

Pay Now Or Pay Later: Providing Interpreter Services In Health Care

Helping the millions of Americans with limited English proficiency can improve the quality of care and reduce the risk of medical errors.

by **Leighton Ku and Glenn Flores**

ABSTRACT: Research amply documents that language barriers impede access to health care, compromise quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency. Federal civil rights policy obligates health care providers to supply language services, but wide gaps persist because insurers typically do not pay for interpreters, among other reasons. Health care financing policies should reinforce existing medical research and legal policies: Payers, including Medicaid, Medicare, and private insurers, should develop mechanisms to pay for interpretation services for patients who speak limited English.

A MAJOR DEMOGRAPHIC CHANGE shaping the United States is the growth of the foreign-born population. New immigrant workers fueled half of the growth in the U.S. labor force in the 1990s.¹ Health care providers are encountering rising numbers of patients who have limited English proficiency (LEP), defined as speaking English less than very well or not at all. For example, U.S. census data show that between 1990 and 2000, the percentage of Americans (older than age five) speaking a language other than English at home rose from 13.8 percent to 17.8 percent, and the LEP population grew by one-third, from 6.1 percent to 8.1 percent.²

Title VI of the Civil Rights Act obligates medical caregivers to provide interpretation and translation services so that LEP patients can have access to health care services equal to that of English speakers; this constitutes a protection against discrimination based on national origin.³ But the regrettable truth is that thousands of patients face language barriers every day, either because they cannot communicate with their medical caregivers or because communication is distorted by poorly trained, inexperienced, or inappropriate (for example, child) interpreters. This can be a problem whether the patient speaks Spanish—the language spoken

Leighton Ku (ku@cbpp.org) is a senior fellow at the Center on Budget and Policy Priorities in Washington, D.C. Glenn Flores is director of the Center for the Advancement of Underserved Children and an associate professor of pediatrics, epidemiology, and health policy, all at the Medical College of Wisconsin in Milwaukee.

at home by one in ten Americans—or, less commonly, Asian, European, or African languages.⁴ Patients with limited English proficiency experience barriers to health care access; they also risk misdiagnosis, medical errors, and poor quality of care.

Many reasons exist for language barriers, but one major obstacle is that insurers usually do not pay for interpretation and related services (such as written translations or telephone language lines). Although providers are obligated to offer these services to LEP patients, lack of payment deters their actual availability. Only a few states pay for interpretation under Medicaid. Moreover, Medicare does not pay for interpretation, and it appears that private insurers generally do not, although both payers serve large numbers of LEP beneficiaries.

This paper aims to summarize the scientific evidence concerning medical interpretation services; examine selected demographics of the population with limited English proficiency and the policy ramifications for insurance coverage; and explore options for financing interpretation services.

■ **Why interpretation matters.** Numerous studies document the profound adverse impact of language barriers across many dimensions of access to and quality of care. LEP patients are more likely than others to report being in fair or poor health, defer needed medical care, leave the hospital against medical advice, miss follow-up appointments, or experience drug complications; they are also less likely to have a regular health care provider.⁵

A survey of Latino parents revealed that language issues were cited as the single greatest barrier to health care access for their children.⁶ One-fourth of parents identified language as an access barrier, specifically, with lack of interpreter services and providers who do not speak Spanish. Six percent of parents reported not bringing their child in for needed medical care because of language barriers. Also, a growing body of research shows that lack of adequate interpreter services compromises the quality of care for patients with limited English proficiency.⁷

Language barriers can lead to inefficient care because clinicians are unable to elicit LEP patients' symptoms and, thus, use more diagnostic resources or invasive procedures.⁸ Also, ad hoc interpreters can compromise many aspects of patient care. Analyses of audiotaped pediatric encounters reveal that they are more likely than professional interpreters to commit errors of potential clinical consequence, such as omitting questions about drug allergies or instructions on prescription dose, frequency, and duration.⁹ The lack of adequate interpreter services can be viewed as an important patient safety issue, although errors of interpretation have not generally been examined in the literature on medical errors.¹⁰

