


# Compact of Free Association Migrants and Health Insurance Policies: Barriers and Solutions to Improve Health Equity

INQUIRY: The Journal of Health Care Organization, Provision, and Financing  
Volume 56: 1–5  
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DOI: 10.1177/0046958019894784  
journals.sagepub.com/home/inq  


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## Abstract

This commentary outlines the health insurance disparities of Compact of Free Association (COFA) migrants living in the United States. Compact of Free Association migrants are citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau who can live, work, and study in the United States without a visa. Compact of Free Association migrants make up a significant proportion of the rapidly growing Pacific Islander population in the United States. This article describes the historical and current relationships between the United States and the Compact nations and examines national policy barriers constraining health insurance access for COFA migrants. In addition, the commentary describes the state-level health policies of Arkansas, Hawai'i, and Oregon, which are the states where the majority of COFA migrants reside. Finally, policy recommendations are provided to improve health equity for COFA migrants.

## Keywords

Pacific Islanders, Micronesia, migrants, health policy, health insurance, health disparities, health equity

### What do we already know about this topic?

Compact of Free Association migrants experience barriers in accessing health insurance in the United States.

### How does your research contribute to the field?

The manuscript provides a synthesis of the national policy barriers and describes state-level health policies in the 3 states where the majority of COFA migrants reside.

### What are your research's implications toward theory, practice, or policy?

The manuscript provides policy recommendations to improve health equity for COFA migrants.

## Introduction

Pacific Islanders are the second fastest growing population in the United States increasing by 40% between 2000 and 2010.<sup>1,2</sup> Migration from the US Associated Pacific Islands—Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM, encompassing the states of Chuuk, Kosrae, Pohnpei, and Yap), and the Republic of Palau—constitutes a significant proportion of this population growth.<sup>3,4</sup> These island nations were formerly part of the Trust Territory of the Pacific Islands and are now affiliated with the United States through a Compact of Free Association (COFA).<sup>5,6</sup>

Pacific Islanders migrating to the United States from the RMI, FSM, and Palau are referred to as COFA migrants. Overall, Pacific Islanders have more chronic diseases and are more likely to be uninsured than non-Hispanic Whites in the United States, with 7.8% of Pacific Islanders uninsured

compared with 6.3% of non-Hispanic Whites uninsured.<sup>7</sup> Among Pacific Islanders in the United States, COFA migrants face even greater health disparities and are more likely to be uninsured, with approximately 50% of the COFA migrant population uninsured.<sup>8–10</sup> Because of a lack of insurance, COFA migrants often cannot access preventive care and have a significantly higher prevalence of type 2 diabetes, hypertension,

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Received 31 May 2019; revised November 20 2019; revised manuscript accepted 22 November 2019

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and other chronic conditions.<sup>10-18</sup> To enhance understanding of these health insurance disparities, we describe the historical and current relationships between the United States and the Compact nations, examine national policy barriers constraining health insurance access for COFA migrants, describe the US state-level health policies where most COFA migrants reside (Arkansas, Hawai'i, and Oregon), and provide policy recommendations to improve health equity.

### *Historical and Current Relationships Between the United States and COFA Nations*

The COFA agreements are a legacy of US involvement in the Pacific region of Micronesia during World War II (WWII). From 1947 to 1986, the United States held much of Micronesia as a trust territory assigned by the United Nations after WWII.<sup>19</sup> The RMI became the location of extensive nuclear testing conducted by the US military from 1946 to 1958. Sixty-seven thermonuclear and fission devices equivalent in payload to 7200 Hiroshima-sized bombs were detonated in the RMI.<sup>20</sup> The Castle Bravo test on Bikini Atoll of the Marshall Islands on March 1, 1954, was the largest nuclear test ever conducted. Those living on Bikini were relocated to neighboring islands; however, many Pacific Islanders were exposed to high levels of nuclear fallout because of these tests.<sup>20,21</sup> US scientists initiated Project 4.1 to study the effects on humans exposed to radiation from fallout, but these experiments were carried out without the informed consent of the Pacific Islanders involved and study materials were not translated into the native language.<sup>20</sup> These nuclear tests devastated the environment, contaminated traditional food sources, and forever altered the diet and health of these Pacific Islanders.<sup>22-24</sup>

In 1986, the RMI and the FSM became ostensibly sovereign and entered into COFA agreements with the United States. The Republic of Palau entered into a COFA agreement with the United States in 1994. These treaties defined the governing relationship between the Pacific nations and the United States. Under the terms of the COFA agreements, citizens of the RMI, FSM, and Palau are defined as non-immigrants who are able to enter the United States to live, work, or study without visas. The COFA agreements also allow the US military to maintain control of a large, strategic section of the Pacific between Japan and Hawai'i. The RMI is an important asset for the US military. Kwajalein Atoll is home to the US Army's Ronald Reagan Ballistic Missile Defense Test Site, which has been used for intercontinental ballistic missile and ballistic missile defense testing.<sup>20,25</sup> The COFA agreements also granted access to some (eg, US Department of Education Grants) but not all US domestic programs.

