DEPORTED BEFORE DAWN: BRIDGING POLICY AND FUNDING GAPS TO DISCOURAGE HOSPITALS FROM PRIVATELY REPATRIATING IMMIGRANT PATIENTS

KRISTIE-ANNE PADRÓN*

* J.D. Candidate 2011, Boston University School of Law.

I. INTRODUCTION

Repatriation means, "to restore or return to the country of origin, allegiance, or citizenship."[1] In the United States, the power to enforce immigration laws is typically left to the federal government.[2] However, some hospitals have taken the law into their own hands by privately repatriating[3] indigent immigrant patients.[4] Hospital and medical providers are bound by law to care for all individuals seeking emergency care under the Emergency Medical Treatment and Active Labor Act ("EMTALA").[5] EMTALA's provisions apply equally to all individuals seeking care, regardless of immigration status or ability to pay.[6]

Faced with limited access to funding and high numbers of uninsured patients, some hospitals are choosing to return patients to their countries of origin by either plane or ambulance.[7] Many hospitals in the United States repatriate patients to reduce the cost of providing uncompensated care for uninsured patients who are ineligible for government aid because of their immigration status.[8] Hospital-initiated repatriations are an increasingly common practice, particularly in states with high numbers of immigrants.[9] There is even a com-

---

[1] Merriam-Webster Online Dictionary, http://www.merriam-webster.com/dictionary/repatriation (last visited Feb. 12, 2010).

[2] 8 U.S.C. § 1103 (2009) (stipulating duties of the Secretary of the Department of Homeland Security and the Attorney General in enforcing and administering immigration laws); *see also* Montejo v. Martin Mem'l Med. Ctr. (*Montejo I*), 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004) (finding that the state probate judge had no jurisdiction to authorize Martin Memorial to remove plaintiff to Guatemala) (citing Torros v. State, 415 So. 2d 908 (Fla. Dist. Ct. App. 1982)); Johns v. Dep't of Justice, 653 F.2d 884 (5th Cir. 1981)); *see also* Yamataya v. Fisher, 189 U.S. 86, 101 (1903) (acknowledging that no person shall be "taken into custody and deported without giving him all opportunity to be heard upon the questions involving his right to be and remain in the United States. No such arbitrary power can exist where the principles involved in due process of law are recognized.").

[3] For the purposes of this note, private repatriation and hospital-initiated repatriation are interchangeable terms.

[4] Deborah Sontag, *Deported, by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1, *available at* 2008 WLNR 14451034 [hereinafter Sontag, *Deported, by U.S. Hospitals*] (reporting at least 200 documented hospital-initiated repatriations in 2007).

[5] 42 U.S.C. § 1395dd (2006).

[6] *Id.* § 1395dd(g)-(h).

[7] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[8] *Id.*; Deborah Sontag, *Deported in Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1, *available at* 2008 WLNR 21420449 [hereinafter Sontag, *Deported in Coma, Saved Back in U.S.*].

[9] Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009). There is little documentation of the exact number of patients that are being

pany devoted to providing American hospitals with international hospital transfer services.[10] Typically, patient repatriation involves an uninsured, undocumented immigrant who is hospitalized for an emergency.[11] Repatriation most often occurs when the immigrant requires extensive treatment or long-term care.[12]

One journalist in particular, Deborah Sontag, has highlighted many stories of hospitals' repatriation practices across the United States.[13] In particular, *Montejo v. Martin Memorial Medical Center,* a Florida case, drew much attention in the national media.[14] Currently, *Montejo I* and *Montejo II* are the only state or federal court decisions addressing claims for damages caused by hospital-initiated repatriation.[15] Montejo Gaspar Montejo filed a claim on behalf of his undocumented immigrant cousin, Luis Alberto Jiménez, who was injured by a drunk driver in 2000.[16] In 2003, the hospital treating Jiménez privately transported him to Guatemala, despite the fact that Jiménez was never subject to any federal removal proceeding.[17]

The Florida Court of Appeal ruled in favor of Montejo in 2004, reversing the Probate Court's 2003 decision that legally allowed Martin Memorial to transfer Jiménez, but determined there was no additional remedy at law.[18] The Court of Appeal found that the Probate Court lacked subject matter jurisdiction to permit Jiménez's transfer as it was preempted by federal law.[19] In 2006, the same court heard Montejo's claims against Martin Memorial for the false imprison-

---

repatriated. Different articles have estimated, through anecdotal information, that hospitals have been repatriating several hundred individuals yearly. *Id.*; *see, e.g.,* Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1; Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[10] MEXCARE, http://mexcare.com/services_MexCare.html (last visited Apr. 14, 2010); Kit Johnson, *Patients Without Borders: Extralegal Deportation by Hospitals*, 78 U. CIN. L. REV. 657, 665 (2010).

[11] *See* Wolpin, *supra* note 9, at 152-53.

[12] *Id.*

[13] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1; *see also* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[14] Montejo v. Martin Mem'l Med. Ctr. (*Montejo I*), 874 So. 2d 654 (Fla. Dist. Ct. App. 2004) (appealing probate judge's decision approving Jiménez's transfer); *see also* Montejo v. Martin Mem'l Med. Ctr. (*Montejo II*), 935 So. 2d 1266 (Fla. Dist. Ct. App. 2006) (tort claim for false imprisonment).

[15] *See* Kendra Stead, Comment, *Critical Condition: Using Asylum Law to Contest Forced Medical Repatriation of Undocumented Immigrants*, NW. U. L. REV. (forthcoming 2010) (manuscript at 10) (on file with author) (abstract *available at* http://ssrn.com/abstract=1392576).

[16] *Montejo I*, 874 So. 2d at 656.

[17] *Id.* at 656-57.

[18] *Id.* at 656.

[19] *Id.* at 658.

ment of his cousin.[20] The court ruled favorably and remanded the case to trial,[21] yet on remand the jury did not grant any remedy to Montejo.[22] Montejo's cousin, Jiménez, remains in Guatemala, and due to severe brain injuries, he still requires long-term intensive medical treatment, including treatment for seizures.[23]

Hospital repatriation involves many different areas of the law and many constituencies. There are tensions between the interests of patients seeking medical attention, not-for-profit and for-profit hospitals, and federal and state governments regulating both immigration and reimbursement schemes under Medicare[24] and Medicaid.[25] The inequity between federal regulations that stipulate a minimum level of care for all persons needing emergency medical attention and the minimal reimbursement levels for uncompensated care leaves some hospitals perceiving medical repatriation as their only option.[26] Compounding this problem is the fact that many patients are afraid or unable to purchase private insurance because of their legal status.[27] Hospital-initiated repatriations do not actually solve the conflicts between patients, hospitals, and governments; instead, they allow hospitals to temporarily reduce costs and avoid EMTALA liability.

This Note examines the problems generated by private repatriation, its legal implications, and possible alternatives to repatriation. Part II describes the practice of repatriation, examples of problems this practice creates, and the case law addressing the legal complications. Part III explores the laws that create the need for hospital repatriations, including EMTALA and tax-exemption duties, as well as policies that have limited the funding available to satisfy those duties. Part IV examines the immigration landscape in the United States, in-

---

[20] Montejo v. Martin Mem'l Med. Ctr. (*Montejo II*), 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006).

[21] *Id.* at 1272.

[22] Deborah Sontag, *Jury Rules for Hospital That Deported Patient*, N.Y. TIMES, July 28, 2009, at A10, *available at* 2009 WLNR 14466883 [hereinafter Sontag, *Jury Rules for Hospital That Deported Patient*].

[23] *Montejo I*, 874 So. 2d at 656.

[24] Health Insurance for the Aged and Disabled, Social Security Act, 42 U.S.C. §§ 1395-1395ccc (2006).

[25] Grants to States for Medical Assistance Programs, Social Security Act, 42 U.S.C §§ 1396-1396(v) (2006).

[26] *Undocumented Immigrant Patients in LT-Care Present Challenges to Hospitals*, MED. ETHICS ADVISOR, Sept. 1, 2009, *available at* 2009 WLNR 16709571; *see also* Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1; Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1; Judith Graham & Deanese Williams-Harris, *Fighting to Keep Comatose Man in U.S.: UIC Officials Want to Send the Undocumented Immigrant Back to Mexico for Medical Care*, CHICAGO TRIBUNE, Aug. 20, 2008, at 1, *available at* 2008 WLNR 15682868.

[27] *See* Dana P. Goldman et al., *Immigrants and the Cost of Medical Care*, 25 HEALTH AFF. 1700, 1705 (2006).

cluding the rights to due process, appeal, and other forms of relief available upon attempted removal. Part V discusses currently proposed solutions. Part VI analyzes the limits and benefits of the currently proposed solutions, and argues that the United States should stop allowing private repatriations. Part VI also proposes alternative solutions to remove any incentives for hospital-initiated repatriation and to allow undocumented individuals to insure themselves against catastrophic injuries. Finally, Part VI proposes a comprehensive approach to immigration and health care reform that seeks to reduce and eliminate the humanitarian concerns that private repatriations raise.

II. REPATRIATION IN PRACTICE

A. *Prevalence*

Repatriations are not limited to border states and are occurring all over the country.[28] Repatriations like Jiménez's are common.[29] For example, St. Joseph's Hospital in Phoenix, Arizona repatriates an average of ninety-six patients yearly.[30] Other hospitals repatriate fewer patients, but still employ the practice. Broward General Medical Center, an hour south of Martin Memorial, deports six to eight patients a year, and from early 2007 through the summer of 2008 a Chicago hospital repatriated ten patients to Honduras.[31]

B. *Problems with Hospital-Initiated Repatriation*

Hospitals generally lack information about their patients' immigration statuses because most hospitals are not government entities and are not permitted to inquire as to someone's financial or immigration status upon arrival.[32] Hospital-initiated repatriation poses an additional problem in that it involves quasi-state action by non-state actors.[33] Hospitals provide minimal information regarding the repatriation process, and do not offer the time or process to appeal the decision.[34] Patients often lack legal recourse against hospital-initiated repatriation, unless some public official or advocacy organization intervenes before removal.[35] Furthermore, some patients (or their guardians) are unaware of their own legal status and may accept transfer or repatriation without knowing their

---

[28] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1 (discussing patient facing repatriation to China); Graham & Williams-Harris, *supra* note 26, at 1 (illustrating range of locales facing repatriation challenges).

[29] *See* Wolpin, *supra* note 9, at 152 (estimating hundreds of hospital-initiated repatriations annually, the majority to Latin America).

[30] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[31] *Id.*

[32] *See* 42 U.S.C. § 1395dd(h) (2006).

[33] *See infra* part IV(A) for a discussion of the procedures that immigrants are entitled to when facing removal.

