(5) *Measurement of height and depth of markings.* The depth of all markings required by this section will be measured from the flat surface of the metal and not the peaks or ridges. The height of serial numbers required by paragraph (a)(1)(i) of this section will be measured as the distance between the latitudinal ends of the character impression bottoms (bases).

* * * * *

(Approved by the Office of Management and Budget under control number 1512–0550)

PART 179—MACHINE GUNS, DESTRUCTIVE DEVICES, AND CERTAIN OTHER FIREARMS

Par. 3. The authority citation for 27 CFR Part 179 continues to read as follows:

Authority: 26 U.S.C. 7805.

Par. 4. Section 179.102 is revised to read as follows:

§ 179.102 How must firearms be identified?

(a) You, as a manufacturer, importer, or maker of a firearm, must legibly identify the firearm as follows:

(1) By engraving, casting, stamping (impressing), or otherwise conspicuously placing or causing to be engraved, cast, stamped (impressed) or placed on the frame or receiver thereof an individual serial number. The serial number must be placed in a manner not susceptible of being readily obliterated, altered, or removed, and must not duplicate any serial number placed by you on any other firearm. For firearms manufactured, imported, or made on and after January 30, 2002, the engraving, casting, or stamping (impressing) of the serial number must be to a minimum depth of .003 inch and in a print size no smaller than 1/16 inch; and

(2) By engraving, casting, stamping (impressing), or otherwise conspicuously placing or causing to be engraved, cast, stamped (impressed), or placed on the frame, receiver, or barrel thereof certain additional information. This information must be placed in a manner not susceptible of being readily obliterated, altered or removed. For firearms manufactured, imported, or made on and after January 30, 2002, the engraving, casting, or stamping (impressing) of this information must be to a minimum depth of .003 inch. The additional information includes:

(i) The model, if such designation has been made;

(ii) The caliber or gauge;

(iii) Your name (or recognized abbreviation) and also, when applicable, the name of the foreign manufacturer or maker;

(iv) In the case of a domestically made firearm, the city and State (or recognized abbreviation thereof) where you as the manufacturer maintain your place of business, or where you, as the maker, made the firearm; and

(v) In the case of an imported firearm, the name of the country in which it was manufactured and the city and State (or recognized abbreviation thereof) where you as the importer maintain your place of business. For additional requirements relating to imported firearms, see Customs regulations at 19 CFR part 134.

(b) The depth of all markings required by this section will be measured from the flat surface of the metal and not the peaks or ridges. The height of serial numbers required by paragraph (a)(1) of this section will be measured as the distance between the latitudinal ends of the character impression bottoms (bases).

(c) The Director may authorize other means of identification upon receipt of a letter application from you, submitted in duplicate, showing that such other identification is reasonable and will not hinder the effective administration of this part.

(d) In the case of a destructive device, the Director may authorize other means of identifying that weapon upon receipt of a letter application from you, submitted in duplicate, showing that engraving, casting, or stamping (impressing) such a weapon would be dangerous or impracticable.

(e) A firearm frame or receiver that is not a component part of a complete weapon at the time it is sold, shipped, or otherwise disposed of by you must be identified as required by this section.

(f)(1) Any part defined as a machine gun, muffler, or silencer for the purposes of this part that is not a component part of a complete firearm at the time it is sold, shipped, or otherwise disposed of by you must be identified as required by this section.

(2) The Director may authorize other means of identification of parts defined as machine guns other than frames or receivers and parts defined as mufflers or silencers upon receipt of a letter application from you, submitted in duplicate, showing that such other identification is reasonable and will not hinder the effective administration of this part.

(Approved by the Office of Management and Budget under control number 1512–0550)

Signed: December 15, 2000.

Bradley A. Buckles,

Director.

Approved: January 8, 2001.

Timothy E. Skud,

Deputy Assistant Secretary (Acting), (Regulatory, Tariff and Trade Enforcement).

Editorial note: This document was received at the Office of the Federal Register July 31, 2001.

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DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN 0720–AA66

TRICARE; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); Eligibility and Payment Procedures for CHAMPUS Beneficiaries Age 65 and Over

AGENCY: Office of the Secretary, DoD.

ACTION: Interim final rule.

SUMMARY: This interim final rule implements Section 712 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001. Section 712 extends TRICARE eligibility to persons age 65 and over who would otherwise have lost their TRICARE eligibility due to attainment of entitlement to hospital insurance benefits under Part A of Medicare. In order for these individuals to retain their TRICARE eligibility, they must be enrolled in the supplementary medical insurance program under Part B of Medicare. In general, in the case of medical or dental care provided to these individuals for which payment may be made under both Medicare and TRICARE, Medicare is the primary payer and TRICARE will normally pay the actual out-of-pocket costs incurred by the person. This rule prescribes TRICARE payment procedures and makes revisions to TRICARE rules to accommodate Medicare-eligible CHAMPUS beneficiaries. The Department is publishing this rule as an interim final rule in order to meet the statutorily required effective date. Public comments, however, are invited and will be considered when the rule is published as a final rule.

DATES: This rule is effective October 1, 2001. Written comments will be accepted until October 2, 2001.

ADDRESSES: Forward comments to Medical Benefits and Reimbursement Systems, TRICARE Management

Activity, 16401 East Centretech Parkway, Aurora, CO 80011–9043.

FOR FURTHER INFORMATION CONTACT: Stephen Isaacson, Medical Benefits and Reimbursement Systems, TRICARE Management Activity, telephone (303) 676–3572.

SUPPLEMENTARY INFORMATION:

A. Introduction

On October 30, 2000, the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (Pub. L. 106–398, 114 Stat. 1654) was signed into law. This interim final rule implements section 712 of this Act, and is effective October 1, 2001. It extends TRICARE eligibility to persons age 65 and over. This beneficiary group previously lost TRICARE eligibility due to attaining entitlement to hospital insurance benefits under Part A of Medicare.

This regulation and the statute it implements represent the most significant expansion of benefits in the Military Health System since 1956, when Congress created CHAMPUS to supplement space available care in military treatment facilities. As an indication of this, in FY–2000, DoD spent an estimated $1.4 billion providing space available health care in military facilities to beneficiaries over age 65; in FY–2002, in addition to this anticipated level of military facility services, DoD will spend another approximately $3.9 billion as second payer to Medicare for civilian sector inpatient and outpatient services and primary payer for civilian pharmacy outpatient drugs. These new benefits for retirees and their eligible family members over age 65 result in a remarkably comprehensive health care benefit with minimal beneficiary out-of-pocket costs.

