Many Asian American and Native Hawaiian/Pacific Islander Adults May Face Health Care Access Challenges Related to Limited English Proficiency

Jennifer M. Haley, Stephen Zuckerman, Nikhil Rao, Michael Karpman, and Alena Stern
December 2022

Key Findings

Growing interest in addressing health equity is fueling efforts to better understand the unique challenges faced by Asian American and Native Hawaiian/Pacific Islander (AANHPI) communities. A lack of language accessibility for AANHPI people who are not proficient in English, in particular, could restrict their access to health insurance and quality health care, especially for those who may have to navigate complicated systems to enroll in coverage. In this brief, we assess the extent of limited English proficiency (LEP) among AANHPI nonelderly adults and variation in LEP across AANHPI subgroups, using the most recently available reliable data from the American Community Survey (ACS). We find the following:

- In 2019, about 3 in 10 (30.8 percent) Asian American adults and 1 in 8 (12.1 percent) Native Hawaiian/Pacific Islander (NHPI) nonelderly adults had LEP, compared with 32.9 percent of Hispanic adults, 3.1 percent of Black adults, and 1.4 percent of white adults. An estimated 14.9 percent of Asian American adults lived in a household in which all members ages 14 and older reported having LEP.

- AANHPI adults with LEP were more likely than those proficient in English to be noncitizens and to have economic disadvantages such as lower incomes, lower levels of education, and higher uninsurance rates.

- Whereas almost all Hispanic adults with LEP reported speaking Spanish, the languages AANHPI adults with LEP speak were much more varied, making it more challenging to reach all members of this group with targeted language access interventions.

- Estimated LEP rates varied widely across subgroups of AANHPI adults; for instance, LEP rates were around 12 percent for NHPI adults, whereas more than 40 percent of Chinese, Bangladeshi, Vietnamese, Nepalese, and Burmese adults had LEP.

Overall, AANHPI adults have LEP at rates nearly as high as Hispanic adults. While Spanish is frequently offered in health system settings and materials (e.g., the federal Marketplace for purchasing health insurance coverage or state Medicaid resources) as a language option for people who do not speak English, the diverse languages spoken by AANHPI adults are rarely available. These findings show the need for greater language accessibility for AANHPI adults with LEP in health care and other settings, especially as some pandemic-related health insurance coverage protections expire and the need for clear communication from state health insurance agencies to enrollees continues to grow.

Background

Language can be a barrier to obtaining health insurance coverage, especially for nonelderly adults who may need to navigate complicated enrollment systems. For instance, though the Centers for Medicare & Medicaid Services offers various resources about subsidized coverage options in 18 languages,[1] the federal website for purchasing Affordable Care Act Marketplace coverage is only accessible in English and Spanish. Further, when the website launched, navigators reported challenges with communication on call lines offering interpretation in less-common languages.[2] New research also finds that many state Medicaid websites offer information, applications, or automated phone services only in English, or, if they offer translated materials, they may only be available in Spanish (Musumeci et al. 2022). If applications for or information about public benefits is only available in a limited number of languages and people who speak other languages are directed to a customer service number for translation through an unclear and confusing process, the accessibility of needed benefits may be reduced.[3] Limited language access may also increase the resources needed for community-based enrollment and renewal assistance (Gonzalez, Karpman, and Alvarez Caraveo 2022).

Language barriers can also limit access to health care by making it more difficult to find and communicate with providers. Under federal laws, including Title VI of the Civil Rights Act of 1964 and the Affordable Care Act, providers who receive federal funding are required to offer language services to patients with LEP, and all states have multiple laws regarding language access (Youdelman 2019). However, the availability of language services varies across institutions and health care settings (Schiaffino, Nara, and Mao 2016), and if patients are not aware of their rights, they may face additional language hurdles gaining access to the health system. Even if they do gain access, patients may still face barriers to understanding information from providers such as care instructions and treatment options.

However, the extent of such barriers may be overlooked for AANHPI communities. Because of historical and structural factors such as immigration policies, internment and exclusion laws, colonialism, racial and religious profiling, and discrimination, AANHPI people living in the US have faced unique challenges (Ford et al. 2021). Such difficulties were exacerbated during the COVID-19 pandemic under alarmingly intensified anti-Asian bias and racist hate crimes.[4]

Even given this context, on average, Asian Americans have higher levels of income and education than many other racial groups,[5] fostering the "model minority" myth, which can suggest that AANHPI communities do not face systemic challenges (Yi et al. 2016). Moreover, the model minority myth suggests AANHPI people are monolithic, and aggregated data conceal wide variation in the circumstances under which various subgroups of the AANHPI population immigrated to or were made part of the country through US territorial expansion and conceal persistent within-group inequalities (Quint et al. 2021; Shih et al. 2022).[6] A lack of data disaggregation can also contribute to worsening health inequities; for instance, not separately measuring outcomes for subgroups of AANHPI people or grouping NHPI people within the larger Asian American group can hide harms and result in certain groups' health needs being deprioritized (Ponce, Shimkada, and Tulua 2021; Wang Kong et al. 2022).

The pandemic has exacerbated the difficulties people who do not speak English face in accessing health care and raised the stakes of missed communications,[7] and renewed attention to health equity has drawn attention to the challenges facing AANHPI communities (Pillai, Ndugga, and Artiga 2022; Xi et al. 2022). Moreover, language accessibility could become even more important as pandemic protections expire. For instance, the Families First Coronavirus Response Act's continuous coverage requirement mandates that Medicaid enrollees cannot be involuntarily disenrolled during the public health emergency; however, millions of people will face redetermination of eligibility when the emergency officially ends, necessitating clear communication from state agencies about how to maintain Medicaid or enroll in other coverage to avoid becoming uninsured (Buettgens and Green 2022). Thus, the need to understand the role of language barriers for different subgroups of the population is especially critical now.

In this brief, we provide the most recent available estimates of LEP among nonelderly AANHPI adults from the ACS. We assess the extent of LEP among AANHPI adults as compared with other racial and ethnic groups, how the characteristics of AANHPI adults differ by LEP status, the languages most commonly spoken among AANHPI adults with LEP, and how LEP rates vary across subgroups within the AANHPI population. We conclude with a discussion of policy considerations.

