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Realizing the International Human Right to Health for Non-Citizens in the United States

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INTRODUCTION

Individuals living in the United States who are not citizens comprise seven percent of the U.S. population.[1] These non-citizens have a specific status under U.S. law, and that status dictates entitlement and access to health care benefits and services. And the news is not good. Individuals without so-called legal status suffer tremendous barriers to access to care and are harmed as a consequence.

This article first examines what non-citizens of any country can expect in terms of health and health care by virtue of the existence of the international human right to health. Second, this article explores what non-citizens in the United States can expect in terms of health care under the laws of the United States. Finally, this article will examine how trade law and immigration law can be modified to improve access to health care among non-citizens in ways that conform to the norms established by the international human right to health. The article concludes with a statement of principles that should guide the recognition of the international human right to health for all who live in a country in which they are non-citizens.

I. BACKGROUND

This section reviews the information needed to analyze the two questions posed above. First it reviews the human rights of non-citizens of any country, including the United States. Second it reviews the international and regional treaties recognizing an international human right to health.

A. The Human Rights of Non-Citizens

There are no international or regional treaties that recognize the full array of human rights of immigrants per se. Rather, human rights treaties

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[1] U.S. DEP'T OF HEALTH & HUMAN SERVS., OFFICE OF THE ASSISTANT SEC'Y FOR PLANNING AND EVALUATION, ASPE ISSUE BRIEF, OVERVIEW OF THE UNINSURED IN THE UNITED STATES: AN ANALYSIS OF THE 2005 CURRENT POPULATION SURVEY (2005), *available at* http://aspe.hhs.gov/health/reports/05/uninsured-cps/index.htm (last visited Apr. 8, 2011)[hereinafter ASPE ISSUE BRIEF].

address the human rights of individuals whether or not they are in countries in which they were not born. Nevertheless, international human rights theory recognizes that all individuals are supposed to identify with a political state. And political states have the unquestioned authority to control their borders and to regulate immigration. They must, however, exercise this power in manners consistent with the rule of law.

As a consequence of this reality, the rights of non-citizens within a nation state are dependent on their legal status in that state. Foreign born individuals in any state are distinguished between naturalized citizens and non-citizens. Non-citizens are classified as refugees and asylum seekers, otherwise legal immigrants and undocumented immigrants. Naturalized citizens obviously have the same legal rights as native born citizens. Other legal immigrants have lesser but defined rights. Undocumented workers have only those rights accorded all human beings under any legal authority. They also have legal rights when constitutions and legislation speak in terms of individuals rather than citizens or other classifications. The Fourteenth Amendment of the U.S. Constitution speaks in terms of "persons" rather than "citizens" although its application to undocumented immigrants, particularly regarding the status of their children born in the United States, is controversial.[2]

Other, more general, international and regional human rights treaties do touch on the rights of non-citizens. Specifically, the Universal Declaration of Human Rights (UDHR) recognizes the right of human beings to move among countries in Article 13, which provides:

> (1) Everyone has the right to freedom of movement and residence within the borders of each state.
> (2) Everyone has the right to leave any country, including his own, and to return to his country.[3]

In Article 14, the UDHR also recognizes a human right to seek asylum and refuge from persecution:

> (1) Everyone has the right to seek and to enjoy in other countries asylum from persecution.
> (2) This right may not be invoked in the case of prosecutions genuinely arising from non-political crimes or from acts contrary to the purposes and principles of the United Nations. [4]

[2] *See generally* Gerard N. Magliocca, *Indians and Invaders: The Citizenship Clause and Illegal Aliens*, 10 U. PA. J. CONST. L. 499 (2008) (discussing the application of the 14th Amendment to Native Americans, their children, and children of resident aliens); Dan Stein & John Bauer, *Interpreting the 14th Amendment: Automatic Citizenship for Children of Illegal Immigrants*, 7 STAN. L. & POL. REV. 127 (1996) (discussing whether children born in the U.S. to illegal aliens should be granted automatic U.S. citizenship).

[3] Universal Declaration of Human Rights art. 13, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217 (III) (Dec. 10, 1948) [hereinafter UDHR].

Finally, the UDHR addresses working conditions. Article 4 provides: "No one shall be held in slavery or servitude; slavery and the slave trade shall be prohibited in all their forms."[5] Article 24 provides: "Everyone has the right to rest and leisure, including reasonable limitation of working hours and periodic holidays with pay."[6]

The most apposite body of human rights law is treaties pertaining to the rights and treatment of migrant workers.[7] The conventions and instruments of the International Labor Organization are particularly apposite.[8] The most important U.N. treaty is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.[9] The U.S. has neither signed nor ratified this treaty.[10]

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families contains some provisions that pertain to the right to health. In Article 25, the Migrant Convention provides:

> (1) Migrant workers enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of remuneration and:
>
> (a) Other conditions of work, that is to say, overtime, hours of work, weekly rest, holidays with pay, safety, health, termination of the employment relationship and any other

[4] *Id.* at art. 14.

[5] *Id.* at art. 4.

[6] *Id.* at art. 24.

[7] *See* James A. Gross, *A Long Overdue Beginning: The Promotion & Protection of Workers' Rights as Human Rights*, *in* WORKERS' RIGHTS AS HUMAN RIGHTS 1–22 (James A. Gross ed., 2003); *see also* HUMAN RIGHTS AND REFUGEES, INTERNALLY DISPLACED PERSONS AND MIGRANT WORKERS (Anne F. Bayelfkly et al. eds., 2006) (discussing generally, the protection of refugees, internally displaced persons, and migrant workers).

[8] *See* Lee Swepston, *Closing the Gap between International Law and U.S. Labor Law*, *in* WORKERS' RIGHTS AS HUMAN RIGHTS, s*upra* note 7, at 53–78.

