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HEALTHCARE FOR THE UNDOCUMENTED: SOLVING A PUBLIC HEALTH CRISIS IN THE U.S.

Julianne Zuber*

I. INTRODUCTION

The right to the highest attainable standard of health is a fundamental human right protected by international law. An important element of the right to health is that health care must be affordable and accessible to all without discrimination. In the United States, this fundamental right becomes increasingly complicated when discussing undocumented immigrants. The Department of Homeland Security, in concert with Congress and state and local lawmakers, continues to struggle to find a balance between securing our nation's borders and ensuring human rights are protected. The mandate under which the Patient Protection and Affordable Care Act of 2010 ("PPACA") was passed was to provide "affordable health care to all." However, the PPACA does not afford

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2. Id. at 60.


Healthcare for the Undocumented

undocumented immigrants the opportunity to purchase affordable health insurance.6

As a result, undocumented immigrants will continue to seek and receive health care under the Emergency Medical Treatment and Active Labor Act ("EMTALA"), which requires hospitals to treat all patients, including undocumented immigrants, in emergency situations.7 However, since the EMTALA was enacted in 1986, state governments have spent billions of dollars8 to offset the cost of treatment of undocumented immigrants.9 A 2010 report by the Federation for American Immigration Reform ("FAIR") estimates the total annual costs of undocumented immigration at the federal, state, and local levels to be about $113 billion—nearly $29 billion at the federal level and $84 billion at the state and local levels.10 Moreover, dozens of hospitals in Texas, New Mexico, Arizona, and California have been forced to close their doors, or face bankruptcy, because of this federally-mandated program requiring free emergency room services to


9. See U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-01-747, EMERGENCY CARE: EMTALA IMPLEMENTATION AND ENFORCEMENT ISSUES (2001). (While the GAO has estimated that billions of dollars have been spent, an exact dollar value cannot be determined as upon entering emergency rooms undocumented immigrants typically provide false names, fake ID’s, etc., making it nearly impossible for hospitals to track a specific number).

anyone regardless of their ability to pay, including undocumented immigrants.\(^{11}\)

The budgetary burden placed on states and local hospitals because of the administration of health care to undocumented immigrants, combined with the absence of clear guidance from Congress or the current administration, has led hospitals to step away from their primary mission of patient care to become immigration enforcement.\(^{12}\) This, more often than not, has led to medical repatriations that increase the health risks of undocumented immigrants.\(^{13}\)

This Comment will examine how the latest federal health care legislation, PPACA, has left undocumented immigrants without reasonable access to health care while continuing to place an extreme financial burden on federal, state, and local taxpayers. After surveying the existing legislation, this Comment will identify both current and potential financial, social, and public health challenges that could arise if undocumented immigrants continue to be denied health care, or are confronted with substantial barriers to its access. These challenges, however, are not limited to the undocumented immigrant population because the general population is adversely affected as well. With these challenges in mind, this Comment will address why the federal government should take affirmative steps to provide undocumented immigrants with undeterred access to health care. Lastly, this Comment will make recommendations of how federal, state, and local governments can act together to accomplish this goal.

In order to ensure “health care for all Americans,”\(^{14}\) the driving mandate under which the PPACA was passed, Congress should take legislative action to ensure the protection of a fundamental human right as defined by the international community, and reduce the financial burden being placed on federal, state, and local healthcare programs. Whether the action is in the form of improvements in the mandates provided to state and local lawmakers on existing law,\(^{15}\) or the development of reform legislation

\(^{11}\) Id. at 4.

\(^{12}\) See generally Martin & Ruark, supra note 10.


drawing on the successes in EU countries such as the Netherlands,\textsuperscript{16} immediate action should be taken to reduce the financial cost-burden on states and strengthen public health.

II. REGULATION AFFECTING UNDOCUMENTED IMMIGRANTS' HEALTH CARE

A. Emergency Medical Treatment and Leave Act ("EMTALA")

The Emergency Medical Treatment and Active Labor Act of 1986 ("EMTALA") generally restricts the ability of hospitals to transfer or discharge a patient with an emergency medical condition prior to the patient’s stabilization.\textsuperscript{17} Specifically, Section 1396(b)(v)(3) of the EMTALA states that an emergency medical condition is:

- a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including extreme pain) such that the absence of immediate medical attention could reasonably be expected to result in A) placing the patient’s health in serious jeopardy, B) serious impairment to bodily functions, or C) serious dysfunction of any bodily organ or part.\textsuperscript{18}

"EMTALA was passed as a response to public outrage over alarming reports of hospitals engaging in ‘patient dumping,’\textsuperscript{19} the practice of refusing to treat patients in need of emergency care or transferring such patients prior to their stabilization."\textsuperscript{20} Throughout the 1970s and 1980s, the number of uninsured individuals grew considerably, and amidst a recession and shrinking budgets, more and more hospitals began dumping patients for inability to pay or for other discriminatory, non-medical reasons.\textsuperscript{21}


\textsuperscript{17} See EMTALA, 42 U.S.C. § 1395dd.


\textsuperscript{19} Beverly Cohen, Disentangling EMTALA from Medical Malpractice: Revising EMTALA’s Screening Standard to Differentiate Between Ordinary Negligence and Discriminatory Denials of Care, 82 TUL. L. REV. 645, 648–53 (2007).

\textsuperscript{20} Agraharkar, supra note 6, at 573.

\textsuperscript{21} Cohen, supra note 19, at 653.
EMTALA banned these practices by requiring hospitals to screen all emergency room patients to determine whether or not they have an emergency medical condition. If a hospital determines that a patient has an emergency condition, EMTALA restricts the hospital from transferring the patient until the patient has been stabilized. The only exceptions to this rule are if the patient requests a transfer in writing after being informed of the hospital’s obligations, or if a physician determines and certifies that the medical benefits of a transfer outweigh its risks. EMTALA requires that if a hospital decides to transfer a patient, the hospital provide treatment that minimizes risks to the patient, find a receiving facility that is capable and willing to treat the patient, provide that facility with all medical records relating to the condition, and transport the patient using qualified personnel and proper equipment. Additionally, the hospital may not delay in screening the patient or providing stabilizing treatment in order to resolve concerns about the patient’s “method of payment or insurance status.”

