

facility and VA's CRC program. In order to reach the above determinations, the VA safety expert may request supporting documentation from the CRC facility. VA believes supplying this information will constitute an inconsequential amount of the operational cost for those CRC facilities. VA believes that, at most, only a few CRC facilities would qualify for a waiver. On this basis, the Secretary certifies that the adoption of this interim final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a "significant regulatory action" requiring review by the Office of Management and Budget (OMB), unless OMB waives such review, as "any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order."

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant

regulatory action under Executive Order 12866.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; and 64.022, Veterans Home Based Primary Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of Veterans Affairs. Jose D. Riojas, Interim Chief of Staff, approved this document on May 8, 2013, for publication.

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, Government programs—veterans, Health care, Health facilities, Health professions, Health records, Homeless, Medical and dental schools, Medical devices, Medical research, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Scholarships and fellowships, Travel and transportation expenses, Veterans.

Dated: May 22, 2013.

William F. Russo,

Deputy Director, Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, VA amends 38 CFR part 17 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, and as noted in specific sections.

■ 2. Section 17.65 is amended by adding paragraph (d) to read as follows:

§ 17.65 Approvals and provisional approvals of community residential care facilities.

* * * * *

(d)(1) VA may waive one or more of the standards in 38 CFR 17.63 for the approval of a particular community

residential care facility, provided that a VA safety expert certifies that the deficiency does not endanger the life or safety of the residents; the deficiency cannot be corrected as provided in paragraph (b) of this section for provisional approval of the community residential care facility; and granting the waiver is in the best interests of the veteran in the facility and VA's community residential care program. In order to reach the above determinations, the VA safety expert may request supporting documentation from the community residential care facility.

(2) In those instances where a waiver is granted, the subject standard is deemed to have been met for purposes of approval of the community residential care facility under paragraphs (a) or (b) of this section. The waiver and date of issuance will be noted on each annual survey of the facility as long as the waiver remains valid and in place.

(3) A waiver issued under this section remains valid so long as the community residential care facility operates continuously under this program without a break. VA may, on the recommendation of an approving official, rescind a waiver issued under this section if a VA inspector determines that there has been a change in circumstances and that the deficiency can now be corrected, or a VA safety expert finds that the deficiency jeopardizes the health and safety of residents.

* * * * *

■ 3. Section 17.66, paragraph (c) is amended by removing "\$ 17.51n" and adding, in its place, "\$ 17.67".

[FR Doc. 2013-12641 Filed 5-28-13; 8:45 am]

BILLING CODE 8320-01-P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900-AN99

VA Dental Insurance Program

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: The Department of Veterans Affairs (VA) amends its regulations to establish rules and procedures for the VA Dental Insurance Program (VADIP), a pilot program that offers premium-based dental insurance to enrolled veterans and certain survivors and dependents of veterans. Under the pilot program, VA will contract with a private insurer, through the Federal contracting

process, to offer dental insurance to eligible individuals. The private insurer will be responsible for the administration of the dental insurance plan. VA will form the contract and verify the eligibility of individuals who apply for the private dental insurance.

DATES: This rule is effective June 28, 2013.

FOR FURTHER INFORMATION CONTACT:

Kristin Cunningham, Director, Business Policy, Chief Business Office (10NB), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420, (202) 461-1599. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: On March 1, 2012, VA published in the **Federal Register** (77 FR 12517) a proposed rule to amend VA regulations to establish VADIP, a pilot program that would offer premium-based dental insurance to enrolled veterans and certain survivors and dependents of veterans. Section 510 of title V of the Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163 (2010), requires VA to carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans and survivors and dependents of veterans. To comply with section 510(a), VA will contract with a private dental insurer to offer dental insurance coverage to the individuals identified in section 510(b), specifically veterans enrolled in VA's system of annual enrollment under 38 U.S.C. 1705, and survivors and dependents of veterans who are eligible for medical care under 38 U.S.C. 1781. This final rule establishes rules and procedures for VADIP, in accordance with section 510(k), which requires VA to prescribe regulations.

Interested persons were invited to submit comments to the proposed rule on or before April 30, 2012, and we received 28 comments. Many of the comments were supportive of VADIP, and did not suggest changes to the proposed rule. For the remaining comments, we have organized the discussion below accordingly.

