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Cadence clips

FOCUSED ON WHAT MATTERS MOST.

Lost In Speculation

By Casey Clarke

When someone gets lost, it doesn't happen suddenly, nor does the realization of it. It's a progression from being "not lost", to being a little turned around, to getting somewhat concerned, more concerned, then officially lost. If one gets lost in the presence of their spouse, then there's generally some debate about the issue along that progression. Throw in overconfidence, denial, blame, and eventually, if we're lucky, maybe an admission of some responsibility for getting lost. We all know the feeling when it comes to being lost on the road. Most, if they're being honest, know the feeling of being lost directionally in life, and many are waking up to the fact that we're a bit off the path with respect to social and public health issues. To assume that we aren't or expect we never will be is naïve. Drift happens even with the best of intentions. To the degree that these things tie into financial markets (a lot), and that we seek to be good, well-informed people, we care about making sure we're never too far adrift. When it comes to financial markets and investing, most are lost. Definitively. Without question.

A few months back, we referenced the Scott McNealy quote during the tech stock collapse where he spoke about how irrational it was for investors to pay as much as they were for his company's stock. The gist of the quote was that investors were paying so much for the stock that they couldn't possibly ever expect to recoup their investment through the company's earnings, which means that investors could only make money over time if there were other investors willing to pay more for the stock. This is called "The Greater Fool Theory", and it lives deep in the woods well off the "investing" trail that historically has led hard workers and savers, more times than not, to Financial Independence Peak. The vast majority of investors today, whether they know it or not, are not investing. By putting money into the major market indexes – the S&P 500, Dow, Nasdaq, Russell 2000, etc. – at record valuation levels, they are speculating. They are speculating, because in most cases they cannot expect to earn any reasonable return from dividends or corporate earnings over a reasonable period of time. That, after all, is investing. Instead, what 401(k) participants and others are doing is hoping they can make money through the magic of a rising stock market and without that rise being supported by similarly rising corporate earnings. This is speculation.

Here's the bad news – extreme and widespread speculation doesn't end well. Just as Scott McNealy's company, Sun Microsystems, lost well over -90% of its value, other speculative markets have lost tremendous value as well. The 1929 bubble, over -80%. The tech bubble, over -80%. Japan in late 1989, also over -80%. These are whole markets, which represent hundreds of individual stocks, so one can rest assured that there were many stocks that fell much further than -80% in order to get to that average for the index. And if one thinks today's situation is different, they would be right. The level of speculation is arguably bigger and broader today than in those previous episodes. We are more financialized, have more societal participation in markets, and have been kicking the can on natural corrective forces for years now. This kicking the can part is akin to intentionally keeping the hiker lost and from finding her way back to the trail. It's probably more accurate to say that it's more like guiding entire bus-loads of hikers deep into the woods where there is little chance of survival. Speculative manias, after transitioning to panics, do incredible damage. Most of us over the age of 40 remember plenty of people personally affected by the last two bear markets (2000 and 2008). We were fortunate they were short-lived.

As critical as we are of policy-makers, central banks, and the narrative pushing corporate media for helping to create the hyper-speculative environment we find ourselves in, it's also important that we understand our personal role in all of this. Regardless of the forces that are incentivized to lead us off the responsible path, we still have control and we still have decision-making ability. We can choose not to speculate or limit our level of speculation by saying "no thank you" to the options that no longer make good investment sense and seek out others that more closely resemble an actual investment. We've discussed at length how most commodities and companies that deal in commodities are actually very reasonably priced, making money, and returning a good portion of that money to shareholders. This is "on the path" investing and a good example of where we direct our focus. But, in order to make the best choices, we must also be responsible for understanding the landscape. First, we have to be aware of the wildlife in the woods that could harm us. We should never feel as though our walk down the path is free from danger. Having this awareness is the first step to survival.