[34] *See* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[35] *Id.*

rights.[36] Ultimately, hospitals have no access to means of verifying a person's immigration status; thus, hospitals can easily wrongfully repatriate a legal immigrant or United States citizen.[37] As hospital repatriations are completely private and involve no due process or government adjudication, there is no mechanism to prevent these repatriations, unless someone intervenes by informing the police or by seeking a court injunction.[38] Finally, repatriation poses a considerable barrier to health care access.[39] An American homeless individual prematurely discharged from a hospital and left on the streets can likely obtain emergency medical care at another American hospital; however, an individual removed to another country will not be able to do the same.[40]

One case in particular illustrates one of the essential problems with private repatriations. Essentially, hospitals lack access to official information on any individual's immigration status or the authority to enforce immigration laws.[41] Antonio Torres, an uninsured lawful permanent resident ("LPR"),[42] was hospitalized at St. Joseph's hospital in Phoenix, Arizona for injuries sustained in a car accident.[43] The hospital staff convinced Torres's family to authorize his transfer to an emergency room in Mexico, promising a hospital bed and care upon arrival.[44] Once in Mexico, Torres found himself on a gurney in an emergency room hallway with little care and a worsening infection.[45] Ultimately, Torres's family had him transferred back across the border to another hospital in California, where he was treated for complications caused by his early discharge, including a near-fatal infection.[46] St. Joseph's administrators were in large part motivated to repatriate Torres because of reimbursement concerns

---

[36] *Id.*

[37] *Id.*

[38] *Id.*; *see also* Johnson, *supra* note 10, at 681 ("There is no evidence about how hospitals are concluding that patients are undocumented, that those patients have no right to remain in the United States, much less whether they should be returned to their country of origin.").

[39] *See* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1 (illustrating that immigrants are unable to find the same level of health care they received in the United States).

[40] *Id.* EMTALA was largely created to protect homeless individuals from being "dumped" when they had no resources to pay for care. See *infra*, section III.A.1. However, the potential damages that would ensue were far less permanent than those posed to individuals who are privately repatriated to another country.

[41] *Id.*

[42] *See* 8 U.S.C. § 1101(a)(20) (2006) (defining the term "lawfully admitted for permanent residence" as "the status of having been lawfully accorded the privilege of residing permanently in the United States as an immigrant in accordance with the immigration laws, such status not having changed.").

[43] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[44] *Id.*

[45] *Id.*

[46] *Id.*

and the hospital's general policies towards uncompensated care.[47] Although Torres had legal status, Medicaid would likely refuse to reimburse St. Joseph's because LPRs need five years of legal residency to qualify for Medicaid coverage.[48]

Not all hospitals' attempts to repatriate legal immigrants and U.S. citizens are successful.[49] In several close calls, legal intervention has prevented the removal of a person rightfully in the United States.[50] In one case, a U.S. citizen infant, Elliott Bustamante, was born with Down Syndrome at a Tucson, Arizona hospital.[51] Bustamente also had a heart defect requiring neonatal intensive care.[52] Elliot's parents were undocumented and had little access to legal recourse to prevent the hospital's attempts to remove their child to a hospital in Mexico.[53] The Mexican Consulate referred Elliot's parents to an attorney who, upon contact with the hospital, discovered that the hospital had already arranged to transfer Elliot to a Mexican hospital and was in the process of transporting the child to the airport.[54] The attorney summoned the police, who in turn contacted the hospital and convinced the hospital to return Elliott to the University Medical Center.[55] Thereafter, Elliot received treatment in Arizona, and Arizona Medicaid covered some of the costs associated with Elliot's care.[56]

In 2008, St. Joseph's Hospital in Phoenix, Arizona attempted to send a legal immigrant named Sonia del Cid Iscoa to Honduras because Iscoa was in a coma and uninsured.[57] Iscoa resided in the United States for seventeen years and had seven American-born children.[58] Legal advocates were ultimately able to negotiate with the hospital to prevent Iscoa's removal and maintain the care she needed to come out of her coma.[59] This example demonstrates that hospitals might harbor bias against treating uninsured immigrants, even if such immigrants are legal, if repatriation is an option. It is likely that Iscoa's care would have been at least partially reimbursable under Emergency Medicaid, even if she did not qualify for Medicaid coverage.[60] Under EMTALA, unin-

---

[47] *Id.*

[48] *Id*; *see also* 8 U.S.C. § 1613 (2006).

[49] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] *Id.* In addition to transfer attempts, the Tucson hospital also sought to have the sick child removed as a "trespasser" and continued attempts to transfer the child until Medicaid payment was assured. *Id.*

[55] *Id.*

[56] *Id.*

[57] Sontag, Deported, by U.S. Hospitals, supra note 4, at A1.

[58] *Id.*

[59] *Id.*

[60] *Id.*

sured American citizens requiring life-sustaining care cannot be dumped on the street or sent to another country.[61] However, because Iscoa was born in another country, the hospital thought transferring her to her country of origin would be more affordable than providing charity care.[62]

C. *Case Law: Montejo v. Martin Memorial*

As discussed above, the Florida Court of Appeal is the only jurisdiction to have addressed the legality of hospital-initiated repatriation.[63] Montejo sought relief for Jiménez's transfer to Guatemala,[64] as well as damages for false imprisonment.[65] Martin Memorial, bound by EMTALA transfer policies,[66] sought to have him moved to a lower-cost facility, but found few that would accept an uninsured patient ineligible for federal programs.[67] Martin Memorial finally was able to transfer Jiménez into a rehabilitative center in Guatemala on the condition that Martin Memorial pay for his care.[68] However, Jiménez did not receive appropriate services there, resulting in repeated emergency hospitalizations for complications and bedsores.[69] Although therapy and follow-up care likely would have improved Jiménez's condition because of limited rehabilitation and frequent seizures, he currently has the mental capacity of a young child.[70]

In 2003, after spending approximately $1.5 million on Jiménez's care and receiving only $80,000 in reimbursements, Martin Memorial sought approval from the local Florida Probate Court to transfer Jiménez to Guatemala, his country of origin.[71] The intoxicated driver that caused Jiménez's injuries was uninsured and judgment proof.[72] The probate court ultimately approved the

---

[61] See infra Section III.A.1.

[62] *Id.*

[63] *See* Stead, *supra* note 15 (manuscript at 4).

[64] Montejo v. Martin Mem'l Med. Ctr. (*Montejo I*), 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004).

[65] Montejo v. Martin Mem'l Med. Ctr. (*Montejo II*), 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006).

[66] *See* 42 C.F.R. § 482.43(d) (2009); *see also* discussion *infra* Part 0 (defining EMTALA transfer duties).

[67] *Montejo I*, 874 So. 2d at 656; *see also* Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[68] *See* Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[69] *Id.*

[70] *Id.*

[71] *Montejo I*, 874 So. 2d at 656; *see also* Sontag, *Deported, by U.S. Hospitals, supra* note 4, at A1; *see also* Stead, *supra* note 15 (manuscript at 2-3) (citing Martin Mem'l Med. Ctr., Inc. v. Montejo, No. 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Probate Division June 27, 2003)).

[72] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1; *see also* Choxom v. Bankers

transfer.[73] Montejo filed a motion for a stay and Martin Memorial had notice that the court was going to hear the merits of Montejo's motion.[74] However, Martin Memorial still transported Jiménez to Guatemala the morning after the probate court approved the transfer, before the court could hear Montejo's motion.[75] Since his relocation to Guatemala, Jiménez has not received adequate care or rehabilitation, and suffers from many effects of his injuries.[76]

Montejo brought his claims under Florida law rather than under the EMTALA.[77] The Florida Court of Appeal addressed two separate claims on behalf of Jiménez.[78] In 2004, Montejo appealed the probate court's decision to allow the hospital to repatriate Jiménez.[79] The Court of Appeal found that there was "no competent substantial evidence to support Jiménez's discharge from the hospital" and that "the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jiménez to Guatemala."[80] Although the Court of Appeal found for Jiménez, since Jiménez was already in Guatemala, the court could not give a remedy for his unlawful repatriation other than overturning the probate court judge's decision.[81]

Ins. Co., 877 So. 2d 947, 948-49 (Fla. Dist. Ct. App. 2004) (finding no negligent entrustment liability for the corporation that owned the van that injured Jiménez).

[73] Stead, *supra* note 15 (manuscript at 2-3) (citing Martin Mem'l Med. Ctr., Inc. v. Montejo, No. 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Probate Division June 27, 2003)).

[74] Montejo v. Martin Mem'l Med. Ctr. (*Montejo II*), 935 So. 2d 1266, 1267-68 (Fla. Dist. Ct. App. 2006).

[75] *Montejo I*, 874 So. 2d at 656-57 (noting that the probate court had ordered Montejo to file his response motion by 10:00 a.m., but that Jiménez was transferred before 7:00 a.m. that same morning); Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[76] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1 (documenting the deterioration of Jiménez's condition in Guatemala, where he lives with his mother and receives no medical care or medication despite complications such as violent seizures that result in bouts of unconsciousness).

[77] *See Montejo I*, 874 So. 2d at 658 (appealing the 2003 Probate Court decision); *see also Montejo II*, 935 So. 2d at 1266 (assessing claims of false imprisonment, as well as compensatory and punitive damages).

[78] *See Montejo I*, 874 So. 2d at 658 (appealing the 2003 Probate Court decision); *see also Montejo II*, 935 So. 2d at 1266.

[79] *Montejo I*, 874 So. 2d at 656. The probate court found that Martin Memorial may not have been able to provide the long-term care necessary for Jiménez, but asked for a motion from his guardian, Montejo, for a stay. *See* Stead, *supra* note 15 (manuscript at 11-12) (citing *Martin Mem'l Med. Ctr., Inc. v. Gaspar Montejo, No.* 00-344-CP, slip op. 528, 530 (Fla. Cir. Ct. Probate Division June 27, 2003)). Martin Memorial transferred Jiménez by plane to Guatemala the next morning before the Judge had the opportunity to hear Montejo's petition. *Montejo I*, 874 So. 2d at 656-57.

[80] *Montejo I*, 874 So. 2d at 658.

[81] *Id*; *see also* Stead *supra* note 15 (manuscript at 12) (noting that because Jiménez was undocumented he lost his right to return for ten years under 8 U.S.C. § 1182(a)(9)(B)(i)(II) (2006)).

In 2006, the Court of Appeal addressed Montejo's private tort claim against the hospital for false imprisonment. Montejo sought compensatory damages for Jiménez's future health care costs resulting from his injuries and punitive damages.[82] In deciding Montejo's claims for false imprisonment, the court considered whether Jiménez's detention was: (1) unlawful; (2) against his will; (3) without legal authority; and, (4) unreasonable and unwarranted under the circumstances.[83] The court found that the first three factors were met, reversed the original order, and remanded the case for proceedings on the merits of the "reasonableness" standard.[84]

On remand for the false imprisonment claim, the jury made a finding of fact that the transfer was not "unreasonable and unwarranted under the circumstances," and thereby imposed no liability on Martin Memorial.[85] The implications of this outcome are inconclusive, but some see the jury's verdict as a sign that hospitals will not be held liable for repatriations under current laws.[86] Alternatively, some have argued that the *Montejo* case has drawn attention to the repatriation phenomenon and the policy issues that emerge from the practice.[87] The Florida Court of Appeal explicitly stated that state courts do not have jurisdiction in immigration decisions and that hospitals are not entitled to qualified immunity.[88] Thus, it is possible that the Court of Appeal's decision will prompt hospitals to avoid initiating private repatriation in the future.

III. CAUSES OF THE REPATRIATION PHENOMENON

A. *Hospitals' Legal Duties under Federal Regulations*

To understand why repatriation is an attractive solution to hospitals within

---

[82] *Montejo II*, 935 So. 2d at 1272 (remanding the case after finding that as a matter of law Martin Memorial had met three of the four factors necessary for establishing the tort of false imprisonment).

