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STAYING WITHIN THE LINES: THE QUESTION OF POST-STABILIZATION TREATMENT FOR ILLEGAL IMMIGRANTS UNDER EMERGENCY MEDICAID

Sean Elliott*

INTRODUCTION

In June 2007, amid a torrent of controversy and criticism from across the political spectrum, the United States Senate soundly rejected a bill that would have brought significant reform to America’s immigration system.1 The bill would have granted a path to citizenship for illegal immigrants and established a new guest worker program,2 and it would also have strengthened the border by adding thousands of border patrol personnel and constructing new barriers.3 Although the issue of illegal immigration has long been a mainstay of U.S. politics, the bill awakened unusually striking national divisions and caused many to question to what extent the United States should accommodate not immigrants in general, but rather those who have entered the United States unlawfully.4

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2. Weisman, supra note 1.


The numbers are indeed staggering. The Pew Hispanic Center has estimated the illegal immigrant population in the United States to be eleven to twelve million.\(^5\) The former Immigration and Naturalization Service (INS)\(^6\) has further estimated that the illegal immigrant population doubled between 1990 and 2000.\(^7\) Driving this huge influx of illegal immigration, mostly from Mexico, has been the prospect of work—American employers pay much more than Mexican employers—and the desire to be with family members who have already arrived in the United States.\(^8\) For some illegal immigrants, however, the lure of America is its health care system.\(^9\) Many come to the United States seeking medical treatment that would otherwise be unavailable to them, notwithstanding the fact that they often lack the means to afford such health care in the absence of federally-mandated public assistance.\(^10\)

While the costs of illegal immigration to America’s health care system have not been accurately determined,\(^11\) there is no doubt that they are substantial. Some estimates put the figure in the hundreds of millions of dollars in the southwest border states alone.\(^12\) The financial pressure this has


\(^7\) U.S. GEN. ACCOUNTING OFFICE, UNDOCUMENTED ALIENS: QUESTIONS PERSIST ABOUT THEIR IMPACT ON HOSPITALS’ UNCOMPENSATED CARE COSTS 5 (2004).


\(^10\) See Janofsky, supra note 9.

\(^11\) U.S. GEN. ACCOUNTING OFFICE, supra note 7, at 3.

\(^12\) MGT OF AMERICA, INC., supra note 9, at v; see Janofsky, supra note 9.
placed on health care providers is enormous. In some cases, hospitals have been forced to cut back on staffing and services; in other cases, health care providers have found it necessary to shut down their facilities entirely. Given this untenable situation, the issue of publicly-funded health care for illegal immigrants demands careful attention and consideration of the practical extent to which the United States can and should meet the medical needs of this population.

The policy of the federal government has generally been that illegal immigrants are ineligible for federal, state, or local public benefits. One notable exception found in the web of legislation limiting such benefits for illegal immigrants has been that for "Emergency Medicaid." According to this provision, illegal immigrants are entitled to coverage under the Medicaid program only for treatment for an "emergency medical

13. See Janofsky, supra note 9.


15. 8 U.S.C. §§ 1611, 1621 (2000). This does not mean, however, that states are prohibited from providing public benefits to illegal immigrants altogether. Section 1621(d) provides that

an alien who is not lawfully present in the United States is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section only through the enactment of a State law after August 22, 1996, which affirmatively provides for such eligibility.


16. MGT OF AMERICA, INC., supra note 9, at 8 & n.6 (2002).

17. Medicaid is a state-managed health care program that provides payment to health care providers for the cost of providing treatment to certain categories of eligible individuals who are otherwise unable to afford private care. MGT OF AMERICA, supra note 9, at 12; see also BLACK'S LAW DICTIONARY 444 (2d pocket ed. 2001). Funding for Medicaid comes from both the states and the federal government through the use of matching funds. CTR. FOR MEDICAID & STATE OPERATIONS, CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AT-A-GLANCE 2005 5 (2005), available at http://www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf. Federal matching funds are only provided if the state administering agency structures its Medicaid program in conformity with the limits set forth by the federal government. Health Res. & Servs. Admin., U.S. Dep't of Health & Human Servs., Basic Description of the Medicaid Program, http://www.hrsa.gov/medicaidprimer/ (last visited Nov. 16,
condition,"18 and only where the patient is otherwise eligible for coverage based on the particular state’s requirements for Medicaid eligibility.19 An “emergency medical condition” is defined as “a medical condition (including emergency labor and delivery) 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 [one of three adverse results listed in the statute].”20 Although this provision would seem to suggest a bright line easily interpreted by the states in the administration of their Medicaid programs, in fact the definition of “emergency medical condition” has proven to be somewhat ambiguous. In cases brought by individuals and health care providers, the courts have come up with somewhat conflicting interpretations of this term, leaving open to question the exact scope of Medicaid coverage for illegal immigrants.21 Most of the courts that have interpreted the emergency Medicaid provision in question agree that an illegal immigrant who arrives at the hospital with acute symptoms that could result in serious bodily harm or death if not treated immediately is entitled to coverage under the Medicaid program for the initial stabilizing treatment.22 The courts diverge, however, as to whether such treatment should extend beyond this initial care to post-stabilization services.23 Defining compensable emergency medical services

2007). Certain categorically needy groups must be covered under a state Medicaid plan, while coverage for other medically needy groups is optional. MGT OF AMERICA, INC., supra note 9, at 12.


19. Id.

20. Id.


23. Compare Diaz v. Div. of Soc. Servs., 628 S.E.2d 1, 5 (N.C. 2006) (holding that the patient was not entitled to Medicaid coverage for post-stabilization chemotherapy treatment), with Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin., 75 P.3d 91, 98 (Ariz. 2003) (holding that Medicaid coverage does not necessarily terminate when the patient’s initial injury is stabilized); see also Luna, 589
one way or the other has a substantial impact on the budgets of public health care providers. Since sixty-eight percent of the eleven to twelve million illegal immigrants in the United States\textsuperscript{24} are estimated to lack health insurance,\textsuperscript{25} one can imagine that the scope of coverage under Emergency Medicaid for this segment of the population has far-reaching economic effects. Furthermore, questioning whether the emergency exception should apply only to stabilization treatment or also to services rendered beyond stabilization (such as chemotherapy) forces one to consider the public policy underlying the exception.

Section I.A of this article explores the Emergency Medicaid statute itself, focusing on those provisions describing the treatment that health care providers are required to provide to illegal immigrants if they wish to participate in the Medicaid program. It also sets forth the relevant implementing regulations promulgated by the Department of Health and Human Services. Section I.B describes a number of cases, both federal and state, that have addressed the issue of whether an "emergency medical condition" encompasses services beyond merely stabilization, or whether stabilization ends reimbursable coverage for illegal immigrants under the Medicaid program. Section II focuses on three major considerations affected by the scope of coverage under both a broad and a narrow definition of "emergency medical condition" and attempts to demonstrate how these considerations should inform the interpretation of the Emergency Medicaid provision. Finally, Section III summarizes the conclusions reached in Section II and briefly explores the possible future of Medicaid coverage for illegal immigrants. Throughout, the author argues that the phrase "emergency medical condition" should be construed as extending to treatment even beyond stabilization because such an interpretation best serves the purposes of the Act of which the provision was a part, ensures greater deference towards those best-positioned to determine whether an emergency medical conditions exists, and avoids a situation where health care providers and states are burdened with the negative impact of an ambiguous federal statute.