[9] *See* International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families art. 26, Dec. 18, 1990, G.A. Res. 45/158, U.N. Doc. A/RES/45/158 [hereinafter Migrant Convention]; *see generally* Juhani Lönroth, *U.N. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: An Analysis of Ten Years of Negotiation*, 25 INT'L MIGR. REV. 710 (1991) (analyzing the factors affecting the creation of the new international instrument of the Migrant Worker Convention).

[10] *See* Declarations and Reservations to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 2220 U.N.T.S. 3, U.N. Doc. A/RES/45/158, *available at* http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&lang=en (last visited Apr. 7, 2011); *see* Linda S. Bosniak*, Human Rights, State Sovereignty and the Protection of Undocumented Migrants under the International Migrant Workers Convention,* 25 INT'L MIGR. REV. 737, 752, 756–57 (1991).

> conditions of work which, according to national law and practice, are covered by these terms;[11]

In Article 28, the Migrant Convention continues:

> Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.[12]

Articles 43 and 45 provide that migrant workers and their families shall "enjoy equality of treatment with nationals" in relation to "[a]ccess to social and health services, provided that requirements for participation in the respective schemes are met."[13]

B. The International Human Right to Health of Non-Citizens in the United States

There are numerous international and regional treaties that recognize an international human right to health and cover any human being in the specified jurisdiction of the treaty. Provided below in Figure 1 are the international and regional treaties for which the U.S. is eligible to join and which recognize the international human right to health and specify its content. Canada and Mexico also are eligible to join these treaties.

Figure 1
SIGNATURE AND RATIFICATION OF MAJOR INTERNATIONAL HUMAN RIGHTS INSTRUMENTS BY THE UNITED STATES

INSTRUMENT	SIGNATURE	RATIFICATION
UNITED NATIONS		
U.N. Declaration of Human Rights (Not a Treaty)	Yes	N/A
Constitution of the World Health Organization	Yes	Yes
International Covenant for Civil and Political Rights (ICCPR)	Yes	Yes (June 8, 1992)
International Covenant for Economic, Social and Cultural Rights (ICESCR)	Yes (Oct. 5, 1977)	No

[11] Migrant Convention, *supra* note 9, at art. 25.
[12] *Id.* at art. 28.
[13] *Id.* at arts. 43(1)(e), 45(1)(c) (discussing migrant workers and family members, respectively).

International Convention on the Elimination of All Forms of Racial Discrimination	Yes	Yes (Oct. 21, 1994)
Convention on the Elimination of All Forms of Discrimination Against Women	Yes (July 17, 1980)	No
Convention on the Rights of the Child (CRC)	Yes (Feb 16, 1995)	No
Convention on the Rights of Persons with Disabilities	Yes (Jul. 30, 2007)	No
ORGANIZATION OF AMERICAN STATES		
American Declaration of the Rights and Duties of Man (Not a Treaty)	Yes	N/A
American Convention on Human Rights ("Pact of San José, Costa Rica")	Yes (June 1, 1977)	No
Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador") (art. 10) (1988)	No	No

The major international treaties recognizing the international human right to health are U.N. treaties and instruments.[14] The Constitution of the World Health Organization (WHO) defines "health" broadly as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[15] The WHO Constitution goes on to state that "[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[16]

The UDHR includes a right to health and health care as a recognized international human right. Specifically, Article 25 of the UDHR states: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including . . . medical care . . . and the right to security in the event of . . . sickness [and/or] disability . . . ."[17] Subsequently, the U.N. adopted two covenants to implement the UDHR: the

[14] The material in this section draws from Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 337–40 (2008).

[15] Constitution of the World Health Organization, pmbl., July 22, 1946, 62 Stat. 6349, 14 U.N.T.S. 185, *reprinted in* 15 DEP'T ST. BULL. 211 (1946).

[16] *See id.*

[17] *See* UDHR, *supra* note 3, at art. 25.

International Covenant on Civil and Political Rights (ICCPR)[18] and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[19]

The ICCPR is important in that it precludes state discrimination regarding societal benefits and recognizes that all people have a right to life.[20] The ICCPR also provides that: "Everyone shall have the right to recognition everywhere as a person before the law."[21] The ICESCR is the major U.N. treaty recognizing the international human right to health. According to Article 12 of ICESCR, the right to health includes "the enjoyment of the highest attainable standard of physical and mental health."[22] Article 12 requires that all state parties "recognize [this] right of *everyone*."[23]

A human right to health is also recognized in numerous other U.N. international human rights treaties that address the needs of historically vulnerable populations who have often been the subject of discrimination. Such treaties include the International Convention on the Elimination of All Forms of Racial Discrimination,[24] the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[25] and the Convention on the Rights of the Child.[26] The most recent U.N. convention on human rights is the Convention on the Rights of Persons with Disabilities.[27] All of these

[18] International Covenant on Civil and Political Rights, Mar. 23, 1976, G.A. Res. 2200 (XXI) A, U.N. Doc. A/RES/2200(XXI) [hereinafter ICCPR].

[19] International Covenant on Economic, Social, and Cultural Rights art. 2, Dec. 16, 1966, G.A. Res. 2200 (XXI) A, U.N. Doc. A/RES/2200(XXI) [hereinafter ICESCR]; *see generally* Philip Alston & Gerard Quinn, *The Nature and Scope of States Parties' Obligations Under the International Covenant on Economic, Social and Cultural Rights,* 9 HUM. RTS. Q. 156 (1987) (discussing how economic, social, and cultural rights can have legal legitimacy in a human rights framework).

[20] *See* ICCPR, *supra* note 18, at art. 6.

[21] *See id.* at art. 16.

[22] *See* ICESCR, *supra* note 19, at art. 12.

[23] *Id.* (emphasis added). Article 12 then enumerates several steps to be taken for "full realization" of this right. These steps include:

> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness. *Id.*

[24] International Convention on the Elimination of All Forms of Racial Discrimination, Jan. 4, 1969, S. Exec. Doc. C, 95-2 (1978), 660 U.N.T.S. 195, *available at* http://treaties.un.org/doc/Treaties/1969/03/19690312%2008-49%20AM/Ch_IV_2p.pdf.

