

New SCHIP Prenatal Care Rule Advances Fetal Rights At Low-Income Women's Expense

By Cynthia Dailard

The ink was barely dry on the State Children's Health Insurance Program (SCHIP) before legislators on both sides of the aisle began seeking ways to extend program coverage to pregnant women whose children would be eligible for SCHIP benefits upon birth. With momentum building in Congress in recent years in favor of such proposals, the Bush administration announced in February that it would take steps, in the words of Health and Human Services Secretary Tommy G. Thompson, to "enable states to make immediate use of the extensive funding already available under SCHIP to provide prenatal care for more low-income pregnant women and their babies."

The administration's chosen means to achieve this goal—deeming the fetus an "unborn child" eligible for benefits under the SCHIP law—raised immediate alarm bells within the reproductive health and public health communities about the administration's motivations behind the policy and its impact on the scope of care available to women. By conferring benefits only upon the unborn child, they said, the proposal unnecessarily injects abortion politics into the prenatal care debate in a way that will shortchange pregnant and postpartum women.

Historical Context

Congress enacted SCHIP in 1997 to provide health insurance coverage to the millions of uninsured children in families with incomes above state-set income eligibility ceilings for Medicaid but at or below 200% of the federal poverty level. The statute's

broad parameters allow states considerable latitude to set eligibility standards and to design a package of benefits. Because SCHIP covers children under age 19, the program has enormous potential to bring critical reproductive health services to millions of low-income teenagers, and most states have chosen to cover both family planning and pregnancy-related services in their SCHIP programs ("State CHIP Programs Up and Running, But Enrollment Lags," *TGR*, October 1999, page 6).

While the creation of a health insurance program targeting children made good political sense in an age of incremental health care reform, it also created an unavoidable public

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health problem: Babies who were born to low-income families would be eligible for SCHIP upon birth, but their mothers might not have had adequate prenatal care because their family incomes were not low enough to qualify for Medicaid. The enactment of SCHIP thus renewed attention to low-income women's lack of access to pregnancy-related care in this country. In so doing, it also highlighted that many low-income children—whose health insurance costs would now be borne by federal and state governments—still lacked the healthiest possible start in life.

In response to this dilemma, a diverse and bipartisan group of members of Congress, ranging from Rep. Henry J. Hyde (R-IL) to Rep. Nita M. Lowey (D-NY) and Sen. Jeff Bingaman (D-NM) to Sen. Christopher S. "Kit" Bond (R-MO), introduced several bills designed to amend the SCHIP statute to include coverage for pregnant women. These initiatives built directly on state and federal actions in the 1980s to extend Medicaid coverage to pregnant women whose income exceeded traditional state-determined eligibility ceilings. As did these past expansions, the SCHIP expansion proposals promised to cover women whose newborns would become eligible for the program upon birth. Also following the pattern of the Medicaid expansions, the SCHIP proposals would cover women not only throughout pregnancy but also for 60 days postpartum ("Expanding Eligibility and Improving Outreach Under CHIP," *TGR*, June 2001, page 6).

The Administration Steps In

Given the considerable momentum building in favor of these legislative proposals, it surprised many when Secretary Thompson suddenly announced in February 2002 that the administration would preempt congressional action by publishing a proposed regulation in the *Federal Register* expanding coverage of prenatal care under SCHIP. Equally surprising was the decidedly different tack the administration chose to achieve this goal: deeming a fetus, from conception to birth, to be a child for purposes of interpreting the SCHIP statute.

In soliciting public comments to the proposed rule, Thompson explained that the administration's approach was motivated by the need for a "speedy new [state] option" that would "allow a faster path to providing such coverage" than either waiting for the passage of legislation or requiring states to obtain permission

from the federal government to waive SCHIP rules. The administration, however, had already taken significant steps to simplify and expedite the Medicaid waiver process (“New Medicaid Initiative, State Budget Woes Collide,” *TGR*, October 2002, page 7). Similarly streamlining the SCHIP waiver application process would have provided states with a quick and easy means of extending SCHIP benefits to pregnant women. In fact, New Jersey and Rhode Island already had such waivers, and Colorado now has one as well. Yet the administration rejected such an approach in favor of fetal eligibility.

Significant Implications

The decision to extend SCHIP benefits to fetuses—rather than to the pregnant women carrying them—has significant medical and political implications. By making the fetus the legal beneficiary, the rule limits reimbursement for services during pregnancy to those that directly affect a fetus (see box). As a result, women may not be covered for the full range of medical

services they need during the prenatal period. This contravenes standards of professional medical organizations such as the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), which specify that a pregnant woman and her fetus should be treated together. During labor and delivery, a woman may or may not have coverage for anesthesia to help ease her pain. In all cases, moreover, the woman has no coverage for medical services from the moment the baby is delivered, regardless of her medical condition, and even when she requires immediate life-saving interventions. Her postdelivery hospital stay would also not be covered, even in the event of serious, expensive-to-treat complications.

The rule is clear that women are not covered for any postpartum services “because they are not services for an eligible child.” Yet postpartum care is an integral part of pregnancy-related care. Practice guidelines written jointly by ACOG and AAP recommend that a woman visit her

doctor four to six weeks following a vaginal delivery and sooner in the case of a cesarean section. This clinical examination and counseling session allows a physician to evaluate the woman for complications ranging from infection to postpartum depression; to monitor the woman’s preexisting conditions and those induced by the pregnancy, such as

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diabetes or hypertension; and to discuss topics related to breastfeeding and family planning, among others. Women who lack health insurance during the postpartum period are likely to forgo this important care, according to ACOG, thus further jeopardizing their health.

