Welcome to InFRE’s July, 2017 Issue of Retirement Insight and Trends

Retirement InSight and Trends is the quarterly newsletter for the International Foundation for Retirement Education’s Certified Retirement Counselors® (CRC®s) to help retirement professionals with the practical application of new retirement readiness, counseling, planning and income management concepts for the mid-market. Find out more about the CRC® and InFRE here.

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July, 2017 InFRE Update: Guidelines for the Use of the Certified Retirement Counselor® (CRC®) Mark

retirement-insight.com/july-2017-infre-update/

We've noticed recently that some CRC® Certificants need a reminder on how to properly display the marks on their business cards, email signatures, or on LinkedIn.

Because the CRC® and Certified Retirement Counselor® marks are trademarked, it is important for all Certificants to properly display the marks in commerce. CRC® Certificants are essentially "licensed" the right to use the marks to indicate that they currently meet all the requirements necessary to be a Certified Retirement Counselor®. By all of us doing our part to protect the use of the marks, we maintain their value.

Here is a reminder of how to properly use the marks, excerpted from the CRC® Certificant Handbook, beginning on page 14.

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A *trademark* which uses symbol "®" is a word, phrase, symbol or design, or a combination of words, phrases, symbols or designs, that identifies and distinguishes the source of the goods of one party from those of others. The federal registration symbol "®" may only be used *after* the U.S. Patent and Trademark Office actually registers a mark.

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Retirement Planning Ltd.
123 Lane
Your Town, ST 45678

John Smith, MBA, *CRC*®
1-555-555-1234

Letterhead

Retirement Planning Ltd.
123 Lane
Your Town, ST 45678

March 15, 2013

Dear Client:

Recent changes in tax laws have affected retirement planning by ...

John Smith, MBA
Certified Retirement Counselor®

B. Online (e-mail, websites, domain names, email addresses):

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No, though InFRE prefers that you do use italics when possible. Non-italicized type is acceptable though.

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3. *How do I make the ® in my Word document or Outlook e-mail?*

® = Ctrl+Alt+r (to superscript, highlight the symbol and press Ctrl+Shift

Elder Law Basics

retirement-insight.com/elder-law-basics/

Amber B. Woodland, Esq., Partner at Procino-Wells & Woodland, LLC

Editor's note: This article is an adaptation of the live webinar delivered by Amber B. Woodland, Esq. in 2017. Her comments have been edited for clarity and length.

You can read the summary article here as part of the 2nd Qtr 2017 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.

You may also choose to take the full length course Elder Law Basics: Long Term Care Medicaid & Asset Protection Planning for Seniors – Amber Woodland, Esq for 2.0 hours continuing education (CE) credit.

By Amber B. Woodland, Esq., Partner at ProcinoWells & Woodland, LLC.

This is a topic that I am extremely passionate about. I love what I do; I love serving my community and seniors in my community and helping their families every single day.

Most of us know of someone or have a loved one, friend, or family member, who has experienced some sort of long-term care. I am licensed to practice in the State of Delaware. In Delaware, the cost of a nursing home can be $9,500 a month; the national level is slightly less than that. That's $115,000 a year, and for a lot of people, that can wipe out their life savings.

The cost of nursing home care can quickly reduce a client's net worth, so as professionals who serve seniors, it's vital for us all to understand what asset preservation strategies may be available. The target client is really a middle-class community member. It is not someone who is so wealthy that they can afford to pay for extended long-term care, and it's not someone, either, at the other end of that spectrum who doesn't have any assets to their name and who could otherwise qualify. It's really for that middle class who have worked hard, who have saved some, but $9,500 a month would wipe them out and wipe them out quickly.

So, I really hope you'll leave today being able to spot issues for your clients, avoid common planning mistakes, and identify potential solutions so that they're better served.

The Basic Definition of Elder Law

Elder law is a legal practice that really places an emphasis on issues that affect the growing aging population. We break that out into four major categories.

1. The first is basic estate planning with the use of wills, revocable trusts, powers of attorney, advanced healthcare directives, and asset protection planning for seniors. (Laws in the federal estate tax world have changed and now a married couple can leave $11 million or more at their death free of tax, so there's not as much of a need any longer to do a lot of tax avoidance planning.)
2. Adult guardianships, or conservatorships, for an incompetent adult who does not have a power of attorney in place and is not able to make his or her own legal and financial, or maybe even medical, decisions.
3. Asset protection planning is where we are looking at legal and ethical ways to shelter a person's savings. We necessarily don't save everything, but if we do pre-planning, we can save a bundle. We can also do call

"crisis planning," where we can still shelter between 50 and 60 percent of the remaining assets at the last minute.

4. Obtaining eligibility for government long-term care benefits such as Medicaid and/or Veterans Pension with Aid and Attendance.

What is Medicaid?

I see a lot of confusion about the difference between Medicare and Medicaid, I think mostly because the two names are so similar. The easiest way, I think, to remember the difference is Medicaid has "aid" at the end. It is a needs-based government benefit, or aide. It's assistance that a person must qualify for, whereas Medicare is health insurance for a person who is age 65 or older, who has worked, and who has paid into the system. Medicare is a health insurance benefit that anyone can qualify for, regardless of need, so they can have an unlimited amount of wealth or income and still qualify for health insurance.

The federal government and each individual state share the cost of Medicaid. The states are required to comply with federal requirements to receive the money from the federal government. Every state can do it differently; if the state isn't any more restrictive than what the federal rules allow, then the state is in compliance with the federal framework.

One of the major changes that occurred in 2006 was that the look-back period changed from three years to five years, meaning that any transfers made out of the applicant's name within five years of applying for Medicaid had to be disclosed to Medicaid.

A few relevant resources are "The Program Operations Manual System", often referred to as POMS, and is where the Social Security Administration looks at their policies and procedures. So, if a person is employed by Social Security, they turn to this and look at how the federal regulations are really interpreted. There is also the State Medicaid Manual, which is a federal resource that can be found on the Centers for Medicare & Medicaid Services website.

Payment Options for Long Term Care Costs

If a person needs extended long-term care that costs $100,000 a year, how are they going to pay for it? The first option that we always consider is Medicare. Medicare is interesting because it is a federal program. It pays for doctors' visits, it can pay for prescriptions, and it can pay for hospitalizations, but Medicare will only pay for up to 100 days of care received in a skilled nursing facility.

Once someone no longer needs hospital care, they're discharged to a long-term care facility for rehab. The Medicare program only covers, at full pay, the first 20 days of that rehabilitation in the skilled facility. Days 21 to 100 are paid partially by Medicare, and then, if there's any supplemental insurance, the supplemental health insurance picks up the rest. After 100 days, if the person still needs rehabilitative care and cannot go home because it's not safe or the care in the home is not going to be sufficient for what they need, Medicare stops.

The next payment option is long-term care insurance. If a client has long-term care insurance, it's a great contributor toward the cost of long-term care. However, a lot of my clients don't have long-term care insurance, and it may be because it's very expensive and they don't think that they can afford it. Or it may be because they can't qualify for it due to a previous health concern or diagnosis.

The daily benefit of long-term care insurance generally is still insufficient to pay for the daily rate to the nursing home. A long-term care insurance contract might provide $100 of daily benefit. If the cost of care is $300, there's still a $200 daily shortfall, and that multiplied by months and then years is a staggering figure.

