SEC. 701. CONSOLIDATED TRICARE HEALTH PLAN.

(a) FREEDOM OF CHOICE FOR TRICARE POINTS OF SERVICE.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1073b the following new section:

"§ 1073C. TRICARE program: freedom of choice for points of service

"(a) FREEDOM OF CHOICE.—A covered beneficiary may choose to receive medical and dental care and health benefits care from any of the points of service specified in subsection (b), subject to availability.

"(b) POINTS OF SERVICE.—The points of service specified in this subsection are as follows:

"(1) Facilities of the uniformed services.

"(2) Providers under the TRICARE program designated as network providers for the purposes of this chapter by the Secretary of Defense.

"(3) Providers under the TRICARE program other than those described in paragraphs (1) and (2), to be known as out-of-network providers.".

(b) TRICARE COST-SHARING REQUIREMENTS.—Such chapter is further amended by inserting after section 1074n the following new section:

"§ 1075. TRICARE program: cost-sharing requirements

"(a) IN GENERAL.—This section establishes cost-sharing requirements for beneficiaries under the TRICARE program.

"(b) BENEFICIARIES FOR COST-SHARING PURPOSES.—

"(1) BENEFICIARY CATEGORIES.—The beneficiary categories for purposes of cost-sharing requirements under the TRICARE program are as follows:

"(A) CATEGORY 1: ACTIVE-DUTY MEMBERS.—Category 1 consists of beneficiaries who are covered by section 1074(a) of this title.

"(B) CATEGORY 2: DEPENDENTS OF ACTIVE-DUTY MEMBERS.—Category 2 consists of beneficiaries who are covered by section 1079 of this title.

"(C) CATEGORY 3: DISABILITY RETIREES & FAMILY MEMBERS; FAMILY MEMBERS OF PERSONS DYING ON ACTIVE DUTY.—Category 3 consists of beneficiaries (other than Category 5 beneficiaries) who are—

"(i) covered by section 1086(c)(1) of this title by reason of being retired under chapter 61 of this title or being a dependent of such a member; or

"(ii) covered by section 1086(c)(2) of this title.

"(D) CATEGORY 4: OTHER RETIREES & FAMILY MEMBERS.—Category 4 consists of beneficiaries covered by section 1086(c) of this title other than Category 3 beneficiaries and Category 5 beneficiaries.

"(E) CATEGORY 5: MEDICARE-ELIGIBLE BENEFICIARIES.—Category 5 consists of beneficiaries who are described in section 1086(d)(2) of this title.

"(F) CATEGORY 6: MEMBERS OF THE SELECTED RESERVE.—Category 6 consists beneficiaries covered by section 1076d of this title.

"(2) COST-SHARING GROUPS.—The cost-sharing groups for purposes of cost-sharing requirements under the TRICARE program are as follows:

"(A) GROUP A: JUNIOR ENLISTED BENEFICIARIES.—A beneficiary is a Group A beneficiary if the beneficiary is—

"(i) a Category 2 beneficiary who is a dependent of a member in pay grade E-1 through E-4;

"(ii) a Category 6 beneficiary who is a member of the Selected Reserve of the Ready Reserve in pay grade E-1 through E-4 or dependent of such a member;

"(iii) a Category 3 beneficiary who retired under chapter 61 of this title in pay grade E-1 through E-4 or who is a dependent of such a member; or

"(iv) a Category 3 beneficiary who is covered by section 1086(c)(2) of this title by reason of being a dependent of a member who was in pay grade E-1 through E-4 at the time of death.

"(B) GROUP B: SENIOR ENLISTED BENEFICIARIES; WARRANT OFFICERS; JUNIOR OFFICERS.—A beneficiary is a Group B beneficiary if the beneficiary is—

"(i) a Category 2 beneficiary who is a dependent of a member in pay grade E-5 through O-3;

"(ii) a Category 6 beneficiary who is a member of the Selected Reserve of the Ready Reserve in pay grade E-5 through O-3 or dependent of such a member;

"(iii) a Category 3 beneficiary who retired under chapter 61 of this title in pay grade E-5 through O-3 or who is a dependent of such a member; or

"(iv) a Category 3 beneficiary who is covered by section 1086(c)(2) of this title by reason of being a dependent of a member who was in pay grade E-5 through O-3 at the time of death.

"(C) GROUP C: MID-LEVEL AND SENIOR OFFICERS.—A beneficiary is a Group C beneficiary if the beneficiary is—

"(i) a Category 2 beneficiary who is a dependent of a member in pay grade O-4 or above;

"(ii) a Category 6 beneficiary who is a member of the Selected Reserve of the Ready Reserve in pay grade O-4 or above or dependent of such a member;

"(iii) a Category 3 beneficiary who retired under chapter 61 of this title in pay grade O-4 or above or who is a dependent of such a member; or

"(iv) a Category 3 beneficiary who is covered by section 1086(c)(2) of this title by reason of being a dependent of a member who was in pay grade O-4 or above at the time of death.

"(D) GROUP D: OTHER RETIREES & FAMILY MEMBERS; MEDICARE-ELIGIBLE BENEFICIARIES FOR CARE COVERED BY THE TRICARE PROGRAM.—A beneficiary is a Group D beneficiary if the beneficiary is—

"(1) a Category 4 beneficiary; or

"(2) a Category 5 beneficiary with respect to care not covered by section 1086(d)(3).

"(3) PRIMARY CARE MANAGER PROGRAM ENROLLMENT STATUS.—The Primary Care Manager Program enrollment status for purposes of cost-sharing requirements under the TRICARE program are as follows:

"(A) PCM-MANAGED.—A beneficiary is a PCM-Managed beneficiary if the beneficiary is enrolled in the Primary Care Manager Program established in accordance with subsection (c).

"(B) SELF-MANAGED.—A beneficiary is a Self-Managed beneficiary if the beneficiary is not enrolled in the Primary Care Manager Program and is not a remote area dependent.

"(4) REMOTE AREA DEPENDENTS.—A beneficiary is a remote area dependent if the beneficiary is—

"(A) a dependent of a member of the uniformed services referred to in section 1074(c)(3) of this title and is residing with the member;

"(B) a dependent of a member who, after having served in a duty assignment described in section 1074(c)(3) of this title, has relocated without the dependent pursuant to orders for a permanent change of duty station from a remote location described in subparagraph (B)(ii) of such section where the member and the dependent resided together while the member served in such assignment, if the orders do not authorize dependents to accompany the member to the new duty station at the expense of the United States and the dependent continues to reside at the same remote location;

"(C) a dependent of a reserve component member ordered to active duty for a period of more than 30 days and is residing with the member, and the

residence is located more than 50 miles, or approximately one hour of driving time, from the nearest military medical treatment facility adequate to provide the needed care; or

"(D) a dependent other than one described in subparagraphs (A) through (C) if the Secretary of Defense determines that exceptional circumstances warrant designation for this purpose.

"(c) PRIMARY CARE MANAGER PROGRAM.—

"(1) IN GENERAL.—The Secretary of Defense may establish a program, to be known as the Primary Care Manager Program, to provide reduced cost-sharing amounts for enrolled beneficiaries whose care is provided by or managed by a designated primary care manager.

"(2) ELIGIBILITY.—A Category 2 beneficiary who is not a remote area dependent is eligible to enroll in the Primary Care Manager Program.

"(3) REFERRAL REQUIRED.—A PCM-Managed beneficiary shall, subject to such rules and regulations as the Secretary of Defense shall establish, be required to obtain care or a referral for care from a designated primary care manager prior to obtaining care under the TRICARE program.

"(4) POINT OF SERVICE CHARGE.— If a PCM-Managed beneficiary obtains care without a referral as required under paragraph (3), the cost-sharing requirement for such care shall be equal to the amount that is 50% of the allowed charge for such care.

