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Health Policy Brief

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Limited English Proficient HMO Enrollees Remain Vulnerable to Communication Barriers Despite Language Assistance Regulations

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"HMO enrollees in poorer health experience the biggest language barriers."

SUMMARY: HMO enrollees with limited English proficiency, and particularly those in poorer health, face communication barriers despite language assistance regulations. More than 1.3 million California HMO enrollees ages 18 to 64 do not speak English well enough to communicate with medical providers and may experience reduced access to high-quality health care if they do not receive appropriate language assistance services. Based on analysis of the 2007 and 2009 California Health Interview Surveys (CHIS), commercial HMO enrollees with limited English proficiency (LEP) in poorer health are more likely to have difficulty understanding their doctors, placing this already vulnerable population at even greater risk. The analysis also uses CHIS to examine the potential impact of health plan monitoring starting in 2009 (due to a 2003 amendment to the Knox-Keene Health Care Services Act) requiring health plans to provide free qualified interpretation and translation services to HMO enrollees. The authors recommend that California's health plans continue to incorporate trained interpreters into their contracted networks and delivery systems, paying special attention to enrollees in poorer health. The results may serve as a planning tool for health plans, providing a detailed snapshot of enrollee characteristics that will help design effective programs now and prepare for a likely increase in insured LEP populations in the future, as full implementation of the Affordable Care Act takes place over the next decade.

Almost two-thirds of limited English proficient commercial HMO enrollees who reported communication barriers were in fair or poor health. The recent implementation of regulations to improve commercial HMO provision of language assistance services may eventually help increase understanding, but in the first year of implementation, it does not appear that HMO policies ensuring access to language-appropriate services have led to immediate improvements in communication for the sickest enrollees.

Requirements for HMOs to Provide Language Access Services

In response to the passage of the Knox-Keene amendment in 2003, language access regulations were established in 2007 for all health plans covered by California's Department of Managed Health Care (DMHC) and select plans covered by the California Department of Insurance (CDI). The new regulations require insurers to assess their members' languages of preference and provide verbal interpretation in all languages, and written translation in threshold languages. Threshold languages generally include Spanish and Chinese and, for some health plans,

THE PATIENT ADVOCATE

Funded by the California Office of the Patient Advocate

"LEP Californians will make up a significant portion of the newly insured under health care reform."

Definitions

Threshold languages
Determined by the demographic makeup of a health plan's membership, these are languages for which plans must provide translated vital documents, including applications, consent forms, letters about eligibility or participation criteria, and notices advising changes in benefits and availability of free language assistance.[1]

Knox-Keene Health Care Services Act
California law established in 1975 that regulates managed care plans. The law has been amended multiple times since its inception, including in 2003 to address language access issues as a result of Senate Bill 853.

Limited English Proficiency (LEP)
Individuals who reported speaking English not well or not at all.

Fee-for-Service (FFS)
A method of payment in which health care providers are paid per service rendered. In California, most fee-for-service care is delivered to Medicare beneficiaries and Medicaid enrollees living in rural areas.

Preferred Provider Organization (PPO)
A health insurance plan that encourages members to seek care through contracted providers by requiring patients to pay a larger share for services delivered outside of its contracted network of providers. For example, a patient can see an in-network provider and pay 20% of the provider's fee, or see an out-of-network provider and pay 40% of that provider's fee.

Health Maintenance Organization (HMO)
A health plan that requires members to seek care in a contracted network. HMOs typically use primary care physicians and other protocols to authorize specialty care and medical procedures. Care delivered out-of-network is not covered except in emergency situations.

