

Health Care for Micronesians and Constitutional Rights

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Abstract

Under the Compacts of Free Association (COFA), people from the Freely Associated States — the Republic of Palau (ROP), the Republic of the Marshall Islands (RMI), and the Federated States of Micronesia (FSM) — have been migrating to the United States in increasing numbers. In 1996, Congress passed broad welfare reform (Personal Responsibility and Work Opportunity Reconciliation Act) which limited certain federal benefits previously available to COFA migrants, including Medicaid benefits. Prior to July 2010, the State of Hawai'i had continued to include COFA migrants under its state-funded Medicaid program. In the face of budget constraints, the State removed these people from its Medicaid rolls. A challenge on the legal basis of the denial of equal protection of the laws, ie, the Fourteenth Amendment to the US Constitution, was successful in reinstating health care to the COFA migrants in December 2010. From the health worker's perspective, regardless of various social justice arguments that may have been marshaled in favor of delivering health care to the people, it was an appeal to the judicial system that succeeded. From the attorney's perspective, the legal victories are potentially limited to the four walls of the courtroom without community involvement and related social justice movements. Together, the authors propose that in order to better address the issue of health care access for Micronesian peoples, we must work together, as health and legal advocates, to define a more robust vision of both systems that includes reconciliation and community engagement.

Background

In the aftermath of World War II, most of the small islands of Micronesia — the Northern Marianas, Palau, Yap, Chuuk, Pohnpei, Kosrae, and the Marshall Islands — were held in trust by the United States through a 1947 United Nations Mandate as the “Trust Territory of the Pacific Islands” (TTPI). From 1946 to 1957, the United States tested the vast majority of the megatonnage of its nuclear weapons in the Marshall Islands. Subsequently the Marshall Islands have been used to test ballistic missiles and ballistic missile defense. In the early post-war period, the rest of the islands received little attention, as the United States failed to fulfill its mandate to develop their health and educational infrastructure. Beginning in the 1960s, US aid for the Trust Territory increased: many islanders were employed by the government, and the cash economy expanded. In the late 1980s, the former Trust Territory split into the Commonwealth of the Northern Marianas Islands (CNMI) and the three Freely Associated States (FAS) through separate Compacts of Free Association (COFA): (1) the Republic of Palau (ROP), (2) the Republic of the Marshall Islands (RMI), and (3) the Federated States of Micronesia (FSM). The FSM consists of four states: Yap, Chuuk, Pohnpei, and Kosrae.

In the last decade, migration from the FSM and the RMI to the United States has burgeoned, with many migrants having first relocated to the more economically developed jurisdictions of the CNMI and Guam. The Compacts of Free Association allow citizens of the ROP, the FSM, and the RMI free entry into the United States and the right to employment, without a visa and without requirements for health screening. In return for these travel and employment rights, the United States maintains exclusive military control over

the entire region, as exemplified in its development of the Ronald Regan Ballistic Missile Defense Test Site on Kwajalein Atoll in the RMI. The US military also recruits heavily among COFA residents, who have the highest per capita Army recruitment as compared to all US states.

Episodic disasters and gradual ecological change, making human habitation unsustainable will likely lead to increasing numbers of people migrating from the low-lying atolls of Micronesia — which are particularly vulnerable to sea level rise and severe weather. In December 2008, swells washed over Majuro, the capital of the Marshall Islands, damaging homes and forcing people into shelters.¹ From 2007 through 2008, high tides and wave surges led to salt water damage of up to 90% of the taro crops in the outer islands of the FSM. Since it takes five years of better water conditions (no saltwater intrusion and normal rainfall) for taro to recover, Father Francis Hezel, authority on Micronesian history and culture, states, “Perhaps the larger issue is whether life in the remote atolls remains viable in today's world.”²

As shrinking government budgets lead to fewer jobs and underfunded education and health care, as global climate change leads to inundation of low-lying atolls, as ballistic missile defense testing winds down on Kwajalein it is little wonder that Micronesians are choosing to relocate to the United States. The movement of people from the former colonies from the periphery toward the center is a time-honored historical phenomenon.