B. Eligibility

As specified further in the regulation, to be eligible for TRICARE, a person is required to be a retiree, a dependent, or survivor who is entitled to Medicare Part A, 65 years of age or older, and enrolled in Medicare Part B. Specifically the following are eligible:

- A retired uniformed service member—i.e., a former member of a uniformed service who is entitled to retired or retainer pay or equivalent pay.
- A dependent (except for parents or parents-in-law) of:
- A retired member;
- A member who died while on active duty for more than 30 days; or
- A member who died from an injury, illness, or disease incurred or aggravated while the member was on active duty for less than 31 days, was on active duty for training, was on inactive duty training, or was traveling to or from a place for the performance of such active duty, active duty for training, or inactive-duty training.
- A former spouse who has not remarried and who does not have an employer-sponsored health plan and meets the criteria established by 10 U.S.C. 1072(2).

Note: Although parents and parents-in-law may be considered eligible dependents for care in uniformed services healthcare facilities, and are eligible for the TRICARE Senior Pharmacy benefit, they have never been eligible for TRICARE, and these provisions do not change that in any way.

We are also making a technical change to the regulatory eligibility provisions regarding changes that result in termination of TRICARE eligibility. Currently, the regulation states that when a beneficiary loses TRICARE eligibility due to attainment of entitlement to Medicare Part A at age 65, TRICARE eligibility is lost at 12:01 a.m. on the last day of the month preceding the month of attainment of age 65. This is incorrect. It should be 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare. Otherwise the beneficiary would have no coverage (neither TRICARE nor Medicare) for the last day of the month before becoming entitled to Medicare.

C. Scope of Benefit

Under 10 U.S.C. 1086(c), retirees, authorized dependents and survivors are entitled to TRICARE. In general, TRICARE will pay for medically necessary services and supplies required in the diagnosis and treatment of illness or injury. Benefits include specified medical services and supplies from authorized civilian sources such as hospitals, other authorized institutional providers, physicians, other authorized individual professional providers, and professional ambulance services, prescription drugs, authorized medical supplies, and rental or purchase of durable medical equipment.

Eligibility for these services now no longer expires when the beneficiary attains entitlement to Medicare Part A upon turning age 65, as long as the beneficiary enrolls in Medicare Part B. These beneficiaries are now entitled to both Medicare healthcare services and TRICARE healthcare services. Most healthcare services payable by one program are also payable under the other program. However, there are services that are payable under Medicare or TRICARE that are not payable under the other program. For example, certain chiropractic services are payable by Medicare, but are not payable under TRICARE. Conversely, TRICARE pays much of the cost for prescription drugs for Medicare entitled beneficiaries, a benefit that currently is not available under Medicare. In the case of a beneficiary who has other health insurance also, that insurance will typically pay after Medicare and before TRICARE.

Using the chiropractic services example above, Medicare has the sole responsibility for payment of healthcare services or supplies that are a benefit only under Medicare. The new law extends TRICARE eligibility but does not expand the scope of TRICARE benefits available to this group of beneficiaries beyond the scope of TRICARE benefits available to other retirees and their families. Therefore, if a healthcare service or supply is a benefit payable only by Medicare, but not TRICARE, then Medicare has sole responsibility for payment of the healthcare service or supply, as defined by Medicare, and the beneficiary has the responsibility to pay any corresponding Medicare cost-share or deductible. Likewise, if a healthcare service or supply is a benefit payable only by TRICARE, but not Medicare, then TRICARE has sole responsibility for payment of the healthcare service or supply, and the beneficiary has the responsibility to pay any corresponding TRICARE cost-shares or deductibles.

Whether a healthcare service is a benefit provided and paid for under Medicare only, TRICARE only, or both, will have an impact on the beneficiary's potential cost sharing liability. Both Medicare and TRICARE generally use the same coding systems for identifying the healthcare services or supplies provided to the beneficiary. Both Medicare and TRICARE use the Current Procedural Terminology (CPT) codes to identify the professional services provided to the beneficiary. Both also use the DSM–IV (Diagnostic and Statistical Manual of Mental Disorders, fourth edition) and ICD–9–CM (International Classification of Diseases, ninth revision, Clinical Modification) diagnosis codes and DRG (Diagnostic Related Group) payment codes for inpatient services. Whether a healthcare service or supply is a benefit payable under Medicare and TRICARE, Medicare only, or TRICARE only will normally be accomplished by comparing these various codes and determining whether payment would be made under the facts and circumstances by both Medicare and TRICARE, or only under one of the programs.

Most healthcare services are a benefit provided and paid for by both Medicare

and TRICARE. However, for some healthcare services, Medicare and TRICARE have different requirements or prerequisites that must be met before the service is reimbursable under their respective programs. For example, Medicare will provide payment for skilled nursing facility (SNF) care, but currently requires as a prerequisite that a beneficiary must have been a hospital inpatient for at least three days before the SNF admission. Medicare currently requires the beneficiary to pay no cost share for the first 20 days of the stay, whereupon the cost share increases to about $100 per day thereafter. Medicare will provide payment for up to 100 days of SNF care in a benefit period. TRICARE on the other hand does not require the beneficiary to be hospitalized as an inpatient before admission to a SNF. TRICARE will pay for all medically necessary care, and does not have a 100-day limit in a benefit period. TRICARE's cost-share is also different, in that there is a $150 per individual/$300 per family deductible for healthcare services in a fiscal year, and a cost-share of the lesser of 25% of the institutional charges or a flat fee per day, up to the catastrophic cap limit of $3,000. As another example, TRICARE is required by law to require preadmission authorization before inpatient mental health services may be provided, except in the case of an emergency, and then approval for the continuation of services is required for care beyond 72 hours. If preauthorization is not obtained, it is not a medical service that is payable under both programs.

Both Medicare and TRICARE have cost-shares and deductibles associated with the healthcare services that they provide under their respective plans that the beneficiary is responsible for paying. For healthcare services that are payable only under one plan, and not both, beneficiaries will continue to be responsible for payment of their applicable Medicare or TRICARE cost-share and deductible. However, for healthcare services for which payment may be made under both Medicare and TRICARE, the beneficiary's liability is different. TRICARE will pay up to the beneficiary's legal liability the actual out-of-pocket costs incurred by the beneficiary over the sum of the amount paid for the care under Medicare and the total of all amounts paid or payable by third party payers other than Medicare (such as other health insurance).

