submitted by the Lemon Administrative Committee (Committee) and upon other available information. It is found that this action will tend to effectuate the declared policy of the Act.

This regulation is consistent with the California-Arizona lemon marketing policy for 1989–90. The Committee met publicly on May 22, 1990, in Los Angeles, California, to consider the current and prospective conditions of supply and demand and unanimously recommended a quantity of lemons deemed advisable to be handled during the specified week. The Committee reports that demand for large-sized lemons (140's or larger) is good. However, price discounting continues on small-sized lemons.

Pursuant to 5 U.S.C. 553, it is further found that it is impracticable, unnecessary, and contrary to the public interest to give preliminary notice and engage in further public procedure with respect to this action and that good cause exists for not postponing the effective date of this action until 30 days after publication in the **Federal Register** because of insufficient time between the date when information became available upon which this regulation is based and the effective date necessary to effectuate the declared purposes of the Act. Interested persons were given an opportunity to submit information and views on the regulation at an open meeting. It is necessary, in order to effectuate the declared purposes of the Act, to make these regulatory provisions effective as specified, and handlers have been apprised of such provisions and the effective time.

List of Subjects in 7 CFR Part 910

Lemons, Marketing agreements, and Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 7 CFR part 910 is amended as follows:

PART 910—LEMONS GROWN IN CALIFORNIA AND ARIZONA

1. The authority citation for 7 CFR part 910 continues to read as follows:

Authority: Secs. 1–19, 48 Stat. 31, as amended; 7 U.S.C. 601–674.

2. Section 910.719 is added to read as follows:

Note: This section will not appear in the Code of Federal Regulations.

§ 910.719 Lemon regulation 719.

The quantity of lemons grown in California and Arizona which may be handled during the period from May 27, 1990, through June 2, 1990, is established at 390,000 cartons.

Dated: May 23, 1990.

Robert C. Keeney,

Deputy Director, Fruit and Vegetable Division.

[FR Doc. 90–12386 Filed 5–25–90; 8:45 am]

BILLING CODE 3410-02-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 89–ANE–07; Amdt. 39–6591]

Airworthiness Directives; General Electric Company (GE), CF6–50/–45 Series Turbofan Engines

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD) which requires the installation of a center vent tube extension assembly on GE CF6–50/–45 series turbofan engines. The AD is needed to prevent fire in the low pressure turbine (LPT) rotor cavity, which could result in uncontained LPT rotor failure.

EFFECTIVE DATE: June 25, 1990.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of June 25, 1990.

COMPLIANCE: As indicated in the body of the AD.

ADDRESSES: The applicable service bulletin may be obtained from General Electric Aircraft Engines, CF6 Distribution Clerk, Room 132, 111 Merchant Street, Cincinnati, Ohio 45246, or may be examined at the Regional Rules Docket, Room 311, Office of the Assistant Chief Counsel, Federal Aviation Administration, New England Region, 12 New England Executive Park, Burlington, Massachusetts 01803.

FOR FURTHER INFORMATION CONTACT: Thomas Boudreau, Engine Certification Branch, ANE–142, Engine Certification Office, Engine and Propeller Directorate, Aircraft Certification Service, Federal Aviation Administration, 12 New England Executive Park, Burlington, Massachusetts 01803; telephone (617) 273–7096.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (FAR) to include an AD which requires the installation of a center vent tube extension assembly on certain GE CF6–50/–45 series turbofan engines was published in the **Federal Register** on November 22, 1989, (54 FR 48272).

The proposal was prompted by an incident in which the failure of a main fuel/oil heat exchanger resulted in an uncontained LPT failure due to a fire in the LPT rotor cavity. Internal leakage of the heat exchanger resulted in the accumulation and ignition of a combustible fuel/oil mixture in the LPT rotor cavity aft of the "D" sump. This engine configuration did not incorporate a center vent tube extension, thus the volatile vapors were not vented overboard.

Interested persons have been afforded an opportunity to participate in the making of this amendment. One comment was received concerning the proposed rule and the commenter expressed no objection to its adoption. Accordingly, the proposal is adopted without change.

The regulations adopted herein will not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation involves 397 engines, and will cost approximately $25,000 per engine yielding an approximate total cost of $9,925,000. It has also been determined that few, if any, small entities within the meaning of the Regulatory Flexibility Act will be affected since this final rule affects only operators using aircraft in which GE CF6–50/–45 series turbofan engines are installed, none of which is believed to be a small entity. Therefore, I certify that this action (1) is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the final evaluation prepared for this action is contained in the regulatory docket. A copy of it may be obtained from the Regional Rules Docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety, and Incorporation by reference.

Adoption of the Amendment

Accordingly, pursuant to the authority delegated to me by the Administrator, the Federal Aviation Administration (FAA) amends 14 CFR part 39 of the Federal Aviation Regulations (FAR) as follows:

PART 39—[AMENDED]

1. The authority citation for part 39 continues to read as follows:

Authority: 49 U.S.C. 1354(a), 1421, and 1423; 49 U.S.C. 106(g) (Revised, Pub. L. 97–449, January 12, 1983); and 14 CFR 11.89.

§ 39.13 [AMENDED]

2. Section 39.13 is amended by adding the following new airworthiness directive (AD):

General Electric Co.: Applies to General Electric Company (GE) CF6–50–45 turbofan engines installed on, but not limited to, McDonnell Douglas DC–10, Airbus A300, and Boeing B747 aircraft.

Compliance is required at the next shop visit after the effective date of this AD, but not later than January 1, 1992, unless already accomplished.

To prevent uncontained low pressure turbine (LPT) failure due to a fire in the LPT rotor cavity, accomplish the following:

(a) Install the center vent tube extension assembly and associated hardware in accordance with GE CF6–50 Series Service Bulletin (SB) 72–395, Revision 3, dated June 30, 1989. NOTE: Shop visit for the purpose of this AD is defined as the induction of the engine into the shop for performance of maintenance.

(b) Aircraft may be ferried in accordance with the provisions of FAR 21.197 and 21.199 to a base where the AD can be accomplished.

(c) Upon submission of substantiating data by an owner or operator through an FAA Airworthiness Inspector, an alternate method of compliance with the requirements of this AD or adjustments to the compliance (schedule) times specified in this AD may be approved by the Manager, Engine Certification Office, Engine and Propeller Directorate, Aircraft Certification Service, Federal Aviation Administration, 12 New England Executive Park, Burlington, Massachusetts 01803.

The installation of the center vent tube extension assembly and associated hardware shall be done in accordance with GE CF6–50 Series SB 72–395, Revision 3, dated June 30, 1989, which incorporates the following list of effective pages:

Page No.	Revision No.	Date
Page 1–6	Revision 3	June 30, 1989.
Page 7	Revision 1	April 29, 1977.
Page 8–26	Revision 3	June 30, 1989.

