An Illogical Policy

Protecting the Dignity of Undocumented Immigrants with Chronic Illness

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On September 9, 2009, as President Barack Obama announced to Congress that his health care plan would not insure illegal immigrants, Rep Joe Wilson stunned onlookers as he retorted, "You lie!" Obama, startled, denied Wilson's assertion.[1] Congressman Wilson's outburst is representative of the contentious attitude surrounding illegal immigrants and their access to public benefits. Especially in the last decade, illegal immigration has been a controversial, prevalent topic in U.S. news, and this media coverage fuels political debate and racial tension throughout the country. Because there is no method of tracking the number of undocumented immigrants that arrive in the U.S., there are only approximations of the extent of illegal immigration. The Department of Homeland Security estimates that in 2009, 10.8 million illegal immigrants lived in the U.S., most of whom migrated from Latin America,[2] Around two-thirds of all illegal aliens live in eight states, with the largest populations concentrated in California, Florida and Texas.[3] Despite a concerted effort by the U.S. Border Patrol, thousands of illegal aliens flood the U.S. border every year; therefore, it appears that the border-crossing trend is not ceasing anytime soon. There are many social, moral, political, and economic implications surrounding this influx of immigrants; the question is what, if any, obligation does the U.S. government have to include these illegal, yet productive members of U.S. society in social safety-net programs? In particular, what obligation does the U.S. have to protect the health of undocumented immigrants, and what costs—political, moral, social, or fiscal— does the U.S. incur because of its failure to provide health care for undocumented immigrants?

[1] "Joe Wilson Says Outburst to Obama Speech 'spontaneous' - CNN." *Featured Articles from CNN*. CNN, 10 Sept. 2009. Web. 03 Apr. 2011.
[2] CBS News "Number of Illegal Immigrants Plunges by 1M" 2009. http://www.cbsnews.com/stories/2010/02/11/national/main6197466.shtml
[3] "BBC NEWS | In Depth | US Illegal Immigrants." *BBC News - Home*. Web. 26 Mar. 2011. <http://news.bbc.co.uk/2/shared/spl/hi/guides/456900/456958/html/nn3page1.stm>.

Much of the debate surrounding undocumented immigrants' access to health care focuses on their alleged overuse of emergency departments.[4] While emergency care for uninsured, undocumented immigrants is costly, many times extended care is necessary for severe cases. After the immediate cause of emergency is stabilized, the hospitals' obligations are complete. It is then at the discretion and goodwill of the hospital to continue treatment of the undocumented patient.[5] The Center for Medicaid and Medicare Services (CMS), a sub-division of the Department of Health and Human Services, gives a summary of hospitals' obligations to undocumented immigrants whose chronic conditions will likely require follow-up care:

> [a]n individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his/ her continued care, including diagnostic work-up and/or treatment, could be reasonably performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care as part of the discharge instructions. The [emergency medical condition] that caused the individual to present to the dedicated [emergency department] must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure the necessary follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.[6]

As this paper will demonstrate, this and other policies regulating undocumented immigrants' access to health care are imprecise and illogical, and reviewing U.S. state courts have had much difficulty applying the legislation uniformly in cases.[7] In response, some U.S. hospitals have adopted a policy of forced repatriation of undocumented aliens who need hospital services to survive. There is evidence that hospitals incur gross inefficiency and waste in such

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[4] "Frequent Flyer Study Being Used To Perpetuate Myth That Emergency Room Overcrowding Is Caused by Patients with Non-Urgent Medical Conditions." *American College of Emergency Physicians.* Web. 05 Apr. 2011. <http://www.acep.org/content.aspx?id=45122>.

[5] V. Agraharkar, "Deporting the Sick: Regulating International Patient Dumping by U.S. Hospitals." Columbia Human Rights Law Review,

[6] *Szewczyk v. Department of Social Services,* 881 A.2d at 284 <http://scholar.google.com/scholar_case?case=6607904440131207776&hl=en&as_sdt=2,47&as_vis=1>

[7] [7] McKeefery, Michael J. "A Call to Move Forward: Pushing Past the Unworkable Standard That Governs Undocumented Immigrants' Access to Health Care Under Medicaid." Journal of Health Care Law and Policy (2007): 399. ESBCOhost. Web. 7 Mar. 2011. <http://web.ebscohost.com>.

forced repatriation; for example, some hospitals use private planes to transport patients back to their home country.[8]

This paper assesses the implications of imprecision in federal legislation concerning emergency medical treatment of undocumented immigrants and the obligation of the U.S. to facilitate extended treatment of illegal immigrants in the U.S. Current U.S. code regulating undocumented immigrants' health care is not only fiscally imprudent; it also increases racial tensions and ultimately excludes a productive sector of the U.S. population from receiving health care and a functioning quality of life. Applications of these policies have led many undocumented immigrants, their families and advocates to challenge medical facilities' ethical standards and the legality of the facilities' actions. The ambiguity surrounding the U.S.'s definition of "emergency condition" creates a gap in policy that illogically attempts to draw a line between where emergency care stops and chronic care begins. A lack of Medicaid coverage for illegal immigrants with chronic conditions is a drain on U.S. hospitals' resources and their use of emergency room remains a problem for the U.S. government.[9]