[25] Convention on the Elimination of All Forms of Discrimination Against Women, Dec. 19, 1979, G.A. Res. 34/180 A, U.N. Doc. A/RES/34/180 [hereinafter CEDAW], *available at* http://treaties.un.org/doc/Treaties/1981/09/19810903%2005-18%20AM/Ch_IV_8p.pdf.

[26] United Nations Convention on the Rights of the Child art. 14, Nov. 20, 1989, G.A. Res 44/25, U.N. Doc. No. A/44/736 [hereinafter CRC], *available at* http://treaties.un.org/doc/Treaties/1990/09/19900902%2003-14%20AM/Ch_IV_11p.pdf.

[27] Convention on the Rights of Persons with Disabilities, Dec. 13, 2006, G.A. Res. 61/106, art. 9(1), 25(c), U.N. Doc. A/RES/61/106, *available at* http://treaties.un.org/doc/Publication/CTC/Ch_IV_15.pdf.

treaties have provisions that protect the right to health and health care services of the vulnerable populations they cover.[28] Also, as they apply to all persons in the classification, they are particularly helpful statements of the right to health for non-citizens.

III. Realizing the International Human Right to Health and Health Care for Non-Citizens in the United States

In 2000, the U.N. Economic, Social and Cultural Committee published a General Comment 14 to ICESCR that outlines the content of the international right to health under this treaty.[29] General Comment 14 imposes three types or levels of obligations: the obligations to respect, protect, and fulfill. Using this framework, this article examines whether the United States fully realizes the international human right to health for non-citizens.[30]

In addition to obligations, there are also remedies if states parties do not fulfill the international human right to health. General Comment 14 explicitly provides that a state party "which is unwilling to use the maximum of its available resources for the realization of the right to health is in violation of its obligations under Article 12" and places the burden on the state party to justify that it has made use of "all available resources at its disposal" to satisfy its obligations regarding the right to health.[31] General Comment 14 also specifies violations of Article 12, including "[s]tate actions, policies or laws that contravene the standards set out in [A]rticle 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality."[32]

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[28] International Convention on the Elimination of All Forms of Racial Discrimination, *supra* note 24, at arts. 5–6 ("The right to public health, medical care, social security and social service."); CEDAW, *supra* note 25, at art. 10, 12, 14 ("States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning . . . States Parties shall take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that they participate in and benefit from rural development and, in particular, shall ensure to such women the right. . . . [t]o have access to adequate health care facilities, including information, counseling [sic] and services in family planning."); CRC, *supra* note 26, at arts. 11, 24 ("States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."); Convention on the Rights of Persons with Disabilities, *supra* note 27, at arts. 18, 25 ("States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.").

[29] *See* U.N. Econ. & Soc. Council [ESOSOC], Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14 (art. 12), U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter ICESCR General Comment 14].

[30] *See* Kinney, *supra* note 14, at 340–41.

[31] *See* ICESCR General Comment 14, *supra* note 29, ¶ 47.

[32] *See id.* ¶ 51.

Violations of the obligation to protect include "the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties."[33] Violations of the obligation to fulfill include "failure of States parties to take all necessary steps to ensure the realization of the right to health."[34] General Comment 14 also accords remedies to individual parties.[35]

A. The Duty to Respect and Protect

Pursuant to General Comment 14, the obligation to respect requires states parties to refrain from interfering directly or indirectly with the enjoyment of the right to health.[36] The obligation to protect requires states parties to take measures that prevent third parties from interfering with Article 12 guarantees.[37]

Federal and state civil rights laws prohibit discrimination in public accommodations and access to government programs on the basis of race, religion, gender, and national origin.[38] Two federal laws specifically address discrimination on the basis of physical disability and, thereby, establish an important source of obligations and rights regarding access to health care. Specifically, § 504 of the Rehabilitation Act prohibits discrimination in employment against individuals with handicaps by entities that contract with or receive funds from the federal government. [39] The Americans with Disabilities Act (ADA), with a broader mandate, prohibits discrimination against the disabled in employment, public services, accommodations, and telecommunications.[40] Also, as a condition of receiving construction funds under the federal Hill-Burton program, health care institutions must be open to all people in the relevant service area.[41] States also have civil rights laws that prohibit discrimination on the basis of disability, race, creed, gender, and

[33] *See id.* ¶ 50.
[34] *See id.* ¶ 52.
[35] See id. ¶ 59.
[36] *See id.* ¶ 33.
[37] *See id.*
[38] *See* 42 U.S.C. § 2000a(a) (2010) (pertaining to federal civil rights authorities); 15 AM. JUR. 2D, *Civil Rights* §§ 223–31 (2000) (pertaining to state civil rights authorities); Kinney, *supra* note 14, at 362–63.
[39] *See* Rehabilitation Act of 1973, Pub. L. No. 93-112, § 504, 87 Stat. 355, 394 (codified at 29 U.S.C. § 794 (2010)).
[40] *See* Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327 (codified at 42 U.S.C. § 12101 (2010)); *see also* David Orentlicher, *Deconstructing Disability: Rationing of Health Care and Unfair Discrimination against the Sick*, 31 HARV. C.R.-C.L. L. REV. 49, 51–58 (1996) (discussing the legislative history and judicial interpretation of anti-discrimination laws pertaining to disabilities); Philip G. Peters, Jr., *Health Care Rationing and Disability Rights*, 70 IND. L.J. 491, 494 n.9 (1995) (exploring the legal and ethical legitimacy of whether medical effectiveness should be used as a criterion for allocating health resources).
[41] *See* 42 C.F.R. § 124, subpt. G (2002); 42 U.S.C. § 300o (repealed 1979).

national origin.[42] Civil Rights authorities are useful in protecting immigrants who have legal status in the U.S. but have been limited in protecting undocumented immigrants.[43]

