Human rights and immigrants' access to care

Wendy Parmet, BA, JD,[1] Simon Fischer, BA.[1]

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Abstract

Although the human right to health is well established under international law, many states limit non-citizens' participation in public insurance programs. In the United States, immigrants face especially high barriers due to the lack of recognition of a broad right to health as well as federal statutes restricting many immigrants' eligibility to federally-funded insurance. High rates of uninsurance among immigrants have a detrimental effect on their health, as well as on the health of citizens who live in their communities. *Finch vs. Commonwealth Health Insurance Connector*, a recent case decided by the Supreme Judicial Court of Massachusetts, recognized the rights of legal immigrants in Massachusetts to state-supported health care, and demonstrates the importance of insuring immigrants in broadly-based, rather than immigrant-specific, programs.

Key words: Emigrants and immigrants; human rights; civil rights; national health programs

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Resumen

Aunque el derecho a la salud está bien establecido en el derecho internacional, muchos Estados limitan la participación de los no-ciudadanos en los programas de salud pública. En los Estados Unidos, los inmigrantes enfrentan grandes barreras debido a la falta de reconocimiento a un derecho amplio a la salud y porque los estatutos federales restringen la elegibilidad de muchos inmigrantes a seguros médicos financiados con fondos federales. Las altas tasas de inmigrantes sin seguro médico tienen un efecto perjudicial sobre su salud, así como en la salud de los ciudadanos que viven en sus comunidades. En el caso reciente de *Finch vs. Commonwealth Health Insurance Connector*, la Corte Suprema de Massachusetts reconoció el derecho de los inmigrantes legales en Massachusetts a obtener un seguro médico apoyado por el Estado y demostró la importancia de incorporar a los inmigrantes en programas de salud ya establecidos, en vez de individualizar los programas hacia el inmigrante.

Palabras clave: emigrantes e inmigrantes; derechos humanos; derechos civiles; programas nacionales de salud

The human right to health is well established in international law. Nevertheless, immigrants in many nations, especially those who are not citizens, face unique barriers to accessing health care because of their immigration status. This article examines this contrast between immigrants' human right to health and their access to health care, focusing in particular on immigrants' access to health care in the United States. We begin in Part I by reviewing the status of immigrants' right to health under international law. In Part II we turn to the situation within the U.S., discussing first immigrants' right to health under U.S. domestic law and second, the impact of the denial of care on immigrants' health. In Part III we explore some approaches advocates may use to support immigrants' right to health, emphasizing a recent case from the state of Massachusetts.

(1) Northeastern University. Boston, MA, USA.

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Corresponding author: Wendy Parmet. Northeastern University School of Law. 400 Huntington Ave. Boston, MA 02115, USA
E-mail: w.parmet@neu.edu

Part I

The Universal Declaration of Human Rights famously declares that everyone "has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…."[1] Likewise, Article 12 of the International Covenant on Economic and Social Rights requires States to respect "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[2] The Convention on the Rights of the Child extends this right to children so that they may enjoy, "the highest attainable standards of health and to facilities for the treatment of illness and rehabilitation of health."[3]

Under international law the right to health includes both freedoms and entitlements. The entitlements are not limited to access to health care, and include goods, such as potable water, that are essential to securing health. Still, access to health care is one of the conditions necessary for people to be healthy. Access to preventive services and primary care that can control chronic conditions is especially important. When individuals lack such care, not only does their own health suffer; the health of their communities is also threatened. For this reason, it is common to treat the right to health as implying an entitlement to health care. In many cases access to health care requires health insurance.

Under international law, nondiscrimination is a core principle of the right to health. The World Health Organisation (WHO) Constitution states that "The 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."[4] This right applies regardless of citizenship status. General Comment 14 issued by the Committee on Economic, Social and Cultural Rights (CESCR) asserts that States must "respect the right to health by inter alia refraining from denying or limiting equal access for all persons including asylum-seekers and illegal immigrants, to preventive, curative, and palliative health services."[5] General Comment 14 goes on to declare that health is a "fundamental human right," and that every person is "entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity." [5] In 2008, the CESCR released General Comment 19 which states that "[a]ll persons irrespective of their nationality, residency or immigration status, are entitled to primary and emergency care."[6]

The Committee on the Elimination of Racial Discrimination has likewise noted the need to "[r]emove obstacles that prevent the enjoyment of economic, social and cultural rights by non-citizens, notably in the areas of education, housing, employment and health."[7] The International Convention on the Elimination of All Forms of Racial Discrimination guarantees access to health care services "without distinction as to race, colour, or national or ethnic origin."[8] The United Nations Declaration on the Human Rights of Individuals who are not Nationals of the Country in Which They Live similarly proscribes a right to health protection for non-citizens and a right to receive medical care.[9]

