



October 21, 2011

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

Re: RIN 1210-AB52

Dear Sir/Madam:

On behalf of the California Pan-Ethnic Health Network (CPEHN), we appreciate the opportunity to share our comments with you regarding the federal regulations RIN 1210-AB52: Summary of Benefits and Coverage and the Uniform Glossary.

CPEHN's mission is to improve access to health care and eliminate health disparities by advocating for public policies and sufficient resources to address the health needs of communities of color. We organize multicultural efforts to develop and advance public policies that promote equal treatment and universal access to care.

Background

California's population is one of the most diverse in the country, with almost 60 percent comprised of communities of color and over 100 different languages spoken. More than 40 percent of Californians do not speak English at home, and an estimated six to seven million Californians are limited English proficient (LEP)¹ – meaning they speak English less than “very well.” For some populations, such as Vietnamese and Korean speakers, over 60 percent are limited English proficient, and as a result, they and other LEP individuals are faced with language and cultural barriers when seeking care. Nearly one-third of the consumers eligible for the California Health Benefit Exchange speak English less than very well.²

¹ 2007 American Community Survey.

² California Pan-Ethnic Health Network, Fact Sheet: “Equity through Implementation: Ensuring health care reform meets the diverse needs of California's communities.” Nov. 2010. Available at: <http://www.cpehn.org/pdfs/Implementing%20Reform.pdf>

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When patients are unable to communicate clearly with their health care providers, there is a risk of misdiagnoses and misunderstanding, resulting in lower quality care, and reduced adherence to medication and discharge instructions. These adverse outcomes are unacceptable. Therefore, providing interpretation and translated documents are essential to ensure limited English proficient individuals receive quality health care. Similarly, when critical materials about benefits and coverage options are not available to LEP consumers they cannot make informed decisions about their health and health care options.

Section 2715(b)(2) of the Public Health Service Act provides that the Summary of Benefits and Coverage (SBC) should be presented in a “culturally and linguistically appropriate manner.” The proposed regulations attempt to satisfy this statutory mandate by referring to a standard proposed in the rules for appeals notices pursuant to section 2719 of the ACA, which CPEHN strongly opposed. Under the Interim Final Rules for Appeals, plans in the Exchange would only be required to provide translated consumer notices to 10 percent of the population in a county and oral interpretation in only those same languages.

As currently written, the proposed regulations fail to recognize the needs of the 12 million residents in the United States that do not speak English very well. These individuals are consumers of health programs and insurance, consumers who pay premiums and receive marketing materials in their primary language; however, when it comes to ensuring the vital information they need to understand what benefits are included or excluded from their health plan, the proposed regulations fall drastically short. Without stronger language access policies, these consumers will not have access to vital benefit and coverage information that is directly linked to their quality of care. A lack of culturally and linguistically appropriate materials and interpretation will result in adverse health impacts for limited English proficient individuals in the United States.

In addition to affecting the quality of health care for LEP enrollees, plans risk violating federal laws that prohibit discriminating against individuals or groups based upon national origin. National origin, which includes one’s language, is a protected category under Title VI of the 1964 Civil Rights Act. Under Executive Order signed in 2001, entities receiving federal financial assistance are required to provide “meaningful access” to programs and services to LEP individuals. The Department of Justice (DOJ) and Health and Human Services (HHS) have determined in a guidance to their fund recipients that when five (5) percent or 1,000 persons within a service area speak a non-English language, a threshold is triggered and requires vital documents to be translated into that non-English language. Under the Patient Protection and Affordable Care Act (ACA), health plans within the exchanges will receive federal financial assistance through the tax credits administered by the Internal Revenue Services, making the health plans obligated to comply with Title VI and Section 1557 of the ACA and prohibited from engaging in discrimination based upon national origin. The proposed regulations are in direct violation of federal requirements under Title VI that individuals receive oral interpretation in any language and will create a conflict for plans to either comply with their non-discriminatory obligations under Title VI and Section 1557 of the ACA or these proposed regulations, which provide inadequate language assistance.

