Community Catalyst

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# The Invisible Impact of Medical Debt in Asian American, Native Hawaiian, and Pacific Islander (AANHPI) Communities

# Acknowledgements

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# Executive Summary

Medical debt is a nationwide crisis, yet its impact on Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities is poorly understood due to limited disaggregated data. While national statistics show low rates of medical debt among AANHPIs compared to other racial groups, community leaders report significant hidden burdens shaped by diverse migration histories, languages, cultures, socioeconomic conditions, and systemic inequities. Factors such as immigration status, assimilation journey, generational background, and health-seeking behaviors contribute to these challenges, but have not been adequately studied.

## Our Approach

In October 2023, Community Catalyst conducted a month-long online survey of 951 self-identified AANHPI community leaders and individuals serving these populations to examine barriers to health care access and strategies for managing unaffordable medical bills. Respondents—primarily from East Asian (51 percent), South Asian (22 percent), Native Hawaiian (14 percent), Southeast Asian (10 percent), and Pacific Islander (3 percent) communities—represent trusted entities such as community-based organizations, health workers, and legal aid providers who often assist community members with translation, navigation, and resource access. While results provide valuable insights, limitations include: underrepresentation of Pacific Islander and Native Hawaiian respondents, lack of further ethnic subgroup disaggregation, reliance on an online English-only survey, and potential reluctance to share sensitive information with a national organization without established local ties.

## Our Findings

Findings from Community Catalyst's national survey and literature review reveal:

- Health care affordability, limited understanding of coverage, and language barriers are leading obstacles, with many community members relying on family or community-based organizations for translation rather than hospitals;
- Disaggregated data show significant variation across subgroups, with some facing higher stigma, cultural mismatches, or lack of culturally sensitive providers;
- Very few community members receive hospital financial assistance, often due to poor transparency and cultural stigma, leading many to take on credit card debt, personal loans, or borrow from relatives/friends;
- Historical trauma, discriminatory policies, and generational poverty compound these challenges, while COVID-19 and high uninsured rates—particularly in non-Medicaid expansion states and among undocumented immigrants—have deepened disparities;
- Limited engagement with hospitals, combined with mistrust and information gaps, further isolates AANHPI communities from available resources, underscoring the need for culturally and linguistically tailored interventions and stronger hospital-community partnerships.

## Our Solutions

Non-profit hospitals are mandated to offer financial assistance to low-income patients, yet AANHPI communities and many systemically excluded communities face barriers to accessing this support due to limited transparency, complex processes, and inconsistent enforcement. Coordinated action at the federal, state, and community levels is needed to reduce medical debt, strengthen hospital accountability, and ensure equitable access to affordable health care.

### *Federal Level Recommendations*

- Standardize and enforce hospital financial assistance policies through IRS oversight, uniform applications, presumptive eligibility screening, and public reporting of approval/denial data.
- Invest in community-informed, disaggregated data collection to better understand medical debt impacts within AANHPI subgroups.
- Protect and expand health coverage by maintaining Medicaid funding, opposing cuts, and extending enhanced premium tax credits to keep Marketplace coverage affordable for all enrollees.

### *State Level Recommendations*

- Expand Medicaid in non-expansion states to reduce medical debt, improve credit outcomes, and increase health care access.
- Remove the five-year bar for lawfully present immigrants to allow timely access to Medicaid, CHIP, and other benefits.
- Mandate hospital screening for financial assistance eligibility and extend protections to for-profit hospitals to ensure universal access to charity care.

### *Community Level Recommendations*

- Strengthen hospital–community partnerships by engaging AANHPI leaders, advocacy groups, and trusted organizations in decision-making and community health needs assessments (CHNAs).
- Promote language justice and cultural humility in hospitals through ongoing training and expanded access to interpretation and translated materials.
- Expand consumer assistance programs to include financial counseling, insurance literacy, and education on payment options and preventive care.

# Abstract

This report examines the impact of medical debt on Asian American Native Hawaiian, and Pacific Islander (AANHPI) communities and explores the unique challenges faced by this vastly diverse population. Drawing upon a literature review and stakeholder interviews, this report highlights the specific ways in which AANHPIs are impacted by medical debt, including limited health care access, language and cultural barriers, and socioeconomic disparities. The findings underscore the need for targeted interventions and investment in trusted community-based organizations to effectively address these challenges. Accordingly, the report offers a series of recommendations to mitigate medical debt within the AANHPI community, including improving access and education to health care resources, enhancing language and cultural humility in healthcare delivery, and fostering open dialogue to combat cultural stigmas amongst the community. By implementing these recommendations, this report advocates for a more equitable and accessible healthcare system that acknowledges the diverse needs of AANHPIs and strives to alleviate the burden of medical debt within this community.

# Introduction

Medical debt affects individuals and communities across the United States. The burden of medical debt can have profound implications for an individual's financial well-being and access to health care services. While we have a grasp of how medical debt impacts Black, Latino/Hispanic, and white communities,[i] it is still unclear how medical debt impacts AANHPI communities due to a lack of disaggregated data. Understanding the specific challenges faced by AANHPIs in relation to medical debt is crucial for addressing disparities and developing targeted interventions to mitigate its impact.

Medical debt data for AANHPI communities often reflects an insignificant proportion in comparison to other racial demographics. The U.S. Census compares the share of households with medical debt by race; Asian alone is merely 9.7 percent in comparison to 17.2 percent white (non-Hispanic), 27.9 percent Black, 21.7 percent Hispanic, and 18.6 percent non-Hispanic communities.[ii] Reviewing data sets such as this allows advocates to infer that AANHPI households do not struggle with the financial challenges of medical debt in comparison to other racial communities. Yet, anecdotal evidence from community leaders suggests otherwise.

External factors such as insurance coverage, socioeconomic status, and education, which we already understand are disparate within ethnic groups of this community, contribute to medical debt. However, the impact of medical debt in AANHPI communities has never been further examined in studies.

AANHPI communities represent drastically different populations with complex histories of migration and assimilation, speaking various languages/dialects, and observing different cultural values. Factors such as a family's immigration status, generational upbringing, socioeconomic background, state of residency, health seeking behavior, acculturative stressors, and resettlement journeys also play a significant role in how this community is affected by medical debt. These unique circumstances and drivers are known contributors to the medical debt crisis in the AANHPI community.

In October 2023, Community Catalyst conducted a national survey of self-identified AANHPI leaders to understand the overall impact and potential causes of medical debt among these communities. This paper presents our key findings of the survey and offers recommendations for policymakers and advocates to address this crisis with targeted interventions.

# Unveiling the Impact of Medical Debt and Building Visibility of Health Access Challenges

## Methodology

Community Catalyst conducted an online survey with eleven questions targeting self-identified AANHPI community leaders and individuals with experience working in these communities. Questions focused on understanding barriers to health care access and how AANHPI community members navigate unaffordable medical bills. The survey targeted community leaders, as entities such as community-based organizations, community health workers, and legal aid organizations are often trusted sources in the community to help individuals translate materials and guide community members on how to navigate resources. While community-based organizations often have limited capacity to help every individual on a one-to-one basis, they are often the main contact community members feel comfortable speaking to disclose personal challenges and seek support. The survey was conducted for one month and generated responses from 951 individuals. Respondents’ email addresses were entered into a random drawing to win one of ten $25 Amazon gift cards as an incentive for completing the survey.

As seen in Figure 1 below, a majority of respondents self-identify or work with East Asian communities (51 percent), followed by South Asian communities (22 percent), Native Hawaiian communities (14 percent), Southeast Asian communities (10 percent), and Pacific Islander communities (3 percent).

