



September 4, 2020

**Written Statement for the
“Preliminary Framework for Equitable Allocation of COVID-19 Vaccine”**

The Asian & Pacific Islander American Health Forum¹ (APIAHF), the NYU Center for the Study of Asian American Health² (CSAAH), and the undersigned organizations who together represent the national collaborative of Asian American and Native Hawaiian and Pacific Islander (AA and NHPI) organizations who are the primary contractors with the Centers for Disease Control and Prevention (CDC) to respond to the COVID-19 pandemic³, along with additional leading national and local AA and NHPI organizations across the country, submit this joint comment in response to the *Preliminary Framework for Equitable Allocation of COVID-19 Vaccine (Draft Framework)*. As organizations representing communities that are the fastest growing groups in the United States (U.S.) and who have been and continue to be disproportionately impacted by COVID-19, it is vital that the Draft Framework *explicitly* address disparities in AA and NHPI communities in the development and deployment of COVID-19 vaccine distribution systems.

Both the data, cited below, and the direct experiences of our communities have pointed to the disproportionate impact that COVID-19 is having on AA and NHPI communities throughout the U.S. As the Draft Framework provides recommendations on the equitable allocation of COVID-19 vaccine, the existing inequities and disproportionate impact on AA and NHPI communities must be taken into meaningful consideration.

¹ **APIAHF** is the nation’s oldest and leading health policy organization working to advance the health and well-being of over 20 million AAs and NHPIs across the U.S. and territories. APIAHF works to improve access to and the quality of care for communities who are predominantly immigrant, many of whom are limited English proficient, and may be new to the U.S. healthcare system or unfamiliar with private or public coverage. We have longstanding relationships with over 150 community-based organizations across 35 states and the Pacific, to whom we provide capacity building, advocacy and technical assistance. <https://www.apiahf.org/>.

² **CSAAH** is a National Institutes of Health (NIH) National Institute on Minority Health and Health Disparities (NIMHD) funded National Research Center of Excellence. It is based in the [Section for Health Equity](#) within the [Department of Population Health](#) at NYU School of Medicine. Established in 2003 through an NIH NCMHD Project EXPORT (Excellence in Partnership, Outreach, Research, and Training) Center grant, CSAAH is the only Center of its kind in the country that is solely dedicated to research and evaluation on Asian American health and health disparities. CSAAH is committed to identifying Asian American health priorities and reducing health disparities by integrating and building on the work of researchers and over 55 Asian American community, government, business and academic/medical partners.

³ APIAHF is the only organization working directly with the CDC to do national COVID-19 response in AA NHPI populations. This response work consists of 2 major contracts: (1) *National Healthcare Workforce IPC Training Initiative (Project Firstline)* and (2) *Forging Asian and Pacific Islander Community Partnerships for Rapid Response to COVID-19*. Across these 2 significant national response projects are 10 key organizational partners who represent the reach and breadth of AA and NHPI communities across the country and across the Pacific.

In addition to the statistical basis for vaccine allocation, there are societal conditions which have also played out during COVID-19 which impact the health of AA and NHPs. These include the anti-Asian hate and xenophobia that has swept the nation, falsely associating the pandemic with Asians and others perceived to be foreign or different. In addition, the regulatory environment has chilled the ability of immigrant families, of all forms of residency status, from seeking health care through the public charge rule that had already resulted in dramatic declines in seeking medical care before COVID-19. With the public charge rule still pending, this will likely have a negative impact on vaccine acceptance and seeking, even among those who would be prioritized in the first tiers of vaccine allocation.

The Draft Framework Fails to Address the Disproportionate Impact of COVID-19 on AAs and NHPs

To date, there have been more than 184,000 COVID-19 deaths and over 6,000,000 COVID-19 cases.⁴ Communities of color make up less than 40 percent of the US population, but make up 52 percent of the excess deaths, compared to the average over the last five years.⁵

As of the end of August, the CDC reported that AAs accounted for 3.5 percent (n=78,203) of COVID-19 cases and 5.0 percent (n=5,614) of COVID-19 deaths, while NHPs accounted for 0.3 percent (n=7,171) of cases and 0.2 percent (n=153) of deaths.⁶ However, CDC data on race/ethnicity were missing for 51 percent of COVID-19 cases and 18 percent of COVID-19 deaths. The limited data on AAs and NHPs demonstrate:

- The current available data are undercounting the impact of COVID-19 among AA and NHP communities.⁷
- Recent estimates indicate a high burden of COVID-19 deaths among AAs, with almost 14,000 excess deaths, and AAs have the second-highest increase in deaths following Hispanic Americans.⁸ The rapid increase in COVID-19 cases and deaths among this population make future prevention critical with mounting evidence of waning immunity from natural infection and preliminary reports of re-infection.⁹
- Regional data have reported greater COVID-19 cumulative incidence and case fatality rates (proportion of deaths to cases) among AAs¹⁰ and NHPs (see Figure 1). In contrast to CDC reports, data from the

⁴ Centers for Disease Control and Prevention. Demographic Trends of COVID-19 cases and deaths in the US reported to CDC. CDC COVID Data Tracker. Accessed August 31, 2020. <https://www.cdc.gov/covid-data-tracker>.

⁵ Flagg A, Sharma D, Fenn L, Stobbe M. COVID-19's Toll on People of Color Is Worse Than We Knew. *The Marshall Project*. Published August 21, 2020. Accessed August 31, 2020. <https://www.themarshallproject.org/2020/08/21/covid-19-s-toll-on-people-of-color-is-worse-than-we-knew>.

⁶ Centers for Disease Control and Prevention. Demographic Trends of COVID-19 cases and deaths in the US reported to CDC. CDC COVID Data Tracker.

