COMMENT: LONG-TERM CARE ALERT: AN ANALYSIS OF DELAWARE'S APPROACH TO MEDICAID PLANNING TECHNIQUES AND WHY CURBING MEDICAID PLANNING WILL NOT SOLVE THE NATION'S LONG-TERM CARE PROBLEM

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I. INTRODUCTION

America's population is aging rapidly. The population over age sixty-five grew by thirty-six percent between 1980 and 2000.[1] By 2030, one in five people will be over the age of sixty-five (approximately 71.5 million people).[2] The number of people over the age of eighty-five is expected to triple by 2030.[3] While the growth of the elderly population increases, the growth of the younger population decreases.[4] The U.S. Census Bureau estimates that by 2025, the number of people ages sixty to sixty-nine will be increasing at a faster rate than the number of people aged twenty to twenty-nine.[5]

This demographic shift is beginning to put a strain on the nation's resources for the elderly, especially in terms of long-term care. As the population ages, needs for health care, long-term care, skilled-nursing, and assisted living facilities are increasing. As a result, the key providers of funds for these needs, like the government's Medicaid program[6] and individual families' private resources, are being pushed to the limit. Costs for these benefits are high. For example, the cost of one month of long-term care (one month in a nursing home) in this country can range from $4,000 to $7,000 a month. If a person has worked hard to save $100,000 over a lifetime and enters a nursing home, where the monthly bill is $5,000 (excluding the costs of medication, the telephone and cable bills, and other extras), his or her life savings will be depleted in less than two years!

This paper explores how the long-term care portion of the Medicaid program functions. It also describes how, in reaction to the high cost of long-term care in this country and to the fear of losing their life savings, people are

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1. SOC. WORK LEADERSHIP INST., POPULATION AGING, http://www.socialworkleadership.org/sw/institute/aging.php, (last visited January 2, 2006).

2. Press Release, Nat'l Ass'n of Area Agencies on aging (n4a), The Maturing of America: Getting Communities on Track for an Aging Population – New Initiative Funded by MetLife Foundation (Aug. 16, 2005), http://www.n4a.org/pressrelease53.cfm.

3. SOC. WORK LEADERSHIP INST., *supra* note 1.

4. *Id.*

5. *Id.*

6. NAT'L GOVERNORS ASS'N, MEDICAID REFORM: A PRELIMINARY REPORT 1 (2005), http://finance.senate.gov/hearings/testimony/2005test/mwhtestrpt601505.pdf.

planning in order to qualify for Medicaid benefits from the government. The federal and state governments find these techniques, collectively known as Medicaid planning, abusive and are attempting to curb their use.

This paper analyzes Delaware's attempts to stop one particular Medicaid planning technique in order to illustrate the complexities and deficiencies of the Medicaid program. It compares Delaware's attempts with other states' approaches to demonstrate how other states have addressed the issue and to illustrate how Delaware could have more effectively achieved its goals. The comment concludes with a discussion of the actual impact curbing Medicaid planning will have on the larger problem of supporting the Medicaid system in the face of a rapidly aging population. A brief exploration of how other countries are addressing similar problems in a more broad-minded, holistic way illustrates how the United States could shift its focus in order to provide more effective relief for our aging population.

II. MEDICAID AND LONG-TERM CARE BENEFITS

"Medicaid is the nation's largest health care program."[7] Approximately fifty-three million needy individuals, including low-income pregnant women, children, children's caregivers, disabled individuals, and senior citizens currently receive Medicaid benefits.[8] Medicaid spending has dramatically increased in the last five years, due to a 40% increase in caseload and 4.5% annual increase in the health care price index.[9] The National Governors Association estimates that Medicaid spent a total of $329 billion in state and federal funds in 2005.[10] In terms of long-term care services, Medicaid is the nation's largest provider of funding.[11] Medicaid pays for the costs of two-thirds of all nursing home residents.[12] Because no other government programs provide long-term care benefits, Medicaid "has become the default nursing home insurance of the middle class."[13]

Medic*aid* is not to be confused with Medic*are*. Medicare is primarily a government health insurance program for individuals over the age of sixty-five. Medicare does not generally pay for long-term care.[14] It will only pay for "medically necessary skilled nursing" and only under certain conditions.[15]

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7. NAT'L GOVERNORS ASS'N., *supra* note 6, at 1.
8. *Id.*
9. *Id.*
10. *Id.*
11. *Id.* at 11.
12. *Id.*
13. ElderLawAnswers, *Medicaid* (Introduction), http://www.elderlawanswers.com/elder_info/elder_article.asp?id=2751 (last visited Sept. 30, 2006).
14. U.S. Dep't of Health & Human Servs., Medicare—The Official U.S. Gov't Site for People with Medicare: Long-Term Care, http://www.medicare.gov/LongTermCare/Static/Home.asp (last visited Sept. 30, 2006) [hereinafter Long Term Care].
15. *Id.*

Long-term care is designed to assist people with activities of daily living, such as dressing, bathing, and using the bathroom.[16] Medic*aid*, not Medic*are*, covers this kind of care, known as "custodial care."[17]

The Medicaid program is a joint federal-state program.[18] The federal government provides general guidelines for the states to follow, but actual requirements vary from state to state.[19] Generally, a state agency (in Delaware, the Division of Social Services, a part of the Department of Health and Social Services)[20] considers Medicaid applications, makes qualification determinations, and promulgates regulations interpreting federal law.[21]

III. QUALIFYING FOR MEDICAID

There are general federal financial guidelines that an applicant for long-term care Medicaid benefits must meet, and additional requirements that vary from state to state. The qualification rules described here represent the general federal framework, but the specific numbers cited represent Delaware's rules as of the date of this article. In order to receive Medicaid benefits, an applicant may have no more than $2,000 worth of "countable" assets.[22] If a person's spouse is entering a nursing home, the "community spouse" (the spouse who is not entering the nursing home) may only keep one-half of the couple's assets, not to exceed $99,540.[23] If one-half of the couple's assets are less than $25,000, the community spouse may still keep $25,000.[24]

Some assets do not "count" for purposes of this calculation.[25] An applicant's primary residence, personal possessions (such as clothing and furniture), one car, a prepaid funeral plan, and other "inaccessible" assets are ignored when Medicaid calculates the amount of resources a couple may have.[26] For example, if a couple has $100,000 of assets in addition to a house

16. Long Term Care, *supra* note 14.

17. *Id.*

18. U.S. DEP'T OF HEALTH & HUMAN SERVS. ET AL., MEDICAID AT-A-GLANCE 2005: A MEDICAID INFORMATION SOURCE 1, http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf.