Next, we look at whether there are other sources of income which can be used to help pay for the care, such as

Social Security, pensions, alimony, and required minimum distributions. However, in a lot of cases, because the cost of care is so high, long-term care insurance and other sources of income are still insufficient to pay that nursing home bill. They might then start liquidating assets and privately paying. Some people choose to do this because they don't know of other options or because they don't want to engage in asset protection planning for one reason or another.

The final payment option is public benefit programs. Long-term care Medicaid and/or VA Pension with Aid and Attendance is often what we are looking for. Is there a way to do legal and ethical asset protection planning to qualify an applicant for Medicaid and/or VA? By adding in those additional benefits, we can potentially shelter and protect some of the assets that are left.

How Do You Qualify for Medicaid?

Medicaid has a three-part test. A person is not eligible for Medicaid unless or until they have satisfied all three branches of this test:

1. qualify medically,
2. qualify under the income part of the test, and
3. qualify under the asset and resource part of the test.

If a person is sitting in our office, they're here because they have a loved one who needs care; they're not sitting here because they just want to be admitted to a nursing home. So the medical piece of the test is not something we spend a lot of time on because all applicants who apply for Medicaid must complete a pre-admission evaluation, which is a form submitted in order to start the Medicaid process. They have to be medically eligible.

Where we spend our time in the Medicaid context as elder law attorneys is in the income and resource parts of the test. Let's talk about the income test first. Delaware is known as an "income cap" state. There are 24 income cap states, so nearly half the country has this same rule. The other half of the country does not have an income cap, and when there's no income cap, there is no need to satisfy any type of income test. When there's no income cap, the person is eligible under the income rules.

When you have a married couple and only one spouse needs care, there are rules in terms of income for the well-spouse who is still living in the community, and then for the ill spouse who is receiving care in a nursing home. Generally, there's something under the federal rules called the "spousal impoverishment" rules, and these rules are designed to prevent the well-spouse from becoming poor, destitute, and impoverished.

One of the spousal impoverishment rules says this: The well-spouse is entitled to retain all of her own monthly income. So, if a well-spouse living in the community receives Social Security, receives her pension, and maybe receives alimony from a former marriage, all of those sources of income are retained by the well-spouse. She is under no legal obligation to contribute any of her monthly income toward her ill spouse's cost of care.

There is a rule called the Minimum Monthly Maintenance Needs Allowance, which says the well-spouse could be entitled to a portion of her ill spouse's income if her own income does not equal $2,002.50 (2016). If the well-spouse only has a few hundred dollars coming in from Social Security, even if her spouse is in a nursing home, she would be able to keep enough of his income to put her at $2,002.50 to ensure that she can continue to live in the community, pay her house-related bills, pay for her gas, and pay for her normal, everyday living expenses.

The Medicaid Asset or Resource Test

The third part of the Medicaid test is the asset or the resource part of the test. These rules are so strict, and most, if not all, of our clients have more than they're allowed to under the resource rules. This is where we put our planning

hat on to look at what planning opportunities may be available to strategically, legally, and ethically reduce a person's assets and qualify them for public benefits.

The strict resource limit, under the Medicaid rules, is $2,000, so a single applicant can have no more than $2,000 in assets to qualify for Medicaid. What is counted as a resource? Medicaid says that it's pretty much anything the applicant can put his hands on. If the applicant has the right authority or power to liquidate, that is an available resource under the Medicaid rules. Life insurance, for instance, which has cash value, is an available resource because it could be liquidated for its cash value. We would forego the death benefit, and we would have to use that cash value and spend that down, paying for long-term care.

There are some exclusions. The first exclusion is the person's residence, but in a single-person case, the residence can only be excluded if one of two things occurs. The first is if the applicant is still residing in the home and receiving home-based services under the Medicaid program. Then, the house is protected, because the resident is the applicant and is going to continue to live there.

The second case where the residence can be excluded is if a single applicant is in a nursing home but signs a statement that says he intends to return home. Even if everybody knows that there is no way that he's going to be able to go home, if he is able to sign a statement that says he wants to return home and intends to do so if he ever could, that's enough to delay the house from being considered an available asset.

However, be aware of what's called "estate recovery." Estate recovery is the branch of the Medicaid department that has the right to place a lien against the residence or to file a claim against the decedent's estate after the applicant has passed away, requiring the residence be sold and those proceeds used to satisfy the lien or satisfy the claim against the estate.

A vehicle is excluded. A person's household goods and personal effects are always excluded. Life insurance with no cash-surrender value is off the table, and any prepaid irrevocable funeral arrangements are also off the table. Everything else is available and would have to first be reduced to $2,000 before a person could qualify for Medicaid.

Then there are married couple asset rules. Say you have a family that has done absolutely no planning. One spouse needs nursing home care; the other spouse is well and still able to live at home. Which assets are excluded? The house is excluded, in this case, because the well-spouse lives there. Again, one vehicle, household goods, and personal effects are protected. Life insurance, again, with no cash value is excluded, and prepaid irrevocable funeral arrangements are excluded.

So, if you're looking at a married couple's assets, and you take everything out of the excluded section and set it aside, everything else is what's potentially available to pay for the care of the ill spouse: normal, everyday bank accounts; stocks, bonds, and CDs; life insurance with cash value; and it's the retirement accounts of the ill spouse. We look at all of that together as part of a common pot, and the general rule is this: We split that pot, and we allocate half to the wife and half to the ill spouse.

If she is allocated half of that pot, she's entitled to keep that, but if her half is higher than $119,220, she is capped at only keeping $119,220. Everything else gets allocated to the ill spouse and must be spent down to $2,000 before he can become eligible for Medicaid. There's also a minimum there, so if what's on the table is less, essentially, than $25,000, then the well-spouse gets to keep it all. That happens very, very rarely, but it does happen in some cases.

Medicaid Transfer-Penalty Rules

I mentioned earlier that there's a five-year lookback period, but all that means is that if there have been any transfers made within five years of applying for Medicaid, they must be disclosed. The amount of those disclosed transfers then gets put into a calculation.

There is a current divestment penalty divisor of $301 a day, or $9,156 a month. In other words, if we apply for

Medicaid and we disclose that we gifted, in the last five years, $9,156, that's going to result in one month of ineligibility. If we disclose $18,000 had been gifted, that's two months of ineligibility, and so on. If a penalty period is imposed, we must figure out how we're going to pay for the care that's needed during that penalty period. The penalty period cannot begin until the applicant is otherwise eligible for Medicaid. So, the assets have to be reduced to $2,000 before the 1-, 2-, 3-, 15-, 24-month penalty period would ever even start. Elder law attorneys help get a person otherwise eligible and create a plan to ensure that the applicant is going to have the ability to privately pay during the penalty period.

Medicaid has a presumption. It's a rebuttable presumption, but they presume that any gifts made within five years were done for the purposes of qualifying for Medicaid. That includes charitable gifting. It includes annual exclusion gifting, so right now, that's $14,000 a year that can be given away. That's a tax rule. Under the Medicaid regulations, Dollar 1 of that would count against a potential penalty period.

There are some exceptions: Transfers between spouses don't result in a penalty period, so we could transfer money, assets, or real estate between spouses all day long, and no penalty would be imposed. Transfers can be made to blind or disabled children without penalty. A house can actually be transferred to a caregiver child who has cohabitated and lived in the home for two years before the applicant needs long-term care, without penalty.

