S-4482.1

SENATE BILL 6684

State of Washington 60th Legislature 2008 Regular Session

By Senators Shin, Berkey, Regala, Kohl-Welles, and McAuliffe

Read first time 01/21/08. Referred to Committee on Health & Long-Term Care.

AN ACT Relating to language access services in health care; amending RCW 41.05.017 and 70.47.060; adding new sections to chapter 48.44 RCW; adding a new section to chapter 48.46 RCW; adding a new section to chapter 48.20 RCW; creating new sections; and providing an effective date.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** Hundreds of thousands of patients in Washington need translation and interpretation services to understand medical instructions and diagnoses and to communicate clearly with their doctors. For them, translation and interpretation are essential to assuring that they receive the high quality health care called for by the state's blue ribbon commission. The health care system in the state is not currently meeting the needs of these patients, largely because of unanswered questions about how to fund needed language services.

Studies document that limited English speakers are less likely to have a regular primary care provider or receive preventative care and more likely to experience medical errors, all of which lead to negative health outcomes and higher long-term costs to the health care system.

Furthermore, language barriers impede informed consent for treatment or surgical procedures, leaving health care organizations and providers vulnerable to potentially costly lawsuits.

According to the 2005 American community survey, four hundred fifty-four thousand Washington residents speak English less than very well. Title VI of the civil rights act of 1964 and executive orders issued by President Clinton and President Bush establish the requirement that health care providers who serve patients in federally funded programs must provide language access services to all patients with limited English proficiency. Nevertheless, most health care providers lack systems and financial resources to provide these services.

In a 2006 national survey of hospitals, forty-eight percent cited cost and reimbursement concerns as a primary barrier to providing language services. In Washington state, medicaid and the state children's health insurance program reimburse health care providers for interpreter services. Private insurers and the Washington basic health plan do not. Quality language services lead to better health outcomes and long-term cost savings to the health care system, and the private and public sectors should share the responsibility of covering the cost of these vital services.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.44 RCW to read as follows:

For the purposes of this act, the following definitions apply:

(1) "Language access services" means the interpretation and translation provided for patients or enrollees with limited English proficiency to enable them to have accurate and adequate communications with health care providers, contract representatives or administrators, and affiliated health care staff at every point of contact. Interpretation and translation services must be provided by interpreters and translators who are certified or authorized in medical interpretation through the language testing and certification program administered through the department of social and health services or who are proficient in the patient's primary language and have received forty hours or more of training in interpreting skills; instruction in medical terminology and health care systems; and communications skills

development. Certified or authorized interpreters may include bilingual medical staff, contracted phone interpreters, or contracted in-person interpreters.

(2) "Patients with limited English proficiency" or "enrollees with limited English proficiency" means patients or enrollees who identify themselves as having an inability or a limited ability to speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers.

(3) "Interpretation" refers to the act of listening to something spoken, or reading something written, in one language and orally expressing it accurately and with appropriate cultural relevance into a patient's primary language and the patient's primary language into the English language.

(4) "Translation" refers to the replacement of written text in English with an equivalent written text in the patient's primary language.

(5) "Point of contact" refers to any instance in which an enrollee accesses or seeks to access clinical or nonclinical services from the health care providers or health care services available under their health insurance or health plans.

Sec. 3. RCW 41.05.017 and 2007 c 502 s 2 are each amended to read as follows:

(1) Each health plan that provides medical insurance offered under this chapter, including plans created by insuring entities, plans not subject to the provisions of Title 48 RCW, and plans created under RCW 41.05.140, are subject to the provisions of RCW 48.43.500, 70.02.045, 48.43.505 through 48.43.535, 43.70.235, 48.43.545, 48.43.550, 70.02.110, 70.02.900, and 48.43.083.

(2) All health benefit plans offered to public employees and their covered dependents under this chapter shall identify enrollees with limited English proficiency and provide language access services, as defined in section 2 of this act, to enrollees with limited English proficiency. Language access services shall not be subject to a plan copay, coinsurance, deductible, additional premium charge, or any other cost to the enrollee.

