



Federal Register

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Part III

Department of Veterans Affairs

38 CFR Part 17

**Copayments for Inpatient Hospital Care
and Outpatient Medical Care, Copayments
for Medications; Interim and Final Rule**

DEPARTMENT OF VETERANS AFFAIRS**38 CFR Part 17**

RIN 2900-AK50

Copayments for Inpatient Hospital Care and Outpatient Medical Care**AGENCY:** Department of Veterans Affairs.**ACTION:** Interim and final rule.

SUMMARY: This document amends VA's medical regulations to set forth a mechanism for determining copayments for inpatient hospital care and outpatient medical care. This is necessary to implement provisions of the Veterans Millennium Health Care and Benefits Act and to set forth exemptions from copayment requirements as mandated by statute.

DATES: *Effective Date:* December 6, 2001.*Comment Date:* Comments must be received by VA on or before February 4, 2002.

ADDRESSES: Mail or hand-deliver written comments to: Director, Office of Regulations Management (02D), Department of Veterans Affairs, 810 Vermont Ave., NW., Room 1154, Washington, DC 20420; or fax comments to (202) 273-9289; or e-mail comments to *OGCRegulations@mail.va.gov*. Comments should indicate that they are submitted in response to "RIN 2900-AK50." All comments received will be available for public inspection in the Office of Regulations Management, Room 1158, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays).

FOR FURTHER INFORMATION CONTACT: Nancy L. Howard at (202) 273-8198, Revenue Office (174), Office of Finance, Veterans Health Administration, 810 Vermont Avenue, NW., Washington, DC 20420. (The telephone number is not a toll-free number.)

SUPPLEMENTARY INFORMATION: This document amends VA's medical regulations to set forth a mechanism for determining copayments for inpatient hospital care and outpatient medical care provided to veterans by VA. As explained below, a number of groups of veterans and services would be exempted from the copayment requirements.

The provisions of 38 U.S.C. 1710(a), (f), and (g) state that certain veterans are not eligible for inpatient hospital care or outpatient medical care provided by VA under 38 U.S.C. 1710(a) unless they agree to pay a copayment.

Inpatient Hospital Care

The rule restates provisions of 38 U.S.C. 1710(f), which state that the

copayment for inpatient hospital care during any 365-day period is the sum of:

(i) \$10 for every day the veteran

receives inpatient hospital care, and

(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

Outpatient Medical Care

Previously, the copayment amount for outpatient medical care was \$50.80.

This was based on statutory provisions that required the copayment to be "an amount equal to 20 percent of the estimated average cost (during the calendar year in which the services are furnished) of an outpatient visit in a * * * [VA] facility."

This statutory provision was changed by the Veterans Millennium Health Care and Benefits Act, Public Law 106-117, 113 Stat. 1545. VA now has authority to change the copayment amount to "the applicable amount or amounts established by the Secretary by regulation."

HR Report 106-237, July 16, 1999, which accompanied the Veterans Millennium Health Care and Benefits Act, indicates that the previous copayment for routine outpatient medical care is too high. The Committee noted, at pp. 43 and 44, that "[such copayments] may in many cases approach the full cost for the episode of treatment. Requiring so high a copayment for a routine, primary care visit appears to the Committee to be unreasonable. * * * The Committee recommends that the Secretary not set a single copayment amount, but consider practices within the health care industry to differentiate between primary care and specialty clinic visits."

Accordingly, based on the new statutory authority, we are establishing a copayment amount of \$15 for primary care visits and \$50 for specialty care visits. Further, as discussed below, we would not charge a copayment for certain services.

The \$50 copayment for specialty care visits is essentially the same as the current copayment. However, the \$15 copayment for primary care visits is more in line with copayment amounts charged in the private sector. A VHA copayment work group found that the mean copayment for primary care in HMOs is \$6.84, the mean copayment for mental health care in HMOs is \$15.32, and the mean copayment for emergency care in HMOs is \$28.91. The work group

also found that the most common copayment for all types of HMO care is \$10.00. TRICARE Prime copayments range from \$6 to \$12 for primary and specialty care, from \$6 to \$25 for mental health care, and \$10 to \$30 for emergency care.

A primary care outpatient visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

We believe these definitions of primary care and specialty care are consistent with the common understanding of these terms.

