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A Review of Policies and Strategies to Improve Access to Health Care for Limited English Proficient Individuals in the Asian American, Native Hawaiian, and Pacific Islander Community

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A REVIEW OF POLICIES AND STRATEGIES TO IMPROVE ACCESS TO HEALTH CARE FOR LIMITED ENGLISH PROFICIENT INDIVIDUALS IN THE ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER COMMUNITY

Iyanrick John* and Kathy Ko Chin**

INTRODUCTION

A person's health is influenced by many factors including race, gender, and socioeconomic status. Research indicates that certain groups of people experience health disparities due to a variety of contributing factors.[1] Many studies, including the landmark Institute of Medicine report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* published nearly fifteen years ago, have identified several causes for health disparities including differing policies and practices of health care systems, patient attitudes to

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[1] U.S. DEP'T OF HEALTH & HUMAN SERVICES, THE SECRETARY'S ADVISORY COMMITTEE ON NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES FOR 2020: PHASE I REPORT RECOMMENDATIONS FOR THE FRAMEWORK AND FORMAT OF HEALTHY PEOPLE 2020, at 28 (Oct. 28, 2008), https://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf. "Health disparities," as defined by Healthy People 2020, are "a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion." *Id.* "Healthy People 2020" is a national health promotion and disease prevention initiative developed by the U.S. Department of Health and Human Services to improve the health of all Americans. *Id.* at 4.

receiving care, mistrust of health professionals, and health care provider biases.[2]

Primary language is one major factor that contributes to health disparities, particularly for many racial and ethnic minority communities with a high proportion of individuals who are limited English proficient ("LEP").[3] The inability of a provider to speak the same language as a patient, the lack of good interpretation services offered to patients, and few and/or inadequate translated materials for patients all contribute to adverse health outcomes and health disparities.[4] It is well-documented that LEP individuals experience decreased access to care, lower quality of care, poorer health outcomes, and fewer health care visits than those who speak English well.[5]

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[2] Brian D. Smedley et al., *Abstract*, *in* UNEQUAL TREATMENT: CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE 1 (Brian D. Smedley et al. eds., 2003).

[3] OFFICE OF MINORITY HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVICES, HHS ACTION PLAN TO REDUCE RACIAL AND ETHNIC HEALTH DISPARITIES: A NATION FREE OF DISPARITIES IN HEALTH AND HEALTH CARE 19 (Apr. 2011), http://minorityhealth.hhs.gov/npa/files/plans/hhs/hhs_plan_complete.pdf. *See also Frequently Asked Questions*, LEP.GOV, https://www.lep.gov/faqs/faqs.html (last visited Dec. 21, 2016) (defining "Limited English Proficient" or "LEP" as individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English). The Census Bureau collects data using four categories for households that report speaking a language other than English at home: "very well," "well," "not well," and "not at all." CAMILLE RYAN, U.S. CENSUS BUREAU, LANGUAGE USE IN THE UNITED STATES 2011: AMERICAN COMMUNITY SURVEY REPORTS 2 (Aug. 2013). While not an official U.S. Census definition, LEP individuals are generally regarded as those who speak English less than "very well." *See id.* at 1.

[4] Smedley et al., *supra* note 2, at 17; ACTION FOR HEALTH JUSTICE, IMPROVING THE ROAD TO ACA COVERAGE: LESSONS LEARNED ON OUTREACH, EDUCATION, AND ENROLLMENT FOR ASIAN AMERICAN, NATIVE HAWAIIAN, AND PACIFIC ISLANDER COMMUNITIES 11 (Sept. 2014), http://www.apiahf.org/sites/default/files/2014.10.14_Improving%20the%20Road%20to%20ACA%20Coverage_National%20Report.pdf.

[5] L. Shi et al., *The Influence of English Proficiency on Access to Care*, 14 ETHNICITY & HEALTH 625, 625 (2009); Robin Weinick & Nancy Krauss, *Racial/Ethnic Differences in Children's Access to Care*, 90 AM. J. PUB. HEALTH 1771, 1771 (2000); Rand David & Michelle Rhee, *The Impact of Language as a Barrier to Effective Health Care in an Underserved Urban Hispanic Community*, 65 MT. SINAI J. MED. 1, 1 (1998).

For Asian American, Native Hawaiian, and Pacific Islander ("AA" and "NHPI") populations living in the United States, who have a high proportion of LEP individuals, language poses one of the most significant barriers to access to health care.[6] In the United States, Asian Americans, Native Hawaiians, and Pacific Islanders come from over fifty different ethnic groups that speak over 100 languages.[7] Disaggregated data shows some subgroups have LEP rates that are much higher than the overall U.S. and overall AA or NHPI populations.[8] The AA and NHPI population in the U.S. also includes a high number of foreign-born individuals and those experiencing linguistic isolation – characteristics which also impact access to health care.[9] Maryland also has a high number of LEP and foreign-born individuals, particularly in counties with high Asian American and Hispanic populations, who experience language barriers in accessing health care services.[10]

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[6] SUMMIN LEE ET AL., BARRIERS TO HEALTH CARE ACCESS IN 13 ASIAN AMERICAN COMMUNITIES, 34 AM. J. HEALTH BEHAV. 21 (2010); ASIAN AMERICAN CENTER FOR ADVANCING JUSTICE, A COMMUNITY OF CONTRASTS: ASIAN AMERICANS IN THE UNITED STATES: 2011, at 24 (2011), http://www.advancingjustice.org/pdf/Community_of_Contrast.pdf [hereinafter COMMUNITY OF CONTRASTS].

[7] WINSTON TSENG ET AL., ETHNIC HEALTH ASSESSMENT FOR ASIAN AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS IN CALIFORNIA 10 (2010), http://www.apiahf.org/sites/default/files/PA-factsheet06-2010.pdf.

[8] COMMUNITY OF CONTRASTS, *supra* note 6, at 28. The term "disaggregated data" used here refers to subgroups of the AA and NHPI population, such as Chinese, Vietnamese, Asian Indian, etc. *Id.*

[9] *See, e.g.*, MONTGOMERY COALITION FOR ADULT ENGLISH LITERACY, STATISTICS ON LIMITED ENGLISH PROFICIENT RESIDENTS OF MONTGOMERY COUNTY (2010), http://mcael.org/uploads/file/faqs_data/statistics-on-limited-en-montgomery-county.pdf. The term "linguistic isolation" refers to a household where all members fourteen years old or over have some difficulty speaking English. PAUL SIEGEL ET AL., U.S. CENSUS BUREAU, LANGUAGE USE AND LINGUISTIC ISOLATION: HISTORICAL DATA AND METHODOLOGICAL ISSUES 2–3 (2001), https://www.census.gov/hhes/socdemo/language/data/census/li-final.pdf. As defined by the U.S. Census Bureau, the term refers to a household in which no member fourteen years or over 1) speaks only English or 2) speaks a non-English language and speaks English "very well." *Id.*

[10] American Fact Finder, *American Community Survey*, U.S. CENSUS BUREAU (2015), http://www.factfinder.census.gov [hereinafter *ACS 2015*] (Follow the hyperlink and click on the "Advanced Search" tab at the top of the page. Click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Asian alone or in combination with one or more races" and "Hispanic or Latino of any race." Then click "Close" in the upper right hand corner