Many COFA migrants travel back and forth between the islands and the United States. Migrants report a number of motives for moving: employment, as dependents of job-seekers, education, and for medical reasons.³ The US Census Bureau estimates that 12,215 people from the FAS resided in Hawai'i in 2008,⁴ though many consider this an undercount. Some estimate that as many as 60,000 people from the FAS (approximately one-fourth of the total FAS population) live in the US proper, Guam, and the CNMI.⁵

Access to Health Care for Micronesians

But life is not easy here in Hawai'i for migrants from the Compact Nations. Housing is expensive, and jobs have been hard to come by. Furthermore, access to health care has been difficult. Until July 1, 2010, people from the Compact Nations were able to enroll in Med-QUEST, the State's managed care Medicaid program. While Medicaid is funded partially by states and partially by the US federal government, during the Clinton administration people from the Compact Nations were excluded from federal funding for Medicaid. Although migrants from the FAS have the right of free entry into the United States, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 disallows federal funds from being expended for their participation in Medicaid.⁶ According to State of Hawai'i rules, until July 1, 2010, they had been eligible for health insurance under Hawai'i's managed care Medicaid program, Med-QUEST, as long as they met the eligibility requirements for federal poverty levels. “Compact Impact” funding from the federal government to the State of Hawai'i to offset health and educational

costs have been inadequate, coming in at approximately \$10 million each year. The COFA Task Force developed under the Hawai'i Attorney General's office estimated "Compact Impact" costs at over \$100 million in 2007.⁷ The State argued that this put the burden on the taxpayers of the State, which had to entirely fund Med-QUEST for people from the Compact Nations. These figures, however, fail to consider the contributions of Compact migrants including working people from the Compact Nations who pay income taxes.

State Budgetary Constraints and the Executive Branch Response

Since the economic downturn in 2009, the State of Hawai'i has had a budget shortfall. The response of the administration of Republican Governor Linda Lingle was pay cuts, furloughs, and layoffs for state workers. The public school system closed down on furlough Fridays, giving Hawai'i the shortest school year in the nation during the 2009-2010 academic year. The disenrollment of Micronesians from Med-QUEST was part of the State's cost-cutting measures. In a measure intended to save \$15 million dollars annually, in July 2009, the Hawai'i Department of Human Services announced that approximately 7,500 COFA migrants enrolled in Med-QUEST would be disenrolled beginning on September 1, 2009, and placed in a program with fewer benefits, called Basic Health Hawai'i (BHH).⁸

The State justified its actions with an appeal to anti-immigrant sentiments. Testifying before the State House, Director of Human Services Lillian Koller cited the Compact of Free Association, noting that "Any alien who has been admitted under the Compact or the Compact, as amended, who cannot show that he or she has sufficient means of support in the United States, is deportable," going on to say, "Individuals on any type of public assistance, including Hawai'i's state-only funded medical assistance for COFAs, do not have sufficient means of support."⁹ Responding to the State, two of the pro bono attorneys supporting the Micronesian community wrote:

While the level of public benefits available to needy Hawai'i residents in these difficult times is an open issue, the way in which we talk about these individuals should not be uncivilized. Callously referring to them in public testimony as deportable commodities that should be grateful for their mere continued presence in Hawai'i de-humanizes these individuals, diminishes public discourse on a complex subject and evinces a shocking lack of sensitivity on the part of DHS [Department of Human Services]. Koller should know better.¹⁰

In its first iteration, BHH had no provisions for continued treatment for the estimated 130-160 patients on chemotherapy or 110 patients on hemodialysis.¹¹ The announcement was in English only, some received notice merely days prior to implementation, and the medical community was not given guidance as to maintaining continuity of care. As health and legal providers, we saw first-hand fear and confusion, as well as resolve and resilience, in the Micronesian community as they faced these new and uncertain regulations.

