INTERPRETER SERVICES FOR LIMITED ENGLISH PROFICIENT INSUREDS ARE "REASONABLE" AND "NECESSARY"

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I. Introduction

English is the language spoken by the majority of U.S. residents, and most government entities function primarily in English. The United States is a culturally and linguistically diverse nation. More than 20 percent of the population speaks a language other than English at home, and over 25 million speak English less than "very well."[1] Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English are referred to as limited English proficient ("LEP").[2] In other words, nearly 1 in every 11 Americans is LEP.[3] The

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[1] Camille Ryan, US Bur. Am. Cmty. Survey Reports *Language Use in the United States: 2011* (Aug. 2013), https://www2.census.gov/library/publications/2013/acs/acs-22/acs-22.pdf, *archived at* https://perma.cc/2QW3-KSS6.

[2] Limited English Proficiency (LEP) Lep.gov, A Federal Interagency Website, https://www.lep.gov/faqs/faqs.html, *archived at* (last visited Feb. 22, 2020); *see also* Enforcement of Title VI of the Civil Rights Act of 1964—National Origin Discrimination Against Persons With Limited English Proficiency; Policy Guidance, 65 Fed. Reg. 50,123 (Aug. 16, 2000) (Strategic plan to improve access to federally-funded programs and activities by LEP persons) [hereinafter *DOJ Guidance*]. Throughout this essay, "LEP" refers interchangeably to limited English "proficient" and "proficiency."

[3] Ryan, *supra* note 1.

health care workforce, however, is less racially and ethnically diverse than the population it serves.[4]

Due to language barriers, LEP individuals seeking medical attention experience obstacles to safe, quality care. Communication is integral to obtaining accurate clinical history. Errors can lead to serious adverse effects for LEP individuals[5] and, in some extreme cases, even death.[6] LEP individuals experience longer hospital stays[7] for the same medical or surgical conditions, and they are at increased risk of readmission[8] as compared to English-proficient individuals.[9] Additionally, LEP patients undergo more unnecessary diagnostic testing to fill in language gaps,[10] more often do not understand discharge instructions,[11] and report less overall satisfaction with the care they receive.[12]

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[4] Oregon Health Auth., Office of Health Analytics, The Diversity of Oregon's Licensed Health Care Workforce, Based on data collected during 2016 and 2017 (2019) [hereinafter Diversity of OR's Health Care Workforce], https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/157617, *archived at* https://perma.cc/YWH3-DJN9.

[5] *See e.g.* Adam L. Cohen et al., *Are Language Barriers Associated With Serious Medical Events in Hospitalized Pediatric Patients?*, 116 Pediatrics 575, (2005); *see also* Chandrika Divi et al., *Language proficiency and adverse events in US hospitals: a pilot study*, 19 Int'l J. Qual. Health Care 60, 62 (2007); Melanie Wasserman et al., *Identifying and Preventing Medical Errors in Patients With Limited English Proficiency: Key Findings and Tools for the Field*, 36 J. Healthcare Qual. 5, 5 (2014) ("[C]ommunication problems are among the root causes of 59% of serious adverse events . . . and research suggests that LEP patients are more likely than English-speaking patients to experience safety events caused by communication errors.").

[6] *See, e.g.*, Alice H. Chen et al., *The Legal Framework for Language Access in Healthcare Settings: Title VI and Beyond*, 22 J. Gen. Internal Med. 362, 362 (2007) (describing the tragic story of 13 year-old Gricelda Zamora who died of a ruptured appendix after discharge with a diagnosis of gastritis); *see also* Audrey Daly, *How to Speak American: In Search of the Real Meaning of "Meaningful Access" to Government Services for Language Minorities,* 110 Penn. St. L. Rev. 1005, 1006 (2006); Marc Santora, *Caught in the Health Care Maze: A Korean Family's Story,* N.Y. Times (Jul. 26, 2004) (describing the story of a Korean man who died after being discharged from hospital with the understanding that he was only to take Tylenol).

[7] Ava John-Baptiste et al., *The effect of English language proficiency on length of stay and in-hospital mortality*. J. Gen. Intern. Med. 221, 221 (2004).

[8] U.S. Dep't of Health & Human Servs., Agency for Healthcare Research & Quality, *Re-Engineered Discharge (RED) Toolkit Tool 4: How To Deliver the Re-Engineered Discharge to Diverse Populations* (Mar. 2013), https://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool4.html#Language, *archived at* https://perma.cc/93SQ-4UCR.

[9] *See e.g.* Leah S. Karliner et al., *Influence of language barriers on outcomes of hospital care for general medicine inpatients*, J Hosp. Med. 276, 276 (2010); H. Joanna Jiang et al., *Racial/ethnic disparities in potentially preventable readmissions: the case of diabetes*, Am. J. Pub. Health. Ass'n 1561, 1561 (2005).

[10] Jane Perkins, *Overcoming Language Barriers to Health Care*, 65 Popular Gov't 38, 39 (Fall 1999); *see also* Matthew A. Waxman et al, *Are diagnostic testing and admission rates higher in non–English-speaking versus English-speaking patients in the emergency department?* 36 Annals of Emerg. Med. 456, 456 (2000) ("Significantly more tests are ordered for non–English-speaking patients . . . including 3 times as many abdominal computed tomographic scans.").

[11] U.S. Dep't of Health & Human Servs., Agency for Healthcare Research & Quality, *supra* note 8.

[12] Louis C. Hampers et al, *Language barriers and resource utilization in a pediatric emergency department*, 156 Arch Pediatric Adolescent Med. 1108, 1111 (Nov. 2002); *see also*

The ability to communicate with those around us is often taken for granted. When it comes to medical care, we expect to be able to describe symptoms to our doctor, to understand our diagnosis, and to implement the care protocol that we have been prescribed. We know, for instance, that if we have a car accident, we can explain the details of the incident and seek treatment. We further know that the treatment will be covered by our car insurance —that is, after all, the purpose of insurance.

For those U.S. residents with different national origins, however, things are often not as easy. Although it does not alleviate all the inequities, Title VI of the Civil Rights Act of 1964 protects against discrimination on the basis of race, color, and national origin. Courts, presidents, and executive agencies have interpreted the Title VI prohibition on national origin discrimination to include protections for the benefit of those who, because of their national origin, are LEP persons.[13] Federal agencies and recipients of federal funding must provide LEPs with meaningful access to their programming at the same standard of service that they provide to others.

If LEP individuals are ill and seek medical attention at a hospital that receives federal funds, the hospital will provide them a medical interpreter. The interpreter will bridge the communication gap with their medical provider, assist them in completing intake forms, and help them understand their doctors' home care instructions. If LEP individuals interact with the DMV, or their utility service provider, they will receive their driver's test or utility bill and mailing inserts in languages other than English. If LEP individuals are injured while working, in many states, their employer's workers' compensation ("WC") will provide claims forms in their native language and a medical interpreter to assist at their medical and other treatment appointments—despite the fact that WC insurers are private entities, not subject to mandates applicable to federally-funded entities.