LEP patients who need but do not get an interpreter have the lowest satisfaction with interpersonal aspects of care of any group of patients.¹¹ If such patients use ad hoc interpreters, they are much less likely to be satisfied with their medical visit than LEP patients with bilingual providers or English-proficient patients with monolingual English providers.¹² Language barriers can be particularly problematic in mental health care.¹³ Also, lack of adequate interpreter services can re-

sult in malpractice lawsuits and hospital sanctions. For example, one failure to correctly interpret a Latino boy's statement had serious consequences. A paramedic interpreted the boy's utterance "intoxicado" as "intoxicated," instead of its intended meaning, which is "nauseated." For several days, the boy was worked up for drug abuse. Subsequently, he was found to have damage caused by a ruptured brain aneurysm. The patient ended up quadriplegic and was awarded \$71 million in a malpractice case.¹⁴

■ **Effect of trained interpreters.** Many studies document the positive impact of trained professional interpreters and bilingual providers. Patients with limited English proficiency who are provided with such interpreters make more outpatient visits, receive and fill more prescriptions, do not differ from English-proficient patients in test costs or receipt of intravenous hydration, have outcomes among those with diabetes that are superior or equivalent to those of English-proficient patients, and have high satisfaction with care.¹⁵ LEP patients with bilingual providers ask more questions, have better overall information recall, and are more comfortable discussing sensitive or embarrassing issues; those with hypertension or diabetes have less pain and better physical functioning, psychological well-being, and health perceptions and have high patient satisfaction.¹⁶ Nonetheless, trained interpreters often are not offered in health care settings.¹⁷

The Population With Limited English Proficiency

Since immigrants and others with limited English skills often have low-paying jobs and are disproportionately poor, many people assume that linguistic access is essentially a problem only for Medicaid beneficiaries. In reality, the great majority of Americans with limited English proficiency are not poor, and more than two million are elderly. Payment for language services is not just a Medicaid issue but is a concern for private insurers and Medicare, too.

The 2000 census revealed that there were 17.5 million adults and 3.4 million school-age children with limited English proficiency in the United States (Exhibit 1).¹⁸ About 80 percent of such adults have incomes above the federal poverty level. Since Medicaid eligibility for adults usually is set well below that level, most LEP adults are ineligible for Medicaid. A plurality of LEP children and adults have incomes above 200 percent of poverty. Since most states set income limits for the State Children's Health Insurance Program (SCHIP) at or below 200 percent of poverty, this means that large numbers of children in LEP families are ineligible for Medicaid or SCHIP.

The distribution of limited English proficiency varies. The percentage of LEP nonelderly adults is 21 percent in California, 15 percent in Texas, 13 percent in New York, 12 percent in Florida, and lower in other areas. The immigrant population has grown rapidly in nontraditional areas such as Virginia and Utah, so language issues have spread across the nation.¹⁹ Although people with limited English proficiency are primarily immigrants, about one-tenth are native-born

EXHIBIT 1
Number And Percentage Of Children And Adults Who Have Limited English Proficiency, By Age And Poverty Level, 2000

	Age group (years)				
	5-17	18-44	45-64	65+	18-64
Number with limited English proficiency (millions)	3.4	10.6	4.6	2.3	17.5
Percent of total population in age group with limited English proficiency	4.8%	9.8%	7.5%	6.9%	8.6%
Percent with limited English proficiency by poverty category					
Below 100% of poverty	32.1%	23.8%	16.0%	18.0%	21.0%
100%-200% of poverty	32.3	29.7	22.7	28.1	27.6
Above 200% of poverty	35.6	46.5	61.4	53.9	51.4

SOURCE: Authors' analyses of 2000 census, 1 Percent Public Use Microdata Sample.

