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Health Care for Undocumented Immigrants: Who Pays?

Questions about the legality of the Harris County Hospital District's proposed policy of providing access to free or reduced-cost medical care for undocumented immigrants — those who either overstay their immigration visas or who come to the United States with no legal documents — have sparked debate about whether Texas communities can or should pay for medical assistance for all indigent residents, regardless of their citizenship status.

Asked to issue an opinion on the hospital district's policy, Texas Attorney General John Cornyn concluded that providing non-emergency medical services — with a few specific exceptions such as immunization — to undocumented immigrants would violate federal law and could jeopardize the receipt of federal and state funds. Since the opinion, many hospital districts have chosen to continue to provide care to undocumented immigrants until directed otherwise by a court or by in-house legal counsel. However, those that choose to do so could be subject to legal challenge, including the possibility of criminal charges for misapplication of public funds.

In light of the opinion, hospital districts are evaluating their legal position while state and federal lawmakers study the issue. Among other factors, the debate involves issues related to public health, immigration and naturalization trends, tax participation, and the costs and availability of preventative and acute care services.

Debate centers on whether Texas communities can or should pay for medical assistance for all indigent residents, regardless of citizenship.

Any action that decides the legality of providing health care to undocumented immigrants will have statewide implications. While not all Texas counties have a hospital district, all provide publicly funded care for indigent people, and these services would be affected by a decision on how public funds can or cannot be spent.

The attorney general's opinion

The Harris County Hospital District's policy manual stated that county residents were eligible for health care from the district according to their ability to pay. To participate in the district's medical assistance program, applicants had to demonstrate proof of identity and residency; however, the policy did not address citizenship as it pertained to residency. The policy was applied inconsistently, and some undocumented immigrants who could prove residence in the county obtained non-emergency health care while others were denied.

In response, hospital district executives proposed a formal policy that would permit all county residents who met eligibility standards to obtain non-acute health care — such as doctor's visits, physical therapy, and disease management services — regardless of their immigration status. Under the new policy, an applicant's citizenship or immigration status could not be considered in determining residency, though an applicant could be asked about that status to determine eligibility for other funding sources, such as Medicaid.

Before the hospital district implemented the new policy, the Harris County attorney asked the attorney general for an opinion on its legality under state and federal law and on whether a potential violation of the law could jeopardize the receipt of federal or state funds. The federal law in question is the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), the 1996 welfare-reform law (8 U.S.C., secs. 1601-1646). PRWORA states that undocumented immigrants are not eligible for any state or local public benefit, except for certain health services, including immunization, emergency medical care, and treatment for communicable diseases. However, a state may make these immigrants eligible for additional services by enacting a statute that affirmatively authorizes their eligibility.

As a condition of receiving federal and state funds, hospital districts agree to comply with applicable federal and state laws. Thus, although PRWORA includes no penalties for violating its provisions, the question arose as to whether a violation could jeopardize Medicare and Medicaid payments to the hospital district.

In [Opinion JC-0394](#), issued July 10, 2001, Attorney General Cornyn determined that the Harris County Hospital District's proposed policy would violate PRWORA. He also concluded that this could jeopardize the receipt of state and federal funds and could have legal consequences under state law for making an unauthorized expenditure of public funds. The opinion noted that PRWORA authorizes states to expand undocumented immigrants' eligibility for public benefits by enacting state laws, but the Texas Legislature has enacted no such law.

Under the federal welfare-reform law, undocumented immigrants are not eligible for any state or local public benefit, except for certain health services.

Since PRWORA was enacted in 1996, the Legislature has enacted only two provisions that directly affect undocumented

immigrants' eligibility for public benefits. Both measures, enacted in 1997 by the 75th Legislature in HB 1826 by Goodman, amended the Family Code to allow the use of state and federal funds to provide child protective services without regard to a child's or family's immigration status. Neither the Harris County Hospital District nor the Attorney General's Office has identified any other similar statute that specifically would apply to the receipt of publicly funded health care.

