

FROM *PLYLER* TO PUBLIC HEALTH: THE EQUAL PROTECTION ARGUMENT FOR MEDICAID ACCESS FOR UNDOCUMENTED CHILDREN AND PREGNANT INDIVIDUALS

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I. INTRODUCTION

Dr. Meredith Grey, one of television's most beloved fictional doctors, encounters a heartbreaking situation when she discovers a ten-year-old girl, Nadia, sitting alone and in excruciating pain.¹ Upon further investigation, Dr. Grey and her fellow doctors at Grey Sloan Memorial Hospital find a life-threatening 7.8-pound mass in Nadia's abdomen.² As the doctors prepare to treat Nadia, they discover a worrying truth: Nadia and her mother are undocumented immigrants, and are terrified that their mere presence at Grey Sloan Memorial will result in their deportation.³ This fear, rooted in their immigration status, led Nadia's mother to delay seeking essential care, even as her child's condition worsened.⁴

Nadia's mother delayed seeking care for her daughter due to her fear of the unknown. In her mind, the risk of seeking treatment far outweighed the potential consequences of inaction.⁵ Her decision-making was compounded by her belief that bringing Nadia to the hospital would lead to their separation.⁶ Unable to reconcile her fear of deportation with Nadia's need for medical intervention, Nadia's mother chose to ignore her daughter's condition, and instead desperately hoped the problem would resolve on its own.⁷ She clung to the hope that if she could just survive without drawing attention, things might improve.⁸

This fictional scenario displays a painful reality: an immigrant mother's decisions are not driven by negligence or neglect, but by the all-consuming fear that seeking healthcare would result in the loss of everything she has worked to build for her family. It illustrates the deep vulnerabilities faced by undocumented individuals—particularly parents—who are forced to navigate a healthcare system that is not built for their use. The reason such an illustration was used in place of a real-life story is due to the difficulty and rarity of undocumented immigrants sharing their experiences with those outside their community. This further exemplifies the difficulties undocumented immigrants

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1. *Grey's Anatomy: Only Mama Knows* (ABC television broadcast Oct. 16, 2014).

2. *Id.*

3. *Id.*

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*

8. *Id.*

have when accessing healthcare and how those barriers can impact our own understanding of the issue. Despite many other countries guaranteeing access to healthcare, the United States chooses to impose legal barriers that prevent vulnerable populations from receiving vital care. This purposeful exclusion undermines our country's public health goals, exacerbates health disparities, and increases the cost of healthcare for all.

In *Plyler v. Doe*, the United States Supreme Court set a foundation for expanding healthcare access to undocumented children and pregnant individuals by ruling that the Equal Protection Clause applies to *all* persons within the jurisdiction of the United States.⁹ While *Plyler* dealt with education, its principles should extend to other fundamental public services—particularly healthcare. Just as education is essential for personal and societal advancement, access to healthcare is essential for ensuring a population not only survives but thrives.

The United States' Medicaid Program has long served as a crucial safety net for millions of low-income individuals and families, and expanding it to include undocumented children and pregnant individuals is long overdue.¹⁰ This Note argues that the exclusion of undocumented children and pregnant individuals from Medicaid coverage is a policy failure that contradicts the core objectives of the program and the Equal Protection Clause of the Fourteenth Amendment.¹¹ By examining legal frameworks, public health implications, and economic realities, affecting undocumented immigrant populations, this Note demonstrates that comprehensive federal reform expanding health care access for this underserved population is both necessary and achievable. This proposal not only aligns with the principles of human dignity and the universal right to healthcare but is also required under the Equal Protection Clause. A federal expansion of Medicaid is not only a compassionate approach, but it also represents sound public policy that promotes healthier communities and a more equitable healthcare system.

Part I of this Note explains the historical and legal foundation for expanding Medicaid coverage to undocumented children and pregnant individuals. It examines the history of immigration in the United States and the current demographics of undocumented populations. It also explores the purpose and evolution of Medicaid, including current restrictions on Medicaid eligibility for undocumented individuals under federal law, and the negative outcomes of current policies and legislation that impact undocumented individuals' access to healthcare.

Part II discusses the legal and policy justifications for Medicaid expansion. It applies *Plyler's* Equal Protection principles to the healthcare context, showing parallels between how the Court's decision to allow undocumented children access to education in *Plyler* can be applied to healthcare access for undocumented children and pregnant individuals. This part then explores

9. *Plyler v. Doe*, 457 U.S. 202, 210 (1982).

10. 42 U.S.C. §§ 1396 to 1396w-8 (2018).

11. U.S. CONST. amend. XIV, § 1.

comparative models, evaluating international and state-level approaches to providing healthcare for undocumented populations. Specifically, it examines Thailand and France's approaches and rationale that highlight alternative frameworks for healthcare inclusion. Additionally, this part reviews state-led initiatives, such as California and Illinois's Medicaid expansions, demonstrating that successful models already exist within the United States. These comparative examples, coupled with the reasoning from *Plyler*, illustrate the societal and economic benefits of expanding Medicaid access.

Part III outlines actionable policy recommendations for Medicaid expansion at both the federal and state levels, outlining a path towards comprehensive reform. This part first details specific legislative action, such as amending the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA") and expanding the Affordable Care Act ("ACA"). It then discusses state-level measures that can serve as interim solutions until federal reform is enacted. Additionally, this part argues for why expansion is necessary, using the legal reasoning from *Plyler* to demonstrate that healthcare access—like education—is essential to preventing the creation of a permanent underclass and assisting those who had no say in their status. It further strengthens the case for reform by drawing on economic and public health rationales. Finally, this section addresses counterarguments, refuting common claims about the financial burden and potential for incentivized immigration.

II. MEDICAID, IMMIGRATION, AND THE IMPACT OF EXCLUSION

Undocumented children and pregnant individuals face systemic challenges in accessing healthcare due to legal restrictions, historical exclusions, and economic barriers. These challenges are rooted in two histories. The history of Medicaid, a program founded as a vital safety net program, then reshaped by later amendments and expansions that impacted the delivery of services. The second is the history of immigration in the United States, including current demographics, motivations, and realities many undocumented individuals face. Together, these histories produce the negative outcomes and consequences of current exclusions, which fall into three key areas: economic impact, public health impact, and individual impact.¹²

A. History of Medicaid

Congress established Medicaid in 1965 under Title XIX of the Social Security Act with the intent of providing health coverage to low-income individuals and families, with a focus on those who could not afford private

12. See *infra* Part II. A–C.

health insurance.¹³ This included populations such as low-income children, the elderly, and the disabled.¹⁴ At its conception, Medicaid assisted eligible individuals and families in attaining or retaining their independence and ability for self-care, but only to those deemed to be the “deserving poor.”¹⁵

The Patient Protection and Affordable Care Act of 2010, commonly known as the ACA or Obamacare, provided a significant expansion for Medicaid eligibility.¹⁶ With this expansion, Medicaid now covers nearly all low-income children and adults under sixty-five, regardless of their family status or disability.¹⁷ With the ACA expansion, Medicaid covers approximately eighty-three million low-income individuals and is the largest source of “medical and health-related services” in the United States.¹⁸

Medicaid is a joint federal-state program, with the federal and state governments both having roles in determining an individual’s eligibility.¹⁹ The federal government sets minimum eligibility standards related to financial need or other characteristics that all states must follow.²⁰ This ensures that certain vulnerable groups are covered. The federal government also funds a portion of each state’s Medicaid program.²¹ States have considerable flexibility to determine specific eligibility criteria within the federal framework.²² States may also set additional income limits, expand to cover additional populations, and choose extra benefits beyond those required by the federal government.²³

Under this current framework, states are allowed to expand Medicaid access

13. 42 U.S.C. §§ 1396 to 1396w-8 (2018); Shannon Schumacher et al., *Understanding the U.S. Immigrant Experience: The 2023 KFF/LA Times Survey of Immigrants*, KFF (Sep. 17, 2023), <https://www.kff.org/racial-equity-and-health-policy/kff-la-times-survey-of-immigrants/#d53efe98-31a4-48f1-944f-b1b1aff36c06> [https://perma.cc/YD76-BNVR]; CONG. RSCH. SERV., R43357, *MEDICAID: AN OVERVIEW* 5 (2023); Barbara S. Klees, Christian J. Wolfe & Catherine A. Curtis, *Annual Statistical Supplement, 2015*, SOC. SEC. ADMIN., <https://www.ssa.gov/policy/docs/statcomps/supplement/2015/medicaid.html> [https://perma.cc/8C3G-DWSW] (last visited Oct. 9, 2024).

14. Klees et al., *supra* note 13.

15. BRIETTA R. CLARK ET AL., *HEALTH LAW CASES, MATERIALS, AND PROBLEMS* 639 (9th ed. 2022) (Historically, society has differentiated between those who were poor through no fault of their own, such as elderly or children, as opposed to those perceived as able-bodied).

16. Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001; Jennifer Sullivan et al., *Entering Their Second Decade, Affordable Care Act Coverage Expansions Have Helped Millions, Provide the Basis for Further Progress*, CTR. BUDGET & POL’Y PRIORITIES, <https://www.cbpp.org/research/health/entering-their-second-decade-affordable-care-act-coverage-expansions-have-helped> [https://perma.cc/YD2M-9ANC] (last updated Mar. 25, 2024).

17. Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18001; Sullivan et al., *supra* note 16.

18. Klees et al., *supra* note 13; Rudowitz et al., *10 Things to Know About Medicaid*, KFF (Feb. 18, 2025), <https://www.kff.org/medicaid/10-things-to-know-about-medicaid/> [https://perma.cc/5YDZ-U8GR].

19. CONG. RSCH. SERV., *supra* note 13.

20. *Id.* at 4–5.

21. Rudowitz et al., *supra* note 18; CONG. RSCH. SERV., *supra* note 13, at 1.

22. Klees et al., *supra* note 13.

23. CONG. RSCH. SERV., *supra* note 13, at 4.

to undocumented immigrants.²⁴ However, without a federal requirement, states must fund coverage for populations that federal law excludes, such as undocumented immigrants, using state-funds alone.²⁵ If federal expansion is implemented, states will be required to provide the minimum level of assistance set by the federal government, but they will have the benefit of federal funds to assist in subsidizing the care of an additional population.

