SB-223 Health care language assistance services. (2017-2018)

Date Published: 10/13/2017 09:00 PM

Senate Bill No. 223

CHAPTER 771

An act to amend Section 1367.04 of, and to add Section 1367.042 to, the Health and Safety Code, to amend Section 10133.8 of, and to add Section 10133.11 to, the Insurance Code, and to amend Section 14029.91 of, and to add Sections 14029.92 and 14727 to, the Welfare and Institutions Code, relating to health care coverage.

[Approved by Governor October 13, 2017. Filed with Secretary of State October 13, 2017.]

LEGISLATIVE COUNSEL'S DIGEST

SB 223, Atkins. Health care language assistance services.

(1) 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 and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires the Department of Managed Health Care and the Department of Insurance to adopt regulations establishing standards and requirements for health care service plans and health insurers to provide enrollees and insureds with appropriate access to language assistance in obtaining health care services, including requirements for individual access to interpretation services and requirements to conduct an assessment of the language preferences and linguistic needs of the enrollee and insured population and for the translation of vital documents. For those vital documents that are not standardized but contain enrollee or insured specific information, existing law does not require a health care service plan or health insurer to translate the documents into threshold languages identified by the needs assessment, but instead requires a written notice of availability of interpretation services in threshold languages identified by the needs assessment to be included with those vital documents.

This bill would also require this written notice to be made available, by a health care service plan or health insurer subject to the notification requirements described below, in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services. The bill, with regards to those requirements for individual access to interpretation services, would establish minimum qualification criteria that an interpreter is required to meet in order to provide interpretation services to enrollees and insureds and would prohibit the plan or health insurer from requiring an enrollee or insured with limited English proficiency to provide his or her own interpreter or rely on a staff member who is not a qualified interpreter to communicate directly with the enrollee or insured, or from requiring an enrollee or insured to rely on an adult or minor child accompanying the enrollee or insured to interpret or facilitate communication except in an emergency, as described, if a qualified interpreter is not immediately available, or if the enrollee or insured specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on the accompanying adult for that assistance is appropriate under the circumstances.

The bill would require a health care service plan and a health insurer to notify enrollees or insureds upon initial enrollment and in the annual renewal materials of the availability of language assistance services and of certain nondiscrimination protections available to individuals enrolled in a plan contract or health insurance policy, and would require this information to be included in a

conspicuously visible location in the plan's or health insurer's evidence of coverage, on materials that are routinely disseminated to enrollees or insureds, and to be posted on the Internet Web site maintained by the plan or health insurer. The bill would authorize a specialized health care service plan and a specialized health insurance policy that is not a covered entity, as defined, subject to a specified provision of the federal Patient Protection and Affordable Care Act to request an exemption or a waiver, respectively, from these notification requirements, as specified.

Because a willful violation of these requirements by a health care service plan would be a crime, this bill would impose a state-mandated local program.

(2) Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which health care services are provided to qualified, low-income persons. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Under existing law, one of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed care plans. Existing law provides that specialty mental health services are covered under the Medi-Cal program for eligible Medi-Cal beneficiaries and coverage for those services is provided through mental health managed care plans. Existing law requires the department to require all managed care plans contracting with the department to provide Medi-Cal services to provide language assistance services, including oral interpretation services and translation services, to LEP Medi-Cal beneficiaries, as defined. Existing law exempts mental health plans from these language assistance services requirements.

This bill would require managed care plans, mental health plans, and the State Department of Health Care Services to provide written notice of the availability of free language assistance services in English and in the top 15 languages spoken by LEP individuals in California, as determined by the State Department of Health Care Services, and consistent with specified provisions of federal law. The bill would require oral interpretation services, provided by managed care plans and mental health plans, to be provided by an interpreter who meets specified minimum qualification criteria. The bill would prohibit a Medi-Cal managed care plan and a mental health plan from requiring a Medi-Cal beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who is not a qualified interpreter to communicate directly with the beneficiary, and would prohibit a managed care plan and a mental health plan from relying on an adult or minor child accompanying the beneficiary to interpret or facilitate communication except in an emergency, as defined by the department, and a qualified interpreter is not immediately available, or if the beneficiary specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances. The bill would require the State Department of Health Care Services, managed care plans, and mental health plans to notify Medi-Cal beneficiaries, prospective beneficiaries, and members of the public of the availability of language assistance services and of certain nondiscrimination protections available to Medi-Cal beneficiaries, and would require this information to be included in specified materials distributed to beneficiaries, to be posted in conspicuous physical locations, and on the department's Internet Web site and on the Internet Web site maintained by the managed care plan or mental health plan, as specified. The bill would provide that these provisions are to be implemented only to the extent that federal financial participation is available and is not otherwise jeopardized.

(3) 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.
Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1367.04 of the Health and Safety Code is amended 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 5 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 United States Department of Health and Human Services (HHS) 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. A health care service plan subject to the requirements in Section 1367.042 shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services.

(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.

(4) Requirements for individual enrollee access to interpretation services that include the following:

(A) A requirement that an interpreter meets, at a minimum, all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(B) A requirement that the enrollee with limited English proficiency shall not be required to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (A) to communicate directly with the limited-English-proficient enrollee.

