SUPPLEMENTARY INFORMATION:

Closed Captioning Requirements for Computer Systems Used As Television Receivers

Several manufacturers have requested information on the requirements for displaying closed captioning as they apply to computers that have the capability to receive television signals. This Public Notice describes the Office of Engineering and Technology's (OET) interpretation of the requirements of the Television Decoder Circuitry Act of 1990, and the rules implementing that Act, as they apply to computer systems. As indicated below, computer systems that are sold with a monitor that has a ''viewable picture'' size of 13 inches or greater and that have the capability to receive television service must be able to display closed captions transmitted on television signals. Closed captioning capability is not required for smaller monitors, for systems without television reception capability, for computers sold without monitors, or for ''plug-in'' circuit boards that add television reception capability.

Section 15.119 of the Commission's rules, and the Television Decoder Circuitry Act of 1990 (Pub. L. 101–431) upon which this rule section is based, require that all devices designed to receive television pictures broadcast simultaneously with sound be equipped with built-in decoder circuitry designed to display closed-captioned television transmissions when such a device is manufactured in the United States or imported for use in the United States, and its television picture screen is 33 cm (13 inches) or greater in size. *See* 47 CFR 15.119 and 47 U.S.C. 303(u) and 330(b).

Personal computers can now be equipped to receive and display broadcast television programming. This capability can be marketed in a variety or ways. For example, built-in TV receiver capability can be included in personal computers that are marketed as complete systems, *e.g.*, systems that include both a computer and monitor. Built-in TV receiver capability can also be included in personal computers sold without a monitor. In addition, TV receiver capability can be provided on plug-in circuit cards that can be used to add TV reception capability to an existing personal computer.

The screen sizes for TV receivers and monitors used with personal computers traditionally have been measured differently by manufacturers in the two industries. TV receiver screen size is measured on the basis of the ''viewable picture'' area, in accordance with Federal Trade Commission (FTC) regulations. *See* 16 CFR Part 410. Computer monitors traditionally are measured on the basis of the overall physical size of the picture tube. In many cases, computer monitors marketed as ¼ inches or larger actually have a viewable picture size of less than 33 cm (13 inches). We note that the majority of computer monitors being sold now have a viewable picture size that is smaller than 33 cm (13 inches), although the number of models with larger picture sizes is increasing.

OET interprets that the requirements of § 15.119 apply to computer systems that have the capability to receive TV broadcast signals and include a monitor that has a ''viewable picture'' size of 33 cm (13 inches) or larger, as measured in accordance with the FTC regulations, 16 CFR Part 410. For purposes of this interpretation, a computer system may be a single unit, with the computer and monitor in the same housing, or separate computer and monitor units.

As a practical matter, computers and monitors sold together as systems are often marketed with separate prices. This allows consumers greater flexibility in choosing a system that meets their needs. OET interprets that where computers and monitors are priced separately but sold together, *i.e.*, as part of the same business transaction, they are nonetheless computer systems for purposes of the closed caption display capability requirements and must comply with those requirements if the ''viewable picture'' of the monitor is 33 cm (13 inches) or larger.

The requirements of § 15.119 do not apply to:

—Computers or computer systems that do not have the capability to receive TV broadcast signals;
—Computers sold without monitors;
—Computer systems with monitors that do not have a viewable picture of 33 cm (13″) or larger; or,
—Separate ''plug-in '' circuit boards.

In issuing this interpretation, we wish to emphasize that we recognize the importance of closed captioning display as a feature of TV reception capability included in personal computers. We therefore will monitor the practices of the computer industry with regard to this feature, particularly with regard to the practices of selling computers and monitors together, and will consider appropriate action in the future as may be necessary to ensure this feature is adequately available to the public.

By the Chief, Office of Engineering and Technology.

Office of Engineering and Technology contact: Richard Engelman at (202) 776–1626.

Federal Communications Commission.

William F. Caton,

Acting Secretary.

[FR Doc. 95–7650 Filed 3–28–95; 8:45 am]

BILLING CODE 6712–01–M

OFFICE OF PERSONNEL MANAGEMENT

48 CFR Parts 1604 and 1652

RIN 3206–AG30

Federal Employees Health Benefits Acquisition Regulation Filing Health Benefit Claims; Addition of Contract Clause

AGENCY: Office of Personnel Management.

ACTION: Interim regulations with request for comments.

