No. 22-957

In the Supreme Court of the United States

LAURIE A. DERMODY,

Petitioner,

v.

MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF MASSACHUSETTS,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE MASSACHUSETTS SUPREME JUDICIAL COURT

BRIEF IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the requirement in 42 U.S.C. § 1396p(c)(1)(F)(i), as amended in 2006—to list the state Medicaid program as the first remainder beneficiary, to the extent of Medicaid benefits paid, for an annuity that shelters spousal assets from consideration in the Medicaid eligibility process—applies to the purchase of an annuity for which the community spouse is the annuitant.

2. Whether the purchase of an annuity with spousal resources for which the community spouse is the annuitant, and which names remainder beneficiaries, qualifies as a transfer of assets for the sole benefit of the community spouse under 42 U.S.C. § 1396p(c)(2)(B), thereby exempt from consideration as a transfer of assets triggering a period of ineligibility for Medicaid under 42 U.S.C. § 1396p(c)(1)(A).

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INTRODUCTION

The petition here concerns the subsection of federal Medicaid law, 42 U.S.C. § 1396p(c)(1)(F), that sets forth the conditions under which Medicaid applicants can purchase an annuity to reduce their countable assets for purposes of becoming eligible for Medicaid benefits that cover long-term nursing care. In particular, while § 1396p(c)(1)(F) does permit applicants to shelter certain spousal assets from being counted against the Medicaid asset limit by purchasing annuities meeting certain qualifications, it requires that the state Medicaid program be named as the first beneficiary for any remainder, to the extent of Medicaid benefits paid. This provision was first enacted by Congress in the Deficit Reduction Act of 2005 ("DRA"), Pub. L. 109–171, 120 Stat. 4, 63 (Feb. 8, 2006). Shortly thereafter, Congress amended the provision in December 2006 to remove a reference to recovery of benefits paid on behalf of the "annuitant" and to replace it with a reference to benefits paid on behalf of the "institutionalized individual." Tax Relief and Health Care Act of 2006, Pub. L. 109–432, 120 Stat. 2922, 2998 (Dec. 20, 2006). As explained further below, this change ratified federal guidance that had already been issued interpreting the DRA, providing that, consistent with the joint consideration of spousal assets throughout the Medicaid eligibility process, the beneficiary requirement applies to the purchase of an annuity to shelter assets from consideration regardless whether the annuitant is the institutionalized individual or the community spouse.

Resisting this interpretation of the statute, petitioners have contended that such annuities, when they provide income to a Medicaid applicant's spouse,

are instead governed by a separate Medicaid provision, 42 U.S.C. § 1396p(c)(2), which exempts interspousal transfers of assets from a rule that otherwise penalizes applicants for disposing of assets for less than fair market value within a set period preceding the date of a Medicaid application. Petitioners argue that the purchase of such an annuity is for the "sole benefit" of the community spouse—notwithstanding the naming of remainder beneficiaries like the petitioners here—and therefore, their theory goes, exempts the annuity from the very rule Congress specifically and more recently designed to govern couples' purchase of annuities to "spend down" their assets and gain eligibility for Medicaid.

The petition does not present a split of authority warranting the Court's consideration. Aside from the court below, only the Ninth Circuit has addressed the construction of § 1396p(c)(1)(F) in light of the December 2006 amendment clarifying its scope, and the two courts are in agreement. The Sixth Circuit's conclusion to the contrary arose in a case that principally presented a different question not at issue here, and the applicability of the DRA to community spouse annuities was not fully briefed by the parties because the community spouse conceded that the DRA applied to his annuity (in which he had indeed named the state as a contingent remainder beneficiary). Accordingly, that court can and should correct its own error in an appropriate case. Moreover, there is almost no authority whatsoever concerning petitioners' sole-benefit defense to applicability of the DRA, which to date has been squarely addressed only in that same outlier Sixth Circuit decision and which, for the reasons described below, lacks merit both under the plain terms of the sole-benefit provision itself as well as under

basic canons of statutory construction. The petition should therefore be denied.

STATEMENT

1. Under Medicaid's cooperative program in which the federal government reimburses states for a portion of the medical benefits provided to low-income individuals, each participating state must develop a state plan specifying how it will implement federal Medicaid requirements. *See* 42 U.S.C. § 1396p(a). A state must gather information about applicants' financial resources, make eligibility determinations based on those resources, and, where available, pursue financial recoveries from members and their estates as provided by federal law to offset the costs of medical care provided. *See* Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq*.