Data and Methods

We analyzed the nonelderly (ages 19 to 64) adult population using annual ACS data from 2019, harmonized by the Integrated Public Use Microdata Series, or IPUMS USA (Ruggles et al. 2022). (Data collection challenges for the 2020 ACS rendered the data unreliable.[8]) The ACS is a mixed-mode survey; paper and internet-accessible forms are available in English or Spanish, but telephone interviews are conducted in more than 30 languages (Smalley 2020). We measure racial and ethnic identity from ACS questions asking about individuals' ethnicities and races that allow respondents to select multiple options. Our primary sample consists of adults who identified as non-Hispanic ethnicity and Asian American or Native Hawaiian/Pacific Islander race, either alone or in combination with another race (*n* = 133,678). We group those who identify as only AANHPI (either a single AANHPI ethnicity, such as Indian, or multiple AANHPI ethnicities, such as Japanese and Native Hawaiian) with those who identify as AANHPI and another race (e.g., both Chinese and Black or both Korean and white) to analyze the

broadest group of AANHPI adults and to compare AANHPI-only and other AANHPI adults. We exclude Hispanic AANHPI adults to understand the unique challenges faced by those who are less likely to speak English or Spanish.[9] However, we note this approach differs from conventions used in some other research.[10] Some analyses mentioned here separate subgroups of AANHPI adults who are Asian American only, NHPI only,[11] and multiracial AANHPI (including those who are both Asian and NHPI, or either of those categories plus another race). We further disaggregate AANHPI adults by detailed subgroups defined by category selections or write-in responses to the detailed ACS question about race; we also collapse Asian American adults into several regional or ethnic subgroups (i.e., South Asian, Southeast Asian, and East Asian) defined in Ponce (2021). We also compare non-Hispanic AANHPI adults with the 1.7 million adults in the sample who are not AANHPI, categorized as Hispanic, non-Hispanic Black, non-Hispanic white, or another non-Hispanic race or multiple races (either American Indian/Alaska Native, another race, or more than one race but not AANHPI, who are grouped together because of small sample size).

We define people with LEP as those whose survey responses indicate they (1) speak a language other than English at home and (2) do not speak English "very well" (that is, speak English only "well," "not very well," or "not at all"), which is the definition employed by the federal government.[12] We define a household with LEP as one in which all members ages 14 and older are identified as having LEP.

First, we examined the extent of having LEP by race and ethnicity. Next we tabulated how selected sociodemographic characteristics of AANHPI adults differ by LEP status; the sociodemographic characteristics are as follows:

- citizenship status (US citizen or not US citizen)

- family income as a percentage of the federal poverty level, or FPL (0 to 99 percent of FPL, 100 to 199 percent of FPL, 200 to 399 percent of FPL, and at or above 400 percent of FPL)

- educational attainment (less than high school; high school or general education degree, or GED; some college or associate's degree; and bachelor's degree or more)[13]

- health insurance coverage status at the time of the survey (uninsured; Medicaid or Children's Health Insurance Program; employer-sponsored insurance, Veterans Affairs care, or TRICARE; and other health insurance, which is either Medicare or nongroup coverage)[14]

To show challenges policymakers and providers face when serving AANHPI populations with LEP, we then identified the top 10 languages spoken by AANHPI subgroups with LEP. Finally, we examined variation in LEP rates across detailed subgroups within the AANHPI population, in alignment with the geographic categorization of Asian American and NHPI populations in Ponce (2021). All estimates are weighted, and statistical tests use ACS replicate weights that account for the survey's complex design.

Limitations

This analysis has several limitations. First, we have included as AANHPI both adults whose racial identification is AANHPI only and those who identify as AANHPI and another race, meaning our

estimates may differ from those of analyses that instead group multiracial people in a multiracial or "other" category. However, the majority of our sample (92.8 percent) is single-race AANHPI, two or more Asian ethnicities only, or two or more NHPI ethnicities only. Moreover, to focus on AANHPI people who may not be proficient in English or Spanish, we exclude those who also identify as Hispanic. Thus, our estimates may differ from those of analyses that include Hispanic AANHPI adults. However, as noted below, we conducted some sensitivity analyses with and without the inclusion of Hispanic AANHPI adults and found that patterns did not vary notably (data not shown).

Further, we use the initialism AANHPI but acknowledge that not everyone in this group identifies with this terminology and that it may obscure complexities of racial identity. We further group AANHPI adults by subgroups defined by ethnicity but acknowledge that this may not represent individuals' preferred cultural identification or affiliation (e.g., in the case of a person born in one country to parents born in another country who may consider themselves either ethnicity). Relatedly, for the indicator of language spoken by individuals with LEP, we use information provided in the survey; for instance, respondents may have identified their preferred language as either Mandarin, Cantonese, or Chinese, and we maintain these distinctions even though both Mandarin and Cantonese are dialects of Chinese.

Survey data are self-reported or reported by another household member and may be susceptible to bias and measurement error. Research has suggested an association between household language and survey mode and found higher item nonresponse requiring imputation for households that do not speak English (Smalley 2020), potentially introducing bias for estimates of subgroups that include a larger share of such households.

In addition, because of challenges collecting ACS data in 2020, these analyses are based on prepandemic data and may not capture changes in income, insurance coverage, and other measures that occurred during the pandemic. They may also not capture the experiences of more-recent groups of immigrants and refugees who have arrived in the US since 2019.

Results

In this section, we explore the extent of LEP among AANHPI adults relative to other racial and ethnic groups, how the characteristics of AANHPI adults differ by LEP status, the languages most commonly spoken among AANHPI adults with LEP, and how LEP rates vary across subgroups within the AANHPI population.

What Is the Extent of LEP among AANHPI Nonelderly Adults as Compared with Those in Other Racial and Ethnic Groups?

According to the ACS, an estimated 9.4 percent of all nonelderly adults had LEP in 2019. More than 1 in 4 (27.4 percent) AANHPI adults had LEP (figure 1), including about 3 in 10 Asian American adults (30.8 percent), 1 in 8 NHPI adults (12.1 percent), and 1 in 15 multiracial AANHPI adults (6.8 percent).[15] In comparison, 32.9 percent of Hispanic adults, 3.1 percent of non-Hispanic Black adults, 1.4 percent of

non-Hispanic white adults, and 3.6 percent of non-Hispanic adults of other or multiple races reported having LEP. Thus, Asian American adults were much more likely to have LEP than every other racial or ethnic group examined except for Hispanic adults, who were only slightly more likely to have LEP.[16]

Further, 14.9 percent of Asian American nonelderly adults reported LEP among all members of their households ages 14 and older. In comparison, 14.1 percent of Hispanic adults reported residing in such households, and rates of household LEP for all other non-AANHPI racial and ethnic groups and nonelderly adults overall were at or below 5 percent. Thus, Asian American adults are the most likely of all the racial and ethnic groups examined to live in a household with no proficient English speakers.[17]

