



Health as a Human Right: Expanding Insurance Coverage to Advance Equity and Protect Immigrant Communities in the United States

Laís Ramirez Santoro

I. EXECUTIVE SUMMARY

Health is a fundamental human right, recognized by the World Health Organization, the Universal Declaration of Human Rights, and international humanitarian law. Although the United States has made measurable progress in expanding health care coverage and improving outcomes, significant inequities persist. Cost remains a primary barrier to care, particularly for immigrants and other marginalized communities. This brief examines disparities in health insurance coverage — especially among immigrant populations — and argues for expanded coverage as a strategy to reduce poverty, improve access to care, and promote health equity nationwide.

II. OVERVIEW

Health equity exists when there is a "fair and just opportunity for everyone to attain their highest level of health". One of the most significant barriers to achieving health equity in the United States is unequal access to health insurance. A 2022 study found that Black, Latine, Asian, and American Indian/ Alaskan Native populations that are minoritized are three to four times more likely to be uninsured or underinsured than white

non-elderly Americans. Lack of insurance presents financial barriers to care, delays treatment, increases disease severity at diagnosis, and contributes to higher mortality rates and poorer outcomes. Immigrants—both documented and undocumented—remain persistently underserved. A 2025 KFF survey found that 24% of low-income immigrants report being uninsured, compared to substantially lower rates among higher-income immigrant households.

A. Relevance

Because health is a human right, access to care affects everyone, and the global community has an interest in promoting the well-being of all. Most high-income countries provide universal or near-universal health coverage through public systems, often with private supplemental options. The United States does not.

For undocumented immigrants, health access barriers intersect with additional structural vulnerabilities, including: (1) poverty and low-wage employment; (2) social and political instability in both home and destination countries; (3) risk of deportation; (4) crowded or unstable housing; and (5) workplace exploitation. These overlapping factors compound disparities and reinforce cycles of poor health and poverty.

III. HISTORY

A. Insurance in the U.S. Health Care System

A.A.1 Pre-Affordable Care Act

Before the Affordable Care Act (ACA), health insurance coverage was largely voluntary. Employers were not required to offer insurance, and individuals were not required to purchase it. Only about 10% of people purchased coverage on the individual market.

Public programs such as Medicaid (for low-income individuals) and Medicare (for seniors and certain people with disabilities) were the primary sources of coverage for vulnerable populations. However, approximately half of those eligible for Medicaid remain uninsured due to complex eligibility rules, state variation, and limited outreach.

Undocumented immigrants generally accessed care indirectly—often through citizen children of mixed-status families— or through emergency services. The Children’s Health Insurance Program (CHIP) expanded coverage for children who were ineligible for Medicaid but could not obtain other forms of insurance. CHIP became an important expansion of health care for children.

A.A.2 Bipartisan Roots for Expanding Coverage

The health reforms in the ACA have bipartisan roots. In the 1990s, some Republican lawmakers introduced the Health Equity and Access Reform Today (HEART) Act, which shared structural similarities with the ACA, including regulated insurance markets and coverage mandates.

When the ACA took effect in 2014, it expanded Medicaid eligibility to individuals under 65 with incomes up to 133 percent of the federal poverty line (FPL) and created the Basic Health Program. While politically contested, the ACA reflected longstanding cross-party policy concepts.

A.A.3 Supplemental Insurance and Social Welfare Programs

Programs such as CHIP greatly expanded coverage for children in families above Medicaid limits but were unable to afford private insurance. This program allows federal funding to match state contributions to cover this crucial gap in care. Most states now cover children up to at least 200% of the FPL.

Other social safety net programs that may prevent health issues address the social determinants of health. These include the Supplemental Nutrition Assistance Program (SNAP), energy assistance programs, Temporary Cash Assistance, and Social Security Disability Insurance (SSDI).

While individuals can purchase insurance through the ACA Marketplace, undocumented immigrants are excluded from these programs.

B. Immigration Law and Policy

B.A.1 Federal Access to Care

There is no comprehensive federal program guaranteeing health care for undocumented migrants. Access operates through a patchwork of laws that varies in application by state.

States also have certain access to emergency medical care, regardless of ability to pay, under the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986. Beyond

emergency services, undocumented immigrants rely heavily on safety-net providers, including public and not-for-profit hospitals, Federally Qualified Health Centers (FQHCs), and Disproportionate Share Hospitals (DSHs).