Comments That Compared VADIP Insurance With VA Dental Benefits

Certain commenters who expressed support for VADIP also seemed to advocate that VADIP is necessary because, by comparison, they believe that VA dental care under 38 U.S.C. 1712 (referred to in this preamble as "VA dental benefits") are not adequately administered to veterans. Specifically, these commenters contended that VADIP was necessary because only limited groups of veterans

are eligible to receive VA dental benefits, or because VA staff do not understand or properly communicate the eligibility requirements for VA dental benefits. Generally, we respond that comments regarding veteran eligibility for VA dental benefits or the adequacy of VA dental benefits are beyond the scope of this rulemaking, because section 510 clearly distinguishes between VA dental benefits and VADIP insurance by requiring VA to contract with a private insurer to administer VADIP, and by requiring that VA maintain its statutory responsibility to furnish VA dental benefits to certain veterans even if those veterans also participate in VADIP. See Public Law 111-163, sections 510(e), 510(j). Therefore, we do not specifically respond to these comments because these issues are outside the scope of this rulemaking.

However, we do respond to a few commenters who based their support for VADIP on misinterpretations of eligibility for VA dental benefits, because these misinterpretations seemed to also create confusion for the commenters regarding VADIP eligibility. For instance, multiple commenters misstated that only veterans with a service-connected disability rated at 100 percent are eligible to receive VA dental benefits, and consequently advocated that the rule should permit veterans with less than a 100 percent service-connection rating to enroll in VADIP. We do not make any changes to the rule based on these comments because § 17.169(b)(1) makes clear that any veteran who is enrolled in the VA health care system in accordance with 38 CFR 17.36 is eligible to enroll in VADIP, and enrollment under § 17.36 is not solely based upon a veteran's service-connection rating, at any level. Additionally, we clarify that there are categories of eligibility for VA dental benefits that are based on dental conditions that are service-connected and compensable in degree, but not requiring an overall rating of 100 percent, as well as categories of eligibility that are based on criteria that are unrelated to any level of service-connection. See 38 U.S.C. 1712, 2062; see also 38 CFR 17.160-17.166.

Comments Related to Veteran Family Member Eligibility for VADIP

Some commenters who expressed support for VADIP also advocated that family members of veterans should be eligible to enroll in VADIP. We do not make any changes to this rule based on these comments. Section 510(b)(2) limits VADIP eligibility for veteran family members to only those survivors

and dependents of veterans who are eligible for medical care under 38 U.S.C. 1781, implemented as VA's Civilian Health and Medical Program (CHAMPVA). See 38 CFR 17.270-17.278. Consequently, § 17.169(b)(2) limits VADIP eligibility for veteran family members who are eligible for medical care under 38 U.S.C. 1781 and 38 CFR 17.271.

One commenter asserted more specifically that VADIP insurance should be available to family members of veterans with a 100 percent service-connection rating before it is provided to family members of veterans with lower service-connection ratings, because VA dental benefits are only provided to 100 percent service-connected veterans. We reiterate that VADIP insurance is not VA dental benefits and is not comparable to VA dental benefits, and that VA dental benefits are not limited to only 100 percent service-connected veterans. With regard to the eligibility of family members of veterans for VADIP, we do not make any changes based on this comment. Only survivors and dependents of veterans who are eligible for CHAMPVA may be enrolled in VADIP. Although certain eligibility criteria for CHAMPVA benefits do consider whether a veteran has a service-connected disability or condition, CHAMPVA eligibility is not solely based on a veteran's service-connection rating. See, e.g., 38 CFR 17.271(a)(3).

Although this rule may not expand eligibility for VADIP to veteran family members beyond section 510(b)(2), we do not interpret any part of section 510 as preventing a private insurer, participating in VADIP, from providing a different type of dental insurance plan to veteran family members who may not be eligible for VADIP under section 510(b)(2). Consequently, nothing in this rule prohibits a VADIP-participating private insurer from forming non-VADIP contractual relationships with anyone. However, a VADIP-participating private insurer may not use any VA health information to which it is privy, by virtue of participating in VADIP, to solicit or market directly to any person who is not eligible to enroll in VADIP under section 510(b).

