have in light of the particular nature of the disaster or emergency. Sections 208.4, 208.6, 208.7 and 210.5 of title 31 CFR do not apply to the establishment of accounts or issuance of payments pursuant to this section. For example, the waivers set forth in § 208.4 are not applicable in situations where Treasury is establishing accounts for the express purpose of allowing for the delivery by EFT of Federal payments to disaster victims. The requirement in §§ 208.6 and 210.5 that a Federal non-vendor electronic payment be deposited to a deposit account in the name of the recipient does not apply to accounts established pursuant to § 208.11, nor are agencies required to notify check recipients and newly-eligible payment recipients of options available to them, as is normally required under § 208.7. Further, Treasury will be able to deliver payments to accounts established pursuant to § 208.11, notwithstanding any other instructions from the payment recipient.

Regulatory Analyses

Request for Comment on Plain Language

On June 1, 1998, the President issued a memorandum directing each agency in the Executive branch to write its rules in plain language. This directive is effective for all new proposed and final rulemaking documents issued on or after January 1, 1999. We invite comment on how to make this final rule clearer. For example, you may wish to discuss: (1) Whether we have organized the material to suit your needs; (2) whether the requirements of this final rule are clear; or (3) whether there is something else we could do to make this rule easier to understand.

Regulatory Planning and Review

The final rule does not meet the criteria for a ''significant regulatory action'' as defined in Executive Order 12866. Therefore, the regulatory review procedures contained therein do not apply.

Regulatory Flexibility Act Analysis

Because no notice of proposed rulemaking was required for this final rule, the provisions of the Regulatory Flexibility Act (5 U.S.C. 601 et. seq.) do not apply.

List of Subjects in 31 CFR Part 208

Accounting, Automated Clearing House, Banks, Banking, Electronic funds transfer, Financial institutions, Government payments.

Adoption of the Amendment

■ For the reasons set out in the preamble, under the authority of 5 U.S.C. 301 the interim rule amending 31 CFR Part 208 published at 71 FR 44584 is adopted as a final rule without change.

Dated: August 14, 2007.

Kenneth R. Papaj,

Commissioner.

[FR Doc. 07–4053 Filed 8–17–07; 8:45 am]

BILLING CODE 4810–35–M

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

[DOD–2006–HA–0207]

RIN 0720–AB15

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); TRICARE Reserve Select for Members of the Selected Reserve

AGENCY: Office of the Secretary, DoD.

ACTION: Interim final rule with comment period.

SUMMARY: This interim final rule revises requirements and procedures for TRICARE Reserve Select and restructures eligibility to include all Selected Reservists, except for those individuals either enrolled or eligible to enroll in a health benefit plan under Chapter 89 of Title 5, United States Code. The rule is being published as an interim final rule with comment period in order to comply with statutory effective dates.

DATES: *Effective Date:* This rule is effective October 1, 2007. Submit comments on or before September 19, 2007.

ADDRESSES: You may submit comments, identified by docket number and or RIN number and title, by any of the following methods: Federal eRulemaking Portal: *http://www.regulations.gov.* Follow the instructions for submitting comments. Mail: Federal Docket Management System Office, 1160 Defense Pentagon, Washington, DC 20301–1160. Instructions: All submissions received must include the agency name and docket number or Regulatory Information Number (RIN) for this **Federal Register** document. The general policy for comments and other submissions from members of the public is to make these submissions available for public viewing on the Internet at *http://regulations.gov* as they are received without change, including any personal identifiers or contact information.

FOR FURTHER INFORMATION CONTACT: Jody Donehoo, TRICARE Management Activity, TRICARE Operations, telephone (703) 681–0039.

Questions regarding payment of specific claims under the TRICARE allowable charge method should be addressed to the appropriate TRICARE contractor.

SUPPLEMENTARY INFORMATION:

I. Introduction and Background

A previous interim final rule was published in the **Federal Register** on March 16, 2005, (70 FR 12798–12805) that established requirements and procedures to implement TRICARE Reserve Select under section 701 of the Ronald W. Reagan National Defense Authorization Act for Fiscal Year 2005 (NDAA–05) (Pub. L. 108–375). Section 701 of NDAA–05 authorized premium-based medical coverage for certain members of the Selected Reserve and their family members. By April 2005, Selected Reserve members who served on active duty in support of a contingency operation and fulfilled other statutory qualifications could purchase TRICARE Reserve Select coverage for periods proportional to their period of active duty.

A second interim final rule was published in the **Federal Register** on June 21, 2006, (71 FR 35527–35537). That interim final rule revised requirements and procedures for TRICARE Reserve Select pursuant to sections 701 and 702 of the National Defense Authorization Act for Fiscal Year 2006 (NDAA–06) (Pub. L. 109–163). Section 701 enhanced the existing TRICARE Reserve Select program. Section 702 added two new tiers of premium sharing by the government (50 percent and 85 percent member portion) to the existing premium tier (28 percent member portion), making TRICARE Reserve Select available to all Selected Reservists.

