INTERNAL REVENUE SERVICE

26 CFR Part 1

Filing of Consolidated Returns

CFR Correction

In Title 26 of the Code of Federal Regulations, Part 1 (§ 1.1401 to End), revised as of April 1, 2000, in § 1.1502–75, paragraph (k) is corrected by correctly revising ''See § 1.338(h)(10)–T(d)(7)'' to read ''See § 1.338(h)(10)–1T(d)(7)''.

[FR Doc. 01–55500 Filed 2–8–01; 8:45 am]

BILLING CODE 1505–01–D

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 Medical Benefits for Fiscal Year 2001

AGENCY: Office of the Secretary, DoD.

ACTION: Interim final rule.

SUMMARY: This interim 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 copays 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. The Department is publishing this rule as an interim final rule in order to meet statutorily required effective dates. Public comments, however, are invited and will be considered as to possible revisions to this rule.

DATES: This rule is effective April 10, 2001. Written comments will be accepted until April 10, 2001.

ADDRESSES: Forward comments to 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 (Pub. L. 106–398) was signed into law. This interim final rule implements provisions of this Act that were effective upon the date of enactment or a date within 180 days thereafter. Specifically, this rule implements the following sections of this 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 is 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 late in 2001 of the comprehensive Pharmacy Benefits Program.

II. School Requried 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 (i.e., coverage extends to active duty dependents, retirees and their dependents under TRICARE Prime, Standard and Extra plans). 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 will be 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, replacing the one-year period with an additional two-year extension 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. 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).

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 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 Department of Defense (DoD) Pharmacy and Therapeutics Committee and the comments of 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 until Proposed and Final Rules fully implementing the Pharmacy Benefits Program have been published and required Committees become operational. However, partial implementation of the Pharmacy Benefits Program, including reform of cost sharing requirements under Section 1074g should proceed now 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.

Up to now, cost sharing requirements have been based upon beneficiary status, enrollment or non-enrollment in TRICARE Prime, and the location where the drug or medicine is 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 requirements will no longer be based upon beneficiary status, except for active duty members who never pay copays. Cost sharing requirements of prescription drugs and medicines based upon their status as generic or non-generic are being implemented through this interim final rule. Cost sharing 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), 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 structure is based on commercial industry practices in pharmacy benefit design and benefit management. Cost sharing amounts were selected to assure that all beneficiaries could obtain a reduction in their current cost sharing through use of generic products, and that brand-name cost sharing was substantially higher than generic without unduly penalizing beneficiaries in relation to their current cost sharing levels.

Active duty members do not pay a cost-share. Cost sharing 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 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 will be reduced under the new cost sharing structure; in all cases beneficiaries will have lower costs if they use generic products. The pricing structure reflects a reduction for active duty dependents using the National Mail Order Pharmacy. 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. We solicit comment on the structure and amount of pharmacy cost sharing described above.

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 register in the Defense Enrollment and Eligibility Reporting System (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 will replace 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 interim final 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 eligible sponsor who are not enrolled in TRICARE Prime.

Full implementation of the TRICARE Prime Remote program for active duty family members will be subject of a proposed rule to be published soon. The TRICARE Prime Remote 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 TRICARE Prime Remote program, it will be proposed that eligible beneficiaries will be required to enroll in TRICARE Prime 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. TRICARE Prime Remote (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 TRICARE Prime Remote 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. 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 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. Regulatory Procedures

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 Interim Final 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 interim final 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 interim 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).

This rule is being issued as an interim final rule, with comment period, as an exception to our standard practice of soliciting public comments prior to issuance. The Acting Assistant Secretary of Defense (Health Affairs) has determined that following the standard practice in this case would be impracticable, unnecessary, and contrary to the public interest. This rule implements statutory requirements which became effective on the date of enactment of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106–398), October 30, 2000, or within 180 days thereafter. Public comments could not be solicited and considered within the period allowed by law.

Public comments are invited. All comments will be carefully considered. A discussion of the major issues received by public comments will be included with the issuance of the final rule.