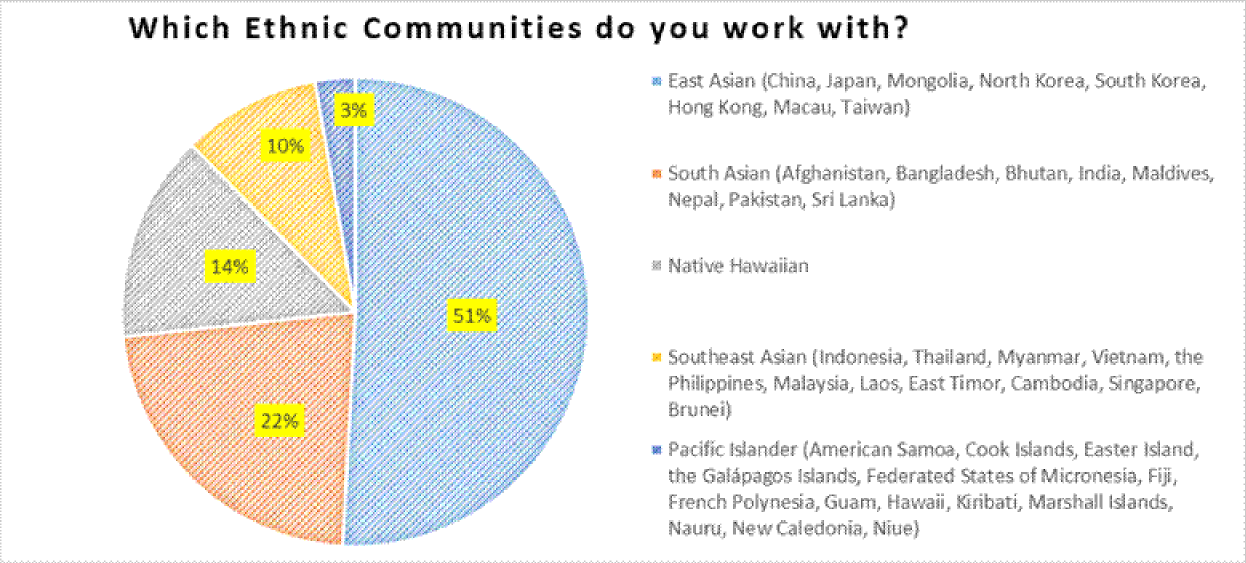

*Figure 1: Ethnic demographics of communities served by survey respondents.*

The results carry certain limitations and warrant a need to oversample from Pacific Islanders and Native Hawaiians. Furthermore, disaggregating the data even further to include specific ethnic groups could have provided more insight into how the cost of health care affects subpopulations. While a regional analysis of these communities offers some insights into how they relate to the larger AANHPI community, notable differences could still exist among the various ethnicities within these regional subgroups. Relying solely on technology and limiting the survey language to English might have limited our ability to reach certain groups. Finally, as a national health policy advocacy organization, Community Catalyst has limited opportunities to build direct relationships/connections with AANHPI community members. Some individuals may hesitate to provide sensitive information to an organization in which they may be unfamiliar and/or do not have a direct connection to on a regular basis.

# Findings

## 1. *AANHPI community members face a plethora of challenges in seeking health care services.*

Survey respondents cited various cultural and linguistic barriers to seeking health care services. In reflecting on some possible barriers among the overall AANHPI community, health care affordability (20 percent), lack of understanding coverage (18 percent) and language barriers (16 percent) were among the top barriers that prevent AANHPI community members from seeking health care services.

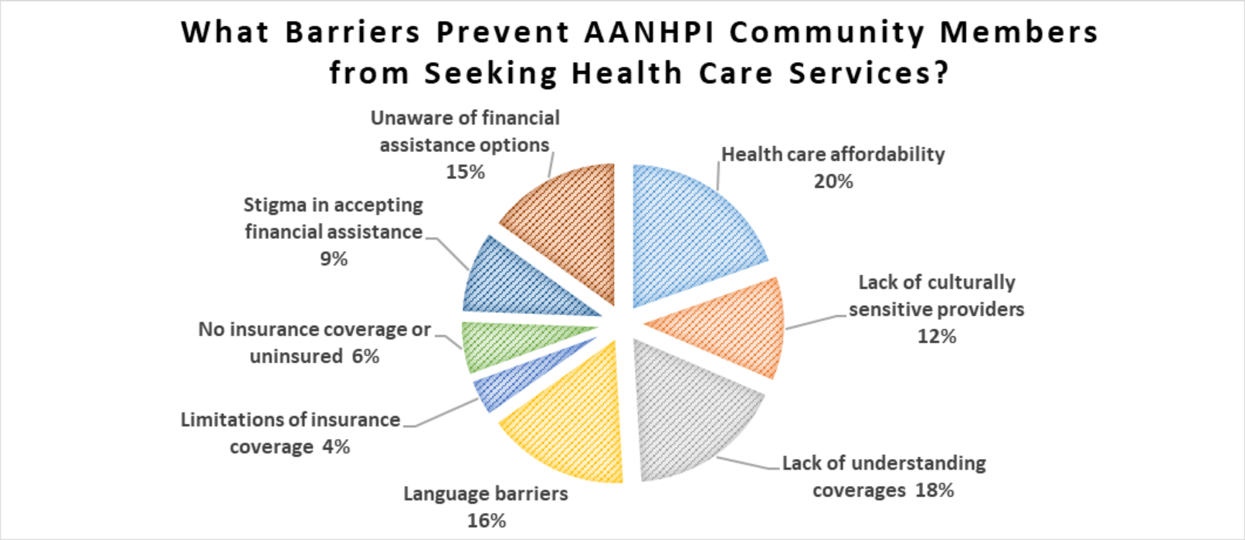

*Figure 2: Survey respondents on barriers AANHPI communities face in seeking health care services*

## *The majority of AANHPI community members receive translation support from their relatives or community-based organizations when navigating medical bills.*

Reflecting on how members of the limited English Proficient AANHPI community navigate understanding often complex medical bills, a significant majority responded that community members receive translation support from family (43 percent) or community-based organizations (42 percent). While hospitals are obligated to provide support with translated materials and interpretation services when requested by patients, only 15 percent of respondents indicated receiving this support from hospitals or providers (Figure 3).

> “*Language can be a significant barrier, particularly for AANHPI individuals who are not proficient in English. The inability to communicate effectively with healthcare providers can lead to misunderstandings and hinder access to appropriate care. While some interpretation/translation services are available, they are still inaccessible for many elders who come from rural backgrounds with no access to formal education.*
>
> **Survey Respondent**

Survey findings are also aligned with findings from a medical debt focus group led by the Pennsylvania Health Access Network (PHAN) and the Philadelphia Chinatown Development Corporation (PCDC) (see Appendix C for additional results). The focus group was conducted in-person in Mandarin Chinese with 20 participants from the Philadelphia Chinatown community. Nearly all participants in the focus group had never heard about hospital financial assistance and were unaware of any payment options available. Participants shared that they do not receive any materials from the hospitals in their preferred language; some had been unknowingly balance billed; and many were unfamiliar with federal poverty levels or significantly underestimated these income levels.

