circumstances which permit exceptions from conducting verifications; *Form Number:* CMS–R–74 (OCN 0938–0467); *Frequency:* Monthly; *Affected Public:* State, Local, or Tribal Governments; *Number of Respondents:* 50; *Total Annual Responses:* 8,520,000; *Total Annual Hours:* 124,054. (For policy questions regarding this collection contact Barbara Washington at (410) 786–9964. For all other issues call (410) 786–1326.)

2. *Type of Information Collection Request:* Type of Information Collection Request: Extension of a currently approved collection; Title of Information Collection: Affordable Care Act Internal Claims and Appeals and External Review Procedures for Non-grandfathered Group Health Plans and Issuers and Individual Market Issuers; Use: The Patient Protection and Affordable Care Act, Public Law 111–148, (the Affordable Care Act) was enacted on March 23, 2010. As part of the Act, Congress added PHS Act section 2719, which provides rules relating to internal claims and appeals and external review processes. On July 23, 2010 (75 FR 43330), interim final regulations (IFR) set forth rules implementing PHS Act section 2719 for internal claims and appeals and external review processes. With respect to internal claims and appeals processes for group health coverage, PHS Act section 2719 and our regulations provide that group health plans and health insurance issuers offering group health insurance coverage must comply with the internal claims and appeals processes set forth in 29 CFR 2560.503–1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor. The DOL claims procedure regulation requires an employee benefit plan to provide third-party notices and disclosures participants and beneficiaries of the plan. In addition, our regulations add an additional requirement that non-grandfathered group health plans and issuers of non-grandfathered health policies provide to the claimant, free of charge, any new or additional evidence considered, or generated by the plan or issuer in connection with the claim.

The IFR also requires issuers offering coverage in the individual health insurance market to also generally comply with the DOL claims procedure regulation as updated by the Secretary of HHS in the IFR for their internal claims and appeals processes.

Furthermore, PHS Act section 2719 and the IFR provide that non-grandfathered group health plans, issuers offering group health insurance coverage, and self-insured nonfederal governmental plans (through the IFR amendment dated June 24, 2011) must comply either with a State external review process or a Federal review process. The IFR provides a basis for determining when such plans and issuers must comply with an applicable State external review process and when they must comply with the Federal external review process. Plans and issuers that are required to participate in the Federal external review process must electronically elect either the HHS-administered process or the private accredited IRO process by January 1, 2012. The election requirements associated with this ICR are articulated through guidance published June 22, 2011 at *http://cciio.cms.gov/resources/files/hhs_srg_elections_06222011.pdf.* The election requirements are necessary for the Federal external review process to provide an independent external review as requested by claimants. Form Number: CMS–10338 (OCN: 0938–1099); Frequency: Occasionally; Affected Public: State, Local, Tribal Governments; Business or other for-profit; Not-for-profit institutions. Number of Respondents: 46,773; Number of Responses: 218,657,161; Total Annual Hours: 930,267. (For policy questions regarding this collection, contact Colin McVeigh at (301) 492–4263. For all other issues call (410) 786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web Site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

In commenting on the proposed information collections please reference the document identifier or OMB control number. To be assured consideration, comments and recommendations must be submitted in one of the following ways by March 5, 2012:

1. *Electronically.* You may submit your comments electronically to *http://www.regulations.gov.* Follow the instructions for ''Comment or Submission'' or ''More Search Options'' to find the information collection document(s) accepting comments.

2. *By regular mail.* You may mail written comments to the following address: CMS, Office of Strategic Operations and Regulatory Affairs, Division of Regulations Development, Attention: Document Identifier/OMB Control Number, Room C4–26–05, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: December 23, 2011.

Martique Jones,

Director, Regulations Development Group, Division B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2011–33752 Filed 1–3–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[Document Identifier CMS–10142 and CMS–R–262]

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: Centers for Medicare & Medicaid Services, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the Agency's function; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

1. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Bid Pricing Tool (BPT) for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use:* Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and implementing regulations at 42 CFR, Medicare Advantage organizations (MAO) and Prescription Drug Plans (PDP) are required to submit an actuarial pricing ''bid'' for each plan offered to Medicare beneficiaries for approval by the Centers for Medicare & Medicaid Services (CMS).

MAOs and PDPs use the Bid Pricing Tool (BPT) software to develop their actuarial pricing bid. The information provided in the BPT is the basis for the plan's enrollee premiums and CMS payments for each contract year. The tool collects data such as medical expense development (from claims data and/or manual rating), administrative expenses, profit levels, and projected plan enrollment information. By statute, completed BPTs are due to CMS by the first Monday of June each year.

