

# SCREEN, STABILIZE, AND SHIP: EMTALA, U.S. HOSPITALS, AND UNDOCUMENTED IMMIGRANTS (INTERNATIONAL PATIENT DUMPING)

Jennifer M. Smith\*

“[A] physician must recognize responsibility to patients first and foremost.”<sup>1</sup>

## I. INTRODUCTION

In response to hospitals failing to provide for uninsured patients with emergency medical treatment equal to what they provide

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\*Formerly, partner and department chair of the South Florida Health Law Group of Holland & Knight LLP, and federal judicial law clerk to the Honorable Joseph W. Hatchett, U.S. Court of Appeals for the Eleventh Circuit. Currently, associate professor of law, Florida Agricultural & Mechanical University (FAMU) College of Law. J.D., University of Miami School of Law; B.S., Hampton University. Professor Smith expresses sincere gratitude for the research grant provided by FAMU; the thoughtful guidance provided by scholarly readers of her drafts; and the research assistance provided by Iris Cruz and LaKisha Davis, FAMU College of Law students, and the FAMU College of Law library assistants. An early draft of this article was presented at the Southeast/Southwest People of Color Legal Scholarship Conference, *AT THE INTERSECTION: CULTURE, RACE & CLASS*, Phoenix, Arizona (March 2009).

<sup>1</sup> American Medical Association, Code of Medical Ethics: Principles of Medical Ethics, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.shtml> (last visited Apr. 22, 2010).

patients with financial resources, Congress enacted the Emergency Medical Treatment and Active Labor Act (“EMTALA”) in 1986.<sup>2</sup> EMTALA requires hospitals receiving federal funding to medically screen and stabilize all persons who present to their emergency department with emergency medical conditions, including undocumented (also referred to as unauthorized or illegal) immigrants.<sup>3</sup> In particular, EMTALA, also coined the Patient Anti-Dumping Act, prohibits hospitals from “dumping” or denying treatment to emergency patients or inappropriately transferring (including discharging) patients in unstable conditions to other hospitals.<sup>4</sup>

For the past several years, hospitals have been renting air ambulances and gratuitously and forcibly “shipping” uninsured, undocumented immigrant patients, who are suffering from catastrophic injuries and remain in need of continuous healthcare, back to their home country (e.g. Mexico, Honduras, or Guatemala) with the tacit approval, but without the active involvement, of American immigration authorities.<sup>5</sup> When the patients arrive back home, it is usually only a matter of time before they die because the

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<sup>2</sup> See Department of Health & Human Services: Medicare Program, Clarifying Policies Related to the Responsibilities of Medicare - Participating Hospitals in Treating Individuals with Emergency Medical Conditions, 68 Fed. Reg. 53, 223 (Sept. 9, 2003) [hereinafter Clarifying Policies]; 42 U.S.C. § 1395dd (2006).

<sup>3</sup> Namratha R. Kandula et al, *Assuring the Health of Immigrants: What the Leading Health Indicators Tell Us*, 25 ANN. REV. PUBLIC HEALTH 357, 359 (2004) (“Undocumented immigrants do not have permission to be in the United States and can be deported if found.”); see also Frank D. Bean & B. Lindsay Lowell, *Unauthorized Migration*, in THE NEW AMERICANS, A GUIDE TO IMMIGRATION SINCE 1965, 70-71 (Waters & Ueda, eds.) (explaining the terms “undocumented immigrants” and illegal immigrants” are essentially improper and choosing instead to use “unauthorized migrants” to refer to “persons who reside in the U.S. but whose status is not that of U.S. citizens, permanent residents, or other authorized visitors”); but see Sana Loue, *Immigrant Access to Health Care and Public Health: An International Perspective*, 17 ANNALS HEALTH L. 213, 214 n.8 (2008) (noting that “undocumented” status and “illegal” status are often used interchangeably, but that such use fails to consider the nuances, e.g., a person born in the United States is a citizen by birth by virtue of being born within the United States; however, because there is no requirement that citizens carry identification cards, the person may be undocumented in that he or she lacks an identification document identifying that he or she is a citizen, yet the person’s presence in the United States is clearly legal).

<sup>4</sup> See Clarifying Policies, *supra* note 2, at 223.

<sup>5</sup> See Case Study *infra* Section II.

patients are usually too poor to pay for the healthcare they need to survive.<sup>6</sup> Their home country often has less than adequate medical facilities for the poor to care for these forced medical repatriations.<sup>7</sup>

Pursuant to EMTALA, patient dumping is illegal in the United States.<sup>8</sup> American hospitals cannot inappropriately discharge or transfer unstable patients to other medical facilities in the United States without violating EMTALA.<sup>9</sup> Yet, American hospitals are doing this very thing—international patient dumping, by inappropriately transferring or discharging (i.e. shipping) indigent undocumented immigrants in arguably unstable conditions to Third World medical facilities in the home country of the immigrant—absent federal government oversight or compliance with EMTALA.<sup>10</sup>

Arguably, there is no legislation—federal or state—that specifically covers these involuntary or forced medical repatriations.<sup>11</sup> Thus, Congress must enact federal legislation to ensure that American hospitals are not engaging in international patient dumping. Further, Congress must fund EMTALA. The funding should come from the billions of dollars in taxes that undocumented immigrants pay yearly for services and benefits that they will never recoup. United States President Barack Obama recently signed into law the Patient Protection and Affordability Act, which is the most significant healthcare reform in the United States, but undocumented immigrants are excluded from the benefits of the

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<sup>6</sup> See Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009) (defining “medical repatriations” as “[t]ransferring uninsured alien patients with significant long-term care needs to facilities abroad”).

<sup>7</sup> *Id.* at 153.

<sup>8</sup> 42 U.S.C. § 1395ff (2006).

<sup>9</sup> *Id.*

<sup>10</sup> Wolpin, *supra* note 6, at 152–53.

<sup>11</sup> See Wolpin, *supra* note 6, at 152 (“[C]urrent federal and state laws do not directly address repatriations.”); Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1 (quoting a lawyer involved in these medical repatriations as stating that there needs to be legislation, but that “[t]here is no program in place to appropriately distribute care to undocumented persons who are catastrophically injured, and there should be.”); Bruce Patsner, *Repatriation of Uninsured Immigrants by U.S. Hospitals: The Jiménez Case*, HEALTH LAW PERSPECTIVES 4 (2008), [http://www.law.uh.edu/healthlaw/perspectives/2008/\(BF\)%20deport.pdf](http://www.law.uh.edu/healthlaw/perspectives/2008/(BF)%20deport.pdf) (stating that medical repatriations are essentially unregulated); *infra* Section VI(c).

legislation.<sup>12</sup> Thus, undocumented immigrants will still be uninsured and will have to delay or forgo healthcare, or obtain healthcare from only hospitals' emergency departments. While healthcare reform proposals were still being considered, there was hope that healthcare reform would assist with the problem of these medical repatriations. Now that this historic healthcare legislation has passed, making sweeping changes in America's healthcare system that still exclude undocumented immigrants, immigration advocates are hoping that immigration reform will provide some relief for these medical repatriations.

It is clear that the federal government cannot continue to ignore this problem. State and local community hospitals are responding in the best way they know how to address a problem that is within the control of the federal government and should be solved by the federal government.

This article showcases Luis Alberto Jiménez, an undocumented Guatemalan laborer who was severely injured by a drunk driver in the United States. He received emergency care from a U.S. hospital, which also determined that Mr. Jiménez would need long-term care. Nevertheless, the hospital sent him back to his home country for continued care, which he never received because he could not afford it, and his country could not afford to provide it to him.<sup>13</sup> The article addresses EMTALA, the status of undocumented immigrants in the United States, and the United States healthcare system. It concludes by recommending government action and other non-government options to ensure that the United States' treatment of undocumented immigrants who suffer critical injury is equal to treatment provided to uninsured U.S. citizens.

## II. CASE STUDY

This article was inspired by the story of Luis Alberto Jiménez,

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<sup>12</sup> Social Security Legislative Bulletin, Number: 111-40, The President Signs H.R. 3590: The "Patient Protection and Affordable Care Act," and the House passes H.R. 4872: The "Health Care and Education Reconciliation Act of 2010," Mar. 24, 2010, [http://www.ssa.gov/legislation/legis\\_bulletin\\_032310.html](http://www.ssa.gov/legislation/legis_bulletin_032310.html) (last visited June 6, 2010).

<sup>13</sup> See generally Sontag, *supra* note 11, at A1.

who, ten years ago, was a young, healthy gardener in Stuart, Florida.<sup>14</sup> He was also an undocumented immigrant.<sup>15</sup> He came to the United States with hopes and dreams similar to the typical immigrant who comes to America.<sup>16</sup> He hoped to work hard and earn enough money to support his family and one day buy some land and return to Guatemala to cultivate it.<sup>17</sup> But, his dream died when he was critically injured by a drunk driver in the early part of 2000.<sup>18</sup> This began the dual dilemma of not only Mr. Jiménez, but also the community hospital, Martin Memorial Hospital (“Martin Memorial”),<sup>19</sup> where Mr. Jiménez was transported after the accident.

While at Martin Memorial, Mr. Jiménez received extensive medical and surgical care, and he survived.<sup>20</sup> Several months later, Mr. Jiménez was transferred to a nursing home when an insurance payout was a possibility.<sup>21</sup> After lost legal battles, including determining that the drunk driver was uninsured and the company that owned the van that the drunk driver stole was not vicariously liable for the accident, the nursing home returned Mr. Jiménez to Martin Memorial emaciated and with serious infections.<sup>22</sup> He remained in a vegetative state and in a fetal position for a little more

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<sup>14</sup> Sontag, *supra* note 11, at A1.

<sup>15</sup> *Montejo v. Martin Mem’l Med. Ctr.*, 874 So. 2d 654, 655 (Fla. Dist. Ct. App. 2004).

<sup>16</sup> Marc L. Berk et al., *Health Care Use Among Undocumented Latino Immigrants: Is Free Health Care the Main Reason Why Latinos Come to the United States, A Unique Look at the Facts*, 19 HEALTH AFF. 51, 56 (2000) (reporting survey findings that immigrants come to the United States mainly for jobs, not healthcare or social services); See generally Alejandro Marcías et al., *Development in a Remittance Economy: What Options Are Viable?*, in FOUR GENERATIONS OF NORTEÑOS, NEW RESEARCH FROM THE CRADLE OF MEXICAN MIGRATION 127 (Wayne A. Cornelius, et al. eds., 2009) (“Lack of economic opportunity is often the determining factor in the decision to migrate”).

<sup>17</sup> Sontag, *supra* note 11.

<sup>18</sup> *Id.*

<sup>19</sup> *Id.* (reporting that approximately 45% of Martin Memorial’s net operating revenues came from Medicaid and Medicare in 2007).

<sup>20</sup> *Id.*

<sup>21</sup> *Id.* (reporting that there was a lawsuit that sought to hold the company who owned the van the drunk driver stole liable because its employees left the keys in the van while they went into a store, but the lawsuit was unsuccessful).

<sup>22</sup> Sontag, *supra* note 11.

than a year, costing Martin Memorial more than a million dollars.<sup>23</sup>

The dilemma for Martin Memorial was that it was a nonprofit hospital that could not afford to continue extended and expensive medical care for Mr. Jiménez. It had a total margin of 3.6 percent in 2007 and 6 percent in 2006.<sup>24</sup> As expected for a nonprofit hospital, it donated almost \$24 million to charity in 2006<sup>25</sup>—the norm for tax-exempt hospitals.<sup>26</sup>

For Mr. Jiménez, however, the dilemma was a bit different. He was no longer able to care for himself, had no ability to pay for care, and was at the mercy of Martin Memorial. Under EMTALA, Martin Memorial could not discharge Mr. Jiménez in his condition without an “appropriate” transfer for post-hospital care; for Mr. Jiménez, this meant “traumatic brain injury” rehabilitation.<sup>27</sup>

Martin Memorial had asked a lawyer to set up guardianship for Mr. Jiménez when he was a newer patient at the hospital.<sup>28</sup> The lawyer took the position that Martin Memorial had to provide the rehabilitative care Mr. Jiménez needed, even if it had to pay for it.<sup>29</sup> Martin Memorial responded by increasing its efforts to contact the Guatemalan government to explain to it that the hospital could no longer care for Mr. Jiménez.<sup>30</sup> The Guatemalan Vice Minister of Public Health responded by letter that the country was prepared to care for Mr. Jiménez, even though it really could not.<sup>31</sup> But now, the

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<sup>23</sup> *Id.* (reporting that the federal government provides emergency Medicaid for illegal and new immigrants, but that amounted to only approximately \$80,000 of the \$1.5 million hospital bill).

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden It Places on Hospitals*, 7 J.L. SOC'Y 146, 150 (2005) (discussing charity care).

<sup>27</sup> *Montejo*, 874 So. 2d at 657.

<sup>28</sup> Sontag, *supra* note 11.

<sup>29</sup> *Id.*

<sup>30</sup> *Montejo*, 874 So. 2d at 656 (“The hospital asserted, among other things, that it had applied for financial assistance for long-term care for Jiménez to no avail because, as an undocumented alien, he is not eligible for Medicaid or any other type of public assistance.”).

<sup>31</sup> *Id.* at 657–58 (finding that the letter stated: “[T]he system of the Rehabilitation and Orthopedic Hospital ‘Dr. Edwin Harold von Ahn,’ is ready to give the necessary care to

lawyer and Mr. Jiménez's guardian, Montejo Gaspar Montejo, were at odds with Martin Memorial. Thus, the parties ended up in court in June 2003.<sup>32</sup>

During the trial court's hearing, Martin Memorial offered the letter from the Guatemala government to comply with the EMTLA federal discharge requirements and its own discharge requirements.<sup>33</sup> The trial judge admitted the letter into evidence over the hearsay objection of Mr. Jiménez's lawyer.<sup>34</sup> Mr. Jiménez's lawyer offered the testimony of a Guatemalan doctor, who is also an expert in the Guatemalan public healthcare system, who testified that the traumatic brain injury rehabilitation needed for Mr. Jiménez was non-existent in public healthcare facilities in Guatemala.<sup>35</sup>

After the hearing, the trial court ruled that Martin Memorial could relocate Mr. Jiménez back to Guatemala.<sup>36</sup> Mr. Jiménez's lawyer filed a motion for reconsideration, which was denied. He then appealed and asked for a stay of the court's order pending the appeal, but a few hours before Martin Memorial had to respond, it flew Mr. Jiménez back to Guatemala.<sup>37</sup>

Mr. Jiménez was taken to the National Hospital of Orthopedics and Rehabilitation ("National Hospital") in Guatemala.<sup>38</sup> National Hospital did not have the rehabilitative brain injury treatment that Mr. Jiménez required, and a few weeks after his arrival, National

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Mister Luis Alberto Jiménez, 28 years of age [sic] and originally from the City of Antigua Guatemala, Sacatepequez [sic] and will do so as soon as he arrives to this county. We will evaluate and transfer him to the most appropriate facility for the treatment of his condition. The medical treatment to be available will be without any cost to Mister Jiménez.”).

