

of the additional first year depreciation deduction claimed for the asset that is attributable to the disposed portion; and

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Legal Processing Division, Associate Chief
Counsel (Procedure and Administration).*

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DoD-2010-HA-0068]

RIN 0720-AB39

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Retired Reserve

AGENCY: Office of the Secretary,
Department of Defense.

ACTION: Final rule.

SUMMARY: TRICARE Retired Reserve (TRR) is a premium-based TRICARE health plan available for purchase worldwide by qualified members of the Retired Reserve and by qualified survivors of TRR members. This final rule responds to public comments received to an interim final rule that was published in the **Federal Register** on August 6, 2010 (75 FR 47452-47457). That rule established requirements and procedures to implement the TRR program in fulfillment of section 705 of the National Defense Authorization Act for Fiscal Year 2010 (NDAA-10) (Pub. L. 111-84). This final rule also revises requirements and procedures as indicated.

DATES: This rule is effective January 30, 2015.

FOR FURTHER INFORMATION CONTACT: Jody Donehoo, Defense Health Agency, TRICARE Health Plan, telephone (703) 681-0039. Questions regarding payment of specific claims under the TRICARE allowable charge method should be addressed to the appropriate TRICARE contractor.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

A. Overview

An interim final rule was published in the **Federal Register** on August 6, 2010 (75 FR 47452-47457), that established requirements and procedures to implement the TRICARE Retired Reserve program in fulfillment

of section 705 of the National Defense Authorization Act for Fiscal Year 2010 (NDAA-10) (Pub. L. 111-84). Section 705 added new section 1076e to Title 10, United States Code. Section 1076e allows members of the Retired Reserve who are qualified for non-regular retirement, but are not yet 60 years of age, as well as certain survivors to qualify to purchase medical coverage equivalent to the TRICARE Standard (and Extra) benefit unless that member is either enrolled in, or eligible to enroll in, a health benefits plan under Chapter 89 of Title 5, United States Code.

B. Public Comments

The interim final rule was published in the **Federal Register** on August 6, 2010. We received 92 online comments. We thank those who provided comments. Specific matters raised by those who submitted comments are summarized below.

II. Provisions of the Rule Regarding the TRICARE Retired Reserve Program

A. Establishment of the TRICARE Retired Reserve Program (§ 199.25(a))

1. *Provisions of Interim Final Rule.* This paragraph describes the nature, purpose, statutory basis, scope, and major features of TRICARE Retired Reserve, a premium-based medical coverage program that was made available for purchase worldwide by certain members of the Retired Reserve, their family members and their surviving family members. TRICARE Retired Reserve is authorized by 10 U.S.C. 1076e.

The major features of the program include making coverage available for purchase by any Retired Reserve member who is qualified for non-regular retirement, but is not yet 60 years of age, unless that member is either enrolled in, or eligible to enroll in, a health benefit plan under Chapter 89 of Title 5, United States Code, as well as certain survivors of Retired Reserve members as specified below. The amount of the premium that qualified members and qualified survivors pay is prescribed by the Assistant Secretary of Defense for Health Affairs (ASD(HA)) and determined using an appropriate actuarial basis. There is one premium for member-only coverage and a second premium for member and family coverage. Additionally, TRICARE rules outlined in Part 199 of Title 32 of the CFR relating to the TRICARE Standard and Extra programs apply unless otherwise specified.

Under TRICARE Retired Reserve, qualified members (or their qualified survivors) may purchase either the

member-only type of coverage or the member and family type of coverage by submitting a completed request in the appropriate format along with an initial payment of the applicable premium at the time of enrollment. When their coverage becomes effective, TRICARE Retired Reserve beneficiaries receive the TRICARE Standard (and Extra) benefit. TRICARE Retired Reserve features the deductible and cost sharing provisions of the TRICARE Standard (and Extra) plan for retired members and dependents of retired members. Both the member and the member's covered family members are provided access priority for care in military treatment facilities on the same basis as retired members and their family members who are not enrolled in TRICARE Prime.

