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United States Senate Finance Committee
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Mister Chairman and Members of the Committee, I am pleased to have the opportunity to testify today on behalf of Erickson Retirement Communities. I applaud the committee for taking on this important issue and I am hopeful that our experience will provide insight into some of the problems surrounding long term care and, more importantly, some immediate steps that can be taken by the Committee to restore some equity and fairness to the Medicaid program.

Erickson Retirement Communities ("Erickson") develops and manages non-profit continuing care retirement communities in nine states. The Erickson network is home to over 16,000 middle-income seniors nationwide. Erickson is one of the most innovative and fastest growing senior housing and health care providers in the nation. Our model of health care delivery is both unique and resident-focused. We can report both better health care outcomes for our residents as well as increased overall satisfaction in their quality of life. We are proud of the fact that we deliver high quality service to our residents at prices that are affordable to seniors of moderate means. However, our model is being threatened by creative attorneys who have counseled their clients to do an end run around the system, inappropriately shifting their assets in a manner that increase the cost to our residents and further strain state Medicaid budgets without any corresponding increase in quality.

Asset Shifting

The overall health of the Medicaid program, especially the costly long-term care component, is increasingly a crisis at the Federal and state levels. Despite rising enrollment and escalating costs, Federal and state policy continues to permit middle-income and wealthy seniors or their adult children to manipulate complex Medicaid eligibility rules and inappropriately shift the costs of their care to the American taxpayer.

Key Points:

1. Current law and practice places the inheritance interests of adult children – at least for those who are sophisticated enough to game the system -- ahead of the real reason Medicaid exists, to provide a high quality health care system to the truly needy.

2. Congress can debate whether it is appropriate to pay for the nursing care of all of its citizens – rich, middle-income and poor alike. However, under current law, the limited resources available to care for those Americans who are genuinely in need are being siphoned off to enhance the inheritances the families of seniors who are wealthy and sophisticated enough to hire an attorney to game the system. Only the middle-class and those whose sense of public responsibility requires them to do so pay their own way. This seems patently unfair.

3. Current law and practice stifles innovation and the creation of high quality settings that are affordable to seniors of moderate means. Health care providers are forced to choose between providing care on an exclusively private-pay basis to the wealthy, or be forced into the reality of virtually all residents becoming Medicaid-eligible.

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Continuing Care Retirement Communities (CCRCs)

CCRCs provide an integrated housing and health care system for seniors. CCRCs typically include independent living, assisted living, and skilled nursing care components on a single campus and under a singe contract. Erickson communities include these three components, plus a wide array of health and supportive services, including physician services, home health care, and extensive resident life programs. Residents of CCRCs experience enhanced quality of life and have significantly better health care outcomes as a result. By keeping seniors out of nursing home care, we can provide better service at a lower price to the government.

In order to gain admission, CCRCs require applicants to disclose their assets and sign a contract that pledges their assets to finance health care needs. CCRC residents pay an entrance fee (which ranges from $100,000 to over $300,000 at Erickson Communities) and monthly fees for the services they receive, including health care, meals, activities, and a variety of other services.

As a result, the CCRC model is only available to middle income and upper income seniors. In Erickson communities and many other CCRCs, the entrance deposit is available to pay for nursing care should a resident spend through other assets. Alternatively, the principal of the entrance deposit is also refundable to the resident if he or she chooses to leave the community or refundable to a designated beneficiary if he or she passes away.

CCRC residents also use dramatically less acute and long term care services than seniors living in the broader community. For example, the typical Erickson resident costs $7,600 per year while the average overall Medicare beneficiary costs $10,000 per year. By encouraging an active lifestyle that focuses on prevention and early engagement, we are able to keep most of our residents out of the nursing home setting altogether.

CCRCs provide tangible value to senior health care and the Medicaid program. First, by providing access to health care and an active social environment, residents of CCRCs are less likely to need nursing home care than the general population. Second, the CCRC contract and large up-front entrance deposit ensure that qualifying individuals privately fund their long term care needs before becoming eligible for Medicaid. This innovative approach can only work if Medicaid is truly a payer of last resort.

Attorneys Employ Loopholes to Inappropriately Qualify Wealthy Seniors for Medicaid

Over the last few years, the business of asset shifting has increased dramatically. In fact, the largest single area of growth within the bar is estate planning. With the aging of the baby boomers, these trends are certain to continue unless the Federal government acts. In the last four years, aggressive attorneys who specialize in asset shifting have targeted CCRCs in two ways to qualify beneficiaries with hundreds of thousands of dollars for costly Medicaid benefits.

Here is the typical argument given. First, the attorneys argue that entrance deposits are excluded assets for Medicaid eligibility purposes. This preserves the significant sums in CCRC entrance deposits for inheritance purposes, while qualifying CCRC residents for Medicaid benefits. CCRC residents with hundreds of thousands of dollars earmarked for their own health care are

instead shifting the costs of their long term care to the tax payers. Second, the attorneys argue that contracts that require the disclosure of assets and the pledging of those assets to pay for services are inconsistent with federal policy. Each of these tactics subvert the CCRC contract into an inheritance preservation device.