This doesn't come up a lot, but if there are cohabitating siblings, and the applicant sibling has an equity interest in the house, and they've been living together for one year, then the house can be transferred, essentially, to the well-sibling, and it would not result in a penalty.

Veterans' Benefits and Long-Term Care

Veterans' benefits, just as a reminder, are another type of benefit that can be used to help pay for long-term care for someone who is facing a large bill. The Department of Veterans Affairs was established in 1930.

Here's the chain of command: Congress passes a law; it's then recorded in the United States Code, but then it's enforced by new regulations that get published in the Code of Federal Regulations, or the CFR. If you're helping someone qualify for Veterans Benefits, you must be accredited.

There are a lot of different types of veterans' benefits. The first type I will mention is a disability benefit. It's often called "service-connected disability" or "disability compensation." This type of benefit is for someone who was injured during active duty.

Where I spend most of my time is dealing with a benefit that's called the Pension benefit program under the VA is, which is essentially the VA's Medicaid program. It's a means-tested disability benefit. The specific name is Service Pension, for a veteran who needs the financial assistance to pay for long-term care, and then Death Pension, which is for the surviving spouse of a veteran who needs that same financial assistance to pay for long-term care.

A married veteran who needs the aid and attendance of another could potentially receive $2,127 of additional monthly income. That's huge for somebody who is facing an outrageous nursing home bill each month, so we look at whether a person may or may not be eligible for veterans' benefits.

Just like Medicaid, there's a three-part test to be eligible. There's a military test, a medical test, and a financial test, and a claimant must qualify under all three parts in order to be eligible for VA Pension.

1. **Military test**. The service requirements are this: A person must have served in active military, naval, or air service. You may be thinking, "Well, what about the Coast Guard or the National Guard?" Those folks are only included in this if they were activated during wartime, so, in most cases, National Guard and Coast Guard are not included. If a person is a veteran who served in active duty, that active duty must have been for a continuous 90 days, and at least one of those days has to have been during a declared period of war. The

veteran also must have been discharged or released under conditions other than dishonorable. If it's a surviving spouse who was not a veteran – the deceased person was the veteran – we're still looking at the deceased veteran's service to determine whether that surviving spouse can get her foot in the door with the VA.

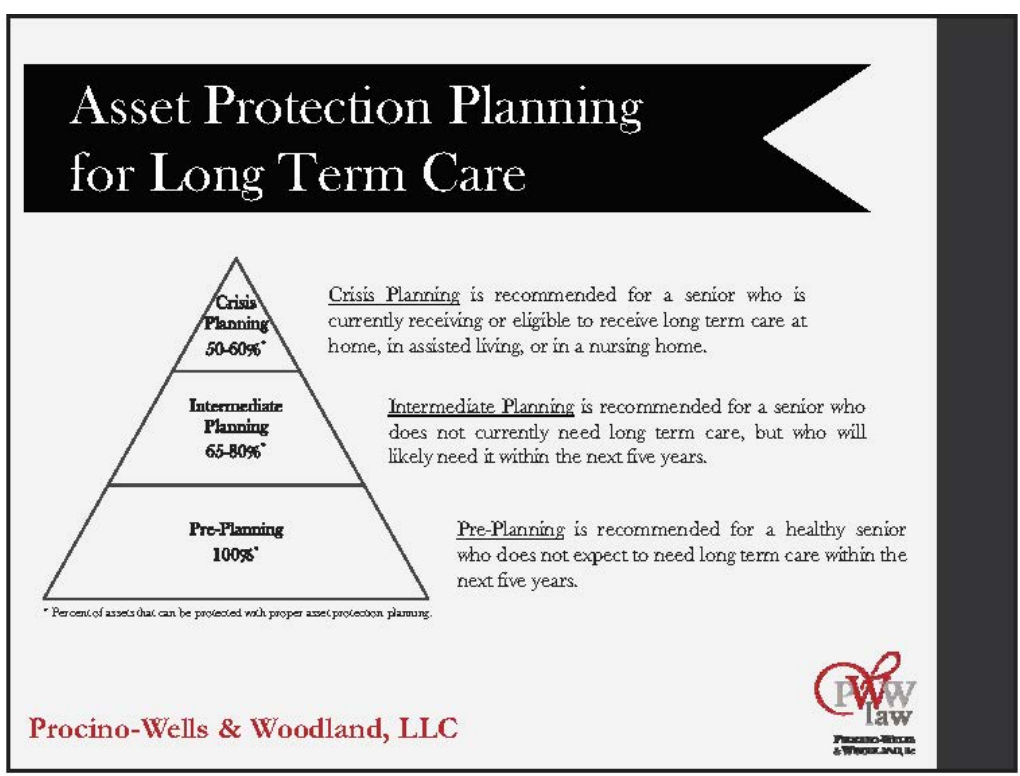
Reserve status is not sufficient. My own grandfather was in Reserve status during a declared period of war, so he would not be eligible.

2. **Medical test.** For Basic Pension, all you must prove is that the claimant's over 65. If the claimant's not over 65, then we must prove that the claimant is permanently and totally disabled. Permanent and total disability is going to mean the Social Security Administration has determined disability: there's been a Parkinson's diagnosis; the person is a nursing home resident. All those things would show permanent and total disability. Basic Pension is the lowest level of Pension.

Most of our clients come to us unable to perform two or more of their activities of daily living. For VA purposes, that means dressing or undressing, keeping clean and presentable, and feeding. If a person is blind, if a person is a nursing home resident or assisted living resident, or is unable to perform two or more activities of daily living, then they would qualify for that increased aid and attendance benefit.

3. **Financial rules.** Under the financial rules, there is an income and asset test. You probably expected that just like under the Medicaid rules. The income rules under the VA can get a little tricky.

Three Levels of Elder Law Planning



We use this pyramid concept to talk about the options available to folks. The bottom of the pyramid, the fattest part of the pyramid, is where we put pre-planning. Pre-planning is recommended for that healthy senior when it's not foreseeable that they'll need any type of long-term care in the next five years. In the pre-planning context, assets

that we set aside are protected at 100 percent, as long as five years or more go by.

The middle part of the pyramid is the intermediate planning context. Intermediate planning is recommended for a senior who does not currently need long-term care, but who will likely need care within the next five years. In the intermediate planning context, there's planning that can be done so that 65 to 80 percent of the assets are still protected.

Crisis planning is that last-minute planning for a senior who is currently receiving, or eligible to receive, long-term care at home, in assisted living, or in a nursing home. With crisis planning – last-minute planning – 50 to 60 percent of the remaining assets can still be protected.

Michele, my business partner, recently had a case where a gentleman had been receiving care in a nursing home for ten years. He had spent over $1 million paying for his long-term care before his family ever came to us. When his family came to us, they still had a few hundred thousand dollars left. It wasn't too late to engage in planning to protect about $150,000 of what was remaining. At least, we could create a little nest egg. We could protect him from being completely broke before he went on Medicaid, and then, ultimately, to leave a legacy to his family of something.

That's a pretty extreme case, but it's just important to know that crisis planning means this: It is never, ever too late to do planning, as long as the person needing care still has assets remaining.

The Goals of Asset Protection and Long-Term Care Planning

The goals of asset protection are, first and foremost, to ensure that there's a payment for the needed services to make sure that a person doesn't outlive their savings. The worst possible thing that could happen is for a person to need long-term care for so long that they blow through all of their life savings, have nothing left, and qualify for Medicaid because there is no nest egg available to supplement the things that Medicaid may or may not provide.

