DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720–AA62

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)/ TRICARE; Partial Implementation of Pharmacy Benefits Program; Implementation of National Defense Authorization Act for Fiscal Year 2001

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule implements several sections of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. The rule allows coverage of physical examinations for beneficiaries ages 5 through 11 that are required in connection with school enrollment; provides an additional two-year period for survivors of deceased active-duty members to remain eligible for TRICARE medical and dental benefits at active-duty dependent rates; extends eligibility for medical and dental benefits to Medal of Honor recipients and their immediate dependents in the same manner as if the recipient were entitled to retired pay; partially implements the Pharmacy Benefits Program establishing revised co-pays and cost-shares for the prescription drug benefit; implements the TRICARE Senior Pharmacy Program by establishing a new eligibility for prescription drug benefits for Medicare-eligible retirees; allows a waiver of copayments, cost-shares, and deductibles for all Uniformed Services TRICARE eligible active duty family members residing with their TRICARE Prime Remote eligible Active Duty Service Member Sponsor within a TRICARE Prime Remote designated area until implementation of the TRICARE Prime Remote for Family Member Program or October 30, 2001, whichever is later; provides for the elimination of TRICARE Prime copayments for active duty family members enrolled in TRICARE Prime; provides for the reimbursement of reasonable travel expenses for TRICARE Prime beneficiaries referred by a primary care provider to a specialty care provider who provides services over 100 miles away; and reduces the maximum amount which retirees, their family members and survivors would be liable from $7,500 to $3,000.

EFFECTIVE DATE: April 1, 2001.

ADDRESSES: Medical Benefits and Reimbursement Systems, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, CO 80011–9043.

FOR FURTHER INFORMATION CONTACT: Tariq Shahid, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, Office of the Assistant Secretary of Defense (Health Affairs), telephone (303) 676–3801. Questions regarding payment of specific CHAMPUS claims should be addressed to the appropriate TRICARE/CHAMPUS contractor.

SUPPLEMENTARY INFORMATION:

I. Overview of the Rule

On October 30, 2000, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Public Law 106–398) was signed into law. On February 9, 2001 (66 FR 9651), DoD published an interim final rule to partially implement the Pharmacy Benefits Program and implement several sections of this Act. On February 15, 2001 (66 FR 10367), March 26, 2001 (66 FR 16400), and March 19, 2002 (67 FR 12472), DoD published administrative corrections to the interim final rule. This final rule is being published as a follow-up to the interim final rule incorporating all three of the administrative corrections. It also makes administrative corrections in Section 199.4(g)(68) and Section 199.22.

The final rule implements provisions of the Act that were effective upon the date of enactment or a date within 180 days thereafter. Specifically, this rule implements the following sections of the Act:

Section 703, school required physicals, which was effective on the date of enactment.

Section 704, two-year extension of benefits for survivors, which was effective on the date of enactment.

Section 706, benefits for Medal of Honor recipients, which was effective on the date of enactment.

Section 711, TRICARE Senior Pharmacy Program, which was effective April 1, 2001.

Section 722, that portion of TRICARE Prime Remote for Family Members that was effective on the date of enactment.

Section 752, elimination of copayments for Active Duty Dependents in TRICARE Prime, which the statute requires be implemented within 180 days.

Section 758, reimbursement of certain travel expenses for TRICARE Prime beneficiaries, which was effective on the date of enactment; and

Section 759, reduction of retiree catastrophic cap, which was effective on the date of enactment.

In addition, because of the effect on the overall pharmacy program of the new TRICARE Senior Pharmacy Program and the change in TRICARE Prime active duty dependent copayments, this rule also partially implements the Pharmacy Benefits Program, as authorized by Section 1074g of title 10, United States Code, as a significant step toward expected implementation in 2002 of the comprehensive Pharmacy Benefits Program.

