to a representative payee applicant with a felony conviction of an attempt to commit any of these crimes or conspiracy to commit any of these crimes.

(1) If the representative payee applicant is the custodial parent of a minor child beneficiary, custodial parent of a beneficiary who is under a disability which began before the beneficiary attained the age of 22, custodial spouse of a beneficiary, custodial court-appointed guardian of a beneficiary, or custodial grandparent of the minor child beneficiary for whom the applicant is applying to serve as representative payee, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(2) If the representative payee applicant is the parent who was previously the representative payee for his or her minor child who has since turned age 18 and continues to be eligible for benefits, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee for that beneficiary. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

(3) If the representative payee applicant received a Presidential or gubernatorial pardon for the relevant conviction, we will not consider the conviction for one of the crimes, or of attempt or conspiracy to commit one of the crimes, listed in this paragraph (f), by itself, to prohibit the applicant from serving as a representative payee. We will consider the criminal history of an applicant in this category, along with the factors in paragraphs (a) through (e) of this section, when we decide whether it is in the best interest of the individual entitled to benefits to appoint the applicant as a representative payee.

■ 11. Amend § 416.624 by revising paragraph (a)(9) and adding paragraph (a)(10) to read as follows:

§ 416.624 How do we investigate a representative payee applicant?

* * * * *

(a)* * *

(9) Determine whether the payee applicant is a creditor of the beneficiary (see § 416.622(e)).

(10) Conduct a criminal background check on the payee applicant.

* * * * *

■ 12. Add § 416.626 to read as follows:

§ 416.626 How do we investigate an appointed representative payee?

After we select an individual or organization to act as your representative payee, we will conduct a criminal background check on the appointed representative payee at least once every 5 years.

[FR Doc. 2019–02483 Filed 2–14–19; 8:45 am]

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[Docket ID: DOD–2017–HA–0039]

RIN 0720–AB70

Establishment of TRICARE Select and Other TRICARE Reforms

AGENCY: Office of the Secretary, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: This final rule implements the primary features of section 701 and partially implements several other sections of the National Defense Authorization Act for Fiscal Year 2017 (NDAA–17). The law makes significant changes to the TRICARE program, especially to the health maintenance organization (HMO)-like health plan, known as TRICARE Prime; to the preferred provider organization (PPO) health plan, previously known as TRICARE Extra and replaced by TRICARE Select; and to the third health care option, known as TRICARE Standard, which was terminated December 31, 2017, and is also replaced by TRICARE Select. The statute also adopts a new health plan enrollment system under TRICARE and new provisions for access to care, high value services, preventive care, and healthy lifestyles. In implementing the statutory changes, this final rule makes a number of improvements to TRICARE.

DATES: This rule is effective March 18, 2019.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Ellis, Defense Health Agency, TRICARE Health Plan, 7700 Arlington Boulevard, Suite 5101, Falls Church, VA 22042–5101, telephone (703) 275–6234.

SUPPLEMENTARY INFORMATION:

I. Executive Summary

An interim final rule (IFR) was published in the **Federal Register** on September 29, 2017 (82 FR 45438–45461) that established TRICARE Select and other TRICARE reforms. This rule is required to implement or partially implement several sections of NDAA–17, including sections 701, 706, 715, 718, and 729. As a ''housekeeping'' matter, this rule also includes necessary changes to the TRICARE program to conform to new statutory specifications enacted in the National Defense Authorization Act for Fiscal Year 2018 (NDAA–18) over which the Department has no administrative discretion. The legal authority for this rule also includes chapter 55 of title 10, United States Code. In implementing section 701 and partially implementing several other sections of NDAA–17, this rule advances all four components of the Military Health System's quadruple aim of improved readiness, better care, better health, and lower cost. The aim of improved readiness is served by reinforcing the vital role of the TRICARE Prime health plan to refer patients, particularly those needing specialty care, to military medical treatment facilities (MTFs) in order to ensure that military health care providers maintain clinical currency and proficiency in their professional fields. The objective of better care is enhanced by a number of improvements in beneficiary access to health care services, including increased geographical coverage for the TRICARE Select provider network, reduced administrative hurdles for TRICARE Prime enrollees to obtain urgent care services and specialty care referrals, and promotion of high value services and medications. The goal of better health is advanced by expanding TRICARE coverage of preventive care services, treatment of obesity, high-value care, and telehealth. Finally, the aim of lower cost is furthered by refining cost-benefit assessments for TRICARE plan specifications that remain under DoD's discretion and adding flexibilities to incentivize high-value health care services.

II. Public Comments

The IFR regarding the establishment of TRICARE Select and other TRICARE reforms was published in the **Federal Register** on September 29, 2017. Online comments were received from eighty-nine individuals, medical affiliated organizations, and military and veterans associations via *www.regulations.gov.* We sincerely appreciated all comments. Specific matters raised by those comments are summarized below. We have carefully considered all public comments. Except as noted below, we reaffirm the policies and procedures incorporated in the IFR and incorporate the rationale presented in the preamble of the IFR into this final rule.