Americans, typically from Puerto Rico or states such as Texas, California, or New York.²⁰

Insurers And Payment For Language Services

Under Medicaid and SCHIP, states may pay for interpretation services, and state expenditures are eligible for federal matching payments of 50 percent or more. According to the National Health Law Program, ten states pay for interpreter services under Medicaid or SCHIP.²¹ Varying approaches are used: Some states authorize reimbursement for interpreter services, while others contract with specific organizations to provide interpretation. This latter approach is particularly useful in outpatient or office settings. One state has separate payment rates for telephone and in-person interpretation. In some areas, hospitals may include interpretation costs as allowable costs used to establish overall payment rates. In at least one case, the state initiative was established to settle a discrimination lawsuit under Title VI of the Civil Rights Act.²²

Although 2.3 million seniors have limited English proficiency, Medicare does not pay for interpretation. This is a particularly noteworthy omission, since the federal government establishes both the civil rights requirement for interpretation and Medicare payment policies. This omission likely reduces access to and quality of care for LEP Medicare beneficiaries and undercuts federal civil rights policies. Moreover, since Medicare payment policies often influence payment methodologies used by private insurers and state Medicaid programs, this omission makes it less likely that other insurers cover interpretation services.

Although data are scarce, it appears that private insurers do not usually reimburse language services. Insurers that provide direct services, such as Kaiser Permanente or Group Health Cooperative, may hire interpreters, but third-party reimbursement for such services appears uncommon.²³ Some managed care plans require that contracted providers offer language services but do not directly reim-

burse for such services. Nonetheless, many health care facilities, particularly hospitals and medical centers, hire interpreters, maintain lists of bilingual staff (who may or may not be trained as interpreters), contract for interpreter services, or offer medical interpretation training for interpreters or language training for staff. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO)—the primary U.S. hospital accreditation organization—includes language services as an element of its accreditation standards, aimed at ensuring patients' rights.²⁴

Options For Financing Language Services

As recently as 2003, the federal government reiterated guidance requiring providers receiving federal funds, such as from Medicaid or Medicare, to offer language assistance to LEP patients if needed.²⁵ Although these federal policies impose obligations, they provide no funding stream. The American Medical Association (AMA) and others have raised concerns about physicians' having to bear the costs of interpretation.²⁶ The AMA is "strongly opposed to allowing the burden of funding written and oral interpretation services for limited-English-proficiency patients to fall on physicians." It points out, for example, that while Medi-Cal (California Medicaid) paid physicians about \$24 for an established patient visit, interpretation could cost physicians much more.

■ **What would it cost?** How much would it cost to meet the costs of language services for LEP patients? A 2002 Office of Management and Budget (OMB) report estimated that it would cost the nation \$268 million a year to provide interpretation services in inpatient hospital, outpatient physician, ED, and dental visits. The OMB estimated that interpretation costs an average of \$4.04 per visit by an LEP patient or 0.5 percent of the total cost of a visit but acknowledged that costs could vary widely.²⁷ (The OMB estimated that interpreters receive \$20–\$26 per hour and that telephone interpretation costs \$132 per hour. It assumed that a substantial share of interpretation is conducted by bilingual providers or volunteer interpreters who incur no additional costs.) Even if one assumes that the estimates should be increased to account for higher salary levels or less use of free services, the costs would still be relatively modest. The OMB's estimate does not discount for the costs of language services already being provided or for reductions in other health costs that might occur if there is better patient-provider communication. Thus, the net additional costs of expanding language services should be lower.

■ **Should insurers pay for language services?** Since Title VI already requires that clinicians offer language services, some might ask why insurers should pay for them. Shouldn't these services simply be considered a "cost of doing business"? Insurers do not separately reimburse for the efforts of billing clerks or for much of the work of nurses in health care settings, but they expect that those services will be financed from general reimbursements to providers.

This same principle does not apply as well to interpretation services, however. Unlike the work of billing clerks or nurses, the costs and burdens associated with

language services are not evenly distributed across providers, and the lack of payment creates harmful disincentives. A general medical clinic whose patient case-load is 80 percent immigrants will face higher interpretation costs than a similar clinic serving no immigrants. In contrast, these clinics would bear similar costs for clerks and nurses. Moreover, clinics have incentives to maintain adequate billing and nursing services to achieve profitability and high quality of care but could believe that offering language access would be a financial drain and merely attract more LEP patients. Insurance reimbursement would remedy existing disincentives for language services.

