5 USCS § 8902

Current through PL 115-30, approved 4/28/17

United States Code Service - Titles 1 through 54 > TITLE 5. GOVERNMENT ORGANIZATION AND EMPLOYEES > PART III. EMPLOYEES > SUBPART G. INSURANCE AND ANNUITIES > CHAPTER 89. HEALTH INSURANCE

§ 8902. Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this *title [5 USCS § 8903* or *8903a*], without regard to section 6101(b) to (d) of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this *title [5 USCS § 8903(2)*], a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shall [*5 USCS § 8903(1)* or (2)] require the carrier--

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter [*5 USCS §§ 8901* et seq] shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this *title [5 USCS § 8903* or 9803a] and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 [*5 USCS §§ 551* et seq.] and chapter 7 of this *title [5 USCS §§ 701* et seq.]. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this *title [5 USCS § 8905a*] whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this *title [5 USCS § 8905a*] who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this *title [5 USCS § 8903* or *8903a*] shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this *title [5 USCS § 8903(1)* and (2)] shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustments in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this *title [5 USCS § 8905a*] is entitled thereto under the terms of the contract.

(k)

(1) When a contract under this chapter [*5 USCS §§ 8901* et seq.] requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/clinical specialist, licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11) [*5 USCS § 8901(11)*], an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this *title [5 USCS § 8905a*] covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, nursing school administered clinic, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

(2) Nothing in this subsection shall be considered to preclude a health benefits plan from providing direct access or direct payment or reimbursement to a provider in a health care practice or profession other than a practice or profession listed in paragraph (1), if such provider is licensed or certified as such under Federal or State law.

(3) The provisions of this subsection shall not apply to comprehensive medical plans as described in section 8903(4) of this *title [5 USCS § 8903(4)*].

(l) The Office shall contract under this chapter for a plan described in section 8903(4) of this *title [5 USCS § 8903(4)*] with any qualified health maintenance carrier which offers such a plan. For the purpose of this subsection, "qualified health maintenance carrier" means any qualified carrier which is a qualified health maintenance organization within the meaning of section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d))

(m)

(1) The terms of any contract under this chapter [*5 USCS §§ 8901* et seq.] which relate to the nature, provision, or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans.

(2) (A) Notwithstanding the provisions of paragraph (1) of this subsection, if a contract under this chapter [*5 USCS §§ 8901* et seq.] provides for the provision of, the payment for, or the reimbursement of the cost of health services for the care and treatment of any particular health condition, the carrier shall provide, pay, or reimburse up to the limits of its contract for any such health service properly provided

by any person licensed under State law to provide such service if such service is provided to an individual covered by such contract in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (*42 U.S.C. 254e*).

(B) The provisions of subparagraph (A) shall not apply to contracts entered into providing prepayment plans described in section 8903(4) of this *title [5 USCS § 8903(4)]*.

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 8903a [*5 USCS § 8903(1)*, (2), or (3) or 8903a], shall require the carrier--

(1) to implement hospitalization-cost-containment measures, such as measures--

(A) for verifying the medical necessity of any proposed treatment or surgery;

(B) for determining the feasibility or appropriateness of providing services on an outpatient rather than on an inpatient basis;

(C) for determining the appropriate length of stay (through concurrent review or otherwise) in cases involving inpatient care; and

(D) involving case management, if the circumstances so warrant; and

(2) to establish incentives to encourage compliance with measures under paragraph (1).

(o) A contract may not be made or a plan approved which includes coverage for any benefit, item, or service for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

History

(Sept. 6, 1966,*P.L. 89-554*, § 1, *80 Stat. 601*, Jan. 31, 1974, *P.L. 93-246*, § 3, *88 Stat. 4*; July 30, 1974, *P.L. 93-363*, § 1, *88 Stat. 398*; Dec. 31, 1975, *P.L. 94-183*, § 2(43), *89 Stat. 1059*; Oct. 8, 1976, *P.L. 94-460*, Title I, § 110(b), *90 Stat. 1952*; Sept. 17, 1978, *P.L. 95-368*, § 1, *92 Stat. 606*; Oct. 13, 1978, *P.L. 95-454*, Title IX, § 906(a)(2), (3), *92 Stat. 1224*; Jan. 2, 1980, *P.L. 96-179*, § 3, *93 Stat. 1299*; Nov. 8, 1984, *P.L. 98-615*, § 3(2), *98 Stat. 3203*; June 17, 1985, *P.L. 99-53*, § 2(a) in part, *99 Stat. 94*; Feb. 27, 1986, *P.L. 99-251*, Title I, §§ 105(b), 106(a)(3), *100 Stat. 15*, 16; Dec. 22, 1987, *P.L. 100-202*, § 101(m) [Title VI, § 626], *101 Stat. 1329*-430; Nov. 14, 1988, *P.L. 100-654*, Title II, §§ 201(c), 202(a), *102 Stat. 3845*; Nov. 5, 1990, *P.L. 101-508*, Title VII, Subtitle A, § 7002(a), *104 Stat. 1388*-329; Nov. 5, 1990, *P.L. 101-509*, Title IV, *104 Stat. 1421*; Oct. 6, 1992, *P.L. 102-393*, Title V, § 537(a), (b), *106 Stat. 1765*; April 30, 1997, *P.L. 105-12*, § 9(g), *111 Stat. 27*; Oct. 19, 1998, *P.L. 105-266*, §§ 3(c), 8, *112 Stat. 2366*, 2370.)

(As amended Jan. 4, 2011,*P.L. 111-350*, § 5(a)(15), *124 Stat. 3842*.)

Prior law and revision:

Derivation	U.S. Code	Revised Statutes and Statutes at Large
.....	*5 U.S.C. 3005.*	Sept. 28, 1959, Pub. L. 86-382, Sec. 6, *73 Stat. 712*. Mar. 17, 1964, Pub. L. 88-284, Sec. 1(7)-(9), 78 Stat. 165.

Standard changes are made to conform with the definitions applicable and the style of this title as outlined in the preface to the report.

Annotations

Notes

References in text:

"Section 1310(d)(1) of title XIII of the Public Health Service Act (42 U.S.C. 300c-9(d))", referred to in subsec. (l) of this section, is Act July 1, 1944, ch 373, Title XIII, § 1310(d)(1), as added Dec. 29, 1973, *P.L. 93-222*, § 2, *87 Stat. 930*, which appeared as *42 USCS § 300e-9(d)(1)*; subsec. (d) of such section was redesignated subsec. (c) by Act Oct. 24, 1988, *P.L. 100-517*, § 7(b), *102 Stat. 2580*.

The "Assisted Suicide Funding Restriction Act of 1997", referred to in this section, is Act April 30, 1997, *P.L. 105-12*, *111 Stat. 23*, which appears generally as *42 USCS §§ 14401* et seq. For full classification of such Act, consult USCS Tables volumes.

