Dated: December 10, 1997.

William K. Hubbard,

Associate Commissioner for Policy Coordination.

[FR Doc. 97–32877 Filed 12–16–97; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–R–26]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), 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 functions; (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.

Type of Information Collection Request:

Extension of a currently approved collection; *Title of Information Collection:* Clinical Laboratory Improvement Amendment (CLIA) and the Information Collection Requirements (ICRs) contained in the Supporting Regulations 42 CFR 493.1–2001; *Form No.:* HCFA–R–26 (OMB# 0938–0612); *Use:* The ICRs referenced in 42 CFR 493.1–.2001 outline the requirements necessary to determine an entities compliance with CLIA. CLIA requires laboratories that perform testing on human specimens to meet performance requirements in order to be certified by HHS. HHS conducts inspections in order to determine a laboratory's compliance with the CLIA requirements. CLIA implements certificate, laboratory standards and inspection requirements.; *Frequency:* As needed; *Affected Public:* Individuals or Households, Business or other for profit, Not for profit institutions, Federal Government, State, local or tribal government; *Number of Respondents:* 149,700; *Total Annual Responses:* 631,459; *Total Annual Hours:* 9,133,625.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Attention: Louis Blank, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: December 5, 1997.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards.

[FR Doc. 97–32859 Filed 12–16–97; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

Document Identifier: HCFA–R–205 and HCFA–R–206

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

AGENCY: Health Care Financing Administration.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), 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 functions; (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.

We are, however, requesting an emergency review of the information collections referenced below. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirements for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320. This is necessary to ensure compliance with section 111 of HIPAA necessary to implement congressional intent with respect to guaranteeing availability of individual health insurance coverage to certain individuals with prior group coverage. We cannot reasonably comply with the normal clearance procedures because public harm is likely to result because eligible individuals will not receive the health insurance protections under the statute.

HCFA is requesting OMB review and approval of this collection by 12/31/97, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individuals designated below by 12/29/97. It should be noted that HCFA will continue to consider and respond as appropriate to the public comments received in response to the 04/08/97 **Federal Register** notices requesting public comment on the collections referenced below. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

Type of Information Request: Extension, without change, of a currently approved collection.

Title of Information Collection: Individual Health Insurance. Reform: Portability from Group to Individual Coverage; Federal Rules for Access in the Individual Market; State Alternative Mechanisms to Federal Rules BPD–882–IFC.

Form Number: HCFA–R–205 (OMB approval #: 0938–0703).

Use: These information collection requirements help ensure access to the individual insurance market for certain individuals and allows the States to

implement their own program to meet the HIPAA requirements for access to the individual market. The information collection requirements outlined in this document are necessary for issuers and States to ensure individuals receive protection under section 111 of HIPAA.

Frequency: On occasion.

Affected Public: States, businesses or other for profit, not-for-profit institutions, Federal Government, individuals or households.

Number of Respondents: 1,035.

Total Annual Responses: 3.5 million in 1997; 3 million each in 1998 and 1999; Total Annual Hours Requested: 335,000 to 586,000 hours in 1997; 384,000 to 882,000 in 1998; and 377,000 to 882,000 in 1999.

Total Annual Cost: $4.9 million to $6.8 million in 1997; $5.1 million to $8.7 million in 1998; and $5.4 million to $8.7 million in 1999.

Section 148.120 Guaranteed Availability of Individual Health Insurance Coverage to Certain Individuals With Prior Group Coverage

States are given the flexibility either to enforce the Federal requirements set forth in Sec. 148.120, or to implement an alternative mechanism, under State law, that achieves the statutory mandate of providing eligible individuals with access to individual health insurance, or comparable coverage, without preexisting condition exclusions. However, a State could choose to do nothing, resulting in Federal enforcement of the individual market regulations under HIPAA. Thirty States have indicated to us an intent to implement an alternative mechanism under Sec. 148.128. The information collection requirements associated with implementing and enforcing the alternative mechanism are discussed below for Sec. 148.128.

