COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT

No. DAR-_____

SUFFOLK, SS. APPEALS COURT NO. 2021-P-0632

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMOWNEALTH OF MASSACHUSETTS,

v.

LINDA MARIE MONDOR, and others (AND A COMPANION CASE)[1]

ON A REPORT WITHOUT DECISION OF THE CONSOLIDATED CASES

JOINT APPLICATION FOR DIRECT APPELLATE REVIEW

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[1] *Executive Office of Health and Human Services* v. *Kathleen Ann Bristow*, and others.

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REQUEST FOR DIRECT APPELLATE REVIEW

All parties to these consolidated cases, which have been reported to the Appeals Court without decision pursuant to Mass. R. Civ. P. 64, hereby jointly request direct appellate review.

The consolidated cases raise a complex set of Medicaid and contract law issues that have split the state and federal courts: whether Medicaid law requires that certain annuities—purchased by a "community spouse" in conjunction with their "institutionalized spouse's" application for long-term care benefits—designate the state in a remainder position and, in turn, how such a designation should be interpreted as a matter of contract and estate recovery law.[2] The deepening split surrounding these issues has generated much litigation in the Superior Court, with nineteen cases filed since 2017, fourteen of which remain pending today. This split has also generated widespread confusion concerning MassHealth's treatment of annuities, delayed the payout of large amounts of undisbursed annuity funds, and left insurance companies, MassHealth applicants, and Medicaid advisors all unsure as to their own obligations.

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

All agree that this state of affairs is unsustainable and that appellate resolution is necessary as soon as possible—this, in large part, is why the parties here agreed to proceed expeditiously on a joint statement of material facts. Because the consolidated cases present novel and important issues of law that have divided lower courts, and because the confusion and volume of litigation surrounding these issues will only continue to grow in the absence of a final and comprehensive determination by this Court, the parties jointly request direct appellate review.

PRIOR PROCEEDINGS

This case is currently before the Appeals Court on the Superior Court's report without decision of two consolidated cases known as the "Mondor case" and the "Castle case." Add. 39-40, 44, 92-106.

I. Proceedings in the Mondor Case.

The Mondor case was initially commenced by Standard Insurance Company ("Standard") on October 29, 2020 as an interpleader action, seeking to resolve competing claims to the proceeds of an annuity which was purchased by the now-deceased Edward Mondor and which listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) Defendants-Appellees Linda Marie Mondor, Michelle Mogan, and Cathy Ann Mondor (collectively the "Mondor Beneficiaries") in the contingent (or secondary) beneficiary position. Add. 37, 95-96.

On January 19, 2021, Plaintiff-Appellant the Executive Office of Health and Human Services of the Commonwealth of Massachusetts (the "Commonwealth") answered the interpleader complaint and cross-claimed against the Mondor Beneficiaries for declaratory judgment. Add. 37, 46-53. On March 30, 2021, the Mondor Beneficiaries answered the operative interpleader complaint and the Commonwealth's cross-claim, and cross-claimed against the Commonwealth for declaratory judgment. Add. 38, 54-66.[3] On May 18, 2021, the Commonwealth answered the Mondor Beneficiaries' cross-claims. Add. 38.

On June 11, 2021, all parties stipulated to the dismissal of Standard from the case, with the litigation continuing as to the respective cross-claims for declaratory judgment between the Commonwealth and the Mondor Beneficiaries. Add. 39, 97.

II. Proceedings in the Castle Case.

The Castle case was initially commenced by Standard on April 27, 2021, seeking to resolve competing claims to the proceeds of an annuity which was purchased by the now-deceased James W. Castle and which listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) Defendants-Appellees Kathleen Ann Bristow, Marianne Schwenzfeier, and John

[3] A separate claim for class action relief against the Commonwealth was voluntarily dismissed by the Mondor Beneficiaries. Add. 39.

Francis Castle (collectively the "Castle Beneficiaries") in the contingent (or secondary) beneficiary position. Add. 43, 98.

Standard filed its operative complaint on April 27, 2021. Add. 43. On June 4, 2021, the Commonwealth answered the complaint and cross-claimed against the Castle Beneficiaries for declaratory judgment. Add. 43, 68-77. On June 8, 2021, the Castle Beneficiaries answered the complaint and the Commonwealth's cross-claim, and cross-claimed against the Commonwealth for declaratory judgment. Add. 43, 78-91. On June 10, 2021, the Commonwealth answered the Castle Beneficiaries' cross-claim. Add. 44.

On June 21, 2021, all parties stipulated to the dismissal of Standard from the case, with the litigation continuing as to the respective cross-claims for declaratory judgment between the Commonwealth and the Castle Beneficiaries. Add. 44, 100.

III. The Consolidation and Report of the Mondor and Castle Cases.

On June 17, 2021, the Superior Court consolidated the Mondor and Castle cases. Add. 39. On June 29, 2021, the Commonwealth, the Mondor Beneficiaries, and the Castle Beneficiaries jointly moved to report both cases to the Appeals Court without decision on a statement of agreed material facts. Mass. R. Civ. P. 64; Add. 92-116. The parties also submitted, along with their agreed statement of material facts, an appendix of agreed exhibits. Add. 39, 93. On June 30, 2021, the Superior Court allowed the joint motion to report in a margin order, Add. 106, and that margin

order serves as the notice of appeal, *see* Mass. R. App. P. 5. The consolidated cases entered in the Appeals Court on July 13, 2021 under a single docket number (No. 2021-P-0632).

STATEMENT OF FACTS

The Mondor and Castle cases seek to resolve competing claims to the proceeds of two annuities separately purchased by "community spouses" which name the Commonwealth in the primary beneficiary position. The Commonwealth contends that the "community spouses" were required by Medicaid law to designate the Commonwealth as the primary beneficiary of the annuities to the extent of any MassHealth benefits paid to their "institutionalized spouses," and that the designations should be interpreted accordingly. Add. 49-52. The Mondor Beneficiaries and Castle Beneficiaries contend that no such requirement exists under Medicaid law, and that the designations at most permit the Commonwealth to recover to the extent of any MassHealth benefits paid to the "community spouses" themselves, of which there were none. Add. 56-62. The parties' cross-claims for declaratory judgment seek to resolve these competing contentions. Add. 46-91, 102.

I. Annuities in the Context of MassHealth.

MassHealth provides, among other things, long-term care benefits for individuals in nursing homes whose assets and income fall below certain limits. *Forman v. Dir. of Office of Medicaid*, 79 Mass. App. Ct. 218, 222 (2011). To

qualify, an applicant must generally have $2,000 or less in "countable assets." 130 CMR 520.016(A). When an applicant is married and lives with their "community spouse," MassHealth will assess the total combined value of the "countable assets" owned by both spouses "regardless of the form of ownership between the couple." 42 U.S.C. § 1396r–5(c)(2); 130 CMR 520.016(B). From this combined amount, MassHealth will set aside a portion of the couple's assets—known as the community spouse resource allowance ("CSRA")—which the "community spouse" may use without affecting the Medicaid eligibility of the "institutionalized spouse." 42 U.S.C. § 1396r–5(c)(2), (f)(2)(A); 130 CMR 520.016(B)(2). If, after setting aside the CSRA amount, the couple's combined "countable assets" fall below the $2,000 limit, then the asset requirements for eligibility will be met. 130 CMR 520.016(B)(2).[4]

These "countable assets" limits may lead applicants to "spend down" by "deplet[ing] their resources to qualify for Medicaid long-term care benefits when they enter a nursing home." *Daley v. Sec'y of Exec. Office of Health & Human Servs.*, 477 Mass. 188, 192 (2017). One common way in which applicants or their

[4] One exception to state regulations regarding asset verifications and eligibility determinations is the spousal refusal provision. 130 CMR 517.011 states that an institutionalized spouse whose community spouse refuses to cooperate, or whose whereabouts is unknown, will not be ineligible for MassHealth under certain conditions. *See* 130 CMR 517.011(A), (B).

spouses may seek to spend down assets is through the purchase of commercial annuities. *See Normand v. Dir. of Off. of Medicaid*, 77 Mass. App. Ct. 634 (2010).

Under 42 U.S.C. § 1396p(c)(1), G. L. c. 118E, § 28, and 130 CMR 520.018-520.019, MassHealth must review any transfers of resources (including the purchase of annuities) made by an applicant or their spouse during a five-year "look back" period prior to the applicant's application. For any such asset transfer that was made for "less than fair market value," subject to certain exceptions, MassHealth will impose a penalty: the applicant will be deemed 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 facility. 42 U.S.C. § 1396p(c)(1)(E); 130 CMR 520.019(G).

Federal Medicaid law and MassHealth regulations contemplate that, in certain circumstances, an annuity must name the state as a remainder beneficiary of the annuity in order for the purchase of the annuity to be safe from penalty. 42 U.S.C. § 1396p(c)(1)(F); 42 U.S.C. § 1396p(e); 130 CMR 520.007(J)(2)(A). MassHealth and the Federal Centers for Medicare and Medicaid Services (which administers Medicaid at the Federal level) ("CMS") take the position that an annuity naming the "community spouse" as the annuitant must name the state as a remainder beneficiary. *See, e.g.*, CMS Enclosure Section 6012, Changes in Medicaid Annuity Rules Under the Deficit Reduction Act of 2005 (July 27, 2006), available at

https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/TOAEnclosure.pdf. Others, like the Mondor Beneficiaries and Castle Beneficiaries, take the position that, as a matter of law, an annuity naming the "community spouse" as the annuitant need not name the state as a remainder beneficiary. *See, e.g.*, *Hughes v. McCarthy*, 734 F.3d 473, 483-85 (6th Cir. 2013).

The two Federal circuit courts to have considered this issue have reached conflicting results. *Compare Hughes*, 734 F.3d at 483-85 (reproduced at Add. 139) (community spouse annuity not required to name the state as remainder beneficiary), *with Hutcherson v. Ariz. Health Care Cost Containment Sys. Admin.*, 667 F.3d 1066, 1067-70 (9th Cir. 2012) (reproduced at Add. 150) (community spouse annuity required to name the state as remainder beneficiary). The two Massachusetts Superior Court decisions to have considered this issue have also reached conflicting results. *Compare Dermody v. Exec. Office of Health & Human Servs.*, No. 1781CV02342, 2020 WL 742194 (Middlesex Super. Jan. 16, 2020) (reproduced at Add. 118) (community spouse annuity not required to name the state as remainder beneficiary), *with Am. Ntl. Ins. Co. v. Jennifer Breslouf, et al.*, No. 2084CV02374, 2021 WL 2343024 (Suffolk Super. June 3, 2021) (reproduced at Add. 127)

(community spouse annuity required to name the state as remainder beneficiary); *see infra* pp. 24-26 (further discussing *Hughes, Hutcherson, Dermody,* and *Breslouf*).[5]

II. The Annuity in the Mondor Case.

As noted above, the Mondor case concerns an annuity purchased by the now-deceased Edward Mondor ("Edward") and which listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) the Mondor Beneficiaries in the contingent beneficiary position. Add. 108.

Edward's spouse Elda Mondor ("Elda") was admitted to a skilled nursing facility for long-term care on March 20, 2018 at the age of 84. Add. 108. After Elda's admission, Edward purchased an annuity contract with their spousal assets. Add. 108. Specifically, on April 18, 2018, Edward purchased Annuity Contract Number 00BB056000 issued by Standard (hereinafter, the "Mondor Annuity Contract"). Add. 108. Edward paid a premium of $191,215.28 for the Mondor Annuity Contract, with a monthly payment of $4,065.00, payable commencing June 3, 2018 and continuing for a 4-year term. Add 108.

[5] A notice of appeal was filed in *Breslouf* on June 25, 2021, but the Superior Court has not yet assembled the record. The Commonwealth anticipates filing a notice of appeal in *Dermody* after the judgment becomes final. The parties here agree that it would be advantageous for this Court to similarly consider granting direct appellate review in *Breslouf* and *Dermody*, if and when those cases reach the Appeals Court, and consolidating them with the present cases for purposes of argument.

The Mondor Annuity Contract named Edward as the sole annuitant and owner. Add. 108. Edward named the following as the primary beneficiary of the Mondor Annuity Contract: "THE COMMONWEALTH OF MASSACHUSETTS." Add. 108. Edward named his and Elda's daughters, "LINDA MARIE MONDOR," "MICHELLE MOGAN," and "CATHY ANN MONDOR," as the contingent beneficiaries of the Mondor Annuity Contract in equal parts. Add. 108.

On or about June 4, 2018, Elda submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility. Add. 109. On August 29, 2018, MassHealth approved Elda's MassHealth Application, deeming her eligible for MassHealth standard benefits to cover her care in a nursing facility retroactive to May 1, 2018. Add. 110.

Elda presently continues to reside in a skilled nursing facility and continues to receive MassHealth benefits for her long-term care. Add. 110. Edward passed away on April 11, 2020 at the age of 92. Add. 110. Edward never received Medicaid or MassHealth benefits during his lifetime. Add. 111. At the time of Edward's death, $97,720.28 in annuity proceeds remained to be paid. Add. 111.

In a letter dated July 29, 2020, the Commonwealth made a claim on the proceeds of the Mondor Annuity Contract up to the total amount of medical assistance paid on behalf of the MassHealth recipient, Elda, and identified $146,903.57 in such assistance as of July 29, 2020. Add. 110. In a letter dated

August 3, 2020, the Mondor Beneficiaries, in their capacity as the contingent beneficiaries of the Mondor Annuity Contract, made a claim to all proceeds of the annuity remaining after Edward's death. Add. 111.

Standard remains in possession of the balance of the annuity proceeds remaining after Edward's death. Add. 29. Standard has contractually agreed to pay out such funds in accordance with the final judgment, and this agreement is included in the parties' appendix of agreed exhibits.

III. The Annuity in the Castle Case.

As noted above, the Castle case concerns an annuity purchased by the now-deceased James W. Castle ("James") and which listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) the Castle Beneficiaries in the contingent beneficiary position. Add. 111-12.

James's spouse, Carol A. Castle ("Carol"), was admitted to a skilled nursing facility for long-term care on August 3, 2018, at the age of 78. Add. 111. After Carol's admission, James purchased an annuity contract with their spousal assets. Add. 111. Specifically, on November 2, 2018, James purchased Annuity Contract Number 00BB063280 issued by Standard (hereinafter, the "Castle Annuity Contract"). Add. 111. James paid a premium of $176,859.75 for the Castle Annuity Contract, with a monthly payment of $3,031.93 payable commencing November 19, 2018 and continuing for a 5-year term. Add. 111-12.

The Castle Annuity Contract named James as the sole annuitant and owner. As the primary beneficiary of the Castle Annuity, James named: "THE COMMONWEALTH OF MASSACHUSETTS." Add. 112. James named his and Carol's children, "KATHLEEN ANN BRISTOW," "MARIANNE SCHWENZFEIER," and "JOHN FRANCIS CASTLE," as the contingent beneficiaries in equal parts. Add. 112.

On or about December 6, 2018, Carol submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility. Add. 112. On March 22, 2019, MassHealth approved Carol's MassHealth application, deeming her eligible for MassHealth standard benefits to cover her care in a nursing facility retroactive to November 12, 2018. Add. 113.

Carol passed away on April 23, 2020. Add. 113. Between November 12, 2018 and the time of Carol's death, MassHealth paid $123,413.51 in medical assistance on behalf of Carol. Add. 114. James passed away on October 1, 2020 at the age of 88. Add. 113. At the time of James's death, approximately $110,000 in annuity proceeds remained to be paid on the Castle Annuity Contract. Add. 113.

In a letter dated February 22, 2021, the Commonwealth made a claim on the Castle Annuity Contract up to the total amount of medical assistance paid on behalf of Carol. Add. 114. Standard thereafter made five monthly benefit payments under the Castle Annuity Contract of $3,031.93 each to the Commonwealth, for a total of

$15,159.65, reflecting the amounts payable between October 19, 2020 and February 19, 2021. Add. 114. In or around February 2021, the Castle Beneficiaries, in their capacity as the contingent beneficiaries of the Castle Annuity Contract, made a claim to all remaining proceeds of the Castle Annuity Contract and to the $15,159.65 that had been paid to the Commonwealth between October 19, 2020 and February 19, 2021. Add. 114. In response to the competing claims, Standard ceased paying monthly benefit payments effective March 19, 2021. Add. 114.

Standard remains in possession of the balance of all the annuity proceeds accumulated since its last payment to the Commonwealth, and has contractually agreed to pay out such funds in accordance with the final judgment, with this agreement included in the parties' appendix of agreed exhibits. Add. 114.

IV. Other Annuity Cases in the Superior Court.

The Mondor and Castle cases are two of nineteen cases filed in the past several years involving similar disputes over beneficiary language naming the "Commonwealth" in the primary beneficiary position of annuities purchased by "community spouses" in conjunction with MassHealth applications submitted by their "institutionalized spouses." Fourteen of the nineteen cases remain pending today. Thirteen of the nineteen cases were filed within the past year.

The cases are summarized here:

	CASE	***DESCRIPTION***	***SIZE OF ANNUITY***	***PRIMARY BENEFICIARY OF ANNUITY[6]***	***STATUS OF CASE***
1	*Laurie Dermody v. EOHHS et al.*, No. 1781CV02342 (Middlesex Super., filed August 4, 2017)	Action by contingent beneficiaries to recover $118,517.50 paid by insurance company to the Commonwealth, reflecting benefits paid to the institutionalized spouse.	$172,500	"Commonwealth to the Extent Benefits Paid"	Judgment not yet final as to EOHHS, and cross-claims for indemnification and contribution against EOHHS remain pending.
2	*Aline Madden et al. v. Standard Ins. Co. et al.*, No. 1981CV00413 (Middlesex Super., filed Feb. 12, 2019)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$600,000	"Commonwealth"	Settled.
3	*William Engelmann v. Marylou Sudders et al.*, No. 2077CV00178 (Essex Super., filed Feb. 12, 2020)	G. L. c. 30A appeal from decision of MassHealth Board of Hearings Officer determination that annuity purchased by community spouse must name the Commonwealth as a beneficiary.	$139,689 $352,000 (two annuities)	N/A	Voluntarily dismissed by the plaintiff.
4	*Nationwide Life Ins. v. Commonwealth, Megan Collins, et al.*, No. 2084CV00981 (Suffolk Super., filed May 4, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$140,000	"The Commonwealth of Massachusetts, 100%"	Settled.
5	*Linda Carew et al. v. Marylou Sudders, et. al.*, No. 2084CV03020 (Suffolk Super. (BLS), filed June 16, 2020)	Action by contingent beneficiaries to recover $332,814.16 paid by insurance company to the Commonwealth, reflecting benefits paid to the institutionalized spouse.	$800,000	"Commonwealth of Massachusetts/ MassHealth"	Pending.

[6] As alleged in the original complaint in each case.

6	*Allianz Life Ins. Co. of N. Am. v. Commonwealth, Christopher R. Anderson, et al.*, No. 2084CV01321 (Suffolk Super., filed June 23, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$139,937.57 $51,929.51 (two annuities)	"The Commonwealth of Massachusetts to the extent of the total amount of the medical assistance paid on behalf of the annuitant"	Pending.
7	*Nationwide Life Ins. Co. v. Commonwealth and Matthew Quinn*, No. 2084CV01783 (Suffolk Super., filed Aug. 11, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$100,000	"The Commonwealth of Massachusetts to the extent of the total amount of the medical assistance paid on behalf of John Quinn"	Pending.
8	*Standard Ins. Co. v. Michael Teifeld et al.*, No. 2084CV01839 (Suffolk Super., filed Aug. 17, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$460,000	"Commonwealth of Massachusetts"	Voluntarily dismissed following withdrawal of claim by contingent beneficiaries.
9	*Nationwide Life Ins. Co. v. Commonwealth, Christopher R. Anderson, et al.*, No. 2084CV02084 (Suffolk Super., filed Sept. 14, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$250,000 $377,026.56 (two annuities)	"Commonwealth of Massachusetts for at least the total amount of medical assistance paid on behalf of the annuitant."	Pending.

10	*Standard Ins. Co. v. EOHHS Lisa N. Bowler. et al.*, No. 2084CV02121 (Suffolk Super., filed Sept. 14, 2020)	Action by contingent beneficiaries to recover $95,790.13 paid by insurance company to the Commonwealth, reflecting benefits paid to the institutionalized spouse.	$2,049.656 $882,885 (two annuities)	"Commonwealth of Massachusetts for at least the amount of medical assistance paid on behalf of the institutionalized individual."	Pending.
11	*Standard Ins. Co. v. EOHHS, Paul Johnson et al.*, No. 2084CV02181 (Suffolk Super., filed Sept. 24, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$125,268 $293,412 (two annuities)	"Commonwealth of Massachusetts to the extent of benefits paid for the annuitant"	Settled.
12	*Am. Nat'l Ins. Co. v. Commonwealth, Jennifer Breslouf, et al.*, No. 2084CV02374 (Suffolk Super., filed Oct. 16, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$565,000	"Commonwealth of Massachusetts as reminder [sic] beneficiary in first position for the total amount of medical assistance paid on behalf of the institutionalized individual pursuant to 130 CMR 520.007(J)(2)."	Final judgment entered in favor of the Commonwealth on June 3, 2021. Notice of appeal file by contingent beneficiaries on June 25, 2021 but record not yet assembled.
13	*EOHHS v. Linda Marie Mondor et al.*, No. 2084CV02484 (Suffolk Super., filed Oct. 29, 2020)	Declaratory judgment action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$191,215	"The Commonwealth of Massachusetts"	On appeal in the present case.
14	*Standard Ins. Co. v. EOHHS, Stephen Ursino et al.*, No. 2084CV02550 (Suffolk Super., filed Nov. 4, 2020)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$96,000	"Commonwealth of Massachusetts"	Pending

15	*Standard Ins. Co. v. EOHHS, Estate of Kenneth F. Denham et al.*, No. 2184CV00058 (Suffolk Super., filed Jan. 12. 2021)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$350,800 $22,900 (two annuities)	"Commonwealth of MA Medicaid for any lien due"	Pending.
16	*John E. Jackson v. Marylou Sudders et al.*, No. 2181CV00543 (Middlesex Super., filed Mar. 10, 2021)	G. L. c. 30A appeal from decision of MassHealth Board of Hearings Officer determining that annuity purchased by community spouse must name the Commonwealth as a beneficiary.	$381,523 $232,450 $44,000 (three annuities)	N/A	Pending.
17	*Nationwide Life Ins. Co. v. Commonwealth, Kenneth F. Klempa, et al.*, No. 2184CV00587 (Suffolk Super., filed Mar. 15, 2021)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$200,000	"Commonwealth to the extent of the total amount of the medical assistance paid on behalf of the institutionalized individual"	Pending.
18	*EOHHS v. Kathleen Ann Bristow, et al.*, No. 2184CV00962 (Suffolk Super., filed April 27, 2021)	Declaratory judgment action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$176,860	"The Commonwealth of Massachusetts"	On appeal in the present case.
19	*Standard Ins. Co. v. EOHHS, Joseph P. Gorman, Jr., et al.*, No. 2184CV01332 (Suffolk Super., filed June 8, 2021)	Interpleader action where insurance company withheld remaining annuity funds due to dispute between Commonwealth and contingent beneficiaries.	$106,000	"Commonwealth of Massachusetts, for at least the total amount of medical assistance paid on behalf of the institutionalized individual"	Pending.

ISSUES OF LAW RAISED BY THE APPEAL

The parties' joint motion to report the consolidated cases without decision, as filed in the Superior Court, identified the following issues of law raised by the appeal:

1. Do the beneficiary-naming provisions of 42 U.S.C. § 1396p(c)(1)(F), 42 U.S.C. § 1396p(e), and/or 130 CMR 520.007(J)(2)(A) apply to annuities for which the "community spouse" is named as the annuitant?
2. Under the Mondor Annuity Contract and Castle Annuity Contract, is the Commonwealth of Massachusetts the primary beneficiary of annuity proceeds remaining after the death of the annuitants to the extent of MassHealth benefits paid for their institutionalized spouses?
3. Is the receipt of benefits from an annuity by the Commonwealth of Massachusetts, where the Commonwealth of Massachusetts has been designated a beneficiary in the annuity contract, a form of estate recovery that is prohibited under Massachusetts law?

ARGUMENT

The issues presented by these consolidated cases, like many Medicaid issues, are complex issues on which courts have reached differing results.[7] The

[7] *See, e.g.*, *Atlanticare Med. Ctr. v. Div. of Med. Assistance*, 485 Mass. 233, 250 n.11 (2020) (Medicaid "is an incredibly complicated statutory scheme," with "[t]he law

Commonwealth argues that 42 U.S.C. § 1396p(c)(1)(F), 42 U.S.C. § 1396p(e), and 130 CMR 520.007(J)(2)(A) require an annuity purchased by a community spouse to name the Commonwealth as the remainder beneficiary to the extent of the MassHealth benefits paid on behalf of the institutionalized spouse, and that remainder language in annuities like the Mondor Annuity Contract and Castle Annuity Contract should therefore be interpreted accordingly. The Mondor Beneficiaries and Castle Beneficiaries argue that an annuity purchased by a community spouse is a "sole benefit" transfer under 42 U.S.C. § 1396p(c)(2)(B)(i) exempt from any requirement to name the state as a remainder beneficiary, and that remainder language in annuities like the Mondor Annuity Contract and Castle Annuity Contract should therefore be interpreted accordingly. The Mondor Beneficiaries and Castle Beneficiaries further argue that any receipt of remainder benefits by the Commonwealth would be a form of estate recovery prohibited by G. L. c. 118E, §§ 31, 32, and that nothing in MassHealth's enabling statutes or the Commonwealth's Medicaid State Plan allows MassHealth to require annuities like the Mondor Annuity Contract or Castle Annuity Contract to name the Commonwealth in a remainder position.

. . . known for its 'Byzantine construction' . . . mak[ing] it "almost unintelligible to the uninitiated.'") (internal citations and quotation marks omitted).

At the federal level, two circuits have considered these issues, at least in part, and reached differing results. In *Hutcherson*, a community spouse purchased an annuity in conjunction with his wife's Medicaid application, listing the state of Arizona in the first remainder position. 667 F.3d at 1067. After the community spouse died, the institutionalized wife sought a declaratory judgment that the state had no right to recover from the annuity, contending that the state's recovery should be "limited to expenses incurred on behalf of [the community spouse], who was never institutionalized." *Id*. at 1068, 1070. The Ninth Circuit disagreed, concluding that 42 U.S.C. § 1396p(c)(1)(F), as amended in 2006, permits states to "reach a deceased community spouse's annuity for costs incurred on behalf of an institutionalized spouse," and that the remainder language of the annuity at issue should be interpreted accordingly. *Id*. at 1070-71.

Subsequently, in *Hughes*, an institutionalized spouse argued that she was improperly denied Medicaid eligibility by the State of Ohio due to her community spouse's purchase of an annuity that did not name the state in a remainder position. 734 F.3d at 475-78. The Sixth Circuit agreed, concluding that the beneficiary-naming requirements of federal Medicaid law, 42 U.S.C. § 1396p(c)(1)(F), do not apply to an annuity purchased by a community spouse. *Id*. at 483-85. The Sixth Circuit reasoned that a community spouse's purchase of an annuity constitutes a transfer of assets for the "sole benefit" of the community spouse within the meaning

of 42 U.S.C. § 1396(c)(2)(B)(i) and that, under the plain text of the law, a "sole benefit" transfer need not comply with the beneficiary-naming requirements of 42 U.S.C. § 1396p(c)(1)(F). *Id.*

The two Superior Court cases to have considered the issues in the Commonwealth have split along similar lines. In *Dermody*, the Superior Court (Barrett, J.) considered an annuity purchased by a community spouse that listed the Commonwealth as the primary beneficiary "to the extent benefits paid," and determined that the Commonwealth had no right to recover where only the institutionalized spouse received MassHealth benefits. 2020 WL 742194, at *7-8. Citing *Hughes*, the *Dermody* court reasoned that a community spouse's purchase of an annuity is a "sole benefit" transfer exempt from any requirement to name the state in a remainder position. *Id.* at *6-7, citing *Hughes*, 734 F.3d at 483-85. In the alternative, the *Dermody* court reasoned that the contingent beneficiaries should prevail "under basic contract interpretation principles" because "nothing in the plain terms of the contract suggest[ed] the 'benefits paid' language refers to anyone other than [community spouse]." *Id.* at *7-8.

Following *Dermody*, and in the *Breslouf* case, the Superior Court (Squires-Lee, J.) considered an annuity purchased by a community spouse that listed the Commonwealth as the primary beneficiary "in first position for the total amount of medical assistance paid on behalf of the institutionalized individual pursuant to 130

CMR 520.007(J)(2)," and concluded that the designation entitled the Commonwealth to the annuity "proceeds to the extent of total medical assistance paid by MassHealth on behalf of [the institutionalized spouse]." 2021 WL 2343024, at *1, 13. Citing *Hutcherson*, the *Breslouf* court concluded that a community spouse's purchase of an annuity is not a "sole benefit" transfer and that the Commonwealth had "properly interpreted 42 U.S.C. § 1396p(c)(1)(F) as applying to annuities for which the community spouse of an institutionalized individual is named as the annuitant." *Id.* at *9-11, 13. In the alternative, the *Breslouf* court reasoned that the Commonwealth was entitled to recover under the plain terms of the annuity contract itself. *Id.* at *11.

Challenges to MassHealth's interpretation of these statutory provisions are also appearing with increasing frequency in the pre-eligibility administrative context. Certain community spouses, in reliance on *Dermody* and *Hughes*, have purchased annuities without designating the Commonwealth as a remainder beneficiary, which the Commonwealth has deemed disqualifying transfers that necessitate penalties on their institutionalized spouses' eligibility for MassHealth. Add. 155-77. In the two cases to have reached the point of a G. L. c. 30A appeal, *see supra* at pp. 18-21 (Cases 3, 16 in Table), Hearing Officers of the MassHealth

Board of Hearings affirmed MassHealth's imposition of penalties, although largely on grounds different than those set forth in *Breslouf* and *Hutcherson*, Add. 155-77.[8]

* * *

The current state of the law, in sum, is one of pervasive uncertainty. This uncertainty, in turn, is imposing substantial and growing costs on Medicaid applicants and their families, the Commonwealth, and insurance companies that sell and administer Medicaid-related annuities. Multiple insurance companies—now unsure how to meet their own obligations when a deceased community spouse's annuity names the Commonwealth as primary beneficiary—are routinely commencing interpleader actions in an effort to avoid decisions and protect themselves from liability, thereby forcing the Commonwealth and family beneficiaries into costly and inefficient litigation. *See supra* at pp. 18-21. The volume of these largely duplicative cases continues to grow and, across the fourteen cases pending today, hundreds of thousands of dollars in payable annuity funds sit undisbursed by insurance companies, who are unwilling to pay out the funds in the absence of settlements in individual cases or final appellate resolution. Notwithstanding their caution, several insurance companies have faced G. L. c. 93A

[8] One of these G. L. c. 30A appeals (*Engelmann v. Marylou Sudders et al.*, No. 2077CV00178) was voluntarily dismissed by the plaintiff; in the second G. L. c. 30A appeal (*Jackson v. Marylou Sudders et al.*, No. 2181CV00543), no briefs have yet been filed in the Superior Court.

claims from family beneficiaries asserting that the companies' failure to pay all of the remaining annuity funds to them is in itself an unfair and deceptive act or practice. *See, e.g.*, *Breslouf*, 2021 WL 2343024, at *12.

This state of costly uncertainty also extends to initial MassHealth eligibility determinations. *See* Add. 155-77. Institutionalized individuals and their community spouses who are considering purchasing annuities to assist with Medicaid eligibility now too face an unsettled landscape. This uncertainty affects critical aspects of their financial planning and creates prospects of long delays in approval, unwanted litigation, and the risk that Medicaid approval will ultimately be denied. Attorneys who provide Medicaid-planning advice in the Commonwealth are faced with understandable difficulty in advising clients considering purchasing annuities. *See generally* "State can't take annuity for spousal MassHealth costs," *Massachusetts Lawyers Weekly* (January 23, 2020) (reproduced at Add. 178); "MassHealth Notches Key Win on Annuities," *Massachusetts Lawyers Weekly* (June 17, 2021) (reproduced at Add. 182).

Appellate resolution in these consolidated cases is necessary to settle the split in the case law in the Commonwealth, to resolve the many cases now pending in the Superior Court, and to staunch the flow of new cases on the same issues. Appellate resolution is also necessary to restore predictability both as to whether community spouse annuities must designate the Commonwealth as a remainder beneficiary

when purchased at the eligibility stage, and as to how insurance companies should apply such designations upon the death of the annuitant. Because the parties here believe that these goals would be best served by a binding, final, and comprehensive determination by this Court, they jointly request direct appellate review.

STATEMENT OF REASONS WHY DIRECT APPELLATE REVIEW IS APPROPRIATE

As further explained above, direct appellate review is appropriate in this case for the following reasons:

1. To decide, as a matter of first impression that has split the Superior Court and the federal circuits, whether 42 U.S.C. § 1396p(c)(1)(F), 42 U.S.C. § 1396p(e), and/or 130 CMR 520.007(J)(2)(A) require an annuity purchased by a community spouse to designate the Commonwealth as a remainder beneficiary to the extent of any MassHealth benefits paid to their institutionalized spouse.

2. To decide, as a matter of considerable importance to many pending cases in the Superior Court and to the insurance industry's future performance of the terms of such annuities as a whole, how a community spouse's designation of the "Commonwealth of Massachusetts" as primary remainder beneficiary is to be interpreted as a matter of contract and estate recovery law.

3. To decide whether MassHealth's enabling statutes and/or the Commonwealth's State Plan limit or preclude MassHealth's ability to receive

remainder benefits under annuity contracts like Mondor Annuity Contract and Castle Annuity Contract.

Plaintiff-Appellant EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS

Defendant-Appellees LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR, KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER, JOHN FRANCIS CASTLE,

MAURA HEALEY
Attorney General

/s/ Jesse M. Boodoo
Jesse M. Boodoo (BBO No. 678471)
Katherine B. Dirks (BBO No. 673674)
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/s/ Brian E. Barreira
Brian E. Barreira, Esq.
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Plymouth, MA 02360
508-747-8282
office@southshoreelderlaw.com

Date: July 28, 2021

CERTIFICATION PURSUANT TO MASS. R. APP. P. 16(k)

I hereby certify that the foregoing brief complies with all rules of court pertaining to the filing of briefs, including, but not limited to, the requirements of Rules 11, 16, 18, 20, and 21 of the Massachusetts Rules of Appellate Procedure. The brief complies with the applicable length limit in Rule 11(a) because the Argument section contains 1447 words in 14-point Times New Roman font.

