

HEALTH CARE LANGUAGE ASSISTANCE

FREQUENTLY ASKED QUESTIONS #2008-01

Table of Contents

1. Introduction
2. Translation of Vital Documents
3. Language Needs Assessment & Notice to Insureds
4. Supplemental Insurance-Vision, Dental, etc.
5. Reporting to Department of Insurance

1. INTRODUCTION

These Frequently Asked Questions (FAQs) are a result of many questions from insurers, insurance associations and consumer health advocates that arose as they began to implement SB 853, Language Assistance Services. Throughout the lengthy regulatory process, members of the stakeholder groups provided much needed input and guidance to Department staff regarding issues needing to be addressed by the regulations. While many issues have been addressed in the regulations, as insurers began the work of implementing the mandates in SB 853 and the regulations, additional unanticipated questions have arisen. The Department has been asked to provide this document to assist the people responsible for implementing these requirements. The Frequently Asked Questions are provided for your assistance only – they do not have the force of law. In particular, they do not establish an agency guideline, criterion, bulletin, manual, instruction, order, standard of general application, rule, or regulation, as those terms are described in Sections 11340.5 and 11342.600 of the Government Code.

Of note is the fact that the Department of Managed Health Care (DMHC), mandated under the same legislation to develop regulations for implementation of SB 853, has developed FAQs for health plans that they regulate and posted these FAQs on their website. To the extent feasible, our regulations have mirrored the DMHC regulations wherever possible.

2. TRANSLATION OF VITAL DOCUMENTS

2.1 Can an insurer that has specialized health insurance lines of business separate its insured population by line of business for purposes of determining threshold languages and developing its Language Assistance Program?

Response 2.1 – For the purposes of determining the threshold languages into which vital documents should be translated, the aggregate total of the health insurer’s insured population should be used. However, an insurer may choose to survey the language needs of their insureds by line of business if an appropriate business need dictates.

2.2 Do the translated vital documents need to be refilled with the Department or, are they OK if they are translated verbatim?

Response 2.2 – The verbatim translated vital documents do NOT need to be refilled with the Department. Since there is no change in the language of the policy there is no requirement for re-filing. If any changes are made to the language of the policy, the translated document as well as the English source document would need to be filed with the Department through the usual channels.

HEALTH CARE LANGUAGE ASSISTANCE

FREQUENTLY ASKED QUESTIONS #2008-01

2.3 If there are only a small number of policies, do the top 3 languages still apply for the translation of vital documents requirement?

Response 2.3 – Health insurers with a total 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 survey/needs assessment a preference for written material in that language.” If the intent of the statute was to require translation into only one language, the statute would have stated “one” language. Instead it reads, “a language”. The plain meaning of “a language” means any language for which the survey/needs assessment indicates that at least 3,000 or 5% of the insured population, whichever is less, indicate a preference for written material in a language other than English.

2.4 Under the definition of “vital documents” to be translated into threshold languages, subsection (7) identifies a matrix of benefits to be listed in sequential order. Must the matrix list all the benefits in the sequence provided in the regulations?

Response 2.4 – Insurers are only required to list the benefits that are applicable to their line of business. The sequence should be logical and may conform to existing insurer benefits matrixes.

3. LANGUAGE NEEDS ASSESSMENT & NOTICE TO INSUREDS

3.1 Can a health insurer demonstrate compliance with the survey/needs assessment requirement by distributing to all insureds, including all individual insureds under group contracts, a disclosure explaining, in English and in the insurer’s threshold languages, the availability of free language assistance services and how to inform the insurer regarding the preferred spoken and written languages of the insured?

Response 3.1 – The distribution of a survey/needs assessment to all insureds asking for their preferred spoken and written languages meets the requirements of section 2538.3(c) of the regulations. Since the enabling statute requires the Department to develop regulations that include “...requirements for surveying the language preferences and assessment of linguistic needs of insureds (emphasis provided)...” the plain meaning of the statute is clear. “Insureds” is the plural of insured and as such the understanding of the Department is that all insureds should be surveyed.

Regarding the ‘disclosure’, the Department’s regulations require that a Notice be sent to all insureds informing them of the availability of language assistance services and how to access those services [CCR section 2538.3(c)]. The regulations provide that insurers develop this Notice unless it is developed by the Commissioner in which case every health insurer should use the Commissioner’s Notice.

The Commissioner has developed Notice language which insurers should include in their Notice to Insureds. The Commissioner has translated the Notice language into multiple languages to provide as many limited English speaking insureds with initial information about the availability of language assistance services and how to access them. The translated Notice meets the requirements for medical eligible insureds. Insurers will be required to provide this Commissioner developed Notice with translations to all of their insureds.

HEALTH CARE LANGUAGE ASSISTANCE FREQUENTLY ASKED QUESTIONS #2008-01

Additional information provided by insurers as part of this Notice mailing may be translated into various languages other than English. Several insurers are providing their survey/needs assessment information in several languages other than English based on existing data regarding language needs of their insured population.

