



## **FACTUAL HISTORY**

On January 12, 2001 appellant, then a 29-year-old registered nurse, filed a claim for a traumatic injury to her back occurring on January 4, 2001 in the performance of duty. The Office accepted her claim for a herniated disc of the lumbar spine. Appellant stopped work on January 7, 2001 and did not return. The Office placed her on the periodic rolls beginning February 20, 2001.

By letter dated August 30, 2006, appellant informed the Office that she put the wrong code on her health benefits election form. She maintained that, when changing her health benefit coverage from high option to standard option, she placed code 454 on the form based on the advice of an Office claims examiner. Appellant stated:

“In January I received a phone call from Mail Handlers asking if I really wanted to drop my family or if I had just entered the wrong code. I explained to them that I had gotten the code from you and did not realize it was the wrong code. They assured me they would take care of it and could easily understand how that would happen. I called back approximately one month later to verify that I did indeed have family coverage and they assured me that I did. When I called last Friday, the 25<sup>th</sup> of August, they again verified that I did have family coverage.”

Appellant noted that the Office was deducting for single coverage only.

Computer worksheets establish that the Office deducted \$92.52 in premiums for health benefits from appellant's continuing compensation using code 454 beginning January 22, 2006. On November 20, 2006 the Office notified her of its preliminary determination that she received an overpayment of compensation in the amount of \$1,005.00 because it deducted health benefits premiums for single coverage rather than family coverage from January 22 to September 2, 2006. The Office further informed appellant of its preliminary determination that she was without fault in the creation of the overpayment. The Office referenced an accompanying memorandum which described the calculation of the overpayment. The Office deducted \$92.52 from her compensation using health benefits code 454 from January 22 to August 5, 2006 and deducted no premiums for health benefits from August 6 to September 2, 2006, for a total withheld of \$647.64. The Office should have deducted \$206.58 in health benefits using code 455 for family coverage from her continuing compensation for this period, for a total of \$1,652.64. Consequently, appellant received an overpayment of \$1,005.00.

On January 5, 2007 appellant contested that she received an overpayment of compensation. She argued that the Office deducted \$121.86 per month from her compensation rather than \$92.52. Appellant additionally maintained that she has not had family coverage since January 21, 2006. She asserted that the Office had not informed her how it calculated the overpayment of \$1,000.00. Appellant requested a telephone conference.

On February 22, 2007 a claims examiner telephoned appellant and requested supporting financial documents prior to scheduling a telephone conference. Appellant maintained that she did not have family coverage from January 22 to September 2, 2006. The claims examiner called her insurance carrier and stated:

“They confirmed that their records reflect code 455 family effective January 22, 2006 just as the claimant had intended to do with her enrollment card submitted on November 28, 2005, and they also confirmed that some bills for family members had been denied, but that they also paid medical bills for family members in 2006, so the family had coverage and the claimant should pay the premiums accordingly.”

The claims examiner informed appellant of the information she received from the insurance carrier on February 23, 2007 and again requested financial documentation to support waiver prior to scheduling a teleconference.

By decision dated March 12, 2007, the Office finalized its finding that appellant received an overpayment of \$1,005.00. The Office further determined that she was at fault in the creation of the overpayment as her health insurance provider had “retroactively reinstate[d] [her] family coverage, and did pay for family members during 2006....” The Office noted that appellant had not submitted the overpayment recovery questionnaire and found that the overpayment should be repaid by withholding \$300.00 from her continuing compensation.

### **LEGAL PRECEDENT -- ISSUE 1**

An employee entitled to disability compensation may continue his or her health benefits under the Federal Employee Health Benefits Program. The regulation of the Office of Personnel Management (OPM), which administers the Federal Employee Health Benefits Program, provides guidelines for the registration, enrollment and continuation of enrollment for federal employees. In this connection, 5 C.F.R. § 890.502(b)(1) provides:

“An employee or annuitant is responsible for payment of the employee’s share of the cost of enrollment for every pay period during which the enrollment continues. In each pay period for which health benefits withholdings or direct premium payments are not made but during which the enrollment of an employee or annuitant continues, he or she incurs an indebtedness to the United States in the amount of the proper employee withholding required for that pay period.”<sup>1</sup>

In addition, 5 C.F.R. § 890.502(c)(1) provides:

“An agency that withholds less than or none of the proper health benefits contributions for an individual’s pay, annuity or compensation must submit an amount equal to the sum of the uncollected deductions and any applicable agency contributions required under section 8906 of the title, 5 United States Code, to OPM for deposit in the Employees Health Benefits Fund.”<sup>2</sup>

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<sup>1</sup> 5 C.F.R. § 890.502(b)(1).