"(d) INAPPLICABILITY OF COST-SHARING REQUIREMENTS TO CERTAIN CATEGORIES OF BENEFICIARIES AND TYPES OF CARE.—

"(1) CATEGORY 1 BENEFICIARIES (ACTIVE DUTY MEMBERS).—There are no cost-sharing requirements under this section for Category 1 beneficiaries.

"(2) CATEGORY 5 BENEFICIARIES (MEDICARE-ELIGIBLE BENEFICIARIES).—Cost sharing under this section does not apply to a Category 5 beneficiary for care covered by section 1086(d)(3) of this title, except that the catastrophic cap under subsection (h)(3) does apply to such care.

"(3) PCM-MANAGED BENEFICIARIES AND REMOTE AREA DEPENDENTS.—(A) Except as provided in subparagraph (B) and subsection (c)(4), there are no out-patient cost-sharing requirements under subsection (i) or in-patient cost-sharing requirements under subsection (j) for PCM-Managed beneficiaries and remote area dependents.

"(B) For non-emergency care provided by an emergency department to PCM-Managed beneficiaries and remote area dependents, the cost-sharing requirements applicable to Self-Managed beneficiaries under subsection (i) apply.

"(4) EXTENDED HEALTH-CARE SERVICES.—Cost sharing under this section does not apply to extended health care services under section 1079(d) and (e) of this title.

"(5) OTHER PROGRAMS.—This section does not apply to premiums established under this chapter under sections other than 1079 and 1086. For a program under this chapter for which such a premium applies, the enrollment fee under subsection (f) does not apply.

"(e) SPECIAL RULES.—

"(1) PHARMACY BENEFITS PROGRAM.—Required copayments for services under the Pharmacy Benefits Program are set forth in section 1074g of this title. The enrollment

fee, deductible, and catastrophic cap under this section apply to the Pharmacy Benefits Program under that section.

"(2) CALENDAR YEAR ENROLLMENT PERIOD.—Enrollment fees, deductible amounts, and catastrophic caps under this section are on a calendar-year basis.

"(3) CREDITING OF AMOUNTS RECEIVED.—Amounts received under this section for care provided by a facility of the uniformed services shall be deposited to the credit of the appropriation supporting the maintenance and operation of that facility.

"(f) ANNUAL ENROLLMENT FEE FOR CATEGORY 4 BENEFICIARIES (OTHER RETIREES AND FAMILY MEMBERS).—

"(1) REQUIREMENT.—As a condition of eligibility for the TRICARE program in any year (including care in facilities of the uniformed services and pharmacy benefits under section 1074g of this title), a Category 4 beneficiary shall pay an enrollment fee for that year.

"(2) AMOUNT.—The amount of such fee for any year is the baseline amount as adjusted under subsection (k). The baseline amount is the amount that would have been charged for enrollment in TRICARE Prime during fiscal year 2016 under section 1097 of this title on the day before the effective date of this section.

"(g) ANNUAL DEDUCTIBLE.—

"(1) REQUIREMENT.—For a Group A, B, C, and D beneficiaries, the cost-sharing requirements applicable under this section include an annual deductible of the charges for outpatient care received under the TRICARE program during a year.

"(2) AMOUNT.—The annual deductible described in paragraph (1) is the following:

"(A) GROUP A.—For a Group A beneficiary, the first $150 (or $300 for a family group of two or more persons) each year of the charges for outpatient care provided by out-of-network providers..

"(B) GROUP B.—For a Group B beneficiary, the first $300 (or $600 for a family group of two or more persons) each year for outpatient care provided by out-of-network providers.

"(C) GROUP C.—For a Group C beneficiary, the first $300 (or $600 for a family group of two or more persons) each year for outpatient care provided by out-of-network providers.

"(D) GROUP D.—For a Group D beneficiary, the first $300 (or $600 for a family group of two or more persons) each year for outpatient care provided by out-of-network providers.

"(h) CATASTROPHIC CAP.—

"(1) REQUIREMENT.—The total amount of cost sharing required to be paid by a beneficiary under the TRICARE program for a year is limited to a maximum amount, referred to as a catastrophic cap.

"(2) EXCLUSIONS.—The following shall not be counted toward the catastrophic cap:

"(A) An enrollment fee paid under subsection (f).

"(B) A point-of-service charge under subsection (c)(2).

"(3) AMOUNT.—The catastrophic cap has been reached for a beneficiary during a year if the total amount of cost sharing requirements (other than amounts excluded under

paragraph (2)) incurred under the TRICARE program by all beneficiaries in the beneficiary's family group during that year is the following:

"(A) For a Category 2, 3 or 6 beneficiary, $1,500 for health care provided by network providers or $2,500 for all health care.

"(B) For Category 4 or 5 beneficiary, $3,000 for health care provided by military treatment facilities and network providers or $5,000 for all health care.

"(i) OUTPATIENT COST SHARING.—

"(1) IN GENERAL.—A Group A, B, C, or D beneficiary shall be subject to cost-sharing for outpatient care in accordance with the amounts and percentages under the following table, as such amounts are adjusted under subsection (k):

Services	TRICARE Network and Facilities of the Uniformed Services (FUS)			Out-of-Network	
	Group A/ Group B/Group C		Group D	Group A, B, and C	Group D
	PCM MANAGED[c]/REMOTE AREA DEPENDENT	SELF-MANAGED			
Clinical preventive services [a]	$0	$0	$0	$0	$0
Primary care visit	$0/0/0 FUS $0/0/0 network referral	$0/0/0 FUS $10/15/20 network	$10 FUS $20 network	20% [b]	25% [b]
Specialty care visit (including PT, OT, speech)	$0/0/0 FUS or network BH group visit $0/0/0 network referral	$0/0/0 FUS $20/25/30 network	$20 FUS or network BH group visit $30 network	20% [b]	25% [b]
Urgent care center	$0/0/0 FUS visit $0/0/0 network referral	$0/0/0 FUS $25/40/50 network	$30 FUS $50 network	20% [b]	25% [b]
Emergency department – emergency care	$0/0/0 FUS visit $0/0/0 network	$0/0/0 FUS $30/50/70 network	$50 FUS $75 network	20% [b]	25% [b]
Emergency department –non emergency care	$30/50/70 FUS for misuse $30/50/70 network fee for misuse	$30/50/70 FUS fee for misuse $30/50/70 network	$50 FUS $75 network	20% [b]	25% [b]
Ambulance regardless of destination (FUS or network)	$0/0/0 trip	$10/15/20 trip	$20 trip	20% [b]	25% [b]
DME, prosthetics, orthotics, & supplies	$0/0/0 FUS $0/0/0 network referral	10% of negotiated network fee	20% of FUS cost or network negotiated fee	20% [b]	25% [b]
Ambulatory surgery	$0/0/0 FUS $0/0/0 network referral	$0/0/0 FUS $25/50/75 network	$50 FUS $100 network	20% [b]	25% [b]

a. No cost for clinical preventive services as determined by the Secretary consistent with criteria applicable under the Patient Protection and Affordable Care Act (Public Law 111–148), as amended.

b. Percentage of TRICARE maximum allowable charge after deductible is met.

c. If a PCM managed beneficiary obtains care without a referral, Point of Service charges will apply: 50% of the allowed charge after deductible is met.

Note: PT – physical therapy; OT – occupational therapy; BH – behavioral health; DME – durable medical equipment.

"(2) APPLICABILITY OF DEDUCTIBLE.—The cost sharing amounts specified in the table under paragraph (1) shall apply only after any applicable deductible under subsection (g) has been met.

"(3) EMERGENCY ROOM MISUSE.—For purposes of the table under paragraph (1), the Secretary of Defense shall develop guidance for determining emergency room care is clearly inappropriate under the TRICARE program. The Secretary will establish procedures to provide information to beneficiaries about the appropriate sites for such health conditions and services. The Secretary will ensure the availability of, and wide dissemination of information concerning, means (such as a nurse advice line and other methods) for beneficiaries with uncertainty about the appropriate site for care in specific cases to obtain guidance. In any case in which a beneficiary has a reasonable belief, taking into account the beneficiary's (or in the case of a minor, the parent or guardian's) level of maturity and understanding, that the circumstances presented a medical emergency, the care provided will not be considered emergency room misuse.

