



Healthcare for All:

Recommendations for Removing
Barriers to Healthcare Facing Immigrant
Children in the United States

APRIL 2023



Executive Summary

This brief updates a 2021 Children's Health Fund (CHF) [statement on U.S. immigration policy](#) and furthers our belief that all children deserve access to healthcare regardless of race, ethnicity, socio-economic or immigration status. We also believe that health is a human right and that ensuring access to comprehensive healthcare for all children living in the United States is sound economic policy.

[According](#) to the U.S. Census Bureau, 1 in 4 immigrant, noncitizen children in the country lacked health insurance coverage in 2019, compared to 1 in 20 native-born children. A Kaiser Family Foundation [analysis](#) also found that children without insurance are more than four times as likely as children with insurance to lack a usual source of healthcare, five times as likely to delay necessary care and medical treatment, and about three times as likely to have unmet medical needs. Because children without documentation are more likely than native-born children to be uninsured, they are less likely to have access to [primary pediatric healthcare](#), which focuses on the prevention, management, and control of disease through the promotion of health and wellness.

Immigrant families, including those with mixed status, face many and varied challenges accessing adequate pediatric primary healthcare for their children. [For example](#), forced separation can cause children to lose a caregiver who may be responsible for securing their medical care, children in immigrant families may not have access to a culturally sensitive doctor who communicates in their dominant language, or they may live in under-resourced communities where there are a limited number of pediatric primary healthcare providers. Restrictive policies that instill fear in immigrants seeking public benefits, such as the [2019 public charge rule](#) that made it more difficult to obtain a green card, has also been a barrier to care. Children without documentation have unique and daunting challenges: Most are [ineligible](#) for Medicaid and the Children's Health Insurance Program (CHIP), except in states that elect to use non-federal Medicaid and CHIP funding to provide coverage. To date, only [nine](#) states and Washington, D.C., do so. Individuals without documentation, including children, are also [ineligible](#) for private marketplace insurance sold in the marketplace.

While there are other options for children without documentation to access healthcare services in jurisdictions that don't use their own dollars for health insurance coverage, they tend to be limited, inadequate, or expensive. Federally Qualified Health Centers (FQHCs), for instance, provide free or relatively low-cost care (through sliding scale fees) to all residents in their service areas regardless of immigration or insurance status, or ability to pay. However, many places in the country lack FQHCs.

The Emergency Medical Treatment and Active Labor Act, enacted in 1986, is another way for children without documentation to access healthcare. This national law mandates that all Medicare-participating hospital emergency departments (EDs) examine and stabilize anyone seeking treatment for an emergency medical condition. While children without documentation are included if they meet the eligibility requirements for [limited Emergency Medicaid](#), EDs as a usual source of care are far from ideal—they are costly and not set up to provide preventive care and management of chronic disease, even in the short term. Uninsured individuals tend to avoid EDs and therefore delay care because of fees they commonly must pay. [Research](#) has repeatedly demonstrated that delaying medical care worsens illness and is more costly.

Children without documentation can also access healthcare at disproportionate share hospitals. [Federal law](#) requires that state Medicaid programs make payments to hospitals that provide care to large numbers of patients who are either enrolled in Medicaid or are uninsured, including children without legal documentation. Intended to offset the cost of uncompensated care, disproportionate share hospital payments increase the ability of hospitals to provide care to patients who cannot access affordable healthcare. As such, disproportionate share hospitals are an essential feature of the health safety net for children in immigrant families.

With limited access, children in immigrant families are at higher [risk](#) of experiencing worsening symptoms, having symptoms go undetected, or over-utilizing emergency services compared to children who regularly see primary care pediatricians. By not ensuring access, children tend to be sicker and thereby more costly to local, state, and federal governments.

To improve healthcare access and promote health equity, policymakers should enact policies that address the needs of children, such as removing waiting periods that bar newly arrived immigrant children from immediately accessing Medicaid and CHIP, providing more funding for FQHCs, and expanding the number of states that use their own funds to care for children without documentation.

One monumental step in the direction of caring for immigrant children came in mid-April 2023, when the Biden administration [announced plans to expand healthcare coverage](#) to all Deferred Action for Childhood Arrivals (DACA) participants in the United States. While Children's Health Fund applauds this expansion of access, we encourage the administration to continue taking action to protect and advance healthcare access for immigrant children.

