goal is to better serve rights-holders who engage in regular, multiple registrations and other transactions with the Copyright Office every year, and the proposed language reflects this intent with specificity.

The Office also proposes to institute a requirement that every deposit account holder must establish, in consultation with the Copyright Office, a minimum balance for its deposit account. Ideally, this balance will be the lowest amount a deposit account holder can have in his or her account and still be able to pay for their regular number of copyright registration applications. This amount will be set collaboratively so that both the account holder and the office are comfortable that it will be sufficient for the account holder's expected activity.

In the event a deposit account reaches its minimum balance, the Copyright Office will automatically notify the account holder, but take no further action. The minimum balance requirement is intended to act primarily as an indicator to the account holder that the account may need replenishment; going below a minimum balance does not in itself expose the account holder to any adverse consequences.

2. Consequences of Overdrawing a Deposit Account

The Copyright Office proposes that upon the second occasion that a deposit account is overdrawn—meaning the second time there is not enough money in an account to pay the fee for a submitted registration—the account will be closed. In practice this rule will only affect deposit account holders who use paper applications, because eService will not allow an application to be submitted without sufficient funds.

However, a deposit account holder whose account is closed because it has been overdrawn twice is not foreclosed from using a deposit account in the future. The deposit account holder may re-open a new account on the condition that it is funded through the automatic replenishment option. This condition is to protect the account holder from the risk of overdrawing again and to protect the Copyright Office from the risk of further suspended applications.

3. Voluntary Automatic Replenishment

The Copyright Office proposes to offer a voluntary automatic replenishment program to all deposit account holders. Under this program, the deposit account holder would provide pre-authorization to the Copyright Office to replenish the account from the account holder's credit card or bank account. Replenishment would take place when the deposit account reaches its minimum balance, at which time the Office will also immediately notify the account holder of the replenishment. The account holder would determine the amount of replenishment above the pre-determined minimum balance at the time the account holder enters the program.

The Office seeks comment from the public on the following proposed regulations for governing deposit accounts maintained by the Copyright Office.

List of Subjects in 37 CFR Part 201

Copyright, General provisions.

Proposed Regulations

In consideration of the foregoing, the Copyright Office proposes to amend 37 CFR Ch. II as follows:

PART 201—GENERAL PROVISIONS

1. The authority citation for part 201 continues to read as follows:

Authority: 17 U.S.C. 702.

2. Section 201.6(b) is revised to read as follows:

§ 201.6 Payment and refund of Copyright Office fees.

* * * * *

(b) *Deposit accounts.* (1) Persons or firms having 12 or more transactions a year with the Copyright Office may prepay copyright expenses by establishing a Deposit Account. The Office and the Deposit Account holder will cooperatively determine an appropriate minimum balance for the Deposit Account, and the Office will automatically notify the Deposit Account holder when the account reaches that balance.

(2) The Copyright Office will close a Deposit Account the second time the Deposit Account holder overdraws his or her account. An account closed for this reason can be re-opened only if the holder elects to fund it through automatic replenishment.

(3) In order to ensure that a Deposit Account's funds are sufficiently maintained, a Deposit Account holder may authorize the Copyright Office to automatically replenish the account from the holder's bank account or credit card. The amount by which a Deposit Account will be replenished will be determined by the deposit account holder. Automatic replenishment will be triggered when the Deposit Account reaches the minimum level of funding established pursuant to section (b)(1), and Deposit Account holders will be automatically notified of the replenishment.

* * * * *

Dated: October 1, 2010.

Tanya Sandros,

Deputy General Counsel.

[FR Doc. 2010–25129 Filed 10–7–10; 8:45 am]

BILLING CODE 1410–30–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN55

Reimbursement Offsets for Medical Care or Services

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations concerning the reimbursement of medical care and services delivered to veterans for nonservice-connected conditions. The proposed rule would apply in situations where third-party payers are required to reimburse VA for costs related to care provided by VA to a veteran covered under the third-party payer's plan. This proposed rule would add a new section barring offsets by third-party payers and establishing a process by which third-party payers would submit a request for a refund on claims for which there is an alleged overpayment.

DATES: Comments must be received on or before December 7, 2010.