"(j) INPATIENT COST-SHARING.—A Group A, B, C, or D beneficiary shall be subject to cost sharing for inpatient care in accordance with the amounts and percentages under the following table, as such amounts are adjusted under subsection (k):

	TRICARE Network and Facility of the Uniformed Services (FUS)			Out-of-Network	
Services	**Group A/ Group B/Group C**		**Group D**	**Group A/Group B/Group C**	**Group D**
	PCM MANAGED/ REMOTE AREA DEPENDENTS	**Self-Managed**			
Hospitalization	$0 FUS $0 network referred	$0 FUS per day $50/80/110/day network	$17.35 FUS per day $200 network per admission	20% [a]	25% [a]
Inpatient skilled nursing / rehabilitation [b]	$0 network referred	$17/25/35 network per day	$25 day	$25/35/45 day	$250 per day or 20% [a] of billed charges for institutional services, whichever is less, plus 20% for separately billed services

a. percentage of TRICARE maximum allowable charge after deductible is met
b. Inpatient skilled nursing / rehabilitation is generally not offered in MTFs for anyone other than service members.

"(k) ANNUAL ADJUSTMENT TO CERTAIN COST-SHARING AMOUNTS.—

"(1) ADJUSTMENT.—For any year after 2017, the dollar amounts specified in paragraph (2) shall be equal to such dollar amounts increased by the percentage by which retired pay has been increased under section 1401a(b)(2) of this title since 2017, rounded to the next lower multiple of $1.

"(2) AMOUNTS SUBJECT TO ADJUSTMENT.—Paragraph (1) applies to the following:

"(A) The amount of the enrollment fee in effect under subsection (f).

"(B) Each deductible amount in effect under subsection (g).

"(C) Each catastrophic cap amount in effect under subsection (h).

"(D) Each amount in effect under subsection (i) for outpatient care.

"(E) Each amount in effect under subsection (j) for inpatient care.

"(l) REGULATIONS.—

"(1) IN GENERAL.—The Secretary of Defense, after consultation with the other administering Secretaries, shall prescribe regulations to carry out this section.

"(2) MATTERS TO BE INCLUDED.—The regulations prescribed under paragraph (1) shall include the following:

"(A) Provisions to ensure, to the extent practicable, the availability of network providers to at least 85 percent of beneficiaries for whom the TRICARE program provides primary health benefits.

"(B) Provisions for an annual open season enrollment period and for enrollment modifications under appropriate circumstances.

"(C) Priorities for access to care in facilities of the uniformed services and other standards to ensure timely access to care.

"(3) ADDITIONAL MATTERS.—Those regulations may provide for TRICARE eligibility and alternate cost sharing for beneficiaries other than Category 1 beneficiaries who have other health insurance that provides primary health benefits.

"(4) AUTHORITY FOR ADDITIONAL PROVISIONS FOR EFFECTIVE AND EFFICIENT ADMINISTRATION.—Those regulations may include such other provisions as the Secretary determines appropriate for the effective and efficient administration of the TRICARE program, including any matter not specifically addressed in this chapter or any other law.

"(m) DEFINITIONS.—In this section:

"(1) The term 'network provider' means a health care provider referred to in section 1073c(b)(2) of this title.

"(2) The term 'out-of-network provider' means a health care provider referred to in section 1073c(b)(3) of this title.".

(c) TRANSITION RULES FOR LAST QUARTER OF CALENDAR YEAR 2016.—With respect to cost sharing requirements applicable under sections 1079, 1086, or 1097 of title 10, United States Code, to a covered beneficiary under such sections during the period October 1, 2016, through December 31, 2016:

(1) Any enrollment fee shall be one-fourth of the amount in effect during fiscal year 2016.

(2) Any deductible amount applicable during fiscal year 2016 shall apply for the 15-month period of October 1, 2015, through December 31, 2016.

(3) Any catastrophic cap applicable during fiscal year 2016 shall apply for the 15-month period of October 1, 2015, through December 31, 2016.

(d) REPEAL OF SUPERSEDED AUTHORITIES.—The following provisions of law are repealed:

(1) Section 1078 of title 10, United States Code.

(2) Section 1097a of title 10, United States Code.

(3) Section 1099 of title 10, United States Code.

(4) Section 731 of the National Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160; 10 U.S.C. 1073 note).

(e) CONFORMING AMENDMENTS TO TITLE 10, UNITED STATES CODE.—Title 10, United States Code is amended as follows:

(1) Section 1072 is amended by striking paragraph (7) and inserting the following:

"(7) The term 'TRICARE program' means the various programs carried out by the Secretary of Defense under this chapter and any other provision of law providing for

the furnishing of medical and dental care and health benefits to members and former members of the uniformed services and their dependents.”.

(2) Section 1074(c)(2) is amended by striking “the managed care option of the TRICARE program known as TRICARE Prime” and inserting “the TRICARE program”.

(3) Section 1076d is amended—

(A) by striking “TRICARE Standard” each place it appears (including in the heading of such section) and inserting “TRICARE Reserve Select”, and

(B) in clause (f)(2)(B), by striking “subject to the same rates and conditions as apply to persons covered under that section” and substituting “subject to the same scope of benefits as apply to persons covered under that section and cost sharing requirements as provided in section 1075 of this title”.

(4) Section 1076e is amended by striking “TRICARE Standard” each place it appears (including in the heading of such section) and inserting “TRICARE Retired Reserve”.

(5) Section 1076e is further amended by striking “TRICARE Retired Reserve Coverage at age 60” (as inserted by paragraph (4)) and inserting “TRICARE coverage at age 60”.

(6) Section 1079 is amended—

(A) in subsection (b), by striking “of the following amounts:” and all that follows and inserting “of amounts as provided under section 1075 of this title.”; and

(B) by striking subsections (c), (g), and (p).

(7) Section 1079a is amended—

(A) by striking "**CHAMPUS**" in the heading and inserting "**TRICARE program**"; and

(B) by striking "the Civilian Health and Medical Program of the Uniformed Services" and inserting **"**the TRICARE program".

(8) Section 1086(b) is amended by striking "contain the following" and all that follows and inserting "include provisions for payment by the patient as provided under section 1075 of this title.".

(9) Section 1097(e) is amended to read as follows:

"(e) CHARGES FOR HEALTH CARE.—Section 1075 of this title applies to health care services under this section.".

(f) OTHER CONFORMING AMENDMENTS.—

(1) Section 721 of the National Defense Authorization Act for Fiscal Year 1997 (Public Law 104-201; 10 U.S.C. 1073 note) is amended—

(A) in paragraph (7), by striking "the health plan known as the 'TRICARE PRIME' option under"; and

(B) in paragraph (9), by striking all that follows "The term 'TRICARE program'" and inserting "has the meaning given that term in section 1072(7) of title 10, United States Code.".

(2) Section 723(a) of such Act (Public Law 104-201; 10 U.S.C. 1073 note) is amended by striking "section 731 of the National Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160; 10 U.S.C. 1073 note)" and inserting "section 1075 of title 10, United States Code".

(3) Section 706 of the National Defense Authorization Act for Fiscal Year 2000 (Public Law 106-65; 113 Stat. 684) is amended—

(A) in subsection (c), by striking "Prime Remote"; and

(B) in subsection (d), by striking "the TRICARE Standard plan" and inserting "the TRICARE program".

(g) CLERICAL AMENDMENTS.—The table of sections at the beginning of chapter 55 of title 10, United States Code, is amended—

(1) by inserting after the item relating to section 1073b the following new item: "1073c. TRICARE program: freedom of choice for points of service.";

(2) by inserting after the item relating to section 1074n the following new item: "1075. TRICARE program: cost-sharing requirements.";

(3) in the item relating to section 1076d, by striking "TRICARE Standard" and inserting "TRICARE Reserve Select";

(4) in the item relating to section 1076e, by striking "TRICARE Standard" and inserting "TRICARE Retired Reserve";

(5) in the item relating to section 1079a, by striking "CHAMPUS" and inserting "TRICARE program"; and

(6) by striking the items relating to sections 1078, 1097a, and 1099.

