APAMSA

Policy and Research Update
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KFF: Affordable Care Act Insurers are Raising Premiums by an Estimated 26 Percent But Most Enrollees Could See Sharper Increases in What They Pay

https://www.kff.org/quick-take/aca-insurers-are-raising-premiums-by-an-estimated-26-but-most-enrollees-could-see-sharper-increases-in-what-they-pay/
https://www.kff.org/affordable-care-act/8-things-to-watch-for-the-2026-aca-open-enrollment-period/

After the end of the federal government shutdown, uncertainty remains for the Affordable Care Act (ACA) health insurance marketplaces, with enhanced premium subsidies expiring on December 31. KFF estimates that average premiums on the ACA marketplace for 2026 coverage already will increase by 26%, but then will more than double (an average increase of 114%) if the enhanced premiums are not extended. In addition, this year's budget reconciliation legislation eliminates eligibility for ACA marketplace subsidies for some low-income immigrants, including refugees, asylees, and survivors of human trafficking beginning in coverage year 2026. Finally, earlier this year, the Centers for Medicare and Medicaid Services reduced funding for navigators to assist with ACA marketplace enrollment from $100 million to $10 million, making it more difficult for individuals and families to enroll.

U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services: Final Regulation for CY2026 Affordable Care Act Marketplace

The Cities of Columbus and Chicago, Mayor and City Council of Baltimore, Doctors for America, and Main Street Alliance filed a legal challenge to new pre-enrollment requirements, shortening of open enrollment, elimination of special enrollment for low-income consumers, and increases in premiums for the ACA marketplaces for 2026 in the District Court in Maryland on July 1. The District Court issued a preliminary injunction blocking implementation of key parts of the regulation on August 22, and the Fourth Circuit Court of Appeals denied a stay of the preliminary injunction pending appeal on September 18. Given that open enrollment for the ACA marketplaces began on November 1, it is unlikely that these new provisions will be implemented for 2026.
Columbus v. Kennedy, Case 1:25-cv-02114-BAH
Fourth Circuit Case 25-2012
https://storage.courtlistener.com/recap/gov.uscourts.mdd.585385/gov.uscourts.mdd.585385.35.0.pdf

U.S. Department of Health and Human Services Centers for Disease Control and Prevention: Changes in Immunization Schedules

https://www.cdc.gov/media/releases/2025/cdc-immunization-schedule-adopts-individual-based-decision.html

On October 6, the Centers for Disease Control and Prevention announced changes in adult and child immunization schedules, with recommendations for COVID-19 vaccines only for adults 65 and older and those with clinical risk factors, and for varicella (chickenpox) immunization by itself rather than in combination with measles, mumps, and rubella vaccination for infants 12-23 months old. The new recommendations leave COVID-19 vaccines for adults under 65 to "shared clinical decision-making" by individuals and their doctors, nurses, and pharmacists. They also have been made in the context of increased incidence in measles among children, especially in Texas. These changes in recommendations were supported by the newly appointed members of the CDC's Advisory Committee on Immunization Practices.

State Health Compacts Make Independent Recommendations on Vaccines

https://www.gov.ca.gov/2025/09/17/following-trumps-politicization-of-cdc-west-coast-states-issue-unified-vaccine-recommendations-california-breaks-from-future-federal-guidance-with-new-law/

In September, the states of California, Oregon, Washington, and Hawaii have formed the West Coast Health Alliance to make independent recommendations on vaccines for their state residents. The recommendations are for all adults to get the flu vaccine; for all adults 65 and over, and any adult who has risk factors, or is in close contact with individuals with risk factors, or choose to receive the vaccine, to get the COVID-19 vaccine; and for all adults aged 75 years and older, and those over 50 with risk factors, to get the respiratory syncytial virus (RSV) vaccine. For children, the recommendations are for all children 6 months and older to get the flu vaccine; for all children younger than 8 months, and children aged 8 to 19 months with risk factors, to get the RSV vaccine; and for all children between the ages of 6 and 23 months to get the COVID-19 vaccine, and children aged 2 to 18 years to get the COVID-19 vaccine if they have never been vaccinated, or have risk factors.

https://www.mass.gov/news/several-northeastern-states-and-americas-largest-city-announce-the-northeast-public-health-collaborative
https://www.mass.gov/doc/northeast-public-health-collaborative-recommendations-for-the-2025-2026-covid-19-vaccine/download

The states of Connecticut, Maine, Massachusetts, New Jersey, New York State, Pennsylvania, Rhode Island, and New York City have formed the Northeast Public Health Collaborative, and issued similar recommendations for COVID-19 vaccines for adults and for children.

