AMA Journal of Ethics®
September 2025, Volume 27, Number 9: E668-677

MEDICAL EDUCATION: PEER-REVIEWED ARTICLE

Three Things Students and Trainees Should Learn About Public Health Insurance for Children

Aubrey D. Brown, MD, Lauren Ameden, MD, and Brigid Garrity, DO, MS, MPH

Abstract

Despite the inclusion of health equity and public health in undergraduate and graduate medical curricula, many medical students and trainees have minimal understanding of health insurance coverage for children of families with low incomes. Since children's eligibility for Medicaid and the Children's Health Insurance Program (CHIP) significantly influence their care, this article proposes that students and trainees, especially in pediatrics, should receive formal instruction about Medicaid and CHIP in 3 key areas: program structure; eligibility determinations, redeterminations, and range of covered or partially covered services; and enrollment requirements and processes. This article also suggests the nature and scope of expertise required to responsibly offer such instruction in classroom- and clinic-based settings.

Health Economics in Medical Education

While medical students and residents in the United States are taught much about anatomy, physiology, organ systems, and disease management, education on health insurance and Medicaid is lacking. Of topics learned in medical school, trainees have reported having the lowest confidence in their knowledge of health policy and economics.[1] Nevertheless, exposure to health policy and health equity in medical school is occurring through public health clubs or optional public health and health policy electives in medical schools and residencies.[2] For example, one student-led program sought to raise awareness of racial bias in medicine and demonstrate how racial injustice can be incorporated in preclinical medical student education.[3,4] However, few schools or residencies mandate an *extensive* public health curriculum, and fewer provide comprehensive education on public insurance. The Association of American Medical Colleges reported that 132 of 147 medical schools taught some health care financing in required courses preclinically,[5] but, in our experience as recent medical school graduates, this teaching was limited to superficial topics, such as the broad differences between Medicare, Medicaid, and private insurance—content that covered only what is tested on United States Medical Licensing Examination board exams.[6]

Upon reviewing the board exam content distribution for the specialties of emergency medicine, pediatrics, and family medicine, we found that none require knowledge of

health insurance programs, let alone specifics of Medicaid or similar programs.[7,8,9] However, the American Medical Association has adopted a policy encouraging medical schools and residencies to provide more in-depth health care economics education.[10] Thus, the pressure is on medical schools or individual physicians to cover this content more thoroughly.

Given the brief coverage trainees receive, in this article we first discuss the benefits of coverage and then propose several key points about insurance coverage that trainees should understand: (1) the general structure of Medicaid and the Children's Health Insurance Program (CHIP), (2) who qualifies for Medicaid as compared to CHIP and what services each cover, and (3) how patients and families can enroll in Medicaid or CHIP. Additionally, we propose who may be the best qualified to deliver this content to medical students and residents.

Insuring Children

It is estimated that roughly 36% of children in the United States in 2023 had health insurance coverage through a Medicaid program and 10% through CHIP.[11] Additionally, Medicaid and CHIP programs covered two-thirds of children in families with low incomes (below 200% of the federal poverty level, or FPL) in 2015[12] and approximately 44% of children with special health care needs in 2019.[13] Although the rate of uninsured children has dropped to near 5%, it is estimated that approximately 55% of these children qualify for Medicaid or CHIP programs.[14,15] Based on these numbers, one can assume that most medical students and residents will care for patients either eligible for or insured by Medicaid or CHIP.

Research suggests that the expansion of Medicaid and CHIP coverage reduces pediatric hospitalizations, care gaps, and mortality and improves health outcomes.[16,17,18,19,20] There's also mounting evidence of the positive impact of insurance coverage beyond children's immediate health, including higher educational attainment,[21] better adult health, and decreased poverty for children and their families on Medicaid,[22] although it is hard to differentiate between the impacts of CHIP and Medicaid because children frequently switch between programs as their family's income fluctuates.