(h) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), this section and the amendments made by the section shall take effect on January 1, 2017.

(2) TRANSITION RULES.—Subsection (c) shall take effect on October 1, 2016.

Section-by-Section Analysis

This proposal would provide for a consolidated TRICARE health plan to replace the current TRICARE Prime, Standard, and Extra insurance-like products.

Historically, the uniform TRICARE benefit was developed and is currently delivered through a variety of insurance-like products. TRICARE Prime, Standard and Extra were crafted for specific reasons at the time they were created. TRICARE Prime is the HMO-like product with fixed fee cost shares (copayment); beneficiaries are assigned to a primary care provider and authorizations required for all other types of care. TRICARE Standard is the fee-for-service CHAMPUS replacement plan with required percentage-based cost shares (coinsurance) for non-network providers. TRICARE Extra provides access to network providers with reduced rate coinsurance.

The consolidated TRICARE health plan is structured to make it easier for beneficiaries to focus on health (no cost shares for preventive care), to maintain a close relationship with their primary care provider (zero to low cost shares), and to offer beneficiary freedom of choice of providers. The cost sharing structure is designed to steer beneficiaries to Military Treatment Facilities (MTFs) for care, maximizing utilization of investments in the MTF structure and supporting the readiness of military medical providers, while preserving choice based on copays rather than primarily on a bureaucratic authorization process. The cost sharing within each sector of care (MTF, preferred provider, or out-of-network) is designed to minimize overutilization of costly care venues, such as emergency departments, for non-urgent care.

More specifically, subsection (a) would insert in title 10 a new section 1073c to establish certain terms for a uniform TRICARE health plan. TRICARE would have three points of service: facilities of the uniformed services, network providers, and out-of-network providers. Covered beneficiaries would have freedom of choice to choose to receive care from any of these points of service, subject to availability. Subsection (b) would insert in title 10 a new section 1075 to establish cost sharing requirements for TRICARE. Cost sharing requirements vary by category of beneficiary. The categories are: (1) active duty members; (2) active duty dependents; (3) survivors of members who died while on active duty and disability retirees and their family members; (4) other retirees and their family members; (5) TRICARE-for-life beneficiaries; and (6) TRICARE Reserve Select beneficiaries. In addition to those categories, for some copayments, there are scaled amounts based on the grade of the military sponsor: lowest for beneficiaries whose sponsor is in pay grades E-1 through E-4 (Group A); higher for those whose sponsor is in grades E-4 to O-3 (including warrant officers) (Group B); and highest for those whose sponsor is in pay grades O-4 and above (Group C). These pay grade groupings do not apply to cost sharing for other retirees and their family members (including TRICARE-for-life beneficiaries with respect to care not covered by Medicare) (referred to as Group D). Another distinction made for Groups A, B, and C is for primary care manager (PCM)-managed care (for which the beneficiary may voluntarily enroll) versus self-managed care (which has greater beneficiary choice). PCM-managed care generally has zero copays. However, for remote area dependents, who do not have the option of PCM-managed care, cost sharing amounts align with PCM-managed care. The PCM program is described in subsection (c).

Proposed new subsections 1075(d) and (e) provide certain exclusions and special rules for TRICARE cost sharing requirements. There is no cost sharing for active duty members.

Most TRICARE-for-life beneficiary cost sharing is addressed in other sections of law. The current rule would continue that for care not covered by Medicare Parts A and B (such as pharmacy benefits and care overseas), cost sharing applicable to other retires applies. (But the enrollment fee applicable to other retirees does not apply to TRICARE-for-life beneficiaries in any case.) Copayments for the Pharmacy Benefits Program are not addressed by this section, but beneficiaries who are required to pay an enrollment fee for TRICARE need to have met this requirement to be eligible for pharmacy benefits, as well as care in military treatment facilities. This section also does not govern the ECHO program or premiums under other TRICARE programs such as TRICARE Young Adult, TRICARE Reserve Select, TRICARE Retired Reserve, or the Continued Health Benefits Program programs.

Proposed new section 1075(f) establishes an annual enrollment fee for retirees and their families, other than survivors of active duty members, disability retirees and their families, and TRICARE-for-life beneficiaries. The enrollment fee in calendar year 2017 would be the same as the amount that would have been charged for enrollment in TRICARE Prime during fiscal year 2017.

Proposed new section 1075(g) would establish TRICARE deductible amounts (which would not apply with respect to military treatment facility care). The deductible amount would be $150 per person up to a maximum of $300 per family for active duty family members (and other beneficiaries whose cost sharing is the same as active duty family members) whose sponsor is in pay grades 0-1 through 0-4. Other active duty families and retirees and their family members would have a deductible of $300 per person up to a maximum of $600 per family. The deductible only applies to out-of-network care.

Under proposed new section 1075(h), the catastrophic cap would be $1,500 for care provided by network providers or $2,500 for all care for active duty family members, survivors of members who died while on active duty, and disability retirees and their family members. For other retirees and their families, catastrophic cap would be $3,000 for care provided by network providers or $5,000 for all care.

Proposed new section 1075(i) includes a detailed table that would establish specific outpatient copayment amounts for various types of care for the respective beneficiary categories, enrollment status, and points of services. For example, active duty dependents enrolled with a primary care manager and receiving care from or referred by the primary care manager would generally have no copays for care provided by a military treatment facility (MTF) or network provider. The same would apply to emergency room visits unless it is emergency room misuse, in which case a copay would be required of $30 for dependents of sponsors in grades E-1 through E-4, $50 for dependents of sponsors in grades E-5 through O-3 (including warrant officers), or $70 for dependents of sponsors in grades O-4 and above. Specific limitations are included to ensure that only care that is clearly inappropriate for the emergency room would be considered emergency room misuse.

For active duty dependents who prefer self-managed care (and therefore choose not to enroll with a primary care manager), copays for primary care visits would be $10, $15, or $20, respectively for the three sponsor pay grade groups just mentioned. Active duty dependents do

not pay copays for military treatment facility care. Most retirees and their family members would pay $10 for a military treatment facility primary care visit and $20 for a network provider visit. Survivors of members who died while on active duty and disability retirees and their family members would pay the copays applicable to active duty families. For outpatient services other than primary care services, preventive care services have zero copay for all beneficiary categories, while specialty services, emergency room services, and other more intensive services have higher copays. There are higher copays for care from out-of-network providers. For active duty family members accompanying a member assigned to a remote location where PCM enrollment is unavailable, the copayment structure is the same as for active duty family members enrolled to a primary care manager. Proposed new section 1075(j) includes a table that establishes inpatient cost sharing amounts.

As provided in proposed new section 1075(k), adjustments to the cost sharing amounts after 2017 will be the same as the cost of living adjustments made to retired pay. Proposed new subsection 1075(l) authorizes regulations to carry out this section. These will include provisions to ensure, to the extent practicable, the availability of network providers to at least 85% of beneficiaries for whom TRICARE provides primary health program coverage, provisions for an annual open season enrollment period and for enrollment modifications under appropriate circumstances, priorities for access to care in facilities of the uniformed services and other standards to ensure timely access to care, and other appropriate provisions.

The proposal also includes a provision for a transition for the last quarter of calendar year 2016. The reason for this is that the new TRICARE plan will be on a calendar year basis to correspond with most other health plans, rather than the current fiscal year basis that applies to TRICARE deductibles, catastrophic caps and enrollment fees. During this transition quarter, any enrollment fee will be one-fourth of the amount in effect during Fiscal Year 2016. Any deductible and catastrophic cap amounts applicable during Fiscal Year 2016 will apply for the 15 month period of October 1, 2015, through December 31, 2016. The proposal also makes a number of conforming amendments to other provisions of chapter 55 and several free-standing sections of other laws. The effective date for this proposal is January 1, 2017, except the provision of the transition period, which is effective October 1, 2016.

