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Attorneys for Plaintiffs

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI`I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated,

Plaintiffs,

vs.

PATRICIA MCMANAMAN, in her official capacity as Interim Director of the State of Hawai`i, Department of Human Services, and KENNETH FINK, in his official capacity as State of Hawai`i, Department of Human Services, Med-QUEST Division Administrator,

Defendants.

CIVIL NO. 10-00483 JMS-KSC
[Civil Rights Action]
[Class Action]

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS; MEMORANDUM IN SUPPORT OF MOTION; DECLARATION OF CASMIRA AGUSTIN; DECLARATION OF ANTONIO IBANA; DECLARATION OF RENATO MATEO; DECLARATION OF AGAPITA MATEO; DECLARATION OF J. BLAINE ROGERS; EXHIBITS "G" – "J"; CERTIFICATE OF SERVICE

PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS

Plaintiffs CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of those similarly situated, by and through their counsel Lawyers for Equal Justice, Alston Hunt Floyd & Ing, and Bronster Hoshibata, hereby move this Court for entry of a

preliminary injunction prohibiting the State of Hawai`i, Department of Human Services ("DHS") from (1) excluding resident aliens lawfully in the United States for less than five years ("New Residents"), from State health benefit programs that are available to citizens of the United States and other residents of Hawai`i, and (2) enrolling New Residents in Basic Health Hawaii ("BHH"), which provides benefits inferior to those available to other Hawai`i residents under other DHS-administered programs.

Plaintiffs seek this relief because DHS's policy of refusing to allow New Residents access to the same health benefit programs as United States citizens violates the Equal Protection clause of the Fourteenth Amendment of the U.S. Constitution by discriminating against New Residents on the basis of alienage. This policy should be undone. Plaintiffs ask this Court to order DHS to allow New Residents to enroll in DHS-sponsored health benefit programs (*e.g.*, QUEST, QUEST-Net, QUEST-ACE, QExA, SHOTT) for which they would be eligible but for their alienage and immigration status.

This Motion is brought pursuant to Rules 7 and 65 of the Federal Rules of Civil Procedure and is supported by the attached memorandum, declarations, and exhibits and by such additional matters as may be presented to this Court at hearing.

DATED: Honolulu, Hawai`i, April 28, 2011.

/s/ J. Blaine Rogers

VICTOR GEMINIANI
PAUL ALSTON
J. BLAINE ROGERS
ZACHARY MCNISH
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CATHERINE L. AUBUCHON
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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI`I

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MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

FEDERAL CASES

DOCKETED CASES

FEDERAL STATUTES

HAWAI`I ADMINISTRATIVE RULES

MEMORANDUM IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION RE: NEW RESIDENTS

I. INTRODUCTION

This Court has already held that Defendants unlawfully discriminated against immigrants in violation of the Equal Protection Clause of the U.S. Constitution by denying them access to State health benefits on the basis of alienage. Notwithstanding this ruling, Defendants have continued enforcing their discriminatory policies against lawful aliens who have been U.S. residents for less than five years ("New Residents"). By this Motion, Plaintiffs seek an injunction halting these unconstitutional acts and forcing Defendants to allow New Residents to enroll in the same State-funded health benefits programs available to citizens.

II. FACTS

A. Health Services For New Residents

Until 1996, New Residents were eligible for health care under Medicaid, which provides federal funding for state medical services to the poor, disabled, and others in need. 42 U.S.C. §§ 1396 *et seq*. The Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") of 1996, however, eliminated all federal health care coverage for all non-qualified aliens, 8 U.S.C. § 1612(a)(1), and to those legal aliens who have resided in the United States for less than five years, 8 U.S.C. § 1613. Essentially, PRWORA rendered aliens like New Residents ineligible for Federal Medicaid benefits. However,

PRWORA did not restrict states from providing health care programs for certain aliens – including New Residents – with state funds. 8 U.S.C. § 1622.

From 1997 to July 2010, the State of Hawai`i chose to provide health coverage under its own, state-funded health programs to certain classes of aliens. For example, DHS provided health coverage to COFA Residents by enrolling them in the Other Programs, under which they received benefits the same as those provided to other U.S. citizens. *Korab v. Koller*, Civ. No. 10-00483 JMS/KSC, 2010 WL 4688824, at *2 (D. Haw. Nov. 10, 2010). However, DHS did not provide health coverage under the Other Programs to New Residents. Exhibit "H" at 5.[1]

Instead, the State opted to provide medical coverage to New Residents who were not eligible for federally-funded medical assistance through a state-funded Hawaii Immigrant Health Initiative ("IHI"). Although some of the services provided through IHI included primary care, specialty care, and prescription drugs, IHI did not include emergency or inpatient care. Exhibit "I". IHI did not provide the same level of benefits as the more extensive Other Programs.

[1] Exhibits that were originally attached to *Plaintiffs' Motion for Preliminary Injunction*, filed September 13, 2010 (Doc. 10, "First PI Motion"), are attached again here with their original identifiers for the Court's convenience.

In 2010, the New Residents were rendered ineligible under IHI as a result of Defendants' decision to deem some of them into an even more inadequate health benefits program, BHH. In implementing BHH, Defendants specifically targeted New Residents because of their alienage and immigrant status. Hawaii Administrative Rules ("HAR") § 17-1714-2 and § 17-1722.3-7 (describing BHH as a medical assistance program administered by DHS for, *inter alia*, "legal permanent residents who have resided in the United States for less than five years" and deeming any "alien who is not eligible for federal medical assistance and is . . . a legal permanent resident" into the BHH program).

BHH provides only a minimal array of benefits, such as

- no more than ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment;
- a maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions;
- maximum coverage of six mental health visits, limited to one treatment per day; and

- a maximum of four medication prescriptions per calendar month, which "shall not exceed a one-month supply."

HAR § 17-1722.3-18. BHH also does not have any special provisions related to cancer treatments, nor are such treatments covered as an emergency service. Among the exhaustive list of items excluded from BHH coverage are transportation services upon which many elderly, seriously ill, and disabled residents rely to get to and from doctors' visits. HAR § 1722.3-19.

In contrast, DHS's QUEST and QExA programs, from which New Residents are excluded, provide significantly greater benefits than BHH or IHI, and obviously greater benefits than being uninsured. Both QUEST and QExA provide comprehensive medical and behavioral health and unlimited prescription drugs. The QExA program also delivers medical and behavioral health services to certain individuals who are aged, blind or disabled.

BHH also has a 7,000 person statewide enrollment cap, with open enrollment only when enrollment drops below 6,500. HAR § 17-1722.3-10. However, approximately 7,000 COFA Residents were already receiving state-funded medical assistance as of May 31, 2010. Exhibit "J". Eligible COFA Residents, after being disenrolled from the Other Programs, were "deemed into"" BHH without regard to the enrollment cap. HAR § 17-1722.3-33; Exhibit "H".

Because the current enrollment exceeds the cap by 20% or more, however, there is no chance of open enrollment for most New Residents in the foreseeable future.

B. The Effect of the Defendants' Discriminatory Policy on New Residents

In light of their limited coverage or uninsured status, New Residents with serious illnesses do not know if, when, or from where they will be able to get preventative care, essential medical treatment, and an adequate supply of prescription drugs. There are numerous compelling examples of the deleterious effects of Defendants' discriminatory policy on New Residents.

For example, Plaintiff Casmira Agustin ("Agustin"), a lawful permanent resident of the U.S since 2009, and originally from the Philippines, was diagnosed with severe abdominal pain and a cystic mass on her ovary in February of 2010. Agustin Decl. ¶ 8. After applying for insurance coverage under Med-QUEST for a one-time emergency service, Agustin underwent surgery at Kapiolani Women's and Childrens Hospital. *Id.* ¶¶ 11, 13. In April of 2010, however, Agustin received a notice from the DHS Med-Quest Division stating that she was denied medical coverage because of her failure to meet citizen or alienage criteria, and further, that she was ineligible for emergency medical assistance for aliens. *Id.* ¶ 21. Thus, Augustin became liable for over $50,000 in medical bills resulting from the surgery at Kapiolani. *Id.* ¶ 22.

Plaintiff Antonio Ibana ("Ibana"), also from the Philippines, came here in August 2010 to join his family. Ibana Decl. ¶¶ 2-3. Due to his diabetes, he began to experience severe complications with his eyes, and applied for medical coverage under Med-QUEST. *Id.* ¶ 9. Med-QUEST denied Ibana medical and emergency coverage based on his alienage and immigration status, and Ibana was therefore forced to forego treatment on his eyes. *Id.* ¶¶ 12-13. As a result, Ibana awoke to bleeding in his right eye a few months later and he has been informed by doctors that his condition will not improve unless he gets surgery. *Id.* ¶ 18. It is possible that Ibana will go blind without appropriate treatment. *Id.* ¶¶ 10, 21. Ibana cannot afford this surgery. *Id.* ¶¶ 20-21.