B. The Duty to Fulfill

The obligation to fulfill requires states parties to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures toward the full realization of the right to health.[44] Regarding the duty to fulfill, General Comment 14 charges states parties "to take whatever steps are necessary to ensure that everyone has access to health facilities, goods and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health."[45] Implementation also requires adoption of "a national strategy to ensure to all the enjoyment of the right to health, based on human rights principles which define the objectives of that strategy, and the formulation of policies and corresponding right to health indicators and benchmarks."[46] The national health strategy should also "identify the resources available to attain defined objectives, as well as the most cost-effective way of using those resources."[47]

The U.S. has fallen short of fulfilling the international human right to health for its citizens. Until March 2010, the U.S. had public programs only for the aged, disabled, and poor women and children in its Medicare and Medicaid programs.[48] In March 2010, the U.S. Congress enacted, and the President signed, a comprehensive health reform law for the United States.[49] The legislation does not cover all immigrants in the United States.[50]

1. Public Health Insurance Programs in the United States

The Medicare program is a social insurance program available to persons aged sixty five and older, seriously disabled individuals, and people

[42] *See generally* 15 AM. JUR. 2D, *Civil Rights* §§ 223–31 (2000) (addressing state civil rights authorities).

[43] *See, e.g.*, AMERICAN CIVIL LIBERTIES UNION, IMMIGRATION DISCRIMINATION, http://www.aclu.org/immigrants-rights/immigration-discrimination (last visited Apr. 7, 2011) (providing legal and policy-making resources for the protection of undocumented immigrants).

[44] ICESCR General Comment 14*, supra* note 29, ¶ 53.

[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] *See* Social Security Amendments of 1965, Pub. L. No. 89-97, § 102(a), 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395 (2010)); *id.* § 121(a), 79 Stat. 343 (codified as amended at 42 U.S.C. § 1396 (2010)).

[49] *See* Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119–1025 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029–84 (2010).

[50] *See infra* notes 93–94 and accompanying text.

with end-stage renal disease.[51] Basic Medicare benefits include hospital and extended-care services, as well as physician and other outpatient services on a fee-for-service basis,[52] or as part of a prepaid health plan.[53] Medicare also includes an optional prescription-drug benefit.[54]

Medicaid, jointly financed and administered by the federal government and the states, provides health insurance for some disabled and aged poor, as well as poor mothers, infants, and children.[55] The Federal Medicaid statute sets forth requirements for eligibility and benefits that states must adopt and also allows states to cover other groups of poor and provide other benefits at the state's option.[56] The Medicaid program provides basic hospital, physician, and long-term care services to eligible individuals.[57] The State Children's Health Insurance Program covers all children up to 200% of the federal poverty level.[58]

In 2009, Medicare, Medicaid, and other public programs covered 30.6% of the U.S. population, a larger percentage than earlier years.[59] Further, these programs provide limited coverage to individuals who are not citizens of the U.S. In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) which clarified the eligibility rules for non-citizens.[60] PRWORA defined "qualified aliens" for public programs as: legal permanent residents, asylees, and refugees as well as other narrowly defined groups.[61] Only "qualified aliens," which excludes undocumented immigrants, are eligible for "Federal Public Benefits" defined as:

- Any grant, contract, loan, professional or commercial license provided by an agency of the United States or by appropriated funds of the United States; and
- Any retirement, welfare, health, disability, public or assisted housing, postsecondary education, food assistance, unemployment benefit, or

[51] *See* 42 U.S.C. § 1395c (2010).
[52] *See id.* §§ 1395c–1395i; *id.* §§ 1395j–1395w-4.
[53] *See id.* § 1395w-21.
[54] *See id.* § 1395w-101.
[55] *See id.* § 1396.
[56] *See id.* § 1396a.
[57] *See id.*
[58] *See id.* § 1397aa.
[59] *See* CARMEN DENAVAS-WALT ET AL., U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, 21 fig. 7 (2010).
[60] *See* Pub. L. No. 104-193, 110 Stat. 2105 (codified as amended in scattered sections of 42 U.S.C.); ASPE.HHS.GOV, SUMMARY OF IMMIGRANT ELIGIBILITY RESTRICTIONS UNDER CURRENT LAW (As of 2/25/2009), http://aspe.hhs.gov/hsp/immigration/restrictions-sum.shtml (last visited Apr. 7, 2011).
[61] PRWORA § 431 (codified as amended at 8 U.S.C. §§ 1611–14 (2010)); *see* U.S. Dep't of Health & Human Servs., Notice, Personal Responsibility and Work Opportunity Reconciliation Act of 1996; Interpretation of "Federal Public Benefit," 63 Fed. Reg. 41658 (Aug. 4, 1998).

> any other similar benefit for which payments or assistance are provided to an individual, household, or family eligibility unit by the United States or by funds of the United States.[62]

Providers of such benefits are required to verify immigrant status before conferring benefits.[63] In the Deficit Reduction Act of 2005, Medicaid providers are now required to ascertain the immigrant status of beneficiaries before service.[64]

Medicare is thus, under PRWORA, available to otherwise eligible naturalized citizens and legal immigrants, but not to undocumented immigrants.[65] Regarding Medicaid, unauthorized aliens are excluded from Medicaid and other public benefit programs, and qualified "aliens" are subject to a five-year waiting period for Medicaid eligibility.[66] Immigrants who have to file an affidavit of support stating that the applicant will not become a public charge must wait ten years to qualify.[67]

More recently, Medicaid restrictions have loosened up a little. The Medicare Modernization Act of 2003 established an emergency services benefit for undocumented immigrants.[68] The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) authorizes states, at their option, to provide health coverage with federal funding to lawfully residing immigrant children and pregnant women through the Medicaid and Children's Health Insurance Program (CHIP).[69]

The federal government provides a wide range of other programs providing health care, including massive health systems for the military and veterans.[70] The federal government also funds direct health care services

[62] *See* PRWORA § 401 (codified as amended at 8 U.S.C. § 1611 (2010)); Notice, Interpretation of "Federal Public Benefit," *supra* note 61; ASPE.HHS,GOV, *supra* note 60.