II. School Required Physicals

This rule implements Section 703 of the National Defense Authorization Act for Fiscal Year 2001 which extends coverage of physical examinations to CHAMPUS eligible beneficiaries ages 5 through 11 that are required in connection with school enrollment. The scope of the legislative provision encompasses all programs and beneficiary categories. These newly covered school physicals will be recognized as preventive services, and as such, subject to the same cost-sharing/copayment and referral/authorization requirements as prescribed under TRICARE Prime and Standard/Extra clinical preventive benefits. TRICARE Prime enrollees will not be required to pay copayments or seek referral/authorization from their primary care managers (PCMs) unless they go to a non-network provider. While Standard and Extra beneficiaries will not require referral and/or authorization, they will have to pay the applicable cost-sharing and deductibles for preventive services as prescribed under their respective plans.

School physicals for TRICARE Prime enrollees ages 5 through 11 will be covered under the enhanced benefit provision of the CHAMPUS administering regulation (32 CFR 199.18(b)(3)), which allows benefit enhancements and waiver or relaxation of benefit restrictions under the Uniform HMO Benefit at the discretion of the Assistant Secretary of Defense (Health Affairs). However, since coverage also extends to both Standard and Extra beneficiaries, an exception is being added to the preventive care general exclusion (32 CFR 199.4(g)(37)) that will allow school physicals for these beneficiary categories (i.e., active duty family members, retirees and their family members that are seeking care under Standard or Extra plans).

III. Two-Year Extension of Benefits for Survivors

This rule implements Section 704 of the National Defense Authorization Act for Fiscal Year 2001 which amended

chapter 55 of title 10, United States Code, by providing a two-year extension to the one-year period for survivors of deceased active-duty members to remain eligible for TRICARE medical and dental benefits at active-duty dependent rate. Before the Authorization Act, survivors of members who die while on active duty were allowed to continue participation in TRICARE Prime, Extra, or Standard as active-duty dependent family members for a period of one year following the date of death of the deceased member. At the end of the one-year period, these family members continued eligibility for care under TRICARE, but faced higher out-of-pocket costs as non-active-duty dependents. With respect to the TRICARE dental insurance benefits, family members enrolled in the TRICARE Dental Program (TDP) at the time of the member's death, continued to receive benefits for one year from the member's date of death, with the Government paying 100 percent of the TDP premiums.

IV. Benefits for Medal of Honor Recipients

This rule implements Section 706 of the National Defense Authorization Act for Fiscal Year 2001 which amended chapter 55 of title 10, United States Code, by adding a new Section 1074h. Section 1074h expands eligibility to Medal of Honor recipients who are not otherwise entitled to medical and dental care including their immediate dependents. The term *immediate dependent* means a dependent described in title 10, United States Code, chapter 55, section 1072, (2)(A), (B), (C), or (D). They are entitled to the same medical and dental benefit that is provided to former members who are entitled to military retired pay and the dependents of those former members. To receive TRICARE/CHAMPUS benefits, they must register in the Defense Enrollment Eligibility Reporting System (DEERS). Eligible beneficiaries are required to obtain an identification card. The Medal of Honor recipients should visit the Uniformed Service identification card issuing facility nearest to them. The address for the closest location may currently be obtained by calling 1–800–538–9552. The recipient should bring a photo identification card and the departmental order or citation for the Medal of Honor. To register family members in DEERS, the following additional documentation is required: marriage license, birth certificates, and death certification or DD Form 1300, Report of Casualty if the Medal of Honor recipient is deceased.