List of Subjects in 32 CFR Part 199

Claims, Dental health, Health care, Health insurance, Individuals with disabilities, 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. Section 199.3 is amended by revising paragraph (b)(2)(i)(D), by redesignating (b)(3) as paragraph (b)(2)(iii)(B)(*3*), by adding new paragraphs (b)(3) and (b)(4), and by revising paragraph (f)(3)(vi) and 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)(viii) and (f)(3)(ix) of this section; and

* * * * *

(4) *Eligibility under TRICARE Senior Pharmacy Program.* Section 711 of the National Defense Authorization Act for Fiscal Year 2001 (Public Law 106–398, 114 Stat. 1654) established the TRICARE Senior Pharmacy Program effective April 1, 2001. To be eligible for this program, a person is required to be:

(i) Medicare eligible, who is:

(A) 65 years of age or older; and

(B) Entitled to Medicare Part A; and

(C) Enrolled in Medicare Part B, except for a person who attained age 65 prior to April 1, 2001, is not required to enroll in Part B; and

(ii) Otherwise qualified under one of the following categories:

(A) A retired uniformed service member who is entitled to retired or retainer pay, or equivalent pay including survivors who are annuitants; or

(B) A dependent of a member of the uniformed services described in one of the following:

(*1*) A member who is on active duty for a period of more than 30 days or died while on such duty; or

(*2*) A member who died from an injury, illness, or disease incurred or aggravated while the member was:

(*i*) On active duty under a call or order to active duty of 30 days or less, on active duty for training, or on inactive duty training; or

(*ii*) Traveling to or from the place at which the member was to perform or had performed such active duty, active duty for training, or inactive duty training.

Note to paragraph (b)(3)(ii)(B): Dependent under Section 711 of the National Defense Authorization Act for Fiscal Year 2001 includes spouse, unremarried widow/widower, child, parent/parent-in-law, unremarried former spouse, and unmarried person in the legal custody of a member or former member, as those terms of dependency are defined and periods of eligibility are set forth in 10 U.S.C. 1072(2).

(5) *Medal of Honor recipients.* (i) A former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits has the same CHAMPUS eligibility as does a retiree.

(ii) *Immediate dependents.* CHAMPUS eligible dependents of a Medal of Honor Recipient are those identified in paragraphs (b)(2)(i) of this section (except for former spouses) and (b)(2)(ii) of this section (except for a child placed in legal custody of a Medal of Honor recipient under (b)(2)(ii)(H)(*4*) of this section).

(iii) *Effective date.* The CHAMPUS eligibility established by paragraphs (b)(5)(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)(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, and as provided in paragraph (b)(3) of this section. CHAMPUS eligibility is lost at 12:01 a.m. on the last day of the month preceding the month of attainment of age 65 until implementation of section 712 of the National Defense Authorization Act for Fiscal Year 2001.

* * * * *

3. Section 199.4 is amended by revising paragraphs (f)(10)(ii), (f)(10)(iii), and Note to paragraph (f)(10), and by adding new paragraphs (f)(11) and (g)(37)(xii) to read as follows:

§ 199.4 Basic program benefits.

* * * * *

(f) * * *

(10) * * *

(ii) *All other beneficiaries.* For all other categories of beneficiary families (including those eligible under CHAMPVA) the fiscal year cap is $3,000.

(iii) *Payment after cap is met.* After a family has paid the maximum cost-share and deductible amounts (dependents of active duty members $1,000 and all others $3,000), for a fiscal year, CHAMPUS will pay allowable amounts for remaining covered services through the end of that fiscal year.

Note to paragraph (f)(10): Under the Defense Authorization Act for Fiscal Year 2001, the cap for beneficiaries other than dependents of active duty members was reduced from $7,500 to $3,000 effective October 30, 2000. Prior to this, the Defense Authorization Act for Fiscal Year 1993 reduced this cap from $10,000 to $7,500 on October 1, 1992. The cap remains at $1,000 for dependents of active duty members.