19. *Id.*

20. Del. Health & Soc. Servs. - Div. of Social Servs., http://www.dhss.Delaware.gov/dhss/dss/Medicaid.html (last visited Sept. 30, 2006).

21. Medicaid law is constantly changing. In addition to the other caveats on law changes contained herein, the Delaware Medicaid qualification figures are only accurate as of November 2006.

22. ElderLawAnswers, *Medicaid* (Resource (Asset) Rules), http://www.elderlawanswers.com/elder_info/elder_article.asp?id=2751 (last visited Sept. 30, 2006). "Countable" assets are those assets that Medicaid will count when assessing an applicant's assets to make sure that they are below the $2,000 limit.

23. *Id.*; *see also* ElderLawAnswers, *Key Medicaid Information for Delaware*, http://www.elderlawanswers.com/resources/article.asp?id=3725&section=7&state=DE (last visited Sept. 30, 2006).

24. ElderLawAnswers, *Medicaid* (Resource (Asset) Rules), *supra* note 22.

25. *Id.*

26. *Id.*

worth $200,000 and one spouse is going to enter a nursing home, Medicaid will not count the house when calculating the couple's resources.

Medicaid will exempt the house and find that the couple has $100,000 of countable assets. The community spouse may keep half of the countable assets, which is $50,000 in this case. The spouse entering the nursing home may keep $2,000; this leaves $48,000 of assets that must be disposed of before the nursing home spouse can receive Medicaid benefits.

These excess resources must be "spent-down," which means that, before the nursing home spouse can receive Medicaid benefits, the couple must spend the remaining $48,000. When the excess resources are spent, the applicant will qualify for Medicaid benefits. Most commonly, excess resources go to paying for the applicant's nursing home costs. Applicants may also spend down their excess resources by buying a pre-paid funeral, a new car, or making improvements on their primary residence, since these assets do not "count" for Medicaid qualification purposes.

To qualify for long-term care Medicaid benefits, an applicant must also meet certain income requirements. Generally, an applicant must pay all of his or her income to the nursing home, minus a small monthly personal needs allowance.[27] If an applicant's income is over $1,809, the excess income must go into an irrevocable trust, known as a Miller Trust, in order for an applicant to qualify.[28] The excess income also goes to nursing home costs.[29]

If an applicant is married, the community spouse has no income limit and Medicaid does not count the community spouse's income when determining Medicaid eligibility.[30] If most of a couple's income comes from the spouse who will be entering the nursing home, the community spouse may still keep some of that income.[31] A Medicaid agency will determine a community spouse's minimum monthly maintenance needs allowance ("MMMNA") based on the community spouse's housing costs.[32] The MMMNA ranges from $1,650 to $2,488.50.[33] If a community spouse's MMMNA is below his or her income, he or she may retain a portion of the applicant's income, which otherwise would have to go towards nursing home costs, to make up for the shortfall.[34]

For example, imagine that a husband is applying for Medicaid benefits and his wife is still living at home. The husband's monthly income is $1,600 and

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27. ElderLawAnswers, *Medicaid* (Resource (Asset) Rules), *supra* note 22.

28. ElderLawAnswers, *Medicaid* (Treatment of Income), http://www.elderlawanswers.com/elder_info/elder_article.asp?id=2751 (last visited Sept. 30, 2006).

29. *Id.*

30. *Id.*

31. ElderLawAnswers, *Medicaid* (Protections for the Healthy Spouse), http://www.elderlawanswers.com/elder_info/elder_article.asp?id=2751 (last visited Sept. 30, 2006).

32. *Id.*

33. *Id.*

34. *Id.*

the wife's monthly income is only $500. The Medicaid agency determines that the wife's MMMNA is $1,500. Because the wife's monthly income is only $500 and the MMNA is $1,500, the wife may keep an additional $1,000 of her husband's monthly income to pay for her housing costs. The remaining $600 of her husband's income, minus his $44 monthly personal needs allowance, goes to nursing home costs.

In addition to these financial qualification rules, Medicaid applicants will incur a penalty if they transfer their assets for less than fair market value. Depending on the amount of a transfer, an applicant will incur a penalty and become ineligible for Medicaid for a period of time.[35] The ineligibility period or penalty period is the amount of money transferred at less than fair market value divided by a "penalty divisor," which varies from state to state and is roughly equivalent to one month of nursing home care.[36] When assessing a penalty, Medicaid may only look at transactions made within thirty-six months of applying for Medicaid.[37] This thirty-six month period is called the "lookback" period.[38]

In reaction to these harsh qualification rules and the high costs of nursing home care, some people are employing attorneys to help them plan ahead and transfer their assets properly so that they can qualify for Medicaid benefits without losing their life savings.[39] Many techniques exist for people to protect their assets and still receive Medicaid benefits.[40] This paper later explores one common technique.

Many states and the federal government are trying to curb these Medicaid planning practices.[41] Most notably, the Senate and House of Representatives passed the Deficit Reduction Act of 2005 ("DRA") in January 2006.[42] This bill has a huge impact on Medicaid qualification rules. It will increase the period that Medicaid can look at an applicant's financial transactions from thirty-six months (three years) to sixty months (five years).[43] It will also change the transfer penalty rules. Currently, Medicaid assesses a transfer

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35. ElderLawAnswers, *Medicaid* (The Transfer Penalty), http://www.elderlawanswers.com/elder_info/elder_article.asp?id=2751 (last visited Sept. 30, 2006).

36. *Id.* In Delaware, the penalty divisor is $4,905. For example, if a Medicaid applicant transfers $50,000 to her children, she would be ineligible for Medicaid for approximately ten months ($50,000/penalty divisor of $4,905= 10.19).

37. *Id.*

38. *Id.*

39. Michelle Higgins, *Getting Poor on Purpose — States Crack Down on Families that Shed Assets to Get Free Nursing-Home Care; Doing It Legally*, WALL ST. J., Feb. 25, 2003, at D1.

