CPEHN
California Pan-Ethnic Health Network

July 25, 2011

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

Re: Comments on Amendment to Interim Final Rules
RIN 0938-AQ66 Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes

To Whom It May Concern:

On behalf of the California Pan-Ethnic Health Network (CPEHN), I am submitting the following comments regarding the proposed amendments to the Interim Final Rules RIN 0938-AQ66 for Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes.

CPEHN's mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color. We work to ensure that all everyone, regardless of race, ethnicity, language preference, and immigration status, has equal access to quality, culturally competent, affordable health care.

Section 2719 of the Public Health Service Act under the Patient Protection and Affordable Care Act (ACA) requires that appeals notices be provided in a culturally and linguistically appropriate manner. The new Interim Final Rules (IFR) fall woefully short of this requirement. Under the revised rules, plans will only have to provide translated consumer notices in languages that 10% of the population of a county can read, while oral interpretation will be required in only those same languages. These standards are not only weaker, they actually take a step backward, negating the requirement under Title VI of the Civil Rights Act of 1964 that individuals receive oral interpretation in any language.

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. In a state where over 100 different languages are spoken and nearly 20% of the state's population speaks English less than "very well," it is essential that notices be linguistically accessible. As health plan and insurance members, consumers pay premiums and receive marketing materials and calls in their primary language, but under these proposed regulations, they would not be able to access vital plan review and appeals materials, compromising the care and services they will receive. A lack of culturally and linguistically appropriate materials and

interpretation will result in adverse health impacts for limited-English proficient (LEP) individuals in the United States.

We urge the Centers for Medicare & Medicaid Services (CMS), Internal Revenue Service (IRS), and Department of Labor (DOL) to revise these joint Interim Regulations to:

- Require large group plans to provide translated notices to 5% of the plan's population or 500 persons in a plan's service area in keeping with existing thresholds for addressing limited-English proficiency under guidance utilized in both the Department of Health and Human Services and Department of Justice Guidance as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans. Small group plans should be required to provide translated notices to 25% of the population. [1]
- Require health plans to 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). The IFR requires oral interpretation only in the same threshold languages, undermining Title VI and leaving millions of LEP individuals without any assistance from their plans when trying to understand their legal rights and decide whether to file an appeal. It is hard to understand how the statutory requirement to provide culturally and linguistically appropriate notices is upheld if plans can ignore the most basic communication needs of LEP individuals.
- Require the identification and continued dissemination of materials ("tagging and tracking") in a member's spoken and written language as required by Title VI in order to ensure effective communication about medical instructions and vital patient information critical to the provision of quality care. We respectfully request that the Departments reinstate language from the initial IFR which states: "Once a request has been made by a claimant, provide all subsequent notices to the claimant in the non-English language." Once a person indicates they speak a language other than English, health plans and insurers should be required to continue to send information to that person in their primary language as a quality of care issue.

While we appreciate the challenges that health plans and insurers may experience in implementing the IFR, we are concerned about the undue influence they may have had with their exaggerated cost estimates based on their implementation of California's language access law, SB 853. As a sponsor of SB 853, and having monitored its implementation, this is an inappropriate comparison.

California's language access law requires health plans to translate "vital documents," including applications, consent forms, letters containing important information regarding eligibility and participation criteria, the explanation of benefits (EOB), coverage, exclusions, limitations, and cost-sharing requirements.[2] In contrast, the requirements in this regulation only apply to notices related to adverse benefit determinations, appeals, and external review – a small fraction of what health plans have to translate under California law. Additionally, the thresholds in the California law are much lower than the IFR – 1% for a plan with 300,000-1,000,000 members and 0.75% for a plan with over 1,000,000 members – compared to 5% or 500 persons in a plan's service area. Moreover, the costs that health plans are citing are one-time translation costs for documents that will be used

[1] See, e.g. 7 C.F.R. § 272.4(b)(2) (2010); 28 C.F.R. § 55.6 (2010).
[2] *See* California Department of Managed Care, Comment on FR Doc # 2010-18043, ID No. , Sept. 21. 2010.

for many years. An investment in culturally and linguistically appropriate materials will provide significant benefits for health plans and consumers for years to come.

In fact, because of California's law, major plans like United Healthcare have already put the necessary processes into place for providing translations of written documents which could significantly help ease the burden of implementing the proposed rules.[3] In its first biennial report to the Legislature, California's Department of Managed Health Care (DMHC) noted: "there has been no indication that problems or concerns exist regarding health plan implementation of the Language Assistance regulations at this time."

We also question the conclusion based on data from various health plans that "uptake" rates for translated written documents and oral interpretation have been low in California. SB 853 has only been in effect for two years making it difficult to draw major conclusions yet. It will take time for consumers to become aware of their rights under the law and make the "culture shift" that is required to know they are eligible, and need to ask, for oral interpretation and written translation as needed.

At the same time, while many health plans are complying with California's language access requirements, there are still deficiencies by health plans in informing members of language assistance services and a number of complaints have been recorded.[4] Despite the existence of a sample notice created by DMHC in 12 different languages, many plans are using their own notices, which are only available at most in five languages, leaving millions of Californians uninformed about their rights to oral interpretation, which is critical to quality care.

Lastly, some plans have suggested that the low number of complaints is a sign of the lack of demand for translated written documents and oral interpretation. Without the health plans asking their members if they received appropriate language services when filing a compliant, and analyzing the complaints they receive by race/ethnicity and language of the complainant, they do not actually know whether or not there is a problem, as lack of language access is often identified and categorized as a quality of care issue.

While we are encouraged that the Departments have prioritized the standardization of the appeals and notices process which will certainly benefit consumers, the current draft will result in harm to consumers, roll back the progress we have made in advancing language services, and undermines Title VI. We urge the Departments to revise the current IFRs in order to protect consumers to the fullest extent without unduly burdening plans and issuers.

Sincerely,

Caroline B. Sanders
Director, Policy Analysis

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[3] See Table 1: Provision of Translation Services

[4] California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf.