Datalogics Unix Job 1 bschar/0/8125 12-OCT-11 10:42
Style: /opus/environments/proda/edsys/pager/style/journal.bst File: /tigredata/tigredata01/etpl/etpl_582214.txt
Seq: 1 Color: 0c: Format: rls$prod:journal.fmtFree lead 14D*points, Next 120D, Vjust JC1:1

MODERNIZE PLANNING

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.

RICHARD A. OSHINS AND MARTIN M. SHENKMAN, ATTORNEYS

RICHARD A. OSHINS is a member of the law firm of Oshins & Associates, LLC, in Las Vegas, Nevada. He is also a member of the editorial board of ESTATE PLANNING. MARTIN M. SHENKMAN, CPA, MBA, PFS, AEP, J.D., is an attorney in Paramus, New Jersey. The authors would like to thank Jerry Hesch of Carlton Fields, Miami, Florida; Lawrence Brody of Bryan Cave, LLP, St. Louis, Missouri; Professor Christopher Hoyt, University of Missouri, Kansas City, Missouri; Bob Keebler of Keebler & Associates, LLP, Green Bay, Wisconsin; Susan Rounds, CPA, LL.M., Atlanta, Georgia; Kristen Simmons of Oshins and Associates, LLC, Las Vegas, Nevada; and Jeremy Spackman of Oshins and Associates, LLC, Las Vegas, Nevada, for their help in the preparation of this article.

Physicians take advantage of the newest medical advances for their patients. However, many have not kept as current in their own estate, retirement, and asset protection planning. 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 7.5% of physicians are subject to a malpractice claim every year, and about 20% of these result in a payment to the claimant. In some specialties, such as neurosurgery and heart surgery, nearly 20% of the practitioners are sued every year. A physician who is made aware of the quantum of risk is likely to be motivated to action.[1]

This article will present innovative, lesser-known wealth planning techniques that are available to physicians. The analysis starts with relatively simple, basic strategies and then progesses in a laddered approach to more sophisticated 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.

Historical planning paradigms for physicians

The evolution of planning for physicians started with state laws allowing professionals to incorporate, thereby enabling the use of qualified retirement plans (QRPs) and other fringe benefits available to only employees of corporations. This provided income and estate tax avoidance, and asset protection benefits.

Following the *Crummey* court decision, irrevocable life insurance trusts (ILITs) became a more popular vehicle for owning life insurance. New physicians—often with young families and sizable student loans—used life insurance coverage to meet these obligations. ILITs filled a need for them, as ILITs have commonly been used as an estate preservation vehicle to pay death costs without exposing the life insurance death benefits to estate taxes or the reach of the physician's creditors, including malpractice claimants.

Income shifting trusts, including *Clifford* trusts, as well as the trusts funded with annual exclusion gifts, became popular income tax reduction tools because of the steeply graded income tax rates, trust exemptions, and bracket differentials existing at the time. Equipment partnerships were often created as general partnerships in order to shift income tax. Sometimes they were transferred to *Crummey* trusts, *Clifford* trusts, or both.

Years ago, the planner who drafted a trust that resulted in the grantor being taxed on the income was probably missing the mark. The

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.

tax pendulum began to shift, however, as it so often does. Income tax laws evolved over the years and developments included compression of the income tax rate brackets, the enactment and progressive tightening of the "kiddie tax," and the elimination of multiple trust exemptions. As planners responded to these changes, there was a shift to other planning techniques, including the intentional use of grantor trusts. During this time, FLPs also grew in popularity as asset protection, income shifting, and wealth-transfer techniques.

From the early years of their popularity, FLPs had considerable attraction as a result of their ability to allow the physician to retain control, take valuation discounts, and shift income to lower-bracket taxpayers. Again, the pendulum has shifted as a result of the IRS's increased success in attacking FLPs that were not designed, implemented, or monitored correctly. In addition, self-settled trusts (often known as asset protection trusts), based on accessing favorable asset protection laws, have evolved as an integral part of creditor protection planning.