If a person completely runs out of money, is receiving care in a nursing home, and is on Medicaid because they're poor, needs dentures, hearing aids, eyeglasses, a computer, TV, or a recliner, that resident is going to go without because he doesn't have a nest egg that could be used for those things, or his kids and other family members are going to have to chip in their own money to pay for those.

So, the main goal of asset protection planning is to set aside some of the applicant's own money that can be used for the applicant.

The second part of this article on Elder Law Basics will appear in the next issue of Retirement InSight and Trends, and will cover strategies to consider for ensuring there are income and assets to pay for needed services so a person doesn't outlive their savings.

About Amber Woodland, Esq.:

Elder Law Basics: Long Term Care Medicaid & Asset Protection Planning for Seniors – Amber Woodland, Esq.

Amber Woodland, Esq. is a member of the bar of the Supreme Court of the State of Delaware. She is also accredited by the Department of Veterans Affairs (VA) to prepare, present and prosecute claims for veterans before the VA. Amber's practice is focused in elder law including asset protection planning for long term care (Medicaid and VA), wills, trusts, estates, powers of attorney, health care directives and guardianships.

Amber is a graduate of Flagler College (Bachelor of Arts Degree, Psychology, Cum Laude, 2007), Saint Augustine, Florida; and Regent University School of Law (J.D., 2010), Virginia Beach, Virginia.

In law school, Amber served as the Chairperson for the Volunteer Income Tax Assistance Program. She also received recognition in an article titled "Healing Healthcare Through Tax Reform," Regent Journal of Law & Public Policy, Volume 2, Number 1, Spring 2010, 63, for her editing and research assistance. In addition, Amber served as a legal intern for a law office in Newport News, Virginia, where she primarily concentrated in the areas of estate and tax planning.

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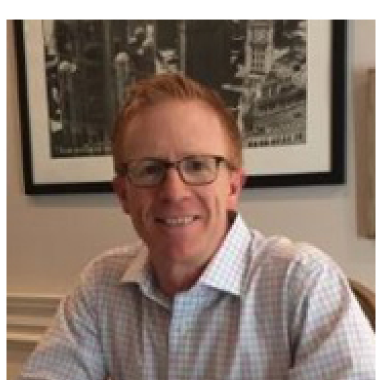
Boost Retirement Security with HSAs

Roy Ramthun, MPH, “Mr. HSA”

By Roy Rantham, MPH, “Mr. HSA” **and Aaron Benway, CFP®, MBA**

Couples who are 65 years old and retiring today are projected by Fidelity to need $260,000 in retirement to cover all of their out-of-pocket costs for the rest of their life, after what Medicare pays. Medicare also does not include long-term care. For those 45-year-old couples today, the United Health Foundation suggests that at age 65 they will need almost $600,000 for out-of-pocket healthcare costs in retirement.

Aaron Benway, CFP®, MBA



Editor’s note: This article is an adaptation of the live webinar delivered by Roy Ramthun and Aaron Benway in 2017. Their comments have been edited for clarity and length.

You can read the summary article here as part of the 2nd Qtr 2017 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.

You may also choose to take the full length course Boost Retirement Security with HSAs: Why Financial Planners and Advisors Should Add HSAs to Client Retirement Strategies – Roy Ramthun and Aaron Benway for 1.0 hour continuing education (CE) credit.

The Employee Benefits Research Institute found that for a 50/50 chance of having saved enough money to cover out-of-pocket expenses in retirement, a 65-year-old man will need over $72,000 set aside by age 65 and a woman will need $93,000. To raise the likelihood to a 90 percent chance that they will have sufficient funds to cover the out-of-pocket healthcare expenses in retirement, the numbers increase to $127,000 for men and $143,000 for women. The Employee Benefit Research Institute also suggests that Medicare will cover only about 65 percent of retirement healthcare expenses, though its ability to do so is at risk as Medicare’s trustees tell us we’re ten years away from insolvency for some portions of the program.

The remaining expenses that will not be covered by Medicare – your out-of-pocket expenses – include things like your premiums, your deductibles, copays, coinsurance, and supplemental costs such as Medicare Advantage plan premiums, or dental and vision care. In sum, Medicare is not going to cover a substantial portion of healthcare expenses in retirement.

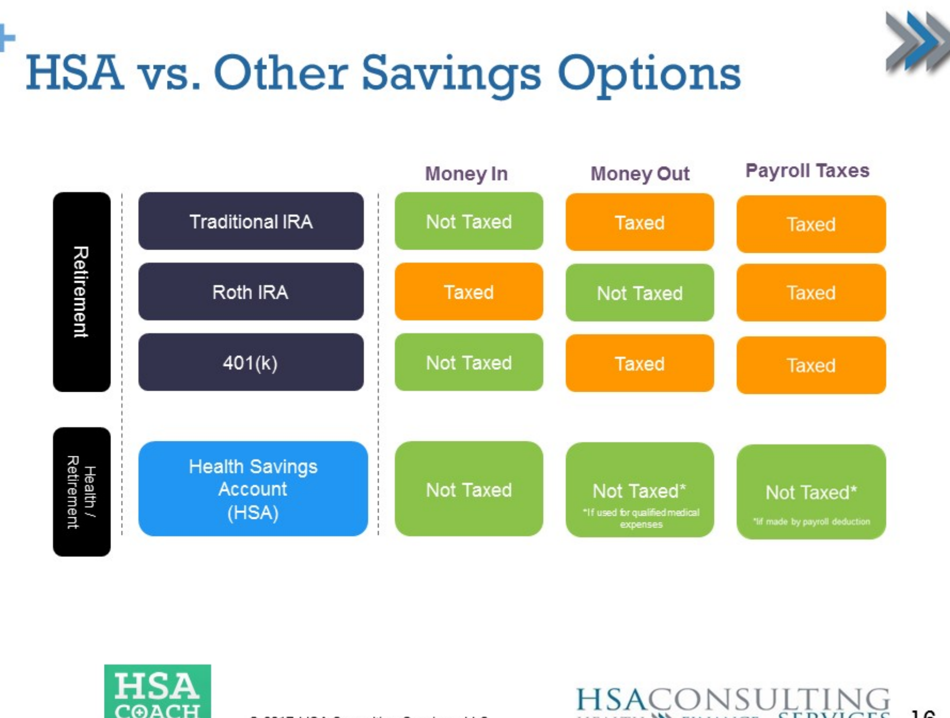
With these dynamics at work, we think there’s a need for a health savings strategy. This naturally presents itself as another opportunity for financial advisors to assist and engage with their clients. This could mean such things as helping grow your clients’ healthcare savings balances, implementing more tax efficient strategies – and this includes withdrawals as well – assisting with allocation decisions, and suggesting strategies on how to address paying for retirement healthcare.

What is a Health Savings Account (HSA)?

An HSA plan couples a qualified high deductible health plan to an IRS-defined, tax managed savings vehicle. Under the guidelines, if the plan itself meets the definition of a qualified high deductible health insurance plan, then the

insuree tax payer can open an HSA. The health insurance plan and HSA are meant to work in tandem. The HSA, like the more traditional or more familiar Flexible Spending Account (FSA), helps you pay deductibles, but it also features tax-deductible deposits and tax-deferred growth, which is what differentiates it from a FSA. It continues to offer tax-free funds for medical care, both now and in the future, which we'll get into later.