<sup>2</sup> *Id.* at § 890.502(d).

Under applicable OPM regulations, the employee or annuitant is responsible for payment of the employee's share of the cost of enrollment.<sup>3</sup> An agency that withholds less than the proper health benefits contribution must submit an amount equal to the sum of the uncollected deductions.<sup>4</sup> The Board has recognized that, when an under withholding of health insurance premiums is discovered, the entire amount is deemed an overpayment of compensation because the Office must pay the full premium to OPM when the error is discovered.<sup>5</sup>

### **ANALYSIS -- ISSUE 1**

Appellant mistakenly put down code 454 for single coverage beginning January 22, 2006 instead of code 455 for family coverage. Her health insurance provider telephoned her in January 2006 to verify the change from family to single coverage. Appellant informed her health insurance provider that she had put down an incorrect code and wanted to continue family coverage. She ascertained in subsequent telephone calls that she had family coverage. From January 22 to August 5, 2006 the Office deducted \$92.52 for health benefits premiums from her compensation using code 454, for a total of \$647.64. The Office did not deduct any health benefits premiums from August 6 to September 2, 2006.

The Office should have deducted premiums of \$1,652.64 for health benefits from January 22 to September 2, 2006 using code 455 for family coverage. The Office's failure to deduct the premiums for health insurance under the family plan coverage from January 22 to September 2, 2006 resulted in an overpayment of \$1,005.00, or \$647.64 subtracted from \$1,652.64. The Board has recognized that, when an under withholding of health insurance premiums is discovered, the entire amount is deemed an overpayment of compensation because the Office must pay the full premium to OPM when the error is discovered.<sup>6</sup> The Board finds that the amount of the overpayment due to the underdeduction of health benefit premiums is \$1,005.00.

Appellant argued that she did not have family coverage from January 22 to February 8, 2006. In her August 30, 2006 letter to the Office, however, she related that her health insurance provider telephoned her in January 2006 to ascertain whether she wanted to change to single coverage. Appellant subsequently confirmed with her health insurance provider on two occasions that she had family coverage. The Office also telephoned her health insurance provider on February 22, 2007 and verified that she had family coverage beginning January 22, 2006.

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<sup>3</sup> *Id.* at § 890.502(b)(1).

<sup>4</sup> *Id.* at § 890.502(d).

<sup>5</sup> *James Lloyd Otte*, 48 ECAB 334 (1997).

<sup>6</sup> *Id.*

Appellant argued that the Office deducted \$121.86 per month for health benefits premiums rather than \$92.52. Computer worksheets, however, support that the Office deducted \$92.52 for health benefits premiums during the applicable time period.<sup>7</sup> Appellant has not submitted any evidence in support of her contention that the Office erred in its calculation of the overpayment.

Appellant additionally argued that the Office did not provide its calculation of overpayment in the decision. The Board notes, however, that in the November 20, 2006 preliminary notification of overpayment, the Office referenced an accompanying memorandum to the file that set forth in detail the calculation of the overpayment.

### **LEGAL PRECEDENT -- ISSUE 2**

Under section 8129 of the Federal Employees' Compensation Act<sup>8</sup> and the implementing regulations, an overpayment must be recovered unless incorrect payment has been made to an individual who is without fault and when adjustment or recovery would defeat the purpose of the Act or would be against equity and good conscience.<sup>9</sup>

Section 10.431 of the implementing regulations provides that, before seeking to recover an overpayment or adjust benefits, the Office will advise the individual in writing that the overpayment exists and the amount of the overpayment.<sup>10</sup> The written notification must also include a preliminary finding regarding whether the individual was at fault in the creation of the overpayment.<sup>11</sup> Additionally, the Office is obliged to advise the individual of his or her right to inspect and copy the government records relating to the overpayment.<sup>12</sup> Lastly, the preliminary notice must inform the individual of his or her right to challenge the fact or amount of the overpayment, the right to contest the preliminary finding of fault in the creation of the overpayment, if applicable, and the right to request a waiver of recovery of the overpayment.<sup>13</sup> The recipient of the alleged overpayment may present evidence in response to the Office's preliminary notice either in writing or at a precoupment hearing.<sup>14</sup> The evidence must be presented or the hearing requested within 30 days of the date of the written notice of

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<sup>7</sup> The Office deducted \$92.52 for health insurance premiums, \$14.40 for basic life insurance and \$14.94 for optional life insurance, a total of \$121.86.

<sup>8</sup> 5 U.S.C. §§ 8101-8193.

<sup>9</sup> 5 U.S.C. § 8129(b); 20 C.F.R. §§ 10.433, 10.434, 10.436, 10.437.

<sup>10</sup> 20 C.F.R. § 10.431(a).

