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National Advocates for Asian American, Native Hawaiian & Pacific Islander Health

October 20, 2011

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
United States Department of Labor
200 Constitution Ave., NW
Washington, DC 20210

Re: Summary of Benefits and Coverage and the Uniform Glossary (RIN 1210-AB52)

To Whom It May Concern:

The Asian & Pacific Islander American Health Forum (APIAHF) thanks the Departments of Treasury, Labor and Health and Human Services (Departments) for the opportunity to comment on the Summary of Benefits and Coverage and the Uniform Glossary (Proposed Rule). The Proposed Rule, addressing the substance and structure of the Summary of Benefits and Coverage (SBC) and Uniform Glossary, will help ensure consumers are able to understand their benefits and coverage options and compare plans.

For 25 years, APIAHF has dedicated itself to improving the health and well-being of Asian American, Native Hawaiian and Pacific Islander communities (AA and NHPI). Asian American and Pacific Islander communities are overwhelmingly immigrant; over 60 percent of Asian Americans and 30 percent of Pacific Islanders living in the U.S. are foreign-born, representing the full spectrum of immigration status categories. Asian Americans, Native Hawaiians and Pacific Islanders trace their heritage to more than 50 countries and speak more than 100 different languages. Data from the Census Bureau's American Community Survey reveal that more than 9 million people in the United States speak Asian and Pacific Island languages at home and more than 4 million of them are considered "limited English proficient," meaning they speak English less than "very well" or not at all.[i] According to an estimate of the projected 2019 Exchange population conducted by the Kaiser Family Foundation, approximately one in four Exchange enrollees will speak a language other than English at home.[ii]

Linguistic and cultural barriers prevent many in these populations from accessing health coverage or attaining quality health care. Language barriers are widely known to reduce rates in enrollment and lower the quality and effectiveness of prevention, treatment and patient education programs.[iii] Poor communication between providers and patients can also lead to medical errors that are dangerous to patients and cost the U.S. health care system more than $69 billion every year. The need to address language barriers is so important that it continues to be a top priority of many HHS strategic plans and initiatives—such as the HHS National Partnership for Action and the CLAS Enhancement Initiative—and many hospitals, health plans, and private physician offices have voluntarily adopted language access practices in an effort to increase patient safety and improve quality.[iv]

For these reasons, we support the Departments' efforts in ensuring all consumers are

able to understand their benefits and coverage options. In addition, we urge the Departments to consider the following modifications and additions around language access to the Proposed Rule.

Language Access in the Summary of Benefits and Coverage

The Affordable Care Act (ACA) includes a number of provisions that seek to reduce language barriers and enhance an individual's ability to communicate, shop for, enroll and maintain health insurance coverage and services.

To ensure LEP persons have meaningful access to federally funded services and programs, Section1331 of the ACA requires all notices provided by health plan issuers be written in "plain language," which includes presenting materials in a culturally and linguistically appropriate manner. Similarly, Section 2715(b)(2) of the Public Health Service Act (PHSA), as added by the ACA, requires all information provided in the SBC be presented in a "culturally and linguistically appropriate manner." In the preamble to the SBC rules regarding language access, the Departments note that "nothing in the proposed 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 prohibits recipients of federal financial assistance from discriminating on the basis of race, color or national origin, and requires recipients to take "reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons." In addition, Section 1557 of the ACA reinforces and expands the non-discrimination protections in Title VI by prohibiting discrimination in any federally conducted program, activity or entity that receives federal funding or financial assistance on the grounds of race, color, national origin, gender and disability. Because every health plan that participates in an Exchange will receive federal financial assistance, APIAHF believes that these plans must provide information and services that are culturally and linguistically appropriate regardless of the SBC or appeal rules. We feel that the SBC is one of the most basic and vital documents that will be issued by a plan. To provide anything less than what is already required of other recipients of federal financial assistance would undermine the intent of Title VI, Section 1557 of the ACA and Section 2715 of the PHSA for culturally and linguistically appropriate services.

Written Translations

Under the Proposed Rule, a plan or issuer can satisfy these language access requirements if they translate written materials into languages spoken by *10 percent or more of the population residing in the consumer's county*. In addition, under the Proposed Rule, plans or issuers must also provide English versions of the SBC that disclose the availability of language services in the relevant language in those same counties.