2. *Analysis of Major Public Comments.* Three commenters suggested alternative plans to include a Preferred Provider Organization (PPO) with group discount until age 60; eligibility for Reserve Retirees to use the Department of Veterans Affairs health care benefits and services; and a tier system that would allow a member to reduce premiums by choosing higher deductibles. Another commenter suggested a tier system with higher deductibles or different options for cost shares and deductibles.

Three commenters requested the implementation/passing of the TRR benefit. One commenter inquired how TRR fits into "Health Care Reform" making health care affordable for every citizen.

Response. In regards to the comments suggesting alternative plans, we observed that the specific provisions of the law governing TRR does not allow implementation of alternative plans as suggested. In fulfillment of law, TRR is a premium-based TRICARE health plan that features the cost sharing, deductible, and catastrophic cap provisions of TRICARE Standard (and Extra) as they pertain to retirees and their family members.

TRICARE Extra is similar to a PPO. TRICARE Standard beneficiaries, including TRR members and their covered family members, are using TRICARE Extra when they receive care from a provider in the TRICARE Network. TRICARE Extra features cost shares that are five percent lower than TRICARE Standard cost shares. All Department of Veterans Affairs hospitals and clinics nationwide currently are in the TRICARE Network through active agreements with TRICARE contractors.

Multiple premium tiers with various levels of deductibles would not be allowed by the statutory provisions that require TRR to be offered under one

program with one monthly premium rate for individual coverage and one monthly premium rate for family coverage.

In regards to the comments requesting the implementation/passing of the TRR benefit, Section 705 of the NDAA for FY 2010 was enacted into law on October 28, 2009; it was implemented by interim final rule effective August 6, 2010; and TRR officially launched September 1, 2010 with health care coverage available beginning October 1, 2010.

In regards to the Affordable Care Act comment, the statutory provisions of that Act did not amend any of the statutes that govern the military health system. Nonetheless, we have projected for a small influx of qualified members of the Retired Reserve into TRR beginning in 2014 when the new mandates for individuals to have health insurance coverage go into effect under the Act.

It should be noted that legislative action subsequent to enactment of Affordable Care Act resulted in TRICARE establishing a program called TRICARE Young Adult. Similar to young adult coverage under the Affordable Care Act, TRICARE Young Adult offers full-cost, premium-based TRICARE coverage for purchase by qualified young adults who have a parent with TRICARE coverage. See the TRICARE Young Adult Interim Final Rule published in the **Federal Register** on April 27, 2011 (76 FR 23479–23485) for details.

3. *Provisions of the Final Rule.* We clarified that certain special programs established in 32 CFR part 199 are not available to members covered under TRICARE Retired Reserve (§ 199.25(a)(4)(i)(B)). We clarified that TRICARE Retired Reserve coverage features the deductible, cost sharing, and catastrophic cap provisions of the TRICARE Standard (and Extra) plan applicable to retired members and dependents of retired members (§ 199.25(a)(4)(iv)). We corrected the cross-reference to § 199.17(d)(1)(i)(E) of this part regarding access priority for care in military treatment facilities for the member and the member's covered family members (§ 199.25(a)(4)(iv)). Otherwise, the final rule is consistent with the interim final rule (75 FR 47452–47457, August 6, 2010).

B. Qualifications for TRICARE Retired Reserve Coverage (§ 199.25(b))

1. *Provisions of Interim Final Rule.* This paragraph defines the statutory conditions under which members of a Reserve Component may qualify to purchase TRICARE Retired Reserve coverage. The Reserve Components of

the armed forces have the responsibility to determine and validate a member's qualifications to purchase TRICARE Retired Reserve coverage. The member's Service personnel office is responsible for keeping the Defense Enrollment Eligibility Reporting System (DEERS) current with eligibility data.

