Regulatory Flexibility Act

The Office of Justice Programs, in accordance with the Regulatory Flexibility Act (5 U.S.C. 605(b)), has reviewed this regulation and by approving it certifies that this regulation will not have a significant economic impact upon a substantial number of small entities for the following reasons:

(1) This rule provides the schedule under which eligible participants receive reimbursements for educational expenses under the Act; and

(2) Such reimbursements impose no requirements on small business or on small entities.

Unfunded Mandates Reform Act of 1995

This rule will not result in the expenditure by State, local, and Tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more in any one year, and it will not uniquely affect small governments. Therefore, no actions were deemed necessary under the provisions of the Unfunded Mandates Reform Act of 1995.

Small Business Regulatory Enforcement Fairness Act of 1996

This rule is not a major rule as defined by section 804 of the Small Business Regulatory Enforcement Fairness Act of 1996. This rule will not result in an annual effect on the economy of $100,000,000 or more; a major increase in cost or prices; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based companies to compete in domestic and export markets.

Paperwork Reduction Act

There are no collection of information requirements contained in this regulation that would require review and approval by the Office of Management and Budget under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

List of Subjects in 28 CFR Part 92

Colleges and universities, Education, Educational study programs, Educational facilities, Law enforcement officers, Schools, Student aid.

For the reasons set forth in the preamble, the interim final rule revising paragraph (b)(7) of 28 CFR Part 92.5, which was published in the **Federal Register** on June 21, 1999, at 64 FR 33016–33018, is adopted as a final rule without change.

Dated: February 4, 2000.

Laurie Robinson,

Assistant Attorney General, Office of Justice Programs.

[FR Doc. 00–3388 Filed 2–15–00; 8:45 am]

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 220

[RIN 0790–AG51]

Collection From Third Party Payers of Reasonable Costs of Healthcare Services

AGENCY: Office of the Assistant Secretary of Defense (Health Affairs), DoD.

ACTION: Final rule.

SUMMARY: This final rule implements several recent statutory changes and makes other revisions to the Third Party Collection Program. The primary matters include: implementation of new statutory authority to include workers' compensation programs under the Third Party Collection Program; the addition of special rules for collections from preferred provider organizations; and other program revisions.

DATES: This final rule is effective March 17, 2000. Section 220.12 is effective from March 17, 2000 through October 1, 2004.

FOR FURTHER INFORMATION CONTACT: Major Rose Layman, Uniform Business Office, Office of the Assistant Secretary of Defense (Health Affairs), TRICARE Management Activity, Resource Management, 5111 Leesburg Pike, Suite 810, Falls Church, VA 22041–3206, 703–681–8910.

SUPPLEMENTARY INFORMATION: This final rule implements several recent statutory changes and makes other revisions to the Third Party Collection Program under 10 U.S.C. 1095, as discussed below.

This rule was published as a proposed rule March 10, 1998, 63 FR 11635, for a 60-day comment period. We received one public comment, which was from an association of health insurance organizations that sponsor health plans under the Federal Employees Health Benefits Program. In general, this comment argued that portions of the proposed rule departed from the long-standing foundation of the Third Party Collection Program that payers must treat claims from medical facilities of the Uniformed Services no less favorably or more favorably than claims from non-federal providers, and would instead require payers to give military hospitals ''preferential treatment.''

We strongly disagree. The proposed rule and the final rule reaffirm the Department's enduring interpretation of the statute and understanding of its purpose. The purpose is to prevent health insurers from gaining a windfall at the expense of the federal government and federal taxpayers by collecting full premiums on behalf of insured persons who are also eligible for military care and then avoiding payment for covered services provided by military facilities. This Congressional purpose is especially compelling when the premium payments also come primarily from the federal government and federal taxpayers, as they do in the Federal Employees Health Benefits Program (FEHPB). In this case, the government has paid the FEHBP plan sponsor a premium to cover essentially all the health care needs of the insured person. When that insured person receives care in a military facility, the government pays again in the form of the costs of providing that care. Practices that have the effect of denying or limiting payment based solely on the fact that the care is provided in a MTF is not permissible. This is not ''preferential treatment;'' it is what is required by section 1095 for all third party payers.

We will discuss additional points made in this comment in the following summary of the features of the final rule.

1. Preferred Provider Organizations

Section 713(b)(1) of the National Defense Authorization Act for Fiscal Year 1994, Pub. L. 103–160, amended the Third Party Collection Program's definition of ''insurance, medical service, or health plan'' to clarify that any ''preferred provider organization'' (PPO) is included in the definition. This amendment codified DoD's previous interpretation. Experience in applying the statutory authority to the context of preferred provider organizations has indicated a need to establish some special rules for plans with PPO provisions or options so that all parties will have a clearer understanding of their obligations and rights under the statute. We do this by amending § 220.12.

It is our interpretation of 10 U.S.C. 1095 that a plan with a PPO provision or option generally has an obligation to pay the United States the reasonable costs of health care services provided through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the plan. No provision of any

PPO plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided through a facility of the Uniformed Services shall operate to prevent collection under this part.

10 U.S.C.1095 strikes a careful balance. On the one hand, it disallows third party payer rules that would have the effect of excluding from coverage or limiting payment because the care was provided in a DoD facility. The law renders inoperative numerous administrative procedures and payment rules of third party payers that would defeat the purpose of 10 U.S.C. 1095 or result in a windfall for a third party payer who has collected premiums but then avoided payments. On the other hand, the statute does not require third party payers to make fundamental changes in their own rules in order to accommodate Government providers. This final rule reflects that balance in our special rules for PPOs.

Consistent with the statutory mandate that the operation of the Third Party Collection Program is not dependent upon a participation agreement or similar contractual relationship between military treatment facilities and third party payers, this final rule states that the lack of a PPO agreement or the absence of privity of contract is not a permissible ground for refusing or reducing payment. Based on this and the careful statutory balance, we believe that under the law, the lack of a contractual relationship between the PPO and the facility of the Uniformed Services may not be a basis for the plan to treat the DoD facility as a non-PPO provider for purposes of the PPO's payment amount, if the facility of the Uniformed Services accommodates the PPO's fundamental price and utilization management standards.

