Internal Revenue
bulletin

Bulletin No. 2011-32
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HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

INCOME TAX

Rev. Rul. 2011–16, page 93.

Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate. For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for August 2011.

Notice 2011–53, page 124.

This notice describes transition rules for phased implementation of Chapter 4 of the Code.

Notice 2011–70, page 135.

This notice enlarges the period within which individuals may request equitable relief from joint and several liability under section 6015(f) of the Code.

EMPLOYEE PLANS

T.D. 9532, page 95.
REG–125592–10, page 137.

Final, temporary, and proposed regulations under section 9815 of the Code contain amendments implementing the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under provisions of the Affordable Care Act. These rules are intended to respond to feedback on the regulations and to assist plans and issuers in coming into full compliance with the law.

EXCISE TAX

T.D. 9532, page 95.
REG–125592–10, page 137.

Final, temporary, and proposed regulations under section 9815 of the Code contain amendments implementing the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under provisions of the Affordable Care Act. These rules are intended to respond to feedback on the regulations and to assist plans and issuers in coming into full compliance with the law.

ADMINISTRATIVE

Notice 2011–62, page 126.

This notice provides a proposed revenue procedure that will update Rev. Proc. 2000–43, 2000–2 C.B. 404, which provides guidance regarding *ex parte* communications between Appeals and other Internal Revenue Service functions. Comments should be submitted by August 18, 2011.

Notice 2011–70, page 135.

This notice enlarges the period within which individuals may request equitable relief from joint and several liability under section 6015(f) of the Code.

Announcement 2011–42, page 138.

Discontinuance of high-low method for substantiating travel expenses. This announcement advises taxpayers that the IRS intends to discontinue authorizing the high-low *per diem* method for substantiating lodging, meal, and incidental expenses incurred in traveling away from home under section 274(d) of the Code.

Finding Lists begin on page ii.

Department of the Treasury
Internal Revenue Service

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly and may be obtained from the Superintendent of Documents on a subscription basis. Bulletin contents are compiled semiannually into Cumulative Bulletins, which are sold on a single-copy basis.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.
This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.
This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.
To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.
This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

Section 42.—Low-Income Housing Credit

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 280G.—Golden Parachute Payments

Federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 382.—Limitations on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 412.—Minimum Funding Standards

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 467.—Certain Payments for the Use of Property or Services

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 482.—Allocation of Income and Deductions Among Taxpayers

Federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 483.—Interest on Certain Deferred Payments

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 642.—Special Rules for Credits and Deductions

Federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 807.—Rules for Certain Reserves

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 846.—Discounted Unpaid Losses Defined

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 1274.—Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 412, 467, 468, 482, 483, 642, 807, 846, 1288, 7520, 7872.)

Federal rates; adjusted federal rates; adjusted federal long-term rate and the long-term exempt rate. For purposes of sections 382, 642, 1274, 1288, and other sections of the Code, tables set forth the rates for August 2011.

Rev. Rul. 2011–16

This revenue ruling provides various prescribed rates for federal income tax purposes for August 2011 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

REV. RUL. 2011–16 TABLE 1

Applicable Federal Rates (AFR) for August 2011

Period for Compounding

	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-term				
AFR	.32%	.32%	.32%	.32%
110% AFR	.35%	.35%	.35%	.35%
120% AFR	.38%	.38%	.38%	.38%
130% AFR	.42%	.42%	.42%	.42%
Mid-term				
AFR	1.90%	1.89%	1.89%	1.88%
110% AFR	2.09%	2.08%	2.07%	2.07%
120% AFR	2.28%	2.27%	2.26%	2.26%
130% AFR	2.48%	2.46%	2.45%	2.45%
150% AFR	2.86%	2.84%	2.83%	2.82%
175% AFR	3.34%	3.31%	3.30%	3.29%
Long-term				
AFR	3.86%	3.82%	3.80%	3.79%
110% AFR	4.24%	4.20%	4.18%	4.16%
120% AFR	4.63%	4.58%	4.55%	4.54%
130% AFR	5.03%	4.97%	4.94%	4.92%

REV. RUL. 2011–16 TABLE 2

Adjusted AFR for August 2011

Period for Compounding

	Annual	*Semiannual*	*Quarterly*	*Monthly*
Short-term adjusted AFR	.44%	.44%	.44%	.44%
Mid-term adjusted AFR	1.62%	1.61%	1.61%	1.60%
Long-term adjusted AFR	3.82%	3.78%	3.76%	3.75%

REV. RUL. 2011–16 TABLE 3

Rates Under Section 382 for August 2011

Adjusted federal long-term rate for the current month	3.82%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	4.17%

REV. RUL. 2011–16 TABLE 4

Appropriate Percentages Under Section 42(b)(1) for August 2011

Note: Under Section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, and before December 31, 2013, shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	7.66%
Appropriate percentage for the 30% present value low-income housing credit	3.28%

REV. RUL. 2011–16 TABLE 5

Rate Under Section 7520 for August 2011

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	2.2%

Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 7520.—Valuation Tables

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 7872.—Treatment of Loans With Below-Market Interest Rates

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of August 2011. See Rev. Rul. 2011-16, page 93.

Section 9815.—Additional Market Reforms

26 CFR 54.9815–2719T: Internal claims and appeals and external review processes (temporary).

T.D. 9532

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Part 54

DEPARTMENT OF LABOR
Employee Benefits Security Administration
29 CFR Part 2590

DEPARTMENT OF HEALTH AND HUMAN SERVICES
45 CFR Part 147

Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes

AGENCIES: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Amendment to interim final rules with request for comments.

SUMMARY: This document contains amendments to interim final regulations implementing the requirements regarding internal claims and appeals and external review processes for group health plans and health insurance coverage in the group and individual markets under provisions of the Affordable Care Act. These rules are intended to respond to feedback from a wide range of stakeholders on the interim final regulations and to assist plans and issuers in coming into full compliance with the law through an orderly and expeditious implementation process.

DATES: *Effective date:* This amendment to the interim final regulations is effective on July 22, 2011.

Comment date: Comments are due on or before July 25, 2011.

ADDRESSES: Written comments may be submitted to any of the addresses specified below. Any comment that is submitted to any Department will be shared with the other Departments. Please do not submit duplicates.

All comments will be made available to the public. *Warning:* Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed. All comments may be posted on the Internet and can be retrieved by most Internet search engines. Comments may be submitted anonymously.

Department of Labor. Comments to the Department of Labor, identified by RIN

1210–AB45, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Email*: *E-OHPSCA2719amend.EBSA@dol.gov*.
- *Mail or Hand Delivery*: Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration, Room N–5653, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210, *Attention*: RIN 1210–AB45.

Comments received by the Department of Labor will be posted without change to *www.regulations.gov* and *www.dol.gov/ebsa*, and available for public inspection at the Public Disclosure Room, N–1513, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Washington, DC 20210.

Department of Health and Human Services. In commenting, please refer to file code CMS–9993–IFC2. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the "More Search Options" tab.

2. *By regular mail*. You may mail written comments to the following address ONLY:

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–9993–IFC2,
P.O. Box 8010,
Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail*. You may send written comments to the following address ONLY:

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Attention: CMS–9993–IFC2,
Mail Stop C4–26–05,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
Room 445-G,
Hubert H. Humphrey Building,
200 Independence Avenue, S.W.,
Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—

Centers for Medicare &
Medicaid Services,
Department of Health and
Human Services,
7500 Security Boulevard,
Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Internal Revenue Service. Comments to the IRS, identified by REG–125592–10, by one of the following methods:

- *Federal eRulemaking Portal*: *http://www.regulations.gov*. Follow the instructions for submitting comments.
- *Mail*: CC:PA:LPD:PR (REG–125592–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.
- *Hand or courier delivery*: Monday through Friday between the hours of 8 a.m. and 4 p.m. to: CC:PA:LPD:PR (REG–125592–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224.

All submissions to the IRS will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW, Washington, DC from 9 a.m. to 4 p.m.

FOR FURTHER INFORMATION CONTACT: Amy Turner or Beth Baum, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 622–6080; Ellen Kuhn, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at (301) 492–4263.

CUSTOMER SERVICE INFORMATION: Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the EBSA Toll-Free Hotline at 1–866–444–EBSA (3272) or visit the Department of Labor's website (*http://www.dol.gov/ebsa*). In addition, information from HHS on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (*http://www.cms.hhs.gov/HealthInsReformforConsume/01_Overview.asp*). Information on health reform can be found at *www.healthcare.gov*.

SUPPLEMENTARY INFORMATION:

I. Background

The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010; the Health Care

and Education Reconciliation Act, Public Law 111–152, was enacted on March 30, 2010 (collectively known as the "Affordable Care Act"). The Affordable Care Act reorganizes, amends, and adds to the provisions in part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term "group health plan" includes both insured and self-insured group health plans.[1] The Affordable Care Act adds section 715(a)(1) to the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) to the Internal Revenue Code (the Code) to incorporate the provisions of part A of title XXVII of the PHS Act into ERISA and the Code, and make them applicable to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans. The PHS Act sections incorporated by this reference are sections 2701 through 2728. PHS Act sections 2701 through 2719A are substantially new, though they incorporate some provisions of prior law. PHS Act sections 2722 through 2728 are sections of prior law renumbered, with some, mostly minor, changes.

On July 23, 2010, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) issued interim final regulations implementing PHS Act section 2719 at 75 FR 43330 (July 2010 regulations), regarding internal claims and appeals and external review processes for group health plans and health insurance issuers offering coverage in the group and individual markets. The requirements of PHS Act section 2719 and the July 2010 regulations do not apply to grandfathered health plans under section 1251 of the Affordable Care Act.[2]

A. *Internal Claims and Appeals*

With respect to internal claims and appeals processes for group health plans and health insurance issuers offering group health insurance coverage, PHS Act section 2719 provides that plans and issuers must initially incorporate the internal claims and appeals processes set forth in regulations promulgated by the Department of Labor (DOL) at 29 CFR 2560.503–1 (the DOL claims procedure regulation) and update such processes in accordance with standards established by the Secretary of Labor. Similarly, with respect to internal claims and appeals processes for individual health insurance coverage, issuers must initially incorporate the internal claims and appeals processes set forth in applicable State law and update such processes in accordance with standards established by the Secretary of HHS.

The July 2010 regulations provided such updated standards for compliance and invited comment on the updated standards. In particular, the July 2010 regulations provided the following additional standards[3] for internal claims and appeals processes:

1. The scope of adverse benefit determinations eligible for internal claims and appeals includes a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at the time).[4]
2. Notwithstanding the rule in the DOL claims procedure regulation that provides for notification in the case of urgent care claims[5] not later than 72 hours after the receipt of the claim, a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer.[6]
3. Clarifications with respect to full and fair review, such that plans and issuers are clearly required to provide the claimant (free of charge) with new or additional evidence considered, relied upon, or generated by (or at the direction of) the plan or issuer in connection with the claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale.
4. Clarifications regarding conflicts of interest, such that decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to an individual, such as a claims adjudicator or medical expert, must not be based upon the likelihood that the individual will support the denial of benefits.
5. Notices must be provided in a culturally and linguistically appropriate manner, as required by the statute, and as set forth in paragraph (e) of the July 2010 regulations.
6. Notices to claimants must provide additional content. Specifically:
   a. Any notice of adverse benefit determination or final internal adverse benefit determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding

[1] The term "group health plan" is used in title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code, and is distinct from the term "health plan", as used in other provisions of title I of the Affordable Care Act. The term "health plan", as used in those provisions, does not include self-insured group health plans.

[2] The Departments published interim final regulations implementing section 1251 of the Affordable Care Act on June 17, 2010, at 75 FR 34538, as amended on November 17, 2010 at 75 FR 70114.

[3] To address certain relevant differences in the group and individual markets, the July 2010 regulations provided that health insurance issuers offering individual health insurance coverage must comply with three additional requirements for internal claims and appeals processes. First, the July 2010 regulations include initial eligibility determinations in the individual market within the scope of claims eligible for internal appeals. Second, health insurance issuers offering individual health insurance coverage are permitted only one level of internal appeal. Third, health insurance issuers offering individual health insurance coverage must maintain all records of claims and notices associated with internal claims and appeals for six years and must make these records available for examination by the claimant, State or Federal oversight agency. 75 FR 43330, 43334 (July 23, 2010).

[4] This definition is broader than the definition in the DOL claims procedure regulation, which provides that a denial, reduction, or termination of, or a failure to provide payment (in whole or in part) for a benefit is an adverse benefit determination eligible for internal claims and appeals processes.

[5] A claim involving urgent care is generally a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of the physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

[6] Under the July 2010 regulations, there is a special exception if the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan.

meaning, and the treatment code and its corresponding meaning.

b. The plan or issuer must ensure that the reason or reasons for an adverse benefit determination or final internal adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the plan's or issuer's standard, if any, that was used in denying the claim. In the case of a final internal adverse benefit determination, this description must also include a discussion of the decision.

c. The plan or issuer must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

d. The plan or issuer must disclose the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

7. If a plan or issuer fails to strictly adhere to all the requirements of the July 2010 regulations, the claimant is deemed to have exhausted the plan's or issuer's internal claims and appeals process, regardless of whether the plan or issuer asserts that it has substantially complied, and the claimant may initiate any available external review process or remedies available under ERISA or under State law.

On September 20, 2010, based on a preliminary review of comments from stakeholders which indicated that they believed more time was needed to come into compliance with PHS Act section 2719 and the additional internal claims and appeal standards in the July 2010 regulations, the Department of Labor issued Technical Release 2010–02 (T.R. 2010–02), which set forth an enforcement grace period until July 1, 2011 for compliance with certain new provisions with respect to internal claims and appeals.[7]

Specifically, T.R. 2010–02 set forth an enforcement grace period until July 1, 2011 with respect to standard #2 above (regarding the timeframe for making urgent care claims decisions), standard #5 above (regarding providing notices in a culturally and linguistically appropriate manner), standard #6 above (requiring broader content and specificity in notices), and standard #7 above (regarding exhaustion). T.R. 2010–02 also stated that, during that period, the Department of Labor and the Internal Revenue Service (IRS) would not take any enforcement action against a group health plan, and HHS would not take any enforcement action against a self-funded nonfederal governmental health plan that is working in good faith to implement such additional standards but does not yet have them in place.[8]

Based on further review of the comments received on the July 2010 regulations and T.R. 2010–02, and other feedback from interested stakeholders, on March 18, 2011, the Department of Labor issued Technical Release 2011–01[9] (T.R. 2011–01), which modified and extended the enforcement grace period set forth in T.R. 2010–02. Specifically, T.R. 2011–01 extended the enforcement grace period until plan years beginning on or after January 1, 2012 with respect to standard #2 above (regarding the timeframe for making urgent care claims decisions), standard #5 above (regarding providing notices in a culturally and linguistically appropriate manner), and standard #7 above (regarding exhaustion). Moreover, whereas T.R. 2010–02 required plans to be working in good faith to implement such standards for the enforcement grace period to apply, T.R. 2011–01 stated that no such requirement would apply for either the extended or the original enforcement grace period.

With respect to standard #6 above (requiring broader content and specificity in notices), T.R. 2011–01 extended the enforcement grace period only in part. Specifically, with respect to the requirement to disclose diagnosis codes and treatment codes (and their corresponding meanings), T.R. 2011–01 extended the enforcement grace period until plan years beginning on or after January 1, 2012.[10] With respect to the other disclosure requirements of standard #6, the enforcement grace period was extended from July 1, 2011 until the first day of the first plan year beginning on or after July 1, 2011 (which is January 1, 2012 for calendar year plans), affecting: (a) the disclosure of information sufficient to identify a claim (other than the diagnosis and treatment information), (b) the reasons for an adverse benefit determination, (c) the description of available internal appeals and external review processes, and (d) for plans and issuers in States in which an office of health consumer assistance program or ombudsman is operational, the disclosure of the availability of, and contact information for, such program.[11]

T.R. 2011–01 also stated the Departments' intent to issue an amendment to the July 2010 regulations that would take into account comments and other feedback received from stakeholders and make modifications to certain provisions of the July 2010 regulations. T.R. 2011–01 went on to state that the relief was intended to act as a bridge until an amendment to the July 2010 regulations was issued.

This amendment to the July 2010 regulations makes changes with respect to the provisions subject to the enforcement grace period under T.R. 2011–01. At the expiration of the enforcement grace period, the Departments will begin enforcing the relevant requirements of the July 2010 regulations, as amended by this rulemaking.

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[7] Technical Release 2010–02 is available at *http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010–02.pdf*. HHS published a corresponding guidance document, available at: *http://cciio.cms.gov/resources/files/interim_procedures_for_internal_claims_and_appeals.pdf*.

[8] T.R. 2010–02 also stated that HHS was encouraging States to provide similar grace periods with respect to issuers and HHS would not cite a State for failing to substantially enforce the provisions of part A of title XXVII of the PHS Act in these situations.

[9] T.R. 2011–01 is available at *http://www.dol.gov/ebsa/pdf/tr11–01.pdf*.

[10] Information related to diagnosis and treatment codes (and/or their meanings) is, however, generally required to be provided to claimants upon request under existing DOL claims procedures. See 29 CFR 2560.503–1(h)(2)(iii), which is also applicable to plans (whether or not they are ERISA plans) and issuers that are not grandfathered health plans pursuant to paragraph (b)(2)(i) of the July 2010 regulations. Nevertheless, a request for such information, in itself, should not be considered to be a request for (and therefore trigger the start of) an internal appeal or external review.

[11] Any enforcement grace period with respect to disclosure requirements that has been provided under T.R. 2010–02 or T.R. 2011–01 does not affect disclosure requirements still in effect for ERISA plans under the DOL claims procedure regulation and/or Part 1 of ERISA.

B. *External Review*

1. *Applicability of Federal and State external review processes*.

PHS Act section 2719, the July 2010 regulations, and technical guidance issued by the Departments[12] provide a system with respect to applicability of either a State external review process or a Federal external review process for non-grandfathered plans and issuers. How this impacts plans and issuers varies, depending on the type of coverage:

a. *Self-insured plans subject to ERISA and/or the Code*.

In the case of self-insured plans subject to ERISA and/or the Code, a Federal external review process supervised by DOL and Treasury applies (the "private accredited IRO process"[13]). On August 23, 2010, the Department of Labor issued Technical Release 2010–01 (T.R. 2010–01), which set forth an interim enforcement safe harbor for self-insured plans not subject to a State external review process or to the HHS-supervised process (the "HHS-administered process").[14] This interim enforcement safe harbor essentially permits a private contract process under which plans contract with accredited independent review organizations (IROs) to perform reviews. Separate guidance being issued contemporaneous with the publication of this amendment makes adjustments to, and provides clarifications regarding, the operation of the private accredited IRO process.

b. *Insured coverage*.

In the case of health insurance issuers in the group and individual market, the July 2010 regulations set forth 16 minimum consumer protections based on the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC) that, if provided by a State external review process, will result in the State's process applying in lieu of a Federal external review process. Moreover, for insured group health plans, as provided under paragraph (c)(1) of the July 2010 regulations, if a State external review process applies to and is binding on the plan's health insurance issuer under paragraph (c) of the July 2010 regulations (regarding State standards for external review), then the insured group health plan is not required to comply with either the State external review process or the Federal external review process. The July 2010 regulations provided a transition period for plan years (in the individual market, policy years) beginning before July 1, 2011, during which any existing State external review process will be considered sufficient (and will apply to health insurance issuers in that State). During the transition period, in States and territories without an existing State external review process (Alabama, Mississippi, and Nebraska, Guam, American Samoa, U.S. Virgin Islands and the Northern Mariana Islands), HHS guidance generally provided that health insurance issuers will participate in the HHS-administered process. As explained later in this preamble, this amendment to the July 2010 regulations modifies the transition period originally issued as part of the July 2010 regulations so that the last day of the transition period for all health insurance issuers offering group and individual health insurance coverage is December 31, 2011.

In addition, the July 2010 regulations provided that, following the conclusion of the transition period, health insurance issuers in a State that does not meet the minimum consumer protection standards set forth in paragraph (c) of the July 2010 regulations will participate in an external review process under Federal standards similar to the process under the NAIC Uniform Model Act, such as the HHS-administered process. Separate guidance being issued contemporaneous with the publication of this amendment announces standards under which, until January 1, 2014, a State may also operate such an external review process under Federal standards similar to the process under the NAIC Uniform Model Act (an "NAIC-similar process"). Accordingly, if HHS determines that a State has neither implemented the minimum consumer protections required under paragraph (c) of the July 2010 regulations, nor an NAIC-similar process, issuers in the State will have the choice of participating in either the HHS-administered process or the private accredited IRO process. HHS is adopting this approach to permit States to operate their external review processes under standards established by the Secretary until January 1, 2014, avoiding unnecessary disruption, while States work to adopt an "NAIC-parallel process," consistent with the consumer protections set forth in paragraph (c) of the July 2010 regulations.

c. *Self-insured, nonfederal governmental plans*.

