Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6142, MSC 9606, Bethesda, MD 20892–9606, 301–443–1513, *bollerf@mail.nih.gov*.

Name of Committee: National Institute of Mental Health Special Emphasis Panel, Review of NIMH Research Education Applications.

Date: March 2, 2010.

Time: 8:30 a.m. to 5 p.m.

Agenda: To review and evaluate grant applications.

Place: The Dupont Hotel, 1500 New Hampshire Avenue NW., Washington, DC 20036.

Contact Person: Rebecca C. Steiner, PhD, Scientific Review Officer, Division of Extramural Activities, National Institute of Mental Health, NIH, Neuroscience Center, 6001 Executive Blvd., Room 6149, MSC 9608, Bethesda, MD 20892–9608, 301–443–4525, *steinerr@mail.nih.gov*.

(Catalogue of Federal Domestic Assistance Program Nos. 93.242, Mental Health Research Grants; 93.281, Scientist Development Award, Scientist Development Award for Clinicians, and Research Scientist Award; 93.282, Mental Health National Research Service Awards for Research Training, National Institutes of Health, HHS)

Dated: January 11, 2010.

Jennifer Spaeth,

Director, Office of Federal Advisory Committee Policy.

[FR Doc. 2010–677 Filed 1–14–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Vaccine Injury Compensation Program: Revised Amount of the Average Cost of a Health Insurance Policy

The Health Resources and Services Administration (HRSA) is publishing an updated monetary amount of the average cost of a health insurance policy as it relates to the National Vaccine Injury Compensation Program (VICP).

Section 100.2 of the VICP's implementing regulation (42 CFR Part 100) states that the revised amounts of an average cost of a health insurance policy, as determined by the Secretary, are to be published periodically in a notice in the **Federal Register**. This figure is calculated using the most recent Medical Expenditure Panel Survey-Insurance Component (MEPS–IC) data available as the baseline for the average monthly cost of a health insurance policy. This baseline is adjusted by the annual percentage increase/decrease obtained from the most recent annual Kaiser Family Foundation and Health Research and Educational Trust (KFF/HRET) Employer Health Benefits survey or other authoritative source that may be more accurate or appropriate.

In 2009, MEPS–IC, available at *http://www.meps.ahrq.gov*, published the annual 2008 average total single premium per enrolled employee at private-sector establishments that provide health insurance. The figure published was $4,386. This figure is divided by 12-months to determine the cost per month of $365.50. The $365.50 shall be increased or decreased by the percentage change reported by the most recent KFF/HRET, available at *http://www.kff.org*. The percentage increase was published at 5 percent. By adding this percentage increase, the calculated average monthly cost of a health insurance policy for 12-month period is $383.78.

The Department will periodically (generally on an annual basis) recalculate the average cost of a health insurance policy by obtaining a new figure from the latest MEPS–IC data and updating this figure using the percentage change(s) reported by the most recent data from KFF/HRET or other authoritative source that may be more accurate or appropriate in the future. The updated calculation will be published as a notice in the **Federal Register** and filed with the Court.

Therefore, the Secretary announces that the revised average cost of a health insurance policy under the VICP is $383.78 per month. In accordance with § 100.2, the revised amount was effective upon its delivery by the Secretary to the United States Court of Federal Claims. Such notice was delivered to the Court on January 4, 2010.

Dated: January 11, 2010.

Mary K. Wakefield,

Administrator.

[FR Doc. 2010–675 Filed 1–14–10; 8:45 am]

BILLING CODE 4165–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

NIH Consensus Development Conference: Lactose Intolerance and Health; Notice

Notice is hereby given by the National Institutes of Health (NIH) of the "NIH Consensus Development Conference: Lactose Intolerance and Health" to be held February 22–24, 2010, in the NIH Natcher Conference Center, 45 Center Drive, Bethesda, Maryland 20892. The conference will begin at 8:30 a.m. on February 22 and 23 and at 9 a.m. on February 24, and it will be open to the public.

Lactose intolerance is the inability to digest significant amounts of lactose, a sugar found in milk and other dairy products. Lactose intolerance is caused by a shortage of the enzyme lactase, which is produced by expression of the lactase-phlorizin hydrolase gene by the cells that line the small intestine. Lactase breaks milk sugar down into two simpler forms of sugar called glucose and galactose, which are then absorbed into the bloodstream. Infants of every racial and ethnic group worldwide produce lactase and successfully digest lactose provided by human milk or by infant formulas. However, by the time many of the world's children reach the age of 3–4 years, expression of intestinal lactase ceases. Most affected individuals, referred to as lactase nonpersisters, in the United States belong to minority groups, especially Asians, African Americans, Hispanics, Native Americans, Alaskan Natives, and Pacific Islanders.

Consumption of lactose-containing products by lactase nonpersisters may cause gas production, bloating, abdominal pain, and diarrhea. These symptoms of lactose intolerance are caused by intestinal bacteria's fermentation of undigested lactose and often cause individuals to avoid lactose-containing products. Lactose intolerance can be diagnosed by drinking one to two large glasses of milk after fasting and measuring breath hydrogen levels a few hours later. Other diagnostic tools include analyzing an intestinal biopsy sample or determining the genetic makeup of the chromosomal region coding for lactase. However, many individuals mistakenly ascribe symptoms of a variety of intestinal disorders to lactose intolerance without undergoing testing. This becomes intergenerational when self-diagnosed lactose-intolerant parents place their children on lactose-restricted diets in the belief that the condition is hereditary.

