United States Department of Labor
Employees' Compensation Appeals Board

R.L., Appellant	)	
and	)	**Docket No. 10-105**
	)	**Issued: September 27, 2010**
DEPARTMENT OF VETERANS AFFAIRS, VETERANS ADMINISTRATION MEDICAL CENTER, Portland, OR, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On October 15, 2009 appellant, through counsel, filed a timely appeal from an October 1, 2009 merit decision of the Office of Workers' Compensation Programs finding that he received an overpayment of compensation and that he was at fault in its creation. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUES

The issues are: (1) whether the Office properly determined that appellant received an overpayment of compensation in the amount of $3,762.82 because it deducted health insurance premiums for single rather than family coverage from May 13, 2007 through February 14, 2009; (2) whether he was at fault in creating the overpayment and (3) whether the Office abused its discretion in requiring recovery of the full amount of the overpayment in a single sum.

FACTUAL HISTORY

This case was previously before the Board. In an October 6, 2008 decision, the Board affirmed the Office's December 5, 2007 decision denying authorization for a total disc

arthroscopy.[1] The facts of the case as provided in the Board's prior decision are incorporated herein by reference.

The Office accepted appellant's April 28, 2006 traumatic injury claim for temporary aggravation of a preexisting cervical degenerative disc disease and placed him on the periodic rolls.[2] Appellant signed a health election form requesting family coverage (code 105), effective July 7, 2006. The record reflects that the Office made deductions from appellant's compensation benefits for self-only coverage (code 104) from May 13, 2007 through February 14, 2009, based on information provided by the employing establishment.

A daily rolls payment worksheet, dated March 6, 2009, indicated that deductions for health care premiums were taken out under code 104 (for single benefits) instead of code 105 (for family benefits) for the period May 13, 2007 through February 14, 2009, creating an overpayment of $3,762.82. In letters dated November 7 and 13, 2007, appellant acknowledged that the Office was withholding a portion of his compensation benefits for health insurance premiums.

The record contains copies of benefits statements for the period August 5, 2007 through June 8, 2009, which reflected continuing payments each 28 days. The record also contains envelopes establishing that the statements were returned to the Office effective August 5, 2007, due to an insufficient address. The record does not contain a copy of an envelope or benefit statement returned prior to that date. On January 10, 2008 appellant notified the Office of a temporary address change to a residence in San Antonio, TX. On May 12, 2008 appellant notified the Office of a permanent change of his address to a location in Luxembourg.

On March 13, 2009 the Office notified appellant of its preliminary determination that he had received an overpayment of compensation in the amount of $3,762.82 because it had deducted health benefit premiums for single coverage rather than family coverage from May 13, 2007 to February 14, 2009. The March 13, 2009 determination was sent to appellant, together with an overpayment recovery questionnaire, to his address of record in Luxembourg. The Office informed appellant of its preliminary determination that he was with fault in the creation of the overpayment as he knew or should have reasonably known the payment he accepted was incorrect. In an accompanying memorandum, the Office described the calculation of the overpayment, noting that it had deducted a total of $2,787.66 from his compensation, using health benefits code 104, during the above-referenced period. Instead, it should have deducted $6,550.48 in health benefits under code 105 for family coverage. Accordingly, appellant received an overpayment of $3,762.82. He was instructed to complete and return the overpayment recovery questionnaire if he disputed the fact or amount of the overpayment or the finding of fault.[3]

[1] Docket No. 08-855 (issued October 6, 2008).

[2] Appellant's March 1, 2006 traumatic injury claim (File No. xxxxxx600) was accepted for cervical disc herniation. Appellant was paid wage-loss compensation benefits under File No. xxxxxx600 until May 12, 2007, when he began receiving benefits under the instant claim. The claims were combined, with the instant claim (File No. xxxxxx589) serving as the master file.

[3] The record reflects that the overpayment recovery questionnaire was scanned into the case file, along with the preliminary determination of overpayment, on the date it was sent to appellant at his address of record.

On March 28, 2009 appellant disagreed with the preliminary overpayment determination and requested a prerecoupment hearing. He stated that he had not received any benefit statements charged under the instant claim, suggesting that the omission was due to the fact that the Office had an incorrect address for him.

During the July 14, 2009 telephonic hearing, appellant disputed the fact and amount of overpayment. He testified that he never filed a claim on behalf of his spouse during the period in question because he was unaware that he had family coverage. Appellant contended that repayment of the overpayment amount would create an undue hardship. He further indicated that he had not received a copy of the overpayment recovery questionnaire referenced in the preliminary overpayment determination. The claims examiner stated that he would send appellant another questionnaire and advised him to provide evidence supporting his financial situation.

On July 16, 2009 the hearing representative forwarded a copy of an overpayment recovery questionnaire to appellant at his address of record in Luxembourg. It instructed him to complete and return the form, together with supporting financial information, within 30 days. In a memorandum dated August 12, 2009, the hearing representative indicated that the overpayment recovery questionnaire had been returned. He noted that he was sending another questionnaire to appellant on that date.