ADDRESSES: Written comments may be submitted through *http://www.Regulations.gov;* by mail or hand delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue, NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to "RIN 2900–AN55, Reimbursement Offsets for Medical Care or Services." Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m. Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number.) In addition, during the comment period, comments may be viewed online through the Federal Docket Management System at *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Anthony Norris, Program Analyst,

Business Operations, Chief Business Office (168), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461–1593. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: Pursuant to 38 U.S.C. 1729, a third-party payer, such as a private medical insurer, has an obligation to pay the United States reasonable charges for the cost of medical care or services furnished to a veteran for a nonservice-connected disability when the veteran or the provider of the care or services would otherwise be eligible to receive payment for such medical care from the third-party payer. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf. VA's authority under section 1729 is generally implemented in 38 CFR 17.101 through 17.105. However, the topic of addressing reimbursement offsets for medical care or services as proposed in this rulemaking is not covered by current VA regulations. As explained below in further detail, this proposed rule is consistent with regulations promulgated by the Department of Defense (DOD) in 32 CFR part 220. DOD's collection statute, 10 U.S.C. 1095, is similar to VA's collection statute, 38 U.S.C. 1729. Therefore, VA proposes to implement section 1729 in a manner substantially similar to DOD's implementation of section 1095. VA's implementation of these changes will provide clarity and uniformity in how third-party payers interact with both Departments.

As a matter of common business practice, third-party payers who are (or who believe that they are) owed a refund from VA based on an overpayment often recoup such money by unilaterally offsetting a future payment amount to VA. As a purchaser and provider of care, VA medical centers are subject to this practice of unilateral offsets. An offset occurs when the payer, alleging that it made an earlier overpayment to VA, reduces or takes back the alleged overpayment by withholding payment owed to VA on an unrelated debt transaction. In an attempt to recoup the overpayment, the payer seldom associates the reduced payment with the alleged overpaid claim. Third-party payer unilateral offsets disrupt VA accounting practices and present certain challenges to VA in managing third-party collections and evaluating account receivables for deficient payments. Further, such practices eliminate VA's opportunity to validate the alleged overpayment and pursue proper review, if deemed appropriate given the circumstances.

This proposed rule would address third-payer offsets and certain policy exclusions and, consequently, improve VA's administration of account receivables and increase efficiency in maintaining third-party payer debts. The proposed rule would provide specific procedures that VA will use to recover payments from third-parties, consistent with our interpretation of our authority to recover payments from third-parties under section 1729. We believe that VA's statutory right to recovery of payment is not contingent upon a third-party payer's assertions regarding previous alleged overpayments and that the authority to compromise a claim rests with the government, not with the payer. Without the consent of the government, a third-party payer cannot compromise a claim premised on a separate disputed transaction. A request must be submitted and adjudicated separately. Several states prohibit third-party payer automatic offsets and require some form of notice and due process. We believe that VA should have protection from off-setting practices similar to that afforded individual states. Although section 1729 does not specifically address all of the issues that are addressed by this proposed rule, we believe that our proposed implementation of the statute is consistent with Congress' intent.

General Rule and Definitions

Proposed paragraph (a)(1) of the proposed rule would explain the general rule, discussed above, that VA has the authority to recover or collect reasonable charges from third-party payers for medical care or services provided for nonservice-connected disability to a veteran who is also covered by the third-party payer's plan. We also state that our right to recover or collect is limited to "the extent that the beneficiary or a non-government provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf." This limitation is statutory, because section 1729 states that VA's right applies only "to the extent that the veteran (or the provider of the care or services) would be eligible to receive payment for such care or services from such third-party if the care or services had not been furnished by a department or agency of the United States."

Proposed paragraph (a)(1) would essentially restate the statute.

Proposed paragraph (a)(2) would provide several definitions applicable to this section. These definitions incorporate and interpret the statutory definitions of *health-plan contract* and *third-party* in section 1729(i). Also, as noted above, this proposed rule would be based upon and consistent with DOD's collection regulations in 32 CFR part 220. We propose to adopt, with only minor non-substantive changes, certain definitions promulgated by DOD in 32 CFR 220.14. Specifically, we propose to define the following terms consistent with the same or similar terms in § 220.14: *Automobile liability insurance, health-plan contract, Medicare supplemental insurance plan, No-fault insurance, participating provider organization,* and *third-party payer.* We intend that these definitions will clearly state the meaning of these terms as commonly used in the insurance industry.