Background: Immigration Status as a Barrier to Healthcare

Children's Health Fund (CHF) has long supported access to healthcare for immigrant children for two principal reasons:

1. CHF agrees with the [World Health Organization](#) and other international and domestic bodies that health is a basic human right and that the United States, like other nations, has a "legal obligation to ensure access to timely, acceptable, and affordable healthcare." We interpret "acceptable" to mean quality healthcare, or that which we would want and expect for our own children.
2. Providing access to comprehensive healthcare—medical, mental health, dental, and addressing health-related social needs—for all children in the United States is also smart: Ensuring access to comprehensive pediatric healthcare reduces unnecessary emergency room visits and hospitalizations, improves health, and lowers costs.

[Approximately](#) 18 million children, or 26% of all youth under the age of 18 in the United States, were either born in a foreign country or live in a mixed-status household with at least one parent who is an immigrant (2021). Of those children, it is estimated that 5.3 million either have a parent who lacks documentation or lack legal documentation themselves. Due to federal healthcare law and immigration policy, children without legal documentation and those living in mixed-status households face challenges accessing Medicaid, CHIP, and private health insurance.

The Value of Pediatric Primary Care

Comprehensive pediatric healthcare starts with primary care—the foundation of an effective healthcare system—within communities where children live, go to school, and play. The focus of primary care is to prevent, manage, and control acute

and chronic disease. Pediatric primary care has particularly great potential for effectively promoting good health through efforts that can prevent the development of many lifelong health problems—obesity-related disease and many mental illnesses, for instance—that often take root in childhood.

Pediatric providers therefore routinely screen for and address growth, development, and psychosocial factors through no less than 30 well-care visits starting soon after birth and continuing throughout childhood, adolescence, and young adulthood (up to age 21). These visits include the administration of vaccines that prevent 17 infectious diseases. Twelve of the recommended well-care visits occur within the first three years of life: the most critical period for cognitive, emotional, physical, and social development. The nervous system, for one, grows at its fastest rate during this time, affecting not only brain architecture, but also immune, cardiovascular, and other bodily systems. Critical stages of growth and development also occur well into the third decade of life. For example, the brain's frontal and parietal lobes—important for critical thinking and attention skills—do not develop fully until the late teens or early twenties. And of course, puberty—the years-long transitional phase for physical, sexual, and emotional growth into adulthood—begins as early as age 8 in girls, 9 in boys.

These nexuses are opportunities for pediatric providers to work with children, adolescents, young adults, and their families and communities to promote health and minimize disease development or progression. When illnesses such as asthma, diabetes, hypertension, and obesity are identified early, treatment is more effective and progression or exacerbation of the disease is minimized. The same is true for common mental health issues such as anxiety, depression, and attention deficit hyperactivity disorder (ADHD). Anticipatory guidance, a staple of pediatric well-care visits, and connecting families to existing resources can actually prevent some illnesses from ever developing. For example, educating mothers about the value of breastfeeding and connecting them to the [Special Supplemental Nutrition Program for Women, Infants, and Children \(WIC\)](#), a federally funded program administered by states, provides access to lactation consultants and nutritious food for mothers and children through 5 years of age living in low-income households. [Research](#) has shown a correlation between enrollment in this program and a decrease in obesity. This translates into a reduction in the development of comorbid and costly conditions, such as hypertension, diabetes, and debilitating orthopedic problems.

Screening for and identifying mental health issues in young children and adolescents also allow for the application of effective and less costly interventions. [ADHD](#), for instance, was estimated to have been diagnosed in an estimated more than 6 million children between 2016 and 2019. This does not take into account [the estimated 8 to 9 million undiagnosed and untreated adults](#). When medically unrecognized and unaddressed, ADHD carries a lifelong burden for the individual, their family and community. However, when diagnosed and managed starting as early as possible in childhood, [its impact can be significantly lessened](#). The American Academy of Pediatrics, a well-recognized authority on childhood health, [recommends](#) screening for ADHD, starting at age 4 and continuing through the 18th birthday.

Vaccines, another staple of pediatric primary care practice, are important and cost-effective for preventing serious illness and even death from more than a dozen diseases. The vast majority of vaccines are more effective when given as a series, beginning in early childhood. They not only protect the children receiving them, but through [community immunity](#), other children and adults and children with who they may come into contact. Vaccines know no geographic boundaries: The more children that are vaccinated, the less likely a disease has the chance to occur or spread.

When children have regular access to [comprehensive primary care](#), including routine well-child visits and immunizations, they are at reduced risk of severe illness and are more likely to develop into healthy adults. Access to comprehensive healthcare is most readily achieved when one has health insurance, whether through a public or private program.

