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Cast Back into "Tempest-Tost Waters": "The Uncharted Seas" of Private Medical Repatriations

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COMMENT

CAST BACK INTO "TEMPEST-TOST" WATERS: THE "UNCHARTED SEAS" OF PRIVATE MEDICAL REPATRIATIONS

While driving on a Florida road during the course of his job as a gardener in the winter of 2000, Luis Jiménez was struck head-on by a drunk driver who had stolen a van.[1] Two of Jiménez's fellow passengers were killed instantly. The driver and Jiménez, both severely injured, were taken to the emergency department at Martin Memorial Medical Center, a not-for-profit community hospital. Jiménez was unconscious and in shock from extensive bleeding. He had two broken thigh bones, a broken arm, multiple internal injuries, facial lacerations, and a severe head injury.[2] Perhaps most significantly to his treatment plan, he also arrived at the hospital as an undocumented and uninsured immigrant.

Jiménez survived the accident, but he did so with serious permanent brain injuries.[3] Though he lingered in an unconscious, unresponsive state for over a year, he eventually—and quite suddenly—awoke and began interacting with those around him.[4] In

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[1] Deborah Sontag, *Deported, by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, at A1 [hereinafter Sontag (August)]. This was one theft in the course of the driver's long criminal record of robberies and drug abuse. Following this accident, the driver was convicted of two counts of DUI manslaughter and served a seven-year prison term. Within four months of his release, he borrowed a neighbor's car and was involved in another hit-and-run accident, for which he was sentenced to twenty-five years in prison. *See* Melissa E. Holsman, *Driver Who Hit Luis Jiménez Sentenced to 25 Years for Repeat Offense*, STUART NEWS, Aug. 17, 2009, *available at* http://www.tcpalm.com/news/2009/aug/17/man-who-hit-luis-jimenez-sentenced-to-25-years/.

[2] Sontag (August), *supra* note 1.

[3] *Id.*

[4] *Id.*

time, he was able to regain mental capabilities comparable to those of an eight- or nine-year-old child.[5]

His basic recovery took quite some time—and an enormous amount of money. The cost of Jiménez's care amounted to over $1 million.[6] Jiménez was uninsured and unable to pay for his care. The federal government covered only $80,000 of the total bill.[7]

Facing an indefinite stay, mounting costs of care, and no government or private funding to support Jiménez's rehabilitative, non-emergency treatment, Martin Memorial began to consider its options. When the hospital suggested that Jiménez be transported to Guatemala, his country of origin, the family and his legal guardian objected.[8] Litigation on the matter ensued, but before the case was fully resolved, the hospital secretly chartered a plane and transported Jiménez to Guatemala without the knowledge of his family or legal guardian.[9] Though a court eventually ruled that the hospital's actions were illegal,[10] it was too late—Jiménez had been medically repatriated.

Jiménez's situation is not unusual—indeed, his roommate for part of his time at Martin Memorial was repatriated to Jamaica.[11] Many immigrants are uninsured. Though hospitals are required to provide emergency treatment to everyone regardless of ability to pay,[12] the government only reimburses the hospitals for a portion of the uncompensated care and ceases all compensation as soon as the patient is medically "stable."[13] Hospitals are required by federal law to arrange for long-term care for those who need it,[14] but Medicaid does not cover long-term care for undocumented immigrants or those who are newly arrived in the U.S.[15] In addition, most long-term care

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[5] *Id.*

[6] Montejo v. Martin Mem'l Med. Ctr. (*Montejo I*), 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004). The average costs for a patient at Martin Memorial are $8,188, and the average stay is 4.1 days. Sontag (August), *supra* note 1.

[7] Sontag (August), *supra* note 1.

[8] *Id.*

[9] *Id.*

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

[11] Sontag (August), *supra* note 1.

[12] *See* 42 U.S.C. § 1395dd (2006) (requiring hospital emergency departments to provide emergency care).

[13] *See* 42 U.S.C. § 1396b(v) (2006) (providing for federal payment to states for treating aliens not lawfully admitted for permanent residence during a medical emergency).

[14] *See* 42 C.F.R. § 482.43 (2008) (prescribing standards for patient discharge plans).

[15] *See* Rachel Benson Gold, *Immigrants and Medicaid after Welfare Reform*, GUTTMACHER REP. ON PUB. POL'Y, May 2003, at 6, *available at* http://www.guttmacher.org/pubs/tgr/06/2/gr060206.html.

facilities will not accept patients who are uninsured or even those who have Medicaid.[16]

"Medical repatriation" refers to a practice in which private hospitals attempt to return immigrants—both documented and undocumented and, in at least one case, a U.S. citizen[17]—to their countries of origin because the hospital determines that it can no longer afford the costs of caring for them. Federal immigration and customs enforcement are not involved in these cases. While most hospitals say that they only conduct cross-border transfers once patients are medically stable, and that they arrange to deliver them into a physician's care in their homeland, "[these] hospitals are operating in a void, without governmental assistance or oversight, leaving ample room for legal and ethical transgressions on both sides of the border."[18] Stephen Larson, a migrant health expert and physician at the Hospital of the University of Pennsylvania, told the New York Times that "[t]he opportunity to turn your back is there [for hospitals] . . . . You're given an out by there not being formal regulations. The question is whether or not litigation, or prosecution, catches up and hospitals start to be held liable."[19]

This Comment explores the legal and regulatory context in which medical repatriations take place. Part I of this Comment will provide a background picture of medical repatriations in the United States. Part II will examine hospitals' legal obligations with a particular emphasis on civil liability under state law and federal statutory law, and will address the inconsistent incentives these laws and regulations promote. Finally, Part III will provide brief suggestions for next steps for resolving some of the tensions in existing law, as well as guiding principles for possible reforms.

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[16] Sontag (August), *supra* note 1.