For self-insured, nonfederal governmental plans (which are subject to the PHS Act, but not ERISA or the Code), previous HHS guidance generally provided that they follow the private accredited IRO process.[15] (In States and territories that did not have an existing external review process (Alabama, Mississippi, and Nebraska, Guam, American Samoa, U.S. Virgin Islands and the Northern Mariana Islands), previous HHS guidance generally provided that such plans may choose to follow the HHS-administered process or follow the private accredited IRO process.) Separate guidance being issued contemporaneous with the publication of this amendment generally treats self-insured nonfederal governmental plans the same as health insurance issuers. That is, a State may temporarily operate such an external review process applicable to a self-insured nonfederal governmental plan under Federal standards similar to the

[12] See DOL Technical Release 2010–01, available at *http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010–01.pdf*; HHS Technical Guidance issued August 26, 2010, available at *http://cciio.cms.gov/resources/files/interim_appeals_guidance.pdf*; and HHS Technical Guidance issued September 23, 2010, available at *http://cciio.cms.gov/resources/files/technical_guidance_for_self_funded_non_fed_plans.pdf*. Additional clarifications were provided in the form of frequently-asked questions (FAQs), available at *http://www.dol.gov/ebsa/faqs/faq-aca.html* and *http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs.html#claims*.

[13] For simplicity, the Federal external review process for self-insured plans subject to ERISA and/or the Code supervised by DOL and Treasury is referred to as the "private accredited IRO process" throughout this preamble. However, the interim procedures for Federal external review issued as DOL Technical Release 2010–01 also recognizes that States may choose to expand access to their State external review process to plans not subject to applicable State laws (such as self-insured ERISA plans) and allows those plans to meet their responsibilities to provide external review under PHS Act section 2719(b) by voluntarily complying with the provisions of that State external review process.

[14] HHS Technical Guidance issued August 26, 2010 provided that, for insured coverage, the Federal external review process would be fulfilled through the HHS-administered process.

[15] See HHS Technical Guidance issued September 23, 2010.

process under the NAIC Uniform Model Act. If no such State-operated process exists, self-insured nonfederal governmental plans have the choice of participating in either the HHS-administered process or the private accredited IRO process.

2. *Scope of claims eligible for external review.*

While the process varies depending on the type of coverage, so does the scope of claims eligible for external review. That is, for insurance coverage and self-insured nonfederal governmental plans subject to a State external review process (either an NAIC-parallel process or an NAIC-similar process), the State determines the scope of claims eligible for external review.[16] For coverage subject to either the HHS-administered process or the private accredited IRO process, the July 2010 regulations provided that any adverse benefit determination (or final internal adverse benefit determination) could be reviewed unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan. As explained later in this preamble, this amendment to the July 2010 regulations modifies the scope of claims eligible for external review under the Federal external review process.

II. Overview of Amendments to the Interim Final Regulations

A. *Internal Claims and Appeals*

1. *Expedited notification of benefit determinations involving urgent care (paragraph (b)(2)(ii)(B) of the July 2010 regulations).*

The July 2010 regulations provided that a plan or issuer must notify a claimant of a benefit determination (whether adverse or not) with respect to a claim involving urgent care (as defined in the DOL claims procedure regulation)[17] as soon as possible, taking into account the medical exigencies, but not later than 24 hours after the receipt of the claim by the plan or issuer, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan or health insurance coverage. This was a change from the DOL claims procedure regulation, which generally requires a determination not later than 72 hours after receipt of the claim by a group health plan for urgent care claims. The preamble to the July 2010 regulations stated that the Departments expected electronic communication would enable faster decision-making than in the year 2000, when the DOL claims procedure regulation was issued.[18]

While some commenters supported the 24-hour rule (particularly consumer advocates and medical associations, including mental health providers who noted the 24-hour standard was especially important for people in psychiatric crisis), concerns were raised by many plans and issuers regarding the burden of a 24-hour turnaround. Some commenters argued that some of the claims constituting "urgent care" and thus qualifying for the expedited timeframe really do not need to be made within 24 hours. Moreover, a number of commenters highlighted that the 72-hour provision was intended only to serve as a "backstop"; as the general rule under both the July 2010 regulations and the DOL claims procedure regulation requires a decision as soon as possible consistent with the medical exigencies involved, making the change to a 24-hour timeframe unnecessary for the most serious medical cases. Some commenters cited the Emergency Medical Treatment and Labor Act (EMTALA)[19], which generally requires hospitals to provide emergency care to individuals with or without insurance or preauthorization and, therefore, mitigates the need for expedited pre-service emergency claims determinations in many situations. Finally, some commenters stated that a firm 24-hour turnaround for urgent care claims will adversely affect claimants, as plans and issuers will not have sufficient time to properly review a claim, adversely affecting the quality of the review process in cases where the provider cannot be consulted in time, and leading to unnecessary denials of claims.

After considering the comments, and the costs and benefits of an absolute 24-hour decision-making deadline for pre-service urgent care claims, this amendment permits plans and issuers to follow the original rule in the DOL claims procedure regulation (requiring decision-making in the context of pre-service urgent care claims as soon as possible consistent with the medical exigencies involved but in no event later than 72 hours), *provided* that the plan or issuer defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care." At the same time, the Departments underscore that the 72-hour timeframe remains only an outside limit and that, in cases where a decision must be made more quickly based on the medical exigencies involved, the requirement remains that the decision should be made sooner than 72 hours after receipt of the claim.

2. *Additional notice requirements for internal claims and appeals (paragraph (b)(2)(ii)(E) of the July 2010 regulations).*

The July 2010 regulations also provided additional content requirements for any notice of adverse benefit determination or final internal adverse benefit determination. The July 2010 regulations required a plan or issuer to:

(a) Ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved. Under the July 2010 regulations, this information included the date

[16] Under paragraphs (c)(2)(i) and (c)(2)(xvi) of the July 2010 regulations, State processes must provide external review for adverse benefit determinations (including final internal adverse benefit determinations) that are based on issuer's (or plan's) requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or that involve experimental or investigational treatment. (A State external review process may also provide for external review of a broader scope of adverse benefit determinations.) At the same, time, paragraph (c)(3) of the July 2010 regulations provides a transition period during which a State external review process will be considered binding on an issuer (or a plan), in lieu of the requirements of any Federal external review process, even if the State process does not meet all the requirements of paragraph (c)(2) of the July 2010 regulations. That transition period is being modified by this amendment, as described below.

[17] Under the DOL claims procedure regulation, a "claim involving urgent care" is a claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

[18] 75 FR 43330, 43333 (July 23, 2010).

[19] 42 U.S.C. § 1395dd.

of service, the health care provider, and the claim amount (if applicable)[20], as well as the diagnosis code (such as an ICD–9 code, ICD–10 code, or DSM-IV code)[21], the treatment code (such as a CPT code)[22], and the corresponding meanings of these codes.

(b) Ensure that the description of the reason or reasons for the adverse benefit determination or final internal adverse benefit determination includes the denial code (such as a CARC and RARC)[23] and its corresponding meaning. It must also include a description of the plan's or issuer's standard, if any, that was used in denying the claim (for example, if a plan applies a medical necessity standard in denying a claim, the notice must include a description of the medical necessity standard). In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

(c) Provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(d) Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist enrollees with the internal claims and appeals and external review processes.[24]

Many comments received on the July 2010 regulations raised concerns about the additional content required to be included in the notices. Comments by a range of stakeholders, including plans, issuers, and consumer advocacy organizations focused heavily on the automatic provision of the diagnosis and treatment codes (and their meanings). Concerns were raised about privacy (because explanations of benefits (EOBs) often are sent to an individual who is not the patient, such as an employee who is the patient's spouse or parent), interference with the doctor-patient relationship,[25] and high costs.[26] More specifically, commenters highlighted that sensitive issues such as mental health treatments would be identified by specific treatment or diagnosis codes and that privacy concerns are magnified for adult dependents under age 26 who may be covered by their parent's health plan. Others pointed out that there are over 20,000 treatment and diagnosis codes in use today, presenting a costly administrative and operational challenge for plans and issuers. Comments also questioned the efficacy of providing the codes, which some argued are often very difficult for the average patient to understand.[27]

Other comments were received in support of the coding provisions. Consumer advocates commented positively on the requirement that denial notices include information for consumers about their right to appeal denials and the availability of state consumer assistance programs (CAPs) that will help consumers file appeals. There were also positive comments on the requirement to provide a rationale for the denial (including a description of the plan's or issuer's standard (such as "medical necessity"), if any, that was used denying the claim). With respect to the provision of coding information, some commented that this would be helpful to consumers because coding errors and missing coding information often are the basis for denying claims.

After considering all of the comments, and the costs and benefits of the additional disclosure, this amendment eliminates the requirement to automatically provide the diagnosis and treatment codes as part of a notice of adverse benefit determination (or final internal adverse benefit determination) and instead substitutes a requirement that the plan or issuer must provide notification of the opportunity to request the diagnosis and treatment codes (and their meanings) in all notices of adverse benefit determination (and notices of final internal adverse benefit determination), and a requirement to provide this information upon request.[28] This amendment also clarifies that, in any case, a plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for (and therefore trigger the start of) an internal appeal or external review.

3. *Deemed exhaustion of internal claims and appeals processes (paragraph (b)(2)(ii)(F) of the July 2010 regulations).*

The courts generally require claimants to exhaust administrative proceedings before going to court or seeking external review. When plans and issuers offer full and fair internal procedures for resolving claims, it is reasonable to insist that claimants first turn to those procedures before seeking judicial or external review of benefit denials. There is less justification, however, for insisting that a claimant exhaust administrative procedures that do not comply with the law. Accordingly, the July 2010 regulations permitted claimants

[20] The amount of the claim may not be knowable or available at the time, such as in a case of preauthorization, or there may be no specific claim, such as in a case of rescission that is not connected to a claim.

[21] ICD–9 and ICD–10 codes refer to the International Classification of Diseases, 9th revision and 10th revision, respectively. The DSM-IV codes refer to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

[22] CPT refers to Current Procedural Terminology.

[23] CARC refers to Claim Adjustment Reason Code and RARC refers to Remittance Advice Remark Code.

[24] To assist plans and issuers in making these disclosures, the Departments provided a current list of relevant consumer assistance programs and ombudsmen in the Appendix to T.R. 2011–01. Plans and issuers with July 1 plan years may rely upon the list in that Appendix when developing their notices of adverse benefit determination and final internal adverse benefit determination for plan years beginning on July 1, 2011. The Departments are committed to reviewing and updating this list. The first update is being made available contemporaneous with publication of this amendment. The first update is available (and any future updates will be made available) at *www.dol.gov/ebsa/healthreform* and *http://cciio.cms.gov/programs/consumer/capgrants/index.html*.

[25] Several commenters raised concerns that providers' initial or suspected diagnosis may not match the ultimate diagnosis or patients' perception of their diagnosis. One commenter gave the example of a patient who has a biopsy procedure. In that case, the patient would receive an EOB with an initial diagnosis code of cancer, however the results of the biopsy may rule out cancer. In that situation, the EOB can result in confusion and unnecessary mental anguish.

[26] In particular, comment letters cited concerns with respect to programming aspects of providing diagnosis codes at a time when plans and issuers are changing over from ICD–9 diagnosis codes to more extensive and technical ICD–10 codes.

[27] Several commenters noted that technical ICD–9 and/or ICD–10 codes can be confusing and/or cause worry. One commenter gave the example of a patient presenting with a white coating on his tongue, who is told not to worry and to brush the tongue with a toothbrush. The diagnosis code is 529.3, hypertrophy of tongue papillae, a term not used by the patient's doctor during the office visit and, therefore, prone to cause confusion and/or concern.

[28] As discussed earlier, in footnote 9, information related to diagnosis and treatment codes (and/or their meanings) is, however, generally required to be provided to claimants upon request under existing DOL claims procedures, which is also incorporated in the July 2010 regulations. *See* 29 CFR 2560.503–1(h)(2)(iii) and paragraph (b)(2)(i) of the July 2010 regulations.

to immediately seek review if a plan or issuer failed to "strictly adhere" to all of the July 2010 regulations' requirements for internal claims and appeals processes, regardless of whether the plan or issuer asserted that it "substantially complied" with the July 2010 regulations. The July 2010 regulations also clarified that, in such circumstances, the reviewing tribunal should not give special deference to the plan's or issuer's decision, but rather should resolve the dispute *de novo*. Consumer groups generally supported this "strict adherence" approach, but the approach received a number of negative comments from some issuers and plan sponsors, who advocate a "substantial compliance" approach.

The Departments continue to believe that claimants should not have to follow an internal claims and appeals procedure that is less than full, fair, and timely, as set forth in the July 2010 regulations. In response to comments, the Departments are retaining the general approach to this requirement, but this amendment also adds a new paragraph (b)(2)(ii)(F)(*2*) to the July 2010 regulations to provide an exception to the strict compliance standard for errors that are minor and meet certain other specified conditions. The new paragraph will also protect claimants whose attempts to pursue other remedies under paragraph (b)(2)(ii)(F)(*1*) of the interim final regulations are rejected by a reviewing tribunal. Under the amended approach, any violation of the procedural rules of the July 2010 regulations pertaining to internal claims and appeals would permit a claimant to seek immediate external review or court action, as applicable, unless the violation was:

(1) *De minimis*;

(2) Non-prejudicial;

(3) Attributable to good cause or matters beyond the plan's or issuer's control;

(4) In the context of an ongoing good-faith exchange of information; and

(5) Not reflective of a pattern or practice of non-compliance.

In addition, the claimant would be entitled, upon written request, to an explanation of the plan's or issuer's basis for asserting that it meets this standard, so that the claimant could make an informed judgment about whether to seek immediate review. Finally, if the external reviewer or the court rejects the claimant's request for immediate review on the basis that the plan met this standard, this amendment would give the claimant the right to resubmit and pursue the internal appeal of the claim.

4. *Form and manner of notice (paragraph (e) of the July 2010 regulations).*

PHS Act section 2719 requires group health plans and health insurance issuers to provide relevant notices in a culturally and linguistically appropriate manner. The July 2010 regulations set forth a requirement to provide notices in a non-English language based on separate thresholds of the number of people who are literate in the same non-English language. In the group market, the threshold set forth in the July 2010 regulations differs depending on the number of participants in the plan:

- For a plan that covers fewer than 100 participants at the beginning of a plan year, the threshold is 25 percent of all plan participants being literate only in the same non-English language.
- For a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language.

These thresholds were adapted from the DOL regulations regarding style and format for a summary plan description, at 29 CFR 2520.102–2(c) for participants who are not literate in English. For the individual market, the threshold is 10 percent of the population residing in the county being literate only in the same non-English language. The individual market threshold was generally adapted from the approach used under the Medicare Advantage program, which required translation of materials in languages spoken by more than 10 percent of the general population in a service area at the time the threshold was established.

Under the July 2010 regulations, if an applicable threshold is met with respect to a non-English language, the plan or issuer must provide the notice upon request in the non-English language. Additionally, the plan or issuer must include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language. Finally, to the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must provide such assistance in the non-English language.

Comments received in response to the July 2010 regulations raised several concerns about this requirement. One group of commenters stated that the thresholds for the group market were difficult to comply with, especially for small plans (where an individual or a small number of individuals could cause a plan to change status with respect to the threshold) and insured plans (where the issuer may be in a very difficult position to determine the English literacy of an employer's workforce). Some commenters stated that the threshold requirements for the group and individual markets should be consistent.

Other commenters were concerned with the high costs of compliance with this rule, particularly the "tagging and tracking requirement" to the extent that individuals who request a document in a non-English language would need to be "tagged" and "tracked" so that any future notices would be provided automatically in the non-English language. Some of these commenters cited the high costs associated with implementing translation requirements pursuant to California State law and the low take-up rates of translated materials in California. Some commenters also cited the importance of having written translation of documents available (at a minimum, upon request), as well as having oral language services for customer assistance.

Following review of the comments submitted on this issue and further review and consideration of the provisions of PHS Act section 2719, the Departments have determined it is appropriate to amend the provisions of the July 2010 regulations related to the provision of notices in a culturally and linguistically appropriate manner. This amendment establishes a single threshold with respect to the percentage of people who are literate only in the same non-English language for both the group and individual markets. With respect to group health plans and health insurance issuers offering group or individual health insurance coverage, the threshold percentage of people who are literate only in the same non-English language will be set at 10 percent or more of the population residing in the claimant's county, as

determined based on American Community Survey data published by the United States Census Bureau.[29] The Departments will update this guidance annually on their website if there are changes to the list of the counties determined to meet this 10 percent threshold for the county's population being literate only in the same non-English language.[30]

This amendment to the July 2010 regulations requires that each notice sent by a plan or issuer to an address in a county that meets this threshold include a one-sentence statement in the relevant non-English language about the availability of language services. The Departments have provided guidance with sample sentences in the relevant languages in separate guidance being issued contemporaneous with the publication of this amendment. For ease of administration, some plans and issuers may choose to use a one-sentence statement for all notices within an entire State (or for a particular service area) that reflects the threshold language or languages in any county within the State or service area. For example, statewide notices in California could include the relevant one-sentence statement in Spanish and Chinese because, using the data from Table 2, Spanish meets the 10 percent threshold in Los Angeles County and 22 other counties and Chinese meets the 10 percent threshold in San Francisco County. This would be a permissible approach to meeting the rule under this amendment.

In addition to including a statement in all notices in the relevant non-English language, this amendment requires a plan or issuer to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request. For this purpose, plans and issuers are permitted to direct claimants to the same customer service telephone number where representatives can first attempt to address the consumer's questions with an oral discussion, but also provide a written translation upon request in the threshold non-English language. Finally, this amendment removes any "tagging and tracking" requirement that would have otherwise applied under the July 2010 regulations.

This amendment to the July 2010 regulations provides standards for providing culturally and linguistically appropriate notices that balance the objective of protecting consumers by providing understandable notices to individuals who speak primary languages other than English with the goal of simplifying information collection burdens on plans and issuers. (Note, nothing in these regulations should be construed as limiting an individual's rights under Federal or State civil rights statutes, such as Title VI of the Civil Rights Act of 1964 (Title VI) which prohibits recipients of Federal financial assistance, including issuers participating in Medicare Advantage, from discriminating on the basis of race, color, or national origin. To ensure non-discrimination on the basis of national origin, recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons. For more information, see, "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," available at *http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html*.)

The Departments welcome comments on this amendment, including whether it would be appropriate to include a provision in the final rules requiring health insurance issuers providing group health insurance coverage to provide language services in languages that do not meet the requisite threshold for an applicable non-English language, if requested by the administrator or sponsor of the group health plan to which the coverage relates. For example, if Chinese does not meet the 10 percent threshold in New York County, but an employer with a large Chinese-speaking population asks the health insurance issuer providing its group health insurance coverage to provide language services in Chinese (as described in the amendment), the Departments invite comment on what obligations should be imposed on the issuer, if any, to provide language services in Chinese.

B. *External Review*

1. *Duration of transition period for State external review processes.*

In general, if State laws do not meet the minimum consumer protections of the NAIC Uniform Model Act[31], as set forth in paragraph (c)(2) of the July 2010 regulations, insurance coverage (as well as self-insured nonfederal governmental plan and church plan coverage) is subject to the requirements of an external review process under Federal standards similar to the process under the NAIC Uniform Model Act, such as the HHS-administered process. Paragraph (c)(3) of the July 2010 regulations provided a transition period for plan years (in the individual market, policy years) beginning before July 1, 2011 in order to allow States time to amend their laws to meet or go beyond the minimum consumer protections of the NAIC Uniform Model Act set forth in paragraph (c)(2) of the July 2010 regulations. HHS has been working closely with States regarding enactment of laws to conform to paragraph (c)(2) and much progress has been made. However, enacting State legislation and regulations can often be a complex and time-consuming process. Accordingly, the Departments are modifying the transition period under paragraph (c)(3) of the July 2010 regulations so that the last day of the transition period is December 31, 2011 to give States, which are making substantial progress in implementing State external review processes that conform to paragraph (c)(2), the requisite time to complete that process. Because the July 2010 regulations would have ended the transition period for plan years (in the individual market, policy years) beginning on or after July 1, 2011, the Departments note that ending the transition period on December 31, 2011 will reduce the length of the transition period for plans

[29] At the time of publication of this amendment, 255 U.S. counties (78 of which are in Puerto Rico) meet this threshold. The overwhelming majority of these are Spanish; however, Chinese, Tagalog, and Navajo are present in a few counties, affecting five states (specifically, Alaska, Arizona, California, New Mexico, and Utah). A full list of the affected U.S. counties in 2011 is included in Table 2 later in this preamble, under the heading, "IV. Economic Impact and Paperwork Burden."

[30] This information will be made available at *www.dol.gov/ebsa/healthreform* and *http://cciio.cms.gov/*.

[31] The NAIC Uniform Model Act in place on July 23, 2010 provides external review for claims involving medical necessity, appropriateness, health care setting, level of care, effectiveness (of a covered benefit), whether a treatment is experimental, and whether a treatment is investigational.

and policies with plan years (in the individual market, policy years) beginning after January 1 but before July 1. When the July 2010 regulations were published, the Departments anticipated that issuers in every State that had not enacted laws to conform to paragraph (c)(2) of the July 2010 regulations would need to participate in the HHS-administered process. Now, the Departments have decided that issuers may continue to participate in a State external review process under Federal standards similar to the process under the NAIC Uniform Model Act (an NAIC-similar process), which the Departments anticipate will reduce market disruption when the transition period ends. Therefore, based on the Departments' concerns for making the consumer protections of the Affordable Care Act available without undue delay and for ensuring as much uniformity as possible in the availability of those protections regardless of the form of a consumer's health coverage, the Departments have decided to end the transition period on December 31, 2011. Therefore, this amendment to the July 2010 regulations provides that, before January 1, 2012, an applicable State external process will apply in lieu of the requirements of the Federal external review process. PHS Act section 2719(c) authorizes the Departments to deem an external review process "in operation as of the date of enactment" of the Affordable Care Act as compliant with the external review requirements of PHS Act section 2719(b). Through December 31, 2011, any currently effective State external review process satisfies the requirements of either PHS Act section 2719(c) or section 2719(b)(2). If there is no applicable State external review process, separate guidance being issued contemporaneous with the publication of this amendment generally provides a choice between the HHS-administered process or the private accredited IRO process.

