No. 09-38

IN THE
Supreme Court of the United States

HEALTH CARE SERVICE CORPORATION,
Petitioner,

v.

JULI A. POLLITT and MICHAEL A. NASH,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

BRIEF OF ALLIANCE OF COMMUNITY HEALTH PLANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

1. Whether the Federal Employees Health Benefits Act ("FEHBA"), 5 U.S.C. §§ 8901-14, completely preempts – and therefore makes removable to federal court – a state court suit challenging enrollment and health benefit determinations that are subject to the exclusively federal remedial scheme established in FEHBA.

2. Whether the federal officer removal statute, 28 U.S.C. § 1442(a)(1), which authorizes federal removal jurisdiction over state court suits brought against persons "acting under" a federal officer when sued for actions "under color of [federal] . . . office," encompasses a suit against a government contractor administering a FEHBA plan, where the contractor is sued for actions taken pursuant to the government contract.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

REGULATIONS

LEGISLATIVE HISTORY

MISCELLANEOUS

INTEREST OF AMICUS CURIAE

Amicus curiae[1] is the Alliance of Community Health Plans ("ACHP"),[2] an association of non-profit, community-based and regional health plans and provider organizations that are dedicated to delivering patient-centered care of the highest quality and value. ACHP submits this *amicus* brief because the Seventh Circuit's opinion in *Pollitt v. Health Care Service Corp.* will adversely impact its non-profit community and regional health plan members and their ability to provide cost-effective

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[1] This amicus brief is filed with the consent of the parties, in accordance with this Court's Rule 37.3(a). In a letter to the Court on December 11, 2009, Respondents provided blanket consent to the filing of amicus briefs. On December 14, 2009, Petitioner filed a letter providing blanket consent to the filing of amicus briefs. Pursuant to Rule 37.6, no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus curiae,* its members, or its counsel made a monetary contribution to its preparation or submission.

[2] ACHP members participating in FEHBP include: Capital District Physicians Health Plan (NY), Capital Health Plan (FL), ConnectiCare (subsidiary of Health Insurance Plan of Greater New York), Fallon Community Health Plan (MA), Geisinger Health Plan (PA), Group Health Cooperative (WA), Group Health Cooperative of South Central Wisconsin (WI), Health Insurance Plan of Greater New York (EmblemHealth), HealthPartners (MN), Independent Health Plan (NY), Kaiser Foundation Health Plan, Presbyterian Health Plan (NM), and UPMC Health Plan (PA).

high quality health services and benefits to their Federal Employee Health Benefits Program ("FEHBP") enrollees. Like Petitioner, ACHP's members furnish health care plan services for federal employees pursuant to Federal Employee Health Benefits Act ("FEHBA"); although, unlike Petitioner, their services are provided under the FEHBA through comprehensive prepaid medical plans under 5 U.S.C. § 8903(4). Most of them contract with the Office of Personnel Management ("OPM") to provide benefits under the FEHBP on a community rated basis. *See* 48 C.F.R. § 1602.170-2.

The FEHBA's federal remedial scheme provides for the judicial review of OPM's and the carrier's administrative decisions *only* in federal court against the OPM. The Seventh Circuit's opinion, if upheld, will result in significant litigation brought against ACHP's members by opening state courts to FEHBA litigation, which properly belongs in federal court. Enrollees in FEHBP – a program covering millions of federal employees – will be able to evade the federal remedial scheme simply by suing the wrong party – such as one of ACHP's members – in state court, rather than suing the proper party – the OPM – in federal court.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Pollitt v. Health Care Service Corporation,* 558 F.3d 615 (7th Cir. 2009), the Seventh Circuit Court of Appeals rejected Petitioner's argument that Respondents' FEHBA claims are completely preempted by federal law and therefore removable.

It also applied an incorrect and unsupported standard for federal officer removal jurisdiction. In denying FEHBA benefits-related claims their proper place in federal court, the Seventh Circuit has created an anomaly in federal health benefits law. Through either complete preemption or federal officer removal principles, plans defending against claims for health coverage or benefits provided in all three other major national health benefit arenas – ERISA, Medicare, and TRICARE – can follow a path to federal court, through removal of claims filed first in state court.

This Court has previously ruled that section 502(a)(1)(B) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), provides federal jurisdiction over "'causes of action within the scope of the civil enforcement provision of § 502(a)'" and that such claims can be removed. *Aetna v. Davila,* 542 U.S. 200, 209 (2004) (*citing Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987)). Likewise, federal courts have held that under 28 U.S.C. § 1442(a)(1), the federal officer removal statute, Medicare, CHAMPUS, and TRICARE claims related to the administration of benefits are removable. The law warrants consistency, and there is, moreover, no policy reason to apply a different standard to FEHBA than applies to ERISA, Medicare and TRICARE. It would be anomalous indeed if suits against plans serving federal employees could be brought in state court without removal authority, while state court claims against private health plans are subject to removal to federal court under ERISA.

The law does not require such a result, and indeed demands the opposite.

For the same reasons claims related to other federal health benefit statutes are subject to removal and entitled to federal jurisdiction, so should FEHBA claims be found subject to federal jurisdiction and removal. If Respondents are allowed to evade the federal remedial scheme and pursue FEHBA benefit and enrollment claims in state court, enrollees in the FEHBP, which covers millions of federal employees, will be permitted to evade the mandatory federal administrative remedy pathway simply by suing the wrong party in state court to avoid removal.

Claims brought in state court challenging FEHBP enrollment and health benefit determinations should be removable to federal court pursuant to complete preemption and/or the federal officer removal statute, 28 U.S.C. 1442(a)(1).

ARGUMENT

I. THE SEVENTH CIRCUIT'S OPINION, IF UPHELD, WILL ADVERSELY IMPACT HEALTH CARE PLANS ADMINISTERING FEHBA HEALTH CARE BENEFIT CONTRACTS

A. The Seventh Circuit's Opinion Adversely Impacts ACHP Members.

Amicus curiae is the Alliance of Community Health Plans ("ACHP"), an organization of prepaid health care plans owned or operated by non-profit entities, who deliver affordable, high-quality

coverage and care to voluntarily enrolled members in more than 20 states and the District of Columbia. ACHP members are consistently among the highest-performing health plans in the nation. ACHP's stated mission is to "improve the health of the communities we serve and actively lead the transformation of health care so that it is safe, effective, patient-centered, timely, efficient and equitable." In achieving this mission, ACHP advocates for better health care, and works to solve the health care challenges facing its members.

ACHP's members are predominantly not-for-profit charitable or social welfare organizations exempt from federal taxation under Sections 501(c)(3) or 501(c)(4) of the Internal Revenue Code of 1986, as amended. These health plans enroll some 18 million individuals nationwide including approximately 600,000 enrollees under the FEHBP. They contract with the federal Office of Personnel Management ("OPM") under the FEHBP as comprehensive health plans, most doing so on a community rated basis. Some member plans have offered an FEHBP option for more than 30 years.

ACHP member plans have a strong and stable presence in the communities they serve and earn the loyalty of their enrollees; many of the health plans offered by ACHP members have retention rates of 90 percent or more. Whether they are organized as fully integrated delivery systems or through contracted networks, ACHP member health plans set standards for selecting providers and work closely with providers to coordinate care, ensure

appropriate utilization of services, and meet goals for quality and affordability. Both the National Committee for Quality Assurance (NCQA) and the U.S. Centers for Medicare and Medicaid Services evaluate health plans on clinical quality, patient satisfaction, and related measures. Eleven of the top 25 commercial plans and 15 of the top 25 Medicare plans are ACHP member plans in the rankings based on the most recent NCQA evaluation.

ACHP submits this *amicus* brief because the Seventh Circuit's opinion in *Pollitt v. Health Care Service Corp.* will adversely impact its members and their provision of benefits to hundreds of thousands of FEHBP enrollees. The Seventh Circuit's opinion, if upheld, will open state courts to FEHBA litigation, resulting in disruption of the scheme contemplated by Congress for resolution of FEHBA enrollment and benefit disputes. It is insufficient protection for ACHP's member plans and the FEHBP itself to count on disparate state courts across the country to consistently and correctly dispose of improperly framed state law claims. It is particularly insufficient because Congress contemplated that a unitary federal standard would be applied in the federal courts following the prescribed administrative review process.

II. THE SEVENTH CIRCUIT'S RULING ALLOWS A PLAINTIFF TO EVADE FEHBA'S FEDERAL REMEDIAL SCHEME

The Petitioner, Health Care Service Corporation ("HCSC"), administers pursuant to a government contract the health care plan covering

Respondent and her son. Like HCSC, ACHP's members contract with OPM to provide plans offering health benefits to federal employees pursuant to FEHBA. Under the Seventh Circuit's ruling, ACHP members facing enrollee claims styled as arising under state law would be foreclosed from the federal courts. The Seventh Circuit's ruling, if upheld, will engender a surge in state court claims burdening ACHP members and risking disruption to the operation of the FEHBP.

Respondent Juli A. Pollitt receives health insurance as a benefit of her federal employment pursuant to the FEHBA. Respondents filed this lawsuit after HCSC ceased payments for claims submitted for Ms. Pollitt's son, Michael, and sought reimbursement from health care providers for the payments HCSC had made on Michael's behalf for the preceding four years. Respondents sued HCSC, the private party who administers the benefit plan, in state court. Respondents' original complaint asked that the Court "enter judgment . . . directing [HCSC] to honor all medical insurance claims for their minor child." J.A. 81. Similarly, the second amended complaint requested that HCSC halt any efforts to collect payments made previously on Respondents' son's behalf. *Id*. at 130. At bottom, the claims in Respondents' original complaint were based on "benefits and administration of FEHBA plans." *Pollitt v. HCSC*, No. 07 C 5961, 2008 WL 6928357, at *1 (N.D. Ill. Sept. 5, 2008). These claims are subject to the federal remedial scheme under the FEHBA and its implementing regulations.

Under FEHBA, the contracts entered into with each carrier shall "contain a detailed statement of benefits offered" and "shall require that the carrier . . . agree to pay for or provide a health service or supply . . . if the Office finds that the . . . person . . . is entitled thereto under the terms of the contract." 5 U.S.C. § 8902(d), (j). OPM has implemented through regulation a remedial scheme for individuals who believe the carrier improperly denied them benefits. *See* 5 C.F.R. § 890.105(a)(1).

FEHBA provides the exclusive enforcement mechanism for enrollment and benefit disputes brought by members of a federal employee health benefit plan. *See Id.* §§ 890.104(a); 890.107(a), (c). The regulations set forth a specific remedial scheme. *See Id.* § 890.105(a)(1). Benefit claims must first be submitted to the carrier of the health care plan. *Id.* If the claim is denied, the individual may seek reconsideration with the carrier. *Id.* If the carrier does not respond or "affirms its denial," the "covered individual may ask OPM to review the claim." *Id.* Only after the individual exhausts both the carrier's and OPM's "review processes," can the individual seek to have the decision reviewed in an action against OPM. *Id.* §§ 890.105(a)(1); 890.107(c).

The regulations prohibit the commencement of a lawsuit prior to the exhaustion of administrative remedies. *Id.* §§ 890.107(c); 890.105(a)(1). Moreover, the regulations require that a "legal action to review final action by OPM involving such denial of health benefits must be brought against OPM *and not against the carrier or carrier's*

subcontractors." *Id*. § 890.107(c) (emphasis added). Any lawsuit against OPM to review the administrative decision must commence in federal court. *See* 5 U.S.C. § 8912; *see also Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677, 696 (2006) (explaining that FEHBA's enforcement provisions "ensure that suits brought by the beneficiaries for denial of benefits *will land in federal court*") (citations omitted) (emphasis added).

