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The Health and Welfare Needs of Elderly Refugees and Asylees in the United States

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Good morning. It is an honor for me to be here today to speak with all of you about Southeast Asian American elders. Thank you, Mr. Chairman and members of the Senate Special Committee on Aging for holding this hearing. My name is Khammany Mathavongsy. I am the California Projects Director for the Southeast Asia Resource Action Center, also known as SEARAC. SEARAC is a national organization founded in 1979 to facilitate the resettlement of Southeast Asian refugees after the Vietnam War and foster the development of nonprofit organizations led by and for Southeast Asian Americans. SEARAC is led primarily by and for Americans with heritage in Cambodia, Laos, and Vietnam. In the past 28 years, SEARAC's work has grown to advance the interests of these communities through leadership development, capacity building work, and public policy advocacy. SEARAC's California-based office specifically focuses on empowering Southeast Asian American elders and bringing greatly needed attention to this underserved population.

Having arrived in the U.S. as a refugee myself, today's hearing is of particular importance for me. I was born in Laos, and at the age of 13, my older sister and I fled to Thailand as political refugees, due to my family's connections with the anti-communist forces in Laos, leaving my mother and four other siblings behind. My sister and I lived for many years in a Lao refugee camp in Napho, Nakorn Pranom in Northeast Thailand, and we were the first from our family to be resettled in United States in 1986. During that same time, my father, an Army Major in the Royal Lao Army, was imprisoned in the "re-education camps" by the communist successors along with thousands of other Royalist military officers and Royal Lao government administrators—including the Lao Royal family. My father survived 13 years of imprisonment, harsh treatment and starvation. He was imprisoned for all of this time because of his service in the Royal Lao Army. He received his military training for his service at the U.S. Armor School in Fort Knox, Kentucky. After his years of severe hardship in the reeducation camps in Laos, my father was able to flee into neighboring Thailand, where he was granted refugee status in 1988 and was reunited with our family in the U.S. in 1989.

Over one million Southeast Asian refugees[1] who resettled in the U.S. share stories much like my own. People from the Southeast Asian countries of Cambodia, Laos, and Vietnam constitute the largest group of refugees to ever build new lives in America. Many have made homes in the states that members of this committee represent—most notably in Wisconsin, Minnesota,

[1] Refugee arrivals to the U.S. from Southeast Asia after the end of the Vietnam War (1975-2002) total 1,146,650. Sources: [1] Office of Refugee Resettlement, Annual Reports to Congress (fiscal years 1981-2000). [2] FY 2001 and 2002 figures (2002 from "preliminary data) are from the Bureau of Population, Refugees, and Migration, U.S. Department of State. Tabulated and presented in Refuge Reports December 31, 2002. [3] Refugee arrival statistics for FY 1975-1980 are from Rumbaut (2000: 182). [4] See also Southeast Asian American Statistical Profile (2004: pg. 10) at http://www.searac.org/seastatprofilemay04.pdf

Florida, Pennsylvania and Oregon[2]. These populations share unique histories with this country because of their support of the United States during the Vietnam War. Many resettled Southeast Asian refugees—including the elders—fought alongside American troops, risking their lives in support of the American ideals which we all value. With the fall of South Vietnam, Cambodia, and Laos to communism, those who supported the U.S. were forced to flee by the thousands by foot, boat, and for the lucky few, U.S. planes that returned for them.

Southeast Asian Americans who were fortunate enough to escape and resettle in the U.S. now live throughout the country and represent a diversity of ethnic cultures and include the Vietnamese, Cambodian (or Khmer), Hmong, Lao, Iu Mien (or Mien), Khmu, Montagnard, Taidam, and ethnic Chinese, all bringing with us unique linguistic and cultural traditions.