Calculating Reasonable Charges

Proposed paragraph (b)(1) would explain that "reasonable charges" for the purposes of section 1729 are calculated using the regulatory method applicable to the particular charge as prescribed in current 38 CFR 17.101. We intend no substantive change regarding VA's reasonable charges methodology and propose this provision only to provide notice that VA would bill third parties a "reasonable charge" as determined under current regulations for its services.

Proposed paragraph (b)(2) would explain that, "If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount." This merely restates the statutory requirement in section 1729(a)(3)(B) that the collectible or recoverable amount must be reduced by any deductible or copayment or both.

VA's Right To Recover or Collect Is Exclusive

Proposed paragraph (c) would establish that VA's right to recover or collect under this section is exclusive and prescribe that "[t]he only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section." This statement would address confusion on the part of third-party payers

regarding whether VA permits offsetting, and explain that payment must be provided to VA and not to any other party. For example, this provision would proscribe third-party payments made directly to the beneficiary for care or service provided in or through a VA medical facility. Section 1729 provides to VA (and not to a third-party beneficiary) the right to recover or collect payments, as we have explained above. Accordingly, payments to anyone other than VA, including payments made by a third-party directly to the patient, cannot satisfy 1729.

Proposed paragraph (c)(1) would allow the United States to file a claim for payment or institute and prosecute legal proceedings against a third-party payer, within six years, to enforce a right of the United States under 38 U.S.C. 1729 and this section. This proposed provision would restate section 1729(b)(2).

Proposed paragraph (c)(2) would restate the United States' right to compromise, settle or waive a claim under the proposed rule, consistent with section 1729(c)(1).

Proposed paragraph (c)(3) would list the statutory authority for the remedies available to the United States in collection actions under section 1729. These remedies include administrative offset and other means to collect.

Pursuant to section 1729(a) and (f), the United States has a right to collect, consistent with the statutory terms, the reasonable charges for medical care and services from a third-party payer. This right is not contingent upon a third-party payer's unsubstantiated assertions regarding previous alleged overpayments, rather a third-party payer must provide information sufficient for VA to determine that an overpayment occurred. Under section 1729(c)(1) and 38 CFR part 2, the authority to compromise, settle, or waive a claim rests with the government, not with the payer.

Therefore, proposed paragraph (c)(4) would prescribe that, without the consent of the government, a third-party payer cannot unilaterally compromise or settle a claim premised on a separate disputed transaction. It would also prohibit offsetting and reducing subsequent payments. A request for refund is a claim against the United States and must be submitted and adjudicated separately.

Assignment of Benefits or Other Submission by Beneficiary Not Necessary

Proposed paragraph (d) would address whether beneficiaries must execute an assignment of benefits form for the third-party payer to pay. No such form would be needed because, under section 1729, the right to collect is already assigned to the government. Unless the patient actually incurs some expenses for the hospital care provided in or through a VA medical facility, the patient likely has no benefit to assign under the terms of the third-party payer's plan. Thus, in general, assuming that the patient has made no payment for the services received, the third-party payer need only recognize that its sole obligation for payment is to the United States and that this obligation is not dependent upon any assignment of benefits. Proposed paragraph (d) would reflect this.

Preemption of Conflicting State Laws and Contracts

Proposed paragraph (e) would restate section 1729(f) and prescribe that any law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would prevent recovery or collection by the United States will have no force or effect on a third-party payer's responsibility under section 1729 or proposed § 17.106.

Impermissible Exclusions by Third-Party Payers

Proposed paragraph (f) would implement section 1729(f), which states: "[N]o provision of any contract or other agreement, shall operate to prevent recovery or collection by the United States." Proposed paragraph (f)(1) would restate this statutory requirement.

Proposed paragraph (f)(2) would establish several general rules derived from the statutory requirements. These general rules would help interested parties resolve issues that may arise in the course of collection actions and are intended to generally clarify VA's interpretation of its authority under section 1729.

