CT NAELA
The Connecticut Chapter of the
National Academy of Elder Law Attorneys

PRACTICE UPDATE

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President's Message

By Attorney Linnea J. Levine

CT NAELA continues to focus on two missions: keeping the elderly in their homes and apprising our chapter members of changes in federal and state law, regulations and policy.

In order to make it possible for more seniors to stay at home, CT NAELA is sponsoring two bills this state legislative session, namely HB 5324 and SB 174. HB 5324, which is supported by State Senator Catherine Abercrombie and CT NAELA's Public Policy Committee, would raise the minimum community spouse's assets from $23,449.80 to $50,000.00. SB 174, *An Act Concerning Fairness in Medicaid Eligibility Determinations for Home Care Clients*, would require DSS to follow federal nursing home eligibility requirements in administering the home care application process. SB 174 (subsequently revised to SB 174) added three month retroactive payments (the three months directly prior to the filing date of the Medicaid application) to applicants for the CT Waiver Home and Community Based Services Program. The CT NAELA Public Policy Committee has argued that, since Connecticut DSS must, as a matter of federal law, apply the federal eligibility rules to home care applications, no fiscal note should be applied to this bill. SB 174 was passed by the Aging Committee and is now pending in the Appropriations Committee. We shall keep you posted on the status of these bills.

CT NAELA is also monitoring DSS efforts to limit current Medicaid exemptions of Veteran's benefits, and will strongly oppose any DSS-sponsored legislative action to count previously-exempt Aid and Attendance benefits as income. (See Attorney Stillman's article in this issue of the Practice Update regarding developments in the Aid and Attendance program.)

Through timely articles in the CT NAELA Practice Update, the Chapter's Spring and Fall educational seminars, and the Chapter's website, CT NAELA and its (Publications, Programs, and Website) committees inform membership of new issues and provide insight into how the developments will affect our members' practices.

CT NAELA's Litigation Committee, which supported the successful Lopes federal court annuity matter, is now ready to take on another legal challenge. The committee is currently considering a challenge to nursing home admission agreements and over-reaching "Responsible Party" provisions. If you are interested in participating in the litigation process or have other litigation ideas, please contact the Litigation Committee.

Finally, as my term as President comes to a close, I want to thank each member of CT NAELA for the service you provide to the under-served elderly and disabled populations. Our work is challenging and we sometimes are not adequately compensated for our diligent efforts. However, be assured that we make a difference in our clients' lives on a daily basis. It has been my pleasure to represent you and to serve as President of this valuable organization. ■

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Avoiding the Institutional Bias:
Why Connecticut Senate Bill #174 Levels the Playing Field for Connecticut Home Care Program Clients

By Attorney Brendan F. Daly

A. Introduction

The Connecticut Department of Social Services (DSS) policy regarding the start date of penalty periods for asset transfers does not track federal law (*See* 42 U.S.C. § 1396p(c)(1)(A)) under the Deficit Reduction Act of 2005 (DRA), P.L. 109-171 section 6011(b)(2). Consequently, the application of the DSS policy yields a result that is more restrictive than federal law for home care applicants. DSS requires eligibility for payment of services before an ineligibility period begins—a result that penalizes those applying for home care services due to the lack of retroactive payment. Moreover, the systemic problem in Connecticut of lengthy Medicaid processing times creates a harsh result: those in need of home care assistance must pay out-of-pocket even longer while the application is pending with DSS.

CTNAELA'S Public Policy Committee recently tackled this issue by proposing that Connecticut promulgate legislation to correct DSS policy and comport to federal law. The result of the Chapter's advocacy is Senate Bill 174: An Act Concerning Fairness in Medicaid Eligibility Determinations for Home-Care Clients. The Bill would require that DSS grant Home Care benefits retroactively to the date of eligibility and begin a transfer penalty resulting from a gift for the purposes to qualify for Medicaid to such date.

B. Statutory construction: Breaking down the State and federal provisions

Under the Uniform Policy Manual (UPM), DSS begins a penalty period on:

> …the date on which the individual is eligible for Medicaid under Connecticut's State Plan and **would otherwise be eligible for Medicaid payment of the LTC** [long term care] **services** described in 3029.05 B based on an approved application for such care but for the application of the penalty period, and which is not part of any other period of ineligibility caused by a transfer of assets. (Emphasis added.) UPM § 3029.05E

But under the DRA, a penalty period begins:

> …the date on which the individual is eligible for Medical assistance under the State plan and **would otherwise be receiving institutional level care based on an approved application for such care** described in subparagraph (C) but for the application of a penalty period…and which does not occur during any other period of ineligibility under this subsection. (Emphasis added.) 42 U.S.C. § 1396p(c)(1)(D)(ii).