40. *Id.* at D2.

41. *Id.* at D1; NAT'L GOVERNORS ASS'N, *supra* note 6, at 4-5; S. REP. NO. 109- __ (2005) (Conf. Rep.), *amending* Deficit Reduction Act of 2005, Pub. L. No. 109-171, 120 Stat. 63, *available at* http://www.rules.house.gov/109/text/s1932cr/109s1932_text.pdf [hereinafter Conference Report].

42. This paper outlines only some of the major changes that the Deficit Reduction Act has on the Medicaid long-term care benefits. For a more comprehensive discussion of other changes to Medicaid law, visit ElderLawAnswers at http://www.elderlawanswers.com.

43. Conference Report, *supra* note 41, § 6011(a), at 20.

penalty from the time a transfer is made.[44] For example, imagine that a person transferred $50,000 to his or her children in January 2005. This transfer, if made within thirty-six months of applying for Medicaid, would create a ten-month period of ineligibility ($50,000/$4,905 penalty divisor = 10.19). If the person who made the transfer applied for Medicaid benefits in January 2006, the penalty would no longer apply. He or she would qualify for Medicaid immediately because the ten-month penalty period lasted from January 2005 (the time the transfer was made) to November 2005.

Under the new law, Medicaid will assess a penalty for any transfers made within the five-year lookback period.[45] Unlike the old law, the penalty assessed will only begin to run when an applicant is in the nursing home receiving services and they would otherwise qualify for Medicaid benefits.[46] In the previous example, for instance, if the person who made the $50,000 transfer in January 2005 applied for Medicaid benefits in January 2006, the penalty period would operate differently. The ten-month penalty would begin only after the applicant was in a nursing home receiving services and qualified for Medicaid but for the penalty. If the applicant entered the nursing home, started receiving services in January 2006, and spent down their excess resources by March 2006, the ten-month penalty period would only begin to run at that time. He or she would now be ineligible for Medicaid benefits from March 2006 to December 2006.

In order to implement these changes at the state level, a state must rewrite its regulations. As of November 2006, Delaware has released proposed regulations on annuities to conform to the DRA, but they have not yet been enacted.[47] Thus, the techniques, regulations, and case law discussed in this comment are still in force. It is not yet known how the new regulations will affect the use of annuities as a Medicaid planning technique in Delaware.

IV. ANNUITIES AND MEDICAID PLANNING

Despite Congress's attempts to curb these practices, some people continue to engage in Medicaid planning. While there are many Medicaid planning techniques available, one of the most common asset-protection techniques is purchasing certain types of annuities to convert otherwise "countable resources" into income.[48] An annuity is "[a] contract or agreement by which one receives fixed payments on an investment for a lifetime or for a specified

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44. ElderLawAnswers, *Medicaid Planning* (Transfers), *available at* http://www.elderlawanswers.com/elder_info/elder_article.asp?id=701#3 (last visited Sept. 30, 2006).

45. Conference Report, *supra* note 41, § 6011(a), at 20.

46. *Id.* § 6011(b)(2)(ii), at 21.

47. The proposed regulations are available at http://www.state.de.us /research/register/november2006/proposed/10%20DE%20Reg%20798%2011-01-06.htm#P8_180.

48. For examples of other types of Medicaid planning techniques not discussed in this article, *see* Higgins, *supra* note 39, at D2.

number of years."[49] When individuals buy annuities, they pay a lump sum of money to an "issuing entity" (such as a bank or insurance company).[50] The issuing entity then promises to make fixed payments for a predetermined period of time or for the life of the individual.[51] Some annuities contain special clauses that provide for a lump sum payment of whatever is left in the annuity to a designated beneficiary upon the death of the person receiving the fixed payments.[52]

In terms of Medicaid planning, this technique is most common for married couples. If an applicant or spouse has too many resources to qualify for Medicaid, the community spouse can take the excess resources and use those resources to purchase an annuity. If an annuity meets certain requirements, it counts as income and not as a resource for purposes of Medicaid. Because a community spouse has no income limit, by purchasing the annuity that entitles the spouse to receive a monthly income, the spouse can essentially convert excess resources into income and qualify for Medicaid. This protects money that would otherwise have to be spent down to qualify for Medicaid.

For example, if a married man applies for Medicaid benefits and a Medicaid agency determines that his spouse has $50,000 of excess resources to spend down, his wife could take the $50,000 and purchase an annuity. The couple would no longer have $50,000 of excess resources, so the man could qualify for Medicaid benefits, and his spouse would be receiving the $50,000 in the form of monthly payments, which is acceptable because a community spouse has no income limit for Medicaid qualification purposes.

To better understand how Medicaid applicants use annuities to qualify for Medicaid, a brief history of the use of annuities for Medicaid planning purposes is necessary. The Medicare Catastrophic Coverage Act of 1998 ("MCCA") outlines basic Medicaid qualification guidelines.[53] The Omnibus Budget Reconciliation Act of 1993 ("OBRA") made stricter requirements for people who were trying to shelter their assets in order to qualify for Medicaid.[54] 42 U.S.C. § 1396p(d)(6), part of OBRA, discusses the treatment of trusts for purposes of Medicaid qualification, and only gives brief reference to the use of annuities. It simply provides: "[A] 'trust' includes . . . an annuity

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49. Dictionary.com, results for: Annuity, http://dictionary.reference.com/browse/annuity (last visited Sept. 27, 2006) (citing AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE (4th ed. 2000)).

50. HEALTH CARE FIN. ADMIN., DEP'T HEALTH & HUMAN SERVS., STATE MEDICAID MANUAL: PART 3 – ELIGIBILITY, TRANSMITTAL NO. 64 § 3258.9(B), at 12 (Nov. 1994), *available at* http://www.elderlawanswers.com/resources/documents/Transmittal/64Sec3258.pdf (interpreting Social Security Act of 1935 § 1917(c), 42 U.S.C. § 1396p (as amended by Omnibus Budget Reconciliation Act of 1993 § 13611, Pub. L. No. 103-66, 107 Stat. 312, 622-27 [hereinafter OBRA])) [hereinafter HCFA].