Over the past fifty years, there have been many significant advances through law and policy to address language barriers in the health care setting for individuals who are LEP.[11] The Civil Rights Act of 1964 provided one of the first legal protections for LEP individuals in accessing services, and since that time, progress continues to be made at both the Federal and state levels.[12] But in spite of the legal protections, LEP individuals continue to experience difficulties enrolling in health insurance and getting adequate health care services.[13]

Many AA and NHPI LEP individuals need trusted community-based organizations and federally-qualified health centers ("FQHCs") that provide in-person, in-language assistance to apply for health insurance coverage, to understand how to use their insurance and how to navigate the health care system to access services.[14] Since the Patient Protection and Affordable Care Act ("ACA") was passed in 2010, consumers have relied on in-person assistance through Navigators, Certified Application Counselors, and other assisters to help them understand health insurance options, complete application forms, submit information to health insurance marketplaces, and enroll

to close the "Select Race and Ethnic Groups" box. In the "Refine your search results" box under "state, county, or place (optional)," type "Maryland" then click "Go." Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" and the row "Foreign born" under "Place of Birth, Citizenship Status and Year of Entry" to see the data.).

[11] Alice Hm Chen et al., *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 J. GEN. INTERNAL MED. 362, 362 (2007).

[12] *Id.*

[13] *Id.*

[14] ACTION FOR HEALTH JUSTICE, *supra* note 4, at 17. Federally qualified health centers ("FQHCs") receive enhanced reimbursement from Medicare and Medicaid and provide comprehensive services to underserved areas or populations. *Id.* Most FQHC patients are low-income, members of racial and ethnic minority groups, and uninsured or publicly insured. *Id.* About two-thirds of FQHC patients are members of racial and ethnic minority groups. AMERICAN OPTOMETRIC ASSOCIATION COMMUNITY HEALTH CENTER COMMITTEE ET AL., THE ROLE OF COMMUNITY HEALTH CENTERS IN RESPONDING TO DISPARITIES IN VISUAL HEALTH, 79 OPTOMETRY 564, 567 (2008), http://www.aoa.org/documents/advocacy/role_of_chcs.pdf.

in coverage.[15] For the AA and NHPI community, in-language, in-person assistance from trusted sources of information in the community has been essential for enrollment in Medicaid and private insurance through the health insurance marketplaces.[16] As millions now have insurance through the ACA, LEP individuals continue to rely on in-language, in-person assistance to understand how to use coverage and access primary care and preventive services.[17]

Part I of this comment will describe some important demographic and socioeconomic characteristics of the AA and NHPI population in the United States and Maryland. Part II of the comment will describe some of the major legal and policy efforts at the Federal level to improve access to health care services for LEP individuals. Part III will explain some Maryland laws and policies addressing language access. Part IV will describe some challenges in the implementation and enforcement of language access policies. Part V will discuss the importance of community-based organizations and FQHCs in helping LEP individuals access health care service. Finally, Part VI will present recommendations for improving access to health care for LEP individuals by exploring ways to integrate CBOs into the healthcare delivery system, collecting language data to improve services for LEP individuals, and enforcing existing laws and policies.

I. DEMOGRAPHIC DATA AND LIMITED ENGLISH PROFICIENCY AMONG ASIANS AMERICANS, NATIVE HAWAIIANS, AND PACIFIC ISLANDERS IN THE UNITED STATES AND MARYLAND

Approximately seventeen million Asian Americans live in the U.S.[18] The Asian American population in the U.S. grew faster than any other group from 2000 to 2010 and their numbers have quadrupled

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[15] OFFICE OF HUMAN SERVICES POLICY, U.S. DEP'T OF HEALTH & HUMAN SERVICES, COMMUNITY ACTION AGENCY ACTIVITIES IN AFFORDABLE CARE ACT OUTREACH AND ENROLLMENT: INSIGHTS FROM CASE STUDIES 4 (Nov. 2015), https://aspe.hhs.gov/sites/default/files/pdf/137696/CAA-ACA.pdf.

[16] *See* ACTION FOR HEALTH JUSTICE, *supra* note 4, at 6. ("At the start of the first Open Enrollment Period, an estimated 1.9 million uninsured AAs and NHPIs were eligible for new options for coverage in the health insurance marketplaces and Medicaid.")

[17] *Id.* at 16.

[18] Paul Taylor, *The Rise of Asian Americans*, PEW RESEARCH CENTER 19 (2013), http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans.

from 1980 to 2010.[19] The Asian immigrant population has also grown rapidly, as the number of newly arrived Asians surpassed the number of newly arrived Hispanics in 2009.[20] About 83% of Asians in the U.S. are from one of six major ethnic groups (Chinese, Indian, Filipino, Vietnamese, Korean, and Japanese), although there are over twenty ethnic groups represented in the country.[21] The Asian American population is expected to continue to grow rapidly, estimated to number forty-one million by 2050, and by 2050 fewer than half of Americans (47 percent) will be foreign-born.[22] About 60 percent of Asian Americans are currently foreign-born and about 70 percent speak a language other than English at home.[23]

The Native Hawaiian and Pacific Islander population in the United States has also grown rapidly, increasing 40 percent from 2000 to 2010, with approximately 1.2 million living in the U.S.[24] Native Hawaiians and Pacific Islanders include over twenty distinct ethnic groups, with Chuukese, Kosraean, Marshallese, Carolinian, and Pohnpeian including some of the fastest growing subgroups in the U.S.[25] As with Asian Americans, immigration status, language barriers, and costs all pose barriers to health care for NHPIs.[26]

Overall, Asian Americans are the highest-income and most well-educated racial group in the United States.[27] Because of this, they

[19] *Id.* at 20. The report includes data from the U.S. Census Bureau and findings from a national telephone survey of Asian Americans conducted in English and seven Asian languages. *Id.*
[20] *Id.*
[21] *Id.* at 19; *see* American Fact Finder, *Asian Alone or In Any Combination by Selected Groups*, U.S. CENSUS BUREAU (2015), https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk.
[22] Taylor, *supra* note 18, at 22.
[23] *Id.* Use the "advanced search" function. Click the "race/ancestry" radial button and type in ""Asian alone (400-499)." Then search. Then click "topics" then "People" then "languages" then "languages spoken at home." Finally, click "Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset to reveal the data.).
[24] COMMUNITY OF CONTRASTS, *supra* note 6, at 2.
[25] *Id.*
[26] *Id.* at 6.
[27] Taylor, *supra* note 18, at 1.

are often described as the "model minority."[28] While this characterization of high income and high education may be accurate for Asians as a whole, it does not provide an accurate picture of the diverse social and economic needs of the many different Asian subgroups.[29] Asians are often characterized and researched as a monolithic group rather than as distinct and unique ethnic groups.[30] Small sample size for some subgroups and low participation in surveys due to language barriers all contribute to the inaccurate picture of the Asian American community.[31]