In *Pollitt*, Respondents attempted to end run FEHBA's requirement that administrative remedies first be exhausted before review may be had in an action against OPM in federal court. Instead of adhering to this procedure, Respondents sued the HCSC in state court under state law. If the Seventh Circuit's ruling is upheld, enrollees in FEHBP will be allowed to evade the federal remedial scheme entirely, simply by suing the wrong party – *i.e.* the plan contractor rather than OPM – in state court.

The Seventh Circuit's opinion denied these benefit-related claims their proper place in federal court. In rejecting Petitioner's argument that these claims are completely preempted and in applying the incorrect standard for federal officer removal, the Seventh Circuit effectively closed the door to litigating these cases in federal court. With respect to complete preemption as a basis for removal, the Seventh Circuit relied on the wrong preemption standard and ignored this Court's most recent decision on complete preemption, *Beneficial Nat'l Bank v. Anderson*, 539 U.S. 1 (2003).

The Seventh Circuit also incorrectly concluded that federal officer removal is only proper if the federal agency "direct[ed]" the carrier to change Respondents' coverage. *Pollitt*, 558 F.3d at 616. The Seventh Circuit improperly focused on whether the agency specifically directed the action, instead of whether Petitioner's conduct stems from its obligations as a government contractor. *Id.* at 616-17. If the Seventh Circuit's improper federal officer removal standard is allowed to stand, it will severely depress the ability of FEHBA plan contractors to remove to federal court.

Moreover, permitting claimants to evade federal court "undermines" the intent of Congress to "achieve uniform administration of FEHBA plans." *Botsford v. Blue Cross & Blue Shield of Mont., Inc.*, 314 F.3d 390, 395 (9th Cir. 2002). Applying differing state standards to FEHBP-based claims, and different state court determinations regarding the applicability of state law to such claims, will "disrupt the nationally uniform administration" of FEHBA benefits, "increase administrative costs," and thereby increase the overall cost of federal health care. *Id.*

If the Seventh Circuit ruling stands, ACHP's members will face similar litigation in state courts. Enrollees or those seeking to pursue claims on their behalf will have an avenue to evade the carefully constructed FEHBP remedial scheme, and bring lawsuits against ACHP members, threatening their ability as non-profit community and regional health

plans to maintain their service levels in the program.

III. IF THE SEVENTH CIRCUIT RULING STANDS, FEHBA WILL BE THE ONLY SIGNIFICANT NATIONAL HEALTH BENEFITS REGIME WITHOUT A PATH FOR DEFENDANTS TO FEDERAL COURT

Through two separate removal schemes, numerous courts have concluded that claims related to the coverage or benefits provided under ERISA, Medicare, and TRICARE all have a path to federal court open to defendants. This Court has previously ruled that section 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), provides complete preemption and, accordingly, that "causes of action within the scope of the civil enforcement provision of § 502(a)" can be removed to federal court. *Aetna v. Davila,* 542 U.S. 200, 210 (2004) (*citing Metropolitan Life,* 481 U.S. at 66). Likewise, numerous federal courts have held that under 28 U.S.C. § 1442(a)(1), the federal officer removal statute, Medicare, CHAMPUS, and TRICARE claims are subject to removal. The Seventh Circuit ruling would deny defendants facing FEHBA-based claims pertaining to the "nature, provision or extent of coverage or benefits" (5 U.S.C. § 8902(m)(1)) the same right of access to a federal court that similar benefit schemes provide, whenever the plaintiff styles their complaint as arising under state law. To restore logical parity, under either complete preemption or federal officer removal, claims relating to the "nature, provision or extent of

coverage or benefits" (5 U.S.C. § 8902(m)(1)) under FEHBA should be removable to federal court.

A. Complete Preemption Provides Federal Courts Jurisdiction Over Claims Relating To The Administration of FEHBP Benefits.

1. Complete Preemption

An action "arising under" federal law may be removed to federal court if the complaint "affirmatively allege[s] a federal claim." 28 U.S.C. § 1441(b); *Beneficial Nat'l Bank,* 539 U.S. at 6. In determining whether the complaint properly alleges a federal claim, courts apply the well-pleaded complaint rule. *Davila*, 542 U.S. at 207. The well-pleaded complaint rule instructs that whether a case arises under federal law "must be determined from what necessarily appears in the plaintiff's statement of his own claim in the bill or declaration, unaided by anything alleged in anticipation of avoidance of defenses which it is thought the defendant may interpose." *Id.* (citing *Taylor v. Anderson*, 234 U.S. 74, 75-76 (1914)).

A state claim can be removed, however, when "a federal statute wholly displaces the state-law cause of action through complete pre-emption." *Id.* The Court has found complete preemption when the cause of action, "even if pleaded in terms of state law, is in reality based on federal law." *Id.* Because the claim "aris[es] under" federal law, it meets the requirements of 28 U.S.C. § 1441(b) and is properly removable to federal court. *Beneficial Nat'l Bank*,

539 U.S. at 8. The Court has found complete preemption under three statutes for certain claims: (1) § 301 of the Labor Management Relations Act, 1947 ("LMRA"); (2) § 502(a) of ERISA; and (3) §§ 85 and 86 of the National Bank Act. *See Avco Corp. v. Machinists*, 390 U.S. 557 (1968) (LMRA); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987) (ERISA); *Beneficial Nat'l Bank*, 539 U.S. 1 (2003) (National Bank Act).

2. ERISA Complete Preemption

ERISA provides minimum standards that cover most voluntarily created private pension and health plans. The Court has held that § 502(a)(1)(B) of ERISA's statutory regime provides complete preemption. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). In *Metropolitan Life,* the Court held that § 502(a)(1)(B) reflected an intent by Congress to "so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character." *Id.* at 63-64. Section 502(a)(1)(B) provides:

> (a) Persons empowered to bring a civil action. A civil action may be brought-- (1) by a participant or beneficiary-- (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

In 2004, the Court further addressed the scope of the complete preemption provided by Section 502(a)(1)(B). *Davila*, 542 U.S. at 210. In *Davila,* the plaintiffs were beneficiaries in ERISA-regulated employee benefit plans. *Id.* at 204. Plaintiffs sued their insurance carriers alleging they suffered injuries from the denial of coverage for certain treatments. *Id.* at 204-05. The Court held that the plaintiffs' claims, which would "remedy only the denial of benefits under ERISA-regulated benefits plans, fall within the scope of, and are completely pre-empted by, ERISA § 502(a)(1)(B), and thus removable to federal court." *Id*. at 221.

In *Davila,* the Court held that § 502(a)(1)(B) covers lawsuits for claims the beneficiary believes he or she is entitled to under the plan, but are not provided. *Id.* at 210. It also covers lawsuits to "generically . . 'enforce his rights' under the plan, or to clarify any of his rights to future benefits." *Id.* Accordingly, any cause of action that falls under § 502(a)(1)(B) is removable to federal court. *Id.* In interpreting § 502(a)(1)(B), the Court concluded that it covered any claim that "could have [been] brought . . . under 502(a)(1)(B) . . . where there is no other independent legal duty that is implicated by a defendant's action." *Id.*

3. FEHBA

a. FEHBA's Unitary Federal Scheme for Review of Claim Denial Disputes Supports Complete Preemption

Numerous courts have concluded that FEHBA's remedy for the denial of benefits completely preempts state law claims based on benefits grievances. *See e.g., Botsford,* 314 F.3d at 399; *BlueCross BlueShield of Tenn., Inc. v. Griffin*, No. 1:03-CV-140, 2004 WL 1854165, at *2 (E.D. Tenn. Jan. 6, 2004) (holding that complete preemption gives rise to "federal question jurisdiction over any claim for reimbursement related to a FEHBA plan and such claims would necessarily arise under federal common law"); *Estate of Williams-Moore v. Alliance One Receivables Mgmt., Inc.*, 335 F. Supp. 2d 636, 652 (M.D.N.C. 2004) ("[M]any courts now hold that the FEHBA completely preempts all state law claims that relate to health insurance or plans, regardless of whether they are inconsistent with the contractual provisions.").

This Court recently examined FEHBA and its federal remedial scheme in *Empire HealthChoice Assurance, Inc. v. McVeigh*, 547 U.S. 677 (2006). In *Empire*, the Court held that FEHBA's exclusive federal remedies did not "extend" to "reimbursement claims between carriers and insured workers." *Id.* at 696. The Court, however, carefully distinguished these claims from benefits disputes, which are covered by the federal enforcement scheme. *Id.* The Court made clear that the FEHBA enforcement

provisions "ensure that suits *brought by the beneficiaries* for denial of benefits will land in federal court." *Id.* (citations omitted) (emphasis added). In contrast, the Court explained that "[h]ad Congress found it necessary or proper to extend federal jurisdiction . . . to encompass contract-derived reimbursement claims between carriers and insured workers" then Congress could have so stated. *Id*. Unlike in *Empire*, where a health insurance carrier brought an action against the estate of a former enrollee, in *Pollitt*, the federal remedial scheme squarely applies to the benefit and enrollment claims brought by a beneficiary. Accordingly, *Empire* supports the application of complete preemption to benefits disputes that are covered by FEHBA remedial scheme.

b. The Breadth of the FEHBP Statutory Preemption Provision Further Supports Complete Preemption of State Law Claims for FEHBP Enrollment and Benefits

In conjunction with the FEHBP's regime for administrative and judicial review of claims denials, the broad express preemption of state law in FEHBP supports complete preemption of the Respondents' claims.

FEHBA's preemption provision provides:

> The terms of any contract under this chapter 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.

5 U.S.C. § 8902(m)(1). Each FEHBP contract, in turn, describes the benefits to be provided, the process for enrollment, and the federally prescribed pathway for resolution of disputes regarding claim denials. *Id.* § 8902(d), (g), (j); 5 C.F.R. §§ 890.105(a)(1), 890.104(a), 890.107(a), (c).

In its original iteration, FEHBA's preemption provision extended only to state and local laws and regulations "inconsistent with [FEHBP] contractual provisions." *Botsford*, 314 F.3d at 393. Several courts used this language to distinguish FEHBA's preemption language from ERISA, and to hold that FEHBA did not provide complete preemption. *See id.* at 393. However, in 1998, Congress amended FEHBA and removed the requirement for preemption that state laws and regulations be "inconsistent." The amended provision provides that the terms of any FEHBP contract "shall supersede and preempt any State of local law, or any regulation issued thereunder, which relates to health insurance plans." 5 U.S.C. § 8902(m)(1).

Removal of the "inconsistent" language illustrated Congress' intent to preempt state law and bring "FEHBA's preemption on par with that of ERISA." *See, e.g.*, *Rievley v. Blue Cross Blue Shield of Tenn.*, 69 F. Supp. 2d 1028, 1034 (E.D. Tenn.

1999). This conclusion is strengthened by the language in the House Report that "confirms the intent of Congress" that FEHBA contract terms "which relate to the nature or extent of coverage or benefits . . . completely displace" local and state laws. H.R. Rep. No. 105-374, at 16 (1997); *see also McCoy v. Unicare Life and Health Ins. Co.*, No. 04 C 1126, 2004 WL 2358277, at *5 (N.D. Ill. Oct. 18, 2004) (emphasizing that "Congress has indicated that the complete preemption doctrine is applicable" to FEHBA benefits claims).

While mere preemption of a state law by express Congressional preemption language does not inherently evidence "complete preemption" permitting removal to federal court, the federally created FEHBP remedial scheme, in conjunction with the broad FEHBA preemption language, as amended, supports complete preemption.

c. In Two Key Respects, The Statutory Basis For FEHBP Complete Preemption Is Even Stronger Than under ERISA

Compared to ERISA, the FEHBP scheme even more plainly favors an exclusively federal forum for claims disputes in two key respects.

