SUPPORTING STATEMENT FOR PAPERWORK REDUCTION ACT 1995 SUBMISSIONS

A. Justification

1. Explain the circumstances that make the collection of information necessary. Identify any legal or administrative requirements that necessitate the collection. Attach a copy of the appropriate section of each statute and regulation mandating or authorizing the collection of information.

Section 734 of the Employee Retirement Income Security Act (ERISA), which was added by the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, Aug. 21, 1996) (HIPAA), provides that the Secretary of Labor, in coordination with the Secretary of Health and Human Services (HHS) and the Secretary of the Treasury, (collectively, the Departments) may promulgate such regulations (including interim final rules) as may be necessary or appropriate to carry out the provisions of Part 7 of ERISA (the HIPAA provisions). In addition, section 701(e)(3) of ERISA, added by HIPAA (with parallel provisions added to the Public Health Service Act (PHSA) and the Internal Revenue Code (the Code)), requires that the Secretary of Labor issue rules to ensure that group health plans, health insurance issuers, and other specified entities provide certain required disclosures to individuals regarding their health care coverage in order to prevent adverse effects on the individual's subsequent health coverage. These required disclosures include individual certifications of prior health coverage (certificates) and, upon the request of a plan that counts or "credits" prior health coverage in determining subsequent coverage for specific categories of benefits, additional information about coverage under these categories of benefits (called the "alternative method" of crediting coverage).

The Department issued Interim Final Rules for Health Insurance Portability for Group Health Plans on April 8, 1997 (62 FR 16894), and Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers under HIPAA Titles I & IV on December 30, 2004 (69 FR 78720) (final HIPAA portability regulations). The HIPAA portability provisions limit the extent to which group health plans and their health insurance issuers can restrict health coverage based on preexisting conditions for individuals that were previously covered by health coverage. The provisions limit all preexisting condition exclusion periods to twelve months, or eighteen months for certain individuals who enroll in the plan after their initial opportunity to enroll. Further, the twelve- or eighteen-month exclusion period must be reduced by the length of an individual's prior continuous health coverage, as reflected in certificates or demonstrated through other means. "Continuous health coverage" means coverage that there were no "significant breaks in coverage." A significant break in coverage, for this purpose, is defined as a period of 63 days or more. Following a significant break in coverage, prior health coverage is no longer "creditable," that is, entitled to be taken as a credit to reduce a plan's preexisting condition exclusion period.

Section 701(e) of ERISA requires group health plans and health insurance issuers to provide certificates of an individual's prior health coverage on termination of coverage, at the time an individual would lose coverage in the absence of continuation coverage ("COBRA"), and when an individual loses coverage after COBRA coverage ceases. Certificates must also be provided on request and may be requested at any time while an individual is covered by the plan and for 24 months after coverage ceases. (Certificates must also be provided by other entities that provide creditable coverage, like Medicare and Medicaid.) The certificate must show the number of days of creditable coverage earned by the individual and also include an educational statement describing the Part 7 rights. The regulations provide model language for the educational statement. In addition, the regulations require a group health plan to establish written procedures governing the process for requesting a certificate.

The individual who receives a certificate may present it to his or her new group health plan in order to receive credit for prior health coverage under the new plan. The certificate provides assurance to the individual's new group health plan or its health insurance issuer that the individual had health coverage for a certain number of days that should be credited toward reducing any preexisting condition exclusion periods under the new health plan.

Because participants may be required to demonstrate creditable coverage and the status of their dependents in some circumstances in order to assert rights under Part 7, the regulations provide the following protections:

a) If an individual is required to demonstrate dependent status, the plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status, and the individual cooperates with the plan's or issuer's efforts to verify the dependent status. (See 29 CFR 2590.701-5(a)(5)(ii).)

b) A plan is required treat an individual as having furnished a certificate if the individual attests to the period of creditable coverage, presents relevant corroborating evidence, and cooperates with the plan's efforts to verify the individual's coverage. (See 29 CFR 2590.701-5(c).)

This ICR also covers an information collection requirement imposed under the regulations in connection with the alternative method of crediting coverage established by the regulations. The regulations permit a plan to adopt, as its method of crediting prior health coverage, provisions that impose different preexisting condition exclusion periods with respect to different categories of benefits, depending on prior coverage in that category. In such a case, the regulations require former plans to provide additional information upon request to new plans in order to establish an individual's length of prior creditable coverage within that category of benefits.