/s/ Jesse M. Boodoo
Jesse M. Boodoo

CERTIFICATE OF SERVICE

I hereby certify that on this day, July 28, 2021, I caused this application to be served by email on counsel for the Appellees:

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/s/ Jesse M. Boodoo
Jesse M. Boodoo

ADDENDUM

2084CV02484 Standard Insurance Company vs. Mondor, Linda Marie et al

- Case Type:
- Contract / Business Cases
- Case Status:
- Open
- File Date
- 10/29/2020
- DCM Track:
- F - Fast Track
- Initiating Action:
- Interpleader
- Status Date:
- 10/29/2020
- Case Judge:
-
- Next Event:
-

All Information | Party | Subsequent Action/Subject | Event | Tickler | Docket | Linked Case | Disposition

Party Information

Standard Insurance Company
- Plaintiff

Alias

Party Attorney
- Attorney
- Magratten, Esq., Brooks R
- Bar Code
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More Party Information

Mondor, Linda Marie
- Defendant

Alias

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More Party Information

Mogan, Michelle
- Defendant

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More Party Information

Mondor, Cathy Ann
- Defendant

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More Party Information

Executive Office of Health and Human Services of the Commonwealth of Massachusetts
- Defendant

Alias	Party Attorney
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More Party Information

Subsequent Action/Subject

Description	Status	SA/Subject #	Pleading Party	Responding Party	*Judgments*	Status Date
Crossclaim	Filed	1	Executive Office of Health and Human Services of the Commonwealth of Massachusetts	Mondor, Cathy Ann	0	01/19/2021
Crossclaim	Filed	2	Mondor, Cathy Ann	Executive Office of Health and Human Services of the Commonwealth of Massachusetts	0	03/31/2021

Events

Date	Session	Location	Type	Event Judge	Result
06/02/2021 11:00 AM	Civil F	BOS-10th FL, CR 1006 (SC)	Motion Hearing	Ames, Hon. Mary K	Held via Video/Teleconference
06/29/2021 11:00 AM	Civil F	BOS-10th FL, CR 1006 (SC)	Rule 16 Conference	Ames, Hon. Mary K	Not Held

Ticklers

Tickler	Start Date	Due Date	Days Due	Completed Date
Service	10/29/2020	01/27/2021	90	
Answer	10/29/2020	02/26/2021	120	
Rule 12/19/20 Served By	10/29/2020	02/26/2021	120	
Rule 12/19/20 Filed By	10/29/2020	03/29/2021	151	
Rule 12/19/20 Heard By	10/29/2020	04/27/2021	180	
Rule 15 Served By	10/29/2020	02/26/2021	120	
Rule 15 Filed By	10/29/2020	03/29/2021	151	
Rule 15 Heard By	10/29/2020	04/27/2021	180	
Discovery	10/29/2020	08/25/2021	300	
Rule 56 Served By	10/29/2020	09/24/2021	330	
Rule 56 Filed By	10/29/2020	10/25/2021	361	
Final Pre-Trial Conference	10/29/2020	02/21/2022	480	
Judgment	10/29/2020	10/31/2022	732	

Docket Information

Docket Date	*Docket Text*	File Ref Nbr.	*Image Avail.*
10/29/2020	Attorney appearance On this date Brooks R Magratten, Esq. added for Plaintiff Standard Insurance Company		
10/29/2020	Case assigned to: DCM Track F - Fast Track was added on 10/29/2020		
10/29/2020	Original civil complaint filed. TRK	1	Image
10/29/2020	Civil action cover sheet filed.	2	
11/09/2020	Amended: interpleader complaint filed by Standard Insurance Company Applies To: Standard Insurance Company (Plaintiff)	3	Image
12/03/2020	Service Returned for Defendant Mondor, Linda Marie: Service made at last and usual;	4	Image
12/03/2020	Service Returned for Defendant Mondor, Cathy Ann: Service made at last and usual;	5	Image
12/03/2020	Service Returned for Defendant Mogan, Michelle: Service made at last and usual;	6	Image
12/04/2020	Service Returned for Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts: Service through person in charge / agent;	7	Image
12/18/2020	Attorney appearance electronically filed. Applies To: Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant)		Image
12/21/2020	Attorney appearance On this date Katherine B Dirks, Esq. added for Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts		
01/19/2021	Answer to original complaint Received from Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts: Answer with crossclaim;	8	Image
02/09/2021	Attorney appearance On this date Tonie Jhun Ryan, Esq. added for Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts		
03/30/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant Linda Marie Mondor		

Docket Date	Docket Text	File Ref Nbr.	Image Avail.
03/30/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant Michelle Mogan		
03/30/2021	Answer to the crossclaim Applies To: Mondor, Linda Marie (Defendant); Mogan, Michelle (Defendant); Mondor, Cathy Ann (Defendant)	9	Image
03/30/2021	Answer to amended complaint Applies To: Mondor, Linda Marie (Defendant); Mogan, Michelle (Defendant); Mondor, Cathy Ann (Defendant) and Crossclaim	10	Image
03/31/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant Cathy Ann Mondor		
04/02/2021	Service Returned for Applies To: Mondor, Cathy Ann (Defendant) service made at last and usual.	11	Image
04/02/2021	Service Returned for Applies To: Mondor, Linda Marie (Defendant) service made at last and usual.	12	Image
04/02/2021	Service Returned for Applies To: Mogan, Michelle (Defendant) service made at last and usual.	13	Image
04/09/2021	Plaintiff Standard Insurance Company's Motion for Interpleader Relief	14	Image
04/09/2021	Standard Insurance Company's Memorandum in support of Plaintiff's Motion for Interpleader Relief	15	Image
04/09/2021	Opposition to Plaintiff's Motion for Interpleader Relief filed by Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Limited Opposition)	16	Image
04/09/2021	Affidavit of No Opposition from the Mondor Defendants or Mr. Barreira	17	Image
04/09/2021	Standard Insurance Company's Memorandum in Reply to the Defendant EOHHS's "Limited Opposition" to Standard's Motion for Interpleader Relief	18	Image
05/07/2021	The following form was generated: Notice to Appear Sent On: 05/07/2021 14:17:57 Notice Sent To: Brooks R Magratten, Esq. Pierce Atwood LLP One Financial Plaza Suite 2600, Providence, RI 02903 Notice Sent To: Brian E Barreira, Esq. 118 Long Pond Rd Suite 206, Plymouth, MA 02360 Notice Sent To: Katherine B Dirks, Esq. Office of the Attorney General One Ashburton Place Trial Division 18th floor, Boston, MA 02108 Notice Sent To: Tonie Jhun Ryan, Esq. Office of the Attorney General One Ashburton Place 18th Floor, Boston, MA 02108		
05/18/2021	Answer to the crossclaim Applies To: Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant)	19	Image
05/19/2021	Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts's Motion for Leave to File a Surreply to Standard Insurance Company's Motion for Interpleader Relief	20	Image
05/19/2021	Proposed Filings/Orders (Executive Office of Health and Human Services' Proposed Surreply to Standard Insurance Company's Motion for Interpleader Relief)		Image
05/26/2021	Attorney appearance electronically filed.		Image
05/26/2021	Attorney appearance On this date Jesse Mohan Boodoo, Esq. added for Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts		

Docket Date	Docket Text	File Ref Nbr.	Image Avail.
06/02/2021	Event Result:: Motion Hearing scheduled on: 06/02/2021 11:00 AM Has been: Held via Video/Teleconference Hon. Mary K Ames, Presiding Staff: Anh T Bungcayao, Assistant Clerk Magistrate		
06/03/2021	The following form was generated: Notice to Appear Sent On: 06/03/2021 12:31:20 Notice Sent To: Brooks R Magratten, Esq. Pierce Atwood LLP One Financial Plaza Suite 2600, Providence, RI 02903 Notice Sent To: Brian E Barreira, Esq. 118 Long Pond Rd Suite 206, Plymouth, MA 02360 Notice Sent To: Katherine B Dirks, Esq. Office of the Attorney General One Ashburton Place Trial Division 18th floor, Boston, MA 02108 Notice Sent To: Tonie Jhun Ryan, Esq. Office of the Attorney General One Ashburton Place 18th Floor, Boston, MA 02108 Notice Sent To: Jesse Mohan Boodoo, Esq. Office of the Attorney General, Trial Division One Ashburton Place, Boston, MA 02108		
06/08/2021	Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts's Assented to Motion to consolidate.	21	Image
06/11/2021	Party(s) file Stipulation of Dismissal (Filed 6/11/21) as to plff vs defts only without prejudice with each party to bear its own costs and attys fees JUDGMENT entered on docket pursuant to Mass R: Civ P 58(a) as amended and notice sent to parties pursuant to Mass R Civ P 77(d) Applies To: Standard Insurance Company (Plaintiff); Mondor, Linda Marie (Defendant); Mogan, Michelle (Defendant); Mondor, Cathy Ann (Defendant); Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant)	22	Image
06/21/2021	Defendant Executive Office of Health and Human Services of the Commonwealth of Massachusetts's Joint Motion to amend case caption.	23	Image
06/21/2021	Endorsement on Motion to consolidate with 21-00962 (#21.0): ALLOWED (dated 6/17/21) notice sent 6/21/21		Image
06/22/2021	Party(s) file Stipulation of Dismissal pursuant to the provisions of Mass.R.Civ.P. Rule 41(a)(l)(ii), hereby stipulate that said action be dismissed as to all Count III of Linda Marie Mondor, Michelle Mogan, and Cathy Ann Mondor's cross-claims without prejudice. Applies To: Mondor, Linda Marie (Defendant); Mogan, Michelle (Defendant); Mondor, Cathy Ann (Defendant)	24	Image
06/22/2021	Event Result:: Rule 16 Conference scheduled on: 06/29/2021 11:00 AM Has been: Not Held For the following reason: Joint request of parties Hon. Mary K Ames, Presiding Staff: Anh T Bungcayao, Assistant Clerk Magistrate		
06/22/2021	Party status: Plaintiff Standard Insurance Company: Dismissed by agreement of parties; Copied from linked case: 2184CV00962		
06/29/2021	Plaintiff Standard Insurance Company's Joint Motion to Report the Consolidated Cases to the Appeals Court Pursuant to Rule 64	25	Image
06/29/2021	Plaintiff Standard Insurance Company's Submission of Rule 64 Statement of Agreed Material Facts	26	Image
06/29/2021	Docket Note: 2 Binders of Exhibits filed with paper numbers 25 and 26		
06/29/2021	Endorsement on Motion to amend the case caption. (#13.0): ALLOWED (date 6/23/21) Allowed W/o opposition Notice 6/28/21 Judge: Brieger, Hon. Heidi Copied from linked case: 2184CV00962		
07/01/2021	Endorsement on Motion to Report the Consolidated Cases to the Appeals Court Pursuant to Rule 64 (#25.0): ALLOWED For the good and sufficient reasons cited herein the joint motion is ALLOWED pursuant to MRCP 64 the court reports these consolidated cases without determination to the Appeals Court (dated 6/30/21) notice sent by email 7/1/21		Image

Docket Date	Docket Text	File Ref Nbr.	Image Avail.
07/01/2021	Defendants Executive Office of Health and Human Services of the Commonwealth of Massachusetts's Notice of No Transcripts are Necessary for Appeal	27	Image
07/07/2021	Notice of assembly of record sent to Counsel Applies To: Magratten, Esq., Brooks R (Attorney) on behalf of Standard Insurance Company (Plaintiff); Barreira, Esq., Brian E (Attorney) on behalf of Mondor, Linda Marie (Defendant); Ryan, Esq., Tonie Jhun (Attorney) on behalf of Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant); Dirks, Esq., Katherine B (Attorney) on behalf of Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant); Boodoo, Esq., Jesse Mohan (Attorney) on behalf of Executive Office of Health and Human Services of the Commonwealth of Massachusetts (Defendant)		
07/07/2021	Notice to Clerk of the Appeals Court of Assembly of Record		
07/08/2021	Endorsement on Motion to Amend Case Caption. (#23.0): ALLOWED (dated 06/30/21) notice sent 07/06/21		Image
07/14/2021	Notice of Entry of appeal received from the Appeals Court In accordance with Massachusetts Rule of Appellate Procedure 10(a)(3), please note that the above-referenced case (2021-P-0632) was entered in this Court on July 13, 2021.	28	Image

Linked Cases

Link Group	Case #	File Date	Link Role
2084CV02484	2184CV00962	04/27/2021	Related Case

Case Disposition

Disposition	Date	Case Judge
Pending		

2184CV00962 Standard Insurance Company vs. Bristow, Kathleen Ann et al

- Case Type:
- Equitable Remedies
- Case Status:
- Open
- File Date
- 04/27/2021
- DCM Track:
- A - Average
- Initiating Action:
- Declaratory Judgment G.L. c. 231A
- Status Date:
- 04/27/2021
- Case Judge:
-
- Next Event:
-

All Information | Party | Subsequent Action/Subject | Tickler | Docket | Linked Case | Disposition

Party Information

Standard Insurance Company
- Plaintiff

Alias

Party Attorney
- Attorney
- Magratten, Esq., Brooks R
- Bar Code
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- Address
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  Providence, RI 02903
- Phone Number
- (401)490-3422

More Party Information

Bristow, Kathleen Ann
- Defendant

Alias

Party Attorney
- Attorney
- Barreira, Esq., Brian E
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More Party Information

Schwenzfeier, Marianne
- Defendant

Alias

Party Attorney
- Attorney
- Barreira, Esq., Brian E
- Bar Code
- 544433
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More Party Information

Castle, John Francis
- Defendant

Alias	Party Attorney
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More Party Information

Executive Office of Health and Human Services
- Defendant

Alias	Party Attorney
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More Party Information

Subsequent Action/Subject

Description	Status	SA/Subject #	Pleading Party	Responding Party	*Judgments*	Status Date
Crossclaim	Open	1	Executive Office of Health and Human Services	Castle, John Francis	0	06/04/2021

Ticklers

Tickler	Start Date	Due Date	Days Due	Completed Date
Service	04/27/2021	07/26/2021	90	
Answer	04/27/2021	08/25/2021	120	
Rule 12/19/20 Served By	04/27/2021	08/25/2021	120	
Rule 12/19/20 Filed By	04/27/2021	09/24/2021	150	
Rule 12/19/20 Heard By	04/27/2021	10/25/2021	181	
Rule 15 Served By	04/27/2021	06/21/2022	420	
Rule 15 Filed By	04/27/2021	07/21/2022	450	
Rule 15 Heard By	04/27/2021	07/21/2022	450	

Tickler	Start Date	Due Date	Days Due	Completed Date
Discovery	04/27/2021	04/17/2023	720	
Rule 56 Served By	04/27/2021	05/17/2023	750	
Rule 56 Filed By	04/27/2021	06/16/2023	780	
Final Pre-Trial Conference	04/27/2021	10/16/2023	902	
Judgment	04/27/2021	04/26/2024	1095	

Docket Information

Docket Date	Docket Text	File Ref Nbr.	Image Avail.
04/27/2021	Attorney appearance On this date Brooks R Magratten, Esq. added for Plaintiff Standard Insurance Company		
04/27/2021	Case assigned to: DCM Track A - Average was added on 04/27/2021		
04/27/2021	Original civil complaint filed.	1	Image
04/27/2021	Civil action cover sheet filed.	2	Image
05/13/2021	Service Returned for Defendant Executive Office of Health and Human Services: Service through person in charge / agent;	3	Image
05/13/2021	Service Returned for Defendant Bristow, Kathleen Ann: Service made in hand;	4	Image
05/13/2021	Service Returned for Defendant Schwenzfeier, Marianne: Service made at last and usual;	5	Image
05/24/2021	Affidavit Of Service of Process Applies To: Castle, John Francis (Defendant)	6	Image
06/03/2021	Attorney appearance On this date Tonie Jhun Ryan, Esq. added for Defendant Executive Office of Health and Human Services		
06/03/2021	Attorney appearance On this date Jesse Mohan Boodoo, Esq. added for Defendant Executive Office of Health and Human Services		
06/03/2021	Attorney appearance On this date Katherine B Dirks, Esq. added for Defendant Executive Office of Health and Human Services		
06/04/2021	Answer with a crossclaim Applies To: Bristow, Kathleen Ann (Defendant); Schwenzfeier, Marianne (Defendant); Castle, John Francis (Defendant); Executive Office of Health and Human Services (Defendant)	7	Image
06/04/2021	Crossclaim filed		
06/07/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant John Francis Castle		
06/07/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant Kathleen Ann Bristow		
06/07/2021	Attorney appearance On this date Brian E Barreira, Esq. added for Defendant Marianne Schwenzfeier		
06/08/2021	Defendant Executive Office of Health and Human Services's Notice of Filing Motion to Consolidate Pursuant to Superior Court Rule 31	8	Image
06/08/2021	Answer to original complaint Applies To: Bristow, Kathleen Ann (Defendant); Schwenzfeier, Marianne (Defendant); Castle, John Francis (Defendant)	9	Image
06/08/2021	Answer to the crossclaim Applies To: Bristow, Kathleen Ann (Defendant); Schwenzfeier, Marianne (Defendant); Castle, John Francis (Defendant)	10	Image

Docket Date	Docket Text	File Ref Nbr.	Image Avail.
06/10/2021	Answer to the crossclaim Applies To: Executive Office of Health and Human Services (Defendant)	11	Image
06/22/2021	Party(s) file Stipulation of Dismissal pursuant to the provisions of Mass.R.Civ.P. Rule 41(a)(l)(ii), hereby stipulate that all claims brought by plaintiff Standard Insurance Company are dismissed without prejudice, with each party to bear it's own costs and attorney's fees. The case will continue as to the cross-claims between the remaining parties. Applies To: Standard Insurance Company (Plaintiff)	12	Image
06/22/2021	Defendants Kathleen Ann Bristow, Marianne Schwenzfeier, John Francis Castle's Joint Motion to amend the case caption.	13	Image
06/22/2021	Party status: Plaintiff Standard Insurance Company: Dismissed by agreement of parties;		
06/29/2021	Endorsement on Motion to amend the case caption. (#13.0): ALLOWED (date 6/23/21) Allowed W/o opposition Notice 6/28/21		Image
06/29/2021	Plaintiff Standard Insurance Company's Joint Motion to Report the Consolidated Cases to the Appeals Court Pursuant to Rule 64 Copied from linked case: 2084CV02484		
06/29/2021	Plaintiff Standard Insurance Company's Submission of Rule 64 Statement of Agreed Material Facts Copied from linked case: 2084CV02484		
06/29/2021	Docket Note: 2 Binders of Exhibits filed with paper numbers 25 and 26 Copied from linked case: 2084CV02484		
07/01/2021	Defendant Executive Office of Health and Human Services's Notice of No Transcripts are necessary for Appeal	14	Image
07/01/2021	Endorsement on Motion to Report the Consolidated Cases to the Appeals Court Pursuant to Rule 64 (#25.0): ALLOWED For the good and sufficient reasons cited herein the joint motion is ALLOWED pursuant to MRCP 64 the court reports these consolidated cases without determination to the Appeals Court (dated 6/30/21) notice sent by email 7/1/21 Judge: Ames, Hon. Mary K Copied from linked case: 2084CV02484		
07/07/2021	Notice of assembly of record sent to Counsel Copied from linked case: 2084CV02484		
07/07/2021	Notice to Clerk of the Appeals Court of Assembly of Record Copied from linked case: 2084CV02484		
07/08/2021	Endorsement on Motion to Amend Case Caption. (#23.0): ALLOWED (dated 06/30/21) notice sent 07/06/21 Judge: Ames, Hon. Mary K Copied from linked case: 2084CV02484		
07/14/2021	Notice of Entry of appeal received from the Appeals Court In accordance with Massachusetts Rule of Appellate Procedure 10(a)(3), please note that the above-referenced case (2021-P-0632) was entered in this Court on July 13, 2021. Copied from linked case: 2084CV02484		

Linked Cases

Link Group	Case #	File Date	Link Role
2084CV02484	2084CV02484	10/29/2020	Related Case

Case Disposition

Disposition	Date	Case Judge
Pending		

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2084CV02484

STANDARD INSURANCE COMPANY,

Plaintiff,

v.

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

Defendant and Cross-Claim Plaintiff,

and

LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR,

Defendants and Cross-Claim Defendants.

DEFENDANT EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES'S ANSWER AND CROSS-CLAIM

Defendant the Executive Office of Health and Human Services ("EOHHS") hereby submits its answer, affirmative defenses, and jury demand to the Plaintiff Standard Insurance Company's Amended Complaint and asserts a cross-claim against defendants Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor.

Introduction

No response is required to the Introduction. To the extent a response is required, the allegations are denied.

Parties

1. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 1 and, therefore, neither admits nor denies such allegations.
2. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 2 and, therefore, neither admits nor denies such allegations.
3. Admitted.
4. Admitted.
5. Admitted.
6. Admitted.

Jurisdiction and Venue

7. Paragraph 8 states legal conclusions as to which no response is required.
8. Paragraph 8 states legal conclusions as to which no response is required.

Facts

9. Admitted.
10. Admitted.
11. Admitted.
12. Admitted.
13. Admitted.
14. Admitted.
15. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 15 and, therefore, neither admits nor denies such allegations.
16. Admitted.

17. Admitted that EOHHS sent the referenced letter to Standard Insurance Company, and that the document speaks for itself.

18. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 18 and, therefore, neither admits nor denies such allegations.

19. Admitted that counsel for the contingent beneficiaries sent the referenced letter, and that the document speaks for itself.

20. Admitted.

COUNT I FOR INTERPLEADER RELIEF

21. EOHHS repeats, re-alleges, and incorporates herein its answers as set forth in Paragraphs 1 through 20, inclusive.

22. Paragraph 22 states legal conclusions as to which no response is required.

23. Paragraph 23 states legal conclusions as to which no response is required.

24. Paragraph 24 purports to characterize the form of relief requested, to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 24.

25. To the extent Paragraph 25 purports to characterize the form of relief requested, no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 25.

RELIEF REQUESTED

EOHHS respectfully requests that the Court resolve the interpleader claim by declaring and ordering that the Commonwealth of Massachusetts is entitled to recover on the annuity contract to the extent of any MassHealth benefits paid, or as may be paid in the future, on behalf of Elda Mondor.

* * *

All allegations that are neither admitted nor denied are hereby denied.

* * *

AFFIRMATIVE DEFENSES

1. The Complaint fails to state claims upon which relief could be granted.
2. The claims against the Commonwealth are barred by sovereign immunity.
3. The Commonwealth is not subject to damages, interests, or costs under the interpleader rule or under the Declaratory Judgment Act.
4. The claims are preempted by federal law.

CROSS-CLAIM FOR DECLARATORY JUDGMENT
(against Defendants Linda Marie Mondor, Michelle Mogan, Cathy Ann Mondor)

Defendant the Commonwealth of Massachusetts hereby cross-claims against Defendants Linda Marie Mondor, Michelle Mogan, Cathy Ann Mondor as follows:

1. In or around March 2018, Elda Mondor ("Elda") was admitted to a nursing facility for long-term skilled nursing care.

2. On or around April 9, 2018, Elda applied for MassHealth long-term care benefits. Michelle Mogan completed the application on Elda's behalf as her authorized designated representative.

3. In order to reduce Elda's countable assets such that Elda would become eligible for MassHealth benefits for her nursing care, Elda's spouse, Edward Mondor ("Edward"), acted to purchase Single Premium Immediate Annuity Contract No. 00BB056000 ("Annuity Contract"), effective April 23, 2018, naming "the Commonwealth of Massachusetts" in the primary beneficiary position.

4. In purchasing the Annuity Contract, and naming the Commonwealth as the primary beneficiary, Edward intended to comply with 42 U.S.C. §§ 1396p(c)(1)(F) and 1396p(e).

5. In purchasing the Annuity Contract and naming the Commonwealth as a beneficiary, Edward intended to comply with 130 CMR 520.007(J).

6. Before the Commonwealth could issue a determination on the eligibility application for MassHealth benefits on behalf of Elda, Elda or her representative was required to complete the "Notice of Preferred Remainder Beneficiary / Annuity Tracking Form" (ANN-3 form) for the annuity Contract. On May 9, 2018, Edward executed the ANN-3 form in support of the application for MassHealth benefits on behalf of Elda. The ANN-3 form identified the Annuity Contract and was submitted it to the Commonwealth.

7. In the ANN-3 form he signed, Edward acknowledged that the "Commonwealth of Massachusetts Executive Office of Health and Human Services has determined that, pursuant to MassHealth regulations at 130 CMR 520.007(J) and federal 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." Edward further acknowledged by signing the form that a "[f]ailure to name and keep the Commonwealth of Massachusetts as a beneficiary of the annuity in the proper position will result in the termination of MassHealth benefits and the Commonwealth may recover MassHealth benefits paid while the individual was not eligible."

8. On August 29, 2018, MassHealth approved Elda's application with a start date of

May 1, 2018. MassHealth's approval of Elda's MassHealth long-term care benefits was based in part on Edward's acknowledgement and representation in the ANN-3 form and the MassHealth application submitted on behalf of Elda.

9. If the Commonwealth of Massachusetts was not the designated primary beneficiary for the Annuity Contract to the extent of benefits paid on behalf of Elda, Elda would not have been eligible for MassHealth benefits for her long-term skilled nursing care and her MassHealth benefits would have been terminated as specified in the ANN-3 forms signed by Edward as part of Elda's MassHealth application.

10. Edward died on April 11, 2020.

11. Elda is still an active MassHealth member and MassHealth continues to pay long-term care benefits on behalf of Elda. MassHealth paid a total of $146,903.57 in such benefits as of September 1, 2020. MassHealth benefit payments on Elda's behalf continue to be made monthly to fund her long-term care.

12. The Commonwealth of Massachusetts contends that it was entitled to the annuity proceeds payable to date but not yet disbursed by Standard after the death of Edward, and that it remains entitled to proceeds from the Annuity Contract to the extent of any MassHealth benefits as were paid in the past, or as may be paid in the future, on behalf of Elda.

WHEREFORE, the Commonwealth of Massachusetts respectfully requests that the Court enter a declaratory judgment in its favor as follows:

a) Declare that EOHHS and MassHealth have properly interpreted 42 U.S.C. § 1396p(c)(1)(F) as applying to annuities purchased by a MassHealth applicant or their community spouse, including annuities for which the "community spouse" of an "institutionalized individual" is named as the annuitant.

b) Declare that 42 U.S.C. § 1396p(e) and the ANN-3 form component of the MassHealth application provide MassHealth with an automatic interest in the annuity proceeds here, to the extent of benefits paid on behalf of Elda Mondor, by operation of law.

c) Declare that the designation of the Commonwealth of Massachusetts as primary beneficiary to the annuity proceeds here shall mean that the Commonwealth of Massachusetts is the beneficiary of such proceeds to the extent of total medical assistance paid by MassHealth on behalf of Elda Mondor.

d) Declare that the remaining annuity benefits payable pursuant to the annuity contract shall be paid to the Commonwealth of Massachusetts to the extent of total medical assistance provided by MassHealth on behalf of Elda Mondor.

Respectfully submitted,

Defendant and Cross-Claim Plaintiff
EXECUTIVE OFFICE OF HEALTH AND
HUMAN SERVICES OF THE
COMMONWEALTH OF MASSACHUSETTS,

By its Attorneys,

MAURA HEALEY
ATTORNEY GENERAL

/s/ Katherine B. Dirks
Jesse M. Boodoo, BBO# 678471
Katherine B. Dirks, BBO# 673674
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Date: January 19, 2021

CERTIFICATE OF SERVICE

I, Katherine B. Dirks, hereby certify that on January 19, 2021, I served a copy of the above document upon counsel for the parties by e-mailing a copy to:

Brooks R. Magratten, Esq.
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/s/ Katherine B. Dirks
Katherine B. Dirks
Assistant Attorney General

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2084CV02484

STANDARD INSURANCE COMPANY,
Plaintiff

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Defendant and Cross-Claim Plaintiff and Cross-Claim Defendant

and

LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR,
Defendants and Cross-Claim Defendants and Cross-Claim Plaintiffs

3/30/2021

EFILED ec

ANSWER OF DEFENDANTS LINDA MARIE MONDOR, MICHELLE MOGAN AND CATHY ANN MONDOR TO AMENDED COMPLAINT OF STANDARD INSURANCE COMPANY

The Defendants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, hereby submit their answer to the Plaintiff Standard Insurance Company's Amended Complaint.

1. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 1 and, therefore, neither admit nor deny such allegations.

2. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor are without knowledge or

information sufficient to form a belief as to the truth of the allegations in Paragraph 2 and, therefore, neither admit nor deny such allegations.

3. Admitted.

4. Admitted.

5. Admitted.

6. Admitted.

7. Paragraph 7 states legal conclusions as to which no response is required.

8. Paragraph 8 states legal conclusions as to which no response is required.

9. Admitted.

10. Admitted.

11. Admitted.

12. Ad mitted.

13. Admitted.

14. Admitted.

15. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 15 and, therefore, neither admit nor deny such allegations.

16. Admitted.

17. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 17 and, therefore, neither admit nor deny such allegations.

18. Admitted.

19. Admitted.

20. Admitted.

21. No response required.

22. Admitted.

23. Admitted.

24. Paragraph 24 states legal conclusions as to which no response is required.

25. Paragraph 25 states legal conclusions as to which no response is required

RELIEF REQUESTED

Defendants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor respectfully requests that the Court resolve the interpleader claim by declaring and ordering that the Commonwealth of Massachusetts is not entitled to recover on the annuity contract to the extent of any MassHealth benefits paid, or as may be paid in the future, on behalf of Elda Mondor.

CROSS-CLAIM OF LINDA MARIE MONDOR, MICHELLE MOGAN AND CATHY ANN MONDOR AGAINST EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS FOR DECLARATORY JUDGMENT AND CLASS ACTION

1. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor hereby file a cross-claim against the Executive Office of Health and Human Services ("EOHHS") of the Commonwealth of Massachusetts.

COUNT 1 – MASSACHUSETTS LAW DOES NOT ALLOW ESTATE RECOVERY AGAINST A COMMUNITY SPOUSE'S ANNUITY

2. Edward Mondor, the father of the Cross-claim Plaintiffs, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, purchased the immediate annuity that is the subject of the interpleader action, then died on April 11, 2020 with payments on the annuity still remaining.

3. The Cross-claim Plaintiffs, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, have claimed that the remaining amount of the annuity should not be paid to the Commonwealth of Massachusetts, but rather to them.

4. By making a claim for the proceeds of the annuity in this case, the EOHHS is attempting to engage in a form of estate recovery that has been prohibited by long-standing Massachusetts law.

5. By making a claim for the proceeds of the annuity in this case, the Executive Office of Health and Human Services ("EOHHS") is attempting to engage in a form of estate recovery that has been prohibited by long-standing Massachusetts law.

6. There is no common law right of recovery in Massachusetts for governmental benefits provided to any citizen.

7. The EOHHS has not identified any specific Massachusetts law that authorizes it to make any type of collection or recovery efforts against the annuity in this case.

8. No governmental benefit program other than Medicaid (which is known in Massachusetts as MassHealth) has an "estate recovery" feature, whereby benefits are later recovered financially as though the governmental expenditure represented a loan to the recipient.

9. The Medicaid estate recovery program was imposed on all states via federal Medicaid law at 42 U.S.C. 1396p(b), with mandatory estate recovery by states against probate assets, and with state options as to whether or not to proceed against non-probate assets.

10. Estate recovery must be construed narrowly because it is phrased in 42 U.S.C. 1396p(b)(1) as a narrow exception to the general rule against it: "No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except…".

11. Massachusetts estate recovery law must be construed narrowly because it is phrased at M.G.L. c. 118E, s. 31 as a narrow exception to the general rule against it: "There shall be no adjustment or recovery of medical assistance correctly paid except as follows."

12. There is no provision in the Massachusetts General Laws that authorizes the EOHHS to expand its estate recovery efforts beyond what is specifically provided in M.G.L. c. 118E, ss. 31 and 32.

13. The current Governor of the Commonwealth of Massachusetts has proposed the expansion of estate recovery in his recent budget proposals, but the Massachusetts Legislature has rebuffed those efforts.

14. If an estate recovery attempt by the EOHHS is not within the specific exceptions in M.G.L. c. 118E, s. 31, it violates Massachusetts law.

15. Massachusetts estate recovery law at M.G.L. c. 118E, s. 31 states: "For purposes of this section, "estate" shall mean all real and personal property and other assets includable in the decedent's probate estate under the General Laws."

16. Massachusetts estate recovery law at M.G.L. c. 118E, s. 31 does not authorize estate recovery against an annuity of any type unless it ends up being includable in the decedent's probate estate.

17. An annuity is not part of a Massachusetts probate estate unless the probate estate is the direct beneficiary of the annuity, or unless the annuity fails to have a beneficiary and the proceeds thereby fall into the probate estate.

18. No estate recovery against the estate of the Medicaid recipient's deceased spouse is allowed under federal law.

19. Under federal law at 42 U.S.C. s. 1396r-5(c)(4), beginning in the month after the institutionalized spouse is determined to be eligible for Medicaid, "no resources of the community spouse shall be deemed available to the institutionalized spouse."

20. As the single state agency designated under M.G.L. c. 118E, s. 1 to deal with the federal government, the EOHHS is answerable to the federal agency that directly oversees it in the federal-state structure, the Centers for Medicare and Medicaid Services ("CMS"), which is a part of the United States Department of Health and Human Services.

21. The State Medicaid Manual is a binding directive from CMS to state Medicaid agencies, as the Foreword to the State Medicaid Manual, at B.1., states: "Contents.-- The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies. This authority is recognized in the introductory paragraph of State plans."

22. The State Medicaid Manual makes no mention of a state agency being allowed to make estate recovery efforts against an annuity purchased by the community spouse or against any other financial holdings of the estate of a MassHealth's recipient's deceased spouse.

23. The State Plan Under Title XIX of the Social Security Act of the Commonwealth of Massachusetts ("State Plan") is a formal, written agreement between the Commonwealth of Massachusetts and the federal government, submitted by EOHHS as the single state agency and approved by CMS, describing how the Commonwealth of Massachusetts administers its Medicaid program.

24. The EOHHS is legally bound with the federal government to follow the State Plan that is filed with CMS, and, accordingly, in filings by the EOHHS for State Medicaid Plan

Amendments with the United States Department of Health and Human Services or CMS, the following certification has been made: "As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan."

25. The State Medicaid Manual, at s. 3810.B, states: "**Definition of Estate. -- Specify in your State plan the definition of estate that will apply. 1. Probate Definition**.-- At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law. **2. Optional Definition**.-- In addition to property and assets under the probate definition, you may include 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). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. … **4. Annuities.--You may collect against an annuity** that was the property of the deceased Medicaid beneficiary if you use State probate law to define estate, and the law includes annuities, or, **if you use the expanded definition of estate found at §3810.B.2. When using the expanded definition of estate, an annuity is considered an "other arrangement.**" (emphasis added)

26. Section 4.17 of the State Plan is entitled "Liens and Adjustments and Recoveries," and is the only section of the State Plan that deals with possible estate recovery by the EOHHS.

27. Section 4.17 of the State Plan defines "estate" as "all real and personal property that passes through the individual's probate estate upon death."

28. The State Plan does not make any mention of the EOHHS's efforts at estate recovery against annuities of deceased spouses of MassHealth recipients.

29. There is no statement in Section 4.17 of the State Plan about the EOHHS making any type of recovery against an annuity purchased by a MassHealth applicant's spouse, or against any other financial holdings of the estate of MassHealth's recipient's deceased spouse.

30. There is no statement anywhere in any part of the State Plan about the EOHHS making any type of recovery against an annuity purchased by a MassHealth applicant's deceased spouse.

31. Section 2.6 of the State Plan is entitled "Financial Eligibility," and its Supplement 9 to its Attachment 2.6-A is entitled "Transfer of Resources."

32. There is no statement in Section 2.6 of the State Plan or in its attachments or supplements that the failure of the community spouse to name the Commonwealth of Massachusetts as a beneficiary of an annuity renders the purchase to be a disqualifying transfer of assets.

33. There is no statement anywhere in any part of the State Plan that the failure of the community spouse to name the Commonwealth of Massachusetts as a beneficiary of an annuity renders the purchase to be a disqualifying transfer of assets.

COUNT 2 – THE COMMONWEALTH OF MASSACHUSETTS CANNOT MAKE A CLAIM AGAINST THE ANNUITY BECAUSE IT WAS FOR EDWARD'S SOLE BENEFIT

34. The Cross-claim Plaintiffs, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, repeat and incorporate herein all of paragraphs 1 through 32 in Count 1 of their Cross-claim as if they were specifically pleaded herein.

35. Edward did not intend to have the EOHHS or the Commonwealth of Massachusetts be reimbursed for his wife Elda's MassHealth benefits from the annuity if he did not survive the term of its payments.

36. Edward's purchase of an actuarially sound annuity, established for his "sole benefit," was allowable under federal Medicaid law at 42 U.S.C. §1396p(c)(2).

