the human environment because it simply promulgates the operating regulations or procedures for drawbridges. We seek any comments or information that may lead to the discovery of a significant environmental impact from this proposed rule.

List of Subjects in 33 CFR Part 117

Bridges.

For the reasons discussed in the preamble, the Coast Guard proposes to amend 33 CFR part 117 as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

1. The authority citation for part 117 continues to read as follows:

Authority: 33 U.S.C. 499; 33 CFR 1.05–1; Department of Homeland Security Delegation No. 0170.1.

2. Amend § 117.1045 by adding the below text as paragraph (b) and changing the current paragraph (b) to read (c) and current paragraph (c) to read (d):

§ 117.1045 Hood Canal.

(b) The draw of the Hood Canal Bridge, mile 5.0, need not open for vessel traffic from 3 p.m. to 6:15 p.m. daily from 3 p.m. May 22 to 6:16 p.m. September 30, except for commercial tug and tow vessels and vessels of the U.S. Navy or vessels attending the missions of the U.S. Navy and other public vessels of the United States. At all other times the bridge will operate in accordance with subparagraph (a) of this section.

Dated: February 6, 2012.

K.A. Taylor,

Rear Admiral, U.S. Coast Guard Commander, Thirteenth Coast Guard District.

[FR Doc. 2012–4928 Filed 2–29–12; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN99

VA Dental Insurance Program

AGENCY: Department of Veterans Affairs and Department of Defense.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations to establish a pilot program to offer premium-based dental insurance to enrolled veterans and certain survivors and dependents of veterans. VA would contract with a private insurer through the Federal contracting process to offer dental insurance, and the private insurer would then be responsible for the administration of the dental insurance plan. VA's role would primarily be to form the contract with the private insurer and verify the eligibility of veterans, survivors, and dependents. The program is authorized, and this rulemaking is required, by section 510 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (the 2010 Act).

DATES: Comments must be received by VA on or before April 30, 2012.

ADDRESSES: Written comments may be submitted through *http://www.regulations.gov;* by mail or hand delivery to the Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. Comments should indicate that they are submitted in response to ''RIN 2900–AN99, VA Dental Insurance Program.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 (this is not a toll-free number) for an appointment. In addition, during the comment period, comments may be viewed online through the Federal Docket Management System at *http://www.regulations.gov.*

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: Pursuant to section 510(a) of the 2010 Act, VA ''shall 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.'' In order to comply with section 510, VA would contract with a private dental insurer that would offer dental coverage to the persons identified in section 510(b) of the 2010 Act. This proposed rule would establish rules and procedures for the VA Dental Insurance Program (VADIP), in accordance with section 510(k) of the 2010 Act, which requires VA to prescribe regulations.

Section 510(c) of the 2010 Act is a ''sunset provision'' that authorizes VADIP to run from January 30, 2011, to January 30, 2014. Public Law 111–163, § 510(c) (''The pilot program shall be carried out during the 3-year program beginning on the date that is 270 days after enactment of this Act,'' which was May 5, 2010). However, we would not include that date limitation in the proposed rule, as we were not able to begin the pilot program on January 30, 2011, due to the need to prescribe regulations, a time-intensive process. We nonetheless interpret section 510(c) to require that the pilot program be administered for no less than three years, and would conduct the program for three years once commenced. Our interpretation is further supported by the Secretary's duty as stated in section 510(a) of the 2010 Act, to ''assess the feasibility and advisability of providing a dental insurance plan to veterans and survivors and dependants of veterans'', and we believe that this assessment would be incomplete unless afforded the full duration of the program as prescribed by law. We can easily ensure the termination of VADIP through contract if no extension is provided and the program is no longer authorized by law. If VADIP is not extended, we would remove the rule from the Code of Federal Regulations and, in the meantime, would no longer offer the benefit.

Paragraph (a)(1) of proposed § 17.169 would generally establish VADIP and explain what the program provides. We would note that ''[e]nrollment in VADIP does not affect the covered beneficiary's eligibility for VA outpatient dental services and treatment, and related dental appliances under 38 U.S.C. 1712.'' This reiterates the requirement in section 510(j) of the 2010 Act.

