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OFFICE OF PERSONNEL MANAGEMENT

5 CFR Part 890

RIN 3206–AH36

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

AGENCY: Office of Personnel Management.

ACTION: Final rule.

SUMMARY: The Office of Personnel Management (OPM) is issuing final regulations revising 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 clarifying the procedures for filing claims for payment or service under the FEHB Program. The purpose of these final regulations is to prescribe 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.

EFFECTIVE DATE: May 6, 1996.

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

SUPPLEMENTARY INFORMATION: On March 29, 1995, OPM published interim regulations in the Federal Register (60 FR 16037) that require individuals who want to bring suit concerning the denial of their health benefits claims to bring such suits against OPM instead of the health benefits carrier, as had been the case previously. The interim regulations also clarified the administrative review procedures that must precede legal action in the courts, the circumstances under which suits may be brought against OPM, and that the court's review is limited to the record that was before OPM when it made its decision.

OPM received 11 comments on the interim regulations. Three commenters suggested that we amend the regulations to clarify that the regulations apply to providers to whom the covered individual has assigned the right to pursue the claim. We have not accepted this suggestion because the right of access to the disputed claims process belongs to the covered individual. We have amended the interim regulations to clarify that another person or entity, whether or not a provider, can gain access to the disputed claims process only when acting on behalf of the covered individual and with the covered individual's specific written consent.

Two commenters thought that the one-year period for initiating the disputed claims process was too long. They suggested a 90-day period instead. The one-year period has been OPM's policy since the disputed claims process was created in 1975. However, we believe that the period can now be reduced to 6 months if there are sufficient safeguards to protect the interests of individuals who, because of medical problems or for other reasons are unable to request reconsideration within the 6 months time limit. Therefore, we are modifying the regulations to require that covered individuals who want to ask the plan to reconsider its denial must do so within 6 months after the denial unless the covered individual shows that he or she was prevented by a cause beyond his or her control from making the request within that time period. In addition, we are adding a provision to allow OPM to reopen a decision it made concerning a disputed claim if it receives evidence that was unavailable at the time OPM made its decision.

Two commenters said that the amount of time carriers have to respond to requests for reconsideration—30 days—is too short, especially when the issue is medical necessity. They suggested that the carriers be allowed 45 days, with the option to extend the period for an additional 30 days, if necessary. They further suggested that the carriers be given 45 days rather than 30 to review additional information received from the covered individual or provider. In both cases, the 30-day period has been in place for a number of years and has been working well enough that we believe that extending the time period to 45 days would unnecessarily lengthen the time required to complete the disputed claims process. Therefore, we have not accepted these suggestions.

Two commenters said that the time period for seeking judicial review should be tied to the date the covered individual receives OPM's decision rather than the date the care or service was provided. One commenter supported the provision basing the time limit on the date the care or service was provided and asked us not to change it. The interim regulations provide that legal action on a disputed claim may not be brought later than December 31 of the 3rd year after the year in which the care or service was provided. After considering these three comments we have decided not to modify our regulations at this time. This timeframe reflects our brochure language over the past several years. It is our experience that this timeframe works well; however, we will continue to monitor all timeframes in these regulations and make changes as warranted.

Four commenters suggested that the regulations should explicitly state that court actions are not to be brought against a carrier or a carrier's subcontractors. One commenter suggested that we amend the regulations to state that the carrier is an indispensable party to the lawsuit. After considering these five comments, we have modified the regulations to specify that court action is not to be brought against the carrier or the carrier's subcontractors. Since it is OPM's decision, not the carrier's, that is being contested, it is appropriate that OPM, rather than the carriers, be the focus of lawsuits related to denial of benefits.

Two commenters said that the interim regulations should be set aside because they adversely affect the covered individual's right: (1) Of access to State courts, (2) to seek monetary compensation for damages, (3) under State law to require insurer to prove that notice was given concerning changes in benefits and that contract language is clear, (4) to have the option to go to court without seeking OPM review, (5) to present evidence that OPM did not have when it made its determination, and (6) to seek an expedited ruling by the court when life or health is at issue. OPM's regulations have never offered

such ''rights.'' The interim regulations simply clarified that these opportunities are not available to covered individuals under the FEHB program. The FEHB law includes a provision specifically stating that FEHB contract provisions that relate to the extent of coverage or benefits supersede and preempt any State law that relates to health insurance or plans to the extent that such law is inconsistent with FEHB contractual provisions. Therefore, we believe the interim regulations accurately reflect the intent of the FEHB law. Further, it has been OPM's policy, and will continue to be OPM's policy, to expedite the dispute resolution process when there are issues of life and health at stake. Premature involvement of the courts at such time is unnecessary. The only real change made by the interim regulations was which party to the FEHB contracts should be named in a suit.