(11) *Beneficiary or sponsor liability under the Pharmacy Benefits Program.* Beneficiary or sponsor liability under the Pharmacy Benefits Program is addressed in § 199.21.

(g) * * *

(37) * * *

(xii) Physical examinations for beneficiaries ages 5 through 11 that are required in connection with school enrollment, and that are provided on or after October 30, 2000.

* * * * *

4. Section 199.5 is amended by revising paragraph (b)(1)(iii)(A) to read as follows:

§ 199.5 Program for Persons with Disabilities (PFPWD).

* * * * *

(b) * * *

(1) * * *

(iii) * * *

(A) For a period of three calendar years from the date an active duty sponsor dies; or

* * * * *

5. Section 199.13 is amended by revising paragraph (c)(3)(ii)(E)(*2*) to read as follows:

§ 199.13 TRICARE Dental Program.

* * * * *

(c) * * *

(3) * * *

(ii) * * *

(E) * * *

(*2*) *Continuation of eligibility for dependents of service members who die while on active duty or while a member of the Selected Reserve or Individual Ready Reserve.* Eligible dependents of active duty members while on active duty for a period of thirty-one (31) days or more and eligible dependents of Selected Reserve or Individual Ready Reserve members, as specified in 10 U.S.C. 10143 and 10144(b) respectively, who die on or after the implementation date of the TDP, and whose dependents are enrolled in the TDP on the date of the death of the active duty, Selected Reserve or Individual Ready Reserve member shall be eligible for continued enrollment in the TDP for up to 3 years from the date of the member's death where the member died on or after October 30, 1997.

* * * * *

6. Section 199.17 is amended by removing paragraph (a)(6)(iii)(D), by revising paragraph (k), by revising paragraph (m)(5), and by adding new paragraphs (m)(7) and (n)(2)(vi) to read as follows:

§ 199.17 TRICARE program.

* * * * *

(k) *Pharmacy services.* Pharmacy services under Prime are as provided in the Pharmacy benefits Program (see § 199.21).

* * * * *

(m) * * *

(5) *Prescription drugs.* Cost sharing for prescription drugs is as provided under the Pharmacy Benefits Program in § 199.21.

* * * * *

(7) *Cost sharing for additional beneficiaries under the TRICARE Prime Remote Program.* (i) Active duty family members, defined as the lawful husband or wife of a member, and children, as defined in § 199.3(b)(2)(ii)(A) through (b)(2)(ii)(F) and (b)(2)(ii)(H)(*1*), (b)(2)(ii)(H)(*2*), and (b)(2)(ii)(H)(*4*), residing with their Active Duty Service Member Sponsor who is TRICARE Prime Remote eligible will have cost-shares, co-payments, and deductibles waived for services provided on or after October 30, 2000. Pharmacy Benefits Program cost-shares established under § 199.21 apply to services provided on or after April 1, 2001. Active Duty Service Member Sponsors who are TRICARE Prime Remote eligible are those who receive a remote permanent duty assignment, and pursuant to the assignment, reside at a location that is more than 50 miles, or approximately one hour of driving time from the nearest military medical treatment

facility adequate to provide the needed care. Remote permanent duty assignments include permanent duty as a recruiter; permanent duty at an educational institution to instruct, administer a program of instruction, or provide administrative services in support of a program of instruction for the Reserves Officers' Training Corps; permanent duty as a full-time adviser to a unit of a reserve component; or any other permanent duty designated by the Secretary. This waiver applies to TRICARE covered benefits only. Claims processed with a date of service beginning on or after October 30, 2000 will waive the cost-share, copayment, and deductible. Active Duty Family Members residing with TPR eligible Active Duty Service Member (ADSM) have copayments, cost-shares, and deductibles for CHAMPUS covered benefits except pharmacy benefits waived until the implementation of TRICARE Prime Remote for Family Members or October 30, 2001, whichever is later. The claims processor will pay the waived portion of the claim to the eligible family member or to the provider, as appropriate.