When looking at subgroups, stark differences in socioeconomic indicators are evident.[32] For example, Japanese and Filipinos have lower poverty rates than Caucasians, while Cambodian, Hmong, Laotian, and Vietnamese have much higher poverty rates than the overall Asian poverty rate.[33] Overall 49 percent of Asians hold a college degree compared to the overall U.S. population at 28 percent.[34] In contrast, when looking at disaggregated data, only 14 percent of Cambodians and Hmong hold college degrees.[35] For income, per capita income for Asians is $28,342 compared to $27,100 for overall U.S. population.[36] However, some groups, such as Hmong,

[28] Bernadette Lim, *"Model Minority" Seems Like a Compliment, But It Does Great Harm*, N.Y. TIMES (Oct. 16, 2015, 3:21 AM), http://www.nytimes.com/roomfordebate/2015/10/16/the-effects-of-seeing-asian-americans-as-a-model-minority/model-minority-seems-like-a-compliment-but-it-does-great-harm. The term "model minority" was first used in 1966 when the New York Times and U.S. News and World Report published stories that Asian Americans were uniformly successful due to their work ethic and perseverance. *Id.* Many Asian groups criticized this characterization, particularly those groups whose problems were overlooked, such as Laotian and Cambodian refugees of the Vietnam War. Jack Linshi, *The Real Problem When It Comes to Diversity and Asian-Americans*, TIME (Oct. 14, 2014), http://time.com/3475962/asian-american-diversity/.

[29] *See* COMMUNITY OF CONTRASTS, *supra* note 6, at 33–34.

[30] Wooksoo Kim & Robert Keefe, *Barriers to Healthcare Among Asian Americans*, 25 SOC. WORK IN PUB. HEALTH 286, 287 (2010).

[31] *Id.* at 288.

[32] *See infra* notes 33–37 and accompanying text.

[33] Kim & Keefe, *supra* note 30, at 288.

[34] Taylor, *supra* note 18, at 25.

[35] COMMUNITY OF CONTRASTS, *supra* note 6, at 31.

[36] *Id.* at 33. "Per capita income" provides a more accurate measure of income for a family than "household income" for Asian Americans because they are more likely

Cambodians, and Laotians, have per capita incomes that are much less than the overall U.S. population (at $10,949, $15,940, and $16,585 respectively).[37]

In terms of health issues, Asian Americans have higher rates of hepatitis and certain cancers than other racial groups.[38] In 2010, before the passage of the ACA, the uninsured rate for the Asian American population was 19 percent, ranging from 8 percent and 11 percent for Japanese and Filipino, respectively, to as high as 23 percent for Pakistani and Bangladeshi. In 2015, that rate dropped to 8 percent (a 59 percent decrease) for Asian Americans overall who now have the lowest uninsured rate among all racial and ethnic groups, although differences still persist between Asian subgroups.[39] Native Hawaiians and Pacific Islanders also experience health disparities, with varying rates of disease and lack of insurance based on NHPI subgroup.[40]

Looking at primary language data in the United States, only 8.6 percent of the overall population is LEP.[41] However, the LEP population for the Asian population is almost four times higher at 30.4 percent and just slightly less than the LEP rate of 31.1 percent for Hispanics or Latinos.[42] Among Asian subgroups, some groups, such as

than other ethnic groups to have three or more workers per household and typically have larger households than other racial groups. *Id.*

[37] *Id.* at 34.

[38] *Id.* at 47.

[39] KELSEY AVERY ET AL., U.S. DEP'T HEALTH & HUMAN SERVICES, ASPE ISSUE BRIEF: AFFORDABLE CARE ACT HAS LED TO HISTORIC, WIDESPREAD INCREASE IN HEALTH INSURANCE COVERAGE 6 (Sept. 29, 2016), https://aspe.hhs.gov/sites/default/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf.

[40] For more specific NHPI health disparities, see WON KIM COOK ET AL., APIAHF, NATIVE HAWAIIAN AND PACIFIC ISLANDER HEALTH DISPARITIES 3 (2010), http://www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf.

[41] Jie Zong & Jeanna Batalova, *The Limited English Proficient Population in the United States*, MIGRATION POL'Y INST. (2015), http://www.migrationpolicy.org/anrticle/limited-english-proficient-population-united-states.

[42] *ACS 2015*, *supra* note 10. The U.S. LEP rate for Native Hawaiians and Pacific Islanders is 8.3%. *Id.* (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Native Hawaiian and Other Pacific Islander alone or in combination with one or more other races," then click "Close" in the upper right hand corner to close the "Select Race and Ethnic

Chinese, Koreans, and Vietnamese, have significantly higher LEP rates in the U.S. (40.4, 34.6, and 47.5 percent, respectively) than Asians overall and Hispanics overall.[43] In Maryland, the overall LEP population is 6.9 percent, with Asians at 26.7 percent and Hispanics or Latinos at 39.0 percent.[44] Disaggregated data by Asian subgroups for Maryland show a similar trend of groups with ever higher LEP rates,

Groups" box. Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

[43] *Id.* (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, search and select "Chinese alone or in any combination," then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).). Repeat search for "Korean alone or in any combination" and "Vietnamese alone or in any combination." *Id.*

[44] *Id.* (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Total Population," "Asian alone or in combination with one or more races," and "Hispanic or Latino of any race" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. In the "Refine your search results" box under "state, county, or place (optional)," type "Maryland" then click "Go." Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).). Due to small samples size for the Native Hawaiian and Pacific Islander population in Maryland, LEP data and disaggregated data for NHPI subgroups are not reported. *Id.* (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Native Hawaiian and Other Pacific Islander alone or in combination with one or more races" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box; in the "Refine your search results" box under "state, county , or place (optional)," type "Maryland" then click "Go." Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

including Chinese (35.4 percent), Korean (40.3 percent), and Vietnamese (46.4 percent).[45]

For NHPIs, 8.3 percent are LEP in the U.S. and 16.7 percent of Maryland NHPIs are LEP.[46] When looking at disaggregated data for NHPIs in the U.S. as a whole, we also see a wide variation in LEP rates, from 2.1 percent for Native Hawaiians and 5.3 percent for Polynesians to 20.2 percent for Fijian and 45.4 percent for Marshallese.[47]

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[45] American Fact Finder, *American Community Survey*, U.S. CENSUS BUREAU (2013) [hereinafter *ACS 2013*] (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Chinese alone or in any combination," "Korean alone or in any combination," and "Vietnamese alone or in any combination" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. In the "Refine your search results" box under "state, county, or place (optional)," type "Maryland" then click "Go." Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2013 ACS 3-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

[46] *ACS 2015*, supra *note* 10. (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Native Hawaiian or Other Pacific Islander alone or in combination with one or more other races," then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box; under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2015 ACS 1-year estimates dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate). For Maryland data, type "Language spoken at home," click "Go." Under the "Refine your search results" box under "state, county, or place (optional)," type "Maryland" then click "Go." Click on the table entitled "DP02, Selected Social Characteristics in the United States" from the 2010 ACS 5-year selected population tables dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home, Language other than English" to see the data (percent estimate).).

