



ST. MARY'S
UNIVERSITY

The Scholar: St. Mary's Law Review on Race
and Social Justice

Volume 10 | Number 4

Article 3

12-1-2007

The Impending Health Care Crisis in Texas: The Status of Health Care for Impoverished Texans.

Raj Aujla

Follow this and additional works at: <https://commons.stmarytx.edu/thescholar>



Part of the [Law Commons](#)

Recommended Citation

Raj Aujla, *The Impending Health Care Crisis in Texas: The Status of Health Care for Impoverished Texans.*, 10 THE SCHOLAR (2007).

Available at: <https://commons.stmarytx.edu/thescholar/vol10/iss4/3>

This Article is brought to you for free and open access by the St. Mary's Law Journals at Digital Commons at St. Mary's University. It has been accepted for inclusion in The Scholar: St. Mary's Law Review on Race and Social Justice by an authorized editor of Digital Commons at St. Mary's University. For more information, please contact egoode@stmarytx.edu, sfowler@stmarytx.edu.

COMMENTS

THE IMPENDING HEALTH CARE CRISIS IN TEXAS: THE STATUS OF HEALTH CARE FOR IMPOVERISHED TEXANS

RAJ AUJLA*

I. Introduction.....	398
II. Legal Background.....	405
A. The Indigent Health Care and Treatment Act.....	405
B. The County Indigent Health Care Program.....	407
C. Texas Hospital Districts.....	410
D. A Texas Hospital District's Duty to Provide Indigent Health Care.....	413
E. House Bill 480—A Failed Attempt to Increase Minimum CICHF Income Requirements.....	416
F. House Bill 3154—Indigent Health Care Review Committee.....	418
III. Legal Analysis.....	419
A. The United States Constitution—No Fundamental Right to Health Care.....	420
B. A Fundamental Right to Health Care? The United States Stands Alone.....	424
C. Is there a Fundamental Right to Health Care in Texas? No.....	428
D. From Needy Inhabitants to <i>Desperately</i> Needy Inhabitants.....	429

* St. Mary's University School of Law, Candidate for Juris Doctorate, May 2008; The University of Texas at Austin, B.A. Government, Liberal Arts Honors, May 2004. I would like to thank my parents, Surinder and Virginia Aujla, for their love, support and guidance, and for instilling values in me which made it possible to write this comment. A special thank you to all my friends and family, your support and encouragement continues to be invaluable. Finally, thank you to the members of *The Scholar*, especially my editor, Andrea Rodriguez, for her guidance and meaningful contributions to this comment.

E. From Needy Persons to <i>Desperately</i> Needed Persons .	431
F. The Harsh Reality for Impoverished Texans	433
G. Income and Health Insurance	434
H. Effects of Uninsured Texans on Their Communities . .	436
I. Texan Tom — A Fictional Character Who Represents a Real Problem	440
J. House Bill 480	442
IV. Conclusion	444

I. INTRODUCTION

The number of people in the United States without health insurance steadily increased over the past twenty-five years.¹ According to the U.S. Census Bureau, in 2006 an estimated forty seven million Americans, or 15.8%, did not have health insurance.² Studies indicate that if the situation is not confronted, then “the number of uninsured is predicted to reach 56 million by 2013.”³ Not only are the figures staggering, but also the “social, health and economic consequences of having a relatively large population without health insurance coverage are substantial.”⁴

Despite the magnitude of the nation’s impending crisis, the “situation in Texas is much bleaker.”⁵ Texas “leads the nation in the percentage of

1. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 20 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“The number of Americans without health insurance has climbed steadily in the past 25 years. . . . [T]here were 46 million uninsured Americans or 15.7[%] of the population in 2004.”). Approximately 82 million people were also without health insurance coverage at some point during 2002-2003. *Id.*

2. CARMEN DENAVAS-WALT ET AL., INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 18 (2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf> (identifying the increase in the percentage and number of uninsured Americans from 2005 to 2006). “Both the percentage and number of people without health insurance increased in 2006.” *Id.* The percentages of both, people in the United States covered by employment-based health insurance and people in the United States covered by governmental health programs, also decreased in 2006. *Id.*

3. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 20 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (stressing the gravity of the nation’s impending health care crisis). Seemingly odd, the health care crisis has occurred regardless of national economic conditions. *Id.*

4. *Id.* (asserting the consequences of such a large segment of the population not having health insurance). Specifically, in communities where a large portion of the population is uninsured, the quality and availability of health care is lower. *Id.* Furthermore, health care providers are adversely affected by having to provide health care without compensation. *Id.*

5. *Id.* at 30 (portraying the significant problem that Texas faces due to the high number of its uninsured residents). The lack of health care for one individual can often cause the health of one family member to negatively impact the health of other family members. *Id.*

the population that is uninsured, with 25.1[%] uninsured in 2004.”⁶ In 2005, the U.S. Census Bureau reported that 5.6 million Texans did not have health insurance, second only to California with 6.6 million uninsured residents.⁷ Currently, one out of every four Texans does not have health insurance.⁸ Also, data indicates that “every major city in Texas has a higher uninsured rate than the national average.”⁹ To put these figures in perspective, “[t]he number of uninsured Texans could fill the [University of Texas] football stadium [seventy] times.”¹⁰

Unfortunately, these are not static figures, and the number of uninsured Texans appears to be on the rise.¹¹ To illustrate this trend, the estimated population in Texas will reach 25.1 million people by 2010 and 30.2 million by 2020, assuming net migration rates remain equal to those from

6. *Id.* at 20 (recognizing that Texas leads the nation with the highest number of people without health insurance).

7. *Id.* at 30–31 (“Texas has the largest percentage and the second largest number (after California with 6.6 million) (U.S. Census Bureau, 2005) of uninsured in the United States.”). In regards to the uninsured problem, a difference that separates Texas from other states is the larger population of Hispanics. *Id.* The Hispanic population exhibits trends of lower average age, lower incomes and lower levels of education, which are all factors that lead to an increased probability of being uninsured. *Id.*

8. *Representative Hinojosa Participates in Border Health Conference*, U.S. FED. NEWS, June 6, 2006.

Today, nearly 46 million Americans, including more than 8 million children, are living without health insurance. In Texas, nearly 5,600,000 people are uninsured; that’s [twenty-five] percent of the population, and an increase of more than half a million people since 2000. More than [eighty] percent of the uninsured in this country are in families with at least one worker. *Id.*

9. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 20 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (emphasizing the magnitude of the health care crisis in Texas and its effect on the state’s major cities).

10. TEXAS HOSP. ASS’N, A STATE IN CRISIS: HEALTH CARE COVERAGE UNAFFORDABLE 1 (2007), available at <http://sahealth.com/CPM/2007%20A%20State%20in%20Crisis.pdf> (representing the enormous amount of Texans without health insurance by way of analogy to the state’s largest sports stadium). “Everything is bigger in Texas, and the percentage of our residents without health care coverage is no exception. Nearly one-fourth of the Texas population – or about 5.6 million men, women and children – lack health insurance coverage.” *Id.*

11. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 39 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“With projections showing a less educated work force and a drop in average income, it is very likely that the current number of uninsured in Texas will increase if changes are not implemented.”). Therefore, if changes are not mandated, Texas is potentially facing a future of an increasing population with less education and lower incomes and with undoubtedly less health insurance along with a higher demand for physician services. *Id.* at 23.

2000-2004.¹² Along with this estimated population growth, Texas is projected to experience an increase in the number of families living at or below the federal poverty threshold: 12.3% by 2010 and 13.1% by 2020.¹³ If these predictions are correct, the number of Texans without health insurance will substantially increase in the near future because “[h]ealth insurance coverage is strongly and positively related to income.”¹⁴ The current percentage of uninsured Texans and the projected increase convinces experts that the state finds itself on a path to a “perfect storm.”¹⁵

People without health insurance experience consequences far greater than being included in a statistical category: their health suffers substantially more than those with health insurance.¹⁶ A study conducted by the Institute of Medicine found that “[t]he uninsured are more likely to forgo needed care, receive fewer preventive services, not receive appropriate care to manage chronic diseases such as cardiovascular disease and diabetes, and obtain substandard care when admitted to a hospital.”¹⁷ Even

12. Texas State Data Ctr. and Office of the State Demographer, Summary of Trends in Texas State Data Center 2006 Populations Projections, Table 1, <http://txsdc.utsa.edu/tpepp/2006projections/summary/prstab-01.txt> (last visited Mar. 1, 2008) (presenting data that projects Texas’s population levels by race/ethnicity from 2010 to 2040).

13. Texas State Data Ctr. and Office of the State Demographer, The Texas Challenge in the Twenty-First Century: Implications of Population Change for the Future of Texas, Table 4.8, <http://txsdc.utsa.edu/pubsrep/pubs/txchalco/cogtab4-08.txt> (last visited Mar. 1, 2008) (estimating the number of families in poverty using the 0.5 scenario, which equals one-half of the 1990-2000 rates of net migration, and the 1.0 scenario, which equals to the 1990-2000 rates of net migration).

14. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 33 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (citing the strong correlation between income and health insurance coverage). “Two-thirds of all uninsured have low income levels. Fifty-nine percent of families with incomes at [fifty] percent FPL or less have all members covered, compared with [ninety] percent of families at 200[%] FPL.” *Id.*

15. *Id.* at 14 (“The health of Texas, economically, educationally, culturally and socially depends on the physical and mental health of its population. The increasing discrepancy between growing health needs and access to affordable health insurance coverage creates the conditions for a ‘perfect storm.’”). To add, quality of life tends to decrease as health care decreases. *Id.*

16. Democratic Pol’y Comm., Number of Uninsured Americans Continues to Rise on Bush Administration’s Watch, http://democrats.senate.gov/dpc/dpc-new.cfm?doc_name=fs-109-2-127 (last visited Mar. 1, 2008) (“The uninsured, who are overwhelmingly members of working families, have less access to care, are in poorer health, and are at greater risk of premature death.”).

17. *Id.* (portraying the health consequences people endure due to a lack of health insurance).

A survey by the Commonwealth Fund found that [fifty-nine] percent of uninsured adults with a chronic illness, such as diabetes or asthma, did not fill a prescription or skipped their medications because they could not afford them and [thirty-five] percent went to an emergency room or stayed overnight in the hospital in the past year be-

when uninsured individuals receive health care, “that care often comes later than it would have if the individual had been insured,” and “it is often inadequate to restore the individual to a reasonable degree of health.”¹⁸ A June 2007 *USA Today* article on the health crisis in Houston, Texas quoted a cardiologist who said, “You prescribe, you send them home, they don’t get well. They die sooner. They have more complications. They are more disabled.”¹⁹ The data clearly shows that people without health insurance suffer difficult consequences of chronic diseases like diabetes, and are more unlikely to receive timely diagnosis of screenable conditions like cancer and high blood pressure.²⁰ To further illustrate the current plight of uninsured Texans, an estimated 2500 of them die prematurely each year as a result of not having access to preventative care.²¹

In addition to the hardships uninsured Texans endure, the uninsured significantly impact their communities.²² They usually cannot pay for the medical services they receive, and these unpaid medical expenses are passed on to others.²³ According to the Texas Hospital Association

cause of their condition (about twice the rate of people with chronic conditions who were insured for the year. *Id.*

18. Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL’Y 1, 62–63 (2005) (expressing the ramifications of an uninsured prolonging needed care). “The uninsured are significantly less likely to receive cancer screening services, such as Pap smears and mammograms. They are far more likely to be diagnosed with late-stage cancer than the insured.” *Id.* This leads to lower survival rates among those with no insurance and those publicly insured than among those privately insured. *Id.* This trend extends to other conditions, such as cardiovascular disease and diabetes. *Id.*

19. Richard Wolf, *What Does a Health Crisis Look Like? See Houston*, USA TODAY, June 19, 2007, at 1A (quoting a Houston, Texas cardiologist’s experience on treating uninsured patients and the health consequences they suffer).

20. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 46 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“Lacking health insurance for longer periods increases the risk of inadequate care for this condition and can lead to uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability such as end-stage renal disease and blindness from diabetic retinopathy.”).

21. *Id.* at 47 (“[One] million uninsured Texans with chronic illnesses do not receive adequate services.”). “[Three] million uninsured Texans are less likely to receive preventative and screening services.” *Id.*

22. *Id.* at 46 (“In addition to affecting the individual, the uninsured dramatically impact the communities in which they live: The uninsured are often unable to pay for medical services they receive.”). “This impacts the finances and ability of emergency rooms to handle trauma. The overuse of an emergency department can even lead to increased local taxes.” *Id.* Ultimately, these expenses are passed on to others through higher insurance premiums and medical fees. *Id.*

23. *Id.* (“These expenses are passed on to others through higher medical fees and insurance premiums.”). Unfortunately, the uninsured often obtain health care through the

(THA), Texas hospitals “spent more than \$10.1 billion in 2005 on uncompensated care,” and such a large deficit could jeopardize health care for all Texans.²⁴ In 2005, Texas families paid an average of \$1500 more a year for health insurance primarily because of the unreimbursed cost of care for uninsured Texans.²⁵ Because uninsured Texans lack access to preventative health care, they often end up receiving primary care in an emergency room, which poses a risk of overburdening local trauma centers.²⁶ Between 1992 and 2003, “Texas hospitals reported a 55[%] increase in the number of emergency room visits from 5.5 million to 8.6 million,” and roughly 31% of those patients either received Medicaid or were uninsured.²⁷ Alarming, Texas hospitals only received an estimated “34 cents for every dollar in charges for emergency services,” and experts indicate that “these trends in utilization of emergency medical care services are not financially sustainable in the long run.”²⁸

most cost ineffective means. *Id.* Often, the uninsured receive health care through the visitation of emergency room, which is the most costly means to obtain health care. *Id.* Emergency rooms are required to take any individuals in need of the health care. *Id.*

24. TEXAS HOSP. ASS'N, MAKING Health Care Coverage Affordable and Accessible: Why You Should Care (2007), available at <http://www.texashospitalsonline.org/PolicyIssues/LegislativeAgenda/Uninsured/WhyCare.pdf> (explaining the financial burden placed on Texas hospitals as a result of providing medical care to uninsured patients). “This places an enormous strain on hospitals’ resources, including funding for emergency room care and the ability to have on-call physician specialists to cover the ER. In the end, access to care for every one of us may be compromised.” *Id.*

25. TEXAS HOSP. ASS'N, FAST FACTS: THE UNINSURED IN TEXAS (2007), available at <http://www.texashospitalsonline.org/PolicyIssues/LegislativeAgenda/Uninsured/FastFacts.pdf> (“In six states, health insurance premiums for families are at least \$1,500 higher due to the unreimbursed cost of care for the uninsured in 2005.”). “These states are New Mexico (\$1,875), West Virginia (\$1,796), Oklahoma (\$1,781), Montana (\$1,578), Texas (\$1,551) and Arkansas (\$1,514).” *Id.*

26. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 46 (2006), available at <http://www.coderedtexas.org/files/Report.pdf> (“Since many uninsured and underinsured individuals obtain primary care at emergency rooms, they risk overburdening of the local trauma system.”). A more cost effective and less burdensome method of obtaining primary care is through federally qualified health care facilities. *Id.*

27. *Id.* at 50 (describing the rising trend of emergency room use in Texas). “The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen emergency patients to determine whether an emergency medical condition exists, and if so, to stabilize the patient regardless of ability to pay.” *Id.*

28. *Id.* (emphasizing the lack of payment received by Texas Hospitals for providing emergency room services).

Trauma care in Texas is regionalized. Most of the uninsured Texans live in urban counties where hospital district hospitals both provide most of the indigent care and are the primary source of Level I (most intensive level of care) trauma centers. The growing number of uninsured places these safety net health systems in double jeopardy. *Id.* at 51.

In order to provide health care to poor uninsured Texans, the state heavily depends on local governments to provide a “safety net.”²⁹ A major component of this safety net is the County Indigent Health Care Program (CIHCP), and it provides “health care services to eligible residents through the counties, hospital districts, and public hospitals in Texas.”³⁰ The indigent population in Texas, for purposes of the CIHCP, is “defined as individuals at or under 21[%] of the federal poverty line (FPL).”³¹ In 2007, the estimated income for a family of four living at 100% of the FPL was \$20,650 for all states except Alaska and Hawaii.³²

Two simple math equations illustrate the degree of poverty that a family of four in Texas must live in to receive the benefits of the county indigent program: (1) $\$20,650 \times .21 = \4336.50 - yearly income for CIHCP eligibility and (2) $\$4336.50 / 12 = \361.38 - monthly income for CHICP eligibility. Furthermore, a household may not be eligible for indigent care if the total countable household resources exceed \$3000 if an eligible aged or disabled individual resides in the household or \$2000 for other households.³³ Also, Medicaid eligibility in Texas is equally difficult to

29. *Id.* at 21 (“Texas relies heavily on local governments to provide a safety net. The resources available to most counties are largely inadequate, and the largest metropolitan public hospitals are disproportionately affected by the uninsured because they find uninsured residents from neighboring counties drifting toward their health care providers.”). Most of this care is performed by medical residents. *Id.* This results in a lag of residency positions available in Texas. *Id.*

30. Texas Dep’t of State Health Servs., County Indigent Health Care Program, <http://www.dshs.state.tx.us/cihcp/default.shtm> (last visited Mar. 1, 2008) (stating that the purpose of the County Indigent Health Care Program is to deliver health care to eligible residents through Texas’s public hospitals, hospital districts, and counties).

31. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 21 (2006), available at <http://www.coderedtx.org/files/Report.pdf> (stating that CIHCPS provides health care for some of a county’s indigent residents).

In addition, many adults cannot qualify for Medicaid in Texas since the limit for eligibility is approximately twenty-one percent FPL. For example, a non-pregnant, non-disabled parent under the age of 65 in a family of three, working full-time all year at minimum wage (\$5.15 per hour) would earn too much to qualify for Medicaid, although his/her income is only \$10,700 and well below the FPL. *Id.* at 32.

32. U.S. Dep’t of Health & Human Servs., The 2007 HHS Poverty Guidelines: One Version of the United States Federal Poverty Measure, <http://aspe.hhs.gov/poverty/07poverty.shtml> (last visited Mar. 1, 2008) (stating that the 2007 Federal HHS Poverty Guideline for a household of a four persons in the forty-eight contiguous states and the District of Columbia is \$20,650). For households consisting of one person, the FPL is \$10,210. *Id.*

33. Texas Dep’t of State Health Servs., County Indigent Health Care Program Eligibility Criteria, <http://www.dshs.state.tx.us/cihcp/eligibility.shtm> (last visited Mar. 1, 2008) (“A household is eligible if the total countable household resources do not exceed: \$3,000.00 when a person who is aged or disabled and who meets relationship requirements lives in the home or \$2,000.00 for all other households.”). “A CIHCP household is a person living alone or two or more persons living together where legal responsibility for sup-

obtain, and in 2006 Congress enacted the Deficit Reduction Act which will make it even harder for Texans to get on Medicaid.³⁴ The short story for many Texans is that they are ineligible for Medicaid and make too much money, but not enough by any standard, to qualify for the county indigent care program.

The Texas Legislature recently declined to increase the minimum county indigent income standards to 100% of the FPL.³⁵ The Legislature left H.B. 480, introduced by State Rep. Jim Jackson, and its companion bill, S.B. 289, authored by State Sen. Royce West pending in subcommittee. Had the Legislature passed these bills, many more uninsured Texans would have gained access to the preventative health care they desperately need. Even though the Legislature did not enact H.B. 480 and S.B. 289, it did pass H.B. 3154 which “create[d] the regional health care systems review committee to study the implications of implementing regional health care service to address indigent health care. . . .”³⁶ H.B. 3154 also “requires the committee to examine whether a regional system providing indigent health care should be offered state wide . . . and to perform a review of certain funding and financing options.”³⁷

This comment seeks to educate readers on the health care crisis in Texas, and it examines the detrimental effect this crisis has on the state’s impoverished residents and proposes needed change. The first section of this comment provides the legal background of the County Indigent Health Care Program and scrutinizes efforts in Texas to fulfill its duty to provide health care to the state’s impoverished residents. The second section of this comment analyzes the effectiveness of the current indigent care program and how legislative action is required to improve the pre-

port exists, excluding disqualified persons. A disqualified person is one who receives or is categorically eligible to receive Medicaid.” *Id.*

34. See FAMILIES USA, MEDICAID ALERT 1 (2006), available at <http://familiesusa.org/assets/pdfs/DRA-101.pdf>.

New Medicaid applicants who claim to be U.S. citizens will have to provide documentation to prove their citizenship status. This documentation includes a passport, a driver’s license (in states that require proof of citizenship to obtain one), or a birth certificate plus one other secondary piece of identification. People currently enrolled in Medicaid will have to provide proof of citizenship when they renew their coverage. People who do not produce the required documents will be denied enrollment into the program (new applicants) or will be cut off (current enrollees). *Id.*

35. TEXAS HOSP. ASS’N, CAPITOL UPDATE, A SUMMARY OF THE 80TH TEXAS LEGISLATURE 9 (2007) (“Rep. Jim Jackson . . . introduced a series of bills amending the indigent care law, but all of his legislation died in a House Public Health Subcommittee.”). “House Bill 480 would have increased the county eligibility standards to 100[%] of poverty.” *Id.*

36. Tex. H.B. 3154, 80th Leg., R.S. (2007) (describing H.B. 3154’s stated goal and its review committee’s duties during the legislative interim).

37. *Id.* (detailing the duties of the Regional Health Care Systems Review Committee).

sent system. Also, section two will discuss the benefits of enrolling more Texas residents in the county indigent program and how this could serve as a way to alleviate the state's current health care crisis. Finally, this comment will propose a plan of action so that Texas can ready itself in the face of this "perfect storm."

II. LEGAL BACKGROUND

A. *The Indigent Health Care and Treatment Act*

The Indigent Health Care and Treatment Act (the Act) provides for health care services to indigent persons who live inside or outside of areas where health care services are provided by public hospitals or hospital districts.³⁸ The Act requires public hospitals and hospital districts to make health care assistance available to eligible residents in their services areas.³⁹ The Act also directs that counties must furnish health care services to eligible residents that reside in the county but who live outside areas covered by public hospitals or hospital districts.⁴⁰ Texas counties provide these health care services through the CIHCP.⁴¹ Furthermore, the Act states that a county is the "payor of last resort" and must provide health care to indigents if no other adequate sources are available.⁴²

38. 42A TEX. JUR. 3D *Healing Arts and Institutions* § 29 (2007).

A public hospital, hospital district, or county may (1) arrange to provide health care services through a local health department, a publicly owned facility, or a contract with a private provider regardless of the provider's location, or through the purchase of insurance for eligible residents; or (2) affiliate with other governmental entities or with a public hospital or hospital district to provide regional administration and delivery of health care services. *Id.*

39. TEX. HEALTH & SAFETY CODE ANN. § 61.052 (Vernon 2007) ("A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area . . .").

40. *Id.* § 61.022 ("A county shall provide health care assistance as prescribed by this subchapter to each of its eligible county residents. The county is the payor of last resort and shall provide assistance only if other adequate public or private sources of payment are not available."); TEX. HEALTH & SAFETY CODE ANN. § 61.002(3) (Vernon 2007) ("'Eligible resident' means a person who meets the income and resources requirements established by this chapter or by the governmental entity, public hospital, or hospital district in whose jurisdiction the person resides.").

41. Texas Dep't of State Health Servs., County Indigent Health Care Program Information, http://www.dshs.state.tx.us/cihcp/CIHCP_info.shtm (last visited Mar. 1, 2007) ("Chapter 61, Health and Safety Code, defines the responsibilities of counties, hospital districts, and public hospitals in providing health care to eligible residents who are considered indigent. Texas Administrative Code, Title 25, Part 1, Chapter 14 establishes the . . . rules regarding program administration, determining eligibility, and providing services.").

42. TEX. HEALTH & SAFETY CODE ANN. § 61.022(b) (Vernon 2007) ("The county is the payor of last resort and shall provide assistance only if other adequate public or private

According to the Act, hospital districts, public hospitals, and counties must provide “primary and preventative” health care services to their respective residents who qualify for indigent care.⁴³ These mandatory health care services include: immunizations, medical screening services and annual physical check-ups.⁴⁴ In order to provide these primary and preventative health care services, hospitals and counties must make the following services available to their eligible residents: (1) inpatient and outpatient hospital services; (2) rural health clinics; (3) laboratory and X-ray services; (4) family planning services; (5) physician services; and (6) payment for not more than three prescription drugs a month and skilled nursing facilities services, notwithstanding the patient’s age.⁴⁵ In addition to the stated mandatory health services, the Act allows hospital districts, public hospitals, and counties to provide other health care services as well.⁴⁶ The Act makes it clear that hospitals and counties maintain the option to provide these additional health care services to their indigent residents; however, they are not required.⁴⁷

sources of payment are not available.”); TEX. HEALTH & SAFETY CODE ANN. § 61.023(a)(1)-(3) (Vernon 2007).

A person is eligible for assistance under this subchapter if: the person does not reside in the service area of a public hospital or hospital district; the person meets the basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; and no other adequate source of payment exists. *Id.*

43. TEX. HEALTH & SAFETY CODE ANN. § 61.028(a) (Vernon 2007) (“A county shall, in accordance with department rules adopted under Section 61.006, provide the following basic health care services.”).

44. *Id.* § 61.028(a) (1)-(2) (categorizing immunizations, medical screening services, and annual physical examinations as primary and preventative services).

45. *Id.* § 61.028 (a)(2)-(8) (“A county shall, in accordance with department rules adopted under Section 61.006, provide the following basic health care services.”).

46. *Id.* § 61.0285(a) (listing possible cost-effective medical services that the county might deem necessary).

In addition to basic health care services provided under Section 61.028, a county may, in accordance with department rules adopted under Section 61.006, provide other medically necessary services or supplies that the county determines to be cost-effective, including: ambulatory surgical center services; diabetic and colostomy medical supplies and equipment; durable medical equipment; home and community health care services; social work services; psychological counseling services; services provided by physician assistants, nurse practitioners, certified nurse midwives, clinical nurse specialists, and certified registered nurse anesthetists; dental care; vision care, including eyeglasses; services provided by federally qualified health centers, as defined by 42 U.S.C. Section 1396d(1)(2)(B); emergency medical services; and any other appropriate health care service identified by board rule that may be determined to be cost-effective. *Id.*

47. *Id.* § 61.028(b) (stating that they have the option to provide additional services, “but may not credit the assistance toward eligibility for state assistance, except as provided by Section 61.0285.”).

B. *The County Indigent Health Care Program*

In order to receive primary and preventative health care services from a county through the CIHCP, Texas residents must meet certain eligibility requirements.⁴⁸ The Texas Department of State Health Services (the Department) establishes the CIHCP eligibility standards and application procedures.⁴⁹ Not only does the Department determine an individual's eligibility for the CIHCP, it also distributes state assistance to counties that provide indigent care.⁵⁰ The Department also has the authority to decide eligibility disputes between a county, public hospital, or hospital district if those entities "cannot agree on a household's eligibility for assistance."⁵¹

48. Medical Indigent Care in Texas Taskforce, *Access to Health Care in Texas: Challenges of the Uninsured and Underinsured*, <http://www.utsystem.edu/hea/taskforce/charge.htm> (last visited Mar. 1, 2008).

In Texas, care for the medically indigent is largely a responsibility of the individual counties while the state has a major financial commitment in support of Medicaid and SCHIP. Eligibility for county-financed care varies widely, with many counties providing such care only for those with extremely low or no income. On the other hand, certain communities such as those in Dallas, Houston, Galveston, San Antonio and Austin must finance and provide care for significant numbers of individuals coming from other parts of the state. *Id.*

49. Texas Dep't of State Health Servs., *County Indigent Health Care Program Eligibility Criteria*, <http://www.dshs.state.tx.us/cihcp/eligibility.shtm> (last visited Mar. 1, 2008) ("A household is eligible if its monthly net income does not exceed 21% of the Federal Poverty Guideline (FPG). Counties may choose to increase the monthly income standard to a maximum of 50% FPG, and still qualify to apply for state assistance funds.").

50. 25 TEX. ADMIN. CODE § 14.1 (2007) (Tex. Dep't of State Health Servs.) (explaining the allocation of state assistance funds).

(a) The Texas Department of Health (department) is responsible for distributing state assistance to eligible counties to the extent appropriated state funds are available; (b) The department establishes the eligibility requirements and internal procedures for a county applying for state assistance; (c) The department determines a county's eligibility for state assistance; (d) The department distributes funds to eligible counties based on a maximum annual allocation: (1) The maximum annual allocation will be based on such factors as spending history, population, and the number of residents living below the Federal Poverty Guideline, (2) The department-established allocation of the state assistance funds will distinguish the amount of funds allocated between the counties that actually were eligible and received state assistance funds the prior state fiscal year and other potentially eligible counties, (3) Up to the legislatively-mandated or department-established appropriated state assistance funds for each county, the department may reallocate the unspent funds to eligible counties, (4) No county can be approved for more than the legislatively-mandated or department-established percent of the appropriated state assistance fund within a state fiscal year. *Id.*

51. *Id.* § 14.2(a) ("If a provider of assistance and a governmental entity or hospital district cannot agree on a household's eligibility for assistance, the provider or the governmental entity or hospital district may submit the matter to the department not later than the 90th day after the eligibility determination was issued.").

Currently, the Department requires that a Texas resident's net household income must equal or fall below twenty-one percent the FPL in order to receive indigent care.⁵² Income, as defined by the Department, is "[a]ny type of payment that is of gain or benefit to the household."⁵³ The Department requires that a household actively pursue and accept all income to which it is legally entitled.⁵⁴ A household is defined as a person who lives alone, or two or more persons living together, who are "legally responsible for the support of the other person(s)."⁵⁵ For purposes of the CICHF, legal responsibility exists between married persons, legal parents and minor children, and managing conservators and minor children.⁵⁶ Furthermore, a member of a household who receives Medicaid, or is eligible to receive Medicaid, cannot receive indigent care and is not included as a member of the household for purposes of calculating the household's net income.⁵⁷ Household members who receive Social Security benefits are neither ineligible nor included as a household member.⁵⁸

52. TEX. HEALTH & SAFETY CODE ANN. § 61.006(b) (Vernon 2007) ("The minimum eligibility standards must incorporate a net income eligibility level equal to twenty-one percent of the federal poverty level based on the federal Office of Management and Budget poverty index.").

53. 25 TEX. ADMIN. CODE § 14.104(a)(1-3) (2007) (Tex. Dep't of State Health Servs.).

Income—Any type of payment that is of gain or benefit to the household. As established by the department, income is either countable or exempt under the department-established budgeting process. Earned income—Income related to employment and entitles the household to deductions not allowed for unearned income. Unearned income—Payments received without performing work-related activities. It includes benefits from other programs. *Id.*

54. *Id.* § 14.104(c) ("A household must pursue and accept all income to which the household is legally entitled. Reasonable time (at least three months) must be allowed for the household to pursue the income. The income is not considered available during this time.").

55. *Id.* § 14.103(a) ("A county health care assistance household is a person living alone, or two or more persons living together, who are legally responsible for the support of the other person(s)."). "Disqualified persons are not household members regardless of their legal responsibility for support." *Id.*

56. *Id.* § 14.103(e) ("Legal responsibility for support exists between persons who are legally married, a legal parent and a minor child, or a managing conservator and a minor child.").

57. *Id.* § 14.103(h)(1)-(3) ("The following persons are disqualified from inclusion in the household: a person who receives or is categorically eligible to receive Medicaid . . . and a Medicaid recipient who has exhausted a part or all of that recipient's Medicaid benefit.").

58. 25 TEX. ADMIN. CODE § 14.103(h)(2) (2007) (Tex. Dep't of State Health Servs.) (Texas Department of State Health Services) ("The following persons are disqualified from inclusion in the household . . . a person who receives TANF or SSI benefits. . .").

While net income is the threshold inquiry in determining a household's eligibility for the CIHCP, other factors are also considered. An otherwise eligible household with a member who is aged or disabled cannot receive indigent care if the household has resources in excess of \$3000.⁵⁹ The resource limit for other households is \$2000.⁶⁰ The Department defines resources as "[b]oth liquid and non-liquid assets a person can convert to meet his immediate needs."⁶¹ Countable resources include the fair market value of an applicant's vehicle, and any real property owned by an applicant, other than the applicant's homestead.⁶² Furthermore, a person must live in the county in which he or she applies for indigent care.⁶³ There are no minimum durational requirements for county residency, and there is no time restriction on a person's absence from the county in which he or she receives indigent care.⁶⁴ However, despite the lack of time requirements for county residency, a person cannot be a resident of two counties and simultaneously qualify for indigent care in both counties.⁶⁵

Although the Department establishes the CIHCP rules and regulations that counties must follow with regard to indigent care, the Department's

59. *Id.* § 14.105(b)(1) ("The total value of non-exempt resources available to the household cannot exceed . . . \$3000 for households which include the applicant or a relative living in the home who is aged or disabled.")

60. *Id.* § 14.105 (b)(2) ("The total value of non-exempt resources available to the household cannot exceed . . . \$2000 for all other households.")

61. *Id.* § 14.105(b)(1).

62. *Id.* § 14.105(d)(1-5).

In determining eligibility: (1) a county must not consider the value of the applicant's homestead; (2) a county must consider as a resource the fair market value of a vehicle that is in excess of the amount exempt under department-established guidelines; (3) If, within three months before application or any time after certification, the household transfers title of a countable resource for less than its fair market value to qualify for assistance, the county must consider the household ineligible for the department-established length of time. This penalty applies if the total of the transferred resource added to other resources affects eligibility for assistance; (4) A county must consider as a resource real property other than a homestead and must count that property in determining eligibility; and (5) a county may disregard the applicant's real property if the applicant agrees to an enforceable obligation to reimburse the county for all or part of the benefits received under the County Indigent Health Care Program. The county and the applicant may negotiate the terms of the obligation. *Id.*

63. 25 TEX. ADMIN. CODE § 14.102(a) (2007) (Tex. Dep't of State Health Servs.) ("A person must live in the Texas county to which he applies for assistance.")

