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Health Insurance Coverage and Access to Care Among Asian Americans, Native Hawaiians, and Pacific Islanders: Recent Trends and Key Challenges

Asian Americans, Native Hawaiians, and Pacific Islanders (AANHPIs) experienced larger relative gains in health insurance coverage than any other racial or ethnic group in the United States since the Affordable Care Act was enacted in 2010.

KEY POINTS

- The uninsured rate for the non-elderly AANHPI population decreased from 16.6 percent in 2010 to 6.2 percent in 2022, representing an increase of 4.6 million AANHPIs with coverage. This 63 percent reduction in the uninsured rate was the largest relative improvement in health care coverage among any racial or ethnic group during this time period.
- Gains in health insurance coverage since 2010 have closed the coverage gap between AANHPIs and non-Latino Whites that existed prior to the implementation of the Affordable Care Act.
- Uninsured rates vary greatly among non-elderly AANHPI subgroups, ranging from 3.6 percent for Japanese Americans to 7.8 percent for Korean Americans and 12.4 percent for Native Hawaiians and Pacific Islanders in 2022.
- AANHPI Americans enroll in Marketplace health insurance coverage at rates far higher than their share of the overall population. More than 1.5 million AANHPI Americans selected Marketplace plans in 2023 (9 percent of Marketplace plan selections compared to 6 percent of the population).
- A total of 4.5 million AANHPI Americans were enrolled in Medicaid comprehensive benefits in 2020 including 1.6 million AANHPIs who were enrolled via the Medicaid expansion pathway.

INTRODUCTION

Asian Americans, Native Hawaiians and Pacific Islanders (AANHPIs) comprised 6.0 percent of the total U.S. population in 2022 and are the fastest growing racial group in the United States.[i] The AANHPI population grew from 15.0 million to 20.0 million between 2010 and 2022, an increase of 33.0 percent, compared to 7.7 percent population growth for the nation as a whole.[1] The largest AANHPI subgroups in 2022 were Asian Indian (4.5 million), Chinese (4.2 million), Filipino (2.9 million), Vietnamese (1.9 million), Korean (1.5 million),

[i] AANHPI in this issue brief refers to non-Latino Asian American, Native Hawaiians, and Pacific Islanders. The number of AANHPIs in this issue brief is measured as the number of non-Latino Asian Americans alone without another race and non-Latino Native Hawaiians and Pacific Islanders alone without another race. Among all AANHPIs the percentage of Latino Asian Americans was 1.4 percent and the percentage of Latino Native Hawaiians and Pacific Islanders was 11.3 percent in 2022.

Japanese (0.7 million), and Native Hawaiian and Pacific Islanders (NHPI, 0.5 million).[ii] About 27 percent of the 46.2 million people in the U.S. born in another country were AANHPI in 2022 and the number of AANHPI Americans born in another country increased by 28 percent between 2010 and 2022.[2]

This Issue Brief is part of a series of ASPE Issue Briefs examining the change in coverage rates among select racial and ethnic populations after implementation of the Affordable Care Act (ACA) and the American Rescue Plan (ARP) and the Inflation Reduction Act (IRA). It is an update to an ASPE brief released in 2021.[3] This brief uses federal survey data from 2010 to 2022 to analyze changes in health insurance coverage and access to and affordability of care among AANHPIs.

DATA SOURCES AND METHODS

This Issue Brief presents data from several federal data sources. Estimates of insurance coverage estimates are from the American Community Survey (ACS), the largest national survey of households, which is conducted by the Census Bureau. The Census Bureau surveys almost 300,000 households each month for the ACS and collects health insurance and demographic information, including race and ethnicity, along with other types of information. This brief used ACS data for selected years between 2010 and 2022 for population, health insurance coverage and demographic estimates. Individuals were defined as uninsured if they did not report having private health insurance, Medicare, Medicaid, the Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plan, or military plan at the time of interview; respondents also were defined as uninsured if they only had Indian Health Service coverage.

Our population estimates combine the total number of non-Latino Asian Americans alone without another race and the total number of non-Latino Native Hawaiian and Pacific Islanders (NHPIs) alone without another race. Throughout the brief, we use the term "Asian Americans, Native Hawaiians, and Pacific Islanders" for estimates encompassing both groups, and "Asian Americans" and "Native Hawaiians and Pacific Islanders," respectively, for estimates for each of those groups separately. It is important to note that some data sources that report data for Asian Americans do not report data for NHPIs due to small sample sizes for the latter population. This brief uses the term "Latino" to refer to all individuals of Hispanic or Latino origin.