This paper begins with an overview of current U.S. regulation on undocumented immigrants' access to long-term care. Then, I explore the standard set forth in *Greenery v. Hammon* and its impact on three other court decisions. Ultimately, this paper argues for a change in policy that no longer focuses on emergency room care, but also recognizes the consequences of denying Medicaid coverage to those undocumented immigrants who are

[8] D. Procaccini,"First, Do No Harm." Boston College Third World Law Journal, Spring2010, Vol. 30 Issue 2, p475-495; V. Agraharkar, "Deporting the Sick: Regulating International Patient Dumping by U.S. Hospitals." Columbia Human Rights Law Review,

[9] A. Ortega, "NOTE AND COMMENT: . . . And Health Care For All: Immigrants in the Shadow of the Promise of Universal Health Care." American Society of Law, Medicine & Ethics, Inc., and Boston University American Journal of Law & Medicine. 2009.

chronically ill. The main justifications for this argument are the moral significance of health and the justice that health protects.[10]

Current U.S. Regulation on Undocumented Aliens' Access to Long-term Health Care: EMTALA and 42 U.S.C. § 1396b(v)

In current U.S. Code, undocumented immigrants, regardless of income, are not entitled to full coverage under Medicaid, Medicare, or any other public benefit. In emergency medical situations, however, undocumented aliens may be able to receive federal assistance. It would be interesting to see if Joe Wilson knows of this emergency condition exception; I am certain that the average American does not know it. In 1986, the federal government passed the Emergency Medical Treatment and Active Labor Act (EMTALA) to protect the life and dignity of these uninsured, undocumented aliens. EMTALA discouraged the practice of "patient-dumping" by U.S. hospitals.[11] Before 1986, hospitals would turn away patients because of budgetary constraints. Under EMTALA, hospitals are required to care for any patient with an emergency health condition, regardless of insurance or citizenship. Thus, it is probable that an uninsured, undocumented immigrant would seek care in an emergency room, as she is guaranteed at least some form of treatment.[12] EMTALA also determines the standards of patient stabilization and establishes criteria for the transfer of patients after they have been stabilized.[13]

[10] Daniels, Norman. *Just Health: Meeting Health Needs Fairly*. Cambridge: Cambridge UP, 2008. Print.
[11] Agraharkar, V. (2010). Deporting the Sick: Regulating International Patient Dumping by U.S. Hospitals. *Columbia Human Rights Law Review p. 573*
[12] Ku, Leighton, and Fouad Perez. "Documenting Citizenship in Medicaid: The Struggle between Ideology and Evidence." *Journal of Health Politics, Policy and Law* 35.1 (2010): 5-28. *Academic Search Complete*. Web. 5 Apr. 2011.
[13] McKeefery, Michael J. "A Call to Move Forward: Pushing Past the Unworkable Standard That Governs Undocumented Immigrants' Access to Health Care Under Medicaid." Journal of Health Care Law and Policy (2007): 414. ESBCOhost. Web. 7 Mar. 2011. <http://web.ebscohost.com>.

Title XIX of the Social Security Act, 42 U.S.C. § 1396b (v) is also pertinent to recent court decisions about long-term medical care of undocumented immigrants because it regulates Medicaid assistance to undocumented immigrants to emergency medical conditions.[14] While this statute prohibits payments made to states for medical assistance to undocumented aliens, it does permit Medicaid coverage to any immigrant with an emergency medical condition.[15] With this act, the U.S. protects hospitals that EMTALA required to provide emergency care from complete financial ruin. In 2004, the Department of Health and Human Services complemented § 1396b (v) by requiring that hospitals prepare a discharge plan for every patient—even an undocumented immigrant—who is expected to need extended care after discharge.[16]

Current Federal Aid to Hospitals

Because of the federal mandate under EMTALA, emergency rooms do not generally track the immigration statuses of patients. To date there has been no study to successfully estimate the impact of illegal immigrants on all U.S. hospitals.[17] However, some states with particularly high undocumented immigrant populations have attempted to estimate their effect on state hospitals. In California, for example, where undocumented immigrants make up 6.9% of population, the estimated cost of uncompensated medical care was about $1.4 billion.[18] EMTALA was originally an unfunded mandate; however, in recent years the government has provided several sources of funding to reimburse hospitals for uncompensated care provided for undocumented immigrants. For one, § 1396b (v) grants Medicaid coverage to undocumented