Contrary to the popular "model minority myth" which purports that all Asian Americans are excelling and face no obstacles, all too frequently, the very real needs and challenges that large numbers of the Southeast Asian population face are overlooked. Unfortunately, many Southeast Asian Americans continue to struggle with economic, educational, and other challenges to a degree seldom understood by policy makers. Many of the challenges facing these communities remain unaddressed.

According to the 2000 Census, 29% of the Cambodian population lives below the federal poverty line. The same can be said for 37% of the Hmong population, 19% of the Laotian population, and 16% of the Vietnamese population.[3] Additionally, the strong link between poverty and high disability rates, particularly among Southeast Asian elders, has been largely ignored up to this point. According to the census, approximately 18% of the overall American population with disabilities lives in poverty. In comparison, the rates for Southeast Asian Americans are much higher. Approximately 28% of Cambodians, 39% of Hmong, 22% of Laotians, and 18% of Vietnamese Americans with disabilities live in poverty. In fact, the Census also found that in 1999, 44% of Cambodian households in poverty had disabled members, as did 48% of the Hmong, 45% of the Laotian, and 38% of the Vietnamese.[4]

Many Southeast Asian refugees, particularly elders, also experience mental health issues, including Post Traumatic Stress Disorder (PTSD), due to trauma experienced during times of war and conflict and having been uprooted from their homes. The Asian Pacific Islander American Health Forum (APIAHF) reports that 40% of Southeast Asian refugees suffer from depression, 35% suffer from anxiety, and 14% from PTSD.[5] This is significant given the fact that

[2] According to the 2000 U.S. Census, Southeast Asian Americans in the following states represented by some members in the Special Committee on Aging are as follows: 84,062 in MN, 47,575 in WI, 46,791 in PA, 44,415 in FL and 31,356 in OR.
[3] Southeast Asia Resource Action Center (SEARAC), *Southeast Asian American Statistical Profile (2004), available at: http://www.searac.org/seastatprofilemay04.pdf*
[4] Ibid.
[5] Asian Pacific Islander American Health Forum (APIAHF), www.apiahf.org/events/idappt/slide09.htm

there are many barriers to addressing these health issues in Southeast Asian communities including stigma and shame from the community. There is also a great need for culturally appropriate services and effective intervention strategies as well as research specific to these populations. Mental health issues among Southeast Asian Americans and elderly refugees are not exclusively linked to their past experiences during war. These issues are often compounded by, but are not limited to, social isolation, the loss of their traditional, respected role within the family[6] as younger generations integrate into American culture and the multiple barriers to attaining self-sufficiency.

For many Southeast Asian American elders who arrived as refugees, Supplemental Security Income (SSI) is their lifeline. Many arrived in the U.S. having had little to no access to formal education and are unable to obtain employment due to language barriers, disabilities, advanced age, or a combination of all the above. For these populations, SSI provides the bare minimum for many, no more than $623 per month for an individual and $934 for a couple, to afford the most basic needs of survival such as food, clothing and shelter. The average monthly payment in January 2007 was $466.70.[7] However, with the seven-year time limit, refugees and other humanitarian immigrants face destitution once they are no longer eligible for SSI.

In order to continue receiving SSI benefits, refugees and humanitarian immigrants must obtain their citizenship within an often unrealistic timeframe of seven years. It is unrealistic for many because the path to citizenship is lengthy and complete with barriers and bureaucratic road blocks. Refugees and humanitarian immigrants must reside in the U.S. for at least one year before they can be eligible to apply for lawful permanent residency, after which they must wait an additional five years to be eligible to apply for naturalization. Within those six years, a number of obstacles may prolong the naturalization process. These obstacles to a timely naturalization include increasing fees, backlogs, processing delays, background checks, and preparation for English language proficiency. The median number of years between legal immigration and naturalization for persons who became U.S. citizens between 2002 and 2005 was eight years.[8] The path to obtaining citizenship can take much longer for many refugees and humanitarian immigrants who are eligible and receive SSI.