\textsuperscript{24} PASSEL, supra note 5, at i.

\textsuperscript{25} RAND CORP., RAND STUDY FINDS UNDOCUMENTED IMMIGRANTS ARE MOST LIKELY TO BE UNINSURED (2005), http://www.rand.org/news/press.05/11.10.html.
I. BACKGROUND

A. 42 U.S.C. § 1396(b)

In July 1986, the United States District Court for the Eastern District of New York struck down a federal regulation restricting Medicaid benefits to those lawfully admitted for permanent residence or permanently residing in the United States under color of law, rejecting the idea that alienage was a lawful consideration in making determinations of Medicaid eligibility. In response, Congress passed legislation, included as part of the Omnibus Budget Reconciliation Act of 1986, denying Medicaid payments to states that provide health care services to illegal immigrants with the exception of treatment for an "emergency medical condition." The relevant provisions, as codified in 42 U.S.C. § 1396b(v), read:

(v) Medical assistance to aliens not lawfully admitted for permanent residence.

(1) Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

(2) Payment shall be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

(A) such care and services are necessary for the treatment of an emergency medical condition of the alien,

(B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter [42 U.S.C. §§ 1396–1396v] (other than the requirement of the receipt of aid or assistance under subchapter IV [42 U.S.C. §§ 601–687], supplemental security income benefits under subchapter XVI [42 U.S.C. §§ 1381–1385], or a State supplementary payment), and


(C) such care and services are not related to an organ transplant procedure.

(3) For purposes of this subsection, the term "emergency medical condition" means a medical condition (including emergency labor and delivery) 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—

(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.

Pursuant to congressional authorization, the Secretary of Health and Human Services promulgated regulations that basically mirrored the language of the federal statute. The most notable difference was the addition of the words "after sudden onset" in the definition of emergency services, so that section (3) read, "[t]he alien has, after sudden onset, a medical condition." This language was added after several commenters expressed concern that the term "emergency medical condition" had been inadequately defined. The Department of Health and Human Services declined to define the term with more precision, however, stating that "the broad definition allows States to interpret and further define the services available to aliens covered by [the emergency medical condition exception] . . . in a consistent and proper manner supported by professional medical judgment." The final regulations, therefore, made relatively clear when emergency medical treatment would begin, but left open the question of when those services would no longer be available, i.e., when the state would no longer be reimbursed for providing those services to illegal immigrants.

B. Case History

Both federal and state courts have grappled with the precise meaning of the words "emergency medical condition," and they have come up with
conflicting interpretations that leave open to question the extent of emergency services available to illegal immigrants under the Medicaid program. While the courts generally agree that the provision of emergency services to illegal immigrants under § 1396b(v) is conditioned on the initial manifestation of an “acute” symptom, the nature of treatment (or lack thereof) beyond the point of stabilization has been a source of considerable disagreement.

While some courts have held that § 1396b(v) only provides benefits for treatment of a medical emergency up until stabilization, and not for continuing care resulting from that same injury, others have held that § 1396b(v) authorizes ongoing treatment for an emergency medical condition so long as the absence of care would result in one of the three negative results listed in the statute, regardless of whether or not the patient was stabilized. Therefore, the difference in Medicaid coverage for illegal immigrants, depending on one’s interpretation of “emergency medical condition,” is enormous, and given the large numbers of illegal immigrants that are not covered by health insurance, any future resolution of the matter will have profound effects on this segment of American society.

In 1998, the Second Circuit in Greenery Rehabilitation Group v. Hammon had occasion to interpret the extent of Medicaid coverage for illegal immigrants and the meaning of the emergency medical condition exception. In that case, three patients, two of them illegal immigrants, “suffered sudden and serious head injuries [requiring] immediate treatment” and required ongoing treatment beyond initial stabilization that included the

34. See 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 (2004).


36. Hospital Reimbursement for Treating Aliens Is Not Limited to Pre-Stabilization Treatment, supra note 35.

37. RAND CORP., supra note 25.

38. Greenery Rehab. Group, 150 F.3d at 226.
assistance of nursing staff with the most basic human needs.\textsuperscript{39} The issue before the court was whether such conditions, described as "chronic," constituted emergency medical conditions for purposes of Medicaid eligibility.\textsuperscript{40} The court emphatically held that that they did not.\textsuperscript{41} In analyzing this provision, the court emphasized that the acute symptoms could not exist independently of the emergency medical condition.\textsuperscript{42} For that reason, the "long term nursing and maintenance care" required by the patients failed to satisfy the plain meaning of the statute, and the rehabilitation facility that provided the treatment was therefore not entitled to federal reimbursement for the care provided beyond stabilization, which marked the end of the emergency medical condition.\textsuperscript{43}

Eight years later, and relying heavily on Greenery, the Supreme Court of North Carolina in Diaz v. Division of Social Services held that Federal Medicaid reimbursement for treating an illegal immigrant's emergency medical condition extended only to acute symptoms and only up to the point of stabilization.\textsuperscript{44} The petitioner in that case, unlike the patients in Greenery, received treatment not for a condition resulting from traumatic injury, but rather for acute lymphocytic leukemia.\textsuperscript{45} Chemotherapy treatments were administered off and on for a period of approximately two years.\textsuperscript{46} Although the court did note in its opinion that the patient would eventually have manifested an emergency medical condition in the absence of treatment beyond the initial course provided, the fact that he had been stabilized meant that Medicaid coverage was no longer available from that

\textsuperscript{39} Id. at 228-29. One patient had suffered severe head injuries as the result of an automobile accident. Id. at 228. Another had been shot in the head. Id. The third sustained serious head injuries after being beaten. Id. at 229.

\textsuperscript{40} Id. at 231.

\textsuperscript{41} Id. at 233.

\textsuperscript{42} Id. at 232.

\textsuperscript{43} Id. at 232-33.

\textsuperscript{44} Diaz v. Div. of Soc. Servs, 628 S.E.2d 1, 5 (N.C. 2006).

\textsuperscript{45} Id. at 2.

\textsuperscript{46} Id.
point forward.\textsuperscript{47} The reasoning of \textit{Greenery} had apparently prevailed, even with an explicit acknowledgment that the petitioner's condition would eventually necessitate treatment that would be covered by Medicaid as an emergency medical condition.

