ASIAN PACIFIC AMERICAN LEGAL CENTER
MEMBER OF ASIAN AMERICAN CENTER FOR ADVANCING JUSTICE

July 25, 2011

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, D.C. 20219
Attention: RIN 1210-AB45

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

CC:PA:LPD:PR (**REG-125592-10**)
Room 5205, Internal Revenue Service
P.O. Box 7604, Ben Franklin Station
Washington, D.C. 20044

Via E-mail: E-OHPSCA2719amend.EBSA@dol.gov

Dear DOL, DHHS, and IRS:

On behalf of the Asian Pacific American Legal Center and the Asian American Justice Center, members of the Asian American Center for Advancing Justice, and the Asian & Pacific Islander American Health Forum, we are submitting the following comments pursuant to the request for public comment published in 76 Fed. Reg. 37208-34 (June 24, 2011) regarding the interim final regulations for Group Health Plans and Health Insurance Issuers: Rules Pertaining to Internal Claims and Appeals and External Review Processes. Our organizations are dedicated to providing the growing Asian American and Pacific Islander community with multilingual and culturally appropriate access to legal and health care services, education, and civil right support.

The Asian American and Pacific Islander community, which is the fastest growing major racial group in the U.S., is extraordinarily diverse with dozens of different cultures and languages. According to the 2000 Census, 79% of the Asian American and Pacific Islander population speak a language other than English at home, 40% are limited-English proficient (LEP), and 29% are linguistically isolated. Numerous studies have documented the need for access to culturally and linguistically appropriate health care services and the serious consequences that can result from the lack of qualified language assistance for LEP individuals.[1]

[1] Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* (2002).

Our comments are directed to section II(A)(4), entitled Form and Manner of Notice [paragraph e] of the July 2010 Regulations. We do not support the proposed changes to the July 2010 interim final regulations with regard to the notice requirements and do not believe that the regulations provide for culturally and linguistically appropriate access for LEP individuals.

Most importantly, both the July 2010 and the July 2011 regulations confuse the provision of oral interpretation services with the provision of translated written materials, such as notices of internal claims and appeals and external review processes. Oral or interpreter services, by competent interpreters or bilingual staff, should be provided to all LEP individuals and not subject to any threshold, and certainly not the changed threshold that is proposed in the July 2011 regulations. We believe that such a restriction violates the intent of Affordable Care Act (ACA), § 1001 (Public Health Service Act § 2719) and § 1557, the non-discrimination provision, because it would mean that millions of LEP persons could not communicate effectively with their health plans or health insurers and could lose their right to appeal and other legal rights. Under Title VI of the 1964 Civil Rights Act, and enacted as part of the ACA pursuant to §1557, it has long been understood that oral language assistance must be provided to every LEP person, regardless of any thresholds triggering the provision of translated written materials. Those statutes recognize the critical importance of basic communication between the enrollees or insureds with their health plan or insurance company and should be used as strong guidance for these related regulations. Therefore, we strongly recommend that this distinction is made clear and that the regulations remove the reference in Section (e)(2)(i) to "any applicable non-English language."

As noted, § 1001 of the ACA requires that relevant notices sent by group health plans and health insurers must be provided in a culturally and linguistically appropriate manner. However, the revised July 2011 interim regulations changed the threshold and weakened the requirement for the translation of the notices in several ways.

First, the rules changed the threshold from the number of literate persons who speak a non-English language in the plan to those in a county. This ignores the fact that it is the linguistic needs of plan participants which should determine whether the notices should be translated into non-English languages, not the number in the county, which might not accurately reflect the composition of LEP participants in the plan, especially if the plan operated statewide, regionally or nationally. Moreover, some plans may market to specific ethnic or racial groups and/or might have a higher number in its enrollee population than the county in which it operates. In fact, the hypothetical posed by the Departments illustrate a situation where an administrator or sponsor of the group health plan might request the insurer to provide language services in languages that do not meet the requisite threshold for an applicable non-English language. In the proposed scenario the language is Chinese and the question is whether the insurer should be obligated to provide language services for Chinese if it does not meet the requisite threshold. We would answer in the affirmative and recommend that the insurer or health plan be required to provide both interpreter services and translated notices for those larger non-English language populations. We also believe the hypothetical supports the need to return to the original thresholds in the July 2010 regulations. It is possible that the Chinese-speaking participants would meet either the 10% of plan participants or the 500 numerical threshold. It is more important that the actual language needs of the participants in the plan or insurance group are met than the language needs of the county