CHIS california health interview survey

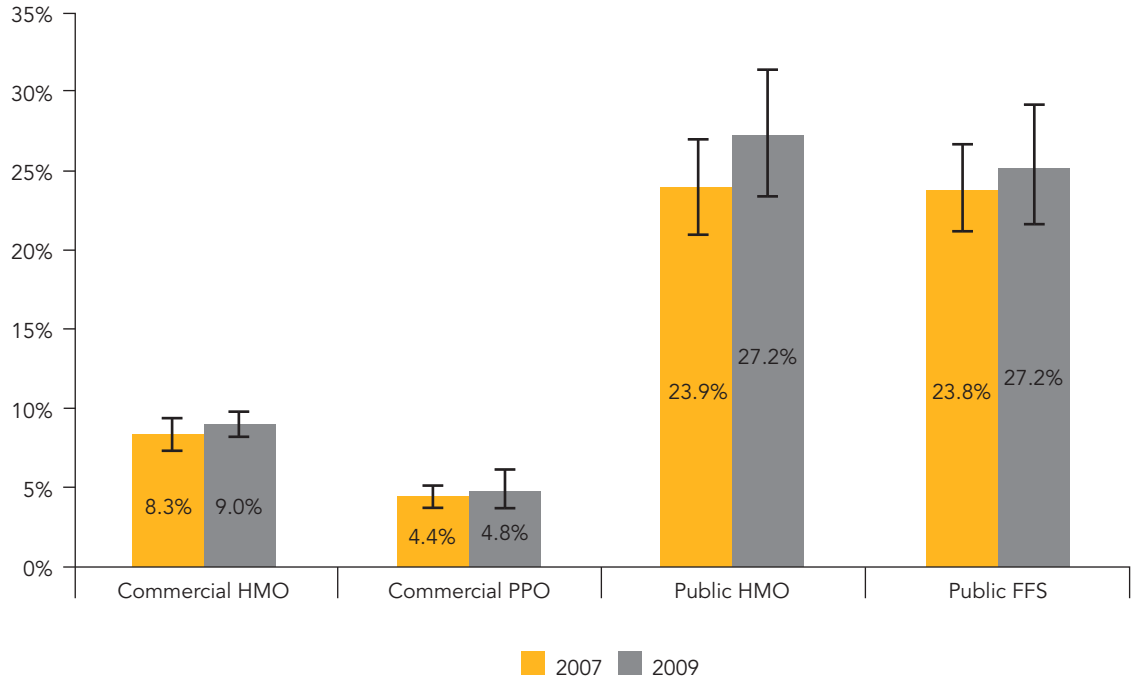
This publication contains data from the California Health Interview Survey (CHIS), the nation's largest state health survey. Conducted by the UCLA Center for Health Policy Research, CHIS data give a detailed picture of the health and health care needs of California's large and diverse population. Learn more at: ***www.chis.ucla.edu***

Vietnamese, Russian, Korean, Tagalog, Khmer, Armenian, Arabic, and/or Hmong.[2] DMHC began monitoring health plan compliance in January 2009, when all HMOs were required to have fully implemented language access policies and procedures.

The law is particularly important in the current health policy environment as LEP populations will make up a significant portion of the newly insured after implementation of the Affordable Care Act, including via the state's health benefits exchange, Covered California. A recent UC Berkeley and UCLA analysis estimated that 29% to 36% of non-elderly adults who take-up subsidized coverage in Covered California will be LEP.[3]

In this study, we examine the LEP HMO enrollee population and attempt to measure communication barriers and early progress since the Knox-Keene amendment went into effect. A limiting factor is that data from 2009 may refer to language barriers that existed as early as September 2007 and as late as April 2010 since respondents are

Percent of Enrollees Who Are Limited English Proficient by Type of Insurance, Ages 18-64, California, 2007-2009 **Exhibit 1**



Note: Based on chi-square test of proportions for each insurance category between 2007 and 2009. See Appendix 1 for further details.

Sources: 2007 and 2009 California Health Interview Surveys

asked about experiences up to two years prior to being surveyed. Although the regulations were published in early 2007, some of the results reported here preceded the implementation deadline in 2009. These data are an intermediate measure of progress toward improved language access after 2009.