V. Partial Implementation of Pharmacy Benefits Program

The Secretary of Defense is required under title 10, United States Code, Section 1074g, to establish an effective, efficient, and integrated Pharmacy Benefits Program. The Secretary may establish cost-sharing/copayment requirements under the Pharmacy Benefits Program as a percentage and/or fixed dollar amount for generic, formulary (non-generic), and non-formulary pharmaceutical agents. Designation of pharmaceutical agents as non-formulary will be based upon an evaluation of the agent's clinical and cost-effectiveness in comparison to other agents in the therapeutic class by the DoD Pharmacy and Therapeutics Committee and the comments on that evaluation by the Uniform Formulary Beneficiary Advisory Committee. The Department is unable to implement the portion of the Pharmacy Benefits Program that allows classification of a drug as non-formulary as outlined in section 1074g until Proposed and Final Rules fully implementing the Pharmacy Benefits Program have been published and required Committees become operational. Existing Department policies on non-formulary pharmaceutical agents remain in effect at this time. However, partial implementation of the Pharmacy Benefits Program, including reform of cost-sharing/copayment requirements under Section 1074g should proceed in connection with the April 1, 2001, start date of the TRICARE Senior Pharmacy Program and overall reform of TRICARE Prime active duty dependent copayments.

The prescription drug and medicine benefit under CHAMPUS includes the Food and Drug Administration approved drugs and medicines that by United States law require a physician's or other authorized individual professional provider's prescription (acting within the scope of their license) that has been ordered or prescribed by them. The benefit does not include prescription drugs for medical conditions that are expressly excluded from the TRICARE benefit by statute or regulation. Pharmaceutical agents are subject to preauthorization or utilization review requirements to assure medical necessity. Until full implementation of the Pharmacy Benefits Program under which all authorized drugs will be classified as generic, formulary, or non-formulary, during this period of partial implementation, drugs and medicines shall be designated as either generic drugs and medicines, which are those that have the identical chemical composition of a name brand drug or medicine, or non-generic (or brand name) drugs.

Before the effective date of this rule, cost-sharing/copayment requirements were based upon beneficiary status, enrollment or non-enrollment in TRICARE Prime, and the location where the drug or medicine was purchased, i.e., the point of sale, such as a military treatment facility, network or non-network pharmacy, or the National Mail Order Pharmacy (NMOP). This led to a complex set of cost sharing requirements, difficult for beneficiaries to understand, lacking in clear incentives for appropriate use, and inconsistent with evolving industry practice. DoD is implementing new cost sharing requirements in this regulation, consistent with the Congressional direction to modernize the pharmacy program. Cost-sharing/copayment requirements will no longer be based upon beneficiary status, except for active duty members who never pay cost-shares/copays. Cost-sharing/copayment requirements of prescription drugs and medicines based upon their status as generic or non-generic are being implemented through this rule. Cost-sharing/copayment requirements will no longer be based upon a beneficiary's enrollment or non-enrollment in TRICARE Prime (except point of service charges will still apply for beneficiaries enrolled in TRICARE Prime), but will be based upon the drug or medicine's status as generic or non-generic and its point of sale.

The new cost-sharing/copayment structure is based on commercial industry practices in pharmacy benefit design and benefit management. Cost-sharing/copayment amounts were selected to assure that all beneficiaries could obtain a reduction in their current cost-sharing/copayment through use of generic products, and that brand-name cost-sharing/copayment was substantially higher than generic without unduly penalizing beneficiaries in relation to their current cost-sharing/copayment levels.

Active duty members do not pay a cost-share/copayment. Cost-sharing/copayment requirements for pharmaceutical agents for all other beneficiaries will be based upon the generic/non-generic status and the point of sale (i.e., network pharmacy, non-network pharmacy, NMOP) from which the agent was acquired. There is a $9.00 copay per prescription required under the retail pharmacy network program for up to a 30-day supply of a non-generic drug or medicine, and a $3.00 copay for up to a 30-day supply of a generic drug or medicine. There is a $9.00 copay per