Under this final rule, a DoD facility accommodates a PPO's fundamental price standards by accepting, in lieu of the normal Third Party Collection Program rates established under § 220.8, the PPO's prevailing rates of payment paid to preferred providers in the same geographic area for the same or similar aggregate groups of services, if such rates are, in the aggregate, less than the DoD rates. A DoD facility accommodates a PPO's fundamental utilization management by complying with the reasonable pretreatment, concurrent, or retrospective review procedures that are required of all preferred providers under the PPO plan and by accepting denials of requested payment that are consistent with prevailing standards in the geographic area of medical necessity and proper level of care for the services involved. In other words, if DoD rates are not representative of what a PPO perceives to be an optimal efficient practice as demonstrated by the rates of other providers in their network, DoD will accept the prevailing rate as payment in full with the provision that the PPO furnish the required information as stated in § 220.12(d). At the same time, if the DoD rates are lower than or equal to the prevailing PPO rates, then DoD will accept DoD rates as payment in full.

By accommodating a PPO's fundamental price and utilization management standards, DoD does not seek to compel the third party payer to make fundamental changes in its PPO program in order to conform to the DoD facility's operations. But other rules and procedures of the PPO that would have the effect of denying or limiting payment are not allowed. This final rule includes several examples of such impermissible PPO requirements. Among these is any PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.

The comment we received objected to this portion of the proposed rule on the grounds that, even if the facility of the Uniformed Services accepts the PPO payment rate and utilization management requirements, it exceeds DoD authority to disallow reduced, non-PPO payments (based on higher beneficiary copayments for using non-PPO providers) unless the facility complies with all other rules of the PPO ''to bill for services rendered using forms, codes, etc. as requested by the payer'' and otherwise ''to reduce administrative and benefit costs.'' We disagree. With Congress amending section 1095(h)(2) to specifically cover PPOs, section 1095(b) now clearly commands that no PPO requirement having the effect of limiting payment of charges shall operate to prevent collection under section 1095 for care provided by a facility of the Uniformed Services that does not have a participation agreement with the PPO. We do not believe this can be reasonably interpreted to mean that PPO requirements that would compel military facilities to sign participation agreements to conform to all of the PPO's forms, codes, and procedures shall be given effect. Rather, we read section 1095(a) and (b) together to strike the careful balance described above, accepting fundamental plan elements but dismissing what might be a myriad of other procedures, caveats, forms, codes, and administrative requirements.

The comment also argued that the proposed rule did not adequately accommodate a PPO's fundamental price standards because it continued to base billings on DoD's cost allocation structure, rather than the PPO's payment methodology. Again, we disagree. The billing structure used by DoD, which by necessity is the point of comparison with the PPO's payment rates to determine whether to accept payments less than DoD's calculated costs, is based specifically on the authority contained in section 1095(f). Thus, the rule is entirely consistent with the statute concerning cost calculations.

There may be a suspicion that the DoD rates, as a representative of reasonable costs, indicate inefficient practices. This impression might be created by trying to compare a DoD average all-inclusive rate with that of an itemized rate methodology. The wide variation in these two pricing methodologies leads to misunderstanding of DoD practices. The cost per DoD eligible is in fact far below the average national expenditure per person on healthcare. However, in an effort to move toward civilian industry practices, DoD will issue a proposed rule this year to implement the new rate methodology authorized by section 716 of the National Defense Authorization Act for Fiscal Year 2000. This change will allow DoD to calculate reasonable charges for both inpatient and outpatient services. These reasonable charges will become the standard DoD rates. More specifically, the new law allows Military Treatment Facilities to adopt the rates and rate structure such as that currently used under CHAMPUS/TRICARE. The CHAMPUS/TRICARE payment rates for professional services are essentially the same as the Medicare fee schedule and are equal to significantly discounted rates by procedure code. As such, these rates are extremely competitive with civilian sector pricing. Billing will conform to common methods used by the insurance industry, utilizing standardized procedure codes, and will facilitate easy rate comparisons.

Although we believe the special rules established by § 220.12 are correct and proper interpretations of the statute, we have added in the final rule a sunset provision for this section of the regulation. It states that these special rules will no longer be in effect as of October 1, 2004. This sunset provision is included to permit both the Department of Defense and third party payers to gain experience with these rules and have an assured opportunity to revisit these rules in a subsequent rule making process. It is our intent to

initiate a new rule making process early in fiscal year 2004. By that time, the new rate methodology discussed above will be in effect, permitting easy rate comparisons.

We will also have experience with other aspects of the implementation of this section. During the fiscal year 2004 rule making process, third party payers will have the opportunity to present evidence of any effects of this section the payers believe are unfair. This includes any evidence or data they may have of a cost impact of this section, a change in utilization by plan members, any effects in particular geographical areas, any litigation results, any management consequences, changes in beneficiary satisfaction or enrollment rates, or any other effects, analysis or observations concerning the implementation of this section. The sunset provision is a good faith effort by the Department of Defense to reexamine after a reasonable implementation period the premises and expectations presented above and to consider perspectives and views of all interested parties then informed by experience with this section.

To recap, under the final rule, we will accommodate a PPO's fundamental price and utilization management standards. But we will not give effect to other requirements unnecessary for the achievement of the PPO's fundamental price and utilization management standards, such as requirements to accept PPO beneficiaries not eligible for military health care, to follow certain licensing, certification, or provider selection criteria, or to restrict patient referrals to providers specified by the PPO. Rules of this kind clearly defeat the purpose of section 1095 and contravene congressional policy. After considering attentively the comment, we conclude that the rule, including the new sunset provision, strikes the careful balance of the statute in the context of PPO implementation.

2. Workers' Compensation Programs

Section 735(b)(1) of the National Defense Authorization Act for Fiscal Year 1997, Pub. L. 104–201, expanded the definition of ''third party payer'' to include any ''workers'' compensation program or plan.'' The final rule adds § 220.13 and a definition of the statutory term to implement this amendment.

