UCLA
AAPI Nexus: Policy, Practice and Community

Title
Aging in America: Asian Americans and Pacific Islanders in 2040

Permalink
https://escholarship.org/uc/item/3b40c7v6

Journal
AAPI Nexus: Policy, Practice and Community, 14(1)

ISSN
1545-0317

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Publication Date
2016

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aapi nexus Vol. 14, No. 1 (Spring 2016): 97-109

Practitioners Essay

Aging in America:
Asian Americans and Pacific Islanders in 2040

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Abstract

Throughout the United States ten thousand people turn sixty-five years old every day (AARP, 2015a). By 2040, one in five U.S. residents will be sixty-five years or older, outnumbering children fifteen and younger for the first time in our nation's history (AARP, 2015a; Congressional Budget Office, 2013; U.S. Census Bureau, 2014). Between 2015 and 2040, Asian American and Pacific Islander (AAPI) older adults are the fastest-growing aging group. There are four strategies to strengthen the economic and health security of AAPI older adults nationwide by 2040: (1) disaggregate data to understand variations between AAPI subpopulations; (2) provide accessible services that are culturally and linguistically appropriate; (3) adapt mainstream solutions for financial security; and (4) innovate long-term services and support.

Introduction

In 1952, when Ling was three, she left Guangzhou, China, and settled in Hawaii with her mother, Mei, and four siblings. Ling's younger siblings left Hawaii to pursue careers when their mother was still working full-time making manapua at the same restaurant she had been employed at since their migration. In 2010, Ling received a call from Mei's boss concerned about her mother's ability to perform tasks. At the age of eighty-two, Mei was diagnosed with dementia. Over the past five years, Ling has been living with and caring for her mother, whose health has been deteriorating due to dementia's rapid progression. Since her retirement, Mei's income has been limited to Social Security, with no retirement savings, relying on Medicare and Medicaid to cover her rapidly rising health care expenditures. Mei's Social Security payments only

cover a third of her monthly rent. Despite hopes of financial security, Ling's siblings are living on fixed incomes and unable to assist with the rising cost of Mei's care.

I cannot shake the sadness I feel for Ling and Mei, whose situation has become increasingly commonplace. I wreck my brain trying to answer, "How are we going to meet the growing and diverse needs of older adults? As the number of those aging in society grows in 2040, is the answer to invest more public funding into services to care for the aged, or do we transform aging services to serve future consumers differently?"

Aging in America: Asian Americans and Pacific Islanders

Throughout the United States ten thousand people turn sixty-five years old every day, a trend that will continue for the next fifteen years (AARP, 2015a). By 2040, one in five U.S. residents will be sixty-five years or older, outnumbering children fifteen and younger for the first time in our nation's history (AARP, 2015a; Congressional Budget Office, 2013). The definition of an older adult lacks uniformity, with an arbitrary range between fifty and sixty-five years of age. Most commonly, however, the chronological age assigned to measure the aging population is based upon pensionable age limits. In developed nations, people are most often able to begin collecting pension benefits at the age of sixty-five and, as such, this is often the marker assigned to data collection on older adults.

As the longevity of our nation increases, a rapid demographic shift is visible across diverse ethnic groups as well. Asian American and Pacific Islander (AAPI) older adults aged sixty-five years and older is the fastest-growing aging group. In 2015, more than two million AAPI older adults reside in the United States, representing 4.64 percent of the national aging population and 10 percent of the total AAPI population (Ong, 2016). In 2010, across AAPI ethnic groups, the fastest-growing populations of older adults were Chinese (accounting for 26 percent of AAPI elders), Filipinos, Japanese, Indians, and Koreans (ibid.). Between now and 2040, alike with other ethnicities, the rise in older adults will find those sixty-five years and older representing a larger percentage of their respective populations. During the next quarter century, Pacific Islander older adults will increase from 7 percent to 13 percent of the Pacific Islander population, and Asian American older adults from 10 percent to 16 percent of the Asian American population (Ong, Ong, and Ong, 2016a; Ong, Ong, and Ong, 2016b).

