At the Intersection of Immigration and Health Care Law: 
The Lack of Clear Standards Governing Medical Repatriation 
and Suggestions for Future Oversight 

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TABLE OF CONTENTS

I. INTRODUCTION .............................................................................................................. 821
II. MEDICAL REPATRIATION: UNDOCUMENTED IMMIGRANTS VS. 
   HOSPITALS.................................................................................................................. 824
   A. Montej o v. Martin Memorial Medical Center ......................................................... 825
   B. The Bottom Line: Why Hospitals Resort to Medical Deportation ...... 828
III. HISTORICAL BACKGROUND .................................................................................. 830
   A. Federal Legislation in 1996: The Immigrant Reform Act and 
      Welfare Reform Act ................................................................................................. 830
   B. Unsuccessful Constitutional Challenges to the Welfare Reform Act .... 831
   C. States Respond to Federal Legislation and More Constitutional 
      Challenges .............................................................................................................. 832
IV. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT ........... 834
V. MEDICAL REPATRIATION IN THE CONTEXT OF FEDERAL IMMIGRATION 
   LAW .............................................................................................................................. 837
   A. Subject Matter Jurisdiction .................................................................................... 837
   B. Removal of Undocumented Immigrants Without Immigration 
      Proceedings ............................................................................................................ 838
VI. OPENING A DIALOGUE: THE NEED FOR OVERSIGHT AND SUGGESTIONS 
    FOR REGULATION ................................................................................................... 841
VII. CONCLUSION ............................................................................................................. 844

I. INTRODUCTION

A report by the Pew Hispanic Center recent l y estimated that 11.9 million 
“unauthorized immigrants” were living in the United States in 2008, and of that

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1. The Pew Hispanic Center is a part of the Pew Research Center, which is supported by 
The Pew Charitable trust and identifies itself as “a non-partisan ‘fact tank’ that provides information 
on the issues, attitudes and trends shaping America and the world.” Pew Hispanic Center Home 
group, an estimated 59% of adults did not have health insurance.\(^3\) Our current health care delivery system in the United States is breaking under rising costs,\(^4\) and undocumented immigrants are an invisible segment of the population that “remain in a sort of health-care purgatory, caught in our two most dysfunctional systems—immigration and health care.”\(^5\) While pundits debate health care issues on the political stage, two players are suffering in the real world.

On one side are undocumented immigrants\(^6\) and legal immigrants who have resided in the United States for less than five years.\(^7\) Under current federal law, these groups of people are banned from receiving federal health care assistance aside from emergency care.\(^8\) In many cases they are working in low-paying jobs with no employee-sponsored health care benefits, and therefore have no access to health insurance.\(^9\) Perhaps due in large part to this lack of coverage, studies show that undocumented immigrants are not as likely to seek preventative care, and when faced with a chronic illness or a sudden life-threatening emergency that may require more long-term treatment, their only option for treatment is the hospital emergency room.\(^10\)

On the other side are the hospitals, which are required by federal law to treat any “individual” who comes into an emergency room.\(^11\) However, after a seriously injured undocumented immigrant is stabilized, he or she often needs more long-term or ongoing treatment, but has neither the income nor the health care coverage required for admission to many nursing homes or long-term care facilities in the


\(^3\) Id. at 18 (noting this number is double the amount of uninsured legal immigrants and four times that of citizen adults).

\(^4\) See, e.g., Elizabeth Pendo, Working Sick: Lessons of Chronic Illness for Health Care Reform, 9 Yale J. Health Pol’y L. & Ethics 453, 468-69 (2009) (arguing that changes in the way health care is delivered, specifically preventative care, could lower overall health care costs).


\(^6\) There are many terms used to describe people who enter the United States illegally such as “illegal alien,” “illegal immigrant,” “undocumented alien,” or “non-citizen.” This article uses the term undocumented immigrant because it most neutrally describes individuals who have relocated from another country and taken up residence in the United States without proper documentation.

\(^7\) See Adrienne Ortega, Note, . . . And Health Care for All: Immigrants in the Shadow of the Promise of Universal Health Care, 35 Am. J.L. & Med. 185, 186 (2009).

\(^8\) See id. at 185-86.

\(^9\) See id. at 186-87.

\(^10\) See id. at 194-95; see also Joseph Wolpin, Medical Repatriation of Alien Patients, 37 J.L. Med. & Ethics 152, 153 (2009).

In these cases, the continuing cost of their care is usually left up to the hospital that originally provided the emergency treatment. In order to save themselves from the enormous cost of providing long-term treatment to undocumented and uninsured immigrants for an indefinite period of time, hospitals are increasingly turning to “medical repatriation” or “medical deportation” to solve their financial problem. Medical repatriation is a practice whereby a private hospital hires a private airplane or ambulance and makes arrangements to transfer an undocumented immigrant patient back to his or her home country, with no oversight or regulation by either the state or federal government.

This article does not advocate for including undocumented immigrants in universal healthcare options, nor does it suggest that this segment of the population should be denied access to life-saving care available in the United States. It merely calls attention to medical repatriation—a practice almost invisible on the legal landscape up to this point—and offers suggestions about how to address this ongoing human rights issue. First, this article focuses on examples of medical repatriation and the valid concerns of both undocumented immigrants and hospitals. Included in this section is an in-depth look at the only case directly addressing this issue, which revealed many questions of law implicated by the practice of medical deportation but provided no definitive legal standard to guide hospitals or undocumented immigrant patients in the future. Next, this article provides a brief history of the federal legislation eliminating Medicaid for undocumented immigrants, the resulting impact on state law, and constitutional challenges to both federal and state laws. The following section examines the Emergency Medical Treatment and Active Labor Act—the only federal legislation that still provides benefits for undocumented immigrants—and its ongoing influence on whether this group will continue to receive


15. See Wolpin, supra note 10, at 155 n.1 (discussing how the terms “medical repatriation” and “medical deportation” are used interchangeably and explaining the author’s choice to use “repatriation” because it is more “neutral”). This paper will use these terms interchangeably, perhaps using “deportation” when it is particularly useful to demonstrate the physical act of removing a person from the United States.

necessary treatment. Further, this article considers the medical repatriation within the framework of current immigration law, including possibilities for undocumented immigrants to advocate for relief from removal from the United States. The final section suggests several options, each very different and perhaps controversial to one or more of the interested parties, to oversee medical deportation for the ultimate protection of both undocumented immigrants and hospitals.

