



## 2014 Division of Workers' Compensation Conference

### Social Security Disability, Medicare, and Workers' Compensation Settlements

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### Four Issues In Every Case?

- Social security disability offset – The “80% Rule”
- Medicare conditional payments
- Shifting future medical treatment to Medicare
- The Medicare and Medicaid State Children's Health Insurance Program Extension Act of 2007 (“MMSEA”), Section 111 reporting, 42 USC 1395y(b)(8)



## Four Issues In Every Case?

- When is someone entitled to Medicare?
  - Entitlement to Medicare is indexed to entitlement to Social Security benefits
  - Medicare eligibility does not occur at the same time as entitlement to SSDI or SSI but eligibility is related to social security entitlement
  - Medicare “entitlement” is the same thing as Medicare “beneficiary.”



## How Does Someone Qualify for Social Security Disability?

- SSA programs: Aged, Blind and Disabled
- 12.4% Gross wages (F.I.C.A.)
- 6.2% Paid each by employer and employee (by payroll deductions) up to \$117,000.00 in 2014 wages (\$113,700.00 in 2013)
- Covers Retirement, Blind, and Disability (SSD-I and SSI) Programs



## SSR: Social Security Retirement

- Full benefits at age 65 ("retirement age") if born on or before 1938
- If born after 1938, "retirement age" is later, up to age 70
- There are no offsets against social security retirement benefits if there is a workers' compensation lump sum settlement after an IW becomes eligible for regular Social Security Retirement benefits.



## SSDI: Social Security Disability and Insurance

- SSD-I (Title II) vs. SSI (Title XVI)
- SSD "earnings" AND "disability" requirements
- SSD-I requires 21 quarters contribution in the 40 quarters prior to the onset of disability (five years of contributions in last 10 years before onset).
- Payment of SSD per month equals the same amount as if the IW reached regular retirement age.
- Currently SSD is max of \$2,800.00 per month for individual, \$5,300.00 max for family.
- Applicant can return to work and reapply for SSD within 60 months without prejudice or keep working and earn a new 21 quarter earnings history.



## More Social Security Disability Info

- Applicant can earn up to \$1,000.00 per month for a 9 month "trial work period" without prejudice to SSD benefits.
- There is a 5 month waiting period for SSD payments to begin from onset date of disability. Disability payments begin on the first day of the sixth month after the onset date.
- IW becomes eligible for Medicare 24 months after eligibility for SSD begins.



## What is Medicare?

### Medicare Parts A, B, C and D

- 2.9% gross wages, no cap.
- 1.45% paid each by employer and employee
- This payroll deduction pays Medicare Part A
- \$96.40 per month optional premium for Medicare Part B, deducted from SSD or regular SSR benefits for existing bennies. \$155.00 per year deductible. Higher premiums for others.
- \$55.90 base per month premium for Medicare Part D Prescription Medication program



## Medicare Part A

- Covers "major medical"
- Hospitalization
- Skilled nursing home care
- Hospice care
- \$1,162.00 deductible for hospitalizations (repeats if you are hospitalized again after 60 days)



## MEDICARE PART B

- Optional coverage - \$96.40 per month premium deduction from SSD or SSR for existing beneficiaries.
- Premium beginning for new members or "non-deductible members" as of 1/1/2010 varies depending on individual or joint income.
- Physician office visits, durable medical equipment, outpatient surgeries, diagnostic imaging studies, IV meds



## MEDICARE PART B

Individual tax return	Joint tax return	You Pay
≤ \$85K	≤ \$170K	\$110.50
\$85K - \$107K	\$170K - 214K	\$154.70
\$107,001 - \$160K	\$214,001-\$320K	\$221.00
\$160,001 - \$214K	\$320,001-\$428K	\$287.30
> \$214K	>\$428K	\$353.60



## Medicare Choice-plus + (Part C)

- Medicare Advantage Plans, combines Parts A, B and D coverage through a private insurer
- Capitated plans like Kaiser Senior Advantage Plan (1997)
- Fee for service plan like Blue Shield/Blue Cross PPO
- Medicare recipient can change plans once a year
- “Medi-gap” plans are optional supplemental plans you can buy that pays deductibles and co-payments.



