U. S. DEPARTMENT OF LABOR

Employees' Compensation Appeals Board

In the Matter of RICHARD B. COMPTON and DEPARTMENT OF THE INTERIOR, CURECANTI NATIONAL RECREATION AREA, Gunnison, CO

Docket No. 00-1872; Submitted on the Record;
Issued July 1, 2002

DECISION and ORDER

Before DAVID S. GERSON, MICHAEL E. GROOM,
A. PETER KANJORSKI

The issues are: (1) whether the Office of Workers' Compensation Programs properly determined that an overpayment in the amount of $1,357.99 was created; and (2) whether the Office properly found that appellant was at fault in the creation of the overpayment.

On August 23, 1995 appellant, then a 60-year-old park ranger, filed a notice of traumatic injury and claim for compensation (Form CA-1), alleging that on August 22, 1995 he injured his left shoulder in the performance of duty.

On March 26, 1996 the Office accepted his claim for left shoulder supraspinatus tear and impingement syndrome.[1]

By letter dated July 30, 1996, the Office advised appellant that he would be paid compensation as set forth in their letter. Appellant was advised that whenever the evidence indicated that he was no longer disabled because of his injury, the Office would send him a copy of that evidence and provide him with an opportunity to comment or to submit other evidence supporting his entitlement, before a decision was made to terminate compensation. He was advised that his first payment was for the period covering July 21 to August 17, 1996. The regular payment for the period from August 18 to September 14, 1996 was $803.24. In the section of the form for Health Benefits "$00.00" was entered. Appellant was advised that if he had optional life insurance and/or health benefits coverage but no deduction for it was listed above, to contact the Office "immediately." He was advised that he continued to be responsible for these premiums. Appellant was also advised that he would receive payment every four weeks until further notice.

[1] The record reflects that, following authorized surgery, appellant relocated to Florida and started work at Everglades National Park for the period November 22, 1996 to April 12, 1997 doing seasonal work. After that appellant stopped working on April 12, 1997 and filed a recurrence of disability claim, which was accepted by the Office. Appellant subsequently returned to Colorado on May 14, 1997.

By letter dated October 28, 1996, the Office again advised appellant that he would be paid compensation as set forth in their letter. Appellant was advised that whenever the evidence indicated that he was no longer disabled because of his injury, the Office would send him a copy of that evidence and provide him with an opportunity to comment or to submit other evidence supporting his entitlement, before a decision was made to terminate compensation. He was advised that his first payment was for the period covering October 13 to November 9, 1996 to December 7, 1996. The regular payment for the period from November 10, 1996 to December 7, 1996 was $874.64. In the section of the form for Health Benefits "$00.00" was entered. Appellant was advised that if he had optional life insurance and/or health benefits coverage but no deduction for it was listed above, to contact the Office "immediately." He was advised that he continued to be responsible for these premiums. Appellant was also advised that he would receive payment every four weeks until further notice.

By decision dated August 29, 1997, the Office did a retroactive loss of wage-earning capacity (LWEC) based on appellant's employment in Florida. After a hearing, the hearing representative set aside the LWEC and directed the Office to determine appellant's compensation entitlement from April 12, 1997.

By letter dated March 12, 1998, the Office again advised appellant that he would be paid compensation as set forth in their letter. Appellant was advised that whenever the evidence indicated that he was no longer disabled because of his injury, the Office would send him a copy of that evidence and provide him with an opportunity to comment or to submit other evidence supporting his entitlement, before a decision was made to terminate compensation. He was advised that his first payment was for the period covering January 1, 1998 to February 28, 1998. The regular payment for the period from March 1 to March 28, 1998 was $1,166.20. In the section of the form for Health Benefits "$00.00" was entered. Appellant was advised that if he had optional life insurance and/or health benefits coverage but no deduction for it was listed above, to contact the Office "immediately." He was advised that he continued to be responsible for these premiums. Appellant was also advised that he would receive payment every four weeks until further notice.

On November 1, 1999 appellant wrote the Office advising that he was contacted that morning by the Bureau of Reclamation's Finance Division and was advised that he was responsible for payment of two years worth of unpaid premiums on his government medical insurance. He advised the Office that it was his understanding that, as he was receiving health and hospital benefits, there was no break in service and he believed that the employing establishment was responsible for his compensation and medical benefits until he was notified otherwise.