The first prong of the analysis between the two statutes is similar: an individual must be financially eligible (having no more than $1,600 in non-exempt assets) and categorically eligible (under age 65 and disabled or over age 65) for Medicaid. Analysis of the second prong results in a significant distinction between the UPM and the DRA. Although the UPM does not reference community-based services (the federal statute makes reference to "subparagraph (C)," which details the community-based waivers), DSS does permit a penalty period to start in home care applications nonetheless—albeit in a manner that contravenes federal law. It is DSS's position that eligibility for "Medicaid payment" means that it cannot assess a penalty period in home care cases until the caseworker makes a decision on the application—as this is when the State would have begun paying for care had the applicant not made the gift:

> For individuals applying for home and community based services under a Medicaid waiver, the penalty will commence on the date that the Department **would have approved the payment** of the services under an approved application, but for the application of the penalty period. (Emphasis added.) February 11, 2009 Memorandum of Michael P. Starkowski responding to individuals who commented on the DSS proposed regulations, at 3-4.

The language in the DRA provision, however, does not condition the penalty period start date on when the State would have approved payment; under the DRA, when an individual is financially eligible and "otherwise receiving institutional level care," a penalty begins. Consequently, in home care cases under the DRA, the penalty period start date is the month an individual: (1) is functionally and financially eligible; and (2) applies for Medicaid.

In its written testimony objecting to Senate Bill 174, DSS states that "[t]he penalty period begins on the date when Medicaid would otherwise pay for long-term care services had the improper transfer not occurred." This statement, though consistent with the UPM, is inconsistent with the DRA. And requiring eligibility for payment of care—as opposed to meeting the asset eligibility threshold alone—results in an inequitable outcome not only because of the lack of retroactive eligibility, but also on account of processing delays.

C. The Problem with Processing Delays in Home Care

Although DSS is required to process Medicaid applications within forty-five days, caseworkers virtually never meet this deadline. *See* UPM § 1505.35C.1.c. The processing delays are pervasive and saddle the home care applicant with the cost of care while the case is pending. While Medicaid applicants in nursing homes receive retroactive benefits for up to three months prior to the month of financial eligibility (*See* UPM § 1560.10A), benefits do not begin in home care cases until DSS actually grants the

application. A realistic processing time that this author has experienced in home care applications is six months or more. And although the processing delays may choke the nursing home, the resident's right to retroactive relief insulates them from the financial hardship.

The financial hardship that home care applicants already endure is exacerbated by the policy of postponing the penalty period start date. While DSS continues a shift in its course from providing for institutionalized care toward broadening home care benefits (with programs such as Money Follows the Person), its draconian policy regarding asset transfers in home care cases threatens to derail this objective. Consequently, the DSS asset transfer policy could result in a reduction in the home care population, particularly in cases where an individual has transferred assets during the look-back period.

D. *Frugard v. Velez*

When New Jersey promulgated its DRA implementation regulations, it removed the possibility of beginning a penalty period in home care cases, subjecting an applicant who transferred assets to a five-year penalty. Specifically, New Jersey did not permit a penalty period to begin until a home care applicant was actually receiving benefits—an impossibility for someone who transferred assets. In *Frugard v. Velez*, 2010 WL 1462944, (D.N.J. 2010), the plaintiffs—three home care applicants—argued that New Jersey's policy was more restrictive than the SSI methodology on asset eligibility. *Id*. at *2.

The State in *Frugard* relied on the CMS July 27, 2006 memorandum to State Medicaid directors:

> For transfers of assets made on or after February 8, 2006, the period of ineligibility will begin with the …date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level of care services…that, were it not for the imposition of the penalty period, would be covered by Medicaid. *Id*. at *4 (emphasis in original), quoting CMS bulletin dated July 27, 2006.