If a State chooses to enforce the Federal guaranteed availability requirements (sometimes referred to as the ''Federal fall back'' requirements), the provisions of Sec. 148.120 apply, and must be enforced by the State under State law. Since many of these requirements are enforced under existing State law, for these instances, they are exempt from the Paperwork Reduction Act (PRA) as described under 5 CFR 1320.3(b)(3). Although applicable PRA burden will vary by State and issuer, we anticipate that ten States will be required to review materials submitted by at most 325 issuers per State on an annual basis to ensure compliance with the requirements of all products guaranteed or alternative coverage, which are not currently required under State laws and regulations. Therefore, the PRA burden imposed under this option is the time required by the ten States to review the materials submitted by the issuers. This burden is 1,625 hours based on each of the ten States reviewing the material for 30 minutes for each issuer on an annual basis. We estimate the cost associated with this burden to be $24,375.

If a State implements neither an alternative mechanism, nor the Federal fall back requirements, we will implement the Federal fall back provisions in that State and will enforce those requirements using the penalty provisions specified in Secs. 148.200 and 148.202. We anticipate that fewer than ten States will rely on Federal enforcement of the statute. In particular, the only jurisdictions that we believe will choose this option are the five U.S. territories.

This section also requires an issuer who elects the alternative coverage option to document any actuarial calculations necessary to satisfy State and/or Federal oversight provisions referenced in Sec. 148.120. Since the majority of issuers rely on automated means of storing their calculations, we estimate the annual burden for this record keeping activity to be 25 hours. This is based on the assumption that it will take approximately 10 issuers per State, in 15 States, on an annual basis, 10 minutes per issuer, to electronically store and verify the storage of their calculations. We estimate the cost associated with this burden to be $375.

Section 148.122 Guaranteed Renewability of Individual Health Insurance Coverage

In this section issuers are only required to report if they are discontinuing a particular type of coverage or discontinuing all coverage. This requirement exists in the absence of this regulation because under current insurance practices, State insurance departments oversee discontinuance of insurance products in their State as a normal business practice. Therefore, these information collection requirements are exempt from the PRA under 5 CFR 1320.3(b)(2) and 5 CFR 1320.3(b)(3). However, under HIPAA, States must review policies during their oversite process to make sure there is a guarantee renewability clause in each policy. For the 21 States that currently require guaranteed renewability, it is our understanding that this is normal business practice. For the other 34 States, however, we see this State burden to be about 10 minutes per policy, since States already review policies for other requirements and this process does not prescribe a timetable for reviewing the policies. We see this as a total annual burden of 20,000 hours. We estimate the cost associated with this burden to be $300,000. If the State identifies a violation and a State has to take some action, we believe that each State will be required to initiate fewer than 10 administrative actions on an annual basis against specific individuals or entities who failed to implement the Federal guarantee renewability requirements.

Section 148.124 Certification and Disclosure of Coverage

Section 148.124 specifies that an issuer in the individual market must provide a written certificate of creditable coverage, and, if required, make other certain disclosures regarding an individual's coverage under an individual policy. In general, the certification and disclosure requirements are substantially identical to the relevant provisions of Sec. 146.115 that apply to health insurance coverage offered by issuers in the group market. The preamble accompanying the group market regulation explains these procedures in detail. In general, the certificates from issuers in the individual market and other disclosure of information are intended to enable individuals to avoid or reduce preexisting condition exclusions included under subsequent group health insurance coverage the individual may obtain.

Individuals have the right to receive a certificate automatically (an automatic certificate) when they lose coverage under an individual policy. A certificate must also be provided upon a request by, or on behalf of, an individual for the period not later than 24 months after coverage ceases. The certificate must be provided at the earliest time that an issuer, acting in a reasonable and prompt fashion, can provide the certificate. The certificate must also be provided consistent with State law.

An issuer of an individual policy is required, to the same extent as an issuer of insurance in the group market, to prepare certificates with respect to the coverage of any of the individual's dependents that are covered under the individual policy.

We anticipate that 3 million individual market-based certificates will be generated on an annual basis. We are assuming that the majority of certificates issued in the individual market will require issuers to find out the application date since many individuals will have less than 18 months of credible coverage with that issuer.