As one of the steps to attaining citizenship, individuals must demonstrate their comprehension of the English language and also pass an exam on U.S. history and civics. While applicants over the age of 55 who have been in the U.S. for over 15 years and those over 50 who have been in the U.S. for over 20 years are eligible to take the exam in their native language and be exempt from the English language requirement, these exemptions are not always helpful for disabled or

[6] Source: *Site Visit and Working Meeting with the Mental Health Services Oversight and Accountability Commission at the Fresno Center for New Americans*, January 26, 2006.
[7] U.S. Social Security Administration, SSI Monthly Statistics, January 2007, http://www.ssa.gov/policy/docs/statcomps/ssi_monthly/2007-01/table07.html
[8] Jeanne Batalova, "Spotlight on Naturalization Trends," Migration Policy Institute, http://www.migrationinformation.org/USfocus/display.cfm?ID=421#14, September, 1, 2006.

elderly refugees.[9] Many refugees and humanitarian immigrants have had little or no form of formal education, which makes learning very difficult. For some, even the written form of their native language is foreign. In addition to learning disabilities, it is known that with advanced age, the ability to learn and retain new information becomes less likely and often impossible for many. Because of such barriers, simply attaining the English capacity to naturalize becomes a goal that is unachievable for a number of the most vulnerable disabled and elderly refugees.

Increasing application fees and the recent unveiling of a newly redesigned naturalization test can also contribute to the delay in naturalization. Recently, United States Citizenship and Immigration Services (USCIS) increased the fees for citizenship and change of status applications, bringing the total cost of the naturalization application up to $675—well over the average SSI payments made in January 2007. Higher fees further delay and often prohibit those who receive and depend on modest SSI benefits from attaining citizenship.

These and other barriers to citizenship not only prohibit many refugees and humanitarian immigrants from becoming fully integrated into American society and civically engaged through citizenship, they also pose as threats to the loss of SSI eligibility and the risks of falling further into poverty.

Bounta Xasiengpat's story is one of many that illustrate the impact of the seven year SSI time limit. She was a Lao refugee resettled in the U.S. in 1996. Because of the seven year time limit on SSI for refugees, her only source of income, her benefits, were discontinued in December of 2004. She subsequently had to move in with her daughter and grandson. Bounta was seriously ill and required dialysis treatments three times a week. In addition to her illness, since her husband's death a few years ago, she had been very depressed—a feeling only compounded with the loss of her SSI benefits. She felt hopeless and unsure of what to do next. Bounta very much wanted to become a U.S. citizen and was actively participating in programming at the Fresno Interdenominational Refugee Ministries in Fresno, California. Unfortunately, she passed away early this year at the age of 81.

Bounta's story is indicative of the fact that for many elderly and disabled refugees who lose their SSI, the ability to regain self sufficiency is very unlikely and that many family members, who may be struggling themselves, will bear the costs. Similar to Bounta, many elderly refugees will spend the rest of their lives attempting to regain the ability to take care of their most basic needs and to attaining the dream of citizenship in the U.S.

Mr. Chairman and Senator Smith, we recognize your leadership in introducing legislation in the 110th Congress to extend the SSI eligibility for refugees from seven to nine years. While the

[9] Melanie Nezer, "America's Broken Promise: The Dire Consequences of Welfare Reform for Jewish Refugees," Summer 2006

legislation has passed in the House, it has stalled in the Senate and we will continue to advocate for its passage in the near future.

Another issue having significant impact on refugee elders is Medicare Part D. The intent of the Medicare Modernization Act of 2003, which contains Medicare Part D, was to ensure that the most vulnerable beneficiaries receive the maximum level of protection. Since its inception, however, Medicare Part D has incurred numerous difficulties for low-income Southeast Asian American elders.