A. Establishment of TRICARE Select

1. Provisions of Interim Final Rule

The rule implements the new law (section 701 of NDAA–17) that establishes TRICARE Select as a self-managed, PPO program. It allows TRICARE Select beneficiaries to use the TRICARE civilian provider network, with fixed copayments for most outpatient services compared to care from non-network providers, as well as MTFs when space is available. Similar to the long operating ''TRICARE Extra'' and ''TRICARE Standard'' plans, which TRICARE Select replaces, a major feature is that enrollees will not have restrictions on their freedom of choice with respect to health care providers. TRICARE Select is based primarily on 10 U.S.C. 1075 (as added by section 701 of NDAA–17) and 10 U.S.C. 1097. With respect to beneficiary cost sharing, the statute introduces a new split of beneficiaries into two groups: One group (which the rule refers to as ''Group A'') consists of sponsors and their family members who first became affiliated with the military through enlistment or appointment before January 1, 2018, and the second group (referred to as ''Group B'') who first became affiliated on or after January 1, 2018. In general, TRICARE Select beneficiary total out of pocket costs (taking into account enrollment fees and copayments) for Group B are higher than for Group A.

In addition to implementing the statutory specifications, the final rule also makes improvements for TRICARE Select Group A enrollees, compared to the features of the former TRICARE Extra plan. One such improvement is to convert the current cost-sharing requirement of 15% for active duty family members and 20% for retirees and their family members of the allowable charge for care from a network provider to a fixed dollar copayment calculated to approximately equal 15% or 20% of the average allowable charge for the category of care involved. Consistent with prevailing private sector health program practices, the fixed dollar copayment is more predictable for the patient and easier for the network health care provider to administer. The breakdown of categories of care (such as outpatient primary care visit, specialty care visit, emergency room visit, etc.) contained in the rule is the same as the categories now specified in the statute for Group B Select enrollees.

A second improvement in TRICARE Select (for both Group A and Group B) is additional preventive care services that previously were only offered to TRICARE Prime beneficiaries will now (under the authority of 10 U.S.C. 1097 and NDAA–17) also be covered for TRICARE Select enrollees when furnished by a network health care provider. These are services recommended by the United States Preventive Services Task Force and the Health Resources and Services Administration of the Department of Health and Human Services.

These improvements are based partly on the statutory provision (10 U.S.C. 1075(c)(2)) that Group A Select enrollee cost-sharing requirements are calculated as if TRICARE Extra were still being carried out by DoD. TRICARE Extra specifications are based on the underlying authority of 10 U.S.C. 1097, which allows DoD to adopt special rules for the PPO plan. This statute was the basis for the original set of rules for TRICARE Extra, which were adopted in 1995, and is the authority for these improved rules for TRICARE Select Group A, adopted as if TRICARE Extra were still being carried out by DoD.

Under the IFR, the cost sharing rules applicable to TRICARE Select Group B are those specified in 10 U.S.C. 1075. For TRICARE Select Group A, in addition to the copayment rules noted above, consistent with 10 U.S.C. 1075, an enrollment fee of $150 per person or $300 per family will begin January 1, 2021, for most retiree families, with annual updates thereafter based on the cost of living adjustment (COLA) applied to retired pay. At the same time, the catastrophic cap will increase from $3,000 to $3,500 for these retiree families. These changes, however, will not apply to TRICARE Select Group A active duty families, survivors of members who died while on active duty, or disability retiree families; that is, no enrollment fee will be applicable to this group and the applicable catastrophic cap will continue to be $1,000 for active duty families as established under 10 U.S.C. 1079(b) and $3,000 for survivors of members who died while on active duty or disability retiree families as established under 10 U.S.C. 1086(b).

2. Analysis of Major Public Comments

The Department received multiple comments expressing dissatisfaction with the TRICARE Select cost sharing, grandfathering, higher catastrophic caps, and how the increased fees were calculated. Many comments generally noted that fixed rates create a barrier to healthcare. It was expressed that service members and their families were promised free health care and that promise has been broken.

Response: We recognize the TRICARE Select cost shares and enrollment fees are higher than many expected. First, for Group B beneficiaries, the newly enacted out of pocket expenses are fixed by law (10 U.S.C. 1075), and the Department has implemented them without any modification.

Second, since the start of the TRICARE program in 1995, we've understood many people enroll in TRICARE Prime not because of a great desire to have their care managed by a primary care manager (PCM) or desire to undergo a referral and authorization process before receiving specialty care, but because of the simplicity of a known fixed copayment amount when seen by a network provider for care. This allows families to budget for their out-of-pocket costs versus paying a percentage of an unknown amount to be billed by the provider. We thought those not enrolled in TRICARE Prime would welcome this simplicity as well and do not perceive that a barrier to healthcare is created by establishing a fixed copayment that is generally comparable to an alternative specified percentage of allowable amounts for similar services. Therefore, because Congress mandated in NDAA–17 that TRICARE Select Group B beneficiaries have fixed copayment amounts for network care, the Department used existing authorities to calculate, to the extent practicable, TRICARE Select fixed copayments for network care also for Group A enrollees. When determined not to be practicable, as in the categories of inpatient admissions and inpatient skilled nursing/rehabilitation admissions, the calculated cost-sharing amounts are not converted to fixed dollar amounts.

While our goal is to provide at least 85% of TRICARE Select enrollees access to network providers, including those in non-PSAs, those using non-network providers will pay the same non-fixed cost shares (*i.e.,* percentage of allowed amounts), whether they are in Group A

or B, the same as if they still had TRICARE Standard/Extra cost shares (a percentage of the Government allowed amount after satisfying the annual deductible amount).