37. Spousal annuities purchased in compliance with the "sole benefit" rule in 42 U.S.C. §1396p(c)(2) need only satisfy the requirement that they be actuarially sound in accordance with the community spouse's life expectancy.

38. The annuity purchased by Edward was actuarially sound in accordance with his life expectancy.

39. Because the "sole benefit" rule is an exception to the disqualifying transfer rules at 42.S.C. §1396p(c)(1), annuities that satisfy the requirements of §1396p(c)(2) do not need to name the state as remainder beneficiary.

40. Where Edward's annuity satisfied the "sole benefit" rule, it did not and does not need to provide for reimbursement to the Commonwealth of Massachusetts for recovery for the costs of his wife Elda's MassHealth benefits.

COUNT 3 – CLASS ACTION

41. The Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, bring this action on their own behalf and on behalf of all persons who are similarly situated, against EOHHS pursuant to Rule 23 of the Massachusetts Rules of Civil Procedure, in that the EOHHS has wrongfully made claims against annuities of the deceased spouses of MassHealth recipients.

42. The Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, bring this action on behalf of themselves and a statewide class (the "Statewide Class") of similarly situated persons defined as: "Beneficiaries and contingent beneficiaries of annuities

purchased by deceased community spouses of MassHealth applicants or recipients and against whom EOHHS has claimed to be the primary beneficiary."

43. Upon information and belief, the EOHHS has had the opportunity to consolidate similar cases with similarly situated annuity beneficiaries, but has chosen not to do so.

44. Upon information and belief, the strategy of the EOHHS has been to deal with similarly situated beneficiaries individually so that the beneficiaries of smaller annuities choose not to proceed with legal action due to the costs thereof.

45. This action is brought as a class action and may be so maintained pursuant to the provisions of the Massachusetts Rules of Civil Procedure, Rule 23. The Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, reserve the right to modify the Statewide Class definition and the class period based on the results of discovery.

46. Numerosity of the Statewide Class: The Statewide Class is so numerous that the individual joinder of all members, in this or any action is impracticable. The exact number or identification of Class members is presently unknown to Plaintiffs, but it is believed that the Class numbers over a dozen Massachusetts citizens. The identity of Class members and their addresses may be promptly ascertained from the records of the EOHHS, which has claimed to be the primary beneficiaries of similar annuities. Class members may be informed of the pendency of this action by a combination of direct mail and public notice, or other means, including through records and date possessed by the EOHHS.

47. Commonality: There is a well-defined community of interest in the questions of law and fact involved affecting the members of the Class. These common legal and factual questions are whether the EOHHS of the Commonwealth of Massachusetts has wrongfully and consistently made claims against annuities of the spouses of MassHealth recipients; included therein would

be whether the EOHHS has acted inconsistently by settling some of their claims for less than the initial claim.

48. Typicality: The claims of the Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, are typical of the claims of the members of the Class because Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, and the Class members would be beneficiaries of annuities if not for the claims against those annuities made by the EOHHS. Plaintiffs and all members of the Class have similarly suffered harm arising from Defendants' violations of law, as alleged herein.

49. Adequacy: The Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, are adequate representatives of the Class because their interests do not conflict with the interests of the members of the Class they seek to represent. The Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, intend to prosecute this action vigorously and will fairly and adequately protect the interest of the members of the Class.

50. This suit may be maintained as a class action pursuant to Massachusetts Rule of Civil Procedure 23(b) because all of the above factors of numerosity, common questions of fact and law, typicality and adequacy are present.

51. The EOHHS has acted on grounds generally applicable to the Cross-claimants, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor, and the Class as a whole, thereby making declaratory and/or injunctive relief proper.

52. Predominance and Superiority: This suit may be maintained as a class action under Massachusetts Rule of Civil Procedure 23 because questions of law and fact common to the Class predominate over the questions affecting only individual members of the Class and a class action is superior to other available means for the fair and efficient adjudication of this dispute.

The damages suffered by each individual Class member, depending on the circumstances, may be relatively small or modest, especially given the burden and expense of individual prosecution of the complex and extensive litigation necessitated by the conduct of the EOHHS. Furthermore, it would be virtually impossible for the Class members, on an individual basis, to obtain effective redress for the wrongs done to them. Moreover, even if Class members themselves could afford such individual litigation, the court system could not. Individual litigation presents a potential for inconsistent or contradictory judgments. Individualized litigation increases the delay and expenses to all parties and the court system presented by the complex legal issues of the case. By contrast, the class action device presents far fewer management difficulties and provides the benefits of a single adjudication, economy of scale, and comprehensive supervision by a single court.

RELIEF REQUESTED

WHEREFORE, Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor respectfully request that the Court enter a declaratory judgment in their favor as follows:

1. That the claim made by the Commonwealth of Massachusetts or the EOHHS against the annuity of Edward Mondor is a prohibited attempt at making estate recovery for the MassHealth benefits provided to his wife, Elda Mondor.
2. That Massachusetts law prohibits the Commonwealth of Massachusetts or the EOHHS from making estate recovery except as specifically provided in M.G.L. c. 118E, ss. 31 and 32.

3. That the Commonwealth of Massachusetts or the EOHHS is not entitled to recover on the annuity contract to the extent of any MassHealth benefits paid, or as may be paid in the future, on behalf of Elda Mondor or any other spouse of a deceased annuity owner.

Respectfully submitted,

Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor

By their Attorney,

Brian E. Barreira, Esq.
BBO #544433
118 Long Pond Road, Suite 206
Plymouth, MA 02360
Telephone: (508) 747-8282
Facsimile: (508) 746-5746
Email: office@southshoreelderlaw.com

Date: March 30, 2021

CERTIFICATE OF SERVICE

I, Brian E. Barreira, hereby certify that on March 30, 2021, I served a copy of the above ANSWER OF DEFENDANTS LINDA MARIE MONDOR, MICHELLE MOGAN AND CATHY ANN MONDOR TO AMENDED COMPLAINT OF STANDARD INSURANCE COMPANY and CROSS-CLAIM OF LINDA MARIE MONDOR, MICHELLE MOGAN AND CATHY ANN MONDOR AGAINST EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS FOR DECLARATORY JUDGMENT AND CLASS ACTION upon counsel for the parties by mailing first class mail and emailing a copy to:

Brooks R. Magratten, Esq.
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One Financial Plaza, 26th Floor
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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2184CV00962-D

STANDARD INSURANCE COMPANY,

Plaintiff

v.

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

Defendant and Cross-Claim Plaintiff,

and

KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER, and JOHN FRANCIS CASTLE,

Defendants and Cross-Claim Defendants.

DEFENDANT EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES' ANSWER TO STANDARD INSURANCE COMPANY'S COMPLAINT AND CROSS-CLAIM FOR DECLARATORY JUDGMENT

Defendant Executive Office of Health and Human Services ("EOHHS") hereby answers Plaintiff Standard Insurance Company's ("Standard") Complaint and cross-claims for declaratory judgment as follows.

PARTIES

1. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 1 and, therefore, neither admits nor denies such allegations.

2. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 2 and, therefore, neither admits nor denies such allegations.

3. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 3 and, therefore, neither admits nor denies such allegations.

4. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 4 and, therefore, neither admits nor denies such allegations.

5. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 5 and, therefore, neither admits nor denies such allegations.

6. Admitted.

JURISDICTION AND VENUE

7. Paragraph 7 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 7.

8. Paragraph 8 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 8.

FACTS

9. Admitted.

10. Admitted.

11. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 11 and, therefore, neither admits nor denies such allegations.

12. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 12 and, therefore, neither admits nor denies such allegations.

13. EOHHS admits that it sent a letter to Standard dated February 22, 2021. The remaining allegations in Paragraph 13 purport to characterize the content of a document, which speaks for itself. To the extent a response is required to the remaining allegations in Paragraph 13, the allegations are denied.

14. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 14 and, therefore, neither admits nor denies such allegations.

15. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 15 and, therefore, neither admits nor denies such allegations.

16. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 16 and, therefore, neither admits nor denies such allegations.

17. Paragraph 17 states a legal conclusion of law to which no response is required. To the extent a response is required, the allegations are denied. To the extent that Paragraph 17 purports to characterize the contents of a document, the document speaks for itself and therefore no response is required.

18. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 18 and, therefore, neither admits nor denies such allegations.

19. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 19 and, therefore, neither admits nor denies such allegations.

COUNT I – DECLARATORY JUDGMENT

20. EOHHS repeats, re-alleges, and incorporates herein its answers as set forth in Paragraphs 1 through 20, inclusive.

21. EOHHS admits receiving payments from Standard. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the remaining allegations in Paragraph 21 and, therefore, neither admits nor denies such allegations

22. EOHHS is without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 22 and, therefore, neither admits nor denies such allegations.

23. Paragraph 23 states legal conclusions to which no response is required. To the

extent a response is required, EOHHS denies the allegations in Paragraph 23.

24. Paragraph 24 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 24.

25. Paragraph 25 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 25.

COUNT II - INDEMNIFICATION

26. EOHHS repeats, re-alleges, and incorporates herein its answers as set forth in Paragraphs 1 through 25, inclusive.

27. Paragraph 27 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 27.

28. Paragraph 28 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 28.

COUNT III - INTERPLEADER

29. EOHHS repeats, re-alleges, and incorporates herein its answers as set forth in Paragraphs 1 through 28, inclusive.

30. Paragraph 30 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 30.

31. Paragraph 31 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 31.

32. Paragraph 32 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 32.

33. Paragraph 33 states legal conclusions to which no response is required. To the extent a response is required, EOHHS denies the allegations in Paragraph 33.

All allegations that are neither admitted nor denied are hereby denied.

RELIEF REQUESTED

EOHHS respectfully requests that the Court resolve the interpleader claim by declaring and ordering that EOHHS is entitled to recover on the annuity contract to the extent of any MassHealth benefits paid, or as may be paid in the future, on behalf of Carol A. Castle.

* * *

AFFIRMATIVE DEFENSES

1. The Complaint fails to state a claim upon which relief could be granted.

2. The claims against EOHHS are barred by sovereign immunity.

3. EOHHS is not subject to damages, interests, or costs under the interpleader rule or under the Declaratory Judgment Act.

4. The claims against EOHHS are barred by estoppel.

5. The claims against EOHHS are barred by laches.

6. The claims are preempted by federal law.

* * *

CROSS-CLAIM

COUNT I – DECLARATORY JUDGMENT
(against Cross-Claim Defendants Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle)

Defendant and Cross-Claim Plaintiff EOHHS hereby cross-claims against Cross-Claim Defendants Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle as follows:

1. Carol A. Castle ("Carol") was admitted to a nursing facility on or about August 3, 2018.

2. On or around November 2, 2018, Carol's spouse, James W. Castle ("James"), and

Standard Insurance Company entered into annuity Contract No. 00BB063280, with an effective date of November 19, 2018. The contract had a premium of $176,859.75 and a monthly benefit of $3,031.93 for a 5-year period. The contract named the Commonwealth of Massachusetts as the primary beneficiary to the annuity proceeds and Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle as contingent beneficiaries.

3. James did not receive MassHealth long-term care benefits during his lifetime.

4. James purchased annuity Contract No. 00BB063280 and named the Commonwealth as primary beneficiary in part or in whole so that Carol would be eligible to receive MassHealth benefits for her skilled nursing care.

5. In purchasing annuity Contract No. 00BB063280, and naming the Commonwealth as a beneficiary, James intended to comply with 42 U.S.C. § 1396p(c)(1)(F) and § 1396p(e).

6. In purchasing annuity Contract No. 00BB063280, and naming the Commonwealth as a beneficiary, James intended to comply with 130 CMR 520.007(J).

7. On or about December 6, 2018, Carol, through an agent at Senior Resource Center, Inc., and with the assistance of Kathleen Ann Bristow, provided the MassHealth Enrollment Center with Carol's application for MassHealth long-term care benefits and accompanying documentation, including a copy of annuity Contract No. 00BB063280.

8. In applying for MassHealth long-term care benefits, Carol or her authorized representative was required to complete the "Notice of Preferred Remainder Beneficiary / Annuity Tracking Form" (ANN-3 form) for annuity Contract No. 00BB063280.

9. On November 2, 2018, James executed the ANN-3 form for annuity Contract No. 00BB063280 on Carol's behalf.

10. In the ANN-3 form, James acknowledged that the "Commonwealth of Massachusetts Executive Office of Health and Human Services has determined that, pursuant to MassHealth regulations at 130 CMR 520.007(J) and federal 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." James further acknowledged that a "[f]ailure to name and keep the Commonwealth of Massachusetts as a beneficiary of the annuity in the proper position will result in the termination of MassHealth benefits and the Commonwealth may recover MassHealth benefits paid while the individual was not eligible."

11. On or about March 22, 2019, MassHealth wrote to Carol and informed her that she was eligible for MassHealth benefits for her skilled nursing care retroactive to November 12, 2018.

12. On or about November 23, 2020, the Commonwealth was made aware that James died on October 1, 2020. Carol had predeceased James on April 23, 2020.

13. As of February 22, 2021, the Commonwealth paid a total of $123,413.51 in MassHealth long-term care benefits on behalf of Carol.

14. On February 22, 2021, the Commonwealth asserted a claim to Standard Insurance Company for annuity Contract No. 00BB063280 in the amount of $123,413.51, the amount of MassHealth long-term care benefits paid on behalf of Carol.

15. On or around March 4, 2021, the Commonwealth received $15,159.65 from Standard Insurance Company for annuity Contract No. 00BB063280.

16. After March 4, 2021, Standard Insurance Company ceased making payments to the Commonwealth for annuity Contract No. 00BB063280 and represented that the contingent beneficiaries, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, have asserted a competing claim to the remaining annuity proceeds. On information and believe, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle have disputed the Commonwealth's claim to the remaining annuity proceeds in the amount of MassHealth long-term care benefits paid on behalf of Carol.

17. EOHHS contends that it is entitled to the remaining proceeds from annuity Contract No. 00BB063280 to the extent of any MassHealth benefits as were paid on behalf of Carol A. Castle.

18. A controversy exists between EOHHS and Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle regarding the distribution of the proceeds from annuity Contract No. 00BB063280 by Standard Insurance Company remaining as of the death of James W. Castle.

19. EOHHS seeks a determination of and a binding declaration of its rights under annuity Contract No. 00BB063280 pursuant to G.L. c. 231A.

RELIEF REQUESTED

WHEREFORE, Defendant and Cross-Claim Plaintiff EOHHS respectfully requests that the Court enter a declaratory judgment in its favor as follows:

a) Declare that 42 U.S.C. § 1396p(c)(1)(F) applies to annuities for which the "community spouse" is named as the annuitant.

b) Declare that 42 U.S.C. § 1396p(e) and the ANN-3 form component of the MassHealth application provide MassHealth with an interest in the annuity proceeds

here, to the extent of total medical assistance paid by MassHealth on behalf of Carol A. Castle, by operation of law.

c) Declare that the designation of the Commonwealth of Massachusetts as primary beneficiary to the annuity proceeds from Standard Insurance Company annuity Contract No. 00BB063280 shall mean that the Commonwealth of Massachusetts is the beneficiary of such proceeds to the extent of total medical assistance paid by MassHealth on behalf of Carol A. Castle.

d) Declare that the remaining annuity benefits payable pursuant to Standard Insurance Company annuity Contract No. 00BB063280 shall be paid to the Commonwealth of Massachusetts to the extent of total medical assistance provided by MassHealth on behalf of Carol A. Castle.

Respectfully submitted,

Defendant and Cross-Claim Plaintiff,
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES,

By its Attorneys,

MAURA HEALEY
ATTORNEY GENERAL

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Date: June 4, 2021

CERTIFICATE OF SERVICE

I, Katherine B. Dirks, Assistant Attorney General, hereby certify that I have this day June 4, 2021, served a copy of the foregoing document upon counsel by e-mailing a copy to:

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/s/ Katherine B. Dirks
Katherine B. Dirks
Assistant Attorney General

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2184CV00962

6/8/2021

EFILED ec

STANDARD INSURANCE COMPANY,
Plaintiff

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Defendant and Cross-Claim Plaintiff and Cross-Claim Defendant

and

KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER and JOHN FRANCIS CASTLE,
Defendants and Cross-Claim Defendants and Cross-Claim Plaintiffs

ANSWER OF DEFENDANTS KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER AND JOHN FRANCIS CASTLE TO COMPLAINT OF STANDARD INSURANCE COMPANY

The Defendants, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, hereby submit their answer to the Plaintiff Standard Insurance Company's Complaint and cross-claim for declaratory judgment as follows.

1. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 1 and, therefore, neither admit nor deny such allegations.

2. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 2 and, therefore, neither admit nor deny such allegations.

3. Admitted.

4. Admitted.

5. Admitted.

6. Admitted.

7. Paragraph 7 states legal conclusions as to which no response is required.

8. Paragraph 8 states legal conclusions as to which no response is required.

9. Admitted.

10. Admitted.

11. Admitted.

12. Ad mitted.

13. Admitted.

14. Admitted.

15. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 15 and, therefore, neither admit nor deny such allegations.

16. Admitted.

17. Admitted.

18. Admitted.

19. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in

Paragraph 19 and, therefore, neither admit nor deny such allegations.

20. No response required.

21. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 21 and, therefore, neither admit nor deny such allegations.

22. Admitted.

23. Admitted.

24. Paragraph 24 states legal conclusions as to which no response is required.

25. Paragraph 25 states legal conclusions as to which no response is required.

26. Paragraph 26 states legal conclusions as to which no response is required.

27. Paragraph 27 states legal conclusions as to which no response is required.

28. Admitted.

29. No response required.

30. Admitted.

31. Admitted.

32. Paragraph 32 states legal conclusions as to which no response is required.

33. Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle are without knowledge or information sufficient to form a belief as to the truth of the allegations in Paragraph 33 and, therefore, neither admit nor deny such allegations.

RELIEF REQUESTED

The Defendants, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, respectfully request that the Court resolve the interpleader claim by declaring and ordering that

the Commonwealth of Massachusetts is not entitled to recover and was not entitled to recover on the annuity contract to the extent of any MassHealth benefits paid on behalf of Carol A. Castle.

CROSS-CLAIM OF KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER AND JOHN FRANCIS CASTLE AGAINST EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS FOR DECLARATORY JUDGMENT

Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle hereby file a cross-claim against the Executive Office of Health and Human Services ("EOHHS") of the Commonwealth of Massachusetts.

COUNT 1 – MASSACHUSETTS LAW DOES NOT ALLOW ESTATE RECOVERY AGAINST A COMMUNITY SPOUSE'S ANNUITY

1. James Castle ("James"), the father of the Cross-claim Plaintiffs, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, purchased the immediate annuity that is the subject of the interpleader action, then died on October 1, 2020 with payments on the annuity still remaining.

2. James's wife, Carol A. Castle, had died on April 23, 2020.

3. When James died, there were thirty-eight (38) payments of $3,031.93 left on the annuity, for a total of $115,213.34.

4. The Cross-claim Plaintiffs, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, have claimed that the remaining amount of the annuity should not be and should not have been paid to the Commonwealth of Massachusetts, but rather to them.

5. The claim made against the annuity by the Executive Office of Health and Human Services ("EOHHS") was for $123,413.51, representing MassHealth benefits that had been expended on behalf of Carol A. Castle, who was the wife of the annuity purchaser, James.

6. The letter to Standard Insurance Company by which the EOHHS made its claim against the annuity was sent by EOHHS's Estate Recovery Unit, asked that the check be made payable to Commonwealth of Massachusetts – ERU, and asked that the check be mailed to the Estate Recovery Unit's address.

7. By making a claim for the proceeds of the annuity in this case, the EOHHS is attempting to engage in a form of estate recovery that has been prohibited by long-standing Massachusetts law.

8. There is no common law right of recovery in Massachusetts for governmental benefits provided to any citizen.

9. The EOHHS has not identified any specific Massachusetts law that authorizes it to make any type of collection or recovery efforts against the annuity in this case.

10. No governmental benefit program other than Medicaid (which is known in Massachusetts as MassHealth) has an "estate recovery" feature, whereby benefits are later recovered financially as though the governmental expenditure represented a loan to the recipient.

11. The Medicaid estate recovery program was imposed on all states via federal Medicaid law at 42 U.S.C. 1396p(b), with mandatory estate recovery by states against probate assets, and with state options as to whether or not to proceed against non-probate assets.

12. Estate recovery must be construed narrowly because it is phrased in 42 U.S.C. 1396p(b)(1) as a narrow exception to the general rule against it: "No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except…".

13. Massachusetts estate recovery law must be construed narrowly because it is phrased at M.G.L. c. 118E, s. 31 as a narrow exception to the general rule against it: "There shall be no adjustment or recovery of medical assistance correctly paid except as follows."

14. There is no provision in the Massachusetts General Laws that authorizes the EOHHS to expand its estate recovery efforts beyond what is specifically provided in M.G.L. c. 118E, ss. 31 and 32.

15. The current Governor of the Commonwealth of Massachusetts has proposed the expansion of estate recovery in his recent budget proposals, but the Massachusetts Legislature has rebuffed those efforts.

16. If an estate recovery attempt by the EOHHS is not within the specific exceptions in M.G.L. c. 118E, s. 31, it violates Massachusetts law.

17. Massachusetts estate recovery law at M.G.L. c. 118E, s. 31 states: "For purposes of this section, "estate" shall mean all real and personal property and other assets includable in the decedent's probate estate under the General Laws."

18. Massachusetts estate recovery law at M.G.L. c. 118E, s. 31 does not authorize estate recovery against an annuity of any type unless it ends up being includable in the decedent's probate estate.

19. An annuity is not part of a Massachusetts probate estate unless the probate estate is the direct beneficiary of the annuity, or unless the annuity fails to have a beneficiary and the proceeds thereby fall into the probate estate.

20. No estate recovery against the probate estate of the Medicaid recipient's deceased spouse is allowed under federal law.

21. As the single state agency designated under M.G.L. c. 118E, s. 1 to deal with the federal government, the EOHHS is answerable to the federal agency that directly oversees it in the federal-state structure, the Centers for Medicare and Medicaid Services ("CMS"), which is a part of the United States Department of Health and Human Services.

22. The State Medicaid Manual is a binding directive from CMS to state Medicaid agencies, as the Foreword to the State Medicaid Manual, at B.1., states: "Contents.-- The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies. This authority is recognized in the introductory paragraph of State plans."

23. The State Medicaid Manual makes no mention of a state agency being allowed to make estate recovery efforts against an annuity purchased by the community spouse or against any other financial holdings of the estate of a MassHealth's recipient's deceased spouse.

24. The State Medicaid Manual, at s. 3810. I. 2. requires notice to affected individuals and the right to apply for a hardship waiver before the EOHHS makes any recovery claim: "Recovery or Adjustment Notice.--You should give a specific notice to individuals affected by the proposed recovery whenever you seek adjustment or recovery. … In the situation where there is no executor or legally authorized representative, the State should notify the family or the heirs. The notice should include, at a minimum, the action the State intends to take, reason for the action, individual's right to a hearing, method by which he/she may obtain a hearing, procedures for applying for a hardship waiver, and the amount to be recovered."

25. There is no Massachusetts law or MassHealth regulation that complies with s. 3810. I.2. of the State Medicaid Manual when the EOHHS makes any recovery claim against an annuity.

26. The State Medicaid Manual, at s. 3810. C., requires that recovery be waived in an undue hardship situation, and that the EOHHS establish procedures and standards to make such determination: "**Where estate recovery would work an undue hardship, adjustment or recovery is waived.** Establish procedures and standards for waiving estate recoveries when they would cause undue hardship. You may limit the waiver to the period during which the undue hardship circumstances continue to exist. **Describe your policy in your State plan.** You have flexibility in implementing an undue hardship provision." (emphasis added)

27. There is no Massachusetts law or MassHealth regulation that complies with s. 3810.C. of the State Medicaid Manual when the EOHHS makes any recovery claim against an annuity.

28. The State Medicaid Manual, at s. 3810. D., requires advance notice to persons who may be able to claim undue hardship: "Collection Procedures.--You must adopt procedures under which individuals who will be affected by recovery of amounts of medical assistance will have the right to apply for an undue hardship waiver. These procedures must, at a minimum, provide for advance notice of any proposed recovery. They must also specify the method for applying for a waiver, the hearing and appeal rights, and the time frames involved. You should specify the procedures used for collection, which must be reasonable."

29. There is no Massachusetts law or MassHealth regulation that complies with s. 3810. D. of the State Medicaid Manual when the EOHHS makes any recovery claim against an annuity.

30. The State Plan Under Title XIX of the Social Security Act of the Commonwealth of Massachusetts ("State Plan") is a formal, written agreement between the Commonwealth of Massachusetts and the federal government, submitted by EOHHS as the single state agency and approved by CMS, describing how the Commonwealth of Massachusetts administers its Medicaid program.

31. The EOHHS is legally bound with the federal government to follow the State Plan that is filed with CMS.

32. In filings by the EOHHS for State Medicaid Plan Amendments with the United States Department of Health and Human Services or CMS, the following certification has been made: "As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan."

33. The State Medicaid Manual, at s. 3810.B, states: "**Definition of Estate. -- Specify in your State plan the definition of estate that will apply. 1. Probate Definition**.-- At a minimum, you must include all real and personal property and other assets included within the individual's estate as provided in your State probate law. **2. Optional Definition**.-- In addition to property and assets under the probate definition, you may include 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). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. … **4. Annuities.--You may collect against an annuity** that was the property of the deceased Medicaid beneficiary if you use State probate law to define estate, and the law includes annuities, or, **if you use the expanded definition of estate found at §3810.B.2. When using the expanded definition of estate, an annuity is considered an "other arrangement.**" (emphasis added)

34. Section 4.17 of the State Plan is entitled "Liens and Adjustments and Recoveries," and is the only section of the State Plan that deals with possible estate recovery by the EOHHS.

35. Section 4.17 of the State Plan defines "estate" as "all real and personal property that passes through the individual's probate estate upon death."

36. The State Plan does not make any mention of the EOHHS's efforts at estate recovery against annuities of deceased spouses of MassHealth recipients.

37. There is no statement in Section 4.17 of the State Plan or in any other part of the State Plan about the EOHHS making any type of recovery against an annuity purchased by a MassHealth applicant's spouse, or against any other financial holdings of the estate of MassHealth's recipient's deceased spouse.

38. Section 2.6 of the State Plan is entitled "Financial Eligibility," and its Supplement 9 to its Attachment 2.6-A is entitled "Transfer of Resources."

39. There is no statement in Section 2.6 of the State Plan or in its attachments or supplements that the failure of the community spouse to name the Commonwealth of Massachusetts as a beneficiary of an annuity renders the purchase to be a disqualifying transfer of assets.

40. There is no statement anywhere in any part of the State Plan that the failure of the community spouse to name the Commonwealth of Massachusetts as a beneficiary of an annuity renders the purchase to be a disqualifying transfer of assets.

41. There are no notice, collection or undue hardship statements or policies anywhere in the State Plan to place the EOHHS in compliance with ss. 3810.I.2, 3810.C. or 3810.D. of the State Medicaid Manual.

42. Federal law at 42 U.S.C. s. 1396r-5 deals with the treatment of assets and income of spouses when one of them is institutionalized, and in 42 U.S.C. s. 1396r-5(c)(4), beginning in the month after the institutionalized spouse is determined to be eligible for Medicaid, "no resources of the community spouse shall be deemed available to the institutionalized spouse."

43. Massachusetts law at M.G.L. c. 118E, s. 21A deals with the assets of spouses, and it makes specific reference to federal law at 42 U.S.C. s. 1396r-5, but it provides no authority for the EOHHS to make the Commonwealth of Massachusetts the beneficiary of any of the community spouse's assets or income.

COUNT 2 – THE COMMONWEALTH OF MASSACHUSETTS CANNOT MAKE A CLAIM AGAINST THE ANNUITY BECAUSE IT WAS FOR JAMES CASTLE'S SOLE BENEFIT

44. The Cross-claim Plaintiffs, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, repeat and incorporate herein all of paragraphs 1 through 43 in Count 1 of their Cross-claim as if they were specifically pleaded herein.

45. James did not intend to have the EOHHS or the Commonwealth of Massachusetts be reimbursed for his wife Carol's MassHealth benefits from the annuity if he did not survive the term of its payments.

46. James' purchase of an actuarially sound annuity, established for his "sole benefit," was allowable under federal Medicaid law at 42 U.S.C. §1396p(c)(2).

47. Spousal annuities purchased in compliance with the "sole benefit" rule in 42 U.S.C. §1396p(c)(2) need only satisfy the requirement that they be actuarially sound in accordance with the community spouse's life expectancy.

48. The annuity purchased by James was actuarially sound in accordance with his life expectancy.

49. Because the "sole benefit" rule is an exception to the disqualifying transfer rules at 42 U.S.C. §1396p(c)(1), annuities that satisfy the requirements of 42 U.S.C. §1396p(c)(2) do not need to name the state as remainder beneficiary.

50. Where James's annuity satisfied the "sole benefit" rule, it did not and does not need to provide for reimbursement to the Commonwealth of Massachusetts for recovery for the costs of his wife Carol's MassHealth benefits.

RELIEF REQUESTED

WHEREFORE, Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle, respectfully request that the Court enter a declaratory judgment in their favor as follows:

1. That the claim made by the Commonwealth of Massachusetts or the EOHHS against the annuity of James Castle is a prohibited attempt at making estate recovery for the MassHealth benefits provided to his wife, Carol A. Castle.
2. That Massachusetts law prohibits the Commonwealth of Massachusetts or the EOHHS from making recovery of MassHealth benefits except as specifically provided in M.G.L. c. 118E, ss. 31 and 32.
3. That the Commonwealth of Massachusetts or the EOHHS is not entitled and was not entitled to recover on the annuity contract to the extent of any MassHealth benefits paid on behalf of Carol A. Castle.
4. That, absent enabling legislation, the Commonwealth of Massachusetts or the EOHHS is not entitled to receive payment from any annuity contract to the extent of any MassHealth benefits paid on behalf of the spouse of a deceased annuity owner.

Respectfully submitted,

Kathleen Ann Bristow, Marianne Schwenzfeier and John Francis Castle,

By their Attorney,

Brian E. Barreira, Esq.
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Date: June 8, 2021

CERTIFICATE OF SERVICE

I, Brian E. Barreira, hereby certify that on June 8, 2021, I served a copy of the above "ANSWER OF DEFENDANTS KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER AND JOHN FRANCIS CASTLE TO COMPLAINT OF STANDARD INSURANCE COMPANY" and "CROSS-CLAIM OF KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER AND JOHN FRANCIS CASTLE AGAINST EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS FOR DECLARATORY JUDGMENT" upon counsel for the parties by emailing a copy to:

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COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2084CV02484-F

STANDARD INSURANCE COMPANY, Plaintiff, v. EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS, Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant, and LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR, Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.	C.A. NO. 2084CV02484-F

CONSOLIDATED WITH

STANDARD INSURANCE COMPANY , Plaintiff and Counter Defendant, v. EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS, Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant, and KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER, and JOHN FRANCIS CASTLE, Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.	C.A. NO. 2184CV00962

JOINT MOTION TO REPORT THE CONSOLIDATED CASES TO THE APPEALS COURT PURSUANT TO RULE 64

All parties to these consolidated actions hereby jointly move, pursuant to Mass. R. Civ. P. 64, to report these two consolidated cases without determination to the Appeals Court on an agreed statement of material facts. The parties' agreed statement of material facts and agreed joint appendix of exhibits are filed contemporaneously herewith. Because the parties agree to the material facts at issue, because the resolution of the dispute requires the resolution of novel and important issues of law, and because substantially similar claims have been asserted in at least twelve other cases pending in various sessions of the Superior Court, with that volume of cases expected to continue to grow in the absence of binding appellate guidance, both this case and the public interest will be served by reporting the cases for determination by the Appeals Court in the first instance.

BACKGROUND

These consolidated actions seek to resolve competing claims to the proceeds of two annuities purchased in conjunction with Medicaid/MassHealth applications that name the Commonwealth of Massachusetts in the primary beneficiary position.

I. Annuities in the Context of MassHealth.

MassHealth provides, among other things, long-term care benefits for individuals in nursing homes whose assets and income fall below certain limits. *Forman v. Dir. of Office of Medicaid*, 79 Mass. App. Ct. 218, 222 (2011). To qualify, an applicant must generally have $2,000 or less in "countable assets." 130 CMR 520.016(A). When an applicant is married and lives with their "community spouse," MassHealth will assess the total combined value of the "countable assets" owned by both spouses "regardless of the form of ownership between the couple." 42 U.S.C. § 1396r–5(c)(2); 130 CMR 520.016(B). From this combined amount, MassHealth will set aside a portion of the couple's assets—known as the community spouse resource allowance

("CSRA")—which the "community spouse" may use without affecting the Medicaid eligibility of the "institutionalized spouse." 42 U.S.C. § 1396r–5(c)(2), (f)(2)(A); 130 CMR 520.016(B)(2). If, after setting aside the CSRA amount, the couple's combined "countable assets" fall below the $2,000 limit, then the asset requirements for eligibility will be met. 130 CMR 520.016(B)(2).[1]

These "countable asset" limits may lead applicants to "spend down" by "deplet[ing] their resources to qualify for Medicaid long-term care benefits when they enter a nursing home." *Daley v. Sec'y of Exec. Office of Health & Human Servs*., 477 Mass. 188, 192 (2017). One way in which applicants or their spouses may seek to spend down assets is through the purchase of commercial annuities. *See Normand v. Dir. of Off. of Medicaid*, 77 Mass. App. Ct. 634 (2010).

Under 42 U.S.C. § 1396p(c)(1), G. L. c. 118E, § 28, and 130 CMR 520.018-520.019, MassHealth must review any transfers of resources (including the purchase of annuities) made by an applicant or their spouse during a five-year "look back" period prior to the applicant's application. For any such asset transfer that was made for "less than fair market value," subject to certain exceptions, MassHealth will impose a penalty: the applicant will be deemed 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 facility. 42 U.S.C. § 1396p(c)(1)(E); 130 CMR 520.019(G).

Federal Medicaid law and MassHealth regulations contemplate that, in certain circumstances, an annuity must name the state as a remainder beneficiary of the annuity in order for the purchase of the annuity to be safe from penalty. 42 U.S.C. § 1396p(c)(1)(F); 42 U.S.C. § 1396p(e); 130 CMR 520.007(J)(2)(A). MassHealth and the Federal Centers for Medicare and

[1] One exception to state regulations regarding asset verifications and eligibility determinations is the spousal refusal provision. 130 CMR 517.011 states that an institutionalized spouse whose community spouse refuses to cooperate, or whose whereabouts is unknown, will not be ineligible for MassHealth under certain conditions not pertinent to these consolidated actions. *See* 130 CMR 517.011(A), (B).

Medicaid Services (which administers Medicaid at the Federal level) ("CMS") take the position that an annuity naming the "community spouse" as the annuitant must name the state as a remainder beneficiary. *See, e.g.*, CMS Amicus Br. *Hughes v. Colbert*, No. 12-3765, 2013 WL 3366469, at *16 (6th Cir. June 2013). Others, like the family beneficiaries in these consolidated cases, take the position that, as a matter of law, an annuity naming the "community spouse" as the annuitant need not name the state as a remainder beneficiary. *See, e.g.*, *Hughes v. McCarthy*, 734 F.3d 473, 483-85 (6th Cir. 2013).

The two Federal circuit courts to have considered this question have reached differing results. *Compare Hughes*, 734 F.3d at 483-85 (community spouse annuity not required to name the state as remainder beneficiary), *with Hutcherson v. Ariz. Health Care Cost Containment Sys. Admin*., 667 F.3d 1066, 1067-70 (9th Cir. 2012) (community spouse annuity required to name the state as remainder beneficiary). The two Massachusetts Superior Court decisions to have considered this question have also reached differing results. *Compare Dermody v. Exec. Office of Health & Human Servs*., No. 1781CV02342, 36 Mass. L. Rptr. 183, 2020 WL 742194 (Middlesex Super. Jan. 16, 2020) (community spouse annuity not required to name the state as remainder beneficiary), *with Am. Ntl. Ins. Co. v. Jennifer Breslouf, et al.,* No. 2084CV02374, 2021 WL 2343024 (Suffolk Super. June 3, 2021) (community spouse annuity required to name the state as remainder beneficiary).