Several other state cases, most notably in Arizona, have interpreted the scope of the emergency medical condition exception providing Medicaid coverage for illegal immigrants to go beyond merely stabilization. The first of these, and indeed the first case to interpret \textsection\textsuperscript{1396b(v)}, was \textit{Mercy Healthcare Arizona, Inc. v. Arizona Health Care Cost Containment System}.\textsuperscript{48} The patient in that case had been severely injured in an automobile accident.\textsuperscript{49} After initial treatment at the hospital, he was later transferred to a "skilled nursing care facility,"\textsuperscript{50} although at the time he "was non-verbal, could not move his lower extremities, had a gastrointestinal tube for feeding, and had a tracheostomy."\textsuperscript{51} The Arizona Court of Appeals rejected the State Medicaid program's argument that the patient's Medicaid coverage ended at the point of stabilization.\textsuperscript{52} Instead, the court held that

\begin{itemize}
\item \textsuperscript{47} Id. at 5.
\item \textsuperscript{49} Mercy Healthcare Ariz., Inc., 887 P.2d at 627.
\item \textsuperscript{50} A "skilled nursing facility" is defined under the Social Security Act as an institution that
\begin{enumerate}
\item is primarily engaged in providing to residents—skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatment of mental diseases;
\item has in effect a transfer agreement (meeting the requirements of section 1395x(l) of this title) with one or more hospitals having agreements in effect under section 1395cc of this title; and
\item meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.
\end{enumerate}
\textsuperscript{51} Mercy Healthcare Ariz., Inc., 887 P.2d at 627.
\item \textsuperscript{52} Id. at 628.
\end{itemize}
[t]he statute . . . mandates that the medical condition manifest itself by "an acute symptom (including severe pain)." The statute then mandates that [Arizona Health Care Cost Containment System] must cover services for treatment of that medical condition so long as absence of immediate treatment for that condition "could reasonably be expected to result in" one of the three consequences defined by statute.53

According to the court, therefore, the statute only required that the emergency medical condition manifest itself initially by acute symptoms, and that Medicaid coverage for the condition would continue so long as the withholding of treatment "could reasonably be expected to result in’ one of the three consequences defined by statute."54

The Arizona Supreme Court finally interpreted the emergency medical condition provision for itself in 2003 in Scottsdale Healthcare, Inc. v. Arizona Health Care Cost Containment System Administration.55 Three cases had been consolidated on appeal, and although their factual circumstances varied significantly, in each case the patient had suffered serious injuries but had been moved "from an acute care ward to a rehabilitative type of ward."56 The court adopted the reasoning of the Mercy court.57 In doing so, it pointed out that the court had not presented a test for determining exactly when the emergency medical condition had ended.58 But in any case it rejected the emphasis on stabilization set forth in Greenery

53. Id. at 629.


55. Id. at 91.

56. Id. at 94. All patients involved were illegal immigrants. Id. In the first case, the patient had suffered serious back and neck injuries and required the assistance of others to sit and stand. Id. at 94 n.3. In the second case, one patient had been involved in a serious car accident and "when transferred had difficulty swallowing and had an impaired cough reflex which placed him at high risk for aspiration" while two other patients were fed through a tube and required constant medical attention. Id. In the third case, the patient had been shot in the abdomen, leaving him with a gaping wound that required several surgeries as well as constant attention to monitor for infection. Id.

57. Id. at 95-97.

58. Id. at 95.
Rehabilitation Group v. Hammon. Instead, the court stated that "the focus must be on whether the patient's current medical condition . . . is a non-chronic condition presently manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical treatment could result in one of the three adverse consequences listed in [§ 1396b(v)]." As a result, the Arizona Supreme Court, while recognizing that the statute only encompassed Medicaid coverage for an emergency medical condition marked by "acute" symptoms, also recognized that the manifestation of acute symptoms and medical stabilization were not mutually exclusive concepts; therefore, stabilization should not be the touchstone for determining the end of the emergency medical condition and the loss of federal reimbursement for the treating facility.

Carefully reviewing the case law that had preceded it, the Supreme Court of Connecticut weighed in on the matter in 2005 in Szewczyk v. Department of Social Services. The plaintiff had overstayed his visa, after which time he developed symptoms of severe pain and nausea similar to those experienced by the patient in Diaz. He was later diagnosed with acute myelogenous leukemia and his doctors administered chemotherapy for approximately one month. The court reversed the appellate court's determination that the plaintiff was not entitled to any Medicaid benefits for this treatment. The court adopted a standard slightly different from both that found in Scottsdale Healthcare, Inc. v. Ariz. Health Care Cost Containment Sys. Admin., 75 P.3d 91, 96-97 (Ariz. 2003). Unlike in Scottsdale, the court here did not believe that


60. Id. at 98 (emphasis added).

61. Id. at 97-98.


64. Szewczyk, 881 A.2d at 262.

65. Id. at 274.

66. Id. at 270.
Greenery had placed excessive emphasis on whether the patient had been stabilized.\textsuperscript{67} It did, however, agree with the Arizona Supreme Court’s view that the existence of an emergency medical condition “does not focus solely on the condition of the patient at one instant in time.”\textsuperscript{68} Thus, the Connecticut court seemed to agree that the Greenery standard was appropriate, but reached the same conclusion as in Scottsdale—that acute symptoms, and therefore coverage for an emergency medical condition, did not necessarily evaporate when the patient was stabilized.

II. Analysis

As is evident from the preceding discussion of the state and federal cases that have addressed the scope of § 1396b(v), the precise definition of “emergency medical condition” bears enormously on the scope of coverage available to illegal immigrants under Emergency Medicaid. And given the staggering number of illegal immigrants without health insurance,\textsuperscript{69} the implications for health care providers and the states in which they are located are similarly daunting. The impact has already been felt in some parts of the country, particularly the border states of the Southwest, where emergency treatment for illegal immigrants has forced some providers to cut back on services or close entirely.\textsuperscript{70} Under these circumstances, more universal acceptance of the broad definition of “emergency medical condition,” encompassing care beyond merely stabilization (such as that adopted in Arizona), would alleviate some of the pressure being placed on states bearing the burden of illegal immigration.

Such an approach would have a number of benefits. First, it would ensure that § 1396b—passed as part of a budget reduction act\textsuperscript{71}—remains true to its original purpose of reducing government expenditures. Second, the broader “beyond-stabilization” definition of emergency medical condition would

\textsuperscript{67} See id.


\textsuperscript{69} RAND CORP., supra note 25.

\textsuperscript{70} Janofsky, supra note 9.

\textsuperscript{71} Statement by President Ronald Reagan upon Signing H.R. 5300, 22 WEEKLY COMP. PERS. DOC. 1421 (Oct. 27, 1986); see also Szewczyk v. Dep’t of Soc. Servs., 881 A.2d 259, 278 (Conn. 2005) (Sullivan, C.J., dissenting).
afford greater deference to health care providers, who are best-positioned to determine whether an emergency medical condition persists beyond the initial stabilizing treatment provided in an emergency room. Third, the broader definition both ensures that the federal government—the entity responsible for control of the nation’s borders—remains responsible for weaknesses in its enforcement of immigration law and that the states are not forced to bear the consequences of either those enforcement weaknesses or the latent ambiguity of the federal statute.

A. The Purpose of § 1396b(v) Is Not Well-Served by a Narrow, Stabilization-Only Interpretation of Treatment for an “Emergency Medical Condition”

Despite its obvious impact on America’s health care providers, state and local governments, and several million people living within the United States, the legislative history of § 1396b(v) is rather thin. It does show, however, that § 1396b(v) was passed in response to a U.S. District Court ruling that struck down Medicaid regulations limiting benefits to lawfully admitted aliens. In its conference report, the House Budget Committee made clear that “nothing in Medicaid law should be construed to require a State to offer coverage to aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the U.S. under color of law.” Not surprisingly, this statement was consistent with the overall purpose of the Omnibus Budget Reconciliation Act (OBRA) of 1986—the larger statute of which § 1396b(v) had been a part—which had been to pull the reins on government spending. It was thus clear that Congress had acted in large part to eliminate the costs the federal government might otherwise incur were the ruling of the U.S. District Court to be adopted nationwide.