A member qualifies to purchase TRICARE Retired Reserve coverage if the member meets both of the following conditions:

(a) Is a member of the Retired Reserve of a Reserve component of the armed forces who is qualified for a non-regular retirement at age 60 under chapter 1223 of title 10, U.S.C., but is not age 60; and

(b) is not enrolled, or eligible to enroll, in a health benefits plan under chapter 89 of title 5, U.S.C.

If a qualified member of the Retired Reserve dies while in a period of TRICARE Retired Reserve coverage, the immediate family member(s) of such member shall remain qualified to continue existing or purchase new TRICARE Retired Reserve coverage until the date on which the deceased member of the Retired Reserve would have attained age 60 as long as they meet the definition of immediate family member specified below. This applies regardless of whether either member-only coverage or member and family coverage was in effect on the day of the TRICARE Retired Reserve member's death.

2. *Analysis of Major Public Comments.* No public comments were received relating to this section of the rule.

3. *Provisions of the Final Rule.* We clarified the exclusion involving the Federal Employee Health Benefits (FEHB) program. Section 199.25(b)(1)(ii) specifies that a member of the Retired Reserve qualifies to purchase TRICARE Retired Reserve coverage if the member is not enrolled in, or eligible to enroll in, a health benefits plan under chapter 89 of title 5, U.S.C. That statute has been implemented under part 890 of title 5, CFR as the "Federal Employee Health Benefits" program. For purposes of the FEHB program, the terms "enrolled," "enroll" and "enrollee" are defined in section 890.101 of title 5, CFR. Otherwise, the final rule is consistent with the interim final rule.

C. TRICARE Retired Reserve Premiums (§ 199.25(c))

1. *Provisions of Interim Final Rule.* Members are charged premiums for coverage under TRICARE Retired Reserve that represent the full cost of providing the TRICARE Standard (and Extra) benefit under this program. The total annual premium amounts shall be determined by the ASD(HA) using an

appropriate actuarial basis and are established and updated annually, on a calendar year basis, by the ASD(HA) for qualified members of the Retired Reserve for each of the two types of coverage, member-only coverage and member-and-family coverage. Premiums are to be paid monthly. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

A surviving family member of a Retired Reserve member who qualified for TRICARE Retired Reserve coverage as described herein will pay premium rates at the member-only rate if there is only one surviving family member to be covered by TRICARE Retired Reserve and at the member and family rate if there are two or more survivors to be covered.

The appropriate actuarial basis used for calculating premium rates shall be one that most closely approximates the actual cost of providing care to the same demographic population as those enrolled in TRICARE Retired Reserve as determined by the ASD(HA). TRICARE Retired Reserve premiums shall be based on the actual costs of providing benefits to TRICARE Retired Reserve members and their family members during the preceding years if the population of Retired Reserve members enrolled in TRICARE Retired Reserve is large enough during those preceding years to be considered actuarially appropriate. Until such time that actual costs from those preceding years become available, TRICARE Retired Reserve premiums shall be based on the actual costs during the preceding calendar years for providing benefits to the population of retired members and their family members in the same age categories as the Retired Reserve population in order to make the underlying group actuarially appropriate.

An adjustment may be applied to cover overhead costs for administration of the program by the government. Additionally, premium adjustments may be made to cover the prospective costs of any significant program changes or any actual experience in the costs of administering the TRICARE Retired Reserve program.

For the portion of calendar year 2010 during which the program is in effect, the monthly premium for member-only coverage will be \$388.31/month (annual premium \$4,659.72/year), and the monthly premium for member and family coverage will be \$976.41/month (annual premium \$11,716.92/year). The 2010 premiums are based on the actual costs during calendar years 2007 and 2008 for providing benefits to the

population of retired members and their family members in the same age categories as the Retired Reserve population in order to make the underlying group actuarially appropriate. The historical costs were trended forward to 2010 and a two-percent adjustment was applied to cover overhead costs for administration of the program by the government.