According to law, on average, out-of-pocket expenses for Group A are not to be any more than what they would have been had we continued the previous TRICARE Standard/Extra cost shares (a percentage of the Government allowed amount). Similar to the copayment for TRICARE Prime, our HMO option, the TRICARE Select calculated copayment amounts do not have separate copayments for ancillary services such as laboratory or radiology associated with the encounter, or for the facility charge if the encounter is in a facility, *e.g.,* a hospital outpatient department. Although some concern was expressed that the inclusion of ancillary services in calculating the fixed copayment for the basic service resulted in a higher fixed copayment than existed under TRICARE Standard/Extra, the slight increase in the calculated copay accounts for separate copayments under TRICARE Standard/Extra for both the basic service and the ancillary service. Now, when a TRICARE Select enrollee pays a copayment for an office visit, any ancillary or facility changes would be part of that fixed copayment amount and no other out of pocket expense is incurred by the beneficiary. Having carefully considered this issue, our conclusion is that the advantages of having a predictable, fixed copayment amount under both TRICARE Prime and TRICARE Select outweigh the concerns about including the ancillary services in the calculation.

Commenters also objected in general to TRICARE out of pocket cost increases, stating they were promised either free health care for life or objected to any future increases in their out of pocket expenses. We gratefully acknowledge the contributions to our Nation by those who have served in uniform as well as their family members. However, as a percentage of total health care costs, the beneficiary's cost share is substantially lower today than when the TRICARE program began more than 20 years ago. Additionally, while beneficiary desires and expectations are understandable, neither the law nor DoD policy ever promised free health care or the availability of TRICARE Prime in all areas. It can be fairly said that they have been promised a very good health care program, and in the context of health plans across the United States, this promise has been kept.

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

B. Continuation of TRICARE Prime

1. Provisions of the Interim Final Rule

A second major feature of the IFR, primarily based on 10 U.S.C. 1075a (also added by section 701 of NDAA–17), is the continuation of TRICARE Prime as a managed care, HMO-like program. It generally features use of MTFs and substantially reduced out-of-pocket costs for authorized care provided outside MTFs. Beneficiaries generally agree to use MTFs and designated civilian provider networks and to follow certain managed care rules and procedures. Like TRICARE Select, with respect to beneficiary cost sharing, the statute introduces a new split of beneficiaries into two groups (again referred to in the rule as Group A and Group B) based on the military sponsor's initial enlistment or appointment before January 1, 2018 (Group A), or on or after that date (Group B). Section 1075a mandated fixed copayments for specific categories of care received by Group B beneficiaries. However, Section 1075a only directed that the copayments for Group A should be calculated in accordance with other authority granted to the Department. At the time of issuance of the IFR, the copayments for Group A had not been calculated but it specified that Group A cost sharing could not exceed the amount for each category of care set for Group B in Section 1075a. The Department continued to have the authority to set the TRICARE Prime Group A copayments, and they were set to match those of the Group B TRICARE Prime enrollees mandated by law. As such, TRICARE Prime copayments for both Group A and Group B enrollees are the same. It's important to note active duty family members (Group A or B) enrolled in TRICARE Prime continue to enjoy a $0 out of pocket expense when authorized care is rendered by a TRICARE network provider.

2. Analysis of Major Public Comments

The government received many comments expressing dissatisfaction with the authority, interpretation and methodology for copayment rates for grandfathered (Group A) beneficiaries. Among the comments was that Congress intended no change for grandfathered beneficiaries.

Response: With the addition of 10 U.S.C. 1075a by NDAA–17, Congress established specific out of pocket expenses for Group B beneficiaries enrolled in TRICARE Prime as of January 1, 2018. In addition to a difference in the amount of the copayments, Congress also created additional categories of visits for Group B enrollees. With respect to Group A beneficiaries enrolled in TRICARE Prime, Congress did not specify copayment amounts but rather directed the Department to calculate cost-sharing requirements under other existing authorities.

The IFR adopted for Group A beneficiaries enrolled in TRICARE Prime the same structure of categories of care that Congress adopted for Group B. In addition, it provided an overview of the authority and discretion of the Department for calculating the actual amount to be established as Group A cost sharing for each category of care. Consistent with that discretion under current statute and regulation, the Department determined the cost sharing for each category of care for Group A shall be the same amount as required for Group B under Section 1075a. The establishment of consistent copayments for all TRICARE Prime enrollees contributes to the effective and efficient administration of TRICARE, removes complexities in network provider billing for Prime enrollees, and simplifies the communication of program information to the public. In addition, it has been determined that the slight increase in fixed copayments for Group A are a reasonable and fair amount considering the overall rise in health care costs since initial establishment of the outpatient visit copayment first at $12 over twenty-three years ago in 1995. In addition, as noted in the preamble to the IFR, TRICARE Prime copays were originally intended to be updated every year or so to maintain ''cost neutrality'' compared to the TRICARE Standard program. But as things worked out, this is the first update in more than 20 years.

The Department is proud that TRICARE remains one of the most comprehensive health benefits available in this country at exceptionally low beneficiary cost—a benefit that is commensurate with the sacrifice of those whom it serves.

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

C. Improved Access to Care

1. Provisions of the Interim Final Rule

A third significant change in the IFR is a set of improvements in standards for access to care. The TRICARE Select plan replaces TRICARE Standard as the generally available plan worldwide. Under TRICARE Select, enrolled beneficiaries can choose any TRICARE authorized provider for their healthcare, and they will enjoy known out of pocket costs if they choose providers within the TRICARE civilian network. The vast

majority of TRICARE beneficiaries located in the United States will have access to TRICARE network providers (it is DoD's plan that at least 85% of the U.S. beneficiary population enrolled in TRICARE Select will have access to a preferred provider network upon implementation), similar to the old TRICARE Extra option, but with the benefit of predictable fixed dollar copayments. In cases in which a network provider is not available to a TRICARE Select enrollee, such as in remote locations where there are very few primary or specialty providers, enrollees will still have access to any TRICARE authorized provider, with cost sharing comparable to the old TRICARE Standard plan (*i.e.,* 25% for retired category beneficiaries).

