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## **MEDICARE PRESCRIPTION DRUG PLANS FAIL LIMITED ENGLISH PROFICIENT BENEFICIARIES**

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**ABOUT NATIONAL SENIOR CITIZENS LAW CENTER**

The National Senior Citizens Law Center (NSCLC) advocates nationwide for the independence and well-being of low-income elderly people and others eligible for Medicaid, Medicare and Supplemental Security Income (SSI). The organization's Oakland, California office has worked on Medicare Part D issues since the inception of the program.

To learn more about NSCLC, visit us on the web at: [www.nsclc.org](http://www.nsclc.org)

This survey was a joint project led by the National Senior Citizens Law Center in collaboration with National Health Law Program, National Immigration Law Center, California Immigrant Policy Center, PALS for Health and ALAS para Tu Salud, Neighborhood Legal Services of Los Angeles, and the California Medicare Part D Language Access Coalition, a broad group of advocates in legal and community based organizations serving Limited English Proficient (LEP) and low-income communities in California.

Volunteers from the following organizations contributed extensive time and energy to the survey by completing calls: Asian Pacific American Legal Center, Bay Area Iranian Parents Group, Bay Area Legal Aid, Cambodian Community Development, Inc., Client Center for Health Education & Advocacy, Coalition for Humane Immigrant Rights of Los Angeles, East Bay Community Law Center, Filipinos for Affirmative Action, Health Rights Hotline, Korean Resource Center, Legal Assistance for Seniors, Neighborhood Legal Services of Los Angeles, PALS for Health and Southeast Asian Resource Action Center.

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## EXECUTIVE SUMMARY

Medicare prescription drug plans are required to provide multi-lingual services to Limited English Proficient (LEP) persons. Many beneficiaries have reported, however, that such services are unavailable. The California Medicare Part D Language Access Coalition, led by the National Senior Citizens Law Center, designed and conducted this survey to assess Medicare prescription drug plan call center service to LEP populations. Because hundreds of thousands of California's low-income dual eligibles (individuals with Medicaid and Medicare) are Limited English Proficient, the survey covers the sponsors of the nine prescription drug plans into which dual eligibles are automatically enrolled. The survey placed a total of 417 telephone calls in eleven of the thirteen most common languages spoken by LEP dual eligibles in California. Results of the survey indicate that plans are falling significantly short of meeting their obligation to provide interpretive services to all LEP beneficiaries.

The market-based design of the Medicare prescription drug program (known as Part D) expects beneficiaries to operate as educated consumers when making difficult choices about coverage. In order to make wise choices, beneficiaries must have ready access to information. Whether shopping for a Medicare prescription drug plan or trying to access benefits, beneficiaries must be able to obtain information directly from Part D plans regarding cost-sharing, drug coverage, pharmacy networks, exceptions and appeals, and more. Without this information, the beneficiary is left stranded in an extremely complex environment, unable to understand and obtain the full benefits of the program.

Recognizing that all beneficiaries must have access to information, the Centers for Medicare and Medicaid Services (CMS), the federal agency that administers the Medicare prescription drug program, requires that the call centers of participating plans provide language services to LEP beneficiaries.

The ability to obtain linguistically appropriate information is particularly important for individuals who qualify for both Medicare and Medicaid (dual eligibles). Dual eligibles are the sickest and poorest Medicare beneficiaries. They are also more likely to be Limited English Proficient than other Medicare beneficiaries. Almost 30% of the approximately one million dual eligibles in California are Limited English Proficient.

### *Key Findings*

- **Plan sponsors are only able to serve Limited English Proficient dual eligible beneficiaries in their primary language 54.7% of the time.**
- **Non-Spanish speaking LEP beneficiaries have even less success communicating with their plans. Plan sponsors are only able to serve non-Spanish speaking Limited English Proficient dual eligible beneficiaries in their primary language 36.6% of the time.**

### *Caller Experiences*

- **The majority of the calls completed during the survey ended without connecting to an individual who spoke the language of the caller.** Of the 417 calls that were made, more than 60% of calls placed never reached an individual speaking the language of the caller. Nearly 57% of calls connected to a live representative, but the caller was unable to speak to someone who understood the caller's language. An additional 6% of calls never reached a live representative speaking any language.
- **More than 50% of all calls completed ended without any attempt by the plan representative to connect the caller to someone speaking the caller's language.**
- **Representatives failed to connect callers to individuals speaking the language of the caller for a variety of reasons.** Unsuccessful calls were most often the result of the representative's inability either to recognize that the caller was speaking a language other than English, or to identify the language being spoken. There were, however, also calls during which the representative correctly identified the language spoken, but still made no attempt to connect the caller to an interpreter. Many representatives told callers that they must speak English if they wanted assistance.
- **Calls that successfully connected to an interpreter speaking the appropriate language did not always result in a successful exchange of information.** While interpreters were generally linguistically competent, they did not always meet professional interpretation standards requiring complete, accurate and undistorted transmission of communications. A lack of health systems literacy among interpreters used by plans resulted in multiple reports of miscommunication and misinterpretation. There were also reports of rudeness and inappropriate interference by interpreters.
- **Translated materials were not available to callers.** With two exceptions, all requests for written materials in a non-English language were denied.

### *Recommendations*

The survey results reveal that plans are falling far short of their obligation to provide service to LEP beneficiaries. In order to comply with the requirements, Medicare prescription drug plans must take the following steps.

- **Develop detailed plans with comprehensive strategies for providing services to LEP individuals.** Plans should take note of existing national standards and best practices for serving culturally and linguistically diverse populations.
- **Provide ongoing monitoring of organizational compliance with LEP plans and strategies and with federal requirements for serving LEP clients.** As plans and strategies alone are not sufficient to ensure access, Part D plans should provide for an

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ongoing system of monitoring organizational compliance with internal plans, and with federal requirements.

- **Provide customer service and language assistance training, including cultural and linguistic competency training and training in procedures to communicate with and correctly identify LEP beneficiaries, to all plan staff that interact with beneficiaries.** Simply contracting with a language assistance line is not sufficient to satisfy the requirement of providing services to LEP beneficiaries. Customer service representatives must be aware of and able to utilize language assistance services.
- **Provide ongoing oversight of contracted and in-house interpreters to ensure knowledge of health systems concepts and terminology and adherence to professional norms of conduct, in addition to language proficiency.** Plans should carefully hire and monitor their interpreters to ensure that they are qualified interpreters (mere bilingual ability alone is not sufficient), that they are familiar with health care systems concepts (such as premiums, co-payments, formularies and more) and that they comply with the standards and ethics of interpretation.
- **Develop and distribute written translated materials.**

The Centers for Medicare and Medicaid Services (CMS) must take the following steps to ensure that plans are meeting federal requirements and providing quality service to all beneficiaries.

- **Strengthen, clarify, monitor and enforce all existing cultural and linguistic requirements imposed on Medicare Part D plans.** Fines and sanctions should be imposed on those plans whose call centers fail to provide service to LEP beneficiaries and on those plans who fail to provide written translations when required.
- **Require plans to create and share with CMS comprehensive and detailed strategies for serving LEP beneficiaries.** Plans should be required to develop comprehensive strategies for serving LEP individuals, with firm deadlines for implementation.
- **Ensure that written materials are available in key languages.**

## **INTRODUCTION**

The Medicare prescription drug program is the federal program that offers prescription drug coverage to Medicare beneficiaries. Under the program, the Centers for Medicare and Medicaid Services (CMS), the federal agency charged with implementing and administering the program, contracts with competing private plan sponsors to provide prescription drug coverage to eligible beneficiaries within a defined service area. It is a complicated, complex program which is difficult for beneficiaries to navigate.