<sup>32</sup> Sontag, *supra* note 11.

<sup>33</sup> *Montejo*, 874 So. 2d at 657.

<sup>34</sup> *Id.*

<sup>35</sup> *Id.* at 658.

<sup>36</sup> *Id.* at 656.

<sup>37</sup> *Id.* (“The next day the hospital, at 7:30 A.M., flew Jiménez to Guatemala, before the court could rule on the stay.”); see also Laura Wides-Munoz, *Jury Rules in Favor of Hospital that Deported Injured Guatemalan*, ASSOC. PRESS., July 28, 2009, available at <http://www.miamiherald.com/news/florida/story/1160221.html> (reporting the hospital chartered a \$30,000 flight to Guatemala).

<sup>38</sup> See Sontag, *supra* note 11.

Hospital discharged Mr. Jiménez because it needed the bed.<sup>39</sup>

In May 2004, the appellate court reversed the trial court's order that allowed Martin Memorial to repatriate Mr. Jiménez to Guatemala.<sup>40</sup> Its rationale was that the trial court lacked subject matter jurisdiction to order Mr. Jiménez's deportation because deportation is solely within the province of the federal government.<sup>41</sup> Furthermore, the appellate court also held that there was no "competent substantial evidence" to show that Mr. Jiménez would get the care he needed at the receiving hospital in Guatemala.<sup>42</sup> The Florida appellate court determined that Martin Memorial failed to meet the federal or hospital's discharge requirements because it lacked specifics to show that National Hospital could meet the medical needs of Mr. Jiménez.<sup>43</sup> That is, the court held that it is unlawful for hospitals to dump immigrant patients absent ensuring appropriate continuing medical care at the new hospital.<sup>44</sup> Although

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<sup>39</sup> *See id.*

<sup>40</sup> *See Montejo*, 874 So. 2d at 658.

<sup>41</sup> *Id.* at 656, 658.

<sup>42</sup> *Id.* at 658.

<sup>43</sup> *Id.*; *see also* Patsner, *supra* note 11 (noting that there is still no case law outside of Florida on this issue and that the Florida appeals court ruling applies only to that jurisdiction).

<sup>44</sup> Sontag, *supra* note 11 (reporting that John DeLeon, a U.S. lawyer, has coined a letter as a result of this case called the "Montejo Gaspar letter." "It's a letter that says, 'Listen, don't take action to dump this individual because you'll be risking legal action. The law is now that hospitals can't dump immigrant patients without securing appropriate after-care. If somebody has a serious illness and needs continuing care, a hospital can't simply discharge them onto the street, much less put them on a plane.'"); Lori A Nessel, Emerging Issues Law Center, Legality and Ethics of Medical Repatriation 2009, <http://www.lexisnexis.com/Community/emergingissues/blogs/emergingissuescommentary/archive/2010/02/17/Lori-A.-Nessel-on-the-Legality-and-Ethics-of-Medical-Repatriation.aspx> (last visited Apr. 22, 2010) ("[T]he Court of Appeal also ruled that the hospital repatriation was unlawful, as the court was preempted by federal law from immigration regulation and thus lacked subject-matter jurisdiction to rule on what was at its heart an immigration matter. Moreover, the Court of Appeal ruled that the hospital was not protected by the doctrine of qualified immunity, as it was acting to further a private interest. Based on these aspects of the Court of Appeal ruling, hospitals considering following the same course might well be facing liability in the future."); *see also* Patsner, *supra* note 11, at 3:

It is not clear from the two Florida court decisions what the "standard" should be for determining whether a U.S. hospital can deport an undocumented immigrant back to his or her country of origin. It is not enough to say that the law is that U.S.

the appellate court overturned the trial judge's deportation order, Mr. Jiménez was already back in Guatemala,<sup>45</sup> making the order void for him. The appellate court, however, discounted the hospital's argument that the issue was moot because it had already transported Mr. Jiménez back to Guatemala and found that "even if this case were moot, we are persuaded that it presents an important issue which is likely to recur."<sup>46</sup>

Mr. Jiménez's guardian then filed a false imprisonment case against Martin Memorial.<sup>47</sup> The hospital filed a motion to dismiss, arguing that (1) Mr. Jiménez's guardian lacked standing and (2) Mr. Jiménez could not state a cause of action because he could not show

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hospitals cannot "dump" immigrant patients without securing appropriate after-care; if that were the case then the Jiménez case would be dismissed since he was transported back to the most advanced rehabilitation hospital in his home country. Rather, it would appear that the issue is whether the medical care, and facility, is comparable to that in the U.S. the patient will be leaving. Given the enormous medical, surgical, and rehabilitation resources available to even most community hospitals in the U.S. compared to those available in every other country in Latin America and many in South America, it is entirely possible that every state court in the U.S. could determine that comparable medical facilities do not exist in the country of origin for any severely injured or neurologically handicapped undocumented immigrant hospitalized in the U.S.

The end result of the Florida appellate court's decision might be that it will be virtually impossible for a U.S. hospital to ever discharge and transport a severely injured, indigent undocumented immigrant to a medical facility in their home country because no facility will be comparable, and thus no facility will be "appropriate." Absent an accepted policy of repatriation, the end result will be an indefinite U.S. taxpayer subsidized stay for these individuals in U.S. acute care hospitals. The subsequent judicial course of the Jiménez case will not make U.S. hospitals any happier: after the Florida appeals court ruling, Mr. Gaspar successfully sued the hospital in a personal injury lawsuit in which Florida judges have already ruled that the Florida hospital can be sued for punitive damages as well as the cost of his continued medical care despite the fact that he no longer resides in the U.S.

<sup>45</sup> *Montejo*, 874 So. 2d at 656; see also Jack Scarola, *Martin Memorial Needs to Correct the 'Wrong' Suffered by Illegal Immigrant*, TC PALM, Feb. 20, 2009, <http://www.tcpalm.com/news/2009/feb/20/jack-scarola-martin-memorial-needs-correct-wrong-s/> (last visited Apr. 22, 2010) ("[U]nless the hospital knew it was acting illegally, why would it forcibly remove Luis in the pre-dawn darkness on the very morning that a court decision was to be made that would have protected Luis' legal rights?").

<sup>46</sup> *Montejo*, 874 So. 2d at 657 ("Hospital industry officials said this case illustrates a major problem faced by Florida providers." (citing HEALTH LAW REPORTER (BNA), No. 29, Vol. 12 at 1130 (July 17, 2003))).

<sup>47</sup> See *Montejo v. Martin Mem'l Med. Ctr.*, 935 So. 2d 1266 (Fla. Dist. Ct. App. 2004).

that the detention was unreasonable or unwarranted.<sup>48</sup> The trial court granted the hospital's motion to dismiss.<sup>49</sup>

The appellate court, however, found that no standing issue existed and that the false imprisonment claim could proceed.<sup>50</sup> The court further found that three of the four elements of a false imprisonment claim were satisfied, but it remanded to the trial court for a jury finding as to whether the fourth element of a false imprisonment claim existed.<sup>51</sup>

On remand to the trial court to decide whether Martin Memorial had falsely imprisoned Mr. Jiménez, the judge instructed the jury that the appellate court "had already established three of the four elements that support a claim of false imprisonment: that Mr. Jiménez had been detained unlawfully, 'without legal authority,' and against the will of his guardian."<sup>52</sup> The jury, however, did not find the fourth element to have been met; after less than two days of deliberation, the jury returned a verdict in favor of Martin Memorial, concluding "that the hospital's actions were [not] 'unreasonable and unwarranted under the circumstances'. . . ."<sup>53</sup> The hospital escaped tort liability, and no money was recovered to pay for care for Mr. Jiménez in Guatemala. However, after the jury verdict and before an appeal, the parties came to a resolution, which assisted Mr. Jiménez.<sup>54</sup>

Mr. Jiménez remains in Guatemala, and he has received brief medical care—his condition has deteriorated over the last year—some calling his medical repatriation "inhumane."<sup>55</sup> A lawyer

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<sup>48</sup> *Id.* at 1268.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> *Id.* at 1272.

<sup>52</sup> Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES, July 27, 2009, at A10, available at <http://www.nytimes.com/2009/07/29/us/29deport.html>.

<sup>53</sup> *Id.*

<sup>54</sup> Daphne Duret, *Martin Hospital Gives \$40,000 to Departed Patient*, PALM BEACH POST, Mar. 18, 2010, at 1B, available at <http://www.tcoasttalk.com/2010/03/17/hospital-gives-40000-to-guatemalan-mans-care-as-his-attorneys-drop-lawsuit/> ("In a joint statement with the hospital, the family's attorney said they would stop appealing the case and the hospital would give Jimenez \$40,000 . . .").

<sup>55</sup> Sontag, *supra* note 11 (quoting Dr. Garcés, the public health advocate in Guatemala City); see also Wides-Munoz, *supra* note 37 (reporting that Mr. Jiménez now lives with his elderly

practicing in the United States who provides counsel to the Mexico, Honduras, and Guatemala consulates says he has been “bombarded by [these types of] cases.”<sup>56</sup>

### III. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (“EMTALA”)

The lack of adequate access to healthcare for undocumented immigrants in the United States is as controversial as it is widespread.<sup>57</sup> It has not been adequately addressed or enforced by legislation. Although hospitals in the United States are required to follow federal, state, and hospital patient discharge requirements, hospitals are ignoring these discharge requirements.<sup>58</sup> Instead, these hospitals are increasingly hiring private planes<sup>59</sup> and shipping undocumented immigrants back to their Third World country of origin in unstable medical conditions in violation of these patient discharge procedures.<sup>60</sup> And, the hospitals are repatriating the patients without the active participation of the federal government.<sup>61</sup>

Because there is no federal or state legislation that is adequately

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mother in a one-room home in a Mayan village).

<sup>56</sup> Sontag, *supra* note 11 (quoting John DeLeon, a lawyer who frequently deals with hospital repatriations).

<sup>57</sup> See Michael J. McKeefery, *A Call to Move Forward: Pushing Past the Unworkable Standard That Governs Undocumented Immigrants’ Access to Health Care Under Medicaid*, 10 J. HEALTH CARE L. & POL’Y 391, 393 (2007); Mary J. Lopez, *Access to Healthcare for Legal and Undocumented Immigrants*, 21 IMMIGR. & NATIONALITY L. REV. 641, 641 (2000).

<sup>58</sup> *Montejo*, 874 So. 2d at 657 (noting that the U.S. hospital was required to comply with federal discharge requirements and the hospital’s own discharge procedures, but not mentioning Florida legislation). See also *infra* notes 215, 216, 219.

<sup>59</sup> See, e.g., Mexcare, <http://www.mexcare.com> (last visited Apr. 22, 2010) (marketing itself as “An Alternative Choice for the Care of the Unfunded Latin American National”).

<sup>60</sup> See Sontag, *supra* note 11 (“Indeed, some advocates for immigrants see these repatriations as a kind of international patient dumping, with ambulances taking patients in the wrong direction, away from first-world hospitals to less-adequate care, if any.”).

<sup>61</sup> See Deborah Sontag, *Deported in a Coma, Saved Back in U.S.*, THE GADSDEN TIMES, Nov. 9, 2008, <http://www.gadsdentimes.com/article/20081109/ZNYT04/811093006> (“Hospitals say the federal government ignores the burden posed by these patients. In fact, Immigration and Customs Enforcement does not assume any responsibility for the health care of illegal immigrants unless they are in federal immigration detention . . . and it does not get involved in repatriations undertaken by hospitals.”).

addressing these medical repatriations,<sup>62</sup> the *Montejo* case is a significant victory for those opposing medical repatriations.<sup>63</sup> The Florida appellate court found that the U.S. hospital failed to comply with EMTALA when it did not show that the Guatemalan public hospital where Mr. Jiménez was being transferred could serve his medical needs.<sup>64</sup> That said, there was no penalty for Martin Memorial for its international patient dumping of Mr. Jiménez. Indeed, Martin Memorial's early morning, forcible removal of Mr. Jiménez to Guatemala's National Hospital actually benefitted Martin Memorial. The court decision gave him a pyrrhic victory; a lot of energy and effort was expended without curing his malady. Although the appellate court found that Martin Memorial did not comply with EMTALA, Mr. Jiménez was already deported. Unless the court required Martin Memorial to bring Mr. Jiménez back to the United States for medical care (which would be outside of the court's jurisdiction), there was really nothing more that the court could do.<sup>65</sup>

Historically, America's hospitals provided emergency aid as a tradition,<sup>66</sup> but this has long been abandoned due to the rising costs of healthcare.<sup>67</sup> When this gratuitous tradition ended, poor people were repeatedly turned away by hospitals. Thus, states sought to mandate that hospitals provide emergency care for the poor, but this

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<sup>62</sup> See Sontag, *supra* note 11.

<sup>63</sup> *Id.* ("Jiménez's case is apparently the first to test the legality of cross-border patient transfers that are undertaken without the consent of the patients or their guardians—and the liability of the hospitals who undertake them.").

<sup>64</sup> See *Montejo*, 874 So. 2d at 658.

<sup>65</sup> Azmina Aboobaker, Emerging Issues Law Center, The Hippocratic Oath and the Repatriation of Uninsured Citizens, <http://www.lexisnexis.com/community/emergingissues/blogs/emergingissuescommentary/archive/2010/02/17/The-Hippocratic-Oath-and-the-Repatriation-of-Uninsured-Noncitizens.aspx> (last visited June 1, 2010) ("It is unlikely that the state court provided Jiménez with the extensive set of advisals an immigration judge provides before an undocumented immigrant is offered the opportunity to depart voluntarily. Under the current immigration framework, it will be particularly difficult for an individual such as Jiménez to return to the United States lawfully after having lived here unlawfully for a number of years. Jiménez might have been eligible for a stay of removal, particularly in light of the humanitarian factors at play in his case, had his case been before the federal Department of Homeland Security." (citations omitted)).

<sup>66</sup> See *Thornton v. S.W. Detroit Hosp.*, 895 F.2d 1131, 1132 (6th Cir. 1990).

<sup>67</sup> See *id.*

failed.<sup>68</sup> In response, the federal government enacted the Hill-Burton Act in 1946.<sup>69</sup> Hill-Burton “required hospitals which received federal funds for construction and capital improvements, to furnish a ‘reasonable’ amount of free or reduced-cost care to indigent patients for a period of twenty years, and to make their services available to all persons residing in the community.”<sup>70</sup> Hill-Burton was largely ineffective, however, because it was not enforced by the United States Department of Health and Human Services (“HHS”).<sup>71</sup> The act’s requirements were undefined, there were no punitive remedies for violations, and patients did not know their rights under the act.<sup>72</sup> Thus, turning away poor people—patient dumping—remained a concern.<sup>73</sup> These patients were either “dumped” back onto the streets or transferred to a public hospital in unstable conditions.<sup>74</sup> EMTALA reduced patient dumping. Congress’ enactment of EMTALA was the direct response to the American public’s outcry over the inhumane treatment of the poor.<sup>75</sup> EMTALA significantly curtailed patient dumping, but it did not stop it.