In rejecting the CMS interpretation, Judge Garrett Brown stated: "Clearly, this enclosure misquotes the statute and is not controlling in any way." *Id*. The court then provided a concise summary regarding the legislative history of the DRA provision; specifically, he referenced the House bill, which initially included the phrase "is receiving institutionalized services" but later changed it to "would otherwise be receiving services." *Id*., quoting 151 Cong. Rec. H10571 (Nov. 17, 2005).

Lastly, the court applied statutory construction to reject any deference to the CMS memorandum, holding that the language in 42 U.S.C. § 1396p(c)(1)(D)(ii) was unambiguous and lacked the need for CMS interpretation. *Id*. at *5. The court concluded that "[t]he penalty period should have begun on the date the Plaintiffs were eligible for medical assistance under the State plan." *Id*. The court granted a permanent injunction, requiring New Jersey to begin penalty periods on the date that a home care applicant is financially eligible for Medicaid, and the State did not appeal the decision.

SEEKING WEB SITE COMMITTEE MEMBERS

Would you consider joining the Web Site Committee? We want our Connecticut Chapter to have one of the best elder law web sites in the nation. Check out the site at www.ct-naela.org. We seek CT-NAELA members who are willing to share ideas and innovative approaches that will make our site a daily resource for Connecticut elder law attorneys. You don't have to be a Steve Jobs or have a degree in computer science. You just have to know what elder law attorneys find useful.

We meet by teleconference for 30 minutes a month and work on assignments generated at the meeting during the month. We have a paralegal helping with updating the site. Consequently, it is not a huge time commitment. Just give me, Joe Cipparone, a call at (860) 442-0150 or send me an e-mail at jac@261law.com. It's a great way to participate in our Chapter and you may learn a bit of elder law along the way. We would love to have you?

Joe Cipparone, Jack Reardon, Hank Weatherby
The CT-NAELA Web Site Committee

E. DSS Position

It is noteworthy that DSS relies on the July 2006 CMS memorandum to support its position that the penalty period begins when the State would have paid for assistance—as opposed to the date an individual is financially and functionally eligible:

> This interpretation [beginning the penalty period when an individual is eligible for payment of services] is supported by the Centers for Medicare and Medicaid Services ("CMS"), which describes the penalty as commencing on the date on which the individual is eligible for medical assistance under the State plan **and is receiving institutional level of care services.** (Emphasis added) February 11, 2009 Memorandum of Michael P. Starkowski, *supra*.

The State justifies its policy on the basis of the CMS interpretation—that home care applicants are not eligible for care until "receiving institutional level of care services," which is the month in which the State would have approved the application.

F. Conclusion

The DSS reliance on the July 2006 memo is misplaced. The Connecticut Legislature should pass Senate Bill 174 to halt the chilling effect on applications for Connecticut's home care programs where the individual has transferred assets and end the institutional bias in these situations. ■

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A VA Practitioner's Thoughts on Developments in Aid and Attendance in Connecticut

By Matthew T. Stillman, JD, LL.M.

In 2011, the State of Connecticut Department of Social Services (DSS) urged the legislature to pass a bill exempting U.S. Dept. of Veterans' Affairs (VA) Aid and Attendance (A&A) benefits as qualifying income for virtually all social services programs in Connecticut. The legislation was passed and the bill was enacted into law in 2012 (P.A. 12-208). This legislative session, DSS has put forth a legislative proposal to "clarify" its original proposal by seeking to exempt only a small portion (about 1/3) of the benefit. (See DSS Agency Legislative Proposal (1) – 2014 Session, Clarification of Aid and Attendance in P.A.12-208).

DSS has explained that this proposal is intended to "clarify" the language in Public Act 12-208. DSS' position is that several attorneys and clients are misinterpreting the current language by asserting that the entire VA pension/A&A should be excluded under said statute. DSS claims that this was never the intent of Public Act 12-208, and that the current proposal seeks to clarify that it is only the Aid and Attendance stipend of the basic monthly pension that is excluded as income. (See DSS Agency Legislative Proposal, Proposal Background, Reason for Proposal).

If this proposal becomes law, hundreds of Veterans and/or their surviving spouses will be disqualified for continuing homecare, Medicare Savings programs, or other benefits within Connecticut because of "excess" income.

