to announce the location and date of the public meeting. 73 FR 76296. In this notice, we announce that public meeting to receive comments on this proposed rule.

In the NPRM, we proposed to expand the applicability of Notice of Arrival and Departure (NOAD) and Automatic Identification System (AIS) requirements to more commercial vessels, modify NOAD reporting requirements, establish a mandatory method for electronic data submission and establish a separate requirement for certain vessels to submit notices of departure. The proposed rulemaking would also clarify existing AIS requirements and extend the applicability of AIS requirements beyond Vessel Traffic Service areas to all U.S. navigable waters.

You may view the NPRM in our online docket, in addition to supporting documents prepared by the Coast Guard (Regulatory Analysis & Initial Regulatory Flexibility Analysis, Valuing Mortality Risk Reductions in Homeland Security Regulatory Analyses—Final Report June 2008, and an Environmental Checklist), and comments submitted thus far by going to *http://www.regulations.gov.* Once there, select the Advanced Docket Search option on the right side of the screen, insert USCG–2005–21869 in the Docket ID box, press Enter, and then click on the item in the Docket ID column. If you do not have access to the Internet, you may view the docket online by visiting the Docket Management Facility in Room W12–140 on the ground floor of the Department of Transportation West Building, 1200 New Jersey Avenue, SE., Washington, DC 20590, between 9 a.m. and 5 p.m., Monday through Friday, except Federal holidays. We have an agreement with the Department of Transportation to use the Docket Management Facility.

We encourage you to participate in this rulemaking by submitting comments either orally at the meeting or in writing. If you bring written comments to the meeting, you may submit them to Coast Guard personnel specified at the meeting to receive written comments. These comments will be submitted to our online public docket. All comments received will be posted without change to *http://www.regulations.gov* and will include any personal information you have provided.

Anyone can search the electronic form of comments received into any of our dockets by the name of the individual submitting the comment (or signing the comment, if submitted on behalf of an association, business, labor union, etc.). You may review a Privacy Act notice regarding our public dockets in the January 17, 2008 issue of the **Federal Register** (73 FR 3316).

Information on Service for Individuals With Disabilities

For information on facilities or services for individuals with disabilities or to request special assistance at the public meeting, contact Lieutenant Sharmine Jones at the telephone number indicated under the **FOR FURTHER INFORMATION CONTACT** section of this notice.

Public Meeting

The Coast Guard will hold a public meeting regarding this proposed rulemaking on March 5, 2009, from 12:30 p.m. to 3 p.m., at the United States Coast Guard Headquarters Building, Room 2415, 2100 2nd Street, SW., Washington, DC 20593. A government-issued photo identification (for example, a driver's license) will be required for entrance to the building.

Parking near the building is limited. Public transportation to the building (Bus Route 71) is limited to rush hours, approximately 6 to 9:30 a.m. and 3 to 6 p.m. Contact the Washington Metropolitan Area Transit Authority for additional information at 202–637–7000 or *http://www.wmata.com/.*

We plan to record this meeting using an audio-digital recorder and to make that audio recording available through a link in our online docket. We will also provide a written summary of the meeting and comments and will place that summary in the docket.

Dated: January 13, 2009.

M.L. Blair,

Captain, U.S. Coast Guard, Acting Director of Commercial Regulations and Standards.

[FR Doc. E9–1135 Filed 1–16–09; 8:45 am]

BILLING CODE 4910–15–P

DEPARTMENT OF VETERANS AFFAIRS

38 CFR Part 17

RIN 2900–AN23

Expansion of Enrollment in the VA Health Care System

AGENCY: Department of Veterans Affairs.

ACTION: Proposed rule.

SUMMARY: The Department of Veterans Affairs (VA) proposes to amend its regulations regarding enrollment in the VA health care system. In particular, it proposes to establish additional subpriorities within enrollment priority category 8 and provide that beginning on the effective date of the rule, VA would enroll priority category 8 veterans whose income exceeds the current means test and geographic means test income thresholds by 10 percent or less.

DATES: Written comments must be received on or before February 20, 2009.