Under this proposal the overall cost sharing impact on beneficiaries is as set forth in the following table.

Cost-Sharing Impact on Beneficiary Families (CY 2017)

		Current TRICARE Triple Option	Consolidated TRICARE Health Plan
Active Duty Family [a] (3 members not including service member)	DoD cost	$ 13,448	$ 13,396
	Family cost	$ 166	$ 188
	Total	$ 13,615	$ 13,584
	% borne by family	1.2%	1.4%
Non-Medicare eligible Retiree Family [b] (3 members, all under age 65)	DoD cost	$ 15,339	$ 14,636
	Family cost	$ 1,377	$ 1,666
	Total	$ 16,715	$ 16,302
	% borne by family	8.2%	10.2%

Note 1. The analysis assumes an average mix of MTF and civilian care within each beneficiary category, and a weighted average of Prime and Non-Prime users for the current TRICARE triple option (or former Prime and Non-Prime users), for the consolidated TRICARE health plan. For those using all civilian care, the percent borne by the family is slightly higher.

Note 2. The annual employer health benefits survey published by Kaiser Family Foundation (KFF)/Health Research & Educational Trust (HRET) offers a useful benchmark for comparison (*http://kff.org/health-costs/*).

a. Active duty family cost-sharing structure also applies to transitional survivors, TRICARE Young Adult beneficiaries with an active duty sponsor, the Transitional Assistance Management Program, and TRICARE Reserve Select.

b. Retiree cost-sharing structure also applies to survivors, TRICARE Young Adult beneficiaries with a retired sponsor, and TRICARE Retired Reserve.

Budgetary Implications: This section would reduce Defense Health Program requirements by $3.1 billion from FY 2016 – FY 2020. However, due to the necessary administrative, contracting, and other changes required within the Military Health System and the January 1, 2017, implementation date, there is an estimated up-front cost of $85 million for the Defense Health Program in FY 2016.

RESOURCE REQUIREMENTS ($MILLIONS)								
	FY 2016	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**Appropriation From**	**Budget Activity**	**Dash-1 Line Item**
Defense Health	85	-502	-859	-899	-951	O&M, Defense Health Program	01	02

Changes to Existing Law: This proposal would make the following changes to chapter 55 of title 10, United States Code, and to several other laws:

TITLE 10, UNITED STATES CODE
CHAPTER 55, MEDICAL AND DENTAL CARE

§ 1072. Definitions

In this chapter:
* * * * *

(7) The term "TRICARE program" means the ***various programs carried out by the Secretary of Defense under this chapter and any other provision of law providing for the furnishing of medical and dental care and health benefits to members and former members of the uniformed services and their dependents.*** ~~**managed health care program that is established by the Department of Defense under the authority of this chapter, principally section 1097 of this title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services**~~**.**

*** * * * ***

§ 1073c. TRICARE program: freedom of choice for points of service

[The text of § 1073c is as set forth above.]
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§ 1074. Medical and dental care for members and certain former members

* * * * *

(c) (1) Funds appropriated to a military department, the Department of Homeland Security (with respect to the Coast Guard when it is not operating as a service in the Navy), or the Department of Health and Human Services (with respect to the National Oceanic and Atmospheric Administration and the Public Health Service) may be used to provide medical and dental care to persons entitled to such care by law or regulations, including the provision of such care (other than elective private treatment) in private facilities for members of the uniformed services. If a private facility or health care provider providing care under this subsection is a health care provider under the Civilian Health and Medical Program of the Uniformed Services, the Secretary of Defense, after consultation with the other administering Secretaries, may by regulation require the private facility or health care provider to provide such care in accordance with the same payment rules (subject to any modifications considered appropriate by the Secretary) as apply under that program.

(2) (A) Subject to such exceptions as the Secretary of Defense considers necessary, coverage for medical care for members of the uniformed services under this subsection, and standards with respect to timely access to such care, shall be comparable to coverage for medical care and standards for timely access to such care under the ~~**managed care option of the TRICARE program known as TRICARE Prime**~~ ***TRICARE program***.

(B) The Secretary of Defense shall enter into arrangements with contractors under the TRICARE program or with other appropriate contractors for the timely and efficient processing of claims under this subsection.

(C) The Secretary of Defense shall consult with the other administering Secretaries in the administration of this paragraph.

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§ 1075. TRICARE program: cost-sharing requirements

[The text of § 1075 is as set forth above.]

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§ 1076d. TRICARE program: TRICARE ~~Standard~~ *Reserve Select* coverage for members of the Selected Reserve

(a) ELIGIBILITY.

(1) Except as provided in paragraph (2), a member of the Selected Reserve of the Ready Reserve of a reserve component of the armed forces is eligible for health benefits under TRICARE ~~Standard~~ ***Reserve Select*** as provided in this section.

(2) Paragraph (1) does not apply to a member who is enrolled, or is eligible to enroll, in a health benefits plan under chapter 89 of title 5.

(b) TERMINATION OF ELIGIBILITY UPON TERMINATION OF SERVICE.

(1) Except as provided in paragraph (2), eligibility for TRICARE ~~Standard~~ ***Reserve Select*** coverage of a member under this section shall terminate upon the termination of the member's service in the Selected Reserve.

(2) During the period beginning on the date of the enactment of this paragraph and ending December 31, 2018, eligibility for a member under this section who is involuntarily separated from the Selected Reserve under other than adverse conditions, as characterized by the Secretary concerned, shall terminate 180 days after the date on which the member is separated.

(c) FAMILY MEMBERS. While a member of a reserve component is covered by TRICARE ~~Standard~~ ***Reserve Select*** under the section, the members of the immediate family of such member are eligible for TRICARE ~~Standard~~ ***Reserve Select*** coverage as dependents of the member. If a member of a reserve component dies while in a period of coverage under this section, the eligibility of the members of the immediate family of such member for TRICARE ~~Standard~~ ***Reserve Select*** coverage shall continue for six months beyond the date of death of the member.

(d) PREMIUMS.

(1) A member of a reserve component covered by TRICARE ~~Standard~~ ***Reserve Select*** under this section shall pay a premium for that coverage.

(2) The Secretary of Defense shall prescribe for the purposes of this section one premium for TRICARE ~~Standard~~ ***Reserve Select*** coverage of members without dependents and one premium for TRICARE ~~Standard~~ ***Reserve Select*** coverage of members with dependents referred to in subsection (f)(1). The premium prescribed for a coverage shall apply uniformly to all covered members of the reserve components.

(3) (A) The monthly amount of the premium in effect for a month for

TRICARE ~~Standard~~ ***Reserve Select*** coverage under this section shall be the amount equal to 28 percent of the total monthly amount determined on an appropriate actuarial basis as being reasonable for that coverage.

(B) The appropriate actuarial basis for purposes of subparagraph (A) shall be determined, for each calendar year after calendar year 2009, by utilizing the actual cost of providing benefits under this section to members and their dependents during the calendar years preceding such calendar year.

(4) The premiums payable by a member of a reserve component under this subsection may be deducted and withheld from basic pay payable to the member under section 204 of title 37 or from compensation payable to the member under section 206 of such title. The Secretary shall prescribe the requirements and procedures applicable to the payment of premiums.

(5) Amounts collected as premiums under this subsection shall be credited to the appropriation available for the Defense Health Program Account under section 1100 of this title, shall be merged with sums in such Account that are available for the fiscal year in which collected, and shall be available under subsection (b) of such section for such fiscal year.

(e) REGULATIONS. The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations for the administration of this section.

(f) DEFINITIONS. In this section:

(1) The term "immediate family", with respect to a member of a reserve component, means all of the member's dependents described in subparagraphs (A), (D), and (I) of section 1072(2) of this title.