(ii) Eligible family members will be able to access their provider without preauthorization. To obtain the waiver of charges, eligible family members are required to use network providers, where available and within the TRICARE access standards. Failure to do so will result in claims being processed under TRICARE Standard rules. For beneficiaries who are enrolled in TRICARE Prime, existing specialty care preauthorization requirements and Point of Service rules remain in effect.

(iii) To the greatest extent possible, contractors will assist eligible members in finding a TRICARE network, participating, or authorized provider. 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.

(n) * * *

(2) * * *

(vi) In accordance with guidelines issued by the Assistant Secretary of Defense for Health Affairs, certain travel expenses may be reimbursed when a TRICARE Prime enrollee is referred by the primary care manager for medically necessary specialty care more than 100 miles away from the primary care manager's office received on or after October 30, 2000. Such guidelines shall be consistent with appropriate provisions of generally applicable Department of Defense rules and procedures governing travel expenses.

* * * * *

7. Section 199.18 is amended by revising paragraphs (c)(2), (c)(3), the heading for paragraph (d), paragraphs (d)(1), (d)(2)(i), (d)(2)(ii), (d)(2)(iii), (d)(2)(iv), (d)(2)(v), (d)(2)(vi), (d)(2)(vii), (d)(3), (e), and (g) to read as follows:

§ 199.18 Uniform HMO benefit.

* * * * *

(c) * * *

(2) *Amount of enrollment fees.* In fiscal year 2001, the annual enrollment fee for retirees and their dependents is $230 individual, $460 family.

(3) *Waiver of enrollment fee for certain beneficiaries.* The Assistant Secretary of Defense (Health Affairs) may waive the enrollment fee requirements of this section for Medicare-eligible beneficiaries.

(d) *Outpatient cost sharing requirements under the uniform HMO benefit*—(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special reduced cost sharing percentages or per service specific dollar amounts are required. The specific requirements shall be uniform and shall be published periodically by the Assistant Secretary of Defense (Health Affairs). For care provided on or before April 1, 2001, no copayment shall be charged for care provided under TRICARE Prime to a dependent of an active duty member, except for the copayments charged under the Pharmacy Benefits Program (see § 199.21) and under the point of service option of TRICARE Prime (see § 199.17(n)(4)).

(2) * * *

(i) For most physician office visits and other routine services, there is a per visit fee for retirees and their dependents. This fee applies to primary care and specialty care visits, except as provided elsewhere in this paragraph (d)(2) of this section. It also applies to family health services, home health care visits, eye examinations, and immunizations. It does not apply to ancillary health services or to preventive health services described in paragraph (b)(2) of this section, or to maternity services under § 199.4(e)(16).

(ii) There is a copayment for outpatient mental health visits. It is a per visit fee for retirees and their dependents for individual visits. For group visits, there is a lower per visit fee for retirees and their dependents.

(iii) There is a cost share of durable medical equipment, prosthetic devices, and other authorized supplies for retirees and their dependents.

(iv) For emergency room services, there is a per visit fee for retirees and their dependents.

(v) For ambulatory surgery services, there is a per service fee for retirees and their dependents.

(vi) There is a copayment for prescription drugs per prescription, including medical supplies necessary for administration, for dependents of active duty members and for retirees and their dependents under the Pharmacy Benefits Program (see § 199.17(m)(5)).

(vii) There is a copayment for ambulance services for retirees and their dependents.

(3) *Amount of outpatient cost sharing requirements.* In fiscal year 2001, the outpatient cost sharing requirements are as follows:

(i) For most physician office visits and other routine services, as described in paragraph (d)(2)(i) of this section, the per visit fee for retirees and their dependents is $12.

(ii) For outpatient mental health visits, the per visit fee for retirees and their dependents is $25. For group outpatient mental health visits, there is a lower per visit fee for retirees and their dependents of $17.

(iii) The cost share for durable medical equipment, prosthetic devices, and other authorized supplies for retirees and their dependents is 20 percent of the negotiated fee.

(iv) For emergency room services, the per visit fee for retirees and their dependents is $30.

(v) For primary surgeon services in ambulatory surgery, the per service fee for retirees and their dependents is $25.

