levied is owned by the taxpayer but is used as the principal residence of the taxpayer's spouse, the taxpayer's former spouse, or the taxpayer's minor child, the Government will send a letter to each such person providing notice of the commencement of the proceeding. The letter will be addressed in the name of the taxpayer's spouse or ex-spouse, individually or on behalf of any minor children. If it is unclear who is living in the principal residence property and/or what such person's relationship is to the taxpayer, a letter will be addressed to ''Occupant''. The purpose of the letter is to provide notice to the family members that the property may be levied. The family members may not be joined as parties to the judicial proceeding because the levy attaches only to the taxpayer's legal interest in the subject property and the family members have no legal standing to contest the proposed levy.

(e) *Levy allowed on certain business assets.* The property described in section 6334(a)(13)(B)(ii) shall not be exempt from levy if—

(1) An Area Director of the Service personally approves (in writing) the levy of such property; or

(2) The Secretary finds that the collection of tax is in jeopardy. An Area Director may not approve a levy under paragraph (e)(1) of this section unless the Area Director determines that the taxpayer's other assets subject to collection are insufficient to pay the amount due, together with expenses of the proceeding. When other assets of an individual taxpayer include permits issued by a State and required under State law for the harvest of fish or wildlife in the taxpayer's trade or business, the taxpayer's other assets also include future income that may be derived by such taxpayer from the commercial sale of fish or wildlife under such permit.

(f) *Levy allowed on certain specified payments.* Any payment described in section 6331(h)(2)(B) or (C) shall not be exempt from levy if the Secretary approves the levy thereon under section 6331(h).

(g) *Inflation adjustment.* For any calendar year beginning after 1999, each dollar amount referred to in paragraphs (a)(2) and (3) of this section will be increased by an amount equal to the dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) for the calendar year (using the language ''calendar year 1998'' instead of ''calendar year 1992'' in section 1(f)(3)(B)). If any dollar amount as adjusted is not a multiple of $10, the dollar amount will be rounded to the nearest multiple of $10 (rounding up if the amount is a multiple of $5).

(h) *Effective date.* This section will apply as of the date final regulations are published in the **Federal Register**.

Robert E. Wenzel,

Deputy Commissioner for Services and Enforcement.

[FR Doc. 03–20473 Filed 8–18–03; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD 6010.8–R

RIN 0720–AA86

TRICARE Program; Coordination of Benefits Between TRICARE and the Department of Veterans Affairs

AGENCY: Office of the Secretary, DoD.

ACTION: Proposed rule.

SUMMARY: Under current rules, beneficiaries who are eligible for both TRICARE and Department of Veterans Affairs (VA) benefits may use only one program for care but cannot use both at the same time. This proposed rule changes that policy to establish VA benefits as double coverage under TRICARE, so that beneficiaries may use TRICARE benefits to augment or replace services being provided through the VA.

DATES: Public comments must be received by October 20, 2003.

ADDRESSES: Forward comments to: TRICARE Management Activity (TMA), Medical Benefits and Reimbursement Systems, 16401 East Centretech Parkway, Aurora, CO 80011–9043.

FOR FURTHER INFORMATION CONTACT: Stephen E. Isaacson, Medical Benefits and Reimbursement Systems, TMA, (303) 676–3572.

SUPPLEMENTARY INFORMATION:

Coordination of TRICARE and the Department of Veterans Affairs Benefits

According to 10 USC 1086(g) TRICARE is to ensure ''that no person eligible for health benefits under this section may be denied benefits under this section with respect to care or treatment for any service connected disability which is compensable under chapter 11 of title 38 solely on the basis that such person is entitled to care or treatment for such disability in facilities of the Department of Veterans Affairs''.

In applying this statutory provision, TRICARE has established a policy that would ensure free access to care under either program and continuity of care for beneficiaries while also ensuring that TRICARE and the Department of Veterans Affairs (VA) do not duplicate benefits. This policy allows beneficiaries to use either TRICARE or the VA for any episode of care, but they cannot use both. Often beneficiaries make the choice of which program to use, not by any definitive action, but simply by going first to either TRICARE or the VA for care. Once that is done, the other program cannot be involved. For example, if a beneficiary experiences back pain and goes to the VA for care, the beneficiary must then receive all care related to that back pain from the VA. If the beneficiary subsequently goes to a civilian physician for the back pain and submits a claim to TRICARE, TRICARE will deny the claim.

This limitation on care has been based on ''episodes of care'' which has never been fully defined under TRICARE, in either the regulation or any TRICARE manual. It is generally accepted to be all care related to a single injury or illness, but it has been left to the TRICARE managed care support contractors to actually determine what constitutes an episode of care when a claim is received that might be subject to this limitation. There has also not been any universal policy as to when an episode of care ends. Using the previous example of the beneficiary with back pain, if the beneficiary goes for thirty days without receiving any care for the back pain, does that end the episode of care? Should it be sixty days? Or ninety days? The end of the episode of care is important, because the limitation on using only TRICARE or the VA applies only to episodes of care. That is, if the beneficiary has elected to use the VA for one episode of care, the beneficiary can elect to use TRICARE for a different episode of care. That episode of care can overlap the initial episode of care if it is for a totally different injury or illness. If it is for the same injury of illness, an appropriate amount of time must have passed without the beneficiary receiving any care.