Amendments:

1974 . Act Jan. 31, 1974 (effective with respect to any contract entered into or renewed on or after the date of enactment, as provided by § 4(c) of such Act, which appears as a note to this section), added subsec. (j).

Act July 30, 1974 (effective with respect to any contract entered into or renewed on or after the date of enactment, as provided by § 2 of such Act, which appears as a note to this section), added a second subsec. (j).

1975 . Act Dec. 31 1975 redesignated the second subsec. (j), as added by Act July 30, 1974, as subsec. (k).

1976 . Act Oct. 8, 1976 (effective 10/8/76, as provided by § 118 of such Act, which appears as *42 USCS § 300e* note), added subsec. (l).

1978 . Act Sept. 17, 1978 (applicable to services provided under any contract entered into or renewed after 12/31/1979, as provided by § 3 of such Act, which appears as a note to this section), added subsec. (m).

Act Oct. 13, 1978 (effective 90 days after enactment, as provided by § 907 of such Act, which appears as *5 USCS § 1101* note), in subsec. (a), substituted "Office of Personnel Management" for "Civil Service Commission"; and substituted "Office" for "Commission" wherever it appears.

1980 . Act Jan. 2, 1980 (applicable as provided by § 5(b) of such Act, which appears as a note to this section), in subsec. (m)(2)(A), substituted "in a State where 25 percent or more of the population is located in primary medical care manpower shortage areas designated pursuant to section 332 of the Public Health Service Act (*42 U.S.C. 254e*)." for "who is a member of a medically underserved population (within the meaning of section 1302(7) of the Public Health Service Act (*42 U.S.C. 300e-17*)".

1984 . Act Nov. 8, 1984 (effective 180 days after enactment, as provided by § 4(a)(2) in part of such Act, which appears as *5 USCS § 8341* note), in subsec. (g), substituted "employee, annuitant, family member, or former spouse" for "employee or annuitant" each place it appears; in subsecs. (j) and (k), substituted "family member, or former spouse" for "or family member".

1985 . Act June 17, 1985, in subsecs. (a), (e), and (i), inserted "or 8903a".

1986 . Act Feb. 27, 1986 (effective with respect to contracts entered into or renewed for calendar years beginning after 12/31/1986, as provided by § 105(c) of such Act, which apepars as *5 USCS § 8901* note), in subsec. (k), designated the existing provisions as para. (1), in para. (1), as so designated, deleted "The provisions of this subsection shall not apply to group practice prepayment plans.", and added para. (2).

Such Act further (effective with respect to services provided after 12/31/1984, as provided by § 10(b) of such Act, which appears as a note to this section), in subsec. (m)(2)(A), added the sentence beginning "This paragraph shall apply . . .".

1987 . Act Dec. 22, 1987, in subsec. (k), in para. (1), inserted "or by a qualified clinical social worker as defined in section 8901(11)," and ", qualified clinical social worker", redesignated para. (3), as para. (2), and deleted para. (2), which read:

"(2) When a contract under this chapter requires payment or reimbursement for services which may be performed by a qualified clinical social worker, an employee, annuitant, family member, or former spouse covered by the contract shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed. As a condition for the payment or reimbursement, the contract--

"(A) may require that the services be performed pursuant to a referral by a psychiatrist; but

"(B) may not require that the services be performed under the supervision of a psychiatrist or other health practitioner.";

and, in subsec. (m)(2)(A), deleted "This paragraph shall apply with respect to a qualified clinical social worker covered by subsection (k)(2) of this section without regard to whether such contract contains the requirement authorized by clause (i) of the second sentence of subparagraph (A) of such subsection (k)(2)." following "254e)."

1988 . Act Nov. 14, 1988 (applicable as provided by § 203 of such Act, which appears as a note to this section), in subsecs. (g), (j), and (k)(1) substituted "former spouse, or person having continued coverage under section 8905a of this title" for "or former spouse".

1990 . Act Nov. 5, 1990, *P.L. 101-508* (applicable as provided by § 7002(g) of such Act, which appears as a note to this section) added subsec. (n).

Act Nov. 5, 1990, *P.L. 101-509*, in subsec. (k)(1), substituted "performed by a clinical psychologist, optometrist, nurse midwife, or nurse practitioner/clinical specialist" for "performed by a clinical psychologist or optometrist" and substituted "qualified clinical social worker, optometrist, nurse midwife, or nurse practitioner/nurse clinical specialist" for "qualified clinical social worker or optometrist".

1992 . Act Oct. 6, 1992 (applicable as provided by § 537(b) of such Act, which appears as a note to this section) substituted subsec. (k) for one which read:

"(1) When a contract under this chapter requires payment or reimbursement for services which may be performed by a clinical psychologist, optometrist, nurse midwife, or nurse practitioner/clinical specialist licensed or certified as such under Federal or State law, as applicable, or by a qualified clinical social worker as defined in section 8901(11), an employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title covered by the contract shall be free to select, and shall have direct access to, such a clinical psychologist, qualified clinical social worker, optometrist, nurse midwife, or nurse practitioner/nurse clinical specialist without supervision or referral by another health practitioner and shall be entitled under the contract to have payment or reimbursement made to him or on his behalf for the services performed.

"(2) The provisions of this subsection shall not apply to group practice prepayment plans.".

1997 . Act April 30, 1997 (effective and applicable as provided by § 11 of such Act, which appears as *42 USCS § 14401* note) added subsec. (o).

1998 . Act Oct. 19, 1998, in subsec. (k), redesignated para. (2) as para. (3), and added new para. (2); and, in subsec. (m), substituted para. (1) for one which read: "(1) The provisions of any contract under this chapter which relate to the nature or extent of coverage or benefits (including payments with respect to benefits) shall supersede and preempt any State or local law, or any regulation issued thereunder, which relates to health insurance or plans to the extent that such law or regulation is inconsistent with such contractual provisions.".

2011 . Act Jan. 4, 2011, in subsec. (a), substituted "section 6101(b) to (d)" for "section 5".

Other provisions:

Authority of carrier to contract for comprehensive medical services from a group practice unit or organization. Act Oct. 30, 1970, P.L. 91-515, Title IV, § 401, 84 Stat. 1309, provided:

"(a) The Secretary of Health, Education, and Welfare may, in accordance with the provisions of this section, authorize any carrier, which is a party to a contract entered into under chapter 89 of title 5 [5 USCS §§ 8901 et seq.], United States Code (relating to health benefits for Federal employees), or under the Retired Federal Employees Health Benefits Act, or which participates in the carrying out of any such contract, to issue in any State contracts entitling any person as a beneficiary to receive comprehensive medical services (as defined in subsection (b)) from a group practice unit or organization (as defined in subsection (c)) with which such carrier has contracted or otherwise arranged for the provision of such services.