prescription required under the NMOP program for up to a 90-day supply of a non-generic drug or medicine, and a $3.00 copay for up to a 90-day supply of a generic drug or medicine. There is a 20 percent or $9.00 (whichever is greater) copay per prescription required for all drugs obtained under the retail pharmacy non-network program for up to a 30-day supply. The TRICARE Standard annual deductible of $150 individual/$300 family (or $50 individual/$100 family for lower grade enlisted families) applies only to services obtained from non-network pharmacies. The TRICARE annual catastrophic cap of $1,000 for active duty families and $3,000 for retiree families (as reduced by the Fiscal Year 2001 National Defense Authorization Act) also applies. TRICARE Prime enrollees generally face higher ''point-of-service'' cost-sharing when they obtain non-network services, as described in § 199.17(n). With regard to pharmacy services, TRICARE Prime beneficiaries who use non-network pharmacies will face point-of-service cost-sharing rather than the 20 percent cost-sharing which applies to TRICARE Standard beneficiaries. This point-of-service cost-sharing includes a deductible of $300 individual or $600 family, and a 50 percent cost-share. No deductibles apply to prescription drugs acquired from network retail pharmacies and NMOP.

The revised co-pay amounts simplify the cost-share structure and are consistent with the best business practices used in the private sector. The co-pay amounts were selected because they provide an equitable adjustment across the current co-pay matrix, will encourage the use of cost effective sources of pharmaceuticals for both the beneficiaries and the government, and will encourage the use of generic products where clinically appropriate. For most beneficiaries and in most circumstances, cost-sharing/copayments will be reduced under the new cost-sharing/copayment structure; in all cases beneficiaries will have lower costs if they use generic products. The pricing structure reflects a reduction for active duty family members using the NMOP. In some cases, beneficiaries will pay more than at present if they obtain brand-name products: active duty family members will pay $4 to $5 more for brand-name products, and retirees and their family members will pay $1.00 more for mail order brand-name products.

VI. TRICARE Senior Pharmacy Program

This rule implements Section 711 of the National Defense Authorization Act for Fiscal Year 2001, which establishes the TRICARE Senior Pharmacy Program for DoD beneficiaries who are 65 years of age and older, effective April 1, 2001. Under the TRICARE Senior Pharmacy Program, the Act requires the same coverage for pharmacy services and the same requirements for cost-sharing and reimbursement as are applicable under Section 1086 of title 10, United States Code.

As specified further in the regulation, to be eligible for the TRICARE Senior Pharmacy Program, a person is required to be a retiree, dependent, or survivor who is Medicare eligible, 65 years of age or older, and enrolled in Medicare Part B (except for a person who attained age 65 prior to April 1, 2001).

To receive benefits under the TRICARE Senior Pharmacy Program, beneficiaries must be registered in DEERS. Currently, the TRICARE Senior Pharmacy Program beneficiaries are not eligible to enroll in TRICARE Prime.

The benefit under the TRICARE Senior Pharmacy Program includes the Basic Program pharmacy benefit as found under 32 CFR 199.4(d)(vi). The senior beneficiaries are entitled to the same pharmacy benefit that was found at 32 CFR 199.17(k), but it is no longer limited to the Base Realignment and Closure (BRAC) sites and access to non-network retail drugstores is included. These beneficiaries will have access to retail network pharmacies, non-network pharmacies, and the National Mail Order Pharmacy (NMOP) program with the associated revised copays and cost-shares as described under Partial Implementation of Pharmacy Benefits Program, above. For prescription drugs acquired from non-network retail pharmacies, the Senior Pharmacy Program beneficiaries are subject to TRICARE Standard annual deductible of $150 individual/$300 family. The catastrophic cap of $3000.00 per federal fiscal year, as reduced by the Fiscal Year 2001 National Defense Authorization Act, will apply to beneficiaries who are eligible under the TRICARE Senior Pharmacy Program.

The double coverage rules in 32 CFR 199.8 are applicable to services provided to all beneficiaries under the retail pharmacy network, retail pharmacy non-network, or NMOP programs. For this purpose, to the extent they provide a prescription drug benefit, Medicare supplemental insurance plans or Medicare HMO plans are double coverage plans and will be the primary payor.

The TRICARE Senior Pharmacy Program replaces the BRAC pharmacy benefit and the Pharmacy Redesign Pilot Program in accordance with Section 711 of the Act.

