D. 103.19—Reports by Brokers or Dealers in Securities of Suspicious Transactions

Section 103.19 instructs broker and dealers in securities to report suspicious transactions using a ''Suspicious Activity Report—Brokers or Dealers in Securities'' (SAR–BD) form. Because the name of the form has been changed to ''Suspicious Activity Report by the Securities and Futures Industries'' (SAR–SF), section 103.19 is being amended to reflect the new name of the form.

IV. Regulatory Flexibility Act

FinCEN certifies that this final regulation will not have a significant economic impact on a substantial number of small entities. The average currency exchange is approximately $300, an amount which is substantially below the $2,000 threshold that triggers reporting under the amendments to 31 CFR 103.20. Thus, FinCEN believes the rule will not have a significant economic burden on small entities.

V. Executive Order 12866

The Department of the Treasury has determined that this final rule is not a significant regulatory action under Executive Order 12866.

VI. Paperwork Reduction Act

The collection of information contained in this final regulation has been approved by the Office of Management and Budget (''OMB'') in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3507(d)) under control number 1506–0015. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by OMB.

The collection of information in this final rule is in 31 CFR 103.20(b)(3) and (c). This information is required to be provided pursuant to 31 U.S.C. 5318(g) and 31 CFR 103.20. This information will be used by law enforcement agencies in the enforcement of criminal and regulatory laws. The collection of information is mandatory. The likely recordkeepers are businesses.

The estimated average recordkeeping burden associated with the collection of information in this final rule is 20 minutes per recordkeeper. The burden estimate relates to the recordkeeping requirement contained in the final rule. The reporting burden of 31 CFR 103.20 will be reflected in the burden of the SAR–MSB form. FinCEN anticipates that the final rule will result in an annual filing of a total of 3,100 SAR–MSB forms. This result is an estimate, based on a projection of the size and volume of the industry.

Comments concerning the accuracy of this burden estimate should be directed to the Financial Crimes Enforcement Network, Department of the Treasury, Post Office Box 39, Vienna, VA 22183, and to the Office of Management and Budget, Attn: Joseph F. Lackey, Jr., Office of Information and Regulatory Affairs, Office of Management and Budget, New Executive Office Building, Room 3208, Washington, DC 20503.

List of Subjects in 31 CFR Part 103

Authority delegations (Government agencies), Banks and banking, Currency, Investigations, Law enforcement, Reporting and recordkeeping requirements.

Amendments to the Regulations

For the reasons set forth above in the preamble, 31 CFR Part 103 is amended as follows:

PART 103—FINANCIAL RECORDKEEPING AND REPORTING OF CURRENCY AND FOREIGN TRANSACTIONS

1. The authority citation for part 103 continues to read as follows:

Authority: 12 U.S.C. 1829b and 1951–1959; 31 U.S.C. 5311–-314, 5316–5332; title III, secs. 314, 352, Pub. L. 107–56, 115 Stat. 307.

2. In Subpart B, amend §§ 103.19(b)(1), (b)(2), (b)(3), (c)(1), (d), and (e) by removing the word ''SAR–BD'' each place it occurs and adding in its place the word ''SAR–S–F.''

3. In Subpart B, amend § 103.20 as follows:

a. Revise the first sentence of paragraph (a)(1),

b. Add new paragraph (a)(2)(iv), and

c. Add a new sentence to the end of paragraph (b)(3).

The additions and revisions read as follows:

§ 103.20 Reports by money services businesses of suspicious transactions.

(a) *General.* (1) Every money services business, described in § 103.11(uu) (1), (3), (4), (5), or (6), shall file with the Treasury Department, to the extent and in the manner required by this section, a report of any suspicious transaction relevant to a possible violation of law or regulation. * * *

(2) * * *

(iv) Involves use of the money services business to facilitate criminal activity.

* * * * *

(b) * * *

(3) * * * Money services businesses wishing voluntarily to report suspicious transactions that may relate to terrorist activity may call FinCEN's Financial Institutions Hotline at 1–866–556–3974 in addition to filing timely a SAR–MSB if required by this section.

* * * * *

Dated: January 31, 2003.

James F. Sloan,

Director, Financial Crimes Enforcement Network.

[FR Doc. 03–3112 Filed 2–7–03; 8:45 am]

BILLING CODE 4810–02–P

DEPARTMENT OF DEFENSE

Office of the Secretary

32 CFR Part 199

RIN–0720–AA52

TRICARE Program; Double Coverage; Third-Party Recoveries

AGENCY: Office of the Secretary, DoD.