Several regional human rights instruments also recognize that the human right to health belongs to all. For example, the Addition Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights proclaims the right to receive health care and obligates parties to exercise rights "without discrimination of any kind for reasons related to race, color, sex, language, religion, political or other opinions, national or social origin, economic status, birth or any other social condition."[10] The Organization for American States also emphasizes the health care needs of migrant workers in their "Inter-American Program for the Promotion and Protection of the Human Rights of Migrants, Including Migrant Workers and their Families."[11] This program aims to protect the human rights of migrant workers and provide them with sanitary medical care.

Despite these general principles, there is some ambiguity in international law that states may rely on in discriminating against non-citizens with respect to entitlements to health care services. For example, while Article 28 of the International Covenant on the Protection of the Rights of All Migrant Workers and their Families affirms that migrants have the "right to receive any medical care that is urgently required for the preservation of life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals,"[12] it is silent about other forms of health care. In fact, most states deny access to insurance for services other than emergency or essential care to at least some classes of non-citizens. Even states with robust national health insurance programs, such as Canada and the United Kingdom, discriminate against some immigrants with respect to non-emergency care.[13] In Canada, for example, undocumented immigrants are commonly excluded from health insurance plans, and limitations on coverage of other immigrants are common. Even those immigrants awaiting permanent residence status receive inferior health care. With the recent cuts to health expenditures, refugee claimants with pending claims are entitled to physician services "only for an urgent or essential nature" and to medications and vaccines only when necessary to "prevent or treat a disease that is a risk to public health or a condition of public safety."[14]

Likewise, immigrants that enter the United Kingdom from outside the European Union are forced to demonstrate evidence of medical insurance if they wish to receive non-emergency care, and the National Health Service imposes charges on immigrants for doctor visits.[15] Undocumented immigrants also face substantial barriers in many other European nations, including in Denmark, Sweden, and the Netherlands.[16]

Part II

Non-citizens in the United States face especially high barriers to accessing care. In part, this is because the U.S. does not recognize a right to health, even for its own citizens. The U.S. has not ratified the International Covenant on Economic, Social and Cultural Rights, or many of the other U.N. conventions that support the right to health. Moreover, the U.S. Supreme Court has found that federal Constitution does not provide any positive right to health.[17] Any enforceable right to health that exists must come from legislation.

Although Congress, which serves as the national legislature, has enacted many laws supporting access to care, including the 2010 landmark Affordable Care Act (ACA), it has never established a broad nationwide right to health care. Instead, Congress has enacted a hodgepodge of laws and programs, each with their own eligibility criteria and exclusions.

Most U.S. citizens under 65 years of age receive their health insurance through private employer-provided plans.[18] Non-citizens, however, tend to work in sectors of the economy, such as agriculture and the service industry, that often fail to provide insurance.[19-21] As a result, non-citizens are a little more than half as likely as citizens to have private insurance.[22]

The only nationwide statutory right to health that applies to everyone, regardless of citizenship status, is created by the Emergency Medical Treatment and Active Labor Act (EMTALA) which requires hospital emergency rooms to stabilize patients with medical emergencies regardless of their citizenship status or ability to pay.[23] EMTALA, however, is very limited in its scope. The right it offers ends when a patient is stabilized. Neither primary nor follow-up care is required.[20] Moreover, EMTALA does not provide health insurance. Patients may be charged for the emergency care that hospitals are required to provide.

Many residents of the U.S. receive insurance through federally-supported programs. The federal Medicare program covers almost all citizens over the age of 65. The Medicaid program, which is jointly run by the federal government and the states, insures many low-income Americans, though the eligibility criteria for Medicaid varies by state. Immigrants' access to both Medicare and Medicaid is significantly limited by the 1996 federal Personal Responsibility & Work Opportunity Reconciliation Act (PRWORA).[24] PRWORA denies federal public benefits to many classes of immigrants, including undocumented immigrants and most legal immigrants who have not held their legal status for at least 5 years. Because the federal government has so-called plenary power over immigration, courts have found this discrimination against non-citizens to be constitutional. [25,26]