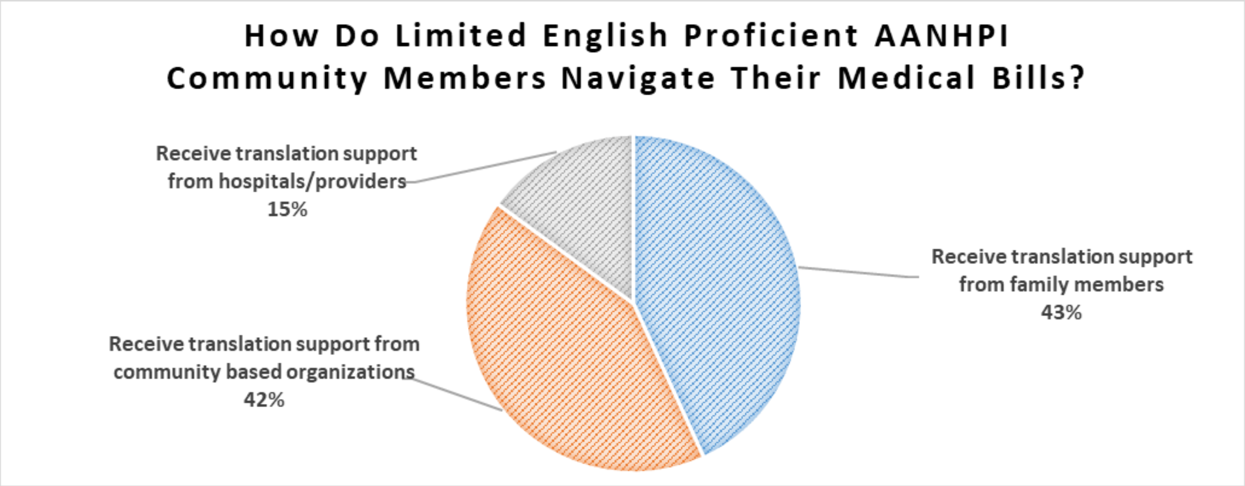

*Figure 3: Navigating Medical Bills with Limited English Proficiency*

2. *Disaggregated data among subgroups reveals communities face different challenges when accessing health care.*

### a. *Affordability*

Health care affordability was consistently rated as the largest barrier among all ethnic subgroups. 21 percent of East Asians, 18.7 percent of Native Hawaiians, 19.2 percent of Pacific Islanders, 15.5 percent of South Asians, and 13.2 percent of Southeast Asians indicated challenges with affordability.

### b. *Language Barriers*

Language barriers presented consistent challenges across communities. 14.4 percent of Southeast Asians, 11.7 percent of South Asians, 17.5 percent of Pacific Islanders, 18 percent of Native Hawaiians, and 19.2 percent of East Asians indicated that language barriers prevented community members from seeking health care services.

### c. *Stigma in seeking assistance*

There was a wider variance in how stigma in accepting financial assistance could be a barrier to communities. There were more respondents that indicated stigma was a barrier in Southeast Asians (16 percent) and South Asians (16 percent) communities.

While stigma in accepting financial assistance is certainly a barrier across AANHPI communities, Pacific Islander, Native Hawaiian, and East Asian communities respondents rated this as a lower barrier.

### *d. Cultural barriers*

The lack of culturally sensitive providers was identified as a significant barrier among Pacific Islander (18.7 percent) and Native Hawaiian (18.7 percent) communities. This was also a prevalent barrier for Southeast Asian (12.8 percent) and South Asian (14.5 percent) communities, while East Asian (6.7 percent) communities indicated this was a lower barrier.

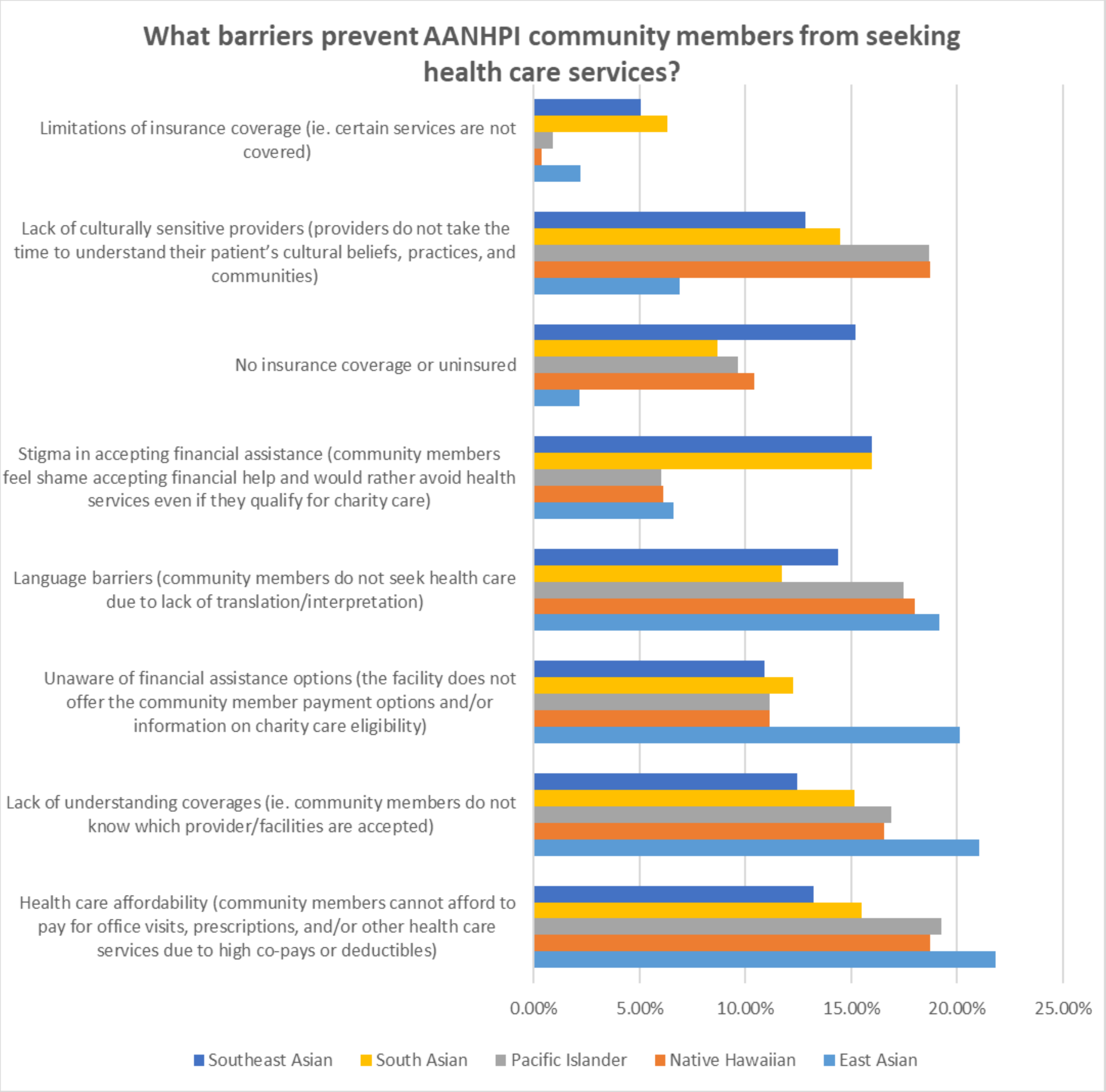

*Figure 4: Regional disaggregated data on barriers AANHPI communities face in seeking health care services*

3. *A majority of respondents indicated that AANHPI community members utilize credit cards to pay for medical bills or opt to take a personal loan from the bank.*

Unsurprisingly, the fewest respondents indicated that community members receive financial assistance from hospitals for an unexpected medical bill. Hospitals often lack transparency in advertising financial assistance options, hiding it in complex language and inconsistent communication that prevent community members from knowing its existence. Native Hawaiians indicated the highest rate (20 percent) of receiving financial assistance from hospitals, while South Asians had nearly 0 percent seeking this option. All AANHPI groups indicated borrowing from friends and family, suggesting that this may be a common practice among the community when members are in financial distress.

