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Resource Paper

Forging a Path Toward Health Equity in 2040

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Abstract

Dramatic shifts in the demographic makeup of the U.S. population in 2040 will pose new challenges and opportunities for policy makers, researchers, and community members working to address health and health care inequities. Traditional approaches utilizing a health disparities framework may not be enough to address the health needs of an increasingly diverse and multiracial population of Asian Americans and Native Hawaiians and Pacific Islanders (NHPIs). This article provides an overview of the current and projected health and health care needs of Asian Americans and NHPIs in 2040, and proposes new policy solutions and frameworks for addressing these complex needs.

Introduction

In a little more than a generation, almost half of the United States population will be a person of color (U.S. Census Bureau, 2015a). Asian Americans and Native Hawaiians and Pacific Islanders (NHPIs) will account for the fastest population growth, constituting nearly one in ten Americans (Ong , Ong, and Ong, 2015).[1]

Diversity in the United States will also become increasingly complex, as more and more Americans identify as multiracial. Multiracial Asian Americans in particular are projected to lead the pack with a 130 percent growth (ibid.). There will also be notable differences by generation; Asian Americans and Pacific Islanders twenty-nine years and younger will more likely be U.S.-born, while Asian Americans and Pacific Islanders sixty years and older will more likely be foreign-born (ibid.).

These dramatic shifts in the demographic makeup of the future U.S. population will pose new challenges and opportunities for policy

makers, researchers, and community members as they continue to tackle health and health care inequities.[2] Traditionally, advocates utilized a health disparities framework to analyze differences in health outcomes, conditions, and health care service delivery based on race. Under this framework, researchers made comparisons between minority populations and the majority white population. They also developed policy solutions and interventions that targeted specific racial and ethnic populations. Yet, as the country shifts toward a "minority majority" population, will a disparities approach be the most appropriate way to address health needs, particularly for Asian Americans and NHPIs?

Current State of Health and Health Care for Asian Americans and NHPIs

An estimated 20.3 million Asian Americans and 1.5 million NHPIs currently reside in the United States (U.S. Census Bureau, 2015b). Asian Americans and NHPIs are comprised of diverse groups originating from more than fifty different countries and speaking more than one hundred languages and dialects (Pew Research Center, 2012). One in five Asian Americans is "limited English proficient (LEP)," meaning the individual speaks English less than very well (Zong and Batalova, 2015). About 60 percent of Asian Americans are foreign-born, representing the highest proportion of foreign-born among all racial groups in the United States. Among Pacific Islanders, more than one in seven are foreign-born (Empowering Pacific Islander Communities and Asian Americans Advancing Justice, 2014).

Uninsured rates among Asian Americans and NHPIs are comparable to the general U.S. population—in 2013, about 15 percent of Asian Americans and 18 percent of NHPIs lacked health insurance compared with 15 percent of the overall U.S. population (U.S. Census Bureau, 2013). However, uninsured rates vary dramatically when disaggregated by ethnic group. For example, Pakistanis, Koreans, and Bangladeshi all have rates of 22 percent or higher (Asian & Pacific Islander American Health Forum, 2012a). Asian American and NHPI children also experience high rates of being uninsured or underinsured.[3] Approximately 8 percent of Asian American children and 11 percent of NHPI children are uninsured. Asian American children also have the highest rate of underinsurance among all racial groups, at 20 percent (Asian & Pacific Islander American Health Forum, 2011a). These disparities in coverage rates correlate with income differences among Asian Americans and NHPIs. Despite popular perceptions of Asian Americans and NHPIs as

high achieving and financially prosperous, nearly two million are poor (National Coalition for Asian Pacific American Community Development, 2013).[4] The 2007 recession also demonstrated that many more live on the brink of poverty. Asian Americans, NHPIs, and Latinos were the hardest hit by the recession, which increased the number of poor Asian Americans and NHPIs by 38 percent (ibid.).