EMTALA provides all individuals, regardless of their ability to pay, relatively equal access to emergency medical treatment. The provisions also subject noncompliant hospitals to private actions by patients who suffer personal harm as a result of violations. However once a patient is considered “stabilized,” a hospital’s duties to protect the patient under EMTALA are extinguished. Per EMTALA, “stabilized” is defined as the point at which “no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility.” Additionally, courts have held and

22. See Agraharkar, supra note 6, at 573-74.
24. Id. § 1395dd(c).
25. Id. § 1395dd(c)(2).
26. Id. § 1395dd(h).
27. Id.
29. Id.
30. Id.
subsequent regulations have agreed, that a hospital also discharges its obligations under EMTALA once it admits an individual as an inpatient, even if the individual has not yet been stabilized.\textsuperscript{31}

\textbf{B. Role of the Medicare and Medicaid Programs}

EMTALA helps protect patients who are uninsured as well as those who have Medicare, Medicaid, or private insurance. It requires all hospitals that accept Medicare for any patient to provide necessary emergency care to all patients who come to the emergency department. Therefore, the financial impact of the undocumented immigrant usage of EMTALA “cannot be understood without a general overview of both the Medicare and Medicaid programs, particularly the coverage disjunction between the two as it affects disabled undocumented immigrants.”\textsuperscript{32}

\textbf{1. Medicare Reimbursement and Antidumping Laws}

Medicare is a federal health insurance program created in 1965 that insures medical care for people sixty-five and over as well as for people under sixty-five who are entitled to disability benefits.\textsuperscript{33} Most hospitals receive Medicare payments.\textsuperscript{34} The program is funded through payroll taxes paid by U.S. workers and the amount paid is matched by their employers.\textsuperscript{35} Medicare does not pay for nursing home care unless the patient requires skilled nursing care for the treatment of an acute medical problem.\textsuperscript{36}

\textsuperscript{31} See id.


\textsuperscript{34} See, e.g., Sontag, supra note 13, at A1.

\textsuperscript{35} See DONALD A. BARR, \textit{INTRODUCTION TO U.S. HEALTH POLICY: THE ORGANIZATION, FINANCING, AND DELIVERY OF HEALTH CARE IN AMERICA} 116 (2d ed. 2007). These tax revenues are deposited into a Medicare trust fund. Hospitals that treat Medicare recipients are paid by private companies who have contracted with the government. These companies are subsequently paid from the Medicare trust fund. \textit{Id.}

\textsuperscript{36} \textit{Id.}
As previously discussed, under EMTALA, hospitals that receive Medicare funding and have emergency treatment facilities must treat all patients with emergency medical conditions who present themselves in the emergency department, regardless of the patient's insurance status. Hospitals that fail to comply with these so-called "anti-dumping" laws are subject to civil monetary penalties for each violation. If hospitals fail to comply with their obligation to treat all emergency patients, in addition to paying fines, they risk losing their status as Medicare providers. Because most hospitals are dependent on Medicare funds, they therefore comply with the emergency treatment rules.

However, when a patient's discharge plan requires continuing care and the hospital can make no provisions, both the hospital and the patient are left in limbo. The hospital cannot discharge the patient without violating Medicare regulations (in order to receive federal funding), and the patient remains in the hospital but without receiving the type of treatment doctors have deemed medically appropriate. Additionally, because undocumented immigrant patients are ineligible for any sort of federal financial assistance and cannot typically pay out of pocket, the hospital continues to incur the costs of housing and caring for the patient at a much higher daily rate than that associated with long-term care.

Pursuant to EMTALA, all hospitals receiving federal Medicare funds are required to provide emergency care to all patients, regardless of immigration status or ability to pay. In 2003, the Medicare Modernization Act

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38. RAFFEL & BARSUKIEWICZ, supra note 33, at 32.

39. See 42 U.S.C. §1395dd(d)(1)(A) (2006). Penalties can be assessed up to $50,000 per incident or, in a hospital with fewer than 100 beds, $25,000 per incident. Id.

40. Id.


42. See generally, Sontag, supra note 13.

43. Id.

Healthcare for the Undocumented

("MMA") overhauled the Medicare public health program to improve services, including prescription drugs, provided to eligible individuals. As a part of the MMA, Congress appropriated $1 billion of the $549 billion dollar program to help hospitals and certain other providers cover their costs of "providing emergency services required under [EMTALA] to undocumented immigrants." EMTALA, however, only requires hospitals to stabilize an emergency medical condition and ensure that the transfer will not cause any further deterioration in the patient's condition. It is therefore up to the doctors and hospital staff to determine whether or not the deterioration of the condition is likely. If a facility is found to be refusing patients or transferring them before they're stabilized (i.e. "patient dumping"), the hospital may be found in violation of EMTALA and thus subject to penalties, including civil monetary penalties, and license revocation.

While studies have shown that patient dumping has increased, the U.S. Department of Health and Human Services ("HHS") enforcement of EMTALA violations impacting undocumented immigrants has been "lax." Over the past several years, the HHS caseload primarily consisted of cases involving Center for Medicare and Medicaid Services ("CMS") sanctions against nursing homes or HHS Inspector General ("IG") exclusion cases.


46. Id.


49. Id. § 1395dd(d)(1).


2. Medicaid Criteria and Administration

Medicaid, created by the federal government in 1965, is a program that provides health care to the poor.52 While Medicare is administered by the federal government, Medicaid is administered by the states and funded through a combination of state and federal funds.53 Unlike Medicare, which provides universal coverage for those below the poverty line,54 particularly those over the age of sixty-five, coverage provided by Medicaid to those below the federal poverty line is dependent on how the state designs its program of coverage.55

Although state-specific, the general Medicaid requirements specify that, in most cases, recipients must be U.S. citizens, although certain noncitizen legal immigrants are entitled to Medicaid.56 Generally, there are three classes of people whose members are eligible for Medicaid: low-income families with children, elderly people who meet certain income requirements, and disabled people who meet certain income requirements.57 The Refugee Act of 1980 added to this list by making immigrants who receive a grant of asylum entitled to receive Medicaid funds.58 For such

52. See BARR, supra note 35, at 148.

53. 42 U.S.C. § 1396 (2006). The Medicaid statute specifies three groups of people whose members are eligible for Medicaid, low-income families with children, elderly people who meet certain income requirements, and disabled people who meet certain income requirements; see also, Stead, supra note 32, at 313. In order for a state to receive federal reimbursement, all members of the specified groups within the state must be eligible for Medicaid under the state's eligibility criteria. Id.