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 Ave., 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–AN23—Expansion of Enrollment.'' 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. In addition, during the comment period, comments may be viewed online through the Federal Docket Management System (FDMS) at *http://www.Regulations.gov.*

FOR FURTHER INFORMATION CONTACT: Tony Guagliardo, Director, Business Policy, Chief Business Office (163), Veterans Health Administration, Department of Veterans Affairs, 810 Vermont Avenue, NW., Washington, DC 20420, (202) 461–1591. (This is not a toll free number.)

SUPPLEMENTARY INFORMATION: Public Law 104–262, the Veterans' Health Care Eligibility Reform Act of 1996, required VA to establish a national enrollment system to manage the delivery of inpatient hospital care and outpatient medical care, within available appropriated resources. It directed that the enrollment system be managed in such a way as ''to ensure that the provision of care to enrollees is timely and acceptable in quality,'' and authorized such subprioritization of the statutory enrollment categories ''as the Secretary determines necessary.'' The law also provided that starting October 1, 1998, most veterans had to enroll in the VA health care system as a condition for receiving VA hospital and outpatient care.

In a document published in the **Federal Register** on January 17, 2003 (68 FR 2670), VA published an interim final rule that amended 38 CFR 17.36 to add two new subpriorities to both enrollment priority categories 7 and 8, for a total of four subpriorities in each category. It also announced that

beginning January 17, 2003, VA would enroll all priority categories of veterans except that those veterans in priority category 8 who were not in an enrolled status on January 17, 2003, or who requested disenrollment after that date, would not be eligible to be enrolled. The veterans in this priority category are those whose incomes exceed certain income limits and who do not qualify for enrollment in another priority category. Since then, VA has not enrolled veterans in priority category 8 unless they had been enrolled in another priority category and no longer qualified for enrollment in that category.

This proposed rule would establish additional subpriorities within enrollment priority category 8 and would provide that beginning on the effective date of the rule, VA would enroll priority category 8 veterans whose income exceeds the current means test and geographic means test income thresholds by 10 percent or less. These veterans would continue enrollment in these subpriority groups (even if their income exceeds the current tests by more than 10 percent) unless they become eligible for enrollment in a higher category or subpriority; a request for disenrollment is made; or a decision is made to disenroll their particular subpriority or category. This proposed rule would also amend the medical regulations by making a nonsubstantive change to reflect an alternative method to submit VA's Application for Health Care Benefits (VA Form 10–10EZ).

Projections for Increasing Enrollment of Priority Category 8 Veterans Whose Income Exceeds the Current VA Means Test and Geographic Means Test Income Thresholds by 10 Percent or Less

An existing regulation (38 CFR 17.36(c)) requires that the Secretary determine which categories of veterans are eligible to be enrolled and that the Secretary notify eligible enrollees of the determination by announcing it in the **Federal Register**. In making that determination, the Secretary must consider an array of factors including economic information such as available resources, projections of demand for enrollment, and the length of waiting times for appointments for care.

The actual number of total enrollees who were enrolled at any time in 2003 was 7,120,347. The corresponding number in 2008 was 7,802,382. The increase in the veterans enrolled in the VA health care system between 2003 and 2008 is, therefore, 682,035.

The 2009 Appropriations Act provided funding in VA's health care appropriation to increase priority category 8 enrollment. The Veterans Health Administration's (VHA) total FY 2009 medical care appropriation is $40.434 billion. This is supplemented by an additional $3.717 billion from collections for copayments, third-party reimbursements for services, other revenue, and carry-over funds. The sum of these resources is $44.151 billion. The following table shows the projected enrollment for FY 2009 together with the projected expenditures that would be needed to provide the medical benefits package to enrollees under VA's current enrollment policy:

FY 2009 PROJECTIONS UNDER VA'S CURRENT ENROLLMENT POLICY [1]

Priority category	Enrollment	Expenditures	Cumulative expenditures
1	1,079,852	$10,552,245,777	$10,552,245,777
2	595,548	2,352,417,015	12,874,662,792
3	1,090,376	3,517,387,015	16,392,050,361
4	233,153	3,461,043,477	19,853,093,838
5	2,361,166	11,513,021,012	31,366,114,850
6	354,785	606,349,476	31,972,464,326
7	1,056,733	2,041,244,267	34,013,708,592
8	1,286,626	2,692,952,224	36,706,660,817
Total	8,058,238	36,706,660,817	

[1] This table *does not* include projections regarding the impact of the proposed regulatory change.

