ity of TRICARE Prime in regions described in subsection (d)(1)(B).

''(2) MATTERS INCLUDED.—The report under paragraph (1) shall include the following:

''(A) A description of the implementation of the transition for affected eligible beneficiaries under the TRICARE program who no longer have access to TRICARE Prime under TRICARE managed care contracts as of the date of the report, including—

''(i) the number of eligible beneficiaries who have transitioned from TRICARE Prime to the TRICARE Standard option of the TRICARE program since October 1, 2013;

''(ii) the number of eligible beneficiaries who transferred their TRICARE Prime enrollment to a more distant available Prime service area to remain in TRICARE Prime, by State;

''(iii) the number of eligible beneficiaries who were eligible to transfer to a more distant available Prime service area, but chose to use TRICARE Standard;

''(iv) the number of eligible beneficiaries who elected to return to TRICARE Prime pursuant to subsection (c)(1); and

''(v) the number of affected eligible beneficiaries who, as of the date of the report, changed residences to remain eligible for TRICARE Prime in a new region.

''(B) An estimate of the increased annual costs per affected eligible beneficiary incurred by such beneficiary for health care under the TRICARE program.

''(C) A description of the efforts of the Department to assess the impact on access to health care and beneficiary satisfaction for affected eligible beneficiaries.

''(D) A description of the estimated cost savings realized by reducing the availability of TRICARE Prime in regions described in subsection (d)(1)(B).

''(c) ACCESS TO TRICARE PRIME.—

''(1) ONE-TIME ELECTION.—Subject to paragraph (3), the Secretary shall ensure that each affected eligible beneficiary who is enrolled in TRICARE Prime as of September 30, 2013, may make a one-time election to continue such enrollment in TRICARE Prime, notwithstanding that a contract described in subsection (a)(2)(A) does not allow for such enrollment based on the location in which such beneficiary resides. The beneficiary may continue such enrollment in TRICARE Prime so long as the beneficiary resides in the same ZIP code as the ZIP code in which the beneficiary resided at the time of such election.

''(2) ENROLLMENT IN TRICARE STANDARD.—If an affected eligible beneficiary makes the one-time election under paragraph (1), the beneficiary may thereafter elect to enroll in TRICARE Standard at any time in accordance with a contract described in subsection (a)(2)(A).

''(3) RESIDENCE AT TIME OF ELECTION.—

''(A) Except as provided by subparagraph (B), an affected eligible beneficiary may not make the one-time election under paragraph (1) if, at the time of such election, the beneficiary does not reside—

''(i) in a ZIP code that is in a region described in subsection (d)(1)(B); and

''(ii) within 100 miles of a military medical treatment facility.

''(B) Subparagraph (A)(ii) shall not apply with respect to an affected eligible beneficiary who—

''(i) as of December 25, 2013, resides farther than 100 miles from a military medical treatment facility; and

''(ii) is such an eligible beneficiary by reason of service in the Army, Navy, Air Force, or Marine Corps.

''(4) NETWORK.—In continuing enrollment in TRICARE Prime pursuant to paragraph (1), the Secretary may determine whether to maintain a TRICARE network of providers in an area that is between 40 and 100 miles of a military medical treatment facility.

''(d) DEFINITIONS.—In this section:

''(1) The term 'affected eligible beneficiary' means an eligible beneficiary under the TRICARE Program (other than eligible beneficiaries on active duty in the Armed Forces) who, as of the date of the enactment of this Act [Jan. 2, 2013]—

''(A) is enrolled in TRICARE Prime; and

''(B) resides in a region of the United States in which TRICARE Prime enrollment will no longer be available for such beneficiary under a contract described in subsection (a)(2)(A) that does not allow for such enrollment because of the location in which such beneficiary resides.

''(2) The term 'TRICARE Prime' means the managed care option of the TRICARE program.

''(3) The term 'TRICARE program' has the meaning given that term in section 1072(7) of title 10, United States Code.

''(4) The term 'TRICARE Standard' means the fee-for-service option of the TRICARE Program.''

[Pub. L. 113–291, div. A, title VII, §723(b), Dec. 19, 2014, 128 Stat. 3418, which directed amendment of subsec. (b)(3)(A) of section 732 of Pub. L. 112–239, set out above, by substituting ''subsection (d)(1)(B)'' for ''subsection (c)(1)(B)'', was executed by making the substitution in subsec. (c)(3)(A) of section 732 of Pub. L. 112–239, to reflect the probable intent of Congress and the prior amendment by section 723(a)(1) of Pub. L. 113–291, which redesignated subsec. (b) as (c).]

§ 1097b. TRICARE program: financial management

(a) REIMBURSEMENT OF PROVIDERS.—(1) Subject to paragraph (2), the Secretary of Defense may reimburse health care providers under the TRICARE program at rates higher than the reimbursement rates otherwise authorized for the providers under that program if the Secretary determines that application of the higher rates is necessary in order to ensure the availability of an adequate number of qualified health care providers under that program.

(2) The amount of reimbursement provided under paragraph (1) with respect to a health care service may not exceed the lesser of the following:

(A) The amount equal to the local fee for service charge for the service in the service area in which the service is provided as determined by the Secretary based on one or more of the following payment rates:

(i) Usual, customary, and reasonable.

(ii) The Health Care Finance Administration's Resource Based Relative Value Scale.

(iii) Negotiated fee schedules.

(iv) Global fees.

(v) Sliding scale individual fee allowances.

(B) The amount equal to 115 percent of the CHAMPUS maximum allowable charge for the service.