A second IFR enhancement for access to care is that if a TRICARE Prime enrollee seeks to obtain an appointment for care from the managed care support contractor but is not offered an appointment within the applicable access time standards from a network provider, the enrollee will be authorized to receive care from any TRICARE authorized provider without incurring the additional fees associated with point-of-service care.

A third access to care improvement under the IFR is that the TRICARE Prime referral requirement may be waived for urgent care visits for Prime enrollees other than active duty members. This is similar to the former pilot program, which waived the referral requirement (other than for active duty members) for up to two urgent care visits per year. The specific number of urgent care visits without a referral will be determined annually prior to the beginning of the open season enrollment period. During plan year 2018, there is no limit to the number of urgent care visits that a Prime beneficiary (other than an active duty member) may receive without a referral from a PCM. The Department has no current plans to change that, but in order to evaluate the ongoing appropriateness of this policy, it remains a year-by-year determination.

A fourth access to care improvement is adoption of the new statutory provision that a PCM who believes a referral to a specialty care network provider for outpatient care is medically necessary and appropriate need not obtain preauthorization from the TRICARE regional contractor. TRICARE regional contractor preauthorization is only required in this particular context with respect to a PCM's referral for inpatient hospitalization, inpatient care at a skilled nursing facility, inpatient care at a residential treatment center, or inpatient care at a rehabilitation facility.

It is important to note that the removal of the need for TRICARE Prime PCMs to get managed care support contractor preauthorization approval for referral to specialty care in NDAA–17 Section 701(c) [amending 10 U.S.C. 1095f] applies to the specialty consult itself but does not serve to preauthorize specific treatments, tests, or procedures that may be indicated by such consult. In other words, the treatment-specific preauthorization requirements separately set forth in the TRICARE Manuals still apply across the board. That change also applies only to referrals by a PCM to other network providers or within the network for covered services. Any referral to non-network specialty providers or services is not exempt from the preauthorization requirements. It is essential that the NDAA language concerning PCM referrals not be taken out of context and read too broadly—that language does not affect the longstanding and separate preauthorization requirements that apply to certain treatments/services/equipment generally.

To explain further, Section 701 restrictions on prior authorizations (*i.e.,* 10 U.S.C. 1095f(b) and (c)) only apply to TRICARE Prime enrollees. Thus, the IFR states in § 199.17(i): ''All quality assurance, utilization review, and preauthorization requirements for the basic CHAMPUS program, as set forth in this part (see especially applicable provisions in §§ 199.4 and 199.15), are applicable to Prime and Select except as provided in this chapter.'' The preauthorization requirements that are generally applicable under TRICARE independent of TRICARE Prime referrals, including those under the Pharmacy Benefits Program (under 10 U.S.C. 1074g and § 199.21), certain laboratory and other ancillary services, and durable medical equipment.

Therefore, TRICARE Select enrollees are also subject to all TRICARE Basic program preauthorization requirements even if the TRICARE Select enrollee seeks specialty care from a network provider. In sum, the preauthorization and referral requirements under TRICARE are an integral part of the program, were not entirely removed by NDAA–17, and can be complex in certain circumstances.

2. Analysis of Major Public Comments

The government received many comments regarding the improved access to care and urgent care policy. Comments were received from beneficiaries who do not live near active military installations and expressed concerns about finding TRICARE authorized providers in their area or being discriminated against because the TRICARE Prime HMO option is not offered where they live. Other general concerns were expressed regarding inability to get timely scheduled appointments at MTFs. However, overall, comments were favorable about allowing unregulated urgent care visits.

Response: As to the issue of beneficiaries who do not live near military installations not being able to find TRICARE authorized providers, we believe those who enroll in TRICARE Select will have better access to care from network providers than previous TRICARE Standard beneficiaries. It is the Department's plan that the TRICARE contractors offer improved access to ensure that at least 85% of TRICARE Select enrollees in each region in the U.S. have access to networks of providers near where they live. Therefore, for the majority of TRICARE Select enrollees, they will enjoy access to network providers that will charge no more than the established TRICARE copayment or cost share and will file claims on their behalf. Otherwise, TRICARE Select enrollees who do not live near an established network of preferred providers may use any TRICARE authorized provider. Finally, as a self-managed plan, TRICARE Select enrollees may elect to seek care from any TRICARE authorized provider, whether network or network, and also enjoy space available care at military hospitals and clinics. Therefore, TRICARE Select enrollees will generally have greater access to care but in no case less access than TRICARE Standard beneficiaries have always enjoyed.

Several commenters claimed the Department discriminates against them because it does not offer the TRICARE Prime (HMO-like) option as they do not live near an active military installation. As noted in the IFR, the locations where TRICARE Prime will be offered will be determined by the Director, Defense Health Agency (DHA) and announced prior to the annual open season enrollment period. The final rule continues our principle that the purpose of TRICARE Prime is to support the medical readiness of the armed forces and the readiness of medical personnel in areas of one or more MTFs. The rule preserves the Department's discretion with respect to the locations where TRICARE Prime is offered.