"(b) As used in this section, the term 'comprehensive medical services' means comprehensive preventive, diagnostic, and therapeutic medical services (as defined in regulations of the Secretary), furnished on a prepaid basis; and may include, at the option of a carrier, such other health services including mental health services, and equipment and supplies, furnished on such terms and conditions with respect to copayment and other matters, as may be authorized in regulations of the Secretary.

"(c) As used in this section:

"(1) The term 'group practice unit or organization' means a nonprofit agency, co-operative, or other organization undertaking to provide, through direct employment of, or other arrangements with the members of a medical group, comprehensive medical services (or such services and other health services) to members, subscribers, or other persons protected under contracts of carriers.

"(2) The term 'medical group' means a partnership or other association or group of persons who are licensed to practice medicine in a State (or of such persons and persons licensed to practice dentistry or optometry) who (A) as their principal professional activity and as a group responsibility, engage in the coordinated practice of their profession primarily in one or more group practice facilities, (B) pool their income from practice as members of the group and distribute it among themselves according to a prearranged plan, or enter into an employment arrangement with a group practice unit or organization for the provision of their services, (C) share common overhead expenses (if and to the extent such expenses are paid by members of the group), medical and other records, and substantial portions of the equipment and professional, technical, and administrative staff, and (D) include within the group at least such professional personnel, and make available at least such health services, as may be specified in regulations of the Secretary.

"(d) Nothing in this section shall preclude any State or State agency from regulating the amounts charged for contracts issued pursuant to subsection (a) or the manner of soliciting and issuing such contracts, or from regulating any carrier issuing such contracts in any manner not inconsistent with the provisions of this section.".

Application of Jan. 31, 1974 amendment. Act Jan. 31, 1974, P.L. 93-246, § 2(c), 88 Stat. 4, provided: "Section 3 [adding subsec. (j) of this section] shall become effective with respect to any contract entered into or renewed on or after the date of enactment of this Act.".

Application of July 30, 1974 amendment. Act July 30, 1974, § 2, P.L. 93-363, *88 Stat. 398*, provided: "The amendment made by this Act [adding a second subsec. (j) of this section, redesignated subsec. (k)] shall become effective with respect to any contract entered into or renewed on or after the date of enactment of this Act.".

Effective date and limitations of Sept. 1978 amendments. Act Sept. 17, 1978, P.L. 95-368, § 3, 92 Stat. 606; as amended Feb. 27, 1986, P.L. 99-251, Title I, § 106(a)(1), 100 Stat. 16, effective as provided by § 106(b) of such Act, which appears as a note to this section, provided: "The provisions of section 8992(m)(2) of title 5, United States Code, as added by the first section of this Act, shall apply to services provided under any contract entered into or renewed after December 31, 1979.".

Application of 1980 amendment. Act Jan. 2, 1980, *P.L. 96-179*, § 5(b), *93 Stat. 1300*; as amended Feb. 27, 1986, *P.L. 99-251*, Title I, § 106(a)(2), *100 Stat. 16*, effective as provided by § 106(b) of such Act, which appears as a note to this section, provided: "The amendments made by section 3 [amending this section] shall apply to services provided after December 31, 1979, under any contract entered into or renewed after December 31, 1979.".

Effective date of Act Feb. 27, 1986. Act Feb. 27, 1986, *P.L. 99-251*, Title I, § 106(b), *100 Stat. 16*, provided: "The amendments made by subsection (a) [amending subsec. (m) of this section, and notes to this section] shall take effect with respect to services provided after December 31, 1984.".

Repeal of rate reduction for medicare eligible Federal annuitants. Act July 1, 1988, *P.L. 100-360*, Title IV, Subtitle C, § 422, *102 Stat. 810*, was repealed by Act Dec. 13, 1989, *P.L. 101-234*, Title III, § 301(a), *103 Stat. 1985*, effective 1/1/90 as provided by § 301(e) of such Act, which appears as *42 USCS § 1395u* note. Such § 422 related to the rate reduction for medicare eligible Federal annuitants.

Applicability of amendments made by Title II of Act Nov. 14, 1988. Act Nov. 14, 1988, *P.L. 100-654*, Title II, § 203, *102 Stat. 3845*, provides:

"(a) In general. The amendments made by this title [adding this note, among other things; for full classification, consult USCS tables volumes] shall apply with respect to--

"(1) any calendar year beginning, and contracts entered into or renewed for any calendar year beginning, after the end of the 9-month period beginning on the date of the enactment of this Act; and

"(2) any qualifying event occurring on or after the first day of the first calendar year beginning after the end of the 9-month period referred to in paragraph (1).

"(b) Definition. For the purpose of this section, the term 'qualifying event' means any of the following events:

"(1) A separation from Government service.

"(2) A divorce, annulment, or legal separation.

"(3) Any change in circumstances which causes an individual to become ineligible to be considered an unmarried dependent child under chapter 89 of such *title [5 USCS §§ 8901* et seq.].".

Applicability of amendments made by § 7002 of Act Nov. 5, 1990. Act Nov. 5, 1990, *P.L. 101-508*, Title VII, Subtitle A, § 7002(g) *104 Stat. 1388*-331, provides: "Except as provided in subsection (f) [amending *5 USCS § 8904*], the amendments made by this section [amending this section and *5 USCS §§ 8909* and *8910*] shall apply with respect to contract years beginning on or after January 1, 1991.".

Applicability of 1992 amendment of subsec. (k). Act Oct. 6, 1992, *P.L. 102-393*, Title V, § 537(c), *106 Stat. 1765*, provides: "The amendments made by this section [amending subsec. (k) of this section] shall be effective with respect to contract years beginning after the date of enactment of this Act.".

Full disclosure in health plan contracts. Act Oct. 19, 1998, *P.L. 105-266*, § 5, *112 Stat. 2368*, provides: "The Office of Personnel Management shall encourage carriers offering health benefits plans described by section 8903 or *section 8903a of title 5, United States Code*, with respect to contractual arrangements made by such carriers with any person for purposes of obtaining discounts from providers for health care services or supplies furnished to individuals enrolled in such plan, to seek assurance that the conditions for such discounts are fully disclosed to the providers who grant them.".

