

insurance benefits under Part A of Medicare.

DATES: This rule was effective October 1, 2001.

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SUPPLEMENTARY INFORMATION:

I. Summary of Final Rule Provisions

This final rule implements section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106-398, 114 Stat. 1654), and was effective October 1, 2001. It extends TRICARE eligibility to beneficiaries age 65 and over. This beneficiary group previously lost TRICARE eligibility due to attaining entitlement to hospital insurance benefits under Part A of Medicare. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in the supplementary medical insurance program under Part B of Medicare. In general, in the case of medical or dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person. This rule prescribes TRICARE payment procedures and makes revisions to TRICARE rules to accommodate Medicare-eligible CHAMPUS beneficiaries.

The reader should refer to the interim final rule that was published on August 3, 2001, (66 FR 40601) for detailed information regarding eligibility requirements, the scope of the benefit, and other aspects of this significant expansion of the Military Health System.

We also want to clarify an erroneous statement in the preamble to the interim final rule. Since the error was in the preamble and not in the regulatory language, it does not actually affect this final rule, but we want to ensure the TRICARE policy is understood. In section C. of the supplementary information on page 40603, we stated in two places that if a TRICARE-required preauthorization is not obtained, TRICARE will make no payment. This is not correct. If a required preauthorization is not obtained, TRICARE will still pay for any covered services, but the TRICARE payment will be reduced by not less than 10 percent.

II. Public Comments

We issued this rule as an interim final rule, with comment period, as an exception to our standard practice of soliciting public comments prior to

issuance. The Assistant Secretary of Defense (Health Affairs) determined that following the standard practice would have been impracticable, unnecessary, and contrary to public interest. This determination was based on the fact that this change directly implemented a statutory entitlement enacted by Congress expressly for this purpose, with a statutory effective date of October 1, 2001. Public comments were invited, though, and we received comments from one individual.

Comment—Individuals who are over age 65, are currently employees of the U.S. Government, are retired from the military, and meet all eligibility requirements for TFL, should be able to drop their coverage under the Federal Employees Health Benefits Program (FEHBP) and subsequently re-enroll in the FEHBP during any open season with no penalty.

Response—This is permitted.

Comment—TRICARE should pay any premium and deductible costs for employer-provided insurance for individuals eligible for TFL and who are employed. Alternatively, any such costs paid by individuals eligible for TFL should be applied to that individual's catastrophic cap.

Response—TRICARE has statutory authority only to pay for medically necessary services and supplies. We have no authority to pay for the type of costs identified in this comment.

Therefore, this type of change goes beyond the regulatory process and would require a legislative change.

Comment—An individual who is eligible for TFL and is also enrolled in employer-provided health insurance should not have to file the paperwork, i.e., submit claims. Providers should be required to submit all claims.

Response—We cannot, through the regulatory process, require providers to submit claims to employer-provided health insurance plans that are primary to TRICARE. Nevertheless, we recognize that having to submit claims can present a significant burden to our beneficiaries, but there are several things that mitigate this burden. Under current procedures for both TRICARE and Medicare, providers are required to submit the claim in the vast majority of cases. More importantly, we have gone to great efforts to establish a process under TFL so that after the Medicare contractors process a claim, they send the claims directly to the appropriate TRICARE contractor with no beneficiary action required. As a result, there are almost no instances where beneficiaries have had to submit their claim to TRICARE.

III. Changes in the Final Rule

The only change we have made to the language in the interim final rule is to clarify certain provisions in § 199.17 regarding TRICARE Standard. In the interim final rule there were a number of areas where enrollment in TRICARE Standard was explicitly stated or implied. TRICARE Standard is the default coverage under TRICARE, and there is no enrollment action required of beneficiaries to be covered under Standard. We have, therefore, reworded various places in § 199.17 to ensure that this is clear. These changes have no substantive effect on the policies or procedures contained in either the interim final rule or this final rule.

IV. Regulatory Procedures

This final rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3511).

Executive Order 12866 requires certain regulatory assessments for any significant regulatory action, defined as one which would result in an annual effect on the economy of \$100 million or more, or have other substantial impacts. The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This final rule is an economically significant regulatory action under Executive Order 12866, as it implements a statutory program that has added about \$1.7 billion for DoD in annual healthcare benefit and administrative costs based on cost data collected for October 1, 2001, through September 30, 2002. These costs exclude pharmacy benefits that are addressed in the rulemaking for the TRICARE Senior Pharmacy Program. The benefits of this final rule include an increased level of health care for Medicare-eligible beneficiaries of the Department of Defense military health system. It has been determined to be major under the Congressional Review Act. However, this rule does not require a regulatory flexibility analysis, as it is not economically significant and will not significantly affect a substantial number of small entities. This rule has been designated as significant and has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866.