The first concerns their respective statutory preemption language. ERISA "supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ," but excepts from preemption state laws regulating insurance,

banking and securities, through what is commonly referred to as the ERISA preemption "savings clause." *See* 29 U.S.C. § 1144(a), (b)(2)(A). Thus, in mandating preemption in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), of *all* state law claims for benefits under ERISA plans, even if the state law claim purported to be based on insurance law and was against an insurance company, this Court had to put in context the ERISA "savings clause" by focusing on the intended exclusivity of ERISA's Section 502(a)(1)(B) remedial scheme.

In FEHBA, in contrast, Congress has expressly preempted all state law claims for the benefits provided under FEHBP contracts. State law claims are preempted whether they purport to arise under state insurance law or not, and whether or not they are made against the government or against the contracting health benefit plan or carrier. *See* 5 U.S.C. § 8902(m)(1). Here, there is no "saving clause" to be construed. The FEHBA statutory preemption language is on its face stronger than ERISA's in this regard. In conjunction with the remedies afforded through the exclusively federal forums contemplated in the remedial scheme created under the FEHBP, the case for complete preemption is all the stronger.

Second, Congress specifically provided in ERISA that state courts have concurrent jurisdiction over ERISA plan participants' federal claims for benefits. 29 U.S.C. § 1132(e). Despite this provision contemplating a state court forum for pursuit of federal ERISA claims, the Court has nonetheless

found that the federal scheme completely preempts state law claims creating a sufficient basis for removal under ERISA, even with respect to claims that, once understood as properly raising a federal claim, may properly be maintained in state court. *See generally Davila*, 542 U.S. 200. In contrast, the FEHBP scheme for review and adjudication of claim denial disputes is exclusively federal, with no recognition of state courts as an appropriate forum in any respect. *See* 5 U.S.C. § 8912; 5 C.F.R. §§ 890.105(a)(1), 890.107(c). The case for complete preemption and removal to federal court is in that respect even stronger than in ERISA.

d. The Jurisdictional Language of FEHBA Is Consistent With Complete Preemption.

In determining whether complete preemption applies, in *Metropolitan Life,* the Court considered the language in ERISA's jurisdictional subsection, Section 502(f). *Metropolitan Life,* 481 U.S. at 65. With regard to FEHBA, the jurisdictional provision provides: "The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter." 5 U.S.C. § 8912. The jurisdictional provisions of ERISA and LMRA, are phrased more broadly, "creat[ing] federal jurisdiction over various parties, and various defendants, not merely the United States." *Botsford*, 314 F.3d at 397 (discussing 29 U.S.C. § 1132(f); 29 U.S.C. § 185(a)

(LMRA)); 29 U.S.C. § 1132(f) ("The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.").

Comparing ERISA § 502(f) to the FEHBA jurisdiction provision at 5 U.S.C. § 8912, the *Botsford* court concluded that while the jurisdiction statement may seem "narrower," when "considered in the context of the entire statute and its purposes," the language "is as broad as it can be." *Botsford,* 314 F.3d at 397. The differences are readily explained by differences in the scope of the statutes. ERISA covers health plans offered by private parties, and permits lawsuits to be brought against employers or plan administrators. *Id*. at 398. The LMRA, similarly, governs private sector labor-management matters. FEHBA, however, involves only one employer – the United States – and the regulatory scheme contemplates only a single defendant in any resultant coverage or benefits litigation – again the United States. *Id.* Accordingly, as explained in *Botsford*, FEHBA's remedial scheme and jurisdiction provision are intended to ensure that lawsuits are brought only against the United States. *Id.* Because the federal remedies provided in the remedial scheme are the "only intended remedies under FEHBA, . . . the federal remedies displace state remedies." *Id.*

In brief, Congress's language is more than sufficient to support complete preemption where the employee benefits program claims involve the

employees of the United States itself, when complete preemption has already been found with respect to the claims of plan participant employees of private employers. Complete preemption is, therefore, proper.

e. Complete Preemption is Further Supported by FEHBA's Goal of "Uniform Administration"

As explained in *Botsford,* Congress sought to create a "cost-efficient" and "comprehensive" health care coverage program for federal employees. *Botsford*, 314 F.3d at 395. A separate – and for this analysis significant – goal was to "achieve uniform administration of FEHBA plans." *Id.* If cases like the Respondents' proceed in state courts, the "application of different state standards would disrupt the nationally uniform administration" of FEHBA benefits. *Id.* Moreover, the "disruption would increase administrative costs," thereby increasing the overall cost of federal health care benefits. *Id.* Permitting these cases to proceed in state courts under varying state laws would "undermine congressional intent." *Id.*

For the reasons articulated above, and in Petitioner's Brief on the Merits, complete preemption should apply to claims that are, in fact, seeking FEHBP enrollment or benefits, pursuant to the FEHBA, 5 U.S.C. §§ 8901-14. This makes state court claims challenging enrollment and health benefit determinations removable to federal court.

B. The Federal Officer Removal Statute Provides Federal Courts Jurisdiction Over Respondents' Claims

1. The Federal Officer Removal Statute

The federal officer removal statute provides that a civil action may be removed to federal court when

> [t]he United States or any agency thereof or any officer (*or any person acting under that officer*) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

28 U.S.C. § 1442(a)(1) (emphasis added). The words "acting under" any officer of an agency "are broad, and . . . must be 'liberally construed.'" *Watson v. Philip Morris Cos.*, 551 U.S. 142, 147 (2007), (quoting *Colorado v. Symes*, 286 U.S. 510, 517 (1932)).

The Court has recognized the availability of § 1442(a)(1) as a basis for removal by government contractors acting at the direction of federal officers. In *Watson*, the Court noted that in contrast to regulated private corporations, "[t]he assistance that private [government] contractors provide federal officers goes beyond simple compliance with the law

and helps officers fulfill other basic governmental tasks." *Watson*, 551 U.S. at 153. Where a government contractor is sued, and "the relationship between the contractor and the Government is an unusually close one involving detailed regulation, monitoring, or supervision" that "helps fulfill basic governmental tasks," removal under § 1442(a)(1) is proper. *Id.* at 153-54; *see also Isaacson v. Dow Chem. Co.*, 517 F.3d 129, 137 (2d Cir. 2008) (upholding removal by government contractor under § 1442(a)(1)).

FEHBP plans are subject to comprehensive and particularly close federal regulation covering virtually every aspect of their operations, including their qualifications for contracting, claims processing, coverage requirements, enrollment eligibility and processing, payments to providers, subscription rates, government review and approval of their member coverage brochures, and the review and appeals process for claim denials, laid out not only in their government contract but also in more than 140 pages of federal regulations, a "carrier handbook," additional reporting requirements, and a series of annual "carrier letters" providing additional instruction. *See* 48 C.F.R. parts 1600 - 1699; 5 C.F.R. part 890; FEHB Carrier Letters and Carrier Handbook, *available at* http://www.opm.gov/carrier/. Furthermore, providing health benefits to its own employees is a basic government task carried out via the Employees Health Benefits Fund established by Congress in the Treasury of the United States for all payments to health benefits plans in the FEHBP. *See* 5 U.S.C. § 8909(a).

Application of the federal officer removal statute in the FEHBA context should parallel its application to contractors under the TRICARE and Medicare programs.

2. TRICARE

While FEHBA provides health care benefits to active and retired civilian employees of the United States government, the TRICARE program provides similar benefits to military personnel and their dependents. In 1967, the United States Department of Defense established the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), a civilian health care program for members of the United States armed forces and their dependents. *See* 10 U.S.C. § 1071; *see also* 32 C.F.R. § 199.3 (designating beneficiaries). In 1995 the Defense Department established TRICARE, a managed care program covering the same beneficiaries as CHAMPUS and supplementing CHAMPUS. Like FEHBA, under TRICARE, private regional contractors process health care services claims pursuant to contracts between the contractors and the Department of Defense.

Courts have concluded that claims relating to benefits coverage and payment under CHAMPUS/TRICARE are subject to removal under the federal officer removal statute where the state court claims "stem from the defendants' activities administering claims on behalf of the federal government." *See Lombardi v. Triwest Healthcare Alliance Corp.*, No. CV-08-02381-PHX-FJM, 2009 WL 1212170, at *2 (D. Ariz. May 4, 2009).

For example, in *Lombardi v. Triwest Healthcare Alliance Corp.*, the plaintiff sued the government contractor administrating his TRICARE benefits after his wife's claims were denied or left unpaid. *Id.* at *1. Like Respondents here, the plaintiff asserted state tort claims including emotional distress allegedly suffered as a result of the unpaid claims. *Id.* Also like here, after the lawsuit was filed, the defendant voluntarily paid all outstanding claims, then removed the action to federal court on the basis of federal question jurisdiction or the federal officer removal statute. *Id.*

The district court in *Lombardi* held that removal was proper under § 1442(a)(1) because the TRICARE contractors "derive their authority from a detailed system of federal regulations." *Id.* at *2. The District Court thus concluded that the defendants are "closely aligned with the [federal] government" and were "acting under federal control" pursuant to 28 U.S.C. § 1442(a)(1) when defendants undertook the actions alleged in plaintiff's complaint. *Id.* The court concluded that "even if the plaintiff no longer seeks the payment of TRICARE benefits, his claims stem from the defendants' activities administering claims on behalf of the federal government." *Id.*

Likewise, in *Holton v. Blue Cross and Blue Shield of South Carolina*, 56 F. Supp. 2d 1347 (M.D. Ala. 1999), a medical provider sued a CHAMPUS contractor for failure to pay various claims that the plaintiff had submitted. The district court concluded

that when "carrying out its duty to administer [the] CHAMPUS contract" the contractor was "act[ing] under the direction of the officers and of the United States and agencies thereof, and act[ing] under the color and authority of those officers." *Holton*, 56 F. Supp. 2d at 1351. Thus the federal court had jurisdiction to entertain the claim pursuant to 28 U.S.C. § 1442(a)(1).

3. Medicare

In addition to TRICARE and FEHBA, Medicare is another government health benefits program that relies on private parties as government contractors. Medicare, the social insurance program administered by the United States government, principally provides health coverage to people aged 65 and older, and to disabled persons. Medicare provides health coverage for over 43 million Americans. There are four parts to Medicare: (A) Medicare Part A covers, subject to certain time limits and co-payments, inpatient hospital stays and convalescence in nursing facilities; (B) Medicare Part B helps pay for services and products not included in Part A, including physician and nursing services, tests, vaccinations and durable medical equipment; (C) Medicare Part C, also known as Medicare Advantage (formerly known as Medicare Plus Choice), offers Medicare benefits through coordinated care and other contracted health plan programs; and (D) Medicare Part D, prescription drug coverage that requires participation in either a Prescription Drug Plan or a Medicare Advantage Plan with drug coverage.

Courts have found removal appropriate pursuant to 28 U.S.C. § 1442(a)(1) in suits relating to the administration of Medicare benefits brought against private contractors, including fiscal intermediaries and contractors providing private health benefits.[3] *Manorcare Potomac v. Understein*, No. 8:02-CV-1177-T-23EAJ, 2002 WL 31426705, at *1 n.1 (M.D. Fla. Oct. 16, 2002) (holding that removal by third-party defendant Aetna Health Inc., pursuant to Aetna's obligations as a Medicare + Choice provider, satisfies the requirements of 28 U.S.C. 1442(a)(1)); *Lifecare Hosps., Inc. v. Ochsner Health Plan, Inc.*, 139 F. Supp. 2d 768, 770 (W.D. La. 2001) (noting that case brought by hospital against Medicare + Choice plan was removed pursuant to several statutes, including 28 U.S.C. § 1442(a)(1)); s*ee also Peterson v. Blue Cross/Blue Shield of Tex.*, 508 F.2d 55, 58 (5th Cir. 1975), *cert. denied*, 422 U.S. 1043 (1975); *Reg'l Med. Transp., Inc. v. Highmark, Inc.*, 541 F. Supp. 2d 718, 724-25 (E.D. Pa. 2008);

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[3] The Eleventh Circuit recently held in *Dial v. Healthspring of Alabama, Inc.*, 541 F.3d 1044 (11th Cir. 2008) that federal courts lack subject matter jurisdiction over claims arising under the Medicare Act that are not brought against the Secretary for judicial review in federal court. *Id.* at 1048. Instead of dismissing the improper claims so that the claims could be brought under the federal remedial scheme, the Eleventh Circuit determined it lacked subject matter jurisdiction and ordered that the case be remanded to state court. *Id.* at 1047-48. Respectfully, ACHP believes this aspect of *Dial* was wrongly decided.