Before a final rule could be issued subsequent to the interim final rule published in the **Federal Register** on June 21, 2006, (71 FR 35527–35537) for the TRICARE Reserve Select program, Section 706 of the NDAA–07 amended the statutory provisions in sections 701 and 702 of the NDAA–06 which were implemented in the interim final rule.

Therefore, this interim rule addresses provisions of the National Defense Authorization Act for Fiscal Year 2007 (NDAA–07) (Pub. L. 109–364). First, section 706 of the NDAA–07 expands the availability of the 28 percent premium tier to all Selected Reservists with one exception. Those individuals either enrolled or eligible to enroll in a

health benefit plan under Chapter 89 of Title 5, United States Code are specifically excepted from eligibility under this legislation. Second, this section eliminates fixed length periods of coverage. Third, this section eliminates the 50 percent and 85 percent premium tiers to reflect the repeal of Section 1076b of Title 10, United States Code, in its entirety.

The law authorizing the TRICARE Reserve Select program uses the term ''eligibility'' to identify conditions under which a Reserve component member may purchase coverage. For purposes of program administration, the terms ''qualifying'' or ''qualified'' shall generally be used in lieu of such terms as ''eligibility'' or ''eligible'' to refer to a Reserve component member who meets the program requirements allowing purchase of TRICARE Reserve Select coverage.

The latter interim rule (June 21, 2006) introduced certain terminology for TRICARE Reserve Select intended to reflect critical elements that distinguish it from other long-established TRICARE health programs. For instance, the effective date of eligibility for TRICARE has long been understood to mean that the eligible individual may obtain care under the military health system as of that date. However, that is not what it means in the context of TRICARE Reserve Select. To avoid the inevitable misunderstanding, this rule uses the term ''qualify'' to mean that the member has satisfied all the ''qualifications'' that must be met before the member is authorized to purchase coverage. Only then may the member purchase coverage by submitting a completed request in the appropriate format along with payment of the applicable one month premium. The term ''coverage'' indicates the benefit of TRICARE covering claims submitted by TRICARE authorized providers, hospitals, and suppliers for payment of covered services, supplies, and equipment.

II. TRICARE Reserve Select Program

A. *Establishment of the TRICARE Reserve Select Program* (paragraph 199.24(a)). This paragraph describes the nature, purpose, statutory basis, scope, and major features of TRICARE Reserve Select, a premium-based medical coverage program that was made available worldwide to certain members of the Selected Reserve and their family members. TRICARE Reserve Select is authorized by 10 U.S.C. 1076d.

The major features of the program include the following. TRICARE Reserve Select coverage is available for purchase by any Selected Reserve member if the member fulfills all of the statutory qualifications. The amount of the premium that members pay is prescribed by the Secretary of Defense as one premium for member-only coverage and a second premium for member and family coverage. The statute eliminates the former tiered premium rate structure of TRICARE Reserve Select. Additionally, TRICARE rules apply unless otherwise specified; certain special TRICARE programs are not part of TRICARE Reserve Select, including the Extended Care Health Option (ECHO) program, the Special Supplemental Food Program (also known as the Women, Infants, and Children—Overseas Program), and the Supplemental Health Care Program, except when referred by a Military Treatment Facility (MTF) provider for incidental consults and the MTF provider maintains clinical control over the episode of care. The TRICARE Dental Program is already available under 10 U.S.C. 1076a to all members of the Selected Reserve and their family members whether or not they purchase TRICARE Reserve Select coverage.

Under TRICARE Reserve Select, Selected Reserve members who fulfill all of the statutory qualifications may purchase either the member-only type of coverage or the member and family type of coverage by submitting a completed request in the appropriate format along with payment of the applicable monthly premium at the time of enrollment. When their coverage becomes effective, TRICARE Reserve Select beneficiaries receive the TRICARE Standard (and Extra) benefit. TRICARE Reserve Select features the deductible and cost share provisions of the TRICARE Standard (and Extra) plan for active duty family members (ADFM) for both the member and covered family members.

B. *TRICARE Reserve Select premiums* (paragraph 199.24(b)). Members are charged premiums for coverage under TRICARE Reserve Select that represent 28 percent of the total annual premium amount that the Assistant Secretary of Defense, Health Affairs (ASD(HA)) determines on an appropriate actuarial basis as being appropriate for coverage under the TRICARE Standard (and Extra) benefit for the TRICARE Reserve Select eligible population. Premiums are to be paid monthly, except as otherwise established as part of the administrative implementation of TRICARE Reserve Select.