2. *Analysis of Major Public Comments.* Seventy-six of the commenters expressed that the premiums were too high. Six commenters requested that the TRR premium-rate calculations be investigated or reviewed. One commenter suggested a separate premium be established for member-plus-spouse-only. One commenter requested employers be allowed to pay members' monthly TRR premiums. One commenter suggested that TRR should not cost one third more than Continued Health Care Benefit Program. One commenter requested the Fiscal Year 2012 premium rates.

Response. We recognize that the premiums were much higher than many expected. In fulfillment of law, TRR premiums represent the full cost of delivering the benefit without the Department of Defense absorbing any of the cost. In other words, the Department cannot cover or share any of the cost of the premiums by law; TRR members pay full-cost premiums.

TRR premiums were determined on an appropriate actuarial basis using actual costs during preceding calendar years for providing benefits to the population of retired members and their family members in the same age categories as the Retired Reserve population in order to make the underlying group actuarially appropriate. In other words, the data-driven premiums were derived from highly relevant actual TRICARE cost data. This approach is very similar to the approach we used for TRICARE Reserve Select (TRS) in fulfillment of applicable law; however, premiums payable by members in TRS represent only twenty-eight percent of the actual cost of TRS coverage delivered in preceding years.

We endeavored to be very open and transparent with the detailed information that we provided in the preamble of the interim final rule about the establishment of TRR premiums. Nonetheless, we would be glad to participate in a Congressionally-directed request or a request under proper and applicable authority as appropriate to study the actuarial approach used to establish the TRR premium rates.

In regard to the comment about a separate premium for member plus spouse only, we were required by law to establish only two monthly premium rates: One rate for TRR member-only coverage and one rate for TRR member and family coverage.

In regard to the comment about allowing employers to pay members' monthly TRR premiums, law requires members to pay premiums for their purchased TRR coverage.

In regard to the comment comparing TRR premiums to premiums for the Continued Health Care Benefit Program, note that these are two separate and distinct programs under law and regulation with different requirements for premium establishment for each. A final rule was published September 16, 2011 (76 FR 57637-41) that describes the applicable requirements for establishing Continued Health Care Benefit Program premiums.

In regards to the question about the fiscal year 2012 premiums, the Assistant Secretary of Defense for Health Affairs established the calendar year 2012 premiums as required by regulation on August 24, 2011 and posted them as Health Affairs Policy 11-013 on the Health Affairs Web site, www.health.mil. For calendar year 2012, the TRR premium for member-only coverage was \$419.72/month (annual premium \$5,036.64/year), which represented a 2.9% increase over the 2011 rate. The 2012 premium for TRR member and family coverage was \$1,024.43/month (annual premium \$12,293.16/year), which represented a 0.4% increase over the 2011 rate. The 2012 premiums were based on the actual costs during calendar years 2009 and 2010 for providing benefits to the population of retired members and their family members in the same age categories as the Retired Reserve population in order to make the underlying group actuarially appropriate. The historical costs were trended forward to 2012 and a two percent adjustment was applied to cover overhead costs for administration of the program by the government.

The calendar year 2013 premiums were established and posted on the Health Affairs Web site, www.health.mil, on September 13, 2011 as Health Affairs Policy 12-008.

We also clarified that the Director, Healthcare Operations in the Defense Health Agency may establish procedures for administrative implementation related to premiums (§ 199.25(c)).

3. *Provisions of the Final Rule.* We made one minor administrative clarification that premiums are to be

paid monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the Director, Healthcare Operations in the Defense Health Agency (§ 199.25(c)). We added a cross-reference to paragraph (d)(1) of this section where each of the two types of coverage, member-only coverage and member-and-family coverage are described (§ 199.25(c)(1)). Otherwise, the final rule is consistent with the interim final rule.

D. Procedures (§ 199.25(d))

1. *Provisions of Interim Final Rule.* The Director, TRICARE Management Activity (TMA), may establish procedures for the following:

—*Purchasing Coverage.* Procedures may be established for a qualified member, including surviving family members, to purchase one of two types of coverage: Member-only coverage or member-and-family coverage.