51. *Id.*

52. *Id.* This is another provision that will change if The Deficit Reduction Act of 2005 passes.

53. Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, 102 Stat. 683 (codified at 42 U.S.C. § 1396r-5 (2000)).

54. OBRA, *supra* note 50 (codified at 42 U.S.C. § 1396p(d)(6) (2000 & Supp. III 2003)).

only to such extent and in such manner as the Secretary specifies."[55] Initially, because of this vague language and no provisions to the contrary, people bought various kinds of annuities and used them to qualify for Medicaid in the manner described above.

In reaction to the lack of authority as to whether annuities were countable resources for Medicaid purposes, the Health Care Financing Administration ("HCFA") (now the Center for Medicare and Medicaid Services) issued HCFA Transmittal No. 64 ("Tr. 64").[56] Tr. 64 recognizes that "[a]nnuities . . . are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid."[57] Tr. 64's key requirement for determining whether an annuity is legitimate or not is the actuarial soundness of the annuity.[58] Tr. 64 states: "If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound."[59] Tr. 64 makes reference to attached life expectancy tables, taken from information published by the Office of the Actuary of the Social Security Administration.[60] Tr. 64 states that if, according to the life expectancy tables, the remaining life expectancy of the person with the annuity is equal to the life of the annuity, then the annuity is actuarially sound.[61] If the reasonable estimate of life expectancy of the person is less than the life of the annuity, then the annuity is not actuarially sound.[62]

For example, imagine a sixty-one year-old female, who has a life expectancy of 22.06 years according to the table. If she purchased an annuity to be paid over twenty-two years, the annuity would be actuarially sound because the life of the annuity is commensurate with the female's life expectancy. If, however, the annuity would be paid over twenty-five years, it would not be actuarially sound because the female's life expectancy is less than the life of the annuity. Tr. 64 is currently the only federal guidance for the use of annuities in Medicaid qualification. Because Tr. 64 is vague, every state interprets it differently and has its own law addressing annuities and Medicaid qualification.[63]

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55. OBRA, *supra* note 50, § 13611(b)(6), 107 Stat. at 626 (codified at 42 U.S.C. § 1396P(d)(6)).

56. HCFA, *supra* note 50, § 3258.9(B), at 12.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

61. HCFA, *supra* note 50, § 3258.9(B), at 12.

62. *Id.*

63. *See* Thomas D. Begley & Jo-Anne Herine Jeffreys, *Planning for Eldercare: Use of Annuities in Medicaid Planning*, LONG TERM CARE LINK, 2006, http://www.longtermcarelink.net/ncpz_0204.htm.

V. DELAWARE AND MEDICAID ANNUITIES

The current law in Delaware with respect to the use of Medicaid annuities is based on a mixture of case law and regulations.[64] Current Delaware law allows the use of certain types of annuities in Medicaid planning.[65] Why has Delaware chosen the approach it has? Did Delaware's latest change of regulations really make it more difficult for people to use annuities for Medicaid planning purposes? This section explores Delaware's approach to illustrate weaknesses in the state's attempt to curb the use of annuities. It further explores how other states, such as Pennsylvania, New Jersey, Wisconsin, and Michigan, have addressed the issue.[66] An analysis of other states' approaches offers insight into how Delaware could have more effectively achieved its goal of curbing the use of annuities for Medicaid qualification purposes.

Delaware permits the use of annuities for Medicaid planning purposes.[67] In the 2000 *Dean* case, William Dean purchased a $53,000 "irrevocable, nonassignable, immediate and actuarially sound" annuity in order to spend down his resources for the purpose of qualifying his wife for Medicaid benefits.[68] When he applied for Medicaid on behalf of his wife, the caseworker informed him that his resources were above the allowable limit by $51,743.[69] The Delaware Division of Social Services ("DSS") argued that the language of Tr. 64 did not apply and that the purchase of the annuity was an impermissible transfer of assets.[70]

The Delaware Supreme Court ruled that the language of Tr. 64 controls the use of annuities for Medicaid qualification purposes in Delaware.[71] Thus, as long as an annuity is actuarially sound according to the life expectancy tables of Tr. 64, the annuity is not considered an impermissible transfer of assets.[72] The court further held that if a property right cannot be liquidated (as was the case with Dean's standard, irrevocable, commercial annuity), it is not a resource for Medicaid qualification purposes.[73] Because the property right cannot be liquidated, it takes the form of income under the federal definition.[74] The court also commented that absent a legislative presumption that a transfer of assets during the look-back period occurred for less than fair market value,

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64. The author would like to remind the reader that although the DRA has passed, Delaware has not yet issued new regulations on the use of annuities and Medicaid planning. When it does, Delaware law on annuities could be substantially different.

65. *See* 8 Del. Reg. Regs. 1651 (June 1, 2005).

66. This comment examines these states' approaches before the DRA was passed.

67. *See* Dean v. Del. Dep't of Health & Soc. Servs., No. Civ. A00A-05-006, 2000 WL 33201237, at *7 (Del. Super. Ct. Dec. 6, 2000), *aff'd*, 781 A.2d 693 (Del. 2001).

68. *Id.* at *2.

69. *Id.* at *1.

70. *Id.* at *2.

71. *Id.* at *4.

72. *Dean*, 2000 WL 33201237, at *6.

73. *Id.* at *8.

74. *Id.*

the court must use Tr. 64 as guidance.[75] Thus, the *Dean* case established that in Delaware, irrevocable, nonassignable, actuarially sound annuities are not countable resources for Medicaid qualification purposes; instead, these types of annuities are income, and there is no penalty assessed for transfers to these types of annuities.[76]

In June 2005, DSS promulgated a new regulation addressing annuities in an attempt to count the income stream generated by an annuity as an available resource for Medicaid qualification purposes. The regulation states: "[T]he stream of income generated by the annuity is a countable asset. DSS will determine if there is a market to purchase the annuity stream of income. If there is a market, DSS will consider it to be available for the applicant's or spouse's support and maintenance."[77] The regulation states that if there is a market to purchase an annuity stream of income, the income is considered "available" because the applicant or applicant's spouse would be able to sell the resource for cash. If the applicant or applicant's spouse can get cash for the resource, then it follows that that cash could go towards the applicant's cost of care in a nursing home and should therefore factor into the Medicaid qualification calculations.