Case Notes

1. Generally

Federal Employees Health Benefits Act (FEHBA), *5 USCS § 8902*, did not affirmatively authorize creation of federal common law and federal jurisdiction because plan administrator's claims were breach of contract claims which arose under state not federal law and there was no indication that New York state contract law conflicted meaningfully with federal interests underlying FEHBA as plan administrator's briefs on appeal failed to mention single state law or state-imposed duty that demonstrated "actual, significant" conflict between New York state law and these federal interests. *Empire Healthchoice Assur., Inc. v McVeigh (2005, CA2 NY) 396 F3d 136, 34 EBC 1490,* reh den (2005, CA2 NY) *402 F3d 107* and affd *(2006) 547 US 677, 126 S Ct 2121, 165 L Ed 2d 131, 37 EBC 2729, 19 FLW Fed S 265.*

Because Congress' explicit command to Office of Personnel Management with respect to rate-setting was that rates should reflect costs--with no relaxation of that requirement in year when contract is not renewed--*48 CFR § 1652.216-70(b)(6)* conflicts with *5 USCS § 8902(i)* and is thus invalid. *GHS HMO, Inc. v United States (2008, CA FC) 536 F3d 1293.*

Under *5 USCS § 8902*, role of Civil Service Commission (now Office of Personnel Management) is confined to contracting with qualified health insurance carriers. *Director, Edward J. Meyer Memorial Hospital v Stetz (1977, WD NY) 433 F Supp 323.*

Federal employees engaged in negotiation of contract for federal employees' health benefit plans are absolutely immune from all nontort actions; official immunity extends to all acts necessary to further effective functioning of official, and once task is within federal official's jurisdiction, immunity bars even suit alleging intentional torts. *Burda v National Asso. of Postal Supervisors (1984, DC Dist Col) 592 F Supp 273,* affd without op (1985, App DC) *248 US App DC 415, 771 F2d 1555.*

5 USCS § 8902's prohibition against contracts which exclude individual because of race, sex, or health status does not confer any benefit upon consumers and does not confer standing upon consumers. *Zeigan v Blue Cross & Blue Shield (1985, SD NY) 607 F Supp 1434, 1985-1* CCH Trade Cases P 66627.

Judicial employee was denied preliminary injunction in her case seeking, by writ of mandamus, to have Office of Personnel Management (OPM) rescind its prior guidance to her insurance company to deny her same-sex partner benefits as precluded by Defense of Marriage Act and to comply with prior orders in her employment dispute resolution claim because she did not establish that OPM had clear and nondiscretionary duty to act; not only was OPM invested by Congress under Federal Employees Health Benefits Act to interpret insurance plan pursuant to *5 USCS § 8902(j)*, but prior orders at issue, which provided contrary interpretation to that of OPM, were issued by circuit court chief judge sitting in capacity of administrative hearing officer under *28 USCS § 332* (not as U.S. Const. art. III judge), and, as such, did not trump decision of *OPM. Golinski v United States OPM (2011, ND Cal) 781 F Supp 2d 967, 111 BNA FEP Cas 1709.*

In quest for judicial review of denial of claims under *5 USCS § 8902* related to Federal Employees Health Benefits Act (FEHBA), *5 USCS § 8901*; designation of U.S. Office of Personnel Management as sole defendant in suit to

challenge denial of health benefits claim under FEHBP is component of scheme designed to provide national uniformity of coverage for federal employees. *Neuner v Horizon Blue Cross Blue Shield (In re LymeCare, Inc.) (2003, BC DC NJ) 301 BR 662, 32 EBC 1268.*

2. Purpose

Petition for rehearing was denied because health insurer's action was not suit to determine contract rights of U.S., but suit to vindicate insurer's own rights against another private party and, contrary to government's argument as amicus, critical factor of Congressional intent was embodied in preemption provision, *5 USCS § 8902(m)(1)*, part of Federal Employees Health Benefits Act, *5 USCS §§ 8901-8914*, which did not confer federal jurisdiction over insurer's claims. *Empire HealthChoice Assur., Inc. v McVeigh (2005, CA2 NY) 402 F3d 107.*

Purposes in enacting Federal Employees Health Benefits Act are to protect federal employees against high and unpredictable costs of medical care and to assure that federal employee health benefits are equivalent to those available in private sector so that federal government can compete in recruitment and retention of competent personnel. *American Federation of Government Employees v Devine (1981, DC Dist Col) 525 F Supp 250.*

Unpublished Opinions

Unpublished: Employee was not entitled to seek health care in another state because she lived in medically underserved state; this section simply expanded categories of covered medical professionals in medically underserved states who could provide covered services. *Porta v United States OPM (2014, CA10 NM) 2014 US App LEXIS 17113.*

3. Pre-emption

5 USCS § 8902 pre-empts state unclaimed property act in view of intent of section to pre-empt conflicting state laws. *Blue Cross & Blue Shield, Inc. v Department of Banking & Finance (1986, CA11 Fla) 791 F2d 1501, 7 EBC 1922,* reh den, en banc (1986, CA11 Fla) *797 F2d 982.*

Louisiana's penalty provision for unreasonable delay in paying health and accident insurance claims is inconsistent with and therefore preempted by federal law regulating federal employee health benefits. *Burkey v Government Employees Hosp. Ass'n (1993, CA5 La) 983 F2d 656, 16 EBC 1682.*

New Jersey Health Insurance Reform Act's premium assessments, under which all insurance carriers in state pay assessment used to defray financial losses incurred by carriers that provide disproportionate share of higher-risk individual insurance coverage in state, were preempted by Federal Employees Health Benefits Program (FEHBP) when applied to insurance plans governed by FEHBP since they increased cost of individual health care benefits to federal employees which are payable from *FEHB Fund. Health Maintenance Org. v Whitman (1995, CA3 NJ) 72 F3d 1123, 19 EBC 2508.*

Montana Code Ann. § 33-18-201(1) conflicts with, and is therefore preempted by, *Federal Employees Health Benefits Act. Botsford v Blue Cross & Blue Shield of Mont., Inc. (2002, CA9 Idaho) 314 F3d 390, 2002 CDOS 12264, 2002* Daily Journal DAR 14468, amd on other grounds (2003, CA9 Idaho) *319 F3d 1078, 2003 CDOS 1244, 2003* Daily Journal DAR 1570.

Independent review provisions of Texas statute were preempted by Federal Employees Health Benefits Act, *5 USCS §§ 8901* et seq. *Corporate Health Ins., Inc. v Tex. Dep't of Ins. (2002, CA5 Tex) 314 F3d 784, 29 EBC 1801.*

Given Employee Retirement Income Security Act's (ERISA's) comprehensive civil enforcement mechanisms and legislative history "fully confirming" that ERISA's remedies were meant to be exclusive, Second Circuit has reject suggestion that courts should rely on ERISA-related precedent to determine preemptive reach of Federal

Employees Health Benefits Act, *5 USCS § 8902(m)(1)*. *Empire Healthchoice Assur., Inc. v McVeigh (2005, CA2 NY) 396 F3d 136, 34 EBC 1490,* reh den (2005, CA2 NY) *402 F3d 107* and affd *(2006) 547 US 677, 126 S Ct 2121, 165 L Ed 2d 131, 37 EBC 2729, 19 FLW Fed S 265.*

Unfair Prescription Drug Practices Act (UPDPA), *Me. Rev. Stat. Ann. tit. 22, § 2699*, was not preempted by Federal Employee Health Benefits Act (FEHBA) *5 USCS § 8902*, or Employee Retirement Income Security Act of 1974 (ERISA), *29 USCS § 1144(a)*, because UPDPA did not preclude ability of plan administrators to administer their plans in uniform fashion and did not act exclusively upon *FEHBA or ERISA plans. Pharm. Care Mgmt. Ass'n v Rowe (2005, CA1 Me) 429 F3d 294, 36 EBC 1065,* cert den *(2006) 547 US 1179, 126 S Ct 2360, 165 L Ed 2d 280, 37 EBC 2888.*

