



# IMMIGRANT OUTREACH: APPLYING HEALTH CARE ENROLLMENT BEST PRACTICES TO DEFERRED ACTION

Lessons for advocates and policy makers

September 2015



## TABLE OF CONTENTS

---

<b>ABOUT THE ASIAN &amp; PACIFIC ISLANDER AMERICAN HEALTH FORUM</b>	<b>3</b>
<b>INTRODUCTION: DEFERRED ACTION AND LESSONS FROM AFFORDABLE CARE ACT ENROLLMENT</b>	<b>5</b>
<b>APPLICATION ROADBLOCKS</b>	<b>7</b>
<b>LESSONS LEARNED FROM THE AFFORDABLE CARE ACT</b>	<b>10</b>
<b>CONCLUSION</b>	<b>12</b>

## ABOUT THE ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

The Asian & Pacific Islander American Health Forum (APIAHF) is a health justice non-profit organization dedicated to improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. We believe that all persons have the right to be healthy, the right to live in a thriving community, and the right to quality, affordable, and accessible health care.

For the past 29 years, APIAHF has worked with community advocates, public health leaders, and policymakers to generate policies, programs, and systems changes to improve the health of Asian American, Native Hawaiian, and Pacific Islander communities. Through our policy and advocacy efforts, APIAHF was instrumental in the creation of the White House Initiative on Asian Americans and Pacific Islanders, fought for the passage of the Patient Protection and Affordable Care Act, and continues to demand the inclusion of Asian Americans, Native Hawaiians, and Pacific Islanders in the collection and reporting of local, state, and national health data. APIAHF works with local and state-based CBO's in 20 states and territories who provide services and advocate for AA and/or NHPI communities.

### MISSION

The Asian & Pacific Islander American Health Forum (APIAHF) influences policy, mobilizes communities, and strengthens programs and organizations to improve the health of Asian Americans, Native Hawaiians, and Pacific Islanders.

### VISION

APIAHF envisions a world where all people share responsibility and take action to ensure healthy and vibrant communities for current and future generations.

### VALUES

Our work derives from three core values:

**Respect** because we affirm the identity, rights, and dignity of all people.

**Fairness** in how people are treated by others and by institutions, including who participates in decision making processes.

**Equity** in power, opportunities, and resources to address obstacles hindering vulnerable communities and groups from living the healthiest lives.



## EXECUTIVE SUMMARY

More than 630,000 Asian Americans and Pacific Islander (AAPIs) immigrants may be eligible to apply for new deferred action programs created by the Obama Administration, known as Deferred Action For Childhood Arrivals (DACA), expanded DACA (DACA+) and Deferred Action for Parents of Americans (DAPA).<sup>1</sup> Despite the large number of AAPIs eligible for relief, AAPI candidates from Korea, Philippines, China and India have the lowest application rates among the top 10 countries of origin for DACA, the only one of President Obama's new programs to be implemented.<sup>2</sup> The programs offer deferred action from immigration proceedings for qualified undocumented immigrants who came to the United States as children or are parents of U.S. citizens or lawful permanent residents (LPRs). Under the policies, beneficiaries are given temporary protection from removal proceedings and renewable work authorization. While DACA was implemented in August 2015, the newer programs, DACA+ that removes age limits for DACA candidates and DAPA, intended for undocumented parents of U.S. citizens and LPRs, are on hold pending federal litigation.

Current DACA beneficiaries show the positive power and potential of deferred action programs. DACA recipients have obtained new jobs and increased their earnings, obtained internships and drivers' licenses, opened bank accounts and credit cards, achieved educational goals, and other increased opportunities that allow them to more fully settle and integrate into their communities. In the area of health, DACA beneficiaries now have increased access to affordable health care from college enrollment, new employment-based plans and some state-based programs for low-income residents.

Meanwhile, insight gained during the first two Affordable Care Act (ACA) open enrollment periods provide valuable lessons for advocates and policy makers as they seek to maximize applications for the new deferred action programs and promote greater integration by immigrants into their communities.<sup>3</sup> This report provides an overview of the barriers that AAPI youth and their families face in applying for new government programs, whether in the immigration or health care spheres. Identified barriers include concerns about negative government interference, impact that applications would have on their future legal status or that of family members, cultural barriers and confusion based on information and interviews with community-based organizations (CBOs) that conduct outreach and education or offer application assistance for the DACA program and, or ACA Health Insurance Marketplaces. In addition this report points to lessons and policy changes to overcome these challenges such as engaging AAPIs, building partnerships, addressing language and cultural barriers and championing AAPI voices to fully support integration and economic opportunity for AAPI undocumented immigrants.