EMTALA is a federal statute that was specifically enacted to ensure that federally-funded hospitals provide the same medical care to all persons who present to them with emergency medical conditions irrespective of the patients’ ability to pay. EMTALA became law in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).<sup>76</sup> “The avowed purpose of

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<sup>68</sup> See Tiana Mayere Lee, *An EMTALA Primer: The Impact of Changes in the Emergency Medicine Landscape on EMTALA Compliance and Enforcement*, 13 ANNALS HEALTH L. 145, 146 (2004).

<sup>69</sup> 42 U.S.C. § 291 (2008).

<sup>70</sup> Maria O’Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 BYU L. REV. 971, 980 (1992).

<sup>71</sup> See Lee, *supra* note 68, at 147.

<sup>72</sup> See *id.*

<sup>73</sup> MARK M. MOY, *THE EMTALA ANSWER BOOK*, xxxiv, (2009) (citing H.R. REP. NO. 100-531, 2d Sess. 2-3 (1988)) (defining “dumping” as transferring patients between different hospitals without the patients being stabilized, refusing to provide medical treatment to patients, or delaying medical treatment to patients because they were either uninsured or too poor to pay for their care).

<sup>74</sup> See *id.* at xxxiv (citing J.R. REP. NO. 99-241, pt. 2, at 27 (1986)).

<sup>75</sup> *Id.*

<sup>76</sup> See Sara Rosenbaum et al., *EMTALA and Hospital “Community Engagement”: The Search for a*

EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care, but instead to provide an 'adequate first response to a medical crisis' for all patients and 'send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress.'"<sup>77</sup> Notwithstanding the actual language, and the avowed purpose suggesting EMTALA's applicability to only Americans, EMTALA applies also to undocumented immigrants.<sup>78</sup>

Pursuant to EMTALA, hospitals must ensure that: (1) any person who comes to a hospital's emergency department and requests examination or treatment of a medical condition receives an "appropriate medical screening examination"; and (2) if an "emergency medical condition" is uncovered or the patient is a female in "labor", then the hospital must either provide for "further medical examination and such treatment" to stabilize the medical condition or provide for a "transfer of the individual to another medical facility" pursuant to federal standards.<sup>79</sup> It applies to Medicare-participating hospitals, which are hospitals that have entered into a Medicare provider agreement with the federal government.<sup>80</sup> Thus, virtually all hospitals with an emergency department in the United States must comply with EMTALA because almost all of them have such agreements.<sup>81</sup>

EMTALA defines an "emergency medical condition" as a medical condition that manifests itself by acute symptoms of

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*Rational Policy*, 53 BUFF. L. REV. 499, 504 (2005-06) (stating that due to political conflicts the legislation is titled "1985," but that it was enacted into law in 1986).

<sup>77</sup> Moy, *supra* note 73, at xl.

<sup>78</sup> See *id.* at 1-21.

<sup>79</sup> 42 U.S.C. § 1395dd(a)-(b)(1) (2008); 42 C.F.R. § 489.24(b) (2008); see also Rosenbaum, *supra* note 76, at 507.

<sup>80</sup> See 42 U.S.C. § 1395dd(e)(2) (2008); Rosenbaum, *supra* note 76, at 506 ("EMTALA imposes fundamental obligations on all Medicare-participating hospitals, regardless of the insured status of persons seeking care.").

<sup>81</sup> See Laura D. Hermer, *The Scapegoat: EMTALA and Emergency Department Overcrowding*, 14 J.L. & POL'Y 695, 699 (2006). But see Moy, *supra* note 73, at 1-15 ("Hospitals that do not accept Medicare funds, such as some Veterans Administration hospitals, Indian reservation hospitals operated by the U.S. Public Health Service, and a few private hospitals (generally psychiatric hospitals), do not have to comply with EMTALA.").

significant severity that failure to obtain immediate attention could result in “imminent danger of death or serious disability.”<sup>82</sup> Federal regulations further define an “emergency medical condition” as not only a physical condition of severe pain, but also a psychiatric disturbance.<sup>83</sup> EMTALA is satisfied if a hospital applies the same standard of screening to all patients.<sup>84</sup> Thus, “[a]s long as a hospital applies the same screening procedures to indigent patients which it applies to paying patients,” the hospital has satisfied EMTALA medical screening requirements.<sup>85</sup>

In addition to the screening requirement, EMTALA requires hospitals to stabilize patients suffering from an emergency medical condition before discharge or transfer to another facility.<sup>86</sup> EMTALA defines “stabilize” as “such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility. . . .”<sup>87</sup> In determining whether the patient has been stabilized, “the fact-finder must consider whether the medical treatment and subsequent release were reasonable in view of the circumstances that existed at the time the hospital discharged or transferred the individual.”<sup>88</sup> The focus is

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<sup>82</sup> 42 U.S.C. § 1395dd(e)(1) (2008); *Thornton*, 895 F.2d at 1133–34.

<sup>83</sup> 42 C.F.R. § 489.24(b).

<sup>84</sup> Jennifer M. Smith, *EMTALA Basics: What Medical Professionals Need to Know*, 94 J. NAT'L. MED. ASS'N. 426, 426 (2002) (stating that EMTALA is a nondiscrimination statute that imposes affirmative obligations on hospitals so that all patients obtain the same level of healthcare irrespective of their financial status).

<sup>85</sup> *Holcombe v. Monahan*, 30 F.3d 116, 117 (11th Cir. 1994).

<sup>86</sup> 42 U.S.C. § 1395dd(e)(3)(A); *see also* *Torres Otero*, 115 F. Supp. 2d 253 (D.P.R. 2000).

<sup>87</sup> 42 U.S.C. § 1395dd(e)(3)(A); *see also* Emergency Medical Treatment and Labor Act (EMTALA) Interpretive Guidelines – Responsibilities of Medicare Participating Hospitals in Emergency Cases: 42 C.F.R. § 489.24(b) at V-25, <http://www.emtala.com/ig.pdf> (last visited Apr. 22, 2010) (“A patient is considered stable for discharge (vs. for transfer from one facility to a second facility) when, within reasonable clinical confidence, it is determined that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the patient is given a plan for appropriate follow-up care with the discharge instructions.”).

<sup>88</sup> *Otero*, 115 F. Supp. 2d at 259; *see also* Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 592 (2003) (“A stabilization can be brief or lengthy, depending on the

not “on the result of the plaintiff’s condition after the release, but rather on whether the hospital would have considered another patient in the same condition as too unstable to warrant his or her release or transfer.”<sup>89</sup> EMTALA does not require hospitals to treat nonemergency cases or to continue to render aid after the emergency condition has been stabilized.<sup>90</sup>

Pursuant to EMTALA, a violation arises when a hospital either (1) fails to properly screen a patient; or (2) turns away, discharges, or improvidently transfers (or “dumps”) the patient without first stabilizing his or her emergency medical condition.<sup>91</sup> But, the Office of Inspector General (“OIG”), an HHS agency, has no idea how much patient dumping occurs; the OIG is only aware of what is reported to it, and hospitals generally do not report patient dumping.<sup>92</sup>

Penalties under EMTALA vary. First, there are governmental penalties. HHS is the government agency responsible for enforcing EMTALA, which is a complaint-driven process.<sup>93</sup> The Centers for Medicaid and Medicare Services (“CMS”), an agency of HHS, is responsible for terminating the hospital’s Medicare provider agreement,<sup>94</sup> and the OIG is responsible for imposing fines.<sup>95</sup> Second, two avenues for civil lawsuits exist. A receiving hospital may recover monies from a transferring hospital’s EMTALA violation, if the

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condition.”).

<sup>89</sup> *Otero*, 115 F. Supp. 2d at 259–60.

<sup>90</sup> See 42 U.S.C. § 1395dd(a)–(b) (2008).

<sup>91</sup> See *Harry v. Marchant*, 291 F.3d 767, 770 (11th Cir. 2002) (en banc); see also *Roubert Colon v. Hosp. Dr. Pila*, 330 F. Supp. 2d 38, 42 (D.P.R. 2004) (“[To] establish an EMTALA violation, a plaintiff must show that (1) the hospital is a participating hospital covered by EMTALA, that operates an emergency department or an equivalent treatment facility); (2) the patient arrived at the facility seeking treatment; and (3) the hospital either (a) did not afford the patient an appropriate medical screening in order to determine if he/she had an emergency medical condition, or (b) bade farewell to the patient (whether by turning him/her away, discharging him/her, or improvidently transferring him/her) without first stabilizing the emergency medical condition.”).

<sup>92</sup> *Hylton*, *supra* note 70, at 984.

<sup>93</sup> *Moy*, *supra* note 73, at 5-1.

<sup>94</sup> *Id.* at 5-1 (A Medicare termination could close a hospital that has significant Medicare volume).

<sup>95</sup> *Id.*

receiving hospital suffered financial losses.<sup>96</sup> A private party may recover monies from a hospital if he or she suffered personal harm as a result of an EMTALA violation.<sup>97</sup>

Although EMTALA certainly filled a void in medical care, Congress provided little funding for its compliance.<sup>98</sup> Thus, what should have been a celebrated victory in healthcare has become a nightmare for hospitals. This is because the financial burden is largely on the hospitals, which are required to screen and stabilize the patient. With rising healthcare costs, an increase in the United States' population of uninsured and underinsured citizens, and a surge of undocumented immigrants who have populated the country, EMTALA, the generally unfunded mandate, has caused significant controversy. The federal, state, and local governments were expected to be responsible parties for EMTALA.<sup>99</sup>

Although the federal government has provided some EMTALA compliance assistance to hospitals, greater aid is required. For example, hospitals that disproportionately treat a large number of indigent patients may receive a disproportionate share hospital (DSH) subsidy payment.<sup>100</sup> Nevertheless, this payment is insufficient.<sup>101</sup> Also, the Balanced Budget Act of 1997 allotted \$25 million dollars per year for 1998-2001 to the twelve states hosting the largest number of undocumented immigrants, to pay for associated emergency hospital services.<sup>102</sup> In December 2003, additional

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<sup>96</sup> 42 U.S.C. § 1395dd(d)(2)(B) (2008).

<sup>97</sup> 42 U.S.C. § 1395dd(d)(2)(A) (2008) (stating that "damages [are] available for personal injury under the law of the State in which the hospital is located . . .").

<sup>98</sup> Lee, *supra* note 68, at 166.

<sup>99</sup> *Id.* at 148 (quoting Senator David Durenberger who stated that "[a]ll Americans, rich or poor, deserve access to quality health care. This question of access should be the government's responsibility at the federal, state, and local levels."); *see also* Rosenbaum, *supra* note 76, at 506 (stating that Medicare finances over 30 percent of hospital care costs in the United States).

<sup>100</sup> *Id.* at 167-68 (citing 42 U.S.C.A. § 1395ww(d)(5)(F) (West 2003)).

<sup>101</sup> *Id.* at 168 (stating that the DSH payment is inadequate because "it does not appropriately compensate the hospitals that treat a disproportionate share of indigents").

<sup>102</sup> CENTER FOR MEDICARE & MEDICAID SERVICES, CMS LEGISLATIVE SUMMARY FOR THE H.R. 1, MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003, P.L. 108-173, 127-28 (Apr. 2004), <http://www.cms.hhs.gov/mmaupdate/downloads/PL108-173summary.pdf> [hereinafter CENTER FOR MEDICARE & MEDICAID SERVICES].

assistance came with the enactment of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").<sup>103</sup> The MMA allotted \$250 million per year for the three-year period between 2005-2008, to be divided among the states based upon each state's total percentage of undocumented immigrants.<sup>104</sup>

Notwithstanding this assistance, EMTALA has remained a tremendous financial burden on hospitals. EMTALA requires hospitals to care for uninsured citizens, and indigent undocumented aliens.<sup>105</sup> As the immigrant populations continue to climb, hospitals likely perceive caring for undocumented aliens to be a significant drain on their sustainability. This financial concern has spawned an increase in hospitals' gratuitous and forced medical repatriations of undocumented immigrants.<sup>106</sup>

#### IV. IMMIGRANTS

Public surveys show that Americans have had mixed feelings about immigrants,<sup>107</sup> and resentment of this group seems to be on the

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<sup>103</sup> Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 (2003).

<sup>104</sup> CENTER FOR MEDICARE & MEDICAID SERVICES, *supra* note 102, at 128 ("Two-thirds of that amount will be allotted for use in all 50 states and the District of Columbia, based on their relative percentages of the total number of undocumented aliens. The remaining one-third will provide additional allotments for the six states with the largest number of undocumented alien apprehensions. The Secretary must directly pay hospitals, physicians, and ambulance providers (including IHS and Tribal) for their otherwise un-reimbursed costs of providing services required by sec. 1867 of the Social Security Act (EMTALA) and related hospital inpatient, outpatient and ambulance services, as defined by the Secretary, furnished to undocumented aliens, aliens paroled into the U.S. at a U.S. port of entry for the purpose of receiving such services, and Mexican citizens permitted temporary entry to the U.S. with a laser visa. Payment will be made from the allotment amounts for the state where the providers are located. The payments will be made quarterly and may be made on the basis of advance estimates with retrospective adjustments.").

<sup>105</sup> See Hylton, *supra* note 70, at 980 (observing that EMTALA creates a duty for anyone presenting with an "emergency medical condition.").

<sup>106</sup> See James Dwyer, *When the Discharge Plan is Deportation: Hospitals, Immigrants, and Social Responsibility*, 23 *BIOETHICS* ii (2009) (reporting precise numbers are not available but that in one year a Florida hospital repatriated seven patients, an Arizona hospital repatriated 100 patients, and the practice is so common that companies now specialize in finding patients placements and shipping them back to Latin America).

<sup>107</sup> See Mary C. Waters & Reed Ueda, *Introduction*, in *THE NEW AMERICANS: A GUIDE TO*

rise.<sup>108</sup> This unfavorable attitude is not directed to any particular group. “Central Americans are perceived as welfare abusers who stubbornly refuse to learn English, Haitians are seen as AIDS carriers, Russian Jews are considered to be Mafiosi, and Asians are seen as international terrorists.”<sup>109</sup> Conversely, polls also reveal that “exposure to and experience with immigrants” results in a favorable opinion of them.<sup>110</sup> Significantly, the majority of immigrants residing in the United States come from Latin America.<sup>111</sup> Although immigrants previously tended to migrate to particular states, immigration has become a national issue as increasing numbers of immigrants settle in states that had previously seen little immigration.<sup>112</sup>

Over two decades ago, President Ronald Reagan signed into law the Immigration Reform and Control Act (“IRCA”) of 1986.<sup>113</sup> IRCA resulted in approximately 3 million undocumented immigrants given

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IMMIGRATION SINCE 1965, at 5 (Waters & Ueda eds., 2007).

