COMMONWEALTH OF MASSACHUSETTS

MIDDLESEX, ss.

SUPERIOR COURT
CIVIL ACTION
NO. 1781CV02342

LAURIE A. DERMODY

vs.

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

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

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

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.

1 Nationwide Financial Insurance Company.

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

Robert designated the "State of MA Medicaid Per Application" as the primary beneficiary. His annuity application provides that the Commonwealth shall be the primary recipient of residual benefits to the "Extent Benefits Paid." Robert listed the plaintiff as the contingent beneficiary.

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

On December 23, 2016, Robert died. At the time of his death, he was residing at the Langdon Place assisted living facility in Nashua, New Hampshire. On December 29, 2016, Nationwide sent a letter to the MassHealth Estate Recovery Unit, which stated, in part:

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

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

After having received the Commonwealth's June 27 letter, Attorney Michael DellaMonaca, who previously represented Joan in connection with her MassHealth application,

contacted Nationwide on July 13, 2017, demanding that it refrain from issuing any payment to the Commonwealth. The next day, on July 14, 2017, Nationwide responded that it already had distributed the remaining balance of the contract to the Commonwealth.

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

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

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

On October 25, 2017, the plaintiff amended her complaint, adding Nationwide to the suit. The claims are as follows. Count 1 seeks a declaration against the Commonwealth and

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

DISCUSSION

I. Standard of Review

Summary judgment shall be granted when there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Mass. R. Civ. P. 56(c); *Kourouvacilis v. General Motors Corp.*, 410 Mass. 706, 714 (1991). The moving party bears the burden of affirmatively demonstrating the absence of a triable issue. *Pederson v. Time, Inc.*, 404 Mass. 14, 17 (1989). The moving party may satisfy this burden by submitting affirmative evidence negating an essential element of the opposing party's case or by demonstrating that the opposing party has no reasonable expectation of proving an essential element of his case at trial. *Flesner v. Technical Commc'ns Corp.*, 410 Mass. 805, 809 (1991); *Kourouvacilis*, 410 Mass. at 716. Once the moving party establishes the absence of a triable issue, the party opposing the motion must respond with evidence of specific facts establishing the existence of a genuine dispute. *Pederson*, 404 Mass. at 17. The opposing party cannot rest on its pleadings and mere assertions of disputed facts to defeat the motion for summary judgment. *LaLonde v. Eissner*, 405 Mass. 207, 209 (1989).

When deciding a motion for summary judgment, the court considers pleadings, deposition transcripts, answers to interrogatories, admissions on file, and affidavits. Mass. R.

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

II. Overview of Medicaid Program and MassHealth

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

The Federal Medicaid Act, 42 U.S.C. §§ 1396 et seq., was enacted in 1965 as Title XIX of the Social Security Act. *Daley v. Secretary of Exec. Office of Health & Human Servs.*, 477 Mass. 188, 189 (2017). It is a voluntary, cooperative federal and state program, which provides payment for medical services to eligible individuals and families. *Forman v. Director of Office of Medicaid*, 79 Mass. App. Ct. 218, 221-222 (2011). If states choose to participate in the program, they must comply with federal Medicaid law in order to receive federal funding. *Daley*, 477 Mass. at 189-190. It has become one of the largest programs in the federal budget as well as a major expenditure for state governments, who must finance a significant portion of Medicaid benefits on their own. *Id.* at 190.

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

To qualify for a MassHealth contribution toward nursing home expenses, an applicant must have $2,000 or less in "countable assets." See 130 Code Mass. Regs. § 520.003(A)(1) (2014). If the applicant has a spouse that is not institutionalized and does not receive Medicaid benefits, the spouse, also known as a community spouse, may have up to $126,420 in countable assets.[3] See 130 Code Mass. Regs. § 520.003(A)(1) (2014); 130 Code Mass. Regs. § 520.016(B)(2) (2014) (amount adjusted for inflation). "This asset limit often requires applicants to 'spend down' or otherwise deplete their resources to qualify for Medicaid long-term care benefits when they enter a nursing home." *Daley*, 477 Mass. at 192. To prevent asset transfers that are undertaken solely to allow the applicant to qualify for MassHealth, strict rules have been promulgated that limit the amount of assets an applicant and their spouse can dispose of without affecting the applicant's eligibility for assistance.[4] See 42 U.S.C. § 1396p; 130 Code Mass. Regs. § 520.007 (2014).

To determine eligibility, MassHealth reviews an applicant's and their spouse's transfers of resources during a statutorily created "look-back" period prior to the applicant's application. *Forman*, 79 Mass. App. Ct. at 222. The transfer at issue in this case is Robert's annuity, which

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.

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]

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

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).

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. 109-171, § 1932, 120 Stat. 4, 62-64, in an attempt to reduce government spending on certain programs, such as Medicaid. The act added, among other things, subparagraph (F) to § 1396p(c)(1), which states:

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

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

IV. Summary of Dispute

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

To place this issue into context, Robert named the Commonwealth as the primary beneficiary of his annuity to the "Extent Benefits Paid," and he named the plaintiff as his contingent beneficiary. His annuity contract, however, is silent on the identity of the individual for whom benefits were paid, and "Joan" or "institutionalized individual" is not mentioned anywhere in his annuity application. The Commonwealth, nonetheless, argues that if the court finds that a transfer of assets to purchase an annuity must satisfy both provisions – the sole benefit rule and subparagraph (F) – then the court also must find that the "Extent Benefits Paid" language in Robert's contract necessarily refers to Joan.[6] Otherwise, MassHealth would have deemed Robert's annuity purchase a disqualifying transfer under subparagraph (F), and Joan would have been subject to a period of ineligibility. In other words, to have approved Joan's MassHealth application without subjecting her to a period of ineligibility, the Commonwealth claims that Robert was required, pursuant to subparagraph (F), to name the Commonwealth as his primary beneficiary to the extent benefits were paid on *Joan's* behalf. Therefore, even though neither Joan's name nor the phrase "institutionalized individual" appears in Robert's annuity application or contract, the Commonwealth, nevertheless, contends that it is was properly listed as the primary beneficiary of Robert's annuity and that it is entitled to the remaining balance of the contract because it paid for Joan's nursing home care costs.