Share of Adults Ages 19 to 64 with Limited English Proficiency, by Race or Ethnicity, 2019
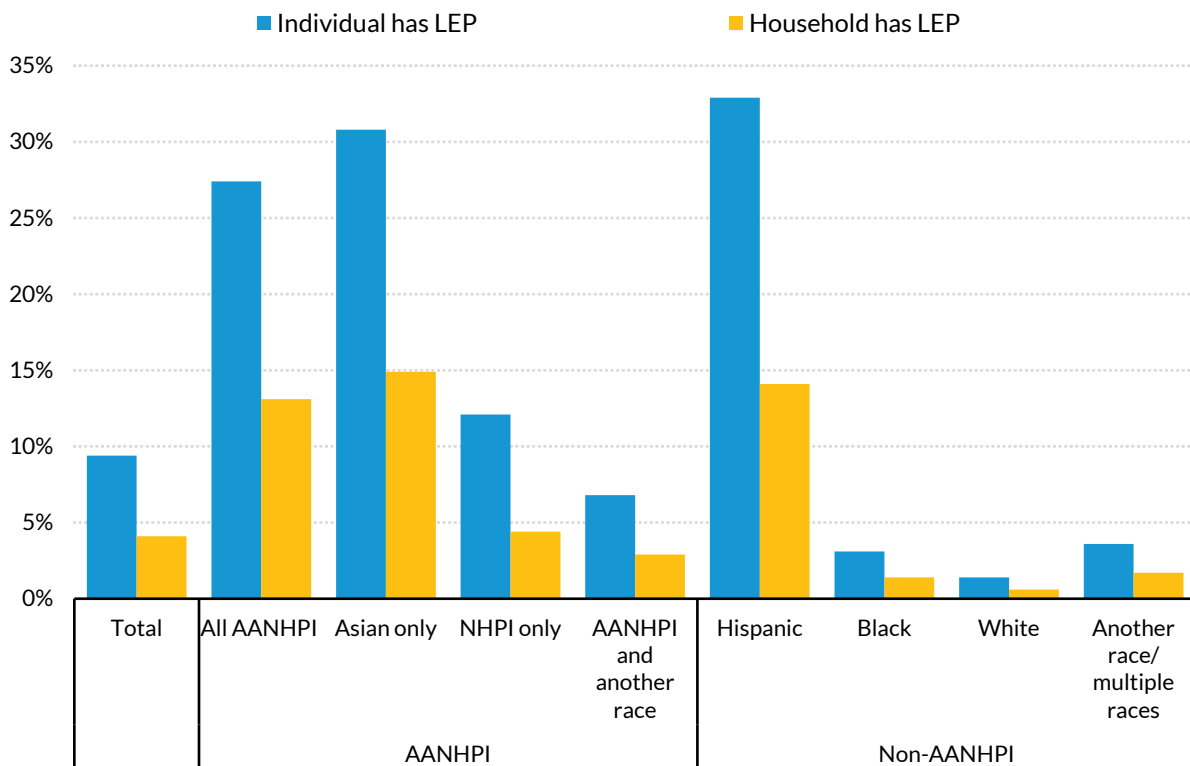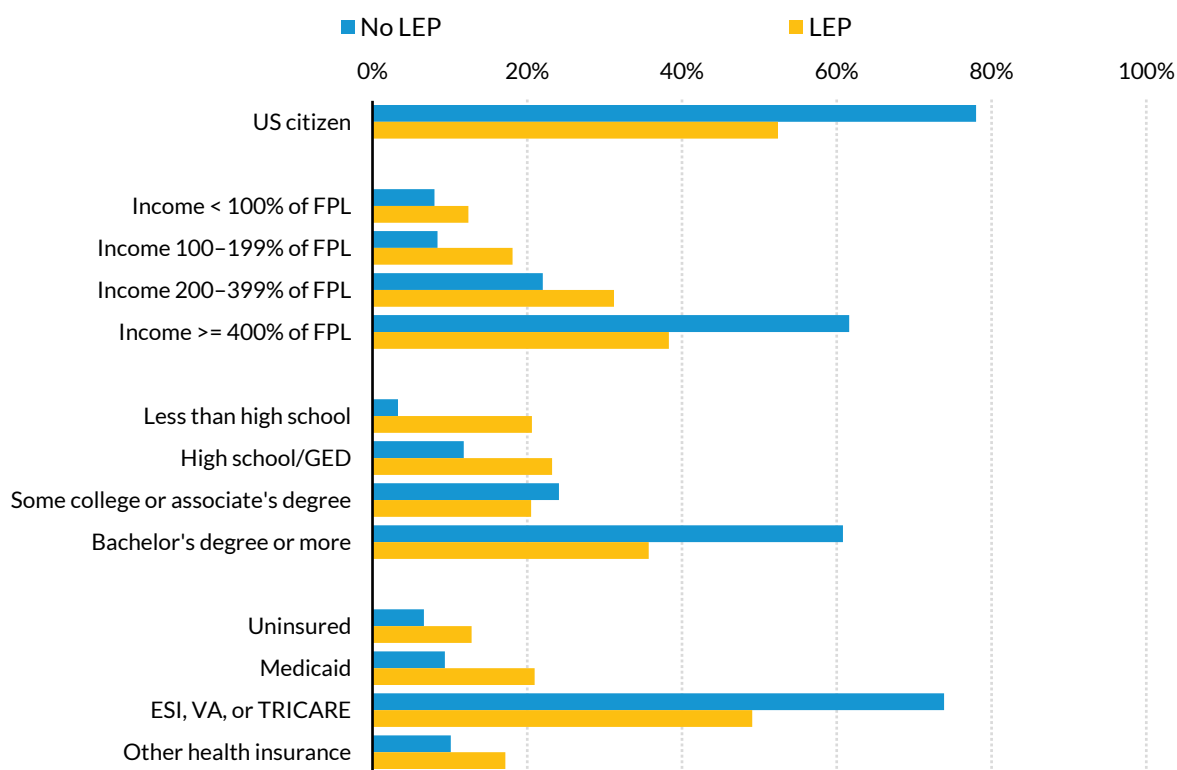

URBAN **INSTITUTE**

Source: Authors' analysis of American Community Survey data from the Integrated Public Use Microdata Series.
Notes: LEP = limited English proficiency; adults with LEP speak another language, do not speak English very well, or do not speak English. AANHPI = Asian American and Native Hawaiian/Pacific Islander. NHPI = Native Hawaiian/Pacific Islander. "Household has LEP" refers to households in which every person ages 14 and older has LEP. All Hispanic adults, regardless of race, are in the Hispanic group; every other group is non-Hispanic. The Asian American group includes both single-race and multiracial Asian individuals; the NHPI group includes both single-race and multiracial NHPI individuals; and "another race or multiple races" includes people who are either American Indian/Alaska Native, another race, or more than one race but not AANHPI. Estimates for all subgroups are statistically different from the estimate for the Hispanic group, and estimates for all non-AANHPI subgroups are statistically different from the estimate for the AANHPI group overall at the $p < 0.05$ level.

How Do the Characteristics of AANHPI Adults Differ by LEP Status?