Comments Related to Geographic Areas in Which VADIP Will Be Offered

Multiple commenters who expressed support for the rule additionally advocated that VADIP should be broadly available geographically. One commenter specifically stated that VADIP should be offered in all VA Integrated Service Networks (VISN),

instead of select VISNs. It is unclear why the commenter believed VADIP would be administered only in select VISNs; the proposed rule did not implement regional restrictions, and we do not intend that VADIP be administered only in certain VISNs. Therefore, we do not make any changes to the rule based on this comment. Although section 510(d) does state that the VADIP pilot program “shall be carried out in such [VISNs] as the Secretary considers appropriate,” we reiterate, from the proposed rule, that the intent is that VADIP insurance be provided as broadly as possible, given the insurer’s coverage capabilities as determined during the Federal contracting process. See 77 FR 12518. Although VA cannot predict the breadth of geographic coverage, limitations will only be due to what insurers ultimately are able to provide. To this end, VA will attempt, via the Federal contracting process, to ensure that VADIP geographic coverage is broad.

Some commenters advocated making VADIP available in the Philippines and Guam. We do not make any changes to the rule based on these comments. As noted above, the rule does not limit VADIP insurance from being provided in any particular VISN; both the Philippines and Guam are located in VISN 21. We note that the provision of VADIP insurance in areas outside the United States is controlled by section 510 and not by any other VA authorities to provide VA care outside of the United States, because VADIP insurance is not VA care and is not administered by VA as a medical benefit. We are not guaranteeing or advocating coverage in any specific geographic area, because coverage may be limited by multiple factors that are beyond VA’s control. For example, insurers may be limited to providing VADIP coverage only in areas where they are licensed to provide insurance.

Comments Related to VADIP Costs for Enrollees

As mandated by section 510(h)(3), § 17.169(c)(1) requires that VADIP premiums and any copayments will be paid by the insured. Multiple commenters advocated that VA should ensure that these costs are affordable for VADIP enrollees, without specifically requesting changes to the rule except as noted below. First, we address the general concerns as expressed by commenters related to cost. Under section 510(h)(1) and (h)(2), VA must establish VADIP premium amounts and adjust those amounts annually. Section 510 is silent about VA establishing copayment amounts, although section

510(h)(3) states that VADIP enrollees will be responsible for the full cost of any copayment amounts.

Under § 17.169(c)(1), both premium and copayment amounts will be determined through the Federal contracting process. To the extent that commenters may wish for VA to actually establish the costs of VADIP premiums and copayments in the rule, and further ensure that such costs are affordable, we will not know such costs until contracts with insurers are negotiated. We expect, through the Federal contracting process, to negotiate with insurers to establish multiple tiers of coverage within the comprehensive listing of dental care services in § 17.169(c)(2). This will help ensure that VADIP enrollees have a choice to pay premium and copayment amounts proportionate to the services they want covered.

Multiple tiers of coverage will prevent all VADIP enrollees from being required to pay higher premium amounts or copayments that would typically be associated with covering the full range of services listed in § 17.169(c)(2). Establishing tiers of coverage in this manner is standard practice in the dental insurance industry, and will assist in keeping premium and copayment costs manageable for VADIP enrollees. Multiple tiers of coverage with varying premium and copayment amounts are also supported by section 510. See Public Law 111–163, sections 510(h)(1), (h)(3) (indicating that multiple “[p]remiums” will be established and adjusted by VA, and that each individual covered by VADIP will be responsible to pay the full cost of any “copayments”). We do not make any changes to the rule to set forth specific tiers of coverage, however, because such determinations are better suited to the contract negotiations that VA will conduct with insurers.

We additionally note that for purposes of analyzing insurer risk, typically a large number of enrollees can assist with keeping premiums, copayments, and other administrative costs low. As reported in the proposed rule, VA anticipates that between 101,000 and 201,000 individuals will apply to enroll in VADIP each year, based on the sizable groups of individuals eligible to enroll under section 510(b). See 77 FR 12520. We will conduct the Federal contracting process anticipating this large number of expected enrollees and attempt to secure reasonable premium and copayment pricing for VADIP plans.

