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

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General Comment

I wish to comment on the proposed 10% threshold for translation and oral interpretation of private plan materials in internal review and appeal contexts.

The proposed standards fail to recognize the needs of the 12 million residents in the United States who do not speak English well, over half of whom reside in California.
As health plan and insurance members, they pay premiums and receive marketing materials and calls in their primary language, but under these proposed regulations, they would not be able to access plan review and appeals materials to ensure they receive the care they need.

The Centers for Medicaid & Medicare Services (CMS), Internal Revenue Service (IRS), and Department of Labor (DOL) should immediately revise these joint Interim Regulations.
Specifically they should:

Require large group plans to provide notices to 5% of the plan's population or 500 persons in a plan's service area and 25% of the population for small group plans.
Provide oral interpretation in all languages at all times under Title VI of the Civil Rights Act of

1964, reiterated in Section 1557 of the ACA, and by Executive Order published at 65 Fed. Reg. 50,121-22 (Aug. 16, 2000).

Require the identification (“tagging and tracking”) of a member’s spoken and written language need as required by Title VI Office of Civil Rights in order to ensure effective communication about medical instructions and vital patient information critical to the provision of quality care.

Reject bogus claims by health plans that these regulations will be too costly by using California’s language access law, SB 853, as an example. These federal regulations apply to a much narrower set of documents – notices about appeals and denials of medical coverage – than those covered by SB 853. In addition, the costs health plans are citing are one time translation costs for documents that will be used for many years.