The second step is knowing what actions we need to take to stay on the "investing" path. Say no to creepy speculative narratives and check your compass periodically, which means educating yourself on the current status of the markets and your portfolio holdings to see whether they've drifted into speculative territory. If you have neither the time, interest, nor inclination to do this, then get help from a professional to evaluate these things – a trail guide if you will. Although it can be done alone, it's often wise to team up when embarking on such a perilous journey. An extra set of eyes and a brain that's trained to fend off creatures and read a compass properly can be a real retirement-saver.

We've often used the term "anti-bubble" to describe the assets that we currently hold in our client portfolios. The asset class and individual stock positions we favor for the medium to long term we do so because they are sound investments, not popular, speculative ones. We are genuinely concerned for the vast majority of savers today who are lost in speculation. I'm both sad for the inevitable outcome and the fact that our system and its players have led them to speculate without their knowing it. I often ponder what more we can do to help people understand the risks and protect themselves from the fallout when this speculative cycle turns. This is why we write every month, without fail, about things that we feel might be relevant and impactful. Our hope is that our clients forward these scribblings to those they care about who may not be as well-informed. Our main focus and mission of course, is to help guide our clients as best we can, and although growing our firm exponentially is not our goal as it would compromise the personal nature of our work, we will invariably extend our reach to others by serving our clients well. Our job, and one that we take very seriously, is to deliver our clients to their destination regardless of the circumstances. To do that, we need to stay true to the definition of investing and not conflate it with speculation. And to do that, we also need to understand more than just financial instruments, or the boots and apparel for the hike. We need to understand the woods, everything that lives in them, and their ability to pull us off our path.

3 Important Things to Know About Long-Term Care

By Steve DeBoth

Any newsletter piece attempting to provide comprehensive information on long-term care would be so long and detailed that no human brain could endure it. Every state, every facility, every health insurance policy, and every long-term care insurance company has its own set of specifics, and trying to provide all the information that could be relevant for any particular person just isn't feasible. However, considering how 70% of retirees will need some type of long-term medical care according to the US Department of Health and Human Services, it is still really important that you do not ignore the topic.

Although you need to discuss this with those in your life that may be affected by your needing some kind of care, and you should certainly discuss it with your Cadence advisor, there are still some things about which we should all be aware. Accordingly, this piece covers three important things we think you should know:

1) **Medicare does not pay for most long-term care services, and even for those it does, it will only do so for a limited amount of time under specific circumstances.**

2) **Medicaid WILL pay for most long-term care services, but the conditions that must be met for it to do so are pretty extreme.**

3) **Long-term care insurance, when structured properly, can prevent care facilities from ever accessing hundreds of thousands of your dollars.**

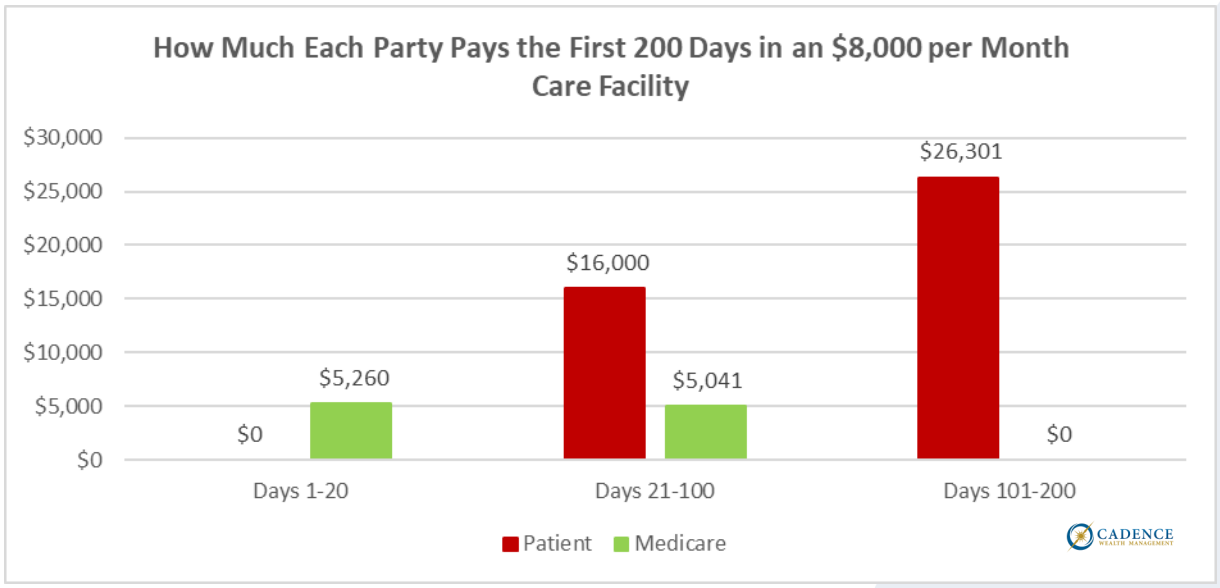
I promise, reviewing this material will not be too painful. At the very least, skim through the material so you have a good starting point for when you have your first, or next, conversation on this topic. For those clients who read it all and commit enough of it to memory, I encourage you to discuss it openly at the next party you attend. I guarantee it will generate interest, because as much as people don't usually enjoy researching and reading this information, they still very much want to know it. You'll be the life of the party, discussing long-term care!