Proposed paragraph (a)(2) would define the terms ''insured'' and ''participating insurer,'' which are used throughout the proposed rule to identify persons enrolled in an insurance plan through VADIP and providers of VADIP insurance, respectively. Defining the terms as such would help ensure that the proposed rule is easily understood.

Proposed paragraph (b) would identify the persons who are eligible for insurance through VADIP, and would require that a participating insurer offer coverage to such persons. These individuals are clearly identified by section 510(b) of the 2010 Act, and the proposed rule would use language that is virtually identical to the language used in section 510(b). We would require that a participating insurer offer coverage to all persons identified in the paragraph in order to ensure that we have fully assessed the feasibility and advisability of VADIP, as required by section 510(a) of the 2010 Act. We note that we would not geographically limit coverage by regulation, but would allow the participating insurer to incorporate

such limitations in the contract with VA. Section 510(d) of the 2010 Act requires that VADIP ''be carried out in such Veterans Integrated Services Networks [VISNs] as the Secretary considers appropriate.'' We believe that such consideration must be made in the context of the Federal contracting process. VA's limitation of this pilot program to particular VISNs, as regional groupings, could be detrimental to contract formation, as dental services can be provided by insurers through national contracts, regional contracts, or partnerships between national and regional group practices. We cannot predict at this time whether private insurance companies will want to provide limited or nationwide coverage through VADIP, but will attempt through the contracting process to obtain the widest possible geographic coverage for veterans and their survivors and dependents.

Proposed paragraph (c)(1) would address premiums, coverage, and selection of the participating insurer. Premiums and copayments would be paid by the insured in accordance with the terms of the insurance plan. Responsibility for payment is so mandated by section 510(h)(3) of the 2010 Act. The amount of premiums and copayments would be based on the contract with the participating insurer. We do not propose to require a minimum or maximum amount in the proposed rule, because we believe that this matter would be best handled through the contracting process, during which factors such as competition between insurers, locations where services are provided, and the range of services offered would determine the amounts. VA will not know the range of amounts for premium and copayment rates until the proposals received from insurers are reviewed, and then based on that review and subsequent negotiation, the insurers would be selected. Proposed paragraph (c)(1) would additionally require annual premium adjustments, and also require that insureds be notified of the amount and effective date of such adjustments, in accordance with section 510(h)(2). The burden of notifying the insureds would be placed on the participating insurer, and we would additionally require that such notice be provided in writing.

Proposed paragraph (c)(2) would specify the minimum coverage that must be offered by the participating insurer. We believe that the described coverage must be provided in order for the dental plan to be meaningful, as well as to comply with the minimum requirements established in section 510(f) of the 2010 Act, which are that the benefits include appropriate ''diagnostic services, preventative services, endodontics and other restorative services, surgical services, and emergency services.'' We note that a more detailed discussion of covered services, and additional services, would be established in the actual insurance plan offered by the participating insurer, which VA would approve by contract.

Proposed paragraph (c)(3) would state that VA would use the Federal competitive contracting process to select a participating insurer and would further provide that the selected insurer would administer the program, in accordance with section 510(e) of the 2010 Act, which requires that VA contract with a dental insurer to administer the dental insurance plan pilot program. Section 510(e) of the 2010 Act makes clear that the Secretary's duty is to contract with a dental insurer, and that insurer would then administer the dental insurance plan as provided under the pilot.

Proposed paragraph (d)(1) would establish that VA, in connection with the participating insurer, would market VADIP through existing VA communication channels to notify all eligible persons of their right to voluntarily enroll in VADIP. Enrollment must be purely voluntary under section 510(g)(1) of the 2010 Act. We would require that further procedures associated with voluntary enrollment, beyond notification of eligible persons, would be the responsibility of the participating insurer. VA would be responsible for verifying eligibility using established VA data storage systems. As previously stated, VA is not required by section 510 of the 2010 Act to take an active role in the administration of the actual dental program, as the law is merely designed to facilitate the provision of private insurance to the specified VA beneficiaries. Requiring that the private insurer take on a majority of responsibility for enrollment procedures would help ensure that only minimal VA resources are devoted to VADIP, and that VA may optimally manage its resources to provide VA dental benefits to VA beneficiaries as applicable. Section 510(j) makes clear that the Secretary's responsibilities to provide VA dental benefits under 38 U.S.C. 1712 shall not be affected by the administration of this pilot, and in fact that the Secretary must not allow a veteran's dental care under that section to be affected even in instances where that veteran is also participating in the pilot.