Thousands of plans operate in multiple regions across the country. In 2007, for California, there are 55 stand alone Prescription Drug Plans (PDPs) offered statewide and an additional 4 to 49 Medicare Advantage Prescription Drug Plans offered in each county. Each of the plans provides different benefits at a different price. Plans also have their own distinct network of pharmacists and processes for filing exceptions and appeals.

In order to receive the benefits provided by Part D, beneficiaries must be able to communicate directly with the plans. The structure of Medicare Part D requires that all beneficiaries have access to full and exact information from plan sponsors. Plans serve as the primary source of information for plan enrollees. A beneficiary who is shopping for a plan must be able to call the plan in order to obtain information about that particular plan's costs and coverage. Beneficiaries who are already enrolled in a plan must be able to contact plans to obtain information about coverage, costs, pharmacy networks, exceptions and appeals, and more.

Recognizing that all beneficiaries have a right to access important plan information, CMS requires plan call centers to provide multi-lingual services to LEP Medicare beneficiaries. The CMS requirement is straightforward and comprehensive: "Call centers must be able to accommodate non-English speaking/reading beneficiaries. Organizations should have appropriate individuals and translation services available to call center personnel to answer questions non-English speaking beneficiaries may have concerning aspects of the prescription drug benefit."<sup>1</sup>

This requirement is extremely important. If plans do not provide services to LEP beneficiaries in their language, beneficiaries will be unable to access important information about their prescription drug coverage. Immigrant and non-English speaking populations have higher rates of prescription drug complications,<sup>2</sup> and it is especially critical that plans take appropriate measures to provide services to LEP individuals.

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<sup>1</sup> Centers for Medicare and Medicaid Services, "Medicare Marketing Guidelines for MA, MA-PDs, PDPs and 1876 Cost Plans," at 115; see also Addendum 2, Customer Service Call Center Requirements. The Prescription Drug Plan Call Letter defines the obligations and requirements of plans participating in Part D and reiterates this requirement. See "Instructions for 2007 Contract Year," April 3, 2006 at <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2007PDPCallLetter.pdf> (accessed Feb. 8, 2007).

<sup>2</sup> Glenn Flores, M.D., "Language Barriers to Health Care in the United States," *The New England Journal of Medicine*, July 2006, 230.

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### *Special Needs of Dual Eligibles*

While this requirement is important for all LEP beneficiaries, it is particularly important for LEP beneficiaries who are dual eligibles (individuals who receive both Medicare and Medicaid). There are more than six million dual eligibles nationally and approximately one million in California; approximately 30% of California's dual eligibles are Limited English Proficient.

Due to their complex medical needs, dual eligible beneficiaries are more likely to require assistance from their Part D plan than other Medicare recipients. Dual eligibles tend to be sicker than other Medicare beneficiaries – averaging ten more prescriptions per month than other Medicare beneficiaries.<sup>3</sup> Sixty percent of all dual eligibles live below the federal poverty level (\$10,210/year) and 94% have incomes below 200% of the federal poverty level.<sup>4</sup> The vulnerable health of dual eligibles makes accurate and timely communication with plans essential. In addition, their poverty increases the urgency of the need for appropriate assistance. While other beneficiaries might be able to pay the full cost of a prescription if a coverage problem arises, dual eligibles usually cannot afford to do so and are likely to go without needed medication if they do not receive assistance.

CMS has built some minimal protections for dual eligibles into the Part D program. Dual eligibles automatically qualify for the Low-Income Subsidy (“Extra Help”) and are automatically assigned to a “benchmark plan”<sup>5</sup> by CMS if they do not affirmatively choose a drug plan. These protections, however, do not make communication with plans any less vital for dual eligibles. For example, since the process of auto-assignment does not take into account their drug needs or ease of pharmacy access, many dual eligibles have had to shop for and switch to a plan that better meets their needs.

Language access, which is an important right for all Part D beneficiaries, is an especially critical need for LEP dual eligibles.

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<sup>3</sup> Kaiser Family Foundation, “Medicare Part D: Issues for Dual Eligibles on the Eve of Implementation, November 2005,” at [www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf](http://www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf).

<sup>4</sup> See note 3.

<sup>5</sup> Benchmark plans are stand alone Prescription Drug Plans (PDPs) that provide the “standard” Part D benefit and have premiums at or below a benchmark set annually by CMS. Dual eligibles who enroll in benchmark plans pay no premium. The vast majority of dual eligibles, whether self-enrolled or auto-enrolled, are in benchmark plans. See “Part D State Enrollment Data 1.16.07,” at [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02\\_EnrollmentData.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp)



## PURPOSE

This survey was designed and conducted to determine whether the “benchmark plans” into which dual eligibles have been automatically enrolled are meeting the requirement that they provide language services to Limited English Proficient beneficiaries.

Specifically, we sought to discover the approximate rate at which a Limited English proficient dual eligible beneficiary in California could expect to speak with a Medicare Part D Prescription Drug Plan (PDP) customer service representative or third party interpreter in his or her primary language. Recognizing that it is not sufficient to merely connect beneficiaries to individuals able to communicate in their language, the survey also sought to evaluate the quality of interpretation and other services provided to LEP callers. In addition, we wanted to determine the availability of written materials in languages other than English.

### METHODOLOGY IN BRIEF

- All seven sponsors of the 2007 benchmark plans in California were surveyed.
- Calls were completed in eleven languages, including:
  - Armenian
  - Cantonese
  - Cambodian
  - Farsi
  - Hmong
  - Korean
  - Lao
  - Mandarin
  - Russian
  - Spanish
  - Vietnamese
- Callers only spoke the designated language, except that the survey protocol permitted callers to use the English word for the test language (e.g., “Spanish”) and/or a country associated with that language (e.g., “China”).