## Medicare Part D Rx Plan

- Optional except for Medi-Cal (Medicaid) recipients who are automatically enrolled
- \$55.90 per month "national base" premium
- Payments for first \$2,250.00 in annual drug costs
- "Donut Hole" No coverage between \$2,250.00 and \$6,440.00 in annual drug costs (will be eliminated by 2020 – 50% reimbursement for generics)
- Medicare pays for 95% of prescription drugs over \$6,440.00 and recipient pays 5% co-payments
- At least \$3,600.00 per year medication costs are not covered by Medicare
- For MSA purposes, CMS uses average wholesale pricing of medications as of 3/3/09



## SSD Generally

- "Disability": Person has medically determinable physical and/or mental impairments that given the Claimant's age, education, occupational history, medical conditions and residual functional capacities, he or she is unable to engage in any kind of substantial gainful activities for at least twelve consecutive months or which results in death 42 USCA 416(I).
- AMA Guides and "non-exertional" factors
- ODAR hearings
- SSI – workers' compensation cases almost always wipe out SSI benefits
- Steve Webster, Keith Dietterle, William Ordas, David Marcus are now ALJs with ODAR



## SSD Offsets – the “80% Rule”

- See 42 USCA 424(a), 20 CFR 404.317 and 404.408
- TTD rates today cover 67% of wages up to \$83,821.92 (max TTD rate is \$1,074.64 per week)
- But only 104 weeks of TTD per Labor Code Section 4656(c)
- There is more pressure to file for SSD since the maximum rate for SSD is now \$2,800.00 per month, and about \$5,300.00 per month for family with minor children.



## SSD Offsets – The 80% Rule

- SSD benefits are reduced “If SSD benefits plus other public mandated benefits exceed 80% of the Claimant’s highest calendar year’s earnings in the last 5 years before the onset of disability.”
- Public mandated benefits = SDI, workers’ compensation indemnity.
- LTD plans are not “publically mandated” but plan will assume SSDI entitlement after one year of eligibility for LTD payments and will reduce monthly payments by amount of SSDI payments.



## The 80% Rule

- Examples
- \$30,000.00 per year
- \$60,000.00 per year
- \$15,000.00 per year
- Federal "POM" (Procedure Operations Manual) requires SSA to use one of three formulas most favorable to the Claimant
- Is a workers' compensation settlement wage loss or loss of bodily functions?
- TTD = wage loss, PD = loss of bodily functions due to AMA Guides



## SOCIAL SECURITY ADDENDUM

Essential elements needed in an SSD addendum:

- Applicant's pre-injury monthly earning capacity
- Applicant's age on P&S date
- Applicant's life expectancy as of the P&S or settlement date
- Gross C&R amount
- PD rating (not the impairment rating!)
- Less deductible amounts = net proceeds
- Future medical costs not covered by Medicare
- Life expectancy (in months) multiplies times pre-injury earning capacity = loss of earnings
- Amortization of net proceeds over the Applicant's life expectancy as loss of future earnings caused by work related impairment



## Social Security Addendum

1. Applicant's pre-injury earning capacity is \$ \_\_\_\_\_ per year which is \$ \_\_\_\_\_ per month.
2. Applicant's date of birth: \_\_\_\_\_ and his/her life expectancy is \_\_\_\_\_ years which is \_\_\_\_\_ months.
3. Applicant's permanent and stationary date is \_\_\_\_\_ based on the report of Dr. \_\_\_\_\_.
4. Applicant's permanent disability rating before apportionment is \_\_\_\_\_% based on the report of Dr. \_\_\_\_\_.
5. Applicant requests an allocation/characterization of settlement proceeds as follows:
  1. Gross settlement: \_\_\_\_\_
  2. Less Attorneys Fees: \_\_\_\_\_
  3. Less SJDB: \_\_\_\_\_
  4. Less Proposed WCMSA: \_\_\_\_\_
  5. Less Present Value of FMTx\*: \_\_\_\_\_
  6. Net Proceeds: \_\_\_\_\_

\*The present value of future medical treatment includes \$ \_\_\_\_\_ per month for life for medical expenses not covered by Medicare or other insurance such as mileage reimbursement, deductibles, co-payments and Applicant's share of prescription costs.