Funding Structures

Medicaid is jointly state and federally funded and designed to help individuals with low incomes, including pregnant individuals, families, the elderly, and individuals with disabilities.[23] Each state must follow minimum federal requirements but otherwise may administer Medicaid as they see fit.[24] There is no cap to the funding match that the federal government provides for qualified services, and states may apply for waivers to administer the program in other ways if it is determined that the proposed changes are in line with Medicaid goals.[24,25] Therefore, there is significant variation from state to state in services covered, payment structures, and qualifying income levels. For example, the default pay structure is fee-for-service; however, most states adopt managed care plans.[26] Additionally, Medicaid benefits that states can opt into include, but are not limited to, dental care, physical therapy, home health care, hospice, prosthetics, and targeted case management programs.[26,27]

Although Medicaid covers both adults and children, CHIP is focused solely on expanding health insurance coverage for children. CHIP was initially created in 1997 to offer coverage to children in families with household incomes too high to qualify for Medicaid but too low for health care to be affordable.[28] CHIP can be operated by states as a

separate program from Medicaid or as a Medicaid expansion wherein CHIP is a subprogram of Medicaid. Similarly to Medicaid, CHIP is jointly state and federally funded. While the percentage of CHIP's funding from the federal government is larger than Medicaid's (approximately 15% higher), unlike Medicaid, there is a federal cap to the CHIP funds allocated to each state annually.[29] Thus, if a state has hit its annual cap, applicants are not allowed to enroll or are placed on a waiting list.

Although pediatric Medicaid and CHIP cover many of the same services, such as routine checkups and vaccinations,[27,30] there are some key differences between the two. The federal government mandates that Medicaid programs in every state fully cover all services outlined under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program for any child under the age of 21, which includes comprehensive and preventative care consisting of vision and hearing care, mental health care, developmental services, and dental care.[20,30,31] CHIP programs are not subjected to the same EPSDT coverage minimums, which can lead to gaps in services depending on the state, as states can opt in to offer some services that are optional at the federal level. Moreover, for pediatric Medicaid programs, premiums and cost sharing are federally prohibited in most cases, whereas many CHIP programs have premiums or cost sharing that increase in proportion to family income.[32]

Qualifying for Medicaid and CHIP

Eligibility for pediatric Medicaid and CHIP is primarily based on a child's age, family income, family size, and insurance status. Unlike Medicare for persons at least 65 years of age, eligibility for both pediatric Medicaid and CHIP requires the child to be uninsured; CHIP and Medicaid cannot be used as secondary insurance.[33] Additionally, a child cannot be on *both* Medicaid and CHIP in the traditional sense of primary and secondary insurance.[33] For both programs, modified adjusted gross income (MAGI) is used to determine eligibility expressed as a percentage of the FPL.[34] For a family of 3 in the 48 contiguous states and the District of Columbia, as of 2024, the FPL is $25 820 and has increased annually with inflation.[35] (The FPL is slightly higher in Hawaii and Alaska due to increased cost of living[35]). The percentage of FPL that is used as a cutoff varies by state.[34] Recent state-specific data on pediatric Medicaid and CHIP eligibility from 2024 demonstrate a range of FPL cutoffs stratified by age—from 107% of the FPL ($27 627) in North Carolina (ages 6-18) to 324% of the FPL ($83 657) in Washington, DC (ages 0-19)[36] (see Table). If Medicaid is expanded in a state, there are often higher income limits for both programs, with CHIP most often having the highest family MAGI eligibility cutoff. Finally, it should be noted that children in the foster care system may qualify for extended coverage until age 26, although the availability of this provision varies by state.[23]

Table. 2024 Income Maximums ($ US) for Federally Funded Pediatric Health Insurance Programs by Child Age and State

State	0–1 years[a]	1–5 years[a]	6–18 years[a,b]
Alabama	37 697	37 697	27 627–37 697
Alaska	41 054–53 706	41 054–53 706	32 017–53 706
Arizona[c]	39 246	37 697	26 853–35 632
Arkansas	37 955	37 955	27 627–37 955
California[d]	53 706–67 132	36 664–68 681	27 886–68 681
Colorado	37 955	37 955	27 886–37 955
Connecticut	51 898	51 898	51 898

