Physician Wealth Planning: Modernizing the Advisor's Toolbox

Qualified retirement plans offer less advantage than they did some decades ago, but trusts—including life insurance trusts—can be designed to meet concerns faced by physicians.

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Although physicians generally take advantage of the newest medical advances when caring for their patients, many have not kept their personal estate, retirement, and asset protection planning current. They regularly monitor patients' medical well-being, typically in the form of annual (or more frequent) physical exams, as well as state-of-the-art imaging techniques, but often do not appreciate the necessity of doing their own periodic financial and estate planning reviews to protect their assets and take advantage of new developments. Skipping periodic reviews, or forgoing the newest wealth planning techniques, can jeopardize a physician's wealth planning, similar to how skipping routine exams, or not using the newest medical advances, can jeopardize a patient's physical health.

Statistics suggest that every year 7.5% of physicians are subject to a malpractice claim, and about 20% of these result in a payment to the claimant. In some specialties, such as neurosurgery and heart surgery, each year nearly 20% of the practitioners are sued. A physician who is made aware of the quantum of risk is likely to be motivated to action.[1]

This article presents modern wealth planning techniques that are available to physicians. The analysis starts with relatively simple, basic strategies, and then progresses in a laddered approach to more complex techniques. As this article focuses on the gaps in planning, it does not discuss the more common arrangements that have been generally used by physicians, other than issuing a caveat with respect to family limited partnerships and family limited liability companies (collectively, "FLPs") that are too often not properly maintained. If the FLP is not formed and administered properly, the value of the assets in the FLP could be exposed to estate taxes and creditors.

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Historical planning paradigms for physicians

For decades, the planning foundation for most physicians was built on four key components. While these concepts are familiar to practitioners, a summary of them provides a touchstone for analyzing more modern physician planning techniques discussed below and addressing the maintenance and evolution of possibly antiquated planning.

- *QRPs.* Qualified retirement plans (QRPs) came into vogue as state laws were modified to permit professionals to incorporate. This permitted physicians, as employees of their professional corporations, to take advantage of these benefits. QRPs generated current income tax deductions, avoided estate taxation, and provided asset protection benefits. The deduction for contributions and income tax-deferred accumulation were particularly attractive. Moreover, until the early 1980s, the assets in a QRP were excluded from estate tax, and the use of QRPs for physicians was an integral part of their planning.
- *ILITs.* Insurance trusts became more popular as a physician planning tool following the *Crummey* court decision which recognized that gifts to trusts could qualify for the gift tax annual exclusion. The sanctioning of this technique meant physicians could make gifts to an irrevocable life insurance trust (ILIT) without using their lifetime exemption. New physicians with modest estates, young families, and sizable debt used life insurance coverage to assure that their families would be protected and their obligations met. ILITs provided a vehicle to pay death costs without exposing the life insurance death benefits to estate taxes or creditors, including malpractice claimants.
- *Income-shifting trusts.* Physicians were commonly in high income tax brackets, so techniques designed to shift income to lower bracket family members were common. These included *Clifford* trusts, for example. Trusts funded with annual exclusion gifts also became popular because of the progressivity of the income tax rate structure, trust exemptions, and bracket differentials. In these years, the planner who drafted a trust that resulted in the grantor being taxed on the income probably made an error in drafting or implementation.

As valuation discounts became more common, and marginal income tax rates declined, FLPs became primarily a wealth-transfer technique and their use as an income-shifting vehicle waned.

- *Partnerships.* Partnerships, particularly equipment partnerships, were created to shift income tax to lower bracket family member partners. Many were formed as general partnerships because they were simpler and less costly than limited partnerships (LPs). As long as they followed the family partnership rules, income could be shifted. Sometimes partnership interests were transferred to trusts created as part of the physician's plan. Over time, FLPs grew in popularity as asset protection grew in importance to the physician client, and they also served as income-shifting and wealth-shifting tools. FLPs were also attractive because they allowed the physician to retain a degree of control while, nevertheless, achieving other planning benefits.

The planning landscape evolved. The tax pendulum began to shift, however, as it so often does. The legal and investment landscape evolved as well. While many physicians' plans adapted, many did not and still need to be addressed.

- *FLPs.* As valuation discounts became more common, and marginal income tax rates began to decline, FLPs became primarily a wealth-transfer technique and their use as an income-shifting vehicle waned.
- *Trusts.* The compression of the income tax rate brackets, enactment and progressive tightening of the "kiddie tax," and the elimination of multiple trust exemptions all changed the planning focus and techniques used. As planners responded to these changes, there was a shift to the use of grantor trusts. Legal developments were also reflected in changing planning dynamics. When some states enacted legislation permitting self-settled domestic asset protection trusts (DAPTs), physicians in the ongoing quest for safety from malpractice claimants, began to use DAPTs with greater frequency.[2]
- *QRPs.* Many physicians and their financial advisors were overly enamored by the ability to obtain an income tax deduction for plan contributions. Because of the instant gratification of an immediate deduction, they often did not give adequate credence to the many negative features inherent in QRPs. Commencing with

1 Stobbe, "Study: Only 1 in 5 Medical Malpractice Cases Pay," NYLI, 8/19/2011, page 5, citing a study funded by the RAND Institute for Civil Justice.

2 Many physicians have used, and continue to use, Foreign Asset Protection Trusts (FAPT). For many advisors, there was a shift from FAPTs to DAPTs. Powerful variants of the traditional DAPT have grown in popularity as recent tax and state legislation has fostered improved planning. These are explained in greater depth below.

ERISA in 1974, the benefits of QRPs were sharply reduced over time. The requirements to cover more employees, and the costs of doing so, have increased. The minimum required distributions leak assets out of the QRP's tax-deferred growth and asset-protected environment. Furthermore, from an estate tax perspective, QRPs are problem assets. QRPs are income in respect of a decedent (IRD) and, therefore, are subject to both income tax and estate tax. Planning considerations for QRPs are discussed below.

Newer trends. Tax and legal developments continue to affect the physician estate planning landscape. If higher marginal income tax rates are imposed (exacerbated by the new Medicare tax on investment income), and discounts are legislatively restricted, the FLP planning pendulum may again swing back to an income-shifting focus. The potential risk of changes to the present (i.e., 2012) $5.12 million gift tax exemption have created a time pressure to take advantage of the opportunities the large exemption offers before Congress acts to change it.

