Ensuring Health Access and Equity for Immigrant Asian American and Pacific Islander Women

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For nearly two decades, a complicated web of federal and state policies has created significant barriers to accessing health insurance coverage for millions of immigrants in the United States. These policies disproportionately impact the most vulnerable members of society, including low-income women, women of color, and children. Exclusion from access to comprehensive health coverage has serious negative implications for immigrant Asian American and Pacific Islander (AAPI) women and can interfere with their ability to contribute effectively to society.

HEALTH DISPARITIES FOR IMMIGRANT AAPI WOMEN

An estimated 18.1% of AAPIs are uninsured, compared with 16.3% of all Americans.[1] However, the extent of uninsurance varies considerably by ethnic subgroup, with rates of uninsurance reaching as high as 19.8% for Vietnamese Americans, and 25.5% for Korean Americans.[2] Although men are more likely to be uninsured than women, within the AAPI community, the opposite is true.[3]

Many AAPIs rely heavily on accessible and affordable health insurance programs. Even before Medicaid expansion under the Patient Protection and Affordable Care Act (ACA), more than 1 in 10 Asian Americans were enrolled in Medicaid.[4] For certain populations, such as the Southeast Asian American community, enrollment was as high as 19%.[5] After Medicaid expansion, over half of all uninsured AAPIs had incomes low enough to make them eligible for Medicaid.[6]

UNDOCUMENTED AAPI WOMEN

Of the estimated 11.4 million undocumented individuals in 2012, 1.3 million are of Asian origin and more than 5.3 million are immigrant women.[7] Several Asian countries—including China, India, Korea, the Philippines, and Vietnam—rank among the top ten countries of origin for undocumented immigrants living in the United States.[8]

Undocumented immigrants are largely unable to access health services due to restrictive policies, including ineligibility for Medicaid and the Children's Health Insurance Program (CHIP). Compounding these disparities in health and access is the fact that even those in dire health conditions may choose to forego health services altogether out of fear of detention or deportation. For immigrant AAPI women, these barriers exacerbate the existing negative health outcomes already faced by the community. For example, while mortality from cervical cancer is declining for women born in the U.S., mortality rates for immigrant women are increasing,[9] an especially alarming trend for AAPI women who already experience disproportionately high rates of the disease.

Further, studies have revealed the following negative reproductive health outcomes for undocumented immigrant women: (1) undocumented immigrant women begin prenatal care later and have fewer prenatal visits compared with the general population; (2) birth complications are more common among undocumented women; and (3) neonatal morbidity is more common among undocumented immigrant women.[10] Access to comprehensive health coverage, regardless of immigration status, is crucial to reducing these disparate health outcomes.

HEALTH CONDITIONS COMMON IN AAPI WOMEN:

Breast cancer; cervical cancer; diabetes; heart disease; Hepatitis B; high blood pressure; high cholesterol; HIV/AIDs; liver cancer; lupus; mental health issues and suicide; osteoporosis; obesity; sexually transmitted infections; stomach cancer; tuberculosis

SOURCE: U.S. DEP'T OF HEALTH & HUMAN SERVICES, Minority Women's Health: Asian Americans, available at http://www.womens health.gov/minority-health/asian-americans/index.html (last updated Mar. 2012).

A MAZE OF STATE AND FEDERAL POLICIES

As the vision of the ACA recognizes, comprehensive health care must be accessible to all, regardless of race, gender, or income. Although the ACA has increased access to comprehensive health services to millions of Americans, it did not fully address the barriers to

coverage created by the previously existing system of federal and state laws that determined whether immigrant women and children would have access to health care.

The Five-Year Ban

With the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act, or "welfare reform," in 1996, immigrants were barred from Medicaid and CHIP coverage for the first five years in which they have lawful immigration status.[11] Because Medicaid is the single largest source of reproductive and other health coverage for the low-income, the five-year ban makes it impossible for many immigrant AAPI women to access critical and even life preserving health services.