However, the reach of Title VI protections only goes so far. If LEP individuals in many states have the misfortune of getting into a car accident, even while insured, , they face uncertain prospects. Will they be able to find medical attention in a language they can understand? Very few primary care providers speak a language other than English, and those who do may not be in a convenient location. As a private entity, not subject to the mandates of Title VI, a motor vehicle insurance company may or may not cover medical interpreting services. The ultimate decision to provide language access or not may depend on the internal policy of the insurer, or on the individual

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JOSEPH R. BETANCOURT ET AL, U.S. DEP'T OF HEALTH & HUMAN SERVS., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, AHRQ Publication No. 12-0041, IMPROVING PATIENT SAFETY SYSTEMS FOR PATIENTS WITH LIMITED ENGLISH PROFICIENCY: A GUIDE FOR HOSPITALS (Sept. 2012); Elisabeth Wilson et al., *Effects of limited English proficiency and physician language on health care comprehension*, 20 J GEN INTERN MED. 800, 800 (2005).

[13] For a general overview of the "forty-year regulatory history" leading up to the HHS Guidance (discussed below note 76), see *Colwell v. Dep't of Health & Human Servs.*, 558 F.3d 1112, 1116–19 (9th Cir. 2009) (of particular significance is Section I "Statutory and Regulatory Background").

adjustor assigned to the LEP's claim. The choice is at the discretion of the insurer.

LEP persons are less likely than their English proficient counterparts to have comprehensive medical insurance[14] and are thus more likely to rely on no-fault injury protection, such as automobile personal injury protection ("PIP") coverage or WC, if injured in an accident. The costs of providing their own interpreter, on top of any income lost[15] due to their injury, often has the effect of deterring injured LEPs from seeking treatment altogether, or sometimes results in attempts to communicate with their doctor without an interpreter.

Take a minute to imagine the last time you had a moderate injury. Now imagine trying to explain to someone who spoke only a different language how you hurt yourself. Pantomime or a Three Stooges skit come to mind. If the scenario were a cartoon, hilarity would ensue. But, when the scenario is an all too common real-life occurrence for up to approximately nine percent of the adult U.S. population who is LEP, the scene loses its amusement.

The effects of receiving subpar health care when one needs to regain health in order to get back to taking care of his or her family and get on with life can be devastating. Since LEP persons are required by law to purchase motor vehicle insurance— including PIP coverage—to legally drive in most, if not all, states, they should have an equal opportunity to utilize their insurance coverage, when appropriate, to get the medical treatment they need. No one should have to choose between paying for coverage that they cannot use and losing their driving privileges.

"Effective communication between patient and doctor is critical to good medical outcomes."[16] Medical treatment without communication is simply not medical treatment. In other instances where patients are unable to communicate their ills (e.g. pets in a veterinary office or babies attended to by a pediatrician),[17] the patient is not alone—there is an intermediary, such

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[14] Kaiser Commission on Medicaid and the uninsured, *Overview of Health Coverage for Individuals with Limited English Proficiency - Fact Sheet* (Aug. 2012), https://www.kff.org/disparities-policy/fact-sheet/overview-of-health-coverage-for-individuals-with/, *archived at* https://perma.cc/4WRM-G7TB (Half of LEP adults are uninsured—nearly three times the uninsured rate of English proficient adults); *see also* Monica Eneriz-Wiemer et al., *Parental Limited English Proficiency and Health Outcomes for Children with Special Health Care Needs: A Systematic Review*, 14 Academic Pediatrics 128, 128 (2014) (LEP parents were substantially more likely than English-proficient parents to report that their special needs child was "uninsured").

[15] Expenses from an unexpected accident and subsequent loss of income can have a substantial impact—especially since 57-69% of Americans have less than $1,000 in savings. Kathleen Elkins, *Here's How Much Money Americans Have in Their Savings Accounts*, CNBC Make It (Sept. 13, 2017), https://www.cnbc.com/2017/09/13/how-much-americans-at-have-in-their-savings-accounts.html, *archived at* https://perma.cc/APE7-99VN.

[16] Karen Scott Collins et al., New York: Commonwealth Fund, Diverse communities, common concerns: Assessing health care quality for minority Americans. Findings from the Commonwealth Fund 2001 Health Care Quality Survey 21 (2002).

[17] Amanda Scioscia, *Language Isn't the Only Thing Getting Lost in the Translation as Hispanic Patients Struggle to Communicate with English-Speaking ER Doctors*, Phx. New Times (June 29, 2000).

as a pet owner or parent, present to help communicate. Surely, adults deserve at least as much. Limited English proficient insureds should be able to rely on their motor vehicle insurance to cover the actual treatment necessary for their recovery in order to receive treatment that is on par with the English proficient insurance-holders.

In theory, an injured claimant may recover "the reasonable value of the medical expenses for which he was billed and which were necessary to treat his injuries"[18] under certain state PIP laws. Personal Injury Protection insurance benefits should, therefore, cover the expense of medical interpretation services for LEP individuals because communicating with one's doctor is necessary for medical treatment.[19] Despite the general policy toward construing PIP laws liberally to favor the insurance-buying public and the right of insureds to reimbursement for "*all* reasonable and necessary expenses of medical . . . services,"[20] PIP insurance providers nonetheless routinely deny coverage of interpreter service. Denial letters include such wording as "interpretation services are not [ ] medical expenses" or "interpretive services are not considered medical expenses under the automobile policy," and "[i]nterpretation services are not considered medical treatment and therefore are not covered by our policy."[21]

This paper examines the need for healthcare interpretation services and the interplay between federal guidelines intended to provide reasonable access to all U.S. residents regardless of English language proficiency—often a proxy for national origin—and the private insurance that individuals are obligated to purchase, but is not always useful in time of need. Because motor vehicle insurance requirements and coverage minimums vary from state to state, here I focus on law from the state of Oregon to serve as an example of what is a common problem throughout the United States. I chose to focus on Oregon for several reasons. First, Oregon is typical of other lesser linguistically diverse states[22] in the nation that more recently has experienced growth language demands without a matching linguistically diverse provider supply.[23] Second, state agencies had conducted studies or

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[18] *See, e.g.*, *White v. Jubitz Corp.*, 219 P.3d 566, 583 (2009).

[19] E-mail from Nathan Sosa, Oregon personal injury practitioner, to Julie Preciado, 2L at Willamette University College of Law (Mar. 26, 2019) (on file with author) (Attorney discussion groups on the Oregon Trial Lawyers Association list serve reinforce this idea).

[20] Or. Rev. Stat. § 731.016 (2019); Or. Rev. Stat. § 742.524(1)(a) (2019).

[21] Letter from Claims Adjustor, Country Financial, to Colibri Language Services NW, healthcare interpreting service provider (Nov. 17, 2014); Letter from Claims Adjustor, Country Financial, to Colibri Language Services NW, healthcare interpreting service provider (May 12, 2010); Letter from Claims Adjustor, State Farm, to Language Services NW, healthcare interpreting service provider (Apr. 5. 2019) (on file with author) ("[PIP] pays for reasonable necessary medical treatment related to injuries sustained in a covered loss.").

[22] As is true in the majority of states, in Oregon LEPs made up more than 1%, but less than 10%, of the population for the last year on which there is data at LEP.gov. https://www.lep.gov/maps/2015/national/US_state_LEP_pct.ACS_5yr.2015.pdf (last visited Feb. 22, 2020), *archived at* https://perma.cc/DFJ3-WHWT.

[23] This situation, common to many states, is as opposed to states like California or Texas, which have long been more linguistically diverse states. Due to the long history of linguistic

surveys[24] investigating the then-current status of offerings and how they affected the LEP population. These were helpful in understanding the status quo and how the state viewed language need issues in terms of public health and public policy. Third, the fact that the Oregon Workers' Compensation Division had determined that WC insurers – similarly situated private providers of a no-fault insurance – must provide interpreter services to LEPs, it seemed like a glaring omission that providers of PIP insurance would not be held to the same standard. Finally, having worked for years as a medical interpreter in Oregon, my firsthand knowledge of the inner workings within the state provided additional insight.