An increasingly popular planning technique is the use of a "captive" insurance company to insure against a wide range of risks for which the physician (or his or her professional entity) otherwise self-insures. Captive insurance companies offer economic benefits as well as certain tax and creditor protection advantages. Family wealth shifting entities, such as BDITs (discussed below), may own captives. Further discussion of captives is beyond the scope of this article.[3]

Planning with QRPs, IRD, and life insurance

Because so many physicians have QRPs, and many continue to rely on QRPs as a core of their investment and asset protection planning, developments affecting both QRPs and the relative advantages life insurance planning might offer warrant further elaboration. The optimal use of QRPs and life insurance can be critical to achieving physician planning goals. Many physicians make assumptions that are often not necessarily correct.

Life insurance and the younger physician. Often physicians acquired life insurance early in their careers when they had limited cash flow, student loans, mortgages, debts, and family demands to address. In such instances, many physicians acquired as much life insurance coverage for as cheap a price as they could—buying either term, or a blend of permanent and term that depended on a substantial allocation of term to make the premiums affordable.

Investing in QRPs or life insurance. Acknowledging the limitations of a QRP versus life insurance discussion, the points raised nevertheless warrant discussion given the importance of each to many physician clients.

- *Tax-deferred growth.* Income tax-free or tax-deferred growth is a powerful and desirable component of a physician's planning. The two predominant vehicles to accomplish tax-free compounding are QRPs and cash-value life insurance (CVLI). The various features of a CVLI policy and QRP are compared in Exhibit 1. So long as the life insurance contract is not a modified endowment contract (MEC), it should provide this tax advantage.
- *Investment risk.* Many physicians subscribe to the theory of "buy term and invest the difference," particularly if they can shift the savings into their QRPs. Recent stock market volatility demonstrates that this approach does not assure success. The availability of minimum guaranteed rates of return, if secured by economically sound financial institutions, minimize the economic exposure of life insurance as an asset class. A properly structured life insurance plan may also offer a potential for growth in excess of the guaranteed return. A QRP with $1 million that then loses half of its value must over-perform to just make up the $500,000 loss. Mathematically, it is similar to a failing grantor retained annuity trust (GRAT) without the ability to terminate it and start over by re-GRATing the asset. CVLI policies acquired from a high-quality carrier provide the physician with a conservative asset class, comparable to a municipal bond. This feature is material during the retirement years when a substantial diminishment in wealth cannot be re-earned. Life insurance is increasingly being recommend-

[3] For a discussion of captive insurance companies, see Bunting, Kirkpatrick, and Kurtz, "Possibilities and Pitfalls With Captive Insurance Companies," 38 ETPL 3 (August 2011).

EXHIBIT 1
Comparison of a CVLI Policy and a QRP

The following compares a CVLI policy and a QRP. When used in conjunction with a CGDAPT or BDIT, the benefits are magnified.

Qualified retirement plan:

1. Income tax deduction for contributions.
2. Tax deferral—not exempt.
3. Tax at ordinary income rates—often converts capital gain into ordinary income to the recipient.
4. IRD—subject to both income and estate tax.
5. Non-alienation—prohibits transfer to escape the estate tax.
6. Contributions and withdrawals—too much, too soon, too little, too late; problems with both contributions and withdrawals.
7. Administrative and legal costs.
8. Fiduciary obligations.
9. Subject to changes in the law.
10. Nondiscriminatory.

CVLI—in CGDAPT or BDIT:

1. Tax-exempt access to the investment fund through borrowing.
2. Tax-free or deferred accumulation grows exponentially; thus in order to best achieve the benefits, estate owner must survive and not withdraw for a long period. The client risks early death with a QRP. With a CVLI, the policy matures on early death, making the undertaking economically successful as to the survivors.
3. Estate planning strategies (e.g., split-dollar, dynastic trusts, CGDAPTs, and BDITs) enable the proceeds to be transfer tax exempt, yet be available to the client.
4. Contributions are with after-tax income.
5. Income tax—basis step-up at death.
6. No administrative or legal costs on the life insurance component.
7. Fully discriminatory.
8. Hedges the "tax burn" and other wealth-shifting techniques. If there is an early death, the family receives the death benefit (a wonderful rate of return); in the event of a later death, the tax burn provides a larger benefit.
9. Safety—guarantees backed by the carrier.
10. In a CGDAPT or a BDIT, estate tax exempt.

ed by professional advisors as a conservative, non-correlated asset class investment.

- *Accessibility.* CVLI is not subject to the restrictions of QRPs. Non-MEC CVLI has the advantage over the QRP in that the tax-deferred growth is accessible income tax-free while the insured is alive. In contrast, the QRP distributions are always taxed as ordinary income, and lifetime access has substantial restrictions.

Integrating CVLI into modern trust planning. Placing the CVLI policy in a BDIT/ILIT (or a CGDAPT/ILIT), both discussed below, insulates the death benefits from the estate tax system. If owned by a dynastic trust, this benefit will last as long as the proceeds are retained in trust. This transfer tax avoidance does not exist for QRPs.

In order for the physician to be assured access to the cash value, he or she has to own the policy personally, which then exposes the death benefit to estate tax inclusion. Two of the strategies described below, the completed gift domestic asset protection trust (CGDAPT) and the beneficiary defective inheritor's trust (BDIT), enable the physician to shift ownership of a policy to a trust and have it be outside of the physician's taxable estate. Most importantly, the physician can be a discretionary beneficiary of either of these two types of trusts. This decision-making with regard to life insurance on the physician's life must be at the discretion of an independent trustee, who could be a person chosen by the physician, thus making the cash value indirectly accessible to the physician. Obviously, estate tax inclusion issues must be planned for and monitored. Integrating insurance into trust planning is discussed in greater detail below.

Planning for IRD. While the most important item of IRD is typically a QRP, physicians often have salary continuation plans, unpaid receivables, deferred compensation, and other items of IRD. These IRD items are all subject to both estate tax and income tax. Therefore, planning for the receipt of IRD is essential.

