As COVID-19 exerts financial strain on clinicians nationwide, its impact on health equity is a pressing concern. In recent surveys, 57% of primary care providers reported their payments were insufficient to cover costs, and 20% reported at least temporarily closing their practice, along with layoffs and furloughs.¹ As providers are forced to cut costs, what services are cut—and whom would be most affected by such cuts—could exacerbate existing disparities. Medical interpretation services for more than 25 million individuals with limited English proficiency (LEP) in the United States is a key example.

Adequate interpreter services were limited even before the current pandemic. Currently, less than 70% of all US hospitals offer language concordant care, partly because providers must pay for the services themselves. As a result, patients with LEP often face language-related barriers to care in addition to existing inequities. Cutting medical interpreter services in the face of COVID-19, despite short-term savings, may further hinder the care patients receive.

Even before COVID-19, few insurers directly reimbursed for interpreter services. Outside of some Medicaid plans, health care providers are expected to pay these costs, ranging from $30 to $400 per patient visit. In 1 study, providers spent an average of $234 per patient with LEP per year on interpreter services.² Meanwhile, most Medicaid programs pay physicians roughly $30 to $50 per office visit, meaning that some providers may lose money by seeing patients with LEP.

In this context, it is perhaps unsurprising that a quarter of clinicians considered the cost of interpreter services an obstacle to care. Now with sharp revenue losses due to COVID-19, that number may have grown. The pandemic may force providers to reduce or forego interpreter services—compounding its disproportionate impact on already disadvantaged populations.

### Importance of Medical Interpreters

Evidence suggests that medical interpreters help address disparities in access and outcomes, as their services increase patient satisfaction, improve adherence, shorten admissions, and reduce the likelihood of adverse events.²

Reflected by the existence of various state and federal regulations, various levels of government have recognized the importance of medical interpreters. For example, providers who receive federal funding must comply with Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin, and provide necessary language assistance free of charge. In addition, Title III of the Americans With Disabilities Act, revised in 2010, requires accommodations for individuals with communication disabilities. However, infrequent enforcement and inconsistent funding for interpreter services may in part explain the uneven access to interpreters.

Some may argue that the cost of interpreter services should be considered an operating expense. After all, insurers do not reimburse for nursing or ancillary staff—hospitals and practices pay their salaries. However, those employees generally serve all patients, and their reduction would not necessarily complicate the care of disadvantaged patients disproportionately. Foregoing interpreter services, on the other hand, disrupts the care of patients with LEP directly. In this way, health care providers who primarily see these patients have additional overhead on top of reduced revenue due to having fewer privately insured patients. Reimbursing for interpreter services would not only counter disparities in access but would also be a nudge toward pricing parity between the providers.
who care for a majority of Medicaid patients and those with a higher proportion of commercially insured populations.

Payers may also benefit by covering interpreter services. Although data are limited, studies suggest that when physicians struggle to communicate with patients, they are more likely to order unnecessary tests and treatments. This not only puts patients at increased risk but also directly increases payer spending. Patients with LEP may need care more frequently or seek treatment in more expensive settings, such as the emergency department, when they cannot communicate with primary care providers. Similar to insurers in fee-for-service arrangements, risk-bearing provider groups in alternative payment models face a similar incentive to curtail unnecessary or wasteful utilization.

**Reimbursement Models**

In a fee-for-service context, insurers could reimburse providers for interpreter services per visit or at a rate per time. Existing billing codes for interpreter services (eg, T1013, sign language or oral interpretive services, per 15 minutes) may facilitate implementation.

Alternatively, reimbursement rates or care management fees for providers of patients with LEP could be adjusted upward to account for interpreter costs indirectly. While provider eligibility and variations in the underlying costs of interpreter services may complicate policy making, this might also be done by provider organizations internally, especially those under global budget arrangements that have flexibility within the budget to invest in interpreter services or in their clinicians who serve patients with LEP.

Insurers might consider contracting with remote interpreter services directly for their members. Although telephone services may be more challenging than in-person interpretation, contracting with remote interpreters is more practical for patients who speak less common languages or providers who serve areas with too few patients with LEP to invest in in-person translators. With interpreters by phone (or video) available on call, providers could then access interpretation for whom and when it is needed. This would also ensure that patients receive a standardized service of similar quality. Fee-for-service arrangements could continue to support in-person interpreters for clinicians with large volumes of patients with LEP.

Reimbursement for virtual or machine translation tools, such as Google Translate, is another consideration. Current technology, however, does not appear yet to match human interpreters in quality. Recent studies report variable accuracy depending on the language and user, and thus it may not yet be time for all providers to systematically adopt these services. As such technology improves in accuracy, it may make sense for payment models to increasingly include them, with attention to standardization of services and monitoring of quality.

**Conclusion**

The COVID-19 pandemic has magnified racial and socioeconomic disparities in the US health care system, in which language is a key dimension of inequity. Paying for interpreter services—from cost-based reimbursement, to their inclusion in prospective payment models, to insurer-led contracting for remote interpreters—would not only directly address this disparity but also help support practices facing financial peril due to the pandemic.

**ARTICLE INFORMATION**

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Corresponding Author: Zirui Song, MD, PhD, Department of Health Care Policy, Harvard Medical School, 180A Longwood Avenue, Boston, MA 02115 (song@hcp.med.harvard.edu).
Author Affiliations: Harvard Medical School, Boston, Massachusetts (Shah, Velasquez, Song); Massachusetts General Hospital, Boston, Massachusetts (Song).

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