II. Factual and Procedural Background.

A. The Mondor Case.

The Mondor case was initially commenced by Standard Insurance Company ("Standard") on October 29, 2020 as an interpleader action, seeking to resolve competing claims to the proceeds of an annuity which was purchased by the now-deceased Edward Mondor ("Edward") and which

listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) Linda Marie Mondor, Michelle Mogan, and Cathy Ann Mondor (collectively the "Mondor Beneficiaries") in the secondary (or contingent) beneficiary position.

Edward's spouse Elda Mondor ("Elda") was admitted to a skilled nursing facility for long-term care on March 20, 2018 at the age of 84. After Elda's admission, Edward purchased an annuity contract with their spousal assets to assist in making Elda eligible for MassHealth benefits for her long-term care. Specifically, on April 18, 2018, Edward purchased Annuity Contract Number 00BB056000 issued by Standard (hereinafter, the "Mondor Annuity Contract"). Edward paid a premium of $191,215.28 for the Mondor Annuity Contract, with a monthly payment of $4,065.00, payable commencing June 3, 2018 and continuing for a 4-year term.

The Mondor Annuity Contract named Edward as the sole annuitant and owner. Edward named the following as the primary beneficiary of the Mondor Annuity Contract: "THE COMMONWEALTH OF MASSACHUSETTS." Edward named his and Elda's daughters, LINDA MARIE MONDOR, MICHELLE MOGAN and CATHY ANN MONDOR, as the secondary (or contingent) beneficiaries of the Mondor Annuity Contract in equal parts.

On or about June 4, 2018, Elda submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility. On August 29, 2018, MassHealth approved Elda's MassHealth Application, deeming her eligible for MassHealth standard benefits to cover her care in a nursing facility retroactive to May 1, 2018.

Elda presently continues to reside in a skilled nursing facility and continues to receive MassHealth benefits for her long-term care. Edward passed away on April 11, 2020 at the age of 92. Edward never received Medicaid or MassHealth benefits during his lifetime. At the time of Edward's death, $97,720.28 in annuity proceeds remained to be paid. In a letter dated July 29,

2020, the Commonwealth made a claim on the proceeds of the Mondor Annuity Contract up to the total amount of medical assistance paid on behalf of the Medicaid recipient, Elda, and identified $146,903.57 in such assistance as of July 29, 2020. In a letter dated August 3, 2020, the Mondor Beneficiaries, in their capacity as the secondary (or contingent) beneficiaries of the Annuity Contract, made a claim to all proceeds of the annuity remaining after Edward's death. Standard remains in possession of the balance of the annuity proceeds remaining after Edward's death, and has agreed to pay out such funds in accordance with the final judgment in the case.

Standard filed its operative Amended Interpleader Complaint on November 3, 2020. On January 19, 2021, the Executive Office of Health and Human Services of the Commonwealth of Massachusetts answered the Amended Interpleader Complaint and cross-claimed against the Mondor Beneficiaries for declaratory judgment. On March 30, 2021, the Mondor Beneficiaries answered Standard's Amended Interpleader Complaint and the Commonwealth's cross-claim, and filed a three-count cross-claim against the Commonwealth: (1) "Massachusetts Law Does Not Allow Estate Recovery Against a Community Spouse's Annuity"; (2) "The Commonwealth of Massachusetts Cannot Make a Claim Against the Annuity Because It Was for Edward's Sole Benefit"; and (3) "Class Action." On May 18, 2021, the Commonwealth answered the Mondor Beneficiaries' cross-claims.

On June 11, 2021, all parties stipulated to the dismissal of Standard from the case, with the litigation continuing as to the remaining parties' respective cross-claims. On June 21, 2021, the Mondor Beneficiaries voluntarily dismissed Count 3 ("Class Action") of their cross-claim against the Commonwealth.

B. The Castle Case.

The Castle case was initially commenced by Standard on April 27, 2021, seeking to resolve competing claims to the proceeds of an annuity which was purchased by the now-deceased James W. Castle ("James") and which listed: (i) the Commonwealth of Massachusetts in the primary beneficiary position; and (ii) Kathleen Ann Bristow, Marianne Schwenzfeier, and John Francis Castle (collectively the "Castle Beneficiaries") in the secondary (or contingent) beneficiary position.

James's spouse, Carol A. Castle ("Carol"), was admitted to a skilled nursing facility for long-term care on August 3, 2018, at the age of 78. After Carol's admission, James purchased an annuity contract with their spousal assets to assist in making Carol eligible for MassHealth benefits for her long-term care. Specifically, on November 2, 2018, James purchased Annuity Contract Number 00BB063280 issued by Standard (hereinafter, the "Castle Annuity Contract"). James paid a premium of $176,859.75 for the Castle Annuity Contract, with a monthly payment of $3,031.93 payable commencing November 19, 2018 and continuing for a 5-year term.

The Castle Annuity Contract named James as the sole annuitant and owner. James named the following as the primary beneficiary of the Castle Annuity: "THE COMMONWEALTH OF MASSACHUSETTS." James named his and Carol's children, "KATHLEEN ANN BRISTOW," "MARIANNE SCHWENZFEIER," and "JOHN FRANCIS CASTLE", as the secondary (or contingent) beneficiaries of the Castle Annuity Contract in equal parts.

On or about December 6, 2018, Carol submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility. On March 22, 2019, MassHealth approved Carol's MassHealth application, deeming her eligible for MassHealth standard benefits to cover her care in a nursing facility retroactive to November 12, 2018.

Carol passed away on April 23, 2020. Between November 12, 2018 and the time of Carol's death, MassHealth paid $123,413.51 in medical assistance on behalf of Carol. James passed away on October 1, 2020 at the age of 88. At the time of Edward's death, approximately $110,000 in annuity proceeds remained to be paid on the Castle Annuity Contract.

In a letter dated February 22, 2021, the Commonwealth made a claim on the Castle Annuity Contract up to the total amount of medical assistance paid on behalf of Carol. Standard thereafter made five monthly benefit payments under the Castle Annuity Contract of $3,031.93 each to the Commonwealth, for a total of $15,159.65, reflecting the amounts payable between October 19, 2020 and February 19, 2021. In or around February 2021, the Castle Beneficiaries, in their capacity as the contingent beneficiaries of the Castle Annuity Contract, made a claim to all remaining proceeds of the Castle Annuity Contract and to the $15,159.65 that had been paid to the Commonwealth between October 19, 2020 and February 19, 2021. In response to the competing claims, Standard ceased paying monthly benefit payments effective March 19, 2021.

Standard remains in possession of the balance of all the annuity proceeds accumulated since its last payment to the Commonwealth on February 19, 2021, and has agreed to pay out such funds in accordance with the final judgment in the case.

Standard filed its operative Complaint on April 27, 2021. On June 4, 2021, the Executive Office of Health and Human Services of the Commonwealth of Massachusetts answered the Complaint and cross-claimed against the Castle Beneficiaries for declaratory judgment. On June 8, 2021, the Castle Beneficiaries answered the Complaint and the Commonwealth's cross-claim, and filed their own two-count cross-claim against the Commonwealth: (1) "Massachusetts Law Does Not Allow Estate Recovery Against a Community Spouse's Annuity"; and (2) "The Commonwealth of Massachusetts Cannot Make a Claim Against the Annuity Because It Was for

James Castle's Sole Benefit." On June 10, 2021, the Commonwealth answered the Castle Beneficiaries' cross-claim.

On June 21, 2021, all parties stipulated to the dismissal of Standard from the case, with the litigation continuing as to the remaining parties' respective cross-claims.

III. Other Similar Cases.

These cases are two of fourteen cases currently pending in various sessions of the Superior Court that all involve substantially similar disputes over the interpretation of beneficiary language naming the "Commonwealth" in the primary beneficiary position of annuities purchased by "community spouses" in order to assist their "institutionalized spouses" in becoming eligible for MassHealth benefits.

In the first-filed of these cases, the Superior Court (Barrett, J.) considered a community spouse annuity that listed the Commonwealth as the primary beneficiary "to the extent benefits paid," and determined that the Commonwealth had no right to recover where only the institutionalized spouse (and not the community spouse) received MassHealth benefits. *See Dermody v. Exec. Office of Health & Human Servs*., No. 1781CV02342, 36 Mass. L. Rptr. 183, 2020 WL 742194 (Middlesex Super. Jan. 16, 2020). The *Dermody* decision reasoned that MassHealth had no right to recover based on the plain language of the contract and, in the alternative, that community spouse annuities need not name the Commonwealth as a remainder beneficiary in general. *Id.* at *8, citing *Hughes*, 734 F.3d at 483-85.

In the wake of the January 16, 2020 *Dermody* decision, these cases and others followed.[2] All of the cases involve disputes over the distribution of remaining annuity funds from

[2] *See Allianz Life Ins. Co. of N. Am. v. Commonwealth, Christopher R. Anderson, et al.*, No. 2084CV01321 (Suffolk Super., filed June 23, 2020); *Nationwide Life Ins. Co. v. Commonwealth and Matthew Quinn*, No. 2084CV01783 (Suffolk Super., filed Aug. 11, 2020); *Nationwide Life*

"community spouse" annuities when both the Commonwealth and contingent beneficiaries have asserted competing claims. The parties to these cases believe that similar actions will continue to be filed absent binding appellate guidance on the issues.

ARGUMENT

Under Mass. R. Civ. P. 64(a), "[t]he court, upon request of the parties, in any case where the parties agree in writing as to all the material facts, may report the case to the appeals court for determination without making any decision thereon." This requires a report of the "whole case," *Cusic v. Commonwealth*, 412 Mass. 291, 293 (1992), rather than particular "question[s]," *Rhode v. Beacon Sales Co.*, 416 Mass. 14, 15 n.2 (1993). In other words, "[t]he report must be of the entire case and in such form that [the appellate court] can enter or order the entry of a final decree disposing of the case." *Dorfman v. Allen*, 386 Mass. 136, 138 (1982) (internal citations and quotation marks omitted). Thus, the Superior Court may (but need not) include specific, suggested questions of law along with its report of the whole case. *See Matter of Est. of Kendall*, 486 Mass. 522, 523 (2020); *Shabshelowitz v. Fall River Gas Co.*, 412 Mass. 259, 262 (1992). A report of the case under Mass. R. Civ. P. 64(a) is appropriate where "the question is one of exceptional novelty,

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Ins. Co. v. Commonwealth, Christopher R. Anderson, et al., No. 2084CV02084 (Suffolk Super. filed Sept. 15, 2020); *Standard Ins. Co. v. Commonwealth, Lisa N. Bowler, et al.*, No. 2084CV02121 (Suffolk Super., filed Sept. 16, 2020); *Am. Nat'l Ins. Co. v. Commonwealth, Jennifer Breslouf, et al.*, No. 2084CV02374 (Suffolk Super., filed Oct. 16, 2020); *Standard Ins. Co. v. Commonwealth, Stephen M. Ursino, et al.*, No. 2084CV02550 (Suffolk Super., filed Nov. 6, 2020); *Linda Carew et al v. Marylou Sudders as Sec'y of the Exec. Office of Health and Human Servs., et al.*, No. 2084CV03020 (Suffolk Super. (BLS), filed Dec. 29, 2020); *Standard Ins. Co. v. Commonwealth, Estate of Kenneth F. Denham, et al.*, No. 2184CV00058 (Suffolk Super., filed Jan. 12, 2021); *Nationwide Life Ins. Co. v. Commonwealth, John A. Klempa, et al.*, No. 2184CV00587 (Suffolk Super., filed Mar. 15, 2021); *Standard Ins. Co. v. Commonwealth, Kathleen Ann Bristow, et al.*, No. 2184CV00962 (Suffolk Super., filed Apr. 27, 2021); *Nationwide Life Ins. Co. v. Commonwealth, Coleen Shannon, et al.*, No. 2084CV00981 (Suffolk Super., filed May 7, 2020); *Standard Ins. Co. v. Joseph P. Gorman, et al.*, No. 2184CV01332 (Suffolk Super., filed June 7, 2021).

would be determinative in other pending cases, has some significance beyond the immediate case, or presents a situation when an expedited resolution at the appellate level is required." *Transamerica Ins. Grp. v. Turner Const. Co.*, 33 Mass. App. Ct. 446, 447 n.2 (1992).

Here, the parties have agreed on all the material facts and to a joint appendix of exhibits, as filed herewith. The underlying question in the cases is whether a community spouse's naming the Commonwealth as the primary beneficiary of an annuity contract entitles MassHealth to collect annuity proceeds to the extent of MassHealth benefits paid to an institutionalized spouse. A declaration regarding the meaning of that language will be sufficient to resolve both of these cases in their entirety. The questions of how to interpret such annuity language, and whether community spouse's annuities must name the Commonwealth in a remainder position in general, have never been decided by the Appeals Court or SJC and have generated a significant (and still growing) amount of litigation in the Superior Court. Superior Court judges have reached different conclusions as to the question, and the question also remains unsettled at the federal level. *See supra* p. 3-4. The parties believe that the expedited appellate resolution of these matters will bring much-needed clarity to this area of the law, will be either determinative or significantly helpful to the determination of the other similar cases that are now pending in the Superior Court, and will be the most efficient course, inasmuch as all parties agree that their competing claims cannot be resolved or settled in the absence of appellate resolution of the issues.

The parties believe that the following questions of law, among others, will be presented by the reported cases:

1. Do the beneficiary-naming provisions of 42 U.S.C. § 1396p(c)(1)(F), 42 U.S.C. § 1396p(e), and/or 130 CMR 520.007(J)(2)(A) apply to annuities for which the "community spouse" is named as the annuitant?

2. Under the Mondor Annuity Contract and Castle Annuity Contract, is the Commonwealth of Massachusetts the primary beneficiary of annuity proceeds remaining after the death of the annuitants to the extent of MassHealth benefits paid for their institutionalized spouses?
3. Is the receipt of benefits from an annuity by the Commonwealth of Massachusetts, where the Commonwealth of Massachusetts has been designated a beneficiary in the annuity contract, a form of estate recovery that is prohibited under Massachusetts law?

WHEREFORE, for the foregoing reasons, the parties jointly request that the Court act, pursuant to Mass. R. Civ. P. 64, to report these consolidated cases without determination to the Appeals Court on the agreed statement of material facts and agreed appendix of exhibits filed herewith.

Respectfully submitted,

COMMONWEALTH OF MASSACHUSETTS,

By its Attorneys,

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By their Attorney,

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Date: June 24, 2021

CERTIFICATE OF SERVICE

I, Jesse M. Boodoo, hereby certify that on June 24, 2021, I served a copy of the above document upon counsel for the parties by e-mailing a copy to:

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/s/ Jesse M. Boodoo
Jesse M. Boodoo
Assistant Attorney General

NOTIFY

Notified by email 1 July '21 Christie Hayes Asst. Clerk

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2084CV02484-F

STANDARD INSURANCE COMPANY,
Plaintiff,

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant,

and

LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR,
Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.

C.A. NO. 2084CV02484-F

SUFFOLK SUPERIOR COURT
CIVIL CLERK'S OFFICE
2021 JUN 29 P 12:09

CONSOLIDATED WITH

STANDARD INSURANCE COMPANY ,
Plaintiff and Counter Defendant,

v.

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS,
Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant,

and

KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER, and JOHN FRANCIS CASTLE,
Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.

C.A. NO. 2184CV00962

JOINT MOTION TO REPORT THE CONSOLIDATED CASES TO THE APPEALS COURT PURSUANT TO RULE 64

In the good and public interest leave is allowed pursuant to Mass. R. Civ. P. 64 the court hereby reports the consolidated cases without determination to the Appeals Court. 6.30.2021 Hillman J

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

SUPERIOR COURT
C.A. NO. 2084CV02484-F

STANDARD INSURANCE COMPANY, Plaintiff, v. EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS, Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant, and LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR, Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.	C.A. NO. 2084CV02484-F

CONSOLIDATED WITH

STANDARD INSURANCE COMPANY , Plaintiff and Counter Defendant, v. EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES OF THE COMMONWEALTH OF MASSACHUSETTS, Defendant, Cross-Claim Plaintiff, and Cross-Claim Defendant, and KATHLEEN ANN BRISTOW, MARIANNE SCHWENZFEIER, and JOHN FRANCIS CASTLE, Defendants, Cross-Claim Defendants and Cross-Claim Plaintiffs.	C.A. NO. 2184CV00962

RULE 64 STATEMENT OF AGREED MATERIAL FACTS

The Mondor Case (C.A. No. 2084CV02484)

1. Linda Marie Mondor, Michelle Mogan and Cathy Ann Mondor ("Mondor Beneficiaries") are the daughters of Elda Mondor ("Elda") and Edward J. Mondor ("Edward").

2. Edward was Elda's spouse.

3. Elda, who was born on April 21, 1933, was admitted to a skilled nursing facility for long-term care on March 20, 2018, at the age of 84.

4. On April 18, 2018, Edward purchased an annuity, Annuity Contract Number 00BB056000 issued by Standard Insurance Company ("Standard") (hereinafter, the "Mondor Annuity Contract").

5. Edward paid a premium of $191,215.28 for the Mondor Annuity Contract, using funds held in a traditional IRA account for Edward.

6. The Mondor Annuity Contract named Edward as the sole annuitant and owner.

7. The monthly payment for the Mondor Annuity Contract is $4,065.00, payable commencing on June 3, 2018 and continuing for a 4-year term.

8. Edward named the following as the primary beneficiary of the Mondor Annuity Contract: "THE COMMONWEALTH OF MASSACHUSETTS."

9. Edward named the following as the contingent beneficiaries of the Mondor Annuity Contract in equal parts: "LINDA MARIE MONDOR, MICHELLE MOGAN, CATHY ANN MONDOR."

10. The Mondor Annuity Contract is nontransferable, nonforfeitable, nonassignable, noncommutable and irrevocable.

11. On or about June 4, 2018, Elda, through her agent and authorized representative, submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility.

12. But for Edward's purchase of the Mondor Annuity Contract, Edward and Elda's joint assets would not have fallen below the "countable asset" limit for purposes of Elda's MassHealth application.

13. Elda's MassHealth application states that if the applicant or their spouse, or someone on the applicant's or spouse's behalf, purchased or in any way changed an annuity, then "[t]o be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.)."

14. The July 2017 MassHealth Senior Guide, the version of the Senior Guide in effect during June 2018, states:

> Repayment from annuities
>
> The Commonwealth must be named as a remainder beneficiary of any annuity bought, annuitized, or otherwise changed by a MassHealth applicant, member, or spouse on or after February 8, 2006, for the total amount of medical assistance paid for the institutionalized individual. This beneficiary designation must not be removed.
>
> See the MassHealth regulations at 130 CMR 520.000 for more information.

15. Elda's MassHealth application disclosed her and Edward's assets, including the Mondor Annuity Contract.

16. Elda, through her agent and representative, provided MassHealth with a copy of a completed Notice of Preferred Remainder Beneficiary ("ANN-3 Form") for the Mondor Annuity Contract.

17. The completed ANN-3 Form identified the Mondor Annuity Contract and was signed by Edward on May 9, 2018.

18. The completed and signed ANN-3 Form for the Mondor Annuity Contract was thereafter provided by MassHealth to Standard.

19. On June 20, 2018, MassHealth wrote to Elda to request more information before making a final decision on her eligibility for MassHealth benefits, including a request for the following: "Annuity THE STANDARD: Current 2018 statement with Commonwealth of Mass as beneficiary."

20. On July 18, 2018, Barbara Strollo, of the Senior Resource Center, Inc., and acting on Elda's behalf, sent MassHealth additional documents requested by MassHealth, including: "The Standard Beneficiary page (Commonwealth of MA.)."

21. On August 29, 2018, MassHealth approved Elda's MassHealth Application, deeming her eligible for MassHealth Standard benefits to cover her care in a skilled nursing facility retroactive to May 1, 2018.

22. Elda presently continues to reside in a skilled nursing facility and continues to receive MassHealth benefits for her long-term care.

23. Edward passed away on April 11, 2020, at the age of 92.

24. At the time of Edward's death, $97,720.28 in annuity proceeds remained to be paid on the Mondor Annuity Contract.

25. In a letter dated July 29, 2020, the Commonwealth made a claim on the proceeds of the Mondor Annuity Contract up to the total amount of medical assistance paid on behalf of the Medicaid recipient, Elda, and identified $146,903.57 in such assistance as of July 29, 2020.

26. In a letter dated August 3, 2020, the Mondor Beneficiaries, in their capacity as the contingent beneficiaries of the Mondor Annuity Contract, made a claim to all remaining proceeds of the annuity.

27. MassHealth has paid $191,865.61 in medical assistance on behalf of Elda through March 31, 2021.

28. Standard remains in possession of the balance of all the annuity proceeds accumulated since Edward's death and that will be payable by the expiration of the Annuity term.

29. As of May 6, 2021, a total of $97,560 in proceeds remains to be paid from the Mondor Annuity Contract. Of this, $48,780 has accumulated since Edward's death and is currently payable, and $48,780 in annuity proceeds will be due between June 2021 and May 2022, when the Annuity's 4-year term expires.

30. Edward never applied for or received Medicaid or MassHealth benefits during his lifetime.

The Castle Case (C.A. No. 2184CV00962)

31. Kathleen Ann Bristow, Marianne Schwenzfeier, and John Francis Castle ("Castle Beneficiaries") are the children of Carol A. Castle ("Carol") and James W. Castle ("James").

32. James was Carol's spouse.

33. Carol, who was born on September 17, 1939, was admitted to a skilled nursing facility for long-term care on August 3, 2018, at the age of 78.

34. On November 2, 2018, James purchased an annuity, Annuity Contract Number 00BB063280 issued by Standard (hereinafter, the "Castle Annuity Contract").

35. James paid a premium of $176,859.75 for the Castle Annuity Contract, using funds held in a traditional IRA account for James.

36. The Castle Annuity Contract named James as the sole annuitant and owner.

37. The monthly payment for the Castle Annuity Contract is $3,031.93, payable commencing on November 19, 2018 and continuing for a 5-year term.

38. James named the following as the primary beneficiary of the Castle Annuity Contract: "COMMONWEALTH OF MASSACHUSETTS."

39. James named the following as the contingent beneficiaries of the Castle Annuity Contract in equal parts: "KATHLEEN ANN BRISTOW," "MARIANNE SCHWENZFEIER," and "JOHN FRANCIS CASTLE."

40. The Castle Annuity Contract is nontransferable, nonforfeitable, nonassignable, noncommutable and irrevocable.

41. On or about December 6, 2018, Carol, through her agent and authorized representative, submitted an application for MassHealth benefits for her long-term care in a skilled nursing facility.

42. But for James' purchase of the Castle Annuity Contract, James and Carol's joint assets would not have fallen below the "countable asset" limits for purposes of Carol's MassHealth application.

43. Carol's MassHealth application states that if the applicant or their spouse, or someone on the applicant's or spouse's behalf, purchased or in any way changed an annuity, then "[t]o be eligible, you may be required to name the Commonwealth as a remainder beneficiary. (See the Senior Guide for more information.)."

44. The July 2017 MassHealth Senior Guide, the version of the Senior Guide in effect during December 2018, states:

> Repayment from annuities

> The Commonwealth must be named as a remainder beneficiary of any annuity bought, annuitized, or otherwise changed by a MassHealth applicant, member, or spouse on or after February 8, 2006, for the total amount of medical assistance paid for the institutionalized individual. This beneficiary designation must not be removed.
>
> See the MassHealth regulations at 130 CMR 520.000 for more information.

45. Carol's MassHealth application disclosed her and James's assets, including the Castle Annuity Contract.

46. Carol, through her agent and representative, provided MassHealth with a copy of a completed Notice of Preferred Remainder Beneficiary ("ANN-3 Form") for the Castle Annuity Contract.

47. The completed ANN-3 Form identified the Castle Annuity Contract and was signed by James on November 2, 2018.

48. The completed and signed ANN-3 Form for the Castle Annuity Contract was thereafter provided by MassHealth to Standard.

49. On March 22, 2019, MassHealth approved Carol's MassHealth Application, deeming her eligible for MassHealth Standard benefits to cover her care in a skilled nursing facility retroactive to November 12, 2018.

50. Carol passed away on April 23, 2020.

51. MassHealth paid $123,413.51 in medical assistance on behalf of Carol between November 12, 2018 and Carol's death on April 23, 2020.

52. James passed away on October 1, 2020, at the age of 88.

53. At the time of James's death, approximately $110,000 in annuity proceeds remained to be paid on the Castle Annuity Contract.

54. In a letter dated February 22, 2021, the Commonwealth made a claim on the proceeds of the Castle Annuity Contract up to the total amount of medical assistance paid on behalf of the Medicaid recipient, Carol, and identified $123,413.51 in such assistance that had been paid.

55. Standard thereafter made five monthly benefit payments under the Castle Annuity Contract of $3,031.93 each to the Commonwealth, for a total of $15,159.65, reflecting the amounts payable between October 19, 2020 and February 19, 2021.

56. In or around February 2021, the Castle Beneficiaries, in their capacity as the contingent beneficiaries of the Castle Annuity Contract, made a claim to all remaining proceeds of the Castle Annuity Contract and to the $15,159.65 that had been paid to the Commonwealth between October 19, 2020 and February 19, 2021. In response to the competing claims, Standard ceased paying monthly benefit payments effective March 19, 2021.

57. Standard remains in possession of the balance of all the annuity proceeds accumulated since its last payment to the Commonwealth on February 19, 2021 and that will be payable by the expiration of the Annuity term.

58. James never applied for or received Medicaid or MassHealth benefits during his lifetime.

Respectfully submitted,

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Date: June 24, 2021

CERTIFICATE OF SERVICE

I, Jesse M. Boodoo, hereby certify that on June 24, 2021, I served a copy of the above document upon counsel for the parties by e-mailing a copy to:

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36 Mass.L.Rptr. 183
Superior Court of Massachusetts,
Middlesex County..

Laurie A. DERMODY
v.
The EXECUTIVE OFFICE OF
HEALTH & HUMAN SERVICES et al. [1]

[1] Nationwide Financial Insurance Company.

1781CV02342
|
January 16, 2020

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

C. William Barrett, Justice of the Superior Court

***1** 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 complaint 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*.

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

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).

***2** 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).

***3** 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 189-90. 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. 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).

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).

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.

***4** 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-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]

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).

Section 1396p(c)(2)(B) (hereinafter, "the sole benefit rule" or "paragraph [2]") contains an exception to that 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—
>
> ***5** (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), 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.

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).

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.

***6** 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 484-86.

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 484-85, 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 485-86. 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). Therefore, 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.

***7** 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, 253-54 (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).

***8** 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]

[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 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.

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

ii. Failure to Investigate

***9** 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.

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, 956-57 (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 *Gully 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 s. 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.

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).

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

***10** 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.

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*.

All Citations

Not Reported in N.E. Rptr., 36 Mass.L.Rptr. 183, 2020 WL 742194

End of Document

2021 WL 2343024
Only the Westlaw citation is currently available.
Superior Court of Massachusetts,
Department of the Trial Court, Suffolk County.

AMERICAN NATIONAL INSURANCE COMPANY
v.
Jennifer BRESLOUF and
Commonwealth of Massachusetts

C.A. No. 2084CV02374
|
June 3, 2021

MEMORANDUM OF DECISION AND ORDER ON DEFENDANTS'/CROSS-CLAIMANTS' CROSS MOTIONS FOR SUMMARY JUDGMENT AND PLAINTIFF/COUNTERCLAIM DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Debra A. Squires-Lee, Justice of the Superior Court

***1** Julius Breslouf bought an annuity contract issued by American National Insurance Company (American National) to make his wife, Suzanne Breslouf, eligible for MassHealth benefits to pay for her nursing home care. Julius [1] named the Commonwealth of Massachusetts as the primary beneficiary of the annuity in the event of his death and his and Suzanne's daughter, Jennifer Breslouf, as the contingent beneficiary. Julius died on April 24, 2020, before the end of the annuity period, and the Commonwealth and Jennifer made competing claims for the remaining proceeds. American National filed this interpleader action seeking a declaratory judgment as to who has the right to the proceeds of the annuity. Jennifer filed a crossclaim against the Commonwealth seeking a declaratory judgment that the Commonwealth is not entitled to any proceeds of the annuity and asserting a claim for violation of 42 U.S.C. § 1983. Jennifer also filed a counterclaim against American National alleging breach of contract and violation of G. L. c. 93A.

1 Because all the individuals involved in this case share a last name, I will refer to them as Julius, Suzanne, and Jennifer.

The Commonwealth filed a Motion for Summary Judgment on the interpleader declaratory judgment claim and Jennifer's counterclaims (Commonwealth Motion). Jennifer cross-moved for summary judgment on all claims between her and the Commonwealth (Cross Motion). American National moved for summary judgment on Jennifer's counterclaims (American National Motion). After hearing and review and for the reasons stated below, the Commonwealth's Motion is **ALLOWED**; Jennifer's Cross Motion is **DENIED**; and American National's Motion is **ALLOWED**.

BACKGROUND

The following factual summary comes from the undisputed, admissible evidence in the summary judgment record with certain details reserved for later discussion. See Bulwer v. Mount Auburn Hosp., 473 Mass. 672, 674, 680 (2016).

Jennifer is Julius and Suzanne's daughter. In July 2017, Suzanne, then 78 years old, was admitted to a skilled nursing facility for long-term care. Upon Suzanne's admission, Suzanne and Julius had approximately six hundred, ninety-nine thousand dollars in countable assets for Medicaid and MassHealth eligibility purposes.

In October 2017, Julius purchased an immediate, irrevocable annuity in the amount of $565,000 (Annuity) to spend down marital assets before Suzanne applied for MassHealth benefits. Julius was the sole annuitant with a monthly payment of $9,531.49 to run from November 18, 2017 to October 18, 2022, or for five years, which was Julius' actuarial lifespan at the time he purchased the Annuity. As the primary beneficiary of the Annuity, Julius named the "Commonwealth of Massachusetts as reminder [sic] beneficiary in first position for the total amount of medical assistance paid on behalf of the institutionalized individual pursuant to 130 CMR 520.007(J)(2)." Julius named Jennifer as the contingent beneficiary.

In early November 2017, Suzanne submitted a MassHealth Application for long-term benefits. The MassHealth Application required that applicants such as Suzanne identify any annuity purchased by the applicant or their spouse and name the Commonwealth as a remainder beneficiary of any such annuity "for the total amount of medical assistance paid for the institutionalized individual." Suzanne was represented by counsel in connection with her application and Jennifer signed the application as Suzanne's attorney-in-fact. Suzanne disclosed Julius's purchase of the Annuity as part of her MassHealth Application and, as requested by

MassHealth, provided MassHealth a copy of the Annuity contract. Suzanne's counsel stated in a cover letter submitted with the MassHealth application that the purchase of the Annuity was meant to spend down Julius and Suzanne's assets.

***2** In November 2017, MassHealth requested that Suzanne complete and sign the Notice of Preferred Remainder Beneficiary ("ANN-3 Form"). Suzanne's application was denied on January 13, 2018 due to lack of verifications. Thereafter, Suzanne completed the ANN-3 Form identifying the Annuity, and certifying that failure to name the Commonwealth as a beneficiary would result in termination of her MassHealth benefits and, potentially, allow recovery by MassHealth of benefits paid while she was not eligible. MassHealth approved Suzanne's application on March 16, 2018.

In March 2020, Jennifer filed a renewal application on Suzanne's behalf for MassHealth benefits. The renewal application identified the Annuity and described it as a "Medicaid-qualifying annuity purchase." Suzanne remains in a skilled nursing facility and continues to receive MassHealth benefits.

Julius died on April 24, 2020. From October 2015 until January 2019, Julius paid approximately $5,745 per month to live at an assisted living facility. From January 2019 until his death, Julius lived in a skilled nursing facility and paid approximately $18,614 per month for his care. Julius never received any Medicaid / MassHealth benefits during his lifetime. As of the time of the briefing on the instant motions, the value of the Annuity was $270,000.

After Julius's death, Jennifer made a claim to the proceeds remaining on the Annuity. MassHealth also made a claim on the proceeds alleging that MassHealth had paid $98,745.15 in assistance for Suzanne's care through June 11, 2020.[2] After receipt of the competing claims for the proceeds of the Annuity, American National commenced this action to resolve the controversy as to whether the Commonwealth and / or Jennifer is entitled to be paid and the amount.

[2] Jennifer does not dispute that MassHealth made a claim for the proceeds of the Annuity, or that MassHealth paid for skilled nursing care for Suzanne, she disputes the amount paid. Further, MassHealth asserts the right to recover the total amount paid for Suzanne's care which continues to grow since Julius's death and since MassHealth submitted a claim to American National.

DISCUSSION

"Summary judgment is appropriate where there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law." Correia v. Fagan, 452 Mass. 120, 129 (2008). Where, as here, summary judgment turns on the interpretation of a statute, I must "give due deference to the underlying legislative intent as expressed by the plain language of the statute." Hopkins v. Medeiros, 48 Mass. App. Ct. 600, 610 (2000), citing Boswell v. Zephyr Lines, Inc., 414 Mass. 241, 247 (1993). In interpreting a statute, the court looks primarily to its language to ascertain the intent of the Legislature. Allison v. Eriksson, 479 Mass. 626, 633 (2018). The court gives the words used their ordinary and approved meaning, considering the cause of the enactment and the main object to be accomplished. Polanco v. Sandor, 480 Mass. 1010, 1011 (2018); Camargo's Case, 479 Mass. 492, 497-498 (2018).

Here, as between the Commonwealth and Jennifer, the issue is whether an annuity purchased for the benefit of a spouse not in need of Medicaid benefits, called a "community spouse," such as the one Julius bought to make Suzanne eligible for MassHealth benefits, must satisfy *both* 42 U.S.C. §§ 1396p(c)(1)(F) and 1396p(c)(2)(B)(1), or *only* § 1396p(c)(2)(B)(1). If both provisions must be satisfied, then the Commonwealth would be entitled to the proceeds of the Annuity. If only section 1396p(c)(2)(B)(1) need be satisfied, then, depending on the Commonwealth's contractual argument that it is entitled to the remainder of the proceeds as a matter of contract law, see infra, Jennifer may be entitled to the proceeds of the Annuity.

***3** As between Jennifer and American National, the question is whether, based on the material undisputed facts, Jennifer can establish that American National breached the Annuity or violated Chapter 93A when, instead of paying Jennifer on the Annuity, American National filed this action.

I. Jennifer's and the Commonwealth's Cross-Motions for Summary Judgment

A. The Medicaid / MassHealth System and Medicaid Planning

Medicaid is a joint federal-state program that provides medical assistance to eligible low-income people. See 42 U.S.C. § 1396-1; Moe v. Secretary of Admin. & Finance, 382 Mass. 629, 633 (1981). "Primary oversight of Medicaid is handled at the Federal level, but each State ... administers its own Medicaid program." Law v. Griffith, 457 Mass. 349, 350 n.3 (2010). "Massachusetts has opted to participate in Medicaid via the establishment of a State Medicaid program known as MassHealth." Daley v. Secretary of Exec. Office of Health & Human Servs., 477 Mass. 188, 190 (2017). "Medicaid has become one of the largest programs in the Federal budget as well as a major expenditure for State governments, which must finance a significant portion of Medicaid benefits on their own." Id. "The demand for Medicaid long-term care benefits, which cover nursing home care as well as other forms of personal long-term care services, has grown steadily as a result of our country's aging population and the expense of paying privately for nursing homes or other long-term care." Id. at 191. Medicaid pays for the care of two-thirds of people in nursing homes in the United States. Id.