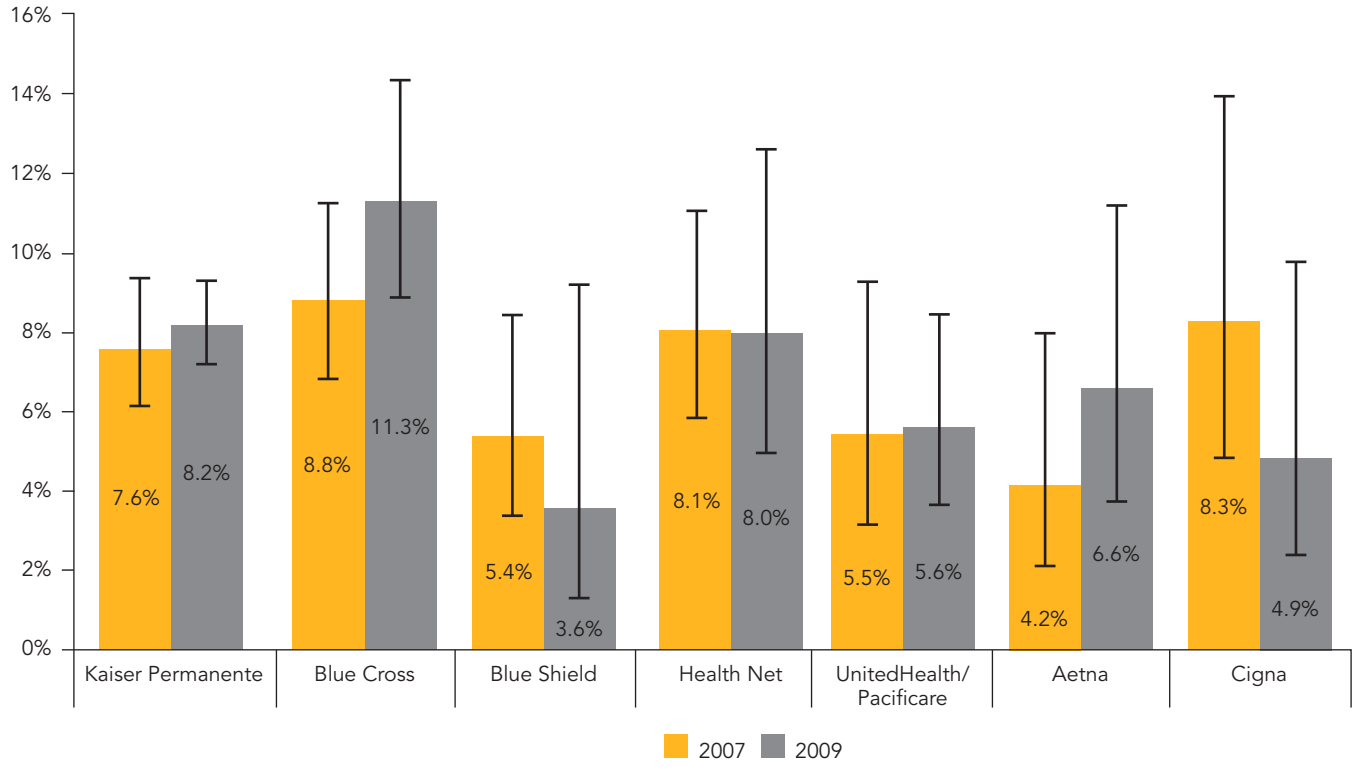
Limited English Proficient a Substantial Proportion of HMO Membership

In 2009, nearly one in eight HMO enrollees in California was LEP. A much larger proportion of enrollees in public programs such as Medicare and Medicaid (27.2%) were LEP when compared to those in commercial plans (9.5%), but the total number of LEP enrollees in commercial HMOs (842,000) was substantially larger than in public HMOs (460,000) given the greater number of people with commercial coverage (Exhibit 1 and Appendix 1). Examining large commercial insurers individually, LEP enrollees represented a substantial proportion of membership in many HMO plans (Exhibit 2 and Appendix 2).

The change in LEP as a percentage of all enrollees did not change significantly from 2007 to 2009 for commercial or public HMOs. This suggests that the plans have a relatively consistent membership profile to gauge demand and plan for language assistance services or language concordance with health care providers.

"LEP enrollees represent a substantial portion of membership in many HMO plans."

Exhibit 2 **Percent of Enrollees Who Are Limited English Proficient by Commercial HMO Plan, Ages 18-64, California, 2007-2009**



Note: See Appendix 2 for further details.
Sources: 2007 and 2009 California Health Interview Surveys

"Nearly half of LEP commercial HMO enrollees needing assistance did not receive professional interpretation."

Minimal Change in Patient-Doctor Communication

The proportion of LEP commercial HMO enrollees who had seen a doctor at least once in the past two years and reported having trouble understanding their physician remained stable from 2007 (12.1%) to 2009 (9.5%; Exhibit 3). For public HMO enrollees, difficulty understanding their physician was also stable from 2007 (9.1%) to 2009 (12%). The small changes in both variables were not statistically significant. However, change was not expected in public HMOs as the programs were already subject to more stringent regulations prior to DMHC monitoring of commercial plans.

