Overview of Marshallese Community History

- Marshallese in Arkansas
  - ~10,000-14,000 Marshallese in Arkansas
  - Largest Marshallese population in the continental US
- Marshallese History
  - From 1946 through 1958, the US military tested nuclear weapons
  - Tests were equivalent to 7,200 Hiroshima-sized bombs
  - The largest test, carried out on March 1, 1954, had a yield of 15 megatons (over 1,000 times the strength of the bomb dropped on Hiroshima) and exposed Marshall Islanders to significant levels of nuclear radiation
  - US missile defense and missile testing program currently leases 12 islands in the Republic of Marshallese Islands and is home to the Ronald Reagan Ballistic Missile Defense Test Site located on Kwajalein Atoll
  - Compact of Free Association in 1986 allows Marshallese to live, work, and study without a visa or permanent resident card
Geographic Location of the Marshall Islands
US Marshallese Health Disparities

- Disproportionately high rates of diabetes
  - 25% to 40% for Marshallese adults compared to 9% for the US population and 4% worldwide
- Disproportionately high rates of infectious disease
- Marshallese mothers in the US also have high rates of low birth weight babies (8.4%) and preterm birth (18.8%)
- Marshallese individuals often postpone healthcare services until their disease or condition reaches a crisis stage
Restricted Access to Healthcare Worsens Health Disparities

• In 1996, as part of welfare reform, Marshallese and other COFA migrants were excluded from Medicaid and Children’s Health Insurance Program (CHIP)

• Benefits incrementally restored for other legal immigrants; however, Marshallese continue to be excluded

• Many Marshallese individuals lack access to even the most basic healthcare services

• Affordable Care Act expanded healthcare coverage for many, but COFA migrants are not included in Medicaid expansion
Methods

- Qualitative design explores how Marshallese interpret the ACA and related health policies.
- Research Questions: For Marshallese living in Arkansas,
  - What is their understanding of, and what are their experiences with, the ACA and related health policies?
  - What effect do the ACA and related health policies have on the community’s health?
- Semi-structured interview guide developed with input from community stakeholders.
- Bilingual research staff conducted focus groups and interviews.
Participants

• Inclusion Criteria
  • 18 years of age or older
  • Self-reported as Marshallese
• 5 Focus Groups; 3 individual interviews
• N = 48
• Completed brief survey to capture demographic information prior to focus groups/interviews
<table>
<thead>
<tr>
<th>Response Category</th>
<th>N</th>
<th>Percent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-24 years of age</td>
<td>3</td>
<td>6.5</td>
</tr>
<tr>
<td>25-30 years of age</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td>31-40 years of age</td>
<td>9</td>
<td>19.6</td>
</tr>
<tr>
<td>41-50 years of age</td>
<td>17</td>
<td>37.0</td>
</tr>
<tr>
<td>51-60 years of age</td>
<td>9</td>
<td>19.6</td>
</tr>
<tr>
<td>61-70 years of age</td>
<td>4</td>
<td>8.7</td>
</tr>
<tr>
<td>71 years of age and above</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Annual Income</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Below $10,000</td>
<td>17</td>
<td>37.0</td>
</tr>
<tr>
<td>$10,000-$20,000</td>
<td>10</td>
<td>21.7</td>
</tr>
<tr>
<td>$20,000-$30,000</td>
<td>14</td>
<td>30.4</td>
</tr>
<tr>
<td>$30,000-$40,000</td>
<td>3</td>
<td>6.5</td>
</tr>
<tr>
<td>$40,000-$50,000</td>
<td>2</td>
<td>4.3</td>
</tr>
<tr>
<td><strong>Do you have health insurance?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25</td>
<td>54.3</td>
</tr>
<tr>
<td>No</td>
<td>21</td>
<td>45.7</td>
</tr>
<tr>
<td><strong>Do you have a primary doctor for your family’s health needs?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>21</td>
<td>45.7</td>
</tr>
<tr>
<td>No</td>
<td>25</td>
<td>54.3</td>
</tr>
</tbody>
</table>

Note: Percentages are based on number of responses for each item.
Results

• Themes and Sub-themes
  • Content analysis revealed six primary themes (three a priori and three emergent)

• A Priori Themes
  • Understanding
  • Experience
  • Effect

• Emergent Themes
  • Relational/Historical Lenses
  • Economic Contribution
  • Plea
Table 2. Themes and Sub-themes