We assess trends in several self-reported measures of health care access for AANHPI Americans using data from the National Health Interview Survey (NHIS) for the years 2010-2022. The health care access measures we analyze are: not having a usual source of care, delaying medical care due to cost, delaying prescription refills to save money and worrying about medical bills.

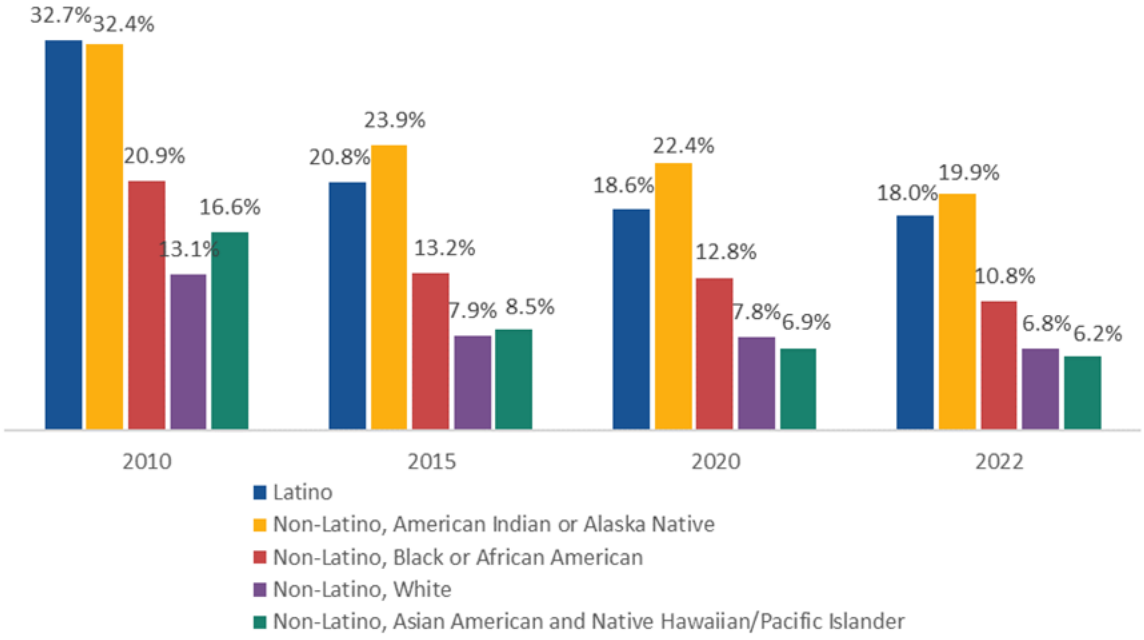
HEALTH COVERAGE

Figure 1 presents estimates of the uninsured rate for selected years from 2010, the year the ACA was enacted but before the main coverage provisions went into effect, and 2022, the most recent year for which ACS data are available. The uninsured rate among the nation's non-elderly AANHPI population, ages 0-64, decreased from 16.6 percent in 2010 before the full implementation of ACA provisions to 6.2 percent in 2022, a drop of

[ii] The Census includes Chinese, Hmong, Japanese, Korean, Mongolian, Okinawan, and Taiwanese under East Asian, Asian Indian, Bangladeshi, Bhutanese, Maldivian, Nepalese, Pakistani, Sikh, Sinhi, and Sri Lanken under South Asian, Bruneian, Burmese, Cambodian, Filipino, Indonesian, Laotian, Malaysian, Mien, Singaporean, Thai, and Vietnamese under Southeast Asian, and Afghan, Kazakh, Kyrgyz, Tajik, Turkmen, and Uzbek under Central Asian, for a total of 33 Asian subgroups. Under Native Hawaiian and Other Pacific Islanders, the Census includes Cook Islander, East Islander, French Polynesian, Maori, Native Hawaiian, Niuean, Polynesian, Rotuman, Samoan, Tahitian, Tokelauan, Tongan, Tuvaluan, and Wallisian and Futunan under Polynesian, Fijian, Melanesian, New Caledonian, Ni-Vanuatu, Papua New Guinean, and Solomon Islander under Melanesian, and Carolinian, Chamorro, Chuukese, Guamanian, I-Kiribati, Kosraean, Mariana Islander, Marshallese, Micronesian, Nauruan, Northern Mariana Islands, Palauan, Pohnpeian, Saipanese, and Yapese under Micronesian, for a total of 36 NHPI subgroups.