2. *Scope of the Federal External Review Process*

Paragraph (d)(1) of the July 2010 regulations sets forth the scope of claims eligible for external review under the Federal external review process. Specifically, any adverse benefit determination (including a final internal adverse benefit determination) could be reviewed unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (*i.e.*, worker classification and similar issues were not within the scope of the Federal external review process).

Comments received in response to the July 2010 regulations were mixed on the scope of claims eligible for external review. Some commenters argued that PHS Act section 2719 requires the Federal external review process to be "similar to" the NAIC Uniform Model Act and that the broader scope of claims eligible for the Federal external review process is a major departure from the NAIC Uniform Model Act. In addition, some comments from plans and issuers stated that the IROs that are used in the private accredited IRO process traditionally have expertise in adjudicating medical claims, and questioned IROs' experience and expertise with legal and contractual claims. Other comments from IROs and the IRO industry stated that these organizations do currently conduct reviews that involve both medical judgment issues and legal and contractual issues, and that there is sufficient capacity for conducting reviews of such disputes.

Some plan and issuer comments highlighted that, with a limited number of accredited IROs and increased demand for their services, the cost of external review for self-insured group health plans will likely increase. By contrast, an IRO association group commented that member organizations are not at capacity with regard to the volume of work they can perform, and that they are confident that the number of accredited IROs can adequately handle the volume of reviews anticipated for the Federal external review process.

Some plans and issuers stated that handing plan document interpretation and legal interpretation issues over to an IRO may raise issues of consistency of interpretations within a plan, unwarranted consistency across plans that have unique standards, ERISA fiduciary responsibility concerns, and possible conflicts. At the same time, other comments generally supported the broad scope of claims eligible for the Federal external review process as set forth in the July 2010 regulations. These commenters argued very strongly that it is nearly impossible to adjudicate contractual claims through traditional ERISA enforcement (which generally relies on Federal court adjudication), leaving plan participants and beneficiaries with no effective means of enforcing their rights to benefits under a plan. Consumer organizations further commented that external review finally provides the free, independent means of enforcement to level the playing field of claims adjudication and, therefore, the scope of claims eligible for the Federal external review process should be as broad as possible.

After considering all the comments, with respect to claims for which external review has not been initiated before September 20, 2011, the amendment suspends the original rule in the July 2010 regulations regarding the scope of claims eligible for external review for plans using a Federal external review process (regardless of which type of Federal process), temporarily replacing it with a different scope. Specifically, this amendment suspends the broad scope of claims eligible for the Federal external review process and narrows the scope to claims that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage. The more narrow scope under this amendment is more similar to the scope of claims eligible for external review under the NAIC Uniform Model Act. This amendment provides an example describing a plan that generally only provides 30 physical therapy visits but will provide more with an approved treatment plan. The plan's rejection of a treatment plan submitted by a provider for the 31st visit based on a failure to meet the plan's standard for medical necessity involves medical judgment and, therefore, the claim is eligible for external review. Similarly, another example describes a plan that generally does not provide coverage for services provided on an out-of-network basis, but will provide coverage if the service cannot effectively be provided in network. In this example, again, the plan's rejection of a claim for out-of-network services involves medical judgment. Additional examples of situations in which a claim is considered to involve medical judgment include adverse benefit determinations based on:

- The appropriate health care setting for providing medical care to an individual (such as outpatient versus inpatient care or home care versus rehabilitation facility);
- Whether treatment by a specialist is medically necessary or appropriate (pursuant to the plan's standard for medical necessity or appropriateness);
- Whether treatment involved "emergency care" or "urgent care", affecting coverage or the level of coinsurance;
- A determination that a medical condition is a preexisting condition;
- A plan's general exclusion of an item or service (such as speech therapy), if the plan covers the item or service in certain circumstances based on a medical condition (such as, to aid in the restoration of speech loss or impairment of speech resulting from a medical condition);
- Whether a participant or beneficiary is entitled to a reasonable alternative standard for a reward under the plan's wellness program;[32]
- The frequency, method, treatment, or setting for a recommended preventive service, to the extent not specified, in the recommendation or guideline of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or the Health Resources and Services Administration (as described in PHS Act section 2713 and its implementing regulations);[33] and
- Whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.[34]

The suspension is intended to give the marketplace time to adjust to providing external review. It will also allow the Departments time to evaluate IROs' capacity for handling external reviews; to consider whether current accreditation standards are sufficient to ensure that IROs are capable of making accurate and consistent decisions (both across different plans and across different IROs) regarding legal and contractual issues that do not involve medical judgment or rescissions; and to assess the mechanics of the Federal external review process (and any potential adjustments). The Departments solicit comments on these issues, including on whether limiting the scope of claims during the suspension period will impose administrative costs in determining whether a claim is eligible for external review. The Departments also welcome any data on external review claims actually performed to date under private contracts pursuant to the private accredited IRO process for implementing PHS Act § 2719(b), including number of claims reviewed, type of review (such as whether it involved any medical judgment or not), and costs associated with the review. The Departments expect that the suspension will be lifted by January 1, 2014, when other consumer protections under the Affordable Care Act take effect. Moreover, if, after taking into account all the relevant information, including public comments, the Departments decide to return to the original rule providing for a broad scope of claims or permanently modify the scope of claims through rulemaking, the Departments will give sufficient advance notice to enable plans, their service providers, IROs, and other affected parties sufficient time to comply with a new rule.

Separate guidance being issued contemporaneous with the publication of this amendment announces standards under which, until January 1, 2014, a State may operate an external review process under Federal standards similar to the process under the NAIC Uniform Model Act (an NAIC-similar process). The Departments are adopting this approach to permit States to operate their external review processes under standards established by the Departments until January 1, 2014, avoiding unnecessary disruption, while States work to adopt the consumer protections set forth in paragraph (c) of the July 2010 regulations. Paragraph (d)(1) of the July 2010 regulations, as amended, will govern the scope of a State external review process under Federal standards similar to the process under the NAIC Uniform Model Act. Because the amended paragraph (d)(1) creates a broader scope of external review than is required under the NAIC Uniform Model Act, and because it would be illogical to require States to make changes to their process to encompass the broader scope of paragraph (d)(1) in their external review process while they work to adopt the consumer protections of the NAIC Uniform Model Act (which has a narrower scope), the Departments are also amending paragraph (d)(1) to permit the Secretaries to modify the scope of the Federal external review process in future guidance to permit State external review processes (both NAIC-similar processes and NAIC-parallel processes) to the scope that applies under the NAIC Uniform Model Act.

3. *Clarification regarding requirement that external review decision be binding*

The Departments have received a number of comments on the requirement that an IRO decision be binding on parties. Specifically, the July 2010 regulations provided that an external review decision by an IRO is binding on the plan or issuer, as well as the claimant, except to the extent that other remedies are available under State or Federal law.[35] This binding requirement is also one of the minimum con-

[32] See 26 CFR 54.9802–1(f)(2)(iv)(A), 29 CFR 2590.702(f)(2)(iv)(A), and 45 CFR 146.121(f)(2)(iv)(A), requiring that wellness programs that require individuals to satisfy a standard related to a health factor in order to obtain a reward allow a reasonable alternative standard (or waiver of the otherwise applicable standard) for obtaining the reward for any individual for whom, for that period, it is either unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or medically inadvisable to attempt to satisfy the otherwise applicable standard.

[33] See 26 CFR 54.9815–2713T, 29 CFR 2590.715–2713, and 45 CFR 147.130; see also FAQ 8, FAQs About the Affordable Care Act Implementation Part II, regarding the scope, setting, or frequency of the items or services to be covered under the preventive health services recommendations and guidelines (available at *http://www.dol.gov/ebsa/faqs/faq-aca2.html* and *http://cciio.cms.gov/resources/factsheets/aca_implementation_faqs2.html*).

[34] See Code section 9812 and 26 CFR 54.9812–1T, ERISA section 712 and 29 CFR 2590.712, and PHS Act section 2726 and 45 CFR 146.136.

[35] See 26 CFR 54.9815–2719T(d)(2)(iv), 29 CFR 2590.715–2719(d)(2)(iv), and 45 CFR 147.136(d)(2)(iv).

sumer protections set forth in paragraph (c) of the July 2010 regulations.[36]

Some comments received in response to the July 2010 regulations highlighted the importance of this consumer protection and expressed approval that this requirement would minimize delays that could further hurt claimants, as the plan or issuer must provide coverage or payment for the claim immediately upon receipt of a notice of a final external review decision. Other commenters questioned whether the requirement that external review is binding eliminates the plan's or issuer's option to choose to pay a claim at any time during or after the external review process.

Nothing in PHS Act section 2719(b), the July 2010 regulations, or related guidance precludes a plan or issuer from choosing to provide coverage or payment for a benefit. Instead, the Departments read the requirement of the NAIC Uniform Model Act, which is incorporated into the July 2010 regulations, to require plans and issuers to provide a benefit if that is the decision of the IRO. A plan or issuer may not delay payment because the plan disagrees and intends to seek judicial review. Instead, while the plan may be entitled to seek judicial review, it must act in accordance with the IRO's decision (including by making payment on the claim) unless or until there is a judicial decision otherwise. However, the requirement that the IRO's decision be binding does not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including following a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

After considering all the comments on the requirement that an IRO decision be binding on the plan and issuer, as well as the claimant, this amendment clarifies the language in paragraphs (c)(2)(xi) (regarding the minimum standards for State external review processes) and (d)(2)(iv) (regarding Federal external review process standards). Specifically, these two provisions are amended to add language stating that, for purposes of the binding provision, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. The Departments welcome comments as to whether any additional clarifications about the binding provision would be helpful.

C. *Separate, Contemporaneous Technical Guidance*

Separate technical guidance is being issued by the Departments contemporaneous with the publication of this amendment. This technical guidance addresses both State- and Federally-administered external review processes. An appendix to this technical guidance contains revised versions of the three model notices issued by the Departments in connection with the July 2010 regulations. The updated versions of the model notice of adverse benefit determination, model notice of final internal adverse benefit determination, and model notice of final external review decision reflect the requirements contained in the provisions of this amendment and the guidance. This technical guidance will be available at *http://www.dol.gov/ebsa/healthreform* and *http://cciio.cms.gov*.

HHS is issuing also two additional technical guidance documents. The first provides instructions for self-insured nonfederal governmental plans and health insurance issuers with respect to election of a Federal external review process. The second provides, for transparency purposes, updated information on how the county-level estimates pertaining to the 10 percent threshold were calculated for the rules related to culturally and linguistically appropriate notices. Both of these documents will be available at *http://cciio.cms.gov*.

III. Interim Final Rules

Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act authorize the Secretaries of the Treasury, Labor, and HHS (collectively, the Secretaries) to promulgate any interim final rules that they determine are appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and part A of title XXVII of the PHS Act, which include PHS Act sections 2701 through 2728 and the incorporation of those sections into ERISA section 715 and Code section 9815. The amendments promulgated in this rulemaking carry out the provisions of these statutes. Therefore, the foregoing interim final rule authority applies to these amendments.

Under the Administrative Procedure Act (APA) (5 U.S.C. 551 *et seq.*), while a general notice of proposed rulemaking and an opportunity for public comment is generally required before promulgation of regulations, this is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The provisions of the APA that ordinarily require a notice of proposed rulemaking do not apply here because of the specific authority to issue interim final rules granted by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act. Moreover, even if the APA requirements for notice and comment were applicable to this regulation, they have been satisfied. This is because the matters that are the subject of these amendments have already been subjected to public notice and comment, as they were addressed in the July 2010 regulations, and are a logical outgrowth of that document. The amendments made in this interim final rule are being made in response to public comments received on the July 2010 regulations. While the Departments have determined that, even if the APA were applicable, an additional opportunity for public comment is unnecessary in the case of these amendments, the Departments are issuing these amendments as an interim final rule so as to provide the public with an opportunity for public comment on these modifications.

IV. Economic Impact and Paperwork Burden

A. *Summary and Need for Regulatory Action—Department of Labor and Department of Health and Human Services*

As stated earlier in this preamble, the Departments previously issued the July 2010 regulations implementing PHS Act section 2719, which were published

[36] See 26 CFR 54.9815–2719T(c)(2)(xi), 29 CFR 2590.715–2719(c)(2)(xi), and 45 CFR 147.136(c)(2)(xi).

in the **Federal Register** on July 23, 2010 (75 FR 43330). The July 2010 regulations set forth rules with respect to internal claims and appeals and external appeals processes for group health plans and health insurance issuers that are not grandfathered health plans.

As described in detail in Section II of this preamble, after the July 2010 regulations were issued, the Departments received public comments expressing concerns about the burdens associated with several of the regulations' provisions. In response to such comments, the Departments are hereby amending the following provisions of the July 2010 regulations:

- Expedited notification of benefit determinations involving urgent care (paragraph (b)(2)((ii)(B) of the July 2010 regulations);
- Additional notice requirements with respect to notice of adverse benefit determinations or final internal adverse benefit determination (paragraph (b)(2)(ii)(E) of the July 2010 regulations);[37]
- Deemed exhaustion of internal claims and appeals processes (paragraph (b)(2)(ii)(F) of the July 2010 regulations);
- Providing notices in a culturally and linguistically appropriate manner (paragraph (e) of the July 2010 regulations);
- The duration of the transition period for State external review processes (paragraph (c)(3) of the July 2010 regulations); and
- The scope of claims eligible for external review under the Federal external appeals process (paragraph (d)(1) of the July 2010 regulations).

The Departments crafted these amendments to the July 2010 regulations to secure the protections intended by Congress. In accordance with OMB Circular A–4, the Departments have quantified the costs of these amendments where feasible and provided a qualitative discussion of some of the benefits and costs that may stem from them.

The Departments believe that (i) the costs associated with the amended rules are less than the costs associated with the July 2010 regulations, (ii) the amended rules adequately protect the rights of participants, beneficiaries, and policyholders, and (iii) the benefits of the amended rules justify their costs relative to the pre-Affordable Care Act baseline and the July 2010 regulations.

B. *Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services*

Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated a "significant regulatory action" although not economically significant, under section 3(f) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

The Departments provide an assessment of the potential costs and benefits associated with each amended regulatory provision below, as summarized in Table 1.

TABLE. 1—*Accounting Table*

Benefits

Qualitative: Amendments to the interim final regulations ensure urgent care benefit determinations are made in a timely manner, increase patient privacy, ensure non-English speakers understand their rights, and provide that claimants will be deemed to have exhausted their administrative proceedings and can proceed to court or external review if a plan or issuer fails to strictly adhere to the regulatory requirements with the exception of the requirements that are described in the amendment. These amendments are expected to reduce compliance costs while still ensuring patient protections.

Costs	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($millions/year)	1.7	2011	7%	2012–2014
	1.7	2011	3%	2012–2014

Qualitative: Monetized costs are for providing notices upon request in a culturally and linguistically appropriate manner. Non-monetized costs include costs for plans and issuers to respond to requests for diagnostic and treatment codes, and costs incurred by claimants to resolve whether a plan or insurer's failure to strictly adhere to the regulatory requirements is sufficient for a claimant to proceed directly to an external or court review.

[37] Under the July 2010 regulations, this included the date of service, the health care provider, and the claim amount (if applicable), as well as the diagnosis code (such as an ICD–9 code, ICD–10 code, or DSM-IV code), the treatment code (such as a CPT code) , and the corresponding meanings of these codes.

1. Estimated Number of Affected Entities

For purposes of estimating the entities affected by these amendments to the July 2010 regulations, the Departments have defined a large group health plan as an employer plan with 100 or more workers and a small group plan as an employer plan with fewer than 100 workers. The Departments make the following estimates about plans and issuers affected by these amendments: (1) there are approximately 72,000 large and 2.8 million small ERISA-covered group health plans with an estimated 97.0 million participants in large group plans and 40.9 million participants in small group plans;[38] (2) there are 126,000 governmental plans with 36.1 million participants in large plans and 2.3 million participants in small plans;[39] and (3) there are 16.7 million individuals under age 65 covered by individual health insurance policies.[40]

The actual number of affected individuals depends on several factors, including whether (i) a health plan retains its grandfather status, (ii) the plan is subject to ERISA, (iii) benefits provided under the plan are self-funded or financed by the purchase of an insurance policy, (iii) the applicable State has enacted an internal claims and appeals law, and (iv) the applicable State has enacted an external review law, and if so the scope of such law, and (v) the number of new plans and enrollees in such plans.

2. Benefits and Costs

The benefits and costs of the amendments to the July 2010 regulations are discussed together under this section, because the primary effect of the amendments is to reduce the cost of compliance.

a. *Expedited notification of benefit determination involving urgent care*. As discussed in detail above, the July 2010 regulations generally provide that a plan or issuer must notify a claimant of a benefit determination with respect to an urgent care claim as soon as possible taking into account the medical exigencies, but no later than 24 hours after the receipt of the claim by the plan or issuer. This was a change from the DOL claims procedure regulation, which requires an urgent care determination to be made not later than 72 hours after receipt of the claim by a group health plan. The Departments received several comments regarding the burdens associated with meeting the 24-hour turnaround. Some commenters argued that some of the claims constituting "urgent care" and thus qualifying for the expedited timeframe really do not need to be decided within 24 hours. Moreover, a number of commenters highlighted that the 72-hour provision was never anything more than a "backstop"; the general rule under both the July 2010 regulations and the DOL claims procedure regulation is for a decision as soon as possible consistent with the medical exigencies involved, making the change to a 24-hour timeframe unnecessary for the most serious medical cases. Finally, some commenters cited the Emergency Medical Treatment and Labor Act (EMTALA)[41], which generally requires emergency room care to be treated with or without insurance or preauthorization and, therefore, mitigates much of the need for expedited pre-service emergency claims determinations in many situations.

After considering the comments, and the costs and benefits of an absolute 24-hour decision-making deadline, the amendment permits plans and issuers to follow the original rule in the DOL claims procedure regulation (requiring decision-making in the context of pre-service urgent care claims as soon as possible consistent with the medical exigencies involved but in no event no later than 72 hours), *provided* the plan or issuer defers to the attending provider with respect to the decision as to whether a claim constitutes "urgent care."

The Departments expect that this amendment will ensure urgent care benefit determinations are made in a timely manner while reducing burden on plans and issuers for several reasons. ERISA-covered plans were already subject to this requirement; therefore, there is no additional burden imposed on such plans from the pre-Affordable Care Act baseline. For self-insured nonfederal governmental plans and issuers in the individual market, the 72-hour requirement would increase burden from a pre-Affordable Care Act baseline to the extent that such plans and issuers are not already meeting this standard. The Departments do not have sufficient data to estimate the fraction of plans and issuers that were not already in compliance with this standard. Many claims filed with self-insured nonfederal governmental plans and individual market issuers already could have been meeting this requirement for urgent care claims, because ERISA claims constitute a large portion of health claims, and the Departments understand that, in general, issuers and service providers apply the same claims and appeals standards to ERISA-covered and non-ERISA-covered plans.

Plans and issuers that previously were not subject to the DOL claims procedure regulation and that are not already meeting the claims and appeals standard under the DOL claims procedure regulation, could incur additional costs to become compliant with the 72-hour standard, but the Departments expect these costs to be less than those associated with a 24-hour standard. Speeding up the notification process for these determinations to meet the 72-hour standard could necessitate incurring additional cost to add more employees or find other ways to shorten the timeframe, but again such costs are expected to be less than the costs associated with meeting the 24-hour standard provided in the July 2010 regulations. Additional costs for claimants may be associated with this requirement if meeting the 72-hour timeframe results in more claims being denied than would have been denied under a longer notification period, but again such costs are expected to be less than the costs associated with meeting the 24-hour standard provided in the July 2010 regulations. The Departments do not have sufficient data to estimate such costs.

b. *Additional notice requirements for internal claims and appeals*. As discussed above, the July 2010 regulations had

[38] All participant counts and the estimates of individual policies are from the U.S. Department of Labor, EBSA calculations using the March 2009 Current Population Survey Annual Social and Economic Supplement and the 2008 Medical Expenditure Panel Survey.

[39] Estimate is from the 2007 Census of Government.

[40] US Census Bureau, Current Population Survey, March 2009.

[41] 42 U.S.C. §1395dd.

additional content requirements for the required notices. The Departments received comments addressing the requirements to include the diagnosis code (such as an ICD–9 code, ICD–10 code, or DSM-IV code), the treatment code (such as a CPT code), and the corresponding meanings of these codes. Concerns were raised about patient privacy, interference with the doctor-patient relationship, and high costs. Commenters also pointed out that there are currently over 20,000 treatment and diagnosis codes in use today, presenting a costly administrative and operational challenge for plans and issuers. Comments also questioned the efficacy of providing codes which some argued are often very difficult for the average patient to understand.

After considering all the comments, and the costs and benefits of the additional disclosure, the amendment to the July 2010 regulations eliminates the requirement to automatically provide the diagnosis and treatment codes as part of a notice of adverse benefit determination (or final internal adverse benefit determination) and instead requires plans and issuers to provide notification of the opportunity to request the diagnosis and treatment codes (and their meanings) in all notices of adverse benefit determination (and notices of final internal adverse benefit determination) and to provide this information upon request.