Applicant requests that the WCAB make a finding that the Applicant's net proceeds, \$ \_\_\_\_\_, based upon this allocation, be designated towards his/her loss of future earnings as the equivalent of \$ \_\_\_\_\_ per month for life on account of his or her loss of bodily functions due to the industrial injuries that are settled herein.

Dated: \_\_\_\_\_ Signatures of Applicant and his/her attorney\_\_\_\_\_



## Message to WCJs re SSD Addendums

- Should WCJs pay attention to them?
- Isn't it between the Applicant and the SSA; the WCAB and defendants have no interest in them?
- Is the Applicant's informed consent enough?
- See, Santa Maria Bonita School District vs. WCAB (Recinos) 2003, 67 Cal. Comp. Cases 848.
- Paragraph 11 of the C&R
- Allocation of benefits needs to be evidence based for SSA approval.
- If you ignore the C&R addendum you may make an otherwise adequate C&R inadequate



## More WCJs and SSD Addendums

- If the WCJ does not approve allocation of C&R proceeds then SSA will use whole C&R as SSD offset at the TTD maximum weekly rate until the total amount of the C&R is "paid out."
- SSD benefits get reduced or eliminated as a result of a C&R without an allocation of benefits



## Things Not Subject To SSD Offsets

- Attorneys fees
- SJDB
- Penalties and interest
- Right to file a Petition to Reopen
- Death benefits
- Mileage reimbursement
- Insurance deductibles and co-payments
- \$3,600.00 plus 5% of prescription drugs over \$6,440.00 per year that are not covered under Medicare Part D



## But Wait!

- There is no offset against regular social security retirement (SSR) benefits because of a Compromise and Release!
- But watch out for Medicare!!!!



## WCJ'S Order of Approval of a C&R

- Protects the Applicant against an SSD offset
- Must be written on the original OAC&R and not on a "Supplemental Order" page.
- Example language: "The Court has considered the proposed characterization of proceeds in the Social Security Addendum attached to the C&R. The Court adopts, incorporates and accepts the proposed allocation of proceeds and finds that the Applicant's net recovery of \$\_\_\_\_\_ is equivalent to the sum of \$\_\_\_\_ per month for life because of the Applicant's loss of future earning capacity that is caused by his or her impairments."
- Should DWC, WCAB OR Court Administrator have guidelines?
- Sometimes you cannot avoid an SSD offset because of a large C&R.



## Medicare – The Fear Factor



## Medicare – The Law

- Section 1862(b)(2) Social Security Act (42 USC 1395y(b)(2)) says Medicare may not pay for medical treatment that has been made or can be reasonably expected to be paid under a workers' compensation law or plan.
- The Medicare Secondary Payer Act, 42 USC 1395y, applies to auto accidents, personal injury claims and workers' compensation claims where there is a "primary payer."
- Sections 1862(b)(5)(D) and (b)(6) require that CMS ask beneficiaries about payers who may be primary to Medicare.



## Medicare – The Problem

- Medicare addendums to C&Rs mean nothing
- Medicare set aside arrangement may or may not be necessary
- “Compromise” means settlement of past medical treatment that is included in a settlement
- “Commutation” means settlement of future medical treatment
- A C&R is both under Federal law
- Medicare set aside trusts apply only to settlement of future medical treatment
- Any identified claims for past injury related medical treatment must be reimbursed to the Medicare Trust Fund



## Medicare – The Problem

- Actually, there are two problems:
- Medicare conditional payments: Payments made by Medicare prior to settlement of WC case for medical treatment that should have been paid for by the WC claims administrator.
- Costs and expenses of future medical treatment for industrial injuries cannot be shifted from WC claims administrator to Medicare without “considering Medicare’s interests.”
- Sort of like CIGA – If there is “other insurance” Medicare does not pay. WC claims administrator is primary payer.