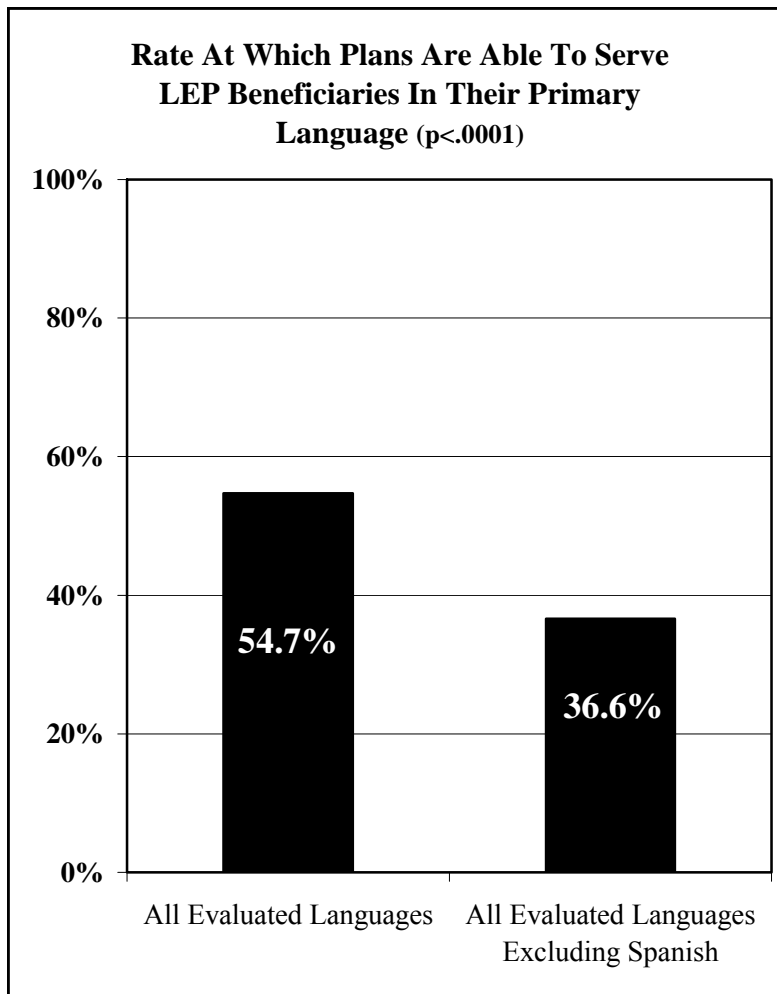
*[See Appendix A for a detailed discussion of the methodology of this survey.]*

## KEY FINDINGS

Plan sponsors are only able to serve Limited English Proficient dual eligible beneficiaries in their primary language 54.7% of the time.<sup>6</sup>

Non-Spanish speaking LEP beneficiaries have even less success communicating with their plans. Plan sponsors are only able to serve non-Spanish speaking Limited English Proficient dual eligible beneficiaries in their primary language 36.6% of the time.<sup>7</sup> [See Figure 1.]

Figure 1.



Survey results were weighted to reflect the relative prevalence of the test language within the dual eligible population. [See Appendix D for quantitative methods.]

<sup>6</sup> Margin of error:  $\pm 4.78$ .

<sup>7</sup> Margin of error:  $\pm 4.88$ .

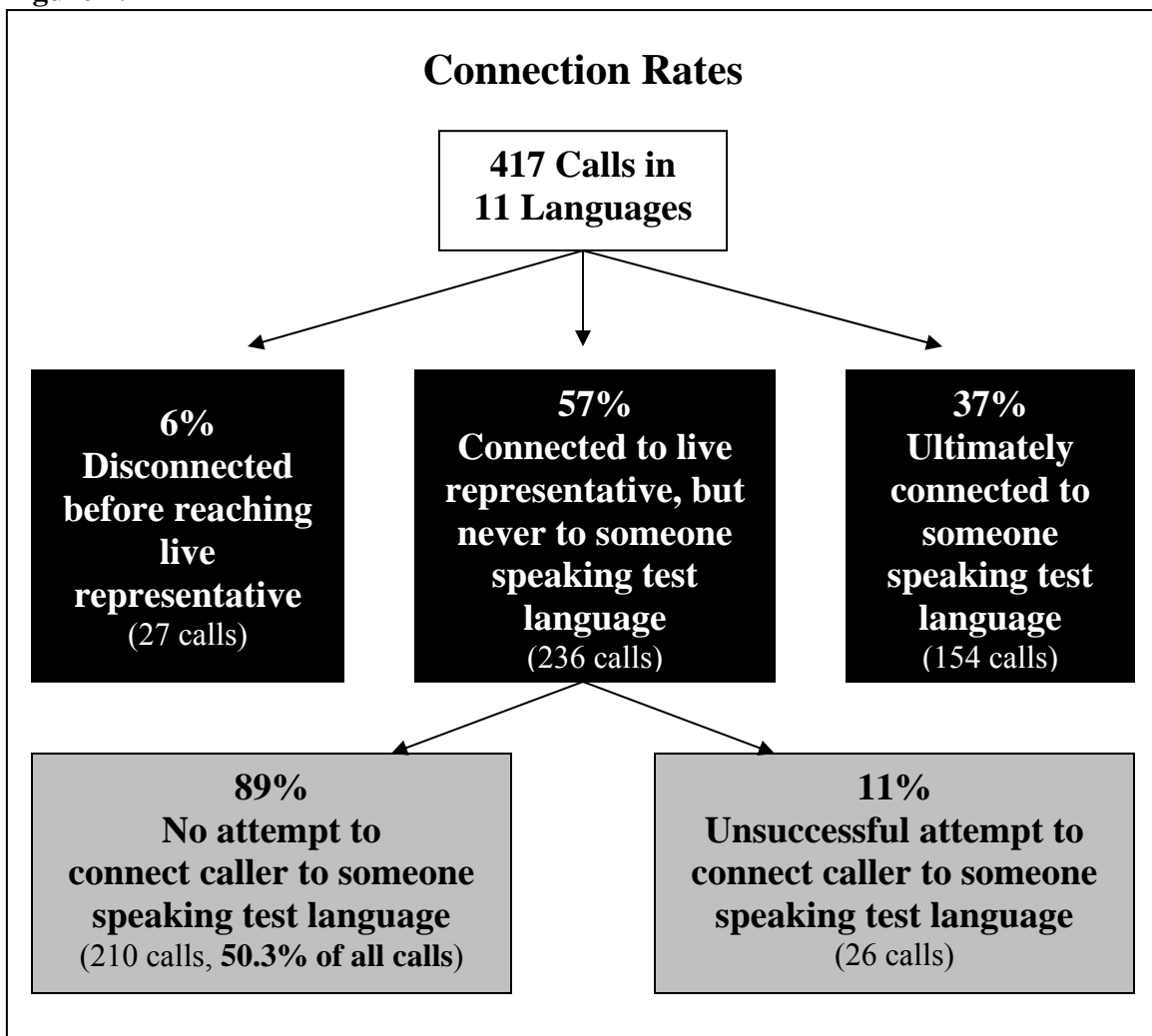
## CALLER EXPERIENCES

**The majority of the calls completed during the survey ended without connecting to an individual who spoke the language of the caller.**

Of the 417 calls made, over 60% never reached someone speaking the language of the caller.

- Only 37% of calls were ultimately connected to someone who spoke the language of the caller.
- 57% of calls connected to a live representative, but not to anyone speaking the caller's language (236 of 417 calls).
- The remaining 6% of calls did not connect to a live speaker. [See Figure 2.]

**Figure 2.**



**More than 50% of all calls completed ended without any attempt by the plan representative to connect the caller to someone speaking the caller’s language.**

Calls that connected, but did not reach anyone speaking the language of the caller, can be further broken down based on the customer service representative’s attempt to connect to a language assistance employee. *Nearly 90% of these calls ended without any attempt on the part of the plan representative to connect the callers to someone who spoke their language.* This represented 50.3% of all calls (210 of 417 calls). Among the remaining 11% of these calls, customer service representative attempts to connect to an interpreter failed due to limited resources in a specific language, such as lack of available interpreters or language assistance line busy signals (26 of 417 calls). [See Figure 2.]

