CALIFORNIA DEPARTMENT OF INSURANCE
Response to Public Comments
SB 853 - Health Care Interpreter Regulations
First Comment Period
8/11/06 – 9/26/06

#	Person Submitting Comment	Action Taken	Issues or Comments	CDI Response
1	**AHIP** **Martin Mitchell, Samantha Silva, America's Health Insurance Plans**	**Decline**	***§2538.1 (a): Authority and Purpose*** At (a): The proposed regulation makes no reference to Section 4 of SB 853 (Escuitia, 2003) as enacted which amended Insurance Code Section 1033.8(C)(8) and provides "that in developing the regulations, standards, and requirements the commissioner shall consider [,,,] (8) The cost of compliance and the availability of translation and interpretation services." We believe that this provision is an important statutory provision which provides specific regulatory implementation guidance to the Commissioner and is deserving of incorporation into this section.	The statute is clear and unambiguous on this issue. Therefore, it is unnecessary to further define this section in the regulations.
		Decline	***§2538.2 (a), (e) and (l): Definitions of Interpreting and Source Language*** ***At (a):*** We request that the word "race" be stricken from that definition of "demographic profile." The statute establishes standards and requirements for language assistance for certain classes of insured who establish other-than –English language preferences in accordance with the terms of the statute. The statue makes no provision for health insurers to collect, maintain, or report to the Commissioner any race based information.	The identification of "race" is a primary component in understanding the cultural context in which health care services are to be provided to LEP insureds. There is a distinction between "race" and "ethnicity" which will better inform the insurer and provider as to the appropriate language to provide to an LEP insured.
		Accept.	***At (e) and (l):*** The proposed regulation for both "interpreting" and "interpretation", and for: source language": includes sign language. AHIP believes this goes beyond the statutory language of SB 853, which clearly applies to non-English languages. Sign language is a means of communication for the hearing impaired which is not the subject of SB 853 and this regulation. This can be seen for example in the required assessment of language preferences of enrollees; in the required translation of vital documents in languages other than English; and in the regulation's definition of "language preferences and linguistic needs assessment" which refers to spoken and written language preferences, not for sign language. AHIP request the deletion of "sign language" and "signer" from these respective definitions in the regulation.	"Sign language" has been deleted from the regulations.
		Accept	***§2538.2(o): Definition of Vital Documents*** The definition of vital documents requires insurers to translate "individual insurance policies and certificates of insurance." AHIP believes this goes beyond the statutory requirements of SB 853 which only includes: (i) applications; (ii) consent forms; (iii) letters containing important information regarding eligibility or	"Individual insurance policies and certificates of insurance" has been deleted from the regulations.

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			participation criteria; (iv) notices pertaining to the denial, reduction, modification or termination of services and benefits, the right to file a compliant or appeal; and (v) notices advising Limited English Proficient persons of the availability of free language assistance and other outreach materials that are provided to insured. In addition, SB853 states in §10133.8(b)(B) that the specification of vital documents shall not exceed that of the Department of Health and Human Services Office of Civil Rights (OCR) Policy Guidance,. The OCR guidance provides direction on what to translate and states: "If written translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will not find the translation of written materials necessary for compliance with Title VI" The Guidance found published by the federal Department of Health and Human Services, Office of Civil Rights on August 30, 2000 establishes no requirement in its section on Translation of Written Materials (page 52767) that a covered entity, that is an entity subject to Title VI of the Civil Rights Act of 1964, provide translated versions of those program documents which outline its program benefits such as its certificates of insurance. While numerous other documents are identified for translation including "a cover letter outlining conditions of participation in a Medicaid managed care program..." the Guidance did not take the next step and include the program documentation. The inclusion of specific sets of information that are not identified in either the OCR Guidance or in SB 853 is an conflict with the statue and AHIP requests the department revise the regulatory provisions to more closely follow the statutory requirements.	
		Accept	***§2538.3: Language Assistance Program (LAP)*** As part of the LAP, the proposed regulation requires insurers to include a notice of the availability of language assistance services in "multiple languages." AHIP is supportive of making insured aware of such a	The requirement of notice in "multiple languages" has been deleted from both the regulations as well as the definition

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			program; however, we believe the department has exceeded the statutory requirements by requiring such notices to be in *multiple languages* which is defined as *"the number of and specific languages into which voting/ballot materials are translated as determined by the California Secretary of State for the current calendar year."* Requiring notice in multiple languages as defined goes beyond the statutory language. Section 10133.8 (b)(3)(A) requires vital documents, of which notices of the availability of the program are one, be translated into the top two languages other than English as determined by the needs assessment required for insurers with more that 1 million enrollees and one of more non-English languages for other insurers depending on the percentage of enrollees insurerds that speaks a specified-language. AHIP requests the proposed regulation's multiple language requirement be deleted and the regulation be made consistent with the statutory language. This would also require the deletion of the multiple language definition in section §2538.2. The deletion of "multiple languages" would also be consistent with provisions contained in §2538.5 of the regulation.	section.
		Accept	***§2538.4: Needs Assessment of Insured Population*** This section of the proposed regulation requires insurers to survey the language assistance preferences and assess the linguistic needs of insured's in multiple languages as defined in the proposed rule. AHIP requests that the "multiple languages" requirements of this section also be deleted. See comments in §2538.5 above.	See response above.
		Decline	***§2538.6: Individual Access to Oral Interpretive Services*** AHIP believes that the DOI has established a burdensome regulatory model for providing translation services that are predominately designed for the medical care setting. Federal Law, specifically the 1964 Civil Rights Act and HHS rules and Guidance that has been laid down over the previous 40 years, addresses the issue of the need for translation services to ensure LEP individuals have fair access to the healthcare system. To establish yet another layer of regulation over the federal requirement will only add confusion and cost of the system, AHIP request that the Commissioner reexamine the issue of translation services that are required for health insurer compliance with the language assistance requirements to ensure assess to the provision of benefits and the access to vital documents as required under SB 85..	SB 853 establishes the specific documents that are required to be translated into the threshold languages by health insurers. Regulations cannot reduce or limit the underlying statutory requirements. The Commissioner has carefully and fully examined this issue in an effort to develop regulations that implement the law while

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				allowing insurers the greatest degree of flexibility in the manner in which they develop the LAP.
2	**Jim Knox, American Cancer Society**	**No response needed.**	The American Cancer Society, California Division supports the leadership of the Department of Insurance in requiring health insurers to meet the unique needs of communities of color. We join our colleagues at the California Pan Ethnic Health Network in supporting the provision in the draft Health Care Language Assistance Program regulation that requires health insurers to collect data on the race, ethnicity, and primary language of their members. The American Cancer Society advocates for a health care system that provides services in a humane, patient-friendly, and culturally appropriate manner.	Supports inclusion of "race" in definition.
3	**Marty Martinez The California Pan-Ethnic Health Network**	**Decline** **Decline**	**§2538.4 Definition and Collection of Demographic Profile.** First, we strongly support the proposed definition of "demographic profile," which includes data on an enrollee's "primary language, race, and ethnicity." Second, we support the Department's language regarding reporting requirements: "Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements of their insured population every three years." This statement is strong and clear that insurers must collect this information on an individual basis from each insured and update it every three years. We would suggest the Department also include language that: 1) ensures individual enrollees' privacy and that enrollees are informed as to the purpose and use of the information and 2) specifies that the information collected from insurers be reported to the Department and made publicly available in a way that protects the privacy of individual enrollees and 3) the survey that insurers are required to conduct, at 2538.4, should be modified to make clear that not it is not only language that must be collected by this survey, but also other elements of the demographic profile, especially race and ethnicity, must be collected through this survey process as well. **§2538.2(d) Definition of "Interpreting/ Interpretation."** We strongly support the current definition of "interpreting" or "interpretation" to include signed message and signed language. We appreciate the Department's recognition of the language access needs of the deaf and	This section requires insurers to survey and update the linguistic needs, demographic profile and language translation requirements every three years. "Demographic profile" is defined in the definition section of the regulations to include race and ethnicity; therefore, it is unnecessary to define "demographic profile" again in this section. The Commissioner has deleted "sign language" from the definition of "interpreting" because of lack of statutory

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		Decline in part; accept in part. **No response needed** **Decline in part; accept in part.**	hearing impaired community. **<u>§2538.6(c) Prohibition on Minors As Interpreters.</u>** We strongly support language prohibiting the use of minors as interpreters. The statutory intent of the original legislation was to ensure that LEP insureds have access to a *qualified interpreter*. In our opinion, a minor can never meet this definition. **<u>Quality Interpretation and Translation Services.</u>** We support language requiring health insurers to ensure the quality of interpretation and translation services, staff training on the language assistance plan, and that translation and interpretation services require sensitivity and recognition of cultural differences and diversity. **<u>§2538.6(a) Individual Access to Oral Interpretation Services.</u>** In the section entitled, Individual Access to Oral Interpretation Services, we suggest adopting a requirement from the Healthy Families Program, which requires health plans to provide face-to-face interpreter services unless it is not feasible, wherein health plans can utilize a telephone interpreter. Adding this provision to the current language would help clarify health plans' responsibility in providing quality interpretation services as required by the legislation. Further, the legislation allows for the use of existing standards and practices, such as the Healthy Families requirements, in establishing the regulations to implement SB 853. We also believe 'timely' should be defined unless there are extenuating circumstances - we have suggested 15 minutes in prior comments. We also believe that the regulations should require insurers who rely on self-identified bilingual providers to have a policy in place as to how they verify the bilingual capabilities of these providers. This is also a Healthy Families requirement. We also agree and appreciate that "timely interpretation services" incorporate contracting with outside interpreters, including certified sign language interpreters as specified in Section 2538.6(4)(C)).	authority. The Commissioner has modified the language to delete "prohibited" and insert "strongly discourage" the use of minors as interpreters. Clarifies the distinction between the use of a minor in an emergency and non-emergency situation. This change was made to ensure that an adult insured would have access to interpretation if their only choice, after being offered a qualified interpreter at no cost, is to use a minor as an interpreter. The regulations intend to provide insurers with maximum flexibility in providing the statutorily required language services to insureds. The regulations list a variety of types of interpretation services that may be provided to insureds rather than determining for insurers the order of interpretation services to be provided. The regulations have been amended to further define "timely".

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		Decline **Decline**	**§2538.5 Translation of Documents.** We suggest adding a requirement to the translation of written documents that translations be appropriate to the literacy level of the target population. **Informing Insureds about the Availability of Language Assistance Services.** As you know, we are in the process of submitting comments to similar regulations being drafted by the Department of Managed Health Care (DMHC). To ensure consistency with the legislation as well as in the implementation of the language access standards, we urge you to consider utilizing similar language as drafted by DMHC. For instance, we suggest including language similar to DMHC's regarding informing insureds of the availability of language services: "(ii) A copy of the plan's notice of availability of language assistance services, as approved by the Department, shall be provided with all vital documents, all pre-enrollment materials and all correspondence, if any, from the plan confirming a new or renewed enrollment. (iii) Statements about the availability of free language assistance services and how to access them shall be included, in English and in the ten non-English - languages identified by the plan as most likely to be encountered among its enrollees, in brochures, newsletters, outreach and marketing materials and other materials that are routinely disseminated to the plan's enrollees and potential enrollees." (E) The procedures a plan will implement to promote effective identification of LEP enrollee language assistance needs at points of contact and facilitate enrollee access to language assistance services. Full service plans shall provide LEP enrollees with language identification cards, and maintain a 24 hours per day, 7 days per week toll free telephone line that enrollees and providers may call to obtain the plan's assistance in arranging language assistance services. The language identification card shall identify the card holder's preferred language and shall contain the following statement in English and in the preferred language: "Please call [telephone number] to obtain assistance from [plan name] to arrange interpretation services.	There is no statutory authority to include "literacy level" as a component of translation requirements in these regulations. There is no statutory authority to require the notice of availablilty of language services to be provided to insureds in multiple languages. The Commissioner strongly encourages insurers to make the notice available in multiple languages in order to implement the intent of this statute—if the insured does not understand the notice stating that interpretation services are available, how will this law be implemented? DMHC is considering deleting this language from their regulations.