[14] McKeefery, M. p. 391
[15] McKeefery, 399
[16] 42 C.F.R., § 482.43 (2004). http://edocket.access.gpo.gov/cfr_2007/octqtr/pdf/42cfr482.43.pdf
[17] *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Health Care Costs*. Rep. United States General Accounting Office, May 2004. Web. 8 Apr. 2011. <http://www.gao.gov/new.items/d04472.pdf>
[18] "FAIR: Ilegal Immigration and Public Health." *FAIR: Federation for American Immigration Reform*. Web. 14 Apr. 2011. <http://www.fairus.org/site/News2?page=NewsArticle>.

immigrants who suffer from an emergency medical condition.[19] Moreover, the Medicare Modernization Act of 2003 allocated $1 billion, or $250 million a year, for fiscal years 2005-08 exclusively to reimburse hospitals for healthcare provided to undocumented immigrants. This funding, however, does not cover all uncompensated expenses incurred by hospitals. [20]

In 2004, the U.S. General Accounting Office undertook a study to determine the impact of undocumented immigrants' impact on costs in U.S. hospitals. According to their survey, 7 out of 10 states interviewed claimed that "a concern of hospitals is the cost of treatment for undocumented aliens that continues beyond emergency services and is not covered by Medicaid."[21] This finding supports the argument that further investigation into policy reform on this issue is needed. Since the commencement of this study in 2004, the undocumented alien population grew from 7 million to over 10.8 million.[22] [23] This steady increase over only five years suggests that hospitals may currently be worse off than the 2004 estimates have indicated. The undocumented immigrant population is not getting smaller, and the U.S. government must respond accordingly to the strain on hospitals.

Greenery Rehabilitation Group vs. Hammon, EMTALA, and Beyond

To outline the progression of this health care debate in the U.S., this section examines several court cases that have impacted states' decisions to provide long-term Medicaid assistance to undocumented immigrants. A discussion of *Greenery Rehabilitation Group v. Hammon*

[19] U.S. Code 42. http://www.law.cornell.edu/uscode/42/1396b.html
[20] *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Health Care Costs*. Rep. United States General Accounting Office, May 2004. Web. 8 Apr. 2011. <http://www.gao.gov/new.items/d04472.pdf>
[21] *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Health Care Costs*. Rep. United States General Accounting Office, May 2004.
[22] *Undocumented Aliens: Questions Persist about Their Impact on Hospitals' Uncompensated Health Care Costs*. Rep. United States General Accounting Office, May 2004.
[23] CBS News "Number of Illegal Immigrants Plunges by 1M" 2009.

facilitates an understanding of why the case set precedence based on its interpretations of § 1396b (v) to decide the outcome. In *Greenery*, the court attempted to delineate the point at which an illness is no longer an "emergency medical condition," for which the federal government must reimburse hospitals. A description of the cases that followed *Greenery* highlights the impact of *Greenery* on these cases and why the rule constructed in *Greenery* is impractical for use by other courts.[24] The following four cases in which a health facility chose to deny medical care to a chronically ill patient are indicative of a lasting problem in the U.S., where illegal immigrants cannot be curtailed completely from entering the country.

In *Greenery Rehabilitation Group, Inc. v. Hammon,* the court examined whether an "emergency medical condition" exists after patient stabilization is achieved. This case is important to the understanding of more recent court decisions because its findings have set precedent for state courts in deciding cases dealing with non-citizen health care.[25] The plaintiff, Greenery Rehabilitation Group, stated that the New York City Human Resources Association (NYCHRA) refused to pay for the care of three of NYCHRA clients who were referred to Greenery. The two parties had previous agreed that NYCHRA would refer only clients eligible for Medicaid to Greenery Rehabilitation Group. The three patients were immigrants ineligible for Medicaid. Two of the patients were undocumented and the third was ineligible for Medicaid

[24] McKeefery, Michael J. "A Call to Move Forward: Pushing Past the Unworkable Standard That Governs Undocumented Immigrants' Access to Health Care Under Medicaid." Journal of Health Care Law and Policy (2007): 391-419. ESBCOhost. Web. 7 Mar. 2011. <http://web.ebscohost.com>.
[14] McKeefery, M.

because he had not met the required 5-year residency mark. Excluding their non-citizen status, all three patients would have been eligible for Medicaid based on income.[26]

An examination of the *Greenery* decision involves understanding the controversial aspects of § 1396b (v). The case of Leon Casimir, an undocumented immigrant from Trinidad, is a good example of the complexities involved in drawing the line between emergency care and chronic care. Casimir suffered a gunshot wound to the head and was rushed to the emergency room, where he received emergency care covered by Medicaid. After several days, he was determined to be "stabilized" by the hospital.[27] With respect to an emergency medical situation, Section 1395dd of the EMTALA states that "the term 'stabilized' means…that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or, with respect to an emergency medical condition."[28] In simpler terms, a patient must be able to leave the initial hospital or facility without risk of death or serious harm as a result of this removal. These transfer regulations are enforced regardless of immigration status, if the transfer will endanger the patient's health.[29]

Casimir was then transferred to Greenery Rehabilitation Group without any threat to his stabilization. The real dispute in Greenery, however, was whether or not Casimir was eligible for continued care covered under Medicaid once the immediate cause of the emergency was alleviated. Because § 1396b (v) only allows for Medicaid coverage of illegal immigrants with