In relation to the scope of VADIP coverage and pricing, one commenter stated that veterans and their family

members need coverage for “all dental preventive and corrective care that is more affordable [than] the current Delta Dental Plan.” This commenter further criticized “the current Delta Dental Plan” for instituting waiting periods for certain dental services, such that these services are not considered covered until after an insured is enrolled for a specific period of time. We are unsure of the specific plan to which the commenter intended to refer, but we interpret this comment to advocate that VA should ensure that VADIP provides more dental services at a less expensive price, and with fewer restrictions, than typically provided in an insurance plan that is offered by a large dental insurer like Delta Dental. We do not make any changes based on this comment.

VA must contract with a private dental insurer to administer VADIP, and therefore the administration of VADIP will be subject to standard practices and market factors that are present in the dental insurance industry. For example, VA may not be able to negotiate a contract with a private insurer that does not institute waiting periods for certain services or procedures, if the standard practice in the dental insurance industry is to institute such waiting periods. VA must ensure that an insurer offers the coverage VA prescribes, that premiums are established and adjusted annually, and that certain other requirements, as mandated by section 510, are met. VA must also contract with dental insurers within the framework of the dental insurance industry to implement these requirements, and as such these dental insurers may administer VADIP according to certain standard industry practices that commenters expressed were objectionable. Consequently, VADIP coverage may not be priced less expensively than other comparable coverage typically offered in the dental insurance industry, and coverage may be subject to restrictions that typically exist in comparable dental insurance plans. We further note that dental benefits that must be offered under § 17.169(c)(2) are comprehensive, and reiterate, as stated above, that VA will attempt to secure reasonable premium and copayment pricing through multiple tier options to allow enrollees to choose coverage that is appropriate and affordable for them.

One commenter from the dental insurance industry recommended multiple options to include in VADIP plans that, in the commenter’s opinion, would keep costs lower for VADIP enrollees. These options included instituting waiting periods for certain specific benefits; establishing fixed fees

that VA may charge for internal administrative needs related to the VADIP contracts; and instituting lock-out periods, a provision for those insureds who opt to leave VADIP, so that such individuals would be prevented from re-enrolling in VADIP before a specific period of time had passed. This commenter did not request that the rule should enact such options as mandatory provisions, but only that these options should be considered in the insurance plans themselves, which would be formed when VA contracts with private insurers to administer VADIP. VA will consider contract options with insurers to reduce costs for VADIP enrollees as part of the negotiation process, which may include some or all of the above suggestions.

Although we interpret the cost-saving suggestions made by this commenter to relate to the contracting process rather than to the regulation, the suggestion to make re-enrollment subject to lock-out periods is a contract option that would be prevented if the regulation text is not changed. Section 17.169(d)(2), as proposed, alerted the public to a month-to-month enrollment option, after the 12-month initial enrollment period. This could be interpreted to mean that an insured may re-enroll at any time on a month-to-month basis regardless of any lock-out period in a VADIP contract. Lock-out periods are standard in most dental insurance contracts to discourage individuals from enrolling on an intermittent basis, only as services are needed. Continuous enrollment is thus incentivized, which helps ensure lower premiums for all insureds by increasing predictability of the insured group's size, and allowing for sufficient premiums to be collected to cover anticipated treatments costs. Therefore, we amend the language of § 17.169(d)(2) from the proposed rule to make the month-to-month enrollment subject to a new paragraph (e)(5) in the rule. Paragraph (e)(5) will read “[m]onth-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.” This change reflects our original intent to consider cost-saving contract options.

One additional option advanced by this industry commenter was to enable enrollees to use pre-tax dollars for premiums and copayments. We interpret this as a request that VA permit enrollees to treat premium payments and certain other VADIP costs as a pre-tax deduction, for purposes of

reducing an enrollee's overall taxable income. Although not stated by the commenter, we interpret this suggestion as referring to “cafeteria” insurance plans, which allow employers to offer or sponsor insurance plans that may provide tax savings to both employees and employers. See 26 U.S.C. 125. Enrollment in a “cafeteria” plan can create tax savings for an employee, typically because the employee will contribute a portion of his or her salary on a pre-tax basis to pay for the qualified insurance benefits. These contributions are usually made pursuant to salary reduction agreements between the employer and the employee. Because these contributions are reductions in salary and are not received by the employee, they are not considered wages for income tax purposes.