Given both the OBRA’s general purpose of reducing government spending and the specific purpose of § 1396b(v) to restrict Medicaid benefits


73. H.R. REP. No. 99-1012, at 399.

74. Statement by President Ronald Reagan upon Signing H.R. 5300, 22 WEEKLY COMP. PRES. DOC. 1421 (Oct. 27, 1986); see also Szewczyk, 881 A.2d at 278 (Sullivan, C.J., dissenting).
to illegal immigrants, the proper focus in interpreting the scope of the emergency medical condition exception with regards to treating illegal immigrants should be on cost reduction. This being the case, any effort to narrow the definition of "emergency medical condition" according to whether or not a patient has been stabilized misses the point. In fact, it may prove more costly than if a broader definition is applied, encompassing the initial injury or illness (manifesting itself by acute symptoms) as well as continuing symptoms that may result in one of the three statutorily defined negative results.

The problem with applying a narrow, stabilization-only definition of emergency medical condition is that it fails to consider the possibility of a given patient's condition regressing and resulting in one of the three negative results listed in the statute if treatment is withheld after the point of stabilization. That is, applying a narrow definition focused primarily on stabilization fails to consider that sending a patient on his way after the initial injury or illness is stabilized may result in that patient returning to the emergency room for precisely the same condition soon after being discharged. This problem was noted by the *Diaz* court, which observed that "if petitioner had not received chemotherapy treatments, he would have eventually regressed into a state of an emergency medical condition."75 While ultimately withholding benefits because the petitioner did not require immediate treatment beyond stabilization to avoid the negative results listed in the statute, the court in *Diaz* nonetheless acknowledged that the absence of treatment might eventually result in an emergency medical condition anyway.76 Such a conclusion does not serve the OBRA's overarching purpose of reducing government expenditures. Instead, it simply puts health care providers in the business of "putting out fires" rather than treating emergency medical conditions in a way that diminishes the likelihood that the illegal immigrant will return to the emergency room for treatment for exactly the same condition.77 For that reason, focusing on stabilization and

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76. *Id.*

77. One doctor in Arizona, noting the financial pressure on hospitals in his region caused by treating illegal immigrants, pointed out that many hospital officials are now forced to provide stabilization services rather than treatment of patients' illnesses. For example, doctors may decide to stabilize a patient who turned up at the hospital exhibiting signs of gallstones, rather than conducting surgery to remove the stones. *See Janofsky, supra* note 9. Nevertheless, the argument that stabilizing such a patient rather than treating his condition is economical would be difficult to sustain unless one assumes that this patient would expire before his next visit to the emergency room. The possibility of future emergency room admissions for patients who previously received
whether or not a patient would immediately expire upon discharge from the hospital may not be the most cost-effective approach to this exception in Medicaid law for treating an otherwise ineligible population. Given OBRA's cost-savings objective, this would be contrary to the spirit of the legislation.

Despite the possible increased costs involved in stabilizing and re-stabilizing a patient to satisfy the emergency medical condition exception, one could argue that the Department of Health and Human Services (HHS) has intended in its regulations to limit emergency treatment for illegal immigrants to end at stabilization. The argument is not entirely without merit. In 1990, HHS observed that it was making a minor change in the definition of emergency medical condition to harmonize the definition in § 1396b(v) with that found in the Emergency Medical Treatment and Active Labor Act (EMTALA).\(^7\) The emergency medical condition provision in that statute explicitly provides that if a patient arrives at the hospital and medical personnel determine that the patient is suffering from an emergency medical condition, the hospital must provide the treatment necessary to stabilize the patient.\(^7\) This cross-reference to EMTALA could therefore be construed as indicating that Congress intended to provide emergency services to illegal immigrants under § 1396b(v) only up to the point of stabilization, as required of hospitals in EMTALA.\(^8\)

only stabilizing treatment was also hinted at by a doctor who testified in connection with a 2004 case in North Carolina. The doctor "expressed her opinion that Medicaid should not pay after 3 January 2000, because petitioner 'had been stabilized and that an abrupt onset would be necessary for each admission to qualify as an emergency medical condition.'" Luna v. Div. of Soc. Servs., 589 S.E.2d 917, 921 (N.C. Ct. App. 2004).

78. The minor change involved was the addition of the words "after sudden onset" to the description of covered emergency services found in the regulations, which otherwise mirrored the language of § 1367b(v)(3). Medicaid Program; Eligibility of Aliens for Medicaid, 55 Fed. Reg. 36813, 36816 (Sept. 7, 1990) (to be codified at pt. 435-36, 440); 42 C.F.R. § 440.255 (2006).


80. Szewczyk v. Dep't of Soc. Servs., 881 A.2d 259, 280-81 (Conn. 2005) (Sullivan, C.J., dissenting). This argument was not lost on the Chief Justice of the Supreme Court of Connecticut, who in his dissenting opinion in Szewczyk forcefully asserted that the definition of "emergency medical condition" found in § 1396b(v) was intended to be same as that found in EMTALA. His argument explored in great detail the legislative history of EMTALA and addressed other sections of the Social Security Act before he arrived at the conclusion that the plaintiff should not have been entitled to Medicaid.
In further support of the stabilization-only argument, one might observe that it would be an odd result for EMTALA, an act intended to expand treatment opportunities for individuals who might otherwise be turned away,\textsuperscript{81} to offer less coverage than § 1396b(v), a provision designed to restrict coverage for illegal immigrants.\textsuperscript{82} Indeed, it would appear that in jurisdictions adopting a broader definition of “emergency medical condition” (e.g. Arizona\textsuperscript{83} and Connecticut\textsuperscript{84}), an illegal immigrant might be entitled to Emergency Medicaid coverage for treatment of an emergency medical condition, but the hospital would have no obligation to treat him under EMTALA because he has already been stabilized.

The apparent contradiction described above dissipates when one considers the public policy underlying both EMTALA and Emergency Medicaid coverage for illegal immigrants. The Medicaid provisions in § 1396b(v) form an exception to a public benefit program that is otherwise not available to those who are not lawful residents of the United States.\textsuperscript{85} In fact, Congress has made quite clear its policy judgment that illegal immigrants should not be eligible for any state or local public benefit (except for limited exceptions, which include Emergency Medicaid under § 1396b(v)).\textsuperscript{86} When an illegal immigrant seeks treatment for an emergency medical condition, federal funding ceases when that condition no longer exists.\textsuperscript{87} On the other hand, EMTALA does not address the availability of benefits \textit{per se}. It only states that when an individual arrives at the hospital seeking treatment for an emergency medical condition, the hospital must provide treatment necessary

\textsuperscript{81} Id. at 279-80 (citing 131 Cong. Rec., Pt. 21, 28,568 (1985) (statement of Sen. Durenberger)).


\textsuperscript{84} Szewczyk, 881 A.2d at 259.


