Title Page

**Ensuring Meaningful Access to Care for Persons with Limited English Proficiency: A Policy Brief and Future Directions**

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Abstract

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University of Pittsburgh, 2020

**Abstract**

In the United States, more than 25 million individuals have Limited English Proficiency, or LEP, which has a large impact upon interactions with the health care setting. The language barriers faced by these individuals impact their receipt of a wide range of health care services, ranging from preventative, primary, and emergency care, while also impacting medication adherence and management of care. Ultimately, those with LEP incur great disparities in health outcomes. Both federal and state law have evolved since the 1960s to reflect better understanding of such disparities and to ensure better access to care for those facing language barriers. Laws continue to evolve, primarily at the state level, to mandate provision of quality, reimbursable interpretive services for patients with LEP. In May of 2019 the Department of Health and Human Services announced proposed revisions to its regulations implementing Section 1557 of the Affordable Care Act. These changes would relax requirements that covered health care entities notify patients and members of their rights to interpretive services and relax quality standards for remote interpretive services, among other changes. These proposed changes would disincentivize the provision of meaningful language access and are not in line with the policy direction that state and organizational leaders are pursuing. As technological advancements continue to impact the manner in which care is provided, it is of great public health significance that policymakers craft legislation on the national level that ensures patients with LEP are provided meaningful access to care and that the benefits of such technological advancements are realized in an equitable fashion.

Table of Contents

[1.0 Introduction 1](#_Toc39262239)

[2.0 Literature Review 3](#_Toc39262240)

[2.1 Impact of LEP on Access to Care 3](#_Toc39262241)

[2.2 Impact of LEP on Care Utilization 4](#_Toc39262242)

[2.3 Impact of LEP on Disparities in Health Outcomes 5](#_Toc39262243)

[2.4 Use of Medical Interpreters to Remedy Health Disparities 6](#_Toc39262244)

[3.0 Evolution of U.S. Law Surrounding Language Access in Health Care 10](#_Toc39262245)

[3.1 The Beginnings: The Civil Rights Act of 1964 10](#_Toc39262246)

[3.2 Policy Changes Under the Clinton Administration 11](#_Toc39262247)

[3.3 Policy Changes Under the Bush Administration 12](#_Toc39262248)

[3.4 Policy Changes Under the Obama Administration: The ACA 13](#_Toc39262249)

[4.0 New Policy Proposal from the Trump Administration 16](#_Toc39262250)

[4.1 Proposed Changes to Section 1557 of the ACA 16](#_Toc39262251)

[4.2 Potential Effects of Proposed Policy Changes 19](#_Toc39262252)

[5.0 Alternative Approaches to Language Access Policy 22](#_Toc39262253)

[5.1 Current State Legislation Addressing Language Access 22](#_Toc39262254)

[5.2 Medical Interpretation Legislation 24](#_Toc39262255)

[5.3 Health Care Provider Language Access Practices 26](#_Toc39262256)

[6.0 Conclusion 28](#_Toc39262257)

[Bibliography 30](#_Toc39262258)

# Introduction

According to the U.S. census estimates, approximately 61.6 million individuals living in the United States spoke a language other than English at home. While many of these individuals also speak English fluently, about 41 percent, or 25.1 million individuals, are classified as having Limited English Proficiency, or LEP. The U.S. Census Bureau uses LEP to refer to anyone above age five who reports speaking English less than “very well” on their census forms. In total, the population classified as having LEP represented 8% of the United States population aged 5 and older in 2013 (Zong and Batalova, 2015). This population has increased dramatically over the past few decades, growing by nearly 80% since 1990. Those with LEP can be found in higher proportions living in cities with large immigrant communities that have developed organically to meet the community needs of such individuals. However, LEP remains a large barrier to quality health services even in these communities, and across the United States in general, as it can be difficult for patients to find a health provider who speaks their preferred language. An estimated 42% of physicians report having fluency in at least one language other than English (Moreno, 2010), though only 18% of hospitals that report having bilingual doctors or nurses offer a process for assessing such self-reported fluency (Huang, 2009). Individuals with LEP, therefore, are at high risk of experiencing language barriers in the healthcare setting that lead to suboptimal patient-provider communication that adversely affects their experience of care delivery. Over the past several decades, beginning with the passage of the Civil Rights Act of 1964, policymakers have attempted to address issues of health disparities for those with LEP through enhanced legislation dictating requirements for the provision of language access services. The current Administration has proposed changes to these requirements that have the potential to greatly impact the availability of interpretive services to those most in need. These proposed policy changes are not in sync with state and organizational efforts to improve interpretive service offerings to better address the health needs of those with LEP and the health disparities that they face.

# Literature Review

## Impact of LEP on Access to Care

Language barriers can lead to a range of adverse effects on a patient’s experience in the health care setting, not only with respect to health outcomes, but also throughout the process of accessing and receiving care. Access to care can include aspects such as health insurance coverage, access to a regular source of primary care, and availability of preventative care services.