Delaware	50 091–56 029	37 955	28 402–36 632
District of Columbia	53 189–83 657	37 697–83 657	28 918–83 657
Florida[e,f]	49 574–54 480	37 439	28 918–36 632
Georgia	54 222	39 763	29 177–36 632
Hawaii	49 316–80 817	35890–80 817	34 341–80 817
Idaho	37 955	37 955	27 627–36 632
Illinois	36 664–82 108	36 664–82 108	27 886–82 108
Indiana	40 537–54 997	36 406–42 087	27 369–42 087
Iowa[g]	61 968–98 116	44 410	31 500–44 410
Kansas	44 152	39 763	29 177–35 632
Kentucky	50 349–56 288	36 664–56 288	28 144–56 288
Louisiana	36 664–56 029	36 664–56 029	27 886–56 029
Maine	49 316–78 751	36 148–78 751	34 082–53 706
Maryland	50 091–83 140	35 632–83 140	28 144–83 140
Massachusetts	47 767–52 931	34 361–40 021	29 435–40 021
Michigan[h]	50 349–56 029	36 923–56 029	28 144–56 029
Minnesota[i]	71 005–74 362	72 296	72 296
Mississippi	51 382	38 214	27 627–35 632
Missouri	51 898	38 214–40 021	28 402–40 021
Montana	38 214	38 214	28 144–38 214
Nebraska	41 828–56 288	37 439–56 288	28 244–56 288
Nevada	42 603	42 603	31 500–35 632
New Hampshire	50 607–83 399	50 607–83 399	50 607–83 399
New Jersey	51 382	37 955	27 627–37 955
New Mexico	51 640–78 751	51 640–78 751	35 632–63 259
New York	57 579	39 763	28 402–39 763
North Carolina	50 091–55 771	36 406–55 771	27 627–55 771
North Dakota	37 955–52 931	37 955–52 931	28 660–52 931
Ohio	36 406–54 480	36 406–54 480	27 627–54 480
Oklahoma[j]	43 636–54 222	38 988-54 222	29 693–54 222
Oregon	34 341–49 058	35 632	25 820–35 632
Pennsylvania	56 804	41 828	30 756–35 632
Rhode Island	49 058–68 681	36 664–68 681	28 144–68 681
South Carolina	50 091–54 997	36 923–54 997	27 627–54 997
South Dakota	37 955–48 283	37 955–48 283	28 660–48 283
Tennessee	50 349–55 771	36 664–55 771	28 144–55 771
Texas	52 415	38 472	28 144–35 632
Utah	37 181	37 181	27 111–35 632
Vermont	61 193–81 849	61 193–81 849	61 193–81 849
Virginia	38 214	38 214	28 144–38 214
Washington	55 513	55 513	55 513
West Virginia	42 087	37 697	27 886–35 632
Wisconsin[k]	79 009	49 316	26 078–40 297
Wyoming	39 763–52 931	39 763–52 931	30 726–52 931

Adapted with permission from the Kaiser Family Foundation using data from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families.[36]

Range of income maximum cutoffs for Medicaid and Children's Health Insurance Program (CHIP) federally funded or subsidized pediatric health insurance programs using modified adjusted gross income (in dollars) for a family of 3 calculated from a percentage of the federal poverty level as published by each state. In states where no range exists, this reflects a unified income eligibility maximum across pediatric Medicaid and CHIP programs.