<sup>108</sup> See Stephen Moore, *Give Us Your Best, Your Brightest: Immigration Policy Benefits U.S. Society Despite Increasing Problems*, in *THE MIGRATION READER* 329, 329 (Anthony M. Messina and Gallya Lahav eds., 2006) (reporting that current public opinion canvassing confirms that Americans’ attitudes towards immigration are often negative); see also Francine, J. Lipman, *The Taxation of Undocumented Immigrants: Separate, Unequal, and Without Representation*, 9 *HARV. LATINO L. REV.* 1, 14 (2006) (“[D]espite the hundreds of times every day undocumented immigrants across the United States interact with U.S. citizens as an unrecognized driving force in the economy, they are feared, hated, and misunderstood.”); Brietta Clark, *The Immigrant Health Care Narrative and What it Tells Us About the U.S. Health Care System*, 17 *ANNALS HEALTH L.* 229, 241 (2008) (“Immigrants are often seen as threatening our economic stability and security by stealing our jobs, identities, and scarce public resources.”); *Faces of Immigration Reform Broadens*, CBS NEWS, Nov. 26, 2009, <http://www.cbsnews.com/stories/2009/11/26/national/main5788729.shtml> (“For far too long, the Latino population in the U.S. has really borne the brunt of the anti-immigrant sentiment,” said [U.S. House] Rep. Yvette Clarke).

<sup>109</sup> Moore, *supra* note 108, at 329.

<sup>110</sup> See Waters & Ueda, *supra* note 107, at 5.

<sup>111</sup> Kathryn Pitkin Derose et al., *Immigrants and Health Care Access, Quality, and Cost*, 66 *MED. CARE RES. & REV.* 355, 356 (Aug. 2009).

<sup>112</sup> See Waters & Ueda, *supra* note 107, at 5 (stating California, New York, Florida, New Jersey, Illinois, and Texas house 67 percent of the foreign-born population, but states in the South, West, and Midwest, such as North Carolina, Georgia, Nevada, Arkansas, Utah, Tennessee, Nebraska, Arizona, and Colorado, are seeing record-setting growth in the number of new immigrants making homes there).

<sup>113</sup> Immigration Reform and Control Act of 1986, Pub. L. No. 99-603, 100 Stat. 3359.

a new status as legal immigrants.<sup>114</sup> Currently, there are about 39 million immigrants residing in the United States, which equals about 12 percent of the United States' population.<sup>115</sup> Approximately one third of the 39 million are legal permanent residents,<sup>116</sup> another one third are naturalized citizens,<sup>117</sup> and another one third or almost 12 million are undocumented immigrants.<sup>118</sup>

Undocumented immigrants often come to the United States and to other wealthy countries to "earn more money, provide better support for their families, and construct better lives."<sup>119</sup> They often abandon their home country because of "[p]overty, unemployment, structural adjustment policies, war, and environmental degradation."<sup>120</sup> Thus, they are usually assigned the most menial labor in the most undesirable environments—performing such jobs as sewing, washing dishes, cleaning toilets, farming, and slaughtering animals.<sup>121</sup> There is no conclusive evidence that

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<sup>114</sup> See Migration Policy Institute, *A New Century: Immigration and the US*, Migration Information Source (Feb. 2005), <http://www.migrationinformation.org/USfocus/display.cfm?ID=283>.

<sup>115</sup> JEFFREY S. PASSEL, *A PORTRAIT OF UNAUTHORIZED IMMIGRATION IN THE UNITED STATES 3* (2009), <http://pewhispanic.org/files/reports/107.pdf>; see also Derose et al., *supra* note 111, at 355.

<sup>116</sup> See Bean & Lowell, *supra* note 3, at 70 (defining a legal permanent resident as someone who has been given formal permission by the national government to live and work there); L. Vázquez et al., *Jumping the Legal Hurdles: Getting Green Cards, Visas, and U.S. Citizens, in FOUR GENERATIONS OF NORTENOS: NEW RESEARCH FROM THE CRADLE OF MEXICAN MIGRATION*, 104–05 (Wayne A. Cornelius et al. eds., 2009) (defining a legal permanent resident as someone with a green card which is a ten year visa that permits an immigrant to legally live and work in the United States and also allows them to own U.S. property, join the military, and attend public schools).

<sup>117</sup> See Peter H. Schuck, *Citizenship and National Policy*, in *THE NEW AMERICANS: A GUIDE TO IMMIGRATION SINCE 1965*, at 45 (Waters & Ueda eds., 2007) (defining a naturalized citizen as a legal permanent resident who has resided in the United States as a legal permanent resident for five years, is of good moral character, has a proficiency in the English language, and has a basic knowledge of American government and history).

<sup>118</sup> PASSEL, *supra* note 115, at i; Derose et al., *supra* note 111, at 356.

<sup>119</sup> Dwyer, *supra* note 106, at iii.

<sup>120</sup> *Id.*

<sup>121</sup> *Id.*; Lipman, *supra* note 108, at 14 ("Undocumented immigrants are gardeners, housekeepers, cooks, nannies, waiters, dishwashers, seamstresses, handymen, facilities maintenance personnel, construction workers, factory workers, welders, and producers of low-priced food.").

immigrants come to the United States for public assistance<sup>122</sup> or emergency healthcare.<sup>123</sup> Undocumented workers who get injured while in the United States are left with few options for medical care.<sup>124</sup>

Because legislators wanted to save money and promote individual responsibility, most public assistance excludes immigrants. Immigration opponents portrayed immigrants who obtained legal status under IRCA as burdens on the welfare system.<sup>125</sup> Indeed, in 1995 federal legislators introduced several bills in Congress that would limit immigrants' access to public benefits.<sup>126</sup> In 1996, two of these bills were passed that significantly impacted both authorized and unauthorized immigrants. They were passed to reduce unauthorized migration by restricting public benefits to noncitizen immigrants.<sup>127</sup>

Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") in 1996 as a part of "welfare reform."<sup>128</sup> PRWORA targeted legal immigrants.<sup>129</sup> The act

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<sup>122</sup> TOVA ANDREA WANG, THE CENTURY FOUNDATION, WELFARE REFORM AND IMMIGRANTS, <http://www.tcf.org/Publications/MediaPolitics/welfarereform.pdf>.

<sup>123</sup> See Rosenbaum, *supra* note 76, at 512, 527 (finding emergency use mostly by insured patients); Clark, *supra* note 108, at 247 (noting that the attitude that undocumented immigrants come to the U.S. for free emergency care is ludicrous when you understand that "emergencies are by definition unanticipated, and are therefore unlikely to be a primary motivation for entering the United States illegally"); Susan Okie, *Immigrants and Health Care - At the Intersection of Two Broken Systems*, 356 N. ENG. J. MED. 525, 526 (2007) ("Many immigrants do not seek medical treatment unless they are injured or acutely ill . . ."). But see Craig Conway, *Florida Deportation Case Further Fuels Debate Surrounding Health Care for Illegal Immigrants*, HEALTH LAW PERSPECTIVES, Aug. 2009, [http://www.law.uh.edu/Healthlaw/perspectives/2009/\(CC\)%20Immigrants.pdf](http://www.law.uh.edu/Healthlaw/perspectives/2009/(CC)%20Immigrants.pdf) ("A study by the United States/Mexico Border Counties Coalition found that hospitals along the border spent nearly \$200 million on emergency health care alone to undocumented immigrants in 2000.").

<sup>124</sup> Clark, *supra* note 108, at 236 (stating that immigrants continue to have access to emergency care pursuant to EMTALA, that immigrants continue to have access to diagnosis and treatment of communicable diseases, and that detainee immigrants have a limited right to medical care due to their inability to access medical care any other way as a detained person).

<sup>125</sup> See Vázquez et al., *supra* note 116, at 117.

<sup>126</sup> See Lopez, *supra* note 57, at 654.

<sup>127</sup> Bean & Lowell, *supra* note 3, at 72.

<sup>128</sup> Derose et al., *supra* note 111, at 356.

attached greater responsibility to those who sponsored legal immigrants by either making affidavits of support legally enforceable by the government agency providing the social services or by the immigrants themselves.<sup>130</sup> The act also rendered legal immigrants ineligible for Supplemental Security Income (SSI) and food stamps.<sup>131</sup> Furthermore, PRWORA eliminated all federally-funded preventive healthcare for illegal immigrants, and left only emergency services and treatment for communicable diseases.<sup>132</sup> It was estimated that the implementation of PRWORA would save the federal government \$54 billion over the next six years.<sup>133</sup> PRWORA was reported to have caused a double-digit percentage increase in uninsurance among immigrant single women and their children.<sup>134</sup> Thus, analysts believed that this may have “created fear among immigrants and diminished their enrollment in safety net programs.”<sup>135</sup>

That same year, Congress also passed the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (“IIRIRA”).<sup>136</sup> This act significantly altered the landscape for undocumented immigrants and immigration in general. The act toughened enforcement by “doubling the number of border agents, constructing physical

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<sup>129</sup> *Id.* at 365 (reporting how the act restricted legal immigrants’ eligibility for services that were federally funded, such as Medicaid).

<sup>130</sup> See Aristide R. Zolberg, *Immigration Control Policy: Law and Implementation*, in *THE NEW AMERICANS: A GUIDE TO IMMIGRATION SINCE 1965*, at 38 (Waters & Ueda eds., 2007).

<sup>131</sup> Connie Chang, Comment, *Immigrants Under the New Welfare Law: A Call for Uniformity, A Call for Justice*, 45 *UCLA L. REV.* 205, 205 (1997).

<sup>132</sup> Seam Park, *Substantial Barriers in Illegal Immigrant Access to Publicly-funded Health Care: Reasons and Recommendations for Change*, 18 *GEO. IMMIGR. L. J.* 567, 569, 573 (2003–04) (citing 8 U.S.C. § 1611(c) (2000)); Jones et al., *My Brother’s Keeper: Uncompensated Care for Illegal Immigrants*, 44(3) *J. OF VASCULAR SURGERY*, 679, 680 (2006) (noting that half of the cases of tuberculosis diagnosed in the U.S. are from immigrants).

<sup>133</sup> See generally Jon Jeter, *States Face Dilemma on Immigrants, U.S. to End Welfare for Legal Noncitizens*, *WASH. POST*, Aug. 15, 1996, at C1; Vázquez et al., *supra* note 116, at 117 (noting that immigration opponents estimated that PRWORA would save the government billions of dollars by restricting legal immigrants’ use of food stamps, SSI, and aid for the poor and disabled).

<sup>134</sup> See Derosé et al., *supra* note 111, at 365 (citing N. Kaushal and R. Kaestner, *Welfare Reform and Health Insurance of Immigrants*, *HEALTH SERVICES RESEARCH* 40(3), 697–721(2005)).

<sup>135</sup> *Id.* at 366.

<sup>136</sup> See Zolberg, *supra* note 130, at 38.

barriers in heavily trafficked areas, stiffening civil and criminal penalties for illegal entry and for assisting it, buttressing state and local authority to enforce immigration laws, and creating an 'integrated entry and exit data system.'"<sup>137</sup>

IIRIRA imposed harsh penalties for undocumented immigrants. The act "impose[d] increased penalties for document fraud on illegal migrants, including civil fines and the barring of future entry (a serious penalty for someone with close or nuclear family members living in the United States)."<sup>138</sup> Scholars also perceived that IIRIRA shifted liability toward individual immigrants and away from the INS courts, essentially placing INS outside of the limits of judicial scrutiny.<sup>139</sup>

In addition to PRWORA and IIRIRA, Congress also passed the Anti-terrorism and Effective Death Penalty Act of 1996 ("AEDPA"), which allowed greater ease to "arrest, detain, and deport non-citizen immigrants by providing for the automatic deportation of immigrants who had committed an 'aggravated felony.'"<sup>140</sup> Also, the AEDPA broadened the definition of "aggravated felony" to include more petty crimes and included retroactive impact of the new laws.<sup>141</sup>

Since the passage of PRWORA, financial conditions for impoverished legal immigrants have significantly worsened.<sup>142</sup> Although some states attempted to fill the void caused by the removal of federal government assistance, the help was spotty and slack, and thus ineffective.<sup>143</sup> Because the Act's restriction of food stamps negatively impacted children, the elderly, and the disabled, subsequent legislation was required to restore food stamps to a

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<sup>137</sup> *Id.*

<sup>138</sup> Gallya Lahav, *The Rise of Nonstate Actors in Migration Regulation in the United States and Europe: Changing the Gatekeepers or Bringing Back the State?*, in *THE MIGRATION READER* 301-02 (2006).

<sup>139</sup> *Id.* at 302; Zolberg, *supra* note 130, at 38.

<sup>140</sup> Vázquez et al., *supra* note 116, at 117.

<sup>141</sup> *Id.* (finding that after the 1996 reforms, a legal permanent resident who had been found guilty some 20 years earlier of jumping a subway turnstile could now face deportation).

<sup>142</sup> See WANG, *supra* note 122.

<sup>143</sup> *Id.*

quarter-million legal immigrants.<sup>144</sup> PRWORA's passage also impacted healthcare—now, many legal immigrants no longer had health insurance or their access to basic medical care was limited.<sup>145</sup> “Legal immigrants pay all the same taxes as citizens and serve in the military when there is a draft. They carry most of the responsibilities citizens do and yet are currently denied much of the government assistance they might need.”<sup>146</sup>

Undocumented immigrants are entitled to and receive even less than legal immigrants. Although often perceived as societal burdens, undocumented immigrants serve the United States in significant ways. Undocumented immigrants pay about the same amount of taxes<sup>147</sup>—federal and state income taxes—Social Security, Medicare, and sales taxes as U.S. citizens, but they will not realize a return on their contributions to Social Security and Medicare, which constitute a net gain to federal and state treasuries.<sup>148</sup> Empirical studies consistently show that undocumented immigrants “actually contribute more to public coffers in taxes than they cost in social services.”<sup>149</sup> Economists have concluded that undocumented immigrants have had a positive (74 percent) or neutral (11 percent) effect on the American economy.<sup>150</sup>

Yearly, undocumented immigrants increase federal, state and local government purses by billions of dollars in income, property, excise, sales, and payroll taxes, including contributions to unemployment, Medicare, and Social Security benefits.<sup>151</sup>

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<sup>144</sup> *Id.* (citing General Accounting Office, “Welfare Reform: Many States Continue Some Federal or State Benefits for Immigrants,” GAO/HEHS-98-132, July 1998, p. 3).

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> See Lipman, *supra* note 108, at 20–21 (“As a result of the mandatory obligation [under IRCA requiring employees to prove their identify and permission to work in the United States], there is now widespread use of counterfeit Social Security cards among unauthorized workers, making ‘it more common and easier than ever for undocumented workers to enter and function in the U.S. labor market.’”).

<sup>148</sup> Jones et al., *supra* note 132, at 680 (citing Sidney Weintraub, *Illegal Immigrants in Texas: Impact on Social Services and Related Consideration*, 18 INT’L MIGRATION REV. 733, 733 (1984)).

<sup>149</sup> See Lipman, *supra* note 108, at 2.

<sup>150</sup> *Id.* at 4.

<sup>151</sup> *Id.* at 5.