Initial Legal Challenges to BHH

On August, 31, 2009, the day before the State was set to reduce healthcare coverage for COFA migrants, attorneys from the non-profit Lawyers for Equal Justice and the law firm Alston Hunt Floyd & Ing filed a legal complaint on behalf of residents of Hawai'i from the Compact Nations objecting to BHH on constitutional and procedural

grounds. The next day, on September 1, 2009, US District Judge Michael Seabright issued a temporary restraining order to prevent the State from carrying out the change, citing a lack of adequate procedural protections. Thus BHH was halted for nearly a year during which time the State attempted to address its procedural defects. Despite the temporary judicial relief, confusion persisted in both the Micronesian and health provider communities. Health practitioners and service providers began hearing stories about patients wrongly denied prescriptions from pharmacies and about patients who simply stopped seeking primary and preventive healthcare because they did not know or understand that a legal injunction had been issued. In response to the legal ruling, the State disseminated draft rules and held the required public hearings. Then, on July 1, 2010, the BHH plan was implemented.

Implementation of BHH and its Health Effects

Basic Health Hawai'i, as its name suggests, had rather limited coverage — 10 hospital days, 12 outpatient visits per year, and 4 outpatient medications per month. Furthermore, reimbursement for community health centers to provide services such as language interpretation was cut. Federal funds intended for emergency services were utilized to pay for chemotherapy and dialysis. While BHH was in effect during the latter half of 2010, the authors heard stories from patients and clients that a number of patients had stopped their medications or simply stopped obtaining care. Some fragile patients deteriorated, and ended up in the hospital with severe complications. Those who were not previously enrolled in Med-QUEST, such as those newly arrived from the Compact Nations could not obtain any coverage at all. One such patient with thyroid cancer ended up with a \$23,000 hospital bill for a thyroidectomy. In that hospitals are unlikely to collect on such bills, a portion of the costs saved by the State via BHH were actually borne by hospitals.

In Defense of Constitutional Rights

In August 2010, Lawyers for Equal Justice and pro bono attorneys from Alston Hunt Floyd & Ing and Bronster & Hoshibata initiated another class action lawsuit against the State on behalf of COFA migrants to Hawai'i. The plaintiffs challenged the constitutionality of the BHH plan because it cut health benefits to individuals solely based on their alienage and national origin. This, they argued, was a violation of the Equal Protection clauses of the Hawai'i Constitution and the 14th Amendment of the US Constitution, which states that "No State shall...deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws." The suit also raised civil rights claims under the Americans with Disabilities Act.

As noted by Victor Geminiani and Deja Ostrowski of Lawyers for Equal Justice, the suit relied on declarations by patients and physicians. Patients emphasized their work histories in Hawai'i and outlined the difficulties of obtaining necessary care under BHH. Working with pro bono attorneys, physicians documented the deterioration of health of individuals and noted that costs would increase as patients with advanced illnesses would eventually present for care requiring more intensive services.¹²

Finally, in the waning days of the Lingle administration, Judge Seabright granted the plaintiffs' injunction and reinstated full Med-QUEST benefits for COFA migrants. In his December 13, 2010

decision, he acknowledged that without an injunction, “Plaintiffs will suffer irreparable harm...because they would be left without adequate medical coverage, which will force them to pay for treatment on their own or completely forego the treatment.”¹³ This significant legal victory to reinstate medical benefits had immediate and potentially life-saving impact. The legal opinion also affected other pending court cases on behalf of immigrants across the country. But the victory was not solely a legal one; rather, it was forged from social justice lawyering practices that embraced a broader vision of what a “win” means for lawyers, for health workers, and ultimately for the community.

Advocating for Access to Health Care

The BHH legal case spurred thinking about the different approaches to advocate for people from the Compact Nations to receive health care. Next, we propose additional collaborative, social justice dimensions to enhance traditional public health and judicial advocacy approaches. In particular, we suggest that reparations and community organizing perspectives enhance the current legal approaches to the COFA health issue. Finally, the health and human rights perspective is discussed.