A married applicant's Medicaid eligibility is based on the combined value of the resources of both the applicant ("individualized spouse") and the applicant's spouse living in the community ("community spouse"). 42 U.S.C. §§ 1396r–5(c)(2), (h)(1)-(2). From this combined amount, a portion of the couple's resources—known as the community spouse resource allowance ("CSRA")—is set aside, which the community spouse may use without affecting the eligibility of the institutionalized spouse. 42 U.S.C. §§ 1396r–5(c)(2), (f)(2)(A). The institutionalized spouse may be financially eligible for Medicaid benefits if, after setting aside the CSRA amount, the couple's combined countable resources fall below the eligibility threshold set forth in their state's Medicaid plan. 42 U.S.C. §§ 1396a(a)(10), (51).

The Medicaid eligibility thresholds lead some applicants to spend down their resources in order to qualify for Medicaid long-term care benefits after they enter a nursing home. *See Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 480 (2002). Congress has enacted various limitations on Medicaid eligibility to provide some financial protection to community spouses while also "preventing financially secure couples from obtaining Medicaid assistance." *Id.*

One of these limitations is the "look back" rule. If an applicant or spouse transfers assets to someone for less than fair market value within the five years preceding the Medicaid application, then the transfer results in a penalty in the applicant's eligibility calculation. *See* 42 U.S.C. § 1396p(c)(1). Subject to certain exceptions, the applicant will be deemed ineligible for Medicaid benefits for a period of time (determined by dividing the value of such a transfer by the average monthly cost of the nursing facility). 42 U.S.C. § 1396p(c)(1)(E).

One exception to the look-back rule is the sole-benefit provision, 42 U.S.C. § 1396p(c)(2)(B), enacted in 1988 as part of the Medicare Catastrophic Coverage Act of 1988 ("MCCA"). Pub. L. 100–360, § 303, 102 Stat. 683, 761 (1988). Under the sole-benefit provision, if a transfer of assets is made to or from "the individual's spouse or to another for the sole benefit of the individual's spouse," then it shall not be the basis for a transfer penalty. 42 U.S.C. § 1396p(c)(2)(B). Prior to the MCCA, the states generally did not treat resources held individually by the community spouse as available to the institutionalized spouse—which in some cases allowed "couples with ample means [to] qualify for [Medicaid] when their assets were held in

the community spouse's name." *Blumer*, 534 U.S. at 480. Because the MCCA newly required jointly counting the resources of the spouses, a transfer of assets simply from one spouse to the other should have no impact on the calculation of countable resources in determining Medicaid eligibility for the institutionalized spouse. 42 U.S.C. § 1396r–5(c)(2)(A).

The Deficit Reduction Act of 2005 placed new conditions on the use of certain financial instruments for Medicaid-planning purposes, including annuities. Pub. L. 109–171, 120 Stat. 4, 63. Prior to the DRA, some wealthy couples had purchased commercial annuities in order to shelter their assets while qualifying for Medicaid. *See* Centers for Medicare and Medicaid Services ("CMS"), Important Facts for State Policymakers, Deficit Reduction Act (Jan. 8, 2008) (reproduced at M.A.II 168-69).[1] In the DRA, Congress placed guardrails on the purchase of such annuities for purposes of Medicaid planning, providing that the purchase of an annuity would be deemed a transfer of assets for less than fair market value, subject to a penalty for purposes of Medicaid eligibility, unless the annuity met several requirements. Most relevantly here, Congress initially provided in the DRA that, to avoid a transfer penalty, an annuity must name the state as a remainder beneficiary "for at least the total amount of medical assistance paid on behalf of the annuitant." Pub. L. 109–171, 120 Stat. 4, 63. The DRA also provided that the states shall require Medicaid applications to "disclose a description of any interest

[1] The record below in the consolidated Mondor and Castle cases contained a three-volume appendix, which is cited as M.A.I, M.A.II, and M.A.III. The two-volume appendix in the Dermody case is cited as D.A.I and D.A.II.

the individual *or community spouse* has in an annuity" and to "include a statement that . . . the State becomes a remainder beneficiary under such an annuity . . . by virtue of the provision of . . . medical assistance." *Id.* (emphasis added).[2]