⁷ Moore JT. Disparities in Incidence of COVID-19 Among Underrepresented Racial/Ethnic Groups in Counties Identified as Hotspots During June 5–18, 2020 — 22 States, February–June 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69. doi:10.15585/mmwr.mm6933e1. Goldfarb A, Rivera JM. COVID-19 Race and Ethnicity Data: What's Changed, and What Still Needs Improvement. The COVID Tracking Project. Accessed August 31, 2020. <https://covidtracking.com/blog/covid-19-race-and-ethnicity-data-whats-changed-and-what-still-needs>.

⁸ Flagg A, Sharma D, Fenn L, Stobbe M. COVID-19's Toll on People of Color Is Worse Than We Knew. *The Marshall Project*.

⁹ Young K. COVID-19: Waning Antibodies / Seroprevalence of Antibodies / Thromboses. *NEJM Journal Watch*. 2020;2020. doi:10.1056/nejm-jw.FW116855. See also Ibarondo FJ, Fulcher JA, Goodman-Meza D, et al. Rapid Decay of Anti-SARS-CoV-2 Antibodies in Persons with Mild Covid-19. *New England Journal of Medicine*. Published online July 21, 2020: null. doi:10.1056/NEJMc2025179.

¹⁰ Yan B, Ng F, Nguyen TT. *High Mortality from COVID-19 among Asian Americans in San Francisco and California*. UCSF School of Medicine and Asian American Research Center on Health (ARCH); 2020. https://asianarch.org/press_releases/Asian%20COVID-19%20Mortality%20Final.pdf. See also Yan B, Ng F, Chu J, Tsoh J, Nguyen T. Asian Americans Facing High COVID-19 Case Fatality. *Health Affairs Blog*. doi:10.1377/hblog20200708.894552.

NHPI COVID-19 Data Policy Lab Dashboard reported 12,992 COVID-19 NHPI cases and 211 COVID-19 NHPI deaths as of August 26, 2020.¹¹

- Initial research suggests there may be lower testing among AA populations.¹²
- In at least 10 states, AAs have a case fatality rate that is disproportionately higher than the general population, while the same is true for NHPIs in 8 states.¹³ For example, in South Dakota, the case rate for AAs is 6 times higher as a proportion of their population in the state.¹⁴ These numbers may be larger, but many states are not reporting out data in sufficient enough detail to evaluate disparities, while the CDC has not reported out any data about AA or NHPI subpopulations, many of whom often face distinct health disparities.¹⁵
- In some localities, like King County, Washington, and San Francisco County, California, NHPIs have rates 3 times or more their proportion in the population.¹⁶ In Spokane County, Washington, Marshall Islanders make up less than 1% of the county's population, but make up 30% of confirmed COVID-19 cases.¹⁷
- Across the country, Pacific Islanders are being hospitalized with COVID-19 at up to 10 times the rate of other racial groups. In Washington, the rate of confirmed cases for NHPIs are 9 times higher than those of whites. In Oregon, Pacific Islanders make up .4% of the population, but represent nearly 3% of all COVID-19 infections. Summarily, in Arkansas, Pacific Islanders make up .3% of the population, but account for 8% of COVID-19 cases. In Hawaii, Pacific Islanders make up 4% of the population, but 25% of COVID-19 cases.¹⁸

¹¹ UCLA Center for Health Policy Research. NHPI COVID-19 Data Policy Lab Dashboard. Accessed August 31, 2020. https://public.tableau.com/views/NHPI_CDPL_Dashboard_with_extract/NHPICDPLDashboard?:embed=y&:showVizHome=no&:host_url=https%3A%2F%2Fpublic.tableau.com%2F&:embed_code_version=3&:tabs=no&:toolbar=yes&:animate_transition=yes&:display_static_image=no&:display_spinner=no&:display_overlay=yes&:display_count=yes&:language=en&:publish=yes&:loadOrderID=0.

¹² Kandula N, Shah N. Asian Americans invisible in COVID-19 data and in public health response. *Chicago Reporter*. Published June 16, 2020. Accessed August 31, 2020. <https://www.chicagoreporter.com/asian-americans-invisible-in-covid-19-data-and-in-public-health-response/>. See also Quach T, Doãn LN, Liou J, Ponce N. Simultaneously Blamed and Ignored: Barriers, Behaviors, and Impact of COVID-19 on Asian Americans. *JMIR Preprints*. Published online August 30, 2020. doi:10.2196/preprints.23976.

¹³ Testimony from the National Council of Asian Pacific Islander Physicians to the Committee on Ways and Means (June 9, 2020). Available at: https://mcusercontent.com/d7f02dd24377959c916d14de6/files/5ebe9b24-21f8-4d67-93d2-4f218db2e323/NCAPIP_Statement_to_House_Ways_and_Means_Committee_on_COVID_19_Disparities.pdf.

¹⁴ Wen, Leana and Nakisa Sadeghi, Addressing Racial Health Disparities In The COVID-19 Pandemic: Immediate And Long-Term Policy Solutions, *Health Affairs*. Published July 20, 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200716.620294/full/>.

¹⁵ For example, APIAHF analysis of 2018 American Community Survey data shows that while the overall uninsured rate for Asian Americans is 6.2%, the uninsured rate for Nepalese is 13.4% and 9.4% for Pakistanis.