[17] *See* Deborah Sontag, *Deported in Coma, Saved Back in U.S.*, N.Y. TIMES, Nov. 9, 2008, at A1 [hereinafter Sontag (November)]. Elliott Bustamante was born in a Tucson, Arizona hospital with Down syndrome and a heart condition. Just two days later, the same hospital attempted to transfer him to Mexico for care even though he was a United States citizen. *Id.* Elliott's mother explained to the *New York Times*: "We were so scared. They said we had no rights, the baby neither. They said they would send the baby with or without me. When Elliott was two weeks, they told me to gather my things because the baby was leaving in 15 minutes with a lady. It was very ugly. We contacted the Mexican consulate. They got us a lawyer." *Id.* Despite communications with the hospital, the lawyer actually had to ask police to intercept the baby on the way to the airport with hospital officials. *Id.* Several days later, the hospital told the parents that "[l]egally . . . the baby could be considered to be trespassing" due to unpaid medical bills. *Id.* After much back and forth, Elliott eventually qualified for Medicaid, and he was not transported to Mexico. *Id.*

[18] Sontag (August), *supra* note 1.

[19] Sontag (November), *supra* note 17.

I. MEDICAL REPATRIATIONS IN AMERICA

In 1970, there were approximately 9.6 million immigrants in the United States.[20] In 2005, the United States Census Bureau reported that there were 35.2 million,[21] over three and a half times the number in 1970. In 1970, 4.7% of the United States population was made up of immigrants; in 2005, that percentage rose to 12.1%.[22] Of the 35.2 million immigrants residing in the United States in 2005, approximately 9.6 to 9.8 million were estimated to be undocumented.[23] More than half of all immigrants in the United States are from Latin America, and just over a third are from Central America, including Mexico.[24] California, Texas, Arizona, Illinois, New York City, and Florida have the highest numbers of immigrants.[25]

Nearly one quarter of those living in poverty in the United States are immigrants and their children.[26] One third of immigrants do not have health insurance (compared to only 13% of native-born Americans),[27] and approximately 65% of undocumented immigrants lack health insurance.[28] One study found that annual per capita expenses for health care were 86% lower for uninsured immigrant children than for uninsured U.S.-born children—but emergency department expenditures were more than three times as high.[29] Whether or not they have health insurance, immigrants overall have much lower per capita health care expenditures than native-born Americans,[30] and recent analyses indicate that they contribute more to the economy in taxes than they receive in public benefits.[31] In a study from the RAND Corporation, researchers estimated that undocumented adult immigrants account for only about 1.5% of U.S.

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[20] *See* Steven A. Camarota, *Immigrants at Mid-Decade: A Snapshot of America's Foreign-Born Population in 2005*, BACKGROUNDER (Ctr. for Immigration Studies, Washington, D.C.), Dec. 2005, at 5 fig.2, *available at* http://www.cis.org/articles/2005/back1405.pdf.

[21] *Id.*

[22] *Id.*

[23] *Id.* at 23.

[24] *See* NOLAN MALONE ET AL., U.S. CENSUS BUREAU, THE FOREIGN-BORN POPULATION: 2000, at 2 (2003), *available at* http://www.census.gov/prod/2003pubs/c2kbr-34.pdf.

[25] *See* MICHAEL HOEFER ET AL., OFFICE OF IMMIGRATION STATISTICS, U.S. DEPT. OF HOMELAND SEC., ESTIMATES OF THE UNAUTHORIZED IMMIGRANT POPULATION RESIDING IN THE UNITED STATES: JANUARY 2005, at 7 tbl.4 (2006), *available at* http://www.dhs.gov/xlibrary/assets/statistics/publications/ILL_PE_2005.pdf.

[26] *See* Camarota, *supra* note 20, at 14–15.

[27] *Id.* at 15.

[28] *Id.* at 26.

[29] *See* Sarita A. Mohanty et al., *Health Care Expenditures of Immigrants in the United States: A Nationally Representative Analysis*, 95 AM. J. PUB. HEALTH 1431, 1435 (2005).

[30] *See id.*

[31] *Id.*

medical costs.[32] Many immigrants do not seek medical treatment unless they are injured or acutely ill. It is amidst this context that the issue of medical repatriations arises.

As noted above, "medical repatriations" are private transfers of patients from hospitals in the United States to health care facilities in other countries. These transfers do not occur with the involvement or oversight of the federal government, which has exclusive jurisdiction over immigration and deportation matters.[33] While most repatriations involve undocumented immigrants like Luis Jiménez, some involve immigrants who are legally present in the United States. For example, a nineteen-year-old farm worker named Antonio Torres was repatriated from a hospital in Phoenix to Mexico, despite his status as a lawful permanent resident.[34] He was uninsured, and the Phoenix hospital was unwilling to cover the costs of his post-accident care, even though the hospital had determined that "there was no hope" for Torres.[35] Against the wishes of his parents, Torres, then comatose and connected to a ventilator with pneumonia and a very high white blood cell count, was transported to Mexico. After four days of receiving no attention in a Mexican emergency room, his parents were able to find a hospital in California that agreed to treat him.[36] They borrowed an ambulance and drove Torres back to the United States, where he arrived in septic shock with a raging infection.[37] Despite these setbacks, the hospital was able to save his life and he made a good recovery.[38] Others have been less fortunate.

It is difficult to estimate the frequency with which these repatriations occur. However, it is apparent that they happen frequently enough to create a market for at least one company that specializes in repatriation services. MexCare, which advertises itself as "an alternative choice for care of the unfunded Latin American

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[32] Dana P. Goldman et al., *Immigrants and the Cost of Medical Care*, 25 HEALTH AFF. 1700, 1709 (2006).

[33] *Montejo I*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004) (citing Johns v. Dep't of Justice, 653 F.2d 884 (5th Cir. 1981); Torros v. State, 415 So. 2d 908 (Fla. Dist. Ct. App. 1982)).