Plaintiffs Agapita Mateo ("A. Mateo") and Renato Mateo ("R. Mateo") came from the Philippines in September of 2006, and are lawful permanent residents of the U.S. A. Mateo Decl. ¶ 3; R. Mateo Decl. ¶ 3. A. Mateo has diabetes and needs to take daily insulin. A. Mateo Decl. ¶ 7. In January of 2007, her husband R. Mateo was diagnosed with colon cancer. R. Mateo Decl. ¶ 7. Although R. Mateo had coverage from his work insurance for the surgery to remove the tumor, he was unable to work following the surgery and subsequently lost his insurance. *Id.* ¶ 12. His follow-up chemotherapy treatments and other

follow-up treatments cost more than $1,300 per month. *Id.* They struggled to make ends meet in order to pay these medical bills. *Id.* ¶ 14.

In June of 2009, R. Mateo's cancer returned and spread to his liver. R. Mateo Decl. ¶ 17. Although by this time R. Mateo had gotten a new job, he was terminated prior to a second surgery, thus ending his health coverage. *Id.* ¶ 22. Eventually, the Mateos were unable to afford even the COBRA payments, their insurance policy was cancelled, and the Mateos began to rely on friends and family for money and food. *Id.* ¶ 24. As a result, R. Mateo was unable to get his required chemotherapy treatment. *Id.* ¶ 26. Although the Mateos applied for state-funded health coverage, they were denied in March of 2011 because R. Mateo did not satisfy BHH's citizenship or alienage status. *Id.* ¶ 31.

C. Procedural Background

Plaintiffs filed their initial Complaint on August 23, 2010. On September 9, 2010, Defendants filed their *Motion to Dismiss* (Doc. 8). On September 13, 2010 Plaintiffs filed the First PI Motion. Although the briefing addressed Plaintiffs' claims as they related to New Residents, the parties agreed at the November 2, 2010 hearing that the Court would limit its analysis to COFA Residents only.

On November 10, 2010, this Court issued an *Order Denying Defendants' Motion to Dismiss for Failure to State a Claim Upon Which Relief*

May Be Granted As to COFA Residents (Doc. 30, "First Order"). On December 13, 2010, this Court granted the First PI Motion. *Order Granting Plaintiffs' Motion for Preliminary Injunction*, issued December 13, 2010 (Doc. 42, "Second Order") (together with the First Order, the "Orders"), at 3. Together, the Orders clearly held that Defendants' discriminatory policy of denying benefits under the Other Programs based on alienage or immigration status was subject to heightened scrutiny and, absent compelling justification, violated clearly established constitutional rights.

III. ARGUMENT

A. Standard For Granting Preliminary Injunctive Relief

A party seeking a preliminary injunction must demonstrate that he is likely to succeed on the merits, that irreparable harm is likely in the absence of preliminary relief, that the balance of equities tips in favor of such relief, and that an injunction is in the public interest. *Winter v. Natural Res. Def. Council*, --- U.S. ----, 129 S.Ct. 365 (2008); *Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009). A preliminary injunction is also appropriate when the moving party demonstrates "that serious questions going to the merits [are] raised and the balance of hardships tips sharply in the [moving party's] favor," so long as that party can establish the other factors established by the Supreme Court in *Winter*, including the likelihood of irreparable harm. *Alliance for Wild*

Rockies v. Cottrell, --- F.3d ----, No. 09-35756, 2010 WL 2926463, at *7 (9th Cir. July 28, 2010). "In other words, 'serious questions going to the merits' and a hardship balance that tips sharply toward the plaintiff can support issuance of an injunction, assuming the other two elements of the Winter test are also met." *Id.*

A mandatory injunction is not granted unless "extreme or very serious damage will result and are not issued in doubtful cases or where the injury complained of is capable of compensation in damages." *Marlyn Nutraceuticals, Inc. v. Mucos Pharma GmbH & Co.*, 571 F.3d 873, 879 (9th Cir. 2009) (quoting *Anderson v. United States*, 612 F.2d 1112, 1114 (9th Cir. 1980)).

B. Plaintiffs Will Prevail On The Merits Of Their Equal Protection Claim

The Fourteenth Amendment provides that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." The Equal Protection Clause "keeps governmental decision makers from treating differently persons who are in all relevant respects alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992). The term "person" in the equal protection context "encompasses lawfully admitted resident aliens as well as citizens of the United States and **entitles both citizens and aliens to the equal protection of the laws of the State in which they reside**." *Graham v. Richardson*, 403 U.S. 365, 371 (1971) (citations omitted; emphasis added).

Here, Plaintiffs will succeed on their constitutional claim because the State's policy of denying New Residents equal access to health insurance programs unjustifiably discriminates in the provision of health care benefits based on alienage and immigrant status, in violation of the Equal Protection Clause.[2]

1. This Court Has Already Held that the State's Denial of Equal Access for Aliens to State Health Programs Violates the Equal Protection Clause and is Subject to Strict Scrutiny Review

The United States Supreme Court has categorically established that under the U.S. Constitution, classifications based on alienage are inherently suspect and subject to strict scrutiny. *Graham*, 403 U.S. at 371-72 ("[T]he power of a state to apply its laws exclusively to its alien inhabitants as a class is **confined within narrow limits**." (Citations, footnotes, and quotations omitted; emphasis added.)). While *Graham* contemplated that the level of scrutiny might differ from this heightened standard when a state is following federal direction, subsequent case law has confirmed that only in the situation where Congress has established a uniform rule regarding alienage would a state's action in following Congress' mandate be subject to a review other than strict scrutiny. *Graham*, 403 U.S. at

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[2] Plaintiffs may move for class-wide relief before moving to certify a class. *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1114 n.6 (N.D. Cal. 2009); *Brantley v. Maxwell-Jolly*, 656 F.Supp.2d 1161, 1178 n. 14 (N.D. Cal. 2009) ("District courts are empowered to grant preliminary injunctions 'regardless of whether the class has been certified.' ")

382-83; *Plyler v. Doe*, 457 U.S. 202, 219 n.19 (1982) ("[I]f the Federal Government has by uniform rule prescribed what it believes to be appropriate standards for the treatment of an alien subclass, the State may . . . follow the federal direction."); *Sudomir v. McMahon*, 767 F.2d 1456, 1464-66 (9th Cir. 1985) (rational basis test applies when State adopts federal **uniform** rule of classification).

Here, this Court has already decided that (1) the State's health benefit programs classify individuals based on alienage, and (2) that the State's actions are not protected from heightened strict scrutiny, because there was no uniform rule established by PRWORA. First Order at 27-28. Therefore, strict scrutiny applies to the State's discriminatory actions towards New Residents.

Specifically, in the First Order, this Court held that "on its face, the State's health benefit programs appear to classify individuals based on alienage – citizens and qualified residents receive benefits under the Other Programs, while COFA Residents are eligible for BHH only." *Id.* at 17. This conclusion is equally applicable to New Residents – while citizen and qualified residents receive benefits under the Other Programs, New Residents are eligible for BHH only.

After an exhaustive analysis of pertinent case law, this Court then held that PRWORA validly granted states the authority to classify individuals based on alienage in determining eligibility or the State's health benefit programs, and that

this grant of discretion did not "comport[] with the uniformity requirement" under *Plyler* and its progeny. *Id.* at 18, 21. Here, as with COFA Residents, the PRWORA "does not dictate any particular state action as to [New Residents]," and instead "gives states a choice as to whether [New Residents] should be eligible for any state public benefits." *Id.* at 23. Accordingly, PRWORA did not establish a uniform rule because it did "not **require** that Defendants provide lesser benefits to [New Residents] than it does to those qualified under the [Other] Programs." *Id.* at 24.

Thus, this Court's conclusion in the Orders is controlling as to New Residents. "[R]egardless of how Defendants attempt to characterize their actions, Defendants' implementation of the [Other] Programs and BHH classify individuals based on alienage – citizens and certain groups of aliens are eligible to participate in the [Other] Programs, while [New Residents] are eligible to participate in BHH. Because Defendants were not following any uniform rule established by federal law in making these distinctions, these classifications are subject to strict scrutiny." *Id.* at 27-28.