2. Indicate how, by whom, and for what purpose the information is to be used. Except for a new collection, indicate the actual use the agency has made of the information received from the current collection.

This information collection implements statutorily prescribed requirements necessary to permit individuals to establish prior creditable health coverage and to enable group health plans and issuers to verify creditable coverage. Group health plans and the plans' health insurance issuers are required to issue certificates as proof of prior creditable health coverage. These certificates assist individuals in retaining prior health coverage upon changes in employment or in other circumstances when coverage ends. A model certificate, which includes a model educational statement ("Statement of HIPAA Rights"), appears in the Final Regulations. The model certificate contains the minimum information required for such a certification. The information is used by participants in group health plans and by group health plans and health coverage issuers to establish an individual's rights to group health coverage under Part 7.

3. Describe whether, and to what extent, the collection of information involves the use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses, and the basis for the decision for adopting this means of collection. Also describe any consideration for using information technology to reduce burden.

Under 29 C.F.R. § 2520.104b-1(b) of ERISA, "where certain material, including reports, statements, and documents, is required under Part I of the Act and this part to be furnished either by direct operation of law or an individual request, the plan administrator shall use measures reasonably calculated to ensure actual receipt of the material by plan participants and beneficiaries." Section 2520.104b-1(c) establishes the manner in which disclosures under Title I of ERISA made through electronic media will be deemed to satisfy the requirement of § 2520.104b-1(b), including the certificate of creditable coverage. Under these rules, all pension and welfare plans covered under Title I of ERISA may use electronic media to satisfy disclosure and recordkeeping obligations, subject to specific safeguards.

However, because the information collections covered by this ICR are most frequently provided to individuals when they lose coverage under a group health plan, or by individuals to group health plans when they first become eligible for new coverage, and because of the importance of the certificate as tangible proof of prior creditable coverage, the Department has assumed that the certificates will generally be provided in writing. Therefore, although the Department believes that a substantial number of group health plans have adopted electronic media as means of communication generally with participants and beneficiaries, the burden estimates in this ICR reflect costs of providing written documents.

4. Describe efforts to identify duplication. Show specifically why any similar information already available cannot be used or modified for use for the purposes described in Item 2 above.

Before enactment of the HIPAA provisions, despite incremental state reforms in the laws affecting the group health insurance market, group health plans and health insurance issuers had not been required to provide eligible individuals with information about creditable coverage. This information collection therefore does not create any duplication of effort, and no similar information is already available elsewhere.

Although certain information about an individual's health coverage may be available in other formats, for instance health coverage or payroll records, the Department believes that there is no existing means for documenting prior creditable health coverage other than the certification required by HIPAA and described in this ICR. The information required to complete the certification is generally readily available to group health plans and health insurance issuers as part of regularly maintained business and plan records. Finally, to simplify the certification process, the Department has provided, in the Final Rules, a model for the certificate.

Separate certifications are not required where the same information applies to more than one individual in a family. Also, an insured plan can satisfy the certification requirement if the issuer of the insurance coverage provides the certificates (for the coverage it issues) under an agreement between the plan and the issuer.

5. If the collection of information impacts small businesses or other small entities (Item 5 of OMB Form 83-I), describe any methods used to minimize burden.

For the purpose of determining burden, "small entities" are defined by the Department to include employee benefit plans covering fewer than 100 participants. Although some large employers may have small plans, most small plans are maintained by small businesses. Accordingly, assessing the impact on small plans is an appropriate substitute for evaluating the effects on small entities.

Because the Department believes that all affected individuals need the same certificates and information regarding prior creditable coverage, the information collection requirements of the regulations apply uniformly to both large and small plans. However, the final HIPAA portability regulations contain model language meeting the regulatory requirement that plans and issuers can use to provide certificates, thereby reducing the burden on both large and small plans that use the model rather than drafting a new document.

The final regulations also reduce burdens on plans and issuers of all sizes by providing that: (1) an issuer need not provide a certificate when an individual merely changes options under a plan – instead information may simply be transferred to the plan; (2) only one certificate need be

provided to two or more members of a family if the information is the same; (3) certification may be done by telephone if the receiving plan and the prior plan agree; (4) only the last continuous period of coverage without a significant break (63 days or more) need be listed on an automatic certificate; (5) the periods that must be shown on an on-request certificate are only periods of coverage that ended within 24 months before the date of the request; and (6) plans and issuers need only use reasonable efforts to determine dependent coverage information, and are not required to furnish an automatic certificate for a dependent until they know or should know that the dependant's coverage has ended.