VII. TRICARE Prime Remote for Family Members

This rule implements Section 722(b)(2) of the National Defense Authorization Act for Fiscal Year 2001 (Public Law 106–398) which modified Section 731(b) of the National Defense Authorization Act for Fiscal Year 1998 (Public Law 105–85). This rule provides a waiver of charges for TRICARE eligible family members residing with their active duty uniformed services TRICARE Prime Remote (TPR) eligible sponsor.

Full implementation of the TPR program for active duty family members will be subject of a proposed rule to be published soon. The TPR program will supplant the waiver of charges described in this rulemaking, effective October 30, 2001 or later. In order to obtain coverage under the follow-on TPR program, it will be proposed that eligible beneficiaries will be required to enroll in TPR and be subject to many of the rules of TRICARE Prime. Full details will be provided in the proposed rule to be published soon.

Some Active Duty Service Members (ADSM) are assigned Permanent Change of Station Orders to locations where Military Treatment Facilities are unavailable. TPR was established by Section 731(b) of the National Defense Authorization Act for Fiscal Year 1998 to provide a TRICARE Prime-like benefit. As defined by 10 U.S.C. 1074(c)(3) the benefit is for ADSM assigned to remote locations, who pursuant to that assignment, work and reside at a location that is more than 50 miles, or approximately one hour of driving time to the nearest military medical treatment facility. ADSM who are TPR eligible are required to enroll in TPR. Starting October 30, 2000, TRICARE eligible Active Duty Family Members residing with TPR eligible ADSM sponsors within a TPR designated area, have copayments, cost-shares, and deductibles waived for CHAMPUS covered benefits, except for pharmacy benefits, until the implementation of TRICARE Prime Remote for Family Members or October 30, 2001 whichever is later. Non-covered CHAMPUS benefits are not waived and shall be processed according to current requirements. The claims processor will pay the waived portion of the claim to the eligible

family member or the provider, as appropriate. If the claims processor is able to determine the eligible family member has already paid the waived portion of the claim, the processor shall reimburse the family member. Retrospective payments of waived charges for dates of service on or after October 30, 2000 are authorized.

Eligible family members will be able to access authorized providers without preauthorization for services covered by TRICARE. However, when accessing care, eligible family members are required to use network providers where and when available within the TRICARE access standards to obtain the waiver of charges. If a network provider cannot be identified within the access standards established under TRICARE, the eligible family member shall use an authorized provider to be eligible for the waiver. Existing specialty care preauthorization requirements remain in affect for eligible family members enrolled in TRICARE Prime. To the greatest extent possible, contractors will assist eligible family members in finding a TRICARE network, participating, or authorized provider.

VIII. Elimination of TRICARE Prime Copayments for Dependents of Active Duty Members

Section 752 of the National Defense Authorization Act for Fiscal Year 2001 provides that no copayment shall be charged for care provided under TRICARE Prime to a dependent of a member of the uniformed services. Copayments for prescriptions and point-of-service (POS) charges are not covered by this provision and will continue to be applied. Copayments for prescriptions will be in accordance with those authorized by 10 U.S.C. 1074g, partially implemented by this rule. This is consistent with the Conference Committee Report statement that ''it is not the intent of the conferees to eliminate copayments for pharmaceutical benefits under the mail order pharmacy program or such similar cost shares.'' (H. Conf. Rept. No 106–945, p. 819–20.) Point-of-service (POS) charges are not covered by Section 752 because they are not for care provided under TRICARE Prime, but rather for care provided outside the TRICARE Prime network structure under the POS option. The POS option allows enrollees to self-refer for non-emergency health care services to any TRICARE authorized civilian provider. The elimination of copayments applies to all CHAMPUS-covered services received by a TRICARE Prime active duty family member on or after April 1, 2001.

IX. Reimbursement of Reasonable Travel Expenses for Distant Referrals of TRICARE Prime Beneficiaries

Section 758 of the National Defense Authorization Act for Fiscal Year 2001 provides reimbursement of reasonable travel expenses for TRICARE Prime beneficiaries referred by their primary care manager to a specialty care provider who provides services more than 100 miles from the primary care manager's office.