Figure 2 displays sociodemographic characteristics of AANHPI adults by LEP status, showing notable variation between subgroups with and without LEP. Only about half (52.4 percent) of AANHPI adults with LEP were US citizens in 2019, compared with more than three-quarters (78.0 percent) of their English-proficient counterparts. AANHPI adults with LEP had lower family incomes and lower levels of education on average: compared with English-proficient AANHPI adults, those with LEP were almost twice as likely to have incomes below 200 percent of FPL (30.5 versus 16.4 percent) and were about six times more likely to not have a high school degree (20.6 versus 3.3 percent).[18] In addition, AANHPI adults with LEP were much more likely to be uninsured (12.8 versus 6.7 percent) and much less likely to have employer-sponsored or military health insurance coverage (49.1 versus 73.9 percent) than AANHPI adults with English proficiency. And despite being more likely to face citizenship-related and other eligibility and enrollment barriers, a larger share of AANHPI adults with LEP reported having Medicaid coverage (21.0 versus 9.4 percent), in line with their lower average family income. Similar patterns emerge when disaggregating AANHPI adults by subgroup, as shown in appendix table 1, suggesting many socioeconomic disadvantages associated with having LEP exist across these groups.

FIGURE 2

Characteristics of Non-Hispanic Asian American and Native Hawaiian/Pacific Islander Adults Ages 19 to 64, by Limited English Proficiency Status, 2019

URBAN **INSTITUTE**

Source: Authors' analysis of American Community Survey data from the Integrated Public Use Microdata Series.

What Are the Most Commonly Spoken Languages among AANHPI Adults with LEP?

Table 1 shows the top 10 languages spoken by AANHPI adults with LEP by subgroup. Among Asian American adults with LEP, the largest shares spoke Chinese (20.7 percent), Vietnamese (16.6 percent), or Korean (9.2 percent), but together these top three languages were spoken by less than half of all Asian adults with LEP. About a third of Asian American adults with LEP reported speaking one of the next-most-common languages (Filipino/Tagalog, Mandarin, Cantonese, Bengali, Hindi, Japanese, or Urdu), but nearly a quarter of them spoke a language other than 1 of the top 10. Languages spoken by NHPI adults with LEP varied slightly less; nearly three-quarters of NHPI adults with LEP (72.2 percent) spoke one of the top five languages spoken by this subgroup (unspecified Malayan languages, Samoan, Marshallese, Trukese, and Tongan). Further, among multiracial AANHPI adults with LEP, 17.4 percent spoke Arabic, and 14.0 percent spoke Persian, Iranian, or Farsi; smaller shares spoke the other most-common languages, and more than 31.8 percent spoke a language other than 1 in the top 10.

TABLE 1

Top 10 Languages Spoken by Non-Hispanic Asian American and Native Hawaiian/Pacific Islander Adults Ages 19 to 64 with Limited English Proficiency, by Subgroup, 2019

Asian American Only		NHPI Only		Multiracial AANHPI	
Language	**%**	**Language**	**%**	**Language**	**%**
Chinese	20.7	Unspecified Malayan languages	16.8	Arabic	17.4
Vietnamese	16.5	Samoan	16.2	Persian, Iranian, Farsi	14.0
Korean	9.2	Marshallese	14.4	Unspecified Asian languages	6.0
Filipino, Tagalog	8.4	Trukese	12.9	Pashto, Afghan	5.9
Mandarin	6.7	Tongan	11.9	Russian	4.8
Cantonese	4.9	Hindi	11.4	Vietnamese	4.6
Bengali	3.0	Czech	6.2	Dari	4.2
Hindi	2.7	Chamorro, Guamanian	3.6	Filipino, Tagalog	4.1
Urdu	2.6	Hawaiian	1.8	Panjabi	3.6
Japanese	2.6	Vietnamese	0.9	Hindi	3.6
Top 10 languages as share of total	77.1	*Top 10 languages as share of total*	96.0	*Top 10 languages as share of total*	68.2

Source: Authors' analysis of American Community Survey data from the Integrated Public Use Microdata Series.
Notes: NHPI = Native Hawaiian/Pacific Islander. AANHPI = Asian American and Native Hawaiian/Pacific Islander. AANHPI people, including those who are multiracial, are not Hispanic. People with limited English proficiency speak another language, do not speak English very well, or do not speak English. The sample size of NHPI-only adults with LEP is small, so estimates for this subgroup should be interpreted with caution.

In contrast, 99.6 percent of Hispanic adults with LEP spoke Spanish (data not shown). Thus, although the share of adults with LEP is smaller among AANHPI adults than among Hispanic adults, AANHPI adults with LEP speak a much more diverse set of languages than Hispanic adults with LEP.

How Do LEP Rates Vary across Subgroups of the AANHPI Population?

Figure 3 shows LEP rates for subgroups of AANHPI adults. LEP rates were lowest among multiracial (6.8 percent) and NHPI (12.1 percent) subgroups and highest among East Asian (37.9 percent) and Southeast Asian (32.2 percent) subgroups. But this conceals large differences within each of these regional and racial subgroups. The single-race AANHPI subgroups with the highest LEP rates were Burmese (73.3 percent), Nepalese (52.5 percent), Vietnamese (49.6 percent), Bangladeshi (48.5 percent), Chinese (41.8 percent), and Thai (40.0 percent). The group that had the lowest share with LEP was Native Hawaiian adults (0.9 percent).

