HSH C&D Newsletter

THE MALL MALISOW FIRM, P.C.

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PENSION PROTECTION ACT OF 2006

Important New IRA & Qualified Plan Rules

EXECUTIVE SUMMARY

In what one could argue as being one of the most dramatic and exciting periods in legislative history, on August 3, 2006, the U.S. Senate, in a 93-5 vote, voted to ratify the Pension Protection Act of 2006. Although the primary focus of the new law was on reforming defined benefit plans, there are some provisions that deal with to IRAs and other qualified defined contribution plans. Specifically, the new law provides for:

- Permanency of the pension and individual retirement arrangement provisions of the Economic Growth and Tax Relief Reconciliation Act of 2001 (EGTRRA).
- Non-spousal beneficiary transfers of inherited qualified retirement plan benefits into inherited IRAs.
- Tax-free distributions from IRAs for charitable purposes.
- Direct rollovers of qualified retirement plans to Roth IRAs

The new tax law allows the post-mortem transfer of qualified retirement plans to inherited IRAs by non-spousal beneficiaries. Further, this new law also permits the post-mortem transfer of these plans to inherited IRAs which are held by trusts for the benefit of the non-spousal beneficiaries. Both of these provisions apply to distributions made after December 31, 2006.

Next, the new tax law now allows taxpayers to make IRA distributions to a charity directly without including the distribution in their gross income. Specifically, the new tax law permits up to $100,000 to be contributed each year directly to charity (as described in IRC §170(b)(1)(A)) for the 2006 and 2007 tax years. This direct IRA contribution is limited by the following conditions:

1. The transferor (i.e. IRA owner) must be at least 70½ on the day of the transfer,
2. The distribution will only qualify to the extent that the distribution would have otherwise been includible in the gross income of the tax payer.
3. The distribution must qualify under the general charitable deduction rules of IRC §170.
4. The distribution cannot be taken into account for the determining the "other" charitable contributions to be allowed as a deduction under IRC §170 (i.e. the distribution cannot be added to adjusted gross income for purposes of the adjusted gross income limitations).

Keep in mind that this transfer from the IRA to the charity must be direct in order for the distribution to qualify for the income exclusion. This means the trustee of the IRA must draft the check to the charity.

In the past, if taxpayers wanted to do a Roth IRA conversion, they would have to first roll the funds from the qualified retirement plan (e.g. 401(k) plan) to a traditional IRA and then convert the traditional IRA to a Roth IRA. Under the Pension Protection Act of 2006, taxpayers are now able to directly roll funds from "eligible retirement plans" (as defined under IRC §402(c)(8)(B)) to Roth IRAs starting in the 2008 tax year. It is important to note that the current rules governing Roth IRA conversions (i.e. $100,000 Adjusted Gross Income limitation) remain the same.

PLR 200620025: Inherited IRA Transferred to a SNT

In IRS Private Letter Ruling 200620025, Mr. A died and the court, on petition of the guardian of one of Mr. A's sons (who has a disability and is receiving Medicaid), proposed to substitute an irrevocable Special Needs Trust (presumably a "(d)(4)(A)" trust) for son B's share. A new "inherited IRA" account would be set up with son B's share, set up and maintained in the name of Mr. A to benefit son B "through" the SNT. The minimum required distributions will then be paid to the SNT and not to son B. The IRS ruled favorably, that (i) this was not an income-tax triggering event and (ii) son B's life expectancy may be used in figuring minimum required distributions. These results were based upon the trust in question being a grantor trust (or a (d)(4)(A) Trust).

This is a valuable technique for a client who needs the protection of a SNT. Had the IRA been simply titled in the name of son B, a person with a disability, it would immediately disqualify him from Medicaid and other needs based public benefits.

Congratulations

to Sanford Mall, for his election to Chair of the Elder Law and Disability Rights Section of the State Bar of Michigan (formerly the Elder Law & Advocacy Section of the State Bar of Michigan).

VA Benefits for Former Prisoners Of War

Did you know that former American prisoners of war (POWs) are eligible for special veterans benefits, including enrollment in Department of Veterans Affairs (VA) medical care for treatment in VA hospitals and clinics without copayments as well as disability compensation for injuries and diseases that have been associated with internment. These benefits are in addition to regular veterans benefits and services.