SUMMARY: The Office of Personnel Management (OPM) is issuing interim regulations to add a new contract clause of the Federal Employees Health Benefits Acquisition Regulation (FEHBAR). The clause clarifies for both FEHB carriers and covered individuals the circumstances under which OPM may render a decision regarding a covered individual who asks OPM to review a health benefits plan's denial of a claim if the plan has either affirmed its denial when the covered individual requested reconsideration, or failed to respond to the covered individual's request for reconsideration as provided by OPM's regulations. The clause further clarifies the circumstances under which claimants may seek court review of benefit denials under the FEHB Program. The purpose of these interim regulations is to clarify that covered individuals who wish to bring legal action regarding a denial of an FEHB benefit must pursue such claim against OPM. Further, the interim regulations clarify the administrative review process that must precede legal action in the courts.

DATES: These interim regulations are effective March 29, 1995. Comments must be received on or before May 30, 1995.

ADDRESSES: Send written comments to Lucretia F. Myers, Assistant Director for Insurance Programs, Retirement and Insurance Service, Office of Personnel Management, P.O. Box 57, Washington, DC 20044; or deliver to OPM, Room 3451, 1900 E Street NW., Washington, DC; or FAX to (202) 606–0633.

FOR FURTHER INFORMATION CONTACT: Margaret Sears, (202) 606–0004.

SUPPLEMENTARY INFORMATION: Historically, OPM has required that

covered individuals who want to bring suit because an FEHB carrier has denied their claim for health benefits must sue the carrier, not OPM. These interim regulations provide that legal actions arising out of a denial of FEHB benefits should be brought against OPM rather than the FEHB carrier that made the initial denial decision. Because OPM has the authority under the FEHB law to order the carrier to pay the claim, OPM has determined it is appropriate under current statute for the covered individuals to bring suit against OPM if OPM declines to order the carrier to pay the claim. The clause clarifies the process and circumstances for bringing legal actions under the FEHB Program and gives the administrative review process that must be completed before suit is brought.

The legislative history of § 8902(j), title 5, United States Code, shows that Congress intended OPM (at that time the Civil Service Commission) to provide an administrative appeal process, binding upon the carriers, that would save covered individuals the expense and delay of being forced into the courts to recover on meritorious claims for benefits. Based upon this directive and its central role in the administration of the FEHB Program, OPM established a detailed administrative review process for benefits claims leading to a final decision on such claims by OPM. It is OPM's view that this administrative review process must be followed before legal action is pursued in the courts. Further, the matter to be reviewed by a court upon appeal is the OPM decision affirming the carrier's denial of benefits, with the court's review being limited to an examination of OPM's administrative decision to deny the claim for payment or services.

Health insurance contracts under the FEHB Program are Federal contracts under 5 U.S.C., chapter 89. Accordingly, legal actions concerning disputes arising or relating to those contracts are controlled by Federal, rather than State law. Congress, in the FEHB Act, mandated Federal uniformity for all matters that relate to (1) the nature or extent of coverage; (2) benefits; and (3) payment of benefits under the FEHB Program. By statute, all health insurance contracts require the carrier to agree to pay or provide a health service or supply in an individual case if OPM finds that the covered individual is entitled to the benefit under the terms of the contract. Congress also directed OPM to take a central role in determining whether a health service or supply should be provided in individual cases to covered individuals and, if it should be provided, to require carriers to pay for such health service or supply. These interim regulations reaffirm the principle of uniformity in the FEHB Program by providing that in judicial disputes regarding the denial of a health benefits claim, review is to be limited to the record that was before OPM and that was the basis of the OPM decision to disallow the benefit. In the event that an appropriate court concludes that benefits should have been awarded under the FEHB Act, the court possesses ample authority to require OPM to order that such payments be made to the covered individual from the carrier. These interim regulations clarify that OPM intends for its decision to be upheld unless the Court concludes that the OPM decision affirming the carrier's denial of benefits was inconsistent with the standard for final agency action under applicable Federal law.

The new clause reflects the administrative review procedures that must precede court review. These procedures are prescribed by regulations at 5 CFR 890.105 and reflects minor changes that OPM is making to 5 CFR 890.105 by interim regulations being published in conjunction with this interim regulation The new clause also reflects regulations and 5 CFR 890.107 regarding court review and reflects changes OPM is making to 5 CFR 890.107 by regulations also being published in conjunction with this interim regulations.

OPM proposes to incorporate these procedures into the FEHB contract by adding a new clause 1652.204–72, Filing Health Benefit Claims/Court Review of Disputed Claims, to Subpart 1652.2 of the Federal Employees Health Benefits Acquisition Regulation (FEHBAR).