The following table shows the projected enrollment and expenditures for FY 2009 if the expanded enrollment as proposed in this document is implemented. The projections are based on reopening enrollment for Priority 8 veterans whose income exceeds the current VA means test (VMT) and geographic means test (GMT) income thresholds by 10 percent or less. The means tests are currently based on Calendar Year (CY) 2007 income.

Priority 8 veterans eligible to enroll under VMT/GMT+10 percent are assumed to enroll at higher rates than the average historical rates evidenced in the current Priority 8 enrollee population. Experience shows that veterans in the lower income ranges for Priority 8 veterans are more likely to enroll. The FY 2009 enrollment projections also reflect an expected surge in enrollment when the suspension is lifted and veterans who have not been able to enroll take advantage of this opportunity. The higher enrollment rates for VMT/GMT+10 percent veterans were increased by 17.5 percent for FY 2009 to reflect the expected surge. In absence of any data to support a different assumption, the projections for VMT/GMT+10 percent assume the new Priority 8 enrollees will have the same reliance and morbidity as current Priority 8 enrollees.

FY 2009 PROJECTIONS UNDER VA'S CURRENT ENROLLMENT POLICY PLUS GMT/VMT 10 PERCENT SCENARIO [1]

Priority category	Enrollment	Expenditures	Cumulative expenditures
1	1,079,852	$10,552,245,777	$10,522,245,777
2	595,548	2,352,417,015	12,874,662,792
3	1,090,376	3,517,387,568	16,392,050,361
4	233,153	3,461,043,477	19,853,093,838
5	2,361,166	11,513,021,012	31,366,114,850

FY 2009 PROJECTIONS UNDER VA'S CURRENT ENROLLMENT POLICY PLUS GMT/VMT 10 PERCENT SCENARIO [1]—Continued

Priority category	Enrollment	Expenditures	Cumulative expenditures
6	354,785	606,349,476	31,972,464,326
7	1,056,733	2,041,244,267	34,013,708,592
8	1,545,331	3,178,199,353	37,191,907,945
Total	8,316,943	37,191,907,945	

[1] FY 2009 Projections in this table include projections under Current Enrollment Policy *plus* the impact of the proposed regulatory change.

The previous tables display 2009 projections based on the 2008 Enrollee Health Care Projection Model, VA's health care actuarial model. The VA Enrollee Health Care Projection Model (the ''Model'') supports the VHA health care budget, projects the number of veterans who will be enrolled, the health care services they will choose to get from VHA, and the expenditures associated with that utilization for 20 years. The utilization and expenditure projections are developed based on where enrollees live to support population-based long-term planning. Base year unit costs are based on FY 2007 unit cost data from VA's financial accounting system—Decision Support System (DSS). The base year unit costs are trended forward using health care cost trends and adjusted for the impact of enrollee aging and changes in VA's level of health care management over the 20-year projection period. The expenditures projected by this model reflected in these tables exclude services such as Long Term Care, Readjustment Counseling, Spina Bifida, Foreign Medical Programs, Non-Veteran Medical Care, and the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). Total expenditures for medical care not included in the model are projected to be $6.959 billion in FY 2009. The following tables show VA's projections for enrollment through 2019 under the current enrollment policy and how the proposed expansion of enrollment in priority category 8 would affect that.