residents. We would therefore recommend that the regulation should be changed back to using the number of, and not the number in the county. With regard to those plans that conduct marketing and outreach to specific racial, ethnic, or language populations, we would recommend that the Departments adopt an additional requirement to provide language services to any language group for which the plan specifically markets. This would ensure that the plan could not simply conduct marketing and outreach to enroll LEP individuals but then fail to provide needed assistance to the LEP enrollees.

Second, the numeric threshold was eliminated in the revised regulations for group plans and the 10% threshold is the only trigger. Originally, the threshold for requiring translation of notices for plans in the group market was set at 10% of plan participants in a given language or 500 persons, whichever is less, and where a group plan had less than 100 participants, a 25% threshold was used. For individual plans, the threshold for translation of notices was set at 10% of the county population.

For group plans, the 10% threshold without the numeric threshold of 500 LEP members renders the requirement meaningless, given the low number of jurisdictions and languages that can meet it. As noted in the footnote 29 and Table 2, there are only 177 counties, outside of Puerto Rico (which has 78 requiring Spanish) which would require translated notices. Spanish-speakers will be left out in most of the country, as only 172 counties meet the 10% county population threshold (this is out of 3,143 counties in the United States). Besides Spanish, the new proposed translation threshold is only met by Navajo in 3 counties (1 county each in Arizona, New Mexico, and Utah, Tagalog in 2 counties (both in Alaska), and Chinese in one county in California. Only one county in the entire country, the Aleutians West Census Area (with a total population of 5,505), would have translations in more than one language: Spanish and Tagalog. This last example reveals the arbitrariness of the 10% threshold. Thus, the new proposed standards completely fail to recognize the needs of the approximately 7 million LEP individuals in the United States that are estimated to be affected, the vast majority of Asian American and Pacific Islander language populations, and virtually all other LEP populations.

Many agencies, including the Department of Labor (DOL), the Department of Justice (DOJ), and the Department of Health and Human Services (DHHS), recognize the need for both a percentage and numeric threshold.[2] As the Departments explained in the Federal Register notice, the original thresholds were adapted from the DOL regulations regarding style and format for a summary plan description, which used the 500 person numeric threshold.[3] We strongly recommend that the Departments reinstate the numeric threshold to ensure that the intent and requirement to provide culturally and linguistically appropriate notices will be met.

Moreover, the Departments also explain that the original 10% threshold was based on the Medicare Part C and D marketing regulation. Interestingly, the regulation has since been changed as of April 15, 2011 to a 5% threshold to trigger translation of vital documents.[4] The 5% threshold is also used in the DOJ and DHHS LEP Guidances

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[2] *See* http://www.lep.gov/guidance/guidance_index.html.
[3] 29 CFR 2520.102-2(c).
[4] 76 Fed. Reg. 21432, 21559-60 (April 15, 2011). *See also,* Id. at 21512-13.

as well.[5] Therefore, while we agree that there should be a single threshold for both the group and individual markets, we strongly recommend that the final regulations follow the DOL regulations and the DOJ and DHHS LEP Guidance as models for a combined threshold of 5% of all plan members who are non-English speaking language population or 500 non-English speaking members in the plan, whichever is less, for those plans with 100 or more plan participants for both the group and individual market.

Third, although we agree that each notice sent by a plan or issuer must include a one-sentence statement about the availability of language services, we do not believe that it should only be provided in the relevant non-English languages or only to an address in a county that meets the threshold since we believe the revised thresholds using county numbers cover too few LEP individuals. As pointed out earlier, oral interpreter services must be provided to any LEP person and by limiting it to the proposed thresholds, only four languages in the entire United States would be covered. This cannot realistically meet the cultural and linguistic needs of the majority of LEP plan participants.