A survey of the national no-fault insurance landscape shows similarities in state law requirements vis-a-vis what drivers are required to purchase and what insurers are required to cover, and a dearth of statutes and case law on the subject of obligatory coverage of healthcare or medical interpretation, or other provision of language services to LEPs, by PIP or other no-fault insurance.[25] In particular, across the board, there is a general "liberal construction" of insurance statutes[26] and similar language and interpretation of wording like "reasonably medically necessary" or "reasonable and necessary expense of medical services."

The inherent need for communication with one's medical provider is common sense, and interpretation services should be covered under PIP as an essential part of "all reasonable and necessary expenses of medical . . . services" expended for treatment and recovery after an automobile accident. To show that medical interpreting services for LEP individuals are "medically necessary" under PIP, the paper walks through each step of controlling law. First, the paper gives an overview of what PIP is, how it originated, and what it is typically understood as being required by such policies. Second, the paper discusses the need for healthcare interpretation in terms of patient safety, better health outcomes, and physician liability. Third, the paper lays out the federal basis of language-based protections, including Title VI, E.O. 13166, and federal agency guidelines. Fourth, the paper examines Oregon-specific case and statutory law. Finally, it compares another common no-

diversity in certain states, there may be less of a reliance on interpreter service due to the inherent presence of more bilingual medical providers and staff.

[24] *See, e.g.*, *Diversity of OR's Health Care Workforce, supra* note 4; *see also Interpreter Servs. Study*, *infra* note 108.

[25] *See, e.g.*, *Dowell v. Oregon Mut. Ins. Co.*, 388 P.3d 1050, 1065–66 (2017) (en banc) (Walters, J., dissenting) (analyzing various states' case law exploring whether PIP statutes require reimbursement of insureds' transportation costs incurred in connection with medical treatment that is reasonably medically necessary).

[26] "If an insurer uses language that is uncertain, any reasonable doubt will be resolved against it. . . . The rule that policies are afforded a liberal construction in favor of coverage is designed . . . to interpret the provisions of the policy so as to effectuate the reasonable coverage expectations of the members of the public who purchase it . . . ." *See* Statement of general rule and its application, 2 Couch on Ins. § 22:14 (noting that "'the contract is to be construed against the insurer'" is one of "the most familiar expression in the reports of insurance cases").

fault insurance system to the PIP system and argues for similar action as that taken in the arena of worker's compensation.

II. An Overview of Personal Injury Protection ("PIP")

To retain driving privileges, all drivers in Oregon are required under ORS 806.010[27] to maintain motor vehicle liability insurance that includes no-fault personal injury protection.[28] ORS 742.518 to 742.544 govern PIP benefits, which "consist of payments for expenses, loss of income and loss of essential services."[29] Regardless of who is at fault in an automobile accident, auto insurers must provide PIP benefits to their insureds to cover "[a]ll reasonable and necessary expenses of medical . . . services incurred within two years after the date of the person's injury, but not more than $15,000 in the aggregate for all such expenses of the person."[30] The PIP statutes were created "to provide, promptly and without regard to fault, reimbursement for some out-of-pocket losses resulting from motor vehicle accidents."[31] In 2017, the Oregon Supreme Court held in *Dowell v. Oregon Mutual Insurance Co*., 388 P.3d 1050, 1065–66 (Or. 2017) (en banc), that the phrase "expenses of medical . . . services" requires an insurer to pay for "costs that originate with, or that are actuated by, the rendered medical treatment or the physician's performance of work . . . includ[ing] the medications and medical supplies and equipment that a physician prescribes for treatment of the injured person."[32] In other words, PIP covers "healthcare bills and items that a physician or other healthcare provider prescribes for treatment, such as medications and medical supplies and equipment."[33]

The PIP statutes presume that expenses of medical services claimed by a "provider" on behalf of an insured are reasonable and necessary, unless the insurer timely denies the claim.[34] The term "provider" is statutorily defined as "a person licensed, certified or otherwise authorized or permitted by laws of this state to administer medical or mental health services in the ordinary course of business or practice of a profession."[35] An insurer may deny a

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[27] Or. Rev. Stat. § 806.010 (2019).

[28] Or. Rev. Stat. § 742.520 (2019) ("Every motor vehicle liability policy issued . . . in this state . . . shall provide personal injury protection benefits to the person insured . . ., members of that person's family residing in the same household, . . . [and] passengers occupying the insured motor vehicle.").

[29] Or. Rev. Stat. § 742.520(3) (2019).

[30] Or. Rev. Stat. § 742.524(1)(a) (2019).

[31] *Perez v. State Farm Mut. Auto. Ins. Co.* 613 P.2d 32, 35 (Or. 1980).

[32] *Dowell*, 388 P.3d at 1059 (evaluating what constitutes an "expense of medical . . . service," in Oregon by analyzing the text, context, and legislative history of Or. Rev. Stat. § 742.524(1)(a), ultimately holding that an insured's transportation costs of travelling to receive medical care is not a covered benefit).

[33] *Id.* at 1063.

[34] Or. Rev. Stat. § 742.524(1)(a) ("Expenses of medical . . . services shall be presumed to be reasonable and necessary unless the provider is given notice of denial of the charges not more than 60 calendar days after the insurer receives from the provider notice of the claim for the services.").

[35] Or. Rev. Stat. § 743.801[13] (2019) (as referenced in § 742.518(10)).

PIP claim for medical expenses, but the "potential existence of a cause of action in tort does not relieve an insurer from the duty to pay [PIP] benefits."[36] Disputes over PIP payments may be adjudicated by use of binding arbitration, if both parties agree, or an insured who believes he or she was wrongly denied PIP benefits may choose to file a civil action against the insurer.[37]

Oregon law states that the "Insurance Code shall be liberally construed and . . . administered and enforced to give effect to the policy"[38] and that "the Insurance Code is for the protection of insurance-buying public."[39] Oregon[40] and other jurisdictions[41] confronted with the question of whether a particular service should be covered under a no-fault PIP automobile insurance policy have tended to adopt the "liberal construction" as a general maxim of statutory construction in insurances cases. Even the expense of medical reports to an attorney or an insurance company regarding an insured's condition have been considered recoverable expenses under PIP, as "[o]nly the treating doctor can prepare such a report."[42] However, the Oregon Supreme Court in a 4-3 split in *Dowell* held that transportation was not an "expense of medical . . . services" under PIP. Chief Justice Walters and two other Justices dissented, arguing that the plain language of the PIP statute "require[d] payment of" costs "incurred to secure the benefit of medical services," and that the context and legislative history of the statutes demonstrated that the legislature intended liberal construction of PIP statutes for "the protection of the insurance-buying public."[43] In enacting PIP statutes, the "legislature intended to require insurers to promptly pay their insureds' economic losses to increase insureds' chances for full recovery and to avoid the need for contentious third-party litigation."[44]