\textsuperscript{86} Id. § 1621.

\textsuperscript{87} Id. § 1396b(v).
to stabilize the emergency condition and may not transfer the patient to another facility unless he or she has been stabilized (with certain exceptions). 88 The statute does not contemplate that public assistance will necessarily end. EMTALA only guarantees that hospitals will not engage in the practice of "patient dumping" by refusing to treat indigent patients or those who would otherwise depend on public insurance programs to pay for their treatment. 89 In other words, EMTALA protects patients who may still have coverage under Medicaid after they are stabilized and their emergency medical condition has ended; however, § 1396b(v) clearly indicates that public assistance for illegal immigrants will stop after their emergency medical condition has ended. 90

It should also be noted that the word "stabilization" does not appear anywhere in the language of § 1396b(v). 91 While EMTALA expressly requires health care providers to provide "treatment as may be required to stabilize the [emergency] medical condition," 92 § 1396b(v) makes no such explicit reference to stabilization, 93 despite the fact that the definition of an emergency medical condition in both statutes is nearly identical. 94 As indicated earlier, this would suggest that Congress was concerned with stabilization in the context of EMTALA, but not concerned with stabilization in the context of Emergency Medicaid. 95 EMTALA directs health care providers to stabilize individuals arriving with an emergency medical condition. 96 Section 1396b(v) provides reimbursement to states that

88. Id. § 1395dd.


90. See 42 U.S.C. § 1396b(v).

91. See id.

92. Id. § 1395dd.

93. Id. § 1396b(v).

94. Compare id. § 1396b(v)(3) (Emergency Medicaid), with id. § 1395dd(e)(1) (EMTALA).


provide treatment (no mention of stabilization) to an illegal immigrant for an emergency medical condition.\textsuperscript{97} It therefore appears that while the definition of an emergency medical condition is the same in both statutes, the scope of treatment contemplated in each of them is different.\textsuperscript{98}

Finally, apart from any concern about the compatibility of § 1396b(v) with the overall budget-reducing objectives of OBRA, or the relationship of § 1396b(v) to EMTALA, critics of an expansive reading of § 1396b(v) could point to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Welfare Reform Act)\textsuperscript{99} as evidence of Congress' intent to restrict benefits provided to illegal immigrants. Indeed, Title IV of the Welfare Reform Act explicitly states that "an alien who is not a qualified alien (as defined in section 431) is not eligible for any federal public benefit [with the exception of emergency medical procedures as described in § 1396b(v)(3)]."\textsuperscript{100} The Act further states that "it is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits."\textsuperscript{101} The legislative history of this Act also makes it clear that, aside from reducing the incentive for illegal immigration, Congress further intended to exclude illegal immigrants presently in the United States from public welfare benefits.\textsuperscript{102} Given this clear statement of congressional policy, one might wonder how a broad reading of the Emergency Medicaid provision can square with any reasonable interpretation of the Welfare Reform Act.

Despite the seeming contradiction between a post-stabilization reading of § 1396b(v) and the Welfare Reform Act, the two statutes need not defeat each other's purpose. Congress well understood this when it passed the 1996 Act, making an exception for the general rule of benefit exclusion by carving out an exception for the treatment of an "emergency medical

\textsuperscript{97} Id. § 1396b(v).

\textsuperscript{98} See discussion infra Part II.B.


\textsuperscript{100} 8 U.S.C. § 1611 (2000).

\textsuperscript{101} Id. § 1601.

condition as defined in [§ 1396b(v)]. This cross-reference would seem to indicate that Congress intended to incorporate a definition of "emergency medical condition" not based on stabilization alone. Congress could have referenced the more restrictive language in EMTALA as well, but it did not. Nor has subsequent legislation clarified the intended meaning of "emergency medical condition" in any meaningful way. Thus, a broader reading of § 1396b(v) need not conflict with the Welfare Reform Act, and the impact of that Act, because its goals will continue to be met, need not be weakened. Illegal immigrants will continue to be denied public welfare benefits generally, a policy that clearly serves to reduce the incentive to enter the United States illegally and penalizes those illegal immigrants already here. To the extent that a broader, post-stabilization reading of § 1396b(v) frustrates the goals of the Welfare Reform Act, one need only remember that § 1396b(v) forms an explicit and narrow exception to a very broad range of benefits that might otherwise be available to illegal immigrants had the 1996 legislation not been implemented.

B. The Broader Definition of "Emergency Medical Condition" Appropriately Affords Greater Deference to Health Care Providers

Both HHS and the courts appear to have shown substantial deference towards health care providers in determining the existence of an emergency medical condition on the facts of a given case. HHS specifically felt that such an approach was appropriate and stated as much after commenters on the implementing regulations expressed concern that the phrase "emergency medical condition" was too vague and needed to be clarified. HHS stated that

the broad definition allows States to interpret and further define the services available to aliens covered by [§ 1396b(v)] which are any services necessary to treat an emergency medical condition in a . . . manner supported by professional medical judgment. Further, the significant variety of potential emergencies . . . are so varied that it is neither practical nor possible to define with more precision all those

103. 8 U.S.C. § 1611.


conditions which [sic] will be considered an emergency medical condition.\textsuperscript{106}

In deliberately choosing to accept and promulgate a broadly defined regulation, therefore, HHS implicitly recognized that doctors and state medical advisors, rather than federal agencies or courts, were best positioned to determine whether an individual suffered from an emergency medical condition.\textsuperscript{107} This approach—deference towards the judgment of medical professionals and state advisory boards—is wholly consistent with sound medical practice, insofar as health care providers are ethically bound to provide necessary treatment,\textsuperscript{108} and the approach ensures that these providers are able to exercise their informed medical discretion within the bounds of the statute.

An examination of the cases, applying a narrow, stabilization-only reading of § 1396b(v), reveals the disconnect such an interpretation might create between health care professionals on the one hand and the nation’s courts on the other. For example, in \textit{Greenery Rehabilitation Group}, the court undertook an extensive examination of the language of § 1396b(v) before reaching its conclusion that the patients treated by the appellee were not entitled to Medicaid coverage.\textsuperscript{109} Part of the court’s inquiry involved discussing the dictionary definitions of the key words found in the Emergency Medicaid provision, such as “acute,” “manifest,” “immediate,” and “emergency.”\textsuperscript{110} After this discussion, the court stated that it had “some doubt as to whether [the patients’] health would be jeopardized by the absence of ‘immediate medical attention.’”\textsuperscript{111}

Doubt based in part on a court’s understanding of medical terminology drawn from dictionaries would seem to thwart HHS policy. This policy allows states to apply a broad definition of emergency medical condition and

\textsuperscript{106} \textit{Id.} (emphasis added).

\textsuperscript{107} \textit{See} U.S. GEN. ACCOUNTING OFFICE, \textit{supra} note 7, at 13.

\textsuperscript{108} MGT OF AMERICA, INC., \textit{supra} note 9, at 1; \textit{see also} Nat’l Ass’n of Pub. Hosps. & Health Sys., Benefits Restoration for Legal Immigrants (Mar. 2003), http://www.naph.org/Template.cfm?Section=Immigration&Template=/ContentManagement/ContentDisplay.cfm&ContentID=3070 (“NAPH members are committed to providing health care services to all patients regardless of ability to pay or immigration status.”).