NCAPIP represents Asian American, Native Hawaiian, and Pacific Islander physicians committed to the advancement of the health and well-being of their patients and communities, with the goal of optimal health for all.
APAMSA is a national organization of medical and pre-medical students committed to addressing the unique health challenges of Asian American, Native Hawaiian, and Pacific Islander communities.

Make America Healthy Again Commission Report
The Presidential Commission to Make America Healthy Again, established by Executive Order 14212, has issued its Make Our Children Healthy Again Strategy Report, with strategies to advance research, realign incentives, foster private sector collaboration, and increase public awareness.
https://www.whitehouse.gov/wp-content/uploads/2025/09/The-MAHA-Strategy-WH.pdf
https://www.hhs.gov/press-room/maha-commission-report-childhood-disease-strategy.html

New Injunction and Decisions Continue to Block Implementation of Executive Order 14160 Restricting Birthright Citizenship
Litigation continues against Executive Order 14160, which seeks to re-interpret the 14th Amendment, and end the constitutional right to U.S. citizenship by birth. On June 27, the U.S. Supreme Court ruled that nationwide preliminary injunctions could not be issued against executive actions, but did not address the constitutionality of the executive order. The plaintiffs in the U.S. Supreme Court case amended their lawsuit as a class action, and on August 7, the federal District Court in Maryland certified a nationwide class, and issued a new preliminary injunction on behalf of that nationwide class blocking implementation of the executive order. The federal government has appealed to the Fourth Circuit Court of Appeals.
CASA v. Trump, Case 8:25-civ-00201-DLB
Fourth Circuit Court of Appeals Case 25-2188
https://storage.courtlistener.com/recap/gov.uscourts.mdd.574698/gov.uscourts.mdd.574698.131.0.pdf
In addition, on July 10, the federal District Court in New Hampshire certified a nationwide class, and issued a preliminary injunction on behalf of that nationwide class blocking implementation of the executive order. On September 8, the federal government appealed to the First Circuit Court of Appeals, and on September 26, the federal government requested an emergency review by the U.S. Supreme Court.
Barbara v. Trump, Case 1:25-cv-00244-JL-AJ
First Circuit Court of Appeals Case 25-1861
U.S. Supreme Court Case 25-365
https://www.supremecourt.gov/DocketPDF/25/25-365/378052/20250926163053178_TrumpvBarbaraCertPet.pdf
Meanwhile, two appellate federal courts have ruled that the executive order is unconstitutional; the federal government also has requested emergency review by the U.S. Supreme Court.
Washington v. Trump, Case 2:25-civ-00127-JCC
Ninth Circuit Court of Appeals Case 25-807
https://storage.courtlistener.com/recap/gov.uscourts.ca9.3b7bc70c-6fcb-460e-9232-c6bc8ad16303/gov.uscourts.ca9.3b7bc70c-6fcb-460e-9232-c6bc8ad16303.167.0.pdf
U.S. Supreme Court Case 25-364
https://www.supremecourt.gov/DocketPDF/25/25-364/378054/20250926163913772_Trump%20v.%20Washington%20with%20appendix.pdf
Doe v. Trump, 1:25-civ-10135-LTS
First Circuit Court of Appeals Case 25-1169
https://storage.courtlistener.com/recap/gov.uscourts.mad.279876/gov.uscourts.mad.279876.74.0.pdf
New Hampshire Indonesian Community Support v Trump, Case 1:25-cv-00038-JL-TSM
First Circuit Court of Appeals Case 25-1348
https://storage.courtlistener.com/recap/gov.uscourts.ca1.52725/gov.uscourts.ca1.52725.00108348635.0.pdf