Hospital's third-party nonderivative claim against health plan administrator was not preempted under Employee Health Benefits Act (FEHBA), *5 USCS § 8902(m)(1)*; FEHBA did not provide remedies that displaced state law because hospital could not invoke FEHBA's administrative review process, and FEHBA did not conflict with state law because hospital's breach of contract claim based on administrator's refusal to reimburse for services provided to plan enrollee did not "relate to" benefits to enrollee. *Cedars-Sinai Med. Ctr. v Nat'l League of Postmasters (2007, CA9 Cal) 497 F3d 972, 42 EBC 1343.*

Federal employee benefits plan beneficiary's challenge to subrogation lien was removable under federal officer removal statute, *28 USCS § 1442(a)(1)*; federal government, through Federal Employees Health Benefits Act of 1959 (FEHBA), *5 USCS §§ 8901-8914*, had delegated authority to private insurance carrier, which raised colorable federal defense of FEHBA preemption. *Jacks v Meridian Res. Co., LLC (2012, CA8 Mo) 701 F3d 1224.*

Insured had to reimburse insurers because federal common law displaced Kansas anti-subrogation regulation, which, if applied to plan, would conflict with uniquely federal interests; alternatively giving weight to views of Office of Personnel Management regarding meaning of Federal Employees Health Benefits Act of 1959's preemption provision, reimbursement provision in plan related to nature, provision, or extent of coverage or benefits, and therefore preempted state law. *Helfrich v Blue Cross & Blue Shield Ass'n (2015, CA10 Kan) 804 F3d 1090.*

District court properly granted summary judgment in favor of health care plan administrator because *Tex. Ins. Code Ann. § 1301.001* et seq. (Chapter 1301), did not apply to insurance company's administration of health care plans at issue and Federal Employee Health Benefits Act of 1959 (FEHBA), *5 USCS § 8902(m)(1)*, preempted application of Chapter 1301 to claims administered by insurance company under *FEHBP. Health Care Serv. Corp. v Methodist Hosps. of Dallas (2016, CA5 Tex) 814 F3d 242.*

Employee's state-law defense that she was not required to use monies obtained from alleged tortfeasor's insurer to reimburse federal plan for medical benefits it paid was preempted by *5 USCS § 8902(m)(1)* given that reimbursement provision restricted payment of benefits, required reimbursement, and nothing in statute suggested narrower meaning. *Bell v Blue Cross & Blue Shield (2016, CA8 Ark) 823 F3d 1198, 62 EBC 1281.*

Issue whether insurer has breached contract with employee by failing to consider entitlement to reimbursement for expenses of private duty nursing care divested within limitations of previous contract is decided under federal principles rather than under state insurance law since state law inconsistent with contract is pre-empted and superseded by contract provisions. *Tackitt v Prudential Ins. Co. (1984, ND Ga) 595 F Supp 887,* affd (1985, CA11 Ga) *758 F2d 1572.*

Opthalmologist's claims for fees allegedly owed him under health benefits plan must be dismissed, where plan is established and operated under Federal Employees Health Benefits Act (FEHBA) (*5 USCS §§ 8901* et seq.), because (1) court lacks jurisdiction to hear breach-of-contract claim since opthalmologist has not exhausted his administrative remedies before Office of Personnel Management, and (2) equitable claims under doctrines of estoppel and quantum meruit are preempted by *5 USCS § 8902(m)(1)*. *Lieberman v National Postal Mail Handlers Union, Div. of Laborers' Int'l Union (1993, SD NY) 819 F Supp 344.*

Health benefit plan's claim against plan enrollee to recover benefits enrollee received from insurer is granted summarily, because reimbursement provision of plan relates to nature or extent of coverage or benefits and therefore preempts any incompatible state law pursuant to 5 USCS § 8902(m)(1) and is enforceable in court of law. NALC Health Benefit Plan v Lunsford (1995, ED Mich) 879 F Supp 760, 19 EBC 1233.

Government employee's claim regarding nature and extent of coverage under his Federal Employees Health Benefit Plan (FEHBA) is governed by Federal Employees Health Benefit Act (5 USCS §§ 8901 et seq.), but federal court does not have exclusive jurisdiction over claim and claim should be remanded, where employee brought his cause of action in state court, contending that he is entitled to medical expense reimbursements in amount of $ 20,000 under his government health-care plan, which government removed on grounds of federal question jurisdiction, because state courts have power to hear claims calling for application of federal law, and preemption provision of FEHBA, 5 USCS § 8902(m)(1), only provides for preemption when state law and terms of contract at issue are inconsistent and employee's claim only concerns interpretation of contract, not inconsistency in law. Lambert v Mail Handlers Benefit Plan (1995, MD Ala) 886 F Supp 830.

Diversity case brought on behalf of minor patient against health maintenance organization (HMO) may proceed only to extent that it seeks to hold HMO liable for medical malpractice on respondeat superior principles, where this is only claim not based on contractual benefit, because contractual claims are all preempted by provision in health insurance plan and by 5 USCS § 8902(m)(1). Negron v Patel (1998, ED Pa) 6 F Supp 2d 366.

Federal employee's fraudulent inducement claim against health insurer is preempted, under either old or new version of 5 USCS § 8902(m)(1), because claim "relates to" federal employee health insurance plan, requires interpretation of plan, and any recovery on claim will invariably expand insurer's obligations under plan. Carter v Blue Cross & Blue Shield, Inc. (1999, ND Fla) 61 F Supp 2d 1241.

Congress clearly has manifested intent to preempt state law regarding terms and benefits of health insurance plans governed by 5 USCS § 8902(m)(1). Rievley v Blue Cross Blue Shield (1999, ED Tenn) 69 F Supp 2d 1028.

5 USCS § 8902(m)(1) did not completely preempt state-law claims arising from denial of benefits under Federal Employee Health Benefits Act health plan. Ramirez v Humana, Inc. (2000, MD Fla) 119 F Supp 2d 1307 (criticized in Doyle v Blue Cross Blue Shield of Ill. (2001, ND Ill) 149 F Supp 2d 427, 26 EBC 2114).

Where patient's allegations were essentially contesting eligibility for benefits rather than treatment decisions, claims fit within remedy provisions of Federal Employee Health Benefits Act of 1998 and scope of preemption. McCoy v Unicare Life & Health Ins. Co. (2004, ND Ill) 34 EBC 2047.

Federal health plan participant's family member conceded that any state law claims that she raised in her suit against plan administrator, arising from its denial of her claim for coverage for gastric bypass surgery, would be preempted under 5 USCS § 8902(m)(1), which applied because plan at issue was issued through Federal Employees Health Benefits Program. Turley v Coventry Health Care of Iowa, Inc. (2008, SD Iowa) 590 F Supp 2d 1126.