Sec. 4. RCW 70.47.060 and 2007 c 259 s 36 are each amended to read as follows:

The administrator has the following powers and duties:

(1) To design and from time to time revise a schedule of covered basic health care services, including physician services, inpatient and outpatient hospital services, prescription drugs and medications, and other services that may be necessary for basic health care. In addition, the administrator may, to the extent that funds are available, offer as basic health plan services chemical dependency services, mental health services and organ transplant services; however, no one service or any combination of these three services shall increase the actuarial value of the basic health plan benefits by more than five percent excluding inflation, as determined by the office of financial management. All subsidized and nonsubsidized enrollees in any participating managed health care system under the Washington basic health plan shall be entitled to receive covered basic health care services in return for premium payments to the plan. The schedule of services shall emphasize proven preventive and primary health care and shall include all services necessary for prenatal, postnatal, and well-child care. However, with respect to coverage for subsidized enrollees who are eligible to receive prenatal and postnatal services through the medical assistance program under chapter 74.09 RCW, the administrator shall not contract for such services except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider. The schedule of services shall also include a separate schedule of basic health care services for children, eighteen years of age and younger, for those subsidized or nonsubsidized enrollees who choose to secure basic coverage through the plan only for their dependent children. In designing and revising the schedule of services, the administrator shall consider the guidelines for assessing health services under the mandated benefits act of 1984, RCW 48.47.030, and such other factors as the administrator deems appropriate.

(2)(a) To design and implement a structure of periodic premiums due the administrator from subsidized enrollees that is based upon gross family income, giving appropriate consideration to family size and the ages of all family members. The enrollment of children shall not require the enrollment of their parent or parents who are eligible for

the plan. The structure of periodic premiums shall be applied to subsidized enrollees entering the plan as individuals pursuant to subsection (11) of this section and to the share of the cost of the plan due from subsidized enrollees entering the plan as employees pursuant to subsection (12) of this section.

(b) To determine the periodic premiums due the administrator from subsidized enrollees under RCW 70.47.020(6)(b). Premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level shall be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level shall not exceed one hundred dollars per month.

(c) To determine the periodic premiums due the administrator from nonsubsidized enrollees. Premiums due from nonsubsidized enrollees shall be in an amount equal to the cost charged by the managed health care system provider to the state for the plan plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201.

(d) To determine the periodic premiums due the administrator from health coverage tax credit eligible enrollees. Premiums due from health coverage tax credit eligible enrollees must be in an amount equal to the cost charged by the managed health care system provider to the state for the plan, plus the administrative cost of providing the plan to those enrollees and the premium tax under RCW 48.14.0201. The administrator will consider the impact of eligibility determination by the appropriate federal agency designated by the Trade Act of 2002 (P.L. 107-210) as well as the premium collection and remittance activities by the United States internal revenue service when determining the administrative cost charged for health coverage tax credit eligible enrollees.

(e) An employer or other financial sponsor may, with the prior approval of the administrator, pay the premium, rate, or any other amount on behalf of a subsidized or nonsubsidized enrollee, by arrangement with the enrollee and through a mechanism acceptable to the administrator. The administrator shall establish a mechanism for

receiving premium payments from the United States internal revenue service for health coverage tax credit eligible enrollees.

(f) To develop, as an offering by every health carrier providing coverage identical to the basic health plan, as configured on January 1, 2001, a basic health plan model plan with uniformity in enrollee cost-sharing requirements.

(3) To evaluate, with the cooperation of participating managed health care system providers, the impact on the basic health plan of enrolling health coverage tax credit eligible enrollees. The administrator shall issue to the appropriate committees of the legislature preliminary evaluations on June 1, 2005, and January 1, 2006, and a final evaluation by June 1, 2006. The evaluation shall address the number of persons enrolled, the duration of their enrollment, their utilization of covered services relative to other basic health plan enrollees, and the extent to which their enrollment contributed to any change in the cost of the basic health plan.

(4) To end the participation of health coverage tax credit eligible enrollees in the basic health plan if the federal government reduces or terminates premium payments on their behalf through the United States internal revenue service.

(5) To design and implement a structure of enrollee cost-sharing due a managed health care system from subsidized, nonsubsidized, and health coverage tax credit eligible enrollees. The structure shall discourage inappropriate enrollee utilization of health care services, and may utilize copayments, deductibles, and other cost-sharing mechanisms, but shall not be so costly to enrollees as to constitute a barrier to appropriate utilization of necessary health care services.