2. The State's Discriminatory Denial of Equal Access to State Health Programs Cannot Pass Strict Scrutiny

Under a strict scrutiny standard, a state must show that the classification is "suitably tailored to serve a compelling state interest." *Cleburne v.*

Cleburne Living Center, 473 U.S. 432, 440 (1985). There is no compelling interest or any tailoring here.

a. Defendants' Discriminatory Policy Towards New Residents Does Not Serve a Compelling Interest

There is no compelling State interest in denying New Residents health benefits provided to other citizens. Defendants have no particular interest in denying equal access to State health programs to New Residents besides cutting costs, which the Supreme Court has explicitly held is a "particularly inappropriate and unreasonable" ground upon which to base an alienage classification. *Graham*, 403 U.S. at 376; *Mathews v. Diaz*, 426 U.S. 67, 85 (1976) ("Insofar as state welfare policy is concerned, there is little, if any, basis for treating persons who are citizens of another State differently from persons who are citizens of another country. Both groups are noncitizens as far as the State's interests in administering its welfare programs are concerned." (Footnote omitted.)).

Moreover, any cost savings as a result of denying health benefits to New Residents are only short term and may be entirely ephemeral. Cuts in coverage for preventative and acute care will, in fact, end up costing the State more money as persons who are denied preventative care suffer serious—and costly—medical emergencies for which the State would normally have to pay.

b. Defendants' Discriminatory Policy Towards New Residents Is Not Narrowly Tailored

There is also no indication that DHS "narrowly tailored" the BHH rules or its discriminatory policy to achieve the goals of the legislature. Suspect classifications like race, alienage, and ancestry "are simply too pernicious to permit any but the most exact connection between justification and classification." *Gratz v. Bollinger*, 539 U.S. 244, 270 (2003) (internal quotation marks omitted). There are several factors that are relevant in determining whether a suspect classification is narrowly tailored, including "the efficacy of alternative remedies," and "the flexibility and duration of the relief." *Western States Paving Co., Inc. v. Washington State Dept. of Transp.*, 407 F.3d 983, 993 (9th Cir. 2005) (citing *United States v. Paradise*, 480 U.S. 149, 171 (1987)).

There is no evidence that Defendants adequately considered alternatives to their discriminatory policies. For example, DHS has done nothing to ensure that existing patients or previously disenrolled patients with disabilities or with serious medical conditions will get the long-term or critical care that they need. Nor does it appear that DHS examined the programs administered by Med-QUEST as a whole when considering other possible cost-cutting measures.

Moreover, there is no indication that DHS has any plan on how to handle the dire consequences that have resulted and will continue to result from its

discriminatory policies. Nor is there any indication that DHS has been assisting the various medical providers currently providing medical services to New Residents despite their lack of health coverage. Neither good conscience nor strict scrutiny countenance Defendants' actions (or lack thereof).

At minimum, Plaintiffs have shown a likelihood of success on their equal protection claim.

C. Plaintiffs Face Irreparable Injury

The reduction or elimination of public medical benefits irreparably harms persons who cannot participate in these programs. *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982) (holding that possibility that plaintiffs would be denied Medicaid benefits sufficient to establish irreparable harm); *Cota v. Maxwell Jolly*, 688 F. Supp. 2d 980, 997 (N.D. Cal. 2010) ("the reduction or elimination of public medical benefits is sufficient to establish irreparable harm to those likely to be affected by the program cuts); *Newton-Nations v. Rogers*, 316 F. Supp. 2d 883, 888 (D. Ariz. 2004) (citing *Beltran* and finding irreparable harm shown where Medicaid recipients could be denied medical care as a result of their inability to pay increased co-payment to medical service providers); *Edmonds v. Levine*, 417 F. Supp. 2d 1323, 1342 (S.D. Fla. 2006) (finding that state Medicaid agency's denial of coverage for off-label use of prescription pain medication would irreparably harm plaintiffs).

Here, there is abundant evidence New Residents have been and will continue to suffer significant harms to their health and physical well-being without equal access to the Other Programs. R. Mateo Decl. ¶¶ 27-29; A. Mateo Decl. ¶¶ 7, 19, 21-22, 27-30; Agustin Decl. ¶¶ 8-12; and Ibana Decl. ¶¶ 5, 13, 18, 21. As a result, New Residents are forced to reduce the amount of critical medical services they use. For some, like Mr. Agustin, this will lead to diminished health over the course of a few years; for others, like R. Mateo, death could happen in a matter of weeks or months. In addition, it is well established that patients denied preventative and routine care also face irreparable injury in the form of late diagnosis and potentially irreversible health consequences.[3]

Finally, the threat of harm here is broad. Patients forced to seek health care and expensive life-saving treatments at emergency rooms and through health providers willing to accept uninsured patients will impose significant financial burdens on these entities and the health care system as a whole. Exhibit "G".

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[3] American Cancer Society; Eddy D: Guidelines for the Cancer Related Checkup; CA-A Cancer Journal for Clinicians 1980; 30:194-237 (emphasizing the importance of preventative care in reducing potentially irreversible health consequences and late diagnosis of disease); Medical Practice Committee, America College of Physicians: Ann Intern Med 1981: 95:729-732 (same); U.S. Preventative Services Task Force, Guide to Clinical Preventative Services, (2d Ed. Williams & Wilkins 1996) (same).

The threat of harm to New Residents is immediate and significant. Defendants' claimed cost savings are a mirage.

D. The Balance of Equities Favors Plaintiffs

Plaintiffs will suffer grave irreparable harms if a preliminary injunction is not granted, whereas DHS will suffer only minimal harms and will arguably benefit by allowing New Residents to enroll in the Other Programs. Accordingly, the equities favor an injunction.

In addition to the medical harms that have and will befall them, New Residents have faced – and will continue to endure – financial and emotional injuries. It is indisputable that without access to State health programs, New Residents will suffer physically. R. Mateo Decl. ¶¶ 27-29; A. Mateo Decl. ¶¶ 7, 19, 21-22, 27-30; Agustin Decl. ¶¶ 8-12; and Ibana Decl. ¶¶ 5, 13, 18, 21. Additionally, Plaintiffs will suffer financially. New Residents have low, if any, income. The meager funds they have are quickly depleting or have already been exhausted. R. Mateo Decl. ¶¶ 23-25, 35; A. Mateo Decl. ¶¶22- 23, 31-33; Agustin Decl. ¶ 23; Ibana Decl. ¶¶ 9, 11, 22. The financial burden is tremendous.

New Residents also will suffer immeasurable emotional harms. The named Plaintiffs have testified to the severe emotional distress that they are already suffering. R. Mateo Decl. ¶¶ 18, 35; A. Mateo Decl. ¶¶ 27-28, 31; Agustin Decl. ¶ 22; Ibana Decl. ¶ 21. Adding to the stress of trying to navigate the complexities of

obtaining medical assistance while seriously ill is the fact that New Residents are often trying to do so in a foreign language. This task is Herculean.

Conversely, the State will not suffer an immense financial injury. In fact, cuts in coverage for preventative and acute care will end up costing the State more money as persons who are denied preventative care suffer serious—and costly—medical emergencies. Palafox Decl. ¶ 14.[4]

If the Court were to order the injunctive relief requested here, the State will be incur the same costs it should have been incurring since its discriminatory policy was implemented. Therefore, the balance of equities tips in favor of the Plaintiffs.

E. A Preliminary Injunction Is In The Public Interest

The public is not served by the State's denial of DHS-sponsored health benefit programs for New Residents. When uninsured patients are forced to seek life-saving treatments in emergency rooms as a result of being deprived of preventative and critical medical care it costs the State, and therefore the tax paying public, more time and money. Emergency room visits are exponentially more costly than outpatient facilities. Palafox Decl. ¶ 13.

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[4] The Palafox Declaration was attached to the First PI Motion.

The general public is likely to suffer from increased waiting times in emergency rooms, and from eventual increases to health care costs necessitated by uncovered treatment of New Residents.

IV. CONCLUSION

Based on the foregoing, Plaintiffs respectfully request that this Court issue a preliminary injunction requiring DHS to allow New Residents to enroll in the Other Programs for which they would be eligible but for their alienage status.

DATED: Honolulu, Hawai`i, April 28, 2011.

/s/J. Blaine Rogers
VICTOR GEMINIANI
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Attorneys for Plaintiffs

DECLARATION OF CASMIRA AGUSTIN

I, **CASMIRA AGUSTIN**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows

2. I am from San Nicolas, Illocos Norte, Philippines. I am fifty two years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai'i since February 2009. My husband and I immigrated to Hawai'i to join my daughter Sherly and her family. Sherly has been living in the United States for over eight years.