PROJECTED PRIORITY CATEGORY 8 ENROLLMENT: FY 2009–2019 [1]

Fiscal year	Current enrollment policy [2]	GMT/VMT 10% scenario [3]	Total enrollment
2009	1,286,626	258,705	1,545,331
2010	1,291,964	265,571	1,557,535
2011	1,294,969	271,755	1,566,724
2012	1,295,921	281,598	1,577,518
2013	1,293,672	295,772	1,589,444
2014	1,288,124	290,583	1,578,707
2015	1,280,054	294,617	1,574,671
2016	1,269,050	297,001	1,566,051
2017	1,258,489	299,393	1,557,882
2018	1,244,623	300,847	1,545,470
2019	1,228,603	300,798	1,529,401

[1] The enrollment projections begin with VetPop data, 20-year projections of the veteran population that are produced by the VA Office of the Actuary. At this time, VetPop does not provide veteran projections by Priority Levels so VetPop data is combined with other data sources to create VetPop Proxy data, which provides veteran projections by Priority Level.

Historical enrollment data are analyzed to develop enrollment rates by Priority Level, Age Band, Geographic Area, and Special Conflict Status. The enrollment rates are then applied to the enrollment pool, which is VetPop minus the enrolled veteran population, to determine projected enrollees for any given year.

Mortality rates specific to age, gender, and Priority Level are then applied to the enrollee population, and the enrollment and potential enrollee pool are aged one year at the end of each fiscal year to arrive at the projections for the beginning of the next fiscal year. The process of applying enrollment and mortality rates then repeats for the duration of the enrollment projections.

The VA Enrollee Health Care [Projection Model (EHCPM) also accounts for geographic migration and enrollees who transition between enrollment Priority Levels.

[2] FY 2009–2019 Projections under Current Enrollment Policy *do not* include the impact of the proposed regulatory change.

[3] FY 2009–2019 Projections under GMT/VMT 10 percent represent the impact of the proposed regulatory change.

PROJECTED TOTAL PRIORITY CATEGORY 1–8 ENROLLMENT: FY 2009–2019

Fiscal year	Current enrollment policy [1]	Current enrollment plus GMT/VMT 10% scenario [2]	Change from current policy
2009	8,058,238	8,316,943	258,705
2010	8,173,270	8,438,842	265,578
2011	8,274,706	8,546,461	271,755
2012	8,341,713	8,623,310	281,598
2013	8,378,061	8,673,833	295,772
2014	8,384,127	8,674,710	290,583
2015	8,364,224	8,658,841	294,617
2016	8,318,496	8,615,497	297,001

PROJECTED TOTAL PRIORITY CATEGORY 1–8 ENROLLMENT: FY 2009–2019—Continued

Fiscal year	Current enrollment policy [1]	Current enrollment plus GMT/VMT 10% scenario [2]	Change from current policy
2017	8,277,135	8,576,528	299,393
2018	8,231,823	8,532,671	300,847
2019	8,181,196	8,481,994	300,798

[1] FY 2009–2019 Projections under Current Enrollment Policy *do not* include the impact of the proposed regulatory change.
[2] FY 2009–2019 Projections in this column include projections under Current Enrollment Policy *plus* the impact of the proposed regulatory change.

As can be seen from the FY 2009 medical care appropriation and the tables above, VA projects that available resources to expand enrollment will be adequate to support the proposed expansion of enrollment of Priority 8 veterans.

Previous Interim Final Rules and Responses to Comments

This document includes proposed changes in the provisions adopted in the interim final rule published in the **Federal Register** on January 17, 2003 (68 FR 2669, RIN 2900–AL51). We received five comments on that interim final rule. All of the commenters expressed disagreement with VA's decision to suspend enrollment of additional veterans in priority category 8. Each of the commenters generally expressed the view that VA should provide care to all veterans seeking care because they had served their country. Thoughtful consideration was given to the comments received. However, as discussed in the preamble accompanying publication of the interim final rule, VA is required to assess available resources and determine the number of veterans it is able to enroll to ensure that medical services provided are both timely and acceptable in quality. An enrollment system is necessary because the provision of VA health care is discretionary and can be provided only to the extent that appropriated resources are available for that purpose. The enrollment decision made in January 2003 was based on available resources, and the comments do not suggest that VA's assessment of available resources was incorrect.

Unfunded Mandates

The Unfunded Mandates Reform Act requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before 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 in any given year. This rule would have no such effect on State, local, or tribal governments.

