EXHIBIT 3—ESTIMATED ANNUALIZED COST

Cost component	Total cost	Annualized cost
Review of literature	$20,000	$20,000
Cognitive interviews	60,000	60,000
Field test	90,000	90,000
Data analyses	40,000	40,000
Finalize survey	39,000	39,000
AHRQ project management	50,000	50,000
Total	299,000	299,000

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: Aug 31 2011.

Carolyn M. Clancy,

Director.

[FR Doc. 2011–23543 Filed 9–14–11; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Agency for Healthcare Research and Quality

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Agency for Healthcare Research and Quality, HHS.

ACTION: Notice.

SUMMARY: This notice announces the intention of the Agency for Healthcare Research and Quality (AHRQ) to request that the Office of Management and Budget (OMB) approve the proposed information collection project: ''Medical Expenditure Panel Survey—Insurance Component 2012–2013.'' In accordance with the Paperwork Reduction Act, 44 U.S.C. 3501–3521, AHRQ invites the public to comment on this proposed information collection.

This proposed information collection was previously published in the **Federal Register** on June 30th, 2011 and allowed 60 days for public comment. No comments were received. The purpose of this notice is to allow an additional 30 days for public comment.

DATES: Comments on this notice must be received by October 17, 2011.

ADDRESSES: Written comments should be submitted to: AHRQ's OMB Desk Officer by fax at (202) 395–6974 (attention: AHRQ's desk officer) or by e-mail at *OIRA_submission@omb.eop.gov* (*attention:* AHRQ's desk officer).

Copies of the proposed collection plans, data collection instruments, and specific details on the estimated burden can be obtained from the AHRQ Reports Clearance Officer.

FOR FURTHER INFORMATION CONTACT: Doris Lefkowitz, AHRQ Reports Clearance Officer, (301) 427–1477, or by e-mail at *doris.lefkowitz@AHRQ.hhs.gov*.

SUPPLEMENTARY INFORMATION:

Proposed Project

Medical Expenditure Panel Survey—Insurance Component 2012–2013

Employer-sponsored health insurance is the source of coverage for 85 million current and former workers, plus many of their family members, and is a cornerstone of the U.S. health care system. The Medical Expenditure Panel Survey—Insurance Component (MEPS–IC) measures the extent, cost, and coverage of employer-sponsored health insurance on an annual basis. These statistics are produced at the National, State, and sub-State (metropolitan area) level for private industry. Statistics are also produced for State and Local governments.

This research has the following goals:

(1) To provide data for Federal policymakers evaluating the effects of National and State health care reforms;

(2) to provide descriptive data on the current employer-sponsored health insurance system and data for modeling the differential impacts of proposed health policy initiatives; and

(3) to supply critical State and National estimates of health insurance spending for the National Health Accounts and Gross Domestic Product.

This study is being conducted by AHRQ through an interagency agreement with the U.S. Census Bureau and pursuant to AHRQ's statutory authority to conduct surveys to collect data on the cost, use and quality of health care, including the types and costs of private health insurance. 42 U.S.C. 299b–2(a).

Method of Collection

To achieve the goals of this project the following data collections for both private sector and state and local government employers will be implemented:

(1) Prescreener Questionnaire—The purpose of the Prescreener Questionnaire, which is collected via telephone, varies depending on the insurance status of the establishment contacted. (Establishment is defined as a single, physical location in the private sector and a governmental unit in state and local governments.) For establishments that do not offer health insurance to their employees, the prescreener is used to collect basic information such as number of employees. Collection is completed for these establishments through this telephone call. For establishments that do offer health insurance, contact name and address information is collected that is used for the mailout of the establishment and plan questionnaires. Obtaining this contact information helps ensure that the questionnaires are directed to the person in the establishment best equipped to complete them.

(2) Establishment Questionnaire—The purpose of the mailed Establishment Questionnaire is to obtain general information from employers that provide health insurance to their employees. Information such as total active enrollment in health insurance, other employee benefits, waiting periods, and retiree health insurance is collected through the establishment questionnaire.

(3) Plan Questionnaire—The purpose of the mailed Plan Questionnaire is to collect plan-specific information on each plan (up to four plans) offered by establishments that provide health insurance to their employees. This questionnaire obtains information on total premiums, employer and employee contributions to the premium, and plan enrollment for each type of coverage offered—single, employee-plus-one, and family—within a plan. It also asks for information on deductibles, copays, and other plan characteristics. This information is needed in order to provide the tools for Federal, State, and academic researchers to evaluate current and proposed health policies and to support the production of important statistical measures for other Federal agencies.