Because states are required to provide Medicaid benefits only to "individuals who are unable to cover the costs of their basic needs and who already receive or are eligible for certain forms of public assistance[,]" Daley, 477 Mass. at 190, citing Roach v. Morse, 440 F.3d 53, 59 (2d Cir. 2006), and there are limits on the assets that individuals and married couples may own and still qualify for Medicaid, many individuals and couples engage in Medicaid planning. [3] "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." Daley, 477 Mass. at 192. However, when "affluent individuals use Medicaid qualifying trusts and similar 'techniques' to qualify for the program, they are diverting scarce Federal and State resources from low-income elderly and disabled individuals, and poor women and children." Id., quoting H.R. Rep. No. 265, 99th Cong., 1st Sess., pt. 1, at 72 (1985).

3 In Massachusetts:

> In order to qualify for Medicaid in Massachusetts, MassHealth requires that "[t]he total value of countable assets owned by or available to" an individual applicant not exceed $2,000. 130 Code Mass. Regs. § 520.003(A)(1)(2014). For a couple living together, the limit is $3,000. 130 Code Mass. Regs. § 520.003(A)(2)(2014). 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 191–192.

Congress has attempted to constrain Medicaid planning in some respects. Relevant here, Congress enacted the "look-back" rule which imposes a penalty if an individual or individual's spouse transfers an asset for less than fair market value within five years of the individual's application for Medicaid benefits. 42 U.S.C. § 1396p(c)(1)(A). Section 1396p(c)(1)(A) provides that the disposal of an asset for less than fair market value after the five-year look back date by an institutionalized individual *or the spouse of an institutionalized individual* renders the individual ineligible for Medicaid for a period of time. More particularly, "[i]f *either* spouse tries to give away assets" for less than fair value during the look-back period, "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 v. Arizona Health Care Cost Containment Sys. Admin., 667 F.3d 1066, 1069 (9th Cir. 2012) (emphasis added); see also Daley, 477 Mass. at 193, citing 42 U.S.C. § 1396p(c)(1)(E) ("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."); Hegadorn v. Department of Human Servs. Dir., 931 N.W.2d 571, 593 (Mich. 2019) (McCormack, J. concurring) ("[I]f either spouse disposes of assets for less than fair market value after the look-back date, the institutionalized spouse is disqualified from receiving financial assistance for a period that approximates the uncompensated value of the transferred assets."). "The effect is to treat couples who dispose of assets as if those assets were available to the couple to pay for medical care." Hutcherson, 667 F.3d at 1069.

***4** Congress also has attempted to constrain the ability of wealthy married couples to shift assets to or from each other to obtain Medicaid benefits. Prior to 1988, "[u]nique problems arose regarding Medicaid eligibility for spouses given that they generally share income and assets." Hutcherson, 667 F.3d at 1068. "For example, states 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." Id. "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 simply holding their assets solely in the name of the community spouse." Id. See also Morris v. Oklahoma Dep't of Hum. Servs., 685 F.3d 925, 928–929 (10th Cir. 2012) (discussing the "unintended consequences" of the system of transferring assets to a community spouse to obtain Medicaid eligibility) (citations omitted). "Congress responded to this problem by passing the Medicare Catastrophic Coverage Act of 1988 ("MCCA"), which had the dual aim of ending the 'pauperization' of community spouses and preventing wealthy couples from qualifying for Medicaid assistance by sheltering their assets." Hutcherson, 667 F.3d at 1068; see also Morris, 685 F.3d at 929, quoting H. R. Rep. No. 100–105, pt. 2, at 65 (1987) ("By passing the MCCA, Congress intended to 'protect community spouses from "pauperization" while preventing financially secure couples from obtaining Medicaid assistance.' ").

To prevent wealthy couples from sheltering assets, "after subtracting the [community spouse resource allowance], Medicaid administrators must count all remaining 'resources held by either the institutionalized spouse, community spouse, or both' as 'available to the institutionalized spouse.' " Morris, 685 F.3d at 929, quoting 42 U.S.C. § 1396r–5(c)(2)(A); see also 130 Code Mass. Regs. § 520.003(A)(2). In Massachusetts, after subtracting the community spouse resource allowance of $128,640, the maximum value of countable assets a couple may own to qualify for Medicaid benefits is $3,000. 130 Code Mass. Regs. §§ 520.003(A)(2), 520.016(B)(2). If the community spouse's resources exceed the allowance, the "institutionalized spouse is ineligible for Medicaid benefits until the excess resources are depleted." Lopes v. Department of Soc. Servs., 696 F.3d 180, 182 (2d Cir. 2012), citing 42 U.S.C. §§ 1396r–5(c)(2)(B), 1396r–5(f)(2)(A). On the other hand, to protect community spouses and avoid their pauperization, a community spouse's income, subject to limited exceptions that are inapplicable here, is not "deemed available to the institutionalized spouse." 42 U.S.C. § 1396r-5(b)(1) ("During any month in which an institutionalized spouse is in the institution ... no income of the community spouse shall be deemed available to the institutionalized spouse."). [4]

[4] Certain specified assets, such as the couple's home and one automobile, do not count against the eligibility of the institutionalized spouse. 42 U.S.C. § 1382b(a).

B. Sections 42 U.S.C. §§ 1396p(c)(1)(F) and 1396p(c)(2)(B)(i)

An annuity is a contract consisting of a "a sum of money payable yearly or at other regular intervals." Annuity Definition, https://www.merriamwebster.com/dictionary/annuity (last visited May 28, 2021). Put elsewise, the purchase of an annuity is a way to turn an asset – a sum of money – into income. In 2005, Congress passed the Deficit Reduction Act ("DRA"), which addressed the use of annuities in connection with Medicaid planning and excepted certain types of annuities from the look-back rule. See Hutcherson, 667 F.3d at 1069. As the Ninth Circuit described:

> The DRA added several requirements that must be met before an annuity is exempt from the [look-back] transfer penalty. For instance, 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). In addition, and of particular relevance to this case, the DRA originally provided that the purchase of an annuity is allowable only where "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*." 42 U.S.C. § 1396p(c)(1)(F)(i) (2005) (emphasis added).
>
> ***5** In 2006, Congress amended the language of § 1396p(c)(1)(F)(i). Under the amended language, spouses may purchase an annuity to spend down their assets only if "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) (2006) (emphasis added); see also Tax Relief and Health Care Act of 2006, Pub. L. No. 109–432, 120 Stat. 2922, 2998 (2006).

Id. at 1069-1070.

Thus, in the 2005 and 2006 revisions to the DRA, Congress inserted two subsections into the section of the Medicaid law dealing with the look-back penalty, 42 U.S.C. §§ 1396p(c)(1)(F) and (G), that exempt from the look-back penalty any annuity purchased by the institutionalized individual or their spouse that satisfies the requirements set forth therein. Although those subsections do not specifically address annuities in which the annuitant is the community spouse, the language of § 1396p(c)(1)(F), particularly in view of the 2006 revision to that subsection, applies where the

community spouse is the annuitant. By changing "annuitant" to "institutionalized individual," Congress accounted for the fact that the institutionalized individual may not be the annuitant. Congress also passed 42 U.S.C. § 1396p(e), which provides that states must require applicants for Medicaid assistance to (i) disclose "any interest the individual *or community spouse* has in an annuity ... regardless of whether the annuity is irrevocable or treated as an asset" and (ii) acknowledge that 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)(1) (emphasis added). Section 1396p(e) also requires that when an applicant makes a 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." Id. § 1396p(e)(2)(A); see also 130 Code Mass. Regs. § 520.007(J)(2).

The dispute in this case arises because of 42 U.S.C. § 1396p(c)(2), which enumerates exceptions to the look-back provision of section 1396p(c)(1). Among other things, it 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). Jennifer argues that because the Annuity was a transfer of assets to another—American National—for the sole benefit of Julius, then the annuity provisions of the look-back rule simply do not apply, even though Julius named the Commonwealth as the primary remainder beneficiary. In other words, according to Jennifer, as an annuity that falls under one of the exceptions listed in subsection (c)(2), an annuity for the sole benefit of a community spouse is not subject to the beneficiary naming requirements of subsection (c)(1)(F).

C. Caselaw and HHS Guidance

Only two Federal Circuit Courts of Appeal have addressed precisely this issue—whether an annuity purchased for a community spouse must comply with 42 U.S.C. § 1396p(c)(1)(F) by naming the state as a beneficiary entitled to recover the amounts paid for the institutionalized spouse.

***6** In Hutcherson, the Ninth Circuit held that the "2006 amendment to 42 U.S.C. § 1396p(c)(1)(F)(i) creates a right in the State to recover as a remainder beneficiary against a community spouse's annuity for an institutionalized spouse's medical costs." Hutcherson, 667 F.3d at 1067. Hutcherson is factually on all fours with this case. There, the daughter of a couple that had purchased an annuity for the benefit of the community spouse and who was named as the second remainder beneficiary after the Arizona Medicaid agency (the Arizona Health Care Cost Containment System Administration [AHCCCS]), filed suit after her father, the annuitant and community spouse, passed away. Hutcherson, 667 F.3d at 1067. The daughter sought to recover the remaining proceeds of the annuity and argued that AHCCCS had no right to recover from the community spouse's annuity at all or, alternatively, had no right to recover for any costs incurred for the care of the institutionalized spouse received after the community spouse's death. Id. at 1068.

In reaching its conclusion that section 1396p(c)(1)(F) applied to the annuity, the Hutcherson Court carefully considered the interrelationship between assets and income, and the need to protect a community spouse from pauperization. The Court wrote:

> [T]he provisions regarding transferring assets were tailored to balance Congress's desire to avoid impoverishment of the community spouse, on the one hand, and closing loop-holes that allowed wealthy couples to game the system, on the other hand. The annuity payments to AHCCCS as a beneficiary functioned precisely the way the statute was intended to work. The Hutchersons were able to qualify [the institutionalized spouse] for Medicaid assistance, while ensuring that [the community spouse] did not become impoverished. As part of that balance, AHCCCS was named as the primary remainder beneficiary of John's annuity so that it could recoup its costs for the medical care that [the institutionalized spouse] received in the event that [the community spouse] died before the annuity had run its course.
>
> Accepting Appellant's position that the state should not recover and, instead, she should inherit what remained in John's annuity would frustrate the purpose of the Medicaid statute. As we have noted above, Congress prevents the community spouse from disposing of assets that would otherwise be available to pay for the institutionalized spouse's medical care. For instance, if [the community spouse], instead of purchasing the annuity, attempted to transfer funds to Appellant, [the institutionalized spouse] would have been ineligible for Medicaid for the approximate length of time that the funds could have covered [the institutionalized spouse's] medical costs. By

> purchasing an annuity, [the community spouse] avoided this transfer penalty. Consistent with the Medicaid Act's objective of protecting the community spouse from destitution, [the community spouse] was entitled to collect monthly payments from the annuity for as long as he lived. When [the community spouse] died before the annuity ran its course, however, funds remained in the annuity that could have otherwise been used to pay for [the institutionalized spouse's] medical care.

Hutcherson, 667 F.3d at 1071–1072. The Hutcherson Court did not address the interplay between § 1396p(c)(1)(F) and § 1396p(c)(2)(B). But neither have other Courts that have considered the requirement that a community spouse's annuity must name the state as the contingent beneficiary pursuant to § 1396p(c)(1)(F). See, e.g., Carlini v. Velez, 947 F. Supp. 2d 482, 486 (D.N.J. 2013) (allowing preliminary injunction to Medicaid applicant and holding that spouse's annuity did not constitute an improper transfer of assets where annuity named state as remainder beneficiary "in accordance with § 1396p(c)(1)(F)").

The Sixth Circuit reached a different conclusion, albeit in a different factual scenario. In Hughes v. McCarthy, the Ohio Medicaid agency penalized an institutionalized individual under the look-back provision based on the purchase of an annuity by a community spouse. 734 F.3d 473, 474-475 (6th Cir. 2013). "Because the transfer occurred before the Ohio agency determined that Mrs. Hughes was eligible for Medicaid coverage and § 1396p(c)(2)(B)(i) permits an unlimited transfer of assets 'to another for the sole benefit of the individual's spouse,' " the Sixth Circuit reversed. Id. at 475. In Hughes, the community spouse had not died, and the first remainder beneficiary of the annuity was the institutionalized spouse and the second was the Ohio Medicaid agency. Id. at 477. Thus, the annuity in Hughes did not provide for the transfer of some or all the spousal assets to an heir or third party. Compare Hutcherson, 667 F.3d at 1067 (annuity purchased for benefit of community spouse named his daughter as remainder beneficiary).

***7** The Sixth Circuit went on, however, to address the Ohio Medicaid agency's alternative arguments, including that the annuity must nonetheless comply with § 1396p(c)(1)(F). The Court reasoned as follows:

> Although "it is axiomatic that a general provision yields to a specific provision when there is a conflict," Reg'l Airport Auth. of Louisville v. LFG, LLC, 460 F.3d 697, 716 (6th Cir. 2006), there 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. The two provisions complement rather than contradict one another. Section 1396p(c)(1)(F) is not rendered illusory. It applies to all annuities not excepted by another provision such as § 1396p(c)(2)(B), including annuities benefiting non-exempt children or a spousal annuity that is not actuarially sound.

Hughes v. McCarthy, 734 F.3d at 485. Thus, the Court held that, "an annuity that satisfies § 1396p(c)(2)(B)(i) need not satisfy § 1396p(c)(1)(F)." Hughes, 734 F.3d 484. Because the Court found the statutory language clear, it held that the evidence of Congressional intent—that the "DRA was enacted to close loopholes related to the purchase of annuities"—was "unavailing." Hughes, 734 F.3d at 486.

While there is no controlling precedent in the Commonwealth, a Superior Court, faced with a similar scenario, agreed with the reasoning of the Sixth Circuit, which it found "highly persuasive." Dermody v. Executive Office of Health & Human Servs., No. MICV2017-02342, 2020 WL 742194, at *5-*6 (Mass. Super. Jan. 16, 2020) ("[A]ny 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)"). [5]

5 The Commonwealth cites to cases which, it argues, are to the same effect as Hutcherson. See Comm. Br. at 20. Having reviewed those cases, I disagree as to their relevance to the issue before me. While some obliquely address in dicta the issue of whether an asset transfer to an annuity that satisfies 42 U.S.C. § 1396p(c)(2)(B)(1) must also satisfy § 1396p(c)(1)(F)—see Lancashire Hall Nursing & Rehab. Ctr. v. Department of Pub. Welfare, 995 A.2d 540, 543 (Pa. Commw. Ct. 2010) (affirming application of look back penalty to community spouse's purchase of annuity that "did not designate the Commonwealth of PA as the

> remainder beneficiary"); Hegadorn v. Department of Human Servs. Dir., 931 N.W.2d 571, 595 (Mich. 2019) (McCormack, J. concurring), citing 42 U.S.C. 1396p(c)(2)(B)(i) and (ii) ("The purchase of a community-spouse annuity that satisfies the requirements of 42 U.S.C. 1396p(c)(1)(F) and (G)—a 'qualified' community-spouse annuity—will not trigger a divestment penalty, because the transfer is for 'the sole benefit of' the community spouse.")—most were not analogous at all.

***8** Also relevant here is the position of the Secretary of the Department of Health and Human Services (HHS), the federal agency that oversees Medicaid, on this statutory interpretation question.[6] HHS submitted an amicus brief to the Sixth Circuit in connection with the Hughes case providing its interpretation that an annuity for a community spouse must name the state as a contingent beneficiary to avoid the look back rule. According to HHS, "[t]he transfer of a community resource to purchase an actuarially sound annuity for a community spouse that provides payments commensurate with the community spouse's life expectancy, *and* that designates the institutionalized spouse as the primary remainder beneficiary and the state as the contingent beneficiary, is a transfer 'for the sole benefit of the individual's spouse' under 42 U.S.C. 1396p(c)(2)(B)(i)." Brief for the U.S. Dep't of Health and Human Servs. at 14, Hughes v. McCarthy, 734 F.3d 473 (6th Cir. 2013) (No. 12-3765), 2013 WL 3366469 (emphasis added). Further, HHS argued that:

> Section 1396p(c)(1)(F), added in the 2005 DRA, imposes an additional requirement (on top of the requirements that apply to transfers of assets in general) for annuities purchased for the sole benefit of a spouse, to ensure that those annuities do not confer a remainder benefit to *any party* other than a community spouse, a minor or disabled child, or the state (as specifically provided in the statute). Under this provision, if the state is named as a remainder beneficiary in the first position or in the second position after a community spouse or a minor or disabled child, the purchase of that annuity is not considered a transfer of assets for less than fair market value. This provision ensures that if either an institutionalized or community spouse annuitant does not survive the annuity's terms, the state, rather than a third-party beneficiary or heir, other than those specified in the preceding sentence, will be paid the remaining annuity payments up to the total amount of Medicaid assistance paid on behalf of the institutionalized spouse.

Id. at 19-20 (emphasis added). HHS also noted that, because in the Hughes case the annuity named the institutionalized spouse as the first beneficiary and the state Medicaid agency as the second, which did not strictly comply with the provisions of § 1396(c)(1)(F), the state would "benefit regardless" because "the remaining value of the annuity transfers from the deceased community spouse to the surviving institutionalized spouse and will affect the institutionalized spouse's Medicaid eligibility." Id. at 20.

6 Persuasive HHS guidance on the federal Medicaid statutes is entitled to respect under Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). See also Daley, 477 Mass. at 200.

The Commonwealth, through the Office of Medicaid (MassHealth) of the Executive Office of Health and Human Services, also has consistently interpreted § 1396p(c)(1)(F) to mean that annuities purchased with the community spouse as the annuitant must name the state as a remainder beneficiary to the extent of payments made on behalf of the institutionalized spouse. Those conclusions of the federal and state agencies charged with interpreting and applying the Medicaid law are entitled to deference. See Shelales v. Director of Off. of Medicaid, 75 Mass. App. Ct. 636, 640, (2009) (agency's interpretation of statute and regulations afforded " 'considerable leeway' ... unless the statute unambiguously bars the agency's approach.") (citations omitted).

D. Analysis

Julius bought the Annuity to spend down his and Suzanne's assets and make Suzanne eligible for Medicaid. Consistent with 42 U.S.C. § 1396p(c)(1)(F)(i) and the

applicable Massachusetts regulations, Julius named the Commonwealth as a remainder beneficiary for the total amount of medical assistance paid on behalf of Suzanne, the institutionalized individual. After careful review, I agree with the Commonwealth that the 2006 amendment to the DRA was intended to allow states to reach community spouse annuities and, therefore, community spouse annuities must comply with 42 U.S.C. § 1396p(c)(1)(F)(i).

***9** Although the Hutcherson Court did not discuss 42 U.S.C. § 1396p(c)(2)(B)(i), which I will address further below, I agree with the Hutcherson Court's reasoning.[7] Allowing Jennifer to inherit what remains in the Annuity would frustrate the Medicaid statute. Julius would not have been permitted to transfer $270,000 in cash to Jennifer while Suzanne was institutionalized without triggering the look-back penalty and should not be able to do so now, via the Annuity, simply because he died before the expiration of the Annuity term. That there is no limitation on the amount of assets that can be placed in a community spouse's annuity further undercut's Jennifer's argument. In other words, taking Jennifer's argument to the logical extreme, there would be no reason that a community spouse could not put millions of dollars into an annuity and name the couple's children as beneficiaries as long as it was irrevocable and actuarially sound, i.e., the annuity payments would equal or exceed the purchase price. Then, if the community spouse died before the end of the annuity, the married couple would have been able to shield assets for the benefit of their heirs and to the detriment of the state, which had been and was still paying for the institutionalized spouse's care. Such a result would utterly frustrate the widely understood purpose of the MCCA, which was to prevent wealthy couples from qualifying for Medicaid assistance by sheltering their assets. Here, allowing Jennifer to take the $270,000 remaining in the Annuity—which was a spousal asset at the time Suzanne applied for MassHealth benefits—without recompense to MassHealth for the benefits provided to Suzanne frustrates the MCCA.

[7] I disagree with Jennifer's argument that, because Hutcherson did not address the sole benefit exception of section 1396p(c)(2)(B)(i), it is not on point and not persuasive. As noted, the facts in Hutcherson are squarely on point and the sole benefit provision pre-existed the enactment of the annuity rules in section 1396p(c)(1)(F). Further, I find Hughes, on which Jennifer relies, to be distinguishable. There, the community spouse had not died, the issue before the Court was the application of the look-back provision to the purchase of the annuity, the remainder beneficiaries on the annuity were the institutionalized spouse and the state, and thus the state would, in any scenario, recover for the institutionalized spouse's care, and the Court did not need to but chose to address the issue of the applicability of section 1396p(c)(1)(F) to "promote finality in this litigation, as the issues require no further factual development and have been sufficiently presented for our review." Hughes, 734 F.3d at 481; see also 478-479.

The "sole benefit" provision of 42 U.S.C. § 1396p(c)(2)(B)(i) does not alter my conclusion. That the transfer of assets from one spouse to the other or to a third party for the "sole benefit" of the other spouse would not trigger the look-back penalty provision contained in section 1396p(c)(1) makes perfect sense where Congress provided that *all* of the resources of both spouses, however titled or held, would be considered to determine Medicaid eligibility of the institutionalized spouse. See 42 U.S.C. § 1396r–5(c)(2)(A); see also Hegadorn, 931 N.W.2d at 594 (McCormack, J. concurring) ("[I]n plainer terms: there is no reason to penalize an interspousal transfer of assets because resources belonging to both spouses are combined in determining an applicant's *eligibility*. Because spousal resources are accounted for in the Medicaid eligibility process no matter which spouse holds them, there is no need to penalize a transfer from one spouse to the other."). Section 1396p(c)(2)(B)(i) simply makes clear that a transfer of assets to or from a spouse will not trigger the look-back period. It says nothing about the purchase of an annuity for a spouse naming an heir or other third party as the remainder beneficiary.

Although, section 1396p(c)(2)(B)(i) provides an exception to the look-back contained in subsection (c)(1), I do not believe Congress intended to immunize community spouse annuities entirely from the requirements of section 1396p(c)(1)(F). Permitting a community spouse to purchase an annuity —thus spending down assets to create Medicaid eligibility for the institutionalized spouse—but name a third party as the beneficiary of the annuity in the event the community spouse's death would allow the community spouse potentially to shelter those assets without limitation, a result directly contrary to the purposes of the MCCA and the DRA. Certainly, the third-party beneficiary would recover nothing if the community spouse were to live his or her actuarial lifespan, but that does not change the very real potential that wealthy individuals could create the possibility of a large

transfer of wealth to their heirs to the detriment of the state that is paying for the institutionalized spouse's care.

***10** I agree with the Commonwealth that there is no conflict between the two provisions because the purchase of an annuity that provides for a beneficiary other than the state is not an asset transfer for the "sole benefit" of the community spouse.[8] Thus, even though section 1396p(c)(2)(B)(i) is an exception to the look-back and annuity provisions contained in subsection (c)(1), it is not applicable to this situation, where a community spouse transfers assets to an annuity that provides for the possible transfer of those assets to the couple's heirs or another third party. Such an annuity is not for the "sole benefit" of the community spouse.

8 As a result, Jennifer's textual argument—that section 1396p(c)(1)(F) is limited to "this paragraph"—is not relevant.

As an initial matter, I give CMS's interpretation of what constitutes "sole benefit" substantial deference. CMS has consistently interpreted "sole benefit" to prohibit transfers that provide the potential for funds to pass to contingent remainder beneficiaries. Indeed, the CMS State Medicaid Manual provides:

> 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.

Transmittal 64, § 3257(B)(6). I do not agree with the Sixth Circuit's analysis in Hughes. Although it recognized that neither the statute nor federal regulations define the term "sole benefit," 734 F.3d at 481, the Hughes concluded that an annuity is for the "sole benefit" of the community spouse if it is actuarially sound. That conclusion improperly collapses two concepts—actuarial soundness and sole benefit. Actuarial soundness is not the same as sole benefit and the terms are used differently in different parts of 42 U.S.C. § 1396p. Compare 42 U.S.C. §§ 1396p(c)(1)(G)(ii), (c)(1)(I)(i) and 42 U.S.C. § 1396p(c)(2)(B)(i). See also Mohamad v. Palestinian Auth., 566 U.S. 449, 456 (2012) ("We generally seek to respect Congress' decision to use different terms to describe different categories of people or things."). As noted, CMS has concluded that "sole benefit" means no one else may benefit from the asset transfer. Actuarial soundness, on the other hand, as applied to annuities, refers to whether "the individual's life expectancy is commensurate with or coincides with the annuity term," and is used to discern whether the annuity was an abusive asset shelter. Zahner v. Secretary Pa. Dep't of Human Servs., 802 F.3d 497, 516 (3d Cir. 2015) (internal quotation marks and alterations omitted). As stated in the CMS State Manual:

> Annuities, although usually purchased in order to provide a source of income for retirement, are occasionally used to shelter assets so that individuals purchasing them can become eligible for Medicaid. In order to avoid penalizing annuities validly purchased as part of a retirement plan but to capture those annuities which abusively shelter assets, a determination must be made with regard to the ultimate purpose of the annuity (i.e., whether the purchase of the annuity constitutes a transfer of assets for less than fair market value). If the expected return on the annuity is commensurate with a reasonable estimate of the life expectancy of the beneficiary, the annuity can be deemed actuarially sound.

Transmittal 64, § 3258.9(B). Thus, actuarial soundness is a necessary attribute of an annuity that is for the sole benefit of the community spouse but is not alone a sufficient attribute. As set forth above, an annuity for the sole benefit of the community spouse must also be arranged so that if the annuitant passes away before the end of the term, the only party that stands to benefit from the remaining balance is the state.

***11** Further, as noted, the Hughes court was not presented with a situation where spousal assets were sheltered from the state via the annuity. That is because the first named beneficiary was the institutionalized spouse. See Hughes, 734 F.3d at 477. As a result, after the community spouse died, the

amount remaining in the annuity would not have been placed out of reach of the state for purposes of Medicaid. Whether the institutionalized spouse received the income stream or the entire remaining value of the annuity, those funds would offset Medicaid eligibility in whole or in part. Hughes simply did not address the situation here, the potential transfer of assets, via an annuity, to an heir. [9]

9 The DRA provides for the possibility of preserving some assets for minor or disabled children. See §§ 1396p(c)(1)(F)(ii) and (c)(2)(A)(ii).

Put concretely, before Julius purchased the Annuity, he and Suzanne had slightly more than a half a million dollars, which they were required to use to pay for Suzanne's nursing home care. Rather than use those funds for Suzanne's care, Julius purchased the Annuity to remove half a million dollars from his and Suzanne's countable assets to make Suzanne eligible for MassHealth and have the Commonwealth pay for her nursing home care. That was permissible only so long as the annuity was irrevocable, actuarially sound, *and* the Commonwealth was the named remainder beneficiary pursuant to 42 U.S.C. § 1396p(c)(1)(F).

I further conclude, consistent with the reasoning in Hutcherson, that the Commonwealth's recovery is not limited to the amounts paid for Suzanne's care up to the date of Julius's death. See Hutcherson, 667 F.3d at 1072 ("To limit AHCCCS's recovery to the medical expenses incurred before [the community spouse's] death would allow the [couple] to keep money and transfer money that would have otherwise made them ineligible for Medicaid. The Medicaid Act, through the transfer penalty and the DRA amendments to the annuity provision, reflect a clear intent to prevent individuals from sheltering funds in this manner.").

Finally, if I am wrong on the statutory interpretation question, Julius designated the Commonwealth as the remainder beneficiary "for the total amount of medical assistance paid on behalf of the institutionalized individual pursuant to 130 CMR 520.007(J)(2)." Jennifer argues that the term "institutionalized individual" refers not to Suzanne but to Julius. Read without reference to the Medicaid statutory scheme, the language "institutionalized individual" is, at best, ambiguous. Based on the undisputed record, it is evident, and I find, that Julius intended "institutionalized individual" to refer to Suzanne. As noted, (i) Suzanne identified the annuity as a Medicaid qualifying annuity for *her* benefit; (ii) Julius was not a Medicaid applicant nor an institutionalized individual at the time he purchased the Annuity; (iii) Suzanne acknowledged that Julius's failure to keep the Commonwealth as a "beneficiary of the annuity in the proper position" would result in the termination of *her* MassHealth benefits; and (iv) Jennifer does not dispute that Julius bought the Annuity in connection with the Medicaid application process for Suzanne. Accordingly, there is no evidence whatsoever that the term "institutionalized individual" referred to Julius rather than Suzanne. See Nadherny v. Roseland Prop. Co., 390 F.3d 44, 49 (1st Cir. 2004), quoting Boston Five Cents Sav. Bank v. Secretary of Dep't of Hous. and Urban Dev., 768 F.2d 5, 8 (1st Cir. 1985) (court may resolve contract ambiguity on summary judgment where there is undisputed extrinsic evidence that resolves the ambiguity as a matter of law or the extrinsic evidence is "so one-sided that no reasonable person could decide to the contrary."). Cf. Hershman-Tcherepnin v. Tcherepnin, 452 Mass. 77, 87 (2008) (resolving ambiguity in will on summary judgment record where "no party raise[d] a genuine dispute of material fact about the extrinsic facts surrounding the making of the will that would warrant a trial.").

***12** When read against the backdrop of the Medicaid scheme, the meaning of the term "institutionalized individual" becomes clearer. See, e.g., Springfield v. Department of Telecomm. and Cable, 457 Mass. 562, 568 (2010), citing Restatement (Second) of Contracts § 202(3) (1981) (terms of art to be given technical meaning when used within specialized field); see also Normand v. Director of Office of Medicaid, 77 Mass. App. Ct. 634, 644 (2010) (justice requires consideration of intent as the "governing statute provides"). "The term 'institutionalized individual' is specifically defined by the statute to mean '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.' " Hutcherson, 667 F.3d at 1070-1071, quoting 42 U.S.C. § 1396p(h)(3). Here, that definition captures only Suzanne.

Because I have held that the Commonwealth is entitled to recover on the Annuity for the amounts paid for Suzanne's nursing home care, Jennifer's 42 U.S.C. § 1983 claim fails as well. See McNamara v. Honeyman, 406 Mass. 43, 52 (1989) ("To establish a claim based on 42 U.S.C. § 1983, a plaintiff must show that the conduct complained of was committed by a person acting under color of State law and that the conduct deprived a person of rights, privileges or immunities secured by the Constitution or laws of the United States.").

Further, Jennifer's claim under 42 U.S.C. § 1983 fails because the Commonwealth is not subject to suit under that statute. See id. ("[T]he Commonwealth is not a 'person' under § 1983."); Will v. Michigan Dep't of State Police, 491 U.S. 58, 71 (1989) ("[N]either a State nor its officials acting in their official capacities are 'persons' under § 1983."); Canales v. Gatzunis, 979 F. Supp. 2d 164, 171 (D. Mass. 2013) ("It is well established, however, that neither states nor state officials sued in their official capacities for damages are 'persons' for purposes of § 1983.").

II. American National's Motion for Summary Judgment

Jennifer asserted counterclaims against American National for breach of contract and violation of G. L. c. 93A and c. 176D. When a dispute arose between the Commonwealth and Jennifer regarding the proper recipient of the remaining funds under the Annuity, American National appropriately filed a preemptive declaratory judgment action seeking clarification from the Court as to the rights and duties of the parties and appropriately brought an interpleader action pursuant to Mass. R. Civ. P. 22.

"General Laws c. 231A, § 1, allows courts to 'make binding declarations of right, duty, status and other legal relations sought thereby, either *before* or after a breach or violation thereof has occurred in any case in which an actual controversy has arisen and is specifically set forth in the pleadings.' " Sahli v. Bull HN Info. Sys., Inc., 437 Mass. 696, 705 (2002) (emphasis added), quoting G.L. 231A, § 1. "The purpose of this statute is to provide a plaintiff relief from uncertainty and insecurity with respect to rights, duties, status, and other legal relations." Id. Disputes about contractual obligations are the quintessential subjects for declaratory judgment proceedings because parties to a contract can seek judicial resolution without potentially breaching the contract. See id. ("The determination of contractual rights is a proper subject of a declaratory judgment proceeding."). Finally, the purpose of interpleader "is to sort out the amounts and priorities of competing claims to a fund." National Lumber Co. v. Canton Inst. for Savings, 56 Mass. App. Ct. 186, 188 (2002).

***13** Here, American National did not delay and did not take any steps to prejudice Jennifer. When confronted with the dispute over the proper recipient of the proceeds of the Annuity, American National took the appropriate and wise course, and that, by definition, cannot be a violation of G. L. c. 93A or 176D and does not constitute a breach of contract. See Rawan v. Continental Casualty Co., 483 Mass. 654, 663 (2019) (General Laws c. 176D and G. L. c. 93A prohibit "unfair claim settlement practices" by insurers, such as where an insurer refuses to pay a claim without having conducted an investigation and/or after "liability has become reasonably clear").

ORDER

For the foregoing reasons, the Commonwealth's Motion for Summary Judgment is **ALLOWED**; Jennifer Breslouf's Cross-Motion for Summary Judgment is **DENIED**. Judgment shall enter for the Commonwealth on the Interpleader and Declaratory Judgment Counts as follows:

The Court hereby **DECLARES** that the Commonwealth, the Executive Office of Health and Human Services and MassHealth properly interpreted 42 U.S.C. § 1396p(c)(1)(F) as applying to annuities for which the community spouse of an institutionalized individual is named as the annuitant.

The Court hereby **DECLARES** that the designation of the Commonwealth of Massachusetts as primary beneficiary to annuity proceeds in Annuity Contract No. 70010873, issued by American National Insurance Company, shall mean that the Commonwealth of Massachusetts is the beneficiary of such proceeds to the extent of total medical assistance paid by MassHealth on behalf of Suzanne Breslouf.

It is **FURTHER ORDERED** that for the remaining annuity benefit payments payable pursuant to Annuity Contract No. 70010873, issued by American National Insurance Company, American National Insurance Company shall direct such benefits to the Commonwealth of Massachusetts to the extent of the total medical assistance paid by MassHealth on behalf of Suzanne Breslouf.

The Motion for Summary Judgment of the Plaintiff and Counterclaim Defendant, American National Insurance Company is **ALLOWED**.

All Citations

Not Reported in N.E. Rptr., 2021 WL 2343024

2021 WL 2343024

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734 F.3d 473
United States Court of Appeals,
Sixth Circuit.

Carole L. HUGHES; Harry Hughes, Plaintiffs–Appellants,
v.
John B. McCARTHY, Medicaid Director, Defendant–Appellee.

No. 12–3765.
|
Argued: March 7, 2013.
|
Decided and Filed: Oct. 25, 2013.

Synopsis

Background: Nursing home resident and her community spouse filed § 1983 action, claiming that director of Ohio Department of Job and Family Services (ODJFS) violated federal Medicaid statutes by placing resident on 10-month restricted coverage as penalty for her spouse's purchase of annuity for sole benefit of himself with his individual retirement account (IRA) funds. The United States District Court for the Northern District of Ohio, Benita Y. Pearson, J., 872 F.Supp.2d 612,granted director summary judgment. Spouses appealed.

The Court of Appeals, Helene N. White, Circuit Judge, held that community spouse's purchase of annuity for his sole benefit did not warrant transfer penalty for resident.

Reversed.

Procedural Posture(s): On Appeal; Motion for Summary Judgment.

Attorneys and Law Firms

***474 ARGUED:** William J. Browning, Browning, Meyer & Ball, Co. LPA, Worthington, OH, for Appellants. Rebecca L. Thomas, Office of the Ohio Attorney General, Columbus, OH, for Appellee. **ON BRIEF:** William J. Browning, Browning, Meyer & Ball, Co. LPA, Worthington, OH, for Appellants. Rebecca L. Thomas, Office of the Ohio Attorney General, Columbus, OH, for Appellee. René H. Reixach, Woods Oviatt Gilman LLP, Rochester, NY, Eugene P. Whetzel, Ohio State Bar Association, Columbus, OH, Howard S. Scher, United States Department of Health and Human Services, Washington, D.C., for Amici Curiae.