As concerns the issue of timely appointments at MTFs, we are diligently working to improve beneficiary access and satisfaction with care at MTFs and to address the concerns raised with MTF same day care and scheduling MTF appointments. Regarding concerns about the quality of MTF care, all MTFs

have avenues to address concerns from patients, and we urge beneficiaries to utilize the services of the Customer Service and/or Quality Officers to address specific health care concerns.

With respect to access to care standards for TRICARE Select enrollees, we did not specifically highlight this issue in the IFR because there was more focus on TRICARE Prime access standards. But the provisions of the IFR regarding the size, composition, and mix of providers being adequate to meet the needs of the enrolled population served apply to both TRICARE Prime and TRICARE Select enrollees. Because TRICARE Select is a self-managed plan where enrollees may choose to get care when and where they wish with no referrals, there are some differences between the TRICARE Prime and TRICARE Select plans regarding how those standards are implemented. But the access standards regarding availability of routine primary care, specialty care, urgent care, and emergency services are the same. As a means of monitoring implementation for TRICARE Select enrollees, their satisfaction with access to care will be surveyed and compared with those of high-performing health care systems in the United States.

4. Provisions of the Final Rule: The final rule is consistent with the IFR.

D. Promotion of High Value Services and Medications and Telehealth Services

1. Provisions of the Interim Final Rule

The IFR made a number of other improvements in TRICARE Prime and TRICARE Select based on provisions of sections 701(h), 706, 718, and 729 of NDAA–17. These involved high value services and medications, population-based health outcomes and focus more on preventive care, medical intervention programs, to address chronic diseases and other conditions and healthy lifestyle interventions, and telehealth services.

The IFR authorizes coverage under TRICARE Prime and TRICARE Select for medically necessary treatment by a network provider of obesity even if it is the sole or major condition treated.

2. Analysis of Major Public Comments

The Department received several comments expressing dissatisfaction with how the Department plans to implement coverage for medically necessary treatment of obesity, even if it is the sole of major condition treated. Registered Dietitian Nutritionists (RDNs) recommended that the provision more specifically include RDNs in the treating of obesity as RDNs are experts in food and nutrition and may be more knowledgeable than other health practitioners in treating this nutrition-related disease through diet and behavior modification.

Response: Regarding the comment about a RDN's role in the treatment of obesity, the TRICARE regulation recognizes Registered Dietitians and Nutritionists as TRICARE authorized providers if they meet the required professional training and licensing requirements. If the otherwise qualified RDN provides medically necessary services in the treatment of obesity for an eligible beneficiary while under the supervision of a physician, the services will be covered as a TRICARE benefit. Nothing is required to be added by the final rule to authorize RDN services in the treatment of obesity.

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

E. Changes to Health Plan Enrollment System

1. Provisions of the Interim Final Rule

A fourth major change in the IFR is the implementation of the new statutory design for the health care enrollment system. Starting in calendar year 2018, beneficiaries other than active duty members and TRICARE-for-Life beneficiaries must elect to enroll in TRICARE Select or TRICARE Prime in order to be covered by the private sector care portion of TRICARE. While TRICARE-for-Life beneficiaries under the age of 65 are permitted to enroll in TRICARE Prime under limited circumstances, their failure to enroll will not affect their coverage by the private sector care portion of TRICARE. Enrollment will be done during an open season period prior to the beginning of each plan year, which operates with the calendar year. An enrollment choice will be effective for the plan year. As an exception to the open season enrollment rule, enrollment changes can be made during the plan year for certain qualifying events, such as a change in eligibility status, marriage, divorce, birth of a new family member, relocation, loss of other health insurance, or other events.

Eligible Prime or Select beneficiaries who do not enroll will no longer have private sector care coverage under the TRICARE program (including the TRICARE retail pharmacy and mail order pharmacy programs) until the next open enrollment season or they have a qualifying event except that they do not lose any statutory eligibility for space-available care in military medical treatment facilities. There is a limited grace period exception to this enrollment requirement for calendar year 2018, as provided in section 701(d)(3) of NDAA–17, to give beneficiaries another chance to adjust to this new requirement for annual enrollment. For the administrative convenience of beneficiaries, there are also procedures for automatic enrollment in TRICARE Prime or TRICARE Select for most active duty family members, and automatic renewal of enrollments of covered beneficiaries, subject to the opportunity to decline or cancel.

Due to a compressed implementation schedule that precluded an annual open season enrollment period in calendar year 2017 for existing TRICARE beneficiaries to elect or change their TRICARE coverage, the Department converted existing TRICARE Standard coverage to TRICARE Select coverage effective January 1, 2018. All other existing TRICARE coverages were renewed effective January 1, 2018. As noted previously, beneficiaries may elect to change their TRICARE coverage anytime during the limited grace period in calendar year 2018.

2. Analysis of Major Public Comments

We received one public comment regarding the enrollment changes and open enrollment times. Instead of having to enroll in a TRICARE health plan, eligible beneficiaries simply would show their military identification card to any civilian provider, and then TRICARE would reimburse the provider. Or alternatively, the federal government should pay for the most expensive, lowest deductible plan offered by any insurance company, and charge retirees a reasonable percentage of the costs.