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		Decline	(F) Standards that conform with the requirements of Section 1300.68(b)(3) and (7) of these regulations, including standards to ensure that LEP enrollees receive information regarding their rights to file a grievance and seek an independent medical review in threshold languages and through oral interpretation. (i) All plans shall ensure that grievance forms and procedures in threshold languages are available in contracting provider offices. (ii) All plans shall inform contracting providers that informational notices explaining how enrollees may contact their plan, file a complaint with their plan, obtain assistance from the Department and seek an independent medical review are available in non-English languages through the Department's web site. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814. (G) The plan's processes and standards for informing contracting providers of the plan's standards and mechanisms for providing language assistance services at no charge to enrollees, and for making LEP enrollee data available to its contracting providers." **VII. Contracts Between Insurers and Health Care Providers**. We also suggest mirroring the following passages from the DMHC proposed regulations regarding contracts between insurers and providers: (4) Every contract between a health care provider and a plan, including a specialized plan, that is issued, amended, delivered or renewed on or after July 1, 2008, shall require compliance with the plan's language assistance program standards developed pursuant to Section 1367.04 and this section. The contract shall require the provider to cooperate with the plan by providing any information necessary to the plan's assessment of compliance.	There is no statutory authority to include language regarding insurer's contracts with providers or networks. This is one area that the insurance code sections differ from the DMHC statutory authority.

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			(A) No plan shall require a contracting health care provider to assume the financial risk of providing the language assistance services required by Section 1367.04 and this section." **Addendum to joint comments submitted by consumer advocates –**	
		Decline	**§2538.2(i) Definition and use of "multiple languages"** We support the Department's definition of "multiple languages" as defined in Section 2538.2 as: "the number of and specific languages into which voting/ballot materials are translated as determined by the California Secretary of State for the current year." We believe the Department is clearly within its statutory authority to use this definition of "multiple languages." Senate Bill 853 provided a list of documents and standards for consideration in the development of these regulations. We would specifically point to number (5) in this list which states the Department may consider: "publications, guidelines, reports and ***recommendations issued by state agencies*** or advisory committees…" (emphasis added) in developing the regulations.	"Multiple languages" has been deleted from the regulations for lack of statutory authority.
		Decline in part; accept in part.	§2538.3 In addition, we believe that the Department is within its statutory authority with regard to the proposed language in Section 2538.3, which requires plans to establish notices in multiple languages informing LEP insureds about the availability of interpreter services. As co-sponsors and supporters of the legislation, it was our intent that all individual LEP insurers be aware of the availability of interpreter services. This is stated in SB 853 in Section (D) wherein health care plans and insurers are required to "advise Limited English proficient insureds of the availability of interpretation services." We appreciate the Department's interpretation of the statute. According to SB 853, this requirement is separate from the requirements governing the translation of documents, either into the threshold languages or for enrollee specific information. We believe the current proposed language makes it very clear that all individual LEP insureds should have information about how to access interpretation services and that neither the provision of these services nor informing LEPs should be limited to the threshold languages. We appreciate the Department's current proposed language and would encourage the Department to adopt language proposed language by the Department of Managed Health Care, which requires plans to translate this notice in at least	While the requirement for notice in "multiple languages" has been deleted, in order to address the serious issue of LEP insureds receiving notice of the availability of interpretation services in a language that they can understand, the Commissioner has amended the regulations to provide for a notice to be developed by the Department which insurers shall provide to all insureds. It is the intention that this notice shall be written in multiple languages.

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		Decline in part; accept in part. **Decline**	the top ten non-English languages as set by the U.S Census Bureau. **<u>Quality interpretation and translation services</u>** We would like to reiterate our support for the Department's current language requiring health insurers to ensure interpretation and translation services require "sensitivity and recognition of cultural differences and diversity." Again, SB 853 encourages the Department to consider a wide range of documents, publications and current standards from state and federal agencies in developing the regulations. Included in this list are the references to the Healthy Families and Medi-Cal program requirements as well as the Culturally and Linguistically Appropriate Services (CLAS) standards in Health Care developed by the United States Department of Health and Human Services, Office of Minority Health. All of these requirements and standards recognize that cultural awareness is an essential component of "quality interpretation services." Therefore, we would support the maintenance of this provision. In addition to maintaining the language regarding cultural diversity, we encourage the Department to consider providing further guidance to health insurers regarding their language assistance policies and procedures to ensure the quality of interpretation and translation services. Currently, Sections 2538.5 and 2538.6 of the current proposed language, paraphrased below, requires every health insurer to develop: "policies and procedures to ensure the quality and timeliness [of interpretation and translation] services. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing interpretation [and translation] services."	While the language "culturally competent" has been deleted from the regulations, insurers are required to report to the department on their "internal policies and procedures related to cultural appropriateness". This will require insurers to identify and review the cultural issues related to interpretation services to LEP insureds. The regulations require "quality interpretation services". It is up to the insurer to develop a LAP that defines and ensures such quality.
4	**Anne Eowan Association of California Life & Health Insurance**		**<u>SECTION 2538.2 DEFINITIONS</u>** **(1) Subdivision (b)** limits the application of the regulations to those insurers writing health insurance that enter into a contract with a provider to provide covered benefits. We are seeking **clarification** as to the intent of this definition. It appears to only affect those carriers that directly contract with providers and provider groups, as opposed to carriers that lease a provider network from a contracting agent. Section 10133.8 (a) of the IC applies the requirements of SB 853 to all group and individual policies of health insurance, without	

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	Companies		limiting the application to those carriers that directly contract. However, we are seeking clarification if the authority for this provision comes from the department's interpretation of 10133.8 (e), which states: (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. **(2) Subdivision (e)** defines "interpreting" or "interpretation" as the "process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately, and objectively in another spoken or signed language, taking the cultural and social context into account." (emphasis added). ACLHIC would point out that there is nothing in the statute that requires interpretive services for hearing impaired persons. Instead, the statute is focused on non-English translations and interpreter services for Limted English proficient insureds (Section 10133.8 (b) (3) (D). This is further clarified in 10133.8 (b) (6) which requires the department to develop "standards to ensure the quality and timeliness of oral interpretation services." We would question the authority for inclusion of sign language interpreters in the requirements on the regulations. Secondly, related to Subdivision (e), we would point out that Section 10133.9 is limited to the insurer's internal programs and services and external informative communications related to the needs assessment on linguistic preferences, not the ability to have translation services. Thus, we feel the incorporation of cultural and social context into translation services to be beyond the scope of the law and would be difficult to comply with. For example, if a person called an AT&T TDD line for translation assistance, it would be impossible for the insurer to know whether the translator was taking all the cultural and social contexts of the insured into account. By the same token, it would be difficult, if not impossible, for the Department to establish reasonable measurements for enforcement. As a party to the negotiations and many discussions on SB 853, ACLHIC would point out that there was a	

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			reason why cultural appropriateness requirements were placed in a separate section, and not included and incorporated into the translation requirements of Section 10133.8. As a result of negotiations, the sponsors agreed to place a requirement that carriers themselves meet certain cultural appropriateness standards, including diversity among staff, training of staff, and development of various communications and educational information that is culturally appropriate. Thus, we see this definition, as well as its application within the regulations, as extending this criteria into the language interpretation provisions of the statute as going beyond the authority in law. **(3) Subdivision (i)** defines "Multiple languages" as those languages into which ballot/voting materials are translated. We will comment on this issue under Section 2538.3 (c). **(4) Subdivision (j)** defines "Points of Contact" as "an instance in which an insured accesses the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in-person contacts." We view this as potentially too broad and beyond those situations for which translation may be necessary. Consistent with Section 2538.6 (b) (1) of the regulations, we would ask that the definition be limited as follows: (j) "Points of Contact" an instance in which an insured accesses *those* ~~the~~ services covered under a health insurer's policy or certificate, *that can be reasonably anticipated,* including administrative ~~and clinical~~ services, *and physician and patient dialogue in clinical settings* .~~telephonic and in-person contacts~~ **(5) Subdivision (o) (4)** includes individual insurance policies and certificates of insurance as "vital documents" for the purposes of written translation. The statute (10133.8 (b) (3) (B)) is very specific as to those documents that are to be included, but prohibits the translation requirements to exceed the Department of Health and Human Services Office of Civil Rights Policy Guidance (65 Federal Register 52762 (August 30, 2000)). The insurance policy is equivalent to an Evidence of Coverage (EOC) that health care service plans provide their enrollees, and can exceed 100 pages. It was the result of negotiations and the obvious	

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			costs involved in translating such a huge document that policies and EOCs were not included in the statute. We would ask that (o) (4) be stricken. **SECTION 2538.3 LANGUAGE ASSISTANCE PROGRAM** **(1) Subdivision (a)** has an implementation date of January1, 2008. The Department of Managed Health Care have an implementation date under their proposed regulations to implement the law of July 1, 2008. Since many health insurers also have health care service plan licenses and thus will be attempting to implement their language assistance programs as required under both the Department of Managed Care and Department of Insurance, we would ask that the Department amend their regulations to reflect the later date of July 1, 2008 to avoid the costs of implementing two similar programs on two different dates. **(2) Subdivision (c)** requires that health insurers develop a written notice that discloses the availability of language assistance services in multiple languages, as defined in Section 2538.2 (i) as those languages for which ballot and voting materials are translated. According to the Secretary of State's website, those languages currently are: Chinese, Spanish, Tagalog, Vietnamese, Korean and Japanese. These could change as determined by the Secretary of State. ACLHIC would note that the requirement for health insurers to advise LEP insureds of the availability of interpreter services is found in 10133.8 (b) (3) (D). Subdivision (3) in its entirety sets out the requirements for the translation of vital documents, and related standards, including this notice requirement in subparagraph (D). Subdivision (3) limits an insurer's responsibility to translate documents into no more than two languages according to the survey requirements of subparagraph (A) (or more if 0.75 percent or 15,000 enrollee indicates a preference). Thus, the requirement in the regulations to translate the notice into up to 6 languages, many of which may not be threshold languages, exceeds the statute. We would ask that the notice be required to be translated into the threshold languages only, unless an insurer wishes to translate it into more languages.	

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			SECTION 2538.4 NEEDS ASSESSMENT OF INSURED POPULATION **(1) Subdivision (a)** requires that every health insurer survey the language preferences and assess the linguistic needs of insureds within one year of the effective date of these regulations. ACLHIC would ask for some clarity as to how the department interprets the term "insureds," since it is used in the statute without definition. It is not clear whether "insureds" relates to individual insureds or all insureds. We would ask that the Commissioner grant insurers the flexibility under Section 10133.8 (c) (8) and (9) to survey their entire population, rather than each individual insured. Under group settings, carriers would most likely send the survey to the policyholder, or employer, and ask that they submit a preference. Other carriers may wish to use census data to determine the linguistic needs of their insured population. Obviously, having to survey each individual insured, which can be several in each household including children, could be cost prohibitive. We would also object to the requirement that the survey materials be printed in the multiple languages as defined in the regulation. Again, this would exceed statutory authority, as described earlier in this letter. **SECTION 2538.6 INDIVIDUAL ACCESS TO ORAL INTERPRETATION SERVICES** **(1) Subdivision (b) (4) (C)** includes a requirement that insurers contract with outside interpreters, including sign language interpreters. Again, as mentioned previously in this letter, the inclusion of services for the hearing impaired exceeds the statutory intent and authority in this statute. **(2) Subdivision (b) (5)** prohibits the use of minors, under the age of 18, except in the case of a medical emergency. **Subdivision (c)** allows the use of an adult family member or friend as an interpreter, as long as the insured has been informed that a qualified interpreter is available at no charge. If the insured refuses the offer, it must be noted in his/her medical file or health insurer file. While ACLHIC understands the reasons for these limitations and prohibitions, there is nothing in the statute that authorizes the department to place these restrictions on the process. Further, an insurer only knows an insured has accessed care covered under the policy when a claim is submitted. An insurer could not reasonably know nor "police" a provider to	

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			ensure that an offer has been made and a refusal noted. This is exacerbated by the fact that an insured can access any provider, not just network providers, and does not have to go through a primary care provider under a health insurance policy. Thus, this requirement would impose on carriers a responsibility for which they could not reasonably comply. ACLHIC would note that Section 2538.3 (c) requires that health insurers develop a notice disclosing the availability of language assistance services and explaining how those services are to be accessed. The notice is required to be included with all vital documents and all correspondence confirming a new or renewed enrollment. Thus, insureds should know their rights before they access health care. In addition, most providers are already required to provide translation services under Medicare and Medi-Cal and post that information in several languages in the providers' offices. Should an insured choose to take a trusted family member or friend instead of availing themselves of this opportunity, then the insurer should not be held to a documentation standard for which they could not consistently comply. ACLHIC would also point out that many health insurers are national companies that centralize their claims, enrollment and other administrative services. Individual documentation in an insured's files would impose a tremendous cost and resource burden, as this information would have to be hand-inputted. **(3) Subdivision (d)** requires health insurers to develop policies and procedures to ensure the quality and timeliness of oral interpretation services provided to insureds, as required by the statute. However, it also requires that these procedures include mechanisms for ensuring the proficiency of individual interpretation services, including a documented and demonstrated proficiency in the source and target languages, and sensitivity to the LEP person's culture…" (emphasis added). Since many carriers will be contracting with telephonic or other technological services outside of the providers' offices, this would be a requirement for which insurers could not reasonably comply, except to change the vendor upon complaint. It is doubtful that the vendor will be able to provide this information to the insurer. Could the department provide clarity as to how this requirement could be reasonably complied with? **REQUIREMENTS RELATED TO "LIMITED BENEFIT" PLANS**	