ACTION: Final rule.

SUMMARY: This final rule implements section 711 of the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999, as amended by section 716(c)(2) of the National Defense Authorization Act for Fiscal Year 2000, which allows the Secretary of Defense to authorize certain TRICARE claims to be paid, even though other health insurance may be primary payer, with authority to collect from the other health insurance (third-party payer) the TRICARE costs incurred on behalf of the beneficiary.

DATES: This final rule is effective March 12, 2003.

ADDRESSES: TRICARE Management Activity (TMA), Office of General Counsel, 16401 East Centretech Parkway, Aurora, CO 80011–9043.

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

SUPPLEMENTARY INFORMATION:

I. Summary of Final Rule Provisions

This final rule changes the TRICARE ''double coverage'' provisions authorizing payment of claims when a third-party payer, other than a primary medical insurer, is involved rather than delaying TRICARE payments pending payment by the third-party payer. In addition, this final rule changes the TRICARE ''third-party recoveries'' provisions incorporating the authority to collect from third-party payers the TRICARE costs for health care services incurred on behalf of the patient/

beneficiary. The radar should refer to the proposed rule that was published on October 19, 1999 (64 FR 56283), for more detailed information regarding these changes.

II. Public Comments

We provided a 60-day comment period on the proposed rule. We received no public comments.

III. Changes in the Final Rule

We have made changes in the final rule based on section 716 of the National Defense Authorization Act for Fiscal Year 2000, Pub. L. 106–65, which was passed subsequent to preparation of the proposed rule. We have removed paragraph (c)(2)(iii) of Section 199.8 as originally set forth in the proposed rule. The essence of this change is to remove the proposed requirement for contractors to assign the government any rights to seek recovery from third-party payers. Based on the section 716 of the National Defense Authorization Act for Fiscal Year 2000, it is clear that the government, rather than the contractor, has the authority to collect amounts paid on behalf of TRICARE beneficiaries for which there is a liable third party.

Based on Section 8118 of the Fiscal Year 2000 Department of Defense Appropriations Act, we also have eliminated the change to paragraph (d)(2) of Section 199.8 established Medicaid as primary payer to TRICARE under the case management program that is set out in Part 199.4(i). As a result, TRICARE will continue to be primary to Medicaid in all situations including case management.

IV. Regulatory Procedures

Executive Order (EO) 12866 requires that a comprehensive regulatory impact analysis be performed on any economically significant regulatory action, defined as one that would result in an annual effect of $100 million or more on the national economy or which would have other substantial impacts.

The Regulatory Flexibility Act (RFA) requires that each Federal agency prepare, and make available for public comment, a regulatory flexibility analysis when the agency issues a regulation that would have a significant impact on a substantial number of small entities.

This rule has been designated as significant rule and has been reviewed by the Office of Management and Budget as required under the provisions of E.O. 12866. In addition, we certify that this final rule will not significantly affect a substantial number of small entities.

Paperwork Reduction Act.

This final rule, as written, imposes no burden as defined by the Paperwork Reduction Act of 1995. If, however, any program implemented under this final rule causes such a burden to be imposed, approval will be sought of the Office of Management and Budget in accordance with the Act prior to implementation.

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 adding new definitions *automobile liability insurance, no-fault insurance,* and *third-party payer* in alphabetical order:

§ 199.2 Definitions.

* * * * *

Automobile liability insurance. Automobile liability insurance means insurance against legal liability for health and medical expenses resulting from personal injuries arising from operation of a motor vehicle. Automobile liability insurance includes:

(1) Circumstances in which liability benefits are paid to an injured party only when the insured party's tortious acts are the cause of the injuries; and

(2) Uninsured and underinsured coverage, in which there is a third-party tortfeasor who caused the injuries (i.e., benefits are not paid on a no-fault basis), but the insured party is not the tortfeasor.

* * * * *

No-fault insurance. No-fault insurance means an insurance contract providing compensation for health and medical expenses relating to personal injury arising from the operation of a motor vehicle in which the compensation is not premised on whom may have been responsible for causing such injury. No-fault insurance includes personal injury protection and medical payments benefits in cases involving personal injuries resulting from operation of a motor vehicle.