Annual rates for the first year TRICARE Reserve Select was offered (2005) were based on the calendar year annual premiums for the Blue Cross and Blue Shield Standard Service Benefit Plan under the Federal Employees Health Benefits Program, a nationwide plan closely resembling TRICARE Standard (and Extra) coverage, with an adjustment based on estimated differences in covered populations, as determined by the ASD(HA).

Based on an analysis of demographic differences between Blue Cross and Blue Shield members and beneficiaries eligible for TRICARE Reserve Select, the adjustment amount in calendar year 2005 represented a 32 percent reduction from the Blue Cross and Blue Shield annual premium for member-only coverage and represented an 8 percent reduction from the Blue Cross and Blue Shield annual premium for member and family coverage. (The difference in the percentage reductions between member-only and member and family premiums is due to the disproportionately high number of high cost, single, elderly retiree federal employees covered by Blue Cross and Blue Shield member-only coverage).

TRICARE Reserve Select monthly premium rates are established and updated annually, on a calendar year basis, to maintain an appropriate relationship with the annual changes in Blue Cross and Blue Shield premiums, or by other adjustment methodology determined to be appropriate by the ASD(HA) for each of the two types of coverage, member-only coverage and member and family coverage, on a calendar year basis. The monthly rate for each month of a calendar year is one-twelfth of the annual rate for that calendar year.

In addition to these annual premium changes, premium adjustments may also be made prospectively for any calendar year to reflect any significant program changes or any actual experience in the costs of administering the TRICARE Reserve Select Program.

A surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (c)(3) of this section will pay premium rates as follows. The premium amount shall be at the member-only rate if there is only one surviving family member to be covered by TRICARE Reserve Select and at the member and family rate if there are two or more survivors to be covered.

C. *Eligibility for qualifying to purchase TRICARE Reserve Select coverage* (paragraph 199.24(c)). This paragraph defines the statutory conditions under which members of a Reserve component may qualify to purchase TRICARE Reserve Select coverage. Section 706 of NDAA–07 restructures the availability of the 28 percent premium tier by requiring only two qualifying conditions.

The qualifying condition to be ''a member of the Selected Reserve of the Ready Reserve of a reserve component of the armed forces,'' remains in force while all of the other former qualifying conditions are eliminated. The member's Service personnel office is responsible for keeping the Defense Enrollment Eligibility Reporting System (DEERS) current with eligibility data.

One exclusionary qualifying condition is added that excludes ''a member who is enrolled, or is eligible to enroll, in a health benefits plan under chapter 89 of title 5 U.S.C,'' from purchasing TRICARE Reserve Select coverage.

If a member of the Selected Reserve dies while in a period of TRICARE Reserve Select coverage, the family member(s) may purchase new or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death upon payment of monthly premiums.

D. *Procedures* (paragraph 199.24(d)).

—*Purchasing Coverage.* A qualified member, including surviving family members, may purchase one of two types of coverage: member-only coverage or member and family coverage. Immediate family members of the Reserve component member, as defined in section 199.3(b)(2)(i) (except former spouses) and 199.3 (b)(2)(ii) of this Part, may be included in such family coverage. To purchase either type of TRICARE Reserve Select coverage for effective dates of coverage described below, Reserve component members qualified under paragraph 199.24(c) must complete and submit a request in the appropriate format, along with an initial payment of the monthly premium share required under paragraph 199.24(b), to the appropriate TRICARE contractor in accordance with deadlines and other procedures established by the ASD(HA).

—*Continuation Coverage.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage with an effective date immediately following the date of termination of coverage under another TRICARE program in which the member is the sponsor.

—*Qualifying Life Event.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage on the occasion of a qualifying life event that changes the immediate family composition (e.g., birth, adoption, divorce, etc.) that is eligible for coverage under TRICARE Reserve Select. The effective date for TRICARE Reserve Select coverage will be the date of the qualifying life event. It is the responsibility of the member to provide his or her personnel office with the necessary evidence required to substantiate the change in immediate family composition. Personnel officials will update DEERS in the usual manner. The appropriate TRICARE contractor will then take appropriate action upon receipt of the completed request in the appropriate format along with payment of the applicable monthly premium.

—*Open Enrollment.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage at any time. The effective date of coverage will coincide with the first day of a month.

—*Survivor coverage under TRICARE Reserve Select.* Deadlines and other procedures may be established for a surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (c)(3) of this section to purchase new TRICARE Reserve Select coverage or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death. The effective date of coverage will be the day following the date of the member's death.

—*Changing type of coverage.* TRICARE Reserve Select members may request to change type of coverage during open enrollment or on the occasion of a qualifying life event that changes immediate family composition as described above by submitting a completed request in the appropriate format.

—*Termination.* Termination of coverage for the member will result in termination of coverage for the member's family members in TRICARE Reserve Select, except for qualified survivors of Reserve component members covered by TRICARE Reserve Select at the time of death.

