Senate Bill No. 853

CHAPTER 713

An act to amend Section 1367 of, and to add Sections 1367.04 and 1367.07 to, the Health and Safety Code, and to add Sections 10133.8 and 10133.9 to the Insurance Code, relating to health care coverage.

[Approved by Governor October 8, 2003. Filed with Secretary of State October 9, 2003.]

LEGISLATIVE COUNSEL'S DIGEST

SB 853, Escutia. Health care language assistance.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law provides for the regulation of health insurers by the Department of Insurance.

This bill would require the Department of Managed Health Care to adopt, not later than January 1, 2006, regulations establishing standards and requirements to provide health care service plan enrollees with access to language assistance in obtaining health care services. Pursuant to the bill, the regulations would require health care service plans and specialized health care service plans to implement programs to assess enrollee needs, and to provide translation and interpretation for medical services and translation of vital documents to enrollees, and to report to the department regarding internal policies and procedures related to cultural appropriateness. The bill would require the regulations to provide that a health care service plan is in compliance with the requirements if it is required to meet and meets the same or similar standards, as imposed by the Medi-Cal program. The bill would require the department to consider specified factors and to seek public input. The department would be required to regularly review information regarding compliance and make recommendations for changes and to report certain information biennially to the Legislature and specified advisory committees.

This bill would impose similar requirements on the Insurance Commissioner and health insurers that contract with health care providers for alternative rates of payment to ensure that insureds have access to translated materials and language assistance in obtaining health care services.

This bill would require a contract between a health care service plan and a health care service provider to ensure compliance with the standards adopted by the board.

By placing additional requirements on health care service plans, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1367 of the Health and Safety Code is amended to read:

1367. A health care service plan and, if applicable, a specialized health care service plan shall meet the following requirements:

(a) Facilities located in this state including, but not limited to, clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State Department of Health Services, where licensure is required by law. Facilities not located in this state shall conform to all licensing and other requirements of the jurisdiction in which they are located.

(b) Personnel employed by or under contract to the plan shall be licensed or certified by their respective board or agency, where licensure or certification is required by law.

(c) Equipment required to be licensed or registered by law shall be so licensed or registered, and the operating personnel for that equipment shall be licensed or certified as required by law.

(d) The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice.

(e) (1) All services shall be readily available at reasonable times to each enrollee consistent with good professional practice. To the extent feasible, the plan shall make all services readily accessible to all enrollees consistent with Section 1367.03.

(2) To the extent that telemedicine services are appropriately provided through telemedicine, as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, these services shall be considered in determining compliance with Section 1300.67.2 of Title 28 of the California Code of Regulations.

(3) The plan shall make all services accessible and appropriate consistent with Section 1367.04.

(f) The plan shall employ and utilize allied health manpower for the furnishing of services to the extent permitted by law and consistent with good medical practice.

(g) The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management.

(h) (1) Contracts with subscribers and enrollees, including group contracts, and contracts with providers, and other persons furnishing services, equipment, or facilities to or in connection with the plan, shall be fair, reasonable, and consistent with the objectives of this chapter. All contracts with providers shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the plan, and requiring the plan to inform its providers upon contracting with the plan, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(2) A health care service plan shall ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(3) On and after January 1, 2002, a health care service plan shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes.

(i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(j) A health care service plan shall not require registration under the Controlled Substances Act of 1970 (21 U.S.C. Sec. 801 et seq.) as a condition for participation by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 of the Business and Professions Code.

Nothing in this section shall be construed to permit the director to establish the rates charged subscribers and enrollees for contractual health care services.

The director's enforcement of Article 3.1 (commencing with Section 1357) shall not be deemed to establish the rates charged subscribers and enrollees for contractual health care services.

The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities.

SEC. 2. Section 1367.04 is added to the Health and Safety Code, to read:

1367.04. (a) Not later than January 1, 2006, the department shall develop and adopt regulations establishing standards and requirements to provide health care service plan enrollees with appropriate access to language assistance in obtaining health care services.

(b) In developing the regulations, the department shall require every health care service plan and specialized health care service plan to assess the linguistic needs of the enrollee population, excluding Medi-Cal enrollees, and to provide for translation and interpretation for medical services, as indicated. A health care service plan that participates in the Healthy Families Program may assess the Healthy Families Program enrollee population separately from the remainder of its enrollee population for purposes of subparagraph (A) of paragraph (1). A health care service plan that chooses to separate its Healthy Families Program enrollment from the remainder of its enrollee population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (1) is applicable, and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (1). The regulations shall include the following:

(1) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph (B), be translated into an indicated language, as follows:

(i) A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than

English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(ii) A health care service plan with an enrollment of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment as required by this subdivision and any additional languages when 1 percent or 6,000 of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(iii) A health care service plan with an enrollment of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or five percent of the enrollee population, whichever number is less, excluding Medi-Cal enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language.