While specific statutory schemes vary from State to State, workers' compensation plans generally provide compensation to employees or their dependents for loss resulting from the injury, disablement, or death of a worker due to an employment related accident, casualty, or disease. The common characteristic of workers' compensation programs is the provision of compensation based upon a fixed statutory scheme without regard to fault. Payment for the costs and provision of medical care are also common elements of workers' compensation programs, whether the program operates on the basis of insurance, a State fund, or other mechanism.

The new § 220.13 states that a workers' compensation program generally has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary of the workers' compensation program and whose condition is due to an employment related accident, casualty, or disease. We have added several special rules concerning lump-sum payments and compromise settlements. These special rules are modeled after Medicare Secondary Payer rules applicable to workers' compensation programs, which appear at 42 CFR 411.46–47.

3. Other Program Revisions and Clarifications

This final rule makes several other program revisions and clarifications, including:

An amendment to § 220.2(a) to conform with statutory language making 10 U.S.C. 1095 applicable to services provided in or ''through'' a facility of the Uniformed Services.

An amendment to § 220.2(d) to clarify the obligation of the third party payer to pay under the Third Party Collection Program is not only not dependent upon an assignment of benefits, it is also not dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal.

An addition of § 220.2(e) to codify in the regulation our interpretation of the preemptive effect of 10 U.S.C. 1095 in relation to any conflicting State laws or regulations.

An addition of § 220.3(c)(5) to record our interpretation of the applicability of 10 U.S.C. 1095 in connection with Medicare carve-out and Medicare secondary payer provisions of third party payer plans (other than Medicare supplemental plans). This is another application of the general rule that third party payers may not treat claims from facilities of the Uniformed Services less favorably than they lawfully treat claims from other providers (in this context, other providers to whom primary payment would not be made by Medicare or a Medicare HMO).

An amendment to § 220.4 to clarify the permissibility of certain third party payer rules, including utilization review practices, and HMO plan restrictions.

An addition of § 220.4(d) to record our requirement for payers to provide us plan information necessary to establish the permissibility of terms and conditions of third party payers' plans.

An amendment to § 220.7 to clarify the United States' remedies concerning collections from third party payers.

An amendment to § 220.8 to change and clarify DoD's actions in categorizing standardized amounts for the DRG-based payment method for inpatient care, in subdividing outpatient billings, and in replacing the ''same day surgery'' category of care with an expanded ''ambulatory procedure visit'' category.

An amendment to § 220.8(h), a special rule for certain ancillary services ordered by outside providers and provided by a facility of the Uniformed Services, to lower the high cost ancillary threshold value from $25 to $0. For this reason, ''high cost ancillary services'' are now referred to as ''ancillary services ordered by an outside provider and provided by a facility of the Uniformed Services.''

An amendment to § 220.8(j), concerning the former Public Health Service hospitals, to conform to the changes to that program directed by Congress in sections 721 to 727 of the National Defense Authorization Act for Fiscal Year 1997.

An amendment to § 220.9(c) which elaborates on the obligations of beneficiaries to cooperate with facilities of the Uniformed Services in implementing these regulations.

Several additions and amendments to § 220.14 to add and change, as necessary, the definitions of terms used in this part.

The single public comment we received objected to several of these provisions. Among these was the change to § 220.2(d) regarding claims and appeals procedures, to which the comment objected on the grounds that this would result in preferential treatment to military facilities over civilian facilities which need an assignment of benefits from the covered beneficiary. We believe the rule is correct. Under section 1095, the right of the health care provider (*i.e.*, the United States government) to collect is not based on a contractual relationship between the provider and the

beneficiary (*i.e.*, assignment of benefits from the beneficiary to the government), but rather on the right of the United States established by section 1095(a) to collect from the third party payer. To condition this right to collect on some permission from the beneficiary would conflict with section 1095.

The comment also dissented from the new § 220.3(c)(5) concerning Medicare carve-out and Medicare secondary payer provisions because it purports ''to specify what benefits third party payers may or may not provide.'' Actually, it does no such thing. It simply provides that for a Medicare carve-out or Medicare secondary payer exclusion to be used permissibly to refuse to make primary payment to a facility of the Uniformed Services, it must expressly apply to all providers to whom payment would not be made under Medicare. This is nothing more than a restatement in the context of Medicare carve-out and Medicare secondary payer provisions of the general rules of section 1095 that a payer may not discriminate against federal facilities. If a payer applies Medicare carve-out or Medicare secondary payer provisions to avoid payments to a facility of the Uniformed Services similar to payments that it would make to non-federal facilities not reimbursed by Medicare Part A, Part B, a Medicare HMO, or a Medicare Plus Choice plan, then it is discriminating against the facility of the Uniformed Services in violation of section 1095.

Finally, the comment expressed objection to the new § 220.7(d), which disallows plans from offsetting payments, without the consent of an authorized government official, to a facility of the Uniformed Service because the payer considers itself due a refund from the facility of the Uniformed Services arising from earlier payments from that third party payer. The comment argued that this is beyond DoD's authority because such offsets are common industry practice. We do not concur. Under section 1095, the United States has a right to collect, consistent with the statutory terms, the reasonable costs of health care services provided from a third party payer. This right is not contingent upon a third party payer's assertions regarding previous alleged overpayments. Moreover, under section 1095(e)(2), the authority to compromise a claim rests with the government, not with the payer. Without the consent of the government, a third party payer cannot compromise a claim premised on some separate disputed transaction. A request for refund must be submitted and adjudicated separately.

4. Other Issues

Under § 220.10(c), we provide notice of our intention to begin, effective April 1, 2000, to collect from Medicare supplemental plans reasonable costs for inpatient and outpatient copayments, other than the inpatient hospital deductible amount, and other services covered by Medicare supplemental plans. Although this authority is currently established in § 220.10(c), we had previously decided to defer implementation.