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[36] Or. Rev. Stat. § 742.520(5) (2019).
[37] Or. Rev. Stat. § 742.520(6) (2019).
[38] Or. Rev. Stat. § 731.016 (2019).
[39] Or. Rev. Stat. § 731.008 (2019).
[40] *Carrigan v. State Farm Mutual Auto. Ins. Co.*, 949 P.2d 705, 708–09 (Or. 1997) (gunshot injuries caused by carjacker moments after insured left vehicle were within coverage for PIP benefits); *Pierce v. Allstate Ins. Co.*, 848 P.2d 1197, 1200–01 (Or. 1993) (en banc) (acknowledging a rule of "liberal construction" as a general maxim of statutory construction in insurance cases).
[41] For example, the majority approach among states regarding PIP coverage of transportation expenses to and from health care providers, is that transportation is reimbursable under PIP. *See, e.g.*, 12 Couch on Ins. § 171.64 (3d ed. 2018) ("Transportation expenses incurred traveling to and from medical providers for treatment of covered injuries arising out of an automobile accident are compensable under a no-fault or PIP insurance policy because these transportation costs are incurred in connection with, and are causally related to, reasonable and necessary medical services."); 4 Automobile Liability Insurance 4th § 56:1 ("The cost of transportation to and from a doctor's office in order to receive necessary medical treatment is normally a reimbursable medical benefit expense."); *see also* Brief for Or. Trial Lawyers Ass'n as Amicus Curiae Supporting Appellant, *Dowell,* 388 P.3d at 1059 (Or. 2017) (No. S063079), 2015 WL 9394102 (New Jersey, Florida, Colorado, and Michigan courts or legislatures have all decided that transportation costs are expenses covered by PIP).
[42] *Chopp v Miller*, 504 P.2d 106, 108–09 (Or. 1971) (en banc).
[43] *Dowell*, 388 P.3d at 1063–64 (Walters, J., dissenting).
[44] *Id.*

The Oregon Supreme Court has recognized that a presumption that expenses are "reasonable and necessary" applies when "a healthcare provider submits a PIP claim for medical expenses on behalf of an insured."[45] The "reasonable" portion of "reasonable and necessary" is generally regarded as concerning a reasonable fee—"that is, whether [the fee] was both 'usual and customary.'"[46] Many jurisdictions, including Oregon, now follow WC fee schedule to determine reasonable fee limits.[47] Healthcare providers "cannot charge more than the amount in 'fee schedules for medical services' published by the Director of the Department of Consumer and Business Services."[48] Thus, a reasonable fee for necessary medical services is prescribed by both the "reasonable and necessary" standard and the WC fee schedule.[49]

Injured insureds with accepted PIP claims have "a right to reimbursement of all reasonable and necessary medical expenses (up to [the] statutory cap)."[50] In fact, there is a statutory presumption of a right to reimbursement for payments to healthcare providers designed to reduce disputes over medical bills. However, the presumption does not cover all possible "expenses of medical . . . services" that an injured person may claim.[51] Whether a treatment is an "expense of medical . . . services" or is "medically necessary" to treat an insured's injuries is a question of fact. It is possible for a treatment to be determined to be medically necessary in one instance and not in another, depending on the circumstances. Usually, a treatment or care plan must only be consistent with the generally accepted practice of the medical community for the treatment of that particular injury.[52] "The value of medical and related treatment reasonably necessary to minimize or alleviate injury itself or the pain or disability that results from it are almost always recoverable. . . . Any reasonable expense, adequately proved to be the result of the injury," should be recoverable under PIP.[53]

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[45] *Ivanov v. Farmers Ins. Co.*, 185 P.3d 417, 421 (Or. 2008) (en banc).

[46] *Strawn v. Farmers Ins. Co. of Oregon*, 258 P.3d 1199, 1203 (Or. 2011) (quoting *Strawn v. Farmers*, 209 P.3d 357, 362 (2009)), *adh'd to on recons*, 256 P.3d 100 (Or. 2011); *see also* 12 COUCH ON INS. § 171:59 Medical expenses fee limits; workers' compensation fee schedules (3d ed. 2018) (providers generally must use their "usual" or "customary" fees as a basis for determining a reasonable amount to charge an injured claimant under a no-fault claim).

[47] 12 COUCH ON INS. § 171:59; *see also* OR. REV. STAT. § 742.525(1)(b) (2019) (amount charged must "not exceed the fee schedules for medical services published pursuant to OR. REV. STAT. § 656.248").

[48] *Dowell*, 388 P.3d at 1057–58.

[49] Oregon Insurance Division Bulletin Ins. 2003–7. (02/13/2004) ("reasonable and necessary" standard and WC fee schedule are not separate standards for the determination of cost, but rather costs are prescribed by the "lesser than" provision of OR. REV. STAT. § 742.525(1)).

[50] *McBride v. State Farm Mut. Auto. Ins. Co.*, 386 P.3d 679, 687 (Or. Ct. App. 2016).

[51] *Dowell*, 388 P.3d at 1058–59.

[52] 12 COUCH ON INS. § 171:61, Requirement that treatment be "medically necessary."

[53] 2 DAN B. DOBBS, LAW OF REMEDIES: DAMAGES-EQUITY-RESTITUTION § 8.6(3), 375–76 (2d ed. 1993).

III. The Medical Necessity of Language Interpreting Services to LEP Insureds

When medical interpreters are not utilized, often friend or family members will interpret for LEP patients. Not only does this implicate privacy issues and possible omissions due to a patient not wanting to disclose private or embarrassing medical history to a friend or family member,[54] but also the person interpreting also usually has no medical training and is likely unfamiliar with medical terminology, procedure, and protocol. Other times, medical providers use bilingual office staff;[55] this practice is problematic because being bilingual does not necessarily equate to being a proficient interpreter.[56] While using such "ad-hoc interpreters" can be perceived as an easier way to get by than providing a professional language interpreter, ad-hoc interpreters commit more clinically-significant interpretation errors than professional interpreters.[57] Other times, medical providers rely on their own mediocre second-language skills to try to communicate with patients. As one news article puts it,

> No amount of medical training can change the fact that no one here can ask [an LEP patient] his name, where he is having pain, what has happened to him or what medications he is allergic to. No one can explain that the X-rays won't work unless he holds still. No one can explain that they must do a rectal examination to check for internal injuries.[58]

Improper care received by LEP patients can have serious liability implications for the medical providers treating them, and can increase overall costs to the providing system. Health care providers can face tort liability when no qualified interpreter is provided.[59] Not only can medical malpractice result from miscommunication with LEP patients, but medical providers may face legal liability for lack of informed consent, breach of duty to warn, and privacy issues involved with using ad-hoc interpreters.[60] "Individuals who may possess enough English proficiency to undergo a routine medical evaluation do not necessarily possess the proficiency to understand the legal implications of an informed consent form" or other medical procedures that may

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[54] Allison Keers-Sanchez, *Mandatory Provision of Foreign Language Interpreters in Health Care Services*, 24 J. Legal Med. 569, 570 (2003).

[55] LEP.gov, *What is the difference between a bilingual staff person and an interpreter or translator?*, https://www.lep.gov/faqs/faqs.html#OneQ11, *archived at* https://perma.cc/6NCM-B46B (last visited Apr. 19, 2019).

[56] Bruno G. Romero, *Essays From the Honorable James J. Gilvary Symposium on Law, Religion & Social Justice: "Justice for Strangers? Legal Assistance and the Foreign Born,"* 34 U. Dayton L. Rev. 15, 16 (2008) (discussing common misconceptions about proficiency in a foreign language).

[57] Glenn Flores, *The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review*, 62 Med Care Res. Rev. 255, 267, 269 (2005).

[58] Scioscia, *supra* note 17.

[59] Keers-Sanchez, *supra* note 54, at 558.