Records show that 142,246 Americans were captured and interned during World War I, World War II, the Korean War, the Vietnam War, the Gulf War, the Somalia and Kosovo conflicts, and Operation Iraqi Freedom. There were no servicemembers reported missing in action from the Bosnia deployment nor from recent Afghanistan operations. Of the 125,214 Americans surviving captivity, about 29,350 were estimated to be alive at the end of 2005.

Congress has defined a prisoner of war as a person who, while serving on active duty, was forcibly detained by an enemy government or a hostile force, during a period of war or in situations comparable to war. With nine out of ten former POWs having served in World War II, the estimated number of living POWs decreased from nearly 32,500 to 29,000 during 2005 due mainly to the estimated death rates for World War II and Korean POWs.

As of August 2006, there were 16,884 former POWs receiving compensation benefits from VA. Approximately 13,000 of them are rated as 100 percent disabled. Studies have shown that the physical hardships and psychological stress endured by POWs have life-long effects on health and on social and vocational adjustment. These studies also indicate increased vulnerability to psychological stress. The laws on former POW benefits recognize that military medical records do not cover periods of captivity. For many diseases, unless there is evidence of some other cause, VA disability compensation can be paid on the basis of a presumption that a disease present today is associated with the veteran's captivity or internment.

For POWs detained for 30 days or more, such eligibility covers any of the following illnesses that are found at a compensable level (at least 10 percent disabling): avitaminosis; beriberi; chronic dysentery; cirrhosis of the liver; helminthiasis; irritable bowel syndrome and malnutrition, including associated optic atrophy. Also covered are: pellagra and any other nutritional deficiency; peptic ulcer disease; and peripheral neuropathy, except where directly related to infectious causes. Several categories of diseases are presumptively associated with captivity without any 30-day limit: psychosis; any anxiety state; dysthymic disorders; cold injury; post-traumatic arthritis; strokes; and common heart diseases.

The rate of VA monthly compensation, according to degree of disability, ranges from $112 to $2,393 per month. Veterans rated as 30 percent or more disabled qualify for additional benefits based upon the number of dependents. Dependents of those rated 100 percent disabled may qualify for educational assistance. Spouses of veterans who die as a result of service-connected disabilities are eligible for dependency and indemnity compensation. Spouses of former POWs who were rated 100 percent disabled and who died of a condition unrelated to their service also may be eligible, depending on the date of death and how long the veteran held the 100 percent disability rating. Those non-service-connected deaths prior to October 1999 are covered if the former POW had been 100 percent disabled for at least 10 years. More recent non-service-connected deaths are covered under a law that provides the benefit when the former POWs was 100 percent disabled for a year or more.

Former POWs receive special priority for VA health-care enrollment, even if their illness has not been formally associated with their service. Further, the former POWs are exempt from making means test copayments for inpatient and outpatient medical care and medications, but they have the same copay rules as other veterans for extended care. They also are now

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LOW-INCOME SUBSIDY: HERE THIS YEAR, GONE NEXT YEAR?

The Medicare Part D Low Income Subsidy (LIS) provides eligible individuals with assistance with some of their Part D costs. The federal law that established the Medicare Part D prescription drug program requires that beneficiaries eligible for LIS undergo an annual re-evaluation of their eligibility for this "extra help". The process used for this re-evaluation, known as "redetermination" or "re-deeming", varies depending on how a beneficiary originally became eligible for LIS.

Beneficiaries whose eligibility determinations were made through the Social Security Administration (SSA) are subject to a redetermination conducted by SSA. SSA must conduct redeterminations for the first year within the first 12 months of the Part D program. SSA will establish a cycle for conducting subsequent redeterminations. LIS eligibility determinations made by a state Medicaid agency will be conducted by the state Medicaid agency according to the agency's redetermination process. State Medicaid agencies will primarily be responsible for re-deeming LIS eligibility for beneficiaries who were originally deemed eligible for LIS and thus did not have to apply. This group includes Medicare beneficiaries who are eligible for full Medicaid benefits, those who are eligible for one of the Medicaid Savings Programs (MSP) [QMB, SLMB, QI], or those who receive Supplemental Security Income (SSI) but are not automatically eligible for Medicaid.

As a result of re-deeming, some beneficiaries who currently receive LIS assistance with their Part D premiums, cost-sharing, and drug costs while in the donut hole may lose that assistance in 2007. Many of these beneficiaries may not be able to afford their prescription drug coverage without LIS.