(2) The term "TRICARE ~~Standard~~ ***Reserve Select***" means--

(A) medical care to which a dependent described in section 1076(a)(2) of this title is entitled; and

(B) health benefits contracted for under the authority of section 1079(a) of this title and ~~**subject to the same rates and conditions as apply to persons covered under that section**~~ ***subject to the same scope of benefits as apply to persons covered under that section and cost sharing requirements as provided in section 1075 of this title***.

§ 1076e. TRICARE program: TRICARE ~~Standard~~ *Retired Reserve* coverage for certain members of the Retired Reserve who are qualified for a non-regular retirement but are not yet age 60

(a) ELIGIBILITY.

(1) Except as provided in paragraph (2), a member of the Retired Reserve of a reserve component of the armed forces who is qualified for a non-regular retirement at age 60 under chapter 1223 of this title, but is not age 60, is eligible for health benefits under TRICARE ~~Standard~~ ***Retired Reserve*** as provided in this section.

(2) Paragraph (1) does not apply to a member who is enrolled, or is eligible to enroll, in a health benefits plan under chapter 89 of title 5.

(b) TERMINATION OF ELIGIBILITY UPON OBTAINING OTHER TRICARE ~~STANDARD~~ ***RETIRED RESERVE*** COVERAGE. Eligibility for TRICARE ~~Standard~~ ***Retired Reserve*** coverage of a member

under this section shall terminate upon the member becoming eligible for TRICARE ~~**Standard**~~ coverage at age 60 under section 1086 of this title.

(c) FAMILY MEMBERS. While a member of a reserve component is covered by TRICARE ~~**Standard**~~ ***Retired Reserve*** under this section, the members of the immediate family of such member are eligible for TRICARE Standard coverage as dependents of the member. If a member of a reserve component dies while in a period of coverage under this section, the eligibility of the members of the immediate family of such member for TRICARE ~~**Standard**~~ ***Retired Reserve*** coverage under this section shall continue for the same period of time that would be provided under section 1086 of this title if the member had been eligible at the time of death for TRICARE ~~**Standard**~~ coverage under such section (instead of under this section).

(d) PREMIUMS.

(1) A member of a reserve component covered by TRICARE ~~**Standard**~~ ***Retired Reserve*** under this section shall pay a premium for that coverage.

(2) The Secretary of Defense shall prescribe for the purposes of this section one premium for TRICARE ~~**Standard**~~ ***Retired Reserve*** coverage of members without dependents and one premium for TRICARE ~~**Standard**~~ ***Retired Reserve*** coverage of members with dependents referred to in subsection (f)(1). The premium prescribed for a coverage shall apply uniformly to all members of the reserve components covered under this section.

(3) The monthly amount of the premium in effect for a month for TRICARE ~~**Standard**~~ ***Retired Reserve*** coverage under this section shall be the amount equal to the cost of coverage that the Secretary determines on an appropriate actuarial basis.

(4) The Secretary shall prescribe the requirements and procedures applicable to the payment of premiums under this subsection.

(5) Amounts collected as premiums under this subsection shall be credited to the appropriation available for the Defense Health Program Account under section 1100 of this title, shall be merged with sums in such Account that are available for the fiscal year in which collected, and shall be available under subsection (b) of such section for such fiscal year.

(e) Regulations. The Secretary of Defense, in consultation with the other administering Secretaries, shall prescribe regulations for the administration of this section.

(f) Definitions. In this section:

(1) The term "immediate family", with respect to a member of a reserve component, means all of the member's dependents described in subparagraphs (A), (D), and (I) of section 1072(2) of this title.

(2) The term "TRICARE ~~**Standard**~~ ***Retired Reserve***" means--

(A) medical care to which a dependent described in section 1076(b)(1) of this title is entitled; and

(B) health benefits contracted for under the authority of section 1086(a) of this title and subject to the same rates and conditions as apply to persons covered under that section.

* * * * *

~~**§ 1078. Medical and dental care for dependents: charges**~~

~~(a) The Secretary of Defense, after consulting the other administering Secretaries, shall prescribe fair charges for inpatient medical and dental care given to dependents under section 1076 of this title. The charge or charges prescribed shall be applied equally to all classes of dependents.~~

~~(b) As a restraint on excessive demands for medical and dental care under section 1076 of this title, uniform minimal charges may be imposed for outpatient care. Charges may not be more than such amounts, if any, as the Secretary of Defense may prescribe after consulting the other administering Secretaries, and after a finding that such charges are necessary.~~

~~(c) Amounts received for subsistence and medical and dental care given under section 1076 of this title shall be deposited to the credit of the appropriation supporting the maintenance and operation of the facility furnishing the care.~~

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§ 1079. Contracts for medical care for spouses and children: plans

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~~(b) Plans covered by subsection (a) shall include provisions for payment by the patient of the following amounts:~~

~~(1) $ 25 for each admission to a hospital, or the amount the patient would have been charged under section 1078(a) of this title had the care being paid for been obtained in a hospital of the uniformed services, whichever amount is the greater. The Secretary of Defense may exempt a patient from paying such amount if the hospital to which the patient is admitted does not impose a legal obligation on any of its patients to pay for inpatient care.~~

~~(2) Except as provided in clause (3), the first $ 150 each fiscal year of the charges for all types of care authorized by subsection (a) and received while in an outpatient status and 20 percent of all subsequent charges for such care during a fiscal year. Notwithstanding the preceding sentence, in the case of a dependent of an enlisted member in a pay grade below E-5, the initial deductible each fiscal year under this paragraph shall be limited to $ 50.~~

~~(3) A family group of two or more persons covered by this section shall not be required to pay collectively more than the first $ 300 (or in the case of the family group of an enlisted member in a pay grade below E-5, the first $ 100) each fiscal year of the charges for all types of care authorized by subsection (a) and received while in an outpatient status and 20 percent of the additional charges for such care during a fiscal year.~~

~~(4) $ 25 for surgical care that is authorized by subsection (a) and received while in an outpatient status and that has been designated (under joint regulations to be prescribed by the administering Secretaries) as care to be treated as inpatient care for purposes of this subsection. Any care for which payment is made under this clause shall not be considered to be care received while in an outpatient status for purposes of clauses (2) and (3).~~

~~(5) An individual or family group of two or more persons covered by this section may not be required by reason of this subsection to pay a total of more than $ 1,000 for health care~~

~~**received during any fiscal year under a plan under subsection (a).**~~

(b) Section 1075 of this title shall apply to health care services under this section.

(c) ~~**The methods for making payment under subsection (b) shall be prescribed under joint regulations issued by the administering Secretaries.**~~ ***[Reserved.]***

* * * * *

(g)~~**(1) When a member dies while he is eligible for receipt of hostile fire pay under section 310 of title 37 or from a disease or injury incurred while eligible for such pay, his dependents who are receiving benefits under a plan covered by subsection (d) shall continue to be eligible for such benefits until they pass their twenty-first birthday.**~~

~~**(2) In addition to any continuation of eligibility for benefits under paragraph (1), when a member dies while on active duty for a period of more than 30 days, the member's dependents who are receiving benefits under a plan covered by subsection (a) shall continue to be eligible for benefits under TRICARE Prime during the three-year period beginning on the date of the member's death, except that, in the case of such a dependent of the deceased who is described by subparagraph (D) or (I) of section 1072(2) of this title, the period of continued eligibility shall be the longer of the following periods beginning on such date:**~~

~~**(A) Three years.**~~

~~**(B) The period ending on the date on which such dependent attains 21 years of age.**~~

~~**(C) In the case of such a dependent who, at 21 years of age, is enrolled in a full-time course of study in a secondary school or in a full-time course of study in an institution of higher education approved by the administering Secretary and was, at the time of the member's death, in fact dependent on the member for over one-half of such dependent's support, the period ending on the earlier of the following dates:**~~