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

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).

entitled to the remaining balance of her father's annuity as the contingent beneficiary. For the following reasons, the court agrees with the plaintiff.

A. ***Analysis***

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

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

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

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

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

In essence, subparagraph (F) deems all annuity purchases a transfer of assets for less than the fair market value unless the state is named as the primary beneficiary of the annuity. However, subparagraph (F) clearly states that its effect is limited to "*this paragraph*" (e.g.,

paragraph [1]). The sole benefit rule appears in paragraph (2) below and sets forth an exception to the transfer penalty regime in paragraph (1). It states, in pertinent part:

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

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

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

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

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

Furthermore, to the extent that the Commonwealth cites to agency and regulatory memoranda and manuals to support its interpretation, such materials are not the product of formal rulemaking and do not have the force of law. See *Rent Control Bd. v. Cambridge Tower Corp.*, 394 Mass. 809, 814 (1985). Although courts generally consider such interpretations persuasive, they are entitled to respect only if the interpretation is reasonable and has the "power to persuade." See *id.*; *Hughes*, 734 F.3d at 478, quoting *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944). Because the statute is unambiguous, the contradictory agency interpretations are not reasonable.

Finally, the Commonwealth argues that the plaintiff's interpretation strains credulity because if the sole benefit rule is the only provision that applies to annuities purchased by a

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

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

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

The interpretation of a contract is a question of law, as is the question whether an ambiguity exists. *Quinn v. Mar-Lees Seafood, LLC*, 69 Mass. App. Ct. 688, 695 (2007). "Contracts that are free from ambiguity must be interpreted according to their plain terms." *Suffolk Constr. Co. v. Lanco Scaffolding Co.*, 47 Mass. App. Ct. 726, 729 (1999). In interpreting a contract, the court must construe the words according to their usual and ordinary meaning. *Id.* "Contract language is ambiguous where 'an agreement's terms are inconsistent on their face or where the phraseology can support a reasonable difference of opinion as to the meaning of the words employed and the obligations undertaken.'" *Id.*, quoting *Fashion House, Inc. v. K Mart Corp.*, 892 F.2d 1076, 1083 (1st Cir. 1989). However, "an ambiguity is not created simply because a controversy exists between parties, each favoring an interpretation contrary to the other's." *Jefferson Ins. Co. v. Holyoke*, 23 Mass. App. Ct. 472, 475 (1987).

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

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

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.

communications in violation of G. L. c. 176D, § 3(9)(b). Therefore, summary judgment shall enter in Nationwide's favor on this theory.

ii. Failure to Investigate

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

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

iii. "Reasonably Clear" Liability

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

An insurer's duty to settle a claim arises only when "liability has become reasonably clear." G. L. c. 176D, § 3(9)(f). Liability, in that context, encompasses both fault and damages. *O'Leary-Alison*, 52 Mass. App. Ct. at 217. To determine when an insured's liability is "reasonably clear," an objective test is used. *Id.* The fact finder must determine "whether a reasonable person, with knowledge of the relevant facts and law, would probably have concluded, for good reason, that the insured was liable to the plaintiff." *Demeo v. State Farm Mut. Auto Ins. Co.*, 38 Mass. App. Ct. 955, 956-957 (1995).

Typically, subsection (f) is invoked in cases in which an insurer denies liability or contests the amount of money owed. In those situations, it is well settled that "liability under c. 176D and c. 93A does not attach merely because an insurer concludes that it has no liability under an insurance policy and that conclusion is ultimately determined to have been erroneous." See *Guity v. Commerce Ins. Co.*, 36 Mass. App. Ct. 339, 343 (1994), quoting *Pediatricians, Inc. v. Provident Life & Accident Ins. Co.*, 965 F.2d 1164, 1173 (1st Cir. 1992) ("A plausible, reasoned legal position that may ultimately turn out to be mistaken – or simply . . . unsuccessful – is outside the scope of the punitive aspects of the combined application of c. 93A and c. 176D."). See also *O'Leary-Alison*, 52 Mass. App. Ct. at 218 ("An insurer's good faith, but

mistaken, valuation of damages does not constitute a violation of c. 176D."). This case, however, presents a unique situation because neither liability nor the amount of money owed was in dispute. Rather, the crux of the plaintiff's claim is that liability was not reasonably clear because there was a dispute regarding who was Robert's beneficiary, and yet, Nationwide paid the remaining balance, albeit to the wrong party. Determining whether this conduct constitutes a violation of G. L. c. 176D, § 3(9)(f) requires fact finding, particularly with respect to Nationwide's knowledge and intent, which the court cannot do at the summary judgment stage.[9] See *Attorney Gen.*, 386 Mass. at 370. See also *O'Leary-Alison*, 52 Mass. App. Ct. at 217. Accordingly, summary judgment is not appropriate on this theory of liability either.

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

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

ORDER

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).

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**.

O. William Barrett

Justice of the Superior Court

January 16, 2020