The first general rule, in proposed paragraph (f)(2)(i), would state one of the clear mandates of section 1729(f): Express exclusions of limitations inconsistent with 38 U.S.C. 1729 are inoperative under Federal law. We provide, for clarification, that an example of an impermissible exclusion under this paragraph is a provision that purports to disallow payment for services provided by a government entity or paid for by a government program.

Proposed paragraph (f)(2)(ii) would prescribe that no objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. This would extend the first general rule to cover situations in which a third-party payer's plan might at first not appear to treat VA medical facilities less favorably, but nonetheless produces that effect. This interpretation is based on the statutory formulation of the prohibition in terms of provisions that have the effect of excluding or limiting payment. A clarifying example is provided in the proposed text, and explains that a third-party payer cannot refuse or reduce payment based on a provision in the third-party payer's plan that purports to disallow payment when the beneficiary has no legal obligation to pay. Such an exclusion is impermissible under section 1729(a)(1), which provides that the government's right to collect is to the extent the beneficiary or nongovernment provider would receive reimbursement.

A basic statutory characteristic of VA health care and services is that veterans have no obligation to pay (except the nominal co-payments for medication required by 38 U.S.C. 1722A). Recognizing this, Congress concluded that the government collects from third parties as if the veteran has an obligation to pay. Thus, we interpret section 1729 to mean that the fact that a veteran has no actual obligation is irrelevant. The same conclusion would apply to any other exclusion in a third-party plan that is expressed in similar language, such as that no charge would be made if the person had no health insurance.

Proposed paragraph (f)(2)(iii) would restate statutory requirements and prescribe that third-party payers may not treat claims arising from services provided in or through VA medical facilities less favorably than they treat claims arising from services provided in other hospitals. Under section 1729(f), VA has the right to collect reasonable charges from a third-party payer to the extent that the third-party payer would pay for care or services furnished by providers other than VA. The general rule disallowing less favorable treatment would provide a useful method of analyzing situations to assure compliance with the statute.

The proposed clarifying example concerns an employer-sponsored health plan that purports to make ineligible for coverage individuals who are provided medical care and services in or through a VA medical facility. Such an exclusion would clearly have the effect of treating VA medical facilities less favorably than other hospitals.

Proposed paragraph (f)(2)(iv) would prescribe that payments cannot be refused or reduced based on the lack of a participation agreement or the absence

of a specific contractual relationship (referred to as "privity of contract") between a third-party payer and VA or a VA medical facility. This further explains the general rule that disallows preconditions that are inconsistent with the basic nature of medical care and services provided to veterans in or through VA medical facilities.

We note that some VA medical facilities have understandings or agreements with some third-party payers concerning claims procedures for the purpose of facilitating administration of health care and collection of payments. Such understandings or agreements would not offend our rule as long as they do not purport to be preconditions to complying with statutory and regulatory requirements.

Proposed paragraph (f)(2)(v) and (vi) would set forth rules relating to Medicare carve-out and Medicare secondary payer provisions. The usual procedure for Medicare supplemental carriers is to accept claims only after the primary claim has been processed and paid by Medicare. In this way, the remaining liability, which becomes the responsibility of the supplemental policy, is apparent. However, a different process is required in section 1729 cases because, under section 1729(i)(1)(B)(i), there is no claim submitted to Medicare. Instead, the third-party payer is statutorily required to accept the claim as involving Medicare covered services from an authorized provider. Supplemental insurers do not have a statutory entitlement to a particular government adjudicatory process.

Proposed paragraph (f)(2)(vii) would bar Health Maintenance Organizations (HMOs) from excluding claims or refusing to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, it would provide that opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under section 1729 or this section. We interpret section 1729 to mean that HMO plans must pay only to the extent that HMO plans generally cover services (e.g., emergencies) provided by health care facilities not affiliated with the HMO. Further, we interpret the statute to mean that HMO plans that have a point-of-service option are required to pay VA the same amount that would be paid under the plan to nongovernment providers.