II. MEDICAL REPATRIATION: UNDOCUMENTED IMMIGRANTS VS. HOSPITALS

Because there are no official numbers kept on how many medical repatriations occur in the United States, it is impossible to quantify how often patients are deported to their home country; where they are sent; or if they have given consent to be transferred.\(^{17}\) St. Joseph’s Hospital in Phoenix estimates they repatriate about 96 patients per year.\(^{18}\) Broward General Medical Center in Florida reports six to eight patients are repatriated each year, and hospitals in Chicago report at least ten immigrants were repatriated to Honduras since 2007.\(^{19}\) These medical repatriations are often forced upon critically ill patients despite opposition from the patient, guardian, and family.\(^{20}\) In most cases the stories of these undocumented immigrants are never told, but it appears that the practice is not uncommon.\(^{21}\)

Antonio Torres was a legal immigrant working in Arizona when he suffered serious injuries in a car accident, leaving him comatose and on a ventilator.\(^{22}\) Because Mr. Torres was uninsured and unable to pay, the hospital sent him over the United States-Mexico border in an ambulance.\(^{23}\) His distraught parents immediately found a hospital in California that agreed to treat him, and drove him back across the border just in time to successfully treat a deadly infection.\(^{24}\)

In 2007, an undocumented immigrant gave birth to a child with a heart condition in a Tucson hospital; two days later the hospital attempted to repatriate the newborn

\(^{17}\) See id.
\(^{18}\) Id.
\(^{19}\) Id. Over the past five years, the Guatemalan foreign ministry reported 53 known medical repatriations from the U.S. Id.
\(^{20}\) See Paul Harasim, Sending Patients Home, LAS VEGAS REV. J., Aug. 23, 2009, at B1, available at http://www.lvrj.com/news/54286002.html; see also Wolpin, supra note 10, at 153-54 (noting that the California Medical Association and American Medical Association focused specifically on the issue of “forced” repatriation, but did not define what constitutes “force,” and further suggesting that an undocumented immigrant to could be afforded some protection by at least requiring consent before proceeding with repatriation).
\(^{21}\) See Sontag, supra note 12.
\(^{23}\) See id.
\(^{24}\) See id.
to Mexico.\textsuperscript{25} Despite the fact that the baby was born in the United States, and was therefore a United States citizen, the hospital explained that they had a “policy . . . to transfer patients to their ‘community of residence’ for continuing care.”\textsuperscript{26} The hospital was transporting the baby to the airport when a lawyer intervened, arguing that the baby was “abduct[ed] under the guise of medical care.”\textsuperscript{27} The hospital sought court ordered authorization for the baby’s return to Mexico by arguing the baby was trespassing because the parents had not paid the hospital or taken him out of the hospital.\textsuperscript{28} Eventually, the baby qualified for state Medicaid coverage and the hospital’s suit disappeared.\textsuperscript{29} Even though these stories had relatively happy endings, in many cases a hospital will medically repatriate patients regardless of the seriousness of their condition\textsuperscript{30} or whether appropriate medical care is available in their home country.\textsuperscript{31}

Currently, there is no clear legal standard governing medical repatriation,\textsuperscript{32} and essentially no regulation of the practice by state or federal law.\textsuperscript{33} Therefore, undocumented immigrants have no defined recourse to challenge their forcible removal from the United States due to their inability to pay for medical care, and there is “no workable chart to guide health care professionals” as to what legal standards apply when they attempt to medically repatriate a patient.\textsuperscript{34} The practice of medical repatriation was unknown on the national stage until the 2008 coverage by a New York Times reporter of the legal challenges to the practice brought by Luis Jimenez.\textsuperscript{35}

\textit{A. Montejo v Martin Memorial Medical Center}

Luis Alberto Jimenez entered the United States illegally, seeking to support his wife and children left behind in Guatemala.\textsuperscript{36} In February of 2000, Mr. Jimenez was riding back from his landscaping job when his vehicle was hit head-on by a stolen van driven by a heavily intoxicated Donald Lewellyn.\textsuperscript{37} Several passengers were

\textsuperscript{25} See id.
\textsuperscript{26} Id.
\textsuperscript{27} Id.
\textsuperscript{28} See id.
\textsuperscript{29} See id.
\textsuperscript{30} See id. (one patient was comatose, on a ventilator and blood work showed signs of infection; another patient was a newborn with a heart defect and Down’s Syndrome).
\textsuperscript{31} See Sontag, supra note 12.
\textsuperscript{32} Patsner, supra note 13, at 3.
\textsuperscript{33} See Ortega, supra note 7, at 197.
\textsuperscript{34} Patsner, supra note 13, at 4.
\textsuperscript{35} See Sontag, supra note 12; Wolpin, supra note 10.
\textsuperscript{36} See Sontag, supra note 12.
\textsuperscript{37} Id.
killed, and Mr. Jimenez was taken to Martin Memorial Medical Center (“Martin Memorial”) where doctors performed emergency surgery. While he did survive, Mr. Jimenez suffered serious injuries, including multiple broken bones, internal injuries, and severe and permanent brain damage. In June of 2000, Mr. Jimenez was declared incompetent and his cousin, Montejo Gaspar Montejo, was named his guardian. Despite his complete lack of health coverage, Mr. Jimenez was transferred to a skilled nursing facility, which likely accepted him because of the prospect of an insurance settlement from the accident. But in January of 2001, Mr. Jimenez returned to the emergency room at Martin Memorial, suffering from a life-threatening infection. He would subsist at the hospital in a vegetative state for over one year, eventually regaining the ability to minimally communicate. What happened next would bring to light the practice of medical deportation and its many unsolved legal questions in the first, and so far only, reported case of its kind.

Mr. Montejo, acting as guardian, filed a guardianship plan requiring that Mr. Jimenez receive twenty-four hour care at a “hospital or skilled care facility” for one year. Martin Memorial subsequently intervened and filed its own petition, alleging that it was not in the best interests of Mr. Jimenez to remain at the hospital because the facility was not in a position to provide the long-term rehabilitative care the patient required. Specifically, the hospital claimed it would receive no federal financial assistance because Mr. Jimenez was an undocumented alien and therefore was not eligible for Medicaid or any other public assistance. The hospital sought a court order authorizing it to discharge Mr. Jimenez directly to a hospital in Guatemala. After a hearing, on June 27, 2003, the circuit court held that Mr. Montejo could not prevent the hospital from sending Mr. Jimenez back to Guatemala if the hospital did so “at its own expense [with] ‘a suitable escort with the

38. Id.
39. Id.
41. Sontag, supra note 12. The families of the injured and killed passengers attempted to hold the owner of the stolen van liable under a vicarious liability theory because the workers left the keys in the stolen van, but the lawsuit was not successful. See id.
42. Id.
43. Id. During his time at the hospital, staff reported that they treated Mr. Jimenez “like family,” even throwing him birthday parties and giving him gifts. Id. However, he did exhibit typical “[e]motional and behavioral volatility [that] often follows serious head injuries,” including “spitting, yelling out, kicking and defecating on the floor.” Id.
44. See Patsner, supra note 13, at 4.
45. Montejo, 935 So. 2d at 1267.
46. Id.
48. Id.
necessary medical support . . ."49 Mr. Montejo filed a notice of appeal and a motion to stay the court’s order on July 9, 2003.50 The court ordered the hospital to file a response by the following morning, but before 7:00 a.m., with no notice to Mr. Montejo, the hospital loaded Mr. Jimenez onto a chartered plane and relocated him to Guatemala.51