6. Describe the consequence to Federal program or policy activities if the collection is not conducted or is conducted less frequently, as well as any technical or legal obstacles to reducing burden.

This information collection protects individuals and helps the regulated community comply with the HIPAA portability requirements. Congress expressly intended the certification and prior creditable coverage provisions to serve as the mechanism for increasing the portability of health coverage for plan participants and their beneficiaries. Without the Departments' guidance, plans would have difficulty in complying with HIPAA's requirements and in producing the appropriate certificates of prior coverage to assist participants and beneficiaries in reducing any applicable pre-existing condition exclusion periods imposed by a new health plan. Group health plan sponsors would also have less certainty about their conformity with the statute's health coverage portability provisions.

Because of statutory mandates, the collection of information cannot be conducted "less frequently" than is prescribed. The final regulations do, however, reduce burden on plans and issuers in a number of ways, described in the response to Item 5, above. For example, an issuer need not provide a certificate when an individual changes options under a plan. Also, certification may be done by telephone if the receiving plan and the prior plan agree.

7. Explain any special circumstances that would cause an information collection to be conducted in a manner:

- *requiring respondents to report information to the agency more often than quarterly;*
- *requiring respondents to prepare a written response to a collection of information in fewer than 30 days after receipt of it;*
- *requiring respondents to submit more than an original and two copies of any document;*
- *requiring respondents to retain records, other than health, medical, government contract, grant-in-aid, or tax records for more than three years;*
- *in connection with a statistical survey, that is not designed to produce valid and reliable results that can be generalized to the universe of study;*

- *requiring the use of a statistical data classification that has not been reviewed and approved by OMB;*
- *that includes a pledge of confidentiality that is not supported by authority established in statute or regulation, that is not supported by disclosure and data security policies that are consistent with the pledge, or which unnecessarily impedes sharing of data with other agencies for compatible confidential use; or*
- *requiring respondents to submit proprietary trade secret, or other confidential information unless the agency can demonstrate that it has instituted procedures to protect the information's confidentiality to the extent permitted by law.*

None.

8. *If applicable, provide a copy and identify the date and page number of publication in the Federal Register of the agency's notice, required by 5 CFR 1320.8(d), soliciting comments on the information collection prior to submission to OMB. Summarize public comments received in response to that notice and describe actions taken by the agency in response to these comments. Specifically address comments received on cost and hour burden.*

Describe efforts to consult with persons outside the agency to obtain their views on the availability of data, frequency of collection, the clarity of instructions and recordkeeping, disclosure, or reporting format (if any), and on the data elements to be recorded, disclosed, or reported.

Consultation with representatives of those from whom information is to be obtained or those who must compile records should occur at least once every 3 years -- even if the collection of information activity is the same as in prior periods. There may be circumstances that may preclude consultation in a specific situation. These circumstances should be explained.

The Department's notice of the proposed extension of the information collection was published in the Federal Register on June 25, 2012 (77 FR 37920), pursuant to 5 CFR 1320.8(d), providing the public 60 days in which to comment on the proposed extension. No comments were received.

9. *Explain any decision to provide any payment or gift to respondents, other than remuneration of contractors or grantees.*

Not applicable.

10. Describe any assurance of confidentiality provided to respondents and the basis for the assurance in statute, regulation, or agency policy.

No assurance of confidentiality has been provided.

11. Provide additional justification for any questions of a sensitive nature, such as sexual behavior and attitudes, religious beliefs, and other matters that are commonly considered private. This justification should include the reasons why the agency considers the questions necessary, the specific uses to be made of the information, the explanation to be given to persons from whom the information is requested, and any steps to be taken to obtain their consent.

Not applicable.

