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Marshallese COFA Migrants in Arkansas

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Abstract

Arkansas is home to one of the largest populations of Marshallese in the world. Marshallese communities suffer from a disproportionate incidence of chronic diseases, including obesity, cardiovascular disease, diabetes, and infectious diseases, such as Hansen's disease (leprosy), tuberculosis, and types of hepatitis.[1–8] There are a number of structural, legal, economic, and social issues that must be addressed in order to reduce health disparities and increase access to health care for Marshallese living in Arkansas.

Arkansas is home to one of the largest populations of Marshallese in the world. From 1947–1986, the Marshall Islands were administratively controlled by the United States as a United Nations Trust Territory of the Pacific Islands. In 1986, the Republic of the Marshall Islands (RMI) became a sovereign nation under the Compact of Free Association (COFA). Citizens covered by the COFA are allowed to freely enter, lawfully reside, and work in the US. COFA migrants are identified as nonimmigrants without visas and are distinct from other immigrants who are subject to US Citizenship and Immigration Services administration. Migration from RMI to Arkansas and other areas of the US tripled between 2000 and 2010 from 6,700 to 22,434 according to census estimates. Because COFA migrants can come and go freely between the RMI and the US without a visa or resident card, the exact number of COFA migrants is difficult to ascertain. The actual number of Marshallese living in the US is estimated to be much higher. Using school enrollment data, it is estimated that ~10,000–12,000 live in Arkansas and ~40,000 COFA migrants live in the US.[9,10] Due to climate change and the lack of employment opportunities in the RMI, Marshallese migration will likely increase in the coming decades.

US Nuclear Testing and Its After-effects

The US nuclear testing conducted in the Pacific is important for contextualizing the current health disparities and legal status of Marshallese COFA migrants. Between 1946 and 1958, the US military tested numerous nuclear weapons resulting in the exposure of Marshall Islanders to significant levels of radiation.[11] Residents of atolls near the test sites were not relocated and suffered exposure to radiation through fallout and the consumption of contaminated water and food. This perpetuated a radical shift in the lifestyle and diet of Marshall Islanders.[11] US military presence continues in the RMI, centered at the Ronald Reagan Ballistic Missile Defense Test Site. In addition, RMI citizens join the US military at higher per capita rates than US citizens.

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Health Issues in the Marshallese Community

Marshallese communities suffer from a disproportionately high incidence of many chronic diseases, including obesity, cardiovascular disease, diabetes, and infectious diseases, such as Hansen's disease (leprosy), tuberculosis, and types of hepatitis.[1–7,12] For example, the prevalence of type 2 diabetes among adult RMI residents and Marshallese living in the US is 25% to 50% (compared to 8.3% US). Marshallese mothers in the US also have high rates of babies born with low birth weight.[6] These disparities are aggravated by numerous cultural and structural barriers, which constrain access to health care.[13–15]

There are a number of structural, legal, economic, and social issues that must be addressed in order to reduce health disparities and increase access to health care for Marshallese living in Arkansas.

Access to Health Care and Health Insurance

Local needs assessments estimate that approximately 50% of Marshallese living in Arkansas are uninsured. From the approval of the COFA agreement in 1986 until the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, often referred to as "welfare reform," COFA migrants were eligible for federal benefits programs, which included Medicaid and Children's Health Insurance Program (CHIP). However, after PRWORA, COFA migrants were excluded from federal Medicaid, which left state governments the option to continue Medicaid coverage using only state funds. While a number of states have extended Medicaid or Medicaid-like programs to COFA migrants, Arkansas does not offer Medicaid or any state-funded insurance program to Marshallese, leaving many uninsured.

The Affordable Care Act (ACA) expanded health coverage options in the US by creating marketplaces where subsidized health plans are available for purchase, extending to states the option to expand Medicaid coverage for more residents, as well as requiring legal US residents to obtain health insurance. Arkansas chose to implement Medicaid expansion through a "private option," using Medicaid funds to purchase private health insurance for the Medicaid-eligible population. COFA migrants are not eligible for this coverage, regardless of income, because of the federal prohibition in PRWORA. They are, however, required to purchase health insurance in a Qualified Health Plan offered through the Insurance Marketplace and are subject to standard penalties for failure to enroll. COFA migrants are eligible for advance premium tax credit subsidies and cost-sharing reductions, but are not eligible for Medicaid-funded plans. This combination of regulations leaves the poorest migrants with the requirement to purchase health insurance but without the means to do so.