Executive Order 12866, the Unfunded Mandates Reform Act and Public Law 96–354, ''Regulatory Flexibility Act'' (5 U.S.C. 601)

This rule has been reviewed in accordance with the provisions of Executive Order of 12866 and the Regulatory Flexibility Act (5 U.S.C. 601–612), and it is not believed to meet the criteria for an economically significant regulatory action. Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when rulemaking is necessary, to select regulatory approaches that maximize net benefits including potential economic, environmental, public health, safety distributive and equity effects. The Unfunded Mandates Reform Act, Public Law 104–4, requires that agencies prepare an assessment of anticipated costs and benefits on any rulemaking that may result in an expenditure by State, local, or tribal government, or by the private sector of $100 million or more in any given year.

Executive Order 12866 requires that all regulations reflect consideration of alternatives, costs, benefits, incentives, equity, and available information. While 32 CFR part 220, Collection From Third Party Payers of Reasonable Costs of Healthcare Services, implements several changes to the Third Party Collection Program, we believe that this final rule should have no significant economic impact. The greatest concern expressed has been by the Office of Personnel Management (OPM) in regards to the addition of special rules for collections from PPOs and financial impact on the Federal Employees Health Benefits Program (FEHBP).

A cost benefit analysis to assess the full financial impact of this final rule is difficult as neither OPM nor DoD have a basis for a solid estimate of a precise number of DoD beneficiaries who have a Preferred Provider Organization plan throughout the industry, or in the FEHBP segment of the industry. In addition, current information systems do not provide an exact accounting of dollars and reasons for denied claims for this one population of patients. Therefore, cost estimates for FEHBP and total PPO denials are based on a limited manual review of claims data from Army Military Treatment Facilities (MTFs). The Army reported the dollar amount billed and the dollar amount denied due to non-PPO status with respect to all health plans. This percentage was then applied to total claims data from all Services.

A review of these results leads to an estimate of $49 million in annual reductions because the MTF provider was considered a non-preferred network provider by the payers. We estimate that FEHBP plans represent approximately 20–25% of all military treatment facility claims to third party payers. This leads to an estimate of annual impact on the FEHBP segment of the industry of $9.8 million to $12.25 million. These are good faith estimates based on very limited data.

Executive Order 13132, Federalism

We have reviewed this rule under the threshold criteria of Executive order 13132 of August 4, 1999, Federalism, published in the **Federal Register** on August 10, 1999 (64 FR 43255). Executive Order 13132 establishes special procedures for final regulations that have federalism implications. We have determined that this rule does not significantly affect the rights, roles, and responsibilities of States.

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

Information collection in compliance with this CFR, specifically section 220.9 '' Rights and obligations of beneficiaries'', is currently obtained on the DD form 2569, covered under OMB clearance 0704–032.

List of Subjects in 32 CFR Part 220

Claims, Health care, Health insurance.

For the reasons stated in the preamble, 32 CFR part 220 is amended as follows:

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE COSTS OF HEALTH CARE SERVICES

1. The authority citation for 32 CFR part 220 continues to read as follows:

Authority: 5 U.S.C. 301, 10 U.S.C. 1095.

2. Section 220.2 is amended by revising paragraphs (a) and (d) and by adding a new paragraph (e) to read as follows:

§ 220.2 Statutory obligation of third party payer to pay.

(a) *Basic rule.* Pursuant to 10 U.S.C. 1095(a)(1), a third party payer has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the third party payer's plan. The obligation to pay is to the extent that the beneficiary would be eligible to receive reimbursement of indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

* * * * *

(d) *Assignment of benefits or other submission by beneficiary not necessary.* The obligation of the third party payer to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States. Nor is the obligation to pay dependent upon any other submission by the beneficiary to the third party payer, including any claim or appeal. In any case in which a facility of the Uniformed Services makes a claim, appeal, representation, or other filing under the authority of this part, any procedural requirement in any third party payer plan for the beneficiary of such plan to make the claim, appeal, representation, or other filing must be deemed to be satisfied. A copy of the completed and signed DoD insurance declaration form will be provided to payers upon request, in lieu of a claimant's statement or coordination of benefits form.

(e) *Preemption of conflicting State laws.* Any provision of a law or regulation of a State or political subdivision thereof that purports to establish any requirement on a third party payer that would have the effect of excluding from coverage or limiting payment, for any health care services for which payment by the third party payer under 10 U.S.C. 1095 or this part is required, is preempted by 10 U.S.C. 1095 and shall have no force or effect in connection with the third party payer's obligations under 10 U.S.C. 1095 or this part.

3. Section 220.3 is amended by adding a new paragraph (c)(5) to read as follows:

§ 220.3 Exclusions impermissible.

* * * * *

(c) * * *

(5) *Medicare carve-out and Medicare secondary payer provisions.* A provision in a third party payer plan, other than a Medicare supplemental plan under § 220.10, that seeks to make Medicare the primary payer and the plan the secondary payer or that would operate to carve out of the plan's coverage an amount equivalent to the Medicare payment that would be made if the services were provided by a provider to whom payment would be made under Part A or Part B of Medicare is not a permissible ground for refusing or reducing payment as the primary payer to the facility of the Uniformed Services by the third party payer unless the provision:

(i) Expressly disallows payment as the primary payer to all providers to whom payment would not be made under Medicare (including payment under Part A, Part B, a Medicare HMO, or a Medicare+Choice plan); and

(ii) Is otherwise in accordance with applicable law.

4. Section 220.4 is amended by revising paragraphs (b)(2), (c)(2), and (c)(3) and by adding a new paragraph (d) to read as follows:

§ 220.4 Reasonable terms and conditions of health plan permissible.

* * * * *

(b) * * *

(2) Except as provided by 10 U.S.C. 1095, this part, or other applicable law, third party payers are not required to treat claims arising from services provided in or through facilities of the Uniformed Services more favorably than they treat claims arising from services provided in other facilities or by other health care providers.

(c) * * *

(2) *Generally applicable utilization review provisions.* (i) Reasonable and generally applicable provisions of a third party payer's plan requiring pre-admission screening, second surgical opinions, retrospective review or other similar utilization management activities may be permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan.

