

Appendix A: Supporting Statement for Paperwork Reduction Act Submissions  
CMS Plan Benefit Package (PBP) and Formulary CY 2027  
(CMS-R-262, OMB 0938-0763)

*The Plan Benefit Package (PBP), Formulary, and Supporting Regulations Contained in 42 Code of Federal Regulation (CFR): 422.100, 422.101, 422.102, 422.103, 422.105, 422.106, 422.108, 422.110, 422.111, 422.112, 422.113, 422.114, 422.250, 422.252, 422.254, 422.256, 422.258, 422.262, 422.264, 422.266, 422.270, 422.300, 422.304, 422.306, 422.308, 422.310, 422.312, 422.314, 422.316, 422.318, 422.320, 422.322, 422.324, 423.100, 423.104, 423.112, 423.120, 423.124, 423.128, 423.132, 423.136, 423.251, 423.258, 423.265, 423.272, 423.286, 423.293, 423.301, 423.308, 423.315, 423.322, 423.329, 423.336, 423.343, 423.346, 423.350.*

## **Background**

Under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), and implementing regulations at 42 CFR, specifically § 422.254 and § 423.265, Medicare Advantage (MA) and Prescription Drug Plan (PDP) organizations are required to submit a bid for each plan they intend to offer in their service area for the upcoming year. In addition to actuarial pricing, which is addressed in OMB 0938-0944, each bid submission consists of a description of the plan benefit package and the plan formulary. MA and PDP organizations use the Plan Benefit Package (PBP) software to describe their organization's plan benefit packages, including information on premiums, cost sharing, authorization rules, and supplemental benefits. They also generate a formulary to describe their list of drugs, including information on prior authorization, step therapy, tiering, and quantity limits. CMS uses the PBP and formulary data to review and approve the plan benefit packages proposed by each MA and PDP organization.

CMS is requesting a revision of this package for the continued collection of plan benefit package and formulary data in support of the annual plan bid submission process. The revisions include: (a) routine PBP updates (e.g., modify dropdown values and reword questions), (b) changes required by the Inflation Reduction Act (IRA), and (c) updates required by CMS policy changes. All changes are reflected in the mockups and screenshots provided as part of Appendix C.

CMS estimates that 717 MA organizations and 47 PDP organizations will be required to submit plan benefit package information in CY 2027. This is a decrease from the prior year, where 734 MA organizations and 51 PDP organizations were required to submit. Additionally, the number of CY 2026 formulary submissions decreased from 484 to 427. Since we use previous year's actual submissions to estimate burden, this also affected the overall burden rate and estimation of plans. The decrease in MA organizations, and decrease in formulary submissions, has caused an overall decrease in the burden estimate.

## **A. Justification**

### **1. Need and Legal Basis**

This information is mandated by the Social Security Act in order to collect plan bids that will establish the Medicare Advantage (Part C) and Prescription Drug (Part D) plan benefit package options to be offered to Medicare beneficiaries during the next annual open enrollment period. The Part C bid deadline (the first Monday in June) is stated at Section 1854(a)(6)(A) of the Social Security Act. The same deadline is applied to Part D bids by reference to the Part C requirement at Section 1860D-11(b)(1) of the Act and is cited in the 42 CFR references listed above. Copies of these references are provided in Appendix D.

This revision package includes the following: (a) clarifications and updates to improve data quality; (b) routine changes to improve module usability.

## 2. Information Users

This information is used by both CMS and the public.

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

CMS uses this data to review and approve the benefit packages that the plans will offer to Medicare beneficiaries. This allows CMS to review the benefit packages in a consistent way across all submitted bids during with incredibly tight timeframes. This data is also used to populate data on Medicare Plan Finder, which allows beneficiaries to access and compare Medicare Advantage and Prescription Drug plans.

The PBP is broken into six specific sections:

- 1.) The **General Set-up** Section defines certain plan-specific data characteristics in the Plan Benefit Package (PBP). This Section consists of plan level information, which allows organizations to indicate if they are offering a bid that mirrors fee-for-service cost sharing, the Medicare and Supplemental benefits offered for the plan, prior authorization and referral requirements, visitor/travel and plan level cost-sharing. The plan level cost sharing consists of:
  - a. Plan Deductible
  - b. Maximum Enrollee Out-of-Pocket Costs
  - c. Maximum Coverage for Supplemental Benefits
  - d. Balance Billing (PFFS only)
  - e. Medical Savings Account Information (for MSA plans only)
  - f. Medicaid Covered vs. Plan Covered Cost sharing (for MMPs only)

Note: Changes include: Updates to questions in this section.

