

July 25, 2011

Submitted Electronically

To: CMS/Department of Health and Human Services

EBSA/Department of Labor

IRS/Department of Treasury

Re: Department of Health and Human Services File Code CMS-9993-IFC2; Department of Labor File Code RIN 1210-AB45; Department of Treasury REG-125592-10

The National Senior Citizens Law Center, a non-profit organization whose principal mission is to protect the rights of low-income older adults, submits these comments with respect to the above referenced “Amendment to interim final rules with request for comments” relating to “Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes.” These comments are limited to issues related to language access.

We believe that the proposals in these Interim Final Rules (IFR) relating to language access are significantly flawed and fail to acknowledge and provide for the needs of limited English proficient (LEP) individuals in the manner and spirit called for under the Affordable Care Act (ACA) and civil rights laws. The importance of linguistic access for this population is extremely high. Effective communication about appeal rights is foundational to access to health benefits.

We call upon the Department of the Treasury, the Department of Health and Human Services, and the Department of Labor (hereafter “Departments”) to improve significantly upon the IFR prior to finalizing them.

The Departments acknowledge in the IFR that they estimate that there are about 12 million individuals living in the counties covered by the regulations who are non-literate in English, and has used a rough estimate to propose that some significant proportion of these individuals are LEP persons in affected private plans. Because the methodology for calculating the LEP persons is quite rough, and because LEP individuals are difficult to catch in the Census data collection process, a considerable undercount is likely.<sup>1</sup> After

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<sup>1</sup> That LEP individuals are undercounted by the Census has been documented and has been recognized by the Federal Government. See, e.g., “Implementing the Department of Transportation’s Policy Guidance Concerning

acknowledging that large numbers of individuals – perhaps seven million - would benefit from language assistance, the Departments have then proceeded to *decrease* access for this population. The standards adopted in the first iteration of the IFR for written translation and oral communication thresholds have now been greatly restricted –reducing the provision of assistance to a relatively small proportion of those who would have benefited from the original proposal.<sup>2</sup>

We believe that these actions fail to meet the statutory intent of the requirement of Section 1001 of the Affordable Care Act that an appeals process include notices to enrollees that are provided “in a culturally and linguistically appropriate manner.” Congress, in passing the ACA and including this provision, clearly intended for plans to take specific note of cultural and linguistic needs and in so doing, to *increase*, rather than decrease, access for limited English proficient enrollees. Section 1557 of the ACA affirmatively extends existing civil rights law in prohibiting discrimination by health insurers or health plans as recipients of Federal funds, and by entities established under the ACA. Finally, Title VI of the Civil Rights Act of 1964 has well settled law, regulations and guidance relating to the prohibition on discrimination on the basis of race, color or national origin (including LEP individuals) by entities receiving federal financial assistance.

In spite of the clear statutory intent of the ACA, and the protections against discrimination of Section 1557 of the ACA and Title VI of the Civil Rights Act discussed above, the regulations as currently proposed have the impact of dramatically lessening protections for this important and vulnerable population. We therefore offer the following comments:

1. **Written Thresholds for Group Health Plans/Health Insurance Issuers:** The Departments have now set this threshold at 10% of county population, changing this from the prior, more generous standard of 10% of plan participants who speak a given language or 500, whichever is less (or 25% where a group plan has less than 100 participants). We believe that the prior standard included significant protections in line with the intended statutory meaning of the ACA:
  - a. **Revised Written Percentage Threshold to Reflect CMS Precedent:** We believe the 10% percentage threshold is simply too high. A 5% threshold for the large group plans is more appropriate and would be consistent with safe harbor provisions in Department of Justice and HHS LEP guidance<sup>3</sup>, as well as with the

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Recipients’ Responsibilities to Limited English Proficient (LEP) Persons,” p. 16, available at: [www.fta.dot.gov/documents/LEP\\_Handbook.doc](http://www.fta.dot.gov/documents/LEP_Handbook.doc).

<sup>2</sup> Under the current scenario described in the notice, only 177 counties out of the 3,143 counties (outside of Puerto Rico) in the United States would have any translation at all; and of these, only five counties would have any language other than Spanish. The Departments recognize that some large proportion, but significantly more than half of the 12 million LEP individuals are limited English proficient persons in affected plans, so it is difficult to fathom why the Departments would choose to provide access and protections for so few.