[47] *ACS 2013*, *supra* note 45. (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page, click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Native Hawaiian alone or in any combination," "Polynesian alone or in any combination," "Fijian alone or in any combination," and "Marshallese alone or in any combination" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. Under the "Search Results," click on the table entitled "S0201, Selected Population Profile in the United States" from the 2013 ACS 3-year estimates dataset. Scroll down to the row "Speak English less than 'very well'"

When looking at Maryland county-level data, several counties have a significantly greater proportion of Asian LEP individuals compared to the overall Maryland proportion. For example, the LEP rate for Asians in Montgomery County is 33.2 percent, with higher rates for Chinese, Japanese, Korean, and Vietnamese (39.5, 37.4, 43.6, and 52.5 percent, respectively).[48] Baltimore and Howard Counties also have Asian LEP rates (32.6 and 31.9 percent, respectively) that are higher than the overall Maryland rate.[49] The overall LEP rate for

under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

[48] American Fact Finder, *American Community Survey*, U.S. CENSUS BUREAU (2010) [hereinafter *ACS 2010*] (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Asian alone or in combination with one or more race," "Chinese alone or in any combination," "Japanese alone or in any combination," "Korean alone or in any combination," and "Vietnamese alone or in any combination" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. Under the "Refine your search results" box under "state, county, or place (optional)," type "Montgomery County, Maryland" then click "Go." Under the "Refine your search results box under "topic or table name," type "DP02"; under "Search Results," click on the table entitled "DP02, Selected Social Characteristics in the United States" from the 2010 ACS 5-year Selected Population Tables dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

[49] *Id.* (Go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Asian alone or in combination with one or more race," then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box. Under the "Refine your search results" box under "state, county, or place (optional)," type "Baltimore County, Maryland" then click "Go" and type "Howard County, Maryland" then click "Go"; under the "Refine your search results box under "topic or table name," type "DP02"; under "Search Results," click on the table entitled "DP02, Selected Social Characteristics in the United States" from the 2010 ACS 5-year Selected Population Tables dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).). It is interesting to note that Wicomico County has the highest LEP rate for Asians in any Maryland county at 43.5%. While the population size is small, Wicomico County has one of the largest proportions of Asians Americans for any Eastern shore county. A further analysis of the Asian LEP population in Wicomico County could provide additional information as to why the LEP population in this area is so significant. Because of the small NHPI population in Maryland, disaggregated race/ethnicity and primary language data is not available at the county level.

NHPIs in Maryland is 16.9 percent, with a higher rate in (23.9 percent) in Prince George's County.[50]

In addition to a high proportion of LEP individuals, Asian Americans and Pacific Islanders also have high rates of foreign birth and linguistic isolation – factors that also create challenges in accessing healthcare services.[51] Analysis of data from the National Health Interview Survey showed that foreign-born Asian Americans were less likely to access care, use health care services, or see a health care provider in the past twelve months.[52] One study showed that Vietnamese and Chinese patients with LEP skills refrained from asking questions about their health compared to those with better English skills.[53] All of these factors contribute to Asian Americans and Pacific Islanders with limited English proficiency not understanding the healthcare system in the U.S. and experiencing difficulty communicating with health care providers.[54]

II. FEDERAL LAWS AND POLICIES FOCUSED ON LANGUAGE ACCESS IN HEALTH

Various laws and policies have been enacted to help address the language barriers facing LEP individuals.[55] The right to language

[50] *ACS 2015*, supra *note* 10. (For Prince George's County data, go to www.factfinder.census.gov and click on the "Advanced Search" tab at the top of the page; click on the "Race and Ethnic Groups" button in the left side bar, click the "Detailed Groups" tab, click the text "Native Hawaiian or Other Pacific Islander alone or in combination with one or more other races" then click "Close" in the upper right hand corner to close the "Select Race and Ethnic Groups" box; under the "Refine your search results" box under "state, county, or place (optional)," type "Prince George's County, Maryland," then click "Go." Under the "Refine your search results box under "topic or table name," type "DP02." Under "Search Results," click on the table entitled "DP02, Selected Social Characteristics in the United States" from the 2010 ACS 5-year Selected Population Tables dataset. Scroll down to the row "Speak English less than 'very well'" under "Language Spoken at Home and Ability to Speak English" to see the data (percent estimate).).

[51] *See infra* notes 52–54 and accompanying text.

[52] Jiali Ye et al., *Health Care Access and Utilization Among U.S.-Born and Foreign-Born Asian Americans*, 14 J. IMMIGR. & MINORITY HEALTH 731 (2012).

[53] Alexander R. Green et al., *Interpreter Services, Language Concordance, and Health Care Quality: Experiences of Asian Americans with Limited English Proficiency*, 11 J. GEN. INTERNAL MED. 1050, 1050, 1052 (2005).

[54] *See id.*

[55] *See infra* notes 56–86 and accompanying text.

access for individuals is grounded in Title VI of the Civil Rights Act of 1964, which states that "[n]o person in the United States shall, on the 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." [56] The language of an individual has been recognized by many courts, including the U.S. Supreme Court, as a proxy for national origin. [57] The U.S. Department of Health and Human Services (HHS) regulations further describe specific discriminatory practices prohibited by Title VI, including denying an individual or providing in a differing manner any service, financial aid, or other benefit; subjecting an individual to segregation or separate treatment related to the receipt of any service, financial aid, or other benefit; and treating an individual differently with regard to admission, enrollment, or eligibility for any program.[58] Examples of entities in the health care context that receive federal funding from HHS include hospitals, nursing homes, home health agencies; state Medicaid agencies; state, county, and local welfare agencies; and physicians and other providers.[59]

In addition to Title VI and HHS regulations addressing discrimination in health care, Executive Order 13166, signed by President Clinton on August 11, 2000, requires all federal agencies to ensure LEP individuals have meaningful access to agency programs and services by examining their services, identifying specific needs for language minorities, and developing systems to provide services.[60] The Department of Justice issued complementary policy guidance in 2002 to assist Federal agencies in carrying out the requirements of

[56] 42 U.S.C. § 2000(d) (2012).
[57] *See* Lau v. Nichols, 414 U.S. 563, 568 (1974) (holding that the failure of San Francisco schools to provide adequate instructional opportunities for LEP children of Chinese descent resulted in discrimination under Title VI of the Civil Rights Act of 1964).
[58] 45 C.F.R. § 80.3(b)(1) (2016).
[59] *What Qualifies as "Federal Financial Assistance" for Purposes of Civil Rights Complaints Handled by OCR?*, OFFICE FOR CIVIL RIGHTS, U.S. DEP'T HEALTH & HUMAN SERVICES, http://www.hhs.gov/civil-rights/for-individuals/faqs/what-qualifies-as-federal-financial-assistance/301/index.html (last visited Dec. 21, 2016).
[60] Improving Access to Services for Persons with Limited English Proficiency, Exec. Order No. 13,166, 65 Fed. Reg. 50,121 (Aug. 16, 2000).