Population and cost estimates

Much of the debate about providing access to health care for undocumented immigrants revolves around the potential cost. No statewide data exist, however, to determine the burden of these immigrants on the health-care system. In 1999, Texas counties spent about \$870 million on all health care for indigent people, according to The Access Project, a health-care policy initiative.

The most recent available census data on undocumented immigrants are for 1996, when the U.S. Immigration and Nationalization Service (INS) estimated that 5 million undocumented immigrants lived in the United States and that this population was growing by about 275,000 per year. At that time, an estimated 700,000 of these immigrants lived in Texas. Assuming that annual growth has remained steady at 5.5 percent since then, Texas' undocumented immigrant population would be about 915,000 today. However, some researchers estimate the total number of undocumented

immigrants nationally at 9 million to 11 million or higher, and the numbers in Texas could be proportionately higher as well.

According to the Harris County Hospital District, undocumented immigrants account for about 23 percent of visits to its facilities. The district estimates that it spent \$330 million on health care for undocumented immigrants over the past three years, \$105 million of which was reimbursed with federal funds. Taxpayers, insurers, and patients paid the remaining \$225 million.

Preventative versus acute care

Free or reduced-cost health care is a cornerstone of Texas' public health policy. The value of preventative care and preventing the spread of communicable disease are key considerations in evaluating policy options for health care for undocumented immigrants.

While the United States has reduced or eliminated many infectious diseases through immunization and other public health initiatives, the Texas-Mexico border region experiences much higher rates of communicable disease than does the rest of the nation. In many border counties, rates of hepatitis A, chicken pox, dengue fever, and tuberculosis are more than double the national average. Health officials blame the prevalence of disease on the transience of the population between Mexico and the United States and on unsanitary, crowded living conditions.

Federal exemptions to PRWORA allow undocumented immigrants to obtain vaccinations and treatment for communicable disease. However, these services alone are not sufficient to protect the public health, according to supporters of providing access to preventative health care for undocumented immigrants. They contend that the state would be better off paying for care for all types of disease to ensure that immigrants can resist infectious disease. Opponents argue that vaccination campaigns are the only type of public health program that has been shown to reduce disease and that the PRWORA exemption allows the state to fulfill its responsibility to protect public health.

The federal Emergency Medical Treatment and Active Labor Act (EMTALA), enacted in 1986, governs when and how a patient may be refused treatment or transferred from one hospital to another when in an unstable medical condition. The law requires any hospital with an emergency room to provide acute care to any patient who requests it and to stabilize any patient with an emergency condition, without regard to a patient's residency, citizenship, or ability to pay.

Acute care costs more than non-acute care for a variety of reasons, including the use of more diagnostic tests in an emergency room for liability purposes, the higher recurrence rate without disease management, more acute episodes of recurrence, and the missed benefit of ongoing drug therapy. For example, a diabetic patient who receives ongoing treatment at a clinic may manage the disease by monitoring blood-sugar levels and by taking an oral medication that lowers blood sugar. That patient also may receive educational materials about changes in meal planning, exercise, and weight loss that could improve his condition. In contrast, a diabetic patient who visits an emergency room with symptoms of high blood sugar or advanced diabetes may require expensive procedures to diagnose and stabilize his condition and, without access to ongoing services, is likely to return for the same level of care.

Supporters of paying for health care for undocumented immigrants say that counties already pay for care for these people by funding emergency rooms' unreimbursed costs. They claim that counties would save money by paying for preventative and ongoing care in the first place so that patients would not present untreated, advanced diseases in emergency rooms.

The value of preventative care and preventing the spread of communicable disease are key factors in evaluating health care for undocumented immigrants.

Opponents say that, in the case of undocumented immigrants, the perceived higher cost of emergency care versus that of ongoing care is a myth. While a single visit to an emergency room costs more than a visit to a doctor's office or clinic, the low frequency with which people use emergency rooms results in a lower overall cost. Unlike diabetes, most illnesses do not require ongoing care. People consult their doctors for colds, flu, and mild infections, and the frequency of those visits causes the cost of non-acute health care to exceed that of acute care. They say that EMTALA, ensuring that all people,

regardless of citizenship, have access to emergency care, strikes the optimal balance between health and cost.