almost two-thirds (63 percent). This was the largest relative decrease[iii] in the uninsured rate from 2010 to 2022 among racial and ethnic demographic groups, followed by Blacks and non-Latino Whites (48 percent), Latino (45 percent), and American Indians and Alaskan Natives (AI/AN, 39 percent). By 2022, the uninsured rate for AANHPIs was slightly lower than the rate for non-Latino Whites and the difference is statistically significant. The estimated number of AANHPI Americans with health coverage increased by 4.6 million from 2010 to 2022.

Figure 1. Uninsured Rates for Non-Elderly US Population by Race and Ethnicity Selected Years from 2010-2022

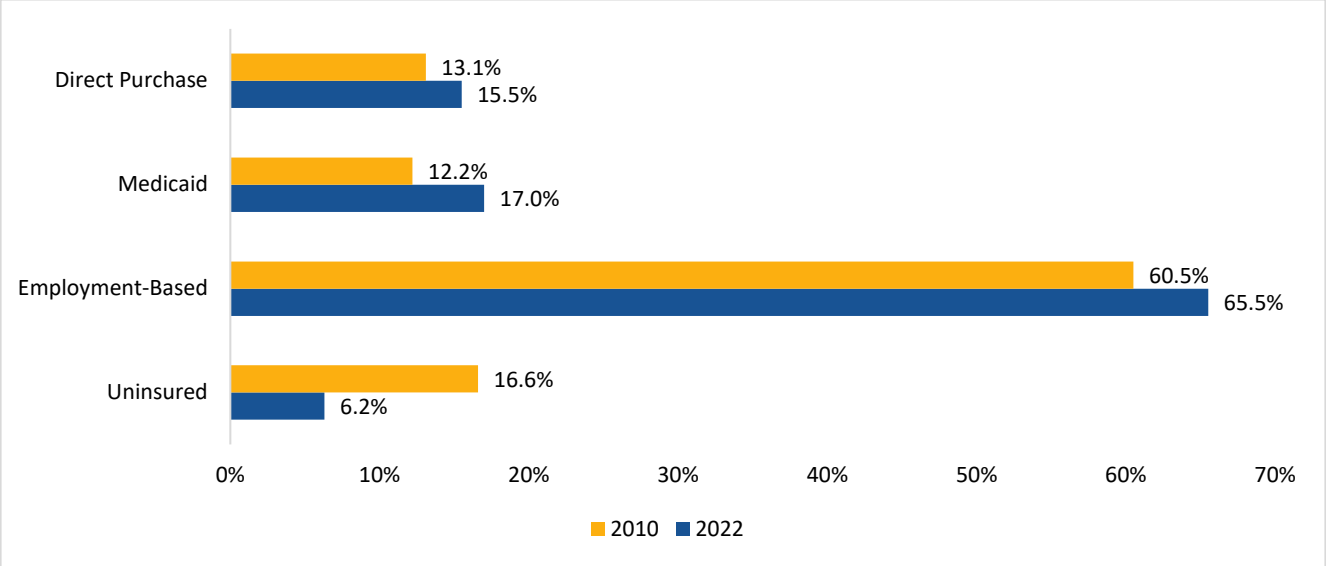


Source: 2010-2022 American Community Survey.
Notes:
In this analysis, individuals were defined as uninsured if they did not have any private health insurance, Medicare, Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government plan, or military plan. Individuals were also defined as uninsured if they had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. Data are based on household interviews of a sample of the civilian non-institutionalized population. Non-Latino Black Americans are defined as anyone who identified as non-Latino Black or African American alone without any other race. Non-Latino American or Alaskan Native are Non-Latino American Indians and Alaska Natives. Non-Latino Asian American Native Hawaiian/Pacific Islander are Non-Latino Asian Americans, Native Hawaiians, and Pacific Islanders alone without another race. Due to pandemic-related survey collection concerns, the Census Bureau urges caution when comparing the experimental 2020 ACS dataset to previous years. Results are ACS survey-weighted estimates.