(B) Specification of vital documents produced by the plan that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

(i) Applications.

(ii) Consent forms.

(iii) Letters containing important information regarding eligibility and participation criteria.

(iv) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal.

(v) Notices advising limited-English-proficient persons of the availability of free language assistance and other outreach materials that are provided to enrollees.

(vi) Translated documents shall not include a health care service plan’s explanation of benefits or similar claim processing information that is sent to enrollees, unless the document requires a response by the enrollee.

(C) (i) For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health care service plans shall not be required to translate the documents into the

threshold languages identified by the needs assessment as required by this subdivision, but rather shall include with the documents a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment as required by this subdivision.

(ii) Upon request, the enrollee shall receive a written translation of the documents described in clause (i). The health care service plan shall have up to, but not to exceed, 21 days to comply with the enrollee's request for a written translation. If an enrollee requests a translated document, all timeframes and deadline requirements related to the document that apply to the health care service plan and enrollees under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health care service plan's issuance of the translated document.

(iii) For grievances that require expedited plan review and response in accordance with subdivision (b) of Section 1368.01, the health care service plan may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health care service plans advise limited-English-proficient enrollees of the availability of interpreter services.

(2) Standards to ensure the quality and accuracy of the written translations and that a translated document meets the same standards required for the English language version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(3) Requirements for surveying the language preferences and needs assessments of health care service plan enrollees within one year of the effective date of the regulations that permit health care service plans to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, subscriber newsletters, or other mailings. Health care service plans shall update the needs assessment, demographic profile, and language translation requirements every three years.

(3) Requirements for individual enrollee access to interpretation services.

(4) Standards to ensure the quality and timeliness of oral interpretation services provided by health care service plans.

(c) In developing the regulations, standards, and requirements, the department shall consider the following:

(1) Publications and standards issued by federal agencies, such as the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, such as Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health care service plans that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health care service plans.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists established by Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health care service plans, including existing practices.

(7) Information gathered from complaints to the HMO Helpline and consumer assistance centers regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in plan networks and method of service delivery. The department shall allow for health care service plan flexibility in determining compliance with the standards for oral and written interpretation services.

(d) The department shall work to ensure that the biennial reports required by this section, and the data collected for those reports, are consistent with reports required by government-sponsored programs and do not require duplicative or conflicting data collection or reporting.

(e) The department shall seek public input from a wide range of interested parties through the Advisory Committee on Managed Health Care or other advisory bodies established by the director.

(f) A contract between a health care service plan and a health care provider shall require compliance with the standards developed under this section. In furtherance of this section, the contract shall require providers to cooperate with the plan by providing any information necessary to assess compliance.

(g) The department shall report biennially to the Legislature and the Advisory Committee on Managed Health Care, or other advisory bodies established by the director, regarding plan compliance with the standards, including results of compliance audits made in conjunction with other audits and reviews. The reported information shall also be included in the publication required under subparagraph (B) of paragraph (3) of subdivision (c) of Section 1368.02. The department shall also utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The department may also delay or otherwise phase in implementation of standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(h) (1) Except for contracts with the State Department of Health Services Medi-Cal program, the standards developed under this section shall be considered the minimum required for compliance.

(2) The regulations shall provide that a health plan is in compliance if the plan is required to meet the same or similar standards by the Medi-Cal program, either by contract or state law, if the standards provide as much access to cultural and linguistic services as the standards established by this section for an equal or higher number of enrollees and therefore meet or exceed the standards of the regulations established pursuant to this section, and the department determines that the health care service plan is in compliance with the standards required by the Medi-Cal program. To meet this requirement, the department shall not be required to perform individual audits. The department shall, to the extent feasible, rely on audits, reports or other oversight and enforcement methods used by the State Department of Health Services.

(3) The determination pursuant to paragraph (2) shall only apply to the enrollees covered by the Medi-Cal program standards. A health care service plan subject to paragraph (2) shall comply with the standards established by this section with regard to enrollees not covered by the Medi-Cal program.

(j) Nothing in this section shall prohibit a government purchaser from including in their contracts additional translation or interpretation

requirements, to meet linguistic or cultural needs, beyond those set forth pursuant to this section.