\textsuperscript{110} \textit{Id.} at 232.

\textsuperscript{111} \textit{Id.} at 233.
reimburse State Medicaid agencies for "any services necessary to treat an emergency medical condition in a consistent and proper manner supported by professional medical judgment." This problem would of course be most significant in cases where the State Medicaid agency and/or the treating physicians might believe that a given patient's condition falls within the definition of an emergency medical condition and where a court interpreting the provision holds otherwise. Furthermore, it is important to remember the difference between determining the scope of Emergency Medicaid coverage on the facts of a given case and the scope of the law itself. It is one thing for the courts to apply an expansive interpretation of "emergency medical condition," allowing for the reimbursement of post-stabilization treatment in accordance with sound medical judgment. It is quite another for the courts to apply a narrow, stabilization-only interpretation of that same provision, possibly withholding treatment of a condition that health care providers would otherwise have classified as an emergency medical condition.


113. To be fair, this was not the case in Greenery Rehabilitation Group. In its opinion, the Second Circuit relied in part on the testimony of the two treating physicians involved in the matter. One of the physicians stated his understanding of an emergency medical condition as referring to "the care you give to stabilize the patient, I could consider that up to the stabilization as emergency care." This interpretation of "emergency medical condition" had also apparently been recognized by the New York City Human Resources Administration, the agency responsible for administering the Medicaid program in the New York City area. In effect, then, the court was simply reaffirming the decision made by the administrative agency, although its mode of interpretation would clearly conflict with the notion of allowing a broader interpretation for the purposes of permitting medical professionals to exercise their professional discretion within the reasonable scope of the statute. Greenery Rehab. Group, 150 F.3d at 229, 232.

114. In Mercy Healthcare Arizona, for example, the appellant health care provider sought reimbursement from the state Medicaid administrator for expenses that the provider argued were related to treatment for an emergency medical condition. Mercy Healthcare Ariz., Inc. v. Ariz. Health Care Cost Containment Sys., 887 P.2d 625, 628 (Ariz. Ct. App. 1994). Although it was the state administrator that initially defined the Emergency Medicaid provision narrowly, rather than a court, id. at 27, one can still see the tension that may result between physicians and either Medicaid administrators or courts where § 1396b(v) is construed narrowly to encompass only pre-stabilization treatment. Resolving this tension in favor of the narrow construction may, therefore, result in health care providers not being compensated for expenses related to the treatment of an emergency medical condition, at least as defined by those in direct
Whether State Medicaid administrators or health care providers choose to classify a given condition as compensable under Emergency Medicaid or not, a broader interpretation of the term "emergency medical condition" at least allows for physicians to continue providing needed care—care that in their judgment consists of emergency services—without concern that the law will constrain their providing this service. This is not to say that health care providers should not be subject to the clear intent of Congress that illegal immigrants not be provided with services beyond those described as treating an emergency medical condition. Rather, this merely ensures that this narrow exception is interpreted in accordance with the medical discretion HHS has determined deserves considerable deference.\(^\text{115}\)

C. A Narrow Interpretation of "Emergency Medical Condition" Results in States and Health Care Providers Bearing the Consequences of an Ambiguous Federal Statute in an Area in Which the Federal Government Exercises Sole Authority

According to a 2000 opinion poll, an overwhelming majority of Americans felt that the costs of providing emergency medical treatment to illegal immigrants should be borne by the federal government alone.\(^\text{116}\) Other polls also reveal the widely held belief that not only should the federal government cover expenditures for emergency treatment of illegal immigrants, but that illegal immigrants should in fact be entitled to such treatment.\(^\text{117}\) At least one state governor, Janet Napolitano of Arizona, has expressed a similar sentiment.\(^\text{118}\) Indeed, it is the job of the federal government, not state and local government, both to secure the U.S. border and to enforce immigration law.\(^\text{119}\) One could therefore make a reasonable contact with the patients and thus in the best position to determine whether an individual in fact suffered from such a condition.


116. MGT OF AMERICA, INC., supra note 9, at iii.

117. Id. at 4.

118. Governor Napolitano has expressed disappointment with the federal government's failure to provide hospitals with sufficient funds to ease the burden of providing care to illegal immigrants. Janofsky, supra note 9.

119. MGT OF AMERICA, INC., supra note 9, at 1.
argument that the federal government should bear the expense of providing emergency care for individuals who have entered the United States illegally and evaded immigration law.

Given the tension between the responsibilities of the federal government and the pressures of providing emergency health care to illegal immigrants faced by states and health care providers, a narrow interpretation of the Emergency Medicaid exception for illegal immigrants only strains the state/federal relationship further. It should be noted that physicians are obligated, both ethically and legally, to provide necessary health care. It should also be noted that the Emergency Medicaid exception for illegal immigrants is textually ambiguous, as is evident from a reading of the language itself. These circumstances combine to create substantial unfairness to health care providers when the exception is construed narrowly to permit reimbursement only for pre-stabilization treatment. While extending Medicaid coverage to illegal immigrants beyond stabilization in some circumstances may not resolve the tension between physicians and states on one hand and the federal government on the other, it certainly alleviates some of the pressure faced by physicians and states. It also places more responsibility on the federal government to resolve a situation of its own making—that of defective immigration enforcement mechanisms and faulty legislative drafting.

The pressure placed on health care facilities to provide necessary treatment to illegal immigrants is substantial, and lies partly in their ethical obligations as medical professionals and partly in federal law that mandates emergency treatment for all persons, regardless of immigration status. The National Association of Public Hospitals and Health Systems has stated its position as being that “[i]ts] members are committed to providing health care services to all patients regardless of ability to pay or immigration status.”

Public health care facilities, therefore, have an ethical obligation to provide emergency treatment to illegal immigrants who turn up on their doorstep. In addition, however, emergency rooms have an unequivocal legal obligation to provide emergency care under EMTALA. As discussed earlier, EMTALA states that hospitals are required to screen patients to determine the existence of any emergency medical condition and, if

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120. Id.


122. MGT OF AMERICA, INC., supra note 9, at 1.

necessary, provide treatment until the patient has been stabilized.\textsuperscript{124} The distinction between EMTALA and the Emergency Medicaid provision of § 1396b(v), with respect to who pays the costs, is critical, and reveals how a narrow interpretation of Emergency Medicaid care may exacerbate a problem already made worse by federal legislation.

In addition to EMTALA's stated purpose of halting "patient dumping,"\textsuperscript{125} it is important to note that there are no eligibility requirements for this mandated treatment.\textsuperscript{126} It applies to anyone who arrives at a hospital seeking treatment, regardless of immigration status or eligibility for public benefits.\textsuperscript{127} The problem is that, unlike Emergency Medicaid, EMTALA does not by itself provide for federal reimbursement for emergency treatment.\textsuperscript{128} Section 1396b(v), on the other hand, only provides for federal reimbursement when a patient "otherwise meets the eligibility requirements for medical assistance under the State plan approved under [Medicaid]."\textsuperscript{129}

As a result, hospital emergency rooms may be forced to treat patients from whom they can expect to receive no payment whatsoever, either from the patient or the federal government. Hospitals that neglect to do so may be subject to severe financial penalties,\textsuperscript{130} and in some circumstances physicians may even be excluded from public funding entirely.\textsuperscript{131} It is clear, then, that a hospital's responsibilities under EMTALA are broader than they are under Emergency Medicaid,\textsuperscript{132} placing a hopeless financial burden on hospital emergency rooms that treat illegal immigrants.\textsuperscript{133} While EMTALA

\textsuperscript{124} Id.