The federal government does provide limited support for undocumented immigrants who receive emergency care. The Emergency Medicaid program reimburses hospitals that provide emergency care to undocumented immigrants who have an "emergency medical condition" and would have been eligible for Medicaid but for their immigration status.[27] However, coverage under the Emergency Medicaid program is quite stringent. Hospitals are only reimbursed if the immigrant has an emergency medical condition defined as one "(including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (A) placing the patient's health in serious jeopardy, (B) serious impairment to bodily functions, or (C) serious dysfunction of any bodily organ or part."[27] Because of these limitations, a large portion of the immigrants who receive care under the Emergency Medicaid program do so for childbirth and related complications.[28] Although Congress at one point allocated additional funds to hospitals for the treatments of uninsured immigrant populations, this support ended in 2007.[29]

As a result of the many barriers to coverage, non-citizens are almost three times as likely as citizens to be uninsured. Higher rates of uninsurance exist at every income level. Undocumented immigrants are especially likely to be uninsured.[20,21] One study in *Health Affairs* reported that 65 % of undocumented immigrants were uninsured.[30]

In 2014 President Obama's signature health reform law, the ACA, will be fully implemented.[31] The Act was intended to increase access to insurance and will do so significantly for citizens. However, once the Act is fully in effect, non-citizens will form a larger percentage of the uninsured in the U.S. than they do today.[20] This is because the ACA leaves in place PRWORA's restrictions on immigrants' access to Medicare and Medicaid. Moreover, while the ACA will provide lawfully present non-citizens with tax subsidies and credits to buy insurance on the newly created insurance exchanges where individuals and small businesses are expected to

purchase insurance,[21] undocumented immigrants will be barred from the exchanges.[20] Included among the class barred are young adults, known as the dreamers, who came to the U.S. as children and by virtue of an Executive Order can now stay and work in the U.S.[20,32] The ban on the participation in the exchanges of non-citizens who are not considered lawfully present also means that some who now have insurance will lose it if their employers decide, as many are expected to do, to move their health insurance programs to the exchanges.

The low rate of insurance among non-citizens has significant health consequences. Non-citizens are less likely than citizens to have a usual source of care.[33] They have problems receiving primary care and treatment for chronic conditions such as diabetes. Their children have lower vaccination rates and higher emergency room costs.[34] The lack of access to basic care also affects the overall health of the communities in which non-citizens reside. Low vaccination rates allow diseases such as measles and pertussis to break out in communities in which they were once rare. Likewise, restrictions on access to health care, including primary care and a usual source of care, may delay treatment for communicable diseases, including sexually transmitted infections (STIs) and tuberculosis, that can easily spread from immigrant populations to native born populations. In fact, "evidence suggests that factors that influence the level of access to basic health services among immigrants may directly impact the burden of infectious disease in the general population."[33]

Non-citizens' lack of insurance also imposes significant uncompensated costs on hospitals, especially in communities with large immigrant populations. A 2007 *Perspective* in the *New England Journal of Medicine* suggested that the uncompensated costs for treating undocumented immigrants in California might be as high as $740 million per year.[35] The costs hospitals bear for treating uninsured immigrants invariably impact other patients, through cost-shifting, reduction in services, and even hospital closings. These strains have led to some hospitals closing dialysis units and other critical services, leaving already burdened communities in an even worse position.[36] The denial of benefits to non-citizens also poses an ethical dilemma for health care workers. Nephrologists in particular have written about the ethical burdens they face when they must tell patients that they cannot be dialyzed until they experience an acute emergency.[37]

Immigrants' lack of insurance also imposes costs on their countries of origin. Anecdotal evidence suggests that significant numbers of immigrants return to their native country for medical care. Some have even been forcibly repatriated by U.S. hospitals that argue that they cannot afford to care for uninsured immigrants once they are stabilized. Last December an appellate court in the state of Iowa rejected a false imprisonment claim brought by the families of two Mexican immigrants who were flown back to Mexico while still semi-comatose.[38] The patients suffered traumatic brain injury in an automobile accident. Due to the severity of their injuries they each required long-term rehabilitative services. Rehabilitation facilities in Iowa refused to accept them as patients because of their undocumented status and lack of insurance. Rather than provide the rehabilitation services, the treating hospital chartered a plane and sent the patients back to Mexico to receive the necessary medical care.[38] The Iowa court speculated that such medical repatriations were increasingly commonplace, noting that because the patients were in stable condition, the hospital had not violated EMTALA.[38] A recent study has confirmed the court's speculations, finding evidence of over 800 cases of attempted or completed repatriations by hospitals in a six-year period.[39]

Part III

In recent years, human rights groups in the United States have had some success in expanding immigrants' access to health insurance. The federal government now pays for coverage for pregnant women and non-citizen children.[40] In addition the 2009 Children's Health Insurance Program (CHIP) Reauthorization Act permitted states to use federal funds to enroll lawfully residing children in CHIP up to age 19 and pregnant women through 60 days postpartum in Medicaid.[41] The federal government also permits states to create their own programs for low-income immigrants. Many states have done so, generally through programs that mirror their state Medicaid program but are financed solely by the state and are limited to legal immigrants.