Absent Congressional intervention, these attorneys will continue to exploit current loopholes to preserve the substantial sums in CCRC entrance deposits for inheritance purposes, while shifting the costs of nursing home care to Medicaid. The following is just a small sample of the creative ways attorneys are trying to use the Medicaid program for the benefit of their middle and higher income clients (and their adult children).

> We had one active member of the bar suggest that we actually raise the price of our entrance deposits and market our community as an effective way to shelter more money for inheritance purposes.
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> We had a couple move into an Erickson community and disclose over $500,000 in assets. They paid an entrance deposit of over $200,000. Within four months of admission, the husband was declared eligible for Medicaid.
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> We have had attorneys argue against using entrance deposits to pay for the health care needs of nursing home residents, yet at the same time, use the funds in the entrance deposits to pay their own legal fees.
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> In one of our Massachusetts communities, there is a couple with over $300,000 reserved in an entrance deposit. The entrance deposit is contractually available to pay for health care. Despite this significant sum, the couple is receiving Medicaid benefits.

Asset Shifting Upheld By Courts:

Absent a clear Congressional declaration of public policy intent, the courts have often looked favorably on the practice of asset shifting to gain Medicaid eligibility. The adult children of CCRC residents have successfully challenged the private pay financing structure for middle income and wealthy seniors. Under interpretations of current law, a CCRC or a state recovery program cannot enforce contracts signed by seniors who disclose assets and pledge those assets to fund their own care.

> In Oak Crest Village vs. Murphy, (379 Md. 229, 841 A.2d 816) Maryland's highest court upheld a ruling that endorsed asset shifting. A couple entered the community disclosing net worth of nearly $500,000 and pledged those assets available to fund their own care. In the same month as signing the contract to pay for their own care, the assets were shifted to an annuity and one of the spouses applied for Medicaid nursing home benefits.

The Erickson experience is limited to CCRCs. However, asset shifting is widespread throughout long term care.

In In Re Keri, (181 N.J. 50, 853 A.2d 909) the New Jersey Supreme Court endorsed the principle of asset shifting. In this case, a nursing home resident's son also served as Power of Attorney (POA). As the POA, the son decided to take all of his mother's assets and shift the costs of his mother's care to the tax payers. Ignoring the cost implications to Medicaid, the Court noted that a "competent, reasonable individual … would prefer that his property pass to his child rather than serve as a source of payment for Medicaid and nursing home care bills."

The Keri Court models its decision on New York state case law, which permits POAs "to engage in asset shifting even when the guardians themselves may be the recipients of transfers from the wards' assets."

Asset Shifting Places the Inheritance Interests of Adult Children Ahead of Adequate Funding for Health Care for Poor Americans.

(1) In Maryland, the Governor's budget proposed over $70 million in cuts to the Medicaid program. In New Jersey, the Governor's budget proposes a $100 million cut to the nursing home component of the Medicaid program. These cuts may result in reduced services overall, lower quality services to Medicaid recipients, and increased medical standards for eligibility. Prior to cutting services and limiting enrollment for the poor, Federal and state governments should crack down on loopholes that allow significant numbers of wealthy seniors to qualify for benefits.

(2) If providers cannot count on using contracts that rely on disclosed and pledged private financing, it is difficult to see an alternative to relying exclusively on Medicaid as a primary source for all future senior health services. Prohibiting a provider from relying on private financing sources stifles current and future innovative models of housing and health care.

(3) Allowing asset shifting to continue significantly undermines policy aims to encourage private financing of long term care, including long term care insurance and reverse mortgages.

(4) Court opinions on this topic typically uphold the legality of asset shifting relying on analysis that suggests that Congress is well aware of the significant loopholes and has chosen not to act to change the law.

(5) The benefits of asset shifting are only available to citizens sophisticated enough to hire an attorney, who specializes in asset shifting, at great expense.

Specific Recommendations:

Once again, I applaud the committee for examining ways to improve the provision of long term care. I encourage the committee to include the following changes as it develops its Medicaid reform legislation this year.

CCRCs Policy Reform:

- Encourage seniors to privately fund their long-term care needs by clarifying that CCRC contracts that require residents to spend disclosed assets prior to applying for Medicaid are enforceable; and

- Clarify in statute that CCRC entrance deposits that are available to pay for long term care costs must be spent prior to being eligible for public assistance such as Medicaid.

General Medicaid Policy Reform:

- Clarify that the policy intent of Congress is that Medicaid is the payer of last resort.

- Close loopholes that treat income and assets differently-allowing the use of annuities to shelter significant sums of assets;

- Lengthen the 3 year look back period; and

- Increase the penalties for inappropriately gifting assets.

Once again, I deeply appreciate the willingness of the committee to more fully understand the growing problem of asset shifting and its short and long term impacts on the Medicaid program and the provision of long term care in general. In closing, I recommend to you the following Wall Street Journal editorial which does an excellent job of addressing the current situation as well as demonstrating its potential impact on our health care system.