For many physicians, a revocable trust, QRP, ILIT, and perhaps FLP have been the extent of their planning. These plans have often been instituted without attention to attendant legalities, such as the proper transfer of assets, monitoring beneficiary designations, proper *Crummey* letters, commingling of assets, and disregard of partnership formalities, for example. As with many clients, careful administration of ILITs and FLPs has been neglected. When enhanced planning, or a review of current planning is suggested, a common client reaction is, "I have an FLP so I am protected, and my planning has been done," with no idea of the risks if they do not follow the appropriate procedures. Indeed, it is rare for clients to correctly monitor their FLPs and follow the formalities under the terms of the partnership agreement, such as the requirement for annual meetings.

Business owners are trained to observe the rules of their entities; doctors, less so. If the physician does not follow and respect the rules of the entity, why would he or she expect the IRS and courts to do so? ILITs suffer from similar neglect and risks.

Preliminary observations

Practitioners should consider some general observations, including the ones that follow, when representing physician-clients.

A process, not a document. 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 reasonable monitoring is essential and applies to the physicians' own estate planning. The time demands and other pressures most physicians face make it difficult, if not impossible, for many, however capable and well meaning, to administer their own plans. Nonetheless, periodic reviews are essential to address ongoing entity and trust maintenance, changes in the law, particularly tax laws, and changes in family dynamics.

Estate planning, business planning, and asset protection planning are continuously evolving 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 tax-free wealth-shifting strategies available to the planner. Yet many physicians do not take advantage of the considerable estate tax and creditor sheltering benefits this technique can afford.

The periodic check up should include a review of the physician's life insurance holdings as well. Life insurance products have improved over time; mortality has improved, making life insurance less costly; the quality of carriers has changed; some policies are under-performing and may need an infusion of cash or should be exchanged for a more stable 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 often will be cheaper than they were just a few years earlier, even though the insured is older. Depending on the risk profile of a particular physician's assets, and the return actually realized on their investment portfolio, an increased allocation to conservative insurance products as a conservative asset class may enhance the overall results or lessen the financial risk.

Malpractice limits. 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 these same characteristics when selecting their estate planning team. Too often the intelligent selection process is bypassed and instead a friend, a golfing buddy, or a lawyer who practices in another area of the law, is chosen to give them estate planning counsel with no perception of the wide disparity between quality planning and ineffective advice. This differential can expose the physician and his loved ones to unnecessary economic hardship.

In addition, the selection process will typically involve fee comparisons (too often 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 a bad result for themselves and their family? But too often they do.

Billing. Physicians operate 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 planning is going to be undertaken.

Physician planning goals and concerns

As with all clients, the tax and asset protection planning for physicians should be customized to meet individual needs. First, several generalizations and suppositions need to be addressed to provide a useful framework for approaching planning for physicians. Practitioners initially need to identify the basic desires and needs of the physician. As a general proposition, physicians want to accomplish planning results similar to those of most other clients. A greater emphasis, however, is placed on asset protection (due to malpractice exposure) and providing for retirement.

Business owners often receive continuing distributions from their family business after retirement or substantial proceeds from the sale of the business after retirement; these are generally not available to 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, his or her retirement will be secure. Typically, the goals on a physician's planning "wish list" are:

- Creditor protection—particularly against malpractice lawsuits.
- Tax savings—including income, gift, estate, and generation-skipping transfer (GST) taxes.
- Providing for retirement.
- Control.
- Estate creation—for those who have family obligations.

Before discussing some of the most up-to-date planning opportunities for physicians, the article will first lay the foundation through a discussion of the techniques that were most commonly used in the past and the improvements that led to today's more sophisticated options. This article will address:

1 Traditional (often archaic) trust planning compared to modern trust planning.

2 The newer creditor protection planning tools.

3 Alternatives for retirement planning that often achieve or exceed the benefits of QRPs.

Trust planning generalizations

Frequently, physicians (as well as some of their advisors) are simply unaware of, or do not give sufficient attention to, a fundamental fact of estate and asset protection planning. The key concept they so often miss is that assets are always more valuable to the recipient beneficiary when received in a trust set up by someone else than those same assets would be if received outright. Simply because assets are received in trust, and continue to be held in trust, they have advantages that do not and cannot exist if those assets are received outright.

The trust, if properly structured and domiciled in a protective jurisdiction, "shelters" the assets from the beneficiary's estate, gift, and GST taxes; certain income taxes; and creditors, including divorcing spouses. This is true even though the beneficiary has managerial control, the use and enjoyment of the trust assets, and the right essentially to re-write the trust's dispositive scheme by giving the physician a testamentary special power of appointment. Thus, the general rules discussed below should be observed.