Paperwork Reduction Act

This proposed rule contains no provisions constituting a new collection of information, but would change, merely by adding an option of a new method of submission, a collection of information that has been approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501–3521). OMB assigns a control number for each collection of information it approves. 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. The information collection provisions affected by this proposed rule have been approved under control number 2900–0091.

Executive Order 12866 and Congressional Review Act

This is an economically significant regulatory action under Executive Order 12866 and constitutes a major rule under the Congressional Review Act.

Executive Order 12866 directs agencies to assess all 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, and other advantages; distributive impacts; and equity). Executive Order 12866 classifies a ''significant regulatory action'' requiring review by 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 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 entitlement recipients; 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.

VA has examined the economic, interagency, budgetary, legal, and policy implications of this proposed rule and has concluded that it is an economically significant regulatory action under Executive Order 12866 because it is likely to result in a rule that may have an annual effect on the economy of $100 million or more and may raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order. This proposed rule is also a major rule under the Congressional Review Act because it is likely to result in an annual effect on the economy of $100 million or more.

VA has attempted to follow OMB circular A–4 to the extent feasible in this analysis. The circular first calls for a discussion of the need for the regulation. The Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Pub. L. 110–329) was enacted on September 30, 2008. The accompanying report language stated that funding was included to reopen priority category 8 enrollment. The preamble above discusses the need for the regulation in more detail. There are not any alternatives to publishing this proposed rule that will accomplish the stated provisions in the report language of the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Pub. L. 110–329).

VA uses the Enrollee Health Care Projection Model (Model), a health care actuarial model, to project veteran demand for VA health care. To project enrollment and expenditures under this proposed regulatory change, VA first identified the number of non-enrolled veterans whose income exceeds the current VA means test and geographic means test income thresholds by 10

percent or less. VA then projected the number of those veterans who would enroll based on historical priority category 8 enrollment rates. The projected health care service utilization for these new enrollees was based on the historical morbidity and reliance rates of the current priority category 8 enrollee population. The projected expenditures represent the cost to provide the projected health care services to these new enrollees.

Using the 2008 Model, VA projects that this proposed regulatory change would result in an additional 258,705 priority category 8 enrollees in FY 2009. The projected increase in total health care service expenditures associated with this new enrollment is $485 million in FY 2009. The revenues generated by the first- and third-party collections are projected to be $121 million,[1] resulting in a $364 million growth in net health service expenditures for FY 2009, and $375 million was provided in the Consolidated Security, Disaster Assistance, and Continuing Appropriations Act, 2009 (Pub. L. 110–329). VA's expenditures related to this proposed regulatory change are projected to be approximately $2.931 billion for five years.[2] These expenditures exclude services such as Long Term Care, Readjustment Counseling, Spina Bifida, Foreign Medical Programs, Non-Veteran Medical Care and CHAMPVA.

[1] *The first party collections are based on the projected health care service utilization of the new Priority 8 enrollees. In the base year (2007), we applied the appropriate co-payment to the projected services. We then balanced the resulting co-payment revenue projections to the actual collections for 2007 for four categories (inpatient, outpatient, residential rehabilitation, and pharmacy) and by Veterans Integrated Service Network (VISN) to account for the amount actually collected. The resulting first-party revenue per service developed for 2007 is applied to the projected services in future years to project the first-party revenue associated with health care utilization of the new Priority 8 enrollees. Further, the pharmacy co-payment is increased over time based on the legislated Consumer Price Index (CPI) schedule.*

To develop the third-party collections, we calculated the percentage of third-party revenue collected in 2007 as a percent of 2007 expenditures by VISN, priority level, and two age bands (under and over age 65). We then applied these percentages to the projected expenditures for the new Priority 8 enrollees in future years. For 2010, the percentages were increased to reflect VHA's initiatives to increase third-party revenue collections.