[83] *Id.* at 1268 (stating the elements necessary for a plaintiff to establish a false imprisonment claim).

[84] *Id.* at 1272.

[85] Sontag, *Jury Rules for Hospital That Deported Patient*, *supra* note 22, at A10; *see also* MED. ETHICS ADVISOR, *supra* note 26 (quoting jury findings in *Montejo II*, 935 So. 2d at 1266) (discussing the implications of the jury's findings on Martin Memorial, the defendant, and the hospital industry as a whole).

[86] *See, e.g.*, Lori A. Nessel, *The Legality and Ethics of Medical Repatriation*, 2009 EMERGING ISSUES 4404, 4404 (Oct. 6, 2009) (noting that the decision in Jiménez seemed to "signal a green light to similarly situated hospitals debating whether to forcibly repatriate uninsured immigrants."); MED. ETHICS ADVISOR, *supra* note 26 (quoting "Carla Luggiero, J.D., senior associate director for federal relations for the American Hospital Association, that the jury's decision 'may make [hospitals] a little more comfortable in moving forward' if they decide to repatriate a patient.").

[87] Nessel, *supra* note 86, at 4404 (postulating that the California Medical Association and the American Medical Association have come to address the issue as a result of this case).

[88] *Id.*

our medical system, lawyers, hospital directors, and scholars need to understand the legal framework in which hospitals make these decisions. Not-for-profit hospitals are required to create certain types of community benefits in order to maintain their tax-exempt status.[89] Additionally, hospitals are expected to be indiscriminate in accepting patients into their emergency rooms, particularly as to indigent or Medicaid patients.[90] In addition to federal regulations, hospitals have state-imposed and common law duties to patients.[91]

1. EMTALA

The most relevant medical regulation concerning hospital repatriations is EMTALA.[92] Congress passed EMTALA in 1986 to prevent patient dumping.[93] Patient dumping involves discharging patients in need of care because they lack funds to pay for treatment.[94] Congress drafted EMTALA as a second, more comprehensive attempt to address patient dumping, after the Hill-Burton Act of 1946—which did not encompass private hospitals—failed.[95] Studies completed in the 1980's demonstrated that uninsured or government-insured persons were often discharged without having received adequate care.[96]

To combat this practice, Congress created EMTALA, specifying duties for hospitals to screen and stabilize any patient entering a hospital's emergency room.[97] Additionally, EMTALA stipulates that hospitals must provide either "such treatment as may be required to stabilize the [patient's] medical condi-

---

[89] *See* 26 U.S.C. § 501(c)(3) (2006); *see also* Rev. Rul. 83-157, 1983-2 C.B. 94 (ruling that hospitals that provide patients emergency services regardless of ability to pay fulfill the community benefits requirement to retain tax exempt status).

[90] *See* 42 U.S.C. § 1395dd (2006); *see also id.* § 501(c)(3) (2006).

[91] *See generally* Azmina Aboobaker, *The Hippocratic Oath and the Repatriation of Uninsured Noncitizens*, 2009 EMERGING ISSUES 4403 (Oct. 6 2009).

[92] 42 U.S.C. § 1395dd (2009); 42 C.F.R. § 489.24 (2009).

[93] Lauren A. Dame, The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care, 8 HEALTH MATRIX 3, 6 (1998) (citing David A. Ansell & Robert L. Schiff, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 JAMA 1500, 1500 (1987)).

[94] Wendy W. Bera, Comment, *Preventing "Patient-Dumping": The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA*, 36 HOUS. L. REV. 615, 616-17 (1999).

[95] Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden it Places on Hospitals*, 7:1 J.L. SOC'Y 146, 146 (2005).

[96] *See* Dame, *supra* note 93, at 6-7. EMTALA is generally protective of patient's rights; however, many argue that it contains insufficient enforcement capabilities. *See generally* Vivian L. Regehr, *Please Resuscitate! How Financial Solutions May Breathe Life Into EMTALA*, 30 U. LA VERNE L. REV. 180 (2008); *see generally* Bera, *supra* note 94.

[97] 42 U.S.C. § 13955dd(a) (2009) ("the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department"); *see also* 42 C.F.R. § 489.

tion" or "transfer of the individual to another medical facility."[98] Hospitals' duties under EMTALA extend to all patients, regardless of their ability to pay.[99] A hospital must evaluate and stabilize the patient before asking for any information with regards to payment.[100] Hospitals that receive Medicare or Medicaid reimbursements[101] are bound to treat a patient until he or she is sufficiently stable to be transferred to a facility which has "available space and qualified personnel" and has "agreed to accept transfer."[102]

EMTALA's transfer provision has substantial implications for repatriations. Before transferring a patient, the treating facility must ensure that the patient is sufficiently stable and that the receiving institution is capable and willing to treat the patient.[103] However, hospitals are often unable to find long-term care facilities within the United States willing to accept indigent patients with no guarantee of payment, either by federal programs or private insurance.[104] Moreover, EMTALA does not explicitly require any non-emergency facilities to accept transfers;[105] EMTALA duties apply only to the first hospital treating the individual.[106] Legally, if no transfer facility is willing to accept the patient, then a hospital is duty-bound to provide indefinite life-sustaining care.[107] The fact that no other entity is bound to care for these types of patients creates problems in that hospitals are not able to fulfill their duties at a reasonable cost.[108]

Unfortunately, EMTALA has not been effective in preventing patient dump-

---

[98] 42 U.S.C. § 1395dd(b)(A)-(B).

[99] *Id.* § 1395dd(d)(1) (stipulating "non-discrimination" of an individual who requires such specialized capabilities or facilities if the hospital has the capacity to treat the individual, and "[no] delay in examination or treatment . . . in order to inquire about the individual's method of payment or insurance status," as well as civil and financial penalties for violations).

[100] *Id.* § 1395dd (b)(1)(a).

[101] *See id.* § 1395cc(a)(1)(I) (2006) ("Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(e) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—in the case of a hospital or critical access hospital—(i) to adopt and enforce a policy to ensure compliance with the requirements of section 1395dd of this title and to meet the requirements of such section"); *see also* 42 C.F.R. § 489.24 (a)(1) (2209).

[102] 42 U.S.C. § 1395dd(c)(2)(B) (2006).

[103] 42 C.F.R. § 489.24 (2009) (explaining emergency care and stabilization requirements); 42 C.F.R. § 482.43 (2009) (delineating discharge requirements).

[104] *See* Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[105] 42 U.S.C. § 1395dd(c)(2)(B)(ii) (2006).

[106] *Id.* § 1395dd.

[107] Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1.

[108] *Id.* § 1395dd(c)(2)(B)(ii) (designating that a transfer recipient entity must be willing to accept the patient).

ing.[109] The indigent, mentally-ill, and homeless are still particularly susceptible to being discharged without receiving adequate care.[110] Although private hospitals receive federal Medicaid reimbursements,[111] they often transfer indigent emergency room patients to larger, public hospitals to avoid paying for their care.[112] Other hospitals have employed the repatriation methods to remove high-cost immigrant indigent patients.

In practice, it is unknown whether medical repatriation actually fulfills hospitals' transfer duties to indigent patients.[113] While EMTALA does not specify that it must be a domestic facility, it does establish required factors such as that "the medical benefits . . . at another medical facility outweigh the increased risk to the individual . . . from effecting the transfer."[114] Furthermore, the receiving hospital must have "available space and qualified personnel."[115] It seems unlikely that many of the facilities that hospitals are sending immigrant patients to would actually reach these levels.[116] For instance, the foreign facilities may have inappropriate technology, medical training, or resources to keep the patient stable. As per some of the documented cases mentioned above, sometimes the recipient facilities do not even know that the patient is being trans-

---

[109] There are currently several cases that have been prosecuted by the Office of the Inspector General of the Department of Health and Human Services. *See Patient Dumping*, U.S. DEP'T OF HEALTH AND HUMAN SERV., OFFICE OF THE INSPECTOR GEN., http://oig.hhs.gov/fraud/enforcement/cmp/patient_dumping.asp (last visited Apr. 13, 2010); *see also* Regehr, *supra* note 96, at 186 (citing data from the OIG that shows an increase in confirmed patient-dumping violations, which peaked in 1996 at 191 violations and decreased slightly to 168 cases in 1998); *More Patient Dumping on Skid Row Investigated*, L.A. TIMES, Aug. 22, 2007, at B4; Editorial, *Off the Street? A Court Order in an L.A. Patient-Dumping Case Could Lead to a Coordinated System of Care*, L.A. TIMES, Apr. 10, 2009, at 28, *available at* 2009 WLNR 6730178.

[110] *Off the Street?*, *supra* note 109, at 28.

[111] Regehr, *supra* note 96, at 180, 182, 186.

[112] *Id.* at 182 (citing BRYAN A. LIANG, HEALTH LAW & POLICY: A SURVIVAL GUIDE TO MEDICOLEGAL ISSUES FOR PRACTITIONERS 204 (2000)).

[113] *See* Stead, *supra* note 15 (manuscript at 10); Johnson, *supra* note 10, at 666-67; Anna Hunsinger, Comment, *Medical Repatriation or Deportation?: Redefining Medicare Regulations to Better Protect Immigrants from International Patient Dumping*, 39 STETSON L. REV. (forthcoming 2010) (manuscript at 6) (on file with author) (abstract *available at* http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1536172). There have been no state or federal cases regarding EMTALA's application in the very specific context of hospital-initiated repatriations. Montejo's claims were all state-based torts claims. *See supra* section II.C.

[114] 42 U.S.C. § 1395dd(c)(1)(A)(ii) (2006).

[115] *Id.* § 1395dd(c)(2)(B)(i).

[116] *See generally* Hunsinger, *supra* note 113 (manuscript at 9); *see also* MED. ETHICS ADVISOR, *supra* note 26, at 3 (quoting interview with William Greenough, M.D., stating that "the only way to know anything about the quality of care—and the likelihood of survival of a patient about to be . . . repatriated . . .—is to have data about the hospital in the country to which the patient is being referred.").

ferred there or requires life sustaining care.[117] Even transfers between domestic hospitals result in high mortality rates,[118] so it is easy to imagine that the mortality rates for international hospital transfers decreases the likelihood a patient will survive.

Since EMTALA often fails to meet the needs of those patients Congress intended to protect, patients that are extremely vulnerable—such as those lacking immigration status—are left with little recourse.[119] Many have found that EMTALA is largely ineffective, not because of its provisions, but because of insufficient enforcement and funding.[120]

2. IRS 501(c)(3) – Tax Exemption for Charitable Organizations

Section 501(c)(3) of the Internal Revenue Code exempts many hospitals from federal taxes.[121] To qualify as a charitable organization, a hospital must be formed for charitable purposes and operate as such.[122] As part of the "charitable purposes" requirement, hospitals are generally required to provide a benefit to the community.[123] However, the amount of benefit required is unspecified, and there are no fixed percentages or levels of charitable cases hospitals must accept free of charge.[124] Although there is no reimbursement available for this charitable care under the tax code,[125] not-for-profit hospitals can presumably use the money they save by not having to pay federal taxes (property taxes, income taxes, and bond taxes) to supplement the costs of uncompensated care.[126]

---

[117] *See* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1 (discussing the conditions Antonio Torres endured when St. Joseph's hospital transferred him to a facility in Mexico).