Nevertheless, they are foreclosed from most government benefits, such as food stamps, Medicaid, federal housing programs, Supplemental Security Income, unemployment insurance, Temporary Assistance for Needy Families, and Earned Income Tax Credit.<sup>152</sup> The only services left are emergency medical care, if they qualify, and public education.<sup>153</sup> Some states have also determined that undocumented workers are entitled to workers' compensation.<sup>154</sup> But, most undocumented immigrants refuse to access these necessary government services because of the very real fear of deportation.<sup>155</sup> This surge of immigrants has impacted all of the United States' major institutions, such as schools, housing, labor markets, and hospitals.<sup>156</sup>

## V. MEDICAL REPATRIATIONS

### A. U.S. Healthcare and Unauthorized Immigration

Immigration is a politically sensitive topic in the United States. Undocumented immigrants are a voiceless people, and thus, Americans easily find fault with their presence in the United States while simultaneously overlooking their overwhelming contributions to the country. One area in which we fault undocumented immigrants is the United States' healthcare system. It is easy to blame the failures and closings of American hospitals and emergency rooms on undocumented immigrants,<sup>157</sup> but that will tell only part of the

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<sup>152</sup> *Id.* at 5–6.

<sup>153</sup> *Id.* at 6.

<sup>154</sup> See *Farmers Bros. Coffee v. Workers' Comp. Appeals Bd.*, 133 Cal. App. 4th 533 (Cal. Ct. App. 2005); see also AMERICAN ASSOCIATION OF STATE COMPENSATION FUNDS, WORKERS COMPENSATION AND THE UNDOCUMENTED WORKER, ¶2 (2007), [http://www.aasf.org/public/Third\\_Quarter\\_2007/undocumented.htm](http://www.aasf.org/public/Third_Quarter_2007/undocumented.htm). But see Darin Van Vlerah, *Bill Limiting Immigrant Worker's Compensation Benefits*, EMPLOYER L REP., March 22, 2010, <http://www.employerlawreport.com/2010/03/articles/workers-compensation/bill-limiting-immigrant-workers-compensation-benefits/> (describing Sen. Bill Seitz's bill proposal to bar illegal immigrants from worker's compensation).

<sup>155</sup> See Lipman, *supra* note 108, at 6; Janet Calvo, *The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP*, 17 ANNALS HEALTH L. 175, 203 (2008).

<sup>156</sup> See Waters & Ueda, *supra* note 107, at 3.

<sup>157</sup> See, e.g., Michael O. Adams et al., *Immigration and Healthcare Systems in the United States*:

story of the failure of American hospitals.

America is currently in the midst of an historic transformation of the country's healthcare system. Before this year, America was the only industrialized nation without universal healthcare.<sup>158</sup> For decades, Americans have been seriously concerned about the lack of universal healthcare, but for decades, nothing had changed the status of the American healthcare system. For the past year, President Obama and Congress have embarked on a healthcare odyssey. This resulted in the passage of landmark legislation, the Patient Protection and Affordable Care Act ("PPACA").<sup>159</sup> This bill was drafted by the Senate as an alternate to the House bill, known as the Affordable Health Care for America Act of 2009.<sup>160</sup> The House bill would have prevented government subsidies to undocumented immigrants to help them purchase health insurance, but it would have allowed undocumented immigrants the opportunity to purchase healthcare with their own money.<sup>161</sup> The PPACA does not allow undocumented immigrants to obtain health insurance even with their own money. After the Senate passed its bill on December 24, 2009, the Senate gained one more Republican seat, which was enough to sustain a filibuster on the bill and some thought perhaps derail healthcare reform.<sup>162</sup> Therefore, the House opted to pass the PPACA and amend

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*Policy and Administrative Implications*, 5 EUR. J. SOC. SCI. 1, 1 (2007) ("Illegal immigration has created an unprecedented huge burden on our country's already hampered healthcare system. Specifically, it has caused our healthcare system to become dysfunctional based on a less than effective system of funding, lack of quality in healthcare for all citizens, and has caused a moral and ethical dilemma for its administering officials."); Sana Loue, *Health Care Rationing and the Undocumented Alien: An Examination of Its Impact and a Proposal for Alternative Methods to Access Care*, 21 W. ST. U. L. REV. 95, 95 (1993-94) ("Illegal immigration has been politically targeted as the root cause of hospital's bankruptcies, states' deficits, and the 'overwhelming' burden placed on U.S. taxpayers.").

<sup>158</sup> Maxwell J. Mehlman, *"Medicover": A Proposal for National Health Insurance*, 17 HEALTH MATRIX 1, 3 (2007).

<sup>159</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

<sup>160</sup> H.R. Con. Res. 3962, 111th Cong. (2009) (enacted).

<sup>161</sup> *Id.*

<sup>162</sup> See Karen Tumulty, *Does Brown's Senate Win Mean the End of Health Reform?*, TIME, Jan. 20, 2010, <http://www.time.com/time/politics/article/0,8599,1954980,00.html>; Ceci Connolly, *How Obama Revived his Health-Care Bill*, WASHINGTON POST, March 23, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/22/AR2010032203729.html?hpid=topnews> (indicating that Obama and others were concerned the reform would

it with another bill.<sup>163</sup> Two days after President Obama signed the PPACA, Congress then passed the Health Care and Education Reconciliation Act of 2010 (“HCERA”).<sup>164</sup> The HCERA was a reconciliation bill to change the PPACA, and include student loan reform. Student loan reform was attached to HCERA as a rider because only one reconciliation bill can be passed in each budget year. President Obama signed HCERA into law on March 30, 2010.<sup>165</sup>

Although the health reform provisions will be implemented in various stages in the next several years, America now has comprehensive healthcare reform—something Americans have strongly desired for decades.<sup>166</sup> In 1935, President Franklin D. Roosevelt signed legislation creating the Social Security system; in 1965, President Lyndon B. Johnson signed legislation creating Medicare; and in 2010, President Barack Obama signed legislation establishing a comprehensive healthcare system for the United States.

While the healthcare bill became law, it has caused significant controversy—mainly along the lines of Democrats in favor of it and Republicans against it.<sup>167</sup> By the time all of the health reform provisions kick in, 32 million more people living in America will have healthcare, 23 million will remain uninsured, and one-third of

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be halted).

<sup>163</sup> David M. Herszenhorn, *Pelosi Signs Reconciliation Bill*, N.Y. TIMES, March 26, 2010, <http://prescriptions.blogs.nytimes.com/2010/03/26/pelosi-presides-at-health-bill-ceremony/>.

<sup>164</sup> Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, *available at* <http://www.govtrack.us/congress/billtext.xpd?bill=h111-4872>.

<sup>165</sup> *Id.*

<sup>166</sup> See Scott Wilson, *Obama Signs Health-Care Reform Bill*, WASH. POST, March 24, 2010, <http://www.washingtonpost.com/wp-dyn/content/article/2010/03/23/AR2010032301071.html?hpid=topnews>.

<sup>167</sup> *Id.*; see also *Healthcare Changes Head to Obama for Signature*, REUTERS, March 26, 2010, <http://www.reuters.com/article/idUSN2616625320100326> (“Republicans remained united in their opposition to the sweeping \$940 billion overhaul and have vowed a campaign to repeal it.”); Ricardo Alonso-Zalvidar, *Obama Health Insurance Requirement Taken from GOP*, ABC NEWS, March 27, 2010, <http://abcnews.go.com/Business/wireStory?id=10217080> (“Republicans were for President Barack Obama’s requirement that Americans get health insurance before they were against it. The obligation in the new health care law is a Republican idea that’s been around at least two decades. It was once trumpeted as an alternative to Bill and Hillary Clinton’s failed health care overhaul in the 1990s. These days, Republicans call it government overreach.”).

this 23 million will be undocumented immigrants.<sup>168</sup>

Thus, even with this new healthcare reform, undocumented immigrants will continue to be forced to seek emergency medical care in hospitals. The anti-immigrant sentiment held by so many Americans drove the exclusion of undocumented immigrants from the healthcare bills.<sup>169</sup> The legislators wanted to ensure re-election, so they tried to balance the will of many Americans by excluding undocumented immigrants.

Before America's current recession that began in December 2007,<sup>170</sup> approximately 46 million Americans lacked healthcare, and another sixteen million were underinsured.<sup>171</sup> Approximately 11 million of the 46 million uninsured are foreign nationals (immigrants), and the remaining are citizens.<sup>172</sup> Since the recession, the number of uninsured is reported to have increased.<sup>173</sup> Although

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<sup>168</sup> See Jill Lawrence, *Health Reform: A Year-by-Year List of What Happens and When*, POLITICS DAILY, March 26, 2010, <http://www.politicsdaily.com/2010/03/26/health-reform-a-year-by-year-list-of-what-happens-and-when/>.

<sup>169</sup> See Roger Mahony, *Coverage without Borders*, N.Y. TIMES, Dec. 8, 2009, <http://www.nytimes.com/2009/12/08/opinion/08mahony.html> ("In many conversations with people around the country, I have found that the dreadful anti-immigrant rhetoric that dominates talk shows does not represent the views of a majority of Americans, who do not reject immigrants out of hand as a burden. Instead, they want to find a way for these people to emerge from the shadows and to begin down a path to legal status. To deny our immigrant brothers and sisters basic health care coverage is immoral. To allow people's basic health needs to be trumped by divisive politics violates American standards of decency and compassion. We should pass health care reform that provides access to all, in the interests of the common good. We must also enact comprehensive immigration reform that better balances our country's need for a stable work force with the orderly flow of immigrants to help bring greater prosperity to all Americans. Otherwise, in our country there will remain a permanent underclass left standing in the waiting room, asking for a doctor's visit that will never come.").

<sup>170</sup> Conor Dougherty, *Recession Takes Toll on Living Standards*, WALL ST. J., Sept. 11, 2009, at A3, available at <http://online.wsj.com/article/SB125259099642699581.html> (reporting that the recession began in December 2007).

<sup>171</sup> See Mehlman, *supra* note 158, at 2-3.

<sup>172</sup> Richard Wolf, *Rising Health Care Costs Puts Focus on Illegal Immigrants*, USA TODAY, JAN 21, 2008, available at [http://www.usatoday.com/news/washington/2008-01-21-immigrant-healthcare\\_N.htm](http://www.usatoday.com/news/washington/2008-01-21-immigrant-healthcare_N.htm) (reporting that about 15% of the nation's forty-seven million uninsured are undocumented immigrants).

<sup>173</sup> Mary Beth Lehman, *Report: 4 million Americans lost health insurance since recession began*, THE BUS. REV., Feb. 22, 2009, <http://albany.bizjournals.com/albany/stories/2009/02/16/daily58.html> ("An estimated 4 million Americans have lost their health

there is disagreement as to whether more citizens have lost their healthcare insurance since the recession,<sup>174</sup> it is hard to imagine that such a phenomenon has not occurred because, unlike many other countries, health insurance is often tied to employment in the United States.<sup>175</sup> Surely, more Americans have lost their jobs since the recession began.<sup>176</sup> Additionally, those who would have qualified to extend health insurance for eighteen months after a job loss under COBRA cannot afford the costs of coverage.<sup>177</sup> Thus, a more realistic perspective is that Americans who lose their jobs simultaneously lose health insurance, resulting in an increase of uninsured individuals.

With large numbers of citizens out of work, the nation's emergency departments are experiencing more overcrowding.<sup>178</sup>

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insurance since the recession began, and as many as 14,000 people could be losing their health coverage every day, according to a report by liberal think tank Center for American Progress' Action Fund. The report also claims at least half of the 4 million who lost their insurance coverage still are uninsured. Before the recession started there were an estimated 46 million Americans without health insurance.”).

<sup>174</sup> Dougherty, *supra* note 170, at A3 (“About 700,000 more people didn't have health insurance in 2008 than the year before, though the share of the population without coverage was about the same.”); Judy Woodruff, *Number of Newly Uninsured Americans Rises Along With Jobless Rate*, PBS NEWS HOUR, Feb 11, 2009, [http://www.pbs.org/newshour/bb/health/jan-june09/medicaid\\_02-11.html](http://www.pbs.org/newshour/bb/health/jan-june09/medicaid_02-11.html) (“After more than 2 million American workers were laid off in the past three months, the numbers who have lost their health insurance and applied for Medicaid have also risen rapidly.”); *but see* Terrence P. Jeffrey, *Despite Recession and Rising Unemployment, Rate of Uninsured Did Not Increase, Says Census Bureau Data*, CNN NEWS, Sept. 10, 2009, <http://www.cnn.com/news/article/53842> (“Even though the nation was in a recession and unemployment rates were rising, the percentage of people lacking health insurance in the United States did not increase during 2008, according to data released today by the Census Bureau. The actual number of people lacking health insurance ticked up slightly during the year, but so did the actual number of people who were insured, as the overall population increased from 299.10 million in 2007 to 301.48 million in 2008. There was also a slight movement of people from private insurance into government insurance—including seniors moving into Medicare.”).

<sup>175</sup> See Timothy Stoltzfus Jost, *Access to Health Care: Is Self-Help the Answer?*, 29 J. LEGAL MED. 23, 26 (2008) (finding that employment-based health insurance has been the primary source of healthcare coverage for working age Americans).

<sup>176</sup> Conor Dougherty, *Soaring Job Losses Drives Stimulus Deal*, WALL ST. J., Feb. 7, 2009, <http://online.wsj.com/article/SB123392627601156735.html> (stating that “[T]he economy lost 3.6 million jobs since the recession started in December 2007”).

<sup>177</sup> Woodruff, *supra* note 174.

<sup>178</sup> JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, *MANAGING PATIENT FLOW: STRATEGIES AND SOLUTIONS FOR ADDRESSING HOSPITAL OVERCROWDING 2004*, (quoting the American College of Emergency Physicians defining overcrowding of hospital

EMTALA has been described as “a backdoor way to get people universal access to at least emergency room care.”<sup>179</sup> But, there is nothing novel about overcrowded emergency rooms or about patients using the emergency departments for non-medical emergency conditions.<sup>180</sup>

Up until the sixties, with the end of house calls and new rations on healthcare, the emergency rooms were utilized by patients who desired a broader access of services than available from individual doctors.<sup>181</sup> The federal dollars from the Hill-Burton Act provided monies to construct emergency departments that provided a wider range of services than individual physicians.<sup>182</sup> Thus, emergency rooms were the place of choice for patients. Emergency rooms were crowded, but providers were paid through private insurance, payments from patients, and eventually the government (Medicare and Medicaid).<sup>183</sup> In the late sixties and into the seventies, white flight to the suburbs left a large minority (and indigent) community in urban areas with a reduced number of physicians to serve the urban population.<sup>184</sup> Poor patients were unable to pay for their care, federal funding diminished, healthcare costs increased, and charity services from hospitals decreased.<sup>185</sup> The overcrowding was now a crisis, and it put a severe strain on the hospitals and became a financial crisis for them as well.<sup>186</sup> In the eighties private hospitals began “dumping” poor, uninsured patients onto the already overcrowded municipal and county hospitals that had to turn away

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emergency departments as “a situation in which the identified need for emergency services outstrips available resources in the emergency department. This situation occurs in the hospital emergency departments when there are more patients than staffed ED [emergency department] treatment beds and wait time exceed a reasonable period.”).