Because emergency rooms must treat all people who request care, regardless of their ability to pay, high rates of uninsured residents translate into financial losses for hospitals. Hospitals' precarious financial situations across Texas make it difficult for them to expand emergency room facilities and services to meet their federally mandated mission.

When an emergency room is nearing capacity, administrators have two options to divert patients to other facilities.

Hospital bypass diverts ambulance patients to the nearest and most appropriate hospital emergency room, while *hospital*

closure diverts all patients except those whose condition likely will result in hospitalization. Once viewed as ways to protect a regional trauma center's ability to care for trauma patients at times of extraordinarily high demand, bypass and closure are becoming more common in emergency rooms across the state.

Supporters of paying for ongoing health care for undocumented immigrants say that it would alleviate some of the burden on emergency rooms. Instead of visiting emergency rooms for non-acute health conditions, these immigrants could schedule routine visits at doctors' offices or clinics, making it easier for the entire health-care system to handle the flow of patients. Supporters say this would benefit all Texans by ensuring that local emergency rooms are ready when needed.

Opponents say that the effect of such a policy on emergency rooms would be negligible. The problem of patients clogging emergency rooms with non-acute conditions, they say, is due more to people's impatience than to their ability to pay. Furthermore, undocumented immigrants and other indigent patients have access to a number of private free or sliding-scale clinics in most metropolitan areas, yet emergency rooms continue to be misused.

Tax participation

The extent to which undocumented immigrants pay taxes that support public health care depends on the

source of funds. Hospital districts and other forms of county health-care programs are funded through local sales and property taxes. State health-care programs, such as the state's portion of Medicaid, are funded through sales taxes, fees, and other general revenue. Federal funding for health-care programs, such as Medicare and the federal portion of Medicaid, is supported by federal income taxes and Medicare contributions.

While undocumented immigrants are not formally "on the books," the *Washington Post* reported on April 15 that many pay uncredited Social Security taxes using false numbers and have federal income taxes withheld from their salaries.

Privacy laws currently restrict using confidential documents

filed with the Social Security Administration and the Internal Revenue Service to trace undocumented immigrants. Nevertheless, to avoid detection, many such immigrants are paid in cash and do not pay federal income or Social Security taxes.

Undocumented immigrants living and working in Texas contribute to sales taxes and may contribute to property taxes, which pay for indigent health care at the local level. Supporters of providing access to health care for undocumented immigrants say that because the majority of a hospital district's funds are supported by taxes in which undocumented immigrants participate, these residents should be entitled to health-care benefits.

Opponents argue that undocumented immigrants actually do not participate in all of the taxes that support indigent health care and therefore should not receive the benefits. Medicaid, the cost of which is split between state and federal funding, and Medicare are primary revenue streams for community hospitals. These hospitals could not operate without federal funds, opponents say, so many undocumented immigrants have not participated fully in the taxes that pay for indigent health care.

Immigration and naturalization issues

Effect on immigration. According to the 2000 census, the share of the foreign-born population that entered the United States illegally has risen to 28 percent, up from 13 percent in 1994. The Urban Institute

estimates that between one-quarter and one-third of the current annual immigration flow is undocumented. These trends suggest that the enactment of PRWORA, prohibiting undocumented immigrants from receiving public benefits, has not reduced immigrants' desire to come to the United States.

Supporters of providing health care say that immigrants come to the United States to work, not to obtain benefits, and that providing health care for undocumented immigrants would not encourage more people to cross the border. They also point out that nothing prevents patients from moving from one county to another to gain access to better health services. This type of movement, they contend, creates more of a problem in terms of health-care costs to counties than does movement from Mexico into Texas.