 One hurdle to accessing health care services for those with LEP is disparities in health insurance coverage for members of this population. Prior to the expansion of Medicaid coverage under the Patient Protection and Affordable Care Act (ACA) provisions beginning in 2014, ethnicity and English proficiency were strongly correlated with lower rates of insurance, especially among Hispanic Americans. According to the Kaiser family foundation, among English-speaking citizen families, Latino children are about as likely to be insured as white children, while a non-citizen, Spanish-speaking Latino child is over four times more likely to lack insurance coverage than a white citizen child (KFF, 2003). Lack of insurance coverage limits the availability of primary and preventative care services and impacts the early health outcomes of those with LEP, especially for those at greatest risk of developing health concerns.

According to the Institute of Medicine, individuals with LEP are more likely to experience infectious disease, and are more likely to report risk factors for chronic diseases, such as heart disease and diabetes (IOM, 2003). However, these individuals are less likely to have a designated provider of primary care services (Weinick, 2000). Among pediatric populations, African American and Hispanic children are substantially less likely than white children to have a regular source of primary care, even after controlling for insurance coverage and socioeconomic status (Weinick, 2000). These disparities in access to care are related to language abilities, indicating that LEP affects access to care from the beginning of an individual’s interaction with the health care system.

In addition to the impact on access to primary care services, LEP also affects the ability of population health initiatives, such as preventative care services, to reach these individuals. Women with a primary language other than English are less likely to receive important preventative services such as mammograms and PAP testing (Woloshin, 1997). Additionally, Spanish-speaking patients are less likely to receive the influenza vaccination (Fiscella, 2002). Receipt of these preventative care services can help identify health issues at early stages, leading to significant quality of life improvements and cost savings for the overall health care system.

## Impact of LEP on Care Utilization

Even among those who have accessed primary and preventative care services, those with LEP report significantly fewer visits to their primary care physician prior to utilization of more emergent health services (Derose, 2000). The California Health Interview Survey found that among those parents who solely speak Spanish and whose children have primary care providers, these parents are 70% less likely to communicate with providers over phone or email, and are significantly less likely than English-speaking parents to feel that they are being listened to by their child’s providers (Ortega, 2017). Language proficiency, therefore, has effects not only on access to the health care system, but also on the extent that health care services are effectively utilized once accessed.

## Impact of LEP on Disparities in Health Outcomes

Within the health care system, language ability has a significant impact upon patients’ experiences of care, affecting utilization of care services, comprehension of follow-up care recommendations, experience of medical errors and malpractice, and disparities in health outcomes. The greatest disparity in the receipt of health care services for patients with LEP is related to health outcomes for those seeking treatment. Patients with LEP are more likely to suffer an adverse event during their care, and these adverse events are more likely to result in physical harm and death (Divi et. al 2007). Among pediatric patients, Spanish-speaking patients who have a language barrier have an increased risk for serious medical events during hospitalization than those without such a barrier (Cohen et al, 2005). These adverse events occurring during the care of LEP patients are more likely to be the result of communication errors, demonstrating a link between language barriers and patient outcomes.

Language barriers also affect a patient’s ability to comprehend care directives, follow discharge instructions, and actively participate in care coordination planning. Lack of thorough explanation of medication side-effects correlates negatively with medication compliance, as well as patient satisfaction with medical care (David, 1998). LEP also negatively impacts a patient’s ability to understand medical situations, medication labels, and to recognize adverse medication reactions (Wilson, 2005). Given concerning information about the increased risk faced by LEP patients, when confronted with a language barrier, physicians may alter their behavior in an attempt to compensate for the uncertainties of the situation. For example, the presence of a language barrier between patients and providers leads to an increase in utilization of diagnostic testing services, and thus an increase in charges for health services, as well as longer emergency department stays for these patients (Hampers, et. al 1999).

Communication barriers have a large impact on the manner in which patients perceive their care and the extent to which they are able to develop relationships with their providers. LEP is one factor, along with health literacy, that affects patient’s trust in their providers. This trust is essential to effective conversations around care planning and coordination. Communication barriers between providers and patients with LEP are correlated with suboptimal shared decision making when it comes to such important conversations (Barton, 2014). Language barriers can also affect provider communication with caretakers in situations in which the patient is incapacitated. Families with non-English speaking members are at risk of receiving less information about their loved one’s critical illness, as well as less emotional support from their providers (Thornton, 2010). Barriers to relationship-building ultimately play a role in patients’ satisfaction with the care they receive in the health care system. Non-English speakers are less satisfied, on average, with their care and report being less willing to return to providers for further care (Carrasquillo, 1999). This dissatisfaction with care has been directly tied, among Spanish-speaking patients, to dissatisfaction with provider communication (Morales, 1999).