Reprint from Wall Street Journal Editorial

Medicaid for Millionaires

February 24, 2005; Page A1
4

Medicaid was established in 1965 with the worthy aim of providing medical care for the poor; it was never intended as a middle-class entitlement or as inheritance protection for the children of well-off seniors. Yet the latter is precisely what has happened -- to the point that sheltering assets and income to qualify for Medicaid is now as routine as writing a will.

If you don't believe us, Google "Medicaid estate planning" on the Web and see what pops up. There's a whole "elderlaw" industry out there dedicated to the children of seniors who want to make sure that other taxpayers, not they, pay for nursing-home care via Medicaid should mom or dad ever need it. As one advertiser puts it, "You can qualify for Medicaid while preserving most assets & savings!"

Such "asset-shifting" may be morally questionable, but in most cases it is entirely legal. Anyone can give away most of his assets and three years later become eligible for Medicaid with no questions asked. Or, since a home, business and car of unlimited value are excluded from the calculation of assets, someone who wishes to qualify for Medicaid may shield his money by remodeling his house, investing in the family business, or purchasing expensive cars that he then gives away to family members (the notorious "two Mercedes rule"). Term life insurance -- also of unlimited value -- is excluded as well.

Medicaid "planners" often counsel well-to-do clients to save enough money to pay for a year of care at a private, high-quality nursing home, which under federal law can't kick you out if you then switch over to Medicaid. As Stephen Moses of the Center for Long-Term Care Financing points out, "Poor people don't have key money, so they end up in the least desirable 100%-Medicaid facilities, while the lawyers' clients occupy the scarcer Medicaid beds in nicer nursing homes." About 70% of nursing-home patients are on Medicaid.

Who Pays?

Nursing-home costs are increasingly borne by Medicaid.

	1968	2001
Medicaid	23.7%	47.5%
Out of Pocket	55.9	27.8
Other*	12.3	13.6
Medicare	8.2	11.7
Total	$2.9 billion	$98.9 billion

* In 2001 other expenditures included private health insurance and Veterans Administration spending. In 1968, they were mostly spending by federal, state and local governments.

Source: Centers for Medicare & Medicaid Services

Congress has periodically tried to clamp down on abuses but usually ends up making things worse. In 1993 it passed a

law requiring states to recover the cost of benefits from the estates of deceased recipients (or from the estates of the spouses they pre-decease). This bombed, as most states make only half-hearted efforts to recover Medicaid costs. In 2002, state Medicaid programs spent $46.5 billion on nursing home care but recovered a measly $350 million from estates.

An excellent way to keep seniors off Medicaid would be to encourage more to buy their own long-term care insurance. The Department of Health and Human Services was experimenting with a "Partnership" program to do just that in the early 1990s, only to be shut down by Congressman Henry Waxman (D., Calif.).

Under the Partnership program, a consumer who purchases, say, $100,000 in long-term care insurance can exempt that sum before drawing down the rest of his assets and, if necessary, going on Medicaid. Not only does this give the senior a guaranteed amount of money to preserve for his heirs, the insurance payouts give him the freedom to purchase the long-term care of his choice. If he wishes to use the money for home care, he can do so.

The four states that had already implemented Partnerships before Mr. Waxman imposed a ban -- New York, Connecticut, Indiana and California -- were permitted to proceed and 13 years later their experience suggests that incentives work. According to Michael O'Grady, an assistant secretary at HHS, 180,000 insurance policies have been sold (a faster rate than in non-Partnership states), 2,000 policyholders have received insurance payments, yet only 86 people have gone on Medicaid.

Long-term Care Partnerships are an even better idea now that baby boomers are approaching retirement and every state is looking for ways to slow the growth in Medicaid spending. As part of its proposed reforms, the Bush Administration wants Congress to lift the Waxman ban. Mr. Waxman's office says he remains skeptical, which is not surprising since he is renowned for using his power to make more Americans dependent on government. Many liberals actually want more of the middle class to get hooked on Medicaid because it helps them build support for higher taxes.

The Administration also wants Congress to update the look-back law, so that the three-year grace period for giving away assets doesn't begin until a senior enters a nursing home or goes on Medicaid. Other measures worth considering include eliminating the home exemption, and requiring seniors who need long-term care to take out reverse mortgages (borrowing against the value of their home) to pay for it.

Ohio is considering a proposal under which the state would claim title to a senior's assets, giving him a zero-interest loan against Medicaid benefits until he is deceased and the assets are used to offset the costs incurred by the state for his care. Seniors who choose cheaper care options would get to keep more assets. This is "the most aggressive effort to control long-term care costs anywhere in the nation," says John Goodman of the National Center for Policy Analysis.

Long-term care accounts for about one-third of federal and state expenditures on Medicaid, to the tune of $100 billion this year. It is the biggest driver of skyrocketing

Medicaid costs that are bankrupting many states and localities. Medicaid was created 40 years ago to care for the needy. The rest of us have an obligation to pay for our own care -- or to protect our wealth with private insurance.