[60] *Id.* at 558–62.

have legal implications. In a notable Oregon case, an injured LEP individual, Mr. Urbina, lost his eyesight due to lack of an interpreter and was successful in a lawsuit against his medical service provider.[61] Mr. Urbina was unable to communicate to the doctor attending to him that he had been operating a nail gun without eye protection at the time of his injury.[62] This led to a misdiagnosis of corneal abrasion caused by wood hitting the eye, rather than an intra-ocular foreign body injury.[63] Urbina underwent four surgeries attempting to restore his sight, but ultimately lost vision in his eye due to his inability to communicate with his healthcare provider.[64] The suit resulted in an award of money damages in the amount of $388,544.89,[65] over half a million in 2020 dollars.[66]

Interpretation improves LEP patients' utilization of preventative and primary care services, which in turn reduces overall medical care costs by preventing costly complication of conditions.[67] Although studies have been inconclusive regarding whether the use of an interpreter increases physicians' time with a patient,[68] use of interpreters in conjunction with medical assistants and other healthcare support staff ensures that LEP patients receive effective care and that the process is smooth while preserving the fast-paced nature of the health care setting.[69] Interpreters facilitate communication and enhance comprehension between medical providers and LEP patients, and they help give voice to LEP patients.[70] "The utilization of language services . . . has been shown to improve cross-cultural communication, leading to increased compliance with recommended treatment plans, improved health care outcomes, overall reduction of healthcare cost, and, ultimately, reduction in health disparities."[71]

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[61] Edward J. Carbone et al., *Without proper language interpretation, sight is lost in Oregon and a $350,000 verdict is reached*, May L. Rev. Comment Suppl. Healthcare Risk Mgmt 1, 1–3 (May 2003).

[62] Third Amended Complaint and Demand for Jury Trial at 5, 11, *Urbina v. Providence Health Systems and Lou Ann Goodrich*, 2001 WL 35806566 (Or. Cir.).

[63] *Id.* at 6.

[64] *Id.* at 9.

[65] *Urbina v. Providence Health Systems and Lou Ann Goodrich*, 2001 WL 35805380 (Or. Cir.). Defendants' Motion for Judgment Notwithstanding the Verdict was denied. *See Urbina v. Providence Health Systems and Lou Ann Goodrich*, No. 000606026, 2001 WL 35973327 (Or. Cir. Dec. 07, 2001).

[66] Saving.org Inflation Calculator, https://www.saving.org/inflation/, *archived at* https://perma.cc/P7CM-BX5C (last visited Mar. 30, 2019) ($1 in 2001 is worth $1.48 in 2020).

[67] Elizabeth A. Jacobs et al., *Overcoming language barriers in health care: costs and benefits of interpreter services*, 94 Am J Pub. Health 866, 868 (2004).

[68] *Compare* Richard Kravitz et al., *Comparing the use of physician time and health care resources among patients speaking English, Spanish, and Russian*, 38 Med. Care 728, 728 (2000), *with* Thomas M. Tocher et al., *Do physicians spend more time with non-English-speaking patients?*, 14 Gen. Intern. Med. 303, 303 (1999).

[69] Jeffery Alborn et al., *Use of and interaction with medical interpreters*, 71 Am. J. of Health-System Pharmacy 1044, 1047 (2014).

[70] Margaret S. Wu et al., *"It's the difference between life and death": The views of professional medical interpreters on their role in the delivery of safe care to patients with limited English proficiency*, 12 PLoS ONE e0185659 (2017), https://doi.org/10.1371/journal.pone.0185659.

[71] *Diversity of OR's Health Care Workforce*, *supra* note 4, at 3.

The Oregon Legislature issued findings in 2001 that LEP persons "are often unable to interact effectively with health care providers . . . [b]ecause of language differences . . ."[72] They "are often excluded from health care services, experience delays or denials of health care services or receive health care services based on inaccurate or incomplete information."[73] Without interpreters, communication between health care providers and patients is not free-flowing, "preventing clear and accurate communication and the development of empathy, confidence and mutual trust," thought to be "essential for an effective relationship between health care provider and patient."[74] Certified or qualified health care interpreters must be used "whenever possible" to ensure the accurate and adequate provision of health care to persons as required by ORS 413.552(3).[75] The findings also suggest that health care for LEP persons should "be provided according to the guidelines established under the policy statement issued August 30, 2000 by the U.S. Department of Health and Human Services [("HHS")], Office for Civil Rights,"[76] as well as "the 1978 Patient's Bill of Rights."[77]

IV. The Federal Backdrop: History of Language-based Protection

Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d, provides that no person shall "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance."[78] This provision authorizes and directs federal agencies that are empowered to extend federal financial assistance to any program or activity "to effectuate" the Civil Rights Act through the issuance of "rules, regulations, or orders of general applicability."[79] Regulations prohibit recipients of federal funding from

> [U]tiliz[ing] criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their . . . national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program with respect to individuals of a particular race, color, or national origin.[80]

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[72] Or. Rev. Stat. § 413.552(1) (2019) (renumbered from 409.617 in 2011).
[73] *Id.*
[74] Or. Rev. Stat. § 413.552(2).
[75] *Id.*
[76] Or. Rev. Stat. § 413.552(2); Title VI of the Civil Rights Act of 1964: Policy Guidance on the Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency, 65 Fed. Reg. 52,762 (Aug. 30, 2000) [hereinafter *HHS Guidance*].
[77] Or. Rev. Stat. § 413.552(4).
[78] Title VI of the Civil Rights Act of 1964 § 601, 42 U.S.C. 2000d.
[79] 42 U.S.C. 2000d-1.
[80] 45 C.F.R. 80.3(b)(2).

Due to the perceived connection between language and national origin, courts have categorized language discrimination as a form of discrimination on the basis of national origin.[81] In *Lau v. Nichols*, the U.S. Supreme Court interpreted Title VI regulations to prohibit conduct that has a disproportionate effect on LEP persons because such conduct constitutes discrimination on the basis of national origin.[82]

On August 11, 2000, President Bill Clinton issued Executive Order 13166 ("EO 13166"), "Improving Access to Services for Persons with Limited English Proficiency."[83] Under EO 13166, every federal agency must "develop and implement [plans] by which LEP persons can meaningfully access those services consistent with . . . the fundamental mission of the agency," and work to ensure that recipients of federal funding "take reasonable steps to ensure meaningful access to their programs and activities by LEP persons."[84] Executive Order 13166 did not "create a new mandate"[85] that recipients have to provide interpreters and translations—that requirement existed all along under Title VI of the Civil Rights Act of 1964;[86] the executive order merely clarified rights and responsibilities under Title VI in regard to "meaningful access" for the benefit of LEP communities.[87] As President John F. Kennedy said in 1963: "Simple justice requires that public funds, to which all taxpayers of all races [colors, and national origins] contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial [color or national origin] discrimination."[88] Concurrently

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[81] *See Olagues v. Russoniello*, 797 F.2d 1511, 1520 (9th Cir. 1986) (noting that "an individual's primary language flows from his or her national origin"); *Asian Am. Bus. Group v. City of Pomona*, 716 F. Supp. 1328, 1332 (C.D. Cal. 1989) (holding that the use of foreign languages is clearly an expression of national origin).

[82] *Lau v. Nichols*, 414 U.S. 563 (1974) (San Francisco school district that had a significant number of non-English speaking students of Chinese origin was required to take reasonable steps to provide them with a meaningful opportunity to participate in federally funded educational programs); *but see Alexander v. Sandoval*, 532 U.S. 275, 121 S. Ct. 1511, 149 L. Ed. 2d 517 (2001) (holding that there is no private right of action to enforce such regulations).