[26] Greenery Rehabilitation Group v. Hammon. United States Court of Appeals for the Second Circuit. 28 July 1998. *American College of Healthcare Executives*. Web. 20 Mar. 2011. <http://www.ache.org/pubs/hap_companion/Wing/ch.%204-7/greeneryrehabhammon.pdf>
[27] Rehabilitation Group v. Hammon. United States Court of Appeals for the Second Circuit.
[28] http://caselaw.findlaw.com/fl-district-court-of-appeal/1247476.html
[29] Procaccini, D. J. (2010). First, Do No Harm: Tort Liability, Regulation, and the Forced Repatriation of Undocumented Immigrants. *Boston College Third World Law Journal* , 475-495.

emergency conditions, NYCHRA needed to prove that Casimir's state was still an emergency medical condition. According to EMTALA, an emergency medical condition is defined as:

> A 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: 1) placing the patient's health in serious jeopardy;2) serious impairment to bodily functions, or 3) serious dysfunction of any bodily organ or part.[30]

His initial condition, a gunshot wound, placed his health in serious jeopardy and resulted in both impairment of bodily function and dysfunction of an organ, satisfying conditions 1, 2, and 3 of EMTALA. Thus, Casimir was indisputably eligible for emergency treatment of the gunshot wound.[31] However, NYCHRA also believed that Casimir's resulting incapacities should be considered an emergency medical condition for which Medicaid should reimburse Greenery Rehabilitation Group. The gunshot wound left him unable to walk, with the need for constant monitoring and medication for seizures and behavioral problems that were caused by his injury. Moreover, he needed help bathing, dressing, eating and using the restroom.[32]

The district court decided that Casimir's condition was in fact an emergency medical condition because without continued treatment, his health could be at risk. The 2nd Circuit Court, on the other hand, overturned the lower court's decision. It stated that Mr. Casimir was ineligible for Medicaid because although "Casimir undoubtedly require[d] ongoing maintenance care, [the court had] some doubt as to whether [his] health would be jeopardized by the absence of 'immediate medical attention.'" In the court's discussion of its decision, it failed to provide reasoning for its assertions of such 'doubt.' Moreover, the court's decision also failed to consider the gravity of Mr. Casimir's need for assistance. Mr. Casimir needed aid to perform

[30] "U.S. Code 42." http://www.law.cornell.edu/uscode/html/uscode42/usc_sec_42_00001396---b000-.html
[31] McKeeffery
[32] Greenery v. Hammon

basic functionings, such as feeding himself. If he did not receive assistance, he would probably develop life-threatening emergency medical conditions. [33]

Despite its use as precedent, the court's decision in *Greenery* is inconsistent with a true understanding of the consequences of not providing care for chronic conditions. Most disturbingly, the court never determined what constitutes a situation that requires immediate care, and to date, different courts have varied in their application of the standards set by *Greenery*. Further, *Greenery* reveals that EMTALA is not complete in its definition of emergency medical condition. In fact, the application of this definition continues to challenge the rationale behind using the *Greenery* standard.

Quiceno vs. Department of Social Services

In 1999, shortly after *Greenery*, a Connecticut court also found an undocumented immigrant ineligible for long-term health coverage under Medicaid. In *Quiceno v. Department of Social Services*, the court noted that the decision in favor of defendant was "dictated by the recent decision in [Greenery]. [34] Astrid Quiceno, an undocumented immigrant, suffered from renal failure and was in need of frequent dialysis treatments. As in the *Greenery* decision, the Connecticut court ignored the fact that a chronic condition could revert to an "emergency medical condition" if treatment is terminated. [35] In the language of the court, "the fatal

[33] Greenery v. Hammon
[34] Quiceno v. Department of Social Services. Superior Court of Connecticut, Judicial District of Hartford. 27 Jan. 1999. *Find Law*. Web. 23 Mar. 2011. <http://caselaw.findlaw.com/ct-superior-court/1404137.html>.
[35] McKeefery, 403

consequences of the discontinuance of such ongoing care does not transform into emergency medical condition care." Before a decision was reached in this case, Astrid Quiceno died.[36]

Szewczyk v. Department of Social Services

In 2005, the Connecticut Supreme Court found that Medicaid could cover ongoing treatments of illegal immigrants. Despite expiration of his visa, Zbigniew Szewczyk remained in the United States. He was taken to a Connecticut hospital with severe symptoms and was diagnosed with acute myelogenous leukemia. Due to the severity of this disease, Szewczyk required rapid treatment through chemotherapy, biopsies and surgery. In about 32 days, Szewczyk's medical expenses rose to $82,046.85. Although Szewczyk's applied for Medicaid coverage, he was denied any benefits. He then filed a complaint in the trial court. As in *Quiceno*, this trial court applied *Greenery's* definition of an "emergency medical condition" and interpretation of § 1396b (v) to Szewczyk's case.

