

Planning for Aging and Chronic Illness

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Published by: [National Association of Estate Planners & Councils](#)

Why planning for aging and chronic illnesses belongs at the center of your practice.

Clients are living longer, with a higher probability of cognitive decline, multimorbidity, and caregiver stress, and effective planning must reflect those realities rather than focusing solely on tax thresholds and dispositive formulas. An estimated 6.9 million Americans age sixty-five and older are living with Alzheimer's dementia, with total dementia care costs projected at approximately \$360 billion in 2024.[\[1\]](#)

A majority of Americans over age sixty are living with at least one chronic illness, and most are managing multiple conditions simultaneously.[\[2\]](#)

You should therefore frame estate, tax, and fiduciary work in a coordinated risk-management program that anticipates capacity fluctuations, aligns fiduciary governance with medical and family dynamics, and documents decisions defensibly.

Reengineering intake and advisory cadence.

Consider normalizing health and functional-status questions in client questionnaires and at meetings and even annual reviews, as conditions that affect judgment and financial management may emerge between episodic estate planning updates. Published prevalence and cost data show that dementia

touches a large share of older households and imposes significant caregiver burdens,[\[3\]](#) making routine health-status screening in your intake practical and defensible. Also consider establishing standing client authorizations for cross-advisor communication so that the wealth adviser who sees cashflow anomalies, the CPA who sees late or inconsistent filings, and you as counsel can compare observations in compliant ways under engagement agreements. Be aware that the client's estate planning attorney may need to be discreet in certain communications to avoid jeopardizing the attorney-client privilege. Depending on the circumstances it may be best for the attorney to retain one or more non-attorney advisers to consult through the attorney to maintain privilege.

Documenting collaboration, capacity, and consent.

Try to memorialize the client permission for adviser-to-adviser collaboration, establish a communications plan, and capture contemporaneous evidence of client understanding at key inflection points. For example, ABA Model Rule 1.14, central in elder law, estate planning, special needs planning, and all situations involving cognitive impairment, directs lawyers (other advisers ought to consider this as well) to maintain the ordinary relationship and to take only what protective measures are reasonably necessary, while limiting any disclosures to what is necessary to protect the client's interests. You might, as appropriate, tailor your file protocol to include dated summaries of goals-of-care discussions, identification of accommodation needs, and explicit client instructions about information sharing with named family members and professionals.

Using remote meetings and transcripts without sacrificing nuance.

You may find that video meetings reveal functional context that traditional conference-room meetings obscure, and you can supplement that with accurate transcripts and summaries. Research and professional guidance agree that multitasking can degrade comprehension,[\[4\]](#)[\[5\]](#) so offloading notetaking to a transcription workflow may help you focus on client affect and cognition which

are often quite subtle. Also, in contrast to in-person meetings in the adviser's office, a Zoom, or other web-based meetings with a client in their home environment may provide valuable information as to who is with them, what their environment looks like, and more. AI can analyze transcripts to identify trends and incidents that may have escaped the observation of the adviser.

Modernizing the financial power of attorney.

Consider drafting durable financial powers of attorney (POAs) appropriate for your client's situation and compliant with the client's state's applicable law. Be cautious granting any "hot powers" such as the right for an agent to make gifts, beneficiary changes to retirement plan and other beneficiary designations, trust modification, or digital-asset access. These powers are referred to as "hot" as they can be quite powerful and may facilitate an agent modifying the client's dispositive plan. They need to be expressly mentioned in the power of attorney and often require careful discussion with the client and careful tailoring in the legal document.

Hardened revocable trusts as the disability platform.

You might reposition the revocable trust as the primary incapacity vehicle and harden it with administrative and oversight provisions that POAs alone rarely match. Consider a Taxpayer Identification Number (TIN), not the client's SSN, for an added layer of client protection. TINs assigned to a revocable trust are less accessible to outsiders than the client's Social Security Number. That may provide some insulation against identity theft and unauthorized access to the client's personal financial information.

Independent care manager reporting to surface risk earlier.

You could embed a requirement for periodic visits and written assessments by an independent, licensed care manager, with reports delivered to the trustee, trust protector, and the healthcare agent. That way, the various people who should be concerned with the care and wellbeing of the client are informed of the real status

of the client by a professional who is trained to identify aging and health issues and who is required to report to authorities any suspected abuse.

Healthcare directives that reflect telehealth, surrogacy, and values.