Two commenters said that the interim regulations should be set aside because they violated the Administrative Procedure Act in that they became effective before completing a comment period. The interim regulations were promulgated to provide immediate guidance and information to alleviate any burden on the FEHB enrollees in cases of possible litigation. It was OPM's view that immediate implementation of regulations that clarify and more fully explain the proper judicial review of an OPM decision sustaining a health benefit plan's denial of coverage would minimize unnecessary litigation and uncertainty. Thus, the interim regulations were intended to more clearly specify a review procedure that sometimes appeared to be unclear and was not always applied consistently.

One commenter inquired whether the interim regulations removed a restriction so that there was good cause for issuing them in this form. It was OPM's view that the interim regulations remove the restriction requiring that enrollees sue a health benefits carrier when contesting an OPM decision that affirmed the carrier's determination that the benefit is not covered under the carrier's plan. Previously, enrollees could not bring suit against OPM directly even though they ultimately were contesting OPM's decision.

One commenter asserted that the regulations should specify that they have no impact on an individual's rights under the Federal Sector Equal Employment Opportunity rule set forth in 29 CFR Part 1614. That is, individuals who believe they have been discriminated against in regard to insurance benefits because of disability or another protected basis are not required to pursue or exhaust the administrative remedy provided by these regulations before pursuing their rights under 29 CFR Part 1614. Since OPM has no authority concerning the provisions of title 29 of the Code of Federal Regulations, it would not be appropriate to address an individual's rights under title 29 in title 5. Instead, the circumstances under which one may access remedies related to title 29 should be included in title 29.

One commenter felt that the interim regulations do not expressly prescribe time limits when the carrier fails to make its decision within 60 days after requesting, but not receiving, information from the covered individual. We have modified the regulations to clarify that this circumstance is included in the administrative process.

One commenter objected to the requirement that the claimants must express their reasons in terms of the brochure provisions because enrollees sometimes do not have brochures. Since a dispute about a claim must be based on whether or not the claim was payable under the FEHB contract and the brochure sets forth those contract provisions, individuals need a brochure in order to know whether they have a dispute. They also need a brochure to obtain information on the procedures for disputing carriers' denials of claims. Further, brochures are easily obtainable from the plan. We find that this requirement is important in encouraging the individual to express his or her reasons in a manner that will facilitate a successful result when there is a valid dispute.

Two commenters suggested that the regulations be revised to require that OPM's decision contain a notice of the covered individual's right to bring suit. We are not adopting that suggestion because we are adding that information to the brochures. The brochures will give complete information about the disputed claims process from the initial request to the carrier for reconsideration through the requirements for bringing suit when OPM concurs with the carrier's reconsideration decision to deny the claim.

We have also modified the regulations at § 890.107(c) to clarify that recovery in the FEHB Program is accomplished through a directive from OPM to the carrier to make payment according to the court's order.

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.* (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual'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 (c) 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.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 6 months 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. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(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 the time limit set forth in this paragraph (b)(2)(iii).

(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 the time limit set forth in paragraph (b)(2) of this section. 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;

(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.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

4. Section 890.107 is revised to read as follows:

§ 890.107 Court review.

(a) A suit to compel enrollment under § 890.102 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 Federal statute (5 U.S.C. chapter 89). 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 and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay 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. 96–8373 Filed 4–4–96; 8:45 am]
BILLING CODE 6325–01–P

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 98

[Docket No. 94–006–2]

Importation of Embryos From Ruminants and Swine From Countries Where Rinderpest or Foot-and-Mouth Disease Exists

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Final rule.

SUMMARY: We are amending the regulations to allow, under specified conditions, the importation of embryos from all ruminants, including cervids, camelids, and all species of cattle, and from swine from countries where rinderpest or foot-and-mouth disease exists. The regulations currently provide for importing only embryos from certain species of cattle in countries where rinderpest or foot-and-mouth disease exists. Research now indicates that embryos from all species of cattle, from ruminants other than cattle, and from swine, which are produced, collected, and handled under certain conditions in countries where rinderpest or foot-and-mouth disease exists, can be imported with virtually no risk of introducing communicable diseases of livestock into the United States. This action will make additional sources of genetic material available to domestic animal breeders.

EFFECTIVE DATE: April 5, 1996.

