#### O. Enrollment Procedures (Section 199.17(o))

# 1. Provisions of Proposed Rule

This paragraph describes procedures for enrollment of beneficiaries other than active duty members, who must enroll. The Prime plan features open season periods during which enrollment is permitted. Prime enrollees will maintain participation in the plan for a 12 month period, with disenrollment only under special circumstances, such as when a beneficiary moves from the area. A complete explanation of the features, rules and procedures of the Program in the particular locality involved will be available at the time enrollment is offered. These features, rules and procedures may be revised over time, coincident with reenrollment opportunities.

#### 2. Analysis of Major Public Comments

One commenter asked us to define the "significant effect on participant's costs or access to care" which would trigger an opportunity to change enrollment status under 199.17(0)(3).

One commenter asked if the installment method would be available for payment of the enrollment fee, and urged that no maintenance fee apply if

Response. Regarding definition of "significant effect" on costs or access, which would trigger an opportunity to change enrollment status, we define a significant effect as follows: a change in cost sharing or access policy expected to result in an increase in average annual beneficiary out-of pocket costs of \$100

Regarding installment payment of enrollment fees, a provision has been added to authorize installment payments; we hope to offer allotment payments in the future. While the rule provides only a general provision in this regard, we would point out that current practice in TRICARE is to offer a quarterly payment option, with the option to pay the full amount remaining at any time; an additional charge of \$5.00 is added to each periodic payment to cover the additional administrative costs associated with the installment method. Some beneficiaries have expressed concern about the inclusion of such a "maintenance fee." Our position is that, given that the enrollment fee has been set at the minimum amount needed to comply with statutory requirements of budget neutrality, we cannot ignore the additional costs associated with installment payment methods. We believe it is appropriate, and consistent with private sector practice, to add a

small amount to each payment, rather than to spread this cost across all beneficiaries who enroll in TRICARE Prime.

The rule also includes exclusion from TRICARE Prime for one year for failure to make an installment payment on a timely basis, including a grace period. Eligibility for TRICARE Standard and Extra would be unaffected by the exclusion penalty.

### Provisions of the Final Rule

The final rule is consistent with the proposed rule, with several exceptions. Provisions regarding open season enrollment have been broadened to include continuous open enrollment, wherein beneficiaries may enroll at any time, and each enrollee has an individualized, specific anniversary date. In addition, provisions have been added regarding the installment payment option.

# P. Civilian Preferred Provider Networks (Section 199.17(p))

#### 1. Provisions of Proposed Rule

This paragraph sets forth the rules governing civilian preferred provider networks in the TRICARE Program. It includes conformity with utilization management and quality assurance program procedures, provider qualifications, and standards of access for provider networks. In addition, the methods which may be used to establish networks are identified.

DoD beneficiaries who are not CHAMPUS-eligible, such as Medicare beneficiaries, may seek civilian care under the rules and procedures of their existing health insurance program. Providers in the civilian preferred provider network generally will be required to participate in Medicare, so that when Medicare beneficiaries use a network provider they will be assured of a participating provider.

# 2. Analysis of Major Public Comments

Two public comments indicated that the requirement for providers to accept Medicare assignment would adversely affect network development, one suggesting that the requirement was unlawful and repugnant. One commenter indicated that reductions in CHAMPUS payment amounts in recent years will make it increasingly difficult to establish and maintain an adequate network of providers, leading to lower quality providers and dissatisfaction on the part of beneficiaries.

One commenter pointed out that some categories of providers, while not ineligible for Medicare participation, have not participated in Medicare

because it is irrelevant to their lines of business. The commenter suggested that, in such cases, the requirement to participate in Medicare should not apply.

One commenter objected to the requirement that preferred providers must meet all other qualifications and requirements, and agree to comply with all other rules and procedures established for the network, suggesting that any such additional requirements must be subjected to the rulemaking process.

One commenter questioned the lack of specificity in 199.17(p)(6) regarding special reimbursement methods for network providers, and recommended additional specificity in the final rule. Another commenter recommended that the rule specify if rate setting methods for network providers will be the same as in standard CHAMPUS, and that any differences in rate setting for the "any qualified provider method" be made subject to the rulemaking process.

One commenter recommended that network requirements specify the inclusion of psychiatrists, allowed to provide a full range of diagnostic and

treatment services.

One commenter urged that we require that the network contain a sufficient number and mix of all provider types, not just physicians, and explicitly prohibit discrimination against a health care provider solely on the basis of the professional's licensure or certification, to prohibit exclusion of an entire class of health care professional.

One commenter asked who would pay for travel or overnight accommodations if a beneficiary must travel more than 30 minutes from home to a primary care delivery site.

One commenter asked why 199.17(p)(5)(ii) allows a four-week wait for a well-patient visit, and a two-week wait for a routine well-patient visit.

One commenter suggested that the wide latitude in network development methods provided by 199.17(p)(7)would create undesirable inconsistencies across the nation.

One commenter suggested that any qualified provider be allowed into the preferred provider network, regardless of the method used to develop the network.

One commenter recommended that the rule specify if rate setting methods for network providers will be the same as in standard CHAMPUS, and that any differences in rate setting for the any qualified provider method be made subject to the rulemaking process.

Response. Regarding the requirement that providers accept Medicare assignment as a condition of