[34] *See* Sontag (November), *supra* note 17.

[35] *Id.* Torres' father reported that the social worker told him that "there was no hope for our son and that it would be best to unplug him [from the ventilator]. . . . And if he wakes up, he will not be able to do much." *Id.* He said that when he and his wife refused to unplug the ventilator, the social worker told him that the hospital could not keep their son without insurance. *Id.*

[36] *Id.* An executive at the California hospital that agreed to treat Torres told the New York Times: "We don't export patients . . . . I can understand the frustrations of other hospitals, but the flip side is the human being element." *Id.*

[37] *Id.*

[38] *Id.*

national," was founded in 2001.[39] The company contracts with hospitals to transfer stabilized individuals from the hospital to health care facilities outside of the United States, thus serving as a way to reduce costs for the hospital.[40]

The *Los Angeles Times* told the story of one nineteen-year-old patient for whom a hospital had utilized MexCare's (then "Nextcare") services.[41] After a car accident, the patient arrived at the hospital's emergency room with a shattered leg and broken jaw. He was transferred to a hospital in Mexico. According to MexCare and the hospital, his transfer was voluntary, and the decision was unpressured.[42] According to the patient, he agreed to the transfer because he was hungry and was told that the hospital in Tijuana could take the wires out of his jaw.[43] Because of "poor communication and follow-up," however, the patient's gums were infected and grew over the wires in his mouth, ultimately causing him severe pain—and immense hunger.[44]

Responding to criticism from the *New York Times*, MexCare's Web site emphasizes that it only transfers patients who have provided written consent, and claims that the transfers are beneficial both to the hospitals as well as the patients it serves.[45] When compared to repatriations that occur without a company such as MexCare, this may be true. Most hospitals conduct repatriations without oversight and without the guidance of established policies and procedures.[46] Setting aside the troubling issues that arise from implementing non-governmental deportations, MexCare at least attempts to provide a comparable level of health care for its clients. Though not always successful—as the story mentioned above demonstrates—MexCare claims that it abides by an individualized discharge plan, enrolls the

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[39] MexCare, http://mexcare.com/index.html (last visited Oct. 25, 2009).

[40] MexCare Services, http://mexcare.com/services_MexCare.html (follow "How we do it" hyperlink) (last visited Oct. 25, 2009).

[41] Lisa Richardson, *Patients Without Borders: Amid Rising Health Costs, Illegal Immigrants in San Diego-Area Hospitals Are Being Transferred Back to Mexico for Treatment*, L.A. TIMES, Nov. 5, 2003, at A1; *see also* Brietta R. Clark, *The Immigrant Health Care Narrative and What It Tells Us About the U.S. Health Care System*, 17 ANNALS HEALTH L. 229, 229 (2008).

[42] Richardson, *supra* note 41. The article reported that the executive vice president of the Hospital Association of Southern California said that "[s]ending such patients back to Mexico 'is a responsible and inventive way of dealing with a shortage of beds for indigent patients' . . . . 'When you talk about our border states and counties like San Diego, they're tired of waiting for the federal government to deal with this problem.'" *Id.*

[43] *Id.*

[44] *Id.*

[45] Press Release, MexCare, The New York Times Gets It Wrong! (Aug. 15, 2008), *available at* http://mexcare.com/pressRelease_MexCare.html.

[46] Sontag (November), *supra* note 17.

patient in one of its partnering clinics, and makes an effort to follow up on the patient's progress,[47] which is more than can be said of other hospitals that do not affiliate themselves with a company like MexCare. As the *New York Times* noted, though some hospitals repatriate patients by force, "others do so only with consent—although consent is a murky concept when patients are told they have no alternative. While some hospitals pay for an immigrant's repatriation and for their care in their homelands; others never make any inquiries into how deported patients have fared."[48] Though potentially less harmful than repatriations by hospitals, the existence of and demand for a company like MexCare is one symptom of a deeply disturbing system that is based purely upon financial incentives and provides for no oversight and little accountability.

II. LEGAL OBLIGATIONS

Though there is currently little accountability in the practice of medical repatriations, there are some possible avenues for legal challenges. An understanding of the laws—and lack thereof—that permit and perpetuate this practice is vital in understanding why repatriations occur and what can be done about them.

A. State Law

1. State-Specific Medicaid Provisions

Medicaid is administered on the state level, with some states providing more protection for immigrants than others. For example, while almost all states do not provide funds for non-emergency care of undocumented immigrants, California has budgeted for long-term care as part of its state Medicaid program, and this care is available to undocumented immigrants.[49] A state-by-state examination of Medicaid is beyond the scope of this Comment; however, as far as the Author is aware, no state has specifically addressed the issue of medical repatriations in its Medicaid programming.

2. Civil Liability

Luis Jiménez's situation is the only one to have been fully litigated on the precise issue of medical repatriations. Two separate actions

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[47] MexCare Press Release, *supra* note 45.

[48] Sontag (November), *supra* note 17.

[49] Sontag (August), *supra* note 1. New York City also provides for long-term care for undocumented immigrants through the Health and Hospitals Corporation of New York City. *Id.*

were filed, and the results have yielded mixed signals about the likely success of future civil cases.

In the first case, Montejo Gaspar, Jiménez's cousin, initiated guardianship proceedings for Jiménez.[50] Martin Memorial Medical Center intervened as an "interested party" to seek approval to discharge Jiménez from the hospital and transport him to Guatemala, his country of origin.[51] Judge John Fennelly granted the hospital's request.[52] Gaspar's attorneys immediately filed a notice of appeal and asked for a stay of the court's order while the appeal was pending.[53] Judge Fennelly asked Martin Memorial to file a response by ten o'clock the following morning so that he could rule upon the request for a stay.[54] Just hours before the response was due, however, the hospital chartered a private plane for $30,000 and transported Jiménez to Guatemala.[55] When Gaspar arrived at the hospital that morning to visit his cousin, he was gone.[56] The family received no notice of the hospital's intention to deport Jiménez.