\textsuperscript{125} See discussion supra Part II.A.


\textsuperscript{127} See id.

\textsuperscript{128} Cosman, supra note 14, at 6.

\textsuperscript{129} 42 U.S.C. § 1396b(v) (2000).

\textsuperscript{130} Cosman, supra note 14, at 6.


\textsuperscript{132} MGT OF AMERICA, INC., supra note 9, at v.

\textsuperscript{133} Cosman, supra note 14, at 6.
and § 1396b(v) may serve different purposes, allowing reimbursement for an “emergency medical condition” under Emergency Medicaid that goes beyond merely stabilization may alleviate hospitals’ concerns about violating EMTALA and would help them to recuperate some of the financial losses they may have sustained as a result of non-reimbursement under the Medicaid program.134

Given the pressure placed by the law upon physicians to treat all patients who arrive at the emergency room, construing § 1396b(v) to apply only to care provided up to the point of stabilization places health care providers in the unfortunate situation of having to choose between possible violations of EMTALA (and their ethical obligations) and the possibility of non-compensation from the Medicaid program. Construing § 1396b(v) to apply to post-stabilization treatment of emergency conditions would therefore lessen the burden faced by these care providers and place more of it with the federal government, which, as discussed earlier, is ultimately responsible for enforcement of the nation’s immigration laws. In other words, resolving the ambiguity of § 1396(b) and the definition of “emergency medical condition” in favor of greater coverage for illegal immigrants places more of the burden for their treatment on those responsible both for their presence in this country (the executive and legislative branches) and those responsible for muddying the legal waters with a statute which has resulted in differing standards of coverage throughout the country (Congress).135

Notwithstanding the debate over the relative duties of health care providers and the federal government in dealing with the problem of illegal immigration, opponents of a broad interpretation of § 1396b(v) could nevertheless argue that doctors ought to be involved in the apprehension and reporting of illegal immigrants. Such an argument might flow from the fact that health care providers already collect identifying information from their patients and would be in a unique position to assist the federal government

134. Although the author has not found support for this proposition, it is conceivable that physicians’ concerns with respect to EMTALA violations might lead them to provide care beyond stabilization to illegal immigrants, as the definitions of “emergency medical condition” provided in EMTALA and § 1396b(v) could espouse conditions which some health care providers do not recognize as emergency conditions. Cosman, supra note 14, at 6. Rather than risk that an illegal immigrant’s condition is not an emergency and discharge or transfer the patient, physicians might provide treatment far beyond reasonable stabilization to avoid the severe penalties imposed for EMTALA violations. The problem, then, would be one of overcorrection.

135. To simplify, the narrower the interpretation of “emergency medical condition,” the greater the burden on health care providers resulting from the federal government’s ineffective border enforcement and concededly ambiguous drafting of § 1396b(v).
in its immigration enforcement efforts. In fact, the Welfare Reform Act provides explicit protection for state and local governmental entities that choose to provide immigration information to the appropriate authorities. When one city challenged the constitutionality of this provision, the Second Circuit Court of Appeals held that a city cannot force its public employees to protect information pertaining to immigration status given the federal statute. The court’s ruling has not been disturbed. Logically, it might seem that the narrowest possible interpretation of § 1396b(v) should therefore apply. Otherwise, health care providers would be applying two ostensibly conflicting federal statutes—the one giving them wide discretion to provide medical services to illegal immigrants, the other seeking their cooperation in fighting the influx of these same immigrants. Illegal immigrants themselves even seem to recognize the mixed message sent by Congress. By many reports, otherwise eligible individuals are fearful of applying for Medicaid out of fear that their immigration status may be reported to federal authorities.

136. See supra notes 99–103 and accompanying text.

137. Section 434 of the Welfare Reform Act provides:

Notwithstanding any other provision of Federal, State, or local law, no State or local government entity may be prohibited, or in any way restricted, from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status, lawful or unlawful, of an alien in the United States.


138. The City of New York had attempted, through an Executive Order issued by Mayor Koch in 1989, to prevent public employees from sharing information about a person’s immigration status with the INS (with very limited exceptions). City of New York v. United States, 179 F.3d 29, 31-32 (2d Cir. 1999). The Executive Order came into direct conflict with Section 434 of the Welfare Reform Act when the latter was passed in 1996. See id. at 32. The city sued the United States, claiming that Section 434 violated the Tenth Amendment as well as the Guarantee Clause of the U.S. Constitution, assuring the states a republican form of government. Id. at 33. The Second Circuit Court of Appeals affirmed the dismissal of the City’s claims by the District Court, holding that “states do not retain under the Tenth Amendment an untrammeled right to forbid all voluntary cooperation by state or local officials with particular federal programs.” Id. at 35.

The argument above is unconvincing. Section 434 of the Welfare Reform Act may seem incongruous with the Emergency Medicaid exception in §1396b(v) if applied broadly to encompass post-stabilization treatment at the discretion of the health care provider. But the job of health care providers is simply to care for the infirm in accordance with their duties as medical professionals; it is the job of federal immigration authorities to enforce immigration laws, whether at the border or within U.S. territory. To the extent that the federal government has failed to uphold its responsibilities, health care providers should not be burdened with filling the gap. Insisting that medical providers withhold treatment beyond stabilization for illegal immigrants in the interests of federal immigration policy would have that effect. Perhaps that is why the drafters of Section 434 of the Welfare Reform Act chose to make reporting of immigration status by public entities discretionary, rather than compulsory. Anything more would amount to the conscription of health care providers and states to enforce federal immigration law—a requirement that would be nothing less than overbearing. If Congress believes that a narrow, stabilization-only interpretation of §1396b(v) is necessary to battle illegal immigration, it may clarify the scope of Emergency Medicaid. So far, Congress has failed to do this.

In sum, it must be recognized that doctors cannot back away from their responsibilities for treating illegal immigrants suffering from an emergency medical condition, and that an ambiguous statute, interpreted differently


141. MGT OF AMERICA, INC., supra note 9, at 1; see also Lozano v. City of Hazleton, 496 F. Supp. 2d 477, 521-22 (M.D. Pa. 2007) (discussing federal preemption of state law in matters of immigration).