This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from General Electric Aircraft Engines, CF6 Distribution Clerk, Room 132, 111 Merchant Street, Cincinnati, Ohio 45246. Copies may be inspected at the Regional Rules Docket, Office of the Assistant Chief Counsel, Federal Aviation Administration, New England Region, 12 New England Executive Park, Room 311, Burlington, Massachusetts 01803, or at the Office of the Federal Register, 1100 L Street, NW., Room 8301, Washington, DC 20591.

This amendment becomes effective on June 25, 1990.

Issued in Burlington, Massachusetts, on April 26, 1990.

Arthur J. Pidgeon,

Acting Manager, Engine and Propeller Directorate, Aircraft Certification Service.

[FR Doc. 90–12251 Filed 5–25–90; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 301

[T.D. 8296]

RIN 1545–AM02

Disclosure of Return Information to the Bureau of the Census

AGENCY: Internal Revenue Service, Treasury.

ACTION: Correction of final regulations (T.D. 8296).

SUMMARY: This document contains corrections to final regulations amending the Regulations on Procedure and Administration authorizing the disclosure of additional items of return information to the Bureau of the Census for use in certain statistical programs and deleting the authority to disclose those items of return information that the Bureau no longer needs.

EFFECTIVE DATE: March 28, 1990.

FOR FURTHER INFORMATION CONTACT: Paul Winkler, 202–566–4430 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

The final regulations (T.D. 8296) which are the subject of this correction concerns the disclosure of return information to the Bureau of the Census.

Need for Correction

As published, the final regulations contain errors which may prove to be misleading and are in need of clarification.

Correction of Publication

Accordingly, the publication of T.D. 8296 which was the subject of FR Doc. 90–6935, published on March 28, 1990, at 55 FR 11367, is corrected to read as follows:

Par. 1. On page 11367, column 2, the "RIN" number in the heading which reads "RIN 1545–AMOZ" should be corrected to read "RIN 1545–AMO2".

Par. 2. On pages 11367 and 11368, all references to "301.6103(j)(1)–1" should be corrected to read "301.6103(j)(1)–1".

Dale D. Goode,

Federal Register Liaison Officer, Assistant Chief Counsel (Corporate).

[FR Doc. 90–12148 Filed 5–25–90; 8:45 am]

BILLING CODE 4830–01–M

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 220

Collection From Third Party Payers of Reasonable Hospital Costs

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule amends the current DoD regulation governing collection from third party payers of reasonable inpatient hospital care costs incurred on behalf of retirees and dependents under title 10, U.S. Code 1095. The final rule clarifies rights and obligations of third party payers and health care beneficiaries under this statute and establishes applicable procedures.

EFFECTIVE DATE: This final rule is effective June 28, 1990.

ADDRESSES: Office of the Assistant Secretary of Defense (Health Affairs), room 1B657, Pentagon, Washington, DC 20301–1200.

FOR FURTHER INFORMATION CONTACT: Steve Lillie, telephone (202) 697–8975.

SUPPLEMENTARY INFORMATION:

I. Background

As part of the Consolidated Omnibus Budget Reconciliation Act of 1985, Congress enacted 10 U.S.C. 1095 to require the Department of Defense to collect from third party payers reasonable inpatient hospital care costs incurred on behalf of nonactive duty DoD health care beneficiaries. This legislation was based on the premise that private health care plans should not avoid payment for inpatient health care services provided to their plan beneficiaries because those

beneficiaries also happen to be entitled to space available care in military facilities. Currently, the law applies only to inpatient care; it does not apply to outpatient services.

To implement this statute, the Department of Defense issued a proposed rule October 8, 1986, and a final rule September 25, 1987. This part, 32 CFR part 220, established basic rules and procedures for carrying out what was referred to as the "coordination of benefits" program.

After several years of experience, it has become apparent that the basic Congressional purpose is not being effectuated. As an illustration, although it was estimated that collections could reach $100 million per year when the program reached full operation, fiscal year 1988 results show a much lower level of activity: $32 million billed, $16 million collected. In fiscal year 1989, $38 million was billed and $17 million was collected.

In its desire to improve the effectiveness of this program, Congress has very recently amended 10 U.S.C. 1095 to provide that funds collected under this program, rather than being turned over to the general treasury, be credited to the appropriations account supporting the facility at which the care was provided. National Defense Authorization Act for Fiscal Year 1990, Public Law 101–189, section 727. The intent of this provision is to provide an incentive for facilities of the uniformed services more aggressively to implement this program. In addition, the Department of Defense Appropriations Act, 1990, Public Law 101–165, section 9101, expressed support for "increasing collections form third party payers" under this program.

Another noteworthy development is that the Office of the Inspector General of the Department of Defense is in the process of completing an exhaustive audit documenting a number of reasons for the disappointing results. These include an inadequate effort on the part of many military hospitals to identify cases covered by 10 U.S.C. 1095 and to seek payment from the applicable third party payer in accordance with the law. Another reason may be that the Department of defense has not previously provided a substantial amount of regulatory guidance to interested parties concerning implementation of the statute.

The purpose of this final rule is to remedy the latter problem and to do so in a manner that will facilitate smooth handling of the anticipated increased billings that will result from efforts (including the recent legislative amendment) to remedy the former problem.

This final rule is the product of a rulemaking process that included publication of a proposed rule for public comment, January 16, 1990, 55 FR 1473. One public comment was received. The final rule reflects only minor revisions from the proposed rule.

II. Provisions of the Final Rule

With this as background, the following is a section-by-section description of the final rule. Preliminarily, however, two introductory points are noteworthy. First, for purposes of clarity, our final rule is set forth as a complete revision of part 220, made up of some provisions carried over with little or no substantive change, as well as a number of completely new provisions. Also, some of the provisions of the current part 220 that have not been carried over to this final rule are requirements purely internal in nature. These types of provisions will be incorporated in revised internal instructions in the near future. All substantive requirements applicable to external parties are intended to be included in this final rule.

The second introductory comment is that we adopt the title "Collection from third party payers of reasonable hospital costs," for part 220, which is derived from the statutory headnote of 10 U.S.C. 1095. The current title of part 220 is "Coordination of Benefits." This term, which the insurance industry uses to label the process of sorting out respective responsibilities when more than one third party payer is involved, is something of a misnomer for the statutory mandate of 10 U.S.C. 1095.

A. Purpose and applicability (§ 220.1). This section simply states the purpose and applicability of part 220 in relation to the statute.