Estimated Annual Respondent Burden

Exhibit 1 shows the estimated annualized burden hours for the respondent's time to provide the requested data. The Prescreener questionnaire will be completed by 31,552 respondents and takes about 5 ½ minutes to complete. The Establishment questionnaire will be completed by 25,839 respondents and takes about 23 minutes to complete. The Plan questionnaire will be completed by 23,230 respondents and will require an average of 2.1 responses per respondent. Each Plan questionnaire takes about 11 minutes to complete. The total annualized burden hours are estimated to be 21,440 hours.

Exhibit 2 shows the estimated annualized cost burden associated with the respondents' time to participate in this data collection. The annualized cost burden is estimated to be $614,256.

EXHIBIT 1—ESTIMATED ANNUALIZED BURDEN HOURS

Form name	Number of respondents	Number of responses per respondent	Hours per response	Total burden hours
Prescreener Questionnaire	31,552	1	0.09	2,840
Establishment Questionnaire	25,839	1	0.38	9,819
Plan Questionnaire	23,230	2.1	0.18	8,781
Total	80,621	na	na	21,440

EXHIBIT 2—ESTIMATED ANNUALIZED COST BURDEN

Form name	Number of respondents	Total burden hours	Average hourly wage rate*	Total cost burden
Prescreener Questionnaire	31,552	2,840	28.65	$81,366
Establishment Questionnaire	25,839	9,819	28.65	281,314
Plan Questionnaire	23,230	8,781	28.65	251,576
Total	80,621	21,440	na	614,256

*Based upon the mean hourly wage for Compensation, Benefits, and Job Analysis Specialists occupation code—1141, at *http://www.bls.gov/oes/current/oes_nat.htm#13–0000* (U.S. Department of Labor, Bureau of Labor Statistics.)

Estimated Annual Costs to the Federal Government

Exhibit 3 shows the estimated annualized cost of this data collection. The total cost over the 2 years of this clearance is $22,954,000.

EXHIBIT 3—ESTIMATED TOTAL AND ANNUALIZED COST

[$ thousands]

Cost component	Total cost	Annualized cost
Project Development	$3,338	$1,669
Data Collection Activities	7,789	3,895
Data Processing and Analysis	7,789	3,895
Project Management	2,925	1,463
Overhead	1,113	557
Total	22,954	11,477

Note: Components may not sum to Total due to rounding.

Request for Comments

In accordance with the Paperwork Reduction Act, comments on AHRQ's information collection are requested with regard to any of the following: (a) Whether the proposed collection of information is necessary for the proper performance of AHRQ healthcare research and healthcare information

dissemination functions, including whether the information will have practical utility; (b) the accuracy of AHRQ's estimate of burden (including hours and costs) of the proposed collection(s) of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information upon the respondents, including the use of automated collection techniques or other forms of information technology.

Comments submitted in response to this notice will be summarized and included in the Agency's subsequent request for OMB approval of the proposed information collection. All comments will become a matter of public record.

Dated: Aug 31 2011.

Carolyn M. Cancy,

Director.

[FR Doc. 2011–23539 Filed 9–14–11; 8:45 am]

BILLING CODE 4160–90–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

[Docket No. FDA–2011–N–0400]

DEPARTMENT OF AGRICULTURE

Food Safety and Inspection Service

[Docket No. FSIS–2011–0014]

Approaches to Reducing Sodium Consumption; Establishment of Dockets; Request for Comments, Data, and Information

AGENCY: Food and Drug Administration, HHS; Food Safety and Inspection Service, USDA.

ACTION: Notice; establishment of dockets; request for comments, data, and information.

SUMMARY: The Food and Drug Administration (FDA) and the Food Safety and Inspection Service (FSIS) are announcing the establishment of dockets to obtain comments, data, and evidence relevant to the dietary intake of sodium as well as current and emerging approaches designed to promote sodium reduction. FDA and FSIS are particularly interested in research that will help both organizations understand current and emerging practices by industry in sodium reduction in foods; current consumer understanding of the role of sodium in hypertension and other chronic illnesses, sodium consumption practices; motivation and barriers in reducing sodium in their food intakes; and issues associated with the development of targets for sodium reduction in foods to promote reduction of excess sodium intake. Excess sodium intake is linked to increased risk of heart disease and stroke. FDA and FSIS recognize ongoing efforts by a number of members of the restaurant and packaged food industries to reduce sodium and appreciate the complexities of reducing sodium in foods. Continued input and support from industry and other stakeholders are important to support further progress on this significant public health issue.