Neurological Assoc. v. Blue Cross/Blue Shield of Fla., Inc., 632 F. Supp. 1078 (S.D. Fla. 1986).

A case often cited for this proposition is *Peterson v. Blue Cross/Blue Shield of Texas*, 508 F.2d 55 (5th Cir. 1975). In *Peterson*, a physician brought an action against Blue Cross/Blue Shield of Texas for repayment and in connection with his suspension from practicing within the Medicare program. *Id.* at 56. His claims related to both Medicare Part A and Part B. *See Peterson v. Weinberger*, 508 F.2d 45, 48 (5th Cir. 1975), *cert. denied*, 423 U.S. 830 (1975). The Fifth Circuit concluded that the defendants, as fiscal intermediaries, were "acting pursuant to a contract with the government. . . under the sovereign immunity umbrella." *Peterson*, 508 F.2d at 57-58. The Fifth Circuit explained that the "purpose" of the federal officer removal statute is to "prevent federal officers or persons acting under their direction from being tried in state courts for acts done within the scope of their federal employment." *Id.* at 58. Relying on this Court's mandate that the "federal officer removal statute is not 'narrow' or 'limited'" and that "'the test for removal should be broader, not narrower, than the test for official immunity,'" the Fifth Circuit held that defendants were "persons acting within the purview of § 1442(a)(1) and that the suits were properly removed." *Id.* (citing *Willingham v. Morgan*, 395 U.S. 402, 405 (1969) & *Colorado v. Symes*, 286 U.S. 510, 517 (1932)).

Similarly, courts have concluded that the federal officer removal statute applies to those

contracting to provide Medicare health benefit plans. For example, in *Manorcare Potomac v. Understein*, Aetna Health, Inc., a provider of "Medicare + Choice" benefits (predecessor to the current Medicare Advantage program) pursuant to a contract with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) of the U.S. Department of Health and Human Services, successfully removed the case to federal court. *Understein,* No. 8:02-CV-1177-T-23EAJ, 2002 WL 31426705, at *1 n.1 (M.D. Fla. Oct. 16, 2002). The Middle District of Florida held that Aetna had "sufficiently allege[d]" that its role as a provider of Medicare benefits "qualifie[d] Aetna as a 'person acting under' an agency or officer of the United States for the purpose of the Federal Officer Removal Statute." *Id.*; *see also Lifecare Hosps.,* 139 F. Supp. 2d at 770 (noting that case brought by hospital against Medicare + Choice plan was removed pursuant to several statutes, including 28 U.S.C. § 1442(a)(1)).

4. FEHBA

The Seventh Circuit applied an incorrect standard for federal officer removal when it focused on whether a government agency specifically directed the action, instead of whether Petitioner's conduct stems from its obligations as a government contractor. *Pollitt,* 558 F.3d at 616-17. The determinative factor for federal officer removal is whether "the acts complained of . . . were taken 'under color of federal office,'" not whether they were specifically directed by the government. *Isaacson*,

517 F.3d at 137 (quoting 28 U.S.C. § 1442(a)(1)). "The hurdle erected by this requirement is quite low" and the contractor "must only establish that the act that is the subject of Plaintiffs' attack . . . occurred *while* Defendants were performing their official duties." *Id.* at 137-38 (emphasis in original). The defendant need not show that the activities underlying the complaint were "specifically contemplated by the government contract." *Id.* at 138. Rather, "it is enough that the contracts gave rise to" those activities. *Id.*

The FEHBA regulations make clear that the federal government is responsible for directing the enrollment and benefits-payment activities of an FEHBP plan. *See* 5 C.F.R. §§ 890.102(a)-(f), 890.103, 890.104. Moreover, while it is the contractor who makes the initial benefits determination, that determination is appealable through the federal administrative agency, and FEHBA regulations require that a "legal action to review final action by OPM involving such denial of health benefits must be brought against OPM *and not against the carrier or carrier's subcontractors*." 5 C.F.R. § 890.107(c) (emphasis added). It is the government, and not the carrier, who is ultimately responsible for defending the benefit decision. Where the government itself has mandated that claims related to the actions of a government contractor are to be made against the government, and only against the government, it is particularly evident that a suit against the contractor may be removed under the federal officer removal principles. For these reasons and those further articulated in Petitioner's Brief on

the Merits, the Court should find that a suit against a government contractor offering a FEHBA plan for actions taken pursuant to the government contract meets the requirements of 28 U.S.C. § 1442(a)(1) and that such a case can be removed to federal court.

CONCLUSION

For the foregoing reasons, the Court should hold that FEHBA completely preempts - and therefore makes removable to federal court - a state court suit challenging enrollment and health benefit determinations that are subject to the exclusive federal remedial scheme established by FEHBA. Moreover, the Court should find that the federal officer removal statute, 28 U.S.C. § 1442(a)(1) encompasses a suit against a government contractor administering a FEHBA plan, for actions taken pursuant to the government contract.

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APPENDIX

APPENDIX

I. STATUTES

FEDERAL EMPLOYEE HEALTH BENEFITS ACT PROVISIONS

5 U.S.C. § 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, without regard to section 5 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, 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) this title shall 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 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 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 and chapter 7 of this title. 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

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 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, over-insurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title 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 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 readjustment 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 is entitled thereto under the terms of the contract.

(k)(1) When a contract under this chapter 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), 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, 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.

(*l*) The Office shall contract under this chapter for a plan described in section 8903(4) of this title 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 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 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. 2543).

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

(n) A contract for a plan described by section 8903(1), (2), or (3), or section 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.

5 U.S.C. § 8903. Health benefit plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service Benefit Plan. – One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

(2) Indemnity Benefit Plan. – One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) Employee Organization Plans. – Employee organization plans which offer benefits of the types

referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations described in section 8901(8)(A) of this title, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive Medical Plans. –

(A) Group-practice prepayment plans. – Group-practice prepayment plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include at least 3 physicians who receive all or a substantial part of their professional income from the prepaid funds and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan.

(B) Individual-practice prepayment plans. – Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their

offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

(C) Mixed model prepayment plans. – Mixed model prepayment plans which are a combination of the type of plans described in subparagraph (A) and the type of plans described in subparagraph (B).

5 U.S.C. § 8909. Employee Health Benefits Fund

(a) There is in the Treasury of the United States an Employees Health Benefits Fund which is administered by the Office of Personnel Management. The contributions of enrollees and the Government described by section 8906 of this title shall be paid into the Fund. The Fund is available--

(1) without fiscal year limitation for all payments to approved health benefits plans; and

(2) to pay expenses for administering this chapter within the limitations that may be specified annually by Congress.

Payments from the Fund to a plan participating in a letter-of-credit arrangement under this chapter shall, in connection with any payment or reimbursement to be made by such plan for a health service or supply, be made, to the maximum extent

practicable, on a checks-presented basis (as defined under regulations of the Department of the Treasury).

(b) Portions of the contributions made by enrollees and the Government shall be regularly set aside in the Fund as follows:

(1) A percentage, not to exceed 1 percent of all contributions, determined by the Office to be reasonably adequate to pay the administrative expenses made available by subsection (a) of this section.

(2) For each health benefits plan, a percentage, not to exceed 3 percent of the contributions toward the plan, determined by the Office to be reasonably adequate to provide a contingency reserve.

The Office, from time to time and in amounts it considers appropriate, may transfer unused funds for administrative expenses to the contingency reserves of the plans then under contract with the Office. When funds are so transferred, each contingency reserve shall be credited in proportion to the total amount of the subscription charges paid and accrued to the plan for the contract term immediately before the contract term in which the transfer is made. The income derived from dividends, rate adjustments, or other refunds made by a plan shall be credited to its contingency reserve. The contingency reserves may be used to defray increases in future rates, or may be applied to reduce the contributions of enrollees and the Government to, or to increase the benefits provided by, the plan

from which the reserves are derived, as the Office from time to time shall determine.

(c) The Secretary of the Treasury may invest and reinvest any of the money in the Fund in interest-bearing obligations of the United States, and may sell these obligations for the purposes of the Fund. The interest on and the proceeds from the sale of these obligations become a part of the Fund.

(d) When the assets, liabilities, and membership of employee organizations sponsoring or underwriting plans approved under section 8903(3) or 8903a of this title are merged, the assets (including contingency reserves) and liabilities of the plans sponsored or underwritten by the merged organizations shall be transferred at the beginning of the contract term next following the date of the merger to the plan sponsored or underwritten by the successor organization. Each employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title affected by a merger shall be transferred to the plan sponsored or underwritten by the successor organization unless he enrolls in another plan under this chapter. If the successor organization is an organization described in section 8901(8)(B) of this title, any employee, annuitant, former spouse, or person having continued coverage under section 8905a of this title so transferred may not remain enrolled in the plan after the end of the contract term in which the merger occurs unless that individual is a full member of such organization (as determined under section 8903a(d) of this title).

(e)(1) Except as provided by subsection (d) of this section, when a plan described by section 8903(3) or (4) or 8903a of this title is discontinued under this chapter, the contingency reserve of that plan shall be credited to the contingency reserves of the plans continuing under this chapter for the contract term following that in which termination occurs, each reserve to be credited in proportion to the amount of the subscription charges paid and accrued to the plan for the year of termination.

(2) Any crediting required under paragraph (1) pursuant to the discontinuation of any plan under this chapter shall be completed by the end of the second contract year beginning after such plan is so discontinued.

(3) The Office shall prescribe regulations in accordance with which this subsection shall be applied in the case of any plan which is discontinued before being credited with the full amount to which it would otherwise be entitled based on the discontinuation of any other plan.

(f)(1) No tax, fee, or other monetary payment may be imposed, directly or indirectly, on a carrier or an underwriting or plan administration subcontractor of an approved health benefits plan by any State, the District of Columbia, or the Commonwealth of Puerto Rico, or by any political subdivision or other governmental authority thereof, with respect to any payment made from the Fund.

(2) Paragraph (1) shall not be construed to exempt any carrier or underwriting or plan administration

subcontractor of an approved health benefits plan from the imposition, payment, or collection of a tax, fee, or other monetary payment on the net income or profit accruing to or realized by such carrier or underwriting or plan administration subcontractor from business conducted under this chapter, if that tax, fee, or payment is applicable to a broad range of business activity.

(g) The fund described in subsection (a) is available to pay costs that the Office incurs for activities associated with implementation of the demonstration project under section 1108 of title 10.

5 U.S.C. § 8912. Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Court of Federal Claims, of a civil action or claim against the United States founded on this chapter.

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES PROVISION

10 U.S.C. § 1071. Purpose of this chapter

The purpose of this chapter is to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents.

NATIONAL BANK ACT PROVISIONS

12 U.S.C. § 85. Rate of interest on loans, discounts and purchases

Any association may take, receive, reserve, and charge on any loan or discount made, or upon any notes, bills of exchange, or other evidences of debt, interest at the rate allowed by the laws of the State, Territory, or District where the bank is located, or at a rate of 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and no more, except that where by the laws of any State a different rate is limited for banks organized under state laws, the rate so limited shall be allowed for associations organized or existing in any such State under title 62 of the Revised Statutes. When no rate is fixed by the laws of the State, or Territory, or District, the bank may take, receive, reserve, or charge a rate not exceeding 7 per centum, or 1 per centum in excess of the discount rate on ninety-day commercial paper in effect at the Federal reserve bank in the Federal reserve district where the bank is located, whichever may be the greater, and such interest may be taken in advance, reckoning the days for which the note, bill, or other evidence of debt has to run. The maximum amount of interest or discount to be charged at a branch of an association located outside of the States of the United States and the District of Columbia shall be at the rate allowed by the laws of the country, territory, dependency, province, dominion, insular

possession, or other political subdivision where the branch is located. And the purchase, discount, or sale of a bona fide bill of exchange, payable at another place than the place of such purchase, discount, or sale, at not more than the current rate of exchange for sight drafts in addition to the interest, shall not be considered as taking or receiving a greater rate of interest.