5 USCS § 8902(m) (1) did not provide federal jurisdiction over action by West Virginia Attorney General based solely on generic-drug pricing law, W. Va. Code § 30-5-12b, and violations of West Virginia Consumer Credit and Protection Act, W. Va. Code § 46A-1-101 et seq., because defendant retailers failed to establish that Attorney General's claims impermissibly related to coverage or benefits as established by terms of FEHBA contract. W. Va. ex. rel. McGraw v CVS Pharm., Inc. (2010, SD W Va) 748 F Supp 2d 580, 50 EBC 1561.

California Unfair Competition Law claim was not expressly preempted under Federal Employee Health Benefits Act's express preemption provision. In re Anthem Data Breach Litig. (2016, ND Cal) 162 F Supp 3d 953, 61 EBC 2062.

Trial court erroneously granted summary judgment to uninsured motorist insurer, where injured claimant, who was also federal employee, fell under purview of federal compensation law; thus, under these federal provisions,

medical benefits insurer and workers' compensation insurer had subrogation liens and were able to enforce them upon injured party's receipt of settlement from liable third party, regardless of state's requirement that such action be preceded by determination that injured person had been fully compensated. *Thurman v State Farm Mut. Auto. Ins. Co. (2004) 278 Ga 162, 598 SE2d 448, 2004 Fulton County D R 1880.*

Federal Employee Health Benefits Act did not preempt Missouri law barring subrogation of personal injury claims, because subrogation provision in favor of health insurer created contingent right to reimbursement and bore no immediate relationship to nature, provision or extent of insured's insurance coverage and benefits. *Nevils v Group Health Plan, Inc. (2014, Mo) 418 SW3d 451.*

Office of Personnel Management regulation, *5 CFR § 890.106(h)*, did not establish that Federal Employee Health Benefits Act (FEHBA) preempted Missouri law prohibiting subrogation of personal injury claims because text of FEHBA preemption clause had not changed, and *5 CFR § 890.106(h)*, did not overcome presumption against preemption and demonstrate Congress' clear and manifest intent to preempt state law. *Nevils v Group Health Plan, Inc. (2016, Mo) 492 SW3d 918.*

4. --Complete vs. defensive pre-emption

Hospital's claim against health insurer for reimbursement for services must be remanded, where insurer removed case to federal court claiming federal question jurisdiction on basis of Federal Employee Health Benefits Act (*5 USCS §§ 8901* et seq.), because well-pleaded complaint reveals no issues of federal law, and complete preemption doctrine will not be extended to Act. *Baptist Hosp. v Timke (1993, SD Fla) 832 F Supp 338, 7 FLW Fed D 446.*

Hospital corporation's action against insurer, alleging that it admitted patient for care and treatment in reliance on insurer's representations regarding coverage, is remanded to state court, where insurer claimed terms of policy are governed by FEHBA (*5 USCS §§ 8901*-*8913*), because although FEHBA broadly preempts state law relating to federal employee health benefit plans, it does not completely preempt field so as to turn state claim into federal cause of action. *Transitional Hosps. Corp. v Blue Cross & Blue Shield (1996, WD Tex) 924 F Supp 67.*

Federal health plan enrollee's claim for coverage need not be remanded to state court, where Federal Employee Health Benefits Act (*5 USCS §§ 8501* et seq.) was intended to govern recovery of health benefits under federal employee plan, because complete preemption doctrine applies and recharacterization of state breach-of-contract claim as federal is appropriate. *Hanson v Blue Cross Blue Shield (1996, ND Iowa) 953 F Supp 270.*

While *5 USCS § 8902(m)(1)* may have preempted state-law claims against health plans and medical association regarding quality of medical care rendered to plan beneficiaries, defendants failed to demonstrate complete, rather than defensive, preemption of any cause of action so as to support removal to federal court. *Cyr v Kaiser Found. Health Plan (1998, ND Tex) 12 F Supp 2d 556.*

Action for denial of benefits under federal health insurance plan need not be remanded, even though employee argues that her claims are controlled purely by state law, because both express wording of *5 USCS § 8902* and legislative history indicate that Federal Employees Health Benefits Act (*5 USCS §§ 8901* et seq.) now completely preempt her state-law breach-of-contract claim. *Carter v Blue Cross & Blue Shield, Inc. (1999, ND Fla) 61 F Supp 2d 1237.*

In hospital's suit against health insurer alleging breach of medical services agreement, Federal Employees Health Benefits Act, *5 USCS §§ 8901*-*8914*, completely preempted hospital's state law claims involving enrollees in nationwide government health plan for federal employees. *St. Mary's Hosp. v Carefirst of Md., Inc. (2002, DC Md) 192 F Supp 2d 384, 27 EBC 2724* (criticized in *Cedars-Sinai Med. Ctr. v Nat'l League of Postmasters (2007, CA9 Cal) 497 F3d 972, 42 EBC 1343).*

There was no federal question jurisdiction over contract action brought by administrator of federal employee health benefits plan against estate of beneficiary to obtain reimbursement for medical benefits paid under plan; as

provided in 5 USCS § 8902m(1), part of Federal Employees Health Benefit Act, *5 USCS §§ 8901* et seq. (FEHBA), does not preempt state law where it is not alleged that state law is inconsistent with terms of FEHBA benefit or coverage contract. *Empire Healthchoice Assur. v McVeigh (2003, SD NY) 31 EBC 2828,* affd (2005, CA2 NY) *396 F3d 136, 34 EBC 1490,* reh den (2005, CA2 NY) *402 F3d 107* and affd *(2006) 547 US 677, 126 S Ct 2121, 165 L Ed 2d 131, 37 EBC 2729, 19 FLW Fed S 265.*

5. --Tort claims

Preemption of state law in favor of contract provisions under *5 USCS § 8902(m)(1)* provides no basis for federal-court jurisdiction; where private health insurer of federal employees, seeking reimbursement from plan beneficiary for medical bills paid by insurer, where beneficiary, unaided by insurer, had recovered damages in state-court tort action against third party alleged to have caused accident from which bills resulted, court found that contract-derived reimbursement claim is not creature of federal law; thus, § 8902(m)(1) did not confer jurisdiction to federal courts. *Empire HealthChoice Assur., Inc. v McVeigh (2006) 547 US 677, 126 S Ct 2121, 165 L Ed 2d 131, 37 EBC 2729, 19 FLW Fed S 265.*

Tort claims arising out of manner in which benefit claim is handled are not separable from terms of contract, and claims "relate to" plan under *5 USCS § 8902(m)(1)* as long as they have connection with or referred to plan, and because all appellants' state law claims referred to plan and invariably expand obligations under terms of plan, claims are inconsistent with plan and, hence, preempted under *5 USCS § 8902(m)(1)*. *Hayes v Prudential Ins. Co. (1987, CA9 Cal) 819 F2d 921,* cert den *(1988) 484 US 1060, 98 L Ed 2d 980, 108 S Ct 1014.*