Here we want to compare a health savings account to other more traditional retirement plans such as an individual retirement arrangement (IRA), a Roth IRA, or a 401(k).



Typically, saving in tax-deferred accounts is just a strategy of paying me now or paying me later through the lens of the U.S. Treasury. We add a third column, payroll taxes, because since it doesn't impact traditional retirement plans, it's not often talked about. But lower payroll taxes for both the employer and the employee is an additional benefit of using the high deductible plan/HSA combination. You'll notice that for qualified medical expenses, the health savings account, which is the bottom row, is the only plan not taxed when money is earned, money goes in, or money goes out.

Many HSA providers – not all of them – will restrict the funds available to invest in. You can certainly find a few that don't. Unlike a FSA, which is a checking account whose funds expire at the end of each year, an HSA can be invested in assets that look very familiar to those who already own an IRA or 401(k) or both, such as stocks, bonds, mutual funds, ETFs, or real estate (via funds, that is).

If you haven't been following HSAs, they are growing very rapidly. Over the last five years, the number of accounts has tripled to over 20 million as of the end of 2016, and that growth trend has been on a tear of about 20 percent per year. There were around $37 billion in HSAs as of the end of 2016. Based on these current growth trends it is expected there will be $53 billion dollars in HSAs by the end of 2018.

Employer Health Insurance Plans and Health Savings Plans (HSAs)

An HSA needs to be paired with a qualified high deductible health plan. Employers are increasingly offering this option, and in some cases, making this the only option that the employees have when choosing their health insurance. Mercer suggests that by the end of 2019 over 72 percent of employers will be offering health insurance

plans that can be paired with an HSA. A third of all employees are enrolled in these types of plans as of the end of 2016.

These trends are largely driven by rising health insurance costs. Employers are struggling to keep annual rates of cost increases in the single digits. The main way they're doing that is by raising deductibles to keep premium increases at more manageable levels. You have to wonder what premium increases would be if deductibles remained static.

Around 10 percent of employers offer high deductible plans as the only choice for their employees. This is clearly being driven by larger employers, with middle-sized employers and smaller employers increasingly looking to these options as a solution to their rising healthcare costs. So many employees are going to find themselves where they are now eligible to have an HSA. This trend is likely going to continue, so position yourself to take advantage of it.

Why are employers switching to these plans? Every September, the Kaiser Family Foundation and Human Resources Education Trust publishes an analysis of employer-sponsored health plans, and they have a whole chapter devoted to high deductible plans. They compare them to the more traditional plans with lower deductibles, and in the most recent survey found that the premium difference is on average about 13 percent less. This saves both the employer and the employee money that can then be available to deposit into HSAs rather than be paid to the insurance company in the form of premium. Average employee contributions to insurance premiums are $1,746 less and average employer contribution to HSA accounts is $1,208. The total "free" money available to then contribute to an HSA is approximately $3,000.

A more recent study from Fidelity suggests that employees saving in their HSAs are not cutting back on their 401(k) contributions, so their overall savings rates are higher compared to those who only save money in a 401(k). In addition, nearly 90 percent of the HSA participants either maintained or increased their 401(k) savings after they enrolled in the HSA. This is powerful evidence that an HSA is an additional retirement planning tool, and people are starting to understand and take advantage of it.

Why Are Health Savings Accounts (HSAs) such a Great Saving Opportunity?

A few years back the Employee Benefits Research Institute analyzed the potential accumulations in an HSA account given various time horizons up to 40 years, with different rates of return assumptions. Annual contributions to an HSA over 40 years at 7.5% returns can accumulate to over $1 million. The power of being able to invest additional funds tax free provides an opportunity to put aside significant funds to supplement retirement expenses.

There are many advantages to saving in an HSA:

1. This is the single-most, tax-advantaged account. Somewhere along the way with most other retirement accounts you pay taxes. With HSAs, the money contributed is tax-deductible, money taken out for qualified expenses is tax-free, and earnings grow tax-free. 2017 contribution limits are $3,400 for individuals and $6,760 for families, plus another $,1000 for those over age 50.
2. There are no required minimum distributions for HSAs.

1. They are completely portable, like an IRA. Unlike a FSA, which you leave behind when you leave your employer, the HSA goes with you.
2. There is no expiration to this account, even after you die. It can be transferred tax-free to your spouse who can continue to use it. If your spouse is no longer living, it becomes an asset in your estate and can go to other beneficiaries.
3. Another huge advantage is that at age 65, you are no longer subject to penalties for taking your funds out of the HSA and using them for non-healthcare expenses. However, ordinary income taxes will apply. At this point, an HSA looks no different than having put money into an IRA, which is also taxable for these types of

withdrawals.

Portability is a very strong feature of the HSA. Account holders can decide which financial institution holds their account; you don't have to stick with the employer-chosen HSA account if you don't like certain features, although I do recommend that you continue with that account if the employer is contributing money and paying fees. In other words, you will have to accept the provider the employer has chosen to accept payroll deduction deposits if you want the benefit of reduced payroll taxes. At any time, you can move money throughout the year to a different institution; there are no vesting restrictions.

You can continue to contribute to your HSA if you are enrolled in an HSA-qualified high-deductible plan until you enroll in Medicare at age 65. There are a growing number of individuals who may be able to delay their enrollment in Medicare because they work for a larger firm (20+ employees) that provides HSA-qualified coverage, so they could continue to make HSA contributions beyond age 65. A couple things to keep in mind before that is done: first make sure you have creditable coverage from your employer so you are not faced with any late enrollment penalties in Medicare Part B and Part D at a later date, and second, you must delay taking Social Security because of its linkage to Medicare Part A. The minute you take Social Security before your full retirement age, you are going to be automatically enrolled in Medicare Part A at age 65.

Depending on our level of income we may be forced to deal with "means testing" of Medicare Parts B and D premiums. The good news is that HSA withdrawals are not reported as income, so they aren't included in the income that determines premium surcharges. There are tiered income brackets for those earning above $85k for singles and $170k for those married filing jointly that determine the surcharge. At higher incomes, Part B premiums (currently $150 a month) can double.

How Health Savings Accounts Can Be Used Tax-free to Pay Expenses

There are many ways out-of-pocket medical expenses can be paid for tax-free with HSA funds. If the HSA did not exist, expenses might have to be paid with dollars taxed upon withdrawal from a retirement plan.

1. Medicare premium surcharges are an allowed expense.
2. Medicare Advantage Plan premiums can be paid with HSA funds. A third of Medicare beneficiaries are enrolled in one of these private options to traditional Medicare. (Medigap supplemental plan premiums are excluded).
3. Qualified out-of-pocket expenses not covered by Medicare are allowed expenses.
4. Long-term care insurance premiums and long-term care expenses are eligible to be reimbursed tax-free with HSA funds.
5. Allowed expenses include not only those incurred by yourself but also your spouse and any dependents you may have at that point in your life.

In addition, the HSA tax penalty for nonqualified withdrawals goes away at age 65 and essentially turns the HSA into a 401(k) or IRA where you simply pay ordinary income tax on withdrawals that are not for qualified medical expenses.

Here is a high-level example of the tax impact on someone using only a 401(k) to save for retirement versus a 401(k) and HSA combination. We assume a salary of $60,000, which is around the median income for a family of four, an 11 percent retirement contribution, and an $1,800 employer match. Highlighted in red is an HSA contribution of $3,000, which is roughly equivalent to the sum of what the average employer contributes to an HSA and the premium savings between a traditional PPO plan and a high deductible plan. We also assume an annual 401(k) contribution of $8,400 a year.