Federal and state governments jointly fund the Children's Health Insurance Program (CHIP). This program serves as a bridge for families whose income exceeds the amount for Medicaid, but whose income does not allow them to afford private health insurance. Under PRWORA's initial prohibition, COFA migrant children were ineligible for CHIP or Medicaid coverage. However, the 2009 passage of the Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states the authority to extend CHIP and Medicaid

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benefits to children lawfully residing in the state, which would include COFA migrants. CHIPRA provides for federal matching funds that pay for most of the coverage, especially in lower-income states such as Arkansas. Many states have extend CHIP coverage to COFA children, but Arkansas has not. Arkansas's CHIP program, ARKids First, is not available to COFA migrants living in Arkansas, leaving many Marshallese children without health insurance.

Addressing the challenges

Several organizations in Arkansas are working to address Marshallese health disparities. The Arkansas Department of Health has established the Dr. Joseph Bates Outreach Clinic to reach Marshallese with public health services. In addition, the Community Clinic provides primary care, prenatal care, and other health services. The University of Arkansas for Medical Sciences (UAMS) Northwest Campus is utilizing community-based participatory (CBPR) approaches to facilitate research and community health programs, and has established an interprofessional clinic focused on diabetes. UAMS has also developed, and is implementing, a family model of diabetes self-management education based on the collectivist values of the Marshallese community. While these organizations' work is important, significant policy and structural barriers continue to perpetuate the disparities in the Marshallese Community.

Recommendations for Improving Health Care Access for COFA Migrants

There are a number of ways that health disparities can be addressed by local health care organizations, the Arkansas state government, and federal policy-makers.

Organizational

Hire Marshallese staff and community health workers

One of the best ways to facilitate effective communication and culturally sensitive health care is to hire Marshallese staff members and Marshallese community health workers. Community health workers can help bridge many cultural barriers and facilitate effective partnerships between patients and the health care community.

Community-based participatory research (CBPR) with the Marshallese Community

There has been much interest in research with the Marshallese community, which has left the Marshallese community open to even greater exploitation with little information or benefit returned to the community. Other researchers have focused on participatory methods that engage the Marshallese community in all aspects of research from choosing research priorities to disseminating the results. It is important that more translational research be conducted with CBPR approaches to help address the health disparities faced by the Marshallese community.

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State

Cover COFA children under CHIPRA

While federal funding would offset the costs of CHIP, Arkansas has not yet taken the necessary steps to cover Marshallese children. In order to cover COFA children under CHIP, Arkansas needs to submit a state plan amendment to CMS. It is imperative that this step be taken to extend CHIP coverage so Marshallese and other COFA children will have better access to basic health care services.

Federal

Restore Medicaid

Following the passage of PRWORA, coverage has been incrementally restored for most other legal immigrant groups, but COFA migrants have been left out of the restorations. There are currently two bills before congress that would extend coverage to COFA migrants. The first is H.R. 1774: Health Equity and Access under the Law (HEAL) for Immigrant Women and Families Act of 2015 and the second is S. 1301 Restoring Medicaid for COFA Act of 2015. It is imperative that Medicaid be reinstated for COFA migrants.

Pass Compact Impact Aid

Hawaii, Guam, the Commonwealth of the Northern Mariana Islands, and American Samoa receive Compact Impact Aid under the 1985 COFA agreement to offset costs associated with COFA migrants. However, other states with high numbers of COFA migrants including Arkansas, Oklahoma, and Utah do not receive any Compact Impact funds to mitigate the financial cost of COFA migrant populations. As more migrants move inland, Compact Impact Aid is needed to provide financial support to the affected states.

Conclusion

In spite of the ongoing benefits that the US and Arkansas derived from its relations with the RMI and the Marshallese people, Marshallese living in Arkansas continue to face constrained access to health insurance and quality health care. One repeated refrain by Marshallese interviewed through our CBPR is that they have been “good friends to the US.” They do not understand why the US does not honor the friendship commitment to the Marshallese people. The Marshallese community discusses their exclusion from federal programs, which were provided when they signed the COFA, as a betrayal of the basic conditions of their historic and current relationship with the US.

Marshallese COFA migrants’ need for health insurance and quality health care services must be addressed at multiple levels in order to mitigate the ongoing epidemics of type 2 diabetes, Hansen’s disease, tuberculosis, and hepatitis, which have both personal and public health consequences. Action should be taken at a federal level to restore Medicaid and fairly distribute Compact Impact Aid. It is also imperative that the Arkansas state government and local health care providers work collaboratively to address the health disparities of the Marshallese community in Arkansas.

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