No. _____

IN THE

Supreme Court of the United States

LAURIE A. DERMODY,
Petitioner,

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Respondent.

LINDA MARIE MONDOR, ET AL.,
Petitioners,

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Judicial Court of Massachusetts

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

In determining the Medicaid eligibility of a married institutionalized individual, the assets of both spouses are normally considered. Under 42 U.S.C. § 1396p(c)(1), an institutionalized spouse is penalized (*i.e.*, becomes ineligible for benefits) to the extent the married couple's assets were transferred for less than fair market value during a specified look-back period.

Section 1396p(c)(1) provides that for purposes of this transfer penalty, "the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless . . . the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual." 42 U.S.C. § 1396p(c)(1)(F)(i). Section 1396p(c)(2), however, lists a number of conditions under which "[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1)." *Id.* § 1396p(c)(2). One such condition is where "the assets . . . were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse." *Id.* § 1396p(c)(2)(B)(i).

The question presented is:

Whether an annuity that satisfies the condition in Section 1396p(c)(2)(B)(i) must name the State as the first remainder beneficiary in order to avoid Section 1396p(c)(1)'s transfer penalty.

PARTIES TO THE PROCEEDING

Petitioner in *Dermody* is Laurie A. Dermody, who was Plaintiff-Appellee in the Supreme Judicial Court of Massachusetts. Petitioners in *Mondor* are Linda Marie Mondor, Michelle Mogan, Cathy Ann Mondor, Kathleen Ann Bristow, Marianne Schwenzfeier, and John Francis Castle, who were collectively Defendants-Cross-Claimants-Appellees in two consolidated cases in the Supreme Judicial Court of Massachusetts.

Respondent in both *Dermody* and *Mondor* is the Executive Office of Health and Human Services of the Commonwealth of Massachusetts, which was Defendant-Appellant in the Supreme Judicial Court of Massachusetts in *Dermody* and Defendant-Cross-Claimant-Appellant in the Supreme Judicial Court of Massachusetts in *Mondor*.

Nationwide Insurance Company was Defendant-Cross-Claimant in the Massachusetts Superior Court, Middlesex County, in *Dermody*, but is no longer a party to the case and is not a respondent in this Court.

Standard Insurance Company was Interpleader-Plaintiff in the Massachusetts Superior Court, Suffolk County, in each of the two consolidated cases in *Mondor*, but is no longer a party to the cases and is not a respondent in this Court.

RELATED PROCEEDINGS

Superior Court of Massachusetts, Middlesex County:

Laurie A. Dermody v. The Executive Office of Health & Human Services, et al., No. 1781CV02342 (Jan. 16, 2020)

Superior Court of Massachusetts, Suffolk County:

Standard Insurance Company v. Linda Marie Mondor, et al., No. 2084CV02484 (July 1, 2021)

Standard Insurance Company v. Kathleen Ann Bristow, et al., No. 2184CV00962 (July 1, 2021)

Supreme Judicial Court of Massachusetts:

Laurie A. Dermody v. Executive Office of Health and Human Services, No. SJC-13199 (Jan. 27, 2023)

Executive Office of Health and Human Services v. Linda Marie Mondor, et al., No. SJC-13179 (Jan. 27, 2023)

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PETITION FOR A WRIT OF CERTIORARI

Petitioners Laurie A. Dermody and Linda Marie Mondor, et al., respectfully petition for a writ of certiorari to review the judgments of the Supreme Judicial Court of Massachusetts.

Pursuant to this Court's Rule 12.4, Petitioners are filing a "single petition for a writ of certiorari covering all the judgments" because multiple judgments "are sought to be reviewed on a writ of certiorari to the same court and involve identical or closely related questions."

OPINIONS BELOW

In *Dermody*, the opinion of the Supreme Judicial Court of Massachusetts (Pet. App. 1a-18a) is reported at 201 N.E.3d 285. The memorandum of decision and order of the Superior Court of Massachusetts, Middlesex County (Pet. App. 28a-52a), is unreported but is available at 2020 WL 742194.

In *Mondor*, the opinion of the Supreme Judicial Court of Massachusetts (Pet. App. 19a-27a) is reported at 201 N.E.3d 281. There was no opinion issued by any lower Massachusetts court.

JURISDICTIONAL STATEMENT

The judgments of the Supreme Judicial Court of Massachusetts were entered on January 27, 2023. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

RELEVANT STATUTORY PROVISIONS

The pertinent section of the U.S. Code, 42 U.S.C. § 1396p, is reproduced in the appendix to this petition. Pet. App. 53a-85a.

STATEMENT

A. Statutory Background

1. Medicaid is a state-federal cooperative program through which States provide medical benefits to low-income individuals and the federal government reimburses the States for some of those costs. *See Wis. Dep't of Health & Fam. Servs. v. Blumer*, 534 U.S. 473, 479 (2002). Participating States develop plans setting forth benefits and eligibility criteria pursuant to federal statutes and regulations. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981).

For a time, States would determine Medicaid eligibility for married individuals by considering both spouses' income and the couple's jointly held assets, but not assets held solely in the name of the "community spouse" (*i.e.*, the spouse of the "institutionalized spouse"). *See Blumer*, 534 U.S. at 479-80. This "produced unintended consequences." *Id.* at 480. In some cases, a community spouse would be "left destitute by the drain on the couple's assets necessary to qualify the institutionalized spouse for Medicaid." *Id.* And if a wealthy couple held all spousal assets in the community spouse's name alone, the institutionalized spouse might qualify for Medicaid benefits notwithstanding the couple's "ample means." *Id.*

2. Against this backdrop, Congress enacted the Medicare Catastrophic Coverage Act of 1988 (MCCA), Pub. L. No. 100-360, 102 Stat. 683, "to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance." *Blumer*, 534 U.S. at 480 (quoting H.R. Rep. No. 100-105, pt. 2, at 65 (1987)). The MCCA "amended the Medicaid rules so that in determining eligibility, a couple's combined assets are considered available to the applicant regardless of specific ownership." Pet. App. 8a. In addition, the MCCA "installed a set of intricate and interlocking requirements" governing allocation of a married couple's resources and income. *Blumer*, 534 U.S. at 480; *see id.* at 480-84.

In determining the institutionalized spouse's initial Medicaid eligibility, the MCCA allowed some of the couple's assets to be "reserved for the benefit of the community spouse." *Blumer*, 534 U.S. at 482 (citing 42 U.S.C. § 1396r-5(c)(2)). That amount is known as the "community spouse resource allowance," or the "CSRA." *Id.* at 478. "The CSRA is considered unavailable to the institutionalized spouse in the eligibility determination, but all resources above the CSRA (excluding a small sum set aside as a personal allowance for the institutionalized spouse . . .) must be spent before eligibility can be achieved." *Id.* at 482-83 (citing 42 U.S.C. § 1396r-5(c)(2)).

3. The Medicaid Act requires States to impose a penalty when either an institutionalized individual or her spouse has transferred assets for less than fair market value during a five-year look-back period. 42 U.S.C. § 1396p(c)(1); *see Hutcherson v. Ariz. Health*

Care Cost Containment Sys. Admin., 667 F.3d 1066, 1069 (9th Cir. 2012). When this transfer penalty applies, the institutionalized spouse is deemed ineligible for Medicaid benefits for the number of months equal to the "the total, cumulative uncompensated value of all assets transferred" during the look-back period divided by "the average monthly cost to a private patient of nursing facility services in the State." 42 U.S.C. § 1396p(c)(1)(E)(i)(I)-(II). In other words, "if either spouse tries to give away assets, the institutionalized spouse will be ineligible for Medicaid benefits for the length of time that those assets could have covered the spouse's medical costs." *Hutcherson*, 667 F.3d at 1069. The transfer-penalty provisions appear in Section 1917(c)(1) of the Medicaid Act, 42 U.S.C. § 1396p(c)(1), captioned "[t]aking into account certain transfers of assets." Pet. App. 65a-72a.

The MCCA made several changes to the transfer-penalty provisions. Among others, the MCCA added Section 1917(c)(2) to the Medicaid Act, 42 U.S.C. § 1396p(c)(2), which listed circumstances under which "[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1)," *i.e.*, an asset transfer for less than fair market value would not be penalized. MCCA § 303(b), 102 Stat. at 761; Pet. App. 73a-75a. As relevant here, one such circumstance was where "the resources were transferred to (or to another for the sole benefit of) the community spouse." MCCA § 303(b), 102 Stat. at 761 (adding 42 U.S.C. § 1396p(c)(2)(B)). After several minor amendments, that "sole benefit" exception took its current form in 1993. *See* Omnibus Budget Reconciliation Act of 1993,

Pub. L. No. 103-66, § 13611(a), 107 Stat. 312, 623. The exception now provides that "[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that . . . the assets . . . were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse." 42 U.S.C. § 1396p(c)(2)(B)(i).[1]

4. A community spouse may shield personal or spousal assets by using them to purchase an annuity.[2] The purchase of an annuity converts the community spouse's *assets* (which are considered in determining the institutionalized spouse's eligibility for Medicaid benefits, *see* 42 U.S.C. § 1396r-5(c)(1)(A)) into *income* (which is not, *see id.* § 1396r-5(b)(1)). And under certain circumstances, the community spouse's use of assets to purchase an annuity within the look-back period does not give rise to a period of Medicaid ineligibility for the institutionalized spouse.

As part of a broad slate of amendments to the Medicaid laws, Title VI of the Deficit Reduction Act of 2005 (DRA), Pub. L. No. 109-171, 120 Stat. 4 (2006), added a new requirement that some annuities must meet to remain exempt from consideration in Medicaid eligibility

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[1] The provision also exempts assets "transferred from the individual's spouse to another for the sole benefit of the individual's spouse," 42 U.S.C. § 1396p(c)(2)(B)(ii), and other transfers involving trusts, *see id.* § 1396p(c)(2)(B)(iii)-(iv).

[2] An annuity is "[a]n obligation to pay a stated sum, usu[ally] monthly or annually, to a stated recipient." *Annuity*, *Black's Law Dictionary* 113 (11th ed. 2019).

determinations. Section 6012(b) of the DRA provided that for purposes of the transfer penalty, "the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless . . . the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant." 120 Stat. at 63 (adding 42 U.S.C. § 1396p(c)(1)(F)(i)).[3]

Congress quickly amended that new provision. Later the same year, Congress made a "technical correction" to Section 1396p(c)(1)(F)(i) as amended by the DRA, "[c]larifying" that the exemption applies when the State is named as the first remainder beneficiary for at least the amount of benefits paid on behalf of the "*institutionalized individual*," not the "annuitant." Medicare Improvements and Extension Act of 2006, Pub. L. No. 109-432, div. B, § 405(b)(1), 120 Stat. 2975, 2996, 2998 (amending 42 U.S.C. § 1396p(c)(1)(F)(i)) (emphasis added). The change was made retroactive to the effective date of the DRA. *Id.* § 405(b)(2), 120 Stat. at 2998.

Neither the DRA nor the later clarifying amendment made any change to Section 1396p(c)(2)(B), which continued to provide that "[a]n individual shall not

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[3] The DRA's amendment also exempted the purchase of an annuity from the transfer penalty if "the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value." DRA § 6012(b), 120 Stat. at 63 (adding 42 U.S.C. § 1396p(c)(1)(F)(ii)).

be ineligible for medical assistance by reason of [Section 1396p(c)(1)] to the extent" that assets were transferred "for the sole benefit" of the community spouse. 42 U.S.C. § 1396p(c)(2)(B)(i).

B. Factual Background

These cases each involve an annuity purchased by the spouse of an elderly individual admitted to a skilled-nursing facility for long-term care. Pet. App. 2a, 19a-20a. The purchases of the annuities allowed the community spouses to ensure monthly income while reducing the couple's assets, thus making the institutionalized spouses eligible for benefits through MassHealth, the program through which the Commonwealth of Massachusetts participates in Medicaid. *Id.* at 2a-4a, 20a-25a. MassHealth is administered by the Commonwealth's Executive Office of Health and Human Services (EOHHS), the sole Respondent in each case. *Id.* at 5a; *see* Mass. Gen. Laws ch. 118E, §§ 9-9A.

The community spouses in each case listed the Commonwealth of Massachusetts as the primary remainder beneficiary on the annuity and their children as the contingent remainder beneficiaries. Pet. App. 3a, 21a, 23a-24a. In each case, the community spouse died before the annuity was fully paid out, leading to a dispute between the children and the Commonwealth as to who was entitled to the remaining funds. *Id.* at 4a, 23a, 25a.

1. In June 2015, Robert Hamel used spousal resources to purchase an annuity from Nationwide Life Insurance Company so that his wife Joan—who had been admitted to a long-term nursing facility the previ-

ous month—would become eligible for MassHealth benefits. Pet. App. 3a. The annuity application listed "Commonwealth of MA the Extent Benefits Paid [*sic*]" as the primary remainder beneficiary and the couple's daughter, Petitioner Laurie Dermody, as the contingent remainder beneficiary. *Id.* (alteration in original). Neither the application nor the issued annuity (which listed the primary remainder beneficiary as "State of MA Medicaid Per Application") clarified whether the limit on the Commonwealth's recovery was to the extent benefits had been paid on behalf of Robert or Joan. *See id.* at 3a & n.4. Joan then began to receive MassHealth benefits for her care. *Id.* at 3a.

Robert died in December 2016 without having personally received MassHealth benefits. Pet. App. 3a. EOHHS then asserted that it was entitled to the approximately $119,000 remaining on the annuity, which was less than the medical coverage it had provided on behalf of Joan. *Id.* at 3a-4a. After Nationwide distributed the remainder to the Commonwealth, Ms. Dermody brought suit in Massachusetts court, seeking a declaratory judgment that she was entitled to the funds. *Id.* at 4a.[4]

2. In April 2018—the month after his wife Elda was admitted to a long-term nursing facility—Edward Mondor purchased an annuity from Standard Insurance Company using funds in his individual retirement ac-

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[4] Ms. Dermody also asserted unfair-business-practice claims against Nationwide, but those claims were later settled and are not at issue in this Court. *See* Pet. App. 4a n.6, 46a-51a.

count. Pet. App. 20a-21a. Edward named the Commonwealth as the primary remainder beneficiary and the couple's three daughters—Petitioners Linda Marie Mondor, Michelle Mogan, and Cathy Ann Mondor (Mondor Petitioners)—as the contingent remainder beneficiaries. *Id.* at 21a; *see id.* at 20a. Having paid for the annuity in full, Edward and Elda's joint assets were reduced to the point that Elda became eligible for MassHealth benefits, which she began to receive. *Id.* at 21a-23a. Edward never received any MassHealth benefits. *Id.* at 23a.

Edward died in April 2020 with approximately $98,000 remaining on the annuity. Pet. App. 23a. The Commonwealth claimed that it was entitled to those funds, having paid more than that in benefits on behalf of Elda. *Id.* Mondor Petitioners also claimed entitlement to the funds. *Id.* Standard retained the money and brought an interpleader suit against Mondor Petitioners and the Commonwealth to resolve the controversy. *Id.* at 25a.

3. In November 2018, James Castle similarly used individual retirement funds to purchase an annuity from Standard so that his wife Carol, who had been admitted to a long-term nursing facility several months earlier, would be eligible for MassHealth benefits. Pet. App. 23a-24a. James named the Commonwealth as the primary remainder beneficiary and the couple's three children—Petitioners Kathleen Ann Bristow, Marianne Schwenzfeier, and John Francis Castle (Castle Petitioners)—as the contingent remainder beneficiaries. *Id.* at 24a; *see id.* at 23a. James never received any MassHealth benefits. *Id.* at 24a-25a.

James died in October 2020 with approximately $110,000 remaining on the annuity—less than the amount of medical benefits the Commonwealth had paid on behalf of Carol. Pet. App. 24a. Standard disbursed some of the funds to the Commonwealth after it asserted its entitlement to the remainder. *Id.* at 25a. But when Castle Petitioners asserted their interest, Standard ceased making payments and instead sued both Castle Petitioners and the Commonwealth. *Id.*

C. Proceedings in the Massachusetts Courts

1. a. The Massachusetts trial court granted summary judgment to Ms. Dermody, holding that she was entitled to the funds remaining on her father's annuity. Pet. App. 28a-52a.

The court took the view that under state contract law, Ms. Dermody would prevail *unless* the Medicaid Act compelled a contrary conclusion. As the court explained, Robert's annuity "designates the 'State of MA Medicaid Per Application' as his primary beneficiary, and his annuity application states that the Commonwealth's right to recover is limited to the 'Extent Benefits Paid.'" Pet. App. 45a. It further observed that "Robert was the sole annuitant of the contract, and Joan is not referenced anywhere in the contract." *Id.* "Accordingly," the court found, "nothing in the plain terms of the contract suggests the 'benefits paid' language refers to anyone other than Robert." *Id.* Under this interpretation, all remaining benefits would go to Ms. Dermody because the Commonwealth had not paid any benefits on behalf of Robert (as opposed to Joan).

The Commonwealth, however, invoked 42 U.S.C. § 1396p(c)(1)(F)(i) to argue that it was entitled to the remaining funds. It asserted that the Medicaid Act required it to be named as the first remainder beneficiary to the extent it had paid for Joan's care, notwithstanding the fact that the annuity purchase was for the "sole benefit" of Robert and was thus subject to Section 1396p(c)(2)(B)(i). *Id.* § 1396p(c)(2)(B)(i); *see* Pet. App. 38a-39a. The Commonwealth argued that "if the court finds that a transfer of assets to purchase an annuity must satisfy both provisions," *i.e.*, Section 1396p(c)(1)(F)(i) and 1396p(c)(2)(B)(i)—"then the court also must find that the 'Extent Benefits Paid' language in Robert's contract necessarily refers to Joan" in order to justify the Commonwealth's approval of Medicaid benefits without subjecting Joan to the transfer penalty. *Id.* at 38a; *see id.* at 38a-39a. The trial court thus characterized the "gravamen of this dispute" as "hing[ing] on whether an annuity that satisfies the sole benefit rule must also satisfy the annuity rules under § 1396p(c)(1)(F)." *Id.* at 38a.