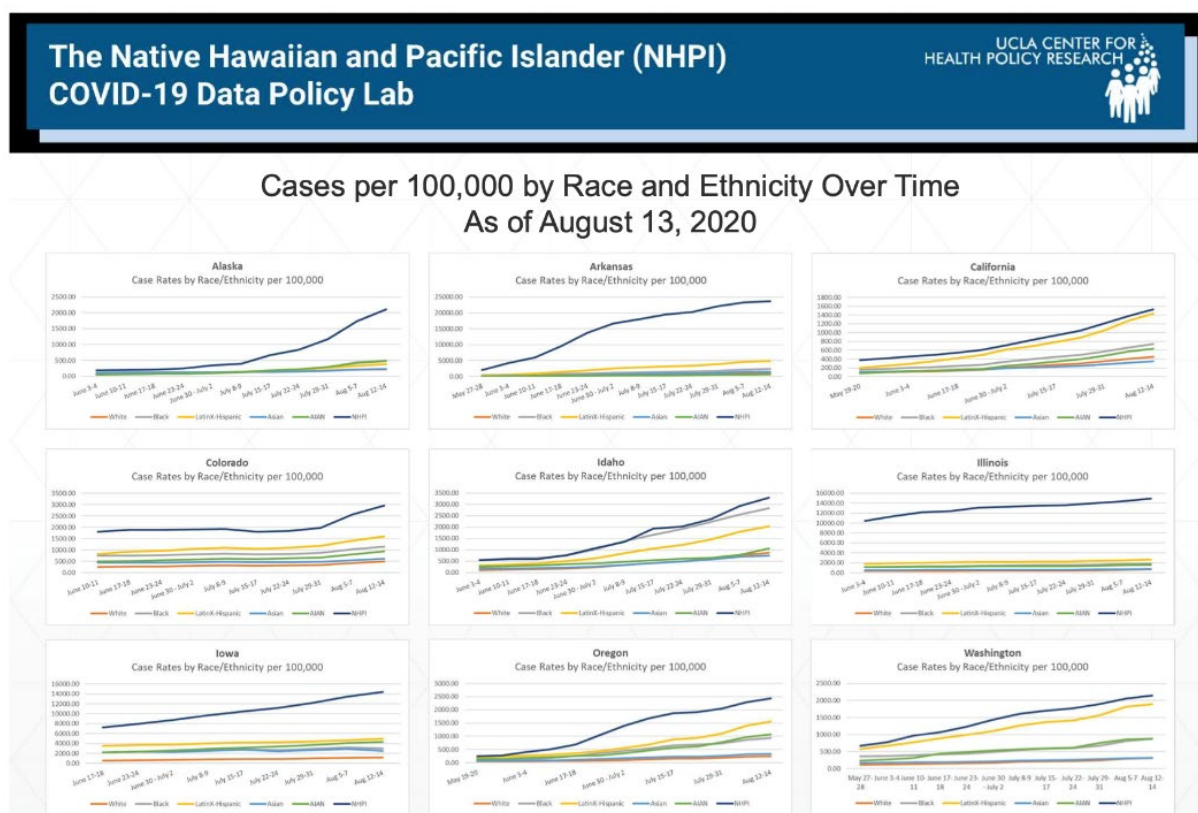
¹⁶ “Devastating COVID-19 Rate Disparities Ripping Through Pacific Islander Communities in the U.S.,” *Pacific Islander Center on Primary Care Excellence*. Published April 27, 2020. Available at: https://mk0picopce2kx432grq5.kinstacdn.com/wp-content/uploads/2020_0424-PICOPCE-COVID19-Press-Release.pdf.

¹⁷ Jackson, Lagipoiva, “Pacific Islanders in US Hospitalized with COVID-19 at up to 10 Times the Rate of Other Groups,” *The Guardian*. Published July 26, 2020. Available at: https://www.theguardian.com/world/2020/jul/27/system-is-so-broken-covid-19-devastates-pacific-islander-communities-in-us?CMP=share_btn_link.

¹⁸ *Id.*

- Initial research from San Francisco suggests that AAs had the highest proportion of deaths due to COVID-19 across all other racial groups.¹⁹ While AAs make up one-third of the city’s population, they make up half of its COVID-19 deaths.²⁰
- In California, the NHPI community makes up .3% of the state’s population, but accounts for .6% of cases, while AAs represent 11.8% of COVID-19 deaths and 15% of the state population.
- AAs represent 16% of COVID-19 deaths and 15% of the state population, while NHPs make up 1.6% of cases but .3% of the state’s population.²¹
- Using what limited information is available, researchers have found that Filipino-Americans are dying of the virus at very high rates, accounting for 35% of COVID-19 deaths amongst California’s AA population.²²

Figure 1: COVID-19 cases per 100,000 by race/ethnicity over time



Citation: Chang RC, Penaia C, Thomas K. Count Native Hawaiian And Pacific Islanders In COVID-19 Data—It’s An OMB Mandate. Health Affairs Blog. doi:10.1377/hblog20200825.671245.

¹⁹ Constance, Agnes, Asian American Death Rate in San Francisco Concerning, Researchers Say, *NBC News*. Published May 20, 2020. Available at: <https://www.nbcnews.com/news/asian-america/asian-american-covid-19-death-rate-san-francisco-concerning-researchers-n1211491>.

²⁰ Palomino, Joaquin, Why has coronavirus taken such a toll on SF’s Asian American community? Experts perplexed over high death rate, *San Francisco Chronicle*. Published May 2020, 2020. Available at: <https://www.sfchronicle.com/health/article/Why-has-coronavirus-taken-such-a-toll-on-SF-s-15282096.php>.

²¹ COVID-19 Updates, *California Department of Public Health COVID-19 Cases and Deaths by Race/Ethnicity*. Accessed September 3, 2020. Available at <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Race-Ethnicity.aspx>.

²² Wong, Tiffany, Little noticed, Filipino Americans are dying of COVID-19 at an alarming rate, *Los Angeles Times*. Published July 21, 2020. Available at: <https://www.latimes.com/california/story/2020-07-21/filipino-americans-dying-covid>.

