

PROJECT CHARGE

Introduction

Project CHARGE was created in 2008 through a recognition that there needed to be a more concerted and coordinated effort to bring the Asian Pacific American (APA) community together to address health issues impacting our diverse communities. Today, it is a collaborative of 17 organizational partners and a long-term project evaluator.

Project CHARGE is mostly composed of social service providers based in New York City that provide services such as mental health counseling, chronic disease outreach, education, and screening (cardiovascular disease, cancer, HIV/AIDS), immigrant services, youth services, and many more to the Asian Pacific American community. Among the partners, are two community health centers, two research centers, and a settlement house. The majority of the client base or target populations with whom they work are Asian Pacific immigrants from over 16 countries and speaking 25 different languages and dialects—many with unique challenges based on their immigrant status, occupation, language needs, and access to culturally competent providers and services.

Project CHARGE believes that access to affordable, quality health care is integral to ensuring the well-being of New York State’s diverse children, families, workers, and seniors.

The creation of the New York State of Health and the implementation of the Affordable Care Act (ACA) were moves in a positive direction for our communities. The Affordable Care Act (ACA) makes healthcare more accessible by lowering the costs of healthcare, increasing health providers our community members can choose from, holding health insurance companies more accountable, improving the quality of health care, and extending coverage to over 40 million people nationally, including 200,000 Asian Pacific Americans in New York State.

While many improvements and benefits come from the ACA, there is still a long road ahead to health equity and to create a truly inclusive and accessible health care system in which no one is left out.

Demographic of Asian Pacific Americans

The Asian Pacific American population is 1.6 million (8%) of New York State. Currently, the Asian Pacific American community is by percentage the fastest growing group in New York City, nearly doubling every decade since 1970, and encompasses 1.3 million (**15% of NYC's population**).

- Of the **1.3 million Asian Pacific Americans** living in New York City's five boroughs:
 - 78% are foreign-born
 - 28% speak little or no English
 - 42% of are linguistically isolated meaning that no one over the age of 14 in a household speaks English well

- **Poverty** in the Asian Pacific American community is the **second highest of all racial groups in New York City**
 - 53% are born into poverty
 - 26% live in poverty
 - 1 out of 25 Asian Pacific American children live in poverty
 - This means that immigrants face significant cultural and language barriers and struggle to access information and resources

- Asian Pacific American **children**
 - 1 in 8 children in New York City are Asian Pacific Americans
 - Asian Pacific American children are the only racial group that saw an increase in population in the last Census (16%)
 - Population growth mostly among US-born children
 - Increase mostly from Chinese, Bangladeshi, Pakistani, and Japanese children

- Asian Pacific American **small businesses**
 - New York State comes in 2nd as having the highest number of Asian Pacific American small businesses
 - Among cities, New York City had the largest number of Asian Pacific American-owned business
 - Among counties, Queens County was 2nd behind Los Angeles County
 - In New York City, Asian Pacific American-owned businesses contributed \$38B in sales and employed 160K in 2007
 - Highest number of firms were among Chinese, Indians, and Koreans
 - Overrepresented in accommodation and food services; transportation and warehousing; and wholesale trade

Top Policy Priorities for 2020

Language Access

Healthcare settings in New York State are required to provide language assistance to individuals with limited English proficiency (LEP). LEP individuals are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. Yet, with over 70 laws addressing language access in healthcare settings currently on the books on both the local and federal levels, there is still an observable deficit in accessibility to language assistance in essential healthcare settings--especially for those LEP individuals who belong to Asian Pacific American communities. There have been a number of hearings and oversight meetings on the monitoring and implementation of these laws, and each has shown a dire need for the City and State to live up to the requirements they themselves established in previous legislation. Stories like that of an individual asking for a Japanese interpreter and being connected to one who speaks Mandarin seem to be universal in community based organizations (CBOs). In order to achieve full health equity, robust language assistance must be available and accessible to *all* members of a community.

Our partners and community members have noticed that there appears to be two key barriers to the full and equal implementation of language access regulations in the healthcare setting: a lack of proper or sufficient reimbursement and a lack of an ability to leverage technology.

Cultural Competence

Often cultural competence and language access are conflated to be the same thing in healthcare settings. This is far from the truth, however, as language access is merely a single facet of cultural competence. A culturally competent health care system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relations, recognizes the potential impact of cultural differences, expands cultural knowledge, and adapts services to meet culturally unique needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care. A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities. Examples of strategies to move the health care system towards these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care.

Ways in which a healthcare setting may be able to improve their cultural competence:

- Collect race, ethnicity and language preference data.
- Identify and report disparities.
- Provide culturally and linguistically competent care.
- Develop culturally competent disease management programs.

- Increase diversity and minority workforce pipelines.
- Involve the community.
- Make cultural competency an institutional priority.

Priority Ask: Support the passage of **S06767** and **S03577** which requires cultural awareness and competence training for all medical professionals as part of their licensing requirements and a community health improvement plan for its region for the purpose of promoting the delivery of healthcare services in the region, improving the quality and accessibility of care, including cultural competency, respectively.