Although COFA migrants are not US citizens and are not eligible to vote, they do pay taxes. Compact of Free Association migrants serve in the US military in large numbers. In fact, COFA migrants serve in the military at greater per capita rates than US citizens do. The COFA agreements provide limited

pathways to US citizenship or permanent residency. Compact of Free Association migrants who desire US citizenship must apply for green cards.

### *Increasing Migration to the United States*

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.<sup>23,26</sup> Compact of Free Association migrants seeking employment, education, and health care services have established large communities in Northwest Arkansas, Hawai'i, and the Pacific Northwest. It is estimated that there are currently 13 700 COFA migrants living in Hawai'i,<sup>25</sup> approximately 12 000 to 15 000 living in Arkansas,<sup>27</sup> and roughly 9000 COFA migrants residing in Oregon.<sup>28</sup> A 2017 PBS Newshour segment estimated that a considerable proportion of the Marshallese population has left the RMI for the US mainland.<sup>29</sup> There are more than 56 000 migrants from COFA nations currently living, working, and studying in the United States.<sup>30</sup>

### *Policy Barriers Perpetuating Health Disparities*

Compact of Free Association migrants face barriers to health insurance coverage in the United States. When the COFA agreements were first signed, COFA migrants were eligible for Medicaid as lawfully present migrants.<sup>30-32</sup> After the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted in 1996, COFA migrants were excluded from Medicaid because they were not included in the category of "qualified immigrants."<sup>30-32</sup> With the enactment of the Affordable Care Act (ACA) in 2010, COFA migrants are required to purchase health insurance. They are eligible for advanced premium tax credit subsidies and are subject to financial penalties for not enrolling in a health plan. Although many meet the income and asset requirements of Medicaid, COFA migrants are not eligible for Medicaid or Medicaid Expansion established through the ACA.<sup>30-32</sup>

### *National-Level Policy Efforts to Restore Medicaid to COFA Migrants*

Twenty-two bills to reinstate COFA eligibility for Medicaid have been introduced at the federal level since 2001.<sup>30</sup> The most current US congressional effort is The Health Equity and Accountability Act (HEAA) of 2018 sponsored by Rep. Barbara Lee and Rep. Judy Chu of the Congressional Asian Pacific American Caucus and Senator Mazie Hirono (D-HI). Health Equity and Accountability Act is co-sponsored by Senator Hirono's colleagues in the Congressional Black Caucus and the Congressional Hispanic Caucus. This partisan bill is supported by 71 Democratic Representatives, 9 Democratic Senators, and 1 Independent Senator.<sup>33,34</sup> No Republican Representatives or Senators have given their support to HEAA.<sup>33,34</sup> A version of the HEAA has been

introduced in each Congress for the past 10 years. The HEAA is a broad proposal for achieving health equity for COFA migrants that includes many policy provisions including restoring Medicaid and removing immigration status as a barrier for COFA migrants across public programs and data collection. The HEAA outlines investments Congress should make to comprehensively address health disparities and provide quality health care to everyone.<sup>35</sup> More recently, a bipartisan bill, Covering Our FAS Allies Act (COFA Act), was introduced on October 23, 2019, in the House of Representatives and is companion legislation to the HEAA introduced in the Senate.<sup>36</sup> The COFA Act intends to reinstate Medicaid eligibility for COFA migrants living in the United States and its territories.<sup>36</sup> However, little progress has been made to restore Medicaid to COFA migrants at the federal level.

### *State-Level Health Policies in Arkansas, Hawai'i, and Oregon*

With no progress made at the national policy level since 1996, it has been up to individual states to decide if or how to continue Medicaid coverage for COFA migrants with state funds. Arkansas, Hawai'i, and Oregon have responded to the issue of COFA migrant insurance coverage in different ways.

**Arkansas.** The COFA migrant community of Marshallese in Springdale, Arkansas, is the largest in the continental United States with 12 000 to 15 000.<sup>27,37</sup> A local needs assessment found that 50% of Marshallese in Arkansas are uninsured.<sup>10</sup> Compact of Free Association migrants are ineligible for the Private Option, Arkansas's Medicaid-funded private insurance coverage for individuals at or near the poverty level.<sup>38</sup> The state has not funded Medicaid for COFA migrants; nor is there any pending legislation to do so. However, Arkansas has extended coverage to COFA migrant children through the state's Children's Health Insurance Program (CHIP) known as ARKids. In 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) gave states the power to access federal funds to extend CHIP and Medicaid benefits to children lawfully residing in the state.<sup>39</sup> A 2017 resolution was passed by the Arkansas state legislature to encourage Republican Governor Asa Hutchinson to submit a state plan amendment to the Centers for Medicare and Medicaid Services that would include COFA migrant children in the ARKids program.<sup>40</sup> Marshallese adults still lack Medicaid coverage in Arkansas.