X. Reduction of Retiree Catastrophic Cap

Section 759 of the National Defense Authorization Act for Fiscal Year 2001 modified chapter 55 of title 10, United States Code, by amending Section 1086(b)(4) and reducing the catastrophic cap on payments from $7,500 to $3,000 for retirees, their family members and survivors.

XI. Public Comments

We published the interim final rule on February 9, 2001, and provided a 60-day comment period. We received public comments from one commenter who indicated that she was writing on behalf of over 150 recruiting families remotely located in Wisconsin and the upper peninsula of Michigan. This commenter made two recommendations.

The first recommendation pertains to the coverage for school required physicals. While she applauded the addition of coverage for school required physicals for CHAMPUS eligible beneficiaries ages 5 through 11, the commenter raised concerns that the scope of such coverage with regard to age is too limited. The commenter stated that a physical examination in reality is a necessity and recommended to extend coverage for yearly physical examinations to all CHAMPUS eligible dependent children. The recommendation cannot be accommodated since the legislative language was specific regarding the requirements for coverage under the program. Section 703 of the National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106–398) restricts coverage of school physicals to beneficiaries ages 5 through 11 required in connection with school requirement. Legislative action would be required in order to extend physical examinations to all eligible dependent children.

The second recommendation pertains to the higher cost-shares for TRICARE Prime enrollees under the point-of-service option when they use non-network pharmacies. The point-of-service cost sharing includes a deductible of $300 individual or $600 family, and a 50 percent cost-share. The commenter stated that TRICARE Prime enrollees, located in areas where Military Treatment Faciities are unavailable (remote locations), face an unjust hardship financially with this rule and quite often in remote locations they do not have a choice of pharmacies for filling their prescriptions. She gave an example of a situation where a medication was not available through network pharmacies or the mail order pharmacy but was available through a non-network pharmacy and raised her concerns regarding the higher point-of-service cost sharing in this case when according to her the use of non-network pharmacy was the only choice. With reference to section 199.21(f)(4), regarding application of point-of-service cost-share of 50 percent for Prime enrollees who use non-network pharmacies without proper authorization, she requested clarification of the wording ''without proper authorization.'' The commenter recommended that TRICARE Prime enrollees should face, at most, the same cost-share and deductibles faced by TRICARE Standard beneficiaries when using non-network pharmacies. The Standard beneficiaries pay 20 percent or $9.00 copay, whichever is greater, per prescription from non-network retail pharmacies for a 30-day supply of a drug. We non-concur with the commenter's recommendation. The point-of-service cost sharing for TRICARE Prime enrollees is the same as existing policy and is simply restated in the rule for completeness. The advantages of establishing retail networks is to keep prices down for both the beneficiary and the government. Non-network pharmacies can charge the government and the beneficiary higher prices. Network pharmacies are under contract to provide services at negotiated prices. As with all national health plans, enrollees who do not take advantage of established networks will pay an additional portion of the cost-share that could have been avoided had they used the networks established by their plan sponsor. Regarding the example on availability of drugs, the availability of prescription drugs generally is the same for networks as non-network pharmacies. Normally, if a covered drug is available at a non-network pharmacy, it should also be available at a network pharmacy. If a TRICARE Prime enrollee is encountering availability problems of a specific medication, then the Managed Care Support (MCS) contractor for that TRICARE region should be contacted for

assistance. The term ''proper authorization'' applies to authorization that must be given by the MCS contractor when the enrollee requires the use of non-network source of care. The primary focus of this clause is for extenuating circumstances and situations involving out of region care. With these authorizations, enrollees are not subject to the point-of-service cost sharing. Situations for remote locations are also being addressed in a separate rule on TRICARE Prime Remote for Family Members.

All comments within DoD and from other interested federal agencies have been reviewed and considered.