The classification of a DSH can vary depending on whether they primarily serve uninsured and low-income populations or other marginalized and vulnerable groups, like people living with HIV accessing Ryan White Centers.

Undocumented immigrants largely fall into this category due to their limited access to higher-paying jobs, lack of political influence and stability, along with other vulnerabilities that prevent them from obtaining health insurance. Combating poverty is a key initiative for these centers, but many undocumented immigrants still face barriers to entry due to limited funding and eligibility restrictions.

B.A.2 State-Specific Access to Care

State programs may choose to enact their own provisions to expand coverage. For example, the All-Kids Illinois program covers non-emergency healthcare for all eligible children under 19, regardless of immigration status. Depending on the state, immigrant children under 21 and pregnant women granted deferred action under DACA can apply for Medicaid and CHIP or enroll in the state's high-risk insurance pool. Access clearly varies dramatically by geography.

IV. POLICY PROBLEM

A. Stakeholders

Key stakeholders include healthcare providers (hospitals, clinics, pharmacies, and health systems),

state and local health departments, employers offering insurance, insurers, community organizations, and individuals or families seeking care.

State and local health departments are also crucial actors. Medicaid, CHIP, and other social programs are state-administered under the state's general police power. Therefore, they bear significant financial and administrative responsibilities, many of which are growing under the Trump Administration. Given the breakdown of healthcare programs across state lines, each state and local health department must make commitments and implement initiatives that best serve its population. Federal contributions are fluctuating widely, meaning states will face increasing challenges in either reallocating funds or risking reduced services.

Employer-based health care is also very important for people to obtain health insurance. Employers may also choose to share the costs in different ways, either by improving or placing a greater burden on individuals to pay out of pocket.

Further, individuals and communities play an important role in advocating for more expansive health insurance programs. They can also make individual choices that improve their health, reducing strain on the overall system.

B. Risks of Indifference

Health insurance expansion saves lives.

A 2025 National Bureau of Economic Research analysis estimated that Medicaid expansion alone has saved approximately 27,000 lives.

As a country, demonstrating health as a value on the national level is incredibly important for

leveling the playing field and not letting your state or zip code dictate how healthy you are. Beyond funding, coverage decisions reflect societal values- who is considered deserving of care and protection.

C. Bipartisan Framing

Expanding access to health care need not be partisan, though it unfortunately plays out that way in the US. The principle that health is foundational to economic productivity, family stability, and community well-being transcends party lines. Grounding reform in shared human rights principles and economic pragmatism can foster broader consensus.

V. TRIED POLICY

A. 2010 Patient Protection and Affordable Care Act

The ACA remains the most comprehensive expansion of health access in modern U.S. history. It drastically improved health outcomes through insurance expansion, particularly in states that fully adopted it.

However, administrative burdens and shifting financial responsibilities may discourage full state participation, potentially widening disparities.

B. Medicare for All and Healthy People 2030 – Federal Health Policy Interventions

Healthy People 2030, a campaign led by the Department of Health and Human Services and the Office of Disease Prevention and Health Promotion, aims to increase national insurance coverage to 92.4%. As of 2024, approximately 90.1% of Americans are insured, down from 91.1% in 2023, but the goal is 88%. Continued

progress requires targeted outreach and sustained policy commitment.

C. State Policy Expansions: Comparison of Massachusetts and Mississippi

States that fully implemented the ACA and expanded Medicaid consistently perform better on access, prevention, and general health outcomes. The states with the best healthcare outcomes and that have done this include Massachusetts, Hawaii, New Hampshire, Rhode Island, and the District of Columbia. The 10 states that have not expanded Medicaid or the ACA are also among the worst-performing in healthcare.

Massachusetts ranks among the top states in healthcare performance, with low uninsured rates (2% for children; 3% for adults 19-64 in 2025), strong preventive care metrics, and low mortality rates. They performed best in access and affordability, healthiest lives, and 2nd in prevention and treatment efforts. 10% of children did not have all their recommended vaccines, and the highest percentage of adults had all the relevant age- and gender-appropriate cancer screenings. Though they can improve care outcomes for populations aged 65 and older, they have very low infant mortality and highly prioritize preventive care, which can help lead to healthier lives later.

