HHR Health and Human Rights

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VIEWPOINT

A Multi-Level Approach to Promoting the Health Rights of Immigrant Children in the United States

LARS LINDGREN AND KARLA FREDRICKS

Introduction

The Convention on the Rights of the Child (CRC) stresses the importance of children's right to the highest attainable standard of health. The CRC outlines the health rights to which all children are entitled, and it has been ratified by 196 countries—the United States being the only holdout—highlighting the global consensus on the importance of protecting child health rights. Likewise, other human rights sources, such as article 25 of the Universal Declaration of Human Rights and article 12 of the International Covenant on Economic, Social and Cultural Rights, emphasize the special importance of child health and development. Due to children's unique vulnerability and the disproportionate harm that they stand to face from the denial of a healthy upbringing, these documents make it clear that the obligation to protect these rights is indiscriminate and without regard for citizenship or immigration status.

While sweeping reforms that pursue health rights for marginalized groups, such as immigrant children, are well suited for national-level (federal) governments to implement, state- and local-level solutions are also practical and feasible ways to support a robust system of health services for all children when national policies or programs are insufficient. This viewpoint reviews initiatives in the United States across each level of governance to show how multi-level approaches can help fulfill the health rights of immigrant children, despite shortcomings at a national level.

Lars Lindgren, JD, is a researcher with the Program for Immigrant and Refugee Child Health at Baylor College of Medicine/Texas Children's Hospital in Houston, Texas, United States.

Karla Fredricks, MD, MPH, is an assistant professor of pediatrics and director of the Program for Immigrant and Refugee Child Health at Baylor College of Medicine/Texas Children's Hospital in Houston, Texas, United States.

Please address correspondence to Lars Lindgren. Email: lindgr.lars@gmail.com.

Competing interests: None declared.

National-level approaches to addressing child health inequities

National governance plays a significant role in shaping health care accessibility for immigrant children within a country's borders. Some countries have national policies that ensure that all children, regardless of their immigration status, have access to health care. For example, Sweden introduced legislation in 2013 entitling undocumented migrants under the age of 18 to access the national health system, reflecting its commitment to upholding the health rights of immigrant children as equal to those of its own citizens. In contrast, countries such as the United Kingdom (despite having a national health care system) do not provide all immigrant children the same access to health care as their own citizens. The United States does not have a national health care system, nor does it ensure equal access to health care for all children.

It is possible that these inequities could be remedied through national lawmaking. For instance, in the United States, Congress could move federal policy in line with the 2023 statement from the American Academy of Pediatrics entitled "Medicaid and the Children's Health Insurance Program: Optimization to Promote Equity in Child and Young Adult Health," which calls for the universal eligibility of children for federally funded public health insurance coverage and improved and consistent access to high-quality pediatric care across state lines. Although some proposals (e.g., HEAL for Immigrant Families Act of 2023) have attempted to move toward this end, political divide in Congress makes advancing policies like these challenging. It is therefore important to alternatively consider how similar goals can be pursued at state and local levels, circumventing federal barriers.

Plugging gaps at the state level

In countries that do not adequately protect children's health rights at a national or federal level, action at the state or regional level can offer piecemeal remedies. For example, the United States' shared power between federal and state governments creates significant opportunities for states to plug gaps and implement recommendations from organizations like the American Academy of Pediatrics to enhance the health and well-being of all children within their borders.

States that have taken advantage of this flexibility can serve as models on how to expand health care access and improve child health. Although funded separately from states' federally endorsed Medicaid and Children's Health Insurance Program (CHIP) plans (which provide free or low-cost health coverage for children whose families cannot afford other health programs), many of these state-level health programs share equivalent eligibility requirements, benefits, and coverage for immigrant children who cannot access federally funded Medicaid (see Table 1).

States also have leeway to shape the benefits Medicaid provides. For example, section 1115 of the Social Security Act allows states to apply for waivers to federal Medicaid mandates and implement budget-neutral experimental demonstration projects. These waivers cannot be used to bypass citizenship requirements. However, they can augment the definition of what constitutes a medical emergency and therefore increase eligibility for emergency Medicaid coverage, fund uncompensated care pools to support safety-net hospitals that provide charity care for uninsured children, and establish support for health-related social needs, including housing, food, and transportation for low-resource communities.

A limited, but possibly more feasible, interim step for state expansion of immigrant health care access is available under section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), which allows states to waive the five-year waiting period for health care coverage for lawfully residing children. This option has resulted in 28 states or territories expanding immigrant children's access to CHIP and 39 states or territories expanding immigrant children's access to Medicaid. This can be especially important for child applicants for asylum or Special Immigrant Juvenile status, as both are considered to be lawfully residing. However, adopting section 214 of CHIPRA does not offer Medicaid or CHIP eligibil-

ity to all immigrant children—thus, while it can be a beneficial step, further reforms are still needed.

The role of local-level solutions

Local governmental and nongovernmental collaborations can create additional opportunities for children to receive health care services in the absence of, or supplementary to, state or federal programs. In the United States, organizations such as community health centers provide access to health services through sliding-scale discount programs for children and adults who are not able to obtain health insurance. Although service and coverage options at this level can be limited due to practical economic constraints and are vulnerable to political instability, they can still be effective. The Care for Kids program in Montgomery County, Maryland, and the Harris Health System financial assistance program in Harris County, Texas, are local initiatives that increase access to care in states that do not offer Medicaid or CHIP eligibility for all low-income children. Care for Kids uses county funds to provide low-cost or free health services at community and school-based providers to children who are not eligible for state or federal health insurance coverage options. Likewise, the Harris Health System uses a sliding-scale approach to mitigate the cost of care for low-income families.

Local solutions can also be tailored to the immediate health needs of the surrounding community. As one example, Colorado's Title V-funded program for children with special health care needs, known as HCP, is county based and administered through local public health departments to better connect families to community health organizations and other social services.

Conclusion

In the absence of equal access to national-level child health programs and services, state- and local-level programs can provide services to help achieve health equity. However, this should not distract from international human rights obligations on all governments to respect, protect, and fulfill children's right to health. Ultimately, a strong commitment at the federal level to uphold international

TABLE 1. US state-funded programs that expand public health insurance access to children regardless of immigration status

State	Name of expansion program (name of original program if it now includes expansion)	Age of eligibility	Family income threshold (% of federal poverty level)
California	Health4All Kids (Medi-Cal)	<19	266
Colorado	Cover All Coloradans/Health Benefits for Children and Pregnant Persons (Health First Colorado/CHP+) (comes into effect 1/1/2025)	<19	250
Connecticut	State HUSKY A/State HUSKY B for Children (HUSKY Health)	<16 (but available to age 18 if enrolled before age 16)	323
District of Columbia	Immigrant Children's Program	<21	200
Illinois	All Kids	<19	130*
Maine	MaineCare	<21	213
Massachusetts	Children's Medical Security Plan (MassHealth)	<19	Any income
New Jersey	NJ FamilyCare	<19	355
New York	Child Health Plus	<19	220*
Oregon	Cover All Kids (Oregon Health Plan)	<19	305
Rhode Island	Cover All Kids (RIte Care)	<19	261
Utah	State Children's Health Insurance Program	<19	200
Vermont	Immigrant Health Insurance Plan	<19	300
Washington	Apple Health for Kids	<19	215*

*Income threshold for free insurance; costs increase with higher income

human rights agreements and implement inclusive health care policies remains crucial for further eliminating child health inequities and advancing public health goals within and across borders.

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