(vi) The copayments for prescription drugs are established under the Pharmacy Benefits Program (see § 199.21).

(vii) The copayment for ambulance services for retirees and their dependents is $20.

(e) *Inpatient cost sharing requirements under the uniform HMO benefit*—(1) *In general.* In lieu of usual CHAMPUS cost sharing requirements (see § 199.4(f)), special cost sharing amounts are required. The specific requirements shall be uniform and shall be published periodically by the Assistant Secretary of Defense (Health Affairs). For services provided on or after April 1, 2001, no co-payment shall be charged for inpatient care provided under TRICARE Prime to a dependent of an active duty member except under the point of service option of TRICARE Prime (see § 199.17(n)(4)). In addition, for services provided on or after April 1, 2001, no copayment shall be charged for inpatient care provided under TRICARE Prime to a dependent of an active duty member in military medical treatment facilities.

(2) *Structure of cost sharing.* For services other than mental illness or substance use treatment, there is a nominal copayment for retired members, dependents of retired members, and survivors. For inpatient mental health and substance use treatment, a separate per day charge is established. For services provided on or after April 1, 2001, no inpatient copayment shall be charged an active duty dependent enrolled in TRICARE Prime. This elimination of inpatient copayments applies to active duty dependents enrolled in TRICARE Prime who are admitted to a civilian or military inpatient facility.

(3) *Amount of inpatient cost sharing requirements.* In fiscal year 2001, the inpatient cost sharing requirements for retirees and their dependents for acute care admissions and other non-mental health/substance use treatment admissions is a per diem charge of $11, with a minimum charge of $25 per admission. For mental health/substance use treatment admissions, and for partial hospitalization services, the per diem charge for retirees and their dependents is $40.

* * * * *

(g) *Updates.* The enrollment fees for fiscal year 2001 set under paragraph (c) of this section and the per service specific dollar amounts for fiscal year 2001 set under paragraphs (d) and (e) of this section may be updated for subsequent years to the extent necessary to maintain compliance with statutory requirements pertaining to government costs. This updating does not apply to cost sharing that is expressed as a percentage of allowable charges; these percentages will remain unchanged.

8. A new § 199.21 is added to read as follows:

§ 199.21 Pharmacy Benefits Program.

(a) *In general*—(1) *Statutory authority.* 10 U.S.C. 1074g requires that the Department of Defense establish an effective, efficient, integrated Pharmacy Benefits Program for the Military Health System. This law is independent of a number of section of title 10 and other laws that affect the benefits, rules, and procedures of CHAMPUS/TRICARE, resulting in changes to the rules otherwise applicable to TRICARE Prime, Standard, and Extra. Among these changes is an independent set of beneficiary co-payments for prescription drugs.

(2) *Partial implementation during interim period.* Beginning April 1, 2001, 10 U.S.C. 1074g is partially implemented to coincide with the start of the TRICARE Senior Pharmacy Program and substantial cost sharing changes for active duty dependents enrolled in Prime. Some authorities and requirements of Section 1074g, such as the classification of drugs as formulary or non-formulary under a ''uniform formulary of pharmaceutical agents,'' are not yet implemented. In this section, references to ''interim implementation period'' mean the period beginning April 1, 2001.

(b) *Program benefits.* During the interim implementation period, prescription drugs and medicines are available under the otherwise applicable rules and procedures for military treatment facility pharmacies, TRICARE Prime, Standard, and Extra, and the Mail Order Pharmacy Program. There is not during this interim implementation period a ''uniform formulary'' of drugs and medicines available in all of these parts of the system. All cost sharing requirements for prescription drugs and medicines are established in this section for pharmacy services provided throughout the Military Health System.

(c) *Providers of pharmacy services.* There are four categories of providers of pharmacy services: military treatment facilities (MTFs), network retail providers, non-network retail providers, and the mail service pharmacy program. Network retail providers are those non-MTF pharmacies that are a part of the network established for TRICARE Prime under § 199.17. Non-network pharmacies are those non-MTF pharmacies that are not part of such a network.