In July 2006, CMS promulgated initial guidance, authorized under 42 U.S.C. § 1396p(e)(3), to assist the states in implementing the DRA's new requirement for Medicaid-planning annuities. CMS, New Medicaid Transfer of Asset Rules Under the Deficit Reduction Act of 2005 (July 27, 2006) (reproduced at M.A.II 184-85). That guidance stated that the remainder beneficiary provision in the DRA requires that the state be named as a remainder beneficiary not just for annuities purchased by the Medicaid applicant (the individualized spouse), but also for annuities purchased by the applicant's spouse (the community spouse). *Id.*

Five months later, in December 2006, Congress quickly acted to amend § 1396p(c)(1)(F)(i), clarifying that the provision does indeed apply to annuities purchased by a Medicaid applicant *or* an applicant's community spouse. Pub. L. 109–432, 120 Stat. 2922, 2998 (titled "Clarifying Treatment of Certain Annuities"). As initially enacted, the new DRA provision required the state to be named as a remainder beneficiary "for at least the total amount of medical assistance paid on behalf of the *annuitant*." Pub. L. 109–171, 120 Stat.

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[2] Massachusetts has promulgated a form for the provision of the disclosures required by 42 U.S.C. § 1396p(e) and 130 Code Mass. Regs. 520.007(J), referred to as the ANN-3 form. *See* Pet. App. 21a-22a; Massachusetts Executive Office of Health and Human Services, Office of Medicaid, Eligibility Operations Memo 07-14B (June 15, 2008) (reproduced at M.A.II 207-10) (explaining the revised disclosure requirement in light of the DRA).

4, 63 (emphasis added). The December 2006 amendment, reflected in the language of the Medicaid Act now appearing at 42 U.S.C. § 1396p(c)(1)(F), switched that reference from benefits paid on behalf of the "annuitant" instead to benefits paid on behalf of "the institutionalized individual," *i.e.*, not necessarily the annuitant:

> (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.

42 U.S.C. § 1396p(c)(1)(F)(i) (emphasis added); *see* Pub. L. 109–432, 120 Stat. 2922, 2998.

Massachusetts administers Medicaid through the MassHealth program. Mass. Gen. Laws ch. 118E, § 9 (2014). The Commonwealth amended its MassHealth regulations in 2008 to conform with the December 2006 amendment found in § 1396p(c)(1)(F) and to require Medicaid-planning annuities to name the Commonwealth as a remainder beneficiary to the extent of

benefits paid "on behalf of the institutionalized individual." 130 Code Mass. Regs. 520.007(J)(2)(a) (reproduced at M.A.III 565-66); *see* Massachusetts Executive Office of Health and Human Services, Office of Medicaid, Eligibility Operations Memo 07-14B (June 15, 2008) (reproduced at M.A.II 207-10) at 2 (explaining the regulation's revised annuity requirement in light of the clarification of the DRA). Other states have promulgated the same requirement.[3]

2. This petition involves three annuities purchased by three community spouses in connection with the Medicaid applications of their respective institutionalized spouses. The annuity in the Dermody case was purchased for $172,000 by now-deceased Robert Hamel ("Robert") in June 2015, was issued by Nationwide Life Insurance Company ("Nationwide"), and provided for a monthly payment of $2,873.69 over a five-year term. Pet. App. 3a. The Mondor annuity was purchased for $191,215.28 by Edward Mondor

[3] *See, e.g.*, 10 Colo. Code Regs. § 2505-10:8.100.7.I.5.b (requiring annuities with community spouse annuitants to name the state as remainder beneficiary); Haw. Admin. R. § 17-1725.1-52(c) (same); 10-144 Me. Code R. ch. 332, pt. 16, § 4.3.B(2)(b) (same); 23 Miss. Admin. Code 103, R. 6.4.C.1 (same); N.M. Admin. Code § 8.281.500.14.D (same); Ohio Admin. Code § 5160:1-6-06.1 (same); 55 Pa. Code § 178.104a(h)(4) (same); S.D. Admin. R. 67:46:05:53 (same); Utah Admin. Code § R414-305-11(6) (same). *See also* Maryland Department of Health, Medical Assistance Manual § 800.13(a)(1) (July 2012), https://tinyurl.com/yfb9y5tu (instructing applicants to name the state as remainder beneficiary for annuities with community spouse annuitants); New York State Department of Health, Medicaid Reference Guide § 359.3 (Apr. 2008), https://tinyurl.com/2686ykek (same); Texas Health and Human Services Commission, Medicaid for the Elderly and People with Disabilities Handbook, § F-7230 (June 2013), https://tinyurl.com/23xvrbnw (same).