Immediate family members of the Retired Reserve member may be included in such family coverage. To purchase either type of TRICARE Retired Reserve coverage, Retired Reserve members or their survivors qualified as above must complete and submit a request in the appropriate format, along with an initial payment of the applicable premium required above.

—*Continuation Coverage.* Procedures may be established for a qualified member or qualified survivor to purchase TRICARE Retired Reserve coverage with an effective date immediately following the date of termination of coverage under another TRICARE program.

—*Qualifying Life Event.* Procedures may be established for a qualified member or qualified survivor to purchase TRICARE Retired Reserve coverage on the occasion of a qualifying life event that changes the immediate family composition (e.g., birth, death, adoption, divorce, etc.). The effective date for TRICARE Retired Reserve coverage will coincide with the day of the qualifying life event. It is the responsibility of the member to provide personnel officials with the necessary evidence required to substantiate the change in immediate family composition. Personnel officials will update DEERS in the usual manner. Appropriate action will be taken upon receipt of the completed request in the appropriate format along with an initial payment of the applicable premium in accordance with established procedures.

- Open Enrollment.* Procedures may be established for a qualified member or qualified survivor to purchase TRICARE Retired Reserve coverage at any time. The effective date of coverage will coincide with the first day of a month.
- Survivor coverage under TRICARE Retired Reserve.* Procedures may be established for a surviving family member of a Retired Reserve member who qualified for TRICARE Retired Reserve coverage as described above to continue existing or to purchase new TRICARE Retired Reserve coverage. Procedures similar to those for qualifying life events may be established for a qualified surviving family member to purchase new or continuing coverage with an effective date coinciding with the day of the member's death. Procedures similar to those for open enrollment may be established for a qualified surviving family member to purchase new coverage at any time with an effective date coinciding with the first day of a month.
- Changing type of coverage.* Procedures may be established for TRICARE Retired Reserve members or qualified survivors to request to change type of coverage during open enrollment or on the occasion of a qualifying life event that changes immediate family composition as described above by submitting a completed request in the appropriate format.
- Termination.* Termination of coverage for the member will result in termination of coverage for the member's family members in TRICARE Retired Reserve, except for qualified survivors as described above.
- Coverage will terminate whenever a member (or qualified survivors) ceases to meet the qualifications for the program. For purposes of this section, the member no longer qualifies for TRICARE Retired Reserve when the member has been eligible for more than 60 days for coverage in a health benefits plan under Chapter 89 of Title 5, U.S.C. This affords the member sufficient time to make arrangements for health coverage and avoid any lapses in health coverage. Further, coverage shall terminate when the Retired Reserve member attains the age of 60 or, if survivor coverage is in effect, when the deceased Retired Reserve member would have attained the age of 60.
- Coverage may terminate for members who gain coverage under another TRICARE program.
- Failure to make a premium payment in a timely manner in accordance with established procedures will result in termination of coverage for the member and any covered family members and will result in denial of claims for services with a date of service after the effective date of termination.
- Procedures may be established for covered members and survivors to request termination of coverage at any time by submitting a completed request in the appropriate format.
- Members whose coverage under TRICARE Retired Reserve terminates upon their request or for failure to pay premiums will not be allowed to purchase coverage under TRICARE Retired Reserve to begin again for a period of one year following the effective date of termination.
- Processing.* Upon receipt of a completed request in the appropriate format, the appropriate enrollment actions will be processed into DEERS in accordance with established procedures.
- Periodic revision.* Periodically, certain features, rules or procedures of TRICARE Retired Reserve may be revised. If such revisions will have a significant effect on members' or survivors' costs or access to care, members or survivors may be given the opportunity to change their type of coverage or terminate coverage coincident with the revisions.
- 2. Analysis of Major Public Comments.** No public comments were received relating to this section of the rule.
- 3. Provisions of the Final Rule.** We clarified that the Director, Healthcare Operations in the Defense Health Agency may establish procedures for TRR (§ 199.25(d)). We added a cross-reference for immediate family members of the Retired Reserve member that may be included in such family coverage (§ 199.25(d)(1)).
- We clarified the rule that procedures may be established for TRR coverage to be suspended for up to one year followed by final termination for members or qualified survivors if they fail to make premium payments in accordance with established procedures or otherwise if they request suspension/termination of coverage (§ 199.25(d)(3)). Suspension/termination of coverage for the TRR member/survivor will result in suspension/termination of coverage for the member's/survivor's family members in TRICARE Retired Reserve, except as described in § 199.25(d)(1)(iv). Procedures may be established for the suspension to be lifted upon request before final termination is applied.
- E. Preemption of State Laws (§ 199.25(e))**
- 1. Provisions of Interim Final Rule.** This paragraph explains that the preemptions of State and local laws established for the TRICARE program also apply to TRICARE Retired Reserve. Any State or local law or regulation pertaining to health insurance, prepaid health plans, or other health care delivery, administration, and financing methods is preempted and does not apply in connection with TRICARE Retired Reserve.
- This includes State and local laws imposing premium taxes on health insurance carriers, underwriters or other plan managers, or similar taxes on such entities. Preemption does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees or other payments are applicable to a broad range of business activity. For the purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).
- 2. Analysis of Major Public Comments.** No public comments were received relating to this section of the rule.
- 3. Provisions of the Final Rule.** The final rule is consistent with the interim final rule.
- F. Administration (§ 199.25(f))**
- 1. Provisions of Interim Final Rule.** This paragraph provides that the Director, TRICARE Management Activity, may establish other rules and procedures necessary for the effective administration of TRICARE Retired Reserve and may authorize exceptions to requirements of this section, if permitted by law, based on extraordinary circumstances.
- 2. Analysis of Major Public Comments.** No public comments were received relating to this section of the rule.
- 3. Provisions of the Final Rule.** We clarified this provision by removing the phrase, "based on extraordinary circumstances" and clarified that the Director, Healthcare Operations in the Defense Health Agency has authority to perform this activity.