57. 42 U.S.C. §1396.

individuals, the statute limits the receipt of Medicaid funds to a period of seven years after asylum is granted.\textsuperscript{59} The burden of providing long-term or lifelong care to "unfunded" immigrant patients, asylum or otherwise, has led some hospitals to repatriate patients to their country of origin.\textsuperscript{60} While under the Medicaid statute each state has the option of covering a particular class of patients who are not in one of the three specified groups, but whose income falls below a state-specified level,\textsuperscript{61} hospitals tend to find repatriation or deportation a less burdensome means.\textsuperscript{62}

C. \textit{Seeking Asylum in the U.S. (Refugee Act and the Immigration and Nationality Act ("INA"))}

To qualify for asylum in the United States, an applicant must show that he or she is a refugee within the meaning of the Immigration and Nationality Act ("INA").\textsuperscript{63} Because asylees are eligible for Medicaid, a successful asylum claim could be a potential solution to both the patient and the hospital. Some undocumented immigrants seeking health care may be likely to have strong asylum claims.\textsuperscript{64}

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\textsuperscript{59} See id.

\textsuperscript{60} Stead, supra note 32, at 314; see also, e.g., Marcus Barham, \textit{Uninsured Immigrant Patients Sent Home for Care Against Their Will}, ABC News (May 22, 2008), http://abcnews.go.com/Health/Story?id=4903138&page=1. See also 42 U.S.C. §1396 (stating that Medicaid pays for the cost of long-term care, an undocumented immigrant who is hospitalized after a traumatic injury and later requires sub-acute care can be transferred to a nursing home or rehabilitation facility because he will qualify for Medicaid).

\textsuperscript{61} See Stead, supra note 32, at 313.

\textsuperscript{62} Medical deportation? 9OYS Finds Jesus Cornelio's Plight Is Not Unique, \textit{9 On Your Side Immigration Watch} (Sept. 30, 2011), http://www.kgun9.com/news/local/130889953.html (one of the largest hospitals in Tucson, the University Medical Center, has admitted to having over 15 deportations a year).


\textsuperscript{64} See Stead, supra note 32, at 317; see also Aliens and Nationality Act, 8 U.S.C. § 1158(b)(1)(B)(i) (2006) (stating that the burden of proof is on the applicant to establish that the applicant is a refugee; in establishing the statutory grounds for asylum Congress
The INA defines a refugee as a person outside the country of his nationality who is unable or unwilling to return to 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. A refugee applicant must show he or she fits within one of the five protected categories and link the persecution to that status. As judicial interpretation of the Refugee Act has evolved, the restrictions imposed by the five categories have "proved to be among the most substantial barriers to relief."

D. 2010 Patient Protection and Affordable Care Act ("PPACA")

In 2010, the PPACA was passed under the mantra of providing "Health care for All." However, the House version of the bill stated that, "nothing in this subtitle shall allow federal payments for affordability credits on behalf of individuals who are not lawfully present in the United States." sought to bring U.S. law into compliance with the 1951 United Nations Convention Relating to the Status of Refugees ("Convention") and its modifications in the 1967 Protocol ("Protocol").

65. See Stead, supra note 32, at 317; see also 8 U.S.C. § 1101(a)(42)(A) (2006) (indicating that the definition of the term "refugee" was modified by the Refugee Act of 1980 specifically to track the language of the Protocol).

66. See Stead, supra note 32, at 317; see also Hincapie v. Gonzales, 494 F.3d 213, 217 (1st Cir. 2007) (holding that another element of an asylum claim based on persecution involves the nexus requirement, that is, whether the harm, if otherwise sufficient, has occurred (or is anticipated to occur) on account of one of the five statutorily protected grounds).

67. See Stead, supra note 32, at 317; see also Mark Von Sternberg, The Grounds of Refugee Protection in the Context of International Human Rights and Humanitarian Law: Canadian and United States Case Law Compared (The Hague: MartinusNijhoff 2002) (describing the criteria for applications for asylum, specifically they must be filed within one year of arrival into the United States unless the applicant can demonstrate that extraordinary circumstances beyond his control prevented him from filing or that a change in circumstances has affected his eligibility for asylum).


Thus, the law explicitly prohibits undocumented immigrants from participating in the new health insurance exchanges.\(^{70}\) As a result, there is currently no domestic framework in the U.S. to ensure adequate long term access to health care for undocumented immigrants.

One of the objectives of the PPACA was to reduce the use of emergency room ("ER") care by the uninsured through imposing the "individual mandate" requirement.\(^{71}\) The intention of the PPACA was to reduce the demand on ER care, thus EMTALA is still necessary.\(^{72}\) If the uninsured could access care in cheaper clinical settings, they could get the same or better services at a lower total cost than the hospital ER facility.\(^{73}\) In reality, studies conflict on what the actual cost of ER care is in comparison with a specialized clinic, and it is still up for debate how much it is possible to increase efficiency and how much efficiency loss might result from clinical waste in routine services used by the newly insured.\(^{74}\)

### E. International Protection of Human Rights

#### 1. Right to Life and Health Care—Universal Declaration of Human Rights

On December 10, 1948, the General Assembly of the United Nations adopted and proclaimed the Universal Declaration of Human Rights ("UDHR"), which called upon all member countries to publicize the text of the UDHR and "to cause it to be disseminated, displayed, read and expounded principally in schools and other educational institutions, without

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\(^{70}\) Id.


\(^{72}\) See PPACA, 124 Stat. at 171.