2.) The **Benefit Details Section** collects in-network benefit information for MA plans. This includes cost sharing for any Medicare and Supplemental benefits offered. The benefit details are broken into the following sections:

- a. Inpatient Hospital Services
- b. Skilled Nursing Facility (SNF)
- c. Cardiac and Pulmonary Rehabilitation Services
- d. Emergency Care/Urgently Needed Services
- e. Partial Hospitalization
- f. Home Health Services
- g. Health Care Professional Services
- h. Outpatient Procedures, Tests, Labs & Radiology Services
- i. Outpatient Services
- j. Ambulance/Transportation Services
- k. DME, Prosthetics and Medical & Diabetic Supplies
- l. Dialysis Services
- m. Other Supplemental Services
- n. Preventive and Other Defined Supplemental Services
- o. Medicare Part B Prescription (Rx) Drugs
- p. Dental
- q. Eye Exams/Eyewear
- r. Hearing Exams/Hearing Aids
- s. Prescription Drugs (ONLY for Cost Plans not offering Part D)

Note: Changes include: Addition of a new service category, and updates to questions to clarify benefits collected in this section.

3.) The **Cost Share Groups** Section collects detailed cost-sharing information for benefits data that have multiple groups/offerings of benefits. Each cost share group has a management screen to manage the groups created as part of the section. The following sections are available (only MA plans complete this section):

- a. Out-of-Network
- b. Point-of-Service (POS)
- c. Combined Supplemental Benefits
- d. Reduction in Cost Sharing (RICS)
- e. Optional Supplemental benefit packages

Note: Changes include: new questions to clarify benefits collected in this section.

4.) **Section Rx** contains all Part D information. All plans that offer Part D must complete this section. This includes:

- a. Medicare Rx Screens
- b. Pre-Initial Coverage Limit (ICL) Screens

- c. ICL Screens
- d. Gap Coverage Screens
- e. Out-of-Pocket Threshold Screens
- f. Locations and location supply Screens
- g. Rx attestations
- h. Medicare Rx Notes

Note: Changes include: questions have been clarified, and an additional attestation has been included.

5.) **Section Rx VBID** (only for plans offering the Part D VBID) includes:

- a. Part D Rewards & Incentives packages
- b. Part D reduced cost sharing (for Defined Standard Plan Types)
- c. Part D reduced cost sharing packages (for all other Part D plan types, and collects data at the tier level)

Note: No changes for this year.

6.) **Section VBID/Uniformity Flexibility (UF)/Supplemental Benefits for the Chronically III (SSBCI)** packages includes:

- a. Identification of which benefits the plan is offering (either 1, 2, or 3 of the benefits in this section)
- b. VBID Wellness and Health Care Planning (only if VBID is offered)
- c. VBID Hospice (only if VBID is offered)
- d. VBID Rewards and Incentives (only if VBID is offered)
- e. Reduction in Cost Sharing Packages
- f. Additional Benefits Packages

Note: Changes include: Updates to clarify benefits collected.

The formulary submission contains the following files:

- 1.) Formulary Submission File (required for all Part D plans offering a formulary. This file lists all Part D covered drugs offered by the plan) Note: This file includes suggested changes.
- 2.) Formulary Over-the-Counter (OTC) Drugs File (required for any plans offering OTC drugs as part of their Part D plan)
- 3.) Formulary Prior Authorization (PA) File (required for any Part D plans requiring PA for any drugs on their formulary) Note: This file includes suggested changes.
- 4.) Formulary Partial Gap Coverage File (required if there is partial tier gap coverage for the Part D plan)
- 5.) Formulary Free First Fill File (required if any drugs are offered for free for their first fill)
- 6.) Formulary Excluded Drug File (required if the Part D plan offers excluded drugs)

## 7.) Formulary Additional Demonstration Drug File (only required for MMP plans)

Exact layouts of the formulary files and detailed PBP data collect can be found within the Appendix C documents.