The trial court then rejected the Commonwealth's interpretation of the Medicaid Act. In light of the Act's "unambiguous" text," Pet. App. 41a, the court concluded that an annuity satisfying Subparagraph (c)(2)(B)(i) "need not satisfy the annuity rules set forth in [Subparagraph (c)(1)(F)]," *id.* at 43a-44a; *see id.* at 39a-44a. Accordingly, the court held that Ms. Dermody "is entitled to the remaining balance of Robert's annuity as the contingent beneficiary." *Id.* at 45a.

b. The Supreme Judicial Court of Massachusetts[5] reversed. Pet. App. 1a-18a.

The Supreme Judicial Court began by noting, as the trial court had, that "determination of the rightful owner of the annuity's remainder proceeds turns on our interpretation of the Medicaid Act." Pet. App. 4a. The court then held that the Medicaid Act required the annuity to name the Commonwealth as the first remainder beneficiary in order to avoid the transfer penalty. Pet. App. 11a-14a. It reached that conclusion based on an analysis of the purpose of the Medicaid Act, the general intent of the DRA's amendment, and the practical effects of a contrary ruling. *See id.* at 12a-14a.

The Supreme Judicial Court first observed that one of the purposes of the "aptly named *Deficit Reduction* Act was to close loopholes in the Medicaid Act that allowed affluent couples to shelter their assets." Pet. App. 12a. And it explained that Section 1396p(c)(1)(F)(i), the provision added by the DRA requiring the State to be named as an annuity beneficiary, did not itself contain a "carve-out for those annuities purchased for the sole benefit of the community spouse," and the court "decline[d] to add one." *Id.* at 12a-13a.

The Supreme Judicial Court noted the Sixth Circuit's contrary conclusion in *Hughes v. McCarthy*, 734 F.3d 473 (2013), that "the sole benefit provision [*i.e.*,

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[5] The Supreme Judicial Court agreed to hear the case on direct appeal, bypassing the Commonwealth's intermediate appellate court. *See* Mass. R. App. P. 11.

Section 1396p(c)(2)(B)(i)] 'carves out an exception to paragraph (1)'s transfer penalties.'" Pet. App. 13a (quoting *Hughes*, 734 F.3d at 485). But the court rejected this reading of the two provisions on the basis that it would "frustrate[] the purpose of § 1396p(c)(1)(F)(i)." *Id.* at 13a n.18. On the Sixth Circuit's reading, the court explained, "the sole-benefit loophole would remain open, frustrating not only the purpose of the beneficiary naming provision (added by the DRA), but also one of the central goals of the Medicaid program, which is to provide health care to those who cannot afford it." *Id.* at 13a-14a. The court therefore concluded that "subsections (c)(1)(F)(i) and (c)(2)(B)(i) both must apply to ensure that an annuity purchased does not become a vehicle for sheltering assets that otherwise properly would be used to pay for medical care." *Id.* at 14a.

Having resolved the disputed interpretation of the Medicaid statutes, the Supreme Judicial Court held that the Commonwealth was entitled to the funds remaining on Robert Hamel's annuity. Pet. App. 15a; *see id.* at 15a-18a. The court explained that because the Medicaid Act required the Commonwealth to be named as the first remainder beneficiary to the extent it had paid benefits on behalf of Joan, the annuity must be interpreted as giving the Commonwealth this rightful benefit. *Id.* at 16a-17a. The court further noted that even if the annuity had not named the Commonwealth as a beneficiary, the Commonwealth would still be entitled to the funds pursuant to the transfer penalty because the annuity would be noncompliant with Section 1396p(c)(1)(F)(i)'s requirement. *Id.* at 17a n.22.

Finally, the Supreme Judicial Court rejected the argument that a Massachusetts statute would bar the Commonwealth from recovering the remainder of the annuity. Pet. App. 17a-18a. That statute, which governs the Commonwealth's ability to recoup Medicaid benefits, provides that "[t]here shall be no adjustments or recovery of medical assistance correctly paid except" under specified conditions—all of which involve recovery from the estate of an *institutionalized* individual, not her spouse. Mass. Gen. Laws ch. 118E, § 31(b). The court explained that to the extent Commonwealth law would preclude it from recovering, that law would be preempted by the federal Medicaid Act. Pet. App. 17a-18a.

2. In an unsigned opinion issued the same day as its opinion in *Dermody*, the Supreme Judicial Court of Massachusetts[6] held that disposition of the remaining funds from the Mondor and Castle annuities was "governed in all material respects by our decision" in *Dermody*. Pet. App. 26a; *see id.* at 19a-27a.

The Supreme Judicial Court explained that "[i]n *Dermody*, we concluded that . . . in order to avoid a determination of ineligibility or the imposition of a disqualifying transfer penalty under 42 U.S.C. § 1396p(c)

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[6] The trial court reported the cases involving the Mondor and Castle annuities for appellate determination without issuing a judgment. *See* Mass. R. Civ. P. 64; Mass. R. App. P. 5. As in *Dermody*, the Supreme Judicial Court agreed to exercise direct appellate review and consolidated the two cases. *See* Mass. R. App. P. 11.

with respect to annuity transactions . . . , any annuity purchased by a community spouse for Medicaid planning purposes in order to achieve the Medicaid eligibility of an institutionalized spouse and designated for the 'sole benefit' of the community spouse under § 1396p(c)(2) must also satisfy the beneficiary naming requirement of § 1396p(c)(1)(F)(i)." Pet. App. 26a. The court also noted its "conclu[sion] in *Dermody* that to the extent that the State Medicaid estate recovery statute . . . would prevent the Commonwealth from collecting annuity proceeds it is designated to receive as the primary remainder beneficiary, the State statute is preempted by the Medicaid Act." *Id.*

The Supreme Judicial Court therefore concluded, as it had in *Dermody*, that "the relevant 'institutionalized individual[s]' for purposes of § 1396p(c)(1)(F)(i) are the individuals whose eligibility for Medicaid long-term benefits was made possible by the purchase of the annuities and whose eligibility for Medicaid long-term care benefits turned on the proper disclosure and treatment of the annuities in accordance with the Medicaid Act." Pet. App. 26a-27a (alteration in original) (quoting 42 U.S.C. § 1396p(c)(1)(F)(i)). Thus, the Commonwealth was entitled to the funds remaining on both annuities. *Id.* at 27a.

REASONS FOR GRANTING THE PETITION

In determining that an annuity that complies with 42 U.S.C. § 1396p(c)(2)(B)(i) must nevertheless name the State as the first remainder beneficiary under Section 1396p(c)(1)(F)(i) to avoid the Medicaid Act's transfer penalty, the Supreme Judicial Court of Massachusetts expressly rejected the contrary view of the Sixth

Circuit in *Hughes v. McCarthy*, 734 F.3d 473 (2013). Unlike the Sixth Circuit, which interpreted the two provisions according to their plain and unambiguous text, the Supreme Judicial Court relied on statutory titles and purpose to reach a flatly atextual reading of the Act.

In so doing, the Supreme Judicial Court deepened an existing split of authority—its judgments align with the position taken by the Ninth Circuit, which has also staked out a position irreconcilable with the Sixth Circuit's. And the question on which the court erred has deep importance to elderly individuals, the estate planners who advise them, state Medicaid agencies, and state legislatures making budget determinations. The judgments below are incorrect, and these cases present ideal vehicles for resolving the question presented.

This Court should grant the petition.

I. THE DECISIONS BELOW DEEPENED A SPLIT OF AUTHORITY.

A. The Supreme Judicial Court Expressly Rejected the Position of the Sixth Circuit.

In *Hughes*, *supra*, the Sixth Circuit held that an annuity satisfying Section 1396p(c)(2)(B)(i) is not subject to the transfer penalty even if it fails to name the State as the first remainder beneficiary. 734 F.3d at 483-86. That holding is in square conflict with the decisions below.

1. Like these cases, *Hughes* involved an annuity purchased by a community spouse in order to help an institutionalized spouse become eligible for Medicaid.

734 F.3d at 477. The Ohio state agency treated the transfer as improper for failure to name the State as the first remainder beneficiary, and accordingly determined that the institutionalized spouse was ineligible for "the number of months that the difference between [the community spouse's] CSRA and the annuity would have paid for nursing home costs." *Id.* Among other arguments made in support of its determination, the state agency posited that "the transfer of a community resource to purchase an annuity by or on behalf of the community spouse that satisfies § 1396p(c)(2)(B)(i)'s sole-benefit rule must also satisfy the annuity rules under § 1396p(c)(1)(F)." *Id.* at 483; *see id.* at 479-86.

The Sixth Circuit rejected the state agency's argument, holding that "its reading of the two provisions defies the text and structure of the statute." *Hughes*, 734 F.3d at 484; *see id.* at 483-86. Instead, the court of appeals held that "an annuity that satisfies § 1396p(c)(2)(B)(i) need not satisfy § 1396p(c)(1)(F)." *Id.* at 484. The court relied on a textual analysis of the two provisions, explaining that by its plain text and clear structure, Section 1396p(c) "places § 1396p(c)(1)(F) within paragraph (1)'s transfer-penalty framework and specifically sets forth § 1396p(c)(2)(B)(i)'s sole-benefit rule as an exception to paragraph (1)." *Id.* at 485.

The Sixth Circuit was also unpersuaded by the state agency's invocation of "floor statements by members of Congress" that "indicat[ed] in general terms that the DRA was enacted to close loopholes related to the purchase of annuities." *Hughes*, 734 F.3d at 486. The court did not agree that those floor statements "reveal[ed] Congressional intent to subject § 1396p(c)(2)(B)(i) to

§ 1396p(c)(1)(F)'s annuity rules," *id.* at 486 n.16, and explained that it would not matter anyway because the statutory language is "unambiguous[]," *id.* at 486. The court further observed that the DRA did not amend Section 1396p(c)(2)(B)(i) and that "[i]f Congress prefers the interpretation that applies § 1396p(c)(1)(F) notwithstanding § 1396p(c)(2)(B)(i), it need only amend the statute." *Id.*

The Department of Health and Human Services (HHS) took a contrary position in an *amicus* brief filed in *Hughes*. *See* 734 F.3d at 484-85. The Sixth Circuit rejected HHS's view, observing that HHS presented it "without any reference to the statutory text, meaningful analysis, or reference to authority." *Id.* at 484. Instead, HHS relied solely on an informal "letter enclosure" asserting that Section 1396p(c)(1)(F) applies to annuities purchased by the community spouse without any analysis of Section 1396p(c)(2)(B)(i). *Id.* at 484-85; *see* Ctr. for Medicaid & State Operations, Ctrs. for Medicare & Medicaid Servs., Enclosure, Sections 6011 and 6016: New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005, at 13-14 (2006), https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/toaenclosure.pdf. Finding that "HHS's rationale lacks reasoning and contravenes the plain language of [both provisions]," the court declined to afford the agency's view even mild deference under *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). *Hughes*, 734 F.3d at 485.

2. The Supreme Judicial Court could not have made clearer that its interpretation of Section 1396p(c) was contrary to the Sixth Circuit's holding in *Hughes*.

The court observed that Ms. Dermody "rel[ied] heavily on the reasoning of the Sixth Circuit in *Hughes*," Pet. App. 11a; it cited *Hughes* repeatedly, *see id.* at 11a-13a; and it expressly "reject[ed] [*Hughes*'s] interpretation" as "frustrat[ing] the purpose of § 1396p(c)(1)(F)(i)," *id.* at 13a n.18.

Indeed, the conflict between *Hughes* and the decision below is plain. *Hughes* relied on the text and structure of Section 1396p(c) to hold that an annuity satisfying the sole-benefit rule in Subparagraph (c)(2)(B)(i) need not comply with Subparagraph (c)(1)(F)(i)'s rule that annuities are subject to a transfer penalty if they do not name the State as the first remainder beneficiary to the extent it has paid for benefits on behalf of the institutionalized spouse. 734 F.3d at 483-86. The decisions below, relying on the DRA's purpose to close purported "loopholes" in the Medicaid statutes, rejected that plain-text interpretation and instead concluded that in order to further Congressional purpose, both provisions must be applicable. Pet. App. 12a-14a, 26a-27a.

In short, the conclusions of the Supreme Judicial Court of Massachusetts and the Sixth Circuit are in binary opposition.

B. The Ninth Circuit Has Reached the Same Conclusion as the Supreme Judicial Court.

In *Hutcherson v. Arizona Health Care Cost Containment System Administration*, 667 F.3d 1066 (2012), the Ninth Circuit confronted a set of facts materially identical to those in the cases below and, in accord with the Supreme Judicial Court, held that the State of Ari-

zona was "entitled to recover as the primary remainder beneficiary from [the community spouse's] annuity for the amount of medical costs it paid on behalf of [the institutionalized spouse]." *Id.* at 1071.

Like these cases, *Hutcherson* involved a husband who purchased an annuity with spousal assets so that his institutionalized wife would be eligible for Medicaid benefits. 667 F.3d at 1067. That annuity paid monthly benefits to the husband, *see id.*; in other words, it was for his "sole benefit," 42 U.S.C. § 1396p(c)(2)(B)(i). After the husband's death, the couple's daughter claimed that the State "had no right to recover from [the] annuity." *Hutcherson*, 667 F.3d at 1068. She pointed out that the amendment to Section 1396p(c)(1)(F)(i) that changed "on behalf of the annuitant" to "on behalf of the institutionalized individual" was labeled by Congress as a "technical correction." Medicare Improvements and Extension Act of 2006, Pub. L. No. 109-432, div. B, § 405(b)(1), 120 Stat. 2975, 2996, 2998 (amending 42 U.S.C. § 1396p(c)(1)(F)(i)); *see Hutcherson*, 667 F.3d at 1070. She argued that "the 'technical' character of the amendment indicates that Congress was merely trying to 'clarify' the law and not to make substantive changes to the law," and that Congress thus intended that "'institutionalized individual' [be interpreted] to mean 'annuitant' despite the different meanings of those words." *Hutcherson*, 667 F.3d at 1070.

The Ninth Circuit disagreed, concluding that the amendment effected a substantive change to the statute. *Hutcherson*, 667 F.3d at 1070-71. The court of appeals therefore held that the State was "entitled to recover as the primary remainder beneficiary from [the]

annuity for the amount of medical costs it paid on behalf of [the institutionalized wife]." *Id.* at 1071. In other words, *Hutcherson* held that under the same circumstances present in the cases below, the State was entitled to recover as a remainder beneficiary even though the annuity was purchased "for the sole benefit of the [institutionalized] individual's spouse," 42 U.S.C. § 1396p(c)(2)(B)(i).[7]

Hutcherson did not expressly address the specific argument, asserted below and in *Hughes*, that the State was not required to be named as the first remainder beneficiary because the annuity, having satisfied Section 1396p(c)(2)(B)(i)'s sole-benefit rule, was exempt from Section 1396p(c)(1)(F)(i)'s transfer penalty. But having construed the statute in *Hutcherson*, *stare decisis* principles would bind the Ninth Circuit to the same conclusion as the one reached in the cases below, even if the individuals in a future case raised different arguments. That is why courts have treated *Hutcherson* as dispositive of the statutory dispute at issue here. *See, e.g.*, *Am. Nat'l Ins. Co. v. Breslouf*, No. 2084CV02374, 2021 WL 2343024, at *9 & n.7 (Mass. Super. Ct. Suffolk Cnty. June 3, 2021) (relying on *Hutcherson* "[a]lthough [it] did not discuss 42 U.S.C. § 1396p(c)(2)(B)(i)" and rejecting the argument that "because *Hutcherson* did not address the sole benefit exception of section 1396p(c)(2)(B)(i), it is not on point").

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[7] *Hutcherson* further held that the State could recover for continuing Medicaid benefits paid on behalf of the surviving wife even after her husband's death. *See* 667 F.3d at 1071-72.

II. THE QUESTION PRESENTED IS DEEPLY IMPORTANT AND SHOULD BE RESOLVED IN THESE CASES.

This Court should grant certiorari and resolve the conflict of authority. The proper interpretation of the Medicaid Act provisions at issue here is extraordinarily important to elderly couples planning for end-of-life care and for their estates. States, too, face uncertainty over how federal law will compel them to expend their budgets. These cases are ideal vehicles to resolve the split, and the Court should do so.

1. To begin, this Court should grant review because the conflict of authority creates serious estate-planning challenges for a large number of individuals in the United States. Over one-quarter of those in this country who reach age 57 will spend 100 or more days in a skilled-nursing facility at some point in the future.[8] And it is typical that institutionalized elderly individuals will rely on public funding to pay for this care: the average annual cost for skilled-nursing care is roughly $100,000, and Medicare does not cover long-term stays. *See* 42 C.F.R. § 409.61(b).[9]

In determining how to finance this care, married couples must make important decisions about whether

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[8] *See* Michael D. Hurd et al., *Distribution of Lifetime Nursing Home Use and of Out-of-Pocket Spending*, 114 Proc. Nat'l Acad. Scis. 9838, 9839 (2017).