The advisor should consider transferring items of IRD to the surviving spouse in the marital deduction disposition or, alternatively, to satisfy charitable giving desires. Items of IRD are generally considered to be a wasting asset because income tax is paid on its receipt. In marital dispositions, the physician's estate obtains a marital deduction for the full value and the spouse receives the payments and pays income tax on those payments. This reduces the surviving spouse's estate so that only the unspent amount is included for estate tax purposes. Apart from the tax drawbacks, IRD assets tend to be desirable to the surviving spouse as they eventually generate cash flow. For charitable recipients, because they are income tax exempt, the assets received are available without diminishment.

Practitioners should be cautious of a potential trap created by IRD assets. If a pecuniary marital deduction (or charitable deduction) formula is used, the funding of the debt obligation with an item of IRD results in immediate gain at the funding. The advisor should consider a specific bequest of the items of IRD to the surviving spouse or a marital deduction trust. A specific bequest avoids the immediate income tax. To avoid overfunding, a formula limiting the bequest to the IRD necessary to reduce the estate tax to zero can be used.

Options that address QRP shortcomings. A notable planning opportunity is for a medical practice to establish a Roth 401(k) plan that operates concurrently with the firm's traditional 401(k) plan. For example, with a "safe-harbor 401(k)" (where there are matching contributions for employee contributions—roughly 3% or 4%, when an employee contributes 5% or more), a physician can set aside $17,000 in nondeductible dollars into a Roth 401(k) account each year. This amount is increased to $22,500 if the physician is at least age 50. Thereafter, all distributions, including investment income, will usually be income tax-free. This effectively eliminates the issues of IRD after death because after five years, all Roth distributions are usually tax-free.

Practitioners must strive to educate their physician-clients that the medical model of periodic monitoring is essential and applies to the physicians' own estate planning.

At retirement, the physician would roll over his or her Roth 401(k) account into a Roth IRA. Because a Roth IRA does not have required distributions after age 70½, it can solve the "leakage" problem associated with required distributions after age 70½. In addition, the Roth strategy generates more wealth compared to a traditional qualified plan with pretax dollars, triggering taxable income at distribution, and IRD after death. Another planning opportunity is a Roth IRA conversion—i.e., to convert a traditional IRA or 401(k) account into a taxable IRA.

Periodic reviews and maintaining existing structures

The QRP, ILIT, and FLP remain the extent of many physicians' planning. While useful, these techniques do not afford most physicians adequate planning benefits. Shoring up existing plans is often a prerequisite to pursuing more sophisticated planning. Frequently, these plans have been operated without attention to legal and tax formalities so that the QRP, ILIT, and FLP plan may afford little real benefit. The steps that should be taken might include:

- *QRPs.* Proper plan amendments, monitoring, and updating beneficiary designations, etc.
- *FLPs.* Proper structuring and maintenance of the FLP, including adhering to all formalities.
- *ILITs.* Proper transfer of assets to trusts, issuance and maintenance of *Crummey* letters, avoiding commingling of personal and trust assets, etc.

Educating physician-clients that estate planning is an ongoing process. If the physician does not follow and respect the rules of the entity, he or she cannot expect the IRS or courts to do so. A common physician reaction when confronted with the need for regular review and maintenance of the plan is, "I have an FLP so I am protected, and my planning has been done." Most do not believe, or do not wish to address, the risks of not following appropriate procedures. Indeed, it is rare for any client to correctly monitor their FLPs and follow formalities. The IRS's increased success in attacking FLPs that were not designed, implemented, or monitored correctly, should serve as a clarion call to client action to properly maintain, not only FLPs, but all of their planning.

Practitioners understand that estate planning is a process, not a document. However, many physicians tend to view estate planning as the execution of a document. Therefore, practitioners must strive to educate their physician-clients that the medical model of periodic monitoring is essential and

applies to the physicians' own estate planning.

Estate planning, business planning, and asset protection planning are continuously changing processes and must be treated as such. New strategies that are constantly evolving for both creditor protection and tax planning purposes, and the current in-force techniques, should be reviewed periodically. For example, the "tax burn" (i.e., depletion resulting from structuring an irrevocable trust to be taxed as a grantor trust for income tax purposes) has come to be recognized as one of the most powerful wealth-shifting strategies available to the planner. Yet many physicians and advisors do not give adequate recognition to the considerable estate tax and creditor-sheltering benefits this technique can afford.

Life insurance is a part of many people's estate plans, but, as with so much of planning, is viewed as a one-time action that is often forgotten and not later reviewed after the initial purchase is made. Practitioners need to educate physicians that insurance planning also is a continual process. The periodic planning review should include an analysis of the physician's life insurance holdings as well.

- Life insurance products have improved over time; mortality risk has lessened, the quality of carriers has changed; some policies may be under-performing and may need an infusion of cash, or should be exchanged for a better product; and family needs are continually changing. To illustrate, as a result of increasing life expectancies, premiums for a policy of the same face amount may be less costly than they were a few years earlier, even though the insured is older.
- Depending on the risk profile of a particular physician's asset base, and the return actually realized on his or her investment portfolio, an increased allocation to permanent insurance products may provide a solid investment alternative for their overall portfolio. Only recently has substantial consideration of life insurance as a conservative asset class garnered attention, and, for the appropriate physicians, this should be a component of the review.

Physicians typically place a greater emphasis on asset protection, especially malpractice protection, than other clients.

- Another recent development illustrates the need for ongoing planning reviews. The recent enactment of the $5.12 million (in 2012) gift tax exemption affords what might prove a historic window of opportunity to unwind existing split-dollar arrangements, transfer policies with cash value to an ILIT, as well as other significant insurance planning options.