* * * * *

Third-party payer. Third-payer means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a worker's compensation program or plan, and any other plan or program (*e.g.,* homeowners insurance) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For purposes of the definition of ''third-party payer,'' an insurance, medical service, or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

Note: TRICARE is secondary payer to all third-party payers. Under limited circumstances described in § 199.8(c)(2) of this part, TRICARE payment may be authorized to be paid in advance of adjudication of the claim by certain third-party payers. TRICARE advance payments will not be made when a third-party provider is determined to be a primary medical insurer under § 199.8(c)(3) of this part.''

* * * * *

3. Section 199.8 is amended by revising paragraphs (a), (c)(1), and (d)(3), redesignating paragraphs (b)(3), (c)(2) and (c)(3) as paragraphs (b)(4), (c)(4) and (c)(5), respectively, and adding new paragraphs (b)(3), (c)(2), and (c)(3) to read as follows:

§ 199.8 Double coverage.

(a) *Introduction.* (1) In enacting TRICARE legislation, Congress clearly has intended that TRICARE be the secondary payer to all health benefit, insurance and third-party payer plans. 10 U.S.C. 1079(j)(1) specifically provides that a benefit may not be paid under a plan (CHAMPUS) covered by this section in the case of a person enrolled in, or covered by, any other insurance, medical service, or health plan, including any plan offered by a third-party payer (as defined in 10 U.S.C. 1095(h)(1)) to the extent that the benefit is also a benefit under the other plan, except in the case of a plan administered under title XIX of the Social Security Act (42 U.S.C. 1396 *et seq.*).

(2) The provision in paragraph (a)(1) of this section is made applicable specifically to retired members, dependents, and survivors by 10 U.S.C. 1086(g). The underlying intent, in addition to preventing waste of Federal resources, is to ensure that TRICARE beneficiaries receive maximum benefits while ensuring that the combined payments of TRICARE and other health and insurance plans do not exceed the total charges.

* * * * *

(b) * * *

(3) *Third-party payer.* A third-party payer means an entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no-fault insurance carrier and a workers' compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies. For purposes of the definition of ''third-party payer,'' an insurance, medical service or health plan includes a preferred provider organization, an insurance plan described as Medicare supplemental insurance, and a personal injury protection plan or medical payments benefit plan for personal injuries resulting from the operation of a motor vehicle.

* * * * *

(c) * * *

(1) *TRICARE last pay.* For any claim that involves a double coverage plan as defined in paragraph (b) of this section, TRICARE shall be last pay *except* as may be authorized by the Director, TRICARE Management Activity, or a designee, pursuant to paragraph (c)(2) of this section. That is, TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.

(2) *TRICARE advance payment.* The Director, TRICARE Management Activity, or a designee, may authorize payment of a claim in advance of adjudication of the claim by a double coverage plan and recover, under § 199.12, the TRICARE costs of health care incurred on behalf of the covered beneficiary under the following conditions:

(i) The claim is submitted for health care services furnished to a covered beneficiary; and,

(ii) The claim is identified as involving services for which a third-party payer, other than a primary medical insurer, may be liable.

(3) *Primary medical insurer.* For purposes of paragraph (c)(2) of this section, a ''primary medical insurer'' is an insurance plan, medical service or health plan, or a third-party payer under this section, the primary or sole purpose of which is to provide or pay for health care services, supplies, or equipment. The term ''primary medical insurer'' does not include automobile liability insurance, no-fault insurance, workers' compensation program or plan, homeowners insurance, or any other similar third-party payer as may be designated by the Director, TRICARE Management Activity, or a designee, in any policy guidance or instructions issued in implementation of this Part.

* * * * *

(d) * * *

(3) *TRICARE and Workers' Compensation.* TRICARE benefits are not payable for a work-related illness or injury that is covered under a workers' compensation program. Pursuant to paragraph (c)(2) of this section, however, the Director, TRICARE Management Activity, or a designee, may authorize payment of a claim involving a work-related illness or injury covered under a workers' compensation program in advance of adjudication and payment of the workers' compensation claim and then recover, under § 199.12, the TRICARE costs of health care incurred on behalf of the covered beneficiary.

* * * * *

4. Section 199.12 is revised as follows:

§ 199.12 Third party recoveries.

(a) *General.* This section deals with the right of the United States to recover from third-parties the costs of medical care furnished to or paid on behalf of TRICARE beneficiaries. These third-parties may be individuals or entities that are liable for tort damages to the injured TRICARE beneficiary or a liability insurance carrier covering the individual or entity. These third-parties may also include other entities who are primarily responsible to pay for the medical care provided to the injured beneficiary by reason of an insurance policy, workers' compensation program or other source of primary payment.