[9] *See also* Genworth Fin., Inc., Genworth Cost of Care Survey: Median Cost Data Tables 1 (2022), https://pro.genworth.com/riiproweb/productinfo/pdf/282102.pdf.

to use their own assets or to rearrange those assets according to the prescriptions of federal law so that the institutionalized spouse will be eligible for Medicaid benefits. A popular—and perfectly lawful—strategy is for spousal assets to be converted to an annuity that pays monthly income to the community spouse. To decide whether this strategy is appropriate, it is imperative that couples understand what will happen with the annuity's remainder in the event the community spouse dies earlier than is actuarially expected.

2. The conflict of authority also hinders the States. Medicaid spending accounts for 27% of state budgets, and long-term skilled-nursing care represents a significant portion of state Medicaid expenditures.[10] In planning their budgets, States need and deserve clarity as to the circumstances under which they will be entitled to reimbursement for benefits provided.

Even before the Supreme Judicial Court issued its ruling, state agencies reached divergent conclusions on the interpretive question presented here. For example, Michigan has taken the position (following *Hughes*) that annuities purchased for the sole benefit of the community spouse need not name the State as a remainder beneficiary. Mich. Dep't of Health & Hum. Servs., BPB

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[10] *See* Ctrs. for Medicare & Medicaid Servs., *Medicaid Long Term Services and Supports Annual Expenditures Report: Federal Fiscal Year 2019*, at 7, 10, 29 (2021); *How Do States Pay for Medicaid?*, Peter G. Peterson Found. (Apr. 26, 2022), https://www.pgpf.org/budget-basics/budget-explainer-how-do-states-pay-for-medicaid.

2015-007, BEM 401 Annuity Policy Bulletin 1 (effective May 1, 2015), https://dhhs.michigan.gov/olmweb/exf/BP/Public/BPB/2015-007.pdf. Arkansas (without binding state or circuit precedent) initially followed suit, but then sowed confusion by issuing inconsistent guidance the next year.[11]

Other States offer contradictory guidance in an attempt to simply reproduce the statutory text. For instance, regulations in Pennsylvania (also without state or circuit precedent) treat annuities "as a transfer of assets for less than [fair market value]" if they do not name the Commonwealth as the first beneficiary, 55 Pa. Code § 178.104a(h), but then also state without clarification that "[a]n individual will not be ineligible for nursing facility services if" the assets at issue "were transferred to . . . another for the sole benefit of the individual's spouse from the individual's spouse," *id.* § 178.174(e).[12]

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[11] *Compare* Memorandum from Rich Rosen, Att'y, Off. of Chief Counsel, Ark. Dep't of Hum. Servs., LTC: CS Annuity—Deeds—Sale of Business Property 2 (Sept. 29, 2015), https://www.medicaidannuity.com/wp-content/uploads/2015/10/AR_memo.pdf, *with* Memorandum from Off. of Chief Counsel, Ark. Dep't of Hum. Servs., LTSS LTC Applicant with a Spouse with an Annuity 2-3, 3 n.2 (May 10, 2016), https://www.medicaidannuity.com/wp-content/uploads/2016/05/OCC-Opinion-Letter-for-CS-Annuity-State-not-a-Beneficiary.pdf.

[12] Indeed, Massachusetts itself appears to have taken its current view only in about 2016, roughly a decade after the DRA's enactment. Before that time, EOHHS advised informally that annuities like those at issue in these cases need not name

In short, States do not know what to do when a community spouse purchases an annuity and then dies earlier than expected. The Supreme Judicial Court's decision will only exacerbate that confusion.

3. The issue in this case recurs frequently. In its brief before the Supreme Judicial Court, the Commonwealth listed twenty-two cases in the Massachusetts trial courts involving disputes over ownership of annuity remainders—among them, *twenty* filed in 2020 and 2021 alone. *See* EEOHS Sup. Jud. Ct. Br. addendum at 140-44 (Nov. 8, 2021).

The fact that there are only three cases from federal courts of appeals or state supreme courts reflects an unfortunate reality of Medicaid litigation: litigants often run out of money. When an annuitant fails to name the State as the first remainder beneficiary (because he believes he is not required to do so under Section 1396p(c)(2)(B)(i)'s sole-benefit rule) and the State disagrees, the effect of the disagreement is that the State will deem the institutionalized spouse ineligible for Medicaid benefits for a period of time, pursuant to the transfer penalty's formula. The community spouse—who has just transferred the bulk of spousal assets into the annuity and whose spouse is ill to the point of needing institutionalization—will rarely have the wherewithal or the appetite to litigate that issue against the State.

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the Commonwealth as a remainder beneficiary. *See* Mondor-Bristow Sup. Jud. Ct. Br. 47-50 (Dec. 20, 2021).

Further, when a community spouse complies with the State's official policy that it will apply the transfer penalty (and deny Medicaid benefits) for annuity purchases that do not name the State as the first remainder beneficiary, there is nothing left to fight about if the community spouse dies earlier than expected and money is actually handed over to the State. At that point, the State is entitled to the money no matter what because it *was* named as the first remainder beneficiary—even if it did not *have to be* so named.

These cases, however, properly present an opportunity to resolve the question. The annuities themselves are not clear on whether Massachusetts is entitled to the remaining funds; as the Massachusetts courts all agreed, the Commonwealth's entitlement therefore turns on the appropriate interpretation of the Medicaid Act. This Court should take advantage of the clean posture in which the question arises here and grant certiorari in these cases.

4. Nor is additional percolation needed. In recent years, this Court has stepped in to resolve splits of authority on the proper interpretation of the Medicare and Medicaid laws without awaiting a lengthy percolation among lower courts. *See, e.g.*, *Becerra v. Empire Health Found. ex rel. Valley Hosp. Med. Ctr.*, 142 S. Ct. 2354, 2361 (2022) (conflict among three circuits); *Marietta Mem'l Hosp. Emp. Health Benefit Plan v. DaVita Inc.*, 142 S. Ct. 1968, 1972-73 (2022) (conflict between two circuits, both of which issued their decisions in 2020); *Gallardo ex rel. Vassallo v. Marstiller*, 142 S. Ct. 1751, 1757 (2022) (conflict between one federal court of appeals and one state high court); *Wos v.*

E.M.A. ex rel. Johnson, 568 U.S. 627, 632 (2013) (same). The Court should follow the same path here. The Sixth Circuit and the Supreme Judicial Court of Massachusetts have issued detailed opinions on both sides of the question presented, and additional decisions are unlikely to illuminate the legal issues any further.

5. These cases are ideal vehicles for resolving the split of authority on the proper interpretation of the Medicaid Act.

The Supreme Judicial Court cleanly resolved the federal issue in these cases, and its resolution of that federal issue was dispositive. At the outset of its discussion, the court framed the threshold question as one of federal law: "whether certain provisions of the Medicaid Act bearing on the application of asset transfer penalties are meant to operate together or separately." Pet. App. 5a. Only after resolving that threshold issue would the court analyze "the contract terms in light of our interpretation of those provisions." *Id.*

Consistent with that framing, the Supreme Judicial Court began its "[a]nalysis" by interpreting the Medicaid Act in the manner advocated by the Commonwealth. Pet. App. 11a; *see id.* at 11a-15a. After its ruling on federal law, the court then addressed the "plaintiff's additional arguments, grounded in State law," *id.* at 15a, and found that its resolution of the federal question dictated the outcome of the plaintiff's state-law claims. In particular, Ms. Dermody argued that regardless of the proper interpretation of the Medicaid Act, the correct construction of the annuity was that the Commonwealth was named as a beneficiary only to the extent it had paid benefits on behalf of Robert (*i.e.*, $0).

Id. at 15a-16a. The Superior Court had agreed with Ms. Dermody's analysis as a matter of state contract law, *see id.* at 45a, but the Supreme Judicial Court reversed that determination, finding that the Medicaid Act required construing the annuity in a manner favorable to the Commonwealth, *see id.* at 15a-17a. Indeed, because the Medicaid Act *required* the Commonwealth to be the first remainder beneficiary to the extent it had paid benefits on Joan's behalf, the Supreme Judicial Court explained that it would have reached the same result even had the annuity not named the Commonwealth as a remainder beneficiary at all. *Id.* at 17a n.22.

Ms. Dermody separately argued that a Commonwealth statute would bar its recovery from Robert's estate. Pet. App. 17a (citing Mass. Gen. Laws ch. 118E, § 31(b)(1)). But the Supreme Judicial Court rejected that argument on the basis that the Commonwealth statute would be preempted by federal law to the extent it barred recovery where federal law explicitly authorized it. *Id.* at 17a-18a. This reasoning again underscores that the court's interpretation of federal law dictated the outcome of these cases. These cases are therefore an ideal vehicle to determine whether that interpretation is correct.

III. THE DECISIONS BELOW ARE WRONG.

The Medicaid laws have been described as "among the most completely impenetrable texts within human experience," *Rehab. Ass'n of Va. v. Kozlowski*, 42 F.3d 1444, 1450 (4th Cir. 1994), but the question presented in these cases is not difficult. One of the two provisions at issue sets out a general rule about the circumstances in which the purchase of an annuity is considered an asset

transfer that triggers the transfer penalty. The other provision states clearly, however, that the transfer penalty does not apply when assets are transferred for the sole benefit of the community spouse. These cases each involve just such a transfer, so the penalty is plainly inapplicable.

A. The provisions at issue appear in 42 U.S.C. § 1396p(c), which is captioned "[t]aking into account certain transfers of assets." Paragraph (1) of that subsection governs the circumstances in which an institutionalized individual will be ineligible for Medicaid benefits if either she "or the spouse of such an individual . . . disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i)." *Id.* § 1396p(c)(1)(A). The next several subparagraphs discuss the length of the look-back period, *id.* § 1396p(c)(1)(B); the extent of Medicaid ineligibility as a result of covered transfers, *id.* § 1396p(c)(1)(E); and other technical details, *id.* § 1396p(c)(1)(C)-(D). Then, Subparagraph (c)(1)(F) provides (in relevant part):

> For purposes of this paragraph [*i.e.*, Section 1396p(c)(1)], the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—
>
> > (i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter . . . .

Id. § 1396p(c)(1)(F).

Thus, Section 1396p(c)(1)(F)(i) sets forth a general rule. A transfer of assets for less than fair market value during the look-back period can lead to a corresponding period of Medicaid ineligibility. The purchase of an annuity counts as such a disqualifying transfer unless the State is listed as the first remainder beneficiary (to the extent the State has paid Medicaid benefits on behalf of the institutionalized individual).

Paragraph (2) of Section 1396p(c) carves out an exception to the ineligibility rule set forth in Paragraph (1). It states (in relevant part):

> An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—
>
> . . . .
>
> (B) the assets—
>
> (i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse . . . .

42 U.S.C. § 1396p(c)(2).

Section 1396p(c)(2) is not an annuity-specific rule; it governs *all* asset transfers. It provides in clear terms that Paragraph (1) does not penalize asset transfers for less than fair market value (such as property sales or the purchases of annuities) when the transfer is solely to benefit the Medicaid recipient's spouse.[13]

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[13] As HHS agrees, an annuity whose remainder reverts to another only after the death of the annuitant is "for the sole bene-

The applicability of the two provisions to the annuities at issue in these cases is straightforward. Take the *Dermody* annuity. Section 1396p(c)(1)(F)(i), standing alone, would deem Robert Hamel's purchase of the annuity an asset transfer for less than fair market value—and therefore make Joan ineligible for Medicaid benefits for a corresponding period—unless the annuity named the Commonwealth as the first remainder beneficiary to the extent it had paid benefits on Joan's behalf. But because the annuity was for the "sole benefit of" Robert, it was exempt from the transfer penalty under Section 1396p(c)(2)(B)(i), which makes the penalty provisions of Section 1396p(c)(1) inapplicable in the case of such asset transfers. Robert thus had no obligation to name the State as the first remainder beneficiary.

B. The Supreme Judicial Court reached the contrary conclusion only by ignoring the statutory text and choosing instead the interpretation that would best effectuate what it believed was Congress's "intent." Pet. App. 14a. The court *started* its analysis by relying on the DRA's title—explaining that "one purpose of the

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fit" of the annuitant within the meaning of Section 1396p(c)(1)(F). *See Hughes*, 734 F.3d at 481-83; *see also* Brief for the United States Department of Health & Human Services as *Amicus Curiae* at 14-16, *Hughes*, 734 F.3d 473 (No. 12-3765), 2013 WL 3366469. Accordingly, the annuities at issue in these cases were each "for the sole benefit" of the respective community spouses, even though they named others (the Commonwealth and the respective couples' children) as remainder beneficiaries.

aptly named *Deficit Reduction* Act was to close loopholes in the Medicaid Act that allowed affluent couples to shelter their assets." *Id.* at 12a. And it found that if an annuity did not need to name the State as a remainder beneficiary, "the sole-benefit loophole would remain open, frustrating . . . the [perceived] purpose of the beneficiary naming provision" and "one of the central goals of the Medicaid program, which is to provide health care to those who cannot afford it." *Id.* at 13a-14a.

That is no way to interpret statutes. "In statutory interpretation disputes, a court's proper starting point lies in a careful examination of the ordinary meaning and structure of the law itself." *Food Mktg. Inst. v. Argus Leader Media*, 139 S. Ct. 2356, 2364 (2019). And the "inquiry should end" there as well where, as here, "the statute's language is plain." *Puerto Rico v. Franklin Cal. Tax-Free Tr.*, 579 U.S. 115, 125 (2016) (quoting *United States v. Ron Pair Enters.*, 489 U.S. 235, 241 (1989)).

Accordingly, the Supreme Judicial Court's concerns about wealthy individuals evading limitations on Medicaid eligibility should have played no role in the analysis; such "practical considerations are meritless and do not justify departing from the statute's clear text." *Pereira v. Sessions*, 138 S. Ct. 2105, 2118 (2018). As this Court has explained, a court's role "is to apply the statute as it is written—even if [it] think[s] some other approach might "'accor[d] with good policy.'"" *Burrage v. United States*, 571 U.S. 204, 218 (2014) (final alteration in original) (quoting *Comm'r v. Lundy*, 516 U.S. 235, 252 (1996)).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

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APPENDIX A

SJC-13199

LAURIE A. DERMODY vs. EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES.

Middlesex. February 2, 2022. – January 27, 2023.

Present: Budd, C.J., Gaziano, Lowy, Cypher, Kafker, Wendlandt, & Georges, JJ.

Medicaid. MassHealth. Annuity. Contract, Construction of contract. Federal Preemption. Statute, Construction, Federal preemption.

Civil action commenced in the Superior Court Department on August 4, 2017.

The case was heard by C. William Barrett, J., on motions for summary judgment.

The Supreme Judicial Court granted an application for direct appellate review.

Jesse M. Boodoo, Assistant Attorney General, for the defendant.

Lisa M. Neeley for the plaintiff.

Patricia Keane Martin, Clarence D. Richardson, Jr., & C. Alex Hahn, for Massachusetts Chapter of the National Academy of Elder Law Attorneys, amicus curiae, submitted a brief.

BUDD, C.J. Robert G. Hamel purchased an annuity issued by Nationwide Life Insurance Company (Nationwide) to help his wife, Joan Hamel,[1] become eligible for Medicaid benefits to pay for her long-term care. Robert named the Commonwealth as the primary remainder beneficiary to the "extent benefits paid," and the plaintiff, his daughter Laurie A. Dermody, as the contingent remainder beneficiary. When Robert died before the end of the annuity period, the plaintiff brought suit against the Executive Office of Health and Human Services (Commonwealth) and Nationwide contending that she, rather than the Commonwealth, was entitled to the remainder of the annuity. A Superior Court judge agreed with the plaintiff. For the reasons that follow, we reverse.[2]

Facts and prior proceedings. We recite the undisputed facts, reserving some details for later discussion.

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[1] As they share a surname, we refer to Joan and Robert Hamel by their given names.

[2] We acknowledge the amicus brief of the Massachusetts Chapter of the National Academy of Elder Law Attorneys.

In May 2015, Joan was admitted to a skilled nursing facility for long-term care. The following month, Robert used spousal resources to purchase an annuity contract (annuity) from Nationwide. Robert paid a single premium of $172,000 for the annuity, which provided for a monthly payment to him of $2,873.69 for a five-year term.[3] It is undisputed that the purchase of the annuity was intended to help Joan become eligible for long-term care benefits pursuant to the Medicaid Act and MassHealth regulations. In the application for the annuity, Robert listed "Commonwealth of MA the Extent Benefits Paid [sic]" as the primary remainder beneficiary and the plaintiff as the contingent remainder beneficiary.[4]

In July 2015, Joan submitted an application for MassHealth long-term care benefits, which was approved in December of that same year. Robert, who never applied for or received MassHealth benefits on his own behalf, died in December 2016. In June 2017, MassHealth informed Nationwide that it was making a claim on the annuity up to the total amount of medical

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[3] The parties do not dispute that the annuity Robert purchased was sound actuarially, meaning it was intended to be paid out in full to Robert during his lifetime according to his life expectancy. See Normand v. Director of the Office of Medicaid, 77 Mass. App. Ct. 634, 637 (2010).

[4] The annuity itself states that the primary remainder beneficiary is "State of MA Medicaid Per Application" and the contingent beneficiary is the plaintiff.

assistance paid on behalf of Joan, which at that time totaled $135,511.99.[5] In July 2017, Nationwide paid $118,517.50 to the Commonwealth, which was the full remaining value of the annuity proceeds.

In August 2017, the plaintiff brought a declaratory judgment action against the Commonwealth and Nationwide, claiming that she was entitled to the remaining proceeds in the annuity rather than the Commonwealth. After the Commonwealth's motion to dismiss was denied, all parties filed cross motions for summary judgment. A Superior Court judge subsequently granted summary judgment for the plaintiff and ordered the Commonwealth to turn over to the plaintiff the remaining annuity proceeds it received from Nationwide.[6] The Commonwealth unsuccessfully sought an interlocutory appeal pursuant to Mass. R. Civ. P. 64, as amended, 423 Mass. 1410 (1996). After final judgment entered, the Commonwealth filed a timely notice of appeal, and we allowed the plaintiff's application for direct appellate review.