64. *Id.* § 14.102(b)(c) ("No time limit is placed on a person's absence from the county."). "If a person proves county residence at application, the person remains a county resident until factual evidence proves otherwise . . . there are no durational requirements for residency." *Id.*

65. *Id.* § 14.102(e) ("A person cannot qualify for county health care assistance from more than one county simultaneously.")

authority extends to public hospitals as well hospital districts.⁶⁶ The Act directs hospital districts and public hospitals to implement the CIHCP income requirements set forth by the Department.⁶⁷ However, the Act does not restrict hospital districts and public hospitals from implementing less restrictive requirements than those imposed on counties by the Department.⁶⁸ In addition to a hospital district's statutory duty found in the Act, a hospital district has a constitutional duty to provide health care to its indigent residents as well.⁶⁹

C. *Texas Hospital Districts*

The legislative authority to create hospital districts is found in the Texas Constitution.⁷⁰ Texas hospital districts are created by the constitution and exist by virtue of the constitution's provisions and the district's implementing legislation.⁷¹ A hospital district's power and responsibilities are determined by examining the constitutional provision that authorizes its creation, its enabling legislation, and the applicable provisions of

66. Op. Tex. Att'y Gen. No. GA-0198, at 4 (2004) (“[A] hospital district or the private entity that provides indigent care on the district's behalf may not require an uninsured applicant for indigent health care, as a prerequisite to receiving the care, to obtain health insurance through the applicant's employer.”).

67. TEX. HEALTH & SAFETY CODE ANN. § 61.052(a)(1) (Vernon 2007) (“A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area who meets: the basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested”).

68. *Id.* § 61.052(a)(2) (“A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area who meets: a less restrictive income and resources standard adopted by the hospital or hospital district serving the area in which the person resides.”).

69. Op. Tex. Att'y Gen. No. GA-0467, at 1 (2006) (“Hospital districts created pursuant to this constitutional provision [TEX. CONST. art. IX, § 9] assume responsibility for providing medical and hospital care to indigent residents.”). “The East Coke County Hospital District, created by special law under [A]rticle IX, section 9 of the Texas Constitution has authority to operate a long-term health care facility and to levy taxes to maintain and operate this facility.” *Id.* at 4.

70. TEX. CONST. art. IX, §§ 4, 5, 7, 8, 9, 9A, 11, 13 (referring to all areas of the Texas Constitution which refer to the legislative authority to create hospital districts).

71. 36 DAVID B. BROOKS, TEXAS PRACTICE: COUNTY AND SPECIAL DISTRICT LAW § 26.20 (2d ed. 2007).

Hospital districts are created by the Texas Constitution and exist only by virtue of those provisions and the implementing legislation. It is always necessary in determining the authority and powers of a hospital district in Texas to examine the specific statutory authority under which it operates. In many cases, this authority can be found only in the legislature's “session laws” since the statutes are often local and special legislation. *Id.*

the Texas Health and Safety Code.⁷² Article IX, Section 4 of the Texas Constitution authorizes the Texas Legislature to create county-wide hospital districts in counties that have a population in excess of 190,000.⁷³ A hospital district created by this provision has the authority to:

[I]ssue bonds for the purchase, acquisition, construction, maintenance and operation of any county owned hospital, or where the hospital system is jointly operated by a county and city within the county, and to provide for the transfer to the county-wide Hospital District of the title to any land, buildings or equipment, jointly or separately owned, and for the assumption by the district of any outstanding bonded indebtedness theretofore issued by any county or city for the establishment of hospitals or hospital facilities; to levy a tax not to exceed seventy-five (\$.75) cents on the One Hundred (\$100.00) Dollars valuation of all taxable property within such district, provided, however, that such district shall be approved at an election held for that purpose, and that only qualified voters in such county shall vote therein[.]⁷⁴

Also, this provision authorizes these hospital districts to invoke the governmental power of eminent domain.⁷⁵

72. Op. Tex. Att’y Gen. No. DM-37, at 1–2 (1991) (“A hospital district’s authority and duties are found in the Texas Constitution, the hospital district’s enabling statute, and provisions of the Health and Safety Code pertaining to hospital districts generally.”).

73. TEX. CONST. art. IX, § 4 (“The Legislature may by law authorize the creation of county-wide Hospital Districts in counties having a population in excess of 190,000 and in Galveston County. . .”).

74. *Id.* (quoting the specific authority a hospital district has under the Texas Constitution).

75. TEX. HEALTH & SAFETY CODE ANN. § 281.054(a) (Vernon 2007) (“The district has the power of eminent domain to acquire any interest in real, personal, or mixed property located in the district if the property interest is necessary or convenient for the exercise of the rights or authority conferred on the district by this chapter.”); TEX. HEALTH & SAFETY CODE ANN. § 281.054(b) (Vernon 2007) (“The district must exercise the power of eminent domain in the manner provided by Chapter 21, Property Code, but the district is not required to deposit with the trial court money or a bond as provided by Section 21.021(a), Property Code.”); TEX. HEALTH & SAFETY CODE ANN. § 281.054(c)(1)-(3) (Vernon 2007) (“In a condemnation proceeding brought by the district, the district is not required to: (1) pay in advance or give bond or other security for costs in the trial court; (2) give bond for the issuance of a temporary restraining order or a temporary injunction; or (3) give bond for costs or supersedes on an appeal or writ of error.”); TEX. HEALTH & SAFETY CODE ANN. § 286.080(a) (Vernon 2007) (“A district may exercise the power of eminent domain to acquire a fee simple or other interest in property located in the territory of the district if the property interest is necessary to the exercise of the rights or authority conferred by this chapter.”).

Following the adoption of Article IX, Section 4 of the Texas Constitution, the Legislature adopted Article IX, Section 9 in 1962.⁷⁶ Section 9 created “hospital districts without regard to county lines.”⁷⁷ A hospital district created by Article IX, Section 9 possesses the authority to:

[I]ssue bonds for the purchase, construction, acquisition, repair or renovation of buildings and improvements and equipping same, for hospital purposes; providing for the transfer to the hospital district of the title to any land, buildings, improvements and equipment located wholly within the district which may be jointly or separately owned by any city, town or county, providing that any district so created shall assume full responsibility for providing medical and hospital care for its needy inhabitants and assume the outstanding indebtedness incurred by cities, towns and counties for hospital purposes prior to the creation of the district, if same are located wholly within its boundaries, and a pro rata portion of such indebtedness based upon the then last approved tax assessment rolls of the included cities, towns and counties if less than all the territory thereof is included within the district boundaries providing for the levy of annual taxes at a rate not to exceed seventy-five cents (\$.75) on the One Hundred Dollar [\$100.00] valuation of all taxable property within such district for the purpose of meeting the requirements of the district's bonds, the indebtedness assumed by it and its maintenance and operating expenses, providing that such district shall not be created or such tax authorized unless approved by a majority of the qualified voters thereof voting at an election called for the purpose[.]⁷⁸

Hospital districts created by the Legislature under this section also maintain the governmental power of eminent domain.⁷⁹

Furthermore, hospital districts created by the Legislature in accord with the Texas Constitution have the authority to impose an annual property tax on the real property located within their boundaries.⁸⁰ This tax-

76. TEX. CONST. art. IX, § 9 (chronicling the amendment to Article IX, § 4 of the Texas Constitution).

77. 36 DAVID B. BROOKS, TEXAS PRACTICE: COUNTY AND SPECIAL DISTRICT LAW § 26.20 (2d ed. 2007).

78. TEX. CONST. art. IX, § 9 (quoting the authority inherent in a hospital district created under Article IX, § 9 of the Texas Constitution).

79. TEX. HEALTH & SAFETY CODE ANN. § 286.080(a) (Vernon 2007) (“A district may exercise the power of eminent domain to acquire a fee simple or other interest in property located in the territory of the district if the property interest is necessary to the exercise of the rights or authority conferred by this chapter.”).

80. 36 DAVID B. BROOKS, TEXAS PRACTICE: COUNTY AND SPECIAL DISTRICT LAW § 26.23 (2d ed. 2007).

ing authority is limited to a maximum rate of \$.75 per \$100.00 of value assessed on real property within the district.⁸¹ Any tax imposed by a hospital district must be approved by the district's voters.⁸² A hospital district may only levy taxes for purposes authorized in the constitution and the district's enabling legislation.⁸³ To that end, a 2000 Texas attorney general opinion stated that the "most significant lawful hospital district expense is that for indigent medical care."⁸⁴

D. *A Texas Hospital District's Duty to Provide Indigent Health Care*

In addition to the authority given to hospital districts, the Legislature also gave the districts significant responsibilities.⁸⁵ It is well established that Texas hospital districts have a constitutional and statutory duty to

Hospital districts created by special legislation under Article IX, Section 9 of the Constitution have the authority to levy an annual property tax not to exceed seventy-five cents on the one hundred dollar valuation for the purpose of meeting the requirements of the district's bonds, the indebtedness assumed by it and its maintenance and operating expenses. *Id.*

81. Op. Tex. Att'y Gen No. JC-0247, at 2 (2000) ("Article IX, section 9 of the Texas Constitution authorizes a hospital district to provide 'for the levy of annual taxes at a rate not to exceed seventy-five cents . . . on the One Hundred Dollar valuation of all taxable property within such district. . . .'").

82. TEX. CONST. art. IX, § 9; TEX. HEALTH & SAFETY CODE ANN. § 286.161(a) (Vernon 2007) ("A majority of voters in a district or proposed district may, at the creation election under Subchapter B or in conjunction with any other district election, authorize the district to impose a property tax."); TEX. HEALTH & SAFETY CODE ANN. § 286.161(b) (Vernon 2007) ("The [hospital district] board annually may impose property taxes in an amount not to exceed the limit approved by the voters at the election authorizing the levy of taxes.").

83. *See Bexar County Hosp. Dist. v. Crosby*, 327 S.W.2d 445, 448–49 (Tex. 1959) ("The effect of the legislative act was to provide that since the District was charged with the duty and responsibility of maintaining and operating the hospitals in Bexar County, the taxes levied for that purpose should be administered by it."). The Texas Supreme Court concluded that the Enabling Act must be reviewed to determine if it allows the transfer of delinquent tax money when it is collected. *Id.* at 447. To determine this, the Court looked at whether the money was part of a general fund or if it was levied for a particular function and used solely for that purpose. *Id.*

84. Op. Tex. Att'y Gen No. JC-0220, at 6 (2000) ("Article IX, section 9 was adopted to maintain or improve public health care and facilities, especially for indigent persons and shift the financial burden of providing the care and facilities from cities and counties to hospital districts.").

85. TEX. CONST. art. IX, § 4 interp. commentary (Vernon 2007). ("By an amendment adopted in November, 1954, this section was added to the Constitution authorizing the Legislature to provide by law for the creation of county-wide hospital districts to furnish medical and hospital care for the indigent and needy in counties having a population in excess of 190,000 and in Galveston County.").

None of the large communities in Texas have sufficient hospitals to serve fully the needs of both nonpaying and paying cases, and public hospitalization is a desperate

provide health care to their indigent residents.⁸⁶ These responsibilities were first documented in 1954 by the language which created county-wide hospital districts.⁸⁷ This constitutional language expressly provided that county-wide hospital districts “shall assume full responsibility for providing medical and hospital care to needy inhabitants of the county. . . .”⁸⁸ Eleven years after the creation of county-wide hospital districts, an attorney general opinion emphasized their importance and role in providing indigent care.⁸⁹

In fact, one Texas attorney general opinion stated that a hospital district’s duty to provide health care for its needy inhabitants is “absolute.”⁹⁰ Once a hospital district is established, its duty to provide health care is not only absolute, but also it is exclusive.⁹¹ Article IX, § 9 of the Texas

need in Texas, which at the time of the adoption of the amendment ranked among the lowest states in providing hospital facilities for its needy citizens. *Id.*

86. Op. Tex. Att’y Gen. No. M-1154, at 5 (1972) (“The [Bexar County] Hospital District has the constitutional and statutory duty to furnish medical and hospital care to the indigent and needy persons residing in its District.”).

87. TEX. CONST. art. IX, § 4 interp. commentary (Vernon 2007) (“It was admitted that greater unification rather than greater diversity was necessary for efficient local government in Texas, but under the present Constitution such unification seemed impossible, thus the only answer was to create another local governmental agency with tax power.”).

88. Op. Tex. Att’y Gen. No. C-382, at 2 (1965) (“[A] patient should not be refused admittance to the hospital facilities simply because he may be able to pay for his care, either in whole or in part.”). It must be noted that the primary function of the Hospital District is the furnishing of medical care and hospital care for the indigent and needy of the county, and that such function, should take precedence over all others. *Id.*

89. *Id.* at 2 (“[A] patient should not be refused admittance to the hospital facilities simply because he may be able to pay for his care, either in whole or in part.”). “It must be noted that the primary function of the Hospital District is the furnishing of medical care and hospital care for the indigent and needy of the county, and that such function, should take precedence over all others.” *Id.* at 2.

90. Op. Tex. Att’y Gen. No. JC-0220 (2000) (“Thus under this constitutional provision, a hospital district is directed to assume responsibility for providing hospital and medical care to its needy inhabitants; and, moreover, other political subdivisions within the district are prohibited from providing or raising revenues for hospital or medical care once a district is created.”). “Because of its absolute duty to provide medical and hospital care for its needy inhabitants, a hospital district is responsible for those medical expenses.” *Id.*

Authority to levy and use the proceeds for the District’s needy residents’ hospital and medical care is neither limited to nor contingent on ownership or operation of a physical hospital. Clearly, a hospital district may provide hospital and medical care to its indigent through its own hospital facility. But it must provide that care even if it does not own or operate a hospital facility. *Id.* at 10.

91. Op. Tex. Att’y Gen. No. DM-380, at 2 (1996) (stating that a hospital district has an exclusive duty to provide health care). The hospital district’s enabling act mirrors Article IX, § 9 of the Texas Constitution, which authorizes the legislature to provide for the creation of hospital districts so long as “any district so created . . . assumes[s] full responsibility for providing medical and hospital care for its needy inhabitants.” *Id.* After the creation of a hospital district, Article IX § 9 states, “no other municipality or political subdivision

Constitution states “no other municipality or political subdivision shall have the power to levy taxes or issue bonds . . . for providing medical care within the boundaries of the district. . . .”⁹² This duty exists even if a hospital district does not own or operate a hospital because a district is solely responsible for the expenses of its indigent population.⁹³

Although the Texas Constitution expressly states that hospital districts “shall assume full responsibility for providing medical and hospital care for its needy inhabitants,” the constitution provides no guidance as to who qualifies as a “needy inhabitant.”⁹⁴ This issue was first addressed in a Texas attorney general opinion in 1975.⁹⁵ After searching Texas case law to no avail, the attorney general concluded that “needy” should be given its ordinary meaning: “indigent.”⁹⁶ Subsequent opinions follow this ruling and affirm that “needy inhabitant” has the same meaning as “indi-

shall have the power to levy taxes or issue bonds or other obligations . . . for providing medical care within the boundaries of the district.” *Id.*

92. *Id.* at 2 (emphasizing that a Texas hospital district has an absolute duty to provide medical care to its needy inhabitants). “A hospital district must provide to a resident of the hospital district the health care services required under the Texas Constitution and the hospital district’s enabling act.” *Id.* at 2. *See also* TEX. CONST. art. IX, § 9.

93. Op. Tex. Att’y Gen. No. JM-858, at 3 (1988).

Presidio County Hospital District has an absolute obligation to provide medical services, but the district has failed to establish the facilities within its boundaries to accomplish this duty. Rather, residents of Presidio County travel to a hospital that is operated by another hospital district in an adjacent county to receive medical treatment. The district is liable for the medical expenses of its indigents. *Id.*

Op. Tex. Att’y Gen. No. M-171, at 5 (1967) (“Where the hospital district cannot discharge its full responsibility to such needy inhabitant within the hospital district because of a lack of sufficient medical or hospital facilities, it may send the inhabitant to a hospital facility outside the district and legally pay for such expense.

94. TEX. CONST. art. IX, §§ 4, 9 (discussing the lack of qualifiers, a definition or guideline for the term “needy inhabitant” as described in the Texas Constitution Article IX, §§ 4 and § 9).

95. Op. Tex. Att’y Gen. No. H-703, at 3041-42 (1975) (“We believe the word ‘needy’ as contained in article 9, sections 4 and 9, should be given its normal meaning, indigent.”).