B. Statutory obligation of third party payer to pay (§ 220.2).

1. Basic rule

Paragraph 220.2(a) restates a third party payer's basic obligation under the statute. The statute requires that in the case of nonactive duty health care beneficiaries,

> the United States shall have the right to collect from a third party payer the reasonable costs of inpatient hospital care incurred by the United States on behalf of such person through a facility of the uniformed services to the extent that the person would be eligible to receive reimbursement or indemnification from the third party payer if the person were to incur such costs on the person's own behalf.

10 U.S.C. 1095(a)(1).

A commenter suggested that it exceeded the statutory authority of section 1095 to construe the government's "right to collect from a third party payer" under the statute as establishing for a third party payer "an obligation to pay the United States" in the regulation. We disagree. We believe this is an appropriate, indeed unavoidable, interpretation of the statutory mandate and is fully consistent with the legislative intent.

2. Application of cost shares

Paragraph 220.2(b) restates the statutory provision (the second sentence of 10 U.S.C. 1095(a)(1)) that the payment due the United States may take into account any copayments and deductibles under the third party payer's health plan.

3. Claim from United States exclusive

Paragraph 220.2(c) attempts to clarify the Department of Defense's interpretation of the statute in connection with one of several issues identified by the Inspector General as being a possible source of confusion. The issue is how 10 U.S.C. 1095 applies to a situation in which the third party payer made payment directly to the beneficiary for care provided in a facility of the uniformed services. As noted above, the statute says "the United States shall have the right to collect from a third party payer. * * *" It is our view that a third party payer's obligation under this section is not satisfied by the third party payer paying the patient. Not only would payment to the patient not satisfy 10 U.S.C. 1095, it is also very doubtful that any valid claim could be made by the patient to the third party payer. Typically, an insured person can only be reimbursed by the insurer for expenses actually incurred; a patient who did not pay for the health care services would not be entitled to reimbursement from the third party payer.

Thus, payments from the third party payer to the patient would not be appropriate under 10 U.S.C. 1095 and would probably also not be appropriate under the third party payer's policy or program. The latter issue, of course, would be between the third party payer and the patient. As far as the Department of Defense's posture is concerned, it is that: payment to the patient does not satisfy 10 U.S.C. 1095; the 10 U.S.C. 1095 claim must be paid by the third party payer to the Department of Defense; and in cases in which the third party payer erroneously pays the beneficiary, it is the third party payer's responsibility to recover from the

beneficiary. This position is reflected in paragraph 220.2(c).

4. Assignment of benefits not necessary

Paragraph 220.2(d) deals with another issue on which the Inspector General's report will suggest guidance: whether beneficiaries must execute an assignment of benefits form for the third party payer to pay. It is our view that no such form is needed because under 10 U.S.C. 1095, the right to collect is already assigned to the government. Unless the patient actually incurs some expenses for the hospital care provided in the facility of the uniformed services, the patient likely has no benefit to assign under the terms of the third party payer's plan. Thus, in general, assuming that the patient has made no payment for the services received (this issue is discussed below in connection with paragraph 220.8(b)), the third party payer need only recognize that its sole obligation for payment is to the United States and that this obligation is not dependent upon any assignment of benefits. Paragraph 220.2(d) reflects this position.

C. Exclusions impermissible (§ 220.3)

Section 220.3 attempts to provide useful operational rules to implement 10 U.S.C. 1095(b) of the statute, which states:

> No provision of any insurance, medical service, or health plan contract or agreement having the effect of excluding from coverage or limiting payment of charges for certain care if that care is provided through a facility of the uniformed services shall operate to prevent collection by the United States * * *.

1. Statutory requirement

Paragraph 220.3(a) restates this statutory requirement.

2. General rules regarding exclusions

Paragraph 220.3(b) establishes several general rules derived from the basic statutory requirement. We believe these general rules will help interested parties resolve issues that may arise later that have not been expressly addressed in the regulation. The first general rule states one of the obvious results of 10 U.S.C. 1095(b): Express exclusions of limitations inconsistent with 10 U.S.C. 1095 are inoperative.

The second general rule is that no objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third party payers. This extends the first general rule a little bit to cover situations in which a third party payer's plan might at first not appear to treat facilities of the uniformed services less favorably, but does produce that effect. This interpretation is based on the statutory formulation of the prohibition in terms of provisions that "have the effect" of excluding or limiting payment.

The third general rule is that third party payers may not treat claims arising from services provided in facilities of the uniformed services less favorably than they treat claims arising from services provided in other hospitals. This interpretation is based on the key concepts embodied in the statute that the obligation to pay is "to the extent" the third party payer would pay other hospitals (10 U.S.C. 1095(a)) and that provisions that have the effect of excluding or limiting payment are prohibited (10 U.S.C. 1095(b)). We believe the general rule disallowing less favorable treatment provides a useful method of analyzing situations to assure compliance with the statute.

Finally, the fourth general rule set forth in paragraph 220.3(b) states that no objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services. This deals with one kind of circumstance that the second general rule addresses: a provision that looks neutral on its face, but if applied to a facility of the uniformed services would be contrary to the essential character of such facilities. This is based on our interpretation that Congress clearly understood the basic nature of facilities of the uniformed services and viewed provisions inconsistent with that nature as "having the effect" of improperly defeating the statutory purpose.

3. Examples of Impermissible Exclusions

Paragraph 220.3(c) provides specific examples of exclusions impermissible under the statutory requirement and the general rules. These examples are not all inclusive; rather, they are illustrative. Also, although one example is given for each of the general rules, some of the examples could be said to pertain to more than one of the general rules.

Care provided by a government facility. The first example of an impermissible exclusion is a provision that purports to disallow payment for services provided by a government entity or paid for by a government program. This is an example of the first general rule stated above. Congressional intent regarding the elimination of the exclusions such as this was made clear by the legislative history of 10 U.S.C. 1095. The House Committee Report stated:

> The principal reason that military medical facilities do not presently attempt to collect for the cost of care is that many insurance contracts contain exclusionary clauses. These exclusionary clauses relieve the insurance carrier of liability for payent where the policy holder has no legal obligation to pay or where the care is provided in a government facility, notwithstanding the fact that the insurance carrier would have provided reimbursement for the cost of care for the same individual if that care were provided in a nongovernmental hospital. [The legislation] would assert the government's authority to collect for the cost of such care notwithstanding any exclusionary clauses that might be included in the policy.