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because the regulation merely incorporates administrative procedures and regulatory requirements into FEHB contracts.

List of Subjects in 48 CFR Parts 1604 and 1652

Government employees, Government procurement, Health insurance.

Office of Personnel Management.

James B. King,

Director.

Accordingly, OPM proposes to amend 48 CFR chapter 16 as follows:

PART 1604—ADMINISTRATIVE MATTERS

1. The authority citation for parts 1604 and 1652 continue to read as follows:

Authority: 5 U.S.C. 8913; 40 U.S.C. 486(c); 48 CFR 1.301.

2. In part 1604 subpart 1604.71 is added to read as follows:

Subpart 1604.71—Disputed Health Benefit Claims

1604.7101 Filing Health Benefit Claims/Court Review of Disputed Claims.

Guidelines for an Federal Employees Health Benefit (FEHB) Program covered individual to file a claim for payment or service and for legal actions on disputed health benefit claims are found at 5 CFR 890.105 and 890.107, respectively. The contract clause at 1652.204–72 of this chapter, reflecting this guidance, must be inserted in all FEHB Program contracts.

PART 1652—CONTRACT CLAUSES

3. Subpart 1652.2 is amended by adding section 1652.204–72 to read as follows:

Subpart 1652.2—Texts of FEHBP Clauses

1652.204–72 Filing Health Benefit Claims/Court Review of Disputed Claims.

As prescribed in 1604.7101 of this chapter, the following clause must be inserted in all FEHB Program contracts.

FILING HEALTH BENEFIT CLAIMS/COURT REVIEW OF DISPUTED CLAIMS

(a) *General.* The Carrier resolves claims filed under the Plan. All health benefit claims must be submitted initially to the Carrier. 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 (b) of this clause, 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 clause before seeking judicial review of the denied claim.

(b) *Time limits for reconsidering a claim.* (1) The covered individual has 1 year 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.

(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 clause if the Carrier fails to act within 30 days after the covered individual's request for reconsideration or the Carrier's receipt of additional information.

(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 30 days after the date it receives the request or within 30 days after the date it receives the additional information requested. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this clause.

(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 clause.

(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; or

(ii) If the Carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this clause, 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 clause, 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.

(f) *Court review.* (1) A suit to compel enrollment under § 890.102 of Title 5, Code of Federal Regulations, must be brought against the employing office that made the enrollment decision.

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

(3) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute (chapter 89, title 5, United States Code). 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. The recovery in such a suit will be limited to the amount of benefits in dispute.

(4) An action under paragraph (f)(3) of this clause to recover on a claim for health benefits:

(i) May not be brought prior to exhaustion of the administrative remedies provided in paragraphs (a) through (e) of this clause;

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

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

(End of Clause)

[FR Doc. 95–7792 Filed 3–28–95; 8:45 am]

BILLING CODE 6325–01–M

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

48 CFR Parts 1801, 1804, 1806, 1808, 1813, 1815, 1816, 1832, 1836, 1840, 1841, 1842, 1845, 1851, 1852, and 1870

[NFSD 89–18]

RIN 2700–AB83

NASA FAR Supplement; Miscellaneous Amendments

AGENCY: Office of Procurement, Acquisition Liaison Division, National Aeronautics and Space Administration (NASA).

ACTION: Final rule.

SUMMARY: This document amends the NASA Federal Acquisition Regulation Supplement (NFS) to reflect a number of miscellaneous changes dealing with NASA internal and administrative matters, such as the NASA FAR Supplement rewrite, procurement integrity, cost-reimbursement contracts, architect-engineer services, acquisition of utility services, and audit tracking and resolution.

EFFECTIVE DATE: March 31, 1995.

FOR FURTHER INFORMATION CONTACT: Mr. David K. Beck, (202) 358–0482; e-mail: dbeck@proc.hq.nasa.gov.

SUPPLEMENTARY INFORMATION:

Background

A cross-reference is added to 1813.7104(a) due to FAC 90–24. The FAC allows the head of contracting activity to exclude contracting officers (with micro-purchase authority only) from the procurement integrity definition of ''procurement official'' if the HCA determines that it is unlikely that the contracting officer's acquisitions will exceed $20,000 in any 12-month period.

Sections 1816.301, 1816.301–3 and 1816.403 are removed due to FAC 90–24's removal of FAR 16.301 and 16.403.