Given these alarming and documented disparities, there is a critical need for better understanding that these data are important to control the spread and reduce the impact of COVID-19 among racial and ethnic communities. The social determinants of health that underlie these disparities in COVID-19 deaths include increased incidence of xenophobic hate and violence. AA and NHPI organizations have documented at least 1,900 hate incidents in 46 states.²³ In addition, AA and NHPIs have increased risk of adverse COVID-19 outcomes (e.g., burden of chronic conditions and multigenerational homes), and a large proportion of AA and NHPI frontline essential workers.²⁴

Despite the documented disparities and underlying social determinants of health impacting AAs and NHPIs, the **Draft Framework fails to include a single reference to AA and NHPI disparities** when discussing the impact on Black, Hispanic or Latinx, American Indian and Alaska Native populations. In failing to explicitly identify AA and NHPI disparities along with other communities of color, the Draft Framework erases these disparities, potentially creating the false sense that they do not exist or that AAs and NHPIs are not being uniquely impacted by COVID-19. As advocates for AA and NHPI communities, we note this is a glaring omission that must be addressed in any final framework. Failure to include AAs and NHPIs will continue to exacerbate a culture of exclusion of these communities, resulting in them being excluded from COVID-19 vaccine allocations at a time when they are deeply impacted.

- Page 37, line 777 – Add Asian American and Native Hawaiian and Pacific Islander populations to “A significantly higher burden is experienced by Black, Hispanic or Latinx, and American Indian and Alaska Native populations.”
- Page 38, lines 792-793 – Add the sovereignty of Native Hawaiians to “In addition, any vaccine allocation plan implemented at the federal and state levels must respect the tribal sovereignty of American Indian and Alaska Native nations.”
- Page 48, line 1069 – Add Asian American and Native Hawaiian and Pacific Islander populations to “...and Black, Hispanic or Latinx, and American Indian and Native Alaskan communities given the ways in which these risks disproportionately affect people in these groups.”
- Page 76, lines 1785-1787 – Add Asian American and Native Hawaiian and Pacific Islander populations to “The data clearly demonstrate that people of color—specifically Black, Hispanic or Latinx, and American Indian and Alaska Native—have been disproportionately impacted by COVID-19 with higher rates of morbidity, mortality, and transmission.”

Given the existing inequitable distribution and allocation of health resources, if not further addressed and replicated in vaccine allocation, COVID-19 will further health inequities and have negative impacts on health outcomes for AA and NHPI populations. COVID-19 interventions and clinical trials that are substantive for and meaningful to AA and NHPI communities will be needed at all phases, as well as for risk criteria to mitigate health inequities in the development and deployment of vaccine distribution systems.

Vaccine Allocation for AA and NHPI Health Essential Workers

Essential workers face higher risks of COVID-19 infection because of increased exposure to the virus. About 10 percent of the US workforce are employed in jobs where they are exposed to infection or disease at least once per

²³ Ko JY, Danielson ML, Town M, et al. Risk Factors for COVID-19-associated hospitalization: COVID-19-Associated Hospitalization Surveillance Network and Behavioral Risk Factor Surveillance System. *medRxiv*. Published online July 27, 2020:2020.07.27.20161810. doi:10.1101/2020.07.27.20161810.

²⁴ Kaholokula JK, Samoa RA, Miyamoto RES, Palafox N, Daniels S-A. COVID-19 Special Column: COVID-19 Hits Native Hawaiian and Pacific Islander Communities the Hardest. *Hawaii J Health Soc Welf*. 2020;79(5):144-146. See also Krisberg K. Essential workers facing higher risks during COVID-19 outbreak: Meat packers, retail workers sickened. *The Nation's Health*. 2020;50(6):1-16. See also Jurado L-FM, Saria MG. Filipino nurses in the United States. *Nursing Management*. 2018;49(3):36-41. doi:10.1097/01.NUMA.0000530423.71453.58.

week.²⁵ About 30 percent of AAs and NHPs are represented in the essential workforce, including healthcare, food preparation services, personal care, protective services, sales and production (see Figure 2). Pacific Islanders also have a high concentration in the meat- and poultry-processing industry, another essential industry. The burden of exposure to infection or disease at least once a week was more than 75 percent among healthcare support and healthcare practitioner workers, and about 30 percent among protective services workers.¹⁷ In some states, AAs and NHPs make up the highest share of healthcare workers, with a large proportion who are immigrants.²⁶

In response to Page 60, lines 1316-1319 - Among AAs and NHPs, there are several populations that have been reported to have a greater burden of COVID-19 deaths, in addition to the higher risk of COVID-19 disease and severe higher rates of comorbid conditions.

- Filipino nurses make up a large proportion of health workers, are employed in hospital settings (58.5 percent), and are represented in acute care and critical care (42.5 percent) and geriatrics or gerontology (7 percent).²⁷ In California, almost one-fifth of registered nurses are Filipino and are overrepresented compared to the patient population.²⁸ In addition to their occupational exposures, a high proportion of Filipino nurses in the US were born in the Philippines (94.2 percent).²⁹
- AAs and NHPs make up over 71 percent of the share of all healthcare workers in Hawaii and over 26 percent of healthcare workers in California.³⁰
- In the healthcare workforce in the US, Filipinos represent 18.4 percent in the share of healthcare workers compared to 9.1 percent of all AAs and NHPs.³¹
- In the food preparation workforce in the US, Chinese, Filipino, and NHPs represent 6.1, 4.9, and 6.8 percent, respectively, in the share of food preparation workers compared to 4.9 percent of all AAs and NHPs.³²

²⁵ Krisberg K. Essential workers facing higher risks during COVID-19 outbreak: Meat packers, retail workers sickened. *The Nation's Health*. 2020;50(6):1-16. See also Baker MG, Peckham TK, Seixas NS. Estimating the burden of United States workers exposed to infection or disease: A key factor in containing risk of COVID-19 infection. *PLOS ONE*. 2020;15(4):e0232452. doi:10.1371/journal.pone.0232452.