Journal of Health Care for the Poor and Underserved: Diabetes Outcomes in Under-Engaged Asian Immigrants Through Culturally Tailored Education and Partner-Supported Enrollment
Southworth A, Perrine SM, Lozano P, Maene C, Bhargava S, Baig AA, Randal FT. (2025). The All One Community (A1C) Program boosts diabetes outcomes in under-engaged Asian immigrants through culturally tailored education and partner-supported enrollment. Journal of Health Care for the Poor and Underserved 36(3, suppl.), 135-159
https://muse.jhu.edu/pub/1/article/967365/pdf
The All One Community (A1C) program is a nine-month, culturally and linguistically tailored diabetes self-management education and support intervention for South Asian, Arab, and Rohingya populations in Greater Chicago. The program includes education about Type 2 diabetes and social support from family, friends, and community health workers to address barriers such as limited English proficiency, low health literacy, and social isolation. Of 247 participants, 199 completed at least 10 of 13 sessions, with 91 having diabetes (HbA1c ≥ 6.5). The program significantly reduced body mass index (BMI) and systolic blood pressure, with greater BMI improvements among those enrolled with a partner, and greater blood pressure and cholesterol improvements among uninsured participants. Participants also reported achieving personal goals, including healthier eating, diabetes control, and increased social support. The program demonstrates that culturally and linguistically tailored education combined with social and community support can improve diabetes outcomes and address health disparities in underserved immigrant populations.

JAMA Health Forum: Cardiovascular Health at the Intersection of Race and Gender in Medicare Fee for Service
Babbs G, Offiaeli K, Hughto JMW, Hughes LD, Shireman TI, Meyers DJ. Cardiovascular health at the intersection of race and gender in Medicare fee for service. JAMA Health Forum. 2025;6(8):e253014
https://jamanetwork.com/journals/jama-health-forum/fullarticle/2837798
Medicare fee-for-service enrollment and claims data from 2011 to 2020 were analyzed, using an established algorithm (based on diagnosis, prescription drug, and procedure codes) to identify transgender and gender diverse beneficiaries, and stratification by race and ethnicity and by age. Among over 36,000 transgender and gender diverse beneficiaries, Asian and Pacific Islanders, Blacks, and Hispanics had higher rates of cardiovascular-related conditions and risk factors (peripheral vascular disease, congestive heart failure, diabetes, hypertension, and chronic obstructive pulmonary disease) than Whites. Asian and Pacific islander transgender

and gender diverse beneficiaries had the highest prevalence of diabetes (44%) and the second highest prevalence of hypertension (58%) among all racial and ethnic groups. Asian and Pacific Islander transgender and gender diverse beneficiaries also had the largest absolute difference in all the cardiovascular-related conditions, compared to Asian and Pacific Islander cisgender beneficiaries. Asian and Pacific Islander transfeminine and nonbinary beneficiaries had a higher prevalence of chronic obstructive pulmonary disease than Asian and Pacific Islander cisgender men or cisgender women. A key principle of intersectionality is that social categories such as gender, race, and ethnicity are socially constructed, interconnected, and mutually influential. Quantitative intersectional methods can illuminate the impact of intersectional factors such as gender and race and ethnicity on health status and health disparities.

Health Equity: Acculturation and Health in Asian American Communities

Yi SS, Kwon SC, Doan LN. Acculturation and health in Asian American communities: Time for a reset. Health Equity. 2025;9(1): 608-611
https://www.liebertpub.com/doi/epdf/10.1177/24731242251383353

Researchers have often used acculturation as a static determinant of health for Asian American communities, using a unidimensional model and proxies for measures of acculturation that focus on cultural practices rather than cultural values and identity, and failing to consider context including othering, discrimination, and anti-immigrant sentiment, and global changes over time, especially in access to technology for communications and information. Reliance on acculturation as explanatory can reinforce both the perpetual foreigner and healthy immigrant stereotypes. The authors recommend using validated scales, contextualizing findings in global contexts, and considering multi-level influences in both sending and receiving counties when using acculturation as an explanatory variable.