The rule provides that if a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copayment amount is the copayment for one primary care outpatient visit. The rule also provides that if a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copayment amount is the copayment for one specialty care outpatient visit. This is intended to encourage veterans to get as much care as they can get scheduled on the same day. Further, we believe that this will help veterans meet their appointments and, consequently, will help veterans obtain the care they need as quickly as possible.

Exceptions

As mandated by statutory authority, the rule provides that the following veterans are not subject to the

copayment requirements for inpatient hospital care or outpatient medical care:

- A veteran with a compensable service-connected disability;
- A veteran who is a former prisoner of war;
- A veteran awarded a Purple Heart;
- A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty;
- A veteran who receives disability compensation under 38 U.S.C. 1151;
- A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151;
- A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay;
- A veteran of the Mexican border period or of World War I;
- A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106-117, 113 Stat. 1545; and
- A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

Also, as mandated by statutory authority, the rule provides that veterans are not subject to the copayment requirements for inpatient hospital care or outpatient medical care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Gulf War veterans, or post-Gulf War combat-exposed veterans. Further, as mandated by statutory authority, the rule provides that care provided for a veteran's noncompensable zero percent service-connected disability is not subject to the copayment requirements for inpatient hospital care or outpatient medical care.

We have authority to impose a copayment for inpatient hospital care and outpatient medical services only if the care or services are provided under 38 U.S.C. 1710. Accordingly, the rule also exempts the following from the copayment requirements for inpatient hospital care and outpatient medical services because they are provided under authorities other than 38 U.S.C. 1710:

- Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service;

- Counseling and care for sexual trauma as authorized under 38 U.S.C. 1720D;

- Compensation and pension examinations requested by the Veterans Benefits Administration;
- Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303;
- Outpatient dental care provided under 38 U.S.C. 1712;
- Readjustment counseling and related mental health services authorized under 38 U.S.C. 1712A;
- Emergency treatment paid for under 38 U.S.C. 1725 or 1728;
- Extended care services authorized under 38 U.S.C. 1710B; and
- Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck.

The rule also exempts publicly announced VA public health initiatives (e.g., health fairs) or outpatient visits solely consisting of preventive screening and immunizations (e.g. influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening). These initiatives are viewed as cost-effective for health care in that they often provide early detection of irregularities or abnormalities that can be resolved without major intervention. Charging a copayment for these services would deter a veteran from obtaining these services. Also, these health care screenings often are provided at no charge to the patient in private health care settings.

The rule provides that laboratory services, flat film radiology services, and electrocardiograms are not subject to the copayment requirements. These services are considered to be a part of the initial provision of care and a separate copayment would not be charged.

The rule provides that outpatient care is not subject to the outpatient copayment requirements under this section when provided to a veteran during a day for which the veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract. We believe that this will encourage veterans to obtain outpatient care needed which should reduce medical problems for patients in a hospital, nursing home, or domiciliary.

Administrative Procedure Act

We have found good cause to dispense with the notice-and-comment and delayed effective date provisions of the Administrative Procedure Act (5 U.S.C. 553) because compliance with such provisions would be impracticable and contrary to the public interest. It is necessary to reduce primary care copayments for outpatient medical care as quickly as possible to encourage enrolled veterans to utilize VA primary outpatient care services, thereby helping to avoid potentially more costly specialty services.

Unfunded Mandates

The Unfunded Mandates Reform Act requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of \$100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501-3520).

OMB Review

This document has been reviewed by OMB under Executive Order 12866.

Regulatory Flexibility Act

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (RFA), 5 U.S.C. 601-612. This amendment would not directly affect any small entities. Only individuals could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers for the programs affected by this document are 64.005, 64.007, 64.008, 64.009, 64.010, 64.011, 64.012, 64.013, 64.014, 64.015, 64.016, 64.018, 64.019, 64.022, and 64.025.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government

contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and record-keeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: November 30, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is amended as set forth below:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. An undesignated center heading and § 17.108 are added to read as follows:

Copayments

§ 17.108 Copayments for inpatient hospital care and outpatient medical care.

(a) *General.* This section sets forth requirements regarding copayments for inpatient hospital care and outpatient medical care provided to veterans by VA.