Among the many reasons for an increasing AAPI population, the rapid growth rate is largely due to immigration, contrary to the argu-

ment that immigration is slowing the aging of our society. Immigration will continue to have an impact on the impeding demographic shift and increase the percentage of retirees into the future (Camarota, 2012). In 2010, 80 percent of AAPI elders were foreign-born, and 65 percent had become naturalized citizens of the United States (National Asian Pacific Center on Aging, 2013b). The majority of those who are foreign-born have lived in the United States for twenty-one years or more. At a disaggregated glance, the dissimilarity on immigration between ethnic subgroups is vast, however. More than 97 percent of Bangladeshis, Cambodians, Vietnamese, Indonesians, Asian Indians, and Sri Lankans sixty-five years and older are foreign-born, compared with 32 percent of Samoans (ibid.). The continuously changing ethnic profile and immigration history of older Americans requires policy makers to pay particular attention to the unique needs of AAPI older adults.

A rapidly aging population demands public attention to develop proactive approaches. This includes paying particular attention to policies impacting social determinants of health, such as the economic and health security of a diverse and growing population of older adults. Combined, the economic and health status of our nation's older adults will have profound impacts on federal and state support systems, for example Social Security, Medicare, and long-term services and supports (LTSS) through the Older American's Act, such as with Mei's example. Older adults' reliance on Social Security and Medicare challenges many to maintain self-sufficiency as they become more frail and in need of care.

In 2015, during the White House Conference on Aging, aging organizations, older adult advocates, and public entities agreed with several public policy priorities to address the imminent demographic shift. By 2040, policy issues—such as rebuilding the foundations of retirement security; transforming our health care system; developing a comprehensive approach that provides access to quality LTSS, including support for caregivers; strengthening quality and safety protections for vulnerable older adults; and enabling older adults to remain active and connected to their communities—will have commanded solutions. As we look toward 2040, without reform, policy issues that impact older adults will also extend to AAPI elders, such as solutions to economic security as people age and the complexity of illnesses such as Alzheimer's Disease and related dementias. Additional challenges, however, elevate the difficulty of fostering AAPI elders' economic and health security.

Limited English Proficiency

Limited English proficiency (LEP) can isolate AAPI older adults, the majority of whom are foreign-born. In 2010, only 15 percent of AAPI older adults spoke English at home; 60 percent had LEP (National Asian Pacific Center on Aging, 2013b). Thirty-one percent of AAPI older adults are linguistically isolated, meaning that all members of the household speak English less than "very well" (ibid.). There are substantial subpopulation variations, however. More than 85 percent of Cambodian, Vietnamese, Hmong, and Laotian older adults are LEP, whereas the lowest rates among AAPIs are with Native Hawaiians, with only 2 percent of elders being linguistically isolated (ibid.).

The LEP of many AAPI elders often restricts their access to vital information, supports, and services. Systems that support older adults, such as health care and legal systems, must become integrated, culturally competent, and linguistically accessible. Eliminating the silos that currently exist between the systems of support will allow for the needs of AAPI older adults to be prioritized. For example, with stronger linkages between systems, a hospital social worker could identify an LEP older adult in need of an advanced health care directive and/or estate planning. The social worker would be aware of culturally appropriate services and communicate directly with the in-language legal service provider to facilitate assistance for the older adult. Once integrated, AAPI older adults will have access to in-language, culturally competent service systems that are person centered and consumer directed; simply put, these services will be led by the AAPI older adult and tailored to their individual strengths, goals, preferences, needs, and desired outcomes.

Economic Security

A commonly believed myth of AAPIs is that they are all self-sufficient and upwardly mobile. However, the prevalence of poverty is severe when disaggregating the data by ethnic groups. In 2010, more than one in five Koreans (20.4 percent), Tongans (21.2 percent), Hmong (21.5 percent), and Marshallese (29.9 percent) elders sixty-five years and older were below the poverty level, yet older adult Malaysian households had a median income of $90,625, well exceeding the U.S. median income of $33,906 (National Asian Pacific Center on Aging, 2013c). Among the most impoverished AAPI older adult subpopulations are Hmong older adults, who have a median household income of $18,598, and Bhutanese, of whom 63 percent are living in poverty (ibid.).

Far exceeding other ethnic groups, AAPI elders often live in over-

crowded households, or those with more than one person per room. Sixty-two percent of Bhutanese live in overcrowded homes compared with 14.6 percent of Bangladeshi (ibid.). Home ownership and housing costs vary drastically. Three percent of Bhutanese older adults are home owners compared to 83 percent of Taiwanese, and approximately 40 percent of AAPI older adults are spending more than 30 percent of their income on housing (ibid.).