[118] MED. ETHICS ADVISOR, *supra* note 26, at 4 (quoting interview with William Greenough, M.D., stating that the baseline state criteria for allowing transfers are ineffective because he has tracked transferred patients and found high mortality rates even among those patients that technically qualified as stable); *see also* William Greenough, *Clinical Case: Treating and Repatriating: An Unacceptable Policy,* 11 AM. MED. ASS'N J. ETHICS 502, 503 (2009) (discussing the ethical dimensions of transferring an unstable indigent patient).

[119] Neda Mahmoudzadeh, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465, 468-69 (2007).

[120] *See id.* at 474-76 (detailing EMTALA's funding and enforcement problems).

[121] *See* 26 U.S.C. § 501(c)(3) (2006). The charitable organization must be organized and operated for charitable purposes and the earnings of the organization must not be inured to private interests. *Id.*

[122] *See id.*

[123] *See* Rev. Rul. 83-157, 1983-2 C.B. 94.

[124] *Id.*

[125] *See id*; *see also* 26 U.S.C. § 501(c) (tax exemption requires a charitable purpose, but provides no reimbursement for any costs of charitable activities).

[126] *See* Rev. Rul. 83-157, 1983-2 C.B. 94; *see also* 26 U.S.C. § 501(c) (tax exemption requires a charitable purpose, but provides no reimbursement for any costs of charitable activities).

B. *Lack of Funding and Enforcement of Duties*

1. Funding

EMTALA requires that hospitals provide services for anyone requiring emergency care, but EMTALA has no mechanism to ensure that hospitals can comply while remaining financially solvent.[127] In particular, not-for-profit hospitals face increasing demands for uncompensated or minimally-compensated care, which is compounded by increasing numbers of indigent patient transfers from private to public hospitals.[128] Thus, many scholars have identified underfunding as EMTALA's primary issue.[129] Furthermore, changes in social welfare schemes have limited personal Medicaid insurance coverage, and are thereby forcing hospitals to rely on federal funding for uncompensated care reimbursement.[130]

Passed in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act[131] ("PRWORA") and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("IIRIRA")[132] dictate how individuals can qualify for Medicaid, limiting the compensation available for hospitals caring for both permanent residents and undocumented immigrants.[133] Medicaid draws from both state and federal funding, so the federal Medicaid statute creates some general restrictions, but allows states discretion in certain components of their Medicaid program.[134] Under Medicaid, a state can create programs that cover certain undocumented immigrants, such as children and pregnant women.[135]

While states have the right to distribute state funds to provide coverage or services to undocumented immigrants, federal Medicaid funding is no longer available for undocumented immigrant hospitalizations.[136] Even lawful permanent residents are generally denied the benefits of federally funded programs

---

[127] Lebedinski, *supra* note 89, at 171.

[128] *Id.* at 158.

[129] *See, e.g.*, Regehr, *supra* note 111, at 186-87; Lebedinski, *supra* note 95, at 154.

[130] *See generally* Mahmoudzadeh, *supra* note 119, at 465.

[131] Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105, (1996) (codified as amended in scattered sections of 8 U.S.C).

[132] Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. No. 104-208, 110 Stat. 3009 (2006) (codified as amended in scattered sections of 8 U.S.C).

[133] Morgan Greenspon, *The Emergency Medical Treatment and Active Labor Act and Sources of Funding*, 17 ANNALS HEALTH L. 309, 313 (2008); *see generally* Mahmoudzadeh, *supra* note 119, at 465.

[134] *See* 42 U.S.C. § 1396a(10)(a)(i) (2010) (stipulating required groups that must be covered under State Medicaid schemes).

[135] *See id.* § 1396a (providing for optional groups that states can choose to cover provided they do not exceed certain income requirements); *see also* Jim P. Stimpson et al., *Trends in Health Care Spending for Immigrants in the United States*, 29 HEALTH AFFAIRS 544, 544 (2010).

[136] Mahmoudzadeh, *supra* note 119, at 468, 471 (citing Seam Park, Note, *Substantial Barriers in Illegal Immigrant Access to Publicly-funded Health Care: Reasons and Recom-*

because they do not meet certain state residency requirements for Emergency Medicaid eligibility.[137] Many scholars have argued that PRWORA and IIRIRA make it impossible for hospitals to meet their EMTALA duties and provide adequate care to immigrants.[138] Congress enacted further barriers to Medicaid funding under the Deficit Reduction Act of 2005 ("DRA"), which implemented new identification requirements for all Medicaid recipients, reducing enrollment in many states.[139]

There has been one federal statute that attempted to address uncompensated medical care and the funding issues it creates, but it has not been robust enough to solve the problem. While PRWORA, IIRIRA and the DRA were intended to disincentivize immigration by preventing individual immigrants from seeking federal welfare or health care benefits, the Medicare Modernization Act of 2003 ("MMA")[140] designated federal funding for hospitals providing uncompensated emergency care to undocumented aliens.[141] This scheme designated $250 million per year for four years to compensate hospitals that provide care to undocumented aliens.[142] The MMA's 2003 scheme granted states funding roughly in proportion to their undocumented immigrant population numbers.[143] Specifically, the MMA provided supplementary funding to the six states with the most undocumented residents seeking care.[144] However, even with these funds, the MMA did not provide sufficient funding to subsidize the uncompen-

---

mendations for Change, 18 GEO. IMMIGR. L.J. 567, 573-74 (2004) and citing 8 U.S.C.A. § 1612(a)(1), (3) (2001)).

[137] 8 U.S.C. § 1612 (2006 & Supp. II 2008).

[138] *See* Regehr, *supra* note 111, at 182-83; *see generally* Lebedinski, *supra* note 95, at 146; Mahmoudzadeh, *supra* note 119, at 465.

[139] Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6036, 120 Stat. 4 (2006) (codified as amended in scattered sections of U.S.C.); *see also Deficit Reduction Act of 2005: Implications for Medicaid*, THE KAISER COMMISSION ON MEDICAID AND THE UNINSURED, 1 (Feb. 2006), http://www.kff.org/medicaid/upload/7465.pdf.; Susan Okie, *Immigrants and Health Care—At the Intersection of Two Broken Systems*, 357 N. ENG. J. MED. 525, 528 (2007).

[140] Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Act, Pub. L. No. 108-173, Title X, Subtitle B, § 1011, 117 Stat. 2432 (2003).

[141] Johnson, *supra* note 10, at 662; Greenspon, *supra* note 133, at 309, 314.

[142] *See* Pub. L. No. 108-173, Title X, Subtitle B, § 1011 (a)(1).

[143] In 2008 the MMA scheme distributed funding as follows: Arizona: $ 44.6 million, California: $ 72.2 million, Florida: $ 9.1 million, New Mexico: 5.1 million; New York: $ 12.2 million; and, Texas: $ 44.4 million. *See FY 2008 State Allocations for Section 1011 of the Medicare Modernization Act,* CENTER FOR MEDICARE AND MEDICAID SERVICES, (2008), http://www.cms.hhs.gov/UndocAliens/downloads/fy08_state_alloc.pdf (referring to funding available under Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens Act, Pub. L. No. 108-173, Title X, Subtitle B, § 1011(b), 117 Stat. 2432 (2003)).

[144] Pub. L. No. 108-173, Title X, Subtitle B, § 1011(b). This calculus is based on the DHS's "undocumented alien apprehensions" for each state. *Id.*

sated care that many hospitals were forced to either absorb or pass on to other patients.[145] One of the main reasons for the MMA's insufficiency was the federal government's inability to assess the number of undocumented immigrants seeking care.[146] Despite its flaws, the MMA did partially address the underfunding problems existing under EMTALA. Unfortunately, this source of funding ended in 2008 when the funding scheme expired.[147]

Because EMTALA cannot effectively improve patient care without adequate subsidies or funding,[148] scholars have suggested alternatives to EMTALA. For example, increased funding for preventative care would incentivize treatment of patients before high-cost emergency services are needed.[149] This type of proposal is intended to avoid the unequal distribution of low-cost preventative care, which would likely reduce the burden on any single hospital or provider.[150]

2. Enforcement

EMTALA can be enforced through private action as well as government sanctions.[151] Wronged individuals can bring civil actions for personal injuries against hospitals violating EMTALA.[152] However, private rights of action are limited in scope under EMTALA, allowing a private cause of action against hospitals, but not against physicians, and requiring that state personal injury law apply to the suit.[153] As such, courts have only enforced EMTALA in a limited way to avoid unnecessary expansion into traditional state jurisdiction such as tort law.[154] Essentially there is no federal remedy for discrimination against a patient based on her ability to pay, unless the patient suffers physical harm.[155]

Government sanctions for EMTALA violations include monetary fines as

---

[145] Lebedinski, *supra* note 95, at 171-72.

[146] *Id.* at 172.

[147] *See* MED. ETHICS ADVISOR, *supra* note 26, at 2; *see also FY 2008 State Allocations*, *supra* note 143.

[148] Regehr, *supra* note 111, at 185-86.

[149] *Id.* at 198.

[150] *Id.* at 199.

[151] *See* 42 U.S.C. § 1395dd(d) (2006). The HHS Office of the Inspector General often also enters into agreements with offending entities in order to avoid prosecution. *See generally Patient Dumping*, *supra* note 109; Lawrence Bluestone, Comment, *Straddling the Line of Medical Malpractice: Why There Should Be a Private Cause of Action Against Physicians via EMTALA*, 8 CARDOZO L. REV. 2829 (2007).

[152] 42 U.S.C. §1395dd(d)(2)(a).

[153] *Id.*; *see also* Bluestone, *supra* note 151, at 2854-55.

[154] *See* Bera, *supra* note 94, at 637.

[155] Bluestone, *supra* note 151, at 2863-64 (attributing federalism issues as well as federal court overload as reasons why Congress would want to avoid a federal malpractice statute).

well as the potential for Medicare reimbursement denial.[156] However, the Department of Health and Human Services ("HHS") does not consistently or sufficiently enforce EMTALA.[157] One factor contributing to under-enforcement is the arduous process, where the HHS Secretary must consult with a peer review board, which conducts a sixty-day investigation before initiating sanctions against a hospital.[158] Furthermore, full EMTALA sanctions are often unenforced because removing Medicare funding from a large hospital would exacerbate medical care shortages.[159]

Another possible problem with implementing EMTALA is insufficient physician accountability in the process of transferring patients, because individual doctors face limited liability.[160] There are provisions for sanctions against individual physicians that negligently violate certification requirements specified in EMTALA, but the civil monetary sanctions are limited to $50,000 per incident.[161] EMTALA currently allows private actions against hospitals or institutions, but not the treating physician.[162] To remedy this problem, scholars have suggested expanding the right of private action under EMTALA to include individual physicians.[163] This would create additional deterrents for individual doctors who inappropriately allow the hospital to transfer a patient.[164] Since doctors must approve a transfer,[165] it is possible that personal accountability and greater penalties for EMTALA violations could also alleviate the repatriation problem.[166] Furthermore, physicians have duties to all patients under the Hippocratic oath.[167] Even without EMTALA, it is likely that many hospitals and physicians would still have a duty to *any* patient seeking care at an emergency room.[168]

---

156 *See* 42 U.S.C. § 1395dd(d)(1).

