



November 9, 2015

VIA ELECTRONIC SUBMISSION

Ms. Jocelyn Samuels
Director, U.S. Department of Health and Human Services Office for Civil Rights
200 Independence Ave. SW, Room 509F
Washington, DC 20201

RE: RIN 0945-AA02
Nondiscrimination in Health Plans and Activities

Dear Ms. Samuels:

Asian Americans Advancing Justice | Los Angeles (Advancing Justice | LA), the Asian & Pacific Islander American Health Forum (APIAHF), and the Association of Asian Pacific Community Health Organizations (AAPCHO) thank the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) for the opportunity to comment on the Nondiscrimination in Health Programs and Activities proposed rule implementing Section 1557 of the Patient Protection and Affordable Care Act (ACA). Our comments below focus on ensuring access to health programs and activities for all individuals, but with specific emphasis on individuals with limited English proficiency (LEP) and individuals living in families with different immigration statuses ("mixed-status families").

In August 2013, our organizations, along with Advancing Justice | AAJC, started a major national outreach effort about the ACA and created a collaborative of over 70 community-based organizations and federally-qualified health centers (FQHCs), known collectively as "Action for Health Justice" (AHJ), with the purpose of maximizing health insurance enrollment for Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPIs) and building capacity to empower community-based organizations to serve and advocate for AA and NHPI health. One of our key objectives is to track barriers to enrollment and monitor the civil rights enforcement of language access and access of eligible immigrants to ensure that national and state agencies implementing health reform are accountable to AA and NHPI communities.

During the first two ACA open enrollment periods, Action for Health Justice partners connected with nearly 850,000 individuals across 22 states to provide outreach, education, and enrollment assistance. Representatives of AHJ partner organizations connected with people in many ways, from town hall meetings to one-on-one appointments and provided assistance in over 50 languages. AHJ members utilized a variety of partnerships to do ACA outreach, including working with faith-based organizations, ethnic media, and small businesses. Through all of these interactions, language and immigration status were and continue to be some of the major barriers to enrollment for AA and NHPI communities. These proposed regulations to implement Section 1557 of the ACA are extremely important to ensure that LEP individuals and immigrants have access to health insurance coverage through the health insurance marketplaces, as well as access to health care services once they obtain coverage.

Advancing Justice | AAJC and Advancing Justice | LA are dedicated to promoting a fair and equitable society for all by working for civil and human rights and empowering AAs and NHPs and other underserved communities. We provide the growing AA and NHPI communities with multilingual support and culturally sensitive legal services, community education, and public policy and civil rights advocacy. Advancing Justice | LA also leads the Health Justice Network (HJN), a statewide collaborative of over 30 community-based organizations, health care providers, and small business associations working in California's AA and NHPI communities to conduct outreach, education, enrollment and advocacy efforts to ensure the fair and equitable implementation of health care reform in the state for our communities.

APIAHF is a national health justice organization that influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of AAs and NHPs. For 29 years, APIAHF has dedicated itself to improving the health and well-being of AA and NHPI communities living in the United States and its jurisdictions. We work on the federal, state and local levels to advance sensible policies that decrease health disparities and promote health equity.

AAPCHO is a national not-for-profit association of 35 community-based health care organizations, mostly federally qualified health centers, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of medically underserved AAs and NHPs in the United States, its territories, and its freely associated states. AAPCHO advocates for policies and programs, including research, that improve the provision of health care services that are community-driven, financially affordable, linguistically accessible, and culturally appropriate.

Incorporation of Other Comments

National Language Access Advocates Network. We support the comments submitted by the National Language Access Advocates Network (N-LAAN) on ensuring access to health programs and activities and related compliance and enforcement approaches to Title VI under Section 1557. N-LAAN is a national organization of attorneys and legal services advocates whose collective expertise on language discrimination and language rights provides the most current analysis on legal mechanisms that will best protect low-income and disadvantaged individuals with LEP.

Leadership Conference on Civil and Human Rights. We support the comments submitted by the Leadership Conference on Civil and Human Rights ("the Leadership Conference") and its Health Care Task Force on the following issues: sex discrimination (including pregnancy, gender identity, sex stereotypes, and sexual orientation); disability discrimination; types of programs and activities that should be considered health programs or activities under Section 1557; health electronic and information technology; and compliance and enforcement approaches. The Leadership Conference is a coalition charged by its diverse membership of more than 200 national organizations to promote and protect the civil and human rights of all persons in the United States.

National Health Law Program. We support the comments submitted by the National Health Law Program addressing enforcement authority, opposition to including a religious exemption to the sex discrimination provision, definition of gender identity and sex stereotypes, protection on the basis of sexual orientation.

National Immigration Law Center. We support the comments submitted by the National Immigration Law Center (NILC) addressing nondiscrimination based on national origin and for families that include immigrants.

