I. Introduction

II. Repatriation in Practice
   A. Prevalence
   B. Problem with Hospital-initiated Repatriation
   C. Case Law: Montejio v. Martin Memorial

III. Causes of the Repatriation Phenomenon
   A. Hospital’s Legal Duties under Federal Regulations
      1. EMTALA
      2. IRS 501(c)(3) – Tax Exemption for Charitable Organizations
   B. Lack of Funding and Enforcement of Duties
      1. Funding
      2. Enforcement
   C. State and Local Policies Affect Hospital Choices to Repatriate
   D. Misconceptions about Immigrant Health Care Consumption

IV. Immigration Law Background
   A. Removal Procedures
   B. Asylum as a Means of Legal Status or Relief from Deportation

V. Proposed Solutions
   A. Patients Can Apply for Asylum to Avoid Repatriation
   B. Hospitals Can Repatriate Indigent Patients Through the DHS and Thereby Ensure Due Process
   C. Amend EMTALA to Require Domestic Transfer

VI. Analysis and Alternatives to Currently Proposed Solutions
   A. Weaknesses of Currently Proposed Solutions
      1. Asylum Fails to Address Root Causes
      2. Hospitals Should Not Be Agents of DHS
   B. Important Factors Necessary to End Hospital-Initiated Repatriation

VII. Conclusion
Deported Before Dawn: Bridging Policy and Funding Gaps to Discourage Hospitals from Privately Repatriating Immigrant Patients

Kristie-Anne Padrón*

I. Introduction

“The measure of a country’s greatness should be based on how well it cares for its most vulnerable populations.”

- Mahatma Gandhi

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, privately repatriating3 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, either by plane or

---

* J.D. Candidate 2011, Boston University School of Law.
2 8 U.S.C. § 1103 (stipulating duties of Secretary of the Department of Homeland Security and the Attorney General in enforcing and administering immigration laws); see also Montejo v. Martin Memorial Med. Ctr. (Montejo I), 874 So. 2d 654 (Fla. 4th 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. 2d Dist. Ct. App. 1982) and 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.
6 Id. § 1395dd(g)-(h).
ambulance. Many American hospitals began repatriating patients to reduce costs of providing uncompensated care for uninsured patients who are ineligible for government aid because of their immigration statuses. Hospital-initiated repatriations are an increasingly common practice, particularly in states with high numbers of immigrants. There is even a company devoted to providing international hospital transfer services to American hospitals. A typical example of patient repatriation involves an uninsured, undocumented immigrant hospitalized for an emergency. Repatriation most often occurs when the immigrant requires extensive treatment or long-term care.

Several journalists have recently highlighted stories of hospitals’ repatriation practices across the United States. A Florida case in particular drew much attention in the national media—Montejo v. Martin Memorial Medical Center. Currently, these decisions are the only state or federal court decisions addressing claims for damages caused by hospital-initiated repatriation. 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. In 2003, the hospital

---

7 Sontag A, supra note 4.
9 Joseph Wolpin, Medical Repatriation of Alien Patients, 37 J.L. MED. & ETHICS 152, 152 (2009). There is little documentation of the exact numbers of patients that are being repatriated. Different articles have estimated, through anecdotal information, that hospitals have been repatriating several hundred individuals yearly. Wolpin, supra note 9 at 152; See e.g., Sontag A, supra note 4; Sontag B, supra note 8.
11 See Wolpin, supra note 9 at 152-53.
12 Id.
13 Sontag A, supra note 4; see also Sontag B, supra note 8.
15 See Stead, infra note 215 at 10.
16 Montejo I, 874 So. 2d at 656.
treated Jiménez privately transported him to Guatemala despite the fact Jiménez was never subject to any federal removal proceeding.17

The Florida Court of Appeals ruled in favor of Montejo in 2004, reversing the Probate Court 2003 decision in 2003 that allowed Martin Memorial to transfer Jiménez, but that there was no additional remedy at law.18 They found that the Probate Court was preempted by federal law and lacked subject matter jurisdiction to permit Jiménez’s transfer.19 In 2006, the same court heard Montejo’s claims against Martin Memorial for false imprisonment of his cousin.20 The court ruled favorably and remanded the case to trial, yet on remand the jury did not grant any remedy to Montejo.21 Montejo’s cousin, Jiménez remained in Guatemala, and due to severe brain injuries resulting from the car accident, he still requires long-term intensive medical treatment, including treatment for seizures.22

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 Medicare23 and Medicaid.24 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.25 Compounding this problem is the fact that

17 Id. at 656-657.
18 Id. at 656.
19 Id. at 658.
20 Montejo II, 935 So. 2d at 1268.
21 Id. at 1272; see also Deborah Sontag, Jury Rules for Hospital That Deported Patient, N.Y. TIMES, July 28, 2009, at A10, available at 2009 WLNR 14466883 [hereinafter Sontag C].
22 Montejo I, 874 So. 2d at 656.
24 Grants to States for Medical Assistance Programs, Social Security Act, 42 U.S.C §§ 1396-1396(v) (2010).
25 Undocumented Immigrant Patients in LT-care Present Challenges to Hospitals, MED. ETHICS ADV. available at 2009 WLNR 16709571. See Sontag A, supra note 4; Sontag B, supra note 8; Judith Graham & Deanese Williams-
many patients are afraid or are unable to purchase private insurance because of their legal
status. Hospital-initiated repatriations do not actually solve the conflicts between patients,
hospitals, and governments; instead, it allows hospitals to temporarily reduce costs and avoid
EMTALA liability.

This Note examines the problems generated by and the legal implications of private
repatriation and discusses 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 repatriation creates. 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, including the rights to due process, appeal, and other forms of relief 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 disincentivize
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 reduction and elimination of the humanitarian
concerns private repatriations raise.

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 1562868.
26 See Dana P. Goldman, James P. Smith & Neeraj Sood, Immigrants and the Cost of Medical Care, 25 Health
II. Repatriation in Practice

A. Prevalence

Repatriations are taking place not only in border states, but also all over the country.\(^\text{27}\) Repatriations like Jiménez’s are common.\(^\text{28}\) For example, St. Joseph’s Hospital in Phoenix, Arizona repatriates an average of ninety-six patients yearly.\(^\text{29}\) Other hospitals are less prolific, 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 summer of 2008 a Chicago hospital repatriated ten patients to Honduras.\(^\text{30}\)

B. Problems with Hospital-initiated Repatriations

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 at a hospital.\(^\text{31}\) Hospital-initiated repatriation poses an additional problem in that it involves quasi-state action by non-state actors.\(^\text{32}\) Hospitals provide no process and minimal information, and patients often lack legal recourse against hospital-initiated repatriation unless someone intervenes before removal.\(^\text{33}\) Furthermore, some patients (or their guardians) are unaware of their own legal status and may accept transfer or repatriation without knowing their rights.\(^\text{34}\) With such minimal information, hospitals can thus

---

\(^\text{27}\) Sontag B, supra note 8 (discussing patient facing repatriation to China); Graham & Wiliams-Harris, supra note 25 (illustrating range of locales facing repatriation challenge).

\(^\text{28}\) See Wolpin, supra note 9 at 152 (estimating hundreds of hospital-initiated repatriations annually, the majority to Latin America).

\(^\text{29}\) Sontag A, supra note 4.

\(^\text{30}\) Id.

\(^\text{31}\) See 42 U.S.C. § 1395dd(h).

\(^\text{32}\) See infra part IV(A) for a discussion of the immigration procedures that immigrants are entitled to when facing removal.

\(^\text{33}\) See Sontag B, supra note 8.