TOPIC #1: MEDICARE DOES NOT PAY FOR MOST LONG-TERM CARE

Long-term care refers to a variety of services deemed necessary to take care of your health and medical needs over an extended period of time. Medicare will pay for a limited amount of long-term care services, under specific circumstances. Here are the following long-term care services that Medicare covers:

Skilled nursing facilities: A skilled nursing facility can provide medical or health-related services from a professional or technical staff to monitor, manage, or treat a health condition. Generally, a person must first be in a hospital for three days before transferring to a skilled nursing facility for Medicare to pay. Additionally, Medicare will only pay for all covered services for days 1-20 in a skilled nursing facility. For days 21-100, Medicare will only pay for any amount above $200 per day, which means up to $16,000 out of pocket. After day 100, Medicare will not pay for anything.

In the following example, a patient spends 200 days in an $8,000 per month skilled nursing facility that qualifies for some level of Medicare coverage.



After 200 days, Medicare will have paid around $10,300, and the patient will have paid around $42,300. Every day from there on in, the patient will pay around $263 per day, until and unless Medicaid steps in, which is covered later in this piece.

In-home care: In-home care involves any healthcare services that you receive in your home. Typically, these in-home care services are coordinated with a home health care agency. Both Medicare parts A and B can cover this type of care. Medicare only covers medically necessary services. Custodial care, meal preparation, and cleaning aren't covered. If you have Medicare, you won't pay anything for covered in-home healthcare services. Medicare will also pay 20 percent of the cost for any necessary durable medical equipment (DME). Examples of DME include wheelchairs, walkers, or hospital beds.

If you have Medicare, you qualify for in-home care if your doctor classifies you as "homebound." This means that you have trouble leaving home without assistive equipment (such as a wheelchair) or the help of another person. Your doctor must also certify that you need skilled medical services that can be provided at home. Examples include part-time skilled nursing care, physical therapy, or occupational therapy. Your doctor will create a plan of care for you.

Hospice care: Hospice care is a special type of care that someone receives when they're terminally ill. Hospice focuses on managing symptoms and providing support. Medicare Part A generally covers all costs of hospice care, with the possible exception of small copays for respite care or prescriptions. Medicare also doesn't pay for room and board while you're receiving hospice care. In addition, there are some expenses that Medicare will no longer cover after hospice benefits start. These include any medication or treatment intended to cure a terminal illness. It's important to coordinate a plan with a hospice care team to make sure everything is organized and covered.

Bottom Line: Medicare covers some types of long-term care including in-home care, hospice care, and short stays at skilled nursing facilities. To be eligible for coverage, you must meet certain rules. There are some aspects of long-

term care that aren't covered by Medicare. These include nonmedical services that are commonly provided at nursing homes and assisted living facilities, such as custodial care, which entails assistance with daily living activities like eating, dressing, and using the toilet. Custodial care is a large component of the care that's provided in nursing homes or assisted living facilities, and is the majority of the expense people incur when needing long-term care. The fact that Medicare does not pay for this type of care means even though it does pay for some care in some situations, Medicare cannot be relied on to pay for the majority of the long-term care a person may require.