■ **Can we afford to pay for language services?** The OMB analysis cited above suggests that the additional costs for language services are relatively small compared with the gaps in health care access and medical spending that now exist for patients with limited English proficiency.

Exhibit 2 presents data on the average annual cost of medical services received by adults ages 18–64, classified by race/ethnicity and insurance status. Since this data source does not measure English proficiency, we view race/ethnicity as a rough proxy for English proficiency, since Latinos and Asians are far more likely than whites to have limited English proficiency. Whether a person is insured or uninsured for a full year, Latinos and Asians have mean medical costs that are 20–60 percent lower than those of non-Hispanic whites. One likely explanation is that patients who have limited English proficiency and are immigrants have poorer health care access and use fewer services, as documented in earlier research.²⁸ The amounts needed to pay for language services (0.5 percent, according to the OMB estimate) are far less than the large disparities in medical spending that exist between white patients and Latino and Asian patients. Paying for language services may help reduce the existing racial/ethnic disparities in health care.

EXHIBIT 2
**Medical Spending And Insurance Coverage For Adults Ages 18–64, By Race/
 Ethnicity And Insurance Coverage, 2000**

	Insured all year	Insured part of year	Never insured in year	Overall mean/total
Average annual medical spending				
White, non-Hispanic	\$2,325	\$2,287	\$ 943	\$2,175
Latino	1,840 ^a	1,468	402 ^a	1,284 ^a
Asian	1,471 ^a	661	1,774	1,379 ^a
Percentage of adults ages 18–64 by level of insurance coverage				
White, non-Hispanic	77.8%	11.7%	10.5%	100.0%
Latino	49.4	16.0	34.5	100.0
Asian	68.6	16.8	14.6	100.0

SOURCE: 2000 Medical Expenditure Panel Survey.

^a Mean for minority group differs significantly from white, non-Hispanics with 95 percent confidence.

Payment Models And Issues

How could insurers pay for language services? We present here four payment approaches, based partly on models already in use in state Medicaid programs. Multiple approaches may be needed.

■ **Payment models.** One alternative is insurance reimbursement for professional interpreters, paid hourly or per visit. This approach is relatively straightforward and appropriate for in-person interpretation. But it raises questions about the professional standards used to determine which interpreters qualify for reimbursement.

Another alternative is for insurers to contract with telephone interpretation firms and to let providers use the contracted service with direct billing back to the insurer. Telephone interpretation is particularly useful when the patient's language is less commonly spoken or when the provider is located in an area with few LEP patients, which makes in-person arrangements more difficult. Here, too, there are questions about professional standards and the quality of interpretation.

A third alternative is funding community organizations to form "language banks" that recruit, train, and organize medical interpreters for local health care facilities. This infrastructure approach helps develop the local pool of interpreters who meet a standard of competency but still requires a reimbursement system for services rendered. Such groups could serve as preferred contractors for insurers.

A final alternative is to modify standard health care reimbursements when LEP patients are treated, such as by modifying physicians' relative value scale payments for such patients, raising the reimbursement by X dollars or Y percent because of the additional services needed for these patients. This gives providers more flexibility to use the funds to increase the number of bilingual clinicians or reimburse interpreters. But it also forces providers to be responsible for paying interpreters, a burden some might not want.

■ **Underlying issues.** An underlying issue for any of these options is competency standards. Research shows that trained professional interpreters provide better-quality services. But how do we know when an interpreter is adequately trained or competent or when a clinician is sufficiently proficient in a second language?²⁹ Professional standards would improve quality but might create barriers that limit the supply of interpreters for less common languages.

There are also logistical challenges that must be addressed in trying to arrange language services in different settings (hospitals versus physicians' offices versus other settings) or situations (scheduled versus unscheduled visits). For example, clinics could schedule patients who speak certain languages during specific days of the week to optimize the use of interpreters and bilingual clinicians.