12 U.S.C. § 86. Usurious interest; penalty for taking; limitations

The taking, receiving, reserving, or charging a rate of interest greater than is allowed by section 85 of this title, when knowingly done, shall be deemed a forfeiture of the entire interest which the note, bill, or other evidence of debt carries with it, or which has been agreed to be paid thereon. In case the greater rate of interest has been paid, the person by whom it has been paid, or his legal representatives, may recover back, in an action in the nature of an action of debt, twice the amount of the interest thus paid from the association taking or receiving the same: *Provided,* That such action is commenced within two years from the time the usurious transaction occurred

JUDICIARY AND JUDICIAL PROCEDURE PROVISIONS

28 U.S.C. § 1441. Actions removable generally

(a) Except as otherwise expressly provided by Act of Congress, any civil action brought in a State court of

which the district courts of the United States have original jurisdiction, may be removed by the defendant or the defendants, to the district court of the United States for the district and division embracing the place where such action is pending. For purposes of removal under this chapter, the citizenship of defendants sued under fictitious names shall be disregarded.

(b) Any civil action of which the district courts have original jurisdiction founded on a claim or right arising under the Constitution, treaties or laws of the United States shall be removable without regard to the citizenship or residence of the parties. Any other such action shall be removable only if none of the parties in interest properly joined and served as defendants is a citizen of the State in which such action is brought.

(c) Whenever a separate and independent claim or cause of action within the jurisdiction conferred by section 1331 of this title is joined with one or more otherwise non-removable claims or causes of action, the entire case may be removed and the district court may determine all issues therein, or, in its discretion, may remand all matters in which State law predominates.

(d) Any civil action brought in a State court against a foreign state as defined in section 1603(a) of this title may be removed by the foreign state to the district court of the United States for the district and division embracing the place where such action is pending. Upon removal the action shall be tried by the court without jury. Where removal is based upon

this subsection, the time limitations of section 1446(b) of this chapter may be enlarged at any time for cause shown.

(e)(1) Notwithstanding the provisions of subsection (b) of this section, a defendant in a civil action in a State court may remove the action to the district court of the United States for the district and division embracing the place where the action is pending if—

> (A) the action could have been brought in a United States district court under section 1369 of this title; or
>
> (B) the defendant is a party to an action which is or could have been brought, in whole or in part, under section 1369 in a United States district court and arises from the same accident as the action in State court, even if the action to be removed could not have been brought in a district court as an original matter.

The removal of an action under this subsection shall be made in accordance with section 1446 of this title, except that a notice of removal may also be filed before trial of the action in State court within 30 days after the date on which the defendant first becomes a party to an action under section 1369 in a United States district court that arises from the same accident as the action in State court, or at a later time with leave of the district court.

(2) Whenever an action is removed under this subsection and the district court to which it is removed or transferred under section 1407(j) has made a liability determination requiring further proceedings as to damages, the district court shall remand the action to the State court from which it had been removed for the determination of damages, unless the court finds that, for the convenience of parties and witnesses and in the interest of justice, the action should be retained for the determination of damages.

(3) Any remand under paragraph (2) shall not be effective until 60 days after the district court has issued an order determining liability and has certified its intention to remand the removed action for the determination of damages. An appeal with respect to the liability determination of the district court may be taken during that 60-day period to the court of appeals with appellate jurisdiction over the district court. In the event a party files such an appeal, the remand shall not be effective until the appeal has been finally disposed of. Once the remand has become effective, the liability determination shall not be subject to further review by appeal or otherwise.

(4) Any decision under this subsection concerning remand for the determination of damages shall not be reviewable by appeal or otherwise.

(5) An action removed under this subsection shall be deemed to be an action under section 1369 and an action in which jurisdiction is based on section

1369 of this title for purposes of this section and sections 1407, 1697, and 1785 of this title.

(6) Nothing in this subsection shall restrict the authority of the district court to transfer or dismiss an action on the ground of inconvenient forum.

(f) The court to which a civil action is removed under this section is not precluded from hearing and determining any claim in such civil action because the State court from which such civil action is removed did not have jurisdiction over that claim.

28 U.S.C. § 1442. Federal officers or agencies sued or prosecuted

(a) A civil action or criminal prosecution commenced in a State court against any of the following may be removed by them to the district court of the United States for the district and division embracing the place wherein it is pending:

(1) The United States or any agency thereof or any officer (or any person acting under that officer) of the United States or of any agency thereof, sued in an official or individual capacity for any act under color of such office or on account of any right, title or authority claimed under any Act of Congress for the apprehension or punishment of criminals or the collection of the revenue.

(2) A property holder whose title is derived from any such officer, where such action or prosecution

affects the validity of any law of the United States.

(3) Any officer of the courts of the United States, for any act under color of office or in the performance of his duties;

(4) Any officer of either House of Congress, for any act in the discharge of his official duty under an order of such House.

(b) A personal action commenced in any State court by an alien against any citizen of a State who is, or at the time the alleged action accrued was, a civil officer of the United States and is a nonresident of such State, wherein jurisdiction is obtained by the State court by personal service of process, may be removed by the defendant to the district court of the United States for the district and division in which the defendant was served with process.

LABOR MANAGEMENT RELATIONS ACT PROVISION

29 U.S.C. § 185. Suits by and against labor organizations

(a) Venue, amount, and citizenship

Suits for violation of contracts between an employer and a labor organization representing employees in an industry affecting commerce as defined in this chapter, or between any such labor organizations, may be brought in any district court of the United States having jurisdiction of the parties, without

respect to the amount in controversy or without regard to the citizenship of the parties.

(b) Responsibility for acts of agent; entity for purposes of suit; enforcement of money judgments

Any labor organization which represents employees in an industry affecting commerce as defined in this chapter and any employer whose activities affect commerce as defined in this chapter shall be bound by the acts of its agents. Any such labor organization may sue or be sued as an entity and in behalf of the employees whom it represents in the courts of the United States. Any money judgment against a labor organization in a district court of the United States shall be enforceable only against the organization as an entity and against its assets, and shall not be enforceable against any individual member or his assets.

(c) Jurisdiction

For the purposes of actions and proceedings by or against labor organizations in the district courts of the United States, district courts shall be deemed to have jurisdiction of a labor organization (1) in the district in which such organization maintains its principal office, or (2) in any district in which its duly authorized officers or agents are engaged in representing or acting for employee members.

(d) Service of process

The service of summons, subpena, or other legal process of any court of the United States upon an

officer or agent of a labor organization, in his capacity as such, shall constitute service upon the labor organization.

(e) Determination of question of agency

For the purposes of this section, in determining whether any person is acting as an "agent" of another person so as to make such other person responsible for his acts, the question of whether the specific acts performed were actually authorized or subsequently ratified shall not be controlling.

EMPLOYEE RETIREMENT INCOME SECURITY ACT PROVISIONS

29 U.S.C. § 1132(a), (e), (f). Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary –

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), (6), (7), (8), or (9) of subsection (c) of this section or under subsection (i) or (l) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection;

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title or the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts; or

(10) in the case of a multiemployer plan that has been certified by the actuary to be in endangered or critical status under section 1085 of this title, if the plan sponsor –

(A) has not adopted a funding improvement or rehabilitation plan under that section by the deadline established in such section, or

(B) fails to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section,

by an employer that has an obligation to contribute with respect to the multiemployer plan or an employee organization that represents active participants in the multiemployer plan, for an order compelling the plan sponsor to adopt a

funding improvement or rehabilitation plan or to update or comply with the terms of the funding improvement or rehabilitation plan in accordance with the requirements of such section and the funding improvement or rehabilitation plan.

* * *

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1201(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant

the relief provided for in subsection (a) of this section in any action.

* * *

29 U.S.C. § 1144(a), b(1), b(2). Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

* * *

II. REGULATIONS

FEDERAL EMPLOYEE HEALTH BENEFITS ACT REGULATIONS

5 C.F.R. § 890.102. Coverage

(a) Each employee, other than those excluded by paragraph (c) of this section, is eligible to be enrolled in a health benefits plan at the time and under the conditions prescribed in this part.

(b) An employee who serves in cooperation with non-Federal agencies and is paid in whole or in part from non-Federal funds may register to be enrolled within the period prescribed by OPM for the group of which the employee is a member following approval by OPM of arrangements providing that (1) the required withholdings and contributions will be made from Federally-controlled funds and timely deposited into the Employees Health Benefits Fund, or (2) the cooperating non-Federal agency will, by written agreement with the Federal agency, make the required withholdings and contributions from

non-Federal funds and transmit them for timely deposit into the Employees Health Benefits Fund.

(c) The following employees are not eligible:

(1) An employee (other than an acting postmaster, a Presidential appointee appointed to fill an unexpired term, and an appointee whose appointment meets the definition of provisional appointment set out in §§ 316.401 and 316.403 of this chapter) who is serving under an appointment limited to 1 year or less and who has not completed 1 year of current continuous employment, excluding any break in service of 5 days or less.

(2) An employee who is expected to work less than 6 months in each year, except for an employee who is employed under an OPM approved career-related work-study program under Schedule B of at least 1 year's duration and who is expected to be in a pay status for at least one-third of the total period of time from the date of the first appointment to the completion of the work-study program.

(3) An intermittent employee – a non-full-time employee without a prearranged regular tour of duty.

(4) A beneficiary or patient employee in a Government hospital or home.

(5) An employee paid on a contract or fee basis, except an employee who is a citizen of the United

States who is appointed by a contract between the employee and the Federal employing authority which requires his personal service and is paid on the basis of units of time.

(6) An employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(7) An individual first employed by the government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeth's Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub.L. 98-621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Defense Services Parole, Adult Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government; and

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub.L. 105-33 (111 Stat. 251).

(8) An individual first employed by the

government of the District of Columbia on or after October 1, 1987. However, this exclusion does not apply to:

(i) Employees of St. Elizabeth's Hospital who accept offers of employment with the District of Columbia government without a break in service, as provided in section 6 of Pub.L. 98-621 (98 Stat. 3379);

(ii) The Corrections Trustee and the Pretrial Services, Parole, Audit Probation and Offender Supervision Trustee and employees of these Trustees who accept employment with the District of Columbia government within 3 days after separating from the Federal Government;

(iii) Effective October 1, 1997, judges and nonjudicial employees of the District of Columbia Courts, as provided by Pub.L. 105-33 (111 Stat. 251); and

(iv) Effective April 1, 1999, employees of the Public Defender Service of the District of Columbia, as provided by Pub.L. 105-274 (112 Stat. 2419).

(d) Paragraph (c) of this section does not deny coverage to:

(1) An employee appointed to perform "part-time career employment," as defined in section 3401(2) of title 5, United States Code, and 5 CFR part 340, subpart B; or

(2) An employee serving under an interim appointment established under § 772.102 of this chapter.

(e) The Office of Personnel Management makes the final determination of the applicability of this section to specific employees or groups of employees.