In our view a translation of indigency into precise income levels involves factual matters. Under article 9, sections 4 and 9, we believe that in the first instance a hospital district should reasonably determine this figure. Where a reasonable standard of indigency is in use by a hospital district, that same standard would be applicable to article 9, sections 4 and 9. Otherwise the district would be classifying similarly situated persons differently, and in the absence of a rational basis would be in violation of the equal protection clause of the 14th amendment. *Id.*

96. *Id.* at 3041 (“We have discovered no Texas case offering a definition of ‘needy;’ however, it is generally accepted to mean ‘indigent, necessitous, very poor.’”). At the conclusion of the opinion, the summary reiterates that a hospital districts’ needy inhabitants are, in fact, its indigent residents. *Id.* at 3044.

gent.”⁹⁷ Regardless of the meaning given to the term “needy inhabitant,” a hospital district cannot adopt procedures and eligibility standards that circumvent its constitutional duty to “provide medical and hospital care for its needy inhabitants.”⁹⁸ Moreover, it is undisputed that a hospital district must adhere to one of two standards: (1) the income and resource standards proscribed by the Indigent Health Care and Treatment Act or (2) less restrictive means standards adopted by the district.⁹⁹

E. *House Bill 480—A Failed Attempt to Increase Minimum CICHF Income Requirements*

H.B. 480, authored by State Rep. Jim Jackson, and its companion bill, S.B. 298, authored by State Sen. Royce West, would have increased the minimum CICHF income requirement from twenty-one percent of the FPL to 100% of the FPL.¹⁰⁰ However, H.B. 480 was left pending in sub-

97. Op. Tex. Att’y Gen. No. JM-858, at 2 (1988) (“Your first question concerns the meaning of the terms ‘needy’ and ‘inhabitant of the district’ as those terms are used in the pertinent constitutional and statutory provisions. This office addressed this question in Attorney General Opinion H-703 (1975). That opinion equated a ‘needy inhabitant’ with an ‘indigent resident.’”).

98. Op. Tex. Att’y Gen. No. DM-380, at 7 (1996) (“A hospital district may not adopt eligibility standards or application procedures that are inconsistent with its enabling act. Moreover, we do not believe a hospital district may establish standards or procedures that circumvent the hospital district’s constitutional duty to provide ‘medical and hospital care for its needy inhabitants.’”).

99. TEX. HEALTH & SAFETY CODE ANN. §§ 61.052(a)(1)-(2) (Vernon 2007).

A public hospital or hospital district shall provide health care assistance to each eligible resident in its service area who meets: the basic income and resources requirements established by the department under Sections 61.006 and 61.008 and in effect when the assistance is requested; or a less restrictive income and resources standard adopted by the hospital or hospital district serving the area in which the person resides. *Id.*

TEX. HEALTH & SAFETY CODE ANN. § 61.052(b) (Vernon 2007) (“If a public hospital used an income and resources standard during the operating year that ended before January 1, 1985, that was less restrictive than the income and resources requirements established by the department under Section 61.006, the hospital shall adopt that standard to determine eligibility under this subchapter.”); TEX. HEALTH & SAFETY CODE ANN. § 61.052(d) (Vernon 2007).

A public hospital established after September 1, 1985, shall provide health care services to each resident who meets the income and resources requirements established by the department under Sections 61.006 and 61.008, or the hospital may adopt a less restrictive income and resources standard. The hospital may adopt a less restrictive income and resources standard at any time. *Id.*

100. TEX. HEALTH & SAFETY CODE ANN. § 61.006 (b) (Vernon 2007) (“The minimum eligibility standards must incorporate a net income eligibility level equal to twenty-one percent of the federal poverty level based on the federal Office of Management and Budget poverty index.”); Tex. H.B. 480, 80th Leg., R.S. (2007).

committee on March, 27, 2007, where it stayed for the remainder of the 80th Session of the Texas Legislative due to opposition from Texas counties.¹⁰¹ This H.B. would have amended § 61.006 (b) of the Texas Health and Safety Code (Indigent Health Care and Treatment Act) to read as follows: “The minimum eligibility standards must incorporate a net income eligibility level equal to 100 [21] percent of the federal poverty level based on the federal Office of Management and Budget poverty index.”¹⁰²

Additionally, H.B. 480 would have also amended § 61.023 (b) of the Texas Health and Safety Code. The amended version would have read as follows: “A county may use a less restrictive standard of eligibility for residents than prescribed by Subsection (a). A county may credit toward eligibility for state assistance under this subchapter *only* the services provided to a [each] person who is an eligible resident under a standard of *eligibility prescribed by Subsection (a)*. . . .”¹⁰³ The effect of this proposed amendment would have allowed counties to provide health care to persons that had a net income in excess of the FPL because, as amended, subsection (a) sets the minimum net income requirement at 100% of the FPL.¹⁰⁴ Currently, the statute permits counties to provide health care to persons who have a net income less than fifty percent of the FPL, instead of the twenty-one threshold as promulgated by the Texas Department of State Health Services.¹⁰⁵

101. Texas Legislature Online, <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=80R&Bill=HB480> (last visited Mar. 1, 2008) (stating H.B. 480’s last action before the Texas House of Representatives). The subcommittee considered the bill in a public hearing and heard testimony. *Id.*

102. Tex. H.B. 480, 80th Leg., R.S. (2007) (describing the proposed changes to the current version of the Indigent Health Care and Treatment Act); Tex. S.B. 298, 80th Leg., R.S. (2007) (“The minimum eligibility standards must incorporate a net income eligibility level equal to 100 [21] percent of the federal poverty level based on the federal Office of Management and Budget poverty index.”). S.B. 298 is the companion bill to H.B. 480. *Id.*

103. *Id.* (corresponding with the proposed changes to § 61.006(b), thus enabling a greater number of residents to qualify for indigent care).

104. *Id.* (reiterating the effect that H.B. 480 would have on the Indigent Health Care and Treatment Act). “Subsection (a)” of H.B. 480 correlates with the proposed change in the minimum eligibility standards for determining eligibility for indigent health care. *Id.*

105. TEX. HEALTH & SAFETY CODE ANN. § 61.023 (b) (Vernon 2007).

A county may use a less restrictive standard of eligibility for residents than prescribed by Subsection (a). A county may credit toward eligibility for state assistance under this subchapter the services provided to each person who is an eligible resident under a standard that incorporates a net income eligibility level that is less than [fifty] percent of the federal poverty level based on the federal Office of Management and Budget poverty index. *Id.*

F. *House Bill 3154—Indigent Health Care Review Committee*

H.B. 3154, authored by State Rep. Jodie Laubenberg and co-authored by State Rep. Jim Jackson, created a committee to study the potential for a “regional health care system in certain counties.”¹⁰⁶ H.B. 3154 was signed by the governor on June 15, 2007 and went into effect on September 1, 2007.¹⁰⁷ The bill was enacted in response to the recent discussion of “regionalization of indigent health care throughout the State.”¹⁰⁸ The Health and Human Services Committee recognized that while regionalizing indigent health care is a potential solution to the state’s health care situation for indigents, other alternatives should be explored.¹⁰⁹ The goal of H.B. 3154 is to explore what those options may be by working with county hospitals and local county governments.¹¹⁰

The counties of Region Three, created by the Department of State Health Services, will be the focus of H.B. 3154’s review committee.¹¹¹ Region Three includes: “Collin, Cooke, Dallas, Denton, Ellis, Erath, Fannin, Grayson, Hood, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rockwall, Somervell, Tarrant and Wise counties.”¹¹² The review committee is directed to issue a report on its findings by September 1, 2008.¹¹³ The report will summarize committee hearings, studies, any leg-

106. TEXAS HOSP. ASS’N, CAPITOL UPDATE, A SUMMARY OF THE 80TH TEXAS LEGISLATURE 9 (2007).

107. Texas Legislature Online, <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=80R&Bill=HB3154> (last visited Mar. 1, 2008) (detailing the action of the proposed bill during the 80TH Texas legislative session).

108. HOUSE COMM. ON PUBLIC HEALTH, BILL ANALYSIS, Tex. H.B. 3154, 80th Leg., R.S. (2007) (“Much discussion of late has centered around the regionalization of indigent health care throughout the state.”).

109. *Id.* (“However, the discussion should include both public hospitals and local county officials. While regionalized health is a possible solution to the state’s indigent health care situation, all options should be explored.”).

110. *Id.* (“Accordingly, CSHB 3154 seeks to encourage such study by establishing a regional health care systems review task force, which would include the local county governments and county hospitals.”).

111. Tex. H.B. 3154, 80th Leg., R.S. (2007) (stating the purpose of the act is “the creation of a review committee to study the potential for a regional health care system in certain counties”).

112. HOUSE COMM. ON PUBLIC HEALTH, BILL ANALYSIS, Tex. H.B. 3154, 80th Leg., R.S. (2007); TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 37 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“[Dallas] county’s only public hospital, Parkland Health and Hospital System, which provides [fifty] percent of the care to the uninsured, is facing overcrowding as more uninsured patients resort to emergency-room care.”).

113. Tex. H.B. 3154, 80th Leg., R.S. (2007) (“Not later than September 1, 2008, the committee shall issue a report summarizing: (1) hearings conducted by the committee; (2) studies conducted by the committee; (3) any legislation proposed by the committee; (4) and any other findings or recommendations of the committee.”).

isolation proposed, and other findings or recommendations.¹¹⁴ H.B. 3154 requires the review committee to submit their report to the state's highest government officials by December 1, 2008.¹¹⁵ Dallas County, the largest county in Region Three, encompasses the second largest number of uninsured residents in the state, with 23.7% of its population uninsured.¹¹⁶

III. LEGAL ANALYSIS

The 2007 FPL threshold income level for a family of four is \$20,650.¹¹⁷ If an American family's income is equal to or less than \$20,650, then the family is classified as living in poverty. Twenty-one percent of \$20,650 is \$4336.50. If a Texas family of four earns a yearly net income equal to or less than \$4336.50, provided the household can meet the applicable resource requirements, only then is the family eligible to receive health care

114. HOUSE COMM. ON PUBLIC HEALTH, BILL ANALYSIS, Tex. H.B. 3154, 80th Leg., R.S. (2007) ("The committee may also accept certain funds to carry out its functions, and it is required to issue a report on its findings, recommendations and legislative proposals, no later than September 1, 2008.").

115. Tex. H.B. 3154, 80th Leg., R.S. (2007) ("Not later than December 1, 2008, the committee shall submit a copy of the summary report to the governor, the lieutenant governor, and the speaker of the house of representatives.").

116. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 37 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> ("Dallas County, with 23.7[%] of its residents uninsured, has the second-highest number of uninsured in Texas. Dallas County has about an equal population of Hispanic and non-Hispanic white individuals, at 35.6[%] and 38.4[%] respectively. African-Americans are 20.1[%] of the population, while 4.7[%] are Other.").

117. U.S. Dep't of Health & Human Servs., The 2007 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure, <http://aspe.hhs.gov/poverty/07poverty.shtml> (last visited Mar. 1, 2008) (stating that the FPL threshold income level for a family of four in the forty-eight contiguous states and the District of Columbia is \$20,650). The following chart displays the Department of Health and Human Services' 2007 Poverty Guidelines:

2007 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,210	\$12,770	\$11,750
2	13,690	17,120	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	39,750
For each additional person, add	3,480	4,350	4,000

Id.

through the CIHCP.¹¹⁸ This extremely low income level is also the standard that hospital districts must follow unless the districts choose to implement less restrictive standards, as noted earlier.¹¹⁹

Because the Texas Constitution does not define “needy inhabitants” or “needy persons” for purposes of providing indigent health care, the Department defines “needy inhabitants” and “needy persons” as people living at less than one-fourth of the FPL. In other words, by way of the Department’s rules and regulations regarding indigent care, “needy inhabitants” and “needy persons” is now preceded by a word that is not expressly mentioned in the text of the constitution: that word is “desperately”.

A. *The United States Constitution—No Fundamental Right to Health Care*

Fundamental rights are those rights that are either “explicitly or implicitly guaranteed by the Constitution.”¹²⁰ Rights which have been recognized as fundamental include: the right to vote, right to procreate, right to engage in interstate travel, rights guaranteed in the First Amendment, and rights of personal privacy.¹²¹ Currently, the U.S. Supreme Court does not recognize a positive right to health care in the U.S. Constitution,

118. TEX. HEALTH & SAFETY CODE ANN. § 61.006 (b) (Vernon 2007) (stating that \$4336.50 is the minimum net income for a family of four required for CIHCP eligibility, because \$4336.50 is twenty-one percent of the 2007 FLP).

119. *Id.* §§ 61.052(a)(1)-(2).

120. *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1 (1973) (discussing the Court’s view on fundamental constitutional rights).

Thus, the key to discovering whether education is “fundamental” is not to be found in comparisons of the relative societal significance of education as opposed to subsistence or housing. Nor is it to be found by weighing whether education is as important as the right to travel. Rather, the answer lies in assessing whether there is a right to education explicitly or implicitly guaranteed by the Constitution. *Id.* at 33.

121. *Massachusetts Bd. of Ret. v. Murgia*, 427 U.S. 307, 313 (1976) (citing precedent on what constitutes a fundamental right); *e.g.*, *Roe v. Wade*, 410 U.S. 113, 152 (1973) (“[T]he Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.”); *Bullock v. Carter*, 405 U.S. 134, 142 (1972) (“[T]he Court held that Virginia’s imposition of an annual poll tax not exceeding \$1.50 on residents over the age of 21 was a denial of equal protection.”); *Shapiro v. Thompson*, 394 U.S. 618, 629 (1969) (“[T]he nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement.”); *Williams v. Rhodes*, 393 U.S. 23, 30 (1968) (“[F]reedom protected against federal encroachment by the First Amendment is entitled under the Fourteenth Amendment to the same protection from infringement by the states.”); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (“We are dealing here with legislation which involves one of the basic civil rights of man. Marriage and procreation are fundamental to the very existence and survival of the race.”).

nor does the Court acknowledge that the government has an obligation to provide health care.¹²² The Court's reluctance to recognize basic social and economic needs as fundamental rights is wholly inconsistent with its "progressive" view on political and civil rights.¹²³ Fundamental constitutional interpretation may be one reason to explain the Court's inconsistent treatment of health care; the Constitution does not grant social welfare rights, such as the right to health care, and the Court is hesitant to supplant its judgment with text of the Constitution.¹²⁴

State courts echo a similar sentiment. In 1982, the New Jersey Supreme Court ruled that no fundamental right to health exists under the New Jersey Constitution or the U. S. Constitution.¹²⁵ The New Jersey Supreme Court held that New Jersey "accords a high priority to the preservation of health," but it declined to characterize health as a fundamental right.¹²⁶ American courts' refusal to recognize health care as a fundamental right significantly impacts impoverished Texans.¹²⁷ Not only

122. William P. Gunnar, *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 *ANNUALS HEALTH L.* 151, 177–78 (2006) ("The foundation of the U.S. health care system as embodied by the U.S. Constitution, Supreme Court jurisprudence, state constitutions, and federal and state statutes will never support universal health care.").

123. Ann I. Park, Comment, *Human Rights and Basic Needs: Using International Human Rights Norms to Inform Constitutional Interpretation*, 34 *UCLA L. REV.* 1195, 1253–54 (1987).

In the area of civil and political rights, American law is very progressive by international standards. Indeed, many of the civil and political guarantees enshrined in international human rights instruments were originally modeled after the American Bill of Rights. However, in the realm of social and economic rights, the United States has remained relatively backward. American constitutional law is still a long way from expressly recognizing the principle that government has a positive obligation to fulfill basic needs. *Id.*

124. *Id.* at 1254 ("The fundamental obstacle is the problem of interpretation, given that the Constitution itself does not provide for social welfare rights and there is little hope of so amending it."). "Courts must engage in 'noninterpretive review' to recognize a constitutionally mandated duty on the part of government to provide basic needs." *Id.*

125. *Right to Choose v. Byrne*, 450 A.2d 925, 934 (N.J. 1982) ("Although we decline to proceed as far as the Chancery Division in declaring that the New Jersey Constitution guarantees a fundamental right to health . . . we recognize that New Jersey accords a high priority to the preservation of health.").

126. *Id.*

More than 70 years ago, Chancellor Pitney recognized that [a]mong the most [important] of personal rights, without which man could not live in a state of society, is the right of personal security, including "the preservation of a man's health from such practices as may prejudice or annoy it," a right recognized, needless to say, in almost the first words of our written Constitution. *Id.*

127. Dana Derham-Aoyama, Comment, *U.S. Health Care Reform: Some Lessons from Japanese Health Care Law and Practice*, 9 *TEMP. INT'L & COMP. L.J.* 365, 368 (1995) ("The purest model of a predominantly private health insurance system can be found in the

does this refusal deny access to health care for those who are unable to afford it, but it also allows that denial to survive an Equal Protection or Due Process challenge under federal and state constitutions.

Pursuant to the U.S. Constitution, a statutory classification is examined under strict scrutiny if the classification implicates a fundamental right.¹²⁸ Strict scrutiny analysis requires that the state demonstrate a compelling need to justify the legislation and no “less restrictive alternative” will achieve that objective.¹²⁹ Undoubtedly, if health care was recognized as a fundamental right, the current version of the Indigent Health Care and Treatment Act would not survive strict scrutiny review under an Equal Protection or Due Process challenge.

Conversely, if a statutory classification does not implicate a fundamental right, then it must only be “rationally related to a legitimate governmental purpose to survive an equal protection challenge.”¹³⁰ Rational basis review of legislative action takes place on a “hypothetical plane.”¹³¹ Two U.S. Supreme Court cases that are most cited to illustrate rational basis analysis reflect this view: *Williamson v. Lee Optical of Oklahoma* and *FCC v. Beach Communications*. *Lee Optical* stated that “it might be thought that the particular legislative measure was a rational way to cor-

United States.”). “Employers buy private health insurance for employees and their dependents, while the government may offer coverage for those individuals not covered through an employer.” *Id.*

128. *Flores v. State*, 215 S.W.3d 520, 525 (Tex.App.—Beaumont 2007, pet. granted) (“Under the federal constitution, a statutory classification is evaluated under strict scrutiny if it implicates a fundamental right or discriminates against a suspect class.”).