In situations where third-party reimbursement for interpreter services is not available, are there interim measures that health care institutions might use to improve language access? One possibility is to increase the foreign-language skills of health professionals. Medical or other health professions schools could require medical Spanish, Chinese, or other languages in their curricula. Bonuses also

could be paid to clinicians who demonstrate fluency in appropriate languages. Community-based organizations could collaborate with hospitals and clinics to train and certify volunteer interpreters. Universities could provide medical terminology training to foreign-language majors, who then could serve as a foreign-language “bank” for health care facilities. Existing state telemedicine infrastructures could be used cost-efficiently to provide statewide interpreter services using a centrally located staff.

We do not know how to solve to all of these issues, but we believe that the United States should begin to develop research, experience, and consensus to develop payment policies in the coming years.

REDUCING LANGUAGE BARRIERS SHOULD BE an important component of efforts at every level of the health care system to improve quality of care, reduce the risk of medical errors, and increase access to services. Despite its alacrity in picking up on new medical technologies, the U.S. health care system has lagged in accepting—and paying for—medical interpretation services, which multiple studies have found to result in improved quality of care, better outcomes, lower costs, and greater patient satisfaction.

The United States, which has always been a nation of immigrants, has a growing number of people who are not proficient in English but are vital members of the nation and its economy. It is shortsighted to ignore this demographic reality. Stinting on efforts to communicate with such patients not only violates their civil rights but threatens the quality and safety of their health care. The federal government, which has emphasized reducing racial/ethnic disparities in health care, should assume leadership in promoting the availability of and payment for language services under the various federally funded health care programs. Some states have taken the lead in paying for interpretation under Medicaid and SCHIP, but more should follow suit. Private insurers and employers also should pay attention to the needs of their foreign-born workers and their dependents by fostering language services.

The United States has already established the legal and ethical obligation of health care providers to offer language services to patients with limited English proficiency. The system should catch up and begin paying for these services. We can either pay a small amount up front to ensure that all patients receive equitable, high-quality care, or pay a lot more later for unnecessary tests and procedures, preventable hospitalizations, medical errors and injuries, and expensive lawsuits.

.....
The views expressed are those of the authors and should not be viewed as those of the Center on Budget and Policy Priorities (CBPP) or the Medical College of Wisconsin. The authors gratefully thank Sashi Nimalendran of the CBPP and Elise Richer of the Center on Law and Social Policy for tabulations of the Medical Expenditure Panel Survey and census data. Glenn Flores is supported in part by a Robert Wood Johnson Foundation Generalist Physician Faculty Scholars Program award and an Independent Scientist Award from the Agency for Healthcare Research and Quality.