("Edward") in April 2018, was issued by Standard Insurance Company ("Standard"), and provided for a monthly payment of $4,065.00 over a four-year term. Pet. App. 20a-21a. And the Castle annuity was purchased for $176,859.75 by James W. Castle ("James") in November 2018, was issued by Standard, and provides for a monthly payment of $3,031.93 over a five-year term. Pet. App. 23a-24a.

All three annuitants were community spouses who purchased the annuities after their spouses were admitted to nursing facilities for long-term medical care. *See* Pet. App. 3a, 20a, 23a. All three annuities were purchased in order for the institutionalized spouses to become eligible for Medicaid; otherwise, the funds used to purchase the annuities would have counted against the asset limit in Massachusetts for Medicaid eligibility. *See* Pet. App. 3a ("It is undisputed that the purchase of the [Dermody] annuity was intended to help [the institutionalized spouse] become eligible for long-term care benefits pursuant to the Medicaid Act and MassHealth regulations."); Pet. App. 20a ("eligibility for Medicaid long-term care benefits was achieved by the purchase of" the Castle and Mondor annuities).

The annuities named the respective community spouses as annuitants, named the Commonwealth as the primary remainder beneficiary, and named the adult children of the respective community spouses as the secondary remainder beneficiaries. Pet. App. 2a-3a, 20a-21a, & 23a-24a. The institutionalized spouses were all deemed eligible for MassHealth benefits after the purchase of the annuities. Pet. App. 3a, 22a, & 24a. All three community spouses died before the end

of the annuities' terms, having never applied for or received any Medicaid benefits on their own behalf. Pet. App. 3a, 23a, & 24a-25a. The institutionalized spouses, for their part, have each received more than $100,000 in Medicaid benefits. Pet. App. 3a-4a, 23a, & 25a.[4]

3. The Dermody case was commenced by Laurie Dermody on August 4, 2017 as a declaratory judgment action, seeking to resolve competing claims to the proceeds of the annuity and a declaration that the Commonwealth has no remainder interest in her father's annuity. Pet. App. 4a. The trial court allowed Dermody's motion for summary judgment as to the declaratory judgment claim, which the Commonwealth appealed to the Massachusetts Appeals Court.[5] *Id.* The Supreme Judicial Court allowed direct appellate review of the trial court's decision. *Id.*

The consolidated Mondor and Castle cases arose from interpleader claims filed by Standard, seeking to resolve disputes between the Commonwealth and the respective family beneficiaries to the proceeds of the Mondor and Castle annuities. Pet. App. 25a. The trial

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[4] The MassHealth applications for Edward's institutionalized spouse and James's institutionalized spouse also included completed ANN-3 forms, in which the institutionalized spouse acknowledged the requirement to name the Commonwealth of Massachusetts as a beneficiary in the proper position. *See* Pet. App. 21a-22a, 24a. The record for the Dermody case does not disclose whether an ANN-3 form was submitted with the MassHealth application for Robert Hamel's institutionalized spouse.

[5] In January 2020, the trial court ordered the Commonwealth to pay the $118,517.50 in received annuity proceeds to Dermody. Pet. App. 4a.

court allowed the parties' joint motion to report both cases to the Massachusetts Appeals Court without decision, to determine in the first instance the parties' respective rights to the proceeds of the two annuities. *Id.* The Supreme Judicial Court allowed direct appellate review. Pet. App. 19a-20a, 25a.

In the decisions below, the Supreme Judicial Court held that 42 U.S.C. § 1396p(c)(1)(F)(i) applied to the three annuities based on the statute's plain language requiring annuities purchased with spousal assets to name the state as a primary remainder beneficiary to the extent of Medicaid benefits paid for the institutionalized individual, and that the provision does not make an exception for annuities that name the community spouse as annuitant. Pet. App. 12a-13a. The court dismissed the family beneficiaries' defense—that the purchase of a community spouse annuity was a transfer for the sole benefit of the spouse under § 1396p(c)(2), and as such was exempt from the requirement of § 1396p(c)(1)(F)—as contrary to the purpose of the provisions governing annuities. Pet. App. 12a-14a. The court reasoned that an exemption for community spouse annuities would frustrate the purpose of Congress's enactment of § 1396p(c)(1) in the DRA, which was to close a loophole allowing annuities to be used as a vehicle to transfer wealth to heirs regardless Medicaid benefits paid, and would also frustrate the general purpose of the Medicaid law to provide health care to those who cannot afford it. *Id.* The court concluded that § 1396p(c)(2) could not be read to have such an effect, and that the remainders of all three annuities belonged to the Commonwealth up to the amount it has paid for the care of the institutionalized spouses of the annuitants. Pet. App. 14a-15a, 26a-27a.

