



**WRITTEN STATEMENT FOR THE RECORD**

**FOR THE HEARING ENTITLED “THE DISPROPORTIONATE IMPACT OF COVID-19 ON COMMUNITIES OF COLOR”**

**UNITED STATES HOUSE OF REPRESENTATIVES**

**COMMITTEE ON WAYS AND MEANS**

**May 27, 2020**

**BY THE**

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The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the May 27, 2020 hearing before the House Ways & Means Committee entitled “The Disproportionate Impact of COVID-19 on Communities of Color.”

APIAHF is the nation’s oldest and leading health policy organization working to advance the health and well-being of over 20 million Asian Americans, Native Hawaiians and Pacific Islanders (AA and NHPI) across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient, and may be new to the U.S. healthcare system or unfamiliar with private or public coverage. We have longstanding relationships with over 150 community-based organizations across 35 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance.

For 35 years, we have focused our policy efforts on: 1) improving access to health insurance and care for AA and NHPI and immigrant communities; 2) ensuring the collection, analysis and reporting of detailed demographic health data; and 3) protecting and advancing the language rights of the 1 in 3 AAs and NHPIs who are limited English proficient.

As such, we have a strong understanding of the needs and barriers to good health that were already experienced by AA and NHPI communities across the country and ways in which COVID-19 is magnifying and exacerbating inequities among communities of color. It is imperative that Congress take action to address these disparities as they threaten to undermine our collective national response and recovery.

### **COVID-19 National Crisis is Disproportionately Impacting Communities of Color**

The novel COVID-19 virus is a global pandemic that demonstrates that public health has no boundaries. Yet the impact is being unevenly felt among communities of color who, due to a combination of structural, economic, social and environmental disparities and discrimination, are experiencing higher burdens associated with the pandemic. As a result, COVID-19 is disproportionately leading to severe illness and mortality within these communities.

We wish to emphasize that, in the face of narratives to the contrary, these communities facing disparities are in no way to blame. COVID-19 has exposed what advocates for health equity have known for decades, if not centuries: our history of racism and prejudice has led to serious health consequences that continue today. Or as put recently by journalist Zeeshan Aleem, “it’s not people of color driving up America’s casualties, but America that is driving up people of color’s casualties.”<sup>1</sup>

In recent weeks, state and local officials have documented that communities of color are being disproportionately impacted by the COVID-19 outbreak.<sup>2</sup> Sixty percent of COVID-19 hospitalizations are among people of color.<sup>3</sup> Limited data available on AAs and NHPIs has shown that:

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<sup>1</sup> Aleem, Zeeshan, “HHS Secretary Alex Azar suggests health problems in communities of color explain coronavirus death numbers,” *Vox* (May 17, 2020). Available at: <https://www.vox.com/covid-19-coronavirus-us-response-trump/2020/5/17/21261708/alex-azar-coronavirus-trump-economy-african-american>.

<sup>2</sup> Initial data reported by federal, state and local authorities has shown that certain racial and ethnic minority populations are disproportionately experiencing COVID-19. Data reported by the Centers for Disease Control Morbidity and Mortality Weekly Report suggests that black populations might be disproportionately affected by COVID-19 when examining hospitalization rates. See *Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report March 1-30, 2020*, available at [https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm#F2\\_down](https://www.cdc.gov/mmwr/volumes/69/wr/mm6915e3.htm#F2_down). In Michigan, African Americans make up 14.1% of the population, but represent about 40% of COVID-19 deaths. See *State of Michigan COVID-19 Data*, available at [https://www.michigan.gov/coronavirus/0,9753,7-406-98163\\_98173---,00.html](https://www.michigan.gov/coronavirus/0,9753,7-406-98163_98173---,00.html). In Arizona, American Indians represent 20% of COVID-19 deaths, but only about 5% of the state’s population. See *Arizona Department of Health Services, COVID-19 Deaths in Arizona*, available at <https://www.azdhs.gov/>. In New York City, Hispanics have the highest death rate from COVID-19 at 34%, but account for 29% of the city’s population. See *New York City Health*, available at <https://www1.nyc.gov/assets/doh/downloads/pdf/imm/covid-19-deaths-race-ethnicity04082020-1.pdf>.