The Social Healing Through Justice Perspective

Traditionally the reparations approach is defined as the righting of past injustices. We propose employing a modern reparations framework of “social healing through justice” developed by legal scholar Eric Yamamoto. Briefly stated, this framework “elevates the role of ‘social healing’ and links group and societal healing to ‘doing justice.’” This framework embraces concepts of “reconciliation (rather than compensation)”; the need for group participation in genuinely addressing societal healing; “recognition, responsibility, reconstruction, and reparation;” and “material change in socio-economic conditions underlying the group relationship.” Of particular relevance here, Yamamoto states:

People must recognize the humanity of others and the historical roots of group-to-group grievances. This includes articulation of the group harms and acknowledgment of the deeply embedded prejudices reflected in the stock stories we tell about others. The afflicting party must accept responsibility for healing group-based wounds, whether grounded in personal culpability, receipt of privileges and benefits, or a simple desire to build community. Acts of reconstruction are aimed at building a new productive relationship, including apologies and other acts of atonement, along with efforts to restructure social and economic institutions. Reparations encompass public education, symbolic displays, and financial support for those in need.¹⁴

While rooted in legal theory, notions of healing and the need for material change to improve current (health) conditions should also resonate for medical and public health professionals.

This approach, of course, requires some familiarity with the history of the US relationship with Micronesia – starting with the Pacific War, through nuclear testing in the Marshall Islands during the Trust Territory, to its continued use for weapons development. Into the 1960s, the US government conducted human radiation experiments on Marshallese without their knowledge or consent.¹⁵ Of the Micronesian peoples, it is clearly the Marshall Islanders that have suffered the greatest injustices. Yet in the post-war period, all of the Trust Territory was entrusted to the United States with the

understanding that it would develop the islands’ infrastructures, health, and education systems. Under the current Compact agreements, the United States continues to benefit from its unfettered use and control of the region militarily.

Because it was the United States as a nation that utilized and continues to utilize Micronesia for its strategic ends, many in Hawai‘i believe that the State has been unfairly shouldered with a national burden. However, a social healing through justice approach calls for engagement by all groups – victims, perpetrators, those harmed by and those benefiting from the injustices – in a process of recognition, responsibility, reconstruction, and reparation.

The modern reparations perspective would demand not only that we ensure the health of people from the Compact Nations in the United States, but that we continue to engage in healing all aspects of the legal, social and interpersonal relationships stemming from past political agreements. Many Micronesians think so themselves. At a rally at the State Capitol in August 2009, a Marshallese woman described being a child as nuclear fallout “rained down” on her, then declared, “The United States has an obligation after what they’ve done to us,” and “We have earned the right to be here. I have earned the right to Med-QUEST.”

A reparations approach that embraces “social healing through justice” elements moves us away from the traditional reparations argument that confines us to monetary compensation for the effects of nuclear testing in the Marshall Islands. Practitioners (including doctors and lawyers), policy-makers, and community members who wish to engage in a social healing through justice process should spend time learning and sharing the history of burdens and advantages – on both “sides” – and discussing the impact on the health, education, and employment of COFA residents in Micronesia and Hawai‘i. This approach would enhance subsequent litigation and legislative BHH advocacy by creating a framework to link history to current health issues, and to engage the greater community in social healing through doing justice.

Political Education and Community Mobilization

Appeals to the US legal responsibility for Micronesia under the Trust Territory or the Compacts carry little weight these days in Washington, DC. When he was in the House of Representatives, Hawai‘i’s current Democratic governor (since December 2010), Neil Abercrombie inserted into the House version of the health reform bill language reinstating Medicaid for people from the Compact Nations. It did not make it in the final version of the law, however. Given the current push to cut federal spending, we cannot expect much relief from the US Congress.