Wealth receipt planning—inherit in trust. Some physicians have fairly affluent parents or grandparents, and even those physicians who will be receiving only moderate gifts or bequests should consider designing the manner of inheritance or bequest of any anticipated wealth transfers such that the recipient is a well-structured trust. Inheritances (or substantial gifts) a physician receives should not be outright. Instead, they should be in trust and continue in trust for the physician's lifetime (and thereafter for the life-

times of the physician's spouse and descendants) subject to the physician (or subsequent beneficiary) altering the structure through the exercise of a special power of appointment. The trust can continue indefinitely after the physician's death for descendants, to the extent the special power of appointment is not exercised, subject to the applicable rule against perpetuities.

This structuring must be 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.

Consider the absurdity of a physician, or any other client, receiving a gift or inheritance outright, and then trying to create a plan that mirrors the advantages that a properly structured bequest or gift in trust could have provided from inception. Inheriting in trust is consistent with each of the general planning objectives set forth above. If at all possible, the physician should be involved in the wealth-receipt planning.

If the family dynamics permit, he or she should make a request to parents or other potential transferors that they make gifts and inheritances in a tax- and creditor-protected trust. The transferors might not be amenable to paying for, or being involved in the complexities of designing the wealth planning. This is common for elderly parents who may have had little sophisticated legal counsel previously. In this situation, a reasonable course of action involves the physician paying for and designing the recipient trust. Then the parent or other benefactor would merely name that trust (rather than the physician personally) as the recipient. This can make the process simple and very inexpensive for the parent/benefactor. Payment for the creation of the trust is not a gift to the trust, which would expose the trust to self-settled trust statutes.

One planning consideration that may provide productive results for both transfer tax and asset protection purposes is that a trust set up by someone else for the physician may become the general partner in an FLP. If the physician was the management trustee of the trust, he or she would be in control of the partnership. This control, in a fiduciary capacity, should not be attributed to the physician when valuing the limited partnership interests at the death of the physician. It is vital that the trust domicile be a state having favorable state laws with respect to creditor protection and does not give rights to exemption creditors, such as divorcing spouses.

Moreover, jurisdiction selection should take into account other factors, such as no state income tax, an extended rule against perpetuities, and the costs (such as trustee fees) to obtain jurisdiction in the preferable state. With respect to the extended perpetuity benefit, it is important to remember that the termination of the trust, as a result of state perpetuity statutes, is similar to "force out" provisions in the trust—it terminates the tax and creditor benefit shield of the trust.

Wealth transfer planning—give and bequeath in trust. The physician's estate planning documents should make lifetime gifts or bequeath assets in a continuing trust for his or her loved ones. Because the assets are transferred in trust, they will be more valuable than if those same 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.[2] These trusts, if established inter vivos, may serve as components of the physician's own personal estate and asset protection planning.

Modern trust design. Assets received in trust significantly enhance the recipient's benefits, provided the trust is properly drafted. Many physicians have "old-fashioned trusts." These trust do the following:

1 Pay out all income.

2 Provide for distributions for health, education, maintenance, and support (HEMS standard).

3 Provide the annual right to withdraw the greater of 5% or $5,000.

4 Pay out corpus at staggered ages, such as 1/3 at each of ages 25, 30, and 35.

Rights of distribution or withdrawal in a "support trust"[3] or a "five or five" power unnecessarily expose the accessible assets to potential claimants. Further, some of the modern trust designs, such as

2 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).

3 S. Oshins, "Asset Protection Other Than Self-Settled Trusts: Beneficiary Controlled Trusts, FLPs, LLCs, Retirement Plans and Other Creditor Protection Strategies," 30 U. Miami Inst. on Est. Plan., Ch. 3, (2005).

paying out a unitrust amount, or incentive trusts, are the opposite of prudent tax and asset protection planning. Not only is the mandatory distribution of money from the trust structure inefficient for tax planning purposes, it also unnecessarily exposes the assets to creditors.

Consider the unfortunate plight of a plastic surgeon in Beverly Hills 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. Assuming there are no current predators, money mandatorily distributed out of a trust needlessly increases the wealth subject to future creditors and estate taxes. In addition, the right to withdraw principal, even if subject to an ascertainable standard, exposes the trust to potential creditors and state laws that let creditors step into the shoes of the beneficiary and enforce the standards.