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (“PRWORA”), also referred to as the Welfare Reform Act, codified significant limitations on access to public benefits for undocumented immigrants.²⁶ Section 401 of PRWORA explicitly bars undocumented immigrants from receiving federally funded public health benefits, which includes Medicaid coverage.²⁷ However, the Emergency Medical Treatment and Labor Act of 2010 (“EMTALA”) required hospitals to provide emergency medical care to any patient, regardless of immigration status or ability to pay.²⁸ Medicaid then reimburses the hospital for the emergency services provided to such individuals.²⁹ Under this requirement, a hospital is only required to stabilize a patient.³⁰ Once a patient is stabilized, EMTALA imposes no further obligation, even where the original injury requires long-term treatment or additional procedures.³¹

B. History of Immigration

The United States is a nation built by immigrants, which has shaped the country’s demographics and economic landscape. As of 2023, there are close to fifty million foreign-born individuals in the United States, accounting for approximately 14.3% of the United States population.³² Most of these immigrants are documented, but there are an estimated ten to eleven million

24. See Tanya Broder, *Medical Assistance Programs for Immigrants in Various States (Table)*, NAT’L IMMIGR. L. CTR. (Mar. 6, 2025), <https://www.nilc.org/resources/medical-assistance-various-states/> [perma.cc/FWA2-TL5X] (noting a number of states and the District of Columbia have expanded their Medicaid programs to include undocumented children and pregnant individuals without federal assistance. Several also allow undocumented pregnant individuals to access Medicaid for prenatal and/or postnatal care, but do not allow undocumented children access).

25. *Id.*

26. Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, Pub. L. No. 104-193, § 401, 110 Stat. 2105, 2261–62 (codified as amended at 8 U.S.C. § 1611).

27. 8 U.S.C. § 1611.

28. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1395dd(a)–(b) (2010).

29. *Id.*

30. *Id.* at § 1395dd(b).

31. *Id.* at § 1395dd(a)–(b).

32. Mohamad Moslimani & Jeffery S. Passel, *What the data says about immigrants in the U.S.*, PEW RSCH. CTR. (Sep. 27, 2024), <https://www.pewresearch.org/short-reads/2025/08/21/key-findings-about-us-immigrants/> [https://perma.cc/8RX8-MLJ7].

undocumented immigrants present in the United States.³³ There are many reasons these immigrants come to the United States. Most come for more or better opportunities for themselves and their children, including better educational opportunities and better economic opportunities.³⁴ Many immigrants also seek more personal rights and freedoms, and some flee unsafe or violent conditions.³⁵

Undocumented immigrants come to the United States from a wide variety of origin countries. It is estimated that the current largest undocumented immigrant populations originally hail from Mexico, El Salvador, and India.³⁶ Additionally, the vast majority of immigrant households are “mixed status.”³⁷ This means that both undocumented and lawfully present or United States-born residents reside together in the same household.³⁸

In recent years, the immigration enforcement landscape has shifted drastically. Since the start of the second Trump administration in January 2025, interior immigration enforcement has intensified, with the number of deportations from within the United States increasing roughly five times their late 2024 levels and ICE arrests quadrupling.³⁹ This enforcement surge has heightened fear within immigrant communities, including among the lawfully present and U.S.-born members of mixed-status households.⁴⁰ As of 2025, 41% of immigrant adults reported worrying that they or a family member could be detained or deported, up from 26% in 2023.⁴¹ That fear carries direct consequences for healthcare access: one in five immigrant parents reported that they or a family member had avoided seeking medical care since January 2025 because of immigration-related concerns, twice the rate of adults without children. This reluctance is compounded by the administration’s reversal of prior policy limiting immigration enforcement at “sensitive locations” such as

33. Moslimani & Passel, *supra* note 32; Mohammad M. Fazel-Zarandi et al., *The number of undocumented immigrants in the United States: Estimates based on demographic modeling with data from 1990 to 2016*, 13 PLOS ONE 9, 2 (2018) (noting that while typical studies estimate the number of undocumented immigrants to hover around eleven million, an alternative approach to estimating the number of undocumented immigrants reveals there may be a much higher undocumented population than previously thought).

34. Schumacher et al., *supra* note 13.

35. *Id.*

36. Moslimani & Passel, *supra* note 32.

37. *Id.*

38. *Id.*

39. See Graeme Blair & David Hausman, *One Year of Immigration Enforcement Under the Second Trump Administration*, DEPORTATION DATA PROJECT (Apr. 7, 2026), <https://deportationdata.org/analysis/immigration-enforcement-first-year.html> [<https://perma.cc/KNF8-26GZ>].

40. Akash Pillai, Drishti Pillai & Samantha Artiga, *Potential Impacts of Mass Detention and Deportation Efforts on the Health and Well-Being of Immigrant Families*, KFF (Feb. 6, 2025), <https://www.kff.org/racial-equity-and-health-policy/potential-impacts-of-mass-detention-and-deportation-efforts-on-the-health-and-well-being-of-immigrant-families/> [<https://perma.cc/KG8M-CXAU>].

41. *Key Facts on Health Coverage of Immigrants*, KFF (May 19, 2026), <https://www.kff.org/racial-equity-and-health-policy/key-facts-on-health-coverage-of-immigrants/> [<https://perma.cc/VL8G-X2R8>].

hospitals.⁴² As discussed below, this dynamic deepens the very barriers to care that Medicaid exclusion already imposes on undocumented children and pregnant individuals.

C. Negative Outcomes of the Status Quo

Excluding undocumented children and pregnant individuals from Medicaid has consequences that extend far beyond those directly affected. The harms fall into three areas. Economically, exclusion drives up overall healthcare spending by shifting care to costlier emergency and uncompensated services.⁴³ From a public health standpoint, it raises the risk of outbreaks, deepens health inequities within vulnerable communities, and undermines federal public health initiatives.⁴⁴ At the individual level, the lack of preventive care leads to worse maternal and infant outcomes, along with developmental delays and untreated conditions in children.⁴⁵

1. Economic Impact of Exclusion from Healthcare

The economic rationale for expanding healthcare access is compelling. Individuals with access to healthcare experience improved health outcomes, greater financial stability, and better access to preventive care.⁴⁶ Healthy workers—of which there are approximately 8.3 million in the United States—are better equipped to maintain steady employment, contribute to the economy, and support their families.⁴⁷ Conversely, individuals denied access to healthcare are more likely to suffer chronic conditions, resulting in lost productivity, higher healthcare costs, and greater reliance on social safety nets.⁴⁸

Long-term, inclusive healthcare policies generate substantial returns on the initial investment.⁴⁹ Healthier populations contribute more to the workforce, pay

42. Drishti Pillai et al., *Health and Health Care Experiences of Immigrant Parents and Their Children During the Second Trump Term*, KFF (Mar. 2, 2026), <https://www.kff.org/immigrant-health/health-and-health-care-experiences-of-immigrant-parents-and-their-children-during-the-second-trump-term/> [https://perma.cc/JEE6-7K2T].

43. See *infra* Part II.C.1.

44. See *infra* Part II.C.2.

45. See *infra* Part II.C.3.

46. See Thomas Buchmueller et al., *Improving Access to Affordable and Equitable Health Coverage: A Review from 2010 to 2024*, ASPE ISSUE BRIEF No. HP-2024-11 (June 7, 2024), <https://www.ncbi.nlm.nih.gov/books/NBK611354/> [https://perma.cc/QZL7-3EGZ]; see also *Report: The Importance of Health Coverage*, AM. HOSP. ASS'N, <https://www.aha.org/guides-reports/report-importance-health-coverage> [https://perma.cc/LB4B-DP7J] (last visited Nov. 5, 2024).

47. *Id.*; Kevin Appleby, *The Importance of Immigrant Labor to the US Economy*, CTR. FOR MIGRATION STUD. (Sep. 2, 2024), <https://cmsny.org/importance-of-immigrant-labor-to-us-economy/> [https://perma.cc/BT8K-22FW].

48. AM. HOSP. ASS'N, *supra* note 46.

49. See Rebecca Masters et al., *Return on investment of public health interventions: a systematic review*, 71 J. EPIDEMIOLOGY & CMTY. HEALTH 827 (2017).

taxes, and stimulate economic growth, while reducing the financial burden of treating advanced illnesses.⁵⁰ Policymakers in other countries have recognized this benefit and have implemented universal healthcare systems that prioritize access for all residents, including undocumented individuals.⁵¹ These programs demonstrate that the initial costs of expanding healthcare access are later offset by savings in emergency care and long-term social benefits.

Denying Medicaid coverage to undocumented children and pregnant individuals does not eliminate their need for healthcare—it merely shifts the cost burden to emergency services and uncompensated care, which are far more expensive and less efficient.⁵² Emergency departments are required under EMTALA to provide stabilizing care to all patients, regardless of their ability to pay or immigration status.⁵³ However, this care is limited to emergencies and does not address the long-term management of chronic conditions or preventive care, leading to repeated hospital visits and escalating healthcare costs.

Providing preventive care is significantly less costly than relying on emergency services.⁵⁴ A single visit to the emergency room for a preventable condition can cost several thousand dollars, compared to a few hundred dollars for a routine doctor's visit.⁵⁵ Thus, excluding undocumented children and pregnant individuals from Medicaid increases a state's healthcare costs by neglecting preventive measures.

2. Public Health Impact of Exclusion from Healthcare

Excluding undocumented immigrants from healthcare access poses significant risks to public health. Denying care to undocumented children and pregnant individuals escalates the risk of communicable diseases spreading within vulnerable communities.⁵⁶ By incorporating undocumented children and pregnant individuals into Medicaid, society would be better able to shoulder and reduce the spread of disease while also promoting healthier, more stable communities.

Furthermore, the exclusion of these populations exacerbates health inequities rooted in the social determinants of health. Immigrant communities

50. AM. HOSP. ASS'N, *supra* note 46.

51. See Wudan Yan, *Only One Country Offers Universal Health Care to All Migrants*, NPR (Mar. 31, 2016), <https://www.npr.org/sections/goatsandsoda/2016/03/31/469608931/only-one-country-offers-universal-health-care-to-undocumented-migrants> [<https://perma.cc/L7PC-WV6Q>]; Jean-Marie André & Fabienne Azzedine, *Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance*, 37 PUB. HEALTH REV. 5 (2016); See *infra* Part III.B.

52. AM. HOSP. ASS'N, *supra* note 46.

53. Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. § 1396b (2010).

54. Shirley Musich et al., *The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures*, 19 POP. HEALTH MGMT. 389 (2016).

55. AM. HOSP. ASS'N, *supra* note 46.

56. Jean Edward, *Undocumented Immigrants and Access to Health Care: Making a Case for Policy Reform*, 15 POL'Y, POL., & NURSING PRAC. 5, 8 (2014).

are disproportionately affected by barriers to healthcare access.⁵⁷ Poverty, unstable housing, limited access to nutritious food, and unsafe working conditions already place undocumented immigrant communities at a higher risk of poor health outcomes.⁵⁸ Denying undocumented children and pregnant individuals healthcare only deepens their vulnerabilities, potentially creating a public health crisis that could be avoided, and leaving immigrants with significantly worse health outcomes than their non-immigrant counterparts.