## Use of Medical Interpreters to Remedy Health Disparities

In the ideal case, patients would be able to communicate with a provider who speaks their preferred language without the need for interpretation. While many physicians self-report fluency in a non-English language, there are large gaps, though, between the non-English languages spoken by physicians compared to those spoken by the general United States population (Doximity, 2017). Spanish is the most common second language of providers, but patients with other preferred languages are more likely to experience language barriers and the resulting impacts to health care and outcomes**.** Medical interpreters and medical interpretive services, however, attempt to bridge these communication gaps, helping to relay important information about patient concerns and provider recommendations during interactions in the health care setting. The use of professional interpreters, specifically, appears to decrease communication errors, increase patient comprehension, equalize health care utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services for patients with LEP (Karlinger, 2006). When it comes to health outcomes, interpretive services have great potential to bridge language barrier-associated disparities. A study by Hampers and McNulty found that patients presenting to the ED and seen by a bilingual physician had the lowest rates of admission, test orders, and delivery of intravenous fluids. Those seen by a provider in partnership with an interpreter had longer visit lengths, but similar quality of care outcomes. Decision making was most cautious, as seen in highest rates of admission, IV fluid delivery, and testing costs, among those patients treated in the absence of any bilingual or interpretive services (Hampers, 2002).

 Other research shows similar positive results related to the use of interpretive services in health care settings. Interpretive services are especially helpful when it comes to the provision of health education to patients with LEP (Ngo-Metzger, 2007). Additionally, interpretive services can increase the delivery of clinical services and the use of preventative care services among patients with LEP (Jacobs, 2001). Interpreters serve to improve the flow of information between patients and their providers, helping to facilitate important conversations around care plans. This ultimately leads to increased rates of satisfaction among non-English speaking patients with the care they receive (Lee, 2002).

 When not trained properly, however, interpreters can be the source of errors in medical transcripts and subsequent care, especially when ad hoc interpreters are relied upon, such as bilingual staff members, and patient family members. Reliance upon such ad hoc interpreters, often children under age 15, can impact care due to a tendency of providers to avoid sensitive medical topics such as reproductive health, domestic violence, drug and alcohol use, and end of life treatment with ad hoc interpreters (Flores, 2006a). Additionally, errors in medical interpretation, especially omissions, are rather common when using untrained interpreters, with most of these errors having potential clinical consequences (Flores, 2003). Proper training for medical interpretive services, therefore, is necessary for interpretive services to aid in reducing health outcome disparities for LEP patients.

An additional challenge to interpretive services is their availability to patients. While many health organizations have recognized the quality and outcomes benefits of improving language access, there remain deficiencies in the offering of language services in healthcare settings. As recently as 2013, fewer than two out of three U.S. hospitals provided language services for those living within their service areas. Additionally, of those hospitals in service areas with high or moderate need for language services, one-fourth do not offer such services, with for-profit and government-run hospitals being less likely to offer language services to patients than private not-for-profit health care organizations (Schiaffino et al 2016). There also remain differences in interpreter use across different clinical settings. The use of professional interpreters, for example, is infrequent overall, but particularly low with respect to patient interactions with nurses as compared to physicians. In order for interpretive services to be of true assistance to patients, they must be regularly available in the settings in which they are most needed.

Hospitals and health systems that do choose to implement interpretive service offerings have the potential to realize improved quality measures and increased cost savings related to improved care for patients with LEP. In the absence of interpretive services at admission and discharge, patients with LEP have significantly longer hospital length of stays. Additionally, once discharged, these patients are more likely to be readmitted to the hospital within 30 days. (Lindholm, 2012). As many health insurers, including federal and state governments transition to payment models that incentivize value and quality in health outcomes, often through capitated payments, health care systems must recognize the risk that failure to effectively bridge communication gaps can lead to increases in health expenditures for their patient populations.

# Evolution of U.S. Law Surrounding Language Access in Health Care

## The Beginnings: The Civil Rights Act of 1964

As the understanding of health outcomes disparities for those with LEP has grown, lawmakers and public health advocates have crafted an evolutionary path of policies and regulations in an attempt to remedy these disparities. Most of the onus of legal requirements has fallen upon health care systems and providers through obligations to provide language translation services. Throughout the past several decades, starting with the Civil Rights Act of 1964, federal and state lawmakers have passed progressively more advanced requirements for interpretive services in the health care setting, in attempts to improve health care quality and access for those with LEP.

 The legal origin of language access policy stems from Title VI of the Civil Rights Act of 1964, which reads:

 “No person in the United States shall, on the grounds 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 financial assistance” (1964).