In Hawai‘i, funding for Med-QUEST for people from the Compact Nations competes with everything else that receives state funding. Although the citizens of Hawai‘i are generally welcoming of newcomers, in these times everyone is struggling to make ends meet. Faced with continuing budget constraints as governor, Neil Abercrombie has said that he will not take Med-QUEST away from Micronesians, but that his administration will appeal Judge Seabright’s decision because it involves entitlements.

Since the State will always pose competing financial and social interests against each other during lean economic times, and judicial oversight may only address the narrow legal issues raised, communities must also engage in community organizing and public

education to present what is at stake for the general public. During the BHH struggle, the Micronesian community in Hawai'i did just that. They held rallies, testified at public hearings, hosted fundraisers and shared their stories in the media. They also engaged a larger group of non-Micronesian allies to frame their situation in its proper historical and political context.

In some respects, the Micronesian community in Hawai'i engaging in key community organizing to bring context and a face to the narrow legal issues — in a manner reminiscent of the Japanese American redress movement, where community organizing and public education were not an afterthought but a key element of the legal redress strategy. Legal scholars Eric Yamamoto and Susan Serrano state, “the real bulwark against governmental excess and lax judicial scrutiny, then, is political education and mobilization, both at the front end when laws are passed and enforced and at the back end when they are challenged in courts.”¹⁶ Further, they state:

In today's climate [post Sept. 11] of fear and anger, our first task in protecting both people and key democratic values is to be pro-active at the front end.... We need to organize and speak out.... We need to mobilize and raise challenges.... Through political analysis, education and activism, our job is to compel powerful institutions, particularly the courts, to be vigilant, to “protect all.” Our second task is to be assertive at the back end—to call out injustice when it occurs, to spell out the damage it does to real people in our midst and to our constitutional democracy, and to demand accountability to principles of equality and due process.¹⁷

In the real world, therefore, it was not treaty obligations or federal legislation that reinstated Med-QUEST for people from the Compact Nations. Rather, it was a legal appeal to constitutional rights, alongside community mobilization and collaborative practice.

Health and Human Rights

Judge Seabright's decision, which references cases of immigrant rights in other states, reminds us that the struggle of the Micronesian community in Hawai'i has parallels to that of immigrant communities across the nation. Anti-immigrant forces are wont to decry public assistance given to immigrants. Immigrants and their advocates point to the contributions that immigrants make to society — particularly to the fact that immigrants often perform the work that others do not want. In Hawai'i, many Micronesians work as janitors, dishwashers, hotel housekeepers, parking lot attendants, and fast food servers. Their struggle for acceptance by the wider community parallels that of other ethnic groups that immigrated to Hawai'i in generations past. Micronesian children go to school with everybody else's children. Their parents want them to stay out of trouble and to have better lives than their own. It is only a matter of time before families become intertwined in the way that ethnicities have always mixed in Hawai'i.

Whether or not federal funding for health care for Micronesians is forthcoming, the compelling reason for Micronesians to be included in Med-QUEST are the simple premises that health is a human right, and all humans should be included “under the rubric ‘human.’”¹⁸ The first clause of Article 25 of the Universal Declaration of Human Rights, adopted by the United Nations in 1948, reads,

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.¹⁹

In the end, it comes down to this: What does it say about us who live in Hawai'i to deny health care to people in our midst, to allow people in our midst to fall ill and die? While we need to continue to press the case that all people should have the human right to health²⁰ — it is an uphill battle.

Conclusion

In conclusion, we suggest that those of us in law, medicine, and public health take a social justice approach — one that is geographically broad and historically deep. Serious study of large-scale historical and social forces will reveal that we have many commonalities. We should call for reparations where they are appropriate. We should work to spread the idea of health as a human right. We should utilize the legal and public policy frameworks alongside political education and community mobilization to ensure the people's health. We should do all of this in the context of “doing justice.”

Disclosure Statement

The authors declare that they do not have any conflict of interest in the matters discussed in this article.

