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VIA RULEMAKING PORTAL

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: *CMS-9982-P, Summary of Benefits and Coverage
And the Uniform Glossary*

Dear Sir/Madam:

Thank you for this opportunity to comment on the notice of proposed rulemaking pertaining to the Summary of Benefits and Coverage and the Uniform Glossary (SBC).

The SBC will become perhaps the most important insurance-related document – certainly one of the most important documents – Americans will obtain. It will help them to evaluate plans, compare plans, select plans, and understand the plans they select. As such, it must be clear, readily available, and brief.

The majority of our comments relate to the language access provision of the NPRM. However, we offer a few additional remarks:

1. We disagree with the Departments' decision, reflected in paragraph (a)(1)(iii), to send only one SBC to an address where several beneficiaries are known to reside. First, if any of those beneficiaries have moved, a copy will not be forwarded to them, whereas an individual piece of mail would be forwarded if the beneficiary has changed address. Second, if only one copy is sent, addressed to one individual, the risk that the other beneficiaries in the household will not see it is quite high. Once the SBC is prepared, the cost of mailing another one or two copies is negligible. Minor children who are beneficiaries would not have to be send a copy of the SBC.
2. One of the aspects of health insurance that people frequently misunderstand is reimbursement for out-of-network benefits. For plans

offering out-of-network benefits, we would recommend that a coverage example demonstrating how the beneficiary will be reimbursed be added, along with an explanation of balance billing.

3. It would be very desirable to permit plans and issuers to input plan- or policy-specific information into a central Internet portal, such as www.healthcare.gov. This is so not only so that consumers can obtain this information readily, but also so that navigators, agents, brokers, and organizations like ours can access as much information as possible about as many plans as possible so that we can advise consumers accordingly.
4. We strongly urge the Departments to add a definition of the word "formulary" to the uniform glossary.
5. We urge the Departments to direct that the contact information for the state's consumer assistance program be included in the SBC.
6. Consumers in group plans should receive an SBC for all available plans at open enrollment, not just the plan they were in during the prior year. Once the SBC is prepared, it is not costly to provide a copy of it to each group member. Without it, consumers in group plans cannot compare their plans. Indeed, they may not fully appreciate that there are significant differences among plans. They should be given the SBC for each available plan without having to request them all.
7. The SBC should not be buried in the Summary Plan Description. The length and legalistic nature of an SPD is intimidating and many people do not read their SPD. In addition, SPDs do not always contain detailed information about coverage and cost sharing for each type of coverage. Further, when a change to a plan is made, if it is material, a new SPD is not issued; instead, the employees receive a Summary of Material Modifications. A new SBC may be required more often than a SMM. It is simpler to conceptualize the two documents separately.
8. Certificates of coverage almost never are available in small group plans. The employer is given one or two copies. Most Human Resources department do not share access to them with employees. Telling consumers in group plans to consult a certificate of coverage is entirely meaningless when those consumers do not have access to such documents.
9. Not everybody has a computer, and some people access computers in non-private settings like libraries. While it is very useful to provide documents electronically, that should not be the exclusive means of access. There should always be the option of receiving hard copies of materials.

As to language access, our comments are extensive. 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 Departments have attempted to satisfy this statutory mandate by incorporating the rules for providing appeals notices pursuant to section 2719 of the ACA

(hereinafter “appeal rules”).¹ The appeal rules provide that, in counties in which at least ten percent of the population residing in the county is literate in only the same non-English language, both translation and interpretation services must be provided upon request.² In the preamble to the SBC rules, the Departments expressly state, though, that nothing in the proposed regulations should be construed to limit rights conferred by Federal or State civil rights laws, including Title VI of the Civil Rights Act of 1964, which prohibits recipients of Federal financial assistance from discriminating on the basis of race, color, or national origin. 76 Fed. Reg. 52450 (Aug. 22, 2011). This requires recipients of Federal financial assistance to take “reasonable steps to ensure meaningful access to their programs and activities by limited English proficient persons.” *Id.*

We strongly oppose applying the same standards to this rule. The Departments propose to severely limit limited English proficient (LEP) persons’ access to arguably the most important document regarding their health insurance to which they will have access, the document that allows them to compare plans, shop for plans, and understand the terms and limitations of the plan in which they enroll. We contend not only that this is unwise, but also that it violates PHSa § 2715, Title VI and Section 1557 of the ACA.