TOPIC #2: MEDICAID WILL PAY FOR LONG-TERM CARE, BUT THERE'S A CATCH. . .

Medicaid is the largest provider of long-term care payments in the United States. Unfortunately, that says more about the poor average financial health of older Americans than it does about how robust Medicaid is as a source of payments. Each state manages its own Medicaid program and any prospective or potential Medicaid recipient will need to familiarize themselves with the specifics in their state, but in general to be eligible to have Medicaid pay for long-term care expenses the following conditions have to be met:

Income Limits: In most states, you can make up to 300% of the SSI income limit and still qualify to have Medicaid pay for long-term care expenses. 300% of the SSI limit, $914, is $2,742 per month in 2023. Any amount above $2,742 per month that a Medicaid applicant makes from any source would have to go toward paying long-term care expenses before Medicaid will pay for the difference.

When only one spouse applies for Nursing Home Medicaid, only the income of the applicant spouse is counted towards Medicaid's income limit. Any income that the non-applicant spouse receives is disregarded. However, an issue arises when the applicant spouse is the only one who receives income or receives the majority of the couple's household income. For all states in 2023, the maximum income a married Medicaid applicant can make before having to contribute toward long-term care expenses is $3,715 per month. The gist is the partner needing the care can keep $3,715 per month to pay the living expenses for themselves and their spouse, not including whatever income the spouse makes on their own, before Medicaid would require the Medicaid applicant pay for a portion of their own care.

Asset Limits: In most states, Medicaid recipients can only retain a nominal amount of assets, however there are some assets that do not count toward eligibility that recipients can retain, notably:

- A car.
- A home, if a spouse, minor child, or blind or disabled child lives in it.
- A home, if the Medicaid recipient intends to return to it, and with a maximum amount of equity.
- Household and personal belongings.
- One wedding and one engagement ring of any value.
- Burial plots and pre-paid funeral expenses.
- A very small whole life insurance policy.

Outside of these "exempt" assets, a Medicaid recipient can only have $2,000 to their name; $3,000 if married. So, before a Medicaid applicant can receive assistance paying for long-term care, nearly all their financial assets will need to be liquidated to pay for any received care, at which point, once they're pretty much destitute, Medicaid will begin paying.

For the purposes of paying for long-term care, all financial assets are considered joint assets, including IRAs, 401(k)s, or other financial accounts owned by just one spouse. Even the assets of the spouse not receiving care have to be spent down before the receiving spouse can qualify for Medicaid. For most states, the maximum amount of assets a married couple can possess without those assets having to be liquidated to pay for care is around $137,000. Joint financial assets, or assets held in just one of the partner's names cannot total more than that before the extra amount is expected to be liquidated to help pay for care.

Bottom Line: Unlike Medicare, Medicaid will pay for custodial care, whether it be at home or in a facility. However, the catch is that a person has to be pretty much destitute to qualify, and though some assets are exempted from needing to be liquidated to pay for care before Medicaid would step in, the financial assets a non-care receiving spouse is allowed to shelter are low enough for that spouse not to be allowed to keep much to pay for their own lifestyle over time. Each state has its own specific amounts and requirements, but by and large these are the rough amounts of income and assets a person and a married couple are allowed for Medicaid to pay for care.

TOPIC #3: LONG-TERM CARE INSURANCE CAN HELP YOU SHELTER MORE ASSETS THAN YOU REALIZE

Transferring some of the financial risk of needing long-term care to an insurance company is an option that helps overcome Medicare's not paying for custodial care and Medicaid's low level of allowed income and assets. Most people by now are familiar with the concept of long-term care insurance, but one of the features of this insurance that is not well known is the added ability that long-term care policy owners have to shelter more of their assets from Medicaid should they ever apply. A long-term care insurance policy needs to be structured to include a few specific elements in order to be considered "long-term care partnership insurance" in the eyes of a given state.