CMS publishes beneficiary education information using a variety of formats. The specific education initiatives that utilize PBP and formulary data include web application tools on [www.medicare.gov](http://www.medicare.gov) and the plan benefit insert in the *Medicare & You* handbook. All other information collected through the PBP follows the rules described in Section 10: Confidentiality.

### 3. Improved Information Technology

Since CY 2001, the Health Plan Management System (HPMS) has been utilized to upload completed benefit information during the ACRP process. Under MMA and in support of the bidding process, CMS enhanced the HPMS upload functionality to incorporate the necessary submission changes to include the formulary to supplement the plan benefit package submission.

CMS continues to improve the PBP module and formulary submission with guidance from CMS policy and operations groups and the solicitation of industry comment. In Appendix C, the hardcopy PBP screen prints and formulary submission materials are provided to illustrate a thorough overview of the tools; however, this information cannot accurately display the streamlining effect of the tools on the bidding process.

Prior experience coupled with the continued relationship with the industry for the past several years has helped to further enhance the already user-friendly nature of the plan benefit package submission process. CMS has maximized the usability of the PBP by using standardized pick lists, intelligently pre-filled data fields, and integrated online help screens.

Also, the plan benefit package data and its many outputs have served to reduce burden as it relates to the creation and publication of beneficiary education materials. The PBP serves primarily as a tool for organizations to describe and report their benefits for the upcoming contract year. The formulary supplements this information to include the drug lists associated with the plan's benefits. However, these data are also central to plan marketing and education efforts. As a result, CMS chose to take advantage of these data being collected via an electronic mechanism.

Specifically, CMS developed the PBP so that it standardizes the collection of benefits data. The formulary and PBP are both used by CMS in the comparative web application tools on [www.medicare.gov](http://www.medicare.gov) that facilitate the comparison of plan choices available to beneficiaries. In addition, the PBP data is used by CMS to generate plan benefits information in the *Medicare & You* handbook. By consolidating this data reporting, CMS can use the information to perform numerous activities without placing additional burden on the organization.

### 4. Duplication of Similar Information

The information collected in the PBP and formulary is not duplicated through any other CMS effort. In fact, CMS has eliminated potential duplication by consolidating the collection of plan benefits data. The collected data are then used to support numerous activities, including the marketing material review process, the generation of plan marketing materials, and other program oversight and development activities. Because the PBP and formulary collects the information that populates the [www.medicare.gov](http://www.medicare.gov) website and in the *Medicare & You* Handbook, there is no need for organizations to complete multiple marketing data reporting activities for CMS.

## 5. Small Businesses

Small businesses are not significantly affected by this collection. Where small businesses may participate in these programs, they are required to submit these same data, per statutory requirements. This module is designed to provide all participating businesses with a straightforward and efficient method for delivering these data to CMS.

## 6. Less Frequent Collection

Since CY 2001, CMS has collected the benefit package once a year as required by the Social Security Act. Under MMA, this collection is now part of the annual bidding process, where organizations are required to submit their proposed plan benefit packages (including the PBP and formulary) for the upcoming contract year. If an organization would propose mid-year benefit enhancements to their existing plans, propose new plans, or enter the Medicare program as a new organization, the organization would be required to submit the benefit package materials during the contract year.

If this collection were not conducted or were conducted less frequently than described above, there would be adverse consequences, including but not limited to, the following:

- Organizations would not be able to increase the number of plan or enhance current plan choices available to Medicare beneficiaries.
- Organizations would not be able to make changes to the formulary that could enhance the therapeutic options or lower cost-sharing for beneficiaries.
- CMS would not be able to accurately or effectively educate Medicare beneficiaries on the plan choices available to them.
- CMS would not be able to effectively review and approve plan marketing materials.
- CMS would not be able to effectively review and approve the PBP and formulary, as required by statute.
- Beneficiaries would not receive accurate, updated plan information via the website.

## 7. Special Circumstances

Organizations may be required to submit benefit data more often under certain circumstances. Each organization must submit a new PBP and an updated formulary on an annual basis as part of the annual bidding process. Under certain circumstances, an organization could choose to enhance an existing plan benefit package mid-year or offer new plans, which would require a second submission. Additionally, organizations must submit any changes in their formulary prior to removing a covered Part D drug or when making any change in the preferred or tiered cost sharing status of a covered Part D drug as required by the regulations.