²⁶ Dang E, Huang S, Kwok A, Lung H, Park M, Yueh E. COVID-19 and Advancing Asian American Recovery. *McKinsey & Company* <https://www.mckinsey.com/~media/McKinsey/Industries/Public%20and%20Social%20Sector/Our%20Insights/COVID%2019%20and%20advancing%20Asian%20American%20recovery/COVID-19-and-advancing-Asian-American-recovery-final.pdf>. See also *New American Economy Research Fund*. Asian Americans and Pacific Islander Americans on the Frontlines. Published May 21, 2020. Accessed August 31, 2020. <https://research.newamericaneconomy.org/report/aapi-americans-on-the-frontlines/>.

²⁷ Jurado L-FM, Saria MG. Filipino nurses in the United States. *Nursing Management*. 2018;49(3):36-41. doi:10.1097/01.NUMA.0000530423.71453.58.

²⁸ Wong T. Little noticed, Filipino Americans are dying of COVID-19 at an alarming rate. *Los Angeles Times*. <https://www.latimes.com/california/story/2020-07-21/filipino-americans-dying-covid>. Published July 21, 2020. Accessed September 3, 2020. See also Waneka R, Spetz J. *The Diversity of California's Registered Nursing Workforce – 2013 Update*. California Board of Registered Nursing; 2013. Accessed October 2, 2011. [http://0-proquest.umi.com.library.touro.edu/pqdweb?index=0&did=2166665531&SrchMode=1&sid=1&Fmt=3&VInst=PROD&VTy](http://0-proquest.umi.com.library.touro.edu/pqdweb?index=0&did=2166665531&SrchMode=1&sid=1&Fmt=3&VInst=PROD&VType=PQD&RQT=309&VName=PQD&TS=1317549965&clientId=31638)

²⁹ Jurado L-FM, Saria MG. Filipino nurses in the United States. *Nursing Management*. 2018;49(3):36-41. doi:10.1097/01.NUMA.0000530423.71453.58.

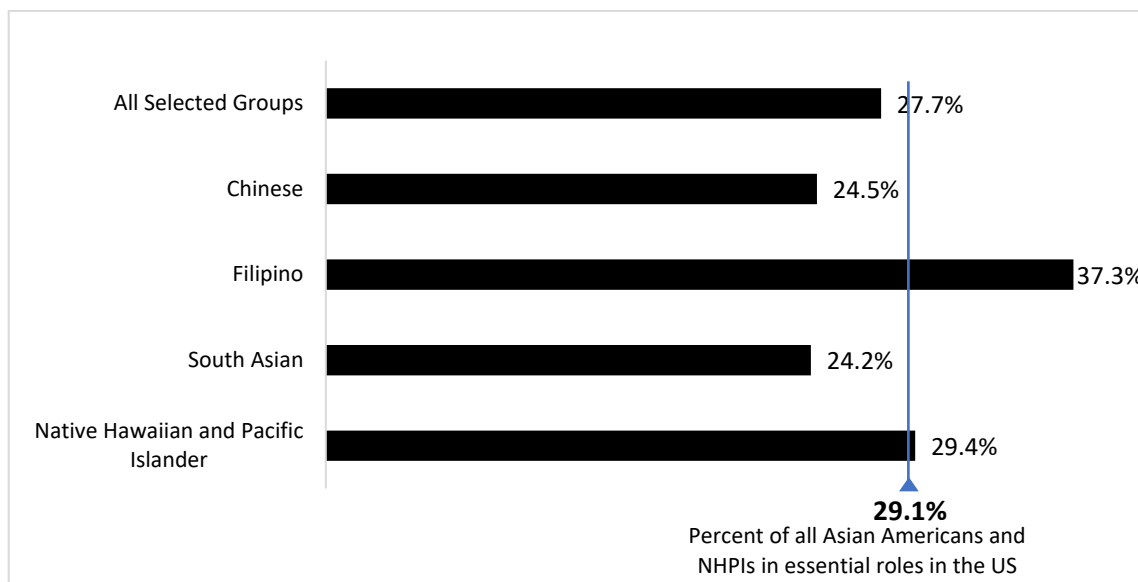
³⁰ Asian Americans and Pacific Islander Americans on the Frontlines. *New American Economy Research Fund*. Published May 21, 2020. Accessed August 31, 2020. <https://research.newamericaneconomy.org/report/aapi-americans-on-the-frontlines/>.

³¹ US Census Bureau. 2018 American Community Survey 1-Year Estimates. Accessed April 21, 2020.

³² *Id.*

- In the production workforce in the US, South Asians and NHPIs make up 4.1% and 3.9%, respectively, compared to 3.8% of all AAs and NHPIs.³³

Figure 2: Representation of select AA and NHPI groups in essential roles



Note: Essential workers include healthcare, food preparation services, personal care, protective services, sales and production workers. Source: 2018 the 2018 American Community Survey (ACS) 1-year Estimates. Data analyzed by L. Doan on 8/26/2020.