(d) *Classifications of drugs and medicines.* During the interim implementation period, a distinction is made for purposes of cost sharing between generic drugs and non-generic (or brand name) drugs.

(e) *TRICARE Senior Pharmacy Program.* Section 711 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106–398, 114 Stat. 1654) established the TRICARE Senior Pharmacy Program for Medicare eligible beneficiaries effective April 1, 2001. These beneficiaries are required to meet the eligibility criteria as prescribed in § 199.3. The benefit under the TRICARE Senior Pharmacy Program includes the Basic Program pharmacy benefit as found under § 199.4(d) and the pharmacy benefit and cost sharing as found under this part. The TRICARE Senior Pharmacy Program applies to prescription drugs and medicines provided on or after April 1, 2001.

(f) *Cost sharing.* Beneficiary cost sharing requirements for prescription drugs and medicines are based upon the generic/non-generic status and the point of sale (i.e., MTF, network pharmacy, non-network pharmacy, mail service pharmacy) from which they are acquired. For this purpose, a generic drug is a non-brand name drug. A non-generic drug is a brand name drug. In the case of a brand name drug for which there is no generic equivalent, the non-generic cost share applies.

(1) *Military treatment facilities.* There are no cost sharing requirements for drugs and medicines provided by MTF pharmacies.

(2) *Retail pharmacy network program.* There is a $9.00 co-pay 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 co-pay for up to a 30-day supply of a generic drug or medicine. There is no annual deductible for drugs and medicines provided under the retail pharmacy network program.

(3) *Mail service pharmacy program.* There is a $9.00 co-pay per prescription required under the mail service pharmacy program for up to a 90-day supply of a non-generic drug or medicine, and a $3.00 co-pay for up to a 90-day supply of a generic drug or medicine. There is no annual deductible for drugs and medicines provided under the mail service pharmacy program.

(4) *Non-network retail pharmacies.* There is a 20 percent or $9.00 (whichever is greater) co-pay per prescription required for up to a 30-day supply of a drug obtained from a non-network pharmacy. A point of service cost-share of 50 percent applies in lieu of the 20 percent copay for TRICARE Prime enrollees who obtain their prescriptions from a non-network retail pharmacy without proper authorization. In addition, these TRICARE Prime enrollees are subject to higher deductibles as provided in § 199.17(m)(1)(i) and (m)(2)(i). For prescription drugs acquired from non-network retail pharmacies, beneficiaries other than Prime enrollees (including TRICARE Senior Pharmacy Program beneficiaries) are subject to the $150.00 per individual or $300.00 maximum per family (or for dependents of sponsors in pay grades below E–5, $50 per individual or $100 per family) annual fiscal year deductible.

(g) *Effect of other health insurance.* The double coverage rules of § 199.8 are applicable to services provided under the Pharmacy Benefits Program. 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.

(h) *Procedures.* The Director, TRICARE Management Activity shall establish procedures for the effective operation of the Pharmacy Benefit Program. Such procedures may include restrictions of the quantity of pharmaceuticals to be included under the benefit, encouragement or requirement of the use of generic drugs, implementation of quality assurance and utilization management activities, and other appropriate matters.

9. Section 199.22 is amended by revising paragraph (d)(1)(i), the first sentence of paragraph (d)(3), and paragraph (d)(5) 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 a former member of the armed forces who is a Medal of Honor recipient and who is not otherwise entitled to medical and dental benefits who has requested medical and dental care benefits in the manner described in § 199.3(j)(1) or their immediate dependents as defined by § 199.3(b)(ii);

* * * * *

(3) *Election of coverage.* In order to initiate dental coverage, election to enroll must be made by the member or eligible dependent. * * *

* * * * *

(5) *Period of coverage.* TRICARE Retiree Dental Program coverage is terminated when the member's entitlement to retired pay is terminated, the member's status as a member of the Retired Reserve is terminated, the member's status as a Medal of Honor recipient is terminated, a dependent child loses eligible child dependent status, or in the case of remarriage of the surviving spouse.

