Unborn v. Undocumented: A Collision of Policy and Politics

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When President Bush announced his proposal to expand coverage to unborn children using money from the State Children's Health Insurance Program (SCHIP)[1], abortion rights activists derided the idea as a way to establish legal personhood for fetuses without the necessity of legislative action. States, on the other hand, recognized an opportunity to at least partially recover payment for maternity care provided to undocumented females. Although at least seven states were using state tax dollars for similar efforts even before the Bush administration proposal,[2] the expansion put the unborn children of undocumented women in competition with already born children for diminishing SCHIP resources.[3]

The flood of comments received before adoption of the final rule implementing services to the unborn via SCHIP reflected the perspective of pro-choice advocates that this was a regulatory action both "cynical" and lacking "ethical and medical justification."[4] Critics were not the only ones issuing comments however. One commentator noted that unborn children were included in the Medicaid program until 1986 when the status was replaced with a "coverage category tied directly to the woman's pregnancy status."[5] The commentator further noted that tying service eligibility to the unborn child would give states the option of extending "public health insurance to pregnant women who are currently unqualified in their own right."[6] Another commenter noted that Congress was considering legislation to expand prenatal coverage to low income women under the SCHIP program, though none of the proposed bills specifically incorporated undocumented women.[7]

Despite the criticisms of those concerned that the action was yet another assault on a woman's right to abortion, the final rule was adopted, and several states[8] started programs to provide health coverage for the unborn through their SCHIP programs. All of these programs include provision of prenatal care to the unborn being carried by undocumented women. One of the largest such programs is in Texas, which has over 18,000 unborn children enrolled in its CHIP "Perinate Program."[9]

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[1] 61 FR 9936.
[2] Neva Kaye, Cynthia Pernice, and Ann Cullen, *Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs*, National Academy for State Health Policy, September, 2006 (hereinafter Charting SCHIP III).
[3] Elisabeth H. Sperow, *Redefining Child Under the State Children's Health Insurance Program: Capable of Repetition, Yet Evading Results*, 12 Am. U. J. Gender Soc. Pol'y & L 142-143.
[4] 67 FR 61960.
[5] 67 FR 61958.
[6] *Id.*
[7] 67 FR 61959 citing S. 1016/H. R. 3729, S. 724/H. R. 2610 and S. 582/H. R. 1143 all filed in the 107th Congress, though none passed.
[8] Charting SCHIP III, *Prenatal Care/Unborn Coverage*, *supra* note 2.
[9] http://www.hhsc.state.tx.us/research/Medicaid_Chip_ChipPerinatal_Counts.html.

Although the states clearly knew they were going to use these dollars to support prenatal care for undocumented women, that supposition apparently was not clear to all who work at the Centers for Medicare and Medicaid Services (CMS). As a result, when Louisiana submitted its initial claim for reimbursement for services provided to these unborn children under its CMS-approved SCHIP waiver,[10] CMS initially denied the claim, arguing that SCHIP is a federally funded program, and that the federal enabling legislation does not authorize service to undocumented residents.[11] Hours later the denial was reversed.[12]

The Louisiana flap over reimbursement, however brief, puts the spotlight on several little discussed aspects of the SCHIP prenatal care program. Because prenatal coverage for women over the age of 19 was not included in the federal enabling legislation, the adoption of this expansion by rule means that only the most ardent policy advocates were aware of or commented on its provisions, and most focused on its potential impact on abortion rights. It is useful then to re-examine what this expanded coverage does and does not provide.

First, because the unborn child, not the pregnant woman, is the intended beneficiary of the services covered, medical care for the mother either does not extend beyond delivery or ceases no more than 60 days after delivery, regardless of the mother's medical condition.[13] Several commentators raised questions about the extent of coverage for the pregnant woman under the rule as proposed. Their questions, focusing on coverage for a woman with other health conditions that may impact pregnancy such as diabetes, hypertension or even cancer, were answered with essentially a non-answer. That is, states may cover whatever they think is appropriate in their benefit package under this expansion, but services not specifically intended to benefit the child (including post partum care for the mother) cannot be paid for with federal dollars.[14] The response to other comments reinforced that any benefits provided to the pregnant woman must have a nexus with the health of the unborn child. Thus treatment for other disorders from broken bones to mental illness or giving pain relieving medication during labor must be demonstrated to be related to the delivery of a healthy child in order to be reimbursed under the SCHIP coverage for the unborn.[15]