According to Supreme Court of Connecticut's decision, the trial court and subsequently, the Appellate Court decided that "the biopsy and catheterization were not `emergency events,'" and that the plaintiff "would not have immediately died on the date of admission." Contrastingly, the Supreme Court "disagreed with the Appellate Court's conclusion that the plaintiff's condition was not sufficiently severe, short-lived and urgent to meet the standard in that case."[37]

Ultimately, the *Greenery* rationale only slightly influenced the Supreme Court's decision; rather, the court followed the rationale of *Diaz v. Division of Social Services*, in which the North Carolina court granted an undocumented immigrant Medicaid benefits for all necessary chemotherapy treatments. In contrast to preceding court cases involving

[36] Qucieno v. Department of Social Services
[37] Szewczyk v. Department of Social Services. Supreme Court of Connecticut., footnote 10

undocumented alien cancer patients, Szewczyk's cancer manifested in "acute symptoms," which without chemotherapy would have continued to require "immediate medical attention. In the words of the North Carolina court, without chemotherapy "[his] health would have been placed in serious jeopardy and he would have died." [38] Despite confirmation of "effective" stabilization, the court decided that coverage of on-going treatment acceptable.[39]

The Issue of Forced Repatriation: *Montejo v. Martin Memorial Medical Center*

Many hospitals do not receive substantial reimbursement from the federal government for providing extended medical care to undocumented immigrants, and due to a lack of federal restrictions, they are able to transfer the patient to an "appropriate" facility in the patient's native country.[40] For example, an unqualified alien may be forced to return to her home country when the hospital incurs exorbitant treatment expenses, regardless of the patient's healing progress.

According to Daniel J. Procaccini from Boston College Law School, this policy is at odds with the moral obligations of doctors to "first, do no harm," and challenges the rights of even legal, uninsured immigrants.[41] The federal government does not regulate forced repatriation of illegal immigrants. According to the New York Times, "Immigration and Customs Enforcement does not assume any responsibility for the health care of illegal immigrants unless they are in federal immigration detention….and it does not get involved in repatriations undertaken by hospitals."[42]

In *Montejo v. Martin Memorial Medical Center*, a Florida court permitted a hospital to transfer Luis Alberto Jimenez, a traumatically injured, illegal immigrant, to his native Guatemala

[38] Szewczyk v. Department of Social Services. Supreme Court of Connecticut. 20 Sept. 2005. *Google Scholar*. Web. 23 Mar. 2011. <http://scholar.google.com/scholar_case?case=6607904440131207776&hl=en&as_sdt=2,47&as_vis=1>.
[39] McKeefery, 407
[40] Agrahahkar, 574
[41] D. Procaccini, p. 475
[42] Sontag, Deborah, PIlar Conci, and Tina Lee. "Getting Tough: Deported in a Coma, Saved Back in U.S." *New York Times: Health*. 9 Nov. 2008. Web.

against the will of his guardian, a legal U.S. immigrant. Jimenez suffered a traumatic brain injury as the result of a car accident. Although the hospital provided extended care to Jimenez for over a year, it took steps to send Jimenez back to Guatemala because of his illegal status and lack of available transfer options in the U.S. In an apparent contradiction, Martin Memorial Medical Center stated that it believed it would be imprudent for Jimenez's guardian to continue to allow the Medical Center to treat Jimenez because he needed specialized "brain trauma rehabilitation services that the hospital could not provide." Yet, without sufficient evidence that Jimenez would be provided with such specialized care in Guatemala, a Florida court granted Martin Memorial the right to transfer Jimenez to a Guatemalan facility. In reality, Jimenez ended up at his mothers' home in a small village in Guatemala, with no access to health services. [43] According to the courts, the trial court was incorrect in granting the hospital permission to repatriate Jimenez for two reasons. First, in U.S. Code, "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."[44] In this case, the hospital did not adequately follow EMTALA.

Problems with Denying Medicaid Coverage of Extended Care

The cases above highlight some of the legal and ethical controversies surrounding EMTALA and the exclusion of undocumented immigrants in Medicaid policies. Emergency-room visits are more costly than clinic costs, and the number of visits to emergency departments in the U.S. increased by 32 percent between 1996 and 2006.[45] According to the American College of

[43] Proccacini
[44] Montejo v. Martin Memorial Medical Center. District Court of Appeal of Florida, Fourth District. 5 May 2004. *Google Scholar*. 2004. Web. 5 Apr. 2011.
[45] Jordan, Miriam. "Illegal Immigration Enters the Health-Care Debate - WSJ.com." *Business News & Financial News - The Wall Street Journal - Wsj.com*. 15 Aug. 2009. Web. 05 Apr. 2011.