REASONS TO DENY THE WRIT

I. The Petition Does Not Present a Split of Authority on the Two Questions Presented Warranting the Court's Consideration.

The petition's alleged 2-1 split of authority is shallow to begin with—and closer examination yields further reason to permit additional percolation of questions that have so far received scant attention and on which all of the courts may yet reach agreement. For now, only the court below and the Ninth Circuit have reached the question whether § 1396p(c)(1)(F) applies to community spouse annuities in light of the 2006 amendment to the statute, and both have concluded that it does. And only one appellate court, the Sixth Circuit, has squarely addressed the question whether the sole-benefit exemption in § 1396p(c)(2) applies to community spouse annuities, despite the naming of contingent beneficiaries like petitioners here. This Court's review is therefore unwarranted at this time. *See* Sup. Ct. R. 10.

A. The Two Courts That Have Squarely Considered the Question Whether 42 U.S.C. § 1396p(c)(1)(F)(i), as Amended in December 2006, Governs Community Spouse Annuities Have Reached the Same Conclusion.

While the petition claims a 2-1 split on the question whether the beneficiary requirement in 42 U.S.C. § 1396p(c)(1)(F)(i) applies to community spouse annuities, only two of the identified courts analyzed the statute in full, including Congress's December 2006 amendment ratifying CMS's interpretation—and those two courts have come to the same conclusion. The Sixth Circuit's contrary conclusion, in a case

where this question was not the principal issue presented and was not fully briefed, can and should be corrected by that court itself in a future case where the issue is fully aired.

Among the federal courts of appeals, only the Ninth Circuit has squarely interpreted the DRA in light of the 2006 amendment thereto. Consistent with the decisions below, Pet. App. 10a-13a, 26a, the Ninth Circuit held in *Hutcherson v. Arizona Health Care Cost Containment System Administration* that the beneficiary requirement of § 1396p(c)(1)(F) does apply to community spouse annuities: Because the statute "provides that spouses may not 'spend down' by purchasing an annuity 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[,]'" the court concluded, "[b]y its plain terms, the provision allows the State to recover the expenses incurred on behalf of 'the institutionalized individual,' in this case, Betty." 667 F.3d 1066, 1070 (9th Cir. 2012). The court based its analysis on the plain meaning of the DRA as amended in December 2006, rejecting an argument that the import of the December 2006 amendment should be disregarded because Congress designated the amendment a "technical correction." *Id.* at 1069-71. The Ninth Circuit thus duly recognized that when Congress amended § 1396p(c)(1)(F)(i) in 2006, it did so to make clear that the "institutionalized individual" and the "annuitant" need not be the same person in order for the beneficiary requirement to apply. *Id.* at 1071-72.

The Sixth Circuit's outlier interpretation of the DRA in *Hughes v. McCarthy* failed to acknowledge or

address the fact of Congress's December 2006 amendment clarifying the scope of the beneficiary requirement. 734 F.3d 473, 483-85 (6th Cir. 2013). Notably, the fact of the amendment does not appear to have been brought to the court's attention in the parties' briefing—and for understandable reason. The "primary issue" in *Hughes* arose from the State of Ohio applying a Medicaid eligibility penalty period as a result of the community spouse purchasing an annuity that *did* name Ohio as a contingent remainder beneficiary. *Id*. at 477-78. The issue of the DRA's applicability to community spouse annuities was not fully briefed, because the community spouse *conceded* throughout that Ohio was entitled to be named as a contingent remainder beneficiary for his annuity under the DRA and to recover funds expended for his wife's care if he died and left a remainder.[6] *See id.* at