In general, to be partnership qualified a long-term care policy must:

- Be purchased by a resident of a long-term care partnership state.
- The policy should have a benefit inflation component for applicants under 61, or at least have been offered for applicants between ages 61 and 75.
- The policy must be considered federally "tax qualified", which means its provisions include:
  - Being guaranteed renewable and noncancelable regardless of health;
  - Not delaying coverage of pre-existing conditions more than six months;
  - Not conditioning eligibility on prior hospitalization;
  - Not excluding coverage based on a diagnosis of Alzheimer's disease, dementia, or similar conditions or illnesses; and

- Requiring a physician's certification that you're either unable to perform at least two of six Activities of Daily Living or you have a severe cognitive impairment and that this condition has lasted or is expected to last at least 90 days.

There are some differences in these requirements across the states, but the majority of the partnership eligible states adhere to these general requirements to consider a long-term care insurance policy partnership qualified.

Benefits of partnership qualified long-term care insurance policies: Though it does vary some by state, partnership qualified insurance policies allow for a policyholder to:

➲ Shelter from Medicaid eligibility an amount of assets equal to the total amount of insurance purchased, including to what those benefits will grow with the inflation protection.

- If a qualified policy was for $5,000 per month in benefits for 3 years, this would allow the policyholder to shelter an additional $180,000 ($5,000 X 12 X 3) in financial assets from the Medicaid eligibility requirements. This is in addition to the $137,000 that is already sheltered for a non-care receiving spouse.

- In 20 years, with 3% compound inflation on those benefits, the policyholder would be able to shelter an additional $325,000 in assets from the Medicaid eligibility requirements.

➲ The ability to move to a different state and still be able to shelter assets from Medicare eligibility requirements, provided the two states both participate in the partnership program.

Which states DO NOT participate in the long-term care partnership program?

Alaska, **Massachusetts**, Mississippi, Vermont. Nor does Washington DC.

All other states allow for some level of long-term care partnership benefits, including allowing you to have purchased the insurance in a different state while allowing you to shelter your assets in the new state.

Bottom Line: First, a long-term care policy will allow you to keep more in assets by paying for care, which means you do not have to liquidate assets to cover those expenses. Second, once the long-term care benefits are used up, you will be allowed to shelter from Medicaid eligibility requirements an additional amount of financial assets for your spouse or your other beneficiaries equal to the policy's benefit total when you started needing the care. That's a pretty good deal.

WHAT DOES MASSACHUSETTS HAVE INSTEAD OF THE LONG-TERM CARE PARTNERSHIP PROGRAM?

The extra benefits for long-term care insurance policyholders in Massachusetts may not be as robust as for those in partnership states, but they are not nothing. (Somewhere my various English teachers sensed my double negative in that sentence and let out exasperated sighs.) In Massachusetts, provided at the time a person would enter into a nursing home their policy still has at least two years of benefits left for at least $130 per day, their home would be excluded from needing to be liquidated before MassHealth would pay their nursing home costs. Additionally, MassHealth would not require the home to be liquidated after the benefit recipient dies to repay them for the nursing home benefits that were paid. This is regardless of if a spouse, child, or other beneficiary is residing in the home or not.

Bottom Line: Considering a lot of Massachusetts residents have the bulk of their equity in their homes as opposed to financial accounts, sheltering that asset can have some very positive benefits for surviving spouses and other beneficiaries. There are some more specific details to the Massachusetts program that should be researched by anyone hoping to take advantage of these benefits.

See, that wasn't so bad! Though long-term care, Medicare, Medicaid, and long-term care insurance are all very dense and complicated topics, you now know three of the most important things that most people do not. It is important the details concerning any potential long-term care received and paid for by you or a loved one be discussed in advance, with a plan in place to navigate the costs and benefits before any care is needed. Of course, we as advisors can help you with this, so please turn to us when you are ready for this conversation. Long-term care may not be the most entertaining of topics, but down the stretch, it may end up being the most important.