(f) An employee of the District of Columbia Financial Responsibility and Management Assistance Authority (the Authority) who makes an election under the Technical Corrections to Financial Responsibility and Management Assistance Act (section 153 of Pub.L. 104-134, 110 Stat. 1321) to be considered a Federal employee for health benefits and other benefit purposes is subject to this part. If the employee is eligible to make an election to enroll under § 890.301, such election must be made within 60 days after the later of either the date the employment with the Authority begins or the date the Authority receives his or her election to be considered a Federal employee. Employees of the Authority who are former Federal employees are subject to the provisions of § 890.303(a), except that a former Federal employee employed by the Authority before October 26, 1996, and within 3 days following the termination of the Federal employment may make an election to enroll under § 890.301(c). Annuitants who have continued their coverage under this part as annuitants are not eligible to enroll under this paragraph. An election to enroll under this part is effective under the provisions of § 890.306(a) unless the employee requests the Authority to make the enrollment effective on the

first day of the first pay period following the date the employee entered on duty in a pay status with the Authority.

(g) Notwithstanding any other provision in this part, the hiring of a Federal employee, whether in pay status or nonpay status, for a temporary, intermittent position with the decennial census has no effect on the withholding or Government contribution for his/her coverage or the determination of when 365 days in nonpay status ends.

5 C.F.R. § 890.103. Correction of errors

(a) The employing office may make prospective corrections of administrative errors as to enrollment at any time. The employing office may make retroactive corrections of administrative errors that occur after December 31, 1994.

(b) OPM may order correction of an administrative error upon a showing satisfactory to OPM that it would be against equity and good conscience not to do so.

(c) The employing office may make retroactive correction of enrollee enrollment code errors if the enrollee reports the error by the end of the pay period following the one in which he or she received the first written documentation (i.e. pay statement or enrollment change confirmation) indicating the error.

(d) OPM may order the termination of an enrollment in any comprehensive medical plan described in section 8903(4) of title 5, United States Code, and permit the individual to enroll in another health benefits plan for purposes of this part, upon a showing satisfactory to OPM that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the comprehensive medical plan's affiliated health care providers.

(e) Retroactive corrections are subject to withholdings and contributions under the provisions of § 890.502.

5 C.F.R. § 890.104. Initial decision and reconsideration enrollment

(a) Who may file. Except as provided under § 890.1112, an individual may request an agency or retirement system to reconsider an initial decision of its employing office denying coverage or change of enrollment.

(b) Initial employing office decision. An employing office's decision is considered an initial decision as used in paragraph (a) of this section when rendered by the employing office in writing and stating the right to an independent level of review (reconsideration) by the agency or retirement system. However, an initial decision rendered at the highest level of review available within OPM is not subject to reconsideration.

(c) Reconsideration.

(1) A request for reconsideration must be made in writing, must include the claimant's name, address, date of birth, Social Security number, name of carrier, reason(s) for the request, and, if applicable, retirement claim number.

(2) The reconsideration review must be an independent review designated at or above the level at which the initial decision was rendered.

(d) Time limit. A request for reconsideration of an initial decision must be filed within 30 calendar days from the date of the written decision stating the right to a reconsideration. The time limit on filing may be extended when the individual shows that he or she was not notified of the time limit and was not otherwise aware of it, or that he or she was prevented by circumstances beyond his or her control from making the request within the time limit. An agency or retirement system decision in response to a request for reconsideration of an employing office's decision is a final decision as described in paragraph (e) of this section.

(e) Final decision. After reconsideration, the agency or retirement system must issue a final decision, which must be in writing and must fully set forth the findings and conclusions.

5 C.F.R. § 890.105. Filing claims for payment or service

(a) General.

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

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

(b) Time limits for reconsidering a claim.

(1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

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

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

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

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written

request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

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

(c) Information required to process requests for reconsideration.

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

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

(i) Specifically identify the information needed;

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

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

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

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

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

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

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

(e) OPM review.

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

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

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

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

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

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

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

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

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

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

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

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

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

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

5 C.F.R. § 890.107. Court review

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

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

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (5 U.S.C. chapter 89). A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

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

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

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

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

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES REGULATIONS

32 C.F.R. § 199.3. Eligibility

(a) General. – This section sets forth those persons who, by the provisions of 10 U.S.C. chapter 55, and the NATO Status of Forces Agreement, are eligible for CHAMPUS benefits. A determination that a person is eligible does not automatically entitle such a person to CHAMPUS payments. Before any CHAMPUS benefits may be extended, additional requirements, as set forth in other sections of this part, must be met. Additionally, the use of CHAMPUS may be denied if a Uniformed Service medical treatment facility capable of providing the needed care is available. CHAMPUS relies primarily on the Defense Enrollment Eligibility Reporting System (DEERS) for eligibility verification.

(b) CHAMPUS eligibles –

(1) Retiree. A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

(2) Dependent. Individuals whose relationship to the sponsor leads to entitlement to benefits. CHAMPUS eligible dependents include the following:

(i) Spouse. A lawful husband or wife of a member or former member. The spouse of a deceased

member or retiree must not be remarried. A former spouse also may qualify for benefits as a dependent spouse. A former spouse is a spouse who was married to a military member, or former member, but whose marriage has been terminated by a final decree of divorce, dissolution or annulment. To be eligible for CHAMPUS benefits, a former spouse must meet the criteria described in paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section and must qualify under the group defined in paragraph (b)(2)(i)(F)(1) or (b)(2)(i)(F)(2) of this section.

(A) Must be unremarried; and

(B) Must not be covered by an employer-sponsored health plan; and

(C) Must have been married to a member or former member who performed at least 20 years of service which can be credited in determining the member's or former member's eligibility for retired or retainer pay; and

(D) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section; and

(E) Must not be the dependent of a NATO member; and

(F) Must meet the requirements of paragraph (b)(2)(i)(F)(1) or (b)(2)(i)(F)(2) of this section:

(1) The former spouse must have been married to the same member or former member for at least 20 years, at least 20 of which were creditable in determining the member's or former member's eligibility for retired or retainer pay. Eligibility continues indefinitely unless affected by any of the conditions of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section.

(i) If the date of the final decree of divorce, dissolution, or annulment was before February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care received on or after January 1, 1985.

(ii) If the date of the final decree of the divorce, dissolution, or annulment was on or after February 1, 1983, the former spouse is eligible for CHAMPUS coverage of health care which is received on or after the date of the divorce, dissolution, or annulment.

(2) The former spouse must have been married to the same member or former member for at least 20 years, and at least 15, but less than 20 of those married years were creditable in determining the member's or former member's eligibility for retired or retainer pay.

(i) If the date of the final decree of divorce, dissolution, or annulment is before April 1, 1985, the former spouse is eligible only for care received on or after January 1, 1985, or the date of the divorce, dissolution, or annulment, whichever is later. Eligibility continues indefinitely unless affected by any of the conditions of paragraphs (b)(2)(i)(A) through (b)(2)(i)(E) of this section.

(ii) If the date of the final decree of divorce, dissolution or annulment is on or after April 1, 1985, but before September 29, 1988, the former spouse is eligible only for care received from the date of the decree of divorce, dissolution, or annulment until December 31, 1988, or for two years from the date of the divorce, dissolution, or annulment, whichever is later.

(iii) If the date of the final decree of divorce, dissolution, or annulment is on or after September 29, 1988, the former spouse is eligible only for care received within the 365 days (366 days in the case of a leap year) immediately following the date of the divorce, dissolution, or annulment.

(ii) Child. A dependent child is an unmarried child of a member or former member who has not reached his or her twenty-first (21st) birthday,

except an incapacitated adopted child meeting the requirements of paragraph (b)(2)(ii)(H)(2) of this section, and who bears one of the following relationships to a member or former member of one of the Uniformed Services:

(A) A legitimate child; or

(B) An adopted child whose adoption has been legally completed on or before the child's twenty-first (21st) birthday; or

(C) A legitimate stepchild; or

(D) An illegitimate child of a member or former member whose paternity/maternity has been determined judicially, and the member or former member directed to support the child; or

(E) An illegitimate child of a member or former member whose paternity/maternity has not been determined judicially, who resides with or in the home provided by the member or former member, and is or continues to be dependent upon the member or former member for over one-half of his or her support, or who was so dependent on the former member at the time of the former member's death; or

(F) An illegitimate child of a spouse of a member who resides with or in a home provided by the member and is, and continues

to be dependent upon the member for over one-half of his or her support; or

(G) An illegitimate child of a spouse of a former member who resides with or in a home provided by a former member or the former member's spouse at the time of death of the former member, and is, or continues to be, or was, dependent upon the former member for more than one-half of his or her support at the time of death; or

(H) An individual who falls into one of the following classes:

(1) A student. A child determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, who is not married, has passed his or her 21st birthday but has not passed his or her 23rd birthday, is dependent upon the member or former member for over 50 percent of his or her support or was dependent upon the member or former member for over 50 percent of his or her support on the date of the member's or former member's death, and is pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C. chapters 34 and 35.

Note: Courses of education offered by institutions listed in the "Education Directory," "Higher Education" or "Accredited Higher Institutions" issued periodically by the Department of Education meet the criteria approved by the Administering Secretary or the Secretary of Education. For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to 38 U.S.C. chapters 34 and 35, a statement may be obtained from the Department of Education, Washington, D.C. 20202.

(2) An incapacitated child. A child determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, who is not married and is incapable of self-support because of a mental or physical disability that:

(i) Existed before the child's twenty-first (21st) birthday; or

(ii) Occurred between the ages of 21 and 23 while the child was enrolled in a full-time course of study in an institution of higher learning approved by the Administering Secretary or the Department of Education (see NOTE to paragraph (b)(2)(ii)(H)(2)(iii) of this section), and is or was at the time of the member's or former member's death dependent on the member or former

member for over one-half of his or her support; and

(iii) The incapacity is continuous. (If the incapacity significantly improves or ceases at any time, CHAMPUS eligibility cannot be reinstated on the basis of the incapacity, unless the incapacity recurs and the beneficiary is under age 21, or is under age 23 and is enrolled as a full-time student under paragraph (b)(2)(ii)(H)(2)(ii) of this section. If the child was not incapacitated after that date, no CHAMPUS eligibility exists on the basis of the incapacity. However, incapacitated children who marry and who subsequently become unmarried through divorce, annulment, or death of spouse, may be reinstated as long as they still meet all other requirements).

Note: An institution of higher learning is a college, university, or similar institution, including a technical or business school, offering post-secondary level academic instruction that leads to an associate or higher degree, if the school is empowered by the appropriate State education authority under State law to grant an associate, or higher, degree. When there is no State law to authorize the granting of a degree, the school may be recognized as an institution of higher learning if it is accredited for degree programs by a recognized accrediting agency. The term also shall include a hospital offering educational programs at the post-secondary level regardless of whether the hospital grants a post-

secondary degree. The term also shall include an educational institution that is not located in a State, that offers a course leading to a standard college degree, or the equivalent, and that is recognized as such by the Secretary of Education (or comparable official) of the country, or other jurisdiction, in which the institution is located (38 U.S.C. chapter 34, section 1661, and chapter 35, section 1701).

Courses of education offered by institutions listed in the "Education Directory," "Higher Education" or "Accredited Higher Institutions" issued periodically by the Department of Education meet the criteria approved by the Administering Secretary or the Secretary of Education. For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, D.C. 20202.

> (3) A child of a deceased reservist. A child, who is determined to be a member of one of the classes in paragraphs (b)(2)(ii)(A) through (b)(2)(ii)(G) of this section, of a reservist in a Uniformed Service who incurs or aggravates an injury, illness, or disease, during, or on the way to or from, active duty training for a period of 30 days or less or inactive duty training, and the reservist dies as a result of that specific injury, illness or disease.

(4) An unmarried person. An unmarried person placed in the home of a member or former member prior to adoption. To be a dependent child, the unmarried person must not have reached the age of 21 (or otherwise meets the requirements of a student or incapacitated child set out in paragraphs (b)(2)((ii)(H)(1) or (b)(2)(ii)(H)(2) of this section) and has been placed in the home of the member or former member by a recognized placement agency or by any other source authorized by State or local law to provide adoption placement, in anticipation of legal adoption by the member or former member.