Each of our organizations has also submitted individual organization comments, so we support the individual comments submitted by **Advancing Justice | LA**, **AAPCHO**, and **APIAHF**.

Our comments are focused on the following specific areas of the proposed rule:

1. Definition of Qualified Interpreter and Translator (§ 92.4)

2. Data Collection (§ 92.5)
3. Notices and Taglines (§ 92.8)
4. Meaningful Access for Individuals with Limited English Proficiency (§ 92.201)
5. Alternative Approaches for Providing Language Services
6. Enforcement Mechanisms (§§ 92.301-92.303)

§ 92.4 Definitions

Language Access

We strongly support codification of the definition of “Individual with limited English proficiency” as reflected in the HHS LEP Guidance. Moreover, we strongly support the requirement for and definition of a “qualified” interpreter. In addition, we strongly urge HHS to include a definition of a qualified translator in the definitions to ensure that anyone providing translation services has the requisite knowledge, skills and abilities to interpret. This goes beyond merely being bilingual. We support the detailed recommendations proposed by the Leadership Conference for the definitions of “qualified interpreter” and “qualified translator”.

§ 92.5 Assurances required (Data Collection)

OCR’s proposed rule requires an assurance of compliance with Section 1557 for all covered entities. In order to ensure full compliance, data collection on the entities served must be as granular and comprehensive as possible. In addition, proper and accurate data collection ensures that covered entities provide tailored programs and services for populations like those who are limited English proficient. As such, we strongly encourage requiring data collection to fully demonstrate compliance with Section 1557.

We strongly urge HHS to require covered entities to collect data on race, ethnicity, language, sex, gender, gender identity, sexual orientation, disability status, and age. This should also include disaggregated data by race and ethnicity, to best assess the differing needs and health issues that exist within broad racial and ethnic categories. Race and ethnicity categories should follow the categories outlined in Section 4302, rather than the aggregate categories designated by the Office of Management and Budget. In addition, data collection for race should include an open field after “Other Asian” and “Other Pacific Islander” to ensure the accuracy of self-reporting (e.g. to provide the option/ensure ethnicity data granularity for someone originally from Tonga to write as such when choosing “Other Pacific Islander,” or when someone from Bangladesh chooses “Other Asian”). To ensure collection of all possible racial and ethnic groups, an additional category for “Other Race” should be included.

We recommend that covered entities be required to assess the populations they serve and are eligible to serve, using the criteria listed above, on a regular basis. Proper data collection would ensure that entities can appropriately plan how to meet the needs of their clients and/or patients through data from their assessments. HHS needs to provide guidelines as to how to conduct an assessment, what data may be readily available, and how covered entities can access the data.

In addition the collecting data, we recommend that covered entities should also report data to HHS on a regular basis. A reporting requirement will allow HHS to ensure that covered entities are adequately collecting the specific data required by Section 1557. Reporting data to HHS can also be useful for HHS to work with covered entities to assist with conducting and improving population assessments. At a minimum, covered entities should be required to report disaggregated race, ethnic, primary oral and written language, and disability status (the Section 4302 data categories) in order to help document and track health disparities.

RECOMMENDATION: Add new subsection (d) to § 92.5 as follows

(d) Data Collection.

(i) An entity receiving Federal financial assistance to which this part applies shall, as a condition of receipt of such funds, collect and report demographic data of all of the individuals served.

(ii) An entity established under Title I of the ACA that administers a health program or activity and The Department shall collect and report demographic data of all of the individuals served.

(iii) These data shall include, at a minimum, disaggregated race, ethnicity, primary oral and written language, disability status, sex, sexual orientation, gender identity and age according to Section 4302 of the ACA.

(iv) The data received pursuant to this section shall be made publicly available upon request without personally identifiable information included.

§ 92.8 Notice requirement

1) §92.8(a)(1)

To ensure that covered entities are adequately aware of their responsibility to notify the individuals they serve and the public at large of the full scope of applicable nondiscrimination protections under § 1557, the language in § 92.8(a)(1) and the proposed Appendix to Part 92 ("Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements") must reflect the full scope of protected classes described in § 92.4.

RECOMMENDATION: We recommend that § 92.8(a)(1) be revised as follows:

- The covered entity does not discriminate on the basis of race; color; national origin, ***including primary language and immigration status***; sex, ***including pregnancy, gender identity, sex stereotypes, or sexual orientation***; age; or disability.