Executive Order 13166.[61] HHS subsequently released its own initial guidance for recipients of its federal financial assistance in February 2002 followed by Revised HHS LEP Guidance in 2003.[62] The revised HHS Guidance aligned with other agencies in identifying four factors for recipients to assess language access:

> (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs.[63]

The Guidance discusses how the four factors should be applied in determining the extent to which language services should be provided by recipients.[64] The Guidance also cautions against the use of the clients' friends or family members, especially children, as interpreters unless the client has been informed of the availability of free and competent services and the client still prefers to use a friend or family member as an interpreter.[65] It includes suggestions on considerations for providing interpretation services, such as identifying when to hire staff interpreters or contractual interpreters, circumstances for using telephone interpretation lines, and in what limited situations to allow use of family members for interpretation.[66] The Guidance provides information on evaluating what documents should be translated ("vital" vs. "non-vital" documents) and includes a "safe harbor" for when certain actions of recipients to provide language assistance will

[61] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455 (June 18, 2002).
[62] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 68 Fed. Reg. 47,311 (Aug. 8, 2003).
[63] *Id*. at 47,314.
[64] *Id.* at 47,314–16.
[65] *Id.* at 47,318.
[66] *Id.* at 47,317.

be considered strong evidence of compliance with written-translation obligations.[67]

To further address language access, HHS published a plan in 2013 identifying specific action steps for divisions within agencies to ensure that language access goals and strategies are fully implemented.[68] The content of the HHS Plan includes ten elements and provides recommendations for how divisions should address areas such as oral language assistance services, written translations, staff training, stakeholder consultation, and digital information.[69] For example, under the digital information section, action steps include prominently "displaying links on the agency's English language website to documents that are also available for viewing or downloading in languages other than English" and exploring ways to use social media to increase awareness by LEP individuals of agency programs, activities, language assistance services, and written products available in non-English languages.[70] Each HHS agency is required establish a point of contact (a specific office, individual, or phone number) for LEP individuals.[71] Agencies must also "identify documents used in areas where the program regularly encounters non-English languages in serving customers" and translate those documents in appropriate languages.[72] Examples include online and paper applications, notices as part of emergency preparedness and risk communications, and notices about the availability of language assistance services.[73] Within HHS, the Centers for Medicare and Medicaid Services (CMS) also developed its own strategic language access plan in 2014, which includes many of the same elements as the

[67] *Id.*
[68] U.S. DEP'T OF HEALTH & HUMAN SERVICES, LANGUAGE ACCESS PLAN 2013, at 22 (2013), https://www.hhs.gov/sites/default/files/open/pres-actions/2013-hhs-language-access-plan.pdf [hereinafter LANGUAGE ACCESS PLAN]. This plan was developed in response to an Attorney General memo entitled "Federal Government's Renewed Commitment to Language Access Obligations under Executive Order 13166, dated February 17, 2011, which requested agencies to take eight specific actions, including evaluated and updating LEP services and existing plans. *Id.* at 3. For the eight specific action steps requested in the Attorney General's memorandum, see *id.* app. C.
[69] *Id*. at 6.
[70] *Id.* at 18.
[71] *Id*. at 9.
[72] LANGUAGE ACCESS PLAN, *supra* note 68, at 11.
[73] *Id*. at 22.

overall HHS language access plan, but also includes two additional elements on resource utilization and emergency preparedness.[74]

The Patient Protection and Affordable Care Act (ACA), enacted in 2010, includes specific non-discrimination provisions to protect the rights of LEP individuals. In May 2016, HHS issued final regulations implementing Section 1557 of the ACA, which prohibits discrimination on the basis of race, color, national origin, sex, age or disability in any health program or activity that receives funding from HHS or is administered by HHS, and any entity created under Title I of the ACA.[75] The final rule applies to a wide range of health-related entities and programs including hospitals and community health centers, State Medicaid agencies, Medicare, federal and state health insurance Marketplaces, and health insurance issuers that participate in the Marketplaces.[76] With regard to language, Section 1557 requires all covered entities to take reasonable steps to provide meaningful access to LEP individuals.[77] Covered entities are required to post notices with the following components: (1) statement that they do not discriminate on the basis of national origin, (2) statement that language assistance services are available, (3) provide instructions on how to access those services, and (4) include information on how to file a complaint if individuals experience discrimination.[78] Covered entities must also post taglines on significant communications and publications, websites, and physical locations in the top fifteen LEP languages spoken in the state.[79] The rule also includes requirements for "qualified" interpreters and translators, and restrictions on using family members and minor children as interpreters.[80]

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[74] U.S. DEP'T OF HEALTH & HUMAN SERVICES, STRATEGIC LANGUAGE ACCESS PLAN TO IMPROVE ACCESS TO CMS FEDERALLY CONDUCTED ACTIVITIES BY PERSONS WITH LEP (2014), https://www.cms.gov/About-CMS/Agency-Information/OEOCRInfo/Downloads/StrategicLanguageAccessPlan.pdf.

[75] 45 C.F.R. § 92.1 (2004). Entities created under Title I of the ACA include the following: state-based, state partnership, and federally facilitated marketplaces. 42 U.S.C. § 18116 (2010). Section 1557 of the ACA is the first Federal civil rights law to prohibit discrimination on the basis of sex in all health programs and activities that receive Federal financial assistance. *Id.*

[76] 45 C.F.R. § 92.4 (2004).

[77] 45 C.F.R. § 92.201 (2004).

[78] 45 C.F.R. § 92.8(a) (2004).

[79] 45 C.F.R. § 92.8(d) (2004).

[80] 45 C.F.R. § 92.201 (d)–(e) (2004).

In addition to laws and guidance to improve language access, the collection and reporting of primary language data by federal government agencies is equally important to develop targeted strategies and allocate resources to assist LEP individuals.[81] Section 4302 of the ACA strengthens data collection standards and applies to all population health surveys sponsored by the HHS.[82] The standards require data collection on primary language, in addition to race, ethnicity, sex, and disability.[83] For primary language, HHS Implementation Guidance for Section 4302 follows the standard used by the American Community Survey to measure English proficiency by asking the question "How well do you speak English?" with response choices of "very well," "well," "not well," and "not at all."[84] The Guidance notes that additional questions may be added to surveys if more specific information on language is desired.[85] The additional questions inquire if a language other than English is spoken at home, " with the option of filling in the specific language.[86]

III. Maryland Laws and Policies on Language Access

Many states, including Maryland, have implemented state laws and policies to address languages access.[87] States have engaged in a variety of initiatives such as requiring cultural and linguistic competency training for providers, creating healthcare interpreter certification programs, and providing reimbursement for interpreter services under state Medicaid programs and State Children's Health Insurance Programs (SCHIP).[88]

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[81] *See infra* notes 82–86 and accompanying text.
[82] 42 U.S.C. § 1396w-5 (2010).
[83] *Id.*; *see also* The Patient Protection and Affordable Care Act, Pub. L. No. 111–48 § 4302, 124 Stat. 578 (2010).
[84] U.S. DEP'T OF HEALTH & HUMAN SERVICES, IMPLEMENTATION GUIDANCE ON DATA COLLECTION STANDARDS FOR RACE, ETHNICITY, SEX, PRIMARY LANGUAGE, AND DISABILITY STATUS 5–6 (2011), https://aspe.hhs.gov/sites/default/files/pdf/76331/index.pdf.
[85] *Id.* at 6.
[86] *Id.*
[87] *See* Chen et al., *supra* note 11, at 364 (discussing language access laws in various states); *see also infra* notes 88–99 and accompanying text (discussing Maryland laws and policies).
[88] *Id.*