12. Provide estimates of the hour burden of the collection of information. The statement should:

- *Indicate the number of respondents, frequency of response, annual hour burden, and an explanation of how the burden was estimated. Unless directed to do so, agencies should not conduct special surveys to obtain information on which to base hour burden estimates. Consultation with a sample (fewer than 10) of potential respondents is desirable. If the hour burden on respondents is expected to vary widely because of differences in activity, size, or complexity, show the range of estimated hour burden, and explain the reasons for the variance. Generally, estimates should not include burden hours for customary and usual business practices.*
- *If this request for approval covers more than one form, provide separate hour burden estimates for each form and aggregate the hour burdens in Item 13 of OMB Form 83-I.*
- *Provide estimates of annualized cost to respondents for the hour burdens for collections of information, identifying and using appropriate wage rate categories. The cost of contracting out or paying outside parties for information collection activities should not be included here. Instead, this cost should be included in Item 1*

The Department derived the aggregate number of existing private-sector group health plans from data in the 2009 Medical Expenditure Panel Survey Insurance Component (MEPS-IC), and estimated that number to be approximately 2.3 million, of which 71,000 plans were assumed to have 100 or more participants (large plans) and 2.2 million were assumed to have less than 100 participants (small plans).

This ICR covers the requirement that group health plans or issuers provide certificates to covered individuals upon the occurrence of a variety of events (including on request); it also covers the requirement that group health plans or issuers respond to requests from other group health plans or issuers that use the alternate method of crediting prior coverage for further information on prior coverage. The Department therefore developed an estimate of the aggregate number of individuals who annually terminate employment in which they were covered by private-sector health insurance coverage, plus the number of dependents of such individuals (spouses and children). This estimate is considered the best available surrogate information on which to base an estimate of the number of events occurring annually that will trigger the requirement to provide a certificate. Because of the size of the affected population and the lack of more direct measures of the number of triggering events for providing a certificate, the Department believes that the estimates described below for triggering events are adequate to cover the rare instances in which an individual will request a certificate or a plan will request additional information on specific coverages, which the Department believes will be very rare.

The number of triggering events leading to providing certificates annually was derived from data analysis and several assumptions. The 2009 Medical Expenditure Panel Survey Household Component (MEPS-HC) was used to estimate the number of employees/dependents who terminate health plan coverage, as well as the share of such individuals who had less than 18 months of continuous coverage upon termination. Based on the 2009 Medical Expenditure Panel Survey Household Component (MEPS-HC), we have estimated that approximately 16.3 million individuals and their dependents leave private-sector health insurance coverage annually.

The 2012 March Supplement to the Current Population Survey was used to estimate the share of dependents with employer-sponsored coverage who live at a separate residence from their parents. This data in combination yielded an assumed number of events triggering the requirement to provide a certificate and an assumed number of such events involving dependents, which, together, indicated the number of copies of certificates required to be distributed, allocated between events following 18 months of continuous coverage and events occurring when an individual had fewer than 18 months of coverage.[1] The resulting numbers of events are displayed in the following table:

	Number of Plans	Number of Certificates at 1st Address		Number of Certificates at 2nd Address	Total Certificates
		Leaver	Dependent		
Use Service Provider	2,265,860				
Less than 18 months		617,572	541,586	13,887	1,173,045
18 months or more		6,478,181	5,726,773	93,118	12,298,072

1 Certificates issued following continuous coverage periods of fewer than 18 months must include additional information, such as the date when coverage began, and are assumed to require 5 minutes to prepare; those involving at least 18 months are assumed to require 4 minutes. An additional burden of 2 minutes per dependent is assumed when dependents are included in the certification.

Total Certificates		7,095,752	6,268,359	107,005	13,471,117
In-House Certificates	17,852				
Create Certificates	1,209				
Less than 18 months		131,000	114,882	2,946	248,828
18 months or more		1,374,160	1,214,770	19,752	2,608,682
Total Certificates		1,505,160	1,329,652	22,698	2,857,510
Total Certificates	2,283,712				
Less than 18 months		748,572	656,468	16,833	1,421,872
18 months or more		7,852,340	6,941,543	112,871	14,906,754
Total Certificates		8,600,912	7,598,011	129,703	16,328,626

The Department is aware that a large proportion of group health plans employ service providers to satisfy various disclosure requirements, including the requirements to provide creditable coverage certificates. It was assumed, for this burden analysis, that all small group health plans and 75 percent of large plans, for a total of almost 2.3 million plans will hire service providers for these requirements.[2] For purposes of this analysis, therefore, paperwork burden under this ICR for all small plans and for 75 percent of large plans is treated entirely as cost burden and is described in the response to Item 13, below.