The Appendix to Part 92 ("Sample Notice Informing Individuals about Nondiscrimination and Accessibility Requirements") should similarly be revised as follows:

- [Name of covered entity] complies with applicable federal civil rights laws and does not discriminate on the basis of race; color; national origin, ***including primary language and immigration status***; age; disability; or sex, including ***pregnancy***, sex stereotypes, ***and gender identity, and sexual orientation***. [Name of covered entity] does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

2) Location of notices §92.8(b)

We support the alternative approach that covered entities be **required**, and not merely encouraged, to post the in-language notices in the most prevalent languages spoken by individuals with limited English proficiency in the covered entities' geographic service areas, as determined by the covered entities. As OCR notes in the NPRM, the notices serve a crucial role of educating individuals about their rights and legal obligations of covered entities and as such, outweighs the burdens of posting notices on wall space.

3) Translation of sample notices §92.8(c)

The proposed rule provides that the notice described in §92.8(a) shall be translated for covered entities by the Director in the "top 15 languages spoken by individuals with limited English proficiency nationally." Using this national standard will leave out many languages spoken by large numbers of individuals with limited English proficiency and fail to accurately ensure meaningful access.

As an alternative, we recommend that translated notices should be made available in the top 15 languages spoken by individuals with limited English proficiency in each state. Relying on state data would require translating the notice into 15 additional languages and would include languages with significant representation in certain states. For example, in Illinois, the top 15 languages spoken by limited English proficient individuals would include 5 languages (Gujarati, Serbo-Croatian, Hindi, Urdu, and Greek) that are *not* part of the top 15 languages nationally.¹ In California, Hmong is one of the top 15 languages spoken by individuals with limited English proficiency in the state, accounting for approximately 33,000 individuals. Similarly, in New Jersey, Gujarati is one of the top 15 languages spoken by individuals with limited English proficiency in the state, representing approximately 30,000 individuals. These additional languages represent significant numbers of individuals with limited English proficiency that must have access to translated notices advising them of their rights. Covered entities should be required to provide these translated notices in the top 15 languages for each state where they provide services. Adopting this standard balances being able to broaden the scope of covered languages included while ensuring a much larger proportion of limited English proficient individuals in a covered entity's service area are reached. We recommend that HHS translate the notices into the top 15 languages nationally and the additional ones generated by state data to promote consistency and use of resources. Further, we thank HHS for assuming the role of translating notices in the NPRM.

RECOMMENDATION: We recommend amending §92.8(c) to be rewritten as follows:

- For use by covered entities, the Director shall make available, electronically and in any other manner that the Director determines appropriate, the content of a sample notice that conveys the information in paragraphs (a)(1) through (7) of this section in English and in the top 15 languages spoken by individuals with limited English proficiency nationally *in each State served by the covered entity*.

4) *Taglines §92.8(d)*

As with the translated notices, we recommend that the taglines be made available in the top 15 languages spoken by limited English proficient persons by state. This would not be overly burdensome, as it would require translation into approximately 10 to 15 additional languages. For example, Hindi is not one of the top 15 languages nationally for individuals with limited English proficiency. However, when looking at state data, Hindi is one the top 15 languages in at least 7 states, including California, Texas, and Illinois—three of the most populous states in the U.S.

Further, consistent with the National Health Law Program, we believe that the proposed rule should clarify that the covered entity has the responsibility to post State-specific taglines if its service area covers more than one state. For example, a health insurance plan based in New Jersey that also operated in New York would have to post taglines for its New York consumers that included Yiddish, French, and Urdu because those languages are in the top 15 non-English languages in New York, even though they are not in New Jersey.

RECOMMENDATION: We recommend amending §92.8(d) to be rewritten as follows:

- Within 90 days of the effective date of this part, each covered entity shall post taglines in the top 15 languages spoken by individuals with limited English proficiency nationally *in each State served by the covered entity*.

¹ 2013 American Community Survey, 3-year Estimates.

5) § 92.8(f)

Consistent with our comments and recommendations for proposed rule § 92.8(b), we recommend that HHS adopt the alternative approach and require, instead of merely encourage, covered entities to post one or more of their notices in the most prevalent non-English languages frequently encountered by covered entities in their geographic region.²

RECOMMENDATION: We recommend amending proposed rule § 92.8(f)(1) as follows:

- Each covered entity shall post the English-language notice required by paragraphs (a) and (b) of this section ***in English and the 3 most prominent non-English languages encountered in the entity's geographic service area as well as*** and the taglines required by paragraph (d) of this section in a conspicuously visible font size:

6) *Location of required notices §92.8(f)(1)*

Consistent with Title VI, its implementing regulations and the HHS LEP guidance, the proposed rule requires that covered entities post the English language notice and taglines in a conspicuously-visible font size in a variety of publications. The HHS LEP guidance has long required that vital documents include, at minimum, taglines and in some cases, should be translated into additional languages to ensure meaningful access.