Denying Medicaid coverage also impedes the federal government's ongoing efforts to achieve health equity.⁵⁹ Numerous federal initiatives seek to reduce disparities in maternal and child health.⁶⁰ However, these reforms remain incomplete when entire communities are systematically excluded from care—and recent policy developments have only widened that gap. In 2025, the Department of Health and Human Services underwent a significant restructuring, and its proposed budget paired new funding for the “Make America Healthy Again” initiative with deep cuts to maternal health programs.⁶¹ This reprioritization underscores that federal commitment to maternal and child health equity remains uneven, and that commitment will stay unfulfilled so long as undocumented children and pregnant individuals are excluded from coverage. Addressing the gap in coverage is therefore not only a moral imperative, but a necessary step in creating a more equitable healthcare system.

3. *Individual Impact of Exclusion from Healthcare*

Access to healthcare for undocumented children and pregnant individuals is fundamental to improving their health outcomes. Comprehensive prenatal care monitors the health of both the pregnant individual and the developing child, and reduces risks such as preterm birth, low birth weight, and maternal complications.⁶² Without it, the risks rise sharply; research consistently links

57. WHO report shows poorer health outcomes for many vulnerable refugees and migrants, WHO (July 20, 2022), <https://www.who.int/news/item/20-07-2022-who-report-shows-poorer-health-outcomes-for-many-vulnerable-refugees-and-migrants> [https://perma.cc/8WPZ-6UKU].

58. See Samantha Artiga & Olivia Pham, *Addressing Health and Social Needs of Immigrant Families: Lessons from Local Communities*, KFF (Oct. 28, 2019), <https://www.kff.org/racial-equity-and-health-policy/addressing-health-and-social-needs-of-immigrant-families-lessons-from-local-communities/#19129c39-80db-4496-933f-4be87fe080d0> [https://perma.cc/XF5M-6UJG]; WHO, *supra* note 57.

59. See U.S. DEP'T OF HEALTH & HUM. SERV., SURGEON GENERAL'S CALL TO ACTION TO IMPROVE MATERNAL HEALTH (2020), <https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf> [https://perma.cc/UYX6-STCA] [hereinafter Surgeon General's Call to Action].

60. See U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTHY WOMEN, HEALTHY PREGNANCIES, HEALTHY FUTURES: ACTION PLAN TO IMPROVE MATERNAL HEALTH IN AMERICA (2020), <https://aspe.hhs.gov/topics/public-health/hhs-initiative-improve-maternal-health> [https://perma.cc/H5B7-85TP]; see also Surgeon General's Call to Action, *supra* note 59.

61. See Press Release, U.S. Dep't of Health & Human Servs., HHS Announces Transformation to Make America Healthy Again (Mar. 27, 2025), <https://www.hhs.gov/press-room/hhs-restructuring-doge.html> [https://perma.cc/8FR6-UBXL].

62. Surgeon General's Call to Action, *supra* note 59.

inadequate prenatal care to higher rates of maternal and infant mortality.⁶³ Early childhood care, which includes regular pediatric visits, vaccinations, and developmental screenings, is also critical to a child's physical, cognitive, and emotional growth during formative years.⁶⁴

While undocumented pregnant individuals may go to a hospital emergency department to deliver their child, the care is subject to serious limitations.⁶⁵ EMTALA classifies a pregnant individual experiencing contractions as an emergency medical condition, but treatment is only required *after* doctors have determined that there is not adequate time to transfer the parent to another hospital or that the transfer could endanger the "health or safety" of the parent or unborn child.⁶⁶ These rules, coupled with the ethical and economic considerations doctors will grapple with when an undocumented individual presents for care, could result in a delay of care when a pregnant individual has a critical need. Quality and immediate care for pregnant individuals during birth is essential to the continued health and wellness of both the parent and child, and delaying this care can result in negative consequences for both.⁶⁷

The consequences of denying healthcare do not end at birth. The absence of regular medical check-ups and early interventions during critical periods can lead to delays in cognitive and motor development.⁶⁸ This reality places an undue burden on not only the children and their families, but also on the entire healthcare system, which must eventually address more serious health problems that could have been prevented through early care. The constitutional guarantee of birthright citizenship for U.S.-born children, regardless of their parents' immigration status, derives from the Fourteenth Amendment's Citizenship Clause.⁶⁹ In January 2025, Executive Order 14160 sought to limit birthright citizenship for children of parents lacking lawful status; the order has been enjoined by every court to consider it, and the Supreme Court heard argument on its constitutionality in *Trump v. Barbara* on April 1, 2026, with a decision expected by summer 2026.⁷⁰

63. See Cristina Novoa, *Ensuring Healthy Births Through Prenatal Support*, CTR. FOR AM. PROG. 20 (Jan. 31, 2020), <https://www.americanprogress.org/article/ensuring-healthy-births-prenatal-support/> [https://perma.cc/Q2BX-P5R9]; see also NAT'L ACAD. SCI., ENG'G., & MED., VIBRANT AND HEALTHY KIDS: ALIGNING SCIENCE, PRACTICE, AND POLICY TO ADVANCE HEALTH EQUITY 311 (2019).

64. See Paul H. Lipkin & Michelle M. Macias, *Promoting Optimal Development: Identifying Infants and Young Children with Developmental Disorders Through Developmental Surveillance and Screening*, 145 AM. ACAD. PEDIATRICS 1, 2 (2020); see NAT'L ACADEMIES SCI., ENG'G., & MED., *supra* note 63.

65. 42 U.S.C.A. § 1395dd(e)(1).

66. *Id.* at § 1395dd(e)(1)(A)–(B)(ii).

67. Novoa, *supra* note 63.

68. Lipkin & Macias, *supra* note 64.

69. See U.S. CONST. amend. XIV, § 1; *United States v. Wong Kim Ark*, 169 U.S. 649 (1898).

70. *Trump v. Barbara*, 146 S. Ct. 879 (2025) (granting certiorari); *Trump v. Barbara (Birthright Citizenship)*, SCOTUSBLOG, <https://www.scotusblog.com/cases/trump-v-barbara/> [https://perma.cc/6MBK-SSBM] (last visited June 1, 2026).

III. ANALYSIS OF LEGAL AND POLICY FRAMEWORKS FOR MEDICAID EXPANSION

Expanding Medicaid to include undocumented children and pregnant individuals requires both legal justification and policy implementation. The constitutional foundation for expansion lies in *Plyler v. Doe*, whose equal-protection reasoning should extend from education to healthcare.⁷¹ Comparative studies reinforce the case: the healthcare systems of Thailand and France, international human-rights principles, and state-level expansions in California and Illinois all demonstrate that extending coverage to undocumented populations is both workable and beneficial.⁷²

A. The Legal Framework for Medicaid Expansion

In *Plyler v. Doe*, the United States Supreme Court held that the Equal Protection Clause of the Fourteenth Amendment applies not just to United States citizens, but to all “persons” within the jurisdiction of the United States, including undocumented immigrants.⁷³ This case established a precedent that discriminatory treatment based solely on immigration status is subject to an intermediate level of scrutiny and should be narrowly tailored to further a substantial state interest.⁷⁴ The core holding of *Plyler* was that undocumented children are entitled to equal protection under law, specifically in the context of access to public education, and denying them access to education did not further any substantial state interest.⁷⁵ The Court recognized that excluding undocumented children from basic educational opportunities—based solely on their immigration status—violated their right to equal protection.⁷⁶

The Equal Protection Clause requires that states treat individuals in similar situations alike.⁷⁷ When a state action classifies individuals based on certain characteristics, courts will apply varying levels of scrutiny: strict, intermediate, or rational basis.⁷⁸ Strict scrutiny is applied to classifications involving fundamental rights or suspect classes, such as race or national origin.⁷⁹ The state must show that the action serves a compelling state interest and is narrowly tailored to achieve that interest.⁸⁰ Intermediate scrutiny is applied to

71. See *infra* Part III.A.

72. See *infra* Part III.B.1–4.

73. *Plyler v. Doe*, 457 U.S. 202, 210–12 (1982).

74. *Id.* at 217–18; see *infra* notes 84–90 and accompanying text (explaining the tiers of constitutional scrutiny).

75. *Plyler*, 447 U.S. at 202, 230.

76. *Id.* at 221–22.

77. U.S. CONST. amend. XIV, § 1.

78. *Equal Protection*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/equal_protection [<https://perma.cc/SXY5-7JZF>] (last updated Nov. 2022).

79. *Strict Scrutiny*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/equal_protection [<https://perma.cc/GK9U-6SXS>] (last updated July 2025).

80. *Id.*

classifications such as gender or legitimacy.⁸¹ Under intermediate scrutiny, the state must show that the action serves an important government interest and is substantially related to achieving that interest.⁸² Rational basis review is applied to all other classifications.⁸³ Under this test, there must be a legitimate state interest, and it must be rationally related to the statute's goals.⁸⁴

Plyler focused solely on providing education to undocumented children. The Court considered whether Texas could deny undocumented children free public education that it also provides to citizen children.⁸⁵ The Texas legislature revised its education laws in 1975 to withhold state funds “for the education of children who were not ‘legally admitted’ into the United States.”⁸⁶ A class action suit was filed on behalf of school-aged children who were unable to establish their legal admittance into the country.⁸⁷ A district court ruled in favor of the children, deciding that the children were entitled to equal protection under the Fourteenth Amendment, and that the Texas law violated the Supremacy Clause, as immigration policy is a matter of federal authority.⁸⁸ The Fifth Circuit upheld the decision with respect to equal protection, but decided the District Court had erred regarding the Supremacy Clause.⁸⁹ The Supreme Court then granted certiorari.⁹⁰

The Court began their evaluation by determining whether undocumented children were considered “persons” for purposes of the Fourteenth Amendment.⁹¹ The Court ruled that undocumented children were “persons” in the ordinary sense, and that legal precedent had long recognized them as such.⁹² Furthermore, the Court rejected Texas’ argument that even if the undocumented children were “persons,” they were not afforded protections under the Equal Protection Clause.⁹³ The Court reiterated previous decisions, stating that the provisions of the Equal Protection Clause are universal to all persons within the borders of a State.⁹⁴

Next, the Court evaluated the nature of the burden imposed on the undocumented children and the lack of control they have over their immigration status. The Court reasoned that while undocumented status was the result of unlawful action, holding this misconduct against children, who lacked power or

81. *Intermediate Scrutiny*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/intermediate_scrutiny [<https://perma.cc/285B-N4YS>] (last updated June 2023).