Making the codes only available upon request protects patients' privacy while reducing the burden for plans and issuers to redesign notices. However, plans and issuers will still incur costs to establish procedures to receive, process, and mail the requests. The Departments do not have a basis to estimate the net cost associated with this amendment, because they do not have sufficient data available to estimate the savings that will result from plans and issuers not needing to redesign notices or calculate the number of future requests.

c. *Deemed exhaustion of internal claims and appeals process*. The July 2010 regulations provide that claimants can immediately seek judicial or external review if a plan or issuer failed to "strictly adhere" to all of the July 2010 regulations' requirements for internal claims and appeals processes, regardless of whether the plan or issuer asserted that it "substantially complied" with the July 2010 regulations. This approach received a number of negative comments from some issuers and plan sponsors, who prefer a "substantial compliance" approach, especially in cases where deviations from the regulatory standards were minor.

In response to these comments, the Departments are retaining the approach to this requirement, but this amendment also adds a new paragraph (b)(2)(ii)(F)(*2*) to the July 2010 regulations to provide an exception to the strict compliance standard for errors that are minor and meet certain other specified conditions. The new paragraph will also protect claimants whose attempts to pursue other remedies under paragraph (b)(2)(ii)(F)(*1*) of the interim final regulations are rejected by a reviewing tribunal. Under the amended approach, any violation of the procedural rules of July 2010 regulations pertaining to internal claims and appeals would permit a claimant to seek immediate external review or court action, as applicable, unless the violation was:

(1) *De minimis*;

(2) Non-prejudicial;

(3) Attributable to good cause or matters beyond the plan's or issuer's control;

(4) In the context of an ongoing good-faith exchange of information; and

(5) Not reflective of a pattern or practice of non-compliance.[42]

The Departments expect that this amendment will protect patients' right to proceed to external review while lowering costs based on the assumption that internal appeals are less expensive than external reviews or litigation. However, the amendment may add some costs, because participants and policyholders now may face uncertainty regarding whether a particular violation is minor. Many claimants may incur a cost to seek professional advice, because they will not be able to make this judgment on their own behalf. Alternatively, some claimants might seek immediate external review or judicial review and be denied it. The Departments do not have a sufficient basis to estimate these costs.

d. *Culturally and Linguistically Appropriate Notices*. PHS Act section 2719 requires group health plans and health insurance issuers to provide relevant notices in a culturally and linguistically appropriate manner. The July 2010 regulations set forth a requirement to provide notices in a non-English language based on separate thresholds of the number of people who are literate in the same non-English language. In the group market, the threshold set forth in the July 2010 regulations differs depending on the number of participants in the plan as follows:

- For a plan that covers fewer than 100 participants at the beginning of a plan year, the threshold is 25 percent of all plan participants being literate only in the same non-English language.
- For a plan that covers 100 or more participants at the beginning of a plan year, the threshold is the lesser of 500 participants, or 10 percent of all plan participants, being literate only in the same non-English language.[43]

For the individual market, the threshold is 10 percent of the population residing in the county being literate only in the same non-English language.[44]

Under the July 2010 regulations, if an applicable threshold is met with respect to a non-English language, the plan or issuer must provide the notice upon request in the non-English language. Additionally, the plan or issuer must include a statement in the English versions of all notices, prominently displayed in the non-English language, offering the provision of such notices in the non-English language. Finally, to the extent the plan or issuer maintains a customer assistance process (such as a telephone hotline) that answers questions or provides assistance with filing claims and appeals, the plan or issuer must pro-

[42] In addition, the claimant would be entitled, upon written request, to an explanation of the plan's or issuer's basis for asserting that it meets this standard, so that the claimant could make an informed judgment about whether to seek immediate review. Finally, if the external reviewer or the court rejects the claimant's request for immediate review on the basis that the plan met this standard, this amendment would give the claimant the right to resubmit and pursue the internal appeal of the claim.

[43] These thresholds were adapted from the DOL regulations regarding style and format for a summary plan description, at 29 CFR 2520.102–2(c) for participants who are not literate in English.

[44] The individual market threshold was generally adapted from the approach used under the Medicare Advantage program, which required translation of materials in languages spoken by more than 10 percent of the general population in a service area at the time the threshold was established.

vide such assistance in the non-English language.

As discussed earlier in this preamble, the Departments received comments that raised concerns regarding the burdens imposed by this provision. In response to these comments, the Departments have decided to amend the July 2010 regulations' provisions related to the provision of notices in a culturally and linguistically appropriate manner to establish a single threshold with respect to the number of people who are literate only in the same non-English language for both the group and individual markets. Under the amended provision, for group health plans and health insurance issuers offering group or individual health insurance coverage, the threshold percentage of people who are literate only in the same non-English language will be set at 10 percent or more of the population residing in the claimant's county, as determined based on American Community Survey (ACS) data published by the United States Census Bureau. Table 2, below provides a chart listing those 255 U.S. counties (78/255 are in Puerto Rico) in which at least 10 percent of the population speak a particular non-English language and speak English less than "very well." These data are applicable for 2011 and are calculated using 2005–2009 ACS data. The Departments will update this guidance annually on their website if there are changes to the list of the counties determined to meet this 10 percent threshold for the county's population being literate only in the same non-English language.

TABLE 2.—*Percent of the County Population that Speak a Particular Non-English Language and Speak English Less Than "Very Well", by U.S. County*[45]

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
AK	Aleutians West Census Area	13		16	
AK	Aleutians East Borough			35	
AR	Sevier County	17			
AZ	Apache County				12
AZ	Maricopa County	11			
AZ	Yuma County	22			
AZ	Santa Cruz County	39			
CA	Colusa County	27			
CA	Fresno County	15			
CA	Glenn County	14			
CA	Imperial County	32			
CA	Kern County	16			
CA	Kings County	18			
CA	Los Angeles County	19			
CA	Madera County	18			
CA	Merced County	20			
CA	Monterey County	25			
CA	Napa County	14			
CA	Orange County	14			
CA	Riverside County	15			
CA	San Benito County	21			
CA	San Bernardino County	15			
CA	San Diego County	11			
CA	San Francisco County		12		

[45] Data are from the 2005–2009 ACS available at *www.census.gov/acs*. Only those counties where at least 10% of the county speak a particular non-English language and speak English less than "very well" are listed.

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
CA	San Joaquin County	12			
CA	Santa Barbara County	15			
CA	Santa Cruz County	12			
CA	Stanislaus County	13			
CA	Sutter County	12			
CA	Tulare County	21			
CA	Ventura County	14			
CO	Adams County	12			
CO	Costilla County	11			
CO	Denver County	12			
CO	Eagle County	16			
CO	Garfield County	12			
CO	Lake County	11			
CO	Phillips County	12			
CO	Prowers County	12			
CO	Saguache County	15			
CO	Yuma County	10			
FL	Collier County	13			
FL	DeSoto County	21			
FL	Glades County	10			
FL	Hardee County	22			
FL	Hendry County	26			
FL	Miami-Dade County	31			
FL	Okeechobee County	12			
FL	Osceola County	16			
GA	Atkinson County	12			
GA	Echols County	20			
GA	Hall County	16			
GA	Telfair County	10			
GA	Whitfield County	18			
IA	Buena Vista County	12			
ID	Clark County	22			
ID	Minidoka County	11			
ID	Owyhee County	12			
ID	Power County	13			
IL	Kane County	15			
KS	Finney County	16			
KS	Ford County	23			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
KS	Grant County	16			
KS	Hamilton County	11			
KS	Seward County	26			
KS	Stanton County	19			
KS	Stevens County	11			
KS	Wichita County	12			
KS	Wyandotte County	10			
NC	Alleghany County	14			
NC	Duplin County	14			
NE	Colfax County	23			
NE	Dakota County	14			
NE	Dawson County	15			
NJ	Hudson County	18			
NJ	Passaic County	16			
NJ	Union County	13			
NM	Chaves County	11			
NM	Dona Ana County	18			
NM	Hidalgo County	12			
NM	Lea County	11			
NM	Luna County	18			
NM	McKinley County				15
NM	Mora County	11			
NM	Santa Fe County	12			
NM	Chaves County	11			
NV	Clark County,	11			
NY	Bronx County	20			
NY	New York County	10			
NY	Queens County	12			
OK	Texas County	18			
OR	Hood River County	15			
OR	Marion County	11			
OR	Morrow County	14			
TX	Andrews County	11			
TX	Atascosa County	11			
TX	Bailey County	18			
TX	Bexar County	12			
TX	Brooks County	18			
TX	Calhoun County	12			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
TX	Cameron County	30			
TX	Camp County	11			
TX	Castro County	20			
TX	Cochran County	18			
TX	Concho County	29			
TX	Crane County	10			
TX	Crockett County	20			
TX	Crosby County	11			
TX	Culberson County	15			
TX	Dallam County	12			
TX	Dallas County	18			
TX	Dawson County	12			
TX	Deaf Smith County	20			
TX	Dimmit County	33			
TX	Duval County	26			
TX	Ector County	12			
TX	Edwards County	10			
TX	El Paso County	29			
TX	Frio County	16			
TX	Garza County	35			
TX	Gonzales County	14			
TX	Hale County	12			
TX	Hall County	14			
TX	Hansford County	16			
TX	Harris County	18			
TX	Hidalgo County	35			
TX	Howard County	16			
TX	Hudspeth County	31			
TX	Jim Hogg County	26			
TX	Jim Wells County	13			
TX	Karnes County	17			
TX	Kenedy County	14			
TX	Kinney County	15			
TX	Kleberg County	11			
TX	La Salle County	22			
TX	Lamb County	15			
TX	Lipscomb County	14			
TX	Lynn County	12			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
TX	Maverick County	48			
TX	Midland County	11			
TX	Moore County	19			
TX	Nueces County	12			
TX	Ochiltree County	17			
TX	Parmer County	22			
TX	Pecos County	18			
TX	Presidio County	36			
TX	Reagan County	21			
TX	Reeves County	27			
TX	San Patricio County	12			
TX	Schleicher County	12			
TX	Sherman County	14			
TX	Starr County	43			
TX	Sterling County	11			
TX	Sutton County	18			
TX	Tarrant County	10			
TX	Terrell County	12			
TX	Terry County	11			
TX	Titus County	20			
TX	Travis County	12			
TX	Upton County	11			
TX	Uvalde County	15			
TX	Val Verde County	29			
TX	Ward County	12			
TX	Webb County	49			
TX	Willacy County	20			
TX	Winkler County	13			
TX	Yoakum County	23			
TX	Zapata County	36			
TX	Zavala County	33			
UT	San Juan County				12
VA	Manassas city	17			
VA	Manassas Park city	18			
WA	Adams County	23			
WA	Douglas County	11			
WA	Franklin County	27			
WA	Grant County	16			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
WA	Yakima County	17			
PR	Anasco Municipio	85			
PR	Adjuntas Municipio	86			
PR	Aguada Municipio	81			
PR	Aguadilla Municipio	78			
PR	Aguas Buenas Municipio	90			
PR	Aibonito Municipio	82			
PR	Arecibo Municipio	83			
PR	Arroyo Municipio	84			
PR	Barceloneta Municipio	78			
PR	Barranquitas Municipio	87			
PR	Bayamon Municipio	78			
PR	Cabo Rojo Municipio	82			
PR	Caguas Municipio	80			
PR	Camuy Municipio	88			
PR	Canovanas Municipio	83			
PR	Carolina Municipio	77			
PR	Catano Municipio	82			
PR	Cayey Municipio	86			
PR	Ceiba Municipio	73			
PR	Ciales Municipio	88			
PR	Cidra Municipio	86			
PR	Coamo Municipio	84			
PR	Comero Municipio	93			
PR	Corozal Municipio	88			
PR	Culebra Municipio	76			
PR	Dorado Municipio	77			
PR	Fajardo Municipio	78			
PR	Florida Municipio	81			
PR	Guayama Municipio	80			
PR	Guayanilla Municipio	85			
PR	Guaynabo Municipio	69			
PR	Gurabo Municipio	81			
PR	Gußnica Municipio	83			
PR	Hatillo Municipio	86			
PR	Hormigueros Municipio	74			
PR	Humacao Municipio	83			
PR	Isabela Municipio	85			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
PR	Jayuya Municipio	91			
PR	Juana Diaz Municipio	86			
PR	Juncos Municipio	85			
PR	Lajas Municipio	83			
PR	Lares Municipio	87			
PR	Las Marias Municipio	91			
PR	Las Piedras Municipio	85			
PR	Loiza Municipio	89			
PR	Luquillo Municipio	79			
PR	Manati Municipio	84			
PR	Maricao Municipio	95			
PR	Maunabo Municipio	88			
PR	Mayaguez Municipio	77			
PR	Moca Municipio	86			
PR	Morovis Municipio	87			
PR	Naguabo Municipio	83			
PR	Naranjito Municipio	91			
PR	Orocovis Municipio	91			
PR	Patillas Municipio	84			
PR	Penuelas Municipio	86			
PR	Ponce Municipio	80			
PR	Quebradillas Municipio	83			
PR	Rincon Municipio	73			
PR	Rio Grande Municipio	85			
PR	Sabana Grande Municipio	83			
PR	Salinas Municipio	86			
PR	San German Municipio	85			
PR	San Juan Municipio	73			
PR	San Lorenzo Municipio	83			
PR	San Sebastian Municipio	84			
PR	Santa Isabel Municipio	86			
PR	Toa Alta Municipio	80			
PR	Toa Baja Municipio	80			
PR	Trujillo Alto Municipio	79			
PR	Utuado Municipio	83			
PR	Vega Alta Municipio	83			
PR	Vega Baja Municipio	76			
PR	Vieques Municipio	83			

		NON-ENGLISH LANGUAGE			
STATE	COUNTY	Spanish %	Chinese %	Tagalog %	Navajo %
PR	Villalba Municipio	88			
PR	Yabucoa Municipio	86			
PR	Yauco Municipio	85			
PR	Yauco Municipio	85			

These amendments also require each notice sent by a plan or issuer to an address in a county that meets this threshold to include a one-sentence statement in the relevant non-English language about the availability of language services to be provided by the Departments. The Departments have provided guidance with sample sentences in the relevant languages in separate guidance being issued contemporaneous with the publication of this amendment.

In addition to including a statement in all notices in the relevant non-English language, a plan or issuer would be required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon request.

The Departments expect that the largest cost associated with the amended rules for culturally and linguistically appropriate notices will be for plans and issuers to provide notices in the applicable non-English language upon request. Based on the ACS data, the Departments estimate that there are about 12 million individuals living in covered counties that are literate in a non-English Language. The ACS did not start collecting insurance coverage information until 2008. Therefore, to estimate the percentage of the 12 million affected individuals that were insured, the Departments used the percentage of the population in the State that reported being insured by private or public employer insurance or in the individual market from the 2009 Current Population Survey (CPS). [46] This results in an estimate of approximately seven million individuals who are eligible to request translation services.

In discussions with the regulated community, the Departments found that experience in California, which has a State law requirement for providing translation services, indicates that requests for translations of written documents averages 0.098 requests per 1,000 members. While the California law is not identical to the amendment to the July 2010 regulations, and the demographics for California do not match other counties, for purposes of this analysis, the Departments used this percentage to estimate of the number of translation service requests that plan and issuers can expect to receive. Industry experts also told the Departments that while the cost of translation services varies, $500 per document is a reasonable approximation of translation cost.

Using the ACS and the CPS, the Departments estimate 34 million insured lives in the affected counties. Based on the foregoing, the Departments estimate that the cost to provide translation services will be approximately $1.7 million annually (34,087,000 lives * 0.098/1000 * $500).

e. *Duration of the transition period for State external review processes.* These amendments to the July 2010 regulations modify the transition period under paragraph (c)(3) so that the last day of the transition period is December 31, 2011. Modifying the transition period gives states additional time to implement State external review processes that conform to paragraph (c)(2). This modification produces benefits and costs to participants and beneficiaries depending upon which state they live in and the timing of the beginning of the plan year. HHS is working closely with states to help them have external review processes that meet the requirements of paragraph (c)(2). The July 2010 regulations would have participants living in states with laws that do not meet the minimum consumer protections in paragraph (c)(2) entering the Federal external review process that would provide more consumer protections. However, this requirement to enter the Federal external review process would take effect upon the start of a new plan year beginning on or after July 1, 2011.

This modification delays coverage of external review for participants whose plan year would have started between July 1, 2011 and December 31, 2011, but provides coverage sooner for participants in plans with plan years beginning after January 1, 2012, and has no change for participants in plans with plan years beginning on January 1, 2012.

The annual reporting form for certain ERISA covered health plans, the Form 5500, has information on health plan year end dates and also the number of participants in health plans. While most health plans with less than 100 participants are not required to file the Form 5500, the Departments are able to observe the plan year end dates and hence the plan year start dates for large plans. The Departments looked at the dispersion of plan year start dates for plans that filed the Form 5500 and found that nearly 76 percent of participants are in plans with a plan year start date of January 1, 2012 and hence will not be effected by the change in the rule; nearly 13 percent of participants are in plans that could possibly see a delay in receiving the protections of external review, while just over 10 percent of participants will be able to access the protections sooner. These estimates did not take into account the state in which the plan was located. The Departments do not have data on the start date of policies in the individual market. While on net about 2.4 percent of participants in affected plans could see a delay in receiving the protections, these costs are offset by giving states, and issuers additional time, and hence lower costs, to prepare for complying with the rule.

[46] Please note that using state estimates of insurance coverage could lead to an over estimate if those reporting in the ACS survey that they speak English less than "very well" are less likely to be insured than the state average.

f. *Scope of Federal External Review.* Paragraph (d)(1) of the July 2010 regulations provides that any adverse benefit determination (including a final internal adverse benefit determination) could be brought to the Federal external review process unless it related to a participant's or beneficiary's failure to meet the requirements for eligibility under the terms of a group health plan (*i.e.*, worker classification and similar issues were not within the scope of the Federal external review process). As discussed earlier in this preamble, comments received in response to the July 2010 regulations indicate that the scope of external review claims was too broad.

After considering all the comments, with respect to plans subject to the Federal external review process, for claims for which external review has not been initiated before September 20, 2011, the amendment suspends the original rule in the July 2010 regulations regarding the scope of claims eligible for external review for plans using the Federal process, temporarily replacing it with a different scope. Specifically, this amendment suspends the broad scope of claims eligible for external review and narrows the scope to those that involve (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (2) a rescission of coverage. The suspension is intended to give the marketplace time to adjust to providing external review. The Departments believe that, once the market has so adjusted, it will become clear that the benefits of the July 2010 regulations' broader scope would be likely to justify its costs.

C. *Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services*

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the APA (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Under Section 553(b) of the APA, a general notice of proposed rulemaking is not required when an agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary, or contrary to the public interest. The interim final regulations were exempt from the APA, because the Departments made a good cause finding that a general notice of proposed rulemaking is not necessary earlier in this preamble. Therefore, the RFA did not apply and the Departments were not required to either certify that the regulations or this amendment would not have a significant economic impact on a substantial number of small entities or conduct a regulatory flexibility analysis.

Nevertheless, the Departments carefully considered the likely impact of the rule on small entities in connection with their assessment under Executive Order 12866. Consistent with the policy of the RFA, the Departments encourage the public to submit comments that suggest alternative rules that accomplish the stated purpose of the Affordable Care Act and minimize the impact on small entities.

D. *Special Analyses-Department of the Treasury*

Notwithstanding the determinations of the Department of Labor and Department of Health and Human Services, for purposes of the Department of the Treasury, it has been determined that this Treasury decision is not a significant regulatory action for purposes of Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the APA (5 U.S.C. chapter 5) does not apply to these temporary regulations. For the applicability of the RFA, refer to the Special Analyses section in the preamble to the cross-referencing notice of proposed rulemaking published elsewhere in this issue of the Bulletin. Pursuant to section 7805(f) of the Code, these temporary regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small businesses.

E. *Paperwork Reduction Act*

1. *Department of Labor and Department of the Treasury*

Currently, the Departments are soliciting 60 days of public comments concerning these disclosures. The Departments have submitted a copy of these interim final regulations to OMB in accordance with 44 U.S.C. 3507(d) for review of the information collections. The Departments and OMB are particularly interested in comments that:

- Evaluate whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, for example, by permitting electronic submission of responses.

Comments should be sent to the Office of Information and Regulatory Affairs, Attention: Desk Officer for the Employee Benefits Security Administration either by fax to (202) 395–7285 or by email to *oira_submission@omb.eop.gov*. A copy of the ICR may be obtained by contacting the PRA addressee: G. Christopher Cosby, Office of Policy and Research, U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, NW, Room N–5718, Washington, DC 20210. Telephone: (202) 693–8410; Fax: (202) 219–4745. These are not toll-free numbers. E-mail: *ebsa.opr@dol.gov*. ICRs submitted to OMB also are available at *reginfo.gov* (*http://www.reginfo.gov/public/do/PRAMain*).

a. *Department of Labor and Department of the Treasury: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans*

These amendments make two changes to the interim final regulations that affect the paperwork burden. The first is an amendment no longer requiring that diagnosis and treatment codes be included on notices of adverse benefit determination and final internal adverse benefit determination. Instead, they must notify claimants of the opportunity to receive the codes on request and plans and issuers must provide the codes upon request. The Departments expect that this change will lower costs, because plans and issuers no longer will have to provide the codes on the notices. Plans and issuers will incur a cost to establish procedures for receive, process, and mail the codes upon request; however, the Departments are unable to estimate such cost due to a lack of a basis for an estimate of the number of requests that will be made for the codes.