XII. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any significant regulatory action, defined as one 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 rule is a significant regulatory action under Executive Order 12866, as it would add over $200 million for DoD in annual healthcare benefit costs. This cost estimate is based on historical TRICARE costs and an assessment of potential users times average benefit costs per person for each of the provisions addressed. Benefits of the rule include an increased level of health care, particularly pharmacy coverage 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 would have no significant economic impact on a substantial number of small entities. This rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511).

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, Military personnel.

The interim final rule published on February 9, 2001 (66 FR 9651), and corrected on February 15, 2001 (66 FR 10367), March 26, 2001 (66 FR 16400), and March 19, 2002 (67 FR 12472) is adopted as final with the following changes:

PART 199—[AMENDED]

1. The authority citation for part 199 continues to read as follows:

Authority: 5 U.S.C. 301; 10 U.S.C. chapter 55.

2. Section 199.3 is amended by revising paragraphs (b)(2)(i)(D), (b)(4)(iii), (f)(3)(vi) and the text of paragraph (f)(3)(vii) preceding the note to read as follows:

§ 199.3 Eligibility.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(D) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii) and (f)(3)(ix) of this section; and

* * * * *

(4) * * *

(iii) *Effective date.* The CHAMPUS eligibility established by paragraphs (b)(4)(i) and (ii) of this section is applicable to health care services provided on or after October 30, 2000.

* * * * *

(f) * * *

(3) * * *

(vi) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (b)(3), (f)(3)(vii), (f)(3)(viii) and (f)(3)(ix) of this section. (This also applies to individuals living outside the United States where Medicare benefits are not available.)

(vii) Attainment of age 65, except for dependents of active duty members, beneficiaries not eligible for Part A of Medicare, beneficiaries entitled to Part A of Medicare who have enrolled in Part B of Medicare; and as provided in paragraph (b)(3) of this section. For those who do not retain CHAMPUS, CHAMPUS eligibility is lost at 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare.

* * * * *

3. Section 199.4 is amended by revising paragraph (g)(68) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(g) * * *

(68) *Travel.* All travel even though prescribed by a physician and even if its purpose is to obtain medical care, except as specified in paragraph (a)(6) of this section in connection with a CHAMPUS-required physical examination and as specified in § 199.17(n)(2)(vi).

* * * * *

4. Section 199.22 is amended by revising paragraph (d)(1)(i) and adding a Note after paragraph (d)(1)(v) to read as follows:

§ 199.22 TRICARE Retiree Dental Program (TRDP).

* * * * *

(d) * * *

(1) * * *

(i) Members of the Uniformed Services who are entitled to retired pay, or former members of the armed forces who are Medal of Honor recipients and who are not otherwise entitled to dental benefits;

* * * * *

(v) * * *

Note to paragraphs (d)(1)(iii), (d)(1)(iv), and (d)(1)(v): Eligible dependents of Medal of Honor recipients are described in § 199.3(b)(2)(i) (except for former spouses) and § 199.3(b)(2)(ii) (except for a child placed in legal custody of a Medal of Honor recipient under § 199.3(b)(2)(ii)(H)(*4*)).

* * * * *

Dated: March 20, 2002.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 02–7862 Filed 4–2–02; 8:45 am]

BILLING CODE 5001–08–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

49 CFR Part 659

[FTA–A–2002–11440]

RIN 2132–AA69

Rail Fixed Guideway Systems; State Safety Oversight

AGENCY: Federal Transit Administration, DOT.

ACTION: Direct final rule.

SUMMARY: The Federal Transit Administration (FTA) is revising the definition of ''accident'' as used in the State Safety Oversight regulation to achieve consistency with the reporting requirements of the revised Safety and Security Module of the National Transit Database (NTD), updated February 2002. The term and definition of ''accident'' is removed and replaced with the term and definition ''major incident.''

DATES: This rule is effective July 2, 2002 unless a written adverse comment, or written notice of intent to submit an adverse comment, reaches the Docket Management Facility on or before June 3, 2002. If an adverse comment, or notice of intent to submit an adverse comment, is received, FTA will