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Health Care Reform and the Rights of Immigrants

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The United States confronts a crisis in health care. Proposals for reform offer the hope of better care for the poor and disenfranchised as well as the prospect for improved protection of individual rights, increased personal autonomy, and greater equality of opportunity. However, if not properly designed, health care reform also poses a threat to civil liberties. Congress is presently considering several health care proposals. These range from the creation of a national, single-payer system, to various forms of "managed competition" and modest insurance market reform. Each proposal raises different, though related, civil liberties concerns. This paper focuses on the Health Security Act proposed by President Clinton and addresses the impact of the Act's immigration-related provisions upon both immigrants and citizens.[2]

DENIAL OF UNIVERSAL COVERAGE

One of the central constitutional issues raised by health care reform is equal protection. Equal protection concerns arise whenever the government provides services or benefits to some of its constituents and not to others. While in many respects the Health Security Act would provide far more equitable treatment than our present health care system, the Clinton plan nevertheless creates some sharp inequities that must be addressed.

The Health Security Act identifies universal coverage as one of the cornerstones of a reformed health care system: "health insurance and high quality health care should be secure, uninterrupted, and affordable for all

individuals in the United States" (§ 2(2)(A)). The Act goes far toward satisfying the principle of universal coverage. Nevertheless, some groups - notably many noncitizens - would remain outside of, and underserved by, the proposed health care system.

While the Health Security Act does not limit its cover age to U.S. citizens, it does exclude a significant portion of the immigrant community, including many who are not "undocumented." Under the Act, only long-term nonimmigrants, lawful permanent residents and a limited group of immigrants who meet the Act's narrow definition of "permanently residing in the U.S. under color of law" are eligible to enroll in health plans (§ 1001(c)(2), (3); 1902(1)). Among the excluded are long-time residents of the United States who have INS authorization to be employed, immigrants with documentation who are in the United States with short-term, long-term or indefinite permission from the INS, many immigrants who are eligible for such programs as Medicaid, and all persons deemed "undocumented," including children, pregnant women and members of "mixed" households (where some family members qualify for coverage and others do not).

By excluding such individuals, the Act not only fails to achieve truly "universal" coverage but it actually takes a significant step backwards. Many of these individuals currently receive health coverage through employer plans, private insurance, or existing state and federal health programs. The Clinton proposal would relegate these individuals to emergency hospital services and to a limited number of "qualified community health groups" whose funding is not assured by the Act (*see* §§ 3421-3429).

In the ACLU's view, the Act's denial of coverage to these immigrants is counterproductive, inconsistent with the principle of comprehensive care that informs the President's proposal, unnecessarily punitive toward immigrants, and unfair to the communities where immigrants reside. As public health specialists recognize, excluding any group from coverage is not sound medical policy and will put everyone at greater risk of contracting contagious diseases. Furthermore, one of the basic premises of the Health Security Act is that the overall cost of health care can be sharply reduced by encouraging people to seek preventive services and prompt treatment rather than waiting until medical problems escalate and require emergency attention. Yet the latter track is precisely the one to which many immigrants would be driven, resulting in enormous additional costs - especially for cities. Moreover, denying coverage will penalize the underserved poor neighborhoods and communities of color where many immigrants who are denied coverage reside. As a result, urban areas that already suffer from federal neglect will be forced to shoulder the cost of care. For these reasons, and in contrast to the Clinton plan, groups like the American Public Health Association and the New York State Governor's Health Care Advisory

Board Task Force endorse coverage for all immigrants regardless of immigration status.

CIVIL LIBERTIES

The President's plan is also deficient in the area of civil rights. The plan does contain a few very strong civil rights provisions. However, in our view the plan does not fully take advantage of the opportunity presented by health care reform to bolster existing civil rights provisions. Moreover, certain features of the plan would create new civil liberties problems.

Impact of National Health Identification Card

The Health Security Act requires the creation of a health security card and a unique identifier system for individuals, and it gives a National Health Board substantial discretion in determining the type of card and identifier (*see* §§ 5104–5105). The creation of any type of national card raises serious civil liberties problems. The type of national health card and identifier scheme outlined in the Act are especially problematic for several reasons. Experience shows that the national health care card envisioned by the Act would result in widespread discrimination against foreign-appearing citizens and residents, would likely become a *de facto* national identity card, and would greatly increase the threat to personal privacy.

Discrimination. The Act's health care card would lead to discrimination in at least two significant ways. At the outset, foreign-appearing U.S. citizens and residents are likely to face discrimination when applying for a card and when attempting to replace it. Because the Act proposes to exclude a large segment of the immigrant community, some type of screening process would presumably be necessary to determine who is eligible for a card. The Act does not specify who would be responsible for administering this process. Whether it is a federal, state or private entity, immigrants and "foreign-appearing" citizens, especially Latinos, Asians, Caribbeans and persons with accents, are likely to be subjected to greater scrutiny and disparate treatment by skeptical administrators charged with deciding who should receive a card.

