Review of the History of Compact of Free Association Migrant Health Conditions and Health Access

Version 1.4

The Māpuna Lab
Department of Social Work
Thompson School of Social Work & Public Health
University of Hawai'i at Mānoa

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Summary:

This literature review was conducted to assess challenges faced by Compact of Free Association (COFA) migrants (citizens from the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau) and the associated history relating to healthcare access. Historical relations with the United States (US) brought both benefits and drawbacks for the COFA migrant population. COFA migrants had access to Medicaid until the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) removed their eligibility. After decades of reduced healthcare access COFA migrant eligibility for Medicaid was finally restored in 2020 as part of the COVID-19 omnibus bill.

Background

Compact of Free Association (COFA) migrants include citizens from the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau (ROP). Citizens of the FSM represent one of the fastest growing populations in the United States (US) (Empowering Pacific Islander Communities, 2014). A 2009 study reporting education, employment, and housing statistics estimated that of a sample of 2,522 Micronesians living in Hawai‘i, 23.6% had at least one medical condition. Results also showed that 48.8% speak only their native languages at home, 45.2% use both their native language and English, and only 5.8% speak only English (Pobutsky, 2009).

Another study of a sample of US citizens and immigrants found that immigrants with language barriers had relatively lower education, family income, and health insurance. The same immigrants also suffered from higher unemployment rates, unhappiness, depression, and anxiety when compared to US citizens without language barriers, concluding that those with language barriers were more stressed which may have been a factor of poorer health. (Ding, 2009). According to Philios Uruman (2021), a Chuukese interpreter from the Federated States of Micronesia, a lack of language assistance programs “makes it difficult for [COFA migrants] to apply for any government assistance or even understand what services are available.’” In times of crisis, it is critical that frontline responders are prepared to overcome these barriers to provide essential services.

Health access, educational access (including language), employment, and housing security are just some of the conditions that the Centers on Disease Control and Prevention (CDC) include as aspects of social determinants of health which may cause health inequities (Centers on Disease Control and Prevention, 2021). Due to a higher infection rate in the Micronesian population of Hawai‘i caused by socioeconomic factors, Hosaka (2021) also describes the recent COVID-19 pandemic as a “syndemic - where cases cluster ‘on a background of social and economic disparity’”.

These sources illustrate the importance of access to resources for any given population with respect to quality of life. Despite this importance, efforts to sustain COFA migrant Medicaid eligibility have been a consistent barrier to accessing care for decades. This review focuses on the history of events that shaped COFA migrant health care access and some related prevalent health conditions. The goal of this review is to illustrate how lack of access to resources has impacted pathways to health equity for citizens of the Compacts living in the United States, specifically in Hawai‘i.

Methodology

This study was conducted on 6/10/21-9/23/21 as part of the State Disaster Response Cultural Training Project requested by the State of Hawaii Department of Health, Alcohol and Drug Abuse Division. Searches for relevant material were performed on Google and the University of Hawai‘i at Mānoa Library OneSearch. Additional historical and political context was provided by on staff subject matter experts.

Findings

Historical events including nuclear testing on the Marshall Islands, related migration to the US, and a staggering history of Medicaid ineligibility may have had an effect on prevalence of and vulnerability to health issues such as diabetes, obesity, and communicable diseases amongst the COFA migrant population. After over two decades of reduced medical benefits, Medicaid eligibility was restored in 2020.

Contrasting history with the US: TTPI & Nuclear Testing, COFA & New Opportunities

The history of the Compacts begins after World War II in 1947 when the United States claimed control over the Trust Territory of the Pacific Islands (TTPI), which included Northern Marianas, Palau, Yap, Chuuk, Pohnpei, Kosrae, and the Marshall Islands, after initiating nuclear testing in the Marshall Islands (Shek, 2011). Though test sites were vacated, surrounding atolls were exposed to a significant amount of radiation which critically endangered the lifestyle and diet of the Marshallese population at the time (McElfish, 2015). A 2010 study estimated that as much as 170 cancer cases among residents of the Marshall Islands born before or during 1948-1970 were related to radiation. This estimate represents 1.6% of the total of 10,600 cancer cases occurring in residents of the Marshall Islands born through 1970. Residual contamination due to the nuclear testing did not reach negligible levels on the atolls until 1970 (Simon, 2010).

Although aid for TTPI increased in the 1960s through the US offer of employment and related economy expansion (Shek, 2011), the Marshall Islands ultimately separated from the TTPI and restarted relations with the US through the COFA in 1986 which promised RMI, FSM, and ROP citizens benefits of entry and opportunities in the US in exchange for military control of the areas (Ahlgren, 2014). According to the Asian & Pacific Islander American Health Forum (2019), “Since 1986...the Compacts allow citizens of the [Freely Associated States (FAS)] to apply for admission to the U.S. as ‘non-immigrants’ and without visa requirements...COFA citizens pay taxes and play a role in driving our economy.”