With respect to insured's local-law tort and breach of contract claims against health-care insurer that had denied coverage of surgical procedure, Federal Employees Health Benefits Act of 1959 did not completely preempt claims based on statutory language, judicial precedent, and regulatory framework of Office of Personnel Management. Lopez-Mu?oz v *Triple-S Salud, Inc. (2014, CA1 Puerto Rico) 754 F3d 1.*

With respect to insured's local-law tort and breach of contract claims against health-care insurer that had denied coverage of surgical procedure, preemption clause of Federal Employees Health Benefits Act of 1959 did not completely preempt claims because it was not sufficiently broad, such that removal was not justified. Lopez-Mu?oz v *Triple-S Salud, Inc. (2014, CA1 Puerto Rico) 754 F3d 1.*

Government employee's bad faith tort claim against health insurer is not preempted by *5 USCS § 8902(m)(1)*, which makes provisions of insurance contract preempt conflicting state or local law regarding health insurance, where House report reflects that section was intended to preempt inconsistent state laws or regulations which specify types of medical care, providers of care, extent of benefits, coverage of family members, age limits for family members or other matters relating to health benefits or coverage, because while it is clear that provisions of insurance contract at issue preempt state statute of limitations, it is not clear that state bad faith insurance tort is inconsistent with any specific contractual provision. *Eidler v Blue Cross Blue Shield United (1987, ED Wis) 671 F Supp 1213.*

Federal employee's claim against insurer for tortious interference with his contract with co-defendant insurer was not properly removed since federal question involved, interpretation of policy issued pursuant to Federal Employees' Health Benefits Act, arose only in defensive posture. *Craig v Government Employees' Ins. Co. (1991, DC Md) 134 FRD 126.*

Insured's tort claims against health insurer are preempted, where health-benefits plan provides that federal law governs claims for relief that relate to benefits under plan and tort claims all relate to manner in which insurer handled health-benefits request, because *5 USCS § 8902(m)(1)* has been broadly interpreted to preempt state or local law in order to ensure uniformity in administration of federal employee health benefits. *Williams v Blue Cross & Blue Shield (1993, ED Va) 827 F Supp 1228.*

Patient's claims for fraud and tortious interference with contract, asserted against health plan governed by 5 USCS §§ 8901 et seq. in connection with financial incentive program that allegedly encouraged physicians to reduce quality of care, were removable to federal court under complete preemption doctrine, where 5 USCS § 8902(m)(1) provided mandatory administrative process for review of denied claims. *Kight v Kaiser Found. Health Plan (1999, ED Va) 34 F Supp 2d 334.*

Third-party health care provider's state law claim that FEHBA plan sponsor negligently misrepresented that plan participant's infant child was covered by plan is not preempted by 5 USCS § 8902(m)(1). *Macon-Bibb County Hosp. Auth. v National Treasury Emples. Union (1995) 265 Ga 557, 458 SE2d 95, 95 Fulton County D R 1828, 19 EBC 1501.*

6. Judicial review

Federal employees whose claims were governed by FEHBA were required to appeal disputed claims to OMP before seeking judicial review. *Kennedy v Empire Blue Cross & Blue Shield (1993, CA2) 989 F2d 588, 28 EBC 1091, 25 FR Serv 3d 141.*

Office of Personnel Management's interpretation of benefit plan is entitled to deference because of its intimate and extensive involvement in negotiation and interpretation of federal health-insurance plans. *Weight Loss Healthcare Ctrs. of Am., Inc. v OPM (2011, CA10 Kan) 655 F3d 1202.*

Although court determined that Office of Personnel Management (OPM) had reasonably interpreted benefit plan language, court reversed because OPM neither reviewed evidence that would show whether insurer had correctly calculated plan allowance, nor explained why such review was unnecessary (OPM apparently just took insurer at its word, and to do so without explanation was arbitrary and capricious). *Weight Loss Healthcare Ctrs. of Am., Inc. v OPM (2011, CA10 Kan) 655 F3d 1202.*

Discretion of Civil Service Commission [now Office of Personnel Management] under Health Benefits Act (5 USCS §§ 8901 et seq.), though broad, is bounded by § 8902(i) and it is to courts that task of policing boundary falls; that section provides courts with law to apply. *National Treasury Employees Union v Campbell (1978, App DC) 191 US App DC 146, 589 F2d 669.*

Civil Service Commission's rate-making action setting rates for federal employees' health insurance was not committed to agency discretion by law but subject to judicial review. *National Treasury Employees Union v Campbell (1978, App DC) 191 US App DC 146, 589 F2d 669.*

OPM's determination debarring petitioner from participating as provider in Federal Employees' Health Benefits Program was not "determination" within court's appellate jurisdiction since it did not originate with OPM, rather it debarred petitioner after HHS excluded her from participating in certain programs under Social Security Act following her state prosecution for health-care fraud crimes, pursuant to OPM's regulation that debarment or suspension by one federal agency shall have governmentwide effect. *Chertkov v Office of Personnel Management (1995, CA FC) 52 F3d 961, 19 EBC 1397,* reh den (1995, CA FC) *1995 US App LEXIS 11303.*

Because Congress' explicit command to OPM with respect to rate-setting was that rates should reflect costs, with no relaxation of that requirement in year when contract was not renewed (final year), *48 CFR § 1652.216-70(b)(6)* conflicted with *5 USCS § 8902(i)* and was thus invalid; however, even if regulation were valid, it was arbitrary and capricious because (1) OPM provided little evidence that problem regulation was supposedly designed to address--difficulty in obtaining data from carrier during final year--actually existed, and (2) even if problem existed, OPM failed to persuade appellate court that reconciliation should never take place in final year, even where adequate records existed, simply because some firms, at some time, have had bad records. *GHS HMO, Inc. v United States (2008, CA FC) 536 F3d 1293.*

Judicial review of agency renegotiation of contract so as to provide reduced coverage for private nursing care in home is reviewable under "arbitrary and capricious" standard of *5 USCS § 706* since judicial review is not precluded and there is law to apply under *5 USCS §§ 8902* and *8904*. *Tackitt v Prudential Ins. Co. (1984, ND Ga) 595 F Supp 887,* affd (1985, CA11 Ga) *758 F2d 1572.*

Government worker disputing denial of health insurance coverage need not exhaust her administrative remedies before seeking judicial review of claim denial, where *5 USCS § 8902(m)(1)* makes provisions of insurance contract govern health insurance coverage or benefit claims, contract brochures advise claimant that review of claim denials "may" be sought through Office of Personnel Management (OPM) administrative process, *5 USCS § 8902(j)* binds health insurer to OPM decision, but legislative intent of Federal Employee Health Benefits Act (*5 USCS §§ 8901* et seq.) shows establishment of administrative review was for benefit of claimants, because neither contract nor statutory language precludes judicial review of claim denial without prior administrative appeal. *Eidler v Blue Cross Blue Shield United (1987, ED Wis) 671 F Supp 1213.*