Ensuring Equity – Social Vulnerability Index and Social Determinants of Health

If a vaccine is to be equitably accessible, the social conditions and determinants of health for AA and NHPI communities must be considered.³⁴ This includes the rates of un- or under-insurance, immigration status, language access, cultural awareness, chronic health conditions, and more. APIAHF has sent a letter to the Office for Civil Rights at HHS on the needs of our community, yet their recent publication regarding civil rights protections and discrimination during COVID-19 failed to reference AAs and NHPIs.³⁵

Disproportionate impact of chronic diseases amongst AAs and NHPIs

³³ *Id.*

³⁴ Written Statement for the Record for the Hearing Entitled ‘The Disproportionate Impact of COVID-19 on Communities of Color’ Committee on Ways and Means, *Asian & Pacific Islander American Health Forum*. Published May 27, 2020. Available at: <https://www.apiahf.org/wpcontent/uploads/2020/05/5.26.2020-Asian-Pacific-Islander-American-Health-Forum-WrittenTestimony-to-Ways-and-Means-Committee-1.pdf>.

³⁵ Letter to HHS OCR in Response to Civil Rights Protections Prohibiting Race, Color and National Origin Discrimination During COVID-19, *Asian & Pacific Islander American Health Forum*. Published July 31, 2020. Available at: <https://www.apiahf.org/resource/letter-to-hhs-ocr-in-response-to-civil-rights-protections-prohibiting-race-color-and-national-origin-discrimination-during-covid%e2%80%90/>.

The high prevalence of underlying health conditions like diabetes and pre-diabetes³⁶ are a large contributing factor to COVID-19 disparities among AAs and NHPIs. According to the CDC, among COVID-19 confirmed hospitalized adults, over 90 percent of adults had an underlying health condition that included hypertension (56.9 percent), obesity (47.6 percent), metabolic disease (41.4 percent), and cardiovascular disease (32.5 percent).³⁷ Additionally, COVID-19 morbidity and mortality have been associated with diabetes in several recent studies.³⁸ Diabetes is of particular concern for Filipino, South Asian and NHPI communities affecting 12 percent, 11 percent and 9 percent, respectively (vs. 8.5 percent in US total).³⁹

- NHPIs have disproportionately high prevalence of cardiometabolic diseases including diabetes and obesity, and are among the highest-risk populations in the US.⁴⁰
- Studies have found that Asians as an aggregate have greater diabetes prevalence than their white counterparts⁴¹ and have the highest proportion of undiagnosed diabetes among all racial and ethnic groups.⁴²
- Furthermore, there is variation in the prevalence of diabetes when data are disaggregated by Asian subgroups. For example, a study by Uchima et al. (2019) using data from the Hawai'i Behavioral Risk Factor Surveillance System found that NHPI (9.9 percent), Filipino (11.2 percent), and Chinese (9.1 percent) adults had significantly higher prevalence of diabetes than white adults (5.4 percent).⁴³ Another study found that all AA women and men (Asian Indian, Chinese, Filipino, Japanese, Korean, and Vietnamese) had greater prevalence of type 2 diabetes compared to non-Hispanic whites, with Asian Indian and Filipinos reporting the highest rates among AA subgroups.⁴⁴

Multi-generational households

³⁶ Ko JY, Danielson ML, Town M, et al. Risk Factors for COVID-19-associated hospitalization: COVID-19-Associated Hospitalization Surveillance Network and Behavioral Risk Factor Surveillance System. *medRxiv*. Published online July 27, 2020:2020.07.27.20161810. doi:10.1101/2020.07.27.20161810.

³⁷ Centers for Disease Control and Prevention. COVID-NET: COVID-19-Associated Hospitalization Surveillance Network. Accessed August 31, 2020. https://gis.cdc.gov/grasp/COVIDNet/COVID19_5.html.

³⁸ Apicella M, Campopiano MC, Mantuano M, Mazoni L, Coppelli A, Prato SD. COVID-19 in people with diabetes: understanding the reasons for worse outcomes. *The Lancet Diabetes & Endocrinology*. 2020;8(9):782-792. doi:10.1016/S2213-8587(20)30238-2. See also Holman N, Knighton P, Kar P, et al. Risk factors for COVID-19-related mortality in people with type 1 and type 2 diabetes in England: a population-based cohort study. *The Lancet Diabetes & Endocrinology*. Published online August 13, 2020. doi:10.1016/S2213-8587(20)30271-0.

³⁹ Wyatt LC, Russo R, Kranick J, et al. *Health Atlas 2012-2017 for AANHPI: A Comprehensive Look at Health for AANHPI in the U.S. 2020*.

⁴⁰ Mau MK, Sinclair K, Saito EP, Baumhofer KN, Kaholokula JK. Cardiometabolic Health Disparities in Native Hawaiians and Other Pacific Islanders. *Epidemiol Rev*. 2009;31:113-129. doi:10.1093/ajerev/mxp004.

⁴¹ Menke A, Casagrande S, Geiss L, Cowie CC. Prevalence of and Trends in Diabetes Among Adults in the United States, 1988-2012. *JAMA*. 2015;314(10):1021-1029. doi:10.1001/jama.2015.10029. See also Wang EJ, Wong EC, Dixit AA, Fortmann SP, Linde RB, Palaniappan LP. Type 2 Diabetes: Identifying High Risk Asian American Subgroups in a Clinical Population. *Diabetes Res Clin Pract*. 2011;93(2):248-254. doi:10.1016/j.diabres.2011.05.025.

⁴² Menke A, Casagrande S, Geiss L, Cowie CC. Prevalence of and Trends in Diabetes Among Adults in the United States, 1988-2012. *JAMA*. 2015;314(10):1021-1029. doi:10.1001/jama.2015.10029.

⁴³ Uchima O, Wu YY, Browne C, Braun KL. Disparities in Diabetes Prevalence Among Native Hawaiians/Other Pacific Islanders and Asians in Hawai'i. *Prev Chronic Dis*. 2019;16. doi:10.5888/pcd16.180187.