Healthcare providers are concerned that many lactose-intolerant individuals are avoiding dairy products, which constitute a readily accessible source of calcium and are fortified with vitamin D and other nutrients. Therefore, these individuals may not be meeting recommended intakes of these essential nutrients. Insufficient intakes of calcium carry a risk of decreased bone mineral density. This may have effects on bone health and increase the risk of fracture throughout the lifecycle, especially in

postmenopausal women. Very low intake of vitamin D can lead to the development of rickets, especially in those of African descent and other highly pigmented individuals. Although milk alternative products are typically fortified with vitamin D and other nutrients, they are often more expensive and less widely available than conventional products.

The public health burden from deficiencies attributable to lactose intolerance is difficult to quantify. Additionally, it is challenging to identify and manage lactase nonpersisters. Questions remain as to the amount, if any, of lactose that can be tolerated by lactose nonpersisters and how best to assist these individuals in meeting recommended intakes. To examine these important issues, the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development and the Office of Medical Applications of Research of the National Institutes of Health will convene a Consensus Development Conference from February 22 to 24, 2010, to assess the available scientific evidence related to the following questions:

- What is the prevalence of lactose intolerance, and how does this prevalence differ by race, ethnicity, and age?
- What are the health outcomes of dairy exclusion diets?
- What amount of daily lactose intake is tolerable in subjects with diagnosed lactose intolerance?
- What strategies are effective in managing individuals with diagnosed lactose intolerance?
- What are the future research needs for understanding and managing lactose intolerance?

An impartial, independent panel will be charged with reviewing the available published literature in advance of the conference, including a systematic literature review commissioned through the Agency for Healthcare Research and Quality. The first day and a half of the conference will consist of presentations by expert researchers and practitioners and open public discussions. On Wednesday, February 24, the panel will present a statement of its collective assessment of the evidence to answer each of the questions above. The panel will also hold a press telebriefing to address questions from the media. The draft statement will be published online later that day, and the final version will be released approximately six weeks later. The primary sponsors of this meeting are the NIH *Eunice Kennedy Shriver* National Institute of Child Health and Human Development and the NIH Office of Medical Applications of Research.

Advance information about the conference and conference registration materials may be obtained from the NIH Consensus Development Program Information Center by calling 888–644–2667 or by sending e-mail to *consensus@mail.nih.gov*. The Information Center's mailing address is P.O. Box 2577, Kensington, Maryland 20891. Registration information is also available on the NIH Consensus Development Program Web site at *http://consensus.nih.gov.*

Please Note: The NIH has instituted security measures to ensure the safety of NIH employees, guests, and property. All visitors must be prepared to show a photo ID upon request. Visitors may be required to pass through a metal detector and have bags, backpacks, or purses inspected or x-rayed as they enter NIH buildings. For more information about the security measures at NIH, please visit the Web site at *http://www.nih.gov/about/visitorsecurity.htm.*

Dated: January 7, 2010.

Raynard S. Kington,

Deputy Director, National Institutes of Health.

[FR Doc. 2010–672 Filed 1–14–10; 8:45 am]

BILLING CODE 4140–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

NIH State-of-the-Science Conference: Enhancing Use and Quality of Colorectal Cancer Screening

Notice is hereby given by the National Institutes of Health (NIH) of the "NIH State-of-the-Science Conference: Enhancing Use and Quality of Colorectal Cancer Screening" to be held February 2–4, 2010, in the NIH Natcher Conference Center, 45 Center Drive, Bethesda, Maryland 20892. The conference will begin at 8:30 a.m. on February 2 and 3, and at 9 a.m. on February 4, and will be open to the public.

Colorectal cancer is the second-leading cause of cancer-related deaths in the United States. Approximately 50,000 people in the United States are expected to die from colorectal cancer in 2009. Colonic polyps, abnormal growths of tissue on the inner lining of the colon, are relatively common findings in men and women 50 years and older. Most of these growths are not cancerous, but one type of polyp, known as an adenoma, can develop into colorectal cancer. Screening tests for colorectal cancer generally either seek to identify and remove adenomas or examine the stool for signs of early cancer in people who have no symptoms. A range of colorectal cancer screening tests is available in the United States. The U.S. Preventive Services Task Force currently recommends that average-risk adults aged 50 to 75 years undergo screening for colorectal cancer with annual fecal occult blood testing, sigmoidoscopy (internal examination of the lower part of the large intestine) every 5 years, or colonoscopy (internal examination of the entire large intestine) every 10 years. Additional tests that may be used for colorectal cancer screening include computed tomography (CT) colonography and fecal DNA testing.

Although colorectal cancer is an important cause of mortality in the United States, screening for this disease is currently underutilized among eligible individuals. Despite evidence supporting the value of screening, in 2005 only 50 percent of U.S. adults aged 50 and older had been screened according to guidelines. Rates of screening for colorectal cancer are consistently lower than those for other common cancers, particularly breast and cervical cancer. Reasons for this disparity are complex. Unlike most other preventive services, in colorectal cancer screening there are multiple test options from which to choose, and patients and providers may have varying preferences for or access to the tests. Successful completion of colorectal cancer screening requires effort on the part of the patient to obtain stool samples for testing or to clean the colon in preparation for endoscopic examination. Test options may also differ in cost and availability for a given community. Patient, provider, and healthcare system characteristics may each play a unique role in influencing the use and quality of colorectal cancer screening.

Adding to the complexity of this issue, colorectal cancer screening may be overused or misused in certain situations. Despite uncertainty regarding the benefit of removing small polyps, many people undergoing sigmoidoscopy or colonoscopy have all identified growths removed. This may put them at increased risk for possible complications from these procedures, which can include rectal bleeding or colonic perforation (a tear in the wall of the intestine that can cause a serious abdominal infection). In addition, follow-up testing of individuals who have previously had polyps removed may occur more frequently than available evidence supports, which again may put people at risk for complications and have both cost and