Modern, and more protective trust structuring,[4] uses a fully discretionary trust that does not have enforceable rights a creditor can assume. The physician can be the management trustee and have control of the identity of the independent trustee (subject to Section 672(c) and Rev. Rul. 95-58[5]) without exposing the wealth to the transfer taxes or creditors.

A fully discretionary trust with an independent distribution trustee, domiciled in a state with preferable tax and asset protection laws, is the ultimate wealth protection tool available to planners.[6] 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.

Further, 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. As the primary beneficiary (and subsequent beneficiaries) can be given substantial control of the trust, yet still receive the "in trust" protections, the modern trust is consistent with the "wish list" set out above.

(Sidebar:) Planning Tip

If a trust is funded by someone else, the physician (and at the physician's death, subsequent primary beneficiaries—i.e., spouse, children, grandchildren, etc.) can be given all or some the following benefits, rights and controls without adversely compromising the tax and creditor protection benefits of the trust:

• *Control.* Full management control and the right to determine the identity of the distribution trustee, who must be an independent trustee. This does not include the right to withdraw for himself or herself since in certain jurisdictions this power exposes the trust to potential claimants.

• *Use.* The ability to use and enjoy the trust property

• *Substitution right.* The right to fire and replace the independent trustee with another independent trustee, who can be a close friend. (Section 672(c); Rev. Rul. 95-58, 1995-2 CB 191.)

• *A special power of appointment.* The ability to give a beneficiary the right essentially to re-write the trust, subject to relatively negligible restrictions. (Section 2041(b)(1).)

• *Creditor protection.* This can benefit all beneficiaries.

• *Estate, gift, and GST tax savings.* This would be to the extent the trust is GST exempt.

• *Certain income tax savings.*

These benefits satisfy the "wish list" set out in the article, except for the estate creation. That component can be satisfied with the addition of life insurance.

Source: S. Oshins, "Asset Protection Other Than Self-Settled Trusts: Beneficiary Controlled Trusts, FLPs, LLCs, Retirement Plans and Other Creditor Protection Strategies," 30 U. Miami Inst. on Est. Plan., Ch. 3, (2005).

Multiple entities: divide and conquer

The proper use and structure of multiple entities is often fundamental in planning for most clients, and that planning model applies to physicians even more strongly because of their tendency to have substantial malpractice concerns.

4 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).

5 1995-2 CB 19.

6 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).

Practice structure. 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 patient being injured on the premises) and from claims by another physician's patient.

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.

Medical equipment. For many physicians, such as emergency room physicians, the "divide and conquer" planning is limited by the fact that they may not have transferable business assets. For those who have substantial equipment or who own their building, 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, or as an intellectual property LLC that owns a practice name, telephone number, website, logo, and other rights that are then licensed to the medical practice. Creative but realistic segregation of practice and non-practice assets is a key to 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, such as equipment held in an equipment leasing LLC or an office building in an LLC, would all be protected.

Lawsuits against any one entity should generally not expose the other entities, or the individual physicians (subject to the singular exception of a physician who was responsible for the malpractice) to liability or to arguments of an integrated business entity claim. Claims outside of the practice against an individual physician would not expose the operating entity, the other doctors, or the entities to liability.

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. Not taking advantage of the favorable laws is inferior planning and may result in the advisor being criticized and potentially exposed for not suggesting that course of action.

How does an advisor justify summarily using inferior state laws and not providing his or her clients with the best potential structure? 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.

In addition to the creditor protection benefits inherent in the use of multiple entities, using entities to hold separate assets, other than the interest in the medical practice, is a strategy that is advantageous in the tax and asset protection planning process. Transfers of interests in equipment LLCs, medical building LLCs, and other entities owned by physicians, are appropriate assets to be used in wealth-shifting. The cash flow generated from leasing the assets held in the entities will generally support the sale of the assets by the physician tax-free to income tax defective dynasty or asset protection trusts; with proper structuring, no income tax gain needs to be reported. In addition, annual exclusion gifts and transfers using the current $5 million gift tax exemption may supply 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.