<sup>3</sup> “COVID-19 Laboratory-Confirmed Hospitalizations,” *Centers for Disease Control and Prevention* (May 16, 2020). Available at: [https://gis.cdc.gov/grasp/COVIDNet/COVID19\\_5.html?utm\\_campaign=fyi\\_newsletter&utm\\_medium=email&utm\\_source=govdelivery](https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html?utm_campaign=fyi_newsletter&utm_medium=email&utm_source=govdelivery).

- Best available data from multiple states and municipalities indicate that AAs have a case fatality rate that is disproportionately higher than the general population.<sup>4</sup> This could be because AAs are not getting access to testing or are more likely to die once infected, or both.
- In Oregon and California, Pacific Islanders have case rates three times the state average, while in Salt Lake City, Utah, it is more than twice the state's average rate.<sup>5</sup>
- Initial research from San Francisco suggests that Asian Americans had the highest proportion of deaths due to COVID-19 across all other racial groups.<sup>6</sup> While Asian Americans make up one-third of the city's population, they make up half of its COVID-19 deaths.<sup>7</sup>
- In California, Asian Americans represent 16% of COVID-19 deaths and 15% of the state population, while Native Hawaiians and Pacific Islanders make up 1.6% of cases but 0.3% of the state's population.<sup>8</sup>

These inequities are compounded by the dual challenges that AA and NHPI communities are facing amidst a public health emergency and the ugly backdrop of xenophobic hate and violence. AA and NHPI organizations have documented at least 1,900 hate incidents in 46 states.<sup>9</sup> Racialized rhetoric is sadly being exacerbated by some political leaders, looking for an easy scapegoat for this public health crisis instead of addressing the needs of our most vulnerable. As a nation, we must unequivocally condemn this furthering of anti-Asian stereotypes and blame that has existed throughout our nation's history amid similar moments of crisis, from the Chinese Exclusion Act to Japanese internment during World War II, to the murder of Vincent Chin.

At the same time AA and NHPI communities are experiencing the dual blow of COVID-19 and COVID-19 hate, an estimated 2,000,000 AA and Pacific Islander essential workers are on the front lines and contributing to vital public safety sectors. These include the 21% of physicians<sup>10</sup> who are AA and the nearly 10% of registered nurses<sup>11</sup> who are Filipino, as well as 21% of

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<sup>4</sup> National Community Dialogue on Asian American & National Hawaiian/Pacific Islander COVID-19 Mortality Data, with national leaders and representatives from National Council of Asian Pacific Americans and academic and medical partners to identify and review existing and available data (May 22, 2020).

<sup>5</sup> "Devastating COVID-19 Rate Disparities Ripping Through Pacific Islander Communities in the U.S.," *Pacific Islander Center on Primary Care Excellence* (April 27, 2020). Available at: [https://mk0picopce2kx432grq5.kinstacdn.com/wp-content/uploads/2020\\_0424-PICOPCE-COVID19-Press-Release.pdf](https://mk0picopce2kx432grq5.kinstacdn.com/wp-content/uploads/2020_0424-PICOPCE-COVID19-Press-Release.pdf).

<sup>6</sup> Constance, Agnes, "Asian American Death Rate in San Francisco Concerning, Researchers Say," *NBC News* (May 20, 2020). Available at: <https://www.nbcnews.com/news/asian-america/asian-american-covid-19-death-rate-san-francisco-concerning-researchers-n1211491>.

<sup>7</sup> Palomino, Joaquin, "Why has coronavirus taken such a toll on SF's Asian American community? Experts perplexed over high death rate," *San Francisco Chronicle* (May 2020, 2020). Available at: <https://www.sfchronicle.com/health/article/Why-has-coronavirus-taken-such-a-toll-on-SF-s-15282096.php>

<sup>8</sup> "COVID-19 Updates," *California Department of Public Health COVID-19 Cases and Deaths by Race/Ethnicity* (last accessed May 25, 2020). Available at <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx>.