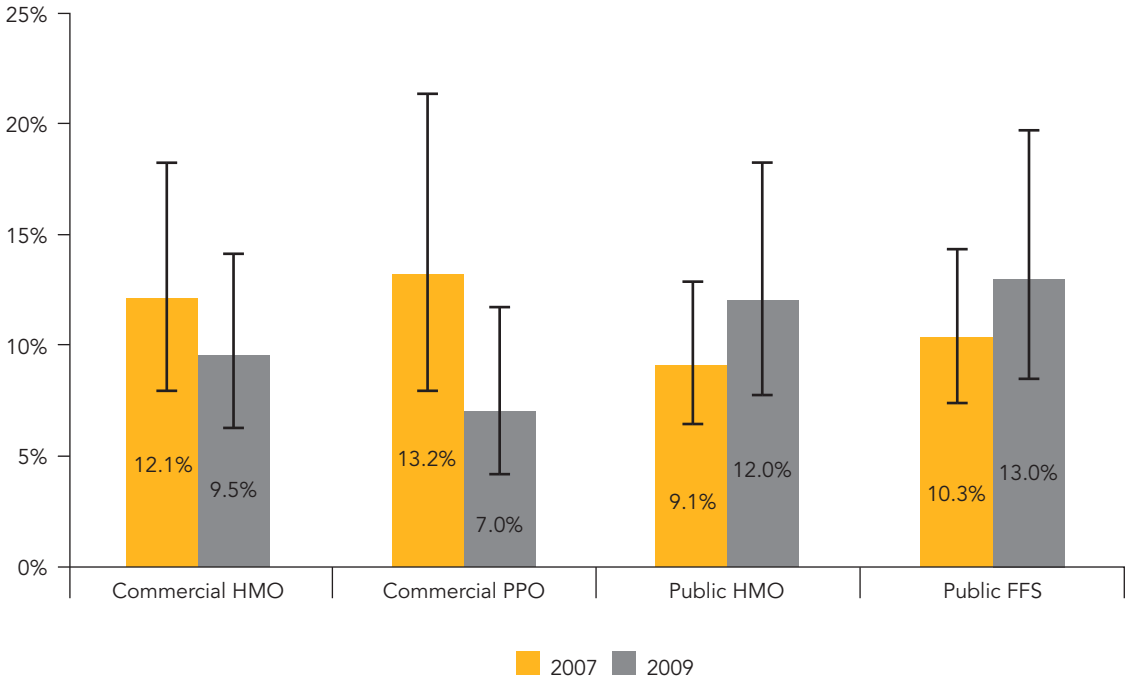
The limited change exhibited in CHIS 2009 data may be a reflection of the short time period since the implementation of the language access regulations. The data nonetheless offer a valuable planning tool to understand the LEP population and the subset of LEP individuals who report difficulty understanding their physician (Exhibit 4).

Sicker Limited English Proficient Enrollees Have Greater Communication Problems

In commercial HMOs and public fee-for-service plans, members in fair or poor health were more likely than their counterparts in better health to report difficulty understanding their physician. In commercial HMOs, the sickest enrollees made up over one-third of all LEP members (36.4%) but represented nearly two-thirds of those reporting communication troubles (63.5%). These results make clear that health plans must be particularly vigilant about ensuring access to language services to LEP enrollees in poorer health.

Percent of Limited English Proficient Enrollees Who Had Hard Time Understanding Doctor at Last Visit by Type of Insurance, Ages 18-64, California, 2007-2009

Exhibit 3



Note: Logistic regression model adjusted for income, gender, race/ethnicity, level of education, and percent of life spent in the U.S.

Sources: 2007 and 2009 California Health Interview Surveys

Nearly Half of Limited English Proficient Commercial HMO Enrollees Needing Assistance Did Not Receive Professional Interpretation

The regulations that resulted from the Knox-Keene amendment (codified in section 1300.67.04 of title 28 of the California Code of Regulations) require health plans to provide all enrollees with free "qualified interpretation services." The services were defined as in-person, telephonic or video assistance by someone who is trained in interpreting ethics, conduct and confidentiality, and has demonstrated proficiency in source and target language as pertains to standard communication, health care terminology and health care delivery systems.[4] Despite the efforts of health plans to train bilingual staff and contract with outside interpreting agencies, more than 40% of LEP commercial HMO enrollees who needed help to understand their doctor reported receiving assistance from a non-professional (Exhibit 4). The continued use of non-professionals as interpreters (including family members) suggests inconsistent quality of interpretation.

The solution to this variation can be found in a more detailed and consistent process for assuring language access, including the requirement that health care providers utilize trained staff or contracted professionals regardless of the availability of untrained patient companions. DMHC's 2011 Biennial Report to the Legislature on Language Assistance cites health plan deficiencies in ensuring adequate language access services at all points of contact, proficiency of bilingual staff, and offering interpreters when bilingual family members are present.[5] If bilingual staff members are an important asset to health plans in complying with regulations, these staff members must be able to perform tasks that require different skills from those for which

"Health care providers should use trained staff or interpreters even if bilingual family members are available."