Asian Americans and NHPIs also experience certain diseases and chronic conditions at a higher rate than other racial groups. The rate of Asian Americans suffering from tuberculosis was more than twenty times higher than that of non-Hispanic whites from 1993 to 2012 (Centers for Disease Control, 2013). Approximately one out of two individuals with chronic hepatitis B is Asian American or Pacific Islander (Centers for Disease Control, 2015a). Diabetes and overweight/obesity prevalence also poses a serious threat to Asian American and NHPI health. NHPIs have a higher prevalence of diagnosed diabetes at over 14 percent compared to non-Hispanic whites at 8 percent. (Centers for Disease Control, 2015b). Asian Americans are also 30 to 50 percent more likely to have diabetes than their non-Hispanic white counterparts, even though Asian Americans are less likely to be overweight or obese according to standard measures (Hsu et al., 2015). Furthermore, rates of overweight and obesity prevalence among Asian American and NHPI children are growing at the fastest rate among all other racial and ethnic groups (Asian Pacific Partners for Empowerment, Advocacy and Leadership, 2014). This growing epidemic is especially prevalent among low-income children and NHPI children (Centers for Disease Control, 2015c; Shabbir et al., 2010). Indeed, income continues to be one of the most consistent predictors of health and disease (Minnesota Department of Health, 2014).

Mental health is also a major health concern for Asian Americans and NHPIs. Research shows a direct relationship between depression and chronic diseases including asthma, arthritis, cardiovascular disease, cancer, diabetes, and obesity (Chapman, Perry, and Strine, 2005). For example, Southeast Asian refugees who experienced severe trauma often suffer from high rates of posttraumatic stress disorder, cardiovascular disease, and diabetes (Wagner et al., 2013).

Yet Asian Americans and NHPIs are at increased risk for health problems as their mental health concerns often go unreported due to the stigma and shame associated with the topic. There is a critical lack of service providers who utilize an integrated approach to care and understand the role of culture, language, and historical trauma impacting Asian Americans and NHPIs. As a result, Asian Americans and NHPIs

are the least likely of any group to seek mental health services (Abe-Kim et al., 2007). Yet the consequences of unreported mental health needs are dire; individuals with serious mental health conditions die twenty-five years earlier than the general population, and 70 percent of the deaths are due to co-occurring medical conditions such as cardiovascular disease and diabetes (Colton and Manderscheid, 2006).

Implications of 2040 Population Projections

The projections of Ong et al. show some significant estimated shifts in age, nativity, ethnicity, and sex among Asian Americans and NHPIs in 2040 compared to the population today. The proportion of foreign-born among Asian Americans will decrease from around 60 percent to 50 percent, while foreign-born Pacific Islanders will also experience a slight decrease from 20 to 16 percent (Ong and Ong, 2015). The decline in the proportion of foreign-born will be even more pronounced among younger generations, resulting in a generational divide. Only 40 percent of twenty-eight- to thirty-four-year-old Asian Americans and a little more than 10 percent of Pacific Islanders will be foreign-born in 2040, while their elder counterparts (aged sixty-five years and older) will be mostly foreign-born—around 85 percent amongst Asian Americans and 34 percent among Pacific Islanders (Ong and Ong, 2015).

Both the Asian American and NHPI inclusive populations will also see significant growth in the number of older adults. Asian Americans and NHPIs aged sixty and older will experience at least a 100 percent growth in the population by the year 2040 (ibid.).[5] The population of Asian American women aged sixty years and older will also increase nearly 60 percent, while NHPI women in that age group will grow by more than 50 percent (ibid.). Finally, the 2040 projections indicate the likelihood of a more multiracial society with an estimated 130 percent growth in multiracial Asian Americans.

These changes in the Asian American and NHPI population mean policy makers, health care, and other service providers and advocates must make policy and system improvements to increase health care access; strengthen the full spectrum of health care services including mental, behavioral, and preventive health and services tailored to foreign-born seniors; implement new information technologies; and plan for the future workforce needs in the country's health care system.

Access to Quality Health Care and Coverage

Public health insurance programs such as Medicaid, Medicare, and

the Children's Health Insurance Program are critical sources of coverage for many Asian American and NHPI individuals and families. Approximately one in five Asian Americans and one in three NHPIs receive health insurance coverage through these programs (U.S. Census Bureau, 2013). The Affordable Care Act (ACA) increased access to these public insurance programs and created new health insurance marketplaces that provide subsidized private health insurance coverage for low- to moderate-income individuals. An estimated 1.9 million Asian Americans and NHPIs became eligible for the ACA's new health care coverage options when the marketplace first opened in 2014 (U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and Office of Minority Health, 2014).

Yet, a significant portion of the Asian American and Pacific Islander community is excluded from participating in these programs due to their immigration status. For example, lawful permanent residents (LPRs), also known as "green card" holders, are barred from participating in the Medicaid program in most states until they have continuously resided in the United States for at least five years.