The proposed rule requires that the English notice and taglines be included in “significant publications or significant communications targeted to beneficiaries, enrollees, applicants or members of the public” and provides examples of such documents. We recommend the below changes to the proposed language. We also request that HHS clarify the difference between “vital” as used in HHS LEP Guidance since 2000 and “significant” as used in the NPRM. Specifically, we request information as to whether “significant” is more expansive than “vital.” Regardless of the difference, we recommend that at a minimum, HHS should continue to require that vital documents be translated and that all English versions of vital documents include in-language taglines advising individuals of their right to language services.

Consistent with 2003 HHS LEP Guidance, whether or not a document (or the information it solicits) is “vital” may depend upon the importance of the program, information, encounter, or service involved, and the consequence to the LEP person if the information in question is not provided accurately or in a timely manner. Similarly, existing Department of Justice LEP.gov FAQs provide that a document is “vital if it contains information that is critical for obtaining federal services and/or benefits, or is required by law.” Consideration of the “importance” and “consequences” of the document in the current HHS LEP Guidance are a few—and not definitive—factors in determining if a document is “critical,” and therefore, “vital.”

The proposed rule should include examples of what constitutes vital or significant publications. These documents should be the same as the current definition of vital documents listed in HHS LEP Guidance, the critical publications as defined in 45 C.F.R. §§ 155.205, 156.250 and those that are required of Medicaid managed care plans in 42 C.F.R. §438.10, as well as any internet pages that reference or contain the documents outlined in those regulations. In addition, vital documents should include, but are not limited to: Evidence of Coverage, Summary of Benefits and Coverage, Explanation of Benefits, internal claims appeals for Qualified Health Plans, Benefits of Coverage, provider lists, and other standard member materials and drug labels on prescription medicines.

Additionally, taglines should be positioned on the cover page and toward the front of these vital and significant publications. These include comprehensive documents such as patient handbooks and other multi-page publications. If taglines are placed at the end of these publications, individuals with limited English proficiency will be less likely to

² See 80 Fed. Reg. at 54,179.

see the taglines and know that they can get language assistance services. For example, during the past two ACA enrollment periods, assistors working with consumers in the Marketplaces reported numerous cases where individuals with limited English proficiency did not see taglines on critical Marketplace notices pertaining to their rights. Consumers received multi-page notices requesting additional documentation or other actions, but individuals often did not see the taglines located at the end of the notice. As a result, they discarded their notices, resulting in termination of coverage and other negative outcomes. This experience underscores the importance of both the content of the notice and location within a communication.

Scope of Significant Publications

The proposed rule seeks comment on how to define the scope of significant publications and communications. We recommend the proposed rule add the following language, providing examples of vital or significant publications or communications.

RECOMMENDATION: We recommend amending § 92.8(f)(1)(i) as follows:

- In ***vital and*** significant publications and ***vital and*** significant communications targeted to beneficiaries, enrollees, applicants, or members of the public, ***with taglines placed at the beginning of publications and communications;***

RECOMMENDATION: Add the following language to §92.8:

- ***Vital or significant publications and communications includes, but is not limited to: patient handbooks; outreach publications; written communications, including notices related to eligibility, change in status (including service reduction or denial), appeals or termination; documents required to be disseminated by law or regulation; and any other documents pertaining to rights or benefits or requiring a response from an individual or those required by law.***
- ***Where written translation is not practicable, taglines may be used to notify consumers of their rights, except where a document, publication, or communication is required by law and/or pertains to rights or benefits requiring a response from an individual. Taglines are not sufficient for legally required documents, publications or communications, such as notice of inconsistency, termination, adjustment or appeals.***

RECOMMENDATION: We recommend amending § 92.8(f)(1)(iii) as follows:

- ***With respect to the English-language notice required by paragraphs (a) and (b) of this section, in a conspicuous location accessible from the home page of the covered entity's website; with respect to the taglines required by paragraph (d), in a conspicuous location accessible from on the home page of the covered entity's website.***

§ 92.201 Meaningful access for individuals with limited English proficiency

Threshold Languages

We are disappointed that HHS did not include any thresholds for translating materials. Since promulgation of the HHS LEP Guidance fifteen years ago, federal fund recipients have been on notice that translating materials when certain thresholds are met ensures compliance with Title VI. Given that significant numbers of the entities covered by Section 1557 have already been required to comply with Title VI and the LEP Guidance since at least 2000, we strongly believe that these regulations, too, should include threshold standards for translating documents.

We recommend that, as a mandatory minimum requirement to comply with Section 1557 (as well as Title VI), covered entities should be required to translate vital documents into the threshold languages, thereby dispensing with the “safe harbor” system set forth in the HHS LEP Guidance. Vital documents should be translated for each language group that makes up 5 percent or 1,000 persons, whichever is less, of the population of persons eligible to be served or likely to be affected by the program or recipient in its service area. This percentage and numeric threshold is already employed in other federal agency policy guidance, with some programs and agencies employing even lower thresholds. HHS’s long-standing methodology to determine threshold languages – currently a 5 percent and 1,000 person standard to determine threshold languages – is something that recipients have worked with for years. We recommend that HHS continue this standard and reinforce this language access by requiring written translations in the threshold languages.