Opponents counter that the trends in undocumented immigration after PRWORA do not tell the full story. Even though the law denies most public benefits to undocumented immigrants, opponents say, other factors have encouraged immigration, including educational opportunities and private businesses' demand for labor. The U.S. Supreme Court's *Plyler v. Doe decision* (457 U.S. 202 (1982)) requires public schools to accept children who are undocumented aliens without their having to pay tuition. The establishment of businesses that serve undocumented immigrants, such as check cashing businesses and day labor agencies, reflects a changing environment for undocumented immigrants. Opponents say that by creating a safer and more attractive environment for these immigrants, Texas would undermine the nation's immigration laws and encourage illegal activity. They also say that Texas should not reward undocumented immigrants for breaking U.S. laws by giving them health care.

Naturalization trends. The growing number of undocumented immigrants and their working conditions have sparked debate over a possible amnesty or other federal action that could result in legalizing their presence in the United States. Twice in the past two decades, Congress has enacted similar programs in response to high numbers of undocumented immigrants. The Immigration Reform and Control Act of 1986 granted legal status to about 2.8 million formerly undocumented immigrants,

and the Immigration Act of 1990 expanded legal immigration by another 40 percent. According to the INS, almost half of immigrants admitted to the United States in 1977 had become citizens by 1995.

If the federal government enacted a policy that would allow Texas' undocumented immigrants to become legal residents, at least half would be likely to pursue citizenship within the next 20 years. This is significant from a health standpoint, because when immigrants become citizens, they become eligible for public benefits. Also, the demographics of the immigrant population are such that they are likely to be higher consumers of health services after they become citizens. Because most undocumented immigrants come to the United States to work, they tend to be young to middle-aged adults. Supporters of access to medical care note, however, that such immigrants are likely to have more costly medical problems when they become eligible for services as older adults.

Services for legal immigrants. PRWORA excludes most legal immigrants from medical assistance unless they have contributed 40 quarters of Social Security earnings, are veterans or serving in the military, are refugees, or are over age 65 or disabled. All other legal immigrants are prohibited from receiving medical assistance, except immunization, emergency care and treatment for communicable disease. States can choose to provide medical assistance to legal immigrants who entered the United States after August 22, 1996, have lived continuously in the United States for five years, and are otherwise eligible for Medicaid.

The 77th Texas Legislature enacted SB 1156 by Zaffirini, an omnibus Medicaid bill that would have extended Medicaid eligibility to these recent legal immigrants, but Gov. Rick Perry vetoed the bill. Without a change in the Medicaid rules, most legal immigrants cannot obtain state medical assistance. They can participate in local programs, including those funded through hospital districts, but those programs do not receive federal matching funds. Some critics of paying for health care for undocumented immigrants say that legal immigrants should have access to state programs before undocumented immigrants are admitted to local programs.

Immigration and naturalization trends are significant, because when immigrants become citizens, they become eligible for public benefits.

Delivering Medical Care for the Indigent

Sixty percent of Texans have private health insurance that pays for all or some of their health-care needs, according to The Access Project. An additional 20 percent, about 4 million people, obtain public health insurance through federal or state programs, including Medicare, the federal program that serves adults over age 65; Medicaid, the federal-state program that serves low-income and disabled people; and the Children's Health Insurance Program, the federal-state program that serves children in low-income families who are not eligible for Medicaid. Eligibility for these programs is determined by age, income, or disability.

The remaining 20 percent of Texans have no health insurance and receive health care that is paid for locally. State law requires counties to provide health care for their indigent residents, as determined by income and assets as a percentage of the federal poverty level (currently 21 percent, or about \$1,800 per year for an individual). Counties have three basic options in serving their indigent residents: formation of a hospital district, a public hospital, or a county indigent health-care program.

Hospital districts are special taxing districts created in the Texas Constitution or by local election. Under the Constitution, the maximum tax rate that a hospital district can impose is 75 cents per \$100 of property valuation. A single county may comprise a hospital district, multiple counties may join in a single district, or a county may be split into separate districts. District sizes vary widely, both in area and population served.

