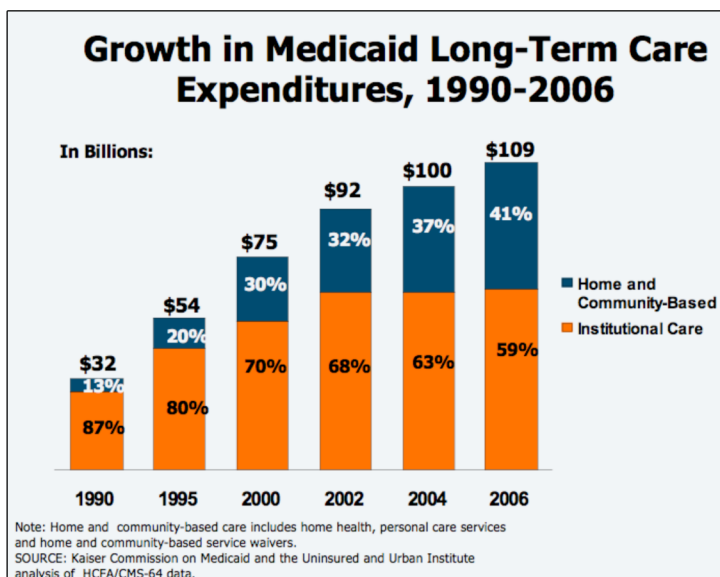


Rethinking Annuities Amid Medicaid Reform

Deficit reduction is difficult work. Every government program, while wasteful to some, is vital to others.

As a result, when looking at ways to control the costs of Medicaid – the state and federal government-sponsored health insurance program for the needy ushered in during the Johnson administration in the sixties – the choices are difficult for consumers, state governments and the federal government.

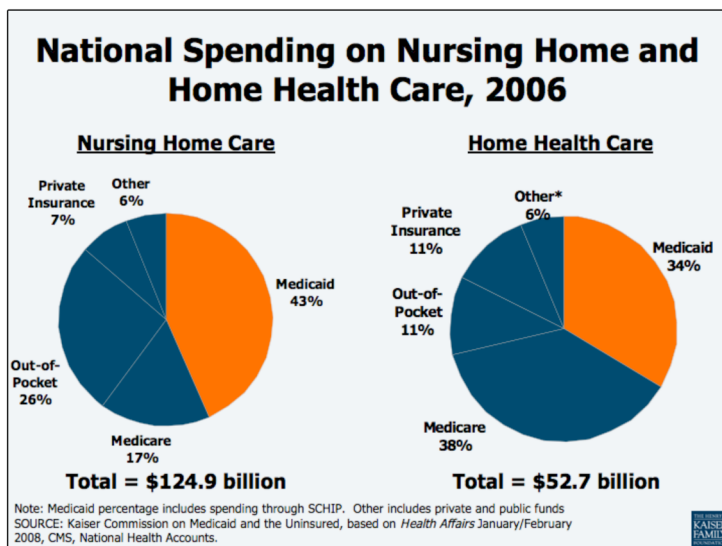
These choices are embodied in the Deficit Reduction Act of 2005. Ultimately, the reforms in the DRA have the potential to reduce the growth in annual mandatory Medicare and Medicaid spending by \$40 billion over the next five years.



Compound annual growth in Medicaid long term care expenditures of nearly 8% per year is straining state and federal budgets.

The DRA is sweeping legislation that seeks to accomplish this through a package of incentives, partnerships, pilot programs, and by providing states with new levels of flexibility to fulfill their Medicaid obligations.

By far however, one of the most important aspects of the bill are the provisions related to the transfer of assets. The Health & Human Services Department's Centers for Medicare & Medicaid Services (HHS CMM) notes on its website that:



Medicaid is now the largest payor for nursing and home health care services in the United States.

“Some individuals, with assistance from financial planners and attorneys, have developed methods of arranging assets in such a way that they are preserved for the individual and/or family members, but are not countable when Medicaid eligibility is determined. Various techniques are used to artificially impoverish Medicaid applicants, including gifting of assets to family members, investing assets in financial instruments that are inaccessible, and executing financial transactions for which fair market value is not actually received.”

The HHS CCM further notes that the Deficit Reduction Act “includes several provisions designed to discourage the use of such ‘Medicaid planning’ techniques and to impose penalties on transactions which are intended to protect wealth while enabling access to public benefits.”