Gaspar moved forward with the appeal.[57] Judge Klein, writing for a unanimous three-judge panel, determined that while the hospital was an "interested party" and, therefore, could intervene in the guardianship proceedings, the evidence did not support the trial court's order permitting Martin Memorial to discharge Jiménez and transport him to Guatemala.[58] Specifically, the court held that the evidence was not sufficient to show that the hospital complied with its own policies or the discharge requirements for Medicare providers found in 42 U.S.C. § 1395X(ee) and 42 C.F.R. § 482.43.[59] The court explained:

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[50] *Montejo I*, 874 So. 2d 654, 656 (Fla. Dist. Ct. App. 2004).

[51] *Id.*

[52] *Id.* The *New York Times* reported that in explaining his decision, Judge Fennelly noted that: "This Court . . . sails on uncharted seas." Sontag (August), *supra* note 1.

[53] Sontag (August), *supra* note 1.

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] On appeal, the hospital argued that the matter was moot because Jiménez was in Guatemala and the issue of whether or not he could return would be preempted by federal immigration law. *Montejo I*, 874 So. 2d at 656. The court, however, explained that this reasoning merely undermined the hospital's position that the trial court ever had subject matter jurisdiction to issue a valid authorization for the hospital to deport Jiménez, as federal immigration law preempts private repatriations. *Id.* The court also pointed out that the hospital was able to make a mootness argument only because of its own actions in transporting Jiménez to Guatemala before Judge Fennelly was able to rule on the motion to stay. *Id.* at 656–57. Judge Klein noted that, even if the case had been moot, the court would have heard the case because it presented an important issue which was likely to recur. *Id.* at 657.

[58] *Id.* at 656, 658.

[59] *Id.* at 657.

> Under 42 C.F.R. section 482.43(d), the patient can be transferred by a hospital only to an "appropriate facility" where the patient would receive post-hospital care. Such a facility is defined as one which can meet the patient's medical needs. . . . Similarly, the hospital's own discharge policies and procedures require that the discharge plan identify the next appropriate level of care required by the patient, identify by name and address the receiving facility, provide the name of the supervising medical doctor who will take responsibility for the patient's care at the receiving facility, and confirm that the doctor will provide the patient with the identified appropriate level of care.[60]

In Jiménez's case, the hospital had determined that the next level of necessary care would be traumatic brain injury rehabilitation.[61] While several facilities in Florida could have provided this type of care, Jiménez did not have sufficient funds for ongoing treatment and was ineligible for Medicaid due to his immigration status.[62]

The appellate court also found that the trial court did not have sufficient evidence to determine that Jiménez's transfer to Guatemala would be to an "appropriate facility" that could meet his medical needs—namely, traumatic brain injury rehabilitation services.[63] The trial court, over the objections of Mr. Gaspar's attorney, had admitted a letter from the Vice Minister of Public Health in Guatemala stating that a facility in Guatemala was prepared to provide the "necessary care" for Jiménez without cost.[64] The appellate court determined that this letter was hearsay and, as such, was improperly admitted into evidence.[65] The court also noted that even if it had not been hearsay, the letter was "not nearly specific enough to satisfy either the federal regulations or the hospital's discharge procedures."[66] The court stated that the only admissible evidence was the testimony of an expert on the Guatemalan public health care system, who testified that there were no public healthcare facilities equipped to provide traumatic brain injury rehabilitation in Guatemala.[67]

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[60] *Id.*

[61] *Id.*

[62] *Id.*

[63] *See id.* at 658.

[64] *Id.* at 657.

[65] *Id.* at 658.

[66] *Id.*

[67] *Id.* Jiménez was put in the care of a small Guatemalan clinic that had no traumatic brain injury rehabilitation services. Sontag (August), *supra* note 1. Jiménez's wife was contacted by the clinic to request that she and their sons pick Jiménez up. Jiménez did not recognize his wife when she arrived. *Id.* He was transferred to another facility, where he was found by his brother

Summarizing its holding, the appellate court stated: "We therefore reverse because (1) there was no competent substantial evidence to support Jim[é]nez's discharge from the hospital, and (2) the trial court lacked subject matter jurisdiction to authorize the transportation (deportation) of Jim[é]nez to Guatemala."[68] In a somewhat ironic conclusion, then, it turned out that both of Jiménez's crossings over the border were illegal.

In the second case, Gaspar filed suit against Martin Memorial, seeking monetary damages for falsely imprisoning Jiménez.[69] Under Florida law, there are four elements of a false imprisonment claim: "1) the unlawful detention and deprivation of liberty of a person 2) against that person's will 3) without legal authority or 'color of authority' and 4) which is unreasonable and unwarranted under the circumstances."[70] The hospital initially argued that the trial court's order authorizing it to deport Jiménez, though eventually declared to be void, entitled it to immunity from the false imprisonment claim.[71] The court disagreed, explaining that, although Martin Memorial acted in reliance upon a court order, that court order was void for lack of subject matter jurisdiction, and "Martin Memorial was not cloaked with absolute immunity from civil liability when acting pursuant to a void court order . . . ."[72] The court reversed and remanded the case for further proceedings on the false imprisonment issue.

On remand, the matter went to a jury trial. The judge instructed the jury that, because of the first appellate court decision, the case met three of the four elements of false imprisonment as a matter of law, and the only issue for their deliberation was whether or not the hospital acted "unreasonably."[73] The all-white, non-Hispanic jury found that the hospital did not act in a way that was "unreasonable and unwarranted under the circumstances" when it transferred Jiménez to Guatemala against the wishes of his guardian.[74]

"lying in the hallway on a stretcher, covered in his own excrement." *Id.* at 20. As of the last date the *New York Times* spoke with a family member, Jiménez, who was living with his mother, was receiving no medical treatment at all, and he had suffered numerous violent seizures. *Id.* Without consistent medical care, Jiménez is unlikely to make a recovery.