H. Rept. No. 99–300, 99th Cong., 1st Sess., 8–9.

No obligation to pay. An example of the second general rule stated above is a provision in a third party payer's plan that purports to disallow payment when the beneficiary has no legal obligation to pay. Our interpretation that such an exclusion is impermissible is based on the statutory wording (in 10 U.S.C. 1095(a)(1)) that the government's right to collect is to the extent the beneficiary would receive reimbursement "if the person were to incur such costs on the person's own behalf." A basic statutory characteristic of the military health services system is that beneficiaries have no obligation to pay (except nominal amounts called for by law). Recognizing this, Congress specifically expressed the government's right to collect in terms to make clear that it should be considered as if the beneficiary has an obligation to pay. Thus, it is our interpretation that the fact that the beneficiary has no actual obligation to pay has been made expressly irrelevant by 10 U.S.C. 1095. This is an example of a provision that would defeat the clear statutory purpose of 10 U.S.C. 1095. The same conclusion applies to any similar exclusion expressed in slightly different words, such as that no charge would be made if the person had no health insurance.

Exclusion of military beneficiaries. An example of the third general rule is a provision in an employer sponsored health plan which purports to make ineligible for coverage individuals who are military health care beneficiaries. Such an exclusion would clearly have the effect of treating facilities of the uniformed services less favorably than other hospitals.

No participation agreement. An example of the fourth general rule is a provision in a third party payer's plan that would exclude payment to a hospital that has no participation agreement with the third party payer. Prior to the issuance of our original part 220, the issue arose of whether a third party payer could insist that as a precondition to payment under 10 U.S.C.

1095, the facility of the uniformed services must enter into a participating provider agreement with the third party payer. DoD Instruction 6010.15 (the present 32 CFR part 220, paragraph 220.4(c)) addressed this issue:

> Participating hospital agreements are premised on compliance with State and local laws and regulations by a State nonprofit health care corporation. Since Federal entities are governed by Federal statutes and regulations, the Department of Defense medical treatment facilities should not enter into local participating hospital agreements.

Consistent with this, paragraph 220.3(c)(4) states that the lack of a participation agreement or the absence of a specific contractual relationship (often referred to as "privity of contract") between a third party payer and a facility of the uniformed services is not a permissible ground for refusing payment under 10 U.S.C. 1095. This is an example of the general rule that disallows preconditions that are inconsistent with the basic nature of facilities of the uniformed services. (We note that some facilities of the uniformed services have understandings with some third party payers concerning claims procedures and the like for the purpose of facilitating smooth administration. Such understandings would not offend our rule as long as they do not purport to be preconditions to complying with statutory and regulatory requirements, rather than instruments to facilitate compliance.)

D. Reasonable terms and conditions of the plan permissible (§ 220.4)

Section 220.4 attempts to describe the flip side of § 220.3. Whereas that section discusses impermissible exclusions, this section describes reasonable terms and conditions of the third party payer's plan that are permissible.

1. Statutory requirement

As mentioned above, 10 U.S.C. 1095 defines its applicability "to the extent that" the third party payer would pay the patient if the patient incurred the costs personally. This is the starting point for the concept that under the statute, third party payers are permitted to apply to inpatient hospital care provided in facilities of the uniformed services reasonable terms and conditions of the plan. Thus, this point is reiterated in paragraph 220.4(a).

2. General rules

As in the last section, several general rules would appear to aid application of the statute to particular factual situations. The first general rule is that, after impermissible exclusions have been eliminated, reasonable terms that apply generally and uniformly to services provided in all facilities may be applied to facilities of the uniformed services. A key concept embodied in this general rule is that the terms and conditions apply generally and uniformly.

The basic statutory principle can also be restated in terms similar to one of the general rules on exclusions. As stated in § 220.3, facilities of the uniformed services may not be treated less favorably than other hospitals. The flip side of that is that third party payers need not treat facilities of the uniformed services more favorably than other hospitals. This is stated as a second general rule for identifying permissible terms and conditions.

3. Example of permissible terms and conditions

Paragraph 220.4(c) lists three examples of permissible terms and conditions.

Coverage provisions. Under 10 U.S.C. 1095, if there are certain types of medical care or certain medical services that are not covered by the third party payer's plan, such services provided by a military treatment facility need not be reimbursed by the third party payer. The third party payer is not required to accord military hospitals more favorable treatment than is provided to all other hospitals under the terms of the third party payer's program or plan. For example, if psychiatric care is excluded from a third party payer's plan, the payer is not required to provide third party payment for psychiatric care provided in a facility of the uniformed services.

Utilization review activities. Utilization review activities can be more subtle and complicated. An increasingly common feature of health plans is the incorporation of mechanisms, adopted in recognition of concerns regarding both costs and quality of care, to avoid unnecessary services. Such utilization review mechanisms include preadmission screening, concurrent review, second surgical opinions, retrospective review, and other activities. These mechanisms typically include some payment consequences, such as a total or partial denial of a claim, for deviations from the specified requirements.

The statute does not disallow reasonable utilization review activities. The legislative history discussed utilization review activiteis:

> The right to collect could be asserted only to the extent that the benefits were covered by the insurance plan and would be subject to the terms and conditions of the plan * * * [T]o the extent that insurance plans have conditions that require, for example, pre-admission screening and second opinions before surgery, the Department of Defense would be expected to comply in order to collect under those contracts.

H. Rept. 99–300, page 9.

Based on these points, paragraph 220.4(c)(2) states our interpretation that the statute does not require a third party payer to reimburse facilities of the uniformed services in a manner contrary to the payer's generally applicable utilization review program. It may be that in some cases the military facility will, due to staffing levels, established administrative procedures, provider practices, patient expectations or other reasons, provide health care services without regard to a third party payer's utilization review procedures. In such cases, the payer is allowed to follow the terms of the plan. For example, if a third party payer's plan requires preadmission certification and reduces from 100 percent to 50 percent the amount of charges that will be reimbursed in any case in which a nonemergency admission was not precertified, an admissions to a facility of the uniformed services not precertified may be reimbursed at the reduced 50 percent rate. However, in this example, the request for payment from the facility of the uniformed services may not be reduced to any greater extent than is specified under the generally applicable utilization review program.

Exclusions in Health Maintenance Organization (HMO) plans. Paragraph 220.4(c)(3) lists another example of the general rules regarding permissible terms and conditions: generally applicable restrictions in health maintenance organization plans of nonemergency services provided outside the HMO are permissible. The legislative history of 10 U.S.C. 1095 indicates how this general rule applies in the context of an HMO plan. The House Committee Report states:

> * * * [P]rivate insurers would not be liable for services that are not covered by their policies. Similarly, in recognition of the unique nature of health maintenance organizations, collection from a health maintenance organization of the reasonable cost of care provided at military medical facilities would be undertaken only when the care is covered emergency care as defined in the health maintenance organization's contract.