"There is a disconnect between health plan perceptions of interpreter service provision and the actual experiences of enrollees."

they were hired, and their (or an interpreter's) availability must be ensured at all points of contact with the health care system.

Conclusions and Policy Implications

The implementation of language assistance programs with regulatory oversight by DMHC and CDI was an attempt to ensure equitable health care access for California's limited English proficient HMO enrollees. Based on DMHC's findings to date, most health plans have established language access mechanisms according to their specific enrollee populations.[5] However, the lack of progress in enrollees' ability to understand their physician and the disparities within LEP populations by health status suggest that there is a disconnect between health plan perceptions of interpreter service provision and the actual experiences of enrollees. Delegated HMO models and shifts in network participation could compromise the ability of health plans to proactively plan and implement language assistance strategies with their contracted providers throughout the state. DMHC should encourage more consistent contact between health plans and their providers to ensure that regulations for health plans are translated into clearer communication processes at the individual provider level for LEP enrollees, particularly for those in poor health, at all points of contact.

Given that respondents in CHIS 2009 were asked to recall past events and could be reporting on doctor visits prior to the implementation of the law, the future availability of CHIS 2011/2012 data will be important in understanding the impact of the policy change. Language access may continue to improve as DMHC monitoring becomes more established over time, but regulations alone will not be sufficient. Insurers and providers must continually contract with

Exhibit 4

Characteristics of the Limited English Proficient Population and Those Reporting Hard Time Understanding Doctor, Ages 18-64, California, 2009

	Commercial				Public			
	HMO		PPO		HMO		FFS	
	LEP	Hard Time	LEP	Hard Time	LEP	Hard Time	LEP	Hard Time
Total number	792,000	71,000	290,000	18,000	460,000	47,000	486,000	54,000
Gender (%)								
Female	50.9	63.8	41.9	65.7	56.6	57.8	69.7	53.2
Male	49.1	36.2	58.1	34.3	43.4	42.2	30.3	46.8
Age (mean years)	44.6	43.1	42.8	43.1	41.0	44.2	38.1	42.3
Race/Ethnicity (%)								
Latino	64.9	64.4	53.4	46.5	69.9	56.5	76.1	71.1
Asian/Pacific Islander	18.6	19.6	35.2	40.4	14.9	26.0	9.8	8.4
Other	16.5	16.0	11.4	13.1	15.2	17.5	14.1	20.5
Language (%)								
Spanish	79.6	80.1	62.7	59.6	82.5	70.2	89.8	91.2
Chinese	7.4	2.9	12.3	8.7	5.1	3.0	5.6	4.0
Vietnamese	3.1	9.6	2.0	6.9	4.6	4.2	2.2	3.3
Korean	1.2	<0.1	6.3	6.5	<0.1	0.1	0.2	<0.1
Other	8.7	7.4	16.7	18.3	7.8	22.5	2.2	1.5
Health Status (%)								
Excellent/Very Good/Good	63.6	36.5*	68.9	65.5	57.5	47.1	60.4	29.9*
Fair/Poor	36.4	63.5*	31.1	34.5	42.5	52.9	39.6	70.1*
Income (%)								
<200% FPL	55.7	50.7	64.6	64.8	91.6	93.9	95.1	98.9
≥200% FPL	44.3	49.3	35.4	35.2	8.4	6.1	4.9	1.1
Type of Help (%)**								
Professional		56.0		71.4		72.2		79.0

* Statistically significant at a level of $p<0.05$. In the marked insurance categories, the distribution of respondents reporting hard time understanding their doctor by health status is significantly different from the distribution of the overall LEP population by health status.

** Type of Help refers to the person aiding respondents who reported needing help to understand their doctor. Professional help is considered to be bilingual staff and professional interpreters. All other respondents either received help from informal, untrained sources or did not receive help at all.

Sources: 2007 and 2009 California Health Interview Surveys

outside professional interpreters, screen and train bilingual staff to be better equipped to handle the rigors and responsibilities of medical interpretation, and pay special attention to the communication needs of LEP enrollees in poorer health. Equal access to high-quality care is more important than ever given the expected increase in health care coverage and use by the LEP population through the Affordable Care Act and creation of Covered California.