Authority. (1) *Third-party payers.* This part implements the provisions of 10 U.S.C. 1095b which, in general, allow the Secretary of Defense to authorize certain TRICARE claims to be paid, even though a third-party payer may be primary payer, with authority to collect from the third-party payer the TRICARE costs incurred on behalf of the beneficiary. (See § 199.2 for definition of ''third-party payer.'') Therefore, 10 U.S.C. 1095b establishes the statutory obligation of third-party payers to reimburse the United States the costs incurred on behalf of TRICARE beneficiaries who are also covered by the third-party payer's plan.

(2) *Federal Medical Care Recovery Act.* (i) *In general.* In many cases covered by this section, the United States has a right to collect under both 10 U.S.C. 1095b and the Federal Medical Care Recovery Act (FMCRA), Public Law 87–693 (42 U.S.C. 2651 *et. seq.*). In such cases, the authority is concurrent and the United States may pursue collection under both statutory authorities.

(ii) *Cases involving tort liability.* In cases in which the right of the United States to collect from an automobile liability insurance carrier is premised on establishing some tort liability on some third person, matters regarding the determination of such tort liability shall be governed by the same substantive standards as would be applied under the FMCRA including reliance on state law for determinations regarding tort liability. In addition, the provisions of 28 CFR part 43 (Department of Justice regulations pertaining to the FMCRA) shall apply to claims made under the concurrent authority of the FMCRA and 10 U.S.C. 1095b. All other matters and procedures concerning the right of the United States to collect shall, if a claim is made under the concurrent authority of the FMCRA and this section, be governed by 10 U.S.C. 1095b and this part.

(c) *Appealability.* This section describes the procedures to be followed in the assertion and collection of third-party recovery claims in favor of the United States arising from the operation of TRICARE. Actions taken under this section are not initial determinations for the purpose of the appeal procedures of § 199.10 of this part. However, the proper exercise of the right to appeal benefit or provider status determinations under the procedures set forth in § 199.10 may affect the processing of federal claims arising under this section. Those appeal procedures afford a TRICARE beneficiary or participating provider an opportunity for administrative appellate review in cases in which benefits have been denied and in which there is a significant factual dispute. For example, a TRICARE contractor may deny payment for services that are determined to be excluded as TRICARE benefits because they are found to be not medically necessary. In that event the TRICARE contractor will offer an administrative appeal as provided in § 199.10 of this part on the medical necessity issue raised by the adverse benefit determination. If the care in question results from an accidental injury and if the appeal results in a reversal of the initial determination to deny the benefit, a third-party recovery claim may arise as a result of the appeal decision to pay the benefit. However, in no case is the decision to initiate such a claim itself appealable under § 199.10.

(d) *Statutory obligation of third-party payer to pay.* (1) *Basic Rule.* Pursuant to 10 U.S.C. 1095b, when the Secretary of Defense authorizes certain TRICARE

claims to be paid, even though a third-party payer may be primary payer (as specified under § 199.8(c)(2)), the right to collect from a third-party payer the TRICARE costs incurred on behalf of the beneficiary is the same as exists for the United States to collect from third-party payers the cost of care provided by a facility of the uniformed services under 10 U.S.C. 1095 and part 220 of this title. Therefore the obligation of a third-party payer to pay is to the same extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) *Application of cost shares.* If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third-party payer is the cost of care incurred on behalf of the beneficiary less the appropriate deductible or copayment amount.

(3) *Claim from the United States exclusive.* The only way for a third-party payer to satisfy its obligation under 10 U.S.C. 1095b is to pay the United States or authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy 10 U.S.C. 1095b.

(4) *Assignment of benefits not necessary.* The obligation of the third-party to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States.

(e) *Exclusions impermissible.* (1) *Statutory requirement.* With the same right to collect from third-party payers as exists under 10 U.S.C. 1095(b), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided or paid by the United States shall operate to prevent collection by the United States.

(2) *Regulatory application.* No provision of any third-party payer's plan or program purporting to have the effect of excluding or limiting payment for certain care that would not be given such effect under the standards established in part 220 of this title to implement 10 U.S.C. 1095 shall operate to exclude or limit payment under 10 U.S.C. 1095b or this section.