The five-year ban has a significant impact on women, who generate less income than men[12] and require health services that men do not, including reproductive health care and services. The ban's impact on AAPI women is even further compounded by the economic insecurity resulting from language and cultural barriers, the complexity of their immigration status, the responsibility of caring for extended family members, concentration in low-paying jobs, and ineligibility for many public benefit programs.[13]

For AAPI women and children, particularly for those facing life-threatening conditions, waiting five years for affordable health care can determine their very survival. Given high rates of diseases within the community, such as breast cancer, cervical cancer, and HIV, timely detection and treatment can be the difference between life and death.

Angela Kim was born in South Korea 22 years ago. As her father was a traveling businessman, her family moved from Australia to Brazil and eventually settled in the United States with the hopes of a better life. While she and her family were living in Brazil, Angela got into a severe accident that left her in a coma for two weeks. When she awoke, she discovered that the right side of her body was paralyzed and she had to relearn how to do just about everything. Moving to the United States, her family hoped she could avoid the stigma associated with being disabled that is prevalent in South Korea as well as receive a better education and medical care. Due to complications in her legal paperwork, however, Angela and her family became undocumented and she could not receive proper physical care for her condition. As a result, her body is rapidly deteriorating. The limitations on her physical condition posed in tandem with her undocumented status left her in a state of worsening health and an uncertain future. But Angela eventually realized that she could not let her fear consume her and instead, could use her story to inspire others. She thus came out as undocumented and continues to share her story with others. Today, Angela is a recent graduate from UCLA with a degree in Psychology and hopes to one day become a social worker.

ANGELA'S STORY ILLUSTRATES THE WIDE-RANGING IMPLICATIONS OF BEING DENIED ACCESS TO HEALTH CARE ON THE BASIS OF IMMIGRATION STATUS.

SOURCE: NAT'L COUNCIL OF ASIAN PACIFIC AMERICANS, 2012 Policy Platform: Framing Issues and Recommendations to Improve the Lives of Asian American, Native Hawaiian, and Pacific Islander Communities (2012), available at http://ncapaonline.org/wp-content/uploads/2014/09/NCAPA-2012-Policy-Platform.pdf.

State Exceptions

Under the five-year ban, lawfully present immigrants remain ineligible for Medicaid absent emergency circumstances, unless their individual state chooses to cover them in separate programs or they qualify under narrow exceptions.

One of these exceptions is part of the State Children's Health Insurance Program (SCHIP), which was enacted in 2002 under the Bush administration and provides additional coverage only to pregnant women and children. Under SCHIP, states can choose to provide prenatal care to undocumented and lawfully present low-income immigrant women.[14] Fifteen states have enacted SCHIP programs.[15]

Another exception was created in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. CHIPRA permits states to waive the five-year ban for pregnant women and children who are otherwise eligible for Medicaid or CHIP.[16] Under CHIPRA, twenty states allow coverage for pregnant immigrant women and twenty-five states allow coverage for immigrant children.[17]

Left Behind Under the ACA

The ACA provides some relief to immigrants by allowing those with green cards who are unable to access Medicaid as a result of the five-year ban the option of purchasing coverage from state exchanges and to receive subsidies. However, no similar relief has been afforded to undocumented immigrants, who remain completely ineligible for subsidies and are even prohibited from purchasing coverage from the exchanges at full cost. As a result, access to health services for undocumented

immigrants is fully conditioned upon their ability to attain legal status. For low-income individuals who may have language barriers, this is an often difficult, time consuming, and prohibitively expensive barrier to obtaining health coverage.

The exclusion of certain recipients of deferred action from access to ACA marketplaces and subsidies is yet another barrier to health coverage faced by AAPI immigrants. Enacted in 2012, the Deferred Action for Childhood Arrivals (DACA) program allows undocumented young people who immigrated to the U.S. as children to remain in the U.S. for renewable periods.[18] In November 2014, President Obama announced an executive action expanding DACA and creating a new Deferred Action for Parents of Americans and Legal Permanent Residents (DAPA) program.[19] Under DAPA, certain eligible parents of U.S. citizens and legal permanent residents would be allowed to remain in the U.S. for renewable periods.*

However, those who qualify for DACA and DAPA are specifically excluded from both the Medicaid and CHIP programs, effectively placing these individuals in the same vulnerable situation as undocumented immigrants. This exclusion means DACA and DAPA recipients would only be able to obtain health insurance through an employer, assuming it is available and affordable. Moreover, the years during which individuals are lawfully present under DACA and DAPA do not count toward the five-year waiting period before they are eligible to receive Medicaid or CHIP. These bars exist, despite the fact that those who receive non-DACA and non-DAPA deferred action can enroll in certain state Medicaid and CHIP options, are able to purchase private insurance, and can apply for financial assistance through health insurance exchanges.