Share of Non-Hispanic AANHPI Adults Ages 19 to 64 with Limited English Proficiency and Population Size (in Thousands), by Regional and Racial Subgroups, 2019
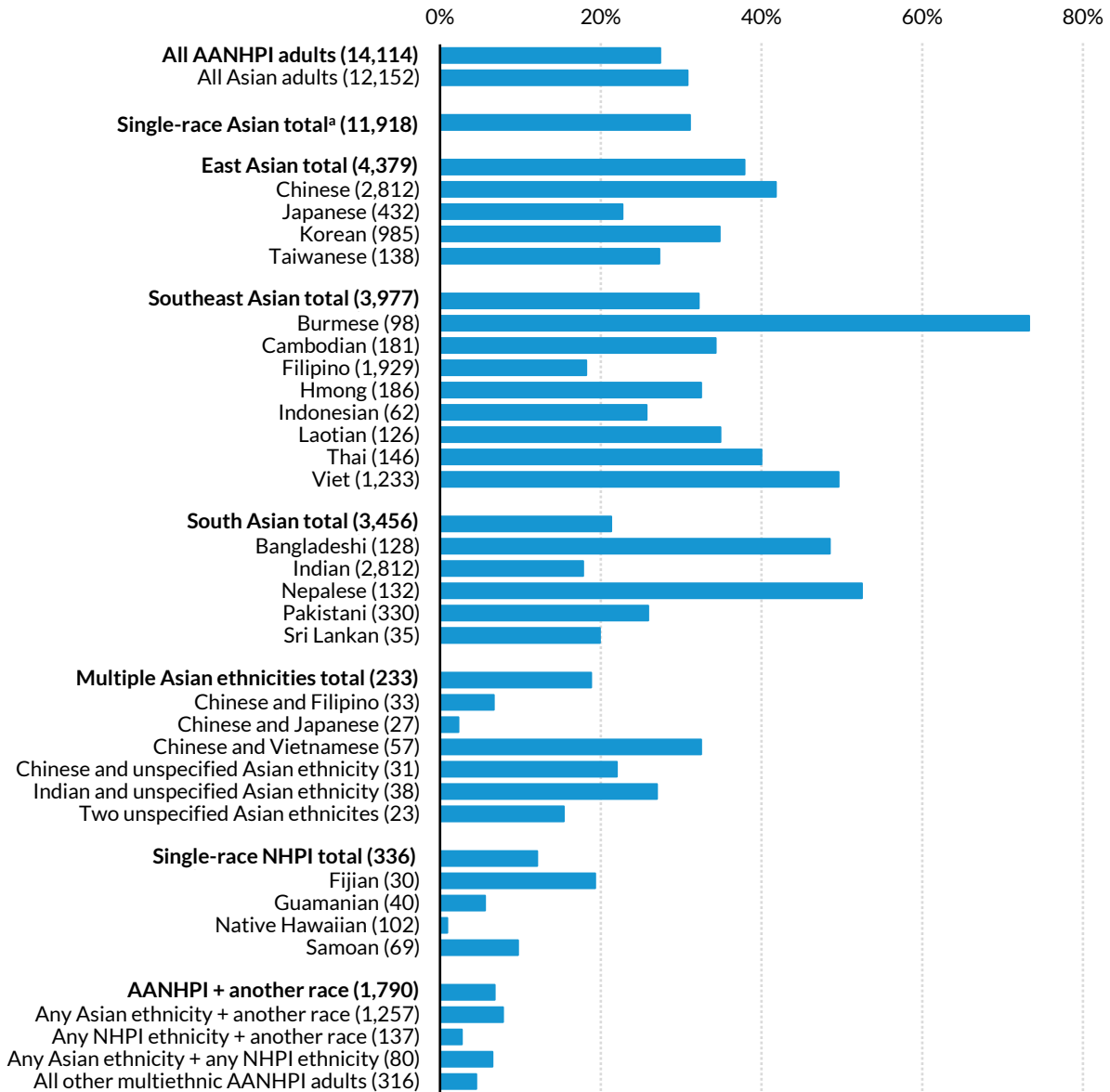
Source: Authors' analysis of American Community Survey data from the Integrated Public Use Microdata Series.
Notes: AANHPI = Asian American and Native Hawaiian/Pacific Islander. NHPI = Native Hawaiian/Pacific Islander. Population size (in thousands) is shown next to the y-axis labels. Adults with limited English proficiency speak another language, do not speak English very well, or do not speak English. For each grouping, the first, bolded group is made up of the subgroups below it. AANHPI individuals are non-Hispanic. East Asian, Southeast Asian, and South Asian groupings are drawn from Ninez A. Ponce, "Achieving Health Equity for Asians, Native Hawaiians and Pacific Islanders," ASHEcon Economics of Health Equity Interest Workshop webinar given October 6, 2021. Subgroups with sample sizes smaller than 200 people are not shown; these subgroups include Bhutanese, Chinese and Korean, Filipino and Japanese, Malaysian, Mongolian, Tongan, unspecified Micronesian, and other multiethnic subgroups, which together make up less than 1 percent of the total non-Hispanic AANHPI population.
[a] The "single-race Asian total" group is made up of the East Asian, Southeast Asian, and South Asian groups.

Discussion

According to the ACS, about 1 in 4 AANHPI adults had LEP in 2019, including about 3 in 10 Asian American adults and 1 in 8 NHPI adults. These adults were more likely than their English-proficient counterparts to be noncitizens and to have economic disadvantages. Thus, despite stereotypes of AANHPI people being a model minority and not facing disadvantages, many of these adults faced several barriers that could reduce their access to health insurance and health care and make it more challenging for them to meet their and their family's health needs. And because LEP rates varied dramatically across subgroups of AANHPI adults, such barriers likely vary widely across AANHPI communities. For example, fewer than 1 percent of Native Hawaiian adults had LEP, compared with more than 40 percent of Chinese, Bangladeshi, and Vietnamese adults and more than half of Nepalese and Burmese adults, highlighting the diversity of language resources needed across subgroups of the AANHPI population. These findings also emphasize the importance of data disaggregation for understanding variations in the challenges faced by AANHPI subgroups, which aligns with recent research on data disaggregation best practices (Shimkada, Scheitler, and Ponce 2021).

Broadening language access has been a focus of some recent efforts to improve health equity and the accessibility of health care. In line with evidence of the role of language as a barrier to health care access and quality, language and literacy are included as social determinants of health in Healthy People 2030 goals.[19] The Biden administration recently proposed a rule related to Section 1557 of the Affordable Care Act that would strengthen the enforcement of antidiscrimination regulations, including those related to the language services Medicaid agencies provide,[20] and the Title VI Interagency Working Group has offered several suggestions for improving digital language accessibility (LEP Committee 2021). Some recent efforts may particularly benefit AANHPI people with LEP: In the fall 2021 open enrollment period, the Centers for Medicare & Medicaid Services began advertising for publicly subsidized coverage options in Chinese (Mandarin and Cantonese), Korean, Vietnamese, Tagalog, and Hindi and released materials about Medicare in Chinese, Korean, and Vietnamese.[21] Furthermore, the Biden administration recently recognized an initiative that highlights the contributions of AANHPI communities, condemns hatred and xenophobia, and establishes key priorities for advancing equity for AANHPI people.[22] Among the recommendations identified by the President's Advisory Commission on Asian Americans, Native Hawaiians, and Pacific Islanders within the Department of Health and Human Services are supporting greater efforts for data disaggregation and providing federal documents and digital resources in languages other than English and Spanish (President's Advisory Commission on Asian Americans, Native Hawaiians, and Pacific Islanders 2022).

But offering translated materials in common languages would still leave gaps for many AANHPI adults. Fewer than half of all Asian American adults with LEP spoke the top three languages used by this group (Chinese, Vietnamese, or Korean), and nearly a quarter reported speaking a language other than 1 of the top 10. Thus, whereas using Spanish reaches nearly all Hispanic adults with LEP, it would be difficult to reach all Asian American adults with LEP across the country with even a dozen language options. This suggests local and state-level resources must be targeted to meet the specific language needs in each community.