In a memorandum to the file dated September 16, 2009, the hearing representative stated that he had called the Blue Cross operations center in Washington, DC to determine whether appellant's spouse was enrolled on his health insurance policy during the period in question. He was informed that the spouse was added to the policy effective July 23, 2006, and the code was changed to 105 on that date. The hearing representative was further advised that the spouse had utilized the insurance in 2007 and 2008.

By decision dated October 1, 2009, the Office finalized its determination that appellant had received an overpayment of $3,762.82 for the period May 13, 2007 through February 13, 2009. It noted that deductions for code 105 should have been made in the amount of $6,550.48 but that deductions were actually made under code 104 in the amount of $2,787.66, resulting in an overpayment of $3,762.82. The Office further determined that appellant was at fault in the creation of the overpayment, as he was aware or should have been aware that the correct premiums for health insurance were not being deducted. It noted that the specific health code was listed on the benefit statement issued with every compensation payment. Although benefit statements after August 5, 2007 were returned to the Office for insufficiency of address, the record reflects that benefit statements were sent to appellant at his address of record prior to that time, and there was no evidence that he failed to receive them. The Office found that having received benefit statements for the period between March and July 2007, appellant should reasonably have been aware that his health insurance benefits were being incorrectly withheld. As he was at fault in the creation of the overpayment, he was not entitled to waiver. It found that the overpayment should be repaid in full, as a payment plan could not be considered due to appellant's failure to return the overpayment recovery questionnaire.

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 regulations 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."[4]

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."[5]

Under applicable OPM regulations, the employee or annuitant is responsible for payment of the employee's share of the cost of enrollment.[6] An agency that withholds less than the proper health benefits contribution must submit an amount equal to the sum of the uncollected deductions.[7] 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.[8]

ANALYSIS -- ISSUE 1

The Board finds that appellant received an overpayment of compensation in the amount of $3,762.82. Appellant received total disability compensation on the periodic rolls. During the period May 13, 2007 to February 14, 2009, the Office deducted health insurance premiums at an incorrect rate. Appellant signed a health election form requesting family coverage (code 105), effective July 7, 2006. The record reflects that the Office made deductions of $2,787.66 from appellant's compensation benefits for self-only coverage (code 104) from May 13, 2007 through

[4] 5 C.F.R. § 890.502(b)(1).

[5] *Id*. at § 890.502(d).

[6] *Id*. at § 890.502(b)(1).

[7] *Id*. at § 890.502(d).

[8] *James Lloyd Otte*, 48 ECAB 334 (1997).

February 14, 2009; rather than deductions under code 105 in the amount of $6,550.48 during the period in question. Based on the underdeduction of health insurance premiums, appellant received an overpayment of compensation in the amount of $3,762.82 for the period May 13, 2007 to February 14, 2009. The Board will affirm the fact and amount of overpayment.

On appeal, appellant disputed the fact of the overpayment, contending that he did not have family coverage during the period in question. The record reflects, however, that he had family coverage from March 13, 2007 through February 14, 2009 and availed himself of the benefits. Appellant signed a health benefit election form requesting family coverage effective July 9, 2006. His health insurance carrier confirmed his spouse was enrolled on his health insurance policy during the period in question; that she was added to the policy effective July 23, 2006; that the code was changed to 105 on that date; and that his spouse utilized the insurance in 2007 and 2008.

Appellant also disputed the amount of the overpayment, contending that the overpayment calculation included the entire cost of family coverage, with no credit for the amount deducted for self-only coverage. The record reflects, however, that the Office calculated the overpayment amount by determining that $6,550.48 should have been deducted from appellant's compensation benefits under code 105 during the period in question, but that only $2,787.66 was deducted under code 104. This underdeduction of premiums resulted in an overpayment of $3,762.82 to appellant. The Board finds that the Office properly calculated the amount of the overpayment.

LEGAL PRECEDENT -- ISSUE 2

The Office may consider waiving an overpayment only if the individual to whom it was made was not at fault in accepting or creating the overpayment. Each recipient of compensation benefits is responsible for taking all reasonable measures to ensure that payments he or she receives from the Office are proper. The recipient must show good faith and exercise a high degree of care in reporting events which may affect entitlement to or the amount of, benefits. A recipient who has done any of the following will be found to be at fault with respect 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; (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 known to be incorrect (this provision applies only to the overpaid individual).[9]

Whether or not the Office determines that an individual was at fault with respect to the creation of an overpayment depends on the circumstances surrounding the overpayment. The degree of care expected may vary with the complexity of those circumstances and the individual's capacity to realize that he or she is being overpaid.[10]

[9] 20 C.F.R. § 10.433(a).

[10] *Id.* at § 10.433(b).

ANALYSIS -- ISSUE 2

The Board finds that appellant was at fault in the creation of the overpayment, thereby precluding waiver.