(iii) Abused dependents. –

(A) Categories of abused dependents. An abused dependent may be either a spouse or a child. Eligibility for either class of abused dependent results from being either:

(1) The spouse (including a former spouse) or child of a member who has received a dishonorable or bad-conduct discharge, or dismissal from a Uniformed Service as a result of a court-martial conviction for an offense involving physical or emotional abuse of the spouse or child, or was administratively discharged as a result of such an offense. Until October 17, 1998, Medical benefits are limited to care related to the physical or emotional abuse and for a period of 12 months following the

member's separation from the Uniformed Service. On or after October 17, 1998, medical benefits can include all under the Basic Program and under the Extended Care Health Option for the period that the spouse or child is in receipt of transitional compensation under section 1059 of title 10 U.S.C.

(2) The spouse (including a former spouse) or child of a member or former member who while a member and as a result of misconduct involving abuse of the spouse or child has eligibility to receive retired pay on the basis of years of service terminated.

(B) Requirements for categories of abused dependents. –

(1) Abused spouse. As long as the spouse is receiving payments from the DoD Military Retirement Fund under court order, the spouse is eligible for health care under the same conditions as any spouse of a retired member. The abused spouse must:

(i) Under paragraph (b)(2)(iii)(A)(1) of this section, be a lawful husband or wife or a former spouse of the member; or

(ii) Under paragraph (b)(2)(iii)(A)(2) of this section, be a lawful husband or wife or a former spouse of the member or former member, and the spouse is receiving payments from the Department of Defense

Military Retirement Fund under 10 U.S.C. 1408(H0 pursuant to a court order; and

(A) Be a victim of the abuse; and

(B) Have been married to the member or former member at the time of the abuse; or

(C) Be the natural or adoptive parent of a dependent child of the member or former member who was the victim of the abuse.

(2) Abused child. The abused child must:

(i) Under paragraph (b)(2)(iii)(A)(1) of this section, be a dependent child of the member or former member.

(ii) Under paragraph (b)(2)(iii)(A)(2) of this section,

(A) Have been a member of the household where the abuse occurred; and

(B) Be an unmarried legitimate child, including an adopted child or stepchild of the member or former member; and

(C) Be under the age of 18; or

(D) Be incapable of self support because of a mental or physical incapacity that existed before becoming 18 years of age

and be dependent on the member or former member for over one-half of his or her support; or

(E) If enrolled in a full-time course of study in an institution of higher learning recognized by the Secretary of Defense (for the purpose of 10 U.S.C. 1408(h)), be under 23 years of age and be dependent on the member or former member for over one-half of his or her support.

(F) The dependent child is eligible for health care, regardless of whether any court order exists, under the same conditions as any dependent of a retired member.

(3) TAMP eligibles. A former member, including his or her dependents, who is eligible under the provisions of the Transitional Assistance Management Program as described in paragraph (e) of this § 199.3.

(iv) An unmarried person who is placed in the legal custody of a member or former member by a court of competent jurisdiction in the United States (or possession of the United States) for a period of at least 12 consecutive months. The unmarried person shall be considered a dependent of the member or former member under this section provided he or she otherwise meets the following qualifications:

(A) Has not reached the age of 21 unless he or she otherwise meets the requirements of a student set out in paragraph (b)(2)(ii)(H)(1) of this section or the requirements for being incapacitated as set out in paragraph (b)(2)(ii)(H)(2) of this section and the incapacitation occurred while he or she was a dependent of the member or former member through court ordered legal custody;

(B) Is dependent on the member or former member for over one-half of the person's support;

(C) Resides with the member or former member unless separated by the necessity of military service or to receive institutional care as a result of disability or incapacitation or under such other authorized circumstances; and,

(D) Is not a dependent of a member or former member under any other provision of law or regulation.

(3) Eligibility under TRICARE Senior Pharmacy Program. Section 711 of the National Defense Authorization Act for Fiscal Year 2001 (Public Law 106-398, 114 Stat. 1654) established the TRICARE Senior Pharmacy Program effective April 1, 2001. To be eligible for this program, a person is required to be:

(i) Medicare eligible, who is:

(A) 65 years of age or older; and

(B) Entitled to Medicare Part A; and

(C) Enrolled in Medicare Part B, except for a person who attained age 65 prior to April 1, 2001, is not required to enroll in Part B; and

(ii) Otherwise qualified under one of the following categories:

(A) A retired uniformed service member who is entitled to retired or retainer pay, or equivalent pay including survivors who are annuitants; or

(B) A dependent of a member of the uniformed services described in one of the following:

(1) A member who is on active duty for a period of more than 30 days or died while on such duty; or

(2) A member who died from an injury, illness, or disease incurred or aggravated while the member was:

(i) On active duty under a call or order to active duty of 30 days or less, on active duty for training, or on inactive duty training; or

(ii) Traveling to or from the place at which the member was to perform or had performed such active duty, active

duty for training, or inactive duty training.

Note to paragraph (b)(3)(ii)(B): Dependent under Section 711 of the National Defense Authorization Act for Fiscal Year 2001 includes spouse, unremarried widow/widower, child, parent/parent-in-law, unremarried former spouse, and unmarried person in the legal custody of a member or former member, as those terms of dependency are defined and periods of eligibility are set forth in 10 U.S.C. 1072(2).

(4) Medal of Honor recipients.

(i) A former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits has the same CHAMPUS eligibility as does a retiree.

(ii) Immediate dependents. CHAMPUS eligible dependents of a Medal of Honor Recipient are those identified in paragraphs (b)(2)(i) of this section (except for former spouses) and (b)(2)(ii) of this section (except for a child placed in legal custody of a Medal of Honor recipient under (b)(2)(ii)(H)(4) of this section).

(iii) Effective date. The CHAMPUS eligibility established by paragraphs (b)(4)(i) and (ii) of this section is applicable to health care services provided on or after October 30, 2000.

(5) Reserve Component Members Issued Delayed-Effective-Date Orders.

(i) Member. A member of a reserve component of the armed forces who is ordered to active duty for a period of more than 30 consecutive days in support of a contingency operation under a provision of law referred to in section 101(a)(13)(B) of Title 10, United States Code, that provides for active-duty service to begin on a date after the date of the issuance of the order.

(ii) Dependents. CHAMPUS eligible dependents under this paragraph (b)(5) are those identified in paragraphs (b)(2)(i) (except former spouses) and (b)(2)(ii) of this section.

(iii) Effective date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section shall begin on or after November 6, 2003, and shall be effective on the later of the date that is:

(A) The date of issuance of the order referred to in paragraph (b)(5)(i) of this section; or

(B) 90 days before the date on which the period of active duty is to begin.

(iv) Termination date. The eligibility established by paragraphs (b)(5)(i) and (ii) of this section ends upon entry of the member onto active duty (at which time CHAMPUS eligibility for the dependents of the member is established under paragraph (b)(2) of this section) or upon cancellation or amendment of the orders referred

to in paragraph (b)(5)(i) of this section such that they no longer meet the requirements of that paragraph (b)(5)(i).

(c) Beginning dates of eligibility.

(1) Beginning dates of eligibility depend on the class to which the individual belongs and the date the individual became a member of the class. Those who join after the class became eligible attain individual eligibility on the date they join.

(2) Beginning dates of eligibility for each class of spouse (excluding spouses who are victims of abuse and eligible spouses of certain deceased reservists) are as follows:

(i) A spouse of a member for:

(A) Medical benefits authorized by the Dependents' Medical Care Act of 1956, December 7, 1956;

(B) Outpatient medical benefits under the Basic Program, October 1, 1966;

(C) Inpatient medical benefits under the Basic Program and benefits under the Extended Care Health Option, January 1, 1967;

(ii) A spouse of a former member:

(A) For medical benefits under the Basic Program, January 1, 1967.

(B) Ineligible for benefits under the Extended Care Health Option.

(iii) A former spouse:

(A) For medical benefits under the Basic Program, dates of beginning eligibility are as indicated for each category of eligible former spouse identified within paragraph (b)(2)(i) of this section.

(B) Ineligible for benefits under the Extended Care Health Option.

(3) Beginning dates of eligibility for spouses who are victims of abuse (excluding spouses who are victims of abuse of certain deceased reservists) are as follows:

(i) An abused spouse meeting the requirements of paragraph (b)(2)(iii)(A)(1) of this section, including an eligible former spouse:

(A) For medical and dental care for problems associated with the physical or emotional abuse under the Basic Program for a period of up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(B) For all medical and dental benefits under the Basic Program for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(C) For medical and dental care for problems associated with the physical or emotional abuse under the Extended Care Health Option for a period up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(D) For all medical and dental benefits described in section 199.5 for the period that the spouse is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(ii) An abused spouse meeting the requirements of paragraphs (b)(2)(iii)(A)(2) of this section, including an eligible former spouse:

(A) For all benefits under the CHAMPUS Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(4) Beginning dates of eligibility for spouses of certain deceased reservists, including spouses who are victims of abuse of certain deceased reservists, are as follows:

(i) A spouse meeting the requirements of paragraph (b)(2)(i) of this section, including an eligible former spouse:

(A) For benefits under the Basic Program, November 14, 1986.

(B) Ineligible for benefits under the Extended Care Health Option.

(ii) An abused spouse of certain deceased reservists, meeting the requirements of paragraphs (b)(2)(iii) of this section, including an eligible former spouse, for the limited benefits and period of eligibility described in paragraphs (b)(2)(iii) of this section:

(A) For benefits under the Basic Program, November 14, 1986.

(B) For benefits under the Extended Care Health Option, November 14, 1986.

(iii) An abused spouse of certain deceased reservists, including an eligible former spouse, meeting the requirements of paragraphs (b)(2)(iii) of this section:

(A) For benefits under the Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(5) Beginning dates of eligibility for each class of dependent children, (excluding dependent children of certain deceased reservists, abused children and incapacitated children whose incapacity occurred between the ages of 21 and 23 while enrolled in a full-time course of study in an institution of higher learning), are as follows:

(i) Legitimate child, adopted child, or legitimate stepchild of a member, for:

(A) Medical benefits authorized by the Dependents' Medical Care Act of 1956, December 7, 1956;

(B) Outpatient medical benefits under the Basic Program, October 1, 1966;

(C) Inpatient medical benefits under the Basic Program and benefits under the Extended Care Health Option, January 1, 1967;

(ii) Legitimate child, adopted child or legitimate stepchild of former members:

(A) For medical benefits under the Basic Program, January 1, 1967.

(B) Ineligible for benefits under the Extended Care Health Option.

(iii) Illegitimate child of a male or female member or former member whose paternity/maternity has been determined judicially and the member or former member has been directed to support the child, for:

(A) All benefits for which otherwise entitled, August 31, 1972.

(B) Extended Care Health Option benefits limited to dependent children of members only, August 31, 1972.

(iv) Illegitimate child of:

(A) A male member or former member whose paternity has not been determined judicially:

(B) A female member or former member who resides with, or in a home provided by the member or former member, or who was residing in a home provided by the member or former member at the time of the member's or former member's death, and who is or continues to be dependent on the member for over one-half of his or her support, or was so dependent on the member or former member at the time of death;

(C) A spouse of a member or former member who resides with or in a home provided by the member or former member, or the parent who is the spouse of the member or former member or was the spouse of a member or former member at the time of death, and who is and continues to be dependent upon the member or former member for over one-half of his or her support, or was so dependent on the member or former member at the time of death; for:

(1) All benefits for which otherwise eligible, January 1, 1969.

(2) Extended Care Health Option limited to dependent children of members only, January 1, 1969.

(6) Beginning dates of eligibility for children of certain deceased reservists who meet the requirements of paragraph (b)(2)(ii)(H)(3) of this section, excluding incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section, for:

(i) Benefits under the Basic program, November 14, 1986.