Response: Neither suggestion is feasible. First, the law requires a TRICARE enrollment system, with specified enrollment fees, for all TRICARE eligible beneficiaries except for TRICARE-for-Life beneficiaries (*i.e.,* those eligible for the Medicare wraparound coverage under 10 U.S.C. 1086(d)) and beneficiaries accessing space available care at MTFs. Under the required enrollment system, an eligible beneficiary is required to elect which option—TRICARE Prime or Select—to enroll in in order to be covered under the private sector health care benefit program. So, the proposed alternative is not consistent with the requirements of law. Second, the alternative of allowing the government to purchase a commercial insurance plan for beneficiaries also is not envisioned under the law. The law mandates

TRICARE as the program, as administered through the TRICARE regulation, by which authorized beneficiaries obtain DoD coverage on their civilian health care claims.

3. *Provisions of the Final Rule:* The final rule is consistent with the IFR.

F. Additional Provisions of the Interim Final Rule

1. Provisions of the Interim Final Rule

The IFR has several other noteworthy provisions. These included the continuation of benefits for TRICARE-for-Life beneficiaries, cost sharing levels for active duty family members, and TRICARE basic program benefits. Additionally, NDAA–17, section 701 directed Prime and Select beneficiary cost sharing be on a calendar year basis. In addition, a technical amendment enacted in NDAA–18, section 739(d), similarly directed that cost sharing of civilian health care by other beneficiaries also be on a calendar year basis.

The IFR adopted several changes to regulatory provisions applicable to the TRICARE Young Adult, TRICARE Reserve Select, TRICARE Retired Reserve, and TRICARE dental coverage.

Also, the IFR adopted several changes to regulatory provisions applicable to benefit coverage of medically necessary food and vitamins. Section 714 of NDAA–17 confirms long-standing TRICARE policy authorizing benefit coverage of medically necessary vitamins when prescribed for management of a covered disease or condition. In addition, while section 714 confirms long-standing TRICARE policy authorizing medical nutritional therapy coverage of medically necessary food and medical equipment/supplies necessary to administer such food when prescribed for dietary management of a covered disease or condition, the law also allows the medically necessary food benefit to include coverage of low protein modified foods. Consistent with this we also recognize the role of Nutritionists and Registered Dieticians in the appropriate planning for the use of medically necessary foods.

2. Analysis of Major Public Comments

Regarding changes to the regulation provisions on medically necessary food, we received two comments from national medical associations that suggested that the statute covers ''partial or exclusive'' feeding while TRICARE policy issuance implementing the regulation continues to only cover foods that provide ''primary source'' of calories. Also, one commenter challenged the exclusion of over-the-counter formula that don't need prescriptions arguing that the language of the statute allows medical foods furnished ''pursuant to prescription, order, or recommendation (as applicable)'' of a qualified provider.

Response: The TRICARE Medically Necessary Food policy (TRICARE Policy Manual, Chapter 8, Section 7.2), as revised in implementation of the IFR, allows coverage of specifically formulated and processed food for the partial or exclusive feeding of an individual. Regarding the issue of over-the-counter formula, we note that the rule language is consistent with the statutory language in that one of the criteria for coverage of medically necessary food is a prescription, order, or recommendation of a TRICARE authorized provider. No revision in the final rule is required. However, the specific issue of coverage of over-the counter formula will be further reviewed to ensure TRICARE policy implementing the rule provides reasonable access to formula when qualifying as medically necessary food.

As noted, the IFR adopted several conforming changes to regulatory provisions applicable to general TRICARE administration reflecting transition from program administration on a fiscal year to a calendar year basis and creating a program plan year for enrollment and benefit coverage on a calendar year basis. Further review has identified the need to provide flexibility in the updating of certain prospective payment methodologies to more closely correspond with the pertinent program plan benefit year. In that regard, the IFR will be revised in the final rule to provide such flexibility in § 199.14(a)(1)(i)(D) for the update of the TRICARE Diagnostic Related Group (DRG) system.

3. Provisions of the Final Rule: The final rule is consistent with the interim final rule except for revision of the TRICARE DRG system updates in § 199.14(a)(1)(i)(D) transitioning such updates to the TRICARE program plan year.

G. Cost Sharing Tables

1. Provisions of the Interim Final Rule:

The preamble to the IFR included tables recapping the new cost sharing requirements for beneficiaries as outlined in the summary of provisions of the IFR as the rates specifically related to calendar year 2018. At the time, the tables were incomplete in that certain requirements had not yet been determined. In addition, notice was given that all fees are subject to review and annual updating for future calendar years in accordance with law. The final rates for calendar year 2018 were published in the **Federal Register** on January 5, 2018, including the two official recap tables as Appendix A. The official tables are also available at *www.health.mil/rates.* In future years, a summary of changes in the TRICARE program (including updated rates) will be published in connection with the open season enrollment period. In view of the public notice of the official rates for calendar year 2018 and their availability on the *www.health.mil/rate* website, the recap tables are not included as background information for this final rule.

In addition, notice was given that all fees are subject to review and annual updating for future calendar years in accordance with law. Consistent with our previous implementation of law applicable to TRICARE Prime, we will utilize the overall annual COLA percentage increase under 10 U.S.C. 1401a(b)(2) when necessary to update the fixed dollar amounts in the tables for TRICARE Prime and TRICARE Select beginning calendar year 2019. This will permit maintaining uniform rates to facilitate efficiency and effectiveness in program administration.

2. Provisions of the Final Rule: The final rule is consistent with the IFR.

H. Comments Submitted Beyond Scope of Interim Final Rule

We received three comments that were beyond the scope of the IFR which included; opioid overdoses, dual basic allowance for housing for members in the same residence, and chiropractic benefits. Though not addressed in the final rule, these comments will be reviewed for action by appropriate DoD subject matter experts.