<sup>3</sup> See, [www.lep.gov/guidance/guidance\\_index.html](http://www.lep.gov/guidance/guidance_index.html).

recently revised marketing regulations finalized by the Centers for Medicare & Medicaid Services on April 15, 2011.<sup>4</sup> Those regulations govern the translation of marketing materials by private Medicare Part C and D plans. The Departments should set a percentage standard that is consistent with that recent rulemaking. As CMS found: “a 5 percent threshold that focuses on primary language would be the most appropriate approach for beneficiaries and plans.”<sup>5</sup>

- b. **Using a Count of Plan Participants is Preferable to General Population:** We believe that the original standard used by the Departments, “plan participants,” is the correct standard.<sup>6</sup> Basing the standard on general population by county, instead of plan participants fails to recognize that general population statistics may not have any relationship at all to plan participation. Plans may operate regionally or nationally or market to specific language/cultural/ethnic groups, and may have a much greater number of LEP enrollees than county statistics would warrant. A far more appropriate and equitable method would be to have plans track data on LEP enrollees and provide translated notices according to minimum thresholds for plan enrollees. This is particularly important in furthering the goal of providing culturally and linguistically appropriate processes in order to rationally use scarce resources to reduce *actual* health disparities rather than providing somewhat randomly determined linguistic access. (See, “Tracking,” below at 4.a).
- c. **Importance of Numerical Threshold:** We urge the Departments to reinstate the original numerical threshold set out in the July, 2010 IFR. Removing the numerical threshold of 500 plan members from the mix considerably dilutes the effectiveness of the language access protections in the ACA and, in fact, eviscerates the statutory provision. There is a definite need to pair numerical and percentage thresholds, and existing DOL regulations as well as HHS (and Department of Justice) guidance recognize the need for a dual standard, with percentage and threshold figures.<sup>7</sup> No numerical threshold at all, however, leaves far too many millions of persons without access to translated materials, is

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<sup>4</sup> 76 Fed. Reg. 21569, 21577.

<sup>5</sup> Id. at 21432, 21559-60. See also, Id. at 21512-13.

<sup>6</sup> We recognize that the recent CMS regulation used general population data to establish percentage thresholds. The agency noted that it did so, in part, because it did not have plan specific information available. That practical obstacle can be overcome if plans collect language preference data from their members.

<sup>7</sup> See, footnote 3, above.

inconsistent with statutory and civil rights law and creates arbitrary and illogical access distinctions for LEP individuals. For example, although there may be tens of thousands of Vietnamese speakers in Los Angeles County, translations would not be required because Vietnamese does not meet the 10% threshold. Yet translations are required in two languages in the Aleutians West Census Area, Alaska, where the total population is 5,505.<sup>8</sup> Implementation of this provision without the threshold may in fact dilute the standard to the point that language access protections are weaker than prior to the enactment of the ACA.

- d. **Smaller Group Plans:** Applying a separate standard for smaller group plans may be appropriate, if costs for those plans are a grave concern. Existing HHS and DOJ guidance provide for a four factor analysis, which includes not only the importance of a benefit to people’s lives (highly relevant here), but also the numbers of LEP persons served and the resources of the entities providing the services. Given these factors, a numerical threshold only, such as 500 persons in the plan, may be appropriate for smaller group plans.

## 2. Thresholds for Translation for Individual Market

- a. **General Thresholds:** We recommend a standard of 5% or 500 of plan participants,<sup>9</sup> whichever is lower, for individual plans as well, and incorporate the relevant provisions of the discussion above by reference (1.a-d.).
- b. **Importance of CMS Precedent for Individual Plans:** We additionally note that the Departments *expressly* based their 10% threshold for individual market “on the approach used under the Medicare Advantage program, which required translation of materials in languages spoken by more than 10% of the general population in a service area at the time that the threshold was established.” As of April 15, 2011, CMS has *changed* this very threshold from 10% to 5% of the general population in a service area. This change was made after CMS undertook a careful and deliberative process that took into account private plans’ needs and the importance of language access for health plan

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<sup>8</sup> Population statistic is from 2005-2009 ACS, available at [www.census.gov/acs](http://www.census.gov/acs).

<sup>9</sup> We recognize that the recent CMS standards used for private Medicare Part C and D plans is 5% of the plan benefit package service area, and not plan participants. However, as discussed in 1.b., above, we strongly recommend that plan enrollee information be collected and that the percentage threshold be related directly to plan participants.

beneficiaries.<sup>10</sup> The Departments should accordingly change the individual market percentage standard to a parallel 5% standard.