---

1 Wong, Tom K, AAPI Undocumented Immigrations in the United States (2015), <http://ccis.ucsd.edu/aapi-undocumented-immigrants-in-the-u-s/>.

2 Batalova, Jeanne, Sarah Hooker, Randy Capps with James D. Bachmeier, DACA At The Two Year Mark (2014), <http://www.migrationpolicy.org/sites/default/files/publications/DACA-Report-2014-FINALWEB.pdf>.

3 The Asian & Pacific Islander American Health Forum partnered directly with 13 community-based organizations across 16 states and was a national partner of Action for Health Justice to provide outreach, education and enrollment assistance and this report is based on biweekly and yearly reports, webinars and conference calls, listening and discussion sessions and convenings with in-person assisters.

## INTRODUCTION: DEFERRED ACTION AND LESSONS FROM AFFORDABLE CARE ACT ENROLLMENT

On June 15, 2012, President Obama announced the creation of DACA through executive action, a policy that offers deferred action for qualified undocumented young adults who came to the United States as children. Under the policy, DACA beneficiaries are given temporary protection from immigration proceedings and work authorization for a 2 year period that can be renewed for an additional 2 years. Since September 2012, about 750,000 individuals have been granted DACA status.<sup>4</sup> For these individuals, DACA status has resulted in increased civil protections and privileges, as well as demonstrated benefits for the greater U.S. economy. In a survey with 2,684 respondents, 60% of DACA beneficiaries reported obtaining a new job since receiving DACA and 45% increased their earnings.<sup>5</sup> With their new legal status, DACA beneficiaries have also obtained internships and drivers' licenses, opened bank accounts and credit cards, achieved educational goals, and other increased opportunities that allow them to more fully settle and integrate into their communities. In the area of health, DACA beneficiaries now have increased access to affordable health care from college enrollment, new employment-based plans and some state-based programs for low-income residents.

In September 2014, on the heels of DACA's success, President Obama announced DACA+ to remove an age cutoff limit and begin issuing 3-year employment verifications. At the same time, President Obama announced a new program called DAPA to offer deferred action for undocumented parents of U.S. citizens and lawful permanent residents.<sup>6</sup> The announcement was immediately followed by a lawsuit by 26 states that has halted implementation of DACA+ and DAPA. Meanwhile, an estimated 4.9 million people eligible for DACA+ and DAPA wait for deferred status that would support the entire U.S. economy and expand access to jobs, education and health coverage for these immigrants.<sup>7</sup>

---

4 Mathay, Angelo, Margie McHugh, DACA At The Three-Year Mark (2015), <http://www.migrationpolicy.org/sites/default/files/publications/DACARenewals-FINALWEB.pdf>.

5 Ewing, Walter, The Power of DACA Continues to Grow (2014), <http://immigrationimpact.com/2014/06/16/the-power-of-daca-continues-to-grow/>.

6 Expanded DACA would remove the age limit for DACA eligibility and DAPA would be offered to parents of U.S. citizens and Legal Permanent Residents (LPRs). Currently, U.S. Citizenship and Immigration Services (USCIS) is not accepting applications for the expanded DACA program for youth or the **Deferred Action for Parents of Americans and Lawful Permanent Residents (DAPA)** program. A federal district court in Texas has issued an order that temporarily blocks the DAPA and expanded DACA programs from being implemented. This means that people will not be able to apply for DAPA or expanded DACA until a court issues an order that allows the initiatives to go forward. More resources at <http://www.nilc.org/dapa&daca.html>.

7 United States Citizenship and Immigration Services, Executive Actions on Immigration (2015), <http://www.uscis.gov/immigrationaction>.

Despite these legal challenges, DACA implementation continues and advocates working to promote robust participation can look to lessons learned from providing outreach education and enrollment assistance for health insurance through the ACA. Hundreds of thousands of young people are eligible, but have yet to apply. Of these, an estimated 198,800 AAPI youth could be eligible for DACA, but application rates have been lower for eligible youth from Asian and Pacific Islander countries.<sup>8</sup> For example, Korea, Philippines, China and India have the lowest application rates of the top 10 countries of origin for DACA eligible youth.<sup>9</sup> In order to increase the application rate for AAPI immigrants, it is important to identify and address the barriers that eligible AAPI youth currently face and anticipate barriers that DAPA eligible parents will experience in learning about and applying for the DACA and DAPA programs.