(ii) Such provisions are not permissible if they are applied in a manner that would result in claims arising from services provided by or through facilities of the Uniformed Services being treated less favorably than claims arising from services provided by other hospitals or providers.

(iii) Such provisions are not permissible if they would not affect a third party payer's obligation under this part. For example, concurrent review of an inpatient hospitalization would generally not affect the third party payer's obligation because of the DRG-based, per-admission basis for calculating reasonable costs under § 220.8(a) (except in long stay outlier cases, noted in § 220.8(a)(4)).

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of non-emergency or non-urgent services provided outside the HMO (or similar exclusions) are permissible. However, HMOs may not exclude claims or refuse to certify emergent and urgent services provided within the HMO's service area or otherwise covered non-emergency services provided out of the HMO's service area. In addition, opt-out or point-of-service options available under an HMO plan may not exclude services otherwise payable under 10 U.S.C. 1095 or this part.

(d) *Procedures for establishing reasonable terms and conditions.* In order to establish that a term or condition of a third party payer's plan is permissible, the third party payer must provide appropriate documentation to the facility of the Uniformed Services. This includes, when applicable, copies of explanation of benefits (EOBs), remittance advice, or payment to provider forms. It also includes copies of policies, employee certificates, booklets, or handbooks, or other documentation detailing the plan's health care benefits, exclusions, limitations, deductibles, co-insurance, and other pertinent policy or plan coverage and benefit information.

5. Section 220.7 is amended by revising the section heading and paragraph (c) and by adding a new paragraph (d) to read as follows:

§ 220.7 Remedies and procedures.

* * * * *

(c) The authorities provided by 31 U.S.C. 3701, *et seq.*, 28 CFR part 11, and 4 CFR parts 101–104 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

(d) A third party payer may not, without the consent of a U.S. Government official authorized to take action under 10 U.S.C. 1095 and this part, offset or reduce any payment due under 10 U.S.C. 1095 or this part on the grounds that the payer considers itself due a refund from a facility of the Uniformed Services. A request for refund must be submitted and adjudicated separately from any other claims submitted to the third party payer under 10 U.S.C. 1095 or this part.

6. Section 220.8 is amended by revising paragraphs (a)(2), (a)(6), (e)(1), (f), and (h); by redesignating paragraph

(j) as paragraph (j)(1); and by adding a new paragraph (j)(2), to read as follows:

§ 220.8 Reasonable costs.

* * * * *

(a) * * *

(2) *Standardized amount.* The standardized amount shall be determined by dividing the total costs of all inpatient care in all military treatment facilities by the total number of discharges. This will produce a single national standardized amount. The Department of Defense is authorized, but not required by this part, to calculate three standardized amounts, one for large urban, other urban/rural, and overseas areas, utilizing the same distinctions in identifying the first two areas as is used for CHAMPUS under 32 CFR 199.14(a)(1). Using this applicable standardized amount, the Department of Defense may make adjustments for area wage rates and indirect medical education costs (as identified in paragraph (a)(4) of this section), producing for each inpatient facility of the Uniformed Services a facility-specific ''adjusted standardized amount'' (ASA).

* * * * *

(6) *Outpatient billings.* Outpatient billings (including those for ambulatory procedure visits) may, but are not required by this part, to be subdivided into two categories:

(i) Professional charges (which refers to professional services provided by physicians and certain other providers); and

(ii) Outpatient services (which refers to overhead and ancillary, diagnostic and treatment services, other than professional services provided in connection with the outpatient visit).

* * * * *

(e) *Per visit rates.* (1) As authorized by 10 U.S.C. 1095(f)(2), the computation of reasonable costs for purposes of collections for most outpatient services shall be based on a per visit rate for a clinical specialty or subspecialty. The per visit charge shall be equal to the outpatient full reimbursement rate for that clinical specialty or subspecialty and includes all routine ancillary services. A separate charge will be calculated for cases that are considered ambulatory procedure visits. These rates shall be updated and published annually. As with inpatient billing categories, clinical groups representing selected board certified specialties/subspecialties widely accepted by graduate medical accrediting organizations such as the Accreditation Council for Graduate Medical Education (ACGME) or the American Board of Medical Specialties will be used for ambulatory billing categories. Related clinical groups may be combined for purposes of billing categories.

* * * * *

(f) *Ambulatory procedure visit rates.* A separate charge will be calculated for ambulatory procedure visits (APVs). APVs are same day surgery visits and other outpatient visits provided by designated, special treatment units in facilities of the Uniformed Services. APV rates shall be based on the total cost of immediate (day of procedure) pre-procedure; procedure; and immediate post-procedure care performed in the ambulatory procedure unit setting for care requiring less than 24 hours in the facility. An APV is not inpatient care. The Department of Defense is authorized, but not required by this part, to establish multiple ambulatory procedure visit reimbursement categories based on the clinic or subspecialty performing the ambulatory procedure. The average cost of APVs will be published annually.

* * * * *

(h) *Special rule for ancillary services ordered by outside providers and provided by a facility of the Uniformed Services.* If a Uniformed Services facility provides certain ancillary services, prescription drugs or other procedures requested by a source other than a Uniformed Services facility and are not incident to any outpatient visit or inpatient services, the reasonable cost will not be based on the usual Diagnostic Related Group (DRG) or per visit rate. Rather, a separate standard rate shall be established based on the cost of the particular services, drugs, or procedures provided. Effective April 1, 2000, this special rule applies to all services, drugs or procedures ordered by an outside provider and provided by a facility of the Uniformed Services. For such ancillary services provided prior to April 1, 2000, this special rule applies only to services, drugs or procedures having a cost of at least $25. The reasonable cost for the services, drugs or procedures to which this special rule applies shall be calculated and made available to the public annually.

* * * * *

(j) * * *

(2) The special rule set forth in paragraph (j)(1) of this section expires September 30, 1997. Effective October 1, 1997, collections for health care services provided by these facilities are no longer covered by this part, but are covered by 32 CFR 199.8 (CHAMPUS Double Coverage).