(3) In establishing rates and procedures for reimbursement of providers and other administrative requirements, including those contained in provider network agreements, the Secretary shall, to the extent practicable, maintain adequate networks of providers, including institutional, professional, and pharmacy. For the purpose of determining whether network providers under such provider network agreements are subcontractors for purposes of the Federal Acquisition Regulation or any other law, a TRICARE managed care support contract that includes the requirement to establish, manage,

or maintain a network of providers may not be considered to be a contract for the performance of health care services or supplies on the basis of such requirement.

(b) THIRD-PARTY COLLECTIONS.—(1) A medical treatment facility of the uniformed services under the TRICARE program has the same right as the United States under section 1095 of this title to collect from a third-party payer the reasonable charges for health care services described in paragraph (2) that are incurred by the facility on behalf of a covered beneficiary under that program.

(2) The Secretary of Defense shall prescribe regulations for the administration of this subsection. The regulations shall set forth the method to be used for the computation of the reasonable charges for inpatient, outpatient, and other health care services. The method of computation may be—

(A) a method that is based on—

(i) per diem rates;

(ii) all-inclusive rates for each visit;

(iii) diagnosis-related groups; or

(iv) rates prescribed under the regulations implementing sections 1079 and 1086 of this title; or

(B) any other method considered appropriate.

(c) CONSULTATION REQUIREMENT.—The Secretary of Defense shall carry out the responsibilities under this section after consultation with the other administering Secretaries.

(Added Pub. L. 106–65, div. A, title VII, § 716(a)(1), Oct. 5, 1999, 113 Stat. 690; amended Pub. L. 112–81, div. A, title VII, § 715, Dec. 31, 2011, 125 Stat. 1477.)

AMENDMENTS

2011—Subsec. (a)(3). Pub. L. 112–81 added par. (3).

EFFECTIVE DATE

Pub. L. 106–65, div. A, title VII, § 716(d), Oct. 5, 1999, 113 Stat. 692, provided that: ''The amendments made by subsection (a) [enacting this section] shall take effect one year after the date of the enactment of this Act [Oct. 5, 1999].''

REPORT ON IMPLEMENTATION

Pub. L. 106–65, div. A, title VII, § 716(b), Oct. 5, 1999, 113 Stat. 691, directed the Secretary of Defense to submit to Congress a report assessing the effects of the implementation of the requirements and authorities set forth in this section not later than 6 months after Oct. 5, 1999.

§ 1097c. TRICARE program: relationship with employer-sponsored group health plans

(a) PROHIBITION ON FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN.—(1) Except as provided in this subsection, the provisions of section 1862(b)(3)(C) of the Social Security Act shall apply with respect to financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a health plan which would (in the case of such enrollment) be a primary plan under sections 1079(j)(1)[1] and 1086(g) of this title in the same manner as such section 1862(b)(3)(C) applies to financial or other incentives for an individual entitled to benefits under title XVIII of the Social Security Act not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of enrollment) be a primary plan (as defined in section 1862(b)(2)(A) of such Act).

(2)(A) The Secretary of Defense may by regulation adopt such additional exceptions to the prohibition referenced and applied under paragraph (1) as the Secretary deems appropriate and such paragraph (1) shall be implemented taking into account the adoption of such exceptions.

(B) The Secretary of Defense and the Secretary of Health and Human Services are authorized to enter into agreements for carrying out this subsection. Any such agreement shall provide that any expenses incurred by the Secretary of Health and Human Services pertaining to carrying out this subsection shall be reimbursed by the Secretary of Defense.

(C) Authorities of the Inspector General of the Department of Defense shall be available for oversight and investigations of responsibilities of employers and other entities under this subsection.

(D) Information obtained under section 1095(k) of this title may be used in carrying out this subsection in the same manner as information obtained under section 1862(b)(5) of the Social Security Act may be used in carrying out section 1862(b) of such Act.

(E) Any amounts collected in carrying out paragraph (1) shall be handled in accordance with section 1079a of this title.

(b) ELECTION OF TRICARE-ELIGIBLE EMPLOYEES TO PARTICIPATE IN GROUP HEALTH PLAN.—A TRICARE-eligible employee shall have the opportunity to elect to participate in the group health plan offered by the employer of the employee and receive primary coverage for health care services under the plan in the same manner and to the same extent as similarly situated employees of such employer who are not TRICARE-eligible employees.

(c) INAPPLICABILITY TO CERTAIN EMPLOYERS.—The provisions of this section do not apply to any employer who has fewer than 20 employees.

(d) RETENTION OF ELIGIBILITY FOR COVERAGE UNDER TRICARE.—Nothing in this section, including an election made by a TRICARE-eligible employee under subsection (b), shall be construed to affect, modify, or terminate the eligibility of a TRICARE-eligible employee or spouse of such employee for health care or dental services under this chapter in accordance with the other provisions of this chapter.

(e) OUTREACH.—The Secretary of Defense shall, in coordination with the other administering Secretaries, conduct outreach to inform covered beneficiaries who are entitled to health care benefits under the TRICARE program of the rights and responsibilities of such beneficiaries and employers under this section.

(f) DEFINITIONS.—In this section:

(1) The term ''employer'' includes a State or unit of local government.

(2) The term ''group health plan'' means a group health plan (as that term is defined in section 5000(b)(1) of the Internal Revenue Code of 1986 without regard to section 5000(d) of the Internal Revenue Code of 1986).

[1] See References in Text note below.