Once a national card is in place, foreign-appearing citizens and residents would face discrimination outside of the health care context. Despite proposed penalties against the use of the card for nonhealth-related reasons, it would - as discussed below - become the document demanded by private and public entities to prove identity and status. Moreover, just as the Social Security Act's original strict prohibition against use of that number for any unrelated purposes has been ignored/gradually legislated away over time, so too will any legislative restrictions on a national health care card. Citizens

and residents of Latino, Asian or Caribbean origin would be particularly vulnerable to constant status and identity checks. That these individuals might be able to produce the card when asked does not, of course, lessen the harm caused by singling out such individuals for suspicion.

In addition, immigrants ineligible for comprehensive health care under the Act - many of whom possess work authorization and are residing in the United States with INS permission - would be unable to produce a card and might, therefore, erroneously be denied the nonhealth-related rights and benefits to which they are entitled, such as police protection, access to credit, insurance and housing, enforcement of minimum wage and hour laws, and various federal and state programs. Private and public entities will either ignore or be unaware of the prohibitions against requiring the card for nonhealth-related reasons. The prospect of such discrimination is not speculative. A 1990 report by the General Accounting Office (GAO) has documented the widespread discrimination resulting from Congress' 1986 decision to require employers to verify the immigration status of every job applicant.[3] The Health Security Act is likely to result in similar discrimination.

National Identity Card. Independent of the discrimination that would be faced by foreign-appearing persons, the card could easily, and perhaps inevitably, evolve into a *de facto* national identity card, threatening the privacy of all U.S. residents and citizens. At present, any number of local, state and federal documents serve to establish a person's identification. Once a single, uniform national card is created, it would emerge as the form of identification demanded for all functions in society. Citizens and residents - regardless of appearance or immigration status - would need to carry and show the card to prove identity and status to merchants, banks, landlords, law enforcement agencies, and others.

Privacy and the Social Security Number. Decisions about medical treatment are among the most sensitive questions we face, and our medical records contain some of the most intimate and confidential information about our lives. For this reason, the protection of informational privacy and sensitive medical records is central to any health care reform proposal. The Act's threat to privacy is particularly great if the National Health Board adopts the social security number as the health identifier since the number is already so widely disseminated, is used for a multitude of private and public purposes, and is, therefore, accessible to countless persons. As a result, if the social security number is used as the number for accessing health care records and services, the critical "gateway" to every person's private health information would lack any confidentiality and would be available to virtually anyone. If the social security number is revealed on the face of each card, it would become disseminated even more widely.

In addition, many immigrants who are and would remain entitled to at least emergency care are ineligible to receive a social security card or

number. Therefore, reliance on the social security number would complicate the delivery of emergency care and would risk creating a *de facto* two-tier emergency care system: one level for persons with cards and a lower level for those without.

The most effective way to avoid all these civil liberties problems is to eliminate the health card from the Act. We recognize that health care providers would benefit from ready access to an individual's relevant medical history. We also recognize that a health system that covers only some U.S. residents may need a mechanism for identifying eligible participants. Yet both of these objectives can be accomplished without a national card, and further study must be given to alternatives to such a card.

If, however, some form of national card is approved, it must contain the following features. First, to eliminate discrimination against foreign-appearing individuals, a card must be provided to all persons, regardless of their immigration status or the extent of their coverage under the Act. Issuing a card to all residents of the United States is a viable alternative since every resident, regardless of immigration status, should be eligible for at least emergency care. Moreover, one of the principal health care rationales for issuing a card - ready access to an individual's relevant medical history - counsels in favor of giving a card to all residents, especially to those immigrants who are likely to receive most of their care in emergency rooms where immediate access to medical histories is the most limited. Second, to ameliorate the threat to privacy and the specter of a national identity passport, no card, whether issued to some or to all, must contain any visible information allowing the card to function as an identity or "status" document. The card should resemble an automated teller card, which contains little information on its face, which need not show a name, which does not rely on an individual's social security number, and which is useable only by an individual entering his or her unique and confidential security code.

Inadequate Remedies for Discrimination

In addition to the inclusion of substantive provisions that further equal protection, it is important that health care reform legislation contain protections against discrimination. Any health care reform plan as complex as the Health Security Act necessarily creates numerous opportunities for discrimination. The Act does incorporate a number of provisions that prohibit discrimination (*see, e.g.*, §§ 1203, 1328, 1402, 1605, 1607, and 4004), but these sections take a scattershot approach that differs in terms of the entities covered, the forms of discrimination outlawed, and the legal standard for finding a violation. A more systematic response to discrimination is required. The Act should contain a separate, comprehensive antidiscrimination section that, at a minimum, meets each of the following requirements.

Covered Entities. The prohibition against discrimination should extend to all entities that are assigned functions or responsibilities under the Act and should apply to all actions taken by those entities in fulfilling those functions and responsibilities. Covered entities would include at least the following: the National Health Board and other agents of the federal government assigned responsibilities under the Act; state, regional and corporate alliances; health plans; health care providers; and employers.

Prohibited Discrimination. The Act should broadly prohibit various forms of discrimination, whether or not it seems likely that a particular form of discrimination would occur in a specific context. The Act should prohibit discrimination based on any of the following characteristics or perceived characteristics: race, national origin, gender, age, religion, disability, socioeconomic status, citizenship or immigration status, sexual orientation, language, political beliefs, family status, health status or anticipated need for health services.