Redeterminations for Beneficiaries Who Applied for LIS through SSA

Starting in late August, SSA will send letters to between 1.2 and 1.6 million beneficiaries who applied and were found eligible for LIS through the SSA process before May 2006. People whose eligibility for LIS was determined by SSA during and after May 2006 will not be subject to redetermination until August 2007. The latter group of beneficiaries will not receive the redetermination letter.

The SSA redetermination letter contains beneficiary-specific information about income, assets, and household size. The SSA letter tells beneficiaries that they do not have to do anything if the information has not changed or if the income and asset amounts are lower than indicated in the letter. Note: An increase in income due to the Social Security cost of living adjustment (COLA) does not count as an increase in income that must be reported to SSA.

A beneficiary who does not respond to the letter will be assumed to have had no change in his or her situation. SSA will conduct a data match with other federal agencies to confirm no change in financial status or household size. The beneficiary will be re-certified LIS-eligible for 2007 if the data match also shows no change in circumstances. These beneficiaries will NOT receive a letter from SSA confirming their LIS-eligibility for 2007.

The SSA letter will include a form for beneficiaries whose circumstances have changed to send back to SSA to request a redetermination statement (SSA Form 1026-B). The form must be returned within 15 days of receipt of the letter. Beneficiaries may also call SSA for the Form 1026-B redetermination statement.

Beneficiaries who request and receive a redetermination statement must complete the statement, indicate how their circumstances have changed, and return the statement to SSA within 30 days. They may request an extension if they are unable

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PRESCRIPTION DRUG DISCOUNT CARDS MAY BE USEFUL DURING THE DONUT HOLE

Recently, the Center for Medicare Advocacy has become aware that some insurers are marketing their drug discount cards as a means to provide beneficiaries with additional prescription drug coverage during the "donut-hole" gap in coverage.

Discount Cards and other pharmacy discounts may indeed be useful, particularly to someone who enters the donut hole late in the year, and others who will not get out of the donut-hole before the end of the year because their drug costs are too low to meet the required out-of-pocket payment threshold. Beneficiaries will need to do the math to see if these cards are useful in their individual case.

If a beneficiary uses a Discount Card or other pharmacy discount at a network pharmacy, the price they pay for their medication should count toward their True Out-of-Pocket expenses (TrOOP), which determines how quickly they will exit the donut hole. The beneficiary is responsible for submitting the receipt for such payments to their plan.

An example of the use of Discount Cards in the donut hole is available on page three of the CMS Tip Sheet, recently analyzed by the Center for Medicare Advocacy, "How the Coverage Gap Works for People with Medicare Prescription Drug Plans", which is available online at <http://www.cms.hhs.gov/partnerships/downloads/PartneTipSheetExplCovGap080206.pdf>.

For more information on these topics, contact the Center for Medicare Advocacy's Washington, DC office at (202) 216-0028.

YOU ARE INVITED TO ATTEND

THE

SECOND "SINGLE POINT OF ENTRY" INFORMATIONAL FORUM

MONDAY, SEPTEMBER 25, 2006

AT THE

Capital View Building

Conference Room A, B, C

210 Townsend Street, Lansing, Michigan

10:00 am – Noon

An informational session for stakeholders and persons interested in learning about the newly forming Single Point of Entry for long-term care services in Michigan. Presentations will be followed by a question and answer period.

FUTURE MEETINGS:

October 23, Michigan Home Health Association

10:00 am - Noon

2140 University Drive, Suite 220, Okemos, Michigan (517) 349-8089 (Directions attached)

November 27, Michigan Library & Historical Center, Auditorium

10am - Noon

702 West Kalamazoo, Lansing, Michigan (Directions attached)

Sponsored by the Office of Long-Term Care Supports & Services
Michigan Department of Community Health

For More Information: 517.373.3860 or thelen@michigan.gov **RSVP not required.**

The Single Point of Entry will be a highly-visible and trusted source of information and assistance about long term care, aiding Michigan residents with planning and access to needed services & supports, in accordance with their preferences.