(f) *Records available.* When requested, TRICARE contractors or other representatives of the United States shall make available to representatives of any third-party payer from which the United States seeks payment under 10 U.S.C. 1095b, for inspection and review, appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the TRICARE costs incurred on behalf of beneficiaries which are the subject of the claims for payment under 10 U.S.C. 1095b were incurred as claimed and the health care service were provided in a manner consistent with permissible terms and conditions of the third-party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

(g) *Remedies.* Pursuant to 10 U.S.C. 1095b, when the Director, TRICARE Management Activity, or a designee, authorizes certain TRICARE claims to be paid, even though a third-party payer may be primary payer, the right to collect from a third-party payer the TRICARE costs incurred on behalf of the beneficiary is the same as exists for the United States to collect from third-party payers the cost of care provided by a facility of the uniformed services under 10 U.S.C. 1095.

(1) This includes the authority under 10 U.S.C. 1095(e)(1) for the United States to institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 10 u.S.C. 1095b and this section.

(2) This also includes the authority under 10 u.S.C. 1095(e)(2) for an authorized representative of the United States to compromise, settle or waive a claim of the United States under 10 U.S.C. 1095b and this section.

(3) The authorities provided by the Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et. seq.*) and any implementing regulations (including § 199.11) regarding collection of indebtedness due the United States shall also be available to effect collections pursuant to 10 U.S.C. 1095b and this section.

(h) *Obligations of beneficiaries.* To insure the expeditious and efficient processing of third-party payer claims, any person furnished care and treatment under TRICARE, his or her guardian, personal representative, counsel, estate, dependents or survivors shall be required:

(1) To provide information regarding coverage by a third-party payer plan and/or the circumstances surrounding an injury to the patient as a conditional precedent of the processing of a TRICARE claim involving possible third-party payer coverage.

(2) To furnish such additional information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment are being given and concerning any action instituted or to be instituted by or against a third person; and,

(3) To cooperate in the prosecution of all claims and actions by the United States against such third person.

(i) *Reponsibility for recovery.* The Director, TRICARE Management Activity, or a designee, is responsible for insuring that TRICARE claims arising under 10 U.S.C. 1095b and this section (including claims involving the FMCRA) are properly referred to and coordinated with designated claims authorities of the uniformed services who shall assert and recover TRICARE costs incurred on behalf of beneficiaries. Generally, claims arising under this section will be processed as follows:

(1) *Identification and referral.* In most cases where civilian providers provide medical care and payment for such care has been by a TRICARE contractor, initial identification of potential third-party payers will be by the TRICARE contractor. In such cases, the TRICARE contractor is responsible for conducting a preliminary investigation and referring the case to designated appropriate claims authorities of the Uniformed Services.

(2) *Processing TRICARE claims.* When the TRICARE contractor initially identifies a claim as involving a potential third-party payer, it shall request additional information concerning the circumstances of the injury or disease and/or the identify of any potential third-party payer from the beneficiary or other responsible party unless adequate information is submitted with the claim. The TRICARE claim will be suspended and no payment issued pending receipt of the requested information. If the requested information is not received, the claim will be denied. A TRICARE beneficiary may expedite the processing of his or her TRICARE claim by submitting appropriate information with the first claim for treatment of an accidental injury. Third-party payer information normally is required only once concerning any single accidental injury on episode of care. Once the third-party payer information pertaining to a single incident or episode of care is received, subsequent claims associated with the same incident or episode of care may be processed to payment in the usual manner. If, however, the requested third-party payer information is not received, subsequent claims involving the same incident or episode of care will be suspended or denied as stated above.

(3) *Ascertaining total potential liability.* It is essential that the appropriate claims responsible for

asserting the claim against the third-party payer recive from the TRICARE contractor a report of all amounts expended by the United States for care resulting from the incident upon which potential liability in the third party is based (including amounts paid by TRICARE for both inpatient and outpatient care). Prior to assertion and final settlement of a claim, it will be necessary for the responsible claims authority to secure from the TRICARE contractor updated information to insure that all amounts expended under TRICARE are included in the government's claim. It is equally important that information on future medical payments be obtained through the investigative process and included as a part of the government's claim. No TRICARE-related claim will be settled, compromised or waived without full consideration being given to the possible future medical payment aspects of the individual case.