Additional solutions have been proposed for improving language accessibility in health care settings, such as

- building coalitions with community-based organizations that may have expertise in specific languages common to their local areas,

- improving visibility of in-language taglines on printed materials,

- increasing the use of medical interpreters instead of relying on informal family member interpretation,

- monitoring and improving multilingual call-center quality,

- incorporating training in medical schools on how to inform patients of their rights to language services and use remote translation effectively,

- and improving language accessibility in patient portals, telemedicine platforms, and electronic health records.[23]

Research has shown that many state Medicaid programs do not account for the language needs of potentially eligible AANHPI individuals (Musumeci et al. 2022), which may lead to them not getting the benefits they need. Our analysis adds to that research by highlighting that efforts to advance health equity for AANHPI people will need to focus on improving language accessibility and incorporating data disaggregation to understand the disparate needs of various AANHPI communities. With Asian Americans being the fastest-growing racial or ethnic subgroup in the US,[24] improving language accessibility in health care for AANHPI people with LEP will only grow in importance for advancing health equity.

Characteristics of Non-Hispanic Asian American and Native Hawaiian/Pacific Islander Adults Ages 19 to 64, by Limited English Proficiency Status and Subgroup, 2019

| | | Asian American Only | | | | | |
	All AANHPI	All Asian	East Asian	Southeast Asian	South Asian	NHPI only	Multiracial AANHPI
Population totals	14,114,441	12,151,511	4,379,401	3,976,808	3,455,599	336,146	1,789,776
Share with LEP (%)	27.4	30.8	37.9	32.2	21.3	12.1	6.8
Citizenship status (%)							
US citizen	71.0	67.7	65.2	78.5	56.8	80.6	90.8
No LEP	78.0*	74.4*	77.1*	85.2*	59.9*	86.3*	93.8*
LEP	52.4	52.6	45.8	64.6	45.7	40.0	48.4
Family income (%)							
Income < 100% of FPL	9.2	9.0	11.4	7.9	6.9	12.6	10.7
No LEP	8.0*	7.5*	9.7*	6.8*	5.6*	11.9	10.0*
LEP	12.4	12.3	14.3	10.0	11.7	17.7	19.4
Income 100–199% of FPL	11.1	10.9	10.4	12.9	9.1	15.8	12.0
No LEP	8.4*	7.7*	7.1*	9.7*	6.3*	14.7*	11.3*
LEP	18.1	17.9	15.9	19.7	19.1	23.7	21.3
Income 200–399% of FPL	24.5	24.0	21.9	29.6	20.2	36.0	26.6
No LEP	22.0*	20.8*	18.2*	26.6*	17.4*	36.0	26.1*
LEP	31.2	31.1	27.9	35.7	30.3	35.6	33.5
Income >= 400% of FPL	55.2	56.2	56.3	49.7	63.8	35.6	50.7
No LEP	61.6*	64.0*	65.1*	56.9*	70.6*	37.3*	52.6*
LEP	38.3	38.7	42.0	34.5	38.9	23.1	25.8
Education (%)							
Less than high school	8.1	8.4	7.4	11.3	6.4	11.6	5.6
No LEP	3.3*	3.0*	2.3*	4.3*	2.5*	8.8*	4.1*
LEP	20.6	20.5	15.7	25.9	20.9	31.7	25.5
High school/GED	14.9	13.9	13.0	18.8	9.3	36.2	18.4
No LEP	11.8*	9.9*	7.7*	15.2*	6.4*	36.5	17.9*
LEP	23.2	23.0	21.6	26.4	20.1	33.5	25.4
Some college or associate's degree	23.1	21.2	19.3	29.9	13.1	34.3	33.9
No LEP	24.1*	21.6*	19.0	32.3*	12.9	35.7*	34.7*
LEP	20.5	20.4	19.8	25.0	13.8	24.1	21.7

| | All AANHPI | Asian American Only | | | | NHPI only | Multiracial AANHPI |
		All Asian	East Asian	Southeast Asian	South Asian		
Bachelor's degree or more	53.9	56.4	60.3	40.0	71.1	17.9	42.1
No LEP	60.8*	65.5*	71.0*	48.2*	78.2*	19.0*	43.2*
LEP	35.7	36.1	42.9	22.7	45.2	10.6	27.4
Health insurance (%)							
Uninsured	8.3	8.2	8.3	8.9	7.2	14.6	8.8
No LEP	6.7*	6.2*	5.6*	7.6*	5.2*	12.7*	8.6*
LEP	12.8	12.8	12.7	11.7	14.7	28.5	12.2
Medicaid	12.5	12.3	12.8	13.5	10.0	17.3	13.6
No LEP	9.4*	8.6*	8.6*	10.3*	6.6*	16.8	12.2*
LEP	21.0	20.6	19.8	20.2	22.6	20.7	33.9
ESI, VA, or TRICARE	67.1	66.8	63.4	66.5	71.7	63.3	68.6
No LEP	73.9*	74.6*	73.4*	72.8*	78.0*	65.7*	70.6*
LEP	49.1	49.3	46.9	53.3	48.3	46.1	40.6
Other health insurance	12.1	12.7	15.5	11.0	11.1	4.7	8.9
No LEP	10.1*	10.6*	12.4*	9.2*	10.3*	4.7	8.6*
LEP	17.2	17.3	20.6	14.8	14.3	4.7	13.4

Source: Authors' analysis of American Community Survey data from the Integrated Public Use Microdata Series.

Notes: AANHPI = Asian American and Native Hawaiian/Pacific Islander. NHPI = Native Hawaiian/Pacific Islander. LEP = limited English proficiency; people with LEP speak another language, do not speak English very well, or do not speak English. FPL = federal poverty level. GED = general education degree. ESI = employer-sponsored insurance. VA = Veterans Affairs health care. TRICARE is the health care program for uniformed service members, retirees, and their families. "Other health insurance" includes Medicare and nongroup coverage. All groups, including multiracial AANHPI, are non-Hispanic. East Asian, Southeast Asian, and South Asian groupings are drawn from Ninez A. Ponce, "Achieving Health Equity for Asians, Native Hawaiians and Pacific Islanders," ASHEcon Economics of Health Equity Interest Workshop webinar given October 6, 2021.

* Estimate is significantly different from that for the LEP group at the $p < 0.05$ level.

Notes

1   "Resources by Language," Centers for Medicare & Medicaid Services, accessed September 21, 2022, https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/resources-by-language; and "Application Forms for Individuals and Families," Centers for Medicare & Medicaid Services, accessed September 21, 2022, https://marketplace.cms.gov/applications-and-forms/individuals-and-families-forms.

2   Kathy Ko Chin, "HHS Must Improve Language Access to Make Meaningful Access a Reality," *Health Affairs Forefront*, July 22, 2016, https://www.healthaffairs.org/do/10.1377/forefront.20160722.055907/full/.

3   Katie Zhang and Rodrigo Soto, "As a State of Many Languages, Virginia Needs Languages Access," Commonwealth Institute, July 29, 2021, https://thecommonwealthinstitute.org/the-half-sheet/virginia-needs-language-access/.

