

# The ElderLaw Report

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## SELF-FINANCING LONG-TERM CARE: THE ELDER LAW ATTORNEY AS INVESTMENT COUNSELOR

By Jerry A. Hyman

I am surprised when elder law attorneys tell me, as many do, that they don't do financial planning. "We refer clients who need financial planning to someone else," they often say. But the reality is that elder law attorneys *art*, financial planners by virtue of what they do in their practices. In this article, I present the case for the elder law attorney as financial planner and outline the critical need for some investment expertise when assisting clients with the self-financing alternative to Medicaid.

The Certified Financial Planner Board of Standards—the professional licensing, regulatory, and standards-setting organization for Certified Financial Planners—defines the job knowledge requirements for its licensees as:

- 1) General Principles (including assessment of client behavior and risk tolerance, financial statements and budgets, time value of money principles, and legal aspects of financial planning);
- 2) Insurance Policies and Strategies;
- 3) Investment Theory, Vehicles and Strategies;
- 4) Tax Planning;
- 5) Government Benefits;
- 6) Retirement and Employee Benefit Plans; and
- 7) Estate Planning.

There should be little disagreement that at least six of these seven fields of financial planning knowledge are part of the repertoire of elder law attorneys as well. The only knowledge component that is likely missing from most elder law practices is "investment theory, vehicles and strategies." This may be what elder law attorneys are thinking of when they say, "We don't do financial planning." But investments are only one small part of financial planning, and elder law attorneys are already doing the rest. They are financial planners.

Furthermore, I would argue that elder law practitioner shouldn't ignore investments. For example, a knowledge of investments is essential to helping clients evaluate the "self-financing" approach to funding nursing home care. I find that

many people prefer to avoid Medicaid if at all possible, and that in about 10 to 20 percent of my nursing home financing cases a self-financing plan can achieve better results than a Medicaid plan. But evaluating the viability of such an approach for clients requires a level of financial planning expertise that elder law attorneys may not, but probably should, have.

### *Medicaid Planning as Financial Planning*

A major component of most elder law practices is Medicaid planning, an endeavor that can involve a whole panoply of financial planning skills. For example:

John Henry, age 87, comes to see you about his wife, Alice, also 87. She has suffered a series of strokes in recent years, her mood and behavior have become increasingly erratic, and she was recently diagnosed with an unspecified form of dementia. At the beginning of the month, Mrs. Henry entered a local hospital, and last week she was discharged to a nursing home with a "private pay" rate of \$140/day. Mr. Henry is frightened. This seems like a lot of money to him and he doesn't think he can pay it for very long. But he also realizes that, due to her condition (and his advanced age and his own well-being), his wife shouldn't return home. You ascertain that Medicare benefits have been exhausted, no VA benefits are applicable, and the couple has no long-term care insurance.

Believing that Medicaid is the only possible option, you explain some of the basics of the program and how it is administered in your state. Then you gather the relevant financial information (see box on page 2).

You inform Mr. Henry of the Medicaid exemption for his residence. You also mention the small exemption (probably no more than \$1,500) allowed for life insurance, noting that cash value in excess of that amount will count against Mrs. Henry in determining her Medicaid eligibility.

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**Assets**

Residence	\$135,000
Bank savings and checking accounts	22,000
Bank CDs (yielding about 4.5%)	170,000
Brokerage account (primarily in bonds or bond mutual funds yielding 4-7%)	330,000

Life Insurance policies (all on Mr. Henry's life, Mrs. Henry beneficiary):

	<u>Face Value</u>	<u>Cash Value</u>
Policy #1	\$10,000	\$3,000
#2	3,000	2,200
#3	1,000	2,000

Fixed Income:

Mr. Henry	Mrs. Henry
\$ 968 Social Security (net)	\$755 Social Security (net)
152 pension (net)	25 pension (net)
<hr/>	<hr/>
\$1,120	<b>\$780</b>