Proposed paragraph (d)(2) would require a minimum initial enrollment period of 12 calendar months, followed by month-to-month enrollment at the option of the insured. We are required to prescribe a minimum period of enrollment by section 510(g)(2) of the 2010 Act, and we believe that a minimum of one year is required to assess the viability of VADIP. Allowing month-to-month enrollment thereafter, as long as the enrollee chooses to continue, would help ensure that enrollment remains voluntary, as required in section 510(g)(1) of the 2010 Act.

Proposed paragraph (d)(3) would require an insurer to continue to provide coverage for at least 30 calendar days after an insured ceases to be eligible under proposed paragraphs (b)(1) and (2), to ensure the completion of any services scheduled but not yet provided. This continued coverage is critical for certain services in proposed paragraph (c)(2) that typically would be provided in multiple stages, such as when an insured would receive a crown. The insured would be required to pay any premiums due during this 30-day continued coverage period. This 30-day continued coverage period would not be available to those insureds who become disenrolled under proposed paragraph (e), but only to those who cease to be eligible under proposed paragraphs (b)(1) and (2).

Under proposed paragraph (e), we would include five voluntary bases for insureds to disenroll from VADIP, consistent with section 510(i) of the 2010 Act, and would also authorize participating insurers to disenroll insureds who fail to pay the required premiums. Disenrollment for failure to pay premiums would be at the discretion of the participating insurer, in accordance with the details of the insurance plan. Because insureds are required by section 510(h)(3) of the 2010 Act to make such payments, we do not believe that VA has any duty to regulate disenrollment on this basis, beyond authorizing involuntary disenrollment for non-payment. Proposed paragraphs (e)(1)(i) through (iii) would set forth the bases for voluntarily disenrollment that are established by section 510(i) of the 2010 Act. Under proposed paragraph (e)(1)(i), we would require the participating insurer to allow disenrollment ''[f]or 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.'' We would require that no claims were filed because such an action would require the insurer to expend resources, and would also

indicate the insured's desire to participate in the plan, and because VA is required by section 510(i)(1)(B) of the Act to ensure that disenrollment criteria do not ''jeopardize the fiscal integrity of the dental insurance plan.'' Proposed paragraph (e)(1)(ii) would require the participating insurer to allow disenrollment if the insured relocates to an area outside the jurisdiction of the plan that prevents the use of the benefits under the plan, as required by section 510(i)(2)(A) of the 2010 Act. Proposed paragraph (e)(1)(iii) would require the participating insurer to allow disenrollment if the insured is prevented by serious medical condition from being able to obtain benefits under the plan, as required by section 510(i)(2)(B) of the 2010 Act.

Section 510(i)(2)(C) of the 2010 Act also authorizes VA to prescribe additional bases for voluntary disenrollment. We propose two additional bases in paragraphs (e)(1)(iv) and (e)(1)(v). Proposed paragraph (e)(1)(iv) would establish the first additional basis of disenrollment to be that the insured could voluntarily disenroll if he or she would suffer severe financial hardship by continuing in VADIP. Proposed paragraph (e)(1)(v) would establish the second additional basis to be that an insured could voluntarily disenroll for any reason at any time after the initial 12-month enrollment period. Both these bases further support VA's obligation under section 510(g)(1) of the 2010 Act to ensure that enrollment in the dental insurance plan be voluntary. All bases of voluntary disenrollment in proposed paragraphs (e)(1)(i) through (v) either reiterate specific Congressional requirements in section 510(i) of the 2010 Act, or are additional bases to ensure that enrollment remains voluntary, as also mandated in section 510(i).