Several states have argued that there is a secondary market for purchasing Medicaid annuities.[78] They contend that Internet-based companies will buy the right to receive an annuity income stream.[79] Despite this argument, the type of nonassignable annuity at issue in the *Dean* case does not have this kind of secondary market.[80] Because the *Dean* annuity is nonassignable, it cannot be liquidated and is therefore unavailable as a resource for Medicaid qualification. Assignable and nonassignable annuities are two distinguishable kinds of annuities, the former of which has a secondary market and the latter of which does not. Thus, while the DSS acknowledged that the reasoning behind the promulgation of the 2005 regulation was the discovery of a loophole that estate planners used to shelter clients' assets,[81] the regulation

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75. *Dean*, 2000 WL 33201237 at *7. The court cited a Pennsylvania statute that created a presumption that any assets transferred during the look-back period were transferred for an improper purpose. *Id.* at *6 (citation omitted). Delaware does not have such a presumption. *Dean*, 2000 WL 33201237, at *6.

76. *Id.* at *4-8.

77. 8 Del. Reg. Regs. 1651 (June 1, 2005) (citation omitted).

78. *See, e.g.*, Estate of Gross v. N.D. Dep't of Human Serv., 2004 N.D. 190, ¶ ¶ 11-12, 687 N.W.2d 460, 465 (citing language in the annuity contract stating that the payee of the annuity could be changed at any time).

79. Estate of F.K. v. Div. of Med. Assistance & Health Servs., 863 A.2d 1065, 1072 (N.J. Super. Ct. App. Div. 2005).

80. *Id.* at 1077 (stating that nothing in the record shows that there is a secondary market for the income stream of an irrevocable and nonassignable annuity). *In re* Estate of Pladson v. Traill County Soc. Servs., 2005 ND 213, ¶ 15, 707 N.W.2d 473, 479 (distinguishing *Gross* because the language in the *Gross* annuity contract stated that the payee of the annuity could be changed "at any time," while the *Pladson* annuity did not have that language).

81. 8 Del. Reg. Regs. 1650.

does not address the type of annuity at issue in the *Dean* case because there is no secondary market for it.

Delaware attempted to make it more difficult to use annuities for Medicaid planning when they promulgated the new regulations. Unfortunately, the new regulations have actually made the use of annuities in Medicaid planning easier. In its Final Order Regulation, DSS acknowledged that the "reasoning behind the adoption of this rule" was that "Delaware has discovered that estate planners have exploited a loop hole which allows people to shelter their assets in annuities rather than private pay for the services they need."[82] Despite this acknowledgement, the regulation proceeded to codify the allowance of the exact type of annuity that DSS so vigorously challenged in *Dean.* The regulation stated that it will only count the annuity as a resource if there is a secondary market.[83] Because there is no secondary market for an "irrevocable, nonassignable, immediate and actuarially sound" annuity, such as the one that was at issue in the *Dean* case, the regulation essentially permits the use of these types of annuities.

In addition to the continued allowance of the use of annuities to qualify for Medicaid benefits in the case of married couples, the regulations also leave room for even more aggressive Medicaid planning strategies, such as the use of "balloon annuities." A "balloon annuity" is an annuity that pays out a very small monthly amount for the life of the annuity with a very large lump sum paid at the end of the annuity period.[84] "Balloon annuities" are aggressive because they allow single people, as well as married couples, to qualify immediately for Medicaid with the purchase of an annuity. Because this technique is available to single people, it allows another large segment of the population to qualify immediately for Medicaid benefits.

For example, if a single woman has $50,000 of countable resources, she must spend down $48,000 in order to be below the $2,000 resource limit for a single person. If she takes the $48,000 and buys a "balloon annuity" to receive monthly payments of $30, she will have converted her $48,000 of countable resources into an uncountable resource. Her income will still be below the $44 personal needs allowance limit, and she will no longer be over the resource limit.

Annuity contracts may contain clauses assigning remaining payments due to a beneficiary other than the annuitant. Therefore, when the annuitant dies, the remaining payments, including the large lump sum payment at the end of the life of the annuity, may go to a designated beneficiary (known as a "remainder beneficiary").[85]

As stated in the *Dean* case, Tr. 64 controls in Delaware. Balloon-type annuities can meet the requirements of the life expectancy table and the

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82. 8 Del. Reg. Regs. 1650.

83. *Id.* at 1651.

84. Medicaid-Annuity.com, *Types of Immediate Annuities Used in Medicaid Planning*, http://www.medicaid-annuity.com/types-immediate-annuities.htm (last visited Oct. 13, 2006).

85. The Budget Deficit Reduction Act of 2005 also requires that a Medicaid agency always be the remainder beneficiary. Conference Report, *supra* note 41, § 6012(e)(1), at 24 (codified as amended at 42 U.S.C. § 1396p(c)(1)(F) (Supp. VI 2006)).

definition of actuarial soundness in HCFA Transmittal No. 64. They can also be designed in a way that makes it impossible for there to be "a market to purchase the annuity stream of income,"[86] as required by the new regulations. Additionally, they can be structured to be "irrevocable, nonassignable, immediate and actuarially sound"[87] so that they cannot be sold on the secondary market. Tr. 64, the *Dean* case, and the new Delaware regulation provide the framework for Delaware's current law on annuities. Because a balloon annuity can meet the requirements of Tr. 64 and the requirement of the new Delaware regulation which requires that it cannot be sold on the secondary market, current Delaware law seems to permit this aggressive strategy.

DSS's vigorous challenge of the use of annuities in *Dean* and subsequent cases,[88] as well as the promulgation of the 2005 annuity regulation, demonstrate that DSS is concerned about this Medicaid planning technique. It is curious that the new regulation continues to permit the type of annuity that DSS so strongly protested in the *Dean* case, while also leaving the door open for the use of the more aggressive, balloon-type annuities. In sum, Delaware has wasted time and resources to promulgate an ineffective regulation.