Non-elderly AANHPIs gained insurance through all sources of coverage from 2010 to 2022, as shown in Figure 2. Direct purchase is health insurance purchased as an individual rather than through an employer or other group and since 2014 includes insurance purchased through the ACA Marketplaces. The percentage of AANHPIs with such coverage increased from 13.1 percent to 15.5 percent between 2010 and 2022. AANHPI Medicaid enrollment increased from 12.2 to 17.0 percent over this period and employment-based insurance coverage increased from 60.5 to 65.5 percent.

[iii] These percentage decreases show relative declines from 2010. In absolute percentage point reductions in uninsured rates, Latino and AI/AN populations, which had the highest uninsured rates in 2010, experienced the largest gains in coverage.

Figure 2: Sources of Coverage for Non-Elderly AANHPI Population, 2010 and 2022



Source: 2010 and 2022 American Community Surveys

Table 1 shows uninsured rates of non-elderly AANHPIs by income levels and age groups for 2010, 2015, 2020, and 2022. The two lowest income levels (0 to 100 percent of the Federal Poverty Level (FPL) and 101 to 200 percent FPL had the highest reduction in uninsured rates. The income eligibility limit for Medicaid expansion is 138 percent FPL and Marketplace premium tax credits are more generous for lower income levels. The age group 19-25 had the highest reduction in uninsured rates (70.3 percent) from 2010 to 2022. To help cover young adults, who had the highest uninsured rates, the Affordable Care Act (ACA) allowed parents to keep their children on their health plans up to age 26 even if the children do not live with the parents or are not students or tax dependents. This provision was effective September 23, 2010 and has provided coverage to millions of young adults.[4]

Coverage rates vary considerably by non-elderly AANHPI subgroup, with uninsured rates of 3.6 percent for Japanese Americans, 3.8 percent for Indian Americans, 4.9 percent for Chinese Americans, 4.0 percent for Filipino Americans, 7.2 percent for Vietnamese Americans, 7.8 percent for Korean Americans, and 12.4 percent for Native Hawaiian and Pacific Islander Americans (NHPIs) in 2022.[5] Differences among AANHPI subgroups can be explained at least in part by variation in employment, employer size, and income.[6] For example, Korean and Vietnamese Americans are more likely to be self-employed – 7.6 percent for Korean Americans and 9.1 percent for Vietnamese Americans, compared to 5.2 percent for Asian Americans, 4.5 percent for NHPIs, and 6.2 percent for non-Latino Whites in 2022.[7] All AANHPI subgroups reduced their uninsured rates substantially between 2010 and 2022.

Currently, among AANHPI subgroups, only NHPIs have double-digit uninsured rates (12.4 percent). This is a substantial change from pre-ACA data when all subgroups except for Japanese Americans had uninsured rates of at least 10 percent.

English proficiency is correlated with insurance coverage. AANHPIs who don't speak English had the highest uninsured rates in 2010 – 2022, followed by AANHPIs who don't speak English well, although all AANHPI groups had significant decreases in uninsured rates.

Table 1. Uninsured Rates for Non-Elderly AANHPIs, Selected Years (2010, 2015, 2020, 2022)

	AANHPI Share in 2022	2010	2015	2020	2022
Percentage of Poverty Level					
0-100	11.2%	28.4%	16.1%	13.1%	11.4%
101-200	11.2%	29.1%	14.8%	12.5%	10.8%
201-400	23.0%	19.2%	10.1%	9.1%	8.2%
>400	54.6%	7.1%	3.5%	3.5%	3.5%
Age Group					
0-18	23.5%	8.2%	4.3%	3.6%	3.9%
19-25	10.6%	26.3%	11.6%	9.1%	7.8%
26-34	16.7%	19.5%	10.9%	8.9%	8.0%
35-50	29.7%	17.1%	8.7%	7.0%	6.5%
50-64	19.5%	19.4%	9.5%	7.7%	6.7%
AANHPI Subgroups					
NHPI	2.5%	17.0%	10.1%	12.0%	12.4%
Korean	7.4%	26.6%	11.7%	9.0%	7.8%
Pakistani	2.8%	21.8%	11.6%	8.0%	7.2%
Vietnamese	9.3%	20.1%	9.3%	8.0%	7.2%
Chinese	22.4%	14.1%	6.7%	5.3%	4.9%
Filipino	14.5%	11.3%	6.6%	5.9%	5.0%
Asian Indian	22.8%	11.0%	5.1%	4.1%	3.8%
Japanese	3.0%	7.0%	4.1%	3.9%	3.6%
English Proficiency					
Does not speak English	1.6%	40.8%	23.6%	16.8%	14.1%
Yes, but not well	7.4%	33.0%	17.4%	11.8%	10.9%
Yes, well*	85.6%	14.8%	7.5%	6.5%	5.8%