CPEHN's Recommendations

CPEHN recommends that the proposed regulations clarify and specify the plain language and language assistance requirements to ensure LEP consumers have meaningful access. Our comments include recommendations on how the proposed regulations can better increase access to care and provide stronger consumer protections for communities of color. Our recommendations are based upon policies and practices currently utilized by federal or state agencies to provide meaningful access to LEP individuals.

We urge all of the departments proposing these regulations, including the Department of Treasury (DOT), Employee Benefits Security Administration (EBSA), Centers for Medicaid & Medicare Services (CMS), Department of Health and Human Services (HHS), Internal Revenue Service (IRS), and Department of Labor (DOL) to revise these joint proposed regulations to adopt the following:

Adhere to plain language writing requirements. Plain writing is essential to helping individuals better understand their health coverage and is consistent with the requirement in section 2715(b)(2) that the SBC “utilizes terminology understandable by the average plan enrollee.” By October 12, 2011, agencies must write all new or substantially revise documents in plain writing.³ The SBC template HHS releases should meet the requirements of the Act. The NAIC working group that designed the recommended template for the SBC and uniform glossary, which the Departments propose for adoption, strived to meet “plain language” requirements but strongly advised that testing and assessment be done in consultation with representative consumer organizations.⁴ A review of the current SBC through *ThoughtForm* provides illuminating examples of how the SBC could be designed to be clearer.⁵

Before the Secretary authorizes the SBC and uniform glossary, the Departments should 1) contract with recognized literacy/plain writing experts to test the proposed SBC and uniform glossary templates for language, structure, and layout; 2) focus test the revised forms with the intended audience so individuals can examine and comment on the content and the presentation of the materials; and 3) make appropriate revisions to provide additional information to individuals or to improve the efficacy of the disclosures.

Revise thresholds for written documents. The proposed regulations should require large group plans to translate the summary of benefits and coverage (SBC) when five percent (5%) of the plan's population or 500 persons in a plan's service area speak a non-English language. This requirement is aligned with existing thresholds utilized in the Department of Justice (DOJ) and Health and Human Services (HHS) LEP Guidance⁶ as well as recently revised regulations from the Centers for Medicare & Medicaid Services (CMS) governing marketing by Medicare Part C & D plans. Small

³ 5 U.S.C. §(4)(b).

⁴ Letter from the National Association of Insurance Commissioners to Secretary Sebelius and Secretary Solis, Dec. 17, 2010. Available at http://www.naic.org/documents/committees_b_consumer_information_ppaca_letter_to_sebelius.pdf.

⁵ http://www.naic.org/documents/committees_b_consumer_information_110505_literacy_review.pdf.

⁶ Available at <http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php>.

group plans should be required to translate SBCs when 25 percent of the population within a small group plan speaks a language other than English.⁷ The use of a ten percent county-level threshold is not useful for determining thresholds for interpretation required by health plans for several reasons. County demographics may not be reflective of a plan's demographics because plans may be marketing to particular ethnic groups at a regional, statewide or national level and thus may have a higher number of LEP enrollees than at the county level. These county level thresholds would ignore the need to provide translation and interpretation services to the appropriate level of LEP enrollees.

Add a numeric threshold with written thresholds. As currently proposed, the regulations omit a dual threshold standard -- a percentage and a numeric threshold. By omitting the use of a numeric threshold, the standard for providing vital translations is now weaker after the enactment of the ACA than before and will provide fewer covered individuals with language assistance. The SBC is one of the most *important* documents for *all* consumers. This document will provide information to individuals about the benefits covered or excluded in their health plan, critical information allowing consumers to compare and contrast available benefits when choosing a health care plan. To ensure that LEP individuals have the necessary information they need to make informed decisions about their health care plan of choice, CPEHN recommends including a numeric threshold of 500 LEP enrollees in a health plan along with the five percent threshold. This numeric threshold is also consistent with the recently revised regulations from CMS governing marketing by Medicare Part C and D plans.