Most hospital districts use the taxes they collect to fund public hospitals that serve the entire population and collect revenue from paying patients. The state also contributes to hospital districts through the Tertiary Care Fund, a pool of unclaimed lottery revenue with which the state reimburses private and public hospitals for emergency health-care services they administer to residents of other counties. The first \$40 million of unclaimed lottery winnings each year is allocated to

teaching hospitals, and the Tertiary Care Fund receives any additional unclaimed amount. In fiscal 2000, the fund received no income because unclaimed lottery winnings totaled less than \$40 million, but in fiscal 2001, the fund received \$17.2 million.

Two federal programs also provide funding for hospital districts. The Disproportionate Share Hospital program, part of Medicaid, provides funds to hospitals that administer care to a disproportionately high number of indigent and Medicaid-eligible patients. The Graduate Medical Education program pays teaching hospitals to train medical students by supplementing Medicaid and Medicare payments.

A second option for counties to serve their indigent residents is to establish a public hospital. This approach differs from the hospitals in a hospital district only in the source of local revenue. Rather than through property taxes, public hospitals are funded through other local tax dollars, usually sales or use taxes. Public hospitals also are eligible to receive the same types of state and federal funding as hospital districts.

The third option is a county indigent health program or CIHP, conceptually like insurance in that the county pays providers for services rendered to eligible patients. A CIHP is funded by local taxes up to a certain threshold, after which the state shares the cost. A county that spends more than 8 percent of its annual budget on a CIHP receives reimbursement from the state equal to 90 cents on each dollar the county spends. In fiscal 2000-01, the state set aside \$32 million to reimburse counties.

Uninsured Texans also obtain health care from emergency rooms, private hospitals, free clinics, public health services, and many other charitable sources, as well as from state entities such as the University of Texas Medical Branch at Galveston, the Texas Department of Mental Health and Mental Retardation, and the Texas prison system.

Indigent Health-Care Structures in Texas

	Number of counties served	Total population of counties served (in thousands)	Average population of counties served (in thousands)	Percent of state population served
Hospital district	87	11,378.3	130.8	56.9%
Public hospital	29	601.3	20.7	3.0
County indigent health program (CIHP)	110	6,373.0	57.9	31.9
Mixed: hospital district/CIHP	25	877.0	35.1	4.4
Mixed: public hospital/CIHP	3	765.8	255.3	3.8
Total	254	19,995.4	499.8	100.0%

Note: Population data are for 1999.

Source: *Providing Health Care to the Uninsured in Texas: A Guide for County Officials*, The Access Project, September 2000.

Role of health-care providers. Most health-care programs for indigent patients require documentation of a patient's income eligibility and residency. If all hospital districts were prevented from spending public funds on care for immigrants, districts would have to verify patients' citizenship during the application process. Critics say this would place health-care providers in an inappropriate position. They say that county health-care workers are not employed by the INS and should not have to perform INS functions. Others respond that requesting documentation of citizenship is no different from verifying residency, a function that county health-care workers already perform. In many cases, applicants already are asked about their citizenship to determine their eligibility for third-party reimbursement.

Prenatal care. Children born on U.S. soil are U.S. citizens even if their parents are not, and children of undocumented immigrants are likely to be eligible for public benefits such as Medicaid. Pregnant undocumented immigrants who are denied access to prenatal care may experience poor birth outcomes for their infants, including low birth weights. These infants' conditions then must be treated and paid for by Medicaid. Supporters say that if county hospital districts provided access to health care for pregnant undocumented immigrants, the state ultimately would save on Medicaid payments for infants who received inadequate prenatal care.

Opponents, while acknowledging that prenatal care is important to birth outcomes, claim that pregnant undocumented immigrants would be particularly unlikely to take advantage of publicly supported prenatal care for fear of possible deportation. If they are deported before giving birth, their infants will not be U.S. citizens.