4. Before I came to Hawaii in 2009, I did not have any health concerns. I saw my doctor in the Philippines for a complete physical before getting my visa to the United States. He issued a medical certificate to certify my good health.

5. When I first came to Hawaii, I visited KKV for a medical check-up. Usually the costs to see the doctor at KKV would be covered under insurance from the Hawaii Immigrant Health Initiative. That program ended soon after I came to Hawaii, sometime around August 2009.

6. On the night of about February 9, 2010, I started to have severe pain in my abdomen. I went to use the restroom, but I had to call my daughter in to help me. The pain was so severe I could not get up from the toilet, pull up my underwear or even stand to walk.

7. On February 10, 2010, that next morning my daughter brought me to see a doctor in Waipahu because I was in so much pain. The doctor told me that I should be admitted to the Emergency Room because he thought I had acute appendicitis.

8. My daughter brought me to HMC-West emergency room and I was admitted immediately. At HMC-West they did an ultrasound, and they discovered that it was not appendicitis like the doctor thought causing the pain, but a cystic mass ~~bulbic~~ pelvic on my ovary. I was discharged from HMC-West, however, because I did not have health insurance. I was told to follow up with an Ob/Gyn doctor, but they told me to come back to the ER to get medication each day.

9. For the next couple of days my daughter and I called around to find a doctor who could take me though I did not have insurance. We talked to doctors at KKV, but they did not have an opening for an Ob-Gyn appointment until March.

10. I was still experiencing such severe pain, my daughter was worried, so she started to call different hospitals to see if they would take me. Finally, she called Kapiolani Medical Center to ask to see a gynecology doctor. When she explained the situation, they told her to bring me to the ER immediately.

11. On February 12, 2010 I went to the ER at Kapiolani Women's and Children's Hospital. At the ER, my daughter was told that I may be eligible for insurance coverage for Med-Quest for a one time emergency, so we filled out the

application, and I was admitted immediately that same day for surgery to remove the cyst from my right ovary.

12. At Kapiolani, they found out that I had pneumonia and a fever because of the infection on my ovary. They could not perform the surgery while the infection remained. I had to remain in the hospital as an inpatient for three days while they waited for the infection to clear.

13. On February 16, 2010 the doctors at Kapiolani performed surgery to remove the cyst from my ovary. After removal, they found the cyst was not cancerous.

14. I stayed in the hospital two more days to recover from the surgery, and I was discharged from the hospital on February 18, 2010.

15. Soon, the medical bills started to arrive at my house. First we received a bill from HMC-West for my first ER visit.

16. We were billed separately for the ultrasound that was performed at HMC-West, a bill of around $5,000.

17. We received a bill from Kapiolani for the surgery to remove the cyst totaling $48,529.10.

18. The anesthesiologist from the surgery at Kapiolani bills separately, so we also receive a bill from his office of around $1000.00.

19. We had applied on February 12, 2010, and I thought that I would be eligible for the emergency medical insurance through Med-Quest. When the medical bills started coming to our house, I just waited to see if the insurance coverage would come through.

20. I started to pay the anesthesiologist just what I could afford, about $20.00 every month on the bill, just to show them we were not ignoring them. Now I owe him about $800.00.

21. In April I received in the mail a notice from DHS Med-Quest Division dated April 19, 2010 denying medical insurance. The notice said that I did not meet the citizen or alien status requirements and that I was not eligible for the medical assistance under emergency benefits for aliens.

22. I was so worried and I did not know how I would be able to pay for such a costly emergency surgery. I have medical bills that total almost $50,000.00. I called the eligibility worker at KKV to see how I could work out a plan to pay for my medical bills. She helped me apply for charity to help pay for some of the bills.

23. Finally on November 12, 2010 I found out that Catholic Charities had agreed to cover the cost of the surgery at Kapiolani. However, though they covered 100% the cost of my surgery, I do not know how I can afford to pay off

the remaining bills with the anesthesiologist and for my emergency room visit at HMC. Those bills are almost $7,000.

24. I do not have, and cannot pay for, any other medical insurance.

25. I declare under penalty of perjury under the laws of the State of Hawaii and the United States of America that the foregoing is true and correct.

Executed this____th day of March, 2011 in Kalihi, HI.

Casimira Agustin
CASMIRA AGUSTIN

DECLARATION OF ANTONIO IBANA

I, ANTONIO IBANA, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

2. I am a new resident who arrived in Hawaii on August 5, 2010 from Vintar, Illocos Norte, Philippines. I am fifty-two years old.

3. My parents, three brothers and two sisters are all U.S. residents, with my sister and brothers holding U.S. Citizenship. I came with my wife to join my family in the United States.

4. In the Philippines, I worked as a town councilman.

5. I am a diabetic, and must take both oral medication and insulin injections to manage my condition. I take oral medication and an insulin shot three times a day.

6. When I moved to Hawaii, I brought with me as much insulin and medication for my diabetes that I could afford. I brought only about a month supply, as costs to relocate to the U.S. were very high.

7. Late last year, my diabetes began to affect my eyesight. In October 2009, I had laser eye surgery in the Philippines.

8. I began to have problems again with my eyes earlier this month. I went to Kokua Kalihi Valley (KKV). KKV referred me to an eye specialist.

9. I did not have money to pay for the eye specialist. I applied for Med-Quest insurance for new residents. They scheduled me for an interview for August 24, 2010.

10. While I was waiting for my application to Med-Quest, I went to see the eye specialist. He told me my eye condition was very serious and needed immediate attention. He warned me if I did not get surgery, I will go blind.

11. I went ahead with two procedures with my eyes, even though I did not know if I would have medical coverage. I paid the consultation fee of $160 out of my pocket and an extra $100 for those procedures with the eye specialist. I still owe for those two procedures to prepare me for surgery.

12. On the morning of August 24, 2010, right before I was going to leave the house for my interview, a Med-Quest representative called me and told me I did not need to come for my interview, because I was denied insurance coverage. I pleaded with her on the phone to let me come for my interview, or to reconsider, but she would not listen. The Med-Quest agent told me I would only get coverage for medical emergencies.

13. I was scheduled for another procedure with my eye specialist on that same day, August 24th. Instead of going to my eye appointment, I just went to work at McDonalds. I knew I was denied medical insurance, so there was no way I could pay for that procedure.

14. Later on I received a letter of denial in the mail from Med-Quest.

15. With no medical insurance, I decided to go to a community health clinic, Kokua Kalihi Valley. At KKV my doctor checked my eyes, and told me I must see a retina specialist before its too late. I told her I was only going to be covered for medical emergencies. My doctor submitted the paperwork to Med-Quest to get my eye surgery covered as she felt it was an emergency.

16. Later in September, my doctor told me I was denied for emergency surgery coverage for my eyes.

17. Even though I did not have coverage, I went to see the doctor three or four more times.

18. Around February 8, I woke up and I felt a bleeding in my right eye. I could not see clearly, so I went to the doctor. My doctor told me that continued laser treatment would not be effective. He told me again, my condition will not get any better, and I need surgery if my eyes get worse.

19. I have had trouble finding employment in the United States because of my health problems. When I first came, I had a job at McDonalds for five days. I transferred jobs because I knew I would not get continued full time employment. I worked at Utako Japanese Restaurant, but I had to leave the job because the affects on my health. I went back to work at McDonalds, but I still did not get full-time employment. I applied and got a job for G-Force security solutions. I was hired

for temporary employment. I got a call for a job in February, but I could not accept the position because of the problems with my bleeding eyes. Finally, I have found work through a contractor at the Ilikai hotel. I am only employed on an on call basis.

20. I am still unable to afford to see the retina specialists to get the surgery needed to take care of my eye problem. Even though I don't have insurance, I went to see my eye specialist. He was very alarmed with severity of the problems I have with my eyes. The doctor was kind enough to make an arrangement for me to pay what I can afford for my check ups. Right now, my bills are almost $3,000 as of March 7, 2011. I have no insurance to help cover the cost.

21. I am very concerned and worried about my eyesight. I get so desperate thinking that if I do not do something soon, I will go blind. My doctors keep telling me that I need the surgery, but I cannot pay for it, and I do not have health insurance. I have problems finding a job because of my eye problems. I do not know how I can continue to manage my condition with no health coverage.

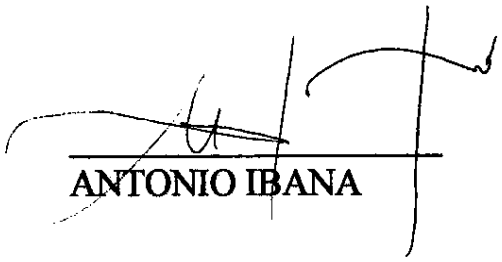
22. I do not have, and cannot pay for, any other medical insurance.