The most common situation will be where the healthcare provided is a benefit payable under both Medicare and TRICARE. The beneficiary will normally have no out-of-pocket expense. In these instances, TRICARE payment will be equal to the remaining beneficiary liability after Medicare processes the claim. For example, if the first claim of the fiscal year for a physician's services were submitted for $50, Medicare would apply the entire amount to the Medicare deductible, and TRICARE would pay the full $50 (assuming the full amount is allowable under TRICARE), so that the beneficiary would have no out-of-pocket expense.

There are exceptions to the provision that the beneficiary will have no out-of-pocket expense. The healthcare service must not only be a benefit under both Medicare and TRICARE, but it must be payable by both Medicare and TRICARE. There are circumstances when Medicare cannot make any payment even though the service is generally a benefit under Medicare. These include services provided to a beneficiary who lives or travels overseas and instances when the beneficiary has exhausted his or her Medicare benefits (e.g., inpatient hospital care beyond 150 days in a benefit period). In these circumstances TRICARE will process the claim as a primary payer and the beneficiary will have the same cost sharing requirement as do retirees and their dependents under age 65. Beneficiary out-of-pocket expenses would be limited to $3,000 by the TRICARE catastrophic cap. It is important to note that in order for beneficiaries who live or travel overseas to retain TRICARE eligibility, the law requires that they still must be enrolled in Part B of Medicare even though Medicare will make no payment for services provided overseas.

As noted above, for some healthcare services, Medicare and TRICARE have different requirements or prerequisites that must be met before the service is reimbursable under their respective programs. These give rise to special payment approaches. In the case of skilled nursing facility care that does not qualify for Medicare reimbursement (because the patient was not a hospital inpatient prior to the skilled nursing facility admission, or for days of care beyond the 100-days Medicare limit) TRICARE will be the primary payer, and applicable TRICARE beneficiary cost sharing would be charged. Beneficiary out-of-pocket expenses would be limited to $3,000 by the TRICARE catastrophic cap. In the case of a nonemergency mental health admission for which TRICARE preadmission authorization is not obtained, TRICARE would not provide payments secondary to the Medicare payments.

There may also be some special circumstances that arise in connection with Medicare-eligible beneficiaries enrolled in a Medicare+Choice plan. TRICARE will cover the normal copayments under a Medicare+Choice plan, but special claims procedures will be applicable. Another special circumstance would arise if a Medicare+Choice enrollee obtains unauthorized out-of-system care that the Medicare+Choice plan will not cover or will only partially cover. Because Medicare already paid for the health care the beneficiary needs in the form of a capitation payment to the Medicare+Choice plan, TRICARE will not become primary payer for the services that would have been covered by the Medicare+Choice plan had the beneficiary followed applicable requirements. If TRICARE did become primary payer, the result would be double payment by the Government for the services, which is not supportable under the statute. In such a case, the TRICARE payment is limited to the amount TRICARE would have paid had the beneficiary received care within the structure and procedures of the Medicare+Choice plan. This is consistent with long-standing CHAMPUS payment rules pertaining to double coverage in the case of health maintenance organizations or other plan requirements, which we are codifying in section 199.8.

It should also be noted that under the statute, if a Medicare-eligible beneficiary also has other health insurance, the other health insurance pays after Medicare and before TRICARE. For this purpose, other health insurance includes Medicare supplemental insurance. This means that TRICARE is secondary to Medicare supplements. Some Medicare supplements are available to some beneficiaries based upon their spouse's past employment, or their employment after retirement from the uniformed services. Some Medicare supplements are available to anyone who is age 65 or older, regardless of past employment status. Since TRICARE will provide benefits that are significantly more generous than most Medicare supplements for Medicare entitled beneficiaries, in addition to requiring no premium, we expect that most beneficiaries who qualify for TRICARE will drop their Medicare supplements that are not based upon their past employment.

In the special case of persons who continue to work after age 65, and have health insurance provided pursuant to their employment, Medicare is the secondary payer to the employer-based

health insurance. Because TRICARE is always last payer when a beneficiary has Medicare and/or any other health insurance, TRICARE would be the tertiary payer in this special case.

D. Beneficiaries Under Age 65

In 1992 and 1993 there were several statutory changes that extended TRICARE eligibility for certain beneficiaries who became eligible for Medicare. These beneficiaries had to be eligible for Medicare due to disability or end stage renal disease, had to be under age 65, and had to be enrolled in Part B of Medicare. Based on the congressional intent at that time, we have processed claims for these beneficiaries using the double coverage procedures applicable to all other double coverage situations. As a result, depending on the circumstances of the claim, the beneficiary could be liable for out-of-pocket expenses, even when the service is a benefit under both Medicare and TRICARE. These beneficiaries who are under age 65 and entitled to both Medicare and TRICARE will now have the same payment procedures applied to them as those used for beneficiaries who are entitled Medicare Part A because of age. This will be effective October 1, 2001.

On another matter relating to Medicare-eligible beneficiaries under age 65, section 712 of the National Defense Authorization Act for Fiscal Year 2001 made a conforming amendment to title 10 United States Code section 1086(d). That statute requires that the administering Secretaries develop a mechanism to notify persons under age 65 who would be eligible for both Medicare and TRICARE, except that they have declined to enroll in Medicare Part B. We carried out a match of our eligibility records with Medicare records in 1998, and in 1999 sent letters to about 16,000 beneficiaries identified as eligible for Medicare Part A but not enrolled in Part B. A mechanism for ongoing identification and notification of such persons is being developed.

E. Appeals

Medicare has sole responsibility for paying for healthcare services that are a benefit payable only by Medicare. TRICARE has sole responsibility for paying for healthcare services that are a benefit payable only by TRICARE. Medicare has primary responsibility for paying for healthcare services that are a benefit payable under both programs. Both Medicare and TRICARE offer an appeal process when a claim for healthcare services or supplies is denied. TRICARE beneficiaries entitled to Medicare Part A, who are enrolled in Medicare Part B, and/or their providers will have the same appeal rights as other TRICARE beneficiaries and their providers under sections 199.10 and 199.15 of this Part for services or supplies that are payable by TRICARE, but not Medicare.

Most healthcare services and supplies are a benefit payable under both Medicare and TRICARE. In these situations, Medicare is the primary payer, and TRICARE will pay the out-of-pocket costs of the beneficiary, up to the legal liability limit of the beneficiary, after any payments by third party insurance. In order to avoid confusion on the part of beneficiaries and providers and to expedite the appeal process, services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in sections 199.10 and 199.15 are applicable to initial determinations by TRICARE under the TRICARE program.