Discussion. Our determination of the rightful owner of the annuity's remainder proceeds turns on our interpretation of the Medicaid Act, as well as the annuity

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[5] The Commonwealth represented in November 2021 that Joan continued to receive MassHealth benefits at a rate of over $5,000 per month. As of September 30, 2021, MassHealth had paid a total of $439,100.04 in benefits on Joan's behalf.

[6] The judge further permitted the plaintiff's claim against Nationwide under G. L. cc. 93A and 176D to proceed to trial. Nationwide subsequently settled the claims against it and dismissed its cross claims against the Commonwealth.

contract. More specifically, first we must decide whether certain provisions of the Medicaid Act bearing on the application of asset transfer penalties are meant to operate together or separately, and then we must view the contract terms in light of our interpretation of those provisions.

1. Medicaid program. a. Overview. The Medicaid Act, passed by Congress in 1965, "created a cooperative State and Federal program to provide medical assistance to individuals who cannot afford to pay for their own medical costs." Daley v. Secretary of the Executive Office of Health & Human Servs., 477 Mass. 188, 189 (2017). See Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq.

A State choosing to participate in the Medicaid program "develops a plan containing reasonable standards . . . for determining eligibility for and the extent of medical assistance within boundaries set by the Medicaid statute and the Secretary of Health and Human Services" (quotation and citation omitted). Wisconsin Dep't of Health & Family Servs. v. Blumer, 534 U.S. 473, 479 (2002). All participating States "must comply with certain requirements imposed by [Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq.,] and regulations promulgated by the Secretary through [the Centers for Medicare and Medicaid Services]." Daley, 477 Mass. at 190, citing Wilder v. Virginia Hosp. Ass'n, 496 U.S. 498, 502 (1990). Massachusetts participates in Medicaid through MassHealth, which is administered through the Executive Office of Health and Human Services (EOHHS). See G. L. c. 118E, § 9.

The provisions comprising the Medicaid Act have been described as "among the most completely impenetrable texts within human experience." Briggs v. Commonwealth, 429 Mass. 241, 243 n.3 (1999), quoting Rehabilitation Ass'n of Va., Inc. v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994), cert. denied sub nom. Metcalf v. Rehabilitation Ass'n of Va., Inc., 516 U.S. 811 (1995). This is due to the fact that they are "dense reading," but also because "Congress . . . revisits the area frequently, generously cutting and pruning in the process." Briggs, supra. In many cases, Congress has made changes to the Medicaid Act in response to "Medicaid planning" by "individuals with 'significant resources [who] devise strategies to appear impoverished in order to qualify for Medicaid benefits.'"[7] Fournier v. Secretary of the Executive Office of Health & Human Servs., 488 Mass. 43, 45 (2021), quoting Lebow v. Commissioner of the Div. of Med. Assistance, 433 Mass. 171, 172 (2001). That is, the amendments have been attempts to ensure that Medicaid benefits go to those who need them rather than to those who can afford to pay. The Medicare Catastrophic Coverage Act of 1988 (MCCA), 42 U.S.C. § 1396r-5, is one such example.

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[7] We do not suggest that Medicaid planning is discouraged; however, because the process is open to abuse, Congress closely monitors and regulates its use. See Morris v. Oklahoma Dep't of Human Servs., 685 F.3d 925, 934 (10th Cir. 2012) ("Indeed, rather than close the annuity 'loophole,' Congress has twice amended the Medicaid statutes to specify the types of annuities capable of producing uncountable spousal income" [citation omitted]).

Prior to the passage of the MCCA, "[S]tates generally considered income from either spouse and jointly-held assets in determining the Medicaid eligibility for the institutionalized spouse, but did not consider assets held solely in the name of the community spouse."[8] Hutcherson v. Arizona Health Care Cost Containment Sys. Admin., 667 F.3d 1066, 1068 (9th Cir. 2012). "As a result, some community spouses were left destitute so that the institutionalized spouse could qualify for Medicaid assistance, while some wealthy couples were able to qualify for assistance by holding their assets solely in the name of the community spouse." Id.

With the passage of the MCCA, "Congress sought to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance" (citation omitted). Blumer, 534 U.S. at 480. The MCCA amended the Medicaid Act to allow the community spouse to retain a certain amount of income and assets for monthly maintenance needs (community spouse resource allowance [CSRA]).[9] 42 U.S.C. § 1396r-5(c), (f). See 130 Code Mass. Regs.

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[8] The term "institutionalized spouse" means "an individual who . . . is in a medical institution or nursing facility . . . [and] is married to a spouse who is not in a medical institution or nursing facility." 42 U.S.C. § 1396r-5(h)(1). The term "community spouse" means "the spouse of an institutionalized spouse." 42 U.S.C. § 1396r-5(h)(2).

[9] As of January 1, 2023, the standard maximum CSRA amount is $148,620. See Eligibility Figures for Residents of a Long-Term-Care Facility, https://www.mass.gov/doc/eligibility-figures-for-residents-of-a-long-term-care-facility-2/download [https://perma.cc/LY22-BWJQ].

§ 520.016(B)(2) (2013). "[A]ll resources above the CSRA . . . must be spent before eligibility can be achieved." Blumer, supra at 483, citing 42 U.S.C. § 1396r-5(c)(2).

The MCCA also amended the Medicaid rules so that in determining eligibility, a couple's combined assets are considered available to the applicant regardless of specific ownership.[10] See Morris v. Oklahoma Dep't of Human Servs., 685 F.3d 925, 929 (10th Cir. 2012), citing 42 U.S.C. § 1396r-5(c)(2)(A). See also 130 Code Mass. Regs. § 520.003(A)(2) (2019). Moreover, the MCCA added a provision generally penalizing asset transfers for less than fair market value during a particular period of time prior to an applicant's initial eligibility determination ("look-back" period).[11] See 42 U.S.C. § 1396p(c)(1).[12] This transfer penalty renders the applicant ineligible for

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[10] A married applicant is eligible for long-term care benefits through MassHealth if, after subtracting the community spouse resource allowance, he or she has $3,000 or less in combined "countable assets." 130 Code Mass. Regs. § 520.003(A)(2) (2019).

[11] The look back period initially was three years but was extended to five years by the Deficit Reduction Act of 2005. See note 15, infra.

[12] Title 42 U.S.C. § 1396p(c)(1)(A) states in pertinent part:

> "[I]f an institutionalized individual or the spouse of such an individual . . . disposes of assets for less than fair market value on or after the look-back date . . . the individual is ineligible for medical assistance for services described in subparagraph (C)(i) . . . [for a calculable period of time]."

benefits for the period of time that the assets could have been used to pay for long-term care.[13]

We turn now to the two provisions at issue here, both of which affect the operation of the look-back rule -- the sole benefit provision (42 U.S.C. § 1396p[c][2][B][i]) and the beneficiary naming provision (42 U.S.C. § 1396p[c][1][F][i]).

b. Section 1396p(c)(2)(B)(i) and 1396p(c)(1) (F)(i). To provide an avenue for couples to spend down their assets to become Medicaid-eligible without becoming completely impoverished, Congress exempted from the look-back rule those transfers made for the "sole benefit" of the community spouse. 42 U.S.C. § 1396p(c)(2)(B)(i), as amended by the Omnibus Budget Reconciliation Act of 1993, Pub. L. No. 103-66, Title XIII, § 13611(a), 107 Stat. 622 (1993).[14] Such transfers traditionally have been accomplished through the purchase of an annuity for the benefit of the community spouse. See State Medicaid Manual § 3258.9. In this

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[13] "In its present form, the 'look-back' rule provides that, if such a transfer occurs, the applicant is ineligible for Medicaid benefits for a period of time determined by dividing the value of the transfer by the average monthly cost of the nursing home facility." Daley, 477 Mass. at 193, citing 42 U.S.C. § 1396p(c)(1)(E).

[14] Title 42 U.S.C. § 1396p(c)(2)(B)(i) provides in relevant part:

> "An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that . . . the assets . . . were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse."

way, assets that otherwise would be considered in determining an institutionalized spouse's eligibility for Medicaid are converted to an income stream for exclusive use by the community spouse, which is not counted for eligibility purposes. See Hutcherson, 667 F.3d at 1069. See also 42 U.S.C. § 1396r-5(b)(1), (c)(1).

However, the sole benefit provision made it theoretically possible for married couples to shelter an unlimited amount of assets by converting them to income for the community spouse without being subject to the transfer penalty, regardless of need. The widespread use of this "loophole" prompted Congress to make additional changes to the Medicaid Act. In 2005, Congress passed the Deficit Reduction Act of 2005 (DRA), which, among other things, strengthened the constraints on Medicaid planning. See Pub. L. No. 109-171, 120 Stat. 4, 61-67 (2006). See also Hughes v. McCarthy, 734 F.3d 473, 486 (6th Cir. 2013), cert. denied, 572 U.S. 1034 (2014) ("floor statements by members of Congress . . . indicating in general terms that the DRA was enacted to close loopholes" specifically "related to the purchase of annuities"); Hutcherson, 667 F.3d at 1069-1070, and cases cited (collecting sources discussing DRA's purpose "to further close loopholes in the Medicaid Act" by, in part, "add[ing] several requirements that must be met before an annuity is exempt from the transfer penalty").

The DRA imposed a number of requirements that annuities had to meet to be exempt from the transfer penalty. Among other things, "the annuity must (i) be irrevocable and nonassignable, (ii) be actuarially sound, and (iii) provide for payments in equal amounts with no deferral and no balloon payments." 42 U.S.C.

§ 1396p(c)(1)(G)(ii). See Hutcherson, 667 F.3d at 1069. As relevant here, the DRA also requires annuities to name the State as the primary remainder beneficiary on the death of the community spouse (beneficiary naming provision).[15] 42 U.S.C. § 1396p(c)(1)(F)(i).[16] Thus, if the community spouse survives for the term of the annuity, he or she receives all of the income from the annuity; however, if the community spouse dies before all of the annuity funds have been distributed, the Commonwealth is entitled to any remaining proceeds up to the amount it paid for benefits on behalf of the institutionalized spouse (who achieved Medicaid eligibility in part or in toto by way of the purchased annuity).

c. Analysis. Relying heavily on the reasoning of the United States Court of Appeals for the Sixth Circuit in Hughes, 734 F.3d at 485-486, the plaintiff contends that an annuity that satisfies the sole benefit rule in § 1396p(c)(2)(B)(i) need not also satisfy the beneficiary naming requirement in § 1396p(c)(1)(F)(i). She reasons that the language "[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1)" in

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[15] The DRA also requires applicants to disclose any interest in "community spouse annuities," and extended the "look-back" period from three to five years for transfers occurring after the DRA's effective date. 42 U.S.C. § 1396p(c)(1)(B)(i), (e).

[16] Title 42 U.S.C. § 1396p(c)(1)(F)(i) states in relevant part:

> "For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless . . . the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter."

§ 1396p(c)(2)(B)(i) means that asset transfers meeting the sole benefit rule are exempted from the whole of § 1396p(c)(1) (paragraph [1]), including the transfer penalty and the beneficiary naming exception to that penalty. See Hughes, supra at 485. We disagree.

When interpreting statutory provisions, we begin, as always, with the plain language, keeping in mind that the fundamental goal is to discern the intent of the law-making body. See Harvard Crimson, Inc. v. President & Fellows of Harvard College, 445 Mass. 745, 749 (2006), citing Hanlon v. Rollins, 286 Mass. 444, 447 (1934). See also Negonsott v. Samuels, 507 U.S. 99, 104 (1993), quoting Griffin v. Oceanic Contrs., Inc., 458 U.S. 564, 570 (1982) (ultimate task "is to give effect to the will of Congress"). Thus, "the words of a statute must be read in their context and with a view to their place in the overall statutory scheme." Davis v. Michigan Dep't of the Treasury, 489 U.S. 803, 809 (1989). See New England Power Generators Ass'n v. Department of Envtl. Protection, 480 Mass. 398, 410 (2018) ("The court does not determine the plain meaning of a statute in isolation but rather in consideration of the surrounding text, structure, and purpose of the . . . act . . ." [quotations and citation omitted]).

As explained supra, one purpose of the aptly named Deficit Reduction Act was to close loopholes in the Medicaid Act that allowed affluent couples to shelter their assets.[17] Notably, in spelling out the beneficiary naming requirement, the plain language of § 1396p(c)(1)(F)(i)

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[17] See Olmstead v. Department of Telecomms. & Cable, 466 Mass. 582, 589 & n.12 (2013) (title of act is relevant to statutory interpretation).

does not include a carve-out for those annuities purchased for the sole benefit of the community spouse, and we decline to add one. See Commonwealth v. Palmer, 464 Mass. 773, 778 (2013) ("[W]e will not add words to a statute that the Legislature did not put there, either by inadvertent omission or by design" [citation omitted]).

Moreover, we do not agree with the plaintiff that the sole benefit provision "carves out an exception to paragraph (1)'s transfer penalties."[18] Hughes, 734 F.3d at 485. Instead, we read § 1396p(c)(2)(B)(i) as being applicable to asset transfers generally, whereas § 1396p(c)(1)(F)(i) applies only to annuity purchases.

If we were to adopt the plaintiff's interpretation of these provisions, the sole-benefit loophole would remain open, frustrating not only the purpose of the beneficiary naming provision (added by the DRA), but also one of

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[18] The plaintiff cites to the Hughes court's explanation of the way the two provisions work together:

> "[T]here is no inherent conflict between the two provisions, and each provision is specific in its own way. Section 1396p(c)(1)(F) purports to govern all annuities through the imposition of a transfer penalty under paragraph (1) if the annuity does not satisfy certain rules. On the other hand, § 1396p(c)(2)(B)(i) carves out an exception to paragraph (1)'s transfer penalties. The language of § 1396p(c)(1)(F) limits its annuity rules '[f]or purposes of this paragraph.' The language of § 1396p(c)(2)(B)(i) provides that '[a]n individual shall not be ineligible for medical assistance by reason of paragraph (1)' if a transfer satisfies, in relevant part, the sole-benefit rule."

Hughes, 734 F.3d at 485. As discussed supra, we reject this interpretation, as it frustrates the purpose of § 1396p(c)(1)(F)(i).

the central goals of the Medicaid program, which is to provide health care to those who cannot afford it. See 42 U.S.C. § 1396a(a)(10)(C); Moe v. Secretary of Admin. & Fin., 382 Mass. 629, 633 (1981). When affluent individuals engage in schemes to hide assets in order to qualify for programs to which they are otherwise not entitled, their actions improperly "divert[] scarce Federal and State resources from low-income [qualifying individuals]." Cohen v. Commissioner of the Div. of Med. Assistance, 423 Mass. 399, 404 (1996), cert. denied sub nom. Kokoska v. Bullen, 519 U.S. 1057 (1997), quoting H.R. Rep. No. 265, 99th Cong., 1st Sess., pt. 1, at 72 (1985). See Lebow, 433 Mass. at 172, ("The Medicaid program . . . is designed to provide health care for indigent persons. Individuals are expected to deplete their own resources before obtaining assistance from the government. The unfortunate reality is that some individuals with significant resources devise strategies to appear impoverished in order to qualify for Medicaid benefits").

As there is no exemption directing us to disregard the beneficiary naming provision, and because creating one would contravene Congress's intent to limit the use of annuities for Medicaid planning purposes, subsections (c)(1)(F)(i) and (c)(2)(B)(i) both must apply to ensure that an annuity purchased does not become a vehicle for sheltering assets that otherwise properly would be used to pay for medical care.

Evaluated with this reading of the statutory provisions in mind, the annuity at issue here met the requirements set forth in the Medicaid Act to be exempt from the transfer penalty. The annuity was sound actuarially and was structured such that it was intended to be for

Robert's "sole benefit" during his lifetime under § 1396p(c)(2)(B)(i). Further, the Commonwealth was named as primary remainder beneficiary to the extent of benefits paid on Joan's behalf pursuant to § 1396p(c)(1)(F)(i).[19] Thus, the annuity properly was executed such that Joan did not incur an eligibility penalty as a result of the transfer, and on Robert's passing, the remainder of the annuity properly belongs to the Commonwealth up to the amount it has paid for Joan's care.[20]

2. State law claims. The plaintiff's additional arguments, grounded in State law, regarding her claim to the remainder proceeds are unavailing. First, she argues that based on the wording of the annuity contract

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[19] The plaintiff's claim that Congress's use of the term "institutionalized individual" in § 1396p(c)(1)(F)(i), rather than the more specific term "institutionalized spouse," means that the Commonwealth can only claim recovery of expenses paid on Robert's behalf (which are zero, in this case) is without merit. See Hegadorn v. Department of Human Servs. Director, 503 Mich. 231, 272 n.3 (2019) (McCormack, C.J., concurring).

[20] As mentioned supra, § 1396p(c)(1)(F)(i) allows the State, as the primary remainder beneficiary, to recover "at least the total amount of medical assistance paid on behalf of the institutionalized individual." We have not been asked to decide whether the amount to which the Commonwealth is entitled is limited to the total amount expended at the time of Robert's passing. However, restricting the Commonwealth's recovery in such a way would leave open a potential loophole. That is, after the death of the community spouse, the transfer to family members of any assets that had been placed in a community spouse annuity to help the institutionalized spouse become Medicaid-eligible would frustrate the purpose of the Medicaid Act. See Hutcherson, 667 F.3d at 1072.

she, rather than the Commonwealth, is the rightful remainder beneficiary. We are not persuaded.