The somewhat pejorative language used to describe the transfer of assets and the ultimate effects of such strategies is not limited to the Health and Human Services department, which is charged with overseeing the Medicaid program.

In a February 8, 2006 press release accompanying the signing of the Deficit Reduction Act, the White House noted that prior regulations allowed applicants to “game” the system.

The state of Connecticut posted the following consumer advisory notice on the Health and Human Services section of its website:

“Contrary to what you may have heard in a recent seminar or read in advertisements or articles, in Connecticut there is no such thing as an annuity that will guarantee avoidance of Medicaid spend-down rules! According to the Connecticut Department

of Social Services' Medicaid Office, those selling these financial planning tools, often referred to as 'Medicaid Annuities' are misleading residents into believing that these annuities will allow individuals to protect (keep) assets and/or income and still be eligible for Medicaid."

In our opinion, the strident language used by regulators at several levels suggests not just frustration, but a heightened degree of determination to enforce the regulations pertaining to the transfer of assets. Accordingly, seniors as well as the professionals who advise them must gain a new understanding of Medicaid eligibility and the treatment of certain assets which affect this eligibility.

This paper will provide an overview of the key Transfer of Asset provisions of the Deficit Reduction Act of 2005. In addition, it will examine more closely the treatment of annuities, since they represented a staple of financial planning strategies to preserve Medicaid eligibility for millions of seniors. Finally, this paper will provide some insight on the secondary market for annuities and the role that it plays in helping seniors and their advisors address Medicaid eligibility issues in light of the Deficit Reduction Act.

Key Transfer of Asset Provisions in the DRA

The following overview of the Transfer of Asset Provisions was largely excerpted from the Health and Human Services Centers for Medicare & Medicaid Services. Taken together, these provisions substantially tighten the treatment of almost all of the financial resources of applicants when determining Medicaid eligibility.

Extension of Look-Back Period and Beginning Date of Penalty Period

When an individual applies for Medicaid coverage for long-term care, states conduct a review, or "look-back," to determine whether the individual transferred assets (e.g., cash gifts to children, transferring home ownership) to another person or party for less than fair market value (FMV).

The DRA lengthened the "look-back period" to 60 months (five years) prior to the date the individual applied for Medicaid. Previously, the look-back period was 36 months, though there was variance on the look back period among states. When individuals transfer assets at less than FMV they are subject to a penalty that delays the date they can qualify to receive Medicaid long-term care services. Previously, the penalty period began with the month the assets were transferred. This provided an opportunity for individuals to avoid part or all of a penalty by transferring assets months or years before they actually entered a nursing home. Under the DRA, the penalty period for transfers made on or after February 8, 2006,

now begins on either the date of the asset transfer or the date the individual enters a nursing home and is found eligible for coverage of institutional level services that Medicaid would pay for if it were not for the imposition of a transfer penalty—whichever is later.

Impacts:

- Increases degree of difficulty associated with application process.
- Likely increase in Medicaid denials for lack of documentation associated with asset sales.
- Likely increase in transfer penalties.

Treatment of Annuities

Prior to the DRA, annuities were often used to shelter assets, especially in situations where one member of a couple entered a nursing home. To discourage the use of annuities to shelter funds for heirs while qualifying for Medicaid long-term care services, the DRA changed the treatment of annuities. As a condition of eligibility for coverage of long-term care services, Medicaid applicants are now required to disclose any interest in an annuity. Also, in some states, annuity owners must name the state as the primary remainder beneficiary (or as the second remainder beneficiary after a community-based spouse or minor or disabled child) for at least the value of the Medicaid assistance provided. If the annuity does not name the state as a remainder beneficiary in the proper position, the annuity may be treated as a transfer of assets for less than fair market value. The full purchase price of the annuity is the amount that is subject to penalty.

Annuities purchased by or on the behalf of an individual who applied for Medicaid coverage for long-term care shall be treated as an asset transfer for less than FMV unless the annuity meets certain requirements pertaining to retirement plans as set forth in the Internal Revenue code, or unless the annuity is irrevocable, non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

Impacts:

- Reduction of the sale of “Medicaid Annuities”
- Increase in assignment of annuity benefits to states
- Increase in the outright sale of annuity prior to the application for Medicaid benefits.