In comparison, Mississippi performed 50th on its report card. They ranked 50th in access and affordability, 48th in prevention and treatment, and in the bottom 10 states for income disparity, healthiest lives, avoidable hospital use and cost, and racial health equity. Approximately 15% of adults aged 19-64 were uninsured. Mississippi also

had high infant mortality rates, low preventive care rates, and significant racial and income disparities. Many of their best outcomes are related to home health programs, suggesting a potentially beneficial intervention to expand access. Low vaccination rates and limited investment in preventive care may be affecting future generations of children in that state. They also had some of the lowest Medicare spending per enrollee.

It is important to note the difference in affluence and racial disparities between the two states. These can influence what kind of care people can access and the political power to enforce equitable, affordable access to health care. Both states have majority white residents, but around 38% of the population in Mississippi is Black, compared to 10% in Massachusetts. Around 1/5 of the population of Mississippi lives in poverty, with the lowest life expectancy at 74.4 years. Fifteen percent of residents are also food insecure, and the highest child poverty rate. Meanwhile, Massachusetts is the wealthiest state, with a GDP per capita of approximately \$110k.

Addressing poverty and investing in preventative care are crucial complements to insurance expansion.

VI. POLICY OPTIONS

A. VALUE-BASED APPROACH

The US health care system still largely relies on profit and quantitatively measured outcomes rather than on quality care that improves people's health.

Goals include: 1) reducing the uninsured rate to

below 7%; 2) maintaining coverage for over 300 million Americans; and 3) improving subsidy targets for safety-net providers.

Some more targeted goals include improving the subsidy system for safety health care providers that largely serve immigrant populations and other marginalized groups. For instance, there are current reforms in place to help safety-net providers avoid further financial harm and ensure that subsidies reach the centers that need them most, rather than being distributed to other government departments.

B. STRENGTHENING THE SAFETY NET

Safety nets serve a social mission that is not fully supported by profit-driven models. Shared financial responsibility across providers—such as pooled contributions— could distribute the burden of uncompensated care more equitably. There must be broad-based anti-racist and anti-poverty values instilled in these, and that is just not something the market-based system values.

Further collaboration between medical systems and the social determinants of health may also prove beneficial. Rewarding health systems and providers that prioritize this can incentivize more states and systems to adopt them.

C. REDUCING COSTS AND WASTE

Reforms to reduce overall cost and waste in the system include reducing premiums, extending

premium tax credits, modifying cost-sharing structures, and reducing administrative waste.

Around 25% of the money spent on US health care is wasted, according to a 2020 study by the Peter G. Peterson Foundation (PGPF). Per the Journal of the American Medical Association, around \$760-\$935 billion is wasteful – it is not used well or used at all where it needs to go through services that are harmful or do not deliver benefits, and excess costs that could be avoided by replacing services or products with cheaper alternatives that have identical or better benefits., including avoidable services, administrative overhead, and inefficient pricing. Improving coordination, preventing fraud, and simplifying payer systems could redirect substantial funds toward coverage expansion.

For example, a few reports have documented state budget savings from the availability of federal dollars to cover previously state-funded expenses, such as state spending on substance use disorder initiatives, health care for incarcerated individuals, and other non-Medicaid health programs. Additionally, because Medicaid expansion increased revenue for many insurers and providers, several states collected higher revenue from existing provider and insurer taxes. However, inconsistent reporting of state funding contributions complicates oversight. Improved transparency in federal-state funding arrangements would promote accountability and sustainability.

Gathering better data on the sources of the non-federal share of Medicaid and Medicare funding can also help evaluate which sources to invest in and increase their legitimacy. GAO conducted a 2019 study that found that states are not required to report the non-federal share of their funding.

The budget reconciliation bill that the House passed in May 2025 calls for expanding the Federal Medical Assistance Percentage to 80% instead of 90% in states that use state funds to provide Medicaid or similar coverage to undocumented immigrants.

VII. CONCLUSIONS

Despite progress, the U.S. health system continues to struggle with inequitable access, high costs, and fragmented coverage. Expanding insurance — particularly for immigrants and low-income populations— would reduce preventable mortality, improve economic stability, and strengthen communities.

Data-driven policy, targeted funding, poverty reduction, and structural reform can move the United States closer to a system in which access to health care is not determined by income, geography, or immigration status, but recognized as a universal human right.