Administrative and other considerations. To assure the proper maintenance of existing planning, and to identify improvements and appropriate new techniques, a periodic review meeting is essential. However, for the physician client in particular, these meetings raise a number of issues that, while perhaps obvious, practitioners nonetheless must address:

- *Time constraints.* The work demands make it difficult, if not impossible, for many physicians, however capable and well-meaning, to administer their own plans, or to even meet to do so. Nonetheless, periodic reviews are essential to address ongoing entity and trust maintenance, changes in the law, particularly tax laws, and changes in family dynamics. Practitioners can address these realities by automating the process for many tasks, such as issuing *Crummey* power notices, so that lower cost associates can handle these tasks for the physician. Additionally, web conferencing technology makes it feasible and productive to hold meetings on shorter notice and without the travel time that might impede the physician from following through.
- *Malpractice exposure.* Many physicians operate under the erroneous belief that the limits of their malpractice insurance provide a cap on the maximum award they could be charged. Educating them on the fact that their personal assets could indeed be at risk is vital to understanding the magnitude of their malpractice exposure. Many will not pursue planning with the rigor that is appropriate, and often this and other misconceptions lie at the core of their indifference. Sheltering wealth in creditor-protected trusts and entities reduces the attachable assets for claimants and increases the probability of quicker and cheaper settlements.
- *Specialization.* Although physicians recognize expertise and specialization in their chosen profession, they often fail to

appreciate similar skills when selecting their estate planning team. All too often an intelligent selection process is bypassed. Instead, a friend, golfing buddy, or a lawyer who practices in another area of the law, is chosen to provide estate planning counsel—with no perception of the wide disparity between quality specialized planning and ineffective advice. This differential can expose the physician, and his or her loved ones, to unnecessary economic hardship.

- *Costs and billing.* In addition, the selection process typically involves fee considerations, which too often are an "apples to oranges" comparison. Would anyone select a heart surgeon based on a cost comparison? Of course not. Then why compromise the quality of the wealth planning team, possibly leading to an adverse result for themselves and their family? Unfortunately, too often they do. Physicians operate their practices with a dramatically different billing paradigm and often do not understand or find comfort with hourly billing. It is important to address this issue directly, especially if more sophisticated and costly planning will be undertaken.

With this background, the planning goals for a typical physician client should be reviewed, and then the more modern planning options explored, to meet those goals.

Physician planning goals and concerns

As with all clients, the tax and asset protection planning for physicians should be customized to meet individual needs. However, several generalizations and suppositions can provide a useful framework for approaching physician planning. The typical goals on a physician's planning "wish list" are discussed below.

Creditor protection. Physicians typically place a greater emphasis on asset protection, especially malpractice protection, than other clients. Early in their law school training, lawyers learn that the use of an entity, such as a corporation, is essential in the planning process for someone who is going into any business with risk, in order to protect personal assets from potential creditors of the business. Indeed, not recommending this strategy would be malpractice.

The trust ideally should be a fully discretionary trust that does not have any enforceable rights that a creditor of the physician beneficiary can assume.

Do the physician's advisors have the obligation to recommend asset protection planning to a physician? Does that include at least a plain vanilla APT? Not offering such a recommendation to a client, especially a physician who faces potential malpractice exposure is, at a minimum, insufficient advice. As the law evolves, advisors could potentially be exposed to liability for not suggesting appropriate creditor protection planning strategies, which might include the creation of an APT in a protective jurisdiction, spendthrift trusts, and other trust planning.

For those physicians who have current liability exposure, however, the use of many of these strategies is impermissible, or at least severely limited, and could be a fraudulent transfer, possibly subjecting the physician and participating advisors to civil and criminal liability and adverse professional ethical repercussions. Nonetheless, even a physician who is under legitimate attack should take certain protective steps, such as wealth-receipt planning (i.e., making sure the gifts and bequests to the physician are insulated from the reach of creditors). The goal is to preserve and protect the maximum allowed under law for the physician and his or her family. The use of each of these is discussed at greater length below.

Retirement security. Business owners often plan on receiving continuing distributions from their family business, or substantial proceeds from the sale of the business, after retirement. These resources are generally not available, or, if available, not assured for physicians. Many physicians worry that changes in insurance reimbursements and other external forces beyond their control may greatly limit the proceeds they might realize on the future sale of their practice. The passage of a major health care bill in Washington could undermine their practice value in a manner that few other business clients fear. Even for a physician with a valuable practice, a backstop is often desired to assure that, after many decades of labor, retirement will be secure.

Control. Given the malpractice and financial risks described above, it should be no surprise that physician-clients are often concerned about retaining sufficient control over their estate and financial planning, while protecting their wealth from potential claimants.

Estate creation. For physicians new to practice who have not yet accu-

mulated wealth, and especially those who have family obligations, creating an estate in the event of adversity is a critical component of planning. Even established physicians, however, remain concerned about asset creation because of the concerns described above.

Use of trusts

Frequently, physicians, as well as some of their advisors, are simply unaware of, or do not give sufficient attention to, the fundamental importance of estate and asset protection planning. The very nature of the wealth planning system enables someone to "give" rights, benefits, and controls to someone else in trust, which the individual cannot "retain" for themselves without exposing the assets to loss. Assets are always more valuable when received in a trust set up by someone apart from the recipient than those same assets would be if received outright. Simply by being received and held in trust, those assets have advantages that do not and cannot exist if those assets were received outright. The tax benefits that can be obtained from leaving property in a continuing trust are substantial, particularly with respect to the transfer tax system. Irrespective of the tax benefits, the creditor and divorce protection that spendthrift trusts provide cannot be overstated.[4] These trusts, if established inter vivos, may serve as components of the physician's own personal estate and asset protection planning

Wealth transfers to physician. Whether the physician has affluent parents or grandparents, or even more modest benefactors, consider designing the manner in which the physician receives any gift or inheritance in a well-structured trust. The trust can continue indefinitely after the physician's death for descendants (or anyone else), to the extent that any special power of appointment is not exercised, and subject to the applicable state law rule against perpetuities.

The trust must be structured, designed, and created before the physician receives the property. If the transfers are received outright instead, the physician has lost the opportunity to maintain the property in the most creditor-protected and tax-efficient structure available. Once received outright, there are limitations, and the physician certainly cannot establish the most effective structure for his or her own benefit. While some of the benefits of trust-owned property can be achieved, the cost and complexity will be greater, and the benefits less. Inheriting in trust is consistent with each of the general planning objectives set forth above.

The transferors might not be amenable to paying for, or being involved in, the complexities of designing the trust planning. This is common for elderly parents who may have had minimal sophisticated legal counsel previously. In this situation, the physician might pay for and design the recipient trust. Then the parent or other benefactor would merely name that trust, rather than the physician personally, as the donee or beneficiary. This can make the process simple and very inexpensive for the parent/benefactor.