129. *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 439–41 (1985) (“The Equal Protection Clause of the Fourteenth Amendment commands that no State shall ‘deny to any person within its jurisdiction the equal protection of the laws,’ which is essentially a direction that all persons similarly situated should be treated alike.”); *Chamber of Commerce of U.S. v. State*, 445 A.2d 353, 367 (N.J. 1982) (emphasizing the level of judicial scrutiny a law must pass if it implicates a fundamental right in order to be constitutionally permissible).

130. *Walker v. State*, 222 S.W.3d 707, 711 (Tex.App.—Houston [14th Dist.] 2007, pet. ref’d) (illustrating the different level of judicial scrutiny for non-fundamental right analysis).

If a statutory classification does not interfere with a fundamental right or discriminate against a suspect class, it need only be rationally related to a legitimate governmental purpose to survive an equal protection challenge. This is the “rational basis test.” Those attacking the rationality of a legislative classification have the burden to negate every conceivable basis that might support it. *Id.*

131. Jacob Press, Comment, *Poor Law: The Deficit Reduction Act’s Citizenship Documentation Requirement for Medicaid Eligibility*, 8 U. PA. J. CONST. L. 1033, 1057 (2006) (“The Court concludes that ‘it might be thought’ that the Oklahoma statute was a rational response to the desire to ensure that citizens had regular eye examinations; the statute is, accordingly, upheld.”). “The *Lee Optical* rational basis review thus takes place entirely on a hypothetical plane.” *Id.*

rect it,”¹³² while *Beach* added that “a legislative choice is not subject to courtroom fact-finding and may be based on rational speculation unsupported by evidence or empirical data.”¹³³ These statements by the Court make it clear that the overwhelming majority of constitutional challenges to laws fail under rational basis review.

Not only is legislative action that interferes with a fundamental right reviewed under strict scrutiny analysis, but also legislative action that discriminates against a suspect class is subjected to strict scrutiny analysis.¹³⁴ Unfortunately for impoverished Texans, financial need alone does not identify “a suspect class for purposes of equal protection analysis.”¹³⁵ However, it cannot be denied that each denial of primary health care to an “indigent creates a wealth classification” as compared to a non-indigent who is able to pay for primary medical care.¹³⁶ Moreover, courts hold that:

In the area of economics and social welfare, a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some “reasonable basis,” it does not offend the Constitution simply because the classifi-

132. *Williamson v. Lee Optical of Okla.*, 348 U.S. 483, 487–88 (1955). (“The Oklahoma law may exact a needless, wasteful requirement in many cases. But it is for the legislature, not the courts, to balance the advantages and disadvantages of the new requirement.”).

133. *FCC v. Beach Comm’n*, 508 U.S. 307, 315 (1993) (illustrating the great deference courts afford state action which does not implicate fundamental rights or discriminates against a suspect class of persons). The Court later stated that Equal Protection is not vehicle by which the Court can judge the intelligence of the legislature or their actions. *Id.* at 313. “The Constitution presumes that, absent some reason to infer antipathy, even improvident decisions will eventually be rectified by the democratic process and that judicial intervention is generally unwarranted no matter how unwisely we may think a political branch has acted.” *Id.* at 314.

134. *See Smith v. State*, 149 S.W.3d 667, 670–71 (Tex. App.—Austin 2004, pet ref’d.) (“A statute is evaluated under strict scrutiny if it implicates a fundamental right or discriminates against a suspect class.”). “A statutory classification that does not discriminate against a suspect class need only be rationally related to a legitimate governmental purpose to survive an equal protection challenge.” *Id.*

135. *Cf. Harris v. McRae*, 448 U.S. 297, 323 (1980) (emphasizing that financial status does not create a suspect class for purposes of constitutional equal protection analysis).

The equal protection component of the Fifth Amendment prohibits only purposeful discrimination, and when a facially neutral federal statute is challenged on equal protection grounds, it is incumbent upon the challenger to prove that Congress ‘selected or reaffirmed a particular course of action . . . [for the purpose of adversely affecting] an identifiable group.’ *Id.* at 323.

136. *See Maher v. Roe*, 432 U.S. 464, 471 (1977) (“In a sense, every denial of welfare to an indigent creates a wealth classification as compared to non-indigents who are able to pay for the desired goods or services.”). “But this Court has never held that financial need alone identifies a suspect class for purposes of equal protection analysis.” *Id.*

cation “is not made with mathematical nicety or because in practice it results in some inequality.” “The problems of government are practical ones and may justify, if they do not require, rough accommodations-illogical, it may be, and unscientific.” “A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.”¹³⁷

It is clear that courts give a great amount of deference to state action in the area of economic and social welfare, and if there is some rational basis for the state action, then it is constitutionally sound. The U.S. “[C]onstitution does not provide judicial remedies for every social and economic ill,” and courts have consistently given states wide latitude in deciding how to allocate limited public funds.¹³⁸ Moreover, under rational basis analysis, legislative action is not unconstitutional “merely because the classifications made by its laws are imperfect.”¹³⁹

B. *A Fundamental Right to Health Care? The United States Stands Alone*

A fundamental right to health care is not merely an aspiration without a solid foundation; nor is it simply an issue that serves as a good topic for a constitutional and social welfare debate. Rather, it is an idea that is widely accepted in the international community.¹⁴⁰ In fact, the United States is one of the few industrialized nations that does not recognize a fundamental right to health care, and it is the *only* democracy that does

137. See *Dandridge v. Williams*, 397 U.S. 471, 485 (1970) (quoting *McGowan v. Maryland* 366 U.S. 420, 426 (1961); *Metropolis Theatre Co. v. City of Chicago*, 228 U.S. 61, 69–70 (1913); *Lindsley v. Natural Carbonic Gas Co.*, 220 U.S. 61, 78 (1911)). Although these cases involve state regulation of business or industry, the constitutional standard is the same for the administration of public welfare assistance. *Id.*

138. See *Maher*, 432 U.S. at 479 (highlighting the great amount of deference the Court affords states in matters of social and economic legislation). “Our cases uniformly have accorded the States a wider latitude in choosing among competing demands for limited public funds.” *Id.* “Our conclusion . . . is not based on a weighing of its wisdom or social desirability, for this Court does not strike down state laws because they may be unwise, improvident, or out of harmony with a particular school of thought.” *Id.*

139. See *Dandridge*, 397 U.S. at 485 (“The administration of public welfare assistance . . . involves the most basic economic needs of impoverished human beings. We recognize the dramatically real factual difference between the cited cases and this one, but we can find no basis for applying a different constitutional standard.”).

140. W. Kent Davis, *Answering Justice Ginsburg’s Charge That the Constitution is “Skimpy” in Comparison to Our International Neighbors: A Comparison of Fundamental Rights in American and Foreign Law*, 39 S. TEX. L. REV. 951, 952–977 (1998) (“In addition to generally citing other national constitutions, [Justice Ginsburg] stated that most of the modern international declarations of human rights have also called for the guarantee of such fundamental rights as housing, employment, and health care.”).

not provide universal health care to its citizens.¹⁴¹ Furthermore, international human rights law views health care as a fundamental right.¹⁴² Also, several international declarations acknowledge that an inherent human right to health exists.¹⁴³

In 1946, the World Health Organization adopted its constitution and declared that the “enjoyment of the highest attainable standard of health be a fundamental right recognized by the international community.”¹⁴⁴ To that end, in 1948 the United Nations adopted the “Universal Declaration of Human Rights.”¹⁴⁵ Article 25 of the Declaration states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing,

141. Gwendolyn L. Pulido, Comment, *Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care*, 2 SCHOLAR 323, 328–29 (2000) (noting that the United States appears to be behind the times regarding the concept of universal health care).

Under the United States Constitution, no right to health care has ever been found by the United States Supreme Court, nor is there an affirmative governmental obligation to provide health care. Among industrialized nations, the United States is one of the few that does not grant its citizens health care as a fundamental right. Among democracies, the United States stands alone in its failure to recognize universal entitlement to medical care. *Id.*

142. Jason B. Saunders, Note, *International Health Care: Will the United States Ever Adopt Health Care for All? – A Comparison Between Proposed United States Approaches to Health Care and the Single-Source Financing Systems of Denmark and the Netherlands*, 18 SUFFOLK TRANSNAT’L L. REV. 711, 713–14 (1995) (“International human rights law supports health care as a social welfare right. Health care systems are committed to values of equity and social justice. International law provides for the right of everyone to the highest attainable standard of physical and mental health, naming health care as a right essential to human dignity.”).

143. Gwendolyn L. Pulido, Comment, *Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care*, 2 SCHOLAR 323, 326–27 (2000) (recognizing that human health is an important concept from the past and now). “Historically, several international declarations have acknowledged the inherent human right to health.” *Id.* “In 1946, the World Health Organization (WHO), an international organization responsible for the formulation of standards to protect and promote human health, defined the fundamental right to health in its Constitution as the ‘enjoyment of the highest attainable standard of health.’” *Id.*

144. Satvinder Juss, Symposium, *Global Environmental Change: Health and the Challenge for Human Rights*, 5 IND. J. GLOBAL LEGAL STUD. 121, 149–50 (1997) (emphasizing the World Health Organization’s view that each person should have access to health care). “The WHO also emphasizes the importance of health promotion, defined as ‘the process of enabling people to increase control over, and to improve, their health.’” *Id.*

145. Gwendolyn L. Pulido, Comment, *Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care*, 2 SCHOLAR 323, 327 (2000) (“[I]n 1948, the United Nations adopted the Universal Declaration of Human Rights (Universal Declaration), [which is] regarded as one of the primary sources of international standards of fundamental rights.”).

housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.¹⁴⁶

Proponents for recognizing a fundamental right to health care cite the Declaration as a basis to criticize Congress and the courts' reluctance to establish or recognize a fundamental right to health care.¹⁴⁷ While a constitutional fundamental right has a different meaning than that intended by the United Nations, General Comment 14 to the Declaration states that the "right to primary health care is one of the 'most basic obligations assumed by a state that becomes a party to the Covenant.'"¹⁴⁸ Much more than an enumeration of lofty goals for international human rights, the Universal Declaration serves as the "status of customary international law in many respects, and thus has been recognized as legally binding in many countries."¹⁴⁹

In addition to the international community's recognition of a fundamental human right to health care, four American presidents proposed national health care plans premised on the fundamental right to health

146. Universal Declaration of Human Rights, G.A. Res. 217A (III) art. 25 § (1) (Dec. 10, 1948).

Now, Therefore THE GENERAL ASSEMBLY proclaims THIS UNIVERSAL DECLARATION OF HUMAN RIGHTS as a common standard of achievement for all peoples and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and effective recognition and observance, both among the peoples of Member States themselves and among the peoples of territories under their jurisdiction. *Id.*

147. Levi Burkett, Commentary, *Medical Tourism: Concerns, Benefits, and the American Legal Perspective*, 28 J. LEGAL MED. 223, 241 (2007) ("[C]ommentators have looked to the language of the U.N. treaty [The International Covenant of Economic, Social and Cultural Rights (ICESCR)] to critique the United States' policy towards the right to health care.").

148. *Id.* at 241 ("General Comment 14 states that a right to primary health care is one of the 'most basic obligations assumed by a state that becomes a party to the Covenant.'"). "Yet, despite this unequivocal language, both Congress and the courts have refused to establish or recognize, respectively, a fundamental right to health care." *Id.*

149. W. Kent Davis, *Answering Justice Ginsburg's Charge That the Constitution is "Skimpy" in Comparison to Our International Neighbors: A Comparison of Fundamental Rights in American and Foreign Law*, 39 S. TEX. L. REV. 951, 976-77 (1998) ("Even U.S. case law and legal commentaries have recognized that a large number of norms found in the Universal Declaration have achieved customary international law status, such as the prohibitions against torture, arbitrary detention, summary execution, cruel or inhuman treatment, genocide, and systematic racial discrimination.").

care.¹⁵⁰ In 1912, President Theodore Roosevelt championed a national universal health care system to no avail.¹⁵¹ Next, in the latter part of the 1930s President Franklin D. Roosevelt proposed a form of national health insurance which was rejected.¹⁵² Then in 1948, President Harry Truman again proposed a national health insurance plan which met heavy resistance from the American Medical Association and was ultimately defeated.¹⁵³ The last presidential effort to create a universal health care plan was put forth by President Bill Clinton in the early 1990s. Despite strong public support, President Clinton's plan was also defeated.¹⁵⁴

Commentators assert that the different views on access to health care in the United States and European countries can be analogized to the conflict between a privilege and a right.¹⁵⁵ The former being the position of the United States while European countries adhere to the latter.¹⁵⁶

150. Gary A. Benjamin & Shaakirrah R. Sanders, *Michigan's Duty to Provide Access to Health Care*, 6 J. L. Soc'y 1, 22-23 (2005) ("As other industrialized countries have developed comprehensive systems of social health care insurance, the United States continues to debate 'the appropriate role of government in medicine and in health care.' In the twentieth century, four United States presidents proposed some type of national health care plan."). The article explains Canada's universal health care plan started with one province and soon became a national practice; the article compares Canadian success with the United States's failed efforts that began almost 100 years ago and continue today. *Id.* at 21-22.

151. *Id.* at 23 (indicating America's initial efforts to gain universal health care).

152. *Id.* (exemplifying the consistent defeat of national health care proposals). "In the late 1930s, President Franklin D. Roosevelt also proposed some form of national health insurance; both [Truman's and Roosevelt's] plans were defeated." *Id.*

153. *Id.* (detailing how after over four decades of defeated national health plans the only thing to emerge was public health insurance).

Then in 1948, President Truman's proposal for national health insurance was defeated by the American Medical Association's public relations and lobbying campaign. In the subsequent decades, private health insurance emerged, as well as advocacy for public health insurance for the elderly and the poor, which resulted in the passage of Medicare and Medicaid in 1965. *Id.*

154. *Id.* at 24 (showing that even after the public agreed with a national health plan, another presidential proposal was lost). "Finally, in the early 1990s, President Clinton's proposal for universal health care was defeated, despite strong support from the public." *Id.*

155. Robert F. Rich, *Health Policy, Health Insurance and the Social Contract*, 21 COMP. LAB. L. & POL'Y J. 397, 399 (2000).

Historically, the United States and other major "Western democracies" have differed substantially in their conception of appropriate health care policies and in their perspectives on what the appropriate role of government is in the development of the health care delivery system, as well as the logic and assumptions, which provide the foundations for these policies. The legal "right" to health care is at the core of these differences. *Id.*

156. *Id.* ("In the United States, health care is considered to be a privilege, which is usually expressed as a benefit of employment, while in Europe it is considered to be a

However, this assertion is misguided. A *Gallup Poll* conducted in 1938, roughly the same time that President Franklin D. Roosevelt's national health insurance plan was defeated, showed that eighty-one of Americans believed that "government should be responsible for medical care for people who can't afford it."¹⁵⁷ While some may argue that this figure is a result of the hardships Americans endured during the Great Depression, a *Gallup Poll* result fifty years later serves to dispel that notion. That poll revealed that eighty percent of Americans felt that the government should provide health care for those that are unable to afford it.¹⁵⁸ Contrary to the suggestion that the United States views health care as a privilege, it appears that "[t]he belief that health care is a right is deeply ingrained in the American consciousness, especially [the] government's obligation to ensure health care for those who are too poor to pay for it"¹⁵⁹

C. *Is there a Fundamental Right to Health Care in Texas? No.*

Despite the U.S. Supreme Court's refusal to recognize that the Constitution guarantees a fundamental right to health care, Texas is free to provide such a right to its residents.¹⁶⁰ However, Texas refuses to grant this right. Because no fundamental right to health care exists in Texas, the

'right' of citizenship."). The article strives to look at the latter difference through the scope of the "social contract," which is the implicit agreement between the state and its people that defines tax-based benefits. *Id.* at 397. While claiming that the social contract has been devastated by weakness and difficulty in the United States, this article holds that Europe's embrace of the contract is partly responsible for universal health care. *Id.* at 398.