The range of time estimates, shown in the table below, are based on

discussions with industry individuals. We believe that as a routine business practice, the issuers' administrative staff have the necessary information readily available to generate the required certificates. In addition, we have determined that the majority of issuers have or will have the capability to automatically computer generate and disseminate the necessary certification when appropriate.

	Total respondents	Total responses	Average time (in minutes) per response (range)	Burden hours (range)	Cost (range)
1997	1,000	3,418,052	4.63	263,548	$3,897,932
	.....	.....	8.95	509,665	5,716,826
1998	1,000	2,929,759	6.94	338,781	4,542,924
	.....	.....	17.11	835,517	8,035,131
1999	1,000	2,929,759	6.81	332,480	4,746,736
	.....	.....	17.11	835,517	8,035,131

Section 148.126 Determination of an Eligible Individual

In this section, issuers may maintain records for those individuals who they determine are not HIPAA eligible individuals. We estimate this to be on average less than 50 individuals per the 1,000 issuers nationwide each year. At 20 minutes per record, this represents an annual burden of 16,667 hours. We estimate the cost associated with this burden to be $183,000.

Section 148.128 State Flexibility in Individual Market Reforms—Alternative Mechanisms

As explained above, 30 or more States may implement acceptable alternative mechanisms as allowed under this section. It is estimated that this reporting burden will range from 33,000 to 38,500 hours depending on the number of States that choose to submit the required information. We estimate the cost associated with this burden to be $495,000 to $577,500.

Section 148.200 Enforcement and Section 148.202 Civil Money Penalties

We anticipate identifying violations through individual nonstandardized consumer complaints. Therefore, the complaints submitted and our enforcement activities do not fall within the requirements of the PRA, as outlined in 5 CFR 1320.3(c) and 5 CFR 1320.4(a).

Type of Information Request: Extension, *without change*, of a currently approved collection.

Title of Information Collection: Information Requirements Referenced in HIPAA for Group Health Plans.

Form Number: HCFA–R–206 (OMB approval #: 0938–0702).

Use: This regulation and related information collection requirements will ensure that group health plans provide individuals with documentation necessary to demonstrate prior creditable coverage, and that group health plans notify individuals of their special enrollment rights in the group health insurance market.

Frequency: On occasion.

Affected Public: State and local governments, Business or other for profit, not-for-profit institutions, individuals or households, Federal government.

Number of Respondents: 1,430.

Total Annual Responses: Due to the rolling effective dates in the statute, the number of annual responses is estimated to be 32.5 million in 1997, but will increase to 41 million in 1998 and 42.5 million in 1999.

Total Annual Hours Requested: 1.8 million to 3.6 million hours in 1997; 2.3 million to 5.8 million hours in 1998; and 2.6 million to 5.9 million hours in 1999.

Total Annual Costs: $36.8 million to $53.9 million in 1997; $42.4 million to $76.3 million in 1998; and $43.5 million to $77.3 million in 1999. 45 CFR Secs. 146.120, 146.122, 146.150, 146.152, 146.160, and 146.180 of this document contain information collection requirements.

45 CFR 146.120 Certificates and Disclosure of Previous Coverage

This section sets forth guidance regarding the certification and other disclosure of information requirements relating to prior creditable coverage of an individual. In general, the certificate must be provided in writing and must include the following information: (1) The date any waiting or affiliation period began, (2) the date coverage began, and (3) the date coverage ended (or indicate if coverage is continuing). The regulations also allow a plan or issuer in an appropriate case to simply state in the certificate that the individual has at least 18 months of creditable coverage that is not interrupted by a significant break and indicate the date coverage ended. In general, individuals have the right to receive a certificate automatically (an automatic certificate) when they lose coverage under a plan and when they have a right to elect COBRA continuation coverage.