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			As the department is aware, the requirements of SB 853 (2003) impose a much greater burden on limited benefit policies, otherwise known as "supplemental" policies. These include vision-only, dental-only and other plans that are very low premium and have very limited clinical settings. While we realize the statute does not necessarily exempt these policies, we would ask that the department allow, under Section 10133.8 (c) (8) and (9), to allow greater flexibility in how the requirements of the law are met. Specifically, ACLHIC would like to request that limited benefit plans be allowed the option of foregoing the expensive needs assessment, and instead translate documents into the top two threshold languages as identified by health insurers writing coverage for more comprehensive coverage in their Language Assistance Program as submitted to the department. For example, if the department, upon receipt of the LAP documents from health insurers determines that the most common two threshold languages identified in those documents is Spanish and Chinese, then limited benefit plans could have the option to translate their documents in those two languages, rather than go through an expensive needs assessment. Again, we would point out these low premium products are disproportionately impacted by the costs associated with the requirements of SB 853. Secondly, we would ask that the department include similar authority as included in the Department of Managed Health Care proposed regulations to allow limited benefit plans to demonstrate adequate availability and accessibility of competent bilingual providers and office staff to provide meaningful access to LEP enrollees as satisfying the translation requirements at points of contact. Again, we would point to the need for flexibility and cost effectiveness as applies to these products. You may note that we are using the term "limited benefit policies." There is no definition for these products in statute or regulations currently. However, this is the term that the department uses in approving these products. We are proposing a definition below, which we are requesting be incorporated into the definition section of the regulation, which would incorporate the description that the department requires in the Outline of Coverage for these products, as well as describing those products that generally fit into this category. You'll note that this list also is consistent with those products that routinely are exempted from mandated	

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			benefit legislation and other legislation not aimed at more comprehensive "major medical" insurance. We hope this definition will add clarity to our request and the regulations. *The term "limited benefit policy" means an individual or group policy of health insurance that is not marketed or sold as a substitute for comprehensive hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Such limited benefit policies include, but are not limited to, vision-only, dental-only, short-term limited duration health insurance, Medicare-supplement, Champus-supplement insurance, or hospital indemnity, hospital-only, accident-only, or specified disease disability insurance that does not pay benefits on a fixed benefit, cash payment only basis.*	
5	**Armand Feliciano BC Life & Health**		After reviewing the proposed regulations, it is our position that some provisions exceed statutory authority, unclear, inconsistent, and costly. In particular, we are concerned with the following: 1. Requirement to consider culture in providing linguistic services; 2. Reference to multiple languages as opposed to threshold languages; 3. Requirement to provide for notice of language assistance; 4. Requirement to include individual insurance policies and certificates of insurance as part of vital documents; 5. Potential liability of health insurers; and 6. Overall costs of the regulations. As discussed below, we address these major concerns as well as technical issues. **I. The requirement to consider culture in providing linguistic services must be stricken because it lacks statutory authority and is unclear. Similarly, the inclusion of sign language as part of the definition of "interpreting," "source language," and "individual access to oral interpretation services" must be excluded because they lack statutory authority.**	

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			Based on SB 853's legislative history, the Legislature intended to exclude cultural factors from the regulation requiring health insurers to provide language assistance. We specifically cite SB 853 as amended on September 4, 2003, whereby "and culturally competent health care services, as appropriate" was stricken from the requirement that CDI develop standards to provide insureds with appropriate access to translated materials and language assistance. In that same version of SB 853, the "operational definition of cultural competency" was also expressly deleted from the bill. Furthermore, we believe that "culture" is sufficiently unclear because it could have more than one meaning. Does it mean that interpreters have to be aware of an insured's customary beliefs or specific behaviors? Must an interpreter somehow have access to detailed information regarding an insured's background and social history? As to the inclusion of sign language, we believe this goes beyond statutory authority as well because such requirement has never been stated in the final or any of the amended legislative versions of SB 853. We, therefore, suggest the following deletions below: § 2538.1-Authority and Purpose (b) The purpose of these regulations is to accomplish maximum accessibility to language assistance services, ~~including culturally competent oral interpretation~~ and written translation assistance and to set forth …. § 2538.2- Definitions (e) "Interpreting" or "interpretation" means the process of understanding and analyzing a spoken ~~or signed~~ message and re-expressing that message faithfully, accurately and objectively in another spoken ~~or signed~~ language, ~~taking the cultural and social context into account.~~ (g) "Language preferences and linguistic needs assessment" means assessing and	

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			determining the spoken and written language preferences ~~and cultural needs~~ of the insured population. (l) "Source language" means the language used by the speaker ~~or signer~~ and out of which the message is interpreted into a target language. § 2538.3- Language Assistance Program (b) (6) Provision of adequate and ongoing training regarding the LAP for all staff who have contact with LEP persons. The training shall include instruction on …, ~~and cultural differences among and diversity of the health insurer's insured population~~; § 2538.5- Written Translation of Vital Documents (c) Health insurers may implement the translation of vital documents in phases by submitting a written request to the Commissioner detailing their plan, timeframe, rationale and projected impact on the receipt of ~~culturally and~~ linguistically competent health care by insureds. § 2538.6- Individual Access to Oral Interpretation Services (b)(1)(C) Contracting with outside interpreters ~~including certified sign language interpreters;~~ (d) Every health insurer shall develop policies and procedures to ensure the quality and timeliness of oral interpretation services provided to insureds. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing interpretation services, including a documented and demonstrated proficiency in the source and target language, ~~sensitivity to the LEP person's culture~~ and a demonstrated ability to	

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			convey information accurately in both languages. § 2538.7- Health Insurer Monitoring, Evaluation & Reporting (c) Within one year after the health insurer's initial assessment, every health insurer shall report to the Department of Insurance on the implementation of its Language Assistance Program and its internal policies and procedures ~~related to cultural appropriateness~~. **II. The references to "multiple languages" exceed statutory authority and are inconsistent with existing law.** Upon reviewing the legislative history of SB 853, we did not find any statutory authority for "multiple languages … as determined by the California Secretary of State for the current year." However, SB 853 states in part the following: For those documents described in subparagraph (B) that are not standardized but contain enrollee specific information, health insurers 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**. (Ins. Code § 10133.8) We believe this language is instructive. It is imperative to clarify at the outset that health insurers are required to identify "threshold languages," as opposed to "multiple languages." Indeed, adhering to the legislative requirements of SB 853, the Department of Managed Health Care provided for a definition of "threshold languages" in its proposed regulation. (1300.67 (b)(4)). It is equally important to clarify that health insurers are required to provide	

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			the notice of the availability of interpretation services in "threshold languages," rather than "multiple languages." Additionally, SB 853 requires the CDI to consider the cost of compliance and to allow for health insurer flexibility in determining compliance. (Ins. Code & 10133.8 (c) (8) (9)). We believe "multiple languages … as determined by the California Secretary of State for the current year" is much more expansive and costly than what is required under SB 853, and is fundamentally inconsistent with the intent of the Legislature as reflected in the express language of the statute. Among other things, the multiple languages determined by the Secretary of State may indeed differ from the threshold languages determined by a needs assessment of a particular insurer in its particular market. In light of these concerns we recommend the following changes below: § 2538.2- Definitions (Delete the definition of multiple languages and replace it with a definition of threshold languages) ~~(i) "Multiple languages" means the number of and specific languages into which voting/ ballot materials are translated as determined by the California Secretary of State for the current year.~~ **(i) "Threshold Languages" means the languages identified by a health insurer pursuant to Ins. Code & 10133.8. (b) of the Act.** § 2538.3- Language Assistance Program (Delete the reference to multiple languages and replace it with threshold languages)	

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			(c) Health insurers shall develop a written notice that discloses the availability of language assistance services to insureds and explains how to access those services. This notice shall contain the required information in ~~multiple languages~~ **threshold languages**, as defined above. § 2538.5- Written Translation of Vital Documents (Delete the reference to multiple languages and replace it with threshold languages) (b) For those vital documents that contain insured-specific information, …, written in ~~multiple languages~~ **threshold languages**, as defined …. **III. The requirement to provide for notice of language assistance should be modified to minimize the cost of implementation and allow for health insurer flexibility.** As mentioned above, SB 853 requires the CDI to consider the cost of compliance and to allow for health insurer flexibility in determining compliance. (Ins. Code § 10133.8 (c) (8) (9)).” In cases where a health insurer has identified the insured’s preferred language, we think it is cost-efficient to provide the notice that discloses the availability of language assistance services only in the insured’s preferred language. For example, if we are aware that our insured’s primary language is Spanish, then that member should receive the notice only in Spanish. We suggest adding the following language: § 2538.3- Language Assistance Program (Add (i) to (c)) **(i) If an insured’s preferred language is identified, this section shall be satisfied by including the notice only in the insured’s preferred language.** **IV. The requirement to include individual insurance policies and certificates of insurance as part of**	

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			the definition of vital documents must be deleted because it is inconsistent with existing law. The final version of SB 853 explicitly stated the types of vital documents that must be translated such as applications and consent forms. It also specified that "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)) …." The OCR guidance sets forth the following standard: > If written translation of a certain document or set of documents would be so financially burdensome as to defeat the legitimate objectives of its program, or if there is an alternative means of ensuring that LEP persons have meaningful access to the information provided in the document (such as timely, effective oral interpretation of vital documents), OCR will not find the translation of written materials necessary for compliance with Title VI. As noted above, SB 853 requires the CDI to consider the cost of compliance and to allow for health insurer flexibility in determining compliance. (Ins. Code § 10133.8 (c) (8) (9)). We believe that requiring health insurers to translate individual insurance policies and certificates of insurance is financially burdensome that it defeats one of the legitimate objectives of SB 853. Based on SB 853's legislative history, it is apparent that the cost of providing linguistic services was a major concern for health insurers. To address this concern, the Legislature agreed to delete the requirement that health insurers translate **documents produced by the health insurer that are distributed to enrollees** and **documents required by contract with providers** (See SB 853 as amended on September 4, 2003). As reflected in the final	

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			version of SB 853, the Legislature also agreed to adopt language stating that the cost of compliance must be considered by the CDI. An individual insurance policy is about 60 pages in length. We estimate the total cost of translating an individual insurance policy into three languages could cost up to $7.8 million; this is financially burdensome when added to other costs associated with the proposed regulation. Alternatively, we believe that there is a less burdensome approach to ensure that LEP persons have meaningful access to the information provided in the individual insurance policy and certificate of insurance. In particular, the proposed regulations require health insurers to provide individual access to interpretation services and adequate training to all staff who have contact with LEP persons (§ 2538.3 (b)(5)(6)). Under Section 2538.3, an insured can simply contact our staff and obtain oral interpretation of an individual insurance policy and certificate of insurance. This approach avoids adding unnecessary costs and provides flexibility to health plans. **V. The potential liability in the event of a miscommunication should be addressed in the proposed regulation to be consistent with existing law.** As previously raised in other sections, SB 853 requires the CDI to consider the cost of compliance. (Ins. Code § 10133.8 (c) (8)). Under the proposed regulations, health insurers could potentially be sued for any miscommunication that may occur as a result of interpretations conducted by vendors. We believe this falls under the cost of compliance, and therefore request the following language to be adopted: § 2538.3- Language Assistance Program	

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			(e) Health insurers are not liable for any miscommunication that may occur as a result of interpretations conducted by vendors who meet or exceed the standards promulgated by the California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare. **VI. Overall Costs of the Regulation to Health Insurers** As discussed above, we remain concerned with the expansive approach proposed by the CDI in implementing the health care language assistance program. In our thorough review of SB 853's legislative history, we affirm that it is the will of the Legislature to have a narrow application of the health care language assistance program and for the CDI to give full consideration to the cost of compliance. Although it is difficult to quantify the total cost of the proposed regulation at this time, below is a list of anticipated costs we expect from the proposed regulation: • Expand Health Information Technology to accommodate expenses associated with translation of vital information- $2.7 million • Translate individual insurance policies into 3 languages- $7.8 million • Liability exposure to health care service plans - unknown at this time but could be significant.	
6	**Keith Pugliese Brown & Toland**		• **Section 2538.2(a)**: The following definition should be changed in accordance with the scope of the underlying statute: "'Demographic profile' means~~, at a minimum,~~ primary/preferred spoken and written language, race, and ethnicity of insureds who reside in California~~, race and ethnicity~~." • **Section 2538.2(e):** The proposed requirements of "signing" and "taking the cultural and social context into account" in the definition of "interpreting" and "interpretation" are not supported by the underlying statute and therefore should be stricken.	