Proposed paragraph (e)(2) would establish that 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 proposed (e)(1)(i)-(v). Requests for disenrollment because of a serious medical condition or severe financial hardship would include the insured's submission to the insurer 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 would prevent the insured's use of benefits. These standards obviate the need to define the statutory terms ''serious medical condition'' or ''severe financial hardship,'' because under the regulation all that would be required is that the insured provide written documentation that shows that conditions exist which prevent him or her from maintaining the insurance benefits, and which did not exist prior to the start of coverage.

Section 510(i)(3) of the 2010 Act requires VA to ''establish procedures for determinations on the permissibility of voluntary disenrollments,'' i.e., disenrollment initiated by the insured pursuant to proposed paragraphs (e)(1)(i) through (v). Section 510(i)(3) requires that ''[s]uch procedures shall ensure timely determinations on the permissibility of such disenrollments,'' but section 510 of the 2010 Act does not require that VA adjudicate or participate in such appeals. Moreover, section 510 of the 2010 Act is silent as to VA's role in appeals of issues other than disenrollment, such as denials of benefits. We propose minimum timeframes for disenrollment appeals and subsequent decisions and we propose an appeals process to ensure that appropriate notice and an opportunity to respond is provided to insureds. VA would not be involved in the appeals process beyond establishing these criteria. Particularly, the decisions of the insurer with regards to an insured appeal must be final, so that VA does not become involved with the adjudication of appeals. In proposed paragraph (e)(3), we would require that, when requests for voluntary disenrollment are denied because the insured does not meet any criterion under proposed paragraphs (e)(1)(i)–(v), the insurer must provide notification of the denial and the right to appeal to the insured in writing within 30 days after receipt of the insured's request to voluntarily disenroll. The form of the appeal would be established by the participating insurer, and may include oral appeals rather than (or in addition to) written appeals, but the insured must be provided at least 30 days to appeal. The participating insurer would be required to issue a final decision in writing on such an appeal within 30 days after receiving the appeal. We believe that by requiring these timeframes we can ensure compliance with requirements in section 510(i)(3) of the 2010 Act that VA establish procedures for determinations of disenrollment and ensure those determinations are timely, while ensuring VA is not actively involved in the determination process. Participating insurers would be free to provide additional rights to insureds, but at a minimum would be required to comply with the procedural framework set forth in proposed paragraph (e)(3).

In proposed paragraph (f), we would state that ''[p]articipating insurers will establish and be responsible for determination and appeals procedures for all issues other than voluntary disenrollment.'' This would allow participating insurers to establish determination procedures consistent with the generally accepted administration of private insurance plans or with their current practice. We are not required by section 510 of the 2010 Act to regulate determination of matters other than voluntary disenrollment, and we believe that including proposed paragraph (f) would help clarify the narrow scope of VA's obligation.

Effect of Rulemaking

The Code of Federal Regulations, as proposed to be revised by this proposed rulemaking, would represent the exclusive legal authority on this subject. No contrary rules or procedures are authorized. All VA guidance would be read to conform with this proposed rulemaking if possible or, if not possible, such guidance would be superseded by this rulemaking.

Paperwork Reduction Act

This proposed rule includes a collection of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521) that requires approval by the Office of Management and Budget (OMB). Accordingly, under section 3507(d) of the 2010 Act, VA has submitted a copy of this rulemaking to OMB for review. OMB assigns a control number for each collection of information it approves. Except for emergency approvals under 44 U.S.C. 3507(j), VA may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Proposed § 17.169(d) and (e) contain collections of information under the Paperwork Reduction Act (44 U.S.C. 3501–3521). If OMB does not approve the collections of information as requested, VA will immediately remove the provisions containing a collection of information or take such other action as is directed by OMB.

Comments on the collections of information contained in this proposed rule should be submitted to the Office of Management and Budget, Attention: Desk Officer for the Department of Veterans Affairs, Office of Information and Regulatory Affairs, Washington, DC

20503, with copies sent by mail or hand delivery to: the Director, Office of Regulation Policy and Management (02REG), Department of Veterans Affairs, 810 Vermont Ave. NW., Room 1068, Washington, DC 20420; fax to (202) 273–9026; or through *www.Regulations.gov.* Comments should indicate that they are submitted in response to ''RIN 2900–AN99, VA Dental Insurance Program.''