This type of inheritance trust planning can be extended to provide the physician with additional transfer tax and asset protection benefits. A trust set up by the physician's benefactor may serve as the general partner in an FLP. The physician could be named as the investment trustee of that trust, and he or she would have significant control over the partnership without the exposure of serving directly as the general partner. This control, which would be exercised according to the terms of the trust in a fiduciary capacity, should not be attributed to the physician when valuing the FLP interests for gift or estate tax purposes.

Wealth transfers from physician. The physician should make lifetime gifts or bequests in continuing trusts for the physician's loved ones. This planning, and the rationale behind it, are no different than the trust planning advocated for when the physician is the recipient of the wealth transfer.

Use modern trust design

While inheriting and bequeathing in trusts is almost always the optimal planning approach, the trusts suggested in the preceding discussion must be appropriately designed to provide the desired benefits.

Traditional trust drafting is inadequate. Many physicians have "old-fashioned trusts" and continue to rely on this antiquated approach to planning. These trusts might provide that all income be paid out, distributions of principal be made for health, education, maintenance, and support (the "HEMS" standard), the annual right to withdraw the greater of 5% or $5,000 (the "5/5 power"), and often distribute corpus at staggered ages, such as one-third at each of ages 25, 30, and 35. These rights all unnecessarily expose trust assets to potential claimants, including the IRS.

Some trust designs, such as using a unitrust payment to comport with investment allocation and distribution theory, or incentive trusts, are

[4] R. Oshins and Kasner, "The Dynastic Trusts Under the Relief Act of 2001," Tax Notes (10/8/2001), page 247; see also Fox and Huft, "Asset Protection and Dynasty Trusts," 37 Real Property, Probate and Trusts J. 287 (Summer 2002); see also Fox, Hirschey, Keebler, Kess, Krass, R. Oshins, and Slavutin, "Asset Protection," Financial and Estate Planning (November 2007).

the opposite of prudent tax and asset protection planning. The mandatory distribution of money from a unitrust is inefficient for transfer tax planning purposes and unnecessarily exposes the distributions to the beneficiary's creditors.

Example. A plastic surgeon in Beverly Hills is being sued for malpractice or going through a divorce. The surgeon earns $5 million per year and is the beneficiary of an incentive trust that matches his or her earned income. "Force out" provisions in a trust needlessly increase the wealth subject to creditors and transfer taxes. In addition, a right to withdraw principal, even if subject to an ascertainable standard, often exposes the trust to potential creditors and state laws that let certain types of creditors step into the shoes of the beneficiary and enforce the standards.[5]

The results achievable with modern trust planning satisfy the "wish list" set out in this article, except for the estate creation goal. In appropriate circumstances, that component may be addressed with the addition of life insurance.

Elements of modern trust design. Modern, and more protective trust structuring,[6] is based on the following characteristics:

- *Distributions.* The trust ideally should be a fully discretionary trust that does not have any enforceable rights that a creditor of the physician beneficiary can assume. Distribution decisions should be made by an "independent" distribution trustee." "Independent trustee" does not mean confrontational. It could be a trusted friend or advisor.
- *Investment decisions.* The physician may serve as the investment or management trustee and have control, in a fiduciary capacity, over the investment of trust assets.
- *Control over the distribution trustee.* The physician can control the identity of the distribution trustee subject to the restrictions of Section 672(c) and Rev. Rul. 95-58[7]) without exposing the wealth held in the trust to the physician's transfer taxes or claimants.
- *Situs.* The trust should be domiciled in a state with preferable tax and asset protection laws, to provide an optimal wealth protection tool available to planners.[8] The trust should be formed in a state that does not give rights to exception creditors, such as divorcing spouses. Moreover, jurisdiction selection should consider each of the following: (1) no state income tax, (2) an extended rule against perpetuities, and (3) the costs (such as trustee fees) to obtain jurisdiction in that state. The extended perpetuity benefit is recommended because the termination of the trust as a result of a state's perpetuity statute would "force out" all trust assets, thus terminating the tax and creditor benefit shield of the trust.
- *Use of assets.* The trust should be structured so that the trustee can acquire assets for the benefit or enjoyment of the beneficiary and permit the beneficiary to use the trust assets. For example, instead of the physician personally acquiring an office building or new vacation home, the trust can purchase the property and permit the physician/beneficiary to use it.
- *Powers of appointment.* The trust should have broad powers of appointment so that the physician can change the disposition if there is a change in law (tax or otherwise), or a change in family dynamics. This flexibility should be continued for future generations. The primary beneficiary, and subsequent beneficiaries, can be given substantial control of the trust through properly crafted powers, yet still receive the "in trust" protections. The ability of a beneficiary essentially to re-write the trust is subject to relatively negligible restrictions provided in Section 2041(b)(1).

Modern trust design for a third-party settler. If a trust is funded by someone other than the physician, the physician (and at the physician's death, subsequent primary beneficiaries—i.e., spouse, children, grandchildren, etc.) can be given all of the benefits, rights, and controls described in the preceding section without adversely compromising the tax and creditor protection benefits of the trust.

[5] S. Oshins, "Asset Protection Other Than Self Settled Trusts: Beneficiary Controlled Trusts, FLPs, LLCs, Retirement Plans and Other Creditor Protective Strategies," 3061 Miami Institute on Estate Planning, Chapter 3 (2005).

[6] Keydel, "Trustee Selection, Succession, and Removal Ways to Blend Expertise with Family Control," 23 U. Miami Inst. on Est. Plan., Ch 4 (1989); see also Aucutt, "Structuring Trust Arrangements for Flexibility," 35 U. Miami Inst. On Est. Plan., Ch. 9 (2001); see also Calleton, McBryde, R. Oshins, "Building Flexibility and Control Mechanisms Into the Estate Plan—Drafting From the Recipients Viewpoint," 61st NYU Inst. on Taxation (2003).

[7] 1995-2 CB 19.

[8] A discretionary trust with "*... the distribution discretion held by an independent trustee ... is the ultimate in creditor and divorce protection—even in a state that restricts so called "spendthrift' trust—since the beneficiary himself has no enforceable rights against the trust."* (emphasis supplied) Keydel, "Trustee Selection, Succession and Removal; Ways to Blend Expertise With Family Control," 23 Miami Inst. on Est. Plan., Ch. 4 (1989).