NOTES

1. A. Sum et al., *Immigrant Workers and the Great American Job Machine: The Contributions of New Foreign Immigration to National and Regional Labor Force Growth in the 1990s*, August 2002, www.businessroundtable.org/pdf/781.pdf (10 December 2004).
2. U.S. Census Bureau, "Language Use and English-Speaking Ability: 2000," Pub. no. C2KBR-29 (Washington: U.S. Census Bureau, 2003). The Census Bureau's definition of "limited English proficiency" is those who speak English less than very well or not at all. Census data do not measure all language skills, such as reading proficiency.
3. J. Perkins, *Ensuring Linguistic Access in Health Care Settings: An Overview of Current Legal Rights and Responsibilities*, August 2003, www.kff.org/uninsured/upload/22093_1.pdf (6 January 2005); and Presidential Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," *Federal Register* 65, no. 159 (2000): 50121.
4. U.S. Census Bureau, "Language Use and English-Speaking Ability: 2000."
5. B. Kirkman-Liff and D. Mondragón, "Language of Interview: Relevance for Research of Southwest Hispanics," *American Journal of Public Health* 81, no. 11 (1991): 1399–1404; G. Flores et al., "Access Barriers to Health Care for Latino Children," *Archives of Pediatrics and Adolescent Medicine* 152, no. 11 (1998): 1119–1125; M. Alpert et al., "The Language Barrier in Evaluating Spanish-American Patients," *Archives of General Psychiatry* 29, no. 5 (1973): 655–659; R. Weinick and N. Krauss, "Racial/Ethnic Differences in Children's Access to Care," *American Journal of Public Health* 90, no. 11 (2000): 1771–1774; and T.K. Gandhi et al., "Drug Complications in Outpatients," *Journal of General Internal Medicine* 15, no. 3 (2000): 149–154.
6. Flores et al., "Access Barriers."
7. See, for example, D.W. Baker et al., "Use and Effectiveness of Interpreters in an Emergency Department," *Journal of the American Medical Association* 275, no. 10 (1996): 783–788; and R.A. David and M. Rhee, "The Impact of Language as a Barrier to Effective Health Care in an Underserved Urban Hispanic Community," *Mount Sinai Journal of Medicine* 65, no. 5–6 (1998): 393–397.
8. See, for example, L.C. Hampers et al., "Language Barriers and Resource Utilization in a Pediatric Emergency Department," *Pediatrics* 103, no. 6, Part 1 (1999): 1253–1256; L.C. Hampers and J.E. McNulty, "Professional Interpreters and Bilingual Physicians in a Pediatric Emergency Department: Effect on Resource Utilization," *Archives of Pediatrics and Adolescent Medicine* 156, no. 11 (2002): 1108–1113; and S. LeSon and M.E. Gershwin, "Risk Factors for Asthmatic Patients Requiring Intubation: I. Observations in Children," *Journal of Asthma* 32, no. 4 (1995): 285–294.
9. G. Flores et al., "Errors in Medical Interpretation and Their Potential Clinical Consequences in Pediatric Encounters," *Pediatrics* 111, no. 1 (2003): 6–14; and P. Ebdet et al., "The Bilingual Consultation," *Lancet* 1, no. 8581 (1988): 347.
10. Such errors are not discussed as a patient safety issue in L.T. Kohn, J.M. Corrigan, and M.S. Donaldson, eds., *To Err Is Human: Building a Safer Health System* (Washington: National Academies Press, 1999).
11. D.W. Baker, R. Hayes, and J.P. Fortier, "Interpreter Use and Satisfaction with Interpersonal Aspects of Care for Spanish-Speaking Patients," *Medical Care* 36, no. 10 (1998): 1461–1470.
12. L.J. Lee et al., "Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-In Clinic," *Journal of General Internal Medicine* 17, no. 8 (2002): 641–645; and David and Rhee, "The Impact of Language."
13. See, for example, J.E. Sabin, "Translating Despair," *American Journal of Psychiatry* 132, no. 2 (1975): 197–199; and L.R. Marcos, "Effects of Interpreters on the Evaluation of Psychopathology in Non-English-Speaking Patients," *American Journal of Psychiatry* 136, no. 2 (1979): 171–174.
14. P. Harsham, "A Misinterpreted Word Worth \$71 Million," *Medical Economics* 61, no. 12 (1984): 289–292.
15. T.S. Bell et al., "Interventions to Improve Uptake of Breast Screening in Inner City Cardiff General Practices with Ethnic Minority Lists," *Ethnic Health* 4, no. 4 (1999): 277–284; T.M. Tocher and E. Larson, "Quality of Diabetes Care for Non-English-Speaking Patients: A Comparative Study," *Western Journal of Medicine* 168, no. 6 (1998): 504–511; D. Kuo and M.J. Fagan, "Satisfaction with Methods of Spanish Interpretation in an Ambulatory Care Clinic," *Journal of General Internal Medicine* 14, no. 9 (1999): 547–550; and Lee et al., "Effect of Spanish Interpretation Method."
16. R. Seijo, H. Gomez, and J. Freidenberg, "Language as a Communication Barrier in Medical Care for Hispanic Patients," in *Hispanic Psychology—Critical Issues in Theory and Research*, ed. A.M. Padilla (Thousand Oaks, Calif.: Sage Publications, 1995), 169–181; Kuo and Fagan, "Satisfaction with Methods"; E.J. Pérez-Stable, A. Napoles-Springer, and J.M. Miramontes, "The Effects of Ethnicity and Language on Medical Outcomes of

