

# NATIONAL IMMIGRATION LAW CENTER

## Issue Brief:

### PRENATAL COVERAGE FOR IMMIGRANTS THROUGH THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

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A recent amendment to the Department of Health and Human Services' State Children's Health Insurance Program (SCHIP) regulations enables states to use federal funds to provide prenatal health services to women who are not eligible to receive federal benefits such as Medicaid. These include women who are not "qualified" immigrants, under the 1996 welfare law, as well as qualified immigrants who are subject to a five year 'bar' on federal means tested benefits. The option also extends to low-income women who exceed the income eligibility limits for Medicaid but meet SCHIP's higher income limits.

The amendment achieves this important expansion in a complicated manner, by giving states the option of enrolling fetuses in SCHIP.<sup>1</sup> Thus a fetus, rather than the pregnant woman, is the recipient of SCHIP-funded services. This approach potentially limits the scope of services available to the pregnant woman to those directly related to the health of the fetus.

HHS states that the intent of the rule is to expand the availability of prenatal care, but many advocates are concerned that the regulations may undermine the availability of comprehensive health care for pregnant immigrant women by competing with state-funded programs that cover pregnant women and legislative campaigns to restore (or extend) federal eligibility to pregnant immigrant women.<sup>2</sup> Experience has validated this concern. Michigan, one of the first states to implement the option, narrowed the scope of services previously available through its state-funded prenatal care program when it replaced the program with SCHIP. In contrast, Rhode Island, also an early implementer, is continuing to provide the full scope of services available through its state-funded program by using state-only funds to supplement the services available through SCHIP.

#### Background

SCHIP provides health coverage for uninsured, low-income children whose family income is too high to qualify for Medicaid. Like Medicaid, the program is funded by a combination of state and federal funds, with federal funds provided as a 'match' to state expenditures. States must administer the program in compliance with federal statutes and regulations in order to receive the

<sup>1</sup>State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children, Final Rule, 67 Fed. Reg. 61956 (October 2, 2002), available online at [www.access.gpo.gov/su\\_docs/fedreg/a021002c.html](http://www.access.gpo.gov/su_docs/fedreg/a021002c.html).

<sup>2</sup> For example, the Immigrant Children's Health Improvement Act, HR 1689, S. 845, would give states the option of providing comprehensive Medicaid and SCHIP health coverage to lawfully present pregnant women who are currently barred from receiving benefits because of their immigration status and date of arrival in the U.S.



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federal share of funding. To demonstrate compliance, states must submit a “state plan” describing all aspects of their program for Department of Health and Human Services (HHS) approval on an annual basis. Despite this oversight, SCHIP was designed to give states significant flexibility. States may provide SCHIP by expanding Medicaid eligibility, by operating a separate state-administered program, or through a combination of the two approaches. States have greater discretion in the design and operation of separate state-administered programs, because Medicaid expansions must be operated in compliance with Medicaid statutes and regulations.

Before the amendment, the SCHIP regulations defined a ‘child’ as an individual under age 19. The amendment changed this definition to include, at state option, “the period from conception to birth.” States that wish to extend SCHIP to fetuses must submit a state plan amendment to HHS to exercise the option.

Since the fetus is the SCHIP “recipient,” the immigration status of the pregnant woman is irrelevant to the eligibility determination, as it would be to a parent’s application for SCHIP on behalf of a child. However, as applied by HHS, this “eligible fetus” approach limits the covered services to those connected to the health of the fetus. Therefore, a pregnant woman can receive prenatal care, but would remain uninsured with respect to conditions that do not affect the gestation or delivery of the fetus. Senator Jeff Bingaman has identified these as including “cancer, medical emergencies, accidents, broken bones and mental illness.”<sup>3</sup> HHS’s explanation of the regulations also states that SCHIP would not cover the pregnant women for any postpartum services – she would, in effect, become uninsured at the moment she gives birth. HHS softened its approach in subsequent guidance, authorizing states that usually pay for pregnancy-related services through a bundled payment or global fee method that includes prenatal care, labor and delivery and postpartum care to receive federal reimbursement if they use this method.<sup>4</sup>

States receive a higher percentage of federal matching funds for their participation in SCHIP than for Medicaid. Under rules that prevent states from exploiting SCHIP’s higher match rate by enrolling Medicaid eligible individuals in SCHIP, persons eligible for Medicaid are generally ineligible for the SCHIP program. Anyone applying for SCHIP must first be screened to determine his or her eligibility for Medicaid. HHS has incorporated this “screen and enroll” rule into the amended regulations as a requirement that the pregnant woman must be screened for Medicaid eligibility before enrolling her fetus in SCHIP. Some immigrants who would be eligible to enroll their fetuses in SCHIP could be deterred by the Medicaid application process, which inquires about immigration status and requests a social security number. Agencies responsible for eligibility determinations in states that exercise the option will need to ensure that their screen and enroll procedures are sensitive to the confidentiality concerns of immigrant women, in order to avoid deterring their enrollment.

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<sup>3</sup> Senator Jeff Bingaman (New Mexico), Health Care Issues Release, October 2, 2002.

<sup>4</sup> Center for Medicare and Medicaid Services Center for Medicaid and State Operations letter to State Health Officials SHO #02-004 (November 12, 2002). Available at <http://cms.hhs.gov/states/letters/sho111202.pdf>

## Issues to Consider in Evaluating Whether to Implement the Fetus Option

Whether implementation of the fetus option is good public policy for any particular state depends on a number of factors, including the state's political and economic climate and the existence of other health care resources for not-qualified immigrants. The following list of questions is intended to help state advocates and agencies think about whether pursuing the fetus coverage option is good public policy for their states, and the factors needed to implement the best possible program.