401(k) vs. 401(k)+HSA: Mind the (Tax) Gap!

	401(k) Only	401(k) + HSA
Salary	$60,000	$60,000
11% Retirement	$6,600	$6,600
401 (k) contribution	$6,600	$3,600
Employer 401(k) match	$1,800	$1,800
HSA contribution	$0	$3,000
Total 2017 contribution to “retirement” plans	$8,400	$8,400
Needed to pay $3,000 Medical Bill in retirement (25% tax bracket)	$4,000	$3,000
Needed to pay $260,000 Medical Bills in retirement (25% tax)	$346,667	$260,000

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Assume there is a $3,000 medical bill in retirement. In a non-Roth 401(k)-type environment, you would pay taxes on funds withdrawn to pay the bill – $4,000 at a 25% bracket – versus only needing $3,000 from the HSA. Because funds can be withdrawn tax-free when needed, you need less saved to fund future retiree health expenses.

“Shoe boxing” is a strategy that recognizes there is no time limit on withdrawing funds for a qualified medical expense. Let’s say little Johnny, your tax dependent, falls out of a tree and breaks his arm. You end up with $1,000 medical bill as a result. You can choose to take the $1,000 out of your HSA today or instead allow that $1,000 to stay in the HSA until retirement. The IRS expects the taxpayer to maintain records so that in the event of an audit, you can demonstrate that you reimbursed yourself the qualified medical expenses from little Johnny’s fall. The IRS doesn’t require you to submit these expenses; just maintain them. For taxpayers with sufficient cash flow, paying today’s health expenses out-of-pocket can be a tax efficient savings strategy for your HSAs, because it allows you to use them as a future IOU.

An HSA is owned by the individual taxpayer. It may be sponsored by the employer, but the account owners themselves have the ability to do a trustee-to-trustee transfer at any time if they’re not happy with the HSA provider’s investment selection. In addition, FSAs cannot be used in combination with a health savings account. A limited purpose FSA, designed to cover medical and dental expenses, can be coupled with an HSA and works as a traditional FSA so the funds disappear at the end of the year if you don’t use them. Those who have this option have another way to maximize their use of the tax code to their advantage.

Some advisors recommend that after contributing enough to get the 401(k) match, put the next incremental marginal dollar into the HSA, maxing that contribution before returning to the 401(k) or IRA.

Key Takeaways

HSAs are here to stay and are likely to be improved on or expanded in the years to come. Growth in the high deductible healthcare plans coupled with an HSA is not going to go away. Your clients will increasingly be exposed to high deductible plans and HSAs, so there is a financial planning opportunity that will continue to grow in the future.

Boost Retirement Security with HSAs: Why Financial Planners and Advisors Should Add HSAs to Client Retirement Strategies – Roy Ramthun and Aaron Benway

About the authors:

Roy Ramthun, MPH, "Mr. HSA", is the President and Founder of "Ask Mr HSA". Roy is a nationally-recognized expert on Health Savings Accounts and consumer-directed health care issues. He is an active advocate for consumerism in health care and is a frequent speaker at conferences and seminars around the country.

Mr. Ramthun has over twenty-five years of health care and public policy experience, both in government and in the private sector. He led the U.S. Treasury Department's implementation of HSAs after they were enacted into law in 2003. President George W. Bush then tapped Mr. Ramthun to be his health care policy advisor at the White House, where he developed the President's proposals to expand HSAs while overseeing the implementation of the Medicare prescription drug benefit (Part D). He has served on the staff of the U.S. Senate Committee on Finance and the U.S. Health Care Financing Administration (now known as the Centers for Medicare & Medicaid Services). He also spent eight years with Humana Inc. and led the West Health Policy Center for two years.

Aaron Benway, CFP®, MBA is Co-Founder of HSA Coach. Aaron is also Founder of AB Financial which offers financial planning and investment management guidance. Aaron is passionate about health, financial wellness and achieving one's goals in life, whatever they are.

Prior to founding HSA Coach, Aaron was the CFO of HelloWallet, an online financial guidance application sold to employers as part of a financial wellness program. Morningstar (NASDAQ: MORN) purchased HelloWallet in 2014. Prior to joining HelloWallet, Aaron was the head of financial planning and Analysis (FP&A) at General Motors (NYSE: GM), and before coming to GM Aaron was an investor at the Carlyle Group (NASDAQ: CG).

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Where Senior Living and Retirement Planning Intersect, Opportunities Emerge

Brad Breeding, CFP®, president and co-founder of MyLifeSite.net

Editor's note: This article is an adaptation of the live webinar delivered by Brad Breeding in 2017. His comments have been edited for clarity and length.

You can read the summary article here as part of the 2nd Qtr 2017 Retirement InSight and Trends Newsletter, worth 1.0 CE when read in its entirety (after passing the online quiz.)

You may also choose to take the full length course Where Senior Living and Retirement Planning Intersect, Opportunities Emerge – Brad Breeding for 1.0 hour continuing education (CE) credit.

By Brad Breeding, CFP®, President and Co-Founder of MyLifeSite

I was in the financial planning business for 14 years. I still maintain my CFP® designation because I don't want to ever take that test again, but I'm no longer actively practicing. Rather, I am focusing on the business that I'm running today, MyLifeSite.net. The idea for for this company evolved out of my financial planning business when clients were asking me about the retirement communities in our area. What jumped out to me quickly is that there wasn't a good source out there for third party information tools and guidance to help people make a more informed decision when it comes to these types of choices. I could see a need for advisors out there for this topic, particularly as the older adult population grows in this country.

The Phases of Retirement

It is helpful when you're working with clients to break retirement down into different stages. The early phase of retirement is kind of a moving target. So many people now are working beyond the traditional age 65 retirement date. But nonetheless, it is in that early period of retirement when people make budget adjustments, lifestyle adjustments, etc.

It's also very helpful to think about the mid and late phases of retirement. The mid phase is such a critical point. All these years they've been planning to be able to retire, and hopefully, they've achieved that objective with your help. But now it's time to really start looking at a different kind of planning, and that's planning for the later phases of life.

If clients that are in the mid phase of retirement, ages early to mid-70s, they're probably still independent, maybe still very active and able bodied. It's a period when they need to be thinking about, "What's very important to me if in the future my health should decline dramatically? What do I want to avoid?", which can happen suddenly or sometimes it can happen more gradually. "What are the discussions we need to be having now with our advisor, with our family members, doctors, and others to make sure that to the extent possible, there's a plan in place for that later phase of retirement when health begins to decline?" Too many families in our society, and even many advisors, simply don't address this in the capacity that they should, and it often leads to crisis types of situations within a family, scrambling to figure out the options. Siblings often have bitter disputes, and it's just not a good situation.

A few years ago Merrill Lynch and Age Wave asked people over 65 about their biggest concerns about living a long lifetime. They said:

1. Serious health problems
2. Not being a burden on my family
3. Running out of money to live comfortably
4. Being lonely
5. Not having a purpose
6. Having nothing to leave the children and grandchildren.

The thing that is important in these survey results is that four of the six don't have much to do with money. Furthermore, these four can be impacted in a dramatic way by where someone lives as they transition through the phases of retirement.