<sup>11</sup> *Id.* at § 10.431(b).

<sup>12</sup> *Id.* at § 10.431(c).

<sup>13</sup> *Id.* at 10.431(d).

<sup>14</sup> *Id.* at § 10.432.

overpayment.<sup>15</sup> Failure to request the hearing within this 30-day time period shall constitute waiver of that right.<sup>16</sup>

Office procedures provide as follows:

“a. *When a preliminary finding on the question of fault is made, the OE will prepare a memorandum for the file stating the finding and the rationale. The OE will then immediately release the preliminary finding (Form CA-2201 or Form CA-2202), which informs the claimant of the fact and amount of the overpayment, and of the preliminary finding on the question of fault.*”<sup>17</sup>

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“(1) *If the claimant is determined to be with fault, Form CA-2201 must be released (along with an OWCP-20) within 30 days of the date the overpayment is identified. Both the reason that the overpayment occurred and the reason for the finding of fault must be clearly stated. Form CA-2201 informs the claimant of the right to submit evidence and the right to a precoupment hearing on the issues of a) fact and amount of the overpayment; b) fault; and c) waiver. Along with Form CA-2201, the OE should provide a clearly written statement explaining how the overpayment was calculated.*

(2) *If the claimant is determined to be without fault, Form CA-2202 must be released (along with an OWCP-20) within 30 days of the date the overpayment is identified. This letters advises the claimant of the fact and amount of the overpayment, and of the preliminary finding that the claimant is without fault in the creation of the overpayment. The reason that the overpayment occurred must be clearly stated in the preliminary decision and the OE should provide a clearly written explanation indicating how the overpayment was calculated.*”<sup>18</sup>

### **ANALYSIS -- ISSUE 2**

The Office informed appellant on November 20, 2006 of its preliminary determination that she was without fault in the creation of the overpayment. In its March 12, 2007 decision, however, the Office determined that she was at fault in creating the overpayment.

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<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

<sup>17</sup> Federal (FECA) Procedure Manual, Part 6 -- Debt Management, *Initial Overpayment Actions*, Chapter 6.200.4a (May 2004).

<sup>18</sup> *Id.*

The Office's regulations provide that, before seeking to recover an overpayment or adjust benefits, the Office will advise the individual in writing that the overpayment exists and the amount of the overpayment.<sup>19</sup> The written notification must also include a preliminary finding regarding whether the individual was at fault in the creation of the overpayment.<sup>20</sup> The Office must inform the individual of his or her right to challenge the fact or amount of the overpayment, the right to contest the preliminary finding of fault in the creation of the overpayment, if applicable, and the right to request a waiver of recovery of the overpayment.<sup>21</sup> The Office's procedure manual further provides that a preliminary finding of overpayment must be provided within 30 days and must clearly identify the reason that the overpayment occurred and the basis for any fault finding.<sup>22</sup>

The Office issued a final decision which changed the preliminary finding that she was without fault to a finding of fault in creating the overpayment. According to the Office's implementing regulations and its procedure manual, the Office should have reissued a preliminary determination if it was changing its determination of fault before finalizing a fault finding. Consequently, the Board finds that the Office failed to follow its regulations in changing the fault determination. The case is remanded for the Office to issue a preliminary determination on the issue of fault and waiver.<sup>23</sup>

### **CONCLUSION**

The Board finds that the Office properly determined that appellant received an overpayment of \$1,005.00 because it deducted health insurance premiums for single rather than family coverage from January 22 to September 2, 2006. The Board further finds that the case is not in posture for decision on the issue of whether appellant was at fault in creating the overpayment as the Office found that she was at fault in its overpayment decision without providing her with proper notice.

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<sup>19</sup> 20 C.F.R. § 10.431(a).

<sup>20</sup> *Id.* at § 10.431(b).

<sup>21</sup> *Id.* at § 10.431(d).

<sup>22</sup> Federal (FECA) Procedure Manual, Part 6 -- Debt Management, *Initial Overpayment Actions*, Chapter 6.200.4(a)(1) (May 2004).

<sup>23</sup> In view of the Board's disposition on the issue of fault, the issue of whether the Office properly determined that it would withhold \$300.00 per month from appellant's continuing compensation to repay the overpayment is premature.

**ORDER**

**IT IS HEREBY ORDERED THAT** the decision of the Office of Workers' Compensation Programs dated March 12, 2007 is affirmed in part and set aside in part and the case is remanded for further proceedings consistent with this opinion of the Board.

Issued: October 24, 2007  
Washington, DC

Alec J. Koromilas, Chief Judge  
Employees' Compensation Appeals Board

David S. Gerson, Judge  
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge  
Employees' Compensation Appeals Board