The amendments also change the method for determining who is eligible to receive a notice in a culturally and linguistically appropriate manner, and the information that must be provided to such persons. The previous rule was based on the number of employees at a firm. The new rule is based on whether a participant or beneficiary resides in a county where ten percent or more of the population residing in the county is literate only in the same non-English language.

Participants and beneficiaries residing in an affected county and speaking an applicable non-English language will now receive a one-sentence statement in all notices written in the applicable non-English language about the availability of language services. In addition to including the statement, plan and issuers are required to provide a customer assistance process (such as a telephone hotline) with oral language services in the non-English language and provide written notices in the non-English language upon requests.

The Departments understand that oral translation services are already provided for nearly all covered participants and beneficiaries. Therefore, no additional burden is associated with this requirement of the amendment. The Departments estimate that plans will incur an annual cost burden of $1.2 million to translate written notices into the relevant non-English language.[47]

Based on the foregoing, the Departments have adjusted the total estimated cost burden for this information collection. The cost burden is $243,000 in 2011, $1.7 million in 2012, and $1.8 million in 2013.

Type of Review: Revised collection.

Agencies: Employee Benefits Security Administration, Department of Labor; Internal Revenue Service, U.S. Department of the Treasury,

Title: Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-Grandfathered Plans

OMB Number: 1210–0144; 1545–2182.

Affected Public: Business or other for-profit; not-for-profit institutions.

Total Respondents: 1,020,000 (three-year average).

Total Responses: 111,000 (three-year average).

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 233 hours (Employee Benefits Security Administration); 233 hours (Internal Revenue Service) (three-year average).

Estimated Total Annual Burden Cost: $628,900 (Employee Benefits Security Administration); $628,900 (Internal Revenue Service) (three-year average).

2. *Department of Health and Human Services*

a. *ICR Regarding Affordable Care Act Internal Claims and Appeals and External Review Disclosures for Non-grandfathered Plans*

As discussed above in the Department of Labor and Department of the Treasury PRA section, these amendments make two changes to the interim final regulations that affect the paperwork burden. The first is an amendment no longer requiring that diagnosis and treatment codes be included on notices of adverse benefit determination and final internal adverse benefit determination. Instead these codes are available upon request. The Departments expect that this change will lower costs compared to the July 2010 regulations because plans and issuers no longer will have to provide the codes on the notices. Plans and issuers will incur a cost to establish procedures for receiving, processing, and mailing the codes upon request; however, the Departments are unable to estimate such cost due to lack of a basis for an estimate of the number of requests that will be made for the codes. Second, the amendments also changes who is eligible to receive a notice in a culturally or linguistically appropriate manner.

The Departments estimated the new cost burden of providing the translation of requested notices into the applicable non-English language. The annual cost burden is estimated to be $430,000 annually starting in 2012. The derivation of this estimate was discussed above in the Economic Impact section.

Due to the amendments, the Department has adjusted the total estimated costs of this information collection. The Department estimates that State and local governmental plans and issuers offering coverage in the individual market will incur a total hour burden of 570,804 hours in 2011, 998,807 hours in 2012, and 1.22 million hours in 2013 to comply with equivalent costs of $28.2 million in 2011, $57.4 million in 2012, and $70.5 million in 2013. The total cost burden for those plans that use service providers, including the cost of mailing all responses is estimated to be $20.7 million in 2011, $37.9 million in 2012, and $51.7 million in 2013.

The hour and cost burden is summarized below:

Type of Review: Revised collection.

Agency: Department of Health and Human Services.

Title: Affordable Care Act Internal Claims and Appeals and External Review Disclosures

OMB Number: 0938–1099.

Affected Public: Business; State, Local, or Tribal Governments.

Respondents: 46,773 (three-year average).

Responses: 218,650,000 (three-year average).

Frequency of Response: Occasionally.

Estimated Total Annual Burden Hours: 929,870 hours (three-year average).

[47] The Department's methodology for this estimate is explained in IV, B, 2, d, above.

Estimated Total Annual Burden Cost: $36,600,000 (three-year average).

We have requested emergency OMB review and approval of the aforementioned information collection requirements by July 1, 2011. To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access CMS' Web site at *http://www.cms.gov/PaperworkReductionActof1995/PRAL/list.asp#TopOfPage* or email your request, including your address, phone number, OMB number, and CMS document identifier, to *Paperwork@cms.hhs.gov*, or call the Reports Clearance Office at 410–786–1326.

If you comment on any of these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the ADDRESSES section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget,

Attention: CMS Desk Officer, CMS–9993-IFC2

Fax: (202) 395–6974; or

Email: *OIRA_submission@omb.eop.gov*

F. *Congressional Review Act*

These amendments to the interim final regulations are subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and have been transmitted to Congress and the Comptroller General for review.

G. *Unfunded Mandates Reform Act*

The Unfunded Mandates Reform Act of 1995 (Public Law 104–4) requires agencies to prepare several analytic statements before proposing any rules that may result in annual expenditures of $100 million (as adjusted for inflation) by State, local and tribal governments or the private sector. These amendments to the interim final regulations are not subject to the Unfunded Mandates Reform Act because they are being issued as interim final regulations. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regulation has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector, while achieving the objectives of the Affordable Care Act.

H. *Federalism Statement—Department of Labor and Department of Health and Human Services*

Executive Order 13132 outlines fundamental principles of federalism, and requires the adherence to specific criteria by Federal agencies in the process of their formulation and implementation of policies that have "substantial direct effects" on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the regulation.

In the Departments' view, these amendments to the interim final regulations have federalism implications, because they have direct effects on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among various levels of government. However, in the Departments' view, the federalism implications of these interim final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action to implement an internal and external appeals process that will meet or exceed federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a)) apply so that the HIPAA requirements (including those of the Affordable Care Act) are not to be "construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement" of a Federal standard. The conference report accompanying HIPAA indicates that this is intended to be the "narrowest" preemption of State laws. (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018.) States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Affordable Care Act requirements that are the subject of this rulemaking. State insurance laws that are more stringent than the Federal requirements are unlikely to "prevent the application of" the Affordable Care Act, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law. Furthermore, the Departments have opined that, in the instance of a group health plan providing coverage through group health insurance, the issuer will be required to follow the external review procedures established in State law (assuming the State external review procedure meets the minimum standards set out in these interim final rules).

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected State and local officials, including attending conferences of the National Association of Insurance Commissioners (NAIC), meeting with NAIC staff counsel on issues arising from the interim final regulations and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the Affordable Care Act requirements, including the provisions of section 2719 of the PHS Act. Throughout the process of developing these amendments to the interim final regulations, to the extent feasible within the specific preemption provisions of HIPAA as it applies to the Affordable Care Act, the Departments have

attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to these regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare and Medicaid Services have complied with the requirements of Executive Order 13132 for the attached amendment to the interim final regulations in a meaningful and timely manner.

V. Statutory Authority

The Department of the Treasury temporary regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor interim final regulations are adopted pursuant to the authority contained in 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L.104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Secretary of Labor's Order 6–2009, 74 FR 21524 (May 7, 2009).

The Department of Health and Human Services interim final regulations are adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 USC 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

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Steven T. Miller,
Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved June 21, 2011.

Emily S. McMahon,
Acting Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on June 22, 2011, 4:15 p.m., and published in the issue of the Federal Register for June 24, 2011, 76 F.R. 37208)

DEPARTMENT OF THE TREASURY
Internal Revenue Service
26 CFR Chapter I

Accordingly, 26 CFR Part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The general authority citation for part 54 continues to read as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Section 54.9815–2719T is amended by:

1. Revising paragraphs (b)(2)(ii)(B), (b)(2)(ii)(E)(*1*), (b)(2)(ii)(F), (c)(2)(xi), (c)(3), (d)(1), (d)(2)(iv) and (e).

2. Redesignating (b)(2)(ii)(E)(*2*), (b)(2)(ii)(E)(*3*), and (b)(2)(ii)(E)(*4*) as (b)(2)(ii)(E)(*3*), (b)(2)(ii)(E)(*4*), and (b)(2)(ii)(E)(*5*), respectively.

3. Adding new paragraph (b)(2)(ii)(E)(*2*).

The revisions and addition read as follows:

§54.9815–2719T Internal claims and appeals and external review processes (temporary).

* * * * *

(b) * * *

(2) * * *

(ii) * * *

(B) *Expedited notification of benefit determinations involving urgent care*. The requirements of 29 CFR 2560.503–1(f)(2)(i) (which generally provide, among other things, in the case of urgent care claims for notification of the plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim) continue to apply to the plan and issuer. For purposes of this paragraph (b)(2)(ii)(B), a claim involving urgent care has the meaning given in 29 CFR 2560.503–1(m)(1), as determined by the attending provider, and the plan or issuer shall defer to such determination of the attending provider.

* * * * *

(E) * * *

(*1*) The plan and issuer must ensure that any notice of adverse benefit determination or final internal adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

(*2*) The plan and issuer must provide to participants and beneficiaries, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination or final internal adverse benefit determination. The plan or issuer must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal under this paragraph (b) or an external review under paragraphs (c) and (d) of this section.

* * * * *

(F) *Deemed exhaustion of internal claims and appeals processes* — (*1*) In the case of a plan or issuer that fails to adhere to all the requirements of this paragraph (b)(2) with respect to a claim, the claimant is deemed to have exhausted the internal claims and appeals process of this paragraph (b), except as provided in paragraph (b)(2)(ii)(F)(*2*) of this section. Accordingly, the claimant may initiate an external review under paragraph (c) or (d) of this section, as applicable. The claimant is also entitled to pursue any available remedies under section 502(a) of ERISA or under State law, as applicable, on the basis that the plan or issuer has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

(*2*) Notwithstanding paragraph (b)(2)(ii)(F)(*1*) of this section, the internal claims and appeals process of this paragraph (b) will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the claimant so long as the plan or issuer demonstrates that

the violation was for good cause or due to matters beyond the control of the plan or issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the plan and the claimant. This exception is not available if the violation is part of a pattern or practice of violations by the plan or issuer. The claimant may request a written explanation of the violation from the plan or issuer, and the plan or issuer must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process of this paragraph (b) to be deemed exhausted. If an external reviewer or a court rejects the claimant's request for immediate review under paragraph (b)(2)(ii)(F)(*1*) of this section on the basis that the plan met the standards for the exception under this paragraph (b)(2)(ii)(F)(*2*), the claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the plan shall provide the claimant with notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon claimant's receipt of such notice.

* * * * *

(c) * * *

(2) * * *

(xi) The State process must provide that the decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

* * * * *

(3) *Transition period for external review processes*. (i) Through December 31, 2011, an applicable State external review process applicable to a health insurance issuer or group health plan is considered to meet the requirements of PHS Act section 2719(b). Accordingly, through December 31, 2011, an applicable State external review process will be considered binding on the issuer or plan (in lieu of the requirements of the Federal external review process). If there is no applicable State external review process, the issuer or plan is required to comply with the requirements of the Federal external review process in paragraph (d) of this section.

(ii) For final internal adverse benefit determinations (or, in the case of simultaneous internal appeal and external review, adverse benefit determinations) provided on or after January 1, 2012, the Federal external review process will apply unless the Department of Health and Human Services determines that a State law meets all the minimum standards of paragraph (c)(2) of this section.

(d) * * *

(1) *Scope* — (i) *In general*. Subject to the suspension provision in paragraph (d)(1)(ii) of this section and except to the extent provided otherwise by the Secretary in guidance, the Federal external review process established pursuant to this paragraph (d) applies to any adverse benefit determination or final internal adverse benefit determination (as defined in paragraphs (a)(2)(i) and (a)(2)(v) of this section), except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan is not eligible for the Federal external review process under this paragraph (d).

(ii) *Suspension of general rule*. Unless or until this suspension is revoked in guidance by the Secretary, with respect to claims for which external review has not been initiated before September 20, 2011, the Federal external review process established pursuant to this paragraph (d) applies only to:

(A) An adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and

(B) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(iii) *Examples*. This rules of paragraph (d)(1)(ii) of this section are illustrated by the following examples:

Example 1. (i) *Facts*. A group health plan provides coverage for 30 physical therapy visits generally. After the 30th visit, coverage is provided only if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Individual *A* seeks coverage for a 31st physical therapy visit. *A*'s health care provider submits a treatment plan for approval, but it is not approved by the plan, so coverage for the 31st visit is not preauthorized. With respect to the 31st visit, *A* receives a notice of final internal adverse benefit determination stating that the maximum visit limit is exceeded.

(ii) *Conclusion*. In this *Example 1*, the plan's denial of benefits is based on medical necessity and involves medical judgment. Accordingly, the claim is eligible for external review during the suspension period under paragraph (d)(1)(ii) of this section. Moreover, the plan's notification of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because it fails to make clear that the plan will pay for more than 30 visits if the service is preauthorized pursuant to an approved treatment plan that takes into account medical necessity using the plan's definition of the term. Accordingly, the notice of final internal adverse benefit determination should refer to the plan provision governing the 31st visit and should describe the plan's standard for medical necessity, as well as how the treatment fails to meet the plan's standard.

Example 2. (i) *Facts*. A group health plan does not provide coverage for services provided out of network, unless the service cannot effectively be provided in network. Individual *B* seeks coverage for a specialized medical procedure from an out-of-network provider because *B* believes that the procedure cannot be effectively provided in network. *B* receives a notice of final internal adverse benefit determination stating that the claim is denied because the provider is out-of-network.

(ii) *Conclusion*. In this *Example 2*, the plan's denial of benefits is based on whether a service can effectively be provided in network and, therefore, involves medical judgment. Accordingly, the claim is eligible for external review during the suspension period under paragraph (d)(1)(ii) of this section. Moreover, the plan's notice of final internal adverse benefit determination is inadequate under paragraphs (b)(2)(i) and (b)(2)(ii)(E)(*3*) of this section because the plan does provide benefits for services on an out-of-network basis if the services cannot effectively be provided in network. Accordingly, the notice of final internal adverse benefit determination is required to refer to the exception to the

out-of-network exclusion and should describe the plan's standards for determining effectiveness of services, as well as how services available to the claimant within the plan's network meet the plan's standard for effectiveness of services.

* * * * *

(2) * * *

(iv) These standards will provide that an external review decision is binding on the plan or issuer, as well as the claimant, except to the extent other remedies are available under State or Federal law, and except that the requirement that the decision be binding shall not preclude the plan or issuer from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits. For this purpose, the plan or issuer must provide any benefits (including by making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the plan or issuer intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

* * * * *

(e) *Form and manner of notice* — (1) *In general*. For purposes of this section, a group health plan and a health insurance issuer offering group health insurance coverage are considered to provide relevant notices in a culturally and linguistically appropriate manner if the plan or issuer meets all the requirements of paragraph (e)(2) of this section with respect to the applicable non-English languages described in paragraph (e)(3) of this section.

(2) *Requirements* — (i) The plan or issuer must provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals (including external review) in any applicable non-English language;

(ii) The plan or issuer must provide, upon request, a notice in any applicable non-English language; and

(iii) The plan or issuer must include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan or issuer.

(3) *Applicable non-English language*. With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

* * * * *

Part III. Administrative, Procedural, and Miscellaneous

Chapter 4 Implementation Notice

Notice 2011–53

I. BACKGROUND AND PURPOSE

On March 18, 2010, the Hiring Incentives to Restore Employment Act of 2010, Pub. L. 111–147 (H.R. 2847) (the Act) added chapter 4 (Chapter 4) to Subtitle A of the Internal Revenue Code (Code). Chapter 4 (comprising sections 1471 through 1474 of the Code) imposes information reporting requirements on foreign financial institutions (FFIs) with respect to U.S. accounts and imposes withholding, documentation, and reporting requirements with respect to certain payments made to certain foreign entities.

On August 29, 2010, the Department of the Treasury (Treasury) and the Internal Revenue Service (IRS) released Notice 2010–60, 2010–37 I.R.B. 329, providing preliminary guidance regarding the implementation of Chapter 4 and requesting comments on issues addressed in that notice and otherwise relevant to the implementation of Chapter 4. On April 8, 2011, Treasury and the IRS released Notice 2011–34, 2011–19 I.R.B. 765, which modified and supplemented the guidance in Notice 2010–60. Unless otherwise defined, terms used in this notice have the same meanings as set forth in sections 1471 through 1474, Notice 2010–60, and Notice 2011–34.

Treasury and the IRS have received numerous comments concerning the practical difficulties in implementing aspects of the Chapter 4 rules within the time frames provided in the Act and under Notice 2010–60 and Notice 2011–34. The challenges identified relate to the time to develop compliance, reporting, and withholding systems necessary to comply with Chapter 4 and the implementing notices. In addition, a number of stakeholders have noted that complying with certain provisions may require coordination with a number of foreign governments. Treasury and the IRS have met with stakeholders and foreign governments to understand the specific administrative and legal challenges that must be addressed and the time necessary to do so. While the Act provides that the provisions of Chapter 4 are effective beginning in 2013, Treasury and the IRS have determined that because Chapter 4 creates the need for significant modifications to the information management systems of FFIs, withholding agents, and the IRS, it is reasonable for regulations to provide for a phased implementation of the various provisions of Chapter 4.

In light of these considerations, this notice describes the timeline for the implementation of Chapter 4 and discusses certain substantive and procedural matters that will be addressed in regulations issued by Treasury and the IRS. As described below, those regulations will provide that certain obligations of participating FFIs will commence in 2013. Further, those regulations will provide that the section 1471(a) and section 1472(a) withholding obligations of withholding agents with respect to amounts described in section 1473(1)(A)(i) (U.S. source FDAP payments) will begin on January 1, 2014. FFIs that would otherwise be subject to Chapter 4 withholding will be identified as participating FFIs and therefore should not be subject to such withholding if they have registered as participating FFIs and entered into FFI Agreements by June 30, 2013. The section 1471(b)(1)(D) withholding obligations of participating FFIs with respect to passthru payments will be specified in future regulations, but will begin no earlier than January 1, 2015.

II. PHASED IMPLEMENTATION TIMELINE

A. *Participating FFIs: Registration and Due Diligence*

1. *Registration of FFIs Beginning in 2013*

The IRS will begin accepting FFI applications through its electronic submissions process no later than January 1, 2013. An FFI must enter into an FFI Agreement by June 30, 2013, to ensure that it will be identified as a participating FFI in sufficient time to allow U.S. withholding agents to refrain from withholding beginning on January 1, 2014. Because of the time needed for the IRS to process FFI applications and for U.S. withholding agents to verify whether a payee is a participating FFI, FFIs that enter into FFI Agreements after June 30, 2013, but before January 1, 2014, will be participating FFIs with respect to 2014, but might not be identified as such in time to prevent withholding beginning on January 1, 2014. The effective date of an FFI Agreement entered into any time before July 1, 2013, will be July 1, 2013. The effective date of an FFI Agreement entered into after June 30, 2013, will be the date the FFI enters into the FFI Agreement.

2. *Participating FFI Due Diligence*

a. *New Accounts*

A participating FFI will be required to put in place account opening procedures described in Notice 2010–60, as implemented in regulations, to identify U.S. accounts among accounts opened on or after the effective date of its FFI Agreement.

b. *Pre-Existing Accounts*

i. *Certain Pre-Existing Private Banking Accounts (Equal to or Greater than $500,000)*

Within one year of the effective date of its FFI Agreement, a participating FFI will be required to have completed Step 3 of the pre-existing account due diligence procedures described in Section I.A.2 of Notice 2011–34 (the private banking procedures), for all accounts opened before the effective date of its FFI Agreement that are associated with a private banking relationship (including individual and entity accounts) and that have a balance or value of at least $500,000 on the effective date of the FFI Agreement.

ii. *Private Banking Accounts Less than $500,000*

A participating FFI will be required by the later of December 31, 2014, or the date that is one year after the effective date of its FFI Agreement, to complete the private banking procedures for all accounts opened before the effective date of its FFI Agreement that are associated with a private banking relationship and are not described in (i), above.

iii. *Due Diligence for All Other Pre-Existing Accounts*

For all pre-existing accounts not covered in sections (i) and (ii) above, a participating FFI must complete due diligence procedures as prescribed in Notice 2010–60, Notice 2011–34, and forthcoming regulations within two years of the effective date of its FFI Agreement.

iv. *Private Banking Guidance*

Regulations will provide further guidance on the scope of the private banking procedures and the associated search of account holder files. Regulations will also provide that, for purposes of applying the private banking procedures: (1) although private banking relationship managers must identify any client for which such relationship managers have actual knowledge that the client is a U.S. person and request a Form W–9 from such person, as set forth in Notice 2011–34, the review of account files may be completed by any person designated by the participating FFI; and (2) accounts subject to due diligence procedures and identified as either U.S. accounts or non-U.S. accounts under such procedures will not be subject to additional due diligence procedures in subsequent years unless the account undergoes a change of circumstance.