4   Mary Findling, Robert J. Blendon, John Benson, and Howard Koh, "COVID-19 Has Driven Racism and Violence against Asian Americans: Perspectives from 12 National Polls," *Health Affairs Forefront*, April 12, 2022, https://www.healthaffairs.org/do/10.1377/forefront.20220411.655787.

5   Abby Budiman and Neil G. Ruiz, "Asian Americans Are the Fastest-Growing Racial or Ethnic Group in the U.S.," Pew Research Center, April 9, 2021, https://www.pewresearch.org/fact-tank/2021/04/09/asian-americans-are-the-fastest-growing-racial-or-ethnic-group-in-the-u-s/.

6   Budiman and Ruiz, "Asian Americans Are the Fastest-Growing Racial or Ethnic Group."

7   Lala Tanmoy Das, Eric J. Kutscher, and Christopher J. Gonzalez, "Addressing Barriers to Care for Patients with Limited English Proficiency during the COVID-19 Pandemic," *Health Affairs Forefront*, July 29, 2020, https://www.healthaffairs.org/do/10.1377/forefront.20200724.76821/full/.

8   US Census Bureau, "Census Bureau Announces Changes for 2020 American Community Survey 1-Year Estimates," news release, July 29, 2021, https://www.census.gov/newsroom/press-releases/2021/changes-2020-acs-1-year.html.

9   Just 2.9 percent of the total AANHPI sample reported being Hispanic. An estimated 83.8 percent of Hispanic AANHPI adults with LEP speak Spanish.

10 Among the AANHPI sample, 88.7 percent is a single race.

11 The sample size of NHPI-only adults with LEP is small, so estimates for this subgroup should be interpreted with caution.

12 "Source and Methodology," US Department of Justice, Limited English Proficiency, March 11, 2020, https://www.lep.gov/source-and-methodology.

13 We include adults of all ages in this tabulation but note that estimates among AANHPI nonelderly adults are similar when limiting to ages 25 and older.

14 To address potential misclassifications of coverage on the ACS, we applied a set of coverage edits (Lynch et al. 2011).

15 Patterns were similar when including AANHPI adults who also reported being Hispanic.

16 Comparisons between Asian and other groups, except the AANHPI group overall, are statistically significant at the $p < 0.05$ level; results not shown.

17 Household LEP status may also be related to variation in the prevalence of multigenerational households. We also found that among adults living in households with LEP, Asian adults are more likely to have some English-speaking ability than Hispanic adults, who are more likely to not speak English at all; data not shown. Comparisons between Asian and other groups, except the AANHPI group overall, are statistically significant at the $p < 0.05$ level; results not shown.

18 Estimates for educational attainment among AANHPI nonelderly adults are similar when limiting to ages 25 and older.

[19] "Language and Literacy," US Department of Health and Human Services, Healthy People 2030, accessed September 25, 2022, https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/language-and-literacy#cit2.

[20] US Department of Health and Human Services, "HHS Announces Proposed Rule to Strengthen Nondiscrimination in Health Care," news release, July 25, 2022, https://www.hhs.gov/about/news/2022/07/25/hhs-announces-proposed-rule-to-strengthen-nondiscrimination-in-health-care.html.

[21] US Department of Health and Human Services, "Open Enrollment Kicks Off at HealthCare.gov with Record Low Premiums," news release, November 1, 2021, https://www.hhs.gov/about/news/2021/11/01/open-enrollment-kicks-off-healthcaregov-record-low-premiums.html; and Centers for Medicare & Medicaid Services, "'Medicare & You' Handbook Now Available in Chinese, Korean, and Vietnamese, " news release, October 20, 2021, https://www.cms.gov/newsroom/press-releases/medicare-you-handbook-now-available-chinese-korean-and-vietnamese.

[22] White House, "FACT SHEET: President Biden Establishes the White House Initiative on Asian Americans, Native Hawaiians, and Pacific Islanders," news release, May 28, 2021, https://www.whitehouse.gov/briefing-room/statements-releases/2021/05/28/fact-sheet-president-biden-establishes-the-white-house-initiative-on-asian-americans-native-hawaiians-and-pacific-islanders/.

[23] Sansanee Craig, Angela Shen, Kate Wallis, Priscilla Ortiz, Suzinne Pak-Gorestein, Katherine Yun, and George Dalembert, "How Health Systems Can Help Address Language Barriers to Achieve Digital Health Equity," *CHOP Policy Lab Blog*, May 27, 2021, https://ldi.upenn.edu/our-work/research-updates/how-health-systems-can-help-address-language-barriers-to-achieve-digital-health-equity/; Ko Chin, "HHS Must Improve Language Access To Make Meaningful Access a Reality," *Health Affairs Forefront*; and Tanmoy Das, Kutscher, and Gonzalez, "Addressing Barriers to Care for Patients with Limited English Proficiency during the Pandemic," *Health Affairs Forefront*.

[24] Budiman and Ruiz, "Asian Americans Are the Fastest-Growing Racial or Ethnic Group."

References

Buettgens, Matthew, and Andrew Green. 2022. "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?" Washington, DC: Urban Institute.

Ford, LesLeigh, Bhavani Arabandi, Cary Lou, Janelle Wong, Aryani Ong, John Sankofa, and Serena Lei. 2021. *Advancing Equity for AAPI Communities*. Washington, DC: Urban Institute.

Gonzalez, Dulce, Michael Karpman, and Clara Alvarez Caraveo. 2022. "Immigrant Families in California Faced Barriers Accessing Safety Net Programs in 2021, but Community Organizations Helped Many Enroll." Washington, DC: Urban Institute.

LEP Committee (Limited English Proficient Committee, Title VI Interagency Working Group). 2021. "Improving Access to Public Websites and Digital Services for Limited English Proficient (LEP) Persons." Washington, DC: US Department of Justice.

Lynch, Victoria, Genevieve M. Kenney, Jennifer Haley, and Dean Resnick. 2011. *Improving the Validity of the Medicaid/CHIP Estimates on the American Community Survey: The Role of Logical Coverage Edits*. Washington, DC: US Census Bureau.

Musumeci, MaryBeth, Sweta Haldar, Emma Childress, Samantha Artiga, and Jennifer Tolbert. 2022. "A 50-State Review of Access to State Medicaid Program Information for People with Limited English Proficiency and/or Disabilities ahead of the PHE Unwinding." San Francisco: Kaiser Family Foundation.

Pillai, Drishti, Nambi Ndugga, and Samantha Artiga. 2022. "Health Care Disparities among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) People." San Francisco: Kaiser Family Foundation.

Ponce, Ninez A. 2021. "Achieving Health Equity for Asians, Native Hawaiians and Pacific Islanders." ASHEcon Economics of Health Equity Interest Workshop webinar given October 6.