\(^\text{34}\) Id.
easily wrongfully repatriate a legal immigrant or United States citizen.\textsuperscript{35} 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.\textsuperscript{36} Finally, repatriation poses a permanent bar to health care access.\textsuperscript{37} An American homeless individual prematurely discharged from a hospital and left on the streets can likely still seek emergency medical care quite easily; however, an individual removed to another country will not likely be able to do the same.\textsuperscript{38}

One case in particular illustrates the problem of lack of information and hospital authority. Antonio Torres, an uninsured \textit{lawful permanent resident} (“LPR”),\textsuperscript{39} was hospitalized at St. Joseph’s hospital in Phoenix, Arizona for injuries sustained in a car accident.\textsuperscript{40} The hospital staff convinced Torres’ family toauthorize transfer of Torres to an emergency room in Mexico, promising a hospital bed and care upon arrival.\textsuperscript{41} Once in Mexico, Torres found himself on a gurney in an emergency room hallway with little care and a worsening infection.\textsuperscript{42} Ultimately, Torres’ 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.\textsuperscript{43} St. Joseph’s administrators were in large part motivated to repatriate Torres because of reimbursement concerns and their general policies towards uncompensated

\footnotesize {\textsuperscript{35} Id.  
\textsuperscript{36} Id. \textit{See also} Johnson, infra note 230 at 33-34 (“There is not 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.”).  
\textsuperscript{37} \textit{See} Sontag B, supra note 8 (illustrating that immigrants are unable to find their way back to the same level of health care they received in the United States).  
\textsuperscript{38} Id.  
\textsuperscript{39} \textit{See} 8 U.S.C. § 1101(a)(20) (defining a Lawful Permanent Resident as having “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.”).  
\textsuperscript{40} Sontag B, supra note 8.  
\textsuperscript{41} Id.  
\textsuperscript{42} Id.  
\textsuperscript{43} Id.}
Although Torres had legal status, St. Joseph’s was likely unable to be reimbursed for his care because LPRs need five years of legal residency to qualify for Medicaid coverage.\textsuperscript{45}

Not all attempted repatriations of legal immigrants and U.S. citizens are completed.\textsuperscript{46} There have been several close calls requiring legal intervention to prevent the removal of a person rightfully in the United States.\textsuperscript{47} In one case, a U.S. citizen infant, Elliott Bustamante, was born at a Tucson, Arizona hospital with Down’s Syndrome and a heart defect requiring neonatal intensive care.\textsuperscript{48} Elliot’s parents were undocumented and had little recourse for the hospital’s attempts to remove their child to a hospital in Mexico.\textsuperscript{49} The Mexican consulate referred Elliot’s parents to an attorney; however, the hospital arranged to transfer Elliot to a Mexican hospital and transported the child to the airport before the family had a chance to intervene.\textsuperscript{50} Ultimately, police intervened and stopped the plane from departing with Elliott. Thereafter, Elliot received treatment in Arizona, and Arizona Medicaid ultimately covered some of costs associated with Elliot’s care.\textsuperscript{51}

Deborah Sontag, a journalist for the New York Times, reported a situation in 2008 in which St. Joseph’s Hospital in Phoenix, Arizona attempted to send a woman named Sonia del Cid Iscoa to Honduras because Iscoa was in a coma and uninsured.\textsuperscript{52} Iscoa was a legal immigrant residing in the United States for many years and had seven American-born children.\textsuperscript{53} Legal advocates were able to negotiate with the hospital, prevent Iscoa’s removal, and maintain the care she

\textsuperscript{44} Id.
\textsuperscript{45} Id.
\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Id.
\textsuperscript{49} Id.
\textsuperscript{50} Id. In addition to transfer attempts, the Tucson hospital also sought to have the sick child removed as a “trespasser” and continued trying to transfer the child until Medicaid payment was assured. Id.
\textsuperscript{51} Id.
\textsuperscript{52} Sontag A, supra note 4.
\textsuperscript{53} Id.
needed to come out of her coma.\textsuperscript{54} While this example is not as dramatic as others, it shows that hospitals will have a bias against treating uninsured \textit{legal} immigrants while repatriation is an option. It is likely that Iscoa’s care would have been reimbursable at least in part under Emergency Medicaid, even if she herself were not qualified for Medicaid coverage.\textsuperscript{55} Under EMTALA, uninsured American citizens requiring life-sustaining care cannot be dumped on the street or sent to another country, but because Iscoa had been born in another country, the hospital thought transfer would be more affordable than provision of charity care.\textsuperscript{56}

C. Case Law: Montejo v. Martin Memorial

The Florida Court of Appeals is the only jurisdiction to have addressed the legality of hospital-initiated repatriation.\textsuperscript{57} Montejo sought relief for Jiménez’s transfer to Guatemala\textsuperscript{58} as well as damages for false imprisonment.\textsuperscript{59} Martin Memorial, bound by EMTALA transfer policies,\textsuperscript{60} sought to have him moved to a lower-cost facility, but found few that would accept an uninsured patient ineligible for federal programs.\textsuperscript{61} Martin Memorial finally was able to transfer Jiménez into a rehabilitative center paid for by Martin.\textsuperscript{62} However, Jiménez did not receive appropriate services there, resulting in repeated emergency hospitalizations for complications and bedsores.\textsuperscript{63} Although therapy and follow up care likely would have improved Jiménez’s condition, due to limited rehabilitation and frequent seizures, he currently has the mental capacities of a young child.\textsuperscript{64}

\textsuperscript{54} Id.
\textsuperscript{55} Id.
\textsuperscript{56} Id.
\textsuperscript{57} See Stead, \textit{infra} note 215 at 4.
\textsuperscript{58} Montejo v. Memorial Med. Ctr. (\textit{Montejo I}), 874 So. 2d 654, 658 (Fla. Dist. Ct. App. 2004).
\textsuperscript{59} Montejo v. Martin Memorial Med. Ctr. (\textit{Montejo II}), 935 So. 2d 1266, 1268 (Fla. Dist. Ct. App. 2006).
\textsuperscript{60} See 24 C.F.R. § 482.43(d). \textit{See also} discussion \textit{infra} Part III.A.1 (defining EMTALA transfer duties).
\textsuperscript{61} \textit{Montejo I}, 874 So. 2d at 656. \textit{See also} Sontag A, \textit{supra} note 4.
\textsuperscript{62} See Sontag A, \textit{supra} note 4.
\textsuperscript{63} Id.
\textsuperscript{64} Id.
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.\(^{65}\) The intoxicated driver causing Montejo’s injuries was uninsured and judgment proof.\(^{66}\) The probate court approved the transfer.\(^{67}\) 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.\(^{68}\) 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.\(^{69}\) Since his relocation to Guatemala, Jiménez has not received adequate care or rehabilitation, and suffers from many effects of his injuries.\(^{70}\)

Montejo brought his claims under Florida law, not under EMTALA.\(^{71}\) In the proceedings on behalf of Jiménez, the Court of Appeals addressed two separate claims, one in 2004 and one in 2006.\(^{72}\) In 2004, the Florida Court of Appeals addressed a claim appealing the probate court’s decision to allow the hospital to repatriate Jiménez.\(^{73}\) The court found that there was “no

---

\(^{65}\) Montejo I, 874 So. 2d at 656; Sontag A, supra note 4; See also Stead infra note 215 at 2-3 (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) (on file with author)).


\(^{67}\) Stead, infra note 215 at 2-3 (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) (on file with author)).

\(^{68}\) Montejo v. Martin Mem’l Med. Ctr. (Montejo II), 935 So. 2d 1266, 1267-68 (Fla. Dist. Ct. App. 2006) (noting that the probate court had ordered Montejo to file its response motion by 10:00 a.m. but that Jiménez was transferred before 7:00 a.m. that same morning).

\(^{69}\) Montejo I, 874 So. 2d at 656-57; Sontag A, supra note 4.

\(^{70}\) Sontag A, supra note 4 (documenting the conditions of Jiménez’s care in Guatemala, where he has little access to medical attention or medications, and lives with seizures causing further brain injury).