The annuity states that the primary remainder beneficiary is the "State of MA Medicaid Per Application." The application, in turn, lists "Commonwealth of MA the Extent Benefits Paid [sic]" as the primary remainder beneficiary. The plaintiff argues that as there is no mention of Joan as the recipient of benefits, the contract must refer to benefits paid on Robert's behalf. Because Robert did not receive any benefits from the Commonwealth, the plaintiff reasons that the condition was not fulfilled and therefore she is entitled to the remaining annuity proceeds as the second contingent beneficiary.

This argument is flawed. Admittedly, the annuity contract is not a model of clarity. However, it is undisputed that Robert purchased the annuity as part of a strategy to spend down the couple's assets so that Joan would be eligible for MassHealth benefits.[21] Because a community spouse annuity must list the State as the remainder beneficiary to the extent benefits are paid for the institutionalized spouse to be exempted from a transfer penalty, we conclude that Joan, as the institutionalized spouse, is the presumed recipient of benefits referenced in the remainder clause. And the Commonwealth is the rightful beneficiary of the remainder proceeds up to the amount it paid on behalf of Joan. See Robert & Ardis James Found. v. Meyers, 474 Mass. 181, 188 (2016) (contract is construed so as "to give it effect

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[21] To that end, the existence of the annuity was disclosed on Joan's MassHealth application, as required by 42 U.S.C. § 1396p(e).

as a rational business instrument and in a manner which will carry out the intent of the parties"); Starr v. Fordham, 420 Mass. 178, 192 (1995) (same).[22]

The plaintiff also contends that the Commonwealth's claim is barred by the State Medicaid estate recovery statute, G. L. c. 118E, § 31 (b) (1), because, she argues, the statute only allows the Commonwealth to seek repayment for benefits from the estate of the institutionalized spouse.[23]

As discussed supra, the Medicaid Act exempts from transfer penalties only those annuities naming the State as the primary remainder beneficiary. See 42 U.S.C. § 1396p(c)(1)(F)(i). Moreover, 42 U.S.C. § 1396a(a)(18) specifically requires participating States to "comply with the provisions of [the Medicaid Act] with respect to[, among other things,] recoveries of medical assistance correctly paid." Because a State statute may not "stand[] as an obstacle to the accomplishment of Federal

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[22] Because an annuity that does not name the Commonwealth as the primary remainder beneficiary is subject to a transfer penalty, the Commonwealth would be entitled to the amount due even if we were to conclude that the contract language was not sufficiently clear to name the Commonwealth as the remainder beneficiary. See generally 130 Code Mass. Regs. § 520.019(K)(2)(b) (2013) ("Curing a transfer").

[23] General Laws c. 118E, § 31 (b) (1), states in pertinent part:

> "There shall be no adjustments or recovery of medical assistance correctly paid except as follows: . . . . Recovery from the Permanently Institutionalized: From the estate of an individual, regardless of age, who was an inpatient in a nursing facility or other medical institution when he or she received such assistance."

objectives," Boston v. Commonwealth Employment Relations Bd., 453 Mass. 389, 396 (2009), it makes no difference whether the plaintiff's interpretation of G. L. c. 118E, § 31, is correct. That is, to the extent the provision would prevent the Commonwealth from collecting the annuity proceeds Robert designated it to receive, the State statute is preempted by Federal law.[24]

Conclusion. For the reasons discussed supra, we vacate the judgment of the Superior Court, we reverse the order of the Superior Court allowing the plaintiff's motion for summary judgment and denying the Commonwealth's motion for summary judgment as to the plaintiff's claim for declaratory judgment, and we remand the case for further proceedings consistent with this opinion.

So ordered.

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[24] The plaintiff also argues in passing that under G. L. c. 118E, § 31 (c), the Commonwealth can recover from only an individual's probate estate, which does not include nonprobate assets such as annuities with named beneficiaries. Assuming the plaintiff's interpretation is correct, like § 31 (b), § 31 (c) would be preempted by Federal law.

APPENDIX B

SJC-13179

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES vs. LINDA MARIE MONDOR & others[1] (and a consolidated case[2]).

January 27, 2023.

Medicaid. MassHealth. Annuity. Federal Preemption. Statute, Construction, Federal preemption.

The parties to these consolidated cases seek a judgment declaring their respective rights to the remainder proceeds of two annuity contracts, each of which names the Commonwealth as primary remainder beneficiary and the individual defendants as contingent remainder beneficiaries. In each case, the plaintiff, the Executive Office of Health and Human Services (Commonwealth),

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[1] Michelle Mogan and Cathy Ann Mondor.

[2] Executive Office of Health and Human Services vs. Kathleen Ann Bristow & others.

only claims entitlement to remainder proceeds up to the amount of medical assistance paid on behalf of an "institutionalized spouse"[3] whose eligibility for Medicaid long-term care benefits was achieved by the purchase of the annuity during the relevant "look-back" period as defined by Federal statute. See 42 U.S.C. § 1396p(c). For the reasons discussed infra, we remand the consolidated cases for entry of a declaratory judgment in favor of the Commonwealth.

Background. 1. Facts. We recite the facts as set forth in the parties' statement of agreed material facts pursuant to Mass. R. Civ. P. 64, as amended, 423 Mass. 1410 (1996).

a. Mondor annuity. Defendants Linda Marie Mondor, Michelle Mogan, and Cathy Ann Mondor (collectively, Mondor beneficiaries) are the daughters of Elda Mondor and Edward J. Mondor.[4] Edward was Elda's spouse. Elda was admitted to a skilled nursing facility for long-term care in March 2018, at the age of eighty-four.

In April 2018, Edward purchased an annuity contract (Mondor annuity) issued by Standard Insurance Company (Standard). Edward paid a premium of $191,215.28

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[3] The term "institutionalized spouse" means "an individual who . . . is in a medical institution or nursing facility . . . [and] is married to a spouse who is not in a medical institution or nursing facility." 42 U.S.C. § 1396r-5(h)(1). The term "community spouse" means "the spouse of an institutionalized spouse." 42 U.S.C. § 1396r-5(h)(2).

[4] For convenience, we hereinafter refer to Elda and Edward Mondor by their first names.

for the Mondor annuity using funds held in a traditional individual retirement account (IRA) for Edward. The Mondor annuity named Edward as the sole annuitant and owner. The Mondor annuity provided that Edward, as annuitant, would receive monthly payments in the amount of $4,065, commencing June 3, 2018, and continuing for a four-year term. Edward named the "Commonwealth of Massachusetts" as the primary remainder beneficiary of the Mondor annuity, and he named the Mondor beneficiaries as the contingent remainder beneficiaries. The Mondor annuity is nontransferable, nonforfeitable, nonassignable, noncommutable, and irrevocable.

In June 2018, Elda submitted an application for MassHealth[5] long-term care benefits. But for Edward's purchase of the Mondor annuity, Edward and Elda's joint assets would have exceeded the allowable limit for Elda to be deemed eligible for MassHealth long-term care benefits. Elda's application for MassHealth benefits disclosed the Mondor annuity, as required by 42 U.S.C. § 1396p(e), and Elda also provided MassHealth with a completed Notice of Preferred Remainder Beneficiary, known as an "ANN-3" form. The completed

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[5] MassHealth refers to the State program by which the Commonwealth participates in Medicaid, "a cooperative Federal and State program that provides medical assistance to low income persons based on financial need" (quotation and citation omitted). Fournier v. Secretary of the Executive Office of Health & Human Servs., 488 Mass. 43, 45 (2021). The plaintiff, the Executive Office of Health and Human Services (Commonwealth), is the State agency responsible for administering MassHealth. See Daley v. Secretary of the Executive Office of Health & Human Servs., 477 Mass. 188, 190 (2017).

ANN-3 form, signed by Edward as Elda's authorized representative, identified the Mondor annuity and stated in relevant part:

> "The [Commonwealth] has determined that, pursuant to MassHealth regulations at 130 [Code Mass. Regs. §] 520.007(J) and [F]ederal law at 42 U.S.C. [§] 1396p(e), the Commonwealth of Massachusetts must be named as a preferred remainder beneficiary in the first position (primary beneficiary) if there is no community spouse or minor or disabled child . . . . The Commonwealth may collect up to the total amount of medical assistance paid on behalf of the individual if there is no community spouse or minor or disabled child. In accordance with [F]ederal law 42 U.S.C. [§] 1396p(e), the Commonwealth must notify the annuity issuing company of its interest as a preferred remainder beneficiary under the annuity and will do so by way of sending the company a copy of this form."

The Commonwealth provided Standard with a copy of the completed ANN-3 form regarding the Mondor annuity.

Before approving Elda's MassHealth application, MassHealth requested additional documentation, including a current statement from the Mondor annuity "with Commonwealth of Mass[.] as beneficiary." After the additional documentation was provided, MassHealth approved Elda's application, deeming her eligible for long-term care benefits retroactive to May 1, 2018. At the time of the filing of the complaint, Elda continued to

reside in a skilled nursing facility and receive MassHealth benefits for her long-term care.

Edward died on April 11, 2020. At the time of his death, $97,720.28 in annuity payments remained to be paid on the Mondor annuity. The Commonwealth made a claim on the proceeds of the Mondor annuity up to the total amount of medical assistance paid on behalf of Elda. The Commonwealth asserted that as of July 29, 2020, it had paid $146,903.57 in medical assistance on Elda's behalf. The Mondor beneficiaries also made a claim to all remaining proceeds of the Mondor annuity.

As of March 31, 2021, MassHealth had paid $191,865.61 in medical assistance on behalf of Elda. Edward never applied for or received Medicaid or MassHealth benefits during his lifetime. Standard remains in possession of all the remainder proceeds from the Mondor annuity.

b. Castle annuity. Defendants Kathleen Anne Bristow, Marianne Schwenzfeier, and John Francis Castle (collectively, Castle beneficiaries) are the children of Carol A. Castle and James W. Castle.[6] James was Carol's spouse. Carol was admitted to a skilled nursing facility for long-term care in August 2018, at the age of seventy-eight.

In November 2018, James purchased an annuity contract (Castle annuity) issued by Standard. James paid a premium of $176,859.75 for the Castle annuity, using funds held in a traditional IRA for James. The Castle

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[6] For convenience, we hereinafter refer to Carol and James Castle by their first names.

annuity named James as the sole annuitant and owner. The Castle annuity provided that James, as annuitant, would receive monthly payments in the amount of $3,031.93, beginning on November 19, 2018, and continuing for a five-year term. James named the "Commonwealth of Massachusetts" as the primary remainder beneficiary of the Castle annuity, and he named the Castle beneficiaries as the contingent remainder beneficiaries. The Castle annuity is nontransferable, nonforfeitable, nonassignable, noncommutable, and irrevocable.

In December 2018, Carol submitted an application for MassHealth long-term care benefits. But for James's purchase of the Castle annuity, James and Carol's joint assets would have exceeded the allowable limit for Carol to be deemed eligible for MassHealth long-term care benefits. Carol's application for MassHealth benefits disclosed the Castle annuity, per 42 U.S.C. § 1396p(e), and Carol also provided MassHealth with a completed ANN-3 form, signed by James as Carol's authorized representative, which identified the Castle annuity and contained language identical to that quoted supra from the ANN-3 form in connection with the Mondor annuity. The Commonwealth later provided a copy of the ANN-3 form to Standard.

MassHealth approved Carol's application, deeming her eligible for long-term care benefits retroactive to November 12, 2018. Carol died on April 23, 2020. As of that date, MassHealth had paid $123,413.51 in medical assistance on Carol's behalf.

James died on October 1, 2020. At the time of his death, approximately $110,000 in annuity proceeds remained to be paid on the Castle annuity. James never

applied for or received Medicaid or MassHealth benefits during his lifetime.

The Commonwealth made a claim on the proceeds of the Castle annuity up to the total amount of medical assistance paid on behalf of Carol, which was identified as $123,413.51. In or around February 2021, the Castle beneficiaries also made a claim to the remaining proceeds of the Castle annuity.

Standard initially made payments to the Commonwealth in response to its claim as primary remainder beneficiary, but then ceased making payments in response to the competing claims of the Castle beneficiaries. As of February 19, 2021, Standard had made payments to the Commonwealth for a total of $15,159.65. Standard remains in possession of the balance of the Castle annuity proceeds.

2. Prior proceedings. The cases before us were commenced by Standard, at least in part as interpleader actions, to resolve the competing claims to the proceeds of the Mondor and Castle annuities. In each case, the parties filed cross motions for declaratory judgment, and then stipulated to Standard's dismissal from the case. The cases were consolidated in the Superior Court, and the parties jointly moved to report the cases to the Appeals Court without decision on a statement of agreed material facts pursuant to Mass. R. Civ. P. 64. A judge in the Superior Court allowed the motion, and after the cases were entered in the Appeals Court, this court granted the parties' joint motion for direct appellate review.

3. Discussion. The consolidated cases are governed in all material respects by our decision today in Dermody v. Executive Office of Health & Human Servs., 491 Mass. (2023). In Dermody, we concluded that under the Federal Medicaid Act, 42 U.S.C. §§ 1396 et seq., in order to avoid a determination of ineligibility or the imposition of a disqualifying transfer penalty under 42 U.S.C. § 1396p(c) with respect to annuity transactions occurring after February 8, 2006, any annuity purchased by a community spouse for Medicaid planning purposes in order to achieve the Medicaid eligibility of an institutionalized spouse and designated for the "sole benefit" of the community spouse under § 1396p(c)(2) must also satisfy the beneficiary naming requirement of § 1396p(c)(1)(F)(i). We also concluded in Dermody that to the extent that the State Medicaid estate recovery statute, G. L. c. 118E, § 31 (b) (1), would prevent the Commonwealth from collecting annuity proceeds it is designated to receive as the primary remainder beneficiary, the State statute is preempted by the Medicaid Act.

On the facts presented here, in order for the Medicaid applications of the institutionalized spouses, Elda and Carol, to be approved without the imposition of a transfer penalty, the Mondor and Castle annuities were required to, and did, name the Commonwealth as primary remainder beneficiary pursuant to § 1396p(c)(1)(F)(i). Further, on the deaths of the annuitants, the Commonwealth became entitled to remainder proceeds from the annuities to the extent of benefits paid by the Commonwealth on behalf of the "institutionalized individual[s]" pursuant to § 1396p(c)(1)(F)(i). In accordance with our

opinion in Dermody, the relevant "institutionalized individual[s]" for purposes of § 1396p(c)(1)(F)(i) are the individuals whose eligibility for Medicaid long-term benefits was made possible by the purchase of the annuities and whose eligibility for Medicaid long-term care benefits turned on the proper disclosure and treatment of the annuities in accordance with the Medicaid Act, see 42 U.S.C. § 1396p(c)(1)(F)(i), (e). Here, the relevant "institutionalized individual[s]" of the Mondor and Castle annuities are Elda and Carol, respectively.

The consolidated cases are remanded to the Superior Court for entry of a declaratory judgment in favor of the Commonwealth and for any further proceedings necessary to permit Standard to disburse the remainder proceeds from the Mondor and Castle annuities in a manner consistent with this opinion.[7]

So ordered.

Jesse M. Boodoo, Assistant Attorney General, for Executive Office of Health and Human Services.

Brian E. Barreira for Lisa Marie Mondor & others.

Patricia Keane Martin, Clarence D. Richardson, Jr., & C. Alex Hahn, for Massachusetts Chapter of the National Academy of Elder Law Attorneys, amicus curiae, submitted a brief.

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[7] To the extent that the Mondor and Castle beneficiaries raise issues not explicitly addressed in this opinion, we have not overlooked them. Rather, we find them without merit and decline to discuss them.

APPENDIX C

COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss. SUPERIOR COURT
CIVIL ACTION
NO. 1781CV02342

LAURIE A. DERMODY

vs.

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES & another[1]

MEMORANDUM OF DECISION AND ORDER ON PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND DEFENDANTS' CROSS MOTIONS FOR SUMMARY JUDGMENT

The plaintiff, Laurie A. Dermody ("plaintiff"), filed this action against the Executive Office of Health and Human Services ("Commonwealth") and Nationwide Life Insurance Company ("Nationwide"),[2] seeking residual benefits payable under an annuity that her father purchased from Nationwide. The matter is presently before the court on the plaintiff's motion for summary judgment on all counts, the Commonwealth's cross motion for summary judgment on Count 1 of the complaint, and Nationwide's cross motion on all counts of the com-

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[1] Nationwide Financial Insurance Company.

[2] Nationwide contends that its name is incorrect in the caption of the First Amended Complaint ("complaint").

plaint as well as its cross claim against the Commonwealth for indemnification. For the following reasons, the plaintiff's motion and Nationwide's cross motion are **ALLOWED**, in part and **DENIED**, in part, and the Commonwealth's cross motion is **DENIED**.

BACKGROUND

The following undisputed facts are taken from the summary judgment record, with certain additional facts reserved for later discussion.

On July 7, 2015, the plaintiff's father, Robert Hamel ("Robert"), purchased a single premium immediate annuity contract from Nationwide ("annuity contract" or "the contract"). The purchase amount was $172,000. Robert was the named owner and annuitant of the contract. Robert designated the "State of MA Medicaid Per Application" as the primary beneficiary. His annuity application provides that the Commonwealth shall be the primary recipient of residual benefits to the "Extent Benefits Paid." Robert listed the plaintiff as the contingent beneficiary.

Although Robert never applied for or received MassHealth benefits during his lifetime, his wife, Joan Hamel ("Joan"), requires long-term care in a skilled nursing facility. She presently resides at the Apple Valley Center in Ayer, Massachusetts. On July 23, 2015, approximately two weeks after Robert purchased the annuity, Joan applied for and subsequently received MassHealth long-term care benefits, retroactive to June 2015, which pays for her nursing home costs.