In short, the SCHIP rule represents a dramatic break from both accepted standards of medical practice and long-standing federal Medicaid policy, which includes coverage for a comprehensive benefits package that treats prenatal care, delivery and postpartum services as a continuum of care. On a practical level, it places health care providers in what may prove to be an untenable position: The failure to follow ethical and professional standards requiring comprehensive care may constitute malpractice, yet rendering uncompensated care, especially during and immediately following delivery, could place them at substantial financial risk. This catch-22 may very well prompt health care providers to decline to treat pregnant women whose fetuses are SCHIP enrollees but who lack their own health insurance coverage.

The administration’s decision to increase access to prenatal care in a manner that fails to provide optimal care to women also strongly suggests

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During pregnancy: “States have the flexibility to define and provide comprehensive services that are related to the pregnancy or to conditions that could complicate the pregnancy....Services related to conditions that could complicate the pregnancy include those for diagnosis or treatment of illnesses or medical conditions that might threaten the carrying of the unborn child to full term or the safe delivery of the unborn child....However, SCHIP eligibility is limited by statute to targeted low-income children and there must be a connection between the benefits provided and the health of the unborn child” (*emphasis added*).

During labor and delivery: “[I]f a woman’s pain during labor and delivery is not reduced or properly relieved, adverse and sometimes disastrous effects can occur for the unborn child. There is no question that analgesia/anesthesia is required in order to perform a C-section and such a procedure cannot even be considered if some form of pain relief is not provided. In terms of vaginal deliveries, without relieving the mother’s pain from uterine contractions, the progress and labor may be interrupted and not efficient, which in turn can cause fetal complications, such as fetal distress and infection from prolonged labor and prolonged rupture of membranes and other complications.”

Following delivery: “[C]are after delivery, such as postpartum services could not be covered...because they are not services for an eligible child.”

that motivations beyond improving the public health are at play. Indeed, by directly conferring federal benefits upon an “unborn child,” the administration’s approach unnecessarily injects abortion politics into the debate. “Although the rule on its face does not change the status of legal abortion,” explains Kate Michelman, president of the National Abortion and Reproductive Rights Action League, “any challenge to *Roe v. Wade* that reaches the Supreme Court will surely contend that an evolving legal trend recognizes fetuses as persons....[T]his new SCHIP rule will be an essential piece of evidence in their argument.”

Damage Control

The administration’s damage control efforts since the rule was finalized in October suggest its discomfort with mounting criticism that the rule shortchanges women and hinders the practice of medicine. In November, it issued a guidance to state Medicaid directors indicating that those states that reimburse health care providers for the traditional package of pregnancy-related services (including prenatal care, delivery and postpartum care) through a single “bundled” payment may continue to do so. Only 28 states provide such a bundled payment, however, and such payments typically cover only “routine” care. Thus, even in those states, women will still be left to foot the bill for serious and costly medical complications.

To further deflect criticism, the administration is actively touting the rule’s alleged advantages, particularly its ability to bring health care to immigrants. Whether by design or as an unintended consequence, the administration’s approach extends SCHIP prenatal care benefits to the fetuses of immigrant women—fetuses that will become U.S. citizens upon birth. Many of the immigrant women carrying these fetuses are barred from receiving public

health benefits in their own right as the result of the 1996 welfare reform law (“Implications for Family Planning of Post-Welfare Reform Insurance Trends,” *TGR*, December 1999, page 6). Explains the administration, “[u]nborn children do not have immigration status as ‘aliens’ and thus are not precluded from receiving Federal means-tested benefits”; thus, states may ensure that prenatal care is “available to benefit unborn children independent of the mother’s eligibility status.”

Lourdes Rivera of the National Health Law Program dubs this a “divide-and-conquer approach,” since public health and immigrants’ advocates have fought tirelessly since 1996 to restore immigrants’ eligibility for public health care benefits—efforts that the administration has otherwise rebuffed. Moreover, Rivera points out that the rule’s promise of bringing prenatal care to immigrants may prove to be an empty one insofar as it explicitly allows states to report pregnant

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immigrant women who apply for prenatal care under SCHIP to the Immigration and Naturalization Service. This will create a powerful disincentive for many immigrant women to seek care, she says.

Finally, the administration also boasts that its approach will allow states to take immediate advantage of \$2.8 billion dollars in unspent SCHIP funds that would otherwise revert to the federal government. (These funds amassed during SCHIP’s early years when states took time to establish and implement their programs.) Yet this supposed

advantage of the administration’s approach also may prove illusory, since only certain states currently enjoy such surpluses. Other states are expected to exhaust their SCHIP allotments and may have difficulty simply maintaining coverage for existing enrollees or be forced to scale back current enrollment efforts.

According to the administration’s own estimate, the number of children insured through SCHIP will fall by 900,000 within the next three years unless Congress passes legislation that will fix this problem. Given the popularity of the program, such action is likely. In fact, immediately following the November elections, Sen. Chuck Grassley (R-IA), the incoming chairman of the Senate Finance Committee, pledged to take up the issue. Whether there is also the political will to revive legislative proposals extending SCHIP coverage to pregnant women is another question entirely. Undoubtedly, this will prove increasingly difficult given the November elections, which not only put Republicans in control of the Senate but also is likely to embolden the administration to pursue its strategy of personifying the fetus in law whenever possible—and thus lay the foundation for eventually overturning *Roe v. Wade*. ☹