To Whom It May Concern:

I am writing to comment on the July 2011 amendment to the interim final regulations which had been promulgated jointly by the CMS, IRS and the DOL's Employee Benefits Security Administration (EBSA) in June 2010. These regulations govern language access during internal claims and appeals and external review processes for private group health plans and health insurance issuers. 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. The three areas affected by the amendments being contemplated are:

1. **Written translations for group health plans**:
The threshold for determining whether translation of vital documents is required is:
2011: **10%** of ***county population*** for group health plans.
2010: **10%** of ***plan participants*** in a given language or **500** persons, whichever is less; where a group plan has less than **100** participants, **25%** was used.

2. **Written translations for individual plans:**
The threshold for determining whether translation of vital documents is required is:
2011: **10%** of ***county population***.
2010: **10%** (had been set based on the Medicare Part C and D marketing regulation and was changed to **5%** since 4/15/2011, as a result of comments submitted against the **10**%)

3. **Oral interpretation:**
Although it has been well settled that civil rights law mandates that oral interpretation should be provided in the health and health insurance contexts for all languages, the proposed regulations set a new precedent and require oral interpretation ONLY in the languages that meet the ***10% county population threshold.***

At the time of publication of this amendment, only 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 in five states (specifically, Alaska, Arizona, California, New Mexico, and Utah).

The new proposed standards completely fail to recognize the needs of the approximately 12 million Limited English Proficient (LEP) individuals in the United States that are estimated to be affected by these regulations. Many of these individuals may receive marketing materials and calls in their primary languages, but will not be able to access plan review and appeals under the new rules. Even Spanish speakers will be left out in most of the country, as only 172 counties meet the 10% county population threshold for Spanish (out of 3,143 counties in the United States). Besides Spanish, the new proposed translation threshold is met by Navajo in three counties (one county each in AZ, NM and UT), Tagalog in two counties (both in AK), and Chinese in one county (CA). Only 177 counties would require translated materials. Only one county in the entire nation would have translations in more than one language: the Aleutians West Census Area (population of 5,505 total persons) would have Spanish and Tagalog translations.

The threshold percentage of people who are literate only in the same non-English language is determined on the basis of the American Community Survey data published by the United States Census Bureau. However, this data may not truly reflect the linguistic diversity and extent of LEP speakers whose access to medical care depends on adequate language access. Below is the only language-related question that is used to determine literacy on this survey:

14 a. Does this person speak a language other than English at home?
Yes
No. *SKIP to question 15a*
b. What is this language?

_____
For example: Korean, Italian, Spanish, Vietnamese
c. How well does this person speak English?
Very well
Well
Not well
Not at all

The 10% standard is far too high. A more appropriate standard would be "5% of the plan's population or 500 persons in the plan's service area, whichever is less" for large group plans, and 25% of the population for small plans. Oral interpretation should be provided in all languages at all times.

Although it is understood that nothing in these amended 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, it is also expected that recipients be required to take ***reasonable*** steps to ensure meaningful access to their programs and activities by LEP persons. Relaxing the regulations governing linguistic access will be counterproductive and conducive to less than desirable outcomes for patients who are not able to fully communicate in English with their plans and providers.

A particularly troublesome aspect of this change is that the threshold for the provision of oral interpretation will leave out many LEP speakers who rely on a human voice to navigate through the system because they cannot read at all, or because their reading comprehension of English may be even more limited than their spoken skills. One must take into consideration the legal ramifications of a medically adverse result due to improper or absent language access.

I appeal to you to review these amendments and trust that the same institutions that see fit to reach out to consumers in multiple languages in their promotional materials also see the benefits of reaching out to the majority of those they intend to service in a way that is inclusive, responsive and responsible.

Best regards,

Laura K.T. Schriver

President and CEO
Language Services Associates