- Patients with Hypertension or Diabetes,” *Medical Care* 35, no. 12 (1997): 1212–1219; and Lee et al., “Effect of Spanish Interpretation Method.”
17. Baker et al., “Interpreter Use and Satisfaction”; and C. Ginsberg et al., *Interpretation and Translation Services in Healthcare: A Survey of U.S. Public and Private Teaching Hospitals* (Washington: National Public Health and Hospital Institute, 1995), 1–49.
 18. We could not identify national surveys with good data on insurance status and language proficiency for every household member. Since national surveys are conducted only in English or use English as the default language, respondents are typically the member most likely to speak English. Thus, the proficiency of the primary respondent underestimates the prevalence of low English proficiency in the household.
 19. R. Capps, M.E. Fix, and J.S. Passel, “The Dispersal of Immigrants in the 1990s” (Washington: Urban Institute, November 2002).
 20. E. Richer, “Expanding Employment Prospects for Adults with Limited English Skills” (Paper presented at National Association for Welfare Research and Statistics meeting, 15 July 2003, San Diego, California).
 21. M. Youdelman, “Medicaid/SCHIP Reimbursement Models for Language Services,” in *Language Services Action Kit* (Boston: Access Project, 2003); and M. Youdelman and J. Perkins, *Providing Language Interpretation Services in Health Care Settings: Examples from the Field* (New York: Commonwealth Fund, 2002).
 22. A. Morse, “Language Access: Helping Newcomers Navigate Health, Social Service Systems,” *State Health Notes* 23, no. 281 (2002): 1–5.
 23. We could not find published reports of the extent to which private insurers provide reimbursement for interpretation services. The National Health Law Program (NHeLP) just completed a survey of fifty small medical group practices and medical administrators; none of the respondents reported any private insurance reimbursement for interpretation (Mara Youdelman, staff attorney, NHeLP, personal communication, November 2004). In addition, we discussed this with representatives of the National Council on Interpreting in Health Care (Cynthia Roat, cochair, NCIHC personal communication, August 2003) and several insurance officials, who concurred that private insurance reimbursement for interpretation is uncommon.
 24. Joint Commission on Accreditation of Healthcare Organizations, *2004 Hospital Accreditation Program Standards* (Oakbrook Terrace, Ill.: JCAHO, 2003). These standards also apply to ambulatory, behavioral, and long-term care facilities.
 25. U.S. Department of Health and Human Services, Office of Civil Rights, “Guidance to Federal Financial Assistance Recipients regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons,” *Federal Register* 68, no. 153 (2003): 47311–47323. Also see Note 5.
 26. M. Hawryluk, “AMA: Doctors Shouldn’t Pay for Translators; Interpreters’ Fees Often Exceed Medicaid Payments for Office Visits,” *American Medical News* 45, no. 2 (2002): 5–6; and S.J. Landers, “Doctors Resent Being Forced to Find, Pay for Interpreters,” *American Medical News* 43, no. 43 (2000): 5–6.
 27. Office of Management and Budget, *Report to Congress, Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency*, March 2002, www.whitehouse.gov/omb/inforeg/lepfinal3-14.pdf (10 December 2004).
 28. L. Ku and T. Waidmann, *How Race/Ethnicity, Immigration Status, and Language Affect Health Insurance Coverage, Access to Care and Quality of Care among the Low-Income Population*, August 2003, www.kff.org/uninsured/kemu4132report.cfm (10 December 2004); and L. Ku and S. Matani, “Left Out: Immigrants’ Access to Health Care and Insurance,” *Health Affairs* 20, no. 1 (2001): 247–256.
 29. See, for example, NCIHC, “Guide to Initial Assessment of Interpreter Qualifications,” April 2001, www.ncihc.org/NCIHC_PDF/InitialAssessmentofInterpreterfinalversionMay2001.pdf (10 December 2004).