Migration & Enduring Efforts for Health Care Access

The migration to the US has increased since the Compacts were established. McElfish (2019) states that “nuclear contamination, climate change, rising sea levels, and the lack of employment and educational opportunities have created a large Micronesian diaspora to the United States.” There was a total of 3,968 non-Chamorro Micronesians in Hawai‘i in 1990. This number jumped up to 12,724 in 2000 (Pobutsky, 2009). From 2000-2010 it was estimated that the Micronesian population grew 130% (Empowering Pacific Islander Communities, 2014). Finally, the 2018 US Census estimate of the total COFA migrant population in Hawai‘i was 16,680 (U.S. Census Bureau, 2019).

A 2009 study listed better medical/health care for themselves or family members as the top reason for Micronesian migration to Hawai‘i (Pobutsky, 2009). Despite increased access to health care, migration to the US may increase risk of developing chronic health conditions such as obesity and diabetes as a result of assimilation to an American lifestyle. A 2009 study consisting of 2,522 Micronesian migrants in Hawai’i estimated that 23.6% had at least one medical condition and 11% had at least two medical conditions. Some of the top reported conditions recurring among participants of the study were diabetes (8.7%), cardiovascular conditions (6.5%), lung conditions (5%), and asthma (4.2%). Other studies have illustrated high prevalence of sexually transmitted diseases, tuberculosis, Hansen’s disease, cancer, and obesity. In addition, education, employment, and housing opportunities have also been less comprehensive than promised. In the same 2009 study, 36% of those that were 19 years old and above were highschool graduates and 4.8% were college graduates. The study also stated that “About one-fourth of adults were reported to be unemployed (or retired, disabled, or at home caring for children or other relatives)” and that “16.3% of the households [in] this sample were to be homeless or living in a homeless shelter” (Pobutsky, 2009; Yamada, 2009). These persisting conditions may be attributed to the long-lasting battle for Medicaid eligibility described below.

In 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted. One of the changes that was implemented to the PRWORA was a revision to the definition of “qualified immigrants" which no longer included COFA migrants. As such, their access and eligibility to federal programs such as Medicaid was removed (McElfish, 2015).

At the federal level, there have been many efforts to reestablish healthcare access for COFA migrants. According to McElfish (2019), “Twenty-two bills to reinstate COFA eligibility for Medicaid have been introduced at the federal level since 2001.” Some recent efforts at the national level include the Health Equity and Accountability Act of 2018 (HEAA) which included provisions to restore Medicaid and remove immigration status for COFA migrants and the Covering our FAS Allies Act (COFA Act) of 2019 which also focused on reinstating Medicaid eligibility for COFA migrants living in the US and its territories (McElfish, 2019).

At the state level, when PRWORA removed Medicaid eligibility for COFA migrant individuals in Hawai‘i were eligible for Med-QUEST, the managed care Medicaid program offered by the state. Unfortunately the federal government provided limited resources to the state of Hawai‘i to oversee

the Compacts. Although there was a federal appropriation of approximately $10 million per year dedicated to Compact assistance in Hawai‘i, actual costs in the state were estimated to be over $100 million with costs of single state agencies nearing or exceeding the $10 million appropriation (e.g. Department of Education had $53.6 million of costs, Department of Human Services had $37.1 million of costs, and Department of Health had $6.8 million of costs) (State of Hawai‘i Department of the Attorney General, 2008). The limited resources combined with the financial crisis unfortunately led the state to roll over COFA migrants from Med-QUEST to Basic Health Hawaii (BHH) which provided extremely limited coverage. According to Shek, 2011 “In its first iteration, BHH had no provisions for continued treatment for the estimated 130-160 patients on chemotherapy or 110 patients on hemodialysis”, and coverage was limited to “10 hospital days, 12 outpatient visits per year, and 4 outpatient medications per month.” Shek, 2011 also emphasized that newly arriving migrants had no coverage and provided an example of a patient who was billed over $20,000 for a thyroidectomy. At this time, pregnant women and children were eligible for benefits under the Children’s Health Insurance Program Reauthorization Act (H.R.2 111th Congress (2009-2010), 2009; McElfish, 2015; Riklon, 2010).

Following widespread community-organized advocacy (e.g. All Mike Tournaments, Vital Voices, Masters of the Current, Civil Beat, etc.), there was a preliminary injunction issued that temporarily prevented BHH from going into full effect due to lack of due process, but after holding public hearings the state reinstated BHH in 2010. In December of the same year, a court decision temporarily restored Med-QUEST coverage until 2014 when another court decision allowed the state to legally deny Medicaid coverage to COFA migrants and the state implemented its plan to remove thousands of COFA migrants off of Med-QUEST in 2015. As they were required to choose a new health care plan under the Affordable Care Act, the state received permission from the federal government to automatically rollover individuals into either Kaiser or HMSA plans. (Hagiwara, 2015)

In December of 2020, US Congress passed the COVID-19 Omnibus bill which included an amendment to the original 1996 PRWORA and restored Medicaid access for COFA migrants. Effective December 28, 2020, the Omnibus bill COFA citizens in the 50 states and District of Columbia were once again eligible for Medicaid after over two decades of advocacy (Asian & Pacific Islander American Health Forum, 2020).

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