## Medicare – Conditional Payments

- Medicare has a lien as a matter of law against Applicant, Defendant, both attorneys – everyone except the WCJ - who has received money from a primary payer.
- 42 U.S.C.S. 1395y(b)(2)(A) and (b)(2)(b); 42 C.F.R. 411.21 through 411.37
- Who to contact to settle Medicare liens:
  - MSPRC – letters are sent by CMS to the IW, his or her attorney, if known, and the employer's claims administrator, if known
  - BEST PRACTICES: IW's attorney should file and serve communications from MSPRC with a proof of service



## Medicare – Conditional Payments

- When contacting the COBC or MSPRC by phone or in writing, provide the following information:
  - Applicant's name
  - Applicant's SSN or Medicare Health Insurance Claim Number (HICN)
  - Date(s) of injury
  - Nature of illness or injury (parts of body injured or claimed)
  - Name, address of WC claims administrator
  - Names and addresses of all legal representatives
  - Name of employer
  - Claim number(s)



## Medicare Set-Aside Arrangements

- Applicant is already entitled to Medicare (Part A, B, or both) regardless of the settlement amount.
- OR
- Applicant has a "reasonable expectation" of Medicare enrollment within 30 months of the settlement date AND settlement is greater than \$250,000.00.



## What is a "Reasonable Expectation?"

- Applicant has already filed for SSD; or
- SSD has been denied but the Applicant anticipates re-filing or appealing the denial; or
- Applicant is 62 years, six months old (30 months from retirement age) at the time of C&R; or
- Applicant has ESRD; or
- Applicant is under 65 years but has been receiving SSD for at least two years; or
- Applicant is over 65 years old at the time of the C&R.



## What is required In a Proposed WCMSA?

- Applicant's health insurance claim number or SSN if not yet eligible for Medicare.
- The same information in a C&R (each party's address), claim number and counsels' addresses.
- Total workers' compensation settlement amount.
- Proposed WCMSA amount.
- Applicant's life expectancy.
- Life care plan.
- Copy of C&R with addendums.
- Current treatment info.
- Future treatment info., Including medication needs (medical reports).
- Applicant's medical recovery prognosis.



## What Else is Required in a WCMSA?

- Amount of future medical treatment.
- Proposed Medicare set aside amount.
- Administrator?
- Fees?
- Set aside funds are only used for injury related medical services that would otherwise be covered by Medicare at the time applicant is Medicare eligible (not before).
- Can you appeal a CMS denial of an WCMSA? No, see 42 CFR 405.926 and 928.
- Add some money in accordance with a CMS letter.
- NEW FOR 2014: All medical reports, records, prescriptions filled for any reason for last 2 years prior to submission of proposed WCMSA to CMS



## Other WCMSA Considerations

- Applicant can be the administrator.
- Segregated interest earning checking account.
- Applicant pays for Medicare Part A, B and D then Medicare pays.
- It takes up to 60 days for CMS to approve an WCMSA.
- WCJs should approve a C&R with an WCMSA approval pending if parties agree: "Applicant agrees to add funding to the WCMSA from his or her net proceeds from the C&R if CMS rejects the MSA that was previously submitted. Applicant agrees to hold defendant harmless from any additional liability for the MSA amount submitted as of the date of the C&R approval."



## Additional Medicare Info

- [www.medicare.gov](http://www.medicare.gov) has a drop-down menu for everything that is covered by Medicare
- MEDICARE COVERAGE INFORMATION:  
1-800-MEDICARE  
1-800-633-4227



## WCMSAs and Medicare Part D

- 12/30/2005 Guidance Memorandum: MSAs have to take into account Medicare's interest in the cost of future prescription medication for work related injuries.
- Regardless of the DOI, the last two years of costs of medical treatment and drugs must be disclosed as part of the MSA proposal.
- After 3/3/09, Medicare uses "AWP" of medication costs regardless of how much Defendant actually had previously paid in the claim.
- Recent case C&R was \$425,000.00 and WCMSA was \$235K, \$195K was for Rx!



## WCMSAs and Medicare Part D

- Medicare Part D prescription drugs do not cover:
  - Vitamins, supplements
  - Over the counter medications
  - Off-label use of drugs
  - Limited opioid or opiate based pain medications
  - Limited benzodiazapines (anxiety meds)
  - Eye glasses
  - Expensive memory foam beds
- Medicare Parts A and B do not cover:
  - Home assistance for laundry, gardening, window cleaning, meal preparations, other maid services
  - Mileage reimbursement
  - Transportation services (taxis, limos, bus passes)
  - Home modifications