Without intervention, there will be an increase in AAPI older adults reliant on Social Security and other publicly funded benefits to remain economically stable. Social Security benefits are an important source of income for AAPI older adults, with 26 percent of older adult married couples and 52 percent of those unmarried relying on their benefits for 90 percent or more of their income (ibid.). For refugees and recent immigrants, however, the ability to retain this benefit hinges upon citizenship. AAPIs entering the United States may receive Social Security for up to seven years, at which point they must obtain citizenship or risk losing their benefits (ibid.). Average Social Security incomes range from $2,659 to $10,867 per year for AAPI subpopulations (National Asian Pacific Center on Aging, 2013c). AAPI older adults also disproportionately rely on food stamps, with 14 percent collecting this benefit compared to 9 percent of the U.S. population sixty-five years and older (AARP, 2014b).

Paving the way to 2040 will require economic options for AAPI older adults that extend beyond Social Security, for example, other forms of savings and pensions. The voices of AAPI elders are amplifying the significance of additional options to support their retirement security and self-sufficiency. An analysis of AAPI older adults employed in New York City revealed that a staggering 63 percent were not confident they will be able to retire (ibid.). AAPI older adults' high dependence on Social Security benefits is also leading to longer and higher labor force participation, compared to U.S. total population (42.5 percent vs. 38.1 percent, respectively, among aged fifty-five years and older) (National Asian Pacific Center on Aging, 2013c). Only 22 percent of AAPI elders have retirement income, compared to 37 percent of the older adult population throughout the United States (AARP, 2014b). Although financial challenges afflict all ethnicities, there are additional challenges to AAPI older adults' economic security that must be considered.

Health Insurance

The lack of health insurance coverage has profound impacts on AAPI older adults' economic and health security. AAPI older adults are

more likely to be covered by Medicare only, or Medicare and Medicaid, compared to the U.S. population (National Asian Pacific Center on Aging, 2013c). Only 33 percent of Asians have private insurance, compared to 52 percent of older adults nationally (ibid.). Of grave concern, the uninsured rate of AAPI older adults far exceeds the national rate. Seven out of the top ten uninsured ethnic groups in the United States are AAPIs (National Council of Asian Pacific Islander Physicians, 2015). For example, 23 percent of Bangladeshi, 15 percent Tongan, and 15 percent of Pakistani older adults were uninsured, compared to 1 percent of the total U.S. older adult population (National Asian Pacific Center on Aging, 2013c).

Enactment of the Patient Protection and Affordable Care Act (ACA) highlights a promising future for accessible health care among all Americans, including AAPI older adults. The launch of the ACA found 1.4 million AAPI older adults eligible for health insurance (National Asian Pacific Center on Aging, 2012). Although ACA enrollment data on AAPIs is limited and difficult to find, it was estimated that only six hundred thousand AAPIs gained insurance after the first round of ACA enrollment. This leaves 1.2 million remaining uninsured (Ramakrishnan and Ahmad, 2014).

By 2040, it is critical to mitigate barriers that impact AAPI older adults from receiving equitable access to health care. For example, the lack of culturally and linguistically competent resources, poor health literacy, unreliable enrollment platforms, immigration-related verification issues, funding challenges, and insufficient state policies have been cited as a few of the challenges afflicting AAPI older adults (National Council of Asian Pacific Islander Physicians, 2015). A serious lack of in-language resources to assist and educate AAPI older adults in ACA enrollment is of particular concern. A recent analysis revealed that the majority of in-language ACA resources on federal and state websites were in English and Spanish (ibid.). Although AAPIs have been targeted in outreach efforts for ACA enrollment, in-language resources are not readily available and those that exist often require extensive navigation through websites, many of which are in English and pose an additional barrier (ibid.). Access to in-language resources that guide ACA enrollment is critical because of the increase of LEP AAPI elders who remain uninsured.

Health Disparities

The health and functional challenges faced by AAPI older adults are similar to the issues afflicting the aggregated older adult population throughout the United States. However, the prevalence and impacts

they have on AAPI subpopulations vary extensively. Looking at AAPI older adults' disability status—that is, collectively considering their functional limitations, limitations in activities of daily living, cognitive problems, and blindness or deafness—the highest disability rates are evident among Native Hawaiians, Pacific Islanders, and Vietnamese older adults, although the specific disability issues are very different (Fuller-Thompson, Brennenstuhl, and Hurd, 2011). Vietnamese older adults, for example, have a disproportionately high prevalence of cognitive problems (16.6 percent), more than double the rate for Koreans at 7.6 percent (ibid.). Likewise, Native Hawaiian older adults have higher rates of obesity and type 2 diabetes (ibid.). Additionally, Native Hawaiian women have the highest overall cancer death rates out of any ethnicity (ibid.).