H. Rept. 99–300, page 10.

It is our interpretation of 10 U.S.C. 1095 that it requires payment by HMO plans only to the extent those HMO plans generally cover services (e.g., emergencies) provided by health care

facilities not affiliated with the HMO. A commenter suggested that this proposition be extended to Preferred Provider Organization (PPO) programs on the grounds that PPOs have similar restrictions. It is our view that because there are so many different forms and shapes of PPOs, the rule Congress established for HMOs may not be appropriate in the PPO context. Rather, it appears that the closed, exclusive nature of HMOs was the main characteristic Congress wanted to recognize.

E. Records available (§ 220.05)

In § 220.5, we restate the requirement of 10 U.S.C. 1095(c) that facilities of the uniformed services will make available, upon request, to representatives of third party payers health care records of the patients regarding whose care payment is sought under 10 U.S.C. 1095. The records that will be made available are those necessary to verify that the services were provided and that permissible terms and conditions of the plan were met.

F. Certain payers excluded (§ 220.6)

Section 220.6 identifies certain third party payers that are excused from any obligation under 10 U.S.C. 1095.

1. Medicare and Medicaid

Paragraph 220.6(a) restates the rule of 10 U.S.C. 10 U.S.C. 1095(d), which specifically excludes the Medicare and Medicaid programs from the reach of 10 U.S.C. 1095.

2. Supplemental plans

Paragraph 220.6(b) establishes our interpretation that Medicare and CHAMPUS supplemental insurance programs and income supplemental plans are not covered by 10 U.S.C. 1095. Concerning Medicare supplemental plans, the essential character of these plans is that they are secondary to Medicare. They define themselves and their coverages, limitations, terms and conditions as functions of the underlying Medicare program to which they are supplements. Because Congress specifically excluded Medicare, it is an arguable interpretation of legislative intent that the closely related Medicare supplemental plans should also be determined to be outside Congress' intended reach of 10 U.S.C. 1095.

A clear case can be made that CHAMPUS supplemental policies should be viewed, as is indicated in our current part 220, as beyond the reach of 10 U.S.C. 1095. One of the basic attributes of CHAMPUS is that Congress intended it be in many respects secondary to care in facilities of the uniformed services. This is indicated, for example by the requirement of 10 U.S.C. 1079(a)(7) that hospital care generally be obtained from facilities of the uniformed services before looking to CHAMPUS. CHAMPUS supplemental policies are, in turn, secondary to CHAMPUS. To hold these CHAMPUS supplemental policies liable for care provided in facilities of the uniformed services would be a fundamental change in the common understanding of the nature of these policies. Thus, paragraph 220.6(b) states our interpretation that CHAMPUS supplemental insurance policies are excluded from 10 U.S.C. 1095.

We are also excluding Medicare supplemental programs. However, we should also note that we believe strong policy arguments can be made in support of collecting from Medicare supplemental insurance plans. These plans stand in very much the same shoes as all third party payers stood prior to enactment of section 1095: The plans enjoy something of a windfall when their insured beneficiaries receive care in a facility of the uniformed services because they avoid paying for care that would be their obligation had the patient received the same care in a civilian hospital. Further, Medicare supplemental insurance policies are different from CHAMPUS supplemental policies in that, whereas facilities of the uniformed services and Medicare are on an equal footing in terms of the beneficiary's entitlement to care, facilities of the uniformed services are, under the law, primary to CHAMPUS. Thus, our exclusion of Medicare supplemental insurance plans from the reach of section 1095 is not because we believe such collections would depart from appropriate government policy, but because of our conclusion that, in view of the ambiguous legislative intent, this would be the less contentious legal interpretation of the current statute. We are, however, now considering whether to suggest to Congress a legislative amendment to section 1095 to cover Medicare supplemental insurance policies. Such a recommendation is included in the upcoming Inspectors General's report.

3. Third party plans prior to April 7, 1986

In enacting 10 U.S.C. 1095, Congress made it applicable "only with respect to an insurance, medical service, or health plan agreement entered into, amended, or renewed on or after the date of enactment" of the statute. Public Law 99–272, section 2001(b). Paragraph 220.6(c) restates this requirement.

G. Remedies (§ 220.7)

Section 220.7 pertains to remedies relating to the right of the United States to collect under 10 U.S.C. 1095. Paragraph 220.7(a) restates the authority of 10 U.S.C. 1095(e)(1) for the United States to institute legal proceedings against a third party payer to enforce a right of the United States. Section 220.7(b) restates the authority of 10 U.S.C. 1095(e)(2) for an authorized representative of the United States to compromise, settle or waive a claim under 10 U.S.C. 1095. Paragraph 220.7(c) states that authorities provided by 32 CFR part 90 regarding collection of indebtedness due the United States shall be available to effect collections pursuant to 10 U.S.C. 1095. These authorities include administrative offset and other means to collect.

H. Reasonable costs (§ 220.8)

Section 220.8 of the rule pertains to the computation of reasonable costs. 10 U.S.C. 1095(f) states that the Department of Defense's regulations "shall provide for the computation of the reasonable cost of inpatient hospital care" and that this computation may be based on per diem rates or other appropriate method.

1. Per diem rates

Paragraph 220.8(a) states that per diem rates will be used. It further states that the per diem rates will be subdivided into three categories: hospital charges, physician charges and ancillary charges. This provision is unchanged from our current instruction.

2. Medical services and subsistence charges included

Another issue that the Inspector General will recommend be clarified relates to the treatment of the relatively nominal medical services charges and subsistence charges which patients in facilities of the uniformed services are required to pay under 10 U.S.C. 1075 and 1078. We provide that clarification in paragraph 220.8(b) by stating that these charges are included in the per diem rate. This means that in cases identified for action to recover under 10 U.S.C. 1095, facilities of the uniformed services will not collect the medical services or subsistence charges from the beneficiary. As a result, third party payers will know that the claim made pursuant to 10 U.S.C. 1095 will (with the exception of Partnership Program cases, discussed below) satisfy all of the third party payer's obligations arising from the inpatient hospital care provided by the facility of the uniformed services on that occasion. This also conforms with the positions reflected in proposed

paragraph 220.2 (c) and (d) and discussed above that payment must be made to the authorized representative of the United States and that no assignment of benefits form is needed.

3. Alternative determination of reasonable costs

Paragraph 220.8(c) implements the direction contained in the Conference Committee report pertaining to the enactment of 10 U.S.C. 1095 that any third party payer that can demonstrate prevailing rates of payment less than those established by the Department of Defense should be able to have the lower rates apply. H. Conf. Rept. 99–453, p. 394.