III. Changes Made to the Rule To Implement Provisions of the NDAA–18

Certain provisions of the NDAA–18 amended or provided technical corrections to the provisions of the NDAA–17. Necessary revisions in the final rule based on these provisions are included to the extent the Department has no administrative discretion. The following provisions of NDAA–18 are noted.

(1) Section 701(a) and (b) of NDAA–18 amended 10 U.S.C. 1076d (TRS) and 1076e (TRR), respectively, to correct the unintentional deletion of space available access to care to MTFs by TRS and TRR enrollees. Section 199.24(a)(4)(iv) for TRS and § 199.25(a)(4)(iv) for TRR already include provisions for space available care at MTFs, when authorized, for

enrollees. Therefore, no regulatory change is needed.

(2) Section 739(a) of NDAA–18 amended the definition of ''TRICARE Standard'' in 10 U.S.C. 1072(15) to correct the statutory authorities of ''TRICARE Standard'' to be section 1079(a) or 1086(a) of this title. The definition otherwise remains intact. The final rule makes a conforming change to the regulatory definition of ''TRICARE Standard.''

(3) Section 739(b)(1)(A) of NDAA–18 amended 10 U.S.C. 1075(d) by adding at the end a new paragraph pertaining to TRICARE Select, providing that the cost-sharing requirements applicable to services not specifically addressed in the statue shall be established by the Secretary. The final rule (section 199.17(1)(1)(ii)) makes a conforming change to the regulation.

(4) Section 739(b)(1)(B) of NDAA–18 amended 10 U.S.C. 1075(d)(1) in the first column of the table pertaining to TRICARE Select cost sharing amounts by striking out: ''Ambulance civilian network'' and inserting ''Ground ambulance civilian network.'' Section 199.17(k)(2)(vi) included the Department's interpretation and implementation of the law as applying to ground ambulance services. NDAA–18 merely supports that interpretation. Therefore, no regulatory change is needed.

(5) Section 739(b)(2)(A) of NDAA–18 amended 10 U.S.C. 1075a(b) by adding a new paragraph providing that the cost-sharing requirements applicable to services not specifically addressed in the table set forth in the statute shall be established by the Secretary. We are making a conforming change to the regulation (§ 199.17(1)(2)(ii)).

(6) Section 739(b)(2)(B) of NDAA–18 amended 10 U.S.C. 1075a(b)(1) in the first column of the table pertaining to TRICARE Prime cost sharing amounts by striking out ''Ambulance civilian network'' and inserting ''Ground ambulance civilian network.'' Section 199.17(k)(2)(vi) included the Department's interpretation and implementation of the law as applying to ground ambulance services. NDAA–18 merely supports that interpretation. Therefore, no regulatory change is needed.

(7) Section 739(d)(1) and (2) of NDAA–18 amended 10 U.S.C. 1079(b) and 1086(b) respectively to reflect transition of deductibles, catastrophic caps, and program reimbursement limitations, as applicable, from fiscal year to calendar year for TRICARE beneficiaries not otherwise covered under the TRICARE Prime and Select programs. The IFR included this transition for consistency and ease of general TRICARE administration. The NDAA–18 amendments reflect congressional agreement through codification of the transition. Therefore, no regulatory change is needed.

(8) Section 739(e) of NDAA–18 amended 10 U.S.C. 1095f(b) by adding a new paragraph requiring TRICARE Prime enrollees to obtain preauthorization with respect to a referral for inpatient care at a residential treatment facility. Section 199.17(n)(2)(iv)(D) already included this language. Therefore, no regulatory change is needed.

(9) Section 739(f) of NDAA–18 amended 10 U.S.C. 1110b(c)(1) to clarify that an eligible beneficiary who enrolls in the TRICARE Young Adult (TYA) program will pay the TYA premium in lieu of either the otherwise applicable TRICARE Prime or Select premium. Section 199.26(a)(4)(ii) included the clarification regarding the applicable premium for a TRICARE Young Adult enrollee based on any option to purchase TRICARE Prime or Select program coverage. Therefore, no regulatory change is needed.

IV. Technical Corrections to the Interim Final Rule

The following technical corrections are being made to the IFR by the final rule.

(1) In § 199.17(f)(4), the reference to ''paragraph (f)(5)'' is revised to read ''paragraph (f)(4).''

(2) In § 199.17(n)(2)(vi), the reference to ''paragraph (l)(1)(iv)'' is revised to read ''paragraph (l)(1)(iii).''

V. Regulatory Procedures

Executive Order (E.O.) 13771, ''Reducing Regulation and Controlling Regulatory Costs''

E.O. 13771 seeks to control costs associated with the government imposition of private expenditures required to comply with Federal regulation and to reduce regulations that impose such costs. This rule does not include government imposition of private expenditures required to comply with Federal regulation or requires regulations that impose such costs. Therefore, consistent with the analysis of transfer payments under OMB Circular A–4, this final rule does not involve regulatory costs subject to E.O. 13771.

Executive Order 12866, ''Regulatory Planning and Review'' and Executive Order 13563, ''Improving Regulation and Regulatory Review''

Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distribute impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. It has been determined that this rule is not a significant regulatory action. The rule does not: (1) Have an annual effect on the economy of $100 million or more or adversely affect in a material way the economy; a section of the economy; productivity; competition; jobs; the environment; public health or safety; or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another Agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs, or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in these Executive Orders.