Source: 2010, 2015, 2020, and 2022 American Community Surveys. *Speaking well includes (only speaking English, speaking well, and speaking very well).

Uninsured Rates by State

Non-elderly AANHPIs as percentage of state population and their uninsured rates in 2010 and 2022 are shown in Table 2. California, New York, Texas, New Jersey, and Washington State have the largest number of AANHPI Americans. AANHPIs in these five states all had double digit percentage decreases in uninsured rates between 2010 and 2022.

Table 2. Non-Elderly AANHPI Uninsured Rates by State, 2010 and 2022

State	Number (2022)	AANHPI Share (2022)	2010 Uninsured Rate	2022 Uninsured Rate	Percentage Point Change
Alabama	70,396	1.7%	21.8%	11.5%	-10.3
Alaska	**				
Arizona	243,550	4.1%	13.7%	6.6%	-7.1
Arkansas	**				
California	5,091,993	15.5%	16.4%	4.1%	-12.3
Colorado	175,236	3.6%	18.7%	8.1%	-10.7
Connecticut	157,805	5.3%	12.2%	6.2%	-6.1
Delaware	**				
District of Columbia	**				
Florida	547,226	3.1%	25.8%	9.0%	-16.8
Georgia	439,574	4.7%	26.9%	9.9%	-17.0
Hawaii	467,202	40.8%	8.4%	4.4%	-4.0
Idaho	**				
Illinois	649,536	6.2%	16.9%	8.5%	-8.3
Indiana	161,129	2.8%	16.6%	8.1%	-8.5
Iowa	75,201	2.9%	13.7%	5.2%	-8.4
Kansas	82,176	3.4%	15.9%	12.2%	-3.8
Kentucky	**				
Louisiana	72,151	1.9%	26.5%	10.7%	-15.8
Maine	**				
Maryland	341,384	6.7%	14.5%	5.5%	-8.9
Massachusetts	453,463	7.9%	3.8%	2.2%	-1.7
Michigan	301,638	3.7%	12.3%	4.7%	-7.6
Minnesota	278,003	5.9%	10.9%	6.5%	-4.4
Mississippi	**				
Missouri	124,048	2.4%	13.6%	8.1%	-5.6
Montana	**				
Nebraska	**				
Nevada	248,578	9.4%	20.2%	10.4%	-9.8
New Hampshire	**				
New Jersey	810,819	10.6%	16.2%	4.7%	-11.5
New Mexico	**				
New York	1,526,472	9.5%	17.8%	5.7%	-12.1
North Carolina	317,636	3.6%	19.2%	8.7%	-10.5
North Dakota	**				
Ohio	271,251	2.8%	12.9%	6.6%	-6.3
Oklahoma	90,105	2.7%	20.1%	11.3%	-8.8
Oregon	184,793	5.4%	17.0%	5.6%	-11.5
Pennsylvania	439,627	4.2%	14.4%	7.3%	-7.0
Rhode Island	**				

State	Number (2022)	AANHPI Share (2022)	2010 Uninsured Rate	2022 Uninsured Rate	Percentage Point Change
South Carolina	83,034	1.9%	24.2%	8.1%	-16.2
South Dakota	**				
Tennessee	126,189	2.2%	17.9%	10.6%	-7.3
Texas	1,478,381	5.7%	21.5%	9.8%	-11.7
Utah	108,812	3.7%	15.4%	14.4%	-1.0
Vermont	**				
Virginia	532,636	7.4%	16.3%	6.7%	-9.6
Washington	711,544	11.0%	16.0%	5.2%	-10.8
West Virginia	**				
Wisconsin	168,494	3.5%	13.5%	6.4%	-7.1
Wyoming	**				

Source: 2013-2022 American Community Survey.
**ACS population estimates of less than 65,000 are not shown.