As language access advocates, we are deeply concerned about the proposed 10% threshold for translation. Under this standard, many LEP consumers will be unable to understand their benefits and coverage options and compare plans, as they will not be able to access SBCs in a language they can understand.

The proposed threshold's reliance on the population in a *county*, rather than the

percentage of persons in a *plan* is the wrong metric for determining compliance with federal nondiscrimination law. By focusing on the percentage of a county, the proposed threshold fails to consider the disproportionate language assistance needs of most populations. Under the proposed threshold, very few counties in the United States will meet the 10% threshold for translation. For example, California's federal district 9 (encompassing a portion of Alameda county) is 8 percent Chinese, over half of whom are LEP, yet Chinese plan enrollees in this county would not be able to receive translated SBC materials.[v] Moreover, the 10 percent threshold is so high that even Spanish speakers would be left without translated materials as only about 172 counties, out of the over 3,000 in the United States, would meet the threshold. Similarly, only one county in the U.S. would meet the threshold for Chinese.

The population in a county metric also fails to consider the fact that due to differences in marketing, plan enrollee demographics may not be the same as those in a particular county. For example, some plans may specifically market in particular regions of a state, while other plans may operate nationally. Therefore, we strongly urge the Departments to set the threshold requirement for the translation of written materials on the basis of the percentage of LEP persons in a *plan* and not a *county* to ensure the needs of LEP persons in each plan are met.

In addition, the Proposed Rule does not include a *numeric* threshold for plans to require translation, and instead focuses only on a *percentage* threshold. Omitting a numeric threshold creates a standard that is out of step with both Department of Labor (DOL) regulations and Department of Justice (DOJ)/HHS guidance, which recognizes the need for both numeric and percentage thresholds for translating written documents. The lack of a numeric threshold for translating notices in the Proposed Rule weakens, not strengthens, the standard that was in place before the enactment of the ACA.

For these reasons, we strongly recommend the Departments substitute the 10% threshold with the following:

> Plans must provide translated SBCs in any language that is spoken by more than **5% of the population in a plan, or 500 LEP individuals in the plan**, whichever is lower.

The 5% threshold is utilized in both the Department of Justice and HHS LEP Guidance's, CMS Language Access Strategic Plan, as well as recently revised regulations from CMS governing marketing by Medicare Part C & D plans. The numeric 500 LEP individuals threshold reflects current DOL regulations.

Additionally, plans should be required to collect data on its LEP enrollees and provide translated notices for LEP consumers once a consumer has requested materials in another language. Collecting data on the language needs of their enrollees helps ensure good customer service and allows plans to provide services that are culturally and linguistically appropriate.

<u>Oral Interpretation</u>
Oral interpretation services should be provided to all LEP individuals and not subject to any threshold. Indeed, it is difficult to imagine how the Departments can

meet the statutory requirement in Section 2715 to provide the SBC in a culturally and linguistically appropriate manner if plans can ignore the most basic communication needs of LEP individuals. Federal law requires entities subject to Title VI, and by extension, Section 1557 of the ACA, to provide oral interpretation services to every individual, regardless of whether thresholds to provide written materials are met.[vi] The Proposed Rule is silent on the issue of oral assistance, therefore we urge the Departments to ensure that oral interpretation is provided to all LEP enrollees. We also strongly encourage the Departments to reference the protections in Section1557 to ensure plans provide meaningful access to care for LEP individuals.

The Departments should also require that, once an LEP consumer has requested materials translated into their spoken language or requested other language services, plan issuers track and record the request to prevent the consumer from having to make repeated requests for assistance.

Marketing and Costs

Some plans specifically market and outreach to certain communities and populations. As such, we recommend the Departments require that where a plan specifically conducts marketing and outreach activities to a particular ethnic/cultural/language group, the plan is required to provide language services to that same group that it markets to. This requirement should be in addition to meeting the minimum threshold requirement recommended above.

Lastly, we understand there will be costs (initial and recurring) associated with complying with the 5% threshold. We support the comments offered by the National Health Law Program that conclude that many costs associated with compliance will be initial and non-recurring. In addition, we offer cost-effective recommendations specifically tailored to the sample SBC provided in the Proposed Rule.