Require written translations to be competent. The Departments must ensure that translation is competent and not done through machine translation, which does not produce competent translations. "Machine translation" refers to the use of a computer program that automatically translates words from one language to another. These programs do not provide sufficiently accurate translations as they are not reviewed by an individual for context, cultural significance, or linguistic appropriateness. Therefore, plans should be prohibited from using machine translation to develop translated materials. Instead plans should be advised to utilize best practices recognized by the American Translators Association (ATA) for translating documents. ATA offers a guide called "Getting it Right" that offers advice on what to look for when evaluating translation services.⁸

Add requirements for the provision of oral interpretation. The proposed regulations **must be** revised to **require** health plans to provide oral interpretation in all languages at all times in order to be in compliance with federal anti-discrimination laws. The provision of oral interpretation is required under Title VI of the Civil Rights Act of 1964, reiterated in Section 1557 of the ACA, and by Executive Order published at 65 Fed. Reg. 50,121-22 (Aug. 16, 2000). The proposed regulations for the SBC require oral interpretation only in the same threshold languages that meet the requirement for written interpretation. This leaves millions of LEP individuals without access to assistance with oral interpretation should these individuals have questions about the SBC.

⁷ See, e.g. 7 C.F.R. § 272.4(b)(2) (2010); 28 C.F.R. § 55.6 (2010).

⁸ The guide is available at: http://www.atanet.org/publications/getting_it_right.php.

Require taglines in non-English languages. CPEHN strongly recommends that the Departments require health plans and insurers to provide taglines in at least 15 languages with the SBC to inform LEP enrollees of how to access language services. This recommendation is based upon current government practice. The Social Security Administration through its Multilanguage Gateway translates many of its documents, including a recent decision to translate Medicare forms, into 15 languages. This is also practice with some managed health care plans in California. Plans that operate in California provide notices in 12 languages about the availability of language access services. As one example, Standard Insurance Company sends an insert with all Coverage of Benefits documents that includes the following tagline:

“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.”

Taglines should be accompanied by the SBC in English to provide individuals with a record of communication and obtain information from advocates for others about its content, if available. However, only providing oral information or a tagline is insufficient to meet the requirement of providing enrollees with SBCs. Thus, a document with taglines must also include the SBC in English.

Specify subsequent materials must be in non-English languages. CPEHN recommends that the Departments require plans to provide all subsequent information in the non-English language originally requested by the LEP consumer. We respectfully request that the Departments require the plans to include the following language: “Once a request has been made by an enrollee all subsequent notices to the enrollee should be provided in the non-English language.” Once a person indicates they speak a language other than English, health plans should be tracking the request and send subsequent information to that person in their primary language. Plans should be collecting data on their enrollees’ language needs, both to ensure services are available as well as to provide culturally and linguistically appropriate information. Once an LEP enrollee identifies his language needs, the plan should track this information rather than require the enrollee to continually request information in that language, which could impact the time in which an LEP enrollee would receive translated documents. Managed health care plans and health insurers are currently required in California to assess their enrollee population, which is good standard practice for all health plans. In California, some health plans are assessing their enrollee population using surveys. For example, Standard Insurance Company sent its enrollees a Language Assistance Survey to gather data on enrollees’ language needs. This way, once an LEP enrollee has identified his language choice, the plan will automatically provide the translated document and thus avoid delays in sending information or continual burdens upon LEP individuals to request translated documents. Thus, CPEHN strongly urges the Departments to require health plans to provide subsequent documents in the non-English language, which can be obtained through accurate data collection and needs assessments of a plan’s enrollee population.

Ensure marketing material trigger translation and interpretation requirements. As some plans may undertake specific marketing and outreach activities to particular ethnic, cultural, and language groups, we also recommend that the Departments adopt a requirement that plans provide language services to any language group to which the plan specifically markets. This requirement must be in addition to the basic thresholds and would recognize that a plan should not be allowed to conduct marketing and outreach to enroll LEP members and then fail to provide language assistance for vital documents, benefits and coverage information, or health care services generally.

Thank you for the opportunity to comment on these important proposed regulations.

Sincerely,

A handwritten signature in black ink, appearing to read "Ellen Wu". The signature is fluid and cursive, with a prominent loop at the end.

Ellen Wu, MPH
Executive Director