B. *Reporting*

1. *New Accounts, Documented U.S. Accounts, and Private Banking Accounts*

An account for which a participating FFI has received a Form W–9 from the account holder (or, with respect to an account held by a U.S. owned foreign entity, from a substantial U.S. owner of such entity) by June 30, 2014, must be reported to the IRS as a U.S. account by September 30, 2014. These accounts generally will include: (1) private banking accounts identified as U.S. accounts under the procedures set forth above and for which a Form W–9 has been collected by June 30, 2014; (2) new U.S. accounts opened after the effective date of the FFI's FFI Agreement and for which a Form W–9 has been collected; (3) documented U.S. accounts described in Section I.A.2 Step 1 of Notice 2011–34; and (4) existing U.S. accounts documented pursuant to Section 1.A.2 Steps 4 and 5 of Notice 2011–34 for which a Form W–9 is obtained by June 30, 2014. With respect to these identified U.S. accounts, a participating FFI that does not elect to report under section 1471(c)(2) must report in accordance with Notice 2011–34, except that for this first year of reporting, the participating FFI will only be required to report the following information:

i. the name, address, and U.S. TIN of each specified U.S. person who is an account holder and, in the case of any account holder that is a U.S. owned foreign entity, the name, address, and U.S. TIN of each substantial U.S. owner of such entity;
ii. the account balance as of December 31, 2013, or, if the account was closed after the effective date of the FFI's FFI Agreement, the balance of such account immediately before closure; and
iii. the account number.

The reporting described above is intended to provide participating FFIs greater flexibility to satisfy the reporting requirements of section 1471(c) and section IV.B of Notice 2011–34, and is not intended to change the information that generally must be reported as set forth in Notice 2011–34. Accordingly, reporting in 2014 will be made on the same forms as will be used in subsequent years to report all required information, and participating FFIs may elect for 2014 to report any or all of the additional information described in section IV.B of Notice 2011–34 with respect to U.S. accounts. With respect to a participating FFI that elects reporting under section 1471(c)(2) for such accounts, the FFI may report only the items listed in (i) and (iii), above, for its report filed by September 30, 2014.

In accordance with its normal practice, the IRS will assess the accuracy of the reported information and communicate with the FFI to resolve discrepancies in the information, such as those regarding U.S. TINs. Unresolved discrepancies could result in an account being treated as held by a recalcitrant account holder.

For each account for which the participating FFI is not able to report the information above, because, for example, the account holder has not waived any applicable reporting restrictions, the FFI will report the account among its recalcitrant account holders with U.S. indicia in accordance with section IV.F of Notice 2010–60 and as prescribed in future guidance. The reporting with respect to recalcitrant account holders identified by June 30, 2014, will be required to be filed with the IRS by September 30, 2014.

2. *Reporting with respect to Post–2013 Years*

Reporting with respect to 2014 and subsequent years will be required as contemplated in Notice 2010–60 and Notice 2011–34 and as implemented in future regulations.

C. *Withholding*

1. Withholdable payments

Pursuant to the phased implementation procedures contemplated in this notice, regulations under Chapter 4 will implement withholding by withholding agents on withholdable payments in two phases. For payments made on or after January 1, 2014, withholding agents (whether domestic or foreign, including participating FFIs) will be obligated to withhold under section 1471(a) and section 1472(a) only on U.S. source FDAP payments. For payments made on or after January 1, 2015, withholding agents will be obligated to withhold under section 1471(a) and section 1472(a) on all withholdable payments (including both U.S. source FDAP payments and gross proceeds described in section 1473(1)(A)(ii)).

2. Passthru payments

Participating FFIs will be obligated to withhold on withholdable payments of U.S. source FDAP under section 1471(a) and section 1472(a) for payments made on or after January 1, 2014, but will not be required to withhold under section 1471(b)(1)(D) with respect to other passthru payments made before January 1, 2015. Accordingly, the obligations of participating FFIs with respect to computing and publishing their passthru payment percentage as set forth in Notice 2011–34 will not begin before the first calendar quarter of 2014.

III. TIMELINE FOR PUBLISHED GUIDANCE

Treasury and the IRS anticipate issuing proposed regulations incorporating the guidance provided in Notice 2010–60 as amended and supplemented by Notice 2011–34 and this notice and providing further guidance on implementing Chapter 4 by December 31, 2011. After consideration of comments, Treasury and the IRS anticipate publishing final regulations in the summer of 2012. In conjunction with these regulations, Treasury and the IRS also anticipate issuing draft versions followed by final versions of the associated FFI Agreement and reporting forms for use by withholding agents and participating FFIs in the summer of 2012.

IV. MISCELLANEOUS

A. *Qualified Intermediary and Other Withholding Agreements Expiring in 2012*

All qualified intermediary agreements, withholding foreign partnership agreements, and withholding foreign trust agreements of entities qualifying as FFIs that expire on December 31, 2012, will be automatically extended until December 31, 2013. Any FFI that enters into an FFI Agreement on or before December 31, 2013, will be considered to have renewed its qualified intermediary agreement, withholding foreign partnership agreement, or withholding foreign trust agreement, as the case may be.

B. *Clarification of the Scope of Grandfathered Obligations*

Section 501(d)(2) of the Act provides that Chapter 4 shall not require any amount to be deducted or withheld from any payment under any obligation outstanding on March 18, 2012, or from the gross proceeds of any disposition of such an obligation. Section I of Notice 2010–60 defined the term "obligation" for this purpose to mean any legal agreement that produces or could produce withholdable payments, but not including any instrument treated as equity for U.S. tax purposes, or any legal agreement that lacks a definitive expiration or term. Questions have been raised regarding whether legal agreements that give rise to passthru payments other than withholdable payments are excluded from the definition of "obligation" for this purpose. Treasury and the IRS intend to issue regulations clarifying that, for purposes of section 501(d)(2) of the Act, the term "obligation" means any legal agreement that produces or could produce passthru payments (including withholdable payments), but not including any instrument treated as equity for U.S. tax purposes, or any legal agreement that lacks a definitive expiration or term.

DRAFTING INFORMATION

The principal author of this notice is John Sweeney of the Office of Associate Chief Counsel (International). For further information regarding this notice, contact Mr. Sweeney at (202) 622–3840 (not a toll-free call).

Ex Parte Communications Between Appeals and Other Internal Revenue Service Employees

Notice 2011–62

This notice provides a proposed revenue procedure that will update Rev. Proc. 2000–43, 2000–2 C.B. 404, which provides guidance regarding *ex parte* communications between Appeals and other Internal Revenue Service functions. The proposed revenue procedure sets forth the background concerning the *ex parte* communication rules, the reasons for updating Rev. Proc. 2000–43, a summary of the proposed changes to Rev. Proc. 2000–43 and the proposed text of the updated revenue procedure. Before issuing an updated revenue procedure addressing the *ex parte* communication rules, the Department of the Treasury and the IRS invite comments from the public regarding the proposed revenue procedure. Until an updated revenue procedure is issued with respect to the *ex parte* communication rules, Rev. Proc. 2000–43 will remain in effect.

Comments should be submitted by August 18, 2011 to:

Internal Revenue Service
Attn: CC:PA:LPD:PR
(Notice 2011–62)
Room 5203
P.O. Box 7604
Ben Franklin Station
Washington, D.C. 20044

or hand deliver comments Monday through Friday between the hours of 8 a.m. and 4 p.m. to:

Courier's Desk
Internal Revenue Service
Attn: CC:PA:LPD:PR
(Notice 2011–62)
1111 Constitution Avenue, N.W.
Washington, D.C. 20224

Alternatively, persons may submit comments electronically via e-mail to the following address: *Notice.Comments@irscounsel.treas.gov*. Persons should include "Notice 2011–62" in the subject line. All comments submitted by the public will be available for public inspection and copying in their entirety.

Proposed Rev. Proc. [XXXX–XX]

SECTION 1. BACKGROUND

Section 1001(a) of the Internal Revenue Service Restructuring and Reform Act of 1998, Pub. L. No. 105–206, 112 Stat. 685 (RRA), required the Commissioner of Internal Revenue to develop and implement a plan to reorganize the Internal Revenue Service. In addition, the RRA specifically directed the Commissioner to "ensure an independent appeals function within the Internal Revenue Service, including the prohibition * * * of *ex parte* communications between appeals officers and other Internal Revenue Service employees to the extent that such communications appear to compromise the independence of the appeals officers." RRA section 1001(a)(4). In accordance with that directive, the Department of the Treasury and the IRS issued guidance in Rev. Proc. 2000–43, 2000–2 C.B. 404.

Since the issuance of Rev. Proc. 2000–43 in October 2000, the IRS has made changes to some of its business practices and adopted new ones that did not exist at the time that the revenue procedure was issued. Accordingly, the Department

of the Treasury and the IRS are revising Rev. Proc. 2000–43 to address these changed circumstances, as well as to clarify and modify the rules in light of the IRS' experience working with that revenue procedure. Also, the revenue procedure has been redesigned from a question and answer format to a narrative format to improve usability. In connection with that change, the material has been rearranged and organized under appropriate headings to make it easier to find.

The procedures set forth in this revenue procedure are designed to accommodate the overall interests of tax administration, while preserving operational features that are vital to Appeals' case resolution processes within the structure of the IRS and ensuring open lines of communication between Appeals and the taxpayer/representative. Consistent with section 1001(a)(4), this revenue procedure does not adopt the formal *ex parte* procedures that would apply in a judicial proceeding. It is designed to ensure the independence of the Appeals organization, while preserving the role of Appeals as a flexible administrative settlement authority, operating within the IRS' overall framework of tax administration responsibilities.

.01 *Highlights*. As previously provided in Rev. Proc. 2000–43:

(1) Appeals will retain procedures for:

(a) Returning cases that are not ready for Appeals consideration.

(b) Raising certain new issues.

(c) Seeking review and comments from the originating function with respect to new information or evidence furnished by the taxpayer/representative.

(2) Appeals will continue to be able to obtain legal advice from the Office of Chief Counsel, subject to the limitations set forth in section 2.06(1), below.

(3) The Commissioner and other IRS officials responsible for overall IRS operations (including Appeals), as referenced in section 2.07(5), below, may continue to communicate *ex parte* with Appeals in order to fulfill their responsibilities.

.02 *Significant Changes*

(1) Guiding principles have been added to aid in understanding the overall approach to applying the *ex parte* communication rules.

(2) Definitions for certain terms have been added or clarified.

(3) Transmittals and the permissible content of the administrative file have been clarified.

(4) The application of the *ex parte* communication rules to collection due process cases, including those CDP cases that are remanded by the Tax Court, has been addressed.

(5) The discussion of Appeals' involvement in multifunctional meetings has been expanded.

(6) The application of the *ex parte* communication rules in the context of alternative dispute resolution proceedings has been addressed.

(7) The remedies available to taxpayers in the event of a breach of the *ex parte* communication rules have been clarified.

(8) A statement that the *ex parte* communication rules do not create substantive rights affecting a taxpayer's liability or the IRS' ability to determine, assess or collect that tax liability has been added.

SECTION 2. GUIDANCE CONCERNING *EX PARTE* COMMUNICATIONS AND THE APPLICATION OF RRA SECTION 1001(a)(4)

.01 *Definitions*. For purposes of this revenue procedure and the application of RRA section 1001(a)(4), the terms set forth below are defined as follows:

(1) *Ex Parte Communication*. An "*ex parte* communication" is a communication that takes place between any Appeals employee (*e.g.*, Appeals Officers, Settlement Officers, Appeals Team Case Leaders, Appeals Tax Computation Specialists) and employees of other IRS functions, without the taxpayer/representative being given an opportunity to participate in the communication. The term includes all forms of communication, oral or written. Written communications include those that are manually or electronically generated.

(a) *Communications Outside the Scope of the Term "Ex Parte Communication"*. The term "*ex parte* communication" does not include the following (not an exhaustive list):

(i) *Database Inquiries*. Account inquiries, transcript requests and other similar inquiries conducted in an electronic environment are not considered communications because they do not involve a dialogue or interaction between two or more individuals. This exception does not apply to the administrative file, which may be maintained electronically in whole or in part. For a discussion of the rules applicable to the administrative file, see section 2.03(4), below.

(ii) *Communications Solely Between or Among Appeals Employees*. These are not considered *ex parte* communications because they do not involve employees from IRS functions outside of Appeals.

(iii) *Communications with IRS Functions Other than Originating Functions*. Special rules apply to communications between Appeals employees and employees of certain IRS functions other than originating functions, as defined in section 2.01(2), below. Employees in other IRS functions include those in Counsel, Criminal Investigation, Competent Authority, and Taxpayer Advocate Service, and the Commissioner and other IRS officials with overall supervisory responsibilities. For a discussion of communications with those functions, see 2.06, 2.07(2), 2.07(3), 2.07(4) and 2.07(5), respectively.

(iv) *Communications with Other Governmental Entities.* These are not considered *ex parte* communications because RRA section 1001(a)(4) only applies to communications between Appeals and other IRS employees and the persons with whom Appeals is communicating at other governmental entities do not fall into that category. See section 2.08, below, for examples.

(v) *Communications in Which the Taxpayer/Representative Is Given an Opportunity to Participate*. These are not considered *ex parte* communications because the taxpayer/representative is offered a chance to be involved in the communication. Even if the taxpayer/representative chooses not to participate in the communication, the *ex parte* communication rules do not apply.

(2) *Originating Function*. An "originating function" is an organization within the IRS that makes determinations that are subject to the Appeals process. For purposes of this revenue procedure, the term includes the Examination, Collection and Service Center (Campus) functions, or their successor organizations. For a discussion of communications with Criminal Investigation or Counsel, see sections 2.07(2) and 2.06, respectively. For a discussion of communications with other IRS

functions or other governmental entities, see sections 2.07 and 2.08, respectively. None of those functions are originating functions.

(3) *Opportunity to Participate*.

(a) *Oral communications*. The phrase "opportunity to participate" means that the taxpayer/representative will be given a reasonable opportunity to attend a meeting or be a participant in a conference call between Appeals and the originating function when the strengths and weaknesses of the facts, issues or positions in the taxpayer's case are discussed. The taxpayer/representative will be notified of a scheduled meeting or conference call and invited to participate. If the taxpayer/representative is unable to participate in the meeting or conference call at the scheduled time, reasonable accommodations will be made to reschedule it. See also section 2.01(3)(d), below.

(b) *Written communications*. A taxpayer/representative is considered to have been given an "opportunity to participate" with respect to a written communication that is received by Appeals if the taxpayer/representative is furnished a copy of the written communication and given a chance to respond to it either orally or in writing.

(c) *Waiver*. If the taxpayer/representative is given an opportunity to participate in a discussion but declines to participate, Appeals should proceed with the discussion or meeting but should document the taxpayer/representative's declination. A taxpayer/representative has the option of granting a waiver on a communication-by-communication basis or a waiver covering all communications that might occur during the course of Appeals' consideration of a specified case. If a taxpayer/representative provides a blanket waiver with respect to a particular case, the taxpayer/representative may revoke that waiver at any time effective with respect to communications occurring subsequent to the revocation.

(d) *Unreasonable delay*. The IRS will not delay scheduling a meeting for a protracted period of time to accommodate the taxpayer/representative. Facts and circumstances will govern what constitutes a reasonable delay. If the taxpayer/representative seeks to unreasonably delay a meeting or conference call, Appeals should proceed with the discussion or meeting but should document the reason for proceeding without the taxpayer/representative. Appeals should share with the taxpayer/representative the substance of the discussion, as appropriate, and give the taxpayer/representative a reasonable period of time within which to respond.

.02 *Guiding Principles*. Except as specifically addressed in other provisions of this revenue procedure, the following guiding principles govern communications between Appeals and other IRS functions, including Counsel.

(1) *Principles of Tax Administration*. It is the role of the IRS, and those employees charged with the duty of interpreting the law, to determine the reasonable meaning of various Code provisions in light of the Congressional purpose in enacting them; to apply and administer the law in a reasonable and practical manner; and to perform this work in a fair and impartial manner, with neither a government nor a taxpayer point of view. See Rev. Proc. 64–22, 1964–1 C.B. 689.

(2) *Appeals Independence*. Appeals serves as the administrative dispute resolution forum for any taxpayer contesting an IRS compliance action. It has long been Appeals' mission to "resolve tax controversies, without litigation, on a basis that is fair and impartial to both the Government and the taxpayer in a manner that will enhance voluntary compliance and public confidence in the integrity and efficiency of the Service." IRM 8.1.1.1(1). RRA section 1001(a)(4) established a statutory basis for Appeals' independence by requiring that the Commissioner "ensure an independent appeals function within the Internal Revenue Service . . . ." Rather than establish an external appeals function (as suggested in some legislative proposals), RRA maintained Appeals within the IRS while seeking to significantly reinforce its independence. Consequently, despite their distinct roles within tax administration and required adherence to policies set by the Commissioner, Appeals and other IRS functions, including Counsel, share a responsibility to interact — in all circumstances — in a manner that preserves and promotes Appeals' independence. To further this independence, Appeals must continue its practice of impartial decision making while coordinating with other IRS functions to carry out the Commissioner's policies on tax administration.

Independence, therefore, is one of Appeals' most important core values, and the RRA statutory prohibition on *ex parte* communications "to the extent that such communications appear to compromise the independence of the appeals officers" is a significant component of Appeals' independence. The guidance set forth in this revenue procedure is designed to accommodate the overall interests of tax administration while ensuring that Appeals is adequately insulated from influence (or the appearance of influence) by other IRS functions, thereby providing Appeals with an unencumbered working environment within which to objectively and independently evaluate the facts and law that are relevant to each case and quantify the hazards of litigation based on that evaluation.

(3) *Legal Advice*.

(a) *In General*. The Chief Counsel is the legal adviser to the Commissioner and the IRS' officers and employees on all matters pertaining to the interpretation, administration and enforcement of the internal revenue laws and related statutes. I.R.C. § 7803(b)(2)(A). As reflected in the Chief Counsel mission statement, the IRS mission statement and section 2.02(1), above, attorneys in the Office of Chief Counsel are expected to provide legal advice based on an independent determination of the "correct and impartial interpretation of the internal revenue laws" and by applying "the [tax] law with integrity and fairness to all." The fact that various attorneys in the Office of Chief Counsel may be simultaneously engaged in multiple activities, including some activities involving an advocacy role, does not diminish the responsibility of each to exercise independent judgment in rendering legal advice.

(b) *Appeals*. Appeals employees generally are not bound by the legal advice that they receive from the Office of Chief Counsel with respect to their cases. Rather, the legal advice is but one factor that Appeals will take into account in its consideration of the case. Appeals employees remain ultimately responsible for independently evaluating the strengths and weaknesses of the issues in the cases assigned to them and making independent judgments concerning the overall strengths and weaknesses of the cases and the hazards of litigation. Accordingly, Appeals may obtain legal advice from the Office of Chief Counsel consistent with this revenue pro-

cedure without compromising Appeals independence.

(4) *Opportunity to Participate*. As provided in section 2.01(1) and (3), above, by definition, if the taxpayer/representative is given an opportunity to participate with respect to a communication, that communication is not *ex parte*, and thus, the communication is permissible under the *ex parte* communication rules.

(5) *Exceptions*. Not all communications between Appeals employees and employees of other IRS functions are prohibited, even if *ex parte*. For example, as described in more detail in section 2.03(2), below, communications regarding ministerial, administrative or procedural matters are permissible. Similarly, as described in more detail in section 2.04, below, Appeals may listen to or be briefed on generic, noncase-specific discussions of issues without violating the *ex parte* communication rules.

(6) *Communications with Other IRS Functions*. To fulfill its role of providing an independent dispute resolution function within the IRS, Appeals must be able to make fully informed, independent judgments regarding the strengths and weaknesses of positions and to properly evaluate the hazards of litigation in cases within its jurisdiction. To accomplish these tasks, Appeals stays abreast of relevant legal and tax administration developments, including the views and analysis of stakeholders, as well as the Commissioner's policies and operational goals. One effective and efficient way of obtaining some of this information is for Appeals to participate in generic, noncase-specific discussions with other IRS functions, including Counsel, such as participation in multifunctional meetings. Hence, Appeals' participation in these discussions or meetings is permissible under the *ex parte* communication rules, as described in more detail in section 2.04, below.

In general, Appeals may not engage in discussions of the strengths and weaknesses of the issues and positions in cases with the originating function without providing the taxpayer/representative an opportunity to participate. Similarly, the taxpayer/representative normally must be given an opportunity to participate in any case discussion with the originating function regarding matters other than ministerial, administrative or procedural matters. For a fuller discussion of these rules, see section 2.03, below.

(7) *Curing a Breach of Ex Parte Communication Rules*. Most breaches of the *ex parte* communication rules may be cured by timely notifying the taxpayer/representative of the situation, sharing the communication or information in question and affording the taxpayer/representative a reasonable period of time within which to respond. The specific administrative remedy that may be made available in any particular case is within the sole discretion of Appeals.

(8) *No Substantive Rights*. The *ex parte* communication rules set forth in this revenue procedure do not create substantive rights affecting the taxpayer's tax liability or the IRS' ability to determine, assess or collect that tax liability, including statutory interest and any penalties, if applicable.

.03 *Communications with Originating Function*

(1) *General Rule*. *Ex parte* communications between Appeals employees and employees of originating functions are prohibited to the extent the communications appear to compromise Appeals' independence. See RRA section 1001(a)(4). As discussed more fully below, not all *ex parte* communications are prohibited.

(2) *Ministerial, Administrative or Procedural Matters*. Communications between Appeals and an originating function regarding ministerial, administrative or procedural matters during any stage of a case are permissible without involving the taxpayer/representative. If communications with the originating function extend beyond ministerial, administrative or procedural matters in that the substance of the issues in the case is addressed, those communications are prohibited unless the taxpayer/representative is given an opportunity to participate.