82. *Id.*

83. *Rational Basis Test*, LEGAL INFO. INST., https://www.law.cornell.edu/wex/rational_basis_test [<https://perma.cc/46TZ-2EXX>] (last updated Mar. 2024).

84. *Id.*

85. *Plyler v. Doe*, 457 U.S. 202, 205 (1982).

86. *Id.*

87. *Id.* at 206.

88. *Id.* at 207–08.

89. *Id.* at 208–09.

90. *Id.* at 210.

91. *Id.*

92. *Id.*

93. *Id.* at 211.

94. *Id.* at 212.

control over their status or how it came to be, would go against “fundamental conceptions of justice.”⁹⁵ Furthermore, it would be difficult to have a legitimate justification for imposing such a discriminatory burden on the children when they have no control over their status.⁹⁶

The Court next considered the significance of education in our society and the potential costs of denying access to education.⁹⁷ While education is not considered a right under the Constitution, the Court recognized its fundamental role in maintaining the fabric of society and reasoned that the deprivation of education would impact a child for their entire life.⁹⁸ The Court further reasoned the denial of education would be an affront to the Equal Protection Clause, as it would create an unreasonable obstacle to individual advancement.⁹⁹ Finally, the Court acknowledged that access to education benefits all of society, and preventing access to tools to better oneself negatively impacts the fabric of society.¹⁰⁰

The Court continued by determining the proper level of scrutiny to be applied, and what additional considerations were needed.¹⁰¹ The Court determined that undocumented children were not a suspect class, and that education was not a fundamental right, meaning the Texas law was not subject to strict scrutiny.¹⁰² Instead, Texas was required to demonstrate how its statute furthered a legitimate state interest to the extent necessary to overcome intermediate scrutiny.¹⁰³ Texas argued that the undocumented status of the children itself justified their exclusion from public education,¹⁰⁴ but the Court found that this reasoning did not align with any federal immigration policies and did not further Texas’ interest in preserving state resources.¹⁰⁵

Texas argued it needed to preserve resources for the education of lawful residents, but this argument was quickly dismissed by the Court.¹⁰⁶ First, there was no evidence suggesting that undocumented immigrants severely burdened Texas’ economy.¹⁰⁷ In fact, the evidence suggested that undocumented immigrants “underutilize[d] public services,” and actually contributed to the state economy through labor and taxes.¹⁰⁸ Second, the court found no support for the claim that barring undocumented children from schools improves the quality of education.¹⁰⁹ Undocumented children were considered “basically

95. *Id.* at 220.

96. *Id.*

97. *Id.* at 221–222.

98. *Id.* at 221.

99. *Id.* at 221–22.

100. *Id.* at 221.

101. *Id.* at 223–24.

102. *Id.* at 223.

103. *Id.* at 224–25.

104. *Id.* at 224.

105. *Id.* at 227.

106. *Id.*

107. *Id.* at 228.

108. *Id.*

109. *Id.* at 229.

indistinguishable” from lawful residents.¹¹⁰

Finally, the Court dismissed the idea that the transient nature of the children leads to their education not benefitting the state.¹¹¹ The Court determined there was nothing to suggest *any* child educated in the State of Texas would use their education for the benefit of another state, and that many undocumented children would likely remain in Texas indefinitely, so any alleged savings from refusing them education would be insubstantial.¹¹²

Plyler was decided under intermediate scrutiny, recognizing the unique circumstances of undocumented children and the role of education in society.¹¹³ While *Plyler* established a critical precedent for the educational rights of undocumented children, its direct application beyond K-12 education has been limited.¹¹⁴ Additionally, based on the ideological leanings of the current Supreme Court, it is difficult to say whether *Plyler* would be decided the same today. However, the underlying principles of *Plyler*, which emphasize the dangers of creating a permanent underclass and that children should not be penalized for their parents’ actions, should be applied in many other fields, including healthcare.

B. Comparative Studies

Several states and other countries have implemented policies that provide healthcare access to undocumented populations. Thailand and France both extend health care to undocumented immigrants, though care under different frameworks. International human-rights law reinforces the principle that the International Covenant on Economic, Social, and Cultural Rights treats healthcare as a fundamental right, offering a useful model for reform. California and Illinois have already expanded coverage to undocumented children and pregnant individuals using state funds alone, which demonstrates that workable models of reform already exist within the United States.¹¹⁵

1. Thailand’s Migrant Health Insurance Scheme and Migrant Fund

Only one nation provides healthcare to all, regardless of immigration status and time in-country.¹¹⁶ Thailand views healthcare as a universal right and a cornerstone of public welfare, and this influenced their broad policy on access

110. *Id.*

111. *Id.* at 230.

112. *Id.*

113. *Id.* at 217–18.

114. See *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 459 (1988) (quoting *Plyler v. Doe*, 457 U.S. 202, 239 (Powell, J., concurring)) (recognizing that *Plyler* applied only to the “unique circumstances” of undocumented children, which include (1) penalizing children for their parents’ illegal conduct, and (2) risking significant and enduring adverse consequences to the child).

115. See *infra* Part II.B.

116. Yan, *supra* note 51.

to healthcare.¹¹⁷ Thailand has a long history of relying on migrant labor, particularly from neighboring countries such as Myanmar, Cambodia, and Laos.¹¹⁸ Recognizing the need to provide healthcare access to these populations, the Thai government has implemented various health insurance schemes to cover undocumented migrants.¹¹⁹ These broad policies are a collaborative effort between the public and non-profit sectors, with the aim of caring for a vulnerable and critical population.¹²⁰ The Migrant Health Insurance Scheme (“MHIS”) and The Migrant Fund (“M-FUND”), are the insurance options available to undocumented migrants in Thailand.¹²¹

Both MHIS and M-FUND are designed to be relatively affordable for undocumented migrants. The annual premium for MHIS is approximately 11 USD for children and 49 USD for adults, making it one of the lowest-cost insurance options in the region.¹²² However, enrollees must also pay a one-time medical check-up fee ranging from 15–27 USD, which can be a financial burden for some.¹²³ M-FUND operates on a different model, financed primarily through donor contributions and individual payments rather than government support.¹²⁴ Monthly premiums range up to 10 USD, depending on the level of coverage selected.¹²⁵

Costs are low for both programs, with MHIS’s annual premium only amounting to 11 USD for children and 49 USD for adults.¹²⁶ M-FUND, being donor and contributor financed, does not cost more 10 USD a month depending on the specific coverage obtained.¹²⁷ Unlike MHIS, M-FUND does not require a lump-sum annual payment, making it even more accessible to migrants who cannot afford upfront costs.¹²⁸

Eligibility for MHIS is tied to employment status and documentation

117. *Id.*

118. *Id.*

119. See INT’L LAB. ORG., SOCIAL PROTECTION IN ACTION: BUILDING SOCIAL PROTECTION FLOORS FOR ALL, EXTENDING SOCIAL HEALTH PROTECTION IN THAILAND: ACCELERATING PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE (2021), <https://www.social-protection.org/gimi/gess/gess/Media.action?id=18734> [<https://perma.cc/BL25-6WEP>]; Tuangratananon et al., *In Thailand, Noncitizen Health Matters*, THINK GLOB. HEALTH (Sep. 16, 2020), <https://www.thinkglobalhealth.org/article/thailand-noncitizen-health-matters> [<https://perma.cc/NZM3-QDLE>].

120. Yan, *supra* note 51; Tschirhart et al., *Including undocumented migrants in universal health coverage: a maternal health case study from the Thailand-Myanmar border*, 21 BMC HEALTH SERV. RSCH. 1315 (2021); Tangcharoensathien et al., *Implementing health insurance for migrants, Thailand*, 95 BULL. WORLD HEALTH ORG. 146, 147 (2017).

121. Tschirhart et al., *supra* note 120.

122. Tuangratananon et al., *supra* note 119.

123. *Id.*

124. See Nareerut Pudpong et al., *Assessment of a Voluntary Non-Profit Health Insurance Scheme for Migrants along the Thai–Myanmar border: A Case Study of the Migrant Fund in Thailand*, 16 INT’L J. ENV’T. RSCH. & PUB. HEALTH 2581 (2019).

125. *Id.*

126. Tuangratananon et al., *supra* note 119.

127. Pudpong et al., *supra* note 124.

128. *Id.*

efforts.¹²⁹ Migrants must be over 18 years old and in the process of obtaining a work permit to qualify.¹³⁰ This means that those who do not intend to legalize their status or cannot secure employment sponsorship may eventually lose access to the program. However, MHIS may also cover dependents of adults who qualify.¹³¹ In contrast, M-FUND is open to all undocumented migrants, regardless of work status.¹³² There are no residency or employment requirements, making it an easy alternative for those unable to meet MHIS criteria.¹³³ Dependents, including children, can also be covered under M-FUND for a small fee.¹³⁴

While these programs expand healthcare access beyond the norm, there are some challenges migrants might face when attempting to enroll. One of the most significant barriers is the documentation required for MHIS enrollment.¹³⁵ Undocumented migrants must begin the process of obtaining a work permit and legal presence to remain eligible.¹³⁶ In contrast, M-FUND does not require any legal status or documentation, but it is not available in every Thai province, limiting its availability.¹³⁷ However, it is available in border provinces, which are high entry points for migrants.¹³⁸

Additionally, MHIS and M-FUND are entirely voluntary, meaning that undocumented migrants are not automatically enrolled and must be proactive in obtaining coverage.¹³⁹ Because enrollment is not compulsory, some migrants remain uninsured, either due to lack of awareness, financial constraints, or distrust of government-affiliated programs.¹⁴⁰ Despite inconsistent coverage among migrant populations, both programs have improved healthcare access and migrant health in Thailand.¹⁴¹

2. France's Aide Médicale d'État Program

France also offers broad access to health insurance for undocumented immigrants through its Aide Médicale d'État program, also known as State Medical Aid ("SMA"). SMA ensures that undocumented immigrant individuals

129. INT'L LAB. ORG., *supra* note 119, at 5.

130. *Id.*

131. *Id.*

132. Pudpong et al., *supra* note 124.

133. Pudpong et al., *supra* note 124 (with no residency or employment requirements, M-FUND aims to "leave nobody behind" based on citizenship or ethnic status, which supports the move towards Universal Health Coverage).