[63] *See* PRWORA §§ 401–04 (codified as amended at 8 U.S.C. §§ 1611–14 (2010)).

[64] *See* Pub. L. No. 109-171 § 6306, 116 Stat. 716 (codified as amended Social Security Act § 1903, 42 U.S.C. §1396b (2010)).

[65] *See supra* note 61 and accompanying text.

[66] *See supra* notes 61 and accompanying text.

[67] *See* PRWORA §§ 401–04 (codified as amended at 8 U.S.C. §§ 1611–14 (2010)).

[68] *See* Medicare Prescription Drug, Modernization and Improvement Act, Pub. L. No. 108-173 § 1011, 17 Stat. 2066, (codified as amended 42 U.S.C. 1395dd); *see also* NATIONAL IMMIGRATION LAW CENTER, CENTERS FOR MEDICARE AND MEDICAID SERVICES ISSUES FINAL GUIDANCE ON REIMBURSING HEALTH CARE PROVIDERS FOR EMERGENCY SERVICES TO UNINSURED IMMIGRANTS (2005), *available at* http://www.nilc.org/immspbs/health/health033.htm (last visited Apr. 7, 2011) (providing guidance on the Medicare Prescription Drug, Modernization and Improvement Act).

[69] Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. No. 111-3 § 214, 123 Stat. 8 (2009) (codified as amended at Social Security Act § 1903(v), 42 U.S.C. 1396b(v) (2010)); *see* National Immigration Law Center, *Federal Funding for States to Provide Health Coverage to Immigrant Children and Pregnant Women*, FACTS ABOUT (2010), *available at* http://www.nilc.org/immspbs/cdev/ICHIA/ICHIA-facts-2010-08-06.pdf (last visited Apr. 7, 2011).

[70] *See* 38 U.S.C. §§ 1701–84.

through various block grants to states.[71] A crucial federal program provides direct services to the poor through community health centers in rural and medically underserved areas through community health services around the country.[72] All of these programs, many of which are defined as Federal Public Benefits under PRWORA,[73] have strict citizen verification requirements as a determinant of eligibility for services.[74]

Finally, the federal government, through the Emergency Medical Treatment and Active Labor Act (EMTALA),[75] imposes a duty on hospitals that serve Medicare patients to screen and stabilize all patients, including non-citizens, who present at the emergency room for treatment. Many states also have laws that impose duties on emergency services of hospitals to address needs of all people presenting themselves for care regardless of ability to pay.[76] Interestingly, this body of law mandating hospitals to provide emergency treatment does much to realize the human right to emergency medical treatment for migrants and their families in the International Covenant on the Protection of the Rights of All Migrant Workers and Members of Their Families.[77]

2. Private Health Insurance in the United States

The great majority of the U.S. population (67.9%) has private health insurance—either through an employer or a commercial insurance company.[78] State insurance regulators regulate private commercial health insurance plans and health maintenance organizations (HMOs).[79] The federal Employee Retirement Income Security Act regulates the employee-welfare benefit plans,

[71] *See* 42 U.S.C. §§ 300w–300y-11.

[72] *See id*. §§ 254b–254c-1.

[73] *See supra* note 61 and accompanying text.

[74] *See* NATIONAL IMMIGRATION LAW CENTER, HOW ARE IMMIGRANTS INCLUDED IN HEALTH CARE REFORM? (2010), *available at* http://www.nilc.org/immspbs/health/immigrant-inclusion-in-HR3590-2010-04-19.pdf (last visited Apr. 7, 2011).

[75] *See* Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA), Pub. L. No. 99-272, 100 Stat. 82, (codified as amended at Social Security Act § 1867, 42 U.S.C. § 1395dd (2010)); Final Rule, Centers for Medicare & Medicaid Services (CMS), Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare-Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53, 221 (Sept. 9, 2003) (codified at 42 C.F.R. pts. 413, 482, 489).

[76] *See* Karen H. Rothenberg, *Who Cares: The Evolution of the Legal Duty to Provide Emergency Care*, 26 HOUS. L. REV. 21, 75 (1989).

[77] *See supra* note 12 and accompanying text.

[78] DENAVAS-WALT ET AL., *supra* note 59, at 21 fig. 7.

[79] *See* Paul v. Virginia, 75 U.S. 168, 184–85 (1868) (holding that the business of insurance was not in interstate commerce and did not fall within Congressional power); *see generally* KATHLEEN HEALD ETTLINGER ET AL., STATE INSURANCE REGULATION (1995) (discussing state insurance laws and their effect on healthcare disparity).

including health insurance, of private employers.[80] Employers are encouraged to provide health coverage to employees because employee health insurance is a deductible business expense under federal and state income tax codes.[81] ERISA establishes requirements for employee benefit plans that are eligible for favorable federal tax treatment designed to protect plan participants and beneficiaries.[82] One very important characteristic of private health insurance is that it is available for purchase without proof of citizenship.

3. The Uninsured and the Patient Protection and Affordable Care Act of 2010

In 2009, there were 50.7 million uninsured individuals in the United States—16.7% of the U.S. population.[83] Non-citizens constitute about 21% of the uninsured.[84] They also have characteristics associated with higher rates of lack of health insurance. Specifically, they are more likely to have characteristics associated with higher uninsured rates. Non-citizens are more likely than citizens to be Hispanic (59% versus 12%), have incomes below 200 percent of the federal poverty level (51% versus 30%), be young adults age eighteen to thirty-four (42% versus 22%), and work for small firms with fewer than 100 employees (34% versus 22%).[85] Immigrants tend to have more limited access to health insurance and health care services.[86] They also suffer greater adverse effects on health due to social disparities.[87]

The Patient Protection and Affordable Care Act (PPACA),[88] as amended by the Health Care and Education Reconciliation Act of 2010,[89] initiated comprehensive health reform to address the problem of the uninsured

[80] *See* Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 15 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

[81] *See* I.R.C. § 162(a) (2006) (pertaining to employer deduction); *id.* § 106 (pertaining to employer contributions to employee health plans).