**The number of successful calls varied greatly by language. Non-Spanish speaking callers had much more trouble connecting to someone speaking their language.**

Significant differences existed between calls in Spanish and calls in all other languages.<sup>8</sup> For example, while Spanish callers were able to successfully reach someone speaking their language 71% of the time (n = 42), Mandarin callers recorded a much lower success rate (41%; n = 70), and Hmong callers recorded a mere 5% success rate (n = 62). Only Spanish calls exceeded a 50% success rate. [See Appendix C for the total number of calls completed per language and the number of those calls which were successful.]

**Representatives failed to connect callers to individuals speaking the language of the caller for a variety of reasons.**

In some cases, the customer representative was unaware that the caller was speaking a foreign language or misidentified the language spoken. In other cases, the representative correctly identified the language, but made no further effort to serve the caller in that language. There were also a number of calls in which representatives rudely and summarily rejected the caller’s request for assistance in a test language.

**“The live operator kept asking ‘Do you want to speak to someone named China?’”  
– Mandarin Caller**

Plan representatives were unable to identify a non-English language. Representatives were commonly unable to serve callers

because they were unable to recognize the request for services in a test language, even when callers used the English name of the language to make the request. Several examples clearly illustrate this problem.

One Korean speaking caller explained that the plan representative “kept repeating she couldn’t help me. (She) wanted to know if I wanted to speak to a person named Courtney.” A caller speaking Mandarin was unable to explain to the customer service representative that she was requesting an interpreter and would need someone who spoke her language. As part of the call protocol, volunteers were permitted to say the English

<sup>8</sup> See ‘Key Findings’ above indicating that there is a statistical difference in the ability of Spanish callers to reach a customer service representative or interpreter in comparison to all other test languages (p<.0001).

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name of the language they spoke or the country where the language is primarily spoken in order to convey their request for an interpreter. In this particular case, the Mandarin speaking caller chose to say the name of the country. In response, the live operator kept asking, *‘Do you want to speak to someone named China?’*” A Hmong speaker encountered a similar response from the plan representative. “Every time she asked questions I say *‘Hmong’* and she says: *‘How can I help you?’ ‘Do you say Mona? There is no Mona here.’ ‘Sorry, I can’t help you.’*”

### Plan representatives misidentified languages.

Another common mistake was language misidentification, sometimes resulting in a connection to an interpreter or multi-lingual employee speaking the wrong language. Misidentification occurred at least once for all eleven languages, including Spanish. In most cases, plan representatives believed the language spoken and requested by our callers to be Spanish when it was another language. “[The representative] tried to speak Spanish to me, assuming that Lao is the same as Spanish. Later [he] transferred me to a female operator who is bilingual in Spanish.” Few non-Spanish callers who were connected to a Spanish speaker were eventually re-routed to an individual speaking the correct language. Most of these calls were simply disconnected without an attempt to identify the actual language of the caller.

**“(The representative) tried to speak Spanish to me, assuming that Lao is the same as Spanish. Later (he) transferred me to a female operator who is bilingual in Spanish.”**  
– Lao Caller

Plan representatives made no attempt to connect callers to an interpreter, even when clearly understanding the request. Many instances were reported where plan representatives understood that the caller did not speak English and could recognize the requested language, but made no attempt to contact an interpreter. “She was nice; she didn’t know how to respond – I think she hesitated, but said *‘No one here speaks Armenian – sorry.’*” A caller speaking Spanish describes, “[I stated] *‘¿Habla Español?’* Representative replied, *‘No Ma’am.’* I stated again, *‘¿Habla Español?’* Representative again said, *‘No ma’am, I don’t.’*” A Cantonese speaking caller noted a similar experience. “The person who answered my call kept on speaking English and said *‘Unfortunately there is no one who could speak Chinese’* and hung up.” In each of these instances, the plan representative accurately identified the language of our caller and made no attempt to connect the caller to an interpreter.

In addition, plan representatives pushed the responsibility of providing interpretation services onto the caller. Customer service representatives, in many instances, told the caller that they could only provide service in English. “The operator told me in English *‘ONLY ENGLISH!’* I repeated *‘Russian’* and she said *‘NO!’*” In other cases, plan representatives asked the callers to call back with an English speaking individual to assist them. “The operator said, *‘Do you speak English?’* After I make a request in Mandarin, she asked me to hold in English. She came back and

***“Can someone who speaks English make the call?”*** – Customer Service Representative

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said, ‘*I only speak English. Can someone who speaks English make the call?*’ Then she put me on hold again. Later she came back saying, ‘*I’m not able to help you. I think you have the wrong number.*’”

Plan representatives were rude and condescending. Several survey volunteers noted plan representatives exhibiting a rude tone of voice or discourteous behavior. “The operator was rude. He asked me why I called if I didn’t speak English. He told me to get a pen and spelled C-A-L-L B-A-C-K. Then he hung up on me.” One caller reported this response from customer service representatives: “He told me he doesn’t ‘*speak Español or whatever language you are speaking.*’ His voice was very annoyed when I spoke to him. He asked me to hold and hung up right away.”

**“He asked me why I called if I didn’t speak English. He told me to get a pen and spelled C-A-L-L B-A-C-K.”**  
– Hmong Caller

**Calls that successfully connected to an interpreter speaking the appropriate language did not always result in a successful exchange of information.**

In evaluating the quality of successful calls, callers rated both the ability of the interpreter to accurately communicate questions and answers and reported details about the interactions with the interpreters. While interpreters were generally linguistically competent, they did not always meet professional norms requiring complete and accurate rendering of information without omissions, additions or distortion. A lack of health systems literacy among interpreters used by plans resulted in multiple reports of miscommunication and misinterpretation. There were also reports of rudeness and inappropriate interference by interpreters.

Most interpreters exhibited linguistic competency. Callers rated interpreters for language competence. Language skill ratings were categorized into three skill levels: (1) *very well / excellent*, (2) *good / fair*, and (3) *not very well / poor*. Individuals able to communicate effectively and understand complex wording and jargon such as “She is low-income and on Medi-Cal” and “Does your plan cover drugs that do not need a prescription?” were given a skill level rating of *very well / excellent* if no other obvious lack of proficiency was demonstrated. Interpreters given a rating of *not very well / poor* were unable to form complete sentences, struggled with simple non-English vocabulary, or did not interpret accurately. Callers were advised to refrain from demoting an interpreter’s skill level based on tone of voice or other personal bias such as variation from preferred accent.

**Table 1. Language Assessment Rating (n = 133)**

<b>Skill Level</b>	<b>Quality Rating (%)</b>
Very Well / Excellent	64.66
Good / Fair	27.07
Not Very Well / Poor	8.27

Callers reported high levels of language competence in interpreters. [See Table 1.] More than 91% of all callers who spoke with an individual in their non-English language rated

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the interpreter's communication skill as very well/excellent or good/fair. [See Appendix A, "Methodology," for the definitions used for language evaluation.]

Callers reported multiple instances of rudeness and interference and failure to properly interpret conversations by interpreters, including failure to maintain impartiality and the boundaries of the professional interpreter role. Callers, though rating interpreters high on language ability, reported numerous instances in which interpreters interfered with interactions with plan representatives or were hostile, rude or otherwise intrusive. In several instances, interpreters failed to properly interpret conversations between the caller and the plan representative.