Asset protection planning

Early in their law school training, lawyers learn that the use of an entity such as a corporation, LLC, or a similar limited liability entity is essential in the planning process for someone who is going into a business with risk in order to protect personal assets from potential creditors of the business. Indeed, it would be malpractice not to recommend this strategy. Do the physician's advisors have the obligation to recommend asset protection planning to a physician? Does that include the minimal pure vanilla asset protection trust (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 planning strategies, which might include the creation of an APT in a protective

jurisdiction, especially if future creditors are able to reach the asset[7]

Certainly, the use of entity planning, exemptions, and spendthrift trusts should also be considered as part of the global planning for physicians. For those physicians who have current liability exposure, however, the use of many of these strategies is impermissible and would be a fraudulent transfer, possibly subjecting the physician and participating advisors to civil and criminal liability, and adverse professional ethical repercussions. Nonetheless, even for a physician who is under legitimate attack, certain protective steps should be taken, such as wealth-receipt planning. The goal is to preserve and protect the maximum allowed under law for the physician and his or her family.

Qualified retirement plans (QRPs)

Initially, state statutes were enacted to enable physicians to incorporate and take advantage of QRPs and other corporate fringe benefits. The income tax deferred accumulation was 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 the planning for physicians. Commencing with ERISA in 1974, the benefits of QRPs were sharply reduced over time. A cost/benefit analysis of QRPs has become less attractive, as the negative features have increased substantially. The requirements to cover more employees, and the costs of doing so, have increased.

Many physicians, who intended to use their QRPs for retirement, acquired sufficient wealth outside the QRP to fund retirement needs. For a physician who has achieved that level of financial security, 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. For the planner, QRPs are the most difficult asset to plan. Thus, physicians and their advisors might find that the benefits initially anticipated from a QRP later prove to create irresolvable complications.

Many physicians and their financial advisors are overly enamored by the ability to obtain an income tax deduction for the plan contributions. Because of the instant gratification of an immediate deduction, they often simply overlook, or do not give adequate credence to, the many negative features inherent in QRPs. Potentially better alternatives are discussed below.

Income in respect of a decedent

Physicians generally have assets that are IRD, which is subject to both estate tax and income tax to the recipient. The most important item of IRD generally is a QRP. In addition, however, physicians often have salary continuation plans, unpaid receivables, deferred compensation, and other items of IRD. Therefore, planning for the receipt of IRD is essential.

The advisor should consider transferring items of IRD other than QRPs to the surviving spouse in the marital deduction disposition. Items of IRD are generally considered to be a wasting asset because income tax is paid on its receipt. The physician's estate will obtain a marital deduction for the full value; the spouse will receive the payments and pay income tax on those payments—thus reducing the estate—so only the unspent net amount will be included for estate tax purposes in the survivor's estate. IRD assets tend to be desirable to the surviving spouse as they eventually turn into cash or cash flow.

Caveat. If a pecuniary marital deduction formula with date-of-death-value funding is used, the funding of the debt obligation with an item of IRD results in immediate gain—at the funding, although often without the money to pay the tax. 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.[8] A formula limiting the bequest to the

7 Bernardo, "Ethical, Civil and Criminal Risks of Asset Protection Transactions," 2009 Hawaii Tax Inst. Outlines; see also Nenno, "Planning with Domestic Asset-Protection Trusts: Part I," 40 Real Property, Probate and Trusts J. 263 (Summer 2005) ("Attorney's might face exposure if they do not advise the client to [engage in asset protection planning] and creditors later reach the client's assets."); see also Rubin and Goldberg, "Consider the Implications," Trusts and Estates, 44 (Nov. 2005) ("Perhaps, once upon a time a well-designed estate plan did not need to involve deliberate consideration of the asset protection implications to the client. That time has long passed."); see also Mata, "Piercing of Spendthrift Trusts, Family Limited Partnerships, and Other Threats to Estate Planning Structures, ABA RPTE e-Report, 7/1/2008 (failure to advise a wealthy or at-risk client of asset-protection possibilities may constitute malpractice if the client's assets are needlessly exposed to a subsequent judgment or other legal claim); see also Rothschild and Rubin, "Asset-Protection Planning: Ethical? Legal? Obligatory?," Trusts and Estates at 42 (Sept. 2003) (it is only a matter of time before clients make claims against estate planners who did not raise the subject of asset protection planning as part of the planning process-when it arguably would have worked); see also Mata, "ALI-ABA Asset Protection Planning Update-2005," page 250 ("failure to so advise a wealthy or at risk client may constitute malpractice if the client's assets are needlessly exposed to a subsequent judgment or other legal claim.") cited in Roth, "Liability Issues for Lawyers and Other Fiduciaries," 44 U. Miami Inst. On Est. Plan., Ch. 16 (2010), page 105.