4. Special rule for former Public Health Service facilities

Paragraph 220.8(d) establishes a special rule for calculating government costs of care provided in the former Public Health Service facilities that are "deemed" to be "facilities of the uniformed services" by section 911 of Public Law 97–99, 42 U.S.C. 248c. Government costs for care provided in these facilities is higher than the rates calculated for care provided in military hospitals. Therefore, a different, higher amount may be billed to the third party payer for this care. There are 10 facilities in the United States that have this special status, although not all of them provide inpatient care covered by this regulation.

5. Special rule for Partnership Program

Paragraph 220.8(e) establishes as an exception to the usual rule that payment of the claim from the facility to the uniformed services will satisfy all of the third party payer's obligations arising from the inpatient care on that occasion. This exception is necessary because in cases covered by the Partnership Program (or similar program under the authority of 10 U.S.C. 1096), the professional services portion of the total inpatient care is not provided by the facility of the uniformed services, but is provided by CHAMPUS. The Partnership Program permits military hospital commanders to allow private sector health care providers who are CHAMPUS authorized to come into the military hospital to provide care to CHAMPUS beneficiaries. In connection with inpatient services, the hospital services and ancillary services are provided by the military hospital, with the physician fee the responsibility of CHAMPUS. Combining the two activities allows the inpatient services to be provided more economically.

Because the professional services in Partnership Program cases are not provided by the military hospital, charges related to them are not covered by the third party collection program of 10 U.S.C. 1095 and this part. Rather, they are covered by the statutory and regulatory requirements of the CHAMPUS program. These requirements include the rule that CHAMPUS is secondary payer to other insurance and health plans (except Medicare), under 10 U.S.C. 1079(j)(1). Based on these CHAMPUS requirements, in cases (which will be quite infrequent) in which inpatient care provided in a military hospital included professional services provided under the Partnership Program, a third party payer will receive two claims: one from the military hospital, which will exclude the physician fee portion of the per diem rate, and one from the individual health care provider.

I. Rights and obligations of beneficiaries (§ 220.9)

Section 220.9 establishes several rights and obligations of beneficiaries arising from or pertaining to 10 U.S.C. 1095.

1. No additional cost share

Paragraph 220.9(a) implements the requirement of 10 U.S.C. 1095(a)(2) of the statute that the beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services charges (applicable to dependents) or subsistence charges (applicable to retirees). This provision states that in cases in which payment is collected from the third party payer, it will be considered as satisfying the medical services or subsistence charges the beneficiary would be required to pay if no third party payment were made. Thus, no further payment by the beneficiary to the facility of the uniformed services will be required. We are aware that the Department of Defense has authority to require beneficiaries to pay all or some of their normal charges in any case in which the third party payer, because of a deductible or copayment requirement in the plan, pays less than the full amount of the per diem charges. However, because the third party payer collection will almost certainly exceed the normal medical services or subsistence charges and in order to avoid administrative complexity, we feel it preferable to adopt a rule that considers the third party payment as satisfying the normal dependents' medical services charges or retirees' subsistence charges.

2. Availability of hospital care unaffected

Paragraph 220.9(b) states that whether or not a beneficiary is covered by a third party payer's plan will not be considered in a decision on admitting a beneficiary for hospital care in a facility of the uniformed services. Whether or not to admit a beneficiary for hospital care is based on medical need and the availability of needed facilities and personnel at the particular facility; the potential or lack of potential for third party payment is irrelevant to the issue of admission.

3. Obligation to disclose information

Paragraph 220.9(c) states that beneficiaries have an obligation to provide accurate information to the facility of the uniformed services regarding whether the beneficiary is covered by a third party payer plan. We believe such an obligation is fully in keeping with the intent of Congress in 10 U.S.C. 1095 that the United States collect from third party payers the reasonable cost of hospital care provided by facilities of the uniformed services. Because facilities of the uniformed services are dependent upon the information provided by beneficiaries in order to carry out the mandate of 10 U.S.C. 1095, it is imperative that beneficiaries provide accurate information. The paragraph states that intentionally providing false information or other willful failure on the part of a beneficiary to satisfy this obligation is grounds for disqualification for health care services from facilities of the uniformed services.

J. Definitions (§ 220.10)

Section 220.10 defines several key terms used in part 220.

1. Facility of the uniformed services

Paragraph 220.10(a) states that a facility of the uniformed services is any medical or dental treatment facility of the Army, Navy, Air Force, Marine Corps, Coast Guard, the commissioned corps of the National Oceanic and Atmospheric Administration and the commissioned corps of the Public Health Service. Also, by statutory directive, facilities of the uniformed services include each former Public Health Service facility which is "deemed to be a facility of the uniformed services for the purposes of chapter 55 of title 10, United States Code" pursuant to section 911 of Public Law 97–99 (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

2. Inpatient hospital care

Paragraph 220.10(b) defines inpatient hospital care in the same manner as does our existing regulation.

3. Insurance plan

Paragraph 220.10(c) defines insurance plan in the same manner as does our existing regulation.

4. Medical services or health plan

Paragraph 220.10(d) defines medical service or health plan in the same manner as does our current regulation.

5. Medicare and CHAMPUS supplemental plan

Proposed paragraph 220.10(e) defines a Medicare or CHAMPUS supplemental plan as a plan exclusively for the purpose of supplementing an eligible person's benefit under Medicare or CHAMPUS. This provision also states that no plan provided by an employer to an employee may be a supplemental plan. In respose to a public comment, we have clarified that this exclusion applies only to plans provided by an employer to an employee; it does not apply to a plan provided to a former employee. For readers not familiar with CHAMPUS, it is the Civilian Health and Medical Program of the Uniformed Services. The CHAMPUS regulation is at 32 CFR part 199.

6. Third party payer

Paragraph 220.10(f) defines third party payer in the same way as does our current regulation. This definition is consistent with the statutory definition at 10 U.S.C. 1095(g).

7. Third party payer plan

Paragraph 220.10(g) defines a third party payer plan as any insurance or medical service or health plan provided by a third party payer.

8. Uniformed services beneficiary

Paragraph 220.10(h) defines uniformed services beneficiary for purposes of this part as any person who is covered by 10 U.S.C. 1074(b) (retired members), 1076(a) (dependents of active duty members), and 1076(b) (dependent of retired member or survivor). For purposes of this part, a uniformed services beneficiary does not include active duty members of the uniformed services.

III. Regulatory Procedures.

A. Executive Order 12291 and the Regulatory Flexibility Act.

This final rule is not a major rule under Executive Order 12291. It does not have an impact of $100 million or other significant economic impacts. Similarly, the rule does not significantly impact a substantial number of small entities within the meaning of the Regulatory Flexibility Act. As noted above, for the most part, this rule provides the Department of Defense's interpretations of current statutory requirements, guidelines for applying the statute and basic procedures for implementation. This rule does not create new regulatory burdens that will have economic impacts of the type covered by these regulatory review authorities.

List of Subjects in 7 CFR Part 220

Claims, Health insurance, Medical records.

For the reasons stated in the preamble, 32 CFR Part 220 is revised to read as follows:

PART 220—COLLECTION FROM THIRD PARTY PAYERS OF REASONABLE HOSPITAL COSTS

Sec.

Authority: 10 U.S.C. 1095; 5 U.S.C. section 301.

§ 220.1 Purpose and applicability.

This part implements the provisions of 10 U.S.C. 1095. In general, 10 U.S.C. 1095 establishes the statutory obligation of third party payer health plans to reimburse the United States the reasonable costs of inpatient hospital care provided by facilities of the uniformed services to most uniformed services medical care beneficiaries who are also participants in the third party payer's health plan. This part establishes the Department of Defense interpretations and requirements applicable to all health care services subject to 10 U.S.C. 1095.

§ 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 inpatient hospital care provided in 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 or indemnification from the third party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(b) *Application of cost shares.* If the third party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third party payer is the reasonable cost of the care provided less the appropriate deductible or copayment amount.

(c) *Claim from United States exclusive.* The only way for a third party payer to satisfy its obligation under 10 U.S.C. 1095 is to pay the facility of the uniformed service or other authorized representative of the United States. Payment by a third party payer to the beneficiary does not satisfy 10 U.S.C. 1095.

(d) *Assignment of benefits 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.

§ 220.3 Exclusions impermissible.

(a) *Statutory requirement.* Under 10 U.S.C. 1095(b), no provision of any third party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided in a facility of the uniformed services shall operate to prevent collection by the United States.

(b) *General rules.* Based on the statutory requirement, the following are general rules for the administration of 10 U.S.C. 1095 and this part.

(1) Express exclusions of limitations in third party payer plans that are inconsistent with 10 U.S.C. 1095(b) are inoperative.

(2) No objection, precondition or limitation may be asserted that defeats the statutory purpose of collecting from third party payers.

(3) Third party payers may not treat claims arising from services provided in facilities of the uniformed services less favorably than they treat claims arising from services provided in other hospitals.

(4) No objection, precondition or limitation may be asserted that is contrary to the basic nature of facilities of the uniformed services.

(c) *Specific examples of impermissible exclusion.* The following are several specific examples of impermissible exclusions, limitations or preconditions. These examples are not all inclusive.

(1) *Care provided by a government entity.* A provision in a third party payer's plan that purports to disallow or limit payment for services provided by a government entity or paid for by a government program (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(2) *No obligation to pay.* A provision in a third party payer's plan that purports to disallow or limit payment for services for which the patient has no obligation to pay (or similar exclusion) is not a permissible ground for refusing or reducing third party payment.

(3) *Exclusion of military beneficiaries.* No provision of an employer sponsored program or plan that purports to make ineligible for coverage individuals who are uniformed services health care beneficiaries shall be permissible.

(4) *No participation agreement.* The lack of a participation agreement or the absence of privity of contract between a third party payer and a facility of the uniformed services is not a permissible ground for refusing or reducing third party payment.

§ 220.4 Reasonable terms and conditions of health plan permissible.

(a) *Statutory requirement.* The statutory obligation of the third party to pay is not unqualified. Under 10 U.S.C. 1095(a)(1) (as noted in § 220.2 of this part), the obligation to pay is to the extent the third party payer would be obliged to pay if the beneficiary incurred the costs personally.

(b) *General rules.* (1) Based on the statutory requirement, after any impermissible exclusions have been made inoperative (see § 220.3 of this part), reasonable terms and conditions of the third party payer's plan that apply generally and uniformly to services provided in facilities other than facilities of the uniformed services may also be applied to services provided in facilities of the uniformed services.

(2) Third party payers are not required to treat claims arising from services provided in facilities of the uniformed services more favorably than they treat claims arising from services provided in other hospitals.

(c) *Specific examples of permissible terms and conditions.* The following are several specific examples of permissible terms and conditions of third party payer plans. These examples are not all inclusive.

(1) *Generally applicable coverage provisions.* Generally applicable provisions regarding particular types of medical care or medical conditions covered by the third party payer's plan are permissible grounds to refuse or limit third party payment.

(2) *Generally applicable utilization review provisions.* Generally applicable provisions of the third party payer's plan requiring preadmission screening, second surgical opinions, retrospective review or other similar utilization review activities are permissible grounds to refuse or reduce third party payment if such refusal or reduction is required by the third party payer's plan. Such provisions, however, may not be applied in a manner that would result in claims arising from services provided by facilities of the uniformed services being treated less favorably than claims arising from services provided by other hospitals.

(3) *Restrictions in HMO plans.* Generally applicable exclusions in Health Maintenance Organization (HMO) plans of nonemergency services provided outside the HMO (or similar exclusions) are permissible.

§ 220.5. Records available.

Pursuant to 10 U.S.C. 1095(c), facilities of the uniformed services, when requested, shall make available to representatives of any third party payer from which the United States seeks payment under 10 U.S.C. 1095 for inspection and review appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the services which are the subject of the claims for payment under 10 U.S.C. 1095 were provided as claimed and were provided in a manner consistent with permissible terms and conditions of the third party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

§ 220.6. Certain payers excluded.

(a) *Medicare and Medicaid.* Under 10 U.S.C. 1095(d), claims for payment from the Medicare or Medicaid programs (titles XVIII and XIX of the Social Security Act) are not authorized.

(b) *Supplemental plans.* Medicare and CHAMPUS (see 32 CFR part 199) supplemental plans and income supplemental plans are excluded from any obligation to pay under 10 U.S.C. 1095.

(c) *Third party payer plans prior to April 7, 1986.* 10 U.S.C. 1095 is not applicable to third party payer plans which have been in continuous effect without amendment or renewal since prior to April 7, 1986. Plans entered into, amended or renewed on or after April 7, 1986, are subject to 10 U.S.C. 1095.

§ 220.7. Remedies.

(a) Pursuant to 10 U.S.C. 1095(e)(1), the United States may institute and prosecute legal proceedings against a third party payer to enforce a right of the United States under 10 U.S.C. 1095 and this part.

(b) Pursuant to 10 U.S.C. 1095(e)(2), an authorized representative of the United States may compromise, settle or waive a claim of the United States under 10 U.S.C. 1095 and this part.

(c) The authorities provided by 32 CFR part 90 regarding collection of indebtedness due the United States shall also be available to effect collections pursuant to 10 U.S.C. 1095 and this part.