A. Title VI and Section 1557 of the ACA Require Broader Access for LEP Individuals

Unlike the appeals rules, the proposed SBC rules expressly state that the intention is to meet the requirements of Title VI, 42 U.S.C. § 2000d *et seq.*, which prohibits discrimination by any entity receiving Federal financial assistance. In addition, Section 1557 of the ACA prohibits discrimination in any “health program or activity, any part of which is receiving Federal financial assistance, “including credits, subsidies, or contracts of insurance” Every health plan that participates in an Exchange will receive Federal financial assistance, at least in the form of advanced payment tax credits. Thus, every one of those plans is obligated under both Title VI and Section 1557 not to discriminate, and that means that they must provide culturally and linguistically appropriate services, independent of the appeal or SBC rules. Further, the language of § 2715 itself requires that the SBC be provided in a culturally and linguistically appropriate manner. We do not believe that a 10 percent threshold for translation and provision of oral language assistance would ensure the provision of culturally and linguistically appropriate services as that standard is much higher than standards currently adopted by the Departments of Justice and Health and Human Services in their “LEP Guidances” (see www.lep.gov) and the Department of Labor in its regulations governing group plans for the provision of notices of appeals.

It is well documented that language barriers affect access to health care. The Institute of Medicine has stated that:

¹ 26 C.F.R. § 54.9815-2715(a)(5); 29 C.F.R. § 2590.715-2715(a)(5); 45 C.F.R. § 147.200(a)(5).

² 26 C.F.R. § 54.9815-2719T(e); 29 C.F.R. § 2590.715-2719(e); 45 C.F.R. § 147.136(e).

Language barriers may affect the delivery of adequate care through poor exchange of information, loss of important cultural information, misunderstanding of physician instruction, poor shared decision-making, or ethical compromises (e.g., difficulty obtaining informed consent). Linguistic difficulties may also result in decreased adherence with medication regimes, poor appointment attendance, and decreased satisfaction with services.³

It is, thus, critical that consumers have access to vital information about their insurance plan in a language in which they are conversant.

The Departments acknowledge the complexity of selecting and understanding a health plan. For example, the Departments have required that a copy of the uniform glossary be made available to all individuals to whom a SBC is provided in recognition of the fact that even English-proficient consumers may have difficulty fully understanding the terms of art contained in the SBC. If insurance is complicated enough so as to require a uniform glossary even for those for whom English is not a challenge, there can be no question that understanding the SBC is likely to pose an even greater challenge to those who are LEP.

Thus, the Departments recognize the importance of the SBC as is at the crux of ensuring access as it is the most basic document that is focused on providing individuals information to understand what services are or are not covered by different plans and helping individuals make informed decisions about what plan to select. Yet somehow it is not viewed as critical for LEP individuals since the requirements to translate this document are so high that it will only be translated into Spanish for a small segment of Spanish-speakers and virtually no other languages. If this critical information is not accessible to LEP individuals, it will only further affect LEP individuals' access to care as they will be unable to make informed decisions about selecting a plan.

This is exactly the kind of discrimination that Title VI and Section 1557 are supposed to prohibit. Although the Departments have not yet issued proposed or final regulations interpreting Section 1557, the Department of Health and Human Services has, over the years, issued guidance on LEP under Title VI.⁴ This Guidance built upon Executive Order 13166, which required federal agencies to publish guidance on how their recipients can provide meaningful access to LEP persons.⁵ In that Guidance, HHS recognized that "[t]he more frequent the contact with a particular language group, the more likely that enhanced language services in that language are needed."⁶ The Guidance provided two "safe harbors" or rules recipients of Federal funds could follow and be sure they were in compliance with

³ Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health* 17 (2002)(citations omitted).

⁴ "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons," 68 Fed. Reg. 47311 (August 8, 2003).

⁵ This Executive Order was reaffirmed on June 28, 2010 and again on February 17, 2011.

⁶ 68 Fed. Reg. 47314.