This report provides recommendations for maximizing DACA and DAPA enrollment by examining successful strategies and best practices for educating and enrolling Asian Americans, Native Hawaiians, and Pacific Islanders (AAs and NHPs) in health insurance coverage through the ACA. During the first and second ACA open enrollment periods, APIAHF was a national partner of Action for Health Justice, a coalition of over 70 community health centers and CBOs that provided outreach, education, and enrollment assistance services to nearly 850,000 AAs and NHPs in 22 states.<sup>10</sup> Action for Health Justice worked to promote coverage both in the Health Insurance Marketplaces and Medicaid.

AAPI individuals who are eligible for DACA and DAPA face many of the same challenges learning about their options and applying for deferred action as those faced in the ACA context. The lessons learned from Action for Health Justice can be applied to inform the outreach and application assistance strategies for DACA, and DACA+ and DAPA when implemented. Family decisions about whether and how to apply for coverage under the ACA brought up many of the same considerations as for DACA and DAPA, as they are all new and unfamiliar government programs. As such, they invoke deeply held beliefs, fears and in many cases misinformation or gaps in information for potential beneficiaries. This report provides the context for these enrollment barriers by examining strategies employed to maximize coverage under the ACA. Many of the same strategies can help improve DACA outreach, education and application assistance and DAPA implementation for AAPI immigrant communities.<sup>11</sup>

---

8 Migration Policy Institute, *Deferred Action for Childhood Arrivals Profile United States* (2015), <http://www.migrationpolicy.org/content/deferred-action-childhood-arrivals-daca-profile-united-states>.

9 Batalova, Jeanne, Sarah Hooker, Randy Capps with James D. Bachmeier, *DACA At The Two Year Mark* (2014), <http://www.migrationpolicy.org/sites/default/files/publications/DACA-Report-2014-FINALWEB.pdf>.

10 Action for Health Justice, *Two-Year Overview Infographic* (2015), <http://www.apiahf.org/resources/resources-database/action-health-justice-two-year-overview-infographic>.

11 The Asian & Pacific Islander American Health Forum partnered directly with 13 community-based organizations across 16 states to provide outreach, education and enrollment assistance and this report is based on biweekly and yearly reports, webinars and conference calls, listening and discussion sessions and convenings with in-person assisters.

## APPLICATION ROADBLOCKS

An estimated 198,800 AAPI youth are eligible to apply for DACA.<sup>12</sup> More than 430,000 are estimated to be eligible for DAPA and DACA+, when implemented.<sup>13</sup> The top countries of origin for eligible people from Asia under the deferred action programs are India, China, Korea, and Philippines. Based on key informant interviews<sup>14</sup> conducted with staff at community-based organizations doing both ACA and DACA outreach and application assistance work, there are many similarities between the target populations and some overlap with mixed status families.<sup>15</sup> Key informants identified the following application roadblocks, many of which occurred simultaneously and were responsible for the low rates of AAPI DACA applications:

- Feelings of shame, fear and guilt
- Language barriers for some DACA eligible youth and parents of DACA eligible candidates
- Confusion and misinformation about the DACA program and application process
- Lack of resources for community-based organizations to adequately conduct outreach and provide assistance

### Shame, Fear, and Guilt

All key informant interviewees reported strong elements of fear, shame and guilt felt by AAPI DACA eligible youth and their families as well as for ACA eligible families who were uninsured. There is a strong element of shame associated with many AAPI cultures for not having legal immigration status and therefore being seen as “lawbreaking” by fellow community members. Informants reported that legal status equates to higher social status in many AAPI communities and therefore DACA eligible youth and their families were reluctant to “come out” and make their undocumented status public. In many AAPI families, children do not realize they are undocumented because parents keep their status hidden over their own shame.

Immigration-related fears were a major barrier in both the ACA and DACA context. AAPI families feared applying either for health insurance or for DACA because they mistakenly believed doing so would negatively impact their ability to apply for further permanent status applications. This belief is understandable given the rise of the anti-immigration sentiment and existing policies that make immigrant participation in some government-operated public programs subject to a “public charge” determination that will adversely affect one’s ability to become a U.S. citizen or LPR.<sup>16</sup> Others feared the

---

12 Migration Policy Institute, Deferred Action for Childhood Arrivals Profile United States.

13 Wong, Tom K, AAPI Undocumented Immigrations in the United States.

14 Key informant interviews were conducted with staff at community-based organizations in New York, New Mexico and California who provide ACA outreach, education and enrollment assistance and, or, DACA outreach, education and application assistance.