Even if eligible, many immigrants have trouble navigating the complex enrollment process and therefore remain uninsured (Action for Health Justice, 2014). For example, immigrant Asian Americans and Pacific Islanders over the age of sixty-five who meet the federal government's definition of "lawfully present" are eligible for some aspects of the Medicare program, while other Medicare features are limited to the narrower group of LPRs who have resided continuously in the United States for at least five years (National Immigration Law Center, 2013).

These restrictions create confusion and unnecessary barriers to enrollment, particularly among those who are LEP. Looking ahead, policy makers will need to respond to the continuing barriers facing immigrant Asian Americans and Pacific Islanders. As the population of foreign-born Asian Americans and Pacific Islanders increases dramatically among persons sixty years old and older, access to health insurance will be a critical issue. A rise in the number of uninsured seniors will translate into increased health care costs for all. However, removal of eligibility restrictions based on immigration status—such as the five-year bar for LPRs, the exclusion of young adults granted deferred action,[6] and categorical exemptions on individuals without lawful status—could help bend the cost curve and promote the public health goals of prevention and good health outcomes for all.

For the remaining uninsured, there are few options to seek non-

emergency care. Those who are fortunate enough to have access to a federally qualified health center (FQHC) are able to receive health care services regardless of immigration status or ability to pay. Many FQHCs located in communities with a high concentration of Asian Americans and NHPIs also provide health care services in multiple Asian and Pacific Islander languages. Currently, nearly nine hundred thousand Asian Americans and NHPIs receive care at FQHCs (Association of Asian Pacific Community Health Organizations, 2015).

The ACA created an $11 billion Health Center Growth Fund to create new health center sites in medically underserved areas (MUAs) and to expand services. However, the current designations of MUAs and medically underserved populations do not adequately capture underserved Asian American and NHPI populations (Association of Asian Pacific Community Health Organizations, Asian & Pacific Islander American Health Forum, and Out of Many, One, 2010). Policy makers have an opportunity to release new designations to ensure a robust safety net is put into place for Asian American and NHPI communities in the future.

Health Care Delivery and Services

Health care providers, community-based organizations (CBOs), and hospital systems will need to plan for a growing population of older Asian Americans and NHPIs who are disproportionately LEP and immigrant. While health insurance coverage is a critical first step to improving individual health, access to health care alone is not enough. The quality of the health care services Asian American and NHPI consumers receive can affect the frequency of visits, openness to communicate, and likelihood of patient adherence between Asian Americans and NHPIs and their providers.

One of the most common factors affecting Asian American and NHPI patients' health care experience is language accessibility and cultural sensitivity. The Agency for Healthcare Research and Quality has long recognized that language barriers are a deterrent to seeking medical attention, and found the percentage of patients who reported not getting care as soon as they wanted was significantly lower for English speakers than non-English speakers (U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, 2014). Patients with both LEP and low health literacy—defined as not being able to read and understand content of health information—are also more likely to have poor health status (Sentell and Braun, 2012).

Asian Americans and NHPIs also underutilize health care services,

and many subgroups lack a usual source of care. For example, 25 percent of Korean Americans and 18 percent of NHPIs lack a usual source of care compared to 10 percent of whites (Ponce et al., 2009). Studies have found Asian Americans were the least likely to report being very satisfied with the quality of their health care (Collins et al., 2002). An examination of California Health Interview Survey data also showed that Asian Americans were more likely to report lower quality of care (Sorkin, Ngo-Metzger, and De Alba 2010). Both studies surmised that English fluency and perceived discrimination had profound effects on Asian Americans during their clinical visit. As such, language accessibility and culturally appropriate care approaches are critical for many Asian Americans and NHPIs and should be considered essential in the delivery of services.

Health providers should anticipate an increased demand for women's health care services among Asian Americans and NHPIs. The Asian American and NHPI female population is expected to increase by nearly 50 to 60 percent over all age groups. Like other women, Asian American and NHPI women and girls will have many health care needs including life-saving preventive services and the full spectrum of reproductive health care. Asian American and NHPI women and girls report persistently low Pap screening rates, even though certain ethnic groups such as Vietnamese American women have the highest rate of cervical cancer for any racial or ethnic group in the United States (Ma et al., 2012). Breast cancer is also the most commonly diagnosed cancer for Asian American women, yet Asian American women aged fifty to seventy-four years are the least likely racial group to get a mammogram (Centers for Disease Control, 2012).