At this point I like to present to clients the "do nothing" alternative. What if the Henrys simply spend down their assets until Medicaid eligibility is obtained? Roughly speaking, it would likely take Mrs. Henry at least 110 months (approximately nine years) to qualify for Medicaid in this fashion, during which time more than \$440,000 of the Henry's assets would disappear (\$644,200 of total assets, minus the value of exempt assets and other assets that Medicaid permits the Henrys to retain). The rate of spend-down is calculated as follows:

<b>\$ 4,400/month</b>	Mrs. Henry's nursing home costs
<b>+ 1,500/month</b>	Mr. Henry's budget for himself
<hr/>	
<b>\$ 5,900/month</b>	The couples' cost of living
<b>- 1,900/month</b>	The couples' total fixed income
<hr/>	
<b>\$ 4,000/month</b>	Rate of spend-down

$\$441,700 \text{ countable "excess" assets} = 110.4 \text{ months}$

**\$4,000/month** spend-down

In reality, however, the Henrys have an additional \$2,000 to \$2,500 per month of interest income that would further slow the rate of spend-down. While it is true that this interest income would decline as the principal eroded during the spend-down, and that over time costs would increase for both the Henrys, the actual spend-down process will likely take longer than ten years.

When Mr. Henry expresses dissatisfaction with this option, you outline how Medicaid planning might work. You suggest that Mr. Henry might increase exempt assets by putting more countable assets into his house and into pre-paid funerals. You tell him that he can give away assets, and you explain the 36-month and 60-month look-back rules and how transfer penalty periods are calculated. Perhaps you also tell him that he can buy an annuity for himself, as long as it meets Medicaid's test of "actuarial soundness", or he might petition the Medicaid agency to keep more than the \$84,000 spousal allowance. Finally, you explain to him that each of these planning options can be used by itself or in combination to qualify Mrs. Henry for Medicaid in far less than nine years and without spending down \$440,000.

If Mr. Henry is like most of my clients, his eyes have now glazed over and he has a headache. But at some point in the Medicaid planning process he's going to ask two questions: "From which accounts do I take the money to give away, or put into my house, or buy an annuity?" and, "What are the tax consequences of all this?"

Clearly from this stage onward, Mr. Henry's elder law attorney is Mr. Henry's financial planner. The attorney has already helped Mr. Henry create a budget and has had an

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opportunity to gauge Mr. Henry's financial sophistication and level of comfort with various financial moves. Now the attorney must determine which assets to deal with first. When does each CD mature? Will there be penalties for early withdrawal? Which of the bonds or bond funds should be liquidated, and which held intact? Should any of the life insurance policies be cashed or borrowed against? If assets are to be transferred, can they be transferred intact, or liquidated first and then the cash proceeds transferred?

What if Mr. Henry dies before Mrs. Henry? Shouldn't the attorney suggest to Mr. Henry that he not leave his estate to Mrs. Henry? What are the best alternatives in the Henrys' state of residence? Who should be the beneficiary of any of Mr. Henry's insurance policies that remain?

If Mr. Henry is interested in an annuity, how much should be invested in it? How much income will it produce? Most people who've never purchased an annuity (and even some who have) don't fully understand the concept. The elder law attorney should explain it to Mr. Henry, and help guide his choice of options among "straight life", "term certain", or "life with term certain" annuities. Should the attorney shop for the annuity on Mr. Henry's behalf? If so, the attorney ought to have at least a rudimentary understanding of the financial solvency ratings of insurance companies that sell annuities.

And, of course, the attorney can't ignore Mr. Henry's question about taxes. Will there be a federal or state gift tax resulting from Medicaid transfers? Is a gift tax return required, even though there may be no tax liability? How can the income tax consequences of liquidating assets be minimized? Should we transfer income-producing assets to family members in lower tax brackets? How valuable will the medical expense tax deduction be during any period when Mrs. Henry might be privately paying for nursing home care?

### *The Self-Financing Alternative*

The Henrys' situation, not untypical, illustrates that Medicaid planning involves highly sophisticated financial planning. But perhaps before launching into the analysis of Medicaid planning, the attorney might have at least considered a simpler alternative.