⁴⁴ Wang EJ, Wong EC, Dixit AA, Fortmann SP, Linde RB, Palaniappan LP. Type 2 Diabetes: Identifying High Risk Asian American Subgroups in a Clinical Population. *Diabetes Res Clin Pract*. 2011;93(2):248-254. doi:10.1016/j.diabres.2011.05.025.

Living in more crowded homes, and/or multi-generational homes, may increase the risk of COVID infection, particularly among households with vulnerable populations (e.g., older adults) or essential workers and limited space to isolate.⁴⁵

- AAs and NHPIs are more likely to live in multigenerational homes than other racial/ethnic groups.⁴⁶ More than 70 percent of AAs and NHPIs lived in multigenerational homes, with about 13 percent of AAs and NHPIs living in three-generational households.⁴⁷ The percent of adults 65 years and older living in multigenerational homes ranged from 4.6% among NHPIs to 12.1% among Filipinos.⁴⁸
- Among AA and NHPI groups, Filipinos (18.7 percent) and NHPIs (16.4 percent) reported the percentages of living in three-generational households.⁴⁹
- NHPIs have higher COVID-19 death rates than any other racial or ethnic group, especially in regions with dense populations of NHPIs like Louisiana, Arkansas and Iowa.⁵⁰
- About 24.1 percent of NHPIs live in 19 hotspot counties where NHPI populations are disproportionately affected by COVID-19 and 5.1 percent of AAs live in 4 hotspot counties where AA residents are disproportionately affected by COVID-19.⁵¹

Language access a barrier for 1 in 3 Asian Americans and Pacific Islanders

One third of AAs and Pacific Islanders are limited English proficient (LEP), meaning they speak little to no English, creating a substantial barrier to accessing routine care, let alone critical information and access to vaccines and clinical trials. Despite existing federal law and regulation requiring protections for LEP communities, who account for 25 million Americans, including over 6 million AAs and over 100,000 NHPIs, and established language access plans of federal agencies, language remains a significant barrier for the health of AAs and NHPIs.⁵²

Our concerns are further confirmed by a survey commissioned by APIAHF with 45 community-based partners working with AA and NHPI communities which found that 9 in 10 respondents reported that existing language resources related to COVID-19 are inadequate.⁵³ As such, it is critical that any vaccine framework address

⁴⁵ Dougherty C. 12 People in a 3-Bedroom House, Then the Virus Entered the Equation. *The New York Times*. <https://www.nytimes.com/2020/08/01/business/economy/housing-overcrowding-coronavirus.html>. Published August 1, 2020. Accessed August 31, 2020. See also Mejia MC, Cha P. Overcrowded Housing and COVID-19 Risk among Essential Workers. Public Policy Institute of California. Accessed August 31, 2020. <https://www.ppic.org/blog/overcrowded-housing-and-covid-19-risk-among-essential-workers/>.

⁴⁶ Cohn D, Passel JS. Record 64 million Americans live in multigenerational households. *Pew Research Center*. Published April 5, 2018. Accessed August 31, 2020. <https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/>.

⁴⁷ US Census Bureau. 2018 American Community Survey 1-Year Estimates.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Chang RC, Penaia C, Thomas K. Count Native Hawaiian And Pacific Islanders In COVID-19 Data—It's An OMB Mandate. *Health Affairs Blog*. doi:10.1377/hblog20200825.671245.

⁵¹ Centers for Disease Control and Prevention. Demographic Trends of COVID-19 cases and deaths in the US reported to CDC. CDC COVID Data Tracker.

⁵² COVID-19 Language Access Letter to Congressional Leadership, *Asian & Pacific Islander American Health Forum*. Published July 23, 2020. Available at: <https://www.apiahf.org/resource/covid19-lep-letter/>.

⁵³ What Asian American, Native Hawaiian and Pacific Islander Organizations Need in the Face of the COVID-19 Pandemic, *Asian & Pacific Islander American Health Forum*. Published July 20, 2020. Available at: <https://www.apiahf.org/resource/covid-19-need-to-know/>.

language access barriers and advocate for allocation of resources, at the trial, distribution and public education of any COVID-19 vaccine.

Immigration status and other social determinants of health

While the Affordable Care Act (ACA) has resulted in more than 20 million Americans gaining coverage through Medicaid and the Health Insurance Marketplace, coverage remains unequal with millions of immigrants ineligible for Medicaid and other public health insurance programs.⁵⁴ Federal restrictions, dating back to the 1996 Personal Responsibility and Work Opportunity Reconciliation Act of 1996, bar many categories of immigrants from coverage while undocumented immigrants are not even able to buy unsubsidized insurance on the ACA marketplaces. As a result, 31% of noncitizens are uninsured, compared to 8% of naturalized citizens and 7% of native-born citizens.⁵⁵

For example, individuals living in the U.S. under the Compacts of Free Association with the Republic of the Marshall Islands, Federated States of Micronesia and Republic of Palau are categorically ineligible for Medicaid⁵⁶, as are those without green cards or those who have had legal permanent resident status for less than five years. Immigration status is a leading social determinant of health, dividing our nation between those who have coverage and those who do not. This disparity is even more significant in the context of COVID-19 where immigrant communities lack full access to testing and treatment and fear seeking care as a result of public charge and immigration enforcement concerns.

The Importance of Disaggregated Data

The Marshall Project reported in late August that the AA community has been hit just as hard as the Black and Hispanic communities — facing at least a 30% increase in deaths this year.⁵⁷ However, having the data to reveal this has been difficult to secure. One of the key barriers to being able to see the inequities and disparities in health for AA and NHPI populations is the aggregation of data by race and ethnicity.⁵⁸

“[T]he impact on Asian Americans, Native Hawaiians, and Pacific Islanders is less evident because the data on these specific communities are not disaggregated to show the full impact of the coronavirus recession among subgroups of AANHPI communities.