(C) A requirement that the enrollee with limited English proficiency shall not be required to rely on an adult or minor child accompanying the enrollee to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as described in Section 1317.1, if a qualified interpreter is not immediately available for the enrollee with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(5) 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 United States Department of Health and Human Services (HHS) 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 Care 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 former 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 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 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 (1) of subdivision (b) of Section 136000. 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 Care 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 Care 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.

(i) 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. 2. Section 1367.042 is added to the Health and Safety Code, to read:

1367.042. (a) A health care service plan shall notify enrollees and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 1367.04, and how to access these services. This information shall be available in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the State Department of Health Care Services.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) The health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure described in Section 1368, how to file a grievance, including the name of the plan representative and the telephone number, address, and email address of the plan representative who may be contacted about the grievance, and how to submit the grievance to the department for review after completing the grievance process or participating in the process for at least 30 days.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) The information required to be provided pursuant to this section shall be provided to an enrollee with individual coverage upon initial enrollment and annually thereafter upon renewal, and to enrollees and subscribers with group coverage upon initial enrollment and annually thereafter upon renewal. A health care service plan may include this information with other materials sent to the enrollee. The information shall also be provided in the following manner:

(1) In a conspicuously visible location in the evidence of coverage.

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the plan's enrollees.

(3) On the Internet Web site published and maintained by the health care service plan, in a manner that allows enrollees, prospective enrollees, and members of the public to easily locate the information.

(c) (i) A specialized health care plan that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request an exemption from the requirements under this section.

(ii) The department shall not grant an exemption under this subdivision to a specialized health care service plan that arranges for mental health benefits, except for employee assistance program plans.

(iii) The department shall provide information on its Internet Web site about any exemptions granted under this subdivision.

(d) This section shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

SEC. 3. Section 10133.8 of the Insurance Code is amended 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 Healthy 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 affect 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 5 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 United States Department of Health and Human Services (HHS) 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). A health insurer subject to the requirements in Section 10133.11 shall also include with the documents a written notice of the availability of interpretation services in the top 15 languages spoken by limited-English-proficient (LEP) individuals in California as determined by the State Department of Health Care Services.

(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 that include the following:

(A) A requirement that an interpreter meets, at a minimum, all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(B) A requirement that the insured with limited English proficiency shall not be required to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (A) to communicate directly with the limited-English-proficient insured.

(C) A requirement that the insured with limited English proficiency shall not be required to rely on an adult or minor child accompanying the insured to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as described in Section 1317.1 of the Health and Safety Code, if a qualified interpreter is not immediately available for the insured with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(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 United States Department of Health and Human Services (HHS) 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 Care 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 former 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 utilize the reported information to make recommendations for changes that further enhance standards pursuant to this section. The commissioner shall work to ensure that the biennial reports required by this section, and the data collected for the reports, do not require duplicative or conflicting data collection with other reports that 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 government purchasers 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. 4. Section 10133.11 is added to the Insurance Code, to read:

10133.11. (a) An insurer shall notify insureds and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner pursuant to Section 10133.8, and how to access these services. This information shall be available in the top 15 languages spoken by limited-English-proficient individuals in California as determined by the State Department of Health Care Services.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) An insurer does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) How to file a complaint, including the name of the health insurer representative and the telephone number, address, and email address of the health insurer representative who may be contacted about the complaint, and how to submit the complaint to the department for review.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) The information required to be provided pursuant to this section shall be provided to an insured with individual coverage upon initial enrollment and annually thereafter upon renewal, and to insureds with group coverage upon initial enrollment and annually thereafter upon renewal. An insurer may include this information with other materials sent to the insured. The information shall also be provided in the following manner:

(1) In a conspicuously visible location in the evidence of coverage.

(2) At least annually, in or with newsletters, outreach, or other materials that are routinely disseminated to the health insurer's insureds.

(3) On the Internet Web site published and maintained by the health insurer, in a manner that allows insureds, prospective insureds, and members of the public to easily locate the information.

(c) (1) A specialized health insurance policy that is not a covered entity, as defined in Section 92.4 of Title 45 of the Code of Federal Regulations, subject to Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116) may request a waiver from the requirements under this section.

(2) The department shall not grant a waiver under this subdivision to a specialized health insurance policy that arranges for mental health or behavioral health benefits.

(3) The department shall provide information on its Internet Web site about any waivers granted under this subdivision.

SEC. 5. Section 14029.91 of the Welfare and Institutions Code is amended to read:

14029.91. (a) The department shall require all managed care plans contracting with the department to provide Medi-Cal services to provide language assistance services to limited-English-proficient (LEP) Medi-Cal beneficiaries who are mandatorily enrolled in managed care in the following manner:

(1) (A) Oral interpretation services shall be provided in any language on a 24-hour basis at key points of contact.

(B) Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:

(i) Demonstrated proficiency in both English and the target language.

(ii) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(iii) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(C) A managed care plan shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subparagraph (B) to communicate directly with the limited-English-proficient beneficiary.