157 Bera, *supra* note 94, at 636.

158 42 U.S.C. § 1395dd(d)(3). There are exceptions to shorten hospital review to a period of five days for the safety of a patient. *Id.*

159 Bluestone, *supra* note 151, at 2855-56 (discussing the merits of private remedies instead of HHS enforcement).

160 *Id.* at 2866.

161 42 U.S.C. §§ 1395dd(d)(1)(B)i-ii.

162 *Id.* § 1395dd(d)(2)(A) ("Any individual who suffers personal harm as a direct result of a participating hospital's violation . . . may, in a civil action against the participating *hospital*, obtain those damages available for personal injury under the law of the State . . . ." (emphasis added)).

163 Bluestone, *supra* note 151, at 2866.

164 *Id.* at 2852.

165 *Id.* at 2866; *see also* 42 U.S.C. § 1395dd(b)(1)(B).

166 Bluestone, *supra* note 151, at 2866.

167 *See generally* Aboobaker, *supra* note 91 (discussing how physicians may be violating their duties under the Hippocratic oath when undocumented patients are repatriated).

168 Greenough, *supra* note 118, at 503 ("From the earliest times, once a physician takes responsibility for a patient, this obligation trumps all other considerations.").

C. *State and Local Policies Affect Hospitals' Choices to Repatriate*

State Medicaid funding choices can result in disparate services and access to health care programs depending on the policies and revenue base of the state.[169] Each individual state has discretion in how it uses and supplements its federal Medicaid funding, such as establishing eligibility requirements for coverage.[170] In 1996, PRWORA placed many limits on the ways states can use federal Medicaid funds.[171] PRWORA particularly limited access to undocumented immigrants and LPRs living in the United States.[172] However, states retained discretion in some areas, particularly in using the state-contributed funding for the Medicaid program.[173] Programmatic choices even vary on the local level, as some states have granted counties and cities discretion in defining individual eligibility for public health programs.[174]

As a result, hospital administrators in different locales have vastly different outlooks on the need for repatriation.[175] In Phoenix, Arizona, a hospital's Vice President stated that he and his physicians choose to repatriate indigent immigrant patients because "[w]e're trying to be good stewards of the resources we have . . . [w]e can't keep someone forever."[176] Starkly different, the administrators at El Centro Regional Medical Center in California never send an immigrant back to their country of origin.[177] California hospitals generally face higher rates of uncompensated care than do other states, due to larger populations of undocumented immigrants.[178] However, some states and localities, such as many regions of California, have made funding available for emergency treatment of even undocumented immigrants, creating a system in which

---

[169] *See* Stead, *supra* note 15 (manuscript at 8).

[170] 8 U.S.C. § 1621(d) (2006); Mahmoudzadeh, *supra* note 119, at 471-72; Stead, *supra* note 15 (manuscript at 8).

[171] 8 U.S.C. § 1611(a) (2006) (providing that aliens that are not "qualified aliens" are ineligible for federal public benefits); *see also* Mahmoudzadeh, *supra* note 119, at 471-72; Brietta R. Clark, *The Immigrant Health Care Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 235 (2008); Elizabeth R. Chesler, Note, *Denying Undocumented Immigrants Access to Medicaid: A Denial of Their Equal Protection Rights?*, 17 B.U. PUB. INT. L.J. 255, 259 (2008).

[172] 8 U.S.C. § 1641(b) (2006 & Supp. III 2009).

[173] *Id.* § 1621(d) (2006).

[174] Okie, *supra* note 139, at 526 (discussing a variety of local policies towards compensating undocumented immigrant health care).

[175] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[176] *Id.* at 3; *see also* ARIZ. REV. STAT. ANN. § *36-2903.03 (2009) (specifying Arizona's eligibility requirements for health welfare programs).*

[177] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[178] *See* MICHAEL HOEFER ET AL., U.S. DEP'T OF HOMELAND SEC., ESTIMATES OF THE UNAUTHORIZED IMMIGRANT POPULATION RESIDING IN THE UNITED STATES: JANUARY 2009, at 2 (2010) *available at* http://www.dhs.gov/xlibrary/assets/statistics/publications/ois_ill_pe_2009.pdf.

hospitals face less financial pressure to limit treatment in emergency cases.[179]

Treatment disparities may be the result of different approaches by hospital administrators, varied state choices regarding funding allocation, or different regions' political and cultural views of undocumented immigrants.[180] While many regions with high numbers of immigrants have better policies, there are many hospital-initiated repatriations in areas where "hostility toward illegal immigrants is high and state financing for their care is low," such as Arizona.[181] States' discretion in allocating funds for immigrants' emergency care can have serious negative consequences for patients, as evidenced in the Torres cases, where concerns over lack of reimbursement for LPR care effectively resulted in a deportation that greatly jeopardized his health.[182]

D. *Misconceptions about Immigrant Health Care Consumption*

It is important to note that funding immigrant health care is not as expensive as some claim.[183] Immigrants of all statuses tend to underutilize medical care when compared to their relative representation in the U.S. population.[184] Some of the factors causing under-consumption likely include fear of immigration enforcement, underinsurance, and language differences.[185] Assuming that consumption levels remain stable, immigrants would likely be less expensive to cover than the average American. However, it is likely that immigrants would increase their health care consumption if they had access to insurance coverage, federal benefits, or did not feel fear in seeking medical care. Contrary to popular perception, immigrants are not the main contributors to the current cost problems in the American health care system.[186] Furthermore, undocumented immigrants generally contribute more funding through payroll taxes to the pub-

---

[179] Okie, *supra* note 139, at 526.

[180] *Id.* There is not only disparity in Medicaid funding among states, but there are also significant differences in approaches to immigration issues, such as access to workers' compensation and other social services. *See* Brooke Sikora Purcell, Comment, *Undocumented and Working: Reconciling the Disconnect Between U.S. Immigration Policy and Employment Benefits Available to Undocumented Workers*, 43 U.S.F. L. REV. 197, 207-08 (2008) (describing the gamut of workers' compensation coverage available to undocumented workers across different states). Some scholars argue that this disunity in the provision of services creates a confusing message that conflicts with federal policies regarding undocumented immigration. *Id.* at 221.

[181] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[182] *Id.*

[183] *See* Stimpson et al., *supra* note 135, at 550.

[184] Goldman et al., *supra* note 27, at 1710.

[185] Stimpson et al., *supra* note 135, at 549.

[186] *See, e.g.*, Stimpson et al., *supra* note 135, at 550; see also Clark, *supra* note 171, at 254; 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, 61 (2000).

lic benefits system than they consume.[187]

IV. IMMIGRATION LAW BACKGROUND

Immigration enforcement is the duty of the federal government.[188] The Department of Homeland Security ("DHS") estimated that, as of January 2009, there were 10.8 million undocumented immigrants residing in the United States.[189] Although, DHS concluded that the number of undocumented immigrants living in the United States decreased in 2009,[190] the number of illegal immigrants steadily increased during the previous decades.[191] The largest population of undocumented workers in the United States is of Mexican origin.[192] The states with the largest number of undocumented populations are California, Texas, Florida, New York, and Illinois.[193] Arizona, a state known for its repatriation practices and strong anti-immigrant policies,[194] has an estimated 460,000 undocumented immigrants.[195] In comparison, an estimated 2.6 million undocumented immigrants live in California, and yet California has much friendlier policies towards undocumented immigrants than Arizona.[196] As discussed above,[197] each state has developed its own political and legal culture towards undocumented immigrants, ranging from enacting legislation that is intended to deter immigration, to offering social services aiding undocumented immigrants.[198]

A. *Removal Procedures*

If DHS brings an action against an undocumented immigrant, it is likely

---

[187] *See, e.g.*, Clark, *supra* note 171, at 254 n.143.

[188] 8 U.S.C. § 1103 (2006 & Supp. III 2009); *see generally supra* note 2 and accompanying text. However, the federal government can delegate some enforcement duties to local law enforcement agencies through a Memorandum of Agreement. See 8 U.S.C. § 1357(g) (1996), amended by Homeland Security Act of 2002, Pub. L. No. 107-296, 116 Stat. 2135 (codified as amended in scattered sections of 6 U.S.C.).

[189] HOEFER ET AL., *supra* note 178, at 2.

[190] *Id.* at 2.

[191] *Id.* at 7 (reporting that the population was estimated at 11.78 million in 2007).

[192] *Id.* at 4 (finding that between 2000 and 2009, the average growth of the undocumented population of Mexican descent was 220,000 individuals per year).

[193] *Id.*

[194] Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[195] HOEFER ET AL., *supra* note 178, at 4.

[196] *Id.*; *see also* Johnson, *supra* note 10, at 663 (explaining that counties in California and Texas make medical expenditures on undocumented immigrants including long-term care) (citing Alan Zarembo & Anna Gorman, *Dialysis Dilemma; Who Gets Free Care? In California, Officials Say Not Treating Illegal Migrants has High Cost*, L.A. TIMES, Oct. 29, 2008, at A1); *see also* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[197] *See supra* Part III.C.

[198] Purcell, *supra* note 180, at 207-08.

through Immigration and Customs Enforcement ("ICE"), a federal agency under DHS.[199] Removal (commonly known as deportation) is generally considered a harsh legal consequence requiring due process.[200] An ICE officer makes the initial decision to initiate the removal of an alien.[201] The alien then has the opportunity to have a hearing before a DHS officer or an Immigration Judge ("IJ") with the protections of the Immigration and Nationality Act's ("INA") procedural rules and proper notice.[202] While the immigration court is an administrative agency and not a federal court, immigrants have the opportunity to ask for continuances,[203] make discovery,[204] file motions,[205] and provide evidence.[206] Most importantly, an individual with an order of deportation against her may request an appeal of the decision to the Board of Immigration Appeals ("BIA").[207] BIA decisions are reviewable by the federal circuit courts

---

[199] *See* OFFICE OF IMMIGRATION STATISTICS, POLICY DIRECTORATE, U.S. DEP'T OF HOMELAND SEC., IMMIGRATION ENFORCEMENT ACTIONS: 2008, (2009), *available at* http://www.dhs.gov/xlibrary/assets/statistics/publications/enforcement_ar_08.pdf.

[200] *See, e.g.*, Fong Haw Tan v. Phelan, 333 U.S. 6, 10 (1948) ("Deportation is a drastic measure and at times the equivalent of banishment or exile.") (citing Delgadillo v. Carmichael, 332 U.S. 388, 391 (1947)). While immigration court decisions are not considered criminal procedures, the consequences of deportation are so great as to require certain due process protections. Reno v. Flores, 507 U.S. 292, 306 (1993); *see generally* IRA J. KURZBAN, IMMIGRATION LAW SOURCEBOOK 268 (11th ed. 2008). There is however, no right to free counsel in an immigration proceeding. *Id.* at 275 (citing Morales-Izquierdo v. Gonzalez, 486 F.3d 484, 497 (9th Cir. 2007) (en banc)). There is a fundamental right to be "represent[ed] by competent counsel." *Id.* at 339; *see also* 8 C.F.R. § 292 (2010) (describing permissible representatives in Immigration proceedings). There is a right to a translation at a hearing. 8 C.F.R § 1240.5 (2010); *see also* KURZBAN, *supra* note 200, at 379 (giving a detailed analysis of the evolution of the right to a translator).