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			• **Section 2538(2)(i):** The underlying statute does not authorize the use of the term "multiple languages" to include the languages considered for translation by the California Secretary of State. The underlying statute allows one method for determining an "indicated/threshold language" (Insurance Code § 101338(b)(3)(A) – (C)). The underlying statute's intent is to limit interpretive services and translation of vital documents to the threshold languages. • **Section 2538.4**: The scope of the language assistance needs assessment of the insured population needs to be clarified to assess only the language assistance needs of its insured population who reside in California. • **Section 2538.5**: The scope of insured for whom health insurers will write translation of vital documents be contained to only those who reside in California. • **Section 2538.7(a)**: The underlying statute does not modify or reach to the California Business & Professions Code, so therefore the health insurer cannot perform any monitoring, evaluation, and/or reporting of a provider unless the provider has agreed in writing to be delegated any part of the health insurer's language assistance program. • Lastly, Brown & Toland requests that the Department make the regulation clear that cost and funding incurred by the health insurer to implement and provide on an ongoing basis a language assistance program to LEP insureds is not in any way, directly or indirectly, passed on to a provider unless a provider or provider organization negotiates additional administrative compensation and agrees to accepting financial risk of providing any part of a health insurer's language assistance program services.	
7	**Tom Riley**		CAFP offers the following two recommendations:	

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	California Academy of Family Physicians		) There are some instances in which needed translation services extend beyond vital documents, such as in the case of discharge instructions to a patient, signage or in marketing material designed to help a potential buyer of health insurance understand and compare benefits prior to purchasing. Both timely access to services for limited English insureds and the policies and procedures that prescribe this access must address both the written and spoken word, not just verbal interpretation. This problem may be addressed by use of "language assistance" (as defined in Section 2538.2 to mean both oral and written translation) on Page 6, throughout 2538.6 (a) and (b): **§2538.6Individual Access to ~~Oral Interpretation~~ Language Assistance Services** (a) Every health insurer shall provide timely individual access to ~~interpretation~~ language assistance services at no cost to LEP insureds at all points of contact where language assistance is needed in accordance with these regulations. For purposes of this section, "timely" means in a manner appropriate for the situation in which language assistance is needed. (b) Every health insurer shall develop policies and procedures that describe the health insurer's methods for providing timely ~~interpretation~~ language assistance services, including, but not limited to the following: (1) The points of contact where the need for ~~interpreting~~ language assistance may be reasonably anticipated; (2) The types of resources necessary in order to provide effective ~~interpreting~~ language assistance to the health insurer's insureds; (3) The arrangements that the health insurer will make to provide timely access to ~~interpreting~~ language assistance at all points of contact at no charge to insureds; (4) The range of ~~interpreting~~ language assistance services that will be provided to insureds as appropriate for the particular point of contact. The range of services may include, but is not limited to: (A) Bilingual health insurer or contractor/health care provider staff available for the duration of the	

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			need; (B) Hiring staff interpreters and translators; (C) Contracting with outside interpreters and translators including certified sign language interpreters; (D) Making volunteer interpreters and translators available; and (E) Contracting for remote interpreting, as defined, for an LEP person.) We believe that it is the intent of Section 2538.3 (d) to ensure that all language assistance services (provided by physicians whose payment arrangements with insurers fall under the regulatory purview of the Department of Insurance) are paid for or reimbursed by health insurers. We believe that it also the intent of these regulations to allow flexibility in arrangements for this payment and/or reimbursable expense. We are concerned that the expression "delegated financial responsibility" may be misconstrued to mean that it is the option of health insurers to simply delegate this responsibility to contracted providers who have little negotiating power to ensure fair payment for these services. We would propose strengthening the intended purpose of 2538.3 (d) by stating that: "In the event of any dispute between health insurer and provider over financial responsibility for language assistance, the Department shall presume the full financial responsibility to be that of the health insurer."	
8	**Adama Iwu/William Barcelona California Association of**		**Section 2538.2(e):** The definition of "interpreting" and "interpretation" includes elements beyond the authority and reference conveyed by the statute, including the requirement of "signing" and "taking the cultural and social context into account." Neither of these requirements is stated in the underlying statute, SB 853, and no necessity is derived from the underlying authority. **Section 2538.2(i):** There is no authority given in the underlying statute for the use of the definition "multiple languages" to include the languages into which voting materials are translated by the California Secretary of	

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	Physician Groups		State (Spanish, Chinese, Vietnamese, Japanese, Korean and Tagalog). The underlying statute provides only one method for determining an "indicated language" or "threshold language" at Insurance Code § 101338(b)(3)(A) – (C). The statute is silent concerning any difference in the number of languages to be provided for interpretation purposes in contrast to the translation of vital documents. However, the legislative intent to limit interpretive services to the threshold languages is clear from the language of Section 101338(b)((3)(C), which states: *…but rather shall include with the document a written notice of the availability of interpretation services in the threshold languages…* Had the legislature intended for the Department to provide a greater number of languages to LEP enrollees in the interpretive process in contrast to the translation process, it would have provided an alternative process to the one set forth at §101338(b)(3)(A). For these reasons, the Department should delete the proposed language of this section and then revise the language for the definition of "indicated/threshold language(s)" stated at §2538.2(c) to state: *"Indicated/threshold language(s)" means the languages(s) identified by a health insurer pursuant to these regulations into which vital documents shall be translated, and interpretation services provided.* In addition, all subsequent sections of the proposed regulation's text which currently cite the phrase "multiple languages" should be revised to state the phrase "indicated/threshold language(s)" – including, but not limited to: • §2538.3(c) – written notice • §2538.4(a) – needs assessment • §2538.5(b) and (b)(2) – translation requirements **Section 2538.6(a):** This section should be revised to delete the phrase "in accordance with these regulations" and substitute the phrase "the indicated/threshold language(s)" given the foregoing arguments concerning the lack of authority, reference and need for clarity made in the previous section of these comments. The purpose of the regulation is to clarify the underlying statute, which specifies that the number of languages to be provided for interpretive services is limited to the "threshold languages" as stated at §101338(b)((3)(C). **Section 2538.6(c):** This section, which includes the phrase *"An insured may request the use of an adult*	

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			family member or friend as the interpreter in a non-emergency situation" is drafted in an oddly paternal manner. The insurance code conveys jurisdiction over health insurers, not individual consumers or insureds. No authority is conveyed under the statute to require an *individual consumer* to perform a certain act. The cited phrasing implies that there are circumstances under which an insured *may not* obtain health care services without the presence of an interpreter other than of their own choosing. Accordingly, the first and second sentences of this section should be revised to state: "In all non-emergency situations where an insured selects the use of an adult family member or friend as an interpreter, the insured shall be informed in his or her primary identified language that a qualified interpreter is available at no charge to the insured. In addition, the Department lacks authority under the statute to impose jurisdiction over health care providers to make notations in the "medical record" as cited in the second to last sentence of the proposed text of this section. The underlying statute does not add or amend existing law under the Business & Professions Code, and therefore may not compel any action, administrative or other, by a health care provider. The phrase "medical record" should be deleted from this section. Removal of the offending phrase does not negatively impact the proposed regulation as the original purpose and intent of the regulation will ultimately be achieved either by the Plan itself notating the member record or by the Plan and its contracting provider agreeing to work together to make the notation in a manner that is both compliant and acceptable between those parties	
9	**Paul B. Simms California Black Health Network, Inc.**		."No person in the United States shall, on ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance." 1. A HEALTH CARE SYSTEM THAT IS RUN BY PEOPLE WHO SPEND OTHER PEOPLE'S MONEY (OPM) LIKE THEY SPEND THEIR OWN - PRUDENTLY; 2. A HEALTH CARE SYSTEM THAT DOES NOT JUDGE PATIENTS FOR THEIR POVERTY	

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			OR TREAT THEM DIFFERENTLY BECAUSE OF DIFFERENCES IN RACE OR LANGUAGE; 3. A HEALTH CARE SYSTEM THAT DOES NOT OPERATE WITH A "FOOD STAMP" MENTALITY; 4. A HEALTH CARE SYSTEM COMMITTED TO LIVING WITHIN ITS MEANS; 5. A HEALTH CARE SYSTEMS THAT DOES NOT DEFINE POOR PEOPLE AS "TEACHING MATERIAL"; 6. A HEALTH CARE SYSTEMS THAT EMBRACES PATIENTS AND PLACES THEIR NEEDS AND INTERESTS FIRST; 7. A HEALTH CARE SYSTEM THAT IS GOOD ENOUGH FOR OUR GRANDMOTHERS;	
10	**Edmund Carolan California Dental Association**		**Lack of Clarity in Proposed Language;** The enabling authority (**California Ins Code § 10133.8 and 10133.9)** for the proposed regulatory language states that the Department shall develop regulations establishing standards and requirements (emphasis added) to provide individual and group policyholders with appropriated access to translated material and language assistance in obtaining covered benefits. The proposed regulatory language for sections 2538.1through 2538.8 develops few , it any, standards and requirements other than the requirement that health care services plans create a LAP program of the plan's own choosing. It is not even clear from the proposed language if it is a requirement for the health plan to submit its LAP proposal to the Department for approval as there is a lack of explicit language that establishes such a requirement. For the purpose of regulatory approval, clarity is defined as meaning "the writing or displaying in a manner so that the regulations are easily understood by persons directly affected by them." CDA contends that under the proposed regulatory language, the Department will have no authority to require a health insurer to	

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			improve or modify their: LAP program because there are no established standards that and LAP must meet. The Department will be required to accept whatever the health plans present due to the lack of clarity in establishing uniform stands or requirements for LAPs. Areas where CDA finds the "requirement" and standards" inadequate and lacking in clarity include but are not limited to: **Section 2538.6 (b) (2)** Of the proposed regulatory language states that health insurers develop polices and procedures for identifying "the type of resources" needed for providing LAP services. If a plan's only method for identifying these resources is to wait until requests from customers are submitted requesting select resources, would that be sufficient "method" in the Departments opinion? From the proposed regulatory language, there does not appear to be any requirement for approval other than to have polices and procedures for identifying such resources. Absent the use of underground regulations, which are unlawful, the Department will not have any standard or authority to disapprove a health insurer's method for identifying **Section 2539.6 (a)** Of the proposed regulatory language states that "timely; means in manner appropriate for the situation in which the language assistance is needed." Who is determining "appropriate"? The lack of clarity in the proposed regulatory language has far reaching implication that go beyond the ability of the health insurers to develop LAPs;o ; it will be virtually impossible for a consumer to know whether they are being treated fairly when requesting LAP services; the language will place health are providers in the untenable position of trying to decipher multiple LAPs and: the lack of clarity in establishing uniform standards makes enforcement of the law virtually impossible. Furthermore, CDA argues that the Department, given the lack of clarity in defining timely, has not met all the requirements of necessity for promulgating these regulations. The standards for ensuring that enrollees have timely access to language assistance services have not been established as required by law. The Initial Statement of Reason is conspicuously void of any mention of any regulatory language to establish a standard to implement the provision of subsection (b) (6) of Insurance Code §10133.8. This section of law requires the Department to adopt regulations to establish"[S] tandards (emphasis added) to ensure the quality and timeliness of oral interpretation services provided by health care service plans". Instead, the Department has proposed regulatory language that requires the health insurer to provide "timely interpretation services" and	