Emergency Physicians (ACEP), the crowding of emergency rooms is not caused by a growing number of uninsured people—like illegal immigrants— with non-emergency conditions. In fact, non-emergency patients make up only 12 percent of all emergency room visits in the United States. The problem is that a greater number of people have more severe illnesses and the emergency rooms cannot accommodate a growing number of patients while they continue to experience budget cuts. ACEP suggests that the cause of this issue stems from a lower percentage of people receiving preventive care for chronic illness.[46] This information buttresses the argument for providing Medicaid coverage for undocumented immigrants in need of extended care to avoid life-threatening conditions. For example, in the case of Astrid Quiceno, every day she goes without dialysis is a day that she becomes closer to death. She will either die, or go to the emergency room to receive more costly treatment because her condition will be more severe without continued dialysis. This preventable emergency room visit places constraints on the resources of already cash-strapped ERs.

In addition to emergency room visits from chronic conditions, there are many specialized clinics in the U.S. that service undocumented immigrants with chronic needs; however, health clinics all over the U.S. face the risk of shut-down and cannot be relied upon to provide continuous, quality care.[47] These clinics face the same budgetary constraints as emergency departments. For example, in October 2009, Atlanta's Grady Health System closed its outpatient dialysis clinic, where almost all of the 51 patients receiving the life-sustaining procedure are

[46] "Frequent Flyer Study Being Used To Perpetuate Myth That Emergency Room Overcrowding Is Caused by Patients with Non-Urgent Medical Conditions." *American College of Emergency Physicians.* Web. 05 Apr. 2011. <http://www.acep.org/content.aspx?id=45122>.
[47] Cuts, Budget. "Clinics Could Be Affected By Budget Cuts - Local News - Jacksonville, FL - Msnbc.com." *Msnbc.com - Breaking News, Science and Tech News, World News, US News, Local News- Msnbc.com*. 8 Apr. 2011. Web. 14 Apr. 2011.

undocumented aliens.[48] Unfortunately, the cost of dialysis is upwards of $30,000 a year, a cost out of reach for the young, impoverished undocumented immigrant population.[49]

According to Madeleine P. Cosman, a prominent medical lawyer who testified before Congress and authored many anti-illegal immigration journal articles, without the U.S. government's clarity on this issue, states and hospitals will pay large legal fees for an interpretation of EMTALA that is different from the ambiguous interpretation of the court system.[50] As demonstrated by the *Greenery* appeal process, different courts decide differently on the matter of prolonged care for undocumented immigrants. Cosman asserts that "the [U.S.] government imposes viciously stiff fines and penalties on any physician and any hospital refusing to treat any patient that a zealous prosecutor deems an emergency patient, even though the hospital or physician screened and declared the patient's illness or injury non-emergency."[51] Cosman aptly highlights the unfairness that results from the ambiguity of EMTALA.

In *Just Health*, Norman Daniels, a Harvard Professor of Public Health, outlines an argument for the moral importance of health and the justice that health protects.[52] EMTALA's mandate that every hospital must care for a person with an emergency medical condition was designed with a similar moral conscience as the one required by Daniels' argument. Lawmakers did not pass EMTALA because it was fiscally sound policy; rather, they acknowledged the potential for

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[48] Sack, Kevin. "Reprieve Eases Medical Crisis for Illegal Immigrants." *New York Times*. 5 Jan. 2010. Web. 14 Apr. 2011. <http://www.nytimes.com/2010/01/06/us/06grady.html>.

[49] Morrison, Gerry Flynn. "American Assocition of Kidney Patients - Cost Associated with Home Dialysis." American Association of Kidney Patients - Renal Information. Web. 14 Apr. 2011. <http://www.aakp.org/aakp-library/Home-Cost/>.

[50] Williams, Jack. "Madeleine Cosman, 68; Medical Lawyer, Author." *Sign-on San Diego*. Union Tribune, 11 Mar. 2006. Web. 8 Apr. 2011. <http://legacy.signonsandiego.com/news/obituaries/20060311-9999-1m11cosman.html>.

[51] Cosman, Madeleine P. "Illegal Aliens and American Medicine." Journal of American Physicians and Surgeons 10.1 (2005): 6-10. Journal of American Physicians and Surgeons. 2005. Web. 26 Mar. 2011. <http://www.jpands.org/vol10no1/cosman.pdf>.

[52] N. Daniels. Just Health, pp. 29-30.

crimes against human dignity. If not for EMTALA and the harsh sanctions that result from ignoring it, U.S. hospitals would have the discretion to turn away persons in need of emergency care. The exact moral reasoning behind EMTALA can and should be applied to legislation for chronic care of illegal immigrants with life-threatening conditions, specifically § 1396b (v).