(6) To limit enrollment of persons who qualify for subsidies so as to prevent an overexpenditure of appropriations for such purposes. Whenever the administrator finds that there is danger of such an overexpenditure, the administrator shall close enrollment until the administrator finds the danger no longer exists. Such a closure does not apply to health coverage tax credit eligible enrollees who receive a premium subsidy from the United States internal revenue service as long as the enrollees qualify for the health coverage tax credit program.

(7) To limit the payment of subsidies to subsidized enrollees, as

defined in RCW 70.47.020. The level of subsidy provided to persons who qualify may be based on the lowest cost plans, as defined by the administrator.

(8) To adopt a schedule for the orderly development of the delivery of services and availability of the plan to residents of the state, subject to the limitations contained in RCW 70.47.080 or any act appropriating funds for the plan.

(9) To solicit and accept applications from managed health care systems, as defined in this chapter, for inclusion as eligible basic health care providers under the plan for subsidized enrollees, nonsubsidized enrollees, or health coverage tax credit eligible enrollees. The administrator shall endeavor to assure that covered basic health care services are available to any enrollee of the plan from among a selection of two or more participating managed health care systems. In adopting any rules or procedures applicable to managed health care systems and in its dealings with such systems, the administrator shall consider and make suitable allowance for the need for health care services and the differences in local availability of health care resources, along with other resources, within and among the several areas of the state. Contracts with participating managed health care systems shall ensure that basic health plan enrollees who become eligible for medical assistance may, at their option, continue to receive services from their existing providers within the managed health care system if such providers have entered into provider agreements with the department of social and health services.

(10) To receive periodic premiums from or on behalf of subsidized, nonsubsidized, and health coverage tax credit eligible enrollees, deposit them in the basic health plan operating account, keep records of enrollee status, and authorize periodic payments to managed health care systems on the basis of the number of enrollees participating in the respective managed health care systems.

(11) To accept applications from individuals residing in areas served by the plan, on behalf of themselves and their spouses and dependent children, for enrollment in the Washington basic health plan as subsidized, nonsubsidized, or health coverage tax credit eligible enrollees, to give priority to members of the Washington national guard and reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents,

for enrollment in the Washington basic health plan, to establish appropriate minimum-enrollment periods for enrollees as may be necessary, and to determine, upon application and on a reasonable schedule defined by the authority, or at the request of any enrollee, eligibility due to current gross family income for sliding scale premiums. Funds received by a family as part of participation in the adoption support program authorized under RCW 26.33.320 and 74.13.100 through 74.13.145 shall not be counted toward a family's current gross family income for the purposes of this chapter. When an enrollee fails to report income or income changes accurately, the administrator shall have the authority either to bill the enrollee for the amounts overpaid by the state or to impose civil penalties of up to two hundred percent of the amount of subsidy overpaid due to the enrollee incorrectly reporting income. The administrator shall adopt rules to define the appropriate application of these sanctions and the processes to implement the sanctions provided in this subsection, within available resources. No subsidy may be paid with respect to any enrollee whose current gross family income exceeds twice the federal poverty level or, subject to RCW 70.47.110, who is a recipient of medical assistance or medical care services under chapter 74.09 RCW. If a number of enrollees drop their enrollment for no apparent good cause, the administrator may establish appropriate rules or requirements that are applicable to such individuals before they will be allowed to reenroll in the plan.

(12) To accept applications from business owners on behalf of themselves and their employees, spouses, and dependent children, as subsidized or nonsubsidized enrollees, who reside in an area served by the plan. The administrator may require all or the substantial majority of the eligible employees of such businesses to enroll in the plan and establish those procedures necessary to facilitate the orderly enrollment of groups in the plan and into a managed health care system. The administrator may require that a business owner pay at least an amount equal to what the employee pays after the state pays its portion of the subsidized premium cost of the plan on behalf of each employee enrolled in the plan. Enrollment is limited to those not eligible for medicare who wish to enroll in the plan and choose to obtain the basic health care coverage and services from a managed care system participating in the plan. The administrator shall adjust the amount

determined to be due on behalf of or from all such enrollees whenever the amount negotiated by the administrator with the participating managed health care system or systems is modified or the administrative cost of providing the plan to such enrollees changes.