(b) *Copayments for inpatient hospital care.* (1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2) of this section.

(2) The copayment for inpatient hospital care shall be, during any 365-day period, a copayment equaling the sum of:

(i) \$10 for every day the veteran receives inpatient hospital care, and
(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

Note to § 17.108(b): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10-10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(c) *Copayments for outpatient medical care.* (1) Except as provided in paragraphs (d), (e) or (f) of this section, a veteran, as a condition of receiving outpatient medical care provided by VA, must agree to pay VA (and is obligated to pay VA) a copayment as set forth in paragraph (c)(2) of this section.

(2) The copayment for outpatient medical care is \$15 for a primary care outpatient visit and \$50 for a specialty care outpatient visit. If a veteran has more than one primary care encounter on the same day and no specialty care encounter on that day, the copayment amount is the copayment for one primary care outpatient visit. If a veteran has one or more primary care encounters and one or more specialty care encounters on the same day, the copayment amount is the copayment for one specialty care outpatient visit.

(3) For purposes of this section, a primary care visit is an episode of care furnished in a clinic that provides integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal healthcare needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care includes, but is not limited to, diagnosis and management of acute and chronic biopsychosocial conditions, health promotion, disease prevention, overall care management, and patient and caregiver education. Each patient's identified primary care clinician delivers services in the context of a larger interdisciplinary primary care team. Patients have access to the primary care clinician and much of the primary care team without need of a referral. In contrast, specialty care is generally provided through referral. A specialty care outpatient visit is an episode of care furnished in a clinic that does not provide primary care, and is only provided through a referral. Some examples of specialty care provided at a specialty care clinic are radiology services requiring the immediate presence of a physician, audiology, optometry, magnetic resonance imagery (MRI), computerized axial tomography (CAT) scan, nuclear medicine studies, surgical consultative services, and ambulatory surgery.

Note to § 17.108(c): The requirement that a veteran agree to pay the copayment would be met by submitting to VA a signed VA Form 10-10EZ. This is the application form for enrollment in the VA healthcare system and also is the document used for providing means-test information annually.

(d) *Veterans not subject to copayment requirements for inpatient hospital care*

or outpatient medical care. The following veterans are not subject to the copayment requirements of this section:

(1) A veteran with a compensable service-connected disability;

(2) A veteran who is a former prisoner of war;

(3) A veteran awarded a Purple Heart;

(4) A veteran who was discharged or released from active military service for a disability incurred or aggravated in the line of duty;

(5) A veteran who receives disability compensation under 38 U.S.C. 1151;

(6) A veteran whose entitlement to disability compensation is suspended pursuant to 38 U.S.C. 1151, but only to the extent that the veteran's continuing eligibility for care is provided for in the judgment or settlement described in 38 U.S.C. 1151;

(7) A veteran whose entitlement to disability compensation is suspended because of the receipt of military retirement pay;

(8) A veteran of the Mexican border period or of World War I;

(9) A military retiree provided care under an interagency agreement as defined in section 113 of Public Law 106-117, 113 Stat. 1545; or

(10) A veteran who VA determines to be unable to defray the expenses of necessary care under 38 U.S.C. 1722(a).

(e) *Services not subject to copayment requirements for inpatient hospital care or outpatient medical care.* The following are not subject to the copayment requirements under this section:

(1) Care provided to a veteran for a noncompensable zero percent service-connected disability;

(2) Care authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Gulf War veterans, or post-Gulf War combat-exposed veterans;

(3) Special registry examinations (including any follow-up examinations or testing ordered as part of the special registry examination) offered by VA to evaluate possible health risks associated with military service;

(4) Counseling and care for sexual trauma as authorized under 38 U.S.C. 1720D;

(5) Compensation and pension examinations requested by the Veterans Benefits Administration;

(6) Care provided as part of a VA-approved research project authorized by 38 U.S.C. 7303;

(7) Outpatient dental care provided under 38 U.S.C. 1712;

(8) Readjustment counseling and related mental health services authorized under 38 U.S.C. 1712A;

(9) Emergency treatment paid for under 38 U.S.C. 1725 or 1728;

(10) Care or services authorized under 38 U.S.C. 1720E for certain veterans regarding cancer of the head or neck;

(11) Publicly announced VA public health initiatives (e.g., health fairs) or an outpatient visit solely consisting of preventive screening and immunizations (e.g. influenza immunization, pneumococcal immunization, hypertension screening, hepatitis C screening, tobacco screening, alcohol screening, hyperlipidemia screening, breast cancer screening, cervical cancer screening, screening for colorectal cancer by fecal occult blood testing, and education about the risks and benefits of prostate cancer screening); and

(12) Laboratory services, flat film radiology services, and electrocardiograms.