157. Ezekiel J. Emanuel & Linda L. Emanuel, *Preserving Community in Health Care*, 22 J. HEALTH POL. POL'Y & L. 147, 166 (1997) ("A 1938 *Gallup* poll reported that [eighty-one] percent of adults nationwide believed that 'government should be responsible for medical care for people who can't afford it.'"). It is engrained in Americans' consciousness that healthcare is a right. *Id.* If an individual cannot pay for health care, then it is the government's responsibility to provide it. *Id.*

158. *Id.* ("Fifty-three years later the number was [eighty] percent—a remarkably stable conviction."). "DYG's annual trend study also shows that more than three-quarters of the public consistently express the conviction that 'access to health care should be a fundamental right.'" *Id.*

159. *Id.* (illustrating that the majority of Americans believe that health care is a fundamental right, dispelling the notion that American view access to health care as a privilege). Americans do not tend to view matters of justice and their rights as marketable commodities, and as such should not be based on an individual's ability to pay. *Id.* To base the right to health care on the ability to pay for it would "undermine the value of justice." *Id.*

160. Gary A. Benjamin & Shaakirrah R. Sanders, *Michigan's Duty to Provide Access to Health Care*, 6 J. L. Soc'y 1, 10 (2005) ("Even though the United States Supreme Court declined to recognize a universal right to health care under the federal constitution, Michigan is free to guarantee such a right under its own constitution."). Unlike Texas, the state of Michigan expressly provides for the concern of the public health. While this concern

state's impoverished residents are forced to "accept the services available to them."¹⁶¹

The Texas Department of State Health Services is responsible for deciding what medical services are available to indigent population of Texas and more importantly, which residents comprise that population.¹⁶² As discussed earlier, the Department promulgated stringent income eligibility standards (one-fourth of the FPL) to determine who may receive indigent care.¹⁶³ As a result, Texas residents must meet these standards in order to receive what most of the world and Americans consider an unqualified right.¹⁶⁴ Under the current CIHCP income eligibility standards, primary health care for most impoverished Texans is neither a privilege, nor a right; it is virtually unattainable. Fundamental rights aside, the present income eligibility standard set forth by the Department is wholly inconsistent with the Texas Constitution.

D. *From Needy Inhabitants to Desperately Needy Inhabitants*

In order to fully grasp the nature of this inconsistency, it is necessary to revisit Article IX, §§ 4 and 9 of the Texas Constitution. As noted earlier, these sections provide for the creation of county-wide hospital districts and hospital districts without regard to county lines. Article IX, § 4 states "that such Hospital District shall assume full responsibility for providing medical and hospital care to needy inhabitants of the county. . . ."¹⁶⁵ The constitutional language is clear. County-wide hospital districts are constitutionally mandated to provide medical care to their needy inhabitants. Additionally, Article IX, § 9 states "that any district so created shall as-

does not mandate universal health care, it does purport to place health care as a priority. *Id.* at 13.

161. Gwendolyn L. Pulido, Comment, *Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care*, 2 SCHOLAR 323, 349 (2000) (noting that individuals should be grateful for free healthcare, no matter what it entails). "Because health care is not a fundamental right, the indigent seem to be forced to accept the services available to them, regardless of the quality, because they are free." *Id.*

162. TEX. HEALTH & SAFETY CODE ANN. § 61.006(a) (Vernon 2007) ("The department shall establish minimum eligibility standards and application, documentation, and verification procedures for counties to use in determining eligibility under this chapter.").

163. *Id.* § 61.006(b) (noting the rigid twenty-one percent requirement established by the Texas Department of State Health Services).

164. Anne Marie Kilday, *Mental Health Crisis Called 'Acute' / Urban League Leader Concerned About Issues Faced by Black Residents*, HOUS. CHRON., June 15, 2005, at B4 ("One of every 32 uninsured Americans lives in Harris County," Moore said, and she added that [twenty-six] percent of Harris County residents have no health insurance. Moore also said Texas ranks 49th among the 50 states in state funding for health care programs.").

165. TEX. CONST. art. IX, § 4 (stressing a county-wide hospital district's duty to provide health care to the needy inhabitants of the county).

sume full responsibility for providing medical and hospital care for its needy inhabitants. . . .”¹⁶⁶ Again, the constitutional language is clear. Hospital districts are unequivocally required to provide medical care to the needy inhabitants who reside within their boundaries. To further illustrate this duty, a 2000 Texas attorney general opinion referred to a hospital district’s duty to provide medical care to its needy inhabitants as “absolute.”¹⁶⁷

While Texas attorneys general have consistently recognized that a hospital district’s duty to provide medical care to its needy inhabitants is absolute,¹⁶⁸ who compromises the district’s inhabitants remains less clear. On October 1, 1975, Texas Attorney General John L. Hill clarified this issue in an opinion to George N. Rodriguez, Jr., an El Paso County attorney. The opinion addressed a question on the “circumstances under which a hospital district [El Paso County Hospital District] would be liable for the costs of medical care of indigent prisoners.”¹⁶⁹ Attorney General Hill cited the El Paso County Hospital District’s Article IX, § 4 duty to provide medical care to its “needy inhabitants,” and he then referred to Texas case law for the definition of “inhabitant.”¹⁷⁰ Attorney General Hill next addressed the definition of “needy.”

We have discovered no Texas case offering a definition of “needy;” however, it is generally accepted to mean “indigent, necessitous, very poor”. . . . We believe the word “needy” as contained in article 9, sections 4 and 9 should be given its normal meaning, indigent. In our view a translation of indigency into precise income levels involves factual matters.

166. *Id.* § 9 (stressing that hospital districts created by Article IX, § 9 possess the duty to provide health to their needy inhabitants).

167. Op. Tex. Att’y Gen. No. JC-0220, at 5,7 (2000) (“In our opinion, lease of hospital district facilities for the operation of a clinic to provide medical care to county residents, including the needy, is entirely consistent with the requirements of article IX, section 9 of the Texas Constitution.”).

168. *Id.* at 7.

169. Op. Tex. Att’y Gen. No. H-703, at 3042 (1975) (“Where the prisoner is an indigent resident of another hospital district, in our opinion the district of which he is a resident is constitutionally responsible for his care and is liable therefor.”). As the basis for the opinion, Texas Attorney General Hill cites the 1971 Opinion M-870, whereby Texas Attorney General Crawford C. Martin then issued an opinion stating that a hospital district in which an indigent prisoner resides is liable for the medical expenses incurred by treating the prisoner. Op. Tex. Att’y Gen. No. M-870 (1971).

170. *Id.* at 3041 (“‘Inhabitant’ has been held to signify a person who occupies: something more or less permanent, an abode amino manendi, a place where a person lives or has his home, to which, when absent, he intends to return, and from which he has no present purpose to depart.” (citing *Struble v. Struble*, 177 S.W.2d 279, 283 (Tex. Civ. App.-Amarillo 1943, no writ))).

Under article 9, sections 4 and 9, we believe the in the first instance a hospital district should reasonably determine this figure. Where a reasonable standard of indigency is in use by a hospital district, that same standard would be applicable to article 9, sections 4 and 9. Otherwise the district would be classifying similarly situated persons differently, and in the absence of a rational basis would be in violation of the equal protection clause of the [Fourteenth] [A]mendment.¹⁷¹

From October 1, 1975 going forward, hospital districts obtained the discretion to determine which of their residents qualified as indigent, for purposes of complying with their constitutional duty to provide health care to their needy inhabitants. However, the discretion is fettered by the current version of the Act. As discussed earlier, the Act provides guidelines for indigency that hospital districts must follow unless the districts choose to implement less restrictive requirements.¹⁷² Those guidelines state that “[t]he minimum eligibility standards must incorporate a net income eligibility level of 21[%] of the federal poverty level based on the federal Office of Management and Budget poverty index.”¹⁷³ Any guideline that proscribes a net income level of twenty-one of the FPL as the standard for indigency is wholly inconsistent with Article IX, §§ 4 and 9 of the Texas Constitution. Only a constitutional amendment which changes the language of Article IX, Sections 4 and 9 to “hospital districts shall provide medical care to their *desperately* needy inhabitants” could reconcile this inconsistency. No such amendment exists.

E. *From Needy Persons to Desperately Needed Persons*

As previously mentioned, the County Indigent Health Care Program provides health care to indigent Texas residents that do not reside within a hospital district. Article 3, § 51-a (b) of the Texas Constitution grants the Legislature the authority to create programs such as the CIHCP.¹⁷⁴

171. *Id.*, at 3041 (interpreting the constitutional language which created and imposed upon Texas hospital districts the duty to provide health care for their needy inhabitants).

172. TEX. HEALTH & SAFETY CODE ANN. §§ 61.052(a)(1)-(2) (Vernon 2007).

173. *Id.* § 61.006 (b) (reiterating the strict eligibility requirements imposed by the Texas Department of Health Services).

174. TEX. CONST. art. III, § 51-a (b).

The Legislature may provide by General Law for medical care, rehabilitation and other similar services for needy persons. The Legislature may prescribe such other eligibility requirements for participation in these programs as it deems appropriate and may make appropriations out of state funds for such purposes. The maximum amount paid out of state funds for assistance grants to or on behalf of needy dependent children and their caretakers shall not exceed one percent of the state budget. *Id.*

In contrast to the mandatory constitutional provision found in Article IX, §§ 4 and 9, the constitutional language in Article 3, § 51-a (b) is permissive. Language that states “[t]he Legislature may provide . . . medical care” is fundamentally different from the duty imposed on hospital districts by Article IX, §§ 4 and 9, discussed earlier.¹⁷⁵ Yet, the result remains the same for many impoverished Texans—they are needy, but not *desperately needy* to qualify for the benefits of indigent health care.

Furthermore, the Texas Constitution clearly gives the Legislature authority to “prescribe . . . eligibility requirements for participation in [the CIHCP].”¹⁷⁶ While the Legislature possesses the express constitutional authority to set eligibility requirements for state assistance programs like the CIHCP, the Legislature also sets the eligibility standards for hospital districts.¹⁷⁷ This legislative authority is less obvious, but it may be implied from the Legislature’s authority to create hospital districts, *a fortiori*; it stands to reason that the power to create is greater than the power to regulate.

However, no inference is necessary to understand that the phrases “shall assume full responsibility for providing medical and hospital care to its needy inhabitants”¹⁷⁸ and “may provide . . . medical care, rehabilitation and other similar services for needy persons”¹⁷⁹ produce exactly the same result for many impoverished Texans. Hospital districts must, and counties may, provide health care through the CIHCP to Texans living at less than one-fourth of the FPL. The Legislature obviously maintains the authority to remedy this injustice. Thus, in the face of the state’s health care crisis, the Legislature *must* raise the indigent care income standards so that more impoverished Texans without health insurance can receive primary medical care.

175. *Id.* (authorizing the Legislature by means of General Laws the authority to provide for the health care of the poorest citizens of Texas); TEX. CONST. art. IX, §§ 4, 9 (discussing the difference between hospital districts providing medical care and the duties supplied for hospital districts to create health care facilities in Article III, §§ 51 (a) and (b)).

176. *Id.* (enabling the Legislature to prescribe the requirements of eligibility for citizen participation).

177. TEX. HEALTH & SAFETY CODE ANN. §§ 61.052(a)(1)-(2) (Vernon 2007).

178. TEX. CONST. art. IX, §§ 4, 9 (comparing the language in Texas Constitution Article IX, § 4, to the language IX, § 9).

179. TEX. CONST. art. III, § 51-a (b) (empowering the Legislature the authority to provide not just for medical care, but also for rehabilitation and other necessary services).

F. *The Harsh Reality for Impoverished Texans*

“They die sooner. They have more complications. They are more disabled.”¹⁸⁰ The facts are indisputable; people without access to primary health care suffer severe consequences.¹⁸¹ Additionally, an examination of family relationships discloses that “the health of one family member can affect the health and well-being of other family members, even beyond gaining access to care and the obvious diseases.”¹⁸² Moreover, parents suffering from untreated or chronic illnesses display poorer child rearing practices.¹⁸³ Clearly, the lack of access to primary medical care

180. Richard Wolf, *What Does a Health Crisis Look Like? See Houston, USA TODAY*, June 19, 2007, at 1A (“Texas is the case study for system implosion,” says neurosurgeon Guy Clifton, founder of the Houston-area group Save Our ERs.”).

State officials say the biggest problem in Texas is a surging population: about 23.5 million in 2006, up 12.7% from 2000, about twice the national growth rate. Texas’ increase has continued to be fueled by immigrants who cross the nation’s longest border with Mexico. “We have tremendous population growth, and we have to try to keep up with that” says Nora Belcher, senior health adviser to Gov. Rick Perry. *Id.*

181. Darren Barbee, *Are Hospitals Doing Enough Charity Care?*, FORT WORTH STAR-TELEGRAM, July 30, 2006 at A1.

In Tarrant County, there are children who have never been to a doctor and women who cannot afford the follow-up exams they need after mammograms have detected problems. More than 200,000 Tarrant County residents - about fifteen percent of the population - sought no health care when they were sick, according to a 2004 telephone survey by Tarrant County Public Health. The reason: They couldn’t afford it. Texas is the worst in the nation when it comes to health coverage, with 1 in 4 people lacking insurance. *Id.*

182. Dianne Miller Wolman & Wilhelmine Miller, Symposium, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. MED. & ETHICS 397, 401 (2004) (stressing that the consequences of not having access to primary care extend to all members of an uninsured person’s family).

Children with depressed mothers show greater social, behavioral, and academic impairment from infancy through adolescence than do children of non-depressed mothers. Studies that show the direct impact of health insurance for either parent or child on the psychological well-being of the other have yet to be conducted, although the links from insurance to better parental health, to more appropriate parenting practices and healthier children, have been established. *Id.*

Hence, the benefits that result from having access to primary health care spread far beyond the individual receiving treatment and can impact each and every member of the recipient’s immediate family. *Id.*

183. *Id.* (“The studies of health impacts of uninsurance on individuals demonstrate that uninsured adults are more likely to suffer poorer physical and mental health and premature death, which can affect their ability to parent.”). Parents who are suffering from ill health usually have overlapping problems, such as both a physical and mental condition. *Id.* This can lead to poor parenting. *Id.* This problem is particularly prevalent among low-income families, where the uninsured parent cannot afford treatment. *Id.*

creates a ripple effect whereby all members of an impoverished family suffer.¹⁸⁴

According to the American Hospital Association, “Texas has the highest percentage of uninsured adults . . . who say they are in poor or fair health, rather than good or excellent health.”¹⁸⁵ Cora Sylvester’s story illustrates this crisis on a personal level. Sylvester, age 50, of La Porte, Texas waited almost a year to seek medical care after discovering “a lump on her breast because she was poor, uninsured—and busy.” Sylvester added, “It’s always an issue to not have any type of insurance. You feel like you just fell in a hole.”¹⁸⁶ She eventually received treatment, but her long-term diagnosis is questionable. Ms. Sylvester’s plight is not unlike that of many impoverished uninsured Texans.

G. *Income and Health Insurance*

A person’s income level is an accurate indicator of whether that person has health insurance.¹⁸⁷ The Institute of Medicine stated that “[h]ealth insurance coverage is strongly and positively related to income.”¹⁸⁸ Two-

184. *Id.*

Similarly, if parents use health care services, their children are more likely to receive services, too. Several studies have demonstrated that a parent’s lack of connection to the health care system may be a more important barrier to care for the child than his or her own lack of insurance. Uninsured adults, particularly those of racial and ethnic minorities, are more likely to report negative experiences with the health care system, which may in turn affect their attitudes and behavior in seeking care for their children. *Id.*

185. Richard Wolf, *What Does a Health Crisis Look Like? See Houston, USA TODAY*, June 19, 2007, at 1A (highlighting the severity of the health crisis in Texas and its effects on Texas residents).

The large numbers of uninsured and overburdened health care system have consequences: Studies done during the past 25 years indicate that being uninsured is hazardous to your health. The uninsured are more likely to have high infant mortality rates. They are more likely to develop high blood pressure and hypertension. They are less likely to get treatment for trauma. They are less likely to receive timely cancer diagnoses. They are more likely to die from heart attacks. *Id.*

186. *Id.* (“As the Houston area struggles to deal with a rising tide of uninsured, it offers a lesson for the nation: Let the problem get out of hand - to a point where nearly 1 in 3 people have no coverage - and you won’t just have a less healthy population. You’ll have an overwhelmed health care system.”).

187. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 33 (2006), available at <http://www.coderedtexas.org/files/Report.pdf> (correlating that as income level decreases, so does the number of insured decrease). “Health insurance is strongly and positively related to income.” *Id.*

188. *Id.* (providing an example that only fifty-nine percent of families with incomes at fifty percent of FPL or less have all members covered). This statistic is further exemplified by the fact that families with an income of 200% over FPL have at least ninety percent of their families covered. *Id.*

thirds of all uninsured have low income levels.”¹⁸⁹ The Institute of Medicine also found that “[56%] of Americans below the FPL were uninsured during some or part 2001 and 2002, compared with 16[%] of those at 400[%] of the FPL or more.”¹⁹⁰

There is a practical reason behind these percentages. People living below the FPL simply cannot afford private health insurance. An estimated premium for a standard employment-based plan would cost a family living at the poverty level almost half of the family’s income.¹⁹¹ Texas families living at or below the FPL have a choice: pay for food, housing, and other necessities *or* pay for health insurance.¹⁹² In reality, they have no choice at all. Even worse, families that cannot afford health insurance generally have a small number of assets and little, if any, ability to borrow money, if they do in fact face significant medical bills.¹⁹³ Unfortunately,

189. *Id.*

Even though they have low incomes, [seventy-one] percent of the uninsured were employed either full-time or part-time during 2001-2002. In Texas the percentage is slightly higher at [seventy-nine] percent. Unfortunately, many have jobs where health insurance is not offered, and many Texas industries are reducing health care coverage. Workers in construction, manufacturing, and wholesale and retail trade account for more than half of all uninsured Texans. These industries typically offer part-time and seasonal employment, cyclical work patterns with frequent layoffs, and relatively low cash wages and limited non-cash compensation.

190. *Id.* (illustrating the strong correlation between a person’s income level and health insurance coverage).