The remaining 18,000 large plans (25% of 71,000) are assumed to provide certifications using in-house resources, and the paperwork burden for preparing and distributing these certifications is estimated as hour burden. Because large plans cover 73 percent of participants, these plans will provide a disproportionate number of certificates. We estimate that these large plans will annually provide 18 percent of the certificates, or 2.9 million certificates.

Because plans can use an identical template certificate for all participants, modifying it only slightly to add individual coverage information, we have assumed annual preparation burden for a plan only in the first year of its operation. The data from 2009 Form 5500 filings indicate that 4,800 new, large health plans are established annually. Assuming that 25 percent of such new plans will satisfy these information collection requirements using in-house resources, 1,200 plans are estimated to incur burden to develop a template certificate per year. Because the regulations provide a model certificate, we have assumed such new plans will need one half-hour each to create a new certificate. The aggregate annual burden hours for creating a certificate were found to be 605 hours. The equivalent cost of those burden hours is estimated at $75,000 using an hourly labor rate of $124.57 for a legal professional.[3]

2 These assumptions are consistent with the Department's assumptions concerning preparation of other required participant disclosures, such as summary plan descriptions (SPDs).

3 The Department estimates 2012 hourly labor rates include wages, other benefits, and overhead based on data from the National Occupational Employment Survey (June 2011, Bureau of Labor Statistics) and the Employment Cost Index (September 2011, Bureau of Labor Statistics); the 2010 estimated labor rates are then inflated to 2012 labor rates.

The estimated total annual hour burden for creating, completing, and distributing the 2.9 million individual certificates (in-house) is 148,000 hours. This assumes 5 minutes for each certificate involving less than 18 months of coverage, 4 minutes for each certificate involving 18 or more months of coverage, and 2 minutes for each additional certificate to a dependent in either category. [5 minutes times 131,000 certificates, plus 2 minutes times 118,000 (115,000 +3,000) for periods less than 18 months; plus 4 minutes times 1.4 million plus 2 minutes times 1,220,000 (1.2 million + 20,000) for periods of 18 months or more; plus the 30 minutes times 1,200 for new plans that create a template certificate.]

The equivalent cost of this hour burden is estimated at $4.2 million assuming a $28.21 hourly rate for generating the certificates (the hourly labor rate of a clerical staff worker) and a $124.57 labor rate for a legal professional's time for creating initial certificates. The hour burden attributable to the Department under this ICR is one-half of 148,000, or 74,000 hours.[4]

The cost burden for this ICR, including direct mailing and copying costs and fees paid for service providers, is accounted for separately in the response to Item 13, below.[5]

13. Provide an estimate of the total annual cost burden to respondents or recordkeepers resulting from the collection of information. (Do not include the cost of any hour burden shown in Items 12 and 14).

The cost estimate should be split into two components:(a) a total capital and start-up cost component (annualized over its expected useful life); and (b) a total operational and maintenance and purchase of services component. The estimates should take into account costs associated with generating, maintaining and disclosing or providing information. Include descriptions of methods used to estimate major cost factors including system and technology acquisition, expected useful life of capital equipment, the discount rate(s), and the time period over which the costs will be incurred. Capital and start-up costs include, among other items, preparations for collecting information such as purchasing computers and software; monitoring, sampling, drilling and testing equipment; and record storage facilities.

4 Because the Department of Labor and the Department of the Treasury share enforcement jurisdiction against group health plans and employers under the HIPAA portability provisions (see section 701 of ERISA and section 9801 of the Internal Revenue Code), the aggregate paperwork burden of this information collection is divided equally between those two Departments. The Department of Health and Human Services (HHS) is given only secondary jurisdiction under the HIPAA provisions against issuers in States that implement the HIPAA requirements as State law but fail substantially to enforce a HIPAA provision.

5 Actual unrounded numbers have been entered into the ROCIS PRA Module, for purposes of calculating the burden of the information collection, to produce the following results: 2,283,712 respondents and 8,164,356 responses.

If cost estimates are expected to vary widely, agencies should present ranges of cost burdens and explain the reasons for the variance. The cost of purchasing or contracting out information collection services should be a part of this cost burden estimate. In developing the cost burden estimates, agencies may consult with a sample of respondents (fewer than 10), utilize the 60 day pre-OMB submission public comment process and use existing economic or regulatory impact analysis associated with the rulemaking containing the information collection, as appropriate.