(f) *Additional care not subject to outpatient copayment.* Outpatient care is not subject to the outpatient copayment requirements under this section when provided to a veteran during a day for which the veteran is required to make a copayment for extended care services that were provided either directly by VA or obtained for VA by contract.

(Authority: 38 U.S.C. 1710)

[FR Doc. 01-30182 Filed 12-5-01; 8:45 am]

BILLING CODE 8320-01-P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900-AK85

Copayments for Medications

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends VA's medical regulations to set forth copayment requirements for medications. This is necessary to implement provisions of the Veterans Millennium Health Care and Benefits Act.

DATES: *Effective Date:* February 4, 2002.

FOR FURTHER INFORMATION CONTACT: Nancy L. Howard at (202) 273-8198, Revenue Office (174), Office of Finance, Veterans Health Administration, 810 Vermont Avenue NW., Washington, DC 20420. (This is not a toll-free telephone number).

SUPPLEMENTARY INFORMATION: In a document published in the **Federal Register** on July 16, 2001, we proposed to amend VA's medical regulations to set forth copayment requirements for medications provided to veterans by VA

(66 FR 36960). Interested persons were given 60 days to submit comments. We received over 1000 comments, almost all of which opposed all or portions of the proposal. Based on the rationale set forth in the proposed rule and this document, we are adopting the provisions of the proposed rule as a final rule.

A number of commenters asserted that VA should not charge any veteran a medication copayment. Other commenters asserted that VA should not charge veterans who had combat service a medication copayment. Other commenters asserted that military retirees should not be charged a medication copayment. Other commenters asserted that veterans who are service-connected should not be charged a medication copayment for any condition. No changes are made based on these comments. With certain statutory exceptions set forth in § 17.110(c) of this final rule, the provisions of 38 U.S.C. 1722A require veterans to pay a copayment for each 30-day or less supply of medication furnished on an outpatient basis. The applicable statutory provisions do not allow an exemption based merely on the fact that an individual is a veteran, that an individual was a combat veteran, or that a veteran is a military retiree. The provisions in the final rule concerning service-connection are also reflections of statutory requirements. The final rule exempts from the copayment requirements medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability. The final rule also exempts from the copayment requirements medication for a veteran's service-connected disability. However, VA has no authority to exempt from the medication copayments medication for a nonservice-connected condition of a veteran whose total service-connected disabilities are rated at less than 50%.

The vast majority of commenters opposed the proposal to increase the copayment amount from \$2 to \$7. Some asserted there should be no increase at all. Others asserted that the increase was just too great. Others asserted that the increase would cause them a financial hardship. Some of the commenters asserted that the Prescription Drug Component of the Medical Consumer Price Index should not be used to determine whether the copayment amount should be increased since this is typically greater than the overall inflation rate. A number of the commenters also asserted that the copayment increase also would cause the annual caps to be too high. A few

were in favor of the proposal. No changes are made based on these comments.

The copayment amount was set at \$2 in 1990 by 38 U.S.C. 1722A for each 30-day or less supply of medication and until now has never been changed. The Veterans Millennium Health Care and Benefits Act, Public Law 106-117, amended 38 U.S.C. 1722A authorizing VA to increase the copayment amount and to establish maximum annual copayment amounts. Clearly, the statutory intent was for VA to increase the copayment amount. In helping VA to determine the amount of the copayment, the House Conference Report (H. Rept. 106-237, July 16, 1999) specifically noted that the copayment for DOD's Tricare Prime Plan included a \$9 copayment for each 30-day prescription. Further, the House Conference Report indicated, at page 42, that "[a] survey of copayment trends in 1996-7 found the most common [prescription drug] copayment among members of the American Association of Health Plans * * * [to be] in the range of \$5 to \$10 per prescription." Also, as we stated in the proposal, we believe that the proposed \$7 medication copayment would be lower than or equal to most medication copayments charged by the private health care industry. Many recent newspaper articles have reported dramatic increases throughout the health care industry for medication copayment amounts which are reflective of increases in medication costs.