VA is not offering VADIP plans as an employer, and therefore may not offer or sponsor VADIP as a “cafeteria” plan under 25 U.S.C. 125 for the purposes of pre-tax treatment of insurance premiums. VA will not participate in the collection of premiums or otherwise establish automatic deduction mechanisms for the payment of premiums. Instead, under § 17.169(c)(1), VADIP insureds will make premium and copayments in accordance with the terms of their VADIP insurance plan. We, therefore, do not make any changes to the rule based on this comment.

Comments Related to Federal Preemption of State Insurance Law

A commenter from the dental insurance industry stated that “[i]t is important that VA exercise Federal preemption similar to that of the [Department of Defense TRICARE Retiree Dental Program (TRDP)] and the Federal Employee Dental and Vision Insurance Program (FEDVIP).” The commenter asserted that Federal preemption of State insurance law or regulation was necessary for VADIP to be successful, because such preemption would allow for the implementation of uniform benefits in all States and would reduce the overall cost of VADIP. We agree with the commenter that uniformity of benefits provided at a reasonable cost are important interests for VA to consider in implementing VADIP. Although we interpret that Congress intended to legislate about the business of insurance in several subsections of section 510, and in turn that certain provisions of this rule could have preemptive effect, we make no changes to the rule based on this comment. We intend to publish a separate direct final rule to address preemption in VADIP to ensure that all

affected parties have notice of VA's intent to assert the preemptive effect of certain subsections of section 510, and to provide VA an opportunity to consult with States and State officials in compliance with Executive Order 13132, Federalism.

Comment Related to the Duration of VADIP as a Pilot Program

Lastly, a commenter advocated that the duration of the VADIP pilot program should be extended from 3 years to 5 years, because this longer time frame would help ensure higher enrollment, would help spread initial administrative costs over a longer time, and would provide VA with more time to collect data on the administration of VADIP to determine if VADIP is feasible. Section 510(c) is clear that the duration of VADIP is to be no more than 3 years. Therefore, we do not make any changes to the rule based on this comment.

Nonsubstantive Changes Not Requested by Commenters

Two nonsubstantive changes are being made that were not requested by commenters, to ensure consistency in VADIP administration. The first nonsubstantive change is to the headings of § 17.169 and to § 17.169(a)(1), to remove the word “Plan,” so that VADIP is consistently known as the “VA Dental Insurance Program,” and not the “VA Dental Insurance Plan Program.” The second nonsubstantive change is a renumbering of the paragraphs under § 17.169(e), to properly distinguish between involuntary and voluntary disenrollment. Specifically, § 17.169(e)(1) as proposed referred to both involuntary and voluntary disenrollment within one paragraph, and sought to set forth the various bases for voluntary disenrollment under § 17.169(e)(1)(i) through (e)(1)(v). To ensure there is no confusion, we removed language related to voluntary disenrollment from § 17.169(e)(1) as proposed and placed this language in the new § 17.169(e)(2), and renumbered § 17.169(e)(2) and (e)(3) as proposed to § 17.169(e)(3) and (e)(4), respectively. We also corrected the reference to voluntary disenrollment procedures in renumbered § 17.169(e)(3), to refer to paragraphs (e)(2)(i) through (e)(2)(v).

Based on the rationale set forth in the proposed rule and in this document, VA is adopting the provisions of the proposed rule as final with changes to § 17.169(a)(1), (d)(2) and (e).

Effect of Rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final

rulemaking, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

Paperwork Reduction Act

The Paperwork Reduction Act of 1995 (at 44 U.S.C. 3507) requires that VA consider the impact of paperwork and other information collection burdens imposed on the public. Under 44 U.S.C. 3507(a), an agency may not collect or sponsor the collection of information, nor may it impose an information collection requirement unless it displays a currently valid Office of Management and Budget (OMB) control number. See also 5 CFR 1320.8(b)(3)(vi).