[2] FIVE YEAR PROJECTION TABLE

[Present value: (future value)/((1+i−^n)]

($ in billions)	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	5 year
Future Value (FV)	$0.485	$0.533	$0.580	$0.631	$0.702	$2.931
3% discount rate (i)	3.00%	3.00%	3.00%	3.00%	3.00%	.....
7% discount rate (i)	7.00%	7.00%	7.00%	7.00%	7.00%	.....
Number of Years (n)	0	1	2	3	4	.....
Present Value (PV) at 3%	$0.485	$0.517	$0.546	$0.578	$0.624	$2.751
Present Value (PV) at 7%	$0.485	$0.498	$0.506	$0.515	$0.536	$2.540

VA requests comments on all of these projections.

Regulatory Flexibility Act

The Secretary hereby certifies that the adoption of 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 rule would not directly affect any small entities. Only individuals could be directly affected. Therefore, pursuant to 5 U.S.C. 605(b), this rule is exempt from the initial and final regulatory flexibility analysis requirements of sections 603 and 604.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.005, Grants to States for the Construction of State Homes; 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; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.016, Veterans State Hospital Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; and 64.022, Veterans Home Based Primary Care.

List of Subjects in 38 CFR Part 17

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

Approved: January 13, 2009.

James B. Peake,

Secretary of Veterans Affairs.

For the reasons set out in the preamble, VA proposes to amend 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, 1721, and as stated in specific sections.

2. Amend § 17.36 by revising paragraphs (b)(8), (c)(1), (c)(2), and (d)(1) and the authority citation to read as follows:

§ 17.36 Enrollment—provision of hospital and outpatient care to veterans.

* * * * *

(b) * * *

(8) Veterans not included in priority category 4 or 7, who are eligible for care only if they agree to pay to the United States the applicable copayment determined under 38 U.S.C. 1710(f) and 1710(g). This category is further prioritized into the following subcategories:

(i) Noncompensable zero percent service-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(ii) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) of this section and whose income is not greater than ten percent more than the income that

would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(iii) Nonservice-connected veterans who were in an enrolled status on January 17, 2003, or who are moved from a higher priority category or subcategory due to no longer being eligible for inclusion in such priority category or subcategory and who subsequently do not request disenrollment;

(iv) Nonservice-connected veterans not included in paragraph (b)(8)(iii) of this section and whose income is not greater than ten percent more than the income that would permit their enrollment in priority category 5 or priority category 7, whichever is higher;

(v) Noncompensable zero percent service-connected veterans not included in paragraph (b)(8)(i) or paragraph (b)(8)(ii) of this section; and

(vi) Nonservice-connected veterans not included in paragraph (b)(8)(iii) or paragraph (b)(8)(iv) of this section.

(c) * * *

(1) It is anticipated that each year the Secretary will consider whether to change the categories and subcategories of veterans eligible to be enrolled. The Secretary at any time may revise the categories or subcategories of veterans eligible to be enrolled by amending paragraph (c)(2) of this section. The preamble to a **Federal Register** document announcing which priority categories and subcategories are eligible to be enrolled must specify the projected number of fiscal year applicants for enrollment in each priority category, projected healthcare utilization and expenditures for veterans in each priority category, appropriated funds and other revenue projected to be available for fiscal year enrollees, and projected total expenditures for enrollees by priority category. The determination should include consideration of relevant internal and external factors, *e.g.*, economic changes, changes in medical practices, and waiting times to obtain an appointment for care. Consistent with these criteria, the Secretary will determine which categories of veterans are eligible to be enrolled based on the order of priority specified in paragraph (b) of this section.

(2) Unless changed by a rulemaking document in accordance with paragraph (c)(1) of this section, VA will enroll the priority categories of veterans set forth in § 17.36(b) beginning [effective date of regulation], except that those veterans in subcategories (v) and (vi) of priority category 8 are not eligible to be enrolled.

(d) * * *

(1) *Application for enrollment.* A veteran may apply to be enrolled in the VA healthcare system at any time. A veteran who wishes to be enrolled must apply by submitting a VA Form 10–10EZ to a VA medical facility or via an online submission at *https://www.1010ez.med.va.gov/sec/vha/1010ez/.*

* * * * *

(Authority: 38 U.S.C. 101, 501, 1521, 1701, 1705, 1710, 1722)

[FR Doc. E9–1024 Filed 1–16–09; 8:45 am]

BILLING CODE 8320–01–P