<sup>179</sup> Beatrix Hoffman, *Emergency Rooms: The Reluctant Safety Net*, in *HISTORY AND HEALTH POLICY IN THE UNITED STATES: PUTTING THE PAST BACK IN* 268 (Rosemary A. Stevens et al. eds., 2006) (quoting Thomas Scully, former director of the Centers of Medicare and Medicaid Services).

<sup>180</sup> *Id.* at 265.

<sup>181</sup> *Id.* at 266.

<sup>182</sup> *Id.*

<sup>183</sup> *Id.*

<sup>184</sup> Hoffman, *supra* note 179, at 266.

<sup>185</sup> *Id.*

<sup>186</sup> *Id.*

patients from the emergency rooms.<sup>187</sup> America was now in a real crisis with its poor indigent community and healthcare system.

Thus, in the mid-eighties, to prevent patient dumping, Congress enacted EMTALA, but it did not address overcrowded emergency departments or unreimbursed medical care.<sup>188</sup> Then, between 1988 and 1999, over one thousand emergency rooms were closed.<sup>189</sup> There may be a correlation between undocumented immigrants, EMTALA, IRCA, and a dysfunctional healthcare system. But the United States healthcare system was dysfunctional even before the eleven million undocumented immigrants arrived.<sup>190</sup> The dysfunction would remain even if they disappeared.<sup>191</sup>

History reveals that the U.S. healthcare system was slowly deteriorating in the late sixties. Many were calling for a universal healthcare system, but this never became a reality. Additionally, emergency departments closed. These closures were not due to overcrowding or undocumented immigrants,<sup>192</sup> but rather because of mergers and consolidations.<sup>193</sup>

Notwithstanding the prior dysfunction of the American healthcare system, it is true that undocumented immigrants, such as Mr. Jiménez, do put a strain on the nations' emergency departments.<sup>194</sup> There is no doubt that Martin Memorial was

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<sup>187</sup> *Id.*

<sup>188</sup> *Id.*

<sup>189</sup> Hoffman, *supra* note 179, at 266.

<sup>190</sup> Jones et al., *supra* note 132, at 681 (commenting that despite what some say, the 11 million illegal immigrants is too small a population to be the problem for the individual states caring for all the patients who can't pay their medical bills because they are not insured).

<sup>191</sup> See Calvo, *supra* note 155, at 208 (noting that "[t]he difficulties with the current American healthcare system would continue to exist even if the noncitizen population disappeared. The minority noncitizen population has not caused the system's problems. Yet, the exclusion of the members of this population contributes to and exacerbates the negative public health and health system consequences . . .").

<sup>192</sup> See Jones et al., *supra* note 132, at 680 (stating that there has been public outcry that undocumented immigrants places an intolerable parasitic burden" on America's major institutions, one of which is hospitals).

<sup>193</sup> See *id.* at 269 n.9 (noting that the Office of the Inspector General found that urban and rural closings were mainly due to "business related decisions or a low number of patients"); see also Hoffman, *supra* note 179, at 266.

<sup>194</sup> Jones et al., *supra* note 132, at 680 ("In 2005, Houston's Ben Taub General Hospital spent

suffering by providing more than one million dollars in non-refundable medical care to Mr. Jiménez. This figure looks even more astounding when you consider that Martin Memorial provides \$24 million dollars in charity care on an annual basis. The strain of undocumented immigrants, however, is far outweighed by the benefits that they pay to the nation's coffers on a local and national level.<sup>195</sup> Immigrants contribute more to the American society than they can take from it due to their "unauthorized" status. When you specifically look at the hospital system, the picture is even brighter for undocumented immigrants, who as a group do not habitually utilize the emergency departments for fear of their unauthorized status being revealed. Emergency care is mainly used by patients who have health insurance.<sup>196</sup>

Medical repatriations are not just problems in the United States. There are also problems with medical repatriations in industrialized foreign countries which have universal healthcare.

## B. Medical Repatriations Abroad

Presently, there are about 214 million international migrants in the world.<sup>197</sup> Most of these migrants left Third World countries for First World countries, seeking a better life and more economic opportunities. Women comprise almost 50 percent of the migrant population.<sup>198</sup> Of the roughly 214 million international migrants, there are about 20 to 30 million unauthorized migrants in the world.<sup>199</sup> Compared to other countries, the United States is by far the

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\$128 million to treat 57,000 uninsured undocumented aliens. Only \$31 million was reimbursed through government and other sources." (citing B. Murphy, *Country's Cost for Illegal Immigrant's Care Soars*, HOUS. CHRON., 2006)).

<sup>195</sup> See section IV of this paper.

<sup>196</sup> Rosenbaum, *supra* note 76, at 512 (stating that a prominent study found that "increased emergency department utilization was chiefly the result of more visits by insured individuals." (citing PETER CUNNINGHAM & JESSICA MAY, CENTER FOR STUDYING HEALTH SYSTEM CHANGE, INSURED AMERICANS DRIVE SURGE IN EMERGENCY DEPARTMENT VISITS 1 (2003), <http://hschange.org/CONTENT/6131>)).

<sup>197</sup> International Organization for Migration, Global Estimates and Trends, <http://www.iom.int/jahia/Jahia/about-migration/facts-and-figures/global-estimates-and-trends> (last visited Apr. 18, 2010).

<sup>198</sup> *Id.*

<sup>199</sup> *Id.*

host country for the largest group of migrants (see chart below).<sup>200</sup>

**Countries hosting the largest number of international migrants in 2005<sup>201</sup>**

Country	International Migrations (millions)
United States	38.4
Russian Federation	12.1
Germany	10.1
Ukraine	6.8
France	6.5
Saudi Arabia	6.4
Canada	6.1
India	5.7
United Kingdom	5.4
Spain	4.8
Australia	4.1

Unauthorized migrants also travel to countries seeking better economic opportunities. Unlike the United States, however, all other industrialized countries have a universal healthcare system. Notwithstanding that, some of these countries with universal healthcare are also engaged in forced medical repatriations.<sup>202</sup> One

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<sup>200</sup> *Id.*

<sup>201</sup> United Nations, TRENDS IN MIGRANT STOCK: THE 2005 REVISION (CD-ROM, 2005).

<sup>202</sup> See Wolpin, *supra* note 6, at 154; see also Loue, *supra* note 3, at 224 (stating that “[n]ation

popular case garnering international attention, was widely condemned throughout the world, and was referred to by *The Lancet*, a well known medical journal in the United Kingdom, as "atrocious barbarism."<sup>203</sup>

In that case, Ama Sumani, a thirty-nine year old Ghana woman and a widow with two children, traveled to Wales (part of the United Kingdom) several years ago on a student visa, but began working in contravention of the student visa because she was unable to take her course due to her lack of English.<sup>204</sup> In January 2006, she was diagnosed with multiple myeloma.<sup>205</sup> She was receiving life-prolonging dialysis treatment at the University Hospital of Wales.<sup>206</sup> This treatment was necessary after cancer ravaged her body causing her kidneys to fail for more than a year; but, her status as an illegal immigrant meant that she had no right to a bone marrow transplant that would have preserved her life.<sup>207</sup> In January 2008, she was removed from the Welsh hospital and sent back to her hometown of Ghana, where she could not afford dialysis.<sup>208</sup> She died shortly after being deported and two hours before her friend called to inform her that significant sums of money had been raised to fund private medical treatment in the United Kingdom.<sup>209</sup>

The Welsh bishops had called for her return to Wales and said

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states may impose such restrictions on immigrants' ability to access healthcare services in an attempt to conserve the state's financial resources for its own citizens and, in some cases, legal residents; to discourage illegal migrations for any purpose or for health care specifically; and/or to punish those international migrants who are seen as lawbreakers and reward those who have migrated legally.").

<sup>203</sup> Editorial, *Migrant Health: What Are Doctors' Leaders Doing?*, 371 LANCET 178 (2008), available at <http://download.thelancet.com/pdfs/journals/lancet/PIIS014067360801117.pdf>.

<sup>204</sup> *Id.*

<sup>205</sup> *Id.*

<sup>206</sup> Madeleine Brindley, *Bishops Call for Dying African Woman to be Allowed Back Into Wales*, WALESONLINE, Jan. 18, 2008, <http://www.walesonline.co.uk/news/wales-news/2008/01/18/bishops-call-for-dying-african-woman-to-be-allowed-back-into-wales-91466-20364221/>.

<sup>207</sup> *Id.*

<sup>208</sup> *Id.*

<sup>209</sup> *Deported Cancer Woman Dies in Ghana*, PA NEWS, Mar. 20, 2008 <http://www.channel4.com/news/articles/society/health/deported+cancer+woman+dies+in+ghana/1827652>.

the decision to remove her from her Welsh hospital bed was a “breach of her basic human rights.”<sup>210</sup> The Archbishop of Wales, Dr. Barry Morgan, said:

“You cannot follow the letter of the law when it comes to immigration because we are dealing with individual human beings, not commodities. There has to be room for flexibility of rules, a consideration of a person’s dignity, self-respect and basic human rights. We need to exercise compassion. It is never appropriate for a civilised, wealthy society to turn, literally, a sick woman out of her bed and put her on a plane to a very worrying future. What sort of moral example does that send to the rest of the world?”<sup>211</sup>

In contrast, the head of the Border and Immigration Agency in Wales said, “The question anybody has to ask themselves is whether it’s right for somebody who has no right to be in this country to be given medical treatment which would not be available to them had they not become an illegal resident.”<sup>212</sup> Unlike Mr. Jiménez in the United States, Ms. Sumani was removed by British immigration officials, not the hospital.

Forced medical repatriations appear to be regular occurrences abroad and in the United States. Government records are not kept to determine the number of medical repatriations that originate in the United States,<sup>213</sup> but a recent investigation revealed that the number is potentially in the hundreds every year.<sup>214</sup> Because there is no

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<sup>210</sup> See Brindley, *supra* note 206.

<sup>211</sup> *Id.*

<sup>212</sup> *MP Defends Removing Cancer Woman*, BBC NEWS, Jan. 16, 2008, [http://news.bbc.co.uk/2/hi/uk\\_news/wales/7190720.stm](http://news.bbc.co.uk/2/hi/uk_news/wales/7190720.stm).

<sup>213</sup> Sontag, *supra* note 11 (noting that “[m]edical repatriations are happening with varying frequency, and varying degrees of patient consent, from state to state and hospital to hospital. No government agency or advocacy group keeps track of these cases, and it is difficult to quantify them.”).

<sup>214</sup> *Id.* (noting that “A few hospitals and consulates offered statistics that provide snapshots of the phenomenon: some 96 immigrants a year repatriated by St. Joseph’s Hospital in Phoenix; 6 to 8 patients a year flown to their homelands from Broward General Medical Center in Fort Lauderdale, Fla.; 10 returned to Honduras from Chicago hospitals since early 2007; some 87 medical cases involving Mexican immigrants—and 265 involving people injured crossing the border—handled by the Mexican consulate in San Diego last year, most but not all of which ended in repatriation.”); see also Clark, *supra* note 108, at 229 (noting that “[a]s of November 2003, Nextcare [a private company that transfers undocumented immigrant patients from U.S. hospitals to Mexican health facilities] had contracted with five

legislation that adequately addresses medical repatriations, they have continued.

### C. Federal and State Laws Regulating Patient Discharges and Transfers

As mentioned earlier, “arguably” no federal or state legislation adequately addresses these involuntary or forced medical repatriations. The term “arguably” is used because EMTALA governs patient dumping, and as Medicare providers (which most U.S. hospitals are), hospitals must comply with the federal law regarding patient discharges.<sup>215</sup> This is true even if the transferring hospital is

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U.S. hospitals to remove at least fifty uninsured, allegedly unauthorized, immigrant patients to Mexico for follow-up care.”).

<sup>215</sup> Pursuant to 42 U.S.C. Section 1395x:

(ee) Discharge planning process

(1) A discharge planning process of a hospital shall be considered sufficient if it is applicable to services furnished by the hospital to individuals entitled to benefits under this subchapter and if it meets the guidelines and standards established by the Secretary under paragraph (2).

(2) The Secretary shall develop guidelines and standards for the discharge planning process in order to ensure a timely and smooth transition to the most appropriate type of and setting for post-hospital or rehabilitative care. The guidelines and standards shall include the following:

(A) The hospital must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning.

(B) Hospitals must provide a discharge planning evaluation for patients identified under subparagraph (A) and for other patients upon the request of the patient, patient's representative, or patient's physician.

(C) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(D) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including hospice care and post-hospital extended care services, and the availability of those services, including the availability of home health services through individuals and entities that participate in the program under this subchapter and that serve the area in which the patient resides and that request to be listed by the hospital as available and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this subchapter and that serve the area in which the patient resides.

shipping patients to medical facilities outside of the United States.

Additionally, federal regulations contain discharge requirements.<sup>216</sup> In drafting the final rule for 42 C.F.R. Section 482, one commenter asked how an “appropriate facility” is decided and what information must be sent to it; The federal government responded:

“Appropriate facilities” refers to facilities that can meet the patient’s medical needs on a post-discharge basis. Our interpretive guidelines for §482.21(b)(2) give as examples of “necessary” information: functional capacity of an individual, the nursing and other care requirements of the patient, discharge summary, and referral forms.<sup>217</sup>

In addition to federal discharge and transfer requirements, more than half of the states also have statutes that regulate patient discharges and transfers.<sup>218</sup> For example, the Florida statute provides for emergency care to all persons who need it.<sup>219</sup>

(E) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(F) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(G) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel.

(H) Consistent with section 1395a of this title, the discharge plan shall—

(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1395cc(a)(1)(S) of this title) or which has such an interest in the hospital.

<sup>216</sup> See 42 C.F.R. § 482.43 (2008) (“Standard: Transfer or referral. The hospital must transfer or refer patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for follow-up or ancillary care.”).

<sup>217</sup> 42 C.F.R. §§ 405, 482 (supplementary information includes comments and responses).

<sup>218</sup> Hylton, *supra* note 70, at 986 (providing an appendix of all the state statutes).

<sup>219</sup> FL. Stat. § 395.1041(3) states that:

(a) Every general hospital which has an emergency department shall provide

Finally, U.S. hospitals maintain their own patient discharge policies and procedures. In the case of Mr. Jiménez, Martin Memorial had a discharge plan that “require[s] that the discharge plan identify the next appropriate level of care required by the patient, identify by name and address the receiving facility, provide the name of the supervising medical doctor who will take responsibility for the patient’s care at the receiving facility, and confirm that the doctor will provide the patient with the identified appropriate level of care.”<sup>220</sup> Notwithstanding, U.S. hospitals are not following federal, state, or local discharge plans in discharges within the United States.<sup>221</sup> They are also not doing so for medical repatriations.

EMTALA patient dumping violations *within the U.S. borders* are not tracked, often unknown, and thus are not always penalized,<sup>222</sup> and because the state statutes are rarely used, hospitals and healthcare personnel are rarely prosecuted under them.<sup>223</sup> Furthermore, U.S. hospitals are not required to report patient dumping incidents, and so, they do not.<sup>224</sup> Thus, it is easy to see how patient dumping violations *from the U.S. to foreign countries* have even less tracking, less reporting, and thus less oversight.<sup>225</sup>

U.S. hospitals have federal and state discharge obligations, but the governing laws are not adequately addressing the problem of

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emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
  - a. An emergency medical services provider who is rendering care to or transporting the person; or
  - b. Another hospital, when such hospital is seeking a medically necessary transfer, except as otherwise provided in this section.