ACKNOWLEDGMENT

The Institute for Youth in Policy wishes to acknowledge Taylor Beljon-Regen, Patrick Pickren, Tiffany Li, Asher Cohen, Paul Kramer, and other contributors for developing and

maintaining the Fellowship Program within the Institute.

REFERENCES

- [1] “Medicaid: Program History and Prior Initiatives.” Centers for Medicare & Medicaid Services, n.d. <https://www.medicaid.gov/about-us/program-history>.
- [2] Thomas Rice, Lynn Y. Unruh, Ewout van Ginneken, Pauline Rosenau, Andrew J. Barnes, Universal coverage reforms in the USA: From Obamacare through Trump. *Health Policy*, Volume 122, Issue 7, 2018, Pages 698–702, ISSN 0168–8510, <https://doi.org/10.1016/j.healthpol.2018.05.007>.
- [3] https://www.who.int/health-topics/human-rights#tab=tab_1
- [4] Angela Wyse and Bruce D. Meyer, *Saved by Medicaid: New Evidence on Health Insurance and Mortality from the Universe of Low-Income Adults*, NBER Working Paper No. 33719 (National Bureau of Economic Research, Apr. 2025).
- [5] Shrank WH, Rogstad TL, Parekh N. Waste in the US Health Care System: Estimated Costs and Potential for Savings. *JAMA*. 2019;322(15):1501–1509. doi:10.1001/jama.2019.13978
- [6] (Ward 2020, [Bachrach et al. 2016](#))
- [7] Artiga S, Hill L, Damico A. Health coverage by race and ethnicity, 2010–2021. 2022. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>
- [8] Chatterjee P. (2025). Saving the Health Care Safety Net: Progress and Opportunities. *Annual review of public health*, 46(1), 525–539. <https://doi.org/10.1146/annurev-publhealth-071823-121237>
- [9] Centers for Disease Control and Prevention. What is health equity? 2022. <https://www.cdc.gov/nchhstp/healthequity/index.html#print>
- [10] Casalino, Lawrence P., Sean Nicholson, David N. Gans, et al. “What Does It Cost Physician Practices To Interact With Health Insurance Plans?: A New Way of Looking at Administrative Costs—One Key Point of Comparison in Debating Public and Private Health Reform Approaches.” *Health Affairs* 28, no. Supplement 1 (2009): w533–43. <https://doi.org/10.1377/hlthaff.28.4.w533>.
- [11] McCarthy, Douglas McCarthy, David C. Radley, and Susan L. Hayes. *2018 Scorecard on State Health System Performance*. Commonwealth Fund, 2018. <https://doi.org/10.15868/socialsector.30564>.
- [12] Jindal, Monique, Krisda H. Chaiyachati, Vicki Fung, Spero M. Manson, and Karoline Mortensen. “Eliminating Health Care Inequities through Strengthening Access to Care.” *Health Services Research* 58, no. S3 (2023):300–310. <https://doi.org/10.1111/1475-6773.14202>.
- [13] Passel, Jeffrey S., and Jens Manuel Krogstad. *Preliminary Data Indicates Continued Growth into 2024 and a Decrease in 2025*. n.d.
- [14] Rice, Thomas, Lynn Y. Unruh, Ewout Van Ginneken, Pauline Rosenau, and Andrew J. Barnes. “Universal Coverage Reforms in the USA: From Obamacare through Trump.”

Health Policy 122, no. 7 (2018): 698–702.
<https://doi.org/10.1016/j.healthpol.2018.05.007>.

[15] Pillai, Drishti, Samantha Artiga, Liz Hamel, et al. *Health and Health Care Experiences of Immigrants: The 2023 KFF/LA Times Survey of Immigrants*. n.d.

[16] Hepworth, Adam Jared, Anil Shankar, and Lauren Pamela Carboni. *Immigrant Access to*

Health Centers: Confronting Unknowns in the Administration's Revised Interpretation of PRWORA. n.d.

[17] Kobeta, Amy, and Diana McWilliams. "PA HOSPITALS LOSE NEARLY \$400 MILLION CARING FOR UNINSURED KIDS." Press Release. Children First, July 1, 2024.
https://childrenfirstpa.org/news/insure_every_child_7-1-24/?utm_source=chatgpt.com.