Title VI: first, the HHS recipient provides written translation of vital documents for each eligible LEP language group that constitutes five percent or 1,000, whichever is less, of the population of persons eligible to be served; and second, if there are fewer than 50 people in a language group that reaches the five percent threshold, the recipient can provide written notice of the right to receive competent oral interpretation of the written materials, free of cost. If these criteria were practicable for all recipients of Federal financial assistance for more than eight years, why are they suddenly impracticable for insurers participating in an Exchange? Further, the LEP Guidance recognizes that all LEP individuals, regardless of meeting a threshold for translating written documents, must be afforded oral language assistance when needed. The proposed regulations adopt a 10 percent per county threshold for the provision of oral communication assistance, again ignoring longstanding interpretations of Title VI.

In the LEP Guidance, HHS took great pains to consider the cost of compliance to recipients of Federal financial assistance. Indeed, there was recognition that large documents such as enrollment handbooks might not have to be translated *as long as the vital information contained in such documents is translated*.⁷ Surely, a double-sided four-page SBC that contains basic plan information is both vital and short. Indeed, it may be the most vital information a consumer receives from and/or about their health plan. If HHS believes that its own LEP guidance is necessary and appropriate to implement Title VI in other contexts, those same thresholds should apply to the SBC (and to appeal notices, as well). The failure of a plan to comply with these rules violates Title VI and Section 1557 of the ACA.

B. Public Policy Concerns Militate in Favor of Stronger Rules for LEP Individuals

The adoption of a 10 percent per county threshold is not useful for determining thresholds for translation. First, as a practical matter, county demographics may not be reflective of a plan's demographics because a plan may market specifically to particular ethnic/cultural/language groups in a county, a region or nationally, or may serve employers that have high LEP populations, and thus have greater numbers of LEP enrollees than a given county in which the plan operates. We strongly believe that a plan must track data on its LEP enrollees and provide translated notices when the thresholds that we recommend below are met for plan enrollees.

Second, the appeal rules omitted a numeric threshold for plans participating in the group market and merely require translation of notices when 10% of a county's population is LEP. Again, this fails to recognize that plan demographics may differ from a county. As recognized in the appeal rules, very few counties meet the 10% threshold generally, and only 6 counties meet the threshold for any language other than Spanish. Existing DOL regulations as well as LEP Guidance from the Department of Justice as well as HHS (see http://www.lep.gov/guidance/guidance_index.html) recognizes the need for a dual standard for translating documents and includes both numeric and percentage thresholds. We believe that the statutory requirement for providing notices in a culturally and linguistically appropriate manner must have some meaning; indeed, it provides a strong rationale for enhancing current guidelines rather than weakening

⁷ 68 Fed. Reg. 47319.

them. By deleting the numeric threshold, the standard for providing translated notices is now weaker after enactment of the ACA than before and will provide fewer covered individuals with language assistance.

We, thus, recommend that the Departments adopt a combined threshold utilizing the existing DOL regulations and DOJ/HHS LEP Guidances. We suggest that the threshold should be 500 LEP individuals or 5% of a plan's enrollees, whichever is less. The 5% is utilized in both the DOJ/HHS LEP Guidances as well as recently revised regulations from the Centers for Medicare & Medicaid Services governing marketing by Medicare Part C & D plans.

Further, the Departments must ensure that the 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 to automatically translate information from one language to another. At this point in time, neither free nor commercial machine translation programs provide sufficiently accurate translations to rely upon for use with LEP patients. Thus Exchanges, OHPs, and others should be prohibited from using machine translation to develop translated materials and instead utilize best practices as 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. The Guide is available at https://www.atanet.org/docs/Getting_it_right.pdf.

As some plans may undertake specific marketing and outreach activities to particular ethnic/cultural/language groups, we also recommend that the Departments adopt a secondary requirement to provide language services to any language group to which the plan specifically markets. This must be *in addition to* the basic thresholds. This standard would recognize that a plan could not conduct marketing and outreach to enroll LEP members and then fail to provide assistance when those members need additional information.