While we recognize that the proposed rule covered entities of varying sizes, from the smallest provider office to the largest health insurer, we believe that setting some minimum standards is important to highlight the need to translate documents. Without standards, many entities may forego translating materials entirely as they have no guidelines for when to do so. Having both a numeric and percentage threshold assists both large and small covered entities; having the exemption currently in the HHS LEP Guidance if a language group is smaller than 50 individuals further protects smaller entities from having to translate too many documents. For larger entities, we would suggest including stronger translation thresholds, as we discuss below regarding “enhanced obligations.” We suggest the same standards apply to any covered entity that has more than 500,000 individuals enrolled or served.

§ 92.201(a) General requirement

We support the recommendations of the Leadership Conference and N-LAAN that there should not be flexibility as to whether to provide meaningful access, but how to provide it.

RECOMMENDATION: Amend § 92.201(a) as follows:

(a) *General requirement.* A covered entity shall ~~take reasonable steps to~~ provide meaningful access to each individual with limited English proficiency ***who is eligible to be served that it serves or is likely to be affected by encounters in its the entity’s*** health programs and activities.

§ 92.201(b) Evaluation of compliance

We support the recommendations of the Leadership Conference and N-LAAN to apply a “hybrid” of the LEP Guidance four-factor test and the five factors described in proposed § 92.201(b)(2). We also strongly recommend that the regulation incorporate specific language notifying covered entities that the factors outlined in § 92.201(b) should **not** be utilized on an individualized basis to determine if a particular individual who is limited English proficient should receive language services. Rather, these factors must be used in a holistic manner to help a covered entity plan for the types of language services and resources that it will have in place to meet the needs of **all** individuals with limited English proficiency.

RECOMMENDATION: Add new subsection (3) to § 92.201(b) as follows:

(3) A covered entity shall not apply the factors outlined in paragraphs (1) and (2) to determine whether to provide language services to a specific individual with limited English proficiency. A covered entity must provide language services to all individuals with limited English proficiency and should utilize the factors to develop a language access plan that outlines how it will meet its requirements under these regulations.

§92.201(b)(2)(i) Length and complexity

Although the "length and complexity of the communication involved" is one factor to consider, we believe that there should be clarification about this factor because there may be circumstances where it is not dispositive of the importance of a document. For example, a notice of action denying Medicaid benefits may be short and simple, but it has great consequence in the consumer's ability to access healthcare. In the reverse, prioritizing long and complex documents may stall a covered entity's ability to translate other documents that may be simpler but more important. To be sure, we agree with HHS' reasoning that it is helpful to have lengthy or complicated information in written or audio file format for reference. Moreover, if the communication between the doctor and patient was long and complicated, it would support the use of an in-person or face-to-face interpreter, rather than a remote or telephonic interpreter. Therefore, if it is included, examples of its use should be provided and length and complexity should never potentially trump or diminish more important considerations, such as the nature and importance of that document. We also recommend including the current HHS LEP factor of the frequency by which LEP individuals come into contact with the recipient's program, activity, or service.

RECOMMENDATION: We recommend amending §92.201(b)(2)(i) to:

- Take other relevant factors into account. Such factors may include: The length and complexity of the communication involved, ***particularly oral interpretation, in addition to the length and complexity of the communication involved*** ***frequency with which LEP individuals come into contact with the recipient's program (covered entities should note that they have an obligation to provide language services to all individuals with limited English proficiency, even patients who speak a less frequently encountered language); this factor relates to an evaluation of the type of language services that should be provided and not to whether language service should be provided such that telephonic interpreting may be the most effective method of providing language services in less frequently encountered languages but the higher the frequency a language is encountered, the higher the expectation of providing additional types of language services;***

§ 92.201(c) Language assistance services requirements

The proposed rule properly makes clear that language assistance services required under paragraph (a) must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency, consistent with long-standing HHS LEP Guidance. In evaluating what is "timely" the covered entity should provide language assistance at a place and time that ensures equal access to persons of all national origins and avoids the delay or denial of the "right, service, or benefit at issue." Timely services mean that consumers and patients should not wait for more than 30 minutes to receive interpreter services, since at a minimum, a telephone interpreter should be available until an in-person interpreter can be located.

We commend HHS for including a timeliness factor in the regulation. However, we recommend including a specific time limit for written translations, such as covered entities must translate all newly developed vital documents into threshold languages within 30 days after the English version is finalized. Otherwise, it is left to the entity to determine what is considered timely and some documents may not be available for some time, if at all.

