network on a case-by-case basis, under ''TRICARE Extra;'' or they may remain in the standard CHAMPUS benefit plan, called ''TRICARE Standard.'' Enrollees in Prime will obtain most of their care within the network, and pay substantially reduced CHAMPUS cost shares when they receive care from civilian network providers. Enrollees in Prime will retain freedom to utilize non-network civilian providers, but they will have to pay cost sharing considerably higher than under Standard CHAMPUS if they do so. Beneficiaries who choose not to enroll in TRICARE Prime will preserve their freedom of choice of provider for the most part by remaining in TRICARE Standard. These beneficiaries will face standard CHAMPUS cost sharing requirements, except that their coinsurance percentage will be lower when they opt to use the preferred provider network under TRICARE Extra. All beneficiaries continue to be eligible to receive care in military facilities. Active duty dependents who enroll in TRICARE Prime will have a priority over other beneficiaries.

A third major feature of the TRICARE program is a series of initiatives, affecting all beneficiary enrollment categories, designed to coordinate care between military and civilian health care systems. Among these is a program of resource sharing agreements, under which a TRICARE contractor provides to a military treatment facility, personnel and other resources to increase the availability of services from military facilities and providers. Another initiative is establishment of Health Care Finders, which are administrative offices to facilitate referrals to appropriate services in the military facility or civilian provider network. In addition, integrated quality and utilization management services for military and civilian sector providers will be instituted. 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 makes permanent authority for PRIMUS and NAVCAREClinics, which are dedicated contractor-owned and operated clinics. These initiatives will have a major impact on military health care delivery systems, improving services for all beneficiary enrollment 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 out-of-pocket costs for civilian sector care. For example, the current CHAMPUS cost sharing requirements for outpatient care for active duty dependents include a deductible of $150 per person or $300 per family ($50/$100 for dependents of 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 by a standard charge for most outpatient visits of $12.00 per visit, or $6.00 per visit for dependents of E–4 and below sponsors.

For retirees, their dependents and survivors, the current deductible of $150 per person or $300 per family and 25 percent cost sharing will also be replaced by a standard charge, which is likewise $12.00 for most outpatient visits.

Beneficiaries who are not under TRICARE Prime will also have significant opportunities to reduce expected out-of-pocket costs under CHAMPUS. These opportunities include increased availability of MTF services by virtue of resource sharing agreements, the new special pharmacy programs, and access to PRIMUS and NAVCARE Clinics.

With respect to military hospitals, for retirees, their dependents, and survivors, consideration may be given in the future 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 military facility 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 provision of lower cost health care, and not to produce budgetary savings. Accordingly, analysis of alternatives would be based on the assumption that revenue produced by a user fee will be allocated to other benefits or quality of life programs. When this issue is considered for possible implementation in fiscal year 1998, 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. Again, it should be noted that this suggestion of a possible outpatient fee does not include active duty service members or their family members.

Taken as a whole, the TRICARE Program is a major reform of the Military Health Services System—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.

## II. Provisions of Proposed Rule Regarding the TRICARE Program

These regulatory changes are being published as an amendment to the 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 §§ 199.17 and 199.18 to describe the TRICARE Program and the uniform HMO benefit. The major provisions of the proposed new § 199.17 regarding the TRICARE Program are summarized below.

*A. Establishment of the TRICARE Program* (proposed § 199.17(a))

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 a 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 of agreement with a civilian managed care contractor with those services provided in military medical treatment facilities. 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.

*B. Triple Option* (proposed § 199.17(b))

This paragraph presents an overview of the triple option feature of the TRICARE Program. Most beneficiaries are offered enrollment in the TRICARE