(D) A managed care plan shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under either of the following circumstances:

(i) In an emergency, as defined by the department, and an interpreter who meets the qualifications described in subparagraph (A) is not immediately available for the beneficiary with limited English proficiency.

(ii) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(2) Translation services shall be provided to the language groups identified by the department.

(3) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by limited-English-proficient individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(b) The department shall determine when an LEP population meets the requirement for translation services using one of the following numeric thresholds:

(1) A population group of at least 3,000 or 5 percent of the beneficiary population, whichever is fewer, mandatory managed care Medi-Cal beneficiaries, residing in the service area, who indicate their primary language as other than English.

(2) A population group of mandatory managed care Medi-Cal beneficiaries, residing in the service area, who indicate their primary language as other than English, and that meet a concentration standard of 1,000 beneficiaries in a single ZIP Code or 1,500 beneficiaries in two contiguous ZIP Codes.

(c) The department shall make this determination if any of the following occurs:

(1) A nonmanaged care county becomes a new managed care county.

(2) A new population group becomes a mandatory Medi-Cal managed care beneficiary population.

(3) A period of three years has passed since the last determination.

(d) The department shall instruct managed care plans, by means of incorporating the requirement into plan contracts, all-plan letters, or similar instructions, of the language groups that meet the numeric thresholds.

(e) A managed care plan shall notify beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to health care programs or activities to individuals with limited English proficiency.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) A managed care plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of a grievance procedure and how to file a grievance, including identification of, and contact information for, the designated managed care plan representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(f) (1) The information described in paragraph (3) of subdivision (a) and subdivision (e) shall be provided in the following manner:

(A) In the evidence of coverage.

(B) Posted in conspicuous physical locations where the managed care plan interacts with the public.

(C) On the Internet Web site published and maintained by the managed care plan in a manner that allows a beneficiary, prospective beneficiary, and members of the public to easily locate the information.

(2) To the extent the information described in paragraph (3) of subdivision (a) and subdivision (e) is not included in existing informational notices, a managed care plan shall add this information at the time of the next regularly scheduled update of the applicable publication.

(g) The amendments made to this section by the act that added this subdivision shall be implemented by the department only to the extent that federal financial participation is available and is not otherwise jeopardized.

(h) This section does not apply to mental health plans contracting with the department pursuant to Section 14712.

(i) For purposes of this section, a person is “limited-English-proficient” if he or she speaks English less than very well.

SEC. 6. Section 14029.92 is added to the Welfare and Institutions Code, to read:

14029.92. (a) The department shall notify Medi-Cal beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to individuals with limited English proficiency.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) The department does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure and how to file a grievance, including identification of, and contact information for, the designated department representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by limited-English-proficient individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(c) (1) The information described in subdivisions (a) and (b) shall be provided in the following manner:

(A) In the department’s Medi-Cal informational publications.

(B) Posted in conspicuous physical locations where the department interacts with the public.

(C) On the department’s Internet Web site, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information.

(2) To the extent the information described in subdivisions (a) and (b) is not included in existing informational notices, the department shall add this information at the time of the next regularly scheduled update of the applicable publication.

(d) This section shall be implemented only to the extent that federal financial participation is available and is not otherwise jeopardized.

SEC. 7. Section 14727 is added to the Welfare and Institutions Code, to read:

14727. (a) A mental health plan shall notify beneficiaries, prospective beneficiaries, and members of the public of all of the following information:

(1) The availability of language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner, when those services are necessary to provide meaningful access to an individual with limited English proficiency.

(2) The availability of appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternate formats, free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity to participate for individuals with disabilities.

(3) A mental health plan does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

(4) The availability of the grievance procedure and how to file a grievance, including identification of, and contact information for, the designated mental health plan representative.

(5) How to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex.

(b) Written notice of the availability of free language assistance services shall be provided in English and in the top 15 languages spoken by limited-English-proficient individuals in California, as determined by the department, and consistent with the requirements identified in Part 92 of Title 45 of the Code of Federal Regulations and Section 1557 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18116).

(c) (1) The information described in subdivisions (a) and (b) shall be provided in the following manner:

(A) In the beneficiary handbook.

(B) Posted in conspicuous physical locations where the mental health plan interacts with the public.

(C) On the Internet Web site published and maintained by the mental health plan, in a manner that allows beneficiaries, prospective beneficiaries, and members of the public to easily locate the information.

(2) To the extent the information described in subdivisions (a) and (b) is not included in existing informational notices, a mental health plan shall add this information at the time of the next regularly scheduled update of the applicable publication.

(d) Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:

(1) Demonstrated proficiency in both English and the target language.

(2) Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.

(3) Adheres to generally accepted interpreter ethics principles, including client confidentiality.

(e) A mental health plan shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in subdivision (d) to communicate directly with the limited-English-proficient beneficiary.

(f) A mental health plan shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under either of the following circumstances:

(1) In an emergency, as defined by the department, and an interpreter who meets the qualifications described in subdivision (d) is not immediately available for the beneficiary with limited English proficiency.

(2) If the individual with limited English proficiency specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances.

(g) This section shall be implemented only to the extent that federal financial participation is available and is not otherwise jeopardized.

SEC. 8. 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.