Disability outcomes for AAPI older adults are largely affected by education and immigration variables, such as immigration history, citizenship status, and whether or not English is spoken at home (ibid.). When the data is adjusted to accommodate these variables, Native Hawaiians and Pacific Islanders have a higher risk of cognitive issues and activities of daily living impairments, which is two times the risk as compared to Chinese older adults (ibid.).

Of particular concern when considering the health disparities faced by AAPI older adults is their underrepresentation in long-term care facilities. Institutionalization rates vary among AAPI older adults with functional limitations, from 4.7 percent of Asian Indians to 18.8 percent of Korean Americans (Fuller-Thompson and Chi, 2012). Compared to other AAPI subpopulations, Vietnamese older adults have the highest rates of cognitive problems yet the lowest rates of institutionalization (ibid.). Of those most likely to be placed in a nursing home are AAPI older adults eighty-five years and older and those with cognitive problems (ibid.). Notably, AAPI older adults are twice as likely to be placed in an institution if they speak English at home (ibid.). Health care professionals and policy makers should pay particular attention to the barriers to long-term care settings facing AAPI older adults such as citizenship status, prohibitive costs, English proficiency, food preferences, acculturation, and cultural norms (ibid.). Bridging the language gap between AAPI older adults and health care providers is also vital. For example, a provider's ability to understand how language is used to express concerns and what assumptions are brought by AAPI older adults to health care exchanges are essential to ensuring equitable health care for AAPI older adults by 2040.

Without sufficient resources (such as health insurance), health disparities among AAPI older adults will remain prevalent. Similar to oth-

er areas of research on AAPI older adults, and as illustrated through the examples provided within this section, disaggregated data is needed to understand the health disparities faced by the subpopulations. By 2040, disaggregated data will equip health care professionals and policy makers to tailor services, reduce or eliminate health disparities, and provide better access to health care. The role of community-based organizations will continue to be important, as these organizations are often the strongest linkage between AAPI older adults and their community.

Caregiving

Traditional values, such as filial piety, play a role in AAPI older adults' access to health care, institutionalization, and the entire family's economic security. AAPI older adults and their families may perceive institutionalization and formal health care as stigmatizing (ibid.). As many AAPI older adults are foreign-born they are less acculturated than their children, which may isolate the older adult from health care systems and from their communities.

With less reliance on formal systems, AAPI families commonly rely on the family unit to care for one another, and the children are often expected to care for their aging parents. Seventy-three percent of AAPIs believe that caring for parents is expected of them (AARP, 2014a). A disaggregated prevalence of caregiving among AAPI families has not yet been documented; however, according to an AARP survey, 42 percent of AAPI respondents were providing care to an older adult compared to 22 percent of the general population (ibid.). Collectively, more than half of the care provided to older adults throughout the United States is provided by family members and friends (Congressional Budget Office, 2013). During times of increasing strains on the economic health of the United States, caregiving demands a significant dedication, often finding people challenged to adequately uphold their other responsibilities, such as paid employment. With so many AAPI older adults being cared for by family members, it is imperative that caregiving family members receive adequate support to maintain their economic security and ability to care for their families into the future. Caregivers are critical to the viability of the U.S. health care system, with a value of care that was totaled to be approximately $234 billion in 2011 (Congressional Budget Office, 2013).

Recommendations and Strategies for the Future

In conclusion, we present four policy recommendations. Once/if

accomplished by 2040 these recommendations will have significantly strengthened the economic and health security of AAPI older adults nationwide. To be successful, the civic engagement of AAPI older adults must be leveraged. Maximizing the political power of AAPI older adults, while making forward progress on the recommendations presented, requires close partnerships with community-based organizations; these organizations have strong connections to the diverse communities they serve, with solid track records for activating AAPI civic engagement. If effectively mobilized, the political power of AAPI older adults in 2040 will become paramount, as those sixty-five years and older will account for a substantial percentage of the American voter base. Policy issues that have a direct impact on their well-being, as well as problems that AAPI older adults find to be especially important, will command policy solutions.