Immigrant-specific programs, however, are both politically and legally vulnerable. During periods of recession or anti-immigration fervor, states frequently limit or end such programs. Although a few courts have struck down the abolition of immigrant specific programs as discriminatory, some have found that the dissolution of an immigrant-specific program does not discriminate against immigrants.[21, 25, 42] The rationale for this is simple: because only non-citizens benefit from immigrant-specific programs, immigrants are not left worse off than citizens by the programs' abolition.[21]

A recent case in Massachusetts, *Finch vs. Commonwealth Health Insurance Connector Authority*, forged a new path for advocating for immigrants' access to health insurance, while demonstrating that immigrants' health

coverage is more secure if it is embedded in a broadly-based rather than immigrant-specific program.[43,44] The *Finch* case concerned Commonwealth Care, a health insurance program created by the state of Massachusetts in 2006 to insure all uninsured legal residents with incomes under 300% of the federal poverty level. Critically, the program covered all legal residents, including non-citizens. It was financed by both state and federal funds, but due to the PRWORA, the federal government did not contribute to the cost of covering many non-citizens.

In July 2009, after the 2008 financial crisis, the Massachusetts legislature decided to save money by excluding from Commonwealth Care the non-citizens for whom the state did not receive federal funds due to the PRWORA.[43,44] About 43 000 immigrants were affected. Those immigrants who had already been enrolled in Commonwealth Care but were excluded by the legislature's decision were placed in a less costly program that offered access to a less comprehensive network of providers. Immigrants who became eligible for Commonwealth Care after July 2009 but for their immigration status were left without access to any state program.

From a human rights perspective, the state's decision to exclude the PRWORA-ineligible residents from Commonwealth Care was especially troubling. By excluding the immigrants, the state backed away from its earlier recognition of health care as a right of all legal residents; adopting instead the position that health care was a privilege to be granted to some lawful residents but not others. From a public health perspective the danger of this approach was clear: once one group's health insurance was taken away, other groups' insurance also became vulnerable.

Concerned about both the fate of the immigrants who had lost their insurance, as well as what the exclusion meant for the broader right to health, one of the authors (Parmet) and colleagues at Health Law Advocates, a Boston-based NGO, challenged the exclusion in state court. In contrast to most legal challenges regarding immigrants' rights, the claims were based not on the U.S. Constitution, but on the Massachusetts Constitution. This enabled the advocates to emphasize that Commonwealth Care was a unique, near-universal, state-created program and the exclusion of immigrants violated the state's own fundamental principles. The state, in contrast, tried to defend the exclusion by claiming that PRWORA established a national policy of denying benefits to certain classes of immigrants in order to promote their self-sufficiency.

In two opinions issued in 2011 and 2012 the highest court in the state, the Massachusetts Supreme Judicial Court, found for the immigrants.[43,44] Underlying the Court's decisions was the fact that Commonwealth Care was a broadly inclusive program, rather than one that only benefited non-citizens. As a result, the Court was able to see the exclusion of non-citizens as discriminating against them in favor of citizens.[44] If the state had provided health coverage to immigrants through a program exclusive to them, as many other states had done, it would have been much harder to convince the court that the denial of care was discriminatory. The elimination of a program that only benefits immigrants, after all, does not on its own treat them worse off than citizens (since citizens are not eligible for immigrant-only programs.)

Once the *Finch* court saw discrimination, the question became what standard of review the court should apply in determining whether the discrimination was constitutional. In its initial decision, the *Finch* court made two critical rulings: first, discrimination against legal non-citizens is subject to strict scrutiny, the most stringent form of judicial review.[44] As a result, discrimination against legal immigrants will be found unconstitutional unless the state can show that it is necessary to serve a compelling state purpose. Second, the Court held that Congress' policy in PRWORA of denying federal benefits to non-citizens did not justify a lower standard of review in the case at hand.[44] As the Court explained, Congress left the choice of insuring immigrants to the state. The state's exercise of that choice had to conform to the state Constitution and be subject to strict scrutiny.[44]