23. I declare under penalty of perjury under the laws of the State of Hawaii and the United States of America that the foregoing is true and correct.

/

/

Executed this 7th day of March, 2010 in Honolulu, HI.



ANTONIO IBANA

DECLARATION OF RENATO MATEO

I, **RENATO MATEO**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows

2. I am from Santa Ignacia, Tarlac City, Philippines. I am sixty one years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai`i since September 27, 2006. I immigrated to the United States with my wife. We joined my wife's family in the United States.

4. In the Philippines I worked for many years at Toyota.

5. When I came to Hawai`i, I got a job almost immediately with HBM, Hawai`i Building Maintenance. I worked for HBM full-time, bought a car and a van, and enjoyed our new life with extended family in the United States.

6. I had health insurance through my employer starting in October 2006.

7. Sometime in January 2007 I began to have paints in my rectal area and a pulling sensation like I needed to have a bowel movement. At first we thought it was a simple hemorrhoid. I went to the doctor and they performed a colonoscopy. When the results came back, my doctor told me it was colon cancer.

8. After finding out I had colon cancer, I was immediately scheduled for surgery on March 23, 2007 to remove the cancerous tissue.

9. Even though my surgery was scheduled, I kept working. My last day of work was the day before my surgery in March 2007.

10. The surgery to remove the cancer in my colon was successful. My oncologist told me I would not need strong chemotherapy, but I would need to take chemo pills. My wife and I were hopeful that I would get better.

11. After the surgery I was contacted by my health insurance company. They told me that my health insurance through my employer would be cancelled because I was one week short of the probationary period. The insurance company agreed to cover the cost of my surgery but would not cover any more of my medical expenses.

12. I was unable to work and still needed to be able to pay for chemotherapy pills, which cost almost $1,300 per month. I also needed periodic CT scans to monitor my colon and be sure my cancer did not spread or return. I needed to have insurance to be able to afford the treatment I needed to fight the cancer.

13. My wife Agapita began to work long hours at her job as a caregiver so that we could afford to pay the COBRA payments to maintain my health insurance on our own.

14. By November 2007 we were having trouble with other bills even though we were able to pay the COBRA payments to maintain health insurance my

health insurance. I was still taking chemotherapy pills, but I applied with HBM again, my former employee. My monthly CT scans and blood tests to monitor my health showed I was improving, and my doctor cleared me to work.

15. I began work again with HBM in late November 2007. I started health insurance again with my employer. For the next year I had periodic CT scans and blood tests with positive results. My oncologist told me and my wife that the prognosis was good.

16. Around June 2009, I began to have trouble again, feeling the same pain and sensation that I felt previously. The pain became intense. I wanted to see my oncologist, but I had to wait for an appointment. Worried about my condition, my wife called my primary care physician and scheduled an appointment. My primary care physician suggested a new oncologist.

17. I went to see the new oncologist who performed a colonoscopy, endoscopy, rectal scan and CT scan. After these tests, I was told that my cancer had returned. This time, the cancer had metastasized to my liver.

18. My wife and I were devastated. I had gone many months with CT scans and blood tests with positive results. I could not believe that now the cancer had spread to my liver undetected. I questioned the doctor why he did not tell me earlier of any problems. I believed I was cancer free.

19. I was scheduled for surgery on December 19, 2009. I worked at HBM right up until my surgery date. After the surgery, I was told it was an 'open and close' surgery, where the oncologist was only able to biopsy the cancer.

20. The oncologist told me that this time I would need aggressive intravenous chemotherapy to fight the cancer. I started chemotherapy and was granted temporary disability insurance (TDI) for six months from my employer.

21. In January 2010 my wife suffered a back injury at work. Her insurance was terminated because she was not working. She receives workman's compensation payments, but she is unable to work anymore and needs back surgery.

22. In April I found out I was terminated from work and my insurance coverage was also terminated. We wanted to enroll in COBRA again, but the premiums would be $315.00 each per month for me and my wife. We decided to get the COBRA coverage only for myself because of the need to continue my chemotherapy.

23. My TDI expired in June 2010 and we began to really struggle financially. I asked my doctor if he would clear me to be able to work, even though I still need the chemotherapy treatment. My doctor completed the form, but I was unable to get work.

24. By July we were not able to make the $315 COBRA payment. My wife and I were both unemployed and we had only her small workman's compensation payment. We also had all our normal monthly expenses. We had started to rely on family and friends just to have money for food to eat and gas to drive to my chemotherapy appointments.

25. My wife wrote to the insurance company and pleaded with them not to cancel my insurance policy as we tried to get finances from other places to make the COBRA payment. My wife contacted the American Cancer Society (ACS) and also Catholic Charities (CC). I received a one time gas card from ACS, and CC started to give us canned food goods.

26. Despite calls and letters, HMSA cancelled our insurance policy in July and withheld chemotherapy treatment.

27. At this point, things started to feel like a nightmare and we got very desperate. I was starting to feel really sick and was very nauseous from the chemotherapy. I could not get work. My wife was walking with a cane after her back injury and her eyesight was cloudy because of her untreated diabetes.

28. Finally in November 2010 my wife heard about the community health center KKV from others and we went to see if we could somehow get help to start chemotherapy again. I was getting very sick and my wife was so worried.

29. The eligibility worker at KKV helped us fill out an application for Med-Quest insurance on November 17, 2010. We knew it would take some processing time but hoped maybe I would be able to get insurance coverage.

30. At KKV, my primary care physician was able to get a charity to cover my chemotherapy. I resumed treatment. However, they would not be able to get coverage to see any oncologist or specialist, or coverage for CT scans to monitor my progress. For this I would need insurance.

31. On March 2, 2011 I received a letter from Med-Quest denying insurance coverage. The letter is attached as Exhibit "1".

32. I continued to go to chemotherapy treatments every Thursday. I know I did not have insurance, but I believed that charity was going to pay for my bills.

33. On March 10, 2011 I went to my Thursday chemotherapy appointment. After waiting for four hours, I was told I could not be able to get chemotherapy, and I would not get the treatment in the future. I was shocked and extremely upset. I thought that charities would cover my chemotherapy treatment.

34. The staff at the chemotherapy office informed me that they found out the charity grant would provide free chemotherapy drugs. After that, it would only cover a maximum of $2,000 in fees for office visits and administration of the drug. When I first resumed treatment, they had mistakenly thought the charity would cover more of my bills. They told me that office visits and drug administration

costs at least $500. Since July, I have accrued over $85,000 in bills for the chemotherapy treatment. Because I have this much debt and no insurance, I was told they will no longer give me chemotherapy treatment because I can not pay for the office visits.

35. I feel extremely desperate. I can not pay for the treatment needed to get healthy and work again. My wife and I struggle to survive and our bills pile up. We live in one small room in the basement of a house and share a living space with another family. My wife's workman's compensation payment barely covers our rent. We rely on charity for our other needs, feeding ourselves on canned goods and the meal our church provides us each Thursday.

36. I do not have, and cannot pay for, any other medical insurance.

37. I declare under penalty of perjury under the laws of the State of Hawai`i and the United States of America that the foregoing is true and correct.

Executed this 10 th day of March, 2011 in Honolulu, HI.

RENATO MATEO

DECLARATION OF AGAPITA MATEO

I, **AGAPITA MATEO**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

2. I am from Camiling, Tarlac City, Philippines. I am fifty nine years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai`i for four and half years. I immigrated to the United States with my husband on September 27, 2006. My mother is a United States citizen. She was born in Hawai`i in 1919. My grandfather was a U.S. army serviceman, and my grandmother worked as a sakada here in Hawai`i. My mother returned to the Philippines when she was young. Later in 1982 she came to the United States and brought my 5 brothers and 2 sisters with her. There were immigration problems for my brother and I, and we could not immigrate with the rest of our family. My youngest brother and I had to remain in the Philippines and wait as my family petitioned for us separately. It took almost 25 years for the petition to process and I was finally able to join the rest of my family in 2006. By that time, my mother had passed.

4. In the Philippines I graduated with my bachelor's degree. I worked for many years as a mid-wife and health professional.

5. When I came to Hawai`i, I did not immediately get a job. My husband was able to find work with HBM Hawai`i Building Maintenance.