<sup>9</sup> "Hate Incidents," *AAPI Emergency Response Network* (last accessed May 25, 2020). Available at: <https://www.aapiern.org/hate-incidents>.

<sup>10</sup> "COVID-19 in Numbers, Physicians & Surgeons," *Data USA* (last accessed May 25, 2020). Available at: <https://datausa.io/profile/soc/physicians-surgeons>.

<sup>11</sup> "COVID-19 in Numbers, Registered Nurses," *Data USA* (last accessed May 25, 2020). Available at: <https://datausa.io/profile/soc/registered-nurses>.

critical care fellows<sup>12</sup> and 22% of pharmacists.<sup>13</sup> Dr. Chen Fu, a Chinese-American doctor working in a New York City hospital recently told NBC's *The Today Show* how he faced, despite his front line work, animosity and harassment in public.<sup>14</sup>

While Congress has responded to the COVID-19 crisis through four new breathtaking laws in the past three months, such efforts have been woefully insufficient to address the distinct needs of communities of color, in particular immigrant and limited English proficient communities. Failing to address this oversight threatens to perpetuate and exasperate existing barriers, as recent data suggests is already happening, and undermines our collective national response.

### **COVID-19 Has Amplified Unequal and Disparate Health Insurance Coverage for Immigrants and Residents**

While the Affordable Care Act (ACA) has resulted in more than 20 million Americans gaining coverage through Medicaid and the Health Insurance Marketplace, coverage remains unequal with millions of immigrants ineligible for Medicaid and other public health insurance programs.<sup>15</sup> Federal restrictions, dating back to the 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996, bar many categories of immigrants from coverage while undocumented immigrants are not even able to buy unsubsidized insurance on the ACA marketplaces. As a result, 31% of noncitizens are uninsured, compared to 8% of naturalized citizens and 7% of native-born citizens.<sup>16</sup>

For example, individuals living in the U.S. under the Compacts of Free Association with the Republic of the Marshall Islands, Federated States of Micronesia and Republic of Palau are categorically ineligible for Medicaid, as are those without green cards or those who have had legal permanent resident status for less than five years. Immigration status is a leading social determinant of health, dividing our nation between those who have coverage and those who do not. This disparity is even more significant in the context of COVID-19 where immigrant communities lack full access to testing and treatment and fear seeking care as a result of public charge and immigration enforcement concerns.

For example, one of APIAHF's partners, the Arkansas Coalition of the Marshallese (ACOM), based in Springdale, Arkansas, has encountered increased challenges serving thousands of COFA community members as a result of federal restrictions.

***One client, "Ann," who would be Medicaid eligible but for her COFA status, tested positive for COVID-19 and was put on a ventilator. This likely saved her life. However, because she is***

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<sup>12</sup> Lane-Fall MB, Miano TA, Aysola J, Augoustides JGT. "Diversity in the Emerging Critical Care Workforce: Analysis of Demographic Trends in Critical Care Fellows From 2004 to 2014," *Crit Care Med*. 2017;45(5):822-827. doi:10.1097/CCM.0000000000002322.

<sup>13</sup> "COVID-19 in Numbers, Pharmacists," *Data USA* (last accessed May 25, 2020). Available at: <https://datausa.io/profile/soc/pharmacists>.

<sup>14</sup> Nguyen, Vicky, "Threats against Asian Americans are on the Rise Amid Coronavirus Crisis," *The Today Show* (April 24, 2020). Available at <https://www.today.com/video/threats-against-asian-americans-are-on-the-rise-amid-coronavirus-crisis-82510405969>.

<sup>15</sup> "Chartbook: Accomplishments of Affordable Care Act," *Center on Budget and Policy Priorities* (March 19, 2020). Available at: <https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act>.

<sup>16</sup> APIAHF analysis of 2018 American Community Survey data.