DATES: Submit either electronic or written comments and data and information by November 29, 2011.

ADDRESSES: *FDA:* Submit electronic comments and data and information to *http://www.regulations.gov.* Submit written comments and data and information to the Division of Dockets Management (HFA–305), Food and Drug Administration, 5630 Fishers Lane, Rm. 1061, Rockville, MD 20852. All submissions must include the Agency name and docket number FDA–2011–N–0400.

FSIS: Submit electronic comments and data and information to *http://www.regulations.gov.* Submit written comments and data and information to the Docket Clerk, U.S. Department of Agriculture, Food Safety and Inspection Service, FSIS Docket Room, 1400 Independence Avenue, SW., Patriots Plaza 3, Mailstop 3782, Room 163A, Washington, DC 20250–3700. All submissions must include the Agency name and docket number FSIS–2011–0014.

FOR FURTHER INFORMATION CONTACT: *FDA:* Richard E. Bonnette, Center for Food Safety and Applied Nutrition (HFS–255), Food and Drug Administration, 5100 Paint Branch Pkwy., College Park, MD 20740–3835, 240–402–1235.

FSIS: Rosalyn Murphy-Jenkins, Director, Labeling and Program Delivery Division, Office of Policy and Program Development, Food Safety and Inspection Service, U.S. Department of Agriculture, USDA, FSIS, OPPD, LPDD Stop Code 3784, Patriots Plaza III, 8–161A, 1400 Independence Avenue, SW., Washington, DC 20250–3700.

SUPPLEMENTARY INFORMATION:

I. Background

Research shows that excess sodium consumption is a contributory factor in the development of hypertension, which is a leading cause of heart disease and stroke (Ref. 1), the first and fourth leading causes of death in the United States, respectively (Ref. 2). Research also shows that the increase in blood pressure seen with aging, common to most Western countries, is not observed in populations that consume low sodium diets (Refs. 3 and 4) and that the U.S. population consumes far more sodium than recommended (Ref. 5 and 7). Moreover, dietary reduction of sodium can lower blood pressure as has been demonstrated in the Dietary Approaches to Stop Hypertension (DASH)-Sodium trial (Ref. 6). Because over three-quarters of sodium in the diet of the U.S. population is added during manufacturing of foods and preparation of restaurant foods, reduction in sodium consumption in the United States involves reduction in the sodium content of food in the U.S. marketplace (Refs. 5 and 7).

In this document, we refer primarily to ''sodium,'' a component of sodium chloride, commonly known as ''salt.'' Most but not all sodium is added to food in the form of salt and we are interested in all sources of sodium added to foods. The comments, data, and evidence regarding sodium reduction obtained by the establishment of these dockets will provide important information about current and emerging practices and approaches designed to reduce excess sodium intake, primarily coming from salt.

A. Sodium: Current and Recommended Intake

According to national food survey data from the ''What We Eat in America, National Health and Nutrition Examination Survey (NHANES) 2007–2008,'' estimated average sodium intake from foods among persons in the United States aged 2 years or older is approximately 3,300 milligrams per day (mg/d) (excluding salt added at the table) (Ref. 8). Most of this sodium comes from salt used in the manufacture or preparation of foods (Ref. 9). In 2005, the IOM set a Tolerable Upper Intake Level (UL) for sodium at 2,300 mg/d and an Adequate Intake (AI) at 1,500 mg/d for those 9 to 50 years of age, including pregnant and lactating women (AIs are lower for those 0–8 years of age and for those over 50 years of age) (Ref. 1). The 2010 Dietary Guidelines for Americans recommendations are to ''reduce daily sodium intake to less than 2,300 milligrams (mg) and further reduce intake to 1,500 mg among persons who are 51 and older and those of any age who are African American or have hypertension, diabetes, or chronic kidney disease.'' The 1,500 mg recommendation applies to about half of the U.S. population (Ref. 7). Current sodium intake is substantially higher