Life Estates

Under a typical life estate, an individual transfers ownership of his or her own home or other property to another person; for example, a son or daughter, but retains a right to live in the home for the remainder of the individual's life. However, some individuals have used this planning mechanism to purchase a life estate in another

person's home, but without intending to ever reside in that home. This type of life estate transaction is really just an attempt to transfer assets for less than fair market value to someone else. To prevent this, the DRA requires that the purchase of a life estate interest in another person's home be treated as a transfer of assets for less than FMV unless the purchaser actually lives in the home for at least one year after the date of purchase. Additionally, even if the individual lives in the home for at least one year, if the purchase amount of the life estate is greater than the computed value of the life estate's interest, the difference is considered a transfer for less than fair market value that may be subject to penalty.

Impacts:

- Reduction in the purchase of life estates by seniors.
- Increase in transfer penalties.
- Lengthening of application period when questions arise regarding the fair market value of the life estate's interest.

Note and Loans

The DRA requires that states now consider the purchase of a promissory note, loan or mortgage as a transfer of assets for less than fair market value, and thus subject to penalty, unless the following conditions are met: (1) the repayment terms are actuarially sound; (2) payments are made in equal amounts with no balloon payments; and, (3) the note, loan or mortgage prohibits cancellation of the debt upon the death of the lender.

Impacts:

- Reduction of financial transactions between affiliated parties for gaining Medicaid eligibility.

Mandatory "Income First" Rule

The "income first rule" applies when determining whether to allocate additional resources to the community spouse to bring that spouse's income up to the minimum monthly maintenance needs allowance under the Medicaid spousal impoverishment provisions. The DRA requires states to first assume that all income that could be allocated from the institutionalized spouse to the community spouse has been allocated to that spouse before allocating any additional resources. More than half of the states already applied this rule before enactment of the DRA.

Impacts:

- Requirement for more advance planning regarding income needs of institutionalized and community (i.e. not resident in a healthcare facility) spouse.

Excluded Coverage for Substantial Home Equity

The DRA requires states not to pay for Medicaid long-term care services for an individual whose equity interest in his or her home exceeds a certain level. The home equity cut-off is \$500,000, but states can elect to increase that amount up to \$750,000. There is an exception to this requirement for individuals with a spouse or a minor or blind or disabled child residing in the home. Also, states can elect not to apply this provision in cases of documented hardship.

Deposits with Continuing Care Retirement Communities (CCRCs)

The deposits typically required for a CCRC require an entrance deposit, which can be substantial. These entrance deposits are usually placed in an escrow account. Previously, these funds or deposits were excluded from a person's countable resources when determining Medicaid eligibility because they could not be accessed by the applicant. Now, the DRA requires states to consider these funds as countable resources when determining eligibility for Medicaid, provided:

- The funds can be used to pay for care under the terms of the individual's contract with the facility should other resources of the individual be insufficient
- The entrance fee (or remaining portion) is refundable when the individual dies or elects to leave the CCRC
- The entrance fee confers no ownership interest in the community.

The Transfer Penalty

The DRA not only tightened the rules concerning the treatment of assets, but also imposed a penalty for transferring them for less than the fair market value (FMV). In general, the penalty is calculated as follows:

$$\text{Dollar Value of Assets Transferred at Less Than FMV} / \text{Avg. Monthly Cost of Medicaid Benefits} = \text{Months Ineligible for Medicaid Benefits.}$$