Maryland has implemented several laws and regulations to ensure LEP individuals can access health care services.[89] Most Maryland state government departments, agencies, and programs are required to provide equal access to public services for LEP individuals because of legislation passed in 2002.[90] The statute specifically provides for:

> (1) the provision of oral language services for individuals with limited English proficiency, which must be through face-to-face, in-house oral language services if contact between the agency and individuals with limited English proficiency is on a weekly or more frequent basis;
> (2) (i) the translation of vital documents ordinarily provided to the public into any language spoken by any limited English proficient population that constitutes 3% of the overall population within the geographic area served by a local office of a State program as measured by the United States Census; and…
> (3) any additional methods or means necessary to achieve equal access to public services.[91]

In 2012, Maryland also enacted legislation to create a cultural and linguistic competency program for health care professionals – a voluntary program to help health care providers better understand non-English speaking patients and patients from different cultural backgrounds.[92]

Maryland agencies have also engaged in various language access efforts. The Maryland Department of Health and Mental Hygiene (DHMH) issued its own LEP Policy which requires the development of language assistance procedures to assess needs,

[89] *See infra* notes 90–99 and accompanying text.
[90] MD. CODE ANN., STATE GOV'T § 10-110.
[91] MD. CODE ANN., ST. GOV. § 10-1103(b).
[92] MD. CODE ANN., HEALTH-GEN. § 20-1302. Initially enacted as the "Cultural and Linguistic Health Care Provider Competency Program," it was amended in 2012 to be the "Cultural and Linguistic Health Care Professional Competency Program" and added pharmacists and health educators to the list of health care professionals covered under the program. *Id.*

translate communications and documentation, train staff, and monitor and ensure that LEP individuals are receiving equal access to services and are not experiencing discrimination.[93] The Maryland Department of Human Resources and Governor's Office on Community Initiatives released a "Toolkit for Immigrant Integration," which provides state agencies in Maryland with tools and resources to provide meaningful access to services for limited English proficient individuals.[94]

Maryland has language requirements for the managed care organizations (MCOs) utilized by most Medicaid recipients in the state.[95] MCOs are required to provide access to health care services and information in prevalent non-English languages and must, upon request, make interpretation services available free of charge to enrollees who do not speak English.[96] The policy designates a Fair Practices Officer in the DHMH Office of Diversity and Inclusion to monitor the compliance of covered entities with the LEP Policy.[97]

At the county level, a Montgomery County Executive Order from 2010 requires all Executive Branch Departments, offices, and programs to take reasonable steps to remove language barriers to public services for LEP individuals.[98] It includes strategies for agencies to assess the LEP service population, develop and implement language access plans, place in-language signs and other materials, and utilize language access coordinators.[99]

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[93] OFFICE OF EQUAL OPPORTUNITY PROGRAMS, MD. DEP'T OF HEALTH & MENTAL HYGIENE, LIMITED ENGLISH PROFICIENCY (LEP) POLICY (Mar. 9, 2011), http://dhmh.maryland.gov/oeop/pdf/DHMH%20LEP%20Agency%20Self-Assessment%20and%20Language%20Assistance.pdf.

[94] MD. DEP'T OF HUMAN RESOURCES, TOOLKIT FOR IMMIGRANT INTEGRATION: LANGUAGE ACCESS TOOLKIT (2014), https://hispanic.maryland.gov/wp-content/uploads/sites/8/2014/10/toolkit-216c.pdf.

[95] *See infra* notes 96–97 and accompanying text.

[96] COMAR 10.09.66.01A(3); COMAR 10.09.66.01B(1).

[97] *Id.*

[98] Montgomery County Exec. Order 046-10 (2010).

[99] *Id.*

IV. CHALLENGES IN THE IMPLEMENTATION AND ENFORCEMENT OF FEDERAL AND STATE LAWS AND POLICIES ENSURING LANGUAGE ACCESS

Despite the many federal and state laws, policies, and guidance documents that address language access, implementation and enforcement is challenging and inconsistent.[100] As a result, LEP consumers continue to experience difficulties accessing health care services.[101] Interpretation services continue to be inadequate as professional, trained interpreters are not present in many health care settings.[102] Only about one quarter of states reimburse healthcare providers through Medicaid for providing interpretation services and, as such, there is little incentive to offer interpreters to LEP patients.[103] Many providers also do not use interpretation services because they may be unfamiliar with how to access services or feel that the process is too difficult.[104]

When interpretation and translation services are provided, the quality may be poor and further contribute to negative outcomes.[105] For example, a 2012 Annals of Emergency Medicine study reviewing audio recordings from visits at two large pediatric emergency departments in Massachusetts found over one thousand interpreting mistakes, even by professional interpreters.[106] The study found that interpreters omitted or changed words, added their own interpretation and perspective, or directly translated phrases or idioms that did not exist in the patient's primary language.[107] The study did find, however

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[100] Sabriya Rice, *Hospitals Often Ignore Policies on Using Qualified Medical Interpreters*, MODERN HEALTHCARE (AUG. 30, 2014), http://www.modernhealthcare.com/article/20140830/MAGAZINE/308309945.
[101] *Id.*
[102] *Id.*
[103] NATIONAL HEALTH LAW PROGRAM, HOW CAN STATES GET FEDERAL FUNDS TO HELP PAY FOR LANGUAGE SERVICES FOR MEDICAID AND SCHIP ENROLLEES? (2009), http://www.migrationpolicy.org/sites/default/files/language_portal/FederalLanguageAccessFunds_0.pdf.
[104] Rice, *supra* note 100.
[105] *See infra* notes 106–108 and accompanying text.
[106] Glem Flores et al., *Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters*, 60 ANN. OF EMERGENCY MED. 545, 547 (2012).
[107] *Id.* at 546.

that mistakes were less frequent among professional interpreters who received at least 100 hours of training.[108]

Video and telephone interpretation services provide viable alternatives when in-person interpretation is not available. They offer the advantage of providing multiple languages and potential time savings waiting for an in-person interpreter to arrive in the clinical setting.[109] For languages encountered less frequently by healthcare providers, using video or telephone interpretation services may be more efficient and cost-effective than providing services using bilingual staff.[110] However, the quality of in-person interpreting may be better and preferable for patients and providers, as video or telephone interpretation may limit the ability to identify physical or emotional cues that are important in the patient-provider interaction.[111]

V. THE ROLE OF COMMUNITY ORGANIZATIONS AND HEALTH CENTERS

While the continued development and implementation of federal and state laws and policies to improve language access for LEP individuals is needed, community-based organizations (CBOs) play an essential role in helping LEP individuals gain access to health care services.[112] Many LEP individuals in the AA and NHPI community, as well as in other ethnic minority communities, rely on language services and assistance provided by local community-based

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[108] *Id.* at 551.