Retirement Living Choices

When we talk about the different choices your older clients have, there are really two overarching choices. The first is certainly to stay in their own home. Most people want to stay in their own home. You've probably seen the statistics that 80 to 90 percent of people say they want to remain in their own home, and there are some very good, perfectly understandable reasons as to why they would want to do that. The alternative if they don't stay in their home is to move to some sort of retirement community.

What are some of the positives for staying in the home? If you were to ask some of your clients, some of the things you might probably hear are:

- *My home is comfortable and familia*r
- *I have an emotional connection with memories of raising kids and grandkids*
- *It's less expensive* (though that is not always the case; it depends on the specific situation and the needs, particularly if someone has healthcare issues).
- *It avoids the hassle of moving.* For a lot of people, one reason why they never make a decision to look at some other options that could potentially be better for them in the long run, is that they don't want to deal with their stuff.
- *I don't want to leave my home because I don't want to lose my independence* .

There is an awakening going on in our society right now, where people are starting to realize that maybe staying in the home isn't always the best choice. *Aging in the Right Place* was written a few years by a professor of gerontology at the University of Florida. The title is a play on the term "aging in place," which generally means staying in the home. The point of his book can be summed up when he says, "The concept of aging in place has become a mantra in recent years that might prevent older adults from seeking healthier and more holistic alternatives." Another article in the *New York Times* a couple of years ago was titled, "At Home, Many Seniors are Imprisoned by Their Independence".

Emotions are important; people need to feel good about wherever they live. But it's also important to think about the practical, or even the impractical implications of things, such as:

- *Possible home modifications*, depending on whether there are stairs, the height of the cabinets, width of the doorways and hallways; things like that which may not be a big deal at all right now for somebody in that mid phase of retirement. For some clients, it may require significant modifications; for others, maybe very limited. I saw an article that a financial advisor had written about spending almost $200,000 renovating his mother's home because she really wanted to stay there. Within six months or a year, she ended up moving to a skilled nursing facility. So even with all that money they spent to help keep her in her own home, she ended up

having to move anyway. Then the house was not as marketable because of the modifications that had been made.

- *Maintenance of the home.* Interior and exterior maintenance can become quite burdensome over time and be an expense.
- *The risk of social isolation.* As people age, their mobility becomes more limited. Over time, the risk of social isolation for someone staying in their home is much greater than it would be in a community setting. How to maintain social engagement is important because social isolation has a dramatic impact on somebody's health with everything from depression to heart disease. I just saw a study that mortality rates have increased 26 percent for those who are socially isolated versus those who stay more actively involved and engaged socially. It's becoming a very big health issue.
- *Maintaining purpose* kind of goes along with that; everybody needs a purpose in life. With staying in the home, it's important to ask what am I going to do to wake up every morning and maintain purpose, or find renewed purpose? What's going to give me that sense of purpose in my life? A lot of times, where somebody lives can really impact that, and who they have around them.
- *Transportation challenges*. I think it's a little too early to tell right now, but at some point, it will be neat to see what groups and ridesharing programs can help older adults that could make an impact. As it stands now, a lot of times when someone is unable to drive, that can lead obviously to less independence and not more independence.
- People need to consider how they're going to *maintain a balanced, healthy diet* in their own home. I saw with my own grandmother; she tended to fix the same canned foods over and over, every day. It's just not the best thing to do from a dietary standpoint.
- *Delaying a move.* A lot of times, people who want to say in their home end up having to move at some point because of a health concern, and the problem is that it becomes a needs-based move rather than a move made of preference. Usually, the person making the decision is not the person who needs to move. At that point, it's usually a family member. It can become a very difficult situation, and the older someone is and the longer it is before they make a move, the more difficult it can be. It can be a very dramatic issue for them emotionally and physically. That's particularly a problem in the case of couples. If one is independent, what happens if one of us has a stroke or heart attack and we need care, and the other one is still independent? How is that going to work? They might be separated.
- *In-home care* where a person stays in their home and brings in care. Of those who stay in their homes, about 90 percent of older adults are cared for by loved ones in this country. There are 44 million unpaid caregivers in our country, and they're providing the equivalent of $300 billion per year for the care of loved ones. Up to 70 percent of unpaid family caregivers have clinical signs of depression. They have chronic health conditions at nearly twice the rate of non-caregivers. 50 percent of caregivers say caregiving takes time away from friends and family members. Many times, a caregiver must take time away from their own career. Maybe it's even retiring early. It's becoming a big deal in the corporate world right now; how do we deal with this growing trend where more and more of our staff are having to take time away from work to care for an aging loved one? Loss of wages also means that's less than I can contribute to my retirement accounts, and it also can have an impact on Social Security benefits. When you take the present value of that loss of future benefits and wages, it comes to about $304,000 on average. So people may think it's less expensive to have family help, but that the cost is getting indirectly passed on to the next generation in the form of lost wages and benefits.

Planning for Cost of Care and Access to Care

It's important to keep in mind as you talk with your clients that there is a difference between the cost of care and access to care, and both need to be planned for. If we think about the cost of care, we know what care costs. Whether it's assisted living, nursing care, in home care; we know those costs can be exorbitant in many cases.

Many people end up on Medicaid because they have gone through assets paying for care.

There is a broad spectrum of retirement communities. It is important to help your clients narrow down the choices and think about what's often called the continuum of care.

Level of supportive services / healthcare

Active Adult Planned Community
Retirement Village / Cohousing*
Independent Living Community
Independent Plus Community
Assisted Living Community
Skilled Nursing Community
Continuing Care Retirement Comm.

* Resident directed communities. Level of services can vary widely, including care services available through outside providers.

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On the top bar, at far left you'll see a minus sign, the green section, that represents independent living. If any of your clients in retirement are they're living on their own and maybe still very active, they would be on the far left of this scale. Then let's say over time they start to develop some needs; maybe an hour or two of help around the house during the week. They then would be moving towards the right side of the green bar.

The aqua color in the middle represents assisted living. Maybe they need help with bathing, dressing, eating and other activities of daily living. Then as you move on across to the right, you really get into more advanced needs; maybe in some cases needs that can't even be provided in the home, at least not practically. The far right would represent 24-hour skilled nursing care. This represents the full spectrum.

The reason this is important is that as your clients are looking at the different types of retirement communities out there, some providers focus on certain aspects of this continuum, while others may focus on other aspects. For example, an active adult planned community is a 55 and older development with clubhouse style amenities, maybe a pool, and maybe even a golf course. Residents own their home and everybody lives mostly independently. If a resident in a community like this develops assisted living or skilled care needs, it will not be equipped to provide for those needs.

Independent-plus are rental retirement communities. There's a month-to-month rent that includes meals, some housekeeping, and other services. In some cases, it might provide personal care services in their own home if they need it. Others may even have some assisted living units onsite, and even memory care units. That's also called independent-plus because they have independent living plus some assisted living or memory care.

But there again, if they have advanced healthcare needs, acute types of needs or skilled nursing needs, that's not going to be available within those communities. At some point, somebody living in one of these types of communities may have to move again. That's something important to understand because these kinds of moves can be difficult.

Then you have assisted living and skilled nursing communities, they're not even retirement communities even though they're often referred to as retirement homes. More and more people under 65 actually have to move into skilled nursing communities just for disabilities they have and 24-hour needs.