On May 5, 2004, the Florida District Court of Appeal issued an opinion reversing the circuit court order that authorized the hospital to medically repatriate Mr. Jimenez.52 The hospital argued that the appeal was moot because Mr. Jimenez was already in Guatemala and any subsequent decision about his return would be preempted by federal immigration law.53 However, the court strongly rejected this contention, specifically noting that that this argument “only weakens the hospital’s position on a different issue, which is whether the trial court had subject matter jurisdiction to authorize the hospital to transport Jimenez to Guatemala in the first place, because federal immigration law preempts deportation.”54 Also, the court found that this case “presents an important issue which is likely to recur.”55 Overall, the court’s holding was two-fold: first, it found that there was not enough evidence to order Mr. Jimenez’s discharge from the hospital under federal law requiring the transferring facility to ensure that the accepting facility is “appropriate,” which is defined as “one which can meet the patient’s needs.”56 Second, the lower court did not have subject matter jurisdiction to order the “deportation” of Mr. Jimenez out of the country.57 Despite the fact that Mr. Jimenez was already back in Guatemala, this was not the end of the legal battle.58

In September 2004, Mr. Montejo filed a lawsuit alleging false imprisonment when the hospital put Mr. Jimenez on a plane to deport him,59 and seeking one million dollars in damages.60 The hospital argued it had immunity from suit because

49. Montejo, 935 So. 2d at 1267.
50. Id. at 1267-68.
51. Id. at 1268; see also Sontag, supra note 12 (specifically noting the lack of notice given to Mr. Montejo).
52. Montejo, 874 So. 2d at 658.
53. Id. at 656.
54. Id.
55. Id. at 657.
56. Id. at 657-58 (citing 42 C.F.R. § 482.43). The court also found a lack of evidence that the hospital followed its own internal discharge policy. Id. at 658.
57. Id.
59. Id. at 1268.
it was only following a valid court order.\textsuperscript{61} The trial court agreed and granted the hospital’s motion to dismiss.\textsuperscript{62} However, the Florida appellate court reversed in August of 2006, finding there could be no immunity when the hospital relied on a court order that was later held to be invalid based on a lack of subject matter jurisdiction.\textsuperscript{63} The court held that as a matter of law Martin Memorial did not act with legal authority—thereby satisfying one element to find false imprisonment—but remanded for the trier of fact to determine another element of false imprisonment: whether the removal of Mr. Jimenez was “unwarranted and unreasonable under the circumstances.”\textsuperscript{64}

Almost three years later, in July of 2009, a jury found in favor of Martin Memorial on the issue of false imprisonment.\textsuperscript{65} Despite instructions from the judge that Mr. Jimenez was detained “without legal authority” and against the will of his guardian as a matter of law, the jury still found that the repatriation of Mr. Jimenez was not “unwarranted and unreasonable under the circumstances.”\textsuperscript{66} Even though it won the legal battle, Martin Memorial’s president and chief executive emphasized the need for lawmakers to address the matter of paying for the ongoing care of undocumented immigrants.\textsuperscript{67} The estimated $1.5 million dollars that Martin Memorial spent on Mr. Jimenez’s care underscores a major dilemma for health care providers between providing necessary care to undocumented immigrants and finding the money to pay for it.\textsuperscript{68} Also, while the Montejo decisions were cases of first impression on the legal issues surrounding medical repatriation, neither decision offers any real guidance for hospitals as to the appropriate legal standard to be applied in future situations like the case of Mr. Jimenez.\textsuperscript{69}

\textbf{B. The Bottom Line: Why Hospitals Resort to Medical Deportation}

The average stay at Martin Memorial is 4.1 days at an average cost of $8,188.\textsuperscript{70} By contrast, Martin Memorial spent a reported $1.5 million dollars on Mr. Jimenez’s care as he remained a ward of the hospital for over one year.\textsuperscript{71} The hospital received

\begin{itemize}
\item \textsuperscript{61} Montejo, 935 So. 2d at 1268.
\item \textsuperscript{62} Id.
\item \textsuperscript{63} Id.
\item \textsuperscript{64} Id. at 1272.
\item \textsuperscript{66} Sontag, supra note 60.
\item \textsuperscript{67} See id.
\item \textsuperscript{68} See id.
\item \textsuperscript{69} See Patsner, supra note 13, at 3.
\item \textsuperscript{70} Sontag, supra note 12.
\item \textsuperscript{71} See id. It should be noted that to maintain tax-exempt status, a hospital must allocate a
$80,000 in Medicaid reimbursement for Mr. Jimenez’s emergency care only. Although the hospital’s care plan stated that he would require rehabilitative care for his brain injury, long-term care facilities refused to accept him as a patient because he could not pay for care and would receive no Medicaid benefits as an undocumented immigrant. In the hospital’s view, it was left with the Hobson’s choice of either caring for Mr. Jimenez indefinitely or transporting him back to a rehabilitative facility in his home country. The practice has become widespread enough for the California-based company MexCare to build an entire business based on transporting medically repatriated patients back to their home countries by air. It is estimated that the cost to transport an illegal immigrant to their home country, including medical equipment that might not be available at the home country facility, ranges from $35,000 to $200,000. But this amount is still far less expensive than long-term ongoing care for a chronic illness or catastrophic injury.

Hospitals that engage in medical repatriation argue that while the practice is regrettable, it is necessary to transfer these patients to reduce costs and make room for other needy patients. Some hospital administrators even rationalize that patients will have a better recovery if they are closer to their family and home culture. Each hospital has its own policy: some refuse to repatriate any patients, some require consent, and some have a policy of repatriating without even contacting family members or inquiring about the quality of the care available in the patient’s home country. Martin Memorial’s lawyer insists that responsibility for these patients “should be a governmental burden, . . . or the government should step in and otherwise exercise its authority for deportation or whatever it wants to do.”

portion of services for charity care, and Martin Memorial reportedly dedicated $23.9 million for charity care in 2006. Id.

73. See Sontag, supra note 12.
74. See id.
75. See Wolpin, supra note 10, at 153-54; see also Mexcare Home Page, http://mexcare.com/ (last visited Jan. 10, 2010) (marketing the company as “[a]n alternative choice for the care of the unfunded Latin American national”).
76. Harasim, supra note 20.
77. See supra note 14 and accompanying text.
78. See Wolpin, supra note 10, at 153.
79. See id.
80. See Sontag, supra note 22.
81. Sontag, supra note 12.
III. HISTORICAL BACKGROUND

A. Federal Legislation in 1996: The Immigrant Reform Act and Welfare Reform Act

In 1996, Congress passed two pieces of legislation that drastically limited access to public assistance, including health care, for undocumented immigrants. First, the Illegal Immigration Reform and Immigrant Responsibility Act of 199682 ("Immigration Reform Act") increased funding and personnel to stop illegal immigrants from crossing the United States-Mexico border and specifically forbid states from allowing medical professionals to protect undocumented immigrants by not reporting a patient’s immigration status.83 Second, the Personal Responsibility and Work Opportunity Reconciliation Act84 ("Welfare Reform Act") ended undocumented immigrants’ receipt of many federal public assistance programs, including Medicaid.85 As of August 22, 1996, states no longer received federal health care funding for illegal immigrants and, more noticeably, Medicaid would no longer provide funds for legal immigrants who resided in the country for less than five years.86 While undocumented immigrants may still receive certain services, such as immunizations and treatment for communicable diseases, the ban on access to Medicaid left this entire segment of the population without access to routine and preventative medical care.87


83. See Neda Mahmoudzadeh, Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law, 9 SCHOLAR 465, 470 (2007). But see American Medical Association Minority Affairs Consortium Policy Compendium as of Feb. 2010, Policy No. H-440.876, Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients, available at www.ama-assn.org/ama1/pub/upload/mm/19/macompendfinal.pdf (outlining AMA policy that “(b) opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient’s legal resident status; and (c) opposes proof of citizenship as a condition of providing health care”).