191. Dianne Miller Wolman & Wilhelmine Miller, Symposium, *The Consequences of Uninsurance for Individuals, Families, Communities, and the Nation*, 32 J.L. MED. & ETHICS 397, 400 (2004) (“The full premium for a typical employment-based plan would cost nearly half the family’s income at the poverty level and one-quarter of family income at 200% FPL.”). Reasons families have uninsured members vary, but may be because the coverage offered at work is nonexistent or cost prohibitive, and finding insurance that is not offered through the employer is still more costly. *Id.* Individuals may also be denied coverage by the insurance carrier due to preexisting conditions or underwriting concerns. *Id.* For example, some insurance companies hesitate to cover “older individuals, workers in high-risk jobs, or those who had certain medical treatments in the past,” and if coverage is offered at all it is at a higher premium. *Id.*

192. *Id.* (“Families at lower income levels often have no choice about purchasing coverage if they are to pay for food, rent, and other necessities.”). “Uninsured families tend to use fewer health services and defer seeking care because of cost concerns.” *Id.* However, delaying treatment until the illness reaches the point of crisis can sometimes be more expensive in the end than visiting the doctor in the early stages of illness, and can lead to less satisfactory outcomes for the patient’s health. *Id.* This is a result of hospitals charging higher prices for emergency room care for uninsured patients because there is no insurance company to negotiate a lower price and because emergency room visits in general tend to be more costly than a visit to a normal doctor’s office. *Id.*

193. *Id.* (“These families also have few assets and little ability to borrow, should they face large medical bills.”). Paying medical bills is even more likely to be a problem for families without insurance coverage than for those families who do have insurance. *Id.* at

many poor Texans are too familiar with the “hole” that Cora Sylvester found herself in when she desperately needed medical care to fight her breast cancer.

H. *Effects of Uninsured Texans on Their Communities*

Furthermore, impoverished Texans without health insurance and access to primary care may not be able to work, due to untreated health problems, thereby rendering them unable to “provide for their families and [unable to] contribute to the State’s economy.”¹⁹⁴ This problem is magnified in the Texas Rio Grande Valley, where job productivity losses connected with diabetes is estimated to be \$228 million a year.¹⁹⁵ It is also estimated that women who have diabetes make \$3584 less per year than women without the disease and men with diabetes make \$1585 less a year than men without diabetes.¹⁹⁶ For diabetics, lacking access to health

400–01. “Those who are uninsured throughout the year on average pay [thirty-five] percent of their medical bills out of pocket.” *Id.* “Among working-age adults with financial problems resulting from medical bills, almost [sixty] percent are currently or were recently uninsured.” *Id.* “Medical bills are a factor in half of all individual bankruptcy filings, but data do not distinguish whether the family had insurance at the time of service.” *Id.*

194. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 22 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“[D]iagnosis of an illness at a more advanced stage generally leads to higher medical costs. These higher medical costs are cross-subsidized by the insured through higher insurance premiums.”).

Children and adults are less likely to receive necessary treatment without insurance, which means the uninsured may be sicker than the rest of us – they cannot get better jobs, and because they cannot get better jobs they cannot afford health insurance, and because they cannot afford health insurance they get even sicker. *Id.* at 54.

In addition, the inability to combat cardiovascular disease, the United States’ leading cause of death, leaves ten million Americans disabled every year, while individuals with diabetes have twice as many sick days as those that do not. *Id.* at 48. Simple screenings could prevent the full effects of these diseases at an early stage and keep people in the work place. *Id.* “[L]ack of health insurance adversely affects access to screening procedures for cancer and high blood pressure as well as other potentially treatable diseases.” *Id.*

195. *See id.* at 55 (explaining that diabetes, which accounts for a health care increase of forty nine percent, affects both the quality and quantity of work). “As the incidence of disease increases, employer costs are greatly impacted, because illness affects both the quantity of work (people might work more slowly than usual, for instance, or have to repeat tasks) and the quality (they might make more – or more serious- mistakes).” *Id.* Although women are not less likely to work than other women with the disease, diabetes ridden men are 10.5% more likely to not work than those without the disease. *Id.*

196. *See id.* at 54–55 (pointing out that on top of differences in salary, many employees also bear other associated medical costs, such as higher premiums and reduced wages due to co-payments/co-insurance fees). Some employers offer “rich” benefits which impacts *all* employee earnings. *Id.* at 54. If employers do offer “rich” benefits, the impact on wages is viewed by employees as a “pay cut.” *Id.* This in turn causes a higher turnover rate. *Id.*

care for long periods of time leads to “uncontrolled blood sugar levels, which, over time, put diabetics at risk for additional chronic disease and disability”¹⁹⁷

While employee absenteeism is easily observed and its effects are readily calculable,¹⁹⁸ a much more difficult problem to monitor is that of *presenteeism*. Presenteeism is the problem that occurs when workers show up for work, but, due to “illness or other medical conditions,” they do not function at full capacity.¹⁹⁹ In fact, presenteeism is estimated to be much more costly than absenteeism, and it can diminish individual productivity by as much as one-third or more.²⁰⁰ The effects of presenteeism are much more likely to be noticeable in jobs that require manual labor. Studies indicate that less productivity is lost from workers

197. *Id.* at 47 (expressing the serious health consequences for diabetics who do not receive adequate medical care).

198. TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 20 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf.

Poor health status was found to be the most significant predictor of missed work compared to other factors such as wage rate, sick leave benefits, family structure, and age. Compared with healthier workers, workers with health problems have two-and-a-half times the risk of having six or more sick days during the year, holding all other factors constant. *Id.*

A substantial source of lost productivity is attributed to the health problems of employees and their families. *Id.* A number of workers report having chronic health problems, which causes missed days from work; however, a substantial number of workers report that they are in good health, but miss work to care for ill or disabled family members. *Id.*

199. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 55 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“Many of the medical problems that result in presenteeism are, by their nature, relatively benign.”). “Research on presenteeism focuses on chronic conditions such as headaches, back pain, arthritis, gastrointestinal disorders and depression.” *Id.* In a Tufts-New England Medical Center study researchers found that even less severe conditions will lead to presenteeism. *Id.* at 55–56. See also TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 21 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf (“‘Presenteeism’ is a term that describes health-related productivity loss while at work. It describes an employee who is present at work, but is limited in some aspect of job performance by personal health-related problems or problems of a family member.”).

200. See TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 55 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“Researchers say that *presenteeism* – the problem of workers’ being on the job, but, because of illness or other medical conditions, not fully functioning – can cut individual productivity by one-third or more.”). Most companies overlook the \$150 billion cost of employees who fail to produce due to everyday ailments such as “hay fever, headaches and even heartburn.” *Id.* In a 2002 study by Lockheed Martin researching twenty-eight serious and benign medical conditions, the company lost \$34 million a year on presenteeism. *Id.* at 55–56.

staying at home than from them coming to work while suffering from health problems.²⁰¹ Staying home and forgoing the wages of an eight-hour workday is not an option for Texans living at or below the FPL.

Moreover, uninsured persons resort to using emergency room services for primary care which has a detrimental effect on hospital trauma centers in the state.²⁰² The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen emergency room patients in order to determine “whether an emergency medical condition exists, and if so, to stabilize the patient regardless of ability to pay.”²⁰³ Since uninsured, impoverished Texans cannot schedule a visit at a clinic

201. *See id.* at 55–56 (“But the illnesses people take with them to work, even though they incur far lower direct costs, usually account for a greater loss in productivity. This is because they are so prevalent, often go untreated and typically occur during peak working years.”). Employers cannot respond to presenteeism, as they do absenteeism, because they often cannot distinguish which employees are ill. *Id.* “Unlike absenteeism, presenteeism is not always apparent. It is possible to know when someone does not show up for work, but one cannot tell when – or how much – illness or a medical condition is hindering an employee’s performance.” *Id.*

202. *See id.* at 51 (“Trauma care in Texas is regionalized. Most of the uninsured Texans live in urban counties where hospital district hospitals both provide most of the indigent care and are the primary source of Level I trauma centers. The growing number of uninsured places these safety net health systems in double jeopardy.”). Trauma centers that care for the uninsured also cater to the community as Level I and II trauma centers. *Id.* When they are over capacity they must divert patients and ambulances to other hospitals. *Id.* “The Texas Hospital Association reports that emergency room diversions are a significant health policy challenge.” *Id.* In 2003 every Texas hospital diverted patients at some time. *Id.* Unfortunately, these trauma centers do not receive adequate compensation from the state to offset what they spend on uninsured patients. *Id.* “In March 2005 . . . \$18 million in state trauma funds was distributed to the 221 eligible and applying hospitals to offset more than \$208 million reported in uncompensated trauma care.” *Id.* at 51–52.

203. The Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. 1395dd(e)(1)(A)(i)-(iii) (2008) (“The term “emergency medical condition” means: (A) 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 (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. . . .”). *See also* The Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. 1395dd(h) (2008) (“A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) of this section or further medical examination and treatment required under subsection (b) of this section in order to inquire about the individual’s method of payment or insurance status.”); TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 50 (2006), available at <http://www.coderedtxas.org/files/Report.pdf> (“The federal Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to screen emergency patients to determine whether an emergency medical condition exists, and if so, to stabilize the patient regardless of ability to pay.”). “While this act

or doctor's office (because clinics and doctors can refuse to see self-pay uninsured patients), they resort to their only option and go to the local trauma center. Once in the emergency room, the EMTALA guarantees that the patient will receive an initial screening to determine whether the patient has a medical condition which warrants additional care.²⁰⁴ Although this statute ensures that people are treated at an emergency room regardless of ability to pay, this is a highly inefficient use of a trauma care center's resources.

Unfortunately, this type of emergency room utilization is on the rise. The Texas Hospital Association reported a "[fifty-five] percent increase in the number of emergency room visits" from 1992 to 2003.²⁰⁵ Further, in 2005, thirty-one percent of 8.6 million emergency room patients were uninsured or on Medicaid.²⁰⁶ These figures demonstrate a direct causal relationship between the rising number of uninsured Texans and the re-

assures access to emergency services, the payments for these services are largely below costs or unfunded." *Id.*

204. The Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. 1395dd(a) (2008).

In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists. *Id.*

See also The Emergency Medical Treatment and Active Labor Act, 42 U.S.C.A. 1395dd(b)(1)(A)- (B) (2008).

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either—within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or for transfer of the individual to another medical facility in accordance with subsection (c) of this section. *Id.*

205. TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 50–51 (2006), available at <http://www.coderedtexas.org/files/Report.pdf> ("In 2002 there were [five] percent fewer emergency departments than in 1999. Also, the increase in limited-service hospitals has resulted in a decrease in emergency room patient capacity.").

206. See *id.* at 50 ("An estimated [thirty-one] percent of trauma patients are either Medicaid or uninsured patients."). Individuals without healthcare will still seek care, but often times in a more costly manner. *Id.* at 46.

Many individuals without health insurance still seek care, but often not in the most cost-effective manner. Since emergency rooms are obligated to evaluate every patient who comes seeking care and offer immediate services if needed, they are often seen as a reliable source of care. Unfortunately, this is an expensive and inefficient way to receive care. *Id.*

sulting strain placed on local trauma centers. Simply put, this trend is not financially sustainable and places trauma care in jeopardy for all Texas residents.²⁰⁷

I. *Texan Tom — A Fictional Character Who Represents a Real Problem*

Texan Tom has a nice family. His wife works part-time so she can spend time with their two children. Tom works full-time earns \$8 an hour.²⁰⁸ His employer does not offer health insurance to its employees.²⁰⁹ Tom's annual family income is usually \$20,000, just under the FPL for a family of four. As a result, he makes too much money to qualify for indigent care, but too little to pay for private health insurance.

Tom has had a bad cough for more than a month. Tom, though feeling ill, continues to go to work.²¹⁰ His boss notices that Tom's production has

Ideally, the individual could simply go to a FQHC in their area. *Id.* "A more cost-effective setting for the uninsured to seek care is through Federally Qualified Health Centers (FQHCs). . . . Unfortunately, less than [ten] percent of the uninsured population in Texas is served by FQHCs." *Id.*

207. *See id.* ("These trends in the utilization of emergency medical care services are not financially sustainable in the long run."). For example, nationwide there is an increase in use, yet the increase in emergency departments has only grown a percent. *Id.* at 50–51.

Findings from the National Hospital Ambulatory Medical Care Survey indicate that there was an increase in use, in terms of annual visits per one-hundred persons, from 36 visits in 1992 to 37.8 visits. Nationwide, the number of emergency departments grew only [one] percent in that time period, from 5,707 in 1992 to 5,769 in 1999. *Id.*

208. TEXAS HEALTH INST., *A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 1* (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf ("[A]t least [seventy-two] percent of Texas uninsured live in households where one or more family members work full-time; another [ten] percent live in households with a family member who works part-time. Most of these individuals work in one of Texas small businesses – those with 2-50 employees."). Because small employers pose a higher risk to insurers than large employers, their insurance premiums are higher; therefore, small businesses cite affordability as the primary reason for not providing health insurance to their employees. *Id.* at 2. The uninsured are young: twenty-three percent of our uninsured are children younger than 18 years of age. An additional [thirty-six] percent are between the ages of 18 and 34 years of age." *Id.* at 1. Many young people do not necessarily see the value of health coverage and do not believe they need it. *Id.* at 3.

209. *Id.* ("Most uninsured Texans lack coverage because their employer does not offer health insurance, they cannot afford the coverage offered, or they are ineligible for employer supported insurance or publicly-funded programs such as [CHIP] or Medicaid. Currently, only [twenty-four] percent of Texas' small businesses offer health coverage."). For those who can afford average individual health insurance premiums, coverage remains inaccessible because they are considered high risk due to their health conditions. *Id.* In these instances, health insurance becomes an issue of both affordability and availability. *Id.*

210. *Id.* at 21 ("Many workers go to work even when they do not feel well or are worried about a family member who is ill. In addition to creating a heightened risk of

been waning lately and confronts him about it. Tom, upset and embarrassed about the incident at work returns home in a bad mood. As a result, Tom and his wife get into an ugly fight during dinner. In fact, Tom and his wife have been fighting frequently during the past two weeks, and it is affecting their children. Instead of spending time with his family when he gets home from work, Tom now goes straight to bed.

Unfortunately, Tom's cough has steadily gotten worse, and five days ago he developed a fever. Four days ago, at the insistence of his wife, Tom tried to schedule an appointment to see a doctor at the local clinic, but the secretary told him that because he did not have health insurance or qualify for Medicaid the doctor would not see him.²¹¹ Last night, Tom's fever reached its peak at 103 degrees. Out of options and desperately ill, Tom's wife drives him to the local emergency room at Texas Memorial Hospital.

The emergency room is crowded. Tom fills out some paperwork and finds a seat in the hall. In the past five years, the number of patients examined in Texas Memorial's emergency room has significantly increased.²¹² Currently, Texas Memorial is struggling financially due to the large number of patients it treats in its emergency room that do not have health insurance. The hospital estimates that one in three patients treated in its ER are self-pay (no health insurance) or on Medicaid. Hospital officials worry that Texas Memorial's emergency room will be unable to provide emergency services if this trend continues much longer.²¹³

injury or a spread of infectious diseases, such presenteeism exacts an economic price . . . in reduced productivity or output.”). Research shows that fifty-five million workers experience an inability to concentrate at work because of personal or a family member's illness. *Id.* From those workers exists a total of 478 million days per year of reduced productivity due to illness. *Id.* “Assuming these workers were working at half-capacity, and based on their average earnings, the economic output not generated during these days would be valued at \$27 billion.” *Id.*

211. *See id.* at 55 (“Without access to regular medical care, these individuals seek needed treatment in hospital emergency rooms, through county indigent care programs or at free clinics.”); TEXAS INST. FOR HEALTH POL. RES., EMERGENCY AND TRAUMA CARE IN TEXAS: POLICY BRIEF 5 (2001) available at <http://www.forumsinstitute.org/publs/texas-briefs/trauma.pdf> (“If Medicaid patients have difficulties accessing primary care, the uninsured have even more trouble. They sometimes have little choice but to use emergency departments as doctors' offices.”).

212. TEXAS INST. FOR HEALTH POL. RES., EMERGENCY AND TRAUMA CARE IN TEXAS: POLICY BRIEF 1 (2001), available at <http://www.forumsinstitute.org/publs/texas-briefs/trauma.pdf> (“In Texas, hospital emergency departments struggle with overcrowding, financial woes and extreme staff shortages.”). “In mid-March, for example, 12 of Houston's largest hospitals were forced to refuse ambulances due to serious overcrowding.” *Id.*

213. *Id.* at 6 (“The bottom line from a financial standpoint is that too many patients in Texas emergency rooms receive care for which nobody wants to pay.”).

After a long wait, an emergency room physician finally examines Tom. A chest x-ray reveals that Tom has pneumonia. Due to the severity of his condition, the doctor admits Tom to the hospital. He tells Tom that, had he seen a doctor last week, antibiotics and rest would have been enough to make him well.²¹⁴ Tom stays in the hospital for two days. During his hospital stay, Tom incurred hospital bills and missed time from work as well. The hospital also expended resources caring for Tom while he was ill. More than likely, the hospital bills will not be paid. His hospital bills will go unpaid *not* because Tom is irresponsible or dishonest, but rather because Tom has a family to care for and cannot afford to do both with his meager earnings.