[83] Executive Order 13166, Improving Access to Services for Persons with Limited English Proficiency. Exec. Order No. 13,166, 65 Fed. Reg. 50,121 (Aug. 16, 2000) [hereinafter *EO 13166*].

[84] *Id.*

[85] Alborn, *supra* note 69, at 1048.

[86] Dep't of Just., Fifteen Questions for the Fifteenth Anniversary of Executive Order 13166, https://www.justice.gov/crt/fcs/newsletters/summer-2015/FIFTEEN%20QUESTIONS%20FOR%20THE%20FIFTEENTH%20ANNIVERSARY%20OF%20EXECUTIVE%20ORDER%2013166, *archived at* https://perma.cc/PM24-F4U4 (last visited Mar. 31, 2019).

[87] *Id.* (EO 13166 did "impose[ ] a new, parallel language access obligation upon federal agencies that engage in federally conducted programs and activities."); *but cf.* Sharon L. Browne, *Feds Order Physicians & Health Care Providers to Provide Free Language Transl'n Services to LEP Patients: Colwell v. U.S. Dep't of HHS*, 6 Engage 2 (Fed. Soc. Publ'n) (Aug. 11, 2005) ("[T]he executive order almost casually blurs the important distinction between language and national origin . . . ignor[ing] three decades of judicial rejection of the notion of equating language with national origin under Titles VI and VII of the Civil Rights Act.").

[88] Dep't of Just., Title VI of the Civil Rights Act of 1964 42 U.S.C. § 2000d et seq., Overview of Title VI of the Civil Rights Act of 1964, https://www.justice.gov/crt/fcs/TitleVI-Overview, *archived at* https://perma.cc/Q3HJ-YWGE (last visited Mar. 31, 2019).

with EO 13166, the Department of Justice issued[89] a general guidance document ("DOJ Guidance")[90] setting forth compliance standards that recipients of federal funds must follow to ensure that the programs and activities they provide in English are accessible to LEP persons, and "thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964."[91] "[W]hile there is not always a direct relationship between an individual's language and national origin, often language does serve as an identifier of national origin."[92] Two years later, DOJ issued additional guidance outlining a four-factor analysis[93] for use by recipients of federal funding in determining the level of language assistance required under Title VI, and urging the creation of a written plan for the provision of language services to LEP individuals.[94]

Moreover, HHS issued its own guidelines, "Policy Guidance on the Prohibition Against National Origin Discrimination as It Affects Persons with Limited English Proficiency" ("HHS Guidance").[95] The aim of the HHS Guidance is to improve access by LEP individuals to services provided by HHS and HHS-funded entities—including hospitals, and even private medical providers who may receive funding through Medicare or Medicaid programs.[96] The HHS Guidance includes initiatives to assess the needs of clients, to provide language services by ensuring the availability of oral and written interpreting and translation services, and to appropriately train personnel. In addition to the four factors listed in the DOJ Guidance, HHS identifies additional factors to consider when determining what LEP-focused services to provide—the size of the recipient and the objectives of the program.[97] If all these factors are considered when developing a language access plan, the plan should ensure meaningful access and compliance with HHS

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[89] Under authority of Executive Order 12250 (President Jimmy Carter, 1980) to issue guidance and technical assistance to individuals and entities that have rights or responsibilities under Title VI of the Civil Rights Act of 1964.

[90] *DOJ Guidance*, *supra* note 2.

[91] EO 13166, *supra* note 83, at Sec. 1, *Goals*.

[92] *DOJ Guidance*, *supra* note 2, at 50,124 n. 8 (quoting *Hernandez v. New York*, 500 U.S. 352, 370 (1991) (plurality opinion) ("As the Supreme Court observed, '[l]anguage permits an individual to express both a personal identity and membership in a community, and those who share a common language may interact in ways more intimate than those without this bond.'"), https://www.epa.gov/sites/production/files/2015-03/documents/lepguide.pdf.

[93] Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons, 67 Fed. Reg. 41,455 (June 18, 2002), at 41,459 (The factors are: (1) [t]he number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs.).

[94] Alborn, *supra* note 69, at 1048.

[95] *HHS Guidance*, *supra* note 76.

[96] This is a very important umbrella, and is the reason for the *Colwell* suit (although it was brought prematurely). However, this essay primarily focuses on the responsibility of PIP to cover interpreting services, and does not explore the applicability of the federal guidelines to private doctors' offices as potential "recipients" of federal funds. So long as there is an argument about who should pay for interpreting services, LEPs are going without care.

[97] *Id.* at 52, 765.

guidelines. Otherwise, an LEP individual may seek recourse by filing a complaint with HHS's Office of Civil Rights.[98] Covered entities must ensure effective communication between the physician and the LEP person.[99]

Finally, in 2004, the U.S. Office of Minority Health of HHS, seeking to reduce health care disparities among individuals who experience unequal access to health services for linguistic and other reasons, developed the Culturally and Linguistically Appropriate Services ("CLAS") Standards for Health Care.[100] CLAS standards dictate that health care organizations must offer and provide language assistance services (bilingual staff or interpreter services) at no cost to LEP patients and consumers in a timely manner, at all points of contact, during all hours of operation.[101]

Executive Order 13166 is still "good law" nearly 20 years after issuance, as Presidents Bush and Obama reaffirmed it.[102] The DOJ said in 2015, "Support over three successive Administrations demonstrates the federal government's ongoing commitment to overcoming language barriers."[103] Even entities in states and localities with "English-only" laws are subject to the EO and agency-issued guidance.[104] Entities that receive federal funding "have to comply with Title VI, including its prohibition against national origin discrimination by recipients of federal assistance. Failing to make federally assisted programs and activities accessible to individuals who are LEP may violate Title VI and the Title VI regulations."[105] Although the Trump Administration has not issued an official statement with respect to EO 13166, in November 2017, then-Attorney General Sessions issued a memorandum regarding all agency guidance documents.[106] Since then, the DOJ's site now includes a disclaimer about their guidance documents:

> [The DOJ Guidance] provide[s] informal non-binding guidance to assist in understanding the language access requirements of [Title VI], the Department's regulations, and Executive Order 13166. The guidance documents are not intended to be a final agency action, have no legally binding effect, and have no force or effect of

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[98] Note that a private right of action against a recipient of federal funding who discriminates on the basis of language can only be brought if both discriminatory effect and a requisite showing of animus can be shown, as noted in Keers-Sanchez, *supra* note54, 564–65.

[99] *Id.* at 568.

[100] Alborn, *supra* note 69, at 1048.

[101] *Id.*

[102] An anti-immigrant hate group founded by white nationalist, John Tanton, has encouraged President Trump to "repeal" the E.O., but to date, it has not happened. ProEnglish, *Repealing Executive Order 13166*, https://proenglish.org/repealing-13166/, *archived at* https://perma.cc/RB8G-TBQ8 (last visited Mar. 31, 2019) [hereinafter ProEnglish].

[103] *Fifteen Questions*, *supra* note 86 (question 3).

[104] Federal Coordination and Compliance Section, Commonly Asked Questions and Answers Regarding Limited English Proficient (LEP) Individuals (Apr. 2011) (citing 67 Fed Reg 41455 at 41459 and 41468 (June 18, 2002); *Commonly Asked Questions and Answers About Executive Order 13166,* Answer 8), https://www.lep.gov/faqs/faqs.html#OneQ10, *archived at* https://perma.cc/8HL7-ZGDV.