In its second opinion, the Court applied strict scrutiny and found the law denying immigrants access to Commonwealth Care to be unconstitutional.[43] According to the Court, the state had denied the immigrants health insurance simply to save money, a rationale that does not constitute a compelling state purpose.[43] The Court wrote that, "Fiscal considerations alone cannot justify a State's invidious discrimination against aliens."[43] Pointing again to federal policy, the Court added that "the Legislature may not lean on Federal policy as a crutch to absolve it of examining whether its own invidious discrimination is truly necessary."[43]

As a result of *Finch* approximately 43 000 legal immigrants in Massachusetts now have access to comprehensive, state-subsidized health insurance.[45] But not all residents are covered. *Finch* dealt only with legal immigrants; the health needs of undocumented immigrants continue to be overlooked. This oversight is likely to continue even if the U.S. Congress passes major immigration reform. All of the reform proposals now on the table maintain the PRWORA's limitations of immigrants' access to federal benefit programs, as well as the Affordable Care Act's bar against coverage for undocumented immigrants. These exclusions will

likely remain even for immigrants who are placed on a so-called path to citizenship.

Conclusion

The human right to health remains unrealized for many non-citizens, both in the U.S. and around the globe. Programs that aim to address that problem by providing limited coverage specifically for immigrants are both politically and legally vulnerable. Only by moving, as Massachusetts did in 2006, to recognize the human right to health and the humanity of non-citizens, will the health care needs of non-citizens and their communities be secured.

Declaration of conflict of interests. The authors declare that they have no conflict of interests.