Trust-by-trust analysis

The following discussion applies the trust concepts in the context of specific types of trusts. The analysis uses a progressive approach to trust planning opportunities that incorporate all or most of the components of the physician planning "wish list," commencing with what should be the minimal strategy, and then adding enhancements. As planning moves up the ladder, complexities and costs increase, and so do the tax savings, expanded accessibility, control, and asset protection. This simplistic paradigm can be used by practitioners to present the physician a range of selections.

Domestic asset protection trust (DAPT). Our society has become increasingly litigious, especially with respect to medical malpractice claims. Although rights of claimants are subject to a state's statute of limitations, the term may not begin to toll until the discovery of the wrongful act. Even a retired physician is not immune to being sued, putting in jeopardy his or her lifestyle and security. This is truly the planning nightmare for many physicians.

The basic solution is to use a DAPT. The general rule is that a person may not set up a trust for him or herself (a "self-settled" trust) and obtain asset protection benefits. In such an instance, the "spendthrift provisions" are ignored, and the creditor may reach the maximum amount that could be paid to the trust creator, even if it is a discretionary trust and the trustee does not wish to make the payment. A discretionary, self-settled trust, created in a state with DAPT laws, may be established so that the assets transferred to the DAPT are protected from the creator's creditors after a period of time, generally two to four years, depending on the jurisdiction selected. The shortest waiting period is two years in Nevada, South Dakota, and Hawaii. Presently, 13 states have enacted DAPT laws, containing varying degrees of protection.

To obtain maximum protection, the LLC should be formed in a state where the charging order is the exclusive remedy.

Caveat. The asset protection plan generally must be put into place prior to the wrongful act being committed. The ideal physician candidate for a DAPT is one who:

1. Has assets he or she is willing to transfer.
2. Does not expect to need access to those assets, except in unusual circumstances, such as protection after a lawsuit.
3. Does not have any known creditors, or can leave sufficient assets outside of the DAPT to pay those creditors, if necessary.

This protection is not available for a client who is being sued, is about to be sued, or has an existing liability (to the extent of that liability). Thus, the planning should be implemented as early as possible to start running the statute of limitations.

Most states have not enacted laws to provide asset protection to a "self-settled" trust. Thus, there is a vocal minority of advisors who believe that there is the open question as to whether a judgment rendered in one state is enforceable against a DAPT set up in a different state, particularly if the settlor is not domiciled in the state where the DAPT is domiciled. They have voiced that concern and take the position that the DAPT is ineffective because of the full faith and credit clause of the U.S. Constitution. The position of most advisors and commentators is to the contrary, based on the premise that a state is not required to enforce a judgment against a trust validly set up in that state.

The lack of any reported cases challenging the use of a DAPT by an out-of-state resident is proffered as proof of the perceived lack of vulnerability of DAPT statutes. On the other hand, the limited case law demonstrating the *invalidity* of DAPT statutes for the nearly 15 years that the technique has been used can be offered as evidence as to the effectiveness of DAPT statutes. At a minimum, the DAPT should give the client significant negotiating leverage. Some practitioners have reported that settlements have been for pennies on the dollar, which suggests that settlements may be reflective of nuisance value only.

The physician can be given a testamentary power of appointment in the DAPT or a veto power over distributions so that the transfer would be an incomplete gift and no taxable gift to the trust would arise upon funding.

The traditional DAPT has no income, gift, or estate tax benefits. The trust is a grantor trust for both income and transfer tax purposes. It is solely a creditor protection planning technique. However, it needs to have been put into place early enough to ensure that potential creditors are blocked from access, which is a minimum of two years, depending on state statute.

The physician can obtain additional benefits by adding an entity, such as a limited partnership or an entity, which will be owned, in whole or in part, by the DAPT. That additional layer will increase the

creditor protection as a result of the charging order remedy. To obtain maximum protection, the LLC should be formed in a state where the charging order is the exclusive remedy. In addition, the physician may own one unit as the manager and, thus, have investment control.

Completed gift DAPT (CGDAPT). The CGDAPT builds on the DAPT described above by adding transfer tax benefits in addition to creditor protection, according to many practitioners. The physician makes a completed gift to the trust, which is similar to a regular DAPT, but the physician/donor does not retain a power of appointment or veto power over distributions. The assets transferred would not be included in his or her estate for estate tax purposes after the waiting period for access by creditors has ceased pursuant to state law.

Consistent with the general rules for gift transfers, the physician can make annual exclusion gifts, lifetime exemption gifts, or a combination of the two. Thus, the CGDAPT provides both creditor and transfer tax benefits. That general rule exists even though the physician is a discretionary beneficiary, unless the IRS or a claimant can demonstrate that there was an "understanding" that the physician could obtain distributions. The distinction is that if there is no more than an expectancy, for example, that distributions will be made if the physician has financial hardship (such as estate diminishment as a result of poor investing, liability exposure, or the like), it should be safe. In contrast, if the physician has an agreement with the trustee that distributions will be made in response to a request, the estate tax and creditor protection benefits are compromised.

CGDAPT/ILIT. As indicated in the physician's "wish list" above, the physician may desire a conservative guaranteed return for retirement or estate creation if premature death occurs.

- Including a life insurance policy as an asset of the trust can effectively combine and enhance the benefits of both a CGDAPT and an ILIT.
- If the gift is one of income-producing property, the ILIT component would be a funded ILIT.
- If the life insurance product is a CVLI policy, the trust will combine the virtues of three powerful wealth planning techniques—CGDAPTs, ILITs, and QRPs.

The combination of the CGDAPT/ILIT can be an improvement over both the traditional ILIT and the CGDAPT from several perspectives. Successful returns on non-insurance assets in the CGDAPT/ILIT can be used to fund insurance premiums. This can be simpler than the use of annual *Crummey* powers, which can prove a nuisance and, too often, are not properly monitored. Because the physician can be a discretionary beneficiary of the CGDAPT, if the physician falls on hard times, cash can be borrowed from the policy, or possibly the policy can be sold to create funds to support the physician and his or her family if the family financial well-being implodes.