The Henrys have more than \$526,000 of investable assets (counting all the assets in the bank and brokerage account, and assuming the two smaller life insurance policies are cashed). The shortfall between their combined estimated expenses and their disposable fixed income is \$4,000/month, or \$48,000/year. Can their investments be reasonably invested to produce this amount?

\$48,000 shortfall

\$526,000 investment base = 9.125% required income yield

This simple computation shows that if the Henrys' invested assets could produce income in the 9 percent

range, they wouldn't need Medicaid. They could self-finance both Mrs. Henry's nursing home expenses and Mr. Henry's cost of living in the community, essentially without touching principal.

In considering the "self-financing" option, we should not lose sight of the onerous nature of Medicaid. It remains, technically, a welfare program. The application process may take months and require verification of every fact and figure stated in the application, stretching back 36 months or even longer. There will be difficulties obtaining this information, and frustration communicating it to harassed, overworked and poorly-trained Medicaid case-workers. Even if the process goes smoothly, it is a huge invasion of privacy. And it gets repeated every so often, albeit in a more compact version, when the Medicaid agency performs eligibility re-determinations or adjusts the "patient pay" amount. Apart from dealing with the Medicaid agency, there is also the problem of finding and keeping one of the limited number of "Medicaid beds" in a nursing home. When the Medicaid recipient later dies, there is the possibility of estate recovery.

But what rates of return on investment are achievable? Long-term U.S. Treasury securities yield more than 6 percent. That means that a 6 percent return on investments can be achieved with very little risk to principal. Returns in the 6 to 9 percent range are also not difficult to achieve from prudent investments that produce steady yields. Many types of corporate bonds and the dividends of some common, and many preferred, stocks yield 9 percent or even higher.

I also explain to clients that returns in the 9 to 12 percent range are attainable, assuming somewhat greater, but still prudent, market risks. The historic, long-term return from common stocks is about 11 percent. Thus, a large portion of the portfolio could be invested in common stocks with sound fundamental characteristics and good earnings prospects. Carefully timed sales of some shares of such stocks (or stock mutual funds) produce occasional capital gain income to replenish or add to ordinary income. In fact, I suggest some common stocks be a part of all "self-financing" portfolios, even where needed yield is under 9 percent, in order to properly diversify investments.

Most clients are uncomfortable with the risks associated with returns above 12 percent, and so am I. I don't suggest a self-financing plan would require a return above 12 percent, I generally don't suggest it: I proceed with detailed Medicaid planning unless the client suggests otherwise.

However, some cases that appear, at first blush, to require more than a 12 percent return actually do not. Consider the case of Mrs. James, a widow, with \$293,000 of investable assets and nursing home bills that exceed her fixed income by \$3,200 a month (\$38,400 a year). For the \$293,000 to annually produce \$38,400 would require a 13 percent return.

In talking with Mrs. James' son, you learn that she has been in the nursing home for four months and is very unlikely to return home. Her home is vacant and there is no practical way for the family to use it or otherwise maintain it. Despite the Medicaid-planning benefits of trying to preserve it as an exempt resource, the son is concerned that it will lose homeowner's insurance coverage and perhaps become a target of vandals. There appears to be little alternative to selling it.

The house is valued at \$140,000 and has no mortgage debt. If the proceeds of its sale, after expenses, can be \$130,000, then the self-financing scenario becomes much more feasible. Now Mrs. James' investable assets rise to \$423,000, and Mrs. James' \$38,400 per year shortfall can be financed with a 9 percent return on her asset.

## HCFA Restates Position on Post-Eligibility Transfers

The Health Care Financing Administration (HCFA) has reiterated its position that community spouses should incur no penalty when transferring resources to a third party once the institutionalized spouse has become eligible for Medicaid. The confirmation came in an e-mail exchange between attorney **Brian E. Barreira** of Plymouth, Mass., and **Roy Trudel** of HCFA's Center for Medicaid and State Operations in Baltimore, Md.