A. What is Aid and Attendance?

A&A is a special pension offered to Veterans and/or their surviving spouses when they are spending all their income and (in most cases) their life savings on medical expenses. For example, if the Veteran is single and his medical expenses exceed his income, he may qualify for the "low income pension benefit". When the Veteran cannot reasonably leave home without assistance, he is considered "housebound" and can collect an additional "housebound" stipend over and above the basic low income pension benefit. When the Veteran needs assistance from others with his custodial care activities of daily living (ADLs) on a daily basis, he can collect an additional stipend called "Aid and Attendance", bringing the entire monthly payment to $1730. Although the benefits are properly referred to as "Low Income Pension" with an Aid and Attendance stipend, the whole amount is colloquially referred to as "Aid and Attendance".

Wartime veterans and/or their widows will qualify for A&A if they a) meet the service requirements, are b) medically needy (disabled or over the age of 65), c) financially needy (less than $80,000 or $50,000 of total net worth depending on age), and d) are spending either most of or more than their remaining income on payments for medical expenses. When the applicant meets these requirements, the VA offers a tax-free financial payment to help the applicant avoid impoverishment and to reimburse them in part for their (previously) unreimbursed medical expenses.[1]

B. DSS' Position:

DSS' position is that its proposed exemption of only the "Aid and Attendance" stipend of the monthly payments (from $230-$450) instead of the full pension benefit (of up to $1730 for a single Veteran) is merely a clarification of the prior law. DSS and the Office of Policy Management (OPM)'s contends that the rule has been evenly implemented across all districts and the literal reading of the rule is fairly straightforward. However, if so obvious, why do they now seek to "clarify" this rule?

When the testimony from Commissioner Bremby was offered in support of this bill in 2011, the Office of Legislative Research (OLR) put forth supporting testimony detailing benefit amounts which illustrated that the full pension benefit was sought to be excluded, not merely this small portion they seek to clarify. Although DSS' latest position is that it didn't put forth any figures before the legislature, it did nothing to correct the allegedly "incorrect" widespread proposition put forth by OLR.[2]

C. Who Will be Impacted by This Change in Law:

Note that this new rule does not apply if an applicant is institutionalized in a skilled nursing facility either on Medicaid or privately paying for care because the applicant generally cannot seek homecare benefits. Also, if an applicant is living in an assisted living community, this new rule will have only limited application because the applicants are generally not eligible for homecare assistance.

If an applicant is earning more than $2,100 in gross taxable income they are already "over income" for social service benefits and they must work with an elder law attorney to qualify for public service benefits.

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[1] For years, the lack of public disclosure about the benefits, the prohibitive application process, the inordinate delays, and the bureaucracy of the VA caused few of the applicants (about 15-20% of eligible veterans apply) to seek the financial assistance. However, as more of the potential applicants have become aware of the benefit, the VA has restricted the eligibility to those seniors who receive assistance with custodial ADL's (bathing, toileting, transferring, dressing, continence) not merely incidental ADL's (housekeeping, cooking, security, etc.). Additionally, it appears that current applications are now being subjected to a greater scrutiny, requiring greater verification of income, assets, and medical expenses. Overall, the process to "vet" potential applicants has gotten more thorough and longer to endure, making it harder to obtain the VA benefit.

[2] Furthermore, DSS says this "clarification" has been evenly implemented across all districts. I disagree. For my A&A clients (as well as others), DSS has disregarded A&A income over the past two years, only seeking to reverse itself within the past few months to affect "uniform" management. As one VA benefits practitioner confirmed, her A&A homecare client was recently informed that he was being denied benefits for being over the income limits for homecare despite the fact that he received A&A benefits for nearly two years. My clients have had similar experiences, one because he was just $26 over the "allowable income limit", notwithstanding that he had received no additional income.

If an applicant is currently earning such a meager amount of income (for example, less than $1,000/monthly), the DSS "clarification" will most likely not affect him because an additional stipend/payment from the VA should not disqualify the applicant on the basis of income.

So, these legislative proposals will primarily affect the following individuals: Veterans and/or their spouses who receive anywhere from $900 to $2,100/month in gross taxable income; Veterans who have social security and/or a pension but who have little (if any) income to spare; and Veterans and/or their spouse who need every bit of income to be able to afford, homecare, rent, mortgage interest, food, utilities, gas, and other expenses. These are generally Veterans and/or their spouses who can ill-afford to lose any benefits afforded to them.