* * * * *

Dated: February 1, 2000.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 01–3240 Filed 2–6–01; 2:57 pm]

BILLING CODE 5000–01–U

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Parts 95 and 177

[USCG–1998–4593]

RIN 2115–AF72

Revision to Federal Blood Alcohol Concentration (BAC) Standard for Recreational Vessel Operators: Delay of Effective Date

AGENCY: Coast Guard, Department of Transportation.

ACTION: Final rule; delay of effective date.

SUMMARY: In accordance with the memorandum of January 20, 2001, from the Assistant to the President and Chief of Staff, entitled ''Regulatory Review Plan,'' published in the **Federal Register** on January 24, 2001 (66 FR 7702), this action temporarily delays for 60 days the effective date of the rule entitled Revision to Federal Blood Alcohol Concentration (BAC) Standard for Recreational Vessel Operators, published in the **Federal Register** on January 10, 2001, 66 FR 1859. That rule concerns revising the Federal Blood Alcohol Concentration (BAC) standard under which a recreational vessel operator would be considered operating while ''intoxicated''.

DATES: The effective date of the final rule amending 33 CFR parts 95 and 177 published in the **Federal Register** on January 10, 2001, at 66 FR 1859, is delayed for 60 days, from March 12, 2001, until May 11, 2001.

FOR FURTHER INFORMATION CONTACT: Carlton Perry, Project Manager, Office of Boating Safety, U.S. Coast Guard, by telephone at 202–267–0979.

SUPPLEMENTARY INFORMATION: To the extent that 5 U.S.C. section 553 applies to this action, it is exempt from notice and comment because it constitutes a rule of procedure under 5 U.S.C. section 553(b)(A). Alternatively, the Coast Guard's implementation of this action without opportunity for public comment, effective immediately upon publication today in the **Federal Register,** is based on the good cause exceptions in 5 U.S.C. section 553(b)(B) and 553(d)(3). Seeking public comment is impracticable, unnecessary and contrary to the public interest. The temporary 60-day delay in effective date is necessary to give Department officials the opportunity for further review and consideration of new regulations, consistent with the Assistant to the President's memorandum of January 20, 2001. Given the imminence of the effective date, seeking prior public comment on this temporary delay would have been impracticable, as well as contrary to the public interest in the orderly promulgation and implementation of regulations. The imminence of the effective date is also good cause for making this action effective immediately upon publication.

Dated: January 31, 2001.

Terry M. Cross,

Rear Admiral, U.S. Coast Guard Assistant Commandant for Operations.

[FR Doc. 01–3208 Filed 2–8–01; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD11–01–002]

RIN 2115–AE46

Special Local Regulations: Parker International Waterski Marathon

AGENCY: Coast Guard, DOT.

ACTION: Notice of implementation.

SUMMARY: This notice implements 33 CFR 100.1102, Marine Events on the Colorado River, between Davis Dam (Bullhead City, Arizona) and Headgate Dam (Parker, Arizona), for the Parker International Waterski Marathon. The race will consist of power driven vessels ranging in size from 19–26 feet for a waterski competition. These regulations will be effective on that portion of the Colorado River beginning at Bluewater Marina in Parker, AZ, and extending approximately 10 miles to La Paz County Park. Notice of Implementation of 33 CFR 100.1102 is necessary to control vessel traffic in the regulated areas during the event to ensure the safety of participants and spectators.

Pursuant to 33 CFR 100.1102(c), Commanding Officer, Coast Guard Activities San Diego, is designated Patrol Commander for this event; he has the authority to delegate this responsibility to any Coast Guard, public, state, local law enforcement, and/or sponsor provided vessels. For this event, the Coast Guard has designated the Colorado River Indian Tribe Police as Patrol Commander.

EFFECTIVE DATES: This section is effective from 8 a.m. (MST) until 4:30 p.m. (MST) on March 10, 2001 through March 11, 2001. If the event concludes prior to the scheduled termination date and/or time, the Colorado River Indian Tribe Police will cease enforcement of this section.