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Low English Proficiency in the United States Associated with Reduced Healthcare Access Under the Affordable Care Act

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LOW ENGLISH PROFICIENCY IN THE UNITED STATES ASSOCIATED WITH REDUCED HEALTHCARE ACCESS UNDER THE AFFORDABLE CARE ACT

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From 2014-2018, the US Census Bureau reported that 8.3 percent of Americans had limited English proficiency (LEP), defined as speaking English less than very well. Section 1557 of the Affordable Care Act (ACA) ensures meaningful access to care for individuals with LEP. This research aims to identify the current relationship between LEP and healthcare access. Data used in this study were obtained from electronic files from the 2019 Full Year Consolidated File of the Medical Expenditure Panel Survey, or MEPS. Binary logistic regression was used to analyze the relationship between insurance coverage and whether an individual speaks another language at home, was born in the USA, their sex, whether they could afford medical care, their ethnicity, their poverty category, and how well they speak English. A total of 21,722 participants were included in the analysis. A total of 5,274 participants spoke another language, other than English, at home and were therefore asked to self-report on their LEP, with 27.7 percent reporting LEP. When controlling for all other variables, Hispanic/Latino individuals in the same had 2.7 times higher odds of being uninsured compared to non-Hispanic/Latino individuals. Those not born in the U.S. had 1.45 times higher odds of not being insured versus those born in the U.S. Those who spoke another language at home had 1.59 times higher odds for being uninsured than those who only spoke English. In the initial years of ACA's implementation, the racial and ethnic disparities in healthcare access were significantly reduced. Still, however, all of the disparities have not been erased.

Background | From 2014-2018, the US Census Bureau reported that 8.3 percent of Americans had limited English proficiency (LEP), defined as speaking English less than very well.[1] Given that nearly 10 percent of Americans have LEP, studying the relationship between LEP and access to medical care is valuable. Title VI of the Civil Rights Act of 1964 dictated that recipients of federal financial assistance must make their services accessible for eligible individuals with LEP; these services include health insurance.[2] Nevertheless, surveys indicate that subpopulations of US Hispanics with LEP had less access to medical care and use of preventive services.[3] One of the goals of the 2010 Affordable Care Act (ACA) was to reform access to medical care.[4] Section 1557 of this act ensures meaningful access to care for individuals with LEP.[5] Section 1557 of the ACA requires health programs and activities that receive funding from or are part of the United States Department of Health and Human Services to develop plans to increase accessibility for people with LEP.[6] In the years after the ACA, the relationship between healthcare access and English proficiency decreased, resulting in a reduced disparity in access among individuals with LEP.[7] A study in 2020 reported that uninsurance for respondents with LEP decreased by nearly 5 percent in the 6 years after the passage of the ACA.[8] Notably, however, immediately following these 6 years of progress, the number of uninsured increased from 2016-2019, reversing gains in Hispanic insurance coverage that had been increasing after the passage of the ACA.[9]

Methods | Data used in this study were obtained from electronic files from the 2019 Full Year

Consolidated File of the Medical Expenditure Panel Survey, or MEPS. MEPS is conducted by the Agency for Healthcare Research and Quality (AHRQ) and collects data from Americans on the specific health services they use, how often these services are used, the cost of said services, how services are paid for, as well as health insurance data. The survey collects demographic information, healthcare utilization, health status, and healthcare expenditures. Our analyses included participants over the age of 18, as numerous health insurance programs, such as Medicaid and CHIP, exist for those under 18. Binary logistic regression was used to analyze the relationship between insurance coverage and whether an individual speaks another language at home, was born in the USA, their sex, whether they could afford medical care, their ethnicity, their poverty category, and how well they speak English. Logistic regression is used to test multivariate associations between two or more independent/predictor variables and a binary/categorical variable. All variables were recoded to binary variables prior to analysis. Insurance coverage (variable code: INSCOV19) was recoded with any insurance coverage, public or private, as the reference category and uninsured as the variable of interest (coded as 1). Whether an individual speaks another language at home (OTHLGSPK) was recoded with "no" as the reference category and "yes" as the variable of interest. Born in the USA (BORNUSA) was recoded with "yes" as the reference category and "no" as the variable of interest Gender (SEX) was recoded with male as the reference category and female as the variable of interest. Not being able to afford care (AFRDCA42) was recoded with "no" as the reference category and "yes" as the variable of interest. Ethnicity (RACETHX) was recoded with all non-Hispanic/Latino variables as the reference category and Hispanic/Latino as the variable of interest. Poverty level was recoded with middle income or high income as the reference category and low income, near poor and poor/negative as the variable of interest. How well someone speaks English (HWELLSPK) was recoded with "well" or "very well" as the reference category and "not well" or "not at all" as the variable of interest.