6. We bought a car and a van, and enjoyed our new life with extended family in the United States.

7. I have diabetes and need to take daily insulin.

8. When we arrived in Hawai`i I started looking for work. However, it was difficult to find a job.

9. Sometime in January 2007 we found out my husband, Renato, had colon cancer. He had surgery in March to remove the cancerous tissue and started chemotherapy pills. I talked to the oncologist about his situation, and believed that the prognosis was good for total recovery.

10. In March after my husband's surgery I was contacted by his health insurance company. They informed me that they were cancelling his employer sponsored health insurance because he was one week short of the probationary period. The insurance company agreed to cover the cost of his surgery but would not cover further medical expenses.

11. I was very worried about my husband and I knew we could not afford the cost of his treatment. His chemotherapy pills alone cost $1,300 per month.

12. In May 2007 I finally found work as a caregiver. I finally had health insurance through my employer to cover my health needs. Because I did not have

health insurance for some time, I had not visited the doctor. Because of my untreated diabetes, I had to have laser procedure on my eyes. This was covered by my insurance.

13. With my income, we were able to make the COBRA payments to maintain health insurance for my husband while he was recovering and could not work.

14. Paying the COBRA payments to maintain health insurance was top priority, but we started to struggle financially. I would sometimes work 24 hour shifts and was very tired. My husband's health seemed to be improving, though he still needed chemotherapy pills. He asked the doctor if he could be cleared again for work, and they agreed he would be able to work.

15. In November 2007 my husband started to work again with HBM and he got health insurance through is employer. For the next year he continued to have periodic CT scans and blood tests. His doctor always told me everything was 'ok' so I believed that my husband was cancer free.

16. In June 2009 my husband started to complain to me again about always feeling the need have a bowel movement. He went to see a new oncologist. After a colonoscopy, endoscopy, rectal scan and CT scan the doctor told me it was what I most feared. I was devastated: the cancer was back and had spread to my husband's liver.

17. My husband had surgery on December 19, 2009. He worked at HBM right up until his surgery date. After surgery he needed aggressive intravenous chemotherapy to fight the cancer. He was not able to work, and was given six months temporary disability insurance (TDI) from his employer. I was still working as a caregiver and started working longer hours.

18. In January 2010 I injured my back at work and I could not work anymore. I had to start walking with a walker.

19. My back condition worsened and became very painful. I went to see a specialist, and I was told that my back was now 'bone on bone' and that I would need surgery.

20. I was cleared for back surgery to be covered and also receive $494.98 monthly payment as workman's compensation.

21. Before my surgery was scheduled, we found out in April that my husband was terminated from work and our insurance coverage was also terminated. We wanted to enroll in COBRA again, but the premiums would be total $630.00 each per month if both of us were to be covered. I needed insurance to be able to get my diabetes medication, but my husband's situation was much worse. He could not stop his chemotherapy treatments. We decided to get the COBRA coverage only my husband, paying $315.00 per month.

22. Our financial situation became very difficult in June 2010 and we began to really struggle even to find food to eat and gas to take my husband to chemotherapy. My husband wanted to get cleared to work by his doctor, but I knew that he was too weak. I had started to train myself to walk with a cane, not the walker because it was even too difficult for my husband to help me get my walker in and out of the car. We could not afford my insulin anymore.

23. By July we were not able to make the $315 COBRA payment. We also had all our normal monthly expenses. Previously, we had taken out a $1000 loan with our 1988 van as the collateral. I had also taken out pay-day loans to cover expenses. Before I was able to make the high interest payments, but now I could not. We defaulted on our auto loan. Debt collection agencies started to call every day. I did not let my husband know about these calls because I wanted him to focus on getting healthy. I wrote letters to all the debt collections letting them know that I would take responsibility for my debt, but my husband had cancer and we were struggling to keep his medical insurance. We had already relied so much on family and friends just to have money for food to eat and gas, but they were not able to help anymore.

24. I wrote to the insurance company and pleaded with them not to cancel my husband's insurance policy in July but to give me some time to try to get finances from other places to make the COBRA payment.

25. I heard about the American Cancer Society (ACS) and also Catholic Charities (CC). I wrote to them very hopeful that maybe I could receive help. Unfortunately, all that ACS could give me was one gas card. That only lasted us for one week. CC started to give us canned food goods that we still use to eat. None of this was enough to keep our insurance policy.

26. Despite my calls and letters, HMSA cancelled my husband's insurance policy in July and withheld chemotherapy treatment.

27. At this point, I started to get very depressed and even contemplated suicide. I was neglecting my own health because I was worried about my husband. My eyesight had started to become cloudy and we could not afford insulin. I did not sleep at night, and neither did my husband. We would lie in bed and cry together, wondering what we would do.

28. I was so desperate I kept asking for help. I heard about a community health center in Kalihi from others and we went to see if we could somehow get help. My back was very painful and my eye sight had become cloudy because I did not have the money to manage my diabetes.

29. We moved to Kalihi to live in a small room in the shared basement and get treatment at KKV. At KKV I visited the primary care physician. She was able to help me to get my insulin treatment covered by charities. She told me that my I had probably harmed my eyesight irreparably because I had stopped my

diabetes treatment for such a long time. She told me I need to see a retina specialist and may need eye surgery. I can not see a specialist because I do not have insurance coverage.

30. I asked my doctor about the possibility of back surgery. I knew that my workman's compensation would cover the surgery costs. My doctor told me that I could not be cleared for surgery because she thought I may have some problems with my kidney and because of the problems with my eyes. She recommended that I see a kidney specialist. I cannot afford to see a specialist, and they will not see me without health insurance. Now, I just try to deal with my back pain because I cannot get the surgery.

31. I feel very desperate when I think about the future. Our medical bill debts pile up and we worry each month how we have money to keep our housing or gas to see our doctor. Already since July 2010 we have over $85,000 in medical bill debts from my husband's chemotherapy alone. We also have other debts from credit cards and loans. Neither me nor my husband are healthy enough to work.

32. I do not know how I will ever pay back the debts and be able to afford health insurance.

33. I do not have, and cannot pay for, any other medical insurance.

//

34. I declare under penalty of perjury under the laws of the State of Hawai`i and the United States of America that the foregoing is true and correct.

Executed this 10 th day of March, 2011 in Honolulu, HI.

AGAPITA MATEO

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI`I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated, Plaintiffs, vs. PATRICIA MCMANAMAN, in her official capacity as Interim Director of the State of Hawai`i, Department of Human Services, and KENNETH FINK, in his official capacity as State of Hawai`i, Department of Human Services, Med-QUEST Division Administrator, Defendants.	CIVIL NO. 10-00483 JMS-KSC [Civil Rights Action] [Class Action] **DECLARATION OF J. BLAINE ROGERS**

DECLARATION OF J. BLAINE ROGERS

I, J. Blaine Rogers, hereby declare that:

1. I am an attorney, licensed to practice before this court and am one of the attorneys for Plaintiffs in this action. I have personal knowledge of, and am competent to testify to, the matters set forth below.

2. I make this declaration in support of *Plaintiffs' Motion for Preliminary Injunction Re: New Residents*, and am competent to testify to the matters discussed herein.

3. Attached hereto as Exhibit "G" is a true and correct copy of a letter addressed to Governor Linda Lingle, dated August 26, 2009, signed by the Honorable John Mizuno, Chair of the House Committee on Human Services, and by Suzanne Chun Oakland, Chair of the Senate Committee on Human Services. Exhibit "G" was previously authenticated by the Declaration of Elizabeth M. Dunne, dated September 13, 2010 ("Dunne Decl."), ¶ 15, which was attached to *Plaintiffs' Motion for Preliminary Injunction*, filed September 13, 2010 (Doc. 10).

4. Attached hereto as Exhibit "H" is a true and correct copy of the DHS Information Act Response, dated June 15, 2010. Exhibit "H" was previously authenticated by the Dunne Decl. ¶ 16.

5. Attached hereto as Exhibit "I" is a true and correct copy of a description of the Immigrant Health Initiative, available at http://www.hawaiipca.net/40/immigrant-health (last accessed April 28, 2011).

6. Attached hereto as Exhibit "J" is a true and correct copy of a letter from Dr. Kenneth S. Fink to Medicaid Physicians and others, dated August 25, 2009, available at http://www.med-quest.us/PDFs/Provider%20Memos/ACSMEMO2009/ACS%20M09-21.pdf (last accessed April 28, 2011).

I declare under penalty of perjury that the foregoing statements are true and correct.

Executed in Honolulu, Hawai`i on April 28, 2011.