***“If you don’t have enough information that the representative asks, don’t call them!” – Plan Interpreter***

Callers reported inappropriate tone of voice by interpreters and interference. For example: “The interpreter seemed like he didn’t want to speak. While he was

interpreting his sound is angry. He said ‘if you don’t have enough information that the representative asks, don’t call them!’ Representative did not answer any questions that I asked.” Another caller reported: “Interpreter did not translate well. She was arguing with me on why I didn’t want to give my personal information even though the operator was fine with it. (The interpreter) conveyed my sentences in a negative uncooperative manner.”

In another instance, the interpreter advised the plan representative against continuing to assist the caller:

*The interpreter was rude and argued with me instead of interpreting. The agent said there was not Chinese material, but then changed (her answer) and said there is. Agent must have my mom’s DOB before she is willing to send materials, and the interpreter decided that I did not need the materials and asked the agent to hang up without interpreting this to me. Then they hung up.*

Lack of health systems literacy by interpreters led to miscommunication. The complexities of the Medicare prescription drug program and inadequate training of plan representatives also hindered some interpreter performance. Lack of knowledge of Part D and a need for clarification led to frequent communication between the plan representative and interpreter that did not involve the callers. Callers reported being ignored during these dialogues. In other instances, interpreters did not request clarifications and, as a result, interpreted inaccurately. For example:

*The interpreter didn’t understand Plan D (sic), so some interpretations were wrong. For example, ‘three dollar per brand name medicine’ was interpreted as ‘three dollar fee per month if you use brand name medicine.’ Her language skill is great in terms of expression. However, she was confused on the Part D plan, so her*

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*interpretation was not correct. Sometimes, when she has doubt in her mind, she added her own explanation for clarification. She liked to say, 'It seems to be like this...'*

**Translated materials were not available to callers.**

**Callers' requests for written materials in their test language were denied by plan representatives**

Callers who connected with interpreters, except for those who were cut off prematurely, asked the question "Do you have written materials in (*language*)?" Plan representatives indicated that written materials were available in the requested language only twice (once in Spanish and once in Mandarin). In both cases, the materials were never received.

On all the other calls, plan representatives stated that written materials were only available in English. Some representatives stated that written information, particularly in Spanish, would be available January 2007. The survey did not determine whether the responses reflected an actual lack of written materials or ignorance by plan representatives of their existence.

### CONCLUSIONS

The survey results demonstrate a failure by the benchmark plans to comply with clear and unequivocal CMS requirements set forth in CMS marketing guidance:

Call centers must be able to accommodate non-English speaking/reading beneficiaries. Organizations should have appropriate individuals and translation services available to call center personnel to answer questions non-English speaking beneficiaries may have concerning aspects of the prescription drug benefit.<sup>9</sup>

The requirement is reiterated in the 2007 contract instructions: "The call center must provide service to non-English speaking and hearing impaired beneficiaries."<sup>10</sup> These requirements necessarily include an obligation to provide adequate training and necessary re-training to customer service representatives in order to satisfy this CMS requirement.

Plan call centers are ill-equipped to provide service to LEP beneficiaries. Rates at which callers were successful in reaching an individual who spoke their language were unacceptably low. The key findings of this study indicate that LEP dual eligibles who contact plans for information receive service in their primary language less than 60% of the time.

<sup>9</sup> Centers for Medicare and Medicaid Services, "Medicare Marketing Guidelines for MA, MA-PDs, PDPs and 1876 Cost Plans." (see note 1)

<sup>10</sup> "Instructions for 2007 Contract Year." (see note 1)



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Significant differences exist between beneficiary communication in Spanish and communication in all other test languages. Spanish speaking callers were able to speak with an individual who spoke their language more frequently than their non-Spanish speaking counterparts. The key findings of this study reveal that non-Spanish speaking LEP dual eligibles who contact plans for information receive service in their primary language less than 37% of the time. These recipients are, at best, able to correspond with their plan only occasionally.

Although it appeared that all of the surveyed plans had established affiliations with language assistance services, many plan representatives were unaware of the existence of interpretation services and did not even try to connect to a language assistance organization.<sup>11</sup> Plan representatives did not appear to have the knowledge to access these services on a consistent basis. Additionally, plan representatives often were unable to recognize the English name of a foreign language or country.

Survey callers also described numerous instances of poor customer service by both plan representatives and language assistance line employees. When callers did manage to reach an interpreter, more than 90% reported satisfactory language ability; however, several callers encountered rudeness, extensive side conversations between interpreters and plan representatives, and deliberate disconnections. Such actions are inconsistent with principles of professional interpretation which emphasize that the ethical responsibility of the interpreter is “to convert messages rendered in one language to another without losing the essence of the meaning that is being conveyed and including all aspects of the message without making judgments as to what is relevant, important, or acceptable” and to refrain from “counseling, advising or projecting personal biases or beliefs.”<sup>12</sup> Moreover, interpreters demonstrated a lack of understanding in Part D terminology and health care systems in general, including premium and cost sharing designs.

An additional problem highlighted by the survey was the fact that callers were not able to receive any written Part D plan information in their language. Plan representatives were unaware if any such material existed. Most assumed written materials were only available in English. CMS regulations require that marketing materials and enrollment forms be translated in markets “with a significant non-English speaking population.”<sup>13</sup>

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<sup>11</sup> Customer service representatives at each of the plan sponsors surveyed were able to connect to a language assistance line at least once, indicating that all benchmark PDPs in California have some type of contractual relationship with a third-party interpretation organization.

<sup>12</sup> National Council on Interpreting in Health Care, “A National Code of Ethics for Interpreters in Health Care,” July 2004 at 13, 16.

<sup>13</sup> 42 C.F.R. §423.50(d)(5). See also Centers for Medicare and Medicaid Services, “Medicare Marketing Guidelines for MA, MA-PDs, PDPs and 1876 Cost Plans,” at 115, “Organizations should make marketing materials available in any language that is the primary language of more than ten percent of a plan’s geographic service area.”

## RECOMMENDATIONS

This report recommends that Medicare Part D plans and the Centers for Medicare and Medicaid Services take immediate action to address Part D's systemic failure to appropriately serve LEP beneficiaries. Although this report surveyed only a portion of California's Part D plans, the federal requirements to provide services to LEP individuals apply to all Medicare Part D plans including both stand-alone and Medicare Advantage Prescription Drug Plans.

Recommendations to all Medicare Part D plans:

- **Develop detailed plans with comprehensive strategies for providing services to LEP individuals.** These plans should take note of existing national standards and best practices for serving culturally and linguistically diverse populations.<sup>14</sup> Plans should assess the cultural and linguistic needs, both oral and written, of LEP populations (both potential and current members),<sup>15</sup> and develop comprehensive strategies to meet these needs. Plans should create comprehensive written policies describing the plan's language assistance program and provide notice of the availability of language appropriate services to LEP beneficiaries and all plan staff.
- **Provide ongoing monitoring of organizational compliance with LEP plans and strategies and with federal requirements for serving LEP clients.** As plans and strategies alone are not sufficient to ensure access, Part D plans should provide for an ongoing system of monitoring organizational compliance with internal plans, and with federal requirements.
- **Provide customer service and language assistance training, including cultural and linguistic competency training and training in procedures to communicate with and correctly identify LEP beneficiaries, to all plan staff that interact with beneficiaries.** Simply contracting with a language assistance line is not sufficient to satisfy the requirement of providing services to LEP beneficiaries. Customer service representatives must be prepared for LEP beneficiaries to call. They must be aware of the availability of language assistance services and must know how to utilize the services. Knowing how to utilize services includes the ability to recognize that the caller is not speaking English and correctly identify the caller's language.