As noted above, this policy was established in order to ensure continuity of care for our beneficiaries and to ensure there was no duplication of care or payments between TRICARE and the VA. If a beneficiary is receiving care from the VA for an injury or illness, a plan of care will have been established by the VA provider, and subsequently receiving care from a different provider under TRICARE, who might decide on a different course of treatment, may actually negatively impact the beneficiary's progress. At the very least

the services from the second provider would probably be duplicative and result in unnecessary expenditures by TRICARE.

This policy has caused few problems, but there have been cases where a beneficiary has been dissatisfied with the care he/she was receiving from either TRICARE or the VA and has wanted to switch to the other program to receive services for the same episode of care. They have been unable to do so.

Section 708 of the National Defense Authorization Act for FY 2003 (Pub. L. 107–314) addresses this issue. Although it makes no change to the statutes that govern TRICARE (10 U.S.C. Chapter 55), it directs the Secretary of Defense to (1) take actions to establish a process for coordinating care between TRICARE and the VA that ensures patient safety and continuity of care while preventing diminution of access to health care from either source, and (2) prescribe a clear definition of an episode of care for use in the process of coordinating care between TRICARE and the VA.

In analyzing how best to establish this process, we have decided to change our basic policy rather than defining episode of care. By changing our policy we will ensure that no one is inadvertently denied access to care under TRICARE for which they also can receive treatment in a VA facility.

Any attempt to establish a workable definition of episode of care would require some specific and arbitrary end date which undoubtedly would be detrimental to some individual case. We also believe that there are few cases that actually are affected by this policy. For the vast majority of cases, beneficiaries decide to use either TRICARE or the VA for reasons that are important to them, and they are satisfied with continuing to receive their care from the same source.

Therefore, we propose to change our policy to include care from VA medical care facilities under the definition of double coverage for TRICARE. In support of the policy explained above, the TRICARE regulation (32 CFR Part 199) currently states that TRICARE double coverage plans do not include entitlement to receive care from VA medical care facilities. Most other coverages (insurance, medical service or health plans) are considered double coverage, which means that a beneficiary simply must submit a claim for services or supplies to the double coverage plan first. After the double coverage makes payment, TRICARE will process the claim and usually will pay the remaining liability on the claim.

The effect of our proposed change will be to enable individuals who are receiving care from the VA to change to care under TRICARE for the same episode of care. Under this policy the VA will be responsible for payment for the services they provide, either directly through their medical care facilities or through a basic ordering agreement with a civilian provider. A claim can then be submitted to TRICARE for reimbursement of any VA cost-shares. At the same time, the beneficiary may choose to receive care from a civilian provider for the episode of care that has not been arranged by the VA. Claims for this care, so long as it is medically necessary, can be submitted to TRICARE, and they will be reimbursed.

This policy eliminates the need for an arbitrary definition of an episode of care, and it ensures full freedom of choice for beneficiaries who have entitlement to both TRICARE and VA benefits. While there may be some remaining issue regarding continuity of care and duplicative care for a very few cases, this is largely mitigated by the fact that many TRICARE beneficiaries are enrolled in TRICARE Prime. Under Prime, all care is coordinated by an assigned Primary Care Manager who can ensure that any care received under TRICARE does not interfere with or duplicate care being provided by the VA.

Regulatory Procedures

Executive Order (EO) 12866 requires that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one which would result in an annual effect of $100 million or more on the national economy or which would 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 has been designated as significant and has been reviewed by the Office Management and Budget as required under the provisions of E.O. 12866. In addition, we certify that this proposed rule will not significantly affect a substantial number of small entities.

Paperwork Reduction Act

This rule imposes no burden as defined by the Paperwork Reduction Act of 1995.

List of Subjects in 32 CFR Part 199

Claims, handicapped, health insurance, and military personnel.

Accordingly, 32 CFR part 199 is proposed to be amended as follows:

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 199.2 is proposed to be amended by revising the definition *double coverage plan* as follows.

§ 199.2 Definitions.

* * * * *

(b) * * *

* * * * *

Double coverage plan. The specific insurance, medical service or health plan under which a CHAMPUS beneficiary has entitlement to medical benefits that duplicate CHAMPUS benefits in whole or in part. Double coverage plans do not include;

(i) Medicaid.

(ii) Coverage specifically designed to supplement CHAMPUS benefits.

(iii) Entitlement to receive care from the Uniformed Services medical facilities;

(iv) Part C of the Individuals with Disabilities Education Act for services and terms provided in accordance with Part C of the IDEA that are medically or psychologically necessary in accordance with the Individualized Family Service plan and that are otherwise allowable under the CHAMPUS Basic Program or the Program for Persons with Disabilities.

* * * * *

3. Section 199.8 is proposed to be amended by redesignating existing paragraphs (b)(3) and (b)(4) as (b)(4) and (b)(5) respectively, and adding a new paragraph (b)(3) to read as follows:

§ 199.8 Double coverage plan.

* * * * *

(b) * * *

(3) Entitlement to receive care from VA medical care facilities.

* * * * *

Dated: August 12, 2003.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 03–21012 Filed 8–18–03; 8:45 am]

BILLING CODE 5001–08–M