[68] *Montejo I*, 874 So. 2d at 658. The second reason—that the trial court lacked the authority to deport Jiménez—became an important part of the subsequent litigation.

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

[70] *Id.*

[71] *See id.*

[72] *Id.* at 1267.

[73] *See* Deborah Sontag, *Jury Rules for Hospital that Deported Patient*, N.Y. TIMES, July 28, 2009, at A10 [hereinafter Sontag (July)].

[74] *Id.* As of the date of writing, Gaspar's attorneys had filed a motion for a new trial, but the motion had not yet been ruled upon by the judge. *See* Melissa E. Holsman, *Jiménez Lawyers*

It is important to note that, although these two cases arose out of the same set of facts, the finder of fact and the relief requested differed substantially. In the first case, a judge made the determination in Jiménez's favor. In the second, a jury made the decision against Jiménez. As the press reported, the second trial occurred amidst strong public anti-immigrant sentiments with a jury from a small town in which undocumented immigration is a widespread issue.[75] Additionally, while the first action sought to prevent the hospital from taking certain actions, the second sought monetary damages. Because the issue was complicated and the hospital's obligations under existing laws unclear, the jury likely was unwilling to financially penalize the hospital. As noted above, the future predictability of the outcome of civil litigation on the issue of medical repatriations remains unclear in light of the limited number and differing results of these cases.

3. Criminal Liability

In addition to potential civil liability for false imprisonment, hospitals may also be criminally liable under state kidnapping statutes for "repatriating" unwilling individuals. The common law origins of kidnapping closely resemble these situations—kidnapping was defined as forcibly abducting a person from his or her own country and sending him or her into another country.[76] The modern crime of kidnapping focuses on the involuntary detention of the victim in violation of his or her liberty. Under the Model Penal Code, for example, a person is guilty of kidnapping if he or she:

> [U]nlawfully removes [a person] from his [or her] place of residence or business, or a substantial distance from the vicinity where he [or she] is found, or if he [or she] unlawfully confines another for a substantial period in a place of isolation, with any of the following purposes: (a) to hold for ransom or reward, or as a shield or hostage; or (b) to facilitate commission of any felony or flight thereafter; or (c) to inflict bodily injury on or to terrorize the victim or another;

Seek New Trial; Claim They Were 'Robbed of a Fair Trial,' STUART NEWS, Aug. 5, 2009, *available at* http://www.tcpalm.com/news/2009/aug/05/jimenez-lawyers-seek-new-trial-claim-they-were-a/.

[75] *See* Sontag (July), *supra* note 73.

[76] *See* United States v. Garcia, 854 F.2d 340, 343 (9th Cir. 1988); Doss v. State, 123 So. 231, 235 (Ala. 1929); *Ex parte* McDonald, 146 P. 942, 943 (Mont. 1915) (discussing the common law origins of the offense of kidnapping).

> or (d) to interfere with the performance of any governmental or political function.[77]

To the Author's knowledge, no hospital has been charged with kidnapping for performing a medical repatriation. At first glance, it may seem untenable to suggest that a hospital could be criminally liable for medically repatriating an undocumented immigrant. However, if one imagines a scenario identical to that of Jiménez in all respects but his immigration status, the argument may begin to seem less peculiar. If a U.S. citizen, unable to pay her medical bills due to her indigence, were smuggled onto a plane in the early hours of the morning and left in a foreign country because that country supposedly could provide less expensive rehabilitative services, there would surely be immense public outcry against the hospital and demands for the prosecutor to press charges. The public is less likely to be sympathetic when an undocumented immigrant is repatriated. However, immigration status is not an element of the offense of kidnapping. Indeed, even if immigration status is considered, it actually helps fulfill the elements of the crime because a private deportation would "interfere with the performance of [a] governmental or political function"—namely, the government's ability to initiate and administer removal proceedings.

B. Federal Statutory Law

In addition to state law, there is a considerable body of federal statutory law that is relevant to the subject of medical repatriations. However, federal statutory law on the subject of medical repatriations is unclear at best and contradictory at worst. As one author points out,

> [I]mmigration and Medicaid reforms over the past decade have created a *de facto* regulatory framework in which repatriation has become an attractive solution for hospitals faced with increasing costs of uncompensated medical care for uninsured non-citizens. What is currently lacking, though, is a set of legal or regulatory protections that would ensure that these transfers protect patients' interests.[78]

The interaction of the two major federal statutes with the greatest impact on medical repatriations—the Emergency Medical Treatment

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[77] MODEL PENAL CODE § 212.1 (1962).

[78] Joseph Wolpin, *Medical Repatriation of Alien Patients*, 37 J.L. MED. & ETHICS 152, 152 (2009).

and Active Labor Act of 1986 (EMTALA)[79] and the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA)[80]—is examined below.

1. Medicaid and the Requirements of EMTALA

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act ("EMTALA")[81] in response to nationwide reports of "patient-dumping" of uninsured patients by health care facilities. Under EMTALA, "participating"[82] hospitals and ambulance services must provide care to anyone in need of emergency medical treatment who "comes to" an emergency department regardless of the person's ability to pay.[83] The statute includes an enforcement section and provides for monetary penalties to be assessed against hospitals and individual physicians who do not comply with the requirements of the statute.[84] It also provides for the availability of civil monetary damages.[85] The civil damage provision, however, is rarely enforced, and almost never to the full extent possible.[86]

Hospitals are required to provide "such further medical examination and such treatment as may be required to stabilize the medical condition."[87] Several of the definitions in the EMTALA statute have provoked varying interpretations and debate. "Emergency medical condition" is defined, in part, as:

> [A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual

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[79] 42 U.S.C. § 1395dd (2006).

