APPENDIX A

SJC-13199

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

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

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

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

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

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

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

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

Lisa M. Neeley for the plaintiff.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

So ordered.

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