This final rule will impose the following new information collection requirement: Applications are needed so that individuals can voluntarily participate in VADIP. Procedures for voluntary disenrollment, as well as appeals of disenrollment decisions, are needed to ensure that enrollment remains voluntary, and that disenrollment determinations are timely. As required by the Paperwork Reduction Act of 1995 (at 44 U.S.C. 3507(d)), VA has submitted this information collection to OMB for its review. OMB approved the new information collection requirement associated with the final rule and assigned OMB control number 2900–0789.

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601–612. Only dental insurers, certain veterans and their survivors and dependents, which are not small entities, will be affected. Therefore, pursuant to 5 U.S.C. 605(b), this rulemaking is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic,

environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action” which requires review by the Office of Management and Budget (OMB), as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this final rule have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866.

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance Numbers

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.009 Veterans Medical Care Benefits and 64.011 Veterans Dental Care.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of

the Department of Veterans Affairs. Jose D. Riojas, Interim Chief of Staff, approved this document on May 13, 2013, for publication.

List of Subjects in 38 CFR Part 17

Dental health, Government contracts, Health care, Health professions, Health records, Veterans.

Dated: May 22, 2013.

William F. Russo,

Deputy Director, Regulation Policy and Management, Office of the General Counsel, Department of Veterans Affairs.

For the reasons stated in the preamble, VA amends 38 CFR part 17 as follows:

PART 17—MEDICAL

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

Authority: 38 U.S.C. 501, and as noted in specific sections.

■ 2. Add § 17.169 after § 17.166 to read as follows:

§ 17.169 VA Dental Insurance Program for veterans and survivors and dependents of veterans (VADIP).

(a) *General.* (1) The VA Dental Insurance Program (VADIP) provides premium-based dental insurance coverage through which individuals eligible under paragraph (b) of this section may choose to obtain dental insurance from a participating insurer. Enrollment in VADIP does not affect the insured's eligibility for outpatient dental services and treatment, and related dental appliances, under 38 U.S.C. 1712.

(2) The following definitions apply to this section:

Insured means an individual, identified in paragraph (b) of this section, who has enrolled in an insurance plan through VADIP.

Participating insurer means an insurance company that has contracted with VA to offer a premium-based dental insurance plan to veterans, survivors, and dependents through VADIP. There may be more than one participating insurer.

(b) *Covered veterans and survivors and dependents.* A participating insurer must offer coverage to the following persons:

(1) Any veteran who is enrolled under 38 U.S.C. 1705 in accordance with 38 CFR 17.36.

(2) Any survivor or dependent of a veteran who is eligible for medical care under 38 U.S.C. 1781 and 38 CFR 17.271.

(c) *Premiums, coverage, and selection of participating insurer.* (1) *Premiums.*

Premiums and copayments will be paid by the insured in accordance with the terms of the insurance plan. Premiums and copayments will be determined by VA through the contracting process, and will be adjusted on an annual basis. The participating insurer will notify all insureds in writing of the amount and effective date of such adjustment.

(2) *Benefits.* Participating insurers must offer, at a minimum, coverage for the following dental care and services:

- (i) *Diagnostic services.*
 - (A) Clinical oral examinations.
 - (B) Radiographs and diagnostic imaging.
 - (C) Tests and laboratory examinations.
- (ii) *Preventive services.*
 - (A) Dental prophylaxis.
 - (B) Topical fluoride treatment (office procedure).
 - (C) Sealants.
 - (D) Space maintenance.
- (iii) *Restorative services.*
 - (A) Amalgam restorations.
 - (B) Resin-based composite restorations.
- (iv) *Endodontic services.*
 - (A) Pulp capping.
 - (B) Pulpotomy and pulpectomy.
 - (C) Root canal therapy.
 - (D) Apexification and recalcification procedures.
- (E) Apicoectomy and periradicular services.
- (v) *Periodontic services.*
 - (A) Surgical services.
 - (B) Periodontal services.
- (vi) *Oral surgery.*
 - (A) Extractions.
 - (B) Surgical extractions.
 - (C) Alveoloplasty.
 - (D) Biopsy.
- (vii) *Other services.*
 - (A) Palliative (emergency) treatment of dental pain.
 - (B) Therapeutic drug injection.
 - (C) Other drugs and/or medications.
 - (D) Treatment of postsurgical complications.
 - (E) Crowns.
 - (F) Bridges.
 - (G) Dentures.