85. See Mahmoudzadeh, supra note 83, at 470-71.

86. See Ortega, supra note 7, at 191. In reality, the five-year waiting period for legal immigrants is often extended to ten years because an immigrant’s income will include that of his or her “sponsor” and because the sponsor’s income must be above a certain level, the immigrant will “earn” too much money to qualify for Medicaid in most cases. See Julia Field Costich, Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the “Contract With America” Congress, 90 KY. L.J. 1043, 1063 (2002).

B. Unsuccessful Constitutional Challenges to the Welfare Reform Act

From a broader perspective, the federal government does not recognize a constitutional or common law “affirmative right to health care” for all persons. It is therefore not surprising that federal courts have repeatedly upheld the Welfare Reform Act’s provisions denying access to publicly funded health care benefits for undocumented immigrants. In Lewis v. Thompson, the Second Circuit reaffirmed that the federal government has plenary power over immigration and held that denial of Medicaid funding for prenatal care provided to undocumented immigrants did not violate equal protection under the Constitution. Generally, the Supreme Court applies rational basis scrutiny for any decision about immigration and naturalization, which only requires that the federal law be rationally related to a legitimate government interest. Under rational basis review almost any government purpose will be considered legitimate including “deterrence of illegal immigration and cost savings.” Despite differing opinions about whether denial of health care benefits will actually deter illegal immigration, this type of reasoning has resulted in the upholding of federal legislation that denies public assistance for undocumented immigrants, including access to health care. Consequently, individual states must decide if and how they will fill the funding gap left by the removal of federal Medicaid funds to pay for the care of undocumented immigrants.

88. Ortega, supra note 7, at 200. In practice, this principle supports historical and current opposition to the establishment of a federal universal health care program. See id.

89. See Matthews v. Díaz, 426 U.S. 67, 69 (1976) (upholding as constitutional a provision denying Medicare benefits to resident aliens unless they resided in the United States for at least five years and had been admitted for permanent residence); Lewis v. Thompson, 252 F.3d 567, 569 (2d Cir. 2001).

90. See Lewis, 252 F.3d at 583-84. The court also found that children born in the U.S. automatically qualified for benefits and could not be denied Medicaid coverage because the mother was undocumented. Id. at 591-92.


92. Ortega, supra note 7, at 201; see also 8 U.S.C. § 1601(6) (2006) (“It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits.”).

93. See Ortega, supra note 7, at 187 (citing multiple studies that found the overwhelmingly predominate reason for immigration to the U.S. was jobs, followed by family and friends); Costich, supra note 86, at 1069 (arguing “[i]t is clear that health care access is not a significant motivator for immigrants” because they are usually in better health to begin with and would likely not “withstand the physical and mental rigors of immigration” if they were not already in good health).

94. See supra note 89-90 and accompanying text.

95. See Ortega, supra note 7, at 187-88.
C. States Respond to Federal Legislation and More Constitutional Challenges

The Welfare Reform Act prohibits the states from using federal funds to pay for undocumented immigrants’ health care; however, it does allow states to pass their own legislation to assist hospitals in caring for undocumented immigrants.96 This move was rationalized as part of a larger federal policy shift toward “generally bringing the financial burden closer to the place where the care is delivered.”97 While states are allowed to maintain and even expand coverage for undocumented immigrants, many states still do not provide any health care coverage for this segment of the population.98 However, at least twenty-five states independently fund some form of health care for undocumented immigrants and legal immigrants who have been in the country for less than five years,99 although benefits available under these programs vary widely.100 Most states particularly emphasize a State Child Health Insurance Program (“SCHIP”)—a program that is funded by both the federal and state government but is administered by the states—to subsidize prenatal care and health insurance for the children of undocumented immigrants.101 In 2009, President Barack Obama expanded SCHIP funding to the states, and specifically lifted the five-year ban on public services for pregnant women and children who are legal immigrants and have been in the country for less than five years.102 However, most states do not fund post-emergency hospital care for adult undocumented immigrants.103

While constitutional challenges to federal laws on behalf of undocumented immigrants have been largely unsuccessful,104 several state laws have been

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96. See id.
97. Costich, supra note 86, at 1057.
99. Id. States that provide insurance to undocumented immigrants often have a large immigrant population, including: California, Texas, Florida, New Mexico and New York. Id. Arizona is a notable exception, as the only southwestern state not providing any funding to care for undocumented immigrants. See id.
100. See id. at iii (noting many states provide coverage similar to Medicaid or SCHIP; but other states limited coverage depending on the category of immigrant or included cost sharing measures).
101. See Ortega, supra note 7, at 192.
102. See id. at 193.
103. See Sontag, supra note 12. California and New York are exceptions with each state spending $20 million per year on long term care for undocumented immigrants. Id.
104. See supra Part III.B.
successfully struck down as unconstitutional. Aliessa v. Novello dealt with New York’s state-funded Medicaid program, which included the same prohibitions as the Welfare Reform Act—specifically those banning legal immigrants from receiving Medicaid benefits for five years even after they entered the United States legally. There, the Court of Appeals of New York applied a strict scrutiny analysis and held that the portion of the Welfare Reform Act allowing states to differentiate between different groups of immigrants when providing benefits funded by the state violated both federal and state constitutional guarantees of equal protection. The inconsistency of this decision with Lewis—where the Second Circuit Court of Appeals found no constitutional violation in restricting Medicaid funds to undocumented immigrants—is striking and thus-far unresolved.

Advocates for undocumented immigrants challenge the federal government’s power to compel states to comply with these guidelines and call for the Welfare Reform Act restrictions to be removed, but the practical reality is that individual hospitals are the ultimate cost-bearing entity and some have turned to medical repatriation in an attempt to lower skyrocketing costs. Paradoxically, while the federal government does not provide assistance to states or hospitals that treat undocumented immigrants, it is mandatory under The Emergency Medical Treatment and Active Labor Act for hospital emergency departments to treat all patients who show up in the emergency room with an emergency medical condition, regardless of their immigration status.

105. See Graham v. Richardson, 403 U.S. 365, 382-83 (1971) (applying a heightened scrutiny analysis and holding that denial of benefits to resident aliens and aliens that reside in the United States for less than fifteen years was a violation of the Equal Protection Clause); Ehrlich v. Perez, 908 A.2d 1220, 1243-44 (Md. 2006) (applying a strict scrutiny analysis, the court held that denial of Medicaid funds for prenatal care and health care for resident alien children only to those who resided in the state for less than five years was not a “compelling government interest” and therefore violated the Maryland Declaration of Rights); Aliessa v. Novello, 754 N.E.2d 1085, 1098 (N.Y. 2001).