134. *Id.*

135. INT'L LAB. ORG., *supra* note 119.

136. *Id.*

137. König et al., *The impact of the health microinsurance M-FUND on the utilization of health services among migrants workers and their dependents in Thailand: A case-control study*, 9 J. MIGRATION & HEALTH 100236 (2024).

138. *Id.*

139. Tuangratananon et al., *supra* note 119.

140. *See supra* note 119 and accompanying text.

141. König et al., *supra* note 137; Tschirhart et al., *supra* note 120.

residing in France can access health medical services without financial barriers.¹⁴² France's rationale for allowing such broad access is rooted in the recognition that "for health and humanitarian reasons," access to healthcare is required.¹⁴³ Furthermore, these moral and practical justifications both emphasize and acknowledge that denying healthcare to undocumented immigrants would not only violate basic human rights, but pose significant health risks to the entire population.¹⁴⁴

SMA is entirely free for eligible individuals, with no premiums or out-of-pocket charges.¹⁴⁵ As a public program, it is funded by the government.¹⁴⁶ To be eligible, applicants must not earn more than €756 per month and must have resided in France for at least three months.¹⁴⁷ Recipients of SMA remain enrolled for one year, after which they must reapply.¹⁴⁸ However, access to SMA is not automatic, and is instead entirely voluntary.¹⁴⁹ Thus, there is a risk that eligible individuals will not receive aid if they are unable to enroll.

Despite being free, SMA does have strict eligibility requirements that may present a barrier to entry for some individuals. The application process requires undocumented immigrants to prove their residency and income,¹⁵⁰ which could be difficult for a transient population. With the annual renewal requirement, some recipients could lose their coverage if they are unable to provide the required documentation year after year.

Even with potentially burdensome barriers to care, the SMA program's outcomes cannot be denied. SMA has significantly improved healthcare access for undocumented immigrants by ensuring they receive medical care and reducing the strain on emergency departments.¹⁵¹ The program also benefits France's public health efforts by preventing the spread of infectious diseases and allowing early treatment of chronic conditions.¹⁵²

3. *International Covenant*

International human rights law also underscores the importance of healthcare access for all. The International Covenant on Economic, Social, and Cultural Rights ("ICESCR"), adopted by the United Nations General Assembly

142. Marsaudon et al., *Patients like any others? Providing coverage to undocumented migrants in France: effects on access to care and usual source of care*, 34 EUR. J. PUB. HEALTH 1157–1162 (2024).

143. André & Azzedine, *supra* note 51; Johann Caihol et al., *French political bargaining over undocumented migrants' health*, 403 THE LANCET 140, 140 (2024).

144. JUSOT ET AL., ACCESS TO STATE MEDICAL AID BY UNDOCUMENTED IMMIGRANTS IN FRANCE: FIRST FINDINGS OF THE "PREMIERS PAS" SURVEY 2 (2019).

145. Marsaudon et al., *supra* note 142.

146. *Id.*

147. *Id.*

148. *Id.*

149. JUSOT ET AL., *supra* note 144.

150. Marsaudon et al., *supra* note 142.

151. Caihol et al., *supra* note 143; Marsaudon et al., *supra* note 142.

152. André & Azzedine, *supra* note 51; Caihol et al., *supra* note 143.

in 1966 and in force since 1976, establishes key economic, social, and cultural rights that states must realize.¹⁵³ ICESCR contains provisions regarding health and the protection of families, which establish a baseline for their treatment in each country that has ratified the agreement.¹⁵⁴

ICESCR recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” under Article 12.¹⁵⁵ Full realization of this includes taking steps to reduce the stillbirth rate, lower infant mortality, and encourage healthy development of children.¹⁵⁶ Additionally, nations must aim to improve hygiene and prevent, treat, and control diseases.¹⁵⁷ Finally, nations must ensure access to medical services and health care.¹⁵⁸ In sum, Article 12 establishes health as a fundamental human right and requires nations to work towards universal healthcare, sanitation, and access to essential medicines.¹⁵⁹

ICESCR also recognizes the protection of family as a “fundamental group unit of society” under Article 10.¹⁶⁰ It requires special assistance to be given to families, mothers, and children, including special protection for mothers before and after childbirth.¹⁶¹ Additionally, “protection and assistance” should be given to all children regardless of their “parentage or other conditions.”¹⁶² This Article stresses the importance of family stability and the protection of vulnerable groups, including children and pregnant individuals.¹⁶³

The United States has signed, but not ratified ICESCR.¹⁶⁴ Signature without ratification signals an intent to comply with the principles but does not create any obligation to implement the provisions.¹⁶⁵ Furthermore, since the United States has not ratified the ICESCR, it is not legally bound by the covenant’s provisions.¹⁶⁶ Essentially, the United States has acknowledged the importance

153. International Covenant on Economic, Social and Cultural Rights, United Nations General Assembly, *opened for signature* Dec. 16, 1966, 993 U.N.T.S. 3 (entered into force Jan. 3, 1976), https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtmsg_no=IV-3&chapter=4, [<https://perma.cc/SC9S-TBYW>].

154. *Id.*

155. *Id.* at Art. 12.

156. *Id.*

157. *Id.*

158. *Id.*

159. *Id.*

160. *Id.* at Art. 10.1.

161. *Id.*

162. *Id.*

163. *Id.* at Art. 10.

164. See *Status of Treaties*, U.N. TREATY COLLECTION, https://treaties.un.org/pages/ViewDetails.aspx?src=TREATY&mtmsg_no=IV-3&chapter=4&clang=_en#top [<https://perma.cc/2TC5-8ECD>] (last visited Feb. 3, 2025).

165. *Glossary*, U.N. TREATY COLLECTION, https://treaties.un.org/pages/Overview.aspx?path=overview/glossary/page1_en.xml#accession [<https://perma.cc/UW6J-9A8R>] (last visited Mar. 8, 2025) A signature is a step in the ratification process but cannot bind a party to the requirements of the treaty. *Id.*

166. *Id.* (noting that ratification indicates consent to be bound to a treaty, but a “signature does not establish the consent to be bound”).

of the rights contained in ICESCR but has refrained from committing to fully implementing them and thus cannot be held accountable for lack of compliance.

4. *Comparative State-Level Actions from California and Illinois*

California has one of the most comprehensive healthcare access programs for undocumented individuals in the United States.¹⁶⁷ The state provides full Medi-Cal coverage to all children under eighteen, regardless of immigration status, if they reside in California and meet the income standards.¹⁶⁸ In recent years, California has also expanded the Medi-Cal coverage for undocumented pregnant individuals, ensuring access to healthcare during pregnancy and for a period of time after birth.¹⁶⁹ To qualify for these programs, an individual's income must be at least 138% below the federal poverty level, which amounts to approximately \$21,597 of income per year for a single person.¹⁷⁰ Furthermore, to reduce any further financial strain for those who are eligible, Medi-Cal coverage is provided free or at low-cost.¹⁷¹

Despite the broad coverage afforded by Medi-Cal, undocumented immigrants do face several barriers to enrollment. The most significant barrier is distrust of the government.¹⁷² Prior to Trump's reelection, fearing a return of stricter immigration enforcement, many undocumented immigrants were concerned about public charge rules and whether the information provided during enrollment could expose their immigration status.¹⁷³

Even with barriers to entry, there has been success in improving the health of undocumented children and pregnant individuals.¹⁷⁴ California has seen an improvement in health status for undocumented children after expansion, with

167. Paulette Cha and Patricia Malagon, In First-in-Nation State Law, All Low-Income Residents Qualify for Medi-Cal, PUB. POL'Y. INST. OF CAL. (Jan. 3, 2024), <https://www.ppic.org/blog/in-first-in-nation-state-law-all-low-income-residents-qualify-for-medi-cal/> [https://perma.cc/2GZC-XFQN].

168. SB 75 – *Medi-Cal for All Children*, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB75Children.aspx> [https://perma.cc/WV8M-PQ25] (last visited Feb. 3, 2025).

169. Medi-Cal Benefits, Pregnancy, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/medi-cal/benefits/?tab=pregnancytab-4> [https://perma.cc/N7GS-CURC] (last visited June 16, 2026).

170. Eligibility by Federal Poverty Level, DEP'T HEALTH CARE SERVS., <https://www.dhcs.ca.gov/medi-cal/qualify/qualify-for-medi-cal-eligibility-chart/> [https://perma.cc/45FE-YUN2], (last visited June 16, 2026).

171. Apply for Medi-Cal, STATE CAL., [https://perma.cc/V8KA-EBVB], last updated Nov. 21, 2024).

172. Jasmine Aguilera, *Fears Over Past Immigration Policies Chill Medi-Cal Enrollment*, CAL. HEALTH CARE FOUND. (Oct. 1, 2024), <https://www.chcf.org/resource/chilling-effect-medi-cal-enrollment-fears-over-past-immigration-policies/> [https://perma.cc/6FKU-4AJZ].

173. *Id.*

174. See Miller et al., *Covering Undocumented Immigrants: The Effects of a Large-Scale Prenatal Care Intervention*, NAT'L BUREAU OF ECON. RSCH., Working Paper No. 30299, (July 2022), https://www.nber.org/system/files/working_papers/w30299/w30299.pdf [https://perma.cc/3622-WTQU].

the proportion of undocumented children who report being in excellent health raising from 20% to 30%.¹⁷⁵ Furthermore, pregnant individuals with access to Medicaid coverage have higher rates of prenatal care, longer gestation lengths, and higher birth weights, all key indicators of a healthy pregnancy.¹⁷⁶

Illinois also provides critical coverage to undocumented children and pregnant individuals. It operates the “All Kids” Program, which provides coverage to all children in the state, regardless of immigration status.¹⁷⁷ Under All Kids, there are also two programs for pregnant individuals, regardless of immigration status: Medicaid Presumptive Eligibility (“MPE”) and “Moms & Babies.”¹⁷⁸ MPE offers immediate, but temporary, coverage for outpatient care, while Moms & Babies covers pregnant individuals while they are pregnant and for up to a year following birth.¹⁷⁹

For all Medicaid programs open to undocumented immigrants, the costs are low or nonexistent.¹⁸⁰ Under MPE and Moms & Babies, pregnant individuals are not required to pay premiums or co-payments.¹⁸¹ All Kids is free for some families, while some pay premiums and co-payments based on their income level.¹⁸² However, certain services, such as vaccinations and regular check-ups, are free for every child enrolled in All Kids, regardless of parental income.¹⁸³ The income standard for children under All Kids is approximately 318% of the federal poverty level, while the income standard for pregnant individuals is 213%.¹⁸⁴

175. Monica Saucedo & Adriana Ramos-Yamamoto, *California Sees Health Gains for Undocumented Residents After Medi-Cal Expansion*, CAL. BUDGET & POL’Y CTR. (Oct. 2024), <https://calbudgetcenter.org/resources/california-sees-health-gains-for-undocumented-residents-after-medi-cal-expansion/> [<https://perma.cc/VLK7-2ZSZ>] (drawing on 2013–2019 California Health Interview Survey data showing the share of non-citizen children reporting excellent health rose from 20% to 30% following the expansion, while citizen children saw no comparable change).