VI. LOOKING TO OTHER STATES FOR MORE EFFECTIVE SOLUTIONS[89]

An analysis of other states' approaches to the use of annuities for Medicaid planning illustrates how Delaware could have more effectively addressed the problem. Some states have taken a more aggressive approach to their use, while other states' approaches are more lenient. Pennsylvania, a neighboring state, has taken a very aggressive approach to curbing the use of Medicaid annuities. At the time of the *Dean* case, Pennsylvania already had a statutory presumption that any transfer of assets during the thirty-six month look-back period was done for the improper purpose of qualifying for Medicaid.[90] The *Dean* court suggested that if Delaware had such a legislative presumption, DSS could have denied benefits to Dean.[91]

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86. 8 Del. Reg. Regs. 1651 (citation omitted).

87. Dean v. Del. Dep't of Health & Servs., No. civ. A00A-05-006, 2000 WL 33201237, at *2 (Del. Super. Ct. Dec. 6, 2000), *aff'd*, 781 A.2d 693 (Del. 2001)).

88. Despite the Delaware Supreme Court opinion in *Dean*, DSS continued to count actuarially sound annuities as available resources, albeit unsuccessfully. Div. of Soc. Servs., Del. Dep't of Health and Soc. Servs., *Application for Long Term Care Denied for Over Resource* (last visited Oct. 13, 2006), http://www.dhss.delaware.gov/dhss/dss/rfhd2005/xixannuity200541.html.

89. The discussion of other states' approaches to the use of annuities for Medicaid planning represents their approaches *before* they implemented any changes as a result of the DRA.

90. *Dean*, 2000 WL 33201237, at *6 (footnote omitted).

91. *Id.* at *6-7 (footnote omitted).

In July 2005, Pennsylvania further tightened annuity requirements with the passage of "Act 42."[92] Section 441.6 of Act 42 first declares that any language that would limit an owner's ability to sell or to assign the right to his or her annuity payments is void.[93] This means that language in an annuity contract that states that it is nonassignable and irrevocable, like the annuity in the *Dean* case, would be void. The Act further states that there is "a rebuttable presumption that any annuity . . . is marketable without undue hardship."[94] It also requires that annuities pay out in equal monthly installments.[95] This eliminates any use of a balloon-style annuity because balloon-style annuities do not pay out in equal installments.

Finally, the Act requires that the Pennsylvania Department of Public Welfare be the remainder beneficiary of any remaining funds owed on the annuity at the death of the annuitant.[96] This refers to clauses in some annuity contracts that allow an annuitant to designate a beneficiary of remaining funds on death. Under the Pennsylvania legislation, this beneficiary must be the Pennsylvania Department of Public Welfare, so the family of the annuitant is not entitled to any of the remaining funds. Act 42 essentially eliminates the use of annuities for Medicaid planning, because it changes language in annuity contracts to make them marketably available resources and disallows any contract clauses that pass remaining funds onto a family at the death of an annuitant. The language in the Act makes all annuity funds "countable" resources for Medicaid qualification purposes.

Wisconsin and Michigan have also made some changes to their annuity regulations, but they are not as aggressive as Pennsylvania's changes. Michigan's key requirements for purchases of annuities are that the annuity is irrevocable and actuarially sound and that all monthly payments are substantially equal.[97] Wisconsin has the following guidelines: an annuity must be irrevocable; be actuarially sound; nonassignable; nonsurrenderable; make fixed, periodic payments; generate a minimum rate of return; and must not have any value on the secondary market.[98] Most notably, Wisconsin and Michigan both require that annuity payments be made in equal installments. This eliminates the use of balloon-style annuities because many small payments followed by a large lump sum payment are not equal, monthly payments. The Wisconsin and Michigan regulations, however, permit the use

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92. H.B. 1168, 2005 Gen. Assem. (Pa. 2005), *available at* http://www2.legis.state.pa.us/WU01/LI/BI/BT/2005/0/HB1168P2560.pdf.

93. *Id.* § 441.6(b), at 5.

94. *Id.* § 441.6(c), at 5.

95. *Id.* § 441.6(d)(2), at 6.

96. *Id.* § 441.6(d)(3), at 6.

97. MICHIGAN DEP'T OF CMTY. HEALTH (MDCH), HEALTH CARE ELIGIBILITY POLICY: TRANSFER TO AN ANNUITY 10 (2005), *available at* http://www.michigan.gov/documents/HCEP_05-04_132290_7.pdf.

98. Dale M. Krause & Cheryl L. Fletcher-Krause, *Medical Assistance Annuity Update*, ELDER LAW NEWS, Summer 2004, at 10, *available at* http://www.wisbar.org/AM/Template.cfm?Section=Home&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=ID=51897.

of a *Dean*-type irrevocable, nonassignable, nonsurrenderable, actuarially sound annuity.

In contrast, New Jersey has a more lenient approach to the use of Medicaid annuities and Medicaid planning in general. Two recent New Jersey cases, *Estate of F.K. v. Div. of Med. Assistance and Health Servs.*[99] and *A.B. v. Div. of Med. Assistance and Health Servs.*,[100] upheld the use of annuities in Medicaid planning. Relying on the earlier decision of *Estate of F.K.*, the court in *A.B.* reiterated that an actuarially sound annuity is not a countable resource for Medicaid qualification purposes.[101] *A.B.* further held that there was no evidence on the record that there is a secondary market for such an annuity.[102] New Jersey has a presumption in favor of approving Medicaid spend-down proposals.[103] New Jersey also acknowledges that "a reasonable and competent person 'would prefer that the costs of his care be paid by the State, as opposed to his family.'"[104] The allowance of actuarially sound annuities for Medicaid planning and a presumption in favor of approving spend-down proposals illustrate that New Jersey has a more permissive approach to Medicaid planning.

If Delaware wanted to more effectively curb the use of annuities, it could adopt approaches similar to other states. Delaware's Division of Social Services, based on the language of its 2005 regulation[105] opposes the use of annuities for Medicaid planning. Delaware could enact legislation like Pennsylvania's, which voids any language restricting the assignability of an annuity contract and also requires that the Pennsylvania Department of Public Welfare receive any remaining amounts due on the annuity at the annuitant's death. Because the legislation would take away any language in an annuity contract making it nonassignable, it would allow an annuitant to assign it to someone else, thereby creating a secondary market for it and making it an available resource. Legislation such as this, if Delaware chose to enact it, could make annuities countable resources for Medicaid qualification purposes, which is what Delaware acknowledged it was trying to do.[106]

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99. Estate of F.K. v. Div. of Med. Assistance & Health Svcs., 863 A.2d 1065 (N.J. Super. Ct. App. Div. 2005).