Before: KETHLEDGE, WHITE, and STRANCH, Circuit Judges. [*]

[*] We amend the caption as reflected in this opinion.

OPINION

HELENE N. WHITE, Circuit Judge.

Plaintiffs Carole and Harry Hughes (collectively, the Hugheses), a nursing home ***475** resident and her community spouse, appeal the district court's grant of summary judgment in favor of the director of the Ohio Department of Job and Family Services (ODJFS or the Ohio agency), [1] holding that the Ohio agency properly penalized Mrs. Hughes based on Mr. Hughes's purchase of an annuity for himself with funds from his IRA account. The district court held that 42 U.S.C. § 1396r–5(f)(1) [2] precluded the transfer of assets because it exceeded Mr. Hughes's community spouse resource allowance (CSRA). Because the transfer occurred before the Ohio agency determined that Mrs. Hughes was eligible for Medicaid coverage and § 1396p(c)(2)(B)(i) permits an unlimited transfer of assets "to another for the sole benefit of the individual's spouse," we REVERSE.

[1] Since this case's inception, ODJFS has been reorganized. The duties and legal responsibilities of the director of ODJFS have been transferred to the state Medicaid director. *See* Am. Sub. H.B. No. 59, 2013 Ohio Laws 25 (provisions to be codified). In this opinion, we refer to the state Medicaid agency as the Ohio agency.

[2] This provision reads:

> An institutionalized spouse may, without regard to section 1396p(c)(1) ..., transfer an amount equal to the community spouse resource allowance ..., but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility....

42 U.S.C. § 1396r–5(f)(1).

I.

A.

Congress established the Medicaid program in 1965 to provide federal and state funding of medical care for individuals who cannot afford to cover their own medical costs. *See* Social Security Amendments of 1965, Title XIX, Grants to States for Medical Assistance Programs, Pub.L. No. 89–97, 79 Stat. 286, 343–52 (codified as amended at 42 U.S.C. §§ 1396–1396w–5); *Harris v. McRae,* 448 U.S. 297, 301, 100 S.Ct. 2671, 65 L.Ed.2d 784 (1980). The program is administered by the Secretary of Health and Human Services (HHS or the federal agency), who in turn exercises her authority through the Centers for Medicare and Medicaid Services (CMS).[3] To implement the program, "[e]ach participating State develops a plan containing reasonable standards ... for determining eligibility for and the extent of medical assistance within boundaries set by the Medicaid statute[s] and the Secretary of [HHS]." *Wis. Dep't of Health & Family Servs. v. Blumer,* 534 U.S. 473, 479, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002) (internal quotation marks omitted); *see* 42 U.S.C. § 1396a(17).

[3] Until 2001, CMS was known as the Health Care Financing Administration. *See* CMS; State of Organization, Functions and Delegations of Authority; Reorganization Order, 66 Fed.Reg. 35437–03 (July 5, 2001).

In 1988, Congress passed the Medicare Catastrophic Coverage Act (MCCA), Pub.L. No. 100–360, 102 Stat. 683, "to protect community spouses from 'pauperization' while preventing financially secure couples from obtaining Medicaid assistance. To achieve this aim, Congress installed a set of intricate and interlocking requirements with which States must comply in allocating a couple's income and resources." *Blumer,* 534 U.S. at 480, 122 S.Ct. 962 (internal citation and parenthetical omitted). In particular, the MCCA allows the community spouse to keep a portion of the couple's assets—the CSRA—without affecting the institutionalized spouse's Medicaid eligibility.[4] *See* ***476** 42 U.S.C. § 1396r–5(c)(2), (f)(2)(A). As the first step in determining the CSRA, the total of all the couple's resources is calculated as of the time the institutionalized spouse's institutionalization began; half of that total is allocated to each spouse (the spousal share). *Id.* § 1396r–5(c)(1)(A). Once the spousal share is determined, the CSRA is calculated by measuring the spousal share allocated to the community spouse against a statutory formula, which is further defined under each state plan, and subject to a ceiling and floor indexed for inflation. *Id.* § 1396r–5(c)(2)(B), (f)(2), (g).

[4] As relevant here, the term "institutionalized spouse" means an individual who is in a nursing facility and is married to a spouse who is not in a nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. 42 U.S.C. § 1396r–5(h)(1)–(2).

"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." *Blumer,* 534 U.S. at 482–83, 122 S.Ct. 962 (citing 42 U.S.C. § 1396r–5(c)(2)). However, a community spouse's income is not considered available to the institutionalized spouse for eligibility purposes, except in limited circumstances. *See* 42 U.S.C. § 1396r–5(b). Moreover, "after the month in which an institutionalized spouse is determined to be eligible for benefits ..., no resources of the community spouse shall be deemed available to the institutionalized spouse." *Id.* § 1396r–5(c)(4).

B.

A state plan must "comply with the provisions of [§] 1396p ... with respect to liens, adjustments and recoveries of medical assistance correctly paid, [ ] transfers of assets, and treatment of certain trusts." 42 U.S.C. § 1396a(18) (internal footnote omitted). Paragraph (1) of § 1396p(c) requires (in relevant part) that a state plan "must provide that if 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" (which, as relevant here, is defined as thirty-six months prior to the first date on which the institutionalized spouse applies for Medicaid assistance), "the individual is ineligible for medical assistance for services" (such as coverage for nursing home costs) for the numbers of months that the assets would have covered the average monthly cost of such services. *Id.* § 1396p(c)(1)(A); *see id.* § 1396p(c)(1)(B)(i)-(ii), (C)(i)(I), (D)(ii), (E)(i).

In other words, even if the institutionalized spouse is eligible for Medicaid coverage after spending down her assets, § 1396p(c) requires a state to impose a transfer penalty (a period of restricted coverage) if either spouse disposed of assets for less than fair market value during the look-back period. However, the transfer penalties under paragraph (1) do not apply in certain circumstances. As relevant here: "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[.]" *Id.* § 1396p(c)(2)(B)(i). Congress amended § 1396p(c)(2)(B) to its current form in 1993. *See* Omnibus Budget Reconciliation Act (OBRA) of 1993, Pub.L. No. 103–66, § 13611(a)(2), 107 Stat. 312; MCCA of 1988, Pub.L. No. 100–360, § 303(b), 102 Stat. 683.

Congress later passed the Deficit Reduction Act of 2005 (DRA), ***477** Pub.L. No. 109–171, 120 Stat. 4, 62–64, as amended by the Tax Relief and Health Care Act of 2006, Pub.L. No. 109–432, 120 Stat. 2922, 2998, which added provisions to paragraph (1) concerning whether the purchase of certain annuities should be deemed transfers for less than fair market value. *See* 42 U.S.C. § 1396p(c)(1)(F), (G). Congress did not, however, amend § 1396p(c)(2)(B) with the DRA's enactment.

II.

A.

Mrs. Hughes entered a nursing home in 2005. For nearly four years, Mr. Hughes paid for his wife's nursing home costs using the couple's resources, which largely consisted of funds from his IRA account. In June 2009, about three months before Mrs. Hughes applied for Medicaid coverage, Mr. Hughes purchased a $175,000 immediate single-premium annuity for himself using funds from his IRA account. The annuity guarantees monthly payments of $1,728.42 to Mr. Hughes from June 2009 to January 2019, totaling nine years and seven months, which is commensurate with Mr. Hughes's undisputed actuarial life expectancy. Combined with other retirement income, the annuity increased Mr. Hughes's monthly income to $3460.64 after the annuity took effect. In the event of Mr. Hughes's death, Mrs. Hughes is the first contingent beneficiary and the Ohio agency is "the remainder beneficiary for the total amount of medical assistance furnished to annuitant['s] spouse, [Mrs.] Hughes."

Mrs. Hughes applied for Medicaid coverage in September 2009. In December 2009, the Stark County division of the Ohio agency issued a notice that she was eligible for Medicaid as of the month of her application. However, the Ohio agency placed her on restricted coverage from September 2009 to June 2010, deeming her ineligible for coverage of nursing home costs for that time period because of Mr. Hughes's annuity purchase.

The Ohio agency determined that Mr. Hughes's annuity purchase was an improper transfer because he used a community resource (the IRA account) in an amount that exceeded his CSRA of $109,560 and because the annuity failed to name Ohio as the first contingent beneficiary. Thus, the Ohio agency placed Mrs. Hughes on restricted coverage for approximately ten months, the number of months that the difference between Mr. Hughes's CSRA and the annuity would have paid for nursing home costs. The Hugheses appealed the decision. The Ohio agency affirmed in a state-hearing and administrative-appeal level decision. State-court proceedings have been stayed pending this case's resolution.

B.

In August 2010, the Hugheses filed this case under 42 U.S.C. § 1983, alleging that the Ohio agency violated the federal Medicaid statutes, including § 1396p(c)(2)(B)(i), when it placed Mrs. Hughes on restricted coverage due to Mr. Hughes's purchase of an annuity with funds from his IRA account.[5] They claimed, inter alia, that the Medicaid statutes grant them the right to purchase an actuarially-sound[6] immediate ***478** single-premium annuity for the sole benefit of the community spouse.

5 The Hugheses were originally joined by another couple as plaintiffs, who are no longer parties to this action.

6 An annuity is actuarially sound where the entire expected return from the annuity is commensurate with a reasonable estimate of the annuitant's expected lifetime, as determined by the actuarial tables published by the Office of the Actuary of the Social Security Administration. *See* State Medicaid Manual § 3258.9(B).

The district court granted summary judgment in favor of the Ohio agency and denied the Hugheses' request for

injunctive relief. *See Hughes v. Colbert,* 872 F.Supp.2d 612 (N.D.Ohio 2012). [7] Notwithstanding the Hugheses' argument that § 1396p(c)(2)(B)(i) allows an institutionalized spouse to transfer unlimited assets to her community spouse without the transaction being considered an improper transfer, the court ruled that § 1396r–5(f)(1) precludes the transfer of assets to the community spouse that exceeds the CSRA and applies to the pre-eligibility transfer at issue here; and that § 1396r–5's supersession clause "requires resolution of any inconsistency between [§ 1396r–5(f)(1)] and § 1396p(c)(2)(B) in the former clause's favor." *Id.* at 622–23. The Hugheses timely appealed.

7 The district court rejected the Ohio agency's argument that the court should abstain from exercising jurisdiction over this case pursuant to the *Younger* abstention doctrine, and ruled that the Medicaid statutes cited by the Hugheses conferred enforceable rights under § 1983. The Ohio agency does not contest these rulings, and neither issue affects our jurisdiction. Further, the Hugheses do not challenge the district court's dismissal of their equal protection claim or their claim that certain Ohio Medicaid regulations are preempted by Federal law. We deem these issues abandoned.

III.

A.

We review de novo the district court's grant of summary judgment, as well as its interpretation of federal statutes. *Cnty. of Oakland v. Fed. Hous. Fin. Agency,* 716 F.3d 935, 939 (6th Cir.2013). In reviewing questions of statutory interpretation, we employ a three-step framework:

> [F]irst, a natural reading of the full text; second, the common-law meaning of the statutory terms; and finally, consideration of the statutory and legislative history for guidance. The natural reading of the full text requires that we examine the statute for its plain meaning, including the language and design of the statute as a whole. If the statutory language is not clear, we may examine the relevant legislative history.

Elgharib v. Napolitano, 600 F.3d 597, 601 (6th Cir.2010) (citations and internal quotation marks omitted).

To the extent that HHS has issued guidance on the federal Medicaid statutes in the form of opinion letters, an agency manual, and an amicus brief that lack the force of law, its statutory interpretations are not afforded deference under *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837, 104 S.Ct. 2778, 81 L.Ed.2d 694 (1984), but "are 'entitled to respect' under ... *Skidmore v. Swift & Co.,* 323 U.S. 134, 140, 65 S.Ct. 161, 89 L.Ed. 124 (1944), ... only to the extent that those interpretations have the 'power to persuade[.]' " *Christensen v. Harris Cnty.,* 529 U.S. 576, 587, 120 S.Ct. 1655, 146 L.Ed.2d 621 (2000) (internal citation altered); *see In re Carter,* 553 F.3d 979, 987–88 (6th Cir.2009) (applying *Skidmore* to the amicus brief filed by a federal agency charged with administering a statutory scheme); *Caremark, Inc. v. Goetz,* 480 F.3d 779, 787 (6th Cir.2007) (applying *Skidmore* to interpretations of Medicaid statutes set forth by CMS).

B.

The primary issue on appeal is whether the transfer of a community resource to purchase an annuity for the community spouse's sole benefit, which transfer is done after the institutionalized spouse is ***479** institutionalized but before the institutionalized spouse's Medicaid eligibility is determined, can be deemed an improper transfer under 42 U.S.C. § 1396r–5(f)(1), even though § 1396p(c)(2)(B)(i) allows a transfer of assets "to another for the sole benefit of the individual's spouse." [8] The district court accepted the Ohio agency's argument that a transfer of assets that exceeds the CSRA, even if made before the Ohio agency determined that Mrs. Hughes was eligible for Medicaid coverage, was improper under 42 U.S.C. § 1396r–5(f)(1) and that this provision supersedes § 1396p(c)(2)(B)(i) per the MCCA supersession clause, § 1396r–5(a)(1).

8 The Ohio agency concedes that Mr. Hughes's annuity was not a countable resource in determining his wife's Medicaid eligibility. Indeed, the Ohio agency determined that Mrs. Hughes

> was eligible for Medicaid, but placed her on restricted coverage because it deemed improper the transfer of funds from Mr. Hughes's IRA account to purchase the annuity. Thus, we need not decide the question whether the annuity may be considered a countable resource in the initial eligibility determination. *See Lopes v. Dep't of Soc. Servs.,* 696 F.3d 180, 188 (2d Cir.2012) (holding that the payment stream from a non-assignable annuity is not a resource for purposes of determining Medicaid eligibility); *Morris v. Okla. Dep't of Human Servs.,* 685 F.3d 925, 932–33 & n. 5 (10th Cir.2012) (collecting case-law).

We reject the district court's approach. Section 1396r–5(f)(1) reads:

> An institutionalized spouse may, without regard to section 1396p(c)(1) ..., transfer an amount equal to the community spouse resource allowance ..., but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility....

42 U.S.C. § 1396r–5(f)(1).

The provision begins in permissive, not prohibitive, terms. The Ohio agency acknowledges that "the first sentence tells us that a transfer to the community spouse up to the CSRA is allowed." That same sentence states that such transfer is permitted notwithstanding § 1396p(c)(1), which governs transfer penalties. The next sentence provides that this permitted transfer "shall be made as soon as practicable *after* the date of the initial determination of eligibility." (emphasis added). It does not say anything about a transfer made *before* the initial determination of eligibility, let alone that any pre-eligibility transfer that exceeds the CSRA is subject to a transfer penalty.

Tellingly, § 1396r–5(f)(1) is a CSRA provision. It does not appear within § 1396p(c)(1)'s framework, which imposes restricted coverage for the disposal of assets for less than fair market value during the look-back period. Even assuming that § 1396r–5(f)(1) provides authority for a state to impose a period of ineligibility for a transfer that exceeds the CSRA,[9] the statutory language and its relationship with § 1396p(c) do not support the Ohio agency's argument that § 1396r–5(f)(1) controls a transfer made before Medicaid eligibility is established. Thus, § 1396r–5(f)(1) does not supersede § 1396p(c)(2)(B)(i) for pre-eligibility transfers because there is no inconsistency between the provisions.

9 "A State ... 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 [(i.e., § 1396p(c))]." 42 U.S.C. § 1396p(c)(4). The provisions therein do not expressly include penalties for a transfer that exceeds the CSRA.

***480** On this point, we join the Tenth's Circuit's holding: "To avoid rendering § 1396p(c)(2)(B)(i) superfluous, we agree that it and § 1396r–5(f)(1) must be read to operate at distinct temporal periods: one period during which unlimited spousal transfers are permitted, and one period during which transfers may not exceed the CSRA." *Morris v. Okla. Dep't of Human Servs.,* 685 F.3d 925, 935 (10th Cir.2012). When assets are 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), before the institutionalized spouse is determined eligible for Medicaid coverage, "the unlimited transfer provision of § 1396p(c)(2) controls, and [a] transfer penalty [is] improper [under § 1396r–5(f)(1)]."[10] *Morris,* 685 F.3d at 938.

10 The Supreme Court also has referenced § 1396r–5(f)(1) with a post-eligibility understanding. *See Blumer,* 534 U.S. at 482 n. 5, 122 S.Ct. 962.

In response to *Morris* 's holding, the Ohio agency asks us to follow an unpublished district court opinion, *Burkholder v. Lumpkin,* No. 3:09–cv–1878, 2010 WL 522843 (N.D.Ohio Feb. 9, 2010). But *Burkholder* does not support its position because, in that case, the district court held that " § 1396r–5(f) supersedes § 1396p(c)(2) where ... the transfer of assets from the institutionalized spouse to the community spouse occurs after the initial eligibility determination." *Id.* at *7. By contrast, the Ohio agency seeks to impose a penalty for a transfer that occurred before it found Mrs. Hughes eligible for coverage.

Further, the two primary state-court cases the Ohio agency cites in support—*Feldman v. Department of Children & Families,* 919 So.2d 512 (Fla.Dist.Ct.App.2005), and *McNamara v. Ohio Department of Human Services,* 139 Ohio App.3d 551, 744 N.E.2d 1216 (2000)—are unpersuasive.[11] Neither state-court decision engages in any meaningful analysis of the statutory text. Indeed, one commentator has noted that such rulings are "inconsistent with statutory authority" and based on "antipathy" toward alleged sheltering of assets. Eric M. Carlson, Long–Term Care Advocacy § 7.12(5)(e)(ii)(A) (Matthew Bender 2012). "Policy [rationales] cannot prevail over the text of a statute." *Tran v. Gonzales,* 447 F.3d 937, 941 (6th Cir.2006).

11 Unlike this case, the at-issue financial product in *McNamara* was an "annuitized" trust rather than a standard commercial annuity. *See* 744 N.E.2d at 1221.

Our reading of the statute is supported by HHS's guidance. In its amicus brief, HHS explains that § 1396r–5(f)(1) "has nothing to say about the inter-spousal transfers that are permissible before a determination of eligibility." The federal agency's State Medicaid Manual confirms that § 1396r–5(f)(1) applies to post-eligibility reallocation of resources and that § 1396p(c)(2)(B)(i) permits transfers to a third party for the sole benefit of the individual's spouse. *See* State Medicaid Manual §§ 3258.11, 3262.4. HHS has taken the same position in a series of opinion letters issued to state plan administrators and to the public, reasoning that § 1396r–5(f)(1) does not conflict with, and thus does not supersede, § 1396p(c)(2)(B), as the two provisions apply to different situations, before and after eligibility is established; and that permitting inter-spousal transfers under § 1396p(c)(2)(B) does not render § 1396r–5(f)(1) a nullity, as the latter provision still has meaning with respect to resource allocation after eligibility is established. We agree with amici curiae, the National Academy of Elder Law Attorneys and the Ohio State Bar Association (who ***481** appear in support of the Hugheses), that HHS's view on this issue represents a "well thought out explanation of the differences between these two statutes" and thus is due respect under *Skidmore.*

The Ohio agency argues that Congress intended a different result, one that would subordinate § 1396p(c)(2)(B)(i) to § 1396r–5(f)(1)'s CSRA transfer cap. But the statutory text does not provide any indication of such an intent for the reasons described. Moreover, the legislative history does not support the Ohio agency's contention. A Senate amendment to H.R. 2264 (the bill that ultimately became OBRA, which enacted § 1396p(c)(2)(B)(i)) would have subjected the unlimited-transfer provision to § 1396r5(f)(1)'s CSRA transfer cap. *See* 139 Cong. Rec. 7913–01, 7986 (1993) (bill passes the Senate with amendment); *id.* at 8013 (amending § 1396p(c)(2)(B)(i) to provide that "(B) the resources-(i) were transferred to the individual's spouse or to another for the sole benefit of the individual's spouse *and did not exceed the amount permitted under section 1924(f)(1)*" (emphasis added)). In a conference report, the House of Representatives receded from its disagreement with the Senate amendment, but nevertheless offered substitute language that dropped the reference to § 1396r–5(f)(1), and provided the current language of § 1396p(c)(2)(B)(i), which was adopted. H.R. Rep. 103–213, at 1, 324 (1993) (Conf.Rep.), *reprinted in* 1993 U.S.C.C.A.N. 1088. That Congress declined to adopt language supporting the very construction of § 1396p(c)(2)(B)(i) that the Ohio agency now advances is a "compelling" indication of its intent not to subordinate § 1396p(c)(2)(B)(i) to § 1396r–5(f)(1). *INS v. Cardoza–Fonseca,* 480 U.S. 421, 442–43, 107 S.Ct. 1207, 94 L.Ed.2d 434 (1987) ("Few principles of statutory construction are more compelling than the proposition that Congress does not intend *sub silentio* to enact statutory language that it has earlier discarded in favor of other language." (internal quotation marks omitted)).

C.

The Ohio agency raises two alternate grounds for affirmance. To the extent it did not raise the issues before the district court, we address them to promote finality in this litigation, as the issues require no further factual development and have been sufficiently presented for our review. *See In re Morris,* 260 F.3d 654, 664 (6th Cir.2001).

1. Section 1396p(c)(2)(B)(i)'s sole-benefit rule

The Ohio agency argues that the transfer of a community resource to purchase an annuity by or on behalf of the community spouse cannot be "for the sole benefit of the individual's spouse" under § 1396p(c)(2)(B)(i) if—as here—the annuity designates the institutionalized spouse as the first contingent beneficiary and the Ohio agency as the second contingent beneficiary to receive payments in the event of the community spouse's early death, even if the annuity is actuarially sound and payments are made only to the spouse during his life. We disagree.

The statute does not define the term "sole benefit." Nor is the term defined by federal regulation. The Ohio agency's position on this issue rests primarily on the plain meaning of the word "sole," citing dictionaries and other authorities for the proposition that the word means " 'only,' 'solitary,' 'single' or 'exclusive.' " But what a dictionary does not tell us is whether a transfer of assets "to another for the sole benefit of the individual's spouse" means (as HHS contends in its amicus brief and the Hugheses contend in their second supplemental brief) that the transfer may benefit ***482** only the spouse during his life but may include contingent beneficiaries, so long as the financial instrument is actuarially sound and payments are made only to the spouse during his life; or (as the Ohio agency contends) that the transfer may benefit only the spouse at the time of the transfer and also thereafter, such that any remaining assets in the event of the spouse's early death cannot pass to a contingent beneficiary. *Cf.* Sanford J. Schlesinger and Barbara J. Scheiner, Medicaid After OBRA '93, 21 Est. Plan. 74, 76 (1994) (opining that it is an open question whether, under the sole-benefit rule, "a trust for the sole benefit of the spouse for life, with the remainder to someone else, [would] be a trust for the sole benefit of the spouse").

The Ohio agency argues that HHS's position on this issue is inconsistent. The State Medicaid Manual, § 3258.11, explains:

> The exception for transfers to a third party for the sole benefit of the spouse may have greater impact on eligibility because resources may potentially be placed beyond the reach of either spouse and thus not be counted for eligibility purposes. However, for the exception to be applicable, the definition of what is for the sole benefit of the spouse (see § 3257) must be fully met. This definition is fairly restrictive, in that it requires that any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy. If this requirement is not met, the exemption is void, and a transfer to a third party may then be subject to a transfer penalty.

In turn, § 3257 of the manual states:

> A transfer is considered to be for the sole benefit of a spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

Id. § 3257.

Although the phrase "at any time in the future" might be interpreted to mean that contingent beneficiaries cannot be named in the financial instrument, this is not the federal agency's position. As HHS has reasoned in its amicus brief and in a prior opinion letter, the designation of contingent beneficiaries to receive funds remaining in an annuity in the event of the spouse's early death would not necessarily violate the sole-benefit rule, so long as the annuity is actuarially sound and provides for payments only to the spouse during his life. *Accord Mertz v. Houstoun,* 155 F.Supp.2d 415, 426 n. 14 (E.D.Pa.2001) ("If an annuitant receives the amount invested [plus interest] during his lifetime, the annuity is actuarially sound and for his sole benefit.").

HHS's position is mirrored by Ohio's implementing regulation:

> A transfer for the sole benefit of the spouse, blind or disabled child or disabled individual in which there is a provision within the trust, contract or other binding instrument to expend all of the transferred resources [for the benefit of the individual during

> that individual's life expectancy] may provide for other beneficiaries.

Ohio Admin. Code § 5101:1–39–07(F)(1). [12]

12 As another source of guidance, the Social Security Administration—in setting forth its policy that a special needs trust must be for the sole benefit of the designated individual—has defined the term to mean that the trust must benefit no one but that individual, "whether at the time the trust is established or at any time for the remainder of the individual's life." Social Security Program Operations Manual System (POMS), SI 011120.201(F)(2).

The Ohio agency asserts that HHS's position and its state's regulation are ***483** wrong. But if we were to adopt the Ohio agency's definition of sole benefit, it is difficult to conceive what type of financial arrangement could meet it. Under the definition urged by the Ohio agency, it acknowledges that, "universally, ... it seems that no annuity (or at least no typical annuity) could meet this [definition] because it seems to be typical that an annuity instrument names at least one [contingent] beneficiary." We take its reasoning two steps further. Even if an annuity or another financial arrangement does not designate a contingent beneficiary, or even if the arrangement (such as a pure life annuity) expressly provides that payments shall terminate upon the spouse's death, someone other than the spouse will benefit. In the first scenario, the presence of contingent beneficiaries is a certainty under the law whether the beneficiaries are designated in the financial instrument, in the spouse's will, or by the Ohio statute of descent and distribution, Ohio Rev.Code. § 2105.06. In the second scenario, the entity that issued the financial product will benefit upon forfeiture of future payment.

Were we to adopt the Ohio agency's definition, no transfer "to another for the sole benefit of the individual's spouse" under most standard financial arrangements could satisfy § 1396p(c)(2)(B)(i). We reject this "acontextual approach to statutory interpretation." *Flores v. Rios,* 36 F.3d 507, 513 (6th Cir.1994); *see Davis v. Mich. Dep't of Treasury,* 489 U.S. 803, 809, 109 S.Ct. 1500, 103 L.Ed.2d 891 (1989) ("It is a fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.").

We cannot presume that Congress operated in a vacuum when it enacted § 1396p(c)(2)(B)(i). By providing that a couple may transfer assets "to *another* for the sole benefit of the individual's spouse," the term "another" is not limiting. It naturally encompasses standard financial arrangements (such as an annuity) crafted for the spouse's sole benefit during his life. Our reading is supported by HHS, which takes the position that the term "another" includes an entity that issues the annuity. In this context, HHS's construction of the sole-benefit rule gives the statute meaning. The actuarial-soundness requirement reasonably assures that the assets were transferred to a third party for the individual spouse's sole benefit. Any contingent interest becomes relevant only if the spouse dies early. To extend the sole-benefit requirement past a spouse's death is nonsensical. The federal agency's construction is reasonable, supported by the statutory structure, and, thus, due respect under *Skidmore.*

2. Whether an annuity that satisfies § 1396p(c)(2)(B)(i)'s sole-benefit rule must also satisfy the annuity rules under § 1396p(c)(1)(F)

The Ohio agency argues 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), and that because Mr. Hughes's annuity does not name Ohio as "the remainder beneficiary in the first position," it fails to satisfy ***484** § 1396p(c)(1)(F). [13] However, its reading of the two provisions defies the text and structure of the statute.

13 The Ohio agency does not dispute that Mr. Hughes's annuity would satisfy § 1396p(c)(1)(F) if it named Ohio as the first contingent beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized spouse and Mrs. Hughes as the second contingent beneficiary. To the extent the transfer here (based on Mr. Hughes's purchase of an annuity) is not for fair market value under § 1396p(c)(1)(F), it is because of the contingent remainder interest held by the institutionalized spouse, the value of which was not transferred because it is retained by her.

As the Hugheses correctly contend in their second supplemental brief, an annuity that satisfies § 1396p(c)(2)(B)(i) need not satisfy § 1396p(c)(1)(F). The annuity rules under § 1396p(c)(1)(F) fall within § 1396p(c)(1)'s (paragraph (1)) overall transfer-penalty regime:

> "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) (emphasis added). On the other hand, § 1396p(c)(2)(B)(i) is an exception to transfer penalties under paragraph (1):

> 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[.]

Id. § 1396p(c)(2)(B)(i) (emphasis added).

In its amicus brief, HHS takes the position that an annuity that satisfies § 1396p(c)(2)(B)(i)'s sole-benefit rule must also satisfy § 1396p(c)(1)(F). It does so without any reference to the statutory text, meaningful analysis, or reference to authority. The only proffered support for HHS's position is a 2006 CMS letter enclosure concerning the treatment of annuities under the DRA. In that letter, the federal agency reasoned:

> Unlike the new section 1917(c)(1)(G)[14] added by section 6012(c) of the DRA ***485** ..., section 1917(c)(1)(F) does not restrict application of its requirements only to an annuity purchased by or on behalf of an annuitant who has applied for medical assistance for nursing facility or other long-term care services. Therefore, we interpret section 1917(c)(1)(F) as applying to annuities purchased by an applicant or by a spouse, or to transactions made by the applicant or spouse.

14 The provision provides:

> (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 [Title 26, U.S.C.A.]; 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.

42 U.S.C. § 1396p(c)(1)(G) (internal paragraph formatting altered). We need not address the Hugheses' argument that the annuity is saved by § 1396p(c)(1)(G) given our disposition of this appeal on other grounds.

CMS, Changes in Medicaid Annuity Rules under the DRA of 2005 § II.B (July 27, 2006).

As the Ohio agency acknowledges, HHS applies § 1396p(c)(1)(F) to an annuity that otherwise satisfies § 1396p(c)(2)(B)(i) without acknowledging or addressing the structure of § 1396p(c), which 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). HHS's rationale lacks reasoning and contravenes the plain language of § 1396p(c)(2)(B)(i) and § 1396p(c)(1)(F). Thus, we decline to afford its interpretation respect under *Skidmore*. *See Flores v. USCIS,* 718 F.3d 548, 554–55 (6th Cir.2013).

Rather than adopt HHS's rationale, the Ohio agency asks us to hold that Congress could not have enacted § 1396p(c)(1)(F) without intending it to supplement the earlier and more general provision of § 1396p(c)(2)(B)(i).

We disagree with the Ohio agency's characterization of the two provisions. Although "it is axiomatic that a general provision yields to a specific provision when there is a conflict," *Reg'l Airport Auth. of Louisville v. LFG, LLC,* 460 F.3d 697, 716 (6th Cir.2006), there 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. The two provisions complement rather than contradict one another. [15] Section 1396p(c)(1)(F) is not rendered illusory. It applies to all annuities not excepted by another provision such as § 1396p(c)(2)(B), including annuities benefiting non-exempt children or a spousal annuity that is not actuarially sound.

15 With respect to annuity disclosures, 42 U.S.C. § 1396p(e)(1) provides that the Medicaid application must 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." The referenced "paragraph 2" of subsection (e) limits itself to annuities that are subject to § 1396p(c)(1)(F)'s annuity rules (such as naming the state as the remainder beneficiary). *See id.* § 1396p(e)(2)(A) ("In the case of disclosure concerning an annuity under subsection (c)(1)(F) of this section, 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."). Thus, subsection (e) reenforces the conclusion that § 1396p(c)(1)(F) does not control all annuities.

Because the provisions are not in conflict, that Congress enacted ***486** § 1396p(c)(1)(F) after § 1396p(c)(2)(B)(i) does not support a finding that § 1396p(c)(2)(B)(i) must give way to the newer provision, § 1396p(c)(1)(F). *See United States v. Clay,* 982 F.2d 959, 963 (6th Cir.1993) ("When interpreting the effect of a new law upon an old one, ' [o]nly a clear repugnancy between the old law and the new results in the former giving way and then only *pro tanto* to the extent of the repugnancy.' " (alteration in original) (quoting *Georgia v. Penn. R. Co.,* 324 U.S. 439, 457, 65 S.Ct. 716, 89 L.Ed. 1051 (1945))).

Last, the Ohio agency's reference to floor statements by members of Congress—indicating in general terms that the DRA was enacted to close loopholes related to the purchase of annuities—is unavailing given that the statutory language unambiguously limits § 1396p(c)(1)(F) to paragraph (1) and § 1396p(c)(2)(B)(i) is an exception to paragraph (1)'s transfer penalties and was unamended by the DRA. [16] *See Barnhart v. Sigmon Coal Co.,* 534 U.S. 438, 457 n. 15, 122 S.Ct. 941, 151 L.Ed.2d 908 (2002) (noting that floor statements cannot override clear statutory text); *Conn. Nat'l Bank v. Germain,* 503 U.S. 249, 253–54, 112 S.Ct. 1146, 117 L.Ed.2d 391 (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. When the words of a statute are unambiguous, then, this first canon is also the last: judicial inquiry is complete." (internal citations and quotation marks omitted)). If Congress prefers the interpretation that applies § 1396p(c)(1)(F) notwithstanding § 1396p(c)(2)(B)(i), it need only amend the statute.

16 In any event, such referenced statements do not reveal Congressional intent to subject § 1396p(c)(2)(B)(i) to § 1396p(c)(1)(F)'s annuity rules.

IV.

For the foregoing reasons, we REVERSE the district court's judgment and remand for further proceedings consistent with this opinion.

Med & Med GD (CCH) P 304,660

All Citations

734 F.3d 473, Med & Med GD (CCH) P 304,660

667 F.3d 1066
United States Court of Appeals,
Ninth Circuit.

Rebecca G. HUTCHERSON, Plaintiff–Appellant,
v.
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION, and Thomas J. Betlach, in his capacity as Director of AHCCCS, Defendants–Appellees.

No. 10–16426.
|
Argued and Submitted Aug. 30, 2011.
|
Filed Jan. 27, 2012.

Synopsis

Background: Secondary remainder beneficiary filed action seeking declaratory judgment that Arizona Health Care Cost Containment System Administration, as primary remainder beneficiary, did not have right to recover from her dad's annuity at all that he had purchased to enable her mom to qualify for Medicaid assistance or, alternatively, did not have any right to recover for any costs incurred for care that her mom, as institutionalized spouse, received after her dad's death. The United States District Court for the District of Arizona, James A. Teilborg, J., 2010 WL 1962185, granted summary judgment for defendant. Plaintiff appealed.

Holdings: The Court of Appeals, Timlin, Senior District Judge for the Central District of California, sitting by designation, held that:

state had right to recover as remainder beneficiary against community spouse's annuity for institutionalized spouse's medical costs and

state's recovery was not limited to amount that it paid for institutionalized spouse's medical costs as of date of community spouse's death.

Affirmed.

Procedural Posture(s): On Appeal; Motion for Summary Judgment.

Attorneys and Law Firms

***1067** Eric K. Macdonald and Ryan K. Hodges (argued), Jackson White, Mesa, AZ, for the appellant.

Timothy D. Ducar (argued), Lorona Steiner Ducar, Ltd., Phoenix, AZ, for the appellees.

Appeal from the United States District Court for the District of Arizona, James A. Teilborg, District Judge, Presiding. D.C. No. 2:09–cv–00898–JAT.

Before: RAYMOND C. FISHER and JOHNNIE B. RAWLINSON, Circuit Judges, and ROBERT J. TIMLIN, Senior District Judge. *

* The Honorable Robert J. Timlin, United States District Judge for the Central District of California, sitting by designation.