Ponce, Ninez A., Riti Shimkhada, and 'Alisi Tulua. 2021. "Disaggregating California's COVID-19 Data for Native Hawaiians and Pacific Islanders and Asians." Los Angeles: University of California, Los Angeles, Center for Health Policy Research.

President's Advisory Commission on Asian Americans, Native Hawaiians, and Pacific Islanders. 2022. *President's Advisory Commission on Asian Americans, Native Hawaiians, and Pacific Islanders Inaugural Report with Recommendations, May 2022*. Washington, DC: US Department of Health and Human Services.

Quint, Joshua J., Miriam E. Van Dyke, Hailey Maeda, J. Ke'alohilani Worthington, May Rose Dela Cruz, Joseph Keawe'aimoku Kaholokula, Chantelle Eseta Matagi, et al. 2021. "Disaggregating Data to Measure Racial Disparities in COVID-19 Outcomes and Guide Community Response — Hawaii, March 1, 2020–February 28, 2021." *Morbidity and Mortality Weekly Report* 70 (37): 1267–73. https://doi.org/10.15585/mmwr.mm7037a1.

Ruggles, Steven, Sarah Flood, Ronald Goeken, Megan Schouweiler, and Matthew Sobek. 2022. "IPUMS USA: Version 12.0" [dataset]. Minneapolis: IPUMS. https://doi.org/10.18128/D010.V12.0

Schiaffino, Melody K., Atsushi Nara, and Liang Mao. 2016. "Language Services in Hospitals Vary by Ownership and Location." *Health Affairs* 35 (8). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.0955#.

Shih, Howard, Ryan Vinh, Karthick Ramakrishnan, Todd Hughes, and Ninez Ponce. 2022. *The Health, Mental Health, and Social Service Needs of Asian Americans and Pacific Islanders in California*. Riverside, CA: AAPI Data.

Shimkada, Riti, A. J. Scheitler, and Ninez A. Ponce. 2021. "Capturing Racial/Ethnic Diversity in Population-Based Surveys: Data Disaggregation of Health Data for Asian American, Native Hawaiian, and Pacific Islanders (AANHPIs)." *Population Research and Policy Review* 40:81–102. https://doi.org/10.1007/s11113-020-09634-3.

Smalley, Heather Kitada. 2020. "A Longitudinal Perspective on the Effect of Household Language on Data Quality in the American Community Survey." In *The Essential Role of Language in Survey Research*, edited by Mandy Sha and Tim Gabel, 47–74. Research Triangle Park, NC: RTI Press.

Wang Kong, Carolyn, Jennifer Green, Courtnee Hamity, and Ana Jackson. 2022. "Health Disparity Measurement among Asian American, Native Hawaiian, and Pacific Islander Populations across the United States." *Health Equity* 6 (1): 533–39. http://doi.org/10.1089/heq.2022.0051.

Xi, Dan, Ming Lei, Paul Liu, Ramesh Vemuri, and Yihong Ye. 2022. "Advancing Equity through Strengthening Research on Health and Well-Being of Asian American, Native Hawaiian, and Pacific Islander." *Cell and Bioscience* 12:101. https://doi.org/10.1186/s13578-022-00834-2.

Yi, Stella S., Simona C. Kwon, Rachel Sacks, and Chau Trinh-Shevrin. 2016. "Commentary: Persistence and Health-Related Consequences of the Model Minority Stereotype for Asian Americans." *Ethnicity and Disease* 26 (1): 133–38. https://doi.org/10.18865/ed.26.1.133.

Youdelman, Mara. 2019. *Summary of State Law Requirements Addressing Language Needs in Health Care*. Washington, DC: National Health Law Program.

About the Authors

Jennifer M. Haley is a senior research associate in the Health Policy Center at the Urban Institute. Her current work includes understanding ways to improve collection of race and ethnicity data for use by health plans and other stakeholders, monitoring insurance coverage trends among children during the pandemic, exploring how states and stakeholders can help promote continuous coverage during the postpartum period, and assessing challenges to accessing the safety net for immigrant families. She holds an MA in sociology from Temple University.

Stephen Zuckerman is a vice president and senior fellow in the Health Policy Center. He has studied health economics and health policy for 35 years and is a national expert on Medicare and Medicaid physician payment, including how payments affect enrollees' access to care and the volume of services

they receive. He is currently focused on exploring the effects of the COVID-19 pandemic on family health and well-being using data from two internet-based surveys of nonelderly adults designed by the Urban Institute. In addition, Zuckerman has published several recent studies on hospital finances and Medicare Advantage and is completing an evaluation of the State Innovation Model in Michigan, which is trying to improve the connection between primary care and community-based social services. Before joining the Urban Institute, Zuckerman worked at the American Medical Association's Center for Health Policy Research. He received his BA from Lehman College, City University of New York, and his PhD in economics from Columbia University.

Nikhil Rao is a research assistant in the Health Policy Center. He uses quantitative and qualitative methods to study substance use, Medicaid, and structural racism's relationship with health and health care delivery. Rao holds a BSPH in health policy and management from the University of North Carolina at Chapel Hill, where he also studied psychology and public policy.

Michael Karpman is a senior research associate in the Health Policy Center. His work focuses on the implications of the Affordable Care Act, including quantitative analysis related to health insurance coverage, access to and affordability of health care, use of health care services, and health status. This work includes efforts to help coordinate and analyze data from the Urban Institute's Health Reform Monitoring Survey and Well-Being and Basic Needs Survey. Before joining Urban in 2013, Karpman was a senior associate at the National League of Cities Institute for Youth, Education, and Families. He received his MPP from Georgetown University.

Alena Stern is an associate director of data science at the Urban Institute studying policy solutions to advance equity and inclusion in cities. Before joining Urban, she worked as a senior program manager with AidData, an Open Cities fellow at the Sunlight Foundation, and a graduate research assistant at the Center for Data Science and Public Policy, where she used machine learning, natural language processing, statistical analysis, and geospatial data to inform the design of government policies and international development programs. Stern holds a BA in economics and international relations from the College of William and Mary and an MS in computational analysis and public policy from the University of Chicago.

Acknowledgments

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation (RWJF) is committed to improving health and health equity in the United States. In partnership with others, we are working to develop a Culture of Health rooted in equity, that provides every individual with a fair and just opportunity to thrive, no matter who they are, where they live, or how much money they have.

ABOUT THE URBAN INSTITUTE

The nonprofit Urban Institute is a leading research organization dedicated to developing evidence-based insights that improve people's lives and strengthen communities. For 50 years, Urban has been the trusted source for rigorous analysis of complex social and economic issues; strategic advice to policymakers, philanthropists, and practitioners; and new, promising ideas that expand opportunities for all. Our work inspires effective decisions that advance fairness and enhance the well-being of people and places.

500 L'Enfant Plaza SW
Washington, DC 20024

www.urban.org