Congressional Review Act, 5 U.S.C. 804(2)

Under the Congressional Review Act (CRA), a major rule may not take effect until at least 60 days after submission to Congress of a report regarding the rule. A major rule is one that would have an annual effect on the economy of $100 million or more or have certain other impacts. The final rule is not a major rule under the CRA.

Public Law 96–354, ''Regulatory Flexibility Act'' (RFA), (5 U.S.C. 601)

The Regulatory Flexibility Act (RFA) requires that each Federal agency analyze options for regulatory relief of small business if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, small entities include small businesses, nonprofit organizations, and small governmental jurisdictions. This final rule is not an economically significant regulatory action, and it will not have a significant impact on a substantial number of small entities. Therefore, this final rule is not subject to the requirements of the RFA.

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

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any

rule whose mandates require spending in any one year of $100 million in 1995 dollars, updated annually for inflation. That threshold level is currently approximately $140 million. This final rule will not mandate any requirements for state, local, or tribal governments or the private sector.

Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35)

This rulemaking does not contain a ''collection of information'' requirement, and will not impose additional information collection requirements on the public under Public Law 96–511, ''Paperwork Reduction Act'' (44 U.S.C. Chapter 35).

Executive Order 13132, ''Federalism''

This final rule has been examined for its impact under E.O. 13132, and it does not contain 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 powers and responsibilities among the various levels of Government. Therefore, consultation with State and local officials is not required.

List of Subjects in 32 CFR Part 199

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

Accordingly, the interim final rule amending 32 CFR part 199 which was published at 82 FR 45438–45461 on September 29, 2017 is adopted as a final rule with the following changes:

PART 199—[AMENDED]

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

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

■ 2. Section 199.2 is amended in paragraph (b) by revising the definition of ''TRICARE Standard'' to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

TRICARE Standard. The TRICARE program made available prior to January 1, 2018, covering health benefits contracted for under the authority of 10 U.S.C. section 1079(a) or 1086(a) and subject to the same rates and conditions as apply to persons covered under those sections.

* * * * *

■ 3. Section 199.14 is amended by revising paragraph (a)(1)(i)(D) to read as follows:

§ 199.14 Provider reimbursement methods.

(a) * * *

(1) * * *

(i) * * *

(D) *DRG system updates.* The CHAMPUS DRG-based payment system is modeled on the Medicare Prospective Payment System (PPS) and uses annually updated items and numbers from the Medicare PPS as provided for in this part and in instructions issued by the Director, DHA. The effective date of these items and numbers shall not correspond to that under Medicare PPS but shall be delayed until January 1, to align with TRICARE's program year reporting. This allows for an administrative simplicity that optimizes healthcare delivery by reducing existing administrative burden and costs.

* * * * *

■ 4. Section 199.17 is amended by revising paragraphs (f)(4), (l)(1)(ii), (1)(2)(ii), and (n)(2)(vi) to read as follows:

§ 199.17 TRICARE program.

* * * * *

(f) * * *

(4) *High value services.* Under the authority of 10 U.S.C. 1097 and other authority, including sections 706 and 729 of the NDAA–17, for purposes of improving population-based health outcomes and incentivizing medical intervention programs to address chronic diseases and other conditions and healthy lifestyle interventions, the Director may waive or reduce cost sharing requirements for TRICARE Prime and TRICARE Select enrollees for care received from network providers for certain health care services designated for this purpose. The specific services designated for this purpose will be those the Director determines provide especially high value in terms of better health outcomes. The specific services affected for any plan year will be announced by the Director prior to the open season enrollment period for that plan year. Services affected by actions of the Director under this paragraph (f)(4) may be associated with actions taken for high value medications under § 199.21(j)(3) for select pharmaceutical agents to be cost-shared at a reduced or zero dollar rate.

* * * * *

(l) * * *

(1) * * *

(ii) For Group B TRICARE Prime enrollees, the enrollment fee, catastrophic cap, and cost sharing amounts are as set forth in 10 U.S.C. 1075a. The cost sharing requirements applicable to services not specifically addressed in the table set forth in 10 U.S.C. 1075a(b)(1) shall be determined by the Director, DHA.

* * * * *

(2) * * *

(ii) For Group B TRICARE Select enrollees, the enrollment fee, annual deductible for services received while in an outpatient status, catastrophic cap., and cost sharing amounts are as provided in 10 U.S.C. 1075 and as consistent with this section. The cost sharing requirements applicable to services not specifically addressed in 10 U.S.C. 1075 shall be determined by the Director, DHA.

* * * * *

(n) * * *

(2) * * *

(vi) The cost-sharing requirement for a beneficiary enrolled in TRICARE Prime who does not obtain a referral for care when it is required, including care from a non-network provider, is as provided in paragraph (l)(1)(iii) of this section concerning point of service care.

* * * * *

Dated: February 12, 2019.

Aaron T. Siegel,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 165

[Docket Number USCG–2018–1011]

RIN 1625–AA00

Safety Zone for Fireworks Displays; Upper Potomac River, Washington Channel, DC

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing a temporary safety zone for certain waters of the Upper Potomac River. This action is necessary to provide for the safety of life on these navigable waters of the Washington Channel adjacent to The Wharf DC, Washington, DC, for recurring fireworks displays from January 12, 2019, through December 31, 2019. This regulation prohibits persons and vessels from entering the safety zone unless authorized by the Captain of the Port