[6] *See* Plaintiff-Appellants' Brief, *Hughes v. Colbert*, No. 12-3765, 2012 WL 3886803, at *30-31 (6th Cir. Aug. 31, 2012); Plaintiff-Appellants' Reply Brief, *Hughes v. Colbert*, No. 12-3765, 2012 WL 5465686, at *12 (6th Cir. Nov. 2, 2012); Plaintiff-Appellants' Supplemental Brief, *Hughes v. Colbert*, No. 12-3765, 2013 WL 1291128, at *3 (6th Cir. Mar. 21, 2013); Plaintiff-Appellants' Supplemental Brief Pursuant to the Court's July 29, 2013 Order, *Hughes v. Colbert*, No. 12-3765, 2013 WL 4501159, at *6, *9-10 (6th Cir. Aug. 19, 2013); *see also* Brief of Appellee Michael B. Colbert, *Hughes v. Colbert*, No. 12-3765, 2012 WL 5287208, at *41-42 (6th Cir. Oct. 17, 2012) (quoting the DRA as amended but not acknowledging the fact of the amendment); Supplemental Brief of Appellee John B. McCarthy, Filed Pursuant to Court's Order of July 29, 2013, *Hughes v. Colbert*, No. 12-3765, 2013 WL 4501158, at *21-22 (6th Cir. Aug. 19, 2013) (same); Brief of the United States Department of Health and Human Services as Amicus Curiae, *Hughes v. Colbert*, No. 12-3765, 2013 WL 3366469, at *16-18 (6th Cir. June 20, 2013) (simply stating that community spouse annuities must comply with the requirement

484 (commenting on briefing deficiencies concerning interpretation of the DRA). Accordingly, if presented with full briefing on this issue for the first time in a future case, the Sixth Circuit can and should revisit this question and correct its own error.

B. The Need for Further Percolation on These Issues Is Underscored by the Limited Authority on Whether § 1396p(c)(2) Applies to Community Spouse Annuities.

Petitioners' defense to the applicability of the beneficiary requirement Congress created to govern annuities in § 1396p(c)(1)(F) rests entirely on the claimed applicability of a different section of the statute, § 1396p(c)(2), exempting from penalty transfers that are for the sole benefit of the community spouse. The paucity of authority on whether a community spouse annuity is indeed a qualifying transfer of assets for the sole benefit of the community spouse provides further reason the issues here warrant additional percolation.

The Ninth Circuit did not address the sole-benefit rule in § 1396p(c)(2) at all in *Hutcherson*. *See* 667 F.3d at 1070-72. The court below, seemingly assuming that

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of § 1396p(c)(1)(F)). Given the couple's concessions throughout, including in both rounds of supplemental briefing, the basis of the Sixth Circuit's assertion that "the Hugheses . . . contend[ed] in their second supplemental brief . . . [that] an annuity that satisfies § 1396p(c)(2)(B)(i) need not satisfy § 1396p(c)(1)(F)," *Hughes*, 734 F.3d at 484, is unclear. *See* Plaintiff-Appellants' Supplemental Brief Pursuant to the Court's July 29, 2013 Order, *supra*, at *6 ("Appellants agree with HHS that if the community spouse dies, the State, rather than a third party beneficiary, benefits from the remaining payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse.").

community spouse annuities would generally qualify as sole-benefit transfers despite the existence of contingent beneficiaries like the petitioners here, simply held that applicability of the sole-benefit exemption must yield to the more specific and later-enacted annuities-related provisions in § 1396p(c)(1)(F) based on the purposes of the DRA and the Medicaid program more generally. Pet. App. 9a, 13a-14a, 26a.

The Sixth Circuit is thus the only appellate court that has addressed in any detail the question whether a community spouse annuity actually is a sole-benefit transfer under § 1396p(c)(2)—and did so incompletely. *Hughes*, 734 F.3d at 481-83. Turning away from the plain text of the statute requiring that the transfer "sole[ly]" benefit the spouse, the court considered the "context" of "financial instruments" to which § 1396p(c)(2) would apply, and on the basis of its assessment of that context concluded that the sole-benefit term "naturally encompasses" even annuities naming contingent beneficiaries. *Id.* at 483. Importantly, the court did not squarely address how to resolve the conflict that arises between the sole-benefit exemption in § 1396p(c)(2), if applicable, and the beneficiary requirement of § 1396p(c)(1)(F), because, in derogation of the DRA's plain purposes, the court concluded that the latter provision simply did not apply. *Id.* at 485-86.

In sum, there is little appellate authority on the issues presented in this case, and the two courts to consider the issues with the benefit of full briefing have reached the same conclusion. This Court's intervention is not warranted.

II. The Decisions Below Are Correct.

This Court's review is also unwarranted because the decisions below are correct as a matter of statutory interpretation. The beneficiary requirement of § 1396p(c)(1)(F) is plain and unambiguous, and its application to community spouse annuities is the only interpretation consistent with Congress's amendment of the statute in December 2006 ratifying CMS's initial interpretation of the DRA. The proposition advanced by petitioners, that preexisting general sole-benefit language in § 1396p(c)(2) acts to exempt community spouse annuities from the specific language of § 1396p(c)(1)(F) governing annuities, is contrary to not only the text and purpose of the sole-benefit rule, but also elementary canons of statutory interpretation.