*uninsured, she cannot afford the hospital bills. ACOM has dipped into their emergency fund to cover Ann's costs for the moment, but this would not be sustainable for the long term or for many more clients.*

The Department of State and Department of Homeland Security Public Charge rules continue to have a documented chilling effect on many people's willingness to enroll in coverage or even go to the hospital. APIAHF's health clinic partner in Dearborn, Michigan, ACCESS, has reported that many clients are reluctant to go to hospitals for COVID-19 treatment, out of fear for immigration enforcement. UNITED SIKHS, which supports enrollment in coverage in New York and New Jersey, has reported similar fears about reluctance to enroll in health insurance. A new report from the University of Utah's Kem C. Gardner Policy Institute documents local challenges in providing care due to immigration fears.<sup>17</sup>

**Congress must respond to this need by:**

1. Passing the HEROES act to restore Medicaid eligibility for COFA communities and ensure that immigrants who would be eligible for Medicaid but for their immigration status are able to access testing and treatment for COVID-19.
2. Passing the Coronavirus Immigrant Families Protection Act, which would suspend the public charge rules, address coverage gaps and further fix policies that create barriers to immigrant care.
3. Eliminating immigration restrictions on eligibility for health programs by passing Title IV of the Health Equity and Accountability Act and the HEAL for Immigrant Women and Families Act.
4. Ensuring that all future expansions of coverage do not include barriers based on immigration status.

**Failing to Collect, Report and Analyze Detailed Demographic and Language Data Threatens our COVID-19 Response and Recovery**

While state and local authorities have increasingly reported alarming demographic differences among communities impacted by COVID-19, federal data collection efforts led by the Centers for Disease Control and Prevention (CDC) remain inadequate. If reporting entities, including providers, testing laboratories and public health agencies collect data on only aggregate populations, the elevated risk of outbreaks among smaller but particularly exposed groups will be missed.

Tracking demographic data for those who have been tested, infected, hospitalized, recovered, and died from COVID-19 helps the public health workforce identify groups that may have a higher likelihood to get sick and experience severe illness from COVID-19 as the pandemic progresses. This data is essential in helping state, tribal and local agencies, health systems, hospitals, and health care providers invest in and direct resources to provide access to testing,

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<sup>17</sup> Christensen, Marin, Dianne Meppen and Samantha Ball, "New Americans in Salt Lake County A Qualitative Study of Service Providers to Immigrants and Refugees," *Ken. C Gardner Policy Institute* (March 2020). Available at: <https://gardner.utah.edu/wp-content/uploads/New-Americans-Report-May-2020.pdf>.

healthcare, and social services for diverse populations with different needs. Finally, it can help policymakers prioritize and distribute resources based on anticipated need.

The U.S. Department of Health and Human Services must update the COVID-19 surveillance systems to collect data on patients' race, ethnicity, sex, age, primary language, sexual orientation, disability status, gender identity, and socioeconomic status in line with federal standards. As a threshold, such collection should comport with the standards codified by Section 4302 of the Affordable Care Act. We also support ensuring data are collected and reported using all appropriate privacy standards. APIAHF sent a letter to Congress on May 4, 2020, signed by over 250 consumer, public health, industry, faith, provider and racial equity organizations, emphasizing these requests.<sup>18</sup>

We appreciate that the CDC, state public health officials, agencies and providers are trying to ramp up surveillance during this moment of crisis, but many of the challenges facing data collection have been essentially institutionalized. For example, AA and NHPI data is often aggregated together, if it is reported at all, despite federal standards requiring the opposite. Some states combine Asian Americans with Pacific Islanders, while other states label Asian Americans as "other" or misclassify them. Texas, for example, is one of the top 10 states with the largest number of NHPIs, and yet does not report COVID-19 data for this population. Collection and reporting entities must do better by avoiding inaccurate data that erases communities.

**Congress must respond to this need by:**

1. Passing the HEROES Act, particularly its provisions investing in data infrastructure.
2. Passing the Equitable Data Collection and Disclosure on COVID-19 Act.
3. Passing Title I of the Health Equity and Accountability Act, to provide for systemic reforms in health disparities data collection, analysis and reporting.
4. Provide oversight over HHS and CDC, ensuring their data collection and reporting is in compliance with ACA 4302 standards.