\(^{71}\) See Montejo v. Martin Mem’l Med. Ctr. (Montejo I), 874 So. 2d. 654 (Fla. 4th Dist. Ct. App. 2004) (appealing 2003 Probate Court decision); Montejo v. Martin Mem’l Med. Ctr. (Montejo II), 935 So. 2d 1266 (Fla. 4th Dist. Ct. App. 2006) (bringing claim for false imprisonment, as well as compensatory and punitive damages).

\(^{72}\) See supra note 71.

\(^{73}\) Montejo I, 874 So. 2d at 656. The probate court found that Martin Memorial may not have been able to provide long term care necessary for Jiménez, but asked for a motion from his guardian, Montejo, for a stay. See Stead, infra note 215 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) (on file with author)). Martin Memorial transferred Jiménez by plane to Guatemala the very next morning before the Judge had the opportunity to hear Montejo’s petition. Montejo I, 874 So. 2d at 656-657.
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 or removal) of Jiménez to Guatemala.” The court found for Jiménez, but considering that 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.

In 2006, the Court of Appeals addressed a private tort claim against the hospital for false imprisonment for which Montejo sought compensatory damages for Jiménez’s future health care costs resulting from his injuries and punitive damages. In deciding Montejo’s claims for false imprisonment, the court considered whether: 1) the unlawful detention of Jiménez 2) against his will 3) without legal authority 4) was unreasonable and unwarranted under the circumstances. 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.

On remand for the false imprisonment claims, Montejo’s claims on Jiménez’s behalf did not result in any liability for Martin Memorial, as the jury made a finding of fact that the transfer was not “unreasonable and unwarranted under the circumstances.” 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. Alternatively, some have argued that the Montejo

---

74 *Montejo I*, 874 So. 2d. at 658.
75 *Montejo I*, 874 So. 2d at 658. *See also* Stead *infra* note 215 at 12 (noting that Jiménez lost his right to return for ten years under 8 U.S.C. § 1182(a)(9)(B)(i)(II) (2006)).
76 *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).
77 *Montejo II*, 935 So. 2d 1266 at 1268 (stating the elements necessary for a plaintiff to establish a false imprisonment claim).
78 *Id.* at 1272.
79 Sontag C, *supra* note 21; *see also* MED. ETHICS ADV., *supra* note 25 (discussing the implications of the jury’s findings on Martin Memorial, the defendant and the hospital industry as a whole)
80 *See e.g.*, Lori A. Nessel, *On the Legality and Ethics of Medical Repatriation, 2009 EMERGING ISSUES 4404, (Oct. 6, 2009) (seeming to “signal a green light to similarly situated hospitals debating whether to forcibly repatriate uninsured immigrants.”); MED. ETHICS ADV., *supra* note 25 (quoting Carla Luggiero, of the American Hospital
case has drawn attention to the repatriation phenomenon and the policy issues that emerge from the practice.\textsuperscript{81} The Florida Court of Appeals explicitly stated that state courts do not have jurisdiction in immigration decisions and that hospitals are not entitled to qualified immunity.\textsuperscript{82} Thus, it is possible that the Court of Appeals’ 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 within 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.\textsuperscript{83} Additionally, hospitals are expected to be indiscriminate in accepting patients into their emergency rooms, particularly as to indigent or Medicaid patients.\textsuperscript{84} In addition to federal regulations, hospitals have state-imposed and common law duties to patients.\textsuperscript{85} Requirements Under Federal Regulations

1. EMTALA

The most relevant medical regulation concerning hospital repatriations is the EMTALA.\textsuperscript{86} Congress passed EMTALA in 1986 to prevent patient dumping.\textsuperscript{87} Patient dumping

\begin{footnotesize}
\begin{itemize}
\item[81] Nessel, supra note 80 (postulating that California Medical Association and the American Medical Association have come to address the issue as a result of this case).
\item[82] Id.
\item[83] See 26 U.S.C. § 501(c)(3); 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).
\item[84] See 42 U.S.C. § 1395dd; see also 26 U.S.C. § 501(c)(3).
\end{itemize}
\end{footnotesize}
involves discharging patients in need of care because they lack funds to pay for treatment.\textsuperscript{88} 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.\textsuperscript{89} During the 1980’s, uninsured and homeless persons were often discharged back to the street without having received adequate care.\textsuperscript{90}

To combat this practice, Congress created EMTALA, specifying duties for hospitals to screen and stabilize any patient entering a hospital’s emergency room.\textsuperscript{91} Additionally, EMTALA stipulates that hospitals must provide either “such treatment as may be required to stabilize the [patient’s] medical condition” or “transfer of the individual to another medical facility.”\textsuperscript{92} Hospitals’ duties under EMTALA extend to all patients, regardless of ability or inability to pay.\textsuperscript{93} A hospital must evaluate and stabilize the patient before asking for any information with regards to payment.\textsuperscript{94} Hospitals that receive Medicare or Medicaid reimbursement\textsuperscript{95} are bound to treat a

\begin{flushleft}

\textsuperscript{88} Bera, \textit{infra} note 154 at 616-617.


\textsuperscript{90} See Dame, \textit{supra} note 87 at 6. EMTALA is generally protective of patient’s rights, however, many argue that there are insufficient enforcement capabilities available. See generally Regehr, \textit{infra} note 105; Bera, \textit{supra} note 154.

\textsuperscript{91} 42 U.S.C. § 1395dd (a) (“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.

\textsuperscript{92} Id. § 1395dd(b)(A)-(B).

\textsuperscript{93} Id. § 1395dd(g)-(h) (stipulating “non-discrimination” and “[n]o 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).

\textsuperscript{94} Id.

\textsuperscript{95} See 42 U.S.C. § 1395cc(a)(1)(I) (“Any provider of services (except a fund designated for purposes of section 1395(f) 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).
\end{flushleft}
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.”

EMTALA’s transfer provision has substantial implications for repatriations. Before a patient can be transferred, the treating facility must ensure that the patient is sufficiently stable and that the receiving institution is capable and willing to treat the patient. 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. EMTALA does not explicitly require any non-emergency facilities to accept transfers; EMTALA duties apply only to the first hospital treating the individual. 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. In practice, if no transfer facility is willing to accept the patient, then a hospital is duty-bound to provide indefinite life-sustaining care.

Unfortunately, EMTALA has not been effective in preventing patient dumping of American citizens. The indigent, the mentally ill and the homeless are still particularly

---

96 42 U.S.C. § 1395dd(c).
97 42 C.F.R. § 489 (explaining emergency care and stabilization requirements); 42 C.F.R. § 482.43 (delineating discharge requirements).
99 42 U.S.C. § 1395dd(c).
100 Id.
101 Id. § 1395dd(e) (designating that a transfer recipient entity must be willing to accept the patient).
102 Sontag A, supra note 4.
susceptible to being discharged without receiving adequate care.\textsuperscript{104} Although both private and not-for-profit hospitals receive federal Medicaid reimbursements,\textsuperscript{105} private (both for-profit and not-for-profit) hospitals often transfer indigent emergency room patients to larger, public hospitals to avoid paying for their care.\textsuperscript{106} Other hospitals have employed the repatriation methods to remove high-cost immigrant indigent patients.\textsuperscript{107}

In practice, it is unknown whether medical repatriation to a different country actually fulfills hospitals’ transfer duties to indigent patients.\textsuperscript{108} While EMTALA does not specify that it must be a domestic facility, it does establish required factors such as “the medical benefits . . . at another medical facility outweigh the increased risk to the individual . . . from effecting the transfer.”\textsuperscript{109} Furthermore the receiving hospital must have “available space and qualified personnel.”\textsuperscript{110} It seems unlikely that many of the facilities that hospitals are sending immigrant patients to would actually reach these levels.\textsuperscript{111} Some have documented that even domestic transfers often result in higher mortality rates.\textsuperscript{112}