References

1. Universal Declaration of Human Rights, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217 (III) (Dec. 10, 1948).
2. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI)(1966), Art. 12, 21 U.N. GAOR Supp. No. 16, U.N. Doc. A/6316 (Dec. 16, 1966).
3. Convention on the Rights of a Child art. 24. Nov. 20, 1989, 1577 U.N.T.S. 44.
4. World Health Organization, Preamble to the Constitution, Apr. 7, 1948.
5. Comm. On Econ., Soc. & Cultural Rights, General Comment no. 14: The Right to the Highest Attainable Standard of Health, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000)[consulted 2013, October 6]. Available at: http://www.unhchr.ch/tbs/doc.nsf/%28symbol%29/E.C.12.2000.4.En.
6. Comm. on Econ., Soc. & Cultural Rights, General Comment no. 19, The Right to Social Security, U.N. Doc. E/C.12/GC/19 (Feb. 4, 2008), [consulted 2013, October 6] Available at http://www.refworld.org/cgi-bin/texis/vtx/rwmain?docid=47b17b5b39c.
7. Comm. on the Elimination of Racial Discrimination, General Recommendations: Discrimination against Non Citizens (Oct. 1, 2004) [consulted 2013, October 6]. Available at: http://www.unhchr.ch/tbs/doc.nsf/0/e3980a673769e229c1256f8d0057cd3d.
8. United Nations Office of the High Commissioner for Human Rights. International Convention on the Elimination of All Forms of Racial Discrimination, art 5, G.A. res 2106 (Jan. 4, 1969).
9. United Nations. Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live, G.A. res. 40/144, annex, 40 U.N. GAOR Supp. (No. 53) at 252, U.N. Doc. A/40/53 (1985).
10. Organization of American States, Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social, and Cultural Rights "Protocol of San Salvador," 1988 [consulted 2013, October 6]. Available at: http://www.oas.org/juridico/english/treaties/a-52.html.
11. Inter-American Program for the Promotion and Protection of the Human Rights of Migrants, Including Migrant Workers and their Families, AG/RES. 2141 (XXXV-O/05) (Mar. 17, 2003)[consulted 2013, October 6]. Available at: http://www.oas.org/dil/migrant_workers_inter_american_program.htm.
12. United Nations Office of the High Commissioner for Human Rights. International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, Dec. 18, 1990, 2220 U.N.T.S. 93.
13. Elgersma S. Immigration status and legal entitlements to insured health services. Ottawa, ON: Parliamentary Information & Research Service, Political & Social Affairs Division, 28 October, 2008 [consulted 2013, October 6]. Available at http://www.parl.gc.ca/Content/LOP/researchpublications/prb0828-e.pdf.
14. Citizenship and Immigration Canada. Summary of changes to the interim federal health program. Ottawa, ON: Citizenship and Immigration Canada; 2012 [consulted 2013, October 6]. Available at: www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp.
15. Press association. Immigrants to face crackdown on benefits and health care. Huffington post: 2013, March 25 [internet series][consulted 2013, April 26]. Available at: http://www.huffingtonpost.co.uk/2013/03/24/immigrants-curbs-benefits_n_2945224.html.
16. Bogumil T. Realizing the right to health of undocumented immigrants in Europe: legal and social challenges. Proceedings of the 13th World Congress on Public Health; 2012, April 23-27[consulted 2013, October 6]. Available at: http://ssrn.com/abstract=2254580.
17. Harris vs. MacCrae, 448 U.S. 297 (1980).
18. Robert Wood Johnson Foundation. State health access data assistance center [consulted 2013, April 10]. Available at: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/04/state-level-trends-in-employer-sponsored-health-insurance.html.
19. Henry J. Kaiser Family Foundation. Key facts on health coverage for low-income immigrants today and under health reform [consulted 2013, March 26]. Available at: http://www.oucom.ohiou.edu/hpf/pdf/HPF%20January%20Reading%20Assignment%202013.pdf.
20. Sommers BD. Perspective: stuck between health and immigration reform – care for undocumented immigrants. N. Engl J Med 2013; 369:593-595.
21. Parmet WE. Perspective: holes in the safety net – legal immigrants access to health insurance. N Engl J Med 2013; 369 596-598
22. Siskin A. Treatment of noncitizens under the patient protection and affordable care act. Washington, DC: Congressional Research Service, March 2011.
23. 42 U.S.C. 1395dd.
24. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, PL 104–193, August 22, 1996, 110 Stat 2105.
25. Soskin vs. Reinertson, 353 F.3d 1242 (10th Cir. 2004).
26. Lewis vs. Thompson, 252 F.3d 567, 584 (2d Cir. 2001).
27. 42 U.S.C. 1396b(V) (2011).
28. DuBard CA, Massing MW. Trends in emergency medicaid expenditures for recent and undocumented immigrants. JAMA 2007; 297: 1085-1092.
29. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 1011(a), 117 Stat. 2066, 2432 (2003).
30. Zuckerman S, Waiderman TA, Lawton E. Undocumented immigrants, left out of health reform, likely to continue to grow as share of the uninsured. Health Aff (Millwood) 2011; 10:1997-2003.
31. Patient Protection and Affordable Care Act, PL 111-148, March 23, 2010, 124 Stat 119.
32. Pre-Existing Condition Insurance Plan Program, 77 FR 52614-01. (2012).
33. Derose KP, Escare JT, Lurie N. Immigrants and health care access, quality, and cost. Med Care Res Rev 2009; 66: 9-10.
34. Nandi A, Loue S, Galea S, Expanding the universe of universal coverage: the population health argument for increase coverage for immigrants. J Immigr Min Health 2009; 11:433-436.
35. Okie S. Perspective immigrants and health care — at the intersection of two broken systems. N Engl J Med 2007; 357: 525-529.
36. Sack K. Immigrants cling to fragile lifeline at safety-net hospital. The New York Times 2009; September 24, section A: 16.
37. Raghavan R, Nuila R. Perspective: survivors – dialysis, Immigration, and U.S. law. N Engl J Med 2011; 364: 2183-2185.
38. Cruz v. Cent. Iowa Hosp. Corp., 826 N.W.2d 516 (Iowa Ct. App. 2012).
39. Center for Social Justice at Seton Hall Law and the Health Justice Program at New York Lawyers for the Public Interest. Discharge, deportation, and dangerous journeys: a study on the practice of medical repatriation. 2012, December [consulted 2013, October 6]. Available at: http://law.

shu.edu/ProgramsCenters/PublicIntGovServ/CSJ/upload/final-med-repat-report-2012.pdf.
40. Fortuny K, Chaudry A. A comprehensive review of immigrant access to health & human services. Washington, D.C.: Urban Institute 2011.
41. Children's Health Insurance Program Reauthorization Act, 42 U.S.C. § 1397ll (2009).
42. Bruns vs. Mayhew, 931 F. Supp.2d 260 (D.Me. 2013).
43. Finch vs. Commonwealth Health Ins. Connector Auth., 959 N.E.2d 970 (Mass. 2012).
44. Finch vs. Commonwealth Health Ins. Connector Auth., 946 N.E.2d 1262 (Mass. 2011).
45. Ngowi R. Massachusetts immigrants begin to join health care plan. The Boston Globe: 2012 April 6 [consulted 2013 October 6]. Available at: http://www.boston.com/news/local/massachusetts/articles/2012/04/06/mass_immigrants_begin_to_join_health_care_plan/.