Therefore, we strongly believe that the Departments should require plans and insurers to provide taglines in at least 15 languages in all notices, informing LEP enrollees of how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway,[6] translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish.[7] SSA's translations include documents specifically focusing on appeals, including "The Appeals Process," "Your Right to Question the Decision on Your Claim," and "Your Right to Representation." CMS' planned translations include "Notice of Denial of Payment," "Notice of Denial of Medical Coverage," "Notice of Medicare Non-Coverage," "Notice of Denial of Medicare Prescription Drug Coverage," and "Detailed Explanation of Non-Coverage." The notice with 15 taglines should be a requirement regardless of whether a translation threshold is met, again to ensure that enrollees are informed about how to obtain assistance when questions or issues arise.

As noted in the comments, SB 853 requires all plans in the California to develop and maintain a comprehensive Language Access Program. Over 100 plans that operate in California are already required to issue these notices and have adapted to this. In fact, the California Department of Managed Health Care developed a sample notice for use by any plan in 13 languages with the tagline:

> "**IMPORTANT**: You can get an interpreter at no cost to talk to your doctor or health plan. To get an interpreter or to ask about written information in (your language), first call your health plan's phone number at 1-XXX-XXX-XXXX. Someone who speaks (your language) can help you. If you need more help, call the HMO Help Center at 1-888-466-2219."[8]

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[5] 68 Fed. Reg. 47311, 47319 (Aug. 8, 2003) at: http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.pdf.

[6] http://www.ssa.gov/multilanguage.

[7] http://www.cms.gov/EEOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf.

[8] http://www.hmohelp.ca.gov/library/reports/news/snla.pdf.

The California Department of Insurance also has similar requirements to establish Language Access Programs and offers a sample notice with the following tagline in 13 languages:

> "No Cost Language Services. You can get an interpreter and get documents read to you in your language. For help, call us at the number listed on your ID card or xxx-xxx-xxxx. For more help, call the CA Department of Insurance at xxx-xxx-xxxx."

As explained above, the California agencies translated the sample notices for health plans and insurers to use, which helped reduce overall costs to the plans and insurers. Taglines by themselves are an effective and cost-efficient manner of informing LEP individuals and will help assist plans in determining which languages additional materials should be provided. There are also other creative ways to provide this important information, such as putting taglines in the most prevalent languages on the envelope itself to bring attention to the importance of the notice. It is also very important that those taglines be accompanied by an English version so that individuals have a record of communication and may be able to obtain information from advocates or others about its content. Providing oral information or a tagline is insufficient to meet the notice requirements.

Fourth, regarding the removal of the "tagging and tracking requirement," we strongly believe that it is critically important that the plans and insurers have a mechanism to systematically provide notices to LEP members to avoid repeated mistakes of sending notices in English and placing the burden on the LEP member to constantly request a translated notice. Although there may be initial start-up costs to adapt the information technology (IT) system, there are no additional costs to maintain the information n the IT system. In fact, there will be cost savings in staff time by avoiding re-sending of notices, responding to inquires, and possible mistakes with legal consequences. Therefore, we recommend that the Departments reinstate the requirement from the initial interim final regulations: "Once a request has been made by a claimant, provide all subsequent notices to the claimant in the non-English language." For many reasons, plans should be collecting data on their enrollees' language needs to ensure services are available and to provide culturally and linguistically appropriate information. A common practice to develop demographic profiles of their members is for health plans to send enrollees a Language Assistance Survey to gather data on his or her language needs. This can easily be done by group health insurers as well when they receive new members as part of a "welcome packet" explaining benefits. Once an LEP enrollee identifies his language needs, the plan should record and track this information, and not require the enrollee to continue to request information in that language.

Finally, we want to address the issue that some health plans and insurers raised about the cost of compliance for the implementation of SB 853 by referring to the "high cost[s] associated with implementing translation requirements pursuant to California State law and the low take-up rates of translated materials in California." SB 853 was passed because LEP members needed access to culturally and linguistically appropriate services from their health plans and insurers. There was much testimony provided to document the need and the Director of the Department of Managed Health Care, Cindy Ehnes, recognized and publicly acknowledged the importance of these requirements after she heard overwhelming testimony from LEP consumers at hearings held across the state.