~~**(i) The date on which such dependent ceases to pursue such a course of study, as determined by the administering Secretary.**~~

~~**(ii) The date on which such dependent attains 23 years of age.**~~

~~**(3) For the purposes of paragraph (2)(C), a dependent shall be treated as being enrolled in a full-time course of study in an institution of higher education during any reasonable period of transition between the dependent's completion of a full-time course of study in a secondary school and the commencement of an enrollment in a full-time course of study in an institution of higher education, as determined by the administering Secretary.**~~

~~**(4) The terms and conditions under which health benefits are provided under this chapter to a dependent of a deceased member under paragraph (2) shall be the same as those that would apply to the dependent under this chapter if the member were living and serving on active duty for a period of more than 30 days.**~~

~~**(5) In this subsection, the term "TRICARE Prime" means the managed care option of the TRICARE program.**~~ ***[Reserved.]***

* * * * *

~~**(p) (1) Subject to such exceptions as the Secretary of Defense considers necessary, coverage for medical care under this section for the dependents described in paragraph (3),**~~

~~**and standards with respect to timely access to such care, shall be comparable to coverage for medical care and standards for timely access to such care under the managed care option of the TRICARE program known as TRICARE Prime.**~~

~~**(2) The Secretary of Defense shall enter into arrangements with contractors under the TRICARE program or with other appropriate contractors for the timely and efficient processing of claims under this subsection.**~~

~~**(3) This subsection applies with respect to a dependent referred to in subsection (a) who-**~~

~~**(A) is a dependent of a member of the uniformed services referred to in section 1074(c)(3) of this title and is residing with the member;**~~

~~**(B) is a dependent of a member who, after having served in a duty assignment described in section 1074(c)(3) of this title, has relocated without the dependent pursuant to orders for a permanent change of duty station from a remote location described in subparagraph (B)(ii) of such section where the member and the dependent resided together while the member served in such assignment, if the orders do not authorize dependents to accompany the member to the new duty station at the expense of the United States and the dependent continues to reside at the same remote location, or**~~

~~**(C) is a dependent of a reserve component member ordered to active duty for a period of more than 30 days and is residing with the member, and the residence is located more than 50 miles, or approximately one hour of driving time, from the nearest military medical treatment facility adequate to provide the needed care.**~~

~~**(4) The Secretary of Defense may provide for coverage of a dependent referred to in subsection (a) who is not described in paragraph (3) if the Secretary determines that exceptional circumstances warrant such coverage.**~~

~~**(5) The Secretary of Defense shall consult with the other administering Secretaries in the administration of this subsection.**~~ ***[Reserved.]***

* * * * *

§ 1079a. ~~CHAMPUS~~ *TRICARE program*: treatment of refunds and other amounts collected

All refunds and other amounts collected in the administration of the ~~**Civilian Health and Medical Program of the Uniformed Services**~~ ***TRICARE program*** shall be credited to the appropriation available for that program for the fiscal year in which the refund or amount is collected.

* * * * *

§ 1086. Contracts for health benefits for certain members, former members, and their dependents

(a) To assure that health benefits are available for the persons covered by subsection (c), the Secretary of Defense, after consulting with the other administering Secretaries, shall contract under the authority of this section for health benefits for those persons under the same insurance, medical service, or health plans he contracts for under section 1079(a) of this title. However, eye examinations may not be provided under such plans for persons covered by subsection (c).

~~(b) For persons covered by this section the plans contracted for under section 1079(a) of this title shall contain the following provisions for payment by the patient:~~

~~(1) Except as provided in paragraph (2), the first $ 150 each fiscal year of the charges for all types of care authorized by this section and received while in an outpatient status and 25 percent of all subsequent charges for such care during a fiscal year.~~

~~(2) A family group of two or more persons covered by this section shall not be required to pay collectively more than the first $ 300 each fiscal year of the charges for all types of care authorized by this section and received while in an outpatient status and 25 percent of the additional charges for such care during a fiscal year.~~

~~(3) 25 percent of the charges for inpatient care, except that in no case may the charges for inpatient care for a patient exceed $ 535 per day during the period beginning on April 1, 2006, and ending on September 30, 2011. The Secretary of Defense may exempt a patient from paying such charges if the hospital to which the patient is admitted does not impose a legal obligation on any of its patients to pay for inpatient care.~~

~~(4) A member or former member of a uniformed service covered by this section by reason of section 1074(b) of this title, or an individual or family group of two or more persons covered by this section, may not be required to pay a total of more than $ 3,000 for health care received during any fiscal year under a plan contracted for under section 1079(a) of this title.~~

(b) Section 1075 of this title shall apply to health care services under this section.

* * * * *

(d) (1) A person who is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) is not eligible for health benefits under this section.

(2) The prohibition contained in paragraph (1) shall not apply to a person referred to in subsection (c) who--

(A) is enrolled in the supplementary medical insurance program under part B of such title (42 U.S.C. 1395j et seq.); and

(B) in the case of a person under 65 years of age, is entitled to hospital insurance benefits under part A of title XVIII of the Social Security Act [42 USCS §§ 1395c et seq.] pursuant to subparagraph (A) or (C) of section 226(b)(2) of such Act (42 U.S.C. 426(b)(2)) or section 226A(a) of such Act (42 U.S.C. 426-1(a)).

(3) (A) Subject to subparagraph (B), if a person described in paragraph (2) receives medical or dental care for which payment may be made under medicare and a plan contracted for under subsection (a), the amount payable for that care under the plan shall be the amount of the actual out-of-pocket costs incurred by the person for that care over the sum of--

(i) the amount paid for that care under medicare; and

(ii) the total of all amounts paid or payable by third party payers other than medicare.

(B) The amount payable for care under a plan pursuant to subparagraph (A) may not exceed the total amount that would be paid under the plan if payment for that care were made solely under the plan.

(C) In this paragraph:

(i) The term "medicare" means title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(ii) The term "third party payer" has the meaning given such term in section 1095(h)(1) of this title.

§ 1097. Contracts for medical care for retirees, dependents, and survivors: alternative delivery of health care

(a) IN GENERAL. The Secretary of Defense, after consulting with the other administering Secretaries, may contract for the delivery of health care to which covered beneficiaries are entitled under this chapter. The Secretary may enter into a contract under this section with any of the following:

(1) Health maintenance organizations.

(2) Preferred provider organizations.

(3) Individual providers, individual medical facilities, or insurers.

(4) Consortiums of such providers, facilities, or insurers.

* * * * *

(e) CHARGES FOR HEALTH CARE. ***Section 1075 of this title shall apply to health care services under this section.***

~~**(1) The Secretary of Defense may prescribe by regulation a premium, deductible, copayment, or other charge for health care provided under this section. In the case of contracts for health care services under this section or health care plans offered under section 1099 of this title for which the Secretary permits covered beneficiaries who are covered by section 1086 of this title and who participate in such contracts or plans to pay an enrollment fee in lieu of meeting the applicable deductible amount specified in section 1086(b) of this title, the Secretary may establish the same (or a lower) enrollment fee for covered beneficiaries described in section 1086(d)(1) of this title who also participate in such contracts or plans. Without imposing additional costs on covered beneficiaries who participate in contracts for health care services under this section or health care plans offered under section 1099 of this title, the Secretary shall permit such covered beneficiaries to pay, on a quarterly basis, any enrollment fee required for such participation. Except as provided by paragraph (2), a premium, deductible, copayment, or other charge prescribed by the Secretary under this subsection may not be increased during the period beginning on April 1, 2006, and ending on September 30, 2011.**~~

~~**(2) Beginning October 1, 2012, the Secretary of Defense may only increase in any year the annual enrollment fees described in paragraph (1) by an amount equal to the percentage by which retired pay is increased under section 1401a of this title.**~~

* * * * *

§ 1097a. ***[Reserved.]*** ~~TRICARE Prime: automatic enrollments; payment options~~