While this statute was initially primarily designed to prevent racial discrimination in federal programs, the 1974 Supreme Court decision in *Lau v. Nichols* (U.S. Reports, 414) established that supplemental language instruction in public school for students with LEP violated the Civil Rights Act, thereby expanding the interpretation to include language-based discrimination as an extension of discrimination based on national origin. Other courts, in cases such as *Sandoval v. Hagan* (U.S. Reports, 197) and *Almendares v. Palmer* (U.S. Reports 284), have since found that failure by a recipient of federal funds to provide meaningful access to persons with LEP constitutes discrimination on the basis of national origin. The Department of Health and Human Services has historically been responsible for determining how this should be interpreted when it comes to the compliance of programs under its purview, including Medicaid, Medicare, and SCHIP programs, as well as grants administered by the NIH and CDC. In 1980, HHS issued notice 45 Fed. Reg. 82,972-73, stating their intent to develop regulations surrounding language access in health care programs. The notice stated that in response to ongoing language discrimination against beneficiaries with LEP, they were considering requiring HHS funds recipients to conduct evaluations of the extent to which their beneficiary population is of LEP and the extent to which the entity’s services are accessible to such persons. In addition, they would have dictated steps for funds recipients to take in order to demonstrate compliance with language access requirements of Title VI, including use of interpreters or bilingual employees, as well as providing translated forms and informational materials. No guidelines were ultimately issued, although this Carter administration notice shaped internal evaluations of issues of health access for non-English speaking patients receiving care through HHS-funded programs and foreshadowed eventual legal methods of addressing this issue.

## Policy Changes Under the Clinton Administration

The next substantial development in language access regulations at the federal level came under the Clinton Administration in 2000. In August of that year, President Clinton issued Executive Order 13166: *Improving Access to Services for Persons with Limited English Proficiency* (United States, Executive Office of the President [William Clinton], 2)*.* The stated purposed of this Executive Order was to improve access to federally conducted and federally assisted programs and activities for persons with LEP. In tandem with this issuance, the Department of Justice issued a general LEP Guidance document that set forth compliance standards that recipients must follow to ensure that the programs and activities they provide are accessible to persons with LEP. This document served as guidance for all federal agencies, who were then required to develop plans to improve LEP access to their federally funded programs and activities. As a result, the Office of Civil Rights for the Department of Health and Human Services issued their Policy Guidance tailored to assist health care providers and other federal fund recipients in complying with access requirements for persons with LEP (HHS, 2000).

## Policy Changes Under the Bush Administration

 The Policy Guidance issued under the Clinton Administration was upheld during the subsequent Administration, but reissued in August 2003 with substantive revisions. The revised Policy Guidance reflected a stated desire of the Bush Administration to remove undue burdens on small businesses and non-profit organizations, while still ensuring access to federally funded programs for persons with LEP (Chen, 2007). The new Guidance outlined factors that should be considered when evaluating the extent of language services needed by the community served by programs, organizations, and providers (HHS, 2003). These factors included the proportion of persons with LEP served by the entity, the frequency of contact with such individuals, and the nature of the services provided. Lastly, the Guidance included a factor allowing consideration of the entity’s resources available to provide language services, reflecting their desire to remove what was perceived as a burden for smaller organizations and individual providers. The main outcome of this revised Policy Guidance was reduced regulatory requirements for provision of language translation services by healthcare providers, though large health systems, plans, and providers serving populations with higher proportions of non-English speaking individuals still received a higher degree of regulatory scrutiny.

## Policy Changes Under the Obama Administration: The ACA

After several years of the Bush Administration’s revised Policy Guidance for compliance with E.O. 13166 and Title VI of the Civil Rights Act, the law once again changed due to passage of the ACA in 2010 under the Obama Administration. The ACA includes a civil rights provision as outlined in Section 1557 (2010). This section as passed prohibits discrimination on the grounds of race, color, national origin, sex, age or disability in certain programs and activities. This section applies to any health program or activity for which any portion is funded or receives funding from the Department of Health and Human Services. This, therefore, includes health care providers and health systems who receive Medicare and Medicaid payments, health insurance plans participating in the federal Health Insurance Marketplaces, and programs administered by HHS itself. As consistent with previous interpretations of the Civil Rights Act, this new law makes clear that the prohibition of discrimination based on national origin means that entities receiving federal funds from HHS must take meaningful steps to ensure access to persons with LEP who are eligible to receive their health services. The law defines individuals with LEP as those with a primary language other than English who have limited ability to read, write, speak, or otherwise understand English communications. The law also defines what constitutes meaningful steps for covered entities to undertake to ensure access, namely the provision of language assistance services, which may include oral language translation, video translation services, or written translation. The law includes standards for what constitutes acceptable forms of translation services, including standards prohibiting the use of low-quality remote video interpretive services or the reliance upon untrained or ad-hoc staff as translators for those requiring language assistance. Included in the law, however, is still consideration for context-specific factors, such as the nature and importance of the communication, allowing for some flexibility for covered entities, though to a much lesser extent. Additionally, the law requires that evaluations of an entity’s compliance include consideration of the presence and extensiveness of an entity’s language access plan. While still not required, this portion of the law further encourages the adoption of formalized access plans.