[82] *See* 29 U.S.C. § 1001(a) (2006).

[83] *See* DENAVAS-WALT ET AL., *supra* note 59, at 22 fig. 8.

[84] *See* ASPE ISSUE BRIEF, *supra* note 1.

[85] *See id.*

[86] *See* Kathryn Pitkin Derose, et al., *Review: Immigrants and Health Care Access, Quality, and Cost*, 66 MEDICARE CARE RES. & REV. 355, 355–408 (2009); Leighton Ku, *Health Insurance Coverage and Medical Expenditures of Immigrants and Native-Born Citizens in the United States*, 99 AM. J. PUB. HEALTH 1322, 1323 (2009); KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID AND SCHIP ELIGIBILITY FOR IMMIGRANTS (Apr. 2006), *available at* http://www.kff.org/medicaid/upload/7492.pdf (last visited Apr. 8, 2011); Leighton Ku & Sheetal Matani, *Left Out: Immigrants' Access to Health Care and Insurance*, 20 HEALTH AFFS. 247, 249 (2001).

[87] *See* William A. Vega et al., *Health Disparities in the Latino Population*, 31 EPIDEMIOLOGY REV. 99, 103 (2009).

[88] *See* Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119–1025 (2010).

[89] *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029–84 (2010).

in the health care sector of the U.S. The law expands access to health care coverage through expansion of public programs and reform of the private health insurance market. In 2014 and forward, PPACA expands Medicaid eligibility to persons with incomes up to 133% of the federal poverty level.[90]

The bill includes "a national strategy" as directed by General Comment 14 and calls for the development of additional health policy, along with indicators and benchmarks, to implement the strategy called for in General Comment 14.[91] The national health strategy embodied in the law identifies "the resources available to attain defined objectives, as well as the most cost-effective way of using those resources."[92]

Like existing public programs, PPACA distinguishes among naturalized citizens, legal immigrants, and undocumented immigrants. On the one hand, naturalized citizens have the same access and responsibilities regarding health coverage as U.S.-born citizens.[93] On the other hand, undocumented immigrants have no access or rights under PPACA.[94] Indeed, the possible coverage of undocumented immigrants was one of the most contentious issues in the debate on the health reform legislation.[95]

Legal immigrants enjoy coverage under PPACA. However, they are subject to existing requirements for public programs including verification requirements.[96] They are subject to the mandate to purchase insurance, may purchase health coverage from the state health insurance exchanges established under PPACA and enjoy other benefits under the act as well.[97] There are verification requirements attending the purchase of private health insurance through the state exchanges.[98] Although PPACA increases Medicaid eligibility levels,[99] it still maintains the five-year-or-more waiting period for most lawfully residing, low-income immigrant adults. [100]

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[90] *See* PPACA § 2001 (codified as amended at Social Security Act §1902(a)(10)(A)(i), 42 U.S.C. §1396a (2010)).

[91] *See supra* notes 49–50 and accompanying text.

[92] *Id.*

[93] *See* PPACA § 1311(b)(1) (states must allow equal access to all qualified applicants); NATIONAL IMMIGRATION LAW CENTER, *supra* note 74. For an excellent review and analysis of the provisions of PPACA affecting all kinds of immigrants, see Nathan Cortez, *Embracing the New Geography of Health Care: A Novel Way To Cover Those Left Out of Health Reform,* 84 S. CAL. L. REV. (forthcoming 2011).

[94] *See* PPACA § 1312(f)(3).

[95] Jim P. Stimpson et al., *Trends In Health Care Spending For Immigrants In The United States*, 29 HEALTH AFFS. 544, 550 (Feb. 2010); *see also* Jake Tapper, *From the Fact Check Desk: Illegal Immigrants and Health Care Reform*, ABC NEWS, Sept. 10, 2009, http://blogs.abcnews.com/politicalpunch/2009/09/from-the-fact-check-desk-illegal-immigrants-and-health-care-reform.html.

[96] *See supra* notes 93 and accompanying text.

[97] *See* Cortez, *supra* note 93.

[98] *See* PPACA § 1411(b)(2); RUTH ELLEN WASEM, CONG. RESEARCH SERV., RL 40889, NONCITIZEN ELIGIBILITY AND VERIFICATION ISSUES IN THE HEALTH CARE REFORM LEGISLATION 3 tbl. 1 (2010).

[99] *See supra* note 90 and accompanying text.

[100] *See supra* notes 60–64 and accompanying text.

The Congressional Budget Office predicted that the number of uninsured would go from fifty-four million to twenty-three million over the next decade, reducing the percentage of uninsured from nineteen to eight percent.[101] However, twenty-three million remain uninsured and an estimated third of these people will be unauthorized immigrants.[102] PPACA does not even fulfill the international human right to health for all legal residents of the United States including natural born citizens. It clearly, and understandably, falls short when it comes to non-citizens.

IV. A Role for NAFTA and Economic Integration

Other approaches are needed to address the realization of the international human right to health for non-citizens of the U.S. or of any country for that matter. First, it is important to appreciate that immigration policy and law is inextricably related to health policy and law. People are always going to seek better economic opportunity through immigration—even illegal immigration. Furthermore, people are always going to seek health care whether they have the money to pay for it or not, so a more conscious recognition of the interrelatedness of these two sets of law and policy is imperative.