\(^{73}\) Id. at 156.

distinction based on the political status of countries or territories."\(^{75}\)

Extrajudicial medical repatriations violate UDHR's guarantee to "the right to life, liberty and security of person."\(^{76}\)

The United States has fully supported the spirit of the UDHR including signing the two treaties that were intended as legal enforcement mechanisms: the "International Covenant on Civil and Political Rights" and the "International Covenant on Economic, Social and Cultural Rights."\(^{77}\)

While the United States has fully supported the UDHR, it is currently falling short of the intention of these international treaties: by not addressing the fundamental human right and UDHR guarantee of health care for all in the PPACA, continuing to not cover undocumented immigrants, and allowing medical repatriations to continue in the U.S. health care system.

III. CHALLENGES TO PROVIDING UNDOCUMENTED IMMIGRANTS WITH HEALTHCARE

U.S. healthcare providers, states, and the federal government continue to react on a case-by-case basis to the undocumented immigrant crisis. Any solution to this crisis should address the following challenges detailed below, including the financial burden that the states and hospitals continue to carry, the risk of the outbreak of a new disease, and the public perception of human rights violations.

A. States and Hospitals Continue to Burden the Cost

In 2010, a report by FAIR estimated the total annual cost of undocumented immigrants to be "nearly $29 billion at the federal level and $84 billion at the state and local level," primarily at emergency rooms and free clinics.\(^{78}\) The report determined that approximately 21% of those expenditures were related to medical care for undocumented immigrants resulting in $5.9 billion spent at the federal level and approximately a total of $17 billion spent at the state and local levels with primary expenditures


\(^{76}\) Id.

\(^{77}\) Id.

\(^{78}\) See MARTIN & RUARK, supra note 10, at 1, 15.
being in the border and port-of-entry states (e.g., CA, AZ, FL, TX, NY, etc.).

While research has been conducted to estimate the amount of taxes that are paid by undocumented immigrant workers, most undocumented immigrants do not pay income taxes, and those who do are typically able to claim tax credits.

I. Example of Failed Congressional Intervention

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("Welfare Reform Act") was passed by Congress in response to the states’ hostility towards the high cost of providing social services to undocumented immigrants. The Welfare Reform Act reduced reimbursement for hospitals that provided medical care to undocumented immigrants by further restricting Medicaid eligibility. The Welfare Reform Act provided that "it is a compelling government interest to remove the incentive for [undocumented] immigration provided by the availability of public benefits." However, the Welfare Reform Act did not remove every avenue of health care for undocumented immigrants, nor did it ease the financial burden on the states. The legislation contains an exception stating that federal Medicaid assistance is provided for treatment of "emergency medical conditions" and "assistance for immunizations with

79. Id. at 2-4.

80. Id. at 1.


82. 8 U.S.C. § 1611(a) (2006) (denying federal public benefits to those who are not qualified aliens). Even qualified aliens are denied federal public-health benefits for five years. Id. § 1613(a).

83. Id. § 1601(6). The government estimated cost savings of $54 billion over the course of the six years since its enactment.


85. 8 U.S.C. § 1621(b)(1). The term "emergency medical condition" is defined in Section 1396b(v)(3) of Title 42.
respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases," regardless of immigrant status.\textsuperscript{86}

The immigrant provisions in the Welfare Reform Act curtailed states’ ability to serve the immigrant population under Medicaid and thus arguably served as a dis-incentive for illegal entry into the United States. However, the Welfare Reform Act did nothing to address the health care issues that result from undocumented immigrants currently in the country. As a result of the Welfare Reform Act, "states and localities [continue to] bear the brunt of federal policies that attempt to promote immigration policy through programs designed to achieve public-health objectives."\textsuperscript{88} By reducing the availability of federal funds, the Welfare Reform Act merely shifts the financial burden of providing medical care to uninsured, undocumented immigrants to states, localities, and hospitals, but it does not reduce the costs.\textsuperscript{89}

2. \textit{Annual Cost of EMTALA}

As previously mentioned, under EMTALA, hospitals are required to provide emergency medical care to all persons regardless of their immigration status in order to qualify for Medicaid funding.\textsuperscript{90} The Census Bureau data shows that 32% of Hispanics, 20% of African Americans, and 11% of non-Hispanic whites are uninsured.\textsuperscript{91} The percentage of uninsured,

\textsuperscript{86} 8 U.S.C. § 1621(b)(3).

\textsuperscript{87} See Espenshade et al., \textit{supra} note 81, at 772-773.

\textsuperscript{88} See generally Janet M. Calvo, \textit{The Consequences of Restricted Health Care Access for Immigrants: Lessons from Medicaid and SCHIP}, 17 \textit{ANNALS HEALTH L.} 175, 179, 184 (2008) (discussing the conflicting judicial interpretations of the definition of "emergency medical condition" and the conflict between state and federal authorities related to defining the term).

\textsuperscript{89} Lindita Bresa, \textit{Uninsured, Illegal, and in Need of Long-Term Care: The Repatriation of Undocumented Immigrants by U.S. Hospitals}, 40 \textit{SETON HALL L. REV.} 1663, 1667 (2010).


non-citizen Hispanics is 55%.\textsuperscript{92} Moreover, as undocumented immigrants tend to be poor and lack private or employment insurance, they are more likely to use emergency rooms as their principal source of medical care.\textsuperscript{93} It has been estimated that hospitals are collectively spending about $2 billion a year in unpaid medical expenses to treat undocumented immigrants.\textsuperscript{94} This is in addition to the $250 million of reimbursements made to hospitals under EMTALA in 2010.\textsuperscript{95} Between 1993 and 2003, sixty California hospitals were forced to close, and many scaled back their services, due to outstanding bills for services rendered.\textsuperscript{96}

Hospitals receive federal funds to stabilize the patients that enter the emergency rooms.\textsuperscript{97} However, cases where patients require extensive medical care after stabilization are especially problematic. Undocumented immigrants, often uninsured and ineligible for Medicaid, cannot afford such treatments, and no state medical center will accept them without insurance of Medicaid coverage.\textsuperscript{98} Thus, hospitals end up caring for, and absorbing the expenses for, undocumented immigrant patients until they find a way to discharge them.\textsuperscript{99} In doing so, some hospitals go as far as flying or driving the patients to their countries of origin.\textsuperscript{100} Further, the existence of untreated

\textsuperscript{92.} Id.