D. What can be done?

At time of publication, the DSS "clarification" is only a proposal. Representatives of CT NAELA's Accredited Veterans Benefits subcommittee and public policy committee have had discussions with DSS, the Office of Policy and Management (OPM), and the Governor's office in an effort to prevent this proposal from becoming law.

However, should the state continue its "clarification" efforts through other means (possibly an end of session Budget implementer), both Veterans and their counsel should be prepared to contact their legislators to oppose this clarification. ■

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Connecticut's Health Care Applicant Background Check Management System (ABCMS) is Expected to be Launched in April 2014

By Attorney Linnea Levine

This month, Connecticut is set to launch a comprehensive background and fingerprint check system on applicants for jobs with nursing homes, assisted living facilities, hospices, home health care agencies, and other long term care providers to the elderly. The launch follows the State's receipt of a $1.9 million federal Health and Human Services grant award and the Department of Public Health (DPH)'s development of a detailed implementation plan to ensure that potential service providers do not have a history of substance abuse, sexual offenses, patient abuse, or Medicaid or Medicare fraud.

The new program, called the Health Care Applicant Background Check Management System (ABCMS), is described in the DPH Long Term Care Criminal History and Patient Abuse Background Search Program Report to the General Assembly 2012, Feb.1, 2012, which is summarized in this article.

A. Summary of the DPH Report

According to the DPH Long Term Care Criminal History and Patient Abuse Background Search Program Report to the General Assembly 2012, Feb. 1, 2012, the new background check process will include the following:

- A new job applicant[1] will be asked to provide written permission to the long-term care provider to conduct a background check;
- When the applicant consents to the ABCMS background check, the provider enters basic applicant information in the password-secured ABCMS database;
- The facility will then conduct required name-based registry checks of the National Sex Offender Registry; Connecticut Sex Offender Registry; Office of the Inspector General (OIG) exclusion list; Connecticut Nurse Aide Registry; Connecticut Practitioner Licensing and Investigations Section License Verification System; and Judicial Branch Criminal Convictions Database;
- The long-term care entity will record the results of the registry searches into the ABCMS;
- If the provider deems an applicant to be an appropriate candidate for hire after the registry checks, the applicant is provided with a fingerprint authorization form and instructed to proceed to a State Police Troop for LiveScan fingerprinting;
- The Connecticut Department of Emergency Services and Public Protection (DESPP) will electronically transmit the fingerprints through the Integrated Automated Fingerprint Identification System (IAFIS) for a national fingerprint and criminal history search; and
- DESPP will report to DPH and DPH will then report to the long-term care provider any disqualifying offenses identified in the background check; and those job applicants are then determined to be disqualified for hire.

DPH indicates that, once the job applicant personal information is entered into the ABCMS, it will advise a long term care provider of any offense committed by the applicant after hire as well.

B. Summary

Certainly, we welcome these background and fingerprint checks on applicants for long-term care positions, as the elderly and disabled confined to long-term care facilities are often unable to protect themselves. ■

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[1] The ABCMS only applies to new hires, not current employees.

PRACTITIONERS CORNER:

A to Z (Zoe) of Household Employees

By Attorney Elizabeth N. Byrne

Mr. Belvedere. Alice. Alfred. Niles. Mr. French. Geoffrey. Berta. Benson. Hazel. Lurch. Daphne. What did all of these favorite television sitcom characters have in common? They were all household employees.

According to the IRS, "a household employee [is someone] hired to do household work[1] …whether the work is full time or part time … [or] whether [paid] on an hourly, daily or weekly basis, or by the job." (IRS Publication 926 (2014), page 2). Household work is done in or around the home, usually with the homeowner's tools and supplies. Household employees may include nannies, caretakers, domestic workers, companions, health aides, housekeepers, and private nurses. (IRS Pub. 926, page 2-3)

If the worker provides his or her own tools and offers his services to the general public, or if an agency provides the worker and controls what work is done and how it is done, the worker is not a household employee. (IRS Pub. 926, page 3)

As our clients require increasing assistance with their "activities of daily living", more and more of them are choosing to remain at home with the assistance of private-hire health aides and companions. The Census Bureau's annual survey, the American Community Survey (ACS), shows an increase of (reported) hires of nannies, house cleaners and caregivers from 666,435 in 2004 to 726,437 in 2010. (US Census Bureau, DataFerrett, American Community Survey, 2004-2010).