Records

Proposed paragraph (g) would restate section 1729(h), which requires that VA medical facilities make available for inspection and review to representatives of third-party payers appropriate health care records of patients. However, the records would be made available only to verify the care and services provided by VA for which payment, recovery, or collection is sought, and to verify that such care or services met the permissible criteria under the health plan involved. In light of privacy concerns, VA will not provide any other records maintained by a VA medical facility to a third-party payer.

Paperwork Reduction Act

This document contains no new collections of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. This proposed rule would affect mainly large insurance companies. This proposed rule might have an insignificant impact on a few small entities that do an inconsequential amount of their business with VA. Therefore, pursuant to 5 U.S.C. 605(b), this proposed rule is also exempt from the initial and final regulatory flexibility analyses requirements of sections 603 and 604.

Executive Order 12866

Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety, and other advantages; distributive impacts; and equity). The Executive Order classifies a "significant regulatory action," requiring review by the Office of Management and Budget (OMB) unless OMB waives such review, as any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this proposed rule have been examined and it has been determined not to be a significant regulatory action under Executive Order 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100 million or more (adjusted annually for inflation) in any given year. This proposed rule would have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on September 10, 2010, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs—health, Grant programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health

programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: October 4, 2010.

Robert C. McFetridge,

Director, Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons set forth in the preamble, VA proposes to amend 38 CFR part 17 as follows:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, and as noted in specific sections.

§ 17.106 [Redesignated as § 17.107]

2. Redesignate § 17.106 as § 17.107.

3. Add new § 17.106 before the undesignated center heading "Disciplinary Control of Beneficiaries Receiving Hospital, Domiciliary or Nursing Home Care" to read as follows:

§ 17.106 Third party claims for refunds based on amounts previously paid to the Department of Veterans Affairs (overpayments).

(a)(1) *General rule.* VA has the right to recover or collect reasonable charges from a third-party payer for medical care and services provided for a nonservice-connected disability in or through any VA facility to a veteran who is also a beneficiary under the third-party payer's plan. VA's right to recover or collect is limited to the extent that the beneficiary or a non-government provider of care or services would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) *Definitions.* For the purposes of this section:

(i) *Automobile liability insurance* means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(A) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(B) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

(ii) *Health-plan contract* means any plan, policy, program, contract, or liability arrangement that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for medical care or services, items, products, and supplies. It includes but is not limited to:

(A) Any plan offered by an insurer, re-insurer, employer, corporation, organization, trust, organized health care group or other entity.

(B) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(C) Any Employee Retirement Income and Security Act (ERISA) plan.

(D) Any Multiple Employer Trust (MET).

(E) Any Multiple Employer Welfare Arrangement (MEWA).

(F) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(G) Any individual practice association (IPA) plan.

(H) Any exclusive provider organization (EPO) plan.

(I) Any physician hospital organization (PHO) plan.

(J) Any integrated delivery system (IDS) plan.

(K) Any management service organization (MSO) plan.

(L) Any group or individual medical services account.

(M) Any participating provider organization (PPO) plan or any PPO provision or option of any third-party payer plan.

(N) Any Medicare supplemental insurance plan.

(O) Any automobile liability insurance plan.

(P) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

(iii) *Medicare supplemental insurance plan* means an insurance, medical service or health-plan contract primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as "Medicare supplemental policy" in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395, *et. seq.*) and 42 CFR part 403, subpart B.

(iv) *No-fault insurance* means an insurance contract providing compensation for medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on who may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

(v) *Participating provider organization* means any arrangement in a third-party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

(vi) *Third-party payer* means an entity, other than the person who received the medical care or services at issue (first party) and VA who provided the care or services (second party), responsible for the payment of medical expenses on behalf of a person through insurance, agreement or contract. This term includes, but is not limited to the following:

(A) State and local governments that provide such plans other than Medicaid.

(B) Insurance underwriters or carriers.

(C) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(D) Automobile liability insurance underwriter or carrier.

(E) No fault insurance underwriter or carrier.

(F) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

(G) Any other plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for healthcare services or products.

(H) A third-party administrator.

(b) *Calculating reasonable charges.*

(1) The "reasonable charges" subject to recovery or collection by VA under this section are calculated using the applicable method for such charges established by VA in 38 CFR 17.101.