1. *Will implementation undermine existing programs covering pregnant women, or campaigns to establish them?*

Providing prenatal services by making the fetus the eligible entity does not provide comprehensive coverage for needed medical services to the pregnant woman. Therefore, a first step in evaluating whether your state should pursue the fetus coverage option in SCHIP is to determine whether it would undermine existing programs that provide superior coverage. **If your state currently provides prenatal care to qualified immigrants during the five-year bar, “not-qualified” immigrants and/or undocumented immigrants, consider:**

- a. What scope of services is provided? Is post-partum care covered? Do enrolled women receive comprehensive health care or access to services that would be denied under a ‘fetus coverage’ program?
- b. Is the current prenatal program likely to be eliminated, or at risk in the upcoming budget battles, or is it relatively safe? (For example, was it achieved through a public/private process, and are there vested political interests? Are there legal decisions that may require continuation of the program?)
- c. If prenatal services currently provided through another program were moved to SCHIP, would any cost savings be used to provide health or other essential services for low-income residents? How could this be ensured?
- d. If prenatal services currently provided through another program were moved to SCHIP, would funds be available to supplement SCHIP and maintain the current scope of services?

If the state does not currently provide prenatal care to ‘not qualified’ or undocumented women, consider:

- a. Is there a current effort to secure this care outside of SCHIP? How politically viable is the campaign?
- b. Are there other sources of funding that haven't been tapped (e.g. Maternal and Child Health grants, community clinics, state early childhood programs, etc.)?

- c. If the state were to implement fetus coverage through SCHIP, could it be convinced to create a “wrap around” program to provide comprehensive health coverage (including post-partum care) to women ?
  2. *Would implementation of the option undermine other legal rights for women ?*
    - a. How politically vulnerable are reproductive freedom issues in your state ? Does your state protect reproductive rights through constitutional or statutory language? Is implementing the fetus coverage option likely to open a settled issue for debate?
    - b. Could implementing the option affect women’s legal rights to medical services, such as family planning or minor consent services, that are currently available in the state?
    - c. Can the option be implemented without adopting legislative or other official language that identifies a fetus as a child?
  3. *What is the optimal way to exercise the option ?*
    - a. Does the state pay for care through a bundled payment or global fee for services that includes labor and delivery, pain management and post-partum care ? A bundled payment or global fee approach is necessary to obtain federal funding for post-partum care. If not, can this change be accomplished prior to or at the same time as the fetus coverage is implemented?
    - b. HHS requires states simply to submit a state plan amendment to implement the option, but states will need to change administrative procedures for eligibility determinations and other aspects of program operations. Some states also specify program eligibility in their statutes. Can all changes necessary to implement the option be accomplished by the state’s SCHIP agency or would a statutory change be necessary? Even if no statutory change is necessary, would the legislature be required to approve additional funding needed for the program? Could legislative attention to the SCHIP program place the existing scope of coverage at risk?
  4. *Would your state need to change its SCHIP eligibility determination processes to implement the option?*
    - a. How does your state conduct the SCHIP ‘screen and enroll’ procedure? Is a full Medicaid application including questions about immigration status and a requirement to provide the applicant’s social security number (SSN), required? What procedures could your state establish to identify pregnant women who do not meet the immigrant eligibility requirements for Medicaid without discouraging them from seeking SCHIP coverage?
    - b. How does your state determine residency in its SCHIP program? Is residency determined in a flexible manner that is not threatening to “not qualified” or undocumented women?
    - c. Does your state provide retroactivity in SCHIP? HHS permits coverage of fetuses to be retroactive to the time of conception, which provides a means for reimbursement of expenses incurred before SCHIP enrollment.

- d. How does your state enroll eligible newborns in Medicaid? If your state does not provide SCHIP through a Medicaid expansion, will fetuses covered by SCHIP be assessed for Medicaid eligibility at birth?

*5. Other administrative issues to consider*

- a. Who participates in your state's SCHIP provider network? Is there a need to add additional obstetricians and other adult-oriented providers before implementing the option?
- b. HHS has advised states to develop a unique identifier to manage information about fetuses enrolled in the SCHIP program. Does your state's benefit processing system have the capacity to utilize such identifiers?
- c. Does your state's computer system have the capacity to handle negative ages?
- d. Who will be the named insured on the SCHIP benefits card?
- e. Does your state provide 12-month continuous eligibility for children in SCHIP? Can redeterminations be performed prior to the expiration of the 12 months? HHS guidance provides that the 12 month eligibility period begins to run at the time a fetus is enrolled, or if retroactive coverage is provided, at the retroactivity date. Therefore, a family will need to recertify its eligibility for SCHIP within several months after the birth. If your state permits advance or rolling recertification, assisting parents with recertification prior to departure from the hospital could promote retention.
- f. What mechanisms are available to assist a woman whose fetus is enrolled in SCHIP in finding other healthcare resources once the fetus is born?

The decision whether to implement this option thus depends on a number of state-specific factors. These issues should be analyzed and discussed with the groups potentially affected by these changes. Many of these issues arise in the program implementation phase, after a state receives authorization to exercise the option. To ensure that the option is implemented in a manner that protects and promotes the rights of immigrant women, and does not undermine existing rights or services, advocates will need to work closely with the state agency or agencies that administer their Medicaid and SCHIP programs.