142. In City of New York v. United States, the Second Circuit recognized that such a requirement might be constitutionally unsound. Citing U.S. Supreme Court precedent, the Court stated that “even where Congress has the authority under the Constitution to pass laws requiring or prohibiting certain acts, it lacks the power directly to compel the States to require or prohibit those acts.” City of New York, 179 F.3d at 34 (quoting New York v. United States, 505 U.S. 144, 166 (1992)). As suggested by the Court, therefore, any requirement that might be imposed on states and localities to report immigration violators may run afoul of the U.S. Constitution in addition to undermining health care providers’ professional duties to provide needed care. This lends support to the idea that just because state and health care providers can offer information about their patients to immigration authorities, it does not mean that this wink and nod from Congress should therefore dictate a narrow interpretation of the scope of coverage under Emergency Medicaid.
around the country, does not lessen this obligation. The Emergency Medicaid provision of § 1396b(v) leaves room for coverage of treatment beyond merely that required to stabilize the patient. And as discussed earlier, some courts with compelling reasons have supported this understanding. Furthermore, HHS itself has supported an expansive interpretation of "emergency medical condition," to the dismay of commenters on the implementing regulations. Since the federal government has implicitly supported a broad interpretation of "emergency medical condition," and since this same government is responsible for enforcing immigration law, the ambiguity in § 1396b(v) should be resolved in favor of providing post-stabilization treatment, shifting the burden of this problem from health care providers and states to those more responsible for the problem.

III. CONCLUSION

The provision of emergency medical care for illegal immigrants raises numerous economic and social concerns. No single approach to solving this problem has emerged or is likely to emerge anytime in the near future. One need only examine the court decisions cited in this article to see the widely divergent viewpoints that exist. These decisions provide a microcosmic reflection of the deep divisions in society about the extent of emergency health coverage that should be available to those who have entered the United States illegally. Beyond the emotional, visceral reactions that this topic invokes, there are sensible reasons for applying a broad, post-stabilization interpretation to the "emergency medical condition" exception in the Federal Medicaid program. The broader interpretation ensures that the exception satisfies the original purpose of the budget-reducing bill of which it was a part. It also places greater responsibility for determining the existence of an emergency medical condition in the hands of health care providers, rather than with administrative personnel who may not be fully informed on the medical circumstances surrounding a particular case. Finally, the broader interpretation forces the federal government to bear a greater portion of the burden of providing services to illegal immigrants, whose presence in this country is due primarily to the federal government's own failure to enforce existing immigration law. And, by drafting an admittedly ambiguous statute, health care providers have been placed in the difficult position of potentially providing much-needed emergency services to illegal immigrants when reimbursement for those services may ultimately

be denied by the State Medicaid agency, a decision, which, as we have seen, may sometimes be affirmed by the nation’s courts.

Despite the concerns attending a narrow, stabilization-only interpretation of the emergency medical condition exception, political pressures have often favored restricting emergency services for illegal immigrants. In 2002, and largely due to the strain placed on states and providers, Senator Bingaman introduced the Federal Responsibility for Immigrant Health Act of 2002, which would have expanded Medicaid coverage for illegal immigrants to chemotherapy and other major health services. That legislation was allowed to languish in committee. More recently, the federal government has changed the application procedure for Medicaid reimbursement, forcing children of illegal immigrants—many of whom are U.S. citizens—to have an application filed for coverage separately on their behalf. In the past such coverage was provided once the mother was deemed eligible for coverage by virtue of the delivery, a covered expense under the Emergency Medicaid provision. And recognizing Congress’ own failure to pass legislation aimed at tackling the issue of illegal immigration, many states have recently proposed legislation that would sharply restrict the benefits available to illegal immigrants. Given such political statements, one can expect that the debate over emergency health care services for illegal immigrants will continue to be contentious.


147. Id.

148. Fears, supra note 4; see also Claudia Lauer, Ban Could Deny Illegal Immigrants Services, L.A. TIMES, July 14, 2007, at A12 (discussing a local resolution passed by the Prince William County, Virginia Board of Supervisors that seeks to ban illegal immigrants from receiving most county-funded services).

149. The eventual outcome of this debate is of course not a foregone conclusion. Proposed legislation in recent years, in addition to the Comprehensive Immigration Reform Act of 2007, see supra notes 1-4, has attempted to both broaden as well as restrict the available benefits to illegal immigrants. Compare H.R. 144, 110th Cong.
Due to the high stakes of further restricting the provision of emergency health services to illegal immigrants, there will continue to be significant tension between health care providers and the federal government on this issue, with State Medicaid agencies and the courts in the middle. But by allowing Medicaid reimbursement for treatment of post-stabilization emergencies, some of the enormous pressure currently felt by public health facilities and states would be alleviated. To that end, the nation's courts would do well to acknowledge the deference towards health care providers contemplated in the Emergency Medicaid statute. This might help to extract

(2007) (“To amend the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to allow States and localities to provide primary and preventive care to all individuals”), with the Border Protection, Antiterrorism, and Illegal Immigration Act Control Act of 2005, H.R. 4437, 109th Cong. (2005) (“A bill to amend the Immigration and Nationality Act to strengthen enforcement of the immigration laws, to enhance border security, and for other purposes”), and the ENFORCE Act, S. 2117, 109th Cong. § 705 (2005) (adding “employment services” to the list of public benefits unavailable to those not lawfully present in the U.S. under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996). Given the politically toxic nature of the debate over illegal immigration, it remains to be seen whether any combination of political parties as between the executive and legislative branches will be able to assert its strength in either expanding or restricting services for illegal immigrants at the federal level.

Despite strong ideological agreement between many moderate Republicans and the Democratic Party in the U.S. Congress on the issue of illegal immigration, continued gridlock on this issue can undoubtedly be expected as between the states and the federal government. In taking up the Comprehensive Immigration Reform Act, Congress revealed a remarkable degree of bipartisanship in its support for, among other things, the idea of providing a path to citizenship for the illegal immigrants presently in the United States, just as it had in 1986 when it passed legislation legalizing roughly three million illegal immigrants. See Hook, supra note 4. By contrast, many states have balked at the idea and have passed legislation intended to stem the flow of illegal immigrants into their territory, or at least restrict the benefits available to them. Fears, supra note 4; Jennifer Steinhauer, "As States Innovate on Issues, Schwarzenegger Blurs the Party Lines," N.Y. TIMES, Jan. 12, 2007, at A18. While the courts have not spoken conclusively on such legislation, one recent high-profile case involving restrictive local ordinances passed by the City of Hazleton, Pennsylvania resulted in the ordinances being struck down by a federal district court, largely because of federal preemption in immigration matters. See Lozano v. City of Hazleton, 496 F. Supp. 2d 477 (M.D. Pa. 2007). The ruling may signal a trend in the courts toward striking down similar ordinances that seek to restrict services for illegal immigrants independently of federal law. Cynthia Leonor Garza & Mark Babineck, Advocates See Domino Effect in Judge’sIllegal Immigrant Ruling, HOUS. CHRON., July 27, 2007, at A1. The same effect could possibly be seen in challenges to restrictive state laws as well. See Daniel González, Pa. Ruling Heartens Foes of Ariz. Law, ARIZ. REP., July 27, 2007, at A18, available at http://www.azcentral.com/arizonarepublic/news/articles/0727hazletoncase0727.html.
some of the *politics* from this issue and replace it with sensible *policy* that seeks to address the problem of illegal immigrant health care in a way that acknowledges the shared burden of local health care providers, as well as the federal government. To do otherwise would be to broaden the scope of the problem beyond the negative effects already seen to an extent that the United States cannot afford. And that is a scenario that no one should want to see develop.