7. Section 220.9 is amended by revising paragraph (c) to read as follows:

§ 220.9. Rights and obligations of beneficiaries.

* * * * *

(c) *Obligation to disclose information and cooperate with collection efforts.* (1) Uniformed Services beneficiaries are required to provide correct information to the facility of the Uniformed Services regarding whether the beneficiary is covered by a third party payer's plan. Such beneficiaries are also required to provide correct information regarding whether particular health care services might be covered by a third party payer's plan, including services arising from an accident or workplace injury or illness. In the event a third party payer's plan might be applicable, a beneficiary has an obligation to provide such information as may be necessary to carry out 10 U.S.C. 1095 and this part, including identification of policy numbers, claim numbers, involved parties and their representatives, and other relevant information.

(2) Uniformed Services beneficiaries are required to take other reasonable steps to cooperate with the efforts of the facility of the Uniformed Services to make collections under 10 U.S.C. 1095 and this part, such as submitting to the third party payer (or other entity involved in adjudicating a claim) any requests or documentation that might be required by the third party payer (or other entity), if consistent with this part, to facilitate payment under this part.

(3) Intentionally providing false information or willfully failing to satisfy a beneficiary's obligations are grounds for disqualification for health care services from facilities of the Uniformed Services.

8. Section 220.12 in redesignated as § 220.14 and new §§ 220.12 and 220.13 are added to read as follows:

§ 220.12 Special rules for preferred provider organizations.

(a) *Statutory requirement.* (1) Pursuant to the general duty of third party payers to pay under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a plan with a preferred provider organization (PPO) provision or option generally has an obligation to pay the United States the reasonable costs of health care services provided through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under the plan.

(2) This section provides specific rules for applying 10 U.S.C. 1095 and this part in the context of plans with a PPO provision or option.

(b) *PPO plan exclusions and limitations impermissible.* Under 10 U.S.C. 1095(b), no provision of any plan

with a PPO provision or option having the effect of excluding from coverage or limiting payment for certain care if that care is provided through a facility of the Uniformed Services shall operate to prevent collection under this part.

(c) *PPO agreement not required.* The lack of a PPO agreement or the absence of privity of contract between a plan with a preferred provider organization provision or option and a facility of the Uniformed Services is not a permissible ground for refusing or reducing payment by the plan. The lack of a contractual relationship between the plan and the facility of the Uniformed Services may not be a basis for the plan to treat a facility of the Uniformed Services as a non-PPO provider for purposes of the plan's PPO payment amount, if the facility of the Uniformed Services accommodates the plan's fundamental price and utilization management standards for its PPO provision or option, as provided in this section.

(d) *Accommodation of PPO's fundamental price and utilization review standards.* A plan's duty to pay under this section is premised on the accommodation by the facility of the Uniformed Services of the plan's fundamental price and utilization review standards for its PPO provision or option, as provided in this paragraph.

(1) A facility of the Uniformed Services accommodates a plan's fundamental PPO price standards by accepting, in lieu of the rates established under § 220.8, the plan's demonstrated PPO prevailing rates of payment paid to preferred providers in the same geographic area for the same or similar aggregate groups of services, if such rates are, in the aggregate, less than the rates established under § 220.8. The determination of the plan's PPO prevailing rates shall be based on a review of all rates, including the professional and technical components, contained in all valid contractual arrangements with facilities and providers in the PPO network for the year in which the services were rendered. The rates for any specific ancillary procedure must include both professional and technical components.

(2) A facility of the Uniformed Services accommodates a plan's fundamental PPO utilization review standards by complying with the reasonable pretreatment, concurrent, or retrospective review procedures that are required of all preferred providers under the plan and by accepting denials or reductions of requested payment that are consistent with prevailing standards in the geographic area for medical necessity and proper level of care for the services involved.

(e) *Examples of impermissible PPO requirements.* PPO requirements unnecessary for the achievement of the PPO's fundamental price and utilization review standards and would have the effect of excluding or limiting payment to a facility of the Uniformed Services are impermissible. Examples of such impermissible PPO requirements follow:

(1) A requirement that a PPO provider accept all beneficiaries of the PPO's plan. A facility of the Uniformed Services may provide health care services only to persons with eligibility established pursuant to 10 U.S.C. Chapter 55.

(2) A requirement that a PPO provider meet particular credentialing, licensing, certification, or other provider selection requirements intended to promote good quality of care. Facilities of the Uniformed Services comply with federal quality standards and a comprehensive system of provider credentialing and quality assurance.

(3) A requirement that PPO providers restrict patient referrals to particular providers in the PPO network or order ancillary services only from particular providers. Facilities of the Uniformed Services carry out patient referrals and the ordering of ancillary services in accordance with applicable Department of Defense rules and procedures.

(4) Any other PPO requirement that would purport to require a facility of the Uniformed Services, in order to effectuate the legislative purpose of 10 U.S.C. 1095, to act in a manner inconsistent with the basic nature of facilities of the Uniformed Services.

(f) *Sunset of section.* The special rules established by this § 220.12 shall no longer be in effect as of October 1. 2004.

§ 220.13 Special rules for workers' compensation programs.

(a) *Basic rule.* Pursuant to the general duty of third party payers under 10 U.S.C. 1095(a)(1) and the definitions of 10 U.S.C. 1095(h), a workers' compensation program or plan generally has an obligation to pay the United States the reasonable costs of health care services provided in or through any facility of the Uniformed Services to a Uniformed Services beneficiary who is also a beneficiary under a workers' compensation program due to an employment related injury, illness, or disease. Except to the extent modified or supplemented by this section, all provisions of this part are applicable to any workers' compensation program or plan in the same manner as they are applicable to any other third party payer.

(b) *Special rules for lump-sum settlements.* In cases in which a lump-sum workers' compensation settlement is made, the special rules established in this paragraph (b) shall apply for purposes of compliance with this section.