—Coverage will terminate whenever a member ceases to meet the qualifications for the program or a request for termination in the appropriate format is received in accordance with established procedures.

—Coverage may terminate for members who gain coverage under another TRICARE program in which the member is the sponsor.

—Failure to make a premium payment in a timely manner may result in termination of coverage for the member and any covered family members and will result in denial of claims for services received after the effective date of termination.

—The member may request termination of coverage at any time by submitting a completed request in the appropriate format in accordance with established deadlines and procedures. Members whose coverage under TRICARE Reserve Select terminates upon their request or for failure to pay premiums will not be allowed to purchase coverage again under TRICARE Reserve Select for a period of one year following the effective date of termination.

—Coverage for survivors as described herein shall terminate six months after the date of death of the covered Reserve component member.

—*Processing.* Upon receipt of a completed request in the appropriate format the appropriate TRICARE contractor will process enrollment actions into DEERS in accordance with deadlines and other procedures established by the ASD(HA).

—*Periodic revision.* Periodically, certain features, rules or procedures of TRICARE Reserve Select may be revised. If such revisions will have a significant effect on members' costs or access to care, members may be given the opportunity to change their type of coverage.

E. *Relationship to Continued Health Care Benefits Program (CHCBP)* (paragraph 199.24(e)). This paragraph addresses the relationship between TRICARE Reserve Select and the CHCBP. CHCBP is a program that (among other things) allows members released from active duty to purchase continued health care coverage through TRICARE. Coverage under TRICARE Reserve Select counts as coverage under a health benefit plan for purposes of individuals qualifying for the Continued Health Care Benefits Program (CHCBP) under section 199.20(d)(1)(ii)(B) or section 199.20(d)(1)(iii)(B) of this Part. Some members and family members will be eligible for TRICARE Reserve Select, and may also be eligible for CHCBP at the time of release from active duty.

This paragraph of the regulation provides that if a member purchases TRICARE Reserve Select coverage that is later terminated, the member or the covered family members may then purchase CHCBP coverage for whatever period is remaining of the original 18-month eligibility. For example, in the case that TRICARE Reserve Select coverage that is terminated because of

transfer or discharge of a member from the Selected Reserve (such as through a reduction in force or base closure) is within 18 months of release from active duty, the member could choose to continue health care coverage under CHCBP for the remainder of the period at the applicable CHCBP premiums.

F. *Preemption of State laws* (paragraph 199.24(f)). This paragraph explains that the preemptions of State and local laws established for the TRICARE program also apply to TRICARE Reserve Select. Any State or local law or regulation pertaining to health insurance, prepaid health plans, or other health care delivery, administration, and financing methods is preempted and does not apply in connection with TRICARE Reserve Select.

This includes State and local laws imposing premium taxes on health insurance carriers, underwriters or other plan managers, or similar taxes on such entities. Preemption does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees or other payments are applicable to a broad range of business activity. For the purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health services contracts, interpretations shall be consistent with those applicable to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

G. *Administration* (paragraph 199.24(g)). This paragraph provides that the ASD(HA) may establish other rules and procedures necessary for the effective administration of TRICARE Reserve Select.

III. Regulatory Procedures

Executive Order 12866 requires certain regulatory assessments for any significant regulatory action that would result in an annual effect on the economy of $100 million or more, or have other substantial impacts. The Congressional Review Act establishes certain procedures for major rules, defined as those with similar major 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 that would have significant impact on a substantial number of small entities. This interim final rule is not subject to any of those requirements because it would not have any of these substantial impacts. Any substantial impacts associated with implementation of TRICARE Reserve Select are already determined by statute and are outside any discretionary action of DoD or effect of this regulation.

This rule, however, does address novel policy issues relating to implementation of a new medical benefits program for members of the armed forces. Thus, this rule has been reviewed by the Office of Management and Budget under E.O. 12866.

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

We have examined the impact(s) of the interim final rule under Executive Order 13132 and it does not have policies that have federalism implications that would have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government, therefore, consultation with State and local officials is not required.

This rule is being published as an interim final rule with comment period contrary to the normal procedure of soliciting public comment under a proposed rule first, in order to comply with the requirements of the John Warner National Defense Authorization Act for Fiscal Year 2007, Public Law 109–364, section 706, which was enacted on January 6, 2007. This section provides in pertinent part that ''The Secretary of Defense shall ensure that health care under TRICARE Standard is provided under section 1076d of title 10, United States Code, as amended by this section beginning not later than October 1, 2007.'' In order to comply with the statutorily mandated start date, this rule is being published as an interim final rule, with an effective date of October, 1, 2007. Public comments are welcome and will be considered before publication of the final rule.

