resources to an MTF in order to increase the availability of services. It is our expectation that the Partnership Program, an existing mechanism for increasing the availability of services in MTFs, will be phased out as TRICARE managed care support contracts are implemented. Another TRICARE initiative is establishment of Health Care Finders, which facilitate referrals to appropriate services in the MTF or civilian provider network. In addition, integrated quality and utilization management services for military and civilian sector providers will be insituted. Still another initiative is establishment of special pharmacy programs for areas affected by base realignment and closure actions. These pharmacy programs will include special eligibility for some Medicare-eligible beneficiaries. TRICARE also will feature TRICARE Outpatient Clinics, which will be direct care system resources serving as primary care managers and providing related services. (This final rule also provides a transitional authority for continued operation of PRIMUS and NAVCARE Clinics, which are dedicated contractor-owned and operated clinics, until TRICARE is implemented.) These initiatives will have a major impact on military health care delivery systems, improving services for all beneficiary categories.

The fourth major component of TRICARE is the implementation of a consolidated schedule of charges, incorporating steps to reduce differences in charges between military and civilian services. In general, the TRICARE Program reduces beneficiaries' out-of-pocket costs for civilian sector care. For example, the current CHAMPUS cost sharing requirements for outpatient care for active duty family members include a deductible of \$150 per person or \$300 per family (\$50/\$100 for family members of active duty sponsors in pay grades E-4 and below) and a copayment of 20 percent of the allowable cost of the services.

Under TRICARE Prime, which incorporates the "Uniform HMO Benefit," these cost sharing requirements will be replaced, for CHAMPUS beneficiaries who enroll, by a standard charge for most civilian provider network outpatient visits of \$12.00 per visit, or \$6.00 per visit for family members of E-4 and below sponsors. For CHAMPUS-eligible retirees, their family members and survivors, the current deductible of \$150 per person or \$300 per family and 25 percent cost sharing for outpatient services will also be replaced by a standard charge, which is likewise

\$12.00 for most outpatient visits. Retirees, their family members and survivors will also be charged a \$230/\$460 annual individual/family enrollment fee. Active duty members will face no cost sharing under TRICARE Prime.

Beneficiaries who are not enrolled in TRICARE Prime will also have significant opportunities to reduce expected out-of-pocket costs under CHAMPUS. These opportunities include the new special pharmacy programs, and access to network providers and to TRICARE Outpatient Clinics, on a space-available basis.

One design consideration for TRICARE is the mobile nature of our beneficiary population. Some features of TRICARE, such as the uniformity of the benefit and the consistency of program rules across the country, are crafted with this factor in mind. In the future, we hope to increase the "portability" of the TRICARE benefit, by making TRICARE more accessible to beneficiaries who have multiple residences, have family members in several locations, and so forth.

With respect to military hospitals, in the future consideration will be given to establishment of nominal per-visit fees, for some or all retirees, their family members, and survivors, and for some or all types of services for those beneficiaries. Fees would be considered to help control demand for MTF care, to free up capacity and reduce waiting times, and lower the costs of health care.

A user fee can be structured in many different ways, for example, exempting lower income segments of the covered population. Most importantly, the motivation for a fee is to encourage the more efficient use of health care services. When this issue is considered for possible implementation in fiscal year 1988, if the Department decides to establish a nominal fee for some or all outpatient services provided to some or all retirees, their family members, and survivors, a proposed rule will then be issued for public comment.

The TRICARE Program is a major reform of the MHSS—one that will accomplish the transition to a comprehensive managed health care system that will help to achieve DOD's medical mission into the next century.

B. Public Comments

The proposed rule was published in the Federal Register on February 8, 1995. We received 17 comment letters. We thank those who provided comments; specific matters raised by commenters are summarized below in the appropriate sections of the preamble.

II. Provisions of the Rule Regarding the Tricare Program

These regulatory changes are being published as an amendment to 32 CFR Part 199 because the operating details of CHAMPUS will be altered significantly. Our regulatory approach is to leave the existing CHAMPUS rules largely intact and to create new sections 199.17 and 199.18 to describe the TRICARE Program and the uniform HMO benefit. The major provisions of new section 199.17 regarding the TRICARE Program are summarized below. A summary of the relevant proposed rule provision is presented, followed by an analysis of major public comments, and by a summary of the final rule provisions.

A. Establishment of the TRICARE Program (Section 199.17(a))

1. Provisions of Proposed Rule

This paragraph introduces the TRICARE Program, and describes its purpose, statutory authority, and scope. It is explained that certain usual CHAMPUS and MHSS rules do not apply under the TRICARE Program, and that implementation of the Program occurs in a specific geographic area, such as a local catchment area or a region. Public notice of initiation of a Program will include a notice published in the Federal Register.

With respect to statutory authority, major statutory provisions are title 10, U.S.C. sections 1099 (which calls for health care enrollment system), 1097 (which authorizes alternative contracts for health care delivery and financing), and 1096 (which allows for resource sharing agreements). Significantly, the National Defense Authorization Act for Fiscal Year 1995 amended section 1097 to authorize the Secretary of Defense to provide for the coordination of health care services provided pursuant to any contract or agreement with a civilian managed care contractor with those services provided in MTFs. This amendment set the stage for many features of TRICARE, including initiatives to improve coordination between military and civilian health care delivery components and the consolidated schedule of beneficiary charges.

2. Analysis of Major Public Comments

Several commenters objected to the concept that all beneficiaries were "enrolled," and classified into one of five enrollment categories; they suggest that the only true enrollment is in TRICARE Prime.