<sup>220</sup> *Montejo*, 874 So. 2d at 657.

<sup>221</sup> *Hospitals in Nearly Every State Violate Federal Patient Dumping Law, Study Show*, PUBLIC CITIZEN, July 12, 2001, <http://www.citizen.org/pressroom/release.cfm?ID=170> (2001) (reporting that 527 U.S. hospitals violated EMTALA between 1996–2000).

<sup>222</sup> *See Hylton*, *supra* note 70, at 984.

<sup>223</sup> *Id.* at 986–91.

<sup>224</sup> *See id.* at 984.

<sup>225</sup> *See Nessel*, *supra* note 44 (“When hospitals forcibly send immigrants back to their native countries, they are essential enforcing federal immigration laws absent any federal oversight or accountability.”).

patient dumping in the U.S. or abroad, “because there is now no requirement for hospitals to report dumping cases.”<sup>226</sup> Further, there is no program in place to govern how to handle undocumented immigrants who are critically injured.<sup>227</sup> Something must be done to ensure that U.S. hospitals are not issuing “death sentences” by forcibly shipping undocumented immigrants in critical care from first rate hospitals in the U.S. to inappropriate medical facilities abroad in contravention of federal, state and local discharge requirements.<sup>228</sup> Not only is this practice deemed inhumane,<sup>229</sup> but it overlooks the many contributions from undocumented immigrants to American society, including their financial contributions that help stimulate the American economy. Undocumented immigrants are not the cause of the dysfunction of the American healthcare system, and they never were. But they do cause a strain on emergency departments when they present with catastrophic injuries and no insurance. Additionally, this practice of clandestine medical repatriations is not the solution for America’s healthcare dilemmas. Physicians must take a leading role in this problem of international patient dumping to ensure that patient safety is premier.

#### D. Medical Association Resolutions

The California Medical Association (“CMA”) is the first state medical association to propose and pass a resolution addressing forced medical repatriations.<sup>230</sup> CMA’s action was in response to the August 2008 *New York Times* article regarding Mr. Jiménez.<sup>231</sup>

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<sup>226</sup> Hylton, *supra* note 70, at 984 (quoting Public Citizen Director Sydney M. Wolfe) (citing *Health Care, Public Citizen Calls HHS’ Enforcement of Patient Dumping Act “Tragic Failure,”* DAILY REP. FOR EXECUTIVES (BNA) No. 79, at A14 (Apr. 24, 1991).

<sup>227</sup> Sontag, *supra* note 11.

<sup>228</sup> *Id.* (“Repatriation is pretty much a death sentence in some of these cases,” said Dr. Steven Larson, an expert on migrant health and an emergency room physician at the Hospital of the University of Pennsylvania. “I’ve seen patients bundled onto the plane and out of the country, and once that person is out of sight, he’s out of mind.”).

<sup>229</sup> See Nessel, *supra* note 44.

<sup>230</sup> Wolpin, *supra* note 6, at 153 (“CMA’s resolution represents the first time a state medical association has officially addressed the legally, economically, and ethically complex issue of hospital-sponsored repatriations of uninsured aliens.”).

<sup>231</sup> *Doctors Study Repatriation of Uninsured*, N.Y. TIMES, Nov. 11, 2008,

Although the draft of the resolution would have recommended medical repatriations to “be done only with the full consent of the patient and their families and to foreign facilities that can provide adequate long-term care,”<sup>232</sup> it did not pass with that language. Instead, CMA passed a watered down version of the draft resolution declaring that “CMA oppose[s] forced deportations of patients” and “that this [issue] be referred for national action.”<sup>233</sup>

In November 2008, prompted by the CMA’s passage of its resolution a month earlier, the American Medical Association (“AMA”) considered the issue, and rather than assert a position, it voted to initiate a study to determine the legal, financial and ethical issues of medical repatriations.<sup>234</sup> An AMA trustee remarked: “There are conflicting concerns here. On the one hand, patients shouldn’t be dumped. On the other, hospitals need to be solvent. After all, if the care of these patients were actually paid for by some entity, these repatriations would not be happening and this would not be an issue.”<sup>235</sup> The lead counsel in the *Montejo* case stated, “The problem clearly cries out for a legislative solution; however, until such a solution is crafted, we cannot permit the continued victimization of undocumented persons through international patient dumping.”<sup>236</sup>

## VI. RECOMMENDATIONS

International patient dumping converges two of our nation’s most dysfunctional systems—the healthcare system and the immigration system.<sup>237</sup> As indicated, the nation’s healthcare system was broken long before this surge of undocumented immigrants

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<http://www.nytimes.com/2008/11/11/health/policy/11deport.html> [hereinafter *Doctors Study Repatriation*].

<sup>232</sup> Wolpin, *supra* note 6, at 153.

<sup>233</sup> Wolpin, *supra* note 6, at 153, 155 (2009) (citing CMA House of Delegates Res. 105-08a (Oct. 6, 2008)).

<sup>234</sup> *Doctors Study Repatriation*, *supra* note 231 (referring to Sontag, *supra* note 11).

<sup>235</sup> *Id.*

<sup>236</sup> Wolpin, *supra* note 6, at 154 (quoting Jack Scarola).

<sup>237</sup> Nessel, *supra* note 44 (“[T]he practice of hospitals engaging in repatriating uninsured immigrants, most often against their wishes, illustrates the failings of both our health care and immigration regimes.”).

emerged, and would still be broken if they disappeared. Further, deporting the almost 12 million undocumented immigrants would be economically unwise.<sup>238</sup>

Believing that no country could be strong if its citizens were sick, U.S. presidential candidate Theodore Roosevelt called for national health insurance almost a century ago.<sup>239</sup> That the United States must provide universal healthcare to its citizens should be clear.<sup>240</sup> A recent study has concluded that lack of insurance is associated with 45,000 deaths yearly in the United States.<sup>241</sup> This number is double what was thought to be the number of deaths associated with lack of health insurance.<sup>242</sup> However, the United States spends billions on

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<sup>238</sup> See generally IMMIGRATION POLICY CENTER, *THE ECONOMICS OF IMMIGRATION REFORM: WHAT LEGALIZING UNDOCUMENTED IMMIGRANTS WOULD MEAN FOR THE U.S. ECONOMY* (2009), <http://www.immigrationpolicy.org/sites/default/files/docs/EconomicsofCIRFullDoc.pdf>; see also THE PERRYMAN GROUP, *AN ESSENTIAL RESOURCE: AN ANALYSIS OF THE ECONOMIC IMPACT OF UNDOCUMENTED WORKERS ON BUSINESS ACTIVITY IN THE U.S. WITH ESTIMATED EFFECTS BY STATE AND BY INDUSTRY* (2008), [http://americansforimmigrationreform.com/files/Impact\\_of\\_the\\_Undocumented\\_Workforce.pdf#page=69](http://americansforimmigrationreform.com/files/Impact_of_the_Undocumented_Workforce.pdf#page=69) (showing that deporting all undocumented immigrants from the United States would result in the loss of approximately 2.8 million jobs and a decrease in the Gross Domestic Product of \$245 billion).

<sup>239</sup> *It's Time to Cure Health Care*, BUSINESS WEEK, Jan. 23, 2006, [http://www.businessweek.com/bwdaily/dnflash/jan2006/nf20060123\\_1965\\_db013.htm](http://www.businessweek.com/bwdaily/dnflash/jan2006/nf20060123_1965_db013.htm) (reporting that in 1912, Theodore Roosevelt called for universal health care as a presidential candidate but lost the election); see also *A History of Health Care Reform*, N.Y. TIMES, [http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717\\_HEALTH\\_TIME\\_LINE.html](http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIME_LINE.html).

<sup>240</sup> Although the author believes that the need for universal healthcare is clear, there is a raging debate in the House and Senate as to its need. See, e.g., *A Party Both United and Divided*, WASH. POST, Nov. 30, 2009, <http://www.washingtonpost.com/wp-dyn/content/article/2009/11/29/AR2009112902935.html?hpid=topnews> ("The Republican rank and file is largely in sync with GOP lawmakers in their staunch opposition to efforts by President Obama and Democrats to enact major health-care legislation.").

<sup>241</sup> David Cercere, *New Study Finds 45,000 Deaths Annually Linked to Lack of Health Coverage*, HARV. SCL., Sept. 17, 2009, <http://www.harvardscience.harvard.edu/medicine-health/articles/new-study-finds-45000-deaths-annually-linked-lack-health-coverage>; see also Reed Abelson, *Harvard Medical Study Links Lack of Insurance to 45,000 U.S. Deaths a Year*, THE N.Y. TIMES, Sept. 17, 2009, <http://prescriptions.blogs.nytimes.com/2009/09/17/harvard-medical-study-links-lack-of-insurance-to-45000-us-deaths-a-year/?scp=1&sq=Harvard%20Medical%20Study%20Links%20Lack%20of%20Insurance%20to%2045,000%20U.S.%20Deaths%20a%20Year&st=cse>.

<sup>242</sup> See Stan Dorn, *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality*, URBAN INST., Jan. 2008 (reporting that in 2002, the Institute of Medicine (IOM) estimated 18,000 mortalities of Americans yearly because of

the back end for uninsured healthcare that could have resulted in less expense had the uninsured patients received healthcare earlier.<sup>243</sup>

EMTALA was enacted to fill a void until universal care was implemented.<sup>244</sup> Although President Obama recently signed legislation establishing America's universal healthcare system, the law excludes undocumented immigrants from obtaining health insurance at all. Therefore, the United States will continue to spend significant sums of money for healthcare of a group of people who America relies upon for its economy. Undocumented immigrants need to be included in any comprehensive health plan that America adopts.<sup>245</sup> That, however, did not happen and limiting healthcare access for immigrants will negatively impact the entire U.S. healthcare system.<sup>246</sup> Limiting access means that America is only providing partial solutions for its broken healthcare system. Mr. Jiménez would have been covered, and Martin Memorial would have been reimbursed, if Mr. Jiménez had been able to purchase affordable health insurance.<sup>247</sup>

Health care reform failed to provide a solution to these medical repatriations. There must also be an overhauling of the immigration system. Comprehensive immigration reform appears to be a top priority of President Obama's administration.<sup>248</sup> Reform should

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uninsurance, but that each year the number increased and was estimated at 22,000 deaths in 2006).

<sup>243</sup> Jennifer M. Smith, *"Dirty Pretty Things" & the Law: Curing the Organ Donation and Health Care Crises in America*, 12 CHAPMAN L. REV. 361, 379-80 (2008).

<sup>244</sup> Hermer, *supra* note 81, at 731; *see also* Jennifer M. Smith, *Kidney Transplantation: Only for the Well-to-Do?*, 31 CAMPBELL L. REV. 333, 343 (2009) (stating that Medicare coverage for end stage renal disease ("ESRD") implemented in the 70's was done with the anticipation that a universal healthcare program would occur within one or two years but that did not happen).

<sup>245</sup> The City of San Francisco is the first city-sponsored universal healthcare reform that provides access to affordable, basic healthcare, rather than health insurance, for uninsured people, including undocumented immigrants. *See* Healthy San Francisco, <http://www.healthysanfrancisco.org/> (last visited June. 1, 2010).

<sup>246</sup> *See generally* Calvo, *supra* note 155 (restricting access to healthcare for authorized and unauthorized immigrants does not make sense from a public health of health system perspective).

<sup>247</sup> *See generally* *Hospitals Deporting Patients*, NPR (July 29, 2009), <http://www.onpointradio.org/2009/07/hospitals-deporting-patients>.

<sup>248</sup> The Honorable Janet Napolitano, Sec'y, Dep't of Homeland Sec., Testimony on Oversight of

include consideration of such programs as the Earned Legalization Program<sup>249</sup> and the Development, Relief, and Education for Alien Minors Act ("DREAM Act 2009").<sup>250</sup> The immigration reform laws of 1996 that prevented legal and illegal immigrants from access to primary and preventive care should also be overhauled.<sup>251</sup> From an economic standpoint alone, such laws are senseless. Immigration reform may be a long-term solution, and something must be done now to prevent further medical repatriations, which are placing lives in jeopardy.

Many agree that the federal government, not states or local agencies, must act, and it must act quickly.<sup>252</sup> President Obama is

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the Dep't of Homeland Sec. (Dec. 9, 2009), available at [http://judiciary.senate.gov/hearings/testimony.cfm?id=4192&wit\\_id=8358](http://judiciary.senate.gov/hearings/testimony.cfm?id=4192&wit_id=8358) (testifying that "[s]ecuring our borders, enforcing our nation's immigration laws, and providing timely and effective immigration benefits and services to millions of lawful immigrants each year remains one of the Department's most important missions."). Erica Werner, *Obama: Begin Work This Year on Immigration Reform*, THE ASSOCIATED PRESS, May 5, 2010, <http://www.chron.com/disp/story.mpl/nation/6991661.html> (reporting that President Obama has called for immigration reform to begin this year, cited Arizona's new law on immigration as a reason for the urgency, and stated "Make no mistake, our immigration system is broken, and after so many years in which Washington has failed to meet its responsibilities, Americans are right to be frustrated . . . . But the answer isn't to undermine fundamental principles that define us as a nation. Comprehensive reform - that's how we're going to solve this problem.").

<sup>249</sup> See Immigration Policy Center, *Earned Legalization: Repairing Our Broken Immigration System*, <http://www.immigrationpolicy.org/just-facts/earned-legalization-repairing-our-broken-immigration-system> (last visited June 1, 2010) (explaining that "earned legalization" is not amnesty, but requires such things as paying any back taxes, fines and fees, undergoing a criminal background check, learning English, and obtaining a temporary visa).

<sup>250</sup> See Immigration Policy Center, *DREAM Act Introduction Shows Political Muscle for Immigration Reform*, <http://www.immigrationpolicy.org/newsroom/release/dream-act-introduction-shows-political-muscle-immigration-reform> (last visited June 1, 2010) (providing a path to U.S. citizenship for offspring of undocumented immigrants so the children can pursue higher education and contribute to the nation).

<sup>251</sup> See, e.g., Susan Ivey, *Immigrant Women and the Emergency Department*, J. AM. MED. WOMEN'S ASS'N 2 (1998); see also *Faces of Immigration Reform Broadens*, CBS NEWS, <http://www.cbsnews.com/stories/2009/11/26/national/main5788729.shtml> (calling for a repeal of immigration laws negatively impacting immigrants).