As an example, if Medicare processes a claim for a healthcare service or supply that is a Medicare program benefit, and Medicare denies the claim for a patient-specific reason, the claim will be appealed through the Medicare appeal process. The Medicare decision will be final if Medicare denies the claim for a patient-specific reason (such as lack of medical necessity for the service), and TRICARE will pay nothing on the claim. However, if Medicare pays the claim, then the claim crosses over to TRICARE. TRICARE will either pay the remaining liability, or if it is a service or supply that is not a TRICARE benefit, the claim will be denied. The beneficiary or provider will than have the same appeal rights as other beneficiaries or providers under sections 199.10 and 199.15. When Medicare processes a claim and Medicare denies the claim because it is not a covered healthcare service or supply under Medicare, the claim will cross over to TRICARE. TRICARE will either pay the claim as the primary payer (assuming no other health insurance), or the claim will be denied if the healthcare service or supply is not a TRICARE benefit. The beneficiary or provider will have the same appeal rights as other beneficiaries or providers under sections 199.10 and 199.15.

F. Quality and Utilization Review Peer Review Organization Program

The CHAMPUS Quality and Utilization Review Peer Review

Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare quality and utilization review program, subject to adaptations appropriate for the TRICARE program. In recognition of the similarity of purpose and design between the two programs to ensure coverage of quality care as medically necessary and appropriate, and to avoid unnecessary duplication of effort, the CHAMPUS Quality and Utilization Review Peer Review Organization (PRO) program will apply special procedures to supplies and services furnished to Medicare-eligible TRICARE beneficiaries. These procedures will enable TRICARE to rely upon Medicare determinations of medical necessity and appropriateness in the processing of TRICARE claims as a second payer to Medicare. As a general rule, only in cases involving Medicare-eligible TRICARE beneficiaries where Medicare payment for services and supplies is denied for reasons other than medical necessity and appropriateness will the TRICARE claim or request for services or supplies be subject to review for quality of care and appropriate utilization under the CHAMPUS PRO program. However, there are quality and utilization review requirements under TRICARE that by law are more stringent than Medicare's requirements. For example, inpatient mental health services may not be provided to a patient 19 years of age or older in excess of 30 days in any year, absent a waiver because of medical or psychological circumstances of the patient that takes into account the appropriate level of care for the patient, the intensity of services required by the patient, and the availability of that care. Medicare imposes no similar requirement. In circumstances where TRICARE is required to perform a medical necessity review, and Medicare does not, TRICARE will continue to apply its rules for such review.

G. TRICARE Triple Option Benefit

Currently, the TRICARE program features a triple option benefit: a health maintenance organization (HMO)-like option called TRICARE Prime, a preferred provider organization (PPO)-

like option called TRICARE Extra, and an indemnity insurance-like option (i.e., traditional CHAMPUS) called TRICARE Standard. This is based on 10 U.S.C. 1097, which allows DoD to contract with HMOs, PPOs, and insurers for ''alternate delivery of health care.''

As required by law (section 731 of the National Defense Authorization Act for Fiscal Year 1994, Pub. L. 103–160), TRICARE Prime is ''modeled on health maintenance organization plans offered in the private sector and other similar Government health insurance programs.'' This option must offer beneficiaries ''reduced out-of-pocket costs,'' but ''shall be administered so that the costs incurred by the Secretary under the TRICARE program are no greater than would otherwise be incurred'' without this option. TRICARE Prime was structured to comply with this ''cost neutrality'' requirement. In addition, under section 1097(c), ''the Secretary shall, as an incentive for enrollment,'' in TRICARE Prime ''establish reasonable preferences for services'' in military treatment facilities (MTFs).

Current DoD regulations (32 CFR 199.17) implement these statutory provisions for TRICARE Prime. Consistent with the HMO model, enrollees receive reduced copayments in exchange for their agreement generally to ''lock in'' to the designated provider network and follow the referral and utilization management guidance of a primary care manager. As an incentive for enrollment, the MTF priority access system is established in this order: (1) Active duty members; (2) active duty dependents enrolled in Prime; (3) retirees and their dependents enrolled in Prime; (4) active duty dependents not enrolled in Prime; and (5) retirees and their dependents not enrolled in Prime. There is generally no other rationale based on beneficiary grouping for establishing priority access among these five categories or within any of them.

Beneficiaries who do not enroll in TRICARE Prime automatically receive TRICARE Standard coverage, and for practical purposes may be considered to be ''enrolled'' in TRICARE Standard. This option may be preferable for those who prefer freedom of choice of providers. They are not subject to HMO-type management requirements or network lock-in, but they pay standard copayments. They remain eligible for MTF care, but without priority access. Those who wish to use the TRICARE civilian provider network may do so on a visit-by-visit basis under TRICARE Extra. They are not locked in to anything, but obtain some reduced copayments and have the benefit of the TRICARE quality assurance program applicable to network providers.

For several reasons, Medicare-eligible beneficiaries will not fit into the current structure of the triple option benefit when they attain TRICARE eligibility on October 1, 2001. First, they already have zero copayments for most services from civilian providers under their basic TRICARE coverage (i.e., TRICARE Standard), under which Medicare is primary payer and TRICARE pays the Medicare deductible and copayment amounts. Second, Medicare-eligible beneficiaries cannot be ''locked in'' to a DoD-operated HMO-like program while standard Medicare is the primary payer for civilian sector care. Medicare law (sections 1814(c) and 1835(d) of the Social Security Act) prohibits Medicare payments ''to any Federal provider of services'' or for any service for which any provider ''is obligated by * * * a contract with'' a Federal agency ''to render at public expense.'' It is well understood that this means that Medicare will not generally reimburse MTFs. But, in addition, TRICARE Prime's regulation of civilian network operations would, in the case of Medicare-eligible beneficiaries, risk a conflict between the policy of DoD's law that Medicare pay primary to TRICARE and that of Medicare law that Medicare not pay for services covered by another Federal program. Nonpayment by Medicare would conflict with the intended first payer/second payer relationship and also result in a violation of the ''cost neutrality'' requirement for TRICARE Prime. TRICARE Prime is based on the HMO model and there is no way to operate an HMO with two entities administering separate programs.