Although Texan Tom's story is fictional, his circumstances are not. He represents the plight of countless impoverished Texans and the struggles each of them face as consequence of not having access to primary health care. Like Texan Tom, many of these Texans have jobs and work to provide for their families.²¹⁵ Texan Tom's poor health quickly became the problems of others as well. His family was affected, his work production suffered, thereby affecting his employer, and he ultimately ended up at a local trauma center for a condition that should have been treated weeks prior. While this scenario may seem overly simplistic, it paints an accurate picture of the current situation for many impoverished Texans and how their plight affects those around them as well.

J. *House Bill 480*

In the summer of 2007, the Texas Legislature missed an opportunity to improve the quality of life for impoverished Texans. H.B. 480, discussed above, sought to amend the current version of the Indigent Health Care and Treatment Act by raising the indigent health care minimum income standards from twenty-one percent 100% of the FPL.

214. TEXAS HOSP. ASS'N, *A STATE IN CRISIS: HEALTH CARE COVERAGE UNAFFORDABLE 3* (2007), available at <http://sahealth.com/CPM/2007%20A%20State%20in%20Crisis.pdf>.

The lack of health insurance leads to poor health. Compared with the nation, Texas ranks 46th in terms of the health status of the population, and Texans have an especially high incidence of diabetes and heart disease. Uninsured Texans lack access to preventive care that could improve their health and prevent costly disease. *Id.*

215. CTR. FOR PUBLIC POL'Y PRIORITIES, *TEXAS POVERTY 101 at 2* (2007), available at <http://www.cppp.org/files/8/BRP%20Pov101%20Aug%2007.pdf> (asserting that many poor Texans are indeed working and doing so to support their families). "Most poor families with children in Texas are working families." *Id.* "Approximately 1.5 million people, 842,000 of whom are children, live in these worker-headed poor families." *Id.* The low wages attributed to the Texas economy's growth sectors lead to the state's heavy employment yet low-income population. *Id.*

Unfortunately, H.B. 480 was left pending in subcommittee as the 80th Legislative Session ended.²¹⁶ Had the bill passed, many more Texans would have access to primary health care services such as medical screening, annual physical examinations, and payment for up to three prescription drugs per month and immunizations.²¹⁷ Furthermore, the benefits of H.B. 480 would have reached all Texans living at or below the FPL because counties and hospital districts are both required to follow the Act's minimum income requirements.²¹⁸

From 2005 to 2006, an estimated 3.7 million Texans were living in poverty.²¹⁹ Furthermore, an estimated 5.6 million Texans lack basic health insurance coverage.²²⁰ These figures, while viewed in isolation are staggering; however, when examined together, they provide a clearer picture of the relationship between income and health insurance. Simply put, poor people cannot afford health insurance, and the health care crisis in Texas accurately reflects the end result of having such a large percentage of the population living in poverty. To that end, H.B. 480 would have allowed the majority of uninsured poor Texans to receive the primary health they cannot currently afford. H.B. 480 would have improved the lives of impoverished Texans and could have been a major step in restoring the health of the state from critical to stable.

216. TEXAS HOSP. ASS'N, CAPITOL UPDATE, A SUMMARY OF THE 80TH TEXAS LEGISLATURE 9 (2007) (“[H.B. 480] died in a House Public Health Subcommittee.”).

217. TEX. HEALTH & SAFETY CODE ANN. § 61.028 (Vernon 2007).

218. TEX. HEALTH & SAFETY CODE ANN. § 61.006 (Vernon 2007); TEX. HEALTH & SAFETY CODE ANN. § 61.052(a)(1) (Vernon 2007).

219. CTR. FOR PUBLIC POL'Y PRIORITIES, TEXAS POVERTY 101 at 2 (2007), available at <http://www.cppp.org/files/8/BRP%20Pov101%20Aug%2007.pdf> (providing U.S. Census Bureau Population Survey for Texans in poverty in 2005-2006). “Poverty in Texas is more pronounced than in the nation as a whole. The poor are concentrated in the state's largest cities and in the Texas-Mexico border region.” *Id.* “Poverty rates are also much higher for the state's large and growing Latino population and for African-American Texans.” *Id.* In addition to Texas's high poverty rates compared to other states, child poverty in Texas is also higher compared to national rates. *Id.*

220. TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 1 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf (“Texas has the highest rate of uninsured in the nation. More than 5.59 million Texans—nearly [twenty-five] percent of the state's total population—lacks basic health coverage.”). “A nationwide poll conducted by Americans for Health Care reported [eighty-six] percent of Americans support providing affordable healthcare for all Americans.” *Id.*

IV. CONCLUSION

Despite the clear mandate found in the Texas Constitution regarding the state's duty to provide health care to its "needy" residents,²²¹ that duty goes largely unmet. As a result, impoverished Texans bear the brunt of the health care crisis as nearly 2500 uninsured Texans die prematurely each year.²²² Another one million uninsured Texas residents live with chronic illnesses and are forced to go without the health care they desperately need.²²³ Not only do these impoverished Texans lead poorer quality lives, but also the health care crisis affects their communities as well.²²⁴

221. TEX. CONST. art. IX, §§ 4, 9; TEX. CONST. art. III, § 51-a(b) ("The Legislature may provide by General Law for medical care, rehabilitation and other similar services for needy persons. The Legislature may prescribe such other eligibility requirements for participation in the programs as it deems appropriate and may make appropriations out of state funds for such purposes.").

222. See TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 47 (2006), available at <http://www.coderedtexas.org/files/Report.pdf> (acknowledging that uninsured individuals are more likely to die due to a lack of preventative care than those that are insured). "The uninsured receive less preventive care, are diagnosed at more advanced stages of disease, and, once diagnosed, receive less therapeutic care than do the insured. Due to this, the insured suffer from poorer health and are more likely to die early than are those with coverage." *Id.* at 22. A commonplace example of these circumstances leading to premature death is evident in cancer patients. *Id.* at 47.

For those that have access, screening for cancer can be particularly effective. Cancers that can be detected early by screening account for about half of all new cancer cases and include cancers of the breast, colon, rectum, cervix, prostate, oral cavity and skin. In 2005, an estimated 1.3 million people in the United States will be diagnosed with cancer, and over half a million will die of the disease that year. Estimates of the premature deaths that could have been avoided through screening vary depending on a variety of assumptions, but may be as high as [thirty-five] percent. *Id.*

223. See *id.* at 47

The uninsured are more likely to suffer adverse consequences of chronic diseases such as diabetes. More than 1.3 million Texans have been diagnosed with diabetes, and an additional 300,000 are estimated to be undiagnosed, but living with the condition. Conservative estimates rank diabetes as the sixth leading cause of death in Texas and uninsured adults with diabetes are less likely to receive recommended services. *Id.*

224. See *id.* at 47 (explaining that the lack of health care can impact the community by affecting the health care providers and the business and local economies). For example, health care premiums are increasing in order to compensate for these uninsured individuals, thus affecting whole communities. *Id.* at 53.

In Texas, the 2005 health insurance premiums for a family with private, employer-sponsored coverage are \$1,551 higher annually due to the cost of the uninsured. Premiums for individual health insurance coverage are \$550 higher for privately insured Texans in 2005. By 2010, these hidden costs will increase to \$2,786 for premiums for families and \$922 for premiums for individuals. *Id.* at 49.

As it stands, Texas is in a health care crisis.²²⁵ This crisis is fueled by the 5.6 million residents that lack health insurance²²⁶ and the 3.6 million Texans living at or below the FPL.²²⁷ Unfortunately, the number of uninsured residents and Texans living at or below the FPL continues to rise each year.²²⁸ To put it bluntly, the data paints a bleak picture for the future of health care in the state if no action is taken.²²⁹ Furthermore,

225. *See id.* at 20 (“Texas leads the nation in the percentage of uninsured adults, number of uninsured working adults, and the percentage and number of uninsured children.”). “In addition, every major Texas city has a higher uninsured rate than the national average.” *Id.* Also, local governments provide the resources in which Texas so heavily relies. *Id.* at 21. However, the resources available are usually inadequate, and metropolitan hospitals are oftentimes disproportionately affected. *Id.* This demand is met by local residents. *Id.* “Residency programs are fragile nationwide, but Texas is particularly at risk. Texas lags far behind other states in terms of residency positions, with only 5,900, compared to the 14,000 in New York State.” *Id.*

226. TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 1–2 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf (“Every county in Texas has uninsured, but almost half live in Texas’s five largest urban counties: Bexar, Dallas, El Paso, Harris, and Tarrant. The counties whose populations have the highest percent of uninsured however, are along the Texas-Mexico border where between 29 to 34[%] of the residents are uninsured.”).

227. CTR. FOR PUBLIC POL’Y PRIORITIES, TEXAS POVERTY 101 at 2 (2007), available at <http://www.cppp.org/files/8/BRP%20Pov101%20Aug%2007.pdf> (indicating the estimated amount of Texans currently living below the federal poverty level). “The poverty guidelines were originally designed to reflect the minimum amount of income that American households needed to subsist. This amount was derived by multiplying by three the cost of food for each family size.” *Id.* at 1.

Although the poverty guidelines are updated annually for inflation, they are still based on a food-cost-to-income ratio of 1 to 3, despite significant shifts in household expenses. For example, the cost of housing as a share of household income has increased significantly since the 1960s, and families today are more likely to have child care expenses and pay a much higher share of health care costs than was typical in the 1960s. *Id.*

“Because of these weaknesses, critics of the official poverty guidelines—including the Census Bureau itself—have called the measure an antiquated standard that is no longer capable of capturing true economic need.” *Id.* Researchers have been working to develop other ways to measure economic hardship, aside from the poverty guidelines described above. *Id.* at 2

228. *See* TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 42 (2006), available at <http://www.coderedtxas.org/files/Report.pdf>.

Consequently, with an increased number of uninsured, Texas spending on government programs will increase, as will costs to those with coverage. Not only could this lead to an unattractive environment for businesses within the state, but it could also create inaccessible, insufficient and unfulfilling medical services for more than just the uninsured. Increasing health care risks and predictions of Texas funding, demographics, education and business practices must be taken into account to fully understand and ameliorate the current health of Texas. *Id.*

229. *See id.* at 46.

the costs of this crisis are borne by every Texan and its effects are felt in each corner of the state.²³⁰ Undoubtedly this health care crisis poses an enormous challenge for the state,²³¹ but it is a challenge that *must* and can be met.

Moreover, it is a challenge that Texans are ready to meet. Recent polls reveal that a large majority of Texans favor programs that would increase health insurance coverage for those that cannot afford it.²³² Additionally, a majority of Texans support an increase in government funding to expand health coverage for children in low income families, and an increase in funding for programs such as the County Indigent Health Care Program.²³³ Not only would increasing access to primary health care for impoverished, uninsured Texans improve their lives, but also the state would realize benefits as well. In fact, in 2005 economists estimated that

The increasing uninsured population in Texas is also negatively impacting the state and local governments. Emergency rooms are overburdened with the increased admissions, and the uninsured constitute a disproportional share of these admissions. This is leading to increases in the costs of health insurance and the overall delivery of health care services. In addition, local taxes must be used, raising rates for individuals and businesses. Health insurance has become a major expense for businesses, which impacts wages as well as the number of employees. *Id.*

230. *Id.*

231. TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 11 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf.

Where Texans live has important implications for how the state should craft policy solutions and engage in outreach efforts. Half of the state's uninsured live in five large urban counties—Bexar, Dallas, El Paso, Harris, and Tarrant. Ten Texas counties account for almost two-thirds . . . of Texas' uninsured. However, these 10 counties account for only [fifty-eight] percent of the population. When we look at the counties with the highest number of uninsured as a percent of the county's total population, a very different picture emerges. Nine of the 10 Texas counties with the highest percent of uninsured reside along the Texas-Mexico border. Webb County has the highest percent of uninsured in the state with one-in-three residents uninsured. *Id.*

232. *Id.* at 27 (“A poll commissioned by the Texas Hospital Association and released in April 2006 found nearly nine out of 10 Texans agreed with the statement ‘Texas should find a way to increase health insurance among those who need it so that the portion paid by those with health benefits does not continue to increase.’”). Nationwide, as of February 2006, eighty-six percent of Americans supported affordable health insurance for all Americans. *Id.*

233. *Id.* (“Another poll conducted in November 2006 found [seventy-seven] percent approve increased governmental funding for health coverage for children from low-income families and [sixty-nine] percent endorse expanding Medicaid to cover all adults, including single adults, who make less than the federal poverty level.”). One possible reason for why people approve of expanded health care programs is that according to a 2005 study, “annual health insurance premiums for Texas families were about \$1,551 higher than they would otherwise have been due to the cost of caring for uninsured patients.” *Id.* at 1.

by reducing the number of uninsured Texans by half, the state's economy would have benefited by \$9.4 million.²³⁴

While the Texas Legislature declined to increase the indigent health care minimum income eligibility standard to 100% of the FPL during the 80th Legislative Session, another important bill concerning indigent health care passed. On June 15, 2007, Governor Rick Perry signed H.B. 3154, which created a review committee to examine the potential for a regional indigent health care system.²³⁵ Although the committee's focus will be on whether indigent health care should be regionalized and offered state-wide, it is also directed to submit a report to the governor, lieutenant governor, and speaker of the House by December 1, 2008.²³⁶

As part of its report, the committee is required to make recommendations and legislative proposals on how to improve the state's current indigent health care system.²³⁷ Due to the committee's access to the state's highest government officials and its authority to propose legislative change, the committee possesses an opportunity to recommend changes that would significantly improve the lives of impoverished Texans and the health of the state as well. Those recommended changes must include raising the indigent health care minimum income standards from twenty-one to 100% of the FPL.

While it is true that uninsured, impoverished Texans ultimately receive health care, they receive it in the most inefficient way possible. A Houston physician described this by stating, "You prescribe, you send them home, they don't get well. They die sooner. They have more complications. They are more disabled."²³⁸ Currently, 1.6 million uninsured Tex-

234. *Id.* at 2.

The economist determined that reducing the state's uninsured by one half would be beneficial economically. Specifically, the analysis showed that in 2005: The Texas economy would have seen a total increase in annual economic activity of just over \$9.4 billion. Direct health care expenditures in the economy would have increased by an additional \$3.7 billion. Nearly 90,000 new jobs would have been created in all sectors of the economy. Total income (compensation to employees and employers) would have grown by more than \$3.2 billion. Texas state government would have received more than \$162 million in new revenues." *Id.*

The economic benefits of increased healthcare coverage are broadly categorized as greater worker productivity, increased by labor participation and fewer sick days. *Id.* at 1.

235. Tex. H.B. 3154, 80th Leg., R.S. (2007) ("[Creating a committee consisting of] (1) each member of the legislature who represents a district that contains territory in the region; (2) each county commissioner of a county located in the region; (3) each county judge in the region; and (4) the executive director of each public hospital in the region.").

236. HOUSE COMM. ON PUBLIC HEALTH, BILL ANALYSIS, Tex. H.B. 3154, 80th Leg., R.S. (2007).

237. Tex. H.B. 3154, 80th Leg., R.S. (2007).

238. Richard Wolf, *What Does a Health Crisis Look Like? See Houston*, USA TODAY, June 19, 2007, at 1A.

ans live at or below the FPL.²³⁹ An increase in the indigent care minimum income standards from 21% to 100% of the FPL would significantly benefit the lives of uninsured, impoverished Texans. Also, more than one-fifth of the state's uninsured would have access to primary health care, and this could alleviate the heavy burden placed on trauma centers and hospitals throughout Texas.²⁴⁰ Admittedly, more reform is necessary to cure the state's health crisis, but increasing the indigent care income standards to 100% of the FPL is a step that must be taken. One thing is certain, maintaining the current system will ultimately cost all Texans and jeopardize the state's health care system for future generations. As the "perfect storm"²⁴¹ gains strength and ominously looms on the horizon, the Legislature must take action now because the health of Texas depends on it.

239. TEXAS HEALTH INST., A VISION FOR CHANGE: POLICY SOLUTIONS FOR INCREASING HEALTH COVERAGE IN TEXAS 27 (2007), available at http://www.healthpolicyinstitute.org/pdf_files/Vision_rprt.pdf ("Over 1.6 million uninsured Texas adults have income below 100[%] of the federal poverty level. Of these, about 417,000 are parents of Medicaid eligible children."). Among the ten most populous states, Texas possesses one of the lowest income thresholds for Medicaid eligibility. *Id.*

240. See TASK FORCE FOR ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH IN TEXAS 53 (2006), available at <http://www.codered.texas.org/files/Report.pdf>.

While many Texans remain uninsured, costs of insurance, emergency rooms, and health and physician services are increasing. To compensate for care of the uninsured, local communities are taking on health care costs and insurance premiums are increasing. The uninsured are resorting to crisis care in emergency departments, which leads to emergency room diversion and inadequate care. . . . These are areas of increasing concern in maintaining or improving access to care in terms of cost and location. *Id.*

241. *Id.* at 14 ("The increasing discrepancy between growing health needs and access to affordable health insurance coverage creates the conditions for a 'perfect storm.'"). However, the "perfect storm" can be avoided through "vigorous and bold efforts." *Id.* at 168.