To date, the most vulnerable population, the "dual eligibles," those who receive both Medicare and Medicaid, are in greater need of increased protection. Medicare Part D is an incredibly complex issue and is a particular struggle for our limited- or non-English speaking elders. One of the ongoing challenges is the inability of low-income refugees to obtain linguistically appropriate information. Unable to read and write in English, they require intensive one-on-one assistance with choosing or switching plans, resolving problems at the pharmacy, filing for exception and appeals and understanding the notices and information from drug plans. Medicare Part D plans are required to make important information accessible to beneficiaries whose English proficiency is limited. Yet according to a survey conducted by the National Senior Citizens Law Center (NSCLC), drug plans fail their obligation to provide service in languages other than English. In fact, more than 60% of calls placed to call centers never reached an individual speaking the language of the caller[10]. Lack of language access makes it nearly impossible for limited English proficiency beneficiaries to navigate the already complex Part D program on their own.

Secondly, because many Southeast Asian American seniors live in poverty, they also have very high medical needs requiring a variety of prescriptions each month. The higher co-payments of prescription drugs pose significant financial burdens to low income beneficiaries, most of which are on a fixed income. The Medicare Part D requirement of the so-called "nominal" co-payment of up to $5.35 by dual eligibles for each prescription is unduly burdensome and inequitable compared to other Medicaid recipients. For these beneficiaries, co-payments required by Medicare Part D really add up. Under Medicaid, if they were unable to afford co-payments, they were not denied necessary medications. Now, only those in nursing homes receive that level of protection. This financial requirement creates additional barriers to the rights of every low income Medicare beneficiary to receive care in the least restrictive setting available.

I urge the Special Committee on Aging to ensure that the needs of disabled and elderly refugees are made a priority in the 110th Congress to prevent this vulnerable population from further setbacks and destitution. On the needs of elderly refugees pertaining to SSI and Medicare Part D, SEARAC recommends the following:

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[10] Scalia, K., *Medicare Prescription Drug Plans Fail Limited English Proficient Beneficiaries,* National Senior Citizens Law Center and California Medicare Part D Language Access Coalition (Feb. 2007) *available at:* http://www.nsclc.org/areas/medicare-part-d.

- Congress should enact legislation to de-link SSI eligibility from U.S. Citizenship for refugees and humanitarian immigrants. At the very least, Congress should provide a stop-gap measure of extending the seven-year limit on SSI eligibility. Seven years is certainly not sufficient time for thousands who have been affected and thousands more who will be affected by this cut off.
- In April 2007, members of this committee introduced the "Medicare Part D Outreach and Enrollment Enhancement Act of 2007." Among other things, this piece of legislation seeks additional funding for outreach and assistance for those who qualify for Medicare but need additional assistance navigating the complex program. SEARAC applauds this effort and recommends that any congressional efforts to provide additional outreach and assistance on this topic take into consideration the importance of improving language access to the system by providing culturally appropriate materials. Materials on Part D need to be made available in many languages and at an appropriate literacy level. Congress should consider funding a pilot language access project that would promote access for Medicare beneficiaries with Limited English Proficiency (LEP) and increasing funding for State Health Insurance Assistance Programs (SHIPS) and community-based organizations which provide the one-one-one counseling that is necessary in the light of the complexities of Medicare Part D.
- Congress should ensure that the poorest and most vulnerable are not financially devastated by Medicare Part D's cost-sharing requirements by providing co-payment assistance for dual eligible beneficiaries and eliminating the financial burden of low-income beneficiaries.

The U.S. has been a leader in providing refuge for people from around the world, many of whom have faced persecution and dislocation because of conflict and war. Many who find refuge in the U.S. have been longtime allies and supporters of this country and as such, have risked their lives and those of their loved ones to be here. It is unimaginable that we would allow our disabled and elderly refugee population to endure further hardships and destitution because of unfair policies which do not take into consideration the unique circumstances of this vulnerable population.

In conclusion, I would like to thank the Senate Special Committee on Aging again for the opportunity to highlight these issues in a forum such as this and welcome any questions you may have.