## 8. Federal Register Notice/Outside Consultation

### *Federal Register*

N/A

### *Outside Consultation*

**Formulary:** CMS and one of its consultants first drafted the formulary submission for use during CY 2006 by utilizing its considerable experience from the Medicare Prescription Drug Card program and by conferring with the industry on numerous occasions. CMS requests comments and feedback from the industry via a lessons learned process annually. The 2025 format is included in the formulary guidelines.

**PBP:** CMS, with contractor support, prepared the initial draft of the PBP for use during CY 2001 by performing extensive market research, screening, and testing. Since the initial PBP development, CMS has taken numerous opportunities to confer with representatives from the Medicare private plan industry, including MA and PDP organizations and trade groups, to solicit comments and feedback on the PBP module. CMS has also included internal users of the PBP data in these efforts. Participants included staff from each CMS Regional Office, Central Office Medicare Advantage and Prescription Drug staff, and staff from the CMS beneficiary education campaign. These comment opportunities have included the following:

- **Beta Testing** – The functional test PBP module is distributed to plans for the Beta testing to allow for hands-on data entry testing and to identify any potential bugs/defects with the module. CMS is scheduled to hold the PBP 2027 Beta in early February 2026. This process has occurred each year since the start of the PBP.
- **Lessons Learned Comments** – CMS has implemented a formal process for the electronic submission of comments and feedback through the HPMS website. The annual comment period serves as an opportunity to account for lessons learned on the PBP post production and use. The 2026 Lessons Learned comment period was held from July 28, 2025 through August 8, 2025.
- **Ongoing Discussions** – As part of our daily business of assisting organizations and others, CMS has informally received comments concerning the PBP from organizations, trade associations, Central Office, and Regional Offices.

After collecting and compiling these requests and comments during the various timeframes,

CMS reviews each one and decides as to whether the change should be made in the system. The CMS review team consists of the agency component areas that serve as stakeholders for the PBP, including MA and Part D policy and operations, beneficiary education, and systems. Appendix B provides a detailed list of the changes identified for the PBP module package for CY 2027 because of feedback from the Medicare private plan industry community and administrative and legislative directives.

Lastly, CMS is providing numerous instructional sessions and user instructions for the PBP and formulary submission during the upcoming months.

## 9. Payments/Gifts to Respondents

While there are no monetary payments or gifts to respondents, the approval of the contract for the organization is an incentive for their participation in the Medicare program.

## 10. Confidentiality

The information collected through the Plan Benefit Package (PBP) module is considered proprietary until the bids are approved by CMS for the upcoming contract year (September-October timeframe). After bid and contract approval, CMS publishes a subset of PBP data elements for research and analysis purposes on [www.cms.gov](http://www.cms.gov).

Information collected through the formulary contains proprietary information, trade secret, commercial and/or financial information, therefore it is privileged, private to the extent permitted by law, and protected from disclosure. Formulary supporting documentation is considered private to the extent permitted by law and will not be disclosed to the public.

These data are protected from disclosure under Exemption 4 of the Freedom of Information Act (FOIA). Exemption 4 is provided below and is part of the HHA FOIA implementation regulation (45 CFR Section 5.65) available at: <http://www.hhs.gov/foia/45cfr5.html#Subf>:

“Sec. 5.65 Exemption four: Trade secrets and confidential commercial or financial information. We will withhold trade secrets and commercial or financial information that is obtained from a person and is privileged or confidential.

Trade secrets. A trade secret is a secret, commercially valuable plan, formula, process, or device that is used for the making, preparing, compounding, or processing of trade commodities and that can be said to be the end product of either innovation or substantial effort. There must be a direct relationship between the trade secret and the productive process.

Commercial or financial information. We will not disclose records whose information is “commercial or financial,” is obtained from a person, and is “privileged or confidential.” Information is “commercial or financial” if it relates to businesses, commerce, trade, employment, profits, or finances (including personal finances). We interpret this category broadly.



Information is “obtained from a person” if HHS or another agency has obtained it from someone outside the Federal Government or from someone within the Government who has a commercial or financial interest in the information. “Person” includes an individual, partnership, corporation, association, state or foreign government, or other organization.

Information is not “obtained from a person” if it is generated by HHS or another federal agency. However, information is “obtained from a person” if it is provided by someone, including but not limited to an agency employee, who retains a commercial or financial interest in the information.