106. See Aliessa, 754 N.E.2d at 1091-92.

107. See id. at 1098-99.

108. See Lewis v. Thompson, 252 F.3d 567, 583-84 (2d Cir. 2001).

109. See Costich, supra note 86, at 1066-67; see also supra note 90 and accompanying text.

110. See Alison Fee, Forbidding States from Providing Essential Social Services to Illegal Immigrants: The Constitutionality of Recent Federal Action, 7 B.U. PUB. INT. L.J. 93, 99 (1998) (asserting that The Welfare Reform Act’s provisions are unconstitutional because they “infringe on the states’ powers under the Tenth Amendment”).

111. See Costich, supra note 86, at 1067; Ortega, supra note 7, at 204.

112. See supra note 14 and accompanying text.

113. See Ortega, supra note 7, at 193-94.
IV. THE EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

The Emergency Medical Treatment and Active Labor Act ("EMTALA") was instituted in 1986, largely in response to the practice of “patient dumping” whereby hospitals would turn away or discharge severely ill patients who did not have insurance coverage or could not afford to pay the hospital for care. In some cases, private hospital emergency departments ("ED") would transfer uninsured patients to public EDs because public EDs were often required to provide care regardless of ability to pay. One study estimated “250,000 emergency patients annually were transferred or discharged from hospitals because of an inability to pay for necessary medical services.” The constant transferring of patients postponed necessary treatment, at times resulting in serious injury or death. EMTALA made it mandatory for hospitals that contract with the federal government for Medicare services to “provide for an appropriate medical screening examination” to anyone that comes to a “hospital emergency department” with an “emergency medical condition.” Because hospitals depend heavily on federal Medicaid contracts for funding, the statute applies to most hospitals that have an ED. Therefore, EMTALA ensures hospitals will treat all individuals who need emergency care, regardless of their immigration or insurance status.

Under the provisions of EMTALA, every patient that comes to the ED is entitled to “an appropriate medical screening examination” to determine if they have an

115. See Christine Fedas et al., Emergency Treatment Act: A Federal Response to Patient Dumping, 76 M ASS. L. REV. 110, 110 (1991); see also In the Matter of Baby K, 16 F.3d 590, 593 (4th Cir. 1994) (identifying that the purpose of EMTALA was to prevent hospitals from refusing to treat patients or dumping them because of inability to pay). Ironically, in light of the current political debate over universal healthcare, the legislative history of EMTALA shows it was meant to serve as a mere stop-gap measure until more “universal” health care measures could be enacted to ensure health care for all regardless of ability to pay. See Laura D. Hermer, The Scapegoat: EMTALA and Emergency Department Overcrowding, 14 J.L. & Pol’y 695, 725 (2006). That was over twenty years ago.
116. See Hermer, supra note 115, at 695-96. As of 2003, an estimated 60% of patients at public hospitals were on Medicaid or were uninsured. Id. at 703.
117. Fedas et al., supra note 115, at 110.
119. 42 U.S.C. § 1395dd(a) (2006); see also Hermer, supra note 115, at 699.
120. See Hermer, supra note 115, at 699. EMTALA has become controversial in the health care field for many reasons, including: 1) accusations that it has resulted in an extreme overcrowding of emergency departments, and 2) resentment for the federal government turning charity care into a mandatory responsibility instead of allowing it to be voluntary as it has historically been. See id. at 722-23.
121. See Hermer, supra note 115, at 695; see also 42 U.S.C. § 1395dd(b) (2006) (prohibiting any delay in treatment to investigate about the patient’s ability to pay or insurance status).
emergency medical condition.\textsuperscript{122} Screening is evaluated according to the ED’s own uniformly applied internal screening procedures, and within the ED’s own “capability.”\textsuperscript{123} If an emergency medical condition is found, the ED must either provide appropriate treatment to stabilize the patient or, if certain criteria are met, arrange for transfer of the patient to an appropriate facility.\textsuperscript{124} A patient who has not been stabilized can still be transferred if certain conditions are met and the transfer is considered “appropriate” under the statute.\textsuperscript{125} A transfer is appropriate if “the transferring hospital provides the medical treatment within its capacity which minimizes the risks to the individual’s health, and . . . the receiving facility has available space and qualified personnel for the treatment of the individual, and has agreed to transfer of the individual and to provide appropriate medical treatment.”\textsuperscript{126} Also, the transfer must include all medical records and be “effected through qualified personnel and transportation equipment.”\textsuperscript{127}

If the patient is not transferred, EMTALA generally does not require hospitals to provide inpatient care to patients that have been “stabilized,”\textsuperscript{128} even when they still require ongoing care.\textsuperscript{129} Therefore, while a hospital will receive some federal Medicaid funds for the emergency care of an undocumented immigrant as required by EMTALA, the hospital will no longer receive any reimbursement under Medicaid after the patient is stabilized, because the patient no longer has an emergency medical condition.\textsuperscript{130} Consequently, under current federal law, the only remaining access to

\begin{itemize}
  \item \textsuperscript{122} 42 U.S.C. § 1395dd(a) (2006).
  \item \textsuperscript{123}  Id.; see also Baber v. Hosp. Corp. of Am., 977 F.2d 872, 881 (4th Cir. 1992). The court in Baber also noted that Congress could have enacted a “national standard” for what constitutes “appropriate medical screening” under EMTALA, but chose not to, and therefore did not intend for such a standard to exist. Id. at 880.
  \item \textsuperscript{124}  See 42 U.S.C. § 1395dd(b) (2006); see also Burditt v. U.S. Dept. of Health & Human Services, 934 F.2d 1362, 1368 (5th Cir. 1991) (“[p]atients diagnosed with an ‘emergency medical condition’ . . . must either be treated or transferred in accordance with EMTALA.”).
  \item \textsuperscript{125}  42 U.S.C. § 1395dd(c)(1)(B) (2006).
  \item \textsuperscript{126}  § 1395dd(c)(2)(A)-(B).
  \item \textsuperscript{127}  § 1395dd(c)(2)(C)-(D).
  \item \textsuperscript{128}  § 1395dd(c)(3)(A) (an emergency medical condition is “stabilized” if the hospital “provide[s] such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility”).
  \item \textsuperscript{129}  See Bryant v. Adventist Health System, 289 F.3d 1162, 1168 (9th Cir. 2002) (holding that EMTALA stabilization requirement ends when patient is admitted for inpatient care); see also James v. Sunrise Hosp., 86 F.3d 885, 889 (9th Cir. 1996) (holding that EMTALA transfer provision only applies if the patient presents to the emergency room, and therefore does not apply if the patient is admitted). But see Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990) (reasoning that admitting a patient to hospital does not necessarily mean that the emergency medical condition has been stabilized).
  \item \textsuperscript{130}  See Ortega, supra note 7, at 193. Hospitals do not even have to screen for an emergency medical condition if “the request makes it clear that the medical condition is not of an emergency
non-emergency medical funding for an undocumented immigrant turns on the court’s interpretation of what constitutes an emergency medical condition.\textsuperscript{131} EMTALA defines “emergency medical condition” as any medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in... placing the health of the individual... in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part...\textsuperscript{132}

This definition is relatively broad, inspiring at least one state to interpret emergency medical condition as including all dialysis treatment, thereby allowing hospitals in that state to receive emergency Medicaid reimbursement if the patient receiving dialysis is an undocumented immigrant.\textsuperscript{133} However, a different state court held that acute lymphocytic leukemia was not an emergency medical condition and therefore the hospital received no reimbursement under Medicaid for the care provided to an undocumented immigrant.\textsuperscript{134} Hospitals and patients will likely continue to ask the courts for clarification on what constitutes an emergency medical condition under EMTALA.\textsuperscript{135} If the term is interpreted narrowly, hospitals will receive less reimbursement for the care of undocumented immigrants under emergency Medicaid funding, and may turn to medical repatriation in order to reduce costs.