Standard for Discrimination. The prohibition on discrimination should outlaw not only intentional discrimination, but also conduct that has a discriminatory effect. An example of such a provision is § 1402(c)(1). Under such a discriminatory effects provision, any defense based on a claim of "business necessity" must be narrowly circumscribed. The burden must be placed on the defendant to establish both that the discriminatory practice was justified by business necessity and that no less discriminatory alternative is available. Under no circumstance, however, should business necessity be a defense to a claim of intentional discrimination. A model antidiscrimination provision might read:

> No person or entity, in carrying out any functions or responsibilities pursuant to this Act or in connection with the provision of health care in accordance with this Act, shall discriminate or adopt any policy or take any action that has the effect of discriminating, on the basis of race, national origin, gender, age, religion, disability, socioeconomic status, citizenship or immigration status, sexual orientation, language, political beliefs, family status, health status or anticipated need for health services, nor shall any person or entity discriminate, or take any action that has the effect of discriminating, against any individual based upon the manner in which he or she exercises his or her rights under this Act.

If the plan excludes some persons from coverage based on immigration status, the antidiscrimination provision could add a clause at the end providing that citizenship discrimination is not unlawful to the extent expressly authorized by this Act.

Affirmative Action. The Health Security Act contains a number of provisions designed to increase minority representation among health care workers and to improve health care services in underserved minority communities. Any antidiscrimination provision should clearly provide that such programs, as well as other appropriate affirmative efforts to increase services to underserved populations or remedy underrepresentation, do not constitute unlawful discrimination.

Enforcement Provisions. The Act should establish procedures for enforcing its prohibitions against discrimination through private civil actions, administrative enforcement proceedings and civil enforcement measures. In egregious cases, criminal penalties may also be appropriate. Persons aggrieved by violations of the Act's antidiscrimination provision should be able to bring a private civil action for damages and/or equitable relief. Prevailing plaintiffs should be awarded reasonable attorneys' fees, expert witness fees and costs.

Applicability of Existing Antidiscrimination Laws. The Health Security Act should expressly provide that the inclusion of particular antidiscrimination provisions in the Act is not intended to, and does not, preempt the application of existing state or federal antidiscrimination laws to the conduct of persons dispensing health services or otherwise carrying out functions under the Act. Moreover, the Act should expressly provide that all regional alliances, health plans and health care providers receiving payment for services pursuant to the Act shall be treated as recipients of federal financial assistance for purposes of applying the relevant provisions of existing federal civil rights statutes.

Alliance Boundaries. States are prohibited from discriminating in establishing boundaries for alliance areas under § 1402(c)(1) of the Act. Regional alliance boundaries should be subjected to preclearance review in a manner similar to that required for electoral changes under the Voting Rights Act. Preclearance review would provide assurances that alliances are structured in a nondiscriminatory way before they begin operation and would minimize the necessity for dismantling and reorganizing these boundaries after the reformed health care system has taken effect.

Likewise, § 1202 contains language prohibiting states from "otherwise tak[ing] into account" race, national origin, socioeconomic status and the like in establishing alliance boundaries. In our view, states should take these characteristics into account so as to draw alliance boundaries that further our national commitment to insure equality of treatment and services. The Act should expressly instruct states to draw alliance boundaries, subject to preclearance review, that avoid concentrating minorities, the poor, the disadvantaged or immigrants in particular alliances.

CONCLUSION

The Clinton Health Care Plan holds out the promise of genuine and much needed reform. But it falls short on its promise of universal coverage and actually takes a significant step backwards, since many immigrants would lose the health coverage they currently possess. In addition, the Act creates a new threat to the civil liberties of all persons by creating a national health care card and failing to include comprehensive antidiscrimination provi-

sions. If the Clinton Plan, or any other plan, is to fulfill its promise of genuine reform, these problems must be addressed.

NOTES

[1]Some portions of this paper concerning general civil rights protections were written by other ACLU staff and first appeared as part of an ACLU report entitled *Toward a New Health Care System: The Civil Liberties Issues.*

[2]The President's proposal, S. 1757 and H.R. 3600, would divide the country into regional "health alliances," with one or more in each state. An alliance would negotiate health insurance premiums with a variety of "health plans," each of which would be required to offer a "comprehensive benefit package" of services. A range of health plans, including both managed care and fee-for-service plans, would be available in each alliance. Once a year, a family would choose a health plan from among those offered in its vicinity. Large corporations could continue to offer their own health plans to their employees, so long as those plans included the comprehensive benefit package. The military, the Department of Veterans Affairs and the Indian Health Service would also continue to offer separate health programs. All employers would be required to contribute to their employees' health care costs. In general, employers would have to pay 80 percent of the cost of an average-priced health plan, while employees would be responsible for the remaining cost of the premium for the plan they select. The federal government would help subsidize the cost of coverage for small employers, low-income individuals, and families and recipients of Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI).

[3]*Immigration Reform: Employer Sanctions and the Question of Discrimination,* GAO/GGD-90-62(1990).