<sup>252</sup> See Wolpin, *supra* note 6, at 155 (quoting Dr. Margolin who proposed the CMA resolution: "Unfunded mandates are bad in medicine. Either we create federal Medicaid minimum standards for acute illness that cover everyone, or we at least make sure that if we send someone abroad, there is no question that the foreign facility can properly take care of them. After all, we doctors all took an oath to 'First, do no harm.'"); Telephone conference with Susana Barciela, policy director for the Florida Immigrant Advocacy Center on December

aware that there needs to be a federal overhaul of immigration laws, particularly due to Arizona Governor Jan Brewer's recent signing of the nation's strictest immigration law.<sup>253</sup> Presently, Martin Memorial has spent \$1.5 million over the last two years treating another undocumented immigrant—this time from Mexico—with no responses from the United States or Mexican governments for help to repatriate the patient or fund his treatment.<sup>254</sup>

Academicians have proposed arguments to challenge the medical repatriations. One has suggested that constitutional concerns, such as due process, equal protection, and federal preemption principles, may render medical repatriations unconstitutional and that medical repatriations may provide a basis for tort, criminal kidnapping, Racketeer Influenced and Corrupt Organizations Act ("RICO"), EMTALA, and administrative claims.<sup>255</sup> They and others have advanced international human rights concerns<sup>256</sup> and immigration based challenges.<sup>257</sup> Those interested in

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10, 2009 (asking rhetorically whether we really want hospital administrators with bottom line requirements instead of a court of law making these medical repatriation decisions); Nessel, *supra* note 44 ("Certainly, the federal government, rather than individual hospitals, is the appropriate authority for enforcing the nation's immigration laws. However, encouraging hospitals to report the immigration status of patients is ill advised and raises a host of dangers. For example, it would be detrimental to the broader public health if undocumented immigrants are chilled from seeking emergency medical care for fear that they will be put in removal proceedings."); Aboobaker, *supra* note 65 (arguing that the [federal] government must address medical repatriations).

<sup>253</sup> Randal C. Archibold, *Arizona Enacts Stringent Law on Immigration*, N.Y. TIMES, Apr. 24, 2010, at A1, available at <http://www.nytimes.com/2010/04/24/us/politics/24immig.html> (reporting that both supporters and critics of the new law agreed that it "was the broadest and strictest immigration measure in generations, would make the failure to carry immigration documents a crime and give the police broad power to detain anyone suspected of being in the country illegally. Opponents have called it an open invitation for harassment and discrimination against Hispanics regardless of their citizenship status.").

<sup>254</sup> Conway, *supra* note 123.

<sup>255</sup> See Kit Johnson, *Patients Without Borders: Extralegal Deportation By Hospitals*, 78 U. CIN. L. REV. 657 (2010).

<sup>256</sup> Nessel, *supra* note 44 ("Attorneys can argue that private entities such as hospitals are engaging in deportation absent any due process as guaranteed by international human-rights instruments that the United States has ratified or signed, such as the International Covenant on Civil and Political Rights (ICCPR) and the American Convention on Human Rights. Medical repatriation can also be challenged as a violation of the internationally recognized right to health, as guaranteed by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and the Convention on

finding resolutions for uncompensated care for undocumented immigrants have offered solutions.<sup>258</sup>

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the Rights of the Child. Furthermore, President Obama has recently signed the United Nations Convention on the Rights of Persons with Disabilities. Among other provisions, this Convention mandates that state parties, such as the United States, "take . . . all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including . . . humanitarian emergencies." (citations omitted); Aboobaker, *supra* note 65 ("Although Jiménez was in the end unable to recover by means of a tort claim, another legal strategy might have been more successful. For example, his case has the essential elements for a human-rights claim; however, there is little case law to suggest that such a claim would triumph – in the United States or internationally.").

<sup>257</sup> Nessel, *supra* note 44 ("Immigrants facing medical repatriation may also have claims to relief from removal that could be pursued in immigration court. For example, depending upon the medical needs of the client and the existence or lack of appropriate medical care in the native country, as well as the social treatment or acceptance of persons with similar disabilities, attorneys may be able to pursue relief under Article 3 of the United Nations Convention Against Torture or seek asylum protection. Attorneys should interview their clients and conduct country-based research to ascertain how persons with similar disabilities are treated in the native country and whether free medical care is available. If undocumented patients have been in the United States for at least ten years continuously, attorneys should ascertain whether deportation would result in extreme and exceptionally unusual hardship to a U.S.-citizen or lawful-permanent resident family member. If so, the attorney should pursue a remedy known as cancellation of removal. Depending upon the country of nationality, there may be other remedies available, such as temporary protected status. Finally, attorneys should inquire as to the cause of the injury, as there are special U visas available for victims of violent crimes who are willing to assist the government in a criminal investigation." (citations omitted)).

<sup>258</sup> See, e.g. Johnson, *supra* note 255 (recommending a new, federal repatriation program for the medically needy in which hospitals may contact the local Immigration and Customs Enforcement ("ICE") office to report care for an undocumented immigrant patient, then ICE begins an expedited review to determine whether the patient is here illegally and, if so, expedited removal but with an evaluation to determine whether the patient is medically stable and whether the patient will receive medical care in their home country, and if the patient cannot be deported because he or she is medically unstable or the care in the home country would constitute a "death sentence" then the patient should be paroled and Medicaid would be provided to the treating hospital for the patient until removal could be accomplished); Nessel, *supra* note 44 (recommending congressional action to ensure that health-care reform includes undocumented immigrants, that immigration reform allows for a change in status so that the undocumented immigrants could qualify for insurance, and short of that that the AMA issue a strong rebuke of the medical repatriations or court findings of liability to the hospitals). See generally Nathanael J. Scheer, *Keeping the Promise: Financing EMTALA's Guarantee of Emergency Medical Care for Undocumented Aliens in Arizona*, 35 ARIZ. ST. L. J. 1413 (2003) (presenting various alternatives for funding emergency care for undocumented immigrants); Telephone conference with Jack Scarola, December 11, 2009 (stating that resolution of the problem requires federal involvement, perhaps a cooperative agreement with the foreign government or a debt against the foreign government for the amount of the care, but that something must be done soon).

However, to adequately tackle this issue, a combination of short-term solutions must be advanced in addition to the long-term solutions. In the short term, Congress must act. It must enact federal legislation that does not permit forced medical repatriations. U.S. hospitals must ensure adequate care will be provided from the foreign country. There must also be a heightened level of scrutiny when the patient is being shipped to a Third World country, and thus, to poorer medical facilities. It can almost be presumed that any poor patient sent back home will not be able to afford the treatment in his or her home country or that the medical treatment needed is not available or adequate if it is a developing country.<sup>259</sup> Also, the proposed legislation must prevent any medical repatriation absent the knowledge and assent of the United States government, because deportation is within the domain of the federal government. EMTALA prohibits treatment providers from ascertaining a patient's citizenship or immigration status prior to treatment, but if a hospital is already seeking to deport the patient, then it has determined the patient's status as unauthorized and the hospital is attempting to do the very thing that often chills undocumented immigrants from seeking healthcare—deportation. Thus, hospitals' notifying federal authorities before repatriating should not present an additional problem.<sup>260</sup> However, federal legislation enacted to deter medical repatriations should address options, so that undocumented immigrants needing emergency care are not chilled from seeking it. EMTALA does not require reporting the immigration status of patients, and proposed legislation should ensure that injured, undocumented immigrants are not penalized.

It is clear that there needs to be tighter border control, and this is already underway.<sup>261</sup> Far too many unauthorized immigrants are

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<sup>259</sup> See, e.g., Smith, *supra* note 243, at 373–76 (discussing the healthcare systems of various developing countries as it relates to organ trafficking).

<sup>260</sup> See Nessel, *supra* note 44 (stating that “encouraging hospitals to report the immigration status of patients is ill advised and raises a host of dangers. For example, it would be detrimental to the broader public health if undocumented immigrants are chilled from seeking emergency medical care for fear that they will be put in removal proceedings.”).

<sup>261</sup> *Canada-U.S. border should remain tight: Homeland Security chief*, CBC NEWS, Mar. 25, 2009, <http://www.cbc.ca/world/story/2009/03/25/canada-us-napolitano.html> (reporting the Homeland Security Chief's comments about escalating drug violence at the U.S.-Mexican border, prompting President Barack Obama to increase the number of federal agents to

crossing our borders—from Mexico largely, but also Canada—too easily. Americans tend to frown upon the access from immigrants from Mexico due to American attitudes and the Mexican drug trade, but both borders need to be shored up similarly.<sup>262</sup>

Additionally, the U.S. hospital and the federal government must work in tandem with the foreign hospital and government to ensure that the medical repatriation will not jeopardize the life of the undocumented immigrant. Patient safety must come first; this cannot be rhetoric. Physician leadership, such as the American Medical Association, should develop uncompromising and clear ethical guidelines that discourage doctors from signing transfer orders for forced medical repatriations.<sup>263</sup>

Further, EMTALA has failed largely because it is basically an unfunded mandate.<sup>264</sup> Thus, EMTALA must be funded.<sup>265</sup> Undocumented immigrants contribute in the billions to the United States' coffers annually. Part of this money should be redirected to fund EMTALA or establish a common fund for the medical needs of undocumented immigrants.<sup>266</sup> States and local governments are now bearing the greater burden of the costs of undocumented immigrants, but the federal government must accept and cover the greater portion

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border posts and the Mexican interior, as well as redirect \$200 million to fight drug smuggling and violence).

<sup>262</sup> *Id.* ("One of the things that we need to be sensitive to is the very real feelings among southern border states and in Mexico that if things are being done on the Mexican border, they should also be done on the Canadian border," said Janet Napolitano, Homeland Security Chief, at a Canada-U.S. border conference in Washington, D.C.).

<sup>263</sup> Editorial, *supra* note 203 ("The UK has committed an atrocious barbarism. It is time for doctors' leaders to say so-forcefully and uncompromisingly. To stop treating patients in the knowledge that they are being sent home to die is an unacceptable breach of the duties of any health professional.").

<sup>264</sup> Lee, *supra* note 68, at 145.

<sup>265</sup> The appellate court in the *Montejo* case arguably issued a court-ordered unfunded mandate when it ruled that Martin Memorial had to incur additional costs to care for Mr. Jiménez without a mechanism for recovery.

<sup>266</sup> See, e.g., Loue, *supra* note 157, at 103–04 (proposing that monies paid to the federal government for Social Security and Medicare, as well as unpaid tax refunds, could be segregated as a distinct fund for healthcare for undocumented immigrants); Scheer, *supra* note 258, at 1414 (citing Michael Janofsky, *Burden Grows for Southwest Hospitals*, N.Y. TIMES, April 14, 2003, at A14) (noting that then Arizona Governor (later Homeland Security Chief) Janet Napolitano blamed the federal government for not funding federally mandated care for undocumented immigrants in 2003).

of this.<sup>267</sup> Another source of funding may be the penalties and fines from hospitals for non-compliance with EMTALA. Although this would not alleviate hospital costs, it may dissuade non-compliance. Additionally, states may consider adding a small sum to the sales tax for funding undocumented immigrants (and others who will be left out of the nation's comprehensive health reform plan). It is inhumane to use and abuse undocumented immigrants, who the country knows are here and working, rely upon for their financial contributions to the nation's budget, then discard as worthless after they become sick or injured when in the United States.<sup>268</sup> America cannot be a well nation if it prevents access to basic healthcare for a significant population of people with whom our nation's citizens interact and rely upon daily.

Finally, U.S. hospitals must become more creative in their search for solutions. Martin Memorial may have felt that they only had two options—repatriate the patient, or suffer great and continuing monetary losses.<sup>269</sup> But there are other avenues. For example, in one case where a lawsuit was brought and a settlement resulted, the settlement proceeds were used to pay for a clinic in the home country and the insurance company also agreed to provide the foreign hospital with equipment.<sup>270</sup> Also, some hospitals are paying to send

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<sup>267</sup> Clark, *supra* note 108, at 233; see also Bruce Siegel et al., *Health Reform and the Safety Net: Big Opportunities; Major Risks*, J.L. MED. & ETHICS, 426, 427 (Fall 2004) ("State and local subsidies are also critical in financing care for the uninsured and low-income population. According to the National Association of Public Hospitals and Health Systems, state and local funds financed 38 percent of public hospitals' uncompensated care costs in 2001. In 2002, CHC's [community health centers] received over \$531 million from state and local sources. In the end, safety net providers must piece together a myriad of funding sources to provide services to low-income residents because there is no stable and adequate source of financing for the nation's uninsured population.").

<sup>268</sup> Jones et al., *supra* note 132, at 680 ("As it did when it adopted slavery early in the nation's history, America wanted cheap laborers to do the backbreaking jobs, but not the cultural baggage they carried, and certainly not their human needs.").

<sup>269</sup> Patsner, *supra* note 11 ("In the absence of help by foreign governments, or federal regulation of this no-win situation, U.S. hospitals are simply trying to both fulfill their basic obligations for patient care and trying to be rational economic actors, but are faced with a Hobson's choice of either repatriating the patients or losing enormous sums of money which will further complicate their ability to care for indigent U.S. citizens. State courts handling these cases have thus far provided no workable chart to guide health care professionals.").

<sup>270</sup> Telephone conference with John DeLeon, a lawyer who represents patients in these medical repatriations, on Nov. 30, 2009.

patients back home and paying for their treatment in the foreign country until the patient can get insurance, or the foreign government can provide care, because medical care abroad is often much cheaper than medical care in the United States.<sup>271</sup> In the Jiménez case, the hospital ultimately paid a small settlement sum that was well less than the million dollars that it expended in treatment for Mr. Jiménez. As mentioned earlier, this small sum will go a long way in Guatemala. This settlement option could have been negotiated before the hospital had expended such a large sum and when it believed that Mr. Jiménez's health condition was stabilized.

Hospitals must consider options other than forced medical repatriations. U.S. hospitals and government must work together with foreign hospitals and governments to seek creative options to ensure the health and well-being of critically injured undocumented immigrants. The patient's care must come first.

## VII. CONCLUSION

Uncompensated care is a serious dilemma for undocumented immigrants and the treating U.S. hospitals. Martin Memorial's continued care of over a million dollars for Mr. Jiménez reduced the funds available to treat other uninsured patients. But deporting undocumented immigrant patients in unstable medical conditions, or shipping them to foreign medical facilities that cannot adequately care for the patients is not the answer. This is not a problem only for the immigrant patients and the hospitals, but it must also be a top concern of the federal government, which is in the best position to ensure that hospitals do not use self-help and that patient safety is first. A combination of creative strategies must be employed so that undocumented immigrant patients are not treated as commodities because they are costing our nation too much or because their status is not authorized, but rather they must be treated as human beings because that is the model—the moral example—that our nation wants to send to its citizens and the world. "Give me your tired, your

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<sup>271</sup> *Id.*; see also *Hospitals Deporting Patients*, *supra* note 247.

poor, your huddled masses . . . .”<sup>272</sup>

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<sup>272</sup> Statue of Liberty-Ellis Island Foundation, Statue of Liberty, [http://www.statueofliberty.org/Statue\\_of\\_Liberty.html](http://www.statueofliberty.org/Statue_of_Liberty.html) (last visited Jun. 1, 2010) (describing the famous sonnet written by Emma Lazarus and inscribed on a plaque that was placed on the inner walls of the Statue of Liberty since the early 1990’s and “has come to symbolize the statue’s universal message of hope and freedom for immigrants coming to America and people seeking freedom around the world”).