### 3. Oral Interpretation Standards for All Plans

- a. **Vital Importance of Oral Communication in All Languages:** Perhaps our most important request is that the Departments fully recognize that oral communication assistance, whether through competent bilingual interpreters or bilingual staff, is of paramount importance. Effective communication is a necessity in minimizing health disparities and eliminating barriers to access caused by linguistic isolation. In keeping with the requirements of Section 1001 and Section 1557 of the Affordable Care Act as well as Title VI of the Civil Rights Act, it is imperative that the Departments require oral assistance whenever an LEP beneficiary has a need relating to internal claims, or external review and appeals, regardless of language spoken and with no threshold limitations whatsoever.

It should be noted that CMS has long required interpreter assistance of private Medicare Part C and D plans. This requirement was codified in the April, 2011 regulations to ensure that there could be no misunderstanding. CMS noted “call center interpreters must be made available in virtually all languages spoken in the U.S. Fulfillment of this requirement provides a safety net in geographic areas where only a few beneficiaries speak a particular non-English language,”<sup>11</sup> and further stated “The expected benefit of our call center interpreter requirements is that all beneficiaries, regardless of language spoken, will have access to all of the information they need to make appropriate decisions about their health care to utilize their Medicare benefits most effectively.”<sup>12</sup> In finalizing this regulation, CMS explicitly did not accept limiting the provision of oral interpretation for only those speaking languages reaching a 10% threshold (whether or population or of plan membership).<sup>13</sup>

Requirements for private plans’ claims reviews and appeals processes should mirror those that CMS has set for Medicare private plans. Should a beneficiary

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<sup>10</sup> See, footnote 4, above.

<sup>11</sup> 76 Fed. Reg. at 21513 and 21502.

<sup>12</sup> Id. at 21558.

<sup>13</sup> Id. at 21502-3.

speaking a language that does not rise to the level of written translation thresholds, he or she needs oral language assistance or risk total linguistic isolation from access to health care coverage. As has already been noted in the IFR, oral translation services are already provided for nearly all covered beneficiaries and participants<sup>14</sup> – thus the marginal cost of mandating this requirement is very small.<sup>15</sup>

#### 4. Other Issues

In addition to the written threshold and oral communication issues discussed above, there are a number of subsidiary issues that the Departments should address:

- a. **Tracking:** We strongly urge the Departments to require tracking requirements for all languages. In order to have meaningful data to effectively reduce health disparities relating to linguistic access, it is important that plans and plan issuers have in place a viable mechanism to systemically track the need for notices for LEP plan participants. The current system, which provides for written notices only “upon request,” is extraordinarily burdensome for an LEP individual and may cause unfair timing delays that may result in missing claims and appeals deadlines. For access in the appeals and claims review processes to be meaningful for an LEP plan participant, the burden of providing access to translated information or oral communication must be upon the plan for all communications after an initial request is made. At that point, all notices and oral communications should be provided in that language.
- b. **Taglines:** Plans and plan issuers should be required to provide taglines in the most frequently encountered 15 languages for all notices, telling members that free interpreter services are available through plan call centers. Such notices would parallel the Social Security Administration’s practice. To encourage efficiency, the Departments should provide tagline recommended language and translations, paralleling CMS’ recently announced plans to create a 1-page model document to be included with Medicare Part C and D plan mailings.<sup>16</sup> Translated

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<sup>14</sup> Id. at 37226.

<sup>15</sup> Should there be a plan that does not currently have interpreter services, its cost may be similar to that estimated by CMS for private Medicare C& D plan sponsors, at \$9,933 per year, a nominal sum for a health plan issuer. Id. at 21547.

<sup>16</sup> 76 Fed. Reg. at 21514. CMS has indicated that it is creating a multi-lingual one-page document that plan sponsors will be required to use with all Medicare Part C and D marketing materials. This notice will inform

taglines should always include the English language version, for ease of use by those assisting the plan participants.

- c. **Provisions of Templates by Department(s):** Where possible, the Departments should plan to jointly translate templates of appropriate appeals and claims notices, so that the written translations may be standardized or harmonized, and to provide efficiencies of scale. CMS has just issued its plans to take such actions with regard to private Medicare Part C and D plan marketing materials.<sup>17</sup>
- d. **Cost Considerations for Plans:** Although the original June, 2010 IFR indicated that the costs of providing model notices would be small, the June, 2011 IFR noted comments by plans about the “high cost” associated with the translation provisions required by California law since 2009, and the low take-up rates of California users. In fact, the data provided by plans that relates to California state law is quite misleading. California state law requirements are far more thorough and comprehensive than those proposed above, appropriately so because of the high concentration of LEP health consumers in that state. Both in regard to the number of documents that must be translated (not limited to appeals and claims notices) and in the matter of thresholds (a 1% threshold is used for plans with 300,000 – 1 million members; and .75% for plans with over 1 million), California’s requirements are broader and thus more costly, and the most significant expenses should occur, of course, in the first years of implementation.