List of Subjects in 32 CFR part 199

Claims, handicapped, health insurance, and 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; 10 U.S.C. chapter 55.

■ 2. Section 199.2(b) is amended by revising the definition of ''TRICARE Reserve Select'' to read as follows:

§ 199.2 Definitions.

* * * * *

(b) * * *

TRICARE Reserve Select. The program established under 10 U.S.C. 1076d and § 199.24 of this Part.

■ 3. Section 199.24 is revised to read as follows:

§ 199.24 TRICARE Reserve Select.

(a) *Establishment.* TRICARE Reserve Select is established for the purpose of offering TRICARE Standard and Extra health coverage to qualified members of the Selected Reserve and their immediate family members.

(1) *Purpose.* TRICARE Reserve Select is a premium-based health plan that is available for purchase by members of the Selected Reserve and certain survivors of Selected Reserve members as specified in paragraph (c) of this section.

(2) *Statutory Authority.* TRICARE Reserve Select is authorized by 10 U.S.C. 1076d.

(3) *Scope of the Program.* TRICARE Reserve Select is applicable in the 50 United States, the District of Columbia, Puerto Rico, and, to the extent practicable, other areas where members of the Selected Reserve serve. In locations other than the 50 states of the United States and the District of Columbia, the Assistant Secretary of Defense (Health Affairs) may authorize modifications to the program rules and procedures as may be appropriate to the area involved.

(4) *Terminology.* Certain terminology is introduced for TRICARE Reserve Select intended to reflect critical elements that distinguish it from other long-established TRICARE health programs. For instance, the effective date of eligibility for TRICARE has long been understood to mean that the eligible individual may obtain care under the military health system as of that date. However, that is not what it means in the context of TRICARE Reserve Select. To avoid the inevitable misunderstanding, this regulation uses the term ''qualify'' to mean that the member has satisfied all the ''qualifications'' that must be met before the member is authorized to purchase coverage. Only then may the member purchase coverage by submitting a completed request in the appropriate format along with payment of the applicable one month premium. The term ''coverage'' indicates the benefit of TRICARE Standard or Extra covering claims submitted for payment of covered services, supplies, and equipment furnished by TRICARE authorized providers, hospitals, and suppliers.

(5) *Major Features of TRICARE Reserve Select.* The major features of the program include the following:

(i) *TRICARE rules applicable.*

(A) Unless specified in this section or otherwise prescribed by the ASD(HA), provisions of 32 CFR Part 199 apply to TRICARE Reserve Select.

(B) Certain special programs established in 32 CFR Part 199 are not available to members covered under TRICARE Reserve Select. These include the Extended Care Health Option Program (see § 199.5), the Special Supplemental Food Program (see § 199.23), and the Supplemental Health Care Program (see § 199.16) except when referred by a Military Treatment Facility (MTF) provider for incidental consults and the MTF provider maintains clinical control over the episode of care. The TRICARE Dental Program (see § 199.13) is independent of this program and is otherwise available to all members of the Selected Reserve and their eligible family members whether or not they purchase TRICARE Reserve Select coverage.

(ii) *Premiums.* TRICARE Reserve Select coverage is available for purchase by any Selected Reserve member if the member fulfills all of the statutory qualifications. A member of the Selected Reserve covered under TRICARE Reserve Select shall pay 28 percent of the total amount that the ASD(HA) determines on an appropriate actuarial basis as being appropriate for that coverage. There is one premium rate for member-only coverage and one premium rate for member and family coverage.

(iii) *Procedures.* Under TRICARE Reserve Select, Reserve component members who fulfilled all of the statutory qualifications may purchase either the member-only type of coverage or the member and family type of coverage by submitting a completed request in the appropriate format along with payment of the applicable one month premium. Rules and procedures for purchasing coverage and paying applicable premiums are prescribed in this section.

(iv) *Benefits.* When their coverage becomes effective, TRICARE Reserve Select beneficiaries receive the TRICARE Standard (and Extra) benefit including access to military treatment facility services and pharmacies, as described in § 199.17 of this Part. TRICARE Reserve Select coverage features the deductible and cost share provisions of the TRICARE Standard (and Extra) plan for active duty family members for both the member and the member's covered family members. The TRICARE Standard (and Extra) plan is described in § 199.17 of this Part.

(b) *TRICARE Reserve Select premiums.* Members are charged premiums for coverage under TRICARE Reserve Select that represent 28 percent of the total annual premium amount that the Assistant Secretary of Defense, Health Affairs (ASD(HA)) determines on an appropriate actuarial basis as being appropriate for coverage under the TRICARE Standard (and Extra) benefit for the TRICARE Reserve Select eligible population. Premiums are to be paid monthly, except as otherwise provided through administrative implementation, pursuant to procedures established by the ASD(HA).