A. The Beneficiary Requirement of § 1396p(c)(1)(F)(i) Applies to the Purchase of Community Spouse Annuities.

The court below, in concert with the only U.S. court of appeals to consider the question after full briefing, correctly concluded that the beneficiary requirement set forth in § 1396p(c)(1)(F) applies to community spouse annuities.

To begin with, the plain text of § 1396p(c)(1)(F) is unambiguous and makes no exceptions for annuities purchased by or for community spouses. Pet. App. 11a-13a. As discussed above, under current Medicaid law treating couples' assets jointly for eligibility purposes, disposals of assets for less than fair market value—*e.g.*, in order to "spend down" a couple's resources to become eligible for Medicaid—subject a Medicaid applicant to a penalty period of ineligibility, regardless whether the disposal of assets is by the

Medicaid applicant or the spouse. *See* 42 U.S.C. § 1396p(c)(1)(A); *supra* pp. 3-5. The disputed provision here, § 1396p(c)(1)(F), as amended, states broadly that "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). The provision thus applies simply to the purchase of "an annuity," and does not limit its reach to annuities purchased for the institutionalized individual in particular.

The conclusion that the beneficiary requirement applies equally to community spouse annuities is further compelled by Congress's amendment to this provision months after its enactment. As described above, the statute initially commanded that the state be named as beneficiary for at least the total amount of medical assistance paid on behalf of "the *annuitant*"—thus implying that the state could recover only from an annuity purchased for the Medicaid recipient. *See supra* at pp. 5-6. When Congress amended § 1396p(c)(1)(F) in December 2006 to change the term "annuitant" to "institutionalized individual," the plain legal effect and clear intent was to ensure a state's right to recover from community spouse annuities, consistent with CMS's initial guidance on the meaning of the DRA. *See Hutcherson*, 667 F.3d at 1071; *supra* pp. 6-7. And this 2006 amendment to § 1396p(c)(1)(F) cannot be read out of the statute. *See, e.g.*, *Stone v. I.N.S.*, 514 U.S. 386, 397 (1995) ("When Congress acts to amend a statute, we presume it intends its amendment to have real and substantial effect."); *Rumsfeld v. Forum for Acad. & Institutional Rts., Inc.*, 547 U.S.

47, 57-58 (2006) ("We refuse to interpret the [statute] in a way that negates its recent revision, and indeed would render [that revision] a largely meaningless exercise.").

This interpretation of § 1396p(c)(1)(F) also accords with the Medicaid statute's disclosure requirement regarding annuities. Section 1396p(e) provides that states must require Medicaid applications to "disclose a description of any interest the individual *or community spouse* has in an annuity" and to "include a statement that under [§1396p(e)(2)] the State becomes a remainder beneficiary under such an annuity . . . by virtue of the provision of such medical assistance." 42 U.S.C. § 1396p(e) (emphasis added). Requiring the disclosure of an annuity in which a community spouse has an interest (*i.e.*, is an annuitant) and a statement that the state is a contingent remainder beneficiary to that annuity would be nonsensical if such annuities were not subject to § 1396p(c)(1)(F).

Moreover, this interpretation is consistent with the purpose of § 1396p(c)(1)(F). In enacting the DRA, Congress intended to close prior eligibility loopholes that couples had used to retain the benefit of and potentially pass onto heirs their substantial assets, while also receiving Medicaid benefits—in derogation of Congress's longtime goal of ensuring that Medicaid benefits be available only to those without sufficient resources and be a payor of last resort. *See* Pet. App. 12a-14a; *Blumer*, 534 U.S. at 479. By contrast, adopting petitioners' reading would result in § 1396p having the same loophole that the DRA was intended to close: A married couple could purchase an annuity of any conceivable size for the community spouse to reduce

their assets to the eligibility threshold, and if the community spouse died before the expiration of the annuity term, all of the remaining proceeds could go directly to their adult non-disabled children while the institutionalized spouse continued to receive care at taxpayer expense. Petitioners' reading of § 1396p(c)(1)(F) thus cannot be reconciled with the DRA's plain purpose.

In sum, the two courts to consider this question following full briefing have reached the correct result.