On December 23, 2016, Robert died. At the time of his death, he was residing at the Langdon Place assisted

living facility in Nashua, New Hampshire. On December 29, 2016, Nationwide sent a letter to the MassHealth Estate Recovery Unit, which stated, in part:

> "This correspondence is in reference to the primary beneficiary designation of the Commonwealth of Massachusetts for the reimbursement of any Medicaid payments or state assistance received by Robert G Hamel from the Commonwealth of Massachusetts, under the above listed contract owned by Robert G Hamel.
>
> After your review and completion of the documentation provided from Nationwide . . . regarding the death benefit claim . . . Nationwide will release the amount being claimed from the annuity contract by Commonwealth of Massachusetts as primary beneficiary. Please complete the W-9 and Beneficiary Claim Form provided and return along with a copy of the death certificate."

On June 27, 2017, the MassHealth Estate Recovery Unit sent a letter to Nationwide demanding that it pay the balance of the contract to the Commonwealth as reimbursement for care costs paid through May 31, 2017, on Joan's behalf. On July 7, 2017, Nationwide processed the Commonwealth's request and remitted payment for the full residual benefits ($118,517.50).

After having received the Commonwealth's June 27 letter, Attorney Michael DellaMonaca, who previously represented Joan in connection with her MassHealth application, contacted Nationwide on July 13, 2017, demanding that it refrain from issuing any payment to the

Commonwealth. The next day, on July 14, 2017, Nationwide responded that it already had distributed the remaining balance of the contract to the Commonwealth.

Subsequently, the plaintiff retained her own attorney, and on August 4, 2017, the plaintiff filed this action against the Commonwealth, seeking a declaration that she is entitled to the remaining balance of the contract. In particular, she alleges that because the Commonwealth is the primary beneficiary to the "Extent Benefits Paid," and because Robert did not receive MassHealth benefits during his lifetime, the Commonwealth is not entitled to any payout from the contract. Therefore, as the contingent beneficiary, she claims she is entitled to the balance of the contract.

On August 14, 2017, plaintiff's counsel sent a letter to Nationwide alerting it of the disagreement concerning the beneficiary language in the contract, clarifying that Robert did not receive any MassHealth benefits, and demanding that it not distribute the remaining annuity benefits prior to the resolution of the litigation between the plaintiff and the Commonwealth. Two days later, on August 16, 2017, Nationwide responded that it had processed the claim and paid out the remaining balance of Robert's annuity to the primary beneficiary, the Commonwealth, on July 7, 2017.

On September 11, 2017, plaintiff's counsel sent Nationwide a G. L. c. 93A demand letter, outlining the plaintiff's claim that Nationwide violated the terms of the annuity contract by wrongfully paying the remaining balance of the contract to the Commonwealth. Nationwide did not respond to the plaintiff's c. 93A demand letter.

On October 25, 2017, the plaintiff amended her complaint, adding Nationwide to the suit. The claims are as follows. Count 1 seeks a declaration against the Commonwealth and Nationwide that the plaintiff is entitled to the remaining balance of the annuity contract. Count 2 alleges that Nationwide breached the contract by wrongfully paying the remaining balance to the Commonwealth. Count 3 alleges that Nationwide engaged in unfair or deceptive acts or practices in violation of G. L. c. 93A and G. L. c. 176D, § 3(9). In response, Nationwide filed a cross claim against the Commonwealth for indemnification. All parties now move for summary judgment on all counts of the complaint, and Nationwide also moves for summary judgment on its cross claim against the Commonwealth.

DISCUSSION

I. Standard of Review

Summary judgment shall be granted when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Mass. R. Civ. P. 56(c); *Kourouvacilis v. General Motors Corp.*, 410 Mass. 706, 714 (1991). The moving party bears the burden of affirmatively demonstrating the absence of a triable issue. *Pederson v. Time, Inc.*, 404 Mass. 14, 17 (1989). The moving party may satisfy this burden by submitting affirmative evidence negating an essential element of the opposing party's case or by demonstrating that the opposing party has no reasonable expectation of proving an essential element of his case at trial. *Flesner v. Technical Comm'ns Corp.*, 410 Mass. 805, 809 (1991); *Kourouvacilis*, 410 Mass. at 716. Once the moving party establishes the absence of a triable issue, the

party opposing the motion must respond with evidence of specific facts establishing the existence of a genuine dispute. *Pederson*, 404 Mass. at 17. The opposing party cannot rest on its pleadings and mere assertions of disputed facts to defeat the motion for summary judgment. *LaLonde v. Eissner*, 405 Mass. 207, 209 (1989).

When deciding a motion for summary judgment, the court considers pleadings, deposition transcripts, answers to interrogatories, admissions on file, and affidavits. Mass. R. Civ. P. 56(c). The court reviews the evidence in the light most favorable to the nonmoving party but does not weigh evidence, assess credibility, or find facts. *Attorney Gen. v. Bailey*, 386 Mass. 367, 370 (1982). Where, as here, the court is presented with cross motions for summary judgment, the standard of review is identical for all motions. *Epstein v. Board of Appeals of Boston*, 77 Mass. App. Ct. 752, 756 (2010).

II. Overview of Medicaid Program and MassHealth

The crux of this dispute is governed by the proper interpretation of certain statutes and regulations of the Medicaid Act. Many areas of Medicaid law have been referred to as a labyrinth, "rend[er]ing them 'almost unintelligible to the uninitiated'" (citation omitted). *Richardson v. Hamilton*, 2018 U.S. Dist. LEXIS 31127 at *43 (D. Me. 2018). As such, the following is a brief summary of the Medicaid program and some of the relevant statutes and regulations.

The Federal Medicaid Act, 42 U.S.C. §§ 1396 et seq., was enacted in 1965 as Title XIX of the Social Security

Act. *Daley v. Secretary of Exec. Office of Health & Human Servs.*, 477 Mass. 188, 189 (2017). It is a voluntary, cooperative federal and state program, which provides payment for medical services to eligible individuals and families. *Forman v. Director of Office of Medicaid*, 79 Mass. App. Ct. 218, 221-22 (2011). If states choose to participate in the program, they must comply with federal Medicaid law in order to receive federal funding. *Daley*, 477 Mass. at 189-190. It has become one of the largest programs in the federal budget as well as a major expenditure for state governments, who must finance a significant portion of Medicaid benefits on their own. *Id.* at 190.

Massachusetts participates in the program via the establishment of MassHealth. See G. L. c. 118E, § 9. Among other things, MassHealth provides nursing home benefits for individuals who meet certain criteria. *Forman*, 79 Mass. App. Ct. at 222.

To qualify for a MassHealth contribution toward nursing home expenses, an applicant must have $2,000 or less in "countable assets." See 130 Code Mass. Regs. § 520.003(A)(1) (2014). If the applicant has a spouse that is not institutionalized and does not receive Medicaid benefits, the spouse, also known as a community spouse, may have up to $126,420 in countable assets.[3] See 130 Code Mass. Regs. § 520.003(A)(1) (2014); 130 Code Mass.

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[3] To avoid impoverishing the community spouse, Congress enacted certain provisions to protect the spouse, such as 42 U.S.C. § 1396r-5(b)(1), which states that the community spouse's income is deemed unavailable to an institutionalized spouse. See 130 Code Mass. Regs. § 520.016(B)(2) (2014).

Regs. § 520.016(B)(2) (2014) (amount adjusted for inflation). "This asset limit often requires applicants to 'spend down' or otherwise deplete their resources to qualify for Medicaid long-term care benefits when they enter a nursing home." *Daley*, 477 Mass. at 192. To prevent asset transfers that are undertaken solely to allow the applicant to qualify for MassHealth, strict rules have been promulgated that limit the amount of assets an applicant and their spouse can dispose of without affecting the applicant's eligibility for assistance.[4] See 42 U.S.C. § 1396p; 130 Code Mass. Regs. § 520.007 (2014).

To determine eligibility, MassHealth reviews an applicant's and their spouse's transfers of resources during a statutorily created "look-back" period prior to the applicant's application. *Forman*, 79 Mass. App. Ct. at 222. The transfer at issue in this case is Robert's annuity, which he purchased on July 7, 2015, well within the sixty-month look-back period. 42 U.S.C. § 1396p(c)(1)(B); 130 Code Mass. Regs. § 520.019(B)(2) (2014).

If an applicant or an applicant's spouse transfers any resource or an interest in any resource during the look-

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[4] "Through 'Medicaid planning,' individuals attempt to transfer or otherwise dispose of their assets long before they need long-term care so that, when the need arises, they may satisfy the asset limit and qualify for Medicaid benefits. In essence, the purpose of Medicaid planning is to enable persons whose assets would otherwise render them ineligible for long-term care benefits to become eligible for Medicaid benefits by transferring to their children or other loved ones the assets they would otherwise use to pay for long-term care, shifting to the taxpayers the burden of paying for that care." *Daley*, 477 Mass. at 192.

back period for less than the fair market value, it is considered a disqualifying transfer unless subject to a few delineated exceptions. 42 U.S.C. § 1396p(c); 130 Code Mass. Regs. § 520.019(C) (2014). If MassHealth determines that a disqualifying transfer has occurred, it deems the applicant ineligible for nursing home benefits for a period equal to the total, cumulative, uncompensated value of all resources transferred, divided by the average monthly cost to a private patient receiving nursing-facility services in the Commonwealth at the time of the application. 130 Code Mass. Regs. § 520.019(G)(1) (2014).

III. Exceptions to Disqualifying Transfer Rule

As stated above, there are certain exceptions to the disqualifying transfer rule. Of significance in this case are the exceptions set forth in 42 U.S.C. § 1396p(c).

To restate the general rule briefly, § 1396p(c)(1) provides that an applicant will be deemed ineligible for a calculable period of time if the applicant or the applicant's spouse disposes of assets for less than the fair market value during the look-back period.[5]

Section 1396p(c)(2)(B) (hereinafter, "the sole benefit rule" or "paragraph [2]") contains an exception to that

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[5] The court notes that there are Massachusetts regulations that mimic the federal Medicaid statutes; however, because Massachusetts must comply with the federal guidelines, for ease of analysis, the court refers only to the relevant federal statutes from here on out in its analysis. See generally 42 U.S.C. § 1396a(r)(2)(A) (in determining income eligibility, states cannot be more restrictive than federal methodology).

general rule. It permits asset transfers to a spouse directly or to another so long as the transfer is "for the sole benefit" of the spouse. In the latter instance, if assets are transferred to purchase an annuity on the spouse's behalf, the transfer satisfies the sole benefit rule if the annuity is actuarially sound. An annuity is actuarially sound if the expected return from the annuity is commensurate with the annuitant's life expectancy. *Normand v. Director of Office of Medicaid*, 77 Mass. App. Ct. 634, 637 (2010). In other words, an annuity is not actuarially sound if the projected yield to the annuitant during his or her anticipated lifetime is less than the premium paid for the annuity. *Id.* Here, for the purposes of this motion, it is undisputed that Robert's annuity was actuarially sound and that Robert's annuity complied with the sole benefit rule.

In 2006, however, Congress passed the Deficit Reduction Act of 2005 ("the act" or "DRA"), Pub. L. No. 109-71, § 1932, 120 Stat. 4, 62-64, in an attempt to reduce government spending on certain programs, such as Medicaid. The act added, among other things, subparagraph (F) to § 1396p(c)(1), which states:

> "For the purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than the fair market value unless –
>
> (i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual . . . ."

The act, however, did not amend or revoke the sole benefit rule set forth in § 1396p(c)(2)(B).

IV. Summary of Dispute

The gravamen of this dispute hinges on whether an annuity that satisfies the sole benefit rule must also satisfy the annuity rules under § 1396p(c)(1)(F) (hereinafter, "subparagraph [F]"). The answer to this narrow issue dictates which party is entitled to the remaining balance of Robert's annuity. If both provisions must be satisfied, as the Commonwealth contends, then the Commonwealth would be entitled to the remaining balance of Robert's annuity contract. However, if Robert's annuity need only satisfy the sole benefit rule, as the plaintiff suggests, then the plaintiff is entitled to the remaining balance.

To place this issue into context, Robert named the Commonwealth as the primary beneficiary of his annuity to the "Extent Benefits Paid," and he named the plaintiff as his contingent beneficiary. His annuity contract, however, is silent on the identity of the individual for whom benefits were paid, and "Joan" or "institutionalized individual" is not mentioned anywhere in his annuity application. The Commonwealth, nonetheless, argues that if the court finds that a transfer of assets to purchase an annuity must satisfy both provisions—the sole benefit rule and subparagraph (F) – then the court also must find that the "Extent Benefits Paid" language in Robert's contract necessarily refers to Joan.[6] Otherwise, MassHealth would have deemed Robert's annuity purchase a disqualifying transfer under subparagraph (F),

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[6] The Commonwealth claims that the inclusion of "Extent Benefits Paid" language in Robert's annuity contract is derived from the requirements set forth in subparagraph (F).

and Joan would have been subject to a period of ineligibility. In other words, to have approved Joan's MassHealth application without subjecting her to a period of ineligibility, the Commonwealth claims that Robert was required, pursuant to subparagraph (F), to name the Commonwealth as his primary beneficiary to the extent benefits were paid on *Joan's* behalf. Therefore, even though neither Joan's name nor the phrase "institutionalized individual" appears in Robert's annuity application or contract, the Commonwealth, nevertheless, contends that it is was properly listed as the primary beneficiary of Robert's annuity and that it is entitled to the remaining balance of the contract because it paid for Joan's nursing home care costs.

The plaintiff, however, disagrees with the Commonwealth's interpretation and argues that the sole benefit rule is an exception to subparagraph (F). Therefore, she claims that Robert was not required to name the Commonwealth as his primary beneficiary despite Joan's receipt of MassHealth benefits and that because Robert did not receive MassHealth benefits himself, she is entitled to the remaining balance of her father's annuity as the contingent beneficiary. For the following reasons, the court agrees with the plaintiff.

A. ***Analysis***

Resolving the foregoing issue is a matter of statutory interpretation, and it is question of first impression in this jurisdiction. However, the Sixth Circuit Court of Appeals decided the issue in *Hughes v. McCarthy*, 734 F.3d 473 (6th Cir. 2013), cert. denied, 572 U.S. 1034 (2014), which this Court finds highly persuasive.

In *Hughes*, the court found that an annuity that satisfies the sole benefit rule in § 1396p(c)(2)(B) need not satisfy the annuity rules under subparagraph (F). *Id.* at 484. In reaching its conclusion, the court looked to the plain language and structure of the statute. *Id.* at 484-486.

As stated above, § 1396p(c)(1) (hereinafter, "paragraph [1]") sets forth the general rule regarding disqualifying transfers and the penalty that may be imposed when an applicant or spouse makes a disqualifying transfer. With the enactment of the DRA, however, subparagraph (F) was added to paragraph (1), which states:

> "For the purposes of *this paragraph*, the purchase of an annuity shall be treated as the disposal of an asset for less than the fair market value unless –
>
> (i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter" (Emphasis added).

Id. at 484, quoting 42 U.S.C. § 1396p(c)(1)(F).

In essence, subparagraph (F) deems all annuity purchases a transfer of assets for less than the fair market value unless the state is named as the primary beneficiary of the annuity. However, subparagraph (F) clearly states that its effect is limited to "*this paragraph*" (e.g., paragraph [1]). The sole benefit rule appears in paragraph (2) below and sets forth an exception to the transfer penalty regime in paragraph (1). It states, in pertinent part:

> "An individual shall not be ineligible for medical assistance *by reason of paragraph (1)* to the extent that . . . (B) the assets . . . (i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse" (Emphasis added).

Id. at 484-485, quoting 42 U.S.C. § 1396p(c)(2)(B).

Per the unambiguous, plain language of these provisions, subparagraph (F) applies to all annuities not exempt by the sole benefit rule in paragraph (2). *Id.* at 485. Therefore, any transaction that satisfies the sole benefit rule is exempt from the transfer penalty set forth in paragraph (1), including the annuity rules in subparagraph (F). *Id.* at 485-486. Because Robert's annuity satisfies the sole benefit rule in paragraph (2), his asset transfer is exempt from paragraph (1) and thus cannot be analyzed under the annuity rules in subparagraph (F).

The Commonwealth, nonetheless, argues that § 1396p should not be read as one cohesive statute, but rather, as a statute that has been modified and amended multiple times over decades and that the newer, more specific requirements set forth in subparagraph (F) should prevail over the more general sole benefit rule. The court disagrees. Although it is axiomatic that "specific statutory language should control more general language when there is a conflict between the two," see *National Cable & Telecomms. Ass'n, Inc. v. Gulf Power Co.*, 534 U.S. 327, 335 (2002), there is no conflict between subparagraph (F) and the sole benefit rule because the plain language of subparagraph (F) limits its application to the transfer penalty regime in paragraph (1). There-

fore, the sole benefit rule, which appears in the next paragraph, sets forth an exception to that penalty regime. Accordingly, these two provisions do not contradict but rather supplement one another. *Hughes*, 734 F.3d at 485.

Additionally, the Commonwealth references various congressional floor statements, claiming that subparagraph (F) should be read in light of its purpose – that it was enacted to reduce the deficit by foreclosing certain loopholes that permitted applicants and their spouses to shelter assets. However, it is well settled that it is not the role of the court to compensate for an apparent legislative oversight by effectively rewriting a law to comport with one of the perceived or presumed purposes motivating its enactment. See *United States v. Charles George Trucking Co.*, 823 F.2d 685, 688 (1st Cir. 1987). Therefore, where, as here, § 1396p is unambiguous, comments regarding its purported purpose cannot override the clear statutory text. See *Hughes*, 734 F.3d at 486, citing *Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 457 n.15 (2000) (noting floor statements cannot override clear statutory text), and *Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992) ("We have stated time and again that courts must presume that a legislature says in a statute what it means and means in a statute what it says there."). If Congress intended otherwise, then it need only amend § 1396p to reflect that intent.