Second, continuous eligibility for services for the children covered under this program is also poorly understood. One would normally assume that a rule establishing twelve months of continuous eligibility for enrollment (as authorized by the final rule) would be calculated, at a minimum, based on the child's birth date. In reality, the eligibility period for children born under the SCHIP prenatal services rule begins while they are still in utero. States have two options for calculating an unborn child's period of eligibility. The

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[10] Louisiana estimates that approximately 1061 of its unborn SCHIP enrollees will be delivered by undocumented females according to the newspaper reports cited in this article.
[11] Marsha Shuler, *Medical cost flap flares*, 1A THE ADVOCATE, Nov. 14, 2007.
[12] Marsha Shuler, *Feds agree La. to some aid in medical care,20A* THE ADVOCATE, Nov. 15, 2007.
[13] Cynthia Daliard, *New SCHIP Prenatal Care Rule Advances Fetal Rights at Low-Income Women's Expense*, THE GUTTMACHER REPORT ON PUBLIC POLICY, December, 2002.
[14] 67 FR 61969.
[15] 67 FR 61968.

eligibility period may be calculated from the date an application is approved, or it may be calculated with a retroactive date to a date at which treatment during the pregnancy (including confirmation of the pregnancy) began. (Retroactive coverage for treatment is not allowed for already born children enrolled in SCHIP.) Thus an unborn child determined to be eligible for SCHIP prenatal care at six weeks gestation may only have a few months of eligibility remaining after she is born.[16] Once the child is born, he or she is eligible to apply for coverage under a state's existing SCHIP or Medicaid program, whichever would be most appropriate,[17] but coverage eligibility under services to the unborn would expire at the end of the state's set eligibility period, even if the coverage period began just days after conception was confirmed.

A third unique feature of this program is that neither the mother nor the child must furnish social security numbers as part of the eligibility determination. Of course children do not receive social security numbers before actually being born, but children, post birth, must get a social security number in order to be enrolled in either Medicaid or SCHIP.[18] Under the final rule, prior to birth, children are assigned a "unique identifier" in order to process payments.[19] Although a state may not require a social security number from the prospective mother of the unborn child, the state may impose a residency requirement just as it can for eligibility for its SCHIP program for born children.[20]

Fourth, the expansion was clearly calculated to provide coverage to the unborn children of immigrant women who were otherwise barred from participation in Medicaid either because their income was just slightly too high or because they were otherwise qualified aliens but barred by the five year waiting period before becoming eligible for taxpayer subsidized programs. However, commentators concerned about the impact of the rule on immigrant women were disappointed that CMS did not adopt their request that the rule specify that women applying for services under this SCHIP expansion not be subject to having their immigration status questioned with the possibility that undocumented women could be reported to immigration authorities. Although the response indicated that such reports would not be required under the rule and could be considered contrary to the goal of providing care to the unborn,

> [n]othing in this regulation alters section 434 of the 1996 welfare reform statute, which prohibits the Federal government from restricting State or local government entities from sending to or receiving from the Immigration and Naturalization Service information regarding the immigration status of an alien in the U. S. [21]

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[16] 67 FR 61964.
[17] *Id.*
[18] 67 FR 61965.
[19] *Id.*
[20] 67 FR 61694.
[21] 67 FR 61966.

Finally, in response to critics concerned that the rule would simply encourage more women to cross the border in order to receive prenatal care in the United States, CMS noted that states would have to allocate their federal funds judiciously. Since SCHIP federal allocations are similar to a block grant in that each state gets a defined amount, and since no additional funds have been appropriated at the federal level to accommodate this expansion, CMS argues that states will be encouraged to use the "flexibility" of the rule to ensure that they do not exceed their allotment.[22]

The CMS flare-up over payment for services to the unborn SCHIP enrollees in Louisiana highlights a particular irony of the SCHIP prenatal care rule. SCHIP reauthorization is in jeopardy. The current extension includes no new funds for expansion of eligible populations, and critics of the failed reauthorization are concerned that existing funding levels will not cover the growth in currently eligible populations. In addition, given today's fervent discussions about immigration, who could have imagined that pro-choice advocates would find themselves political bedfellows with anti-immigration supporters? Implementation of SCHIP care for the unborn continues to be below the radar screen for the general population as well as many health care policy wonks. Maybe it is time for the policymakers to step back and re-consider whether sound policy can be developed from sound bites.

Health Law Perspectives (January 2008), available at:
http://www.law.uh.edu/healthlaw/perspectives/homepage.asp.

[22] 67 FR 61967.