(1) *Lump-sum commutation of future benefits.* If a lump-sum worker's compensation award stipulates that the amount paid is intended to compensate the individual for all future medical expenses required because of the work-related injury, illness, or disease, the Uniformed Service health care facility is entitled to reimbursement for injury, illness, or disease related, future health care services or items rendered or provided to the individual up to the amount of the lump-sum payment.

(2) *Lump-sum compromise settlement.* (i) A lump sum compromise settlement, unless otherwise stipulated by an official authorized to take action under 10 U.S.C. 1095 and this part, is deemed to be a workers' compensation payment for the purpose of reimbursement to the facility of the Uniformed Services for services and items provided, even if the settlement agreement stipulates that there is no liability under the workers' compensation law, program, or plan.

(ii) If a settlement appears to represent an attempt to shift to the facility of the Uniformed Services the responsibility of providing uncompensated services or items for the treatment of the work-related condition, the settlement will not be recognized and reimbursement to the uniformed health care facility will be required. For example, if the parties to a settlement attempt to maximize the amount of disability benefits paid under workers' compensation by releasing the employer or workers' compensation carrier from liability for medical expenses for a particular condition even though the facts show that the condition is work-related, the facility of the Uniformed Services must be reimbursed.

(iii) Except as specified in paragraph (b)(2)(iv) of this section, if a lump-sum compromise settlement forecloses the possibility of future payment or workers' compensation benefits, medical expenses incurred by a facility of the Uniformed Services after the date of the settlement are not reimbursable under this section.

(iv) As an exception to the rule of paragraph (b)(2)(iii) of this section, if the settlement agreement allocates certain amounts for specific future medical services, the facility of the Uniformed Services is entitled to reimbursement for those specific services and items provided resulting from the work-related injury, illness, or disease up to the amount of the lump-sum settlement allocated to future expenses.

(3) *Apportionment of a lump-sum compromise settlement of a workers' compensation claim.* If a compromise settlement allocates a portion of the payment for medical expenses and also gives reasonable recognition to the income replacement element, that apportionment may be accepted as a basis for determining the payment obligation of a workers' compensation program or plan under this section to a facility of the Uniformed Services. If the settlement does not give reasonable recognition to both elements of a workers' compensation award or does not apportion the sum granted, the portion to be considered as payment for medical expenses is computed as follows: determine the ratio of the amount awarded (less the reasonable and necessary costs incurred in procuring the settlement) to the total amount that would have been payable under workers' compensation if the claim had not been compromised; multiply that ratio by the total medical expenses incurred as a result of the injury or disease up to the date of settlement. The product is the amount of workers' compensation settlement to be considered as payment or reimbursement for medical expenses.

9. Newly redesignated § 220.14 is amended by removing paragraph designations (a) through (l), by revising the definitions of ''insurance, medical service or health plan,'' ''Medicare supplemental insurance plan,'' ''third party payer,'' and ''third party payer plan,'' and by adding in alphabetical order new definitions of ''ambulatory procedure visit,'' ''Assistant Secretary of Defense (Health Affairs),'' ''covered beneficiaries,'' ''preferred provider organization,'' and ''workers' compensation program or plan,'' to read as follows:

§ 220.14 Definitions.

Ambulatory procedure visit. An ambulatory procedure visit is a type of outpatient visit in which immediate (day of procedure) pre-procedure and immediate post-procedure care require an unusual degree of intensity and are provided in an ambulatory procedure unit (APU) of the facility of the Uniformed Services. Care is required in the facility for less than 24 hours. An APU is specially designated and is accounted for separately from any outpatient clinic.

Assistant Secretary of Defense (Health Affairs). This term includes any authorized designee of the Assistant Secretary of Defense (Health Affairs).

* * * * * * * * * *

Covered beneficiaries. Covered beneficiaries are all health care beneficiaries under chapter 55 of title 10, United States Code, except members of the Uniformed Services on active duty.

* * * * ** * * * *

Insurance, medical service or health plan. Any plan (including any plan, policy, program, contract, or liability arrangement) that provides compensation, coverage, or indemnification for expenses incurred by a beneficiary for health or medical services, items, products, and supplies. It includes but is not limited to:

(1) Any plan offered by an insurer, re-insurer, employer, corporation, organization, trust, organized health care group or other entity.

(2) Any plan for which the beneficiary pays a premium to an issuing agent as well as any plan to which the beneficiary is entitled as a result of employment or membership in or association with an organization or group.

(3) Any Employee Retirement Income and Security Act (ERISA) plan.

(4) Any Multiple Employer Trust (MET).

(5) Any Multiple Employer Welfare Arrangement (MEWA).

(6) Any Health Maintenance Organization (HMO) plan, including any such plan with a point-of-service provision or option.

(7) Any individual practice association (IPA) plan.

(8) Any exclusive provider organization (EPO) plan.

(9) Any physician hospital organization (PHO) plan.

(10) Any integrated delivery system (IDS) plan.

(11) Any management service organization (MSO) plan.

(12) Any group or individual medical services account.

(13) Any preferred provider organization (PPO) plan or any PPO provision or option of any third party payer plan.

(14) Any Medicare supplemental insurance plan.

(15) Any automobile liability insurance plan.

(16) Any no fault insurance plan, including any personal injury protection plan or medical payments benefit plan for personal injuries arising from the operation of a motor vehicle.

* * * * *

Medicare supplemental insurance plan. A Medicare supplemental insurance plan is an insurance, medical service or health plan primarily for the purpose of supplementing an eligible person's benefit under Medicare. The term has the same meaning as ''Medicare supplemental policy'' in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss) and 42 CFR part 403, subpart B.

* * * * *

Preferred provider organization. A preferred provider organization (PPO) is any arrangement in a third party payer plan under which coverage is limited to services provided by a select group of providers who are members of the PPO or incentives (for example, reduced copayments) are provided for beneficiaries under the plan to receive health care services from the members of the PPO rather than from other providers who, although authorized to be paid, are not included in the PPO. However, a PPO does not include any organization that is recognized as a health maintenance organization.