We anticipate that approximately 1,400 issuers will be required to produce 30 million certifications per year based on the model certificate provided. Our estimate of issuers (1,400) includes commercial insurers and HMOs, but does not include some types of issuers, such as Preferred Provider Organizations (PPOs); however, these types of issuers are small in number. The time estimate includes the time required to gather the pertinent information, create a certificate, and mail the certificate to the plan participant. This time estimate is based on discussions with industry individuals. We believe that, as a routine business practice, the issuers' administrative staff have the necessary information readily available to generate the required certificates. In addition, we have determined that the majority of issuers have or will have the capability to automatically computer generate and disseminate the necessary certification when appropriate. These estimates include the certificates required by issuers acting as service providers on behalf of group health plans and state and local government health plans. We anticipate that most, if not all, state and local government health plans will contract with an issuer to develop the certificate.

ESTIMATES FOR CERTIFICATIONS

Year	Total respondents	Total responses	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1997	1,400	32,698,845	3.32	1,809,119	$36,366,106
	.....	.....	6.34	3,456,036	53,434,628
1998	1,400	28,072,131	5.19	2,242,866	40,928,939
	.....	.....	12.23	5,720,198	74,859,759
1999	1,400	28,055,984	5.37	2,510,461	42,124,907
	.....	.....	12.41	5,804,408	75,760,119

Note: The costs above include the costs associated with issuers acting as service providers for group health plans. The costs are also included in the Department of Labor's estimates.

Notice to all participants: Under this section, issuers are required to notify all participants at the time of enrollment stating the terms of the issuer's pre-existing condition exclusion provisions, the participant's right to demonstrate creditable coverage, and that the issuer will assist in securing a certificate if necessary.

We have estimated the burden associated with this information collection requirement to be the time required for issuers to develop standardized language outlining the existence and terms of any preexisting condition exclusion under the plan and the rights of individuals to demonstrate creditable coverage. In specific, we anticipate that issuers will be required to develop approximately 660,000 notices in 1997; 5.6 million notices in 1998; and 6.2 million notices in 1999. At 30 seconds for each notice, we estimate the total hour burden to be 4,400 hours in 1997; 30,000 hours in 1998; and 34,000 hours in 1999. The respective costs will be $49,000 in 1997; $330,000 in 1998; and $377,000 in 1999. These estimates and subsequent estimates are based on an hourly wage of $11 for issuers and $15 for State and local government employees. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	320,000	129,826	214,880	664,706
1998	4,878,200	259,653	429,761	5,567,614
1999	5,734,300	259,653	429,761	6,189,714
Total burden hours:				
1997	1,592	1,078	1,784	4,454
1998	14,293	2,155	3,567	30,015
1999	28,557	2,155	3,567	34,279

Notice to individual of period of preexisting condition exclusion. Within a reasonable time following the receipt of the certificate, information relating to the alternative method, or other evidence of coverage, a plan or issuer is required to make a determination regarding the length of any preexisting condition exclusion period that applies to the individual and notify the individual of its determination. Whether a determination and notification is made within a reasonable period of time will depend upon the relevant facts and circumstances including whether the application of the preexisting condition exclusion period would prevent access to urgent medical services. The individual need only be notified, however, if, after considering the evidence, a preexisting condition exclusion period will be imposed on the individual. The basis of the determination, including the source and substance of any information on which the plan or issuer relied, must be included in the notice. The plan's appeals procedures and the opportunity of the individual to present additional evidence must also be explained in the notification.

We estimate that issuers will be required to develop approximately 29,000 notices in 1997; 425,000 notices in 1998; and 498,000 notices in 1999. At 2 minutes for each notice, we estimate the total hour burden to be 960 hours in 1997; 14,000 hours in 1998; and 16,600 hours in 1999. We estimate the respective costs associated with these burdens to be $10,600 in 1997; $156,000 in 1998; and $183,000 in 1999. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	27,650	588	766	29,004
1998	422,136	1,176	1,531	425,143
1999	496,182	1,176	1,531	498,889
Total burden hours:				

Year	Issuers	State health plans	Local health plans	Total notices
1997	921	20	25	29,004
1998	14,057	40	51	14,148
1999	16,553	40	51	16,644

45 CFR 146.117 Special Enrollment Periods

This section in the regulation provides guidance regarding new enrollment rights that employees and dependents have under HIPAA. A health insurance issuer offering group health insurance coverage is required to provide a description of the special enrollment rights to anyone who declines coverage at the time of enrollment. The regulations provide a model of such a description containing the minimum information mandated by the statute.