Results | A total of 21,722 participants were included in the analysis. Of these, 19,638 (90.4%) were insured through either private or public health insurance providers, with the remainder being uninsured (Table 1). A total of 5,274 participants spoke another language, other than English, at home and were therefore asked to self-report on their LEP, with 27.7 percent reporting LEP (Table 2). LEP individuals were individuals that responded that they could speak English "not well" or "not at all." The results of the binary logistic regression can be found in Table 3. When controlling for all other variables, individuals not born in the U.S. had 1.45 times higher odds of not being insured (95% CI 1.259-1.667) versus those born in the U.S., $p < 0.001$. Individuals who spoke another language at home had 1.59 times higher odds for being uninsured (95% CI 1.344-1.88) than those who only spoke English, $p < 0.001$. Females had 41% lower odds of being uninsured (95% CI 0.529-0.649) versus males, $p < 0.001$. Individuals who could not afford medical care had 4.32 higher odds of being uninsured (95% CI 3.728-4.993) than those who could afford medical care, $p < 0.001$. Hispanic/Latino individuals had 2.7 times higher odds of being uninsured (95% CI 2.342-3.12) compared to non-Hispanic/Latino individuals, $p < 0.001$. Individuals who did not speak English or did not speak it well had 1.89 higher odds of being uninsured (95% CI 1.582- 2.250) when compared to those who speak English well or very well, $p < 0.001$.

Discussion | The goal of this cross-sectional study was to determine the utilization of health insurance by people with Limited English Proficiency nine years after the passage of the ACA. After the passage of the ACA in 2010, disparities in health care access by English proficiency narrowed.[8] Our analysis used data from 2019. Furthermore, between 2016 and 2018, insurance coverage gains stalled and began to reverse for some populations. From 2013 to 2016, uninsurance rates of individuals between 18 and 64 were decreasing rapidly. However, after 2016, the uninsurance rates began to climb again.[11] It was our aim to understand the continuation of this trend. A 2020 study that analyzed the role of LEP and access to health insurance in 2016 found that a Spanish speaker with LEP was still 60 percent more likely to be uninsured than an English speaker.[12] Of note, this study divided insurance coverage into public insurance and private insurance while our study grouped both insurance types into one. Our findings show that, in 2019, people with LEP had higher odds of being uninsured relative to individuals proficient in English. An adult with LEP had 1.89 times higher odds of being uninsured than an English proficient adult. In the initial years of ACA's implementation, the racial and ethnic disparities in healthcare access were significantly reduced.[7] Given that uninsured adults have less access to suggested care, receive

inferior care, and experience worse health outcomes than insured adults as shown by a 2002 study on the consequences of uninsurance in the United States from the Institute of Medicine, the negative impacts of uninsurance are significant.[13] Further, the relationship between LEP and insurance coverage transferred to ability to afford care. MEP data showed that 8.1 percent of individuals with LEP could not afford care, compared to only 6.1 percent of those who were English proficient. Five years after the final implementation of the ACA in 2014, adults with LEP still show disparities in insurance coverage compared to English proficient adults. This may be due to the patient-provider communication problems due to LEP as fewer patients with LEP reported that their medical provider always explains things in a way they can understand than English proficient patients did.[14]

Study Limitations

This study provides a strong sense of the impact of LEP on insurance coverage 9 years after the passage of the ACA. The MEPS dataset, which was used to conduct the study, has a high number of participants and is representative of the US population as a whole. Because of the high number of participants, analysis provides precise statistical estimates. Furthermore, this study builds on previous research on this topic. Limitations include study design; as a cross-sectional study, this research does not show the change in insurance coverage over time. However, by looking at this study along with other studies done on the relationship between LEP and insurance coverage after the passage of the ACA, a good sense of the situation can be attained. Additionally, this study does not give insight into contextual factors, social barriers, etc. that might influence why the data is what it is. It does not answer the question: why do LEP individuals have higher rates of uninsurance? The study notes a relationship but does not explain why the relationship occurred or what can be done to improve access to insurance for people with LEP. Despite these limitations, our study contributes important information about the state of insurance utilization by individuals with LEP after a period of total uninsurance increases. Our findings can inform and motivate future research on the effects of the ACA nearly a decade after its passing and how insurance coverage disparities between individuals with LEP and English proficient adults can be mitigated.