G. Terminology (§ 199.25(g))

1. Provisions of Interim Final Rule. The following terms are applicable to the TRICARE Retired Reserve program.

—Coverage. This term means the medical benefits covered under the TRICARE Standard or Extra programs as further outlined in other sections of part 199 of Title 32 of the Code of Federal Regulations, whether delivered in military treatment facilities or purchased from civilian sources.

—Immediate family member. This term means spouse (except former spouse) as defined in § 199.3(b)(2)(i) of this part, or child as defined in § 199.3(b)(2)(ii).

—Qualified member. This term means a member who has satisfied all the criteria that must be met before the member is authorized for TRR coverage.

—Qualified survivor. This term means an immediate family member who has satisfied all the criteria that must be met before the survivor is authorized for TRR coverage.

2. Analysis of Major Public Comments. One commenter wondered if the enrollment eligibility of divorced spouses that have been granted a portion of a reserve member’s retirement benefits had been addressed.

Response. We mentioned that spouses of qualified Retired Reserve members (but not former spouses) are included in TRR member and family coverage. This can be found in this terminology section.

3. Provisions of the Final Rule. The final rule is consistent with the interim final rule.

III. Regulatory Procedures

Executive Order 12866, “Regulatory Planning and Review” and Public Law 96–354, “Regulatory Flexibility Act” (5 U.S.C. 601)

Executive Order 12866 requires that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one that 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 is not an economically significant regulatory action and will not have a

significant impact on a substantial number of small entities for purposes of the RFA, thus this final rule is not subject to any of these requirements.

Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511)

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).

Executive Order 13132, “Federalism”

We have examined the impact(s) of the final rule under Executive Order 13132 and it does not have policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, therefore, consultation with State and local officials is not required.

Sec. 202, Public Law 104–4, “Unfunded Mandates Reform Act”

This rule does not contain unfunded mandates. It does not contain a Federal mandate that may result in the expenditure by State, local and tribal governments, in aggregate, or by the private sector, of \$100 million or more in any one year.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, and Military personnel.