We also strongly believe that the Department should require plans and insurers to provide taglines in at least 15 languages with the SBC, informing LEP enrollees of how to access language services. The request for 15 languages is based on existing government practice. The Social Security Administration, through its Multilanguage Gateway <<http://www.ssa.gov/multilanguage/>>, translates many of its documents into 15 languages and CMS recently announced plans to translate Medicare forms, including notices, into 15 languages in addition to Spanish <<http://www.cms.gov/EEOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>>. For example, some of the forms Medicare will be translating that involve benefit coverage include "Dialysis Facility Compare", "Medicare's Nursing Home Compare", "Medicare's Home Health Compare", "Medicare: Getting Started", "Welcome to Medicare", "Get Help With Your Medicare Costs: Getting Started".⁸ This should be a requirement regardless of whether a translation threshold is met, again to ensure that enrollees are informed

⁸ See CMS, Office of Equal Opportunity and Civil Rights, FY 10 CMS Strategic Language Access Plan Outcome Report, Appendix: Vital Documents/Forms to Translate, available at <https://www.cms.gov/EEOInfo/Downloads/AnnualLanguageAccessAssessmentOutcomeReport.pdf>.

about how to obtain assistance when questions or issues arise. Plans that operate in California are already required to do so and have adapted to this. As one example, Standard Insurance Company sends an insert with all Coverage of Benefits documentation that includes taglines. The tagline used by this insurer states:

"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 by themselves are an effective and cost-efficient manner of informing LEP individuals and will help assist plans in determining in which languages additional materials should be provided. And to reduce costs to plans, the Departments can provide tagline language and translations for plan usage if plans did not wish to develop their own.

We do want to emphasize, however, that taglines must be accompanied by an English SBC so that individuals have a record of communication and may be able to obtain information from advocates or others about its content. Providing oral information or a tagline is insufficient to meet the requirement of providing enrollees with SBCs.

We also recommend that the Departments require that, once a consumer has requested materials in another language, all subsequent communications with that consumer should be in the non-English language." For a variety of reasons, plans should be collecting data on their enrollees' language needs, both to ensure services are available as well as providing culturally and linguistically appropriate information. As one example, Standard Insurance Company recently sent enrollees a Language Assistance Survey to gather data on enrollees' language needs. Once an LEP enrollee identifies his language needs, the plan should track this information and not require the enrollee to continue to request information in that language.

Finally, we strongly believe that ***regardless of whether a plan is required to provide written translations*** of SBCs, the Department must ensure that oral assistance – through competent interpreters or bilingual staff – is provided to ***all*** LEP enrollees. The current appeal rules only require plans to provide language services when the thresholds are met. We do not believe this meets the letter or spirit of PHSA § 2715, Title VI or the nondiscrimination provision of the ACA since this would leave millions of LEP individuals without any assistance from their plans when trying to understand information about services that are and are not covered and to make an educated decision about which plan in which to enroll. It is hard to understand how the statutory requirement in PHSA § 2715 to provide the SBC in a culturally and linguistically appropriate manner is upheld if plans can ignore the most basic communication needs of LEP individuals. In addition, it has been a longstanding recognition under Title VI of the Civil Rights Act of 1964, reiterated with the enactment of the nondiscrimination provision in Section 1557 of the ACA, that oral communication with LEP enrollees must be provided to every individual, regardless of whether thresholds to provide written materials are met. Thus, no less should be required here.

C. Practical Considerations Do Not Weigh Against Language Access

The appeal rules mention that some commenters cited the “high cost associated with implementing translation requirements pursuant to California State law and the low take-up rates of translated materials in California.” We trust that they similarly would object to a broader rule pertaining to the SBC, as well. A review of the comments by California health plans to the July 2010 regulations shows that plan cost estimates are exaggerated and up-take estimates are unclear.

1. Cost of compliance

California health plans must provide written translations of numerous “vital documents,” including applications, consent forms, letters containing important information regarding eligibility and participation criteria, notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal and notices advising LEP enrollees of the availability of free language assistance and other outreach materials, the explanation of benefits (EOB) or similar claim processing information if the document requires a response, specified portions of the plan’s disclosure forms regarding the principal benefits and coverage, exclusions, limitations, and cost-sharing requirements.⁹ Here, we are concerned only with the translation of one double-sided four-page document – a minute fraction of what health plans are required to translate under California law. Thus, when health plans refer to the costs associated with the implementation of the California Language Assistance Program, they are referring to a much more comprehensive program that includes costs unrelated to the scope of the SBC rules – or even the appeal rules. Additionally, the thresholds in the CA law are much lower than the IFR – 1% for a plan with 300,000-1,000,000 members and .75% for a plan with over 1,000,000 members. Thus California plans have to translate both a wider variety of documents as well as into a greater number of languages and thus one cannot conclude that the costs of complying with CA’s law are a good comparison for complying with a more limited IFR focused on limited translation of notices of appeals and external review into fewer languages.