(ii) Not eligible for benefits under the Extended Care Health Option.

(7) Beginning dates of eligibility for children who are victims of abuse, including incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section are as follows:

(i) An abused child meeting the requirements of paragraph (b)(2)(iii)(A)(1) of this section:

(A) Medical and dental care for problems associated with the physical or emotional abuse under the Basic Program for a period of up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(B) For all medical and dental benefits under the Basic Program for the period that the child is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(C) Medical and dental care for problems associated with the physical or emotional abuse under the Extended Care Health Option for a period up to one year (12 months) following the person's separation from the Uniformed Service, November 14, 1986.

(D) For all medical and dental benefits described in section 199.5 for the period that the child is in receipt of transitional compensation under section 1059 of title 10 U.S.C., October 17, 1998.

(ii) An abused child meeting the requirements of paragraphs (b)(2)(iii)(A)(2) of this section:

(A) For all benefits under the CHAMPUS Basic Program, October 23, 1992.

(B) Ineligible for benefits under the Extended Care Health Option.

(8) Beginning dates of eligibility for incapacitated children who meet the requirements of paragraph (b)(2)(ii)(H)(2) of this section, whose incapacity occurred between the ages of 21 and 23 while enrolled in a full-time course of study in an institution of higher learning approved by the Administering Secretary or the Department of Education, and, are or were at the time of the member's or former member's death, dependent on the member or former member for over one-half of their support, for:

(i) All benefits for which otherwise entitled, October 23, 1992.

(ii) Extended Care Health Option benefits limited to children of members only, October 23, 1992.

(9) Beginning dates of eligibility for a child who meets the requirements of paragraph (b)(2)(ii)(H)(4) and:

(i) Has been placed in custody by a court:

(A) All benefits for which entitled, July 1, 1994.

(B) Extended Care Health Option benefits limited to children of members only, July 1, 1994.

(ii) Has been placed in custody by a recognized adoption agency:

(A) All benefits for which entitled, October 5, 1994.

(B) Extended Care Health Option benefits limited to children of members only, October 5, 1994.

(iii) Has been placed in the home of a member by a placement agency or by any other source authorized by State or local law to provide adoption placement, in anticipation of the legal adoption of the member:

(A) All benefits for which entitled, January 6, 2006.

(B) Extended Care Health Option benefits limited to children of members only, January 6, 2006.

(10) Beginning dates of eligibility for a retiree for:

(i) Medical benefits under the Basic Program January 1, 1967.

(ii) Retirees and their dependents are not eligible for benefits under the Extended Care Health Option.

(d) Dual eligibility. Dual eligibility occurs when a person is entitled to benefits from two sources. For example, when an active duty member is also the dependent of another active duty member, a retiree, or a deceased active duty member or retiree, dual eligibility, that is, entitlement to direct care from the Uniformed Services medical care system and CHAMPUS is the result. Since the active duty status is primary, and it is the intent that all medical care be provided an active duty member through the Uniformed Services medical care system, CHAMPUS eligibility is terminated as of 12:01 a.m. on the day following the day the dual eligibility begins. However, any dependent children in a marriage of two active duty persons or of an active duty member and a retiree, are CHAMPUS eligible in the same manner as dependent children of a marriage involving only one CHAMPUS sponsor. Should a spouse or dependent who has dual eligibility leave

active duty status, that person's CHAMPUS eligibility is reinstated as of 12:01 a.m. of the day active duty ends, if he or she otherwise is eligible as a dependent of a CHAMPUS sponsor.

Note: No CHAMPUS eligibility arises as the result of the marriage of two active duty members.

(e) Eligibility under the Transitional Assistance Management Program (TAMP).

(1) A member of the armed forces is eligible for transitional health care if the member is:

(i) A member who is involuntarily separated from active duty.

(ii) A member of a Reserve component who is separated from active duty to which called or ordered in support of a contingency operation if the active duty is active duty for a period of more than 30 consecutive days.

(iii) A member who is separated from active duty for which the member is involuntarily retained under 10 U.S.C. 12305 in support of a contingency operation; or

(iv) A member who is separated from active duty served pursuant to a voluntary agreement of the member to remain on active duty for a period of less than 1 year in support of a contingency operation.

(2) A spouse (as described in paragraph (b)(2)(i) of this section except former spouses) and child (as described in paragraph (b)(2)(ii) of this section) of a member described in paragraph (e)(1) of this section is also eligible for TAMP benefits under TRICARE.

(3) TAMP benefits under TRICARE begin on the day after the member is separated from active duty, and, if such separation occurred on or after November 6, 2003, and end 180 days after such date. TRICARE benefits available to both the member and eligible family members are generally those available to family members of members of the uniformed services under this Part. Each branch of service will determine eligibility for its members and eligible family members and provide data to DEERS.

(f) Changes in status which result in termination of CHAMPUS eligibility. Changes in status which result in a loss of CHAMPUS eligibility as of 12:01 a.m. of the day following the day the event occurred, unless otherwise indicated, are as follows:

(1) Changes in the status of a member.

(i) When an active duty member's period of active duty ends, excluding retirement or death.

(ii) When an active duty member is placed on desertion status (eligibility is reinstated when the active duty member is removed from desertion status and returned to military control).

Note: A member serving a sentence of confinement in conjunction with a sentence of punitive discharge is still considered on active duty until such time as the discharge is executed.

(2) Changes in the status of a retiree.

(i) When a retiree ceases to be entitled to retired, retainer, or equivalent pay for any reason, the retiree's dependents lose their eligibility unless the dependent is otherwise eligible (e.g., some former spouses, some dependents who are victims of abuse and some incapacitated children as outlined in paragraph (b)(2)(ii)(H)(2) of this section).

(ii) A retiree also loses eligibility when no longer entitled to retired, retainer, or equivalent pay.

Note: A retiree who waives his or her retired, retainer or equivalent pay is still considered a retiree for the purposes of CHAMPUS eligibility.

(3) Changes in the status of a dependent.

(i) Divorce, except for certain classes of former spouses as provided in paragraph (b)(2)(i) of this section and the member or former member's own children (i.e., legitimate, adopted, and judicially determined illegitimate children).

Note: An unadopted stepchild loses eligibility as of 12:01 a.m. of the day following the day the divorce becomes final.

(ii) Annulment, except for certain classes of former spouse as provided in paragraph (b)(2)(i) of this section and the member or former member's own children (i.e., legitimate, adopted, and judicially determined illegitimate children).

Note: An unadopted stepchild loses eligibility as of 12:01 a.m. of the day following the day the annulment becomes final.

(iii) Adoption, except for adoptions occurring after the death of a member or former member.

(iv) Marriage of a child, except when the marriage is terminated by death, divorce, or annulment before the child is 21 or 23 if an incapacitated child as provided in paragraph (b)(2)(ii)(H)(2) of this section.

(v) Marriage of a widow or widower, except for the child of the widow or widower who was the stepchild of the deceased member or former member at the time of death. The stepchild continues CHAMPUS eligibility as other classes of dependent children.

(vi) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section. (This also applies to individuals living outside the United States where Medicare benefits are not available.)

(vii) Attainment of age 65, except for dependents of active duty members, beneficiaries not entitled to part A of Medicare, beneficiaries entitled to Part A of Medicare who have enrolled in Part B of Medicare, and as provided in paragraph (b)(3) of this section. For those who do not retain CHAMPUS, CHAMPUS eligibility is lost at 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare.

Note: If the person is not eligible for Part A of Medicare, he or she must file a Social Security Administration, "Notice of Disallowance" certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued. Individuals entitled only to supplementary medical insurance (Part B) of Medicare, but not Part A, or Part A through the Premium HI provisions (provided for under the 1972 Amendments to the Social Security Act) retain eligibility under CHAMPUS (refer to § 199.8 for additional information when a double coverage situation is involved).

(viii) End stage renal disease. All beneficiaries, except dependents of active duty members, lose their CHAMPUS eligibility when Medicare coverage becomes available to a person because of chronic renal disease unless the following conditions have been met. CHAMPUS eligibility will continue if:

(A) The individual is under 65 years old;

(B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426-1(a);

(C) The individual is enrolled in Part B of Medicare; and

(D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(ix) Individuals with certain disabilities. Each case relating to Medicare eligibility resulting from being disabled requires individual investigation. All beneficiaries except dependents of active duty members lose their CHAMPUS eligibility when Medicare coverage becomes available to a disabled person unless the following conditions have been met. CHAMPUS eligibility will continue if:

(A) The individual is under 65 years old;

(B) The individual became eligible for Medicare under the provisions of 42 U.S.C. 426(b)(2);

(C) The individual is enrolled in Part B of Medicare; and

(D) The individual has applied and qualified for continued CHAMPUS eligibility through the Defense Enrollment Eligibility Reporting System (DEERS).

(x) Disabled students, that is children age 21 or 22, who are pursuing a full-time course of higher education and who, either during the school year or between semesters, suffer a disabling illness or injury with resultant inability to resume attendance at the institution remain eligible for CHAMPUS medical benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, CHAMPUS benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in a full time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility and may not qualify for eligibility under the requirements related to mental or physical incapacity as described in paragraph (b)(2)(ii)(H)(2) of this section.

(g) Reinstatement of CHAMPUS eligibility. Circumstances which result in reinstatement of CHAMPUS eligibility are as follows:

(1) End Stage renal disease. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(viii) of the section, when Medicare eligibility ceases for end-stage renal disease patients, CHAMPUS eligibility resumes if the person is

otherwise still eligible. He or she is required to take action to be reinstated as a CHAMPUS beneficiary and to obtain a new identification card.

(2) Disability. Some disabilities are permanent, others temporary. Each case must be reviewed individually. Unless CHAMPUS eligibility has been continued under paragraph (f)(3)(ix) of this section, when disability ends and Medicare eligibility ceases, CHAMPUS eligibility resumes if the person is otherwise still eligible. Again, he or she is required to take action to obtain a new CHAMPUS identification card.

(h) Determination of eligibility status. Determination of an individual's eligibility as a CHAMPUS beneficiary is the primary responsibility of the Uniformed Service in which the member or former member is, or was, a member, or in the case of dependents of a NATO military member, the Service that sponsors the NATO member. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the results of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

(i) Procedures for determination of eligibility. Procedures for the determination of eligibility are prescribed within the Department of Defense

Instruction 1000.13 available at local military facilities personnel offices.

(j) CHAMPUS procedures for verification of eligibility.

(1) Eligibility for CHAMPUS benefits will be verified through the Defense Enrollment Eligibility Reporting System (DEERS) maintained by the Uniformed Services, except for abused dependents as set forth in paragraph (b)(2)(iii) of this section. It is the responsibility of the CHAMPUS beneficiary, or parent, or legal representative, when appropriate, to provide the necessary evidence required for entry into the DEERS file to establish CHAMPUS eligibility and to ensure that all changes in status that may affect eligibility be reported immediately to the appropriate Uniformed Service for action.

(2) Ineligibility for CHAMPUS benefits may be presumed in the absence of prescribed eligibility evidence in the DEERS file.

(3) The Director, OCHAMPUS, shall issue guidelines as necessary to implement the provisions of this section.

OFFICE OF PERSONNEL MANAGEMENT FEDERAL EMPLOYEES HEALTH BENEFITS ACQUISITION REGULATIONS

48 C.F.R. 1602.170-2. Community rate

(a) Community rate means a rate of payment based on a per member per month capitation rate or its equivalent that applies to a combination of the subscriber groups for a comprehensive medical plan carrier. References in this subchapter to "a combination of cost and price analysis" relating to the applicability of policy and contract clauses refer to comprehensive medical plan carriers using community rates.

(b) Adjusted community rate means a community rate which has been adjusted for expected use of medical resources of the FEHBP group. An adjusted community rate is a prospective rate and cannot be retroactively revised to reflect actual experience, utilization, or costs of the FEHBP group.