Section 1557 of the ACA also laid out specific actionable requirements for health care entities to complete in order to be compliant with the new regulations. Covered entities are encouraged to develop and implement a language access plan, which includes specific steps to be taken to ensure access for individuals with LEP. The law also requires covered entities to post written notice of individual’s rights to language assistance and, at a state level, to post taglines notifying individuals of the availability of language assistance in that state’s top 15 most commonly spoken languages by individuals with LEP. Entities must provide notice that they will provide appropriate language services free of charge and in a timely matter, including, but not limited to translated documents and oral interpretative services. This information must be physically posted in all service facilities, online on organization websites, and included in communications sent to the population serviced by the health care entity. The notice must also include instructions on how to obtain such assistance, how to contact the employee responsible for compliance, and how to file a grievance or discrimination complaint. These latter requirements are connected to another portion of the law, which required entities with more than 15 employees to have a designated employee responsible for compliance with Section 1557 and responsible for maintaining the organization’s system for receiving and responding to grievances. Collectively, these posting requirements are designed to improve awareness among patients with LEP of language services available to them and their rights to request access to such services.

While Section 1557 came into effect immediately upon passage of the ACA in 2010, the final rule and regulations issued by HHS went into full effect as of July 2016. The regulations, according to HHS estimates, will cover about 900,000 physicians, 133,343 facilities participating in Medicaid and Medicare, 445,657 clinical laboratories that receive Medicaid, 1300 community health centers, 40 health professional training programs, and over 180 insurers that offer qualified health plans on the federal exchange (Jost, 2016)

# New Policy Proposal from the Trump Administration

## Proposed Changes to Section 1557 of the ACA

Three years after issuance of the final rule regarding the anti-discrimination section of the ACA, the Department of Health and Human Services Office of Civil Rights under the Trump Administration has proposed changes to the rule (HHS, 2019). These changes pertain primarily to the gender-identity and language access protections of Section 1557. With respect to language access services, the two largest changes to Section 1557 are related to the scope of covered entities and the notification requirements of such entities.

First, the proposed rule significantly narrows the scope of covered entities to any health program that receives federal financial assistance from HHS, and any program administered by under Title I of the ACA. This proposed change would exempt HHS programs such as those administered by the CDC and Indian Health Service. Additionally, Section 1557 would no longer apply to ACA marketplace plans, as premium tax credits are delivered to insurers via the IRS, not HHS itself. Additionally, in the case of insurers, Section 1557 would now only apply to operations and lines of business for which they receive direct HHS financial assistance, such as Medicare Advantage plans and Medicaid Managed Care. Unlike under current regulations, other non-ACA products, commercial insurance products, or administrative services for group insurance plans would not automatically be subject to Section 1557 requirements. While the proposed changes would narrow the scope of Section 1557 application, most covered entities no longer under its purview would still be required to meet Title VI requirements set forth in other statutes.

 Second, in addition to narrowing the scope of covered entities to which Section 1557 applies, the proposed changes would also eliminate most requirements that covered entities provide notification of available language assistance services, their availability free of charge and in a timely manner, and how to file complaints with the OCR in the event of non-compliance. This change has the greatest potential to provide cost savings to covered entities, but also the greatest potential to negatively impact access to language access services for persons with LEP.

Third, additional aspects of this proposal would limit compliance oversight of language access services. In addition to removing the requirement of notification, the new policy would also remove the requirement that organizations have a designated employee responsible for monitoring compliance and grievance reporting at the entity level. This change would hinder the ability of patients and members from reporting grievances and instances of non-compliance. The policy change would also remove the requirement that the OCR consider the presence or absence of language access plans when evaluating specific instances of alleged non-compliance. These changes collectively limit the regulatory burden upon covered entities to comply with Section 1557, but also weaken incentives for formalized language access planning and in some cases remove processes for patients and members with LEP to report instances of non-compliance at the entity-level.

In the place of considerations for language access plans, the proposed policy change would revert to the Bush-era factor analysis for assessing compliance with requirements to provide meaningful access for patients with LEP. Flexible, situational standards include number and frequency of encounters with individuals with LEP, the nature and importance of services provided, and the entity’s resources available to cover costs of language access services. This would be a reversion to the 2003 Policy Guidance. Not only do the proposed changes remove consideration of language access plans, the new policy removes any and all mention of these plans.

 Lastly, the final substantive change outlined in the policy proposal involves quality standards for video remote interpreting services. Under the current policy, video interpreting services are required to be clear and audible, and capable of providing real-time service over a high-speed connection. OCR would instead apply similar standards to audio interpreting services, with exception for the deaf and hearing-impaired. This change is designed to encourage use of audio services, which are perceived to be more cost effective than video interpretive services.