Super-charged CGDAPT (SC-CGDAPT). The CGDAPT, including the ILIT variant, can be enhanced by a variety of upscale leveraging techniques. These strategies can be used singularly, or combined with each other, to improve the planning. These planning benefits are those typically associated with what is referred to as a note sale to an intentionally defective irrevocable grantor trust (IDIGT):

- *Freeze.* The physician would transfer to the CGDAPT those assets that are expected to increase in value. This shifts all post-transfer appreciation tax-free outside the estate to the extent the appreciation exceeds the interest on the note.
- *Discounting.* Transfers of discountable interests expand the magnitude of the wealth shift. But, even if future legislation restricts or eliminates the availability of discounts, the other techniques noted unquestionably make the planning quite beneficial, even without discounts.
- *Sales.* The physician can engage in installment sales with the trust so that the trust can pay the purchase price in the future out of subsequent trust earnings. That technique is similar to note sales to IDGTs or BDITs (discussed below).
- *Tax burn.* The "tax burn" is a powerful, underappreciated wealth-shifting strategy that affords substantial opportunity to effect estate depletion as a result of grantor trust status. By transferring assets that produce taxable income into the CGDAPT, the physician can increase the wealth shift, but continue as a discretionary beneficiary and receive distributions if circumstances change.

As a result of grantor trust statutes, the physician must pay the income taxes on all trust income (whether or not distributed), and such tax payments are not gifts. Over time, the tax-free funding as a result of the physician paying income tax on trust income is very substantial, and the tax economies generally exceed the freeze and the discount combined.

Although this is often touted as an estate "tax burn" the asset protection benefits are equally substantial. As assets grow inside the income tax-free envelope of the DAPT, CGDAPT, CGDAPT/ILIT, or BDIT (which is discussed below), the wealth is safer from claimants. Meanwhile, assets in the physician's unprotected estate are reduced, impeding the ability of a claimant to recover. Any reasonable creditor would be deterred from pursuing an action where satisfaction of a judgment is significantly limited as a result of assets having been previously transferred to the DAPT, with the physician's remaining personal assets decreasing each year as a result of the tax burn. Further, the continued payment of income tax as a result of the trust being classified as a grantor trust should not be a fraudulent conveyance, because the tax is the physician's liability under the Internal Revenue Code.

Beneficiary defective inheritor's trust (BDIT). One drawback to the DAPT, CGDAPT, and CGDAPT/ILIT is that the physician is the person establishing the trust and making transfers to it. Because the physician makes the transfer, his or her control over the transferred assets is substantially limited if the desired benefits are to be obtained. This drawback can be improved using a BDIT. The BDIT is the only strategy that enables the physician to be in substantial control of the transferred wealth, have the use and enjoyment of the assets, have the ability to change the trust through a power of appointment, and have creditor protection and estate tax savings—and not have to worry about the perceived risks of self-settled trusts.

The physician's BDIT closely resembles *Crummey* trusts, which have been used for over 40 years, except that the trust is created by someone other than the physician and the physician is the favored beneficiary. The BDIT is an irrevocable trust funded by someone other than the physician himself or herself (such as a parent or grandparent) for the benefit of the physician and typically the physician's spouse and descendants, where the physician is given a lapsing *Crummey* power of withdrawal over the gift. The concept is more easily understood by thinking of the BDIT as the parent's (or other third party's) dynasty/*Crummey* trust that is funded with a gift of $5,000 with a lapsing power of withdrawal. The physician never makes a gift to the trust.

The "tax burn" is a powerful, underappreciated wealth-shifting strategy that affords substantial opportunity to effect estate depletion as a result of grantor trust status.

Because the trust is solely funded by someone else and the physician never makes a gift to the trust, the assets in the trust are sheltered from estate, gift, and GST taxes—as well as protected from current and future creditors of the trust beneficiaries, including the physician. Because the physician never makes a gift to the trust, the physician can be given the controls (managerial and otherwise) and benefits of being a trust beneficiary, discussed previously, without exposing the trust assets to the transfer tax system or to creditors.

As a result of giving the physician the right of withdrawal with a *Crummey* power, Section 678 treats the physician as the owner of the trust assets for income tax purposes. This conclusion has been verified by numerous private letter rulings. Having the physician treated as the owner of the trust income provides two valuable benefits:

1. The physician can transact with the BDIT (or a CGDAPT) income tax-free. Thus, the sale of appreciated assets does not trigger an income tax.
2. Because the physician pays income tax as a result of grantor trust status, his or her estate is depleted over time for both estate tax and creditor protection enhancement.

In effect, the physician may transfer wealth both income tax-free and transfer tax-free into a trust that is protected from estate tax and creditors. Importantly, because the physician did not fund the BDIT and was not the grantor, the assets inside the BDIT are, according to many practitioners who use the technique, more secure from claimants than the DAPT and its variations discussed earlier in this article. The significant benefit of the BDIT structure compared to the previously discussed strategies is that the physician has control and substantial enjoyment of the trust assets. Too much control and enjoyment in the CGDAPT exposes the transferred assets for both tax and asset protection purposes. The negative features are that the costs and complexity of the BDIT is much greater than the CGDAPT.

To illustrate the foregoing, assume a physician owns an interest in an LLC that owns equipment or an office building. Other assets for this type of planning include any other property the physician owns personally, an intellectual property licensing entity, or an interest in an entity that factors the physician's accounts receivable. The physician's

parent or some other third person would fund the BDIT, whereby the physician would be the investment trustee. An independent co-trustee would have the power to make tax-sensitive decisions. The independent trustee would also have the discretionary power to make discretionary distributions of trust assets to the physician and other trust beneficiaries.

The physician will then sell his or her interest in the entity to the trust for an interest-only note at the minimum interest rate required by the tax laws to avoid imputation of interest. This minimum interest rate is based on the current applicable federal rate (AFR). The note would also provide for a balloon payment on maturity. A discount, if appropriate, might be taken on the sale of a noncontrolling interest in an FLP or LLC, which would further leverage the planning benefits. In most instances, the discount is eclipsed over time by the benefit of the grantor trust "tax burn." This technique can be further enhanced with the inclusion of life insurance in the BDIT/ILIT, as discussed below.