Since EMTALA often fails to meet the needs of those Congress intended to protect, those that are extremely vulnerable—such as those lacking immigration status—are left with

\textsuperscript{104} Off the Street?, supra note 103.
\textsuperscript{106} Id. at 183 (citing Brian A. Liang, Health Law & Policy: A Survival Guide to Medicolegal Issues for Practitioners, 205 (2000).
\textsuperscript{107} See supra parts II.A-II.B (discussing prevalence and practice of repatriation).
\textsuperscript{108} See Stead, infra note 215; Johnson, infra note 230; Hunsinger, infra note 255. 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.
\textsuperscript{109} 42 U.S.C. § 1395dd(c)(1)(A)(ii).
\textsuperscript{110} Id. § 1395dd(c)(2)(B)(i).
\textsuperscript{111} See generally, Hunsinger, infra note 255; see also Med Ethics, supra note 25 (quoting interview with William Greenough, MD) (the only way to know about the quality of care- and the likelihood of survival of a patient about toe be . . . repatriated . . . is to have data about the hospital in the country to which the patient is being referred.”
\textsuperscript{112} Med ETHICS, supra note 25 (quoting interview with William Greenough, MD stating that the baseline state criteria to allow transfer are ineffective, as he has been tracking transferred patients and has found that technically qualified as stable have higher mortality rates); see also William Greenough, Clinical Case: Treating and Repatriating: An Unacceptable Policy, 11 AM. MED. ASSOC. J OF ETHICS 502, 503 (2009) (discussing the ethical dimensions of transferring an unstable indigent patient).
little recourse.\textsuperscript{113} Many have found that EMTALA largely ineffective, not because of its provisions but because of insufficient enforcement and funding.\textsuperscript{114}

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.\textsuperscript{115} To qualify as a charitable organization, a hospital must be formed for charitable purposes and operate as such.\textsuperscript{116} As part of the “charitable purposes” requirement, hospitals are generally required to provide an unspecified amount of community benefit.\textsuperscript{117} There are no fixed percentages or levels of charitable cases hospitals must accept free of charge.\textsuperscript{118} Furthermore, there is no reimbursement available for this care under the tax code;\textsuperscript{119} however, not-for-profit hospitals can ostensibly 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.\textsuperscript{120}

B. Lack of Funding and Enforcement of Duties

1. Funding

EMTALA requires that hospitals provide services for anyone requiring emergency care, but has no mechanism to ensure hospitals can comply while remaining financially solvent.\textsuperscript{121} In particular, not-for-profit hospitals face increasing demands for uncompensated care, minimal or nonexistent reimbursement for care provided, and private hospital transfers of indigent patients

\begin{itemize}
  \item \textsuperscript{114} See supra part III.B (detailing EMTALA’s funding and enforcement problems).
  \item \textsuperscript{115} See 26 U.S.C. § 501(c)(3). The charitable organization must be organized and operated for charitable purposes and the earnings of the organization must not be inured to private interests. \textit{Id.}
  \item \textsuperscript{116} See \textit{Id.}
  \item \textsuperscript{118} \textit{Id.}
  \item \textsuperscript{119} See 26 U.S.C. § 501(c)(3) (tax exemption requires charitable purpose but provides no reimbursement for any costs of charitable activities).
  \item \textsuperscript{120} \textit{Id.}
\end{itemize}
to public hospitals. Thus, many scholars have identified underfunding as EMTALA’s primary issue. Furthermore, changes in social welfare schemes limited personal Medicaid insurance coverage and have thereby made hospitals rely on federal funding for uncompensated care reimbursement.

Passed in 1996, the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") dictates how individuals can qualify for Medicaid, limiting the compensation available for hospitals caring for both legal and undocumented immigrants. PRWORA largely limited access to Medicaid coverage for many low-income individuals including permanent residents and the undocumented population. Medicaid is funded by both state and federal funding, so the federal statute creates some general restrictions, but allows states discretion in certain components of their Medicaid program. Under Medicaid, a state can create programs that cover certain undocumented immigrants, including children and pregnant women.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") and the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 ("IIRIRA") dictate the way that welfare and Medicaid funding for all persons, including immigrants, works in the United States. While states have the right to distribute state funds to provide coverage or services to undocumented immigrants, there is no longer any federal

---

122 Id. at 158.
123 See e.g., Regehr, supra note 105 at 182-183 (2008); Lebedinski, supra note 121 at 89.
124 See generally Mahmoudzadeh, supra note 113.
125 Morgan Greenspon, The Emergency Medical Treatment and Active Labor Act and Sources of Funding, 17 ANNALS HEALTH L. 309, 313 (2008).
126 See generally Mahmoudzadeh, supra note 113.
127 See 42 U.S.C. § 1396a(10)(a)(i) (stipulating required groups that must be covered under State Medicaid schemes).
128 See Id. § 1396d (providing for optional groups that states can choose to cover provided they don’t exceed certain income requirements; see also Jim P. Stimpson, Fernando A. Wilson and Karl Eschbach, Trends in Health Care Spending for Immigrants in the United States, 29 HEALTH AFFAIRS 544, 544 (2010).
131 Mahmoudzadeh, supra note 113 at 470-471.
Medicaid funding for undocumented immigrant hospitalizations.\textsuperscript{132} Even lawful permanent residents are generally exempt from federally funded programs and may be covered if they meet certain residency requirements before they can establish their eligibility for Emergency Medicaid funding, depending on the state in which they live.\textsuperscript{133} Many scholars have argued that PRWORA and IIRIRA make it impossible for hospitals to meet their EMTALA duties and provide adequate care to immigrants.\textsuperscript{134} Congress enacted further barriers under the Deficit Reduction Act (“DRA”) of 2005, which implemented new identification requirements for all Medicaid recipients, reducing Medicaid enrollment in many states.\textsuperscript{135}

While PWRORA, IRIRA and the DRA were intended to disincentivize immigration by preventing individual immigrants from seeking federal welfare or health care benefits, the Medicare Modernization Act (“MMA”) of 2003\textsuperscript{136} designated federal funding for hospitals providing uncompensated emergency care to undocumented aliens.\textsuperscript{137} This scheme designated $250 million per year for four years to compensate hospitals that provide care to undocumented aliens.\textsuperscript{138} The MMA’s 2003 scheme granted states funding roughly in proportion to their undocumented immigrant population numbers.\textsuperscript{139} Specifically, the MMA provided

\textsuperscript{132} Id. at 471 (citing 8 U.S.C.A. § 1612 (a)(1), (3)(2001)).
\textsuperscript{133} 8 U.S.C. § 1612; see also Mahmoudzadeh, supra note 113 at 468 (citing Seam Park, Comment, Substantial Barriers in Illegal Immigrant Access to Publicly-funded Health Care: Reasons and Recommendations for Change, 18 GEO. IMMIGR. L.J. 567, 573-574 (2004)).
\textsuperscript{134} See Regehr, supra note 105 at 182-183; Lebedinski, supra note 89; See generally Mahmoudzadeh, supra note 113.
\textsuperscript{137} Johnson, infra note 230; Greenspon, supra note 125 at 309, 314.
\textsuperscript{138} § 1011 (a)(1), 117 Stat. 2432.
\textsuperscript{139} 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; Texas: $ 44.4 million. See Center for Medicare and Medicaid Services, FY 2008 State Allocations for Section 1011 of the Medicare Modernization Act available at http://www.cms.hhs.gov/UndocAliens/downloads/fy08_state_alloc.pdf (referring to funding available
supplementary funding to the six states with the most undocumented residents seeking care.\textsuperscript{140} However, even with these funds, the MMA did not provide sufficient funding to subsidize the uncompensated care that many hospitals were forced to either absorb or pass on to other patients.\textsuperscript{141}