OPINION

TIMLIN, Senior District Judge:

Rebecca Hutcherson ("Appellant") appeals the district court's judgment granting summary judgment to Arizona Health Care Cost Containment System Administration and Thomas Betlach (collectively "AHCCCS"). We hold that the 2006 amendment to 42 U.S.C. § 1396p(c)(1)(F)(i) creates a right in the State to recover as a remainder beneficiary against a community spouse's annuity for an institutionalized spouse's medical costs. We further hold that the State's recovery is not limited to the amount it paid for the institutionalized spouse's medical costs as of the date of the community spouse's death. Accordingly, we affirm.

I.

Appellant is the daughter of John and Betty Hutcherson. [1] At some point, Betty required long-term care in a nursing home or similar facility. In June 2007, Betty applied for Medicaid assistance from AHCCCS. Betty did not qualify for Medicaid assistance at that time because the Hutchersons' assets exceeded the limit to qualify. In order for Betty to qualify for Medicaid assistance, John "spent down" his assets by purchasing an annuity in his name for $100,000. The annuity paid a fixed monthly amount of $2,781.63 for 36

months. AHCCCS was listed as the annuity's remainder beneficiary in the first position, as required by the Medicaid statute, and Appellant was listed as the remainder beneficiary in the second position.

[1] For ease of reference, we will refer to John and Betty Hutcherson by their first names.

On April 5, 2008, John died. At that time, the annuity had a remaining value of approximately $75,000. The annuity provided that, at the time of the annuitant's death, the beneficiary could choose to either be paid a lump sum or receive the remaining monthly annuity payments as scheduled. AHCCCS opted to receive the monthly payments from the annuity.

At the time of John's death, AHCCCS had paid $23,840.51 for Betty's medical ***1068** care. Following John's death, AHCCCS continued to pay for Betty's care at a monthly cost of $2,552.92. AHCCCS deducted this continuing monthly cost from the monthly annuity payments it was receiving and applied the remaining $228.71 to the $23,840.51 that it had paid for Betty's care prior to John's death.

Betty stopped receiving Medicaid assistance from AHCCCS in 2009. The annuity was then used by AHCCCS to pay off the remaining balance of the $23,840.51 and AHCCCS released its claim on the annuity. In total, AHCCCS received $60,840.51 from the annuity before the remaining value was paid to Appellant as the secondary remainder beneficiary.

On April 29, 2009, Appellant filed a declaratory judgment action seeking a declaration that AHCCCS had no right to recover from John's annuity at all or, alternatively, had no right to recover for any costs incurred for the care Betty received after John's death. The parties filed cross-motions for summary judgment following discovery. The district court granted AHCCCS's motion, concluding that (1) 42 U.S.C. § 1396p(c)(1)(F)(i) was validly enacted by Congress and is binding on Appellant; (2) AHCCCS could recover from the annuity for costs it incurred on Betty's behalf; and (3) AHCCCS could recover for amounts it spent on Betty's care after John's death.

Appellant timely filed this appeal.

II.

We have jurisdiction over this case pursuant to 28 U.S.C. § 1291. We review *de novo* a district court's grant of summary judgment. *City of Los Angeles v. San Pedro Boat Works,* 635 F.3d 440, 446 (9th Cir.2011).

III.

Medicaid is a cooperative program through which the federal government reimburses states for some costs they incur in providing medical assistance to the poor. *See Wisconsin Dep't of Health & Family Servs. v. Blumer,* 534 U.S. 473, 479, 122 S.Ct. 962, 151 L.Ed.2d 935 (2002). Each state develops its own plan for determining Medicaid eligibility based on standards established by the federal government, taking into account the income and assets of the applicant. *Id.*

Unique problems arose regarding Medicaid eligibility for spouses given that they generally share income and assets. *See id.* at 479–80, 122 S.Ct. 962. For example, states 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. *Id.*[2] 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 simply holding their assets solely in the name of the community spouse. *Id.* at 480, 122 S.Ct. 962. Congress responded to this problem by passing the Medicare Catastrophic Coverage Act of 1988 ("MCCA"), which had the dual aim of ending the "pauperization" of community spouses and preventing wealthy couples from qualifying for Medicaid assistance by sheltering their assets. *Id.; see also J.P. v. Mo. State Family Support Div.,* 318 S.W.3d 140, 142 (Mo.Ct.App.2010) ("In enacting the MCCA, Congress sought to protect the community spouse ***1069** from poverty, but it also wanted to protect the Medicaid system from abuse.").

[2] "Community spouse" refers to the spouse of an institutionalized person who continues to live at home. *See Blumer,* 534 U.S. at 478, 122 S.Ct. 962.

One provision of the MCCA allows an institutionalized spouse to qualify for Medicaid assistance while reserving for the community spouse a capped amount of assets for the community spouse's benefit, known as the "community spouse resource allowance" or "CSRA." *Blumer,* 534 U.S. at 482, 122 S.Ct. 962. The CSRA is designed to ensure that

the community spouse can meet his or her minimum monthly maintenance needs. *See id.* at 478, 122 S.Ct. 962. All assets above the CSRA must be spent before the institutionalized individual can be eligible for Medicaid assistance. *See id.* at 483, 122 S.Ct. 962.

Congress regulates the means by which couples may spend down their assets to qualify an institutionalized individual for Medicaid assistance. The Medicaid Act prevents wealthy couples from qualifying for Medicaid by imposing a penalty when couples attempt to dispose of assets that could otherwise be used to pay for the institutionalized spouse's medical care. If a couple disposes of any property for less than fair market value during a five-year "look back" period, the institutionalized spouse is not eligible to receive coverage for an amount of time equal to the "total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) ... divided by ... the average monthly cost to a private patient of nursing facility services in the State." 42 U.S.C. § 1396p(c)(1)(A), (E). 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. The effect is to treat couples who dispose of assets as if those assets were available to the couple to pay for medical care.

Congress has, however, provided specific ways that a community spouse may spend down his or her assets without affecting the institutionalized spouse's eligibility for Medicaid. Of relevance here, the Medicaid statute allows the community spouse to purchase an annuity. *See* 42 U.S.C. § 1396p(c)(1)(F)(i). This provision protects the community spouse from destitution by allowing the spouse to convert his or her assets, which are considered in determining the institutionalized spouse's eligibility, to income, which is not considered. *See* 42 U.S.C. § 1396r–5(b)(1), (c)(1).

In 2005, Congress passed the Deficit Reduction Act ("DRA"), which sought to further close loopholes in the Medicaid Act. *See, e.g., N.M. v. Div. of Med. Assist. & Health Servs.,* 405 N.J.Super. 353, 964 A.2d 822, 827–28 (N.J.Sup.Ct.App.Div.2009) (discussing the DRA's legislative history); *see also Mackey v. Dep't of Human Servs.,* 289 Mich.App. 688, 808 N.W.2d 484, 488 n. 7, 2010 WL 3488988, at *4 n. 7 (Mich.Ct.App. Sept. 7, 2010) ("[W]hen signing into law the Deficit Reduction Act of 2005, President George W. Bush stated that the act " 'tightens the loopholes that allowed people to game the system by transferring assets to their children so they can qualify for Medicaid benefits.' " ") (quoting Reif, *A Penny Saved Can Be A Penalty Earned: Nursing Homes, Medicaid Planning, The Deficit Reduction Act of 2005, And The Problem of Transferring Assets,* 34 NYU Review of Law & Social Change 339, 347 (2010)). The DRA added several requirements that must be met before an annuity is exempt from the transfer penalty. For instance, 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. *Id.* § 1396p(c)(1)(G)(ii). In addition, and of particular relevance to this case, the DRA ***1070** originally provided that the purchase of an annuity is allowable only where "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.*" 42 U.S.C. § 1396p(c)(1)(F)(i) (2005) (emphasis added).

In 2006, Congress amended the language of § 1396p(c)(1)(F)(i). Under the amended language, spouses may purchase an annuity to spend down their assets only if "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) (2006) (emphasis added); *see also* Tax Relief and Health Care Act of 2006, Pub. L. No. 109–432, 120 Stat. 2922, 2998 (2006).

IV.

The issues raised on appeal turn on our interpretation of § 1396p(c)(1)(F)(i), as amended in 2006. In construing a statute, we first look to the plain meaning of that statute. *See Hughes Aircraft Co. v. Jacobson,* 525 U.S. 432, 438, 119 S.Ct. 755, 142 L.Ed.2d 881 (1999). If the plain meaning is clear, our analysis generally ends and we apply that plain meaning. *See id.; see also Arlington Cent. School Dist. Bd. of Educ. v. Murphy,* 548 U.S. 291, 296, 126 S.Ct. 2455, 165 L.Ed.2d 526 (2006) (plain language of text controls so long as outcome is not absurd). Interpretation of this provision "depends upon reading the whole statutory text, considering the purpose and context of the statute." *Kasten v. Saint–Gobain Performance Plastics Corp.,* —— U.S. ——, 131 S.Ct. 1325, 1330, 179 L.Ed.2d 379 (2011) (citation omitted).

A.

John purchased the annuity at issue in this case in 2007 to enable Betty to qualify for Medicaid assistance. For the annuity to qualify as a permissible means of "spending down" assets, John named the State as the remainder beneficiary in the first position, as required by § 1396p(c)(1)(F). Appellant, who was named as the second beneficiary, contends that AHCCCS was not entitled to any reimbursement from the annuity because AHCCCS's recovery was limited to expenses incurred on behalf of John, who was never institutionalized. We disagree.

Section 1396p(c)(1)(F)(i) 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." 42 U.S.C. § 1396p(c)(1)(F)(i). By its plain terms, the provision allows the State to recover the expenses incurred on behalf of "the institutionalized individual," in this case, Betty.

Appellant observes that AHCCCS would not have been entitled to recover Betty's medical costs from the annuity under the previous version of § 1396p(c)(1)(F)(i). She urges us to ignore the plain meaning of the 2006 amendment because Congress labeled the amendment as a "technical correction." *See* Tax Relief & Health Care Act of 2006, Pub. L. No. 109–432, 120 Stat. 2922, 2996 (2006). According to Appellant, 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. Thus, Congress intended that we interpret "institutionalized individual" to mean "annuitant" despite the different meanings of those words.

We disagree. The best indicator of congressional intent is the language of a statute itself. *See Sedima, S.P.R.L. v. Imrex Co.*, 473 U.S. 479, 495 n. 13, 105 S.Ct. 3275, 87 L.Ed.2d 346 (1985). The term "institutionalized individual" is specifically ***1071** defined by the statute to mean "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." 42 U.S.C. § 1396p(h)(3). Here, that definition captures only Betty.

That Congress labeled its amendment as a "technical correction" does not defeat the plain language of the statute. *See United States v. R.L.C.*, 503 U.S. 291, 305 n. 5, 112 S.Ct. 1329, 117 L.Ed.2d 559 (1992) (plurality) (rejecting the contention that the usual tools of statutory construction do not apply to technical amendments); *see also id.* at 307, 112 S.Ct. 1329 (Scalia, J., concurring) ("The Court begins its analysis, quite properly, by examining the language of[the statute] ..."). [3]

3 Appellant also notes that the amendment's retroactivity "is an indicia of [its] technical nature." Congress's indication that the amendment should apply retroactively does not alter our analysis in light of the statute's plain language. We express no opinion as to whether retroactive application of the amendment would raise a due process issue.

We will give the plain meaning to the unambiguous language in § 1396p(c)(1)(F)(i), which allows states to reach a deceased community spouse's annuity for costs incurred on behalf of an institutionalized spouse. We therefore hold that AHCCCS was entitled to recover as the primary remainder beneficiary from John's annuity for the amount of medical costs it paid on behalf of Betty.

B.

Appellant argues in the alternative that AHCCCS's interest as a remainder beneficiary in the first position was limited to the amount it had paid on behalf of Betty as of the date of John's death. Appellant's argument again turns on the language of the statute, which requires an annuitant to name the State "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). Appellant contends that the provision's use of "paid" in the past tense evidences a congressional intent to cap a state's recovery at the amount it had paid up to the date of the annuitant's death. Hence, any additional amount from the annuity would be disbursed to the remainder beneficiary in the second position even though the State continues incurring costs on behalf of the annuitant's spouse.

We disagree. To begin with, nothing in the statutory language is inconsistent with permitting AHCCCS to recover from the annuity expenses incurred after John's death. In doing so, AHCCCS would be recovering the "medical assistance paid on behalf of the institutionalized individual," Betty, as § 1396p(c)(1)(F)(i) permits. This interpretation is also the most consistent with the statutory scheme and purpose. As

noted above, the provisions regarding transferring assets were tailored to balance Congress's desire to avoid impoverishment of the community spouse, on the one hand, and closing loop-holes that allowed wealthy couples to game the system, on the other hand. The annuity payments to AHCCCS as a beneficiary functioned precisely the way the statute was intended to work. The Hutchersons were able to qualify Betty for Medicaid assistance, while ensuring that John did not become impoverished. As part of that balance, AHCCCS was named as the primary remainder beneficiary of John's annuity so that it could recoup its costs for the medical care that Betty received in the event that John died before the annuity had run its course.

Accepting Appellant's position that the state should not recover and, instead, she ***1072** should inherit what remained in John's annuity would frustrate the purpose of the Medicaid statute. As we have noted above, Congress prevents the community spouse from disposing of assets that would otherwise be available to pay for the institutionalized spouse's medical care. For instance, if John, instead of purchasing the annuity, attempted to transfer funds to Appellant, Betty would have been ineligible for Medicaid for the approximate length of time that the funds could have covered Betty's medical costs. By purchasing an annuity, John avoided this transfer penalty. Consistent with the Medicaid Act's objective of protecting the community spouse from destitution, John was entitled to collect monthly payments from the annuity for as long as he lived. When John died before the annuity ran its course, however, funds remained in the annuity that could have otherwise been used to pay for Betty's medical care. To limit AHCCCS's recovery to the medical expenses incurred before John's death would allow the Hutchersons to keep money and transfer money that would have otherwise made them ineligible for Medicaid. The Medicaid Act, through the transfer penalty and the DRA amendments to the annuity provision, reflect a clear intent to prevent individuals from sheltering funds in this manner.

We therefore conclude that AHCCCS could be reimbursed as the primary remainder beneficiary from John's annuity for the cost of the medical assistance it paid on Betty's behalf after John's death.

V.

Accordingly, we AFFIRM the judgment of the district court granting summary judgment to AHCCCS and Betlach.

All Citations

667 F.3d 1066, Med & Med GD (CCH) P 303,953, 12 Cal. Daily Op. Serv. 1107, 2012 Daily Journal D.A.R. 1163

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Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

William Englemann
15 Stevens Street # 245
Andover, MA, 01810

Appeal Decision:	Approved in part; Denied in part	**Appeal Number:**	1942190
Decision Date:	JAN 16 2020	**Hearing Date:**	08/30/2019
Hearing Officer:	Alexandra Shube	**Record Open to:**	09/03/2019

Appearance for Appellant:
Julie Low, Esq.
Nancy Petino, Paralegal

Appearance for MassHealth:
Karen Ryan, Tewksbury MEC

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Approved in part; Denied in part	**Issue:**	LTC – disqualifying transfers
Decision Date:	JAN 16 2020	**Hearing Date:**	08/30/2019
MassHealth's Rep.:	Karen Ryan	**Appellant's Rep.:**	Julie Low, Esq. Nancy Petino
Hearing Location:	Tewksbury MassHealth Enrollment Center	**Aid Pending:**	No

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated July 15, 2019, MassHealth denied the appellant's application for MassHealth benefits because he had more countable income than allowed and there was a disqualifying transfer of resources for which MassHealth calculated a period of ineligibility running from February 1, 2019 to September 5, 2023 (see 130 CMR 520.019; 520.009; 520.015; and Exhibit 1). The appellant filed this appeal in a timely manner on July 22, 2019 (see 130 CMR 610.015(B) and Exhibit 2). Denial of assistance is valid grounds for appeal (see 130 CMR 610.032).

The record in this appeal was left open until September 3, 2019 for the appellant to provide additional documentation. MassHealth was given until September 10, 2019 to review and respond to the appellant's submission, but responded on September 3, 2019 and the record was closed.

Action Taken by MassHealth

MassHealth denied the appellant's application for MassHealth benefits because MassHealth determined that the appellant gave away or sold assets to become eligible for MassHealth long-term-care benefits and had more countable income than allowed.

Issue

The appeal issue is whether MassHealth was correct in determining that the appellant had more countable income than allowed and improperly transferred assets to qualify for MassHealth benefits.

Summary of Evidence

The MassHealth representative testified that the appellant is over 65-years-old and has a spouse in the community. He was admitted to the facility on July 10, 2018 and the facility is requesting a start date of February 1, 2019. MassHealth received an application for long-term care benefits on March 13, 2019. The first request for information was sent out on March 26, 2019 and the application was denied on May 1, 2019 for failure to submit verifications. An appeal request was received along with the requested documents on June 3, 2019. The case was re-logged and the appeal was withdrawn with MassHealth honoring the March 13, 2019 application date. The application was then denied on July 15, 2019 for a resource transfer. There are three annuities that do not comply with the regulations and are within the five-year look-back period. One annuity is in the appellant's name, dated June 2016 for the amount of $122,329. The other two are in the spouse's name, one dated June 2016 for $139,688.52 and a second on December 12, 2018 for $352,000.

The appellant's attorney testified at hearing and submitted a legal memorandum. She testified that the requested start date should be December 15, 2018, which she argued was the first day the appellant was below the asset limit and his spouse came within the community spouse limit (but for the annuities). She argued that MassHealth incorrectly calculated the appellant's income by counting his monthly Veterans' Affairs (VA) pension with aid and attendance as income. She stated that the appellant notified the VA about his pending long-term care application and requested that his VA pension benefit reduce from $2,320 per month to $90 per month, which is the maximum permitted when a VA pension beneficiary is receiving Medicaid in a skilled nursing facility. The appellant also requested that the VA send income verification to MassHealth. The appellant's attorney stated that, as 100% of his VA pension is considered aid and attendance, it is not countable income pursuant to the MassHealth regulations.

The appellant's attorney then argued that the annuities were purchased for the sole benefit of the community spouse and are therefore neither countable assets nor disqualifying transfers pursuant to 42 U.S.C. § 1396p(c)(1), as well as the corresponding MassHealth regulation 130 CMR 520.019(D)(1) and (2). The regulations state that transfers made by the institutionalized spouse either directly to the community spouse, or to another for the sole benefit of the community spouse, are exempt from being deemed disqualifying transfers. She stated that the two annuities in the spouse's name were qualifying annuities with no cash surrender value and generate monthly income that is payable solely to the spouse; therefore, they should not be subject to spend down for the appellant's care costs. The appellant's attorney argued that "the annuity was not required to comply

with the beneficiary designation requirements of [42 U.S.C.] § 1396p(c)(1)(F)[1], which mandates that the state be named as remainder beneficiary of an annuity that does not otherwise comply with the 'sole benefit' rule at § 1396p(c)(2)(B)(i).

The MassHealth representative responded that whether the annuity is in the appellant's name or the spouse's, all three needed to have the Commonwealth of Massachusetts named in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual. She provided a copy of Eligibility Operations Memo 16-06 dated September 15, 2016, which provided additional guidance for the regulations at 130 CMR 520.007(J)(2), governing annuity transactions occurring on or after February 8, 2006. It states the following:

> Federal Medicaid law at 42 U.S.C. 1396p(c)(1)(F) requires that the Commonwealth of Massachusetts is named as the remainder beneficiary in the proper position for annuity transactions that occur on or after February 8, 2006…
>
> The naming of the Commonwealth of Massachusetts in the proper position for annuity transactions is applicable to annuity transactions in which the applicant, member, or community spouse is named as an annuitant. Failure to comply with these requirements at 130 CMR 520.007(J)(2) including the failure to maintain the Commonwealth of Massachusetts as the beneficiary of the annuity may result in the denial or termination of long-term care benefits and the need to repay any MassHealth benefits obtained during the time that this requirement was not satisfied.

The record in the appeal was left open until September 3, 2019 for the appellant to provide the most current copy of the annuities listing the beneficiaries. MassHealth was given until September 10, 2019 to respond.

The appellant's attorney responded on September 3, 2019 with copies of the beneficiary change forms that were faxed to the annuity company on July 17, 2019. These show that for the annuity in the appellant's name, the spouse is the primary beneficiary and the "Commonwealth of Massachusetts for the total amount of medical assistance paid on behalf of the institutionalized individual" is listed as the remainder (or contingent) beneficiary. For the two annuities in the spouse's name, the appellant's grown children are listed as the primary beneficiaries and no remainder beneficiary is named. The appellant's attorney stated that, if it would satisfy MassHealth, she would be willing to change the primary beneficiaries on both of the spouse's annuities to the "Commonwealth of Massachusetts up to the total amount of medical assistance paid on behalf of [the spouse]" and list their children in the contingent beneficiary position.

---

[1] 42 U.S.C. 1396p(c)(1)(F) states that the purchase of an annuity will be treated as a disqualifying transfer of resources 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 disposes of any such remainder for less than fair market value."

MassHealth responded on September 3, 2019 that the updated beneficiary information does not change MassHealth's position regarding disqualifying transfers. She stated that the spouse's annuities must also have the Commonwealth of Massachusetts in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual, pursuant to 130 CMR 520.007(J)(2)(a)(i).

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant is over 65 years old, resides in a long-term care facility, and has a spouse in the community (Testimony).

2. MassHealth received an application for long-term care benefits on March 13, 2019 (Testimony).

3. MassHealth issued a request for information on March 26, 2019 and the application was denied on May 1, 2019 for failure to submit verifications. An appeal request was received along with the requested documents on June 3, 2019. The case was re-logged and that appeal was withdrawn with MassHealth honoring the March 13, 2019 application (Testimony and Exhibit 9).

4. The application was then denied on July 15, 2019 for a resource transfer, which is the subject of this appeal and based on the March 13, 2019 application date (Testimony and Exhibits 1 and 9).

5. The appellant and his spouse purchased three annuities within the five-year look back period (Testimony).

6. An annuity, dated June 2016 in the amount of $122,329, is in the appellant's name (Testimony).

7. An annuity, dated June 2016 in the amount of $139,688.52, is in the spouse's name (Testimony).

8. An annuity dated December 2018 in the amount of $352,000, is in the spouse's name (Testimony).

9. All three annuities have no cash surrender value (Exhibit 4).

10. The annuities in the spouse's name generate monthly income that is payable solely to the spouse (Exhibit 4).

11. The appellant receives a VA pension, all of which is considered aid and attendance (Testimony

and Exhibit 4).

12. The appellant's annuity lists the spouse as the primary beneficiary and the "Commonwealth of Massachusetts for the total amount of medical assistance paid on behalf of the institutionalized individual" as the remainder (or contingent) beneficiary in the first position.

13. The two annuities in the spouse's name list the appellant's grown children as the primary beneficiaries and no remainder beneficiary.

14. Eligibility Operations Memo 16-06 dated September 15, 2016 states that "[t]he naming of the Commonwealth of Massachusetts in the proper position for annuity transactions is applicable to annuity transactions in which **the applicant, member, or community spouse** is named as an annuitant." (Emphasis added). (Exhibit 5).

Analysis and Conclusions of Law

An applicant for MassHealth benefits has the burden to prove his or her eligibility, including that a transfer of resources was legitimate, not gratuitous, or for less than fair market value. 130 CMR 515.001, 520.007; and G.L. ch. 118E, § 20. MassHealth considers any transfer during the appropriate look-back period by **the nursing-facility resident or spouse** of a resource, or interest in a resource, owned by or available to the nursing-facility resident . . . for less than fair-market value a disqualifying transfer unless listed as permissible in 130 CMR 520.019(D), identified in 130 CMR 520.019(F), or exempted in 130 CMR 520.019(J). A disqualifying transfer may include any action taken which would result in making a formerly available asset no longer available. 130 CMR 520.019(C).

Permissible transfers, in relevant parts, are described in 130 CMR 520.019(D) as follows:

> The MassHealth agency considers the following transfers permissible. Transfers of resources made for the sole benefit of a particular person must be in accordance with federal law.
>
> (1) The resources were transferred to the spouse of the nursing-facility resident or to another for the sole benefit of the spouse. A nursing-facility resident who has been determined eligible for MassHealth agency payment of nursing-facility services and who has received an asset assessment from the MassHealth agency must make any necessary transfers within 90 days after the date of the notice of approval for MassHealth in accordance with 130 CMR 520.016(B)(3).
>
> (2) The resources were transferred from the spouse of the nursing-facility resident to another for the sole benefit of the spouse.

In addition to the permissible transfers described at 130 CMR 520.019(D), MassHealth will not impose a period of ineligibility for transferring resources at less than fair market value if the resident demonstrates to MassHealth's satisfaction that the resources were transferred

exclusively for a purpose other than to qualify for MassHealth, or the resident intended to dispose of the resource at either fair market value or for other valuable consideration. 130 CMR 520.019(F). Under Federal law, an applicant must make a heightened evidentiary showing on this issue: "Verbal assurances that the individual was not considering Medicaid when the asset was disposed of are not sufficient. Rather, convincing evidence must be presented as to the specific purpose for which the asset was transferred." Gauthier v. Dir., Office of Medicaid, 80 Mass.App.Ct. 777, 785 (2011) (citing State Medicaid Manual, Health Care Financing Administration Transmittal No. 64, § 3258.10(C)(2)). The appellant has not met this burden.

130 CMR 520.007 states the following regarding countable assets:

> Countable assets are all assets that must be included in the determination of eligibility. Countable assets include assets to which **the applicant or member or his or her spouse** would be entitled whether or not these assets are actually received when failure to receive such assets results from the action or inaction of the applicant, member, spouse, or person acting on his or her behalf…

(Emphasis added).

Furthermore, 130 CMR 520.007(J) states the following regarding annuities:

> (1) Treatment of Annuities Established Before February 8, 2006. Payments from an annuity are countable income in accordance with 130 CMR 520.009. If the annuity can be converted to a lump sum, the lump sum, less any penalties or costs of converting to a lump sum, is a countable asset. Purchase of an annuity is a disqualifying transfer of assets for nursing-facility residents as defined at 130 CMR 515.001: *Definition of Terms* in the following situations:
>
> (a) when the beneficiary is other than the applicant, member, or spouse;
>
> (b) when the beneficiary is the applicant, member, or spouse and when the total present value of projected payments from the annuity is less than the value of the transferred asset (purchase price). In this case, the MassHealth agency determines the amount of the disqualifying transfer based on the actuarial value of the annuity compared to the beneficiary's life expectancy using the life-expectancy tables as determined by the MassHealth agency, giving due weight to the life-expectancy tables of institutions in the business of providing annuities;
>
> (c) when the terms of the annuity postpone payment beyond 60 days, the MassHealth agency will treat the annuity as a disqualifying transfer of assets until the payment start date; or
>
> (d) when the terms of the annuity provide for unequal payments, the MassHealth agency may treat the annuity as a disqualifying transfer of assets. Commercial annuity payments that vary solely as a result of a variable rate of interest are not considered unequal payments under

130 CMR 520.007(J)(1)(d).

(2) Treatment of Annuities Established on or after February 8, 2006. In addition to the requirements in 130 CMR 520.007(J)(1), the following conditions must be met.

(a) The purchase of an annuity will be considered a disqualifying transfer of assets unless

(i) the Commonwealth of Massachusetts 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;

(ii) the Commonwealth of Massachusetts is named as such a remainder beneficiary in the second position after the community spouse, or minor or disabled children; or

(iii) the Commonwealth of Massachusetts is named as such a remainder beneficiary in the first position if the community spouse or the representative of any minor or disabled children in 130 CMR 520.007(J)(2)(a)(ii) disposes of any such remainder for less than fair-market value.

(b) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(1) and (J)(2)(a) and is irrevocable and nonassignable, or unless the annuity satisfies 130 CMR 520.007(J)(2)(c).

(c) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(2)(b), or unless the annuity names the Commonwealth of Massachusetts as a beneficiary as required under 130 CMR 520.007(J)(2)(a) and the annuity is

(i) described in section 408(b) or (q) of the Internal Revenue Code of 1986;

(ii) purchased with the proceeds from an account or trust described in section 408(a), (c), or (p) of the Internal Revenue Code of 1986;

(iii) purchased with the proceeds from a simplified employee pension described in section 408(k) of the Internal Revenue Code of 1986; or

(iv) purchased with the proceeds from a Roth IRA described in section 408A of the Internal Revenue Code of 1986.

Additionally, pursuant to 520.015(E), "veterans' aid and attendance benefits, unreimbursed medical expenses, housebound benefits, enhanced benefits ($90 Veterans' Administration pension to long-term-care facility residents, including veterans...)..." are considered noncountable income when determining the financial eligibility of an applicant or member.

As the appellant's VA pension is considered aid and attendance, that portion of his income should not be counted and the appeal is approved as to MassHealth's incorrect calculation of the appellant's income.

The annuity in the appellant's name lists the spouse as the primary beneficiary and the "Commonwealth of Massachusetts for the total amount of medical assistance paid on behalf of the institutionalized individual" as the remainder (or contingent) beneficiary in the first position. Therefore, the annuity in the appellant's name complies with 130 CMR 520.007(J)(2)(a)(i) and is not a disqualifying transfer. The appeal is approved as to that annuity.

In the case of the spouse's annuities, the resources were transferred solely for her benefit; however, to avoid being a disqualifying transfer, the annuities still need to comply with 130 CMR 520.007(J). Read with the Eligibility Operations Memo 16-06, 130 CMR 520.007(J) requires that the Commonwealth of Massachusetts be named in the proper position for "annuity transactions in which the applicant, member, or **community spouse** is named as the annuitant." (Emphasis added). As they are currently designated (with the spouse's adult children as the primary beneficiary and no remainder beneficiaries), the spouse's annuities do not meet the requirements of 130 CMR 520.007(J). Therefore, the appeal is denied as to the spouse's annuities.[2]

Order for MassHealth

Issue a new determination based upon the annuity in the appellant's name being neither a countable asset nor a disqualifying transfer and the annuities in the appellant's spouse's name being a disqualifying transfer. Re-determine income not counting the appellant's VA Pension.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

[2] Based on 130 CMR 120.007(J)(2)(a)(ii), the appellant could cure these transfers by naming the Commonwealth of Massachusetts as the remainder beneficiary in the second position after the appellant's community spouse. If this is the case, neither the regulation nor the Operations Memo requires that the benefits be paid "for at least the total amount of medical assistance paid on behalf of the institutionalized individual." It only needs to name the Commonwealth of Massachusetts. Alternatively, pursuant to 130 CMR 120.007(J)(2)(a)(i), the appellant could cure the transfer by naming the Commonwealth of Massachusetts as the remainder beneficiary in the first position, but if the appellant does this, the regulation requires that it be "for at least the total amount of medical assistance paid on behalf of the institutionalized individual."

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Alexandra Shube
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: Sylvia Tiar, Tewksbury MassHealth Enrollment Center, 367 East Street, Tewksbury, MA, 01876-1957

Julie Low, Esq., Law Office of Julie Low, 4 Federal Stret, Beverly, MA 01915

Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

John E. Jackson
3 Savage Avenue
Billerica, MA 01821

Appeal Decision: Denied Appeal Number: 2009714

Decision Date: FEB 12 2024 Hearing Date: 11/30/2023

Hearing Officer: Christopher James Record Open to: 12/28/2023

Appearance for Appellant:
James Miller, Esq.
Patricia Jackson – POA

Appearance for MassHealth:
Ian Tincknell – Tewksbury Intake
Paul O'Neill, Esq. – Legal

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	LTC – Transfer
Decision Date:	FEB 1 2 2021	**Hearing Date:**	11/18/2020
MassHealth's Rep.:	Stan Finch, Jeff Paul, O'Neil, Esq.	**Appellant's Rep.:**	James Miller, Esq., Daughter
Hearing Location:	Tewksbury MassHealth Enrollment Center – Remote		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated July 28, 2020, MassHealth denied the appellant's eligibility for MassHealth long-term-care benefits from June 1, 2020 through April 28, 2025 because MassHealth determined that the appellant had improperly transferred resources to qualify for MassHealth. Exhibit 2; 130 CMR 520.018, 520.019. The appellant filed this timely appeal on August 4, 2020. Exhibit 2; 130 CMR 610.015(B). Denial of assistance is valid grounds for appeal. 130 CMR 610.032.

The hearing record was left open until December 28, 2020 to allow the appellant an opportunity to reply to MassHealth's legal memorandum and exhibits submitted the day of the hearing, and for MassHealth to address new issues raised by the appellant.

Action Taken by MassHealth

MassHealth denied the appellant's application for long-term-care benefits because marital assets were used to purchase an annuity for which the Commonwealth of Massachusetts was named as the primary beneficiary only to the extent that benefits are paid on behalf of the community spouse.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 520.007(J) and 520.019, in determining that annuities purchased by the community spouse must name MassHealth as the beneficiary in the first position to the extent benefits are paid for the institutionalized spouse.

Summary of Evidence

The appellant applied for long-term-care benefits on June 2, 2020, and benefits are requested to start as of June 1, 2020. This application was denied on July 28, 2020 because: "You recently gave away or sold assets to become eligible for MassHealth long-term-care services. 130 CMR 520.018 520.019." The notice went on to calculate "a period of ineligibility from 06/01/2020 to 04/28/2025." The notice itself does not otherwise identify the basis of the disqualifying transfer. MassHealth's intake worker emailed the appellant's attorney on the same day explaining the denial was based on "a significant resource transfer for the three annuities purchased for [the community spouse]. I spoke with my manager and supervisor about this and they tell me there has been no change in our policy regarding annuity beneficiary language."

The parties agree to the following facts. The three annuities were for $381,522.61; $232,450.00; and $44,000.00.[1] They were purchased from a commercial financial company shortly before the appellant requested Medicaid benefits, and each annuity includes the following language regarding the remainder beneficiary in the first position: "The Commonwealth of Massachusetts to the extent benefits paid for [the community spouse]." The appellant's children are named as the contingent remainder beneficiaries after the Commonwealth. The parties agree that these annuities are actuarially sound. MassHealth's legal department submitted a memorandum into the hearing record. The assets used to purchase these annuities had been the joint assets of the institutionalized and community spouses. The annuities were purchased to reduce the community spouse's assets to below the $130,640 community-spouse-resource allowance ("CSRA"). The appellant further conceded that the purpose of this transaction was to preserve assets so that they need not be spent on the institutionalized spouse's care.

MassHealth argues these annuities are disqualifying transfers because 130 CMR 520.007(J)(2)(a) requires all annuities owned by either spouse to name "the Commonwealth of Massachusetts… for at least the total amount of medical assistance paid on behalf **of the institutionalized individual.**" Because the annuities only named the Commonwealth as a beneficiary to the extent the community spouse received medical assistance paid for by the Commonwealth, MassHealth considered the purchase of these annuities to be disqualifying transfer. The average daily rate for nursing facilities in Massachusetts was $367.21; the total value of the annuities purchased was $657,972.61, which results in a 1,792-day period of ineligibility.

[1] These annuities are included in MassHealth's exhibits at 4E–4F, 4B–4D, and 4G, respectively.

The appellant raises two legal challenges to MassHealth's decision. First is a procedural argument that the appellant's due process rights were violated because MassHealth's notice did not adequately explain the legal and factual bases for the denial. Relying on a judgment issued in the ongoing litigation in Maas v. Sudders, Sup. Ct. CA Nos. 18-129-D, 18-845-D (Wilkins, J. June 22, 2018), the appellant argued that MassHealth's notice was deficient and therefore the application should be approved. The appellant's attorney acknowledged that the email sent to his firm provided him with the needed information, but he felt that this information needed to be included in MassHealth's published notice.

Second is a substantive argument that the annuities should not give rise to disqualifying transfers. The appellant argues transfers to community spouses are permissible transfers, the annuities are for the sole benefit of the community spouse, and the remainder beneficiary in the first position is the Commonwealth of Massachusetts as required by the law.[2] The relevant federal law involves 42 USC §§ 1396p(c)(1)(F) and (c)(2)(B). Subparagraph (1)(F), sets forth a general rule that any annuity purchased by an individual or their spouse shall be treated as a disqualifying transfer 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 … ." Subparagraph (2)(B) is referred to as the "sole benefit" exception, and it states that paragraph (1) does not apply if assets are transferred "for the sole benefit of the individual's spouse."