Ironically, the lack of federal funding makes undocumented immigrants more susceptible to medical repatriation, which is essentially an international form of patient dumping—the very practice that EMTALA was enacted to prevent.\textsuperscript{136} While EMTALA is essential to ensure that undocumented immigrants will receive emergency medical care as enforced by federal law, the financial burden of the long-term care needs of these patients after their emergency medical condition has stabilized rests squarely on the shoulders of the hospitals, and some find the only solution to manage those costs is medical repatriation.\textsuperscript{137}

\textsuperscript{131} 42 C.F.R. § 489.24(c) (1994).
\textsuperscript{132} See Ortega, supra note 7, at 193-95.
\textsuperscript{133} 42 U.S.C. § 1395ddd(e)(1)(A) (2006); see also Thornton, 895 F.2d at 1134 (defining emergency medical condition as “imminent danger of death or serious disability”).
\textsuperscript{134} See Ortega, supra note 7, at 194.
\textsuperscript{136} See Ortega, supra note 7, at 193-94.
\textsuperscript{137} See supra note 115 and accompanying text.
V. MEDICAL REPATRIATION IN THE CONTEXT OF FEDERAL IMMIGRATION LAW

Under the 14th Amendment, “[a]ll persons born . . . in the United States, and subject to the jurisdiction thereof, are citizens of the United States . . . .”\(^{138}\) Further, the Supreme Court of the United States has repeatedly held that it is the province of the federal government, under the plenary power doctrine, to determine who is admitted or expelled from the United States.\(^ {139}\) Thus, control over immigration is an inherent power of the federal government as “an incident of national sovereignty and does not rest with the states.”\(^ {140}\) And presumably, since the removal of any person from the United States can be made only pursuant to this power of the federal government, it would be unlawful for a private party such as a hospital to unilaterally deport a patient from the United States with no oversight by the federal government.

A. Subject Matter Jurisdiction

Subject matter jurisdiction over issues arising under federal immigration law is vested in the federal courts.\(^ {141}\) Therefore, any decision about the deportation of a person cannot be made in a state court because it lacks the requisite subject matter jurisdiction.\(^ {142}\) This basic principle of law is echoed by the 2004 *Montejo* opinion, emphatically stating that the authorization by a state court to deport a person is

\(^{138}\) U.S. Const. amend XIV, § 1.


\(^{140}\) Boswell, supra note 139, at 21; see also Chy Lung v. Freeman, 92 U.S. 275, 280 (1875) (finding it is the federal government, not the states, that has power to regulate immigration). Within the past decade, authority to enforce immigration law in some contexts has actually been delegated to state and local law enforcement officers. See generally Huyen Pham, The Inherent Flaws in the Inherent Authority Position: Why Inviting Local Enforcement of Immigration Laws Violates the Constitution, 31 Fla. St. U. L. REV. 965 (2004) (arguing it is unconstitutional for non-federal authorities to participate in immigration enforcement because it is a power solely of the federal government).

\(^{141}\) See Int’l Longshoremen’s and Warehousemen’s Union v. Meese, 891 F.2d 1374, 1377 (9th Cir. 1989); see also 28 U.S.C § 1331 (federal question jurisdiction); 8 U.S.C § 1329 (original jurisdiction in district court). However, if a “charging document” is filed before an Immigration Judge and those proceedings commence, jurisdiction vests with the Immigration Court. 8 C.F.R § 1003.14 (2003); see also Chan v. Reno, 916 F. Supp. 1289, 1299 (S.D.N.Y. 1996) (finding the federal district court lacked subject matter jurisdiction over action for injunction to adjust immigration status “because [plaintiffs had] not been subjected to deportation proceedings, [so they had] not yet exhausted their administrative remedies . . . .”).

preempted by federal law. As a case of first impression on the legal issues surrounding medical repatriation, the 2004 *Montejo* decision should stand as notice to other state courts that they do not have the subject matter jurisdiction to issue a decision regarding the private deportation of an undocumented immigrant such as Mr. Jimenez. Under the same theory, it seems logical to require that the medical deportation of a seriously ill non-citizen patient be accomplished only pursuant to already established federal procedures for the removal of undocumented immigrants, rather than turning a blind eye to private hospitals that load patients onto airplanes and send them back to their home country without any right to advocate for their right to remain in the United States. Granted, the situation may not resolve in favor of the undocumented immigrant, and the system is not without flaws, but at a minimum each person should have the right to plead their case with a modicum of due process guarantees.

B. Removal of Undocumented Immigrants without Immigration Proceedings

Courts have repeatedly held that undocumented immigrants still have limited Constitutional rights, including the right to due process and equal protection, even if they entered the United States unlawfully. The Immigration Reform Act of 1996 imposed a major restructuring of immigration law, particularly the meaning of the terms “deportation,” “inadmissibility” and “removal.” Generally speaking, if a person has already been legally admitted to the United States, that individual may still be deported based on “grounds of deportability,” but if a person wants to be admitted, and has not been admitted already, he or she must petition to be allowed in despite “grounds of inadmissibility.” Both of these categories are allowed a

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143. *Id.* at 656.
144. See *id.* at 658.
145. See infra Part VB.
146. See U.S. CONST. amend XIV, § 1 (granting due process rights to “any person”); *Zadvydas v. Davis*, 533 U.S. 678, 693 (2001) (finding “the Due Process Clause applies to all ‘persons’ within the United States, including aliens, whether their presence here is lawful, unlawful, temporary, or permanent”); *Plyler v. Doe*, 457 U.S. 202, 210 (1982) (holding that undocumented children in Texas had a right to public school education and stating that “even aliens whose presence in this country is unlawful[] have long been recognized as ‘persons’ guaranteed due process of law by the Fifth and Fourteenth Amendments”); see also Juliet Stampf, *Fitting Punishment*, 66 WASH. & LEE L. REV. 1683, 1686-87 (2009) (noting that “while the enforcement of immigration law has imported substantive criminal law norms,” many procedural rights are *not* guaranteed in immigration proceedings, including “the right to counsel at government expense, the right not to incriminate oneself, protection against double jeopardy, and the prohibition of cruel and unusual punishment, among others.” (footnotes omitted)).
147. *Boswell*, supra note 139, at 24-25.
149. 8 U.S.C. § 1182 (2000); see also *Boswell*, supra note 139, at 25-26 (noting that even if
“removal proceeding” to either gain admission or avoid physical removal (what most would think of as being deported) from the United States.\footnote{150}