\textsuperscript{93.} Dana Canedy, \textit{Hospitals Feeling Strain from Illegal Immigrants}, N.Y. TIMES, Aug. 25, 2002.

\textsuperscript{94.} Id.

\textsuperscript{95.} \textit{See} MARTIN & RUARK, \textit{supra} note 10, at 15.

\textsuperscript{96.} Madeleine Pelner Cosman, \textit{Illegal Aliens and American Medicine}, 10 J. AM. PHYSICIANS & SURGEONS 6 (2005) (suggesting that one of the country's best emergency medical response organizations, Los Angeles County Trauma Care Network, was mostly dismantled as a result of EMTALA and the burden illegal immigrants place on it).


\textsuperscript{98.} Id.

\textsuperscript{99.} \textit{See} Canedy, \textit{supra} note 93 ("Hospitals insist that they are not turning away critically injured people, but they are becoming more aggressive in seeking ways to release them").

\textsuperscript{100.} Id.
immigrants poses a significant risk to the public health. According to the federal Centers for Disease Control and Prevention ("CDC"), from 2006 through 2010, the top five countries of origin of foreign-born persons with tuberculosis ("TB") were Mexico, the Philippines, Vietnam, India, and China, with foreign-born Hispanics and Asians together representing 48% of the national case total. The CDC goes on to state that in order to eliminate TB, efforts to address the disparities (in healthcare) that exist between U.S.-born and foreign-born persons should continue.

In 2003, Congress enacted Section 1011 in the MMA, recognizing that the EMTALA admission requirement constituted a major funding obligation on local medical facilities, and that many medical facilities had begun to close their emergency rooms because of the burden of uncompensated costs. The largest allocations in the 2005 fiscal year went to California, which received $70.8 million; Texas, $46 million; Arizona, $45 million; New York, $12.3 million; Illinois, $10.3 million; Florida, $8.7 million; and New Mexico, $5.1 million. The MMA legislation provided for federal reimbursement of emergency medical care extended to undocumented immigrants. Specifically, it authorized a $1 billion program, at $250 million each year for 2005 through 2008, with a targeted distribution to facilities in the states bordering Mexico.

101. Id.


103. Id.


106. See Pear, supra note 91 (identifying which states were given federal aid to relieve the economic burden that illegal immigrants place on local hospitals).

107. See MARTIN & RUARK, supra note 10, at 15.

108. Id.
The recently adopted PPACA did not provide for participation by undocumented immigrants.109 Because the PPACA did not provide any alternative reimbursement means for hospitals treating undocumented immigrants, the only legal means by which a hospital may be reimbursed for services provided to undocumented immigrants remains the EMTALA.110 This legislation was originally an attempt at a band-aid, however, the federal government cannot continue to bail-out hospitals to alleviate this financial burden. Instead, a more proactive approach should be taken.

3. Fraudulent Use of Medicaid

Although undocumented immigrants are precluded from Medicaid coverage, some fraudulently access this program. Only anecdotal information is available about the amount of Medicaid usage by undocumented immigrants who use stolen identities of U.S. citizens or qualified green card permanent residents, however, in a 2010 report, FAIR estimated the annual cost of undocumented immigrants' use of Medicaid to be approximately $2.4 billion dollars per year.111

Medicaid generally covers about half the cost of medical treatment to low-income families without health insurance. Over the past several years, because of the recession, the federal contribution to Medicaid coverage has been temporarily increased as part of the American Recovery and Reinvestment Act.112 While there is no reliable data on Medicaid fraud because there is no requirement that medical facilities providing Medicaid compensated treatment verify the identity of patients, FAIR assumed that it may be roughly equal to the number of undocumented immigrants who are obtaining emergency medical treatment under EMTALA without falsely claiming Medicaid eligibility.113

Opponents of providing health care for undocumented immigrants highlight the burden placed on the hospitals to finance and provide medical

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111. MARTIN & RUARK, supra note 10, at 17.


113. MARTIN & RUARK, supra note 10, at 8.
care to undocumented mothers for childbirth.\footnote{Pelner Cosman, supra note 96, at 7 (explaining the incentive behind illegal immigrants giving birth within the United States).} This is a phenomenon that is commonly referred to as “anchor babies.”\footnote{Id.} Annually, between 300,000 and 350,000 children born to undocumented immigrants will qualify for citizenship under the Fourteenth Amendment to the United States Constitution.\footnote{Id. “All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and the State wherein they reside.” Id.} According to the 2010 study completed by FAIR, these “anchor babies” equated to nearly $2.3 billion in additional annual federal expenditures for the federal government.\footnote{See Martin & Ruark, supra note 10, at 38.}

Other studies have shown higher childbirth related hospitalizations for the undocumented.\footnote{See Pelner Cosman, supra note 96 (discussing the fact that many immigrant families have children that are American citizens).} For example, 1.7%\footnote{Id. Estimated rates among undocumented immigrants in the survey sites were higher, from 3.4% in Fresno to 4.6% in El Paso. Id.} of the total population in the United States was hospitalized for childbirth-related treatment in 1997.\footnote{Id.} Whereas in the last year, the U.S. Census Bureau reported that undocumented immigrants accounted for 56.4% of the births among immigrants and 17.2% of all births in the United States.\footnote{Steven A. Camarota, Ctr. for Immigration Studies, Backgrounder, Birth Rates Among Immigrants in America: Comparing Fertility in the U.S. and Home Countries (2005), http://www.cis.org/articles/2005/back1105.pdf.} Moreover, in the border states, such as New Mexico, the figures are much higher than the average.\footnote{Census 2010 Data, CENSUS.gov, http://www.cis.org (last visited Feb. 2, 2011) (ranging between 55.1 and 9.7%; in Texas, 54.8 and 16.6%; and in California, 47.7 and 22.1%).}
When an undocumented immigrant gives birth in the U.S., the child is eligible for Medicaid coverage if the household meets the income requirements. The population of U.S.-born children of undocumented immigrants is about 3.4 million, and approximately 2.3 million have no health insurance. Furthermore, about one-third of this population, or 770,000, will meet the income eligibility criteria for enrollment in Medicaid. The share used by the children of undocumented immigrants indicates that the amount of those outlays was nearly $2.4 billion. In 2003 the U.S. health care system, under EMTALA, provided childbirth support for nearly 250,000 undocumented mothers.