Implications for Public Health Practice

People with limited English proficiency face a number of hurdles and barriers to accessing care in the U.S. They are more likely to experience health disparities and less likely to receive adequate care when they visit health care providers.[7] Given that uninsured individuals are less likely than insured individuals to receive preventative care and have worse access to care, lack of insurance coverage can further health complications. 15 LEP individual's limited understanding of the English language contributes to lower health literacy, further challenging their communication with health care providers during receipt of care. Patient-provider communication may also be hindered due to cultural differences in LEP patient populations, and there may be fewer community support resources available to them when compared to English proficient populations.[7] Increasing health insurance coverage among LEP populations is only one piece of the puzzle. It is important that public health professionals work directly with LEP populations to explore these barriers and disparate outcomes and work through a lens of cultural humility to improve both access to care and the quality of care received.[16]

Table 1: *Characteristics of Adults in the United States by Insurance Status (Medical Expenditure Survey Panel 2019)*

	Insured	Uninsured
n	*19824*	*1898*
	Percentages	
Language(s) Spoken at		
Home English Only	78.3%	47.7%
Another Language	21.6%	51.9%
English Proficiency (Only If Another Language Spoken)	16.5%	28.9%
English Proficient	5.2%	23.0%
Low Proficiency		
Ethnicity	82.4%	50.3%
	17.6%	49.7%
Not Hispanic/Latino	82.9%	60.2%
Hispanic/Latino	17.0%	38.9%
Country of Birth		
Born in the US	45.9%	55.1%
Born Outside the US	54.1%	44.9%
Sex/Gender	94.2%	78.9%
	5.0%	17.9%
Male		
Female	69.4%	45.8%
	30.6%	54.2%
Ability to Afford		
Healthcare Could		
Afford Could Not		
Afford		
Income		
Middle/High Income		
Poor/Negative, Near Poor or Low Income		

Table 2: *Characteristics of Adults in the United States by English Proficiency (Medical Expenditure Survey Panel 2019)*

	English Proficient	Low English Proficiency
n	*3811*	*1463*
	Percentages	
Insurance Coverage		
Insured	85.6%	70.1%
Uninsured	14.4%	29.9%
Ethnicity		
Not Hispanic/Latino	38.4%	17.3%
Hispanic/Latino	61.6%	82.7%
Country of Birth		
Born in the USA	46.2%	5.1%
Born Outside the USA	53.5%	93.8%
Sex		
Male	48.7%	38.7%
Female	51.3%	61.3%
Ability to Afford Care		
Could Afford	93.0%	91.3%
Could Not Afford	6.1%	8.1%
Income		
Middle/High Income	63.2%	38.1%
Poor/Negative, Near Poor or Low Income	36.8%	61.9%

Table 3: *Adjusted Odds Ratios (AOR) for Being Uninsured, by English Proficiency (Medical Expenditure Survey Panel 2019)*

	All respondents			Respondents Who Speak Another Language at Home		
	AOR	95% CI	P-Value	AOR	95% CI	P-Value
Speak Another Language at Home (Reference: Speak English Only at Home)	1.59	1.34-1.88	< 0.001	-	-	-
Low English Proficiency (Reference: English Proficient)	-	-	-	1.89	1.58-2.25	< 0.001
Hispanic/Latino (Reference: Not Hispanic/Latino)	2.70	2.34-3.12	< 0.001	3.31	2.70-4.07	< 0.001
Born Outside the US (Reference: Born in the US)	1.45	1.26-1.67	< 0.001	1.19	0.99-1.42	0.063
Poor/Negative, Near Poor, or Low Income (Reference: Middle or High Income)	2.09	1.88-2.31	< 0.001	1.52	1.30-1.77	< 0.001
Female (Reference: Male)	0.59	0.53-0.65	< 0.001	0.61	0.52-0.71	< 0.001
Could Not Afford Care (Reference: Could Afford Care)	4.31	3.73-4.99	< 0.001	3.34	2.62-4.25	< 0.001

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