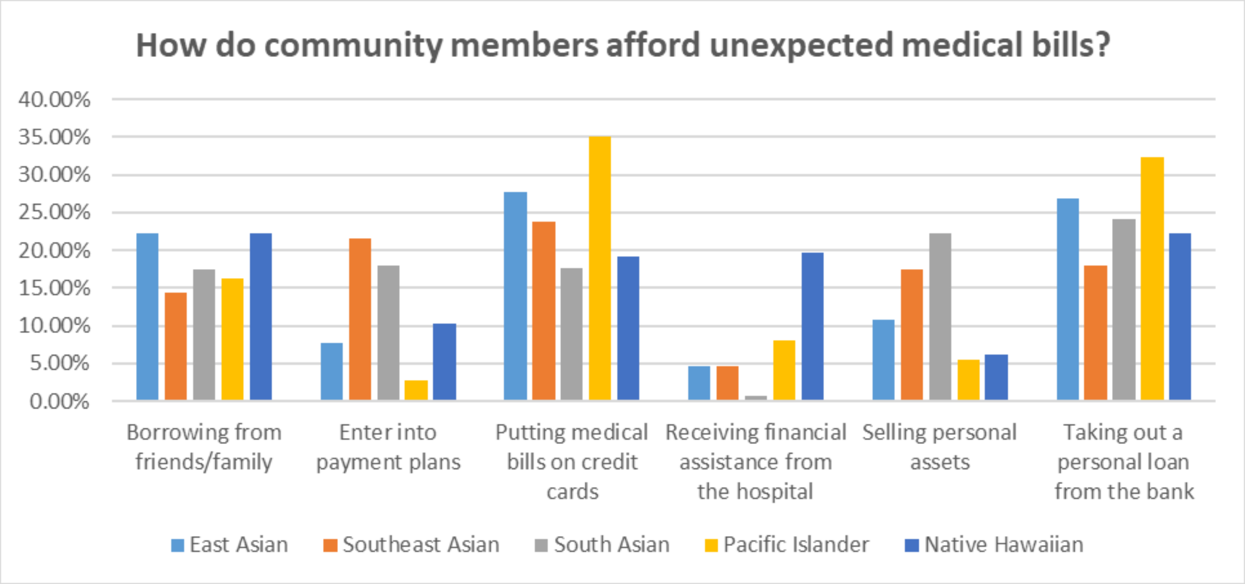

*Figure 5: Regional disaggregated data on how AANHPI communities afford unexpected medical bills*

Additionally, the survey asked open ended questions to understand if community leaders have engaged in discussion with hospital and health care systems about community issues. A few key themes emerged from this question including a lack of trust/partnership, a lack of resources/capacity, and information asymmetry. Among the theme of trust/partnership, approximately 18 percent of responses cited the attitude of hospital staff, the lack of willingness among hospital leadership, and challenges getting to meet with decision makers as barriers to engaging in community discussions with hospital leaders.

> *Institutional barriers: Hospital/health systems may be separated from the community, preventing individuals or organizations from having an effective dialogue with decision makers. This could be due to a lack of interactive platforms, an opaque decision-making process, or poor channels for community participation.*
>
> **Survey Respondent**

A few respondents indicated that they have engaged hospitals and health systems in discussion on community issues but did not receive a follow up response. The survey responses indicated that there is a desire for the community to work more closely with health systems, yet there has been a lack of opportunities for community members to engage and understand the decision-making process. Respondents cited institutional barriers as challenges to meaningful engagement; one respondent stated the lack of interactive platforms, an opaque decision-making process, and poor channels for community participation have separated the community from having an effective dialogue with key decision makers. However, about 5 percent of respondents indicated progress, significant improvement, and positive problem-solving experiences after engaging with hospital leadership.

## A deeper dive into health disparities and medical debt in AANHPI communities

The lack of data on AANHPI communities has obscured understanding of health impacts on individuals and ethnic subgroups (see Appendix A). Traditionally, data sets aggregate by race and often only provide insight on Asian and/or Pacific Islander and Native Hawaiian communities alone. While data sets structured in this way provide some insight, they also uphold structural injustices by often conflating the reality of health outcomes for a limited group of communities. These communities often fare poorly when considering social determinants of health, experiences with racism, challenges with assimilation, and English language proficiency.

### *Disparities in health status*

Existing data broken down by ethnicity reveals stark differences between ethnic subgroups within the AANHPI community. For example, while a study from the Pew Research Center showed that 10 percent of Asian Americans live in poverty overall in comparison to 13 percent of all U.S. households, it also found that 12 out of 19 Asian ethnic subgroups had higher poverty rates than the U.S. average[iii]. Additionally, in geographic areas with high concentrations of Asian Americans such as New York City, Asian Americans have the highest poverty rate yet the lowest enrollment in SNAP of all racial groups.[iv] As seen in Figure 6 and Figure 7, a study from the Urban Institute also found that while the AANHPI community has reported serious psychological distress, the utilization of mental health services remains minimal in comparison to other racial groups. These findings indicate there are existing structural barriers preventing the community from seeking health care services and enrolling in public benefits. Additionally, the lack of culturally sensitive providers has likely deterred AANHPI community members from seeking support.

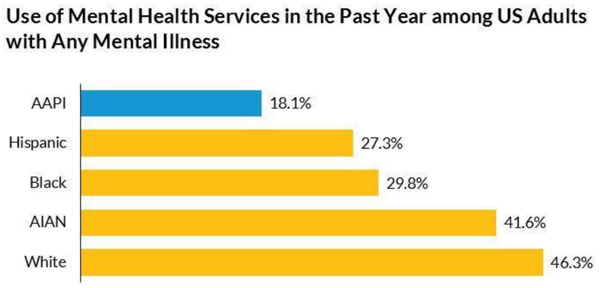

*Figure 6: Use of Mental Health Services in the Past Year among US adults with any Mental Illness*
*Courtesy of Urban Institute*
*Source: SAMSHA National Survey on Drug Use and Health, 2008 – 2012*

*Figure 7: Share of US Adults Reporting Serious Psychological Distress in the Past 30 Days*
*Courtesy of Urban Institute*
*Source: CDC National Health Interview Survey, 2010 - 2014*

The health disparities in AANHPI communities stem from a long history of discriminatory policies (see Appendix B) that have instilled mistrust, characterized the community as foreigners, and perpetuated systemic inequities. For example, historical events and discriminatory policies including, but not limited to, the Chinese Exclusion Act, Japanese internment, U.S. colonization of Pacific Island territories, or the persecution and displacement throughout Southeast Asia have had lasting and broad implications to health-seeking behavior of AANHPI communities today. Many of these communities were ostracized through explicitly racist actions; the United States forced refugees to assimilate with limited resources in impoverished neighborhoods, society at-large often mistreated people due to their racial identities, and the United States government seized land rightfully belonging to these communities. Although these traumatic events are rarely highlighted in mainstream outlets, they have undeniably shaped the social, economic, and cultural fabric of these communities, which in turn have influenced factors such as health care access, employment opportunities, and financial stability. Additionally, intergenerational transference within families also plays a factor in health-seeking behavior. For example, psychological distress developed from fleeing war-torn homes, such as seeing one's family members killed during the Khmer Rouge, can be passed onto future generations. Generational trauma can also impact one's health care decision-making process. The impact of historical events on these communities is critical when examining the broader health care landscape and socioeconomic factors that contribute to medical debt today.

## *Disparities in COVID-19 impact*

The COVID-19 pandemic exposed the most vulnerable AANHPI communities, namely those who often worked low-wage jobs such as in restaurants and salons or worked in environments that required daily face-to-face encounters with the public. Exposed groups were not provided with paid leave options or supportive health care benefits and often resided in crowded multigenerational homes. According to a study from Kaiser Family Foundation, Asians were found to be more likely than white people to die (49 percent) and be hospitalized (57 percent) as a result of contracting COVID-19.[v] In California, Native Hawaiian, and Pacific Islander (NHPI) data was reported separately from Asians and found that NHPI communities had the highest rate of COVID-19 cases and deaths compared to all other racial groups.[vi] While these statistics are alarming, mainstream media outlets rarely spotlighted this disparity. As a result, the community's suffering largely remained invisible and unaddressed. Particularly in elderly AANHPI communities, fear from racial harassment and limited understanding of technology kept many community members from seeking health care and support needed.