Additionally, access to affordable, comprehensive healthcare reduces the risk that patients may delay necessary care due to cost or lack of accessibility. When patients delay care, they may be at increased risk of worsening illness and may incur higher healthcare costs over time. A study published in the [Annals of Internal Medicine](#) found that patients who reported

delays in seeking medical care faced worse symptoms and 9% longer hospital stays compared to those who sought routine care. Additionally, a 2020 [survey](#) conducted by the Larry A. Green Center and the Primary Care Collaborative found that 56% of primary care physicians reported observing worsening symptoms in patients who delayed care. Furthermore, a [nationwide analysis](#) found that patients dealing with heart failure who delayed care had annual healthcare expenses more than \$8,000 higher than those who did not delay care. To ensure that children are able to have all their healthcare needs met, it is essential to expand access to affordable, comprehensive primary care.

Inequities in Uninsured Rates

Children without legal documentation and those living in a mixed-status household disproportionately face barriers to accessing health insurance. In [2020](#), 4% of all children born in the United States were uninsured while 10% of children with at least one noncitizen parent were uninsured. That same year, the uninsured rate reached an estimated 28% for children without legal documentation.

Ineligibility for Medicaid and the Children's Health Insurance Program (CHIP)

[Medicaid](#) is a jointly funded federal and state public health insurance program that provides comprehensive, low-cost coverage to children, elderly individuals, adults with low income, and people with disabilities. The [Children's Health Insurance Program](#) (CHIP) provides healthcare coverage for children under age 19 and pregnant individuals living in households with incomes too high to qualify for Medicaid but too low to afford private insurance.

In [2019](#), over 45 million children were enrolled in Medicaid and CHIP. However, a Migration Policy Institute [study](#) the same year estimated that 2.3 million children in immigrant families met income-based eligibility requirements for Medicaid and CHIP, but about 40% were unable to enroll due to a lack of legal documentation or because they had been "[qualified non-citizens](#)" for less than five years. Qualified non-citizens are immigrants legally authorized to live in the United States, including lawful permanent residents, refugees, and asylees.

To be eligible for Medicaid and CHIP, many immigrants must have [resided](#) as qualified non-citizens for at least five years. However, since enactment of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), states have had the [option](#) to use [federal funds](#) to eliminate this waiting period for [children](#). As of November 1, 2022, 34 states and Washington, D.C., have [removed](#) the wait, allowing children with qualified status to more quickly access the coverage to which they are entitled.

Still, children who lack legal documentation face far more restrictive access to Medicaid and CHIP. United States law [prohibits](#) most immigrants without legal documentation from enrolling in most federally funded benefit programs, including Medicaid and CHIP. To eliminate this barrier, several states have [chosen](#) to use their own funds to implement healthcare programs for children regardless of immigration status.

Inability to Purchase Marketplace Insurance

The [Affordable Care Act](#) (ACA) sought to expand healthcare coverage to millions of people throughout the country. To give people more options for purchasing private insurance, the ACA [mandated](#) the establishment of healthcare exchanges, also known as marketplaces, in all 50 states so individuals who have no other coverage options could purchase insurance. Eligible individuals include U.S. natural-born citizens and residents living in the United States legally.

The combined effect of Medicaid expansion and ACA marketplaces [shrank](#) the uninsured rate among children from 7% in 2013 (the year before Medicaid expansion first took effect) to 4% in 2016. While the national uninsured rate among children dropped by nearly 50%, children without legal documentation did not benefit from these policy changes because they remained ineligible for Medicaid, CHIP, and marketplace insurance.

Public Charge Rule

The [public charge rule](#) allows the U.S. government to deny immigrants admission into the country based on their perceived use of public benefits, including Medicaid and the Supplemental Nutrition Assistance Program (SNAP). Since its [inclusion](#) in the Immigration Act of 1882, the public charge rule has undergone several revisions.

Under a 1999 revision, the federal Department of Homeland Security (DHS) [interpreted](#) a public charge as someone who is “primarily dependent on the government for subsistence,” including use of public cash assistance for income maintenance and long-term institutionalized care at government expense. Under this guidance, the only instance in which an immigrant could be considered a public charge for use of healthcare was if they received long-term institutionalized care through Medicaid or other programs. In all other instances, use of health-related public benefits such as Medicaid, CHIP, and Medicare were excluded from public charge determinations. However, as the result of a 2019 [policy change](#) immigrants could be considered public charges, not only for receiving public benefits, but also for being “more likely than not” to become dependent on government-funded public programs in the future.