/s/ J. Blaine Rogers
J. BLAINE ROGERS

HAWAII STATE LEGISLATURE
STATE CAPITOL
HONOLULU, HAWAII 96813

August 26, 2009

Governor Linda Lingle
State Capitol, Executive Chamber

Dear Governor Lingle:

We are writing you to respectfully request a delay of the implementation of "Basic Health Hawaii." As you know, this new health plan will mean that effective September 1, 2009, over 7,500 Pacific Islanders who are compact migrants from Micronesia, the Marshall Islands, and Palau, as well as all noncitizens who have been in Hawaii less than five years, will no longer have dialysis or chemotherapy treatment coverage. This new medical plan could be a death sentence for many who need but cannot afford life saving kidney dialysis services as well as our cancer patients who also require chemotherapy treatment.

We respectfully ask that these patients be either grandfathered in or delay the implementation for six months. Many patients have not received their notice that such life saving services would be discontinued and others have been sent this notice which is not in their native language. Moreover, we are concerned that this plan was made public only in late July 2009, which is barely one month's notice. This is not enough time to prepare community members who will no longer have such life saving dialysis or chemotherapy services available to them or their loved ones.

We are working with our Congressional delegation and they have a measure to reinstate Medicaid benefits for our compact migrants. This means that the federal government will once again contribute by providing more than $15 million dollars to Hawaii each year. If the state chooses to follow through with these cuts, the decision could be a death sentence for many compact and nonresidents in Hawaii. The decision could also weaken the safety net of community health centers, making Hawaii residents more vulnerable to the spread of communicable diseases, limiting their access to hospitals due to increasing uncompensated costs for compact migrants and noncitizens and thus costing Hawaii tax payers more for the care of compact migrants and noncitizens under the current prevention-centered system.

EXHIBIT "G"

We thank you in advance for your kind consideration to our request. Please feel free to contact us anytime at 586-6050 or 586-6130.

Sincerely,

John M. Mizuno
Chair, House Committee on Human Services
State Representative, House District 30

Suzanne Chun Oakland
Chair, Senate Committee on Human Services
State Senator, Senate District 13

CC: Senate President Colleen Hanabusa
Speaker Calvin K.Y. Say

379

NOTICE TO REQUESTER

(Use multiple forms if necessary)

TO: Elizabeth Dunne – Lawyers for Equal Justice

FROM: Priscilla Thode – DHS Med-QUEST Division Office 692-8140 FAX 692-8173

(Agency/name & telephone number of contact person at agency)

DATE REQUEST RECEIVED: 05/28/10
DATE OF THIS NOTICE: 06/15/10

GOVERNMENT RECORDS YOU REQUESTED (attach copy of request or provide brief description below):

1. 1. Any document(s) reflecting the number of citizens of COFA nations and legal permanent residents eligible for and receiving state medical assistance or financial assistance, as those terms are defined in the BHH rules, HAR, Title 17, Chapter 1722.3 on July 31, 2009.

2. Any document(s) reflecting the number of citizens of COFA nations and legal permanent residents eligible for and receiving state medical assistance or financial assistance, as those terms are defined in the BHH rules, HAR, Title 17, Chapter 1722.3 on May 31, 2010.

3. Any document(s) reflecting the amount of money spent on state medical assistance for citizens of COFA nations for the years 2008, 2009 and 2010.

4. All documents concerning any agreement(s) between the State of Hawaii and the federal government regarding the provision of medical assistance, including dialysis, to aliens and refugees under Medicaid's emergency medical assistance provisions.

NOTICE IS PROVIDED TO YOU THAT YOUR REQUEST:

☒ **Will be granted in its entirety.**

☐ **Cannot be granted because**

- ☐ Agency does not maintain the records. Agency believed to maintain records: _____
- ☐ Agency needs a further description or clarification of the records requested. Please contact the agency and provide the following information: _____
- ☐ Request requires agency to create a summary or compilation from records not readily retrievable.

☐ **Is denied in its entirety** ☐ **Will be granted only as to certain parts**
based upon the following exemption provided in HRS § 92F-13 and/or § 92F-22 and other laws cited below (portions of records that agency will not disclose should be described in general terms).

RECORDS OR INFORMATION WITHHELD	APPLICABLE STATUTES	AGENCY JUSTIFICATION

OIP 4 (rev. 8/29/08)

EXHIBIT "H"

REQUESTER'S RESPONSIBILITIES:

You are required to (1) pay any lawful fees assessed; (2) make any necessary arrangements with the agency to inspect, copy or receive copies as instructed below; and (3) provide the agency any additional information requested. If you do not comply with the requirements set forth in this notice within 20 business days after the postmark date of this notice or the date the agency makes the records available, you will be presumed to have abandoned your request and the agency shall have no further duty to process your request. Once the agency begins to process your request, you may be liable for any fees incurred. If you wish to cancel or modify your request, you must advise the agency upon receipt of this notice.

METHOD & TIMING OF DISCLOSURE:

Records available for public access in their entireties must be disclosed within a reasonable time, not to exceed 10 business days, or after receipt of any prepayment required. Records not available in their entireties must be disclosed within 5 business days of this notice or after receipt of any prepayment required. If incremental disclosure is authorized by HAR § 2-71-15, the first increment must be disclosed within 5 business days of this notice or after receipt of any prepayment required.

Method of Disclosure:

☐ Inspection at the following location: _____.
☒ Copy will be provided in the following manner:
  ☐ Available for pick-up at the following location: _____.
  ☒ Will be mailed to you.
  ☐ Will be transmitted to you by other means requested: _____.

Timing of Disclosure: All records, or first increment where applicable, will be made available or provided to you:

☐ On _____.
☐ After prepayment of fees and costs of $ _____ (50% of fees +100% of costs, as estimated below).
Payment may be made by: ☐ cash ☐ personal check ☐ other _____.

For incremental disclosures, each subsequent increment will be disclosed within 20 business days after:
  ☐ The prior increment (if one prepayment of fees is required and received).
  ☐ Receipt of each incremental prepayment required.
  Disclosure is being made in increments because the records are voluminous and the following extenuating circumstances exist:
    ☐ Agency must consult with another person to determine whether the record is exempt from disclosure under HRS chapter 92F.
    ☐ Request requires extensive agency efforts to search, review, or segregate the records or otherwise prepare the records for inspection or copying.
    ☐ Agency requires additional time to respond to the request in order to avoid an unreasonable interference with its other statutory duties and functions.
    ☐ A natural disaster or other situation beyond agency's control prevents agency from responding to the request within 10 business days.

ESTIMATED FEES & COSTS:

The agency is authorized to charge you certain fees and costs to process your request (even if no record is subsequently found to exist), but must waive the first $30 in fees assessed for general requesters and the first $60 in fees when the agency finds that the request made is in the public interest. See HAR §§ 2-71-19, -31 and -32. The agency may require prepayment of 50% of the total estimated fees and 100% of the total estimated costs prior to processing your request. The following is the estimate of the fees and costs that the agency will charge you, with the applicable waiver amount deducted:

Fees: Search Estimate of time to be spent: _____ $ _____
($2.50 for each 15-minute period)

	Review & segregation	Estimate of time to be spent: _____ ($5.00 for each 15-minute period)	$ _____
	Fees waived	☐ general ($30) ☐ public interest ($60)	<$ _____>
	Other	_____ (Pursuant to HAR § 2-7-31(B))	$_____
	Total Estimated Fees:		$ _____
Costs:	Copying	Estimate of # of pages to be copied: _____ (@ $ _____ per page.)	$ _____
	Other	_____	$ _____
	Total Estimated Costs:		$ No Fee

For questions about this notice, please contact the person named above. Questions regarding compliance with the UIPA may be directed to the Office of Information Practices at 808-586-1400 or oip@hawaii.gov.

In response to your request for information, the following is provided:

(1) The number of citizens of Compact of Free Association nations who were receiving state-only funded medical assistance as of July 31, 2009 was **6,556**.

Non-pregnant adult aliens legally residing in the United States for less than five years are currently not eligible for state-only funded medical assistance or Medicaid. Questions on the receipt of financial assistance should be directed to the Benefit, Employment and Support Services Division.

(2) The number of citizens of Compact of Free Association nations who were receiving state-only funded medical assistance as of July 31, 2009 was **7,793**.

Non-pregnant adult aliens legally residing in the United States for less than five years are currently not eligible for state-only funded medical assistance or Medicaid. Questions on the receipt of financial assistance should be directed to the Benefit, Employment and Support Services Division.

(3) The following table contains the amount spent on medical assistance for citizens of Compact of Free Association nations for 2007, 2008, and 2009. The 2010 data will not be available until sometime later this year.