The only way to offer an HMO involving two financial entities is for them to jointly sponsor the HMO. This was, of course, the rationale for the Medicare Subvention Program that was authorized as a joint demonstration program of DoD and the Department of Health and Human Services under a provision of the Budget Reconciliation Act of 1997. Under the demonstration, DoD operates ''TRICARE Senior Prime.'' This program must meet HHS quality standards and requirements, and Medicare pays for care provided to eligible Medicare beneficiaries. The National Defense Authorization Act for Fiscal Year 2001, section 712, extended the demonstration program for 1 year (through December 31, 2001) and directed the agencies to explore the feasibility of continuing the program. Consistent with that direction, DoD and HHS held discussions on the possibility of extending the program, with the changes that would be necessary to permit this to occur. It has been determined that continuation of the program is not feasible.

Although a Medicare Subvention-type program will not be continued, the Department wants to provide beneficiaries an alternative option for using TRICARE providers without the need to lock in to an HMO-like program. In order to achieve this, the Department has taken steps to establish an MTF enrollment program for primary care, called TRICARE Plus. TRICARE Plus is not addressed in 32 CFR Part 199, because it only affects the operation of military medical treatment facilities, whose operations are not governed by the regulation. We are describing the program here to help the public understand this aspect of TRICARE.

TRICARE Plus builds on another popular demonstration project, the MacDill-65 Demonstration. That program, which has operated at MacDill Air Force Base in Tampa, Florida since 1998, provided opportunity for about 2,000 Medicare-eligible military beneficiaries to enroll to obtain primary care services at the military treatment facility, without being ''locked in'' to an HMO type program. The MacDill demonstration essentially tests the impact of management of available primary care services for Medicare-eligible beneficiaries through a process of ''empanelling'' them with primary care providers at the MTF. For a limited number of enrollees, the MacDill model guarantees primary care access. For care that cannot be provided in the MTF, beneficiaries use their Medicare benefit.

Under TRICARE Plus, beneficiaries eligible for care in MTFs who are not enrolled in TRICARE Prime will be given the opportunity to enroll with an MTF primary care provider, but only to the extent primary care capacity is available. There is no lock-in and no enrollment fee. This will be a way to facilitate primary care appointments when needed. The number of persons accommodated at an MTF will be subject to capacity limitations, so as to assure that their primary care needs will be met. For care from civilian providers, TRICARE Standard or TRICARE Extra rules will apply *provided* the TRICARE Plus beneficiary is eligible for TRICARE Standard or TRICARE Extra. (Beneficiaries eligible for care in an MTF and entitled to Medicare are not required by law to be enrolled in Medicare Part B in order to receive MTF care. Those beneficiaries entitled to Medicare, however, are encouraged to enroll in Part B when enrolling in TRICARE Plus. Otherwise, care received from civilian providers when not

available from the MTF will be the sole financial responsibility of the patient in that the patient is not eligible for TRICARE without enrollment in Medicare Part B.). For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer. For non-MTF care from a network provider for non-Medicare covered services, the reduced cost shares under TRICARE Extra will apply. For non-MTF care from a non-network provider for non-Medicare covered services, the cost shares under TRICARE Standard will apply. This enrollment program is similar to the MacDill demonstration, and is a good potential option for all beneficiaries who have other primary health insurance (Medicare or private insurance). It allows them to take advantage of both of their health programs as well as enroll themselves (without lock-in) with military primary care providers, to the extent they are available.

For retirees and their dependents who have been enrolled in Prime with an MTF primary care manager and are soon to reach age 65, TRICARE Plus will bring several advantages. First, they will likely be able to continue that relationship with their primary care provider, if they wish, subject to availablity. For most care provided in the civilian network, they will have no copayments (as compared to the $12 per visit fee applicable to most visits when they were in Prime). In addition, there will be no enrollment fee. For civilian network care not covered by Medicare, the TRICARE cost share will be 20% rather than the 25% that would be applicable for non-network care. Further, there is no lock-in; for most care they are free to use virtually any civilian provider, with the entire cost paid by Medicare and TRICARE.

For TRICARE Prime enrollees approaching age 65 who have a civilian primary care manager, we expect that in most cases they will be able to continue their primary care relationship. The provider will receive primary payments from Medicare and secondary payments from TRICARE for most services, and the managed care rules of TRICARE Prime will no longer apply.

Thus, on the whole, the transition from TRICARE Prime under 65 to Medicare plus TRICARE at 65 will represent an improved health care benefit. The inclusion of ''TRICARE Plus,'' the new MTF primary care enrollment program offers an additional opportunity for beneficiaries to establish or continue an ongoing relationship with a military health care provider.

If demand for primary care assignment under TRICARE Plus greatly exceeds capacity in MTFs, one option would be to extend the availability of primary care assignment by relying on the civilian provider network established to support TRICARE Prime. The Department does not intend to implement this option unless (1) it can be accomplished within funding constraints, and (2) it is necessary to meet demand for primary care assignment. Incorporation of these requirements into future TRICARE procurements is likely to be more cost-effective than modifying existing contracts.

H. Regulatory Procedures

This interim final rule will not impose additional information collection requirements on the public under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3511).

This rule is being issued as an interim final rule, with comment period, as an exception to our standard practice of soliciting public comments prior to issuance. The Assistant Secretary of Defense (Health Affairs) has determined that following the standard practice in this case would be impracticable, unnecessary, and contrary to public interest. This determination is based on the fact that this change directly implements a statutory entitlement enacted by Congress expressly for this purpose, with a statutory effective date of October 1, 2001. All public comments are invited and will be carefully considered. We anticipate the issuance of a final rule within six months of the end of the comment period.

Executive Order 12866 requires certain regulatory assessments for any significant regulatory action, defined as one which would result in an annual effect on the economy of $100 million or more, or have other substantial impacts. The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation which would have a significant impact on a substantial number of small entities. This interim final rule is an economically significant regulatory action under Executive Order 12866, as it implements a statutory program that will add over $3 billion for DoD in annual healthcare benefit costs. This cost estimate is based on historical TRICARE costs and an assessment of potential users times average benefit costs per person, and excludes pharmacy benefits that were addressed in implementation of the TRICARE Senior Pharmacy benefit earlier this year. (Approximately 1.5 million persons are potential beneficiaries of this program, and expected benefits per person are about $2,000 per year.) The benefits of the interim final rule include an increased level of health care for Medicare-eligible beneficiaries of the Department of Defense military health system. It has been determined to be major under the Congressional Review Act. However, this rule does not require a regulatory flexibility analysis, as it would have no significant economic impact on a substantial number of small entities. The new benefit is estimated to cost about $3.1 billion per year, beginning in FY 2002. This includes health care costs administrative costs, mostly claims processing, of about $250 million per year.