B. Public Health Risks—Spreading Disease

Another challenge that is raised by the absence of clear affordable health care for undocumented immigrants is the threat of the spread of disease. Undocumented immigrants, unlike those who are legally admitted for permanent residence, undergo no medical screening to assure that they are not bearing contagious diseases. This is a tremendous risk to the public health, where we have seen resurgence of contagious diseases that had been

123. See Pelner Cosman, supra note 96 (discussing the fact that many immigrant families have children that are American citizens); see also State Medicaid Fact Sheet, KAISER STATE HEALTH FACTS, http://www.statehealthfacts.org/medicaid.jsp (last visited Mar. 30, 2012) (the number of undocumented immigrants constitutes about 2.6% of all children enrolled in Medicaid; the amount of federal expenditures on Medicaid for children in 2007 is $90.3 billion).

124. MARTIN & RUARK, supra note 10, at 17.

125. Id.

126. Id.

127. Id. at 57.


129. Pelner Cosman, supra note 96, at 8.
totally or nearly eradicated. Excluding undocumented immigrants from receiving government-funded health care services is unlikely to reduce the level of immigration and very likely to affect the well-being of the children who are United States citizens living in immigrant households. Children born to undocumented immigrant families in the United States are less likely to receive available health care due to their parent's immigration status. This will have long-term, adverse effects on the health of United States citizens, a result contrary to state and federal objectives.

A crucial component of controlling the spread of infectious diseases is early identification and treatment. Placing barriers to accessing regular health care for undocumented immigrants threaten community resilience because those with pre-existing health conditions are more vulnerable to suffer severe effects from a disease outbreak or public health emergency. The political decision not to allow undocumented immigrants the option to purchase health care in PPACA could have serious consequences for our nation's health security, especially in the event of another pandemic, or a bioterrorist attack.

An example can be seen in the resurgence of TB across several states, including Maine, Virginia, Florida, Texas, and Michigan. As of the early 1990's, TB had largely disappeared from the U.S. However, in 2001 the

130. Id.

131. Id.

132. Leo R. Chavez et al., Undocumented Latin American Immigrants and United States Health Services: An Approach to a Political Economy of Utilization, 6 Med. Anthropology 6 (1992) (mentioning the case of Sandra Navarrete, the child of an undocumented Mexican couple who died of chicken pox because her parents did not seek medical care until it was too late).


134. See Chavez et al., supra note 132.

135. Id.

136. See Reported Tuberculosis in the United States, supra note 102.

137. Pelner Cosman, supra note 96, at 8.
Indiana School of Medicine studied an outbreak of TB and traced it to Mexican undocumented immigrants.\textsuperscript{138} According to the CDC, 66\% of all TB cases coming to America originate in Mexico, the Philippines, and Vietnam.\textsuperscript{139}

C. Human Rights Concerns

1. Medical Repatriation—Jimenez

In February 2000, Luis Alberto Jimenez was returning home from working as a landscaper in Florida when the car he was riding in was struck by a drunk driver with a blood alcohol level that was four times the legal limit.\textsuperscript{140} Although the drunk driver was a U.S. citizen with a significant criminal history, Jimenez was a 35 year-old undocumented immigrant who had left his family behind in Guatemala two years prior and immigrated to the United States in pursuit of his dream of working hard, earning significantly more money, and ultimately being able to buy land and cultivate his own garden back home to support his family.\textsuperscript{141} As a result of the head-on crash, Mr. Jimenez was catastrophically injured and two of his fellow immigrant landscapers in the car with him died instantly.\textsuperscript{142} Mr. Jimenez was rushed to Martin Memorial Medical Center and was diagnosed as having sustained traumatic brain damage and severe physical injuries, with his prognosis described as “poor.”\textsuperscript{143} Mr. Jimenez was treated and remained hospitalized at Martin Memorial for approximately four months.\textsuperscript{144} In June 2000, Martin Memorial transferred Mr. Jimenez to a

\textsuperscript{138} Id.

\textsuperscript{139} Id.

\textsuperscript{140} Montejo v. Martin Mem’l Med. Ctr., Inc., 874 So. 2d 654, 655-56 (Fla. Dist. Ct. App. 2004); see also Sontag, supra note 13.

\textsuperscript{141} See, e.g., Sontag, supra note 13.

\textsuperscript{142} Id.

\textsuperscript{143} See Montejo, 874 So. 2d at 656; Sontag, supra note 13.

\textsuperscript{144} Montejo, 874 So. 2d at 656 (illustrating that because the accident left Mr. Jimenez incapacitated, both physically and mentally, a court appointed Mr. Jimenez’s cousin as his legal guardian. While at the nursing home, Mr. Jimenez’s health deteriorated dramatically, resulting in his readmission to Martin Memorial for emergency
nursing home for ongoing care and rehabilitation. When Martin Memorial could not find a long-term care facility that would accept Mr. Jimenez, it sought a court order authorizing it to return him unilaterally to Guatemala. On June 27, 2003, over the objections of Mr. Jimenez and his guardian Mr. Montejo, the Florida State Circuit Court granted the order allowing Martin Memorial to charter a private plane and medical attendant to return forcibly Mr. Jimenez to Guatemala. Mr. Jimenez moved for a rehearing but it was denied on July 9, 2003. On that same day, Mr. Montejo filed a notice of appeal along with an emergency motion for a stay pending appeal. However, the next morning, before the court had an opportunity to rule on the emergency stay, Martin Memorial forcibly ushered Mr. Jimenez to a hospital in Guatemala that could not treat brain injuries, which subsequently discharged him to his elderly mother’s house in a mountainous region of Guatemala where he remains to date.