[201] 8 C.F.R. § 287.3(b) (2010) (an examining ICE officer, other than the arresting officer, may make a determination if there is prima facie evidence of an immigration violation). *See also* Johnson, *supra* note 10, at 694 (discussing a proposed solution where hospitals would inform ICE officers if there is a patient they want to repatriate); KURZBAN, *supra* note 200, at 311-14.

[202] 8 U.S.C. § 1229a (2006). This varies if the alien is subject to expedited removal. 8 U.S.C. § 1228 (2006); *see also* Johnson, *supra* note 10, at 694.

[203] *See, e.g.*, 8 C.F.R. § 1003.29 (2010).

[204] KURZBAN, *supra* note 200, at 334-38 (describing rights to discovery, subpoena, and official records).

[205] *Id.* at 267.

[206] *See id.*

[207] 8 C.F.R. §§ 1003.1(b)(1)-(14) (2010) (creating appellate authority for the BIA over, *inter alia*, IJ deportation and asylum decisions); *see also* KURZBAN, *supra* note 200, at 1019. There is no guarantee the BIA will review an immigrant's appeal, but if forms are properly filed in a timely manner, there is a presumption that the BIA will consider appeals regularly. *Id.* at 1026 (citing Rashiah v. Ashcroft, 388 F. 3d 1126, 1130 (7th Cir. 2004)).

of appeal, granting an opportunity to be heard in an Article III court.[208]

While many undocumented immigrants are indeed deportable, immigration laws provide exceptions for those aliens whose removal would be against the public interest.[209] Even if no exception applies at the immigration hearing, there may be opportunities to appeal.[210] The appeals process allows a deportable immigrant the chance to make his or her case to the BIA that the removal would be unlawful or against the public interest.[211] Even those immigrants that are physically removed from the country have the right to appeal a BIA decision from abroad.[212] While there are many protections in place, Congress has created expedited removal procedures for both undocumented and legal immigrants designated as "aggravated criminals."[213]

B. *Asylum as a Means of Attaining Legal Status or Relief from Deportation*

An individual can attain asylum in the United States based on certain conditions or threats to an individual in that person's country of origin.[214] Once an individual is granted asylum, he may be eligible to eventually apply for adjustment of status and become an LPR.[215] An IJ or Asylum Officer ("AO") can only grant asylum if the applicant applies when in the United States or at a border awaiting entry.[216] The requirements include: applying within one year of arrival to the United States; being classified as a refugee or another status that is protected by immigration regulations; and, proof that there is government persecution or little protection from persecution in the applicant's country

---

[208] 8 U.S.C. § 1252 (2006) (establishing federal judicial review and procedures over removals and final IJ decisions); *see also* KURZBAN, *supra* note 200, at 1071.

[209] *See* 8 C.F.R. § 212.5(b)(1)-(3) (2010) (enumerating circumstances such as ill health, pregnancy, or youth, in which a detained alien may not be removed at the discretion of the Secretary of Homeland Security).

[210] *See* 8 C.F.R. § 1003.1(b); 8 U.S.C. § 1252.

[211] *See* 8 C.F.R. § 1003.1(b); 8 U.S.C. § 1252 (enumerating procedures by which the alien petitioner may submit briefs and evidence on federal appeal).

[212] *See, e.g.*, Matter of Keyte, 20 I. & N. Dec. 158, 159 (BIA 1990) (holding that an appeal is not considered withdrawn when appellant leaves the country).

[213] KURZBAN, *supra* note 200, at 131 (citing 8 U.S.C § 1225(b)(1)).

[214] 8 U.S.C. § 1158(b)(1)(a) (2006) (an asylee must be found to be a "refugee" under 8 U.S.C. § 1101(a)(42)(A)). "'[R]efugee' means (A) any person who is outside any country of such person's nationality or, in the case of a person having no nationality, is outside any country in which such person last habitually resided, and who is unable or unwilling to return to, and is unable or unwilling to avail himself or herself of the protection of, that country because of persecution or a well-founded fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion, ...". *Id.* § 1101(a)(42)(A) (2006)).

[215] *Id.* § 1159(b) (2006) (stipulating requirements for adjustment of status for refugees and asylees).

[216] KURZBAN, *supra* note 200, at 431 (listing range of immigrant categories "protected under U.S. law").

of origin.[217] An individual can qualify for an extension if he or she can prove "changed circumstances" in either the country of origin or the individual's situation.[218] Examples of "changed circumstances" include when political conditions change in the asylee's country of origin or when an individual's physical health changes while in the United States.[219]

V. PROPOSED SOLUTIONS

A. *Patients Can Apply for Asylum to Avoid Repatriation*

In her forthcoming student comment, *Critical Condition: Using Asylum Law to Contest Forced Medical Repatriation of Undocumented Immigrants,* Kendra Stead proposes that undocumented individuals file asylum claims to prevent repatriations.[220] Stead acknowledges that undocumented patients facing repatriation would have to surmount several hurdles in claiming asylum, including meeting filing deadlines, meeting "protected status" requirements, and demonstrating "a well-founded fear of persecution."[221] However, Stead argues that serious injury or illness could constitute a circumstance warranting the extension of deadlines.[222] Stead contends this is possible because DHS has granted asylum for pregnant individuals who may face health risks in their home country.[223]

Additionally, Stead argues that the ambiguously defined protected status of "'particular social group' creates an opportunity for immigrants facing repatriation to claim asylum."[224] "Particular social groups" have been defined as individuals sharing "common, immutable characteristic[s]," that cannot be changed.[225] Several IJs have granted asylum to a broad range of individuals based on this flexible category, which may include anything from familial status, to ethnic group, or even a "shared medical condition."[226] Stead notes that

---

[217] 8 U.S.C. § 1158(a)(2)(b) (2006); *Id.* § 1101(a)(42)(A); *see also* 8 C.F.R. § 208.4 (2010).

[218] 8 U.S.C. § 1158(a)(2)(D) (2006) (an extension can be granted if applicant proves "changed circumstances which materially affect the applicant's eligibility for asylum or extraordinary circumstances relating to the delay in filing an application. . .").

[219] 8 C.F.R. § 208.4(a)(4)(i)(A)-(B); *see also* KURZBAN, *supra* note 200, at 474 (describing qualifying examples of changed circumstances).

[220] Stead, *supra* note 15 (manuscript at 24-26, 34).

[221] *Id.* (manuscript at 14).

[222] *Id.* (manuscript at 16).

[223] *Id.* (manuscript at 15) (citing Guo v. Ashcroft, 386 F.3d 556, 560 (3d Cir. 2004) (approving an asylum claim in which a Chinese applicant's second pregnancy was sufficient to prove a changed condition and warrant an extension for asylum relief based on fear of forced abortion or sterilization in her home country)).

[224] *Id.*

[225] KURZBAN, *supra* note 200, at 451 (citing Matter of Acosta, 19 I&N Dec. 211, 23334 (B.I.A. 1985)).

[226] Stead, *supra* note 15 (manuscript at 17-19) (citing Ramdane v. Mukasey, 296 Fed.

the ambiguity of "persecution" will be useful for asylum cases concerning repatriation because AOs or IJs will have discretion in granting asylum.[227] Finally, Stead argues that asylum law provides a potential legal recourse for indigent immigrant patients to qualify as having protected status for their specific types of illnesses or disabilities, though health-based cases are more difficult to prove.[228]

Stead acknowledges that her proposed solution has limited application.[229] Asylum is only available to individuals who are able to prove that they would be persecuted or discriminated against in their home countries.[230] In the context of a health-based asylum claim, a patient would have to show that deportation would in effect be a "death sentence" because of the applicant's special status.[231] Additionally, Stead acknowledges that asylum would protect only undocumented immigrants, and not legal immigrants, from repatriation.[232] Nor would her plan provide hospitals with increased compensation for providing emergency services to immigrants.[233] While asylum seems to be a piecemeal solution to the medical repatriation problem, Stead acknowledges that her proposed solution is only a temporary fix while Congress develops a more permanent legislative solution such as comprehensive immigration reform.[234]

B. *Hospitals Can Repatriate Indigent Patients Through DHS and Thereby Ensure Due Process*

In her article, *Patients Without Borders: Extralegal Deportation by Hospitals*, Kit Johnson addresses the right to due process before deportation.[235] First, Johnson analyzes the repatriating hospital's actions under a state action lens to determine whether hospitals are responsible for violating immigrants' equal protection rights when they privately repatriate an individual to their home county.[236] Johnson argues that private hospitals are unlikely to be subject to

---

Appx. 440, 446-47 (6th Cir. 2008) and Paredes v. U.S. Att'y Gen., 219 Fed. Appx. 879, 883, 886 (11th Cir. 2007)).

[227] *Id.* (manuscript at 16-17).

[228] *Id.* (manuscript at 18).

[229] 8 U.S.C. § 1158 (2006); *see also id.* § 1101 (2006) (defining the requirements to meet the burden of proof for an asylum claim).

[230] Stead, *supra* note 15 (manuscript at 28).

[231] *Id.*

[232] *Id.* (manuscript at 32-33).

[233] *See id.* (manuscript at 31-32) (arguing that her proposal would be beneficial because asylum coupled with Medicaid-covered long-term care facilities is more cost effective than hospitalization).

[234] *Id.* at 34-35 (noting that bringing this issue into the immigration courts may prompt legislative action that helps both the immigrants in need of care, as well as the hospitals providing care).

[235] Johnson, *supra* note 10, at 680-81.

[236] *Id.* at 670-86.

constitutional scrutiny when they engage in repatriation, despite the fact that they are likely interfering with the federal government's jurisdiction.[237] Johnson notes that hospitals are not qualified or capable of making deportation decisions and effectively interfere with federal immigration enforcement schemes by privately removing individuals.[238]

Johnson goes on to explain that private (not-for-profit and for-profit) hospitals are subject to restrictions on this behavior, either under EMTALA or "*de facto* state law."[239] Furthermore, Johnson analyzes the merits of private causes of action for false imprisonment as a mechanism to prevent hospitals from repatriating individuals.[240] The Montejo case is a useful example, as it shows the process by which an individual would pursue damages from a repatriating hospital.[241] However, Johnson finds that inefficiencies, challenges by hospitals, and limited access to counsel, prevent false imprisonment from being an effective or desirable method.[242] Ultimately, Johnson finds that these potential solutions—private causes of actions for false imprisonment and federal sanctions for EMTALA violations[243]—are inadequate to deal with repatriation on a long-term scale.[244]

Alternatively, Johnson "propose[s] a new administrative process whereby hospitals call upon DHS to initiate the expedited removal and transfer of medically needy undocumented migrants."[245] A federal repatriation program would act as a means of ensuring due process to those whom a hospital seeks to remove.[246] Her analysis focuses mainly on the uniformity of such a scheme, and addresses the problems faced by hospitals with incentives to repatriate and patients who may not have adequate information to consent to repatriation.[247]

Johnson's proposed solution includes giving hospitals the option of reporting undocumented immigrants who require extensive and costly care for removal through DHS.[248] Hospitals would have to establish policies whereby physicians ask patients about their legal statuses and then decide whether to report that particular individual to DHS.[249] In her proposed model, Johnson envisions that DHS would then pursue an "expedited form" of removal for patients re-

---

237 *Id.* at 685.

238 *Id.* at 684-85.

239 *Id.* at 685-86.

240 *Id.* at 686.

241 *Id.* at 686-89.

242 *Id.* at 689.

243 *Id.* at 691.

244 *Id.* at 691-92.