However, one of the greatest problems with the MMA was the federal government’s inability to assess the numbers of undocumented immigrants seeking care.\textsuperscript{142} Furthermore, available funds were difficult for hospitals to receive because the requirements were too complex.\textsuperscript{143} Despite its flaws, the MMA did provide a source of funding and recognized that underfunding problems existed under the EMTALA; however, this source of funding ended completely in 2008 when the funding scheme expired.\textsuperscript{144}

EMTALA cannot effectively improve patient care without adequate subsidies or funding.\textsuperscript{145} Scholars have suggested alternatives options to EMTALA, including funding preventative care to incentivize treatment of patients before emergency services are needed, thus avoiding the high costs of emergency care.\textsuperscript{146} This type of proposal is intended to avoid unequal distributions of low-cost preventative care, which would likely reduce the burdens on any single hospital or provider.\textsuperscript{147}

\begin{footnotesize}
\begin{itemize}
\item[\textsuperscript{141}] § 1011 (b), 117 Stat. 2432. This calculus is based on the DHS’s “undocumented alien apprehensions” for each state. \textit{Id.}
\item[\textsuperscript{142}] \textit{Id.} at 171-72.
\item[\textsuperscript{143}] \textit{Id.} at 171-72.
\item[\textsuperscript{144}] \textit{Id.} See also FY 2008 State Allocations, \textit{supra} note 139.
\item[\textsuperscript{145}] \textit{Id.} See \textit{MED. ETHICS ADV.}, \textit{supra} note 25.
\item[\textsuperscript{146}] \textit{Id.} at 198.
\item[\textsuperscript{147}] \textit{Id.}
\end{itemize}
\end{footnotesize}
2. Enforcement

EMTALA can be enforced through private action as well as government sanctions.\(^{148}\) Wronged individuals can bring civil actions for personal injuries against hospitals violating EMTALA.\(^{149}\) Private rights of action are limited in scope in that EMTALA only allows a private cause of action against hospitals (as opposed to physicians) and requires that applicable state personal injury law apply to the suit.\(^{150}\) As such, courts have only enforced EMTALA in a limited way to avoid unnecessary expansion into traditional state jurisdiction.\(^{151}\) Furthermore, there is no federal remedy for discrimination against a patient based on her ability to pay, unless the patient suffers physical harm.\(^{152}\)

Government sanctions for EMTALA violations include monetary fines as well as the potential for Medicare reimbursement denial.\(^{153}\) However, the Department of Health and Human Services ("HHS") does not consistently or sufficiently enforce EMTALA.\(^{154}\) Under EMTALA’s enforcement provision, the HHS Secretary must consult with a peer review board, which conducts a sixty-day investigation before initiating sanctions against a hospital.\(^{155}\) Furthermore, full EMTALA sanctions are often unenforced because removing Medicare funding from a large hospital would exacerbate medical care shortages.\(^{156}\)


\(^{150}\) Id; See also Bluestone, supra note 148 at 2854-55.

\(^{151}\) See Bera, infra note 154 at 637.

\(^{152}\) Bluestone, supra note 148 at 2863-2864 (attributing federalism issues as well federal court overload as reasons why Congress would want to avoid a federal malpractice statute).


\(^{154}\) Wendy W. Bera, Preventing "Patient-Dumping": The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA, 36 HOUS. L. REV. 615, 616 (1999).

\(^{155}\) 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.

\(^{156}\) Bluestone, supra note 148 at 2855-56 (discussing the merits of private remedies instead of HHS enforcement).
Another possible problem with implementing EMTALA is insufficient physician accountability in the process of transferring patients. 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. Additionally, physicians who are on call but refuse to appear are not liable under EMTALA. EMTALA currently allows private actions against hospitals or institutions, but not the treating physician. To remedy this problem, scholars have suggested expanding the right of private action under EMTALA to include individual physicians. This would create additional deterrents for individual doctors who inappropriately allow the hospital to transfer a patient. Since doctors must approve a transfer, it is possible that personal accountability and increased compensation for EMTALA violations could also alleviate the repatriation problem. Physicians also have duties to patients under the Hippocratic oath. Even without EMTALA, it is likely that many hospitals and physicians would still have a duty to any patient presenting for care at an emergency room.

157 Id. at 2866.
158 42 U.S.C. §§ 1395dd(d)(1)(B)i-ii.
159 Id. § 1395dd(d)(1)(C).
160 42 U.S.C. § 1395dd (d)(2) (“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)).
161 Bluestone, supra note 148 at 2866.
162 Id. at 2852.
163 Id. at 2866, See also § 1395dd(b)(1)(B).
164 Bluestone, supra note 148 at 2866.
166 Greenough, supra note 112 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 Hospital Choices to Repatriate

State choice often results in disparate services and access to health care programs depending on the policies and revenue base of the state.\(^{167}\) Each individual state has limited discretion in how it uses and supplements its federal Medicaid funding.\(^{168}\) In 1996 PRWORA placed many limits on the ways states can use federal Medicaid funds, which can attribute up to sixty percent of the total Medicaid program budget, depending on the state.\(^{169}\) PRWORA particularly limited access available to undocumented immigrants and LPRs living in the United States.\(^{170}\) However, states retained discretion in some areas, particularly how they would use the state-contributed funding in their Medicaid program.\(^{171}\) Programmatic choices even vary on the local level, as some states have granted counties and cities discretion in individual eligibility for public health programs.\(^{172}\)

As a result, hospital administrators in different locales have vastly different outlooks on the need for repatriation.\(^{173}\) 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.”\(^{174}\) Starkly different, the administrators at El Centro Regional Medical Center in California never send an

\(^{167}\) See Stead, infra note 215 at 8.
\(^{168}\) See supra part III.C and accompanying text for an explanation of federal and state choices in Medicaid disbursement. See also Mahmoudzadeh, supra note 131 at 471-472; Stead, infra note 215 at 8.
\(^{171}\) Id. § 1621 (d) (2010).
\(^{172}\) Okie, supra note 135 at 526 (discussing variety of local policies towards compensating undocumented immigrant health care).
\(^{173}\) Sontag B, supra note 8.
\(^{174}\) Id. See also Ariz. Rev. Stat. § 36-2903.03 (Lexis 2010) (specifying Arizona’s eligibility requirements for health welfare programs).
immigrant back to their country of origin. California hospitals generally face higher rates of uncompensated care than do other states, due to larger populations of undocumented immigrants. However, some areas in California, among other states, has made funding available for emergency treatment of even undocumented immigrants, thus creating a system in which hospitals face less financial pressure in treating emergency cases.

Treatment disparities may be the result of different approaches of hospital administrators, varied state choices regarding funding allocation, or different regions’ political and cultural views on undocumented immigrants. There seem to be more hospital-initiated repatriations in areas where “hostility toward illegal immigrants is high and state financing for their care is low.” States’ discretion in allocating funds for immigrant’s 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.