**Federal COVID-19 Response is Leaving out Millions of Limited English Proficient Americans**

Existing federal law and regulation requires protections for limited English proficient (LEP) communities, which is critical for the 25 million Americans, including over 6 million AAs and over 100,000 NHPIs who speak English less than very well.<sup>19</sup> These protections include Title VI of the Civil Rights Act of 1964, Executive Order 13166, Section 1557 of the Affordable Care Act and the Language Access Plans generated by agencies, including FEMA and the U.S. Department of Health and Human Services. In practice, however, due to lack of available resources, few documents are translated into other languages and interpreters are rarely available. Currently the CDC has translated their COVID-19 website into only four languages, while their print resources are translated sporadically and not widely disseminated.

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<sup>18</sup> Letter available at: [https://www.apiahf.org/wp-content/uploads/2020/05/2020.05.04\\_COVID-19-Demographic-Data-Sign-on-Letter-to-Congressional-Leaders.pdf](https://www.apiahf.org/wp-content/uploads/2020/05/2020.05.04_COVID-19-Demographic-Data-Sign-on-Letter-to-Congressional-Leaders.pdf).

<sup>19</sup> APIAHF analysis of American Community Survey, 2018 data.

Whether it is accessing public health information, enrolling in and understanding health insurance, and accessing quality care, LEP individuals face numerous challenges that can delay the critical information and care they need and deserve. APIAHF has found that during the past seven Open Enrollment Periods for the Health Insurance Marketplaces, language presented a significant barrier for AAs and NHPs and other LEP communities attempting to enroll in coverage and confirms many of the anecdotal stories that have already been reported as LEP communities respond to COVID-19.

***Miran is of Korean background and lives in Georgia, where she and her husband have been uninsured because of language barriers to understanding the enrollment process. CPACS, an APIAHF community partner based out of Atlanta, connected with her during the Open Enrollment period and assisted her in applying for the first time. Without this language assistance, she would have been unable to afford medical care for her husband’s severe ear infection.***

***Dao lives in Arizona and previously enrolled in ACA coverage. However, she is also LEP, speaking primarily Vietnamese. She received a notice from the Marketplace asking for additional documents to verify her identity; however, because it was written only in English, she did not understand. As a result, Dao lost her ACA subsidy, only finding out why when it was too late. She is scared she will be unable to afford to manage her diabetes now.***

Federal disaster policies, developed after recent national incidents, emphasize the need to support LEP populations in disaster response, including the National Response Framework and National Disaster Recovery Framework. The Recovery Framework notes that “Care must be taken to assure that actions, both intentional and unintentional, do not exclude groups of people based on race, color, ethnicity, national origin (including limited English proficiency), religion, sex, sexual orientation, gender identity, age, or disability.” In 2015, the U.S. Department of Justice issued joint guidance with Homeland Security (DHS), Housing and Urban Development (HUD), Health and Human Services (HHS) and Transportation (DOT) stating:

***“Hurricane Katrina and subsequent emergencies and disasters highlight a recurring lesson: we need to take proactive measures to ensure that all members of our communities are appropriately incorporated into emergency management activities.”***

APIAHF has received several stories from community-based partners that highlight the lack of meaningful access for LEP persons. Further, a recent report from ProPublica<sup>20</sup> raises serious concerns that language barriers could lead to rationing of care, undermining civil rights and the Office for Civil Rights at the U.S. Department of Health and Human Services bulletin issued March 28, 2020.<sup>21</sup>

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<sup>20</sup> Kaplan, Joshua, “Hospitals Have Left Many COVID-19 Patients Who Don’t Speak English Alone, Confused and Without Proper Care,” *ProPublica* (March 31, 2020). Available at: <https://www.propublica.org/article/hospitals-have-left-many-covid19-patients-who-dont-speak-english-alone-confused-and-without-proper-care>.

<sup>21</sup> “OCR Issues Bulletin on Civil Rights Laws and HIPAA Flexibilities That Apply During the COVID-19 Emergency,” *U.S. Department of Health and Human Services, Office for Civil Rights* (March 28, 2020). Available at: <https://www.hhs.gov/about/news/2020/03/28/ocr-issues-bulletin-on-civil-rights-laws-and-hipaa-flexibilities-that-apply-during-the-covid-19-emergency.html>.