Undocumented immigrants, like Mr. Jimenez, have not been legally admitted to the United States and therefore would be subject to removal unless they could prove that they are entitled to admission “clearly and beyond a doubt.”\footnote{151} Regardless of this very high burden of proof, they would at least have a right to a removal hearing where they could argue for relief from removal or challenge the grounds for removal.\footnote{152} To begin the removal process, the government would send a Notice to Appear (“NTA”) to the person subject to removal, including such information as the nature of the proceedings, the legal authority under which he or she is required to appear, the section of law allegedly violated, notice of the right to representation at no expense to the government (and a list of legal service organizations), the time and place of hearing, and the consequences for failing to appear.\footnote{153} A hearing would be scheduled before an Immigration Judge (“IJ”), and the IJ would usually issue a decision immediately.\footnote{154}

Importantly, the person seeking to remain in the United States may seek a “waiver” of a relevant ground for inadmissibility or can ask for complete “relief from removal.”\footnote{155} An IJ has the discretion to grant a waiver of removal, based on a balancing of positive factors—such as family ties and length of time in the United States—against negative factors—such as the existence of a criminal record or “bad moral character.”\footnote{156} However, final decision-making authority lies with the Attorney General, who has the discretion to suspend deportation for broad reasons including “humanitarian purposes, to assure family unity, or when otherwise in the public interest.”\footnote{157}

\footnote{150}{8 U.S.C § 1229a(a)(1) (2006); \textit{see also Kanstroom, supra} note 139, at 11 (noting that under 8 U.S.C § 1228(b) an “expedited administrative removal” could be conducted if certain factors exist, usually criminal convictions, whereby a person may have no right to a physical hearing, rather, the entire process is conducted “on paper”).}

\footnote{151}{8 U.S.C § 1229a(c)(2)(A) (2006).}


\footnote{153}{\textit{See Boswell, supra} note 139, at 38.}

\footnote{154}{\textit{Id.} at 39 (noting that sometimes a written decision is issued if the case is complex, and there is an opportunity for appeal within 30 days).}

\footnote{155}{\textit{Id.} at 42. There are also methods used to temporarily delay removal including; parole, stay of removal, deferred enforced departure, and Temporary Protected Status. \textit{See Stumpf, supra} note 146, at 1697.}

\footnote{156}{\textit{See Boswell, supra} note 139, at 43. Additional grounds may exist for relief from removal. For an in depth discussion \textit{see id.} at 68-72.}

\footnote{157}{8 U.S.C § 1227(a)(1)(E)(iii) (2006).}
When Mr. Jimenez and countless other undocumented immigrants were medically repatriated to their home countries, they were denied any opportunity to advocate within the framework of immigration law for their right to remain in the United States. Under current law, it is almost impossible for an undocumented immigrant to lawfully return to the United States after having lived in the United States unlawfully. Mr. Jimenez or his guardian, acting through legal counsel in the appropriate jurisdiction, could have made several arguments for relief for removal under current immigration law. First, they could have argued for relief from removal based on “the humanitarian purpose” that Mr. Jimenez would suffer great bodily harm if returned to a facility in Guatemala that could not provide appropriate care, and was in fact not likely to keep him as a patient due to overcrowding. Second, under current federal immigration law, an undocumented immigrant with specific health care requirements might seek relief from removal or even argue for asylum protection “depending upon the medical needs of the client and the existence or lack of appropriate medical care in the native country, as well as the social treatment or acceptance of persons with similar disabilities.” Lastly, an undocumented immigrant could seek “cancellation of removal” if he or she has been in the United States for ten continuous years and deportation “would result in extreme and exceptionally unusual hardship to a U.S. citizen or lawful permanent family member.”

158. See supra notes 151-56 and accompanying text.  

160. There are other arguments that could be made based on the specific circumstances of a particular undocumented immigrant. This article focuses more on relief from removal based solely on health care needs.  
161. See Aboobaker, supra note 159; see also 8 U.S.C § 1227(a)(1)(E)(iii) (2006). The facility in Guatemala did, in fact, discharge Mr. Jimenez only a few weeks after he was transferred from the United States. See Sontag, supra note 12.

162. Lori A. Nessel, Lori A. Nessel on the Legality and Ethics of Medical Repatriation, EMERGING ISSUES LAW CENTER, Oct. 6, 2009, http://law.lexisnexis.com/practiceareas/Emerging-Issues/Lori-A-Nessel-on-the-Legality-and-Ethics-of-Medical-Repatriation. The author also proposes additional challenges an attorney could bring in a medical deportation case including: 1) deportation without due process is a violation of rights “guaranteed by international human-rights instruments that the United States has ratified or signed, such as the International Covenant on Civil and Political Rights and the American Convention on Human Rights” and 2) “a violation of internationally recognized right to health, as guaranteed by the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights.” Id.

163. Id. (citing 8 U.S.C § 1229b(b) (2006)).
VI. OPENING A DIALOGUE: THE NEED FOR OVERSIGHT AND SUGGESTIONS FOR REGULATION

Hospitals argue that they are forced to choose between keeping the patients who need long term care indefinitely, finding a long term care facility who will accept them without Medicaid, or resorting to medical repatriation.\textsuperscript{164} Undocumented immigrants respond that, in many cases, medical deportation to their home country is an effective death sentence accomplished without federal oversight or clear legal standards.\textsuperscript{165} Further, scholars argue that medical repatriation by private hospitals is a violation of due process guarantees under both federal immigration laws and international human rights standards.\textsuperscript{166}

Physicians have also weighed in on this issue, possibly because of heavy media coverage.\textsuperscript{167} In 2008, the California Medical Association ("CMA") passed a resolution opposing "forced deportation of patients" and then asked the American Medical Association ("AMA") to similarly oppose the practice.\textsuperscript{168} The AMA has yet to make a formal policy statement, but in 2009 it identified the importance of the issue and commissioned a study to gather more information.\textsuperscript{169} While each of the groups most affected by medical repatriation has raised valid concerns, most suggestions for oversight or regulation of the practice are likely to be politically unpopular with a general public that is deeply divided on both immigration and health care issues.\textsuperscript{170} However, there are several possible approaches to ensure that medical repatriation is limited, or at the very least, regulated according to a discernable legislative standard.