Furthermore, to the extent that the Commonwealth cites to agency and regulatory memoranda and manuals to support its interpretation, such materials are not the product of formal rulemaking and do not have the force of law. See *Rent Control Bd. v. Cambridge Tower Corp.*,

394 Mass. 809, 814 (1985). Although courts generally consider such interpretations persuasive, they are entitled to respect only if the interpretation is reasonable and has the "power to persuade." See *id.*; *Hughes*, 734 F.3d at 478, quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). Because the statute is unambiguous, the contradictory agency interpretations are not reasonable.

Finally, the Commonwealth argues that the plaintiff's interpretation strains credulity because if the sole benefit rule is the only provision that applies to annuities purchased by a community spouse, then when do the annuity rules under subparagraph (F) apply? This argument is not persuasive either. As the court recognized in *Hughes*, subparagraph (F) applies to all annuities not excepted by another provision, including annuities benefiting non-exempt children or a spousal annuity that is not actuarially sound. 734 F.3d at 485. Therefore, it affects more than just actuarially sound annuities purchased by a community spouse. Moreover, even if this Court's interpretation of § 1396p gives rise to some redundancy within the statute, the mere redundancy is not enough for the court to ignore the clear text of the statute. See *Rimini St., Inc. v. Oracle USA, Inc.*, 139 S. Ct. 873, 881 (2019) ("If one possible interpretation of a statute would cause some redundancy and another interpretation would avoid redundancy, that difference in the two interpretations can supply a clue as to the better interpretation of a statute. *But only a clue.* Sometimes the better overall reading of the statute contains some redundancy" [Emphasis added].).

Accordingly, the court agrees with the plaintiff's interpretation, which is that an annuity that is actuarially

sound pursuant to paragraph (2) need not satisfy the annuity rules set forth in subparagraph (F). As a result, the court will enter a declaration that Robert was not required to name the Commonwealth as his primary beneficiary to the extent benefits were paid on Joan's behalf, and because Robert did not receive MassHealth benefits himself, the plaintiff is the proper beneficiary of his annuity contract.

Notwithstanding the above conclusion, even if an appellate court later determines that both requirements – the sole benefit rule and the annuity rules in subparagraph (F) – must be satisfied, the court concludes that the plaintiff still prevails under basic contract interpretation principles.

The interpretation of a contract is a question of law, as is the question whether an ambiguity exists. *Quinn v. Mar-Lees Seafood, LLC*, 69 Mass. App. Ct. 688, 695 (2007). "Contracts that are free from ambiguity must be interpreted according to their plain terms." *Suffolk Constr. Co. v. Lanco Scaffolding Co.*, 47 Mass. App. Ct. 726, 729 (1999). In interpreting a contract, the court must construe the words according to their usual and ordinary meaning. *Id.* "Contract language is ambiguous where 'an agreement's terms are inconsistent on their face or where the phraseology can support a reasonable difference of opinion as to the meaning of the words employed and the obligations undertaken.'" *Id.*, quoting *Fashion House, Inc. v. K Mart Corp.*, 892 F.2d 1076, 1083 (1st Cir. 1989). However, "an ambiguity is not created simply because a controversy exists between parties, each favoring an interpretation contrary to the

other's." *Jefferson Ins. Co. v. Holyoke*, 23 Mass. App. Ct. 472, 475 (1987).

Here, Robert's annuity is not ambiguous. His contract designates the "State of MA Medicaid Per Application" as his primary beneficiary, and his annuity application states that the Commonwealth's right to recover is limited to the "Extent Benefits Paid." Robert was the sole annuitant of the contract, and Joan is not referenced anywhere in the contract. Accordingly, nothing in the plain terms of the contract suggests the "benefits paid" language refers to anyone other than Robert. Therefore, the proper interpretation of Robert's annuity contract is that the Commonwealth was his primary beneficiary to the extent that *he* received MassHealth benefits, and because he did not, the plaintiff is entitled to the remaining balance of Robert's annuity as the contingent beneficiary.[7]

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[7] The court also notes that even if Robert was required to name the Commonwealth as the primary beneficiary of his annuity to the extent benefits were paid on Joan's behalf, his annuity contract did not state as such, and the Commonwealth, nonetheless, approved Joan's MassHealth application without subjecting her to a period of ineligibility. This was an oversight on the Commonwealth's part.

V. Remaining Claims

A. Plaintiff's Remaining Claims Against Nationwide

1.) *Breach of Contract (Count 2)*

Because the court agrees with the plaintiff that she is entitled to the remaining balance of her father's annuity contract, it necessarily follows that the court also must find that Nationwide breached that contract by improperly paying the remaining balance to the Commonwealth. Accordingly, summary judgment shall enter in the plaintiff's favor on Count 2 (breach of contract). However, because the court orders the Commonwealth to turn over to the plaintiff the funds that it received from Nationwide, see Order below, the plaintiff is not entitled to a double recovery from Nationwide for those same funds. Therefore, the plaintiff is permitted only to recover damages from Nationwide that she incurred separate and apart from the actual balance of the annuity contract, which must be determined at trial.

2.) *Chapter 93A and Chapter 176D claim (Count 3)*

Count 3 alleges that Nationwide's actions constitute unfair or deceptive settlement practices in violation of G. L. c. 93A, § 2 and G. L. c. 176D, § 3(9). Pursuant to G. L. c. 93A, § 2, unfair methods of competition and unfair or deceptive acts or practices in the conduct of any trade or commerce are unlawful. In the insurance context, "unfair methods of competition and unfair or deceptive acts or practices" include unfair claim settlement practices. G. L. c. 176D, § 3(9). General Laws. c. 176D, § 3(9) lists several acts or omissions that constitute unfair settlement practices. Here, the plaintiff relies on

four of those enumerated acts or omissions, which the court addresses separately below.

i. Failure to Acknowledge Communications

The first act or omission on which the plaintiff relies falls under subsection (b): "Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies." G. L. c. 176D, § 3(9)(b). In support of this theory, the plaintiff alleges that Nationwide violated this subsection by repeatedly ignoring her settlement demands and paying the remaining balance of Robert's annuity contract to the Commonwealth before the beneficiary dispute was resolved. However, contrary to the plaintiff's assertions, there is no evidence in the record to support this theory of liability.

According to the summary judgment record, the plaintiff's attorney sent Nationwide a letter for the first time on August 14, 2017, demanding that it refrain from distributing the remaining balance of Robert's annuity until the beneficiary dispute was resolved. Nationwide responded to that letter two days later on August 16, 2017, stating that it previously distributed the funds to the Commonwealth on July 7, 2017.[8] The only communication to which Nationwide did not respond was the

[8] Nationwide received a prior communication on July 13, 2017, that raised the beneficiary issue. However, Robert's family attorney sent the letter, and at that time, the funds had already been distributed to the Commonwealth. Nationwide, nonetheless, responded to the letter the next day, on July 14, 2017, indicating that it had received a beneficiary claim request from the

plaintiff's c. 93A demand letter, which she sent on September 11, 2017. However, failing to respond to a demand letter is not in itself a violation of c. 93A; rather, failing to respond is a relevant factor in considering whether a defendant *intentionally* violated c. 93A. See *Dawe v. Capital One Bank*, 2007 U.S. Dist. LEXIS 82870 at *4 n.2 (D. Mass. 2007), citing *Heller v. Silverbranch Constr. Corp.*, 376 Mass. 621, 627 (1978) and *Castanouribe v. McBride*, 2001 Mass. App. Div. 172, 174 (App. Ct. 2001). Accordingly, there is no evidence in the record that Nationwide failed to acknowledge or act reasonably promptly in response to the plaintiff's communications in violation of G. L. c. 176D, § 3(9)(b). Therefore, summary judgment shall enter in Nationwide's favor on this theory.

ii. Failure to Investigate

The next two acts or omissions on which the plaintiff relies are: (c) "Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies" and (d) "Refusing to pay claims without conducting a reasonable investigation based upon all available information." G. L. c. 176D, § 3(9)(c)-(d). Specifically, the plaintiff alleges that Nationwide failed to conduct any investigation from the time it received the Commonwealth's benefit claim form to the time it distributed the remaining balance to the Commonwealth. However, because there are genuine issues of material fact in dispute, summary judgment is not appropriate.

Commonwealth on July 5, 2017, and that it processed the request on July 7, 2017.

First, there is insufficient evidence before the court regarding what steps Nationwide took to investigate this matter. Second, although the plaintiff's attorney did not provide written notice to Nationwide about the beneficiary dispute until August 14, 2017, there are communications in the record suggesting that Nationwide may have been aware of the dispute *before* it paid the remaining balance to the Commonwealth. If Nationwide was aware of the dispute and failed to take reasonable steps to investigate the issue, then the plaintiff would be entitled to relief under c. 93A. However, resolution of this issue is a question of fact, which precludes summary judgment on this theory. See *O'Leary-Alison v. Metropolitan Prop. & Cas. Ins. Co.*, 52 Mass. App. Ct. 214, 217 (2001) ("Resolution of G. L. c. 93A claim . . . depends on a factual determination of the defendant's knowledge and intent.").

iii. "Reasonably Clear" Liability

The fourth and final act or omission on which the plaintiff relies falls under subsection (f): "Failing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." G. L. c. 176D, § 3(9)(f). In essence, the plaintiff alleges that if Nationwide conducted a reasonable investigation, liability would have been "reasonably clear," but instead, Nationwide prematurely paid the remaining balance of Robert's annuity contract to the wrong party – the Commonwealth.

An insurer's duty to settle a claim arises only when "liability has become reasonably clear." G. L. c. 176D, § 3(9)(f). Liability, in that context, encompasses both fault and damages. *O'Leary-Alison*, 52 Mass. App. Ct.

at 217. To determine when an insured's liability is "reasonably clear," an objective test is used. *Id.* The fact finder must determine "whether a reasonable person, with knowledge of the relevant facts and law, would probably have concluded, for good reason, that the insured was liable to the plaintiff." *Demeo v. State Farm Mut. Auto Ins. Co.*, 38 Mass. App. Ct. 955, 956-957 (1995).

Typically, subsection (f) is invoked in cases in which an insurer denies liability or contests the amount of money owed. In those situations, it is well settled that "liability under c. 176D and c. 93A does not attach merely because an insurer concludes that it has no liability under an insurance policy and that conclusion is ultimately determined to have been erroneous." See *Guity v. Commerce Ins. Co.*, 36 Mass. App. Ct. 339, 343 (1994), quoting *Pediatricians, Inc. v. Provident Life & Accident Ins. Co.*, 965 F.2d 1164, 1173 (1st Cir. 1992) ("A plausible, reasoned legal position that may ultimately turn out to be mistaken – or simply . . . unsuccessful – is outside the scope of the punitive aspects of the combined application of c. 93A and c. 176D."). See also *O'Leary-Alison*, 52 Mass. App. Ct. at 218 ("An insurer's good faith, but mistaken, valuation of damages does not constitute a violation of c. 176D."). This case, however, presents a unique situation because neither liability nor the amount of money owed was in dispute. Rather, the crux of the plaintiff's claim is that liability was not reasonably clear because there was a dispute regarding who was Robert's beneficiary, and yet, Nationwide paid the remaining balance, albeit to the wrong party. Determining whether this conduct constitutes a violation of G. L. c. 176D,

§ 3(9)(f) requires fact finding, particularly with respect to Nationwide's knowledge and intent, which the court cannot do at the summary judgment stage.[9] See *Attorney Gen.*, 386 Mass. at 370. See also *O'Leary-Alison*, 52 Mass. App. Ct. at 217. Accordingly, summary judgment is not appropriate on this theory of liability either.

B. Nationwide's Cross Claim against the Commonwealth for Indemnification

Nationwide filed a single cross claim against the Commonwealth for indemnification of all damages for which it may be found liable. To the extent that Nationwide is attempting to avoid having to pay the remaining balance of Robert's annuity contract for a second time, the court agrees that it should not have to do so. However, because the court orders the Commonwealth to turn those funds over to the plaintiff, see Order below, Nationwide's cross claim for indemnification is moot. To the extent that Nationwide claims it is not legally responsible for breaching the annuity contract or engaging in unfair or deceptive acts in violation of c. 93A and c. 176D, it has not cited to any case law to support its position and the facts of this case suggest otherwise. Accordingly, Nationwide's motion for summary judgment on its cross claim for indemnification must be denied.

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[9] As an aside, the court notes that it considered, but was not persuaded by, Nationwide's waiver argument; however, the plaintiff's purported delay in raising the beneficiary issue may be relevant as to whether Nationwide's conduct violated G. L. c. 176D, § 3(9)(c), (d), and (f).

ORDER

For the foregoing reasons, it is hereby **ORDERED** that the plaintiff's motion for summary judgment is **ALLOWED** as to Count 1 (declaratory relief) and the Commonwealth's cross motion is **DENIED**. The court hereby **DECLARES** that the plaintiff is entitled to the remaining balance of the annuity contract, and the Commonwealth is **ORDERED** to turn over to the plaintiff the funds it received from Nationwide within ninety (90) days of the issuance of this order.

It is further **ORDERED** that the plaintiff's motion for summary judgment is **ALLOWED** as to Count 2 (breach of contract) but with respect to liability only.

As for Count 3 (violation of c. 93A and c. 176D), the plaintiff's motion for summary judgment is **DENIED**, and Nationwide's cross motion is **ALLOWED**, in part, only in regards to the plaintiff's "failure to acknowledge communications" theory of liability. Nationwide's cross motion for summary judgment is otherwise **DENIED**.

/s/ *C. William Barrett*
January **16**, 2020 Justice of the Superior Court

APPENDIX D

Section 1917 of the Medicaid Act (Title XIX of the Social Security Act, ch. 531, 49 Stat. 620 (1935), as added by the Health Insurance for the Aged Act, Pub. L. No. 89-97, tit. I, § 121(a), 79 Stat. 290, 343-53 (1965)), as added by the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 132(b), 96 Stat. 324, 370-73, as amended, 42 U.S.C. § 1396p, provides:

§ 1396p. Liens, adjustments and recoveries, and transfers of assets

(a) Imposition of lien against property of an individual on account of medical assistance rendered to him under a State plan

(1) No lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan, except—

(A) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(B) in the case of the real property of an individual—

(i) who is an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and

(ii) with respect to whom the State determines, after notice and opportunity for a hearing (in accordance with procedures established by the State), that he cannot reasonably be expected to be discharged from the medical institution and to return home, except as provided in paragraph (2).

(2) No lien may be imposed under paragraph (1)(B) on such individual's home if—

(A) the spouse of such individual,

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title, or

(C) a sibling of such individual (who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution),

is lawfully residing in such home.

(3) Any lien imposed with respect to an individual pursuant to paragraph (1)(B) shall dissolve upon that individual's discharge from the medical institution and return home.

(b) Adjustment or recovery of medical assistance correctly paid under a State plan

(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State

plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) In the case of an individual described in subsection (a)(1)(B), the State shall seek adjustment or recovery from the individual's estate or upon sale of the property subject to a lien imposed on account of medical assistance paid on behalf of the individual.

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) nursing facility services, home and community-based services, and related hospital and prescription drug services, or

(ii) at the option of the State, any items or services under the State plan (but not including medical assistance for medicare cost-sharing or for benefits described in section 1396a(a)(10)(E) of this title).

(C)

(i) In the case of an individual who has received (or is entitled to receive) benefits under a long-term care insurance policy in connection with which assets or resources are disregarded in the manner described in clause (ii), except as provided in such clause, the State shall seek adjustment or recovery from the individual's estate on

account of medical assistance paid on behalf of the individual for nursing facility and other long-term care services.

(ii) Clause (i) shall not apply in the case of an individual who received medical assistance under a State plan of a State which had a State plan amendment approved as of May 14, 1993, and which satisfies clause (iv), or which has a State plan amendment that provides for a qualified State long-term care insurance partnership (as defined in clause (iii)) which provided for the disregard of any assets or resources—

(I) to the extent that payments are made under a long-term care insurance policy; or

(II) because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy.

(iii) For purposes of this paragraph, the term "qualified State long-term care insurance partnership" means an approved State plan amendment under this subchapter that provides for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of an individual who is a beneficiary under a long-term care insurance policy if the following requirements are met:

(I) The policy covers an insured who was a resident of such State when coverage first became effective under the policy.

(II) The policy is a qualified long-term care insurance policy (as defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the State plan amendment.

(III) The policy meets the model regulations and the requirements of the model Act specified in paragraph (5).

(IV) If the policy is sold to an individual who—

(aa) has not attained age 61 as of the date of purchase, the policy provides compound annual inflation protection;

(bb) has attained age 61 but has not attained age 76 as of such date, the policy provides some level of inflation protection; and

(cc) has attained age 76 as of such date, the policy may (but is not required to) provide some level of inflation protection.

(V) The State Medicaid agency under section 1396a(a)(5) of this title provides information and technical assistance to the State insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

(VI) The issuer of the policy provides regular reports to the Secretary, in accordance with regulations of the Secretary, that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(VII) The State does not impose any requirement affecting the terms or benefits of such a policy unless the State imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In the case of a long-term care insurance policy which is exchanged for another such policy, subclause (I) shall be applied based on the coverage of the first such policy that was exchanged. For purposes of this clause and paragraph (5), the term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

(iv) With respect to a State which had a State plan amendment approved as of May 14, 1993, such a State satisfies this clause for purposes of clause (ii) if the Secretary determines that the State plan amendment provides for consumer protection standards which are no less stringent than the consumer protection standards which

applied under such State plan amendment as of December 31, 2005.