The 2019 public charge rule created fear and confusion. Immigrants worried that participation in public programs would affect their green card application status. According to 2019 [data](#) from the Urban Institute, over 15% of adults in immigrant families reported that they or a family member opted to forgo government benefit programs, including Medicaid and CHIP “for fear of risking future green card status.” A Kaiser Family Foundation [survey](#) also found that over 20% of health centers reported a drop in healthcare use among children in immigrant families.

In December 2022, [DHS](#) reinstated its 1999 guidance. It no longer includes receipt of certain non-cash benefits, including [SNAP](#), Medicaid (for uses other than long-term institutionalization), and any benefits related to immunizations or testing for communicable diseases to determine a public charge. In addition, DHS ended consideration in public charge determinations benefits received by family members other than the applicant. Any future changes to the public charge rule should take into account possible negative impacts on the ability of all immigrant families to access healthcare and health insurance.

Existing Options: How Children in Immigrant Families Access Healthcare

Although children without legal documentation face challenges when accessing healthcare, they do have options. Among them, they can receive care if they live in a state that exclusively uses its own funds to cover children regardless of immigration status. Care is also available at Federally Qualified Health Centers, as well as at hospitals required by the Emergency Medical Treatment and Active Labor Act (EMTALA) to provide emergency examinations and treatment to all patients. In addition, children can access healthcare through Emergency Medicaid, through disproportionate share hospitals (DSHs), or through private health insurance.

Use of State Funds

As of January 1, 2023, [nine states](#) (California, Illinois, Maine, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington) and Washington D.C., use state- or district-only funds to provide affordable, comprehensive healthcare coverage to all children, regardless of immigration status.

Many of the state-funded healthcare [programs](#) provide services similar to those offered through Medicaid and CHIP, yet are not official Medicaid or CHIP programs. Others, such as those in California, Maine, and Vermont, operate as extensions of Medicaid or CHIP.

A few other states have proposed or taken action to expand coverage for children in immigrant families. On January 1, 2023, Connecticut announced it would provide health coverage to all income-eligible children under age 12 regardless of immigration status through its Medicaid program, and that those children can remain enrolled until age 19 as long as they continue to meet eligibility requirements. Children who were older than 12 on January 1 do not qualify. [Colorado](#) announced that it would provide health coverage to all children under 18 without legal documentation through its Medicaid program by 2025.

Care from Federally Qualified Health Centers (FQHCs)

Over [1,400](#) FQHCs across the United States serve more than 30 million people of all ages annually living in under-resourced communities. FQHCs can include community health centers, migrant health centers, health care for the homeless programs, and health centers for residents of public housing.

FQHCs provide free or low-cost healthcare regardless of insurance or immigration status. FQHCs also offer a wide range of services to patients, including primary care, vision services, dental care, and behavioral health services. However, they typically do not provide specialty or inpatient care.

Emergency Medical Treatment and Labor Act (EMTALA)

[EMTALA](#) is a federal law that requires physicians and medical personnel at all Medicare-participating hospitals to provide a medical screening examination to any patient requesting one or treatment for an emergency medical condition regardless of insurance status, ability to pay, or immigration status. In addition, any patient who is determined to have an emergency medical condition must be stabilized before being transferred or discharged.

EMTALA [defines](#) emergency medical conditions as those in which the “absence of immediate medical attention could put the patient in serious jeopardy, seriously impair bodily functions, or cause serious dysfunction to an organ or body part.” These include heart attacks, severe asthma attacks, or emergency labor and delivery.

Because EMTALA forbids hospitals from denying treatment or refusing care to patients because of their insurance status, ability to pay, or immigration status, children without legal documentation can access life-saving medical care.

Emergency Medicaid

While immigrant children without legal documentation do not qualify for traditional Medicaid in most states, they are eligible for [Emergency Medicaid](#). This program allows all income-eligible individuals without insurance to receive Medicaid services for the treatment of an emergency medical condition regardless of immigration status. Emergency Medicaid provides treatment for a maximum of 15 months. However, Emergency Medicaid cannot be a source of primary and preventive care for children without legal documentation.

While Emergency Medicaid reduces cost to patients for receiving care in an emergency facility, it is temporary and limited, only covering emergency medical conditions as [defined](#) under the EMTALA law.

Additionally, emergency rooms are the most expensive form of outpatient care, and it is estimated that receiving care at an emergency room can be as much as [12 times](#) more expensive than at a doctor’s office. In addition, emergency room patients do not receive the continuity of care that they do with primary care physicians.

Until all children have access to a wide range of medical services that meet their healthcare needs, those without legal documentation will be left without full access to comprehensive healthcare.