D. Misconceptions about Immigrant Health Care Consumption

It is important to note that funding immigrant health care is not as expensive as some would imply. Immigrants of all statuses tend to underutilize medical care when compared to
their relative representation in the US population.\textsuperscript{182} Some of the factors causing under-consumption likely include fear of immigration enforcement, underinsurance, and language differences.\textsuperscript{183} If extended access to Medicaid coverage, immigrants would be less expensive to cover at their present levels of consumption, but this would only be the case if consumption levels remain stable. It is likely that immigrants would consume more health care if they had access to insurance coverage, federal benefits or didn’t feel fear in seeking medical care. As this data illustrates, contrary to popular perception, immigrants are not the main contributors to the current cost problems in the American health care system.\textsuperscript{184} Furthermore, many have shown that undocumented immigrants generally contribute more to the public benefits system than they consume.\textsuperscript{185}

\textbf{IV. Immigration Law Background}

Immigration enforcement is the duty of the federal government.\textsuperscript{186} The Department of Homeland Security (“DHS”) estimates that, as of January 2009, there were 10.8 million undocumented immigrants residing in the United States.\textsuperscript{187} The DHS later concluded that the number of undocumented immigrants living in the United States decreased in 2009; however, the number of illegal immigrants steadily increased during the previous decades.\textsuperscript{188} The largest

\begin{footnotesize}
\begin{enumerate}
\item[\textsuperscript{182}] Dana P. Goldman, James P. Smith & Neeraj Sood, Immigrants and the Cost of Medical Care, 25 HEALTH AFFAIRS 1700, 1710 (2006).
\item[\textsuperscript{183}] Id.
\item[\textsuperscript{184}] See e.g., Stimpson, supra note 128 at 550; see also Clark supra note 169 at 254; Berk et al., Health Care Use Among Undocumented Latino Immigrants: Is Free Health Care the Main Reason Why Latinos Come to the United States?, 19 HEALTH AFF. 51, 61 (2000).
\item[\textsuperscript{185}] See e.g., Clark, supra note 169 at n. 143.
\item[\textsuperscript{186}] 8 U.S.C. § 1103; 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), as amended by the Homeland Security Act of 2002, P.L. 107-296, 116 Stat. 2135 (codified as amended in scattered sections of 6 U.S.C.).
\item[\textsuperscript{187}] Hoefer et al., supra note 176 at 2.
\item[\textsuperscript{188}] Id. at 7 (reporting that the population was estimated at 11.78 million in 2007).
\end{enumerate}
\end{footnotesize}
population of undocumented workers in the United States is of Mexican origin.\textsuperscript{189} The states with the largest number of undocumented populations are California, Texas, Florida, New York, and Illinois.\textsuperscript{190} Arizona, a state known for its repatriation practices and strong anti-immigrant policies, has an estimated population of 460,000 undocumented immigrants.\textsuperscript{191} In comparison, an estimated 2.6 million undocumented immigrants live in California, and yet California has much friendlier policies towards undocumented immigrants than Arizona.\textsuperscript{192} As discussed above,\textsuperscript{193} 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.\textsuperscript{194}

A. Removal Procedures

If the DHS brings an action against an undocumented immigrant, it is likely through Immigration and Customs Enforcement ("ICE"), a federal agency under the DHS.\textsuperscript{195} Removal (commonly known as deportation) is generally considered a harsh legal consequence requiring due process.\textsuperscript{196} An ICE officer makes the initial decision to initiate removing an alien.\textsuperscript{197} The

\begin{flushleft}
\textsuperscript{189} 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).

\textsuperscript{190} Id.

\textsuperscript{191} Id.

\textsuperscript{192} Id. See also Johnson, infra note 230 at 9 (explaining that counties in California and Texas make medical expenditures on undocumented immigrants including long term care) (citing Alan Zarembo and 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); see also Sontag B supra note 8.

\textsuperscript{193} See supra part III.C.

\textsuperscript{194} Purcell, supra note 178


\textsuperscript{196} 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 (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 fundamental right to be represented by competent counsel. See e.g., 8 C.F.R. § 292 (describing permissible
\end{flushleft}
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 ("INA") procedural rules and proper notice.\footnote{198} While the immigration court is an administrative agency and not a federal court, immigrants have the opportunity to ask for continuances,\footnote{199} make discovery,\footnote{200} file motions, and provide evidence.\footnote{201} Most importantly, an individual with an order of deportation against her may file a form requesting an appeal of the decision to the Board of Immigration Appeals ("BIA").\footnote{202} BIA decisions are reviewable by the federal circuit courts of appeal, granting an opportunity to be heard in an Article III court.\footnote{203}

While many undocumented immigrants are indeed deportable, the immigration laws provide exceptions for those aliens whose removal would be against the public interest.\footnote{204} Even if no exception applies at the immigration hearing, there may be opportunities to appeal.\footnote{205} While appeals are costly and difficult to attain, the appeals process allows a deported immigrant the chance to make his or her case that the removal would be unlawful or against the public interest to the BIA.\footnote{206} Even those physically removed from the country have the right to appeal a

\footnote{198}{8 U.S.C. § 1229a. This varies if the alien is subject to expedited removal. 8 U.S.C. § 1228; see also Stead, infra note 215 at 53.}
\footnote{199}{8 C.F.R. § 1240.5; see Kurzb... at 379 (giving a detailed analysis of the evolution of the right to a translator).}
\footnote{200}{See Kurzb... note 196 at 268.}
\footnote{201}{See Kurzb... note 196 at 268.}
\footnote{202}{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).}
BIA decision from abroad. While there are many protections in place, Congress has created expedited removal procedures for both undocumented and legal immigrants designated as “aggravated criminals” in order to reduce the costs of incarceration.

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

An individual can attain asylum status in the United States based on conditions or individual threats to an individual in that person’s country of origin. Once an individual is granted asylum status, he is eligible to eventually apply for adjustment of status and become a lawful permanent resident. An IJ or Asylum Officer (“AO”) can only grant asylum if the applicant applies when in the United States or when at a border awaiting entry. Requirements include: applying within one year of arrival to the United States; being classified as a refugee or other another status protected by immigration regulations; and, proof that there would be government persecution or little protection from persecution in the applicant’s country of origin. 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. Examples of

---

207 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 country).
208 KURZBAN, supra note 196 at 131 (citing 8 U.S.C § 1225(b)(1)).
209 8 U.S.C. § 1158(b)(1)(a) (an asylee must be found to be a “refugee” under 8 U.S.C. § 1101(a)(42)(A)) “‘Refugee’ 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,”). 8 U.S.C. § 1101(a)(42)(A)).
210 8 U.S.C. § 1159(b) (stipulating requirements for adjustment of status for refugees and asylees).
211 KURZBAN, supra note 196. at 431 (listing range of immigrant categories “protected under U.S. law”).
213 8 U.S.C. § 1158(a)(2)(d) (an extension can be granted if applicant proves that “changed circumstances materially affect the applicant's eligibility for asylum or extraordinary circumstances relating to the delay in filing an application”).
“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. 214

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. 215 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.” 216 However, Stead argues that serious injury or illness could constitute circumstances warranting extending deadlines. 217 Stead argues this is possible because the DHS has granted asylum on the condition of pregnancy while in the United States. 218

Additionally, Stead argues that the ambiguously defined protected status of “particular social group creates an opportunity for immigrants facing repatriation to claim asylum.” 219 “Particular social groups” have been defined as individuals sharing “common, immutable characteristic[s],” that cannot be changed. 220 Several IJs have granted asylum to a broad range of individuals based on this flexible category, which may include anything from familial status, to

214 8 C.F.R. §§ 208.4(a)(4)(i)(A)-(B); see also Kurzban, supra note 196 at 474 (describing qualifying examples of changed circumstances).
216 Id. at 14.
217 Id. at 16.
218 Id. at 15 (citing Guo v. Ashcroft, 386 F.3d 556, 560 (3d Cir. 2004) (approving an asylum claim in which an 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)).
219 Id. at 15.
220 Kurzban, supra note 196 at 451 (citing Matter of Acosta, 19 I&N Dec. 211, 233-34 (BIA 1985)).
ethnic group or even a “shared medical condition.”\textsuperscript{221} Stead notes that the ambiguity of “persecution” will be useful for asylum cases concerning repatriation because AOs or IJs will have discretion in granting asylum.\textsuperscript{222} 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.\textsuperscript{223}

