July 25, 2011

Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Department of Health and Human Services

Re: Group Health Plans and Health Insurance Issuers: Internal Claims and Appeals and External Review Processes, EBSA-2010-0019-0002

On behalf of Kentucky Equal Justice Center, we wish to comment on the proposed 10% threshold for translation and oral interpretation of private plan materials in the internal review and appeals context. KEJC is a state-wide, civil legal services organization that works closely with legal services programs across Kentucky. We represent the interests of low-income individuals in Kentucky on many issues, including the right to access high-quality health care. We serve many limited English proficiency (LEP) clients and know first-hand the importance or oral interpretation and written translation in health services.

According to the American Community Survey, 19.6% of U.S. residents five years of age or older speak a primary language other than English at home.[1] This statistic reflects the need for high quality, free language services. Studies have shown that language barriers are associated with decreased access to primary and preventive care, limit patient comprehension, decrease patient adherence, and lower patient satisfaction.[2] A systematic review revealed that the use of professional medical interpreter services and bilingual providers can improve communication, satisfaction, and adherence among LEP patients.[3]

We do not want to see the country go backwards in health care for LEP residents. As written, this regulation would do just that. In 2000, President Clinton issued Executive Order 13166, which required healthcare providers who are recipients of federal financial assistance to "take reasonable steps to ensure meaningful access" to their LEP patients.[4] Additionally, subsequent guidance from the Department of Health and Human Services reaffirmed federal commitment to increased health care access for LEP consumers.[5]

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[1] Available at: http://factfinder.census.gov/servlet/ACSSAFFFacts?_event=&geo_id=01000US&_geoContext=01000US%7C04000US21&_street=&_county=&_cityTown=&_state=04000US21&_zip=&_lang=en&_sse=on&ActiveGeoDiv=&_useEV=&pctxt=fph&pgsl=040&_submenuId=factsheet_1&ds_name=ACS_2009_5YR_SAFF&_ci_nbr=null&qr_name=null&reg=null%3Anull&_keyword=&_industry=

[2] See, e.g., Wilson E, Chen AH, Grumbach K, et al. "Effects of limited English proficiency and physician language on health care comprehension." *J Gen Intern Med* 2005 Sep; 20(9): 800-6.

[3] Flores G. "The impact of medical interpreter services on the quality of health care: A systematic review." *Med Care Res Rev* 2005; 62:255-99.

[4] Department of Justice, Limited English Proficiency Access Plan, Executive Order 13166, 65 CFR § 159 (2000).

[5] U.S. Department of Health and Human Services, Office of Civil Rights. Guidance to federal financial assistance recipients regarding Title VI prohibition against national origin discrimination affecting limited English proficient persons [68 CFR § 153]. 2003 Dec; available at: http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/policyguidancedocument.html.

Across the nation, although the number of LEP patients is high, healthcare consumers are spread out over many states and counties. In Kentucky, for example, there are no counties in which any language distinct group's numbers surpass 10% of the population. However, according to the 2010 census, the Hispanic/Latino population increased 112% in the previous ten years,[6] and 5.6% of Fayette County residents speak Spanish at home.[7] Under the proposed regulation, there would be no mandated services in any language other than English in Kentucky. While cost and efficiency is certainly important, the proposed 10% threshold is much too high.

Based on our experience with LEP communities, we would like to propose the following changes to the regulation:

- Oral interpretation should be provided in the health and health insurance contexts for all plan members in all languages. This has been the standard for many years and is necessary for nondiscriminatory, quality health care. The existence of effective "language lines" makes interpretative in any language possible, regardless of location.

- The threshold for written translation in large group health plans should be 5% of the plan's total population or 500 persons in the plan's service area. For small group plans, the threshold should be 25% of the plan's total population.

We believe that these changes would make the regulation stronger, more effective, and more likely to achieve the goals of the Affordable Care Act. Thank you for the opportunity to comment on this important regulation. Please feel free contact us at (859) 233-0323 for more information

Sincerely,
Anne Hadreas, Health Law Fellow
Richard Seckel, Director
Anne Marie Regan, Senior Staff Attorney

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[6] "Two Kentuckys: Cities grow while rural areas decline, Census shows," Lexington Herald-Leader, Mar 18, 2011; available at: http://www.kentucky.com/2011/03/18/1674369/kentuckys-urban-areas-growing.html.
[7] American Community Survey; available at: http://factfinder.census.gov/servlet/ADPTable?_bm=y&-geo_id=05000US21067&-qr_name=ACS_2009_5YR_G00_DP5YR2&-context=adp&-ds_name=&-tree_id=5309&-_lang=en&-redoLog=false&-format=