The data that are disaggregated, for income levels and educational attainment, demonstrate that aggregated data for all Asian Americans, Native Hawaiians, and Pacific Islanders mask serious socioeconomic inequities within and among the many [subgroups in this catch-all category](#). To address both the public health and economic crises, disaggregating U.S. administrative data by detailed race and ethnicity is a critical element of a [broader policy agenda](#) to protect the most vulnerable workers and to address pervasive issues of [systemic racism](#). (Washington Center for Equitable Growth, August 20, 2020)”

⁵⁴ Chartbook: Accomplishments of Affordable Care Act, *Center on Budget and Policy Priorities*. Published March 19, 2020. Available at: <https://www.cbpp.org/research/health/chart-book-accomplishments-of-affordable-care-act>.

⁵⁵ APIAHF analysis of 2018 American Community Survey data.

⁵⁶ APIAHF Letter to Congressional Leaders on COFA and COVID-19, *Asian & Pacific Islander American Health Forum*. Published May 7, 2020. Available at: <https://www.apiahf.org/resource/apiahf-letter-to-congressional-leaders-on-cofa-and-covid-19/>.

⁵⁷ Flagg A, Sharma D, Fenn L, Stobbe M. COVID-19’s Toll on People of Color Is Worse Than We Knew. The Marshall Project. Published August 21, 2020.

⁵⁸ COVID-19 Demographic Data Sign-on Letter to Congress, *Asian & Pacific Islander American Health Forum*. Published May 4, 2020. Available at: <https://www.apiahf.org/resource/covid-19-demographic-data-sign-on-letter-to-congressional-leaders/>.

Where data has been collected and analyzed in a method that is disaggregated by race and ethnicity, the disproportionate impact is revealed as outlined earlier in this comment.

Finally, it is extremely important to look at the underlying conditions (racism, poverty, co-morbidities, lack of access to health info/care/insurance), homelessness, institutionalization, and systemic inequality. Racism is a consequence of systemic inequalities and any framework must acknowledge the potential impact on vaccine allocation and public health.

Sincerely,

Asian & Pacific Islander American Health Forum
NYU Center for the Study of Asian American Health

National AANHPI COVID Health Response Partnership:

Asian Pacific American Labor Alliance, AHL-CIO
Asian Pacific Islander American Public Affairs (APAPA)
Association of Asian Pacific Community Health Organizations (AAPCHO)
Coalition for Asian American Children and Families
National Council of Asian Pacific Americans
NH&PI Hawai'i COVID 3R Team
Pacific Islander Center of Primary Care Excellence
Papa Ola Lōkahi
Philippine Nurses Association of America Inc.

Additional Signatories:

AADAP, Inc.
AANHPI COVID-19 Policy and Research Team
AltaMed Health Services
American Medical Women's Association
APAIT – a division of Special Service for Groups
Asian & Pacific Islander Caucus for Public Health
Asian American Psychological Association
Asian American Research Center on Health (ARCH)
Asian Americans Advancing Justice | AAJC
Asian Americans Advancing Justice – Los Angeles
Asian Pacific Health Care Venture, Inc.
Asian Pacific Forward Movement (APIFM)
Asian Pacific Partners for Empowerment, Advocacy and Leadership (APPEAL)
Asian Resources, Inc.
BPSOS Center for Community Advancement
CA Healthy Nail Salon Collaborative
Chinatown Service Center
Chinatown YMCA
Chinese-American Planning Council
Department of Native Hawaiian Health, University of Hawaii
Empowering Pacific Islander Communities (EPIC)
Faith and Community Empowerment (formerly KCCD)
Healthy House Within A MATCH Coalition
Immigrant and Refugee Community Organization (IRCO)'s Pacific Islander and Asian Family Center (PIAFC)
International Community Health Services, Inc.

Kayamanan Ng Lahi Philippine Folk Arts
Kheir Clinic
Khmer Girls in Action
Korean Community Services
Latino Coalition for a Health CA
LEAP (Leadership Education for Asian Pacifics)
Little Manila Rising
Little Tokyo Service Center
Maternal and Child Health Access
Micronesian Islander Community (MIC)
NAPAWF Bay Area Chapter
National Asian Pacific American Families Against Substance Abuse
National Asian Pacific American Women's Forum (NAPAWF)
National Council of Asian Pacific Islander Physicians
National Pacific Islander Covid-19 Response Team
NHPI Covid-19 Data Policy Lab @ UCLA Center for Health Policy Research
NHPI COVID-19 Resource Team
Orange County Asian and Pacific Islander Community Alliance, Inc. (OCAPICA)
Philippine Nurses Association of Alabama
Philippine Nurses Association of Central Florida
Philippine Nurses Association of Maryland
Philippine Nurses Association of Metropolitan Houston (PNMAH)
Philippine Nurses Association of Metropolitan DC, Inc.
Philippine Nurses Association of Miami and South East Florida
Philippine Nurses Association of New Mexico
Philippine Nurses Association of North H
Philippine Nurses Association of Northeast Florida
Philippine Nurses Association of Northern California
Philippine Nurses Association of New Jersey
Philippine Nurses Association of Southern California
Philippine Nurses Association of Tennessee
Philippine Nurses Association of Texas Golden Triangle
Philippine Nurses Association of Virginia
SHK Global Health
Society of Pediatric Research
South Asian Public Health Association (SAPHA)
Southeast Asia Resource Action Center
Southeast Asian Community Alliance
Southern California Society for Public Health Education
Taulama for Tongans
The Cambodian Family Community Center
UCLA Department of Community Health Sciences
Union of Pan Asian Communities (UPAC)
United Chinese Association of Brooklyn, Inc.
University Settlement at the Houston Street Center
Vietnamese American Cancer Foundation