Marketplace Coverage

In 2023, over 1.5 million AANHPIs selected plans in the ACA Marketplaces. AANHPIs are enrolled in health plans through the Marketplace at rates higher than their share of the U.S. population (9 percent of the Marketplace compared to 6 percent of the U.S. population). In the 33 states using HealthCare.gov in 2023, AANHPIs represented 3.6 percent of the total population but accounted for 7.6 percent of Marketplace health plan selections.[8] In the 18 State-based Marketplaces (SBM), AANHPIs represented 9.5 percent of the population but accounted for at least 14 percent of the 2023 SBM health plan selections.[9] AANHPI SBM enrollment is especially high in several states with large AAHNPI populations:

- In California (home to 30 percent of the total U.S. AANHPI population), AANHPIs comprised 25 percent of the state's 2023 Marketplace enrollees compared to 16 percent of the 2022 state population.[10]
- In New York (home to 9 percent of the total U.S. AANHPI population), AANHPIs comprised 13 percent of the state's 2023 Marketplace enrollees compared to 8 percent of the 2022 state population.[11] New York's Basic Health Program (called Essential Plan) offers health plans with no premiums or deductibles to those with household incomes less than 200 percent FPL who would be otherwise eligible to purchase insurance through the Marketplace. AANHPIs comprised more than 21 percent of Essential Plan enrollees in 2023.
- In Washington State (home to 4 percent of the total U.S. AANHPI population), AANHPIs comprised 19 percent of the state's 2023 Marketplace enrollees compared to 10 percent of the 2022 state population.[12]

The high enrollment rates of AANHPIs in Marketplace health plans may be attributed in part to the efforts of AANHPI nonprofit organizations and AANHPI insurance agents that offer enrollment assistance in Asian languages.[13] Almost three quarters (73 percent) of Asian Americans speak a language other than English at home and 30 percent of them report speaking English as less than "very well."[14] Forty percent of NHPIs speak a language other than English at home and 12 percent of them report speaking English as less than "very well."

For example, the Action for Health Justice, a network of national and local community-based organizations and Federally Qualified Health Centers, was established in July 2013 to reach and educate AANHPIs about health insurance options under the ACA.[15] The Action for Health Justice conducted outreach, education and enrollment assistance in 41 Asian languages and 1,255 media outlets from July 2013 to March 2014. In California, AANHPIs were the racial and ethnic group most likely to enroll through an insurance agent (54

percent in 2014 and 72 percent in 2023).[16,17] In 2023, 86 percent of those Californians who preferred speaking an Asian language enrolled through an insurance agent. Covered California has TV, radio, cable, newspaper, digital, and streaming ads in Mandarin, Cantonese, Korean and Vietnamese and radio ads in Hmong and Laotian.[18] The Centers for Medicare & Medicaid Services (CMS) partners with cultural marketing experts to conduct HealthCare.gov campaigns in different Asian languages to connect customers with local help and resources.[19] Nine of the 57 Navigator grantees in HealthCare.gov states in 2023-2024 were AANHPI nonprofits or had AANHPI sub-awardees or AANHPI subcontractors.[20]

To help mitigate high unemployment and potential loss of health insurance coverage during the COVID-19 pandemic, the Biden-Harris Administration opened a Special Enrollment Period (SEP) on Healthcare.gov. Starting April 2021, the American Rescue Plan Act of 2021 offers more opportunity for premium savings through enhanced and expanded eligibility for Marketplace premium tax credits, which were extended through 2025 by the Inflation Reduction Act of 2022. Under these provisions, an estimated 156,000 uninsured AANHPIs have access to zero-premium plans, and 197,000 uninsured AANHPIs have become newly eligible for premium savings for Marketplace plans. [21,22]

Medicaid Coverage

Medicaid provides coverage to millions of Americans including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. In 2020, 4.5 million AANHPI Americans were enrolled in comprehensive Medicaid benefits including 1.6 million enrolled via the ACA Medicaid expansion eligibility pathway.[23]