Sometimes the client decides to hire through an agency, always at a higher cost because of the agency's agreement to handle all of the labor and tax law reporting requirements. Others determine to "save money" by directly hiring a neighbor, somebody from church, or a friend of a friend. These household employers have significant reporting and tax-paying obligations that they may not realize or understand. Here is a summary of the household employment rules.

A. Immigration Status:

The first inquiry by household employers should be whether the household employee is legally eligible to work in this country, because it is unlawful to knowingly hire or continue to employ an illegal alien.(8 U.S. Code § 1324a - Unlawful Employment of Aliens). Each employer and household employee is required to complete a U.S. Citizenship and Immigration Services (USCIS) Form I-9, Employment Eligibility Verification and each employer must inspect the employee's identification and other documentation. (See the USCIS handbook and forms available at www.uscis.gov). The employer must retain the completed form with the employee's "personnel" records.

B. Federal Employment Taxes:

Next the household employer should review the rules regarding federal employment taxes. If the employer pays cash wages of $1,900 or more (for example, $15 per hour for ten hours a week for 26 weeks) to a household employee in 2014, the household employer must withhold and pay social security and Medicare taxes. The taxes are 15.3% of the cash wages,[2] one-half of which is the employee's share and one-half of which is the employer's share. (IRS Pub. 926, page 4).

If the household employer pays cash wages of $1,000 or more in any calendar quarter (for example, $15 per hour for six hours each week for 12 weeks) in 2013 or 2014 to a household employee, the employer must pay federal unemployment tax of 6% of the cash wages. (IRS Pub. 926, page 4).

The household employer should apply to the IRS for an employer identification number (IRS Pub. 926, page 4) so that he or she will not be disclosing his or her own social security number to the household employee on the various payroll forms.

The household employer must file a separate W-2 form for each household employee, providing copies B, C, and 2 to the employee and forwarding copy A with a Form W-3 to the SSA by March 2, 2015. (*See* www.socialsecurity.gov/employer)

A household employer must complete Schedule H, Household Employment Taxes, with his or her federal 1040 income tax return, or separately if no 1040 is required to be filed. (IRS Pub. 926, page 4). This schedule is used to calculate the total household social security, Medicare, FUTA, and withheld federal income taxes to be added to the household employer's usual income tax liability. Schedule H and the tax payment are due (no later than) April 15th. Installment payments of employment taxes may be made with the household employer's estimated tax payments.

C. State of Connecticut Reporting and Tax Payment Obligations:

Separate from the federal tax reporting requirements, the household employer must consider the State of Connecticut reporting and tax obligations[3]. All Connecticut employers are required to report all newly-hired employees within 20 days of hiring them by faxing a copy of the CT-W4 form to 1-800-816-1108, or mailing a copy to CT DOL, or reporting online at www1.ctdol.state.ct.us/newhires/index).

All employers of one or more persons (full or part-time) must register with the Connecticut Department of Labor by filing an Employer Status Report. (See CT DOL, An Employer's Guide to Unemployment Compensation).

"Employers become liable for Connecticut unemployment taxes… when they pay wages of $1,500 or more in any calendar quarter in either the current or preceding year, or (2) employ at least one individual for some portion of the day in each of 20 different weeks." (See CT DOL, CT Unemployment Compensation Law, An Employer's Guide, page 4).

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[1] Other than "the employer's" spouse, child under age 21, parent, employee under age 18. (IRS Publication (2014), page 4)

[2] Additional Medicare tax withholding is required when the household employee is paid more than $200,000 per calendar year. (IRS Pub. 926 (2014), page 4)

[3] A useful guide to employers is the Connecticut Employer's Tax Guide Circular (2014), which can be located at www.ct.gov/DRS

If the State of Connecticut income tax liability is $2,000 or less for the 12-month look-back period, the employer is required to remit Connecticut income tax withholding with Form CT- 941 by the end of the month following each calendar quarter. Household employers in Connecticut are not required to withhold Connecticut income tax from wages paid to a household employee but may do so voluntarily. If the employer agrees to withhold, the employer must file a Form REG-1 with DRS, and a DRS tax registration number is assigned. A reconciliation CT-941 is required each year, along with CT W-2 forms due to the employee by January 31st, and CT W-3 (paper) forms due to DRS by the end of February. (www.ct.gov/drs:withholdinginformation forhouseholdemployers).