 In summation, the proposed changes would significantly narrow the scope of entities covered under Section 1557 by excluding certain HHS administered programs and relaxing requirements on business operations of entities that are separate from those on the receiving end of federal financial funding and assistance. The policy change would also eliminate provisions that currently encourage the development and implementation of language access plans. Accompanying this is a return to a more relaxed factor analysis to determine Section 1557 compliance, with increased flexibility for smaller entities and those servicing smaller populations of individuals with LEP. Lastly, the largest change with respect to projected cost savings and potential impact on the population of persons with LEP is the elimination of notification requirements that are currently designed to promote awareness of rights to language service offerings and grievance reporting in the event of non-compliance. These proposed changes are part of a larger push to eliminate current regulations within the anti-discrimination Section 1557 of the ACA of 2010.

## Potential Effects of Proposed Policy Changes

The HHS Office of Civil Rights cites reduced regulatory burden and potential for significant cost savings as the primary benefits of the proposed policy change, while acknowledging the potential for negative effects on language access for persons with LEP. The OCR identifies several different sources of cost savings, though the largest portion is related to paper, printing, and mailing notifications and taglines that accompany significant publications and materials distributed by covered entities. The OCR also notes that the majority of the recipients of such materials are not persons with LEP, implying that these requirements result in large expenditures on materials for those to whom the notices do not have value. The related savings, estimated at $3.16 billion over the course of five years, make up the vast majority of the total projected savings of $3.6 billion, which includes projected savings related to relaxed regulation of discrimination on the basis of gender identity, as well (Keith, 2019). OCR also considered requiring that notifications be included in significant publications once annually, but ultimately rejected this proposal in favor of an additional $63 million in projected cost savings.

In addition to projected savings from the elimination of notification requirements, the OCR also projects cost savings of $14.7 million per year related to elimination of reference to language access plans in the policy guidelines. While not a requirement under the current policy, the OCR projects that elimination of consideration for these plans will save covered entities the costs of developing and implementing such plans for those organizations who choose to discontinue them. Opponents of the policy change argue that eliminating requirements for the distribution of taglines conveying information about rights to interpretive services will adversely impact awareness of these rights and, therefore, negatively impact health outcomes for LEP patients. While OCR has implied that these materials are currently being distributed primarily to English-speaking individuals, even for those for whom these materials help to increase awareness of language services, research is unclear as to the impact of awareness on actual utilization and outcomes. Awareness of language access laws is not necessarily associated with interpreter utilization (Grubbs, et al 2006), and further education and promotion of available formal interpreter services is necessary to ensuring the provision of safe and accessible services (Heaney & Moreham, 2002).

The last category of OCR’s anticipated cost savings stems from reduced quality standards for video remote interpretive services. The removal of such requirements is designed to encourage use of less costly audio interpretive services. Projected cost savings as a result of this policy change were not provided, but rather OCR requests further information from covered entities about the extent to which video remote interpretive services are currently utilized to better understand the potential impact of this change. Removing these requirements from video interpretation services in favor of similar requirements for audio services is meant to better align regulations to existing practices and enhance patient’s experience with more common interpretation modalities.

 In reducing regulatory requirements associated with the provision of language access services, the OCR points to the potential for substantive cost savings, but does acknowledge that these changes have the potential to adversely affect access to interpretive services for individuals with LEP receiving care or services from covered entities. In *Fed. Reg.* 27882, HHS notes that repealing the notice and tagline requirements may “[decrease] access to, and utilization of, health care for non-English speakers by reducing their awareness of available translation services.” HHS, however, expects this potential impact to be negligible (Musumeci, 2019). As mentioned, there is some evidence to support the Administration’s claim that elimination of notification requirements will not have a significant impact on language access, as it relates to the ability of awareness to impact interpreter utilization. However, elimination of language regarding access plans and their consideration in compliance assessments may further exacerbate existing issues of compliance with the current law.

Even under existing requirements since passage of the ACA, language services are not uniformly available in health care settings for those in need of them. In 2013, more than a third of U.S. hospitals did not provide language services, including a quarter of those in areas identified as “high need” for interpretive services based on the population of persons with LEP in their service area (Schiaffino, 2016). At the individual provider level, failure to address language barriers continues to have effects on quality of care. A study conducted in 2010, the same year Section 1557 requirements took effect, found that over 2.5% of medical malpractice claims for one large U.S. malpractice insurer were related to a provider’s failure to provide adequate interpretive services (Quan, 2010). Relaxation of regulations governing provision of meaningful language access services are likely to further limit access to such services for the 25 million persons living in the United States with LEP.