[a] Ranges for a state reflect the variation between pediatric Medicaid and CHIP program income cutoffs within the state. States have the option to run CHIP within their Medicaid program or as a separate program or programs based on child age and Medicaid expansion or waiver status. For example, Florida has three separate CHIP programs for ages 1-4, ages 5-18, and children with special health care needs up to age 21.
[b] For ages 6-18, Medicaid funding through rule XXI funds sets cutoffs that are lower than the standard 138% ($35 632) of federal poverty level (FPL), and states may further modify this cutoff.
[c] Arizona expanded eligibility for its separate CHIP program in March 2024 to 230% of the FPL ($59 386) through a Section 1115 demonstration amendment. Due to a technical change in the Affordable Care Act, states are required to use Section 1115 authority to increase CHIP eligibility up to the greater of 200% of the FPL ($51 640) or more than 50 percentage points above their 1997 Medicaid income levels.
[d] In California, children with higher incomes are eligible for separate CHIP coverage in some counties.
[e] Florida has expanded coverage for children with special health care needs through age 21.
[f] Florida did not respond to the 2024 survey; eligibility levels reported are from 2023.
[g] Iowa passed legislation that will reduce eligibility levels for infants in Medicaid to 215% of the FPL ($55 513), effective January 1, 2025. The upper eligibility limit for infants ages 0-1 is now 307% of the FPL ($79 267), down from 380% of the FPL ($98 116).
[h] Michigan provides CHIP-funded Medicaid expansion coverage to children affected by the Flint water crisis with family incomes between 212% of the FPL and 400% of the FPL ($54 738-$103 280).
[i] Minnesota covers children up to age 2 as infants under Medicaid through a Section 1115 waiver.
[j] Oklahoma offers a premium assistance program through its Insure Oklahoma Program to children aged 0-18 years with family incomes up to 222% of the FPL ($57 320) with access to employer-sponsored insurance.
[k] In Wisconsin, children are not eligible for its separate CHIP program if they have access to job-based health insurance coverage where the employer covers at least 80% of the cost.

Additionally, federal regulations on citizenship and immigration status limit Medicaid or CHIP access for noncitizens. Research shows that states without expanded eligibility for noncitizens have less overall pediatric health care utilization.[37] Noncitizens are subject to a 5-year waiting period before being eligible for these services, with exceptions being made for lawful permanent residents (green card holders), Cuban or Haitian entrants, members of nationally recognized Indian Tribes, and for those who entered the United States under asylum or refugee status or immigrated due to being victims of domestic violence or trafficking.[38,39] Reassurance should be offered to immigrants applying for health insurance that, as long as they are not requiring long-term nursing home care, the US Citizenship and Immigration Services does not take into account Medicaid or CHIP utilization as part of the public charge determination for immigration status.[40] However, requirements can change with different presidential administrations and executive guidance on how to apply the public charge ruling—an example being a recent change in guidance for adult patients only.[41] There is some evidence that changes in executive office guidance on the public charge ruling affect applicants' decisions about enrolling or reenrolling in pediatric Medicaid and CHIP. For example, the American Community survey found a 20% drop in Medicaid and CHIP participation among noncitizens between 2016 and 2019, and another 2019 survey of health centers found that 38% reported being aware of immigrant patients declining to enroll their children in Medicaid and 28% reported being aware of immigrant patients disenrolling or declining to reenroll their children in Medicaid over the previous year.[42,43] Even though a child's use of Medicaid or CHIP does not affect immigration applications, 22% of surveyed health centers in 2019 saw a decrease in immigrant parents seeking care for their children.[42]

Enrolling in Medicaid and CHIP

Clinicians' understanding of the basic, state-specific requirements for Medicaid and CHIP eligibility, which vary based on income and legal situation, as well as of the services each covers, can help guide their recommendations to patients and families. Despite the complexities of eligibility and coverage rules, most states have a simple and unified application process for Medicaid and CHIP. Importantly, a parent being ineligible for Medicaid does not mean their child will be ineligible, because familial income cutoffs for children (see Table) are typically higher than adult cutoffs. Even if the adults in the household are insured through their employer, their children are typically still eligible for Medicaid or CHIP if they meet the income cutoffs.[39] Parents, grandparents, and guardians may complete the applications for Medicaid or CHIP on behalf of their

children.[39] Teenagers who are emancipated are also eligible to complete their own application.[39] While social workers can help families navigate the application process, they are often unable to directly file on behalf of someone. Some states have employed health insurance marketplace or Medicaid navigators[44] who are familiar with eligibility rules and can help applicants find the most appropriate plan for a child and their family. Applications can be found on each state's Medicaid or CHIP website, their health insurance marketplace, or the federal government website.[28,45,46]