Generally, estimates should not include purchases of equipment or services, or portions thereof, made: (1) prior to October 1, 1995, (2) to achieve regulatory compliance with requirements not associated with the information collection, (3) for reasons other than to provide information or keep records for the government, or (4) as part of customary and usual business or private practices.

The Department's assumptions regarding the estimated numbers of affected plans and certificates required to be provided annually are described in the response to Item 12, above. As stated in that response, the Department has assumed that all small plans and 75 percent of large plans affected by this information collection will hire service providers to comply with its requirements. The total number of plans that will hire service providers is estimated at approximately 2.3 million plans. Those plans are further estimated to provide, annually, 82 percent of the certificates. Cost burden for the plans hiring service providers includes fees paid by the plans for service provider time and for the direct costs to the service providers of distributing certificates.

For plans using in-house resources, cost burden includes only the direct costs incurred by the plans to prepare and distribute the individual required certificates. Total costs consist of the annual operating and maintenance costs for completing and mailing certificates, both those distributed in-house and those distributed by service providers.

As noted above, service providers will prepare and distribute 13.4 million certificates, for 82 percent of the participants in group health plans. Total estimated cost for such services, which will be purchased by group health plans that hire service providers, is derived by multiplying the number of certificates by the time needed to prepare and distribute a certificate and multiplying by a $28.21 per hour labor rate (618,000 certificates take 5 minutes; 6.5 million take 4 minutes; and 6.3 million take 2 minutes). The resulting cost burden estimate is $20 million.

In addition, we have assumed that plans will pay to service providers the direct costs for mailing and copying all certificates, estimated at $.50 per mailing and $.10 per additional copy, for a total direct cost burden for mailing and copying of $4.2 million. The total estimated annual cost burden to provide certificates for the 82 percent of plans that use service providers is $23.9 million annually.

Similarly, plans that distribute certificates through in-house resources will pay the direct costs for mailing and copying of2.9 certificates. Assuming, a cost of $.50 per mailing and $.10 per additional copy, the affected plans incur a direct cost of $900,000.

The total estimated annual cost burden to provide certificates is approximately $29 million. The annual cost burden attributable to the Department (which is half of the aggregate annual cost burden) is estimated to be approximately $12.4 million.

14. Provide estimates of annualized cost to the Federal government. Also, provide a description of the method used to estimate cost, which should include quantification of hours, operational expenses (such as equipment, overhead, printing, and support staff), and any other expense that would not have been incurred without this collection of information. Agencies also may aggregate cost estimates from Items 12, 13, and 14 in a single table.

There is no reporting to the federal government and, consequently, no cost to the federal government.

15. Explain the reasons for any program changes or adjustments reporting in Items 13 or 14 of the OMB Form 83-I.

There have been no program changes to this ICR since the last submission in 2009. The Department has updated the estimates of respondents (plans) and responses, as well as the assumptions relating to cost (e.g., labor rates and worker characteristics). These changes have resulted in an increase in the numbers of responses, and a corresponding increase in the overall burden of this information collection. Additionally, it appears that the last submission contained a typographical error, whereby the cost of service providers was off by a factor of ten. Correcting this error and updating the inputs in the formula has resulted in an increase in the stated cost of service providers. In addition, the DOL has reassessed how the response burden is allocated between the Departments of Labor and of the Treasury. Previously, the Department had claimed half the burden hours and costs associated with items 12 and 13. The Department of the Treasury claimed the other half. Consistent with the treatment, and to avoid duplication in the DOL and Treasury response counts, the DOL now also has claimed only half the number of responses.

16. For collections of information whose results will be published, outline plans for tabulation, and publication. Address any complex analytical techniques that will be used. Provide the time schedule for the entire project, including beginning and ending dates of the collection of information, completion of report, publication dates, and other actions.

The results of this collection of information will not be published.

17. If seeking approval to not display the expiration date for OMB approval of the information collection, explain the reasons that display would be inappropriate.

There are no forms on which to display the expiration date. The information collection will display a currently valid OMB control number.

18. Explain each exception to the certification statement identified in Item 19, "Certification for Paperwork Reduction Act Submission," of OMB 83-I.

There are no exceptions to the certification statement.

B. Collections of Information Employing Statistical Methods

Not applicable. The use of statistical methods is not relevant to this collection of information.