Over the next twenty-five years, an increasing number of Asian Americans and NHPIs, particularly among younger generations, will be multiracial, adding a layer of complexity to health screenings and services that have traditionally targeted mono-racial groups. Caring for multiracial Asian Americans and NHPIs will also mean fulfilling their mental and behavioral health needs. While research on mental and behavioral health in multiracial Asian Americans and NHPIs is limited, one survey review found significant increased risk of substance abuse by multiracial Asian Americans. In particular, multiracial Chinese American youth were more than four times more likely to use substances than their Chinese American counterparts, and multiracial Vietnamese Americans were nearly four times more likely to use substances than other Vietnamese American youth (Price et al., 2002). One can infer that

such behavioral health risk factors will become more prevalent among multiracial Asian Americans and NHPIs in 2040.

While policy makers, health providers, and advocates will need to be responsive to the demographic shifts among Asian Americans and NHPIs, they will also need to continue to address the health care service needs of children; lesbian, gay, bisexual, and transgender (LGBT) individuals; and other vulnerable populations. For example, LGBT individuals often experience stigma in their communities and from their health providers, leading to adverse health outcomes. Community education, outreach, and interventions are also needed to address the high percentage of underinsured Asian American and NHPI children and the underutilization of preventive services among Asian American and NHPI women. Studies have shown that several subgroups of Asian American women are the least likely among all racial groups to receive early and adequate prenatal care, putting mothers and their babies at increased risk of low-birth weight, preterm birth, and infant mortality (Asian & Pacific Islander American Health Forum, 2012b).

Utilizing New Information Technologies

Along with the ACA, the American Recovery and Reinvestment Act of 2009 (ARRA) provided resources and incentives to adopt and integrate electronic health records (EHRs) into health care systems. ARRA's new federal dollars in EHRs represented a unique opportunity for providers to better monitor and evaluate the efficacy of care, utility of services, and correlate interventions to patients' health outcomes. As a result, the Association of Asian Pacific Community Health Organizations and its member health centers launched an initiative to use EHRs to establish a national data warehouse on Asian American and NHPI health. The hope is that utilization of new technologies to create the data repository will improve the health and wellness of Asian Americans and NHPIs on a population scale through (1) the disaggregation of dozens of Asian American and NHPI racial subgroups and more than two dozen respective languages; (2) national standardization of enabling services, critical nonclinical services that enhance access, continuity, and quality of care; (3) the integration and collection of nationally standardized social determinants of health data; and (4) better care management and reduction of total cost of care.

Health care providers are rapidly adopting new technologies and digital tools to connect patients and providers outside of the examination room. These advancements in the field of health information tech-

nology (HIT) hold great promise in improving access to care and quality. However, these technologies and the systems that support them are not equally accessible to many communities of color, older populations, rural communities, or among individuals who do not speak English well (California Pan-Ethnic Health Network et al., 2013). Thus, providers must be mindful that new HIT tools do not further exacerbate or deter existing service gaps in underserved communities. New innovations, such as mobile applications on smartphones to increase language access, are needed to meet the needs of Asian Americans and NPHIs in 2040.

Creating an effective and technologically integrated health care delivery system capable of improving health outcomes among Asian Americans and NHPIs will also require standardized systems of collecting, monitoring, and reporting disaggregated data. Asian Americans and NHPIs are not a monolithic group, and current data collection and reporting practices that aggregate Asian Americans and NHPIs mask existing inequities. Identifying immigration status—one of the greatest determinants of health insurance coverage and access—in a safe, secure, and trusted fashion is also a particular data collection challenge. As Asian American and NHPI communities continue to grow and become increasingly diverse, it will be important to understand particular health access and outcome challenges related to other demographic factors such as sex, primary spoken/written language, gender identity, and sexual orientation.

Health Care Workforce

The U.S. health care system already faces challenges recruiting and training Asian American and NHPI bilingual and/or bicultural professional and allied health care workers, particularly in underserved areas. With a rapidly growing Asian American and NHPI population expected in just more than a generation, providers, hospital systems, FQHCs, and other health care delivery institutions will experience an increased demand for interpreting services, translated materials, and culturally appropriate approaches when caring for Asian American and NHPI consumers. Multiracial Asian Americans and NHPIs will also benefit from health care providers, workers, and services that recognize the unique needs of individuals who identify with more than one race or ethnicity.

Providers must plan for the increased number of Asian American and NHPI seniors seeking elder care services in 2040. On a per capita basis, the elderly have the most hospital inpatient days, outpatient visits, and emergency department visits (U.S. Department of Health and Human Services, Health Services and Services Administration, 2003).