FOR FURTHER INFORMATION CONTACT: Dr. Roger Perkins, Staff Veterinarian, Import Animals Program, National Center for Import and Export, VS, APHIS, 4700 River Road Unit 38, Riverdale, MD 20737–1231, (301) 734–8170.

SUPPLEMENTARY INFORMATION:

Background

The regulations in 9 CFR part 98 (referred to below as the regulations) govern the importation of animal germ plasm so as to prevent the introduction of contagious diseases of livestock or poultry into the United States. Subpart A of part 98 applies to ruminant and swine embryos from countries free of rinderpest and foot-and-mouth disease (FMD), and to embryos of horses and asses. Subpart B applies to certain cattle embryos from countries where rinderpest or FMD exists. Subpart C applies to certain animal semen.

Subpart B currently allows for the importation of embryos from cattle (*Bos indicus* and *Bos taurus*) from countries where rinderpest or FMD exists only if embryos are produced, collected, and handled under certain conditions. However, research [1] has demonstrated that the same conditions effectively ensure that embryos from all species of cattle, and from swine, and from ruminants other than cattle, including camelids and cervids, can also be imported into the United States from countries where rinderpest or FMD exists without significant risk of introducing these diseases.

At this time, only *Bos indicus* and *Bos taurus* cattle embryos may be imported into the United States from countries where rinderpest or FMD exists. The available gene pool for swine and ruminants other than cattle cannot be enlarged by using embryos from animals in countries where rinderpest or FMD exists. Because of this, U.S. livestock interests, except cattle-related interests, cannot fully participate in the growing international market in germ plasm.

On June 6, 1995, we published in the Federal Register (60 FR 29781–29784, Docket No. 94–006–1) a proposal to amend the regulations in subpart B to allow embryos from all ruminants, including cervids and camelids, from countries where rinderpest or FMD exists, to be imported into the United States under the same conditions under which *Bos indicus* and *Bos taurus* cattle embryos may be imported from those countries into the United States. Also, we proposed to amend the regulations in subpart B to allow embryos from swine from countries where rinderpest or FMD exists to be imported into the United States under conditions that are the same as those for *Bos indicus* and *Bos taurus* cattle embryos, except with respect to the specific diseases for which we would screen.

We solicited comments concerning our proposal for 60 days ending August 7, 1995. We received 30 comments by that date. They were from individuals and groups involved with veterinary medicine, from a State Department of Agriculture, and from individuals, businesses, and associations interested in artificial insemination (AI).

Of the 30 comments received, 2 were supportive. Of the others, 23 were identical form letters. The issues raised in these comments are discussed below by topic.

Treatment-Based Import Conditions

Most of the comments stated that our regulations for importing embryos should be completely revised. The commenters advocated a treatment-based approach to preventing the importation of disease via embryos, rather than the disease prevention/disease avoidance system we now have, which is based on serologic testing.

We have carefully considered these comments. We are constantly reviewing our regulations to ensure that they reflect the latest proven technology and are as effective as possible. The proposed regulations published in June, 1995, included the regulatory changes we believe are technically sound and most needed and desirable at this time. However, we intend to review all the regulations in part 98. At that time, we will consider whether we should adopt a treatment-based approach for any diseases. If we determine that changes are warranted, we will publish proposed regulations for public comment in the Federal Register.

Applying Same Requirements to Other Species

Our regulations currently apply only to embryos from *Bos taurus* and *Bos indicus* cattle from countries where foot-and-mouth disease or rinderpest exists. Many of the commenters questioned the scientific basis for our proposal to allow importation of other species and expressed the belief that it would cause ''undue risk'' or that it was ''not without risk.''

Our regulations require embryos for importation to be washed. Washing removes some disease agents. It is correct that the washing procedures required under our regulations have not been tested for efficacy against all disease agents specific to swine, or against all disease agents of all species of ruminants. However, this is not necessary as our regulations are based on serologic testing of the donor animals. Under proposed § 98.15, we would require donor dams to be obtained from herds which have been free of all diseases of concern for at least 1 year before embryo collection and require donor dams to be tested and found free of all diseases of concern. In this way we would ensure that embryos from donor animals are free of diseases which would pose a disease threat to U.S. livestock.

Washing Embryos With Trypsin

Many of the commenters suggested we amend the regulations to require that

[1] Information about pertinent research may be obtained from the Animal and Plant Health Inspection Service, Veterinary Services, National Center for Import-Export, 4700 River Road Unit 38, Riverdale, Maryland 20737–1231.