Accordingly, 32 CFR part 199 is 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. Amend § 199.25 to read as follows.

■ a. Revise paragraphs (a)(4)(i)(B) and (a)(4)(iv).

■ b. Revise paragraph (b)(1)(ii).

■ c. Revise paragraphs (c) introductory text and (c)(1)(i).

■ d. Revise paragraphs (d) introductory text, (d)(1) introductory text, (d)(3) introductory text, (d)(3)(iii), (d)(3)(iv), and (d)(3)(v).

■ e. Revise paragraph (f).

The revisions read as follows:

§ 199.25 TRICARE Retired Reserve.

(a) * * *

(4) * * *

(i) * * *

(B) Certain special programs established in 32 CFR part 199 are not available to members covered under

TRICARE Retired Reserve. The Extended Health Care Option (ECHO) program (sec. 199.5) is not included. The Supplemental Health Care Program (sec. 199.16) is not included, except when a TRICARE Retired Reserve covered beneficiary is referred by a Military Treatment Facility (MTF) provider for incidental consults and the MTF provider maintains clinical control over the episode of care. The TRICARE Retiree Dental Program (sec. 199.13) is independent of this program and is otherwise available to all members who qualify for the TRICARE Retiree Dental Program whether or not they purchase TRICARE Retired Reserve coverage. The Continued Health Care Benefits Program (sec. 199.13) is also independent of this program and is otherwise available to all members who qualify for the Continued Health Care Benefits Program.

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(iv) Benefits. When their coverage becomes effective, TRICARE Retired Reserve beneficiaries receive the TRICARE Standard (and Extra) benefit including access to military treatment facilities on a space available basis and pharmacies, as described in § 199.17 of this part. TRICARE Retired Reserve coverage features the deductible, cost sharing, and catastrophic cap provisions of the TRICARE Standard (and Extra) plan applicable to retired members and dependents of retired members. Both the member and the member’s covered family members are provided access priority for care in military treatment facilities on the same basis as retired members and their dependents who are not enrolled in TRICARE Prime as described in § 199.17(d)(1)(i)(E).

(b) * * *

(1) * * *

(ii) Is not enrolled in, or eligible to enroll in, a health benefits plan under chapter 89 of title 5, U.S.C. That statute has been implemented under part 890 of title 5, CFR as the Federal Employee Health Benefits (FEHB) program. For purposes of the FEHB program, the terms “enrolled,” “enroll” and “enrollee” are defined in § 890.101 of title 5, CFR.

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(c) TRICARE Retired Reserve premiums. Members are charged premiums for coverage under TRICARE Retired Reserve that represent the full cost of the program as determined by the Director, Defense Health Agency utilizing an appropriate actuarial basis for the provision of the benefits provided under the TRICARE Standard and Extra programs for the TRICARE Retired Reserve eligible beneficiary population. Premiums are to be paid

monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the Director, Healthcare Operations in the Defense Health Agency. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

(1) *Annual establishment of rates.*—(i) TRICARE Retired Reserve monthly premium rates shall be established and updated annually on a calendar year basis by the ASD(HA) for each of the two types of coverage, member-only coverage and member-and-family coverage as described in paragraph (d)(1) of this section.

* * * * *

(d) *Procedures.* The Director, Healthcare Operations in the Defense Health Agency, may establish procedures for the following.

(1) *Purchasing Coverage.* Procedures may be established for a qualified member to purchase one of two types of coverage: Member-only coverage or member and family coverage. Immediate family members of the Retired Reserve member as specified in paragraph (g)(2) of this section may be included in such family coverage. To purchase either type of TRICARE Retired Reserve coverage for effective dates of coverage described below, Retired Reserve members and survivors qualified under either paragraph (b)(1) or (b)(2) of this section must submit a request in the appropriate format, along with an initial payment of the applicable premium required by paragraph (c) of this section in accordance with established procedures.