Relative to the nonelderly, they also have more home health visits per capita and are more likely to be in a long-term care facility. As such, new and existing recruitment and training programs, especially for members of allied health teams such as mid-level providers (e.g., nurse practitioners and physician assistants), physical and occupational therapists, and community and home health workers, are critically needed to ensure that an ethnically, culturally, and linguistically diverse public health, health, and health care workforce and infrastructure is in place by 2040.

Moreover, while the projections of Ong et al. do not show the geographic distribution of Asian American and NHPI population growth, recent U.S. Census data show several states in the South and Midwest are experiencing the fastest Asian American and NHPI growth in the country (Asian Americans Advancing Justice, 2011). Looking ahead, the Asian American and NHPI population in these regions will likely continue to grow and there will be increasing demand for health and social services that can meet their physical, mental, and behavioral health needs. Populations that reside in rural areas will face even greater challenges; many rural areas and Pacific jurisdictions are designated as physician shortage areas.

CBOs can play an effective role in addressing some of the workforce shortage issues, particularly within immigrant, linguistically isolated, and rural communities. CBOs either provide or help facilitate the delivery of culturally and linguistically appropriate health and social services to community members who are not connected to "mainstream" service programs. CBO staff are trusted members of the communities they serve and act as patient advocates, care coordinators, and outreach workers. These organizations have a unique set of knowledge and expertise on underserved communities and can be a valuable partner to care providers, health care systems, and other local institutions.

The ACA highlights the importance of integrated care approaches that address the physical, mental, and behavioral health needs of this country. Yet, there are differing opinions as to the meaning of "integrated care" and many challenges in the development and implementation of integrated models of care (Kodner and Spreeuwenberg, 2002). The definition of *integrated care* will have long-lasting implications on how providers are trained in the physical, mental, and behavioral health arenas; how treatment plans and intervention strategies are developed; what service delivery partners are identified; and the location of services and sharing of medical records. For example, while the federal government does not prohibit same-day billing for physical and mental health

services by the same provider on the same day, only twenty-eight states currently allow for same-day billing (Reynolds, 2012). There is also a need to conduct research on best practices models of integrated care in both health care clinics and CBOs to assess core competencies across disciplines, utilization of paraprofessionals, and investigate systems issues impacting both (Ida, SooHoo, and Chapa, 2012).

Toward a New Vision of Health Equity

The Asian American and NHPI population in the United States will grow and evolve in unprecedented ways over the next decade. The changes in the population's demographics will challenge current and traditional approaches to how health workers provide physical and mental health services, as well as how researchers monitor health care quality and utilization among Asian Americans and NHPIs. Future quality measures will need to include standards for cultural and linguistic appropriateness, while existing analyses that focus singularly on biological traits such as race, ethnicity, or sex will be too limiting.

Instead, anticipating future trends will require a reevaluation of structural barriers and other socioeconomic factors. This approach, also known as a "health determinants" framework, takes into account nonclinical conditions, such as income, social supports, and the physical and social environments where a person lives, works, learns, or plays (McGovern, Miller, and Hughes-Cromwick, 2014). For example, individuals and families with higher incomes are more likely to live in neighborhoods and communities with full-service grocery stores and safe spaces for outdoor activities such as playgrounds and parks. Thus, individuals living in these communities are more likely to live longer, healthier lives compared to those who live in low-income communities that lack these basic living conditions (Minnesota Department of Health, 2014). Racial and ethnic minorities including Asian Americans and NHPIs are more likely than whites to live in low-income communities (Joint Center for Economic and Political Studies, 2013). Adopting a health determinants analysis to measure health outcomes and health care quality may prove useful as Asian Americans and NHPIs as an identity group become increasingly multiracial and experience greater generational differences based on immigration status, English proficiency, and geography. It is important to recognize that this diversification will also take place among other communities of color. As such, achieving Asian American and NHPI health equity will depend on our ability to collaborate on health promotion efforts across all racial and ethnic groups.

The need for a broader framework that recognizes the multiple factors and varied lived experiences of individuals and their families is especially acute within the Asian American and NHPI population. In most federal research and household surveys, Asian Americans and NHPIs are often grouped together in one or two race categories, yet there is no singular, defining Asian American or NHPI experience. Grouping Asian Americans and NHPIs together may serve to provide statistical power, however, it masks the rich and varied cultures and immigration histories that constitute the dozens of ethnic subgroups that make up Asian American and NHPI communities. Similarly, a health determinants approach that contextualizes the social, institutional, community, and individual factors associated with physical, mental, and behavioral health outcomes will be more useful for identifying effective prevention and intervention strategies for the Asian American and NHPI population in 2040.