176. Miller et al., *supra* note 174.

177. *Information for Providers*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/providerinfo.html> [<https://perma.cc/R9CU-LZPA>] (last visited Oct. 10, 2024).

178. *See Moms and Babies*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/momsandbabies.html> [<https://perma.cc/M5B2-4WX2>] (last visited Feb. 3, 2025) [hereinafter *Illinois Moms and Babies*].

179. *Id.*

180. *Illinois Moms and Babies*, *supra* note 178; *About All Kids*, ILL. DEP’T HEALTHCARE & FAM. SERVS., <https://hfs.illinois.gov/medicalprograms/allkids/about.html> [<https://perma.cc/6RK5-5PU4>] (last visited Feb. 3, 2025) [hereinafter *Illinois All Kids*].

181. *See Illinois Moms and Babies*, *supra* note 178.

182. *See Illinois All Kids*, *supra* note 180.

183. *Id.*

184. *Medical Programs*, ILL. DEP’T HUM. SERVS., <https://hfs.illinois.gov/medicalclients/medicalprograms.html> [<https://perma.cc/EGZ7-5WQM>] (last visited June 16, 2026).

IV. RECOMMENDATIONS FOR MEDICAID EXPANSION AND THE LEGAL AND POLICY BASIS

Ensuring Medicaid access for undocumented children and pregnant individuals requires significant reforms of the current system. These reforms are both achievable and necessary. Policymakers can expand access by amending PRWORA, expanding the ACA, and supporting interim state-level measures.¹⁸⁵ The case for these reforms draws on *Plyler*'s equal-protection reasoning, comparative and international models, and the economic and public-health benefits of inclusion¹⁸⁶

A. What Should Happen

Expanding Medicaid on a federal level requires a multi-faceted approach that addresses both legal barriers and systemic gaps. First, the government should amend PRWORA.¹⁸⁷ Amending the PRWORA to exempt undocumented children and pregnant individuals from its bar on federally funded public benefits—which currently excludes them from Medicaid coverage—would address critical gaps in healthcare access for some of the most vulnerable populations. By allowing Medicaid coverage for prenatal care and pediatric services, the federal government could ensure better health outcomes for parents and children, ultimately reducing healthcare costs by avoiding more severe health issues from developing in the future.

Second, the government should expand the ACA to provide subsidized coverage for undocumented children and pregnant individuals.¹⁸⁸ This would bridge a critical gap in the healthcare system, but recent legislation has moved in the opposite direction. The One Big Beautiful Bill Act of 2025 restricted ACA Marketplace subsidies, including for many immigrants, meaningful reform would require reversing those cuts and extending subsidized coverage to undocumented children and pregnant individuals.¹⁸⁹ Expanding access therefore remains essential. This could involve allowing undocumented immigrants to purchase insurance on ACA marketplaces, with subsidies based on income levels. Alternatively, the government could create special ACA provisions that prioritize parent and child healthcare for undocumented populations.

Thirdly, Congress should implement broader immigration reform to address the intersection of immigration status and healthcare access. Legislative proposals such as the HEAL for Immigrant Families Act should expand

185. *See infra* Part IV.A.

186. *See infra* Part IV.B.

187. *See supra* Part II.A.

188. *Id.*

189. One Big Beautiful Bill Act of 2025, Pub. L. No. 119-21 (2025); Ortaliza et al., *How Will the One Big Beautiful Bill Act Affect the ACA, Medicaid, and the Uninsured Rate?*, KFF (June 18, 2025), <https://www.kff.org/affordable-care-act/how-will-the-2025-budget-reconciliation-affect-the-aca-medicaid-and-the-uninsured-rate/> [<https://perma.cc/LG2Y-8J2Q>].

Medicaid and CHIP eligibility for undocumented immigrants.¹⁹⁰ A more comprehensive approach should integrate healthcare access into the framework of immigration reform, recognizing that the health of immigrant populations, especially children and pregnant individuals, is vital to public health and economic stability. Such reforms should include pathways to documented status for undocumented individuals while ensuring immediate access to healthcare services.

Additionally, states should follow suit and use their own funds to expand healthcare coverage for these populations. Encouraging more states to provide care for undocumented children and pregnant individuals is essential to addressing healthcare disparities. States should expand Medicaid to include undocumented children and pregnant individuals, especially in cases where federal legislation is still pending. Through executive orders, state legislation, and budget allocations, states can play a crucial role in filling gaps left by federal inaction.

While federal and state-level Medicaid reforms are essential, community health programs and state-funded safety nets can serve as temporary solutions to address the healthcare needs of undocumented children and pregnant individuals. Federally qualified health centers (“FQHCs”) and other community-based clinics already provide healthcare to underserved populations, including undocumented immigrants, often at reduced costs or for free. Expanding these programs and increasing funding for state-level safety net initiatives would help bridge the healthcare gap while longer-term reforms are pursued.

Comprehensive reform requires the integration of immigration and healthcare policies. Current immigration policies exacerbate disparities by creating barriers to access based on legal status. Policymakers should consider long-term strategies that address immigration reform and healthcare access. For example, healthcare policies could be crafted and revised to ensure that access to essential services is decoupled from immigration status, recognizing that public health is an interconnected issue that affects every person, regardless of residency or documentation.

B. Why Expansion Should Happen

Expanding Medicaid to include undocumented children and pregnant individuals is not just a compassionate policy choice—it is a necessity. The constitutional framework supports expansion, because under *Plyler* immigration status alone is not a sufficient justification for denying fundamental public services.¹⁹¹ Comparative and international experience reinforces the case, as expanded programs already in place and show that the United States is more

190. HEAL for Immigrant Families Act of 2023, H.R. 5008, 118th Cong. (2023) (proposing to expand healthcare access for all immigrants by removing barriers to coverage, recognizing that health insurance is essential in reducing inequities).

191. See *infra* Part IV.B.1.

than equipped to follow.¹⁹² And the economic and public health evidence confirms that restrictive policies only harms the economy and public health instead of protecting it.

1. Fourteenth Amendment Basis for Expansion

The Supreme Court's decision in *Plyler v. Doe* established a critical precedent for applying the Equal Protection Clause of the Fourteenth Amendment to undocumented children.¹⁹³ The Court recognized that immigration status alone is not a sufficient justification for depriving children of a service that is essential for personal development and wellbeing, particularly when such deprivation of public education would relegate them to a permanent underclass.¹⁹⁴ The same legal reasoning that protected undocumented children's right to public education under *Plyler* should extend to healthcare—an equally essential service.

The Equal Protection Clause guarantees that no state shall “deny to any person within its jurisdiction the equal protection of the laws.”¹⁹⁵ In *Plyler*, the Court held that undocumented children are “persons” within the meaning of the Fourteenth Amendment and are thus entitled to its protections.¹⁹⁶ The same principle applies in the healthcare context. Denying Medicaid coverage to undocumented children and pregnant individuals creates an unjustifiable classification that fails to further any substantial state interest.

Although the Court did not deem undocumented children a “suspect class” nor recognize education as a fundamental right, but it applied intermediate scrutiny, reasoning that undocumented children should not be penalized for their parents' actions.¹⁹⁷ The Court's logic—protecting children from bearing the consequences of their parents' immigration status¹⁹⁸—applies even more forcefully to healthcare. Unlike education, which has long-term societal benefits, healthcare is an immediate and life-sustaining necessity. Denying healthcare to undocumented children and pregnant individuals effectively imposes a preventable burden that leads to worsened outcomes, exacerbating the very inequalities *Plyler* sought to mitigate.

The *Plyler* decision recognized that denying education to undocumented children would leave them in a cycle of poverty and social disadvantage, ultimately harming the nation's economy and “fabric of society.”¹⁹⁹ Similarly, denying healthcare creates a structurally disadvantaged class of individuals who will suffer from preventable medical conditions and illness. The Court's concern in *Plyler* about the formation of a permanent underclass resonates in the

192. See *infra* Part IV.B.2–3.

193. *Plyler v. Doe*, 457 U.S. 202, 230 (1982).

194. *Id.* at 219.

195. U.S. CONST. amend. XIV, § 1.

196. *Plyler*, 457 U.S. at 210–12.

197. *Id.* at 217–18.

198. *Id.* at 219–20.

199. *Id.* at 221–22.

healthcare context: a lack of access to essential medical care ensures that undocumented children and those born to undocumented individuals will suffer from poor health throughout their lives, further marginalizing them and impeding their ability to contribute productively to society.

Furthermore, *Plyler* rejected the argument that Texas could withhold education based on fiscal constraints.²⁰⁰ The Court reasoned that undocumented immigrants, while not lawful residents, contribute to state economies, and that their exclusion did not serve a substantial state interest.²⁰¹ The same logic should apply to healthcare. Undocumented immigrants contribute significantly to the United States economy—both directly through labor and taxation and indirectly by sustaining industries that rely on immigrant labor. The exclusion of undocumented children and pregnant individuals from Medicaid is therefore not justified by cost concerns; rather, it creates inefficiencies by increasing reliance on emergency services, which are far more expensive and economically burdensome in the long term.

Plyler also emphasized that states cannot enact policies that conflict with federal immigration law or attempt to impose their own restrictions on undocumented individuals in a manner that undermines broader national interests.²⁰² Healthcare access is a matter of public welfare that extends beyond state borders, and systematically excluding undocumented populations undermines federal efforts to promote public health, prevent the spread of disease, can reduce healthcare disparities. By denying Medicaid access, states create adverse public health consequences that ultimately burden federal healthcare systems, running counter to national public health goals.

Under the *Plyler* framework, state policies that impose burdens on immigration status must be justified by a substantial state interest.²⁰³ In denying Medicaid coverage to undocumented children and pregnant individuals, the government's primary justification often rests on budgetary concerns or deterrence of immigration.²⁰⁴ However, as *Plyler* made clear, financial burdens alone do not justify the denial of fundamental services, especially when the long-term costs of exclusion outweigh the immediate savings.²⁰⁵ Similarly, deterrence-based arguments—that expanding Medicaid would incentivize undocumented immigration—fail under *Plyler* reasoning. Just as there was no evidence that granting education to undocumented children increased unlawful immigration, there is no compelling data to suggest that providing prenatal and pediatric healthcare would create a significant incentive for migration.²⁰⁶ Crucially, children—like those in *Plyler*—have no agency in their immigration status and do not migrate in pursuit of Medicaid benefits. Rather than an

200. *Id.* at 228.