8 Section 663(a)(1).

IRD necessary to reduce the estate tax to zero should be used.

QRP. Planning for the physician's interest in a QRP is more complex. 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 could safely put $16,500 nondeductible dollars into her or his Roth 401(k) account each year ($22,000 if 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.

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 70 1/2, it can solve the "leakage' problem of required distributions after age 70 1/2. In addition, the Roth strategy generates more wealth because the $16,500 (or $22,000 for those at least age 50) put into a Roth account is after-tax dollars (and generating tax-free income) compared to a traditional qualified plan with pre-tax 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.

Analysis of these Roth IRA and Roth 401(k) topics, as well as QRP planning, is beyond the scope of this article, but many other articles have analyzed the pros and cons.[9]

Life insurance

Physicians often acquired the life insurance that they own 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 amount of term to make it affordable. Paradoxically, term insurance typically is the lowest priced coverage. Many physicians believed in the theory of "buy term and invest the difference," particularly if they could shift the savings into their QRPs. Observation of the recent stock market and economic volatility demonstrates that this approach does not assure success.

As the benefits of QRPs were in many instances being compromised, life insurance carriers were developing new strategies to take advantage of the favorable income tax-deferred inside build-up of cash-value life insurance (CVLI), especially life insurance contracts that are not a modified endowment contract (MEC). Life insurance has begun to be discussed among professional advisors as a conservative, non-correlated asset class investment which has many of the favorable attributes of QRPs, particularly tax-deferred compounding, without the inherent costs, complexities, restrictions, and risks of QRPs. In fact, a 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, while the QRP distributions are always taxed as ordinary income.

Many clients like the fact that these policies have a minimum guaranteed rate of return, and thus avoid the economic exposure of pensions. A properly structured insurance plan can 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 sensibly terminate it and start over by re-GRATing the asset.

CVLI is an ideal asset for many physicians, combining the benefits of QRP's tax-deferred growth, safety through a guaranteed build-up secured by some of the most economically sound financial institutions, and a death benefit to protect the family—all the while avoiding some of the negative features of QRPs. At retirement, the relative safety of a CVLI product is quite compelling when compared to the risk of a down market at an inopportune time, such as retirement where cash flow and security are overriding factors. Finally, in some jurisdictions, insurance is afforded a measure of creditor protection under state shield laws.

In order for the physician to be assured access to the cash value, he or she had 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 physi-

9 For excellent discussions on planning with Roth IRA conversions, see various articles by Professor Christopher Hoyt and Bob Keebler, including Hoyt, "Rethinking Roth IRA Conversions" Probate & Property, 12 (Sept./Oct. 2010), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1920440.

cian's taxable estate. Most importantly, the physician can be a discretionary beneficiary of this trust. This decision-making 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.

The following discussion presents a laddered approach to the 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 to present to 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 their planning nightmare for many physicians.

The basic solution is 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 instance, the "spendthrift provision" 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. It has been stated that the first DAPT laws were enacted in 1997 by Delaware and Alaska to provide an exception to the general rule, although Missouri has a statute dating back to 1986. 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 and Hawaii. Presently, 13 states have enacted DAPT laws, containing varying degrees of protection.

Caveat. The asset protection plan must be put into place prior to the wrongful act's 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 Most importantly, does not have any known creditors.

This protection is not available for a client who is being sued, is about to be sued, or has an existing 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. 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 lack of 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 obtain additional benefits by adding a protected entity, such as a limited partnership or an LLC, which will be owned, in whole or in part, by the DAPT. That additional layer would increase the creditor protection as a result of the charging order remedy. Again, to obtain maximum protection, the LLC must 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. The physician would have a testamentary power of appointment so 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. It is a grantor trust for both income and transfer tax purposes. It is solely a creditor protection planning technique, but that benefit may be substantial. However, it needs to have been put into place early enough to ensure that potential cred-

itors are blocked from access, which is a minimum of two years, depending on state statute.