245 *Id.* 660.

246 *Id.* at 692-95.

247 *Id.* at 692.

248 *Id.* at 692-93.

249 *Id.* at 692.

quiring expensive long-term care.[250] Johnson reasons that DHS involvement will improve the procedure by which immigrants can appeal or question their deportation and expedite the removal process, thus reducing hospital costs.[251] She relates her reporting proposal to expedited removal procedures for aggravated felons.[252]

However, Johnson acknowledges that ICE agents' limited medical knowledge, as well as the traditional lack of public representation for immigrants facing deportation, would complicate these cases.[253] To overcome these complications, Johnson proposes using *guardian ad litems* and medical experts.[254] *Guardian ad litems* would work on behalf of the court to investigate and provide suggestions, regarding a patient's best health interests.[255] Both the government and the patient would offer medical expert testimony to prove the safety or dangers of deporting the immigrant based on the patient's condition.[256] Overall, Johnson claims that her due process-based solution would help those patients for which repatriation would result in a "death sentence" and would better identify patients that could be adequately treated in their home countries.[257] The courts would be better able to prevent unjust outcomes, she argues, if the applicant were given the opportunity to prove that she would be in danger if transferred.[258]

C. *Amend EMTALA to Require Domestic Transfer*

Anna Hunsinger has suggested in her forthcoming student comment that hospitals violate HHS regulations[259] when they transfer patients to facilities outside of the country.[260] Hospitals repatriating patients are likely also violating EMTALA because they are sending patients to inferior foreign facilities that would

---

[250] *Id.* at 694-95.

[251] *Id.*

[252] *Id.* at 695. As discussed above, these expedited removal procedures are intended to remove those individuals that have been convicted of certain crimes in order to lessen the costs of incarceration. *See id.*

[253] *Id.* at 695-96.

[254] *Id.*

[255] *Id.* at 695.

[256] *Id.* at 696.

[257] *Id.* at 696-97.

[258] *Id.*

[259] The regulations were originally promulgated by the Health Care Financing Administration ("HCFA") which has since been renamed the Center for Medicare and Medicaid Services ("CMS"). *See* Press Release, Department of Health & Human Services, Remarks by HHS Secretary Tommy G. Thompson at Press Conference Announcing Reforming Medicare and Medicaid Agency, (June 14, 2001), *available at* http://archive.hhs.gov/news/press/2001pres/20010614b.html.

[260] Hunsinger, *supra* note 113 (manuscript at 8).

likely be inappropriate by domestic standards.[261] Hunsinger assesses the level of care that hospitals provide to repatriated patients and finds that recipient facilities, such as the hospital to which Jiménez was sent, are grossly inappropriate.[262] However, Hunsinger acknowledges that the language of the EMTALA statute requiring transfer to an "appropriate facility" has not been well-defined in the regulations promulgated by the Health Care Financing Administration ("HCFA").[263] She suggests that Congress or the Center for Medicare and Medicaid Services ("CMS") should create regulations that explicitly limit transfers under EMTALA to only include domestic facilities.[264]

VI. Analysis and Alternatives to Currently Proposed Solutions

When hospitals transfer patients covered by EMTALA, the hospital and the recipient facility have to meet certain threshold levels for process, as well as for quality.[265] Hospital-initiated repatriations likely violate EMTALA transfer requirements by inappropriately transferring patients to inadequate facilities in other countries.[266] However, HHS is either currently unable or unwilling to enforce EMTALA requirements that would eliminate this practice. This is likely due to the negative implications of shutting down hospitals that are already providing much needed services.

Since EMTALA is often ineffective to prevent repatriation, there needs to be a legislative solution such as amendments to the statute which would explicitly bar individuals from being transferred to inferior foreign health care centers. Several scholars have made useful suggestions to alleviate the repatriation problem, yet none have formulated a comprehensive solution. While it is difficult to envision a law or policy to prevent hospital-initiated repatriations that is acceptable to all the stakeholders, it is important to understand the factors that may make a solution successful. In particular, one must look at the incentives that each scheme creates and whether that proposal will create a more tolerable outcome than the current system of hospital-initiated removals.

---

[261] *Id.* (manuscript at 9) (describing the "second-rate facilities" and consequences of transfer as "a death sentence" (citing Sontag, *Deported, by U.S. Hospitals*, *supra* note 4, at A1)).

[262] *Id.* (manuscript at 9).

[263] *Id.* (manuscript at 10); *see also supra* note 259 and accompanying text.

[264] *Id.* (manuscript at 10).

[265] 42 U.S.C. § 1395dd (2006).

[266] *See* Johnson, *supra* note 10, at 663. Sometimes these facilities do not know to expect transferred patients, and treat them as an emergency case. *See* Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8 (describing Antonio Torres's experience where his family was promised care in Mexico and the receiving hospital had no knowledge of his arrival or facilities available to treat him).

A. *Weaknesses of Currently Proposed Solutions*

1. Asylum Fails to Address Root Causes

Stead proposed asylum status as an effective way to prevent the abuses of hospital-initiated repatriations.[267] However, asylum is a difficult status to attain in the U.S. immigration system; there are many specific requirements for an individual to qualify.[268] Asylum requires a showing of persecution, and a high threshold of proof. Socio-economic factors are not usually considered sufficient to qualify for protection.[269] Additionally, failure to meet procedural requirements (such as applying within one year of entering the country) disqualifies many patients involved in these cases.[270] Thus, health-based asylum is unusual and extremely difficult to obtain.[271]

For example, Jiménez would have had a very difficult time establishing that his deportation to Guatemala would result in near-certain death, a requirement for gaining asylum status.[272] Stead argues that a case like Jiménez's would qualify for asylum because sending him to another country in his condition was akin to a "death sentence."[273] However, it is very possible that an IJ would have denied his application because Jiménez's near-certain death was the result of health reasons, not persecution or the political climate in his country of origin. Even though Jiménez's health problems would possibly fail to meet the legal standard for asylum, most would agree that forcible transfer and permanent brain damage are reprehensible outcomes that an immigration judge may want to prevent. There would have to be an ostensible broadening of the asylum standards for many repatriated individuals to benefit from asylum status.

Asylum is an attractive solution because it provides patients with a final recourse before repatriation, if the individual has the opportunity to apply. Furthermore, asylum recipients are likely eligible for some government aid and health care under Medicaid as they are exempt from the ban that applies to other immigrants.[274] However, asylum only helps one person at a time; this proposed solution does not address the reasons hospitals turn to repatriation and does not protect patients who have no information or resources to apply for asylum. Repatriated patients are often vulnerable individuals with no private insurance and little access to legal advice. Given that the root causes of the

---

267 *See generally* Stead, *supra* note 15 (manuscript at 13, 33).

268 *Id.* (manuscript at 14).

269 *Id.* (citing Hincapie v. Gonzales, 494 F.3d 213, 217 (1st Cir. 2007)).

270 *Id.* (citing 8 U.S.C. § 1158 (a)(2)(B), (D)).

271 *Id.* (manuscript at 29).

272 *Id.*

273 *Id.* at 28.

274 *See* 8 U.S.C. § 1612(a)(2)(A) (2006) (stipulating that refugees and asylees qualify for up to a seven years exception from the general ban on federal program access for aliens); *see also* PRWORA §§ 400-412, 110 Stat. 2105, 2260-76 (1996); Stead, *supra* note 15 (manuscript at 9).

repatriation phenomenon include EMTALA's under-enforcement, limited funding, and gaps in insurance coverage, asylum does little to enforce EMTALA or address hospitals' funding issues.

2. Hospitals Should Not Be Agents of DHS

The lack of procedural due process inherent in hospital-initiated repatriations[275] is one of the most disturbing issues within the current hospital repatriation mechanism. A hospital's domain should be limited to treating and discharging a patient, but hospitals are over-extending their power by transferring and repatriating patients in order to avoid EMTALA violations and cut costs.[276] To address this issue, Johnson suggests that hospitals communicate directly with DHS to repatriate patients.[277] Johnson intends for her reporting scheme to ensure that each patient (or her guardian) has a hearing before being transferred to her country of origin.[278] Hospitals would no longer physically transfer patients, or make the final decision as to their immigration status.

However, Johnson's proposed solution creates more problems than it solves. First, hospitals are not enforcers of immigration policy.[279] Hospitals have no reliable methods to determine an immigrant's status, and they do not have any legal authority to alter an individual's immigration status.[280] Although Johnson's suggestion would not make hospitals private enforcers of immigration law, it would make hospitals reporters of potential undocumented immigrants.[281] This is problematic, as there are difficulties in having even state officials act as reporters to DHS, and it is likely that these difficulties would be exacerbated when involving private actors.[282] While Johnson emphasizes that her solution would involve an optional reporting function,[283] hospitals will essentially have discretion as to whether its patients will be subject to a removal hearing. Furthermore, there is no guarantee that patients reported will only be long-term patients and not just any individual that falls within a hospital's arbitrary definition of undocumented.

---

[275] *See* Johnson, *supra* note 10, at 680 (citing Yamataya v. Fisher, 189 U.S. 86, 100-01 (1903) for the premise that procedural due process requirements should apply to deportation proceedings).

[276] *Id.* at 664 (citing Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1).

[277] *Id.* at 692.

[278] *Id.* at 692-94.

[279] *See generally supra* note 2 and accompanying text.

[280] Johnson, *supra* note 10, at 688.

[281] *Id.* at 692-93.

[282] *See* Paula Sue Smith, *An Argument Against Mandatory Reporting of Undocumented Immigrants by State Officials*, 29 COLUM. J.L. & SOC. PROBS. 147, 164-65 (1995) (arguing that mandatory reporting by state officials will undermine the federal immigration system and diminish uniformity across the states).

[283] Johnson, *supra* note 10, at 692-93.

Hospitals could also use this reporting authority to simply clear out patients without insurance. There would still be an issue of distinguishing between LPRs and undocumented immigrants because hospitals could easily report any non-English speaking patient. Over-reporting could result in unnecessary court costs for both the government and indigent patients. It is likely that most patients facing repatriation, who already face financial problems in paying for their medical care, would be unable to obtain counsel to pursue their case in immigration court. Johnson reasons that hospital reporting would be limited because hospitals have other public health concerns such as deterring patients that need treatment for infectious diseases.[284] However, her argument is flawed in that she does not take into account that there is no guarantee that hospital staff would appropriately distinguish between patients to find those that would actually incur a large financial burden. It is possible that some hospitals could automatically report all "suspect" uninsured individuals in order to reduce costs.

Furthermore, release of patient information to DHS may have implications for doctor-patient confidentiality rights under the Health Insurance Portability and Accountability Act ("HIPAA").[285] There are exceptions in the HIPAA regulations allowing hospitals to disclose health information to public health agencies.[286] However, there are no provisions stating that the HIPAA privacy rules do not apply to undocumented immigrants.[287] In particular, if a doctor or hospital discloses any patient's personal health information to a non-health related agency such as DHS, this disclosure is likely to violate HIPAA.[288]

Undocumented immigrants already fear seeking hospital services.[289] Formalized reporting channels between hospitals and DHS would likely increase immigrants' fears and result in fewer immigrants seeking necessary medical treatment. It is true that many cannot avoid going or being taken to the emergency room because they are involved in catastrophic incidents. However, there are many individuals that may choose not to seek immediate care under this scheme. The public health consequences of this proposal could be dire, especially for cases of highly infectious diseases, such as tuberculosis.[290]

---

[284] *Id.* at 693 (stating that "other hospitals may have overriding public health concerns that will lead them not to seek repatriation assistance from the federal government. For example, some hospitals may not report undocumented migrants because it might discourage other undocumented migrants from seeking needed medical care when suffering from diseases with potentially disastrous public health consequences. . .").