Language Access in the Sample Summary of Benefits and Coverage Examples

The manner in which information is presented in the SBC and Coverage Examples will strongly influence the participation of individuals from diverse cultures and their ability to understand benefits and compare plans. Information contained in the SBC should be presented in a "user friendly" manner, geared toward a fourth to sixth-grade reading level or below and be linguistically and culturally accessible.

One way plan issuers can ensure SBCs are linguistically and culturally accessible is to include a short tagline informing customers of their right to language services and how to access such services. A language services tagline can be added to the "Questions" tagline currently included in the NAIC model SBC. For example, the NAIC model can be modified to read:

> **Questions:** Call 1-800-XXX-XXXX or visit www.insurancecompany.com.
> **No cost language services**: You can get an interpreter and get documents read to you in your language. For help, call 1-800-XXX-XXXX.[vii]
> If you aren't clear about any of the terms used in this form, see the Glossary at www.insuranceterms.gov.

We urge the Departments to require plans to provide these in-language taglines in at least 15 languages in the SBC and Uniform Glossary. Taglines should be provided regardless of whether the threshold for translation is met in a given plan. Notably, the Social Secuirty Administration regularly translates its materials in 15 languages and can serve as a model. Using taglines is also a cost-effective method of informing LEP enrollees of the availability of language services, and most plans will only incur a one-time initial cost for providing the taglines. Plan issuers can further streamline costs by collaborating with HHS to develop standardized tagline language and translations to be used across all informational materials. Having a standardized tagline in all required applications, forms, and notices will help LEP individuals begin to recognize the standardized language.

It should be noted, however, that taglines alone are insufficient to meet the requirement of providing enrollees with SBCs. Taglines must be accompanied by an English language SBC to track communication and help consumers obtain information from advocates or others about its content.

Finally, we strongly encourage the Departments to prohibit the use of "machine translations" to develop translated materials. Translations that are generated through a computer program are often inaccurate and fail to produce competent and culturally appropriate translations.

Conclusion

In summary, the proposed 10% threshold shuts out most LEP individuals from the right to receive documents that they can use and understand. The Proposed Rule is inconsistent with Title VI of the Civil Rights Act and out of step with other HHS regulations, including HHS Title VI guidance, DOJ Title VI guidance and the Title VI guidance of other agencies. We recommend the Departments abandon the proposed threshold and adopt regulations that further the intent of Title VI and the ACA. We appreciate the opportunity to comment on the Proposed Rule and welcome future opportunities to work together.

Respectfully,

Kathy Lim Ko
President & CEO
Asian & Pacific Islander American Health Forum

and the following organizations:

Asian Pacific Partners for Empowerment, Advocacy and Leadership
Asian Pacific Community in Action
Asian Services in Action
Coalition for Asian American Children & Families

MQVN Community Development Corporation
National Asian Pacific American Women's Forum
National Asian Pacific American Families Against Substance Abuse
National Tongan American Society
Project CHARGE
Southeast Asia Resource Action Center
Vietnamese American Young Leaders Association of New Orleans

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[i] U.S. Census Bureau, 2010American Community Survey 1-Year Estimates.
[ii] Kaiser Family Foundation, "A Profile of Health Insurance Exchange Enrollees" (March 2011). Available at http://www.kff.org/healthreform/upload/8147.pdf.
[iii] *See* Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health (2002).
[iv] *See* "Hospitals, Language, and Culture: A Snapshot of the Nation," The Joint Commission (2007). Available at http://www.jointcommission.org/assets/1/6/hlc_paper.pdf.
See also Mara Youdelman and Jan Perkins, National Health Law Program, "Providing Language Services in Small Health Care Provider Settings: Examples From the Field" (April 2005). Available at http://www.commonwealthfund.org/usr_doc/810_Youdelman_providing_language_services.pdf.
[v] "California Speaks: Language Diversity and English Proficiency by Legislative District," Asian Pacific American Legal Center and Asian & Pacific Islander American Health Forum. Available at http://www.apiahf.org/index.php/component/content/article/332.html.
[vi] Title VI of the Civil Rights Act of 1964, amended as 42 USC § 2000d.
[vii] The following example is provided by the National Health Law Program (NHeLP) and currently being used by insurance issuers in California.