SEC. 3. Section 1367.07 is added to the Health and Safety Code, to read:

1367.07. Within one year after a health care service plan's assessment pursuant to subdivision (b) of Section 1367.06, the health care service plan shall report to the department, in a format specified by the department, regarding internal policies and procedures related to cultural appropriateness in each of the following contexts:

(a) Collection of data regarding the enrollee population pursuant to the health care service plan's assessment conducted in accordance with subdivision (b) of Section 1367.06.

(b) Education of health care service plan staff who have routine contact with enrollees regarding the diverse needs of the enrollee population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health care service plan's programs and services with respect to the plan's enrollee population, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the plan's enrollee population and any related strategies to plan providers. Plans may use existing means of communication.

(f) The periodic provision of educational information to plan enrollees on the plan's services and programs. Plans may use existing means of communications.

SEC. 4. Section 10133.8 is added to the Insurance Code, to read:

10133.8. (a) The commissioner shall, on or before January 1, 2006, promulgate regulations applicable to all individual and group policies of health insurance establishing standards and requirements to provide insureds with appropriate access to translated materials and language assistance in obtaining covered benefits. A health insurer that participates in the Healthy Families Program may assess the Health Families Program enrollee population separately from the remainder of its population for purposes of subparagraph (A) of paragraph (3) of subdivision (b). An insurer that chooses to separate its Healthy Families Program enrollment from the remainder of its population shall treat the Healthy Families Program population separately for purposes of determining whether subparagraph (A) of paragraph (3) of subdivision (b) is applicable and shall also treat the Healthy Families Program population separately for purposes of applying the percentage and numerical thresholds in subparagraph (A) of paragraph (3) of subdivision (b).

(b) The regulations described in subdivision (a) shall include the following:

(1) A requirement to conduct an assessment of the needs of the insured group, pursuant to this subdivision.

(2) Requirements for surveying the language preferences and assessment of linguistic needs of insureds within one year of the effective date of the regulations that permit health insurers to utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements every three years. However, the regulations may provide that the surveys and assessments by insurers of supplemental insurance products may be conducted less frequently than three years if the commissioner determines that the results are unlikely to effect the translation requirements.

(3) Requirements for the translation of vital documents that include the following:

(A) A requirement that all vital documents, as defined pursuant to subparagraph B be translated into an indicated language, as follows:

(i) A health insurer with an insured population of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 0.75 percent or 15,000 of the insured population, whichever, number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(ii) A health insurer with an insured population of 300,000 or more but less than 1,000,000 shall translate vital documents into the top one language other than English as determined by the needs assessment pursuant to paragraph (2) of subdivision (b) and any additional languages when 1 percent or 6,000 of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(iii) A health insurer with an insured population of less than 300,000 shall translate vital documents into a language other than English when 3,000 or more or five percent of the insured population, whichever number is less, indicates in the needs assessment pursuant to paragraph (2) of subdivision (b) a preference for written materials in that language.

(B) Specification of vital documents produced by the insurer that are required to be translated. The specification of vital documents shall not exceed that of the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance (65 Federal Register 52762 (August 30, 2000)), but shall include all of the following:

(i) Applications.

(ii) Consent forms.

(iii) Letters containing important information regarding eligibility or participation criteria.

(iv) Notices pertaining to the denial, reduction, modification or termination of services and benefits, the right to file a complaint or appeal.

(v) Notices advising Limited English proficient persons of the availability of free language assistance and other outreach materials that are provided to insureds.

(vi) Translated documents shall not include an insurer's explanation of benefits or similar claim processing information that are sent to insureds unless, the document requires a response by the insured.

(C) For those documents described in subparagraph (B) that are not standardized but contain insured specific information, health insurers shall not be required to translate the documents into the threshold languages identified by the needs assessment pursuant to paragraph (2) of subdivision (b) but rather shall include with the document a written notice of the availability of interpretation services in the threshold languages identified by the needs assessment pursuant to paragraph (2) of subdivision (b).

(i) Upon request, the insured shall receive a written translation of those documents. The health insurer shall have up to, but not to exceed 21 days to comply with the insured's request for a written translation. If an enrollee requests a translated document, all timeframes and deadlines requirements related to the documents that apply to the health insurer and insureds under the provisions of this chapter and under any regulations adopted pursuant to this chapter shall begin to run upon the health insurer's issuance of the translated document.

(ii) For appeals that require expedited review and response in accordance with the statutes and regulations of this chapter. The health insurer may satisfy this requirement by providing notice of the availability and access to oral interpretation services.