201. *Id.*

202. *Id.* at 224–26.

203. *Id.* at 224–25.

204. *Id.* at 227–28.

205. *Id.* at 228.

206. Artiga & Pham, *supra* note 58.

incentive, healthcare access ensures that those already present and those soon to be born can develop into healthy, productive members of society. The Supreme Court already dismissed similar claims in *Plyler*, recognizing that denying public services does not deter immigration, just as providing them does not increase it.²⁰⁷ The vast majority of people who migrate to the United States do so for economic opportunities, family reunification, or safety from violence—not because of Medicaid eligibility.²⁰⁸ The idea that a pregnant individual in another country would uproot their life, risk their safety, and cross a border solely for the *possibility* of healthcare coverage assumes a level of foresight, planning, and risk-taking that is simply not borne out by immigration data.

If healthcare access was truly a driving factor for immigration, we would see significant undocumented migration to states that have already expanded Medicaid to undocumented populations, such as California and Illinois, yet there is little to no evidence to support that claim.²⁰⁹ Immigration patterns are shaped by far broader economic and political factors than the availability of medical care.²¹⁰ The claim that Medicaid expansion would create a flood of undocumented migration is nothing more than a scare tactic designed to avoid engaging with the real benefits of expansion.

The reasoning behind *Plyler* is not confined to education—it is a broader reaffirmation that the Equal Protection Clause does not permit states to arbitrarily exclude undocumented children from essential public services when doing so would impose significant harm. The same fundamental principles of justice and fairness that underpinned the *Plyler* decision demand that Medicaid be expanded to include undocumented children and pregnant individuals. Just as education ensures that children can become productive members of society, healthcare ensures their very survival and well-being. This requires that pregnant individuals also receive healthcare, since the children they carry also had no say in their status and deserve the chance to become productive and healthy members of society.²¹¹

By applying *Plyler*'s precedent, policymakers have a clear legal basis for Medicaid expansion: undocumented children and pregnant individuals are entitled to equal protection under the law, and states cannot justify their exclusion from vital healthcare programs without a substantial state interest.²¹² Given that the economic, public health, and ethical justifications

207. *Plyler*, 457 U.S. at 228.

208. *Id.* (recognizing that employment opportunities, not the availability of public benefits, are the dominant incentive for immigration); see *supra* Part II.B.

209. Vasil Yassenov et al., *States' Medicaid Expansion Counters the "Welfare Magnet" Argument*, IMMIGR. POL'Y LAB, <https://immigrationlab.org/project/states-medicaid-expansion-counters-welfare-magnet-argument/> [<https://perma.cc/9YDR-9EEA>].

210. See *supra* Part II.B.

211. Furthermore, under conservative rhetoric, life begins at conception. If life begins at conception, then despite the current administration's attempt at dismantling birthright citizenship, these unborn children will one day be United States citizens and should receive all benefits of their status.

212. See *supra* Part IV.B.1.

overwhelmingly support inclusion, there is no legitimate basis for continuing the deny Medicaid coverage to such a vulnerable population.

Expanding Medicaid is not just a compassionate policy—it is a constitutional imperative under the Equal Protection Clause. The United States has long struggled with healthcare inequities, and refusing care to those most in need only exacerbates systemic disparities. As *Plyler* recognized, our country's commitment to fairness and opportunity must extend to all individuals, regardless of their immigration status. Medicaid expansion for undocumented children and pregnant individuals is not only legally sound, but essential to upholding the principles of justice, human dignity, and public welfare that *Plyler* sought to protect.

2. Internationally Recognized Human Right

The United States prides itself on being a global leader in human rights and innovation, yet it lags behind not only peer nations, but some of its own states in providing healthcare access to undocumented children and pregnant individuals. By continuing to exclude these vulnerable populations from Medicaid, the United States isolates itself from the well-established global understanding that healthcare is a fundamental right and a necessity for a stable society. If nations with fewer economic resources can recognize the moral and practical necessity of providing healthcare to all residents, regardless of immigration status, the United States has no legitimate justification—or excuse—for failing to do the same.

Beyond economic and practical considerations, the United States is also failing to meet its obligations under international human rights standards. The ICESCR, which the United States has signed, affirms that healthcare is a fundamental human right.²¹³ While the United States has not ratified the treaty, its signature signals an acknowledgment that healthcare access should not be arbitrarily restricted based on immigration status. Article 12 of the ICESCR explicitly calls for access to maternal and child healthcare as part of the right to health.²¹⁴ Article 10 recognizes that children and pregnant individuals require special protections and denying them healthcare contradicts these principles.²¹⁵ By refusing to extend Medicaid to undocumented children and pregnant individuals, the United States is violating not only the spirit of the ICESCR but also its own professed commitment to human rights and public health. If the United States expects to maintain credibility in advocating for human rights and decency on a global level, it cannot continue policies that deny essential services to the most vulnerable residents within its own borders. Failing to provide healthcare access to undocumented children and pregnant individuals is not just an economic and public health failure—it is a moral and international

213. See *supra* Part III.B.3 (discussing the ICESCR and its treatment of healthcare as a fundamental right).

214. See *supra* Part III.B.3 (discussing ICESCR Article 12).

215. See *supra* Part III.B.3 (discussing ICESCR Article 10).

embarrassment.

In many developed nations, the debate over whether undocumented individuals should receive healthcare has long been settled in favor of inclusion. Countries like France and Thailand have recognized that denying healthcare to vulnerable populations is not only ethically indefensible, but also economically and socially counterproductive.²¹⁶ These countries have adopted policies ensuring that all individuals, regardless of immigration status, receive healthcare because they understand the broader consequences of exclusion: increased healthcare costs, worsened public health outcomes, and the erosion of social cohesion. The United States, by contrast, continues to tie healthcare access to immigration status, a policy choice that actively works against its own interests. By denying healthcare to undocumented children and pregnant individuals, the United States is not saving money—it is guaranteeing higher long-term costs through preventable emergency room visits, increased parent and infant mortality, and an overall sicker population that will still require medical attention, but in the least efficient and most expensive way possible. If nations with fewer resources can afford to provide healthcare to undocumented children and pregnant individuals, why does one of the wealthiest nations in the world insist it cannot? The answer is not about feasibility—it is about political will and a refusal to acknowledge that exclusionary policies create more harm than they prevent.

Opponents of Medicaid expansion argue that providing healthcare to undocumented individuals places an undue financial burden on the system; however, comparative models show that the opposite is true. Thailand's MHIS and France's AME program illustrate that integrating undocumented populations into healthcare systems is not an economic drain, but rather, a cost-saving measure.²¹⁷ Thailand, despite being a developing nation, has recognized that early intervention and preventive care are far cheaper than emergency treatments, which has driven Thailand's expansion of health coverage to migrants regardless of status.²¹⁸ France has also avoided the inefficiencies of exclusionary healthcare policies by ensuring that undocumented individuals receive regular medical care, reducing the strain on emergency rooms and overall healthcare costs.²¹⁹

In stark contrast, the United States' model forces undocumented children and pregnant individuals into the most expensive form of care: emergency treatment. Under EMTALA, hospitals are required to treat anyone who comes through their doors, meaning the federal government is already subsidizing care

216. See *supra* Part III.B.1–2 (discussing Thailand's and France's healthcare programs for undocumented immigrants).

217. INT'L LAB. ORG., *supra* note 119; André & Azzedine, *supra* note 51.

218. König et al., *supra* note 137; Tschirhart et al., *supra* note 120.

219. Caihol et al., *supra* note 143; Marsaudon et al., *supra* note 142.

for undocumented children and pregnant individuals.²²⁰ However, it is doing so in the least efficient, most expensive way possible.²²¹ Expanding Medicaid would not create a new financial burden; it would shift existing, uncontrolled costs into a structured, preventive system that is far more effective and less expensive.

3. *Economics of State-Level Successes*

The United States does not need to speculate whether expanding Medicaid for undocumented children and pregnant individuals would be economically viable because state-level experiments have already proven its success. Several states have already done what the federal government refuse to do: recognize that providing healthcare to undocumented children and pregnant individuals is both a moral imperative and a policy necessity. California and Illinois have expanded Medicaid access for these populations, and their experiences dismantle the primary arguments against federal expansion. California's Medi-Cal expansion has led to higher rates of prenatal care, improved birth outcomes, and increased reports of good health among undocumented children—all without crippling the state's budget.²²² If California, a lone state subsidizing this program on its own, can sustain this program, why should the federal government be unable to do so? Illinois' "All Kids" and maternity coverage programs have also prevented emergency healthcare crises and reduced state costs by ensuring that pregnant individuals receive necessary prenatal care.

These programs serve as clear evidence that investing in preventive healthcare for undocumented populations yields significant public health and economic benefits. If state-level expansions do not cause the financial devastation that critics predict, then the federal government's refusal to act is not based on economic concerns, but on an unwillingness to extend the same logic on a national scale. Medicaid expansion for undocumented children and pregnant individuals is not an untested or radical proposal. It is a proven model that some of the country's most economically powerful states have already implemented with success.²²³

The global and state-level evidence is clear: providing healthcare to undocumented children and pregnant individuals is not a matter of feasibility but of political will. Other nations, including those with fewer resources than

220. See *Understanding EMTALA*, AM. COLL. EMERGENCY PHYSICIANS [<https://perma.cc/H5NQ-QZN6>] (last visited Mar. 8, 2025) (If not subsidized by government payouts, then providers are not receiving any compensation for their services, further increasing healthcare costs for everyone else).

221. See *supra* Part II.C.1.

222. See *supra* Part III.B.4 (discussing California's and Illinois's Medicaid expansions and their health outcomes).

223. See *California's Economy (2026)*, PUB. POL'Y INST. OF CAL., <https://www.pplic.org/publication/californias-economy/> [<https://perma.cc/EES5-DDA2>] (last visited June 1, 2026) (reporting California's 2025 GDP of \$4.3 trillion, roughly 14% of national GDP, ranking among the world's largest economies).

the United States, have recognized that healthcare access must extend to all residents, regardless of immigration status. State-level programs in California and Illinois have proven that Medicaid expansion for undocumented populations leads to better health outcomes and is economically feasible. Furthermore, exclusionary policies violate international human rights standards and place the United States at odds with global themes of healthcare as a basic right. The United States can no longer afford to perpetuate a policy that increases healthcare costs, worsens public health outcomes, and undermines its own principles.