Year	Amount
2007	$28,798,721
2008	$33,492,322
2009	$43,053,881
2010	N/A

(4) A copy of the State Plan section on emergency medical assistance is attached.

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: HAWAII

Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Hawaii

Citation		
	3.1(a)(6)	Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act	(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act	(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	(a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act	(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. 94-010
Supersedes TN No. 92-05
Approval Date 9/22/94
Effective Date 8/1/94
HCFA ID: 7982E

Hawaii Primary Care Association

Immigrant Health

What is the Hawaii Immigrant Health Initiative program?

The Immigrant Health Initiative (IHI), provides for low-cost or free health care to recently arrived immigrants who meet certain qualifications. Participation in this program does not make the beneficiary a "public charge" for the purpose of immigration law.

Who administers IHI Program funds?

The Hawai'i Primary Care Association administers IHI funds under contract with the State of Hawaii Department of Human Services.

Who qualifies?

All legal permanent residents (green card holders), ages 19 and older who entered the United States on or after August 22, 1996 and who are not eligible for federally-funded medical assistance for the first five years of residency in the United States. All legal permanent resident aliens must provide proof of Hawaii residency in order to be eligible for this program.

What Medical Services are provided?

Participating community health centers will provide IHI patients with:

- Primary care for eligible adults, including physical exams, diagnoses, and treatment for chronic, episodic and acute conditions.
- Preventive care and education.
- Specialty care.
- Prescription drugs and supplies.
- Follow-up care.
- Tuberculin testing and immunizations.
- Gynecological services, family planning, yearly pap smears, contraceptive management and related follow-up.
- Specialty care services:
  - Outpatient diagnostic and radiology services.
  - Outpatient specialty services.
  - Outpatient therapeutic procedures.
  - Prescription and non-prescription drugs and supplies.
  - Referral services are paid at applicable Medicare rates and may include specialty, diagnostics and procedures as outlined above.

Services Not Included

Inpatient care.
Emergency care (except for emergency dental services).
Visits and treatment for pregnant immigrants (these services are now covered by Medicaid)
Any benefit not provided by Medicaid or QUEST.

EXHIBIT "I"

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 25, 2009

MEMORANDUM ACS M09-21

TO: Medicaid Physicians, Dentists, Other Providers with Prescriptive Authority and Pharmacy Providers

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECTS: FEE-FOR-SERVICE (FFS) PROGRAM ONLY

1. BASIC HEALTH HAWAII, QUEST-NET AND QUEST-ACE FORMULARY EFFECTIVE SEPTEMBER 1, 2009
2. FIRST DATABANK AWP CALCULATION CHANGE EFFECTIVE SEPTEMBER 26, 2009

1. Basic Health Hawaii, QUEST-Net and QUEST-ACE Formulary Effective September 1, 2009

The Department of Human Services (DHS) is implementing a new health insurance program starting September 1, 2009 called Basic Health Hawaii (BHH). This program will provide basic medical care for low-income non-pregnant legally residing adults who are not eligible for federal medical assistance programs.

About 7,000 non-immigrants, namely those from the Compact Free Association nations, will be transferred from the comprehensive QUEST and QUEST Expanded Access (QExA) health care plans into BHH, which will have a benefit package identical to what low-income adults receive through QUEST-ACE and QUEST-Net programs. In addition, immigrants who have been legally residing in the United States for less than five (5) years may also be eligible.

BHH, QUEST-Net and QUEST-ACE will all receive an expanded prescription drug benefit. Some of the savings from the implementation of BHH will be used to fund the expanded drug coverage for more than 8,000 non-pregnant adult clients in QUEST-ACE and QUEST-Net.

Effective September 1, 2009, QUEST-ACE, QUEST-Net and BHH clients may receive up to five (5) generic prescriptions/paid claims per calendar month PLUS contraceptives. A prescription for Regular and NPH insulin may substitute for a generic prescription. Each paid claim is counted as one of the five (5) generic prescriptions. Diabetic supplies (specifically lancets, syringes and test

EXHIBIT "J"

strips) will also be covered and NOT counted as one of the five (5) generic prescriptions. Contraceptives will NOT count towards the limit of five (5) prescriptions (see Table 1). These are the only exceptions to the five (5) generic prescription limits.

Clients currently receiving medical assistance will be deemed eligible for BHH and will not have a break in coverage. However, during the period between when a newly eligible applicant applies and is enrolled in a BHH plan, Hawaii Medicaid FFS will reimburse services. FFS will be covering all generics available to Medicaid FFS recipients, and pharmacy claims are to be submitted to Affiliated Computer Services Pharmacy Benefit Manager (ACS PBM). Diabetic supplies are to be billed to ACS Fiscal Agent (FA).

The QUEST plans will provide ongoing care for BHH recipients and continue to provide services for QUEST-ACE and QUEST-Net. They will each establish their own drug formulary that will include at least one (1) generic per American Hospital Formulary Service (AHFS) therapeutic category. Prior authorization may be required for non-formulary generic products. For inquiries regarding the BHH, QUEST-Net and QUEST-ACE program pharmacy benefit, please contact the appropriate managed care health plans:

AlohaCare:	973-1650, for neighbor islands 1 (800) 434-1002
HMSA:	948-6486, for neighbor islands 1 (800) 440-0640
Kaiser:	432-5330, for neighbor islands 1 (800) 651-2237

2. First DataBank Average Wholesale Price Calculation Change Effective September 26, 2009

Effective September 26, 2009, First DataBank (FDB) will be changing the mark-up value used to calculate the Average Wholesale Price (AWP) for certain drugs in compliance with a lawsuit settlement. As a result, reimbursements to pharmacy providers are expected to be lower for a number of products. The calculation of the State Maximum Allowable Cost (SMAC) may also be impacted. Please see the excerpts below from a FDB notice issued March 31, 2009:

> "According to the terms of the amended settlement as approved by the court, First DataBank will adjust its reporting of Blue Book AWP for those prescription drugs identified in the plaintiffs' previously filed complaint (approximately 1,400 NDCs in number) by reducing the mark-up factor utilized in connection with the calculation of the Blue Book AWP data field to 1.20 times the WAC or Direct Price for those NDCs that are on a mark-up basis."
>
> "Independent of the settlement and on the same schedule as the Blue Book AWP adjustment noted above, First DataBank will apply the same 1.20 markup factor to all other NDCs whose Blue Book AWP is set based upon a markup to WAC or Direct Price in excess of 1.20. First DataBank will also independently discontinue publishing the Blue Book AWP data field for all drugs no later than two years following the date that the Blue Book AWP adjustments noted above are implemented."

For Medicaid FFS Pharmacy policy questions, please contact Lynn Donovan, R.Ph., Pharmacy Consultant, at (808) 692-8116.

Attachment

Med-QUEST Fee-For-Service (FFS)

FFS Window Coverage For Newly Eligible Recipients Waiting For Basic Health Hawaii, QUEST-Net and QUEST-ACE

New Formulary

Effective September 1, 2009

Table 1

Basic Health Hawaii, QUEST-Net and QUEST-ACE	**Formulary Coverage Effective September 1, 2009**	**Up to FIVE (5) generic prescriptions / paid claims every calendar month**
	Generic prescriptions are covered.*	These count toward the five (5) prescription limit.
	Regular and NPH Human Insulin are covered including combinations. Pens are not covered.	These count toward the five (5) prescription limit.
	Diabetic supplies (i.e., lancets, syringes and test strips) up to 100 units per calendar month are covered. Control solution is limited to one (1) bottle per month.	These do **NOT** count toward the five (5) prescription limit.
	Family planning drugs, supplies and devices are limited to generic contraceptive/birth control pills, contraceptive medroxyprogesterone acetate and diaphragms.	These do **NOT** count toward the five (5) prescription limit.

*Individual QUEST health plan may cover some brand medications to better manage health care.

Continue to bill drug claims to ACS PBM and supplies are to be billed to ACS FA.

Please notify the member prior to the health service being provided that it is not a covered benefit or that the coverage limit will be exceeded.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that, on this date and by the methods of service noted below, a true and correct copy of the foregoing was served on the following at their last known addresses:

Served Electronically through CM/ECF:

Lee-Ann N.M. Brewer, Esq. Lee-Ann.N.Brewer@hawaii.gov

John F. Molay, Esq. john.f.molay@hawaii.gov

DATED: Honolulu, Hawai‘i, April 28, 2011.

/s/ J. Blaine Rogers
VICTOR GEMINIANI
ELIZABETH DUNNE
PAUL ALSTON
J. BLAINE ROGERS
ZACHARY A. MCNISH
Attorneys for Plaintiffs