[109] *See* Elizabeth A. Jacobs et al., *Shared Networks of Interpreter Services, at Relatively Low Cost, Can Help Providers Serve Patients with Limited English Skills,* 30 HEALTH AFF. 1930, 1935 (2011), http://content.healthaffairs.org/content/30/10/1930.full.pdf+html.

[110] *See* PAMELA A. HOLCOMB ET AL., URBAN INSTITUTE, THE APPLICATION PROCESS FOR TANF, FOOD STAMPS, MEDICAID AND SCHIP: ISSUES FOR AGENCIES AND APPLICANTS, INCLUDING IMMIGRANTS AND LIMITED ENGLISH SPEAKERS, at iv (2003), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/410640-The-Application-Process-For-TANF-Food-Stamps-Medicaid-and-SCHIP.pdf. This study examined four major public benefits programs (Temporary Assistance for Needy Families, food stamps, Medicaid, and the State Children's Health Insurance Program) in six different U.S. metropolitan areas, and examined how immigrants and LEP individuals obtained assistance to apply for these four programs. *Id.*

[111] *See supra* note 109.

[112] *See infra* notes 113–136 and accompanying text.

organizations.[113] These organizations are mostly small, non-profit entities that provide a multitude of services to communities, including community education on multiple topics, connections for individuals to access social services, and employment assistance.[114] CBOs with health-related services often provide medical interpretation assistance, assist with insurance enrollment, conduct screenings, and offer wellness programs.[115] Because these CBOs are entrenched in the community, often staffed by people who live in the community, they are trusted and provide culturally competent and in-language assistance.[116]

Community organizations that serve AA and NHPI communities have been very important in the implementation of the ACA.[117] The Asian & Pacific Islander American Health Forum, in collaboration with the Association of Asian Pacific Community Health Organizations, Asian Americans Advancing Justice | Los Angeles, and Asian Americans Advancing Justice | Asian American Justice Center collaborated to establish *Action for Health Justice (AHJ)*, a network of organizations focused on educating Asian Americans, Native Hawaiians, and Pacific Islanders about health insurance options under the ACA and helping them enroll in coverage through Federal and state-based health insurance marketplaces.[118] Established in July 2013 just before the first open enrollment period, *AHJ* is comprised of over seventy local and state community-based organizations and FQHCs in twenty-two states.[119] As a collaborative, *AHJ* focuses on assisting AA and NHPI individuals who are "low-income, LEP, or in mixed

[113] ACTION FOR HEALTH JUSTICE, *supra* note 4, at 4.
[114] *Id.* at 5. A comprehensive list of CBOs is included on page 4 of this report. *Id.* at 4.
[115] *Id.*
[116] *Id.* at 5.
[117] *See infra* note 118.
[118] For more information on Action for Health Justice and some of the featured resources developed by this network, see *Healthcare for* Me, APIAHF, http://www.apiahf.org/healthcare4me/action-health-justice (last visited Dec. 21, 2016), and *About Us,* AAPCHO, http://www.aapcho.org/about-us/ (last visited Dec. 21, 2016). For more information on the national organizations that lead the Action for Health Justice Collaborative, see *Who We Are*, ADVANCING JUSTICE LA, http://www.advancingjustice-la.org/who-we-are (last visited Dec. 21, 2016) and *About*, ADVANCING JUSTICE AAJC, www.advancingjustice-aajc.org/about (last visited Dec. 21, 2016).
[119] ACTION FOR HEALTH JUSTICE, *supra* note 4, at 4.

immigration status families, as well as small business owners and employees and young adults."[120]

During the first open enrollment period from October 2013 to March 2014, the *AHJ* partners identified barriers, many due to language, that hindered enrollment of AA and NHPI consumers in the health insurance marketplaces.[121] Very limited translated educational materials were available and many were difficult to read, required a high level of literacy, and had poor quality translations.[122] LEP consumers also experienced inefficient and poor quality interpretation services from Federal and state Marketplace call centers.[123] As a result, CBOs and FQHCs developed their own translated materials, such as brief fact sheets about insurance coverage, often without financial support.[124] In-person assisters at these CBOs and FQHCs spent extra time with LEP individuals to help them understand the enrollment process and submit necessary documentation.[125]

Over the next two enrollment periods, materials and service improved for LEP consumers, as APIAHF and the other national advocacy groups relayed stories from the CBO and FQHC partners to federal and state marketplace administrators.[126] *AHJ* partners developed a glossary of 100 of the most common health insurance terms, which was translated into nine different Asian and Pacific Islander languages utilizing an intensive community review process.[127] As LEP individuals enrolled in coverage, they continued to return to the CBOs and FQHCs that helped them enroll to then get assistance using their new coverage.[128] Consumers needed help understanding

[120] *Id.* at 8.
[121] *Id.* at 10.
[122] *Id.* at 11.
[123] *Id.* at 14. For best practices and lessons learned from CBOs and FQHCs as they helped communities enroll in coverage through the ACA, see *id.* at 14–21. This report provides best practices and lessons learned from CBOs and FQHCs as they helped communities enroll in coverage through the ACA. ACTION FOR HEALTH JUSTICE, *supra* note 4, at 14–21.
[124] *Id.* at 14.
[125] *Id.* at 21.
[126] ACTION FOR HEALTH JUSTICE, *see supra* note 4, at 27.
[127] ACTION FOR HEALTH JUSTICE, HEALTH INSURANCE ENROLLMENT GLOSSARY (2016), http://www.apiahf.org//resources/resources-database/action-health-justice-health-enrollment-glossary [hereinafter Glossary].
[128] ACTION FOR HEALTH JUSTICE, *see supra* note 4, at 27.

the process of paying premiums, meeting deductibles and identifying primary care providers.[129] LEP consumers were also receiving notices from Marketplaces requesting additional information in order to keep their coverage.[130] These notices were only in English, and as a result, LEP consumers did not understand that they needed to submit additional documentation and many had their insurance coverage terminated as a result.[131]

Based on the feedback over the past three enrollment periods, *AHJ* partners have worked with the Centers for Medicare and Medicaid Services (CMS) within HHS to improve access to the Marketplace for LEP consumers.[132] Partners also shared their experiences with state-based marketplaces to strengthen language access in states like California, where the quality of interpretation services provided through Marketplace call centers and availability of translated materials has improved.[133] Advocacy efforts have also resulted in improvement to the tagline language on Marketplace notices and additional research on ways to improve notices so LEP individuals understand their content.[134] For example, the *AHJ* national organizations provided recommendations to move taglines to the front page of all notices and convey more urgency in the tagline message so that LEP consumers can easily get assistance in their primary language and take appropriate action to respond in a timely manner to the notice.[135] APIAHF and the other *AHJ* national partners, continue to work with HHS to improve systems, materials, and the overall marketplace experience for LEP individuals.[136]

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[129] ACTION FOR HEALTH JUSTICE, *supra* note 4, at 12.
[130] *Id.*
[131] *Id.*
[132] For recommendations to improve the enrollment process for LEP individuals provided by AHJ partners in collaboration with CMS leaders, including the CEO of Healthcare.gov, see ACTION FOR HEALTH JUSTICE, IMPROVING THE ROAD TO ACA COVERAGE: POLICY RECOMMENDATIONS FOR ENROLLMENT SUCCESS (2014), http://www.apiahf.org/sites/default/files/2014.09.29_Improving%20the%20Road%20to%20ACA%20Coverage_Policy%20Brief.pdf.
[133] *Id.* at 2.
[134] *Id.* at 12.
[135] *Id.*
[136] APIAHF is working with CMS to address these concerns and have shared detailed recommendations for improving taglines and notices from the Health Insurance Marketplace to make information more accessible to LEP individuals.