STATES GET FEDERAL GRANTS TO HELP PEOPLE WITH DISABILITIES LIVE IN THE COMMUNITY

HHS Secretary Mike Leavitt today awarded nearly $20 million in grants to states to develop programs for people with disabilities or long term illnesses. The "Real Choice Systems Change Grants for Community Living" will help states and territories "rebalance" their long-term support programs to help people with chronic illness or disabilities to reside in their homes and participate fully in community life.

"These grants will help states take full advantage of the opportunities to reform their Medicaid long-term care systems offered by the recently passed Deficit Reduction Act of 2006 and remove barriers to equality for the 54 million Americans living with disabilities." Secretary Leavitt said. "They will help persons with disabilities exercise meaningful choices about how and where to live their lives."

The Bush Administration has promoted the goal of community living for people with disabilities through the *New Freedom Initiative.* Under this initiative ten federal agencies have collaborated to remove barriers to community living. The additional funding for "Real Choice Systems Change Grants for Community Living" approved by Congress for 2006 will augment efforts begun in FY2001 to help states improve their community-based services.

"The grants awarded today will help states make lasting improvements to their home and community based services programs," said Mark B. McClellan, M.D., Ph.D., administrator of the Centers for Medicare& Medicaid Services (CMS). "This program is vital in helping Medicaid move from its institutional bias to a program that truly meets the needs of people who depend upon it." The eight states receiving 2006 awards are; California , Virginia , Michigan , North Carolina , New York , New Jersey , Rhode Island and Kansas. Since 2001, CMS has awarded 306 Real Choices grants, totaling approximately $237 million to 50 states, Guam, the Northern Mariana Islands, and the District of Columbia.

For this round of grant awards, CMS will require states receiving grant money to address at least three of the six goals necessary to transform Medicaid program incentives away from institutional care with options for care at home and in the community. The goals include:

- Improving access to information regarding the full range of community-based services available;
- Promulgation of more Self-Directed Service Delivery Systems;
- Implementation of Comprehensive Quality Management System;
- Development of Information Technology to Support Community Living;
- Flexible financing arrangements that Promote Community Living Options; and
- Long-term Supports Coordinated with Affordable and Accessible Housing.

By providing important support for rebalancing long-term care services, the RCSC program has paved the way for the much more extensive options now available to states since the passage of the Deficit Reduction Act of 2006 to help states create greater opportunities for community living. The centerpiece of these efforts is a major new funding opportunity for states through the Money Follows the Person Rebalancing Demonstration.

This demonstration provides up to $1.75 billion to eligible states to transition individuals from institutions who want to live in the community and rebalance their entire long-term care system to ensure individuals have a choice of where they want to live and receive services. While applications for this demonstration are not due until November 1, 35 states have expressed interest in applying. For more information on the New Freedom Initiative, visit the CMS Web site at: http://www.cms.hhs.gov/newfreedom/.

Patricia E. Kefalas Dudek
&
Sanford J. Mall
are pleased to announce their first combined

TRUSTEE WORKSHOP

When: Tuesday, October 24, 2006
Where: St. Nick's Church
760 West Wattles Road
Troy, MI
Cost: $150 per person, includes continental breakfast, lunch and materials.
(Please note this is a legitimate administration expense for acting as trustee).

Who should attend? Anyone acting as a Trustee of a Special Needs Trust or Amenitites Trust. Anyone named to act as a Trustee in the future, Beneficiaries, Advocates, Trust Protectors and Financial Advisors working with people with disabilities and their families.

Contact Sandy at 248-731-3080 to register. Space is limited and registrations will be filled on a first come first serve basis.

Trustee Workshop Agenda

8:00 to 9:00:	Registration and Continental Breakfast
9:00 to 9:15	Welcoming Comments & Housekeeping *Sanford J. Mall & Patricia E. Kefalas Dudek*
9:15 to 10:15	General Responsibilities of all Trustees The Reasonable Prudent Investor Rule Tax Returns *Sanford J. Mall*
10:15 to 10:30	Break
10:30 to 11:45	EPIC Accountings & Supervised Accountings - What are they and why do they cost so much? *Patricia E. Kefalas Dudek & Mary G. Trayner*
11:45 to 12:00	Break
12:00 to 1:30	Lunch (Round Table Discussion)
1:30 to 2:30	Update of Changes in SSI/Medicaid and Services -DRA -Medicare Part D - Estate Recovery - Spousal Refusal - Co-Payments - What is a Medicaid Covered Service? *Patricia E. Kefalas Dudek & Sanford J. Mall*
2:30 to 2:45	Break
2:45 to 4:00	Real Estate Transactions Property Taxes Complex disbursement situations from Special Needs Trusts *Patricia E. Kefalas Dudek, Sanford J. Mall & Staff*
4:00 to 5:00	Open Question and Answer Session

Low Income Subsidy cont.

to complete Form 1026-B within the 30-day time period. Beneficiaries who request and receive the redetermination statement must return it within the specified time frame even if, upon review, they realize that their circumstances have not changed and they did not need to contact SSA. The redetermination statement includes a section to indicate that income, assets, and household size have not changed.