The note would be paid with the cash flow from the entity sold to the trust. Interests in equipment and office building entities are attractive assets to sell because they generate the income to pay the note from the lease to the practice operating company. As a result of the grantor trust status, the physician reports all items of income, deductions (e.g., depreciation), and credits on the physician's tax return. As income is earned, the physician's exposed personal estate is being reduced and effectively shifted to the protective BDIT. Because the note would be exposed to potential claimants, the physician may elect to transfer all or a portion of the note to another trust, such as a DAPT—including a completed gift DAPT—to protect it.

BDIT/ILIT. Similar to the CGDAPT/ILIT, a BDIT can be enhanced with life insurance to provide the remaining component of the physician "wish list," which is estate creation in the event of premature death. Combining the BDIT with a permanent, well-crafted insurance plan can provide both estate creation and a tax-free investment vehicle. Thus, the BDIT/ILIT can effectively achieve all of the goals on the physician "wish list" outlined above.

A BDIT can be enhanced with life insurance to provide the remaining component of the physician "wish list," which is estate creation in the event of premature death.

A BDIT, coupled with a well-designed CVLI policy, will provide most of the advantages of a QRP, but along with the estate tax avoidance of an ILIT. The controls that the physician/grantor can have with a BDIT, as described in the preceding section, apply to all assets. Even with the BDIT, however, the physician cannot have any power (including a power of appointment) with respect to life insurance on his or her life. The physician, however, can control the identity of the independent trustee who makes the decisions on the life insurance.

Cash flow in excess of the required interest may be used to acquire a life insurance policy, including CVLI, which would offer retirement planning and a conservative asset class to round out the physician's overall investment portfolio. This course of action enables the physician to obtain the dual benefits of estate creation for the family in case of untimely death, as well as the tax-free retirement build-up. The acquisition of the life insurance also provides a fund to pay the death costs during the tax-burn period. Survivorship (second-to-die) life insurance will generally provide increased leverage in accumulating funds tax-free inside of the policy. However, similar to a policy on his or her life, the physician cannot have control over the policy or its proceeds.

In lieu of buying life insurance on the physician's life, some physicians might prefer the BDIT to own life insurance on someone else's life, such as a spouse or child, provided there is an insurable interest. Owning insurance on a life of someone other than the physician mitigates the problems of the physician having control over a policy, or the proceeds of a policy, on his or her own life. This does not resolve the estate creation goal that would be resolved by the death benefit component of the policy, but offers the control feature.

Enhancing modern trust design

Proper use of modern trust designs discussed above can help achieve many physician planning goals, but the results can be enhanced when properly designed trusts are coordinated with appropriately designed entities. The proper use and structure of multiple entities is often fundamental in planning for most clients. This planning applies even more so for physicians because of their malpractice concerns.

General entity planning considerations. Some general principles apply to entity planning:

- *Internal vs. external claims.* In the context of protective asset protection planning, a distinction must be made between "internal" and "external" protection. For example, lawsuits for malpractice expose the operating entity and the physician who committed the wrongful act to claims. Assets owned outside of the practice, however, may be protected. But external claims, such as from an auto accident, can jeopardize the assets held in an improperly structured entity. Entities that provide only charging order remedies to claimants should be favored.
- *Situs.* Although the professional practice entity must be domiciled in each state in which the physician practices, the other entities should be created in states with favorable entity laws. For example, certain states provide that a "charging order" is the exclusive remedy against the owner of an FLP or LLC interest. While there may be a debate as to which top-tier state offers the best laws, the use of certain inferior state laws, however, cannot be rationally reconciled.
- *Integrate entities into overall planning.* Transfers of interests in equipment LLCs, medical building LLCs, and other entities owned by physicians, are often appropriate assets to be used in wealth transfer planning. The cash flow generated from leasing the assets held in the entities may support the sale of the entity interests by the physician to an income tax defective dynasty or asset protection trust. Further, with proper structuring, no income tax will be triggered. In addition, annual exclusion gifts and transfers using the current $5.12 million gift tax exemption may infuse the trust with funds needed to pay for the purchased assets. As a general rule, the tax and creditor protection benefits inherent in the use of multiple entities are enhanced by using them in conjunction with modern irrevocable trusts, especially grantor trusts.

Segregation of different assets. Creative but realistic segregation of each significant practice asset from personal assets, and from each other, is a key to planning.

- *Personal assets.* For almost all physicians, dividing assets and activities into separate legal "envelopes," such as investment real estate limited liability companies (LLCs) and marketable security FLPs, and pairing entities with various irrevocable trusts, is an effective means to implement a "divide and conquer" strategy. For example, an FLP can consolidate assets of the children, children's trusts, family trusts, and the physician personally. FLP interests held by the physician can be given to family trusts, such as those described in this article, to further fractionalize the physician's direct interests and make the retained interests more difficult for a claimant to reach.
- *The practice.* The physician's medical practice should be organized in an entity structure that protects the physician's personal assets from non-malpractice claims (e.g., a vendor being injured on the premises) and from claims by another physician's patient. Valuable practice assets should be addressed separately.
- *Practice physical assets.* For many physicians, such as emergency room physicians, the "divide and conquer" planning is limited by a lack of transferable business assets. For those physicians whose practices require substantial equipment, or who own the building used by the practice, the use of separate entities is essential to the planning process. The modern version sets up an LLC to operate as a real estate LLC leasing an office building to the medical practice.
- *Practice intangible assets.* A separate intellectual property LLC may own a practice name, telephone number, website, logo, and other rights that are then licensed to the medical practice.

Conclusion

Strategic wealth planning for physicians today is quite different from what it was in the past. The combination of separate entities combined with trusts is essential to proper planning for physicians. At a minimum, physicians should consider using a DAPT to protect wealth from creditors. The CGDAPT adds estate tax savings to the equation, and incorporating leveraging techniques can increase these tax savings. However, neither option offers control and use of the transferred assets often desired by estate owners, including physicians. The BDIT adds those components. The BDIT and CGDAPT, coupled with a well-designed life insurance program formed as a CGDAPT/ILIT or a BDIT/ILIT, offers potential estate creation benefits, as well as enhanced retirement planning. ■