List of Subjects in 32 CFR Part 199

Claims, Handicapped, Health insurance, Military personnel.

Accordingly, 32 CFR Part 199 is amended as follows:

PART 199—[AMENDED]

1. The authority citation for Part 199 continues to read as follows:

Authority: 5 U.S.C. 301 and 10 U.S.C. Chapter 55.

2. Section 199.2 is amended by adding at the appropriate place in alphabetical order the following definition:

§ 199.2 Definitions.

* * * * *

Director, TRICARE Management Activity. This term includes the Director, TRICARE Management Activity, the official sometimes referred to in this part as the Director, Office of CHAMPUS (or OCHAMPUS), or any designee of the Director, TRICARE Management Activity or the Assistant Secretary of Defense for Health Affairs who is designated for purposes of an action under this part.

3. Section 199.3 is amended by revising paragraphs (b)(2)(i)(D), (f)(3)(vi), and (f)(3)(vii) and the NOTE following paragraph (f)(3)(vii), as follows:

§ 199.3 Eligibility.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(D) Must not be eligible for Part A of Title XVIII of the Social Security Act (Medicare) except as provided in paragraphs (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section; and

* * * * *

(f) * * *

(3) * * *

(vi) Attainment of entitlement to hospital insurance benefits (Part A) under Medicare except as provided in paragraphs (f)(3)(vii), (f)(3)(viii), and (f)(3)(ix) of this section. (This also applies to individuals living outside the United States where Medicare benefits are not paid.)

(vii) Attainment of age 65, except for dependents of active duty members, beneficiaries not entitled to part A of Medicare, and beneficiaries entitled to Part A of Medicare who have enrolled in Part B of Medicare. For those who do not retain CHAMPUS, CHAMPUS eligibility is lost at 12:01 a.m. on the first day of the month in which the beneficiary becomes entitled to Medicare.

Note: If the person is not eligible for Part A of Medicare, he or she must file a Social Security Administration ''Notice of Disallowance'' certifying to that fact with the Uniformed Service responsible for the issuance of his or her identification card so a new card showing CHAMPUS eligibility can be issued. Individuals entitled only to supplementary medical insurance (Part B) of Medicare, but not Part A, or Part A through the Premium HI provisions (provided for under the 1972 Amendments to the Social Security Act) retain eligibility under CHAMPUS (refer to § 199.8 for additional information when a double coverage situation is involved).

* * * * *

4. Section 199.8 is amended by adding a new paragraph (c)(4) and by revising paragraph (d)(1), as follows:

§ 199.8 Double Coverage.

* * * * *

(c) *Application of double coverage provisions.* * * *

(4) *Lack of payment by double coverage plan.* Amounts that have been denied by a double coverage plan simply because a claim was not filed timely or because the beneficiary failed to meet some other requirement of coverage cannot be paid. If a statement from the double coverage plan as to how much that plan would have paid had the claim met the plan's requirements is provided to the CHAMPUS contractor, the claim can be processed as if the double coverage plan actually paid the amount shown on the statement. If no such statement is received, no payment from CHAMPUS is authorized.

(d) *Special considerations.* (1) *CHAMPUS and Medicare.*—(i) *General rule.* In any case in which a beneficiary eligible for both Medicare and CHAMPUS receives medical or dental care for which payment may be made under Medicare and CHAMPUS, Medicare is always the primary payer. For dependents of active duty members, payment will be determined in accordance to paragraph (c) of this section. For all other beneficiaries eligible for Medicare, the amount payable by CHAMPUS shall be the amount of the actual out-of-pocket costs incurred by the beneficiary for that care over the sum of the amount paid for that care under Medicare and the total of all amounts paid or payable by third party payers other than Medicare.

(ii) *Payment limit.* The total CHAMPUS amount payable for care under paragraph (d)(1)(i) of this section may not exceed the total amount that would be paid under CHAMPUS if payment for that care were made solely under CHAMPUS.

(iii) *Application of general rule.* In applying the general rule under paragraph (d)(1)(i) of this section, the first determination will be whether payment may be made under Medicare. For this purpose, Medicare exclusions, conditions, and limitations will be the basis for the determination.

(A) For items or services or portions or segments of items or services for which payment may be made under Medicare, the CHAMPUS payment will be the amount of the beneficiary's actual out of pocket liability, minus the amount payable by Medicare, also minus amount payable by other third party payers, subject to the limit under paragraph (d)(1)(ii) of this section.

(B) For items or services or segments of items or services for which no payment may be made under Medicare, the CHAMPUS payment will be the same as it would be for a CHAMPUS eligible retiree, dependent, or survivor beneficiary who is not Medicare eligible.

(iv) *Examples of applications of general rule.* The following examples are illustrative. They are not all-inclusive.

(A) In the case of a Medicare-eligible beneficiary receiving typical physician office visit services, Medicare payment generally will be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(A) of this section.

(B) In the case of a Medicare-eligible beneficiary residing and receiving medical care overseas, Medicare payment generally may not be made. CHAMPUS payment will be determined consistent with paragraph (d)(1)(iii)(B) of this section.

(C) In the case of a Medicare-eligible beneficiary receiving skilled nursing facility services a portion of which is payable by Medicare (such as during the first 100 days) and a portion of which is not payable by Medicare (such as after 100 days), CHAMPUS payment for the first portion will be determined consistent with paragraph (d)(1)(iii)(A) of this section and for the second portion consistent with paragraph (d)(1)(iii)(B) of this section.

(v) *Application of catastrophic cap.* Only in cases in which CHAMPUS payment is determined consistent with paragraph (d)(1)(iii)(B) of this section, actual beneficiary out of pocket liability remaining after CHAMPUS payments will be counted for purposes of the annual catastrophic loss protection, set forth under § 199.4(f)(10). When a family has met the cap, CHAMPUS will pay allowable amounts for remaining covered services through the end of that fiscal year.

(vi) *Effect of enrollment in Medicare+Choice plan.* In the case of a beneficiary enrolled in a Medicare+Choice plan who receives items or services for which payment may be made under both the Medicare+Choice plan and CHAMPUS, a claim for the beneficiary's normal out-of-pocket costs under the Medicare+Choice plan may be submitted for CHAMPUS payment. However, consistent with paragraph (c)(4) of this section, out-of-pocket costs do not include costs associated with unauthorized out-of-system care or care otherwise obtained under circumstances that result in a denial or limitation of coverage for care that would have been covered or fully covered had the beneficiary met applicable requirements and procedures. In such cases, the CHAMPUS amount payable is limited to the amount that would have been paid if the beneficiary had received care covered by the Medicare+Choice plan.