The first burden associated with this requirement is the time required for health insurance issuers and state and local government health plans to incorporate the model notice into the plan's standard policy information. We estimate the burden to be 2 hours annually per issuer, for a total burden of 2,800 hours. The cost associated with this hour burden is estimated to be $30,800 annually.

The second burden associated with this requirement is the time required to disseminate the notice to new enrollees. We estimate that issuers will be required to develop approximately 1 million notices in 1997; 5.3 million notices in 1998; and 5.9 million notices in 1999. At 30 seconds for each notice, we estimate the total hour burden to be 8,300 hours in 1997; 43,000 hours in 1998; and 48,000 hours in 1999. We have estimated the costs associated with these hour burdens to be $91,000 in 1997; $469,000 in 1998; and $527,000 in 1999. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	245,508	287,938	500,750	1,034,196
1998	3,750,024	575,875	1,001,500	5,327,399
1999	4,407,828	575,875	1,001,500	5,985,203
Total burden hours:				
1997	1,964	2,304	4,006	8,273
1998	30,000	4,607	8,012	42,619
1999	35,263	4,607	8,012	47,881

45 CFR 146.150 Guaranteed Availability of Coverage for Employers in the PHS Act Group Market Provisions

This section allows a health insurance issuer to deny health insurance coverage in the small group market if the issuer has demonstrated to the applicable State authority (if required by the State authority) that it does not have the financial reserves necessary to underwrite additional coverage and that it is applying this denial uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents. Thus, issuers are only required to report to the applicable State authority if they are discontinuing coverage in the small group market.

This requirement exists in the absence of this regulation because under current insurance practices, State insurance departments oversee discontinuance of insurance products in their State as a normal business practice. Therefore, these information collection requirements are exempt from the PRA under 5 CFR 1320.3(b)(2) and 5 CFR 1320.3(b)(3). However, under HIPAA, States must review policies during their oversight process to make sure there is a guaranteed availability clause in each policy. For the 37 States that currently require guaranteed availability, it is our understanding that this is normal business practice. For the other 18 States, however, we see this State burden to be about 10 minutes per policy, since States already review policies for other requirements and this process does not prescribe a timetable for reviewing the policies. We see this as a total burden of 10,850 hours. We have estimated the cost associated with this hour burden to be $163,000. If the State identifies a violation and a State has to take some action, we believe that each State will be required to initiate fewer than 10 administrative actions on an annual basis against specific individuals or entities who failed to implement the Federal guarantee availability requirements.

45 CFR 146.152 Guaranteed Renewability of Coverage for Employers in the PHS Act Group Market Provisions

In this section issuers are only required to report if they are discontinuing a particular type of coverage or discontinuing all coverage. This requirement exists in the absence of this regulation because under current insurance practices, State insurance departments oversee discontinuance of insurance products in their State as a normal business practice. Therefore, these information collection requirements are exempt from the PRA under 5 CFR 1320.3(b)(2) and 5 CFR 1320.3(b)(3). However, under HIPAA, States must review policies during their oversight process to make sure there is a guaranteed availability clause in each policy. For the 43 States that currently require guaranteed renewability, it is our understanding that this is normal business practice. For the other 12 States, however, we see this State burden to be about 10 minutes per policy, since States already review policies for other requirements and this process does not prescribe a timetable for reviewing the policies. We see this

as a total burden of 6,700 hours. We have estimated the cost associated with this hour burden to be $100,500. If the State identifies a violation and a State has to take some action, we believe that each State will be required to initiate fewer than 10 administrative actions on an annual basis against specific individuals or entities who failed to implement the Federal guarantee renewability requirements.

45 CFR 146.160 Disclosure of Information by Issuers to Employers Seeking Coverage in the Small Group Market in the PHS Act Provisions

This section requires issuers to disclose information to employers seeking coverage in the small group market. This section requires information to be provided by a health insurance issuer offering any health insurance coverage to a small employer. This information includes the issuer's right to change premium rates and the factors that may affect changes in premium rates, renewability of coverage, any preexisting condition exclusion, any affiliation periods applied by HMOs, the geographic areas served by HMOs, and the benefits and premiums available under all health insurance coverage for which the employer is qualified. The issuer is exempted from disclosing information that is proprietary or trade secret information under applicable law.