In a letter dated November 22, 1999, the Office advised appellant that it had made a preliminary determination that an overpayment of compensation had occurred in the amount of $1,357.99. The overpayment was created because the Office did not make deductions for health benefits for the periods March 16 to November 22, 1996 and April 13, 1997 to November 6, 1999. The Office further advised appellant that he was at fault in the creation of

the overpayment.[2] He was further informed of his right to challenge the amount of the overpayment or request a waiver of the overpayment by one of three methods consisting of a request for a telephone conference, a request for a written review of the record or a request for a prerecoupment hearing. If appellant wished a waiver of the overpayment, he was directed to submit financial information by completing an overpayment recovery questionnaire.

By letter dated November 24, 1999, appellant responded to the Office's preliminary determination letter. He stated that sometime after March 19, 1996 he became eligible for workers' compensation benefits and a short while after that date, he received an unsolicited health care benefits card from F.H.P. Health Care, announcing that they were pleased to welcome him as a member and listing the employing establishment as the supporting agency. Appellant stated that he telephoned the F.H.P. and was assured that he was in fact insured by the aforementioned agency. He further stated that, based on this information, he believed that his health care benefits were being provided to him by the employing establishment because he had received them since the date of his injury and because he was entitled to receive such benefits. Appellant also indicated that he did not recall receiving any letters from the Office pertaining to this mater, until "now, four years after the fact when you [are] seeking restitution." He further stated that he did not solicit, authorize, approve, sign, agree or request that any federal agency deduct or not deduct any benefit deductions for any health insurance. Appellant added that, upon receipt of the membership card, he contacted the insurance company and was advised that everything was proper. He added that he was entirely blameless and the indebtedness was incurred through no fault of his own. Additionally, he requested a telephone conference and in the alternative a hearing; however, he "elected" to not submit any financial information, until he received a response to his letter.

By letter dated December 17, 1999, the Office responded to appellant's request and stated that, in order to obtain a waiver, appellant must provide the information in the financial statement. The Office also advised appellant that for a request for a telephone conference, he must provide the financial information with his request. Appellant was advised that if he did not submit the requested financial information by December 28, 1999, a final decision would be rendered. He did not submit any further information.

By decision dated January 7, 2000, the Office found that appellant was at fault in the creation of the overpayment. The Office further advised that the amount of $60.00 would be deducted from continuing compensation payments and that the overpayment would be collected on or about October 6, 2001.

The Board finds that the Office properly determined that an overpayment of $1,357.99 occurred due to failure to deduct health premiums from March 16 to November 22, 1996 and April 13, 1997 to November 6, 1999.

[2] The Office indicated that appellant was advised by letters on July 30, 1996 and March 12, 1998 that the Office was not making deductions for his health benefits coverage and appellant made no attempt to have the oversight corrected, despite being advised twice. In addition, the record indicates appellant actually received a third letter on October 28, 1996, thus informing him on three occasions.

The regulations of the Office of Personnel Management (OPM), which administers the Federal Employees' Health Benefits (FEHB) Program, provide guidelines for registration, enrollment and continuation of enrollment of federal employees. In this connection, 5 C.F.R. § 890.502(b)(1) provides: "[A]n employee or annuitant is responsible for payment of the employee [or annuitant's] share of the cost of enrollment for every pay period during which the enrollment continues…. An employee [or annuitant] incurs an indebtedness due the United States in the amount of the proper employee [or annuitant] withholding required for [each] pay period" that health benefit withholdings or direct premium payments are not made but during which the enrollment continues.

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

> "An agency that withholds less than … the proper health benefits contributions from 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 title 5 United States Code, to OPM for deposit in the Employees Health Benefits Fund."

The record indicates that no deductions were made for health benefits from appellant's compensation benefits during the period March 16 to November 22, 1996 and April 13, 1997 to November 6, 1999. Furthermore, there is no evidence in the record that appellant cancelled his health benefits enrollment or that the employing establishment terminated his health benefits. The Board has previously 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.[3] The amount of the overpayment due to lack of deduction for health benefits is $1,357.99. The Board finds that the Office properly determined that an overpayment in the amount of $1,357.99 was created.

The Board also finds that the Office properly determined that appellant was at fault in creating the $1,357.99 overpayment.