[285] *See generally* 45 C.F.R. § 164.500 (2003).

[286] *See id.* § 164.512.

[287] *Id.* § 164.500.

[288] *See id.* § 164.512.

[289] Park, *supra* note 136, at 581.

[290] Several scholars have cited tuberculosis as a particular public health challenge resulting from limited access to preventative care and screening tests. *See generally* Julia A. Martin, *Proposition 187, Tuberculosis, and the Immigration Epidemic?*, 7 STAN. L. & POL'Y

Furthermore, Johnson's proposal does not stop different states from treating immigrants disparately. Johnson urges that discretion is key because some cities have laws prohibiting reporting undocumented patients.[291] Disparate enforcement of the law would likely continue in similar patterns, and some states could see higher numbers of DHS reports than others. In addition to skewing the perception of immigration problems in a state, unequal reporting interferes with goals of uniformity in federal immigration law.[292] Varied enforcement would misallocate charity care and federal funding as "immigrant-friendly" hospitals could possibly result in an increase in uncompensated cases. Increased burdens on hospitals willing to treat all individuals would continue to exacerbate the current funding problems, creating the economic impetus for repatriations.

Additionally, it is possible that certain states will decide to allocate fewer funds because hospitals would have an alternative to providing uncompensated care. While Johnson's solution would be more humane than private repatriations and would provide patients with a chance to apply for some relief from the government, there would still be issues of detaining or repatriating unstable patients. The standard IJs or AOs would use to adjudicate these cases still remains a question. Furthermore, Johnson's proposal does not solve the issue of funding care for immigrants that IJs find eligible to stay in the United States.

Finally, the comparison of removal for medically needy indigent immigrants with that of aggravated felons is concerning. Johnson proposes using a system similar to the process for removal of aggravated felons, which includes the removal of LPRs.[293] In effect, it is possible that legal immigrants may be eligible for removal because they are ill and not yet eligible for Medicaid coverage. Deporting a lawful permanent resident that commits a felony and thus statutorily loses her privilege to reside in the United States is significantly different from terminating someone's residency because of an accident or illness.

Due process for its own sake would not assuage the underlying issues at

---

REV. 89 (1996) (discussing the incidences and risks associated with withholding medical care access from immigrant populations who are most likely to be carriers of tuberculosis); *see also* Matthew T. McKenna et al., *The Epidemiology of Tuberculosis Among Foreign-Born Persons in the United States, 1986 to 1993*, 332 NEW ENG. J. MED. 1071, 1071 (1995); Adrianne Ortega, Note, . . . *And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Care*, 35 AM. J.L. & MED. 185, 189 (2009); Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 276 n.25 (1992); Cynthia Webb Brooks, Comment, *Health Care Reform, Immigration Laws, and Federally Mandated Medical Services: Impact of Illegal Immigration*, 17 Hous. J. Int'l L. 141, 170 n.224 (1995) (citing proposal that infectious diseases should be covered for all individuals to avoid public health problems).

[291] Johnson, *supra* note 10, at 693 n.238 (citing New York and San Francisco laws prohibiting city employees from inquiring into an individual's immigration status).

[292] *See generally* Smith, *supra* note 282, at 164-65.

[293] Johnson, *supra* note 10, at 695.

stake. While Johnson's goal of promoting due process in removals and avoiding private repatriations[294] is commendable, her proposed solutions are inadequate and create further problems. Hospitals and medical care providers should neither be the enforcers of American immigration policies nor forced to be reporters to DHS. Furthermore, her plan would equate immigrants seeking medical care with felons in that both of these groups would be highly prioritized in immigration enforcement. Johnson's suggestions could ultimately induce struggling health care providers to request removal of LPRs based on their inability to pay for emergency health care.

B. *Important Factors Necessary to End Hospital-Initiated Repatriation*

Hospital-initiated repatriations are caused by a variety of international, legal, financial, and cultural issues. EMTALA is the most applicable statutory scheme, yet it is underfunded and largely unenforced. As seen in the case of Luis Alberto Jiménez, there is little recourse for an individual who has been privately repatriated to his country of origin.[295] Private repatriations illustrate a host of additional health policy problems.[296] However, the issue of uncompensated care is not only a concern for immigrant patients requiring long-term care and ventilators; outpatient care, such as kidney dialysis, is also uncompensated.[297] The United States needs a more comprehensive solution to stop repatriations and increase access generally.

Initially, there must be a legislative mandate outlawing private, involuntary hospital-initiated repatriations. Hunsinger's suggestion that EMTALA explicitly limit transfer facilities to domestic facilities provides a simple legislative solution.[298] Her suggestion would require Congress to create an explicit mandate for hospitals accepting Medicare or Medicaid reimbursement that would not allow private repatriations. However, given EMTALA's enforcement and funding issues, changing the statute would not be a complete solution. Ultimately, there must be options for increased federal reimbursements for uncom-

---

[294] *Id.* at 673-82.

[295] Montejo v. Martin Mem'l Med. Ctr. (*Montejo I*), 874 So. 2d. 654, 656-57 (Fla. Dist. Ct. App. 2004); Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[296] *See generally* Wolpin, *supra* note 9; Greenough, *supra* note 118; Sontag, *Deported in Coma, Saved Back in U.S.*, *supra* note 8, at A1.

[297] *See* Kevin Sack, *Hospital Falters as Refuge for Illegal Immigrants*, N.Y. TIMES, Nov. 21, 2009, at A1, *available at* 2009 WLNR 23500485 (highlighting an Atlanta hospital's attempts to maintain a dialysis program for undocumented immigrants, and the challenges the dialysis patients experienced attempting to find care elsewhere); Cara Mia DiMassa, *Fines for Patient Dumping Supported: Hospitals Could Face Misdemeanor Charges and $25,000 Penalties If Plan Gets Final L.A. City Council Approval*, L.A. TIMES, May 15, 2008, at 3, *available at* 2008 WLNR 9140114; *see also* Greenough, *supra* note 118, at 503 (noting that payor limits place pressures on physicians to transfer all long-term ventilator patients without sufficiently weighing risks).

[298] Hunsinger, *supra* note 113 (manuscript at 10-11, 28).

pensated care, payment, and increased access to private insurance for non-citizens that will mitigate current incentives perpetuating hospital-initiated repatriations.

The practice of providing medical care to undocumented immigrants in the United States has been debated since the 1990s.[299] Given the complexity of the circumstances, it is clear that any solution that only targets the problem of repatriation itself will not resolve the underlying issues. There are economic and social pressures on Congress and federal policymakers to avoid providing funding to undocumented immigrants.[300] However, in practice, limiting funding does not make the problem go away. Comprehensive health care reform must take place in tandem with immigration reform, not separately. While it is not politically feasible for every individual to have free health care, there are more affordable and efficient ways to provide care for those who have no other option.

Immigrants generally under-use health care services in comparison to their representation in the population.[301] A variety of factors contribute to this phenomenon, including minimal access to insurance and fear of deportation.[302] One study estimates that sixty-eight percent of undocumented immigrants in Los Angeles County are uninsured, as opposed to their U.S. citizen (twenty-three percent uninsured) and LPR (thirty-eight percent uninsured) counterparts.[303] Immigrants are not entering the United States to get free medical care.[304] The most common incentive for moving to the United States is the disparity in wages and opportunities between an immigrant's home country and the United States.[305] This economic motivation may be highlighted when there is a correlation with the flow of immigrants and economic conditions.[306] However, many undocumented immigrants pay American payroll and social security taxes, yet may not participate in a government-sponsored health programs.[307]

---

[299] *See generally* Loue, *supra* note 290, at n.319.

[300] *See Shirley S. Wang,* The Health-Care Decision: *Winners and Losers in the Affected Industries*, WALL ST. J., Mar. 22, 2010, at A6; *see also* Julia Preston, *Congress Quarrels on Covering Immigrants*, N.Y. TIMES, Nov. 4, 2009, at A14, *available at* 2009 WLNR 22005192.

[301] *See* Stimpson et al., *supra* note 135, at 547; *see also* Goldman, *supra* note 27, at 1705-06.

[302] Park, *supra* note 136, at 581.

[303] Goldman, *supra* note 27, at 1703.

[304] Alexander Vivero Neill, *Human Rights Don't Stop at the Border: Why Texas Should Provide Preventative Health Care for Undocumented Immigrants*, 4 SCHOLAR 405, 429 (2002); Clark, *supra* note 171, at 254 (noting that most immigrants enter the United States for employment opportunities, not access to public benefits).

[305] Neill, *supra* note 304, at 413; *see also* Berk *supra* note 186, at 56.

[306] HOEFER, *supra* note 178, at 2 (describing the flow of immigration during the economic downturn in 2007-2009).

[307] Clark, *supra* note 171, at 254 n.143.

These individuals are functionally unable to participate in many aspects of society as a result of their undocumented status, despite their contribution to the workforce.

All hospital-initiated repatriations involve patients suffering from some catastrophic injury, coma, or other chronic conditions. Cancer treatment, preventative care, and costly elective procedures are not at issue in preventing repatriations, as there is currently no EMTALA duty to do anything more than provide care in cases of emergency medical conditions.[308] Increasing funding *carte blanche* would be politically and economically unfeasible, especially considering that there has not been funding for this type of uncompensated care since 2008.[309] However, hospitals need access to funding to at least avoid hospital-initiated repatriations.

Furthermore, some of this funding could be used to impose a requirement that less expensive long-term care facilities take patient transfers from hospitals. In the long-term, immigration reform should make it more feasible for all individuals to purchase at least catastrophic care insurance through their employers, or should establish pools for day laborers. This would create a private solution, covering individuals in emergency situations that seldom arise, but which impose high costs for hospitals. ICE and DHS would still have the power to enforce immigration policies, but hospitals and insurers would not be their source of information. Furthermore, individuals would not fear repatriation when deciding whether to seek emergency health care.

VII. CONCLUSION

To avoid the practice of private repatriation of indigent immigrants by hospitals, there are many factors that need to be taken into account, including: (1) hospitals' obligation under EMTALA to care for any individual seeking emergency care; (2) procedures for verifying patients' immigration statuses and their potential coverage under any federal funding scheme; 3) potential injuries from inadequate care in recipient facilities; and, 4) improper economic incentives created by current legislation. Many scholars have offered creative interim solutions, such as using asylum law to prevent repatriation, or creating reporting channels to legalize the deportations. However, the hospital-initiated repatriation problem will not be solved without explicit changes to EMTALA prohibiting private-repatriation. Furthermore, funding and enforcement efforts will have to expand in order to shift hospital incentives and eliminate variation among regions. Ultimately, immigration and health reform legislation should be coordinated to ensure that the basic human rights of any individual in the United States are protected, irrespective of her immigration status.

---

[308] *See* 42 U.S.C. § 1395dd (2006).

[309] *See Undocumented Immigrant Patients in LT-care Present Challenges to Hospitals*, *supra* note 26.