## What Should WCJs Do?

- Paragraph 11 of the C&R form: "ACCEPTING A LUMP SUM SETTLEMENT OF A WORKERS' COMPENSATION CLAIM MAY AFFECT, REDUCE OR ELIMINATE OTHER BENEFITS SUCH AS LTD, SOCIAL SECURITY DISABILITY AND MEDICARE ENTITLEMENTS."
- Add area in C&R that allows an Applicant to initial the following: "MEDICARE AND/OR MEDI-CAL HAVE NOT PAID FOR ANY OF MY MEDICAL TREATMENT FOR THE ALLEGED INDUSTRIAL INJURIES AS OF THE DATE OF THIS SETTLEMENT"; or
- "THE IW CERTIFIES UNDER PENALTY OF PERJURY THAT HE OR SHE IS NOT CURRENTLY A MEDICARE BENEFICIARY."



## Is a WCMSA Required? – Red Flags

- If Applicant is eligible for Medicare on the date of the settlement (Medicare has a lien as a matter of law) – has Medicare paid for treatment? If not, you still need an MSA regardless of the amount of the C&R (But see threshold \$25,000.00 memo).
- Applicant is over 62.5 years of age on date of the settlement that is  $\geq$  \$250K.
- Applicant is going to receive SSD within two years from the date C&R is approved and settlement is  $\geq$  \$250K.



## Is a WCMSA Required? – Red Flags

- Applicant is currently appealing an SSD denial and settlement is  $\geq$  \$250K.
- Applicant is getting SSD at time of C&R approval and was receiving SSD at least two years before date of approval and C&R is  $\geq$  \$25K.
- C&R is  $\geq$  \$250,000.00 and C&R approval is within 30 months of becoming eligible for Medicare.



## Is a WCMSA Required? – Red Flags

- The Affordable Care Act – Is that a red flag too?
  - Covers all pre-existing medical conditions
- Any federally funded subsidy such as “Expanded Medicaid” may result in a triggering for CMS to look for “other insurance”
  - Needs based Medi-Cal program (<138% average annual income gets a federal subsidy) becomes “expanded MediCal”
  - Watch out for CMS!!!



## Medicare and Medicaid SCHIP Extension Act (MMSEA) of 2007

- Section 111 of the MMSEA, 42 U.S.C. 1395y(b)(8) requires claims administrators to report claimants who are eligible for Medicare who have a personal injury, auto accident or workers' compensation claim.
- Requires claims administrators to notify CMS that ongoing medical responsibility (OMR) has terminated (i.e. a C&R).
- Does a Defendant in a workers' compensation claim become the "CMS police?"



## The Right to Discovery in WC Cases that Involve Federal Benefits

- Defense attorneys can ask an IW to disclose whether or not he or she is currently eligible for SSR, SSD and/or Medicare
- Defense attorneys can ask IW to disclose whether or not he/she has applied for SSD
- Defense attorneys can ask IW if his or her health insurance premiums are subsidized by Uncle Sam
- Defense attorneys can require IWs to sign CMS HIPAA, Consent to Release and Notice of Representation forms to permit communications between the claims administrator, CMS, COBC and MSPRC whether there is a C&R or not.
- WCJs can sign an Order Compelling Answers to these questions



## If You Do Not Care...

- Medicare will not cover med tx for body parts claimed in the workers' compensation claim.
- Medicare will use the entire C&R amount as the "set aside" amount to cover future medical treatment for parts of body injured.
- Medicare will seek reimbursement for prior conditional payments from the Applicant, his or her attorney, the insurance company and its attorney.
- \$1,000.00 per day fine per IW who is a Medicare beneficiary and RRE fails to file a report to COBC.



## Worse Case Scenario

- Worse case scenario is no SSD addendum and no WCMSA in a large C&R. Applicant may lose SSD payments based upon weekly TTD rate for entire C&R amount and Medicare will not cover future medical treatment for parts of body injured in work related injury and Medicare will sue the Applicant, his attorney, RRE and its attorney for past treatment costs.
- Responsible Reporting Entity (RRE) gets fined by the feds for its failure to report IW who is a Medicare beneficiary.
- Defendant gets hit for reimbursement for treatment provided in federally subsidized health plan



## California Flavor

- Does IW need an WCMSA?
  - Age  $\geq$  65 (C&R is  $\geq$  \$25,000.00); entitled to SSDI or SSI-D on date of settlement approval, or “reasonable expectation” of entitlement to Medicare within 30 months of settlement AND  $\geq$  \$250,000.00 C&R.
- If IW needs an WCMSA, does the C&R need to be sent to CMS?
  - No, just the amount of the settlement needs to be submitted to CMS for CMS approval of a WCMSA.
  - You send a copy of the signed C&R AFTER CMS has approved the WCMSA to complete the process.