An important way to improve the realization of the international human right to health among immigrants of all types is regularizing immigration laws to reflect what is happening "on the ground." With respect to the U.S. and Mexico and other Latin countries, undocumented immigrants are coming from the Latin countries to fill jobs in the United States that ostensibly would otherwise go unfilled. These immigrants provide important services in the U.S. It only makes sense to rationalize their status so that they can be absorbed into the legal economy and have attending legal rights.[103]

In 1993, the U.S. , Canada, and Mexico adopted and ratified the North American Free Trade Agreement (NAFTA).[104] The basic purpose of NAFTA is to "create an expanded and secure market for the goods and services produced in their territories."[105] NAFTA applies to all economic sectors including social services. The national governments of the three state parties must "ensure that all necessary measures" are taken in order to give effect to the NAFTA's provisions, including their observance by state, provincial, and

[101] *See* Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office (CBO), to Rep. Nancy Pelosi (Mar. 20, 2010) at 9, tbl. 2, *available at* http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf (last visited Apr. 8, 2011) [hereinafter CBO Letter]; Cortez, *supra* note 93.

[102] *See* CBO Letter, *supra* note 101, at 9; Cortez, *supra* note 93.

[103] *See generally* PATRICK TARDON ET AL., ECONOMIC MIGRATION, SOCIAL COHESION AND DEVELOPMENT (2009) (presenting the main aspects and characteristics of migration in the member states of the Council of Europe in determining a policy agenda).

[104] *See* North American Free Trade Agreement, U.S.-Can.-Mex., December 17, 1992, 32 I.L.M. 289 (1993) [hereinafter NAFTA].

[105] *Id.* at pmbl.

local governments.[106] The preamble of NAFTA expressly recognizes—as a cardinal principle—the right of parties to "preserve their flexibility to safeguard the public welfare."[107] NAFTA is playing a major role in integrating the health care sectors of the United States, Mexico and Canada,[108] but not to the benefit of all of the immigrants within each country.

The European Union provides a different, but more human model, for handling the movement of workers in a free trade zone and could serve as a model for NAFTA.[109] Since the establishment of the European Coal and Steel Commission in the early 1950s,[110] the countries of Europe have entered into a series of treaties that have established a common market and economic integration on the European continent.[111] The treaty establishing the European Community calls for the free flow of goods, services, capital and people within the common market. Article 39 addresses the mobility of workers in the E.U.:

> (1) Freedom of movement for workers shall be secured within the Community.
> (2) Such freedom of movement shall entail the abolition of any discrimination based on nationality between workers of the Member States as regards employment, remuneration and other conditions of work and employment.
> (3) It shall entail the right, subject to limitations justified on grounds of public policy, public security or public health:
> (a) to accept offers of employment actually made;
> (b) to move freely within the territory of Member States for this purpose;
> (c) to stay in a Member State for the purpose of employment in accordance with the provisions governing the employment of nationals of that State laid down by law, regulation or administrative action;
> (d) to remain in the territory of a Member State after having been employed in that State, subject to conditions which shall be embodied in implementing regulations to be drawn up by the Commission.

[106] *See id.* at art. 105.

[107] *See id.* at pmbl.

[108] *See* Eleanor D. Kinney, *Realization of the International Human Right to Health in an Economically Integrated North America*, 37 J. L. MED. & ETHICS 807, 808–09 (2009).

[109] See Eleanor D. Kinney, Health Care Financing and Delivery in the US, Mexico and Canada: Finding and Establishing Intentional Principles for Sound Integration, 26 WIS. INT'L L.J. 934, 935, 962–64 (2009).

[110] Treaty establishing the European Coal and Steel Community, Apr. 18, 1951, 261 U.N.T.S. 140, *available at* http://europa.eu/legislation_summaries/institutional_affairs/treaties/treaties_ecsc_en.htm (last visited Apr. 9, 2011).

[111] Consolidated Version of the Treaty Establishing the European Community art. 39, Dec. 24, 2002, 2002 O.J. (C 325) 51 [hereinafter Consolidated EC Treaty], *available at* http://eurlex.europa.eu/en/treaties/dat/12002E/pdf/12002E_EN.pdf (last visited Apr. 9, 2011).

> (4) The provisions of this article shall not apply to employment in the public service.[112]

The E.U. treaties allocate "competencies" to its governing bodies, to the Member States, or to both. In the realm of health care, the European Community has allocated control of social security to the Member States. Specifically, Article 152(5) of the Treaty of Rome provided that: "Community action in the field of public health shall fully respect the responsibilities of Member States for the organization and delivery of health services and medical care."[113]

In the 1997 Treaty of Amsterdam, Article 152 added to these public health provisions and stated the E.U.'s affirmative responsibility to ensure "a high level of human health protection" in the "definition and implementation of all policies and activities" and to work with Member States to improve public health, prevent illness, and "obviate[e] sources of danger to human health."[114] Thus, the Treaty of Amsterdam precipitated the development of health policy at the supranational level.[115]

Of note, the E.U. is committed to the promotion of the European Social Model in the 2000 Charter of Fundamental Rights of the European Union among other instruments.[116] The European Social Model calls for the full development of social services for all residents of Member States and the realization of the so-called European social model.[117] Regarding health care, the Charter provides:

> Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities. [118]

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[112] *Id.* at art. 39.

[113] *Id.* at art. 152.

[114] Treaty of Amsterdam Amending the Treaty on European Union, the Treaties Establishing the European Communities and Certain Related Acts art. 129, Oct. 2, 1997, 1997 O.J. (C 340) 39; *see* Henriette D.C. Roscam Abbing, *Public Health in the Treaty of Amsterdam (Treaty on the European Union)*, 5 EUR. J. OF HEALTH L. 171, 171–73 (1998).

[115] *See* ED RANDALL, THE EUROPEAN UNION AND HEALTH POLICY 115 (2001); Ben Duncan, *Health Policy in the European Union: How it's Made and How to Influence It*, 324 BRIT. MED. J. 1027, 1027 (2002).

[116] Charter of Fundamental Rights of the European Union ch. 4, Dec. 18, 2000, 2000 O.J. (C 364) 15 [hereinafter Charter of Fundamental Rights]; *see* John T. Addison and W. Stanley Siebert, *The Social Charter of the European Community: Evolution and Controversies,* 44 INDUS. & LAB. REL. REV. 597, 597–98 (1991).