Worker's compensation is required if the worker works more than 26 hours each week. "This means an employer with a household employee working 20 or fewer hours a week is not required to provide workers' compensation coverage for that employee. An employee working 20 or fewer hours a week in a household who is injured on the job is not eligible for workers' compensation benefits unless the employer voluntarily purchased such insurance for the worker." (State of Connecticut OLR Research Report, "Employment Law for Household and Live-in Help, 2006-R-0627).

D. Retention of Records:

The household employer must maintain certain personnel records for at least 4 years after the due date of the tax return, including copies of Schedule H, forms W-2, W-3, W-4, wage records, household employee name and social security number. (IRS Pub. 926 (2014), page 11).

E. Penalties for Non-Reporting, Non-Payment, and Non-Compliance:

If our clients are not pursuing a federal judgeship or high-profile governmental appointment, does it matter that they ignore these statutory requirements? Will anyone notice?

Of course, as attorneys, we cannot condone violations of any law, including, in this case, the laws pertaining to household employment.

But further, a close reading of Department of Social Services (DSS) Information Bulletin No. 12-02, Asset Review Procedures for Long-Term Care Medicaid Applications, New Long Term Care Application Processing Procedures, #7, suggests increased State scrutiny of payments made to home health aides and companions. The intake worker is now required to request clarification about any withdrawals from a Medicaid applicant's accounts that "appear questionable", such as "withdrawals of $1,000 per week each month." It is concerning that a client, eager to prove that she made no "bad" transfers during the past five years, may unwittingly back right into an acknowledgement of previously unreported routine payments to a private-hire home health aide.

For each failure to file, register, and pay associated taxes to the State of Connecticut, there are monetary and criminal penalties. Failure to comply with Connecticut withholding requirements will result in an assessment of interest, late payment and late filing penalties, and may result in a penalty for willful evasion and fraud. A civil penalty of not more than $1,000 is imposed where, with fraudulent intent, an employer fails to pay, deduct, withhold, and pay tax or to make or sign any return. (IP 2014(1), Connecticut Employer's Tax Guide – Circular CT, p. 15) Also, any person who willfully fails to pay Connecticut tax, file a return, keep records, or supply information is guilty of a misdemeanor, while a person who willfully files a fraudulent document with DRS is guilty of a felony. (IP 2014(1), Connecticut Employer's Tax Guide – Circular CT, p. 16).

The federal government has matching but harsher fines, penalties, and interest charges for failure to pay household employment taxes. It is important to note as well that there has long been personal liability on the part of fiduciaries when it comes to federal tax matters. A fiduciary is treated by the IRS as if he or she is actually the taxpayer. Upon appointment, the fiduciary automatically has both the right and the responsibility to undertake all actions the taxpayer is required to perform, including the filing of returns and the payment of tax due. (IRS, Form 56 Instructions, Notice Concerning Fiduciary Relationship, Rev. Dec. 2011). According to the IRS, such fiduciaries include administrators, conservators, designees, executors, guardians, receivers, trustees, personal representatives, and persons in possession of property of a decedent's estate. (IRS, Form 56, supra).

It is not enough for a fiduciary to deny knowing anything about the employment of a household employee by the principal, conserved person, decedent or the like. "A person may not escape criminal liability by pleading ignorance if he knows or strongly suspects that he is involved in criminal dealings but deliberately avoids learning more exact information about the nature or extent of those dealings." *United States v. Green,* 648 F. 3d 569, 582 (7th Cir. 2011) "Rather, a person who deliberately evades learning his legal duties has a subjectively culpable state of mind that goes beyond mere negligence, a good faith misunderstanding, or even recklessness." (*United States v. Stadtmauer,* 620 F.3d 238, 256 (3d. Cir. 2010), quoting *United States v. Cheek*, 498 U.S.at 205 (111 S. Ct. at 612).