[80] 8 U.S.C. §§ 1601–1646 (2006).

[81] Pub. L. No. 99-272, § 9121, 100 Stat. 164 (1986) (codified as amended at 42 U.S.C. § 1395dd (2006)).

[82] "Participating" hospitals refers to those hospitals that accept Medicaid/Medicare funds—in other words, almost every hospital in the United States. *See* 42 U.S.C. § 1395dd(e)(2).

[83] *Id.* § 1395dd(a).

[84] *See id.* § 1395dd(d).

[85] *See id.*

[86] *See* Lauren A. Dame, *The Emergency Medical Treatment and Active Labor Act: The Anomalous Right to Health Care*, 8 HEALTH MATRIX 3, 13–18 (1998) (setting forward detailed statistics about the rates of government enforcement and explaining that the government rarely enforces EMTALA). Though a private right of action exists, "the population that has historically been most vulnerable to patient dumping is the poor and uninsured, a group of people often unlikely to have a lawyer to turn to when their rights are violated. Thus, if the government does not enforce EMTALA, or enforces it poorly, given the strong economic incentives of hospitals to 'dump' patients, EMTALA's guarantees will be illusory." *Id.* at 5.

[87] 42 U.S.C. § 1395dd(b).

> (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.[88]

Health care facilities are required to provide services regardless of ability to pay. They cannot turn someone away who "comes to" their emergency rooms. Hospitals, however, have developed a variety of creative ways to discourage immigrants from "coming to" their facilities in the first place. In Texas, for example, one hospital's security guards wear uniforms that look like those the border patrol wears, while another hospital questions those it suspects of being undocumented immigrants about their immigration status and asks for their documentation upon entry.[89] Many patients are aware that hospitals are not restricted under federal law from reporting patients to federal immigration officials, and the possibility of facing questions about legal status or the apparent presence of border patrol officers at the hospital dissuades many from seeking care. These are the overt methods of deterring immigrants from seeking medical help, whether in emergencies or non-emergencies. Many hospitals also employ less obvious strategies to discourage undocumented immigrants from seeking care. Such practices include harassing patients who cannot pay their bills, making public statements about the rising costs of care for "illegals," failing to provide translation services, and publicizing that they will not provide services for immigrants without indicating that they are legally required to provide emergency care.[90] Even less directly, many immigrants know that financial reliance upon the federal government can result in denial of their applications for permanent residency or citizenship,

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[88] *Id.* § 1395dd(e)(1)(A). It can be difficult to determine whether or not a condition falls within this definition of an "emergency medical condition." For example, in *Szewcwyk v. Department of Social Services*, the Supreme Court of Connecticut held that acute myelogenous leukemia was an "emergency medical condition" within the meaning of the statute, and so the state had to reimburse the hospital for treatment. 881 A.2d 259, 261 (Conn. 2005). Similarly, in *Luna v. Division of Social Services*, the North Carolina Court of Appeals found that there had been insufficient evidence at trial to determine that an undocumented immigrant's treatment for cancer did not fall under the definition of an "emergency medical condition." 589 S.E.2d 917, 925 (N.C. Ct. App. 2004). However, in *Diaz v. Division of Social Services*, the Supreme Court of North Carolina found (1) that, for Medicaid purposes, an "emergency medical condition" is one that manifests itself by acute symptoms at the time treatment is sought and requires immediate treatment in order to stabilize the condition, and (2) that an undocumented immigrant's acute lymphocytic leukemia was not an "emergency medical condition" when the individual underwent chemotherapy treatments, and thus the state was not required to reimburse the hospital for the costs of his treatment. 628 S.E.2d 1, 5 (N.C. 2006).

[89] Clark, *supra* note 41, at 230.

[90] *See id.*

since applicants must show that they will not become a "public charge."[91] Such knowledge also deters many from seeking necessary medical treatment.

Even if a patient is admitted, the more difficult question becomes: at what point is the patient "stabilized" and no longer in an "emergency" condition such that he or she can be discharged? And what must the hospital do in order to discharge a patient? For some patients, this is not a difficult issue. Someone who visits an emergency room because of an asthma attack, for example, may receive treatment through an inhaler or steroid dose, regain her ability to breathe effectively, and eventually be able to leave the hospital without a problem. For other patients, however, the question of when they may be released is much more difficult. "Despite EMTALA's prohibitions on 'patient dumping,' hospitals face difficult choices when deciding how and when to discharge uninsured patients who need extensive follow-up care after being stabilized. Under current law, hospitals have a discharge option for non-citizens unavailable for U.S. citizen patients: repatriation."[92]

Even EMTALA's use of the term "stabilize" is somewhat murky:

> The term "to stabilize" means, with respect to an emergency medical condition described in paragraph (1)(A), to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility . . . .[93]

In addition to the stabilization requirement, hospitals are required to release patients to an "appropriate facility."[94] Under the interpretive regulations promulgated for Medicaid, this is defined as a facility that "can meet the patient's medical needs on a post-discharge basis."[95]

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[91] *See* 8 C.F.R. § 213a.2(a) (2008). One author has pointed out that this policy deviates substantially from the idealistic statement inscribed on the Statue of Liberty at what is one of the largest points of immigration—both historically and presently—in the United States: "Give me your tired, your poor, Your huddled masses yearning to breathe free, The wretched refuse of your teeming shore. Send these, the homeless, tempest-tost to me, I lift my lamp beside the golden door!" Ruqaiijah Yearby, *From the Mayflower to Border Patrols: Who Deserves Access to Health Care in the United States?*, 17 ANNALS HEALTH L. i, ii (2008). She writes, "[c]ontrary to this endearing statement of welcome, the United States has intentionally closed its borders to those deemed 'undesirable,' including the aforementioned huddled masses and homeless, particularly if they are public charges." *Id.*

[92] Wolpin, *supra* note 78, at 154.