These limitations have a significant impact on AAPI immigrants. As of August 2014, there are an estimated 108,024 potential DACA beneficiaries from Asia, with South Korea, the Philippines, and India among the top 15 countries of origin for DACA applicants.[20] Moreover, approximately 400,000 AAPI parents are estimated to be eligible under DAPA.[21] The health of these community members remain in jeopardy.

Exclusion of COFA Migrants

Under the 1996 welfare reform law, Compacts of Free Association (COFA) migrants, or citizens of the Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau, were completely stripped of their ability to qualify for federal safety-net programs, including Medicaid and CHIP. Under COFA, these countries allow the U.S. exclusive use and military strategic positioning in the Pacific, while the U.S. allows their citizens migration privileges into the U.S. and provides grants to fund education, health care, and infrastructure. Many COFA migrants suffer from chronic diseases and health conditions linked to the medical effects of U.S. nuclear testing in the region.[22]

Currently, over 56,000 COFA migrants legally reside in the U.S.[23] Although they pay taxes and play a role in driving our economy, they are barred from many of the programs their tax dollars support. Unlike legally present immigrants, COFA migrants are banned from Medicaid and CHIP regardless of income or length of time in the U.S. Although the ACA allows COFA migrants to participate in the health care marketplace and to benefit from tax subsidies, without Medicaid, many COFA migrants continue to struggle to afford the new plans.

IMMIGRANT AAPI WOMEN IN DETENTION

Detention of immigrants in the United States continues to be on the rise. In 2011, an estimated 429,000 immigrants from all countries were admitted into immigration detention, nearly doubling the population from the previous decade.[24] During that year, Indians alone ranked sixth among the countries whose nationals were admitted to detention facilities with over 3,400 detainees.[25] Reports from local AAPI organizations indicate that many more individuals from other Asian countries are also housed in immigration detention centers.[26] Among all immigrant detainees, women comprise at least 9% of the daily immigrant detention population.[27]

Immigrants in detention often face deplorable conditions including limited access to adequate health care. This has particular ramifications for women held in confinement given the unique health care needs of women, including cancer screenings, gynecological services, pregnancy care, family planning services, and mental health services for survivors of gender-based violence. Yet, current detention policies only ensure access to emergency care and fail to guarantee women detainees' access to life-saving preventive care and treatment solutions.

The unfortunate reality is that Immigration and Customs Enforcement (ICE) agents have essentially become gatekeepers who determine whether women detainees are able to obtain basic medical care, such as Pap smears, mammograms, or pre-natal care, and often leave requests for medical assistance unheeded. In addition, frequent transfers of detainees to remote detention facilities and separation from family members can result in gaps in care

* Both the expansion of DACA and the implementation of DAPA are currently on hold pending litigation.

that can have devastating consequences on women detainees' health.

A MATTER OF PUBLIC HEALTH

These restrictive policies not only result in negative health outcomes for AAPI women and their families, but also result in high societal costs. Without access to comprehensive medical examinations and treatments, it is unlikely that health conditions or diseases will be detected early or that these individuals will receive preventative care. It is well established that preventative care is more effective in improving individual health conditions and prevents costly late-stage emergency room treatments. Without access to health coverage, many immigrants may only have access to emergency room treatment, which also increases costs within the health system.

CALL TO ACTION

As integral and committed members of American society, AAPI women should be able to pay their fair share for health care and be included in our health care system regardless of immigration status. Therefore, to ensure that all individuals, regardless of immigration status, have access to comprehensive health services, we call upon policymakers to:

- Restore health insurance under Medicaid and CHIP for all immigrants with lawful status by lifting the five-year ban.
- Allow undocumented immigrants to purchase private coverage in the ACA health insurance exchanges.
- Reverse the decision to exclude DACA- and DAPA-eligible immigrants from ACA health programs.
- Restore Medicaid coverage for COFA migrants.
- Ensure immigrants in detention have access to timely and comprehensive reproductive health services.

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