(1) *Annual establishment of rates.* (i) TRICARE Reserve Select monthly premium rates shall be established and updated annually on a calendar year basis to maintain an appropriate relationship with the annual changes in premiums for the Blue Cross and Blue Shield Standard Service Benefit Plan under the Federal Employees Health Benefits Program, a nationwide plan closely resembling TRICARE Standard (and Extra) coverage, or by other adjustment methodology determined to be appropriate by the ASD(HA) for each of the two types of coverage, member-only and member and family as described in paragraphs (d)(2) of this section.

(ii) Annual rates for the first year TRICARE Reserve Select was offered (calendar year 2005) were based on the Federal Blue Cross and Blue Shield annual premiums, with adjustments based on estimated differences in covered populations, as determined by the ASD(HA).

(2) *Premium adjustments.* In addition to the determinations described in paragraph (b)(1) of this section, premium adjustments may be made prospectively for any calendar year to reflect any significant program changes or any actual experience in the costs of administering the TRICARE Reserve Select Program.

(3) *Survivor coverage under TRICARE Reserve Select.* A surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (c)(3) of this section will pay premium rates as follows. The premium amount shall be at the member-only rate if there is only one surviving family member to be covered by TRICARE Reserve Select and at the member and family rate if there are two or more survivors to be covered.

(c) *Eligibility for (qualifying to purchase) TRICARE Reserve Select coverage*—(1) *General.* The law authorizing the TRICARE Reserve Select program uses the term ''eligibility'' to identify conditions under which a Reserve component member may purchase coverage. For purposes of program administration, the terms ''qualifying'' or ''qualified'' shall generally be used in lieu of such terms as ''eligibility'' or ''eligible'' to refer to a Reserve component member who meets the program requirements allowing purchase of TRICARE Reserve Select coverage. The member's Service personnel office is responsible for keeping DEERS current with eligibility data.

(2) *Member Purchase.* A member who is a member of a Reserve component of the Armed Forces qualifies to purchase TRICARE Reserve Select coverage if the member meets both the following conditions:

(i) Is a member of the Selected Reserve of the Ready Reserve.

(ii) Is not enrolled in, or eligible to enroll in, a health benefits plan under Chapter 89 of Title 5, U.S.C.

(3) *Survivor coverage under TRICARE Reserve Select.* If a member of the Selected Reserve dies while in a period of TRICARE Reserve Select coverage, the family member(s) may purchase new or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death.

(d) *Procedures*—(1) *Purchasing Coverage.* A qualified member may purchase one of two types of coverage: member-only coverage or member and family coverage. Immediate family members of the Reserve component member, as defined in § 199.3(b)(2)(i) (except former spouses) and § 199.3 (b)(2)(ii) of this Part, may be included in such family coverage. To purchase either type of TRICARE Reserve Select coverage for effective dates of coverage described below, Reserve component members qualified under § 199.24(c) must submit a request in the appropriate format, along with an initial payment of the applicable monthly premium required by paragraph (b) of this section to the appropriate TRICARE contractor in accordance with deadlines and other procedures established by the ASD(HA).

(i) *Continuation Coverage.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage with an effective date immediately following the date of termination of coverage under another TRICARE program in which the member is the sponsor.

(ii) *Qualifying Life Event.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select

coverage on the occasion of a qualifying life event that changes the immediate family composition (e.g., birth, adoption, divorce, etc.) that is eligible for coverage under TRICARE Reserve Select. The effective date for TRICARE Reserve Select coverage will be the date of the qualifying life event. It is the responsibility of the member to provide his or her personnel office with the necessary evidence required to substantiate the change in immediate family composition. Personnel officials will update DEERS in the usual manner. The appropriate TRICARE contractor will then take appropriate action upon receipt of the completed request in the appropriate format along with payment of the applicable one month premium.

(iii) *Open Enrollment.* Deadlines and other procedures may be established for a qualified member to purchase TRICARE Reserve Select coverage at any time. The effective date of coverage will coincide with the first day of a month.

(iv) *Survivor coverage under TRICARE Reserve Select.* Deadlines and other procedures may be established for a surviving family member of a Reserve Component service member who qualified for TRICARE Reserve Select coverage as described in paragraph (c)(3) of this section to purchase new TRICARE Reserve Select coverage or continue existing TRICARE Reserve Select coverage for up to six months beyond the date of the member's death. The effective date of coverage will be the day following the date of the member's death.

(2) *Changing type of coverage.* TRICARE Reserve Select members may request to change type of coverage during open enrollment or on the occasion of a qualifying life event that changes immediate family composition as described in paragraph (d)(1)(ii) of this section by submitting a completed request in the appropriate format.