Curricular Administration and Engagement

All this information is essential to providing improved patient care for children and their families. Medical school and residency curricula tend to have limited room for additional lectures and information sessions, but we feel that more in-depth education about Medicaid and CHIP is warranted. We know that improving access to health care improves health outcomes, and students and residents should have the tools and knowledge to advocate for their patients to obtain appropriate health care coverage. Although education on Medicaid and CHIP may be covered during pediatric and family medicine rotations, we also propose that medical schools incorporate this information in the preclinical years of medical education. Social workers and other financial administrative staff who assist patients and families with Medicaid registration, as well as health insurance navigators, may be best equipped to teach this information, although physicians who care for a significant number of underinsured and uninsured patients may also be able to teach these lessons. Lectures from staff at state Medicaid offices may also be beneficial, as they can offer trainees a better understanding of the enrollment process. Moreover, content on Medicaid and CHIP could be included in lectures on public health or in general medicine courses. Students should not have to "opt in" to a class or program that offers this information. Some suggestions for improving students' knowledge of public insurance include rotations with a social worker and spending a day with staff who assist patients in registering for Medicaid and CHIP. All students should enter clinical rotations and residency with this knowledge, and residencies should integrate training on Medicaid and CHIP into their scheduled didactic sessions. Without knowledge of insurance options and coverage for patients with low incomes, physicians cannot provide adequate care for all patients.

In summary, medical schools and residencies should incorporate education on Medicaid and CHIP, as insurance has a substantial impact on patient care and outcomes. Understanding what Medicaid and CHIP are, who qualifies for pediatric Medicaid and CHIP, what services each cover, and how patients and families can enroll in Medicaid or CHIP is essential to improving pediatric health outcomes and health equity.

References

1. Skochelak SE, Hammoud MM, Lomis KD, et al, eds. *Health Systems Science*. 2nd ed. Elsevier; 2020.
2. Public health pathways for medical students. Association of American Medical Colleges. Accessed March 7, 2025. https://students-residents.aamc.org/attending-medical-school/article/public-health-pathways-2
3. Lynn TM, D'urzo KA, Vaughan-Ogunlusi O, et al. The impact of a student-led anti-racism programme on medical students' perceptions and awareness of racial bias in medicine and confidence to advocate against racism. *Med Educ Online*. 2023;28(1):2176802.

4. Ismaeel R, Pusic L, Gottlieb M, Chan TM, Oyedokun TO, Thoma B. Bias in observed assessments in medical education: a scoping review. *Acad Med*. 2024;99(12):1438-1450.
5. Curriculum topics in required and elective courses at medical school programs. Association of American Medical Colleges.
6. Federation of State Medical Boards of the United States; National Board of Medical Examiners. USMLE® content outline. Federation of State Medical Boards of the United States; National Board of Medical Examiners; 2022. Accessed March 7, 2025. https://www.usmle.org/sites/default/files/2022-01/USMLE_Content_Outline_0.pdf
7. American Board of Pediatrics. General pediatrics content outline: in-training, certification, and maintenance of certification exams. American Board of Pediatrics; 2024. Accessed March 7, 2025. https://www.abp.org/sites/public/files/pdf/content-outline-general-pediatrics-2024.pdf
8. Qualifying exam. American Board of Emergency Medicine. Accessed March 7, 2025. https://www.abem.org/get-certified/qualifying-exam/
9. American Board of Family Medicine. ABFM certification examination content. American Board of Family Medicine; 2019. Accessed March 7, 2025. https://www.theabfm.org/app/uploads/2024/02/Exam-Content-Outline.pdf
10. AMA to ensure future physicians receive health care economics training. News release. American Medical Association; November 19, 2019. Accessed March 7, 2025. https://www.ama-assn.org/press-center/press-releases/ama-ensure-future-physicians-receive-health-care-economics-training
11. Vankar P. Share of children aged 19 and under with Medicaid health insurance in the United States from 2017 to 2023. Statista. October 21, 2024. Accessed March 7, 2025. https://www.statista.com/statistics/1334558/children-with-medicaid-coverage-in-the-us/
12. Artiga S, Ubri P. Key issues in children's health coverage. KFF. February 15, 2017. Accessed April 11, 2025. https://www.kff.org/medicaid/issue-brief/key-issues-in-childrens-health-coverage/
13. Osorio A. Research update: Medicaid/CHIP are critical resources for children with special health care needs. Center for Children and Families, Georgetown University McCourt School of Public Policy. October 18, 2021. Accessed June 2, 2025. https://ccf.georgetown.edu/2021/10/18/research-update-medicaid-chip-are-critical-resources-for-children-with-special-health-care-needs/
14. Tolbert J, Cervantes S, Bell C, Damico A. Key facts about the uninsured population. KFF. December 18, 2024. Accessed April 7, 2025. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/
15. Drake P, Rudowitz R, Tolbert J, Damico A. A closer look at the remaining uninsured population eligible for Medicaid and CHIP. KFF. March 15, 2024. Accessed April 8, 2025. https://www.kff.org/uninsured/issue-brief/a-closer-look-at-the-remaining-uninsured-population-eligible-for-medicaid-and-chip/
16. Bermudez D, Baker L. The relationship between SCHIP enrollment and hospitalizations for ambulatory care sensitive conditions in California. *J Health Care Poor Underserved*. 2005;16(1):96-110.
17. Szilagyi PG, Shone LP, Klein JD, Bajorska A, Dick AW. Improved health care among children with special health care needs after enrollment into the State Children's Health Insurance Program. *Ambul Pediatr*. 2007;7(1):10-17.