Information is “privileged” if it would ordinarily be protected from disclosure in civil discovery by a recognized evidentiary privilege, such as the attorney-client privilege or the work product privilege. Information may be privileged for this purpose under a privilege belonging to a person outside the government, unless the providing of the information to the government rendered the information no longer protectable in civil discovery.

Information is “confidential” if it meets one of the following tests:

Disclosure may impair the government’s ability to obtain necessary information in the future;

Disclosure would substantially harm the competitive position of the person who submitted the information;

Disclosure would impair other government interests, such as program effectiveness and compliance; or

Disclosure would impair other private interests, such as an interest in controlling availability of intrinsically valuable records, which are sold in the market by their owner.

The following questions may be relevant in analyzing whether a record meets one or more of the above tests: Is the information of a type customarily held in strict confidence and not disclosed to the public by the person to whom it belongs? What is the general custom or usage with respect to such information in the relevant occupation or business? How many, and what types of individuals have access to the information? What kind and degree of financial injury can be expected if the information is disclosed?”

This information is not published in a manner that identifies individual business decisions, unless otherwise indicated. Information provided for the CMS beneficiary education campaign (i.e., [www.medicare.gov](http://www.medicare.gov) and the *Medicare & You* handbook) is published no earlier than the time frames required for the legislatively mandated annual enrollment period. The PBP module identifies for the user the specific data elements that are used for the beneficiary education campaign.

## 11. Sensitive Questions

There are no sensitive questions included in this collection effort.

## 12. Burden Estimate (Total Hours & Wages)

### *Burden*

The estimates for “number of respondents” and “average number of responses per respondent” are based on the previous years’ bid submissions. Formulary submissions are not submitted by every organization, thus previous year’s responses are used to estimate for these purposes. Wages are based on the result of an industry survey of average hourly wage for individuals completing the data submission.

The estimated hour burden for the PBP and formulary submissions for CY 2027 is 44,178 total burden hours, or 57.8 hours per organization.

### 12.A. Estimated Annual Burden Hours

<b>Submission</b>	<b>Number of Organizations (MA and PDP)</b>	<b>Number of Responses*</b>	<b>Number of Hours to Complete</b>	<b>Total Burden Hours</b>
PBP	764	10	5	38,200
Formulary		427	14	5,978
<b>Total</b>				<b>44,178</b>

### 12.B. Estimated Cost of Response

<b>Submission</b>	<b>Number of Organizations (MA and PDP)*</b>	<b>Number of Responses*</b>	<b>Number of Hours to Complete</b>	<b>Hourly Wage**</b>	<b>Total Labor Costs</b>
PBP	764	10	5	77.00	\$2,941,400
Formulary		427	14	77.00	\$460,306
<b>Total</b>					<b>\$3,401,706</b>

#### Key

\* Source: HPMS actual data

\*\* Source: Wage based on the results of industry survey of average hourly wage for individuals completing the data submissions.

## 13. Capital Costs

There is no capital cost needed for this collection effort.

#### 14. Cost to the Federal Government

The initial burden to the Federal government for the collection of the PBP and formulary data was borne through the development cycle as a one-time cost. The PBP and the formulary are now in maintenance mode with regard to development and enhancements. The maintenance cost and the cost to enhance the PBP and formulary modules as well as the cost of CMS employees' time are calculated to be: **\$2,418,182.98**. The calculations for CMS employees' hourly salary were obtained from the OPM website: <https://www.opm.gov/policy-data-oversight/pay-leave/salaries-wages/2025/general-schedule/> (Effective January 2025 for the Washington-Baltimore- Arlington locality).