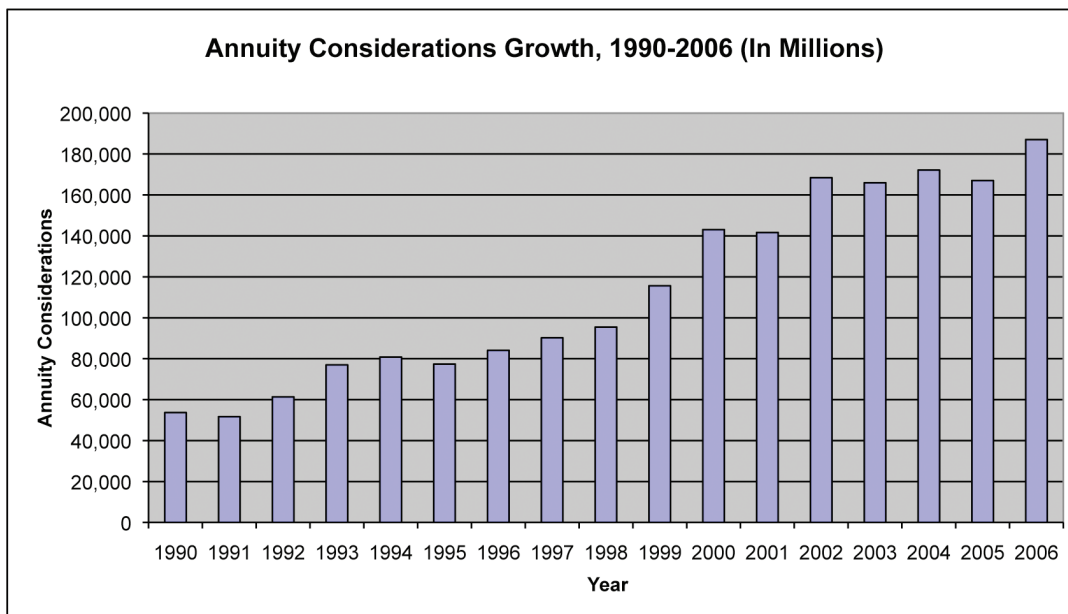
For example, if an applicant transferred property at \$80,000 less than fair market value, and the average monthly cost of care in the applicant's state is \$4,000, the penalty period would be 20 months.

$$\$80,000 / \$4,000 \text{ per month} = 20 \text{ months}$$

The transfer penalty combined with the extension of the look-back period to five years conspire to dramatically reduce and/or defer Medicaid eligibility for many applicants.

Implications for Annuities

One of the reasons that the treatment of annuities is so important is because of the volume of annuities in force. Specifically, since 1990, more than \$1.9 trillion has been invested in annuities.



Source: 2007 Life Insurers Fact Book, American Council of Life Insurers.

Obviously, not all of these annuities were purchased for the express purpose of helping to qualify for Medicaid. But if even if a small percentage were, with nearly \$2 trillion paid in, the implications are serious and far reaching for individuals and couples.

From our perspective as a buyer of annuities, we have seen states focus on the annuities of their Medicaid applicants with varying degrees of intensity and sophistication. In our experience, the following states are among the most pro-active in their treatment of applicant's annuities:

- | | |
|--------------|--------------|
| Oklahoma | Connecticut |
| Kansas | New Jersey |
| North Dakota | Pennsylvania |
| South Dakota | Arizona |
| Wisconsin | Kentucky |

Moreover, our experience in this marketplace suggests that a notable exception for annuities – non assignability – has not stopped Medicaid administrators at the state

level from seeking further clarification on whether or not the funds in an applicant's annuity are accessible. Frequently, applicants are asked to get letters from annuity buyers documenting that their annuity cannot be purchased. Because assignability is not uniformly defined among insurers, and because the right to receive payments may be transferred without assigning the underlying annuity assets, many annuity owners find that their asset can indeed be sold. Thus, whether or not the insurance company states that an annuity has no cash value becomes irrelevant. If a willing-and-arms-length buyer can and will purchase an annuity, it has value.

This has proven productive for Medicaid administrators trying to reduce the disbursement of benefits to applicants with the financial resources to pay for them, and painful and frustrating to those who believe they are entitled to benefits, or those marginally unqualified for benefits.

Options for Annuity Owners

Although the treatment of annuities has changed dramatically, individuals who bought annuities and believed that they would still be able to access benefits are not without options. Specifically they can:

1. Name the state as the primary remainder beneficiary (or as the second remainder beneficiary after a community-based spouse or minor or disabled child) for at least the value of the Medicaid assistance provided.
2. Pay the transfer penalty, i.e. defer the assumption of Medicaid benefits for the prescribed period and find alternative ways to finance needed care.
3. Sell the annuity prior to applying for Medicaid benefits.
4. In some states, name the state as a beneficiary.

Option 1 above may be generally unappealing to many applicants and their families. Settling an estate can be difficult under optimal conditions. Having the state maintain an interest in these proceedings presents a number of legal and logistical issues that many families may not want to voluntarily enter into. Moreover, given the limitations and risks that such an arrangement presents to state Medicaid organizations, and given the peculiarities of Medicaid administration across counties, regions and states, applicants may or may not find this option viable or available.