Journal of Health Care for the Poor and Underserved: Mental Health Equity for Culturally and Linguistically Diverse Farmers in Hawai‘i

Jain S, Souza J, Le TN. Mental health equity for culturally and linguistically diverse farmers in Hawai‘i. J Health Care Poor Underserved, 2025; 36(3 Suppl):160-182
https://muse.jhu.edu/pub/1/article/967366/pdf

Farmers and agricultural workers in Hawai‘i face heightened mental health challenges due to long hours, isolation, financial instability, and cultural stigma, compounded by geographic, linguistic, and historical barriers unique to the state. 34% of farmers in Hawai‘i report depressive symptoms and 8% report suicidal ideation. Native Hawaiian, Pacific Islander, Filipino, and other immigrant farmers experience disproportionate challenges accessing care, including limited English proficiency and cultural attitudes that discourage help-seeking. Federally qualified health centers serve as safety net providers, offering integrated behavioral health, language support, and culturally tailored programs, but most are in urban areas, leaving rural farming communities underserved. Only a small number of these health centers provide farmer-specific services, and language and cultural adaptations remain inconsistent. The study highlights opportunities to improve mental health equity through farmer-focused programs, expanded mobile and telehealth services, improved language access, and integration of culturally responsive practices.

Journal of Health Care for the Poor and Underserved: Identifying Core Symptoms of Depression for Hawai‘i Farmers

Liu M, Le T. Identifying core symptoms of depression for Hawai‘i farmers: A network analysis for PHQ-9 screening tool. J Health Care Poor Underserved. 2025; 36(3 Suppl): 214-226
https://muse.jhu.edu/pub/1/article/967369/pdf

Farmers in Hawai‘i are a high-risk, underserved population with elevated rates of depression and suicide. Using Patient Health Questionnaire-9 (PHQ-9) surveys from 375 farmers, network analysis identified how depressive symptoms clustered, with guilt (feeling bad about yourself, or that you are a failure or have let yourself or your family down) and fatigue (feeling tired or having little energy) emerging as central core symptoms. These two symptoms were used to develop a new Patient Health Questionnaire-2 (PHQ-2) for rapid depression screening, showing strong validity and reliability among this population. Findings highlight the importance of culturally sensitive approaches and network-based analyses for tailoring mental health interventions to farmers, particularly in collectivist communities like Hawai‘i's Asian and Native Hawaiian populations

Journal of Health Care for the Poor and Underserved: Community Centered Education, Interpreter Training, and Advocacy to Improve Language Access for California's Asian Americans, Native Hawaiians, and Pacific Islanders

Tran JH, Hu EG, Menor A, Wong DP. Community centered education, interpreter training, and advocacy to improve language access for California's Asian Americans, Native Hawaiians, and Pacific Islanders. J Health Care Poor Underserved. 2025; 36(3 Suppl):99-108
https://muse.jhu.edu/pub/1/article/967363/pdf

Among California's Asian American and Native Hawaiian and Pacific Islander communities (19% of the state's population), 32% of the Asian Americans and 14% of the Native Hawaiians and Pacific Islanders have limited English proficiency and face significant barriers to accessing culturally and linguistically appropriate health care, which contributes to disparities in health outcomes. 12 of the 18 languages requiring translation in the state's Medicaid program are Asian languages. A statewide collaborative of 12 community-based organizations implemented a multi-pronged approach that included community education about language access, medical interpreter training, and advocacy to improve language access. Achievements include educating over 125,000 community members with limited English proficiency, training 175 interpreters, developing multilingual materials, and influencing local and state policies to improve language access. These efforts demonstrate that

comprehensive, community-centered strategies can increase knowledge, expand interpreter capacity, and promote systemic policy changes to improve health equity for diverse populations who speak languages in addition to English.

JAMA Network Open: Non–English Language Preference and Breast Cancer Outcomes.

Spiegel DY, Levey J, Modest A, et al. Non–English language preference and breast cancer outcomes. JAMA Netw Open. 2025;8(6):e2514036
https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2834941
This cohort study examined the impact of language preference other than English on breast cancer outcomes at an academic center between 2000 and 2020. Among the 238 patients with a language preference other than English, 50% were Asian, and 42% preferred Mandarin or Cantonese as their primary language. Those with a language preference other than English experienced significantly longer delays between biopsy and definitive surgery, compared to English-speaking patients, particularly among patients on Medicare. However, despite these delays, there were no significant differences in disease-specific survival, disease-free survival, or overall survival between the patients with a language preference other than English and English-speaking patients. This suggests the importance of having robust support systems to mitigate language-related disparities, and to optimize breast cancer outcomes for all patients.