Mixed families. According to census data, 18 percent of all Texas children belong to families with at least one noncitizen parent and at least one citizen child. Children who are citizens are eligible for all public benefits as long as they meet income or disability requirements, but their immigrant parents are not eligible. Some observers maintain that if immigrant parents are denied access to the health-care system, they may be more reluctant to apply for the benefits to which their children may be entitled. Access to health care for some, but not all, members of a family could diminish the quality of care for children with coverage. For example, a family might try to share one prescription of antibiotics, preventing the covered child from being treated fully.

Legal and constitutional issues

Since Attorney General Cornyn issued his opinion in July, hospital districts in Dallas, El Paso, Bexar, and Harris counties have chosen to continue to include undocumented immigrants in their medical assistance

programs. Tarrant County's long-standing policy has been to exclude undocumented immigrants. Travis County has no hospital district but operates other indigent care programs that serve undocumented immigrants. Hospital districts and other public facilities that continue to serve these immigrants are watching Harris County to determine possible legal action and the extent of their legal coverage.

Following the attorney general's opinion, the Harris County District Attorney's Office stated that it would not investigate the hospital district unless it received a complaint about the district's policy. Shortly thereafter, a citizen in Harris County filed a complaint, triggering a criminal investigation into whether hospital district officials violated Penal Code, sec. 32.45, relating to misapplication of fiduciary property or property of financial institutions, by authorizing the expenditure of public funds to pay for undocumented immigrants. The Young Conservatives of Texas filed similar complaints in Dallas, El Paso, and Bexar counties.

Defenders of counties' decisions to pay for health care for undocumented immigrants say the hospital districts are not breaking state and federal law. Lawyers for the Harris County Hospital District say that the adoption of a 1999 amendment to the Texas Constitution fulfilled the PRWORA requirement that states must include undocumented immigrants affirmatively in a law enacted after 1996.

Proposition 3 (HJR 62 by Mowery/Shapiro) on the 1999 ballot was designed to eliminate duplicative or obsolete language in the Constitution. Art. 9, sec. 4 of the Constitution requires hospital districts to assume "full responsibility for providing medical and hospital care to needy inhabitants of the county." The amendment approved by voters did not change that language but deleted two other provisions in Art. 9, sec. 4, one requiring hospital district voters to be property taxpayers and the other an obsolete reference to anticipatory enabling legislation. Voters added the language about hospital districts' responsibilities to the Constitution in 1954. Defenders claim that by reaffirming hospital districts' responsibilities, Texas voters affirmatively included undocumented immigrants.

Complainants say that the 1999 amendment was not intended to supersede federal law and does not meet the standard of affirmative inclusion. Because the language about a hospital district's responsibility predates enactment of the federal law, they say, it also does not fulfill PRWORA's requirement that states enact an affirmative inclusion after 1996.

Defenders of counties' decisions to pay for health care for undocumented immigrants say that PRWORA itself is unconstitutional and cannot be the basis for action against a hospital district. The equal-protection clause of the 14th Amendment to the U.S. Constitution prohibits states from denying any person within their jurisdiction the equal protection of the laws. Because PRWORA treats citizens differently from immigrants,

some claim, it is unconstitutional. They also claim that PRWORA may violate the 10th Amendment, which states that "the powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." They say that PRWORA can be interpreted to enlist state and local officials in the administration of immigration regulations, a clear federal responsibility, and that it prohibits the expenditure of state and local funds for health care, a power not delegated to the federal government by the U.S. Constitution.

Federal circuit courts uniformly have upheld PRWORA's constitutionality in denying federal benefits such as Supplemental Security Income, food stamps, and prenatal care to certain aliens (*City of Chicago v. Shalala*, 189 F.3d 598 (7th Cir. 1999, certiorari denied 120 S. Ct. 1530, 146 L.Ed. 2d 345); *Rodriguez v. U.S.*, 169 F.3d 1342 (11th Cir. 1999); *Aleman v. Glickman*, 217 F.3d 1191 (9th Cir. 2000); and *Lewis v. Thompson*, 252 F.3d 567 (2nd Cir. 2001)). These courts have followed legal precedent in determining that differences among classifications of immigrants in federal regulation of immigration policy are justifiable on equal-protection grounds as long as some "rational basis" exists for the differences (*Mathews v. Diaz*, 426 U.S. 67 (1976)).