<table>
<thead>
<tr>
<th>A Priori Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| **1) Understanding.** Participants’ understanding of the ACA and related policies | • Lack of understanding  
• Lack of understanding due to poor follow up  
• Lack of understanding about premiums, co-pays, and who accepts their insurance  
• Lack of understanding and frustration about tax penalties |
| **2) Experience.** Participants’ experiences with ACA and related policies | • Some get approved and some do not  
• The ACA is not affordable  
• Improving the experience |
| **3) Effect.** Participants’ description of how the ACA and related policies’ effect participants/community health | • Health status  
• Treatment differences |

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
</table>
| **4) Relational/Historical Lenses.** Participants’ view of policies in relation to the Compact of Free Association, U.S. nuclear testing, use of their land, and the current relationship with the U.S. military | • Friendship agreement  
• Nuclear testing  
• Value of land  
• Military Service |
| **5) Economic Contribution.** Participants’ view of the policies in relation to participant contributions to state and federal taxes and the local economy | |
| **6) Plea.** Participants’ discuss desire to have their voices and experiences heard and their culture’s method of advocacy | • Hear our voices  
• Culture and advocacy  
• Good friends |
Experience:
Participants’ experiences with ACA and related policies

• Some Marshallese get approved and some do not:
  • “When we visit a doctor the clinic says the cards are not acceptable, and then when we ask why and are told that it is because we are not citizens, so the question is, why were we given insurance and the cards in the first place? ... What’s worse is that after they have collected all our personal information and our social security numbers, date of births, they tell us they are not approved because of our status. I’ve tried many times to apply and I just gave up. I don’t want to try anymore.”
Effect:
Participants’ descriptions of how the ACA and related policies effect community health

• Health Status:
  • “For me, it’s not good because for someone diagnosed with diabetes, sometime I don’t take my medication as I’m suppose because I can’t afford to buy [the medication]. Because I’m not working, and it’s hard to stay healthy when there is little resources to get the help we need. It’s just not healthy.”
Relational/Historical Lenses: Participants’ view of policies in relation to COFA, nuclear testing, use of their land, and relationship with the US military

• Friendship Agreement:
  
  “... everything is different and harder here [in the US]. What I don’t understand, that is mind boggling, is that back in the Marshall Islands, health care is fully funded by the US government, but it is not the same when we are physically here in America. I thought since there was an agreement between my country and the United States, and they [the US] used our lands for nuclear testing that they would help in some ways, but I guess that’s not how they do things here.”
Economic Contribution: Participants’ view of policies in relation to their contributions to taxes and the economy

- “[Marshallese COFA migrants] generate revenue to the city, generates to the state, and to the federal, and now that you actually reside here, they make these our barriers or issues. You don’t qualify for this and that, you can’t because you are Marshallese. Well, I believe that is called being discriminated against.”
6) **Plea:**
Participants’ discuss their desire to have their voices and experiences heard and their culture’s method of advocacy

- **Hear Our Voices:**
  “By recording our voices and discussions today so that Arkansas can recognize us and open these opportunities to us ... That’s why we represent, as our saying goes, Jepilpilin ke ejukaan (interpreted as ‘accomplishment through joint effort’). We’re here now and we’re the voice of the community. And by voicing our discussions through the recorder, it will show our issues.”
Discussion

• Marshallese COFA migrants’ exclusion from Medicaid significantly impacts the health of low income families

• Those who are economically eligible for Medicaid cannot afford private insurance premiums, but face tax penalties

• Significant barriers are present for those who attempt to apply for insurance under the ACA

• Marshallese see the COFA as a compact of friendship being honored by them, but not by the US

• Interviews revealed frustration and dismay that the US is not honoring the agreement; they remain gracious, humble, and kind in their attempts to voice their frustrations, rather than demanding their rights
Recommendations for Policy and Practice

• Federal Level
  • Restore Medicaid eligibility for all COFA migrants

• State and Local Level
  • Additional training for staff who process ACA applications and enrollment on COFA migrants’ status and eligibility
  • Employ more bilingual in-person assistors and navigators to be located in Marshallese/COFA migrant communities
  • Provide print and online bilingual fact sheets to COFA migrants throughout the US
Questions?