Disproportionate Share Hospital (DSH) Payments

Under [federal law](#), state Medicaid programs are required to make disproportionate share hospital (DSH) payments to qualifying hospitals that serve a large number of patients who are either uninsured or enrolled in Medicaid. By enabling safety net hospitals to provide care to patients who are unable to afford it, DSH payments broaden access to healthcare for people in under-resourced communities, including children in families of mixed immigration status. Hospitals receiving DSH payments are an important source of care for children without documentation, especially in states with restrictive immigration policies and large populations of immigrants.

Access to Private Health Insurance

Some immigrant families may be able to access private insurance through their employers and non-ACA marketplaces, as no laws or policies explicitly prohibit them from doing so. However, employer-sponsored insurance and private insurance purchased outside of ACA marketplaces are inaccessible for most immigrants, especially for those without documentation. Many jobs require a work visa or proof of lawfully present status as a term of employment. Because of that, immigrants without legal documentation typically cannot get hired for jobs that provide health insurance. In addition, private health insurance purchased outside of ACA marketplaces is expensive and cannot be subsidized, making this option unaffordable to many immigrants.

Policy Options

To ensure that children in mixed-status families have access to healthcare, policymakers, legislators, advocates, and community members must craft immigration and healthcare policies that address healthcare access for all. Options include expanding Medicaid and CHIP, increasing funding for community health centers, and using state funds.

Medicaid and CHIP Expansion

Medicaid and CHIP coverage should be extended to all eligible children to ensure that they receive care when needed. Medicaid and CHIP expansions through both the ACA and CHIPRA made coverage affordable to millions of children nationwide. Without these efforts, children from under-resourced communities would face barriers to accessing healthcare services. However, in the 16 states that require a five-year waiting period, immigrant children with legal documentation still face significant delays before they can enroll in Medicaid and CHIP. Eliminating the five-year waiting period in these states for children with qualified immigration status will enable them to access healthcare much sooner.

Increased Funding for Federally Qualified Health Centers (FQHCs)

FQHCs receive reimbursement from Medicaid, Medicare, and private insurance. In addition, health centers are funded through federal grants that mandate all patients are seen regardless of ability to pay. As an essential part of the health and social safety net, community health centers need more funding so they can continue providing quality, comprehensive healthcare for people living below 200% of the federal poverty threshold, who lack insurance, or who do not have legal documentation.

Use of State Funds

State funds should be used to provide healthcare to all immigrants, including those without legal documentation. State funds should increase access to healthcare for all children, not limit access for certain categories of immigrants.

States that use their own funds to increase access to coverage for children without legal documentation have shown they have more [flexibility](#) to create more efficient programs. For example, in 2016, California began using state funds to provide healthcare coverage to all children 18 and under regardless of immigration status. Policymakers soon realized a greater need existed for healthcare coverage for young adults up to age 25, so they [amended](#) their Medicaid program in 2019 to reflect that need.

Conclusion

With over 45 million children enrolled in Medicaid and CHIP, public health programs have demonstrated their ability to effectively reach children in low-income communities and lower their uninsured rates. However, children in mixed-status families face a far different picture, and one that will ultimately affect their access to care and their future health outcomes.

Children's Health Fund encourages policymakers to take action to protect and advance the health of immigrant children in the following ways:



Eliminate the Five-Year Waiting Period

With over 900,000 immigrant children who meet the income based Medicaid and CHIP requirements but are barred from access because of immigration status and failure to meet the requirements of qualified non-citizens, now is the time for the remaining 16 states to pursue the CHIPRA option to expand eligibility and to encourage participation in the program.



Expand Funding for Federally Qualified Health Centers (FQHCs)

FQHCs are an important safeguard in rural and urban areas where many children in immigrant families reside. Because FQHCs can offer services on a sliding scale based on ability to pay, and can provide basic health services regardless of immigration status, they play an essential role in the delivery of healthcare to immigrant children and children in mixed status families.



Improve Outreach and Education of Approved Programs

While the 2019 public charge rule was revised in December 2022, DHS, policymakers, and agency leaders need to do more to alert immigrant communities about these changes. In addition, it is critical that promotion of these programs be in accessible languages to avoid confusion and to remove any complexity about program rules.

These changes are needed to ensure that all children, regardless of immigration status, have access to quality, comprehensive healthcare to succeed and to reach their potential in the classroom, at home, and into adulthood. Children without documentation should not be excluded from having their healthcare needs met, which is why policymakers and government officials must commit to creating policies that protect the health and well-being of all children.