Journal of General Internal Medicine: Underrepresentation of Filipino, Laotian, Cambodian, and Indonesians Among US Allopathic Medical Students.

Yang DH, Zhang L, Li BUK, Pang J, Hu JR, Hajduk AM, Chaudhry SI, Yi SS, Doan LN, Kwon SC, Boatright D. Underrepresentation of Filipino, Laotian, Cambodian, and Indonesians among US allopathic medical students. J Gen Intern Med. 2025 Sep 29. doi: 10.1007/s11606-025-09880-1. Epub ahead of print.
https://link.springer.com/article/10.1007/s11606-025-09880-1
This cross-sectional study of applicant and matriculant data from the Association of American Medical Colleges from 2022 to 2023 and American Community Survey population estimates for typical medical school-aged (ages 18 to 34) populations from 2020-2023 found that Cambodian, Filipino, Indonesian, and Laotian applicants and matriculants were underrepresented, with Filipino and Laotian having higher numbers of underrepresented matriculants compared to applicants, and Filipino females having greater underrepresentation than Filipino males. It is noteworthy that during the period of study, there was an increase in the aggregated number of Asian American medical school applicants and matriculants, driven by increases among Chinese, Indian, and Pakistani individuals. This study documents continuing underrepresentation among these Asian American groups, building on analysis of similar data from 2013 to 2021.

Health Equity: Differential Trends in Health Care Utilization and Spending Among Asian American and Pacific Islander Medicare Beneficiaries Before and During the COVID-19 Pandemic

Melanson T, Rao T, Pathak A, Liu M, Haidar T, Barry R. Differential trends in health care utilization and spending among Asian American and Pacific Islander Medicare beneficiaries before and during the COVID-19 pandemic. Health Equity. 2024; 8(1):800-805
https://www.liebertpub.com/doi/epdf/10.1089/heq.2024.0120
This analysis of Medicare fee-for-service claims for 2017 to 2021 found decreases in ambulatory visits, ambulatory visit rates, and ambulatory spending among all racial and ethnic groups, but Asian American and Pacific Islander beneficiaries had the greatest decreases on three measures, compared to other racial and ethnic groups The authors raise the question whether the increase in negative sentiment and hate crimes targeting Asian Americans and Pacific Islanders during COVID-19 may have further discouraged Asian American and Pacific Islander Medicare beneficiaries – often older and/or with disabilities – from seeking ambulatory care. Interestingly, the rate of telehealth utilization among Asian American and Pacific Islander Medicare beneficiaries went from the lowest among all racial and ethnic groups in 2017 (0.04%) to the highest during the pandemic period in 2021 (10%), but did not have a significant impact on their ambulatory utilization or spending.

JAMA Health Forum: Prescription Drug Utilization and Spending by Race, Ethnicity, Payer, Health Condition, and US State

Sahu M, Wagner TD, Thomson A, et al. Prescription drug utilization and spending by race, ethnicity, payer, health condition, and US state. JAMA Health Forum. 2025;6(8):e252329
https://jamanetwork.com/journals/jama-health-forum/fullarticle/2837041
This cross-sectional study analyzed national retail prescription drug utilization and spending data for 6.7 billion prescriptions and $331.4 billion in spending across Medicare, Medicaid, private insurance, and out-of-pocket payers in 2019, stratified by White, Hispanic, Black, Asian or Pacific Islander, and American Indian or Alaska Native populations. Race and ethnicity data were missing for 18% of the Medicaid data and 3% of the Medicare data, and were imputed using primary language and zip code data. Overall, the analysis found underutilization of medicines relative to disease burden among Black populations. Asian or Pacific Islanders had the highest spending per beneficiary among all racial and ethnic groups on Medicare, but the lowest spending per beneficiary among all racial and ethnic groups on both private insurance and on Medicaid. Asian or Pacific Islanders had the highest prescription fills per prevalent case, but the lowest prescription fills per capita for Type 2 diabetes among all racial and ethnic groups, suggesting higher prescription medicine utilization but lower prevalence for Asians and Pacific Islander with Type 2 diabetes. The concept of pharmacoequity, ensuring that all individuals, regardless of race or ethnicity, socioeconomic status, or availability of resources, have access to the highest quality medications, continues to be salient.