§ 220.8. Reasonable costs.

(a) *Per diem rates.* As authorized by 10 U.S.C. 1095(f)(1), the computation of reasonable costs for purposes of collections under 10 U.S.C. 1095 and this part shall be based on per diem rates. The per diem charge shall be equal to the inpatient full reimbursement rate. Per diem rates shall be updated and published annually. For purposes of billing third party payers, per diem rates shall be subdivided into three categories:

(1) Hospital charges.

(2) Physician charges.

(3) Ancillary charges.

(b) *Medical services and subsistence charges included.* Medical services charges pursuant to 10 U.S.C. 1078 or subsistence charges pursuant to 10 U.S.C. 1075 are included in the claim filed with the third party payer pursuant to 10 U.S.C. 1095. For any patient of a facility of the uniformed services who indicates that he or she is a beneficiary of a third party payer plan, the usual medical services or substance charge will not be collected from the patient. Thus, except in cases covered by § 220.8(d), payment of the claim made pursuant to 10 U.S.C. 1095 will satisfy all of the third party payer's obligation arising from the inpatient hospital care provided by the facility of the uniformed services on that occasion.

(c) *Alternative determination of reasonable costs.* Any third party payer that can satisfactorily demonstrate a prevailing rate of payment in the same geographic area for the same or similar services that is less than the per diem rate of the facility of the uniformed services may, with the agreement of the facility of the uniformed services (or other authorized representatives of the United States), limit payments under 10 U.S.C. 1095 to that prevailing rate. The

determination of the third party payer's prevailing rate shall be based on a review of valid contractual arrangements with other facilities or providers constituting a majority of the services for which payment is made under the third party payer's plan.

(d) *Special rule for former Public Health Service facilities.* In connection with the former Public Health Service facilities described in section 220.10(a), the computation of reasonable costs for purposes of collections under 10 U.S.C. 1095 and this part may differ from such computations under § 220.8(a). Reasonable costs for such facilities shall be based on approximate government costs for similar services under CHAMPUS.

(e) *Special rule for Partnership Program providers.* In cases in which the professional provider services are provided under the Partnership Program (or similar program operated under the authority of 10 U.S.C. 1096), the physician charges component of the total per diem rate will be deleted from the claim from the facility of the uniformed services. The third party payer will receive a claim for professional services directly from the individual health care provider, who is not an employee or agent of the Department of Defense. Such claims are not covered by 10 U.S.C. 1095 or this part, but are governed by statutory and regulatory requirements of the CHAMPUS program (see 32 CFR part 199).

§ 220.9. Rights and obligations of beneficiaries.

(a) *No additional cost share.* Pursuant to 10 U.S.C. 1095(a)(2), uniformed services beneficiaries will not be required to pay to the facility of the uniformed services any amount greater than the normal medical services or subsistence charges (under 10 U.S.C. 1075 or 1078). In every case in which payment from a third party payer is received, it will be considered as satisfying the normal medical services or subsistence charges, and no further payment from the beneficiary will be required.

(b) *Availability of hospital care unaffected.* The availability of health care services in any facility of the uniformed services will not be affected by the participation or nonparticipation of a uniformed services beneficiary in a health care plan of a third party payer. Whether or not a uniformed services beneficiary is covered by a third party payer's plan will not be considered in determining the availability of hospital care in a facility of the uniformed services.

(c) *Obligation to disclose information.* 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. Intentionally providing false information or otherwise willfully failing to satisfy this obligation are grounds for disqualification for health care services from facilities of the uniformed services.

§ 220.10. Definitions.

(a) *Facility of the uniformed services.* A facility of the uniformed services means any medical or dental treatment facility of the uniformed services (as that term is defined in 10 U.S.C. 101(43)). Facilities of the uniformed services also include the several former Public Health Services facilities that are deemed to be facilities of the uniformed services pursuant to section 911 of Public Law 97-99 (often referred to as "Uniformed Services Treatment Facilities" or "USTFs").

(b) *Inpatient hospital care.* Treatment provided to an individual other than a transient patient, who is admitted (i.e., placed under treatment of observation) to a bed in a facility of the uniformed services that has authorized beds for inpatient medical or dental care.

(c) *Insurance plan.* Any plan or program that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services and supplies. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(d) *Medical service or health plan.* A medical service or health plan is any plan or program of an organized health care group, corporation or other entity for the provision of health care to an individual from plan providers, both professional and institutional. It includes plans or programs for which the beneficiary pays a premium to an issuing agent as well as those plans or programs to which the beneficiary is entitled as a result of employment or membership in, or association with, an organization or group.

(e) *Medicare and CHAMPUS supplemental plan.* A Medicare or CHAMPUS supplemental plan (referred to in paragraph 220.6(b) is an insurance, medical service or health plan exclusively for the purpose of supplementing an eligible person's benefit under Medicare or CHAMPUS. (For information concerning CHAMPUS, see part 199.) No insurance, medical service or health plan provided by an employer or employer group to an employee may qualify as a Medicare or CHAMPUS supplemental plan.

(f) *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 state and local governments that provide such plans. It includes insurance underwriters and private employers (or employer groups) offering self-insured or partially self-insured and/or partially underwritten health insurance plans.

(g) *Third party payer plan.* A third party payer plan is any insurance or medical service or health plan provided by a third party payer. It does not include any income supplemental plan.

(h) *Uniformed services beneficiary.* For purposes of this part, a uniformed services beneficiary is any person who is covered by 10 U.S.C. 1074(b), 1076(a), or 1076(b). (Note that for purposes of this part, uniformed services beneficiaries do not include active duty members of the uniformed services.)

Dated: May 22, 1990.

Linda M. Bynum,

Alternate OSD Federal Register Liaision Officer, Department of Defense.

[FR Doc. 90-12338 Filed 5-25-90; 8:45 am]

BILLING CODE 3810-01-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[FRL-3782-6]

Approval and Promulgation of Plans, Illinois; Correction

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final Rulemaking; Notice of Correction.

SUMMARY: This notice corrects a codification error which appeared in a final rulemaking on the approval and promulgation of Implementation plans for Illinois. This final rulemaking was published in the October 17, 1988, Federal Register (53 FR 40415).

EFFECTIVE DATE: This action is effective: May 29, 1990.

FOR FURTHER INFORMATION CONTACT: Randolph O. Cano, (312) 886-6036.

SUPPLEMENTARY INFORMATION: In particular, on page 40426 of the October 17, 1988, Federal Register, in the third column, under "§ 52.726 Control strategy-Ozone" the added paragraph dealing with the part D disapproval of