~~(a) Automatic enrollment of certain dependents.~~

~~(1) In the case of a dependent of a member of the uniformed services who is entitled to medical and dental care under section 1076(a)(2)(A) of this title and resides in a catchment area in which TRICARE Prime is offered, the Secretary—~~

~~(A) shall automatically enroll the dependent in TRICARE Prime if the member is in pay grade E-4 or below; and~~

~~(B) may automatically enroll the dependent in TRICARE Prime if the member is in pay grade E-5 or higher.~~

~~(2) Whenever a dependent of a member is enrolled in TRICARE Prime under paragraph (1), the Secretary concerned shall provide written notice of the enrollment to the member.~~

~~(3) The enrollment of a dependent of the member may be terminated by the member or the dependent at any time.~~

~~(b) Automatic renewal of enrollments of covered beneficiaries.~~

~~(1) An enrollment of a covered beneficiary in TRICARE Prime shall be automatically renewed upon the expiration of the enrollment unless the renewal is declined.~~

~~(2) Not later than 15 days before the expiration date for an enrollment of a covered beneficiary in TRICARE Prime, the Secretary concerned shall--~~

~~(A) transmit a written notification of the pending expiration and renewal of enrollment to the covered beneficiary or, in the case of a dependent of a member of the uniformed services, to the member; and~~

~~(B) afford the beneficiary or member, as the case may be, an opportunity to decline the renewal of enrollment.~~

~~(c) Payment options for retirees. A member or former member of the uniformed services eligible for medical care and dental care under section 1074(b) of this title may elect to have any fee payable by the member or former member for an enrollment in TRICARE Prime withheld from the member's retired pay, retainer pay, or equivalent pay, as the case may be, or to be paid from a financial institution through electronic transfers of funds. The fee shall be paid in accordance with the election. A member may elect under this section to pay the fee in full at the beginning of the enrollment period or to make payments on a monthly or quarterly basis.~~

~~(d) Regulations and exceptions. The Secretary of Defense shall prescribe regulations, including procedures, to carry out this section. Regulations prescribed to carry out the automatic enrollment requirements under this section may include such exceptions to the automatic enrollment procedures as the Secretary determines appropriate for the effective operation of TRICARE Prime.~~

~~(e) No copayment for immediate family. No copayment shall be charged a member for care provided under TRICARE Prime to a dependent of a member of the uniformed services described in subparagraph (A), (D), or (I) of section 1072(2) of this title.~~

~~(f) Definitions. In this section:~~

~~(1) The term "TRICARE Prime" means the managed care option of the TRICARE program.~~

~~(2) The term "catchment area", with respect to a facility of a uniformed service, means the service area of the facility, as designated under regulations prescribed by the administering Secretaries.~~

* * * * *

§ 1099. ***[Reserved.]*** **~~Health care enrollment system~~**

~~(a) ESTABLISHMENT OF SYSTEM. The Secretary of Defense, after consultation with the other~~

~~administering Secretaries, shall establish a system of health care enrollment for covered beneficiaries who reside in the United States.~~

~~(b) DESCRIPTION OF SYSTEM. Such system shall—~~

~~(1) allow covered beneficiaries to elect a health care plan from eligible health care plans designated by the Secretary of Defense; or~~

~~(2) if necessary in order to ensure full use of facilities of the uniformed services in a geographical area, assign covered beneficiaries who reside in such area to such facilities.~~

~~(c) HEALTH CARE PLANS AVAILABLE UNDER SYSTEM. A health care plan designated by the Secretary of Defense under the system described in subsection (a) shall provide all health care to which a covered beneficiary is entitled under this chapter. Such a plan may consist of any of the following:~~

~~(1) Use of facilities of the uniformed services.~~

~~(2) The Civilian Health and Medical Program of the Uniformed Services.~~

~~(3) Any other health care plan contracted for by the Secretary of Defense.~~

~~(4) Any combination of the plans described in paragraphs (1), (2), and (3).~~

~~(d) REGULATIONS. The Secretary of Defense, after consultation with the other administering Secretaries, shall prescribe regulations to carry out this section.~~

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 1994 (Public Law 103-160)

~~§ 731. Use of health maintenance organization model as option for military health care.~~

~~(a) USE OF MODEL. The Secretary of Defense shall prescribe and implement a health benefit option (and accompanying cost-sharing requirements) for covered beneficiaries eligible for health care under chapter 55 of title 10, United States Code, that is modelled on health maintenance organization plans offered in the private sector and other similar Government health insurance programs. The Secretary shall include, to the maximum extent practicable, the health benefit option required under this subsection as one of the options available to covered beneficiaries in all managed health care initiatives undertaken by the Secretary after December 31, 1994.~~

~~(b) ELEMENTS OF OPTION. The Secretary shall offer covered beneficiaries who enroll in the health benefit option required under subsection (a) reduced out- of-pocket costs and a benefit structure that is as uniform as possible throughout the United States. The Secretary shall allow enrollees to seek health care outside of the option, except that the Secretary may prescribe higher out-of-pocket costs than are provided under section 1079 or 1086 of title 10, United States Code, for enrollees who obtain health care outside of the option.~~

~~(c) GOVERNMENT COSTS. The health benefit option required under subsection (a) shall be administered so that the costs incurred by the Secretary under the TRICARE program are no greater than the costs that would otherwise be incurred to provide health care to the members of the uniformed services and covered beneficiaries who participate in the TRICARE program.~~

~~(d) DEFINITIONS. For purposes of this section:~~

~~**(1) The term 'covered beneficiary' means a beneficiary under chapter 55 of title 10, United States Code, other than a beneficiary under section 1074(a) of such title.**~~
~~**(2) The term 'TRICARE program' means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United States Code principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services.**~~
~~**(e) REGULATIONS. Not later than December 31, 1994, the Secretary shall prescribe final regulations to implement the health benefit option required by subsection (a).**~~
~~**(f) MODIFICATION OF EXISTING CONTRACTS. In the case of managed health care contracts in effect or in final stages of acquisition as of December 31, 1994, the Secretary may modify such contracts to incorporate the health benefit option required under subsection (a).**~~

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 1997 (Public Law 104-201)

Title VII, Health Care Provisions

Subtitle C. Uniformed services treatment facilities

Sec. 721. Definitions. In this subtitle:

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(7) The term 'health care services' means the health care services provided under ~~**the health plan known as the 'TRICARE PRIME' option under**~~ the TRICARE program.

* * * * *

(9) The term 'TRICARE program' ~~**means the managed health care program that is established by the Secretary of Defense under the authority of chapter 55 of title 10, United States Code, principally section 1097 of such title, and includes the competitive selection of contractors to financially underwrite the delivery of health care services under the Civilian Health and Medical Program of the Uniformed Services**~~ ***has the meaning provided in section 1072(7) of title 10, United States Code***.

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Sec. 723. Provision of uniform benefit by designated providers.

(a) UNIFORM BENEFIT REQUIRED. A designated provider shall offer to enrollees the health benefit option prescribed and implemented by the Secretary under section ~~**731 of the National Defense Authorization Act for Fiscal Year 1994 (Public Law 103-160; 10 U.S.C. 1073 note)**~~ ***section 1075 of title 10, United States Code***, including accompanying cost-sharing requirements.

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NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2000 (Public Law 106-65)

Sec. 706. Health care at former uniformed services treatment facilities for active duty members stationed at certain remote locations.

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(c) APPLICABLE POLICIES. In furnishing health care to an eligible member under subsection (a), a designated provider shall adhere to the Department of Defense policies applicable to the furnishing of care under the TRICARE ~~**Prime Remote**~~ program, including coordinating with uniformed services medical authorities for hospitalizations and all referrals for specialty care.

(d) REIMBURSEMENT RATES. The Secretary of Defense, in consultation with the designated providers, shall prescribe reimbursement rates for care furnished to eligible members under subsection (a). The rates prescribed for health care may not exceed the amounts allowable under the TRICARE ***program*** ~~**Standard plan**~~ for the same care.