## *Disparities in health insurance coverage*

Uninsured rates among AANHPI communities also vary widely between ethnic subgroups. A 2021 analysis from KFF found that 4 percent of nonelderly Asian Indian and Taiwanese were uninsured whereas 28 percent of nonelderly Mongolian and 24 percent of Marshallese were uninsured.[vii] Uninsured adults are at a higher risk of having issues with affording medical bills and/or have a higher likelihood of medical debt than those with adequate insurance coverage. As evident in Figure 8, the implementation of the Affordable Care Act (ACA) in 2014 addressed substantial health coverage disparities for the AANHPI community in Medicaid expansion states as all ethnic subgroups experienced a decrease in uninsured rates. Unfortunately, many AANHPI individuals living in non-expansion states do not have the same benefit. For example, as of 2024, Texas had a population of 2.02 million AANHPI self-identifying individuals, making it the 3rd state with the highest AANHPI population. A study from APIAVote found that in Texas, 10.3 percent of Asian Americans and 16.3 percent of NHPIs are uninsured.[viii] Additionally, the Center on Budget and Policy Priorities found that 16 percent of Asian Americans live in non-expansion states; a disaggregated view found that certain groups overrepresented this statistic with Vietnamese Americans

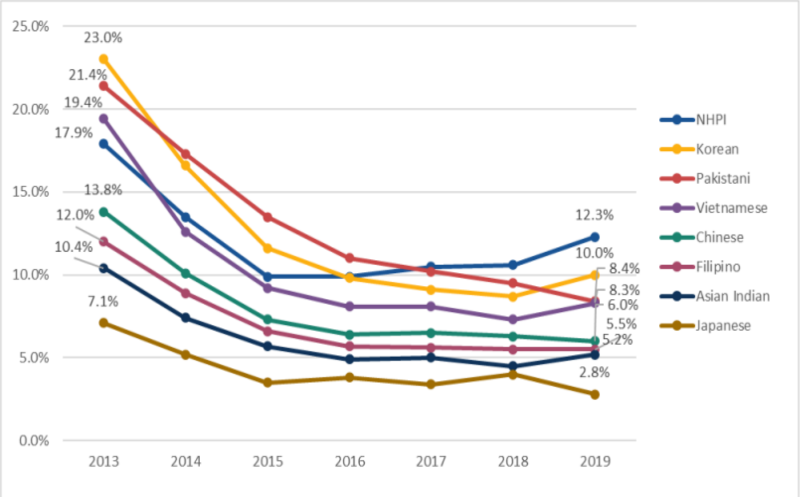

*Figure 8: Uninsured Rates for Total US Population by AAPI Subgroup, 2013 – 2019*

*Courtesy of Department of Health & Human Services*

*Note: NHPI = Native Hawaiian and Other Pacific Islander*

*Source: 2013 – 2019 American Community Survey* comprising 26 percent of those living in non-expansion states.[ix]

While barriers to Medicaid coverage leave many uninsured, undocumented immigrants are even more likely to be uninsured. Undocumented immigrants are ineligible for federally funded coverage options such as Medicaid, the Children's Health Insurance Program (CHIP), Affordable Care Act (ACA) Marketplace coverage, or Medicare.[x] The Center for Migration Studies found that there were an estimated 1.7 million undocumented Asian Americans in the country in 2018. However, the country's political climate around immigration issues have caused widespread mistrust and misinformation. While hospital financial assistance remains an option available to all regardless of immigration status, it's difficult for the community to place trust in public benefit resources as there remains widespread skepticism that these may impact one's ability to remain safely in the country. Undocumented immigrants are less likely to utilize public benefits and lack clarity on which public services could impact their chances of obtaining legal status in the future and remain safely residing in the country. Community leaders have shared frustration with how misinformation can often put many undocumented families in fear that they could be deported for seeking financial support for medically necessary care.

## *Limited understanding of coverages and engagement opportunities*

From the Community Catalyst survey, AANHPI community members cited hesitation to see a medical provider or go to a hospital/health care facility due to unexpected costs, language barriers, cultural differences, racial discrimination, immigration related concerns, and stigma. For many AANHPI communities, the stigma in revealing that a family member is facing financial challenges can be seen as shameful and associated with the family's lack of success. Many AANHPI communities that arrive as immigrants or refugees may also be unfamiliar with the country's credit driven society leaving many with limited credit history and leaving families vulnerable to unregulated practices such as loan sharks. Additionally, AANHPI communities have their own unique cultural background and belief systems, which can lead to skepticism of Western medical systems. AANHPI individuals may have cultural or religious beliefs that influence their perception of health care and treatment and are often not universally understood or respected by health care providers.

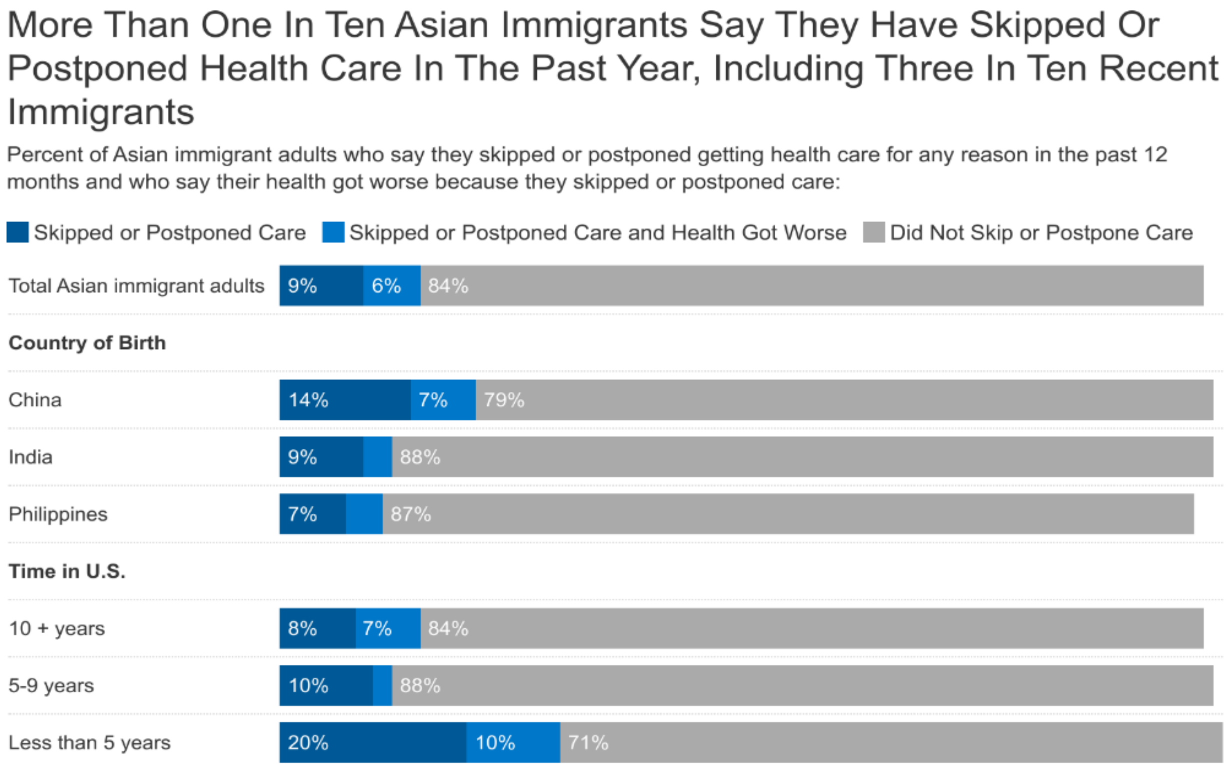

*Figure 9: Percent of Asian immigrant adults who reported skipped or postponed health care in the past 12 months.*
*Courtesy of KFF/LA Times Survey of Immigrants (April 10 - June 12, 2023)*