B. The Sole-Benefit Rule for Spousal Transfers Does Not Exempt Community Spouse Annuities from the Beneficiary Requirement of § 1396p(c)(1)(F)(i).

Contrary to petitioners' assertion, a community spouse's purchase of a Medicaid-planning annuity, naming the state as a remainder beneficiary, is simply not a transfer of assets for the sole benefit of the community spouse. And, in any event, even if the sole-benefit exemption were to apply by its own terms considered in isolation, the beneficiary requirement Congress later enacted in the DRA specifically to govern annuities would still govern community spouse annuities under basic principles of statutory interpretation.

Section 1396p(c)(2) provides that an individual "shall not be ineligible for medical assistance by reason of paragraph (1) [for a disqualifying transfer of assets for less than fair market value] to the extent that . . . the assets were transferred to the individual's spouse or to another for the 'sole benefit' of the community spouse." 42 U.S.C. § 1396p(c)(2). Although the statute does not define the term "sole benefit," its plain meaning is clear: it signifies a transfer of assets

to which only the community spouse can benefit at the time of the transfer or in the future. *See* CMS, The State Medicaid Manual § 3257, at 3-3-109.2 (reproduced at M.A.II 267) (a "transfer is considered to be for the sole benefit of a spouse . . . if the transfer is arranged in such a way that no individual or entity except the spouse . . . can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future").

The purchase of an annuity that provides for income to the community spouse during that spouse's lifetime *and* income to the remainder beneficiaries in the event that the community spouse dies before the end of the annuity's term is not such an asset transfer for the "sole" benefit of the community spouse. That is precisely why Congress required the state to be named as the primary remainder beneficiary for such annuities under § 1396p(c)(1)(F). Congress intended that the state would financially benefit from annuity funds that remain after the community spouse annuitant dies—a benefit offsetting the state's costs of providing Medicaid benefits to the institutionalized spouse. *See supra* pp. 5-7.

Nor is petitioners' reading required in order to effect the purpose of § 1396p(c)(2). As discussed above, this sole-benefit exemption was enacted as part of the MCCA in 1988, which, among other changes, newly provided that spousal assets would be considered jointly for purposes of Medicaid eligibility. *See supra* pp. 4-5; Pet. App. 7a-8a. A transfer of assets between spouses would neither hasten eligibility nor impede it. Reading § 1396p(c)(2) as a general rule that facilitates spousal transfers consistent with the MCCA's joint treatment of spousal assets, rather than as a specific

exemption to the annuities requirement, is consistent with that general legislative purpose. *See Morris v. Okla. Dep't of Human Servs.*, 685 F.3d 925, 929 (10th Cir. 2012) (describing the sole-benefit rule and the MCCA as "allow[ing] for unlimited transfers between spouses"). Providing the same treatment to both types of annuities—those with the community spouse as annuitant and those with the institutionalized spouse as annuitant—still allows resources to flow between spouses at the time of the annuity's purchase and then to benefit the community spouse during the community spouse's lifetime. The plain text of § 1396p(c)(1)(F) thus can and should be read in harmony with § 1396p(c)(2). *See FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 133 (2000) (we must "interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into a[] harmonious whole") (internal citations and quotation marks omitted).

However, even if the sole-benefit rule in § 1396p(c)(2) were read to apply to community spouse annuities by that provision's own terms considered in isolation, Congress's later addition of § 1396p(c)(1)(F) in the DRA would govern the beneficiary requirement for community spouse annuities under the usual canons of construction governing seeming conflicts between statutory provisions. Because the DRA provision deals specifically with the treatment of annuities for Medicaid eligibility purposes, unlike the highly general sole-benefit rule in § 1396p(c)(2) that is applicable to all manner of inter-spousal transfers, the latter cannot displace the former. *See Bloate v. United States*, 559 U.S. 196, 207-08 (2010). And the DRA provisions governing annuities are the more recently enacted provisions, *see Branch v. Smith*, 538 U.S. 254,

273 (2003), and, indeed, were adopted precisely because of Congress's dissatisfaction with the annuity-based loopholes that had arisen under the earlier law, *see Hutcherson*, 667 F.3d at 1069-70.

In sum, the two courts to have considered the interpretation of 42 U.S.C. § 1396p(c)(1)(F) with the benefit of full briefing are plainly correct under familiar principles of statutory construction. Petitioners, whose parents adhered to the beneficiary rule set forth in § 1396p(c)(1)(F) in their respective annuities in order to gain eligibility for Medicaid, cannot side-step the rule now.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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