[93] 42 U.S.C. § 1395dd(e)(3)(A).

[94] *See id.* § 1395dd(c)(2).

[95] 59 Fed. Reg. 64,141, 64,149 (Dec. 13, 1994).

This requirement is called into question with most medical repatriations. As explained above, while some hospitals make an effort to ensure that the patient is transferred to a facility that can provide the type, level, and adequate quality of services needed, others do not. While some follow up to ensure that patients are doing well, many never make contact after the patient is flown or driven back to his or her country of origin. As in the case of Luis Jiménez, patients often receive minimal treatment that is inadequate for their medical needs, leaving significant questions about the compliance of hospitals with their federal discharge requirements.

2. Medicaid and Welfare Reform

Welfare Reform added further complications to the existing confusion under EMTALA. Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (more commonly known as "Welfare Reform"), undocumented immigrants are ineligible for Medicaid and other social services unless the state legislation specifically provides for them.[96] The only exception to this restriction is for emergency services—hospitals must provide emergency treatment to anyone who arrives with an emergency medical condition.[97] The relevant provisions of this emergency services exception are as follows:

> (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,

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[96] *See* 8 U.S.C. §§ 1611, 1621 (2006).
[97] *See* 42 U.S.C. § 1395dd.

> (B) such alien otherwise meets the eligibility requirements for medical assistance under the State plan approved under this subchapter (other than the requirement of the receipt of aid or assistance under subchapter IV of this chapter, supplemental security income benefits under subchapter XVI of this chapter, 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.[98]

The regulations promulgated to interpret this section include the additional words "after sudden onset" in the definition of emergency services.[99] "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."[100] The government will not reimburse hospitals for non-emergency care or post-stabilization care, leaving them in a difficult legal and financial position. As one author has noted:

> Although Congress intended to relieve the financial strain on hospitals and medical centers with the passage of PRWOA [sic], in reality, the Act imposes significant economic hardships on hospitals and emergency rooms. A separate,

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[98] 42 U.S.C. § 1396b(v) (2006).

[99] 42 C.F.R. § 440.255 (2006); *see also* Sean Elliott, *Staying Within the Lines: The Question of Post-Stabilization Treatment for Illegal Immigrants Under Emergency Medicaid*, 24 J. CONTEMP. HEALTH L. & POL'Y 149, 155 (2007) ("The most notable difference [in the regulations] was the addition of the words 'after sudden onset' in the definition of emergency services.").

[100] Elliott, *supra* note 99, at 155.

> pre-existing piece of legislation, the Emergency Medical Treatment and Active Labor Act (EMTALA), requires that any hospital that receives Medicaid funding provide appropriate screening and subsequent stabilizing care to anyone who enters its emergency room doors. Thus, the current legal framework forbids medical practitioners from providing most preventive care to immigrants who fall under PRWOA [sic], yet obliges these same practitioners to treat immigrants with emergency medical conditions under EMTALA. As one doctor explained, treating emergency medical conditions that could have been prevented through primary care is both "bad medicine" and "bad economics."[101]

C. Constitutional Law

In addition to federal statutory concerns, some may look for constitutionally based concerns. The Fourteenth Amendment of the United States Constitution provides that:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.[102]

At first glance, it may seem as though there are compelling due process or equal protection arguments to be made in cases involving medical repatriations. However, because private hospitals are not states or state actors, the Due Process and Equal Protection Clauses are not directly implicated.[103] That private hospitals accept federal

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[101] Ryan Knutson, Note, *Deprivation of Care: Are Federal Laws Restricting the Provision of Medical Care to Immigrants Working as Planned?*, 28 B.C. THIRD WORLD L.J. 401, 404–05 (2008) (footnotes omitted).

[102] U.S. CONST. amend. XIV, § 1.

[103] In cases involving state action, the Equal Protection Clause and Due Process Clause may apply to immigrants, though the law is somewhat murky. In *Plyler v. Doe*, 457 U.S. 202 (1982), the Supreme Court held that undocumented immigrants could claim the benefit of the Equal Protection Clause, *id.* at 215, and that the actions by a public school district in denying access to schools to undocumented immigrant children did not meet the rational basis test, therefore violating the Equal Protection Clause. *Id.* at 230. In *Lewis v. Thompson*, 252 F.3d 567 (2d. Cir. 2001), the Second Circuit held that the Welfare Reform Act's denial of prenatal care to undocumented immigrants had a rational basis and did not violate the Equal Protection Clause, *id.* at 584, but found that denying automatic eligibility for Medicaid coverage at birth to citizen children of non-citizen parents did violate the Equal Protection Clause. *Id.* at 591. In *Graham v. Richardson*, 403 U.S. 365 (1971), the Supreme Court held that provisions of a state welfare law conditioning receipt of benefits on citizenship and imposing durational residency requirements violated the Equal Protection Clause. *Id.* at 382–83. In *Matthews v. Diaz*, 426 U.S. 67 (1976),

money through Medicare/Medicaid is unlikely to change this analysis—accepting federal funding does not, on its own, make an organization a "state actor" for the purposes of the Fourteenth Amendment.[104] Despite the inequities that are clearly implicated in medical repatriations, constitutional arguments are unlikely to provide any viable form of relief.

D. International Law

As with potential challenges arising out of United States constitutional law, actions based in international law are unlikely to be successful. Obligations under international conventions, such as the United Nations Convention on the Elimination of All Forms of Racial Discrimination[105] or the International Covenant on Economic, Social, and Cultural Rights,[106] are not directly implicated because the actions of private hospitals are not state actions. While it may be possible to formulate legal arguments based upon a nation's obligation to ensure the protection of the rights of those found within its borders,[107] courts in the United States have been largely unresponsive and unsympathetic to arguments based in international law.[108]

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however, the Supreme Court held that an act by Congress conditioning an immigrant's eligibility for federal medical insurance on continuous residence in the United States over a five-year period did not deprive the immigrant of liberty or property without due process of law. *Id.* at 87. As one author has summarized: "Ultimately, *Richardson* and *Diaz* led to the understanding that state restrictions [of Medicaid benefits for immigrants], subject to strict scrutiny, would in most cases be struck down, while federal restrictions, dictated by a narrow standard of review, would likely be upheld." Knutson, *supra* note 101, at 413.