In a study from the Urban Institute, limited English proficient AANHPI adults were more likely to be noncitizens and have economic disadvantages including lower incomes, lower levels of education, and high uninsurance rates.[xi] AAPI Data found that 74 percent of Asian Americans speak a language other than English at home in comparison to 71 percent of Latinos and 41 percent of Native Hawaiians and Pacific Islanders.[xii] While AANHPI communities have the highest need for language assistance, targeted interventions are more challenging due to the variance in dialects spoken within the community. Additionally, the Trump administration's executive order designating English as the official language of the United States systemically undermines multilingual access to critical public resources. A report from the Association of Asian Pacific Community Health Organizations found that limited English proficient (LEP) Asian Americans are more likely to forgo medical services while also being more likely to report poor mental and physical health.[xiii]

Findings from Community Catalyst's survey also indicate that hospital financial assistance rights remain largely unknown within the AANHPI community. However, cultural stigma seems to play a large factor in the community's willingness to accept charity care. Cost of health care and limited understanding of insurance coverage also continue to be major barriers for AANHPI communities. The findings on barriers that may prevent AANHPI community members from seeking health care services revealed that while many community members may have some form of health care coverage, there remains a lack of clarity in how to utilize their coverage options. While significant efforts have been made to increase health care coverage enrollment throughout the community, a recurring theme cited difficulty understanding insurance coverage. Individuals cited refusal to seek out medical care due to confusion understanding coverage of services or due to past experiences where a cost was unexpected. Findings also reveal a need for hospitals and health care systems to provide additional transparency and education on payment options such as financial assistance in a patient's preferred language.

## Recommendations

Non-profit hospitals are mandated to provide financial assistance to eligible low-income patients. However, advocates have witnessed minimal transparency and unnecessary barriers with patients surrounding financial assistance availability. Many patients have been crippled by medical debt who should have otherwise qualified for hospital financial assistance. Federal action must be taken to bolster and standardize financial assistance policies and address barriers seen within local communities. Patients should be able to easily access information in their preferred languages, receive individualized assistance in completing the application process, and be provided with ample opportunities to understand their payment and health coverage options. Improving our understanding of how medical debt impacts different communities helps advocates effectively address concerns and improve preventative measures that lead to systemic change.

### *Federal level*

While federal regulations require non-profit hospitals to provide financial assistance to low-income eligible patients, many community members are often unaware of their payment options and opt to delay or refuse care due to cost concerns. Polling from HIT Strategies in 2025 found that AAPI respondents prioritized lowering healthcare costs as their second most important item for congress to work on, after lowering food costs.[xiv] Federal tax regulations require non-profit hospitals to offer a sliding scale discount to patients dependent on federal poverty level (FPL) percentages. While these requirements exist, community advocates have seen minimal compliance from hospitals and community members often are unaware of these protections. Conversely, hospital systems have engaged in egregious billing and collections practices exacerbating the harm of medical debt, such as hiring third party debt collectors and filing lawsuits against patients for non-payment. Addressing medical debt impacts at the federal level should include:

*Investing in community informed practices to ensure representation across ethnic groups*

- Aggregated data often leads to interpretation errors and policy recommendations that do not equitably address issues within the AANHPI community and many studies on medical debt often exclude AANHPI communities from findings. A lack of academic evidence on certain populations significantly impacts support for further research and advocacy efforts. From 1992 to 2018, the National Institute of Health (NIH) allocated a mere 0.17 percent of the total NIH budget for clinical research projects focused on AANHPI participants.[xv] It is critical to advance legislative efforts such as the Health Equity and Accountability Act (HEAA),[xvi] which would address systemic health inequities such as improving agency outreach efforts to regularly consult with community organizations, require federal statistical agencies to extend language access in data collection practices, and require collection of detailed disaggregated data. Some AANHPI communities, particularly among undocumented families, may also be wary of data privacy concerns and hesitant to share information due to the rise of anti-immigrant efforts among policymakers. Community organizations can help tailor culturally sensitive practices and tap into networks the community readily trusts to support their needs and ensure communities have equitable access to high quality affordable health care.

### *Improving requirements for non-profit hospitals*

- Administrative action is required to address key drivers of medical debt and improve hospital transparency such as increased enforcement through the IRS, adopting uniform financial assistance applications, requiring presumptive eligibility and screening procedures, and requiring hospitals to report financial assistance data detailing denial rationale.

### *Continued funding to support Medicaid and Marketplace coverage across states*

- Potential cuts to Medicaid will hurt communities, destabilize entire industries, deepen the health workforce crisis, and increase medical debt for families across the country. As of 2020, 4.5 million AANHPI individuals were enrolled in Medicaid including 1.6 million enrolled through Medicaid expansion.[xvii] Medicaid funding is essential for AANHPI communities as many face barriers to affordable health care due to high uninsured rates, low-wage jobs, and restrictive immigration policies.
- Extending enhanced premium tax credits (ePTCs) is essential in keeping Marketplace coverage affordable, which qualifies more than 40% of enrollees to obtain coverage for $10 or less per month under the current subsidies. Without the enhanced tax credits, premiums would increase by 74 percent for Asian Americans compared to an average increase of 59 percent for white enrollees.[xviii]

## State level

Addressing medical debt impacts at the state level should include:

### *Expanded Health Care Coverage Options*

- Medicaid Expansion: As of 2025, ten states still have not expanded Medicaid coverage. While Medicaid expansion will not put an end to all medical debt challenges, expansion has been directly tied to reducing households' medical debt in collections, improving credit scores, reducing bankruptcies, and reducing evictions.[xix]
- Eliminate the 5-year bar: Lawfully present non-citizens in the U.S. are required to wait at least five years to qualify for Medicaid, Children's Health Insurance Program, Medicare, and other federally funded benefits. The 5-year waiting period has instilled fear and confusion in many mixed-status families on how utilization of public benefits or other safety net programs may impact their ability to attain health coverage in the future. Eliminating this barrier would provide immigrants with essential health coverage and alleviate concerns about using public benefits.

### *Increased access to hospital financial assistance*

- Several states have already implemented stronger medical debt protections beyond federal requirements to ensure transparency and financial assistance for patients. For example, laws in Illinois, Colorado, and New York mandate hospitals to screen uninsured patients, provide income-based discounts, and limit legal action against low-income individuals. While these policies are significant, challenges still remain in public awareness, hospital compliance, and the lack of universal protection, leaving many without affordable health care options.
- Due to common barriers such as lack of awareness of hospital financial assistance policies and challenges navigating health coverage options, states should be encouraged to mandate screening for health coverage and financial assistance options. Additionally, as federal law does not apply to for-profit hospitals, states may also extend protections to ensure all hospital facilities are providing financial assistance options.

## Community level

Community Catalyst's survey indicated a significant desire for AANHPI communities to engage in discussion with hospitals and health systems on community-based challenges. However, the limited capacity of community-based organizations and the lack of trust with these bureaucratic health systems have made it difficult to make their voices heard among key decision makers. This finding warrants the need for further education on opportunities for these communities to make their voices heard, so health systems can invest community benefit dollars into addressing local health care needs. While non-profit hospitals are obligated to develop a triennial Community Health Needs Assessment (CHNA) that includes input from the hospital's local service community, community advocates have cited a lack of meaningful outreach efforts from hospitals and/or frustration in the hospital's lack of follow through in implementing intervention strategies. Addressing medical debt impacts at the local level should include:

### *Meaningful community engagement and education*

- Hospitals and health systems should actively collaborate with AANHPI community organizations, advocacy groups, and leaders to develop policies and programs that address the specific health concerns of the community. Engaging in dialogue, seeking community input, and involving AANHPI voices in the decision-making process can lead to more effective and inclusive practices.
- Community advocates have also shared there is a critical need to promote language justice and cultural sensitivity training among providers and hospital staff. Culturally competent care that respects and understands the values and beliefs of diverse AANHPI communities can help increase trust and engagement in health care services.