1. Disaggregated Data

The ethnic distinctions between AAPI elders calls for a reevaluation of the priorities of public policy and national perceptions of this burgeoning demographic. Robust variations between AAPI subpopulations must be understood and acknowledged to appropriately determine public policy solutions. Aggregating AAPI older adults into one ethnic category obscures meaningful differences between subpopulations. Analyzing the needs of AAPI older adults collectively masks unique subpopulation issues, leading to “one-size-fits-all” public policies that do not comprehensively meet the needs of all older adults. As such, it is recommended that a national policy for data collection for AAPIs be designed, with cross tabs to standardized age categories. Additionally, the national policy and standards should be integrated into federal survey tools (e.g., the U.S. Census).

2. Culturally and Linguistically Appropriate Services

The availability of linguistically accessible information will be essential for AAPI older adults to achieve economic and health security by 2040. Systemically, a more robust integration of AAPI language bilingual staff to conduct front-line work with older adults is crucial. Additional funding for in-language resources (e.g., additional bilingual staff; interpreter services; and in-language programs, services, resources, and websites) is recommended. Finally, as federal and local policies (e.g., the Office of Minority Health’s Culturally and Linguistically Appropriate Services in Health Care standards—the Enhanced National CLAS Stan-

dard and the ACA) recognize the vast number of older Americans who have LEP, ongoing education and monitoring with local providers will be necessary to facilitate stronger health equity among AAPI older adults.

3. Mainstream Solutions for Financial Security

Mentioned earlier, many AAPI older adults rely on their Social Security benefits for 90 percent or more of their income (National Asian Pacific Center on Aging, 2013c). The increasing reliance on Social Security is not unique to AAPI older adults, however. The "three-legged stool for retirement," a historical metaphor used to describe the necessary components for financial security into retirement (Social Security, pension, and personal savings), is outdated. Developing financial security among older Americans is challenging; however, as federal expenditures for Social Security, Medicare, and Medicaid increase with our rapidly aging demographic, there is an urgent need for efficient solutions.

For AAPI older adults to maintain financial security by 2040, it's recommended that mainstream solutions consider the unique needs of this diverse population. In addition, as evidenced by the National Asian Pacific Center on Aging's pilot study of Senior Community Service Employment Program participants, many AAPI older adults have low levels of financial literacy (National Asian Pacific Center on Aging, 2014). In-language financial education, information, and services are needed to strengthen financial literacy among AAPI older adults, thereby fostering their financial security.

4. LTSS Innovation

Similarly, the federal budget cannot sustain the increasing costs of care for the expanding population of older Americans. LTSS, or the care provided to help people meet their functional needs (such as assistance with bathing or managing medications), are most commonly provided in the community. The demand for LTSS will rise dramatically as we approach 2040 (Congressional Budget Office, 2013). While more cost-effective and preferred than institutional care, LTSS are expensive, accounting for $192 billion in 2011, with the largest payers being Medicare and Medicaid (ibid.). Not factored into this economic value is the growing importance of informal caregivers, who provided approximately $234 billion in care in 2011 (ibid.).

Elevating the care required for normative aging, challenging diseases (such as Alzheimer's Disease and related dementias) and complex issue areas (such as financial exploitation) demand solutions that will

enable people to remain safe and age with a high quality of life. Again, as mainstream solutions are developed for systems that will care for older Americans into the future, the unique needs of AAPI older adults must be considered. With the increasing complexity of care, it's also recommended that incentives for innovations in LTSS be provided. By invigorating systems that deliver care to a more diverse cohort of older Americans, there is an opportunity for major government health care programs to be solvent, while also enabling both the economic and health security of older adults and their families. Lastly, as improvements to care systems are made, supports for informal caregivers must become more robust, and as with the cultural considerations recommended for systems that support older adults, systems that support informal caregivers must also consider the unique needs of AAPIs.

Reflecting on the Future

It is the summer of 2040. Ling and I are slowly walking around her Chinatown neighborhood, reminiscing about the changes that have occurred over the past two decades. Twenty years ago, I cared for Ling's mother, Mei, and now I am assisting Ling with managing her LTSS. Despite her age of eighty-nine and minor chronic conditions, Ling has been able to manage her health, reside independently, and access sufficient LTSS. Ling's adult children have moved to other states, but her granddaughter lives with her and helps Ling manage her care. Some of Ling's friends opted to reside in long-term care facilities, as they've made drastic improvements, now providing culturally and linguistically appropriate services. The facilities employ many bilingual and bicultural staff, and the residents enjoy living there. Ling had the option to move in, but she decided that self-directing her own care and living at home with her granddaughter was what she preferred. Since the reform of Social Security and Medicare, Ling's publicly funded benefits have paid for most of her basic living and health care costs, although on some occasions, she dips into her retirement savings. Ling often talks to me about her mother, Mei, who lived with dementia long ago. Ling and I reflect on the improvements to the systems that enable her to remain active and living in her community, the same community where she cared for her mother just twenty years earlier.