RECOMMENDATION: Modify § 92.201(c) as follows:

Language assistance services requirements. Language assistance services required under paragraph (a) of this section must be provided free of charge, be accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. ***Language assistance services will be timely if they are provided as follows: oral interpretation immediately upon request or determined need, written translations within 30 days after the English version is finalized, and taglines simultaneously with English documents.***

We also recommend that as a mandatory minimum requirement to comply with Section 1557 (as well as Title VI) covered entities should be required to translate vital documents into the threshold languages, thereby dispensing with the “safe harbor” system set forth in the HHS LEP Guidance.¹ Translating vital documents is something that recipients have done for years. We recommend that HHS reinforce this language access by making written translations in the threshold languages a mandatory rather than voluntary requirement.

§92.201(d) Specific requirements for interpreter services

We support the proposed regulation regarding specific requirements for interpreter services. It is critical that individuals understand that language services are available free of charge, are accurate and timely, and protect the privacy and independence of the individual with limited English proficiency. All too often, individuals with limited English proficiency do not understand their rights, and will not know their new rights under Section 1557, and thus believe they have to bring their own interpreter or use a child, other patient, or unqualified individual to interpret. The responsibility for informing individuals must reside with the covered entity.

We recommend that HHS require that oral interpreting services be provided in all cases where requested or needed although the manner of providing these services (in-person, telephonic, video) may differ depending on the entity and frequency of language. Consistent with HHS LEP Guidance, covered entities may provide oral interpreting services through the range of options that are available and evaluate the type and manner using a fact-dependent inquiry.

RECOMMENDATION: Amend § 92.201(d) as follows:

Subject to paragraph (a) of this section, a covered entity shall offer a qualified interpreter *services* for an individual with limited English proficiency when oral interpretation is *requested or needed* ~~a reasonable step~~ to provide meaningful access for the individual with limited English proficiency.

§ 92.201(e) Restricted use of certain persons to interpret or facilitate communication

We support the provision that restricts covered entities from (1) requiring individuals with limited English proficiency to provide their own interpreter; and (2) relying on an adult accompanying an individual with limited English proficiency to interpret except in emergency situations or where the individual specifically requests for that adult to interpret. We also strongly support the provision that prevents minor children from interpreting or facilitating communications except in emergency situations involving imminent danger. Research has shown that the ability of a provider to accurately diagnose a patient’s condition can be jeopardized by untrained interpreters, such as family and friends, especially minor children, who are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices.

Alternative Approaches

Should covered entities be systematically prepared to provide language services?

Many covered entities are already required to evaluate the type of language services they are obligated to provide based on the current HHS LEP Guidance. Doing so ensures that covered entities understand the scope of the populations they serve, the prevalence of specific language groups in their service areas, the likelihood of those language groups coming in contact with or eligible to be served by the program, activity or service, the nature and importance of the communications provided and the cost and resources available. Depending on an entity’s size and scope, advance planning need not be exhaustive but is used to balance meaningful access with the obligations on the entity.

We support HHS’s experience that entities are in a better position to meet their obligations to provide language assistance services in a timely manner when those entities identify, in advance, the types and levels of services that

will be provided in each of the contexts in which the covered entity encounters individuals who are LEP through language access plans. This is also consistent with a guideline that covered entities already covered by Title VI and HHS LEP Guidance are familiar with.

As such, we recommend that covered entities be required to be systematically prepared to provide language services by developing a language access plan. As noted in the NPRM's preamble, in response to a question in the Request for Information, many organizations already develop such plans based on the model described in HHS LEP Guidance. We recommend that covered entities develop a language access plan based on the evaluation of the factors outlined in § 92.201(b). Doing so need not be burdensome and the size and scope of the plan may vary depending on whether the covered entity is a small provider or a Qualified Health Plan issuer. This requirement is consistent with the proposed advanced planning requirement that each covered entity that employs 15 or more persons adopt grievance procedures and designate an individual responsible for carrying out those duties.

RECOMMENDATION: Add the following requirement to § 92.201 that covered entities be systematically prepared to provide language services by developing a language access plan:

A covered entity shall be systemically prepared to provide language services to individuals with limited English proficiency by developing a language access plan.

Should certain entities have enhanced obligations, and if so, what should those obligations be?

The proposed rule requests comment on whether certain entities should have enhanced obligations, and if so, what should those obligations be. Section 1557 covers a wide range of covered entities that vary in size, scope and resources and operate in a variety of different service areas. The mix of language services provided by each of these organizations will vary, based on the factors outlined in § 92.201(b). Some entities, however, due to the importance of their programs, size of their programs and business practices (such as marketing and solicitation) will require a more robust range of language assistance services and should thus have enhanced obligations. These entities should include the Department of Health and Human Services; State agencies administering Medicaid or CHIP; Federal, State and Partnership Health Insurance Marketplaces; and Qualified Health Plans.