(13) To determine the rate to be paid to each participating managed health care system in return for the provision of covered basic health care services to enrollees in the system. Although the schedule of covered basic health care services will be the same or actuarially equivalent for similar enrollees, the rates negotiated with participating managed health care systems may vary among the systems. In negotiating rates with participating systems, the administrator shall consider the characteristics of the populations served by the respective systems, economic circumstances of the local area, the need to conserve the resources of the basic health plan trust account, and other factors the administrator finds relevant.

(14) To monitor the provision of covered services to enrollees by participating managed health care systems in order to assure enrollee access to good quality basic health care, to require periodic data reports concerning the utilization of health care services rendered to enrollees in order to provide adequate information for evaluation, and to inspect the books and records of participating managed health care systems to assure compliance with the purposes of this chapter. In requiring reports from participating managed health care systems, including data on services rendered enrollees, the administrator shall endeavor to minimize costs, both to the managed health care systems and to the plan. The administrator shall coordinate any such reporting requirements with other state agencies, such as the insurance commissioner and the department of health, to minimize duplication of effort.

(15) To evaluate the effects this chapter has on private employer-based health care coverage and to take appropriate measures consistent with state and federal statutes that will discourage the reduction of such coverage in the state.

(16) To develop a program of proven preventive health measures and to integrate it into the plan wherever possible and consistent with this chapter.

(17) To provide, consistent with available funding, assistance for rural residents, underserved populations, and persons of color.

(18) In consultation with appropriate state and local government agencies, to establish criteria defining eligibility for persons confined or residing in government-operated institutions.

(19) To administer the premium discounts provided under RCW 48.41.200(3)(a) (i) and (ii) pursuant to a contract with the Washington state health insurance pool.

(20) To give priority in enrollment to persons who disenrolled from the program in order to enroll in medicaid, and subsequently became ineligible for medicaid coverage.

The Washington basic health plan shall offer language access services to those who identify themselves as enrollees with limited English proficiency. Language access services shall not be subject to a plan copay, coinsurance, deductible, additional premium charge, or any other cost to the enrollee.

NEW SECTION. **Sec. 5.** A new section is added to chapter 48.44 RCW to read as follows:

All health service contracts that provide coverage for health care services shall identify enrollees with limited English proficiency and provide language access services, as defined in section 2 of this act, to enrollees with limited English proficiency. Language access services shall not be subject to a plan copay, coinsurance, deductible, additional premium, or any other cost to the enrollee.

NEW SECTION. **Sec. 6.** A new section is added to chapter 48.46 RCW to read as follows:

All health maintenance organizations that provide coverage for health care services shall identify enrollees with limited English proficiency and provide language access services, as defined in section 2 of this act, to enrollees with limited English proficiency. Language access services shall not be subject to a plan copay, coinsurance, deductible, additional premium, or any other cost to the enrollee.

NEW SECTION. **Sec. 7.** A new section is added to chapter 48.20 RCW to read as follows:

All disability insurance contracts providing health care services shall identify enrollees with limited English proficiency and provide language services, as defined in section 2 of this act, to enrollees

with limited English proficiency. Language services shall not be subject to a plan copay, coinsurance, deductible, additional premium, or any other cost to the enrollee.

NEW SECTION. **Sec. 8.** The insurance commissioner shall conduct a study of language access problems encountered by consumers who purchase health insurance contracts in the state of Washington. Such study shall include an analysis and recommendations regarding:

(1) Health care problems encountered by consumers with limited English proficiency;

(2) Barriers that language problems provide for the understanding of insurance contracts, costs, and the resolution of disputes between consumers and health care providers;

(3) The feasibility and benefit of requiring health care insurers to provide for communication with limited English proficiency customers in languages other than English; and

(4) The feasibility of instituting interpretation and translation services by the office of the insurance commissioner for Washington residents to help them receive consumer advice and dispute resolution assistance in languages that they speak and understand. The results of this analysis and associated recommendations shall be reported to the governor and the legislature no later than January 1, 2009.

NEW SECTION. **Sec. 9.** The insurance commissioner shall adopt rules and regulations for the implementation of sections 5, 6, and 7 of this act. In developing these regulations the insurance commissioner shall consult with appropriate stakeholder groups.

NEW SECTION. **Sec. 10.** If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected.

NEW SECTION. **Sec. 11.** Sections 3 through 7 of this act take effect January 1, 2010.

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