(3) *Termination.* Termination of coverage for the member will result in termination of coverage for the member's family members in TRICARE Reserve Select, except as described in paragraphs (d)(1)(iv) of this section. The termination will become effective in accordance with procedures established by the ASD(HA). Members whose coverage under TRICARE Reserve Select terminates under paragraph (d)(3)(iii) or (iv) of this section will not be allowed to purchase coverage again under TRICARE Reserve Select for a period of one year following the effective the date of termination.

(i) Coverage shall terminate for members who no longer qualify for TRICARE Reserve Select as specified in paragraph (c) of this section, including when the member's service in the Selected Reserve terminates.

(ii) Coverage may terminate for members who gain coverage under another TRICARE program in which the member is the sponsor.

(iii) Coverage may terminate for members who fail to make a premium payment in accordance with procedures established by the ASD(HA).

(iv) Members may request termination of coverage at any time by submitting a completed request in the appropriate format in accordance with established deadlines and procedures.

(v) Coverage for survivors as described in paragraph (d)(1)(iv) of this section shall terminate six months after the date of death of the covered Reserve component member.

(4) *Processing.* Upon receipt of a completed request in the appropriate format, the appropriate TRICARE contractor will process enrollment actions into DEERS in accordance with deadlines and other procedures established by the ASD(HA).

(5) *Periodic revision.* Periodically, certain features, rules or procedures of TRICARE Reserve Select may be revised. If such revisions will have a significant effect on members' costs or access to care, members may be given the opportunity to change their type of coverage or terminate coverage coincident with the revisions.

(e) *Relationship to Continued Health Care Benefits Program.* Coverage under TRICARE Reserve Select counts as coverage under a health benefit plan for purposes of individuals qualifying for the Continued Health Care Benefits Program (CHCBP) under section 199.20(d)(1)(ii)(B) or section 199.20(d)(1)(iii)(B) of this Part. If at the time a member who qualifies under paragraph (c) of this section purchases coverage in TRICARE Reserve Select, and the member was also eligible to enroll in the Continued Health Care Benefits Program (CHCBP) under section 199.20(d)(1)(i) of this Part (except to the extent eligibility in CHCBP was affected by enrollment in TRICARE Reserve Select), enrollment in TRICARE Reserve Select will be deemed to also constitute preliminary enrollment in CHCBP. If for any reason the member's coverage under TRICARE Reserve Select terminates before the date that is 18 months after discharge or release from the most recent period of active duty upon which CHCBP eligibility was based, the member or the member's family members eligible to be included in CHCBP coverage may, within 30 days of the effective date of the termination of TRICARE Reserve Select coverage, begin CHCBP coverage by following the applicable procedures to purchase CHCBP coverage. The period of coverage will be as provided in § 199.20(d)(6) of this Part.

(f) *Preemption of State laws.* (1) Pursuant to 10 U.S.C. 1103, the Department of Defense has determined that in the administration of chapter 55 of title 10, U.S. Code, preemption of State and local laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods is necessary to achieve important Federal interests, including but not limited to the assurance of uniform national health programs for military families and the operation of such programs, at the lowest possible cost to the Department of Defense, that have a direct and substantial effect on the conduct of military affairs and national security policy of the United States. This determination is applicable to contracts that implement this section.

(2) Based on the determination set forth in paragraph (f)(1) of this section, any State or local law or regulation pertaining to health insurance, prepaid health plans, or other health care delivery, administration, and financing methods is preempted and does not apply in connection with TRICARE Reserve Select. Any such law, or regulation pursuant to such law, is without any force or effect, and State or local governments have no legal authority to enforce them in relation to TRICARE Reserve Select. (However, the Department of Defense may, by contract, establish legal obligations on the part of DoD contractors to conform with requirements similar to or identical to requirements of State or local laws or regulations with respect to TRICARE Reserve Select).

(3) The preemption of State and local laws set forth in paragraph (f)(2) of this section includes State and local laws imposing premium taxes on health insurance carriers or underwriters or other plan managers, or similar taxes on such entities. Such laws are laws relating to health insurance, prepaid health plans, or other health care delivery or financing methods, within the meaning of 10 U.S.C. 1103. Preemption, however, does not apply to taxes, fees, or other payments on net income or profit realized by such entities in the conduct of business relating to DoD health services contracts, if those taxes, fees or other payments are applicable to a broad range of business activity. For the purposes of assessing the effect of Federal preemption of State and local taxes and fees in connection with DoD health services contracts, interpretations shall be consistent with those applicable

to the Federal Employees Health Benefits Program under 5 U.S.C. 8909(f).

(g) *Administration.* The ASD(HA) may establish other rules and procedures for the effective administration of TRICARE Reserve Select, and may authorize exceptions to requirements of this section, if permitted by law, based on extraordinary circumstances.

Dated: August 14, 2007.