We believe these entities have both the resources and means to meet enhanced obligations. Furthermore, requiring these entities to have enhanced obligations will likely relieve smaller entities of some of the challenges they face in meeting language services obligations. For example, when HHS agreed to translate beneficiary-related Medicare forms into 15 languages, this greatly benefitted all Medicare providers across the country who otherwise would have had to translate these documents, depending on their patient population. The economies of scale and efficiencies of having translations done once by a coordinating entity rather than multiple times by different covered entities are significant.

We believe these entities should also be held to a stricter translation threshold and should translate both vital and significant documents when 5 percent or 500 LEP individuals are present in the entity's state or service area. Having a higher standard for translation will likely result in more documents translated by these entities which then can be used by other covered entities to improve language access. Furthermore, these larger entities both have more resources than smaller covered entities and can likely negotiate better rates for translating documents because of their size, market share, and larger need for translating documents.

Thus, we make the following recommendations regarding enhanced obligations for these entities:

1. Provide oral interpreting in at least 150 languages in their Call Centers and offices (this can be accomplished through telephonic interpreting when in-person interpreters or bilingual staff are unavailable).ⁱⁱ
2. Translate all vital and significant documents into any language spoken by at least 5 percent or 500 persons, whichever is less, of the population of persons eligible to be served or likely to be affected in the covered entity's service area.

RECOMMENDATION: Add the following requirement to § 92.201(a):

- The following entities have enhanced obligations to provide language assistance services: U.S. Department of Health and Human Services, State agencies administering Medicaid or CHIP, Health Insurance Marketplaces and Qualified Health Plans. Enhanced obligations include the following:*
- (1) Provide oral interpreting in at least 150 languages in their Call Centers and offices (this can be accomplished through telephonic interpreting when in-person interpreters or bilingual staff are unavailable).*
 - (2) Translate all vital and significant documents into any language spoken by at least 5 percent or 500 persons, whichever is less, of the population of persons eligible to be served or likely to be affected in the covered entity's service area.*

§§ 92.301-92.303 Enforcement mechanisms

In order to ensure effective anti-discrimination protections under Section 1157, we believe strongly that OCR must create and administer a strong enforcement system for this new statute. It is critical that Section 1557 specifically references the enforcement mechanisms “provided for” and “available under” Title VI, Title IX, Section 504, and the Age Act in order to reflect the entire wide range of equitable relief and enforcement mechanisms established and available under the statutes.

Section 1557 regulations should recognize both discriminatory intent and disparate impact claims. Disparate impact claims are allowed under the civil rights statutes referenced by Section 1557.³ Section 1557 thus imports this important antidiscrimination principle. In particular, we recommend that the rule clearly reflect the statutory language by recognizing that Section 1557: (1) permits judicial claims for disparate impact discrimination and (2) permits private enforcement against any Executive Agency or any entity established under the ACA. The disparate impact standard is crucial for smothering out discrimination in an era in which discrimination takes ever more subtle forms and is often hidden in the very structures of our society. Section 1557 regulations should protect against disparate impact discrimination in the strongest possible terms.⁴

³ Dep't of Justice, *Title VI Legal Manual* (2001), available at <http://www.justice.gov/crt/about/cor/coord/vimanual.php#B> (stating that Title VI regulations “may validly prohibit practices having a disparate impact on protected groups, even if the actions or practices are not intentionally discriminatory.” (citing *Guardians Ass'n v. Civil Serv. Comm'n*, 463 U.S. 582, 582 (1983) and *Alexander v. Choate*, 469 U.S. 287, 293 (1985); Dep't of Justice, *Title IX Legal Manual* (2001), available at <http://www.justice.gov/crt/about/cor/coord/ixlegal.php#2> (stating “[i]n furtherance of [Congress'] broad delegation of authority [to implement Title IX's prohibition of sex discrimination], federal agencies have uniformly implemented Title IX in a manner that incorporates and applies the disparate impact theory of discrimination.” (citing cases).

⁴ *Alexander v. Sandoval* held there is no private right of action for disparate impact discrimination under Title VI of the Civil Rights Act of 1964. 532 U.S. 275, 293 (2001). To resolve disparate impact discrimination, such individuals could only file an administrative complaint with the overworked and understaffed HHS Office for Civil Rights. In effect, when the ACA was implemented in 2010, facially neutral but highly discriminatory policies went largely unchecked. To resolve disparate impact discrimination, such individuals could only file an administrative complaint with the overworked and understaffed HHS Office for Civil Rights, which has allowed facially neutral but highly discriminatory policies to go largely unchecked. As a result, private individuals could only go to court to challenge a federal fund recipient's intentional discrimination on the basis of race, color, or national origin.