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			timely is defined to mean in " manner appropriate for the situation in which language assistance is needed" ***Webster's Desk Dictionary, 1993 (Random House) defines a standard as:*** **1.** something accepted as a basis of comparison **2.** a rule used as a basis for judgment. **3.** the authorized exemplar of a unit of weight or measure. **4.** a flag, as one indication the presence of a sovereign. **5.** an upright support. **6.** being or meeting a standard **7.** of recognized excellence of authority: a starnard reference book **8.** usual of customary How the Department will evaluate and monitor a health insures for compliance with providing timely oral interpretation services is unclear. However, CDA suspects that absent a legally adopted standard for what constitutes timeliness in providing oral interpretation services, the Department will be forced to revert to underground regulations to define such a standard. Nevertheless, the Department should be required to substantiate the necessity of why they have proposed regulatory language that fails to define a standard for providing timely interpretation services. Furthermore, CDA questions under what authority the Department is using to pass the requirements of establishing "standards" for the LAP to the health plans when it is very clear that lawmakers vested the authority for developing regulations for LAP with the Department. **The Proposed Regulation appears to Exceed the Authority of the Department Law.** CDA also believes that portions of the proposed regulatory language exceed the statutory authority given to the Department for developing standards and regulations for LAPs. California law, Government Code Section 11342.1, requires that each regulation adopted, to be effective, shall be within the scope of authority conferred and in accordance with standards prescribed by other provisions of law. For the following items, as proposed by the regulatory language set forth, there is no expressed or implied authority granted to the Department: **1) Section 2538.3 (b) (6)**	

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			Requires health insurers to develop policies and procedures that provide for the training of the insurer's staff in "cultural differences among the diversity of the health insurer's insured population". **Section 2538.6 (d)** Requires that health insurers develop policies and procedures ensuring that the proficiency of the individual providing interpretation services to include "sensitivity to the LEP person's culture" Notwithstanding the lack of clarity in what is meant to be "sensitive" to an LEP culture, the authority cited for the proposed regulatory language requires the Department to adopt standards and requirements for health plan's "language assistance programs" not cultural awareness or cultural sensitivity programs. There is no expressed or implied statutory authority that would require a health insurer to provide its staff with cultural awareness or neither diversity training nor the insurer's staff is sensitive to a person's culture. There fore , such proposed requirements that pertain to cultural diversity and awareness are an unauthorized expansion of the authority given to the Department to adopt regulations for LAPs **2) Section 2538.6 (b)(5)** States The use of minors, under the age of 18, as interpreters is prohibited except in the case of a medical emergency when time is of the essence. Notwithstanding the lack of clarity in defining medical emergency, CDA is not aware of any authority bestowed on the Department by the state policymakers that would allow the Department to tell the parent or legal guardian of a minor child, that that child can not serve as an interpreter for family or friends. CDA would encourage the adoption of language that is neutral for the use of family members, friends or minors as interpreters, with the main emphasis upon the patient's choice in whom they elect to provide interpretation. CDA understands the concerns about such situation. in which an English speaking child having to tell his or her parent that they have a life threatening health issue for instance. However, these concerns in dentistry are extremely rare. Therefore, a plan or provider should not be discouraged from using a child or other family member as an interpreter, should this be the preference of the patient. In fact, use of a family member to interpret will likely be the easiest, which is, the least onerous, means of complying with the intent of the regulations, and may be the preferred choice of the patient.	

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			Standard of Consistency Not Met One of the six requirements that the Office of Administrative Law will use to evaluate a regulatory proposal for compliance with the APA is consistency. Government Code Section 11349, subdivision (d) defines "consistency" to mean: being in harmony with, not in conflict with or contradictory to, existing statutes, court decisions, or other provisions of law. In the proposed regulatory language Section 2538.2 (j) defines point of contact to mean "an instance in which an insured access the services covered under the health insurer's policy or certificate including administrative and clinical services, telephonic and in person contacts". Then, the proposed regulatory language in Section 2538.6 (b)(1), states that "every health insurer shall develop polices and procedures that describe the health insurer's method for providing interpretation services…" to include "[T}he points of contact (emphasis added) where the need for interpreting may be reasonable anticipated". Finally, the proposed regulatory language Section 2538.6 (b)(3) states that the health insurer will develop polices and procedures that result in the insured having assess to interpreting t all points of contact (emphasis added) There appears to be inconsistencies between these three sections of proposed language because it appears that the Department has already defined where the point of contact occurs (section 2538.2(j)). Then the Department has determined that LAP services must be made available at all the points of contact in Section 2538.6(b)(3) . Therefore, it would be inconsistent to ask and to allow health insurers to redefine the points of contact where the health insurer thinks there e might be a need for LAP services as is being asked of the health plans in Section 2538.6(b)(1).	

CALIFORNIA DEPARTMENT OF INSURANCE
Response to Public Comments
SB 853 - Health Care Interpreter Regulations
First Comment Period
8/11/06 – 9/26/06

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11	**Don Schinske California Healthcare Interpreting Association**		To the list of interpreter competencies to de demonstrated under Section 2538.6(d) CHIA requests that insurers develop mechanism for ensuring that interpreters and bilingual staff demonstrate knowledge of interpreting ethics, confidentiality, and professional conduct. CHIA's are in widespread use in California and in other states, and we would urge that training in the CHIA standards specifically be added as minimum requirement. In addition, the National Council on Interpreting in Health Care (NCIHC) has published standards consistent with CHIA's. Also, CHIA asks that the regulations clarify the financial responsibility for both the direct and the associated costs of providing language services. We request that the following language be added to Section 2538.3(d) (d) Health insurers shall require compliance with their language assistance program developed pursuant to these regulations in every contact between a health insurer and a contractor/health care provider and in every contract between and health insurer and a person or other entity to which the health insurer has delegated and part of the health insurer's obligation to develop, implement, oversee the health insurer's Language Assistance program. The health insurer shall retain financial responsibility for the implementation of its Language Assistance Program, except to the extent that delegated financial responsibility has been negotiated separately and incorporated by reference into its contract. *Unless otherwise negotiated, the health insurer will retain the financial responsibility for training the provider's bilingual or interpreter staff and for assessing the employee's language proficiency, and knowledge of interpreting ethics, confidentiality, and professional codes of conduct.*	
12	**Dietmar A. Grellmann California Hospital Association**		California hospitals already provide language assistance services to their patients, and have developed language assistance policies consistent with the requirements of Health & Safety Code§1259 and federal law. CHA also supports efforts to improve these polices and provide better language assistance services to patients. However, portions of this regulation exceed the authority granted in SB 853, conflict with Health & Safety Code §1259, and lack clarity and consistency because it establishes multiple and conflicting standards. SB 853 does not grant the Department of Insurance any new authority to regulate hospitals. Hospitals are licensed by the Department of Health Services, not the Department of Insurance. Health & Safety Code §1259 requires hospitals to adopt and review annually a policy for providing language assistance services to patients with language or communication barriers. Additionally, §1259 requires hospitals to annually transmit to the Department of Health Services its updated language assistance policy with a description of its	

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			efforts to ensure adequate and speedy communication between patients with language or communication barriers and staff. Health & Safety Code §1259 establishes the content and implementation requirements of a hospital's language assistance policies. The Department's failure to coordinate the requirements of SB 853 and Health & Safety Code §1259 means that large centralized insurers, headquartered out-of-state, will establish language assistance policies that conflict with hospital policies developed locally. Hospital services are provided locally to unique and specific populations. Each hospital knows its own community best and can custom tailor policies and services to best meet the needs of its own patients rather than a generic policy developed by an insurer that would apply uniformly to disparate hospitals in different communities and regions. To avoid the problem of conflicting standards on hospitals, the Department should revise the regulations to require insurers to adopt the language assistance policies of their contracting hospitals as long as those policies comply with the requirements of Health and Safety Code §1259 and the language assistance services are provided at no charge to enrollees. Otherwise, the health plan is required to make its own arrangements in compliance with the regulations. This amendment would allow insurers and hospitals to coordinate language assistance requirements imposed by the Department of Health Services as well as this Department's implementation of SB 853. We suggest the regulations be amended to include the following provision: "To the extent that an insurer's contracting hospitals are providing language assistance services at no charge to the insurer's insureds and consistent with the requirements of Health & Safety Code §1259, the insurer shall incorporate, by reference or other appropriate method, into its language assistance program the language assistance policies of the contracting hospitals. Otherwise, the insurer shall make arrangements to provide language assistance services at no charge to the insurer's insureds utilizing the services of the insurer's contracting hospitals in accordance with the requirements of this regulation." We also wish to express our appreciation to the Department for ensuring that insurers do not pass on the costs of their obligation to comply with SB 853 to other parties, including hospitals. CHA supports Section 2538.3(d), which in relevant part provides as follows:	

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			"The health insurer shall retain financial responsibility for the implementation of its Language Assistance Program except to the extent that delegated financial responsibility has been negotiated separately and incorporated by reference into its contract." We have recommended similar language to the Department of Managed Health Care to ensure consistency in the regulation of health insurers and health maintenance organizations. Section 2538.6(5) exceeds the authority granted the Department by SB 853. There is no legal authority for the Department to prohibit a minor from interpreting for a patient *when requested by the patient*. This issue continues to be a matter before the Legislature and should be resolved through legislation, not regulation. Many patients insist on relying on a minor regardless of the fact that a professional interpreter is provided free of charge. *Hospitals are required to provide care and will not be able to force a patient to use a professional interpreter instead of a minor.* Section 2538.6(5) is also inconsistent with the regulation proposed by the Department of Managed Health care in 28 CCR §1300.67.04(I)(iii). Hospitals are not usually able to distinguish between a patient whose insurance is regulated by the Department of Insurance versus the Department of Managed Health Care at the time care is provided, thus creating serious implementation difficulties when a patient insists on using a minor for interpretation services. Section 2538.6(5) also conflicts with Health & Safety Code §1259(b)(2), which allows the use of minors to provide interpretation services if the hospital has made professional language assistance services available to the patient, and the patient has refused those professional services.	
13	**Michael Sexton California Medical Association**		**§ 2538.6 (b) (5)** States that, "the use of minors, under the age of 18, as interpreters is **prohibited except in the case of a medical emergency** when time is of the essence. The minor shall serve as an interpreter only until a qualified adult interpreter becomes available." (emphasis added) This prohibition goes beyond both State and Federal statute/guidance. State law on the use of minors as interpreters in non-existent. And the Federal	

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			Guidance in fact, authorizes the activity. Indeed, the revised Federal Policy Guidance states: Extra caution should be exercised when the LEP person chooses to use a minor as the interpreter. While the LEP person's decision should be respected, there may be additional issues of competency, confidentiality, or conflict of interest when the choice involves using minor children as interpreters. The recipient should take reasonable steps to ascertain whether the LEP person's choice is voluntary, whether the PEP person is aware of the possible problems if the preferred interpreter is a minor child, and whether the LEP person knows that a competent interpreter could be provided by the recipient at no cost. However, a recipient may not require an LEP person to use a family member of friend as an interpreter. In additional, in emergency circumstances that are not reasonably foreseeable, a recipient may not be able to offer free language services, and temporary use of family members of friends as interpreters may be necessary.[1] Accordingly, under these circumstances, it is entirely appropriate to use minors as interpreters and it is therefore inappropriate for the regulations to require that health insurer's policies and procedures to "prohibit" use of minors under the age of 18. **CMA therefore request that proposed Section 2535.6 (b) (5) be amended to remove the "prohibited" language; instead we recommend that the regulations cite the Federal Policy Guidance on the use of minors as interpreters.** **Specifically, we recommend that Section 2538.6)b) (5) be amended as follows:** The health insurer's standards for the use of family, friends, and minors as interpreters. The intent of these regulations is to provide qualified interpreting for all LEP insureds at no cost the LEP insureds at all points of contact where language assistance is needed. The use of minors, under the age of 18, as interpreter is ~~prohibited except~~ allowed if the insured is first informed that a qualified interpreter is available at no cost to the insured and that the insured may benefit from the use of that interpreter and in the case medical emergency when no qualified interpreter is available~~ and then only until a qualified interpreter becomes available~~. The offer of a qualified interpreter and the insured's refusal shall be documented in the medical record or otherwise documented by the health insurer. Secondly, Section2538.3 (b) (2) requires that the health insurer's Language Assistance Program (LAP) provide written policies and procedures regarding how they will inform providers of the LAP requirement.	

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			We do not feel that this clause is comprehensive enough and would like the policy to ensure that physicians are able to navigate the LAP services offered by the health insurer, and without difficulty inform their patients how to access these services. **We therefore suggest that Section 2538.3 (b) (2) be amended as follows:** Notifying contracting providers of the LAP requirement, what LAP services are being offered by the health insurer, and how physicians should instruct LEP patients to access these services. Lastly, Section 2538.5 (a) (4) where the requirements fro written translation of vital documents is outlined, it appears there is a prohibition against a health insurer translating any additional documents, unless required on a case by case basis. We do not want to prevent health insurers from taking the initiative to translate extra documents because of this language. **We therefore request that Section 2538.5 (a) (4) be amended as follows:** It shall not be required that translated document include a health insurer's explanation of benefits or similar claim processing information that is sent to insured's unless the document requires a response by the insured. [1]"Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons." Federal Register 153 (August 8, 2003): 47311-47323	
14	**Elizabeth Abbott Health Access**		**A Mechanism to Anticipate Insureds Language Needs** We believe the proposed regulation should include a mechanism for insurers to anticipate the language needs of their insureds. Insurance companies will not always know who their insureds are in advance of them seeking care, and therefore, would have difficulty anticipating their insureds' language needs. We propose the addition of the following specifics to the regulation: √ **Insurance companies should include a language-need question as part of the enrollment package** for people who sign up as part of the individual market. This would be a straightforward way to capture language preferences for individuals who directly purchase their health insurance.	