(j) *Reporting requirements.* Pursuant to 10 U.S.C. 1079a, all refunds and other amounts collected in the administration of TRICARE shall be credited to the appropriation available for that program for the fiscal year in which the refund or amount is collected. Therefore, the Department of Defense requires an annual report stating the number and dollar amount of claims asserted against, and the number and dollar amount of recoveries from third-party payers (including FMCRA recoveries) arising from the operation of the TRICARE. To facilitate the preparation of this report and to maintain program integrity, the following reporting requirements are established:

(1) *TRICARE contractors.* Each TRICARE contractor shall submit on or before January 31 of each year an annual report to the Director, TRICARE Management Activity, or a designee, covering the 12 months of the previous calendar year. This report shall contain, as a minimum, the number and total dollar of cases of potential third-party payer/FMCRA liability referred to uniformed services claims authorities for further investigation and collection. These figures are to be itemized by the states and uniformed services to which the cases are referred.

(2) *Uniformed Services.* Each uniformed service will submit to the Director, TRICARE Management Activity, or designee, an annual report covering the 12 calendar months of the previous year, setting forth, as a minimum, the number and total dollar amount of cases involving TRICARE payments received from TRICARE contractors, the number and dollar amount of cases involving TRICARE payments received from other sources, and the number and dollar amount of claims actually asserted against, and the dollar amount of recoveries from, third-payment payers or under the FMCRA. The report, itemized by state and foreign claims jurisdictions, shall be provided no later than February 28 of each year.

(3) *Implementation of the reporting requirements.* The Director, TRICARE Management Activity, or a designee shall issue guidance for implementation of the reporting requirements prescribed by this section.

Dated: February 4, 2003.

L.M. Bynum,

Alternate OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 03–3159 Filed 2–7–03; 8:45 am]

BILLING CODE 5001–08–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD07–03–018]

Drawbridge Operation Regulations; Ashley River, Charleston, SC

AGENCY: Coast Guard, DOT.

ACTION: Notice of temporary deviation from regulations.

SUMMARY: The Commander, Seventh Coast Guard District, has approved a temporary deviation from the regulations governing the operation of the Ashley River (US 17) drawbridges across the Ashley River, miles 2.4 and 2.5, Charleston, South Carolina. This temporary deviation allows the bridge owner or operator to keep all spans of the Ashley River drawbridges in the down or closed position for 16 days.

DATES: This temporary rule is effective from 7 a.m. on January 31, 2003 to 7 a.m. on February 15, 2003.

ADDRESSES: Material received from the public as well as documents indicated in this preamble as being available in the docket are part of docket [CGD07–03–018] and are available for inspection or copying at Commander (obr), Seventh Coast Guard District, Room 432, 909 S.E. 1st Avenue, Miami, Florida 33131–3050, between 7:30 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. Michael Lieberum, Project Manager, Seventh Coast Guard District, Bridge Branch at (305) 415–6744.

SUPPLEMENTARY INFORMATION: The Ashley River (US 17) drawbridges across the Ashley River, miles 2.4 and 2.5 are double bascule leaf bridges, with vertical clearances of 14.0 feet at mean high water and horizontal clearances of 100 feet between fenders. The existing operating regulation in 33 CFR 117.915 requires the bridges to open on signal; except that, from 7 a.m. to 9 a.m. Monday through Friday and 4 p.m. to 7 p.m. daily, the draws need be opened only if at least 12 hours notice is given. The draws of either bridge shall open as soon as possible for the passage of vessels in an emergency involving danger to life or property.

On December 30, 2002, The Industrial Company (TLC), representing the South Carolina Department of Transportation, requested a temporary change to the operation of the Ashley River (US 17) drawbridges to allow them to complete the rehabilitation to the structure.

This deviation will have a limited impact on navigation as there is only one marina west of the structure and they have been notified by the contractor of the possible closure of the structure. Mariners have the opportunity to relocate the vessels that would require a bridge opening to one of the marinas located east of the structure.

The Commander, Seventh Coast Guard District has granted a temporary deviation from the operating requirements listed in 33 CFR 117.915 to allow The Industrial Company, representing the owner, to facilitate repairs to the bridge spans. Under this temporary deviation, the Ashley River drawbridges may remain closed to navigation from 7 a.m. on January 31, 2003, to 7 a.m. on February 15, 2003.

Dated: January 29, 2003.

Greg Shapley,

Chief, Bridge Administration, Seventh Coast Guard District.

[FR Doc. 03–3264 Filed 2–7–03; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 19

RIN 2900–AK62

Appeals Regulations: Title for Members of the Board of Veterans' Appeals

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This document amends the Department of Veterans Affairs' (VA) Appeals Regulations to provide that a Member of the Board of Veterans'