(2) If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, VA will recover or collect reasonable charges less that deductible or copayment amount.

(c) *VA's right to recover or collect is exclusive.* The only way for a third-party payer to satisfy its obligation under this section is to pay the VA facility or other authorized

representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy the third-party's obligation under this section.

(1) Pursuant to 38 U.S.C. 1729(b)(2), the United States may file a claim or institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 38 U.S.C. 1729 and this section. Such filing or proceedings must be instituted within six years after the last day of the provision of the medical care or services for which recovery or collection is sought.

(2) An authorized representative of the United States may compromise, settle or waive a claim of the United States under this section.

(3) The remedies authorized for collection of indebtedness due the United States under 31 U.S.C. 3701, *et seq.,* 4 CFR parts 101–104, 28 CFR part 11, 31 CFR part 900, and 38 CFR part 1, are available to effect collections under this section.

(4) A third-party payer may not, without the consent of a U.S. Government official authorized to take action under 38 U.S.C. 1729 and this part, offset or reduce any payment due under 38 U.S.C. 1729 or this part on the grounds that the payer considers itself due a refund from a VA facility. A written request for a refund must be submitted and adjudicated separately from any other claims submitted to the third-party payer under 38 U.S.C. 1729 or this part.

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third-party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third-party payer, including any claim or appeal. In any case in which VA makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third-party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed VA Form 10–10EZ or VA Form 10–10EZR that includes a veteran's insurance declaration will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws and contracts.* Any provision of a law or regulation of a State or political subdivision thereof and any provision of any contract or agreement that purports to establish any requirement on a third-party payer that would have the effect of excluding from coverage or limiting payment for any medical care or services for which payment by the third-party payer under 38 U.S.C. 1729 or this part is required, is preempted by 38 U.S.C. 1729(f) and shall have no force or effect in connection with the third-party payer's obligations under 38 U.S.C. 1729 or this part.

(f) *Impermissible exclusions by third-party payers.* (1) Statutory requirement. Under 38 U.S.C. 1729(f), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in or through any VA facility shall operate to prevent collection by the United States.

(2) General rules. The following are general rules for the administration of 38 U.S.C. 1729 and this part, with examples provided for clarification. The examples provided are not exclusive. A third-party payer may not reduce, offset, or request a refund for payments made to VA under the following conditions:

(i) Express exclusions or limitations in third-party payer plans that are inconsistent with 38 U.S.C. 1729 are inoperative. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(ii) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third-party payers. For example, a provision in a third-party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third-party payment.

(iii) Third-party payers may not treat claims arising from services provided in or through VA facilities less favorably than they treat claims arising from services provided in other hospitals. For example, no provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are eligible to receive VA medical care and services shall be permissible.

(iv) The lack of a participation agreement or the absence of privity of contract between a third-party payer and VA is not a permissible ground for refusing or reducing third-party payment.

(v) A provision in a third-party payer plan, other than a Medicare supplemental plan, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to VA by the third-party payer unless the provision expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare Advantage plan).

(vi) A third-party payer may not refuse or reduce third-party payment to VA because VA's claim form did not report hospital acquired conditions (HAC) or present on admission conditions (POA). VA is exempt from the Medicare Inpatient prospective payment system and the Medicare rules for reporting POA or HAC information to third-party payers.

(vii) Health Maintenance Organizations (HMOs) may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 38 U.S.C. 1729 or this part.

(g) *Records.* Pursuant to 38 U.S.C. 1729(h), VA shall make available for inspection and review to representatives of third-party payers, from which the United States seeks payment, recovery, or collection under 38 U.S.C. 1729, appropriate health care records (or copies of such records) of patients. However, the appropriate records will be made available only for the purposes of verifying the care and services which are the subject of the claim(s) for payment under 38 U.S.C. 1729, and for verifying that the care and services met the permissible criteria of the terms and conditions of the third-party payer's plan. Patient care records will not be made available under any other circumstances to any other entity. VA will not make available to a third-party payer any other patient or VA records.

(Authority: 31 U.S.C. 3711, 38 U.S.C. 501, 1729, 42 U.S.C. 2651)

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