Third party payer. A third party payer is an entity that provides an insurance, medical service, or health plan by contract or agreement. It includes but is not limited to:

(1) State and local governments that provide such plans other than Medicaid.

(2) Insurance underwriters or carriers.

(3) Private employers or employer groups offering self-insured or partially self-insured medical service or health plans.

(4) Automobile liability insurance underwriter or carrier.

(5) No fault insurance underwriter or carrier.

(6) Workers' compensation program or plan sponsor, underwriter, carrier, or self-insurer.

Third party payer plan. A third party payer plan is any plan or program provided by a third party payer, but not including an income or wage supplemental plan.

* * * * *

Workers' compensation program or plan. A workers' compensation program or plan is any program or plan that provides compensation for loss, to employees or their dependents, resulting from the injury, disablement, or death of an employee due to an employment related accident, casualty or disease. The common characteristic of such a plan or program is the provision of compensation regardless of fault, in accordance with a delineated schedule based upon loss or impairment of the worker's wage earning capacity, as well as indemnification or compensation for medical expenses relating to the employment related injury or disease. A workers' compensation program or plan includes any such program or plan:

(1) Operated by or under the authority of any law of any State (or the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands).

(2) Operated through an insurance arrangement or on a self-insured basis by an employer.

(3) Operated under the authority of the Federal Employees Compensation Act or the Longshoremen's and Harbor Workers' Compensation Act.

Dated: February 8, 2000.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 00–3352 Filed 2–15–00; 8:45 am]

BILLING CODE 5001–01–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 310

Department of Defense Privacy Program

AGENCY: Department of Defense.

ACTION: Final rule.

SUMMARY: The Department of Defense is updating policies and responsibilities for the Defense Privacy Program which implements the Privacy Act of 1974, by adding rules of conduct and the composition and responsibilities of the Defense Privacy Board, the Defense Privacy Board Legal Committee, and the DoD Data Integrity Board to DoD Directive 5400.11, DoD Privacy Program for the effective administration of the program.

DATES: This regulation is effective December 13, 1999. Comments must be received by April 17, 2000.

ADDRESSES: Forward comments to the Director, Defense Privacy Office, 1941 Jefferson Davis Highway, Suite 920, Arlington, VA 22202–4502.

FOR FURTHER INFORMATION CONTACT: Mr. Vahan Moushegian, Jr., at (703) 607–2943 or DSN 327–2943.

SUPPLEMENTARY INFORMATION:

Executive Order 12866

It has been determined that this Privacy Act rule for the Department of Defense does not constitute 'significant regulatory action'. Analysis of the rule indicates that it does not have an annual effect on the economy of $100 million or more; does not create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; does not materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; does not raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in Executive Order 12866 (1993).

Regulatory Flexibility Act

It has been determined that this Privacy Act rule for the Department of Defense does not have significant economic impact on a substantial number of small entities because it is concerned only with the administration of Privacy Act systems of records within the Department of Defense.

Paperwork Reduction Act

It has been determined that this Privacy Act rule for the Department of Defense imposes no information requirements beyond the Department of Defense and that the information collected within the Department of Defense is necessary and consistent with 5 U.S.C. 552a, known as the Privacy Act of 1974.

List of Subjects in 32 CFR Part 310

Privacy.

Accordingly, 32 CFR part 310, is amended as follows:

1. The authority citation for 32 CFR part 310 continues to read as follows:

Authority: Pub. L. 93–579, 88 Stat 1896 (5 U.S.C. 552a)

2. 32 CFR part 310, subpart A, is revised to read as follows:

Subpart A—DoD Policy

Sec.

Authority: Pub. L. 93–579, 88 Stat 1896 (5 U.S.C. 552a)

Subpart A—DoD Policy

§ 310.1 Reissuance.

This part is reissued to consolidate into a single document (32 CFR part 310) Department of Defense (DoD) policies and procedures for implementing the Privacy Act of 1974, as amended (5 U.S.C. 522a) by authorizing the development, publication and maintenance of the DoD Privacy Program set forth by DoD Directive 5400.11 [1], December 13, 1999, and 5400.11–R [2], August 31, 1983, both entitled: ''DoD Privacy Program.''

§ 310.2 Purpose.

This part:

(a) Updates policies and responsibilities of the DoD Privacy Program under 5 U.S.C. 552a, and under OMB Circular A–130.[3]

(b) Authorizes the Defense Privacy Board, the Defense Privacy Board Legal Committee and the Defense Data Integrity Board.

(c) Continues to authorize the publication of DoD 5400.11–R.

(d) Continues to delegate authorities and responsibilities for the effective administration of the DoD Privacy Program.

§ 310.3 Applicability and scope.

This part:

(a) Applies to the Office of the Secretary of Defense (OSD), the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Inspector General of the Department of Defense (IG, DoD), the Uniformed Services University of the Health Sciences, the Defense agencies, and the DoD Field Activities (hereafter referred to collectively as ''the DoD Components''). This part is mandatory for use by all DoD Components. Heads of DoD Components may issue supplementary instructions only when necessary to provide for unique requirements within their Components. Such instructions will not conflict with the provisions of this part.

(b) Shall be made applicable to DoD contractors who are operating a system of records on behalf of a DoD Component, to include any of the activities, such as collecting and disseminating records, associated with maintaining a system of records.

(c) This part does not apply to:

(1) Requests for information from systems of records controlled by the Office of Personnel Management (OPM), although maintained by a DoD Component. These are processed in accordance with OPM's 'Privacy Procedures for Personnel Records' (5 CFR part 297).

(2) Requests for personal information from the General Accounting Office (GAO). These are processed in accordance with DoD Directive 7650.1,[4] ''General Accounting Office Access to Records,'' September 11, 1997.

(3) Requests for personal information from Congress. These are processed in

[1] Copies may be obtained: http://web7.whs.osd.mil/corres.htm.

[2] See footnote 1 to § 310.1.

[3] Copies may be obtained: EOP Publications, NEOB, 725 17th Street, NW Washington, DC 20503.

[4] See footnote 1 to § 310.1.