The appellant submitted Dermody v. EOHHS, 36 Mass. L. Rptr. 183, 2020 WL 742194 (Mass. Super. Ct. 2020) (Unpub.), an unpublished superior court decision that analyzes the interplay between 42 USC § 1396p(c)(1)(F) and § 1396p(c)(2)(B). Relying on Hughes v. McCarthy, 734 F. 3d 473 (6th Cir. 2013), Dermody held that the "unambiguous, plain language" of paragraph (c)(2)(B) exempts all spousal transfers for the "sole benefit" of the community spouse, even if the result would have given rise to a disqualifying transfer under paragraph (c)(1)(F).

MassHealth's legal representative argued that neither of these cases are binding authority in this jurisdiction. MassHealth filed for interlocutory appeal on Dermody, but as there are other issues on dispute in that appeal and the appellant objected to the interlocutory appeal, the issue has yet to be raised before the Appeals Court. MassHealth relies upon its regulation, 130 CMR 520.007(J)(2)(a)(i), which requires the "institutionalized spouse" be the party for whom the Commonwealth be reimbursed from any remainder. MassHealth notes that the annuity rules are newer rules created by Congress to reduce the ability of people with means from preserving their assets from being used for long-term-care expenses. Furthermore, the Centers for Medicare and Medicaid ("CMS") issued detailed guidance at the time of the DRA's passage confirming that all spousal annuities must name the Commonwealth as the primary remainder beneficiary for benefits paid for the institutionalized spouse. CMS Section 6012 Changes in Medicaid Annuity Rules Under the Deficit Reduction Act, July 27, 2006. MassHealth has also published its own formal

[2] The appellant's memorandum appears to argue that MassHealth's regulations are improperly more restrictive than the federal law, but only sets out the legal standard that the state rules may not be more restrictive than the federal rules. See Exhibit 3, pp. 7-12.

interpretation of its regulations agreeing with this position. Eligibility Operations Memo 16-06 (Sept. 15, 2016).

In addition to failing to satisfy the annuity rules, MassHealth argues that the structure of these transactions does not satisfy the "sole benefit" rule of 130 CMR 520.019(D). MassHealth notes that CMS guidance on this issue, § 3257(B)(6) of the Medicaid Manual, requires the transfer to be "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 transfer or at any time in the future." Because the annuities list the appellant's children as contingent remainder beneficiaries, MassHealth argues that the "sole benefit" exception would not apply, even if it did exempt the annuities from the annuity specific transfer rules.

Finally, MassHealth argues that the appellant's arguments raise a conflict of law issue that may only be addressed as Superior Court. This requires the fair hearing decision to uphold the agency's position to preserve the issue for appellant review pursuant to 130 CMR 610.082(C).

The record was left open for the appellant to reply to MassHealth's arguments at the hearing. In their reply brief, the appellant argues that the "sole benefit" rule merely requires the annuity be actuarially sound for the community spouse's lifetime, citing the State Medicaid Manual, § 3257.B.6 and Hughes, 734 F. 3d at 483. The appellant notes that the Federal Department of Health & Human Services ("HHS") filed an amicus brief in Hughes, which agreed that the designation of contingent beneficiaries "would not necessarily violate the sole-benefit rule." Hughes reasoned that any annuity would implicitly include a contingent beneficiary, even if not named, otherwise any remainder would revert to the annuity company, escheat to the state, or pass according to the state's intestacy laws. The court ultimately held the "sole benefit" exception exempted any actuarially sound annuity where the annuitant was the community spouse.

The appellant also argues that MassHealth's erroneously applies the definition of "institutionalized individual" to the "institutionalized spouse." The appellant notes the definition of "institutionalized individual" does not include the word spouse, therefore it should not be read into the term in the context of the annuity provision. Because the community spouse here is not institutionalized, her annuity need not name the Commonwealth as the first beneficiary for her institutionalized spouse.

Finally, the appellant clarified that they did not believe the state regulations to conflict with the federal law. Rather, MassHealth's determination relies upon an incorrect interpretation of both federal and state law.

MassHealth requested additional time to file a response, but no response was received prior to the record close date.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant applied for long-term-care benefits on June 2, 2020, and benefits are requested to start as of June 1, 2020. Testimony by MEC representative; Exhibits 3; 4.

2. This application was denied on July 28, 2020 because: "You recently gave away or sold assets to become eligible for MassHealth long-term-care services. 130 CMR 520.018 520.019." The notice went on to calculate "a period of ineligibility from 06/01/2020 to 04/28/2025." Exhibits 2; 3A; 4A.

3. The MassHealth's intake worker emailed the appellant's attorney on the same day, explaining the denial was based on "a significant resource transfer for the three annuities purchased for [the community spouse]. I spoke with my manager and supervisor about this and they tell me there has been no change in our policy regarding annuity beneficiary language." Exhibit 4N.

4. The three annuities were for purchased for $381,522.61; $232,450.00; and $44,000.00. They are actuarially sound annuities with regards to the community spouse's life expectancy. Each annuity includes the following primary beneficiary designation: "The Commonwealth of Massachusetts to the extent benefits paid for [the community spouse]." The appellant's children are named as the contingent remainder beneficiaries after the Commonwealth. Testimony by appellant's and MassHealth's representatives; Exhibits 4B-4G.

5. The assets used to purchase these annuities had been the joint assets of the institutionalized and community spouses. The annuities were purchased to reduce the community spouse's assets to below the CSRA for the purpose of preserving assets so that they need not be spent on the institutionalized spouse's care. Testimony by the appellant's representatives.

6. The average daily rate for nursing facilities in Massachusetts was $367.21; the total value of the annuities purchased was $657,972.61, which results in a 1792-day period of ineligibility. Exhibit 3.

7. Following the hearing, the record was left open for additional legal arguments. The appellant submitted a reply memorandum on December 9. On December 15, MassHealth requested additional time to file its response. No further response was filed. Exhibit 5.

Analysis and Conclusions of Law

Adequate Notice

The appellant argues that MassHealth has failed to provide adequate notice in accordance with federal law because MassHealth's notice did not provide "[a] clear statement of the specific reasons

supporting the intended action" and did not cite the "[t]he specific regulations that support... the action." 42 CFR § 431.210(b)-(c); see also Maas v. Sudders, Sup. Ct. CA Nos. 18-129-D, 18-845-D (Wilkins, J. June 22, 2018). Particularly, the appellant notes that the MassHealth notice does not identify the factual basis for the disqualifying transfers found. MassHealth does not strongly dispute this matter. At the hearing, the agency acknowledged that it is undergoing a review of its disqualifying transfer denials with an eye on including more detailed information. However, with regards to this case, MassHealth argues that the appellant's rights were not infringed because they were provided with actual notice through email and telephone conversations.

The appellant is correct that the formal notice issued by MassHealth is technically inadequate. However, it does not follow that their substantive case should be approved for this reason. Generally, any prejudice caused by inadequate notice can be alleviated by requiring either appropriate notice to be issued by the agency or to otherwise ensure that the appellant is afforded the opportunity to adequately respond to the agency's undisclosed reasoning. In Maas, for instance, the allowed relief was an order that the agency re-issue adequate notice. See Exhibit 3B. Such a procedural outcome would only create further delay in addressing the substantive questions, to which the appellant was provided **actual** notice.

Annuities as Disqualifying Transfers

An applicant for MassHealth benefits has the burden to prove his or her eligibility, including that a transfer of resources was legitimate, not gratuitous, or for less than fair market value. 130 CMR 515.001, 520.007; and MGL Ch. 118E, § 20. If an applicant or member has transferred resources for less than fair-market value, MassHealth long-term-care benefits may not be paid until a period of ineligibility has been imposed and expires. See 42 USC §1396p(c)(1)(A); MGL Ch. 118E, § 28. This prohibition on transfers for less than fair-market value has existed as part of the federal Medicaid Statute since at least 1993:

> **(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 title, the State plan must provide that if 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 ... .

42 USC § 1396p(c)(1)(A); see also The State Medicaid Manual, § 3258.11 (Nov. 1994).

The DRA was passed in 2005, in part, to restrict the use of annuities in sheltering assets when qualifying for Medicaid. See CMS Section 6012 Changes in Medicaid Annuity Rules Under the Deficit Reduction Act, July 27, 2006 (Exhibit 4I). The original language of the annuity provision stated:

> (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 annuitant** under this title; 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.

Public Law 109-171: Deficit Reduction Act of 2005. (120 Stat. 63; Date: 2/8/06) (**emphasis added**).

HHS published guidance shortly after the DRA's passage, on July 27, 2006, explaining the "DRA adds new provisions to section 1917, which include: ... [t]he requirement to name the State as a remainder beneficiary in annuities in which the applicant or spouse is the annuitant ... ." Exhibit 4I. The guidance highlights the difference between subsections (c)(1)(F) and (c)(1)(G):

> Unlike the new section 1917(c)(1)(G) added by section 6012(c) of the DRA ... section 1917(c)(1)(F) does not restrict application of its requirements only to an annuity purchased by or on behalf of an annuitant who has applied for medical assistance ... . Therefore, we interpret section 19171(c)(1)(F) as applying to annuities purchased by an applicant or by a spouse, or to transaction made by the applicant or spouse.

CMS Section 6012 Changes in Medicaid Annuity Rules Under the Deficit Reduction Act, § II.B, July 27, 2006.

Important to this appeal, Congress amended the statute again shortly after the DRA to "substitute 'institutionalized individual' for 'annuitant'" in subsection (c)(1)(F):

(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 USC § 1396p(c)(1)(A), (F) (**emphasis added**); see also Public Law 109-432: Tax Relief and Health Care Act of 2006. (120 Stat. 2998; Date: 12/20/06).

MassHealth's regulations were updated to reflect these changes, but MassHealth did not publish guidance until 2016.[3] MassHealth's guidance mirrors HHS's sentiment: "The naming of the Commonwealth of Massachusetts in the proper position for annuity transactions is applicable to annuity transactions in which the applicant, member, or community spouse is named as an annuitant." EOM 16-06 (Sept. 15, 2016). Therefore, both HHS and MassHealth have long required that annuities name the Commonwealth in the first position to the extent medical benefits are paid on behalf of the "institutionalized spouse," regardless of whether the annuitant (person receiving the income) is the institutionalized spouse or the community spouse.

The Sole Benefit Exclusion

The appellant's contention arises from § 1396p(c)(2):

> (2) 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,**
>
> (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) of this section) established solely for the benefit of, the individual's child described in subparagraph

[3] MassHealth's regulations state:

> (2) Treatment of Annuities Established on or after February 8, 2006. In addition to the requirements in 130 CMR 520.007(J)(1), the following conditions must be met.
>
> (a) The purchase of an annuity will be considered a disqualifying transfer of assets unless
>
> 1. the Commonwealth of Massachusetts 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**;
>
> ...
>
> (b) The purchase of an annuity is considered a disqualifying transfer of assets unless the annuity satisfies 130 CMR 520.007(J)(1) and (2)(a) and is irrevocable and nonassignable, or unless the annuity satisfies 130 CMR 520.007(J)(2)(c).
>
> ...
>
> (5) Additional Regulations About Transfers of Assets. Transfers of assets are further governed by 130 CMR 520.018 and 520.019.

130 CMR 520.007(J)(2).

(A)(ii)(II), or

(iv) were transferred to a trust (including a trust described in subsection (d)(4) of this section) 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);

42 USC § 1396p(c)(2)(B) (emphasis added).

The appellant's position has considerable support for their position from Dermody v. EOHHS, 36 Mass. L. Rptr. 183, 2020 WL 742194 (Mass. Super. Ct. 2020) (Unpub.) (Exhibit , an unpublished superior court decision and Hughes v. McCarthy, 734 F. 3d 473 (6th Cir. 2013). These cases hold that § 1396p(d)(2)(B) exempts transfers "for the sole benefit of the individual's spouse" from being treated as a disqualifying transfer under § 1396p(d)(1).[4] These decisions, and HHS, agree that an annuity satisfies the definition as being "for the sole benefit" of a community spouse if it is actuarially sound (will only make payments to the community spouse for the duration of their life expectancy). See Hughes, 734 F. 3d at 481-83; Mertz v. Houstoun, 155 F.Supp.2d 415, 426 n.14 (E.D. Pa. 2001); see also *The State Medicaid Manual*, §§ 3257.B.6 (Nov. 1994).

MassHealth cites Hobbs ex rel. Hobbs v. Zenderman, 579 F. 3d 1171 (10th Cir. 2009) to support its argument that contingent beneficiaries violate the "sole benefit" requirement. That case deals with a trust that made payments to the Medicaid applicant's family members for caring for them. In Hughes, HHS's amicus brief agreed that an annuity may have contingent beneficiaries if it is structured to make payments only to the annuitant for their actuarial lifetime. 734 F. 3d at 481-83; The State Medicaid Manual, §§ 3258.11 (the sole benefit rule requires "any funds transferred be spent for the benefit of the spouse within a time-frame actuarially commensurate with the spouse's life expectancy."). MassHealth published guidance of its own on this issue, therefore all published guidance concurs that an actuarially sound annuity is for the "sole benefit" of the annuitant.

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[4] MassHealth's regulations do not conflict with this reading of the federal law:

> (C) Disqualifying Transfer of Resources. The MassHealth agency considers any transfer during the appropriate look-back period by the nursing-facility resident or spouse of a resource, or interest in a resource, owned by or available to the nursing-facility resident or the spouse ... for less than fair-market value a disqualifying transfer unless listed as permissible in 130 CMR 520.019(D), identified in 130 CMR 520.019(F), or exempted in 130 CMR 520.019(J). ...
>
> (D) Permissible Transfers. The MassHealth agency considers the following transfers permissible. Transfers of resources made for the sole benefit of a particular person must be in accordance with federal law.
>
> (1) The resources were transferred to the spouse of the nursing-facility resident or to another for the sole benefit of the spouse. ...
>
> (2) The resources were transferred from the spouse of the nursing-facility resident to another for the sole benefit of the spouse.

130 CMR 520.0019(C)-(D)(2).

Does the Annuity Rule Apply to the "Sole Benefit" Exclusion?

The remaining legal dispute is whether an annuity, which is structured to be for the sole benefit of a community spouse, must also satisfy the annuity requirements of § 1396p(c)(1)(F). The appellant and Hughes present a compelling argument relying on the statutory language: "[t]he annuity rules under § 1396p(c)(1)(F) fall within § 1396p(c)(1)'s (paragraph (1)) overall transfer-penalty regime ... . On the other hand, § 1396p(c)(2)(B)(i) is an exception to transfer penalties under paragraph (1)." 734 F. 3d at 484. Therefore, because the annuity satisfies the "sole benefit" exclusion, the annuity rules in paragraph (1) cannot apply.

The remainder of the court's analysis is less satisfying. MassHealth and HHS have published, long-standing guidance that require the application of the annuity rules in paragraph (1) to paragraph (2). As noted above, HHS explains this discrepancy by pointing to the difference between the language in subparagraphs (c)(1)(F) and (c)(1)(G). Subparagraph (G) only applies to annuities purchased by the applicant.[5] Therefore, HHS has always interpreted subparagraph (F) as applying to annuities purchased by community spouses.[6] In Hughes, the state agency had also identified that subparagraph (F) was a more specific rule adopted after the older, general exclusion of paragraph (2) had been in effect.

Hughes concluded that HHS's guidance failed to acknowledge or address the structure of § 1396p(c), therefore it found "HHS's rationale lacks reasoning and contravenes the plain language" of the statute. 734 F. 3d at 485. Because the court found the agencies interpretations unpersuasive, the Hughes did not afford the agencies' interpretations deference under Skidmore v. Swift & Co., 323 US 134 (1944).

The court also dismissed the state agency's argument that subparagraph (F) provided a more specific, later adopted rule to the general exception of paragraph (2).

> Although 'it is axiomatic that a general provision yields to a specific provision when there is a conflict,' ... there 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

[5] " 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 ... ." 42 USC § 1396p(c)(1)(G) (**emphasis added**).

[6] The amendments made by the Tax Relief and Health Care Act of 2006 also make clear that the State must be named as a beneficiary to the extent that benefits are paid on behalf of the "institutionalized spouse."

> part, the sole-benefit rule. The two provisions complement rather than contradict one another. Section 1396p(c)(1)(F) is not rendered illusory. It applies to all annuities not excepted by another provision such as § 1396p(c)(2)(B), including annuities benefiting non-exempt children or a spousal annuity that is not actuarially sound.

734 F. 3d at 485 (internal citations and footnotes excluded).

One difficulty with the court's conclusion is that § 1396p(c)(1)(F) is "rendered illusory" if it does not apply to annuities otherwise excluded by paragraph (2). The court notes that "all annuities not excepted by [paragraph (2)], including annuities benefiting non-exempt children or a spousal annuity that is not actuarially sound" are still governed by subparagraph (1)(F). Id. However, the statute as it existed prior to the DRA would have found these transactions to be disqualifying transfers. The requirement that a spousal annuity be actuarially sound exists in the "sole benefit" exclusion (paragraph (2)), not in the general transfer rule (paragraph (1)). Furthermore, any transfer to non-exempt children is a transfer regardless of whether it is an annuity because the applicant or spouse are receiving no consideration for their gift.

Another difficulty is the deference standard applied by the court. In Massachusetts,

> When an agency's interpretation is reasonable, we afford the agency 'considerable leeway' in interpreting a statute it is charged with enforcing, unless the statute unambiguously bars the agency's approach. We will not overturn an agency's interpretation of its own regulation and statutory mandate unless that 'interpretation is patently wrong, unreasonable, arbitrary, whimsical, or capricious.' Especially is this so when the case involves interpretation of a complex statutory and regulatory framework such as Medicaid.

Shelales v. Dir. of the Office of Medicaid, 75 Mass. App. Ct. 636, 640 (2009) (citations omitted). This deference is especially afforded to initial interpretation that have been consistently applied over time. See Cohen v. Comm'r of the Div. of Med. Asst., 423 Mass. 399, 411 n18 (1996). Finally, the Board of Hearings regulations require that a fair hearing decision "give due consideration to *Policy Memoranda* and any other MassHealth agency representations and materials containing legal rules, standards, policies, procedures, or interpretations as a source of guidance in applying a law or regulation." 130 CMR 610.082(C)(3).

Ultimately, I agree the requirements on annuities created by § 1396p(c)(1)(F) must apply to all annuities, regardless of § 1396p(c)(2).[7] The appellant shall have 90 days to amend the annuities to

[7] As a matter of law, I disagree with MassHealth's argument that its decision must be upheld based upon a conflict of law arguments. See 130 CMR 610.082(C)(2). The appellant's initial memorandum included headers alleging a conflict between state and federal laws, however the substance of their argument only claims a conflict with MassHealth's interpretation of the published law. Indeed, this case would have been far simpler if either HHS or MassHealth had codified their interpretations in regulations.

name MassHealth as the remainder beneficiary in the first position to the extent that medical benefits are paid **on behalf of the institutionalized spouse.**

Order for MassHealth

Allow the appellant 90 days to amend their annuities to be in accordance with the published interpretations of § 1396p(c)(1)-(2) and 130 CMR 520.007(J)(2).

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Christopher Jones

Christopher Jones
Hearing Officer
Board of Hearings

cc: Sylvia Tiar, Tewksbury MassHealth Enrollment Center
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MASSACHUSETTS Lawyers Weekly

State can't take annuity for spousal MassHealth costs

Judge upholds rights of contingent beneficiary

By: Pat Murphy January 23, 2020

The named beneficiary of a decedent's annuity is entitled to residual benefits pursuant to the terms of the annuity contract, notwithstanding the state's asserted entitlement to reimbursement for long-term care payments made by MassHealth on behalf of the annuitant's elderly spouse, a Superior Court judge has ruled.

Scores win for plaintiff

The plaintiff, Laurie A. Dermody, was the contingent beneficiary of an annuity contract purchased from Nationwide Insurance by her father, Robert Hamel. He designated the state Medicaid program as primary beneficiary to the "Extent Benefits Paid."

Upon Robert's death, the state claimed full residual benefits from the annuity despite the fact that he never applied for or received MassHealth benefits. The state staked its claim to the remainder of the annuity based on MassHealth's payment of nursing home costs incurred by the Robert's wife, Joan Hamel.

The plaintiff argued that her father's annuity was "actuarially sound" and therefore in compliance with the federal Medicaid Act's "sole benefit rule," 42 U.S.C. §1396(p)(c)(2)(B). Accordingly, the plaintiff argued that the annuity could not be penalized as a disqualifying transfer of assets, leaving the annuity contract to be enforced in accordance with its terms.

The state argued that a 2006 amendment to the Medicaid Act, 42 U.S.C. §1396(p)(c)(1)(F), required that the "Extent Benefits Paid" language in Robert's annuity contract be interpreted to encompass MassHealth payments on behalf of his institutionalized spouse. Thus, the state argued, it was entitled to the full remaining balance of the annuity.

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."

Moreover, the judge decided that the plaintiff was entitled to summary judgment on her claim that Nationwide breached her father's annuity contract. Barrett further denied in part Nationwide's motion for summary judgment with respect to the plaintiff's claims that the insurance company engaged in unfair and deceptive trade practices in violation of G.L.c. 93A, §2, and G.L.c. 176D, §3(9).

Big win for elder law bar

Lisa M. Neeley, who represented the plaintiff, said the decision is important because it is the first to address recent challenges by MassHealth to contingent beneficiary claims.

"In the past, MassHealth had never brought these challenges to spousal annuities," the Worcester attorney said.

According to Neeley, MassHealth abruptly changed its policy regarding spousal annuities about the time her client's case arose in 2017.

"There's been no clarification [of the new policy]," Neeley said. "Practitioners have been confused about how to advise their clients both when annuities are being purchased and in situations where the community spouse has died and MassHealth has asserted a lien."

Neeley said Judge Barrett properly interpreted the governing federal Medicaid law.

"My argument on how the statutes work together is, as long as the annuity is for the spouse's sole benefit, it doesn't need to have the state named as remainder beneficiary," Neeley said.

Fitchburg elder law attorney Emily S. Starr said Barrett reached the only result he could consistent with the language of the Medicaid statutes.

"It isn't required that the state be reimbursed if the annuity is actuarially sound," she said.

Dermody v. Executive Office of Health and Human Services, et al., Lawyers Weekly No. 12-002-20 (20 pages)

THE ISSUE: Is the named beneficiary of a decedent's annuity entitled to residual benefits pursuant to the terms of the annuity contract, notwithstanding the state's asserted entitlement to reimbursement for long-term care payments made by MassHealth on behalf of the annuitant's elderly spouse?

DECISION: Yes (Superior Court)

LAWYERS: Lisa M. Neeley of Mirick, O'Connell, Demallie & Lougee, Worcester (plaintiff)

Michael Somers of Executive Office of Health and Human Services, Boston (defendant EOHHS)

Matthew C. Welnicki of Melick & Porter, Boston (defendant Nationwide Financial Insurance Co.)

> "It had become open season on annuities. It's gratifying to have a judge who finally understood the issues and applied the law correctly."
>
> — Carol Cioe Klyman, Springfield

According to Carol Cioe Klyman, an elder law attorney in Springfield, the 2006 amendment to the Medicare Act did not change the law protecting the community spouse (the spouse that does not require care) and should not have

Wellesley attorney Patricia Keane Martin, who chairs the advocacy committee for the local chapter of the National Academy of Elder Law Attorneys, said one aspect of the decision that the bar should not overlook is that Barrett allowed breach of contract and unfair trade practice claims against Nationwide to go forward. Martin said she has been troubled by the "complicity" of insurance companies in "going along" with MassHealth requirements and payout demands.

"Nationwide seemingly didn't even scrutinize the accuracy of the demand from the commonwealth [in Dermody,]" she said. According to Martin, for Nationwide not to recognize that the annuity's beneficiary designation language was, at the very least, unclear was a "perfect example of how the insurance companies have made the situation worse."

The Executive Office of Health and Human Services did not respond to a request for comment prior to deadline. Defense counsel for Nationwide also did not respond to a request for comment.

MassHealth claim

According to court records, in July 2015 Robert Hamel purchased a single premium immediate annuity contract from Nationwide for $172,000. He designated the state's Medicaid program, MassHealth, as the primary beneficiary. The terms of the annuity provided that the state would be the primary recipient of residual benefits to the "Extent Benefits Paid." Robert listed the plaintiff as contingent beneficiary.

Two weeks after Robert purchased the annuity, his wife, Joan, applied for and ultimately received MassHealth long-term care benefits associated with her living in a nursing home.

Robert died in December 2016, and in June 2017 the MassHealth Estate Recovery Unit sent Nationwide a letter demanding payment of the balance of the annuity contract as reimbursement for benefits paid on Joan's behalf. Within 10 days of receiving the letter, Nationwide paid the state the full residual benefits under the annuity contract — $119,000.

In August 2017, the plaintiff sued the state, asserting that she was entitled to the balance of the contract as the named contingent beneficiary. The plaintiff subsequently amended her complaint to name Nationwide as a defendant, alleging the insurance company was liable for breach of contract as well as for violations of Chapters 93A and 176D.

Sole benefit rule given effect

The sole benefit rule stated in 42 U.S.C. §1396(p)(c)(2)(B) provides an exception to the disqualifying transfer rule, permitting asset transfers to a spouse or others so long as the transfer is for "the sole benefit" of the spouse. If assets are used to purchase an annuity, the transfer satisfies the sole benefit rule if the annuity is actuarially sound, meaning the expected return is in line with the annuitant's life expectancy.

The parties in Dermody did not dispute that Robert's annuity was actuarially sound. The parties' cross-motions for summary judgment required the court to reconcile two provisions of the federal Medicaid Act, specifically§1396(p)(c)(2)(B)'s sole benefit rule and §1396(p)(c)(1)(F), which was enacted by Congress in 2006 as part of a package of deficit reduction measures.

Section 1396(p)(c)(1)(F) provides in relevant part that 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."

The state argued that an annuity that satisfies the sole benefit rule must also satisfy §1396(p)(c)(1)(F).

Recognizing that the case raised an issue of first impression in Massachusetts, the judge noted that the question

"In essence, subparagraph (F) deems all annuity purchases a transfer of assets for less than the fair market value unless the state is named the primary beneficiary of the annuity," Barrett wrote. "However, subparagraph (F) clearly states that its effect is limited to 'this paragraph.'"

He pointed out that subparagraph (F) is in paragraph (1) of §1396(p)(c), while the sole benefit rule appears in paragraph (2). "Per the unambiguous plain language of these provisions, subparagraph (F) applies to all annuities not exempt by the sole benefit rule in paragraph (2)," Barrett wrote. "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). 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)."

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MASSACHUSETTS Lawyers Weekly

MassHealth notches key win on annuities

Judge: named beneficiary not entitled to funds

By: Pat Murphy June 17, 2021

The defendant's father had purchased an annuity prior to his death to make his wife eligible for MassHealth nursing home care.

The state is entitled to the residue of an annuity purchased by a husband prior to his death to make his wife eligible for MassHealth nursing home care benefits despite a claim to the proceeds by the couple's daughter as the named contingent beneficiary, a Superior Court judge has determined.

The daughter of Julius and Suzanne Breslouf, Jennifer Breslouf, argued that she was entitled to the proceeds of her father's annuity by operation of federal Medicaid law.

But Judge Debra A. Squires-Lee decided that the state is entitled to recover the amounts paid for Suzanne's nursing home care.

"Julius purchased the Annuity to remove half a million dollars from his and Suzanne's countable assets to make Suzanne eligible for MassHealth and have the Commonwealth pay for her nursing home care. That was permissible only so long as the annuity was irrevocable, actuarially sound, and the Commonwealth was the named remainder beneficiary pursuant to 42 U.S.C. §1396p(c)(1)(F)," Squires-Lee wrote.

The 25-page decision is American National Insurance Co. v. Breslouf, et al., Lawyers Weekly No. 12-020-21.

Superior Court split

The decision creates a split in the Superior Court with Judge C. William Barrett III having rejected the state's interpretation of the Medicaid statute in a 2020 case, Dermody v. The Executive Office of Health and Human Services.

In Dermody, Barrett concluded that the named beneficiary of a decedent's annuity is entitled to residual benefits pursuant to the terms of the annuity contract.

Worcester attorney Lisa M. Neeley represented the beneficiaries in both Dermody and Breslouf.

Dermody applied the correct statutory interpretation, Neeley said, noting that under the federal Medicaid statute, there are annuity beneficiary remainder requirements in favor of the state.

"But there's this clear exception under a separate paragraph that exempts that when you have a transfer for the community spouse's sole benefit," she said.

Neeley declined to say whether her client would appeal Breslouf, though she said the divide in the Superior Court signals a need for the Appeals Court to weigh in.

"It's obviously a complex issue," Neeley said. "The split among both the federal [circuit] courts and now the [state] trial courts just makes things more confusing in terms of what to advise clients."

Neeley pointed out that Julius Breslouf was not a wealthy client and that he was simply trying to protect his assets.

"The purpose of these annuities is being presented by the commonwealth as some sort of wealth preservation strategy," Neeley said. "But that's not what the purpose of an annuity is. It is really to provide for the community spouse during his or her lifetime."

She said Julius Breslouf paid out of pocket more than $500,000 for his own assisted living and nursing home care costs, with a large portion coming out of his annuity fund.

Pamela B. Greenfield, president of the Massachusetts chapter of the National Academy of Elder Law Attorneys, said the decision in Breslouf implicates important policy concerns.

"It's really important for our senior clients to be able to cover the cost of their own care and not to be impoverished by the cost of care of the institutionalized spouse," Greenfield said. "In this particular decision, there is the comment that while that's all well and good for the community spouse, the Medicaid laws are not set up for when it comes to passing on assets to the next generation."

According to Greenfield, Breslouf underscores the importance of informing clients that the law is unsettled when it comes to annuities.

"As long as the client is aware of what can go wrong here, we as practitioners have done our job," Greenfield said.

Springfield elder law attorney Carol Klyman said the ruling in Breslouf is troubling.

"I thought Dermody was spot on," Klyman said. "The judge's premise [in Breslouf] was that Congress didn't intend to immunize the community spouse annuities entirely from [the state's] recoupment of its costs for either the institutionalized spouse or for the community spouse should they become ill and need Medicaid."

According to Klyman, there is no statutory basis for reaching such a conclusion.

"The only thing clear about congressional intent with regard to Medicaid is that they don't want to deal with the issue of long-term care for the elderly and how to pay for it," she said.

Klyman pointed out that the estate recovery provisions in the Medicaid statute are draconian with regard to institutionalized spouses, but the opposite is true with respect to community spouses.

"If [an institutionalized spouse] has a probate estate, Massachusetts can come in and take everything," Klyman said. "But that doesn't apply to the community spouse. The community spouse can have all kinds of assets, but those assets are not subject to recoupment unless the community spouse goes on Medicaid."

MassHealth did not respond to a request for comment.

Annuity proceeds dispute

According to court records, Suzanne Breslouf entered a long-term nursing care facility in July 2017. At the time, Suzanne was 78 and the Bresloufs had approximately $699,000 in countable assets for Medicaid and MassHealth eligibility purposes.

In October 2017, Julius purchased an irrevocable annuity issued by American National Insurance Co. in the amount of $565,000 to spend down marital assets in anticipation of Suzanne's application for MassHealth benefits. The annuity provided Julius monthly payments of $9,500 for five years commencing in November 2017.

In accordance with MassHealth regulations, Julius designated the state as the primary remainder beneficiary of the annuity for the full amount of medical assistance paid for the care of his institutionalized spouse. Julius named Jennifer contingent beneficiary.

In November 2017, Suzanne submitted a MassHealth application for long-term benefits, disclosing the annuity purchased by Julius in accordance with state regulations. MassHealth approved Suzanne's application for benefits in March 2018, after she submitted the form required by state regulations certifying the commonwealth as the preferred remainder beneficiary of Julius's annuity.

When Julius died in April 2020, Jennifer submitted a claim with American National for the approximately $270,000 remaining in her father's annuity. MassHealth filed a competing claim, asserting it had paid the $98,745 in long-term care benefits on behalf of Suzanne Breslouf. American National filed an interpleader action in Superior Court to determine the parties' rights to the proceeds.

MassHealth prevails

Squires-Lee recognized that whether Jennifer had a right to any of the proceeds rested on the interplay of two provisions of the Medicaid statute: 42 U.S.C. §§1396p(c)(1)(F)(i) and 1396p(c)(2)(B)(1)(i).

In 2006, Congress amended the language of §1396p(c)(1)(F)(i) to provide that spouses may purchase an annuity to spend down their assets only if "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 original language of the statute authorized state recoupment for the amount of benefits paid on behalf of the "annuitant."

transferred to the individual's spouse or to another for the sole benefit of the individual's spouse."

In claiming entitlement to the proceeds of her father's annuity, Jennifer argued that §1396p(c)(2)(B)(i) created an exception to §1396p(c)(1)(F)(i)'s requirement that the state be designated remainder beneficiary for an annuity whenever the annuity is purchased for the sole benefit of a community spouse such as Julius.

Squires-Lee wrote that the federal appellate courts have been divided over the question of whether an annuity purchased for a community spouse must comply with §1396p(c)(1)(F)(i) by naming the state as a beneficiary entitled to recover the amounts paid for the institutionalized spouse.

In a 2012 decision, Hutcherson v. Arizona Health Care, the 9th U.S. Circuit Court of Appeals held that §1396p(c)(1)(F)(i) affords states the right to recover as a remainder beneficiary against a community spouse's annuity for an institutionalized spouse's medical costs.

THE ISSUE: *Is the state entitled to* the residue of an annuity purchased by a husband prior to his death to make his wife eligible for MassHealth nursing home care benefits even though the couple's daughter is the named contingent beneficiary?

DECISION: Yes (Suffolk Superior Court)

LAWYERS: William P. Rose of Melick & Porter, Boston (plaintiff)
Lisa M. Neeley of Mirick O'Connell, Worcester (defendant Jennifer Breslouf)
Katherine B. Dirks and Jesse Mohan Boodoo, of the Attorney General's Office (defendant commonwealth)

However, the 6th Circuit reached the opposite conclusion in a 2013 case, Hughes v. McCarthy, holding that an annuity that satisfies §1396p(c)(2)(B)(i) need not satisfy §1396p(c)(1)(F).

Squires-Lee noted that the Superior Court judge in Dermody was persuaded by the reasoning of the 6th Circuit in Hughes.

But she sided with MassHealth in adopting the reasoning of the 9th Circuit in Hutcherson. According to Squire-Lee, the 9th Circuit's interpretation was more consistent with the policies underlying the Medicaid statutory scheme.

"Although, section 1396p(c)(2)(B)(i) provides an exception to the look-back contained in subsection (c)(1), I do not believe Congress intended to immunize community spouse annuities entirely from the requirements of section 1396p(c)(1)(F)," Squires-Lee wrote. "Permitting a community spouse to purchase an annuity — thus spending down assets to create Medicaid eligibility for the institutionalized spouse — but name a third party as the beneficiary of the annuity in the event the community spouse's death would allow the community spouse potentially to shelter those assets without limitation."

Accordingly, the judge declared that MassHealth properly interpreted 42 U.S.C. §1396p(c)(1)(F) as applying to annuities for which the community spouse of an institutionalized individual is named as the annuitant.

In addition to concluding that the state is entitled to the proceeds of Julius's annuity to the extent of total benefits paid on behalf of Suzanne, the judge ruled the commonwealth's recovery is not limited to the amounts paid for Suzanne's care up to the date of Julius's death.

Accordingly, Squires-Lee ordered American National to direct to the state the remaining annuity benefit payments "to the extent of the total medical assistance paid by MassHealth on behalf of Suzanne."

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