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OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AF18

Federal Employees Health Benefits Program: Filing Claims; Disputed Claims Procedures and Court Actions

AGENCY: Office of Personnel Management.

ACTION: Interim regulations with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing interim regulations to revise the requirement that legal actions to recover on a claim under the Federal Employees Health Benefits (FEHB) Program should be brought against the health benefits carrier rather than OPM, and to clarify the procedures for filing claims for payment or service under the FEHB Program. The purpose of these interim regulations is to clarify that if a covered individual chooses to bring legal action pertaining to a denial of an FEHB benefit, such legal action should be brought against OPM, and to clarify the administrative review process that must precede legal action in the courts.

DATES: These interim regulations are effective March 29, 1995. Comments must be received on or before May 30, 1995.

ADDRESSES: Send written comments to Lucretia F. Myers, Assistant Director for Insurance Programs, Retirement and Insurance Service, Office of Personnel Management, P.O. Box 57, Washington, DC 20044; or delivery to OPM, Room 3451, 1900 E Street NW., Washington, DC; or FAX to (202) 606–0633.

FOR FURTHER INFORMATION CONTACT: Margaret Sears, (202) 606–0004.

SUPPLEMENTARY INFORMATION: Historically, OPM has required that covered individuals who want to bring suit because an FEHB carrier has denied their claim for health benefits must sue the carrier, not OPM. These interim regulations provide that legal actions arising out of a denial of FEHB benefits should be brought against OPM rather than the FEHB carrier that made the initial denial decision. Because OPM has the authority under the FEHB law to order the carrier to pay the claim, OPM has determined it is appropriate under current statute for the covered individual to bring suit against OPM if OPM declines to order the carrier to pay the claim. The interim regulations also clarify the process and circumstances for bringing legal actions under the FEHB Program. They clearly state that the administrative review process set forth in 5 CFR 890.105 must be completed before suit is brought. To further clarify the purpose and intent of these regulations, we have changed the title of the regulation at 890.107 from ''Legal actions'' to ''Court Review.''

The legislative history of § 8902(j), title 5, United States Code, shows that Congress intended OPM (at that time the Civil Service Commission) to provide an administrative appeal process, binding upon the carriers, that would save covered individuals the expense and delay of being forced into the courts to recover on meritorious claims for benefits. Based upon this directive and its central role in the administration of the FEBH Program, OPM established a detailed administrative review process for benefits claims leading to a final decision on such claims by OPM. It is OPM's view that this administrative review process must be followed before legal action is pursued in the courts. Further, the matter to be reviewed by a court upon appeal is the OPM decision affirming the carrier's denial of benefits, with the court's review being limited to an examination of OPM's administrative decision to deny the claim for payment or services.

Health insurance contracts under the FEHB Program are Federal contracts under 5 U.S.C., chapter 89. Accordingly, legal actions concerning disputes arising or relating to those contracts are controlled by Federal, rather than State law. Congress, in the FEHB Act, mandated Federal uniformity for all matters that relate to (1) the nature or extent of coverage; (2) benefits; and (3) payment of benefits under the FEHB Program. By statute, all health insurance contracts require the carrier to agree to pay or provide a health service or supply in an individual case if OPM finds that the covered individual is entitled to the benefit under the terms of the contract. Congress also directed OPM to take a central role in determining whether a health service or supply should be provided in individual cases to covered individuals and, if it should be provided, to require carriers to pay for such health service or supply. These interim regulations reaffirm the principle of uniformity in the FEHB Program by providing that in judicial disputes regarding the denial of a health benefits claim, review is to be limited to the record that was before OPM and that was the basis of the OPM decision to disallow the benefit. In the event that an appropriate court concludes that benefits should have been awarded under the FEBH Act, the court possesses ample authority to require OPM to order that such payments be made to the covered individual from the carrier. These interim regulations clarify that OPM intends for its decision to be upheld unless the court concludes that the OPM decision affirming the carrier's denial of benefits was inconsistent with the standard for a final agency action under applicable Federal law.

The administrative review process is set forth in 15 CFR 890.105, Filing claims for payment or service. Section 890.105 outlines the procedures for filing claims for payment or service when there is a disagreement over payment or service between the carrier and the covered individual. In addition, the regulations make minor changes in the time limits for carrier reconsideration and OPM review of claims in 890.105 to make the language easier to read.

Waiver of Notice of Proposed Rulemaking

Pursuant to section 553(b)(3)(B) of title 5 of the U.S. Code, I find that good cause exists for waiving the general notice of rulemaking because these interim regulations remove a restriction on the actions of Federal employees and annuitants.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulations primarily affect

individuals enrolled under the Federal Employees Health Benefits Program.

List of Subjects in 5 CFR Part 890

Administrative practice and procedure, Government employees Health facilities, Health insurance, Health professions, Hostages, Iraq, Kuwait, Lebanon, Reports and recordkeeping requirements, Retirement.

Office of Personnel Management.