VI. POLICY RECOMMENDATIONS TO CONTINUE TO IMPROVE LANGUAGE ACCESS IN HEALTH CARE

Several strategies should be pursued in order to continue to improve access to health care and address language barriers for limited English proficient individuals.

A. Providers, Insurers, Researchers, and Policymakers Should Work Together to Explore Alternative Methods and Payment Structures to Integrate Community-Based Organizations into the Healthcare Delivery System

Researchers and federal agencies must continue to conduct research and study the financial implications of providing comprehensive language services and the impact on addressing costs associated with health disparities.[137] Data indicates that health disparities are expensive, with one analysis showing that approximately 30% of total direct medical expenditures for Blacks, Hispanics, and Asian are excess costs due to health inequities, many of which are related to language barriers for Asians.[138] A 2002 Office of Management and Budget analysis indicated that the costs associated with language services are small compared to costs of medical spending for patients with limited English proficiency.[139] The report estimated $268 million per year to provide interpretation services in inpatient hospitals, outpatient physicians, emergency departments, and dental visits.[140] Very few studies have attempted to measure potential cost savings by providing appropriate language services, and more studies and better data is needed so health care providers and policymakers can make informed decisions about providing language services.[141]

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[137] *See infra* note 187 and accompanying text.

[138] THOMAS A. LAVEIST ET AL., JOINT CENTER FOR POLITICAL AND ECONOMIC STUDIES, THE ECONOMIC BURDEN OF HEALTH INEQUALITIES IN THE UNITED STATES 4 (2009), http://www.hhnmag.com/ext/resources/inc-hhn/pdfs/resources/Burden_Of_Health_FINAL_0.pdf.

[139] Leighton Ku & Glenn Flores, *Pay Now or Pay Later: Providing Interpreter Services in Health Care*, 24 HEALTH AFF. 435, 435–44 (2005), http://content.healthaffairs.org/content/24/2/435.full.pdf+html.

[140] *Id.* at 439.

[141] *See supra* note 109 (observational study of interpreter services provided by eight hospitals in California to identify the cost of providing language access services).

Trusted community-based organizations will continue to play an important role in providing in-language in-person assistance to LEP consumers as they utilize their health insurance coverage and access health care services. Insurers, health systems, policymakers, and other stakeholders should explore mechanisms for integrating community-based organizations into the healthcare delivery system and utilize their expertise in providing language assistance to LEP consumers.[142] Many CBOs provide high-quality, culturally appropriate in-language assistance to consumers and, if adequately reimbursed, could contract with health care systems or insurers to ensure that LEP consumers receive meaningful access to health care services.[143] This type of contracting arrangement would allow the CBOs to continue in their area of expertise in providing assistance to LEP communities. Providers and insurers would benefit by paying for the services provided by CBOs instead of creating their own systems which may not be as effective and costlier over time. Ultimately, this partnership between CBOs and the health care system could help consumers better utilize their insurance coverage and access the care for which they are paying. The goal is to remove language as a significant barrier to health access and a factor that contributes to health disparities.

B. Government Agencies and Providers Must Collect Accurate and Adequate Primary Language Data for Patients and Consumers

HHS should ensure that all of its agencies are meeting the Section 4302 standard for collecting primary language data and encourage and help agencies work toward collecting the optional specific spoken language data described in Section 4302. With knowledge of accurate and robust primary language data, tailored interventions and resources can be appropriately allocated to provide necessary language assistance. If providers know the most frequently encountered languages, they can focus efforts and invest resources in providing interpretation services and translated materials in those languages. HHS should share Section 4302 implementation plans for collecting primary language data in all national population health surveys with the public in a timely manner so there is transparency as

[142] *See supra* Part V.
[143] *See supra* Part V.

to when this important data is available for dissemination and sharing with researchers, providers, advocacy groups and others who can use the data to improve services and outcomes for LEP individuals. Additionally, government agencies and providers should prioritize the collection of language data for smaller Asian American and Pacific Islander subgroups, as many of these groups have higher proportions of LEP individuals and greater need for in-language assistance.[144]

C. Continued Enforcement of Existing Civil Rights Laws is Needed

The Office of Civil Rights engages in numerous compliance reviews and complaint investigations every year, resulting in voluntary resolution agreements and specific actions to improve language access services by covered entities.[145] This process is an important avenue for ensuring that recipients of federal financial assistance from HHS are providing adequate language services and complying with existing laws and regulations. Continued attention by OCR and federal funding is needed so this Office can effectively process complaints, conduct investigations, and enforce the new ACA Section 1557 language access requirements.[146] The non-discrimination protections of Section 1557, coupled with effective enforcement, have the potential to address language access barriers to health care services for LEP individuals.[147] Individuals also have the ability to file a private right of action under Section 1557.[148]

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[144] *See supra* Part I.

[145] U.S. DEP'T OF HEALTH & HUMAN SERVICES, ENFORCEMENT SUCCESS STORIES INVOLVING PERSONS WITH LIMITED ENGLISH PROFICIENCY, http://www.hhs.gov/civil-rights/for-providers/compliance-enforcement/examples/limited-english-proficiency/index.html (last visited Dec. 21, 2016).

[146] *Id.* The HHS Office of Civil Rights has a page describing some enforcement success stories for LEP persons. *Id.* As an example, a complaint against a groups of six Chicago hospitals based on their Title VI requirement to provide language assistance services was investigated by OCR and resolved by the hospitals agreement to do the following: appoint a language access coordinator, train employees thirty-seven employees as interpreters, contract with an interpreter agency to provide back-up services, and establish an employee training program on its updated language access policies. *Id.*

[147] *See* 42 U.S.C. § 18116 (2010).

[148] *Id.*

CONCLUSION

Asian American, Native Hawaiian, and Pacific Islander limited English proficient individuals continue to face challenges in accessing health care services.[149] However, federal and state laws and agency guidance and policies have significantly helped to improve access for LEP individuals.[150] With recent provisions of the Affordable Care Act, such as Section 4302 to collect language data and Section 1557 providing regulations to protect LEP individuals from discrimination in accessing health care services, there is great potential for conditions to improve over the next decade.[151] In order to realize the full benefits of these laws and policies, Federal and state agencies must continue with timely implementation and strict enforcement. Primary language data of consumers must be extensively collected and utilized to improve service delivery. Most importantly, community-based organizations and community health centers should receive adequate Federal and private financial support and work with providers, insurers, and the health care system as a whole to continue to provide necessary in-language, in-person assistance for LEP individuals and communities.

[149] *See supra* Part I.
[150] *See supra* Part II, III.
[151] *See supra* Part II.