Beyond a moral argument, there are fiscal costs associated with long-term immigrant health care. The lack of federal legislation on illegal immigrant access to health care is pushing costs onto the states and raising overall health care costs. Because of a lack of reimbursement, any cut in the state funding for illegal immigrant health care costs could continue the trend toward forced repatriation by U.S. hospitals. The problem of crowded emergency rooms and high costs will likely continue for years to come. Not including the estimated 7 million uninsured illegal aliens, there are currently 46.5 million legal U.S. citizens without health insurance.[53] Studies have shown that people who regularly see a primary care physician are less likely to use the emergency room for non-emergency medical conditions.[54]

Possible Arguments Against Care for Undocumented Immigrants

Many of the arguments against providing Medicaid coverage for undocumented immigrants are impassioned but illogical. This paper does not argue for full Medicaid coverage of eligible undocumented immigrants; rather, it claims that the current policy regarding allocation of Medicaid funds for emergency situations is disjointed. In the 1990s, the argument against illegal immigration revolved around guarding the U.S. from foreign-born diseases, such as HIV. Opponents believed allowing illegal immigrants' access to Medicaid funds would encourage

[53] Sack, Kevin. "Reprieve Eases Medical Crises for Illegal Immigrants." *The New York Times*. 5 Jan. 2010. Web. 23 Mar. 2011. <http://www.nytimes.com/2010/01/06/us/06grady.html

[54] Peterson, Laura A., Helen R. Burstin, Anne C. O'Neil, E. John Orav, and Troyen A. Brennan. "Nonurgeny Emergency Department Visits:The Effect of Having a Regular Doctor." *Medical Care* 36.8 (1998): 1249-255. *JSTOR*. Web. 10 Apr. 2011.

their entry into the U.S. to take advantage of the country's high-quality health care system. This rationale may be misguided, as some studies suggest that many undocumented aliens are wary of using free clinics, for fear that they will be found out by the federal government. [55]

Some other opponents cite the fiscal disadvantages of covering undocumented aliens. In reality, without undocumented immigrants, communities throughout the U.S. would lose important consumers and producers of goods and services. Other opponents assert that since undocumented immigrants do not pay taxes, they should not be able to receive public benefits. In fact, according the Social Security Administration, many illegal immigrants do pay social security taxes, and have incentive to prove "good moral character by paying and filing their taxes."[56] If the U.S. ignores the health of this young, growing tax base, it is likely to lose such unauthorized income as the population ages.

Other opponents may contend that since they broke the law and are residing in the country illegally, undocumented immigrants are owed nothing. This argument is ultimately weakened by moral implications of failing to provide care to illegal immigrants. At some point, U.S. lawmakers conscientiously knew that denying a human being access to emergency care for a life-threatening illness would cause great harm and result in a crime against the dignity of life. These lawmakers were not concerned with budgetary matters; rather, they were guided by the devastating implications of ignoring a human being in his time of need. The inception of EMTALA was a result of this conscientiousness and the definition of emergency medical

[55] Markel, Howard, and Stern, Alexandra M. "The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society." *The Milbank Quarterly* 80.4 (2002) :779, 781. *JSTOR.* Web. 9 April. 2011.
[56] United States. Cong. House. Committee on Ways and Means. *The Social Security Administration*. By Subcommittee on Social Security. 108th Cong., 2nd sess. H. Doc. 108-53. 10 Mar. 2004. Web. 10 Apr. 2011. <http://www.socialsecurity.gov/legislation/hearings/HRpt_031004.pdf>.

condition in both EMTALA and § 1396b (v) should be reevaluated so that chronic conditions are included under Medicaid coverage for undocumented immigrants.

Judge Sullivan's "Bright-Line" Standard

In his paper, "A Call to Move Forward," Michael J. McKeefery argues that Judge William J. Sullivan's "bright-line" standard is preferable to the precedence established in *Greenery*. Judge Sullivan is the Chief Judge of the Supreme Court of Connecticut, and his dissenting opinion appears in *Szewczyk v. Department of Social Services*. In his dissent, Judge Sullivan stated that he found the standard set in *Greenery* to be both "incorrect and unworkable."[57] Judge Sullivan also contends that the statute as it was applied in *Szewczyk* was "ambiguous."[58] He proposes an alternative test in which any reviewing court would have to simply determine whether an undocumented immigrant had been stabilized.[59] His definition of emergency medical condition is derived from deduction based on the legislative history of this issue, and it includes only illnesses or injury that require "stabilizing treatment in order 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 or his discharge."[60] Currently, 1396b (v) only defines "emergency medical condition" and does not define stabilization as EMTALA does. In effect, Judge Sullivan's definition of emergency medical condition combines both the "stabilization" and "emergency medical condition" definitions provided by EMTALA and applies the combination to 1396b (v). If the definition in 1396b (v) is interpreted by courts as being identical to the definition in EMTALA, then the "bright-line" for

[57] *Szewczyk*, 881 A.2d at 275
[58] *Szewczyk*, 881 A.2d at 277
[59] McKeefery, 416
[60] *Szewczyk*, 881 A.2d at 281

Medicaid coverage would deny the patient coverage after he has been stabilized from the initial emergency medical condition.[61] By McKeefery's interpretation, Judge Sullivan's proposed alternative will prohibit Medicaid coverage for treatment of chronic illnesses, such as chemotherapy.[62]