Update healthcare proxies, living wills, and HIPAA authorizations to reflect telehealth communications, multistate coordination, and the client's moral or faith-based preferences.

Medical aid in dying (MAID) policies are changing and should inform agent selection.

Advise clients that aid-in-dying statutes are evolving and that agent alignment with client values matters as much as formal authority. As new laws emerge—and existing statutes are amended—clients may face increasingly complex procedural requirements, waiting periods, competency certifications, and provider-based limitations. Because these frameworks can vary widely by jurisdiction and often include conscientious-objection provisions for physicians, hospitals, and religiously affiliated institutions, it is essential that the designated healthcare agent not only possess the legal authority to act but also be personally aligned with the client's values, worldview, and preferences for end-of-life care. A well-chosen agent must be emotionally prepared to make decisions consistent with the client's stated goals, even when those decisions are difficult or controversial within the family system. This includes respecting the client's moral, religious, cultural, and quality-of-life thresholds and being capable of navigating potentially burdensome statutory procedures on short notice.

Lessons from end-of-life litigation.

There have been too many tragic situations where family members and other loved ones have fought over end-of-life decisions because the client did not obtain and sign appropriate health care documents.[\[6\]](#)

Every adult ought to obtain these documents. Practitioners should endeavor to have discussions about these issues and be certain that counsel has memorialized the client's actual wishes in the documents.

Trust drafting to address addiction, relapse risk, and undue influence.

Recognize that aging households often face substance-use and behavioral-health risks in the family system. The National Institute on Drug Abuse (NIDA), a component of the U.S. National Institutes of Health (NIH), states that substance-use disorder is a growing issue among adults sixty-five and older, driven by chronic pain, prescription medication exposure, grief, and loss of independence^[7] — factors that affect entire family systems and caregiving structures.

Additionally, there should be concern if the beneficiaries are disabled, chronically ill, or have addiction issues. Anyone, regardless of age, gender, cultural background, or socioeconomic status, can experience addiction. According to the 2024 United States National Survey on Drug Use and Health (NSDUH), 48.4 million (16.8%) Americans aged twelve and older battled a substance use disorder in 2024.^[8] In these circumstances, beneficiaries struggling with addiction or related challenges may exert pressure to alter estate planning decisions in ways that are inconsistent with the client's expressed wishes.

A substantial portion of beneficiaries are dealing with an addiction that may require discretionary trust structures; third-party trustees willing to serve as trustees for trusts where beneficiaries face these or other challenges; spendthrift clauses; and prohibition on outright distributions (i.e. permitting the trustee to pay expenses for the beneficiary rather than make a distribution to the beneficiary).

Retirement accounts and eligible designated beneficiary status.

Segment retirement-beneficiary planning for disabled or chronically ill beneficiaries because the SECURE Act framework may allow lifetime stretch distributions. Under the SECURE rules, disabled and chronically ill beneficiaries qualify as Eligible Designated Beneficiaries (EDBs), a category that retains the pre-2020 stretch payout structure. This permits required minimum distributions to continue over the beneficiary's life expectancy, preserving tax deferral and reducing the risk that accelerated income recognition will jeopardize eligibility for

public benefits such as SSI or Medicaid. To take advantage of these rules, practitioners must confirm that the beneficiary meets the statutory definition of “disabled” or “chronically ill” under IRC §401(a)(9)(E) and must ensure that all required documentation, including physician certifications, is obtained within the timeframes specified in the final Treasury regulations. The definitions are quite strict, so a beneficiary who has health challenges may not meet the requirements for this benefit.

Portfolio and liquidity alignment inside the disability platform.

Work with the investment adviser to align liquidity in their portfolio to near-term care risks so the trust is not forced to liquidate volatile assets. However, that should be balanced for the circumstances, as many people struggling with a chronic illness may not have their life expectancy materially impacted, so the need for inflation protection and growth may not be obviated merely because of a health issue.

How to operate a tiered, behavior-based fiduciary response.

Estate planners might consider creating a written administration protocol that provides fiduciaries with a clear, repeatable process for managing beneficiaries who present health, behavioral, or financial-stability risks. A well-constructed protocol identifies (1) observable triggers, (2) outlines tiered escalation steps, and (3) defines a documentation cadence that supports fiduciary prudence and judicial defensibility. Consider that having an objective protocol applied toward all beneficiaries with similar challenges may not only make the process more effective for such beneficiaries, but more efficient for trustees, and it may protect the trustee if any beneficiary claims discrimination in the application of the decision process as to them.