(3) *Selection of participating insurer.* VA will use the Federal competitive contracting process to select a participating insurer, and the insurer will be responsible for the administration of VADIP.

(d) *Enrollment.* (1) VA, in connection with the participating insurer, will market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. The participating insurer will prescribe all further enrollment procedures, and VA will be responsible for confirming that a person is eligible under paragraph (b) of this section.

(2) The initial period of enrollment will be for a period of 12 calendar months, followed by month-to-month enrollment, subject to paragraph (e)(5) of this section, as long as the insured remains eligible for coverage under paragraph (b) of this section and chooses to continue enrollment, so long as VA continues to authorize VADIP.

(3) The participating insurer will agree to continue to provide coverage to an insured who ceases to be eligible under paragraphs (b)(1) through (2) of this section for at least 30 calendar days after eligibility ceased. The insured must pay any premiums due during this 30-day period. This 30-day coverage does not apply to an insured who is disenrolled under paragraph (e) of this section.

(e) *Disenrollment.* (1) Insureds may be involuntarily disenrolled at any time for failure to make premium payments.

(2) Insureds must be permitted to voluntarily disenroll, and will not be required to continue to pay any copayments or premiums, under any of the following circumstances:

(i) For any reason, during the first 30 days that the beneficiary is covered by the plan, if no claims for dental services or benefits were filed by the insured.

(ii) If the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan.

(iii) If the insured is prevented by serious medical condition from being able to obtain benefits under the plan.

(iv) If the insured would suffer severe financial hardship by continuing in VADIP.

(v) For any reason during the month-to-month coverage period, after the initial 12-month enrollment period.

(3) All insured requests for voluntary disenrollment must be submitted to the insurer for determination of whether the insured qualifies for disenrollment under the criteria in paragraphs (e)(2)(i) through (v) of this section. Requests for disenrollment due to a serious medical condition or financial hardship must include submission of written documentation that verifies the existence of a serious medical condition or financial hardship. The written documentation submitted to the insurer must show that circumstances leading to a serious medical condition or financial hardship originated after the effective date coverage began, and will prevent the insured from maintaining the insurance benefits.

(4) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(2)(i) through (v) of this section, the

participating insurer must issue a written decision and notify the insured of the basis for the denial and how to appeal. The participating insurer will establish the form of such appeals whether orally, in writing, or both. The decision and notification of appellate rights must be issued to the insured no later than 30 days after the request for voluntary disenrollment is received by the participating insurer. The appeal will be decided and that decision issued in writing to the insured no later than 30 days after the appeal is received by the participating insurer. An insurer's decision of an appeal is final.

(5) Month-to-month enrollment, as described in paragraph (d)(2) of this section, may be subject to conditions in insurance contracts, whereby upon voluntarily disenrolling, an enrollee may be prevented from re-enrolling for a certain period of time as specified in the insurance contract.

(f) *Other appeals procedures.* Participating insurers will establish and be responsible for determination and appeal procedures for all issues other than voluntary disenrollment.

(Authority: Sec. 510, Pub. L. 111–163)

(The Office of Management and Budget has approved the information collection requirement in this section under control number 2900–0789.)

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ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[EPA–R10–OAR–2012–0712; FRL–9817–1]

Revision to the Washington State Implementation Plan; Tacoma-Pierce County Nonattainment Area

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The EPA is approving State Implementation Plan (SIP) revisions submitted by the Washington Department of Ecology (Ecology) dated November 28, 2012. The EPA's final rulemaking approves two revisions to the SIP. First, the EPA is approving the "2008 Baseline Emissions Inventory and Documentation" included as Appendix A to the SIP revision. The emissions inventory was submitted to meet Clean Air Act (CAA) requirements related to the Tacoma-Pierce County nonattainment area for the 2006 fine particulate matter (PM_{2.5}) National Ambient Air Quality Standard