18. Szilagyi PG, Dick AW, Klein JD, et al. Improved asthma care after enrollment in the State Children's Health Insurance Program in New York. *Pediatrics*. 2006;117(2):486-496.
19. Menachemi N, Blackburn J, Sen B, et al. The impact of CHIP coverage on children with asthma in Alabama. *Clin Pediatr (Phila)*. 2012;51(3):247-253.
20. Currie J, Chorniy A. Medicaid and Child Health Insurance Program improve child health and reduce poverty, but face threats. *Acad Pediatr*. 2021;21(8)(suppl):S146-S153.
21. Paradise J. The impact of the Children's Health Insurance Program (CHIP): what does the research tell us? KFF. July 17, 2014. Accessed March 7, 2025. https://www.kff.org/report-section/the-impact-of-the-childrens-health-insurance-program-chip-issue-brief/
22. Wherry LR, Kenney GM, Sommers BD. The role of public health insurance in reducing child poverty. *Acad Pediatr*. 2016;16(3)(suppl):S98-S104.
23. Medicaid and CHIP coverage. HealthCare.gov. Accessed October 5, 2024. https://www.healthcare.gov/medicaid-chip/
24. Burns A, Hinton E, Rudowitz R, Mohamed M. 10 things to know about Medicaid. KFF. February 18, 2025. Accessed May 30, 2025. https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid/
25. Williams E, Mudumala A, Rudowitz R, Burns A. Medicaid financing: the basics. KFF. January 29, 2025. Accessed October 11, 2024. https://www.kff.org/medicaid/issue-brief/medicaid-financing-the-basics/
26. Federal requirements and state options: how states exercise flexibility under a Medicaid state plan. Medicaid and CHIP Payment and Access Commission. August 2018. Accessed March 7, 2025. https://www.macpac.gov/publication/federal-requirements-and-state-options/
27. Medicaid and CHIP Payment and Access Commission. Federal requirements and state options: benefits. Medicaid and CHIP Payment and Access Commission; 2017. Accessed April 8, 2025. https://www.macpac.gov/wp-content/uploads/2017/03/Federal-Requirements-and-State-Options-Benefits.pdf
28. History and impact of CHIP. Medicaid and CHIP Payment and Access Commission. February 5, 2018. Accessed April 9, 2025. https://www.macpac.gov/subtopic/history-and-impact-of-chip/
29. Financing. Medicaid.gov. Accessed October 5, 2024. https://www.medicaid.gov/chip/financing/index.html
30. CHIP benefits. Medicaid.gov. Accessed April 8, 2025. https://www.medicaid.gov/chip/benefits
31. Early and periodic screening, diagnostic, and treatment. Medicaid.gov. Accessed March 7, 2025. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html
32. Key CHIP design features. Medicaid and CHIP Payment and Access Commission. January 11, 2021. Accessed March 7, 2025. https://www.macpac.gov/subtopic/key-design-features/
33. CHIP eligibility and enrollment. Medicaid.gov. Accessed March 7, 2025. https://www.medicaid.gov/chip/chip-eligibility-enrollment/index.html
34. Medicaid, Children's Health Insurance Program, and basic health program eligibility levels. Medicaid.gov. Accessed September 10, 2024. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html