Eighty percent of the nation's AANHPIs lived in the 39 Medicaid expansion states and the District of Columbia, as of November 2023.[iv] In California, the state with the largest. AANHPI population, in 2022, 12.9 percent of the Medicaid expansion adult population reporting race and ethnicity was AANHPI, with 15.6 percent not reporting race or ethnicity, while the non-elderly AANHPI represented 15.5 percent of the state non-elderly population.[24]

Effective December 27, 2020, the Consolidated Appropriations Act, 2021 requires states and the District of Columbia to provide full Medicaid coverage to the citizens of the Freely Associated States living in the United States under the Compacts of Free Association (COFA) provided they otherwise meet Medicaid eligibility requirements. COFA is an agreement between the United States and the three Pacific Island sovereign states of Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau – known as Freely Associated States. Election of this coverage is optional for the U.S. territories (American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands). The extension of full Medicaid benefits to COFA migrants will further increase access to healthcare coverage for this population. In 2018, an estimated 94,000 COFA individuals lived in the U.S. and its territories.[25]

Medicaid enrollment increased in recent years due to states implementing the ACA Medicaid expansion and the continuous enrollment condition in the Families First Coronavirus Response Act of 2020 (FFCRA), which prevented states from disenrolling most Medicaid enrollees enrolled on or after March 18, 2020 as a condition for receiving a temporary increase in their federal Medicaid match rate. This condition ended on March 31, 2023 (under the Consolidated Appropriations Act, 2023) and states began returning to normal Medicaid renewal operations leading to individuals disenrolling from Medicaid (also referenced as Medicaid unwinding), which will be reflected in the 2023 and 2024 Medicaid enrollment data.

[iv] North Carolina implemented Medicaid expansion on December 1, 2023.

ACCESS TO CARE

Access to affordable, high quality, and timely health care may prevent onset of disease and help patients to avoid experiencing health complications of chronic conditions.[26] Health insurance coverage status is a critical facilitator of access to care. Having a usual source of care is associated with receipt of preventive health care and management of chronic diseases[27] and has been well documented to prevent emergency department visits and reduce unmet health needs.[28,29,30,31,32,33] However, even with health insurance, cost barriers can lead to delays in health care access associated with poorer health status.[34,35,36]

Table 3 presents several measures of access to care for AANHPIs in selected years from 2010-2022. The percentage of AANHPIs with no usual source of care decreased from 16.9 percent in 2010 to 10.1 percent in 2022, a 40.2 percent decrease. By comparison the percentage of non-Latino Whites without a usual source of care fell from 12.7 percent to 9.1 percent, a decrease of 28.3 percent (data not shown). The percentage of AANHPIs who delayed care due to cost and who delayed filling prescriptions decreased from 5.7 percent in 2010 to 4.1 percent in 2022 (a 28.1 percent decrease). This is smaller than the corresponding change for non-Latino Whites, among whom the percent who delayed care due to cost decreased from 11.3 percent in 2010 to 6.0 percent in 2022, a decrease of 46.9 percent. Throughout the whole period, many more people said that they worried about medical bills. While this measure of affordability has improved over time, in 2022 half of AANHPI adults report being worried about medical bills.

Table 3. Access to Care for Non-Elderly Non-Latino AANHPIs, Select Years (2010, 2015, 2020, and 2022)

	2010	2015	2020	2022	2010-2022
Access to Care					
No Usual Source of Care	16.9%	13.5%	8.8%	10.1%	-40.2%
Delayed Care Due to Cost	5.7%	4.0%	3.0%	4.1%	-28.1%
Worried About Medical Bills (18-64)*	55.8%	50.1%	51.7%	50.1%	-10.2%
Delayed Filling Prescriptions (18-64)*	5.7%	2.4%	5.7%	4.1%	-28.1%

Source: 2010, 2015, 2020, and 2022 National Health Interview Survey

* Data is from 2011; the first year available

Community Health Centers

The ACA provided additional funding for community health centers, which serve patients with private health insurance and public health insurance such as Medicaid or Medicare, as well as patients without health insurance. The number of AANHPI patients seen in community health centers increased from 0.9 million in 2013 to 1.2 million in 2018, an increase of 41.8 percent, compared to an increase of 31.6 percent for all patients.[37] The number of AANHPI patients seen in community health centers increased by 6.9 percent from 2018 to 2022 while the total number of patients increased by 6.3 percent. The American Rescue Plan of 2021 awarded community health centers more than $6 billion to expand health centers' operational capacity during the pandemic and beyond.[38]