F. Summary:

Oftentimes, when our clients seek our counsel on this topic, they are so physically spent and emotionally drained that they are welcoming strangers into their homes to provide personal care. At the same time, many are unknowingly taking on the obligation of satisfying the complicated federal and state household employment rules. At a minimum, we should be advising the client that the household employment rules are so challenging that they need to consult a certified public accountant for further guidance or retain a payroll company to handle the payroll obligations. But, perhaps better yet, we are advised to point out the advantages of hiring household employees **through a reputable agency** – with the agency handling all of the payroll reporting requirements, providing back-up staffing when needed, and, as Attorney Levine points out in her article, providing full background checks on household employees hired by the agency. ■

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Connecticut Resident's Class Action Suit Challenges Insurance Company's Denial of Claims for Care in Assisted Living Facility

By Attorney Carmine Perri and Taylor Equi

According to Connecticut resident Marie Gardner, a long-term care insurance provider is now attempting to avoid claim liability, after reaping the benefits of decades of premium payments, by drastically limiting the types of facilities that are covered by policies taken out in the 1990's.

According to Mrs. Gardner's class action suit against CNA Financial Corp. (herein "CNA"), CNA's actions affect about three hundred and eighty three (383) people in Connecticut and at least twenty thousand (20,000) people nationwide.

Mrs. Gardner, who is ninety-one (91) years old, purchased a long-term care insurance policy from CNA in 1993, and has been a policyholder ever since. In 2008, Mrs. Gardner fell and broke her hip. Both Mr. and Mrs. Gardner entered The Village at Buckland Court (herein "the Village"), an assisted living facility.[1] Under the terms of Mrs. Gardner's policy, CNA began making monthly payments to the Village. In 2011, however, CNA notified Mrs. Gardner that it had terminated her claim, on account of her medical condition improving, resulting in Mrs. Gardner having to pay for her policy premiums out of her own assets.

Less than a year after CNA terminated Mrs. Gardner's claim, Mrs. Gardner fell again and fractured her pelvis. She, again, applied for her policy benefits to resume paying for her stay at the Village. CNA, despite previously paying for Mrs. Gardner's stay at the Village, rejected Mrs. Gardner's claim.

According to Mrs. Gardner's Complaint, CNA advised Mrs. Gardner that it had a "new law" that requires, in order to meet the requirements of Mrs. Gardner's policy, that the facility have a nurse on its premise 24 hours a day; the Village has a nurse **on call** 24 hours a day. Additionally, while acknowledging that the Village is a licensed ALSA, CNA further alleged that the Village is not a qualified provider since it is not licensed by the State of Connecticut.

CNA's denial came despite Mrs. Gardner having held the same policy for the past twenty years, and the Village having previously been a qualified provider under CNA's own policy.

In Mrs. Gardner's Complaint, which was filed on December 27, 2013, Mrs. Gardner claims, among many other claims, that CNA violated Connecticut's Unfair Trade Practices Act (herein also "CUTPA") by attempting to save itself millions of dollars by reinterpreting policies that otherwise would cover assisted living facility stays. Mrs. Gardner is seeking a temporary and permanent injunction to prevent CNA from denying future claims for assisted living facility stays, as well as compensatory damages, punitive damages, and attorney's fees.

CNA counters that, pursuant to a class action settlement in *Dorothea Pavlov, et al. v. Continental Casualty Company,* No. 07-02580, Doc. 107 (N.D. Ohio October 7, 2009) (herein "*Pavlov*"), it now has the authority to reinterpret its existing policies to narrow the scope of facilities it covers, including policies like Mrs. Gardner's that have been held since the 1990's.

In *Pavlov*, the plaintiffs sued CNA after it denied their claims for stays at assisted living facilities alleging that their policies do not cover such facilities. The plaintiffs were successful in their challenge to CNA's interpretation of this provision. Nonetheless, since 2009, CNA has denied any new claim for assisted living facility stays, alleging that ALSAs do not meet CNA's new interpretation of its policies since *Pavlov.*

Since this case is still pending, it is unclear how it will unfold. That said, what is clear is that the outcome of this case will affect many Connecticut residents and scores of people throughout the nation. Periodically checking on the status of the Marie Gardner matter may prove helpful to elder law practitioners when advising clients in the coming year, especially clients who are either residents of assisted living facilities or contemplating living in one. ■

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[1] The Village is licensed by the Connecticut Department of Public Health (herein "the DPH") as a Managed Residential Community (herein "MRC") as an Assisted Living Services Agency (herein "ALSA"). All ALSAs must, pursuant to the DPH regulation 19-13-D105: (1) be able to provide nursing services to its residents; (2) be under the supervision of a physician; (3) keep a daily medical record for each resident; and (4) have a registered nurse on call 24 hours a day who is available to provide services to its residents 24 hours a day.