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<sup>14</sup> The national standards appropriate for health care service organizations and agencies serving culturally and linguistically diverse populations published by the U.S. Department of Health and Human Services Office of Minority Health, as well as others examples of best practices (Health Industry Collaboration Effort, Cultural and Linguistic Workgroup, "Better Communication, Better Care: Provider Tools to Care for Diverse Populations;" National Health Law Program, "Language Access in Health Care Statement of Principles;" National Health Law Program, "Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance;" The Commonwealth Fund, "Providing Language Services in Small Health Care Provider Settings: Examples from the Field") can be found in the bibliography.

<sup>15</sup> Plans should track the race, ethnicity and the oral and written language needs of each member and make it possible for all plan-related staff and providers to utilize the information.

- **Provide ongoing oversight of contracted interpretation companies and in-house interpreters to ensure knowledge of health systems concepts and terminology and adherence to professional norms of conduct, in addition to language proficiency.** The interpreter errors and interference found in the survey illustrate the potential for serious miscommunication if interpreters lack familiarity with Part D design and terminology, fail to accurately communicate messages without distortion, or interfere with the exchange of information between plan representatives and beneficiaries. Plans should carefully hire and monitor their interpreters to ensure that they are qualified interpreters (mere bilingual ability alone is not sufficient), that they are familiar with health care systems concepts (such as premiums, co-payments, formularies and more) and that they comply with the standards and ethics of interpretation.<sup>16</sup> All plan language assistance programs should include routine assessments of all interpreters, including in-house interpreters and those employed by outside contractors.
- **Develop and distribute written translated materials to appropriately serve LEP populations.** To evaluate plans and access their benefits, beneficiaries need written materials in languages they understand. Customer service representatives must be aware of the existence of these materials and trained to offer them to callers.

This report also recommends that the Centers for Medicare and Medicaid Services (CMS):

- **Strengthen, clarify, monitor and enforce all existing cultural and linguistic requirements imposed on Medicare Part D plans.** Cultural and linguistic access requirements should be strengthened and clarified, so that all Part D plans will clearly understand their obligations to fully serve LEP beneficiaries. Fines and sanctions should be imposed on those plans with call centers that fail to provide service to LEP beneficiaries and on those who fail to provide written translations when required.
- **Require plans to create and share with CMS comprehensive and detailed strategies for serving LEP beneficiaries.** The survey results show that plan deficiencies are systemic and not isolated problems. CMS should take an active role in fixing the problem by requiring thorough reform of plans' language access capabilities. Plans should be required to develop comprehensive strategies for serving LEP individuals, with firm deadlines for implementation.
- **Ensure that written materials are available in key languages.** The survey results make clear that translated materials, whether or not they exist, are not

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<sup>16</sup> The National Council of Interpreting in Health Care has developed the "National Code of Ethics for Interpreters in Health Care," the "National Standards of Practice for Interpreters in Health Care" and the "Guide to Initial Assessment of Interpreter Qualifications" to guide the conduct of health care interpreters.

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getting to beneficiaries. CMS regulations require that marketing materials and other communications with beneficiaries be translated in “markets with a significant non-English speaking population.”<sup>17</sup> This report recommends that CMS enforce this regulation, looking both at materials produced and at efforts by plans to get them into the hands of beneficiaries. Further, the report recommends that CMS define “market” to be the local service area, such as a county. What may appear on a state level as an insignificant language group may constitute a large cluster in any one county in which a plan operates.

Comprehensive strategies to serve the LEP population are critical to providing meaningful access to LEP beneficiaries. CMS must monitor and evaluate the work of plan sponsors in creating, monitoring, and implementing programs that adequately serve LEP beneficiaries.

Failure to provide language assistance services, both oral interpretation and written translations, will further existing health disparities between Limited English Proficient populations and all other individuals. Without adequate access to information, LEP beneficiaries cannot fully participate in the Medicare Part D prescription drug program and, as a result, may not appropriately access the benefits, resulting in serious negative health and financial outcomes for the beneficiaries and economic costs for the communities and states where they live.

All Medicare Part D beneficiaries need information and service, particularly vulnerable dual eligible LEP individuals. It is the responsibility of CMS and the plans to ensure that LEP beneficiaries can access necessary information in their primary language in order to appropriately utilize essential health services.

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<sup>17</sup> See note 13.

## APPENDIX A. METHODOLOGY

Seven Medicare prescription drug plan sponsor telephone hotlines offering nine benchmark stand-alone Prescription Drug Plans (PDPs)<sup>18</sup> were evaluated in eleven non-English languages. A total of 417 calls were completed. All calls were made between October 16 and November 29, 2006 during the hours of 8:00 A.M. and 6:30 P.M., Pacific Standard Time, Mondays through Fridays.<sup>19</sup>

Telephone hotlines operated by each of the plan sponsors were derived from the 2007 Medicare & You Handbook. All seven sponsors were surveyed in each language approximately equally. Below is a list of sponsors.

- CIGNA HealthCare
- Health Net
- Humana Insurance Company
- RxAmerica
- UnitedHealthcare
- WellCare
- WellPoint, Inc.

The survey evaluated the following languages: Armenian, Cantonese, Cambodian, Farsi, Hmong, Korean, Lao, Mandarin, Russian, Spanish, and Vietnamese. Speakers of these languages represent nearly 27% of dual eligible recipients in California. The other two most common languages spoken by dual eligibles in California, Tagalog and Arabic, were not included due to the unavailability of callers in those languages.

Bilingual speakers, all of whom were professional employees or volunteers associated with non-profit organizations across California, called each sponsor hotline to request information in their native non-English language. The number of callers per language was limited to reduce response variability within groups. Number of callers per language did not exceed two.

Callers posed as monolingual speakers for the duration of the call and were instructed not to respond to or reply in English except to request interpretive services. At the beginning of each call, callers asked, in their non-English language, if the customer service representative spoke their language. If they were not successful, they were instructed to follow up by repeating the English name of their language and/or the country of origin of their language in an effort to connect to an interpreter or plan sponsor employee able to communicate in their test language. Callers recorded whether they were successfully

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<sup>18</sup> Two plan sponsors, WellCare and Wellpoint, Inc., each offer two benchmark plans in California. Wellpoint, Inc. offers plans under the company name Blue Cross of California and Unicare.

<sup>19</sup> Plan sponsors are “required to operate a toll-free call center for both current and prospective enrollees that operates seven days a week at least 8:00 A.M. to 8:00 P.M. according to the time zones for the regions in which they operate.” Instructions for 2007 Contract Year (see note 1). To maximize translator availability, survey calls were limited to the 8:00 a.m.-6:30 p.m. timeframe.