# Alternative Approaches to Language Access Policy

The 2019 policy proposal by the Trump Administration primarily addresses perceived regulatory burdens, the elimination of which may result in cost savings at the expense of a degree of patient’s awareness of their legal rights to interpretive services. Additionally, the removal of video interpretation quality standards in favor of ones governing audio interpretive services indicates a move toward aligning policies to address those interpretive services that they perceive to be most utilized by current patients. As research has indicated, within the context of current available interpretive services, further work is still needed in order to ensure that patients with LEP receive safe, timely, and quality care. While Section 1557 of the ACA represents the most extensive policy governing interpretive services and language access at the federal level, many individual states and individual health systems have taken more comprehensive steps to ensuring meaningful language access for all patients.

## Current State Legislation Addressing Language Access

As of 2019, every state and the District of Columbia has enacted laws addressing language access in healthcare settings, with large variation in the degree of comprehensiveness of these policies, the type of entities addressed, and the extent of guidance provided to organizations in order to maintain compliance (Youdelman, 2019). One of the largest trends in language access legislation has dealt with mandating the provision of interpretive services, either by health plans or health care providers, and subsequently addressing concerns of interpreter quality and competency. Currently, fourteen states and the District of Columbia have developed a mechanism to use federal matching funds to pay for language services for enrollees in Medicaid and CHIP programs. In some of these states, physicians must first cover up front costs prior to seeking reimbursement, but regardless, programs such as these help to shift the burden of costs away from providers. DHS permits states to claim federal matching funds for the costs of these oral interpretive services, though decisions about usage of Medicaid funds vary at the state level. (CMS, 2010).

While some states have addressed funding for interpreter services for Medicaid and CHIP program enrollees, others have instead shifted the cost burden of interpreter services from providers to private health insurers. California, home to over 7 million persons with LEP ([Language](https://blog.languageline.com/report-california-limited-english-proficient) Line, 2017), has particularly robust state-level policies addressing accessibility of language services for persons with LEP. California, with its own state-level version of Title VI prohibiting discrimination on the basis of national origin, has the most comprehensive collection of laws governing language access. The state was the first to introduce and pass legislation addressing language access for enrollees in commercial health plans. Senate Bill 853 mandated that all commercial health plans provide enrollees with translated documents and ensure availability of interpretive services at no cost to the enrollee at all points of contact, including clinical encounters (2003). The law provides some guidance in terms of how to monitor compliance, but allows for flexibility on the part of health plans’ implementation of programs, with final programs requiring approval by the Department of Managed Health Care and California Department of Insurance. In addition to requirements placed on health plans, California also mandates, as recently amended in AB 289 in 2015, that hospitals and health facilities annually update their policies for providing language assistance services for those patients with LEP (2015). They must also post this policy online in any commonly spoken languages within the hospital’s service area. This required policy is similar to the language access plans currently encouraged under Section 1557 of federal law that the Trump Administration proposes eliminating from the statute.

 In 2017, California also passed its own version of Section 1557 through Senate Bill No. 223 (2017). In addition to requiring healthcare providers to provide meaningful access to language services, it also laid out strict notice requirements of availability of no-cost language services for patients with LEP in the state. Covered entities must provide written notice at least once annually in the state’s top 15 languages in order to comply with the law. Additionally, this bill defined cleared standards for what constitutes acceptable quality of interpretive services. Interpreters must be proficient in both English and the target language, be knowledgeable of relevant health care terminology in both languages, and adhere to ethical and confidentiality principles. Even with these quality standards in place, and while required to do so, many commercial insurance plans are resistant to reimburse for interpretive services due to questions regarding the quality of such services.

## Medical Interpretation Legislation

Currently, no federal standards exist regarding proper medical interpreter certification, though several states and non-governmental organizations, such as the National Coalition on Health Care Interpreter Certification (NCC), are actively working to fill that gap in accreditation. Establishment of certification criteria will help to ensure quality in medical interpretation, making it easier to justify requirements that such services be reimbursed by health plans that are currently resistant to assuming the associated costs. One organization, the National Council on Interpreting in Health Care, works to develop national standards of practice for health care interpreters. Their standards form part of the basis for nationwide and state-run certification programs. Currently, there are two organizations which provide medical interpreter certifications nationally, The National Board of Certification for Medical Interpreters and the Certification Commission for Healthcare Interpreters. Additionally, some states, such as Washington, also administer their own certification and licensure programs for medical interpreters.

As national policy and guidelines can vary depending on the Administration and party control of Congress, states have taken to enacting their own formal laws regulating the provision of language access services. All states and the District of Columbia currently have regulations in place governing the provision of interpretive services for patients with LEP. As mentioned previously, some states currently use federal funds provided through state-run Medicaid programs to reimburse providers for translation services. California has taken this a step further in requiring commercial insurance plans to offer free translation services at all points of contact, including clinical visits. As more and more states begin to require reimbursement for translation services in order to increase access to care for patients with LEP, it is becoming increasingly important that certification procedures be established to ensure high quality services are provided by formal medical interpreters. The federal government has yet to establish neither interpreter certification standards nor a certification body, though some states and a few national organizations have attempted to fill this gap in order to ensure reimbursement is going toward quality services.