The instant IFR, in contrast, only requires that a small number of notices to be translated, and only at a higher percentage threshold (see above for a discussion of appropriate thresholds), so any projections of high expenses must be largely discounted. A much more accurate cost comparison would be to use the recent cost estimates by CMS when determining the appropriate threshold for Medicare Part C and D plan written translations. As noted at 76 Fed. Reg. 21549,

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beneficiaries that free interpreter services are available through all plan sponsors’ call centers. CMS anticipates having the document available for plan sponsors to use in 2012.

<sup>17</sup> See, Id. at 21513-14, and Memo to Medicare Advantage (MA) Organizations and Prescription Drugs Plan (PDP) Sponsors from Cynthia G. Tudor & Danielle Moon, June 15, 2011, available at [https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2012TranslatedMaterialsRequirementsFinal\\_06.15.11.pdf](https://www.cms.gov/PrescriptionDrugCovContra/Downloads/2012TranslatedMaterialsRequirementsFinal_06.15.11.pdf); and Update – Contract Year 2012 Translated Marketing Materials Requirements and Methodology from Cynthia G. Tudor and Danielle Moon, July 15, 2011, available at [https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Update2012TranslatedMaterialsRequirementsandResourcesFinalHPMSMemo\\_07.15.11.pdf](https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Update2012TranslatedMaterialsRequirementsandResourcesFinalHPMSMemo_07.15.11.pdf).

CMS' research estimated that the cost for a plan sponsor to produce 17 documents in one language for the first year would be \$18,325 (for 91,623 words); costs in subsequent years would be greatly reduced. In the Medicare Part C and D context, in fact, many of the documents now required to be translated are quite lengthy, including the Annual Notice of Change and Evidence of Coverage Documents, Enrollment Forms, and Explanations of Benefits forms that may total over 150 pages. In the claims and appeals context, the combined total pages required to be translated are likely to be considerably fewer. Therefore a comparison to the Medicare Part C and D private plan estimate is much more appropriate (and may be far too generous), than a comparison to the tens of millions of dollars that plans assert they spent to comply with California's broad state laws.

As for the take-up rate issue, it is important to note that the LEP community must be aware of their rights before they can "take-up" the information, and that the California law has only been in effect for just over 2 years, a very small period of time. Further, there have been many complaints relating to the plans' effectiveness and thoroughness in getting appropriate notices and documents to appropriate individuals, all of which may adversely impact take-up rates, particularly in the short run. Beneficiary advocates universally believe that the California law protecting LEP beneficiaries will take time to become widely known, and that 2-3 years is too short a timeframe in which to judge its efficacy.

- e. **Marketing** – If a plan or issuer markets its products to a specific language group, whether by use of written materials, bilingual salespersons or other means, it should be required to translate notices into that language, and to provide full oral communication assistance. The availability of language services should be required to be made known on all marketing and plan documents. These protections should be in addition to the matters presented above.
- f. **Requests by Plan Administrators**- The Departments have explicitly requested comment on obligations to be imposed on issuers where an administrator or sponsor of a group health plan specifically requests language services in a language that does not meet threshold requirements. As discussed above, we recommend that the standard of 5% of the plan participants, or 500 plan participants, whichever is smaller, as an appropriate and rational response for written translation. Additionally requiring written translation upon request may be a useful additional requirement, in some instances, but should not replace



the other standard. Oral translation and communication should be available for all languages spoken by LEP plan participants, no matter how few.

### **Conclusion**

In conclusion, we urge that the Departments mandate oral communication assistance for all languages, and adopt written translation threshold measurements (both percentage and numerical) that are rationally based upon the real-world needs of the seven million or more LEP individuals who rely upon private health plans. Only in so doing, can the Departments meet the statutory intent of the ACA, comply with all civil rights law provisions, and ensure that health disparities are reduced as result of this important rule-making process.

Thank you for the opportunity to submit these comments. We would be happy to provide further information. If any questions should arise, please contact Katharine Hsiao or Georgia Burke at [khsiao@nsclc.org](mailto:khsiao@nsclc.org) or [gburke@nsclc.org](mailto:gburke@nsclc.org).

Sincerely,



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