Category	Cost
PBP - Maintenance and Enhancements	\$1,677,511.77
Medicare Part D Help PBP:	
2 GS-13 (step 5): 2 x \$65.48/hr x 20 hours	\$2,619.20
1 GS -14 (step 5): 1 x \$77.38/hr x 20 hours	\$1,547.60
2 GS -15 (step 5): 2 x \$91.02/hr x 10 hours	\$1,820.40
<i>Subtotal</i>	<i>\$5,987.20</i>
Medicare MA Help PBP:	
2 GS-15 (step 5): 2 x \$91.02/hr x 20 hours	\$3,640.80
4 GS-13 (step 5): 4 x \$65.48/hr x 20 hours	\$5,238.40
<i>Subtotal</i>	<i>\$8,879.20</i>
TOTAL PBP COST:	\$1,692,378.17
Category	Cost
Formulary - Maintenance and Enhancements	\$718,963.11
Medicare Part D Help FDR:	
3 GS-13 (step 5): 3 x \$65.48/hr x 20 hours	\$3,928.80
1 GS -14 (step 5): 1 x \$77.38/hr x 20 hours	\$1,547.60

1 GS -15 (step 5): 1 x \$91.02/hr x 15 hours	\$1,365.30
<i>Subtotal</i>	<i>\$6,841.70</i>
TOTAL FORMULARY COST:	\$725,804.81
<b>Total Cost to the Government:</b>	<b>\$2,418,182.98</b>

## 15. Program Changes

This package includes the following program changes:

PBP:

- 1.) Updated landing page to reflect the CY 2027 year change.
- 2.) Minor wording changes or renaming of categories to clarify questions.
- 3.) New question has been added.
- 4.) Additional updates to better reflect benefits being provided: allowing more granular level identification or updating categories available for selection.

Formulary:

- 1.) Proposed updates to standardize data entry for the PA record layout.
- 2.) Proposed updates to move the PA criteria change indicator to the Formulary file.

MTM:

N/A

The decrease to burden is attributable to a decrease in the number of reporting organizations from 785 to 764, as well as a decrease in the number of formulary submissions from 484 to 427 and estimated reduction in burden hours for completing the formulary submissions.

The number of reporting organizations decreasing from 785 contracts to 764 contracts is based on the most recent numbers extracted from HPMS for organizations planning to provide Medicare to beneficiaries. This number represents the total number of organizations that will submit at least one (1) PBP. Because an organization can submit a formulary that covers multiple contract numbers, only a subset of the 764 organizations will submit distinct formularies.

Cost to the government increased as a direct result of the annual cost of completing the development of the modules as well as the increase in government wages.

The changes to each of the modules are due to internal decisions based on lessons learned, user interactive interviews, and are reflected in the screenshots for the PBP and are directly outlined and referenced in the list of changes.

#### Summary of Changes

Category	ICR Approved on 03/19/2024	Proposed Revisions
Respondents	785	764
Responses	8,337	8,068
Time/Response	5.52	5.47
Hours	46,026	44,178

#### 16. Publication and Tabulation Dates

Using the plan benefits data entry already completed by the user, the PBP automatically generates standardized data in a consistent format that are then displayed to the public through several mechanisms, including the [www.medicare.gov](http://www.medicare.gov) website and the *Medicare & You* handbook. The completed formulary is utilized to display drug benefit information on the [www.medicare.gov](http://www.medicare.gov) website.

In all cases below, the organization is required to electronically submit their formulary no later than the Friday prior to the first Monday of June and the PBP no later than the first Monday of June. The organization may start developing their formulary at any time and may submit the formulary as early as mid-May. Additionally, the organization may start developing their PBP on the first Friday of April.

The following gives a description of each publication of this data:

- **CMS Website** - The formulary information and standardized benefits data from the PBP are displayed on an interactive web tool on [www.medicare.gov](http://www.medicare.gov) that enables beneficiaries to compare plan benefit packages. Prior to posting, organizations are allowed to preview only their own plan benefit data. The initial posting of the benefits data for a new contract year occurs in mid-October (e.g., posting of CY 2023 data in October 2022).
- **Medicare & You Handbook** - CMS uses a small subset of the PBP data to generate high-level, limited plan benefits information (e.g. plan name, monthly premium, physician cost sharing) for the *Medicare & You* handbook. Organizations are provided a preview opportunity prior to printing. The initial printing of the plan benefits portion of the handbook occurs in late September to early October with the handbook being delivered to Medicare beneficiaries in October.

#### 17. Expiration Date

CMS has no objections to displaying the expiration date. The expiration date is posted in the “about PBP” section of the PBP software and under the “OMB clearance” link of the formulary submission module in HPMS.

#### 18. Certification Statement

There are no exceptions to the certification statement.

#### **B. Collections of Information Employing Statistical Methods**

Not Applicable. No statistical methods will be used in this collection effort.