(vii) *Effect of other double coverage plans, including medigap plans.* CHAMPUS is second payer to other third-party payers of health insurance, including Medicare supplemental plans.

(viii) *Effect of employer-provided insurance.* In the case of individuals with health insurance due to their current employment status, the employer insurance plan shall be first payer, Medicare shall be the second payer, and CHAMPUS shall be the tertiary payer.

* * * * *

5. Section 199.10 is amended by revising paragraph (a)(1)(ii) as follows:

§ 199.10. Appeal and Hearing Procedures.

(a) * * *

(1) * * *

(ii) *Effect of initial determination.*

(A) The initial determination is final unless appealed in accordance with this chapter, or unless the initial determination is reopened by the

TRICARE Management Activity, the CHAMPUS contractor, or the CHAMPUS peer review organization.

(B) An initial determination involving a CHAMPUS beneficiary entitled to Medicare Part A, who is enrolled in Medicare Part B, may be appealed by the beneficiary or their provider under this section of this Part only when the claimed services or supplies are payable by CHAMPUS and are not payable under Medicare. Both Medicare and CHAMPUS offer an appeal process when a claim for healthcare services or supplies is denied and most healthcare services and supplies are a benefit payable under both Medicare and CHAMPUS. In order to avoid confusion on the part of beneficiaries and providers and to expedite the appeal process, services and supplies denied payment by Medicare will not be considered for coverage by CHAMPUS if the Medicare denial of payment is appealable under Medicare. Because such claims are not considered for payment by CHAMPUS, there can be no CHAMPUS appeal. If, however, a Medicare claim or appeal results in some payment by Medicare, the services and supplies paid by Medicare will be considered for payment by CHAMPUS. In that situation, any decision to deny CHAMPUS payment will be appealable under this section. The following examples of CHAMPUS appealable issues involving Medicare-eligible CHAMPUS beneficiaries are illustrative; they are not all-inclusive:

(*1*) If Medicare processes a claim for a healthcare service or supply that is a Medicare benefit and the claim is denied by Medicare for a patient-specific reason, the claim is appealable through the Medicare appeal process. The Medicare decision will be final if the claim is denied by Medicare. The claimed services or supplies will not be considered for CHAMPUS payment and there is no CHAMPUS appeal of the CHAMPUS decision denying the claim.

(*2*) If Medicare processes a claim for a healthcare service or supply that is a Medicare benefit and the claim is paid, either on initial submission or as a result of a Medicare appeal decision, the claim will be submitted to CHAMPUS for processing as a second payer to Medicare. If CHAMPUS denies payment of the claim, the Medicare-eligible beneficiary or their provider have the same appeal rights as other CHAMPUS beneficiaries and their providers under this section.

(*3*) If Medicare processes a claim and the claim is denied by Medicare because it is not a healthcare service or supply that is a benefit under Medicare, the claim is submitted to CHAMPUS. CHAMPUS will process the claim under Part 199 as primary payer (or as secondary payer if another double coverage plan exists). If any part of the claim is denied, the Medicare-eligible beneficiary and their provider will have the same appeal rights as other CHAMPUS beneficiaries and their providers under this section.

* * * * *

6. Section 199.15 is amended by revising paragraph (a)(6), as follows:

§ 199.15 Quality and Utilization Review Peer Review Organization Program.

(a) * * *

(6) *Medicare rules used as model.* The CHAMPUS Quality and Utilization Review Peer Review Organization program, based on specific statutory authority, follows many of the quality and utilization review requirements and procedures in effect for the Medicare Peer Review Organization program, subject to adaptations appropriate for the CHAMPUS program. In recognition of the similarity of purpose and design between the Medicare and CHAMPUS PRO programs, and to avoid unnecessary duplication of effort, the CHAMPUS Quality and Utilization Review Peer Review Organization program will have special procedures applicable to supplies and services furnished to Medicare-eligible CHAMPUS beneficiaries. These procedures will enable CHAMPUS normally to rely upon Medicare determinations of medical necessity and appropriateness in the processing of CHAMPUS claims as a second payer to Medicare. As a general rule, only in cases involving Medicare-eligible CHAMPUS beneficiaries where Medicare payment for services and supplies is denied for reasons other than medical necessity and appropriateness will the CHAMPUS claim be subject to review for quality of care and appropriate utilization under the CHAMPUS PRO program. TRICARE will continue to perform a medical necessity and appropriateness review for quality of care and appropriate utilization under the CHAMPUS PRO program where required by statute, such as inpatient mental health services in excess of 30 days in any year.

7. Section 199.17 is amended by revising paragraphs (a) introductory text, (a)(6)(i), (a)(6)(ii), (b) introductory text, (b)(1), (c) introductory text, (c)(3), (c)(4), and (v), by deleting paragraphs (m)(2)(iii) and (m)(4)(iii), as follows:

§ 199.17 TRICARE program.

(a) *Establishment.* The TRICARE program is established for the purpose of implementing a comprehensive managed health care program for the delivery and financing of health care services in the Military Health System.

* * * * *

(6) *Major features of the TRICARE program.* The major features of the TRICARE program, described in this section, include the following:

(i) *Comprehensive enrollment system.* Under the TRICARE program, all health care beneficiaries become classified into one of four enrollment categories:

(A) Active duty members, all of whom are automatically enrolled in TRICARE Prime;

(B) TRICARE Prime enrollees;

(C) TRICARE Standard enrollees, who are all CHAMPUS eligible beneficiaries who are not enrolled in TRICARE Prime;

(D) Non-CHAMPUS beneficiaries, who are beneficiaries eligible for health care services in military treatment facilities, but not eligible for CHAMPUS;

(ii) *Establishment of a triple option benefit.* A second major feature of TRICARE is the establishment of three options for receiving health care:

(A) ''TRICARE Prime,'' which is a health maintenance organization (HMO)-like program. It generally features use of military treatment facilities and substantially reduced out-of-pocket costs for CHAMPUS care. Beneficiaries generally agree to use military treatment facilities and designated civilian provider networks and to follow certain managed care rules and procedures.

(B) ''TRICARE Extra,'' which is a preferred provider organization (PPO) program. It allows TRICARE Standard-enrolled beneficiaries to use the TRICARE provider network, including both military facilities and the civilian network, with reduced out-of-pocket costs. These beneficiaries also continue to be eligible for military medical treatment facility care on a space-available basis.