The Office found that appellant was at fault because he knew or reasonably should have known that an incorrect amount for his health insurance premiums was being deducted from his compensation for the period March 13, 2007 through February 14, 2009. Appellant contends that he had no way of knowing that he was receiving incorrect payments. The Board disagrees based upon the evidence of record. Appellant elected family coverage under code 105 to be effective July 9, 2006 and, therefore had an expectation that deductions for health insurance premiums would begin under code 105 on that date. Every 28 days appellant received benefit statements, which itemized deductions and listed the health benefits code (104) such that a reasonable person would question whether the correct health benefits code and amount was being used by the Office.

Appellant alleged that he did not receive benefit statements during the overpayment period. The Board notes that while benefit statements after August 5, 2007 were returned to the Office for insufficiency of address, the record reflects that benefit statements were sent to appellant at his address of record prior to that time, and there was no evidence that he failed to receive them.[11] After receiving benefit statements over a period of months between March and July 2007, appellant should reasonably have been aware that his health insurance benefits were being incorrectly withheld. Thus, the evidence demonstrates that he accepted a payment which he knew or should have been expected to know was incorrect. Accordingly, he was at fault in creating the overpayment and no waiver of the overpayment is possible.

LEGAL PRECEDENT -- ISSUE 3

Section 10.441(a) of Title 20 of the Code of Federal Regulations provide in pertinent part:

> "When an overpayment has been made to an individual who is entitled to further payments, the individual shall refund to [the Office] the amount of the overpayment as soon as the error is discovered or his or her attention is called to the same. If no refund is made, [the Office] shall decrease later payments of compensation, taking into account the probable extent of future payments, the rate of compensation, the financial circumstances of the individual, and any other relevant factors, so as to minimize any hardship."[12]

Section 10.438(a) provides that the individual who received the overpayment is responsible for providing information about income, expenses and assets as specified by the Office, as this

[11] Under the "mailbox rule," it is presumed, in the absence of evidence to the contrary, that a notice mailed to an individual in the ordinary course of business was received by that individual. This presumption arises when it appears from the record that the notice was properly addressed and duly mailed. *Michele Lagana*, 52 ECAB 187, 189 (2000).

[12] 20 C.F.R. § 10.441(a).

information is needed to determine whether or not recovery of an overpayment would defeat the purpose of the Act or be against equity and good conscience.[13] This information would also be used to determine the repayment schedule, if necessary.

Office procedures provide that debts shall be collected in one lump sum wherever possible.[14]

ANALYSIS -- ISSUE 3

The Board finds that the Office did not abuse its discretion in requiring recovery of the full amount of the overpayment in a single sum.

As appellant was entitled to further compensation payments when the overpayment was discovered, appellant was obligated to refund the entire amount of the overpayment to the Office immediately.[15] When he failed to do so, the Office was required to decrease later payments of compensation, minimizing any hardship by considering his financial circumstances.[16] Appellant however, was responsible for providing information about his income, expenses and assets, so that the Office would be able to determine any possible repayment schedule.[17] The Office asked him to provide financial information to enable it to determine the rate of recovery of the overpayment in light of the factors noted above. Appellant, however, did not provide the evidence necessary for the Office to determine whether recovery of the overpayment would cause him undue financial hardship,[18] or to provide a basis for a payment schedule.

Appellant alleged that he never received a copy of the overpayment recovery questionnaire. The record, however, reflects that he was sent a copy of the questionnaire contemporaneously with the March 13, 2009 preliminary overpayment determination, which he admittedly received. The hearing representative forwarded another copy of the questionnaire to appellant on July 16, 2009. When the document was returned, he promptly forwarded another copy of the questionnaire to appellant at his address of record on August 12, 2009. Absent evidence to the contrary, it is presumed that appellant received the overpayment recovery questionnaire.[19] In spite of the hearing representative's instructions to complete and submit the

[13] *Id.* at § 10.438(a).

[14] Federal (FECA) Procedure Manual, Part 6 -- Debt Management, *Initial Overpayment Actions,* Chapter 6.200.4(d)(1)(a) (September 1994).

[15] *See supra* note 12 and accompanying text.

[16] *Id*.

[17] *Id.* at § 10.438(a).

[18] In establishing the initial collection strategy, the Office must weigh the individual's income, ordinary and necessary expenses and assets in a manner similar to the waiver considerations. When an individual fails to provide requested information on income, expenses and assets, the Office should follow minimum collections guidelines, which state in general that government claims should be collected in full and that, if an installment plan is accepted, the installments should be large enough to collect the debt promptly. *Gail M. Roe*, 47 ECAB 268 (1995); *see Nina D. Newborn*, 47 ECAB 132 (1995).

[19] *See supra* note 11.

questionnaire, together with supporting evidence, appellant submitted no evidence relating to his financial status. The Board, therefore, finds that the Office did not abuse its discretion in determining that the overpayment debt of $3,762.82 was payable in full.[20]

CONCLUSION

The Board finds that the Office properly determined that appellant received a $3,762.82 overpayment of compensation and was at fault in its creation, thereby precluding waiver. The Board further finds that the Office did not abuse its discretion in requiring recovery of the full amount of the overpayment in a single sum.

ORDER

IT IS HEREBY ORDERED THAT the October 1, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: September 27, 2010
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

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

[20] *See supra* note 14 and accompanying text.