Stead acknowledges her proposed solution has limited application.\textsuperscript{224} Asylum is only available to individuals able to prove that they would be persecuted or discriminated against in their home countries.\textsuperscript{225} 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.\textsuperscript{226} Additionally, Stead acknowledges that asylum would protect only undocumented immigrants, and not legal immigrants, from repatriation.\textsuperscript{227} Nor would her plan provide increase hospitals’ compensation for providing emergency services to immigrants.\textsuperscript{228} However limited asylum is in its applicability, Stead also acknowledges that her solution is only a temporary fix while Congress develops a more comprehensive legislative solution.\textsuperscript{229}

\textsuperscript{222} Id. at 16-17.
\textsuperscript{223} Id. at 18.
\textsuperscript{224} 8 U.S.C. § 1158; see also 8 U.S.C. § 1101 (defining the requirements to meet the burden of proof for an asylum claim).
\textsuperscript{225} Stead, supra note 215 at 28.
\textsuperscript{226} Id.
\textsuperscript{227} Id. at 32-33.
\textsuperscript{228} Id. at 31-32.
\textsuperscript{229} 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).
B. Hospitals Can Repatriate Indigent Patients Through the DHS and Thereby Ensure Due Process

In her forthcoming article, *Patients Without Borders: Extralegal Deportation by Hospitals*, Kit Johnson addresses the right to due process before deportation.\(^{230}\) 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.\(^{231}\) Johnson argues that private hospitals are unlikely to be subject to constitutional scrutiny for their actions.\(^{232}\) Johnson notes that hospitals are not qualified or capable of making deportation decisions and that hospitals interfere with federal immigration enforcement schemes by privately removing individuals.\(^{233}\)

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.”\(^{234}\) She also analyzes the merits of private causes of action for false imprisonment as a mechanism to prevent both private and not-for-profit hospitals from repatriating individuals.\(^{235}\) The Montejo case is a useful example, as it shows the process by which an individual would pursue damages from a repatriating hospital.\(^{236}\) However, Johnson finds that inefficiencies, challenges by hospitals, and limited access to counsel would prevent this from being an effective or desirable method.\(^{237}\) Ultimately, Johnson finds that these potential solutions—private causes of actions for false

\(^{231}\) *Id.* at 19-33.
\(^{232}\) *Id.* at 40.
\(^{233}\) *Id.* at 40.
\(^{234}\) *Id.* at 41.
\(^{235}\) *Id.* at 41.
\(^{236}\) *Id.* at 45.
\(^{237}\) *Id.*
imprisonment and federal sanctions for EMTALA violations—\textsuperscript{238}—are inadequate to deal with repatriation on a long-term scale.\textsuperscript{239}

Alternatively, Johnson “propose[s] a new administrative process whereby hospitals can call upon the DHS to initiate the expedited removal and transfer of medically needy undocumented migrants.”\textsuperscript{240} A federal repatriation program would act as a means of ensuring due process to those that a hospital seeks to remove.\textsuperscript{241} 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.\textsuperscript{242}

Johnson’s proposed solution includes giving hospitals the option of reporting undocumented immigrants who require extensive and costly care for removal through the DHS.\textsuperscript{243} Hospitals would have to establish policies whereby physicians ask patients about their legal statuses and then decide whether to report that particular individual to the DHS.\textsuperscript{244} In her proposed model, Johnson envisions that DHS would then pursue an “expedited form” of removal for patients requiring expensive long-term care.\textsuperscript{245} 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.\textsuperscript{246} She relates her reporting proposal to expedited removal procedures for aggravated felons.\textsuperscript{247}

\textsuperscript{238} Id. at 48–49.
\textsuperscript{239} Id. at 49.
\textsuperscript{240} Id. at 49.
\textsuperscript{241} Id. at 50.
\textsuperscript{242} Id. at 50.
\textsuperscript{243} Id. at 52.
\textsuperscript{244} Id. at 51–52.
\textsuperscript{245} Id. at 51–52.
\textsuperscript{246} Id. at 54.
\textsuperscript{247} Id. at 55. As discussed above, these expedited removal procedures are intended to remove those that have been convicted of certain crimes in order to lessen the costs of incarceration. See supra part IV.
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.\textsuperscript{248} To overcome these complications, Johnson proposes using \textit{guardian ad litem}s and medical experts.\textsuperscript{249} \textit{Guardian ad litem}s work on behalf of the court to investigate and provide suggestions regarding the patient’s best health interests.\textsuperscript{250} 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.\textsuperscript{251} 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.\textsuperscript{252} The courts would be able to better prevent unjust outcomes, she argues, if the applicant were given the opportunity to prove that he would be in danger if transferred.\textsuperscript{253}

C. Amend EMTALA to Require Domestic Transfer

Anna Hunsinger has suggested in her forthcoming student comment that hospitals violate HHS regulations\textsuperscript{254} when they transfer patients to facilities outside of the country.\textsuperscript{255} Hospitals repatriating patients are likely also violating EMTALA because they are sending patients to inferior foreign facilities that would unlikely be appropriate by domestic standards.\textsuperscript{256} Hunsinger assesses the level of care hospitals provide to repatriated patients and finds that the recipient

\begin{flushright}
\textsuperscript{248} \textit{Id.} at 55. \\
\textsuperscript{249} \textit{Id.} at 55-56. \\
\textsuperscript{250} \textit{Id.} at 55. \\
\textsuperscript{251} \textit{Id.} at 57. \\
\textsuperscript{252} \textit{Id.} at 57. \\
\textsuperscript{253} \textit{Id.} at 57. \\
\textsuperscript{254} The regulations were originally promulgated by Health Care Financing Administration (“HCFA”) which as since been renamed as the Center for Medicare and Medicaid Services (“CMS”). \textit{See Tommy G. Thompson, Remarks at Press Conference Announcing Reforming Medicare and Medicaid Agency} (2001) http://www.hhs.gov/news/press/2001pres/20010614b.html. \\
\textsuperscript{256} \textit{Id.} 9 (describing the “second-rate” facilities and consequences of transfer as “a death sentence”) (citing Sontag A, \textit{supra} note 3).
\end{flushright}
facilities, such as the hospital Jiménez was sent to, are grossly inappropriate.\footnote{Id. at 9.} 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").\footnote{Id. at 10; see also supra note 254 and accompanying text.} She suggests that Congress or CMS create regulations that explicitly limit transfers under EMTALA to include only domestic facilities.\footnote{Id. at 10.}

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 quality.\footnote{42 U.S.C. § 1395dd.} Hospital-initiated repatriations likely violate EMTALA transfer requirements by inappropriately transferring patients to facilities in other countries.\footnote{See Johnson, supra note 230. Sometimes these facilities do not know to expect transferred patients, and treat them as an emergency case. See Sontag B, supra note 8 (describing Antonio Torres’ experience where his family was promised care in Mexico and the receiving hospital had no knowledge of his arrival nor facilities available to treat him).} However, HHS is either currently unable or unwilling to enforce EMTALA requirements that would eliminate this practice. This is due to either underfunding or just the practical implication of shutting down hospitals that are already providing much needed services.

Since EMTALA is often ineffective to prevent repatriation, there either needs to be an amendment to the statute or some other policy mechanism to prevent individuals from being transferred to inferior foreign health care centers, in violation of EMTALA and immigration laws. 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 polity 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 each scheme creates and whether that proposal will create a more tolerable outcome than the current system of hospital-initiated removals.