[104] *See, e.g.*, Rendell-Baker v. Kohn, 457 U.S. 830, 840 (1982) (holding that the receipt of public funds by private parties is insufficient to make the private party a "state actor" and thereby to trigger constitutional obligations). *But see id.* at 844 (Marshall, J., dissenting) (pointing out that if there is a close nexus between the government and a private party's actions, then courts may treat the private party as a state actor).

[105] International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, 660 U.N.T.S. 195.

[106] International Covenant on Economic, Social, and Cultural Rights, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 [hereinafter ICESCR].

[107] For example, the right to be free from discrimination on the basis of race and/or national origin, or the less widely recognized right to health (derived in part from the ICESCR).

[108] *See, e.g.*, Medellin v. Texas, 128 S. Ct. 1346, 1367 (2008) (stating that judgments of the International Court of Justice do not constitute binding federal law); Roper v. Simmons, 543 U.S. 551, 578 (2005) (explaining that "[t]he overwhelming weight of international opinion against the juvenile death penalty . . . [and] the opinion of the world community, while not controlling [the Court's] outcome, does provide respected and significant confirmation for [the Court's] conclusions").

III. SAILING THE "UNCHARTED SEAS"

In light of the confusing legal and regulatory morass outlined above and in combination with fierce public anti-immigrant sentiment, it is possible to understand why medical repatriations occur. However, it is also very clear that reform is needed, and it is needed now. It is beyond the scope of this Comment to delve deeply into precise recommendations for reform of laws like EMTALA and PRWORA. Other scholars have dealt with these questions in great detail.[109] This Comment merely proposes that any attempts to revise substantive immigration law, health care law, or even state tort law in areas such as false imprisonment, must take the issue of medical repatriations into serious consideration.

First, undocumented immigrant patients must be allowed to avail themselves of the same sorts of judicial processes that would be afforded to those undergoing formal deportation proceedings. A private corporation should not be allowed to effect extra-judicial deportations, particularly when the reason for doing so is purely due to private monetary concerns and is not based on the same interests that are behind federal deportation policies. The federal government has exclusive jurisdiction over immigration matters, and hospitals must be subject to much deeper federal guidance, involvement, and accountability.

Second, the contradictory incentives and requirements of the current system of regulations must be resolved in light of the situation of undocumented immigrants. Policies about what type of care will be provided and when should be based on principles of public health and human dignity rather than on perverse value judgments about "deserving" versus "undeserving" recipients of public funds.

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[109] For in-depth critiques and recommendations of existing legislation, see Julia Field Costich, *Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the 'Contract with America' Congress*, 90 KY. L.J. 1043, 1069–70 (2002) (advocating the repeal of PRWORA and seeking adequate funding for healthcare services, effective outreach, approaches accounting for cultural differences, and a more informed medical community); Dame, *supra* note 86 (addressing problems related to the enforcement of EMTALA); Elliott, *supra* note 99 (arguing for "Medicaid reimbursement for treatment of post-stabilization emergencies" and for courts "to acknowledge the deference towards health care providers contemplated in the Emergency Medicaid statute"); Knutson, *supra* note 101 (addressing the effects of PRWORA, and arguing for repeal of the anti-immigration portions of the Act and for allowing local medical providers to decide which services to provide); Neda Mahmoudzadeh, Comment, *Love Them, Love Them Not: The Reflection of Anti-Immigrant Attitudes in Undocumented Immigrant Health Care Law*, 9 SCHOLAR 465 (2007) (analyzing the drawbacks and ineffectiveness of healthcare regulation in reducing the illegal entry of immigrants into the United States); Vivian L. Regehr, Comment, *Please Resuscitate! How Financial Solutions May Breathe Life into EMTALA*, 30 U. LA VERNE L. REV. 180 (2008) (arguing for abolishment of EMTALA, coupled with provision of financial incentives to hospitals to offer free preventive care through urgent care centers).

Third, it is clear that whatever the specific reforms, the federal government must increase the amount of support and reimbursement funds it provides to hospitals. Private hospitals are crumbling under the weight of uncompensated debt, and without an increase in resources, many more indigent people—both citizens and non-citizens—will face even greater obstacles to access for health care.[110] This additional support to hospitals must go beyond providing more funds for emergency care—it must also incorporate funding for post-stabilization care and, ideally, preventative care to keep the overall costs of health care down over the long term.

Finally, while enforcing or creating a law that prevents hospitals from engaging in medical repatriations is important, stopping there would be an incomplete solution. The issue of medical repatriations stands as an archetypical intersection of "two deeply flawed American systems"[111]: immigration policy and health care policy. Cases like that of Luis Jiménez cannot be boiled down to a simple little-man-versus-the-big-institution narrative because behind the "big institution" (i.e., the hospital) is an even bigger institution (i.e., the federal government), which holds the "big institution" in a legal and financial Catch-22. The issue of medical repatriations "shows patients at the mercy of hospitals and hospitals at the mercy of a system that provides neither compensation nor guidance."[112]

Until the health care system is reformed—and the situation of undocumented immigrants is taken into serious consideration in that process—efforts to protect vulnerable immigrants will come at the expense of underfunded community hospitals, and efforts to protect these community hospitals will come at the expense of vulnerable immigrants.

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[110] *See, e.g.*, Clark, *supra* note 41, at 249.

[111] Sontag (August), *supra* note 1.

[112] Sontag (November), *supra* note 17.

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