(a) *Examples*. Communications regarding ministerial, administrative or procedural matters include, but are not limited to, the following:

(i) Communications about whether certain information was requested and whether it was received.

(ii) Communications about the availability of a document referred to in the workpapers that the Appeals Officer cannot locate in the file.

(iii) Communications to clarify the content of illegible documents or writings.

(iv) Communications regarding case controls on the IRS's management information systems.

(v) Communications relating to tax calculations that are solely mathematical in nature.

(vi) Communications about whether any closed cases exist that involve or affect the taxpayer or a related party, or other information about a closed case (including the terms on which a closed case was resolved), that do not extend beyond what is in the public or administrative record. Examples of these closed cases include, but are not limited to, cases involving bankruptcy, innocent spouse, TEFRA partnership or criminal investigation issues. Any discussion about the substance of a closed case extending beyond what is in the public or administrative record is prohibited unless the taxpayer/representative is given an opportunity to participate. For purposes of the preceding sentence, any information contained in the administrative file for the closed case or any of the IRS' databases is considered to be part of the administrative record. Moreover, the public or administrative record limitation described in this paragraph does not apply to discussions between Appeals and the originating function in connection with a post-settlement conference or equivalent communication. For a discussion of post-settlement conferences, see section 2.03(11), below. Additionally, this paragraph is limited to closed cases and does not apply to communications with respect to the case that Appeals is reviewing. For a discussion of communications relating to other pending cases that involve or affect the taxpayer or a related party, see section 2.03(13), below.

(vii) Communications regarding general information about related cases, such as the number of other pending cases involving the same or substantially similar type of transaction or issue, *e.g.*, tax shelter transactions, industry-wide issues, etc., and the aggregate amount of money in dispute in those cases. This paragraph also includes communications about the existence or status of related cases, such as cases involving a promoter, material advisor, or tax return preparer. For a discussion of communications with respect to closed cases that involve or affect the taxpayer or

a related party, see section 2.03(2)(a)(vi), above. For a discussion of communications relating to other pending cases that involve or affect the taxpayer or a related party, see section 2.03(13), below.

(viii) Communications regarding the status of the case that Appeals is reviewing, such as whether the case or an issue in the case has been resolved or when a case is expected to be closed. This does not include any discussion of the terms of the resolution of an issue prior to the case being closed or the issue resolved with finality, such as by the parties entering into a closing agreement. Permitted communications concerning the status of the case should be limited to a direct, narrow exchange of information without any surrounding discussion. They are not intended to provide the originating function or other IRS function a chance to discuss the strengths and weaknesses of the case or position in the case, advocate for a particular result, object to a potential resolution, or otherwise attempt to influence Appeals' decision in any way.

(ix) Communications regarding mathematical errors affecting the proposed tax liability discovered upon computational review. These errors should be discussed with both the taxpayer/representative and the originating function before the correction is made, but the discussions may be held separately. If the error involves the interpretation of a legal principle or application of the law to a particular set of facts, however, the taxpayer/representative should be given an opportunity to participate in any scheduled meetings with the originating function to discuss this type of discrepancy. In some cases, Appeals may choose to return the case to the originating function for further development and correction.

(x) Communications referring a refund claim filed during the Appeals process to the originating function for consideration. See section 2.03(9), below.

(xi) Communications in connection with a CDP hearing to verify compliance with legal or administrative requirements; communications with respect to verification of assets/liabilities involving an offer in compromise submitted as an alternative payment option during a CDP hearing; or communications regarding deadlines relating to a remanded CDP case. See sections 2.03(10)(b) and (c)(i)(B), below.

(3) *Prohibited Communications*. Examples of communications between Appeals and an originating function that are prohibited unless the taxpayer/representative is given an opportunity to participate include, but are not limited to, the following:

(a) Discussions about the accuracy of the facts presented by the taxpayer and the relative importance of the facts to the determination.

(b) Discussions of the relative merits or alternative legal interpretations of authorities cited in a protest or in a report prepared by the originating function.

(c) Discussions of the originating function's perception of the demeanor or credibility of the taxpayer or taxpayer's representative.

(d) Discussions of the originating function's views concerning the level of cooperation (or lack thereof) of the taxpayer/representative during the originating function's consideration of the case.

(e) Discussions regarding the originating function's views concerning the strengths and weaknesses of the case or the parties' positions in the case.

(f) Communications from the originating function to advocate for a particular result or to object to a potential resolution of the case or an issue in the case.

(4) *Administrative File*

(a) *In General*. The administrative file transmitted to Appeals by the office that made the determination that is subject to the Appeals process (the originating function) is not considered to be an *ex parte* communication within the context of this revenue procedure. The administrative file, which contains, among other things, the proposed determination and the taxpayer's protest or other approved means of communicating disagreement with the proposed determination, sets forth the boundaries of the dispute between the taxpayer and the IRS and forms the basis for Appeals to assume jurisdiction.

(b) *Transmittal*. The transmittal memorandum, a T-Letter, or any similar document that the originating function uses to transmit the administrative file (transmittal) should not include statements or comments intended to influence Appeals' decision-making process. This includes recommendations concerning what Appeals should consider and how Appeals should resolve the case. In contrast, it is permissible to include in the transmittal a neutral list of unagreed issues, without discussion, and to indicate which ones, if any, are coordinated issues. If the transmittal includes the type of statements or comments described in the second sentence of this paragraph, or includes other prohibited communications in a document that is either placed on top of the administrative file as a transmittal or inserted into the administrative file in conjunction with preparing the case for transmission to Appeals, the document must be shared by the originating function with the taxpayer/representative at the time that the administrative file is sent to Appeals.

(c) *Rebuttal to Protest*. If a rebuttal to the taxpayer's protest is prepared by the originating function, it must be shared with the taxpayer/representative by the originating function at the time that it is sent to Appeals.

(d) *Contents of Administrative File*. The administrative file shall be compiled and maintained by the originating function in accordance with the established procedures within that function or as otherwise directed by the reviewer(s) assigned to the case. The originating function, however, shall refrain from placing in the administrative file any notes, memoranda or other documents that normally would not be included in the administrative file in the ordinary course of developing the case if the reason for including this material in the administrative file is to attempt to influence Appeals' decision-making process. For example, the originating function should not include gratuitous comments in the case history, a memo to the file or a transmittal document, such as a T-Letter, if the substance of the comments would be prohibited if they were communicated to Appeals separate and apart from the administrative file.

(5) *Preconference Meetings*. Preconference meetings between Appeals and the originating function without providing the taxpayer/representative an opportunity to participate are an example of the type of communications that the *ex parte* communication rules were designed to prohibit. These meetings should not be held unless the taxpayer/representative is given an opportunity to participate.

(6) *Premature Referrals*. Appeals is the administrative settlement arm of the IRS. If a case is not ready for Appeals

consideration, Appeals may return it for further development or for other reasons described in IRM 8.2.1.6. Appeals may communicate with the originating function regarding the anticipated return of the case, including an explanation of the additional development that Appeals is requesting or other reasons why the case is being returned, but generally may not engage in a discussion of matters beyond the types of ministerial, administrative or procedural matters set forth in section 2.03(2), above, as part of a discussion of whether the premature referral guidelines require further activity by the originating function. When the case is returned to the originating function, Appeals must timely notify the taxpayer/representative that the case has been returned to the originating function, in whole or in part, for further development. In addition, the supplemental report prepared by the originating function reflecting the additional development that was done must be shared with the taxpayer/representative.

(7) *Submission of New Information*. If new information or evidence is submitted to Appeals by the taxpayer/representative, the principles set forth in IRM 8.2.1.9.3 should be followed. In general, the originating function should be given the opportunity to timely review and comment on significant new information presented by the taxpayer. "Significant new information" is information of a nonroutine nature that, in the judgment of Appeals, may have had an impact on the originating function's findings or that may impact Appeals' independent evaluation of the strengths and weaknesses of the issues, including the litigating hazards relating to those issues. Normally, the review can be accomplished by sending the material to the originating function while Appeals retains jurisdiction of the case and proceeds with resolution of other issues. Alternatively, Appeals may return the entire case to the originating function and relinquish jurisdiction, in its sole discretion, in accordance with the IRM. The taxpayer/representative must be timely notified when a case is returned to the originating function or new material not available during initial consideration has been sent to the originating function. The results of the originating function's review of the new information must be communicated to the taxpayer/representative.

(8) *New Issues Raised in Appeals*. Appeals will continue to follow the principles of Policy Statement 8–2 and the "General Guidelines" outlined in IRM 8.6.1.6.2 in deciding whether to raise a new issue. Under Appeals' new issue policy, new issues must continue to meet the "material" and "substantial" tests set forth in the IRM. Communications will be in accordance with the guiding principles in section 2.02(6), above.

(9) *Refund Claims Filed During the Appeals Process*. Refund claims filed during the Appeals process generally are referred to the originating function with a request for expedited review. Referral of these refund claims to the originating function involves no discussion about the strengths and weaknesses of the issue, and thus, fall within the ministerial, administrative or procedural matters exception set forth in section 2.03(2), above. The taxpayer/representative must be timely notified when the refund claim is referred to the originating function. The results of the originating function's review of the refund claim must be communicated to the taxpayer/representative.

(10) *Collection Due Process*

(a) *Collection Cases In General*. The principles applicable to discussions between Appeals employees and officials in originating functions apply to cases that originate in the Collection function, such as collection due process (CDP) appeals, collection appeals program cases, offers in compromise, and trust fund recovery penalty cases. These discussions must be held in accordance with the guiding principles in section 2.02(6), above.

(b) *Ministerial, Administrative or Procedural Matters*. Sections 6320 and 6330 provide that, as part of a CDP hearing, the Appeals officer must obtain verification that the requirements of any applicable law or administrative procedure have been met. Communications seeking to verify compliance with legal and administrative requirements fall within the ministerial, administrative or procedural matters exception set forth in section 2.03(2), above. Therefore, those communications are permissible without providing the taxpayer/representative an opportunity to participate.

(c) *Remand By Tax Court*. As provided in section 2.06(2)(a), below, the *ex parte* communication rules do not apply to communications between Appeals and Counsel with respect to cases docketed in the Tax Court. CDP cases that are remanded by the Tax Court for further consideration (or reconsideration) by Appeals fall into a different category, however. Although remanded CDP cases remain under the Tax Court's jurisdiction, the Appeals employee assigned to the remanded CDP case must be impartial in the review of the remanded case within the meaning of section 6320(b)(3) or 6330(b)(3), as applicable, requiring the application of similar considerations to those underlying the *ex parte* communication rules. Therefore, the following guidelines apply to remanded CDP cases.

(i) *Instructions Regarding the Remand*

(A) The Counsel attorney who handled the CDP case in the Tax Court should prepare a written memorandum to Appeals explaining the reasons why the court remanded the case to Appeals, any special requirements in the court's Order (*e.g.*, whether and to what extent a new conference should be held; whether the case must be reassigned to a different Appeals employee than the Appeals employee who handled the original CDP case; and what material Appeals is prohibited from reviewing, if any), and what issues the court has ordered Appeals to address on remand. The memorandum should not discuss the credibility of the taxpayer or the accuracy of the facts presented by the taxpayer. Nor should the memorandum contain any legal analysis or legal advice. A copy of the memorandum will be provided by the Counsel attorney to the taxpayer/representative.

(B) Communications to Appeals from the Counsel attorney handling the Tax Court case regarding deadlines relating to the remanded CDP case fall within the ministerial, administrative or procedural matters exception, and thus, are permissible communications that may take place without providing the taxpayer/representative an opportunity to participate.

(ii) *Legal Advice*

A request by Appeals for legal advice in connection with a remanded CDP case may be handled by the same Counsel attorney who is handling the Tax Court case.

(iii) *Review of Supplemental Notice By Counsel*. The Counsel attorney handling the Tax Court case should review the supplemental notice of determination before it

is issued to the taxpayer. This review is for the limited purpose of ensuring compliance with the Tax Court's remand Order.

(11) *Post-Settlement Conference*. The post-settlement conference with Examination is held after the case has been closed by Appeals. The purpose of the conference is to inform Examination about the settlement of issues to ensure that Examination fully understands the settlement and the rationale for the resolution. The conference provides an opportunity for Appeals to discuss with Examination the application of Delegation Order 236, or subsequent delegation orders (*i.e.*, settlement by Examination consistent with prior Appeals settlement with the same or related taxpayer). The tax periods that are the subject of the post-settlement conference have been finalized and the participants are cautioned to limit discussion to the results in the closed cycle. Any discussion of the resolution of issues present in the closed periods does not compromise the independence of Appeals, and thus, post-settlement conferences between Appeals and Examination are permissible without giving the taxpayer/representative an opportunity to participate. In contrast, any discussion that addresses open cycles in either Examination or Appeals with respect to the same or a related taxpayer is subject to the guidance provided in this revenue procedure relating to communications with the originating function contained in section 2.03, above.

(12) *Review of Coordinated Issues*

(a) *Cases in Compliance's Jurisdiction*. Delegation Order 4–25 provides the Compliance function with limited authority to settle certain issues with Appeals' review and approval. Specifically, this limited settlement authority applies with respect to issues that are coordinated, for example, in the Technical Advisor Program (or any successor program), and are the subject of either an Appeals Settlement Guideline (ASG) or an Appeals Settlement Position (ASP). Under existing procedures, the proposed settlement generally must be approved by the Examination Technical Advisor and the Appeals Technical Guidance Coordinator (ATGC) for the issue in question. The purpose of the required coordination is to ensure that the resolution by Examination is consistent with the analysis set forth in the ASG or ASP. Communications between Compliance employees and the ATGC in connection with satisfying this coordination requirement are permissible without giving the taxpayer/representative an opportunity to participate.

(b) *Cases in Appeals' Jurisdiction*. Under existing procedures, Appeals settlements involving coordinated issues, including but not limited to issues that are the subject of either an ASG or an ASP, must be approved by the ATGC for that issue. The ATGC serves as a resource person for the Appeals organization. The purpose of the required coordination is to ensure that resolutions of coordinated issues are consistent nationwide. Communications between Appeals employees and the ATGC are entirely internal within Appeals, and consequently, the *ex parte* communication rules do not apply to those communications. See section 2.01(1)(a)(ii).

(13) *Taxpayers with Multiple Open Cases*. Special considerations are required when a taxpayer has multiple open cases. This situation may arise, for example, when the taxpayer has cases involving the same issue pending with different IRS functions, including Counsel, which is common with respect to large corporate taxpayers, or the taxpayer has multiple cases involving the same issue pending with Appeals in both docketed and nondocketed status. The IRS has an interest in coordinating the handling of open cases regarding the same taxpayer to ensure that the responsible offices have complete information to make informed decisions about the cases within their respective jurisdictions.

Discussions held with respect to open cases must be in accordance with the guiding principles in section 2.02(6) and the operative rules set forth in section 2.03, above, as well as sections 2.06, 2.07 and 2.08, below. The *ex parte* communication rules may not apply to some of the open cases, such as those docketed in the Tax Court or under the jurisdiction of the Department of Justice, see sections 2.06(2) and 2.08(2), below, but may apply to one or more other open cases of the taxpayer.

.04 *Participation in Multifunctional Meetings*

(1) *General Rule*. Multifunctional meetings are meetings that include representatives from various IRS components, usually Compliance and Counsel. A meeting of the members of an Issue Management Team (IMT), or its successor type function, is an example of this type of meeting. These multifunctional meetings usually involve general discussions of how to handle technical issues or procedural matters. Appeals does not participate on IMTs but can be briefed by IMTs, as long as the discussion remains generic rather than case specific. Similarly, all participants in any type of multifunctional meeting need to be cognizant of the *ex parte* communication rules and ensure that taxpayer-specific discussions do not take place while Appeals is present.

As provided in sections 2.02(2) and (6), above, in order for Appeals to make fully-informed, independent judgments, Appeals must have access to the views and analysis of stakeholders. Listening to generic, noncase-specific discussions involving other IRS functions, including Counsel, in the context of a multifunctional meeting provides Appeals with an important forum in which to meet, in part, these needs, and enables Appeals to effectively serve as the administrative settlement arm of the IRS. Accordingly, Appeals may attend multifunctional meetings subject to the restrictions in section 2.04(2), below, regarding case-specific discussions.

(a) *Settlement Initiatives*. To achieve their distinct roles, Appeals, Counsel and Compliance must work collaboratively to satisfy the tax administration policies set by the Commissioner. As part of its effort to address particular issues or types of transactions, the IRS sometimes develops settlement initiatives either through an IMT or otherwise. These settlement initiatives are usually based on generic discussions of issues and transactions rather than on specific cases. The success of these settlement initiatives is dependent in large part on taxpayers' knowledge that the resolution of their case within Appeals does not fall outside of the settlement range unless the taxpayer can establish the existence of atypical facts and circumstances. Appeals' involvement in the formulation of the terms contained in the IRS' settlement initiatives is essential to the IRS' ability to resolve cases without litigation. Therefore, Appeals is permitted to participate in the development of settlement initiatives notwithstanding that Appeals' participation entails having discussions with other IRS functions, in-

cluding originating functions, regarding the general strengths and weaknesses of positions, litigation hazards, settlement ranges and the applicability of penalties. If the discussion is case specific, these topics continue to be prohibited, unless the taxpayer/representative is given an opportunity to participate.

(2) *Case-Specific Discussions.* Any discussion of a specific taxpayer's case in connection with a multifunctional meeting should be postponed until such time as it can be conducted outside of Appeals' presence. The preceding sentence does not apply with respect to post-settlement conferences, as discussed in more detail in section 2.03(11), above.

.05 *Alternative Dispute Resolution.*

(1) *Cases Not in Appeals' Jurisdiction.* Certain alternative dispute resolution (ADR) programs, such as fast track settlement, involve the use of Appeals employees to facilitate settlement while the case is still in Examination's jurisdiction. See, *e.g.*, Rev. Proc. 2003–40, 2003–1 C.B. 1044 (Large and Mid-Size Business Fast Track Settlement Program); Announcement 2011–5, 2011–4 I.R.B. 430 (Small Business/Self Employed Fast Track Settlement Program); Announcement 2008–105, 2008–2 C.B. 1219 (Tax Exempt and Government Entities Fast Track Settlement Program); and subsequent published guidance regarding these or similar programs. Private caucuses between the mediator and individual parties are often a key element in the process. The prohibition against *ex parte* communications between Appeals employees and other IRS employees does not apply because Appeals employees are not acting in their traditional Appeals settlement role. Consequently, Appeals employees may have *ex parte* communications with an originating function in connection with ADR proceedings. For a discussion of communications between Appeals and Counsel, see section 2.06, below. In contrast, the *ex parte* communication rules apply in the context of Appeals consideration of an issue under the Early Referral to Appeals process, Rev. Proc. 99–28, 1999–2 C.B. 109, or the Accelerated Issue Resolution program, Rev. Proc. 94–67, 1994–2 C.B. 800 (or subsequent published guidance regarding these programs). *Ex parte* communications are not an integral part of those types of ADR procedures because jurisdiction has shifted to Appeals in those cases.

(2) *Post-Appeals Mediation.* The *ex parte* communication rules do not apply to communications in connection with Post-Appeals Mediation proceedings. Revenue Procedure 2009–44, 2009–40 I.R.B. 462, describes an optional Appeals mediation procedure that is available after Appeals settlement discussions are unsuccessful and when all other issues are resolved except for the issue(s) for which mediation is being requested. See also Announcement 2011–6, 2011–4 I.R.B.433. Section 6.02 of Rev. Proc. 2009–44 states that "the parties are encouraged to include, in addition to the required decision-makers, those persons with information and expertise that will be useful to the decision-makers and the mediator." 2009–40 I.R.B. at 463. Section 6.02 further provides that "Appeals has the discretion to communicate *ex parte* with the IRS Office of Chief Counsel, the originating function, *e.g.*, Compliance, or both, in preparation for or during the mediation session. Appeals also has the discretion to have Counsel, the originating function, or both, participate in the mediation proceeding * * *." *Id.*

.06 *Communications with Counsel*

(1) *General Rule.* As provided in section 2.02(3), above, the Chief Counsel is the legal adviser to the Commissioner and his or her officers and employees (including employees of Appeals) on all matters pertaining to the interpretation, administration and enforcement of the internal revenue laws and related statutes. As part of the legal advice process, attorneys in the Office of Chief Counsel exercise independent judgment in addressing the strengths and weaknesses of the parties' respective positions, the hazards of litigation, the quality and admissibility of the evidence, and how a judge might react to the evidence or particular arguments.

Appeals employees are entitled to obtain legal advice from attorneys in the Office of Chief Counsel and, except as provided below, are permitted to do so under the *ex parte* communication rules. Appeals employees generally are not bound by the legal advice that they receive from the Office of Chief Counsel. The legal advice is but one factor that Appeals will take into account in its consideration of the case. Appeals employees independently evaluate the strengths and weaknesses of the specific issues in the cases assigned to them and make an independent judgment concerning the overall strengths and weaknesses of the cases they are reviewing and the hazards of litigation. See IRM 8.6.2.6.4 and 8.6.4.1.