A New York Times reporter who visited Mr. Jimenez in the summer of 2008 found him largely confined to his bed and suffering from routine seizures; he had not received medical care for over five years. Martin Memorial spent $1.5 million caring for Mr. Jimenez. The federal treatment in January 2001. At the time that Mr. Jimenez was re-admitted, he was “emaciated and suffering from ulcerous bed sores so deep that the tendons behind his knees were exposed.” Mr. Jimenez’s infection was so severe that doctors questioned whether the condition might be terminal. Martin Memorial treated Mr. Jimenez, and he remained in a vegetative state for over a year but then improved).

145. Id.

146. See, e.g., Sontag, supra note 13.

147. Id.

148. Id.

149. See Montejo, 874 So. 2d. at 654.

150. Id.

151. See, e.g., Sontag, supra note 13.

152. See Montejo, 874 So. 2d at 654.

153. Id. at 656.
government reimbursed the hospital approximately $80,000 under the Medicaid provisions for emergency care for undocumented individuals.\textsuperscript{154}

Medical repatriations such as what occurred in the Montejo case violate several international human rights obligations, including the UDHR and the International Covenant on Civil and Political Rights.\textsuperscript{155} However, with mounting budget pressures and an unstable economy, what alternatives to medical repatriation do health care facilities have?

IV. RECOMMENDATIONS FOR REFORM

A. Refugee Status

Unfortunately, the Montejo decision demonstrated that in order for a plaintiff to overcome a hospital’s decision for repatriation, he or she would require direct evidence outside of the hospital’s discharge plan.\textsuperscript{156} However, simply restricting hospitals from repatriating does not change the patient’s medical needs or alleviate the strain on an individual hospital’s budget.\textsuperscript{157}

There are several ways an undocumented immigrant can qualify for asylum in the U.S., including the changed circumstance exception, membership in a particular social group, and fear of persecution on the basis of that membership.\textsuperscript{158} If an undocumented immigrant is able to meet those elements, then he or she can qualify for Medicaid coverage for up to seven years.\textsuperscript{159}

1. Changed Circumstances

Some undocumented immigrants may be able to successfully claim asylum under the change in circumstance exception, based on the situation

\begin{itemize}
  \item \textsuperscript{154} Id.
  \item \textsuperscript{156} See Stead, supra note 32, at 325.
  \item \textsuperscript{157} Id.
  \item \textsuperscript{158} Id.
  \item \textsuperscript{159} Id.
\end{itemize}
that led to their hospitalization. Once an undocumented immigrant is
granted asylum, he or she would then have clear grounds on which to fight
the repatriation or deportation effort. 160 Because those granted asylum
qualify for Medicaid for a period of seven years, a hospital considering
repatriation or deportation would likely stop the process to pursue
reimbursement from Medicaid. 161

For example, a serious accident or illness can be such a transformational
event as to make one a member of a particular social group to which he did
not previously belong. 162 In Mr. Jimenez's situation, the automobile
accident resulted in dramatically reduced cognitive function and his inability
to walk or move himself from bed to wheelchair. 163 As demonstrated by that
case, a disability can form the basis of a cognizable social group. 164 The
acquisition of a disability or debilitating illness could be a change in
circumstances affecting one's eligibility for asylum. 165 Therefore,
imigrants suffering from a severe disability that was acquired more than
one year after they entered the United States should qualify for a changed
personal circumstances exception to the one-year filing bar based on the
recently acquired disability status. 166

2. Particular Social Group

Once an asylum applicant is granted a change in circumstances exception
to the one-year filing period, the applicant will still have to demonstrate
membership in a particular social group and a well-founded fear of
persecution on the basis of that membership. 167 In Tchoukhrova v.

160. Id.
161. See, e.g., Sontag, supra note 13.
162. Tchoukhrova v. Gonzales, 404 F.3d 1181, 1189 (9th Cir. 2005).
163. See, e.g., Sontag, supra note 13.
164. See Tchoukhrova, 404 F.3d at 1189.
165. See, e.g., Sontag, supra note 13.
166. Id.
167. Asylum Protection Fact Sheet, U.S. DEP'T OF JUSTICE,
http://www.justice.gov/eoir/press/05/AsylumProtectionFactsheetQAApr05.htm (last
Gonzales, the U.S. Court of Appeals for the Ninth Circuit declined to say whether “disabled persons” qualify as a particular social group in countries other than Russia and the United States.\textsuperscript{168} It is likely, however, that disabled persons will be recognized as a social group regardless of their home country.\textsuperscript{169}

The United Nations has recognized people with disabilities as a particular group insofar as it has published a set of goals, known as the “Standard Rules,” for promoting and advancing the rights of persons with disabilities.\textsuperscript{170} The Standard Rules, which are not legally binding but are intended to represent a moral commitment of member nations, state that “[i]n all societies of the world there are still obstacles preventing persons with disabilities from exercising their rights and freedoms and making it difficult for them to participate fully in the activities of their societies.”\textsuperscript{171}

The recognition of persons with disabilities as a group by the United Nations, the body that promulgated the five protected categories, certainly lends support to group membership claims based on disability, regardless of the home country.

3. Fear of Future Persecution

Once the applicant has established membership in a particular social group covered by the INA, he still must assert a well-founded fear that he will suffer persecution based upon that membership.\textsuperscript{172} For a patient to claim he fears persecution in his home country based on inadequacy of medical treatment, the applicant must assert not just that disabled persons within the home country receive medical care that is below the standard they would receive within the United States, but also that such persons are discriminated against in the provision of care because of their disabilities.\textsuperscript{173}

\textsuperscript{168} See Tchoukhrova, 404 F.3d at 1189.

\textsuperscript{169} Id.


\textsuperscript{171} Id. at 14-15.

\textsuperscript{172} See Asylum Protection Fact Sheet, supra note 167.

