The Affordable Care Act's Impact on Communities of Color: What's at Stake for Asian Americans, Native Hawaiians and Pacific Islanders if it Goes Away?

In the midst of an increasingly severe public health crisis and the biggest economic downturn since the Great Depression, the Trump administration, 17 Republican attorneys general and one Republican governor are pursuing a lawsuit seeking to topple the entire health care system. The Health Care Repeal Lawsuit, also known as *California v. Texas* (formerly *Texas v. US*), is set to be heard by the Supreme Court in the coming months. If successful, it will end the Affordable Care Act (ACA) and all of the consumer protections it provides, leaving millions of Americans without preventive care, treatment options or long-term coverage.

The ACA is a fundamental part of the fabric of the American health care system. It is inextricably intertwined with Medicare and Medicaid and works with and through those programs to provide care to millions of people across the country when they need it most. It has also resulted in the largest reduction in health inequities for communities of color since the creation of Medicaid in 1965. In that way, the ACA is considered a core piece of civil rights legislation, advancing our nation on a path closer to health equity, though that goal has yet to be achieved.

Though progress has stalled due to the Trump administration's failure to invest in health equity, uninsured rates for people of color have dropped as a result of the ACA. In particular, for Asian Americans (AAs), Native Hawaiians (NHs) and Pacific Islanders (PIs), the ACA has significantly reduced uninsured rates and improved outcomes through improved access to affordable coverage and quality care. As a result, the gap in AAs without coverage compared to whites was eliminated and significantly reduced for NHs and PIs. Here's what's at stake if the ACA goes away.

The Uninsured Rate for AAs and NHPIs Could Double

Thanks to the ACA, an estimated 2 million AAs and NHPIs became eligible for new coverage on the health insurance marketplaces or through Medicaid expansion. Prior to its passage, over 15 percent of AAs and 14 percent of NHPIs were uninsured with some ethnic groups, including Koreans, Pakistanis, and Guamanians or Chamorro having uninsured rates over 20 percent. As of 2018, the uninsured rate had decreased dramatically to just over 6 percent of AAs and 8 percent of NHPIs. Although some, including Pakistanis, Burmese and Samoans still have uninsured rates above 10 percent, the increase enables AAs and NHPIs have better access to care.

Unfortunately, since 2017 as the Trump administration has taken numerous steps to undermine the ACA, including an 84 percent cut in funding to the Navigator program, resulting in fewer trusted community connections to turn to for help enrolling in coverage. The administration has also pushed policies, such as the Department of Homeland Security's Public Charge regulation, that chill immigrant families from accessing care. The public charge rule could lead to between 2 and 4.7 million people disenrolling from CHIP and Medicaid.

Our Fight Against the Pandemic Becomes Even Harder

As the country confronts both the immediate and long-term threats posed by the COVID-19 pandemic, it is more important than ever to retain and expand pathways to coverage. In the short term, the ACA helps ensure that millions of people can get the testing, treatment and care they need to keep our communities safe. For AAs and NHPIs, significant disparities have emerged during the COVID-19 outbreak in some regions of the country. For instance, in Oregon, and

California, NHs and PIs have case rates three times higher than the states' average, while in Salt Lake City, Utah, it is more than twice the state's average rate. In San Francisco, AAs accounted for 13.7 percent of cases but 52 percent of deaths. Data from Los Angeles County and Illinois also indicates that AAs may be receiving disproportionately low rates of testing. In addition to a higher than average death rate as a result of infection, AAs have been blamed for spreading the virus. Reports of anti-Asian violence and assaults are on the rise, and these incidents have shown a notable effect on the mental health of AAs. In fact, an estimated 2 million AAs and PIs are contributing to vital public safety sectors responding to the virus as physicians, nurses and pharmacists.

A cornerstone of the ACA is ensuring access to coverage for people with pre-existing conditions. Compared to their white counterparts, AAs, NHs and PIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention, diagnosis and access to treatment. The pre-existing condition protection has enabled many AAs and NHPIs to enroll in affordable health plans that cover their needed care. In the long-term, COVID-19 has created a number of cascading health care and coverage crises underscoring the efforts to keep the ACA intact. Those who have been infected with the virus may be considered by insurers to have a new pre-existing condition, a devastating label should the ACA's protections be eliminated, and could also suffer long-term effects as a result of COVID19's impact on respiratory, renal, and other vital systems.

All Provisions That Specifically Aim To Reduce Racial and Ethnic Health Disparities and Protect People From Discriminations Would Be Gone

Firstly, the Health Care Rights Law (HCRL—which builds on civil rights protections for patients against discrimination based on race, color, national origin, sex, age and disability) has been in effect since the passage of the ACA. For 25 million individuals with limited English proficiency (LEP) residing in the U.S., the HCRL ensures they have meaningful access to language assistance (i.e. translation and interpretation services) when accessing health care services. Unfortunately, the Trump administration has recently taken actions to roll back these protections. In a Final Rule released on June 12, 2020, the U.S. Department of Health and Human Services removed notice protections—which require insurers and providers to inform LEP people of their right to language assistance. This change could deny over 6 million LEP AAs and over LEP 100,000 NHPIs from accessing important information about their health care and coverage as well as information about the COVID-19 pandemic.

Secondly, data equity standards would be eliminated if the ACA goes away. Section 4302 of the ACA created, for the first time, standards requiring detailed data collection on race, ethnicity, sex, disability, and primary language. Under these standards, federal programs must collect not just aggregated AA, NH and PI data, but detailed data on ethnicities that can reveal otherwise-hidden disparities. While the Trump administration has not complied with Section 4302 in regards to COVID-19 cases, leading to a lack of data about potentially vulnerable communities, important health surveys like the National Health Interview Survey and the National Health and Nutrition Examination Survey do use these standards.

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