(C) ''TRICARE Standard'' which is the basic CHAMPUS program. It preserves broad freedom of choice of civilian providers, but does not offer reduced out-of-pocket costs. These beneficiaries continue to be eligible to receive care in military medical treatment facilities on a space-available basis.

* * * * *

(b) *Triple option benefit in general.* Where the TRICARE program is fully implemented, eligible beneficiaries are given the options of enrolling in TRICARE Prime (also referred to as ''Prime'') or TRICARE Standard (also referred to as ''Standard''). In the absence of an enrollment choice, enrollment in Standard is assumed.

(1) *Choice voluntary.* With the exception of active duty members, the choice of whether to enroll in Prime or Standard is voluntary for all eligible beneficiaries. For dependents who are minors, the choice will be exercised by a parent or guardian.

* * * * *

(c) *Eligibility for enrollment.* Where the TRICARE program is fully implemented, all CHAMPUS-eligible beneficiaries who are not Medicare eligible on basis of age are eligible to enroll in Prime or Standard. CHAMPUS beneficiaries who are eligible for Medicare on basis of age (and are enrolled in Medicare Part B) are automatically enrolled in TRICARE Standard. Further, some rules and procedures are different for dependents of active duty members and retirees, dependents, and survivors. In addition, where the TRICARE program is implemented, a military medical treatment facility commander or other authorized individual may establish priorities, consistent with paragraph (c) of this section, based on availability or other operational requirements, for when and whether to offer the enrollment opportunity.

* * * * *

(3) *Retired members, dependents of retired members, and survivors.* (i) Where TRICARE is fully implemented, all CHAMPUS-eligible retired members, dependents of retired members, and survivors who are not eligible for Medicare on the basis of age are eligible to enroll in Prime. After all active duty members are enrolled and availability of enrollment is assured for all active duty dependents wishing to enroll, this category of beneficiaries will have third priority for enrollment.

(ii) If all eligible retired members, dependents of retired members, and survivors within the area concerned cannot be accepted for enrollment in Prime at the same time, the MTF Commander (or other authorized individual) may allow enrollment within this beneficiary group category on a first come, first served basis.

(4) *Enrollment in Standard.* All CHAMPUS-eligible beneficiaries who do not enroll in Prime will remain in Standard.

* * * * *

(v) *Administrative procedures.* The Assistant Secretary of Defense (Health Affairs), the Director, TRICARE Management Activity, and MTF Commanders (or other authorized officials) are authorized to establish administrative requirements and procedures, consistent with this section, this part, and other applicable DoD Directives or Instructions, for the implementation and operation of the TRICARE program.

Dated: July 27, 2001.

L.M. Bynum,

Alternate OSD Federal Register, Liaison Officer, Department of Defense.

[FR Doc. 01–19184 Filed 8–2–01; 8:45 am]

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 51, 52, 96, and 97

[FRL–7023–8]

Availability of Documents for the Response to the Remands in the Ozone Transport Cases Concerning the Method for Computing Growth for Electric Generating Units

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of data availability for the NO_X SIP Call and the Section 126 Rule.

SUMMARY: The EPA is providing notice that it has placed in the dockets for the two main rulemakings concerning ozone-smog transport in the eastern part of the United States-the Nitrogen Oxides State Implementation Plan Call (NO_X SIP Call) and the Section 126 Rule-data relevant to the remands by the U.S. Court of Appeals for the District of Columbia Circuit (D.C. Circuit) concerning growth rates for seasonal heat input by electric generating units (EGUs). In both the NO_X SIP Call and Section 126 rulemakings, EPA determined control obligations with respect to EGUs through the same computation, which included, as one component, estimates of growth in heat input by the EGUs from 1996 to 2007. In two cases decided earlier this year challenging the Section 126 rulemaking and a pair of rulemakings that made technical corrections to the NO_X SIP Call, the D.C. Circuit considered challenges to EPA's calculation of the growth estimate and its use of growth factors. In virtually identical decisions, the Court remanded the growth component to EPA for a better response to certain data presented by the affected States and industry concerning actual heat input, and for a better explanation of EPA's methodology. The EPA is in the process of responding to those remands. The EPA's preliminary view is that its growth calculations were reasonable and can be supported with a more robust explanation, based on the existing record, that takes into account the Court's concerns. In addition, EPA is considering new data that have recently been placed in the dockets for the NO_X SIP Call and Section 126 Rule. These new data appear to confirm the reasonableness of the growth calculations. The EPA is providing a 30-day period for the public to comment on these new data.

DATES: Documents were placed in the docket on or about July 27, 2001. The EPA is authorizing a 30-day comment period, ending on September 4, 2001. Comments must be postmarked by the last day of the comment period and sent directly to the Docket Office listed in **ADDRESSES** below (in duplicate form, if possible). In addition, EPA encourages commenters to send copies of their comments directly to the contacts identified below under the section, **FOR FURTHER INFORMATION CONTACT**.

ADDRESSES: Comments may be submitted to the Office of Air and Radiation Docket and Information Center (6102), Attention: Docket No. A–96–56 for the NO_X SIP Call and Docket No. A–97–43 for the Section 126 Rule, U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue NW, Washington, DC 20460, telephone (202) 260–7548. The EPA encourages electronic submission of comments following the instructions under **SUPPLEMENTARY INFORMATION** of this document. The e-mail address is A-and-R-Docket@epa.gov. No confidential business information should be submitted through e-mail.

Copies of all of the documents have been placed in the docket for the NO_X SIP Call rule, Docket No. A–96–56, and have been incorporated by reference in the docket for the Section 126 Rule, Docket No. A–97–43. These new documents, and other documents relevant to these rulemakings, are available for inspection at the Docket Office, located at 401 M Street SW, Room M–1500, Washington, DC 20460, between 8 a.m. and 5:30 p.m., Monday through Friday, excluding legal holidays. A reasonable fee may be charged for copying. Some of the documents have also been made available in electronic form at the following EPA website: http://www.epa.gov/airmarkets/fednox/126noda/.

FOR FURTHER INFORMATION CONTACT: Questions concerning today's document should be directed to Kevin Culligan, Office of Atmospheric Programs, Clean Air Markets Division, 6204M, 1200 Pennsylvania Ave. NW, Washington, DC 20460, telephone (202) 564–9172, e-mail *culligan.kevin@epa.gov;* or Howard J. Hoffman, Office of General Counsel,