Health Outcomes for AANHPIs and AANHPI subgroups

AANHPIs have the lowest adjusted death rates, the lowest overall cancer incidence rates, and the lowest or second lowest rate of risk factors for heart disease of any racial or ethnic group in the U.S.[39,40,41] However they have high rates of liver cancer and stomach cancer.[42] AANHPIs also have the highest hepatitis B-related mortality rate and incidence of tuberculosis (16.7 cases per 100,000 compared to 0.5 cases per 100,000 for

non-Latino Whites, as of 2019).[43,44]

Data on disease prevalence rates for specific AANHPI subgroups are limited, but certain select studies demonstrate large health disparities among the subgroups. The rate of diagnosed diabetes was 9.2 percent for Asian Americans, compared to 8.5 percent for non-Latino Whites in 2019-21, but as high as 12.2 percent for Filipinos and 10.2 percent for Asian Indians and as low as 6.1 percent for Koreans.[45] The rate of undiagnosed diabetes was 5.4 percent for Asian Americans, compared to 2.7 percent for non-Latino Whites in 2017-2020.[46] Cervical cancer incidence rates were 7 to 10 times higher for Vietnamese, Samoans, and Laotians, compared to non-Latino Whites in 1998-2002.[47] The Asian American subgroups that had the highest number of years of life lost due to cerebrovascular disease were Asian Indian, Vietnamese, Korean, and Filipino men and Vietnamese, Korean and Filipino women during 2003-2012.[48]

Disaggregated data collection and reporting for Asian American and NHPI communities across the Federal government is the second highest priority of the National Strategy to Advance Equity, Justice, and Opportunity for Asian American, Native Hawaiian, and Pacific Islander Communities.[49] Data disaggregation will help Asian American and NHPI subgroups benefit from federal health and other programs. For instance, studying the differences of cancer incidence among AANHPI subgroups by cancer type by age, sex, and stage of diagnosis can be used to develop programs that are more culturally and linguistically effective in reducing health disparities.[50] There is also underrepresentation of Asian American and NHPI populations and subgroups in data and scientific research, which hinders public health programs and research.[51] NIH has funded a major seven year study of cardiovascular and other chronic diseases among AANHPIs[52] and is committed to inclusivity in clinical trial research.[53]

The first Office of Management and Budget (OMB) revision to Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity since 1997 published on March 29, 2024 requires Federal data collection on six Asian subgroups and six Native Hawaiian or Pacific Islander subgroups and encourages allowing respondents to write in other subgroups.[54]

CONCLUSION

When the ACA was enacted in 2010, non-elderly AANHPIs experienced significantly higher uninsured rates than non-elderly non-Latino Whites: 16.6 percent vs. 13.1 percent. Since then, this disparity in coverage has closed. In fact, in 2022, the most recent year for which ACS data are available, the uninsured rate for AANHPIs (6.2 percent) was lower than the rate for Whites (6.8 percent). The estimated number of AANHPI Americans with health coverage increased by 4.6 million from 2010 to 2022.

Over that period, AANHPI Americans experienced increases in all sources of coverage including coverage gains under the Marketplace, Medicaid, and employer-sponsored insurance. AANHPIs with incomes between 138 percent and 400 percent of the FPL and those living in Medicaid expansion states experienced the largest gains in coverage. A total of more than 1.5 million AANHPIs had Marketplace insurance in 2023 and 1.6 million AANHPIs were enrolled in Medicaid expansion in 2020.

Multi-lingual and culturally competent outreach, in addition to policies that support pathways to coverage for immigrant communities, are essential in further expanding coverage and access to care in the AANHPI population. However, more studies are needed to determine best practices for outreach, education, and enrollment activities and how strategies could be improved for AANHPIs and other groups. Additional research is also needed to assess the impact of Marketplace coverage and Medicaid expansion on utilization of health services and health outcomes among AANHPIs. The passage of the American Rescue Plan of 2021 that expanded Marketplace subsidies, the Inflation Reduction Act of 2022 that extended these subsidies, and other policies to bolster coverage may further improve health care coverage and access among AANHPIs.

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