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connected to an interpreter or plan representative who spoke their language and the circumstances (e.g., operator hung up without attempting a transfer, attempted a transfer and was successful, attempted a transfer and was disconnected, etc.). Automatic disconnections by the plan sponsor hotline when unable to handle the volume of incoming calls, as well as those calls disconnected by volunteer callers after excessive hold time were counted as disconnected calls. Calls where callers encountered a busy signal were not included in the survey.

If they successfully reached a speaker of their language, callers followed a script<sup>20</sup> in which they were to request information in the test language for their hypothetical dual eligible mother.<sup>21</sup> In order to more accurately evaluate the quality of the interpreter's language skills, callers were instructed to engage the interpreter in conversation. The script consisted of the following four questions, which were designed to evaluate language skills in the test language:<sup>22</sup>

1. I am calling for my mother. She has Medicare. She is low-income and on Medi-Cal, too. Do you have a plan for her?
2. Does your plan cover drugs that do not need a prescription?
3. How much will it cost?
4. Do you have written materials in (*language*)?

Callers completed an individual evaluation form for each call considered complete. Complete calls are all calls made to a plan sponsor in which the caller did not encounter a busy signal. The evaluation included a quality rating for calls in which volunteers were connected to someone speaking their language.

Callers were trained to assess quality of language skills based on the following criteria:

Very Well / Excellent	Interpreter/plan representative understood complex or difficult phrasing such as “She is low-income and on Medi-Cal” and “Does your plan cover drugs that do not need a prescription?” and efficiently engaged in conversation in the test language.
Good / Fair	Interpreter/plan representative understood some of what I was saying and could answer questions satisfactorily. However, appeared to be confused or struggled with some language or concepts.

<sup>20</sup> Pre-testing in both Cantonese and Mandarin prior to the start of data collection demonstrated that the text was workable.

<sup>21</sup> Callers requested information on behalf of a hypothetical dual eligible mother rather than themselves due to the difficulties of receiving information from Part D plans without providing specific personal information. Whereas specific personal information (i.e. Medicare identification number, address, full name and birth date) may be difficult to withhold, a caller may appear to have sufficient reason to withhold information regarding another individual for reasons such as privacy concerns or lack of knowledge.

<sup>22</sup> Responses to these questions were not evaluated for accuracy.

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Not Very Well / Poor	Interpreter/plan representative did not understand most of what I was saying. Was only able to offer very basic answers (such as yes/no) or other limited responses. Was unable to form complete sentences, struggled with simple non-English vocabulary, or did not interpret accurately.
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Callers were advised to refrain from demoting an interpreter's skill level based on tone of voice or other personal bias such as variation from preferred accent.

Callers completed an individual evaluation form for each call considered complete. Complete calls are all calls made to a plan sponsor in which the caller did not encounter a busy signal. The evaluation included a quality rating for calls in which volunteers were connected to someone speaking their language.

All callers were trained prior to the start of the survey and were given direct access to an oversight manager upon request. Training incorporated a brief orientation to Medicare Part D and detailed guidelines for conducting the survey, including criteria requirements. Oversight managers were responsible for maintaining contact with all callers throughout the duration of the survey for purposes of consistency between callers.

**APPENDIX B. DEMOGRAPHICS OF DUAL ELIGIBLE POPULATION IN CA**

**Table 1. Demographics of Medicare Part D Dual Eligible Recipients\***

<b>Language</b>	<b>No. of Dual Eligibles by language</b>	<b>% Dual Eligible CA Beneficiaries**</b>
All Sign Language	498	00.05
Arabic	2,455	00.24
Armenian	16,221	01.59
Unknown	235,622	23.18
Cambodian	3,284	00.32
Cantonese	29,215	02.88
English	478,268	47.10
Farsi	7,769	00.76
Hmong	1,997	00.20
Korean	12,198	01.20
Lao	1,914	00.19
Mandarin	11,808	01.16
Other Chinese	3,908	00.38
Other Non-English	13,741	01.35
Russian	12,329	01.21
Spanish	137,176	13.50
Tagalog	16,629	00.02
Vietnamese	31,122	03.06
<b>TOTAL</b>	<b>1,016,154</b>	<b>100%</b>
<p>* <b>SOURCE:</b> California Department of Health Services, Medical Care Statistics Section. "Medi-Cal Beneficiaries by Age/Demographics," October 2006.  ** Due to rounding, percentages do not total exactly to 100%</p>		



APPENDIX C. SUCCESSFUL CALLS BY LANGUAGE

Figure 3.

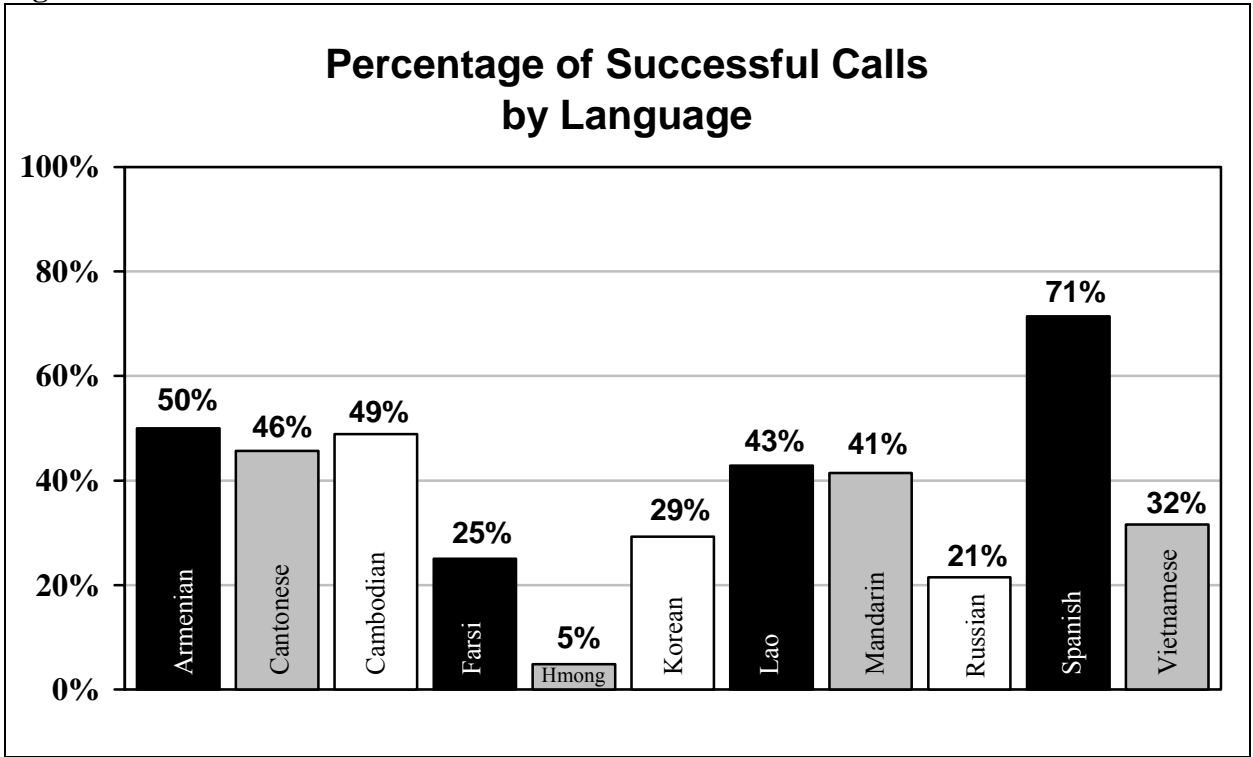


Table 2. Successful Calls by Language

Language	Total Calls	Total Successful Calls
Armenian	18	9
Cantonese	46	21
Cambodian	43	21
Farsi	20	5
Hmong	62	3
Korean	41	12
Lao	28	12
Mandarin	70	29
Russian	28	6
Spanish	42	30
Vietnamese	19	6
<b>TOTAL</b>	417	154