### *Strengthening Consumer Assistance and Public Education*

- While consumer assistance programs are available in a majority of states to help community members enroll in coverages and help navigate issues, there is a need to invest in improving health literacy and awareness of health care coverage options/financial assistance and understand preventative care needs. Expanding consumer assistance programs to include financial counseling and education programs help individuals understand health care costs, insurance coverage terms, and strategies for managing medical expenses.

# Appendix A

## Harms of Inadequate Data in the AANHPI Community

Advocates must be wary of survey collection methodology and the unintended filtering of certain communities through often archaic practices. For example, one of the most utilized surveys is The Behavioral Risk Factor Surveillance Survey (BRFSS). The BRFSS is a highly regarded research system that collects data on U.S. residents regarding health-related behaviors, chronic health conditions, and use of preventative services.[xx] The BRFSS study is conducted verbally in English over a randomly dialed landline. Data collection over cell phones was not implemented until 2011 and the only other language option provided for the survey is Spanish.[xxi]

These practices have been recognized by community leaders as inequitable as it often results in residents being unrepresented in data sets due to language/cultural barriers and stigma/fear in sharing private information with strangers. Collecting data from these communities requires a foundation of trust that systems such as the BRFSS may not be able to replicate regardless of translation and interpretation services offered. As a result, AANHPI-serving organizations often carry the burden of being the voice for these communities and may rely on developing their own small-scale data collection methods to advocate for resources but are often limited by a lack of expertise, capacity, reputability, and/or funding.

A majority of AANHPI communities observe collectivistic cultures that place greater emphasis on the perception of a group rather than an individual.[xxii] Conversely, it introduces a cultural clash with American society which places greater emphasis on individualistic culture, where individuals prioritize their personal needs/perception over the larger collective. In many AANHPI families, admitting that someone has any type of debt can be seen as shameful, and there remains strong cultural obligations to keep any negativity within the immediate family and close friends. There is also a strong cultural norm to associate self-value with the ability to care for one’s own family. Revealing that a family member is facing financial challenges can often be interpreted as the family being unsuccessful. For example, although many AANHPI families face a long history of intergenerational trauma and racial discrimination, AANHPI individuals are highly discouraged from seeking mental health treatment as it may be seen as shameful and/or due to faults in how the family is raised. Similarly, sharing information outside of the family on health issues or financial challenges remains a taboo. The stigma associated with negatively perceived challenges such as financial need or health issues is highly complex and often remains highly guarded within families. As a result, available data for the community may not always be inclusive or adequately represent the reality of challenges faced by individuals. Therefore, while many data sets reveal that AANHPI communities fare better in comparison to other racial demographics in regard to medical debt burdens, it should not be assumed that the community does not face significant challenges with medical debt.

# Appendix B

## Historical Implications on Health Care in the AANHPI community

It is important to recognize that historical events, such as but not limited to the Chinese Exclusion Act, Japanese internment, U.S. colonization of Pacific Island territories, persecution and displacement throughout Southeast Asia have had broader implications that still have visible remnants today. These traumatic events shaped the social, economic, and cultural fabric of these communities, which in turn have influenced factors such as health care access, employment opportunities, and financial stability. Additionally, intergenerational transference within families may also play a factor in health seeking behavior. The impact of historical events on these communities should be considered when examining the broader health care landscape and socioeconomic factors that contribute to medical debt today.

### *Chinese Exclusion Act*

Anti-Chinese sentiment in the mid-1800s occurred during the California Gold Rush as Chinese immigrants began arriving in hopes of improving their economic outlook. Unfortunately, Chinese immigrants were exploited for cheap labor often taking on life-threatening jobs such as infamous railroad construction jobs, which paved the transcontinental railroad across the country. Chinese immigrants were scapegoated and blamed by people in power for taking away jobs from white people, which resulted in the Chinese Exclusion Act in 1882, barring Chinese laborers from entering the United States and contributed to marginalization of the community currently residing in the country. Although the Chinese Exclusion Act did not directly impact health care, its implementation led to several consequences that are still prevalent today. During this time, the bubonic plague and smallpox were widespread, and Chinese immigrants were blamed for the cause of the diseases. Chinese immigrants were forced to quarantine in overcrowded, poor neighborhoods, with no access to health care services. Police shut down Chinese-owned businesses as a public health measure due to misinformed speculation that they were sources of disease. Those who sought care in hospitals were racially discriminated against and billed higher taxes/fees in comparison to white residents. In response to these barriers, Chinese immigrants developed their own health care facilities that offered culturally and linguistically sensitive services as well as traditional medicine practices to the community. Remnants of anti-Chinese sentiment are still prevalent today as we have seen with Asian American individuals scapegoated for originating COVID-19.

### *Japanese Internment Camps*

Similarly, Japanese Internment during World War II imprisoned individuals of Japanese descent solely for their ethnic identity. Internment camps provided minimal medical services and resources. They were often staffed by a small number of health care providers and some interned Japanese American professionals. Chronic disease often went unmanaged, infectious diseases were rampant throughout the unsanitary living conditions, and mental health issues were widespread but untreated. The internment left long-lasting physical and mental health impacts on the Japanese American community that likely still affect many families today. Families with unresolved trauma continue to pass maladaptive coping strategies and distrustful views onto newer generations, likely resulting in avoidance of seeking medical care and lack of trust in enrolling in health care coverage options. Additionally, the lack of culturally sensitive health care services and language barriers caused a mistrust of Western medicine still seen today.

### *Colonization of Pacific Islands and Hawaiʻi*

Colonization of Pacific Islands and Hawaiʻi by the United States unfolded over the 18th and 19th centuries. Wealthy American and European businessmen took particular economic interest in Hawaiʻi by first enacting a reciprocity treaty in 1875 that allowed sugar to be sold into the United States duty-free. Business growth led to a significant reduction in the monarchy's power and extended voting rights primarily to wealthy Americans and European males, who quickly appointed themselves to government positions. There were also immediate efforts to annex Hawaiʻi (through a joint resolution known as the Newlands Resolution) to the United States after failed attempts to restore the monarchy's power. Native Hawaiʻians adamantly believe the annexation was illegal and violated international law, which cultivated mistrust in the government. Prior to annexation, Hawaiʻian natives enjoyed the benefits of free universal health care. King Kamehameha IV established Queen's Hospital in 1859, a hospital that provided native health services free of charge. However, in 1909, the United States government amended the original charter requiring Hawaiʻians to pay health care fees, which many of them could not afford. Colonization of the island introduced foreign disease and unaffordable health care. Today, Native Hawaiʻians have the highest health risks in the state and are susceptible to chronic health issues that stem from a complex history that limited access to affordable health care.[xxiii]

### *Southeast Asian Refugee Resettlement*

It is important to also recognize the impact of persecution and war among Asian countries and how displacement impacts their health seeking behavior. For example, the aftermath of the fall of Saigon, the Laotian Civil War, and the Cambodian genocide in 1975 forced many families from these countries to seek refuge in America. Individuals were forced to flee into refugee camps to avoid persecution. Over 1.1 million Southeast Asian refugees were resettled across America. Voluntary organizations worked with the State Department to help place individuals in the U.S. and sometimes offered a one-time cash stipend. However, many people were hostile towards refugees as they were seen as an economic burden. Many refugees were placed in impoverished neighborhoods, surrounded by gang violence, racial tension and poor schools.[xxiv] Refugees were often forced to become self-sufficient to survive without any support in coping with traumatic events of seeing their own family and friends killed in war or due to grueling conditions of refugee camps and sea travel. Still today, very few individuals from these communities seek out mental health support which often leads to unresolved intergenerational trauma that still transfers to newer generations. Additionally, the narrative of the U.S. withdrawing support and failing to implement contingency plans in the uprising of communist powers within these countries is often overshadowed in the rationale for the largest refugee crisis. Instead, Southeast Asian American refugees are the scapegoat, forced to assimilate in poor conditions, and constantly overshadowed under the model minority myth.