L.M. Bynum,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. E7–16300 Filed 8–17–07; 8:45 am]

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DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 100

[Docket No. CGD05–07–063]

RIN 1625–AA08

Special Local Regulations for Marine Events; Spa Creek and Severn River, Annapolis, MD

AGENCY: Coast Guard, DHS.

ACTION: Temporary final rule.

SUMMARY: The Coast Guard is establishing temporary special local regulations during the ''Annapolis Triathlon'', an event to be held September 9, 2007 on the waters of Spa Creek and the Severn River at Annapolis, MD. These special local regulations are necessary to provide for the safety of life on navigable waters during the event. This action is intended to temporarily restrict vessel traffic in a portion of the Severn River and Spa Creek during the Annapolis Triathlon swimming event.

DATES: This rule is effective from 6 a.m. to 10:30 a.m. on September 9, 2007.

ADDRESSES: Documents indicated in this preamble as being available in the docket are part of docket CGD05–07–063 and are available for inspection or copying at Commander (dpi), Fifth Coast Guard District, 431 Crawford Street, Portsmouth, Virginia 23704–5004 between 9 a.m. and 2 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Ronald Houck, Marine Event Coordinator, Coast Guard Sector Baltimore, at (410) 576–2674 or e-mail at *Ronald.L.Houck@uscg.mil.*

SUPPLEMENTARY INFORMATION:

Regulatory Information

We did not publish a notice of proposed rulemaking (NPRM) for this regulation. Under 5 U.S.C. 553(b)(B), the Coast Guard finds that good cause exists for not publishing an NPRM. The publishing of an NPRM would be impracticable and contrary to public interest since immediate action is needed to minimize potential danger to the participants and the public during the event. The necessary information to determine whether the marine event poses a threat to persons and vessels was not provided with sufficient time to publish an NPRM. The danger posed by the large volume of marine traffic in the Annapolis harbor area makes special local regulations necessary to provide for the safety of swimmers, event support vessels, spectator craft and other vessels transiting the event area. For the safety concerns noted, it is in the public interest to have these regulations in effect during the event. The Coast Guard will issue broadcast notice to mariners to advise vessel operators of navigational restrictions. On-scene Coast Guard and local law enforcement vessels will also provide actual notice to mariners.

Under 5 U.S.C. 553(d)(3), the Coast Guard finds that good cause exists for making this rule effective less than 30 days after publication in the **Federal Register**. Delaying the effective date would be contrary to the public interest, since immediate action is needed to ensure the safety of the event participants, support vessels, spectator craft and other vessels transiting the event area. However advance notification will be made to users of Annapolis harbor via marine information broadcasts, local notice to mariners, commercial radio stations and area newspapers.

Background and Purpose

On September 9, 2007, the City of Annapolis and the Annapolis Triathlon Club will sponsor the ''Annapolis Triathlon''. The swimming segment of the event will consist of approximately 1500 swimmers competing across a one mile course located within Annapolis Harbor, at the entrance of Spa Creek and extending outward to the Severn River. The competition will begin at the Annapolis City dock. The participants will swim along an oval shaped course and across to the finish line located at the Annapolis City dock, swimming approximately one-mile, contained within the inner Annapolis Harbor area. Approximately 30 support vessels will accompany the swimmers. Due to the need for vessel control during the swimming event, the Coast Guard will temporarily restrict vessel traffic in the event area to provide for the safety of participants, support craft and other transiting vessels.

Discussion of Rule

The Coast Guard is establishing temporary special local regulations on specified waters of the Severn River and Spa Creek at Annapolis, Maryland. The temporary special local regulations will be in effect from 6 a.m. to 10:30 a.m. on September 9, 2007. The effect will be to restrict general navigation in the regulated area during the event. Except for persons or vessels authorized by the Coast Guard Patrol Commander, no person or vessel may enter or remain in the regulated area. Vessel traffic may be allowed to transit the regulated area at slow speed as the swim progresses, when the Coast Guard Patrol Commander determines it is safe to do so. The Patrol Commander will notify the public of specific enforcement times by Marine Radio Safety Broadcast. These regulations are needed to control vessel traffic during the event to enhance the safety of participants, spectators and transiting vessels.

Regulatory Evaluation

This rule is not a ''significant regulatory action'' under section 3(f) of Executive Order 12866, Regulatory Planning and Review, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. The Office of Management and Budget has not reviewed it under that Order. We expect the economic impact of this rule to be so minimal that a full Regulatory Evaluation is unnecessary.

Although this regulation restricts vessel traffic from transiting a portion of the Severn River and Spa Creek during the event, the effect of this regulation will not be significant due to the limited duration that the regulated area will be in effect and the extensive advance notifications that will be made to the maritime community via marine information broadcasts, area newspapers and radio stations so mariners can adjust their plans accordingly.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601–612), we have considered whether this rule would have a significant economic impact on a substantial number of small entities. The term ''small entities'' comprises small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.