**APPENDIX D. QUANTITATIVE METHODS**

We calculated the weighted response rate ( $\bar{u}$ ) by summing the products of each language response rate ( $r_i$ ) and the weight of each language ( $w_i$ ). Weights were derived per language strata with a simple quotient of the rate of the language use within the population ( $X_L$ ) and the rate of the language use within our sample ( $x_L$ ). The following formula was used to calculate weights and the weighted response rates, as well as the margin of errors:

Weight per strata and weighted response rate:

$$w_i = \frac{X_L}{x_L}$$

$$\bar{u} = \sum [r_i \cdot w_i]$$

Margin of error:

$$\bar{u} \pm 1.96 \cdot \sqrt{\frac{(1-u) \cdot u}{n}}$$

<u>Key</u>		
$w_i$ = weight	$X_L$ = rate of language use within population	$n$ = sample size
$r_i$ = response rate per language	$x_L$ = rate of language use within sample	$\bar{u}$ = weighted response rate

Statistical hypothesis testing was completed using an independent two-sample z-test with a 95 percent confidence interval ( $\alpha = 0.01$ ). Our hypotheses are that there is no difference between the ability of Spanish speaking callers and callers of all other test languages in reaching someone who spoke the test language and that there is no difference between the ability of all test languages and all languages not including Spanish in reaching someone who spoke the test language.

The following are the hypothesis testing formulas for an independent two-sample z-test:

$$H_0: \bar{u}_1 = \bar{u}_2$$

$$z = (\bar{u}_1 - \bar{u}_2) / \sqrt{\frac{\sigma_1}{n_1} + \frac{\sigma_2}{n_2}}$$

Our results reject the null hypothesis and assert that there is a significant difference between the ability of Spanish speaking callers and callers of all other test languages in reaching someone who spoke the test language ( $p < .0001$ ); the results also assert that there is a statistical difference between the ability of all test languages and test languages not including Spanish in reaching someone who spoke the test language ( $p < .0001$ ).

## BIBLIOGRAPHY

- Centers for Medicare and Medicaid Services, *Instructions for 2007 Contract Year*, April 2006. Available at, [www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2007PDPCallLetter.pdf](http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/2007PDPCallLetter.pdf).
- Centers for Medicare and Medicaid Services, "Part D State Enrollment Data 1.16.07," January 2007. Available at, [http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02\\_EnrollmentData.asp](http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp).
- Centers for Medicare and Medicaid Services, *Medicare Marketing Guidelines for MA, MA-PDs, PDPs and 1876 Cost Plan*, July 25, 2006. Available at, <http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/FinalMarketingGuidelines.pdf>.
- California Department of Health Services, Medical Care Statistics Section. *Medi-Cal Beneficiaries by Age/Demographic*, July 2006. Available at, <http://www.dhs.ca.gov/mcss/default.htm>.
- The Commonwealth Fund, *Providing Language Services in Small Health Care Provider Settings: Examples from the Field*, April 2005. Available at, <http://www.healthlaw.org/library.cfm?fa=download&resourceID=63597&print>.
- Government Accountability Office, *Communications to Beneficiaries on the Prescription Drug Benefit Could Be Improved*, May 2006. Available at, <http://www.gao.gov/new.items/d06654.pdf>.
- Flores, Glenn M.D. *Language Barriers to Health Care in the United States*, The New England Journal of Medicine, July 2006. Available at, [www.hablamosjuntos.org/resources/pdf/GFloresNEJM.PDF](http://www.hablamosjuntos.org/resources/pdf/GFloresNEJM.PDF).
- Health Industry Collaboration Effort, Cultural and Linguistic Workgroup, *Better Communication, Better Care: Provider Tools to Care for Diverse Population*, October 2005. Available at, [http://www.iceforhealth.org/library/documents/ICE\\_C&L\\_Provider\\_Tool\\_Kit.10-06.pdf](http://www.iceforhealth.org/library/documents/ICE_C&L_Provider_Tool_Kit.10-06.pdf).
- Kaiser Family Foundation, *Medicare Part D: Issues for Dual Eligibles on the Eve of Implementation*, November 2005. Available at, [www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf](http://www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf).
- Kaiser Family Foundation, *The Proposed Medicare Prescription Drug Benefit: A Detailed Review of the Implications for Dual Eligibles and Other Low-Income Beneficiaries*, September 2003. Available at,

## Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries

[www.kff.org/%20medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21805](http://www.kff.org/%20medicare/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=21805).

The Medicare Payment Advisory Commission (MedPAC), *Dual Eligible Beneficiaries: An Overview*, June 2004. Available at, [www.medpac.gov/publications/congressional\\_reports/June04\\_ch3.pdf](http://www.medpac.gov/publications/congressional_reports/June04_ch3.pdf).

National Council on Interpreting in Health Care, *A National Code of Ethics for Interpreters in Health Care*, July 2004. Available at, [http://www.ncihc.org/NCIHC\\_PDF/NationalCodeofEthicsforInterpretersinHealthCare.pdf](http://www.ncihc.org/NCIHC_PDF/NationalCodeofEthicsforInterpretersinHealthCare.pdf).

National Council on Interpreting in Health Care, *Guide to Initial Assessment of Interpreter Qualifications*, April 2001. Available at, [http://www.ncihc.org/NCIHC\\_PDF/InitialAssessmentofInterpreterfinalversionMay2001.pdf](http://www.ncihc.org/NCIHC_PDF/InitialAssessmentofInterpreterfinalversionMay2001.pdf).

National Council on Interpreting in Health Care, *National Standards of Practice for Interpreters in Health Care*, September 2005. Available at, [http://ncihc.org/NCIHC\\_PDF/National\\_Standards\\_of\\_Practice\\_for\\_Interpreters\\_in\\_Health\\_Care.pdf](http://ncihc.org/NCIHC_PDF/National_Standards_of_Practice_for_Interpreters_in_Health_Care.pdf).

National Health Law Program, *Language Access in Health Care Statement of Principle*, May 2006. Available at, <http://www.healthlaw.org/library.cfm?fa=download&resourceID=92862&print>.

National Health Law Program, *Language Assistance Self-Assessment and Planning Tool for Recipients of Federal Financial Assistance*, March 2005. Available at, <http://www.lep.gov/selfassesstool.htm>.

U.S. Department of Health and Human Services, Office of Minority Health, *National Standards on Culturally and Linguistically Appropriate Services (CLAS)*, March 2001. Available at, <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15>.

42 Code of Federal Regulations § 423.50, Approval of marketing materials and enrollment forms.