For the reasons set forth in the comments submitted by the NHeLP, we agree that Section 1557 provides for individual, class, and third party complaints to allow OCR to resolve individual and systemic problems of discrimination, which are particularly important in the health care area because of the consequences of allowing system-wide patterns of discrimination to continue, as well as compliance reviews of covered entities and technical assistance to identify and address discriminatory policies and practices and set precedents under this new law.⁵ The results of any complaints or compliance reviews should also be made public. The reports from such reviews can serve as guidance for other covered entities as to what it means to comply with Section 1557.

Compliance reviews should be conducted based on sex, sex stereotypes and gender identity and antidiscrimination protections for LGBT people at hospital systems or the Exchanges.⁶ In general, because the Exchanges are newly created entities under the ACA—and will be a critical point for accessing health insurance for many individuals—OCR could select Exchanges in certain states to review for compliance with Section 1557. Specifically, given the large lower-income population that is LEP—more than half of LEP children and children with LEP parents have Medicaid or CHIP coverage and about 95% of uninsured individuals with LEP will be eligible for Medicaid or Exchange subsidies⁷—both the Exchanges and state Medicaid programs are important focuses for OCR compliance reviews regarding language access services. For the same reason, reviewing Medicaid providers as well as the state Medicaid program for compliance with language access standards is essential.

Further, as the statutory language of Section 1557 authorized the Secretary of HHS to promulgate regulations, we recommend the proposed rule apply to **all** federally funded, supported and conducted activities and not just those of HHS. Thus, it applies to any health program or activity receiving Federal financial assistance, to any Executive Agency, and to any entity established under the ACA. The enforcement regulations must reflect this. It also needs to adhere to the holding of the Supreme Court in *King v. Burwell*,⁸ namely that, unless specifically exempted by the ACA, provisions that apply to State-based Exchanges apply when the Exchange is operated by the State or where such Exchange is operated by the federal government for the State.

RECOMMENDATIONS: Amend § 92.302 as follows:

§ 92.302.Procedures for health programs and activities conducted by **federal fund** recipients and State-based Marketplaces

(c) **For any discrimination claim under Section 1557 or this part, a**An individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the recipient or State-based Marketplace is found or transacts business.

Amend § 92.303 as follows:

⁵ Title IX, Title VI, Section 504, and the Age Act provide for individual, class, and third party complaints. Because Section 1557 incorporates the enforcement mechanisms in those statutes, it too must be interpreted to provide for complaints brought on behalf of an individual, a class, or by a third party.

⁶ See, e.g., Samantha Friedman, et. al. for U.S. Dep't of Housing & Urban Dev., Office of Pol'y Dev. & Res., *An Estimate of Housing Discrimination Against Same-Sex Couples* (June 2013), available at http://www.huduser.org/portal/publications/fairhsg/discrim_samesex.html (describing study using testers that demonstrates evidence of discriminatory treatment of same-sex couples in rental housing advertised over the internet).

⁷ See Kaiser Commission on Medicaid & the Uninsured, *Overview of Health Coverage for Individuals with Limited English Proficiency*, (Aug. 2012) available at <http://kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-for-individuals-with/> (About 95% of uninsured individuals with LEP have incomes below 400% of poverty meaning they will be income-eligible for Medicaid or Exchange subsidies in 2014).

⁸ 135 S. Ct. 2480, 2487, 2496 (2015).

§ 92.303 Procedures for health programs and activities administered by ~~the Department~~ ***an Executive Agency***

(a) This section applies to discrimination on the basis of race, color, national origin, sex, age, or disability in health programs or activities administered by ***an Executive Agency*** ~~the Department~~, including the Federally-facilitated Marketplaces.

(b) The procedural ... shall apply with respect to enforcement actions against the ~~Department~~ ***an Executive Agency*** concerning discrimination....

(c) Access to sources of information. ~~The Department~~ ***An Executive Agency*** shall permit access.... Where any information required of the ~~Department~~ ***Executive Agency*** is in the exclusion possession...., ~~the Department~~ ***Executive Agency*** shall so certify....

(d) Relief. For any discrimination claim under Section 1557 or this part, an individual or entity may bring a civil action to challenge a violation of Section 1557 or this part in a United States District Court in which the Executive Agency is found or transacts business.

(de) *Intimidatory or retaliatory acts prohibited.* ~~The Department~~ ***Executive Agency*** shall not intimidate...

Conclusion

We thank HHS for taking the important step of issuing this NPRM and urge HHS to finalize the rulemaking as quickly as possible to implement these crucial new civil rights protections. These regulations are critically important to ensure that AA and NHPI communities have meaningful access to health programs, activities, and services. If you have any questions regarding our comments, please contact Doreena Wong (Advancing Justice | LA) at dwong@advancingjustice-la.org, Heather Skrabak (AAPCHO) at hskrabak@aapcho.org, or Iyanrick John (APIAHF) at ijohn@apiahf.org. Thank you for your consideration of our comments.

Sincerely,



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