

# **Language Assistance for Health Care Consumers Media Conference Questions & Answers**

## **Q: What law was passed to require these language assistance requirement?**

A: SB 853, authored by former Senator Martha Escutia, required all California health plans to provide translated materials and interpreters for limited English speaking (LEP) members. The legislation directed the DMHC to develop regulations to implement the requirement.

## **Q: How will the DMHC in ensure that health plans are complying with the law?**

A: In order to ensure ongoing compliance, the DMHC will be strictly evaluating the effectiveness of each plan's language assistance program. In addition to required evaluations of health plan services every three years, the DMHC will also conduct "spot checks" of the effectiveness of a plan's program, such as "secret shopper" calls and appointments or unscheduled reviews of plan procedures. If any plan is found to be out of compliance, the DMHC will either require corrective actions or could take appropriate administrative fines or penalties. The DMHC will continue to monitor plan compliance, and will take any enforcement action necessary if deficiencies are found.

## **Q: How do health plan members arrange for an interpreter?**

A: In order to arrange for an interpreter, health plan members should inform their health plan, doctor or other provider that they need the assistance when they make an appointment. If a consumer has a problem getting an interpreter, they should call the DMHC Help Center at 1-888-466-2219, or file a complaint at [www.healthhelp.ca.gov](http://www.healthhelp.ca.gov).

## **Q: Why has it taken so long to implement the law?**

A: The language assistance statute is groundbreaking legislation, the first in the nation, and set the standard for other states to follow. The formal regulation process began in December 2005, following a mandatory moratorium on the development of all regulations at the beginning of the Schwarzenegger Administration, during the initial transition period from the prior administration. The regulation was adopted in December 2006, with the effective date of January 1, 2009. This regulatory effort has been by far the most extensive and transparent ever undertaken the DMHC, including the assistance of language expert advocacy groups, which provided invaluable trainings on issues of cultural and language accessibility. The extension of time was supported by all stakeholders as necessary to make certain that the language services would be available and possible as the legislature intended.

## **Q: How were threshold languages for translation for standardized documents determined?**

A: The law requires that health plans translate standardized documents into a certain number of languages determined by a formula based on its total enrollment. For example, plans with a enrollment of one million or more must translate standardized documents into the top two languages other than English (as determined by a survey of its members), and into an additional language when 75 percent or 15,000 enrollees indicated a preference for it in the survey. Plans

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with 300,000 to one million enrollees must translate vital documents into its top spoken language, and into an additional language if five percent or 3,000 enrollees need it. Plans with enrollment of less than 300,000 must translate vital documents into its top spoken language when five percent or 3,000 or more need materials in that language.

## **Q: How has the DMHC implemented the regulations?**

A: The DMHC's implementation efforts have included:

- Language Assistance Workgroup and Workplan Development (DMHC, Office of the Patient Advocate, California Department of Insurance and Department of Health Care Services)
- Coordination with Industry Collaboration Effort, a health plan advocacy organization
- Coordination with consumer stakeholder groups, such as the California Pan-Ethnic Health Network
- Coordination and implementation of health plan training
- Review of health plans' Language Assistance Proposals
- Development of Help Center consumer assistance policies and training
- DMHC Web site information and Help Center complaint procedures

## **Q: How many health plans submitted language assistance filings?**

A: The DMHC received and approved a total of 80 language assistance proposals from health plans under its jurisdiction, although it licenses nearly 120 plans. Those exempted from filing proposals under the law are:

- 1) Medicare plans
- 2) Inactive plans

## **Q: Must pharmacies comply with the language assistance law?**

A: If a health plan offers pharmacy benefits (whether directly or through a Pharmacy Benefits Manager), a visit to a pharmacy is a "point of contact" that would be covered by the language assistance regulation.