Accordingly, even with the increase we may have one of the lowest copayment amounts. Under these circumstances, we believe that a \$7 copayment amount is reasonable. Further, we believe that increases should be based on the Prescription Drug Component of the Medical Consumer Price Index since it is most relevant to the cost of prescriptions and thereby should be relevant to any general increases in medication copayments in the private sector.

Also, as we stated in the proposal, under 38 U.S.C. 1722A, VA may not require a veteran to pay an amount in excess of the actual cost of the medication and the pharmacy administrative costs related to the dispensing of the medication. VHA conducted a study of the pharmacy administrative costs relating to the dispensing of medication on an outpatient basis and found that VA incurred a cost of \$7.28 to dispense an outpatient medication even without consideration of the actual cost of the medication. This amount covers the cost of consultation time, filling time,

dispensing time, an appropriate share of the direct and indirect personnel costs, physical overhead and materials, and supply costs. Under these circumstances, we believe that a \$7 copayment would not exceed VA's costs.

A number of commenters asserted that the increase in the medication copayment would cause them a financial hardship, particularly in those cases when a veteran would obtain multiple prescriptions requiring multiple copayments. No changes are made based on these comments. The issue of financial hardship caused by copayments was addressed by statute. The text portion of this document restates statutory provisions by providing that certain veterans whose income is less than the VA pension level are exempt from the copayment requirements. Moreover, the final rule includes an annual cap to help eliminate financial hardships for veterans who in unusual circumstances need a significant number of prescriptions. Furthermore, VA has statutory authority under 38 U.S.C. 5302 to waive debts arising from a veteran's failure to pay the pharmacy copayment when collection of the debt would be against equity and good conscience. One factor VA uses in determining whether collection would be against equity and good conscience is whether it would cause undue hardship by depriving the veteran and his or her family of basic necessities.

One commenter asserted that the income threshold for requiring a medication copayment should be raised. No changes are made based on this comment. This reflects a statutory requirement and we have no authority to change the amount.

A number of commenters indicated that they would return to private-sector health care if the copayment were increased. Although some might choose not to obtain their medications from VA, as we indicated above, we believe that our copayment amount is still on the low end of the private-sector copayment scale.

A number of commenters asserted that VA should not charge copayments in those cases when VA is reimbursed by Medicare. No changes are made based on these comments. Medicare does not provide medication coverage and does not reimburse VA for medication costs.

One commenter suggested that the copayment amount should vary based on geographic location. No changes are made based on this comment. We do not believe that this would be administratively feasible.

One commenter suggested that we refrain from establishing a new copayment amount based on the conclusion that the copayment authority is scheduled to expire September 30, 2002. No changes are made based on this comment. We anticipate that a timely extension of the copayment authority will be enacted into law. If this does not occur we would delete the copayment provisions.

Compliance With the Congressional Review Act and Executive Order 12866

This rule is economically significant under Executive Order 12866 and constitutes a major rule under the Congressional Review Act. The rule is necessary to implement the provisions of section 201 of Public Law 106-117, The Veterans Millennium Health Care and Benefits Act. These provisions, which are set forth at 38 U.S.C. 1722A, authorize VA to set the copayment charge for medications.

I. Benefits Costs

This rule would directly impact veterans who receive prescriptions for other than service-connected conditions and who have been paying a \$2 copayment. Based on VA records for fiscal year 2000, we found that approximately 1.1 million veterans averaged 47 30-day supply prescriptions per year. VA collected \$101 million in fiscal year 2000 as copayments. This rule would increase the copayment from the current \$2 level to \$7. We do not believe the increase in the copayment amount will have an impact upon utilization. It is anticipated that the same number of veterans will continue to receive the same average number of prescriptions generating an increase in collections of \$250 million annually.

II. Administrative Costs

The estimated administrative cost for these increased collections would remain the same at the current collection expense of \$17 million. This is based upon an average cost of a GS-5 at \$12/hour x 8.2 million bills per year at the average rate of 10.3 minutes per bill.