Data Disaggregation

There are 1.3 million Asian Pacific Americans living in New York City, but when government agencies collect and issue reports, this diverse population is often not mentioned, or grouped into the generic categories of “Asian”, “Other” or even “White.” Within the 40+ APA subgroups, there are unique social, educational and economic differences associated with each ethnicity that are not being assessed and addressed properly due to insufficient data disaggregation. For decades, the APA community has been praised as the “model minority” in America. Overrepresented in education success stories yet simultaneously underrepresented in stories about poverty, the way data is presented makes it seem as though this stereotype holds true. What this data obscures, however, is how unbelievably unevenly success is distributed among members of the APA community based on ethnic backgrounds. Evidence-based policies and targeted intervention programs cannot succeed properly without proper needs assessments which are borne of precise data reports. Data disaggregation efforts are a necessary step towards recognizing those differences and developing public policy and interventions that acknowledge and respond to the unique needs of historically overlooked and marginalized communities. Inequity in health, education, housing, etc. cannot be tackled through the existing lens of heterogeneity. We speak different languages, practice different religions, and come from different cultural backgrounds, and the consequence of generalization are severely unequal outcomes. As APAs are by percentage, the fastest growing racial group in NY, and the needs of underserved segments of the community outstrips current levels of service, the collection, disaggregation, and reporting of data on APAs can improve government efficiency by helping state agencies.

Priority Ask for City: Collaborate with Project CHARGE to engage Department of Health and Mental Hygiene in addressing health disparities in the APA community.

Priority Ask for State: State a commitment and timeline for the disaggregation of APA data within state agencies.

Expanding Coverage and Addressing Affordability Barriers

Expanding Coverage

The Affordable Care Act (ACA) made history by expanding health insurance to thousands of New Yorkers for the first time. However, it left insurance companies in charge of our healthcare system. Also, even with the ACA, over 1,000,000 New York residents are still uninsured. Despite the progress we have made nationally through the ACA, a host of challenges still face immigrant New Yorkers from accessing quality health care for themselves and their families. New York has a history of providing coverage to immigrant communities excluded from federal programs. The NY Health Act remains the one piece of legislation that will provide coverage for all residents of New York, while simultaneously lowering total healthcare costs for most individuals and for the State. NYHA is explicitly written to cover all residents, so immigrants currently barred from accessing health insurance would be covered. In 2018, a RAND Corporation study affirmed that the NY Health Act could cover everyone with expanded benefits including long-term care and support services, and still cost less in total healthcare dollars than the status quo. Passing the New York Health Act in 2020 will start the multi-year process of establishing a universal, single-payer healthcare program. In the meantime, important steps must be taken in this legislative session to expand coverage and address affordability barriers for residents who need relief in the interim. The state should continue to step up where federal policies fall short and lead nationally on immigrant healthcare issues by enacting a state-funded Essential Plan for immigrants. This program would be offered to the 246,000 unauthorized immigrants below 200% of the federal poverty level and would cost \$532 million. During this time of potential change to our health and immigration landscape, New York can build on its bold leadership for people under threat of losing their immigration status by maintaining state-funded Medicaid eligibility for people losing their Temporary Protected Status. Expanding coverage makes New York's health care providers more financially sound by reducing the burden of unreimbursed care for uninsured patients, and helps payers by bringing more people into coverage, ensuring they experience less cost shifting. With the federal government again attempting healthcare reform, moving more responsibility for healthcare to the states, it's imperative that New York establish a better, truly universal system, which finally gets costs under control. Our state can set the standard for the country by implementing a just and equitable healthcare system.

Addressing Affordability Barriers

There are two methods to achieve this goal. The first would be to offer a state-funded Essential Plan to approximately 120,000 people between 200% and 250% of the federal poverty level. This would cost around \$132 million in the first year. The second option would be to establish—as California has—additional state subsidies for people between 200% and 400% of

the federal poverty level. This option would make coverage more affordable for approximately 155,000 New Yorkers and cost anywhere between \$250 million and \$530 million, depending on the generosity of the subsidies. Support more community-based outreach and enrollment assistance to engage the hard-to-reach eligible but uninsured. New York's current Navigator program is funded at \$27.2 million. But these community-based Navigators haven't had a pay raise, or cost-of-living increase, in over six years. The Legislature should supplement these funds, with an extra emphasis on communities that have a disproportionate percentage of the remaining uninsured. We also must protect New Yorkers from unfair medical billing practices. Proposed legislation would eliminate some of these practices by requiring consolidated, clear hospital bills, shorten the time patients can be sued, and capping interest on medical debt to 3 percent. It would also protect consumers from surprise out-of-network bills caused by provider or plan misinformation; protect patients from unfair facility fees; and improve hospital financial assistance for uninsured patients. Additionally, the state must keep the Medicaid promise and reject harmful cuts that deny coverage or prevent access to care. State leaders should reorient away from an austerity framework, so that the above health care programs can be fully-funded. Doing so will require creating new sources of revenue that restore progressivity to our state's taxing programs to assure that New York is a just state in which to live and work. The state should also reject the annual growth cap on spending which has unnecessarily starved programs and state agencies of adequate resources to succeed.

Priority Ask: Support the passage of Coverage4All (**S3900/A5974**) and the New York Health Act (**A5248/S3577**), expanding access and coverage to *all* New Yorkers, regardless of immigration status or socioeconomic standing. To address affordability barriers, support **S6757/A8639** and reject harmful cuts that deny coverage or prevent access to care.



National Center for Law and Economic Justice



Project CHARGE
c/o CACF
50 Broad Street, 18th Fl.

New York, NY 10004