From the comments by the health plans, it is unclear what the actual costs of translation of materials are in relation to the total costs of implementing a comprehensive Language Assistance Program under SB 853. It involves many more requirements, similar to the requirements under the DHHS LEP Guidance. SB 853's language assistance requirements are much broader than what is being proposed in these regulations. California health plans must provide written translations of numerous "vital documents", including, applications, consent forms, letters containing important information regarding eligibility and participation criteria, notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal and notices advising LEP enrollees of the availability of free language assistance and other outreach materials, the explanation of benefits (EOB) or similar claim processing information if the document requires a response, specified portions of the plan's disclosure forms regarding the principal benefits, and coverage, exclusions, limitations, and cost-sharing requirements.

However, these federal regulations only pertain to the translation of notices related to adverse benefit determinations, appeals and external review, and therefore is only a fraction of the number of documents that must be translated under SB 853. So when health plans refer to the costs associated with the implementation of the California Language Assistance Program, they are referring to a much more encompassing program that includes costs far beyond the scope of these regulations. Additionally, the thresholds in SB 853 are much lower than the thresholds in these federal regulations and probably cover more languages: 1) for plans with over 1,000,000 members, vital documents must be translated in the top two languages plus those languages that meet .75% or 15,000 LEP enrollees/insureds, whichever is less; 2) for those plans with 300,000-1,000,000 members, vital documents must be translated into the top one language plus any additional languages that meet 1% or 6,000 LEP enrollees/insureds, whichever is less; and 3) for plans that are below 300,000, vital documents must be translated for the languages that meet 5% or 3,000 LEP enrollees/insureds, whichever is less. Therefore, California plans have to translate both a much larger number of documents as well as into a greater number of languages. Thus the figures that the plans claim to spend for translation of notices is greatly exaggerated and the costs of complying with SB 853 is not a good measure to estimate the costs of complying with the interim final regulations, which only focus on the limited translation of notices of appeals and external review into far fewer languages.

Moreover, since SB 853 was not fully in effect until 2009, the costs identified by California plans include start-up costs to develop their Language Assistance Program. Once initial costs are spent, such as the initial translation of uniform notices, the costs are spread out over time. In fact, now that over 100 plans, many of which operate across the country as well as California, have invested in the necessary infrastructure, including implementing "tag and track" IT systems since they must collect language data on enrollees, as well as translation of these kinds of notices, it should be easier and involve much lower costs to comply with the federal regulations. Also, as explained above, the California Department of Managed Health Care translated taglines for health plans to save costs, and we recommend that the federal Departments do the same. It not only reduces the costs to the plans but also ensures the use of uniform culturally and linguistically appropriate notices.

One last issue to address is the California health plans reference to "low take-up rates" of translated materials in their comments to the July 2010 regulations. There could be several reasons for the alleged low rate. The law is relatively new and many people do not know they have a right to translated materials and therefore do not ask for them, We know from our work on educating consumers about their right to language assistance services that it takes a long time for a "culture change" to occur where people realize that they have a right to an interpreter or translated materials. For example, Title VI of the 1964 Civil Rights Act has been in effect for 47 years and many beneficiaries in the Medicaid Program, Children's Health Insurance Program, and Medicare Program still do not realize that they have a right to language assistance services. So it is not surprising that many people do not understand their rights under SB 853, which has been in effect for a little more than two years.

It is also unclear which materials the health plans are referring to when they claim the low take-up rate since they are required to translate an extensive list of "vital documents" as noted above. We also know that not all California health plans are complying with the state law language access requirements, as a California report shows deficiencies by health plans in advising enrollees of language assistance and includes a list of the number of complaints recorded.[9] There may be actually be more complaints than those listed in the report since if a plan is not providing enrollees with the proper notice in their language, they may not know that they can call the HMO helpline to file a complaint. Also, the number of complaints categorized as those based on language barriers may not truly reflect the total number of possible language access complaints because they may be masked by quality of care complaints. They may be mis-categorized under communication problems with the provider or other quality of care issues, rather than one based on language barriers.

Thank you for the opportunity to submit our comments to the interim final regulations for group health plans and health insurance issuers relating to internal claims and appeals and external review processes. Please do not hesitate to contact Doreena Wong at (213) 241-0271 if you have any questions.

Sincerely,

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