Appeals employees should not communicate *ex parte* regarding an issue in a case pending before them with a field attorney if the field attorney personally provided legal advice regarding the same issue in the same case to the originating function or personally served as an advocate for the originating function regarding the same issue in the same case. For purposes of this section, in determining whether a field attorney is considered to have personally provided legal advice to the originating function or personally served as an advocate for the originating function, regarding the same issue in the same case, the extent and nature of the field attorney's involvement in the case relating to the issue with respect to which Appeals is seeking legal advice is determinative.

(2) *Docketed Cases.*

(a) *In General.* The *ex parte* communication rules do not apply to communications between Appeals and Counsel in connection with cases docketed in the United States Tax Court. Communications between Appeals and the originating function in docketed cases are still subject to the *ex parte* communication rules if the case is within Appeals' jurisdiction.

(b) *Collection Due Process Cases.* For a discussion of the application of the *ex parte* communication rules to CDP cases remanded by the Tax Court, see section 2.03(10)(c).

.07 *Communications with Other IRS Functions*

(1) *Outside Consultants and Experts.* Outside consultants or experts under contract to the IRS, other than those hired directly by Appeals, are treated as IRS employees for purposes of this revenue procedure. Consequently, communications between Appeals and these outside consultants or experts are subject to the *ex parte* communication rules. See section 2.02(6). In contrast, communications between Appeals and outside consultants or experts hired by Counsel in docketed cases are not subject to the *ex parte* communication rules. See section 2.06(2).

(2) *Criminal Investigation*. Criminal Investigation (CI) is not an originating function as that term is defined in section 2.01(2), above, because Appeals does not review Criminal Investigation's determinations. Communications between Appeals and CI are generally ministerial in nature. For example, Appeals and CI may confirm the existence of a CI investigation, which would freeze Appeals' action, or Appeals may review a CI closed case to find information relevant to the case that Appeals is reviewing. Similarly, CI may communicate *ex parte* with Appeals to obtain information or documents in Appeals' possession that may be relevant to the activities of CI or to ensure that Appeals' actions will not interfere with any ongoing criminal investigation or be inconsistent with any prior criminal investigations. Since these types of communications do not address the strengths or weaknesses of an open case, they are permissible under section 2.02(6), above. For a discussion of communications between Appeals and Criminal Investigation that go beyond the above matters, see section 2.03(13), above.

(3) *Competent Authority*. The United States Competent Authority is responsible for the timely and effective implementation of tax treaties and tax information exchange agreements. Communications between Appeals and IRS employees at the request or on behalf of the competent authority relating to a taxpayer's request for relief under competent authority procedures, see Rev. Proc. 2006–54, 2006–2 C.B. 1035, are permissible. It is presumed that the competent authority is acting at the request and with the consent of the taxpayer. Communications between Appeals and IRS employees that are unrelated to the taxpayer's request for relief under competent authority procedures, however, continue to be subject to the *ex parte* communication rules.

(4) *Taxpayer Advocate Service*. Communications with Appeals that are initiated by the Taxpayer Advocate Service (TAS) are permissible. It is presumed that the TAS employees are acting at the request and with the consent of the taxpayer. Due to the nature of their role within the IRS and their relationship with the taxpayer, TAS employees may discuss with Appeals the strengths and weaknesses of the parties' respective positions and may advocate for a particular result in the case.

(5) *Commissioner and Other IRS Officials with Overall Supervisory Responsibilities*. The Commissioner is responsible for administering, managing, conducting, directing, and supervising the execution and application of the internal revenue laws or related statutes and tax conventions to which the United States is a party. I.R.C. § 7803(a)(2)(A). In the course of exercising that statutory responsibility, the Commissioner and those officials, such as the Deputy Commissioners, who have overall supervisory responsibility for IRS operations may communicate with Appeals about specific cases or issues and may direct that other IRS officials, including Counsel officials, participate in meetings or discussions about cases or issues without providing the taxpayer/representative an opportunity to participate.

.08 *Communications with Other Governmental Entities*

(1) *Joint Committee on Taxation*. Section 6405 requires the IRS to submit a report to the Joint Committee on Taxation concerning any refund or credit in excess of the statutory amount and the IRS must wait at least 30 days after submitting the report before making the refund or credit that is the subject of the report. The Joint Committee or its staff will occasionally question a settlement or raise a new issue. Communications between Appeals and the Joint Committee or its staff are permissible without providing the taxpayer/representative an opportunity to participate. The *ex parte* communication rules only apply to communications between Appeals and other IRS employees. Since the Joint Committee is part of the Legislative Branch, not the IRS, the *ex parte* communication rules do not apply to communications with the Joint Committee or its staff.

(2) *Department of Justice*. Appeals may communicate with employees of the Department of Justice, including the U.S. Attorneys' offices, without giving the taxpayer/representative an opportunity to participate. The *ex parte* communication rules only apply to communications between Appeals and other IRS employees. Since the Department of Justice is not part of the IRS, the ex parte communication rules do not apply to communications with the Department of Justice.

.09 *Monitoring Compliance*. It is the responsibility of all IRS employees to ensure compliance with the *ex parte* communication rules. All IRS employees will make every effort to promptly terminate any communications not permitted by the *ex parte* communication rules. To improve understanding of the *ex parte* communication rules, Appeals and other impacted IRS employees, including Counsel, will receive training on the contents of this revenue procedure and will be encouraged to seek managerial guidance whenever they have questions about the propriety of an *ex parte* communication. Additionally, managers will consider feedback from other functions and will be responsible for monitoring compliance during their day-to-day interaction with employees, as well as during workload reviews and closed case reviews. Breaches will be addressed in accordance with existing administrative and personnel processes.

.10 *Remedies Available to Taxpayers*

(1) *General Rule*. The *ex parte* communication rules set forth in this revenue procedure do not create substantive rights affecting the taxpayer's tax liability or the IRS' ability to determine, assess or collect that tax liability, including statutory interest and any penalties, if applicable. The IRS takes the *ex parte* communication rules seriously and will continue its efforts to ensure compliance through training and oversight. Most breaches of the *ex parte* communication rules may be cured by timely notifying the taxpayer/representative of the situation, sharing the communication or information in question and affording the taxpayer/representative an opportunity to respond. The specific administrative remedy that may be made available in any particular case is within the sole discretion of Appeals. For a discussion of court directed cures for breach of the *ex parte* communication rules, see section 2.10(2), below.

(2) *Collection Due Process Cases*. If the Tax Court determines that a breach of the *ex parte* communication rules occurred during the course of a CDP hearing in Appeals, the Tax Court may remand the case to Appeals for either a new or a supplemental hearing, depending upon what steps the court concludes is necessary to rectify the breach. See section 2.03(10)(c), above.

Section 3. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2000–43, 2000–2 C.B. 404, is amplified, modified and superseded.

Section 4. EFFECTIVE DATE

This revenue procedure is effective for communications between Appeals employees and other IRS employees, including Counsel, that take place after August 8, 2011, the date this revenue procedure was released to the public.

Section 5. DRAFTING INFORMATION

The principal author of this revenue procedure is Henry S. Schneiderman, Office of the Associate Chief Counsel (Procedure and Administration). For further information regarding this revenue procedure, contact Mr. Schneiderman at (202) 622–3400 (not a toll-free number).

Equitable Relief Under Section 6015(f)

Notice 2011–70

PURPOSE

This notice expands the period within which individuals may request equitable relief from joint and several liability under section 6015(f) of the Internal Revenue Code. Specifically, this notice provides that the Internal Revenue Service will consider requests for equitable relief under section 6015(f) if the period of limitation on collection of taxes provided by section 6502 remains open for the tax years at issue. If the relief sought involves a refund of tax, then the period of limitation on credits or refunds provided in section 6511 will govern whether the IRS will consider the request for relief for purposes of determining whether a credit or refund may be available. This notice also provides certain transitional rules to implement this change.

BACKGROUND

In the case of married individuals who file joint income tax returns, each spouse is jointly and severally liable, under section 6013(d), for the tax that is due for the taxable year for which the joint return is filed. Section 6015 provides for relief from joint and several liability in certain circumstances. Section 6015(f) provides for equitable relief from understatements and underpayments when relief is not available under section 6015(b) or (c). By regulation, the Department of Treasury and the Internal Revenue Service established a two-year deadline to request equitable relief under subsection (f), to encourage the prompt resolution of liability determinations and to consider evidence relevant to a request while the evidence remained available. Whether this regulation was a valid exercise of rulemaking authority has been challenged in litigation. Circuit courts that have decided the issue have upheld the validity of the two-year deadline to request equitable relief set forth in the regulations under section 6015(f). *Lantz v. Commissioner*, 607 F.3d 479 (7th Cir. 2010); *Mannella v. Commissioner*, 631 F.3d 115 (3d Cir. 2011); *Jones v. Commissioner*, 642 F.3d 459 (4th Cir. 2011).

Notwithstanding these court decisions, Treasury and the IRS have concluded that the regulations issued under section 6015 should be revised so that individuals who request equitable relief under section 6015(f) will no longer be required to submit a request for equitable relief within two years of the IRS's first collection activity against the requesting spouse with respect to the joint tax liability.

TRANSITIONAL RULES

Pending modification of the Treasury regulations under section 6015(f) to formally remove the two-year deadline for requests for equitable relief, individuals may rely on this notice, and the following transitional rules will apply:

- **Future Requests**

Individuals may request equitable relief under section 6015(f) after the date of this notice without regard to when the first collection activity was taken. Requests must be filed within the period of limitation on collection in section 6502 or, for any credit or refund of tax, within the period of limitation in section 6511.

- **Requests Pending With the IRS**

For individuals who have already submitted requests for relief under section 6015(f) that the IRS has under consideration or in suspense, the IRS will consider the request for equitable relief even if the request was submitted more than two years after the first collection activity was taken, so long as the applicable period of limitation under section 6502 or section 6511 was open when the request for equitable relief was filed with the IRS. Individuals with cases under consideration or in suspense should not reapply for relief under section 6015(f).

- **Requests that Were Denied Solely for Untimeliness and Not Litigated**

Individuals whose requests for equitable relief under section 6015(f) were denied by the IRS solely for untimeliness and were not litigated may reapply for relief under section 6015(f) after the effective date of this notice by filing a new Form 8857, *Request for Innocent Spouse Relief*. In considering this request for relief, the IRS will treat the original Form 8857 as a claim for refund for purposes of the period of limitation on refunds provided by section 6511. This means that any amount for which a refund was available as of the date that the original Form 8857 was filed and any amount subsequently collected may be eligible for refund if warranted by the IRS's reconsideration of equitable relief. The IRS can only grant relief with respect to unpaid liabilities if the period of limitation on collection, under section 6502, remains open as of the date of the reapplication for relief.

- **Requests in Litigation**

In any case in litigation in which the IRS denied a request for equitable relief under section 6015(f) as untimely, the IRS or the United States will take appropriate action in the case as to the timeliness issue consistent with the position announced in this notice. Similarly, if equitable relief under section 6015(f) was raised for the first time in litigation and the two-year deadline was raised as a defense, the IRS or the United States will take appropriate action in the case consistent with the position in this notice. Individuals in these

cases should not reapply for equitable relief.

- **Requests that Were in Litigation and that Litigation Is Now Final**

The IRS will, in the circumstances set forth below, take no further collection activity with respect to an individual who sought equitable relief under section 6015(f) in a judicial proceeding in which the validity of the two-year deadline to request equitable relief was at issue and the decision in the case is final. If the IRS stipulated in the court proceeding that the individual's request for equitable relief would have been granted had the request been timely, the IRS will not seek, after the effective date of this notice, to collect from the individual any portion of the underlying liability for which equitable relief would have been granted. Individuals in these cases do not need to reapply for equitable relief. The decision not to collect is prospective only, and no refunds or credits will be available. The relief from collection provided in this notice applies only to those liabilities for which equitable relief would have been granted under section 6015(f) and does not apply to other liabilities, so the IRS may pursue collection of other unpaid tax liabilities. In cases in which section 6015(f) relief is not provided, individuals may be able to avoid enforced collection activity, such as a levy on the individual's wages or property, if they qualify for a collection alternative, such as an offer in compromise or an installment agreement. See Publication 594, *The IRS Collection Process*, or visit *www.irs.gov*, for more information.

This notice only addresses the time period within which individuals may request equitable relief from joint and several liability under section 6015(f). It has no effect on the statutory two-year deadline to elect relief under section 6015(b) or (c). For more information about equitable relief under section 6015(f) or innocent spouse relief in general, see Publication 971, *Innocent Spouse Relief*.

EFFECTIVE DATE

This notice is effective on July 25, 2011. The transitional rules set forth in this notice may be relied upon until final regulations modifying the two-year rule are published in the **Federal Register** or other published guidance is issued that alters the applicability of this notice.

DRAFTING INFORMATION

The principal author of this notice is Stuart Murray of the Office of Associate Chief Counsel, Procedure and Administration. For further information regarding this notice, contact Stuart Murray at (202) 622–4940 (not a toll-free number).

Part IV. Items of General Interest

Notice of Proposed Rulemaking by Cross-Reference to Temporary Regulations

Requirements for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes under the Patient Protection and Affordable Care Act

REG–125592–10

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice of proposed rulemaking by cross-reference to temporary regulations.

SUMMARY: Elsewhere in this issue of the Bulletin, the IRS is issuing an amendment to temporary regulations (T.D. 9532) published July 23, 2010 under the provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act) regarding internal claims and appeals and external review processes. The IRS is issuing the temporary regulations at the same time that the Employee Benefits Security Administration of the U.S. Department of Labor and the Center for Consumer Information & Insurance Oversight of the U.S. Department of Health and Human Services are issuing a substantially similar amendment to interim final regulations published July 23, 2010 with respect to group health plans and health insurance coverage offered in connection with a group health plan under the Employee Retirement Income Security Act of 1974 and the Public Health Service Act. The temporary regulations provide guidance to employers, group health plans, and health insurance issuers providing group health insurance coverage. The text of those temporary regulations also serves as the text of these proposed regulations.

DATES: Written or electronic comments and requests for a public hearing must be received by July 25, 2011.

ADDRESSES: Send submissions to: CC:PA:LPD:PR (REG–125592–10), room 5205, Internal Revenue Service, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044. Submissions may be hand-delivered to: CC:PA:LPD:PR (REG–125592–10), Courier's Desk, Internal Revenue Service, 1111 Constitution Avenue, NW, Washington DC 20224. Alternatively, taxpayers may submit comments electronically via the Federal eRulemaking Portal at *http://www.regulations.gov* (IRS REG–125592–10).

FOR FURTHER INFORMATION CONTACT: Concerning the regulations, Karen Levin at 202–622–6080; concerning submissions of comments, Oluwafunmilayo Taylor at 202–622–7180 (not toll-free numbers).

SUPPLEMENTARY INFORMATION:

Background and Explanation of Provisions

The temporary regulations published elsewhere in this issue of the Bulletin amend §54.9815–2719T of the Miscellaneous Excise Tax Regulations. The proposed and temporary regulations are being published as part of a joint rulemaking with the Department of Labor and the Department of Health and Human Services (the joint rulemaking). The text of those temporary regulations also serves as the text of these proposed regulations. The preamble to the temporary regulations explains the temporary regulations and these proposed regulations.

Special Analyses

It has been determined that this notice of proposed rulemaking is not a significant regulatory action as defined in Executive Order 12866. Therefore, a regulatory assessment is not required. It has also been determined that section 553(b) of the Administrative Procedure Act (5 U.S.C. chapter 5) does not apply to this proposed regulation. It is hereby certified that the collections of information contained in this notice of proposed rulemaking will not have a significant impact on a substantial number of small entities. Accordingly, a regulatory flexibility analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Section 54.9815–2719T of the temporary regulations, as amended, requires both group health insurance issuers and group health plans to establish internal claims and appeals and external review processes for adverse benefit determinations. Those processes require the plan and issuer to disclose evidence relied upon in making an adverse benefit determination, to disclose any new rationale for upholding an adverse benefit determination as part of an internal appeal, to provide notice of an adverse benefit determination and of a final internal adverse benefit determination, and to disclose the right to an external review. Under the temporary regulations, if a health insurance issuer satisfies the obligations to have effective internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes), those obligations are satisfied not just for the issuer but also for the group health plan. For group health plans maintained by small entities, it is anticipated that the health insurance issuer will satisfy those obligations to have effective internal claims and appeals and external review processes (including these information collection requirements that are an inherent part of those processes) for both the plan and the issuer in almost all cases. For this reason, these information collection requirements will not impose a significant impact on a substantial number of small entities. Pursuant to section 7805(f) of the Internal Revenue Code, this regulation has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Comments and Requests for a Public Hearing

Before these proposed regulations are adopted as final regulations, consideration will be given to any written comments (a signed original and eight (8) copies) or electronic comments that are submitted

timely to the IRS. Comments are specifically requested on the clarity of the proposed regulations and how they may be made easier to understand. All comments will be available for public inspection and copying. A public hearing may be scheduled if requested in writing by a person that timely submits written comments. If a public hearing is scheduled, notice of the date, time, and place for the hearing will be published in the **Federal Register**.

Drafting Information

The principal author of these proposed regulations is Karen Levin, Office of the Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities), IRS. The proposed regulations, as well as the temporary regulations, have been developed in coordination with personnel from the U.S. Department of Labor and the U.S. Department of Health and Human Services.

* * * * *

Proposed Amendments to the Regulations

Accordingly, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 2. Proposed section 54.9815–2719 as published on July 23, 2010, 75 FR 43330, is amended by:

1. Revising paragraphs (b)(2)(ii)(B), (b)(2)(ii)(E)(*1*), (b)(2)(ii)(F), (c)(2)(xi), (c)(3), (d)(1), (d)(2)(iv), and (e).

2. Redesignating (b)(2)(ii)(E)(*2*), (b)(2)(ii)(E)(*3*), and (b)(2)(ii)(E)(*4*) as (b)(2)(ii)(E)(*3*), (b)(2)(ii)(E)(*4*), and (b)(2)(ii)(E)(*5*), respectively.

3. Adding new paragraph (b)(2)(ii)(E)(*2*).

The revisions and addition read as follows:

§54.9815–2719 Internal claims and appeals and external review processes.

* * * * *

(b) * * *

(2) * * *

(ii) * * * (B) [The text of proposed §54.9815–2719(b)(2)(ii)(B) is the same as the text of §54.9815–2719T(b)(2)(ii)(B) published elsewhere in this issue of the Bulletin].

* * * * *

(E) * * * (*1*) [The text of proposed §54.9815–2719(b)(2)(ii)(E)(*1*) is the same as the text of §54.9815–2719T(b)(2)(ii)(E)(*1*) published elsewhere in this issue of the Bulletin].

(*2*) [The text of proposed §54.9815–2719(b)(2)(ii)(E)(*2*) is the same as the text of §54.9815–2719T(b)(2)(ii)(E)(*2*) published elsewhere in this issue of the Bulletin].

* * * * *

(F) [The text of proposed §54.9815–2719(b)(2)(ii)(F) is the same as the text of §54.9815–2719T(b)(2)(ii)(F) published elsewhere in this issue of the Bulletin].

* * * * *

(c) * * *

(2) * * * (xi) [The text of proposed §54.9815–2719(c)(2)(xi) is the same as the text of §54.9815–2719T(c)(2)(xi) published elsewhere in this issue of the Bulletin].

* * * * *

(3) [The text of proposed §54.9815–2719(c)(3) is the same as the text of §54.9815–2719T(c)(3) published elsewhere in this issue of the Bulletin].

(d) * * * (1) [The text of proposed §54.9815–2719(d)(1) is the same as the text of §54.9815–2719T(d)(1) published elsewhere in this issue of the Bulletin].

* * * * *

(2) * * * (iv) [The text of proposed §54.9815–2719(d)(2)(iv) is the same as the text of §54.9815–2719T(d)(2)(iv) published elsewhere in this issue of the Bulletin].

* * * * *

(e) [The text of proposed §54.9815–2719(e) is the same as the text of §54.9815–2719T(e) published elsewhere in this issue of the Bulletin].

* * * * *

Steven T. Miller,
Deputy Commissioner for Services and Enforcement.

(Filed by the Office of the Federal Register on June 22, 2011, 4:15 p.m., and published in the issue of the Federal Register for June 24, 2011, 76 F.R. 37037)

Discontinuance of High-Low Method for Substantiating Travel Expenses

Announcement 2011–42

In Rev. Proc. 2010–39, 2010–42 I.R.B. 459, the Internal Revenue Service requested public comment on the continuing need for the high-low method for substantiating, under § 274(d) of the Internal Revenue Code, lodging, meal, and incidental expenses incurred in traveling away from home. The Service received no comments.

Accordingly, the Service intends to discontinue authorizing the high-low substantiation method. In 2011, the Service plans to publish a revenue procedure providing the general rules and procedures for substantiating lodging, meal, and incidental expenses incurred in traveling away from home (omitting the high-low substantiation method). The Service will publish a revenue procedure in subsequent years only when modifying the substantiation rules and procedures and will publish the special transportation rate in an annual notice.

For additional information regarding this announcement, contact Karla M. Meola of the Office of Associate Chief Counsel (Income Tax and Accounting) at (202) 622–4930 (not a toll-free call).

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.
ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.
PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D. —Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z —Corporation.

Numerical Finding List[1]

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[1] A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2011–1 through 2011–26 is in Internal Revenue Bulletin 2011–26, dated June 27, 2011.

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[1] A cumulative list of current actions on previously published items in Internal Revenue Bulletins 2011–1 through 2011–26 is in Internal Revenue Bulletin 2011–26, dated June 27, 2011.

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