CMS reviews and analyzes the information provided on the Bid Pricing Tool. Ultimately, CMS decides whether to approve the plan pricing (i.e., payment and premium) proposed by each organization. CMS is requesting to continue its use of the BPT for the collection of information for CY2013 through CY2015. *Form Number:* CMS–10142 (OCN: 0938–0944); *Frequency:* Yearly; *Affected Public:* Private Sector—Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 530; *Total Annual Responses:* 4,770; *Total Annual Hours:* 143,100. (For policy questions regarding this collection contact Diane Spitalnic at (410) 786–5745. For all other issues call (410) 786–1326.)

2. *Type of Information Collection Request:* Revision of a currently approved collection; *Title of Information Collection:* Plan Benefit Package (PBP) and Formulary Submission for Medicare Advantage (MA) Plans and Prescription Drug Plans (PDP); *Use:* Under the Medicare Modernization Act (MMA), Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations are required to submit plan benefit packages for all Medicare beneficiaries residing in their service area. The plan benefit package submission consists of the Plan Benefit Package (PBP) software, formulary file, and supporting documentation, as necessary. MA and PDP organizations use the PBP software to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits. They also generate a formulary to describe their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. Additionally, CMS uses the PBP and formulary data to review and approve the plan benefit packages proposed by each MA and PDP organization.

CMS requires that MA and PDP organizations submit a completed PBP and formulary as part of the annual bidding process. During this process, organizations prepare their proposed plan benefit packages for the upcoming contract year and submit them to CMS for review and approval.

CMS is requesting to continue its use of the PBP software and formulary submission for the collection of benefits and related information for CY 2013 through CY 2015. CMS estimates that 571 MA organizations and 64 PDP organizations will be required to submit the plan benefit package information in CY 2013. Based on operational changes and policy clarifications to the Medicare program and continued input and feedback by the industry, CMS has made the necessary changes to the plan benefit package submission. *Form Number:* CMS–R–262 (OCN: 0938–0763); *Frequency:* Yearly; *Affected Public:* Private Sector—Business or other for-profits and not-for-profit institutions; *Number of Respondents:* 635; *Total Annual Responses:* 6,015; *Total Annual Hours:* 53,291. (For policy questions regarding this collection contact Kristy Holtje at (410) 786–2209. For all other issues call (410) 786–1326.)

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS Web site address at *http://www.cms.hhs.gov/PaperworkReductionActof1995,* or Email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov,* or call the Reports Clearance Office on (410) 786–1326.

To be assured consideration, comments and recommendations for the proposed information collections must be received by the OMB desk officer at the address below, no later than 5 p.m. on *February 3, 2012.*

OMB, Office of Information and Regulatory Affairs, Attention: CMS Desk Officer, Fax Number: (202) 395–6974, Email: *OIRA_submission@omb.eop.gov.*

Dated: December 23, 2011.

Martique Jones,

Director, Regulations Development Group, Division-B, Office of Strategic Operations and Regulatory Affairs.

[FR Doc. 2011–33750 Filed 1–3–12; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. App.), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Cell Biology Integrated Review Group; Cellular Mechanisms in Aging and Development Study Section.

Date: February 1–2, 2012.

Time: 8 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Hyatt Regency Bethesda, One Bethesda Metro Center, 7400 Wisconsin Avenue, Bethesda, MD 20814.

Contact Person: John Burch, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institute of Health, 6701 Rockledge Drive, Room 3213, MSC 7808, Bethesda, MD 20892, (301) 408–9519, *burchjb@csr.nih.gov.*

Name of Committee: Cardiovascular and Respiratory Sciences Integrated Review Group; Lung Cellular, Molecular, and Immunobiology Study Section.

Date: February 1–2, 2012.

Time: 8 a.m. to 6 p.m.

Agenda: To review and evaluate grant applications.

Place: Admiral Fell Inn, 888 South Broadway, Baltimore, MD 21231.

Contact Person: George M Barnas, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 2180, MSC 7818, Bethesda, MD 20892, (301) 435–0696, *barnasg@csr.nih.gov.*

Name of Committee: Surgical Sciences, Biomedical Imaging and Bioengineering Integrated Review Group; Surgery, Anesthesiology and Trauma Study Section.

Date: February 1–2, 2012.

Time: 11 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Holiday Inn Fisherman's Wharf, 1300 Columbus Avenue, San Francisco, CA 94133.

Contact Person: Weihua Luo, MD, Ph.D., Scientific Review Officer, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5114, MSC 7854, Bethesda, MD 20892, (301) 435–1170, *luow@csr.nih.gov.*

Name of Committee: Bioengineering Sciences & Technologies Integrated Review Group; Nanotechnology Study Section.

Date: February 2–3, 2012.

Time: 7 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: Fairmont Hotel San Francisco, 950 Mason Street, San Francisco, CA 94108.