References

AARP. 2015a. "The Priorities Book: Building a Better Future 2015–2016." http://www.aarp.org/content/dam/aarp/about_aarp/aarp_policies/2015-05/

AARP-Priorities-Book-2015-2016.pdf (accessed March 7, 2016).
———. 2014a. "Caregiving among Asian Americans and Pacific Islanders Age 50+." http://www.aarp.org/content/dam/aarp/home-and-family/caregiving/2014-11/caregiving_aapis_english.pdf (accessed March 7, 2016).
———. 2014b. "Are Asian Americans and Pacific Islanders Financially Secure?" http://www.aarp.org/content/dam/aarp/home-and-family/caregiving/2014-11/AARP-Report-Are-Asian-Americans-and-Pacific-Islanders-Financially-Secure-Dec2014-eng.pdf (accessed March 7, 16).
Camarota, Steven. 2012. "Projecting Immigration's Impact on the Size and Age Structure of the 21st Century American Population." Center for Immigration Studies. http://cis.org/projecting-immigrations-impact-on-the-size-and-age-structure-of-the-21st-century-american-population (accessed March 7, 2016).
Congressional Budget Office. 2013. "Rising Demand for Long-Term Services and Supports for Elderly People." https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/44363-LTC.pdf (accessed March 7, 2016).
Fuller-Thompson, Esme, and Monica Chi. 2012. "Older Asian Americans and Pacific Islanders with Activities of Daily Living (ADL) Limitations: Immigration and Other Factors Associated with Institutionalization." *International Journal of Environmental Research and Public Health* 9: 3264–79.
Fuller-Thompson, Esme, Brennenstuhl, Sarah, and Marion Hurd. 2011. "Comparison of Disability Rates among Older Adults in Aggregated and Separate Asian American/Pacific Islander Subpopulations." *American Journal of Public Health* 101(1): 94–100.
National Asian Pacific Center on Aging. 2014. "Financial Well-Being among Low-Income Asian Older Workers: Evidence from Senior Community Service Employment Program Participants." http://napca.org/wp-content/uploads/2014/06/SCSEP-financial-well-being-FINAL.pdf (accessed March 7, 2016).
———. 2013b. "Asian American and Pacific Islanders in the United States Aged 65 Years and Older: Population, Nativity, and Language. Data Brief, 1, 3." http://napca.org/wp-content/uploads/2013/10/65+-population-report-FINAL.pdf (accessed March 7, 2016).
———. 2013c. "Asian Americans and Pacific Islanders in the United States Aged 65 Years and Older: Economic Indicators. Data Brief, 1, 4." http://napca.org/wp-content/uploads/2013/10/economic-indicators-FINAL.pdf (accessed March 7, 2016).
———. 2012. "Press Release: NAPCA Statement on the Affordable Care Act Ruling." http://napca.org/wp-content/uploads/2013/01/062812AffordableCareAct.pdf.pdf (accessed January 13, 2016).
National Council of Asian Pacific Islander Physicians. 2015. "The Impact of the Affordable Care Act on Asian Indian, Chinese, Filipino, Korean, Pakistani, and Vietnamese Americans." https://d3n8a8pro7vhmx.cloudfront.net/ncapa/pages/110/attachments/original/1437158772/2015_ACA_policy_brief_

v13_final.pdf?1437158772 (accessed March 7, 2016).
Ong, Jonathan, Ong, Paul, and Elena Ong. 2016a. "The Future of Asian America in 2040." *AAPI Nexus Journal: Policy, Practice, and Community* 14(1): 14–29.
———. 2016b. "The Future of Pacific Islander America in 2040." *AAPI Nexus Journal: Policy, Practice, and Community* 14(1): 1–13.
Ramakrishnan, Karthick, and Farah Ahmad. 2014. "Immigration: Part of the 'State of Asian Americans and Pacific Islanders' Series." Center for American Progress. https://www.americanprogress.org/issues/race/report/2014/04/23/87520/state-of-asian-americans-and-pacific-islanders-series/ (accessed March 7, 2016).

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