Lastly, continuing care retirement communities are unique in that cover the full spectrum; everything from

independent living all the way to skilled care. Residents typically move in when they're healthy or independent, and as time goes on if they need services such as assisted living, memory care, or nursing care, those services are available in one location.

Continuing Care Retirement Communities (CCRCs)

About 75 percent of CCRCs require an entry fee and are the only type that provides contractual priority access to the entire continuum of care. Many offer refundable entry fees or a declining balance contract where a person can receive some portion of that back if they move out within the first three or four years. If they're living there for five, six, seven years or longer, no refund remains. CCRCs are normally considered higher end; usually, the services and amenities offered at a CCRC are going to be pretty nice compared to what you might find in some other places.

There are also monthly fees based on facility size, location, etc. Suppose someone needs assisted living for a couple of years starting in year eight, and then skilled care. Their monthly rate may not change dramatically. It can change for inflationary purposes; maybe there are some ancillary charges. But you won't see a big spike in their expenses once they begin receiving care because they have a "life care" contract. A lot of CCRCs offer this. In many ways, it works like a long-term insurance policy. In other words, you're prepaying for care that you may or may not need in the future.

To contrast that, other communities may offer something called a "fee for service" contract. So if we're comparing two choices, one with life care and one with a fee for service, the client will pay less while living independently. But when they require care, costs will go up and they'll pay the full market rate for those services. So they pay less now but then have unlimited exposure out of pocket when they need care later.

Which is the best choice? If you can tell me how long you're going to live and how much care you're going to need, I can tell you exactly which one to choose.

There are other CCRC contracts that are hybrids; it's a modified contract where if I need care later, maybe I get that care at a discounted rate. Maybe I only pay 70 or 80 percent of the market rate for those services. Every community may have their own sort of contract and the way it works. But conceptually, you either pay more while you're healthy and less later, or pay less while you're healthy and more later.

Evaluating a Continuing Care Retirement Community (CCRC)

It brings peace of mind to people to know they have that extra support if they need it. Obviously, the community needs to be maintained or managed financially in a very prudent way in order to be able to do that.

If your client is looking at a continuing care community, there's more that needs to be evaluated because it's really a big commitment.

- Understand the contract details.
- The financial viability of the community is extremely important; how well managed are they financially? What's their track record?
- What's the business' diversity, the diversity of their board, and so forth?
- How long have they been doing it? You can often get audited financial statements and review those, or have the client's accountant review them. You want to make sure the community is financially in a position to meet the commitment to your client over the long-term.
- Is your client going to be happy there?
- Is it a community that's going to help them live the life they want to live?
- Is it going to not restrict them or feel institutional, but help them maybe open a new chapter in their lives and

experience new things?

- Can your client continue to do the things they want to do in that community and have a support network of new relationships? That's very important.
- What is the quality of care that's provided in that community, because your client will be depending on that healthcare? Visit their healthcare center; many people don't like to do this but I think it's important. Maybe if there are other families you know that have received services there, ask about their experience; would they recommend it?
- What's their rating if they're Medicare CMS (Centers for Medicare & Medicaid Services) certified?

Senior Living Planning Needs and Opportunities

How does this pertain to you as an advisor? What can you do? There's a ton of opportunity here and so often people just don't talk about this. For me to talk about it with my mother is difficult, and I'm in this line of work. It's a very awkward conversation. You can have a big impact on a family. You can be a catalyst for really starting some important conversations. The nice thing is that it can also lead to more business.

If you bring this topic up with your younger adult clients, those maybe in the 45 to 55 year range, they may really like to know that you can help with this. That might lead to them bringing their parents in to talk with you, or maybe some other family members to talk with you because those may be conversations that they want to have but don't know how to have them.

It is extremely valuable for advisors who work with retired clients to prompt the discussion and have a special planning session. I don't know if I'd call it mandatory, necessarily, but maybe you can put a neat name or build a program around it for clients say, in their 70s and beyond that are still living independently. I'm talking about a one-on-one session, although starting with a group session may work as well.

Some of the things to ask clients during this session are:

- What concerns you about your future?
- What's most important to you?
- Have you shared these concerns with your children?
- At this point in your life, what does peace of mind mean to you at this stage of your life?
- How is it different from what you might have said ten or 20 years ago?
- Is it your plan to stay in your home for the long term? Why or why not?
- What's most important to you about that?
- What are some of the contingencies that we need to plan for if you do that?
- Have you thought about what you might do if your health surprisingly declines?
- What steps would you like your family to take?
- How involved do you want your family to be?

For those who want to stay in their own home, if that's really what's most important to them, then obviously you need to talk about all the things we've mentioned today. In addition:

- Will home modifications be necessary?
- Are they going to rely on their family members if they ever need them for care?
- Begin researching the quality of in-home care providers well advance in the need. Know which in-home care

providers are more reputable, and even the local facilities that are nearby if they need that.

- If no family members are nearby, who will make up the support network? Who will manage their needs for them? Somebody else needs to be involved in this process
- What if staying in the home becomes impractical? What are some of the options locally?
- Is long-term care insurance already in place? Obviously, that can be a really big piece of the plan. If not, does a hybrid plan make sense; some type of accommodation, LTC annuity plan or something like that?
- Does it make sense to go ahead and secure a reverse mortgage? Doesn't mean they have to tap into it, but go ahead and secure that line so it can be there, begin growing over time, possibly to be used in the future even to pay family caregivers.

What about moving to a retirement community? If they want to be somewhere where they can be taken care of if necessary, then:

- What type of care is available?
- How much does it cost? They need to choose an option they might prefer: an independent-plus community or a continuing care community and weigh the pros and cons of each.
- What is the plan if needs advance beyond what's available in that retirement community? If they go to an independent-plus community and later need nursing care, is that a concern for them? What are some of the options there?
- Is long-term care insurance in place?
- If I'm going to move to a retirement community, it generally means selling the home, and that's going to free up home equity that can be invested. Some portion of that can be used to cover the monthly fees, maybe for many years depending on how much equity is there.

With CCRCs, again a lot of times with the entry fee, you have that medical tax deduction that's often available. Not always; obviously they need to consult with their accountant or CPA. But if they do qualify for a medical tax deduction on that entry fee, that might be an opportunity for a Roth conversion. If the entry fee is $200,000 or $300,000 – it could be all over the map – and I can deduct 30 or 40 percent of that, I can get a sizeable Roth conversion out of that in terms of protecting the tax liability on the conversion.

Key Takeaways

- You can be a catalyst for prompting important senior living conversations while also enhancing your practice.
- Staying in a home may not always be the best choice or the most practical choice and your clients need to understand that. At least help them to make a more educated decision and know what to plan for.
- Retirement communities are not all created equally; know what distinguishes one from another and what to look for.
- And finally, recognize planning needs and opportunities tied to the senior living topic and other closely related issues.

About the author:

Brad Breeding, CFP®, President and Co-Founder of MyLifeSite, is a nationally recognized expert speaker on retirement planning and the senior living industry.

Brad's extensive knowledge of the senior living industry, combined with his financial planning background, allows him to provide valuable insights to those who are considering a retirement community, as well as to professionals who consult others in the decision process, including financial advisors, accountants, retirement living sales counselors, and others.

Brad and his colleagues at My LifeSite have carefully reviewed close to 1,000 disclosure statements and sample residency contracts for retirement communities across the United States. Before launching MyLifeSite, an online senior living research and forecasting tool, Brad spent 14 years as a personal financial advisor, focusing on sound planning for retirees.

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