\textsuperscript{173} Id.
In Ramdane v. Mukasey, while denying the applicant’s assertion that he had a well-founded fear of persecution, the U.S. District Court suggested that the appropriate standard for analyzing medical-based persecution was whether the applicant “would suffer such a low standard of medical care in [the home country] that he would suffer deprivation of his life or freedom.”174 If a patient can be kept alive and there are medical opinions that repatriation to the home country’s public hospital system is likely to result in the patient’s death, the patient in question is clearly facing a threat to life or freedom that his government is unable or unwilling to control.175 As discussed above, this low standard of care would have to be tied to the patient’s disabled status.176

Mr. Jimenez’s case would likely meet this standard. Not only was he not receiving the rehabilitative services doctors had found he needed, he was not even receiving the most basic levels of hygienic care.177 Without medication or medical attention, Mr. Jimenez was at risk of death from a seizure-related accident or from infection.178 It is important to note, however, that many patients will not be able to demonstrate such a low standard of care in the home country that they will be able to claim successfully a legitimate fear of persecution.179 A standard of care that is merely lower than that available in the United States will not sustain a claim of a well-founded fear of persecution.180

B. Leaving It Up to the States

The states do not currently have the incentives or the legal authority to take on the cost of health care for the undocumented immigrant population. In Aliessa v. Novello, the New York Supreme Court held that state governments were without power to limit the rights of those immigrants


175. Id.

176. See, e.g., Sontag, supra note 13.

177. See id.

178. Id.

179. See Ramdane, 296 F. App’x at 447.

180. Id.
deemed qualified for health care and public benefits under the Welfare Reform Act. In fact in 1994, when California (the border state who spends the most annually out of any other border state on undocumented immigrant health care) attempted to pass its own cost-managing ballot initiative to establish a state-run citizenship screening system and prohibit undocumented immigrants from using health care (known as Proposition 187), a district court judge overruled major portions of Proposition 187 on grounds of preemption. Therefore, there is very little that the states can do independent of federal intervention.

C. The Netherlands as an Example of Health Care Reform

Another possible solution to the challenge of healthcare for undocumented immigrants would be a revision of the PPACA or inclusion of a health insurance mandate in any comprehensive immigration reform that moves forward in Congress. The Netherlands could be used as a potential model of this type of reform legislation. In 2006, the Dutch government implemented health reform under a competitive market theory, where rather than regulating the supply of health care, the Dutch stimulated competition, thus driving down costs.

181. See Aliessa v. Novello, 754 N.E.2d 1085, 1093 n.12 (N.Y. 2001) (holding unconstitutional a New York state statute that denied Medicaid funds to certain legal and “qualified” residents); see also Marjorie A. Shields, Annotation, Validity, Construction, and Application of State Statutes Limiting or Barring Public Health Care to Indigent Aliens, 113 A.L.R. 5th 95, 102 (2003) (noting that by enacting the Welfare Reform Act, which demanded denial of federal, state, and local health care, welfare and post-secondary education grants to aliens who were not “qualified”—i.e. illegal aliens or immigrants living and working in the United States for fewer than ten years—Congress took away the states’ power to regulate allocation of public benefits to those immigrants who were deemed qualified under the Welfare Reform Act).

182. See MARTIN & RUARK, supra note 10.


A distinctive feature of the Dutch health care system is the existence of a health insurance scheme for “exceptional medical expenses” (“AWBZ”), which is compulsory for the entire population, including undocumented immigrants. The “sickness fund scheme” (“ZFW”) is mandatory only for people earning less than a given income (64% of the population). The remaining high-income earners are left to the private health insurance market.

The principle laid down by the 1998 Linkage Law (“Koppelingswet”) is embedded in section 10(1) of the current (2000) Aliens Act: “an alien who is not a lawful resident may not claim entitlement to benefits in kind, facilities and social security benefits issued by decision of an administrative authority.” However, section 10(2) of the Linkage Law includes two exceptions that trump the Aliens Act and enable undocumented immigrants to receive healthcare. These exceptions are the provision of care that is medically necessary and the prevention of situations that would jeopardize public health.

According to the Dutch Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health) health care should include: a) prevention and treatment of life threatening situations or situations of permanent loss of essential functions; b) diagnosis and treatment of communicable diseases (such as TB and HIV/AIDS); c) pregnancy and maternity care; d) preventive youth health, including the supply of vaccines to children in accordance to the national calendar; and e) compulsory


186. Id. at 970.

187. Id. at 980.

188. See PICUM, supra note 1, at 6.


190. Id.

191. Id.
psychiatric treatment. In the Netherlands, the preventative health measures are universally accessible, even to undocumented immigrants.

V. CONCLUSION

Every year, hundreds of thousands of individuals enter the United States without proper documentation. A great number of these individuals enter the country by crossing the United States-Mexico border. These individuals cross into the United States to find jobs and provide a better life for their families. Movement of people across borders is only a natural consequence of ever-increasing cultural and economic globalization.

While several factors exist which make immigration to the United States a desirable choice for Mexicans and other immigrants—unemployment, poverty, governmental instability, corruption, and lack of proper education in the countries of origin—free healthcare and welfare services in the United States are not such factors.

The fact that current healthcare policies have not been successful in deterring illegal entries, coupled with the increasing strain on healthcare institutions providing free emergency services, presents the need to evaluate current immigrant healthcare policies. Providing prenatal and preventative care to undocumented immigrants relieves emergency care facilities and has positive long-term effects that are in line with state and federal interests of protecting future citizens. Healthcare workers should not be distracted from providing medical care by having to act as immigration officials. Charitable and non-federal organizations should be allowed to provide non-emergency medical care to undocumented immigrants.

It is a fact that existing U.S. law does not guarantee the most basic fundamental right—healthcare. While the recent PPACA healthcare bill was passed under the guise of “providing healthcare for all,” the fact that this new law does not include healthcare for the hundreds of thousands of undocumented immigrants clearly shows that the new PPACA falls short in trying to accomplish this mandate. Whether the answer for the U.S.

192. See PICUM, supra note 1, at 6.

193. Id.


195. Id.
healthcare model going forward is to look to other nations, such as the Netherlands, and create a more sustainable healthcare system, or for Congress to provide clearer guidance on our existing law, the fact remains that if we continue on the same path that the U.S. is currently on, the U.S. healthcare system will be anything but sustainable in the very near future and the U.S. will be at the brink of a public health crisis.