100. A.B. v. Div. of Med. Assistance and Health Serv., 865 A.2d 701 (N.J. Super. Ct. App. Div. 2005).

101. *A.B.*, 865 A.2d at 705 (citations omitted).

102. *Id.*

103. *In re* Keri, 853 A.2d 909, 916 (N.J. 2004).

104. *Id.* (quoting *In re* Shah, 733 N.E.2d 1093, 1099 (N.Y. 2000)).

105. The reasoning behind the adoption of this rule is that "Delaware has discovered that estate planners have exploited a loop hole which allows people to shelter their assets in annuities rather than private pay for the services they need." 8 Del. Reg. Regs. 1650 (June 1, 2005).

106. The Pennsylvania legislation is fairly recent. Some attorneys have expressed concern that some of the provisions of the legislation conflict with federal law. ElderLawAnswers, *New Pennsylvania Law Tightens Medicaid Eligibility in A Variety of Ways*,

If Delaware did not want to take such an aggressive approach, it could at least change regulations to curb the use of balloon-type annuities. Michigan and Wisconsin have added requirements to their regulations to eliminate the use of balloon-type annuities. Although Delaware already has some requirements similar to those of Michigan and Wisconsin (such as actuarial soundness and the nonexistence of a secondary market for the purchase of an annuity), it lacks a provision that would eliminate the use of balloon annuities. Michigan and Wisconsin both require that monthly annuity payments all be the same. Specifically, Michigan requires that payments be "substantially equal," and Wisconsin requires "fixed, periodic payments."[107] Because balloon annuity payments are not substantially equal (the payout consists of a series of small payments and one large payment at the end of the payout period),[108] this language eliminates their use. If Delaware included a similar requirement in its regulations, Medicaid applicants would not be able to use balloon annuities in Delaware. This comparative analysis of the use of Medicaid annuities in different states illustrates that states are spending time and resources trying to fight Medicaid planning. It also illustrates how Delaware could have more effectively curbed the use of annuities for Medicaid qualification purposes.

VII. ATTACKING MEDICAID PLANNING: A MISDIRECTED APPROACH

Medicaid planning is under attack. As discussed above, states and the federal government in the Deficit Reduction Act of 2005 are trying to reduce people's ability to make asset transfers in order to qualify for Medicaid benefits. Other groups allege that many affluent individuals, dubbed "millionaires on Medicaid," are deliberately impoverishing themselves to qualify for Medicaid long-term care benefits and that this is the reason why the Medicaid program is so expensive.[109] Several recent studies evaluated whether state and federal law changes to stop Medicaid planning will actually curb overall Medicaid long-term care spending and whether accusations that many wealthy people are taking advantage of Medicaid are accurate.

Contrary to the above-mentioned allegations, empirical studies found that any funds transferred for Medicaid planning purposes have little effect on overall Medicaid expenditures.[110] Most recently, in September 2005, the

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http://www.elderlawanswers.com/resources/article.asp?id=4993&section=7&state (last visited Oct. 18, 2006) (quoting Jeffrey Marshall).

107. MICHIGAN DEP'T OF CMTY. HEALTH, *supra* note 96; Krause & Fletcher-Krause, *supra* note 98.

108. Medicaid-Annuity.com, *supra* note 84.

109. Saul Friedman, *Asset Transfers and Medicaid Planning: Long Term Care Insurance and Medicaid*, For a more extensive discussion of arguments against Medicaid planning, Dec. 17, 2005, http://www.emaxhealth.com/105/4006.html; see ELLEN O'BRIEN, MEDICAID'S COVERAGE OF NURSING HOME COSTS: ASSET SHELTER FOR THE WEALTHY OR ESSENTIAL SAFETY NET? (2005), http://ltc.georgetown.edu/pdfs /nursinghomecosts.pdf.

110. O'BRIEN, *supra* note 109, at 11; UNITED STATES GOV'T ACCOUNTABILITY OFFICE, REPORT TO CONGRESSIONAL REQUESTERS, MEDICAID: TRANSFERS OF ASSETS BY ELDERLY INDIVIDUALS TO OBTAIN LONG-TERM CARE COVERAGE (2005), *available at* http://www.gao.gov/new.items/d05968.pdf.

United States Government Accountability Office conducted a study on transfer of assets of individuals for Medicaid purposes.[111] The study found that most elderly households were not affluent and that those who transferred assets transferred relatively small amounts.[112] In 2002, eighty percent of twenty-eight million elderly households had incomes of $50,000 or less and resources, excluding a primary residence, of $50,000 or less.[113] Only about twenty-two percent of elderly households (six million households) transferred cash, and the average amount of money transferred ranged between $3,910 and $12,010.[114] This evidence of relatively small amounts of transfers, and relatively low resources in elderly populations, illustrates that Medicaid abuses are not so widespread. Most elderly individuals have limited resources, so they cannot shelter large amounts of assets.

Georgetown University's Long-Term Care Financing Project conducted a similar investigation with similar results.[115] The project evaluated several empirical studies and concluded that there is little to no evidence that Medicaid planning burdens the Medicaid system.[116] Ellen O'Brien, the author of the paper concluded:

> The argument that something needs to be done about abuses of the Medicaid eligibility rules is not supported by the facts. The studies reviewed in this paper do not support the claim that asset transfers are widespread or costly to Medicaid, or that restricting Medicaid eligibility would substantially increase savings . . . .[117]

Key findings of the project were: the median wealth of elderly households excluding home equity was only $23,885,[118] seventy-eight percent of elderly applicants would qualify for Medicaid upon nursing home admission,[119] and states estimated that restricting asset transfers would only save between 0.6% and 1.4% over a five-year period.[120] These three figures, among many others contained in the report, dispel many of the misconceptions about Medicaid planning. They show that the majority of the elderly are poor enough to qualify for Medicaid as soon as they need it and that curbing the use of Medicaid planning techniques will save the government negligible amounts of money. The overburdening of the Medicaid system simply cannot be attributed to Medicaid planning. States and the federal government should use

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111. UNITED STATES GOV'T ACCOUNTABILITY OFFICE, *supra* note 110, at 3.
112. *Id.* at 4-5.
113. *Id.* at 4.
114. *Id.* at 5.
115. O'BRIEN, *supra* note 109.
116. *Id.* at 11.
117. *Id.*
118. *Id.* at 4.
119. *Id.* at 5.
120. *Id.* at 8.

their time and resources to look at the long-term care crisis in a more broad-minded way, rather than focusing on trying to curb Medicaid planning.