## **Q: In general, what are the requirements of each plan's proposal?**

A: There are four general requirements for a plan's language assistance program:

1. Complete an Enrollee Assessment - Developing a demographic profile to calculate threshold languages, and surveying enrollees to identify the linguistic needs of each enrollee.
2. Provide Language Assistance Services – By January 1, 2009, health plans must have Had proposals approved by the DMHC to:
  - Implement effective policies & procedures
  - Provide interpretation services
  - Provide translation services, as required by law

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3. Conduct Staff Training - Plans are required to identify and train all plan staff who have routine contact with limited-English proficiency (LEP) enrollees.
4. Perform Compliance Monitoring – Plans are required to monitor their language assistance program, including those of the medical groups and providers with which it contracts.

**Q: In general, how will health plans provide interpreter services in a doctor's office? Will the majority use a language telephone service? What other methods will be used?**

A: Plans are responsible for ensuring that qualified interpretation services are offered to and/or arranged for enrollees in a timely manner, at no cost, and at all points of contact. Plans may provide a range of interpretation services, including (but not limited to):

- Bi-lingual plan or provider staff
- Hiring interpreters
- Contracting with outside interpreter services, such as telephone services
- Arranging formally for the services of voluntary community interpreters
- Contracting for video-conferencing services

**Q: Who will pay for the services in a doctor's office? Will the doctor just send a bill to the plan? The enrollee is not responsible for any extra cost, correct?**

A: Plans are responsible for ensuring that qualified interpretation services are offered to and/or arranged for enrollees in a timely manner, at no cost, and at all points of contact. The enrollee is not responsible for any cost related to interpretation services.

**Q: What if an enrollee needs to see the doctor the same day? How will interpreter services be provided?**

A: Each plan's quality assurance program must specify standards for timely delivery of language assistance services for emergency, urgent and routine health care services. For emergency and urgent health care services (typically received on the same day), each plan is required to ensure that enrollees are provided access to interpretation services in a "timely" manner – appropriate for the medical need. Plans are required to ensure that enrollees have access to interpretative services at all points of contact.

**Q: How many language access complaints has the DMHC received?**

A: Since January 1, 2006 to the present, the Help Center has received 343 complaints where the health plan member identified a language or cultural barrier.

**Q: Must health plans provide language assistance 24/7?**

A: Plans must provide interpretation services at all points of contact – some of which (e.g.

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emergency services) may occur 24/7. The legislation did not define specific standards for providing language assistance services 24/7, but rather focused on ensuring that timely interpretation services are provided. (Timely is defined as in a manner appropriate for the health care situation in which language assistance is needed.)

**Q: Must health plans provide an interpreter for any language if requested by enrollee?**

A: Yes, interpretation services should be provided in any language requested by the enrollee.

**Q: How will this law impact the cost of health care?**

A: Plans and providers have expressed serious concerns about the costs of implementing both the law and regulation. However, now that the law has been passed, it is the DMHC's job to implement it as fairly as possible. Throughout the drafting of the regulation, the DMHC has been very sensitive to rising costs in the health care system. Our goal has been to produce a system that is fair and balanced for all parties. As the implementation of the individual health plan programs progresses, the DMHC will closely monitor the effect of providing language assistance on health care premiums and will work closely with plans and providers to ensure that enrollees continue to have access to effective and affordable health care coverage.

**Q: Are there enough qualified health care interpreters to offer needed services?**

A: It is anticipated that this new law will likely expand the need for health care interpreters. In order to gain DMHC approval of its program, health plans needed to demonstrate that the quality of interpreter services and translations provided are both proficient and culturally sensitive.

**Q: Does this new law ban children from serving as interpreters for their parents during an appointment at a doctor's office?**

A: No. The DMHC regulations do not ban children or other family members from serving as interpreters in doctor's offices. The regulations are flexible to accommodate those who prefer having loved ones serve in this capacity. However, because plans must now provide interpretive services free of charge, the DMHC wants plans to encourage their use so that all patients have the benefit of having complex medical information explained to them by an experienced interpreter in a language they can understand.