(v) The regulations of the Secretary required under clause (iii)(VI) shall be promulgated after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, and shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. The Secretary, as appropriate, shall provide copies of the reports provided in accordance with that clause to the State involved.

(vi) The Secretary, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, the National Association of Insurance Commissioners, State insurance commissioners, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies, shall develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified State long-term care insurance partnerships to a secure, centralized electronic query and report-generating mechanism that the State, the Secretary, and other Federal agencies can access.

(2) Any adjustment or recovery under paragraph (1) may be made only after the death of the individual's surviving spouse, if any, and only at a time—

(A) when he has no surviving child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title; and

(B) in the case of a lien on an individual's home under subsection (a)(1)(B), when—

(i) no sibling of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution), and

(ii) no son or daughter of the individual (who was residing in the individual's home for a period of at least two years immediately before the date of the individual's admission to the medical institution, and who establishes to the satisfaction of the State that he or she provided care to such individual which permitted such individual to reside at home rather than in an institution),

is lawfully residing in such home who has lawfully resided in such home on a continuous basis since the date of the individual's admission to the medical institution.

(3)

(A) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency shall waive the application of this subsection (other than paragraph (1)(C)) if such application would work an undue hardship as determined on the basis of criteria established by the Secretary.

(B) The standards specified by the Secretary under subparagraph (A) shall require that the procedures established by the State agency under subparagraph (A) exempt income, resources, and property that are exempt from the application of this subsection as of April 1, 2003, under manual instructions issued to carry out this subsection (as in effect on such date) because of the Federal responsibility for Indian Tribes and Alaska Native Villages. Nothing in this subparagraph shall be construed as preventing the Secretary from providing additional estate recovery exemptions under this subchapter for Indians.

(4) For purposes of this subsection, the term "estate", with respect to a deceased individual—

(A) shall include all real and personal property and other assets included within the individual's estate, as defined for purposes of State probate law; and

(B) may include, at the option of the State (and shall include, in the case of an individual to whom paragraph (1)(C)(i) applies), any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the

extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(5)

(A) For purposes of clause (iii)(III), the model regulations and the requirements of the model Act specified in this paragraph are:

(i) In the case of the model regulation, the following requirements:

(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

(III) Section 6C (relating to extension of benefits).

(IV) Section 6D (relating to continuation or conversion of coverage).

(V) Section 6E (relating to discontinuance and replacement of policies).

(VI) Section 7 (relating to unintentional lapse).

(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

(IX) Section 11 (relating to prohibitions against post-claims underwriting).

(X) Section 12 (relating to minimum standards).

(XI) Section 14 (relating to application forms and replacement coverage).

(XII) Section 15 (relating to reporting requirements).

(XIII) Section 22 (relating to filing requirements for marketing).

(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than paragraphs (1), (6), and (9) of section 23C.

(XV) Section 24 (relating to suitability).

(XVI) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

(XVII) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

(XVIII) Section 29 (relating to standard format outline of coverage).

(XIX) Section 30 (relating to requirement to deliver shopper's guide).

(ii) In the case of the model Act, the following:

(I) Section 6C (relating to preexisting conditions).

(II) Section 6D (relating to prior hospitalization).

(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

(IV) Section 6F (relating to right to return).

(V) Section 6G (relating to outline of coverage).

(VI) Section 6H (relating to requirements for certificates under group plans).

(VII) Section 6J (relating to policy summary).

(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

(IX) Section 7 (relating to incontestability period).

(B) For purposes of this paragraph and paragraph (1)(C)—

(i) the terms "model regulation" and "model Act" mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000);

(ii) any provision of the model regulation or model Act listed under subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision; and

(iii) with respect to a long-term care insurance policy issued in a State, the policy shall be deemed to meet applicable requirements of the model regulation or the model Act if the State plan amendment under paragraph (1)(C)(iii) provides that the State insurance commissioner for the State certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(C) Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update, or other modification of a model regulation or model Act provision specified in subparagraph (A), or of any provision of such regulation or Act that is substantively related to a provision specified in such subparagraph, the Secretary shall review the changes made to the provision, determine whether incorporating such changes into the corresponding provision specified in such subparagraph would improve qualified State long-term care insurance partnerships, and if so, shall incorporate the changes into such provision.

(c) Taking into account certain transfers of assets

(1)

(A) In order to meet the requirements of this subsection for purposes of section 1396a(a)(18) of this ti-

tle, the State plan must provide that if an institutionalized individual or the spouse of such an individual (or, at the option of a State, a noninstitutionalized individual or the spouse of such an individual) disposes of assets for less than fair market value on or after the look-back date specified in subparagraph (B)(i), the individual is ineligible for medical assistance for services described in subparagraph (C)(i) (or, in the case of a noninstitutionalized individual, for the services described in subparagraph (C)(ii)) during the period beginning on the date specified in subparagraph (D) and equal to the number of months specified in subparagraph (E).

(B)

(i) The look-back date specified in this subparagraph is a date that is 36 months (or, in the case of payments from a trust or portions of a trust that are treated as assets disposed of by the individual pursuant to paragraph (3)(A)(iii) or (3)(B)(ii) of subsection (d) or in the case of any other disposal of assets made on or after February 8, 2006, 60 months) before the date specified in clause (ii).

(ii) The date specified in this clause, with respect to—

(I) an institutionalized individual is the first date as of which the individual both is an institutionalized individual and has applied for medical assistance under the State plan, or

(II) a noninstitutionalized individual is the date on which the individual applies for medical assistance under the State plan or, if later, the date on which the individual disposes of assets for less than fair market value.

(C)

(i) The services described in this subparagraph with respect to an institutionalized individual are the following:

(I) Nursing facility services.

(II) A level of care in any institution equivalent to that of nursing facility services.

(III) Home or community-based services furnished under a waiver granted under subsection (c) or (d) of section 1396n of this title.

(ii) The services described in this subparagraph with respect to a noninstitutionalized individual are services (not including any services described in clause (i)) that are described in paragraph (7), (22), or (24) of section 1396d(a) of this title, and, at the option of a State, other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care.

(D)

(i) In the case of a transfer of asset made before February 8, 2006, the date specified in this subparagraph is the first day of the first month during or after which assets have been transferred for less than fair market value and which does not

occur in any other periods of ineligibility under this subsection.

(ii) In the case of a transfer of asset made on or after February 8, 2006, the date specified in this subparagraph is the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care described in subparagraph (C) based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any other period of ineligibility under this subsection.

(E)

(i) With respect to an institutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall be equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(ii) With respect to a noninstitutionalized individual, the number of months of ineligibility under this subparagraph for an individual shall not be greater than a number equal to—

(I) the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date specified in subparagraph (B)(i), divided by

(II) the average monthly cost to a private patient of nursing facility services in the State (or, at the option of the State, in the community in which the individual is institutionalized) at the time of application.

(iii) The number of months of ineligibility otherwise determined under clause (i) or (ii) with respect to the disposal of an asset shall be reduced—

(I) in the case of periods of ineligibility determined under clause (i), by the number of months of ineligibility applicable to the individual under clause (ii) as a result of such disposal, and

(II) in the case of periods of ineligibility determined under clause (ii), by the number of months of ineligibility applicable to the individual under clause (i) as a result of such disposal.

(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.

(F) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless—

(i) the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual under this subchapter; or

(ii) the State is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

(G) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this subchapter unless—

(i) the annuity is—

(I) an annuity described in subsection (b) or (q) of section 408 of the Internal Revenue Code of 1986; or

(II) purchased with proceeds from—

(aa) an account or trust described in subsection (a), (c), or (p) of section 408 of such Code;

(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

(cc) a Roth IRA described in section 408A of such Code; or

(ii) the annuity—

(I) is irrevocable and nonassignable;

(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(H) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who makes multiple fractional transfers of assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a State may determine the period of ineligibility applicable to such individual under this paragraph by—

(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph

(B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.

(I) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

(i) has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration);

(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).

(J) For purposes of this paragraph with respect to a transfer of assets, the term "assets" includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the assets transferred were a home and title to the home was transferred to—

(i) the spouse of such individual;

(ii) a child of such individual who (I) is under age 21, or (II) (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title;

(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date the individual becomes an institutionalized individual; or

(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date the individual becomes an institutionalized individual, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

(B) the assets—

(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse,

(ii) were transferred from the individual's spouse to another for the sole benefit of the individual's spouse,

(iii) were transferred to, or to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of, the individual's child described in subparagraph (A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4)) established solely for the benefit of an individual under 65 years of age who is disabled (as defined in section 1382c(a)(3) of this title);

(C) a satisfactory showing is made to the State (in accordance with regulations promulgated by the Secretary) that (i) the individual intended to dispose of the assets either at fair market value, or for other valuable consideration, (ii) the assets were transferred exclusively for a purpose other than to qualify for medical assistance, or (iii) all assets transferred for less than fair market value have been returned to the individual; or

(D) the State determines, under procedures established by the State (in accordance with standards specified by the Secretary), that the denial of eligibility would work an undue hardship as determined on the basis of criteria established by the Secretary.

The procedures established under subparagraph (D) shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the personal representative of the individual. While an application for an undue hardship waiver is pending under subparagraph (D) in the case of an individual who is a resident of a nursing facility, if the application meets such criteria as the Secretary specifies, the State may provide for payments for nursing facility services in order to hold the bed for the individual at the facility, but not in excess of payments for 30 days.

(3) For purposes of this subsection, in the case of an asset held by an individual in common with another person or persons in a joint tenancy, tenancy in common, or similar arrangement, the asset (or the affected portion of such asset) shall be considered to be transferred by such individual when any action is taken, either by such individual or by any other person, that reduces or eliminates such individual's ownership or control of such asset.

(4) A State (including a State which has elected treatment under section 1396a(f) of this title) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection. In the case of a transfer by the spouse of an individual which results in a period of ineligibility for medical assistance under a State plan for such individual, a State shall, using a reasonable methodology (as specified by the Secretary), apportion such period of ineligibility (or any portion of such period) among the individual and the individual's spouse

if the spouse otherwise becomes eligible for medical assistance under the State plan.

(5) In this subsection, the term "resources" has the meaning given such term in section 1382b of this title, without regard to the exclusion described in subsection (a)(1) thereof.

(d) Treatment of trust amounts

(1) For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, subject to paragraph (4), the rules specified in paragraph (3) shall apply to a trust established by such individual.

(2)

(A) For purposes of this subsection, an individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

(i) The individual.

(ii) The individual's spouse.

(iii) A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

(iv) A person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) In the case of a trust the corpus of which includes assets of an individual (as determined under subpar-

agraph (A)) and assets of any other person or persons, the provisions of this subsection shall apply to the portion of the trust attributable to the assets of the individual.

(C) Subject to paragraph (4), this subsection shall apply without regard to—

(i) the purposes for which a trust is established,

(ii) whether the trustees have or exercise any discretion under the trust,

(iii) any restrictions on when or whether distributions may be made from the trust, or

(iv) any restrictions on the use of distributions from the trust.

(3)

(A) In the case of a revocable trust—

(i) the corpus of the trust shall be considered resources available to the individual,

(ii) payments from the trust to or for the benefit of the individual shall be considered income of the individual, and

(iii) any other payments from the trust shall be considered assets disposed of by the individual for purposes of subsection (c).

(B) In the case of an irrevocable trust—

(i) if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus

from which, payment to the individual could be made shall be considered resources available to the individual, and payments from that portion of the corpus or income—

(I) to or for the benefit of the individual, shall be considered income of the individual, and

(II) for any other purpose, shall be considered a transfer of assets by the individual subject to subsection (c); and

(ii) any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to the individual shall be considered, as of the date of establishment of the trust (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of subsection (c), and the value of the trust shall be determined for purposes of such subsection by including the amount of any payments made from such portion of the trust after such date.

(4) This subsection shall not apply to any of the following trusts:

(A) A trust containing the assets of an individual under age 65 who is disabled (as defined in section 1382c(a)(3) of this title) and which is established for the benefit of such individual by the individual, a parent, grandparent, legal guardian of the individual, or a court if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on

behalf of the individual under a State plan under this subchapter.

(B) A trust established in a State for the benefit of an individual if—

(i) the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),

(ii) the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual under a State plan under this subchapter; and

(iii) the State makes medical assistance available to individuals described in section 1396a(a)(10)(A)(ii)(V) of this title, but does not make such assistance available to individuals for nursing facility services under section 1396a(a)(10)(C) of this title.

(C) A trust containing the assets of an individual who is disabled (as defined in section 1382c(a)(3) of this title) that meets the following conditions:

(i) The trust is established and managed by a non-profit association.

(ii) A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.

(iii) Accounts in the trust are established solely for the benefit of individuals who are disabled (as defined in section 1382c(a)(3) of this title) by the

parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court.

(iv) To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State plan under this subchapter.

(5) The State agency shall establish procedures (in accordance with standards specified by the Secretary) under which the agency waives the application of this subsection with respect to an individual if the individual establishes that such application would work an undue hardship on the individual as determined on the basis of criteria established by the Secretary.

(6) The term "trust" includes any legal instrument or device that is similar to a trust but includes an annuity only to such extent and in such manner as the Secretary specifies.

(e) Disclosure and treatment of annuities

(1) In order to meet the requirements of this section for purposes of section 1396a(a)(18) of this title, a State shall require, as a condition for the provision of medical assistance for services described in subsection (c)(1)(C)(i) (relating to long-term care services) for an individual, the application of the individual for such assistance (including any recertification of eligibility for such assistance) shall disclose a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as may be specified by the Secretary),

regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form shall include a statement that under paragraph (2) the State becomes a remainder beneficiary under such an annuity or similar financial instrument by virtue of the provision of such medical assistance.

(2)

(A) In the case of disclosure concerning an annuity under subsection (c)(1)(F), the State shall notify the issuer of the annuity of the right of the State under such subsection as a preferred remainder beneficiary in the annuity for medical assistance furnished to the individual. Nothing in this paragraph shall be construed as preventing such an issuer from notifying persons with any other remainder interest of the State's remainder interest under such subsection.

(B) In the case of such an issuer receiving notice under subparagraph (A), the State may require the issuer to notify the State when there is a change in the amount of income or principal being withdrawn from the amount that was being withdrawn at the time of the most recent disclosure described in paragraph (1). A State shall take such information into account in determining the amount of the State's obligations for medical assistance or in the individual's eligibility for such assistance.

(3) The Secretary may provide guidance to States on categories of transactions that may be treated as a transfer of asset for less than fair market value.

(4) Nothing in this subsection shall be construed as preventing a State from denying eligibility for medical assistance for an individual based on the income or resources derived from an annuity described in paragraph (1).

(f) Disqualification for long-term care assistance for individuals with substantial home equity

(1)

(A) Notwithstanding any other provision of this subchapter, subject to subparagraphs (B) and (C) of this paragraph and paragraph (2), in determining eligibility of an individual for medical assistance with respect to nursing facility services or other long-term care services, the individual shall not be eligible for such assistance if the individual's equity interest in the individual's home exceeds $500,000.

(B) A State may elect, without regard to the requirements of section 1396a(a)(1) of this title (relating to statewideness) and section 1396a(a)(10)(B) of this title (relating to comparability), to apply subparagraph (A) by substituting for "$500,000", an amount that exceeds such amount, but does not exceed $750,000.

(C) The dollar amounts specified in this paragraph shall be increased, beginning with 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(2) Paragraph (1) shall not apply with respect to an individual if—

(A) the spouse of such individual, or

(B) such individual's child who is under age 21, or (with respect to States eligible to participate in the State program established under subchapter XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1382c of this title,

is lawfully residing in the individual's home.

(3) Nothing in this subsection shall be construed as preventing an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

(4) The Secretary shall establish a process whereby paragraph (1) is waived in the case of a demonstrated hardship.

(g) Treatment of entrance fees of individuals residing in continuing care retirement communities

(1) In general

For purposes of determining an individual's eligibility for, or amount of, benefits under a State plan under this subchapter, the rules specified in paragraph (2) shall apply to individuals residing in continuing care retirement communities or life care communities that collect an entrance fee on admission from such individuals.

(2) Treatment of entrance fee

For purposes of this subsection, an individual's entrance fee in a continuing care retirement community

or life care community shall be considered a resource available to the individual to the extent that—

(A) the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;

(B) the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing care retirement community or life care community contract and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community.

(h) Definitions

In this section, the following definitions shall apply:

(1) The term "assets", with respect to an individual, includes all income and resources of the individual and of the individual's spouse, including any income or resources which the individual or such individual's spouse is entitled to but does not receive because of action—

(A) by the individual or such individual's spouse,

(B) by a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or such individual's spouse, or

(C) by any person, including any court or administrative body, acting at the direction or upon the request of the individual or such individual's spouse.

(2) The term "income" has the meaning given such term in section 1382a of this title.

(3) The term "institutionalized individual" means an individual who is an inpatient in a nursing facility, who is an inpatient in a medical institution and with respect to whom payment is made based on a level of care provided in a nursing facility, or who is described in section 1396a(a)(10)(A)(ii)(VI) of this title.

(4) The term "noninstitutionalized individual" means an individual receiving any of the services specified in subsection (c)(1)(C)(ii).

(5) The term "resources" has the meaning given such term in section 1382b of this title, without regard (in the case of an institutionalized individual) to the exclusion described in subsection (a)(1) of such section.