## Health Care Provider Language Access Practices

In addition to the legal remedies of individual states, health systems themselves have also taken additional steps beyond what is legally required in order to provide meaningful access to care for patients with LEP. Many health care providers, while not required to do so, have opted to develop and implement language access plans, which contain organization-specific policies and practices outlining how that organization will provide meaningful access to care for those with LEP. These plans typically contain information about collecting and monitoring patient data to appropriately ensure that language services are being offered to those in need of them. When it comes to the language access services provided, health systems vary in the types of services offered, primarily due to differences in costs associated with different degrees of advanced offerings. Health providers and other covered entities are not allowed to require patients to provide their own interpreters, nor to rely on ad hoc interpreters or bilingual staff. There are several translation service options, including in-person interpreters, either staffed internally or through an interpreter agency, and telephonic interpreters, which are typically arranged via contract with an outside organization. Telephonic interpreters can be less costly than internally staffed services, though issues can arise with sound clarity, discomfort with an unknown third party, and lack of availability of visual cues that can be important in the medical setting (Cruz, et. al, 2016). A third class of interpretive services are those conducted via video remote systems. These are also typically done by contracted interpreters using smart phones, web cameras, or tablet devices to communicate remotely. As mentioned previously, HHS has developed standards for video remote interpretation services, including speed and bandwidth requirements, as well as audio and visual clarity standards, however these standards are subject to elimination under the Trump Administration policy proposal.

 Video remote interpreter services are becoming increasingly popular, especially among larger health systems with greater resources to devote to the related infrastructure requirements. One supplier of video remote interpretive services, Stratus, estimates that approximately 16% of U.S. health systems utilize their services in some capacity, including top health systems such as Kaiser Permanente and the Mayo Clinic (Wicklund, 2014). Many large, renowned health care systems such as the Cleveland Clinic and Mayo Clinic offer a range of interpretive services in order to best meet the needs of patients, including in-person, telephonic and video remote interpretive services. The high cost of in-person interpretive services, which involve extensive time requirements and can become costly when encountering less common languages, may lead health systems in the near future to focus language access offerings on remote telephonic and video services.

The Trump Administration’s proposed changes indicate a preference for telephonic services, though as telemedicine services continue to expand nationwide, this may change. As the value of telemedicine in expanding access to care and reducing care expenditures continues to be seen and insurers begin to relax provisions allowing for reimbursement of such services, some interpretive service providers have begun to design service offerings that can be incorporated into a telemedicine platform (CLI, 2019). It is therefore important that policymakers, both at the federal, and the state level, keep pace with technological advancements and encourage health care providers and other key players in the health care industry to utilize technology in cost-effective ways that ensure meaningful access to care for those with LEP.

# Conclusion

The United States is home to over 25 million individuals with LEP. These language barriers barrier have real-life consequences when it comes to the interactions of these individuals with the health care system, and their ultimate care experiences, with great negative impacts to health outcomes. Much historical legislation has focused on expanding language access for persons with LEP in the healthcare settings, though under the current federal Administration, deregulation is leading to efforts with the potential to harm access to care for persons with LEP. Nationally, many states and organizations, however, continue to work to remedy health outcomes disparities resulting from language barriers.

Looking to the future of language access in the United States, more focused effort will be required of both federal and state governments, as well as health care providers, in order to advance the provision of meaningful access to care for those with LEP. At the federal level, policymakers must develop standardized training programs and certification criteria for certified medical interpreters. This would eliminate confusion resulting from the patchwork of state certification programs and provide a necessary foundation for ensuring that interpretive services provided are of acceptable quality. This is a necessary step in mandating that such services be reimbursed by both government and commercial payors. In addition to this legislation, the federal government must enforce the development of language access plans by individual health systems and care providers. While these plans will inevitably vary in size and scope given the populations served and resources available, a mandate addressing their formulation will prioritize language access and ensure that plans are in place to provide services where they are most needed. Lastly, state legislators must work to ensure that quality interpretive services are reimbursable through state Medicaid and SCHIP programs, as has been done already by several states. At this more local level, states have greater flexibility to act in the interest of their specific population in order to address language access needs.

While technological advancements have great potential to improve care delivery, they also pose new challenges when it comes to ensure their benefits can be equally realized by those with LEP. Increasing emphasis on pay-for-value initiatives such as telemedicine has already led to increased utilization of internet-based on-demand interpretive services. However, federal and state legislation is currently inadequate in addressing how such a shift in health care technology can be inclusive of individuals with LEP. It is important that policymakers stay abreast of changes to the manner in which care is delivered and the relative value of new interpretive modalities in order to ensure that meaningful access continues to be available for those with LEP. The Trump Administration’s June 2019 proposed changes to Section 1557 of the ACA not only pose threats to awareness and availability of existing interpretive services, but also fail to advance meaningful language access amid the changing atmosphere of care delivery.

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