Once SSA receives a returned redetermination statement, the agency will evaluate the information for continued LIS eligibility. SSA will also conduct a data match with other federal agencies to confirm the new information. If a beneficiary does not return the statement, SSA will send a letter reminding the beneficiary to return the statement or LIS eligibility will end on December 31, 2006.

The SSA redetermination process is set out in its Program Operations Manual System (POMS), available at <https://s044a90.ssa.gov/apps10/poms.nsf/lnx/0603050011.> The beneficiary letter and the redetermination statement are found at the end of the POMS section. An SSA fact sheet about the process is available at <http://www.socialsecurity.gov/pubs/10111.pdf.> The Spanish version is available at <http://www.socialsecurity.gov/pubs/10111_SP.pdf>

Re-Deeming of LIS Eligibility by State Medicaid Agencies

In July, CMS sent a letter to state Medicaid directors that explained the process for "re-deeming" of LIS eligibility for individuals who were deemed LIS-eligible for 2006. See http://www.cms.hhs.gov/smdl/downloads/SMD070606.pdf.

CMS will review the "MMA file" sent by each state to the agency in July. Individuals who were deemed eligible for LIS in 2006 and who appeared in the July state data (MMA) files will automatically be deemed eligible for LIS in 2007. They will not have to do anything to continue their LIS eligibility. CMS will review the state MMA data files each month so that Medicare beneficiaries who appear in a monthly file between August and December 2006 will also be deemed eligible for LIS through 2007. The July 2006 state files will also be used to determine subsidy levels, including the co-payment amount.

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VA Benefits for POWs cont.

eligible for dental care without any length-of-interment requirement. VA periodically has provided training for its medical staff about former POWs, and an online curriculum is maintained at http://www1.va.gov/VHI/page.cfm?pg=9.

In collaboration with its Advisory Committee on Former Prisoners of War, VA launched a campaign in 2003 to ensure that eligible former POWs are aware of their VA benefits. Direct mail was used where addresses could be found for veterans who were not currently on the rolls. Those already receiving VA benefits were reminded of the possible availability of increased compensation if a condition has worsened, and they also were alerted to the improvement of benefits in recent years. In addition, to seek former POWs for whom VA could not locate an address and to reach widows of veterans who may have died of a service-connected condition, VA issued news releases and provided interviews to alert the public to expanded policies. Brochures, exhibits and VA Web sites were improved to provide more information to former POWs and the public.

Later in 2004 and 2005, VA initiated another outreach campaign to locate former POWs who were experiencing two new presumptive conditions – heart disease or stroke – to alert them to the change in law.

Additional Resources
POW coordinators are assigned to each VA regional office and medical center and are available to provide more information. Former POWs may contact VA regional offices with general benefits questions at 800-827-1000. Medical eligibility questions may be directed to 877-222-8387. Additional information for former POWs also is available from VA's Web site at http://www.vba.va.gov/bln/21/Benefits/POW/.

COMMON ERRORS IN LONG-TERM CARE PLANNING

In assisting seniors and persons with disabilities and their family members in applying for Medicaid assistance, we frequently observe the following planning errors that people make when applying for Medicaid.