35. US Department of Health and Human Services. Annual update of the HSS poverty guidelines. *Fed Regist*. 2024;89(11):2961-2963.
36. Medicaid and CHIP income eligibility limits for children as a percent of the federal poverty level. KFF. May 1, 2024. Accessed September 10, 2024. https://www.kff.org/affordable-care-act/state-indicator/medicaid-and-chip-income-eligibility-limits-for-children-as-a-percent-of-the-federal-poverty-level/
37. Rosenberg J, Shabanova V, McCollum S, Sharifi M. Insurance and health care outcomes in regions where undocumented children are Medicaid-eligible. *Pediatrics*. 2022;150(3):e2022057034.
38. Coverage for lawfully present immigrants. HealthCare.gov. Accessed March 7, 2025. https://www.healthcare.gov/immigrants/lawfully-present-immigrants/
39. Frequently asked questions. InsureKidsNow.gov. Accessed March 7, 2025. https://www.insurekidsnow.gov/find-coverage-your-family/frequently-asked-questions
40. Public charge resources. US Citizenship and Immigration Services. Updated April 8, 2025. Accessed April 11, 2025. https://www.uscis.gov/green-card/green-card-processes-and-procedures/public-charge/public-charge-resources
41. US Citizenship and Immigration Services, Department of Homeland Security. Inadmissibility on public charge grounds; final rule. *Fed Regist*. 2019;84(157):41292-41508.
42. Tolbert J, Artiga S, Pham O. Impact of shifting immigration policy on Medicaid enrollment and utilization of care among health center patients. KFF. October 15, 2019. Accessed March 7, 2025. https://www.kff.org/report-section/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients-issue-brief/
43. Capps R, Fix M, Batalova J. Anticipated "chilling effects" of the public-charge rule are real: census data reflect steep decline in benefits use by immigrant families. Migration Policy Institute. December 2020. Accessed March 7, 2025. https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real
44. In-person assistance in the health insurance marketplaces. Centers for Medicare and Medicaid Services. Updated April 11, 2025. Accessed May 30, 2025. https://www.cms.gov/marketplace/in-person-assisters/programs-procedures/in-person-assistance
45. Find out if you can get health coverage now. HealthCare.gov. Accessed March 7, 2025. https://www.healthcare.gov/screener/
46. Where can people get help with Medicaid and CHIP? Medicaid.gov. Accessed March 7, 2025. https://www.medicaid.gov/about-us/where-can-people-get-help-medicaid-chip/index.html

Aubrey D. Brown, MD is an emergency medicine resident at Boston Medical Center in Massachusetts. Her interests include health equity, critical care, and medical education.

Lauren Ameden, MD is a pediatric emergency medicine fellow at Boston Medical Center in Massachusetts. She completed her pediatrics residency at Children's National Hospital. Her interests include health equity, social determinants of health, and medical education.

Brigid Garrity, DO, MS, MPH is an emergency medicine resident at Boston Medical Center in Massachusetts. Her academic interests include health services research, public policy, and health equity.

Citation
AMA J Ethics. 2025;27(9):E668-677.

DOI
10.1001/amajethics.2025.668.

Acknowledgements
The authors thank the Kaiser Family Foundation.

Conflict of Interest Disclosure
Contributors disclosed no conflicts of interest relevant to the content.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

ISSN 2376-6980