Options 2 and 3 above are similar in that they both may require, ultimately, the sale of the applicant's annuity. Option 3 may be superior in that it offers applicants the opportunity to make a "cleaner" application for Medicaid benefits unencumbered by the delay of a penalty period. Under circumstances of serious illness or the sudden deterioration of health, this may be a material difference.

Considerations When Selling An Annuity

While the secondary market presents significant, potential flexibility and value to annuity owners, getting the best deal still requires some research. What follows are some tips and strategies to help annuity owners make the most of the opportunity to sell their annuity to qualify for Medicaid benefits:

1. Call the insurance company to verify the cash surrender value, if there is one. Annuity owners should determine what options, if any, are available to cash out the annuity with the issuing insurance company directly. If it's an immediate annuity, it's important to learn if the annuity has any cash value from the insurance company – in most cases, the insurance company won't provide a lump-sum from an annuity once the periodic payments have started. If it's a deferred annuity, it's important to learn if the annuity has "surrender charges" which lower the current cash value or if the annuity requires that payments be taken over a minimum of five or 10 years to get the full value.
2. Determine which annuities can be sold in the secondary market. There are plenty of misconceptions about which types of annuities can be sold in the secondary market, so it's important for an individual to contact a reputable buyer of annuities in this market to verify whether their annuity has any cash value. The language in annuity contracts can be confusing. Specifically, some annuities that appear to have no cash value may in fact be salable in the secondary market for a cash lump-sum. So, while it's important to get information from the issuing insurance company, it's even more important to talk to experts in the secondary market when considering the salability and value of a policy in this marketplace.

The main criteria underlying the entire market is that annuities must have a non-qualified tax status. In other words, annuities with a retirement tax status as defined by the IRS (e.g. 401k/403b/IRA Rollovers) cannot be sold in the secondary market. Beyond that, most other annuities can be sold in this marketplace and it's just a matter of determining how much a given policy is worth. As the case is with most other industries, certain players specialize in certain types of policies (e.g. not all providers can buy a life-only payment stream or a variable annuity), so annuity owners shouldn't limit their research to one provider if they hope to get a broad perspective of all their options in this market.

3. Contact reputable buyers of annuities to determine the value. While determining whether or not an annuity can be sold produces an exact answer, the ultimate value of an annuity may be subject to variance from buyer to buyer. This process should cost nothing and should come with no obligations to sell the annuity. When it comes time to sell the annuity, it's advantageous to work with a company that has a solid track record of providing service and value to annuity owners in this marketplace.

4. For annuities in payout, consider how much of the current payment must be sold in order to qualify for Medicaid benefits. One of the real advantages of the secondary market is how much flexibility it offers annuity owners. They don't have to sell their entire payment or the full term. They can sell just a portion. At the same time, if they wanted to maximize their current cash value to pay for immediate care, they could sell the entire annuity, and that full value could be put to use in maintaining their health.
5. Understand the tax impact. There may be a tax impact as a result of selling your annuity. The advice of a qualified tax or legal advisor should be sought, since the tax impact, if any, may affect Medicaid eligibility.

Summary and Conclusions

The Deficit Reduction Act offers a meaningful prospect for Medicaid reform and overall reductions in Medicaid expenditures by the states and the federal government. Budget constraints at the state level in particular are providing new levels of resolve to reduce Medicaid expenditures. While these gains represent progress from a budgetary perspective, they nonetheless represent a challenge, and perhaps a point of pain for individuals who believed, and in fact counted on, access to these government benefits. In our view, more education among consumers as well as the legal and financial advisors who represent them will be an important factor in achieving ongoing reductions in cost. With some \$2 trillion invested in annuities, the states, the federal government and Medicaid applicants will be dealing with the implications of the Deficit Reduction Act for some time to come. We believe that over time more states will adopt the model of the State of Connecticut – which severely restricts if not eliminates the use of annuities to shelter assets and preserve access to Medicaid benefits – and as a result, place more of a premium on understanding the benefits and value which can be derived from the secondary market for annuities.

About the Author

John Zepeda is a senior salesman for J.G. Wentworth and focuses on the firm's Medicaid annuity sales. J.G. Wentworth is the largest buyer of annuities in the United States. Since 1992, the firm has purchased more than \$3 billion of annuities from consumers. For more information, call John at 866-433-9572 or email him at jzepeda@jgwentworth.com.