OMB is required to make a decision concerning the collections of information contained in this proposed rule between 30 and 60 days after publication of this document in the **Federal Register**. Therefore, a comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment on the proposed rule.

VA considers comments by the public on proposed collections of information in—

- Evaluating whether the proposed collections of information are necessary for the proper performance of the functions of VA, including whether the information will have practical utility;
- Evaluating the accuracy of VA's estimate of the burden of the proposed collections of information, including the validity of the methodology and assumptions used;
- Enhancing the quality, usefulness, and clarity of the information to be collected; and
- Minimizing the burden of the collections of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

The proposed amendments to title 38 CFR part 17 contain collections of information under the Paperwork Reduction Act for which we are requesting approval by OMB. These collections of information are described immediately following this paragraph, under their respective titles.

Title: VA Dental Insurance Program.

Summary of collections of information: The proposed rule at § 17.169(d) would allow an individual to voluntarily apply for dental insurance by submitting an application to a participating insurer; the application will be made in accordance with the plan requirements provided by the private insurer. The proposed rule at § 17.169(e)(2) would authorize the submission to the participating insurer of evidence to support an attempt to disenroll from the program. Paragraph (e) would establish procedures for submission of requests for voluntary disenrollment and supporting documentation.

Description of the need for information and proposed use of information: 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 remain voluntary, and that disenrollment determinations are timely.

Description of likely respondents: Veterans, certain survivors and dependents.

Estimated number of respondents per year: Applications: 101,000–201,000. Disenrollment requests: 1,000. Appeals of disenrollment decisions: 500.

Estimated frequency of responses per year: 1.

Estimated burden per response: Applications: 15 min. Disenrollment requests: 30 min. Appeals of disenrollment decisions: 30 min.

Estimated total annual reporting and recordkeeping burden: 26,000–51,000 hours.

Regulatory Flexibility Act

The Secretary hereby certifies that this proposed rule would 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. This proposed rule would not directly affect any small entities. Only dental insurers, certain veterans and their survivors and dependents, which are not small entities, could be affected. Therefore, pursuant to 5 U.S.C. 605(b), this proposed amendment 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) classifies a regulatory action as a ''significant regulatory action,'' requiring review by OMB, unless OMB waives such review, if it is a 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 the Executive Order.

The economic, interagency, budgetary, legal, and policy implications of this proposed 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 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 year. This proposed rule would 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. John R. Gingrich, Chief of Staff, Department of Veterans Affairs, approved this document on February 23, 2012, for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Claims, Dental health, Health care, Veterans.

Dated: February 24, 2012.

William F. Russo,

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

For the reasons stated in the preamble, VA proposes to amend 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 Plan program for veterans and survivors and dependents of veterans (VADIP).

(a) *General.* (1) The VA Dental Insurance Plan 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 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. 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.

(2) 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)(1)(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.

(3) If the participating insurer denies a request for voluntary disenrollment because the insured does not meet any criterion under paragraphs (e)(1)(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.

(f) 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)

[FR Doc. 2012–4879 Filed 2–29–12; 8:45 am]

BILLING CODE 8320–01–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN87

Tentative Eligibility Determinations; Presumptive Eligibility for Psychosis and Other Mental Illness

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: This document proposes to amend the Department of Veterans Affairs (VA) regulation authorizing tentative eligibility determinations to comply with amended statutory authority concerning statutory minimum active-duty service requirements. This document also proposes to codify in regulation statutory presumptions of medical-care eligibility for veterans of certain wars and conflicts who developed psychosis within specified time periods and for Persian Gulf War veterans who developed a mental illness other than psychosis within two years after service and within two years after the end of the Persian Gulf War period. We believe that regulations are necessary because we would interpret the law to allow VA to waive any copayments associated with care pursuant to the statutory presumption and to waive any otherwise applicable minimum service requirements.

DATES: Comments must be received by VA on or before April 30, 2012.