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			√ In the group market setting, the Department could encourage **insurance companies to provide a toll-free telephone number to record the language needs of their insureds as part of the enrollment process** or shortly thereafter. The group plan administrator or employer could advise their members to call the telephone number to establish the need for language services in a language other than English. This would provide a reasonable opportunity for an assessment of language needs prior to an urgent care or emergency encounter or appointment. √ **Language needs should be established or confirmed concurrently with any care actually delivered.** This would act as a fail-safe mechanism to confirm and record language preferences of their enrollees. **Requirements for Interpretation Services** The insurance industry has raised the issue about the minimum requirements for interpretation services. The statutory language in SB 853 is clear. 10133.8 (a) is amended to read as follows: "The commissioner shall. . . 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. . . . (5) Requirements for individual access to interpretation services." [emphasis added]** The requirements enumerated in 10133.8 (2) (3) and (4) deal with translation of documents and reference threshold languages and survey requirements. Section (5) and (6) detail the requirements for interpretation services and are quite specific and are not limited. In addition, we would like to provide some additional information regarding the implementation of this regulation. **Video Medical Interpretation (VMI) as an Example of Cost-Effective Implementation of Language Assistance Services**	

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			It is expected that insurance companies will raise concerns about how to assure cost-effective implementation of language assistance programs. Since1999 Health Access has been instrumental in establishing and nurturing a program that provided video medical interpretation (VMI) services to the very clients intended to be helped by this regulation. We tested whether it was possible to use technology -- specifically the internet -- to provide access to interpretation services. VMI includes not only voice (as is done over the telephone) but also television-quality video made possible by computers and the internet. For example, with this technology a clinic in Hayward that has a Cantonese-speaking patient can access an interpreter at Highland hospital in Oakland: literally the physician and the patient can be in an exam room in Hayward with a computer screen that allows them to see and hear a trained medical interpreter in Oakland. This is not just an untested, but promising concept. Health Access has received foundation funding to pilot this video link in some of the most challenging clinical settings in California specifically to test the idea of using video access in place of live interpreters. This concept is currently being tested in the public county hospitals in Alameda and San Francisco counties. These public county hospitals receive approximately 200,000 requests for interpretation annually. Both facilities had a tradition of providing a range of interpretation services with about 50 full-time interpreters between them. In addition, both facilities are county hospitals, challenged by funding and other management difficulties that made innovation more difficult. The results of the VMI Project are as follows: √ The VMI project has shown that from 45 minutes to less than 10 minutes. **wait times for interpreters could be slashed** √ The **electronic connection** to an interpreter via videoconferencing takes less than one minute. √ **The project provides services in 21 languages**: Amharic, Arabic, Bosnian, Cambodian, Cantonese, Dari, Farsi, Hindi, Korean, Lao, Mandarin, Mien, Pashtu, Punjabi, Russian, Spanish, Tagalog, Thai, Tigrigna, Urdu and Vietnamese.	

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			Based on the success of VMI, Health Access has now spun off the Health Care Interpreter Network (HCIN) which is available to any hospital or clinic in the state. Consumers who live in San Joaquin, Contra Costa, San Mateo, Alameda and San Francisco counties may now experience video-medical interpreters at the public hospitals and clinics. Additional hospital systems which will be testing the Health Care Interpreter Network over the next several months include Riverside County Regional Medical Center and Rancho Los Amigos National Rehabilitation Center. We would be pleased to arrange a demonstration of this video medical interpretation (VMI) project if you or your staff would find it helpful.	
15	**Conrad D. Llaguno Kaiser Permanente**		1. **§ 25382.2 Definitions** ***"Point(s) of Contact" means an instance in which an insured accesses the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in-person contacts.*** KPIC requests that the definition of "Point(s) of Contact" be revised to include the term "reasonably anticipated". As a PPO carrier, KPIC cannot reasonably anticipate every possible point of contact with insureds, considering the open-ended nature of a PPO plan where insureds have access to any licensed provider be in or outside the network. We suggest the following revision: *"Point(s) of Contact" means an instance in which an insurer may reasonably anticipate that an insured will access the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in-person contacts.* ***"Vital Documents" includes but is not limited to the following documents when produced by the health insurer including when the production or distribution is delegated by the health insurer to a third party:***	

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			1) Applications; ***2) Consent forms, including health insurer authorization forms;*** ***3) Letters containing important information regarding eligibility and participation criteria;*** ***4) Individual insurance policies and certificates on insurance;*** ***5) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a complaint or appeal;*** ***6) Notices advising LEP persons of the availability of free language assistance and other outreach materials that are provided to insureds.*** The documents stated under item 4 individual insurance policies and certificate of insurance are outside the scope of the statutory definition of "vital documents" as set forth under section 10133.8 of SB 853. Inclusion of which is not cost effective considering that the certificate of insurance is a lengthy document (50 pages). We suggest that such inclusion be deleted from the proposed regulation. 2. **Section 2538.3 Language Assistance Program** ***"(6) Provision of adequate and on-going training regarding the LAP for all staff ……insured population"*** To the extent that PPO carriers contract with health care provider network, KPIC proposes the revision of the language to allow PPO carriers the flexibility in delegating appropriate policies and procedures, such as the above, to its contracted provider network. 3. **Section 2538.6 Individual Access to Oral Interpretation Services** In line with our proposal for the revision of the definition of "Point of Contact to reflect the term "reasonably anticipated" (see item #1 above), to be consistent with this proposal, the term "reasonably anticipated" be reflected in the entire document, as necessary.	

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			4. **Section 2538.6 Individual Access to Oral Interpretation Services** ***"(5) The health insurer's standards for the use of family……..adult interpreter becomes available."*** In some instances, insureds may feel more comfortable using relatives and even minors to interpret for them. KPIC proposes the revision of this section to be more flexible by adding an option that providers can have insurers sign waivers when family, friends and minors are used as interpreters.	
16	**Eric C. DuPont Metropolitan Life Insurance Company**		The way Metlife Multi-Language program works is the dentist and the patient each have a sheet of questions relating to health history – the dentist in English)it could be another language, as well) and the patient in their language. The questions are in the same order and can be answered with a "yes" or "no". The dentist can go down the questions either reviewing completed responses or pointing to a question and getting the patient response. Currently the Multi-language Health History Program is available in 34 languages. In addition to the Multi-Language Health History program, MetLife Dental currently has Spanish speakers in our call centers who are available to speak with dentists and insureds who speak other languages. **Applicability** The applicability of CIC §§ 10133.8 and 10133.9 to supplemental insurance such as stand-along, limited scope dental insurance is tenuous. Section.2538.1 (a) of the proposed regulations states that "{t}hese regulations are applicable to all individual and group policies of health insurance and to all insurers, as defined in §106 of the CIC. CIC §106 defines, in part, "health insurance" as an insurance policy that provides hospital, medical, or surgical benefits. "Health insurer" as defined in Proposed Regulation §2538.2(b)	
17	**Kris Hathaway National Association of**		NADP appreciates the opportunity to provide comments on the proposed Language Assistance Program ("LAP") regulations, and agree that our member plans should make their best efforts towards helping all their enrollees understand their benefits and receive good dental care. NADP's concern throughout the drafting of these regulations is the cost of compliance in proportion to the enrollment size and premium base of dental	

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	Dental Plans		plans. Dental plans will have to absorb excessive costs in order to comply with the proposed LAP. To better understand its members' projected expenditures, NADP gathered cost estimates associated with compliance on the proposed regulations. Costs for this program vary greatly among stand alone dental plans in part due to their organizational structure and size, benefit designs, enrollment, information technology ("IT") capabilities, and other similar issues. When the various LAP costs were totaled, the conservative average estimate for compliance with the DOI proposed LAP regulations, is approximately **1 to 1.8 million dollars** per plan. This increase in costs will be catastrophic to dental-only insurance plans given that the average monthly premium for a PPO is only $25-$30 per month per an enrollee. Vision plan premiums are even less. To better illustrate these projected costs, we've listed some of the activities and financial requirements our member plans will have to undertake to meet the proposed LAP regulations. **Systems Enhancements:** • Capture and store threshold languages in systems. • Purchase or upgrade program systems to produce translated documents in the threshold languages. • Procure or expand translation memory software. • Convert systems to recognize characters in the threshold languages that are not currently recognizable by IT systems. These actions will require revamping major modifications to data systems including software enhancements and hiring additional IT staff for implementation. We expect this kind of infrastructure enhancement will require **significant** financial and resource investment. **Translation:** • Translate vital documents. • Hire specialized staff to monitor and verify translation of all vital documents.	

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			• Engage consulting services to develop translation memory databases. The translation of vital documents will be an ongoing expense and will be very costly as well. One of our member plans recently translated a 1 1/2 page plan document from English to Spanish at a total cost of $182.40. Currently, the basic fee for translating a document is $95, and each word translated incurs a per-word charge. That is, a plan will be charged $.19 for each English word translated into Spanish and $.30 for each word translated into Japanese or Thai. A sentence stating the availability of language assistance services to enrollees translated into 10 different languages will cost over $1,000. Dental plans in general submit an average of 25-75 filings to the DMHC, each of these filings may consist of vital documents ranging from 5 to 75 pages in length, and the estimated translation costs for these filings alone could exceed $1,000,000 not to mention the costs that would be incurred for translating documents requested by enrollees. **Interpretation** • Contract with telephone interpretation services. • Hire bilingual associates. • Provide training and/or certification for bilingual associates. Plans that currently offer interpretation services reported a low utilization rate of their interpretation services. Therefore, empirical evidence seems to indicate that mandating plans to provide interpretative services will add a significant cost to plans but produce only minimal benefit to enrollees. **Training** • Develop, expand, and/or modify cultural diversity training program. • Provide cultural diversity training for existing and newly hired staff. • Hire, train and equip managerial personnel to implement and administer the diversity training. **Administrative** • Educate providers on their responsibilities.	

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			• Amend all provider contracts. • Monitor providers to ensure compliance. The increased demand and oversight of plans over the providers' day-to-day operations may discourage provider participation and result in a reduction of provider networks and diminished accessibility. • Execute and administer the language preference survey. • Develop tracking and reporting mechanisms to monitor internal policies & procedures. • Reassessing and redesigning of quality assurance audits and guidelines. • Increase administrative overhead. Given that plans are required to update their language survey every three years and the possibility that one or more of the threshold languages may change, plans will face difficulty in making meaningful financial and budgetary forecasts. We appreciate the DOI's need to adhere to the statutory language of SB 853; however, the Legislature, as stated in Sec 2 Section 1367.04 (c), also expressly mandates agencies to consider the cost of compliance, availability of language services, and plan flexibility when drafting their regulations: "*In developing the regulations, standards, and requirements, the department* ***shall*** *consider the following:(8) 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 plans flexibility in determining compliance with the standards for oral and written interpretation services."* We ask that the Department consider the aforementioned cost indications we've identified that clearly demonstrate the adverse impact the proposed regulations will have on specialized plans, such as dental and vision, and exempt us from the more onerous and costly mandates. **Recommendations:**	

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			We highly recommend that the DOI implement the amendments offered by the Association of California Life & Health Insurance Companies. Their modifications are clearly supported by statutory language and give a detailed explanation of how the Department may stay true to the intent of the statute without sacrificing the flexibility that is necessary for "supplemental" plans to continue operation in California. Allowing stand-alone dental and vision plans to utilize cost saving approaches is necessary in keeping dental and vision insurance a viable benefit under the proposed regulations. NADP would encourage: • A broad interpretation of 'vital documents', as stand-alone dental plans may utilize different terminology, enrollment procedures, and forms than those currently listed. • Allowing our member plans to make use of outside assessment techniques for threshold languages, without mandating a costly survey. • Oral interpretation only be mandated to include the threshold languages. • Eliminating the requirement for a multiple language notice. NADP would also encourage the implementation date to coincide with the regulation timeline proposed by the California Department of Managed Health Care of July 1, 2008. As there are many dental and vision plans that offer benefit programs through both the DOI and the DMHC, we would prefer to avoid unnecessary costs if our plans could establish the new Language Assistance Program with each department on the same date.	
18	**Doreena Wong National Health**		**Timeliness** In §2538.6, Individual Access to Oral Interpretation Services, "timely" is defined as "a manner appropriate for the situation in which language assistance is needed." This definition of "timely" is extraordinarily broad,	

[1] 10 N.Y. Comp. Codes R. & Regs. § 405.7(a)(7).