3.2 Will the Commissioner developed Notice meet the medical requirement of Flesch test 6th grade level?

Response 3.2 – Yes. The Commissioner developed Notice has a Flesch score of 6.3 which meets the Medi-Cal requirements.

3.3 What languages does the survey need to be in—can it be in English only or do the regulations also require that the survey needs to be printed in other languages, as well? If so, which ones? Is the following basic language ok—*“What are the primary languages written and spoken by insured members/applicants in your household?”*

Can the survey be included as a simple separate notice with our applications, enrollments forms and certificate renewals etc. in English asking "What is the primary language written and spoken in your household?" Or does the survey need to be more elaborate?

Response 3.3 -- The statute and regulations direct insurers to survey the “language preferences and linguistic needs” of your insureds to “assess and determine the spoken and written language preferences”. The proposed regulations do not address the issue of whether the survey/needs assessment is required to be in languages other than English. However, it would seem difficult to identify the preferred written and spoken language of your insureds if the survey is in English only (which an LEP insured may not be able to understand). You are expected to meet the intent of this legislation which is to identify both the number/percent of insureds whose preferred written and spoken language is other than English and the identity of those other languages.

The survey/needs assessment is the first critical piece in establishing the thresholds for translation of vital documents. It can be simple and basic as long as it clearly asks for both the spoken language preference and written language preference since the two may not be the same. It can be included with the Notice document developed by the Commissioner that is required to be sent to insureds or sent separately.

The survey/needs assessment will also provide insurers with information regarding the interpreter needs of their insureds for oral communication with both the insurer and health care providers. Insurers are charged with ensuring that the appropriate interpretation services are available to insureds when they communicate with their insurer as well as health care providers.

HEALTH CARE LANGUAGE ASSISTANCE

FREQUENTLY ASKED QUESTIONS #2008-01

3.4 Can methodologies such as Geoscape/AMDS be used to collect the required spoken and written language preference data? Can we use the results of this survey to determine the threshold languages before the results of our survey (needs assessment) are compiled?

Response 3.4 -- Sections 2538.4 of the regulations and section 10133.8 (b)(2) of the California Insurance Code require insurers to survey the language preferences and linguistic needs of insureds as well as collect demographic data. Various survey methods may be used; however, each insured should be assessed as to their preferred written and spoken language. Geoscape/AMDS appears to survey the “language spoken at home” by zip code. While this may be a statistically valid methodology to obtain data for interpretation (oral language) services, it does not appear to capture written language preference data. The Commissioner believes that other statistical methodologies will be needed to obtain the required data on preferred written language.

3.5 Can the Notice be included with the application or the survey/needs assessment?

Response 3.5 – Yes. It is important that the consumer be able to distinguish between the document that provides information about language assistance and the document that is asking for a response to questions about language preferences. If the survey/needs assessment is sent to insureds with the Commissioner’s Notice and supporting information it should be clear that the survey/needs assessment will help the insurer determine the languages into which documents will be translated and assist in ensuring that appropriate interpretation services will be available when insureds contact the insurer, third party administrators/networks, and health care providers.

3.6 Can insureds refuse to provide the demographic information about race and ethnicity? How do we ensure that the language preference questions will be answered and responded to even if the race and ethnicity questions are refused?

Response 3.6 – Insurers are required to ask for race and ethnicity data by the regulation. This data will assist both insurers and health care providers to address their insureds/clients in a culturally appropriate and sensitive manner. However, an insured may refuse to provide this information. Insurers should stress the need for the language preference information in order to provide the insureds with appropriate interpretation services and translated written materials.

4. SUPPLEMENTAL INSURANCE ISSUES

4.1 Do the SB 853 requirements apply to dental/vision and other supplemental insurance products?

Response 4.1 – The statute does not provide an exemption to any health insurers except those excluded by Insurance Code section 106(b)(1-8). Supplemental insurance products including dental and vision plans are subject to these regulations. Certain accommodations have been made in the statute and regulations regarding the timeframe for updating the survey/needs assessment of insureds for supplemental insurance products. Small carriers of supplemental products may benefit with assistance from the larger health insurance carriers in language assistance plan development, translation of vital documents and other details of implementation.

HEALTH CARE LANGUAGE ASSISTANCE

FREQUENTLY ASKED QUESTIONS #2008-01

5. REPORTING REQUIREMENTS

5.1 Will the Department develop a format for the required report due December 1st and notify all health insurers about the particulars including how and where to submit the report?

Response 5.1 – The Department has developed a “suggested” format for this first report due December 1, 2007 which has been emailed to health insurers and to ACLHIC for distribution to members. Since the regulations have only been in effect for less than two months, the Department is requesting a brief update on the status of activities to begin the development of the Language Assistance Program. We will be developing a detailed reporting format for subsequent reports due in 2010.