McKeefery contends that Judge Sullivan's definition is clearer and more precise than the interpretation provided by the *Greenery* test because it eliminates two major issues with which past cases have grappled: the inconsistent outcomes for patients and reviewing courts' challenges interpreting the standard for cases with incremental differences. [63] Moreover, McKeefery states that "very simply, a patient is stabilized when the status of that patient will not deteriorate during transfer"; therefore, under Judge Sullivan's objective standard, it is unlikely that reviewing courts would make inconsistent decisions.[64] Further, McKeefery asserts that the standard would "incentivize hospitals to treat undocumented immigrants who require immediate care, because hospital personnel would be better able to predict which patients qualify for Medicaid coverage."[65] However, hospitals are already required to treat undocumented immigrants who need immediate care under EMTALA. Any lawsuit or fine associated with ignoring EMTALA disincentivizes hospitals from refusing to care for undocumented immigrants.

The major hole in the logic of this legislation is not filled by Judge Sullivan's definition of emergency medical condition. It does not consider the potential costs associated with the recirculation of clients in the emergency room, nor the fiscal and legal implications of such a policy. The "objective" standard of Judge Sullivan's stabilization definition also ignores the

[61] McKeefery, 415
[62] McKeefery, 415
[63] McKeefery, 416
[64] McKeefery, 416
[65] McKeefery, 416

ethical issue of denying long-term care to individuals who will likely experience life-threatening conditions if their immediate care is revoked. Under the definition, the patient must be stabilized to be transferred; however, there are many conditions, such as cancer and kidney failure, in which a patient may fit the "stabilization" criteria for some time, but only until they are in need of further treatment.

Recommendations

As demonstrated in the cases above, there are no objective standards for determining if a patient's condition satisfies the definition of emergency medical condition provided by 1396b (v). In fact, what the U.S. has now is an irrational method of making a distinction between emergency room care and chronic care. The U.S. is willing to pay for every visit to an emergency room made by an undocumented immigrant in need of treatment for a life-threatening illness, until that undocumented immigrant dies. Many chronic conditions, if not treated, will result in life-threatening illness. The question remains for logical legislators whether or not it would be more efficient to simply treat the chronic condition in the first place. There have been cases regarding similar maladies, such as cancer, that have produced different outcomes through different court systems. When people visit the emergency room for obvious emergencies, such as a deep wound caused by a kitchen incident, there is no confusion among doctors and hospital staff over whether or not the patient needs treatment. A gray area exists in whether illnesses such as kidney failure, that may take several days or weeks to manifest as an emergency situation, are appropriately covered by EMTALA. Specifically, the inconsistencies between EMTALA and § 1396b (v) represent an illogical policy that ignores the fact that those chronic care patients are even more susceptible to acute, severe, emergency medical conditions than the average person.

If the courts are producing inconsistent results for patients, changes to legislation may be another way to achieve uniform standards on this issue. Rational policy options are those that recognize the connection between emergency room care and chronic care. A comparison of Quiceno and Szewczyk demonstrates the obvious disconnect within current U.S. policy on illegal immigrants' access to care. Both patients would have slipped into life-threatening, emergency conditions that would have culminated in yet another trip to the emergency room. It is seemingly impractical to send Astrid Quiceno to the emergency room every two weeks for her kidney dialysis. Without clear legislation, the federal government places many doctors, hospitals and Medicaid offices in the uncomfortable position of choosing to deny a person with little income the dignity afforded by health. In order to address these issues, legislation should include chronic illnesses as part of Medicaid assistance for undocumented immigrants. Specifically, the term "chronic condition" should be adequately defined. Unlike the bright-line standard, this policy would completely eliminate any confusion regarding treatment of undocumented aliens with long-term, life-threatening conditions. This policy is likely to be more expensive. Hospitals and emergency rooms are right to be concerned about such costs; however, such a policy could save time and money by discouraging the recycling of patients through the emergency rooms. The initial moral argument for passing EMTALA still holds, and if it still holds, the U.S. should pay for the kind of chronic care treatment that's not just keeping people healthier but preventing a threat to their lives or basic functionings at all.

The information presented in this paper ultimately suggests that the most efficient short-term solution to this issue is to provide a path to citizenship for the people that are already living in the United States. This would guarantee that those who develop chronic illnesses are not denied the right to basic health care.

Conclusion

Part of the reason the U.S. pays for emergency room care for undocumented aliens is because it cannot conscientiously deny health care to somebody's whose life and health is in danger. Drawing a bright-line that designates where emergency care and chronic care diverge is impossible. The intricacies involved in attempting such delineation have created inconsistencies in court decisions to provide Medicaid coverage for chronically ill undocumented immigrants. It is unlikely that this debate will be fully developed in the next decade, because it is apparent that the U.S. government has side-lined the issue. Because undocumented immigrants are in the U.S. to stay, it is imperative that the U.S. reevaluate its current policies as to not bankrupt its hospitals because of an inconsistent policy and the legal implications surrounding it.

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