From an initial perspective, as noted by the CMA, individual hospitals should have a policy in place preventing the removal of patients against their will and without the informed consent of the person responsible for their care.\textsuperscript{171} Part of that informed consent should include educating the patients or guardians as to the potential ramifications on their future immigration status if they physically leave country.\textsuperscript{172} In many cases medical repatriation is done without even consulting the patient or the patient’s family, however, requiring some form of consent up front

\textsuperscript{164} See Sontag, \textit{supra} note 22.
\textsuperscript{165} See Ortega, \textit{supra} note 7, at 188.
\textsuperscript{166} See Nessel, \textit{supra} note 162.
\textsuperscript{167} See Wolpin, \textit{supra} note 10, at 153.
\textsuperscript{168} Id.
\textsuperscript{169} See id. As of the writing of this note, the AMA has made no formal pronouncement regarding the practice of medical repatriation.
\textsuperscript{170} See Patsner, \textit{supra} note 13, at 1; see also Wolpin, \textit{supra} note 10, at 154-55.
\textsuperscript{171} See Wolpin, \textit{supra} note 10, at 153-54.
\textsuperscript{172} See id.
would at least provide minimal protection to undocumented immigrants before they are removed.\footnote{173}

From a larger federal regulatory perspective, the first proposed solution is to modify the Welfare Reform Act to allow undocumented immigrants and legal immigrants who have been here less than five years access to minimum Medicaid eligibility for certain “acute illness[es].”\footnote{174} Granted, in light of the vehement opposition to universal health care and open immigration policies, any change to Medicaid law that increases benefits for undocumented immigrants would likely not be politically viable.\footnote{175} However, if, in addition to emergency care, hospitals could receive Medicaid reimbursement to care for some acutely ill patients, they might not turn to medical repatriation because they would receive federal funding for the care of these financially onerous patients. And while this option might sound like it will cost the taxpayers more money, the federal government has already been called upon to alleviate the financial strain on hospitals.\footnote{176} In 2003 the Senate allocated $1 billion over five years to states specifically to provide services for undocumented immigrants.\footnote{177}

Second, immigrants’ rights advocates propose that, at a minimum, the portion of the Welfare Reform Act denying benefits for legal immigrants who have been in the country for less than five years should be struck down—particularly because this group includes workers who pay taxes and make other economic contributions within the United States.\footnote{178} Some have suggested that providing preventative care to undocumented and legal immigrants would ultimately be far less expensive for hospitals than constant emergency care for long-term chronic illnesses.\footnote{179} This suggestion might not lessen the financial burden of caring for undocumented patients injured in sudden and catastrophic events such as car accidents. But in the case of Mr. Jimenez, as stated by his lawyer, it would have been less expensive for the hospital to pay for Mr. Jimenez to receive rehabilitative care in a long-term care facility than to keep him as a ward of the hospital.\footnote{180}

\footnote{173. See id.}
\footnote{174. Wolpin, supra note 10, at 155 (citing personal communication with Dr. Robert J. Margolis to author, November 25, 2008). There is no further discussion in the article as to what category of undocumented immigrant patient would qualify for this “acute care” benefit.}
\footnote{175. See Wolpin, supra note 10, at 155.}
\footnote{176. See Ortega, supra note 7, at 198.}
\footnote{177. Id.}
\footnote{179. See Ortega, supra note 7, at 188-89.}
\footnote{180. See Sontag, supra note 12.}
Third, a less drastic solution would be to extend existing federal health care legislation to encompass regulation of medical repatriation. This could be accomplished within two regulatory schemes.

Under the first regulatory scheme, the transfer provisions of EMTALA\(^{181}\) could be expanded to expressly apply when hospitals medically repatriate patients back to their home countries. EMTALA was enacted to ensure that hospitals could not dump patients who are unable to afford health care, and this policy goal is particularly applicable in the case of severely injured undocumented immigrants.\(^{182}\) Specifically, the facility in the home country must be “appropriate,” which means it has the physical capability to admit and treat the patient in question.\(^{183}\)

A second regulatory solution could be accomplished by applying the 2004 Montejo court’s interpretation of federal law that requires any hospital providing Medicare services to follow certain discharge guidelines when medically repatriating a patient to another facility.\(^{184}\) Under Medicare regulations, the facility accepting the patient must be an “appropriate facility,”\(^{185}\) which has been interpreted to mean one “that can meet the patient’s medical needs on a post-discharge basis.”\(^{186}\) It should be noted, however, that the practical outcome of enacting this type of legal standard in the context of international transfers would be to almost unilaterally prevent any medical repatriations by hospitals because most facilities in a patient’s home countries will not be found “appropriate” when compared to hospitals in the United States.\(^{187}\)

A fourth and final proposed solution is that a hospital wishing to medically repatriate an undocumented patient could be required to contact immigration officials to officially deport the person from the United States—with the requisite due process guarantees under federal immigration law.\(^{188}\) Allowing private actors like hospitals to unilaterally remove people from the United States and send them back to their home countries, regardless of their immigration status, leads one to question whether any private citizen may eventually be allowed to physically remove an undocumented immigrant, or even legal immigrant, with absolutely no government oversight. Immigrant advocates oppose this option because they believe it will chill undocumented immigrants’ likelihood to seek emergency care because of the possibility of being subject to deportation.\(^{189}\) Also, immigration law is complex and

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181. See 42 U.S.C § 1395dd(c) (2006).
182. See supra note 115 and accompanying text.
183. See supra notes 124-26 and accompanying text.
185. Id. (citing 42 C.F.R. § 482.43(d)).
186. Id. (citing 42 C.F.R. § 482.21(b)(2)).
187. See Patsner, supra note 13, at 3.
188. See supra Part V.B.
189. See Nessel, supra note 162.
One judge described “the labyrinthine character of modern immigration law” as “a maze of hyper-technical statutes and regulations that engender waste, delay, and confusion for the Government and petitioners alike.” However, as explained above, allowing undocumented immigrants the opportunity to advocate for relief from removal in federal immigration proceedings is preferable to allowing people to be physically removed from the country with no due process whatsoever.

VII. CONCLUSION

The issues surrounding medical repatriation are complex, and any suggested solution to the problem is fraught with difficulties for both hospitals and undocumented immigrants. But in the meantime, untold numbers of critically ill people are being sent to facilities that cannot care for them, often with very little hope for survival. In the case of Mr. Jimenez, the hospital lost over $1.5 million plus untold fees in multiple lawsuits over a five-year period. Mr. Jimenez was transferred to a long-term care facility in Guatemala, but it was soon forced to discharge him because it could not provide appropriate care and needed to make his bed available for other patients. Now Mr. Jimenez resides with his elderly mother high in the mountains of Guatemala, and receives absolutely no medical care aside from doses of Alka-Seltzer to combat the violent seizures he still experiences as a result of his head injuries.

This article suggests multiple ways to begin regulating this burgeoning human rights issue within existing health care legislation and immigration law. The practice of medical repatriation has been uncovered, and now it must be addressed through Congressional Reform whether by expanding Medicaid eligibility under the Welfare Reform Act, extending federal EMTALA or Medicare regulations, or requiring hospitals to turn over undocumented immigrants so they have access to proceedings under current immigration law. In the meantime, more patients and their families will likely appeal to the courts for relief based on multiple legal theories, including, but not limited to: damages for false imprisonment, human rights violations, constitutional violations of due process and equal protection, and federal preemption. As it stands now, the cases of first impression from Florida did not establish a

191. Id.
192. See supra Part V.B.
193. See Sontag, supra note 12.
194. See id.
195. Id.
196. Id.
clearly discernable legal standard to guide hospitals or patients on the issue of medical repatriation, and no federal health care or immigration law currently addresses this issue. It is imperative that federal and state legislatures open a dialogue to enact legal standards governing medical repatriations and to strike a balance between maintaining the financial viability of United States hospitals and allowing access to life-saving health care for patients like Mr. Jimenez.