The information described in this section must be language that is understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides an outline of coverage, the minimum contribution and group participation rules that apply to any particular type of coverage, and any other information required by the State. An outline of coverage is defined as a general description of benefits and premiums. This would include an outline of coverage similar to the manner in which Medigap policies are presented, allowing the employer to easily compare one policy form to another to determine what is covered and how much the coverage will cost.

We have estimated the total burden associated with this activity to be 2,400 hours. We anticipate that 1,200 issuers will be required to provide disclosure to small employers on an annual basis. We estimate this time to be approximately 2 hours for each issuer to develop and update the standard information related to the general description of benefits and premiums on an annual basis and include this information in their policy information. We have estimated the cost associated with this hour burden to be $36,000.

45 CFR 146.180 Treatment of non-Federal Government Plans

Section 145.180(b) includes rules pertaining to nonfederal governmental plans, which are permitted under HIPAA to elect to be exempted from some or all of HIPAA's requirements in the PHS Act. The regulation establishes the form and manner of the election. In particular, a nonfederal governmental plan making this election is required to notify plan participants, at the time of enrollment and on an annual basis, of the fact and consequences of the election. The burden imposed by this is the requirement for plans to disseminate standard notification language describing the plans' election and the consequences of this election. We anticipate that between 3,500 and 5,000 nonfederal governmental plans will make this election and will therefore be required to disseminate notifications to their participants on an annual basis. Since this is standard language that will be incorporated into plans' existing policy documents, we see the burden as approximately 2 hours per plan to develop and update this standardized disclosure statement on an annual basis. Thus, we estimate the total burden for this activity to range from 7,000 to 10,000 hours. We estimate the cost associated with these hourly burdens to range from $77,000 to $110,000 per year.

The above estimate does not include the cost of disseminating the notices to all plan participants on an annual basis and to new enrollees at the time of enrollment. Although we do not have an accurate estimate of the number of nonfederal governmental plans will choose to opt out of these provisions, we have provided for a range of 50 to 100 percent. Using these ranges, we estimated 400,000 to 800,000 of these notices would need to be produced in 1997 and 800,000 to 1.6 million in 1998 and 1999. At 30 seconds per notice, we estimate the total burden hours to range from 3,400 to 6,800 in 1997; and 6,800 to 13,600 in 1998 and 1999. We have estimated the costs associated with these hour burdens to range from $37,400 to $74,800 in 1997; and from $74,800 to $149,600 in 1998 and 1999.

We have submitted a copy of this notice to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, E-mail your request, including your address, phone number, and HCFA form number(s) referenced above, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

Interested persons are invited to send comments regarding the burden or any other aspect of these collections of information requirements. However, as noted above, comments on these information collection and recordkeeping requirements must be mailed and/or faxed to the designees referenced below, by 12/29/97:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Fax Number: (410) 786–1415, Attn: John Burke HCFA–R–205 and/or HCFA–R–206

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Fax Number: (202) 395–6974 or (202) 395–5167, Attn: Allison Herron Eydt, HCFA Desk Officer.

Dated: December 10, 1997.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards.

[FR Doc. 97–33063 Filed 12–16–97; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WY–921–41–5700; WYW136450]

Notice of Proposed Reinstatement of Terminated Oil and Gas Lease

Pursuant to the provisions of 30 U.S.C. 188 (d) and (e), and 43 CFR 3108.2–3 (a) and (b)(1), a petition for reinstatement of oil and gas lease WYW136450 for lands in Natrona County, Wyoming, was timely filed and was accompanied by all the required rentals accruing from the date of termination.

The lessee has agreed to the amended lease terms for rentals and royalties at rates of $5.00 per acre, or fraction thereof, per year and 16–⅔ percent, respectively.

The lessee has paid the required $500 administrative fee and $125 to