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(3) *Suspension and Termination.* Suspension/termination of coverage for the TRR member/survivor will result in suspension/termination of coverage for the member's/survivor's family members in TRICARE Retired Reserve, except as described in paragraph (d)(1)(iv) of this section. Procedures may be established for coverage to be suspended and/or terminated as follows.

* * * * *

(iii) Coverage may be suspended and finally terminated for members/survivors who fail to make premium payments in accordance with established procedures.

(iv) Coverage may be suspended and finally terminated for members/survivors upon request at any time by submitting a completed request in the appropriate format in accordance with established procedures.

(v) Under paragraph (d)(3)(iii) or (d)(3)(iv) of this section, TRICARE Retired Reserve coverage may first be

suspended for a period of up to one year followed by final termination. Procedures may be established for the suspension to be lifted upon request before final termination is applied.

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(f) *Administration.* The Director, Healthcare Operations in the Defense Health Agency may establish other rules and procedures for the effective administration of TRICARE Retired Reserve, and may authorize exceptions to requirements of this section, if permitted by law.

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Dated: December 22, 2014.

Aaron Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DOD-2013-HA-0164]

RIN 0720-AB61

TRICARE; Coverage of Care Related to Non-Covered Initial Surgery or Treatment

AGENCY: Office of the Secretary, Department of Defense.

ACTION: Final rule.

SUMMARY: This final rule revises the limitations on certain TRICARE basic program benefits. More specifically, it allows coverage for otherwise covered services and supplies required in the treatment of complications (unfortunate sequelae), as well as medically necessary and appropriate follow-on care, resulting from a non-covered incident of treatment provided pursuant to a properly granted Supplemental Health Care Program waiver. This final rule amends two provisions of the TRICARE regulations which limits coverage for the treatment of complications resulting from a non-covered incident of treatment, and which expressly excludes from coverage in the Basic Program services and supplies related to a non-covered condition or treatment.

DATES: This final rule is effective January 30, 2015.

FOR FURTHER INFORMATION CONTACT: Thomas Doss (703) 681-7512.

SUPPLEMENTARY INFORMATION:

Executive Summary

A. Purpose of Regulatory Action

Need for the Regulatory Action

This final rule is necessary for consistency with existing regulatory provisions and to protect TRICARE beneficiaries from incurring unnecessary financial hardships arising from the current regulatory restrictions that prohibit TRICARE coverage of the treatment of complications resulting from certain non-covered medical procedures. On occasion, an authorized official of a uniformed service may request from the Director, Defense Health Agency (DHA) a waiver of TRICARE regulatory restrictions or limitations, when the waiver is necessary to assure adequate availability of health care services to the active duty member. In those cases when a waiver has been properly granted under § 199.16(f), this rule grants benefits coverage for otherwise covered services and supplies required for treating complications arising from the non-covered incident of treatment provided in the private sector pursuant to the waiver. Additionally, with respect to care that is related to a non-covered initial surgery or treatment, the final rule seeks to eliminate any confusion regarding what services and supplies will be covered by TRICARE and under what circumstances they will be covered.

Legal Authority for the Regulatory Action

This regulation is finalized under the authorities of 10 U.S.C. 1073, which authorizes the Secretary of Defense to administer the medical and dental benefits provided in 10 U.S.C. chapter 55. The Department is authorized to provide medically necessary and appropriate treatment for mental and physical illnesses, injuries and bodily malfunctions, including hospitalization, outpatient care, drugs, treatment of medical and surgical conditions and other types of health care outlined in 10 U.S.C. 1077(a). Although section 1077 defines benefits to be provided in the Military Treatment Facilities (MTFs), these benefits are incorporated by reference into the benefits provided in the civilian health care sector to active duty family members and retirees and their dependents through sections 1079 and 1086 respectively.

B. Summary of the Final Rule

The final rule amends the existing special benefit provision regarding complications (unfortunate sequelae) resulting from non-covered initial