[105] *Id.*

[106] Memorandum for All Components: Prohibition of Improper Guidance Documents, from Attorney General Jefferson B. Sessions III (Nov. 16, 2017).

> law. The documents may be rescinded or modified in the Department's complete discretion, in accordance with applicable laws. The Department's guidance documents do not establish legally enforceable responsibilities beyond what is required by the terms of the applicable statutes, regulations, or binding judicial precedent.[107]

V. Application in Oregon and a Comparison to the WC System

Oregon first took action regarding health care interpretation services in 2001 when Senate Bill 790 created the Oregon Council on Health Care Interpreters (the "Council"). The Council was tasked with developing testing, qualification, and certification standards for health care interpreters for LEP individuals.[108] Title 34 of Oregon Revised Statutes,[109] Chapter 413 "Oregon Health Authority," governs Oregon's Health Care Interpreter mandate.[110] The policy set forth in ORS 413.552(4) requires that "health care for persons with limited English proficiency be provided according to the guidelines established under the [HHS Guidance], and the 1978 Patient's Bill of Rights."[111] The Oregon Health Authority promulgated voluntary rules to ensure the availability of quality health care interpretation for LEP patients.[112] What remains unclear from the statute or the rules, however, is under what circumstances health care interpreter services must be used, and who is responsible for covering the costs. With the reference to HHS guidelines for the provision of health care for LEP persons, the Oregon statute may be understood to apply only to federally funded entities subject to Title VI mandates. On the other hand, a state law that "require[s] the use of . . . health care interpreters whenever possible"[113] seems as though it would apply to all health care settings in Oregon.

If all Oregon healthcare settings are subject to the requirement in ORS 413.552(4), then who is responsible for covering the cost of interpretation services? The legislature's policy is to "require the use of . . . interpreters," but is silent on the question of provision. If the legislature intended the HHS Guidance to apply to all Oregon healthcare settings, not only those that re-

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[107] Pop up window on www.LEP.gov that must be accepted by clicking "OK," prior to entering the site (last visited Mar. 31, 2019).

[108] Memorandum from Kara Olsen, Dep't of Consumer & Bus. Servs, Mgmt.-Labor Advisory Comm., Interpreter Services Study – Background Information, at 2 (Jul. 23, 2009) (on file with author and available from WC Div.) [hereinafter *Interpreter Servs. Study*].

[109] Human Services; Juvenile Code; Corrections.

[110] Or. Rev. Stat. §§ 413.550 to 413.560 (2019).

[111] *Diversity of OR's Health Care Workforce, supra* note 4; Or. Rev. Stat. § 413.552(4).

[112] *Diversity of OR's Health Care Workforce, supra* note 4; *see also* Or. Admin. Rule 333-002-0000.

[113] Or. Rev. Stat. § 413.552(3), (emphasis added) ("It is the policy of the Legislative Assembly to *require the use of* certified health care interpreters or qualified health care *interpreters whenever possible* to ensure the accurate and adequate provision of health care to persons with limited English proficiency . . .").

ceive federal funding, it is possible that it also intended that medical providers should provide "meaningful [language] access" at their own expense, through the provision of health care interpreters. However, the HHS Guidance suggests other ways that a recipient of federal funding could provide "meaningful access," including by hiring of bilingual staff—something not mentioned in the Oregon law.

Deciding who needs to cover mandatory interpreters in Oregon is an issue that it appears the legislature intended to skirt. Assuming that private doctors need to pay for interpreters, providing interpreters could be burdensome—especially on small family practices. Because private businesses have more discretion about whom they serve than publicly-funded hospitals, private doctors' offices might stop accepting LEP patients altogether.[114] In *Colwell v. Department of Health & Human Services*, 558 F.3d 1112 (9th Cir. 2009), a physician—with the help of ProEnglish[115]—brought a pre-enforcement challenge to the HHS Guidance regarding the obligation to provide LEP patients with access to HHS funded programs.[116] Colwell alleged that the HHS Guidance "interfere[d] with his one-on-one physician patient relationship by eliminating his professional judgment on how best to communicate with his patients, compel[ed] him to speak in a specific manner not of his choosing, and force[d] him to translate . . . at his own cost."[117] He also alleged that complying with the "translation requirement is extremely onerous and the cost will be prohibitive."[118] Although ultimately dismissed as unripe, *Colwell* represents a resistance by some physicians to the requirement to ensure "meaningful access" to LEP persons.

Oregon PIP, on the other hand, has a statutory maximum coverage of $15,000. Any additional cost incurred due to covering language interpretation services could exhaust PIP benefits more quickly, but would not cost the insurer more, nor would it bestow any special benefits on LEP insureds. In fact, as discussed above, utilizing interpreters can actually decrease medical costs overall, by minimizing the use of unnecessary diagnostic tools and by avoiding costly pitfalls caused by miscommunication. "As a condition to driving an automobile—a virtual necessity for most Americans,"[119] LEP individuals are mandated to purchase liability and PIP insurance. The "insurance-buying public" includes LEP Oregonians, who are just as entitled to the benefits promised by PIP. The purpose of PIP is to reduce litigation and

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[114] This would, however, likely run afoul of Oregon Public Accommodations Law. "[A]ll persons within the jurisdiction of [Oregon] are entitled to the full and equal accommodations, advantages, facilities and privileges of any place of public accommodation, without any distinction, discrimination or restriction on account of race, color, . . . national origin . . . ." Or. Rev. Stat. § 659A.403(1) (2017). Section 3 of this law makes "[i]t is an unlawful practice for any person to deny full and equal accommodations, advantages, facilities and privileges of any place of public accommodation in violation of this section." Or. Rev. Stat. § 659A.403(3) (2017).

[115] ProEnglish, *supra* note 103.

[116] *Colwell v. Dep't of Health & Human Servs.*, 558 F.3d 1112 (9th Cir. 2009).

[117] *Id.* at 1120.

[118] *Id.*

[119] *Wooley v. Maynard*, 430 U.S. 705 (1977).

"ensure that all insured drivers, their families and guests, and pedestrians injured by them, would recover medical and economic losses subject to limits purchased without regard to fault."[120] Medical interpretation costs facilitate communication between injured LEP insureds and their healthcare providers and are therefore expenses incurred in connection with, and vitally related to, reasonable and necessary medical services.

In October 2008, the Oregon Workers' Compensation Division began a study to determine how pervasive the need for interpreter services was within the WC system and to provide recommendations.[121] The study found that in 2008, Department of Consumer and Business Services received over 6,000 calls by LEP persons, over 4,000 of which were WC-related; Oregon OSHA received approximately 500 calls from LEP persons; and the WC Board received over 1,000 calls by LEP persons and provided an unspecified amount of interpreters in WC hearings.[122] The study found that the calls were fielded by "in-house" bilingual staff, and also looked at how Oregon WC language access requirements and practices compared to other states. In a state-by-state comparison, the study found that states were all over the board: in seven to eleven states, the insurer paid for interpreters; in eight states, the insurer paid for an interpreter at hearings; in eight to fourteen states, the decision to pay was at the discretion of the insurer ("insurer decision"); in two states the state itself paid for the interpreters "as a courtesy;" one state allowed for the borrowing of bilingual state workers for occasional courtesy telephonic interpretation; and, at the other end of the spectrum, nine states required workers to provide their own interpreters.[123]

The WC study also found that "interpreters [we]re widely used and needed in the workers' compensation system" and that many insurers were "already paying for interpreter services when needed."[124] Interpreter services were provided and paid for by the insurer at medical arbiter and independent medical exams,[125] and during the appeals process, interpreters were provided through the Oregon Judicial Department.[126] Workers typically had access to interpreter services during the claims process and sometimes through insurer staff. Many workers were using interpreter services provided through the WC Division, or would rely on in-house interpreters at medical offices when available or on family and friends. "The most apparent need for interpreter services" in the WC system "emerged . . . surrounding medical treatment and exams."[127]

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[120] *Monaco v. U.S. Fidelity & Guar.*, 550 P.2d 422, 424 (Or. 1976) (en banc); *see also* Senate Judiciary Committee Minutes 2 (May 19, 1971); House Judiciary Committee Minutes 8 (Apr. 17, 1973).