A. Weaknesses of Currently Proposed Solutions

1. Asylum Fails to Address Root Causes

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

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. 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.” However, it is possible an IJ would have denied his application because Jiménez’s “near-certain death” would be 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

262 See generally Stead, supra note 215 at 13, 33.
263 Id. at 14.
264 See id. at 14 (citing Hincapie v. Gonzales, 494 F.3d 213, 217 (1st Cir. 2007)).
265 See id. at 14 (citing 8 U.S.C. §§ 1158 (a)(2)(B), (D).
266 See id. at 29.
267 Id. at 29.
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 a hospital repatriates them, if the individual is given the opportunity to apply. Furthermore, once an individual is granted asylum he or she is likely eligible for some government aid and health care under Medicaid for up to seven years.\textsuperscript{268} However, asylum only helps one individual at a time; this proposed solution does not address the reasons hospitals turn to repatriation and does not protect patients that have no information or resources to apply for asylum. Repatriated individuals are often vulnerable individuals with no private insurance and little access to legal advice. Given that the root causes of the repatriation phenomenon includes EMTALA’s under-enforcement, limited funding and individual gaps in insurance coverage. Asylum does little to enforce EMTALA or address hospital’s funding issues.

2. Hospitals Should Not Be Agents of DHS

The lack of procedural due process\textsuperscript{269} inherent in hospital-initiated repatriations 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 these hospitals are transferring and repatriating patients in order to avoid EMTALA violations and to cut costs.\textsuperscript{270} To address this issue, Johnson suggested that hospitals communicate directly with DHS to repatriate patients.\textsuperscript{271} Johnson intends her reporting scheme to make sure that each patient (or

\textsuperscript{268} 8 U.S.C. § 1612(a)(2)(A) (2006) (stipulating that refugees and asylees qualify for up to seven years exception from the general ban of federal program access for aliens); See also PRWORA § 400-412, 110 Stat 2105, 2260-2276 (1996); Stead, supra note 215 at 9.

\textsuperscript{269} Johnson, supra note 230 at 31 (citing Yamataya v. Fisher, 189 U.S. 86, 100-101 (1903)) for the premise that procedural due process requirements should apply to Deportation proceedings).

\textsuperscript{270} Id. at 47 (citing Sontag B, supra note 8).

\textsuperscript{271} Id. at 51.
her guardian) has a hearing before being transferred to her country of origin. Hospitals would no longer physically transfer patients, nor would they 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. Hospitals have no reliable methods to determine an immigrant’s status, nor do they have any legal authority to alter an individual’s immigration status. Although Johnson’s suggestion would not make hospitals private enforcers of immigration law, it would make private hospitals reporters of potential undocumented immigrants. While she assures that this will be an optional reporting function, hospitals will have discretion in 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 unofficial definition of undocumented.

Hospitals could also use this reporting authority to regularly 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 easily 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 the deterrence caused by the potential of hospital reporting would be limited because only a small number of cases become long-term care problems. However, her argument is flawed in that she does not take into account that there is no guarantee that hospital staff would distinguish between patients requiring long-term care in their reporting procedures. It is possible that some hospitals could automatically report “suspect” individuals in order to reduce costs. Furthermore, release of patient information to the DHS may have implications for doctor-patient confidentiality rights. These disclosures would extend beyond individuals that are undocumented. If a doctor or hospital is disclosing personal patient information to a non-health related agency such as DHS, this disclosure is unlikely to qualify under a Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rule exception.

Undocumented immigrants already fear seeking hospital services. 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 on the margin that may choose not to seek

---

277 Johnson, supra note 230.
278 See generally 45 C.F.R. § 164.500 (2003). There are no provisions that the HIPAA Privacy Rule does not apply to undocumented immigrants. Id.
279 It could exceed beyond undocumented immigrants because hospitals have no way of actually distinguishing between patients based on immigration status. Thus, patients with legal status or unknown status would be subjected to disclosure of their medical information to DHS which does not fall under the agencies
280 See 45 C.F.R. § 164.5.
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.  

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. 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 the federal immigration law. Varied enforcement would misallocate charity care and federal funding, as “immigrant-friendly” hospitals could possibly see 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


283 Johnson, supra note 230 at 52 (citing New York and San Francisco laws prohibiting city employees inquiring into an individuals immigration status).

284 See generally Smith, supra note 275.
unstable patients. The question remains as to the standard IJs or AOs would use to adjudicate these cases. Furthermore, Johnson’s proposal does not solve the issue of funding care for those immigrants that IJs find are eligible to stay in the United States.

Finally, the comparison of removal for medically needy indigent immigrants with aggravated felons is concerning. Johnson proposes using a system similar to the process for removal of aggravated felons, which includes the removal of lawful permanent residents. In effect, being sick would be grounds for removing an individual living in the United States legally, but not yet eligible for Medicaid coverage. Deporting a lawful permanent resident that commits a felony and thus statutorily loses his privileges to be 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 stake. While Johnson’s goal of promoting due process in removals and avoiding private repatriations is commendable, her proposed solutions are inadequate and create further problems. Hospitals and medical care providers should not 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. 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 we have seen in the case of Luis Alberto Jiménez, there is little recourse

---

285 Id. at 55 (proposing that LPRs would be subject to “traditional removal proceedings at an expedited pace”).
286 See generally Park, supra note 281 at 582-83.
for an individual who has been privately repatriated to his country of origin.\textsuperscript{287} Private repatriations illustrate a host of additional health policy problems.\textsuperscript{288} 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.\textsuperscript{289} 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. Anna Hunsinger’s suggestion that EMTALA explicitly limit transfer facilities to domestic facilities provides a simple legislative solution.\textsuperscript{290} 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 uncompensated 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 in debate since the 1990’s when the Clinton administration attempted health care reform.\textsuperscript{291} 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

\textsuperscript{287} Martin Mem’l Med. Ctr. (Montejo I), 874 So. 2d. 654 (Fla. 4th Dist. Ct. App. 2004) ; Sontag B, supra note 8.
\textsuperscript{288} See generally Wolpin, supra note 9; Greenough supra note 112; see also Sontag B, supra note 8.
\textsuperscript{289} 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 when finding 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 112 at 503 (noting that payor limits place pressures on physicians to transfer all long term ventilator patients without sufficiently weighing risks).
\textsuperscript{290} Hunsinger, supra note 255 at 47.
\textsuperscript{291} See Loue, supra note 282.
economic and social pressures on Congress and federal policymakers to avoid providing funding to undocumented immigrants.  However, in practice, limiting funding does not make the problem go away. Comprehensive healthcare 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 in comparison to their representation in the population. A variety of factors contribute to this phenomenon, including minimal access to insurance and fear of deportation. 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. Immigrants are not entering the United States to get free medical care. While many undocumented immigrants in the United States have entered without inspection, the majority are workers who have overstayed their temporary visas. The biggest incentive for moving to the United States is economic, based on the wage disparity between an immigrant’s home country and the United States. This economic motivation comes to light when the flow of immigrants decreases during a recession. Many undocumented immigrants pay payroll and social security

---

292 Shirley S. Wang, Winners and Losers in the Affected Industries, WALL STREET J., Mar. 22, 2010; See also Julia Preston, Congress Quarrels on Covering Immigrants, N.Y. TIMES, Nov. 4, 2009, at A14.
293 See Stimpson, supra note 128; see also Goldman infra note 26 at 1703.
294 Park, supra note 281 at 581.
295 Goldman, supra note 26 at 1703.
296 Alexander Vivero Neill, Human Rights Don’t Stop at the Border: Why Texas Should Provide Preventative Health Care for Undocumented Immigrants, 4 Scholar 405 (2002); Clark supra note 169 at 254 (noting that most immigrants enter the United States for employment opportunities, not access to public benefits).
297 Id at 412
298 Id. at 412-13; see also Berk, supra note 184 at 56-58.
299 Hoefer, supra note 176 at 2.
taxes, yet never file a tax return or participate in a government-sponsored health program. These individuals are functionally unable to participate in many aspects of society.

All hospital-initiated repatriations involve patients suffering from some catastrophic injury, coma, or other chronic condition. Treatment for cancer, 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 life-saving care. 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. 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 at least 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

300 Clark, supra note 169 at n. 143.
301 See 42 U.S.C. § 1395dd.
302 See MED. ETHICS ADV., supra note 25.
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 by current legislation. Many 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.