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	Law Program		provides little guidance to the plans as to what is acceptable, allows far too great a range of interpretation, and would be difficult to enforce. We strongly recommend providing clearer guidance to the insurers rather than the vague, broad language currently provided. Timeliness should be specifically defined in order to be an effective guideline for insurers to follow. We are concerned that without a range or an outside time limit, LEP patients will have to wait inordinate amounts of time, suffer from rescheduled appointments and/or never receive health care. Guidance regarding the definition of "timely" may be gleaned from other state requirements, such as a New York regulation which requires hospitals to provide skilled interpreters in inpatient and outpatient settings within 20 minutes and in emergency rooms within 10 minutes.[1] The California Health Care Safety Net Institute of the California Association of Public Hospitals defined a "reasonable" wait time as 30 minutes.[2] Given the broad range of options available to the health insurer, ranging from the use of bilingual staff or providers to telephonic interpreters, and the establishment of a written protocol to obtain an interpreter, there should be no reason for delays for more than thirty minutes, preferably within fifteen minutes. Interpretation services should be provided as soon as possible for fear that any delay in providing such services may render the eventual service ineffective. When interpretation services are sought in person, such services should be	

[2] *Straight Talk: Model Hospital Policies and Procedures on Language Access, Introduction* at 19 (2005) available at: http://www.safetynetinstitute.org/UpdatedSite/StraightTalkFinal.pdf
[3] There are state and national standards promulgated by the California Healthcare Interpreters Association (www.chia.org) and the National Council of Interpreting in Health Care (www.ncihc.org), respectively available on their websites
[4] The American Translators Association has standards for health care translators on its website: (*see* http://www.atanet.org.)

[5] Glenn Flores *et al*., *Errors in Medical Interpretation and Their Potential Consequences in Pediatric Encounters*, 111 PEDIATRICS 4 (Jan. 2003). Of 165 total errors committed by nonprofessional interpreters, 77% had potentially serious clinical consequences. *See also,* Garret Condon, *Translation Errors Take Toll on Medical Care*, CLEV. PLAIN DEALER, Jan. 20, 2003, at C3.
[6] Glenn Flores, Abstract, *Pediatric Research,* April 2003, Volume 53, Number 4. For hospital interpreters with at least 100 hours of training, the rate of errors of potential clinical consequence was only 2%.
[7] As stated in the CPEHN letter, we also strongly support all of the provisions relating to the notice requirement proposed by DMHC, particularly the requirement that the every insurer "provide LEP enrollees with language identification cards, and maintain a 24 hours per day, 7 day per week toll free telephone line that enrollees and providers may call to obtain the [insurer's] assistance in arranging language assistance services." (*See* DMHC Proposed Regulation §1300.67.04(c)(2)((E).)

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			rendered within thirty minutes in order to guarantee effectiveness. Therefore, rather than the current open-ended definition, we strongly recommend that the term "timely" be given a specific time period, within fifteen to thirty minutes. Moreover, there is guidance on the interpretation of "timely" from the Office for Civil Rights, U.S Department of Health and Human Services' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting LEP Persons (OCR LEP Guidance), available at: http://www.hhs.gov/ocr/lep/revisedlep.html: > While there is no single definition for "timely" applicable to all types of interactions at all times by all types of recipients, one clear guide is that the language assistance should be provided at a time and place that *avoids the effective denial of the service, benefit, or right at issue or the imposition of an undue burden on or delay in important rights, benefits, or services to the LEP person. When the timeliness of services is important, and delay would result in the effective denial of a benefit, service, or right, language assistance likely cannot be unduly delayed.* (Emphasis added). One of the provisions in our recommended regulation is taken from the OCR LEP Guidance and is included as a means to guarantee that language assistance must be provided in such a way as to avoid undue burden or delay any benefits owed to the LEP person. We also encourage the adoption of language in the Department of Managed Health's (DMHC) revised regulations that require that the language assistance program specify quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services. (*See* §2538.6(a)). **Use of Trained and Competent Interpreters and Translators** According to Cal. Insurance Code §§10133.8(b)(4) & (6), the statute requires that the regulations shall include standards "to ensure the quality" of interpreter services and "the quality and accuracy" of written translations. The DOI regulations lack a clear requirement to use qualified or competent or trained interpreters and translators. The regulations list the range of interpretation services that can be used but does	

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			not require the use of "qualified," trained or competent interpreters. Another section only refers to the proficiency of interpreters and translators but does not require that interpreters or translators be competent, tested or trained.[3] Moreover, proficiency only refers to one's ability to communicate accurately in both English and the target language and proficiency must be assessed or tested as a perquisite to become a certified or trained health care interpreter or translator. One of the documents to which the statute refers as a guide, is OCR LEP Guidance, as noted above. It describes the competence of interpreters and translators and notes that "quality and accuracy" of language assistance services is "critical to avoid serious consequences to the LEP person. (OCR LEP Guidance at 9). It further explains that "competency requires more than self-identification as bilingual" (*id.* at 10). We would strongly recommend that the proposed regulations be clarified by requiring that bilingual staff and all interpreters must be trained and competent. Although there is a reference to "qualified interpreting" in §2538.6(b)(5), it is not defined. Moreover, there is no requirement that translators be trained and competent. Therefore, it would be useful to have the term defined: "Qualified interpreting and translation: interpretation and translation services provided by trained and competent interpreters and translators, respectively, including bilingual staff or providers." (*See* §§2538.2(k), 2538.6(b)(4) and 2538.(d)). Furthermore, we believe that the requirements that the interpreter and translator must be expanded to ensure the competency of the interpreters and translators[4]. (*See* §§2538.5(d) and 2538.6(d)). As noted in CPEHN's letter, similar to the competency of all interpreters and translators, any bilingual provider and bilingual provider staff should be qualified. We strongly believe that there must be a requirement for the insurers to assess the language skills among its contacting providers. This requirement is critical to ensuring that the insurer's provider network is providing adequate interpreter services to LEP enrollees at the provider site. Our Health Consumer Centers assist LEP consumers daily and in our experience bilingual staff are not necessarily qualified interpreters. The insurer should have a system to assess the proficiency and evaluate the effectiveness of the language skills of the provider and/or provider staff.	

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			Furthermore, the DOI regulations do not provide enough guidance to assure the quality and accuracy of the written. There is also no reference to any option of enrollees who cannot read to ask for an oral translation of certain written materials. Our Health Consumer Centers work with LEP consumers who are not literate in any language and need oral assistance. Furthermore, the regulations do not address the appropriate literacy level for which the materials should be translated. Both the Medi-Cal and Healthy Families contracts refer to materials being written at the 6th grade literacy level. Also, OMH CLAS Standard 7 refers to the Multilingual Health Education Network, which uses a 4-6 literacy level (*see* OMH CLAS Final Report at 80). **<u>Use of Family Members or Friends and the Prohibition of Minors As Interpreter</u>** Although we commend DOI's recognition of the dangers of using minors as interpreters and wholeheartedly agree with prohibiting such use, the use of any ad hoc, unqualified or untrained interpreter, including friends or adult family members, as interpreters, also cannot provide "qualified interpreting" as required in the regulation. Although the potential harm is exacerbated when children are used as interpreters, any unqualified or untrained interpreters, including adult family members and friends, are prone to omissions, additions, substitutions, volunteered opinions, semantic errors, and other problematic practices that can seriously distort the interpretation. They may not know critical medical terminology and be unable to interpret medical information vital in ensuring that the doctor understands the patient's condition and the patient understands her diagnosis and course of treatment. The use of family members and friends also can raise confidentiality and privacy concerns. The lack of adequately trained health care interpreters can result in an increased risk of medical errors. One recent study revealed a greatly increased incidence of interpreter errors of potential clinical consequence when untrained interpreters were used instead of those with training.[5] A subsequent study found that while interpretation errors of potential clinical consequence occurred in 12% of encounters using trained interpreters, they occurred in 22% of encounters in which *ad hoc* interpreters were employed.[6] Therefore, we strongly recommend that the two provisions regarding the standards for the use of family,	

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			friends, and minors be changed. Any ad hoc, or unqualified interpreter should also be prohibited, or at a minimum, discouraged from being used except in emergencies or if the LEP person insists on using him or her after being informed of the availability of a qualified interpreter free of charge. These two exceptions should relieve the insurer and provider of any legal liability if the insured insists on using his or her own interpreter. Thus, in section (c), where the proposed regulations allow the use of an adult family member or friend, we would recommend this be changed, at least to require that the insured be informed regardless if he or she has requested the use of the family member or friend as his or her interpreter, before and not "once" the insured requests it. (*See* §2538.6(c). **<u>Specialized Health Plans</u>** Although there may be differences between specialized health plans, such as dental and vision plans, and full service health plans, specialized health plans must meet the same standards as full service health plans since the statute specifically applies to both, and does not allow for any exemption from the statutory requirement to provide language assistance services to LEP enrollees. Our office, as well as many of the Health Consumer Centers of the Health Consumer Alliance (a partnership of consumer assistance programs operated by community-based legal services organizations in twelve counties whose mission is to help low-income people obtain essential health care) have also received complaints by LEP consumers that dental plans have refused to provide interpreters. Thus, it is a problem for smaller, limited scope plans. We believe that there is enough flexibility built in to the regulations for each health plan to meet the cultural and linguistic regulations as promulgated by DOI and do not support the notion of a different or lower standard allowing the dental and vision plans. For those LEP insureds encountered at the dentist's or optometrist's office, a simple telephone call which can be completed in a matter of minutes may be all that is required in order for the insured to understand what information the dentist or optometrist needs to obtain an accurate medical history and/or prescribe an appropriate treatment plan. With regard to the issue of costs, our organization has published a report, *Providing Language Interpretation Services in Small Health Care Settings: Examples From the Field*, which explores the array of options that can be tailored to meet the needs of small care providers' LEP patients. Certain services emerged as	

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			"promising practices"—creative, effective methods that are replicable by other small providers. These practices include recruiting bilingual staff for dual roles (e.g., front desk and interpreter positions); ongoing cultural and language competency training for interpreter staff; using community resources like hospitals, managed care organizations, students, and volunteers; and capitalizing on underutilized funding sources. We have attached a copy of the report to this letter. **LEP Insureds Experiences** We have also attached a report, *Report Back – Community Meeting: On speaking another language at a hospital or clinic*, summarizing the results from a Town Hall meeting that was held in Los Angeles on August 13, 2005 in which public testimony was taken from LEP patients who had experienced access problems due to language barriers with their providers. We hope that the report provides DOI with some real-life examples demonstrating the types of serious consequences, which can result when LEP patients are not provided language assistance services, and illustrates the critical need for effective regulations to implement the statutes establishing DOI's Health Care Language Assistance Program. **Translation of Notices into Multiple Languages** Finally, in response to the issue raised by several insurers during today's hearing in Sacramento requiring the insurers to translate the notice to the insureds in "multiple languages," we believe that the insureds must have notice of the right to interpreter services and the notice must be translated into as many languages as possible. The regulations are clear that any LEP insured is entitled to "timely individual access to interpretation services at no cost … at all points of contact where language assistance is needed." (*See* §2538.6(a)). The statute also has a separate requirement that requires health insurers advise limited-English proficient insureds of the availability of interpreter services. Since there are no thresholds for the provision of interpreter services, the notice must be provided in as many languages as DOI determines necessary. In fact, as CPEHN's letter noted, we would strongly recommend that the notice provisions proposed by the Department of Managed Health Care (DMHC) be used which requires the notices are to be translated into the ten non-English languages identified by the plan as most likely to be encountered among its enrollees. (*See* DMHC Proposed Regulation §1300.67.04(c)(2)((A)(iii).[7] We believe that the insurers have confused the notice	