[121] Olsen, *Interpreter Servs. Study*, *supra* note 108, at 1.

[122] *Id.* at 1 (as required by OR. REV. STAT. § 45.273 (2019)).

[123] *Id.* at 3.

[124] Olsen, *Interpreter Servs. Study*, *supra* note 108, at 1.

[125] *Id.* at 1 (as per Or. Admin. Rule 436-009-0015 and 436-009-0070).

[126] *Id.* at 1.

[127] *Id.*

Oregon's PIP today finds itself in much the same situation as the WC system did in 2008. "[M]edical services present[ ] the biggest opportunity for a gap in communications to occur. There is no requirement for interpreter services to be provided and paid for under current . . . statute or rule."[128] At the time of the WC study, many WC insurers said "they already p[aid] for interpreter services [ ] as needed as part of their claim costs." The same is true for PIP today. Although PIP insurers in some cases cover interpreter services, Oregon is currently in an "insurer decision" phase of the law. Nothing in PIP law prevents the insurer from providing more favorable benefits than required by law.[129] This leaves injured LEP insureds at the mercy of their insurer. Oregon's PIP is modeled after WC in two respects: (1) it is a no-fault insurance system, and (2) it follows the WC fee schedule set by the Department of Consumer and Business Services. Although following the WC fee schedule does not establish "limitations on services and benefits" allowed by PIP,[130] PIP would do well to follow the WC system's lead in establishing statutory or regulatory guidelines for the provision of language access services for LEP insureds.

In practice, common wisdom among Oregon personal injury attorneys is that insurers generally cover interpreter services when faced with an injury suit, lest they find themselves on the wrong side of a wrongful denial claim under 742.061.[131] This is evidenced by lack of litigation on the subject—insurers usually pay for interpreting services in settlement, rather than take the issue of the medical necessity of interpreting services to trial. There is not a lot of upside to insurers challenging these expenses—they are a small fraction of overall costs and could potentially draw negative attention to the insurer.[132] While this is helpful for injured LEPs with attorneys, it leaves others unprotected.

One solution suggested by Chief Justice Walters in her dissent in *Dowell* (for transportation expenses), is that doctors could simply "prescribe" interpreting services for LEP patients.[133] While it is a good idea, many doctors would not think to prescribe such an elementary need.[134]

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[128] *Id.*

[129] Or. Rev. Stat. § 742.532 (2017) states that "[b]enefits may be more favorable than those required" by PIP statutes.

[130] Or. Dept. of Consumer & Bus. Servs., Ins. Div., Oregon Insurance Division Bulletin INS 2003-7, Revision to Bulletin INS 2003-7 Originally Issued on November 10, 2003 C- Change in PIP Benefits under HB 3668 (ch. 813 Oregon Laws 2003), at 2 (Feb. 13, 2004), https://dfr.oregon.gov/laws-rules/Documents/Bulletins/bulletin_2003-07.pdf, *archived at* https://perma.cc/84CQ-B59G.

[131] Email from Nathan Sosa, *supra* note 19.

[132] E-mail from Ben Cox, personal injury attorney with Cox Law, to Julie Preciado, 2L at Willamette University College of Law (Apr. 4, 2019) (on file with author).

[133] *Dowell*, 388 P.3d at 1070 (J. Walters, dissenting) ("Perhaps those in need will be able to seek, and caring physicians will take the time to write, prescriptions for transportation to secure specialized medical care. After all, there is no conceptual difference between a physician's direction to obtain medication and a physician's direction to obtain transportation.").

[134] Additionally, even if a medical provider or interpretation provider decided to go the route of this practical solution of "prescribing" interpreting services, "whether a particular treatment or care plan chosen by a provider is 'medically necessary' to treat an insured's inju-

Moreover, language interpreting service providers, knowing that their invoices will likely be denied, may not provide services for medical appointments unless the provider covers the expense. Another possibility is that the Oregon Supreme Court could hold that interpreting services are of the kind that "that originate with, or that are actuated by, the rendered medical treatment or the physician's performance of work."[135] It is even possible that health care interpreters themselves could be deemed "providers" within the meaning of ORS § 743.801[13], as they are "person[s] licensed, certified or otherwise authorized or permitted by laws of this state to administer medical . . . services[136] in the ordinary course of business or practice of a profession."[137] "Or, perhaps, the legislature will take time from other pressing matters to expressly instruct insurers that 'expenses of medical . . . services' include the reasonable and necessary costs of [medical interpreting services] to procure those services."[138] In the meantime, the chilling effect on service provision leaves many LEPs struggling to understand their doctors with their limited abilities and resources.

VI. Conclusion

To deny PIP coverage of interpreting services would undermine the purpose of the PIP statute because it would prevent many injured LEP persons from getting prompt medical treatment. While the Oregon Supreme Court in *Dowell* considered the related issue of whether statutory PIP coverage included transportation expenses, it did not fully address the question of whether inclusion of transportation supported or violated the "liberal construction" maxim of benefitting the insurance-buying public. "We need not delve into the origin, validity, and effect of the 'liberal construction' maxim of statutory construction, because we need not apply it in this case."[139] Whether the Court would find language interpreting services to be a "reasonable and necessary expense of medical . . . services" is yet to be seen. Language access, however, arguably implicates much higher stakes than transportation to and from medical appointments. Still, it would be hard to argue with a straight face that it is good public policy to limit LEPs to only whatever care happens to be available to them with their particular language proficiency.[140] If rural insureds are burdened by not being able to get to the

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ries is generally a question of fact." 12 Couch on Ins. § 171:61. "The treating physician's opinion that a particular procedure or treatment is necessary is accorded deference but is not dispositive of the issue. An insurer may deny a claim based on its own determination that the treatment is not necessary." *Id.*

[135] *Dowell*, 388 P.3d at 1059.

[136] Or, at the very least, medically-adjacent services.

[137] For an explanation of the majority approach regarding PIP coverage of transportation, see *supra* note 41.

[138] *Dowell*, 388 P.3d at 1070 (although originally referring to expenses related to transportation to and from medical appointments).

[139] *Id.* at 1057, n.6.

[140] Cox, *supra* note 132 (reinforcing this idea).

specialty practitioners in centralized urban hubs, imagine the burden faced by LEPs who cannot receive adequate care because they cannot communicate with their doctors, even when they are able to get to their appointments. Furthermore, language access provision has the force of both federal and state law behind it. Oregon's PIP should cover interpreter services for LEPs, because they are medically necessary and because Title VI, in the case of federally-financed programming or activities, and state law require meaningful access to all those residing in Oregon, regardless of national origin or English language ability.