15 “Mixed status families” are families with at least one family member whose does have an authorized immigrant status to be present in the U.S. and one family member who is a U.S. citizen or legal permanent resident.

16 Based on existing policies that make immigrant participation in some government-operated, “public charge” is a term used by U.S. immigration officials to refer to a person who is considered primarily dependent on the government-operated public programs, including Medicaid. Where this consideration applies, an immigrant who is found to be “likely to become a public charge” may be denied admission to the U.S. or lawful permanent resident status.

fact that DACA is only a temporary status and if future policies change, their DACA applications and statuses could result in negative immigration consequences and future immigration proceedings. In addition, DACA eligible youth expressed fear about other undocumented family members and exposing them by applying for deferred action.

Notably, DACA eligible youth were also influenced by their respect and responsibility for parents and elders, and felt guilt at leaving their undocumented parents behind if they were to apply for DACA. Together, these personal feelings served as an impediment to applying.

## Language Barriers

Even though many AAPI DACA eligible youth speak and read English proficiently, 39% of DACA eligible youth are limited English proficient (LEP), meaning they speak English less than very well or not at all.<sup>17</sup> Key informants confirmed that English proficiency varies and most parents of DACA eligible youth are LEP. Though the U.S. Citizenship and Immigration Services (USCIS) and the U.S. Department of Education have produced DACA educational materials in some AAPI languages, these materials are not sufficient to reach and educate AAPI immigrant families, many with monolingual or LEP parents. As a result, many parents of DACA eligible youth find it hard to access easy to understand information about their children's options, creating a considerable barrier to applying when such a decision is often made jointly by a family.<sup>18</sup>

## Confusion and Misinformation

Key informants reported varying levels of confusion and misinformation about the DACA policy, how to apply and future implications. The DACA application process is a long process that takes on average 4-6 months and requires applicants to submit numerous documents, similar to applications for ACA coverage. DACA applicants must submit proof that the applicant arrived in the U.S. before their 16th birthday, confirmation of immigration status, establish presence in the U.S. when DACA was created, and continuity of residence in the U.S. since 2007, as well as student status. For both ACA and DACA applications, getting the right documents was difficult for families not familiar with or in the habit of keeping documents such as receipts, schools and medical records, and bank statement or that moved around due to seasonal employment or economic and housing insecurity.

---

<sup>17</sup> Migration Policy Institute, Deferred Action for Childhood Arrivals Profile United States.

<sup>18</sup> Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency" requires Federal agencies to implement a policy to provide services in a manner that an LEP persons can have meaningful access to them.

## Insufficient Support Resources

For both the ACA and DACA, there are insufficient resources for outreach, education and application assistance for CBOs that have trusted relationships and reputations among AAPI immigrants. While there were limited grants for AAPI-serving CBOs to conduct ACA outreach, education and enrollment assistance given by the Center for Medicaid and Medicare Services and the Office of Minority Health, USCIS has not provided any funding opportunities for CBOs to support DACA outreach, education and enrollment assistance. Private foundations have attempted to fill the gap by providing grants to CBOs for both ACA and DACA services but dedicated funds to CBOs serving AAPI are small in comparison to those targeting Latino communities. One survey found that only a few of the almost 30 local and national organizations that offer DACA for AAPIs have adequate resources for outreach, education and application assistance.<sup>19</sup> Smaller CBOs are effective at leveraging and maximizing scarce resources due to their language-abilities and long standing trust in the communities to serve the need for ACA and DACA services within AAPI communities despite continuing insufficient resources. CBOs have created their own DACA and ACA outreach and educational materials in AAPI languages. Given the demographic considerations, language resources are essential to supporting enrollment via funding for in-language outreach materials and in-language application assistance.

---

19 Increasing Asian American and Pacific Islander DACA Participation (2014), <https://www.gcir.org/sites/default/files/resources/AAPI%20DACA%20Summary%20Brief%20Design.pdf>.