III. Alternatives

In addition to alternatives discussed above, VA considered establishing higher and lower copayment and cap amounts and considered whether or not to have escalator provisions. However, for the reasons discussed above, we believe that the copayment and cap amounts, and the escalator provisions, are appropriate.

Paperwork Reduction Act

This document contains no provisions constituting a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501-3520).

Unfunded Mandates

The Unfunded Mandates Reform Act requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits before developing any rule that may result in an expenditure by State, local, or tribal governments, in the aggregate, or by the private sector of \$100 million or more in any given year. This rule would have no consequential effect on State, local, or tribal governments.

OMB Review

This rule is economically significant under Executive Order 12866 and major under the Congressional Review Act. This rule has been reviewed by OMB.

Regulatory Flexibility Act

The Secretary hereby certifies that this regulatory amendment will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act (RFA), 5 U.S.C. 601-612. This amendment would not directly affect any small entities. Only individuals could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers for the programs affected by this document are 64.005, 64.007, 64.008, 64.009, 64.010, 64.011, 64.012, 64.013, 64.014, 64.015, 64.016, 64.018, 64.019, 64.022, and 64.025.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Foreign relations, Government contracts, Grant programs-health, Grant programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Philippines, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Approved: November 30, 2001.

Anthony J. Principi,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, 38 CFR part 17 is amended as set forth below:

PART 17—MEDICAL

1. The authority citation for part 17 continues to read as follows:

Authority: 38 U.S.C. 501, 1721, unless otherwise noted.

2. Section 17.110 is added under the undesignated center heading COPAYMENTS to read as follows:

§ 17.110 Copayments for medication.

(a) *General.* This section sets forth requirements regarding copayments for medications provided to veterans by VA.

(b) *Copayments.* (1) Unless exempted under paragraph (c) of this section, a veteran is obligated to pay VA a copayment for each 30-day or less supply of medication provided by VA on an outpatient basis (other than medication administered during treatment). For the period from February 4, 2002 through December 31, 2002, the copayment amount is \$7. The copayment amount for each calendar year thereafter will be established by using the Prescription Drug component

of the Medical Consumer Price Index as follows: For each calendar year beginning after December 31, 2002, the Index as of the previous September 30 will be divided by the Index as of September 30, 2001. The ratio so obtained will be multiplied by the original copayment amount of \$7. The copayment amount for the new calendar year will be this result, rounded down to the whole dollar amount.

Note to Paragraph (b)(1): Example for determining copayment amount. If the ratio of the Prescription Drug component of the Medical Consumer Price Index for September 30, 2003, to the corresponding Index for September 30, 2001, is 1.2242, then this ratio multiplied by the original copayment amount of \$7 would equal \$8.57, and the copayment amount for calendar year 2004, rounded down to the whole dollar amount, would be \$8.

(2) The total amount of copayments in a calendar year for a veteran enrolled in one of the priority categories 2 through 6 of VA's health care system (see § 17.36) shall not exceed the cap established for the calendar year. The cap for calendar year 2002 is \$840. If the copayment amount increases after calendar year 2002, the cap of \$840 shall be increased by \$120 for each \$1 increase in the copayment amount.

(c) *Medication not subject to the copayment requirements.* The following

are exempt from the copayment requirements of this section:

(1) Medication for a veteran who has a service-connected disability rated 50% or more based on a service-connected disability or unemployability;

(2) Medication for a veteran's service-connected disability;

(3) Medication for a veteran whose annual income (as determined under 38 U.S.C. 1503) does not exceed the maximum annual rate of VA pension which would be payable to such veteran if such veteran were eligible for pension under 38 U.S.C. 1521;

(4) Medication authorized under 38 U.S.C. 1710(e) for Vietnam-era herbicide-exposed veterans, radiation-exposed veterans, Persian Gulf War veterans, or post-Persian Gulf War combat-exposed veterans;

(5) Medication for treatment of sexual trauma as authorized under 38 U.S.C. 1720D;

(6) Medication for treatment of cancer of the head or neck authorized under 38 U.S.C. 1720E; and

(7) Medications provided as part of a VA approved research project authorized by 38 U.S.C. 7303.

(Authority: 38 U.S.C. 501, 1710, 1720D, 1722A)

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