**Hawai'i.** Hawai'i has made little progress in extending Medicaid to resident COFA migrants. Until 2009, COFA migrants in Hawai'i had been covered by the state's Medicaid program, Med-QUEST, if they met the income and asset requirements.<sup>18</sup> Subsequent to PRWORA, COFA Medicaid coverage in Hawai'i had been funded solely from state funds. In the midst of the great recession of 2009, the administration of

Republican Governor Linda Lingle announced plans to remove COFA migrants from the state Medicaid rolls in response to state budget constraints.<sup>18</sup> In July 2010, approximately 7500 COFA migrants in Hawai'i were unenrolled from Med-QUEST and enrolled in the Basic Health Hawai'i program, which offered limited benefits—10 hospital days, 12 outpatient visits per year, and 4 outpatient medications per month.<sup>18</sup> Newly arrived COFA migrants were unable to obtain any health coverage.<sup>18</sup>

A class action lawsuit was filed in August 2010 that challenged the constitutionality of the Basic Health Hawai'i plan that deprived individuals of health coverage based on their national origin and immigration status, violating the equal protection clause of the 14th Amendment of the US Constitution.<sup>18</sup> US District Judge Michael Seabright granted a preliminary injunction and reinstated full Med-QUEST benefits to COFA migrants; however, Democratic Governor Neil Abercrombie appealed the decision to the US Ninth Circuit Court.<sup>18,25</sup> In April 2014, the Ninth circuit court ruled Hawai'i is not required to provide health care to COFA migrants through its state-run Medicaid programs.<sup>25</sup> Following this ruling, Hawai'i moved to enroll COFA migrants in the ACA.<sup>25</sup> However, many COFA migrants cannot afford the deductibles and co-payments required by insurance obtained through the ACA.<sup>25</sup> Although 2 bills have been introduced into the state legislature that would require that the state cover the cost of premiums, copays, and deductibles, and replicate the benefits offered under Medicaid, both have stalled and have not been passed.

**Oregon.** Oregon implemented a unique insurance program that pays the ACA health insurance premium for qualified COFA migrants. Under Oregon's HB4071 (2016) COFA Premium Assistance Program, the state supplements health insurance premiums and all out-of-pocket expenses for COFA residents living in Oregon.<sup>41</sup> This legislative action was the result of many years of COFA migrants advocating for significant health policy legislation to improve health care access for their community. Compact of Free Association migrants had bipartisan support from Oregon state representatives and senators who passed HCR21 in 2015 to recognize and thank COFA migrants for their contributions to the state's economy. Advocates for HB4071 successfully showed that by covering the premiums and out-of-pocket cost for COFA migrants, the state would save money in unreimbursed care that was often sought after chronic disease had become more acute and inappropriate emergency care that was sought because of a lack of insurance.<sup>42</sup> The federal contribution toward premiums would be \$9 for every \$1 the state contributed, and it is estimated the total cost to the state would be approximately \$1 to \$1.8 million per year, which is far less than the unreimbursed care that would result if the migrants were uninsured.<sup>42</sup> In 2017, Oregon's SB147 directed the Oregon Department of Consumer and Business Services to conduct a formal study and make recommendations for adding adult dental coverage to the

COFA Premium Assistance Program.<sup>43</sup> Oregon has the most progressive policies to provide COFA migrants with health insurance.

### Policy Recommendations and Conclusions

Compact of Free Association migrants' exclusion from Medicaid must be addressed to improve health equity. This can be achieved by passing the federal HEAA or the COFA Act. As another solution, some advocacy networks, including the COFA Community Advocacy Network (COFACAN) and Asian American & Pacific Islander Health Forum, are urging congressional leaders to amend PRWORA and reclassify COFA migrants as qualified aliens.<sup>25,44,45</sup> This would make COFA migrants eligible for Medicaid and increase federal funding to states who cover COFA migrants.<sup>25</sup> Until a federal resolution is achieved, states should consider solutions modeled after Oregon's HB4071 and pass state legislation to cover out-of-pocket premiums and costs for COFA migrants who would otherwise be covered by Medicaid.

Without health insurance, COFA migrants lack preventive or primary care. While public insurance such as Medicaid might expend less on premiums, the consequence is greater costs to the health care system. Patients often suffer complications from unaddressed chronic disease and end up in emergency departments of hospitals. The financial costs are higher and shifted to hospitals, which are often reimbursed by state or federal funding for the cost of uninsured care. The greater tragedy is, however, that individuals denied preventive and primary care end up getting sicker and dying. State-level policies such as Oregon's HB4071 could actually produce cost savings while also improving health equity.

In addition to federal and state policies to provide access to Medicaid, there is a need for increased community outreach and advocacy to help COFA migrants understand and enroll in the ACA or employee-sponsored health insurance plans. Compact of Free Association Community Advocacy Network and other advocates must continue to educate COFA migrants about their health care rights and how to effectively access and use insurance coverage in the United States.

Compact of Free Association nations and COFA migrants have a long history of commitment to the United States and the US national security, which continues to be evident by allowing the United States a strategic location for its missile defense base and control of the Pacific region. Compact of Free Association migrants serve in the US military and contribute to the US economy. It is a moral imperative to fully include COFA migrants living in the United States in Medicaid and other health insurance programs.

### Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

### Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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