Section 8129(a) of the Federal Employees' Compensation Act provides that where an overpayment of compensation has been made "because of error or fact of law," adjustment shall be made by decreasing later payments to which an individual is entitled.[4] The only exception to this requirement is a situation which meets the test set forth as follows in section 8129(b): "[a]djustment or recovery by the United States may not be made when 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."[5] Thus, the Office may not waive the overpayment of compensation in this case unless appellant was without fault.[6] In evaluation of whether appellant is without fault, the Office will consider whether appellant's

[3] *John E. Rowland*, 39 ECAB 1377, 1378 (1988).

[4] 5 U.S.C. § 8129.

[5] 5 U.S.C. § 8129(b).

[6] *Harold W. Steele*, 38 ECAB 245 (1986).

receipt of the overpayment occurred because he relied on misinformation given by an official source within the Office or another government agency which appellant had reason to believe was connected with the administration of benefits as to the interpretation of the Act or applicable regulations.[7]

In determining whether an individual is at fault, section 10.433 of the Code of Federal Regulations provides in relevant part:

> "A recipient who has done any of the following will be found to be at fault with regard to creating an overpayment:
>
> > (1) Made an incorrect statement as to a material fact which he or she knew or should have known to be incorrect: or
> >
> > (2) Failed to provide information which he or she knew or should have known to be material; or
> >
> > (3) Accepted a payment which he or she knew or should have been known to be incorrect"[8]

In the instant case, the Office relied upon the third criteria in determining that appellant accepted compensation for the periods March 16 to November 22, 1996 and April 13, 1997 to November 6, 1999, which did not include deductions for health insurance premiums which he knew or should have known was incorrect. In order for the Office to establish that appellant was with fault in creating the overpayment of compensation, the Office must establish that at the time appellant received the compensation checks, covering the period March 16 to November 22, 1996 and April 13, 1997 to November 6, 1999, he knew or should have known that the payment was incorrect. The record in this case clearly establishes such knowledge.

The Office based its finding of fault on appellant's receipt of the Form CA-1049 dated July 30 and October 28, 1996 and again on March 12, 1998. In this form letter, the Office advised appellant that, if he had health insurance coverage and no premiums were being deducted for this purpose, he would remain responsible for the premiums. On the portions of the form letter detailing the payments for the periods: July 21 to August 17, 1996 and August 18 to September 14, 1996; October 13 to November 9, 1996 and November 10 to December 7, 1996; January 1 to February 28, 1998 and March 1 to March 28, 1998, the notation "[zero zero]" appeared after the heading "[h]ealth [b]enefits."[9] In each of these letters, $00.00 was in the section of the form for health benefits, clearly signifying that no deduction was being made. The record reflects that appellant did not call the Office to inquire why no deductions were being made for his health benefits. Further, appellant advised that upon receipt of the insurance cards, he called the insurance company and not the Office. He did not explain why he did not call the

[7] 20 C.F.R. § 10.435(b)(1) (January 1999).

[8] 20 C.F.R. § 10.433(a) (January 1999).

[9] This appeared on the March 12, 1998 letter from the Office. The same notation of "[zero zero]" appeared on the July 30 and October 28, 1996 letters.

Office when each of the three letters regarding his benefits showed that no deductions were being made for his health benefits and advised him that he continued to be responsible for their payment. He further confirmed that he used the benefits as he thought he was entitled to them.

Appellant in this case does not dispute the amount of the overpayment on appeal or that it was created by the Office's failure to deduct premiums from his health insurance. Instead, he argues that he was not at fault as he thought he was entitled to the premiums and the overpayment should be waived. He further argued that the first notice he received regarding the premiums was four years after the fact. However, the record clearly shows that on three separate occasions, appellant was advised, contemporaneous with his benefit information that he was responsible for his health insurance premiums. In the instant case, appellant was advised by the Office on July 30 and October 28, 1996 and March 12, 1998 that he was responsible for his insurance premiums and if he did not see a deduction, he should contact the agency. The record shows that appellant contacted the employing establishment regarding numerous items, however, there is no record of appellant contacting the employing establishment regarding having the benefits deducted from his compensation. As appellant knew or should have known that the health insurance premiums should have been deducted, he accepted a payment which he knew or should have been expected to know was incorrect. As appellant was at fault in creating the overpayment, no waiver of the overpayment is possible, and the overpayment was properly recouped as detailed in the Office's January 7, 2000 decision.

The January 7, 2000 decision of the Office of Workers' Compensation Programs is hereby affirmed.

Dated, Washington, DC
July 1, 2002

David S. Gerson
Alternate Member

Michael E. Groom
Alternate Member

A. Peter Kanjorski
Alternate Member