The decision to exclude undocumented children and pregnant individuals from Medicaid is not merely an oversight—it is a deliberate policy failure that prioritizes ideology over evidence and political expediency over public health. The current system forces hospitals, taxpayers, and communities to absorb the financial and human costs of preventable medical crises while denying healthcare to those who need it most. This approach is not only irrational, but self-defeating. If the goal of a healthcare system is to protect the health of a population while controlling costs, then restricting access to essential care for undocumented children and pregnant individuals accomplishes the exact opposite. The refusal to expand Medicaid ignores the reality that denying care today creates exponentially higher costs tomorrow—costs borne not by undocumented individuals alone, but by every person who shares their schools, workplaces, and communities.

Some states may challenge a federal mandate to expand Medicaid, citing concerns about federal overreach and state sovereignty. Legal challenges could arise on the grounds of federalism, with states arguing that they should retain control over Medicaid eligibility. However, such challenges would face significant legal hurdles. The federal government has broad authority under the Spending Clause of the Constitution to impose conditions on federal funding programs, such as Medicaid. Additionally, while the Supreme Court's decision in *Sebelius* allows states to opt out of Medicaid expansion under the Affordable Care Act,²²⁴ this ruling does not preclude the possibility of federal incentives or a narrower expansion targeting undocumented pregnant individuals and children.

While the Supreme Court's ruling in *Sebelius* declared expansion could not be compulsory, as that would amount to coercion, it did not strip the federal government of its power to encourage expansion through funding mechanisms. The ruling did not establish a constitutional prohibition on federal Medicaid expansions; rather, it determined that the federal government could not penalize states by withholding existing Medicaid funding if they refused expansion.²²⁵ This distinction is crucial. The federal government retains the power to offer incentives, set new conditions for funds, and create specific Medicaid categories that states can voluntarily adopt.

224. Nat'l Fed'n of Indep. Bus. v. *Sebelius*, 567 U.S. 519 (2012).

225. *Id.* at 589.

Additionally, a targeted expansion focused on undocumented children and pregnant individuals is distinct from the broad ACA expansion. The *Sebelius* decision was based in part on the argument that the ACA expansion was so dramatic that it effectively rewrote the Medicaid program.²²⁶ A more narrowly tailored expansion, such as one aimed at providing prenatal and pediatric care, does not fundamentally alter Medicaid the same way, and is less likely to be viewed as coercive. The federal government could craft an incentive-based approach that avoids the coercion concerns raised in *Sebelius*, while still encouraging nationwide adoption.

Moreover, the financial argument against Medicaid expansion collapses under the weight of real-world evidence.²²⁷ While there is an upfront investment that will be required, refusing to expand based on this cost is shortsighted since the long-term benefits outweigh the initial cost, especially when considering how uncompensated care would be reduced.²²⁸ Additionally, states like California and Illinois have already expanded Medicaid to undocumented children and pregnant individuals, and the results contradict the claim that such policies would be fiscally unsustainable. These states have seen improved outcomes, proving that investment in early care leads to greater savings over time. The economic reality is clear: when Medicaid expands, costs go down, not up.

4. Public Health Basis for Expansion

A society's health is only as strong as its most vulnerable members. Excluding undocumented children and pregnant individuals from Medicaid is not a private crisis, but a public health disaster in the making. Infectious diseases do not check immigration status before spreading through a community. An undocumented child who cannot receive regular pediatric care does not simply suffer alone; their illness creates greater risks for classmates, teachers, and neighbors. A pregnant individual who is denied prenatal care does not merely put their own health at risk, but increases the risks to the child, both in the womb and outside it with lifelong complications. The consequences of excluding undocumented children and pregnant individuals from Medicaid extends far beyond their own lives, creating a domino effect of worsening health outcomes for every person.

The notion that public health can be compartmentalized—that denying healthcare to one group does not affect the broader population—is a dangerous

226. *Id.* at 583–84.

227. See Jesse Cross-Call, *Medicaid Expansion Continues to Benefit State Budgets, Contrary to Critics' Claims*, CTR. ON BUDGET AND POL'Y PRIORITIES (Oct. 9, 2018), <https://www.cbpp.org/research/health/medicaid-expansion-continues-to-benefit-state-budgets-contrary-to-critics-claims>. (Expansion results in net savings for state budgets since states do not have to spend as much on uncompensated care and other costs).

228. See Bryce Ward, *The Impact of Medicaid Expansion on States' Budgets*, COMMONWEALTH FUND (May 5, 2020), <https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets>.

and deeply flawed assumption. Due to the COVID-19 pandemic, we have already seen what happens when preventable diseases go unchecked, when populations are left vulnerable, and when emergency rooms become the default healthcare provider for people who should have received basic preventive care. When millions of people are excluded from care, diseases spread faster, hospitals become overwhelmed, and communities suffer. Yet despite these lessons, the United States continues to impose arbitrary barriers to Medicaid for undocumented children and pregnant individuals, as if their suffering exists in isolation. Public health is a collective endeavor, and every barrier to care weakens the entire system.

Opponents of Medicaid expansion often claim that covering undocumented individuals would be too expensive, yet this argument ignores the simple economic fact that treating preventable conditions early is far cheaper than waiting until they become medical emergencies. The United States already pays for undocumented individuals' healthcare—but in the most inefficient and expensive way possible. Hospitals cannot legally turn away patients in emergency situations, which means that when undocumented children and pregnant individuals are denied primary care, they inevitably end up in emergency rooms, where treatment costs skyrocket. The government and hospitals absorb these costs, and rather than investing in cost-saving preventive care through Medicaid, they simply pass the burden on.

The numbers make the case even stronger. A single emergency room visit for an untreated infection, a preventable complication in pregnancy, or an unmanaged chronic disease can cost thousands of dollars—often far more than the cost of ongoing primary care would have been. Hospitals cannot afford to absorb these costs indefinitely, so an alternative must be found and implemented.

5. Workforce Stability Benefits from Expansion

Beyond healthcare costs, denying Medicaid to undocumented individuals creates an economic liability that extends beyond the hospital and into the workforce. The United States depends on undocumented labor to sustain critical industries. These workers contribute billions of dollars to the economy, yet they are systematically denied access to healthcare, which weakens the very workforce that keeps the country running. A sick worker is a less productive worker.²²⁹ A parent who must choose between going to work and caring for a sick child—because that child could not get basic medical care—is a parent that contributes less to the economy. The economic harm of this policy is not theoretical—it is already happening.

A healthcare system that actively undermines the well-being of a critical

229. This author feels it necessary to note that no individual should have their value based on their economic worth, but due to the current political landscape and the unerring dedication to capitalism in the United States, it is an argument that must be used.

labor force is a system that undercuts its own economic stability. Expanding Medicaid is not just a public health imperative; it is an investment in the country's workforce. Healthier workers ultimately benefit businesses, tax revenues, and economic growth. The refusal to provide healthcare to undocumented children and pregnant individuals is not saving money—it is costing the United States billions of dollars in lost productivity and preventable absenteeism. The economic choice is not between providing or not providing healthcare; it is between paying for preventive care now or paying more for lost labor and emergency treatments later.

The only thing standing in the way of Medicaid expansion is political inertia and an unwillingness to acknowledge that healthcare is not a privilege reserved for those with the right papers, but a necessity for any functioning society. The question is no longer whether Medicaid expansion should happen, but how much longer the country is willing to pay the price for failing to act. Every day of inaction is another day of unnecessary suffering, higher costs, and preventable deaths. The time to expand Medicaid is not tomorrow, not in some distant future when politics align—it is now. To do anything less is to choose inefficiency, economic waste, and human neglect over the benefits of inclusion.

V. CONCLUSION

The recognition of personhood under the Constitution demands that undocumented individuals, particularly vulnerable groups like children and pregnant individuals, be treated with dignity and fairness. Excluding them from healthcare access contradicts this principle and disregards the foundational values of equality and opportunity of American society. Ensuring access to healthcare is not just a matter of individual wellbeing; it reflects a commitment to societal cohesion, economic stability, and the prevention of systemic inequities.

The exclusion of undocumented populations from essential healthcare services creates ripple effects that extend beyond individual harm. Preventable diseases, untreated conditions, and complications from inadequate prenatal care result in greater reliance on emergency services, higher long-term healthcare costs, and intergenerational impacts on health and economic mobility. These outcomes are not only morally troubling but also fiscally shortsighted. A system that prioritizes emergency care over prevention imposes unnecessary costs on taxpayers and weakens the collective health of society.

While the legal and ethical arguments for reform are clear, the broader benefits of inclusivity are equally compelling. International examples demonstrate that providing broad healthcare access benefits everyone, not just the privileged. Similarly, state-level initiatives show that expanding coverage to undocumented individuals is both feasible and beneficial, offering models for broader policy adoption. These examples underscore the practicality of reform and the tangible rewards of investing in equitable healthcare policies.

Now is the time to move beyond reactive and exclusory healthcare policies

and embrace a more inclusive system that addresses both public health needs and economic efficiency. By expanding Medicaid, the United States can achieve long-term savings, reduce the strain on emergency healthcare systems, and improve the health of entire communities. Efforts by the current administration to dismantle Medicaid threatens not only undocumented individuals, but millions of low-income Americans who rely on it for essential care. Instead of eliminating or further restricting Medicaid, policymakers must strengthen and expand it to ensure that it continues to fulfill its role as a crucial safety net.

The moral and ethical imperatives are equally clear: healthcare is a basic human right. As the United States grapples with persistent healthcare inequities, policymakers must act with both compassion and pragmatism. Denying healthcare to individuals—especially to children and pregnant individuals—because of their immigration status undermines the nation’s commitment to equity and justice. Expanding Medicaid to these populations is about more than money and government; it’s about recognizing the inherent dignity and humanity of every person within our borders.

Policymakers must prioritize federal reforms, such as amending the PRWORA and expanding the ACA to undocumented populations. Simultaneously, state governments must continue leading the way, drawing inspiration from successful initiatives in California and Illinois to create Medicaid expansions tailored to the needs of these vulnerable groups. These efforts underscore the broader values of fairness and public responsibility, emphasizing that healthcare is a necessity for all individuals living within the United States. Expanding Medicaid to undocumented children and pregnant individuals is a critical step toward building a healthier, more equitable society for all. Now is the time to act, ensuring that the most vulnerable among us have access to the care they need and deserve.