List of Abbreviations

BHH — Basic Health Hawai'i (the State-funded program on which Micronesians in Hawai'i were enrolled July-December 2010)
CNMI — Commonwealth of the Northern Marianas Islands
COFA — Compact of Free Association
DHS — State of Hawai'i Department of Human Services
FAS — Freely Associated States
FSM — Federated States of Micronesia
Med-QUEST — Hawai'i's managed care Medicaid program for the non-elderly, non-disabled. “QUEST” stands for: “Quality care, Universal access, Efficient utilization, Stabilizing costs, and Transforming the way health care is provided.”
RMI — Republic of the Marshall Islands
ROP — Republic of Palau
TTPI — Trust Territory of the Pacific Islands

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References

1. Johnson G. Flooding forces hundreds into shelters in Majuro. *Marianas Variety*. December 18, 2008. http://www.mvarietynews.com/index.php?option=com_content&view=article&id=13374:flooding-forces-hundreds-into-shelters-in-majuro&catid=3:pacific-islands&Itemid=43. Accessed December 13, 2009.
2. Hezel FX. High water in the low atolls. *Micronesian Counselor*. 2009; 76:15. <http://www.micsem.org/pubs/counselor/frames/highwaterfr.htm>. Accessed December 13, 2009.
3. Hammond M, Filibert C. *A study of individual and families in Hawaii from the FAS, RMI and other Northern Pacific Islands*. Honolulu: Pacific Educational Resources in Learning (PREL); 2007.
4. U.S. Census Bureau. *2008 Estimates of Compact of Free Association (COFA) migrants*. Washington DC: Author; 2009.
5. LaFrance A. Legal aliens. *Honolulu Weekly*, February 25, 2009. <http://honoluluweekly.com/cover/2009/02/legal-aliens/>. Accessed December 13, 2009.
6. State of Hawaii, House of Representatives. H.C.R. NO. 158. http://www.capitol.hawaii.gov/session2009/bills/HCR158_.pdf. Accessed December 13, 2009.
7. State of Hawai'i Department of the Attorney General. *Final Report of the Compacts of Free Association Task Force*. Honolulu: Department of the Attorney General; 2008.
8. Pacific Business News. Hawaii noncitizens get new insurance plan. *Pacific Business News*. July 28, 2008. <http://www.bizjournals.com/pacific/stories/2009/07/27/daily20.html>, Accessed August 30, 2011.

9. Rogers B, Dunne E. Treatment of COFA residents intolerable. *Honolulu Advertiser*. March 1, 2010; A6.
10. *Ibid.*, A6.
11. Riklon S, Alik W, Hixon A, Palafox NA. The "Compact impact" in Hawaii: focus on health care. *Hawaii Med J*. 2010 69(supp 3):7-12.
12. Geminiani V, Ostrowski DM. Litigation in Federal and State Courts in Hawaii Preserves Critical Health Care for Micronesians. *Clearinghouse Review*. 2011;May-June.
13. Korab v. Koller, Civ. No. 10-00483 JMS/KSC, Order Granting Plaintiffs' Motion for Preliminary Injunction. December 13, 2010.
14. Yamamoto E, Kim SHY, Holden AM. American Reparations Theory and Practice at the Crossroads. *California Western Law Review*. 2007;44(1):1-85.
15. Yamada S. Cancer, reproductive abnormalities, and diabetes in Micronesia: the effect of nuclear testing. *Pacific Health Dialog*. 2004;11(2):216-21.
16. Yamamoto E, Serrano SK. The Loaded Weapon. *Amerasia J*. 2001;27(3)/2001:28(1):51-62.
17. *Ibid.*
18. Farmer P. *Pathologies of Power*. University of California Press, Berkeley, CA, 2003.
19. The Universal Declaration of Human Rights. <http://www.un.org/en/documents/udhr/>. Accessed July 18, 2011.
20. Saunders A, Schiff T, Rieth K, Yamada S, Maskarinec GG, Riklon S. Health as a Human Right: Who is Eligible? *Hawaii Med J*. 2010;69(supp 3):4-6.