[117] *See* Opinion of the European Economic and Social Committee on Social Cohesion: Fleshing Out a European Social Model, 2006 O.J. (C 309) 119.

[118] Charter of Fundamental Rights, *supra* note 116, at art. 35; *see* Tamara K. Hervey, *The 'Right to Health' in European Union Law, in* ECONOMIC AND SOCIAL RIGHTS UNDER THE EU CHARTER OF FUNDAMENTAL RIGHTS 202 (Tamara K. Hervey & Jeff Kenner eds., 2003).

Finally, several decisions of the European Court of Justice (ECJ) on health care issues. Specifically, in the 1990s, the ECJ upheld the right of residents of one Member State to receive health care services in other Member States at the expense of their national health programs.[119] These decisions have precipitated the European Commission to propose rules that further integrate the health sectors of E.U. Member States with more formal provisions for cross border access to health care.[120] There is a considerable concern as well as anticipation about what these cases and policies mean for the future of autonomous national health sectors.[121]

While it is perhaps unrealistic to envision an E.U. style economic community on the North American continent, particularly with all the attending rhetoric about social models and solidarity, the three states partie to NAFTA need to give more attention to the issue of the economic integration of health care services and access to healthcare for non-citizen workers. With respect to immigration, however, U.S. policy seems to be tightening access for legal entry into the U.S. for workers—contrary to the more open approaches used for goods, services and capital.[122] However, there are steps that could be taken to address access to health care services for non-citizens in NAFTA countries.

Specifically, the three North American countries should endeavor to coordinate their public insurance programs and private insurance regulation to enhance access to health insurance for non-citizens in other countries.[123] Regarding public programs, the three countries should at least make them portable so that they cover emergency services throughout NAFTA territory.

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[119] Case C-157/99, Smits and Peerbooms, 2001 E.C.R. I-5473, para. 108; Case C-120/95, Decker v. Caisse de Maladie des Employes Prives, 1998 E.C.R. I-1831, para. 15; Case C-158/96, Kohll v. Union des Caisses de Maladie, 1998 E.C.R. I-1931, para. 8; *see* Rory Watson, *European Court's Ruling Paves Way for Cross-Border Treatment*, 323 BRIT. MED. J. 128, 128 (2001).

[120] *See, e.g.*, Rory Watson, European Commission Proposes Rules for Cross Border Health Care, 337 BRIT. MED. J. 676 (2008) (discussing potential expansion of healthcare in Europe); Stephen Castle, European Plan Would Expand Health Care Access within the Bloc, N.Y. Times, July 3, 2008, http://www.nytimes.com/2008/07/03/world/europe/03health.html (discussing the 2008 European comprehensive healthcare plan).

[121] *See* Tamara Hervey & Louise Trubek, *Freedom to Provide Health Care Services Within the EU: An Opportunity for a Transformative Directive*, 13 COLUM. J. EUR. L. 623, 626–27 (2007); Michael Dougan & Helen Stalford, *The Impact of Migration on Healthcare in the EuropeanUnion*, 14 MAASTRICHT J. EUR. & COMP. L. 209, 210 (2007); Christopher Newdick, *Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity*, 43 COMMON MKT. L. REV. 1645, 1646 (2006); *see generally* Mark L. Flear, *Developing Euro-Biocitizens through Migration for Healthcare Services*, 14 MAASTRICHT J. EUR. & COMP. L. 239 (2007) (examining how migration is affected by the availability of healthcare services).

[122] *See* Peter Andreas, The Escalation of U.S. Immigration Control in the Post-NAFTA Era, 113 POL. SCI. Q. 591 (1999).

[123] *See* Margaret A. Laws, *Foundation Approaches to U.S.-Mexico Border and Binational Health Funding*, 21 HEALTH AFFS. 271, 271–77 (2002).

Over time, it might be possible to consider eligibility for immigrants who meet the criteria for public programs. If benefits were portable, they could use them in their own countries upon return or as contributions to the public programs in their own countries.

Certainly there could be better coordination of the private insurance market which does not have to impose immigration status criteria for purchase of insurance. Professor Nathan Cortez has recently published an article proposing how the private health insurance market might be reformed in order to expand access to health insurance across borders.[124] Professor Cortez's plan would create a new framework for the regulation of health insurance:

> This framework would (i) legally authorize insurers to utilize foreign providers, (ii) give insurers flexibility to design plans that actually appeal to the uninsured, (iii) specify minimum coverage requirements, (iv) identify regulatory proxies for ensuring quality care, and (v) address other legal hurdles that presently discourage cross-border care.[125]

His article compares the experience of the only two states that have formally addressed cross-border insurance: California and Texas. California legalized cross-border plans for a narrow population in 1998,[126] and Texas banned such plans altogether in 2007.[127] Using fair trade law, it might well be argued that these kinds of limitations and bans are trade barriers as they discriminate against foreign providers.

V. Conclusions and Recommendations

In conclusion, immigration and trade law must come together with health law to address the problem of realizing the international human right to health for non-citizens in the United States and other countries of the world. In this joint enterprise, the following five principles should guide the making of law and policy in these three areas:

1. All people are entitled to the international human right to health regardless of their legal status in a particular geographic region.
2. Realizing the international human right to health must be achieved on a global level.
3. Trade agreements and policy should support national health insurance programs and public health efforts.

[124] *See* Cortez, *supra* note 93.

[125] *See* Cortez, *supra* note 93.

[126] *See* 1998 Cal. Legis. Serv. Ch. 1025 (West) (codified as amended at CAL. HEALTH & SAFETY CODE §§ 1345, 1351.2 (West 1998)); Cortez, *supra* note 93.

[127] *See* S.B. 1391, 80th Leg., 2007 Reg. Sess. (Tex. 2007) (codified at TEX. INS. CODE ANN. ch. 1215, later amended as ch. 1216); Cortez, *supra* note 93.

4. Public and private health insurance programs should be portable across national boundaries.
5. Goods, services, capital, and *people* should flow freely across nation states.