(D) A requirement that health insurers advise Limited English proficient insureds of the availability of interpreter services.

(4) Standards to ensure the quality and accuracy of the written translation and that a translated document meets the same standards required for the English version of the document. The English language documents shall determine the rights and obligations of the parties, and the translated documents shall be admissible in evidence only if there is a dispute regarding a substantial difference in the material terms and conditions of the English language document and the translated document.

(5) Requirements for individual access to interpretation services.

(6) Standards to ensure the quality and timeliness of oral interpretation services provided by health insurers.

(c) In developing the regulations, standards, and requirements described in this section, the commissioner shall consider the following:

(1) Publications and standards issued by federal agencies, including the Culturally and Linguistically Appropriate Services (CLAS) in Health Care issued by the United States Department of Health and Human Services Office of Minority Health in December 2000, and the Department of Health and Human Services (FIHS) Office of Civil Rights (OCR) Policy Guidance 65 (65 Federal Register 52762 (August 30, 2000)).

(2) Other cultural and linguistic requirements under state programs, including the Medi-Cal Managed Care Policy Letters, cultural and linguistic requirements imposed by the State Department of Health Services on health care service plans that contract to provide Medi-Cal managed care services, and cultural and linguistic requirements imposed by the Managed Risk Medical Insurance Board on health insurers that contract to provide services in the Healthy Families Program.

(3) Standards adopted by other states pertaining to language assistance requirements for health insurers.

(4) Standards established by California or nationally recognized accrediting, certifying, or licensing organizations and medical and health care interpreter professional associations regarding interpretation services.

(5) Publications, guidelines, reports, and recommendations issued by state agencies or advisory committees, such as the report card to the public on the comparative performance of plans and reports on cultural and linguistic services issued by the Office of Patient Advocate and the report to the Legislature from the Task Force on Culturally and Linguistically Competent Physicians and Dentists required pursuant to Section 852 of the Business and Professions Code.

(6) Examples of best practices relating to language assistance services by health care providers and health insurers that contract for alternative rates of payment with providers, including existing practices.

(7) Information gathered from complaints to the commissioner and consumer assistance help lines regarding language assistance services.

(8) The cost of compliance and the availability of translation and interpretation services and professionals.

(9) Flexibility to accommodate variations in networks and method of service delivery. The commissioner shall allow for health insurer flexibility in determining compliance with the standards for oral and written interpretation services.

(d) In designing the regulations, the commissioner shall consider all other relevant guidelines in an effort to accomplish maximum accessibility within a cost-efficient system of indemnification. The commissioner shall seek public input from a wide range of interested parties.

(e) Services, verbal communications, and written materials provided by or developed by the health insurers that contract for alternative rates of payment with providers shall comply with the standards developed under this section.

(f) Beginning on January 1, 2008, the department shall report biennially to the Legislature regarding health insurer compliance with the standards established by this section, including results of compliance audits made in conjunction with other audits and reviews. The department shall also utilized the reported information to make recommendations for changes that further enhance standards pursuant to this section. The commissioner shall work to ensure that biennial reports required by this section, and the data collected for the reports do not require duplicative or conflicting data collection with other reports as may be required by government-sponsored programs. The commissioner may also delay or otherwise phase in implementation of the standards and requirements in recognition of costs and availability of translation and interpretation services and professionals.

(g) Nothing in this section shall prohibit a government purchaser from including in their contracts additional translation or interpretation requirements, to meet the linguistic and cultural needs, beyond those set forth pursuant to this section.

SEC. 5. Section 10133.9 is added to the Insurance Code, to read:

10133.9. Within a year after the health insurer's assessment pursuant to paragraph (2) of subdivision (b) of Section 10133.8, health insurers shall report to the Department of Insurance on internal policies and procedures related to cultural appropriateness, in a format specified by the department, in the following ways:

(a) Collection of data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Section 10133.8.

(b) Education of health insurer staff who have routine contact with insureds regarding the diverse needs of the insured population.

(c) Recruitment and retention efforts that encourage workforce diversity.

(d) Evaluation of the health insurer's programs and services with respect to the insurer's enrollee populations, using processes such as an analysis of complaints and satisfaction survey results.

(e) The periodic provision of information regarding the ethnic diversity of the insurer's insured population and any related strategies to insurers providers. Insurers may use existing means of communication.

(f) The periodic provision of educational information to insureds on the insurer's services and programs. Insurers may use existing means of communication.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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