- **Medicaid Myths.** Relying on information from family members or friends. Medicaid is a state program funded in part by the federal government. Each state has its own Medicaid rules and regulations; there are 51 Medicaid programs when you include the District of Columbia. Seniors, persons with disabilities and their families should consult with an experienced attorney familiar with the Medicaid program in the state in which the Medicaid application is to be filed.
- **Thinking it's too late to plan.** It is never too late to plan. It is possible to begin planning even after the senior or person with a disability has entered a nursing home. With proper planning it is possible to protect much of the person's assets, and improve the quality of their care.
- **Giving away assets too early.** These assets belong to the senior or person with a disability. Don't put the senior or person with a disability at risk by making premature gifts to family members. Premature gifts can also result in tax and Medicaid problems, particularly with the changes in the law because of the Deficit Reduction Act of 2005 (DRA).
- **Ignoring exempt transfers.** Some transfers do not result in periods of Medicaid ineligibility. These transfers include transfers to children with a disability, minor children, some caretaker children, some siblings, d(4)(A) trusts for disabled persons under the age of 65, and d(4)(C) pooled trusts for disabled persons of any age.
- **Failing to take advantage of spousal protections.** These protections include maximizing the Community Spouse Resource Allowance by increasing countable resources prior to the "snapshot" date, and by purchasing exempt resources, such as a motor vehicle, home, or prepaid burial, or by converting countable resources to income.
- **Applying for Medicaid too early.** As a result of the DRA, applying for Medicaid within five years of making an uncompensated gift can result in a period of ineligibility that will start not when the gift is made, but when the senior or person with a disability is in the nursing home or on the waiver with no funds available to pay for his or her care.
- **Applying for Medicaid too late.** Applying for Medicaid too late can result in spending funds that could have been protected by proper planning.
- **Failing to keep good records.** This is a critical issue in light of the DRA. An experienced Medicaid eligibility worker will examine thoroughly all Medicaid applications. The applicant should retain records to support all items listed on the application, document the applicant's assets as of the date of entry into the nursing home, and verify the disposition of the applicant's assets for the five years period prior to the filing of the application.
- **Not getting expert help.** Medicaid asset protection planning is complicated and ever changing. Most people will require this planning only once during their lives. Because a great deal is at stake, it is wise to consult an experienced attorney when long term care is necessary.

The attorneys at The Mall Malisow Firm and Hafeli Staran Hallahan Christ and Dudek, P.C. are experienced in long-term care planning, and are available to assist clients with these critical issues. Demand for our services remains high, so please do not wait for an emergency before you begin planning.

Low Income Subsidy cont.

Beneficiaries who were deemed eligible for LIS in 2006 but who do not appear in the state files transmitted to CMS in July and in subsequent months through December 2006 will not be deemed eligible for 2007. The July 6 Medicaid director letter tells states that CMS will notify beneficiaries who are currently deemed eligible for LIS, but who were not included in the July data transmission by the states, that they will not be deemed eligible for LIS for 2007. Individuals who are no longer deemed eligible for LIS may still apply for the low-income subsidy through SSA. It has not yet been decided whether these individuals will automatically receive an LIS application with the letter that tells them that they are no longer automatically eligible for LIS.

A beneficiary whose LIS eligibility has been terminated or whose status has been changed from full- to partial- subsidy eligible may file an appeal. Advocates are concerned that the SSA notices in the redetermination process and the CMS letters in the re-deeming process may fail to provide beneficiaries with adequate information about their appeal rights. Even if beneficiaries are adequately informed, questions remain as to whether the appeal processes will be completed before the LIS is terminated or reduced.

Some beneficiaries who lose their deemed eligibility status because they are no longer eligible for full Medicaid benefits may still be eligible for one of the Medicare Savings Programs such as QMB, SLMB, or QI. In addition to being deemed eligible for LIS, MSP recipients also receive assistance with Part B premiums and, in the case of QMB, other cost-sharing. These beneficiaries should be encouraged to apply for MSP.

Similarly, some states have MSP eligibility criteria that are more generous than the LIS eligibility criteria. Beneficiaries who live in these states and who are redetermined by SSA not to be eligible for LIS should also apply for MSP. If found eligible for MSP, these beneficiaries would then be deemed eligible for LIS. Some beneficiaries used their very high prescription drug costs to become eligible for full Medicaid benefits in 2005, and so they were deemed eligible for LIS in 2006. Because LIS paid most of their drug costs in 2006, many of these beneficiaries no longer qualify for Medicaid on a spend-down or medically needy basis. They will therefore lose their deemed eligibility for LIS in 2007, and they will once again be responsible for their medication costs. Once their costs are high enough, some of these beneficiaries may again qualify for Medicaid, and will again be deemed eligible for LIS. Thus, LIS-eligibility for some Medicare beneficiaries in any given year will vary depending on if and when they meet their spend-down obligations.

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