Percent Limited English Proficient and Hard Time Understanding Doctor at Last Visit, by Type of Insurance, Ages 18-64, California, 2007-2009 **Appendix 1**

	2007		2009			
	%	N	%	N	Δ % '07→'09	p-value
Commercial HMOs						
Limited English Proficient (LEP)	8.3 [7.4-9.2]	9,182,000	9.0 [8.3-9.8]	8,804,000	0.7	0.24
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	12.1 [7.8-18.2]	690,000	9.5 [6.3-14.1]	742,000	-2.5	0.42
Public HMOs						
LEP	23.9 [21.0-27.1]	1,452,000	27.2 [23.4-31.3]	1,694,000	3.2	0.20
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	9.1 [6.4-12.8]	325,000	12.0 [7.7-18.3]	395,000	2.9	0.32
Commercial Preferred Provider Organization (PPO)/Fee For Service (FFS)						
LEP	4.4 [3.7-5.2]	6,402,000	4.8 [3.7-6.1]	6,102,000	0.4	0.60
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	13.2 [7.9-21.3]	231,000	7.0 [4.1-11.7]	251,000	-6.2	0.08
Public PPO/FFS						
LEP	23.8 [21.2-26.7]	1,681,000	25.2 [21.6-29.2]	1,926,000	1.4	0.54
Hard Time Understanding Doctor at Last Visit (Among LEP with Visit in Past Two Years)	10.3 [7.3-14.2]	361,000	13.0 [8.4-19.6]	419,000	2.7	0.38

Sources: 2007 and 2009 California Health Interview Surveys

Percent Limited English Proficient by Commercial HMO Plan, Ages 18-64, California, 2007-2009 **Appendix 2**

	2007		2009		
	% LEP	N	% LEP	N	Δ % '07→'09
Main Commercial HMOs					
Kaiser Permanente	7.6 [6.1-9.4]	3,743,000	8.2 [7.2-9.3]	3,653,000	0.6
Blue Cross	8.8 [6.9-11.3]	1,348,000	11.3 [8.8-14.2]	1,278,000	2.5
UnitedHealth/Pacificare	5.5 [3.2-9.3]	707,000	5.6 [3.6-8.4]	492,000	0.1
Blue Shield	5.4 [3.4-8.4]	837,000	3.6 [1.4-9.3]	780,000	-1.8
Health Net	8.1 [5.9-11.1]	794,000	8.0 [5.0-12.6]	814,000	-0.1
Aetna	4.2 [2.2-8.0]	366,000	6.6 [3.8-11.2]	454,000	2.4
Cigna	8.3 [4.8-13.9]	227,000	4.9 [2.4-9.8]	235,000	3.4

Sources: 2007 and 2009 California Health Interview Surveys

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Data Source and Methods

The 2007 and 2009 versions of the California Health Interview Survey (CHIS) were used for this study. Respondents ages 18-64 were included. The variables for HMO enrollment and health plan name were self-reported and manually cleaned using a consistent protocol to logically check for concordance of responses and account for inconsistencies as a result of missing values or incorrect responses. Some insurance type or HMO plan name responses were excluded from this analysis, assigned, or otherwise imputed, due to missing or incorrect values. To obtain additional information on CHIS data collection, methodology, and to download public use files, please visit *www.chis.ucla.edu*.

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Endnotes

1 California Health and Safety Code, Section 1367.04. Accessed on 10/15/2012 at: *http://www.leginfo.ca.gov/cgi-bin/displaycode?section=hsc&group=01001-02000&file=1367-1374.195*

2 California Department of Managed Health Care. *Threshold Languages by Health Plan*. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/thresholdlanguages.pdf*

3 Kominski GF, Jacobs K, Roby DH, Graham-Squire D, Kinane CM, Watson G, Gans D, Needleman J. *Health Insurance Coverage in California under the Affordable Care Act, Revision of the March 22, 2012 Presentation to the California Health Benefit Exchange Board*, UC Berkeley Center for Labor Research and Education and the UCLA Center for Health Policy Research, June 2012. Accessed on 11/30/2012 at: *http://laborcenter.berkeley.edu/healthcare/aca_chartpack.pdf*

4 California Department of Managed Health Care. *Title 28, California Code of Regulations*. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/lart.pdf*

5 California Department of Managed Health Care. Second Biennial Report to the Legislature on Language Assistance. Accessed on 10/12/2012 at: *http://www.dmhc.ca.gov/library/reports/news/11rpt2legisla.pdf*