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			requirements as described in §2538.3(c) with the requirements regarding the translation of vital documents in §2538.5(b), in which the notice of free interpreter services must be translated in the multiple languages and included with the English language document in order for the insured to request an oral translation of the English document.	
19	**Leanne Ripperger PacifiCare**	**Section 2538.1**	(b) The purpose of these regulations is to accomplish maximum accessibility to language assistance services, including culturally competent oral interpretation and written translation assistance and to set forth: a) the methods of surveying the language preferences and linguistic needs of insureds; b) the requirements, standards and quality assurance for translation of vital documents; c) the requirements, standards and quality assurance for individual access to oral interpretation services; and d) the reporting and data collection requirements for health insurers.	**General comment: We believe the purpose of the regulations is to accomplish *reasonable* accessibility to language assistance services…….. Therefore we respectfully request that the word *maximum* be replaced with *reasonable*.**
19	**Leanne Ripperger**	**Cont'd**	(e) "Interpreting" or "interpretation" means the process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another spoken or signed language, taking the cultural and social context into account.	**We suggest the following revised language for your consideration:** **Interpretation: the act of listening to something spoken or reading something written in one language (source language) and orally expressing it accurately and with appropriate *conversational speech* ~~cultural relevance~~**

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				into another language (target language). **<u>Rationale:</u> Some LEP insured's may not have the ability to read and understand written materials; therefore, oral interpretation of written materials may be necessary. Interpreters should be aware of variances within a language and should be able to communicate with insured's using the appropriate colloquial speech.**
19	**Leanne Ripperger**	**Cont'd**	(i) "Multiple languages" means the number of and specific languages into which voting/ballot materials are translated as determined by the California Secretary of State for the current year.	**We suggest the following revised language for your consideration:** **(i) "Multiple languages" means *<u>a language other than English when 10 percent or more of the insured population pursuant to the insured's assessment.</u>***

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				Rationale: Rationale: The DMHC is using 10 languages and the DOI is using the voting/ballot materials as determined by the Secretary of State for the current year. Notices provided in the languages making up 10 percent or more of the insurer's population pursuant to its assessment will provide adequate disclosure.
19	**Leanne Ripperger**	**Cont'd**	(j) "Point(s) of Contact" means an instance in which an insured accesses the services covered under a health insurer's policy or certificate, including administrative and clinical services, telephonic and in-person contacts.	**We suggest the following revised language for your consideration:** **(j) "Points of Contact" an instance in which an insured accesses *those* ~~the~~ services covered under a health insurer's policy or certificate, *that can be reasonably anticipated,* including**

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				administrative ~~and clinical~~ services, *and physician and patient dialogue in clinical settings* ~~.telephonic and in-person contacts~~ **Rationale: The definition appears to be overly broad and beyond those situations for which translation may be necessary.**
19	**Leanne Ripperger**	**Cont'd**	(n) "Translating" or "translation" means the conversion of a written text in one language into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.	**We suggest the following revised language for your consideration:** **Make the definition consistent with DMHC proposed definition as follows:** ***Translation: replacement of a written***

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				text from one language (source language) with an equivalent written text in another language (target language). ***or*** **(n) "Translating" or "translation" means the conversion of a written text in one language into a written text in a second language, *which reflects a meaningful translation.* ~~corresponding to and equivalent in meaning to the text in the first language~~.** **Rationale: Verbatim translation may not accurately or appropriately convey the substance of what is contained in the written materials. Ideally, translated written materials should reflect the dialectic and cultural nuances as well as the acculturation, educational, and literacy levels of the target population. Documents that reflect an awareness of these details demand a more sensitive approach than mere literal translation of text. Translating technical medical and legal**

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				language into consumer-oriented and easily understood language, whether it is English or another language is challenging. Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of insured's. The need to balance medical and legal accuracy with the language, culture, and literacy levels of insured's is a complicated issue.
19	**Leanne Ripperger**	**Cont'd**	(4) Individual insurance policies and certificates of insurance;	**We suggest the following revised language for your consideration:** **(4) *Portions of* individual insurance**

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				policies and certificates of insurance, *shall be translated into the insurers threshold languages upon request* : **Rationale: Insurers are required to notify insured's of the availability of language assistance services and how to access these services. Some LEP insured's may not have the ability to read and understand written materials; therefore, oral interpretation of written materials may be necessary. The intent is to achieve a balance that assures meaningful access to critical services while not imposing undue burden on the health care system. Insurers should create a plan for consistently determining, over time and across various activities, what documents are vital to the meaningful access to services by the LEP populations they serve. Federal guidelines suggest that recipients set benchmarks for completing translations into remaining languages over time. The volume and life span of a document is also a**

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				consideration. When the volume is great and the life span is short plans should evaluate whether or not it is more feasible to translate portions of a document or provide information in appropriate languages as to how to obtain free language assistance. An additional issue relates to translating technical medical and legal language into consumer-oriented and easily understood language, whether it is English or another language. Materials in commonly encountered languages should be responsive to the cultures as well as the levels of literacy of enrollees. The need to balance medical and legal accuracy with the language, culture, and literacy levels of enrollees is a complicated issue. The challenge of addressing the enrollee's level of literacy is complicated by the issue of determining and being responsive to the person's level of acculturation and health and legal literacy.

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19	**Leanne Ripperger**	**Cont'd**	(5) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a complaint or appeal.	**We suggest the following revised language for your consideration:** ***(D) Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal, shall include with the document a written notice of the availability of interpretation services in the threshold languages identified by the insured's needs assessment.*** **Rationale: Vital documents do not include notices that contain enrollee specific information. Therefore it is imperative that the regulation be exceedingly clear so as not to create ambiguity for the operational staff that will ultimately be required to**

#	Person Submitting Comment	Action Taken	Issues or Comments	CDI Response
				implement the regulation and ensure compliance. Insurer's and delegated provider staff worked through the ICE collaborative to create template standardized documents and/or guidelines for use by the industry to ensure consistency and compliance. These template documents allow for the insertion of specific insured information but for the most part are standardized documents, therefore the regulation needs to include language that makes it clear that these documents only need to include a written notice of the availability of interpretation services in the insurer's threshold languages.

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19	**Leanne Ripperger**	**2538.3**	(a) By January 1, 2008, every health insurer shall develop and implement a Language Assistance Program (LAP) that complies with the requirements of Insurance Code sections 10133.8 and 10133.9 and this regulation. The Commissioner shall allow health insurers a reasonable degree of flexibility in the methods by which they achieve compliance.	**<u>General Comment:</u> We respectfully request that the implementation date be set once the regulations are finalized and be consistent with the DMHC. The implementation date should not be established at January 1, 2008 because of the requirement in Section 10133.8(f) which requires the department to begin reporting biennially to the legislature regarding health insurers compliance with the standards established. Providers contract with both health insurers and health care service plan and thus will be attempting to implement their language assistance programs as required under both the DMHC and DOI.**

#	Person Submitting Comment	Action Taken	Issues or Comments	CDI Response
19	**Leanne Ripperger**	**Cont'd**	(c) Health insurers shall develop a written notice that discloses the availability of language assistance services to insured's and explains how to access those services. This notice shall contain the required information in multiple languages, as defined above. A copy of this notice shall be included with all vital documents and all new and renewing insured welcome packets or similar correspondence from the health insurer confirming a new or renewed enrollment. This notice shall be filed with the Department of Insurance prior to use.	**We suggest the following revised language for your consideration:** **(c) Health insurers shall develop a written notice that discloses the availability of language assistance services to insured's and explains how to access those services. This notice shall contain the required information in multiple languages, as defined above. A copy of this notice shall be included with ~~all vital documents and~~ all new and renewing insured *materials* ~~welcome packets~~ or similar correspondence from the health insurer confirming a new or renewed enrollment. This notice shall be filed with the Department of Insurance prior to use.**

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				Rationale: See comment above under section 2538.2(i) – definition of "multiple languages". It does not appear to be necessary to include this notice with vital documents when they have already being translated into the threshold languages?
19	**Leanne Ripperger**	**2538.4**	(a) Every health insurer shall survey the language preferences and assess the linguistic needs of insureds within one year of the effective date of these regulations. Health insurers may utilize various survey methods, including, but not limited to, the use of existing enrollment and renewal processes, newsletters, or other mailings. All survey materials shall be printed in multiple languages, as defined. Health insurers shall update the linguistic needs assessment, demographic profile, and language translation requirements of their insured population every three years.	**General comment:** Please refer to the comments that ACLHIC made requesting clarity as to how the department interprets the term "insured's"

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19	**Leanne Ripperger**	**2538.5**	(b) For those vital documents that contain insured-specific information, health insurers shall not be required to translate the documents into the indicated/threshold languages identified by the needs assessment but rather shall include with the English language document a notice, written in multiple languages, as defined, of the availability of interpretation services in the indicated/threshold languages identified by the needs assessment. (1) Upon request, the insured shall receive a written translation of the documents. The health insurer shall have 21 (twenty-one) days after receipt of the request to provide the written translation to the insured.	**We suggest the following revised language for your consideration:** **(b) For those vital documents that contain insured-specific information, health insurers shall not be required to translate the documents into the indicated/threshold languages identified by the needs assessment but rather shall include with the ~~English language~~ document a *written* notice~~, written in multiple languages, as defined,~~ of the availability of interpretation services in the indicated/threshold languages identified by the needs assessment.**

#	Person Submitting Comment	Action Taken	Issues or Comments	CDI Response
				Rationale: **Section 10133.8 (b)(3)(C) requires that the insured be notified of the availability of interpretation services in the threshold languages.**
19	**Leanne Ripperger**	**Cont'd**	(2) Whenever a requested document requires that an insured take action within a certain period of time, that period of time shall not begin to elapse until the health insurer issues to the insured a translation of that document in accordance with the provisions of this article. For appeals that require expedited review and response, the health insurer may satisfy this requirement by providing notice in multiple languages of the availability and access to oral interpretation services.	**We suggest the following revised language for your consideration:** **(2) Whenever a requested document requires that an insured take action within a certain period of time, that period of time shall not begin to elapse until the health insurer issues to the insured a translation of that document in accordance with the provisions of this article. For appeals that require expedited review and response, the health insurer may satisfy this requirement by providing notice in ~~multiple languages~~ of the availability and access to oral interpretation**

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				services. **<u>Rationale:</u> Section 10133.8 (b)(3)(C)(ii) requires that the insured be notified of the availability of interpretation services in the threshold languages.**
19	**Leanne Ripperger**	**Cont'd**	(d) Every health insurer shall develop policies and procedures to ensure the quality and accuracy of written translations and that each translated document meets the same standards as are required for the English version of the document. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing translation services, including a documented and demonstrated proficiency in the source and target languages and knowledge of applicable specialized terminology in both the source and target languages.	**We suggest the following revised language for your considerations:** **(d) Every health insurer shall develop policies and procedures to ensure the quality and accuracy of written translations and that each translated document meets the same standards as are required for the English version of the document. The policies and procedures shall include mechanisms for ensuring the proficiency of the individual providing translation services, including a documented and**

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				demonstrated proficiency in the source and target languages. ~~and knowledge of applicable specialized terminology in both the source and target languages.~~ **<u>Rationale:</u> Effective translation and interpretation should include an understanding of terminology that may be peculiar to or specialized (for example medical terminology). We are unclear on as to what specialized terminology would include.**
19	**Leanne**	**2538.6**	(c) An insured may request the use of an adult family member or friend as the interpreter in a non-emergency situation. Once the insured has requested the use of an adult family member or friend as his or her	**We suggest the following revised language for your consideration;**

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	Ripperger		interpreter, the insured shall be informed in his or her primary identified language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the adult family member or friend as the interpreter shall be documented in the medical record or health insurer file. This section is not intended to limit any other provisions of California or federal law.	**(c) An insured may request the use of an adult family member or friend as the interpreter in a non-emergency situation. Once the insured has requested the use of an adult family member or friend as his or her interpreter, the insured shall be informed in his or her primary identified language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured's decision to use the adult family member or friend as the** **(d) interpreter shall be documented in the medical record or health insurer file, *as applicable*. This section is not intended to limit any other provisions of California or federal law.** **Rationale: The insurer should not be held to a documentation requirement**

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				for which they could not consistently comply.
19	**Leanne Ripperger**	**2538.7**	(c) Within one year after the health insurer's initial assessment, every health insurer shall report to the Department of Insurance on the implementation of its Language Assistance Program and its internal policies and procedures related to cultural appropriateness. This information and data requested by the Department shall be submitted in a timely manner. Health insurers who do not report in a timely manner shall be subject to fines and penalties as authorized by the Insurance Code. Each health insurers shall report at least the following information: (1) The data regarding the insured population based on the needs assessment as required by paragraph (2) of subdivision (b) of Insurance Code section 10133.8;	**<u>General Comment:</u> We respectfully request that the implementation and reporting dates be set once the regulations are finalized and be consistent with the DMHC. Many health insurers also have health care service plan licenses and thus will be attempting to implement their language assistance programs as required under both the DMHC and DOI.**

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20	**Len Matuszak, United Concordia Dental Health**		Joins with NADP to consider their comments and recommended changes.	