Citing a letter from HCFA Region X, Mr. Barreira stated his understanding that "[u]nder the spousal impoverishment protections, once eligibility is determined, the resources of the community spouse are no longer considered available to the institutionalized spouse. . . . That spouse can do whatever he or she wants with them, including leaving them, via a will, to no particular heirs that do not include the Institutionalized spouse." Trudel replied, in part, "[t]he language quoted. . . Is official HCFA policy on the subject of post-eligibility transfers by community spouses. This policy is not limited to Region X, but rather is applicable nationally. With regard to what actions you can take if a State agency is implementing this policy incorrectly, you could write to the appropriate HCFA regional office . . . and ask the regional office to look into the situation. Otherwise, adverse actions (including denial of payment for nursing home care because of a transfer of asset for less than fair market value) are always subject to appeal. An appeal may well yield a decision from a hearing officer or administrative law judge (or district court judge) that is favorable to your position."

## Limitations and Considerations

The self-financing option is not perfect. Private-pay nursing home expenses may rise faster than returns on investments. Therefore, some erosion of principal may be unavoidable. But few clients live more than three to five years in a nursing home before dying. During that relatively short time, a well-constructed portfolio's returns should be able to keep up with most expenses and require only minor dips into principal. Bear in mind that the Medicaid planning alternative may require much larger spend-downs of principal before any transfer penalty periods expire.

What if the market value of the portfolio goes down? Market downturns inevitably occur and, as a result, clients must expect temporary reductions in the value of their total principal. But this should not be a major worry if the portfolio is prudently invested and well diversified. Many of the investments are purchased for their relatively high, steady income and should continue to pay such income on a regular basis. Remember: high income is the primary need in these cases; growth of principal is secondary.

Furthermore, it is very rare for assets in a properly diversified portfolio to all drop in value at once. At any given time some market sectors lag while others advance. At various times capital gains can be taken from the gainers. As to the laggards! Don't sell them until their market performance improves to the break-even point or better. In short, "losses" in the portfolio should be only paper losses: it should rarely be necessary to sell any investment at a loss.

What about taxes produced by all the additional income? If this strategy is successful, the client will be earning higher interest and dividend income than he or she has in the past. Also, active management and trading in the stock portion of the portfolio may result in frequent, short-term capital gains.

In reality, though, taxes should not be a concern in these cases. The clients are paying privately for nursing home care, which means that most of the additional income will be offset by a dramatically increased medical expense deduction. Furthermore, some clients who had not before benefited from itemized deductions will be able to deduct other medical expenses, any state income and local property taxes, the occasional charitable deduction or other itemized deductions. Even with the tax law's limitations on itemized deductions, I find that they almost completely offset the additional income generated in these cases.

## Conclusion

Elder law attorneys practice financial planning, perhaps without realizing it. Should elder law attorneys become more knowledgeable in investment theory and portfolio management in order to more completely address their clients' nursing home cost concerns? Perhaps. It is impor-

tant that elder law practitioners know enough to present alternatives to Medicaid whenever feasible. Before aggressively planning for Medicaid, taking a moment to make a rudimentary investment return calculation should be a part of the elder law attorney's financial planning process. When self-financing seems reasonable, the elder law attorney ought to discuss it with the client.

Implementing the self-financing strategy and actually managing the portfolio are probably beyond the knowledge base and ability of most elder law attorneys. Having a financial planner as a referral source could be useful. The favor will often be returned; the financial planner will eventually refer clients to you who need estate planning documents drafted, legal advocacy at a nursing home, a guardianship, or even Medicaid planning (when investments are insufficient for self-financing).

For elder law attorneys who wish to more explicitly recognize the role of financial planning in their practices—even to the point of managing investments—other options exist. In a future article, I will present additional client scenarios that involve financial planning, and explore ways for elder law attorneys to explicitly incorporate financial planning activities into their practices (and perhaps increase revenue as well). I will also discuss some of the ethical, licensing and other regulatory issues that may be encountered along the way.

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