ADDRESSES: Written comments may be submitted through *www.Regulations.gov;* by mail or hand-delivery to Director, Regulations Management (02REG), Department of Veterans Affairs, 810 Vermont Avenue NW., Room 1068, Washington, DC 20420; or by fax to (202) 273–9026. (This is not a toll-free number). Comments should indicate that they are submitted in response to ''RIN 2900–AN87, Tentative eligibility determinations; Presumptive eligibility for psychosis and other mental illness.'' Copies of comments received will be available for public inspection in the Office of Regulation Policy and Management, Room 1063B, between the hours of 8 a.m. and 4:30 p.m., Monday through Friday (except holidays). Please call (202) 461–4902 for an appointment. (This is not a toll-free number). In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Kristin J. Cunningham, Director, Business Policy, Chief Business Office, Department of Veterans Affairs, 810 Vermont Avenue NW., Washington, DC 20420; (202) 461–1599. (This is not a toll-free number).

SUPPLEMENTARY INFORMATION: This rulemaking would amend 38 CFR 17.34, ''Tentative eligibility determinations,'' and would establish a new § 17.109 concerning presumptive eligibility for medical care for psychosis and other mental illness.

Current 38 CFR 17.34 applies to veterans who seek medical care but are not enrolled in the VA healthcare system. Administratively, the rule allows us to provide medical care in specified situations, if ''eligibility for [medical] care probably will be established.'' Current § 17.34(a), which is not amended by this notice, authorizes such a tentative eligibility determination in emergencies. The vast majority of applicants who have not yet established eligibility but require medical care fall into this category.

Current § 17.34(b) applies in non-emergency situations to a veteran who seeks medical care ''within 6 months after date of honorable discharge from a period of not less than 6 months of active duty.'' Paragraph (b) authorizes a tentative eligibility determination because of the brief time period between discharge and application. In many of these cases, it is clear that the condition for which the veteran seeks care is one for which service connection ''probably will be established.'' However, current paragraph (b) needs to be revised so that the minimum-active-duty period (''6 months of active duty'') complies with the minimum active-duty service requirements set forth in 38 U.S.C. 5303A. Pursuant to section 5303A(a), ''any requirements for eligibility for or entitlement to any [VA] benefit * * * that are based on the length of active duty served by a person who initially enters such service after September 7, 1980, shall be exclusively as prescribed in [title 38, United States Code].'' Therefore, the current rule would be applicable only to persons who entered a period of service on or before September 7, 1980, and are seeking eligibility based on that period of service. This requirement would be reflected in proposed paragraph (b)(1). Proposed paragraph (b)(2) would require, for persons who entered service after September 7, 1980, that the applicant meet the minimum service requirements in section 5303A, and have filed their application within 6 months after date of honorable discharge. These revisions merely update our regulation to conform to current law.

We would amend VA's regulation on the provision of care to non-enrolled veterans, 38 CFR 17.37, by adding a paragraph that would authorize VA to provide care to veterans for psychosis and mental illnesses other than psychosis. The provision of this care would be pursuant to 38 CFR 17.109, which we propose to create in this rule and discuss in detail below. The proposal to amend § 17.37 authorizes the subsequent changes we propose in this rulemaking.

We also propose a new § 17.109 that would codify in regulation for the first time two presumptions of eligibility for medical care based on specific diagnoses in certain veteran populations. Pursuant to 38 U.S.C. 1702(a), for the purposes of VA's authority to provide medical benefits under chapter 17 of title 38, United States Code, certain veterans who developed an active psychosis within a time period specified in the statute ''shall be deemed to have incurred such disability in the active military, naval, or air service.'' The effect of a presumption of incurrence means that VA must provide medical care to the veteran as if the condition for which the veteran is treated were service connected. Although VA complies with this mandate, this statutory authority has never been articulated in a VA regulation.

The National Defense Authorization Act for Fiscal Year 2008, Public Law 110–181, § 1708(a)(1), (2), 122 Stat. 3, 493–94 (2008), amended 38 U.S.C. 1702 to create a similar presumption for veterans of the Persian Gulf War who develop a mental illness other than psychosis within two years after discharge from military service and within two years after the last day of the Persian Gulf War. We note that the Persian Gulf War is defined by statute as ''the period beginning on August 2, 1990, and ending on the date thereafter prescribed by Presidential proclamation