Completed gift DAPT (CGDAPT)

The CGDAPT builds on the DAPT described above by adding, in addition to creditor protection, transfer tax benefits. The physician would make a completed gift to the trust, which would be similar to a regular DAPT, but the physician/donor would not retain a power of appointment. 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 a tacit 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 and estate creation if death occurs before planned. 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.

Including a permanent life insurance product as one of the CGDAPT assets can effectively combine the benefits of a CGDAPT, QRP, and ILIT. The CGDAPT can own life insurance and be used as the physician's funded ILIT and thus would form a combination of a CGDAPT/ILIT. The combination is actually an improvement over the traditional ILIT and the CGDAPT discussed above from several perspectives. Successful returns on noninsurance 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.

Freeze. Transfer to the CGDAPT those assets that are expected to increase in value. This shifts all post-transfer appreciation tax-free outside the estate.

Discounting. Gifts 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 taxable income-producing assets into the CGDAPT, the physician can increase the wealth shift, but continue as a discretionary beneficiary and receive distributions if circumstances change.

As result of a 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 that is safe from claimants increases. Meanwhile, assets in the physician's unprotected estate are reduced, impeding the

ability of a claimant to recover. No reasonable creditor would pursue an action where satisfaction of a judgment is significantly limited as a result of assets 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 on with 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.

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 power 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. Because the physician is treated as the owner of the trust income, there are 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 a capital gains 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, he or she is moving the wealth both income tax-free and transfer tax-free into a trust that is protected from estate tax and predators. 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 would 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 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

Datalogics Unix Job 1 bschar/0/8125 12-OCT-11 10:42
Style: /opus/environments/proda/edsys/pager/style/journal.bst File: /tigredata/tigredata01/etpl/etpl_582214.txt
Seq: 12 Color: 0c: Format: rls$prod:journal.fmtFree lead 85D*points, Next 120D, Vjust JE1:1

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 introduction 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 moved 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, 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 in 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.

Because the proscription on controlling the life insurance applies to only policies on the physician's life, an alternative is to acquire the CVLI on the lives of the spouse or children instead of on the physician's life. This does not resolve the estate creation goal, but offers the control feature. Some physicians prefer a variation of the life insurance acquisition—buying life insurance on different family members or others, provided there is an insurable interest.

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, because the physician cannot have control of the 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. Because of the unlimited marital deduction, it provides estate tax protection.

Retirement planning

As previously mentioned, estate and financial planning for physicians generally incorporates, or should incorporate the following three or four components:

1 Retirement planning.

2 Asset protection planning.

3 Tax (income and transfer tax) planning.

4 Estate creation (where circumstances dictate).

Those desires can be accomplished by adding a well-designed CVLI policy to the BDIT (or the CGDAPT/ILIT discussed above).

Income tax-free or income 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 CVLI. The various features of a CVLI policy and QRP are compared in Exhibit 1. Furthermore, placing the CVLI policy in a BDIT/ILIT (or the CGDAPT/ILIT, discussed above) 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 maintained in trust. This transfer tax avoidance does not exist for QRPs. Because of the curtailment of benefits in QRPs, the enhancements of a cash-value policy, cash-value policies should be considered as an alternative.

The life insurance will either augment or replace the more traditional QRP for retirement planning purposes, taking advantage of one of the most important concepts in wealth planning, tax-exempt and

tax-deferred growth. CVLI policies acquired from a high-quality carrier provide the physician with a conservative asset class, with many similarities comparable to a municipal bond, and based on current market turmoil, the potential for enhanced safety. This feature is material during the retirement years when a substantial diminishment in wealth cannot be re-earned.

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 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.

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.

Self-settled trusts, based on accessing favorable asset protection laws, have evolved as an integral part of creditor protection planning.

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.

The tax benefits that can be obtained from leaving property in a continuing trust are substantial, particularly with respect to the transfer tax system.

Creative but realistic segregation of practice and non-practice assets is a key to planning.

Even a retired physician is not immune to being sued, putting in jeopardy his or her lifestyle and security.

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

Survivorship (second-to-die) life insurance will generally provide increased leverage in accumulating funds tax-free inside of the policy.