VIII. THE REAL SOLUTION: A MORE BROAD-MINDED APPROACH TO CARING FOR OUR ELDERLY

"Ultimately, a new national dialogue is needed to confront the issues of an aging population . . . ."[121] Perhaps Medicaid long-term care expenditures are so high because of our aging population, the high cost of long-term care, and the lack of any public safety net for long-term care other than Medicaid. If the government looked at the problem from a wider perspective, then perhaps real, effective long-term changes in the program could occur. Many other industrialized countries have already begun to address the problem of an aging population in a more holistic way than the United States. The United States can learn a lot from these programs.

In 2000, Japan introduced a mandatory public long-term care insurance plan to which all people over the age of forty contribute, and for which all people over the age of sixty-five are eligible, regardless of income or family situation.[122] Japanese government municipalities manage the program and make determinations as to the mental and physical condition of those applying for benefits.[123] Participants must pay ten percent of the cost of services out-of-pocket, with an upper limit on payments.[124] In-home services available include home-visit long-term care, bathing, rehabilitation and day service, as well as home renovation (such as adding handrails).[125] Long-term care services at nursing homes are also available.[126] The Japanese Ministry of Health Labour and Welfare cites their goal of this program: "To facilitate a system in which the society as a whole support those who are facing the need of long-term care, society's major cause of concern in terms of becoming old."[127]

In Germany, by the year 2030, approximately thirty-six percent of the population will be over the age of sixty.[128] Germany implemented universal long-term care insurance in 1995.[129] The goal of the program is to "provide relief from much of the financial burden of long-term disability and illness . . . ."[130] Germany's program receives equal contributions from employers and employees (about 1.7% of an employee's income), and people below a certain income threshold must participate;[131] about seventy-five

121. NAT'L GOVERNORS ASS'N, *supra* note 6, at 11.

122. Shunya Ikeda, *Healthcare System in Japan*, 4 PSYCHOGERIATRICS 111, 111 (2004).

123. Ministry of Health, Labour & Welfare, *Long-Term Care Insurance in Japan*, § 2(3) (July, 2002), http://www.mhlw.go.jp/english/topics/elderly/care/2.html.

124. *Id.* § 2(5).

125. *Id.* § 2(11).

126. *Id.*

127. *Id.* § 2(1).

128. Max Geraedts et al., *Germany's Long-Term-Care Insurance: Putting a Social Insurance Model into Practice*, 78 MILBANK Q. 375, 375 (2000).

129. *Id.*

130. *Id.* at 376.

131. *Id.* at 378-79.

percent of the population is below the income threshold and must participate.[132] Those above a certain income level may opt out of the program and buy private insurance, but it is not a requirement.[133] Of the twenty-five percent of the population that may opt out of the program, thirteen percent chose to stay in.[134] The overall force behind the social insurance model is Germany's "cultural values of social responsibility."[135]

Denmark has one of the most progressive programs in the world for the elderly.[136] Administered in conjunction with Denmark's entire public health care system, it includes many innovative programs for the elderly.[137] These innovations include neighborhood-based activity centers and assessment programs where case managers visit people over the age of seventy-five twice a year to evaluate their personal needs.[138] Denmark also has plans to move away from nursing homes towards noninstitutional supporting living arrangements for the elderly.[139]

Japan, Germany, and Denmark are three of the most industrialized countries in the world and are facing the same problem of an aging population as the United States. Their approaches, however, have been more progressive. Germany and Denmark view caring for the elderly as a public responsibility.[140] The Director-General of the World Health Organization ("WHO") in the World Health Report 2000 echoed the theme of public health care as a social responsibility:

> Health care (and long-term care) can be catastrophically costly. Much of the need for care is unpredictable, so it is vital for people to be protected from having to choose between financial ruin and loss of health . . . . The other peculiarity of health is that illness itself . . . can threaten people's dignity and their ability to control what happens to them . . . . Health systems have a responsibility not just to improve people's health, but to protect them against the financial cost of illness . . . reducing the damage to one's dignity and autonomy, and the fear and shame that sickness often brings with it—and to treat them with dignity . . . .[141]

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132. Geraedts, *supra* note 128, at 378-79.

133. *Id.* at 379.

134. *Id.*

135. *Id.* at 377.

136. WORLD HEALTH ORGANIZATION COLLECTION ON LONG-TERM CARE, KEY POLICY ISSUES IN LONG-TERM CARE 102 (2003), *available* at http://www.who.int/chronic_conditions/policy_issues_ltc.pdf.

137. *Id.*

138. *Id.* at 103-04.

139. *Id.* at 104.

140. Geraedts, *supra* note 128, at 377; WORLD HEALTH ORGANIZATION COLLECTION ON LONG-TERM CARE, *supra* note 136, at 102.

141. WORLD HEALTH ORGANIZATION COLLECTION ON LONG-TERM CARE, *supra* note 136, at vii.

Finding a solution for the long-term care problem will not be easy, but as this paper illustrates, spending time and resources on curbing asset transfers and attacking Medicaid planning is misdirected. An analysis of Delaware's approach to the situation also illustrates the ineffectiveness of some of these attempts. Medicaid planning is not the problem; the aging population is. The United States should create a "new national dialogue."[142] It could use the approaches of Japan, Germany, and Denmark as models to create a more holistic, socialized, progressive method of serving the nation's elderly population. The United States might also consider the WHO's concern that caring for our populations is a social responsibility. With a shift in focus away from laying blame and curbing asset transfers and a view toward supporting our aging population in a conscientious way, the United States could also develop a viable long-term care program for our elderly.

142. NAT'L GOVERNORS ASS'N., *supra* note 6, at 11.