# Appendix C

## Findings from a Focus Group in Philadelphia Chinatown

Findings from Community Catalyst's survey aligned with findings from a medical debt focus group led by the Pennsylvania Health Access Network (PHAN) and the Philadelphia Chinatown Development Corporation (PCDC) in January 2024. The focus group was conducted in-person in Mandarin Chinese with 20 participants from the Philadelphia Chinatown community. In part of the medical debt project supported by Community Catalyst, PHAN works to better understand the drivers of medical debt and advocates to strengthen protections for all Pennsylvanian residents.

Unsurprisingly, only one participant had heard about hospital financial assistance prior to the focus group. Staff at PHAN and PCDC explained the concept of financial assistance and eligibility; the participants shared that without this hands-on support, they would not have been able to understand the policies as they are written by the hospitals. The participants shared that they do not get information from the hospitals in their preferred languages, and all notices or billing statements are sent in English. Eight participants shared that they received a medical bill they did not understand, and some had been unknowingly balance billed. The participants found resources about the No Surprises Act particularly helpful. Participants were also unfamiliar with federal poverty levels and significantly underestimated these income levels.

The focus group resulted in additional follow-up needed for multiple individual cases. A participant received a $2,000 bill for an x-ray that was denied by insurance but needed assistance appealing the decision and help with applying for financial assistance. Multiple individuals indicated they received a medical bill months ago and hoped they would still qualify for financial assistance. Participants shared that providers often ask patients for proof of insurance but cannot provide cost estimates. A participant shared that she went to the emergency room with symptoms of numbness in her arms and legs; although she was advised to return for a follow-up as the providers suspected it may have been a stroke, concerns about cost prevented her from returning to get care. Additionally, participants cited cases of possible discrimination from clinics charging for services such as completing school medical forms and instances of charging upfront fees.

**Focus Group Recommendations**

- Extending the timeline to apply for financial assistance if materials are not provided to the patient in their preferred language;
- Specifying a staff member or phone number to call for bilingual assistance;
- Providing financial assistance eligibility in dollar amounts rather than Federal Poverty Levels; and
- Specifying the type of services in which a patient may apply to financial assistance.

# References

[i] Shameek Rakshit, Matthew Rae Twitter, Gary Claxton, Krutika Amin, and Cynthia Cox, "The Burden of Medical Debt in the United States," KFF, February 12, 2024, https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/.

[ii] Neil Bennett, Jonathan Eggleston, Laryssa Mykyta and Briana Sullivan. "19% of U.S. Households Could Not Afford to Pay for Medical Care Right Away," Census.gov, June 7, 2023, https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

[iii] Budiman A, Ruiz NG. "Key Facts about Asian Origin Groups in the U.S.," 2021. Pew Research Center. https://www.pewresearch.org/short-reads/2021/04/29/key-facts-about-asian-origin-groups-in-the-u-s.

[iv] "The Hidden Poverty of the 'Model Minority'," Asian American Federation, 2023, https://www.aafederation.org/research/the-hidden-poverty-of-the-model-minority/

[v] Rubin-Miller L, Alban C, Artiga A, Sullivan S. "COVID-19 Racial Disparities in Testing, Infection, Hospitalization, and Death." 2020. https://www.kff.org/report-section/covid-19-racial-disparities-in-testing-infection-hospitalization-and-death-analysis-of-epic-patient-data-issue-brief.

[vi] Jackie Botts, "Track Us Better: Overlooked Pacific Islanders Hit Hard By Coronavirus," Cal Matters, 2020, https://calmatters.org/health/2020/05/california-pacific-islanders-hit-hard-coronavirus-overlooked.

[vii] Pillai, D., Ndugga, N., & Artiga, S. (2023, May 24). *Health care disparities among Asian, Native Hawaiian, and Other Pacific Islander (NHOPI) people*. KFF. https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-care-disparities-among-asian-native-hawaiian-and-other-pacific-islander-nhopi-people.

[viii] APIA Vote, https://apiavote.org/policy-and-research/aapi-demographics-by-state.

[ix] Gideon Lukes, Laura Harker, "Closing Medicaid Coverage Gap Would Help Diverse Groups and Reduce Inequities," CBPP, July 9, 2024, https://www.cbpp.org/research/health/closing-medicaid-coverage-gap-would-help-diverse-groups-and-reduce-inequities.

[x] "Key Facts on Health Coverage of Immigrants," KFF, September 17, 2023, https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-of-immigrants/.

[xi] Jennifer M. Haley, Stephen Zuckerman, Nikhil Rao, Michael Karpman, Alena Stern, "Many Asian American and Native Hawaiian/Pacific Islander Adults May Face Challenges Related to Limited English Proficiency," The Urban Institute, December 12, 2022, https://www.urban.org/research/publication/many-asian-american-and-native-hawaiianpacific-islander-adults-may-face-health.

[xii] AAPI Data, "State of Asian Americans, Native Hawaiians, and Pacific Islanders in the United States, June 2022, https://aapidata.com/wp-content/uploads/2024/02/State-AANHPIs-National-June2022.pdf.

[xiii] AAPCHO. "Limited English Proficiency of Asian Americans, Native Hawaiians, and other Pacific Islanders." 2014. https://www.aapcho.org/wp/wp-content/uploads/2014/08/AANHOPI-LEP-Fact-Sheet_2014_final.pdf.

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[xiv] "Community Catalyst Healthcare Survey," HITstrategies, 2025.

[xv] Đoàn LN, Takata Y, Sakuma KK, Irvin VL. "Trends in Clinical Research Including Asian American, Native Hawaiian, and Pacific Islander Participants Funded by the US National Institutes of Health," *JAMA Netw Open*. 2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6659145.

[xvi] https://www.congress.gov/bill/118th-congress/house-bill/9161

[xvii] Health Care Access and Coverage. Washington (DC): Office of the Assistant Secretary for Planning and Evaluation (ASPE); June 7, 2024. "Health Insurance Coverage and Access to Care Among Asian Americans, Native Hawaiians, and Pacific Islanders: Recent Trends and Key Challenges". https://www.ncbi.nlm.nih.gov/books/NBK611355/

[xviii] Altman, Jessica, "The Potential Impact Of Marketplace Enhanced Premium Tax Credit Expiration." Health Affairs, 2025. https://www.healthaffairs.org/content/forefront/potential-impact-marketplace-enhanced-premium-tax-credit-expiration.

[xix] Kenneth Brevoort *et al*., "Medicaid and Financial Health," National Bureau of Economic Research Working Paper 24002, November 2017, https://www.nber.org/system/files/working_papers/w24002/w24002.pdf.

[xx] "BRFSS," Centers for Disease Control and Prevention, September 6, 2022, https://www.cdc.gov/chronicdisease/resources/publications/factsheets/brfss.htm.

[xxi] "CDC - BRFSS - BRFSS Frequently Asked Questions (Faqs)," Centers for Disease Control and Prevention, January 2, 2018, https://www.cdc.gov/brfss/about/brfss_faq.htm.

[xxii] Kendra Cherry, MSEd, "Understanding Collectivist Cultures," Verywell Mind, November 8, 2022, https://www.verywellmind.com/what-are-collectivistic-cultures-2794962#toc-individualism-vs-collectivism.

[xxiii] David Keanu Sai, "The Impact of the U.S. Occupation on the Hawaiian People," NEA Today, October 13, 2018, https://www.nea.org/nea-today/all-news-articles/impact-us-occupation-hawaiian-people.

[xxiv] Southeast Asia Resource Center, Asian Americans Advancing Justice, "Southeast Asian American Journeys," 2020, https://www.searac.org/wp-content/uploads/2020/02/SEARAC_NationalSnapshot_PrinterFriendly.pdf.