Some efforts are already underway to actualize a health determinants framework through public policy. Just a few months after the enactment of the ACA, a group of advocates representing a broad cross-section of disease, population, and professional health organizations worked with members of the "Tri-Caucus" to revise and reintroduce the Health Equity and Accountability Act of 2011 (HEAA), the most sweeping health equity bill to date (U.S. Congresswoman Barbara Lee, 2014).[7] Building on the ACA's historic expansion of health insurance coverage to millions of uninsured, HEAA provides a road map for addressing a range of mental, behavioral, environmental, and physical health determinants (Asian & Pacific Islander American Health Forum, 2011b). For example, the bill focuses on ensuring that a full range of culturally and linguistically appropriate health care and public health services are available and accessible to all; creates additional pipeline and training opportunities for minority-serving professional and allied health care workers; and supports community-based prevention efforts to address a range of disease-specific, mental, and behavioral health issues facing communities of color and other barriers such as immigration status, age, disability, obesity, sexual orientation, gender identity, and LEP (Asian & Pacific Islander American Health Forum, 2012c). The bill was introduced by Representative Barbara Lee with eighty-three cosponsors. A Senate companion bill was introduced in 2012, and HEAA was subsequently reintroduced in the House in 2014.

Legislative efforts and policies such as HEAA must be enacted soon to ensure health care systems and other institutions can accommodate

future Asian American, NHPI, and other population groups with diverse and complex needs. Federal, state, and local governments can also take steps today to implement the principles and policy solutions outlined in HEAA and other policy tools to redesign their health and social service infrastructure to meet the needs of Asian Americans and NHPIs in 2040. For example, state and county public health departments could adopt in their health surveys some of HEAA's recommended demographic categories to capture information about residents' ethnicity, primary language, gender identity, and sexual orientation. Similarly, public health departments could work with other agencies to design and implement a set of metrics for measuring and tracking health determinants across a cross-section of socioeconomic factors. What's clear is that transformations are needed, and a continuation of the status quo will not adequately propel Asian American and NHPI communities to healthier outcomes in 2040.

Conclusion

Implementation of the ACA is still underway nearly six years after its historic passage. While the long-term effects are unknown, the short-term impacts of expanded health care coverage, lower premium costs, no-cost preventive care, and other important investments have benefited millions of Americans, including Asian Americans and NHPIs (Burwell, 2015). Health insurance coverage is certainly a universal need in the United States, however health conditions and outcomes among Asian Americans and NHPIs will not improve with mere access to health coverage. Policy makers, public health departments, and health care institutions must implement reforms that recognize the growing and diverse physical, mental, environmental, and behavioral health care needs of Asian Americans, NHPIs, and all Americans through a health determinants lens. With the U.S. Supreme Court's decisions to uphold a key aspect of the ACA, policy makers can finally shift from defending the health reform law to improving it. Inaction will merely exacerbate existing health and health care inequities among Asian Americans and NHPIs, leading to increased costs and burdens on the U.S. health care system in 2040. To achieve our vision for 2040, Asian Americans and NHPIs must advance public health and health equity.

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Notes

1. The 2040 projections reflect the Asian American and NHPI populations in the fifty states, and do not include individuals residing in the U.S. Pacific Island jurisdictions.
2. The authors adopt the definition of health utilized by the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The term 'health and health care inequities' refers to systemic, environmental and structural disparities affecting particular population group(s)" (see Trinh-Shevrin, Islam, Nadkarni, 2015).
3. The term underinsured refers to individuals enrolled in a health plan that does not adequately cover their medical expenses (see Gold, 2009).
4. Defined as having an annual income of $11,770 or less for an individual according to the 2015 federal poverty level.
5. The size of the percent change is the result of small numbers in 2015.
6. The exclusion would also apply to future individuals granted administrative relief through President Obama's executive actions expanding deferred action for young adults and creating a new deferred action program for the parents of U.S. citizens or LPRs. As of this writing, these programs have not been implemented due to pending litigation.
7. The "Tri-Caucus" is comprised of the Congressional Asian Pacific American Caucus, Congressional Hispanic Caucus, and Congressional Black Caucus. The Healthcare Taskforce chairs of each caucus rotate as the lead sponsor of HEAA during each congressional session.

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