District court could not entertain claims asserted by federal health plan family member, arising from sued plan administrator's denial of member's claim for coverage for her gastric bypass surgery, because member had not fully exhausted her administrative remedies as required by *5 CFR §§ 890.105*. 890.107(d), which were regulations promulgated pursuant to Federal Employees Health Benefits Program; it would be futile to allow member to amend her claim to substitute Office of Personnel Management (OPM) for plan administrator because time for filing administrative appeal with OPM had expired approximately nine months earlier. *Turley v Coventry Health Care of Iowa, Inc. (2008, SD Iowa) 590 F Supp 2d 1126.*

Plain language of *5 CFR §§ 890.105*. 890.107(d), which are regulations promulgated pursuant to Federal Employees Health Benefits Program, require covered individual to fully exhaust his or her administrative remedies before filing suit in court arising from dispute over benefits provided in federal health insurance plan. *Turley v Coventry Health Care of Iowa, Inc. (2008, SD Iowa) 590 F Supp 2d 1126.*

7. Limitation of actions

Action by postal worker against health insurer to recover hospitalization expenses is time-barred where action is not brought until more than 6 months after expiration of time provided for commencing actions in government-wide contract between insurer and United States Civil Service Commission, but within period of state statute of limitations, since, by virtue of *5 USCS § 8902(m)(1)*, state statute is superseded and pre-empted by contract. *La Belle v Blue Cross & Blue Shield United (1982, WD Wis) 548 F Supp 251.*

Action to recover benefits under federal employee's health insurance is time-barred, where action may have been brought within Florida 5-year limitations period for commencing action or written contract, but was beyond 2-year period provided in contract between government and insurer, because Federal Employees Health Benefit Act (*5 USCS § 8902(m)(1)*) provides for preemption of state or local law that would otherwise be inconsistent with contractual provisions relating to health insurance or plans. *Fuller v Blue Cross & Blue Shield, Inc. (1987, ND Fla) 677 F Supp 1131.*

8. Conversion

Office of Personnel Management is not mandated to require carriers to provide same level of benefits for conversion to nongroup coverage as provided for federal employees under group policy, and employee who has retired is not entitled to convert to same level of benefits under nongroup plan as employee enjoyed prior to retirement under group plan. *Allen v United States (1984, CA8 Mo) 732 F2d 107.*

OPM did not act arbitrarily or capriciously in interpreting insurance policy to limit benefits for speech therapy for employee's dependent to two months, pursuant to policy's medical and surgical benefits limitation, rather than as covered by policy's mental health benefits section since autism is mental health disorder; although policy may be

susceptible to either reading, OPM offered reasonable interpretation that plan considered speech therapy medical benefit as evidenced by its express reference in that section, and contained no indicating that individual therapy of type contemplated by mental health benefits section, included speech therapy. *Muratore v United States OPM (2000, CA11 Fla) 222 F3d 918, 25 EBC 1859, 13 FLW Fed C 991.*

9. Benefit adjustments

Judicial review of actions of Office of Personnel Management in approving health benefit plans for federal employees is subject to "arbitrary and capricious" standard of *5 USCS § 706*; approval of reductions in benefit levels by government is not arbitrary and capricious where it has effect of lowering premiums while maintaining catastrophic coverage. *Tackitt v Prudential Ins. Co. (1985, CA11 Ga) 758 F2d 1572.*

5 USCS § 8902(j) does not grant OPM authority unilaterally to alter or amend terms of insurance plan covering employees, but requires only that carrier comply with OPM'S interpretation of plan, such that provisions of plan may be altered in subsequent agreements so as to limit benefits which were previously unlimited. *Hayes v Prudential Ins. Co. (1987, CA9 Cal) 819 F2d 921,* cert den *(1988) 484 US 1060, 98 L Ed 2d 980, 108 S Ct 1014.*

5 USCS § 8902 authorizes Office of Personnel Management to make benefit adjustments on annual basis and does not preclude office from adversely affecting benefits being received by insured at time that adjustment is made; subsequent modification may adversely affect benefits being received, and there is no vested right to continue to receive private duty nursing care without limitation on its cost. *Garvey v Prudential Ins. Co. (1984, ED Pa) 596 F Supp 1119.*

Plan's exclusion of benefits for high-dose chemotherapy with autologous bone marrow transplant (HDC-ABMT) does not violate *5 USCS § 8902(f)*, even though that provision prohibits exclusion of individual based on gender, because § 8902(f) applies only to individual's ability to participate in health benefits plan under Federal Employees Health Benefits Act (*5 USCS §§ 8901* et seq.) and not to inclusion or exclusion of benefits. *Reger v Espy (1993, ND Ga) 836 F Supp 869, 63* CCH EPD P 42791.

Employer's health insurer is primarily liable for cancer treatment expenses incurred while employee was insured under both employer's plan and Federal Employees Health Benefits Act (FEHBA) (*5 USCS §§ 8901* et seq.) plan through her husband, even though employer's plan purports to be "always secondary" plan, because Office of Personnel Management's coordination of benefits decision was not arbitrary and capricious but rather was reasonable interpretation and application of *5 USCS § 8902* and FEHBA plan's double coverage provision. *Catholic Diocese of Boloxi Supplemental Medical Reimbursement Plan v Blue Cross, Blue Shield (1997, SD Miss) 960 F Supp 1145.*

10. Policy provisions

Health benefit plan provision barring duplicative payments is not properly invoked as to insurance payments made for pain and suffering rather than medical expenses in reimbursement; Office of Personnel Management is not entitled to disregard express nonmedical nature of other benefits simply because benefits were calculated with reference to medical expenses. *Myers v United States (1985, CA4 SC) 767 F2d 1072.*

Because anti-reconciliation term of Final Year Regulation, *48 CFR § 1652.216-70(b)(6)*, conflicted with requirement of *5 USCS § 8902(i)* that health insurance rates were required to reasonably and equitably reflect cost of benefits provided, policy carriers were entitled to reformation of their contracts with *U.S. Office of Personnel Management. GHS HMO, Inc. v United States (2007) 76 Fed Cl 339,* affd (2008, CA FC) *536 F3d 1293.*

Research References & Practice Aids

Related Statutes & Rules:

This section is referred to in *5 USCS §§ 8902a*, *8910*, *8913*, *8953*, *8983*.

Annotations:

Validity, Construction, and Application of Federal Employees Health Benefits Act (FEHBA), *5 U.S.C.A. §§ 8901* to *8914* [*5 USCS §§ 8901*-*8914*]. *8 ALR Fed 2d 1.*

Validity, Construction, and Application of State Statutes Implementing the Uniform Unclaimed Property Act or its Predecessor--Modern Status. *29 ALR6th 507.*

Liability of employer to employee in connection with selection or retention of group insurer. *10 ALR4th 1267.*

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