In addition, the costs identified by California plans include implementation costs, which are not ongoing costs, such as initial translation of the SBC. Also, the cost for California plans likely includes implementing tag and track IT systems since they must collect language data on enrollees.¹⁰ So if California plans also operate in other parts of the country they will have much smaller costs in expanding the use of this software. Finally, in California, the Department of Managed Health Care translated taglines for health plans to save costs.¹¹

⁹ See California Department of Managed Care, Comment on FR Doc # 2010-18043, Doc. ID No. HHS-OS-2010-0019-0041, Sept. 21, 2010.

¹⁰ The greatest challenge so far has been setting up and reworking existing information technology (IT) systems to support the collection and management of data on members’ primary written and spoken languages.
<http://www.ahrq.gov/populations/languageservicesbr.pdf>

¹¹ California DMHC funded and posted on its public website the translation of a language assistance notice in Spanish, Chinese (traditional), Arabic, Armenian, Khmer, Farsi, Hmong, Korean, Laotian, Russian, Tagalog, and Vietnamese. See California Department of Managed

2. Uptake estimates

When California health plans refer to “low take-up rates” of translated materials, in their comments to the July 2010 regulations, it is unclear which materials they are referring to since they are required to translate the extensive list of “vital documents” referenced above. Also, not all California health plans are complying with the state law language access requirements; a California report shows deficiencies by health plans in advising enrollees of language assistance and includes a list of the number of complaints recorded.¹² There may be actually be more complaints than those listed in the report since, if a plan is not providing enrollees with the proper notice in their language, they may not know that they can call the HMO helpline to file a complaint.

In contrast, the SBC is one document that will be provided to all prospective and actual enrollees in a plan. Near-universal take-up is fair to assume since all individuals will be required to enroll in a plan, and the SBC is the most basic and vital document describing the terms of the plan. Thus, even if we were to give credence to the claims of low take-up rates, the analogy to the SBC is inapposite and unconvincing.

3. Translation at the plan’s request

Many employers and plan sponsors know that they employ a large number of LEP workers and should be able to request translation of information, including SBCs, by health insurance issuers. If an employer or plan sponsor knows that the number of LEP workers meets the thresholds we recommend (5 percent or 500 LEP individuals in a plan), the health insurance issuer should be required to provide translated notices at the request of the employer or plan sponsor. This would help ensure the intent of the law to ensure access to the SBC in a culturally and linguistically appropriate manner without adding any additional burden on employers. Most employer and plan sponsors do not have large enough market power to negotiate the addition of a new translation practice by an issuer which is why the translation does not occur now. We expect there are many employers and plan sponsors that want the plan enrollees to receive the full benefit that is being paid for, which includes knowledge of the plan’s benefits and coverage information.

D. Recommendations and Conclusion

In sum, the SBC is one of the most vital of all documents that will be issued by a plan. To provide anything less than the same language access that is required of other recipients of Federal financial assistance would be to undermine the intent of the ACA’s requirement of linguistic and cultural appropriateness, as well as Title VI

Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at <http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

¹² California Department of Managed Care, Second Biennial Report to the Legislature on Language Assistance Second Biennial Report to the Legislature on Language Assistance (July 1, 2011), available at <http://www.hmohelp.ca.gov/library/reports/news/11rpt2legisla.pdf>.

and Section 1557's promise of non-discrimination. The rule should be amended to bring it into compliance with the HHS Guidance, at the very least.

To summarize, our specific recommendations are as follows:

1. Require plans to competently translate the SBC into any language which comprises 5 percent or 500 LEP individuals in the plan;
2. Require plans to provide oral language services – through competent bilingual staff or interpreters – for all LEP individuals with questions about the SBC; and
3. Require plans to provide taglines in 15 languages with all SBCs.

Conclusion

In our view, the SBC will be perhaps the most important document to which consumers will have access to compare and choose insurance plans, as well as to understand the plan in which they are enrolled. It is, thus, particularly important to get this right. We hope that our comments are helpful to the Departments in accomplishing that goal.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Jennifer C. Jaff". The signature is fluid and cursive, with the first name being the most prominent.

Jennifer C. Jaff, Esq.
Executive Director