James B. King,

Director.

Accordingly, OPM is amending 5 CFR part 890 as follows:

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

1. The authority citation for part 890 continues to read as follows:

Authority: 5 U.S.C. 8913; § 890.803 also issued under 50 U.S.C. 403p, 22 U.S.C. 4069c and 4069c–1; subpart L also issued under sec. 599C of Pub. L. 101–513, 104 Stat. 2064, as amended.

2. In § 890.101 paragraph (a) is amended by adding a definition of ''covered individual'' to read as follows:

§ 890.101 Definitions; time computations.

(a) * * *

Covered individual means an enrollee or a covered family member.

* * * * *

3. Section 890.105 is revised to read as follows:

§ 890.105 Filing claims for payment or service.

(a) *General.* Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the claimant's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (b) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 1 year from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within 30 days after the covered individual's request for reconsideration or the carrier's receipt of additional information.

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within 30 days after the date it receives the request or within 30 days after the date it receives the additional information requested. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) *Information required to process requests for reconsideration.* (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) *Carrier determinations.* The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) *OPM review.* (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed; or

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the

date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph (e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

4. Section 890.107 is revised to read as follows:

§ 890.107 Court Review.

(a) A suit to compel enrollment under § 890.102 of this part must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of State statute (chapter 89, title 5, United States Code). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM. The recovery in such a suit will be limited to the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

[FR Doc. 95–7793 Filed 3–28–95; 8:45 am]

BILLING CODE 6325–01–M

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

8 CFR Parts 103, 286, and 299

[INS No. 1312–93]

RIN 1115–AB78

Establishment of Pilot Programs To Charge a Commuter User Fee at Selected Ports of Entry

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Final rule.

SUMMARY: This rule amends the Immigration and Naturalization Service (Service) regulations to implement pilot programs to charge fees for inspection service provided to selected land border Ports-of-Entry (POEs). Limited resources and increasing commuter traffic over the land borders has resulted in costly delays to transborder travelers. Pilot projects, such as the Dedicated Commuter Lanes (DCLs), in which eligible groups may expeditiously enter the United States through designated lanes, will enabled the Service to increase staffing, enhance inspection services, and reduce delays in crossing the border.

EFFECTIVE DATE: March 29, 1995.

FOR FURTHER INFORMATION CONTACT: Robert A. Mocny, Assistant Chief Inspector, Inspections Division, Immigration and Naturalization Service, 425 I Street NW., Room 7228, Washington, DC 20536, Telephone (202) 514–3275.

SUPPLEMENTARY INFORMATION: Commuter traffic over our land borders has increased significantly each year over the past decade, and in fiscal year 1992 accounted for approximately 90 percent of all inspections completed. At certain locations, traffic backups sometimes last several hours. Such delays are both irritating and costly to the traveling public. Through automation and an increase in the inspection force, the Service could significantly reduce these delays. However, the appropriated funds have not kept up with the rapid growth in land border traffic. Although revenue from the Immigration User Fee Account, authorized by Congress in 1986 and covering commercial air and sea arrivals of POEs, has enabled the Service to more than triple the number of available air and seaport inspectors, these funds may not, by statute, be used to staff land border POEs.

Provisions of Public Laws 101–515 and 103–121

In the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1991, Pub. L. 101–515, dated November 5, 1990, Congress included language which allows for pilot programs on the inspection fee concept on the land borders. This law, added as section 286(q) of the Immigration and Naturalization Act (Act), and amended by section 309(a)(2) of the Miscellaneous and Technical Immigration and Naturalization Amendments of 1991, Pub. L. 102–232, dated December 12, 1991, authorizes the Attorney General to establish pilot projects which include the charging of a fee and provides that the fee collected may be used only to enhance inspection services. Pursuant to this law, such pilot projects are to be developed by the Attorney General after consultation with the Secretary of the Treasury and with Congress. All such pilot projects were scheduled to terminate on September 30, 1993, but were extended by Congress until September 30, 1996, by the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1994 Pub. L. 103–121, dated October 27, 1993. This law also limited these projects only to the northern border of the United States. However, in the Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act, 1995, Pub. L. 103–317, dated August 28, 1994, Congress authorized the expansion of the commuter lane pilot project to land border crossings in California.

Discussion of Comments

The Service Published an interim Regulation on May 13, 1991, at 56 FR 21917–21920, amending 8 CFR Parts 103, 286, and 299. In this rule, the Service sought to use DCLs to enhance services to those border crossers who most frequently enter the United States over the land borders. The interim rule also contained a provision for the establishment of a per vehicle user fee at selected POEs. The interim rule included a request for comments by August 12, 1991. The Service received three responses, each discussing several issues.

Use of Funds

One commenter expressed concern that the revenues generated from the projects will be channeled to the General Fund and not used for the specific purpose of aiding border congestion and delays. The revenues generated by the DCL implementation are controlled by section 286(q) of the Act, which states that such funds will be used to provide land border inspection services. A separate land