State differences in classifying immigrants, on the other hand, are subject to more rigorous "strict scrutiny" review, in which the state must demonstrate that the difference "furthers a compelling state interest by the

The legal debate involves issues related to the Texas Constitution and to the constitutionality of PRWORA itself.

least restrictive means practically available” (*Bernal v. Fainter*, 467 U.S. 216 (1984)). On this basis, the New York Court of Appeals, the state’s highest appellate court, held that a New York state law enacted in response to PRWORA and denying state-funded Medicaid to certain immigrants violates the equal-protection clauses of the U.S. and New York constitutions (*In the Matter of Aliessa v. Novello*, 2001 NY Int. 59, 2001 NY Lexis 1407). The case was brought on behalf of 12 legal residents of the state with life-threatening illnesses who were denied Medicaid benefits. Plaintiffs in the case did not include undocumented immigrants.

The U.S. Supreme Court held in *Plyler v. Doe* that a Texas statute that withheld from local school districts any state funds for education of children who were not “legally admitted” into the United States and that authorized school districts to deny enrollment to such children violated the equal-protection clause by depriving a “disfavored group” of the means of obtaining an education without adequate justification. In *Bernal v. Fainter*, the court struck down a Texas statute requiring that notaries public be U.S. citizens because the court found no compelling state interest in prohibiting noncitizens from performing these services.

In 1988, Texas Attorney General Jim Mattox determined (*JM-962*) that the Texas Commission for the Blind must serve visually handicapped persons eligible to receive such services without regard to their immigration status, because state law did not explicitly prohibit their receiving such services.

Harris County Hospital District administrators are evaluating their legal options as the district attorney’s criminal investigation proceeds. Harris County Attorney Michael Stafford issued an opinion supporting the position that the Texas Constitution and state laws authorize the district to pay for indigent health care without regard to immigration status. He has stated that he may seek a court ruling to clarify the legality of such a policy, because his opinion differed from the attorney general’s.

State and federal options

If state lawmakers decide that hospital districts should be able to include undocumented immigrants in

their indigent health-care programs, a state law could provide undisputed legal authority. This would allow hospital districts to comply with PRWORA through a state exemption.

Recent changes in Texas’ laws regarding undocumented immigrants do not provide a clear picture of how well a proposed law would fare at the state level. The 77th Legislature enacted two bills related to undocumented immigrants. HB 1403 by Noriega, effective September 1, 2001, allows such immigrants to qualify as state residents for purposes of higher education tuition. HB 396 by Wise would have created an exception to the requirement that applicants for driver’s licenses provide their social security numbers. This would have allowed immigrants to obtain driver’s licenses without furnishing proof that they could not obtain a social security number. However, Gov. Perry vetoed this bill on the grounds that immigrants already can obtain driver’s licenses or can drive legally with foreign-issued driver’s licenses.

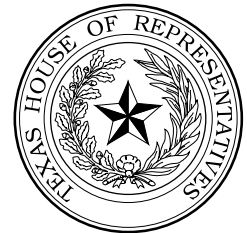
A second option for a permanent legal solution would be to change the federal law. U.S. Rep. Gene Green of Texas introduced legislation (H.R. 2635) in July that would allow state and local programs to provide preventative and primary health care to undocumented immigrants.

Other states are considering providing access to certain services for undocumented immigrants. California and Minnesota are weighing bills similar to Texas’ in-state tuition law, while Tennessee and Utah have dropped the requirement for a social security number from their driver’s license applications.

Arizona faces a similar dilemma to Texas’ in regard to health care. Since 1993, Arizona has funded a program to provide certain life-sustaining medical treatments to undocumented immigrants and to legal immigrants who have lived in the state for less than five years. In a compromise with the federal government to obtain federal funds for an expanded health insurance program for the working poor, Arizona agreed to less flexibility in administering state-funded services and has enacted legislation that will use state funds to continue the program.

— by Kelli Donges

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