## California Flavor

- Should Def require CMS approval of a WCMSA prior to submission of a C&R to the WCAB for approval?
  - No, if the WCMSA is relatively low cost OR if IW is over 65.
  - Yes, if the WCMSA is very high cost OR IW is young (<60 years old) OR if WCMSA is structured amount.
- Don't forget SSD Addendum to avoid the “80% Rule.”
- “Thomas” findings mean nothing to CMS.



## What Does CMS Say About This – What is the “Party Line”?

- Does CMS require the approval of WCMSA's?
  - If the parties to a WC settlement stipulate a WCMSA but do not receive CMS approval, then CMS is not bound by the set-aside amount stipulated by the parties, and it may refuse to pay for future medical expenses in the case, even if they would ordinarily have been covered by Medicare.
  - However, if CMS approves the WCMSA and the account is later appropriately exhausted, Medicare will pay related medical bills for services otherwise covered and reimbursable by Medicare regardless of the amount of care the beneficiary continues to require.



## What Does CMS Say About This – What is the “Party Line”?

- What are the ramifications if the MSA is not approved or if CMS approval is not sought?
  - If CMS does not subsequently provide approval of the funded WCMSA amount as specified in the settlement or proof is not provided to CMS that the CMS-approved amount has been fully funded, CMS may deny payment for services related to the WC claim up to the full amount of the settlement.
  - Only the approval of the WCMSA by CMS and the submission of proof that the WCMSA was funded with the approved amount, would limit the denial of related claims to the amount in the WCMSA.



## What Does CMS Say About This – What is the “Party Line”?

- Is there anything that could be done in regard to the current requirement for medication being priced at AWP?
  - CMS uses either the WC fee schedule (for states that have such schedules) or the full actual charges for its review of a proposed WCMSA based on whichever methodology is used by the individual/entity submitting the proposal.
  - The CMS reviews WCMSAs on a **case-by-case basis** in order to determine whether Medicare has an obligation for services provided after the settlement that originally were the responsibility of the WC plan or insurer. Accordingly, in reviewing a WCMSA, CMS must know whether the arrangement is based on WC fee schedule amounts or full actual charge amounts.



## California Flavor

- What if WCJ makes a specific finding of no injury AOE/COE or no industrial injury to specific body parts?
  - CMS will give full faith and credit to judicial decision of no injury AOE/COE or a specific judicial finding of no injury to specific body parts.
  - CMS will not give any credit to a stipulation between the parties that AOE/COE is in issue or a body part is disputed.
- Does an IW with an WCMSA have to pay separately for the “donut hole?”
  - No, there is no donut hole in a WCMSA. All payments from the account must be for Medicare covered expenses under Parts A, B and D.



## California Flavor

- Is there any way to avoid a WCMSA in a typical case where the IW is a Medicare beneficiary at the time of the settlement?
  - Yes, if the IW has a group health plan that covers him or her until death, regardless of age.
  - Yes, if the parties enter into a Stipulation With Request for Award or C&R that essentially settles everything except future medical treatment.
    - Use WCMSA to determine future mileage reimbursements.
    - Include costs for medical treatment that is not covered by Medicare, including off-label use of Rx or non-covered Rx such as OTC drugs.
    - Include home assistance costs if justified by the medical evidence.



## One Final Message

- Do not obtain a proposed WCMSA if you don't need one!
- Do not submit a proposed WCMSA to CMS if you don't need to!
- WCMSA proposals are VOLUNTARY – there are no statutes, regulations or legal mandates to have them, only office memos from CMS/HHS headquarters in Baltimore to its Regional Offices ("ROs").
- If you obtain a WCMSA in a case where the IW is not a Medicare beneficiary, you are giving AA prima facie evidence of the value of future medical treatment!



The Dog was just Yawning...



.....Were You?

- Thank You For Your Attention!

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