Observation triggers should include objective, behavior-based indicators—such as missed rent payments, abnormal cash-withdrawal patterns, reports from a care manager, relapse indicators, concerns raised by professionals, or evidence of declining capacity—that signal a potential threat to the beneficiary’s well-being or to proper trust administration. These triggers should be defined narrowly enough

to prevent arbitrary action but broadly enough to empower fiduciaries to intervene before harm escalates.

Escalation steps are best structured in tiers, beginning with the least-restrictive response and progressing to more protective measures only if warranted. For example, early interventions may include increased monitoring, temporary distribution limits, or requiring communication with the trustee. If risks intensify, the trustee may pause discretionary distributions pending evaluation, request updated care-manager assessments, involve a trust protector, or coordinate with professionals such as therapists, social workers, or financial counselors. In extreme situations, the protocol may authorize the trustee or protector to require treatment participation, appoint a co-trustee, or replace a conflicted family fiduciary. Bear in mind that the trustee may have only limited latitude in what it may demand of a beneficiary without the beneficiary's consent.

Documentation cadence ought to require trustees to contemporaneously record any observed trigger, conversation, assessment, and action taken. This includes periodic summaries—monthly, quarterly, or event-driven—that memorialize the fiduciary's observations, rationale, and decisions. A disciplined documentation structure strengthens compliance with fiduciary duties, supports transparency among co-fiduciaries and protectors, and provides a defensible record should the trustee's actions later be reviewed in a court or contested by beneficiaries.

Translating values into enforceable documents.

Hold structured interviews to elicit values around independence, risk tolerance, and caregiver boundaries. One could include such questions as:

- Is there anyone you prefer not to involve due to stress, conflict, or their own limitations?
- Are there areas where you do not want family involvement, for example, daily spending or personal care?

- What are the top three independence priorities that you want protected more than anything else?
- Would you accept cameras or home sensors to remain independent? Which areas would be off-limits?

Practice management protocols that reduce malpractice and conflict.

Adopt a periodic checklist for older or health-affected clients that revisits fiduciary slates, communications preferences, security, beneficiary designations, and liquidity.

What you tell clients—and how you prove it—matters.

Explain to clients and families that simplicity may sacrifice protection and document options offered to them.

Closing perspective.

Clients are best served when aging and chronic illness are treated as core planning domains rather than edge cases. Incorporating these realities into documents, communications, and practice management protocols allows attorneys, advisors, and other professionals to work more effectively as a team. The result is not only stronger protection for client intent, but also a reduction in conflict, confusion, and professional risk as clients and families navigate periods of increased vulnerability.

[1] Alzheimer’s Association, *2024 Alzheimer’s Disease Facts and Figures*, Alzheimer’s & Dementia (2024), <https://www.alz.org/alzheimers-dementia/facts-figures>.

[2] Watson et al., *Trends in Multiple Chronic Conditions Among U.S. Adults, by Life Stage, Behavioral Risk Factor Surveillance System, 2013–2023*, 22 Preventing Chronic Disease (2025), https://www.cdc.gov/pcd/issues/2025/24_0539.htm.

[3] This guidance was updated in February 2026 to change the language from maintaining “normal client lawyer relationship” to “ordinary client lawyer relationship,” among other changes.

[4] Lili Liu, Zhishan Liu, & Shuang Li, *Cognitive Load in Multitasking Scenarios: A Qualitative Study Overview—Analysis of Cognition and Experience*, 8 *Journal of Humanities, Arts and Social Science* 1700 (2024), <https://doi.org/10.26855/jhass.2024.07.028>

[5] Yuan, X., & Zhong, L., *Effects of Multitasking and Task Interruptions on Task Performance and Cognitive Load: Considering the Moderating Role of Individual Resilience*, 43 *Current Psychology* 23892 (2024), <https://doi.org/10.1007/s12144-024-06094-2>.

[6] See, e.g., *In re Schiavo*, 780 So. 2d 176 (Fla. Dist. Ct. App. 2001).

[7] Nat’l Inst. on Drug Abuse, *Substance Use in Older Adults DrugFacts*, Nat’l Insts. of Health (2020), <https://nida.nih.gov/publications/drugfacts/substance-use-in-older-adults-drugfacts>.

[8] Substance Abuse & Mental Health Servs. Admin., *Key Substance Use and Mental Health Indicators in the United States: Results from the 2024 National Survey on Drug Use and Health* (2025), <https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases>.

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