## LESSONS LEARNED FROM THE AFFORDABLE CARE ACT

Given the demographic overlap, similar messaging challenges, and fears, ACA enrollment offers a number of lessons that can be adapted to promoting AAPI participation in the DACA, DACA+ and DAPA deferred action programs. They include:

- Engage AAPI community-based organizations
- Build partnerships
- Address language and cultural barriers
- Champion the voices of AAPIs

### Engage AAPIs

CBOs are trusted sources of accurate, easy to understand information and can conduct effective outreach, education and application assistance for government programs. For the ACA, they were very effective at engaging AAPIs who faced shame, fear and guilt about the new health care coverage options made available by the ACA and provided essential support and assistance so AAPIs could successfully submit Health Insurance Marketplace applications. By providing assistance through in-person, one-on-one education sessions, CBO staff were able to dispel the negative perceptions and concerns experienced by individuals, while still remaining sensitive to the cultural elements of shame, fear and guilt. Staff at CBOs addressed myths, validated concerns, provided application support (in-language if requested), and were persistent in their message about the basics and benefits of ACA enrollment. Some successful strategies included going to where the community lives, works, plays and worships to deliver small group education sessions and setting-up store fronts and clinics for application assistance. CBO partners engaged AAPIs at house visits, social clubs, religious study groups, family clan gatherings, apartment complexes, nail salons, taxi garages and taxi stands, ethnic commercial districts and flea markets.<sup>20</sup>

### Build Partnerships

CBOs also can build relationships with trusted partners that already have deeper reach within AAPI communities. These partnerships were used very effectively for ACA enrollment. Some examples include outreach and education partnerships with faith-based organizations and leaders, schools with high concentrations of AAPI students, and small businesses such as ethnic grocery stores to increase ACA information dissemination within AAPI communities. Organizations can also extend their reach by partnering with ethnic media to offer journalists and readers accurate information. For example, effective ethnic media partnerships included interviewing CBO staff on TV and radio talk shows, broadcasting public service messages about the ACA, publishing op-eds and press releases from CBOs and running advertisement for enrollment events and CBO services.

---

<sup>20</sup> For more information about best practices engaging AAs and NHPs in ACA enrollment, see *Improving the Road to Coverage: Lessons Learned on Outreach, Education and Enrollment for Asian Americans, Native Hawaiians and Pacific Islander Communities* (2014), <http://www.apiahf.org/resources/resources-database/improving-road-aca-coverage-lessons-learned-outreach-education-and-enro>.

Nationally coordinated partnerships, such as Action for Health Justice, can be used to share best practices and resources and relay information quickly and efficiently to and from local groups, national organizations and government agencies. For example, in October 2013, U.S. Immigration and Customs Enforcement issued a memo clarifying that no information shared while applying for ACA coverage would be used for purposes of initiating immigration proceedings. This memo was issued in response to concerns raised by Action for Health Justice and CBOs who heard directly from AAPI immigrants. As a national coalition, Action for Health Justice was able to leverage its broad reach and quickly disseminated the information to ethnic media via a press release and shared local templates for CBOs to distribute.

### **Address Language and Cultural Barriers**

During ACA enrollment, CBOs filled the gap created by the lack of translated resources by creating and translating outreach and education materials with community feedback and input. The materials produced by CBOs were accurate and easy to understand. CBOs also provided in-person and in-language education to individuals, small groups and larger audiences and one-on-one application assistance appointments. As many CBOs also had staff that share similar backgrounds and experiences with the population they serve, they were able to deliver outreach and education messages in a culturally attuned way that was underwritten by understanding that ethnic media, community rumors and misinformation and mistrust of government programs are sources of mistrust. These strategies can be employed to increase DACA applications and will be highly effective for DAPA implementation since most DAPA eligible adults speak limited English.

### **Champion the Voices of AAPIs**

CBOs successfully leveraged stories of successful ACA enrollment stories from AAPI consumers to generate public support and good will that can be similarly done for deferred action. CBOs can also play a role in further leadership development of DACA beneficiaries by connecting them to existing immigrant rights groups and movements. These connections help to elevate AAPIs within the undocumented and immigrant rights movement and draw attention to the need for dedicated resources for AAPIs. The increased visibility of AAPI stories help both AAPIs and others to see that the face of the immigrant rights movements and need for comprehensive immigration reform is diverse.

## CONCLUSION

Many of the successful strategies and best practices used by CBOs to help AA and NHPs enroll in coverage through the ACA can be replicated and tailored to help AAPIs apply for deferred action. As immigration status continues to be of the greatest barriers to obtaining health care coverage, it is essential that entities working with immigrants use these strategies to increase the deferred action application rate for AAPIs so they can work and have access to health care and other important benefits of society. The life-changing implications for nearly 198,800 DACA eligible AAPI immigrants are immeasurable. Bringing these individuals into the formal sector would strengthen the U.S. economy and provide a foundation for economic prosperity for applicants and their families. It is time to support a comprehensive and robust outreach and engagement effort for AAPI DACA eligible individuals nationwide.