Further, even where federal agencies such as CDC have provided translated resources, those resources are insufficient and poorly organized. For example, due to the lack of in-language resources from the CDC or local health departments, the Arkansas Coalition of Marshallese had to hold an emergency fundraiser via their Facebook to translate a CDC flier on “what to do if you’re symptomatic.” The translator is working well-below her standard rate to make this possible. Federal agencies must step in to provide these resources going forward.

***“There are certain communities that are going to be left out, simply because they have a language barrier. I’m being bombarded with requests to translate.” – Melissa Laelan, Marshallese advocate in Arkansas<sup>22</sup>***

***APIAHF received a story from a community organization that helps women in abusive situations. One of their clients is eight weeks pregnant and had been trying to get medical care from a health clinic, but she only speaks Vietnamese. The clinic kept returning her calls in English. They had three rounds of back and forth telephone messages but she was unable to get assistance.***

COVID-19 is exacerbating these existing language access challenges. APIAHF recently conducted a survey of 45 community-based organizations and 89% said that they needed in-language and culturally appropriate resources about the virus. As such, we are deeply concerned that LEP patients are not receiving accurate and timely information in a culturally and linguistically accessible manner to learn about COVID-19 and access life-saving treatment and testing.

Even when LEP individuals seek care, they face significant barriers getting language assistance.

***APIAHF staff talked to the daughter of one older woman in a Seattle hospital who is LEP and had COVID-19. She progressed to a point where she needed to be intubated, but the hospital did not make an interpreter available when making that decision. This woman faced a very invasive procedure without being communicated about what was happening in her preferred language.***

Interpretation services are even harder in a COVID-19 environment, when social distancing is required for health and safety. This means that in-person professional interpreters, the best quality standard, are either not possible or difficult. Across the country, hospitals that may have had limited experience with remote interpretation services are struggling to meet the needs of their patients.<sup>23</sup>

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<sup>22</sup> Krug, Teresa, “Race to Translate COVID-19 Info as Some US Communities Left Out,” *AlJazeera* (March 31, 2020). Available at: <https://www.aljazeera.com/news/2020/03/race-translate-covid-19-info-communities-left-200331144408436.html>.

<sup>23</sup> Aguilera, Jasmine, “Coronavirus Patients Who Don’t Speak English Could End Up ‘Unable to Communicate in Their Last Moments of Life’,” *Time* (April 15, 2020). Available at: <https://time.com/5816932/coronavirus-medical-interpreters/>.



Providers have reported that a large cause for noncompliance is the lack of reimbursement for language interpreting services and communication accommodations from Medicare, Medicaid and private issuers. The federal government must ensure providers have the resources they need to effectively communicate with LEP families and communities as well as with anyone with a communication-related disability or condition, and deaf and hard of hearing communities and families. This includes funding that ensures the availability of language access services, qualified interpreters, communication boards and other augmentative communication tools, or ensuring patients have access to people who are trained to support their unique communication modes and needs, as well as other means.

**Congress must respond to this need by:**

1. Passing the COVID-19 Language Access Act, to require all agencies receiving COVID-19 funding to translate documents into at least the 19 languages identified in the FEMA language access plan
2. Providing grants or contracts with community and faith based organizations in relationship with LEP and immigrant communities for the purposes of culturally tailored outreach, language assistance and connections to services.
3. Creating resources so that health providers have access to interpretation services at testing and treatment centers.
4. Passing Title II of the Health Equity and Accountability Act to address systemic language access needs.
5. Providing oversight over all agencies receiving and granting funds for COVID-19 to ensure they and recipients of federal funding are complying with civil rights protections.

It is imperative that Congress respond to the complex crisis that communities of color are experiencing due to COVID-19 and include the supports that are needed. Thank you for this Committee's leadership during this extraordinary time and for receiving this testimony. Please feel contact APIAHF Executive Vice President Juliet K. Choi ([jchoi@apiahf.org](mailto:jchoi@apiahf.org)) and Senior Policy Analyst Ben D'Avanzo ([bdavanzo@apiahf.org](mailto:bdavanzo@apiahf.org)) with any questions.



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